Appendix A Health and Wellbeing Strategy Delivery Plan Update - December 2016

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 of 3 per week and 20 referrals during Q2. Priority is given to women with a BMI 30+. The session is open to all and further partnership work has been developed with the Assistant Director of Operations & Head of Midwifery & Women's Care at Hillingdon Hospital. • Smoking Cessation: During Q2, 27 Referrals were made by midwives to the Hillingdon Smoking Cessation Service. However, a small proportion of the clients were out of borough and duly referred to an appropriate provider. Within Pharmacies, 7 pregnant women set a quit date and 2 quit smoking.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• The Paediatric Business Case is now being taken forward as a Health Commissioning Plan 2016-2020, this is being progressed through the CCG governance systems. Work streams include: • Integrated GP Paediatric Consultant Clinics - economic modelling & logistic planning is now

				progressing. The first clinic becomes operational Dec 2016, this is to test the viability of Community Integrated clinics, including outcome measures. • Ambulatory care pathways – the new Paediatric Assessment Unit was planned to open in mid-July 2016, however it formally opened September and "is seeing good utilisation - with an average of 2.75 patients in each bed per 24 hours". This will continue to be monitored at a NW London sector level. • 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. The roll out continues to take place, with a longer term plan to establish the relationship with the Integrated clinics. • Critical Care Level 1 it is proposed to develop this service to provide quality care for the more complex sick child. This will enable the hospital to deliver care against London wide standards. Preparing for level 2 in the future. This will enable the hospital to care for these children close to home without transferring, to other hospitals. This programme of work is taking place with NW London and neighbouring boroughs as children attend the hospital from other areas as well as Hillingdon. Service specification under development. Plan to commission a service for 2017-18.

				• Meetings of the children's health partnership were paused while CCG appointed a new Clinical Lead, who commenced in post July. This group aims to become a smaller strategic transformation group ensuring it is action-focussed as well as strategic. Membership will be reviewed. The task & finish groups continue. The first renewed meeting was held on 18th November 2016.
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• During Q2 345 people attended 3 tea dances at the Civic Centre and 216 people attended dances at the Winston Churchill Hall. Positive feedback was received at these sessions.
	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 at 16.9%, a reduction from 17.5% on year and less than the England average of 18% *(data obtained from Public Health Outcomes framework & HSCIC statistics on smoking 2016).* • The Smoking cessation target is 1,055 quitters. Between July to September 2016, 81 Hillingdon residents quit through the support of GP's, Pharmacies and specialist advisors. • A regular weekly clinic to support residents diagnosed with mental health conditions is being delivered at Mead House. This Quarter, 10 patients engaged with the service primarily on a harm reduction basis and have achieved 1 successful quit.

				• 11 Health promotion events have been attended to promote the availability and support to residents through stop smoking services. These included the Hayes carnival, QPR health fair - (Rabbs primary school, Wood end park academy, Cranford park academy), Citizens Advice fair at the Pavilions, Wellbeing day at the Brookfields adult centre, Uxbridge college - Fresher's fair, Mead house wellbeing day, MIND wellbeing day, Coteford Children's Centre - Fun day, Hillingdon Hospital wellbeing week, Brunel wellbeing 'looking after your mates'. • The national and well advertised campaign 'Stoptober' has been highlighted to our Healthcare professionals to ensure that they have adequate 'free' material to display in their practices in a bid to drive footfall and engagement of our residents. • A workshop was organised in September to enhance the skills of Hillingdon Pharmacy / GP based stop smoking advisors to improve their current model of delivery thus leading to an increase in numbers of successful quit attempts. The workshop was well attended by over 75 Health care professionals. • Since April 2016, the format of Level 2 smoking cessation training has been modified to ensure that the advisor meets the benchmark competencies through a nationally accredited online programme

				(NCSCT). Successful participants will then be invited to the local authority for a face to face update which will finally accredit them with a level 2 status. This has been well received by healthcare professionals across the borough as it is convenient and accessible, reducing absence from their practice. Q2 saw 7 health care professionals completing the course. • Currently over 60 Pharmacists have been trained to prescribe stop smoking medication which would otherwise only be available through a GP. 45 out of 62 Pharmacies deliver this service within the borough and feedback from residents has been favourable due to minimising delay in accessing this specialist medication. • Almost all 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. GP Practices have been recommended to complete patient searches 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	Wellbeing Service/Public Health	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 new cohorts started in September 2016 and will be completing before the Christmas break.

	Measurement Programme, and raising awareness of the importance of physical activity across the life course			• In 2015/16, 4,174 children aged 4-5 and 3,385 children aged 10-11 were weighed and measured under the National Child Measurement Programme with 99% and 98% completion rates. • Prevalence of obesity for Reception Year remained stable (9.5%), while the rate for Year 6 children (aged 10-11 years) increased by 1.8 percentage points to 21.1%. but is consistent with the national increase. • The council continues to deliver the 'Walks Scheme'. Training is planned for 8 new volunteers in November 2016 with a view to offering a new shorter walk. An 'Every Step Counts' pilot targeting inactive groups is being planned for implementation in January 2017. • The CCG through HENWL is funding a pilot programme between Jan-March 2017 to train staff in Primary Care in childhood obesity, asking and raising the issue and evidenced-based practice. This will inform ongoing training needs.
	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The review of the Air Quality Action Plan requires the Borough to confirm whether the declared Air Quality Management Area (AQMA), which extends south from the Chiltern - Marylebone railway line, is still sound. The GLA pollution modelling has indicated there may be potential pollution areas outside of the current AQMA. On the advice of the

				transport team a detailed study is now underway to ascertain the extent of any pollution problems to ensure a decision to extend the AQMA is taken on an informed basis. This study is due for completion within this financial year. • The drafting of the Air Quality Plan will run in parallel with the transport study and incorporate the findings in relation to the status of the AQMA. The implications of the following will all need to be factored into the Hillingdon Air Quality Plan: - the recent Heathrow expansion announcement; - monitoring of the assurances received by the borough in regard to HS2; - the recent Judgement from the High Court that the Defra Air Quality Plan has been judged over-optimistic and will require a new plan and timetable by which to meet air quality limits. • The Borough's specific actions to improve air quality have been recognised by the awarding by the GLA of Cleaner Air Borough Status.
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	• Support Plans continue to be reviewed and employment and education opportunities continue to be explored. • In Q2, 8 new service users have had the opportunity to undertake paid employment. This has included service users providing presentations to schools, colleges and other LBH Teams on different subjects of Hate/ Mate crime and Disability

				awareness. • 21 service users had the opportunity of unpaid voluntary work to prepare for further paid work. Opportunities included kitchen assistant duties at Queens Walk and Wren, laundry tasks at Queens Walk and work placements at Heathrow Special Needs Centre. Service users have had the opportunity to enrol on and commence a range of college courses.
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 is awaiting sign off from the CCG.
Priority 2 - Prevention and early intervention				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
2.1 Deliver the BCF	**2.1.1** Deliver scheme three: Rapid response and integrated Intermediate Care	LBH/CCG	Quarterly	• During Q2 the Reablement Team received 211 referrals and of these 161 were from hospitals, primarily Hillingdon Hospital and the other 50 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 122 people were discharged from Reablement with no on-going social care needs.

				• In Q2 the Rapid Response Team received 923 referrals, 55% (510) of which came from Hillingdon Hospital, 20% (182) from GPs, 12% (108) from community services such as District Nursing and the remaining 13% (123) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 510 referrals received from Hillingdon Hospital, 367 (72%) were discharged with Rapid Response input, 117 (23%) following assessment were not medically cleared for discharge and 26 (5%) were either out of area or inappropriate referrals. All 413 people referred from the community source received input from the Rapid Response Team. • The first half of 2016/17 saw an increase of 12.6% on the same period in 2015/16 in the number of people aged 80 and over attending Hillingdon Hospital but a reduction of 3.4% in the number being admitted. This is largely attributable to the proactive work being undertaken by the Rapid Response Team. • The Council's Hospital Discharge Team supported the early discharge of 157 people from Hillingdon Hospital and 62 people from other hospitals during the first half of 2016/17. 'Early discharge' means that people were identified and supported into an alternative care setting before an assessment notice under the Care Act was served.

2.2 Deliver Public Health Statutory Obligations	**2.2.1** Deliver the National NHS Health Checks Programme	Public Health	Annually	• The NHS Health Check programme aims to identify at an early stage individuals at moderate to high risk of cardiovascular disease, diabetes, stroke, kidney disease and related metabolic risk. • In 2016/17, **75,341** Hillingdon residents and people registered with Hillingdon GPs are eligible for the NHS Health Check programme. Of these, **15,068 (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 2015/16, the take-up rate was 67%, therefore Hillingdon should be aiming to carry out at least **10,146 (13.5%)** checks during 2016/17. However, it should be noted that the maximum number of NHS Health Checks that can be delivered given the current budget and provider contracts is 8,700 (11.5%). • The mid-year position for 2016/17 as reported to Public Health England (PHE) on 29th October 2016 was: - First Offers: **6,197 (8.2%)**, an increase of **1,724 (39%)** from the mid-year 2015/16 figure; - Completed Checks: **3,515 (4.7%)**, an increase of **231 (7.0%)** from the mid-year 2015/16 figure; - Take-up rate: **57%,** down **16%** on the mid—year 2015/16 figure. • Since the data submission, the mid-year figures have increased slightly to **6,269 (8.3%)** for First

				Offers and **3,556 (4.7%)** for Completed Checks. This is an increase of **1,796 (40%)** First Offers and an increase of **272 (8.3%)** Checks from the mid-year 2015/16 position. • The following targeted actions were taken during Q 2, 2016/17 to increase the numbers of NHS Health Checks offered and carried out: - Three visits to support practices; - The NHS Health Check service was promoted at Hayes Carnival, a Carers' Fair, an Open Evening at Hillingdon Hospital (by the Hospital's Occupational Health Team) and a Wellbeing Day at Mead House.
	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. A revised service specification tailored to meet the needs of service users living with HIV/AIDS is being implemented in 2016/17. • A sexual and reproductive health needs assessment (including user engagement) has been undertaken. The outputs from the needs assessment has been used to inform the development of a new model of service for an integrated sexual and reproductive health service. The near patient HIV testing pilot is being developed by HART. HART are liaising with Hillingdon Hospital's GUM service. • The service went out to tender in September 2016. It is intended that the new service model will go live

				on 1st May 2017. **<u>OUTREACH:</u>** • <u>Men's Health Week:</u> The Chlamydia Outreach Team are planning events for the forthcoming Men's health week (October 2016) with a focus on young men. • <u>Fresher's Week:</u> The Chlamydia Outreach Team are currently preparing for Fresher's Week at Brunel and Uxbridge College – both campuses. In September the Outreach Team visited the following sites and delivered Health Promotion activities: - Uxbridge College - 36 Young People; - Uxbridge College Hayes - 39 Young People; - Bucks University - 6 Young People; - Brunel - 140 Condom Card registrations • <u>RAF Northolt:</u> The Chlamydia Outreach Team continue to visit new recruits briefings at RAF Northolt in collaboration with the Practice Nurse at the base. Wellbeing Event at RAF Northolt has been booked for 12th January 2017 for the new recruits. • <u>SRE outreach: Worked in partnership with</u> targeted schools, academies, Pupil Referral Unit (The Skills Hub) and Uxbridge College to raise awareness regarding sexual health and wellbeing and risks associated with substance misuse. 1. Harefield Academy-Q2 - 250 2. Uxbridge College- Uxbridge Campus- Q2 - 32

				3. Uxbridge College- Hayes Campus-Q2- 41 • <u>Early Intervention and Prevention - Partnership Working:</u> In September the Outreach Team continued to visit the following sites and delivered Health Promotion activities: The Team continue to in-reach into: (a) Children Looked After homes-39 Young People; (b) YMCA hostels – 47 Young People; With specific reference to bars and clubs the Outreach Team piloted the delivery of sexual health and general health and wellbeing information in a local night club for young people. The intervention yielded 44 young people who received brief advice and information and signposting to local services. • <u>Sexual Health Outreach Nurse</u>: The Clinic in a Box Service continues to work on a one to one basis with between 10-15 vulnerable young people – including those who are post abortion. A meeting has been planned with the Abortion Provider to discuss, referral pathways in to local contraception and sexual health 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		• No update this quarter
2.3 Prevent	**2.3.1** Ensure effective	CCG	Quarterly	• No update this quarter

premature mortality	secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia			
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• Increasing levels of physical activity in the Borough amongst those suffering from chronic conditions is being taken forward through the inclusion of the 'Let's get Moving' programme in disease care pathways. • Let's Get Moving data to 30th September 2016: 587 total clients (209 final assessment attendees) 60% achieved all their goals 36% achieved some of their goals 4% failed to achieve their goals 66% achieved overall reduction in BMI 71% achieved reduction in waist measurement 66% achieved an increase in the amount of times that 30 minutes of moderate intensity (breathless) physical activity was undertaken each week. Reduction in BMI for those whose goal it was to lose weight 78% Increase in overall activity level 91% Improved fitness 66% Reduction in GP visits 57% Reduction in pain 46% Reduction in tiredness 55%

				Reduction in depression 39% Improved wellbeing 55% Less short of breath 47% Improved sleep 47% • The internal Weight Action Programme for Council staff has 46 staff registered. Two programmes on a Tues and Weds are currently being delivered over a 10 week period). • 'Get Up & Go' for residents from BME groups looking to improve their wellbeing lifestyle and take part in physical activity. In Q2 there were 6 attendees who are them referred in the Let's Get Moving Programme.
	2.3.3 Reduce excess winter deaths	Public Health/NHS England		• No update this quarter.
	2.3.4 Reduce the number of children with one or more decayed, missing or filled teeth	Public Health & NHS England		• Two new NHS dental practices are planned: One was opened in Harefield on 14th October and another one is planned for West Drayton to ensure equity of NHS dentistry across the borough.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Task/Metric now moved to **3.3.3 Deliver BCF scheme eight: Living well with dementia**
	2.3.6 Improve pathways and response for individuals with mental health needs across	CCG	Annually	• Single Point of Access - the mental health urgent care pathway for Adults has been operational from 2nd November 2015. Community services have

	the life course including the provision of Child and Adolescent Mental Health Services (CAMHS)			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 and Recovery Targets continue to be met in 16/17. As part of the Hillingdon Transformation Plan, the following services are all now in operation: • 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. • 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.
2.4 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 are 10,092 16-18 year olds in Hillingdon. In September 2016, 4.9% (156) 16-18 years old in Hillingdon were NEET compared to 6.3% (221) in September 2015. • The employment, education or training (EET) status of 69.2% (6938) of 16–18 year olds is classified as 'not known', compared to 71.6% (7159) in September last year. This figure must be read in the context of the time of year when 'not known' is expected to be varied upwards nationally at the start of term and at a time of student transition. • Work is being progressed between the Participation Key-work team and Schools Improvement / Education Quality and Strategy to understand the reasons behind the reduction in the number of 16-18 year olds in learning so that improvement actions can be undertaken. • Associated work is being progressed to reduce 'not known' levels in collaboration with education providers and to enable circa 3,000 young people to secure an appropriate EET destination as part of the 'September Guarantee' process which is

				undertaken each year. • Hillingdon delivered its September Guarantee duties to all relevant 6702 young people resident in the borough by making individual contact with each one. 88.3% (5917) are in receipt of an offer of education, employment or training compared to 89.8% (6051) at the same point last year.
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	**3.1.1** Deliver scheme one: early identification of people susceptible to falls, stroke, dementia and/or social isolation	LBH/CCG	Annually	• From 1st July 2016 to 30th September 2016, 1,516 individuals accessed Connect to Support and completed 2,292 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 132 people and 258 sessions on the same period in 2015/16. • The number of providers registered on Connect to Support increased from 195 at the end of Q1 to 253 at the end of Q2. This includes both voluntary sector and private providers. • During the first half of 2016/17 668 residents have accessed the H4All Wellbeing Service and nearly 77% (514) of were aged 75 and over. During this period 357 assessments have taken place using the

				Patient Activation Model (PAM), which tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. 73 people had a second assessment following a period of support and 48 showed an increased score and therefore increased confidence and motivation. However, 25 people either had a reduced score or there was no difference. • There were 355 falls-related emergency admissions during the first half of 2016/17, which is marginally above the 344 total for the same period in 2015/16.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• An information sharing agreement between the Council and the Royal Marsden NHS Hospital Foundation Trust was signed in respect of the advanced planning tool Coordinate My Care (CMC) and Adult Social Care read and write access to this system went live. This will help to improve coordination between organisations providing care for people at end of life.
3.2 Deliver the BCF	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• During Q2 the Hawthorne Intermediate Care Unit (HICU) started to accept referrals on Saturdays, which means that the unit now accepts referrals six days a week. This will assist with patient flow out of the Hospital. • By the end of Q2 arrangements were put in place to enable the management of complex wound care delivered by CNWL to be available seven days a

				week for patients of the Ambulatory Emergency Care Unit at Hillingdon, which helps to prevent admissions that are avoidable. • In Q2 there was a nearly 5% (24) increase in discharges on a Saturday compared to the same period in 2015/16 but a 24% (48) reduction in Sunday discharges. The increase in Saturday discharges was entirely attributable to an increase in discharges of people admitted for planned procedures. The number of people discharged on a Saturday who were admitted as emergencies declined by nearly 16% (34). There was a 17% (29) reduction in discharges on Sundays. • In Q2 there has been an overall reduction in the proportion of people discharged before midday in comparison with the same period in 2015/16. For weekend discharges this has reduced from 35.5% of Saturday discharges in 2015/16 to 31.2 in 2016/17 and from 27% to 23.7% for Sunday discharges.
	3.2.2 Deliver scheme six: Care home and supported living market development	LBH/CCG	Quarterly	• There were 327 emergency admissions from care homes during the first half of 2016/17, which compares to 362 admissions in 2015/16. • A soft market testing exercise was undertaken with four potential providers of care and support for older residents living in extra care sheltered housing. The purpose of the exercise was to identify whether the proposed model was attractive to the market as well as identifying what other factors would encourage

				providers to bid. This exercise has helped to finalise the content of the service specification for the care and wellbeing in extra care service which will be the subject of a competitive tendering exercise in Q4.
	3.2.3 Deliver scheme five: Integrated community-based care and support	LBH/CCG	Quarterly	• During Q2 the Accountable Care Partnership established four task and finish groups that are looking in detail at redesigning the services being delivered by the organisations within the ACP to improve care planning, reduce fragmentation, improve effectiveness and, most importantly, improve the resident experience of care. The work of these groups will help to inform the development of the 2017 to 2019 BCF plan.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q2 2016/17 33 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 61% of the grants provided. • 22% (12) of the people receiving DFG's were owner occupiers, 72% (39) were housing association tenants, and 6% (3) were private tenants. The total DFG spend on older people (aged 60 and over) during Q2 2016/17 was £85k, which represented 30% of the spend during the quarter (£287k)
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for	LBH	Quarterly	• As at 30th September 2016, 4,761 service users (4,306 households) were in receipt of a TeleCareLine equipment service, of which 3,627 people were aged 80 years or older.

	over 80's			• There are also 23 clients using the GPS technology for the Safer Walking device used by clients with early stages of dementia. • Between 1st April 2016 and 30th September 2016, 411 new service users have joined the TeleCareLine Service of which 252 were aged over 80.
3.3 Deliver the BCF	**3.3.1** Deliver BCF scheme seven: Supporting Carers.	LBH	Quarterly	• 191 Carers' assessments were completed in Q2, compared to 259 in Q1. On a straight line projection this would result in 900 assessments being completed in 2016/17, which would represent a 14.9% reduction on the 2015/16 outturn (1,058). • During Q2 183 Carers were provided with respite or another carer service at a cost of £430.7k. This compares to 123 Carers being supported at a cost of £372.9k in Q2 2015/16. • In September 2016 the Carers in Hillingdon contract started provided by the Hillingdon Carers Partnership and led by Hillingdon Carers. This new contract creates a single point of access for Carers. It should lead to better outcomes for Carers and the people they care for. • A multi-agency Young Carers' Strategy was established and held its first meeting during Q2. This enables partners to work collaboratively to take a much more strategic approach to addressing the needs of young carers.

				• Two local Carer Forum meetings took place in Hayes and Northwood, both of which were attended by approximately 30 Carers.
	3.3.2 Deliver BCF scheme eight: Living well with dementia			• Stirling University ran a training session for the designers of Grassy Meadow Court and Parkview Court extra care schemes to ensure that the gold standard for having a dementia friendly environment is achieved. • 90 staff across health and social care, including GP surgery staff, took part in dementia awareness training. • A new health service for people with learning disabilities was implemented in July with a specific focus on identification of people with dementia. This is intended to assist with the early identification, diagnosis and treatment of people with dementia.
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 998 Education, Health and Care Plans of which 663 are transfers from previous Statements. There are a further 853 Statements to transfer by 31 March 2018 in line with the Transfer Plan. • The updated SEND Strategy is awaiting approval from the CCG. • The resource allocation system (RAS) for children with disabilities will go live on 1st December; the RAS for special educational needs will go live by 1st

				April 2017. • An early intervention support plan called My Support Plan is being rolled out. An early intervention funding pilot for pupils with a My Support Plan who would otherwise meet the threshold for an EHC Plan has been approved by Schools Forum. • Disabled Go have completed the initial 1000 access surveys and will launch the Hillingdon Access Guide on 14th December 2016.
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 opened in September 2016 and young people have been started attending. • OHCAT's application for a Free Special School for pupils with social, emotional and mental health difficulties on the YPA site to include sixth form provision was approved by the EFA. • Eden Academy has submitted Free School applications to open two new Free Special Schools; a secondary school in the north of the borough on the Grangewood school site; a primary school in the south of the borough (site options to be confirmed). These schools, if agreed, will provide additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school. • The Additional Needs Strategy has been refreshed

				and will be presented to SMT for approval in Q3. • The Short Break Statement has been reviewed and updated and will be presented to SMT for approval on Q3. A Short Break Strategy has been approved by SMT.

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 benefitting from implementation of BCF schemes	**4.1.1** Improve service user experience e.g. how easy or difficult residents found it to access information and advice by 0.5%	LBH/CCG	Annually	• This metric will be tested by the Adult Social Care Survey undertaken in Q4 2016/17.
	4.1.2 Improve social care related quality of life by 0.2%	LBH/CCG	Annually	• This metric will be tested by the Adult Social Care Survey undertaken in Q4 2016/17.
	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 two-year (2017 - 2019) BCF plan.

	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	• The experience of Carers will be tested in the national carers' survey being undertaken in Q3.
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	• We are working with KIDS, a national voluntary organisation, to develop a Participation Strategy linked to our Participation Network. This is a Government funded initiative as part of the support to implement the SEND reforms.