Health and Wellbeing Board

SUPPLEMENTAL AGENDA 2

DATE: **Thursday 10 January 2019**

AGENDA - PART I

9. SOCIAL PRESCRIBING (Pages 3 - 26)

Report of the Director of Public Health, Harrow Council, and Managing Director Harrow Clinical Commissioning Group

14. ANNUAL REPORT ON IMMUNISATION (Pages 27 - 54)

Report of NHS England

Note: In accordance with the Local Government (Access to Information) Act 1985, the following agenda items have been admitted late to the agenda by virtue of the special circumstances and urgency detailed below:-

Agenda item	Special Circumstances/Grounds for Urgency
9. Social Prescribing	This report was not available at the time the agenda was printed and circulated as consultation was taking place. Members are requested to consider this item, as a matter of urgency.
14. Annual Report on Immunisation	This report was not available at the time the agenda was printed and circulated as consultation was taking place. Members are requested to consider this item, as a matter of urgency.

AGENDA - PART II - NIL

Harrow COUNCIL LONDON

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	10 January 2019
Subject:	Social Prescribing Position paper
Responsible Officer:	Joint Report Javina Sehgal , Managing Director Harrow CCG and Carole Furlong Director of Public Health Harrow Council.
Public:	Yes
Wards affected:	all
Enclosures:	Appendix 1- Social Prescribing Models Appendix 2 – Social Prescribing Interventions Appendix 3 – Adult Social Care Vision

Section 1 – Summary and Recommendations

This report sets out the context and the evidence for Social Prescribing. It has been developed using information from different sources including a number of engagement events and work on developing resilient communities held by the LA. It has culminated in a Task and Finish Group working across the LA and CCG, supported by a wider Community Resilience group working across Harrow. This paper details the Social Prescribing Strategy for Harrow within the context of a wider Community Based Asset Development approach.

Recommendations:

The Board is requested to:

- Support the development of an in house social prescribing coordination for Harrow as outlined and request quarterly briefings on the progress
- Note the interim funding agreed by the CCG and Council for the continuation of the current Social Prescribing service Healthwise run by Capable communities to 31st March 2019. Note that this service was not

funded by the Council or CCG previously but as its current funding from other sources runs out in December 2018.

Section 2 – Report

What is Social Prescribing?

In its simplest form, social prescribing is a method for the health professional to prescribe a structured social activity to a patient with wider social, emotional or practical need which cannot be met by clinical or social care services.

The rationale for this is that health is determined by social, economic and environmental factors and adding social prescribing as another tool in additional to clinical and social care allows a more holistic approach to support patients to manage and take greater control of their health.

Without this support, patients may frequently attend primary care and their health may be further compromised resulting in need for secondary care. It is estimated that around 20% of patients consult their GP for what is primarily a social problem with 15 % of GP visits for social welfare advice. We do not know how much of the demand on front line social workers can be reduced by social prescribing as similar information from social care services is not yet collected. However, one can envisage that loneliness, social isolation, carers' wellbeing are factors that do impact on social care.

The social needs of people can vary from being socially isolated due to limited mobility or carer responsibility, loss of their purpose and meaning of life due to bereavement or retirement, financial challenges due to loss of income. Therefore, a range of structured activities need to be in place for social prescribing to be effective. The prescriptions can include referrals to a variety of services/activities such as arts, volunteering, physical exercise, such as gardening and dance clubs, and/or referring to services that offer advice to debt, benefits and housing.

Social prescribing is a tool for health promotion. Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

What is the Evidence that Social Prescribing works?

A systematic review[1] of the evidence assessing the impact of social prescribing on healthcare demand and cost implications showed average reductions following referral to social prescribing of 28% in GP services, 24% reduction in attendance at A & E and statistically significant drops in referrals to hospital. A systematic review of social prescribing literature was broadly supportive of its potential to reduce demand on primary and secondary care. The quality of that evidence is weak, and without further evaluation, it would be premature to conclude that a proof of concept for demand reduction had been established. Similarly, the evidence that social prescribing delivers cost savings to the health service over and above operating costs is encouraging but by no means proven or fully quantified. Studies have pointed to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety.

One has to remember, that social prescribing projects grew from the need recognized by primary care and were not set up as research projects to collect data. The best example of such a project is the Bromley- by –Bow Centre which has been a successful project. A number of social prescribing projects are now collecting data.

Early results from pre and post analyses from the Merton[2] social prescribing found

- 18% reduction in A& E attendance with a 32% reduction in cost
- 30% reduction in emergency admissions with 56% reduction in cost
- 20% increase in planned (elective) admissions with an increase of 10% cost
- 14% reduction in outpatients with 22% reduction in costs

The evaluation[3] of Rotherham social prescribing service included a similar before and after analyses and at 6 and 12 months (different cohorts) they found the following results:

- 14% and 21% reduction in inpatient admissions
- 12% and 20% reduction in A&E attendance
- 15% and 21% reduction in outpatient attendance

The Rotherham evaluation also measured the progress in feeling positive, self-care and managing symptoms, life style, social connections. The largest benefits were found amongst those that had the lowest score with the following proportion of people making progress:

- 61% feeling positive
- 60% showing improvement in self care
- 57% managing symptoms
- 54% improving social connections
- 76% reporting financial improvement

The Tower Hamlets social prescribing service evaluation[4] found that the there was a reduction in the MyCaW[5] Scores at 12 weeks. The MyCaW is a tool

[1] Polley, M. Bertotti, M. Kimberlee, et al A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications University of Westminster , June 2017

[2] Nobel A Personal communications to Harrow social prescribing task and finish group, Nov 2018. NEL CSU

[3] Centre for economic and social benefits : The Evaluation of economic and social impact of Rotherham Social Prescribing Pilot Summary Evaluation Report Sept 2014 Sheffield Hallam University , 2014

[4] Tower Hamlets Together and UCL Social Prescribing in Tower Hamlets: Evaluation of Borough-wide Roll-out March 2018

that is designed for patients to decide which 1-2 concerns/problems they want to be supported on (e.g. pain, debt) and score from 1-6 how much that concern bothers them before and after support.

There is general consensus that any social prescribing service or pilot needs to have robust evaluation built in from the start.

What do we know about Models of Social Prescribing?

There are different models of social prescribing. Models range from a referral (prescribing) from primary care services to a link worker to building on asset based social capital and health generating models. More advanced include a combination of both. They can also differ in what is offered. The reason for such variation is that social prescribing is based on local needs. Some models and examples are provided below:

1. A mainly sign posting offer with a facilitator (care navigator or link worker) signposting people to appropriate services/activities in the community. In this case the facilitator acts as a bridge between primary care and the community. In some cases, this happens within primary care where a healthcare assistant is trained to be a social prescriber.
2. A prescriptive service with free structured interventions (8-12 weeks) to support people to build the skills/resilience to manage/overcome the main cause that triggered referral with follow up for 12 months. An example of this locally would be the Expert Patient Programme and the Exercise On Referral programme. This may be complimented by signposting to other services/activities of which some may be chargeable.
3. An asset based approach service with a combination of 1, 2 and further building capacity within communities for health improvement.

Examples of different social prescribing models are given in appendix 1. All schemes have a facilitator/care navigator or social prescriber embedded in GP practice, voluntary sector, or council. They can be employed by any one organisation and be trained in motivational interviewing skills.

How does Social Prescribing Fit with current Policy Frameworks?

There has been an interest in social prescribing from the ground for many years and now it is included in different policy /strategy documents nationally as listed below

- Social prescribing is one of the main interventions in the Prime Minster's Strategy to tackle loneliness- Connected Societies (2018). There is an expectation that every GP surgery across the country will be able to offer social prescribing by 2023
- The Department of Health and Social Care announced a fund to invest in social prescription and 23 projects across England were funded through this scheme in 2018.
- The Ministry of Housing, Communities and Local Government has funded £3.3 million Communities Fund, for partnerships to deliver social prescribing interventions to help tackle loneliness amongst the elderly and young people.

[5] Pearson C Measure Yourself Concerns and Wellbeing (MYCAW) Institute of Health Services Research, Peninsula Medical School, University of Exeter, St Luke's Campus, Exeter EX1 2LU

- The NHS forward view (2014) and the GP Practice Forward View (2016)
- The Local Government association has published guidance on social prescription for local authorities
- It is expected that the NHS long term plan to be published will also have social prescribing as one of the key areas of action.

Current situation

Currently the CCG and Council do not commission a social prescribing service in Harrow. However, there are a number of services that health and care professionals can make referrals for wider social and life-style needs of their patients and clients.

The Council runs and funds a number of activities which are suitable for social prescribing and referrals are received from various frontline services.

• Expert patient Programme (EPP) trained volunteers who run 6 weeks course on chronic disease self – management	The Expert Patients Programme (EPP) is a free course is for people who are living with any long-term health condition and/or their carers. It is run by tutors who are also living with long term conditions and will help and support them to manage their conditions more effectively. Courses run for 6 weeks, once a week for 2.5 hours including a 20minute break. All courses have 2 tutors working together as co-tutors. The maximum amount of people on an EPP course is 16 and the minimum 6. It is run at Wealdstone centre
• Healthy walks	50 trained health walkers supporting at least 1 walk per day every week for people of all levels of fitness and abilities (walks also suitable for people in wheel chair) Last year about 350 new walkers joined the walks in Harrow
• Exercise on referral	This is integrated in the contract with Everyone Active
• Books on prescription and reading well initiative	Available through libraries
• Training and capacity building	MHFA training Oral Health training Busy Feet
• Coordination and support for Healthy Schools and Healthy Early Years Programmes	
• Wiseworks	a local mental health pre-vocational work centre provided by the Disability Day Services of Harrow Council. For more than 25 years, the service has worked with people recovering from mental health problems by assessing their work skills, providing comprehensive work rehabilitation and arranging training at local colleges.
• Adult and Family learning	Wellbeing courses – dance and drama therapy,

(learnharrow.ac.uk)	confidence building arts, yoga (these are about £5 for the full course 8-12 weeks) Skills based courses e.g sewing , book keeping, music, cake decorating , excel English language classes, family (intergenerational classes) and courses for parents Harrow learning participated in the community mental health research project. The findings from the research found that The Community Learning Mental Health (CLMH) research project aimed to identify the potential for adult and community learning courses to help people develop the tools, strategies and resilience to manage, and aid recovery from, mild to moderate mental health problems, such as anxiety and depression. This project was designed to build on the existing evidence base supporting the impact of adult and community learning on mental health and wellbeing. **The research reported that 55% of people with common mental health problems such as depression and anxiety that attended the courses at the Learn Harrow showed indications of recovery.**

In June 2017, Capable Communities, received a grant of £69K for 18 months for a social prescribing service- Healthwise. There was expectation that Healthwise would generate income to make the service sustainable. Healthwise has requested funding from CCG and the Council as its current funds including income generated will run out in December 2018.The CCG and Council considered this request as a one off funding of £15K to support the service to March 2019.

According the information received from Capable Communities, for the period June 2017 to December 2018, Healthwise provided access to services across three categories:

- 38% Rights – accessing information, advocacy and advice - mainly housing and welfare benefits
- 34% Health – healthy eating (20%), managing diabetes and /or hypertension (12%), dementia (2%) and falls prevention (1%)
- 28% Wellbeing – reducing isolation, purposeful activities.

Table 1 highlights the type of activity and number of users that Healthwise engaged (the total number has been revised to 4867 but no breakdown of sessions /users is available).

Table 1 Sessions run and number of users engaged (referred?)

Activity	Sessions	Number of users engaged
Dementia Activity Sessions	76	26
Falls prevention Sessions	72	46
Healthy Living Group Sessions	75	56
EPP General sessions	6	17
EPP diabetes sessions	8	17

Health Eating Session	220	421
BP checks	12	157
Walk sessions	700	74
Dementia 3R	16	45
Subtotal		859 (807 individuals?)
Signposting	1744	2002

Around 807 individuals engaged in different sessions and of these, around 700 reported improved scores on the STAR tool.

The information from the project commissioned by Adult Social Care on mapping voluntary and community care services as part of building resilient communities found that there are around 800 voluntary and community organisations in Harrow providing a different range of services that support residents. Many of these may be offering interventions/activities suitable for social prescribing and some are already included in the signposting list from Healthwise.

What is the Size of Population that could benefit?

The ONS mid-year estimate for adult population in Harrow was 189.5 K. Figure 1 below shows the age structure of the adult population. 10% of the population is in the transition stage age of 19-25 years and 10% is 75 + years. Social prescription services required for these two groups will be very different. Figure 2 shows the diversity in Harrow that indicates a need for cultural perspective

Figure 1 Age structure of adult population in Harrow (2018)

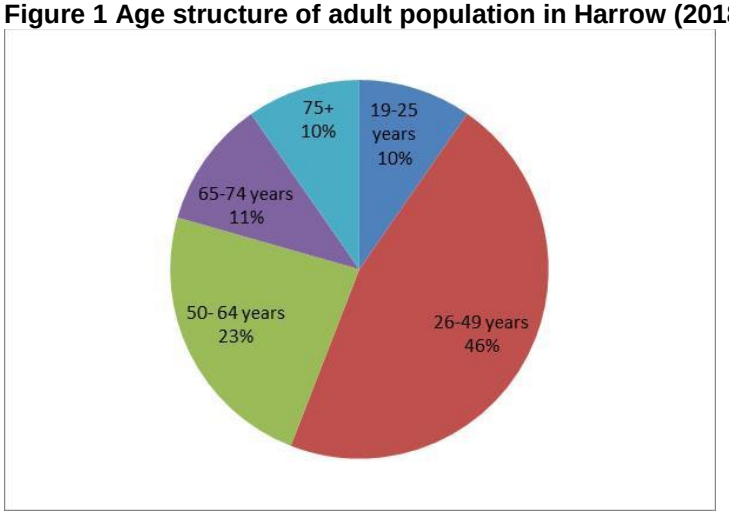
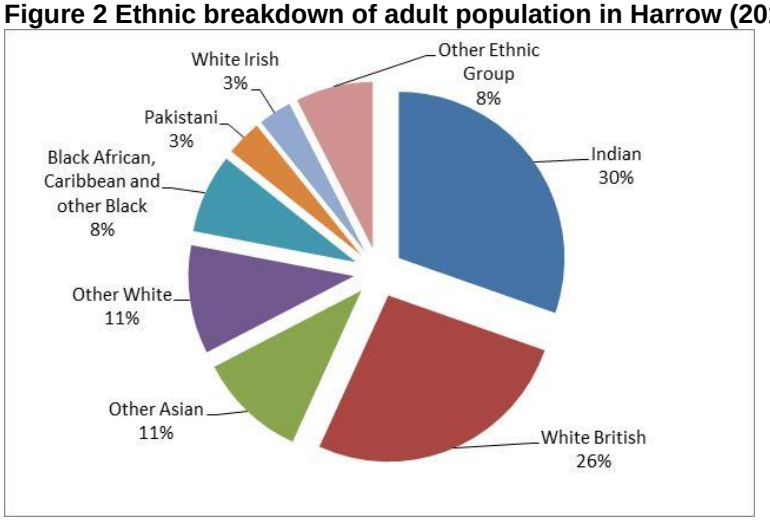
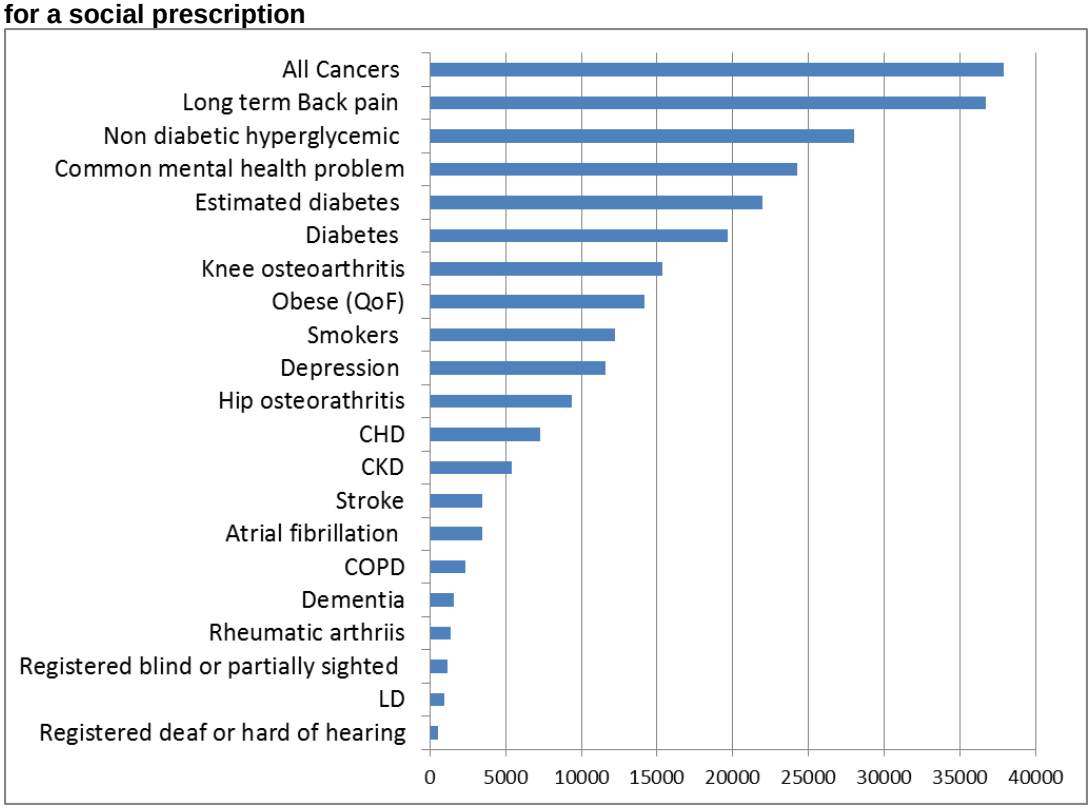


Figure 2 Ethnic breakdown of adult population in Harrow (2018)



The following figure and tables show that there are a large number of people with different long term conditions who may benefit from a social prescription. Many of these people will have multiple conditions so the categories are not mutually exclusive.

Figure 3 The potential cohort size of people with different conditions that are suitable for a social prescription



Source: Produced from various profiles on PHE fingertips 2018

Table 2 Number of people registered as sight impaired/blind in Harrow between 1st April 2016 to March 2017

Type of Sight Impairment	
Blind/severely sight impaired adults (registered)	665
Partially sighted/ sight impaired adults	539
Slightly sight impaired adults with an additional disability	304
Registered partial sighted /sight impaired adults with	276

additional disability	

(SOURCE: SALT Statutory Social Care data return, 2016-17, the latest data available – collected every 3 years)

Table 3 People with learning disability of working age (16-64 years) by employment status (2017/2018)

Gender	In employment		Not in paid employment		Unknown	Total
	less than 16 hours	16 hours or more	Seeking work	Not actively seeking work/retired		
Males	53	2	4	241	0	300
Females	38	0	2	181	0	221
	91	2	6	422		521

Source: SALT Statutory Social Care data return, 1st April 2017- March 2018.

Table 4 Profile of 2018 social service user survey 2018

Gender	44.1% men and 55.9% women
Age	57.6 % under 65 years and 42.4% over 65 years of age
Needs	18.6 % access and mobility issues
	40.7% personal care needs
	11.9% had learning disability
	28.8% had mental health problems

The 2018 Social Care User Survey was sent out to all 1995 users of social care in Harrow and 505 responded. The survey included a question on social isolation. Of those who responded, 29% reported being socially isolated and 22% said they did not find ways to spend their time as they would like.

Areas of gaps

Whilst there are components within Harrow that would be useful for social prescribing there is a need to develop a social prescribing pathway at scale.

What Outcomes would be achieved at population level?

One of the key aims of the social prescribing service is to empower the person to manage the social issue and look after their own health, thus reducing reliance and therefore cost across the health & social care sector. As a result the outcomes may be more personalised, however at population level some of the outcomes can be measured such as

- loneliness,
- health and care service use,
- reduction in symptoms/prevalence
- recovery and rehabilitation,
- quality of life

To provide some indications of the impact of social prescribing in Harrow data from the social prescribing modelling commissioned by Healthy London partnership (HLP) for all boroughs in London is presented in this paper.

The modelling used secondary care activity data (SUS data) to model the number of people who were seen in secondary care (planned and unplanned

activity). It used a number of evidence-based interventions to estimate the reduction in secondary care based on average secondary care service use.

Table 5 shows the potential reduction based on the cohort of secondary care users in 2016/2017. The cohort of population was those that had outpatient and inpatient activity, had between 0-2 days length of stay, which are not complex and do not require specialist services. In brief activity that can be defined as avoidable. National tariffs were then applied to these avoidable activities to estimate reduction in costs. The cost of social prescribing service was calculated as 150-200k per year. The table shows the total current costs (both avoidable and non-avoidable) in 2016/2017 and that which could have been avoided with social prescribing. The model can then be used to forecast future reductions.

Table 5 Modelled opportunities for reduction in avoidable secondary care costs in 2016/2017

Row Labels	Total cost in 2016/2017	amount of costs related to reduction in activity
Self Management for Chronic conditions	£ 7,718,002.0	£ 1,397,119.0
Living with Diabetes	£ 1,403,465.0	£ 208,459.0
New Beginnings Course	£ 329,390.0	£ 202,109.0
Exercise on Prescription	£ 1,805,128.0	£ 276,716.0
Time Banks	£ 718,620.0	£ 194,730.0
Ecotherapy for Substance Abuse patients	£ 1,038,674.0	£ 153,985.0
Social isolation	£ 1,058,528.0	£ 91,281.0
Deafblindness	£ 402,616.0	£ 68,521.0
Arts on Prescription	£ 379,049.0	£ 66,617.0
Mobility	£ 606,203.0	£ 61,080.0
Volunteer befriending service	£ 104,660.0	£ 44,133.0
Smoking cessation interventions for Asthma and COPD Patier	£ 339,016.0	£ 23,233.0
Green Gym	£ 116,080.0	£ 33,451.0
Volunteer Anorexia & Bulimia Care	£ 93,247.0	£ 20,596.0
Dementia Cafe/ Food Clubs	£ 207,491.0	£ 19,010.0
Books on Prescription	£ 322,215.0	£ 5,682.0
Education on Prescription	£ 51,951.0	£ 12,630.0
Information,Advice and Guidance (IAG)	£ 26,617.0	£ 5,166.0
Primary support group problems (e.g. family)	£ 47,206.0	£ 6,028.0
Grand Total	**£ 16,768,158.0**	**£ 2,890,546.0**

Appendix 2 shows the modelled reduction by practice level. The practices with larger list size and older population are likley to see the greatest benefits to their patients from these interventions.

What are the Options for Harrow?

In line with national strategy Harrow will need to implement a social prescribing offer to all GPs by 2023. In addition, it has to be at a scale that all patients that can benefit can be given a social prescription.

To do so, there are a number of innovations to social prescribing that may need to be introduced in line with some of the innovative integration processes already happening in Harrow

- A shift away from GP attendance for social prescribing referral to pharmacy and social worker referrals into SP.

- It should build capacity within communities using an assets based approach to build resilience
- It should be an inclusive service enabling people to undertake activities together (irrespective of physical or mental health conditions) free of charge to the patient.
- Patients needs to followed through the pathway with clear outcomes and follow up data collated and fed back to referrer
- Evaluation needs to be build from the start in the programme.
- It needs to be part of integrated services in future

To deliver a prototype service model that is cost-effective in delivering long-term benefits to the population of Harrow the following options have been considered.

Option 1: Commission the current Healthwise social prescribing services after March 2019.

Advantage: The service is already set up and has clients
Limitations: The service is depended on other services provided by the council such as Expert Patient Programme, Healthy Walks, cookery, adult learning classes being run and will require additional monies to expand it to cover other interventions. The outcomes are not clearly defined in relation to the at risk groups.
Financials: Cost per year £292K is requested by Healthwise from CCG and Council to run a social prescribing service

Option 2 Develop a service specification and procure a social prescribing service.

Advantage: Allows the partners to write a specification to meet the needs in Harrow and test market for providers
Limitations: This will require a commissioning process from a fuller understanding of needs (from both health and social care services), gap analyses and interventions directory to meet those needs. The time and cost associated with this approach needs to be factored into the overall project cost and feasibility.
Financials: To be determined from requirements

Option 3
Develop and test a prototype in-house in 2019/2020

Advantages: The programme will be closely linked to delivery against health and social care needs.
It builds on the success of the coordination and delivery of existing programmes such as healthy walks; EPP programme; adult learning programmes and offers the ability to restock the books on prescription.
The programme is aligned and can link with other current plans in the council and CCG. These include :-
- The adult social care is developing the community resilience vision (appendix 3) that includes developing a digital directory.

- The cultural strategy offer of increasing participation
- CCG health and care integration care pathway modelling and a “one click” referral from EMIS (GP system) for social prescribing and feedback to the GP .This is one of the criticisms of current system.

Limitation: The programme relies on the delivery of a digital directory. There may be reluctance to engage by existing providers of Healthwise services.

Financials: This would require 1.0 FTE at G7 and 0.5 admin at G3 in public health team to coordinate and monitor the social prescribing service. There will be a requirement to train health and care frontline workers on the Social Prescribing pathway. Health Education England may be approached for funding this training or it can be funded by CCG and adult social care with the training provided by public health.
Additional costs associated with the delivery of programmes need to be factored in.
The CCG and Council share the costs with CCG providing the software and training to practices and the public health team providing the coordinator and administration.

Recommendation: We recommend Option three and ask the Board to support this decision.

Implications of the Recommendation

Option 3 is recommended so that the current services can be utilised effectively for developing a local evidence based social prescribing pathway. This will allow integration of other wider local authority services for better health and wellbeing outcomes with the current health and care integration.

Resources, costs and risks

As a prototype programme, we will initially work with two or three practices and the voluntary sector to develop and test the new model of delivery in 2019/2020. We will then roll out to all practices in line with national strategy in 2020. We have been in discussion with Healthy London partnership to support the modelling of activity costs and reductions in social care costs during the prototype. Healthy London partnership will be part of the working group on the prototype.

Staffing/workforce

This would require 1.0 FTE at G7 and 0.5 admin at G3 in public health team to coordinate and monitor the social prescribing service.
There will be a requirement to train health and care frontline workers on the Social Prescribing pathway. Health Education England may be approached for funding this training or it can be funded by CCG and adult social care with the training provided by public health.

Equalities impact

This service should be accessible to all residents that meet the criteria that will be developed for Social Prescribing in Harrow for prototype. It is expected that those with Long term conditions and are socially isolated will benefit the most. A full EQIA will be undertaken as the model is developed.

Community safety
No implications identified.

Financial Implications

The costs of the preferred option to develop and test a prototype are expected to be in the region of £103K in a full year. This will be funded by both the local authority (approx. £53.5k for staffing costs associated with co-ordination and monitoring) and the CCG (approx. £50 K for software and training). The staffing costs will be contained within the existing 2019/20 Public Health budget.

In all options, there is an expectation the current programmes contributing to the social prescribing model that are funded by the council or CCG will continue at their current level. (e.g. Adult learning; Exercise on referral; EPP).

Any wider adoption of the social prescribing model beyond 2019/20 will need to be considered by each partner organisation as part of its annual budget setting process, supported by a business case which identifies the required level of investment and which clearly sets out the return on investment i.e. the ability to reduce health and social care costs across the partnership.

Legal Implications/Comments

(If any)

Risk Management Implications

Identify potential key risks and opportunities associated with the proposal(s) and the current controls (in place, underway or planned) to mitigate the risks.

Equalities implications

Was an Equality Impact Assessment carried out? /No
The EqIA will be carried out as part of the evaluation in the prototype

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

- Making a difference for the vulnerable

This paper sets out a service which will benefit by meeting the wider social needs of those that are vulnerable by providing opportunities to connect, add meaning and purpose and learn.

- Making a difference for communities

This paper sets out a service which provides health and wellbeing improvement opportunities for communities

- Making a difference for local businesses
- Making a difference for families

As found in the research from the adult learning services , family learning opportunities provide intergenerational opportunities to improve wellbeing

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Name: Usha Chauhan Date: 2 January 2019	x	on behalf of the Chief Financial Officer
Name: Sharon Clarke Date: 3 January 2019	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact:
Heema Shukla, Consultant in Public Health – Harrow Council
heema.shukla@harrow.gov.uk
and
Joanna Paul, Programme Integrated Care Programme Harrow – Harrow CCG
Joanna.paul@nhs.net

Background Papers: None

Appendix 1: Social prescribing models

Area	How it is run	Description on offer
Culm Valley Integrated Centre For Health Social prescribing model	Health Facilitator with training in motivational skills	• Being a face to face health resource for patients referred by other professionals (particularly GPs) and self-referred • Provides advice on exercise, nutrition etc…, demonstrate means of self-care such as the free on line Thought Field Therapy programme (rather like CBT) and signpost to voluntary organisations or self-help groups • Acts as catalyst for these self-help/self-care groups, which includes groups for:- o Specific disease areas - e.g. patients with heart disease, diabetes and fibromyalgia. o Specific needs - e.g. "Knit and Natter" group for the socially isolated, Creative writing, printing and book reading groups for patients needing directed activity/socialisation. o Specific form of activity, often led by patients themselves, such as the Amblers Walking Group and Community Gardening Group. • Acts as the interface between local voluntary statutory agencies and individual patients and the surgery itself. This includes awareness of all local voluntary and statutory agencies, directing individual patients to them as necessary and working with individuals involved in them • Acts as the "face" of health promotion at the surgery/Integrated Centre with a room marked "Health Facilitator", wearing an appropriate badge and being very much part of the "scenery" in the waiting room, café and other public areas of the Integrated Centre with advertised and availability in the waiting room and café. Her presence together with a range of self-care activities in the surgery (e.g. patients measure their own blood pressure/weight/BMI on an automated machine and can directly access Calm Zone – thought field therapy) extends the message and ethos of self-care to patients visiting the surgery (90% of registered patients will visit the Centre during the year) and community
Way to Wellness	Ways to Wellness holds the contract for developing the offer for and contracts for	Ways to Wellness is for people with certain long-term health conditions, aged 40 to 74, who attend GP practices within the pre-existing NHS Newcastle West Clinical

	social activities, training for link workers and raises funds and contracts with social investors and manages the referrals and data	Commissioning Group area (now part of Newcastle Gateshead CCG). The eligible long-term health conditions are: • Chronic breathing difficulties (COPD) or Asthma • Diabetes (Type 1 or Type 2) • Heart Disease • Epilepsy • Thinning of the bones (osteoporosis) • Any of the above with depression and/or anxiety
East Riding of Yorkshire	The Council has developed partnership with local GPs and leisure services and libraries	Direct referral by GP to exercise on prescription, Live well programme and books on prescription. This was seen as the most pragmatic approach and is funded by public health.
Blackburn with Darwin	Volunteering on prescription with project officer, care navigator and recovery support officers	GP, social care or other council teams refer to CVS led 2 social prescribing volunteering scheme. One programme is aimed at people with drug and alcohol and the other is for people with mental health problems. Project officers link them with the most appropriate volunteering opportunity with the help of community navigator or recovery support officer
Luton Council	In house social prescribing using the existing infrastructure in place – exercise on referral, volunteering. Care navigators were employed. The programme is funded by public health, better care fund and DCLG	GPs refer to community navigator with patients setting on the goals and preference activities and the navigators arrange 12 week prescription. Patients are given smart cards which they scan when they attend activities so hat the progress can be tracked and measured. The patient returns to community navigator after 12 weeks to have an assessment and progress towards self-care. The programme now has 20 accredited providers covering 5 areas- social activity, volunteering, physical activity, wellbeing and mental health, information advise and guidance.

		Some of he services are run by the Council and some run by external organisations.
Rotherham	Voluntary Action Rotherham in partnership with 20 organisations have five social prescribing workers funded by CCG	Integrated case management led by GPs and including social workers and other health professionals refer to social prescribing workers. The social prescribing worker visits the patient at their home to carry out a guided conversation with the patient and work out what prescription to offer. He prescription can be anything between 8-16 weeks which can include a range of activities such as metalwork clubs for men , range of exercise clubs. Patients can continue with activity after the prescription ends.
Cotswold District Council		
Tower Hamlets	Tower Hamlets has a history of providing social prescribing in two GP practices, the Bromley-by-Bow Centre and the Mission Practice. In 2016, Tower Hamlets Clinical Commissioning Group funded an 18 month roll-out of social prescribing across the borough with the local GP federation, Tower Hamlets GP Care Group, acting as lead provider organisation. The service is delivered by 10 Social Prescribers (9 WTE) through Tower Hamlet's 8 GP Networks. Each GP	The range of needs Social Prescribers have supported clients with demonstrates how holistic the service is (for example, 24% clients presented with weight management issues,1 21% with low level mental health needs, 16% with social isolation, 13% with housing issues and 13% with financial concerns) and the high number of onward referrals and signposts (2,034) to a large range of organisations (333 activities across 279 organisations) in the borough highlights the breadth of services available to primary care users through social prescribing. Nearly a quarter (22%) of clients receiving an onward referral or signpost were given 3 or more referrals.

	practice has a named Social Prescriber.	
Merton	CCG and Public health funded a pilot with 2 GP practices with link worker at each practice. The existing service model involves employing a 'link worker' known as a Social Prescribing Navigator working at each respective practice two days a week. The link worker is visible to the primary care team, and encouraged to be seen as a fully integrated member of the practice team. The post holder has been given appropriate training on EMIS, and has a wealth of local knowledge about services available in the community, as well as strong links to community and volunteer organisations. The post holder is an employee of Merton Voluntary Service Council (MVSC) and is supported by this organisation	The referral is made when a GP refers a patient to the service and the Social Prescribing Navigator books a one-hour initial consultation. At this consultation the navigator offers strategies to self-manage the patient's problems by either: 1) Sign posting – directing patients to non-clinical services / self-directed advice; 2) 1:1 Assessment service where needs are complex. 3) Assisting with form filling, benefits eligibility checks, and initial engagement in counselling. Some other interventions include: 1) Improving stability of home and family life; 2) Promoting better mental health and resilience; 3) Relationship guidance; 4) Volunteering; 5) Social connectedness to reduce isolation. The patient is offered a follow-up appointment and the navigator records notes directly into the patient record.

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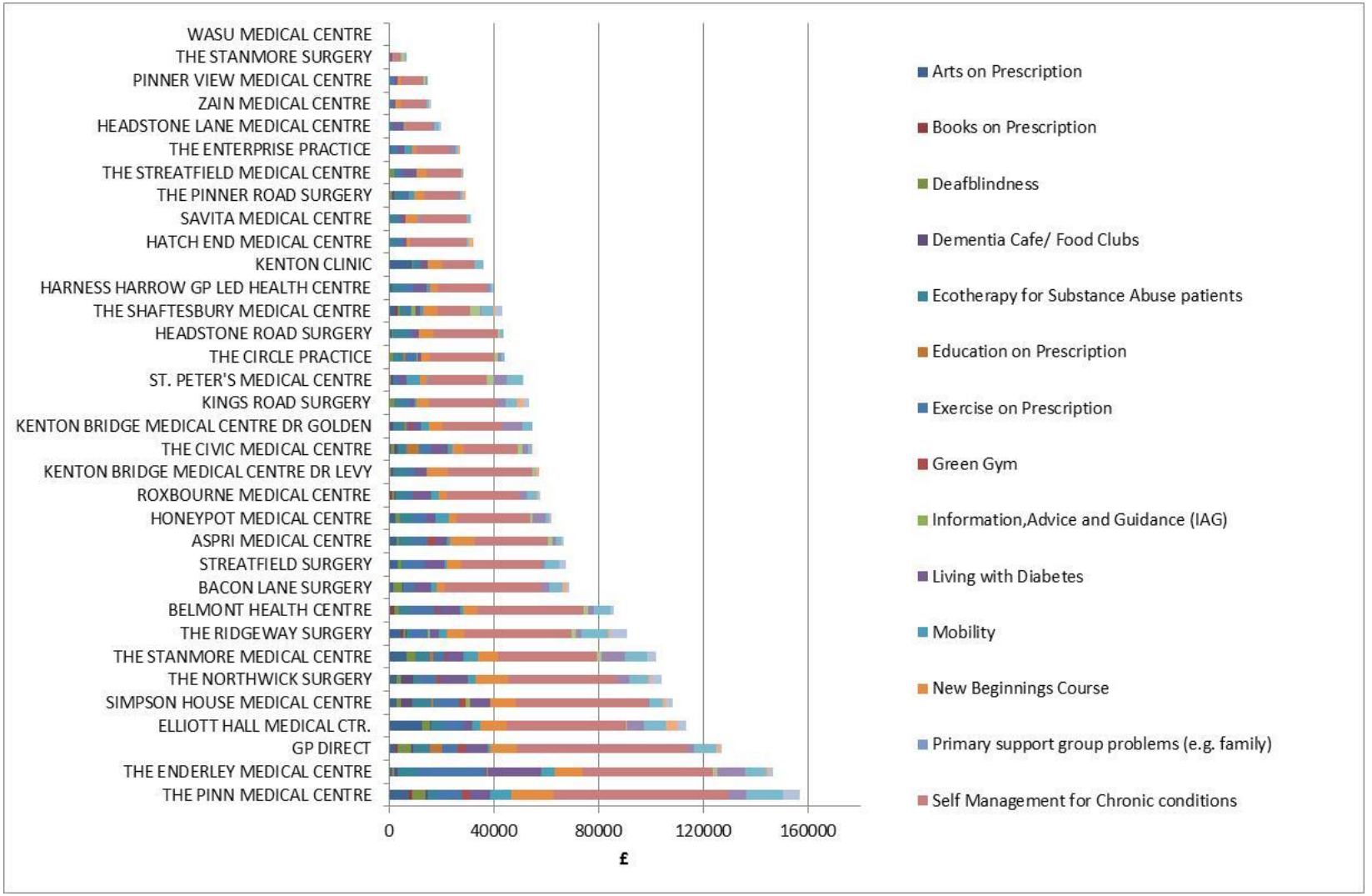
Appendix 2: Social prescribing interventions modelled reductions in secondary care by GP practice



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Appendix 3 : Adult Social Care vision

The vision of adult social care is resilient communities. Community resilience in the context of the Adult Social Care Vision (2018) can be defined as empowering citizens to maintain their well-being and independence, strengthening support networks within their families and communities; enabling them to be stronger, healthier, more resilient and less reliant on formal social care services.

As an enabler to explore a community assets model to support community resilience, an external agency, 'Lateral' were commissioned. Lateral delivered a project to find opportunities within the current system and way of doing things in the current climate of financial constraints and increasing citizen need. Coming from a design stance, Lateral's methodology included developing the 'Lateral' room, a process designed to re-think the 'problem' and 'solutions' in a way which can lead to new ways of thinking.

Key themes that emerged were;

- Information: How might we make information visible and accessible to all.
- The business model: How might we re-think the business models supporting how VCS organisations operate and deliver services to clients, carers and citizens.
- Carers: How might we provide carers with more support, opportunities and services
- Volunteers: How might we recruit and use volunteers more effectively.

From these themes and evidence based, the Lateral piece of work concluded with 3 potential projects areas to pilot and test the hypotheses.

These were:

- Connected Community Hubs e.g. multi-purposes places to connect information, advice, activities and opportunities.
- Connected digital services e.g. a holistic way to access information together.
- Shared lives / Home-share and how might we increase home share programmes to support people with different needs in Harrow.

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	10 January 2019
Subject:	**INFORMATION REPORT** – Childhood and School Age Immunisation Programmes in Harrow
Responsible Officer:	Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination Services, NHS England (London)
Exempt:	No
Wards affected:	All
Enclosures:	Report on Section 7a Immunisation Programmes in London Borough of Harrow

Section 1 – Summary

This report is an update on the delivery of the NHS England (NHSE London) commissioned immunisation programmes. It notes the uptake of the different programmes against nationally set targets, describes exception reports and actions being taken to improve performance or manage any serious incidents affecting Harrow residents..

FOR INFORMATION

Section 2 – Report

This paper provides an overview of Section 7a childhood and school age immunisation programmes in the London Borough of Harrow for 2017/18. The paper covers the vaccine coverage and uptake for each programme along with an account of what NHS England (NHSE) London Region are doing to improve uptake and coverage.

Section 7a immunisation programmes are publicly funded immunisation programmes that cover the life-course and the 18 programmes include:

Antenatal and targeted new-born vaccinations
Routine Childhood Immunisation Programme for 0-5 years
School age vaccinations
Adult vaccinations such as the annual seasonal influenza vaccination

This paper focuses on those immunisation programmes provided for 0-5 years under the national Routine Childhood Immunisation Schedule and those programmes provided for school aged children (4-18).

Members of the Health and Well-Being Board are asked to note and support the work NHSE (London) and its partners such as Public Health England (PHE), the local authority and the CCG are doing to increase vaccination coverage and immunisation uptake in Harrow.

Key messages:

- Harrow's immunisation rates are similar to or slightly higher than the London rates but are generally lower than the national rates.
- NHS England are tackling low immunisation uptake and coverage through
    - Improving data quality;
    - Performance management of immunisation contracts;
    - Improving quality of services; and
    - Raising public awareness and changing perception of immunisation..

Section 3 – Further Information

None

Section 4 – Financial Implications

NHS England is responsible for commissioning Section 7a immunisation programmes.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

As a topic that seeks to reduce the number of cases of and deaths from cancer, the report incorporates the following priorities: .

- Making a difference for the vulnerable
- Making a difference for families

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 8 January 2018		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact:
Miss Lucy Rumbellow, Immunisation Commissioning Manager for North West London, NHSE
Dr Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination Services, NHSE

Background Papers: None

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Report to Health and Well-Being Board on Section 7a Immunisation Programmes in Harrow 2017/18

Report on Section 7a Immunisation Programmes in London Borough of Harrow

Prepared by: Miss Lucy Rumbellow, Immunisation Commissioning Manager for North West London and Dr Catherine Heffernan, Principal Advisor for Commissioning Immunisations and Vaccination Services
Presented to: Health and Wellbeing Board.

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Aim

- The purpose of this paper is to provide an overview of Section 7a childhood and school age immunisation programmes in the London Borough of Harrow for 2017/18. The paper covers the vaccine coverage and uptake for each programme along with an account of what NHS England (NHSE) London Region are doing to improve uptake and coverage.

- Section 7a immunisation programmes are publicly funded immunisation programmes that cover the life-course and the 18 programmes include:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal influenza vaccination

- This paper focuses on those immunisation programmes provided for 0-5 years under the national Routine Childhood Immunisation Schedule and those programmes provided for school aged children (4-18).

- Members of the Health and Well-Being Board are asked to note and support the work NHSE (London) and its partners such as Public Health England (PHE), the local authority and the CCG are doing to increase vaccination coverage and immunisation uptake in Harrow.

2 Roles and responsibilities

- *The Immunisation & Screening National Delivery Framework & Local Operating Model* (2013) sets out the roles and responsibilities of different partners and organisations in the delivery of immunisations.

- Under this guidance, NHS England (NHSE), through its Area Teams (known as Screening and Immunisation Teams), is responsible for the routine commissioning of all National Immunisation Programmes under the terms of the Section 7a agreement. In this capacity, NHS England is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake & coverage levels. NHS England is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

- Public Health England (PHE) Health Protection Teams lead the response to outbreaks of vaccine preventable disease and provide expert advice to NHSE screening and immunisation teams in cases of immunisation incidents. They also provide access to national expertise on vaccination and immunisation queries. In Harrow, this function is provided by the PHE North West Health Protection Team.

- Clinical Commissioning Groups (CCGs) have a duty of quality improvement, and this extends to primary medical care services delivered by GP practices, including delivery of childhood immunisation services.

- Across the UK, the main providers of childhood immunisation are GP practices. In Harrow, all general practices are contracted to deliver childhood immunisations for children aged 0-5 through their primary care contract.

- Central London Community Healthcare NHS Trust (CLCH) are contracted by NHSE (London) to provide neonatal BCG vaccination and the school age immunisations.

- Immunisation data is captured on Child Health Information System (CHIS) for Harrow as part of the NWL CHIS Hub (provided by Health Intelligence). Data is uploaded into CHIS from GP practice records via a data linkage system provided by Health Intelligence. The CHIS provides quarterly and annual submissions to Public Health England for their publication of statistics on 0-5s childhood immunisation programmes. This is known as Cohort of Vaccination Evaluated Rapidly (COVER) and these statistics are official statistics.

- Local Authority Public Health Teams (LAs) are responsible for providing independent scrutiny and challenge of the arrangements of NHS England, Public Health England and providers.

- Apart from attendance at Health and Social Care Overview Panels and at Health and Well-Being Boards, NHSE (London) also provides assurance on the delivery and performance of immunisation programmes via quarterly meetings of Immunisation Performance and Quality Boards. There is one for each Strategic Transformation Partnership (STP) footprint. The purpose of these meetings is to quality assure and assess the performance of all Section 7a Immunisation Programmes across the STP in line with Public Health England (PHE) standards, recommendations and section 7a service specifications as prepared by PHE with NHS England commissioning. All partners are invited to this scrutiny meeting, including colleagues from the Local Authority, CCG, CHIS, NHSE, PHE Health Protection and Community Provider service leads. Data for Harrow is covered in the NWL STP Immunisation Performance and Quality Boards.

- Directors of Public Health across London also receive quarterly reports from the London Immunisation Partnership and updates via the Association of Directors of Public Health. It is through these communication channels that progress on the Bi-annual London Immunisation Plan (2017-19) and its accompanying annual Flu Plans are shared.

3 Headlines for London

- Historically and currently, London performs lower than national (England) averages across all the immunisation programmes.

- London faces challenges in attaining high coverage and uptake of vaccinations due to high population mobility, increasing population, increasing fiscal pressures and demands on health services and a decreasing vaccinating workforce.
- Under the London Immunisation Partnership (formerly the London Immunisation Board), NHS England London Region (NHSE London) and Public Health England London Region (PHE London) seek to ensure that the London population are protected from vaccine preventable diseases and are working in partnership with local authorities, CCGs and other partners to increase equity in access to vaccination services and to reduce health inequalities in relation to immunisations.

4 Routine Childhood Immunisation Programme (0-5 years)

4.1 The routine schedule for 0-5s

- The routine childhood immunisation programme protect against:
  - Diphtheria, Tetanus, Pertussis (whooping cough), Polio, Haemophilus influenza type b (given as the '6 in 1' DTaP/IPV/Hib/HepB vaccine)
  - Pneumococcal disease, (PCV)
  - Meningococcal group C disease (Men C)
  - Meningococcal group B disease
  - Measles, mumps and rubella (MMR)

- Children aged 1 year should have received 3 doses of 6 in 1 (called the primaries) and 2 doses of Men B. If eligible, they may also be offered the targeted BCG and Hep B.

- At 12 months, they are offered first dose of MMR and the boosters of PCV, Hib/Men C and Men B.

- At 2 years and again at 3 years, children are offered annual child influenza vaccine.

- From 3 years 4 months to 5 years, children are offered 2nd dose of MMR and preschool booster (which is the fourth dose of the diphtheria/tetanus/pertussis/polio course).

4.2 Harrow and the challenges

- Harrow is affected by the same challenges that face the London region. London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons for the low coverage include:

  - the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices,
  - London's high population mobility which affects data collection and accuracy,
  - Inconsistent patient invite/reminder (call-recall) systems across London
  - Declining vaccinating workforce
  - Increasing competing health priorities for general practice

- London's high population turnover is a big factor. There is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Harrow's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. A 2017 audit by London's CHIS providers showed that by the age of 12 months, 33% of infants moved address at least once.

- However, despite London's percentage uptake being lower than other regions, London vaccinates almost twice as many 0-5 year olds than any other region. If you look at MMR2 as an indicator of completion of programme, London reported 79.5% uptake for 2016/17 compared to England's 87.6%. We vaccinated 100,293 five year olds with MMR2 in 2016/17, down from 104,031 in 2015/16 but more than any other region – South East (the next biggest region) vaccinated 99,434 (86.2% coverage)

- It could be argued that with a bigger denominator, London has a bigger number of unvaccinated children. However, only a proportion of these 'unvaccinated' children are truly unvaccinated, the others have been vaccinated abroad (there are known difficulties recording these) or within UK (records may not be updated in time for the data extraction). These vaccinations have not been captured on data systems. Similarly, there are children who are vaccinated outside the schedule (either early or late) and are not included in the cohorts reported.

4.3 Harrow's uptake and coverage rates

- COVER monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

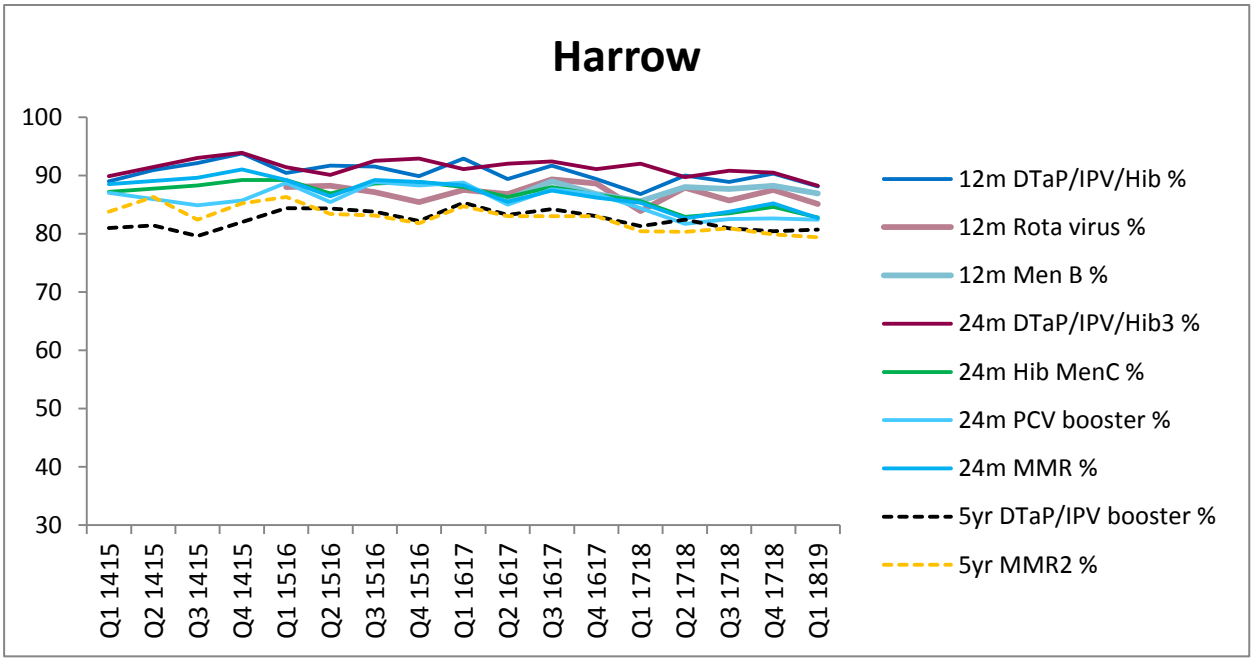
- Like many other London boroughs, Harrow has not achieved the World Health Organisation recommended 95% coverage for the primaries and MMR to provide herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).

- For immunisations, uptake is usually compared with geographical neighbours as immunisation uptake is affected by service provision and neighbouring boroughs in NWL historically have similar general practice provision and thereby provide a better comparison than statistical neighbours.

- Figure 1 provides a snapshot of all Harrow's 0-5 immunisation programmes. It can be seen that the uptake of vaccinations are close together indicating a good quality of service provision (drop off between age 1 and age 2 and again by age 5 indicates system ability to call/recall and track children).

Figure 1

Uptake rates of 0-5 vaccinations for Harrow Q1 2014/15 – Q1 2018/19



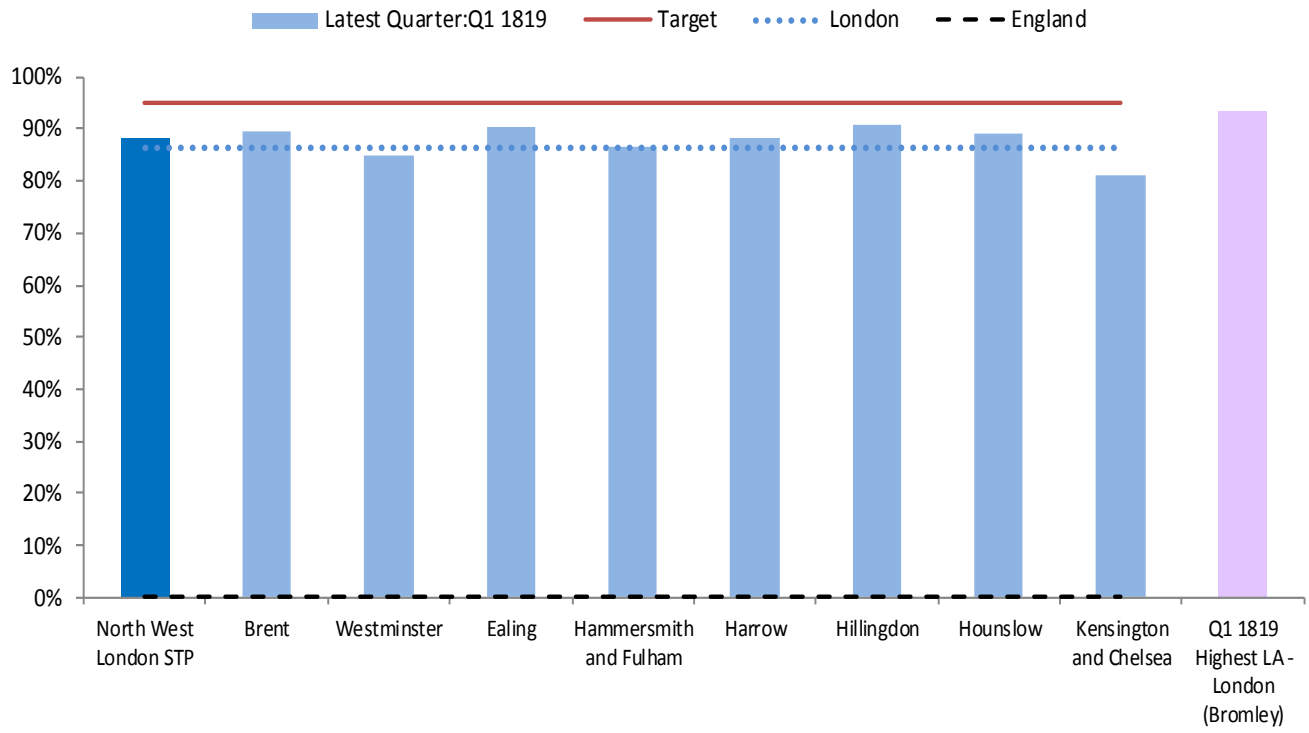
Source: PHE (2018)

- Figures 2-5 illustrate the comparison of Harrow to other North West London boroughs using quarterly COVER statistics for the uptake of the six main COVER indicators for uptake. These are

    - The primaries (i.e. completed three doses of DTaP/IPV/Hib/HepB) are used to indicate completion of age one immunisations
    - PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2
    - Preschool booster and second dose of MMR for age 5.

- Quarterly rates vary considerably more than annual rates but are used here so that Quarter 1 data from 2018/19 (the latest available data) could be included.

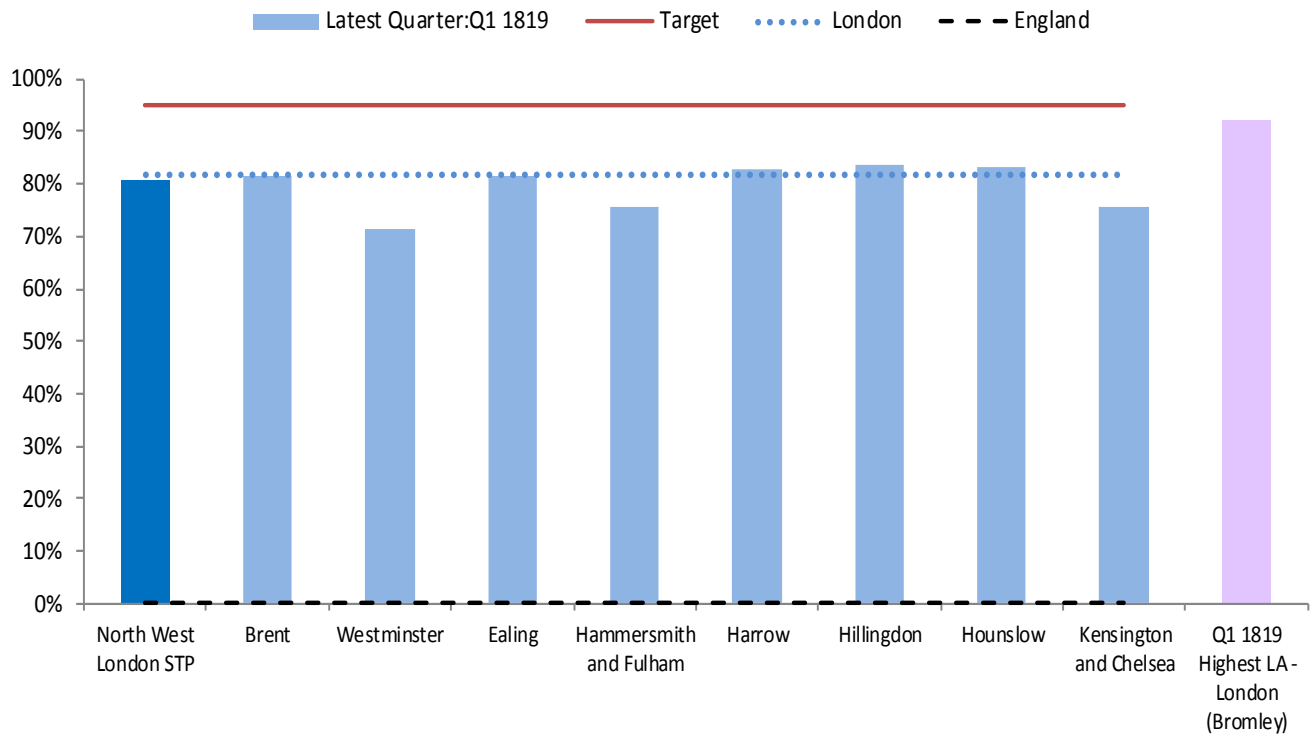
Figure 2
DTAP/IPV/ Hib/Hep B Vaccine – 1 year (quarterly data Q1 17/18 to Q1 2018/19)



	Q1 1718	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Eligible	Vaccinated	Trendline
ENGLAND	**93.0%**	**93.2%**	**93.1%**	**92.6%**	**0.0%**	**160,986**	**-**	
London	**87.3%**	**89.0%**	**88.9%**	**89.1%**	**86.3%**	**31,529**	**27,210**	
North West London STP	**88.8%**	**88.7%**	**88.8%**	**89.1%**	**88.4%**	**7,123**	**6,295**	
Brent	91.2%	89.4%	90.7%	90.1%	89.6%	1,255	1,124	
Westminster	81.7%	83.8%	80.3%	82.2%	85.1%	517	440	
Ealing	91.1%	90.1%	89.6%	91.7%	90.3%	1,264	1,141	
Hammersmith and Fulham	85.9%	88.2%	87.8%	88.5%	86.4%	560	484	
Harrow	86.8%	90.0%	88.9%	90.3%	88.1%	846	745	
Hillingdon	92.3%	91.7%	93.6%	91.9%	90.8%	1,019	925	
Hounslow	90.4%	88.8%	90.0%	90.0%	89.2%	1,078	962	
Kensington and Chelsea	80.9%	81.5%	81.1%	80.1%	81.0%	584	473	
Q1 1819 Highest LA - London (Bromley)					93.5%	1,125	1,052	

Source: PHE (2018)

Figure 3
MMR Vaccine Dose 1 measured at 2 years of age (quarterly data Q1 17/18 to Q1 2018/19)



	Q1 1718	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Eligible	Vaccinated	Trendline
ENGLAND	**91.0%**	**91.1%**	**91.1%**	**90.8%**	**0.0%**	**167,433**	**-**	
London	**82.9%**	**83.5%**	**83.7%**	**84.3%**	**81.6%**	**31,806**	**25,966**	
North West London STP	**83.5%**	**81.2%**	**80.9%**	**82.3%**	**80.7%**	**7,291**	**5,880**	
Brent	85.1%	81.1%	83.0%	82.2%	81.4%	1,242	1,011	
Westminster	74.8%	74.4%	71.7%	75.7%	71.5%	477	341	
Ealing	84.6%	82.3%	82.0%	83.2%	81.7%	1,256	1,026	
Hammersmith and Fulham	89.0%	79.6%	80.5%	80.8%	75.7%	605	458	
Harrow	85.3%	82.6%	83.8%	85.2%	82.7%	885	732	
Hillingdon	83.4%	85.1%	82.6%	86.3%	83.7%	1,106	926	
Hounslow	84.6%	82.3%	82.3%	82.3%	83.2%	1,128	938	
Kensington and Chelsea	74.7%	75.8%	72.9%	76.9%	75.7%	592	448	
Q1 1819 Highest LA - London (Bromley)					92.0%	1,130	1,008	

Source: PHE (2018)

Figure 4
Hib/MenC Vaccines uptake at 2 year (quarterly data) (2017/18 - 2018/19)

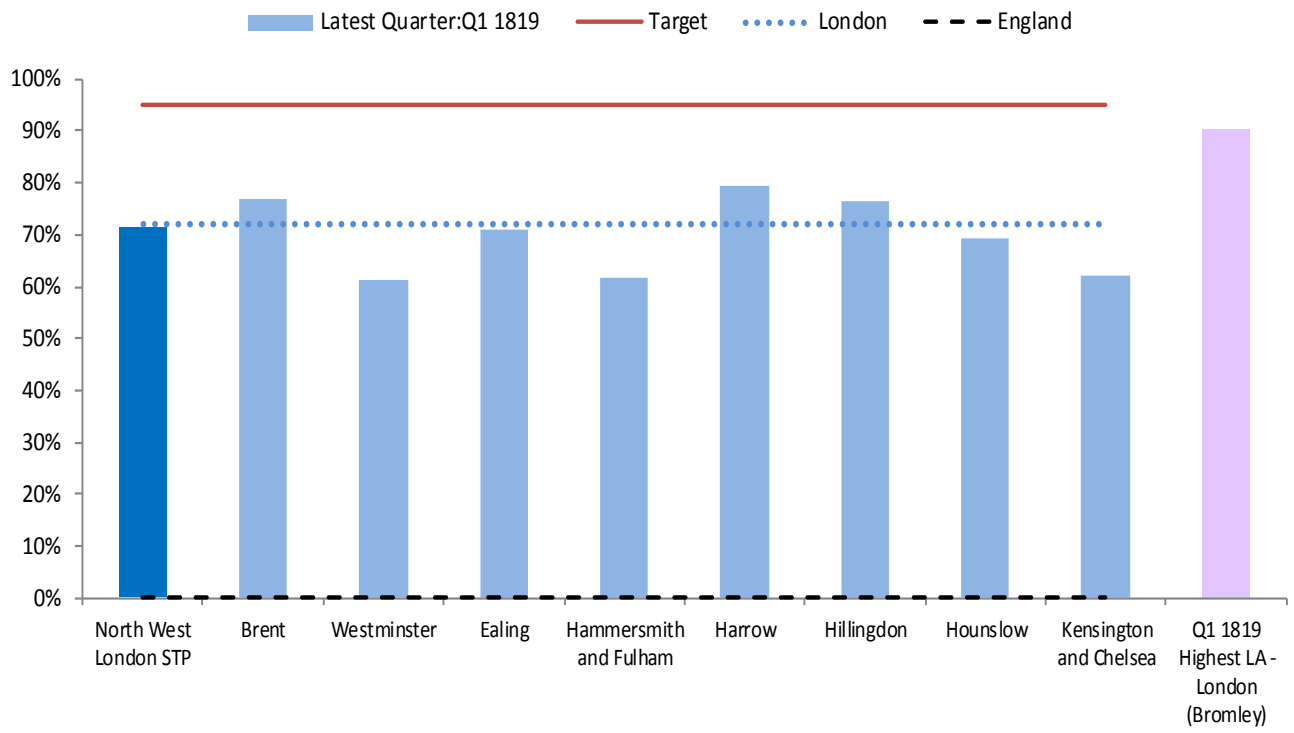
	Q2 1718	Q3 1718	Q4 1718	Q1 1819
ENGLAND	**91.4%**	**91.3%**	**91.2%**	**0.0%**
London	**84.3%**	**84.2%**	**85.2%**	**82.2%**
LA with highest uptake - London	**93.1%**	**91.1%**	**92.1%**	**92.7%**
North West London STP	**81.9%**	**81.3%**	**83.4%**	**81.5%**
Brent	**84.1%**	**83.5%**	**84.8%**	**83.7%**
Ealing	**82.5%**	**83.3%**	**84.7%**	**82.9%**
Hammersmith and Fulham	**80.5%**	**81.1%**	**81.9%**	**76.5%**
Harrow	**82.9%**	**83.5%**	**84.6%**	**82.8%**
Hillingdon	**86.0%**	**83.1%**	**88.7%**	**84.7%**
Hounslow	**81.9%**	**82.8%**	**83.3%**	**83.3%**
Kensington and Chelsea	**75.8%**	**72.0%**	**75.3%**	**75.5%**
Westminster	**74.2%**	**71.5%**	**75.3%**	**72.5%**

PCV Vaccine uptake at 2 year (quarterly data) (2017/18 - 2018/19)

	Q2 1718	Q3 1718	Q4 1718	Q1 1819
ENGLAND	**91.3%**	**91.3%**	**91.2%**	**0.0%**
London	**83.6%**	**84.0%**	**84.7%**	**81.8%**
LA with highest uptake - London	**91.9%**	**91.2%**	**92.3%**	**92.0%**
North West London STP	**90.1%**	**89.6%**	**90.5%**	**89.3%**
Brent	**82.6%**	**82.3%**	**83.2%**	**82.8%**
Ealing	**80.6%**	**81.8%**	**82.4%**	**81.3%**
Hammersmith and Fulham	**79.0%**	**79.9%**	**80.3%**	**74.7%**
Harrow	**81.7%**	**82.5%**	**82.6%**	**82.4%**
Hillingdon	**85.5%**	**82.6%**	**86.9%**	**83.0%**
Hounslow	**79.9%**	**79.9%**	**79.6%**	**81.1%**
Kensington and Chelsea	**76.4%**	**72.9%**	**74.5%**	**73.3%**
Westminster	**72.8%**	**70.9%**	**74.1%**	**71.3%**

Source: PHE (2018)

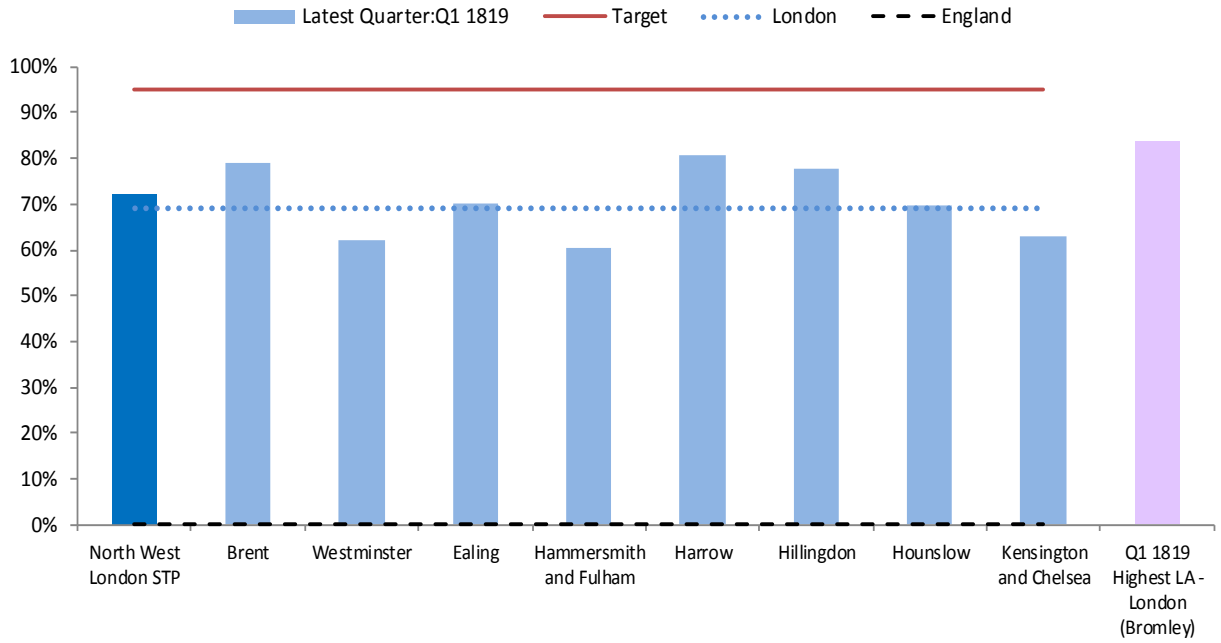
Figure 5
MMR Vaccine Dose 2 – measured at 5 years of age (quarterly data Q1 17/18 to Q1 2018/19)



	Q1 1718	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Eligible	Vaccinated	Trendline
ENGLAND	**87.6%**	**87.6%**	**87.3%**	**87.2%**	**0.0%**	**169,390**	**-**	
London	**76.2%**	**76.9%**	**77.1%**	**77.6%**	**72.2%**	**30,674**	**22,147**	
North West London STP	**75.8%**	**75.1%**	**73.3%**	**75.3%**	**71.5%**	**6,770**	**4,841**	
Brent	81.7%	81.2%	79.6%	80.0%	76.8%	1,093	839	
Westminster	64.0%	62.8%	60.1%	61.8%	61.4%	417	256	
Ealing	75.6%	75.3%	73.2%	75.6%	71.1%	1,229	874	
Hammersmith and Fulham	72.8%	71.6%	68.2%	71.2%	61.6%	552	340	
Harrow	80.4%	80.3%	80.9%	79.9%	79.4%	844	670	
Hillingdon	77.1%	77.0%	76.3%	76.6%	76.5%	1,015	776	
Hounslow	77.9%	75.5%	71.8%	77.1%	69.4%	1,073	745	
Kensington and Chelsea	64.6%	62.5%	62.5%	66.5%	62.2%	547	340	
Q1 1819 Highest LA - London (Bromley)					90.2%	1,023	923	

Source: PHE (2018)

Figure 6
DTAP/IPV (Pre School Booster) Vaccine – measured at 5 years of age (quarterly data Q1 17/18 to Q1 2018/19)



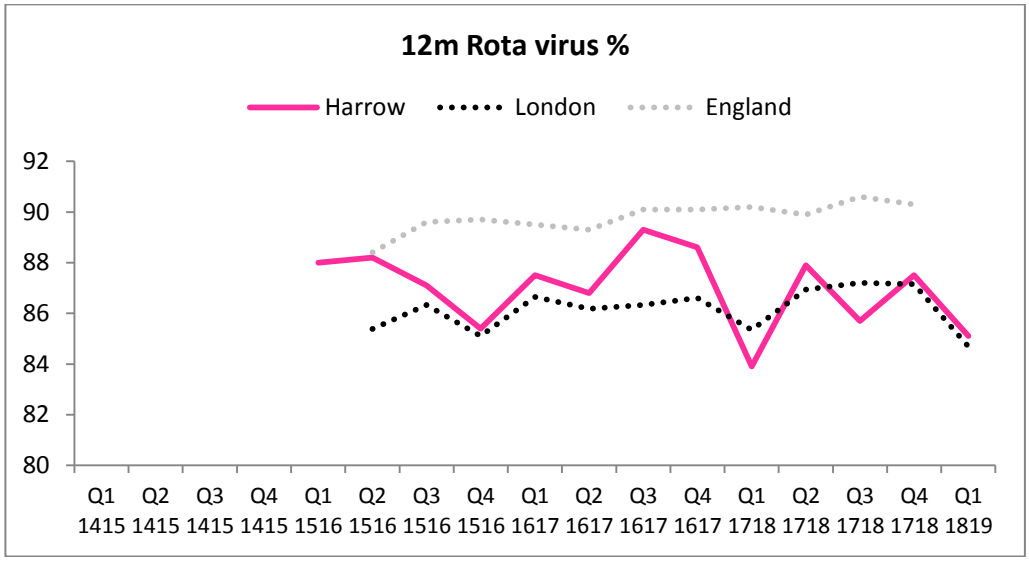
	Q1 1718	Q2 1718	Q3 1718	Q4 1718	Q1 1819	Eligible	Vaccinated	Trendline
ENGLAND	**86.2%**	**86.2%**	**85.9%**	**85.5%**	**0.0%**	**169,390**	**-**	
London	**74.7%**	**77.1%**	**75.0%**	**75.5%**	**69.2%**	**30,674**	**21,222**	
North West London STP	**78.6%**	**75.9%**	**73.5%**	**75.4%**	**72.1%**	**6,770**	**4,882**	
Brent	82.7%	81.8%	80.3%	80.5%	79.0%	1,093	863	
Westminster	70.5%	62.2%	60.5%	60.7%	62.1%	417	259	
Ealing	76.2%	75.7%	71.7%	74.9%	70.2%	1,229	863	
Hammersmith and Fulham	77.8%	71.1%	70.1%	70.3%	60.5%	552	334	
Harrow	81.3%	82.4%	80.9%	80.4%	80.7%	844	681	
Hillingdon	82.1%	78.1%	76.6%	77.7%	77.6%	1,015	788	
Hounslow	78.9%	76.9%	72.3%	77.4%	69.8%	1,073	749	
Kensington and Chelsea	72.4%	63.4%	64.0%	67.2%	63.1%	547	345	
Q1 1819 Highest LA - London (Bromley)					83.6%	1,023	855	

Source: PHE (2018)

4.4 Rotavirus

- Rotavirus is a contagious virus that causes gastroenteritis.
- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and has been reported as part of COVER since 2016.
- In Harrow, coverage (i.e. the 2 doses) of Rotavirus has mostly been above London averages and close to England averages (Figure 7) and was 85.1% in Q1 2018/19 compared to London's 84.7%. Figure 8 illustrates how Harrow has been doing compared to its geographical neighbours up to Q1 2018/19.

Figure 7
Coverage of Rotavirus at 12 months in Harrow compared to London and England Averages



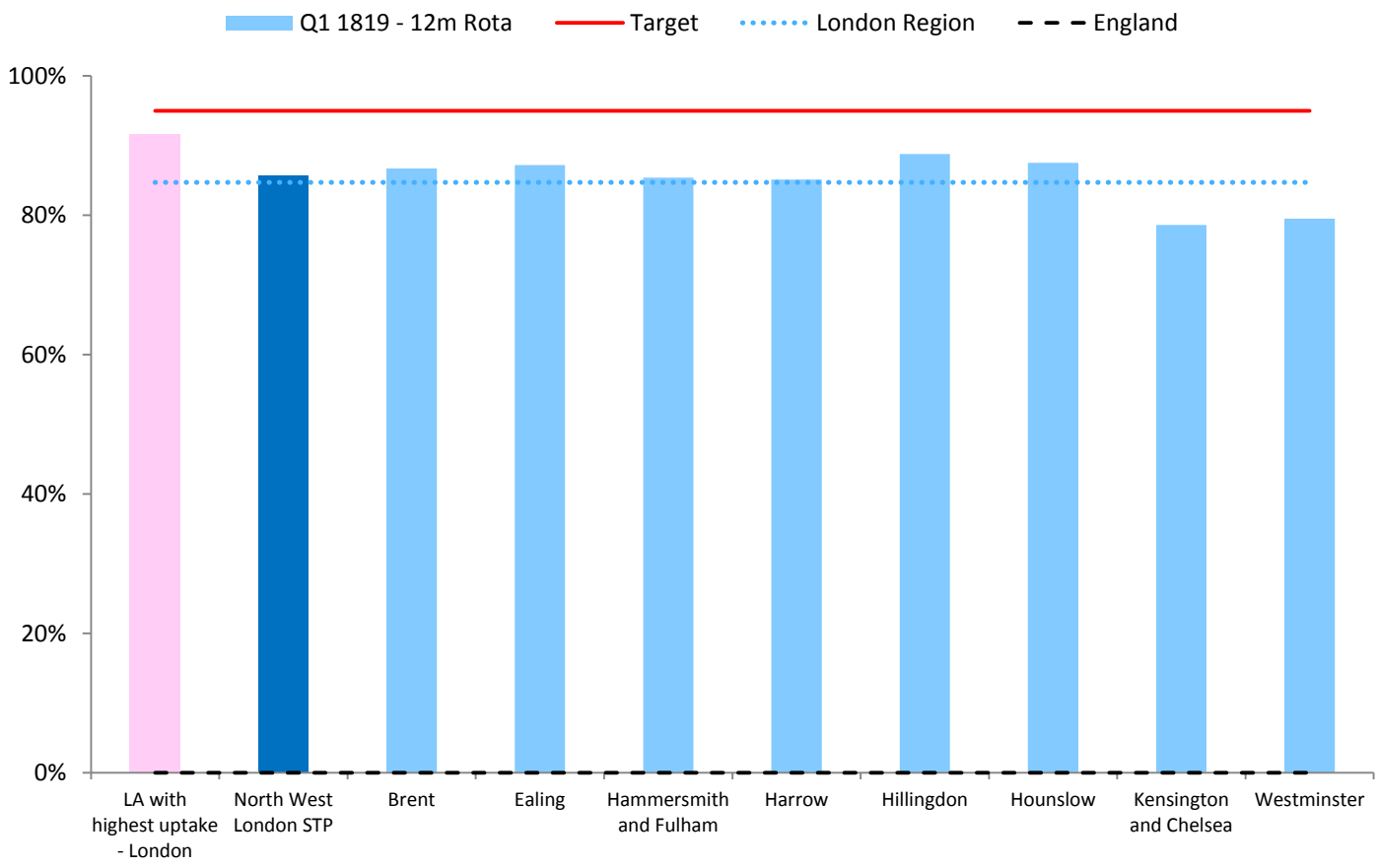
*please note that the vaccine reporting was only introduced in 2015/16

Source: PHE (2018)

Figure 8
Uptake of Rotavirus at 12months in NWL

	Q2 1718	Q3 1718	Q4 1718	Q1 1819
ENGLAND	**89.9%**	**90.6%**	**90.3%**	**0.0%**
London	**86.9%**	**87.2%**	**87.2%**	**84.7%**
LA with highest uptake - London	**92.7%**	**93.8%**	**92.5%**	**91.7%**
North West London STP	**86.9%**	**87.2%**	**86.1%**	**85.7%**
Brent	**86.8%**	**86.5%**	**86.8%**	**86.7%**
Ealing	**88.1%**	**89.7%**	**87.9%**	**87.2%**
Hammersmith and Fulham	**88.0%**	**88.3%**	**87.1%**	**85.4%**
Harrow	**87.9%**	**85.7%**	**87.5%**	**85.1%**
Hillingdon	**90.4%**	**91.7%**	**89.1%**	**88.8%**
Hounslow	**87.5%**	**88.1%**	**86.4%**	**87.5%**
Kensington and Chelsea	**79.8%**	**79.8%**	**78.1%**	**78.6%**
Westminster	**79.8%**	**81.4%**	**79.4%**	**79.5%**

please note that the migration of GP data to the NE London CHIS hub has affected coverage estimates for many of the LAs reported by this hub. As a consequence, London-level coverage figures are under-estimated this quarter. Due to the impact London data has on national figures, England estimates have not been calculated for this quarter.

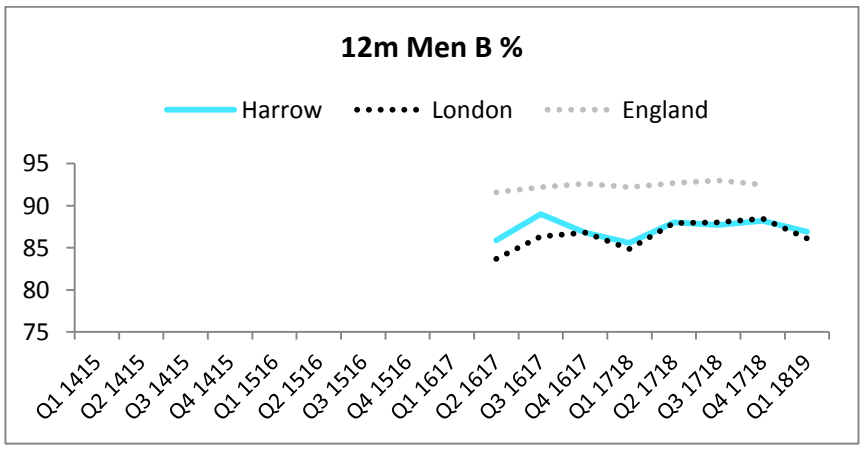


Source: PHE (2018)

4.5 Meningococcal B vaccination

- Since September 2015, all infants are offered a course of meningococcal B (men B) vaccine as part of the Routine Childhood Schedule. Eligible infants were those babies born on or after 1st July 2015.
- It can be seen that Harrow performs mainly just above the London average.

Figure 9
Uptake of two doses of Men B vaccination by 12 months in Harrow compared to London and England



Source: PHE (2018)
**please note the vaccine was only introduced in 2015 so this is the first available data*

4.6 Child 'flu vaccination

- There is a national ambition for 40-60% and from London achieved these in 17/18 for the school age groups.
- Our goal in London was to achieve 40% uptake rates in 2 and 3 year olds and 50% in School Years 1, 2 and 3 and 40% in reception and School year 4
- Age 2 and 3 remain under 40% but the 2017/18 figures reflect the highest ever proportion of children vaccinated with child flu vaccine in these age groups.
- Figure 10 displays the comparison of London's 2017/18 rates to the previous year whilst Figure 11 compares Harrow with the rest of its geographical neighbours and London and England averages. Harrow performs well across the age groups, particularly when the vaccine is given in the school setting by the community provider CLCH, where they achieve the highest rates in the North West area. There are also year on year improvements in each cohort. This can be seen in the 56.6% of reception children being vaccinated, which is higher than the original child 'flu group of Year 4 (they've been receiving the vaccination since Year 1), where 49.8% were vaccinated.

Figure 10
Child 'Flu vaccination rates for London 2016/17 and 2017/18

	Age 2	Age 3	Reception	Year 1	Year 2	Year 3	Year 4
London 17/18	33.1%	33.1%	51%	49%	48%	45%	41%
London 16/17	30.4%	32.5%	n/a	45%	43%	42%	n/a

Figure 11
Uptake of child flu vaccination for Harrow CCG compared to NWL, London and England for Winter 2017/18 (September 1st 2017 – January 31st 2018)

CCG	% of 2 year olds	% of 3 year olds	% of Reception	% of Year 1	% of Year 2	% of Year 3	% of Year 4
Brent	29.7	31.2	30.5	30.5	24.2	22.6	22.1
Central London (Westminster)	27.7	25	51.3	46.9	45.7	32.6	37.1
Ealing	35.9	33.8	38.6	35.4	32.3	30.1	27.4
Hammersmith & Fulham	32.3	31.7	49.5	41.2	43.3	43.3	37.8

Harrow	25.2	29.5	56.6	54.8	53.8	50.1	49.8
Hillingdon	31.9	33	49.1	50.3	47.5	47	41.2
Hounslow	30.8	31.1	55.1	53	59.9	47.7	45.8
Kensington & Chelsea	28.1	26	43.4	40.4	45.8	40.1	42.1
London	33.2	33.3	51.6	49.6	48.2	45.6	43.8
England	42.8	44.7	62.6	61	60.4	57.6	55.8

Source: PHE (2018)

4.7 What are we doing to increase uptake of COVER?

- Harrow like other London boroughs performs below England averages for completed routine childhood immunisations as indicated by MMR 2nd dose and preschool booster. This is also below the recommended WHO 95% recommended uptake levels. Improving uptake rates in Harrow is being undertaken by pan London endeavours as well as local borough partnership work between CCG, local authority, PHE and NHSE London.
- Increasing coverage and uptake of the COVER reported vaccinations to the recommended 95% levels is a complex task. Under the London Immunisation Board, PHE and NHSE (London) have been working together to improve quality of vaccination services, increasing access, managing vaccine incidents and improving information management, such as better data linkages between Child Health Information Systems (CHIS) and GP systems. As well as these pan London approaches, NHSE (London) have been working locally with PHE health protection teams, CCGs and local public health teams in local authorities to identify local barriers and vulnerable or underserved groups (e.g. travelling community) and to work together to improve public acceptability and access and thereby increase vaccine uptake.
- The London wide Immunisation Plan for 2017/18 included sub-sets of plans such as improving parental invites/reminders across London, which the evidence repeatedly states as the main contributor to improving uptake of 0-5s vaccinations (see figure 12). A census of London's 1401 GP practices resulted in the production of 0-5s call/recall best practice pathway and a 0-5s best practice pathway. Under the London Immunisation Partnership PHE and NHSE (London) are evaluating the impact of these pathways over the next few months.
- An evaluation of the 300 practices in London last year in relation to improving uptake of COVER reported vaccinations also concluded that practices need support around information materials to discuss with parents which the NHSE (London) immunisation team are addressing in conjunction with our PHE colleagues.
- Since April 2017, London's child health information systems (CHIS) are being provided by four hubs which feed a single data platform. This has simplified the barriers previously experienced by London have a large number of different data systems 'talking to each other'. Now all CHIS information is on one system fed by three data linkage systems from GP practices, which in turn are now on one of three systems. This change should remove many of the

data errors in the past that had led to an overestimation of unvaccinated children. However, London continues to have a large proportion of children vaccinated overseas which often means that children are reported as unvaccinated when they have been vaccinated but on a different schedule. Work is underway to help GPs code the vaccinations of these new patients.

Figure 12
Infographic of action plan to improve immunisation coverage by working in partnership on each of the four areas below

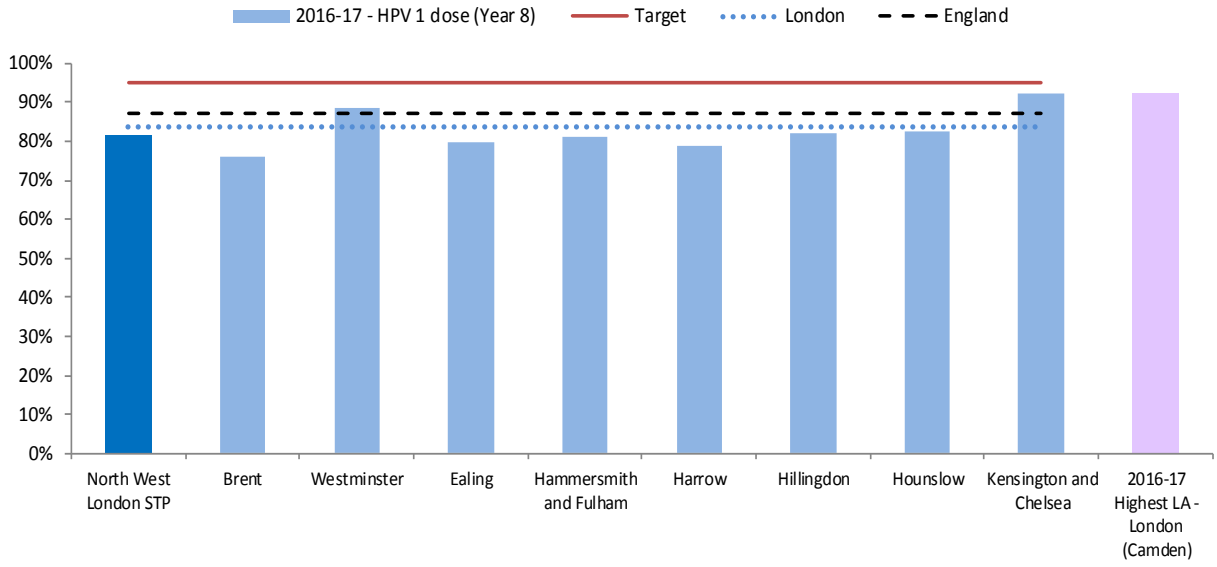
5 School Age Vaccinations

- School Age vaccinations consist of :
    - HPV vaccine for 12-13 year old girls
    - Tetanus, diphtheria, polio booster (Teenage Booster) at age 14/15 for boys and girls
    - Meningitis ACWY at age 14/15
    - Annual child 'flu vaccination programme which in 2017/18 covered Reception to Year 4 in primary schools

5.1 HPV vaccination

- Human papillomavirus (HPV) vaccination protects against viruses that are linked to the development of cervical cancer
- HPV vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 is that two doses are adequate.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. However the introduction of a two course programme instead of a three course programme meant that many providers didn't offer the second dose until the next academic year. For 2015/16, London was the only region to commission both doses to be given within one academic year. This has continued until this year, 2018/19 where providers are now given a choice of whether to deliver both doses in one year or one dose in year 8 and the second in year 9 due to the increasing pressure of the school flu programme which has now expanded. CLCH who deliver the programme in Harrow have opted to deliver in this way for this year and are currently completing the first dose to year 8's in the borough.
- Harrow's uptake for 2 completed doses is 73.2% which is below the London average of 75.3% and higher than the NWL STP area average of 72.1%.

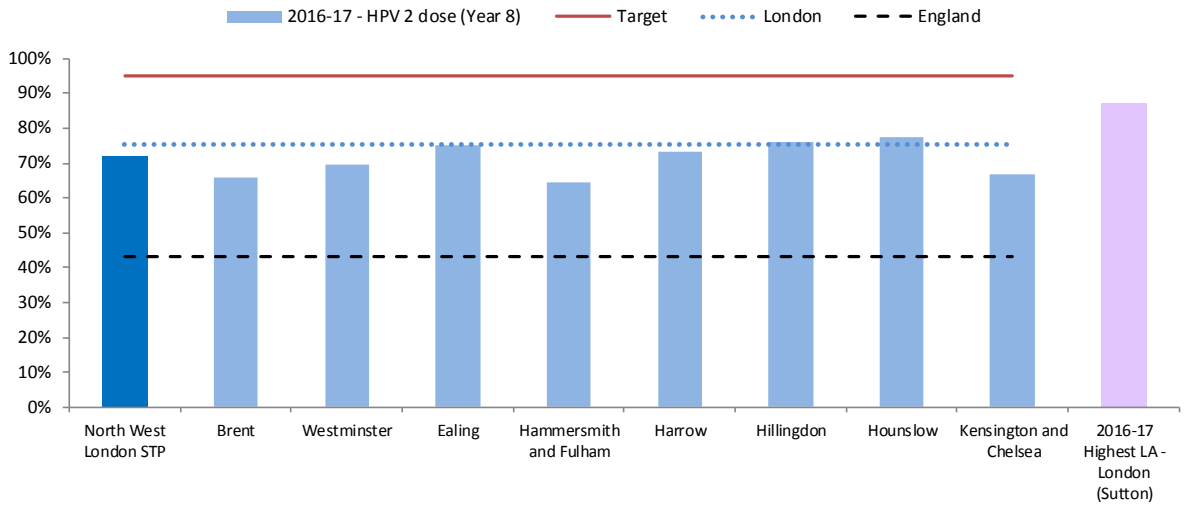
Figure 13
Dose 1 HPV Year 8



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**288,536**	**251,010**	**87.0%**	**299,198**	**260,959**	**87.2%**
London	**42,666**	**35,787**	**83.9%**	**44,535**	**37,336**	**83.8%**
North West London STP	**9,644**	**7,872**	**81.6%**	**10,143**	**8,251**	**81.3%**
Brent	1,618	1,107	68.4%	1,601	1,215	75.9%
Westminster	858	835	97.3%	882	781	88.5%
Ealing	1,701	1,250	73.5%	1,735	1,386	79.9%
Hammersmith and Fulham	703	559	79.5%	954	775	81.2%
Harrow	1,219	1,004	82.4%	1,240	976	78.7%
Hillingdon	1,724	1,554	90.1%	1,776	1,461	82.3%
Hounslow	1,420	1,182	83.2%	1,491	1,229	82.4%
Kensington and Chelsea	401	381	95.0%	464	428	92.2%
2016-17 Highest LA - London (Camden)				925	854	92.3%

Source: PHE (2018)

Figure 14
Completed HPV course Year 8 (2 doses)



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**288,536**	**116,191**	**40.3%**	**299,198**	**128,868**	**43.1%**
London	**42,666**	**31,922**	**74.8%**	**44,535**	**33,535**	**75.3%**
North West London STP	**9,644**	**6,870**	**71.2%**	**10,143**	**7,309**	**72.1%**
Brent	1,618	1,107	68.4%	1,601	1,055	65.9%
Westminster	858	541	63.1%	882	614	69.6%
Ealing	1,701	1,145	67.3%	1,735	1,304	75.2%
Hammersmith and Fulham	703	343	48.8%	954	615	64.5%
Harrow	1,219	932	76.5%	1,240	908	73.2%
Hillingdon	1,724	1,511	87.6%	1,776	1,348	75.9%
Hounslow	1,420	1,101	77.5%	1,491	1,156	77.5%
Kensington and Chelsea	401	190	47.4%	464	309	66.6%
2016-17 Highest LA - London (Sutton)				925	1,348	87.3%

Source: PHE (2018)

5.2 Men ACWY

- This vaccination protects against four main meningococcal strains (A, C, W and Y) that cause invasive meningococcal disease, meningitis and septicaemia.
- As seen in Figure 15, the uptake rate for Harrow was 70.6% for Year 10 which is below the London average.

Figure 15
MenACWY uptake in Year 10 (14-15 years)

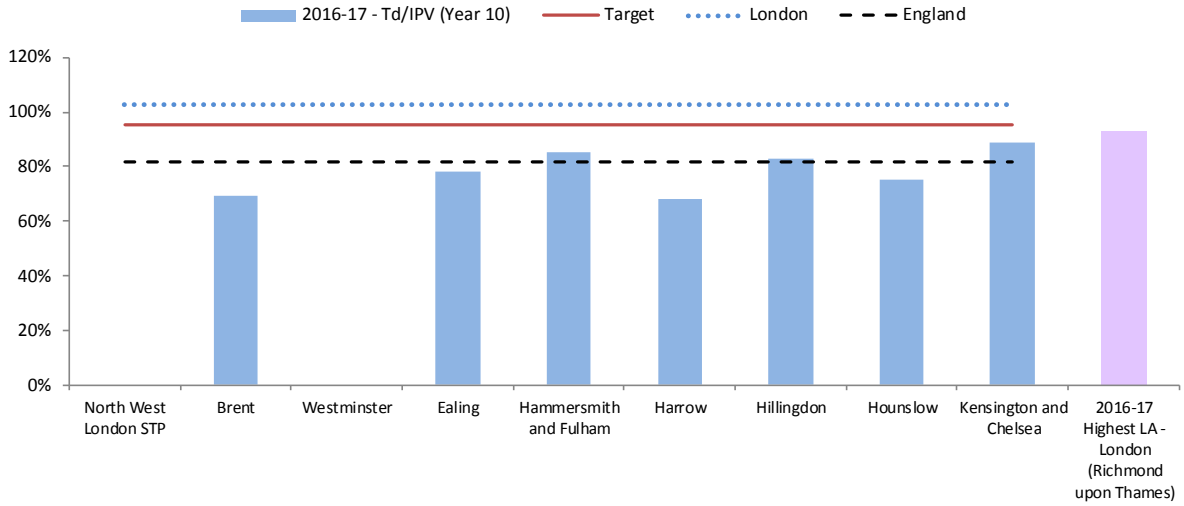
	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**270,383**	**208,759**	**77.2%**	**538,530**	**444,507**	**82.5%**
London	**57,517**	**36,297**	**63.1%**	**69,472**	**51,995**	**74.8%**
North West London STP	**17,773**	**13,333**	**75.0%**	**19,332**	**15,208**	**78.7%**
Brent	2,892	1,859	64.3%	3,103	2,190	70.6%
Westminster	1,604	1,294	80.7%	1,647	1,450	88.0%
Ealing	2,916	2,042	70.0%	3,330	2,628	78.9%
Hammersmith and Fulham	1,374	1,047	76.2%	1,533	1,305	85.1%
Harrow	1,980	1,496	75.6%	2,446	1,728	70.6%
Hillingdon	3,443	2,846	82.7%	3,568	2,956	82.8%
Hounslow	2,781	2,166	77.9%	2,882	2,220	77.0%
Kensington and Chelsea	783	583	74.5%	823	731	88.8%
2016-17 Highest LA - London (Kingston upon Thames)				1,796	1,671	93.0%

Source: PHE (2018)

5.3 Td/IPV

- The school leaver booster is the fifth dose of tetanus, diphtheria and polio (Td/IPV) vaccine in the routine immunisation schedule and completes the course, providing long-term protection against all three diseases.

Figure 16 Td/IPV- Year 10 (14-15 years)



	Eligible	Vaccinated	2015-16	Eligible	Vaccinated	2016-17
ENGLAND	**300,431**	**225,005**	**74.9%**	**530,308**	**433,307**	**81.7%**
London	**62,053**	**39,888**	**64.3%**	**53,158**	**54,469**	**102.5%**
North West London STP	**17,773**	**13,190**	**74.2%**		**14,193**	
Brent	2,892	1,869	64.6%	3,103	2,152	69.4%
Westminster	1,604	1,296	80.8%		614	
Ealing	2,916	2,034	69.8%	3,330	2,598	78.0%
Hammersmith and Fulham	1,374	1,059	77.1%	1,533	1,310	85.5%
Harrow	1,980	1,428	72.1%	2,446	1,669	68.2%
Hillingdon	3,443	2,843	82.6%	3,568	2,955	82.8%
Hounslow	2,781	2,072	74.5%	2,882	2,165	75.1%
Kensington and Chelsea	783	589	75.2%	823	730	88.7%
2016-17 Highest LA - London (Richmond upon Thames)				2,511	2,329	92.8%

Source: PHE (2018)

5.4 What are we doing to improve uptake in Harrow?

- As well as these pan London approaches, NHSE (London) have been working locally with the Harrow CCG team and Harrow Public Health team to focus and identify local barriers and vulnerable or underserved groups and to work together to improve public acceptability and access and thereby increase vaccine uptake.
- Since July 2017, we have had two 'deep dive' workshops with our nine school age vaccination providers across London where we focused on the service factors impacting upon uptake. The main issues were identified as school refusals, lack of return of paper consent forms, self-consent and lack of school support. We have been working with our providers to rectify these and other issues including a pilot of three organisations using e-consent.
- Following on from that, the last quarterly meeting of the London Immunisation Partnership (June 2018) did a deep dive into the factors impacting upon school aged vaccination rates, looking at data management,

quality of services, commissioning and provider performance and public acceptability. An action plan has been devised with our partners which is about to be circulated to the directors of public health. The aim was to make a SMART annual plan that we can deliver together across London to improve uptake.

- As part of the Evaluation, Analytics and Research Group (EAR) of the London Immunisation Partnership, we continue to work with our academic partners in examining the factors impacting upon school aged vaccination uptake. We've completed a study looking at service factors impacting upon Men ACWY and another on HPV (both papers are currently under review for peer review journals). We are collaborating on the evaluation of the e-consent and contributing to a RCT on incentives to improve return of consent forms. We are also working on developing teacher training on school aged vaccinations (an action arising from our deep dive).

6 Outbreaks of Vaccine Preventable Diseases

- PHE NWL Health Protection Team has the remit to survey and respond to cases of vaccine preventable diseases. Where they declare a cluster or an outbreak, NHSE (London) have commissioned Imms01 which is the commissioner response. Under this we can mobilise a provider service response to vaccinate the designated contacts.
- During 2017, a total of 20 confirmed measles cases were reported for NWL. 2 confirmed cases were reported in Harrow. However, at 1.0/100,000 inhabitants, the rate of confirmed measles in NWL in 2017 was much lower than the previous year's peak rate of 3.7/100,000 but higher than the rates from 2013 to 2015. The rate of confirmed mumps in NWL in 2017 was 2.8/100,000 inhabitants, over twice the rate in 2016 (1.2/100,000) and the second annual increase in a row. NHSE (London) are working with PHE Health Protection Teams as part of the London Immunisation Business Group to reduce the number of measles and mumps cases in the population by increasing uptake of MMR in the adolescent and adult populations as well as the under 5s.

7 Next Steps

- NHSE (London) continues to work on delivering the WHO European and national strategies to improve coverage and to eliminate vaccine preventable diseases. In London this is done through the London Immunisation Plan which is reviewed annually by the London Immunisation Partnership.
- Quarterly assurance is provided on Harrow through the NWL Immunisation Performance and Quality Board where challenges and solutions can be discussed around the performance data and the surveillance data.