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	• A programme to engage over-weight pregnant women in ante-natal exercise is now open to ante and post natal women with an average attendance per week of 6. Priority is given to women with a BMI 30+ but the session is open to all. • To end March 2016, smoking prevalence at time of delivery is at 8.0% compared with national 12%. • Total number of women referred into the service in 2015/16 is as follows: 163 referrals, 65 engaged, 21 quits.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• A Paediatric Business Case been developed and includes the development of: • Integrated GP Paediatric Consultant led Clinics, bringing specialist expertise into GP practice to provide clinics that are accessible. 7 new patients will be seen in the morning and 5 case discussions will take place in the afternoon in a Multi-Disciplinary Team meeting, to include health education & social care as relevant per

				case. This moves clinics out from the hospital into community. • Ambulatory care pathways – the new Paediatric Assessment Clinic will see children who require observation, short stay for investigations and low level interventions. Families will be able to receive specialist care without being admitted to hospital. • Implementing the Asthma pathway - Asthma Allergy the roll out of the successful pilot. Children are seen in community/school. Practice nurses are trained in Asthma diploma, building the level of expertise and management into community. This implements the Asthma quality standards. • Critical Care Level 1 it is proposed to develop this service to provide quality care for the more complex sick child. This will enable to hospital to deliver care against London wide standards. Preparing for level 2 in the future. This will enable to hospital to care for these children close to home without transferring the, to other hospitals. • Meetings of the children's health partnership have paused while CCG appoints a new Clinical Lead as chair person. However work continues via task and finish groups.
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• During Q4, 210 people attended three tea dances. Feedback received from participants continues to be generally positive with older people stating that

				the dances encourage them to be more active, make friends and feel less lonely.
	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%. • The Smoking cessation target is 1055 quitters. Between April 2015 April 2016, 1389 residents were recruited. 549 of these residents quit through the support of GP's, Pharmacies and specialist advisors. • The national No Smoking Day (week) campaign in March 2016 was used to raise awareness, promote the service with the aim of increasing referrals. Promotions were set up at libraries, local clinics, GP's & Pharmacies. • A regular weekly clinic to support residents diagnosed with mental health conditions is being delivered at Mead House. Currently 15 patients are engaging with the service and we have achieved 2 quits. • A workshop was delivered to the respiratory nurses of the Hillingdon hospital to increase uptake and referral of smoking cessation by in-patients and discharged patients. • 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. Since February 2016, the format of the training has been changed to an online version. This has been well received by healthcare professionals across the borough as it is convenient and accessible, reducing absence from their practice. • Currently over 60 Pharmacists have been 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 have been trained to deliver Nicotine Replacement Therapy directly to the patient at community clinics. A patient search in GP Practices was completed to engage with the smoking population of that surgery. • A new clinic is being trialled at the Harefield Surgery with patients currently with or at risk of developing COPD.
	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 National Child Measurement programme is underway and it is expected that all eligible children (from Reception year and year 6 in Hillingdon schools) will have been measured by the end of June; well before the final data submission deadline in mid-August. • 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. • Adult weightloss pilot completed in March. 12 week data being collected after which the pilot will be evaluated. Initial results are encouraging. • The council continues to deliver the 'Walks Scheme' with 3,368 attendances and 98 new walkers during 2015/16. • As part of the 'This Hillingdon Girl Can' mother and daughter physical activity programme, 29 free exercise sessions spread across the borough were delivered over a 20 week period. Over 500 people took part in the programme and more than 90% of survey respondents said taking part had improved their wellbeing.
	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The GLA policy and technical guidance in regard to London Local Air Quality Management, and how boroughs are expected to carry out their local air quality management duties, has been published. • The Hillingdon Air Quality Action Plan was adopted in 2004, the new requirement indicates that a review is required. Each borough is now expected to update their Action Plan every five years. The Action Plan review is to be led internally by the Heads of Transport and Public Health to ensure a joint approach to improving air quality. To aid boroughs in this process, the GLA will be providing key environmental information for each borough which can then be used as the basis for the review of individual Air Quality Action Plans. This information will then be provided every four years to

				inform the updating process. The revision of the current Air Quality Action Plan will be informed by the new pollution information and reflect the GLA guidance on the action measures boroughs are expected to consider to reduce pollution.
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	• A new Project Search site offering supported internships for young people with SEND will open in September 2016. This is supported by the local authority and in conjunction with Meadow High School and a local hotel. • An organisation called NEED has agreed to work with the local area to design a range of supported internships aimed at increasing the number of young adults with LD who are in paid employment. • Reviews of Education, Health and Care Plans after age 14 focus on employment as a key outcome for all young people. • All service user care plans evidence the support to access employment or education opportunities. • 24 services users from across the services have been supported to access college course this quarter. 38 service users across services have had the opportunity to undertake unpaid employment opportunities to up skill in readiness for further paid work. • One example of this is that Queens Walk are currently supporting 2 service users to carry out

				work experience within the catering kitchen at Queens Walk supporting catering staff with domestic tasks and meal preparation to enhance their catering skills.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• The draft Autism Plan has been considered by ASC SMT and will be shared with relevant Councillors in June, prior to a stakeholder event taking place. The stakeholder event will capture residents' views to complete the Autism Plan. It will also support prioritisation of the action plan. • Internal Audit undertook consultancy work to ensure compliance with the duties in the Adult Autism Strategy. The findings will inform the final Autism Plan and the work of the Autism Partnership Board. • The Autism Partnership Board is well attended by all partners.
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 Q4 the Reablement Team received 132 referrals and of these 51 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, 45 people were discharged from

				Reablement with no on-going social care needs. • In Q4 the Rapid Response Team received 926 referrals, 54% (499) of which came from Hillingdon Hospital, 22% (202) from GPs, 10% (93) from community services such as District Nursing and the remaining 14% (132) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 499 referrals received from Hillingdon Hospital, 381 (76%) were discharged with Rapid Response input, 112 (22%) following assessment were not medically cleared for discharge and 10 (2%) were either out of area or inappropriate referrals. All 427 people referred from the community source received input from the Rapid Response Team.
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 end of year position for 2015/16, as reported to Public Health England (PHE) on 13th May 2016,

				was: - First Offers: 11,435, an increase of 2,084 (22%) from the 2014/15 figure; - Completed Checks: 7,700, an increase of 1,153 (18%) from the 2014/15 figure. The following targeted actions were taken to increase the take-up rate of NHS Health Checks during 2015/16: • Two NHS Health Check training sessions held for practice and pharmacy staff attended by 44 people; • 12 visits to support practices and pharmacies; • Four presentations made to practice and pharmacy staff at Public Health 'Top Up' sessions; • NHS Health Checks were provided at seven community events including health and wellbeing days at Hayes Islamic Centre, Uxbridge Police Station, Hayes & Harlington Community Centre for Hillingdon Carers and Hayes Mecca Bingo. • Over 230 NHS Health Checks were carried out in Hillingdon Libraries during February's Love Your Heart month. • 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	• The review and health and care needs assessment for HIV Support Services has been completed and a revised service specification tailored to meeting the needs of service users has been agreed. • A sexual health needs assessment (including user engagement) has been undertaken. The outputs from the needs assessment is being used to inform the development of a new model of service based on the integration of sexual and reproductive health services. • The service is due to go out to tender over the summer.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• There have been a small number of outbreaks of suspected or confirmed Norovirus in schools in Hillingdon in 2015/16. • Norovirus, which causes diarrhoea and vomiting, is one of the most common stomach bugs in the UK. It is also referred to as the "winter vomiting bug" because it's more common in winter, although you can catch it at any time of the year. Norovirus can be very unpleasant but it usually clears up by itself in a few days. • The Local Authority receives notification about outbreaks of Norovirus from Public Health England (PHE) for information. When required the Local Authority is asked by PHE to cascade relevant information for schools and nurseries in the form of a 'toolkit' developed by PHE to help prevent and

				control future outbreaks of Norovirus in schools or nurseries. PHE have recently requested that we cascade the toolkit to schools and nurseries this autumn.
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	The three Integrated Services for Long Term Conditions that were approved in 2015/16 are progressing with an update given below for each: • **Cardiology** – The extra posts for Heart Failure Nursing and Cardiac Rehabilitation have been filled. A pilot around Atrial Fibrillation is underway and the 24hr Blood pressure monitoring pilot is being evaluated. Anti-coagulation services are being reviewed. The aim of these schemes is to improve the planning of care for patients, thereby improving outcomes and reducing unplanned attendances and admissions. • **Diabetes –** Service is due to launch in July and is supported by the Diabetes Primary Care Contract. Discussions with GP Networks are underway about patients will be identified and then supported in a multi-disciplinary way. • **Respiratory** – Service is up and running and is already generating benefits through improved outcomes for patients and therefore reduced unplanned attendances and admissions. Further work is being done in this area focused on supporting children with asthma to improve care. In addition to the three Integrated Services we are also

				working on the following initiatives to support local patients: • **Cancer –** We are developing a scheme to reduce the number of patients who are detected as having Cancer following an unplanned attendance and also to improve the coordination of care of patients post substantive treatment. We expect this plan to be in place during the Summer and to start generating benefits in early Autumn onwards. • **Empowered Patient Programme –** This highly effective scheme was piloted in 15/16 and is being extended to a wider group of patients and a wider group of conditions for 16/17. The aim is to improve the ability of patients to self-manage elements of their own care and to understand their condition more effectively. This support is provided in a range of languages to meet the needs of our population. • **Complex Patient Management –** Many patients with one LTC often have two or more and there is a need to move to a more holistic model of care that takes into account not only the primary LTC but also the impact of secondary and other LTCs which could include such things as frailty, social isolation, mental health issues or pain and that seriously impact on the quality of life experienced by patients. HCCG is looking into exploring a new project in targeting patients with more than one LTC and co-morbidities.

	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. • 376 clients have completed the 12 week programme. 71% achieved all their goals in the programme and 26% achieved some. Only 3% failed to achieve any of their goals. • An overall reduction in BMI for those whose goal was to lose weight was achieved in 69% of cases. 76% achieved a reduction in their waist measurement. • 66% achieved an increase in the amount of times that 30 minutes of moderate intensity (breathless) physical activity was undertaken each week. The following results were also reported: -Improved fitness: 77% -Reduction in GP visits: 66% -Reduction in pain: 50% -Reduction in depression: 44% -Improved wellbeing: 63% -Less short of breath: 59% -Improved sleep: 49% • New pathways for the following patients have been developed: -Cancer patients - new session to start Sept 2016 -Falls prevention patients - three new sessions available

				-A new generic low level session at Highgrove leisure centre -Parkinson's patients -Post-natal women • The internal Weight Action Programme for Council staff has 28 staff registered. • Get Up & Go for residents from BME groups looking to improve their wellbeing lifestyle and take part in physical activity. One programme in Q1 (8 attendees) and one due to be completed in June.
	2.3.3 Reduce excess winter deaths	Public Health/NHS England		• Local implementation of the Flu Plan 2016-17 and the National Flu Immunisation programme is an important contribution to increasing resilience across the system through the winter period. • As well as all older people, people at risk categories and two to four year olds, the national Flu plan 2016/17 stipulates that vaccination will be offered via NHS providers to all children of school year 3 age. Children of school years 1 and 2 age will remain eligible. Vaccinating children each year means that not only are the children protected, but also that transmission across the population is reduced, lessening the overall burden of flu.
	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 worked on a joint project to improve access to preventative dental care in Hillingdon. • Two new NHS dental practices are planned for

				Harefield and West Drayton to ensure equity of NHS dentistry across the borough • 3,500 school children completed forms as part of the School Oral Health Project.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Since April 2015 there have been four Alliance meetings. 14 organisations across Hillingdon have joined the Alliance with another four due to come on board. 32 Dementia Friends Champions have been appointed and 3,114 Dementia Friends. • By the end of March 2016, 14 organisations in Hillingdon have signed up to the Dementia Action Alliance and meets quarterly. • A recent Dementia Action Alliance meeting received presentations from the Police and from the Alzheimer's Society project called Connecting Communities. The Connecting communities project has worked in Hillingdon for the past 3 years to raise awareness of dementia in traditionally hard to reach communities. • A Dementia Roadshow was held in February outside the Civic Centre. Enquiries from residents included: where are the local Alzheimer's services; types of dementia; what are the symptoms of dementia; how to manage behaviour; what support is there for carers. • The Dementia coffee mornings in Uxbridge library now have an average weekly attendance of 12 – 15

				per week, raising awareness each week.
	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 was 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, community services has been reconfigured into two hubs and the home Treatment Team now operates out of hours with two members of staff on duty. This service commenced January 2016 and the impact will be evaluated with a report expected in September/ October 2016. • Improving Access to Psychological Therapies - a Business Case was been approved to expand IAPT Services to target hard to reach groups and those with Long Term Health conditions such as Diabetes. CNWL has recruited additional staff to expand the service to ensure 15% access target is maintained 16/17. The Access target was met for 15/16 and the Recovery target was achieved in for the final two quarters of 2015/16 The targets have continued to be achieved in the first two months of 2016/17. 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: • A CAMHs self-harm, crisis and intensive support Team. • Specialist Mental Health provision for Children and

				young People with Learning Disability and Challenging Behaviour Team, with an integrated pathway with LBH Disability Team. • A Community Eating Disorder Service. • 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. This service is currently undergoing an evaluation for further review.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• The Vision Strategy has been approved by Adult Social Care SMT and will be presented to relevant Councillors for final approval prior to publication.
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	LBH	Quarterly	• Work is ongoing between the Council and partners including schools, academies and education and training providers to identify the employment, education and training (EET) status of young people.

	prevent it			• Current data to 31st March 2016 shows that the number of 16-19 year old NEETs is 277 young people or 3.30%. The percentage of NEET in September 2015 was 5.87% representing an improvement of 2.57% in six months. In Hillingdon, 10,072 young people 16-19 are in further or higher education or apprenticeships or employment representing 70.8%. • The tracking of young people to verify their current activity is also ongoing, with 1630 young people's EET destinations unknown following a change in their EET status. Destination identification work is ongoing between the Council's Participation Team and education and training providers to determine the EET status of the cohort.
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 review was undertaken of the falls prevention classes being delivered by the Council's Wellbeing Service under its exercise and referral programme. This twelve week programme is intended to support people who have fallen to regain their confidence by assisting them to be as active as their ability allows and therefore reduce the likelihood of further falls occurring. As a result of the review a further three classes a week will be delivered from Q1 2016/17.
	3.1.2 Deliver scheme two:	LBH/CCG	Quarterly	• A proposal has been developed by the CCG on behalf of the multi-agency End of Life Forum for

	better care for people at the end of their life (EoL)			consideration by Social Finance, a not for profit organisation that partners with the government, the social sector and the financial community to find better ways of tackling social problems in the UK and beyond. • If the proposal is successful it could see the injection of an additional £1.5m over three years to produce a more integrated model of end of life care for Hillingdon residents. The results of the submission are likely to be known in August 2016.
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	• The comparison in discharge activity at Hillingdon Hospital in Q1 - 4 2014/15 and 2015/16 shows an increase in discharges on Saturdays of people admitted to hospital for planned procedures but similar patterns for people admitted for unplanned procedures.
	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• No update.
	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• The Metrohealth GP network covering the north of the borough and Clover Health network in the south merged. This means that there are now four GP networks in the borough. The current networks are seeking to merge into a single network by the end of 2016/17.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q4 2015/16, 24 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which

				represented 43% of the grants provided. • 55% (31) of the people receiving DFG's were owner occupiers, 36% (20) were housing association tenants, and 9% (5) were private tenants. The total DFG spend on older people (aged 60 and over) during Q4 2015/16 was £167K, which represented 36% of the spend during the quarter (£461k).
	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 31st March 2016, 4,674 people were in receipt of a TeleCareLine equipment service, of which 3,582 were aged 80 years or older. • Between 5th April 2015 and 31st March 2016, 1,326 new service users have joined the TeleCareLine Service.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• From 1st April 2015 (launch) to 31st March 2016, over 5,500 individuals have accessed Connect to Support and completed 9,910 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 March 2016 and 58 online assessments have been completed and 39 were by people completing it for themselves and 19 by carers or professionals completing on behalf of another person. • 17 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 was launched in conjunction with the Council's Carer Awareness Campaign in early February 2016 and up to the end of March 2016, 8 assessments were submitted.
	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH/CCG	Biennially	• An evening presentation event was held on 10 May for all those who were nominated and their cared for person. Framed certificates and flowers were presented to the recipients. • Further engagement events are being planned for the next few months to seek Carers' views. • The new contract for the Carers' service is due to start in September 2016.
	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)	LBH/CCG	Quarterly	• As at 31st March 2016, Connect to Support Hillingdon had 202 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 started in February 2016. • Between 1st April 2015 and 31st March 2016 444 carers' assessments were completed. This is 29% (135) more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 192 carers have been provided with respite or other carer services in the period between 1st April 2015 and 31st March 2016 at a total cost of £907k. • The programme of staff training on new policies and procedures continues as required.

	ensuring market oversight and diversity of provision; and e) strengthening the 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 748 Education, Health and Care Plans of which 491 are transfers from previous Statements. This is in line with the Transfer Plan. • Internal Audit reviewed the Local Offer during Q4 to ensure compliance with the Regulations. The Action Plan has been updated to reflect the recommendations where appropriate. A working group is overseeing these improvements. • The self evaluation template has been populated and an evidence bank created. A survey has gone out to parents of children and young people with SEND. A child friendly version will be created and sent out over the summer. All education settings have been invited to complete a compliance checklist. Training has been provided to Special

				Educational Needs Co-ordinators and further support will be provided. • Disabled Go have prepared the list of venues to be surveyed, in conjunction with residents and staff.
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 Orchard Hill College Academy Trust (OHCAT) new specialist college provision is set to open in September 2016 and young people have been allocated places. • OHCAT has submitted an application for a Free Special School for pupils with social, emotional and mental health difficulties on the YPA site (essentially replacing YPA and Skills Hub in the process). • Eden Academy has submitted expressions of interest to establish two new Free Special Schools; a secondary school in the north of the borough probably on the Grangewood school site; a primary school in the south of the borough (site options unknown at this stage). These schools, if agreed, will provide the additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• The draft Short Break Strategy is going through the approvals processes. The Short Break Statement is also being reviewed.
3.6 Assist vulnerable people to	**3.6.1** Provide extra care and supported accommodation	LBH	Quarterly	• Two new six bed services are currently being planned.

secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	to reduce reliance on residential care			

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 target for the percentage of people who felt that they found it easy to gain access to information and advice about access to services and/or benefits was exceeded by 2%.
	4.1.2 Improve social care related quality of life by 2%	LBH/CCG	Annually	• There was an increase in the number of people responding positively to questions about their quality of life compared to 2014/15 but the 2015/16 target was not achieved.
	4.1.3 Increase the overall satisfaction of people who use services with their care and support	LBH/CCG	Annually	• Subject to HWBB approval, residents will be engaged in the development of the plan from April 2016.

	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	Key actions arising from a focus group of Carers that took place in Q4 include: • Involving Carers in reviewing the carers' assessment process. • Creating a help-sheet for use by the Carer at the start of each carer's assessment that outlines its purpose and what to expect from it.
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	• A children and young people participation network has been established, making use of existing groups e.g. special school councils, pupils attending SRPs, Merrifield House, voluntary organisations. • This will be kept under review to ensure it is an effective way of increasing participation giving young people a voice in the review and design of services.