Appendix A Health and Wellbeing Strategy Delivery Plan Update - September 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 6 per week. 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. • During Q1, 18 pregnant women set a date to quit smoking, and 9 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 commissioning plan. Work streams include: • Integrated GP Paediatric Consultant Clinics - economic modelling & logistic planning is now progressing. The aim is to test a clinic as soon as approval is agreed. • Ambulatory care pathways – the new Paediatric Assessment Unit opened in mid-July 2016.

				• 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 , to other hospitals. This programme of work is taking place with neighbouring boroughs as children attend the hospital from other areas as well as Hillingdon • 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 transformation group ensuring it is action-focussed as well as strategic. Membership will be reviewed. Planned quarterly meeting to commence September. The task & finish groups continue.
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• During Q1, 469 people in total attended four tea dances. Feedback received from participants continues to be 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 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 April to June 2016, 155 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. Currently 15 patients are engaging with the service primarily on a harm reduction basis but have achieved 3 successful quits. • 6 Health promotion events have been attended to promote the availability and support to residents through stop smoking services. These included the carers forum in Northwood, Hayes carnival, life after cancer, QPR football fair day, Hillingdon Citizens Advice fair and the well being day at Brookfield health centre. • 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 has been 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. • 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. The next update is scheduled for October and 6 health care professionals have confirmed attendance. • 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 Measurement Programme, and raising awareness of the importance of physical activity across the life course	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 starting in September 2016 and January 2017. • Children in Reception Year and Year 6 were weighed and measured and data was submitted to HSCIC as per the national guidance in advance of the deadline. Data will be summarised in a national report to be released in November. • The council continues to deliver the 'Walks Scheme'. In Q1 there were 356 new walkers and 891 attendances. • 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 new environmental information from the GLA has been received and will form the basis of a consultation process to confirm the areas of concern throughout the borough and help identify the necessary actions needed to improve air quality and public health. It is anticipated that the process will start in September. The final Plan will be subject to a five year review as requested by the Mayor of London. • The borough will ensure that future decisions on major infrastructure projects, which can potentially threaten the improvements to local air quality which the Council is attempting to make, are highlighted within the Plan. This will include issues such as the potential expansion of Heathrow Airport, the construction of HS2 Ltd's high speed line and the implementation of the upgrading of the M4 through the borough to a Smart Motorway.
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	• All service user care plans continue to evidence the support to access employment or education opportunities. • 2 service users have had the opportunity to undertake paid employment opportunities and 22 service users had the opportunity to undertake unpaid employment to up skill in readiness for further paid work. • Examples of the unpaid opportunities have been for service users to carry out laundry tasks at Queens Walk.

				• Staff are also currently supporting 2 service users to carry out work experience within Wren- Day resource for Older people to support with catering staff at Wren 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	• An Autism Stakeholder event took place in June 2016 and the draft Autism Plan has been updated to reflect their views. The Plan will be ready for sign off in September/October 2016. • 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	**2.1.1** Deliver scheme three: Rapid response and integrated Intermediate Care	LBH/CCG	Quarterly	• During Q1 the Reablement Team received 227 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, 102 people were discharged from Reablement with no on-going social care needs. • In Q1 the Rapid Response Team received 886

				referrals, 56% (500) of which came from Hillingdon Hospital, 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals. All 386 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 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 Quarter 1 position for 2016/17 as reported to

				Public Health England (PHE) on 29th July 2016 was: - First Offers: **2,446 (3.2%)**, an increase of **229 (10.3%)** from the Q1, 2015/16 figure; - Completed Checks: **1,624 (2.2%)**, an increase of **189 (13.2%)** from the Q1, 2015/16 figure; - Take-up rate: **66.4**% • Late data submissions from a couple of practices boosted these figures to **2,634 (3.5%)** for First Offers and **1,751 (2.3%)** for Completed Checks. This is an increase of **417 (18.9%)** First Offers and an increase of **316 (22.0%)** Checks from the Quarter 1, 2015/16 position. The take-up rate improved by **1.7%** from **64.7%** to **66.4%** for the same period. • The following targeted actions were taken during Quarter 1, 2016/17 to increase the numbers of NHS Health Checks offered and carried out: - One NHS Health Check training session held for practice and pharmacy staff; - Two visits to support practices; - NHS Health Checks were provided at Hayes & Harlington Community Centre for Hillingdon Carers at their April Café; The NHS Health Check service was promoted at Hayes Carnival and Wellbeing events 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 and a revised service specification tailored to meet the needs of service users living with HIV/AIDS is being

				implemented in 2016/16. • 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 service is due to go out to tender in September 2016. It is intended that the new service model will go live on 1st May 2017. **OUTREACH:** • Men's Health Week: The Chlamydia Outreach Team are planning events for the forthcoming Men's health week (October 2016) with a focus on young men. • Fresher's Week: The Chlamydia Outreach Team are currently preparing for Fresher's Week at Brunel and Uxbridge College – both campuses. • RAF Northolt: The Chlamydia Outreach Team continue to visit new recruits briefings at RAF Northolt in collaboration with the Practice Nurse at the base. • SRE outreach: Worked in partnership with 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. • <u>Early Intervention and Prevention - Partnership Working:</u> The Team continue to in-reach into: (a) the ARCH substance misuse service; (b) Children Looked After homes; (c) YMCA hostels; (d) local bars and Club. 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.
	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 premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia	CCG	Quarterly	• No update this quarter

	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 31st July 2016: 470 total clients (139 final assessment attendees) 71% achieved all their goals 25% achieved some of their goals 4% failed to achieve their goals 68% achieved overall reduction in BMI 76% achieved reduction in waist measurement 67% 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 80% Increase in overall activity level 91% Improved fitness 73% Reduction in GP visits 64% Reduction in pain 50% Reduction in depression 43% Improved wellbeing 60% Less short of breath 55% Improved sleep 45%

				• The internal Weight Action Programme for Council staff has 28 staff registered. 16 completed the programme. The second programme has been confirmed to start in Sept. Due to an overwhelming response (over 40 staff members registered) there will be two programmes 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 Q1 there were 8 attendees.
	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		• 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	• 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 the life course including the provision of Child and Adolescent Mental Health Services (CAMHS)	CCG	Annually	• Single Point of Access - the mental health urgent care pathway for Adults has been operational from 2nd November 2015. Community services have 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. NHSE invited Hillingdon to submit a proposal to become an Early Implementer of the new targets set out in the National Five Year Mental Health Plan, a bid was submitted, the outcome is expected in September 2016. 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.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• The Vision Strategy has been signed off.
2.4 Ensure young people are in Education, Employment or Training	**2.4.1 I**dentify those at risk of becoming Not in Education, Employment or Training (NEET) and implementing appropriate action to prevent it	LBH	Quarterly	• Work is ongoing between the Council and partners including schools, academies and education and training providers to track the employment, education and training (EET) status of young people. This includes each Secondary provider in Hillingdon being asked to share known destination data at the end of summer term 2016. • A letter has been sent to each Hillingdon young person where the Council does not hold telephone or email contacts and home visits continue to be made in order to identify the employment, education or training status of the 16 - 19 cohort. Early indications suggest a positive upturn in identification

				rates. • Current data to 30th June 2016 shows that the number of 16-19 year olds not in employment, education or training (NEET) is 314 young people (3.7% of the cohort). The percentage of NEET in September 2015 was 5.87% representing an improvement of 2.1% in 10 months. In Hillingdon, 7,947 young people 16-19 are in further or higher education or apprenticeships or employment representing 78.8% of the cohort. • 1,702 young people's EET destinations are currently unknown. Numbers are consistent with the season level of student movement at this time of year. Destination identification work is ongoing between the Council's Participation Team and education and training providers to determine the EET status of the cohort over the coming months.
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	• As at 30th June, Connect to Support Hillingdon had 241 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. This represents an additional 39 organisations from the position at the end of March 2016. • The H4All Health and Wellbeing Service became

				operational in April, which will provide support to older people living with long-term conditions at risk of escalating needs. • By the end of Q1 approximately 340 people had been referred to the Health and Wellbeing Service from GP surgeries and 108 assessments using the Patient Activation Model (PAM) had been completed. This tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. • There were 207 emergency admissions of people aged 65 and over related to falls during Q1, which is slightly above the ceiling for the quarter of 195. The ceiling for 2016/17 is 780. • The development of a new Falls Prevention pathway working in partnership with Hillingdon Hospital / Age UK / CCG and clinical professionals is in its early stages.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• Training was provided for Social Care staff in the use of Coordinate My Care (CMC). Information sharing agreements are on track to be signed in Q2 which will then enable social care staff to have read and write access to this system, which should facilitate a more coordinated approach to the provision of care and support to Hillingdon residents who at the end of their life as well as supporting their Carers.
3.2 Deliver the BCF	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• It was agreed by councils participating in the consortium for the dynamic purchasing system (DPS) tender led by LB Ealing to include a

				requirement in the specifications for residential and nursing care home placements to have available suitably qualified staff to enable assessments to support hospital discharge seven days a week. October Cabinet will be asked to approve the results of the tender process. The DPS will enable the Council to comply with procurement regulations in respect of spot placements in care homes. • There was a significant drop in the number of discharges on a Saturday compared to 2015/16, e.g. 347 (2016/17) compared to 546 (2015/16). This is largely accounted for by a drop in discharges of people admitted for planned (also known as elective) procedures from 332 in 2015/16 to 171 in Q1 2016/17. There has also been a reduction in the number of Saturday discharges of people who were admitted in an emergency (non-elective admissions).
	3.2.2 Deliver scheme six: Care home and supported living market development	LBH/CCG	Quarterly	• There were 430 emergency admissions from care homes in Q1 against a ceiling of 427, which means that activity is broadly on target. • A task and finish group comprising of GP representatives, a consultant geriatrician and a representative from CNWL's community health and community mental health teams and also the third sector has met to help shape the care and wellbeing specification for the extra care sheltered housing

				schemes, including two new schemes that will open early in 2018. The service will be tendered in Q3 2016/17.
	3.2.3 Deliver scheme five: Integrated community-based care and support	LBH/CCG	Quarterly	• The use of risk stratification tools within GP practices to identify older people living with long-term conditions who could benefit from care planning as part of a more anticipatory model of care has been expanded to all practices. The intention is to extend the use of these tools to other adults during 2016/17.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q1 2016/17, 26 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 39% of the grants provided. • 64% (43) of the people receiving DFG's were owner occupiers, 33% (22) were housing association tenants, and 3% (2) were private tenants. The total DFG spend on older people (aged 60 and over) during Q1 2016/17 was £68k, which represented 30% of the spend during the quarter (£227k).
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for over 80's	LBH	Quarterly	• A total of 4,727 people were in receipt of the TeleCareLine service at the end of Q1 2016/17. • 224 residents took up the service during Q1. • 3,615 people receiving the TeleCareLine service are aged 80 years or older.

3.3 Deliver the BCF	**3.3.1** Deliver BCF scheme seven: Supporting Carers.	LBH	Quarterly	• In Q1 107 carers' assessments were completed, which is below the quarterly target of 125. • During Q1 130 Carers were provided with respite or another carer service at a cost of £230.7k. • A new Carers' Café was launched in Ruislip, thereby creating increased support opportunities for Carers in this part of the borough. • A successful Carers' Fair was delivered on 7 June 2016. 45 partner organisations held information stalls and 58 new carers were identified.
	3.3.2 Deliver BCF scheme eight: Living well with dementia			• Approximately 100 people were trained during Q1 by Alzheimer's Society to be Dementia Friends. This means that Hillingdon now has 3,500 trained Dementia Friends. • The Council's Wellbeing Service developed a '5-ways to Wellbeing' training package for people living with dementia. The next stage involves working with the Alzheimer's Society and Memory Assessment Service to identify people who may be able to benefit from the training. • Final planning consent was given for the Grassy Meadow extra care sheltered housing scheme, which includes the Dementia Resource Centre.
3.4 Implement requirements of the	**3.4.1** Implement the SEND reforms including	LBH/CCG	Quarterly	• There are 775 Education, Health and Care Plans of which 498 are transfers from previous Statements.

Children and Families Act 2014	introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service planning for children, young people and families			There are a further 973 Statements to transfer by 31 March 2018 in line with the Transfer Plan. • The Local Offer working group is overseeing delivery of the action plan. • The SEND Steering Group is overseeing improvements including readiness for Ofsted/CQC inspection. • Resource allocation systems to deliver personal budgets for children with disabilities and those with special educational needs are being piloted. A creative support planning project is underway for children with disabilities. • Disabled Go are undertaking the accessibility surveys of the 1000 chosen venues in the borough.
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 opens 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 to include sixth form provision. • Eden Academy has submitted expressions of interest to establish 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 the additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school.

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 three-year (2017 - 2020) 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	• 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.