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	• Interviews will be completed with older mothers from BME communities to establish what advice and information is passed onto their daughters, nieces and relatives about having a healthy baby. Interviews are to be conducted in Children's Centre's in late summer. • For Quarter 3 the local figures for Smoking at Time of Delivery is at 6.5%, lower than the previous year's prevalence of 8%. • In 2014/15, a total of 76 pregnant smokers were supported over the year.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• The Programme Board have met and work is progressing on agreeing strategic direction and actions across the work streams. • A joint CAMHs action plan was agreed with partners in May 2015. • A new children's asthma pathway has been agreed so that children can receive seamless support across schools, primary and secondary care. • Work has commenced on the development of the urgent care and long term conditions plans following a scoping workshop in June 2015.
	1.1.3 Deliver a mental wellness and resilience	Public Health		The programme of activity includes: • The 'Five Ways to Wellbeing' message is being rolled out to council staff (so far mainly in the library service)

	programme			with training planned from July for Housing staff, NHS staff and residents. • 507 residents have attended Wellbeing community sessions and events across the borough. • Children and Young people's emotional health and wellbeing needs assessment finalised with 74 young people participating directly in the universal/targeted engagement. Data was also drawn from a survey conducted with Year 8 pupils at one secondary school as part of the Healthy Schools Wellbeing Pilot (112 respondents). • The 'Seasons for Growth', loss and bereavement programme maintained in Hillingdon. 33 active schools and 12 Children's Centre staff trained, Training held for 10 further companions to deliver the programme in schools and children's centres. • 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. • From April-June 2015, there have been two wellbeing days; one during Dementia Awareness Week aimed at older people living with dementia and one 'Eating Well Event' for older people aimed to give information and advice on eating and diabetes, food and dementia and food and dental health. • Since April there have been three Tea Dances with a total of 376 people taking part.
	1.1.4 Deliver a smoking cessation service including supporting the further roll	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

	out of Smoke Free Homes in Hillingdon			quit) - with a rate of 57.5%. • The service reported 1048 successful quitters to HSCIC for 2014/15, an improvement on the previous year of1039. • Prevalence is estimated to be 16.5%, a significant drop on previous year. • During Stoptober, there were approximately 1050 sign ups from residents. This was the third highest sign up to the campaign in London. • No Smoking Day saw activity across supermarkets, Hospital, local colleges and the Pavilions. Over 100 residents were met on the day with a further 80 young people, the majority of whom were smokers receiving Carbon Monoxide testing and prevention messages.
	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 (CSPAN) & Obesity Strategy Working Group	Quarterly	• The overall proportion of children carrying excess weight (overweight + obese) in Reception and Year 6 seems to be stabilising. Although slight increase in the Reception Year obesity rate (9.4% to 10.1%) points to a need for maintaining focus on prevention through early years (despite this increase being similar to the increase in the national average) • Public Health and Early Years Group has plans for improving diets and reducing inactivity levels in families with young children. • The Physical Activity Needs Assessment has been completed and agreed. • A workplace physical activity programme for the council and other large organisations in the borough e.g. THH, Coca Cola, Glaxo, focussing on walking and reducing sedentary behaviour has been agreed by the Cabinet Member responsible for Health. Workplace

				packs are being developed to include advice on walking meetings, standing, stair use, use of pedometers etc. • The adult CSPAN group will be working with the Occupational Health team at Hillingdon Hospital on how to promote workplace physical activity. • In response to requests from The Orchard Practice on how to engage the Somali community in physical activity, a programme has been developed and shared. A meeting is scheduled for the 15 July with the lead GP and members of the Somali community. • The programme of activity includes: o Universal led walks programme and targeted programme in Children Centres o All Hillingdon Children's Centres are joining maternity and health visiting teams to achieve 'Baby Friendly Initiative' status. o Universal healthy lifestyle programme for families with children aged 2-4 years. o Healthy Early Years accreditation for early years settings, e.g. children's centres, nurseries. 6 settings have achieved healthy status under this new scheme. o Lifestyle weight management programme for families with children aged 5-7 years and 7-13 years. A locally designed lifestyle change programmes for teenage children o A new Pharmacy based 12 week multi-component weight management programme (Weight Action Hillingdon) to be piloted from July for adults aged 18+

				○ The 'Ready Steady Groove' programme across the children's centres of which 373 adults have taken part with 76% showing an increase in fitness levels and 69% self reported an increase in the recognition that physical activity is important for their family. ○ 6 early years settings have achieved the new 'Hillingdon Healthy Early Years Award' which has aspects of food and physical activity moderation. ○ 197 Parent Physical activity bags loaned through children's centres to promote families being active.
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	• Of the 5,393 adults with a learning disability (2015 PANSI predictions from 2011 Census), at the end of 2014/15 there were 473 in receipt of long term services provided by Adult Social Care and of these 2.1% are in paid employment. This is a slight increase on the position at the end of 2013/14 of 1.4%. • To end April 2015, 3 service users have received payment for the UPWARD presentation given at St Andrew's school. • Queens Walk Resource Centre staff are exploring work experience development opportunities within the service to develop people's skills. • Service users will be having a yearly review of their support plans to ensure work and education opportunities are discussed and included where appropriate. From these, review goals for the coming year will be identified and plans put in place to support individuals to achieve their aims and aspirations to

				access work, whether it be paid/ unpaid and education to increase their skills. • An open day will be also be facilitated at Queens Walk to support the provision of enrolment of college courses. This is expected to help increase uptake. • 'Project Search' an initiative to give young people with a learning disability the skills to gain competitive paid employment, is being implemented from September 2015. This has approx 60% success rate in securing paid employment as a result of the programme. A further 'Project Search' site is planned for September 2016. • The Rural Activities Garden Centre continues to support adults with learning disabilities, many of whom now access the RAGC on a voluntary basis and there are constant requests from people trying to access the RAGC, either to volunteer or for work experience. • Since April 2015 3 young adults with learning disabilities have accessed the RAGC. The aim is for the young adults to gain skills, experience, and knowledge and to build confidence. It is hoped that this will give opportunity for the young adults to gain employment.
1.3 Develop Hillingdon as an autism friendly borough	1.3.1 Develop and implement an all age autism strategy	LBH	Quarterly	• An Autism Partnership Board has been established and will take responsibility for overseeing the completion of the Autism Strategy. • The strategy is being developed but more work is required prior to sign off.

Appendix A

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	• In Q4 the CCG approved a business case to secure additional consultant geriatrician capacity to support the management of the needs of frail older residents in the community. Hillingdon Hospital is now in the process of recruiting to this post. It is likely to be late autumn before the recruitment process is completed. • It was mutually agreed between the Council and the CCG that direct referrals from Reablement to Rapid Response would be inappropriate due to clinical risk issues, e.g. staff being qualified to identify when a resident is suitable for a referral to Rapid Response rather than to A & E. Reablement will either refer people to the appropriate GP practice or to A & E depending on the nature of the problem faced by the resident. • 5 beds were commissioned in Franklin House to support residents who are likely to be non-weight bearing for at least 3 weeks. In-reach is provided from the Community Rehab Team to support them with the intention of them either going home or to the Hawthorn Intermediate Care Unit (HICU). This new service helps to avoid hospital admission or an increased length of stay in hospital.

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 2014/15, 9,351 Hillingdon residents received a first offer of an NHS Health Check and, of these, 6,547 people went on to receive an assessment. This is an increase on the previous year's performance by 858 residents. • Take up rate was 70% which is ahead of the 66% target. • The local EMIS (GP data system) support is no longer in place which may affect quality of future returns. • In May, 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 in Community Pharmacies:</u> Two new Community Pharmacists have been trained which adds to the complement of existing providers. Brunel University continues to be the location with the highest level of activity, followed by Boots in Uxbridge. Regular

				training continues for Pharmacists as part of the wider public health offer. Next training session due 29th June 2015. • The new data system for recording activity and raising payments went live on the 1st May 2015, this will enable robust monitoring of activity and claims. • Chlamydia Screening: 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. No new data available – the 2013 data remains the latest data reported.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• The final Ebola top line brief was issued in April 2015. Should the situation deteriorate, the Cabinet Office may restart the briefings. • The National Heatwave Plan for England 2015 was published in May 2015. The Met Office will issue Heatwave Alerts from 1 June to 15 September 2015. The Plan is a key component of emergency planning. It provides advice for professionals, organisations to enable them to plan for and respond to heatwaves. It contains advice for local authorities, including Directors of Housing and Planning, Adult Social Services and Children Social Services. The Plan has been disseminated to the aforementioned directors

2.3 Prevent premature mortality	2.3.1 Ensure effective secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia	CCG	Quarterly	• Having undertaken a review of the current state of Risk Stratified Cancer Pathways at THH and discovered that Hillingdon is already doing well in this area, the CCG is under-taking research into how we might support patients with Cancer in other areas. • The first phase of the diabetes project has been successfully implemented (movement of patients from secondary care to community and primary care). The second phase of this project consists of the development of an Integrated Diabetes Service. The service has been designed through collaboration of hospital, community and primary care clinicians and managers. The business case is expected to complete CCG governance processes in August 2015 with the new service live in quarter 4 of 2015/16. • The first phase of the cardiology project has been successfully implemented (includes direct access by GPs to key diagnostic tests at The Hillingdon Hospital and Harefield Hospital. The second phase consists of the development of an integrated service with a particular focus on heart failure and cardia rehabilitation. Collaboration with The Hillingdon Hospital, the Royal Brompton, CNWL and Public Health have led to the development of an Integrated Cardiology Service that is due to receive final approval in July with the service starting in October 2015. • The Integrated Service for Respiratory Care has been approved and work has commenced on

				mobilisation of the scheme with the service expected to be in place by September 2015.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• Reducing the levels of overweight and obesity in Hillingdon through the introduction of Adults Weight Management Care Pathway which will be approved in July 2015 and is designed to support a reduction in levels of obesity in Hillingdon. • Increasing the levels of Physical Activity in the borough amongst those suffering from chronic conditions is being taken forward through the inclusion of 'Let's get Moving' programme in disease care pathways. From October 2014, when the programme started, until mid June 2015, there were 142 referrals made by health professionals with a 68% uptake in having an initial assessment, with 55% going on to complete a 12 week fitness programme. • Alcohol Misuse (a) A question on alcohol use has been included in the NHS Health Checks (b) Substance Misuse: An outcome based service model with greater levels of integration, based on all levels of need, has been commissioned. The new service will 'go live' on 1st August 2015.
	2.3.3 Reduce excess winter deaths	Public Health/NHS England		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 is working with the council to provide 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		• NHS England and Hillingdon Public Health Team are working on a joint project to improve access to preventative dental care in Hillingdon. As part of this initiative o Publicity events were held in The Pavillions shopping centre during March which targeted young families (over 3,900 people) to encourage registration of children with an NHS dentist; o Two new dental practices to be commissioned in Hillingdon o Schools Project will be delivered in Autumn where dentists will deliver fluoride varnish in 10 schools in Hillingdon identified as 'high

				need' • The Policy and Overview Committee for Internal Services conducted a review of dental services for children 0-5. Members considered the report and made a recommendation for the outcomes of the above project to be reviewed by the Health and Wellbeing Board in 2016. • A protocol has been developed with Children's Centres detailing the delivery of a brief intervention on 'Brush for Life' as part of the new parent registration to ensure full coverage of all new families. This is an addition to group sessions and special events and a targeted drop-in by the CDS in 3 Children's Centres.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• 19 May 2015, in partnership with the Alzheimer's Society, the council launched the 'Hillingdon Dementia Action Alliance', part of a National campaign, the aim of which is to act as a vehicle for Hillingdon to becoming a dementia friendly borough. • 12 organisations have committed to three actions each which promote awareness of dementia, include training for their staff and working towards developing dementia friendly environments. • Part of this commitment is the delivery of the 'Dementia Friends Scheme' which continues to be very popular. From April to June 2015, over 100 people have attending the training, including staff from the council and the Pavillions shopping centre as well as Uxbridge College students and care home staff. • A weekly 'Friends Coffee Morning' in Uxbridge

				library was launched as part of Dementia Awareness Week, offering support and activities for people in the early stages of dementia and their families. So far a total of 36 people have taken part with several referrals being made to the Alzheimer Society which have led to home visits. Many of the people taking part had not had any contact with services so far. • The Drummunity project continues to enable older people with dementia to take part in an activity which allows them to communicate creatively, work on their short term memory skills, increase relaxation and develop strength and coordination.
	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 mental health urgent care pathway. It will be taken to the August Governing Body for approval. • 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. CNWL is recruiting additional substantive staff to expand the service to ensure 15% access target is maintained throughout 2015/16. • 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	• The Vision Needs Assessment is being reviewed to include further local information which will inform the strategic plan.
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 have been changes to the way that the NEET service is provided by the Local Authority. The newly formed participation team now wraps school attendance and subsequent EET work into one function, thereby promoting the concept of early intervention for Not in EET (NEET) outcomes and seamless provision for children from the age of 5 to 18 (25 with SEND). • There are now regular drop ins at the Civic Centre for young people to receive information and advice, with sessions at Fountains Mill and Harlington Young People's Centre available by appointment.

				• During the school holidays this summer, the whole of the key working service will focus on the existing NEET cohort to ensure there is something in place for them in September. • 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. • Current in year data to end April 2015, shows that the number of 16-18 year old NEETs is 258 young people or 2.6%, a -10.3% change over the last 12 months.

Appendix A

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 proposal has been developed by the local third sector consortium Hillingdon4All (H4A) for a Health and Wellbeing Gateway which would be the referral point for residents identified as being at risk of falls, dementia and/or social isolation. A funding decision on the proposal is expected from HCCG in July. • Pending the outcome of this funding decision training will be provided in Q3 with the intention of empowering key staff who visit people in their homes to identify risks and make appropriate referrals. This is intended to assist in improving the wellbeing of residents by preventing or delaying a loss of independence. • Part of the H4A proposal includes the use of an assessment tool that looks at how motivated residents are to manage their own health and wellbeing. People who are less motivated run a high risk of escalating needs and would be provided with higher levels of support to prevent this.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• A mapping exercise of services available to people at the end of their life is currently in progress and gaps will be reported to the End of Life Forum in July. • Adult Social Care has put specialist care arrangements in place with a third sector provider to

				address the care needs of people at end of life. This service will be reviewed later in 2015/16 and longer term service provision options to meet the needs of people at end of life in all parts of the borough will be considered by the Council in Q4.
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	• 7-day working priorities were agreed and these include: - earlier in the day confirmation of a package of care being identified; - GP practice cover; - being able to discharge to nursing care homes on a Saturday and Sunday; - being able to discharge patients with wound care needs following planned hospital procedures. • Approval was given by the Council and the CCG to establish an integrated appraisal team comprising of social work, Hospital and CCG staff. This team will be working in the Acute Medical Unit (AMU) at the Hospital to speed up the discharge process. This team will be operational by October 2015.
	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• Medical support for care homes is being considered by individual GP networks. Exactly what this will look like across the borough will vary from network to network, depending on the number of care homes within the respective network. Current models of support will be evaluated in July to inform discussions with the networks in Q3. • Most actions within the scope of this scheme have now been completed including implementation of community matron support to selected care homes.

	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• The Integrated Care Programme (ICP) has been procured from all four GP networks and service will be live from 1st July. • Work on developing a care planning template, running multi-disciplinary team (MDTs) meetings to consider complex cases and secure better outcomes for residents has continued Q1. This is an iterative process and will develop as more practical experience is gained. • This activity is supported by work that is in progress to join up IT systems to share information and limit the number of times residents have to tell their story. This work is also intended to free up staff capacity to provide better care and support. All partners across the system are proactively engaged in this work.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• From April 2014 to March 2015 a total of 223 homes had adaptations completed to enable disabled occupants to continue to live at home. This includes adaptations to the homes of 140 older people, of which 82 were in the private sector. • From 1 April 2015 to 30 June 2015, a total of 146 homes have had adaptations completed which includes adaptations to the homes of 91 older people, of which 42 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 end April 2015, 4,144 service users were in receipt of a TeleCareLine equipment service, of which 3,192 people were aged 80 years or older. There have been 108 new service users in the month of April 2015.

3.3 Implement requirements of the Care Act 2014	3.3.1 Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• Connect to Support Hillingdon launched on 1st April 2015 with information/advice and the marketplace. On-line assessments will go live in Q2 2015, there is a comprehensive communications plan in place to promote the site to staff, residents and providers and to continue developing the content.
	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH/CCG	Biennially	• Council Cabinet and the HCCG Governing Body approved the new Carers Strategy in April 2015. • Detail in the Delivery Plan has been finalised with task and finish working groups being set up to deliver on actions. • The Delivery Plan will be monitored on a quarterly basis with the first update being taken to the Carers Strategy Group in July. • Updates will be provided to Council Cabinet and HCCG Governing Body in November.
	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	LBH/CCG	Quarterly	• The number of private and voluntary sector providers registered on the resident portal Connect to Support increased from 85 at 31/03/15 to 135 at 17/06/15. • Connect to Support was launched on the 1st April with the completed information and advice pages. • Work was undertaken to develop an online social care and financial assessment facility on Connect to Support. This will go live on the 30th June 2015. An online assessment facility for carers will go live at the end of July. • A contract with Hillingdon Carers for them to complete carers' assessments on behalf of the Council in compliance with Care Act requirements was put in place.

	information, advice and advocacy to residents; d) ensuring market oversight and diversity of provision; and e) strengthening the approach to safeguarding adults.			• Staff training on new policies and procedures continued, including tailored sessions for mental health staff. Training will continue until the end of June 2015. • A new independent chairman for the statutory Adults' Safeguarding Board was appointed.
	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 in the final stages of approval and engagement has started with selected providers.
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. There are approx 170 EHC Plans in place. • The Local Offer was published in September 2014 and ongoing development work is taking place. Full consultation will take place in July with comments and feedback being published by 31st August in line with requirements. A full launch will take place in September 2015. • 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.
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. • Pentland Fields School opened in January and will take additional children from September. Three specialist resource provisions (SRPs) - one already open with two to follow - are in place to increase the capacity for children with autism and complex needs. One secondary SRP is expanding in September and another is widening its remit. • A new SEND banded funding model is in place for education settings in relation to funding for children with Statements or Education, Health and Care Plans. SRPs now have service level agreements and new admission criteria. • The number of children with SEND attending independent and non-maintained schools has decreased from 145 in 2014 to 130, thus reducing our reliance on out of area schools.
	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	**3.5.1** Provide extra care and supported accommodation to reduce reliance on residential care	LBH	Quarterly	• Sessile Court opened in mid March. To date, all units are taken, with the majority of placements stepping down from higher need settings. The 6 week placement review showed the majority of placements are progressing well.

by developing extra care and supported housing as an alternative to residential and nursing care				• The two LD schemes, Church Road (6 units) and Honeycroft Hill (16 units) are expected to open early August and December 2015 respectively.

Appendix A

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	• Six awareness raising events took place for GPs, GP practice staff and clinical staff at Hillingdon Hospital about the BCF and the Integration Programme in Hillingdon. • A new communications plan will be developed in Q1 to engage residents and other stakeholders in shaping the next stage of integration in Hillingdon. This will be delivered in Q2 and Q3 and will help to inform recommendations for consideration by the Council and HCCG.
	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	• The Council will undertake a survey in Q3 2015/16 to test improvements against the results of the 2014 Carers Survey. This will provide an opportunity to ask additional questions suggested by partners such as Healthwatch.

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 with ' Headliners' resulted in a film being produced with children, young people and their families. An initial screening has taken place and a workshop to build on the actions and develop a model for ongoing, meaningful participation has been set up. • CYP with SEND have been involved in the development of information for their peers in relation to Preparation for Adulthood. • Short films, with CYP, are being planned explaining various key points of the SEND Reforms to support and enrich the Local Offer.