Appendix A Health and Wellbeing Strategy Delivery Plan Update

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 residents' 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	Wellbeing Service, Public Health & Maternity Services	Annually	• The Public Health and Early Years Partnership Group is currently reviewing its 2014-16 action plan and will be setting targets for the next 2 years against key priorities of Obesity, Mental Health and Oral health. • A new programme primarily to engage over-weight pregnant women in ante-natal exercise started during the summer. This will progress into a post natal session being held at the same time to allow more women to attend a session. • Targeted action will continue to train all health care professionals who come into contact with pregnant smokers to refer to services, working closely with pharmacies and use screening to increase impact and engagement in quit smoking programmes. • To end December 2015, the local value was at 8.0% compared with national 12% of women who keep on smoking throughout pregnancy. Total number of women referred into the service from April to December 2105 was 129 with 55 engaged in service and 19 quitting.

	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 that reports to the Children's Health Partnership and the MH Transformation Board, have met to progress work on agreeing strategic direction and actions across the work streams. • A new children's asthma pathway has been agreed so that children can receive seamless support across schools, primary and secondary care. • A review of clinical guidelines for Ambulatory Care is being undertaken. • Acute Care standards for Children and Young People are currently under review, and once completed will be incorporated into the Hillingdon Hospital Trust Contract for 2016/17
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• Singing For Wellbeing sessions are now run every other week at Uxbridge Library as part of the Dementia Friends Coffee Morning ten people attend. • A series of wellbeing events took place with West Drayton Community Centre and included a general wellbeing day for older people, a tea dance, a line dance for 60 people and then three events aimed at people who are housebound and/or living with dementia. • A total of 1112 people have attended the 8 dances since April 2015. Feedback from the Tea Dances continues to be positive with older people stating

				that the dances encourage them to be more active, make friends and feel less lonely. The Mayor's Christmas Tea Dance which was funded this year by the Leader's Initiative was a great success with 195 people attending. • A Suicide Audit from 55 coroners' files has been completed with recommendations informing the Suicide Prevention Needs Assessment.
	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 (age 18+) rate is estimated to have increased from 16.2% to 17.1% compared with the England average of 18%. • Hillingdon Stop Smoking Service performs well in terms of its quit rate i.e. smokers who join the service have the best chance in London to quit (one of the top 10). • The Smoking cessation target is 1055 quitters. Between April 2015 and September 2015, 838 residents were recruited and helped 423 residents to quit through the support of GP's, Pharmacies and specialist advisors. • The national Stoptober campaign has been used to increase quit rates - Promotions were set up at shopping centres, supermarkets (Tesco / Sainsbury), the Hillingdon hospital, libraries, and Riverside mental health centre. Uptake was good with referrals being made to GP's, Pharmacies and local clinics set by the stop smoking service.

				• A workshop was delivered with CNWL to publicise quit smoking initiatives in mental health settings. CNWL have implemented a smokefree policy across all treatment settings. • Since April 2015, Level 2 smoking cessation training has been provided on three separate occasions to a total of over 60 healthcare professionals within Hillingdon. Qualification has increased the capacity to provide support to local residents who wish to quit. • Over 60 Pharmacists trained to prescribe stop smoking medication. 45 out of 62 Pharmacies deliver this service within the borough. Almost all of the Hillingdon Pharmacies provide COPD screening to patients accessing the stop smoking service. • Specialist advisors were trained to deliver Nicotine Replacement Therapy directly to the patient. A patient search in GP Practices was completed to engage with the smoking population of that surgery.
	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	Wellbeing Service	Quarterly	• The children's weight management programme is being delivered across 3 localities and for ages 2-4, 5-7, 7-13 and 13+ with a new cohort having started in Jan 2016. • Back to Sport is aimed at encouraging adults to participate in playing sport again or for the first time in an informal and fun way. In Q3, 302 adults with a total throughput of 2416 have taken part in the programme in a variety of activities including chair based exercise classes, free jogging sessions and

				tennis classes. This also includes 45 people that have taken part in the cycle loan scheme. • As a follow on to the Council's successful weight management programme for staff, messages relating to healthy eating and physical activity and are now available on Horizon. • The council continues to deliver the 'Walks Scheme' with 2,480 attendances and 65 new walkers. 19 people have been trained as walk leaders including staff from extra care schemes, volunteers and staff from a Children Centre, park officers and local residents. • Physical activity sessions are now taking place that supplement the Get Up and Go programme delivered by CNWL and the Sports Team for overweight women. • The x12 week Fit Teen courses aimed at over-weight teenagers has been developed further into an in-house session at four schools. 48 teenagers are estimated to attend. • As part of the 'Ready Steady Groove' programme, each Children's Centre delivers parent physical activity sessions with crèche care, that run for 45 minutes on a weekly basis. • As part of the 'Mother and Daughter Session' Programme, 18 free exercise sessions spread across the borough will be delivered over a 10 week period. As at 22 January 2016 just over 500 bookings have been made with additional provision

				established to meet demand.
	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The GLA will be publishing the 'London Local Air Quality Management' report by the end of January 2016 which includes guidance for LA's on how they will be obliged to carry out their local air quality management duties. This will include when and how to review air quality action plans. Hillingdon will respond to the Guidance consultation and will start the review of the action plan process when the Guidance is finalised. • With regards enforcement, in Heathrow Villages ward there is a Public Spaces Protection Order which makes it a condition not to leave the engine idling in a stationary vehicle. This is aimed mainly at private hire minicab vehicles where the drivers habitually leave engines on to power heaters, air conditioning and even to charge mobile phones. Fixed Penalty Notices of £80 have been issued in Heathrow Villages for breaching this condition, however at present this type of enforcement is only possible within this ward as it is the boundary of the PSPO area. • In order to make enforcement possible borough-wide, an amendment to the council's enforcement policy is being considered to enable officers to issue FPNs for an offence under the Road Traffic (Vehicle Emissions) Fixed Penalty Regulations 2002.
1.2 Support adults with learning	**1.2.1** Increase the number of adults with a Learning	LBH	Quarterly	• To end of December 2015, the % of people with a learning disability in receipt of long term services

disabilities to lead healthy and fulfilling lives	Disability in paid employment			provided by Adult Social Care in paid employment was 2.4%. • Service users are being supported to explore how they will access employment and education opportunities and individuals support plans are being revised to reflect this. • Work experience duties at Queen's Walk continue and include kitchen and reception tasks. Service users have shown an interest in these and during Q3, 20 service users have undertaken unpaid work experience. 2 service users from Supported housing services also volunteer at the Rural Activities Garden Centre. • Early Intervention & Prevention services are also feeding into the Disability Services Employment Project being led by All Age Disabilities team. College courses are being facilitated by Adult Education at Queens Walk in cookery and music. 9 service users have accessed these courses in Q3. 3 service users from Supported housing services have enrolled and accessed college courses in cooking, Dance/ Fitness and Independent Living Skills. • The Rural Activities Garden Centre sold approximately 150 Christmas trees plus wreaths and Christmas items in December with the gardeners helping to set up and sell products at a

				number of plant and craft sales. • The autumn months were busy with raking up leaves and making the site look tidy for winter and included pruning and painting all outside buildings with wood preservative. The centre continues to get new referrals and two new gardeners started recently with different abilities.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• The Autism Partnership Board met in September and agreed an initial work plan to achieve completion of the Autism Plan. • A forum is being established for people with autism to ensure their feedback is central to the work of the Partnership Board which includes providing input to the Plan. A final version is scheduled for July 2016.
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	• During Q3 the Reablement Team received 332 referrals and of these 95 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 151 people were discharged from Reablement with no on-going social care needs.

				• In Q3 the Rapid Response Team received 918 referrals, 56% (513) of which came from Hillingdon Hospital, 18% (169) from GPs, 11% (105) from community services such as District Nursing and the remaining 15% (131) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 513 referrals received from Hillingdon Hospital, 432 (84%) were discharged with Rapid Response input, 14.5% following assessment were not medically cleared for discharge and 8 (1.5%) were either out of area or inappropriate referrals. All 405 people referred from the community source received input from the Rapid Response Team. • The HomeSafe service providing early supported discharge for residents aged 65 years and over from Hillingdon Hospital has been further developed during 2015/16 with the full service being provided from the specialty wards as well as the Acute Medical Unit (AMU) and the capacity of the community based services correspondingly increased. The service is on track to deliver the targeted increase in the average number of patients being discharged per day from 5.5 to 7.5 by the end of March 2016.
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.

				• In 2015/16, 72,893 Hillingdon residents and people registered with Hillingdon GPs are eligible for the NHS Health Check programme. Of these, 14,579 (20%) people should receive their First Offer (in five years) of a Check. The Check take-up rate should gradually be moving towards 75%. In 2014/15, the take-up rate was 69%, therefore Hillingdon should be aiming to carry out at least 10,060 (13.8%) checks during 2015/16. • The mid-year position as reported to Public Health England (PHE) at the end of Quarter 2 was 73% and is now much closely to the target of 75%. Quarter 3 data are in the process of being collected and the PHE submission is due at the end of January. The following targeted action has been taken to increase take-up rates of health checks: • Two NHS Health Check training sessions held for practice and pharmacy staff attended by 44 people • 10 visits to support practices and pharmacies • Four presentations made to practice and pharmacy staff at Public Health 'Top Up' sessions • NHS Health Checks provided at six community events including health and wellbeing days at Hayes Islamic Centre, Uxbridge Police Station and at Hayes & Harlington Community Centre for Hillingdon Carers. • An Annual Outcomes report for practices to identify the number of patients diagnosed with impaired

				glucose tolerance, impaired fasting glycaemia, diabetes, chronic kidney disease, hypertension and familial hypercholesterolaemia following their NHS Health Check is in development.
	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• As part of the Sexual Health Needs Assessment a "client survey" (all ages) has been conducted. The outputs from the survey are currently being analysed and will be used to inform the assessment of need for sexual health services for Hillingdon residents. • The service specification for the provision of HIV Support Services to Hillingdon residents is being developed. • A number of focus groups have been held in Children Centres to obtain the views of parents with young children regarding their contraception, sexual and reproductive health needs including the accessibility, appropriateness and acceptability of existing current services.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• Seasonal Flu: Winter packs for schools and care homes were sent out in September 2015.
2.3 Prevent premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term	CCG	Quarterly	• The HCCG Governing Body signed off a business case in September 2015 to change the current service model to an Integrated Diabetes Service by entering into an alliance through contract variation

	Conditions including cancer, diabetes and dementia			with existing providers. **Project Progress** The Project Steering group has been formed in order to mobilise plans for the new integrated service. Key progress includes: – Education and training delivery plan complete for primary care readiness 2016/17 – Contract response letter received from Providers 24th December 2016 stating lead provider will be CNWLFT – Contract readiness meeting set 15th January 2016 – Diabetes Primary Care Contract 2016/17 draft ready for HCCG governance sign off including Prevention component for PreDiabetes identification and review – Updated Hillingdon Diabetes Guidelines drafted for February 2016 QSRC sign off – Workforce skills mapping questionnaire and mapping work commenced • The first phase of the cardiology project has been successfully implemented which includes direct access by GPs to key diagnostic tests at The Hillingdon Hospital and Harefield Hospital. The 5 pathways and dyslipidaemia guidance to identify patients at risk of developing cardiovascular disease and to enable earlier diagnosis to prevent premature mortality. • The second phase consists of the development of

				an integrated service with a particular focus on heart failure and cardiac rehabilitation to ensure that heart failure patients have support to manage their condition better. • The third phase will focus on atrial fibrillation (AF) to identify patients not prescribed anticoagulants or not receiving optimal drug therapy. An opportunistic screening programme through the flu clinics is proposed to identify patients >65 with AF especially those that are asymptomatic. Improving diagnosis and drug management of AF patients will reduce mortality rates of this patient cohort from stroke • The Integrated Service for Respiratory Care has also been approved and work has commenced on mobilisation of the scheme with the service expected to be in place in April 2016. • A Long Term Conditions Transformation Group overseeing all the CCG's workstreams on LTC has now been established and a new GP lead is being appointed.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• 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. Jan - Dec 2015, there were 253 referrals made by health professionals that are on the programme with a throughput of 8482. Those that have completed the 12 week programme have indicated that 97% achieved some or all of their goals, 79% have seen a reduction in their BMI and

				71% have increased their physical activity levels. • 6 sessions have taken place with CCG during October and November targeted at BME communities to promote the importance of healthy lifestyle in relation to high blood pressure, high cholesterol and diabetes. 21 referrals were made to weight action, Let's Get Moving and Stop Smoking. A pathway has been designed with local physiotherapists for stroke victims so they can take part in structured activity in a safe and appropriate setting. • Primary care prevention - HCCG are currently reviewing good practice and research from elsewhere with a view to drawing up a prevention plan for primary care. Unlikely to be commissioning additional services by 1st April but as soon as possible in the new financial year once any business case has been signed off.
	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. • Age UK Hillingdon 'Getting ready for Winter'

				campaign. • The council also continues to provide the Heater Loan Service for homeowners over 65 whose heating breaks down. Since October 2015, 7 residents have been provided with heaters over the winter months.
	2.3.4 Reduce the number of children with one or more decayed, missing or filled teeth	Public Health & NHS England		• NHS England and Public Health Team are working on a joint project to improve access to preventative dental care in Hillingdon. • As part of this initiative the Schools Project has recruited 10 schools and 7 dental practices where dentists will deliver fluoride varnish to pupils. This has so far reached approximately 3700 pupils age 4-7 with over 3000 students in Key Stage One planned for Feb - April 2016. • The Brush for Life protocol has been revised with Childrens centres and the Community dental Service, detailing the training, targeting, evaluation and monitoring of the brief intervention they make with the families registering.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Since April 2015 there have been three Alliance meetings. There are currently 13 organisations across Hillingdon who have joined the Alliance with another four due to come on board. So far there have been some real successes like the training of over 1700 dementia friends in Hillingdon and the development of a "Missing Person's Grab Pack"

				with the Police. • The Dementia Coffee Mornings continue to be popular with between 7-10 people regularly attending. The sessions have included talks from the fire brigade and local police cadets on home safety. Feedback from residents has been very positive; they like the venue, staff and appreciate that it is free. • 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. Sessions began at the Alzheimer Society on the 11th September and ten service users regularly attend. • Hillingdon CCG Governing Body approved a Business Case to provide additional investment into Memory Assessment Services to reduce waiting times and increase capacity for ongoing support
	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 approved to develop a single point of access in the mental health urgent care pathway for Adults. The service has been operational from 2nd November 2015. In addition the home Treatment Team now operates out of hours with two members of staff on duty. • 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 and 16/17.The Access target has been met for the first two quarters of 2015/16 and the Recovery target has now been achieved in October and November 2015. • The Children's Emotional Health & Wellbeing Board has been established to oversee the Hillingdon Transformation Plan and Implementation Plan and the NHSE/DH Local Transformation Plan, the latter of which has additional funding for five years to transform CAMHs. The additional funding will be used to develop the following: o A CAMHs self-harm, crisis and intensive support Team. o Specialist Mental Health provision for Children and young People with Learning Disability and Challenging Behaviour Team, with an integrated pathway with LBH Disability Team. o A Community Eating Disorder Service. o Additional resources to reduce waiting times for treatment. • A Business Case to develop a CAMHS Deliberate Self-harm Team has been approved at the HCCG Governing Body in November 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. A Business Case has been approved by Hillingdon CCG Governing Body to further enhance this service with the continuation of the Mental Health Assessment Lounge as a separate facility from Accident and Emergency department
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• Approval of The Vision Strategy will first be sought through Adult Social Care this month and then HCCG with final approval to the H&W Board.
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	• The changes in approach previously reported continue to embed. The Participation Team has been recruited to and is now at full strength. • There are regular drop in's 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. These arrangements have proved to be popular and adequate for young people and will continue. • Current in year data to end November 2015 shows that the number of 16-19 year old NEETs is 205 young people or 2.7% representing an improvement of 3.6%. In Hillingdon, 7142 young people 16-19 are in further or higher education representing 70.8%. • The tracking of young people to verify their current activity remains ongoing.

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	• The mobilisation for the H4All Health and Wellbeing Gateway pilot started following funding approval by the CCG. The service is due to become operational borough-wide during March 2016. • A new fracture liaison nurse based at Hillingdon Hospital started in December. This post will support people who have attended hospital for the first time with low level fractures, e.g. people who may have fallen from standing height or less, and may be living with osteoporosis (bone thinning).
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• A market testing exercise for the end of life services funded by the CCG, e.g. palliative beds, night sitting, etc, took place and showed that there was limited provider interest in delivering these services. The available options are currently under consideration with the objective of reducing fragmentation and improving the experience of care for people at end of life to support the concept of a 'good death'. Proposals for improving end of life care are included within the draft 2016/17 BCF plan which is subject to Board approval.
3.2 Deliver the BCF Workstreams 3 & 4 - Seven day working	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• The comparison in discharge activity at Hillingdon Hospital in Q1 - 3 2014/15 and 2015/16 shows similar discharge patterns for people who have been

and Seamless Community Services				admitted for planned (also known as elective) procedures and unplanned (or non-elective) procedures in both years, e.g. an uneven distribution across the week. Actions that have taken place in Q3 that will help to address this include: o Consultant cover being available over the weekend for a 12 hour period. o The Hawthorn Intermediate Care Unit being able to admit people seven days a week, including people with mental health needs. o The CCG increased funding to CNWL's Tissue Viability Service to support the provision of Vacuum-assisted closure (VAC), which is a specialist therapy for the management of large, complex wounds, as well as chronic wounds that have failed to heal by conventional methods. This therapy was previously available to prevent admission and not to aid discharge and this anomaly has now been addressed. The numbers involved are small but the absence of appropriate treatment in the community can lead to long lengths of stay in hospital. o The CCG also increased the capacity of CNWL's Ambulatory Wound Clinic to ensure that people with non-post operative wounds who are able to walk have to wait no longer than a week to receive appropriate wound care. At the end of Q3 there were no people on the waiting list for this service.

	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• The work within the scope of this scheme has been completed and the task and finish group dissolved. Proposals for future support and development of the care home market in Hillingdon are contained within a separate report on the draft 2016/17 BCF plan for the Board's consideration.
	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• Support continued to be provided to the three GP networks in the south of the borough to ensure that the maximum benefit can be achieved from the use of the MDT process. • In Q3 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 56% of the grants provided. 80% (20) of the people receiving DFGs were owner occupiers, 18% (5) were housing association tenants, 2% (1) was private tenants. The total DFG spend on older people during Q3 was £290k, which represented 58% of the total spend (£495k) in Q3.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q3, 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 56% of the grants provided. • 80% (20) of the people receiving DFGs were owner occupiers, 18% (5) were housing association tenants, 2% (1) were private tenants. The total DFG spend on older people during Q3 was £290k, which represented 58% of the total spend (£495k) in Q3.

	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 30th November 2015, 4,556 service users were in receipt of a TeleCareLine equipment service, of which 3,454 people were aged 80 years or older. • Between 5th April 2015 and 30th November 2015, 907 new service users have joined the TeleCareLine Service of which 607 were aged over 80.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• 2.24 From 1st April (launch) to 31st December 2015, over 5,000 individuals have accessed Connect to Support and completed 7,900 sessions reviewing the information & advice pages and/or details of available services and support. • The online social care self- assessment went live on 1st July 2015 and in period to 31st December 2015 51 online assessments have been completed and 35 were by people completing it for themselves and 16 by carers or professionals completing on behalf of another person. 13 self-assessments have been submitted to the Council to progress and the remainder have been sent to residents at their request in order for them to decide in their own time how they wish to proceed. • The carers' online assessment will be launched in conjunction with the Council's Carer Awareness Campaign in early February 2016.
	3.3.2 Develop a Carers	LBH/CCG	Biennially	• The Joint Carer's Comm's Campaign went live at the beginning of February with posters distributed

	Strategy that reflects the new responsibilities and implementation of the Care Act 2014			across the borough to raise awareness of the caring role. • The Carers Recognition Scheme nominations will open during February with a closing date of the 31 March. An evening event will be held on 10 May for all those who were nominated and their cared for person. • The Carers Assessment is now online and the pathway to access information and support has been reviewed and improved.
	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; and e) strengthening the	LBH/CCG	Quarterly	• As at 31st December 2015, Connect to Support Hillingdon had 186 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. A range of activity to engage more local providers and voluntary organisations in the site will commence in February 2016. • Between 1st April and 31st December 2015 343 carers' assessments were completed. On a straight line projection, this would suggest a total of 457 assessments for 2015/16, which would be 130 (40%) more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 247 carers have been provided with respite or other carer services in the period between 1st April and 31st December 2015 at a total cost of £894k. The forecast for 2015/16 is £1.174k. • The programme of staff training on new policies and procedures continues as required.

	approach to safeguarding adults.			
	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 has been agreed and published on the website.
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	• There are 537 Education, Health and Care Plans in place, 355 of which were transferred from the original Statements. • Hillingdon's local offer which was published in September on www.hillingdon.gov.uk/send provides information on what services children and young people with special educational needs and disabilities and their families can expect from a range of agencies including education, health and social care. • The Local Offer was formally launched on the 4th November in the Middlesex Suite alongside the DisabledGo Project. Marketing and promotional materials have been produced to be distributed

				across a wide range of public venues and services throughout Hillingdon to promote the ongoing engagement of residents and service providers in the development of the Local Offer. • A Multi-Agency group has been set up to prepare for the CQC/Ofsted inspection and a draft self evaluation temaplte is being designed with a new draft SEND strategy being drawn up. • The Local Offer will be subject to scrutiny by the council's Internal Audit department during Q4.
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	• Orchard Hill College Academy Trust is working with Eden Academy to set up specialist college provision on the Pentland Fields site with effect from September 2016. This will make provision for around 15 young people with very significant learning needs including those with autism and behaviour that can challenge. This will reduce the need for young people to attend college out of the area. • Options for delivering the additional special school places required are being developed. Feasibility studies of the Meadow and Hedgewood sites are awaited.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• A draft Short Breaks Strategy has now been developed and the working group will be seeking feedback from service users to identify what amendments may be required prior to circulation. • Work on the Strategy will continue to integrate with

				work taking place on the Local Offer and Carer's Strategy to ensure consistency and maximum visibility and engagement of Hillingdon residents. • There has been significant customer engagement over the last few months to try to capture as many views as possible from residents who may require access to short breaks.
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	• Both Church Road and Honeycroft Supported Housing Units are now open and service users are transitioning into these schemes at the appropriate pace for each individual. Some early comments from service users at Honeycroft are that they love their new flats and are happy with the provider on site. • Sessile Court is now settled and delivering well.

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	• The Adult Social Care Survey is underway to test 4.1.1 - 4.1.3. • Subject to HWBB approval, residents will be engaged in the development of the plan from April 2016.

	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	• A focus group will take place in Q4, the results of which will be reported to the Board as part of the next update.
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	• Co-production with parents and carers is embedded well which includes recruitment processes. • An Engagement Plan is being drawn up in relation to the self evaluation of the SEND reforms.