Health and Wellbeing Board

AGENDA

DATE: Thursday 3 October 2013

TIME: 11.00 am

VENUE: Committee Rooms 1 & 2, Harrow Civic Centre

MEMBERSHIP (Quorum 3)

Chairman: Councillor Susan Hall – Harrow Council

Board Members:

Councillor Margaret Davine	**Harrow Council**
Councillor Krishna James	**Harrow Council**
Dr Amol Kelshiker (VC)	**Harrow Clinical Commissioning Group**
Dr Genevieve Small	**Harrow Clinical Commissioning Group**
Ash Verma	**Harrow Healthwatch**
Councillor Simon Williams	**Harrow Council**
Vacancy	**Harrow Clinical Commissioning Group**

Reserve Members:

Councillor Barry Macleod-Cullinane	Harrow Council
Councillor Mrinal Choudhury	Harrow Council

Non Voting Members:

Catherine Doran, Corporate Director, Children and Families, Harrow Council
Bernie Flaherty, Director Adult Social Services, Harrow Council
Andrew Howe, Director of Public Health, Harrow Council
Rob Larkman, Accountable Officer, Harrow Commissioning Group
Joanne Murfitt, Head of Assurance, NW London NHS England
Paul Najsarek, Corporate Director, Community Health and Wellbeing, Harrow Council
Simon Ovens, Borough Commander, Harrow Police
Deven Pillay, Representative of the Voluntary and Community Sector. Harrow Mencap
Javina Sehgal, Chief Operating Officer, Harrow Clinical Commissioning Group

Contact: Miriam Wearing, Senior Democratic Services Officer
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Harrow COUNCIL LONDON

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Board;
(b) all other Members present.

3. MINUTES (Pages 1 - 16)

That the minutes of the meeting held on 1 August 2013 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS

To receive questions (if any) from local residents/organisations under the provisions of Board Procedure Rule 14 (Part 4B of the Constitution).

There will be a total limit of 15 minutes for the asking and answering of public questions. A question may only be asked if notice has been given in writing, by fax or electronic mail to the Monitoring Officer at publicquestions@harrow.gov.uk no later than 3.00pm two clear days before the day of the meeting.

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Board Procedure Rule 13 (Part 4B of the Constitution).

6. DEPUTATIONS

To receive deputations (if any) under the provisions of Board Procedure Rule 13 (Part 4B) of the Constitution.

7. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS (Pages 17 - 18)

To receive a reference from the Corporate Parenting Panel on 8 July 2013 regarding the Report of Mental Health Care for Children Looked After.

A verbal response will be made at the meeting.

8. 2013/14 FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE - SECTION 256 AGREEMENT (To Follow)

Report of the Head of Commissioning and Partnerships and the Director of Adults.

9. INFORMATION REPORT - OUR PLAN: CHILDREN AND FAMILIES (Pages 19 - 74)

Report of the Corporate Director, Children and Families, Harrow Council and Chief Operating Officer, Harrow Clinical Commissioning Group

10. UPDATE ON NWL INTEGRATION WORK AND PIONEER BID

Joint Verbal Report from the Chair of Harrow Clinical Commissioning Group and Corporate Director, Community Health and Wellbeing.

11. INFORMATION REPORT - REVIEW OF SCHOOL NURSING AND HEALTH VISITING IN HARROW AND BARNET (Pages 75 - 80)

Report of the Consultant, Public Health.

12. INFORMATION REPORT - UPDATE ON CALL TO ACTION; NATIONAL PLAN TO RECRUIT ADDITIONAL HEALTH VISITORS (Pages 81 - 88)

Report from NHS England

13. INFORMATION REPORT FRANCIS REPORT ACTION PLAN (Pages 89 - 94)

Report of the Director of Quality and Safety –BEHH.

14. INFORMATION REPORT - MOVING FROM PARTNERSHIP BOARDS TO STRATEGIC GROUPS FOCUSING ON HWB PRIORITIES (Pages 95 - 158)

Report of the Director of Adult Social Services.

15. INFORMATION REPORT - URGENT CARE (Pages 159 - 168)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group

AGENDA - PART II - NIL

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HEALTH AND WELLBEING BOARD
MINUTES
1 AUGUST 2013

Chairman: * Councillor Krishna James

Board Members:

	Name	Organisation
*	Councillor Margaret Davine	Harrow Council
*	Councillor Zarina Khalid	Harrow Council
*	Councillor Simon Williams	Harrow Council
†	Dr Amol Kelshiker	Clinical Commissioning Group
*	Dr Genevieve Small	Clinical Commissioning Group
*	Ash Verma	Harrow Healthwatch

Non Voting Members:

	Name	Role	Organisation
†	Catherine Doran	Corporate Director, Children and Families	Harrow Council
*	Bernie Flaherty	Director of Adult Social Services	Harrow Council
†	Andrew Howe	Director of Public Health	Adult Health and Wellbeing Group
†	Rob Larkman	Accountable Officer	Harrow Clinical Commissioning Group
*	Joanne Murfitt	Head of Assurance	NW London NHS England
†	Paul Najsarek	Corporate Director, Community Health and Wellbeing	Harrow Council
†	Chief Superintendent Simon Ovens	Borough Commander, Harrow Police	Metropolitan Police
*	Deven Pillay	Representative of the Voluntary and Community Sector.	Harrow Mencap
*	Javina Sehgal	Chief Operating Officer	Harrow Clinical Commissioning Group

* Denotes Member present
† Denotes apologies received

15. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Members:-

Ordinary Member	Reserve Member
Catherine Doran	Melissa Caslake
Andrew Howe	Sandra Husbands
Simon Ovens	Claire Smart

16. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 15 – Healthwatch Harrow
Councillor Graham Henson declared a non-pecuniary interest in that he was partially responsible for creating the framework for Healthwatch Harrow when he was the relevant Portfolio Holder.

17. Minutes

RESOLVED: That the minutes of the meeting held on 19 June 2013, be taken as read and signed as a correct record.

18. Public Questions

(1) The following question had been submitted by a member of the public in accordance with Rule 14.3 of the Health and Wellbeing Board Procedure Rules:-

Question By	Question Of	Text Of Question
Jenny Stephany	Chairman of the Board (Councillor Krishna James)	"The agreed purpose and key responsibilities of the Health and Wellbeing Board, the additional resources to be transferred to Health and Social Care in 2014-15 (Osborne statement June 2013) as well as the application to become a Health and Social Care integration pioneer could offer a unique opportunity for innovative schemes to be piloted. What health and social care groups and processes (including timelines/cycle) for considering requests from the voluntary and community sector and allocating funding are proposed within Harrow? How will these new

arrangements to be published?"

The question was answered orally by the Chairman. The member of the public asked a supplementary question, which the Chair advised would be subject to a written response.

(2) A further question was submitted by a member of the public which did not accord with Rule 14.3 of the Health and Wellbeing Board Procedure Rules. The Board agreed to admit the question to the meeting.

Question by	Question of	Text of Question
Jeff Anderson	Chairman of the Board (Councillor Krishna James)	“What are the immediate concerns and priorities facing the Health and Wellbeing Board and how would it develop partnerships with local stakeholders”.

The member of the public also asked a supplementary question. The Chair advised that both the question and supplementary question would be subject to written responses.

19. Petitions

RESOLVED: To note that no petitions had been received.

20. Deputations

RESOLVED: To note that no deputations were received.

21. References from Council and Other Committees/Panels

RESOLVED: To note that there were no references.

RESOLVED ITEMS

22. Pharmaceutical Needs Assessment

The Board received a report which provided information on its responsibilities in relation to the Pharmaceutical Needs Assessment (PNA), the status of the current document and the plans for the next assessment.

A representative from the Public Health team introduced the report and made the following points:

- the Health and Wellbeing Board now had a statutory responsibility to deliver a PNA;

- the PNA was the document that the NHS used when deciding if new pharmacies were required and to make decisions on which NHS funded services were to be provided by local community pharmacies;

- the Board were required to produce the first PNA by 1 April 2015. It was decided that the PNA should be completed this year as resources were available.

During the discussion on this item, Members of the Board raised a number of queries which were responded to as follows:

- the PNA was about basic dependency functions and not about Public Health services. It would contain information required by statute;

- the PNA had an allocated budget to resource its production. Any underspend would be allocated to other health improvement projects to directly benefit the residents of Harrow.

RESOLVED: That the report be noted.

23. Local Safeguarding Adults Board (LSAB) Annual Report 2012/2013

The Board received a report which provided an overview of the Local Safeguarding Adults Board (LSAB) Annual Report for 2012/13.

A Member of the Board representing Harrow Council introduced the report and made the following points:

- this was the 6th LSAB Annual Report. It provided an overview of safeguarding adults' activity by the Council and its key partners in 2012/13;

- the LSAB was made up of 20 members who talk to wider stakeholders and develop objectives going forwards;

- 657 alerts had been received in 2012/13 in comparison to 554 the year before. The growth in number was seen as positive given as this represents that people are more aware of their safeguarding representation responsibilities and more likely to report concerns;

- Harrow's statistics for the areas where reported abuse did take place, mirrored the national picture and were in line with the national average;

- allegations of physical abuse remained the most common at 29%. Neglect (19%), Financial Abuse (21%) and Emotional Abuse (22%) were the other significant figures;

- outcomes for victims were varied, however 'no further action' and 'increased monitoring' remained the most common;

- outcomes for perpetrators showed a static position in relation to criminal prosecutions;

- in relation to Deprivation of Liberty Safeguards, there were 13 requests for authorisations, 6 for people with dementia and 7 for people with learning difficulties;

- Theme One of the report related to Prevention and Community Engagement. One key development is that District Nurses now had the Safeguarding Adult Service ‘Wallet Card’ fixed to their ID badges;

- there had been a rise in alerts and broadening of sources for referrals e.g. Colleges and GPs;

- there had been a forum established with service users to discuss key concerns which was part of Harrow Mencap’s ongoing Hate Crime campaign;

- there was now an updated risk assessment process giving additional safeguards to users managing their own money;

- outcomes and actions from issues surrounding Winterbourne View were first considered by the LSAB in June 2011 and at all subsequent meetings;

- a West Sussex model for institutional abuse had been piloted and adopted and more training had been provided to those people visiting care homes e.g. GPs and Contracts staff;

- Theme Two related to Training and Workforce Development. 1,478 people had received training in 2012/13, an increase of 220 from the previous year. There were an increased number of briefing sessions including specific briefing sessions for service users. Feedback had been positive;

- the third theme related to Quality and Performance Review. This theme included details of monthly meetings between the SGA Team and the Contracts Team to monitor concerns about care providers, user surveys completed by Age UK Harrow in relation to home care and stats being routinely monitored by the LSAB and SGA team;

- outcomes from this third theme had included a new protocol for working with harder to engage clients, further increase in user/family involvement in case conferences and a Placement Embargo policy had been refreshed to further define issues relating to safeguarding;

- Theme Four of the LSAB related to Policies, Procedures and Governance. Pan London policies and procedures had been used throughout 2012/13 and were covered in all relevant training sessions; an easy to read version of the Annual Report had also been produced;

- key objectives for the LSAB for 2013/14 and Year 1 of the new LSAB Strategic Plan included:

    1. ensuring that prevention of the abuse of adults remained a high priority within Harrow,

    2. ensuring that there was effective communication by the LSAB with its target audiences,

    3. ensuring that safeguarding adults priorities were clearly referenced in wider Community Safety strategies, enabling evidence to be produced that the Harrow LSAB's work was influenced by user feedback and priorities;

- the Health and Wellbeing Board could assist the work of the LSAB by continuing to support its work and ensuring attendance at the LSAB meetings of relevant senior officers. It could also sign the LSAB partner agreement which included a commitment to presenting Annual Reports to Executive or Management Boards;

- a Peer Review would be taking place in November 2013. This would be conducted by the Local Government Association who would work through quality measures for the Council and its partners;

- the Peer Review would last for 3 days and it was hoped that Members of the Board would support a proposal that the findings of this review be published and be made public;

- as a precursor to the Peer Review work had commenced in assessing the LSAB. An expert had visited the Council and that there was a good acknowledgement that safeguarding arrangements are strong in Harrow and that there was good focus and knowledge from senior officers in the Council. There were also positive comments in relation to budget priorities and personal budgets. However it was believed that the LSAB was too big in terms of its numbers and needed to reduce. It was also believed that more senior personnel had to be involved on the Board and that it should include representatives from Public Health and from the Department for Work and Pensions.

RESOLVED: That

(1) the Board agreed that outcomes of the Peer Review due to be held in November 2013 should be published;

(2) the report be noted.

24. Urgent Care

The Board welcomed a representative from the Clinical Commissioning Group who introduced a report which set out information relating to the recent activity

of the Urgent Care Board and the development of the Accident and Emergency Recovery and Improvement Plan.

The representative reported the following points:

- all Accident and Emergency (A & E) departments had a 95% target for patients attending to be seen within 4 hours;

- across the whole country some hospital trusts have had difficulty in meeting this target. Northwick Park Hospital (NPH) had struggled to meet this target;

- the difficulties encountered relating to this target had prompted NHS England to require all Local Area Teams (LATs) to start working on recovery and improvement plans for each local area;

- NHS England had advised that plans to improve current standards should be divided into three phases. This included a short term, medium term and long term strategy where changes made were implemented and sustainable;

- there were a number of issues faced by North West London Hospital Trust (NWLHT) A & E service. These included serious delay breaches and delays with ambulance handovers, having enough clinical staff and an inappropriate level of transfer of care;

- there were additional concerns that the implementation of 'Shaping a Healthier Future' will lead to further pressures on A & E in NPH, including potential increase caused by the potential closure of services in Ealing;

- the A & E Recovery and Improvement Plan had been developed to overcome these and other issues. It was divided into three Key Outcomes and five Top Priorities;

- current A & E performance indicated that NWLHT was improving and was now in line with the national 4 hour standard. Performance had improved significantly between April and June, following worrying performance at the start of the year;

- in the day before this meeting, NWLHT had a performance of 97% of patients being seen within 4 hours. However implementation of the Plan had not yet finished and a high performance would continue to be targeted;

- the Council had agreed a Motion at a previous Full Council meeting expressing concern with the A & E arrangements at NPH. This had been appropriate at the time and the CCG would be formally responding to this shortly;

- Harrow's Urgent Care Board would be responsible for winter pressures during 2013 and had commenced early discussions;

- in 2013/14 Pressure Surge (Winter) Planning will sit within the context of the Recovery and Improvement Plans;

- it was important to plan proactively in anticipation of the additional demands introduced by cold weather if a 95% performance was to be sustained;

- the aim of the Winter Planning was to provide more details about activity and assurance to meet targets whilst maintaining service quality and safety.

During the discussion on this item, Members of the Board raised a number of issues which representatives from the CCG responded to as follows:

- there were a number of actions in place to deal with inappropriate admissions. Within the Integrated Care Pilot work was taking place with the London Ambulance Service to ensure that patients were not brought to A & E inappropriately. In addition to this London Ambulance Services were also being asked to refer cases which did not require A & E admission to NPH to be treated as a day case;

- the STARRS scheme was also in operation which allowed for patients to be treated in the community rather than going to A & E if appropriate. General Practitioners would also be based in A & E to see and treat patients and prevent inappropriate admissions;

- the Recovery and Improvement Plan would be completed by the end of September 2013. At this stage the Plan was 75% complete. There had only been limited new funding to implement the Plan, but most the changes in the Plan had been achieved by making sustainable changes building resilience into the system;

- there had been evidence gathered in previous studies that many patients attended A & E rather than utilising other facilities in the health system, simply because it was more convenient for them to do so;

- there could be a role for the voluntary and community sector to play in assisting in signposting for residents to utilise parts of the health care system other than A & E if appropriate;

- there had been an increase in the number of people registered at GPs surgeries, which partly explained why there were an increasing number of referrals from GPs to A & E.

RESOLVED: That

(1) the report be noted;

(2) CCG provide a report which breaks down who is attending A & E and considers what role public health, social care and the Health and Wellbeing Board could play in supporting this work.

25. 2013/14 Funding transfer from NHS England to social care - section 256 funding

A Board Member from the Clinical Commissioning Group (CCG) introduced a report which set out the conditions, governance and reporting process for the 2013/14 funding transfer from NHS England to social care.

The Board Member reported the following:

- previously the Department of Health had made funding available for 2011/12 and 2012/13 to Primary Care Trusts via a section 256 transfer which was then passed on to the Council for agreed services;

- NHS England had issued a letter to the CCG regarding the allocation for 2013/14. During 2013/14 the money would be paid by NHS England directly to the Council rather than through the CCG;

- the criteria for the funding is that is must be used to support adult social services in each local authority, and must also have a health benefit;

- Local Authorities and the CCG must have regard to the Joint Strategic Need Assessment for their local population, in determining how the funding was used;

- Local Authorities and the relevant CCG must demonstrate how the funding transfer would make a positive difference to social care services;

- the funding could be used to support existing services for transformation programmes;

- it had been proposed in the recommendations of the report to use funding within Harrow in a similar way to previous years subject to further agreement and discussion between the Council and the CCG;

- the CCG proposed at the meeting that due consideration was given to the development of other possible new services to benefit the health care system rather than is using the way that the report proposed;

- it was important to ensure that the funding was used in the best possible way as it was a valuable resource. Innovation was also important.

The Board Member from NHS England commented that it was not appropriate for NHS England to get involved with local decision making on how the funding was utilised. However NHS England did expect a joint agreement on how the funding would be used. Good governance was important and a plan

would be expected by NHS England on how the funding would be used. An 18 month plan was recommended identifying the direction of travel.

An officer from Harrow Council commented that the allocation provided by the Section 256 transfer had already been assumed in the Council's budget for adult social care in 2013/14, this is necessary as the Council's budgets are set in advance of the financial year and without the funding planning for substantial cuts would need to start as early as possible. Further discussions were required and it could potentially have a big impact on the Council.

The Board Member from the CCG responded that it would be helpful if the Board could delegate the decision on how the Section 256 money was used to officers and the CCG to allow further discussions to take place. It was therefore suggested that only recommendations 1, 3 and 4 of the report were agreed to facilitate this. If funding was utilised in a different way than used previously, further information would be presented to future Board meetings on the relevant objectives and targets.

RESOLVED: That:

(1) the funding from NHS England of £3,471,178 for social care for 2013/14 subject to the signing of a Section 256 agreement be noted;

(2) officers be authorised to enter into discussions with Harrow CCG to conclude the Section 256 agreement;

(3) the proposed monitoring arrangements for the spending of the budget, which involves a monthly meeting between the Head of Commissioning and the Head of Unscheduled Care, be agreed.

26. NHS Harrow Clinical Commissioning Group Strategic Planning

The Board received a report which set out the high-level planning process by which Harrow Clinical Commissioning Group (CCG) was developing its 3 year Strategic and Financial Plan.

A Board Member from the CCG introduced the report and made the following points:

- it was recognised by the CCG that they had to develop services to ensure quality and safety for patients;
- good clinical outcomes were achieved and benchmarking was regularly conducted to ensure this continued;
- the CCG was working closely with its partners including the Council, to ensure that resources were used in the right way;
- the Joint Strategic Needs Assessment had allowed the CCG to highlight areas which required the most focus;

- research had been conducted on how the CCG spent its money. It demonstrated that 50% of resources were being spent on 5% of the population who were categorised as very high or high risk;

- the CCG existing plans which looked to transform how acute care was provided were fundamental to delivering higher quality care more effectively;

- the CCG also wanted to investigate further to see whether there could be more proactive and integrated management of high risk / high need patients including their social, mental and physical care needs;

- there would also be a greater focus on primary prevention for lower risk patients and secondary prevention to reduce the rate of increasing needs;

- the Plans of the CCG would be developed to both improve the quality of care and to allow operation within the CCG's financial resources. Once the Plan had been finalised it would be reported back to the Board.

During the discussion on this item, Members of the Board raised a number of issues which Board Members from the CCG responded to as follows:

- when a child was referred to the Child and Family Mental Health Services (CAMHS), it was appropriate for the child's GP to make this referral as opposed to a school nurse. This was because the GP held the entire health record for the child and was fully aware of all medical issues;

- the Public Health service may have further information on how resources were spent on health services on a ward basis within Harrow. It was important to note that there were differences within Harrow.

RESOLVED: That the report be noted.

27. NHS Commissioning Board - Roles, Responsibilities and Relationships

The Board received a presentation from the Board Member representing NHS England which set out its roles, responsibilities and relationships.

The Board Member made the following points:

- the 2012 Health and Social Care Act has resulted in a number of changes to who is responsible for commissioning National Health services;

- from April 2013 new organisations had been created to take on the responsibility for health services commissioning. These included the Clinical Commissioning Groups (CCGs) and the National

Commissioning Board known as NHS England. Local Authorities had been provided with the responsibility of public health functions;

- NHS England had a number of important roles including directly commissioning £25 billion worth of services including primary care and allocating £60 billion to CCGs and supporting them in the effective use of that money to buy local services;

- NHS England within London had been divided into 3 regions. Harrow was under the remit of the North West London Team;

- NHS England worked with a large number of partners nationally;

- NHS England's priorities included improving patient experience, commissioning development and patient safety;

- specific priorities within the North West London Team included participation in and supporting the work in North West London Hospitals in tacking key performance areas. Other priorities included focusing on patient experiences and providing an assurance of CCGs;

- the regional team had 3 key overarching objectives which including acting as assurers of the system, commissioning specific healthcare services and managing the system through strategic project and programme delivery and effective partnerships;

- any CCG that had conditions attached, NHS England were working with them to remove these;

- regions had worked with national colleagues to develop a CCG assurance framework to provide a view of how CCGs were delivering quality and outcomes for patients and continually improving;

- finances were clearly important but there were also other things which NHS England would hold CCGs to account on. These included the quality of care and health outcomes for local people;

- NHS England also commissioned services directly. These included Primary Care services (for e.g. GPs, Dentists and Pharmacists) and offender health services. Consideration was currently being given to how NHS England would be held to account by CCGs for these relevant services;

- NHS England had an overall budget of £95 billion, of which £15.6 billion was allocated to London;

- regulatory responsibilities of NHS England included local responsible officer functions, managing individual performance issues for dentists, pharmacists, GPs and optical providers and helping to secure services for patients following a major incident such as fire, flood or a similar emergency;

- for specialist services, 74 Clinical Reference Groups had been clustered around 5 national Programmes of Care;

- NHS England commissioned a range pf public health services including national immunisation programmes and national screening programmes;

- both the Board and NHS England shared the same objective of improving the health and wellbeing of residents in Harrow and improving health outcomes. This was a key reason why a representative from NHS England should sit on the Board.

During the discussion on this item a Member of the Board queried how NHS England was to be held to account for their services. The Board Member from NHS England responded that it was clear that it should be held to account and a process was being developed. This could involve 360' feedback and surveys being conducted. A report could be presented to the Board in the future on this issue once the details had been finalised.

RESOLVED: That the presentation be noted.

28. Initial Stocktake of Progress against key Winterbourne View Concordat Commitments

The Board received a report which outlined the Winterbourne Stocktake which was submitted to the Winterbourne Programme on 5 July 2013.

An officer introduced the report and made the following points:

- the Winterbourne Programme was established to ensure all local areas deliver the commitments set out in the Concordat following the negative care quality at Winterbourne View Assessment & Treatment Centre;

- the stocktake aimed to provide an initial snapshot of progress;

- the stocktake in Harrow had been very thorough. There had been success in agreement between the Council and the Clinical Commissioning Group (CCG) and submitting the stocktake in time;

- 4 challenges were identified when responding which included concerns about how services will be funded in the future, the lack of an agreed Dispute Resolution Policy, the reviews had not been fully considered and that until recently there had been no agreement on the process for working together to consider Winterbourne clients;

- there was a task and finish group which would deliver the full programme of change required.

The Chair thanked officers for their work on this item.

RESOLVED: That the report be noted.

29. Healthwatch Harrow

The Board received a report setting out the background to Healthwatch Harrow, including governance and management arrangements, its priorities and progress.

The Board Member representing Healthwatch Harrow made the following points:

- there were a number of partners involved with Healthwatch Harrow and it was hoped that in the coming months further partners would become involved;
- Healthwatch Harrow had developed 3 key outcomes. These included developing its engagement and influence, providing information and advice and implanting effective linkages with Complaints Advocacy;
- a clear and detailed system of a monitoring performance framework had been agreed with the Council;
- Key Performance Indications as part of the Performance Monitoring Framework included the percentage of local people who had heard of Healthwatch Harrow, the number of Enter and View visits and the inclusion of unmet needs in the future Joint Strategic Needs Assessment;
- it was intended that the Delivery Board would have 15 Members and include lay people and an Independent Chair. A recruitment and selection process had already been agreed by the Delivery Board and was underway;
- Healthwatch Harrow had produced a Business and Community Engagement Plan. This generally involved obtaining information from the public to feed into the whole process;
- there had been significant progress made in raising the profile of the organisation.

RESOLVED: That the report be noted.

30. Harrow Compact

The Board received a report setting out details of the Compact which was an agreement between the bodies represented on the Harrow Partnership Board containing principles to guide the conduct of relationships with the voluntary and community sector organisations.

A Member of the Board commented that this report was helpful to allow all partners, including those who were new from the Clinical Commissioning Group, to be aware of the existence of the Compact and the principles contained within it.

An officer commented that there were sections of the Compact which were due to be updated at the next Harrow Partnership Board meeting. However, other than this no further refresh was currently required.

A Board Member representing the CCG commented that she would liaise with the CCG and NHS England on the Compact before they committed to it.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 4.03 pm, closed at 6.21 pm).

(Signed) COUNCILLOR KRISHNA JAMES
Chairman

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HEALTH AND WELLBEING BOARD

3 OCTOBER 2013

REFERENCE FROM CORPORATE PARENTING PANEL – 8 JULY 2013

Minute Item 133: Report of Mental Health Care for Children Looked After

The Chair welcomed Melanie Woodcock representing the Child and Family Mental Health Services (CAMHS). In introducing the report she made the following points:

- CAMHS was a community based and universally targeted supporting specialist service;
- Harrow CAMHS operated a triage system which was led by General Practitioners (GPs). There was a quick turnover and access for referrals. The Triage system allowed CAMHS to see clients quickly;
- referrals to CAMHS had to be appropriate but GPs were good at ensuring that this occurred in practice;
- following a referral, the young person was seen within 10 days. This was then followed up with an assessment appointment which was done within 5½ weeks;
- the CAMHS team consisted of 17.74 Full Time Equivalent Staff (FTE). This included part time staff;
- the majority of referrals to CAMHS came from GPs. At present CAMHS had a caseload of 648 cases and only 20 of these involved Looked After Children (CLA);
- the main issues which CAMHS dealt with involved CLA were depression, anxiety and sexual incidents;
- specialist assessments were offered and care pathways were not rigid;
- a wide a range of support was offered by CAMHS including family therapy, clinical psychology, nursing support and play therapy;
- the key message that CAMHS delivered was focusing on the needs to the individual child.

During the discussion on this item, Members of the Panel raised a number of issues which officers and the representative from CAMHS responded to as follows:

- there had been an issue which concerned the Council in relation to the way referrals were made to CAMHS. At present the Council were not allowed to make a direct referral to CAMHS and that this could only go through the health system;

- there was concern from the Council that CLA were not given a priority above all other children particularly in relation to waiting lists or generally as applicable to their circumstances. The representative from CAMHS responded that they were commissioned by the Clinical Commissioning Group who set the relevant thresholds for referrals. There was no specific CLA team within CAMHS and all referrals were treated equally in terms of their importance;

- CAMHS were investigating using more direct psychotherapy in their treatment of children.

At the conclusion of the debate Members of the Panel commented that they had concerns over the referral pathways to CAMHS. They were concerned that referrals could only be made via the health system and that the Council did not have an ability to also do this directly.

An officer commented that these concerns had been raised with the Clinical Commissioning Group (CCG) previously, and they had commented that the decision to accept referrals was ultimately the responsibility of CAMHS.

The representative from CAMHS responded by saying that the final decision did not rest with them and that the CCG were their commissioners. CAMHS were confident that they were not dealing with cases which were better dealt with under targeted and universal services.

A Member of the Panel suggested that a reference be made to the Health and Social Care Scrutiny Sub-Committee and the Health and Well-being Board to investigate these issues further and to commence dialogue with the CCG on analysing and reviewing the referral pathways to CAMHS. This was agreed.

RESOLVED: That a reference be made to the Health and Social Care Scrutiny Sub-Committee and the Health and Well-being Board to investigate liaising with the Clinical Commissioning Group on analysing and reviewing the referral pathways to the Child and Family Mental Health Services (CAMHS).

REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	3 October 2013
Subject:	**INFORMATION REPORT – Our Plan: Children & Families**
Responsible Officer:	Catherine Doran – Corporate Director, Children and Families, Harrow Council and Javina Sehgal – Chief Operating Officer, Harrow Clinical Commissioning Group (Joint LA and CCG)
Exempt:	No
Enclosures:	Our Plan: Children & Families

Section 1 – Summary

Our Plan: Children & Families

We are pleased to introduce the new joint plan for children and family services.

Our Plan: Children & Families is based on the commissioning intentions outlined by the Health and Wellbeing Board. This is a joint declaration with parents and partners to improve outcomes for all children and young people in Harrow, to work in collaboration, prepare for the next transformation programme, and to join up the system of services and support across the Borough.

FOR INFORMATION

Section 2 – Report

Our Plan: Children & Families

We are pleased to introduce the new plan covering the whole children and family system in Harrow. The plan replaces the previous Children and Young People Commissioning Plan 2011-2014. The new plan extends to 2018 and will be refreshed following a wide consultation with partners, professionals and families in six months.

This new plan comes at a time of much greater austerity and challenges of demand and system leadership for statutory partners. We have therefore deviated from a traditional children and young people plan and the following points are highlighted for your consideration:

1. This is a plan for all stakeholders in Harrow, including statutory partners, frontline professionals, external providers (including 3rd sector), community groups, children, young people and their families / carers.

2. The plan is deliberately branded 'Harrow' rather than favouring any one or more statutory partners.

3. Artwork is by children from Harrow schools, the final version is A5 sized as a more accessible booklet. The needs assessment includes "Harrow Village" which is accessible for children to understand needs of their classmates and can be used in lessons.

4. The plan covers a longer period of 2013 to 2018 to align with the Council's transformation programme. The concept of commissioning is explained, to help the Council to become more commissioning led (following in the footsteps of the CCG). In the Council we have developed outcome based service level agreements and service plans for each team which align directly to Our Plan. Specifications for external providers also align.

5. We have been much stronger on emphasising the outcomes for children, young people and families as this will help services to improve efficiency. We have also brought in the concepts of co-production with families to help move towards this culture change, as again this will be one of the foundations of more efficient services in the next few years. The burning platform for change is also articulated to support future service redesign.

6. The final section sequences service areas for recommissioning and explains how this activity will follow the new Strategic Commissioning Framework process. The activities cover the majority of children and family services and add up to a full transformation of services over the next five years. All joint CCG – Council service areas referenced are from the Joint Commissioning Intentions agreed by the Health and Wellbeing Board.

Section 3 – Further Information

The plan will be refreshed in six months following consultation. Consultation will include parents, front line staff, young people, partner and provider organisations. We are disseminating hard copies of the Our Plan to GP Surgeries, Children's Centres, Nurseries, Schools and consultative groups such as the Looked After Children Council and Youth Parliament.

Note that commissioning intentions described in the plan are likely to change over time based on capacity, new priorities and pressures.

Section 4 – Financial Implications

There are no direct financial implications from Our Plan. However, the culture change signalled by the plan and the commissioning activities listed will form the majority of the efficiency improvements anticipated over the next five years for the Council and other statutory partners.

Section 5 - Equalities implications

An equalities impact assessment (EqIA) is not required for the plan, but is required for each commissioning change and service redesign.

Assessment of equalities is built into the Strategic Commissioning Framework process referenced in Our Plan, and equalities are considered at the outset of all commissioning.

Section 6 – Corporate Priorities

Commissioning activities in Our Plan support all Council corporate priorities:

- Keeping neighbourhoods clean, green and safe
- United and involved communities: a Council that listens and leads
- Supporting and protecting people who are most in need
- Supporting our town centre, our local shopping centres and businesses

Priorities and the Community Strategy were considered in writing the plan, although most of the detail about this level of priorities and planning were excluded from the text for the sake of simplicity and accessibility.

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports)

Name: Simon George	x	Chief Financial Officer
Date: 24 September 2013		

Section 7 - Contact Details and Background Papers

Contact:

Catherine Doran, Corporate Director Children and Families
Javina Sehgal, Chief Operating Officer, NHS Harrow CCG

Background Papers:

Our Plan: Children & Families, www.harrow.gov.uk/children

Our Plan: **Children & Families**

2013 to 2018

Hazim, age 5

This is our shared high level plan for improving the lives and outcomes for children and families in Harrow.

Our Plan describes how we are committed to doing the best with limited resources, and shows how partners such as Harrow Council, NHS Harrow, the Police and other providers will work together with children, their families and local communities. The plan includes high level outcomes that we are all signed up to, as well as the overarching needs of Harrow's children and young people, and actions we will take to commission and redesign services.

This version is a working document that will be refreshed following consultation with families and frontline staff.

It's in our hands: We promise our children and young people the best start in life.

www.harrow.gov.uk/children

Contents

To make it easy to follow, this document is divided into three sections: **Vision**, **Drivers**, and **Plan**.

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I. Vision: Our Shared Vision

It's in our hands: We promise our children and young people the best start in life.

Our shared vision is about everyone in Harrow supporting our children – from statutory partners such as the Council, NHS Harrow, Schools and the Police, to community groups, the voluntary sector, and of course families themselves. It is this combination of support that gives a child or young person a good start in life: learning and developing, staying safe, being healthy and growing into an adult who contributes to society with economic security.

In Harrow Council, this vision is delivered through the following mission statement:

Harrow Council is committed to working with families and their communities to educate, support and protect children and young people, ensure they achieve their potential. We will work with partner agencies to provide a range of services that will build on family and individual strengths throughout every child's journey to adulthood.

In the next twelve months, we will develop the shared vision and outcomes more widely with children and families.
An important part of our vision is an agreement between parents and partners about how we will work together to co-produce better outcomes for children and young people. The following co-produced outcome pathway is a working draft that forms the agreement between all parties. Together the

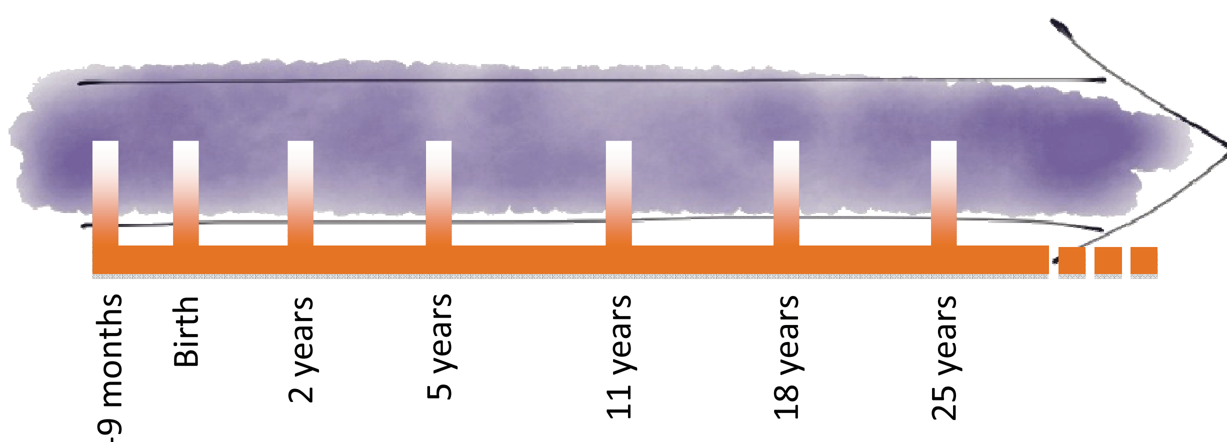
vision and outcomes drive all parts of children and family services, for example:

- Co-production agreements between professionals and families, e.g. Families First
- Core outcomes for commissioning strategies – driving the needs assessment
- Outcome measures and improvement actions in service plans or service specifications and contracts
- Personal development plans for all staff, e.g. Council IPADs, to show the 'golden thread' from outcomes agreed with families and individual performance.

Nikolas, age 6

II. Vision: Co-produced Outcomes

The diagram shows a simplified pathway of a child from pre-birth to 25 years old in Harrow, and the co-produced outcomes we expect at key stages in the child's development.[1]



The expected outcomes for children growing up in Harrow are:

From -9 months
- Parents are ready to have a family

At birth
- A healthy birth
- Baby is safe and cared for
- Brain is developing well and the baby is learning

By 2 years old
- Healthy and thriving
- Child is safe and cared for
- Continued brain development and learning

[1] In some cases the pathway will be different but we still aspire to these outcomes

By 5 years old

- Healthy and thriving
- Safe
- Ready for school

By 11 years old

- Healthy and thriving
- Safe
- Learning to potential
- Preparing for transition to adulthood

By 18 years old

- Healthy and thriving
- Safe
- Contributing to society and potentially in further education

By 25 years old

- Independent and in employment
- Achieving to potential through life-long learning
- Contributing to society

And for a family we expect the following outcomes (to support their role in the child's life)

- Ready to have a family
- Parents are confident and skilled in parenting
- Healthy and thriving
- Safe and protective
- Independent and in employment
- Contributing to society

Nikolas, age 6

III. Drivers: Our High Level Needs

This section summarises issues affecting Harrow's children and families from the comprehensive needs assessment of the local population that was completed by local partners in 2012.[2] These needs follow the pathway of a child from -9 months to 25 years old.

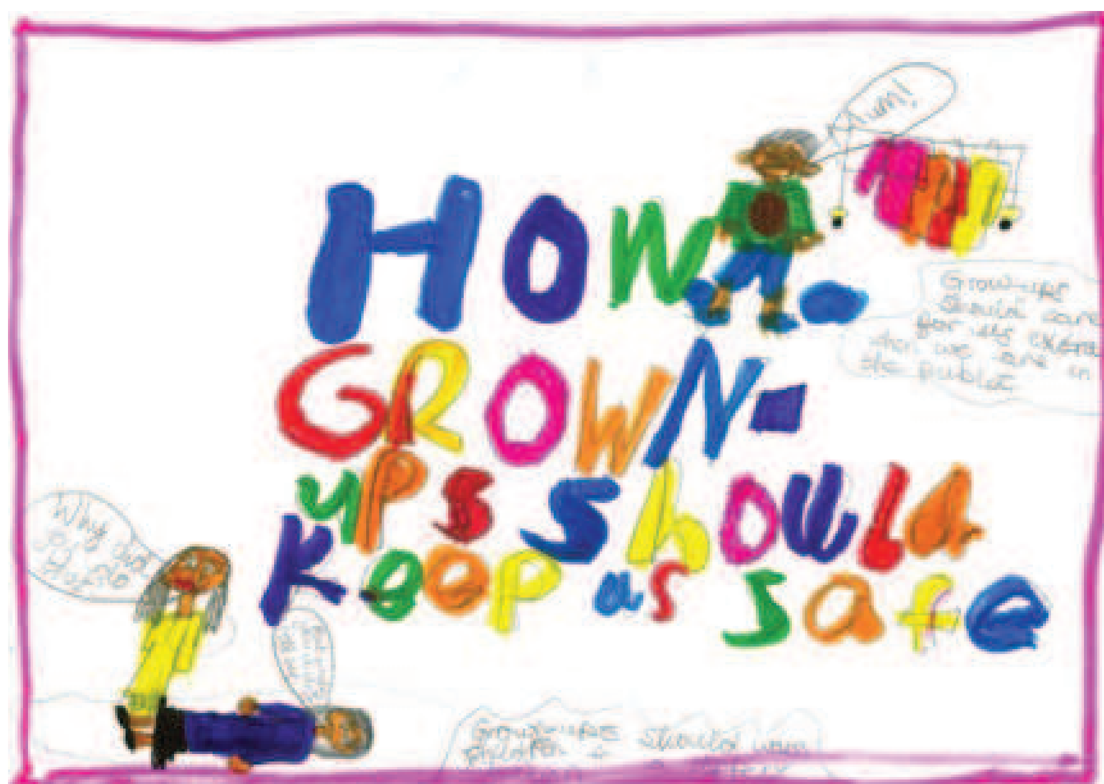
Analysis

Harrow is an area in North West London that is home to more than 230,000 people. It is a comparatively quiet and safe area by London standards, noted for good schools and plenty of green space, and a popular area for families and commuters. If we paint picture of 'Harrow Village', it is thriving community, with many births, new families settling, good general health and low crime. New schools are being built to make space for the growing numbers of children.

The population is one of the most diverse in England, with established Gujarati and Irish communities and more recently Asian, African and Eastern European communities. Harrow does not have a majority ethnic group. Community cohesion is strong and this is an important success to build on. Unemployment is low, and Harrow has the lowest rate of young people not in education, training or employment in England, at less than 3 per 100.

[2] All data from 2012 JSNA unless otherwise stated www.harrow.gov.uk/jsna

Despite this positive picture, there are some significant challenges for local people. There is increasing deprivation, particularly affecting children and young families, and significant health inequality. On average, women in Pinner South can expect to live more than 10 years longer than women in Wealdstone. Men in West Harrow can expect to live for five and a half years longer than men in Greenhill ward.



Zarha, age 7

Some of our successes:

- Harrow **children achieve better** at Key Stage 2 (end of primary school) and GCSE than statistical neighbours
- Absence rates are lower than average in Harrow schools
- Harrow has amongst the highest rates of young people in **education**, **training** and **employment** in England. Rates of young people continuing in education after school are also amongst the highest.
- The number of children **enrolled in Harrow's schools** is increasing significantly, currently primary schools in particular but forecast to impact on secondary schools in 2016-17 – we have been particularly successful in terms of our planning and continue to offer every reception child a school place
- Nearly 7000 children 0-5 accessed Harrow's **Children's Centres** in 2012, with nearly 3000 coming from Harrow's more deprived areas
- **Breast feeding** initiation rates are good compared to England and London as a whole as are the rates of breast feeding at 6-8 weeks[3]
- Harrow has one of the **lowest rates of child deaths and serious injuries from accidents** in the country
- **Teen pregnancy** rates are amongst the lowest in England. STI rates are low

[3] Local analysis shows that this is not exclusive breast feeding and many women are supplementing breast feeding with bottle feeding.

Issues affecting children and families:

- The proportion of women booking with maternity units before week twelve of their **pregnancy** is low but improving
- Half of all Harrow **births** are in the Asian population. Births are increasing year on year with most of the increase coming from the White Other and Asian groups.
- **Infant mortality** rates in Harrow have doubled, although the actual numbers are low and the 3 year average is not significantly different to England as a whole
- Low **birth weight** rates, which are closely related to infant mortality, are amongst the highest in London[4]
- Childhood **immunisation** rates are improving but remain low for some groups, especially incoming population
- Harrow **child development** for under 5s is improving but is not as good as the England average
- Rates of decayed, missing and filled **teeth** in under 5s are below London average but high for West London
- Less than half of the children in Harrow schools speak **English as a first language**. The second most commonly spoken language is Gujarati. The biggest recent increase is in Romanian-speaking children
- In terms of narrowing the **achievement gap** locally, there are some groups who need attention: some black and minority ethnic (BME) groups[5]; children with Special Educational Needs (SEN); those receiving free school meals and children looked after

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[4] Although low birth weight is not a direct measure of infant morbidity, it is frequently used as a marker for poor health at birth because it is a leading risk factor for infant mortality and for subsequent morbidity among surviving infants.

[5] But note that some groups such as 'Indian' and 'Chinese' tend to be high achieving

- 21% of primary school and 25% of secondary school pupils are assessed as having some form of **special educational need**
- **Obesity** in reception year children is above England average but below London average. By year 6, obesity rates are lower than both England and London average

Hannah, age 6

- Nearly 1800 children and young people received a service from Harrow **Social Care** in 2011-12[6]. Abuse or neglect are the biggest reasons for referral to social care, followed by domestic violence
- **Domestic abuse** is high in the borough in comparison with the low overall crime rate. It is estimated that over 5000 women and girls aged 16-59 in the borough will have experienced some form of domestic abuse in the last year[7]
- Local services estimate that the police raise 14-18 alerts a day of incidents of **domestic abuse** involving children
- Harrow had 156 **children looked after** and 130 with **child protection** plans at the end of 2012/13. The rates of both of these groups per population are significantly lower than London averages
- The 2001 census suggested that there were 634 **young carers** in Harrow but the actual number is likely to be much higher than this

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[6] CiN census 2012
[7] Home Office VAWG Reckoner

- National data suggests that 10% of 5-16 year olds have some form of **mental health** disorder, which would equate to over 3000 young people in Harrow
- National estimates suggest that there are around 4000 **young carers** in Harrow[8].

Additional context for Harrow's Families

- Harrow is home to **49,000 children** 0-18 years
- There are around **93,000 households** in the borough
- Three areas of Harrow fall within the top 20% **most deprived** in England; these areas are found in the wards of Hatch End, Stanmore Park and Roxbourne. There are no areas in the top 10% of the most deprived nationally
- 11,000 households are likely to be affected by changes to **Council Tax benefits** – 67% of these households have dependent children and 61% are receiving Child Tax Credit[9]
- 650 households are predicted to be affected by the cap on **housing benefits** – 95% of these households have one or more dependents and 86% are claiming child tax credit
- 80% of all deaths are from three causes, **circulatory disease**, **cancer** and **respiratory disease**, with deaths from each occurring more frequently in the most deprived areas
- 17% of the Harrow adult population **smoke**, and rates are decreasing in all groups except young women and the 'routine and manual' group

[8] 2010 BBC research estimated 700,000 young carers nationally

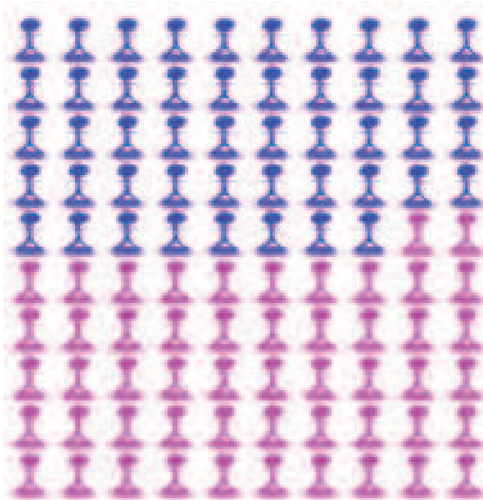
[9] Effects of 2012-13 welfare reforms from local analysis carried out within the Council during 2012

- There are estimated to be around 1300 **opiate** or **crack users** in the borough – in recent treatment programmes over 40% were parents, and around one third had children living with them
- Adult **obesity** rates are slightly higher than the London average and physical activity participation rates are well below average.
- Harrow has a low proportion of **binge drinkers** and a high proportion of people who drink no alcohol. In Harrow, the prevalence of both common mental health problems and neurotic disorders are lower than the England average but they still affect around 190 and 150 people per 100,000 population respectively
- **Crime** rates in Harrow are the fourth lowest in the Metropolitan police area. The geographical areas of concern are Harrow town centre / Greenhill ward; Wealdstone corridor, Edgware and South Harrow.

Shaganaa, age 8

The social context: Harrow Village – 100 children

Let's think about the London Borough of Harrow as a Village with just one hundred children and young people. This Village is a diverse and interesting place…



Gender

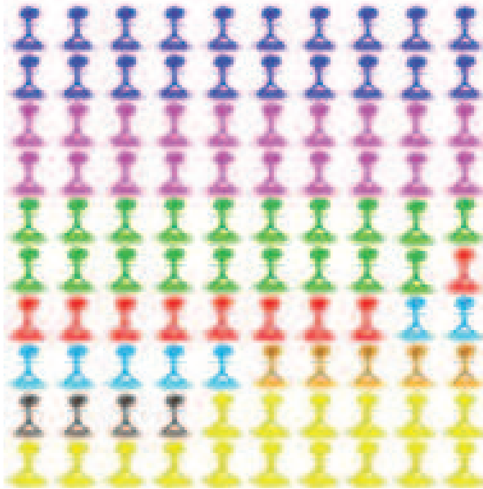
If Harrow is a Village of 100 children, we have the following number of boys and girls:

- 48 Boys
- 52 Girls

Age

In Harrow Village we have the following children and young people at different ages:

- 29 aged zero to four years old
- 26 aged five to nine years
- 27 aged ten to fourteen years
- 18 aged fifteen to eighteen



Ethnicity

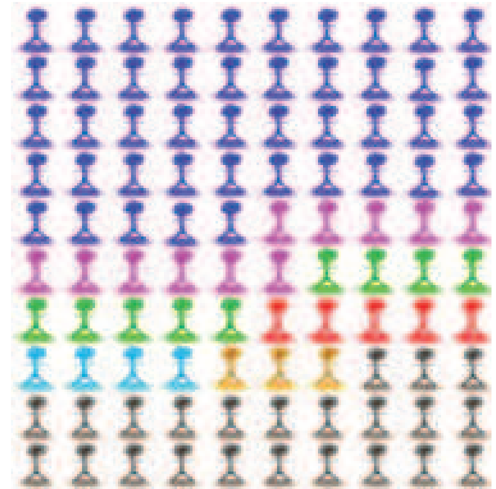
Our village is made up of children and young people with the following ethnicity:

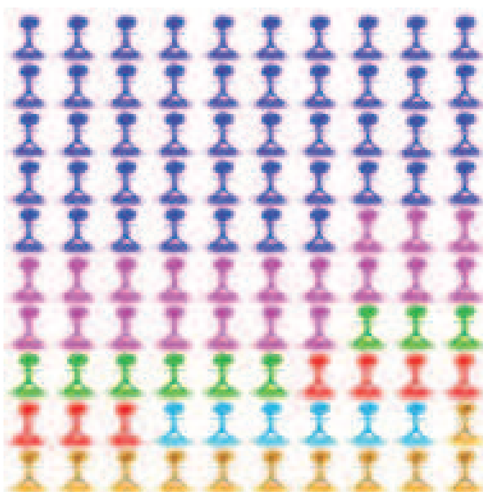
- 20 Indian
- 20 Asian Other
- 19 White British
- 9 Black African
- 7 White Other
- 5 Pakistani
- 4 Black Caribbean
- 16 Other ethnicity

First Language

The first language of children and young people in Harrow Village is:

- 45 English
- 11 Gujurati
- 9 Tamil
- 5 Somali
- 4 Urdu
- 3 Arabic
- 23 Other languages



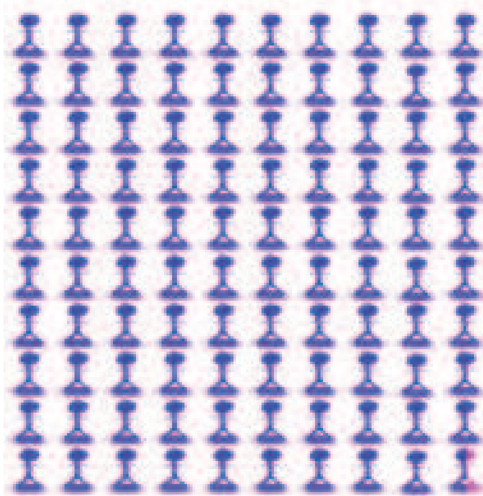


Religion

The parents of children and young people in Harrow Village practice the following religions:

- 47 Christian
- 20 Hindu
- 9 No Religion
- 7 Muslim
- 6 Jewish
- 11Other

Source: 2001 Census
(likely to change significantly for 2011)



Children in Care

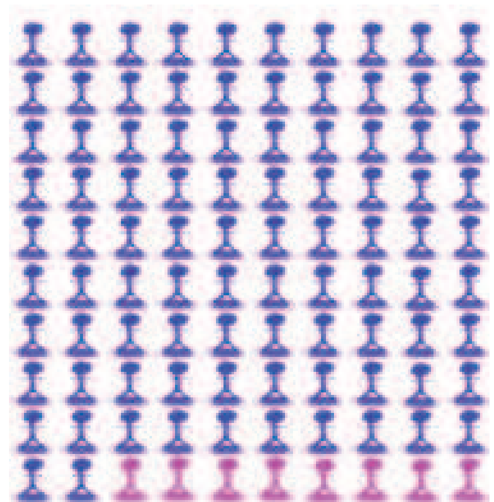
Some children and young people are looked after by the Council rather than their parents:

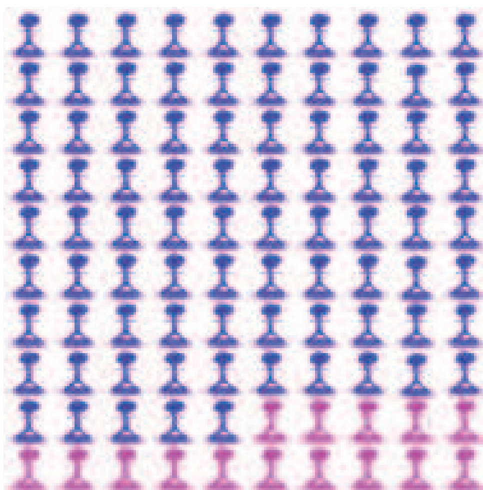
- 0.3 are looked after by the Council at any one time

Young Carers

In Harrow Village some children or young people must care for their parents or a relative:

- 8 children are acting as a young carer

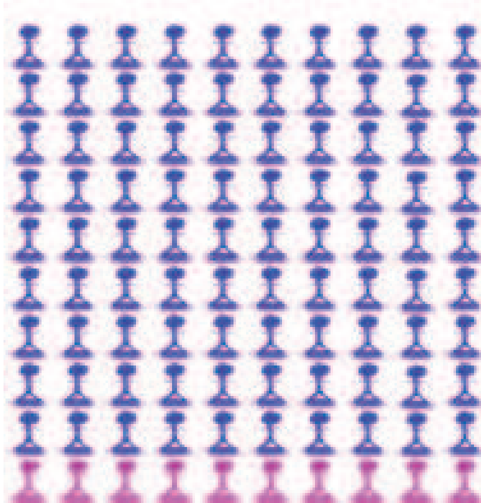




Body Weight

Some children and young people in Harrow Council are clinically defined as obese:

- 15 children are clinically obese



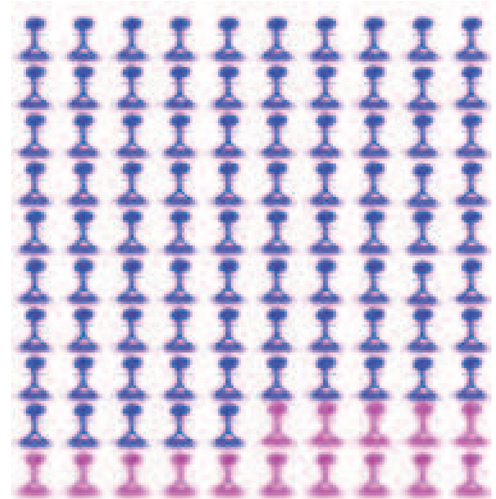
Mental Health
In our Village some children and young people suffer from mental health disorders:

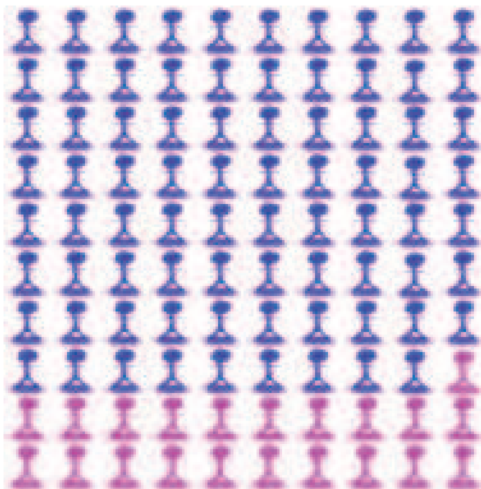
- 10 children will experience a mental health disorder

Domestic Abuse
Some children and young people in Harrow Village suffer from or witness domestic abuse:

- 15 children have experienced some domestic abuse

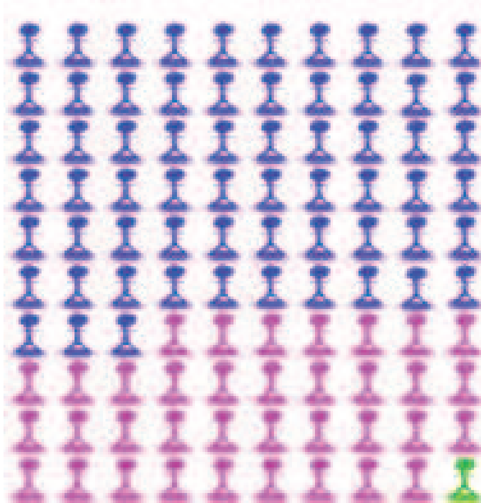
Source: based on average rates for 0-10 and 11-17 year olds from Stanley, Dartington)





Poverty
In our Village some children and young people live in families that do not have sufficient income:

- 21 children live in poverty



Education

And finally, in Harrow Village children taking their GCSEs will achieve the following grades:

- 63 achieve five A* to C grades (including English and Maths)
- 1 child will achieve no passes in any qualification at this key stage

We can use this type of information to reshape and commission services in Harrow. For instance, would Harrow's population have overall better outcomes if we shifted resources to support for young carers, or to mental health, or from young people to babies. The actions at the end of this document will consider these types of changes and what is best for Harrow's children and families.

Hannah, age 6

IV. Drivers: Priorities for Improvement

To deliver the co-produced outcomes from -9 months to 25 years, statutory partners need to prioritise particular aspects of service delivery. We have four constant priorities for service improvement based on the prevalent needs in Harrow; these sit alongside the statutory priorities from central government. Our priorities do not describe everything we do for children and families, but are used to steer all commissioning and service improvement:

Rugayya, age 8

1. **Early intervention** – to identify and support the needs of children and families before they become acute.

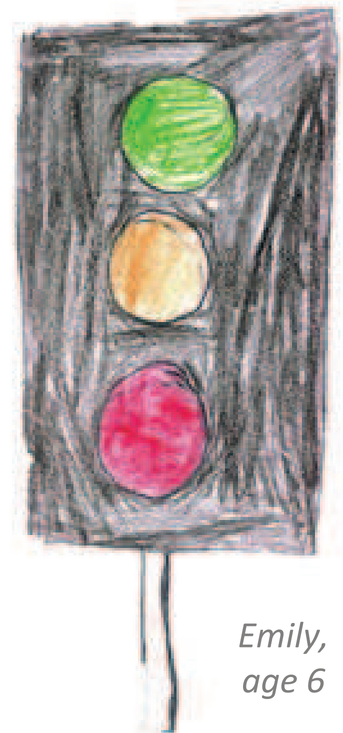
   Early intervention is crucial to give children a good start in life. Low birth weight is an issue in the borough and the development of Harrow children at age 5 is improving but is below national averages. This can only be addressed by co-ordinated efforts amongst parents, schools, health workers, childcare providers and children's centres.

   Another example is how we support parents whose children are missing school or involved in anti social behaviour. This support creates self sustaining change, and prevents further escalation and the need for social care and police intervention.

   At all ages early intervention is the best strategy to create the most efficient, effective and sustainable services, but this requires up-front investment and improvements in targeting.

   This priority also links to the following Harrow Council corporate priorities:

   - Delivering services in the most effective way.



Emily, age 6

2. **Health promotion** – all partners prioritising the mental and physical health of all our children and families and again ensuring issues are addressed before they become acute.

   Overall health of children and families in the borough can be considered to be good, but there is significant inequality and different rates of disease and life expectancy in different areas of the borough. Specific issues affecting child health include tooth decay and immunisation rates. Obesity rates are below average but remain a concern. Information on prevalence of mental ill health in children is limited, but local organisations have historically reported significant levels of unmet need.

   This priority also links to the following Harrow Council corporate priorities:

   - Maintain life expectancy in the borough, but reduce the health inequalities gap.
   - Increase participation in art, sport, leisure and cultural activities.

Sonia, age 6

3. **Safeguarding** – ensuring everyone in Harrow is safe from harm, including children in need and those at risk from violence, bullying and abuse.

   We are constantly improving our safeguarding of children and our partner development plan for the 'Child's Journey' includes five themes of improvement:

- A culture that changes things for the child
- Working together for the child
- Improving the quality of case work and managing risks to the child
- Holding the child's perspective
- Developing good systems.

Harrow has around 160 children who are looked after and a similar number of child protection plans in place over the last few years. These numbers are expected to rise as the population and level of need increases, and as local services become better at identifying concerns.

Adult domestic abuse levels are high compared with the borough's overall crime rate and this is a significant factor is many cases coming to the attention of police, health and social care. Although substance misuse rates are not high in Harrow, one third of those in treatment have children living with them, so there is a significant impact on children.

This priority also links to the following Harrow Council corporate priorities:

- Ensure the most vulnerable children, young people and families are appropriately cared for, safeguarded from harm and abuse.
- Reduce the fear of crime and incidences of anti-social behaviour so people in Harrow feel safe.

4. **Narrow the gap** – we know that in England children from a poorer background generally do less well than their peers – we want to eliminate this gap in Harrow.

   Deprivation affecting children and young families is increasing in the borough, this is thought to be linked to incoming population as well as the economic downturn. Disadvantaged pupils achieve less well in school and narrowing this gap is a priority for local schools. In addition, some other groups perform less well in local schools, notably children from some 'Black and Minority' ethnic groups, 'White Other' category, as well as Children who Looked After. There is also a local priority to significantly reduce the gap for children with special educational needs.

   This priority also links to the following Harrow Council corporate priorities:

   - Reduce the gap between educational attainment of the more vulnerable and disadvantaged groups of young people and the general child population.
   - Residents are supported to have the necessary skills and education to be able to access employment, apprenticeships or training opportunities.

Sonia, age 6

V. Drivers: Why We Need to Change

This is a difficult message that will have real impact on children and their family's outcomes and lives:

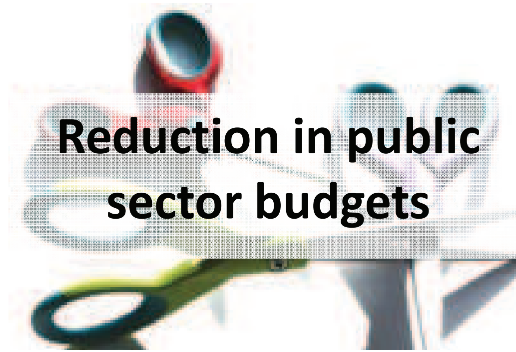
1. The UK **economy** is in recession and in 2013 Gross Domestic Product (GDP) remains 3.5% lower than the peak – this has had a big impact on local communities.

2. All partners in Harrow have been forced to make **efficiency savings** to our services which are likely to continue to 2017. This is unprecedented.

3. **Demand** for our local services is increasing because of service reductions such as benefits – some of our families are facing real hardship. And our **population** is growing, particularly for school age children and older people in Harrow. Both of these increases are welcome but mean additional demand for services that is not being funded by central government.

4. And meanwhile, our shared **expectation** of service quality and outcomes for children remains rightfully high.

Theo, age 5



This is the 'perfect storm' of an economic downturn, budget reductions, growing demand and demographics, and continuing expectation of quality. All partners and services in Harrow will need to become more efficient at using resources, better at targeting need and early intervention, and improve the way we design the whole system of support.

Services in Harrow will therefore need to change, to transform, so that we can meet needs within a much smaller budget. We are committed to transforming all services by 2018 – to do the best for Harrow's children and families.

Darya, age 8

VI. Plan: Systemic Changes to Commissioning

We are making changes to both the way services are commissioned, and how they are provided. We are making these system-wide changes because we can meet the needs of local children and families better, and better tackle the four priorities of early intervention, health promotion, safeguarding and narrowing the gap.

In a nutshell: [10]

> ***Commissioning is how we deliver children and families' outcomes from all of the resources in the best way.***

There are lots of resources in Harrow such as the public money, the workforce and providers, buildings, communities, users and their families. Commissioning is about getting the most from all of these resources and designing the whole system of services. i.e. Getting *much more for less*.

We have described our commissioning in the Strategic Commissioning Framework – this is the set of rules and guidance for commissioning teams in Harrow Council and partner agencies. These are the teams that will have to find 35%+ efficiency improvements – working with partners, providers and users.

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[10] A more complete definition and diagrams can be found in the Strategic Commissioning Framework.

One thing we are very clear about is the need for the child and family's voices to be at the centre of everything we do. From now on, we will ensure:

1. Services are **co-designed** with children and families. Whenever we transform services we will make sure that users are leading that redesign (e.g. parents helping to select provider for the new activities and short breaks market).
2. Every time a service is delivered, it will be delivered *with* the end user. i.e. children and families will help to choose the right service, and personalise it to their needs. We will **co-produce** outcomes with the child, their family and community (e.g. a young person helping to select their foster care placement).
3. We will make sure that the views of children and families are part of the **co-monitoring** information for all services – so that providers know that their performance is judged by user experience and service quality (e.g. user feedback on the quality of speech and language therapy services).

More principles for commissioning are in the Strategic Commissioning Framework.

Riya, age 5

VII. Plan: Systemic Changes to Provision

Children and families in Harrow draw on services from many partners including the Council, Schools, GPs and Health, Police, DWP and the voluntary sector. Wherever possible service teams will work together systemically, and we will co-locate services where they make most sense for children and families, for example, in:

1. Health settings such as GP surgeries
2. Children's Centres and nurseries
3. Schools, including mainstream, alternative, specialist and further education
4. Harrow Civic Centre for more intensive services such as the social care front-door
5. Youth and leisure centres such as Cedars, the Wealdstone Centre and Libraries.

There is no longer a culture of *doing services to people* but we work with them to *co-produce* the desired outcomes. Often we rely on individuals or their families to deliver most of the outcomes from services, e.g. early years, obesity, education, disabled children, teenage pregnancy, rather than the professionals.

We will always be clear about the short and long-term outcomes that we want to achieve, working with children and their families.

Our core principles for service provision are:

1. All services, interventions and decisions are based on a clear **understanding of outcomes** that we are delivering for the child
2. The **child and family's voice** is at the centre of everything we do – we co-produce outcomes with the child and family
3. We have **strong partnerships** between all partners
4. Wherever possible services are **co-located**, and delivered through **multi-agency teams** with **integrated** packages of care
5. There is **one point of contact** and one multi-agency front-door for urgent referrals
6. We operate a **single assessment** of need and effective information sharing between professionals
7. **Funding follows the child's needs**, e.g. through personalisation
8. We work in a **learning environment** – seeking personal development, challenge, user feedback and better practice.

See individual service plans for more details of principles for each service and improvement plans.

Janelle, age 8

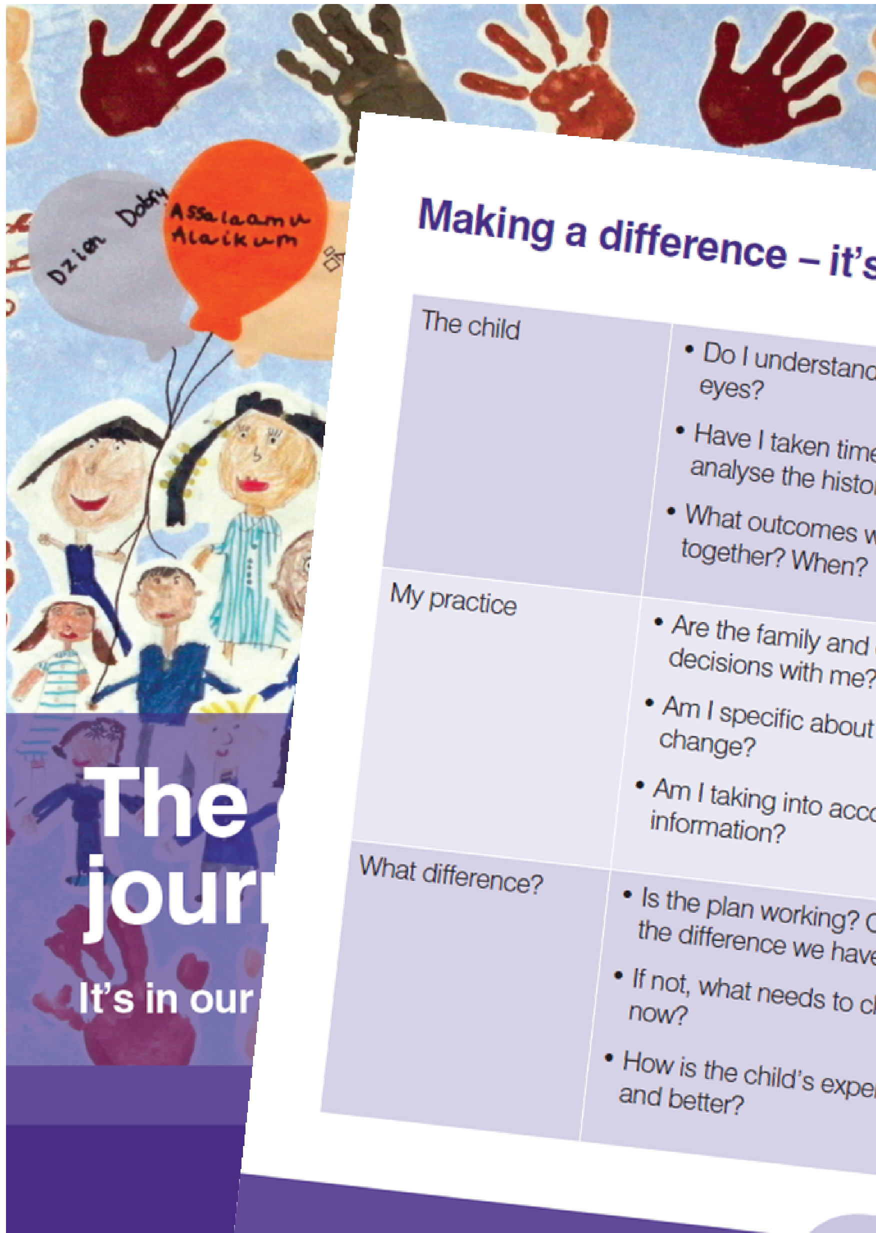
VIII. Plan: Systemic Changes to Practice

One of our most important tasks is to improve the quality of practice by front-line professionals and managers, to make the biggest difference in the lives of children and families.

Each statutory partner has a workforce plan, and also reviews the workforce design when we commission internal or external services. We want all staff to work more systemically with families, i.e. to understand the family history and strengths and build their resilience, work with children and families to co-produce outcomes, and to integrate different services around the family.

Children and families in Harrow can therefore expect the following behaviours from our case-holding staff:

1. Clearly understanding **what needs to change** for the child, with a passion to work proactively to achieve that change
2. Articulate how partners and processes such as risk assessments, planning, core groups, strategy meetings and investigations are **adding value** to each child's outcomes
3. Reflect confidently on their practice and actively welcome **constructive questioning** and **challenge** as part of a **learning culture**
4. Take time to **talk to children on their own**, telling their story based on their lived experience, speaking confidently about how the family history has been used to inform decisions.

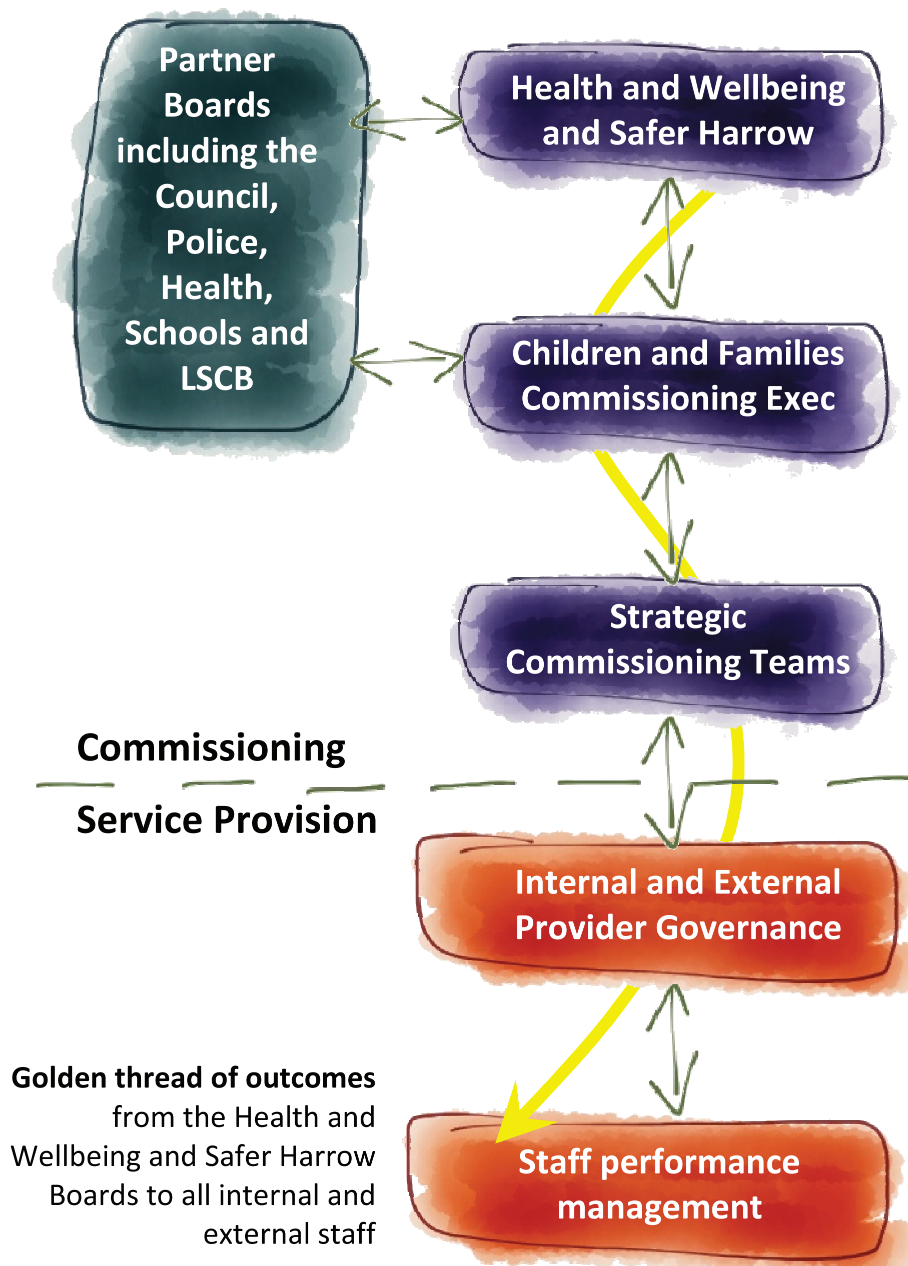

Dzien Dobry
Assalaamu Alaikum
The
jour
It's in our
Making a difference – it's in our hands
The child
• Do I understand, through the child's eyes?
• Have I taken time to understand and analyse the history?
• What outcomes will we achieve together? When?
My practice
• Are the family and child making decisions with me?
• Am I specific about what needs to change?
• Am I taking into account new information?
What difference?
• Is the plan working? Can we point to the difference we have made?
• If not, what needs to change/ happen now?
• How is the child's experience different and better?
Harrow COUNCIL
LONDON

IX. Plan: How we make Decisions

Harrow Council is in transition from a provider to commissioning-led organisation. We are therefore in the process of simplifying our governance and decision making, partly to reduce bureaucracy and partly to improve the way we design the system.

George, age 5

Our joint governance structure includes these main strands and levels:



Golden thread of outcomes from the Health and Wellbeing and Safer Harrow Boards to all internal and external staff

The **Health and Wellbeing Board** and **Safer Harrow Board** include the Council, Health, Police and other partners. Together these partnership boards are responsible for setting and improving outcomes of all residents in Harrow. The Local Safeguarding Children's Board holds partnership boards to account.

The **Commissioning Exec** is dedicated to children and family outcomes and oversees all commissioning of internal and external services, following the commissioning framework.

Each partner agency has **commissioning teams** such as the Clinical Commissioning Group staff for Health, and the Children and Families Strategic Commissioning Team for the Council. These teams are responsible for commissioning strategies and outcomes.

Internal services are managed by Divisional Directors and Service Managers, external services are managed by company or charity boards. Each follows the service level agreement or contract in place agreed with Strategic Commissioning Teams.

Individual staff are performance managed by their managers, against the outcomes they are achieving.

X. Plan: Important Documents

In order to work effectively we need to capture and communicate our plans and procedures. The following are the most important documents describing how we will improve outcomes for Harrow's children and families.

- **Corporate and Partnership Planning** – All partners have a planning and governance process, including setting priorities and targets for the year ahead. These help inform the outcomes and priorities for children and families in Harrow and are incorporated into all Commissioning Strategies. Examples include the Joint Commissioning Intentions that are agreed at the Health and Wellbeing Board to steer all joint commissioning between health and the local authority over the year. www.harrow.gov.uk/downloads/file/13787/corporate_plan_2013-2015

- **Joint Strategic Needs Assessment** – This is a high level needs assessment for all residents in Harrow. The JSNA is used when we develop any commissioning strategy as it is the overarching description of the outcomes that we want to achieve across all services. A summary of needs from Harrow's Joint Strategic Needs assessment is included in this document at section III. www.harrow.gov.uk/jsna

Khalisa, age 5

- **Strategic Commissioning Framework** – This framework sets the rules that we work by when commissioning services. It includes a common understanding of commissioning, principles that we are held to account for, and the agreed cycle of commissioning as well as helpful examples and templates.

- **Our Plan: Children and Families** – This document!

- **Commissioning Strategies** – For each service area (or set of outcomes) we will create a commissioning strategy. These draw on the Joint Strategic Needs Assessment, priorities and intentions from the Health and Wellbeing Board (and partner agency boards), as well as more intensive needs assessment and user engagement. Commissioning Strategies identify the outcomes required, user needs, resources available (money, people, buildings, community, etc), consideration of equalities, what works well, and options for improving outcomes from the resources. Children and families will be involved in designing the options. Commissioning Strategies are an intensive way of reviewing and transforming service areas, and are normally carried out every three to four years.

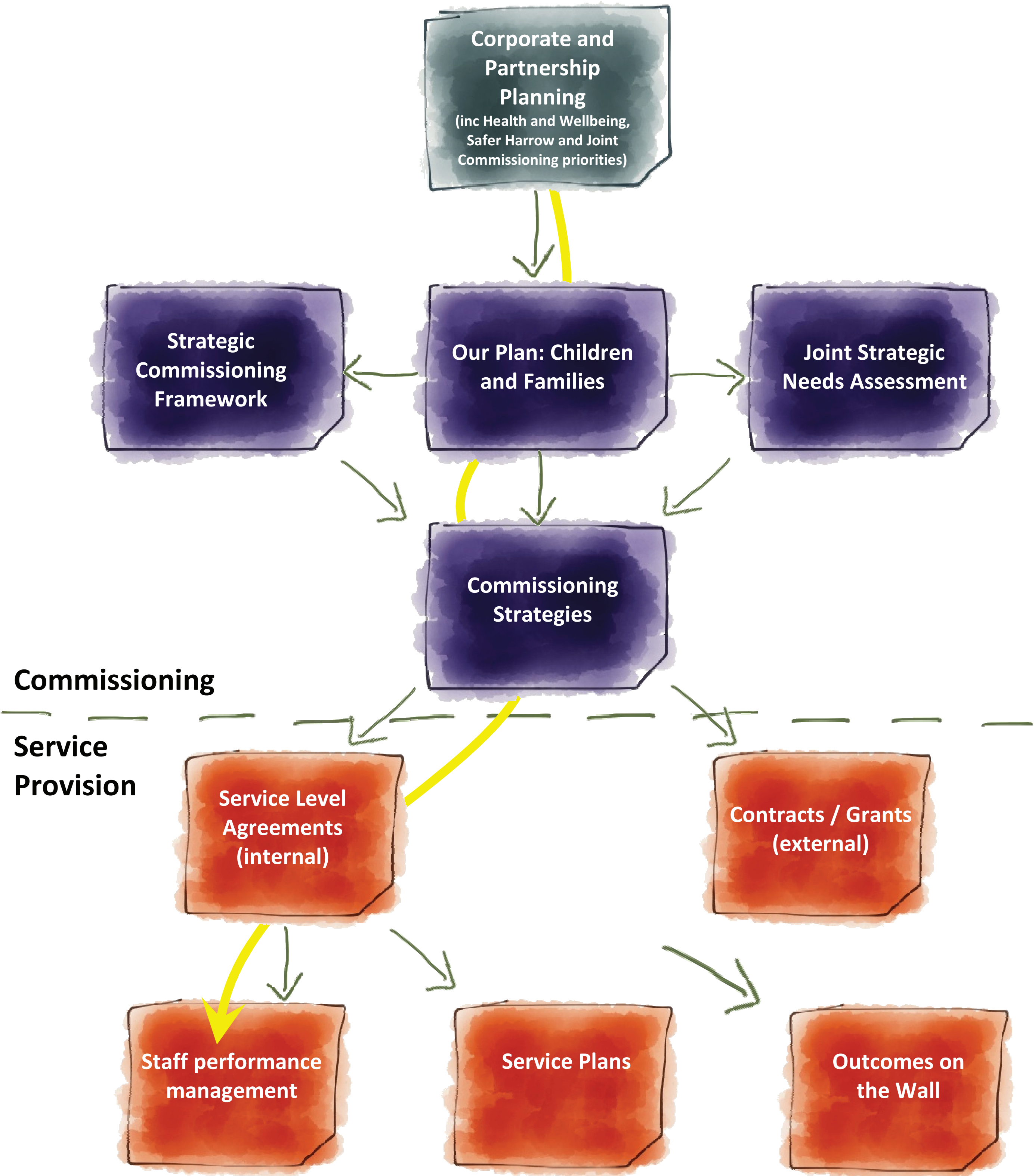
Darya, age 8

- **Contracts / Grants / Service Level Agreements** – The result of a commissioning strategy is often to put an agreement or contract in place with providers (external or internal respectively). These agreements show clearly the outcomes to be delivered as well as legal requirements and performance management. This gives a clear 'golden thread' from strategic priorities and the Joint Strategic Needs Assessment to individual agreements and contracts.

- **Service Plans** – These are the plans written in response to the service level agreement or contract. They are often internal to the service and include actions for improvement over the course of a year or more.

- **Outcomes on the Wall** – It is incredibly important to be clear about the outcomes that each team is delivering. We are now mandating that these outcomes and proxy-measures for outcomes are visible and celebrated by each provider by maintaining a large display on the wall that is updated monthly to demonstrate success in delivering outcomes.

- **Staff performance management** – Each individual is performance managed against the outcomes identified for their service area (in the contract or service level agreement). This is the 'golden thread' from population outcomes defined at the highest level to each and every professional on the front-line.



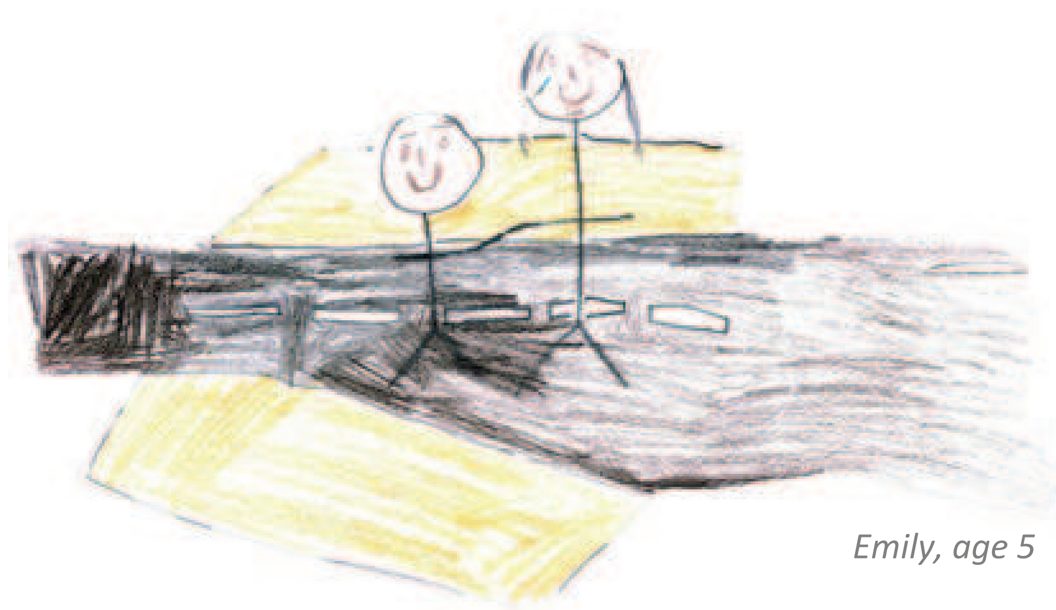
This diagram shows key documents and their relationships. Follow the arrows to see the flow of information and the 'golden thread' relating outcomes and priorities to commissioning strategies, service level agreements, service plans and individual performance management.

XI. Plan: Journey to 2018

Because we are facing a 'perfect storm' of challenges, we need a plan that will wholly transform services for children and families in Harrow. The following short and medium term actions begin our transformation journey, preparing for a very different public sector in 2018.

Our Journey to 2018 is shared by all partners in Harrow as well as community groups, parents, children and young people.

Note that this plan does not pre-empt the results of the commissioning cycle, but sets out when and how services will be strategically reviewed, transformed and re-commissioned. i.e. *How* we will change, not *what* will change. Commissioning will follow the standard process agreed by partners in Harrow's Strategic Commissioning Framework. A 'golden thread' links the actions set out here and more detailed service planning.



Emily, age 5

Service or Outcome Area	Short and Medium Term Actions
Early Intervention	
1.1. Early Years	• Improve outcomes for children at the age of five and reduce the attainment gap. Transformation is in two stages, pre-conception to two years old, and two to five. Three priorities for change: Broadening participation, Building capacity, and Quality for all. • Transformation to include initiation and continuation of breast feeding and healthy weaning, reducing post-natal depression, and support to parents who have problems during antenatal care. • For children aged two to three years an assessment programme including communication and behavioural needs will be developed. • Key principles for transformation are to shift resource to the home learning environment, align pathways and referrals, peer support and training, and to co-produce outcomes. January 2013 to April 2014.
1.2. Families First and Early Intervention Services	• Evaluation and research of what works including action testing of models to inform redesign. June 2013 to June 2014. • Review of parenting support across Early Years and Early Intervention Services. July 2013 to December 2013. • Identify vulnerability factors for families through combining partner data. April 2014 to March 2015. • Redesign of early intervention services to widen scope of the service model from 395 families (central government target) to 1000+ families with a spectrum of additional needs. Testing

Service or Outcome Area	Short and Medium Term Actions
	and prototyping of different models of support for different levels of need. August 2013 to March 2014. • Business case development for increasing partner investment in early intervention and family support through the community budget programme. August 2013 to March 2014.
1.3. Speech and Language Therapy	• Joint commissioning of SALT services between the Clinical Commissioning Group and Local Authority to a new outcome based specification with stronger and more frequent performance management. September 2012 to April 2013. • Based on the performance management, review SALT services including options for schools to commission the service (through a framework), and / or sub-regional commissioning with WLA members (linked to SEN changes). July 2013 to March 2014.
1.4. Positive for Youth	• Recommissioning of a variety of activities for young people, co-designed with users. April 2013 to June 2013. • New commissioning model for activities, potentially through a prime / sub-contractor model with multi-year length of contract. January 2014 to June 2014.
1.5. Community / Volunteer Mentoring	• Redesign of all internal and external services and the support and referral processes. February 2013 to September 2013. • Scale up mentoring (and other volunteering) to rapidly increase capacity and number of children, young people and families who are mentored. May 2014 to August 2014.
1.6. Counselling	• Redesign of services (linked to back office function for Community / Volunteer Mentoring) to improve efficiency and outcome based

Service or Outcome Area	Short and Medium Term Actions
	monitoring of delivery (and segment users of mentoring / coaching / counselling / bereavement services based on need). August 2013 to November 2013.
1.7. Family Information and Resource	• Redesign of the service, tied to the Menu of Support and following the transformation of Early Years. Redesign will make use of community involvement to share knowledge of services, and maintain the Menu of Support for professionals to access. September 2013 to December 2014.
1.8. Housing Support, Benefits, Supporting People	• Redesign of housing support and supporting people services for adults and young people. To refocus on families first, young people on the edge of care and leaving care. July 2013 to March 2014. • Develop a cross partner approach to supporting families affected by welfare reform. Ongoing.
1.9. Parents with mental health or substance misuse issues	• Review of support for parents with mental health or substance misuse issues, where this is impacting on the experience of the child. To include improved identification and support packages in coordination with local authority and health adult services, and public health awareness campaigns for responsible drinking and links to mental health. January 2014 to June 2014.

Health Promotion

2.1. School Nursing	• Novation of contract to the Council and re-specification of services around outcomes. Service to be based in Children's Centres / Schools. October 2012 to March 2013. • Redesign of School Nursing and Health Visiting to streamline the services and target to those most in need. Potential option to share

Service or Outcome Area	Short and Medium Term Actions
	services. December 2013 to April 2014.
2.2. Health Visiting	• Plan for novation of contract from NHS Commissioning Board to the Council. 2013 to 2014. • Redesign of Health Visiting and School Nursing to streamline the services and target to those most in need. Potential option to share services. December 2013 to April 2014.
2.3. Midwifery	• Modernise midwifery services in line with 'Call to Action' agenda and align with health visiting changes. April 2014 to April 2015.
2.4. Substance Misuse	• Novation of contract to the Council and re-specification of services around outcomes. October 2012 to May 2013. • Redesign of substance misuse services with one lead commissioner across the Council, aligned to partner agencies. September 2013 to September 2014.
2.5. Sexual Health	• Novation of contract to the Council and re-specification of services around outcomes. October 2012 to March 2013. • Review of needs and recommissioning of sexual health services across partners. December 2013 to March 2014.
2.6. Emotional Health and Wellbeing	• Tri-partite panel in place where funding streams are required from the local authority, devolved schools grant and health. February 2013 to July 2013. • Clinician / School led review of gaps in provision, referrals and pathways including the whole spectrum of behavioural, emotional and mental health needs. Redesign of local authority, schools and health service system including thresholds and referrals. Reduction in length of stay in specialist services. January

Service or Outcome Area	Short and Medium Term Actions
	2013 to January 2014. • Align or joint commission between NHS Harrow and Council for children's mental health services, including raising awareness of mental health issues in schools. April 2014 to April 2015.
2.7. Continuing Care	• Jointly develop an operating policy for tri-partite assessment, service planning and decision making between the Council and NHS Harrow. January 2013 to April 2013. • Phase in joint commissioning of packages of complex packages of care, prioritising high cost placements. April 2014 to April 2015.
2.8. Paediatrics	• Identify the extent and nature of childhood injuries and accidents through hospital and GP data. 2013 to 2014.
2.9. Leisure and Obesity	• Review obesity and physical activity in Harrow. Implement a school-based wellbeing programme. Review access to leisure and social activities, green spaces and safe areas for children to play (including 27 playgrounds in Harrow parks). April 2014 to December 2014.

Safeguarding

3.1. Domestic Abuse	• Commissioning of Domestic Abuse specialists in Family First services. January 2013 to March 2013. • Transformation of services to support victims of Domestic Abuse with all partners through a community budget. March 2014 to December 2014.
3.2. Looked After Children and Leaving Care	• Develop the West London Alliance fostering framework. August 2012 to March 2013. • Refreshed commissioning strategy and redesign of outcome specification, performance

Service or Outcome Area	Short and Medium Term Actions
	management against outcomes, and user choice in placement decisions and reviews (co-production – leading to an increase in stability). January 2013 to June 2013. • Improving health outcomes including early identification and referral to the MASH. 2013 to 2014. • Commissioning of packages of care including from a new menu of support. April 2013 to September 2013. • Increase choice of support and accommodation for care leavers, and improve transition planning. April 2013 to March 2014. • Identify corporate-parent champions for each child and young person in care for more than six months. September 2013 to December 2013.
3.3. Youth Offending	• Redesign of the Youth Offending Team service, including PCT / LA funded post for mental health. April 2012 to May 2013. • Alignment of commissioning to reduce Gang Activity between the local authority, police, schools, Mothers Against Gangs and other partners. August 2013 to December 2013. • Recommissioning of services to reduce gang activity, and youth offending services. April 2015 to March 2016.
3.4. Children in Need and Front-Door	• Redesign of front-door processes to improve performance. December 2012 to April 2013. • Development of service planning outcome measures for performance management. April 2013 to June 2013. • Implementation of The Child's Journey improvement plan including culture, process, case work, child protection conferences, participation and system changes. April 2013 to December 2013.

Service or Outcome Area	Short and Medium Term Actions
	• Implement POD team design and systemic approach to interventions. February 2013 to December 2013. • Review of social work including retention, recruitment and motivation. May 2013 to March 2014.
3.5. Advocacy	• Redesign of advocacy services and integration with Healthwatch. October 2012 to March 2013. • Updating of services to include web access and a market of provision (via frameworks). October 2013 to March 2014.

Narrowing the Gap

Service or Outcome Area	Short and Medium Term Actions
4.1. Education	• Ensuring sufficient high quality provision. Children and young people attain well and make good progress in high quality educational provision. On-going. • Quality assurance. Educational opportunities for all children and young people are of the highest quality. Ongoing. • Improving outcomes for pupils. Ensuring young people succeed in learning pathways. Ongoing. • Enhancing provision. Enhancing the participation and attainment of new and vulnerable communities, and engagement of voluntary and community providers. Ongoing.
4.2. Harrow Tuition Service	• Recommissioning of the Harrow Tuition Service / Pupil Referral Unit including relocation. January 2013 to August 2013.
4.3. Enhancing participation	• Recommissioning of Information, Advice and Guidance services to improve efficiency. October 2012 to March 2013. • Redesign of Information, Advice and Guidance services with options for sub-regional

Service or Outcome Area	Short and Medium Term Actions
	commissioning or commissioning by schools (through a framework). To include a review of apprenticeships and graduate placement opportunities in local businesses and required through statutory partner contracts. July 2013 to February 2014. • Identify potential bursaries to enable young people in poorer families to go to university, and support the application process. 2013 to 2014.
4.4. Special Educational Needs and Children with Disabilities	• Redesign of Special Needs Transport (SNT3) to improve efficiency of transport routes without impacting on children's outcomes. June 2012 to March 2015. • Commission to redesign SEN to improve personalisation and implement legislative changes. January 2013 to March 2015. • Capital funding to help mainstream and specialist services to be more accessible for disabled children. Changes are based on a social model of disability. Applications will be judged by parents of disabled children. March 2013 to August 2013. • Recommissioning of all SEN placements to improve value for money. April 2014 to December 2014.
4.5. Young Carers	• Review the support provided to young carers, to increase the reach of the service. Redesign to make best use of community and universal service provision to maintain schooling and continuing to live with parents. October 2013 to June 2014.
4.6. Activities and Short Breaks	• Transformation of Activities and Short Break services. New service is designed around direct payments, parental choice, better monitoring, and dramatically increasing the choice of

Service or Outcome Area	Short and Medium Term Actions
	traditional and new services accessible to parents. June 2012 to December 2013. • Transition of Activities and Short Breaks to Shop4Support website with funding following the user. August 2013 to March 2014.

System Change

5.1. Internal service level agreements	• Commissioning of internal services enabled through new service level agreements with all Council services. Outcome based performance measures established, with links to IPADs and Outcomes on Wall. March 2013 to June 2013.
5.2. Programme Management	• Establishing a new programme management office and processes in Children and Families Directorate. December 2012 to July 2013. • Running the PMO and rolling out to all major projects and programmes. On-going.
5.3. Quality Assurance	• Strengthening our quality assurance of front-line services, including performance management against outcomes. On-going.
5.4. Menu of support	• Menu of support services to be developed – this large range of services (e.g. volunteer mentors, family group conferencing, counselling) will be available to EIS and commissioning for looked after children. Further development will make the services more widely available, e.g. to social workers. April 2013 to March 2014.
5.5. Database of all families	• Refresh and maintain a database of all families in Harrow and their needs, linked to data from Experian Mosaic. Develop risk predictions. Database will be used to radically improve the efficiency and effectiveness of early intervention. September 2013 to June 2014.
5.6. Harrow School Improvement	• Review of delivery models for Harrow School Improvement Partnership (HSIP). September

Service or Outcome Area	Short and Medium Term Actions
Partnership	2013 to August 2014.
5.7. Non-core procurement spend	• Transition of procurement for non-core spend (e.g. cleaning) to Buying Solutions for aggregated buying power to reduce spend. December 2012 to April 2013.
5.8. Shared services – WLA	• Continued exploration of options for shared services with WLA members. On-going.
5.9. 2018 Transformation	• Developing and piloting 'Enabling our Transformation' training – open for all partners to access. December 2012 to July 2013. • Drawing on learning from the Cabinet Office Commissioning Academy, and sending a senior delegation. June 2013 to August 2014. • Develop a new relationship with families based on co-production – building on the early years transformation and working with Community, Health and Wellbeing Services, and the Big Volunteering campaign. April 2014 to March 2016. • Improving commissioning capacity, capability and culture to enable transformation – including new commissioning framework and guidance, refreshed governance, internal and external team training and development, recruitment, new relationships with providers and market management. On-going. • Supporting the transformation programme for Harrow post 2018. On-going.

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	October 2nd 2013
Subject:	**INFORMATION REPORT – Review of School Nursing and Health Visiting in Harrow and Barnet**
Responsible Officer:	Dr Laura Fabunmi Consultant Public Health Harrow Council
Exempt:	No
Enclosures:	None

Section 1 – Summary

This report sets out an overview of the proposed Joint review of Health Visiting and School Nursing in Harrow and Barnet to commence October 2013, which aims to identify the model of service delivery which will provide the best outcomes for children and young people, aged 0-19 years in both boroughs.

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Section 2 – Report

Review of School Nursing and Health Visiting

Introduction

The health and well-being of children and young people matters and school nurses and health visitors are key professionals in supporting children and young people in the developing years 0-19 to have the best possible health and education outcomes.

In April 2013, commissioning of public health services for 5–19-year-olds became the responsibility of local authorities under the direction of Directors of Public Health and in 2015, 0-5 year old public health services will also be commissioned by local authorities.

As a consequence of the transfer of responsibility and given the timelines for when the services will be solely commissioned by Harrow and Barnet Councils, there was a collective agreement by both CCG's, councils and NHS England that a review should be undertaken of the services.

A Project Steering Group overseeing the project has membership derived from the shared public health team; children's services of both Councils, the CCG of both Boroughs, an independent expert and NHS England, chaired by the Director of Public Health.
The review will be led by the Consultant in Childrens Public Health and a third party contractor will be procured to carry out the review.

Aims and objectives
The review aims to identify the model of service delivery which will deliver the best outcomes for children and young people aged between 0 and 19 years in both boroughs

The objectives are

- To map current provision across Barnet and Harrow against core offer and national guidance for School Nursing and Health Visiting

- To map current school nurse and health visitor activity and link to levels of identified health needs.
- To understand any gaps in current workforce and identify any risks to and probabilities of achieving expected trajectories

- To gain the views and needs from local families, children and young people concerning the roles of the School Nurse and the Health Visitor in relation to their health needs.
- To integrate the views of the wider health, social care and school communities on the role of school nursing and health visiting teams.
- To inform the development of the School Nursing service from 2014-15 & Health Visiting Service Specifications for 2015/16 and beyond
- To identify for both Councils, the best model for future delivery of school nursing and health visiting with a view to improving potential outcomes for children and young people.

Scope

The scope of the Review is:

- School nursing services for both boroughs
- Health visiting services for both boroughs
- Family nurse partnerships for both boroughs

The review will comprise of:

- Health Needs Assessment –demographic and geographical analysis
- Stakeholder Analysis
- Review of Service
- Workforce Analysis
- Options Appraisal

The review will take into account new issues that arise out of the move to local authority commissioning such as clinical governance, full integration with local authority teams, relationship with CCG commissioners and the implications of the development of free schools.

The review will also take into account the early year's reviews being conducted in both councils and also the current pan London work looking at models for the delivery of Public Health Services to the 0-5 population. The pan London work will provide a London wide perspective on the current provision of health visiting and future service delivery models. This review will look at both school nursing and health visiting services and will reflect local needs and stakeholder views as outlined in the expected outcomes below.

Separate reports will be written for each borough which will reflect the different demographics, needs and strategic direction of travel for each. However where there are areas of similarity which may have an impact on future commissioning arrangements, this will be taken account of.

Expected Outcomes of the Review:

The outcomes of the review are intended to provide options and models for service delivery including:

- Clear options for the delivery of school nursing and health visiting which are expected to produce the best outcomes for children (as measured by Public Health Outcomes Framework, NHS Outcomes Framework, Children's Outcomes Framework and any other appropriate local authority outcomes frameworks/strategies)
- Recommended options are evidenced based, will meet local need, will deliver against national guidance and best practice such as the healthy child programme
- Recommended options reflect the criteria within the Health and Wellbeing strategies, Children and Young People's Plans for both boroughs and the Public Health Outcomes Framework.
- Clear evidence that there has been input from a wide range of stakeholders particularly parents, children and young people and frontline health visitors and school nurses which have shaped the options appraisal for the future of the services

- A clear articulation of any workforce issues which may emerge from the review

- Draft specifications (including clear performance management reporting arrangements) for the health visiting service and school nursing service for 2015-16 which clearly articulate the best model identified.

Current progress

A procurement process has commenced to secure a contractor to carry out the review. The timescales for the implementation and delivery of final recommendations are indicated in the table below.

Key Milestones	Due Date
1. Commence Review	1st October 2013
2. Report on initial findings	6th January 2014
3. Presentation to Project Steering Group	w/b 27th January 2014
4. Feedback to Stakeholders	wb 3rd February 2014
5. Final Report	14th February 2014

Engagement has commenced with current providers of services to inform them of the review and seek their cooperation.

Section 3 – Further Information

A further report will be submitted to the Health and Well being Board in April 2014 which will include the final recommendations from the review.

Section 4 – Financial Implications

The funding for the review has been met through a joint budget between Harrow and Barnet from the Public Health ring fenced grant. The commissioning intentions and budget set for 2014/15 will reflect the outcome of the review and will be contained within the Public Health ring fenced grant for each council.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

Will be part of the review

Section 6 – Corporate Priorities

If a Council or Joint report - Please identify which corporate priority the report incorporates and how:

- United and involved communities: A Council that listens and leads.
- Supporting and protecting people who are most in need..

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 16.9.13		

Section 7 - Contact Details and Background Papers

Contact: Dr Laura Fabunmi, Consultant in Public Health Medicine

Background Papers: Project Specification requirement

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 3rd October 2013

Subject: **INFORMATION REPORT – Update On Call To action; National Plan To recruit Additional Health Visitors**

Responsible Officer: Report From NHS England; London Responsible Officer; Simon Weldon Regional director of Operations and Deliver

Exempt: No

Enclosures: None

Section 1 – Summary

This report sets out the background to the Government's Call to Action; A Plan to increase the number of Health Visitors. It provides details of work undertaken in London to recruit the required number of additional staff. It also makes reference to the planned transfer of Health Visiting Services to London Borough of Harrow from March 2015.

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Section 2 – Report

2.1 Background

The period from prenatal development to age 3 is associated with rapid cognitive language, social, emotional and motor development and a child's early experiences and environment influences brain's development. The mantra of getting a good start in life is widely accepted. As a consequence the Coalition Government and Department of Health have focused on how to provide additional support for those needing help including the most vulnerable families. Intervening early, working with families to build on their strengths, improve parenting confidence and when required intervening early with more specific help is seen as the most effective way of dealing with health, developmental and other problems within the family.

Health Visitors (HVs) working closely with GPs, midwives, Sure Start Children's Centres, and other local organisations play a critical role in leading this process. Health Visitors are trained nurses or midwives with additional specialist training in family and community health and are important in meeting the needs of the family. There are trained to identify issues which may escalate if early intervention does not occur. They are public health nurses trained to work in the community, with families and at individual level and they lead and deliver the Health Child Programme (HCP) which is designed to offer a core evidence based programme of support, starting in pregnancy, and going through the early weeks of life and throughout childhood.

Health Visitors and Health Visiting services are currently commissioned by NHS England, having been transferred over with the demise of Primary Care Trusts in March 2103. As Dr Fabunmi's paper notes the intention is to then transfer the HV service to Local Authorities from April 2015. Health visiting services in Harrow are provided by Ealing Integrated Care Organisation (Ealing ICO).

2.2 Call to Action; the Health Visitor Implementation Plan

Recognising the importance of the Health Visiting service and the role of Health Victors, the Coalition Government has made a commitment to recruiting an extra 4,200 Health Visitors by 2015. The Health Visiting Plan will put in place a new service that all families can expect to access. The new service;

- Will provide communities with a range of services including some Sure Start services Health Visitors will work to develop these and make sure communities know about them
- Will provide universal services set out in the HCP; this includes for example immunisations, health and development checks as well as support for parents and access to a range of community health services

- Universal plus service which gives a rapid response from the Health Visiting team when specific expert help is required e.g. with help on post natal depression, a sleepless baby, weaning etc.
- And the Universal Partnership Plus will provide on-going support from the HV team plus a range of local services working together to deal with more complex issues over time. These include the Sure Start Children's services, other community organisations and where appropriate The Family Nurse Partnership.

To achieve the Call to Action Plan, all parts of the system have a role to play. For example

Partnerships;

- Health and Well Being Boards will have a role to play in ensuring the best fit between health visiting and other local services in ways that best meet the local needs identified in the Joint Strategic Needs Assessment

Commissioners Role (NHS England)

- Implementing the new revised service specification which includes the HCP Programme (HCP) as set out in the HCP national model specification
- Includes all 5 levels of service model set out for HV services ensuring that families are offered the full universal check, with an early focus on improving coverage of the 2-2.1/2 year health and development check
- Developing a national currency and pricing guidance for HCP
- Utilising the model contract for community services
- Working with local paters to ensure best fit with wider local services for children and families

Providers (Ealing ICO)

- Developing the local service offer to families for community, universal, universal plus services and contributes to safeguarding and child protection arrangements working with local partners
- Agreeing with commissioners how to implement the new service and where this cannot be achieved in one commissioning year agree a stage implementation of the new service
- Planning for the health visitor workforce that is required including support for training and development.

2.3 Challenges in Implementing a Call to Action in London

Implementing the Call to Action has a number of challenges principally in terms of recruitment and finances**.** This section will focus on recruitment and retention of Health Visitors.

Nationally the requirement is to increase the number of HVs from 8,092 Full Time Equivalents (FTE) in May 2010, by 4,200 to achieve a total of 12,292 FTES by April 2015. In London this translates to an increase of 813 FTEs by

April 2015 to a total of 1168.3 FTE.s However there is a shortfall and the gap between the numbers in post and required is growing.

NHS England (London), Community Organisations, Universities, and The Local Training and Education Boards (LTEBs) are all working together to identify ways to increase recruitment. They have identified 3 potential sources for this;

- New recruits from these completing their training who started in 2012/3; potential pool of 247 trainees started
- Return to Practice; Only 8 return to Practice Health Visitors started in 2012/3
- International recruitment; From Denmark which has a similar public health role that could be adapted to work in the UK. 125 Recruits are planned to come to London in September/October but will need training/assessments before they will be able to work
- Agency Staff; 76 FTE were employed in London in 2012/3. They might be persuaded to become permanent employees.

However despite these actions, with attrition, there is a gap this year which will increase unless other actions are taken to increase recruitment and stop existing Health Visitors leaving. NHS London data showed that for Ealing ICO that across the 3 Boroughs i.e. Harrow, Brent and Ealing there was a shortfall of 38 Health Visitors and there would then be a need to meet the new targets to recruit in addition to these 38 posts and additional 27 posts in 2014/15. Although there is national shortfall against the target London is currently in the worst position being furthest from its trajectory.

2.4 Next Steps

Recognising the importance of this target NHS England London has established;

- A HV operating Group to drive and manage the full range of implementation plans for getting more student into, through and qualified as HVs, developed a communications strategy to profile London as a dynamic place to work as a HV and has developed a flexible Human Resources environment which welcomes and retains HV e.g. Ealing ICO has a permanent programme to recruit HVs
- A HV Intervention Group with Provides Directors of Nursing which will profile and champion the benefits of HV and health visiting across London
- A HV stakeholder Group which will engage the HVs and their staff side organisations

The intension is to get a Pan London and local engagement from all 19 providers and 33 Local Authorities. Part of the role of the group is to critique HV recruitment plans and offer feedback to different provider organisations.

NHS England London has also convened a Health Visiting Transformation Board with LTEBs, Local Authorities and clinical leads. This group is tasked with steering and driving an integrated strategic work force plan for 2013/4

and 2014/5. The group will also oversee a positive transition to Local Authority Commissioned Services by March 2015.

NHS England London has also established via a Heads of Agreement a renewed Early Years Minimum Data Set which from the beginning of September will measure the NHS and Public Health Outcomes Framework, the National HV specification and Call to Action trajectories by Provider by Borough. Once available these will be circulated to interested parties such as CCGs and Local Authorises

In addition the 3 London LTEBs are working together through one lead to find ways to increase capacity with the training programmes for example by looking at increasing placement capacity in providers and using neighbour counties outside London. Providers have been asked to review planed recruitments, look at flexible working and contracted hours and try to improve the ratio of newly qualified HV working in London through a greater investment in practice teaches. Some of the backfill and additional costs will be picked up by the LTEBs from a £1.5 million budget. This work in London is in addition to the work of the NHS Chief Nurse who continues to profile the HV plan and work with strategic leaders including the Nursing and Midwifery Council and political stakeholders.

In addition London's new commissioning model has allowed greater collaboration with CCGs and Local Authorities and a Memorandum of Understanding and Integrated Governance Framework (IGF) is currently being discussed and agreed across all 33 London Boroughs. So far at least 10 CCGs and 3 Local Authorities have asked to agree an IGF and to start to manage the transition more proactively and in advance of March 2015.

In summary London is behind target with its recruitment trajectories but is being proactive in trying to turn this position around. As for many other areas there are a number of factors which make London a difficult place to recruit to, namely housing costs and the general cost of living expenses. In addition the perceived pressure that some service area are under i.e. working with highly deprived communities with a high number of children on child protection plans has also meant that the London picture is not coherent in terms of vacancies and additional staff required. For example there are few if any vacancies in Richmond were as vacancy rates are much higher in Ealing etc. This makes it imperative that all partners continue to work together to meet this tragedy given the benefits particularly to young children that can be achieved.

2. 6 Links to Paper 'Review of School Nursing and Health Visiting in Harrow and Barnet

Dr Fabunmi's paper sets out a proposal for a joint review of HV and school nursing services in Harrow and Barnet to develop a model of service which will deliver the best outcomes for Harrow ad Barnet's 0-19 population. This review is designed to help shape services in advance of the transfer go HV services to Local Authorities so that by April 2015 Local Authorities will be responsible for the commissioning all 0-19 children's health services as opposed to having only responsibility for the 5-19 population now. The paper notes the need to look at current pan London work and should provide an opportunity for local agreement of the service model to fit local JSNA profile

and local people's views. The work currently being undertaken in London will assist this process and will ensure that once that the HV service in Harrow is effectively transitioned to local accountability within the national framework.

Section 3 – Further Information

Further details on the Dept. of Health (2009) Healthy Child Programme; Pregnancy and the first five years of life can be found at www.dh.gov/en/publicationsandstatistics/publications/publicationsand guidance/DH-107563

Health Visitor Implementation Plan; A Call to Action February 2011 is available on the DH's website under www.dh/gov.uk/publications

Section 4 – Financial Implications

Funding for Health Visiting service currently sits with NHS England and was transferred to NHS England as part of the disaggregation of PCTs in March 2013. Considerable discussion and work has taken place to identify the relevant amounts transferred across to NHs England and to understand Provider's establishment n terns of current funded posts, where funding has been transfer in anticipation of recruitment . Given a certain lack of clarity a zero based budgeting approach is currently being adopted to ensure providers maintain a grip on recruitment to agreed trajectories.

From a Local Authority perspective there are no financial issues in terns of HV services in 2013/4 or in 2014/5. however it would be appropriate for Local Authority Finance Departments to be aware of and involved in discussions on 2014/5 to ensure the correct level of funding is passed over to Local Authorise when the service move over.

Section 5 - Equalities implications

Nationally as part of NHs England's approach to new policy implementation an Equalities Impact will have been undertaken.

However the policy in question is about increasing the number of Health Victors with the intension being that this staff group will work with vulnerable families as well as providing a universal service.

Details of the Equalities assessment undertaken can be made available on request.

Section 6 – Corporate Priorities

If a Council or Joint report - Please identify which corporate priority the report incorporates and how:

- United and involved communities: A Council that listens and leads.

- Supporting and protecting people who are most in need.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Not applicable

Section 7 - Contact Details and Background Papers

Contact: Jo Murfitt Head of Assurance NW London , NHS England

Background Papers: Health Visitor Implementation Plan; A Call to Action February 2011 is available on the DH's website under www.dh/gov.uk/publications

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REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	3 October 2013
Subject:	**INFORMATION REPORT – Francis Report Action Plan**
Responsible Officer:	Ursula Gallagher Director of Quality and Safety -BEHH
Exempt:	No
Enclosures:	Outcomes of the First Meeting of the Francis Workshop held on 6 June 2013.

Section 1 – Summary

This report advises the Board on the action planning in relation to taking forward the recommendations from the Francis Inquiry.

FOR INFORMATION

Harrow COUNCIL
LONDON

Section 2 – Report

Report enclosed

Section 3 – Further Information

In June, the Director of Quality and Safety led a workshop of managers and clinicians from across the four BEHH CCGs to consider in more detail how to take forward key concerns raised by the Francis report. Three working groups have been established to look at collection and use of ‘soft’ information; use of performance and quality monitoring data; and assessing culture.
Francis also recommends commissioners be entitled to intervene in the management of individual patient complaints if it is felt they are not being dealt with satisfactorily. There is a fourth working group that consists of patients and lay people who are working with the CCGs to review the complaints process. This seeks to take account of pertinent issues from Francis and will be re-visited to take account of those recommendations from NHS England as a result of the Clywd review of the national complaints procedure (due to report in the autumn).

Section 4 – Financial Implications

Time of managers and clinicians attending meetings

Section 5 - Equalities implications

No decisions on actions have yet been decided. BEHH will be working with Inner London CCG’s to prepare a workplan, at this stage patients and the public will be consulted and an Equalities Impact Assessment will be undertaken

Section 6 – Corporate Priorities

Treating and caring for people in a safe environment and protecting them from harm –CQC Domain 5

- Supporting and protecting people who are most in need.

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

Not applicable

Section 7 - Contact Details and Background Papers

Contact: Carole Mattock Interim Head of Quality and Safety
BEHH 020 8966 1061

Background Papers:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

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FRANCIS WORKSHOP- FIRST MEETING 06/06/13

Present

Chair- Ursula Gallagher- Director of Quality and safety- BEHH CCG's
Donna Cox- Complaints and Governance Manager BEHH CCG's
Kim Rhymer-Designated nurse- Adult Safeguarding – Brent CCG
Pauline Johnson-Interim Deputy Director of Quality and Safety, BEHH CCGs
Sue Pascoe-Deputy Chief Operating Officer, Ealing CCG
Ann Coles-Designated Nurse Safeguarding Children, Ealing CCG
Sanjay Dighe- Harrow CCG Lay member for PPI
Esme Young- Lead nurse safeguarding- Hillingdon CCG
Nada Schiavonne- Head of Quality and Safety, CSU
Frances Alexander- Programme Manager Quality and Safety, BEHH CCG's

Objectives of the meeting

- To understand how to respond to the report
- To know who should be doing what
- To understand how this report links to other reports and intelligence
- To look at hidden gaps in our knowledge
- To make sure the patient voice is heard
- To decide how to penetrate silent groups
- To make the recommendations clear and concise so people can understand them
- To hear the voice of member practices
- To look at all providers – not just NHS ones

Key themes from the report

- Accountability- Who is accountable in a landscape with lots of different organisations : Providers, CCG's CSU's, NHS England, NHSTA, Monitor, CQC- what is role of CCG in accountability? Where does this fit with transparency and openness and assurance systems? How do we get assurance without micro-managing providers?
- Culture- How do we gain information about an organisations culture, including our own CCG's?
- Other information- how do we gather all sources into something that is intelligent, triangulated and not so complicated it cannot be understood or is an unnecessary burden in capturing data? Should we be involving providers in this discussion? How do we capture information from smaller providers, especially non-NHS ones
- "Soft" Information- how do we gather and feed in information from patients and GP's and where do complaints fit in?

Group Outcomes

To form 3 time limited working groups that will run over June/July/August and then meet again as a continuation of this meeting but with a wider group in early September, to

- provide a revised approach to performance information and intelligence,
- agree accountability framework
- agree recommendations and feed these into the new commissioning round and future specifications

Minutes of this meeting to be sent to COO's, CCG chairs, CD's and those on original invite list for this meeting. Date for September meeting to be agreed ASAP, lunchtime preferred, possibly a Thursday.
Group Chairs to be agreed and invited by UG
Membership of particular groups to be by interested parties e-mailing to Frances Alexander to express an interest, or by invite from UG or CCG exec's

Working efficiently

Nada shared some work from the inner London CCG's work on the Francis report and Ursula will be meeting with the Director of Nursing for the NW sector today and looking at benefits of any of this work being across all 8 CCG's, to avoid duplication of effort.

Summary of Groups

Area for recommendations to be made	Lead	Participants (to be agreed)	Outcomes from meetings
Collection and use of "soft" information	Gerald Ziedman	Sanjay Dlghe Jill Downey Rahul Bhagvat Diana Garanito Trevor Begg Kim Rhymer Amanda Craig Fran Alexander	• To review how information from complaints is used to inform us about quality of services, including GP services • To review if we can get information about services from patients and the public in other ways • To review how GP's can feed into the information sources when patients give them information • To agree a mechanism of feeding that information back
Information and data	Liz James	Bernard Quinn Shoaeb Musa Sue Pascoe Esme Young Carole Mattock Nada Schiavone Sarah Mansuralli Rebecca Wellburn	• To review what data is collected from different sources • To see how this information should be weighted • To review what providers think is important in data capture? • To avoid duplication of data requests and a simplification of data collected if possible.
Assessing Culture	Frances Alexander	Ursula Gallagher Pauline Johnson Ann Coles Carole Mattock Donna Cox	• How can we assess organisational culture? • What is our own organizational culture? • How do providers assess their own culture and how can they share that information with us? • What do we do with the information when we have it?

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	3rd October 2013
Subject:	**INFORMATION REPORT -** Moving from Partnership Boards to Strategic Groups focusing on HWB priorities
Responsible Officer:	Bernie Flaherty – Director of Adult Social Care
Exempt:	No
Enclosures:	Appendix A – EQIA Closure of Learning Disability Partnership Board Appendix B – EQIA Closure of Carers Partnership Board Appendix C – EQIA Close of Physical Disabilities Partnership Board

Section 1 – Summary and Recommendations

This report follows a HWB discussion in June 2013 about the future of Partnership Boards in Harrow. It outlines the subsequent actions taken and conclusions in relation to ending Partnership Boards and details of their replacements.

Recommendations:

1. To note the conclusions of EQIAs and discussion with Partnership Board members to bring the Boards to an end.

2. To note the alternative groups that will be focused on meeting HWB objectives and progress with implementing these.

3. To note that Partnership Boards are not stipulated by statute and are at the discretion of local areas.

4. CCG to nominate leads for Dementia and Carers' Groups

Section 2 – Report

Background

A report about the future of Partnership Boards was discussed in this meeting in June. The purpose of this discussion was that there were questions about the effectiveness of Partnership Boards and it was felt that groups with a clearer focus on delivering health and wellbeing priorities may be a more effective use of limited resources.

There were initially five partnership boards, but only three of these groups continue to meet, with two ceasing a number of years ago. These five groups are:

- Older People (no longer meeting)
- Mental Health (no longer meeting)
- Learning Disability
- Physical Disability
- Carers Partnership

In addition to these Boards there are a number of other boards, that currently meet and that can potentially contribute to the delivery of health and wellbeing priorities.

The Board meeting in June resolved the following actions:

1. To investigate disbanding the existing Partnership Board; confirming that none of these Boards were required by statute;
2. Task and finish groups based on the Health & Wellbeing Board's priorities be established;
3. The timetable for resolution detailed in the Officer report, be agreed.

Current situation

Work in relation to ending partnership boards

Following the Board meeting in June further work has been undertaken. This has included convening each of the Partnership Boards that are still in place to undertake an Equalities Impact Assessment, and discussion on the way that needs of the groups will be represented within alternative arrangements.

The conclusion of this work is that each of the three Boards in their current form have now been discontinued, and all of the members of these groups have been informed. In reaching this conclusion a number of mitigations were considered in the EQIAs (attached at Appendix A, B and C).

Some of the mitigations include:

- Take measures to approach young adults and encourage participation in the new task and finish groups (LD EQIA)
- Encourage participation of under represented religions and beliefs in new sub-groups by linking with community groups, care workers etc. (LD EQIA)
- Ensure the task and finish group has the right make-up to reflect the community of carers, with access to views of people from all parts of the community (Carers EQIA)

- There is the need for more service users from a wider base and from the third sector and voluntary organisations such as service users who have suffered a Stroke to feed into any new board or group. Buildings used for meetings need to be accessible. (PD EQIA)
- Ensure the views of People with sensory/physical disabilities and voluntary groups are heard and understood

Work in relation to establishing groups to meet HBW priorities
The cessation of the Partnership Boards has provided the opportunity to focus on the development of groups around the six joint commissioning intentions proposed by the Health and Wellbeing Board.

As can be seen in the EQIAs attached and the mitigations outlined above, there is a clear need to ensure that these groups have representation that reflects the diverse nature of the community and the diverse needs of vulnerable adults locally.

Ensuring appropriate representation will be a role for the Chair of each of these groups, and should be reflected in their terms of reference.

The table below sets out the Commissioning Intentions, name of the group that will meet it, and the current status:

Commissioning Intention	**Name of Group**	**Lead Officer**	**Current Status of Group-**
Services for older people	Older People Integration Task & Finish Group	Bridget Bergin Nominated (LA)	To be developed following decision on Pioneer status application
Dementia strategy	Dementia Group	CCG to confirm lead (CCG)	First meeting to be convened in November (Dementia Engagement workshop taking place 16/10/13)
Children's services	Children and Young People Commissioning Executive	Catherine Doran (LA)	In place and meeting TBC
Autism strategy	Autism Project Group	Amanda Dade (LA)	In place meeting every 6 weeks
Services for carers	Carer’s Group	CCG to confirm lead (CCG)	First meeting to be convened. Timescale proposed- End of October 2014
Safeguarding adults	Winterbourne Task & Finish	Amanda Dade (LA)	In place meeting monthly
	Adult Safeguarding Board	Bernie Flaherty (LA)	In place and meeting quarterly

Why a change is needed

As outlined in the last meeting the Health and Wellbeing Board have key outcomes to deliver for the community, and need to ensure that resources are being used efficiently to meet these. Whilst the Partnership Boards have made a positive contribution they are not sufficiently focused on meeting priorities for the borough. In addition, there was considerable duplication across Boards of areas of work being taken forward. The Older People’s and Mental Health Boards had been disbanded some time ago and the continuation of the three other Boards was therefore inequitable. Also the three remaining Boards were led by the Local Authority and did not reflect the intended Partnership focus of these Boards.

It is essential that groups have the right people engaged to assist with the delivery of priorities and to inform on issues to be considered when shaping future commissioning priorities.

Timescale for Resolution

Following discussions with Partnership Board members the decision was taken in each Board that the meetings would discontinue.
Members of all three Partnership Boards made this decision based on the proposed improved arrangements for focused groups being established.

As outlined in the table above there are seven groups in place or due to be implemented, which will take forward work on delivering Joint Commissioning Intentions. These groups will replace the original five Partnership Boards. However the rich tacit knowledge which has been accumulated and was available to the Boards will be utilised in the newly formed, focused groups.

Work is being progressed with four groups already meeting and two more groups tasked to have their first meeting by the end of October 2013. The Older People’s Integration Task & Finish Group is awaiting confirmation of Pioneer Status before scope and nature of the group can be defined.

The timescales below outline the key dates to ensure that these groups are effectively meeting HWB priorities:

By end November 2013	All groups will have met and held at least an Initial meeting convened by Lead Officer to discuss membership / scope and consider EqIA recommendations
By December 2013	An established schedule of meetings will have been identified with representative membership, to plan for activities to deliver priority (ies)
By January 2013	Initial report to be presented to the Health & Wellbeing Board on progress and plans by each group
Ongoing	Each Board submits update to Board at agreed interval of 3-6 months

Financial Implications
There are no specific financial implications arising from the structure, however, any financial implications which may arise out of the specific task & finish groups or other boards are contained within existing budgetary provision, or where decisions may have a longer term financial impact, are considered as part of the budget setting and MTFS or equivalent CCG process.

Risk Management Implications
Risk management has been undertaken for each of the groups and is included with the Equality Impact Assessments.

The key risk identified for each group is that service users and/or carers lose the opportunity to have a say and to influence direction. This is mitigated by the actions outlined and efforts to ensure representative membership on groups. It is expected that focusing groups on key priorities will give service users and carers more, rather than less, say in the way that key council services operate but these groups will operate in a more strategic and targeted way.

Equalities implications
We have undertaken an EQIA for each of the three Partnership Boards that continue to meet. Potential impacts have been identified, and some of the mitigations are included above. These EQIAs are attached as an appendix.

An important consideration is that the new arrangements will be more inclusive, and will give the opportunity for people not currently represented by the three active partnership boards to influence decision making. This is a significant positive impact of the changes.

Corporate Priorities
This paper looks to refocus the work of partnership boards to focus on the Health and Wellbeing Board priorities which reflect the corporate priorities of the Council and the Clinical Commissioning Group.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 25 September 2013		

Section 4 - Contact Details and Background Papers

Contact: Trina Thompson, Corporate Affairs Manager, 02084209324 – Trina.Thompson@harrow.gov.uk

Background Papers: Health and Wellbeing Board Terms of Reference

TEMPLATE 2 - Full Equality Impact Assessment (EqIA)

In order to carry out this assessment, it is important that you have completed the EqIA E-learning Module and read the Corporate Guidelines on EqIAs. Please refer to these to assist you in completing this form and assessment.

What are the proposals being assessed? **(Note**: ‘proposal’ includes a new policy, policy review, service review, function, strategy, project, procedure, restructure)	The cessation of the Learning Disability Partnership Board (LDPB), as a result of the introduction of the Health and Wellbeing Board
Which Directorate / Service has responsibility for this?	Community Health and Wellbeing, Adult Social Care
Name and job title of lead officer	Jonathan Price, Head of Provider Services. Tel: 020 8424 1963
Name & contact details of the other persons involved in the EqIA:	Veronica Patel, Project & Change Manager. Tel: 020 8416 8148 Una Taylor, Service User Engagement Officer. Tel: 020 84241022 Deven Pillay, Chief Executive, Harrow Mencap. Tel: 020 8869 8484 David House, LDPB Vice Chair Carol Yarde, Head of Community, Health and Wellbeing Transformation
Date of assessment:	22 July 2013 – Comments from Deven Pillay, with Veronica Patel and Jonathan Price 24 July 2013 – Comments from David House, with Veronica Patel and Jonathan Price 1 August 2013 – Consultation with LDPB members 6 August 2013 – Comments from Sue Spurlock

Stage 1: Overview

1. What are the aims, objectives, and desired outcomes of your proposals?	Approximately 10 years ago as a result of the National Service Frameworks a number of Adult Services Partnership Boards were established and have continued to be in place. The original requirements have

(Explain proposals e.g. reduction / removal of service, deletion of posts, changing criteria etc)	now dissipated which has caused a lack of focus and structure for the Boards. The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. A decision was therefore made to disband the existing LDPB and reconstitute task and finish groups based on the health and wellbeing boards priorities. The introduction of the Health and Wellbeing Board has been seen by the Partnership Boards as an opportunity to review their purpose and direction The original five adult Partnership Boards were Older People (governed by the old National Service Framework for Older People and chaired and facilitated by the PCT/CCG) Mental Health – (facilitated by the PCT) Learning Disability – (governed by the 'Valuing People Framework' chaired and facilitated by the Council) Physical Disability – (chaired and facilitated by the Council) Carers Partnership – (chaired and facilitated by the Council) **Aim of the proposal** The aim of the proposal is to determine any adverse impacts of the cessation of the existing LDPB. The current functions of the LDPB would be delivered through established structures within Adults Services such as the Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the Quality Assurance Quadrant (QAQ). Also delivery will be ensured through existing task and finish groups or by establishing new groups around either the Joint Health and Wellbeing Strategy priorities or Joint Commissioning Intentions. The sub groups would be made up of stakeholders, service users and patients. The Health and Wellbeing Board have some really important joint outcomes to achieve which may not

happen if:

- There is a blurring of Boards purpose
- Too many duplicate meetings
- The Partnership Boards are not governed by the Health and Wellbeing Board

Harrow Council's Safeguarding Assurance & Quality Services team has developed a new Local Account Group. This group consists of users who undertake surveys and mystery shopping. This group was formed post Winterbourne View and in response to the changes to CQC. This group takes on the role of bringing together users feedback and providing an avenue for users to influence service delivery. They along with Healthwatch Harrow will ensure voices are heard.

The Board needs to ensure that the right people are engaged to assist with the delivery of the priorities and also inform the Board of new issues which need to be considered when shaping future commissioning priorities. This includes key stakeholders such as the Public Health Team.

Officer capacity is limited and therefore any groups which are in place need to have a clear purpose and be adequately supported by the Council, the Clinical Commissioning Group and the Voluntary and Community sector. This commitment is central to success.

The recently adopted Health and Wellbeing Board (HWB) Terms of Reference outline the establishment of sub groups, which are based on the Board's priority areas rather than specific client groups. The HWB Terms of Reference state that the sub groups will be reviewed each year and expected to achieve specific outcomes. The sub groups will also have a role to ensure the views of patients and service users are included.

The Health and Wellbeing Board has seven priorities as outlined in the Joint Health and Wellbeing Strategy and also six joint commissioning intentions for 13/14:

Joint Health and Wellbeing Strategy priorities:

- Long term conditions
- Cancer
- Worklessness

	• Poverty • Mental health and wellbeing • Supporting parents and the community to protect children and maximise their life chances • Dementia The current draft Commissioning Intentions Priorities include: 1. Services for older people 2. Dementia strategy 3. Children's services 4. Autism strategy 5. Services for carers 6. Safeguarding adults A number of task and finish groups have also been established recently to address particular service areas: Winterbourne Task and Finish Group (this fits to (6) above) Adults Safeguarding Board (this fits to (6) above) Autism Project Board - (this fits to (4) above)
2. What factors / forces could prevent you from achieving these aims, objectives and outcomes?	Findings of EqIA –any gaps or differential impacts on individuals or groups which cannot be mitigated
3. Who are the customers? Who will be affected by this proposal? For example who are the external/internal customers, communities, partners, stakeholders, the workforce etc.	• Current members of the LDPB • Harrow Mencap • Service Users • LD community in Harrow • Schools & Colleges

4. Is the responsibility shared with another department, authority or organisation? If so: • Who are the partners? Who has the overall responsibility?	No. Council led and resourced
4a. How are/will they be involved in this assessment?	Adults Social Care, Harrow Council will collate information and draft full EqIA in consultation with representatives of the customers identified in point 3 above.

Stage 2: Monitoring / Collecting Evidence / Data

5. What information is available to assess the impact of your proposals? Include the actual data, statistics and evidence (including full references) reviewed to determine the potential impact on each equality group (protected characteristic). This can include results from consultations and the involvement tracker, customer satisfaction surveys, focus groups, research interviews, staff surveys, workforce profiles, service users profiles, local and national research, evaluations etc

(Where possible include data on the nine protected characteristics. Where you have gaps, you may need to include this as an action to address in the action plan)

Age (including carers of young/older people)

Demographic profile of LD service users in Adult Social Care Services

Age Band	Cou nt
18 - 24	90
25 - 34	126
35 - 44	81
45 - 54	94
55 - 64	54
Grand Total	**445**

The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed equalities monitoring forms. 4 are between 25 and 44 years old, 3 between 45 and 64 years old and 1 over 65 (but under 75).

<table>
<tr><td></td><td>Older people and young people are both under represented at the current LDPB.</td></tr>
<tr><td>Disability (including carers of disabled people)</td><td>Demographic profile of LD service users in Adult Social Care Services:

Total of 445 under Adult Social Care however of these 71 also have a physical disability as a secondary category.

All service users attending LDPB have a disability.</td></tr>
<tr><td>Gender Reassignment</td><td>Whilst Harrow Council’s Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic.

The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. 6 completed the question on gender reassignment and of these 6, all responded to say they their gender identity was the same as the gender assigned at birth.</td></tr>
<tr><td>Marriage / Civil Partnership</td><td>The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. 7 responded that they were not married.

Demographic profile of LD clients in Adult Social Care Services

<table><tr><th>Marital Status</th><th>Count</th></tr><tr><td>Divorced</td><td>1</td></tr><tr><td>Married</td><td>2</td></tr><tr><td>Not Known</td><td>1</td></tr><tr><td>Not Stated</td><td>220</td></tr><tr><td>Single</td><td>221</td></tr><tr><td>Grand Total</td><td>445</td></tr></table></td></tr>
<tr><td>Pregnancy and Maternity</td><td>Whilst Harrow Council’s Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

The number of service users that attend LDPB is variable. 8 service users came to the consultation</td></tr>
</table>

	meeting and completed Equalities monitoring forms. 7 responded to say they had not been pregnant and/ or on maternity leave in the last 2 years.
ace	Demographic profile of LD clients in Adult Social Care Services

Ethnicity	Count
Asian or Asian British	**166**
Any other Asian background	38
Bangladeshi	3
Form not completed	4
Indian	104
Pakistani	17
Black or Black British	**31**
African	10
Any other Black background	2
Caribbean	19
Mixed background	**8**
Any other mixed background	2
White and Asian	2
White and Black Caribbean	4
Other Ethnic background	**22**
Any other ethnic group	21
Arab	1
(blank)	
White or White British	**218**
Any other White background	9
Did not wish to reply	1
English	194
Form not completed	1
Irish	13
Grand Total	**445**

Harrow has one of the most ethnically diverse populations in the country; ONS estimates show that Harrow now has the fourth highest proportion of residents from minority ethnic groups, compared to a ranking of

	eighth in 2001. The Greater London Authority (GLA) Datastore, estimates that in 2013, 60% of the total population of Harrow or 57% of people aged 18 and over are from a BAME (Black and minority ethnic) group. By 2018 BAME groups will make up 65% of the total population and 61% of people aged 18 and over; by 2023 the proportion will increase to 68% and 65%, respectively The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. The results showed that 1 was Indian, 1 White, English, 1 White English and Irish, 1 Albanian, 1 Sri Lankan. The white population of services users is fairly represented at LDPB but other groups are underrepresented particularly the Asian or British Asians.
Religion and Belief	Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic. The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. 4 stated that they were Christian (all denominations), 1 Hindu, 1 Jewish, 1 No religion, 1 Zoroastrian. This would indicate more Hindus are required to represent and there are no representative of the next largest group which is Islam. Demographic profile of LD clients in Adult Social Care Services

Religion	Count
Buddhism	1
Catholic	9
Christian (all denominations)	189
Hinduism	105
Islam	58
Jainism	1
Judaism	28
No Religion / Atheist	13
Not Known	6
Not Stated	28

	Other Religion 6 Sikh 1 **Grand Total 445**
Sex / Gender	The 2011 census results show that women outnumber men in all age groups over 34-39, and this difference becomes greater in the over 75s. The Greater London Authority (GLA) Datastore, estimates that in 2013 the male to female ratio of people aged 65 or over is 45%/55% in Harrow changing to 46%/54% by 2023; the 2013 male to female ratio of people aged 75 or over is 39%/61% in Harrow changing to 44%/56% by 2023; the 2013 male to female ratio of people aged 90 or over is 33%/67% in Harrow changing to 44%/56% by 2023. The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. 3 were female and 5 male. This is representative to the LD service users in Adult Social Care. Demographic profile of LD clients in Adult Social Care Services **Gender / Count** Female 197 Male 248 **Grand Total 445**
Sexual Orientation	Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic The number of service users that attend LDPB is variable. 8 service users came to the consultation meeting and completed Equalities monitoring forms. All attendees stated that they were heterosexual.
6. Is there any other (local, regional, national research, reports, media) data sources that can inform this assessment? Include this data (facts, figures, evidence, key findings) in this section.	The Health and Wellbeing Board has seven priorities as outlined in the Joint Health and Wellbeing Strategy and also six joint commissioning intentions for 13/14: Joint Health and Wellbeing Strategy priorities: • Long term conditions

- Cancer
- Worklessness
- Poverty
- Mental health and wellbeing
- Supporting parents and the community to protect children and maximise their life chances
- Dementia

The current draft Commissioning Intentions Priorities include:
1. Services for older people
2. Dementia strategy
3. Children's services
4. Autism strategy
5. Services for carers
6. Safeguarding adults

A number of task and finish groups have also been established recently to address particular service areas:

a) Winterbourne Task and Finish Group (this fits to (6) above)
b) Adults Safeguarding Board (this fits to (6) above)
c) Autism Project Board - (this fits to (4) above)

7. Have you undertaken any consultation on your proposals? (this may include consultation with staff, members, unions, community / voluntary groups, stakeholders, residents and service users)	Yes		No	

NOTE: If you have not undertaken any consultation as yet, you should consider whether you need to. For example, if you have insufficient data/information for any of the protected characteristics and you are **unable** to assess the potential impact, you may want to consult with them on your proposals as how they will affect them. Any proposed consultation needs to be **completed before** progressing with the rest of the EqIA.

Guidance on consultation/community involvement toolkit can be accessed via the link below
http://harrowhub/info/200195/consultation/169/community_involvement_toolkit

Who was consulted?	What consultation methods were used?	What do the results show about the impact on different equality groups (protected characteristics)?	What action are you going to take as a result of the consultation? This may include revising your proposals, steps to mitigate any adverse impact. *(Also Include these in the Improvement Action Plan at Stage 5)*
Deven Pillay, Chief Executive, Harrow Mencap	A meeting was held in order to explain the purposes of the EqIA. The requirements were then fully discussed and views of Harrow Mencap incorporated into document	There was concern that the views of young adults and some religions & races are not currently represented on the LDPB. A 'Task and Finish' approach which are issues based could lead to a dissipation of LD voice. Concerns about the level of influence such an approach will have on users setting the strategic agenda and opportunity for co design.	As the task and finish groups are put together representative organisations groups and members of the current LDPB will be contacted to participate in the new sub groups to ensure these groups are fairly represented and the make up of the groups reflect the LD population in Harrow as well as the focus of the group. It is anticipated that this will be an improvement on the current make up of the board. 'Engagement strategy to be written to set out communication channels and mechanisms.
David House, LDPB Chair and members	A meeting was held in order to explain the purposes of the EqIA. The requirements were then fully discussed and views of the Vice Chair of the Vice Chair of the LDPB incorporated into document.	The main concern was that the views of the Disability group would not be fully heard due to the dissipation of the LDPB. It also recognised that the LDPB does some good work but the	If representation is required at conferences/forums etc to ensure that this continues to be provided. This will be done by using existing members of the group who already represent at events as well giving new members opportunities to do so.

	After the LDPB a workshop was held with all members, facilitated by Una Taylor, Jonathan Price and Veronica Patel. The closure of the LDPB explained and the intended direction required by the Health and Wellbeing board. Comments were taken on board and incorporated into the EqIA.	focus had been lost and there is no arrangement for feedback to a higher level.	Feedback and influence will continue through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means) The Chairs and members of sub groups and task and finish groups, will have experience of ensuring the views of a range of service users and client groups are sought. Whilst representation of all groups cannot be assured, the views of hard to reach groups will be sought by contacting a

			range of voluntary organisations, through existing networks that can provide information on their behalf. This includes the established existing groups and initiatives above.
Sue Whiting	Telephone conversation and email correspondence with Jonathan Price	No comments received	No comments received
Sue Spurlock, Manager, Safeguarding Adults Services	Face to face discussion and email correspondence with Jonathan Price	Overall concern on how briefings and messages will take place with closure of the board.	Through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)

			The Chairs and members of sub groups and task and finish groups, will have experience of ensuring the views of a range of service users and client groups are sought. Whilst representation of all groups cannot be assured, the views of hard to reach groups will be sought by contacting a range of voluntary organisations, through existing networks that can provide information on their behalf. This includes the established existing groups and initiatives above.

Stage 3: Assessing Impact and Analysis

What does your information tell you about the impact on different groups? Consider whether the evidence shows potential for differential impact, if so state whether this is an adverse or positive impact? How likely is this to happen? How you will mitigate/remove any adverse impact?

Protected Characteristic	Positive	Adverse	Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur.	What measures can you take to eliminate or reduce the adverse impact(s)? E.g. consultation, research, implement equality monitoring etc (Also Include these in the Improvement Action Plan at Stage 5)
Age (including carers of young/older people)		None identified	Positive: Younger adults and older people are more likely to be part of smaller task and finish groups as action to be taken to encourage their participation in groups with focused priorities.	More involvement will be possible in groups that are meaningful to them and are focused on specific tasks. Ensure older people from the Older People (OP) group being disbanded are included and fairly represented within the newly established sub groups. Older people will also be approached via existing groups, forums and services in Harrow to

				participate.
Disability (including carers [illegible] disabled [illegible]eople)			Positive: The tasks will be led by the Health and Wellbeing more and mechanisms should be out into place to put actions into place and monitor outputs. Negative: Lack of a central voice to represent the feelings and thought of the group.	A remit of Health and Wellbeing Boards, sub groups and task and finish groups is to seek the views of a range of service users, carer groups and voluntary organisations including people with learning disabilities when collecting evidence, information submissions and consultations, . The lack of a central voice is being mitigated through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)

Gender Reassignment	None identified	None identified		
Marriage and Civil Partnership	None identified	None identified		
Pregnancy and Maternity	None identified	None identified		
Race		None identified	Action to be taken to encourage participation from races not adequately represented in groups with focused priorities	The new sub groups will ensure representative people from the LDPB being disbanded are included and fairly represented within the newly established sub groups. People from different races will also be approached via existing groups and forums in Harrow to participate.
Religion or Belief		None identified	Action to be taken to encourage their participation in groups with focused priorities	The new sub groups will ensure the religions and beliefs in Harrow are fairly represented within the newly sub groups by approaching representatives within the current LDPB to join the sub groups as well existing forums to encourage new members.
[S]ex	None identified	None identified		
Sexual Orientation	None identified	None identified		
Other (please state)	None identified	None identified		

9. Cumulative impact – Are you aware of any cumulative impact? For example, when conducting a major review of services. This would mean ensuring that you have sufficient relevant information to understand the cumulative effect of all of the decisions.	People with learning disabilities are experiencing significant cumulative impact from changes in wider society and in local or national public policy, including the economic position, London's housing market, welfare reform, housing policy changes, personalisation of social care, changes in access to NHS services etc. The proposals to create a new group focused on having measurable impact will support addressing these multiple impacts. Particular areas of

	responsibility include issues around housing, finance, information and support as well as care and health issues.

10. How do your proposals contribute towards the requirements of the Public Sector Equality Duty (PSED), which requires the Council to have due regard to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups.

(Include all the positive actions of your proposals, for example literature will be available in large print, Braille and community languages, flexible working hours for parents/carers, IT equipment will be DDA compliant etc)

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010	Advance equality of opportunity between people from different groups	Foster good relations between people from different groups	Are there any actions you can take to meet the PSED requirements? *(List these here and include them in the Improvement Action Plan at Stage 5)*
The council will ensure that the views of people with learning disabilities are not diminished when the LDPB ceases	Sub groups and task and finish groups will seek the views and evidence of a wide range of groups and individuals, as appropriate throughout their work The Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the QAQ, will ensure that the views and concerns of people with learning disabilities are acted upon. This will be at a strategic and service delivery level within adult services	The Group will guide and delivery public engagement which will work to bring people from different parts of the community together	Co-design approach involving a wide range of people with learning disabilities in key service development and strategic plans for Adults Services Reduced stigma through positive representation of people with learning disabilities

11. Is there any evidence or concern that your proposals may result in a protected group being disadvantaged (please refer to the Corporate Guidelines for guidance on the definitions of discrimination, harassment and victimisation and other prohibited conduct under the Equality Act)?

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes									
No									

If you have answered "yes" to any of the above, set out what justification there may be for this in Q12a below - link this to the aims of the proposal and whether the disadvantage is proportionate to the need to meet these aims. (You are encouraged to seek legal advice, if you are concerned that the proposal may breach the equality legislation or you are unsure whether there is objective justification for the proposal)

If the analysis shows the potential for serious adverse impact or disadvantage (or potential discrimination) but you have identified a potential justification for this, this information must be presented to the decision maker for a final decision to be made on whether the disadvantage is proportionate to achieve the aims of the proposal.

there are adverse effects that are not justified and cannot be mitigated, you should not proceed with the proposal. (select outcome 4)
the analysis shows unlawful conduct under the equalities legislation, you should not proceed with the proposal. (select outcome 4)

Stage 4: Decision

12. Please indicate which of the following statements best describes the outcome of your EqIA (tick one box only)

Outcome 1 – No change required: when the EqIA has not identified any potential for unlawful conduct or adverse impact and all opportunities to enhance equality are being addressed.	
Outcome 2 – Minor adjustments to remove / mitigate adverse impact or enhance equality have been identified by the EqIA. *List the actions you propose to take to address this in the Improvement Action Plan at Stage 5*	
Outcome 3 – Continue with proposals despite having identified potential for adverse impact or missed opportunities to enhance equality. In this case, the justification needs to be included in the EqIA and should be in line with the PSED to have 'due regard'. In some cases, compelling reasons will be needed. You should also consider whether there are sufficient plans to reduce the adverse impact and/or plans to monitor the impact. **(explain this in 12a below)**	
Outcome 4 – Stop and rethink: when there is potential for serious adverse impact or disadvantage to one or more protected groups. (You are encouraged to seek Legal Advice about the potential for unlawful conduct under equalities legislation)	
12a. If your EqIA is assessed as **outcome 3 or have ticked**	

'yes' in Q11, explain your justification with full reasoning to continue with your proposals.	

Stage 5: Making Adjustments (Improvement Action Plan)

13. List below any actions you plan to take as a result of this impact assessment. This should include any actions identified throughout the EqIA.

Area of potential adverse impact e.g. Race, Disability	Action proposed	Desired Outcome	Target Date	Lead Officer	Progress
Age	Take measures to approach young adults and older people and encourage participation in the new sub groups by approaching existing groups and forums as well as members of current LDPB being disbanded. To mitigate through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for	Improve representation of young adults and older people in LD community within the new sub groups Continued engagement and information sharing.	Ongoing	Jonathan Price	

	Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)				
Disability	Send appropriate representation at national and regional conferences and forums. Ensure good Communications and engagement strategy is put in place and quality of output of sub groups	Make sure the new model does provide good instruction, focus and feedback. Make the new sub groups provide better focus than existing LDPB.	Ongoing	Jonathan Price	

	To mitigate through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)	Continued engagement and information sharing.			

Race	To mitigate through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)	Improve representation in new sub groups so that views and needs of all races are fairly considered within new priorities. Continued engagement and information sharing.	Ongoing	Jonathan Price	

Religion or Belief	To mitigate through established groups and initiatives including: The Local Account Group has representation from service users with learning disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with learning disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)	Improve representation in new sub groups so that views and needs of all religions and beliefs are fairly considered within new priorities. Continued engagement and information sharing.	Ongoing	Jonathan Price	

Stage 6 - Monitoring
The full impact of the decision may only be known after the proposals have been implemented, it is therefore important to ensure effective monitoring measures are in place to assess the impact.

14. How will you monitor the impact of the proposals once they have been implemented? How often will you do this? *(Also Include in Improvement Action Plan at Stage 5)*	Equalities monitoring of the sub groups are to be undertaken every 6 months to ensure the protected characteristics are not adversely impacted and that as much as possible fairly represented.			
15. Do you currently monitor this function / service? Do you know who your service users are?	Yes		No	
16. What monitoring measures need to be introduced to ensure effective monitoring of your proposals? *(Also Include in Improvement Action Plan at Stage 5)*	Monitor the make up the task and finish groups and that outputs take protected characteristics into account			
17. How will the results of any monitoring be analysed, reported and publicised? *(Also Include in Improvement Action Plan at Stage 5)*	Data gathered will be shared with partners and the Health and Wellbeing board using protocols to be implemented by the board			
18. Have you received any complaints or compliments about the policy, service, function, project or proposals being assessed? If so, provide details.	No			

Stage 7 – Reporting outcomes
The completed EqIA must be attached to all committee reports and a summary of the key findings included in the relevant section within them.

EqIA's will also be published on the Council's website and made available to members of the public on request.

19. Summary of the assessment **NOTE:** This section can also be used in your reports, however you must ensure the full EqIA is available as a background paper for the decision makers (Cabinet, Overview and Scrutiny, CSB etc) What are the key impacts – both adverse and positive? Are there any particular groups affected more than others? Do you suggest proceeding with your proposals although an adverse impact has been identified? If yes, what are your justifications for this? What course of action are you advising as a result of this EqIA?	It is recognised that the current LDPB has done some excellent work in facilitating the sharing of information across for its members on legislation, policy, health, safeguarding and other issues. The decision to close the board has been met with some apprehension however the LDPB recognises that the replacement of the board has provided some opportunity to make some positive changes. The work carried out through the recently established Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the QAQ, will ensure that the views and concerns of people with learning disabilities are acted upon. This will be at a strategic and service delivery level within adult services. The Health and Wellbeing Board, sub groups and task and finish groups will also deliver the actions that are needed to make improvements for people with learning disabilities in Harrow.		
20. How will the impact assessment be publicised? E.g. Council website, intranet, forums, groups etc	Council website Sent to all LDPB members		
Stage 8 - Organisational sign Off (to be completed by Chair of Departmental Equalities Task Group)			
The completed EqIA needs to be sent to the chair of your Departmental Equalities Task Group (DETG) to be signed off.			
21. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?	Carol Yarde, Sept 2013		
Signed: (Lead officer completing EqIA)		Signed: (Chair of DETG)	

Date:		Date:	

Carers Partnership Board - Full Equality Impact Assessment (EqIA)

In order to carry out this assessment, it is important that you have completed the EqIA E-learning Module and read the Corporate Guidelines on EqIAs. Please refer to these to assist you in completing this form and assessment.

What are the proposals being assessed? **(Note**: 'proposal' includes a new policy, policy review, service review, function, strategy, project, procedure, restructure)	Replacement of the Carers Partnership Board with a Task and Finish / Project Group
Which Directorate / Service has responsibility for this?	Adult Services
Name and job title of lead officer	Tim Miller, Service Manager, Commissioning
Name & contact details of the other persons involved in the EqIA:	NHS Harrow : Sue Whiting Harrow Council: Allison Brice & Mital Vagdia Harrow Carers: Ben White & Mike Coker Independent Carers: Clare Goldschmidt & Varsha Dodhia Mencap: Deven Pillay ASAP: Elizabeth Hugo CNWL: Carol Harrison-Read HAD: Rizwana Malik
Date of assessment:	August 2013

Stage 1: Overview

1. What are the aims, objectives, and desired outcomes of your proposals? (Explain proposals e.g. reduction / removal of service, deletion of posts, changing criteria etc)	To deliver Harrow Health and Wellbeing Board's priorities around carers. To influence strategy and commissioning which relates to carers and those they care for, in part by enabling carers to have an active role in the design, planning and monitoring of services, policies or places. To have a clear purpose and a clear role which enables delivery by the Council, the Clinical Commissioning Group, the Voluntary and Community sector and other partners. In view of the pending legislation "Caring for our Future", understand the impact of the act for the HWBB,

	the Council and Carers
2. What factors / forces could prevent you from achieving these aims, objectives and outcomes?	Lack of a clear purpose for the group Members having limited capacity to undertake their role on the group Weak connection into carers' networks Inability to hold organisations to account for their delivery of plans
3. Who are the customers? Who will be affected by this proposal? For example who are the external/internal customers, communities, partners, stakeholders, the workforce etc.	The Health and Wellbeing Board is 'commissioning' the project group. Colleagues in statutory and voluntary organisations would benefit from, and draw on, the group. Residents of Harrow who have caring roles would be the central customers of the group and it is their improved outcomes or opportunities upon which the group's success should be judged. There is a strong indirect impact on people who are cared for by unpaid carers, who would see benefits from their carers having a better quality of life and greater resilience.
Is the responsibility shared with another department, authority or organisation? If so: • Who are the partners? • Who has the overall responsibility?	NHS Harrow CCG and LB Harrow, but also with providers of NHS community care. Other provider/support agencies who would be on the group, plus those not on the group, but who are responsible for the delivery of action plans. Ultimate responsibility would be a shared accountability between the Council and the CCG.
4a. How are/will they be involved in this assessment?	Key partners put forward the proposals and developed this EQIA through the Carers Partnership Board.

Stage 2: Monitoring / Collecting Evidence / Data

5. What information is available to assess the impact of your proposals? Include the actual data, statistics and evidence (including full references) reviewed to determine the potential impact on each equality group (protected characteristic). This can include results from consultations and the

involvement tracker, customer satisfaction surveys, focus groups, research interviews, staff surveys, workforce profiles, service users profiles, local and national research, evaluations etc

(Where possible include data on the nine protected characteristics. Where you have gaps, you may need to include this as an action to address in the action plan)

Age (including carers of young/older people)

This data is from the 2011 Census

Age	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All categories: Age	24,620	15,889	3,947	4,784
Age 0 to 15	552	450	58	44
Age 16 to 24	1,756	1,362	252	142
Age 25 to 34	2,829	1,940	516	373
Age 35 to 49	6,886	4,340	1,233	1,313
Age 50 to 64	7,968	5,404	1,186	1,378
Age 65 and over	4,629	2,393	702	1,534

Disability (including carers of disabled people)

This isn't recorded on the census and neither the Council's nor GPs records fully capture this. The following is the census data that shows the overall health profile of unpaid carers.

General Health	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All categories: General health	24,563	15,844	3,945	4,774
Very good or good health	18,629	12,843	2,887	2,899
Fair health	4,680	2,473	824	1,383
Bad or very bad health	1,254	528	234	492

Gender Reassignment

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

Marriage / Civil Partnership

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there

is very little information held currently on this protected characteristic

Pregnancy and Maternity

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

Race

This data is from the 2011 Census

Ethnic Group	All categories: Provision of unpaid care	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All categories: Ethnic group	239,056	24,620	15,889	3,947	4,784
White: Total	100,991	11,349	7,593	1,424	2,332
White: English/Welsh/Scottish/Northern Irish/British	73,826	9,390	6,390	1,108	1,892
White: Irish	7,336	778	510	100	168
White: Other White	19,829	1,181	693	216	272
Mixed/multiple ethnic group	9,499	588	411	89	88
Asian/Asian British	101,808	10,483	6,560	2,012	1,911
Black/African/Caribbean/Black British	19,708	1,638	1,029	314	295
Other ethnic group	7,050	562	296	108	158

Religion and Belief

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

Sex / Gender

This data is from the 2011 Census

Sex	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
All persons	24,563	15,844	3,945	4,774
Males	10,794	7,337	1,712	1,745
Females	13,769	8,507	2,233	3,029

We see that Females provide more unpaid care, but this is most pronounced amongst the highest levels of

	care provided
Sexual Orientation	Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

6. Is there any other (local, regional, national research, reports, media) data sources that can inform this assessment? Include this data (facts, figures, evidence, key findings) in this section.	There is significant and growing data sources in Harrow/nationally (e.g. Carers UK analysis of Census data) about the population of carers, their needs and use of services. The evidence shows the significant number of people undertaking caring roles, the difficulties they face and the progress still needed to support them in their role. Specifically, see The State of Caring 2013 by Carers UK.

7. Have you undertaken any consultation on your proposals? (this may include consultation with staff, members, unions, community / voluntary groups, stakeholders, residents and service users)	Yes	Y	No	

NOTE: If you have not undertaken any consultation as yet, you should consider whether you need to. For example, if you have insufficient data/information for any of the protected characteristics and you are **unable** to assess the potential impact, you may want to consult with them on our proposals as how they will affect them. Any proposed consultation needs to be **completed before** progressing with the rest of the EqIA.
Guidance on consultation/community involvement toolkit can be accessed via the link below
http://harrowhub/info/200195/consultation/169/community_involvement_toolkit

Who was consulted?	What consultation methods were used?	What do the results show about the impact on different equality groups (protected characteristics)?	What action are you going to take as a result of the consultation? This may include revising your proposals, steps to mitigate any adverse impact. *(Also Include these in the Improvement Action Plan at Stage 5)*
Carers Partnership Board meeting	Workshop and circulated papers	Carers issues affect all protected characteristics. Proposed changes will have positive impacts on carers broadly and on equalities issues	Actions included in the mitigations below in section 6 as they were developed with consultees.

		as it relates to carers.	

Stage 3: Assessing Impact and Analysis

8. What does your information tell you about the impact on different groups? Consider whether the evidence shows potential for differential impact, if so state whether this is an adverse or positive impact? How likely is this to happen? How you will mitigate/remove any adverse impact?

Protected Characteristic	Positive	Adverse	Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur.	What measures can you take to eliminate or reduce the adverse impact(s)? E.g. consultation, research, implement equality monitoring etc (Also Include these in the Improvement Action Plan at Stage 5)
l Groups	Y		Ensuring carers' action plans are delivered will improve services / outcomes across all protected characteristics Monitoring how the plans affect different groups will be an improvement and allow issues to be addressed where they arise. A new focus on co-ordinating carer engagement and influence to bring their experience into design of services and strategy should positively impact across all strands. Hidden carer populations will be better identified and served by improving monitoring and having dialogue with communities.	No adverse impacts detected
Age (including carers of young/older people)	Y		New proposals contain specific areas of action on young carers and carers of people with dementia who are primarily older.	No adverse impacts detected

Disability (including carers of disabled people)			See reference for 'all groups' above	No adverse impacts detected
Gender Reassignment			See reference for 'all groups' above	No adverse impacts detected
Marriage and Civil Partnership	Y		Overseeing respite is rolled out will help sustain relationships between partners who provide care.	No adverse impacts detected
Pregnancy and Maternity			See reference for 'all groups' above	No adverse impacts detected
Race	Y		Improving the sensitivity / competence of services and service design along cultural and racial preferences and norms will improve access to and outcomes from services. Addressing stigma can be improved through better engagement and communication driven by a more focused group.	No adverse impacts detected
Religion or Belief	Y		Improving the sensitivity / competence of services and service design along religious and faith preferences and norms will improve access to and outcomes from services. Addressing stigma can be improved through better engagement and communication driven by a more focused group.	No adverse impacts detected
Sex			See reference for 'all groups' above	No adverse impacts detected
Sexual Orientation	Y		See reference for 'all groups' above	No adverse impacts detected
Other (please state)				
9. Cumulative impact – Are you aware of any cumulative impact?			**Carers are experiencing significant cumulative impact from changes**	

For example, when conducting a major review of services. This would mean ensuring that you have sufficient relevant information to understand the cumulative effect of all of the decisions. **Example:** A local authority is making changes to four different policies. These are funding and delivering social care, day care, and respite for carers and community transport. Small changes in each of these policies may disadvantage disabled people, but the cumulative effect of changes to these areas could have a significant effect on disabled people's participation in public life. The actual and potential effect on equality of all these proposals, and appropriate mitigating measures, will need to be considered to ensure that inequalities between different equality groups, particularly in this instance for disabled people, have been identified and do not continue or widen. This may include making a decision to spread the effects of the policy elsewhere to lessen the concentration in any one area.	**in wider society and in local or national public policy, including the economic position, London's housing market, welfare reform, housing policy changes, personalisation of social care, changes in access to NHS services etc.** **The proposals to create a new group focused on having measurable impact will support addressing these multiple impacts. Particular areas of responsibility include issues around housing, finance, information and support as well as care and health issues.**

10. How do your proposals contribute towards the requirements of the Public Sector Equality Duty (PSED), which requires the Council to have due regard to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups.

(Include all the positive actions of your proposals, for example literature will be available in large print, Braille and community languages, flexible working hours for parents/carers, IT equipment will be DDA compliant etc)

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010	Advance equality of opportunity between people from different groups	Foster good relations between people from different groups	Are there any actions you can take to meet the PSED requirements? *(List these here and include them in the Improvement Action Plan at Stage 5)*
The new group will be better able to promote issues relating to Carers and improve the support and services available to them, reducing any risk of unlawful treatment within existing services	The new group will be able to promote equality between groups when looking at specific issues by identifying those less well served and developing appropriate adaptations.	The Group will guide and delivery public engagement which will work to bring people from different parts of the community together	1. Communications focused on carer issues across communities 2. Use of carers lived experience / scenarios to have dialogue with carers

	Carers and those they care for across characteristics will be actively involved in design and planning, promoting equality across groups		3. Reduced stigma through positive representation of caring / carers 4. Co-design approach involving a wide range of carers

11. Is there any evidence or concern that your proposals may result in a protected group being disadvantaged (please refer to the Corporate Guidelines for guidance on the definitions of discrimination, harassment and victimisation and other prohibited conduct under the Equality Act)?

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes									
No	NO	NO	NO	NO	NO	NO	NO	NO	NO

If you have answered "yes" to any of the above, set out what justification there may be for this in Q12a below - link this to the aims of the proposal and whether the disadvantage is proportionate to the need to meet these aims. (You are encouraged to seek legal advice, if you are concerned that the proposal may breach the equality legislation or you are unsure whether there is objective justification for the proposal)

If the analysis shows the potential for serious adverse impact or disadvantage (or potential discrimination) but you have identified a potential justification for this, this information must be presented to the decision maker for a final decision to be made on whether the disadvantage is proportionate to achieve the aims of the proposal.

If there are adverse effects that are not justified and cannot be mitigated, you should not proceed with the proposal. (select outcome 4)
If the analysis shows unlawful conduct under the equalities legislation, you should not proceed with the proposal. (select outcome 4)

Stage 4: Decision

12. Please indicate which of the following statements best describes the outcome of your EqIA (tick one box only)

Outcome 1 – No change required: when the EqIA has not identified any potential for unlawful conduct or adverse impact and all opportunities to enhance equality are being addressed.	
Outcome 2 – Minor adjustments to remove / mitigate adverse impact or enhance equality have been identified by the EqIA. *List the actions you propose to take to address this in the Improvement Action Plan at Stage 5*	Yes
Outcome 3 – Continue with proposals despite having identified potential for adverse impact or missed opportunities to enhance equality. In this case, the justification needs to be included in the EqIA and should be in line with the PSED to have 'due regard'. In some cases, compelling reasons will be needed. You should also consider whether there are sufficient plans to reduce the adverse impact and/or plans to monitor the impact. **(explain this in 12a below)**	

Outcome 4 – Stop and rethink: when there is potential for serious adverse impact or disadvantage to one or more protected groups. (You are encouraged to seek Legal Advice about the potential for unlawful conduct under equalities legislation)	
12a. If your EqIA is assessed as **outcome 3 or have ticked 'yes' in Q11**, explain your justification with full reasoning to continue with your proposals.	

Stage 5: Making Adjustments (Improvement Action Plan)

13. List below any actions you plan to take as a result of this impact assessment. This should include any actions identified throughout the EqIA.

Area of potential adverse impact e.g. Race, Disability	Action proposed	Desired Outcome	Target Date	Lead Officer	Progress
	Group to ensure plans have measurable outputs and outcomes in terms of impact across equalities groups Surveys and other exercises to be reported to the group and include analysis by equalities groups	Plans are implemented fairly and appropriately across groups	From formation	Chair	
	Carers across characteristics and other groups to be involved in service design and development	Services are designed around real lives and can be most effective Services are culturally competent	Ongoing	Chair	
	Communications and dialogue to be important	Carers from all groups involved and	From formation	Chair	

	under the new group, which will be accountable to the HWBB Ongoing dialogue with carers to be shaped by targeted engagement approaches for the protected characteristics.	engaged in key issues			

<table>
<tr><td colspan="5">Stage 6 - Monitoring
The full impact of the decision may only be known after the proposals have been implemented, it is therefore important to ensure effective monitoring measures are in place to assess the impact.</td></tr>
<tr><td>14. How will you monitor the impact of the proposals once they have been implemented? How often will you do this? (Also Include in Improvement Action Plan at Stage 5)</td><td colspan="4">Data tracked at Group through regular reporting

Highlights reported to HWBB as required

Feedback and carer engagement to inform annual planning cycles.</td></tr>
<tr><td>15. Do you currently monitor this function / service? Do you know who your service users are?</td><td>Yes</td><td></td><td>No</td><td>No</td></tr>
<tr><td>16. What monitoring measures need to be introduced to ensure effective monitoring of your proposals? (Also Include in Improvement Action Plan at Stage 5)</td><td colspan="4">Monitoring data for action plans tasked to group by HWBB</td></tr>
<tr><td>17. How will the results of any monitoring be analysed, reported and publicised? (Also Include in Improvement Action Plan at Stage 5)</td><td colspan="4">Reported regularly to Group as part of monitoring activity.

Highlights reported to HWBB / others as required</td></tr>
<tr><td>18. Have you received any complaints or compliments about the policy, service, function, project or proposals being assessed? If so, provide</td><td colspan="4">No</td></tr>
</table>

details.	

Stage 7 – Reporting outcomes
The completed EqIA must be attached to all committee reports and a summary of the key findings included in the relevant section within them.

EqIA's will also be published on the Council's website and made available to members of the public on request.

19. Summary of the assessment **NOTE:** This section can also be used in your reports, however you must ensure the full EqIA is available as a background paper for the decision makers (Cabinet, Overview and Scrutiny, CSB etc) What are the key impacts – both adverse and positive? Are there any particular groups affected more than others? Do you suggest proceeding with your proposals although an adverse impact has been identified? If yes, what are your justifications for this? What course of action are you advising as a result of this EqIA?	The current Partnership Board have been involved in developing the proposals for a new group. The Board agrees that much greater impact can be achieved through the proposed arrangement and that this will include positive impacts for protected characteristics and equality. The recommendation to replace the current board is supported by this EqIA.
20. How will the impact assessment be publicised? E.g. Council website, [illegible]tranet, forums, groups etc	Via Health and Wellbeing Board documents in the public domain.

[illegible]age 8 - Organisational sign Off (to be completed by Chair of Departmental Equalities Task Group)

[illegible]e completed EqIA needs to be sent to the chair of your Departmental Equalities Task Group (DETG) to be signed off.

21. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?			
Signed: (Lead officer completing EqIA)		Signed: (Chair of DETG)	
Date:		Date:	

TEMPLATE 2 - Full Equality Impact Assessment (EqIA)

In order to carry out this assessment, it is important that you have completed the EqIA E-learning Module and read the Corporate Guidelines on EqIAs. Please refer to these to assist you in completing this form and assessment.

What are the proposals being assessed? (**Note**: 'proposal' includes a new policy, policy review, service review, function, strategy, project, procedure, restructure)	The cessation of the Physical Disability Partnership Board (PDPB), as a result of the introduction of the Health and Wellbeing Board
Which Directorate / Service has responsibility for this?	Adults Directorate
Name and job title of lead officer	Visva Sathasivam, Chair of the Physical Disability Partnership Board
Name & contact details of the other persons involved in the EqIA:	**Members of the Physical Disability Partnership Board (non council)** Wendie Dove Service User, Bentley NRC William Gregory Service User, Bentley NRC Alan Kennedy Service User, Bentley NRC Maureen McGrath Service User, Bentley NRC Rohit Moorji Service User, Bentley NRC Sally Schwarz Service User, Bentley NRC Lorna Solomon Service User, Bentley NRC Andrew Cox Middlesex Association for the Blind Angela Dias Harrow Association of Disabled People **Members of the Physical Disability Partnership Board (council officers)** Amanda Dade Zinnat Daya Keith Holmes Julia Redican Shaun Riley Visva Sathasivam Peter Singh Sue Spurlock Una Taylor
Date of assessment:	July 2013

Stage 1: Overview	
1. What are the aims, objectives, and desired outcomes of your proposals? (Explain proposals e.g. reduction / removal of service, deletion of posts, changing criteria etc)	**Background** Approximately ten years ago as a result of the National Service Frameworks five adult Partnership Boards were established and have continued to be in place. The original requirements have now dissipated and this has caused a lack of focus and structure for the Boards. For the last few years the adult Partnership Boards have undertaken some good work but they have started to lack some direction and purpose. The original frameworks have also evolved or been deleted and the number of partnership and working groups have grown which is impacting on capacity to service and attend the meetings and achieve work programmes. The existing membership of the Boards has been static and there is often duplication of members across the various groups and with agenda items. The introduction of the Health and Wellbeing Board has been seen by the Partnership Boards as an opportunity to review their purpose and direction. The original five adult Partnership Boards were Older People (governed by the old National Service Framework for Older People and chaired and facilitated by the PCT/CCG) Mental Health – (facilitated by the PCT) Learning Disability – (governed by the 'Valuing People Framework' chaired and facilitated by the Council) Physical Disability – (chaired and facilitated by the Council) Carers Partnership – (chaired and facilitated by the Council) The PDPB last met in 2012, The bi monthly meetings to date in 2013 have all been cancelled. **Aim of the proposal** The aim of the proposal is to determine any adverse impacts of the cessation of the existing PDPB. The current functions of the PDPB would be delivered through established structures within Adults Services such as the Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (Quality Assurance Quadrant)

Also delivery will be ensured through existing task and finish groups or by establishing new groups around either the Joint Health and Wellbeing Strategy priorities or Joint Commissioning Intentions. The sub groups would be made up of stakeholders, service users and patients.

The Health and Wellbeing Board have some really important joint outcomes to achieve which may not happen if:

- There is a blurring of Boards purpose
- Too many duplicate meetings
- The Partnership Boards are not governed by the Health and Wellbeing Board

Harrow Council's Safeguarding Assurance & Quality Services team has developed a new Local Account Group. This group consists of users who undertake surveys and mystery shopping. This group was formed post Winterbourne View and in response to the changes to CQC. This group takes on the role of bringing together users feedback and providing an avenue for users to influence service delivery. They along with Healthwatch Harrow will ensure voices are heard.

The Board needs to ensure that the right people are engaged to assist with the delivery of the priorities and also inform the Board of new issues which need to be considered when shaping future commissioning priorities. This includes key stakeholders such as the Public Health Team.

Officer capacity is limited and therefore any groups which are in place need to have a clear purpose and be adequately supported by the Council, the Clinical Commissioning Group and the Voluntary and Community sector. This commitment is central to success.

The recently adopted Health and Wellbeing Board Terms of Reference outline the establishment of sub groups, which are based on the Board's priority areas rather than specific client groups. The HWB Terms of Reference state that the sub groups will be reviewed each year and expected to achieve specific outcomes. The sub groups will also have a role to ensure the views of patients and service users are included.

The Health and Wellbeing Board has seven priorities as outlined in the Joint Health and Wellbeing Strategy and also six joint commissioning intentions for 13/14:

Joint Health and Wellbeing Strategy priorities:

- Long term conditions
- Cancer
- Worklessness
- Poverty

	• Mental health and wellbeing • Supporting parents and the community to protect children and maximise their life chances • Dementia The current draft Commissioning Intentions Priorities include: 1. Services for older people 2. Dementia strategy 3. Children's services 4. Autism strategy 5. Services for carers 6. Safeguarding adults A number of task and finish groups have also been established recently to address particular service areas: Winterbourne Task and Finish Group (this fits to (6) above) Adults Safeguarding Board (this fits to (6) above) Autism Project Board - (this fits to (4) above)
2. What factors / forces could prevent you from achieving these aims, objectives and outcomes?	• Findings of EqIA –any gaps or differential impacts on individuals or groups which cannot be mitigated
3. Who are the customers? Who will be affected by this proposal? For example who are the external/internal customers, communities, partners, stakeholders, the workforce etc.	• Current PDPB members listed on page 1 The PDPB collectively represents adults with physical disabilities and younger people transitioning from children's services In Harrow, as well as voluntary organisations for and on behalf of people with physical disabilities. The views of carers are being represented through the Carers Partnership Board. In the past the PDPB has formed sub groups for distinct areas of work such as Work Skills & Opportunities, Personalisation and Reablement & Health
4. Is the responsibility shared with another department, authority or organisation? If so: • Who are the partners?	No. The Adults Directorate has overall responsibility for the Physical Disability Partnership Board. The Board is chaired and facilitated by Visva Sathasivam,, Head of Adult Social Care

• Who has the overall responsibility?	
4a. How are/will they be involved in this assessment?	Each PDPB member was invited to feedback their initial views to populate the first draft EQIA between the 1st and 13th August 2013. A subsequent full PDPB meeting took place on 14th August to discuss the first draft and provide comments for the second draft of the EQIA.

Stage 2: Monitoring / Collecting Evidence / Data

5. What information is available to assess the impact of your proposals? Include the actual data, statistics and evidence (including full references) reviewed to determine the potential impact on each equality group (protected characteristic). This can include results from consultations and the involvement tracker, customer satisfaction surveys, focus groups, research interviews, staff surveys, workforce profiles, service users profiles, local and national research, evaluations etc

(Where possible include data on the nine protected characteristics. Where you have gaps, you may need to include this as an action to address in the action plan)

Age (including carers of young/older people)

The age profile of adults with physical disabilities in Harrow is shown in the following table

Age Group	Count
18 - 24	31
25 - 34	55
35 - 44	90
45 - 54	147
55 - 64	210
65 - 74	416
75 - 84	921
85+	1197
Grand Total	**3067**

Disability (including carers of disabled people)

The age profile of adults with physical disabilities in Harrow is shown in the following table

Service User Sub Group	Count
Physical disability, frailty and sensory impairment	**3067**
of which: Deaf / Hearing Impairment	100
Dual Sensory Loss	7
Physical disability, frailty and/or temporary illness	2292
Visual Impairment	88
Not Stated	580
Grand Total	**3067**

Gender Reassignment

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

Marriage / Civil Partnership

The martial status of adults with physical disabilities in Harrow is shown in the following table

Marital Status	Count
Civil Partnership - Same Sex	1
Cohabiting	14
Divorced	96
Married	635
Not Stated	1270
Separated	36
Single	245
Widowed	770
Grand Total	**3067**

Pregnancy and Maternity

Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic

Race

The ethnicity status of adults with physical disabilities in Harrow is shown in the following table

Ethnicity	Count
Asian or Asian British	**1012**
Any other Asian background	209

Bangladeshi	6
Chinese	3
Form not completed	2
Indian	742
Pakistani	49
Sri Lankan	1
Black or Black British	**202**
African	55
Any other Black background	18
Caribbean	128
Somali	1
Mixed background	**29**
Any other mixed background	8
White and Asian	16
White and Black African	1
White and Black Caribbean	4
Not Stated	**28**
Did not wish to reply	21
Form not completed	7
Other Ethnic background	**63**
Any other ethnic group	63
White or White British	**1733**
Any other White background	86
Did not wish to reply	1
English	1515
Irish	128
Polish	2
Scottish	1
Grand Total	**3067**

Harrow has one of the most ethnically diverse populations in the country; ONS estimates show that Harrow now has the fourth highest proportion of residents from minority ethnic groups, compared to a ranking of eighth in 2001.

The Greater London Authority (GLA Datastore) estimates that in 2013, 60% of the total population of

<table>
<tr><td></td><td>Harrow or 57% of people aged 18 and over are from a BAME (Black and minority ethnic) group. By 2018 BAME groups will make up 65% of the total population and 61% of people aged 18 and over; by 2023 the proportion will increase to 68% and 65%, respectively</td></tr>
<tr><td>Religion and Belief</td><td>Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic</td></tr>
<tr><td>Sex / Gender</td><td>The gender of adults with physical disabilities in Harrow is shown in the following table

<table><tr><th>Gender</th><th>Count</th></tr><tr><td>Female</td><td>2129</td></tr><tr><td>Male</td><td>938</td></tr><tr><td>Grand Total</td><td>3067</td></tr></table>
The 2011 census results show that women outnumber men in all age groups over 34-39, and this difference becomes greater in the over 75s. The Greater London Authority (GLA Datastore) estimates that in 2013 the male to female ratio of people aged 65 or over is 45%/55% in Harrow changing to 46%/54% by 2023; the 2013 male to female ratio of people aged 75 or over is 39%/61% in Harrow changing to 44%/56% by 2023; the 2013 male to female ratio of people aged 90 or over is 33%/67% in Harrow changing to 44%/56% by 2023.</td></tr>
<tr><td>Sexual Orientation</td><td>Whilst Harrow Council's Frameworki database system is set up to collect this monitoring information, there is very little information held currently on this protected characteristic</td></tr>
<tr><td>6. Is there any other (local, regional, national research, reports, media) data sources that can inform this assessment?

Include this data (facts, figures, evidence, key findings) in this section.</td><td>The Health and Wellbeing Board has seven priorities as outlined in the Joint Health and Wellbeing Strategy and also six joint commissioning intentions for 13/14:

Joint Health and Wellbeing Strategy priorities:
• Long term conditions
• Cancer
• Worklessness
• Poverty</td></tr>
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	• Mental health and wellbeing • Supporting parents and the community to protect children and maximise their life chances • Dementia The current draft Commissioning Intentions Priorities include: 1. Services for older people 2. Dementia strategy 3. Children's services 4. Autism strategy 5. Services for carers 6. Safeguarding adults A number of task and finish groups have also been established recently to address particular service areas: a) Winterbourne Task and Finish Group (this fits to (6) above) b) Adults Safeguarding Board (this fits to (6) above) c) Autism Project Board - (this fits to (4) above)

7. Have you undertaken any consultation on your proposals? (this may include consultation with staff, members, unions, community / voluntary groups, stakeholders, residents and service users)	Yes		No	

NOTE: If you have not undertaken any consultation as yet, you should consider whether you need to. For example, if you have insufficient data/information for any of the protected characteristics and you are **unable** to assess the potential impact, you may want to consult with them on your proposals as how they will affect them. Any proposed consultation needs to be **completed before** progressing with the rest of the EqIA.
Guidance on consultation/community involvement toolkit can be accessed via the link below
http://harrowhub/info/200195/consultation/169/community_involvement_toolkit

Who was consulted?	What consultation methods were used?	What do the results show about the impact on different equality groups (protected characteristics)?	What action are you going to take as a result of the consultation? This may include revising your proposals, steps to mitigate any adverse impact.

			(Also Include these in the Improvement Action Plan at Stage 5)
The PDPB members	Face to face or telephone meetings Service Users fed back their views during a group meeting on 7th August 2013 Full group meeting on 14/8/13		
Comments of the PDPB included: Angel Dias, Chief Executive, HAD		I think the Partnership Boards will be more useful in looking at single issues such as employment and transport, my concern is more around the consideration of the more specific needs of people with physical disabilities, which may in time fall off the [Partnership Board] agenda	Through established groups and initiatives including: The Local Account Group has representation from service users with physical and sensory disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with physical and sensory disabilities are also delivered through the Carers Revival groups, the Safeguarding

			Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means)
Andrew Cox, Middlesex Association for the Blind		There will be strategic groups for people with physical disabilities to be part of, I am worried about the mechanism to ensure the voices of a range of service users with physical disabilities are represented in sub groups, not just those that appear to be more confident and vocal	The Chairs and members of sub groups and task and finish groups, will have experience of ensuring the views of a range of service users and client groups are sought. Whilst representation of all groups cannot be assured, the views of hard to reach groups will be sought by contacting a range of voluntary organisations, through existing networks that can provide information on their behalf. This includes the established existing groups and initiatives above.
Service Users at Bentley NRC - Wendie Dove, William Gregory, Alan Kenned,Maureen, McGrath, Rohit Moorji, Sally Schwarz, Lorna Solomon		The PDPB was not very effective. At times the professionals spoke with each other, rather than to the service user members. The topics discussed were not presented in such a way that service users present could easily understand. There was a lot of talking but things didn't always seem to get done. We did feel that by being part of the board, we were kept informed	N/A

		more of new developments and initiatives.	

Stage 3: Assessing Impact and Analysis

8. What does your information tell you about the impact on different groups? Consider whether the evidence shows potential for differential impact, if so state whether this is an adverse or positive impact? How likely is this to happen? How you will mitigate/remove any adverse impact?

Protected Characteristic	Positive	Adverse	Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur.	What measures can you take to eliminate or reduce the adverse impact(s)? E.g. consultation, research, implement equality monitoring etc (Also Include these in the Improvement Action Plan at Stage 5)
Age (including carers of young/older people)	None identified	None identified		
Disability (including carers of disabled people)			There are currently seven people with a physical disability that are members of the PDPB, all are service users at Bentley Day Centre and therefore the representation of the wider population of people with physical and sensory disabilities in Harrow is limited. There are few organisations that are able to represent the views of people with physical disabilities at a strategic level, other than Harrow Association of Disabled People The Board offers a voice to people with physical disabilities and provides a platform for their involvement in new initiatives within Adult Social Care The Board meetings are an important source of information sharing between agencies and people	A remit of Health and Wellbeing Boards, sub groups and task and finish groups is to seek the views of a range of service users, carer groups and voluntary organisations including people with physical and sensory disabilities when collecting evidence, information submissions and consultations, . These three points are being mitigated through established groups and initiatives including: The Local Account Group has representation from service users with physical and sensory disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with physical and sensory

			with physical and sensory disabilities. Service users and carer representatives may need training and the costs of travel should be met if they are involved in Health and Wellbeing Boards, sub groups and task and finish groups Board members who are currently service users fed back that their experience of the Board meetings was that often officers and professionals spoke with each other, rather than to the service user members. The topics discussed were not presented in such a way that service users present could easily understand. There is a concern that when considering issues the needs of different groups of people are understood, including people with physical and learning disabilities, as well as carers and people with mental health	disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered services through surveys and other means) Buildings used for meetings will be accessible and travel expenses can be claimed, appropriate training will be offered as and when identified
Gender Reassignment	None identified	None identified		
Marriage and Civil Partnership	None identified	None identified		
Pregnancy and Maternity	None identified	None identified		
Race	None identified	None identified		
Religion or Belief	None	None		

	identified	identified		
Sex	None identified	None identified		
Sexual Orientation	None identified	None identified		
Other (please state)	None identified	None identified		

9. Cumulative impact – Are you aware of any cumulative impact? For example, when conducting a major review of services. This would mean ensuring that you have sufficient relevant information to understand the cumulative effect of all of the decisions. **Example:** A local authority is making changes to four different policies. These are funding and delivering social care, day care, and respite for carers and community transport. Small changes in each of these policies may disadvantage disabled people, but the cumulative effect of changes to these areas could have a significant effect on disabled people's participation in public life. The actual and potential effect on equality of all these proposals, and appropriate mitigating measures, will need to be considered to ensure that inequalities between different equality groups, particularly in this instance for disabled people, have been identified and do not continue or widen. This may include making a decision to spread the effects of the policy elsewhere to lessen the concentration in any one area.	People with physical and sensory disabilities are experiencing significant cumulative impact from changes in wider society and in local or national public policy, including the economic position, London's housing market, welfare reform, housing policy changes, personalisation of social care, changes in access to NHS services etc. The proposals to create a new group focused on having measurable impact will support addressing these multiple impacts. Particular areas of responsibility include issues around housing, finance, information and support as well as care and health issues.

10. How do your proposals contribute towards the requirements of the Public Sector Equality Duty (PSED), which requires the Council to have due regard to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups.

(Include all the positive actions of your proposals, for example literature will be available in large print, Braille and community languages, flexible working hours for parents/carers, IT equipment will be DDA compliant etc)

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the	Advance equality of opportunity between people from different groups	Foster good relations between people from different groups	Are there any actions you can take to meet the PSED requirements? *(List these here and include them*

Equality Act 2010			*in the Improvement Action Plan at Stage 5)*
The council will ensure that the views of people with physical and sensory disabilities are not diminished when the PDPB ceases	Sub groups and task and finish groups will seek the views and evidence of a wide range of groups and individuals, as appropriate throughout their work The Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the QAQ, will ensure that the views and concerns of people with physical and sensory disabilities are acted upon. This will be at a strategic and service delivery level within adult services	The Group will guide and delivery public engagement which will work to bring people from different parts of the community together	Co-design approach involving a wide range of people with physical and sensory disabilities in key service development and strategic plans for Adults Services Reduced stigma through positive representation of people with physical and sensory disabilities

1… Is there any evidence or concern that your proposals may result in a protected group being disadvantaged (please refer to the Corporate Guidelines for guidance on the definitions of discrimination, harassment and victimisation and other prohibited conduct under the Equality Act)?

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes									
No									

If you have answered "yes" to any of the above, set out what justification there may be for this in Q12a below - link this to the aims of the proposal and whether the disadvantage is proportionate to the need to meet these aims. (You are encouraged to seek legal advice, if you are concerned that the proposal may breach the equality legislation or you are unsure whether there is objective justification for the proposal)

If the analysis shows the potential for serious adverse impact or disadvantage (or potential discrimination) but you have identified a potential justification for this, this information must be presented to the decision maker for a final decision to be made on whether the disadvantage is

proportionate to achieve the aims of the proposal.

If there are adverse effects that are not justified and cannot be mitigated, you should not proceed with the proposal. (select outcome 4)
If the analysis shows unlawful conduct under the equalities legislation, you should not proceed with the proposal. (select outcome 4)

Stage 4: Decision

12. Please indicate which of the following statements best describes the outcome of your EqIA (tick one box only)

Outcome 1 – No change required: when the EqIA has not identified any potential for unlawful conduct or adverse impact and all opportunities to enhance equality are being addressed.	
Outcome 2 – Minor adjustments to remove / mitigate adverse impact or enhance equality have been identified by the EqIA. *List the actions you propose to take to address this in the Improvement Action Plan at Stage 5*	
Outcome 3 – Continue with proposals despite having identified potential for adverse impact or missed opportunities to enhance equality. In this case, the justification needs to be included in the EqIA and should be in line with the PSED to have 'due regard'. In some cases, compelling reasons will be needed. You should also consider whether there are sufficient plans to reduce the adverse impact and/or plans to monitor the impact. **(explain this in 12a below)**	
Outcome 4 – Stop and rethink: when there is potential for serious adverse impact or disadvantage to one or more protected groups. (You are encouraged to seek Legal Advice about the potential for unlawful conduct under equalities legislation)	
12a. If your EqIA is assessed as **outcome 3 or have ticked 'yes' in Q11**, explain your justification with full reasoning to continue with your proposals.	

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Stage 5: Making Adjustments (Improvement Action Plan)

13. List below any actions you plan to take as a result of this impact assessment. This should include any actions identified throughout the EqIA.

Area of potential adverse impact e.g. Race, Disability	Action proposed	Desired Outcome	Target Date	Lead Officer	Progress
There are currently seven people with a physical disability that are members of the PDPB, all are service users at Bentley Day Centre and therefore the representation of	A remit of Health and Wellbeing Boards, sub groups and task and finish groups is to seek the views of a range of service users, carer groups and voluntary organisations including people with physical and	To ensure the representation of the views of hard to reach people with physical and sensory disabilities	On going	Visva Sathasivam	

the wider population of people with physical and sensory disabilities in Harrow is limited.	sensory disabilities when collecting evidence, information submissions and consultations.				
There are few organisations that are able to represent the views of people with physical disabilities at a strategic level, other than Harrow Association of Disabled People The Board offers a voice to people with physical disabilities and ovides a platform for eir involvement in new tiatives within Adult Social Care The Board meetings are an important source of information sharing between agencies and people with physical and sensory disabilities.	These three points are being mitigated through established groups and initiatives including: The Local Account Group has representation from service users with physical and sensory disabilities. The group meets on a monthly basis and helps to co produce key service development and strategic plans for Adults Services, as well as the annual local account. The group is also involved in mystery shopping exercises to improve services. Engagement activities that help to represent the views of people with physical and sensory disabilities are also delivered through the Carers Revival groups, the Safeguarding Board and the QAQ (which consider quality assurance for internally delivered	To ensure that people with physical and sensory disabilities continue to have representation and involvement at a strategic level. Continued engagement and information sharing.	On going	Visva Sathasivam	

	services through surveys and other means)				
Service users and carer representatives may need training and the costs of travel should be met if they are involved in Health and Wellbeing Boards, sub groups and task and finish groups	Buildings used for meetings will be accessible and travel expenses can be claimed, appropriate training will be offered as and when identified	The removal of any potential physical, monetary and training barriers for the involvement of people with physical and sensory disabilities within Health and Wellbeing Boards, sub groups and task and finish groups	On going	Visva Sathasivam	

Stage 6 - Monitoring
The full impact of the decision may only be known after the proposals have been implemented, it is therefore important to ensure effective monitoring measures are in place to assess the impact.

14. How will you monitor the impact of the proposals once they have been implemented? How often will you do this? *(Also Include in Improvement Action Plan at Stage 5)*	Effective monitoring of sub groups/task and finish groups at regular intervals			
15. Do you currently monitor this function / service? Do you know who your service users are?	Yes		No	
16. What monitoring measures need to be introduced to ensure effective monitoring of your proposals? *(Also Include in Improvement Action Plan at Stage 5)*	Monitor the make up of sub groups/task and finish groups and that outputs take protected characteristics into account			
17. How will the results of any monitoring be analysed, reported and publicised? *(Also Include in Improvement Action Plan at Stage 5)*	Data gathered will be shared with partners and the Health and Wellbeing Board using protocols implemented by the board			
18. Have you received any complaints or compliments about the policy, service, function, project or proposals being assessed? If so, provide details.	No			

Stage 7 – Reporting outcomes
The completed EqIA must be attached to all committee reports and a summary of the key findings included in the relevant section within them.

EqIA's will also be published on the Council's website and made available to members of the public on request.

19. Summary of the assessment **NOTE:** This section can also be used in your reports, however you must ensure the full EqIA is available as a background paper for the decision makers (Cabinet, Overview and Scrutiny, CSB etc) What are the key impacts – both adverse and positive? Are there any particular groups affected more than others? Do you suggest proceeding with your proposals although an adverse impact has been identified? If yes, what are your justifications for this? What course of action are you advising as a result of this EqIA?	Over the years, the PDPB has proved to be very useful in facilitating the sharing of information across for its members on legislation, policy health, safeguarding and other issues. All of the board members have reported that the time is right for the cessation of the board. The work carried out through the recently established Local Account Group and engagement activities delivered through the Carers Revival groups, the Safeguarding Board and the QAQ, will ensure that the views and concerns of people with physical and sensory disabilities are acted upon. This will be at a strategic and service delivery level within adult services. The Health and Wellbeing Board, sub groups and task and finish groups will also deliver the actions that are needed to make improvements for people with physical and sensory disabilities in Harrow.		
20. How will the impact assessment be publicised? E.g. Council website, intranet, forums, groups etc	Council Website The completed EQIA will be sent to all PDPB members		
Stage 8 - Organisational sign Off (to be completed by Chair of Departmental Equalities Task Group)			
The completed EqIA needs to be sent to the chair of your Departmental Equalities Task Group (DETG) to be signed off.			
21. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?	Carol Yarde, September 2013		
Signed: (Lead officer completing EqIA)		Signed: (Chair of DETG)	
Date:		Date:	

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REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting: 3 October 2013

Subject: **INFORMATION REPORT – Urgent Care**

Responsible Officer: Javina Sehgal
Chief Operating Officer
NHS Harrow CCG

Exempt: No

Enclosures: None

Section 1 – Summary

An urgent care report was presented to the August 2013 HWBB for information

A request was made for further details to be circulated for information to the October HWBB – this paper provides this additional information to cover:
- Current performance
- Next steps
  - Additional A&E funding bids for winter 2013/14
  - Publicising A&E Recovery Plan
  - NHS England assurance process

FOR INFORMATION

Paper developed by NHS Harrow CCG

Harrow COUNCIL
LONDON

Section 2 – Report

2.1 Overview of Harrow's unscheduled care pressures

All Accident and Emergency (A&E) departments have a 95% target for patients attending A&E to be seen within 4 hours. Across the whole country hospital trusts have had difficulty in reaching this.

This has prompted NHS England to require all Local Area Teams (LATs) to start working on recovery and improvement plans for each local area.

The local North West London Hospital Trust (NWLHT) A&E service has been under pressure from a series of issues including:

1. Serious delay breaches and delays with ambulance hand-overs
2. Clinical models include a lack of alternative pathways to A&E, leading to reactive behaviour and fire fighting
3. The level of delayed discharges significantly increased during 2012/13
4. Admissions avoidance schemes that were established to reduce pressure have had a limited impact
5. There have been an increasing number of referrals from GPs
6. A significant proportion of patients do not require A&E and a significant number more are not dealt with efficiently in the hospital
7. Lack of clear understanding of the system wider demand and capacity requirements

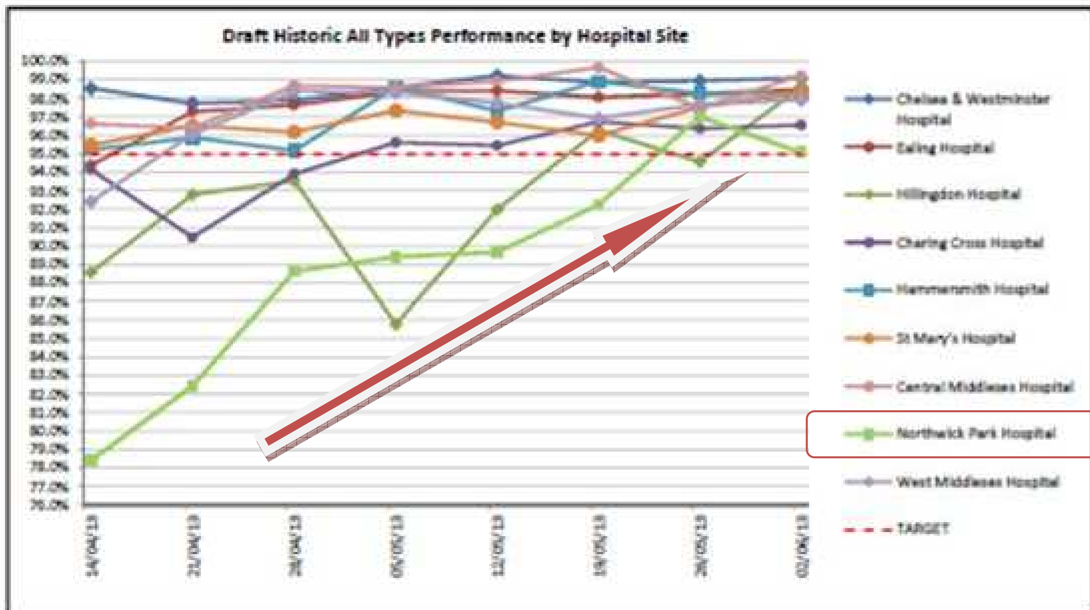
The below data provides a snapshot of NWLHT's performance in relation to unscheduled care activity.

2.2 Current performance of A&E services at NWLHT

All type (1&3) performance - a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients combined with UCC led services

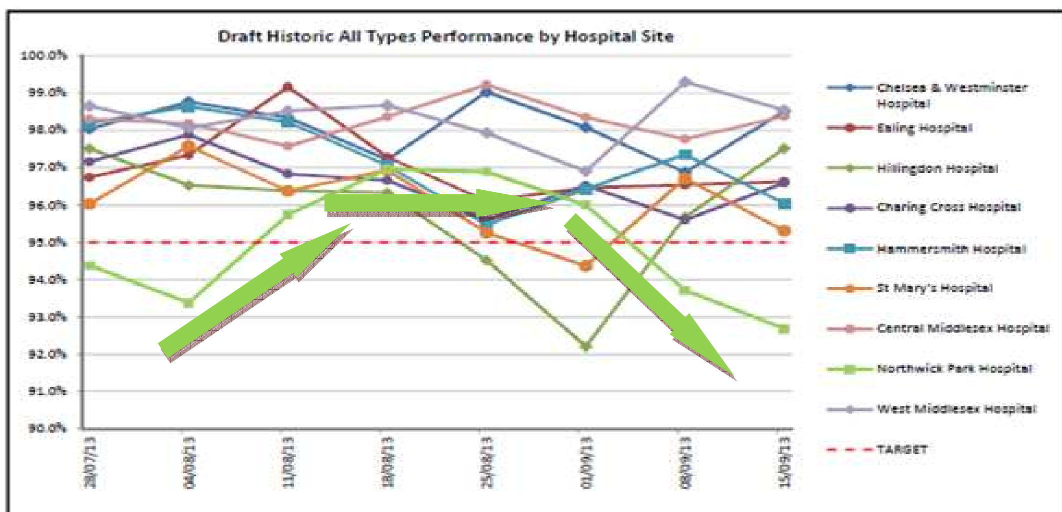
Current A&E performance indicates that NWLHT is improving and is now in line with the national 4 hour A&E standard as shown in the graph below.

In the graph the green line that climbs steadily from 78% to 95% is Northwick Park Hospital performance. The graph shows that this has improved significantly between April and June, following very worrying performance at e start of the year.



The Urgent Care Board is continuing to work to support this sustained improvement by working together to address the actions of the A&E Recovery and Improvement Plan.

SITE	Last 8 Weeks Performance							
	28 July 2013	04 August 2013	11 August 2013	18 August 2013	25 August 2013	01 September 2013	08 September 2013	15 September 2013
Chelsea & Westminster Hospital	98.04%	98.77%	98.34%	97.21%	99.03%	98.08%	96.88%	98.52%
Ealing Hospital	96.74%	97.34%	99.17%	97.29%	96.10%	96.46%	96.54%	96.63%
Hillingdon Hospital	97.51%	96.53%	96.38%	96.33%	94.52%	92.20%	95.68%	97.52%
Imperial College Healthcare NHS Trust	96.77%	97.86%	96.86%	96.88%	95.40%	95.38%	96.53%	95.80%
Charing Cross Hospital	97.16%	97.88%	96.83%	96.66%	95.61%	96.53%	95.60%	96.59%
Hammersmith Hospital	98.20%	98.64%	98.22%	97.07%	95.47%	96.42%	97.36%	96.04%
St Mary's Hospital	96.03%	97.58%	96.37%	96.93%	95.26%	94.37%	96.71%	95.31%
North West London Hospitals NHS Trust	95.46%	94.76%	96.24%	97.35%	97.53%	96.66%	94.84%	94.32%
Central Middlesex Hospital	98.30%	98.18%	97.58%	98.37%	99.23%	98.35%	97.77%	98.38%
Northwick Park Hospital	94.38%	93.38%	95.75%	96.96%	96.89%	96.00%	93.71%	92.68%
West Middlesex Hospital	98.66%	98.07%	98.52%	98.67%	97.93%	96.90%	99.30%	98.54%
North West London Trusts	96.98%	97.10%	97.31%	97.23%	96.60%	95.95%	96.49%	96.47%



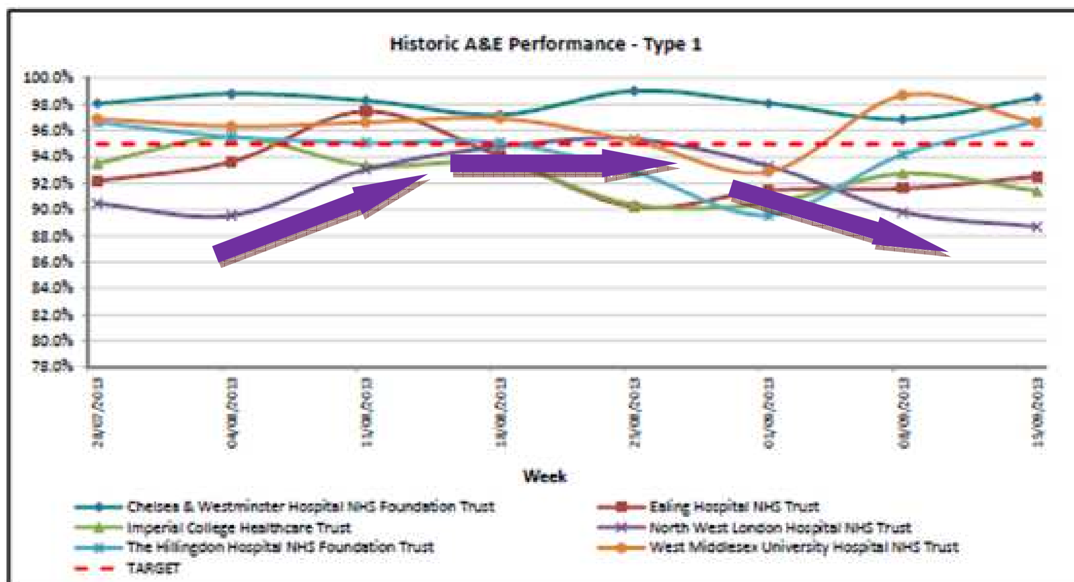
Type 1 performance only – a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients only

NWLHT has continued to struggle to achieve the 95% target for Type 1 activity only

However NWL as a whole has struggled to perform to this standard

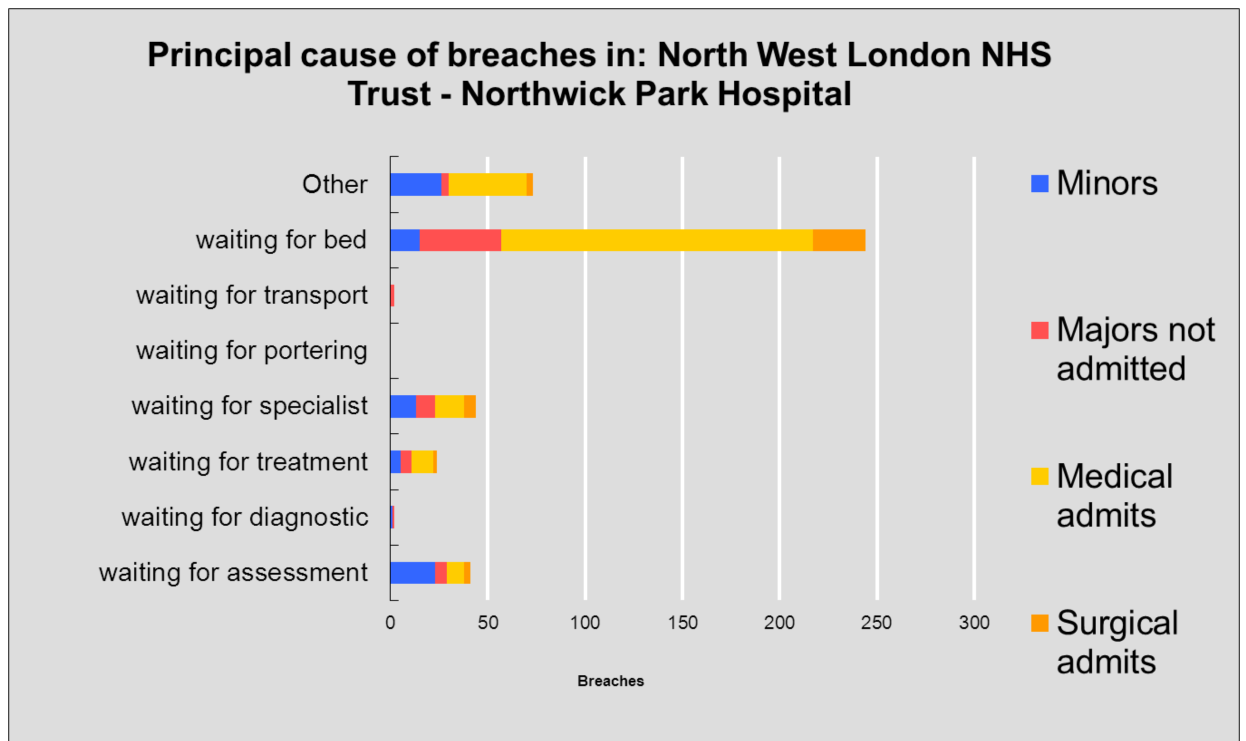
Chelsea and Westminster Hospital repeatedly achieved this standard, however they report activity differently to all other NWL acute trusts

	Last 8 Weeks Sitreps								
Trust	28 July 2013	04 August 2013	11 August 2013	18 August 2013	25 August 2013	01 September 2013	08 September 2013	15 September 2013	YTD
Chelsea & Westminster Hospital NHS Foundation T	98.08%	98.81%	98.29%	97.21%	99.03%	98.08%	96.87%	98.52%	98.48%
Ealing Hospital NHS Trust	92.17%	93.63%	97.47%	94.07%	90.20%	91.46%	91.61%	92.50%	93.78%
Imperial College Healthcare Trust	93.51%	95.51%	93.36%	93.52%	90.37%	90.50%	92.72%	91.42%	92.66%
North West London Hospital NHS Trust	90.47%	89.54%	93.04%	94.79%	95.34%	93.30%	89.81%	88.69%	87.88%
The Hillingdon Hospital NHS Foundation Trust	96.63%	95.52%	95.08%	95.08%	92.85%	89.58%	94.19%	96.71%	93.55%
West Middlesex University Hospital NHS Trust	96.91%	96.33%	96.62%	96.92%	95.22%	92.86%	98.68%	96.61%	94.61%
North West London Trusts	94.66%	94.96%	95.26%	95.14%	93.95%	92.82%	93.84%	93.86%	93.43%



The below table provides a snapshot of the activity admitted to NWLHT (all commissioners. 80% of this activity relates to Harrow

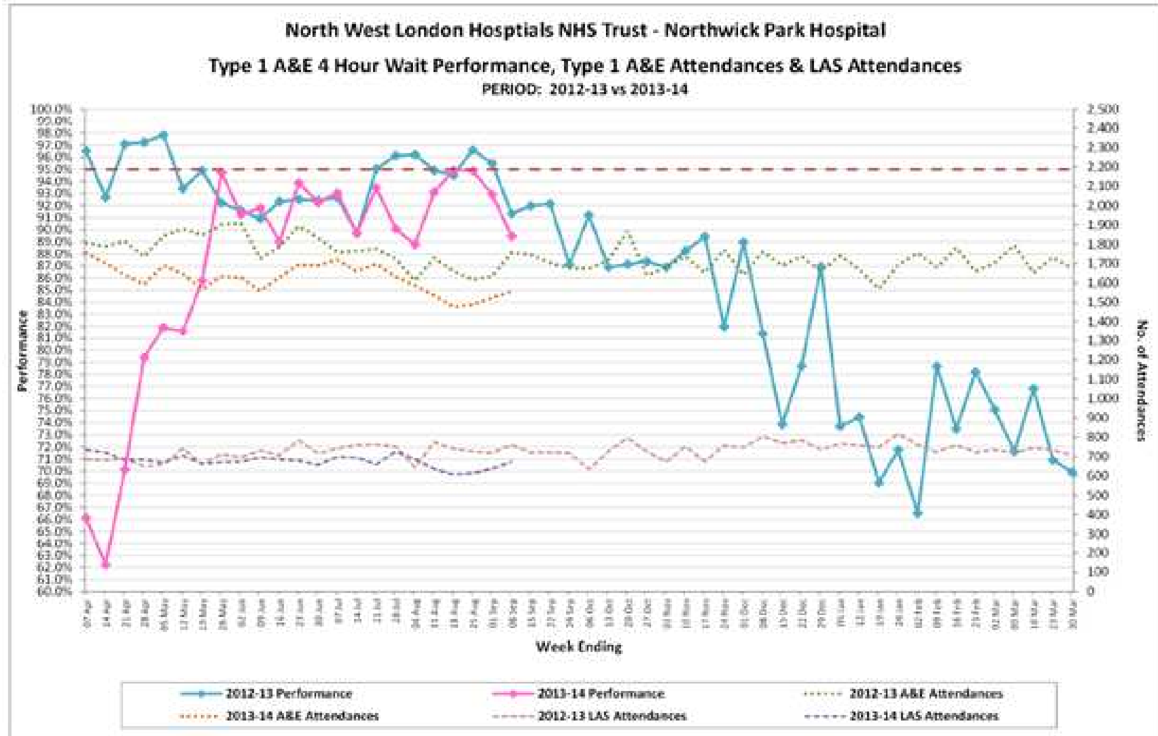
NEL SUS sample - last 2 years activity	
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	24%
Injury, poisoning and certain other consequences of external causes	15%
Diseases of the respiratory system	13%
Diseases of the circulatory system	12%
Diseases of the digestive system	11%
Diseases of the genitourinary system	8%
Diseases of the musculoskeletal system and connective tissue	6%
Certain infectious and parasitic diseases	4%
Neoplasms	4%
Pregnancy, childbirth and the puerperium	4%
Total	100%



Northwick Park Hospital activity comparison 2012-13 against 2013/14

The below graph indicated the following:

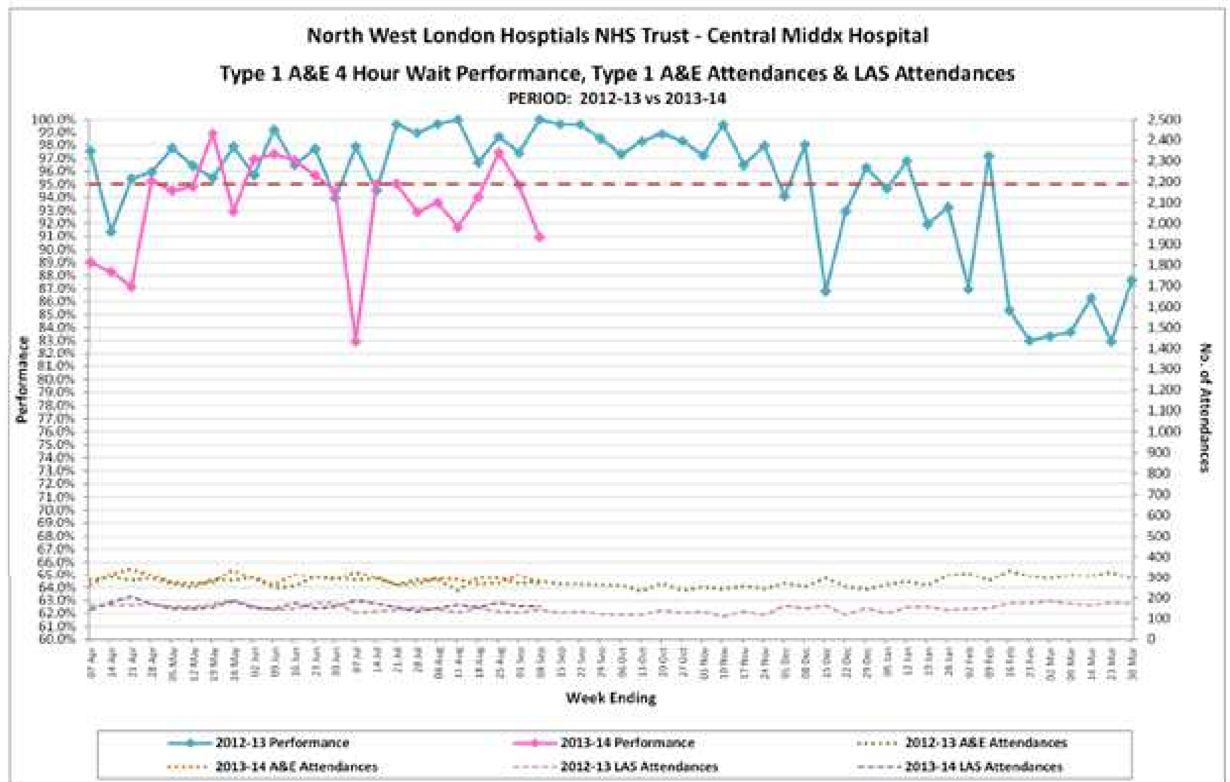
- Type 1 13/14 performance was significantly lower in Q1 compared to 12/13. However current performance is broadly tracking 12/13. Overall Northwick Park Hospital is not performing to the Type 1 13/14 standard
- A&E attendances have decreased compared to 12/13
- LAS attendances are marginally lower compared to 12/13



Central Middlesex Hospital activity comparison 2012-13 against 2013/14

The below graph indicated the following:

- Type 1 13/14 has a varied level of performance to date with periods of achieving the 95% target
- A&E attendances remain broadly the same compared to 12/13
- LAS attendances remain broadly the same compared to 12/13



2.3 Next steps

As part of the whole systems management of the unscheduled care pathway the Urgent Care Board has submitted the winter plan for 2013/14 which aims to support the delivery of the 95% A&E target, which in turn supports an increase in patient experience and has been proven to reduce mortality rates.

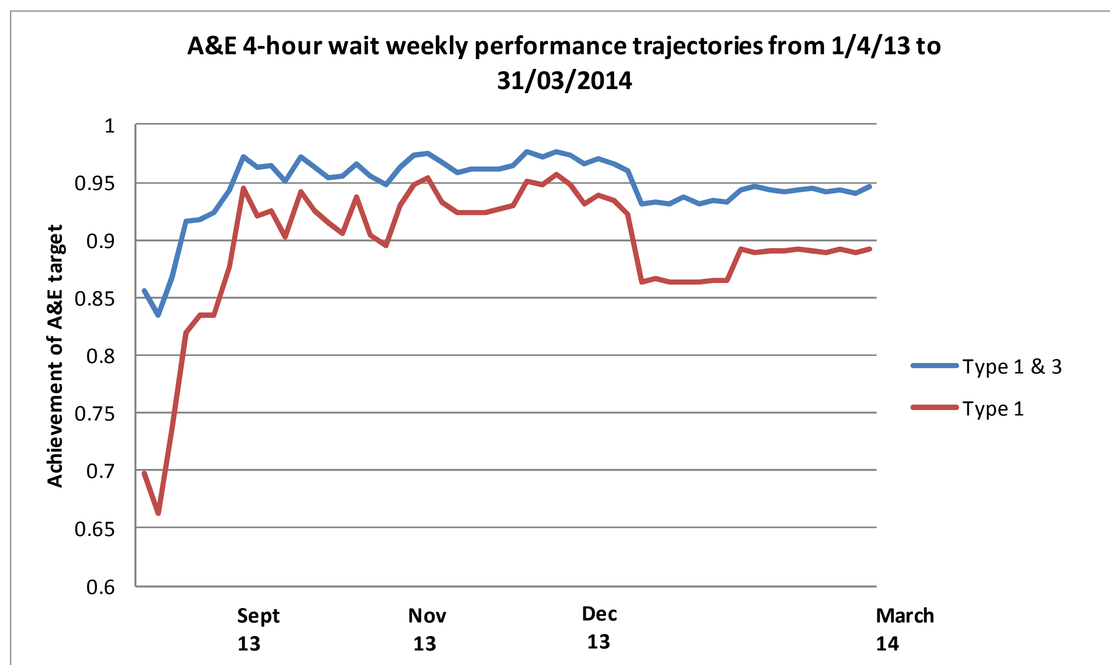
The following trajectory has been developed by NWLHT to support the performance monitoring of quarter 3 and 4 2013/14 A&E activity.

Overall this shows that:

- There is an expectation for Type 1&3 performance to achieve the 95% target September to December. Performance will drop late December and then the system will recover January to March.

- There is an expectation for Type 1 performance to remain below the 95% target with the most significant under performance within January.

- This trajectory has been submitted to NHS England for review and the Urgent Care Board will be discussing the additional actions to be implemented to support continued improvement.



As part of the management of winter, additional NHS England funding has been bid for allocated to the following areas as per the table below.

These schemes aim to support the delivery of safe services across quarters 3 and 4 for 2013/14.

If agreed by NHS England, the Urgent Care Board will monitor the delivery of these schemes and will develop mitigating actions where required.

No.	Winter Surge Scheme	Responsible Organisation	Value £
BH W1	Top slice - NHSE Advised Scheme	NIHR CLAHRC	50,000
BH W2	Top slice - NHSE Advised Scheme	LAS Intelligent conveyancing	190,000
BH W3	Additional bed capacity - 34	NWLHT	2,000,000
BH W4	24/7 working to improve emergency flow:-	NWLHT	2,200,000
	1.Enhanced STARRS		
	2.Weekend therapy		
	3.Extra CEPOD lists		
	4.24hr surgical assessment unit		
	5.Medical 7 day ward rounds		
	6.24HR Stroke service		
	7.Extend the hours of Gynae assessment unit		
	8.24HR critical care outreach		
	9.Extra diagnostic and anaesthetic support		
BH W5	DTOC	Brent/Harrow CCG	CCG's to fund
BH W6	20 Additional beds in Willesden	Brent Community	1,065,000
BH W7	Acute Psychiatric Unit - Co Located	CNWL	459,000
BH W8	Residential Reablement beds x 6	Brent Adult Social	88,000
BH W8	Residential Reablement beds x 6	Harrow Adult Social	88,000
BH W9	Denham	Harrow Community	312,000
		Subtotal	**6,452,000**

2.4 Role public health, social care and Health and Well Being Board

The following is a list of recommendations for the board to consider::

- Triangulation of public health work plans against Urgent Care Board priorities
- Development of single winter communications for providers
- Circulation of the national Choose Well campaign
- Whole system input to Urgent Care Board discussions to steer on going A&E demand management

2.5 Financial Implications
This report is for information only and is not asking for a decision. Therefore there are no financial implications to note.

There are however potential financial implications for all organisations of increasing pressures in A&E and other parts of the health and social care system. These will be considered in appropriate commissioning discussions.

2.6 Risk Management Implications
This report is for information only and is not asking for a decision. Therefore there are no risk management implications to note.

The Urgent Care Board is established to carefully monitor performance and risk, and will ensure that risks of service failure are closely scrutinised.

2.6 Equalities implications
Was an Equality Impact Assessment carried out? No

This is a paper for information only.

2.7 Corporate Priorities
Please identify which corporate priority the report incorporates and how:

- Supporting and protecting people who are most in need.

Section 3 - Statutory Officer Clearance

Not required - paper developed by NHS Harrow CCG

Section 4 - Contact Details and Background Papers

Contact:
Jason Antrobus, Head of Unscheduled Care, NHS Harrow CCG
07904 865 160

Background documents:
None