Health and Wellbeing Board

AGENDA

DATE: **Thursday 30 June 2016**

TIME: **12.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre**

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Sachin Shah**

Board Members:

Councillor Simon Brown	**Harrow Council**
Dr Amol Kelshiker (VC)	**Chair, Harrow Clinical Commissioning Group**
Dr Genevieve Small	**Harrow Clinical Commissioning Group**
Vacancy	**Harrow Clinical Commissioning Group**
Councillor Janet Mote	**Harrow Council**
Councillor Varsha Parmar	**Harrow Council**
Councillor Mrs Christine Robson	**Harrow Council**
Arvind Sharma	**Harrow Healthwatch**

Reserve Members:

Councillor Ms Pamela Fitzpatrick	Harrow Council
Councillor Antonio Weiss	Harrow Council
Councillor Anne Whitehead	Harrow Council

Non Voting Members:

Chris Spencer, Corporate Director, People, 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
Jo Ohlson, NW London NHS England
Simon Ovens, Borough Commander, Harrow Police
Carol Foyle, Representative of the Voluntary and Community Sector
Javina Sehgal, Chief Operating Officer, Harrow Clinical Commissioning Group

Contact: **Miriam Wearing, Senior Democratic Services Officer**
Tel: 020 8424 1542 E-mail: miriam.wearing@harrow.gov.uk

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. AMENDMENT TO TERMS OF REFERENCE

To note the amendment of the terms of reference of the Board to increase the number of Members of the Council nominated by the Leader of the Council from 4 to 5. This decision was taken in accordance with the procedure for minor matters as the next meeting of the Council is not until 22 September 2016.

3. APPOINTMENT OF VICE-CHAIR

To note the appointment of the Chair of the Harrow Clinical Commissioning Group as Vice-Chair of the Board for the 2016-17 Municipal Year.

4. 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.

5. MINUTES (Pages 5 - 12)

That the minutes of the meeting held on 11 May 2016 be taken as read and signed as a correct record.

6. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Board Procedure Rule 14.

Questions will be asked in the order notice of them was received and there be a time limit of 15 minutes.

[The deadline for receipt of public questions is 3.00 pm, Monday 27 June 2016. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

7. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

8. DEPUTATIONS

To receive deputations (if any) under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

9. INFORMATION REPORT - NHS ENGLAND'S ANNUAL UPDATE ON THE DELIVERY OF NATIONAL IMMUNISATION AND SCREENING PROGRAMMES IN HARROW (Pages 13 - 52)

Report of the Director of Public Health Commissioning and Health in the Justice System and Military Health, NHS England London

10. INFORMATION REPORT - WALK-IN CENTRES (Pages 53 - 56)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group.

11. INFORMATION REPORT - FUTURE IN MIND UPDATE (Pages 57 - 70)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group

12. INFORMATION REPORT - BETTER CARE FUND UPDATE (Pages 71 - 76)

Report of the Director of Adult Social Services.

13. HARROW PHYSICAL ACTIVITY AND SPORTS STRATEGY 2016-20 (Pages 77 - 116)

Report of the Director of Public Health.

14. INFORMATION REPORT - UPDATE ON THE HEALTH AND WELLBEING ACTION PLAN (Pages 117 - 132)

Report of the Director of Public Health.

15. UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN (Pages 133 - 138)

Joint report of the Corporate Director People and Chief Operating Officer, Harrow Clinical Commissioning Group.

16. HARROW AND BRENT SYSTEMS RESILIENCE GROUP (SRG) (Pages 139 - 154)

Report of the Assistant Chief Operating Officer, Harrow Clinical Commissioning Group.

17. ANY OTHER BUSINESS

Which the Chair has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II - NIL

* DATA PROTECTION ACT NOTICE

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

HEALTH AND WELLBEING BOARD

MINUTES

11 MAY 2016

Chair:	*	Councillor Anne Whitehead		
Board Members:	*	Councillor Simon Brown		Harrow Council
	*	Councillor Janet Mote		Harrow Council
	*	Councillor Varsha Parmar		Harrow Council
	*	Dr Amol Kelshiker (VC)		Chair of Harrow CCG
		Dr Kaushik Karia		Clinical Commissioning Group
	*	Arvind Sharma		Harrow Healthwatch
	*	Dr Genevieve Small		Clinical Commissioning Group
Non Voting Members:	*	Bernie Flaherty	Director of Adult Social Services	Harrow Council
	*	Carol Foyle	Representative of the Voluntary and Community Sector	Voluntary and Community Sector
	*	Andrew Howe	Director of Public Health	Harrow Council
		Rob Larkman	Accountable Officer	Harrow Clinical Commissioning Group
		Jo Ohlson	Head of Assurance	NW London NHS England
		Chief Superintendent Simon Ovens	Borough Commander, Harrow Police	Metropolitan Police
	*	Javina Sehgal	Chief Operating Officer	Harrow Clinical Commissioning Group
In attendance: (Officers)		Chris Spencer	Corporate Director, People	Harrow Council
		Carole Furlong	Consultant in Public	Harrow Council

Garry Griffiths	Health Assistant Chief Operating Officer	Harrow CCG
Frank Hennessy	Director of Redevelopment	Royal National Orthopaedic Hospital NHS Trust
Jon Manzoni	Head of Strategic Commissioning	Harrow Council
Audrey Salmon	Head of Public Health Commissioning	Barnet and Harrow Joint Public Service
Jane Wheeler	Deputy Director, Mental Health	NHS NW London Collaboration of CCGs

* Denotes Member present

129. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

130. Change in Membership

The Board welcomed Carol Foyle to her first meeting as the representative of Harrow's Voluntary and Community Sector Forum.

RESOLVED: That the change in membership be noted.

131. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 8 – Royal National Orthopaedic Hospital Redevelopment Phase 1 Project

Councillor Janet Mote declared a non-pecuniary interest in that she had been a patient at the hospital as a child. She would remain in the room whilst the matter was considered and voted upon.

Councillor Anne Whitehead declared a non-pecuniary interest in that her daughter was employed as a dietitian at the hospital. She would remain in the room whilst the matter was considered and voted upon.

Agenda Items 11 – Sustainability and Transformation Plan Update and 12 – Information Report – Update on the Better Care Fund

Councillor Simon Brown declared a non-pecuniary interest in that his daughter was employed by CNWL in Harrow. He would remain in the room whilst the matter was considered and voted upon.

Councillor Janet Mote declared a non-pecuniary interest in that her daughter was a nurse at Northwick Park Hospital. She would remain in the room whilst the matter was considered and voted upon.

132. Minutes

RESOLVED: That the minutes of the meeting held on 17 March 2016, be taken as read and signed as a correct record.

133. Public Questions, Petitions and Deputations

RESOLVED: To note that no public questions, petitions or deputations were received at this meeting.

RESOLVED ITEMS

134. Royal National Orthopaedic Hospital (RNOH) Redevelopment Phase 1 Project

The Board received a presentation on the first phase of the redevelopment of the Royal National Orthopaedic Hospital. It was noted that the scheme was subject to planning consent and development plans. Planning permission for reserved matters had been submitted to the Local Planning Authority on 29 April with the aim of consideration by the Planning Committee on 20 July 2016.

The presentation outlined the background and components of the scheme. It was noted that health provision was to be concentrated into the central development zone. Phase 1 did not replace all the current inpatient beds but consisted of 91 beds with the possibility of a further 32 beds on the top floor when funding and use were determined.

The Director of Development undertook to inform the Executive Team of the concern that the issue from the primary and secondary care perspective was the difficulty in accessing services at the hospital for Harrow patients. This had resulted in Harrow residents either having to seek private consultations in order to obtain treatment at the hospital or having to attend city hospitals. A change in policy was sought to develop a better relationship with local CCGs.

In response, the officer stated that as a specialist tertiary hospital it was difficult for local people to obtain access. The hospital team was looking at some partnerships for capacity for more routine orthopaedics. The Board expressed the view that RNOH was not seen as a local hospital and that the difficulty of access was a tertiary problem. Although the hospital was recognised throughout the country as a centre of excellence, it needed better contact with the people of Harrow in order to be seen as part of the community and a facility to be proud of. The Healthwatch representative reported that the organisation had contributed to self assessment and quality reviews and had registered the sense of inequity for Harrow residents. A balance was sought between national and local use to enable a proportion of capacity to be available if required by a Harrow child or the ageing population in Harrow to enable them to benefit from a centre of excellent in the locality.

RESOLVED: That

(1) the proposal to build a 91 bed inpatient ward block as Phase 1 of the 10 phase hospital redevelopment be endorsed;

(2) the concern of the Board with regard to the availability of facilities to Harrow residents and the need for an improved relationship be conveyed to RNOH.

135. Like Minded - Update on the Transforming Care Partnership Plan (TCP) for People With Learning Disabilities, Autism and Challenging Behaviour

The Board received an update on the progress of the North West London Transforming Care Partnership Plan for people with learning disabilities, autism and challenging behaviour. It was noted that feedback had been received the previous week that the NWL plan had been the only London plan to be approved so far. It was intended to submit further detail in July during the period for resubmission of unsuccessful plans.

The representative of the NHS North West London Collaboration of CCGs informed the Board that the Plan brought together best practice in order to share the learning and indicated the areas where there was agreement to align resources, capabilities and expertise. Any differences and nuances, would be outlined in each borough's local plans. There was an emphasis on co-production in areas that reflected the wishes of users and their families.

A CCG representative referred to the existing cohort, for example users of the Kingswood Unit, which despite being local provision was not considered to be meeting the needs of residents and was costly. A report was due to be submitted to the CCG executive on 30 May and to the joint executive between CCG and Harrow Council which would look at the existing cohort and consider the appropriateness of individual or bespoke care, group setting or otherwise to meet need. It was acknowledged that there was a gap in provision and it was being addressed.

In response to questions it was noted that:

- the allocation of the £30million to be made available nationally by NHS England was unknown. As it was understood to be match funding, current investment would be emphasised;

- autism was a priority and featured in both child and adult plans;

- respite provision was a key requirement and best practice and innovation in the eight authorities would be shared, for example, Hillingdon used temporary fostering for respite care.

A clinical representative informed the Board that the Plan provided the opportunity to improve current provision and that the life course approach and pilot for mild to moderate learning difficulties would have a knock on effect as

adults. It was necessary to be realistic regarding timescales and in the long term the cost of the proposals could be neutral.

It was noted that a working group of representatives from the CCG and Harrow Council had been established. The Joint Commissioning Strategy for people with learning disabilities and autism would be resubmitted to the Board.

RESOLVED: That

(1) the direction of travel and priorities in the North West London Transforming Care Partnership Plan be endorsed and it be noted that the final implementation plan would not be agreed until confirmation regarding any additional funding or conditions had been received;

(2) it be noted that the first draft of the plan had been agreed by Harrow CCG Governing Body.

136. Joint Commissioning Strategy for People with Learning Disabilities and Autism

It was noted that the item had been postponed to the next meeting of the Board.

137. Sustainability & Transformation Plan (STP) Update

Members of the Board considered an update on the progress of the Sustainability and Transformation Plan which comprised a North West London Plan and a local operational Plan. The Plan was due to be submitted at the end of June 2016 and would be presented to the Board at its meeting on 30 June 2016.

The Board was informed of the Harrow Sustainability and Transformation Plan Group which had made a submission to the shared five year plan aligned to the strategic objectives in NW London and Harrow. All care organisations had come together on the planning group to develop a local plan which brought together local place-based plans to address the health and care 'gaps' described in the Five Year Forward View. It was noted that all CCGs had been given a notional bid for three years and one for a further two years to enable the planning of submissions.

A CCG representative informed the Board that timescales were tight and that as a result Harrow officers were in attendance at the bi-weekly HSTPG meetings which co-ordinated the STP. In order for the submission to be meaningful for Harrow it would link in local work and indicate the actions to measure outcome. Focus groups would inform the stakeholder engagement and a large Harrow event would be arranged. It was noted that the plans would be submitted to the planning groups and the Board in order for them to keep abreast of developments and enable the endorsement of the five priorities. Although formal approval by the Board was not required, the CCG considered it good governance that the final submission be signed-off by the Chair and Vice Chair.

RESOLVED: That the report be noted and the priorities within be endorsed.

138. INFORMATION REPORT - Update on the Better Care Fund

The Board received an update on the Better Care Fund Plan for 2016/17,together with the outline plan which was submitted on 3 May 2016. It was informed that the Plan was solid and robust and symbolic of the growing strength of partnership between the CCG and the Local Authority

It was noted that three key areas were supported by the BCF Plan for 2016/17. These were: the protection of social care and maintaining levels of activity, Whole Systems Integrated Care and the Transformation of Community Services.

It was noted that approval by NHS England to the outline plan was expected shortly and that the final Plan would be submitted to the Board in June. Whilst the draft Plan had been aspirational, the final 2016/17 Plan was more data driven and backed up by metrics to track progress. There was commitment alongside the plan to look at ways in which the Council and CCG could work together to develop pathways and processes. This included taking forward a review of hospital discharge pathways into community services. Quarterly BCF updates to the Board would continue but with an emphasis on the metrics and data. An officer undertook to circulate the metrics spreadsheet to Members of the Board.

The Board expressed satisfaction at the move towards integrated provision and team work with a focus on addressing provision to all age groups.

RESOLVED: That the report be noted.

139. London Sexual Health Transformation Project

The Board received an update on the collaboration between London boroughs on Genitourinary Medicine (GUM) and Contraception and Sexual Health Service (CaSH) Services. Members of the Board were informed of the Barnet and Harrow Joint Public Health Service's plans to participate in a pan-London procurement for a web-based system to include a 'front end' portal and home/self-sampling. The service would also be participating in the Outer North West London sub-regional arrangements, with the London Boroughs of Brent and Ealing, for the procurement of Genitourinary Medicine and Contraception and Sexual Health Service (CaSH) Services, including primary care sexual health services, outreach and prevention.

It was noted that £2.6 million had been made available in Harrow of which just under £2 million would be allocated to GUM which was the main pressure. As 60% of Harrow service users used the local services there was more control over the cost and spend than most other boroughs.

In response to a question, the Board was informed:

- the focus on high risk and vulnerable residents was strengthened by the procurement process requesting information on how providers would ensure the needs of these groups were met;

- the clinic in a box was delivered to secondary schools and colleges and signposting was available for further information. The challenge was in raising awareness in areas where schools had not taken up the service and the officer undertook to map the information in order to gain an understanding of the situation.

RESOLVED: That the report be noted.

140. INFORMATION REPORT - Illicit Tobacco in Harrow

Consideration was given to a report which described the reasons why illicit tobacco was an important area for tobacco control to address. Board Members were informed of the work being undertaken across London and in the North West London networks as well as the work being undertaken in Harrow.

It was noted that, in order to raise awareness of the scale of the problem, researchers would be undertaking interviews with smokers across London during the following week.

Members expressed support of the initiative to contact magistrates with regard to sentencing guidelines. It was noted that a further report would be submitted to the Board as the tobacco control/stop smoking budget ceased at the end of March 2017.

RESOLVED: That the report be noted.

141. Any Other Business - Last meeting of 2015-2016 municipal year

The Board expressed its appreciation of the hard work undertaken on behalf of the Board by Councillor Anne Whitehead who was attending her last meeting as Chair.

(Note: The meeting, having commenced at 12.30 pm, closed at 1.50 pm).

(Signed) COUNCILLOR ANNE WHITEHEAD
Chair

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REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	30 June 2016
Subject:	INFORMATION REPORT - NHS England's Annual Update on the delivery of national Immunisation and Screening Programmes in Harrow
Responsible Officer:	Joanne Murfitt Director of Public Health Commissioning and Health in the Justice System and Military Health, NHS England London
Public:	Yes
Wards affected:	All wards
Enclosures:	None

Section 1 – Summary

This report provides an update to the Harrow Health and Well Being Board on progress in the delivery of national immunisation and screening programmes. It updates members on performance and actions that NHSE is taking where performance does not meet national targets.

The report enables the Board to note the actions that NHSE is taking to improve performance and Harrow's performance in key national programmes

FOR INFORMATION

Section 2 – Report

Introduction to NHS England commissioned immunisation and screening services in Harrow

The purpose of this paper is to provide an overview of Section 7a immunisation and screening programmes in the London Borough of Harrow for 2015/16. The paper covers the coverage and uptake for each programme along with an account of what NHS England (NHSE) London Region is doing to improve uptake and coverage in the Harrow population.

Section 7a immunisation programmes are universally provided immunisation and screening programmes that cover all ages and comprise of:

- Antenatal and targeted new-born vaccinations
- Routine Childhood Immunisation Programme for 0-5 years
- School age vaccinations
- Adult vaccinations such as the annual seasonal 'flu vaccination
- Cancer Screening Programmes (bowel, cervical and breast)
- Non cancer screening programmes for Diabetic Eye screening and Aortic Abdominal Aneurysm (AAA or Triple A) screening

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

2.1 Antenatal and Newborn Screening Programmes

2.1.1 Introduction to Antenatal and New-born Screening

Screening tests are used to find women & babies at higher risk of a health problem. Early intervention can reduce:

- Mortality
- Morbidity
- Economic cost of life long treatment and support from health, education and social services.

Diagnosing a condition before birth, or identifying that the fetus is at greater risk of having a condition, can reduce illness or severity of illness in childhood and later life. The screening tests can help in decision making about care or treatment during pregnancy or after the baby is born. Some screening tests need to be offered early in pregnancy and some are offered within a matter of hours after the baby born, so timeliness of antenatal and newborn screening is crucial.

There are six Antenatal and New-born (ANNB) screening programmes, screening for

a total of 30 conditions:

 **Foetal Anomaly Screening Programme** (includes Down's Syndrome, Edwards' & Patau's Syndrome screening; congenital anomaly scan at 20 weeks)

 **Infectious Diseases in Pregnancy Screening Programme** (Hepatitis B, HIV, Syphilis)

 **New-born & Infant Physical Examination Screening Programme** (Hips, heart, eyes, testes)

 **New-born Bloodspot Screening Programme** *(CHT, SCD, CF, PKU, MCADD, MSUD, IVA, GA1, HCU)

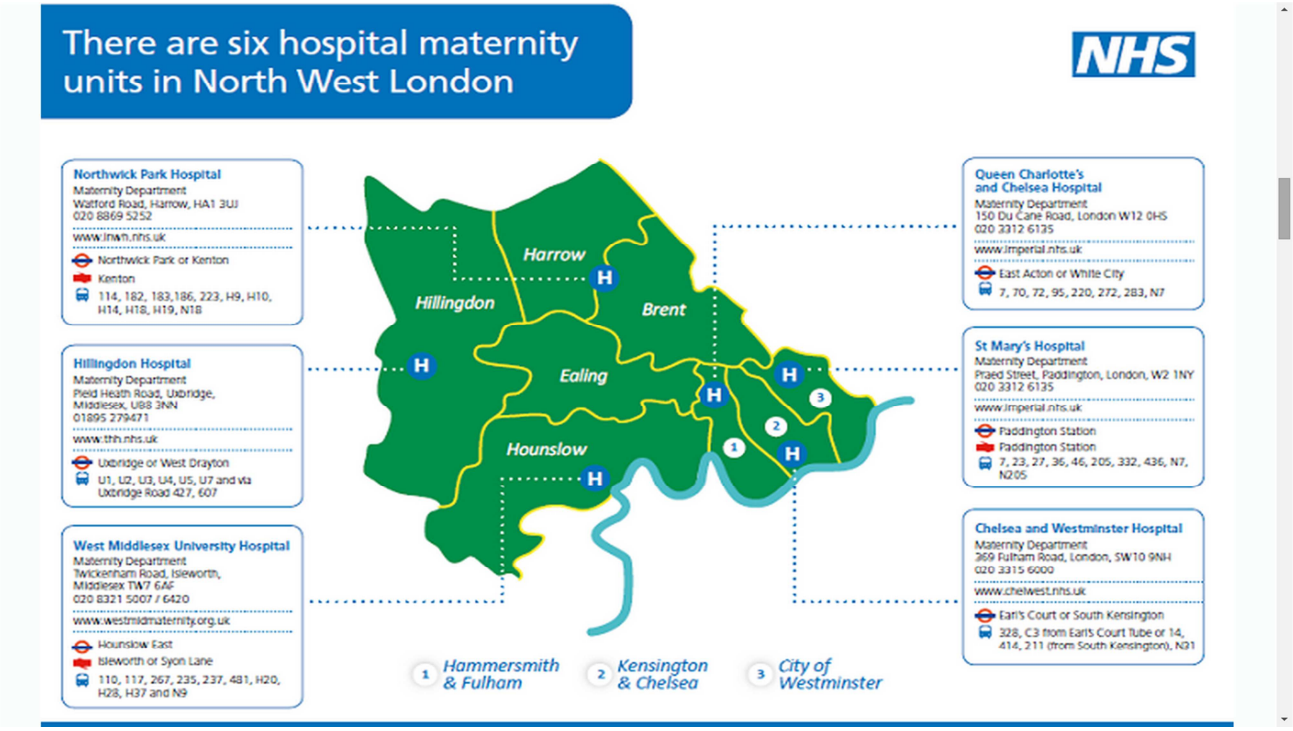
 **New-born Hearing Screening Programme**

 **Sickle Cell and Thalassaemia Screening Programme**

* Conditions screened for in the new-born bloodspot programme are Congenital Hypothyroidism (CHT), Sickle Cell Disease (SCD), Cystic Fibrosis (CF), Phenylketonuria(PKU), Medium-Chain Acyl-CoA dehydrogenase Deficiency (MCADD), Maple Syrup Urine Disease (MSUD), Isovaleric Acidaemia (IVA), Glutaric Aciduria Type 1(GA1), Homocystinuria (HCU).

2.1.2 Maternity Providers for Harrow

Antenatal screening usually starts at the booking appointment, when women are given information about the conditions screened for and informed consent is taken for the tests. *Early booking is crucial* for ensuring that there is sufficient time to screen women and explain the results. Women have a choice of maternity provider. There are six maternity units in North West London, so information on ANNB screening performance across all these units is presented here.



2.1.3 Commissioning for ANNB Screening

Commissioning arrangements for antenatal and new-born screening are complex. NHSE (London) commission screening services as part of the Section 7a arrangements, however, funding for maternity is through a tariff arrangement. The majority of the funding for antenatal screening included within the antenatal tariff, and postnatal screening within the postnatal tariff. CCGs set the contract and commission maternity services from trusts.

NHSE London retains overall responsibility for ANNB screening commissioning, and leads on performance management, implementation of new developments, incident management, and pathway co-ordination.

The ANNB Screening Commissioning Team links to CCGs through the NWL ANNB Screening Performance and Quality Board, and London Maternity Strategic Clinical Network Commissioning Advisory Group. Links to Local Authority Public Health Directorates are via the NWL ANNB Screening Performance & Quality Board and through regular assurance reports to Directors of Public Health.

2.1.4 Key Performance Indicators for ANNB Screening

There are several KPIs for each screening programme. Full data from these is available online at https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting. The most recent data published is from Quarter 3 2015/16, (appendix 2) for London by maternity provider.

Some areas of performance for KPIs in Harrow need further support. These include:

- Timeliness of sickle cell and thalassaemia screening,

- Timely referral to hepatology services for women who screen positive for Hepatitis B,
- Completion of laboratory request forms for Down's, Edwards and Patau's Syndromes.

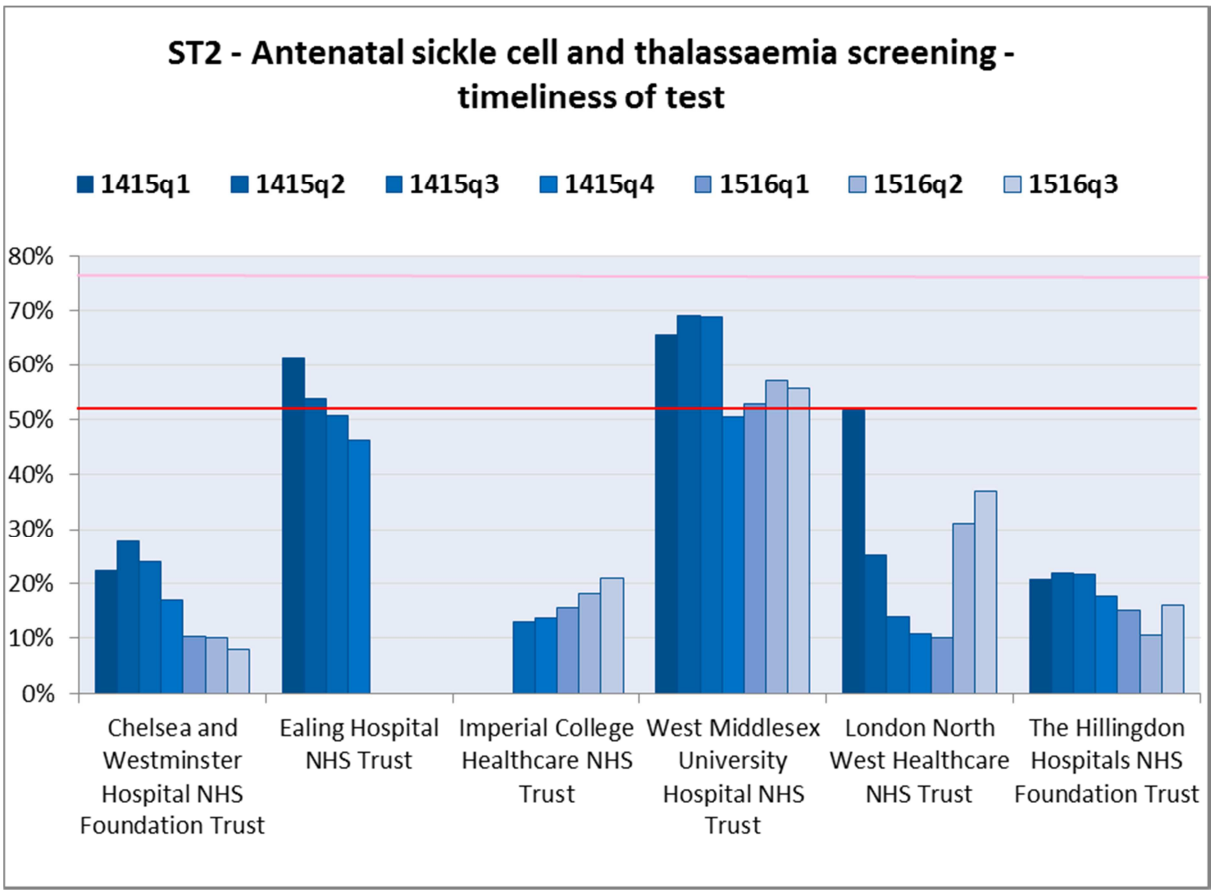
Performance for the newly established KPI for Newborn Infant Physical Examination also appears poor; however the requirement for this indicator is that maternity units should be able to report data by Q1 2016/17, i.e. from April 2016 forward. All NWL maternity units have plans in place to be able to do this.

Sickle Cell & Thalassaemia

KPI ST2 : **Proportion of women with an SCT screening result by 10 weeks gestation.**

This KPI target is set to allow time for those women who screen positive (i.e. are carriers of sickle cell disease or thalassaemia) to have their partner tested, and then if both parents screen positive to consider an invasive diagnostic test on the baby. If the baby tests positive for either sickle cell disease or thalassaemia, parents may then wish to consider termination of the pregnancy, and this option should be available to them before 12 weeks gestation.

Fig 1: Timeliness of antenatal sickle cell & thalassaemia screening North West London 2014 – 15

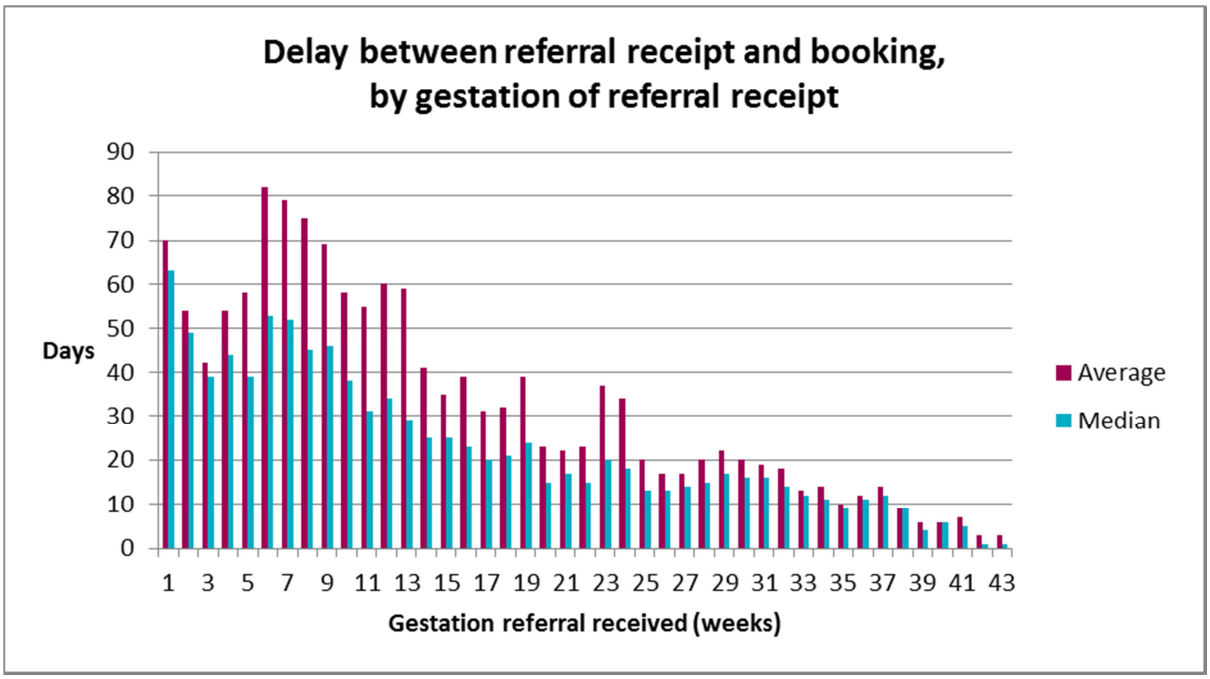


The acceptable level for this KPI is 50% and the achievable level is 75%. *London is the worst performing region* for this measure, and within NWL there is wide variation between hospitals. West Middlesex is the only hospital to consistently meet the acceptable standard, and performance in Chelsea and Westminster, Hillingdon and Imperial College is consistently poor.

Promoting early access to maternity services in Harrow should be a priority.

NHSE has recently carried out a Health Equity Audit of early bookings in London, however only three maternity units from NWL returned data. Only one was able to give data on the gestation the referral was received as well as the gestation when the woman was seen. Across London the audit has shown considerable delay between referrals being received by maternity units and the first booking appointment, with both average and median delays of over a month for referrals received in the first trimester. *Improving processing of referrals within hospitals could greatly improve the proportion of women able to access timely screening*, in addition to having other benefits in improving maternal and child health.

Fig 2: Delays between referral receipt and booking in London 2013/14



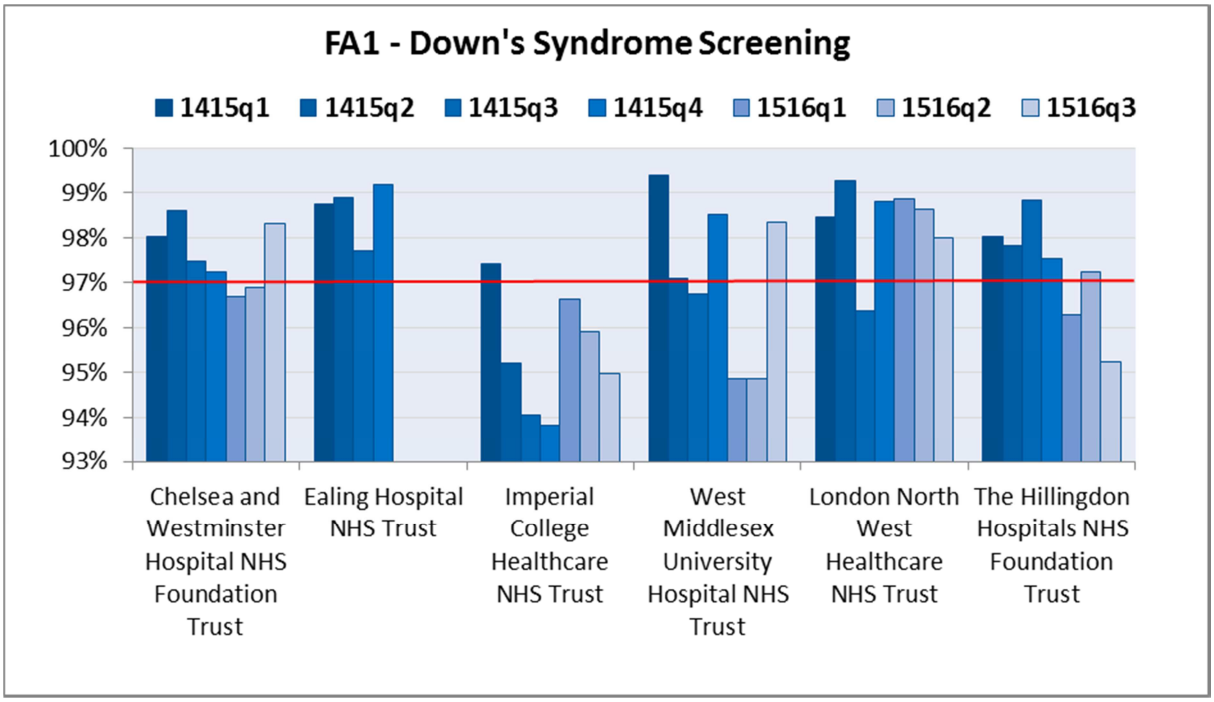
Source: NHSE Health Equity Audit of Early Booking

Foetal Anomaly Screening Programme

KPI FA1: Down's syndrome screening - completion of laboratory request forms

This indicator relates to the completeness of information sent to the Down's Syndrome Screening Laboratory. This information is needed in order for the laboratory to produce an estimate of the risk of the pregnancy being affected by Down's Syndrome, Edwards Syndrome and Patau's Syndrome. Incomplete information on the form will lead to a delay in calculating the risk estimate, and so will reduce the time available for women to have an early invasive diagnostic procedure if this is their choice. The acceptable level for this indicator is 97% and the achievable level is 100%.

Fig 3: Down's syndrome screening - completion of laboratory request forms 2014 -15



Use of electronic forms in some hosptials has greatly reduced the errors in completing forms, and NHSEL are encouraging all maternity units to negotiate with the laboratories that they sub-contract with to introduce the use of electronic forms.

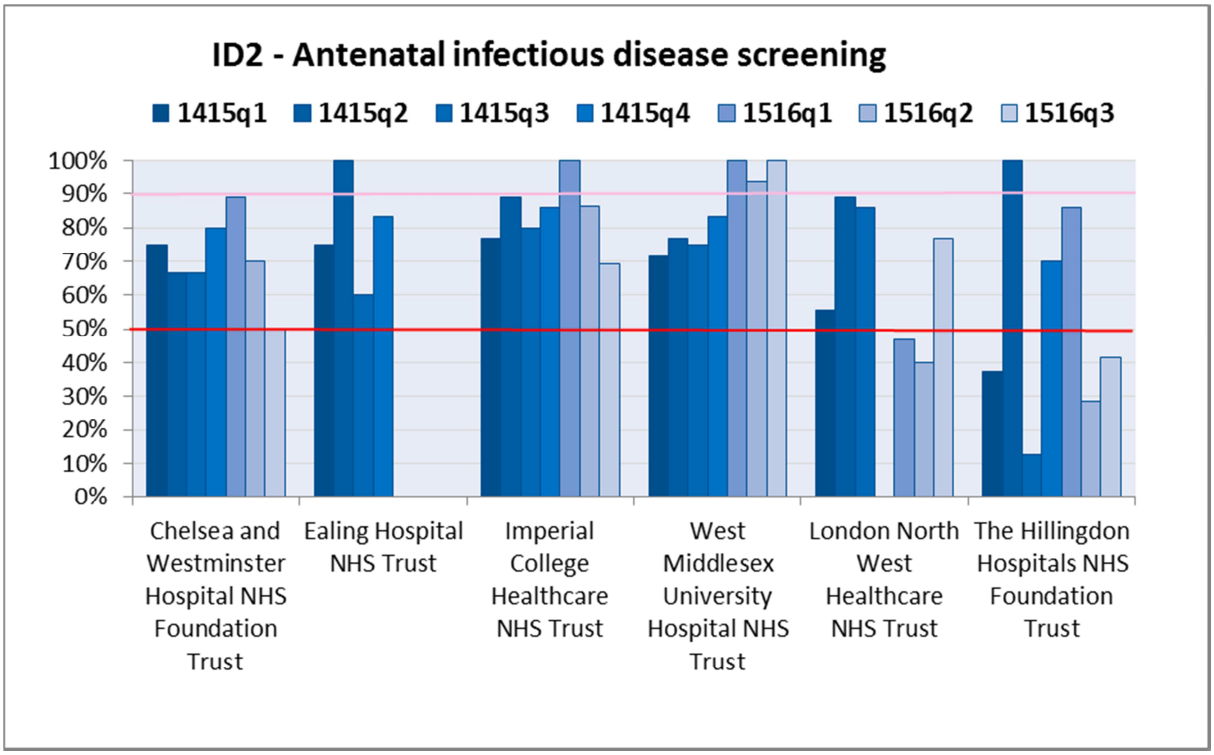
Infectious Diseases in Pregnancy Screening Programme

KPI ID2: Timely referral of women to hepatology

Women who are found to be Hepatitis B positive need to be referred to specialist services for full assessment and further management in order to prevent transmission of Hepatitis B to the baby. Reducing the viral load of women during pregnancy is an important component in reducing the transmission risk, as well as also improving the mother's health. Timely referral is important even for those women who are known to be Hepatitis B positive and are already under specialist care, since pregnancy impacts on the mother's immune system.

The acceptable KPI standard is that 70% of Hepatitis B positive women are seen by a specialist within 6 weeks, and the achievable target is 90%. In Q3 2015/16 (the latest data available) there were 299 women who screened positive for Hepatitis B and only 195 of these had a specialist assessment within 6 weeks (65.2%), meaning that 104 women did *not receive optimum care*. For *North West London maternity units, there were 54 women who were Hepatitis B positive and 36 of these were assessed within 6 weeks (66.7%).* Performance in most hospitals is not yet consistent. West Middlesex is the only unit which has been able to meet the achievable target.

Fig 4: Timely referral of hepatitis B positive women for specialist assessment 2014-15



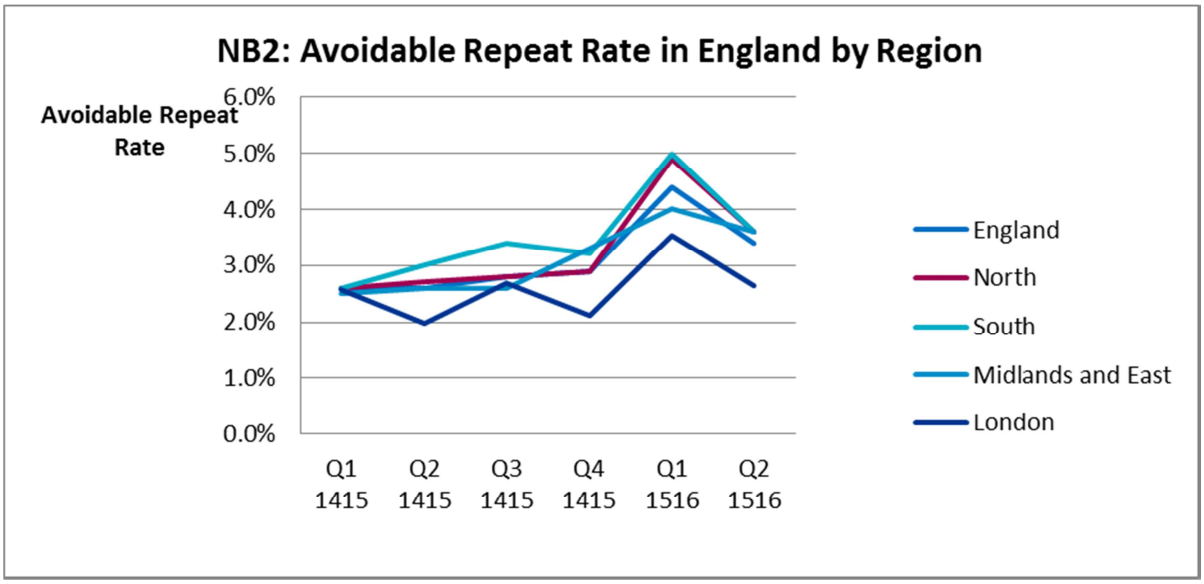
Newborn Bloodspot Screening Programme

KPI NB2: Avoidable Bloodspot repeats

NHSE London has focused strongly in 2015/16 on reducing the proportion of babies having an avoidable repeat bloodspot sample taken. The rate has financial and workforce capacity implications and more importantly can cause anxiety and distress to parents and babies. Information on the reasons behind the avoidable repeats has been fed back to each provider, and a trajectory agreed with each aiming to meet the acceptable standard of 2.0% by the end of 2015/16. North West London Hospital Trust has been set a challenging trajectory of 1.5% driving towards the achievable standard of 0.5%. The work towards this started in mid-2015, and the impact can be

seen on the performance of London compared to other regions from Q4 2014/15 onwards.

Fig 5: Avoidable bloodspot repeat rate by Region 2014/15 to 2015/16



This work has mitigated the impact of the more stringent new standards introduced in April 2015 and London has a smaller percentage of babies requiring an avoidable repeat test than any other region. Nevertheless, in Q3 2015-16 there were 932 babies who did require an avoidable blood sample, causing distress to the baby and family and cost to maternity services. This will continue to be a focus for 2016-17, and trajectories will aim for the achievable standard of 0.5%.

Fig 6: London Region avoidable bloodspot repeats, trajectory and actual 2015 -16

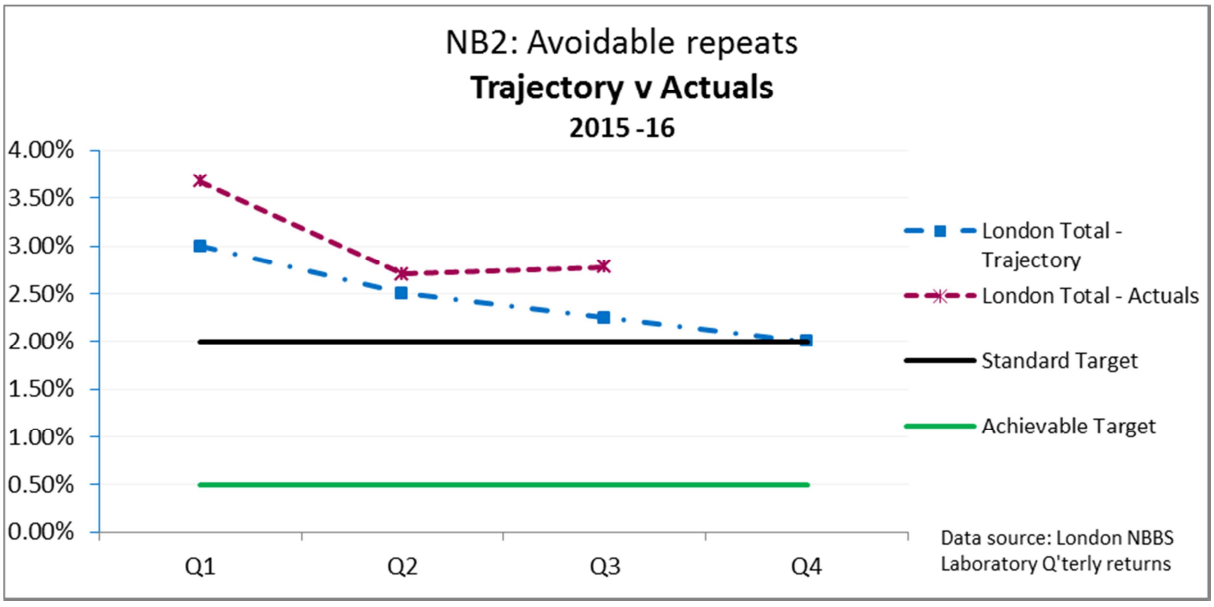
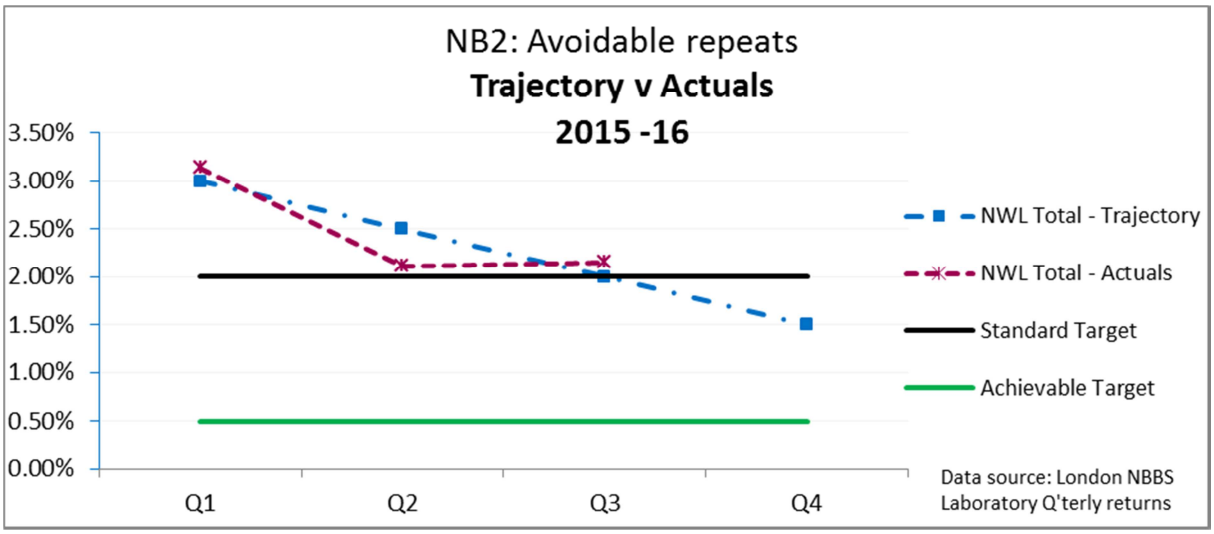


Fig 7: North West London avoidable bloodspot repeats, trajectory and actual



North West London maternity units are achieving close to the acceptable target, and compare well to London as a whole.

NHSE have also been working with the health visiting service in Harrow to strengthen the pathway for older babies, who arrive in the borough without having had a new-born bloodspot completed.

Newborn Hearing Screening Programme

NH1: Newborn Hearing Screening by 28 days (95%acceptable)

In Q3, newborn hearing coverage (NH1) remained high at 98% with the exception of the Kensington Chelsea and Westminster (KCW) programme at 89%. The inclusion of babies born at The Portland Private Maternity Hospital in the KCW data reduces the performance overall. NHS England London have been working collaboratively with the National Programme to include the organisation within NHS reporting data to ensure a failsafe system is in place to track screening for babies born in the private hospital. The programme reporting from all NHS services provides a detailed exception report accounting for 100% of babies.

NH2: Referral to Audiology within 4 weeks /5 weeks NICU babies (90%)

Timely assessment for screen referrals (NH2) remained just below the acceptable threshold at 86.9% but was slightly higher than the 2014 to 2015 England baseline. NH2 is a small number KPI and should be interpreted with caution.

Exceptions are generally due to patient breaches such as DNA and cancellation of appointments by parents. Again all programmes provide an account of 100% of babies to NHS E. Screening services undertake annual patient/user surveys and NHS E London monitor findings and implementation of recommendations. Providers

are keen to undertake detailed breakdown of non-attendance at appointments to ascertain if service improvements could be made to improve attendance

All screening programmes provide exception reports for 100% of babies to NHS England London.

2.1.5 Challenges for Harrow for ANNB screening programmes:

- Supporting early bookings for pregnant women.

  The current target of booking women by 10 weeks (NICE, National Screening Committee). An NHSE (London) Health Equity Audit has identified specific groups at risk of late presentation to maternity services. Local Authorities are asked to ensure all women are aware of the importance of early booking.

- **Tracking of babies moving around London.**

  Ensuring that babies are not lost to follow-up, including key times such as discharge to post-natal care discharge from maternity services to health visiting. Ensuring data returns account for 100% of eligible women.

- Ensuring babies with screen detected conditions requiring follow-up are linked in to health visiting services.

  This includes babies with Hep B positive mothers, who need Hepatitis B immunisations and a blood test at 1 year.

2.1.6 Requests to Harrow for ANNB screening programmes

For Local Authority:

- Support local and London-wide work to increase the proportion of women booking early for ante-natal care, and in particular promote early access for women in vulnerable groups.
- Ensure that LA commissioned services for vulnerable women are able to support these groups to access maternity care early
- Ensure health visiting commissioning arrangements include the provision of bloodspot screening to babies between one month and one year of age, who have not previously had newborn bloodspot screening.

For Harrow Clinical Commissioning Group:

- Support maternity units to improve processing of referrals for maternity care, to reduce delays before the booking appointment.
- Support maternity units in sub-contracting for services to support ANNB screening, e.g. Down's Syndrome laboratories and haematology and virology laboratories.

- Support maternity services to improve IT linkage between different systems within the hospital, and across the screening pathways. Promote electronic data transfer and elimination of hard copy transfers e.g. faxes
- Ensure local acute services have sufficient capacity to be able to offer all pregnant women who are positive for Hepatitis B are able to be seen within 6 weeks.

2.2 Immunisation Headlines

- London performs lower than national (England) averages across all the immunisation programmes.
- London faces challenges in attaining high coverage and uptake of vaccinations due to high population mobility, increasing population, increasing fiscal pressures and demands on health services and a decreasing workforce.
- Under the London Immunisation Board, NHSE and PHE seek to ensure that the London population are protected from vaccine preventable diseases and are working in partnership with local authorities, CCGs and other partners to increase equity in access to vaccination services and to reduce health inequalities in relation to immunisations.
- The London Borough of Harrow (Harrow) on average performs well across the vaccination programmes.

2.2.1 Antenatal and New-born Vaccinations

Pertussis (Whooping Cough) vaccination for Pregnant Women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. In 2012, pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt in the increase of confirmed pertussis (whooping cough) cases. This programme was extended for another 5 years by the Department of Health (DH) in 2014. Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.
- There are seasonal patterns with the winter months of November and December each year reporting the highest proportion vaccinated whilst there is a drop between April and July

- Difference attributed to pertussis given with seasonal 'flu vaccination during November and December
- The latest available annual data for whooping cough vaccine uptake in pregnant women is for 2014/15. London achieved an average uptake rate of 46%, 10% lower than the England rate. This included a decline rate of 0.3% on 2013/14.
- Whooping cough vaccine uptake is reported monthly by PHE. The latest available data for Harrow is for December 2015. Harrow achieved 49.5% uptake, which was lower than London's 52% and the England average of 61.4% for that month. Harrow has consistently performed below England averages every month since the start of the programme.

What are we doing to improve uptake?

- NHSE (London) has been implementing a service level agreement with maternity units across London which will enable women to be vaccinated by maternity staff. This will increase patient choice and access to the vaccine. We are waiting for London North West to decide if they wish to participate in this agreement.
- NHSE (London) has recently undertaken a study of women's experiences of being offered the whooping cough vaccine. The results of this study, along with work being done by research partners in London School of Hygiene and Tropical Medicine, is being used to help plan the future commissioning of maternity vaccination services and to improve the information and advice received by pregnant women about the vaccine.

2.2.2 Universal BCG vaccination

- Since April 2013, NHSE (London) has been rolling out a 100% offer of BCG vaccine to all babies up to the age of one year across London. This action had been recommended by the London TB Board and the London Immunisation Board in 2014. This offer is commissioned to be given in all maternity unites in London with a community offer for those parents who missed out on the vaccine in maternity hospitals or who have recently moved into London.
- Since April 2015, a global shortage of the BCG vaccine resulted in vaccine supply issues within Europe. As a result, the roll-out of the universal offer of BCG was temporarily stalled in London. Once stock was made available again in October 2015, NHSE (London) continued to work with providers across London to deliver the universal offer. A catch up programme was also implemented for those infants who missed out on a vaccine due to the shortage. As per PHE guidance, infants most at risk were prioritised.

- Another stock shortage has since occurred with BCG ordering suspended until further notice. PHE (National) have managed to procure BCG stocks from an alternative provider and a plan to reinstate routine vaccination of neonates is being developed.
- BCG vaccine uptake has been reported for London boroughs to COVER since Q1 2015/16. It is envisioned that by Q4 2015/16, NHSE (London) will be able to make a report on the BCG uptake across London. These rates will reflect the babies turning one year within that quarter and so will not be affected by the vaccine shortages that occurred from April 2015 onwards. Figures for Harrow for Quarters 1-3 2015/16 were 44%, 40.4% and 37.7%.

2.2.3 Neonatal Hep B vaccination

- Babies born to mother who are Hepatitis B positive should receive a course of 4 doses of Hepatitis B vaccine and a serology/dried blood test by 12 months of age. Mothers are identified through the antenatal screening programme and babies are followed up through primary care in Harrow.
- Numbers for babies born to mothers who are Hepatitis B positive are small so annual figures are more robust. The latest annual data available is for 2014/15 (year ending March 31st 2015). Harrow had no data returns on vaccinations given to at risk 12 month old children for that year or for the proceeding years since 2010/11. This was due to very small numbers which cannot be published for reasons of confidentiality.

What are we doing to ensure protection?

- NHSE (London) will be implementing a new integrated care pathway for Hep B at risk babies. This will contain one model of delivery across London – i.e. first vaccine given at birth with the remaining 3 doses and dried blood test done by general practice. Failsafe mechanisms to track infants, including the unregistered, and to ensure completion of the course will be commissioned to support this model of delivery. The new pathway and model is in line with national guidance and directives.

2.2.4 Routine Childhood Immunisation Programme (0-5 years)

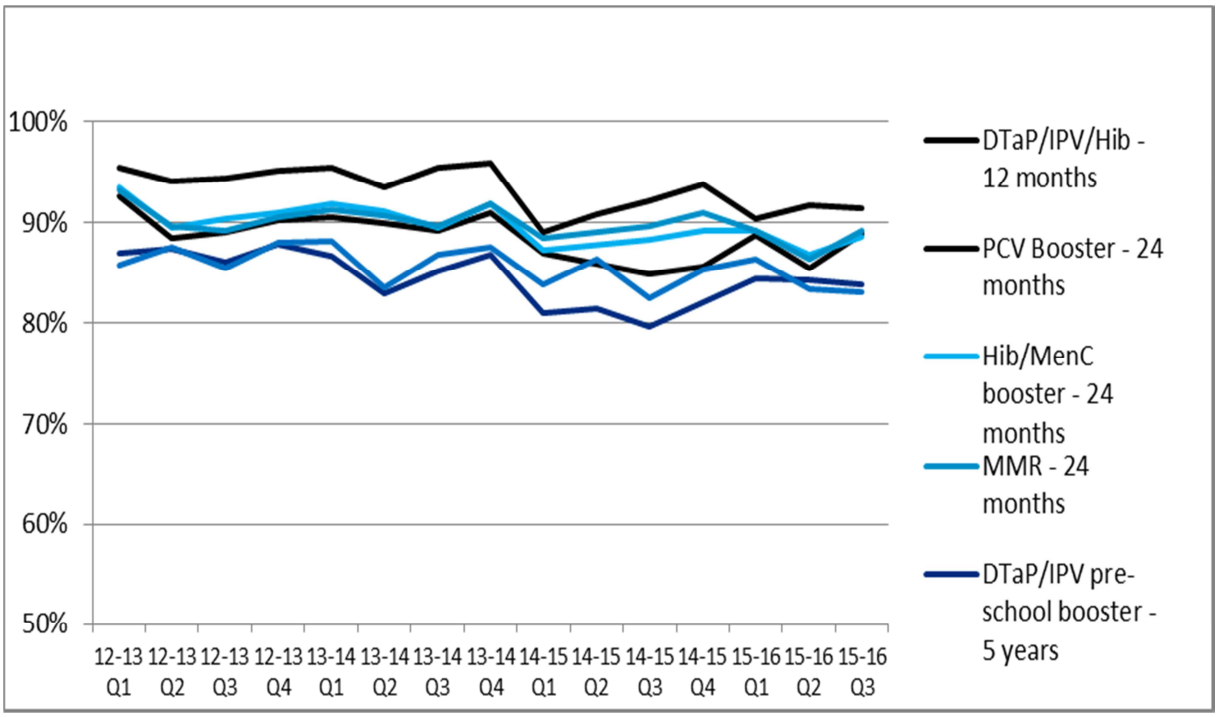
COVER

- Cohort of Vaccination Evaluated Rapidly (COVER) monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have

been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection particularly as there is no real incentive for GPs to submit data for COVER statistics and large numbers of deprived or vulnerable groups. In addition, there is a approx. 20% annual turnover on many GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Harrow's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Harrow has not achieved the required 95% herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).
- Figure 8 illustrates the quarterly COVER statistics for the uptake of the six COVER indicators for uptake. The primaries (i.e. completed three doses of DTaP/IPV/Hib) are used to indicate age one immunisations, PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2 and preschool booster and second dose of MMR for age 5. Quarterly rates vary considerably more than annual rates but are used here so that Quarter 3 data from 2015/16 (the latest available data) could be included.
- Harrow consistently performs above 90% for the Age 1 vaccinations, making it one of the top performers in London.
- Similar to the general pattern across London where coverage rates decrease as age increases, Harrow's rates decrease as the age cohort goes from age 1 to 2 and to age 5. This decrease in coverage rates is affected by data information systems not capturing movements in population (i.e. transfers in and movers out of borough) and also reflects inadequacies in call/recall systems to bring children in for the remaining vaccinations on the Routine Childhood Immunisation Schedule (i.e. calling parents/guardians for appointments and chasing those who do not attend). This is not unique to Harrow and is common across London boroughs.
- The rates for Harrow dipped when the NHS underway change in 2013 but since then there has been a steady improvement. Moreover, the gap between age 2 and age 5 cohorts is closing.

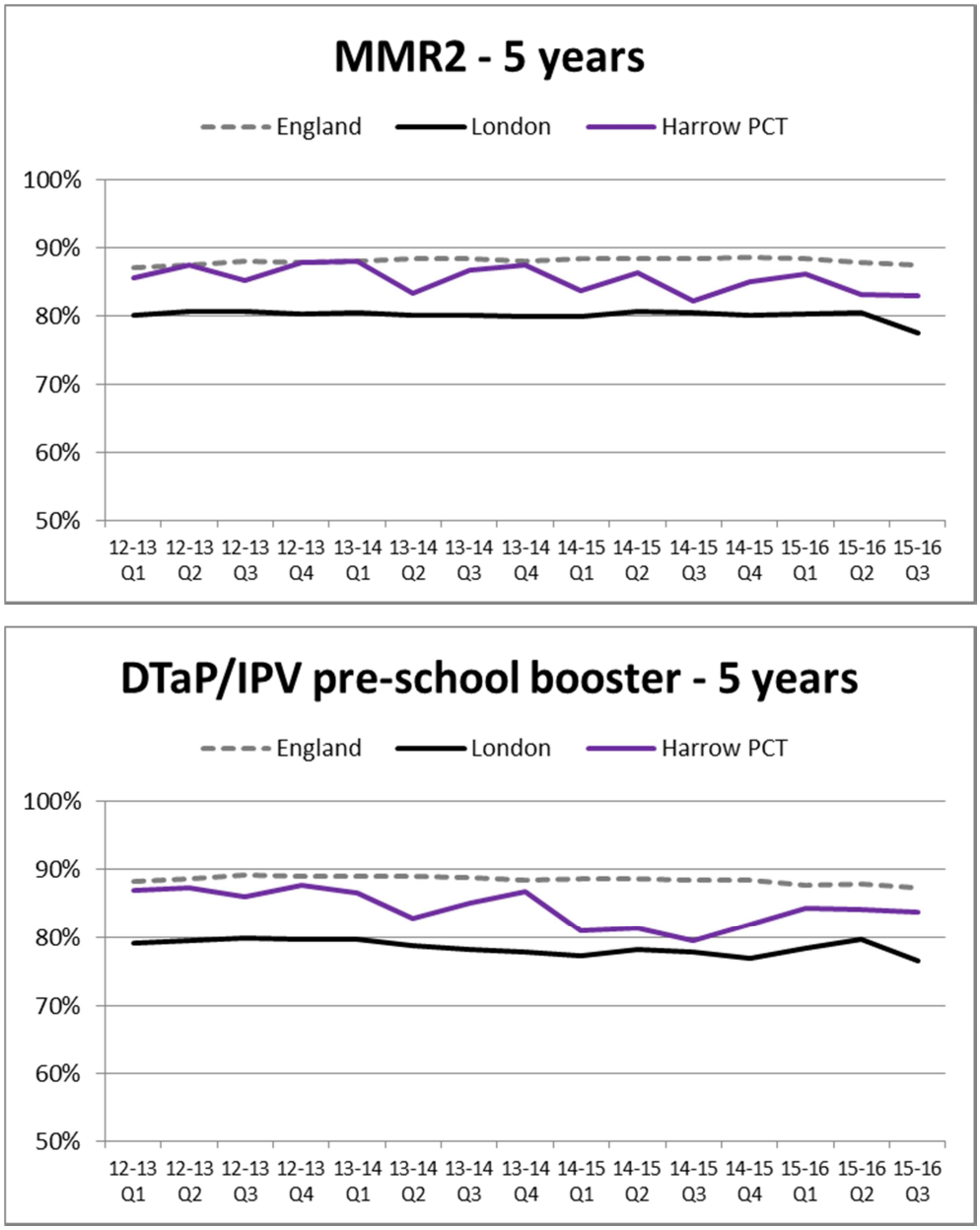
Figure 8 COVER rates for Age 1, Age 2 and Age 5 cohorts in Harrow (2011-2015)



Source: PHE (2016)

- Throughout 2011/12 to 2015/16, London has consistently performed below national on all COVER indicators by ~4% for the age 1 vaccinations, ~6% for age 2 vaccinations and ~10% for the age 5 vaccinations. Similar to Harrow, the rates dipped at the start of 2013/14 but have since increased to the pre-dip levels.
- Figure 9 compares Harrow to the London and England averages for the 2nd dose of MMR and the preschool booster, which are indicators of completed routine childhood immunisation schedule. Harrow consistently performs above London averages and just below England averages.

Figure 9 Comparison of Harrow with London and England averages for MMR2 and Preschool booster for Q1 2013/14 – Q3 2015/16 (the latest available data)



Source: PHE (2016)

What are we doing to increase uptake?

- Increasing coverage and uptake of the COVER reported vaccinations to the recommended 95% levels is a complex task. Under the London Immunisation Board, PHE and NHSE (London) have been working together to improve quality of vaccination services, increasing access, managing vaccine incidents and improving information management, such as better data linkages between Child Health Information Systems (CHIS) and GP systems. As well as these pan London approaches, NHSE (London) have been working locally with PHE health protection teams, CCGs and local public health teams in local authorities to identify local barriers and vulnerable or underserved groups (e.g. travelling

community) and to work together to improve public acceptability and access and thereby increase vaccine uptake.

Rotavirus

- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages have been 90% or over.
- The programme has been very successful in reducing incidences of rotavirus with laboratory reports of rotavirus for July 2013 – June 2014 being 67% lower than the ten season average for the same period in the seasons 2003/04 to 2012/13.
- The latest available data for Harrow CCG is for January 2016, whereby 90.2% of babies received first dose of rotavirus and 80.7% received the two doses. Harrow has consistently performed well each month. London averages were 90.4% and 83.2% whilst England had averages of 93.8% and 88.6% for the first and second dose.

Meningococcal B

- Since September 2015, all infants are offered a course of meningococcal B vaccine as part of the Routine Childhood Schedule. Eligible infants were those babies born on or after 1st July 2015 with a small catch up programme for babies born on or after 1st May 2015.
- There are preliminary data for babies aged 26 weeks in January 2016. In Harrow, 90.4% of those infants had received their first dose of Men B with 75.8% having received two doses. This is similar to the London averages of 89.4% and 78.5% respectively and lower than the England averages of 94% and 84.8%.

2.2.5 School Age Vaccinations

HPV vaccination

- Human papillomavirus (HPV) vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 is that two doses are adequate.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. However the introduction of a two course programme instead of a three course programme meant that many providers did not offer the second dose until the next academic year. As a result a national average could not be computed for 2014/15. London's average was 79.2%, a little lower than the previous year's 80%.

- Like many other London boroughs, Harrow had a decrease in uptake with the move from a three dose schedule to a two dose schedule. For 2014/15, Harrow had a 77.6% uptake, down from the previous year's 83.2%. Only Newham achieved the 90% target. (See Table 1)
- Surveillance data from Public Health England (PHE) already suggest that the programme is achieving its aims. Reductions in the prevalence of HPV 16 and 18 infections (HPV strains 16 and 18 cause 70% of cervical cancers and precancerous cervical lesions) are consistent with very high vaccine effectiveness among those vaccinated and suggest that herd-protection is also lowering prevalence among those who are not vaccinated. These early findings support confidence in the programme delivering its expected impact on cervical cancer and other HPV-related diseases in due course. It is anticipated that, with the new two-dose schedule, higher coverage of the completed course should be achievable, thus increasing the potential impact of the programme

What are we doing to improve uptake?

- NHSE (London) has implemented a contract variation whereby all providers of school age vaccinations must deliver the two dose schedule within one academic year.
- Since September 2015, NHSE (London) has commissioned community health services providers to deliver school age vaccinations in school settings and alternative venues to ensure that every school age child is offered the recommended vaccines irrespective of where they receive their education, including home schooled children.

Other school age vaccinations

- To date, data is not routinely collected and published for Meningococcal C (Men C) vaccination programme and for the teenage booster.
- Following a rise in Meningococcal W (Men W) cases in England, a Men ACWY vaccination programme was introduced to replace the Men C programme in schools and to offer a 'catch up' programme for 18 year olds and university entrants in the summer of 2015 with a catch up offered to year 11 and 12 students. The vaccine offer is also available to eligible cohorts in prisons. Delivery of these programmes are underway.
- Preliminary data is available for the catch up delivered in 2015 (i.e. those aged 18 years). National uptake is estimated to be 33.7% (PHE, January 2016). Uptake in schools will be captured in an annual survey in September 2016 and published by PHE later this year.

2.2.6 Adult Vaccinations

Shingles

- The Shingles vaccination programme commenced in September 2013. Shingles vaccine is offered to people who are 70 years or 79 years old on 1st September in the given year. Data on vaccine coverage is collected between 1st September and 31st August. London has excellent reporting rates with 95.8% of GP practices submitting data returns for 2014/15 (Harrow CCG had returns of 94.3%).
- London and England performed lower for 2014/15 compared to 2013/14 despite the national trend projecting an increase on last year. London's average for uptake amongst the 70 year old cohort was 48.8% (lower than England's 59% and lower than 2013/14 when it was 51.3%). For the same period, London's average for uptake amongst the 79 year old cohort was 49.7% (lower than England's 58.5% and last year's 50.9%).
- The table at the end of this paper (Table 2) illustrates the percentage uptake by CCG in London for both years of the Shingles programme for the two age cohorts. It can be seen that Harrow CCG reports uptake rates are higher than London averages but lower than England averages for 2014/15 – 50.8% of 70 year olds and 53.2% of 79 year olds had the shingles vaccine compared to 48.8% and 49.7% for London. These rates are lower than in 2013/14.
- Nationally and within London, there is no difference between ethnic groups in terms of uptake.

What are we doing to increase uptake?

- Following the success of a London Shingles Vaccine Awareness Week in July 2015 which brought about an increase of 5% to the overall London rate, a pan-London project group consisting of partnership work between PHE (London), NHSE (London), London Councils and the pharmaceutical company responsible for providing the national shingles programme with the vaccine has been working on a campaign to improve shingles vaccine uptake for 2016/17.

PPV

- Pneumococcal Polysachride Vaccine (PPV) is offered to all those aged 65 and older to protect against 23 strains of pneumococcal bacterium. It is a one off vaccine which protects for life.
- Vaccine uptake and reporting coverage is published cumulatively. The latest published data is for 2014/15. Up to and including 31st March 2015, 66.7% of those aged 65 years and older were vaccinated with PPV in Harrow. This is slightly higher than London's average of 65% and lower than England's average

of 69.8%. Reporting coverage rates are good – 98.1% for London and 96.7% for England but only 87.9% in Harrow.

Seasonal 'Flu

- Provisional data for the seasonal 'flu season 2015/16 is available. Figure 10 illustrates the uptake of seasonal 'flu vaccine for each of the identified 'at risk' groups for Harrow CCG compared to London and England averages for the winter 2015 (September 1st 2015 to January 31st 2016). It can be seen that London performs lower than England across the groups. In relation to Harrow CCG, it performs similarly to London averages for the over 65s, the clinically at risk group and the school based programme for years 1 and 2 but performs lower than London for pregnant women and the 2-4 year olds. As it is provisional data, comparisons with the previous winter will not be made at this stage.
- London, England and Harrow all performed below the recommended 75% uptake level for all at risk groups – i.e. over 65s, clinically at risk and pregnant women. All three performed lower than the 40-60% national target for uptake for child 'flu vaccine (Fluenz) programme for 2-4 year olds, given in general practice.
- In relation to the delivery of child 'flu vaccine programme in the school years of Year 1 and 2, both Harrow and London hovers at the 40% uptake mark.

Figure 10 Provisional Data on Uptake of the 'at risk' Groups of Seasonal 'flu for Harrow CCG compared to London and England for Winter 2014 (September 1st 2014 – January 31st 2015)

	Uptake 65 years and over	Uptake 6 months – 65 years 'Clinically at risk'	Uptake pregnant women	Uptake all 2 year olds	Uptake all 3 year olds	Uptake all 4 year olds	Uptake Child Flu School Year 1	Uptake Child Flu School Year 2
Harrow CCG	68.8%	45.7%	34.7%	21.8%	23.7%	18.3%	43.3%	39.5%
London	66.2%	43.6%	38.5%	26.5%	28.8%	21.8%	42.4%	39.9%
England	71%	45.1%	42.3%	35.4%	37.3%	30.1%	55.6%	54.3%

Source: PHE (2016)

2.2.7 Next Steps for Improving Immunisation Uptake

- For 2015/16, each London borough was assigned an immunisation commissioner who worked with local partners, such as the public health team at the London

Borough of Harrow and the CCG in developing a borough specific action plan which is agreed and delivered under local governance arrangements.

- The aim of each plan is to increase uptake and vaccination coverage within the boroughs, which in turn will increase London averages. The plans also address health equities in access to immunisations and health inequalities in uptake.
- A borough specific plan for 2016/17 is currently being developed for Harrow which will be delivered by the newly formed immunisation steering group.

2.3 Cancer Screening Programmes

Screening is effective in either preventing or detecting early stages of disease at a time when there is an intervention that is effective in reducing the impact of the disease in terms of mortality or morbidity. Cancer screening is currently delivered through 3 programmes;

- Cervical cancer screening
- Breast cancer screening
- Bowel cancer screening.

All national screening programmes are agreed by PHE's National Screening Committee. PHE is responsible for the implementation of new programmes. A current example of this is the Bowel scope programme, which offers flexible sigmoidoscopy to all people aged 55 years. Established programmes are commissioned by NHSE with support from PHE embedded staff.

2.3.2 Breast screening

Breast screening is a method of detecting breast cancer at a very early stage. The first step involves an x-ray of each breast - a mammogram. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor.

The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50 and over. Because the programme is a rolling one which invites women from GP practices in turn, not every woman receives an invitation as soon as she is 50. But she will receive her first invitation before her 53rd birthday. Once women reach the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointments. Women in Harrow are screened by the North London Breast Screening Service hosted by the Royal Free. On 1 April 2016, the Royal Free launched the London Breast Screening Hub, which provides the following administrative services for all breast screening services: call-recall, sending of invitation and results letter, setting appointments and routine

reporting. The Hub currently provides administrative services for the North, Central and North East London Breast screening services. The Hub will roll out to the remaining services (West London, South East and South West London) in 2016/17.

2.3.3 Bowel Screening

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year.

Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent[2].

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective.

Bowel cancer screening can also detect polyps. These are not cancers, but may develop into cancers over time. They can easily be removed, reducing the risk of bowel cancer developing.

The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69. People over 70 can request a screening kit by calling the freephone helpline 0800 707 6060.

2.3.4 Cervical Cytology Screening

After the NHS Cervical Screening Programme started in the UK in the late 1980s, cervical cancer incidence rates decreased considerably. In Great Britain, the age-standardised incidence rate almost halved (from 16 per 100,000 women in 1986-1988 to 8.5 per 100,000 women in 2006 - 2008).

Cervical cancer is the 11th most common cancer among women in the UK, and the most common cancer in women under 35.

Between 2008 and 2009, incidence rates increased by more than 20 per cent in women aged 25 to 34 (22 per cent for women aged 25-29 and 21 per cent for those aged 30-34).

Cervical screening is **not** a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). The first stage in cervical screening is taking a sample using liquid based cytology (LBC).

Early detection and treatment can prevent 75 per cent of cancers developing but like other screening tests, it is not perfect. It may not always detect early cell changes that could lead to cancer.

All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years.

In the light of evidence published in 2003[1] the NHS Cervical Screening Programme offers screening at different intervals depending on age. This means that women are provided with a more targeted and effective screening programme.

The screening intervals are:

Age group (years)	Frequency of screening
25	First invitation
25 - 49	3 yearly
50 - 64	5 yearly
65+	Only screen those who have not been screened since age 50 or have had recent abnormal tests

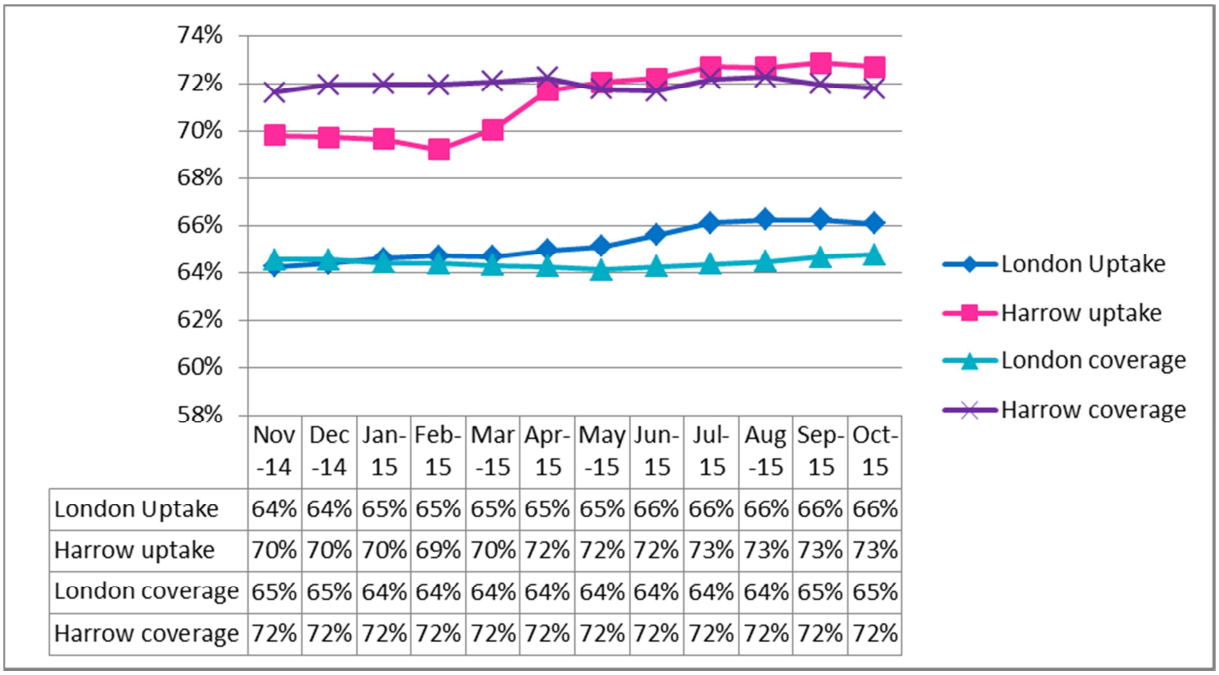
The NHS call and recall system invites women who are registered with a GP. It also keeps track of any follow-up investigation, and, if all is well, recalls the woman for screening in three or five years' time. It is therefore important that all women ensure their GP has their correct name and address details and inform them if these change. Local Authorities as part of their role in supporting the work of NHS E can help by including information on GP registration when sending out information to new residents etc.

2.3.5 Breast Screening Coverage

Breast screening uptake and coverage in Harrow are significantly higher than the London average. (Figure 11) In the twelve months to August 2015, breast screening uptake increased by 3%. (Table 4) This increase is as a result of North London Breast Screening Service (Royal Free) sending appointment text reminders, pre-invitation letters and second-timed appointments to non-attendees in Q3 2014/15. Coverage remained relatively unchanged. This is because coverage is measured over three years, we therefore expect to see an improvement in coverage in 2017.

The consolidation of breast screening administrative functions into the London Breast Screening Administrative Hub and the development of single London-wide breast screening call centre and breast screening appointment and information website, in 2016/17, should improve access and result in further improvements in uptake and coverage for all women in Harrow and London.

Figure 11: Harrow Breast screening uptake and coverage, 50-70 years, November 2014-October 2015



	Nov -14	Dec -14	Jan-15	Feb-15	Mar -15	Apr-15	May -15	Jun-15	Jul-15	Aug -15	Sep-15	Oct-15
London Uptake	64%	64%	65%	65%	65%	65%	65%	66%	66%	66%	66%	66%
Harrow uptake	70%	70%	70%	69%	70%	72%	72%	72%	73%	73%	73%	73%
London coverage	65%	65%	64%	64%	64%	64%	64%	64%	64%	64%	65%	65%
Harrow coverage	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%

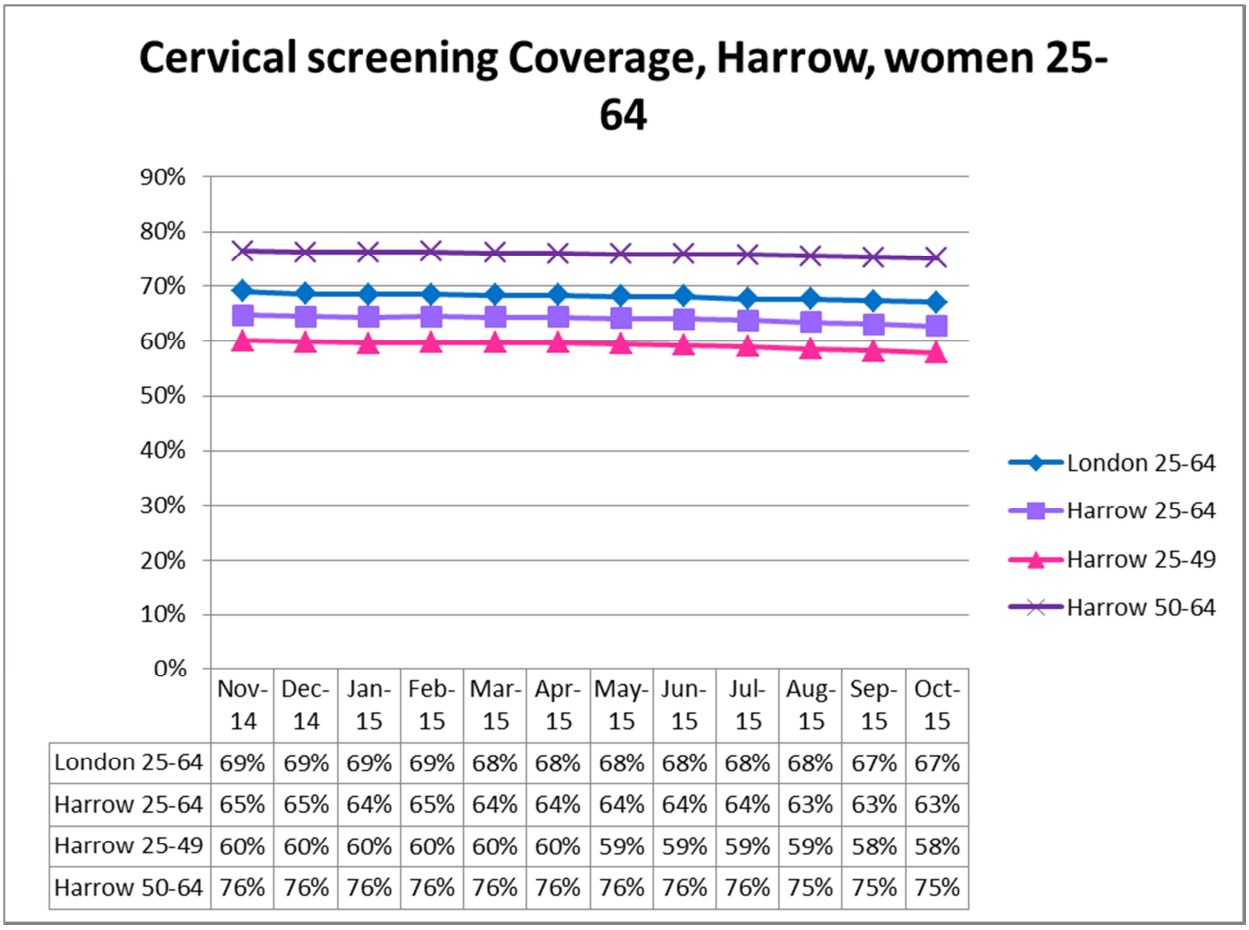
2.3.6 Cervical screening coverage

In the twelve months to October 2015, cervical screening coverage in Harrow declined by 2%. This decline was greater in younger women aged 25 to 49 years of age. (Figure 12) Coverage is lower than the London average, and within the borough, younger women (25-49) have considerably lower coverage rates than women aged 50-64.

There are several initiatives that will improve coverage in London:

- The PMS review currently underway across London, has included cervical screening coverage in the core specification
- Development and cascade of the cervical screening primary care best practice guide will improve uptake and coverage in practices that implement the key recommendations related to cervical screening
- Imperial Hospitals Trust is currently undertaking a randomised controlled trial of texting within the cervical screening in programme in Hillingdon.
- Queens University is designing an HPV self-sampling trial for London

Figure 12 Harrow Cervical screening coverage 25-64 years, November 2014-October 2015



	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
London 25-64	69%	69%	69%	69%	68%	68%	68%	68%	68%	68%	67%	67%
Harrow 25-64	65%	65%	64%	65%	64%	64%	64%	64%	64%	63%	63%	63%
Harrow 25-49	60%	60%	60%	60%	60%	60%	59%	59%	59%	59%	58%	58%
Harrow 50-64	76%	76%	76%	76%	76%	76%	76%	76%	76%	75%	75%	75%

2.3.7 Sample Handling Policy

NHS E London began collecting information on sample handling errors in June 2015 to monitor progress on the implementation of the *Sample Handling Guidance*, issued in March 2015. To support continuous improvement, laboratory staff has been asked to monitor errors and the late receipt of samples (samples sent to laboratory after 4 days)

The aim of collecting data on sample handling errors is helping us to identify individual sample takers, GP practices and clinics that require remedial support to improve the quality of cervical screening. Information late receipt of samples assists in the identification of practices, clinics or lab couriers that contribute to the breach of the NHS Cervical Screening Programme (CSP) standard that 98% of women should receive their test results within 14 days. The information gathered will help to inform plans to improve performance in the 14 day TAT (Turn-around Times). As we start to get a bank of data we are able to identify issues with providers and will be working with CCGs to support practices as part of their role in co- commissioning primary care.

Between July 2015 and March 2016, the error rate in London ranged from 1-7%, with an average of 4%. The Northwick Park laboratory, which serves practices in Harrow, Brent, Ealing and Hillingdon, had an error rate of 2%. This equates to 1,000 women who had their samples discarded and/or screen repeated. This causes unnecessary anxiety in women and reduces confidence in the screening programme. Given the current challenges with the uptake of cervical cytology this is an area where we can drive improvements.

A work plan has been agreed between the labs, NHSE and practices to support this work.

2.3.8 Sample Takers Data Base

As part of our work to improve standards NHSE London has set up a data base that contains details of sample takers who are given a unique PIN number. So far we have 3500 staff registered on the database currently rolling this out across London. Registration will commence in NW London in May 2016 and communication has been sent to all relevant organisations with samples takers in the sector

2.3.9 Colposcopy services

As part of it role in monitoring performance NHSE London monitor the following targets for colposcopy services;

- Waiting times to colposcopy appointment
- DNA rates
- Communication of results letters

- Performance has been steadily improving in London (Table 4)

Figure 13: London Colposcopy performance Q2-Q4 2015/16

Sector & Trust Name	Waiting Times						DNA Rates		Communication of Results	
	High Grade		Moderate Grade		Low Grade		New Patient	Follow up Patients	Results Received in 4 Weeks	Results Received in 8 Weeks
	Offered	Attend	Offered	Attend	Offered	Attend				
	≥90%	≥90%	≥90%	≥90%	≥99%	≥90%	<15%	<15%	≥90%	100%
London Q4	99%	88%	97%	89%	97%	90%	9%	12%	90%	100%
Q3	98%	82%	96%	89%	96%	87%	9%	13%	91%	100%
Q2	90%	68%	89%	64%	92%	72%	10%	14%	89%	100%

We have also signalled in our commissioning intentions that we planned a review of the current configuration of colposcopy services. Our plan for 2016 is to undertake this review and to consider, in discussion with CCGs and Local Authorities if we

should move to a smaller number of providers that can better manage the volume and standards that we expect.

2.3.10 62 Day Cancer Screening Performance

Achieving the overall 62 day cancer waiting target is a key priority for NHSE London. We have been contributing to this by supporting work to reduce and then eliminate any breaches of people identified through screening programmes being admitting to the relevant treatment pathway within 62 days of the referral being made

Performance Q4 2014/15 –Q3 2015/16

In the last four quarters:

- ***Breast screening performance against target has improved***. This is as a result of NHSE working with breast screening units to develop Cancer Waiting Times (CWT) guidance and patient trackers lists. With the support of the London Cancer Alliance, NHSE and units now routinely monitor all breaches and audit the pathway of all screen-detected breast cancers on a quarterly basis.
- ***Bowel screening performance remains variable***. The first 28 days of the 62d pathway are within the screening programme. There are very few breaches across London during this period. The bottleneck appear to occur post-colonoscopy and after referral to treatment services. The PH commissioning team is working with the delivery team to identify the reasons and consider joint actions to support improvement
- ***Cervical screening performance is good but incomplete***. Approximately 70% of women with screen-detected cervical cancers are not put on the urgent 62 day pathway. NHSE convened a Task and Finish Group which undertook a baseline assessment of current cervical cancer CWT pathways across London. Using the responses from providers, the Group has developed guidance and an FAQ which be circulated to all trusts in March.

Figure 14: 62 day wait, screen detected cancers London

	Q3 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16
Breast	**93.0%**	**89.4%**	**95.5%**	**94.5%**
Bowel	**90.0%**	**75.2%**	**89.2%**	**79.5%**
Cervical	**100.0%**	**93.8%**	**100.0%**	**100.0%**

Screening services and screen detected cancers are not incorporated in many trusts' cancer governance arrangements. The pathway to treatment and general performance and quality have not benefited from the rigorous internal and external monitoring that other urgently referred cancers. NHSE London team are working

with providers and systems resilience fora to support the integration of cancer screening quality and performance with broader cancer governance structures within London trusts. In addition the PH team have instigated a number of practical steps to help Trusts including;

- Implementation of an explicit performance improvement framework with the use of contract levers and joint working with CCGs and PHE Screening QA
- Clinically led pathway redesign and improvement e.g. 62 day waits guidance
- Development of polices, guidelines and protocols
- Improvements in reporting and join up of system e.g. with sample handler error reporting
- Supporting Trusts in terms of integrate governance structures

Our aim for 2016/7 is to minimise if not eliminate 62 day screening cancer breaches.

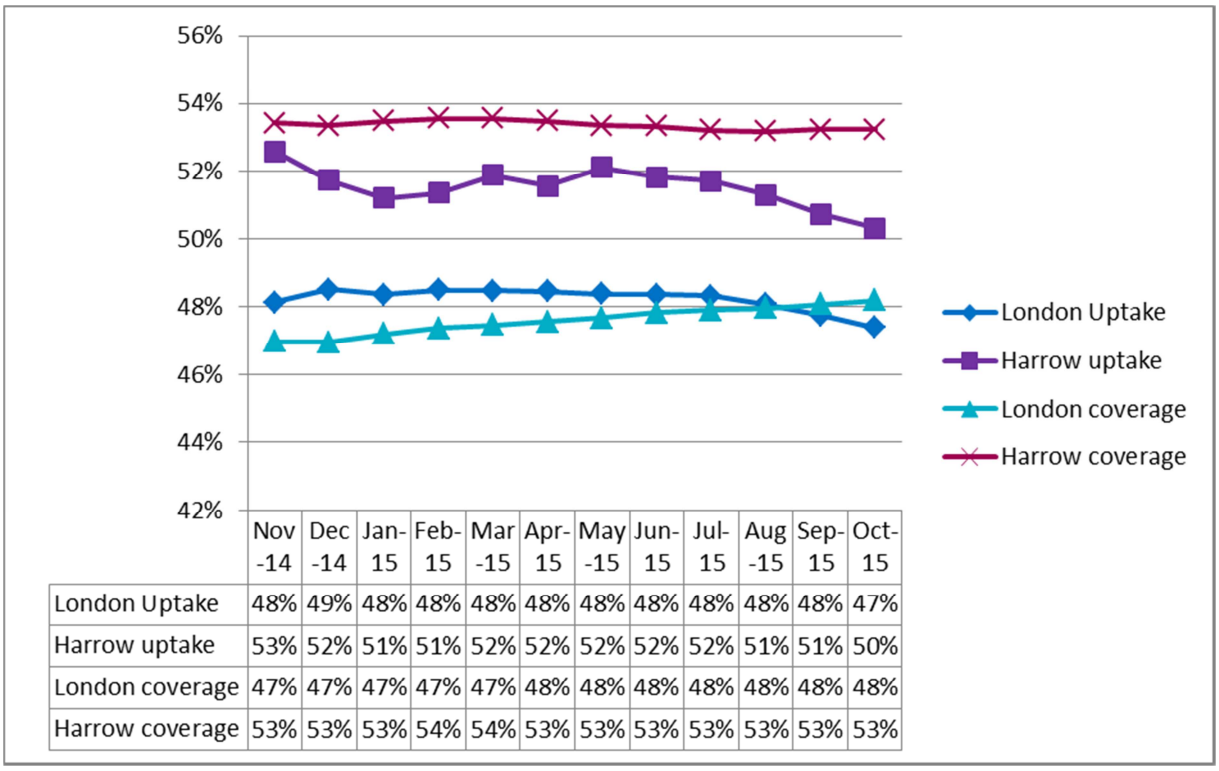
2.3.11 Bowel screening coverage

Between November 2014 and October 2015, Bowel screening coverage in Harrow remained unchanged at 53%. This is significantly higher than the London average of 48%. Uptake has declined by 3%. Monthly bowel screening uptake fluctuates considerably in London, and this is largely due to monthly variations in first time invitees (60 year olds).

London will introduce GP endorsement to the bowel screening invitation letters and enhanced reminder letters in 2016/17. These are highly effective interventions with a robust evidence base.

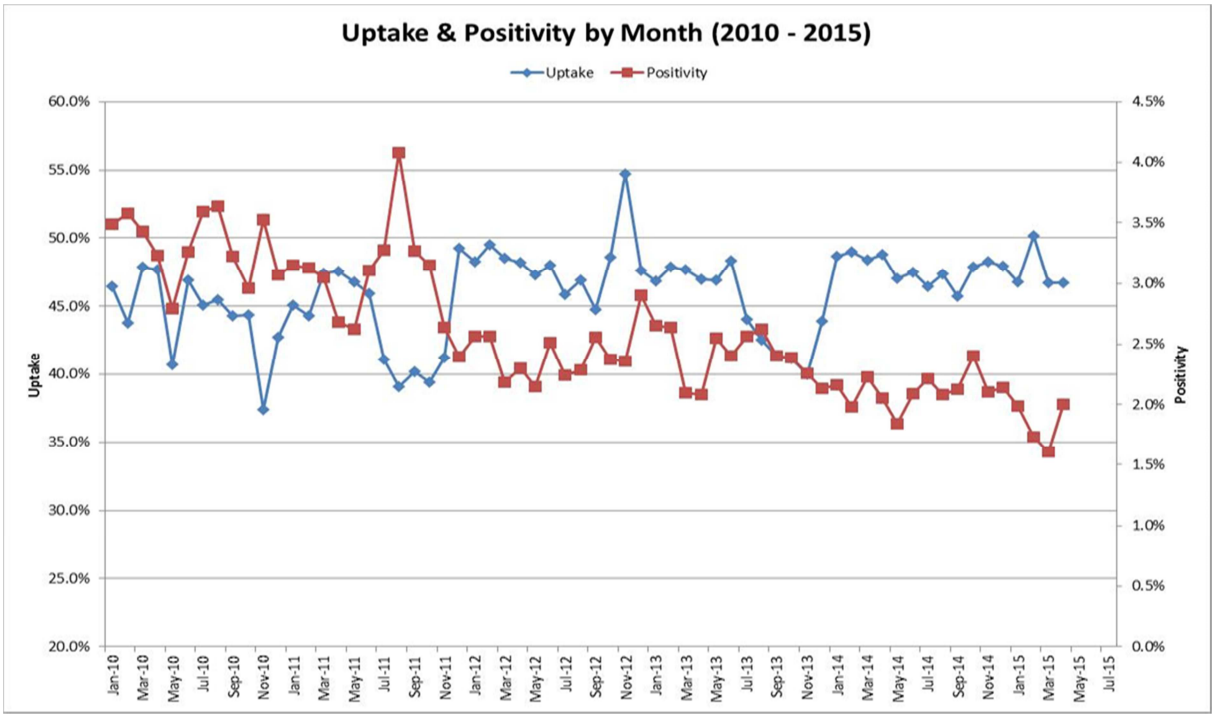
The current bowel screening FOB test will be replaced with faeco-immunochemical testing (FIT) in 2018 subject to agreement nationally. Pilots have shown that FIT has greater acceptability than the current FOB test and therefore results in greater uptake. The London Bowel screening Hub and UCL are undertaking a Randomised Control Trial to assess the impact of texting on uptake.

Figure 15: Bowel screening coverage, 60-74 years, November 2014-October 2015



	Nov -14	Dec -14	Jan-15	Feb-15	Mar -15	Apr-15	May -15	Jun-15	Jul-15	Aug -15	Sep-15	Oct-15
London Uptake	48%	49%	48%	48%	48%	48%	48%	48%	48%	48%	48%	47%
Harrow uptake	53%	52%	51%	51%	52%	52%	52%	52%	52%	51%	51%	50%
London coverage	47%	47%	47%	47%	47%	48%	48%	48%	48%	48%	48%	48%
Harrow coverage	53%	53%	53%	54%	54%	53%	53%	53%	53%	53%	53%	53%

Figure 16: London Bowel screening uptake and positivity, 60-74



2.3.12 Provider performance 2015/16

Royal London North London Breast Screening Service meets or exceeds breast screening performance standards. There was a slight decline in screen to

assessment times in Q1 and Q2 but this improved in Q3. The new breast screening Hub started operation on 1 April 2016 so performance is not available as of yet.

St Marks Bowel screening Service met or exceeded all key performance targets. The centres provides bowel scope screening to all 55 year olds in Harrow, Brent, part of Ealing and part of Hillingdon.

London North West Hospital Trust also hosts the London bowel screening hub.

London North West Hospital *cytology lab* screens cervical samples for Harrow and is one of two HPV testing hub laboratories in London. Laboratory performance is generally good. There was a decline in turnaround times in Q3 due to bank holidays and staff vacancies. This should improve in 2016/17 *Northwick Park colposcopy unit* has met all national performance standards

2.4 Non-Cancer Screening Programmes

NHSE is responsible for commissioning 2 non cancer screening programmes. One for Diabetic Eye Screening which is available to all diabetic patients aged 12 and above. All diabetic patients should be offered an annual eye screen as part of an annual check. The other programme Abdominal Aortic Aneurysm, NHSE commission this for all men aged 65. The programme aims to reduce abdominal aortic aneurysm (AAA) related mortality among men aged 65 to 74. A simple ultrasound test is performed to detect AAA and if an aneurysm over a certain size is found the patient is referred to a vascular service and offered surgery.

2.4.1 AAA Adult Screening

There are currently five AAA screening services in London. NHS England is currently looking at the configuration of these services with a view to procuring to a new model in 2017.

Provider- Imperial

Performance:

Screening uptake in Harrow improved between 2013/14 and 2014/15 and in Q3 of 2015/16 was 81% compared to the NWL sector AAA Programme average of 85%. Harrow is currently achieving the minimum national target of >75%, but remains lower than the achievable target of > 85%. Comparative performance between 2013/14 and Q3 2015/16 is shown in the table below:

Figure 17 Harrow Compared to NWL programme

	Harrow CCG	NWL AAA Programme
Q3 2015/16	81%	85%
2014/15	82%	73%
2013/14	74%	64%

There are two 2 screening venues in Harrow and 12 across the NWL AAA programme area. Men can request to attend any location.

As with all other NHS screening programmes there is a programme of external quality assurance from PHE; the visit protocol for AAA screening has recently been implemented nationally and as yet this programme has not received a formal QA visit.

Challenges for the programme include:

- Maintaining the year on year increase in uptake in 2016/17;
- Workforce recruitment and retention; these are part of the NWL AAA service improvement plan;
- Analysis of men who did not take up their screening offer is in progress;
- Engagement work with GP and Practice nurse and management forums; GP Packs are sent to all practices prior to screening rounds and there is promotional work with local authority health trainers.

2.4.2 Diabetic Eye Screening

NWL Diabetic Eye Screening Programme (DESP)

Following transition, NHSE (London) inherited 17 DES programmes across London. During 2015, NHSE London undertook a procurement exercise to reconfigure the 17 programmes to five, with new contracts starting on 1 November 2015.

The NWL DESP programme covers Hillingdon, Hounslow, Ealing, Harrow, Brent, Hammersmith & Fulham, Kensington Chelsea and Westminster and is provided by Health Intelligence Ltd.

Performance:

As yet, available data relates to the programme prior to its configuration. The data from Q4 for 2015/16 will relate to the reconfigured programme.

DES Programme in Harrow - Q2 2015/16 (prior to transition)

84% of new patients were offered screening within 3 months of referral to programme

Screening uptake was 73% during the quarter. The London minimum target, as defined in the London Service Specification for Diabetic Eye Screening Programmes, is currently 75%, rising to 80% in October 2016

100% of results were issued to patients and GPs within 3 weeks. For London DESP the minimum standard is 90% and the achievable target is 95%.

NWL DESP Q3 2015-16

Data for Q3 is incomplete, due to service transition November 2015; therefore no accurate performance data is available.

Published data shows that uptake across the NWL programme was 83% in Q3, with

99% of results issued to patients and GPs within 3 weeks

Full performance data will be available for Q4.

Challenges include:

Delays to patients' annual screening intervals became evident following transition, completion of data migration and validation. Contributing factors to this delay were:

- Delay data migration due to Information Governance concerns raised by exiting providers led to inherited backlog of patients awaiting screening at transition;
- Identification of 18,666 patients not invited for more than 13 months since their last screening episode , this included invited patients that had Not Attended (DNA) in 2014/15;
- Commencement of GP system data extraction has led to identification of more than 8000 newly identified patients across NWL that have never been screened;
- Data validation highlighted large numbers of patients, who were deceased, moved away or duplicates;
- Workforce training and recruitment required following TUPE of incumbent staff.

The NWL DESP Rectification Plan is on target to address all delays by August 2016, this includes**:**

- Prioritised invitation of newly identified patients and risk stratification according to last date screened;
- Maximisation of appointment slots within existing screening venue clinic location, days and times – with two screeners per clinic;
- Increased use of the existing screening venues clinic – additional days and times over and above those normally in place;

- Recruitment of suitable Optometrist practices to undertake digital retinal photographic screening including evening and weekend screening.

Following the implementation of reminder calls DNA rates have fallen to between 20 and 30% from 50% when the new service was established.

2.5 Conclusions

This report provides a summary on the performance of Section 7a Screening and immunisation programmers in London Borough of Harrow.

Members will note that despite the relatively good performance of Harrow, London in general is not performing well on any of its Section 7a programmers.

This report has set out a number of actions that NHSE, as the responsible commissioners, are taking to address Trust performance issues, problems with access and information etc.

NHSE welcomes the opportunity afforded by London Borough of Harrow and Harrow CCG to support its work to tackle areas of poor performance and to try and ensure that health inequalities and underserved population' s needs are addressed as part of this work.

Table 1 Percentage uptake of HPV for Year 8 girls who completed the HPV course in London for 2014/15 (2 doses) and 2013/14 (3 doses)

Name of Organisation	2014/15 %	2013/14 %
BARKING AND DAGENHAM	83.5	79.2
BARNET	72.6	69.5
BEXLEY	80.5	76.6
BRENT	81.0	81.1
BROMLEY	84.5	86.8
CAMDEN	73.5	77.0
CITY OF LONDON	85.1	85.4
CROYDON	79.2	76.4
EALING	81.3	77.0
ENFIELD	72.7	68.3
GREENWICH TEACHING	79.7	77.6
HACKNEY	64.1	68.2
HAMMERSMITH AND FULHAM	75.1	73.3
HARINGEY	80.5	76.4
HARROW	77.6	83.2
HAVERING	86.3	86.2
HILLINGDON	86.7	86.5
HOUNSLOW	83.5	86.2
ISLINGTON	84.1	87.1
KENSINGTON AND CHELSEA	62.6	78.9
KINGSTON	85.3	81.6
LAMBETH	78.9	80.9
LEWISHAM	73.4	82.9
MERTON	85.4	87.6
NEWHAM	90.9	92.3
REDBRIDGE	79.2	69.2
RICHMOND	76.0	81.8
SOUTHWARK	77.3	85.7
SUTTON	87.7	90.4
TOWER HAMLETS	74.1	75.6
WALTHAM FOREST	73.3	86.8
WANDSWORTH	82.7	79.1
WESTMINSTER	74.7	77.9

Source: PHE (2015)

Table 2 Uptake of Shingles Vaccine for the 70 and 79 age cohorts by London CCG for 2013/14 and 2014/15

CCG	% 70 year olds 2013/14	% 70 year olds 2014/15	% 79 year olds 2013/14	% 79 year olds 2014/15
Barking and Dagenham CCG	51.9	50.2	45.1	51
Barnet CCG	56.1	55.9	55.3	57.5
Bexley CCG	47	53.1	39.8	51.8
Brent	51.8	53.1	50.1	52.5
Bromley CCG	55.6	52.5	57.3	55.4
Camden CCG	50.3	47.6	52.6	47.3
Central London (Westminster) CCG	34.6	33.5	36.7	36.6
City and Hackney CCG	43	40.6	42.5	42.5
Croydon CCG	55.6	53.6	55.1	48.6
Ealing CCG	49.8	42.9	48.4	42.1
Enfield CCG	52	51.2	51.7	52.8
Greenwich CCG	51.4	46.2	48.7	49.7
Hammersmith & Fulham CCG	36.6	33	32.1	29.5
Haringey CCG	47.7	47.5	49.4	46.8
Harrow CCG	**51**	**50.8**	**53.3**	**53.2**
Havering CCG	54.6	50.8	55.1	51.7
Hilllingdon CCG	62	55.8	60.3	59.5
Hounslow CCG	44.6	43.2	44.6	43.8
Islington CCG	51.2	48	45.9	51.8
Kingston CCG	52.6	57.5	56.1	57.7
Lambeth CCG	51.2	42.7	50.1	47.1
Lewisham CCG	49	48	48.5	48.6
Merton CCG	51.1	48.8	54.3	51.2
Newham CCG	60.7	56	59.1	58.3
Redbridge CCG	51.2	47.6	49.4	46.5

CCG	% 70 year olds 2013/14	% 70 year olds 2014/15	% 79 year olds 2013/14	% 79 year olds 2014/15
Richmond CCG	61.8	53.7	59.8	50.9
Southwark CCG	45.5	40.7	46	41.2
Sutton CCG	56.2	58	60.1	59.1
Tower Hamlets CCG	50.9	49.9	56.3	46.9
Waltham Forrest CCG	48.7	46.4	45.5	44.7
Wandsworth CCG	52	51.1	50.5	51.6
West London (K&C & QPP) CCG	42.1	25.6	42	30.8
London	**51.3**	**48.8**	**50.9**	**49.7**
England	**61.8**	**59**	**59.6**	**58.5**

Source: PHE (2015)

Appendix 1: Harrow Cancer Screening practice coverage

Practice Name	Bowel screening Coverage 60-74 August 2015 %	Cervical screening Coverage 25-64 Oct 2015 %	Breast screening Coverage 50-70, Oct 2015 %
ASPRI MEDICAL CENTRE	49.02	65.96	71.50
BACON LANE SURGERY	54.50	66.94	73.10
BELMONT HEALTH CENTRE (E84069)	51.86	65.40	66.14
BRENT & HARROW SAFE HAVEN UNIT	0.00	100.00	0.00
ELLIOTT HALL MEDICAL CTR.	59.57	0.00	76.02
ENDERLEY ROAD MEDICAL CENTRE	55.67	71.42	70.42
GP DIRECT	45.37	64.98	63.46
HARNESS HARROW PRACTICE	49.90	58.64	79.80
HATCH END MEDICAL CENTRE	50.60	60.86	71.65
HEADSTONE LANE MEDICAL CENTRE	45.55	63.85	68.98
HEADSTONE ROAD SURGERY	48.71	57.56	71.35
HONEYPOT MEDICAL CENTRE	48.32	70.20	73.29
KENTON BRIDGE MEDICAL CENTRE DR GOLDEN	53.41	60.99	65.39
KENTON BRIDGE MEDICAL CENTRE DR LEVY	50.31	53.55	72.35
KENTON CLINIC	56.33	58.39	80.47
KINGS ROAD SURGERY	55.72	66.32	71.82
PINNER VIEW MEDICAL CENTRE	58.18	60.73	79.66
ROXBOURNE MEDICAL CENTRE	43.07	67.05	59.15
SAVITA MEDICAL CENTRE	46.05	54.86	58.99
SIMPSON HOUSE MEDICAL CENTRE	54.55	63.35	72.28
ST. PETER'S MEDICAL CENTRE	50.61	61.38	66.67
STREATFIELD HEALTH CENTRE	54.39	64.82	71.43
THE CIRCLE PRACTICE	51.16	57.51	74.39
THE CIVIC MEDICAL CENTRE	46.75	60.82	64.62
THE ENTERPRISE PRACTICE	55.62	63.77	67.92
THE NORTHWICK SURGERY	51.83	63.92	67.94
THE PINN MEDICAL CENTRE	61.84	56.24	78.27
THE PINNER ROAD SURGERY	49.05	69.32	64.68
THE RIDGEWAY SURGERY (E84068)	56.86	56.97	76.00
THE SHAFTESBURY MEDICAL CENTRE	45.55	63.67	69.03
THE STANMORE MEDICAL CENTRE	53.75	63.99	77.80
THE STANMORE SURGERY	51.52	65.41	70.30
THE STREATFIELD MEDICAL CENTRE	47.08	58.43	68.82
WASU MEDICAL CENTRE (Y05080)	38.85	64.61	62.24
ZAIN MEDICAL CENTRE	40.86	58.24	74.89

Appendix 2: KPIs for London by maternity unit Q3 2015/16

	ID1	ID2	FA1	ST1	ST2	ST3	NP1	NB2
	%	%	%	%	%	%	%	%
NC London	**99.8%**	**94.3%**	**98.4%**	**99.8%**	**46.4%**	**95.1%**	**96.4%**	**3.0%**
North Middlesex University Hospital NHS Trust	99.7%	85.7%	96.9%	99.7%	52.6%	89.2%		2.1%
The Whittington Hospital NHS Trust	99.7%	100.0%	97.7%	99.7%	41.2%	100.0%		3.6%
University College London Hospitals NHS Foundation Trust	100.0%	100.0%	99.7%	99.9%	36.1%	96.5%	98.0%	4.7%
Royal Free London NHS Foundation Trust	99.5%	100.0%	99.6%	99.8%	63.1%	99.4%	93.1%	4.1%
Royal Free London NHS Foundation Trust (Barnet)	99.9%	100.0%	98.0%	100.0%	47.9%	92.5%		2.2%
NE London	**99.5%**	**44.3%**	**95.5%**	**99.4%**	**23.1%**	**98.4%**	**90.0%**	**2.7%**
Barking, Havering and Redbridge University Hospitals NHS Trust	100.0%	47.6%	94.5%	100.0%	41.4%	99.1%		2.0%
Homerton University Hospital NHS Foundation Trust	99.5%	55.0%	98.8%	99.4%	14.1%	93.0%	90.0%	4.2%
Barts Health NHS Trust (Newham)	99.9%	15.4%	91.7%	99.6%	31.9%	100.0%		2.4%
Barts Health NHS Trust (Royal London)	98.2%	33.3%	99.0%	98.4%	11.2%	100.0%		4.6%
Barts Health NHS Trust (Whipps Cross)	99.5%	77.8%	95.7%	99.4%	16.6%	100.0%		1.3%
NW London	**99.9%**	**66.7%**	**97.0%**	**99.9%**	**27.0%**	**98.1%**	**95.8%**	**2.0%**
Chelsea and Westminster Hospital NHS Foundation Trust	99.8%	50.0%	98.3%	99.9%	8.0%	92.2%	94.0%	2.5%
Imperial College Healthcare NHS Trust	100.0%	69.2%	95.0%	99.9%	21.1%		96.5%	2.1%
West Middlesex University Hospital NHS Trust	99.8%	100.0%	98.3%	100.0%	55.7%	100.0%		1.3%
London North West Healthcare NHS Trust	99.9%	76.9%	98.0%	99.9%	36.9%	99.8%		2.3%
The Hillingdon Hospitals NHS Foundation Trust	100.0%	41.7%	95.2%	100.0%	16.2%	100.0%	96.8%	1.6%
SE London	**99.8%**	**63.5%**	**99.3%**	**99.9%**	**38.7%**	**97.7%**	**94.6%**	**3.7%**
Guy's and St Thomas' NHS Foundation Trust	99.8%	60.0%	99.5%	99.5%	34.7%	96.4%	91.8%	6.9%
King's College Hospital NHS Foundation Trust	99.9%	52.4%	99.7%	99.9%	37.8%	100.0%		3.1%
King's College Hospital NHS Foundation Trust (PRUH)	99.7%	85.7%	99.8%	99.9%	43.9%	99.9%	98.3%	1.6%
Lewisham and Greenwich NHS Trust (Lewisham)	99.8%	85.7%	98.1%	100.0%	35.0%	96.9%	95.4%	1.4%
Lewisham and Greenwich NHS Trust (QEH)	99.9%	64.3%	99.3%	100.0%	42.1%	95.2%		5.2%
SW London	**99.9%**	**90.5%**	**98.3%**	**99.9%**	**47.9%**	**91.7%**	**92.3%**	**2.5%**
Croydon Health Services NHS Trust	100.0%		99.6%	100.0%	51.6%	99.4%	95.1%	2.9%
Epsom and St Helier University Hospitals NHS Trust	99.9%	100.0%	96.5%	99.9%	51.0%	97.0%		2.9%
Kingston Hospital NHS Foundation Trust	99.9%	71.4%	99.5%	99.9%	53.2%	73.4%		2.1%
St George's University Hospitals NHS Foundation Trust	100.0%	100.0%	98.1%	100.0%	35.3%	99.4%	90.9%	1.7%
Grand Total	**99.8%**	**65.2%**	**97.6%**	**99.8%**	**35.2%**	**96.4%**	**94.5%**	**2.7%**

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

None Required

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Paper

Contact:

Joanne Murfitt,

Director of Public Health Commissioning, Health in the Justice System and Military Health,

NHS England (London Region)

011380 70686

Background Papers: None

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	30 June 2016
Subject:	**INFORMATION REPORT – Walk in Centres**
Responsible Officer:	Javina Sehgal Chief Operating Officer NHS Harrow Clinical Commissioning Group
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary

This report sets out the summary position and progress for the procurement and commissioning progress for Walk in Centres across the borough.

FOR INFORMATION

Section 2 – Report

Outcome of Walk in Centre Procurement:

The following report provides an update to the Health and Wellbeing Board on the progress of the Harrow CCG intention to commission three GP Access Walk in Centres (WiC) across the borough. These services will provide urgent care seven days a week between the hours of 8am-8pm at the following hub locations:

- Pinn Medical Centre
- Alexander Avenue Health and Social Care Centre
- Belmont Health Centre

Further to the competitive, open procurement process that was undertaken between February and April the process resulted in the successful selection of providers for two of the Walk in Centres:

Pinn Walk in Centre; The Pinn Medical Centre was selected as the preferred provider to deliver GP Access Walk in Centres Walk in Centre services and the contract award for Implementation In August 2016 is underway, the Walk in Centre will remain located at the Pinn Medical Centre, where the service currently resides.

The Walk in Centre at Alexandra Avenue Health and Social Care Centre; The Ridgeway Surgery was selected as the preferred provider to deliver Walk in Centre services and the contract award for implementation in August 2016 is underway. Alexandra Avenue Health and Social Care Centre is where the existing Walk in Centre is located.

Proposals to implement and deliver a third Walk in Centre in the East of the Borough unfortunately did not meet the core criteria of the service specification and as such, a preferred provider was not selected.

The Pinn Medical Centre and the Ridgeway Surgery are the incumbent providers of each respective Walk in Centre, therefore continuity of service and a smooth transition of contracts is anticipated.

Both of the new Walk in Centre services will be processed according to the NHS Standard Contract and service specifications will be common for both centres.

Section 3 – Further Information

As the initial procurement process did not successfully select a preferred provider to deliver a Walk in Centre service in the East of the borough, the CCG has instigated a further process with the intention of appointing a provider.

The Walk in Centre will be located within the Belmont Health Centre and the service specification will replicate those commissioned in the two Walk in Centres.

Procurement for this process has begun and is now in the public domain for interested providers.

It is anticipated that the new service at Belmont Health Centre will commence in November 2016, this remains the same as the previously planned and implementation is not delayed.

Section 4 – Financial Implications

The Walk in Centres that have been commissioned for Harrow are being commissioned within the financial parameters of the budget envelope and as was specified within the invitation to tender documentation.

The further procurement process being undertaken to deliver a Walk in Centre at Belmont Health Centre is anticipated to be delivered within the budget envelope that was originally planned.

Section 5 - Equalities implications

An Equality Impact Assessment was undertaken and was detailed in the original report to the board.

NHS North West London Five Year Strategy:

The eight North West London CCGs have developed and agreed a five year strategic plan which outlines five strategic objectives. These are:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports)

Not required

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Adam Mackintosh, Integrated Urgent Care Lead, Harrow CCG

Background Papers: None

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	30 June 2016
Subject:	**INFORMATION REPORT – Future In Mind Update**
Responsible Officer:	Sue Whiting, Assistant Chief Operating Officer, Harrow Clinical Commissioning Group
Exempt:	No
Wards affected:	All
Enclosures:	Harrow Future In Mind Update

Section 1 – Summary

Harrow Future in Mind transformation plan was formally agreed at the Harrow CCG Governing body and Health and Wellbeing Board in October 2015. This report is to update the Boards on the work that has been underway since this time and the next stage of planning going forward.

FOR INFORMATION

Section 2 – Report

Harrow CCG continues to work collaboratively with Harrow Local Authority and other key stakeholders to deliver Harrow's local Future in Mind priorities, of which the main priority is for a joint emotional health and wellbeing service for children, young people and their families.

The key millstones achieved to date are:

- Harrow Project Manager- to implement local priorities
- Harrow Engagement Lead- to implement local priorities and engage with local stakeholders and population
- Local Pilot project to support the joint Emotional Health and Wellbeing Targeted Service consisting of 3.5wte delivering in selected Harrow schools.
- New Community Eating disorder service- Joint Harrow, Brent, Hillingdon, Central and West London CCG commissioned- CNWL providing

The slides attached offer more detail on these milestones and the next steps to achieve our priorities for Future in Mind in Harrow and across NW London.

Section 3 – Further Information

A further update of the project plan and service model will follow, along with further update reports.

Section 4 – Financial Implications

Not applicable for update report.

Section 5 - Equalities implications

Not applicable for update report.

Section 6 – Council Priorities

By its nature and intent the Future in Mind Plan supports the following corporate priorities:

- 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 required

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Jessica Thom, Integrated Children's Commissioning Manager, Harrow CCG. 020 8966 1048

Background Papers:

- Future in Mind Harrow Transformation plan

http://www.harrow.gov.uk/www2/documents/b19790/Supplemental%20agenda%20Wednesday%2014-Oct-2015%2012.30%20Health%20and%20Wellbeing%20Board.pdf?T=9

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CAMHS: Harrow Future in Mind Update

31st May 2016

Author	Jessica Thom
Clinical Lead	Genevieve Small
Senior Lead	Sue Whiting
Commissioning lead	Jessica Thom
Project Manager	Lizzie Streeter

Future in Mind

NHS Harrow Clinical Commissioning Group

- In March 2015 the government published Future in Mind, their strategy for promoting, protecting and improving children and young people's mental health and wellbeing. This was attached to local funding
- Harrow CCG Governing body & Health & Wellbeing Board approved the NWL Future in Mind plan in October 2015
- NHSE Approved the NWL Future in Mind & Harrow Future in Mind Plan December 2015
- NHSE Future in Mind Funding for Harrow CCG to deliver the plan is recurrent until 2020
- Harrow's Local priority is to develop an integrated Emotional Health and Wellbeing Targeted Service
- This will be an early intervention/prevention provision, targeted at children and young people with an identified need, including Children Looked After, children and young people with challenging behaviour, bereavement, life events, school exclusion, OCD, learning difficulties with eating/sleeping, ADHD and ASD

Future in Mind	Funding for Harrow CCG
Transformation funding allocation	£304,840
Eating Disorder funding allocation	£121,785
Total	£426,625

NW London Future in Mind Priorities are:

NHS Harrow Clinical Commissioning Group

- **Supporting Co-Production:** Improving communication with the public utilising young people friendly communication processes and focussing on mental health promotion, information about services and conditions and peer support
- **Training:** For the workforce, professionals, parents working with/ with CYP with mental health needs
- **Community Eating Disorder Service:** A new service for Harrow CYP with an eating disorder or associated need
- **Transforming Pathways:** An integrated pathway of care for CYP in Harrow, including transition and the development of A joint Emotional Health and Wellbeing Targeted Service: Offering open access for Harrow CYP with an identified need. Working to target identified vulnerable CYP in Harrow such as: Children in Need, Children Looked After, and CYP with challenging behaviour, bereavement, life events, school exclusion, OCD, difficulties with eating/sleeping, Learning difficulties, ADHD and ASD. Our ambition is to increase the transition age up to 25years
- **Developing an integrated pathway:** For Learning difficulties, ASD and ADHD
- **Crisis and Urgent Care Pathways**: development of crisis care pathways and capacity. Challenging behaviour: Developing early intervention provision for personality disorder

Future in Mind Update

NHS Harrow Clinical Commissioning Group

Key milestones:

Activity	Date
Full time **Project Manager** for Harrow FiM	From April 2016
Full time **Engagement lead** for Harrow FiM	From April 2016
New Community Eating disorder service 'Live'	From April 2016
Pilot project Harrow (incl Learning disabilities) : selected providers and schools/GP practices	May 2016
CAMHS **Out-Of-Hours Liaison Pilot** working well & being evaluated in July 16	From Jan 2016
Developing the **CAMHS Crisis pathway-**	On-going
Developing a NW London **CAMHS Single point of access SPA**	On-going
NW London CAMHS pathway and **training needs analysis & review of CAMHs Tier 3 pathways** across NW London underway (Anna Freud Centre)	March 2016
Research, development and scoping underway for **Harrow joint service**	April 2016
Draft **service and cost modelling underway**	May 2016
Engagement with key stakeholders (schools, health, social care, parents, children & young people)	April 2016

Engagement/ service update

NHS Harrow Clinical Commissioning Group

New Eating disorder service	• Patients within CAMHs have been transitioning into new service • New service will allow professional and self-referral
CAMHS OOHS Nurse Pilot	• Team of 8 qualified nurses to cover • Chelsea and Westminster Hospital • St Marys Hospital • Northwick Park Hospital • Hillingdon Hospital Has been fully operational since 4 January 2016 • 44 CYP have accessed this pilot since launch and 1 CYP was admitted to hospital
Four Harrow **GP Peer Groups** attended	
Parents workshops held at; Cedars Children's Centre and Kingsley Special School	
Children and young people's workshops; Canons School (Year 9's), Civic Centre, Harrow college and 'Beyond Limits' children looked after youth group	
Regular **newsletter** with project updates to be circulated to all stakeholders	

Engagement update

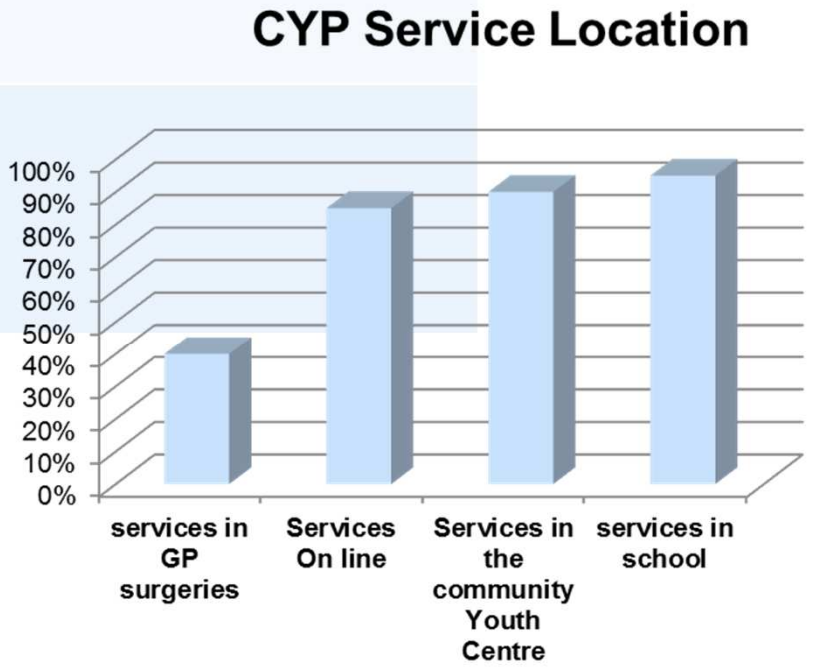
NHS
Harrow
Clinical Commissioning Group

Emerging feedback themes from engagement events

- **Professionals (children's social care, education, health, voluntary sector, GP's)**
- Golden Number
- Reduced waiting times
- Sign posting CYP appropriately
- Better communication with multi-agency working (confidentiality)

- **Parents**
- Holistic and creative therapies
- Access to Community based service
- Home therapies (outreaching)
- Training and information for parents to monitor CYP developmental stages (early intervention)

- **Children and young people**
- Youth Centre based service
- Counsellors in school and mentors outside
- Awareness and training for Parents
- Teaching all CYP resilience



Harrow Pilot ;Emotional Health and Wellbeing Service

- Providers were invited to put forward a proposal bid
- Four proposals were received and evaluated (joint panel – CCG and Local Authority)
- The **Brandon Centre** was the chosen provider for the mainstream schools pilots - providing one Clinical psychologist (Band 8A) and one Clinical psychologist (Band 7)
- **CNWL** was the chosen provider for the special schools pilot – one Clinical Psychologist (Band 7) and one Assistant Psychologist (Band 5)
- Schools put forward expressions of interest to be pilot sites
- Expressions of interest were received from **all school clusters**
- A panel of the CCG, Local Authority and providers met to select the schools for the pilot – the outcome was:
  - **Alexandra Primary and Shaftesbury High School (special schools pilot),**
  - **Central Harrow Cluster (mainstream pilot)- Belmont Primary School, Elmgrove Primary School, Norbury Primary School, Whitefriars Community School & Harrow High School**
- Recruitment underway and pilot will launch in **July 2016**

Project Scoping

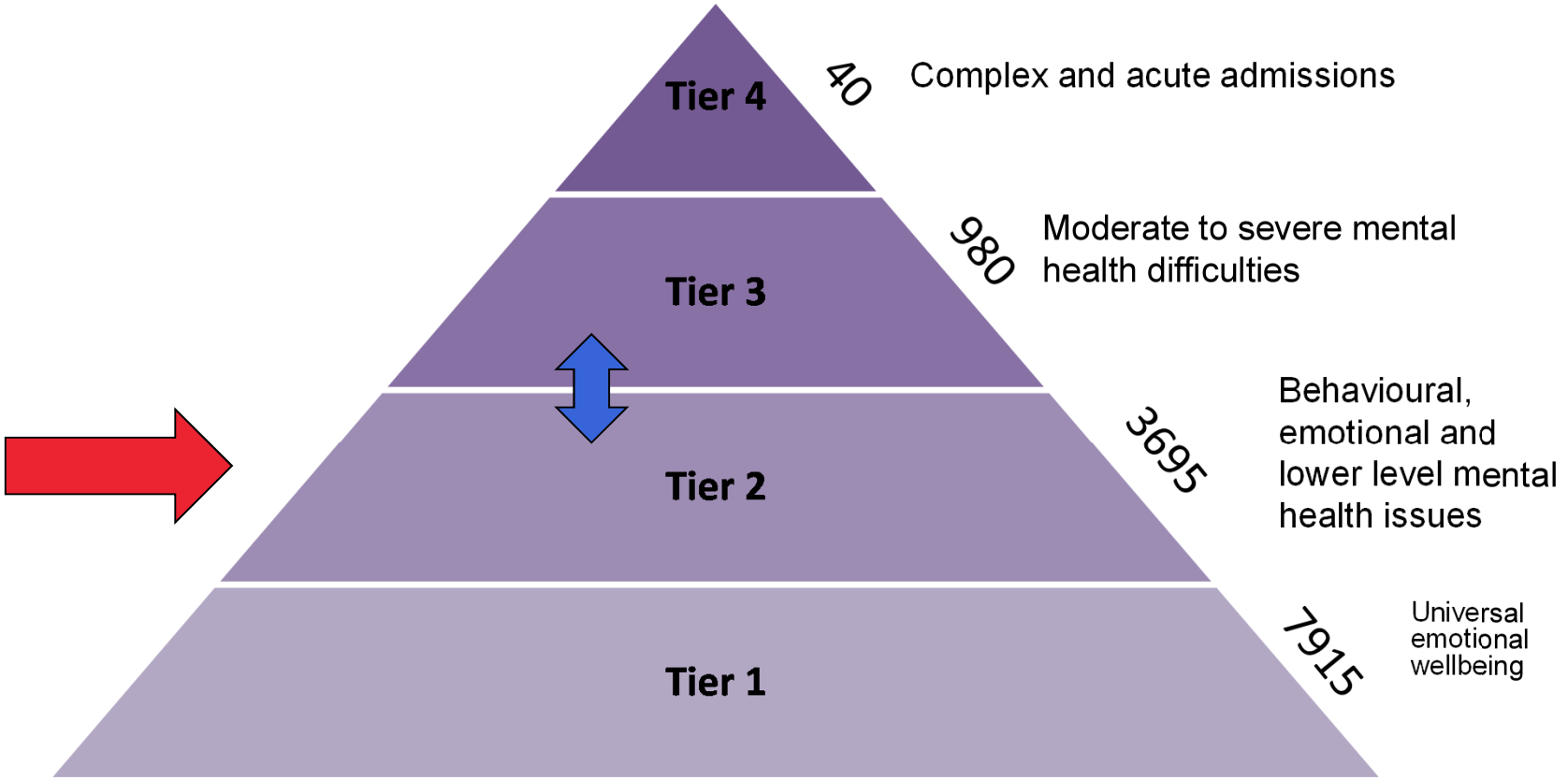
NHS Harrow Clinical Commissioning Group

- Initial scoping of the **joint emotional health and wellbeing targeted service** for Harrow Children and young people is underway
- The service will be:
  - Needs led; short- medium intervention
  - Targeted intervention to prevent escalation of needs
  - An innovative and sustainable model
  - Emotional health wellbeing reliance building for Harrow's CYP & families

- The outcome of the pilot will help inform the types of interventions available in the service model
- The following slide details the scoping, analyse and timeline of the project

		Apr-16				May-16				
Ref	Task	4	11	18	25	2	9	16	23	30
[Phase 1] Scoping and Planning										
Needs Analyse	Map current demand for tier 2/ preventable demand for tier 3 - desk based research and data request to schools plus current demand on Tier 3/4 CAMHS - to identify projected demand. Analyse type and volume of demand - needs, referral routes etc.									
Benchmarking	Desk-based research into tier 2 models in other areas									
Scoping of model	Clarify what is the scope of the model with all stakeholders									
Setting aims & objectives for the service	Visioning exercise with key stakeholders (linking to outcomes)									
Available joint funding	Survey to schools re: current spend on mental health provision. Plus formalise financial commitment from LA.									
Setting outcomes	Develop outcomes with the schools, building on the pilot outcomes and children and young people's views									
3 option model designs	Modelling of different options									
Cost analyse	Cost benefit analysis to include: costs, efficiencies, benefits (ecnomic, social), benefit/cost ratio									
Business case	Produce business case to include: strategic case, economic case, commercial case, financial case, management case									
Draft Service Specification	Following approval of the business case									

Needs analysis for Harrow



Date source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al 2004

Next Steps

NHS
Harrow
Clinical Commissioning Group

- Pilot launches in July 2016
- Continual monitoring & feedback from the pilot
- Revise project/ procurement timeline
- Presentation and agreement on service model
- Agreed investment and timeline from stakeholders for service
- Business case presented to Harrow CCG Governing Body and Health and wellbeing board

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	30 June 2016
Subject:	**INFORMATION REPORT – Better Care Fund Update**
Responsible Officer:	Bernie Flaherty, Director of Adult Social Services
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary

This report sets out progress on the Better Care Fund for Quarter 4 2015/16.

FOR INFORMATION

Section 2 – Report

This report provides an update on progress made for the 4th quarter of the year 2015/16.

The agreed value of the Better Care Fund in Harrow is £14.373m, £1.190m of which reflects the continuation of historic capital funding in relation to Disabled Facility and Community Capacity Grants. The balance of £13.183m is allocated to three agreed schemes.

A section 75 agreement between the Council and the Clinical Commissioning Group (CCG) is in place to underpin the agreement.

The BCF agreed 3 schemes.

1. Whole Systems Integrated Care Programme - £3.023m

This included the expansion of the Integrated Care Pilot (ICP) to provide an end to end case management service, together with the roll out of multi-disciplinary teams to provide personalised long term care and support for individuals at high risk of hospital admission, beginning with older people with one or more long term condition. The success of the pilot has resulted in the scheme being rolled out across the borough.

2. Transforming Community Services - £4.749m

This included better aligning CCG community services to primary care, aligning CCG Short Term Assessment, Reablement and Rehabilitation Service (STARRS) better with community care, establishing a single point of access to community services and the CCG redesigning the pathway for the urgent assessment of mental illness with a focus on avoiding acute admissions and delivering care in community setting.

Through the re-commissioning and re-configuration of community services, services provided in the community will be better aligned with GP practices and the range of services provided will be increased. The CCG has re-tendered its community services contract to deliver a more comprehensive integrated care model that supports Whole Systems Working and supports the delivery of Whole Systems Integrated Care. The contract award was made in December 2015 and the new service provided by Central London Community Healthcare (CLCH) went live on May 4th 2016.

3. Protecting Social Care - £5.411m

To ensure social care provision, essential to the delivery of an effective, supportive, whole system of care is sustained. The scheme includes access and assessment from the acute and community sector, a Reablement service, a diverse range of services to meet eligible needs through personal budgets and comprehensive and effective safeguarding and quality assurance services, including support to carer's.

The council continues to maintain the services meeting its performance output and outcomes. It should be noted that the Quarter 4 national indicator for reablement show that 77% of all clients completing reablement in Harrow were still living independently 91 days after discharge. This is the third highest in London. It is also encouraging to note that the number of social care clients reporting being satisfied has continued to increase for Quarter 4 reflecting the quality of services local people receive.

National Conditions

The BCF plan continues to deliver the national conditions as set out by NHS England.

1) Protection of social care services

2) 7 day services to support patients being discharged

3) Data sharing – The NHS number being used as the primary identifier for health and care services and appropriate agreements in place. To date a target of 85% of matching NHS numbers have been achieved

4) Joint assessments and lead professionals in place for high risk populations

5) Agreement on the impact of changes with the acute sector

NHS England quarterly monitoring

The 16/17 BCF Plan seeks to consolidate the work done in 15/16 and to build upon this. Harrow is also a member of the London ADASS, BCF Peer Network which regularly meets to review national policy updates and planning guidance.

Sustainability and Transformation Plan

In December 2015, NHS England published '*Delivering the Forward View: NHS planning guidance 2016/17–2020/21'.* The guidance states that health

and social care are required to develop a Sustainability and Transformation Plan (STP) which has a shared vision with the local community. The better care fund will make strategic links with the STP. The STP is currently in development with officers who lead on the BCF inputting into the planning document.

Section 3 – Financial Implications

Both the Council and CCG continue to face significant financial challenges, making decisions around the allocation of the BCF funding challenging.

In July 2015, Cabinet received a budget planning process update report which reaffirmed the total budget gap of £52.4m over the three year period 2016/17 to 2018/19 and in February 2016 the Council approved the final revenue budget for 2016/17 and Medium Term Financial Strategy (MTFS) for 2016/17 to 2019/20. The 2016-17 budget noted that £6.5m would be received from the BCF as indicated by the HWBB in January 2015.

The CCG submitted the first draft of the operating plan at the beginning of February, which indicated a deficit in 2016/17 and which was not compliant with NHS business rules (namely a deterioration in the year on year position; achieving a 1% cumulative reserve; and holding 1% of allocation un-committed at the start of the year). The CCG is undertaking further work on the plan to address the gap within the plan, mitigate the risks identified and establish the full impact of the requirements of the planning guidance.

Financial models to support the development of the local and NWL STP are being jointly developed by CCG CFOs. These plans are expected to assist in contributing to and achieving financial balance for health budgets. These plans will be presented as they are developed for consideration and approval through the relevant governance processes (CCG & LA), to ensure that any proposals can be delivered within the existing MTFS and financial plans.

Council and CCG officers have agreed a contribution of £6.558m to enable the national condition for the protection of social care funding to be met for 2016-17 and will be supported by a s75 agreement. This agreed figure is consistent with that noted as part of the Council budget setting process

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports)

Name:Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 14/06/16.		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Jon Manzoni Head of Strategic Commissioning 07976207251

Background Papers: None

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	30 June 2016
Subject:	**Harrow Physical Activity and Sports Strategy 2016-20**
Responsible Officer:	Dr Andrew Howe, Director of Public Health, Harrow Council
Public:	Yes
Wards affected:	All
Enclosures:	Active Harrow – physical activity and sports strategy 2016-20

Section 1 – Summary and Recommendations

This report sets out the strategic priorities to increase levels of physical activity and sport in Harrow with particular focus on those groups more prone to physical inactivity and the ill health this brings. The strategy has been developed in partnership with Sport and Leisure, Traffic and Highways and has produced an action plan based on effective approaches.

Recommendations:

The Board is requested to:

- Endorse the report
- Increase personal levels of physical activity and act as champions in work and home setting
- Support a campaign launch later in the year
- Support further stakeholder engagement
- Consider other strategic opportunities to encourage residents to be more active making physical activity an integral part of policy, planning and commissioning across departments and cross sector.

Section 2 – Report

Half of all adults in Harrow are not doing the minimum amount of activity recommended (150 mins a week) and 1 in 3 are classed as inactive (doing less than 30 mins activity a week). Harrow has higher proportion of inactivity compared to the national and London average. This is not just an inconvenience – inactivity is responsible for 1 in 6 deaths in the UK which makes it as dangerous as smoking[1]!

It is also a financial threat to all public and voluntary sector bodies serving Harrow residents as without action, more people could become dependent on GPs, hospitals, home, nursing and residential care given the association with long term conditions, poor mental health and disability. Getting more people more active will pay dividends not just for health and social care but for children's educational achievement, workplace productivity and absenteeism, crime and antisocial behaviour. More pedestrians will keep our high streets alive and will keep us connected with others, improving social cohesion and reducing isolation. To achieve all these benefits, different parts of the system all need to play their part, working together and acknowledging that there is not a one-size fits all approach, especially in a diverse borough like Harrow. Whilst many of the levers to influence physical activity fall to Harrow Council, Harrow CCG can also play a part by encouraging physical activity in the workplace – both at 'The Heights' but also by encouraging commissioned providers to prioritise health and wellbeing of employees, for example by signing up to the London Healthy Workplace Charter. There is also considerable benefit in health professionals using every opportunity to promote physical activity.

We know older people, women, certain BME groups, those with disabilities and those on low income/living in more deprived areas of Harrow are much more likely to suffer the consequences of inactivity. These are some of the groups the strategy prioritises reaching. The good news is we can do something about this inequality. There is a 3 year difference in life expectancy between those doing the minimum and those completely inactive so if we focus on the most inactive, we can close this life expectancy gap.

This strategy has been developed jointly with teams in the Council leading on sports, travel planning, regeneration and parks/open spaces. This is important given the action needed is not just behaviour change but whole system environmental change which makes physical activity a normal part of everyday life. The strategy is an opportunity to draw new money into the borough as well as empower residents to do more for themselves and each other.

We appreciate there are many other relevant stakeholders we need to engage. Once endorsed by the Health and Wellbeing Board, the working group will engage with wide ranging stakeholders across the borough and it is anticipated that the action plan will grow as more opportunities for collaboration are identified.

[1] Everybody Active Everyday (2014). Public Health England.

Reports will be submitted on the progress of the strategy from the Harrow Physical Activity and Sports Implementation Group which will be overseen by the Physical Activity and Sports Steering Group. This group will report on the strategic action plans and these will be used to develop operational plans. Progress reports will be brought back to the Health and Wellbeing Board on an annual basis.

Financial Implications/Comments

The strategy does not identify any specific resource requirements and any recommended actions arising from the implementation of the strategy will need to be delivered within existing budgetary provision on an ongoing basis.

The Public Health grant is currently ring fenced until March 2018, with future funding subject to consultation around a business rate retention model. The annual budget process will determine the level of available funding in future financial periods.

Increasing physical activity is not a quick win, more an issue that requires long term sustained action. There is a risk that if existing funding arrangements for the partners named in this strategy are reduced significantly, it will not be able to fulfil the aims and objectives set out in this strategy and implement the actions identified.

Legal Implications/Comments

The terms of reference of the Health and Well Being Board include:
To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social wellbeing.

Risk Management Implications

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

Equalities implications

Was an Equality Impact Assessment carried out? Yes

The strategy is focused on improving access to physical activity opportunities for vulnerable groups and initiatives will be tailored and targeted accordingly. The action plan identifies some of the indicators which will be used to measure success but further work is planned to ensure robust and ongoing evaluation.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

Please identify how the report incorporates the administration's priorities.

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

- The strategy outlines an approach to improve Harrow as a place making opportunities for being active easier. It highlights the need to ensure that our planning, transport and regeneration programmes promote and encourage active lives from the moment our residents step out of their front doors with pleasant and safe spaces for walking, cycling, exercise and social activities.
- The focus of the strategy is to ensure that groups within Harrow who have a higher risk of physical inactivity and the resulting health impacts have improved and better opportunities for being active
- A consultation with the identified vulnerable groups has been undertaken and an on-going dialogue will be maintained through implementation
- Specific work has been undertaken to engage with parents and children and schools have been highlighted as a priority group and this has been addressed in the subsequent action plan
- The cost of inactivity to LB Harrow is £16 million.[i] Health cost of inactivity in Harrow is estimated to be £4.0 million. Sports and active recreation adds an economic value of £121.4m in improved quality and length of life plus health care costs avoided. It brings in jobs and opportunities for volunteering.
- There will be support for businesses and the workplace is a key setting identified to promote physical activity and to realise the health benefits of a more active workforce

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

Name: Donna Edwards Date: 27 May 2016		x	on behalf of the Chief Financial Officer
Name: Sharon Clarke Date: 26 May 2016		x	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO** .

Section 4 - Contact Details and Background Papers

Contact: Sarah Crouch, Public Health Consultant, 020 8736 6834

Background Papers: None

References

[i] http://www.ukactive.com/turningthetide/pdf/Turning%20the%20tide%20of%20inactivity.pdf

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Active Harrow

Harrow Physical Activity and Sports Strategy 2016-20

More people more active, more often in a simple, affordable and fun way

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Acknowledgements

Authors

Ferhat Cinar, Health Improvement Officer, Public Health, Harrow Council

Sarah Crouch, Consultant in Public Health, Harrow Council

Anna Kirk, Senior Health Improvement Specialist, Public Health, Harrow Council

Contributors

Leah de Souza-Thomas, Knowledge Manager, Harrow Council

Laura Waller, Health Improvement Officer, Public Health, Harrow Council

Andreas Lagos, Public Health Strategist, Harrow Council

Tim Bryan, Service Manager – Libraries Sport and Leisure, Harrow Council

Harvinder Singh, Sports Development Officer, Harrow Council

Marianne Locke, Programme Director, Cultural Regeneration, Harrow Council

Annabelle Fosu, Travel Planner, Harrow Council

Kerry Edens, Travel Planner, Harrow Council

David Corby, Head of Service, Regeneration, Harrow Council

Carol Yarde, Interim Business Manager, Public Health, Harrow Council

Patricia Johnson, Business support & Contract officer, Harrow Council

Mobashar Mahmood, Everyone Active

Jemima Morris, London Sport Harrow Council Relationship Manager

Femina Makkar, London Sport Physical Activity & Health Manager

Clare Brown, Primary PE Consultant, HSIP

Foreword

Active people in an active environment

Inactivity costs lives and resources. Half of all adults in Harrow are not meeting minimum required level of physical activity guidelines set by Chief Medical Officer (CMO)[i], and three in ten are inactive. Inactivity increases the risk of developing chronic illnesses such as heart disease, diabetes and shortens the lifespan by three to five years[ii]. The cost of inactivity to health services is estimated as £4.0 million[iii] and the cost to the London Borough of Harrow is estimated to be £16 million.[iv] But we can turn the tide.

In Harrow, we want to provide the right environment, facilities and be active role models for our local community. We want to improve our environment, so we have open and green spaces, and leisure facilities that are accessible and conducive to being active no matter what your age. We want to ensure that our planning, transport and regeneration programmes promote and encourage active lives from the moment our residents step out of their front doors with pleasant and safe spaces for walking, cycling, exercise and social activities. We want to ensure that frontline staff is trained in skills to promote activity with their contacts.

We intend to focus particularly on increasing activity among those doing the least. People living in pockets of deprivation in south, east and central Harrow have less access to access to quality green space and facilities. Unemployed, people on low incomes, people with physical or learning disabilities, mental health problems, Long Term Conditions (LTC), Black Asian and Minority Ethnic (BAME) and refugee groups, women, older people, carers have multiple barriers which may prevent them being active. More intensive efforts are needed to bring about environmental and social changes that are conducive to the needs of these groups.

Let's take a small step to be active, make it simple, fun and part of our daily routine. Being active is good for our health, wellbeing and our economy. Even as little as 10 minutes of moderate activity can help people gain considerable improvements in their health and wellbeing. Our message is simple: We will make it easier for people to be active and empower residents to make the active choice, reduce sedentary periods, do few stretches, walk and use the stairs instead of lifts which can be an easy first step towards being more active.

Councillor Sachin Shah
Leader of Harrow Council

Executive summary

Aim	Support people who are not doing any activity into doing some and those doing some activity into doing more	
Objectives	1. Reduce inactivity in priority groups by increasing awareness of the opportunities available and addressing the barriers to participation 2. Increase participation in sport and physical activity in priority groups by improving the accessibility, range and quality opportunities for sport and physical activity. 3. Increase opportunities and awareness for Harrow Council staff to be active 4. Improve the degree to which Harrow as a place supports residents to be active as a routine part of daily life 5. Work in partnership with stakeholders to make the best use of resources and attract new funding into the borough	
The public health importance of physical activity	• Physical activity is a significant risk factor for heart disease, diabetes and MSK conditions • Inactive individuals have three times the rate of moderate to severe depression of active people • Without a focus on physical activity, obesity rates will continue to rise • As little as 10 minutes moderate to vigorous activity a day can reduce the risk of heart disease and diabetes • Inactivity is responsible for 1 in 6 deaths in the UK which makes it as dangerous as smoking • There are considerable inequalities with older people, women, certain BME groups, those with disabilities and those on low income/living in more deprived areas of Harrow much more likely to suffer the consequences of inactivity. • Cost effective interventions are available – e.g. walk programs £6-7 return for every £1 invested	
The issue in Harrow	• Harrow has higher rates of inactivity than London and England average • Harrow has lower rates of sport and active recreation than other London boroughs • 1 in 3 adults in Harrow are inactive (less than 30 mins activity per week) • 1 in 2 adults are not meeting minimum required level of physical activity guidelines set by Chief Medical Officer (less than 150 mins per week moderate activity or 75 mins vigorous) • Two thirds of adults are obese • Almost a third of pupils stop participating in PE and sport when they start secondary school. A further third stop by year 10 and 11. • Six out of ten people who are inactive wants to do more activity • Inactivity costs health sector £4m and the local authority £16m.	
Risk factors	• Deprivation, Low income and unemployment • Lack of access to green and open spaces • Safety issues • Barriers regarding age, gender and ethnicity • Barriers for people with mental health problems, disabilities and Long Term Conditions • Obesity • Workplace related barriers – flexibility issues, facilities, workload, sedentary work	
Protective factors	• Well maintained, multi functional and safe open and green space • Conducive environment and infrastructure for active travel • Affordable leisure services • Targeted physical activity programs for priority groups • Healthy workplaces promoting physically activity • Living wage	
Groups disproportionately affected by physical inactivity - our priority groups	• Low income and unemployed • People living in deprived areas • Women • Older people • Carers	• People with mental health problems • People with disabilities • People with Long Term Conditions • BEMA and refugee communities
What impact will our action (outlined on p.22) have on Harrow residents?	• More people will take up active travel, walk and cycle more, particularly those from priority groups and Harrow Council staff • More people access leisure services • More people from priority communities will take up sport • More people will access parks, green spaces and growing areas	

Introduction

Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport[v].

We are getting less and less active. This is true globally, in the UK and in Harrow. Increasing car use for transport and desk based jobs make it harder to change this trend. Inactivity contributes to poor health outcomes and is increasingly a burden on public resources. We need to build a momentum with joined up effort to change this trend and make physical activity an integrated and habitual part of our daily lives. Local authorities are ideally placed to harness the potential of synergies with *sustainable transport plans; application of planning rules to benefit healthier lifestyles; use of green spaces and other opportunities for physical activity and sport.*

Figure 1 - Government guidelines for minimum amount of physical activity[vi]

<table>
<tr>
<td>Under 5s
 
Children capable of walking unaided should be physically active for at least 180 minutes (3 hours) daily.</td>
<td>Children & Young people
(5-18 years)
 
Should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours daily</td>
</tr>
<tr>
<td>Adults (19-64 years)
 
Should aim to be active daily with moderate intensity activity adding up to 150 minutes (2.5 hours) per week or 75 minutes of vigorous activity per week.</td>
<td>Older adults (65+ years)
 
Should aim to be active daily, a week of moderate intensity activity should add up to 150 minutes (2.5 hours). Regular exercisers should aim for 75 minutes of vigorous activity per week</td>
</tr>
</table>

The government's recommendations for physical activity are based on the "life-course" approach, which reflects our different needs at different stages of life. The guidelines have also shown that a shorter session of activity, from as little as 10 minutes of moderate to vigorous activity a day, can reduce the risk of heart disease and type 2 diabetes.[vii]

Why do we need a physical activity strategy for Harrow?

- *Physical activity is good for a healthy, happy life*

Evidence shows that *physical inactivity and being sedentary* is a significant, independent risk factor for a range of long-term health conditions such as heart disease, diabetes, musculoskeletal, poor mental health and overweight.[viii] *Being active* has been shown to reduce the risk of an early death, heart disease, diabetes, high blood pressure, improve mental health. It can also contribute to educational achievement, support people being independent and contributes to environment through sustainable transport.

- *It is cost effective and good for the economy*

The cost of inactivity to LB Harrow is £16 million.[ix] Health cost of inactivity in Harrow is estimated to be £4.0 million. Sports and active recreation adds an economic value of £121.4m in improved quality and length of life plus health care costs avoided. It brings in jobs and opportunities for volunteering.

- *Physical activity contributes to an active and healthy old age*

An increasing number of us will be affected by long term conditions as we age. Older people have greater health needs in Harrow due to lower levels of activity and social isolation. Physical activity programs incorporating the social connectivity can contribute to wellbeing by giving people community support and opportunities for socialising.

- *Good for the body good for the mind*

Being active and *connecting with others* is one of the five ways as recommended by the Department of Health improving people's mental well-being[x]. Inactive individuals have three times the rate of moderate to severe depression of active people[xi] Participating in physical activity enhances mental wellbeing and protects mental health. Increasing evidence suggests that walking, and physical activity more generally, can be an effective way to enhance positive moods.

- *It helps to deliver Harrow Health and Well Being Strategy*

The *Harrow Health and Wellbeing Strategy 2016-2020* recognises that only 20% of our health in Harrow is determined by health 'services', whilst factors including housing, education, employment, financial security and the built environment make the most difference. The Health and Wellbeing Strategy takes a life –course approach and advocates taking actions which will benefit everyone but with a greater emphasis and intensity on those who are more disadvantaged. The guiding principles for the H&WB Strategy are: *Start well, Develop well, Live well, Work well, Age well and work on social determinants to address the health divide between the rich and the poor.* The Strategy's emphasis is on joint working, integrated services, empowering the community to do more for each other and acting on local intelligence to improve mental health.

- *Without a focus on physical activity, obesity rates will continue to rise*

Harrow Obesity Needs Assessment recommends that staying active should be promoted across Harrow and with particular focus on those wards identified as having higher obesity and lower physical activity in the South and East. The link between inactivity and obesity is established and given that the proportion of 10 to 11 year olds in Harrow with excess weight is higher than the England average and the particular risks for the South Asian population, getting the population more regularly active is very important[xii].

- *We need to respond to national strategy*

At the heart of the most recent government strategy, *Sporting Future: A New Strategy for an Active Nation* 2015[xiii] sit five outcomes: physical health, mental health, individual development, social and community development and economic development. These define the new sports and physical activity pathway and how it is going to be funded. It has a life course approach from 5 years and above. Funding will be targeting those people who tend not to take part in sport, including women and girls, disabled people, those in lower socio-economic groups and older people. The new *Sport England Strategy 'Towards an Active Nation' (2016-21)* has a key area of investment on 'Inactive people becoming active'.[xiv]

- The Strategy will contribute to London Sport's Strategy and the strategy for London which has a target to get 1million people more physically active by 2020.

- Achieve Harrow Council ambition to *Build a Better Harrow, Support Businesses and be More Business –like, Protect the Most Vulnerable and Supporting Families*

A better built environment encourages physical activity; more participation in physical activity is good for local businesses, sports clubs as well as community development; and more importantly through prioritising communities in greatest need this strategy contributes to protecting the most vulnerable.

- *Our Physical Activity and Sports Strategy combines together other relevant local strategic documents around physical activity*

Harrow Open Spaces Strategy (2011) focuses on the maintenance of green spaces and the improvement of their quality. The Core Strategy also points to the need to manage the open space resource; to maximise its multifunctional use – as an amenity and recreational resource, a habitat and wildlife corridor; a transport link for cycling and walking; and to contribute to climate change adaptation.

Harrow Sustainable Transport Strategy's (2013) prime aim is to encourage increased walking and cycling particularly as a healthy mode of travel. This is done through training (Bikeability), lifestyle education and by addressing safety issues and concerns.

Harrow School Travel Plan Combined Strategies (2007) aims to support schools to develop travel plans to promote environmentally sustainable modes of transport (walking, cycling and using public transport) and thereby improving pupils' independent mobility and reducing car use. Strategy aims to remove deterrents to walking, cycling and using public transport and improve the safety and convenience of crossing facilities.

Harrow Road Safety Plan (2015) focuses on education through public information (campaigns and leafleting on road safety issues) and providing public information direct to

school age children. Targeted campaign in community languages, safety education workshops and cycle training is planned to increase accessibility by BEMA and refugee communities.

Harrow Transport Local Implementation Plan (2011-14) formulated key actions to promote active travel, walking and cycling; access to green areas; environmental improvement (to improve safety and make it attractive for active travel), regeneration programs with a view to improving physical activity (walking, cycling, using public transport etc.); Promotion campaigns and public education on active travel.

- *Physical activity promotes community development and cohesion*

Physical activity and sport brings people together and contributes to breaking down social/cultural barriers. It can foster civic and social pride as well as achieving community cohesion.[xv] Sport and physical activity projects can make a significant contribution to the reduction in crime rates and anti-social behaviour.[xvi]

Finally, Harrow and Barnet on the Move (2013-14), Annual Report of the Director of Public Health of the London Boroughs of Barnet and Harrow is a supporting document from which this strategy builds on.[xvii]

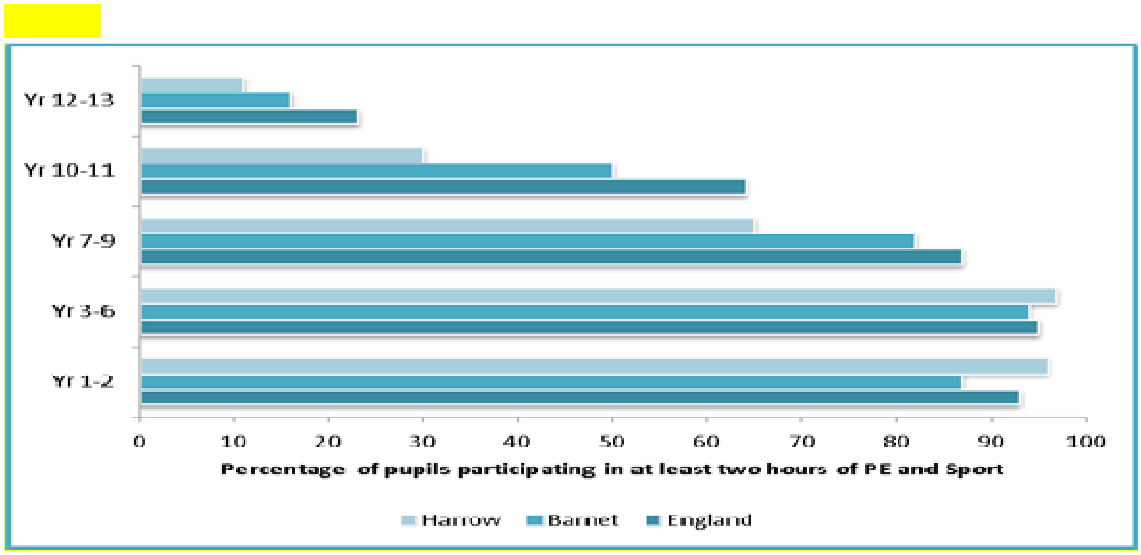
How active are we in Harrow?

Harrow has higher proportion of inactivity and performs low in required levels of physical activity (including active travel) compared to the national and London average. Areas of low activity coincide with areas of deprivation, low access to green space and those areas with high obesity levels.

National surveys suggest that physical activity declines with age to the extent that by 75 years only 1 in 10 men and 1 in 20 women are sufficiently active for good health. Disabled people are half as likely as non-disabled people to be active. Only 11% / 26% of Bangladeshi women and men are sufficiently active for good health, compared with 25% / 37% of the general population. Men are more active than women in virtually every age group. Over a third of lesbian, gay, bisexual and transgender youth do not feel they can be open about their gender identity in a sports club.[xviii]

- *We need to put a stop to the drop in activity in Year 3-6:* Figure 2 shows PE and sport participation in Harrow, almost a third of pupils stopped participating in PE and sport when they started secondary school followed by a further third stopping by Years 10 and 11. Only one in ten continues in Years 12 and 13. It is important to invest between school, community and sports clubs to maintain activity levels in year 3-6 beyond primary school years. Higher levels of activity in childhood generally lead to sustained participation in physical activity in later years.[xix]

Figure 2: Children and young people in school based PE & sporting opportunities



Source: PE and Sport Survey 2009/10

- *Harrow is less active and more inactive than the London and the nation:* Nearly one in three (31%) of the adult population in Harrow is classed as physically inactive falling into the Chief Medical Officer's (CMO) "high risk" health category[xx]. This is higher than the London (27%) and the national (27.7%) level of inactivity. This means that 31% of the adult population in Harrow do less than 30 minutes of moderate intensity physical activity per week. Only 51.4% of adults (16+) report undertaking 150 minutes of moderate intensity physical activity compared to the national average of 57% and the London average of 57.8%.[xxi] Women are less active than men therefore they are a risk group for developing health conditions related to the high levels of inactivity.[xxii]

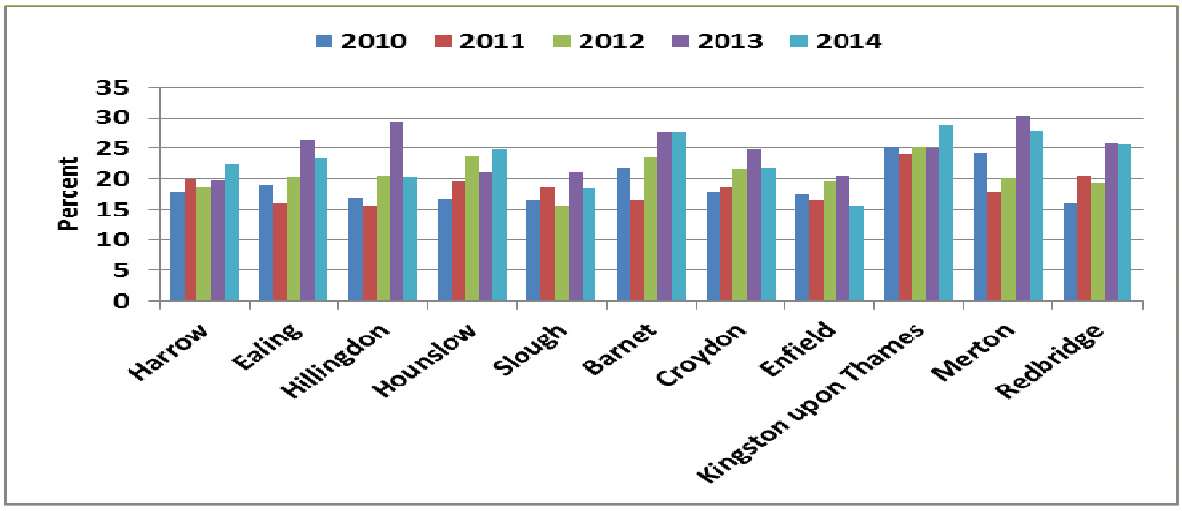
- *Harrow performs poorly for Walking and Cycling:* The percentage of walking trips in the borough has dropped from an average of 30% between 2006/7 to 2008/9 to an average of 28% between 2009/10 to 2011/12 and the percentage of cycling trips has dropped from an average of 0.8% to an average of 0.6% over the same time period. Both walking and cycling rates are lower than the Greater London average, Inner London and even Outer London for cycling.[xxiii]

Figure 3 – Adults walking and cycling rates between 2009/10 to 2011/12[xxiv]

	Harrow	Outer London	Inner London	Greater London
Cycle	1%	2%	3%	2%
Walking	28%	28%	38%	32%

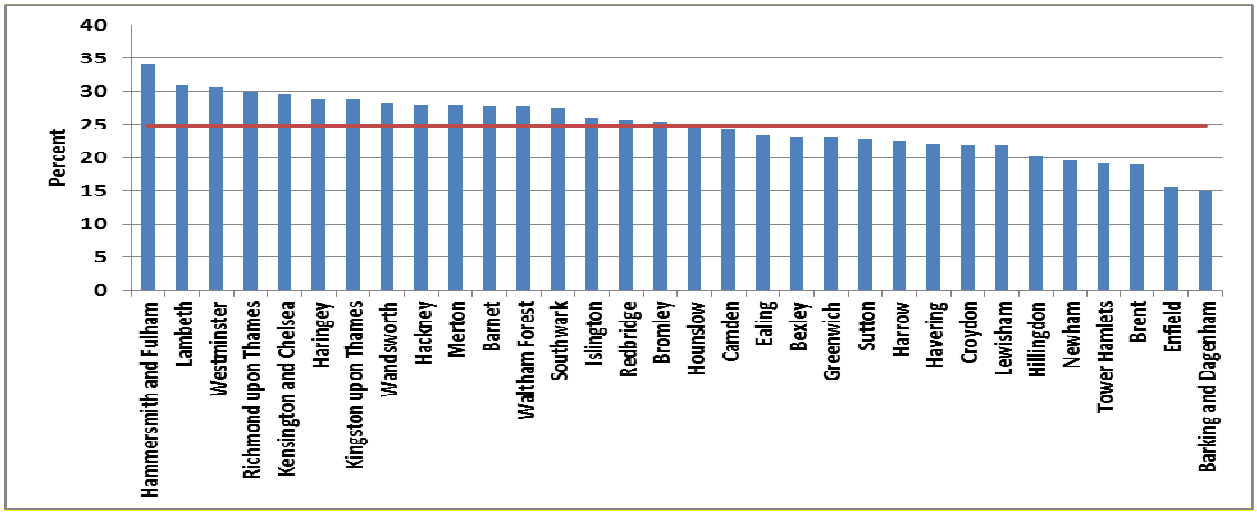
- *Harrow is below average in sports and active recreation compared to its statistical neighbours and other boroughs of London:* The higher levels of participation in 2013 and 2014 may reflect what is known as the Olympic effect – generally these big sporting events are good for economic growth of a country but they also have a positive social impact which governments often seek to capitalise upon when building a legacy which seeks to encourage the take up of sports in the general public.

Figure 4: Sports and active recreation (3x30) Harrow and statistical neighbours, 2010-2014



Source: Sport England

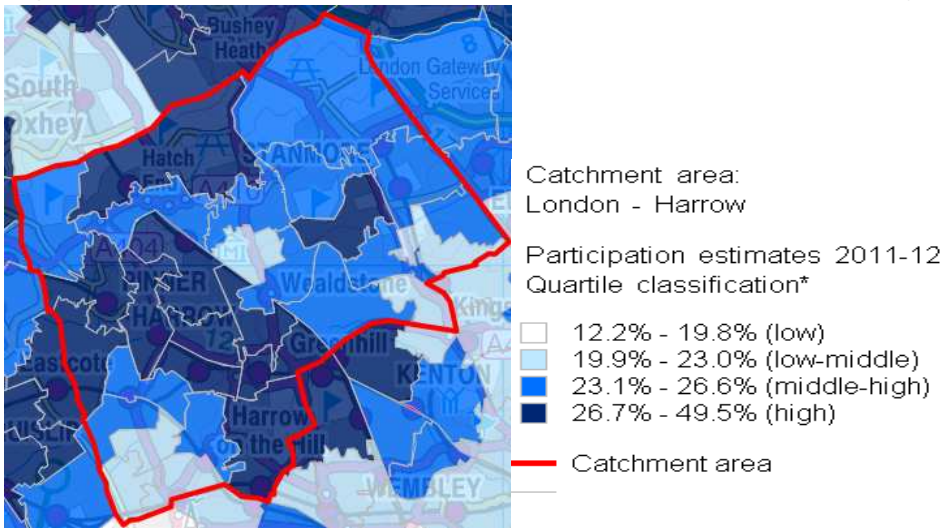
Figure 5: Adult participation in sports (3x30) in all London boroughs (excluding the City of London, 2014



Source: Sport England

- *The areas with low levels of activity coincide with areas of higher deprivation in Harrow and areas with high obesity.*[xxv] The map in figure 6 shows the percentage of the adult population (age 16 and over) who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on three or more days a week.

Figure 6: Sports and active recreation (3x30) active people survey 2011/2012



Source: Sport England

Addressing barriers to physical activity and local consultation

Barriers to Physical Activity

- *Inequities around social class, gender, ethnicity, age and disability impacts on how active we are, whether we have access to well-maintained green space, environment that is conducive to physical activity and affordable leisure services.*

- *Nationally, people living in in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas. Locally, pockets of deprivation in south, east and central parts of Harrow are also least active areas (see figure 6 on page 13).*

- *National surveys show that physical activity levels are lower amongst black and minority ethnic communities; low-income households; adults with mental illness, learning difficulties and physical disability, carers, women, middle aged or elderly, and overweight or obese.*[xxvi]

- *Data from the Health Survey for England suggest that the most cited practical barriers were work commitments, lack of leisure time, caring responsibilities for children or older people and not having enough money.*[xxvii]

- *Barriers to physical activity among BME individuals are influenced by four main concepts: perceptions; cultural expectations; personal barriers; and factors limiting access to facilities.*[xxviii]

- Among South Asians the barriers to exercise includes a lack of understanding, it not being culturally appropriate to exercise and a somewhat fatalistic attitude.[xxix]

Harrow is one of the most ethnically diverse boroughs in the country and 43% are from Asian/Asian British ethnic background. South Asian populations are at higher risk of type 2 diabetes at lower BMI.[xxx] There is some evidence that levels of physical activity are lower among South Asian groups than the general population which may contribute to increased risk of diabetes and coronary heart disease.[xxxi]

When promoting physical activity in the elderly, special attention needs to be paid to the health benefits of physical activity, to the subject's fears, individual preferences and social support, and to constraints related to the physical environment.[xxxii]

- *Nationally, people living in the most deprived areas are less likely to live in the greenest areas, and will therefore have less opportunity to gain the health benefits of green space compared with people living in the least deprived areas.*[xxxiii]

Harrow has large green areas but this is unevenly distributed with less access from the deprived areas of Harrow in the south and east of the borough. As a result people living in these areas have less access to environments that support physical activity such as well maintained parks, open spaces or safe areas for play, and are more likely to have transport

environments less amenable to active travel. This is likely to influence the amount of physical activity that households living in these areas undertake.

Local consultation

Local consultation was carried out with older people, parents of school children and women in Harrow in March/ April 2016 to identify barriers to physical activity, how to address them and effective ways of communicating existing services. We have added to these the results of the workshop with the public health team, Harrow Carers' survey on physical activity and an earlier focus group discussion with people on Long Term Conditions (LTC) on the same topic. Following themes emerged:

- *The common barriers identified across all groups were*: time, cost, accessibility
- For people with LTC, cost, health problems (e.g. back and joint pain and injuries), lack of energy/motivation to exercise, lack of access to and awareness of physical activity facilities and lack of group activities seemed to be the main barriers to physical activity.
- For older people's group (Age UK Harrow) health problems, cost and lack of group based activities (e.g. yoga, swimming, gym sessions) were the main barriers.
- Parents of a primary school children indicated issues around stress due to other commitments and caring responsibilities, time and cost. Health issues and watching TV also came up as barriers with parents and a women's group.
- The results of survey done by Harrow Carers on carers' accessibility to sports and recreation showed that nearly 60 percent of carers didn't have the time and/or money to participate in sports and fitness due to their caring role
- Common themes for the public health staff: time, cost, accessibility, work commitments, distance, safety issues, childcare, distance

How does experience and intelligence suggest we address barriers to physical activity in Harrow?

The Marmot Review[xxxiv] recommends actions to improve the built environment which supports active travel, improves good quality open and green space, develops regeneration programs that leads to active social life, reduce isolation and fully integrates the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

- *Teach every child to enjoy, value and have the skills to be active every day*

Promote physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings: having a workforce skilled in promoting physical activity; providing facilities and opportunities in school buildings

for physical activity; strategic planning to include activity; encouraging participation; involving children and young people in decisions; action on sedentary behaviour.

- *Make activity easy, affordable and part of everyday life*

Being active every day needs to be embedded across every community in every aspect of life and throughout the life course - not something where cost, access or cultural barriers are at issue. We need to intensify our efforts according to the need and prioritise population groups and geographical areas with greatest need to reduce inequalities.

- *Build environments that are age friendly, safe for cyclists and make walking easier. Provide and maintain open/green space with multi function play facilities accessible by all and prioritise targeted communities.*

Green, open spaces should be well maintained, safe with multi activity functions and made accessible on foot by the targeted communities. The health of older people increases where there is more space for walking near home, with parks and tree-lined streets nearby. Children become more active when they live closer to parks, playgrounds, and recreation areas.[xxxv]

- *Make physical activity an integral part of policy, planning and commissioning across departments and cross sector.*

We need to develop co-ordinated cross sector programmes; inclusion in local transport plans; inclusion in travel planning, walking and cycling programmes. Planning applications for new developments should prioritise the need for people to be physically active as a routine part of their daily life; pedestrians and cyclists are given a high priority when developing or maintaining streets and roads;

- *Build on what works- promote walking, cycling*

Walking is ideal as a gentle start up for the sedentary, including the inactive, immobile elderly and can be built into people's every day lives.[xxxvi] It improves physical, mental health and improves community spirit and safety.[xxxvii] The return on investing every £1 for walking is £6 - £7.

- *Make every contact count and lead by example in every public sector workspace by promoting physical activity among staff*

Ensure that staff is trained in skills and knowledge on activating people and promote what is out there to be active. Every public sector workspace should promote physical activity through flexible work patterns, manageable workload, cycle parking, use of stairs, exercise space, showers etc.

- *Promote accessible sports and leisure services*

Provide cost neutral and accessible leisure services and facilities with priority given to people on low income, older people, women, people with disabilities and mental health problems

- *Intensify efforts in accordance with the needs of the population, prioritise level of deprivation and support needs*

People on low income, unemployed and living in deprived areas should be prioritised when planning and implementing our programs. Population specific initiatives for South Asian communities and gender specific tailor made sessions for women can address some of the barriers for these groups. People with support needs, disabled, people with mental health problems with Long Term Conditions (LTC), older people and carers need tailor made sessions with consideration to their support needs.

Which model of behaviour change are we going to use?

It is our view that a combination of different tested models will be used to bring about a mode of behaviour change in our local communities to become more physically active. This will be developed and tested through empowering local community members, through training, to become agents of change in activating their communities.

Community-based social marketing[xxxviii]: Our physical activity program will set in motion a process of ongoing listening, testing, monitoring and adapting our plan and structure of promotion, activities and trainings accordingly.

Defra's 4 Es model[xxxix]: We will be focusing on enabling individuals and communities through information, skills/ capacity training and facilities/environment conducive to physical activity. We will encourage and engage them to become champions, facilitators and leaders in activating their communities.

Cultural Capital Framework[xl]: We will be focusing on tested population wide programs such as walks program that is simple, can be implemented easily across sectors, communities and repeated on an ongoing basis to become a new cultural norm.

Model of Community Empowerment[xli]: Through capacity building and skills development on public health issues with a focus on physical activity our local communities will be empowered with active participation in local democracy.

Chapman's 'System Failure'[xlii]: We will neither be prescriptive nor controlling but will set the general direction to be more physically active, provide examples of tested programs, activities and learn from the local communities as to their preferences and provide support accordingly. We will be risk taking and open to failures in order to improve.

Motivational skills will be developed and diffused into the community to generate peer and community support for people going through the *cycle of change*[xliii] to become more active.

Current physical activity opportunities in Harrow

Following is a brief summary of physical activity and sports opportunities in Harrow. More detailed information would be found in the appendix section.

Parks and outdoor gyms: Harrow has many parks and green areas. Maintaining and expanding community, sports and leisure facilities would greatly enhance public use to be more active. Nineteen parks in Harrow have outdoor gym equipment offering a lot of the same equipment you would find in an indoor gym, but in the great outdoors. Best of all, they're completely free!

Leisure Centres[xliv]*:* Harrow Leisure Centre, Roger Banister Sports Centre and Hatch End Swimming Pool provide a range of sports and physical activity opportunities and supported sessions for people with disabilities, older people and women. Aspire works with people with spinal cord injuries to help them achieve more choice and independence. The Aspire national training center is a fully integrated leisure facility for both disabled and non-disabled people.

Schools: Salvatorian College, Nower Hill High School, Harrow High School and Bentley Wood High School provide various facilities and space for sports and physical activity.

Harrow Health Walks[xlv]*:* Harrow Health Walks is a well established program with around 250 walkers taking part in organised walks every week. We have 22 trained volunteer Health Walk Leaders and 7 volunteer data administrators supporting the program helping it run each week.

Harrow Community Dance: Over 200 people from the target communities benefited from the tailor made dance classes. Plan is in progress to train front line staff in Exercise to Music Skills to sustain the dance and exercise program.

Harrow Park Run: This is a new initiative run by Harrow Athletic Club every Saturday morning at the Harrow Recreation Ground. Volunteers help run the program. Each week over 100 people take part.

London Youth Games: 300 young people from across borough aged 7 - 18 represent Harrow annually in the Balfour Beatty London Youth Games held at Crystal Palace National Sports Centre

School Games [formerly known as the Sainsbury's School Games]: The School Games is a unique opportunity to motivate and inspire millions of young people across the country to take part in more competitive school sport.

Other sports and physical activity programs would include: Our Parks[xlvi]*, Outdoor adventurous activity in schools, Schools Travel Plan program, Walk to school week, Bikeability (free cycle training program for school children), Exercise on Referral, Health Checks, Sportivate (The Sportivate programme gives 11-25 year-olds access to six-to-eight weeks' of free or subsidised coaching in a range of sports). Satellite Clubs, Get Active Harrow, Change4Life Clubs, Harrow Primary Schools Athletics Championships and clubs providing a range of activity sessions for different age groups.*

Aims and Objectives of Harrow's Physical Activity Strategy

Our overarching aim is**:** *To support people who are not doing any activity into doing some and those doing some activity into doing more.*

Priority will be given to the communities in greatest need for a true and longer term impact.

To achieve this we have set ourselves the following objectives:

1. *Reduce inactivity in priority groups by increasing awareness of the opportunities available and addressing the barriers to participation*
2. *Increase participation in sport in priority groups by improving the accessibility, range and quality opportunities for sport*
3. *Increase opportunities and awareness for Harrow Council staff to be active*
4. *Improve the degree to which Harrow as a place supports residents to be active as a routine part of daily life*
5. *Work in partnership with stakeholders to make the best use of resources and attract new funding into the borough*

We will be working towards the following key outcomes:

- *More people will take up active travel, walk and cycle more*
- *More people access leisure services that are affordable*
- *More people will access parks, green spaces and growing areas*
- *More people from priority communities take up sport*
- *Harrow council to achieve London Healthy Workplace Charter level excellence by March 2017*

All aspirations will need to address proportionately those communities in greatest need.

Communities in greatest need includes pocket geographical areas in south, east and central Harrow, unemployed, people on low income, people with physical or learning disabilities, people with mental health problems, BME and refugee groups, women, older people, carers, people with long term conditions. There are clear and significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability.[xlvii]

Our key partners

We will be joining efforts with our partners and act on evidence to ensure success.

- ***London Sport***: London Sport works with a huge range of partners and its purpose is one of offering support, insight, knowledge and expertise, to work together to increase participation in sport and physical activity in London. It support sport clubs, provides funds - Sportivate, support to schools around Schools PE and Sports

Premium and satellite clubs when pupils leave school. London Sport is working closer with each LA/Leisure provider to move further in using digital technology - re Get Active London and the improved version.

- ***Sport England***: Sport England works across the regions to develop sports on a local level. One way of support is through funding: Community Sports Activation Fund, Get Healthy Get Active etc. It provides data, expertise, networking opportunities as well as support for strategic approach. It provides opportunities for your young people through Sportivate, School Games; and working with HE and FE sectors.

- ***Schools and colleges and early years settings:*** The foundations for being physically active are laid in the early years and this is a time when families are open to behaviour change and modifying their lifestyles. As key educational settings schools bring together children, families, clubs and the community. As potential community hubs they can provide after school facilities for the local community and club use. As such they can be as transmission levers to school leaving age and through adulthood. Accessing funding and resources will benefit all ages in the community to get more active. Colleges are key for partnership work to train young people among NEET (Not in employment, education and training) on coaching, fitness etc..

- ***Harrow Community Sport and Physical Activity Network (CSPAN):*** The Harrow CSPAN is made up of individuals from key organisations involved in the provision of sport and physical activity across Harrow. It provides the critical linkage between sub-regional co-ordination and local planning and delivery.

- ***Everyone Active***: Our key delivery partner for providing leisure services for Harrow residents. There is potential work with Everyone Active to explore ways of developing services for the targeted communities in greatest need.

- ***Local sport clubs***: With good links to coaches, volunteers and other professional staff in area of sports, clubs has the basic structure in place for activities after school hours and weekends for school children. They are ideally placed as providing structured sports and physical activity beyond the school age and to adulthood. Often, they would benefit from resources/funding and from good links with schools and local communities.

  All primary schools have received a copy of the sports directory put together by Harvi Singh [CSPAN] and have been encouraged to upload it on to their school websites making it available to children and parents. Schools are also encouraged to signpost children to community clubs.

  At competitions run through HSIP/SGO programme the children competing receive a certificate and on the back is a directory of local community clubs linked to the sport the child has been taking part in.

- ***Voluntary and Community Sector***: Voluntary and community sector has the potential to tap into resources and funding and develop tailor made physical activity programs to target communities in greater need.

- ***Transport for London***: Provides funding to make improvements to the transport network and to encourage more sustainable travel.

- **The Physical Activity Implementation Group** will be responsible for developing an implementation plan in wide consultation with stakeholders and a smaller **steering group** will oversee this quarterly and be accountable to the Harrow Health and Wellbeing Board

PHYSICAL ACTIVITY AND SPORTS STRATEGY 2016-20 ACTION PLAN

This strategy applies a one council approach and the following teams all contribute to the deliverables and are represented in the Physical Activity Implementation Group - Public Health, Sport and Leisure, Traffic and Highways, Community Engagement.

The Physical Activity Implementation Group will be responsible for developing an implementation plan in wide consultation with stakeholders and a smaller steering group will oversee this quarterly and be accountable to the Harrow Health and Wellbeing Board. The Implementation group will ensure engagement with community and voluntary sector groups and also the CSPAN group to develop plans that meet everyone's needs.

Physical Activity and Sports Strategy objective	Overarching action	Outcomes 2020 (unless otherwise stated)	Indicator	Progress
Reduce inactivity in priority groups by increasing awareness of the opportunities available and addressing the barriers to participation	**Public Health:** • To promote walks, cycling programme, outdoor gyms, active travel, parks and open spaces and exercise opportunities through existing networks, CSPAN, local papers etc. • To maintain and expand programme and attendance on Harrow Health Walks programme • To maintain and expand Harrow Park Run events and attendance • Develop tailor made activities for priority groups (e.g. dance) • To work with schools and children centres to promote and implement active travel, active travel plans, Change4Life, Golden Mile (walk/run), safe cycling and swimming training (year 4 and above), achieve accreditation with Healthy Schools London	*More people will take up active travel, walk and cycle more*	• Number of people taking part in walks program • Number of targeted walk programs for priority groups and areas • Number of people from priority communities accessing physical activity opportunities that are available • Number of schools and children taking part in 'Golden Mile'	
	Travel Planning: • To support schools to promote active and healthier journeys • To promote walking and cycling to schools, businesses and residents (campaigns across the year) • Introduction of Bicycle Loan Scheme • To work with school communities to reduce barriers to using sustainable transport • To encourage School communities and the wider public to use active travel options as a means of travelling in the borough, improving health and wellbeing.	*More people will take up active travel, walk and cycle more*	• Increase the amount of pupils travelling to school by sustainable means • Increase the uptake of sustainable journeys to people, living working and visiting the borough • Reduce the amount of car journeys in the borough • Number of active travel plans in operation • Number of active travel maps for schools • To achieve 1% drop each year of the overall proportion of children travelling to school by car (annual survey-schools/travel planning)	
	Sports Development and leisure: • To implement promotion via existing networks for library services, health and sports clubs – • To work with the Council's leisure provider, Everyone Active, to deliver targeted programmes – i.e. 60+, disabilities, females • To work with local clubs and organisations to deliver Sportivate programmes for young people. • To work with the Council's leisure provider, Everyone Active, to promote free swimming	*More people access leisure services that are affordable*	• Numbers of people accessing council subsidised leisure facilities - percentages including post codes are based upon data from Everyone Active card holders. Targets for 16/17 have yet to be confirmed	

	for those aged 60+			
Increase participation in sport and physical activity in priority groups by improving the accessibility, range and quality opportunities for sport and physical activity	**Sports Development and Leisure:** • To deliver of the Council's Outdoor Sports Pitch Strategy using S106 funding from the redevelopment of Harrow View West– improvements to be made to grass playing pitches, changing facilities, and also potentially the installation of artificial grass pitches. • To support the development of local clubs – i.e. develop coaching and volunteering resource, and support clubs to recruit new members. • To ensure the engagement with community sector groups including those representing priority groups in implementation of the strategy	*More people from priority communities take up sport*	• • TBC Targets will be set up for 'On Your Marks' program re: participation from people with mental health problems and people with disabilities • Number of local clubs supported to develop coaching and volunteering resource, and support clubs to recruit new members. • To deliver Council's Outdoor Sports Pitch Strategy (improvements to pitches, changing facilities, and installation of artificial grass pitches).	
	Open Spaces: • To work towards providing better quality sports pitches to encourage higher levels of participation in pitch sports.	*More people from priority communities take up sport*	• To deliver Council's Outdoor Sports Pitch Strategy (improvements to pitches, changing facilities, and installation of 3G grass pitches).	
Increase opportunities and awareness for Harrow Council staff to be active	**Travel Planning:** • To develop a Staff Travel plan for the Civic Centre site with actions for staff based on the outcomes of a survey	*Harrow council to achieve London Healthy Workplace Charter level excellence by March 2017*	• To decrease the amount of car journeys to and from the civic centre • To implement a programme of behaviour change to encourage the uptake of sustainable transport	
	Public Health: • To develop activity program for staff: Mini workouts, lunch time walks, stairs challenge etc.	*Harrow council to achieve London Healthy Workplace Charter level excellence by March 2017*	• Number of Harrow Council staff taking part in activities	
Improve the degree to which Harrow as a place supports residents to be active as a routine part of daily life	**Public Health:** • To make Health Impact Assessments (HIA) integral to any planning, policy, strategy and commissioning to improve environmental opportunities for being active • To promote '*Walking for Health'* to increase physical activity in parks and open spaces	*More people will access parks, green spaces and growing areas*	• Number of Health Impact Assessments carried out • Increased use of parks and open spaces through people taking part in walks, park run, outdoor gym use and recreational activities	
	Travel Planning: • To implement the Sustainable Travel Strategy (2013) measures to reduce reliance on non sustainable forms of transport. • To continue SMOTS (in development) Sustainable Modes of Travel to School Strategy – focusing on increasing sustainable and active journeys to school.	*More people will take up active travel, walk and cycle more*	• To develop a strategy that focus on Smarter Travel to school and has clear achievable objectives and targets • More people will use active transport	

	Sports Development and Leisure: • To deliver the 'Fitness in Our Parks' programme	*More people will access parks, green spaces and growing areas*	Engage minimum of 80 females in the 10 week programme across 4 parks.	
	Open Spaces: • To maintain and improve open/green spaces • To promote campaign to attract more visitors to open spaces (all). • To promote the use of parks and open spaces as places for informal recreation particularly walking and running (all) • To expand MUGA's (Multi Use Games Activity) • To continue expansion of green/outdoor gym to new open space areas to increase participation from priority communities • Support and expand park user groups	*More people will access parks, green spaces and growing areas*	• Maintenance issues with local parks and open spaces resolved in time to residents' satisfaction – number logged as a complaint decreased • Number of newly developed MUGA's • Number of newly developed Green/Outdoor Gyms • Number of new park user groups and expansion of existing ones with new users	
Work in partnership with stakeholders to make the best use of resources and attract new funding into the borough	**All partners work together:** • To develop a joint promotion and social marketing campaign to attract priority communities to opportunities and facilities to be more active • To attract new funding into the borough in order to: ➢ Develop tailor made physical activity opportunities targeted towards priority communities and areas ➢ Expand MUGAs to priority areas ➢ Maintain support for sport clubs ➢ Expand active travel educational workshops for targeted communities	*More people will access parks, green spaces and growing areas* *More people will take up active travel, walk and cycle more*	• A joint communication plan and brand developed by Physical Activity Implementation Group with oversight by Physical Activity Strategy Steering Group • Number of joint promotional events run • Number of funding applications made	

Appendix 1: Physical activity/ Sports facilities in Harrow

Outdoor gyms[xlviii]***:*** 19 Parks in Harrow have outdoor gym equipment. Harrow Council's outdoor gyms are a new way to look at health and fitness offering a lot of the same equipment you would find in an indoor gym, but in the great outdoors. Best of all, they're completely free!

Parks: Harrow has many parks and green areas. Maintaining and expanding community, sports and leisure facilities would greatly enhance public use to be more active. Work is under way to develop and engage park user groups. 5 of Harrow parks have Green Flag status. Roxeth Recreation Ground, Canons Park, Harrow Recreation Ground, Pinner Memorial Park, Kenton Recreation Ground. Green Flag status is the benchmark national standard for parks and green spaces in the UK. It recognizes and rewards the best green and open spaces in the country.

Following outdoor sports facilities provides public with opportunities to be active. All but 2 (Hatch End and Chandos) have accessibility facilities for the disabled.

- Byron Recreation Ground: Bowling green (6 rink green), tennis (3 hard courts - free), football pitches (1 senior, 2 junior, 1 soccer 7s only), basketball target goal, outdoor gym
- Chandos Recreation Ground: cricket Table, tennis (3 hard courts - free), football pitches (1 senior pitch, changing facilities for 2 games at once), basketball target goal, outdoor gym
- Harrow Recreation: Playing fields (2 soccer 7s), cricket tables (2 junior, 2 senior), bowling green (1), outdoor gym
- Harrow Weald Recreation Ground: Bowling green (6 rink green), cricket table, tennis (4 hard courts), football pitches (1 senior, 2 junior), basketball target goal, outdoor gym
- Hatch End Playing Field: Playing fields (3 senior, 1 junior), cricket tables (2)
- Roxbourne Park: Cricket table (1), football pitches (1 senior, 2 soccer 7s), basketball target goal, outdoor gym
- Roxeth Recreation Ground: Tennis 2 hard courts – free, football pitches (2 senior), basketball target goal, outdoor gym
- Shaftesbury Playing Field: Cricket table (exclusive use), 2 rugby pitches, basketball target goal, cricket table, outdoor gym
- Stanmore Recreation Ground: Bowling green (6 rink green), football pitch 1 senior, outdoor gym
- More parks with outdoor gyms: Alexandra Park, Centenary Park, Headstone Manor Recreation Ground, Kenton Recreation Ground, Lowlands Recreation Ground, Pinner

Memorial Park, Queensbury Recreation Ground, Saddlers Mead, Thackeray Drive Open Space, The Croft, West Harrow Recreation Ground

Leisure Centres[xlix]

- Harrow Leisure Centre: Offers a range of sports, leisure and recreational facilities including free swimming sessions for 60+ and Exercise on Referrals sessions
- Aspire: Aspire works with people with spinal cord injuries to help them achieve more choice and independence. The Aspire national training center is a fully integrated leisure facility for both disabled and non-disabled people.
- Roger Banister Sports Centre: The club has modern changing rooms, communal area, a warm up room with weights and athletic equipment such as hurdles and javelins. You can hire the facility for an upcoming function or to play rugby and football on the maintained pitches.
- Hatch End Swimming Pool: Hatch End Swimming Pool, situated about 10 minutes walk from Hatch End station, offers a wide range of sports, leisure and recreation facilities.

Schools: Schools provide facilities available for use after school hours and during weekends

- Salvatorian College offers gym facilities.
- Nower Hill High School offers gym, sports hall, sport fields and hard court.
- Harrow High School offers cricket, football and dance facilities
- Bentley Wood High School offers a gym, sports hall, games area and sports fields.

Current physical activity opportunities in Harrow

Leisure Centre activities: Harrow Leisure Centre provide free swimming classes for 60+. Over 2,000 people access free swimming every month. They offer a series of after school clubs. There is a Community liaison officer who works with schools and community groups to promote activities. Harrow has a large swim school and some schools use the leisure centre gym as part of their curriculum. The centre offers exercise on referral, health checks and cardiac rehab (commissioned by Public Health) which could encourage children's use of the facilities by default through their families.

Outdoor Gym Activators**:** Harrow has volunteer *Outdoor Gym Activators*[l] who can provide support to groups on demand. Last year (2014/15) we have trained 12 volunteer activators, helping them access level 2 fitness instructors training, providing volunteering opportunities at outdoor gym sites. Through events and activities over 500 people were supported though guidance on how to use outdoor gyms and healthy lifestyle. Children centres and schools were key partners.

Harrow Health Walks[li]*:* Harrow Health Walks is a well established exercise program with around 250 walkers taking part in organised walks every week. We have 22 trained volunteer Health Walk Leaders and 7 volunteer data administrators supporting the program

helping it run each week. Total reach over a year exceeds 500 people. Many people with Long Term Conditions (LTC), disabilities and older people greatly benefits from the program.

Harrow Park Run: This is a new initiative run by Harrow Athletic Club every Saturday morning at the Harrow Recreation Ground. Volunteers help run the program. Each week over 100 people take part. The program kick started with a small pot of public health money and now running with the help of volunteers.

Healthy Schools London: An awards scheme where schools can achieve bronze, silver or gold based on health and wellbeing criteria. Bronze schools will have embedded physical activity into school life. For example they will have a dedicated member of the senior leadership team as a physical activity lead and will ensure a minimum of 90mins-2hrs of physical activity is included in the curriculum. The silver and gold awards are more focused and if physical activity is identified as an area for improvement then schools may want to focus on that. Harrow has 22 schools with bronze and 5 with silver.

Our Parks[lii] run weekly group exercise program (Social Netball) at Centenary Park through London Sport funding. It promotes park use for group exercise through qualified instructors. 85 Percent out of the total 69 were inactive before coming to the sessions. They were all women aged between 25-40yrs.

Harrow Community Dance was developed last year to provide fun based, tailor made dance activity to priority groups such as unemployed, people on low income, people with physical or learning disabilities, people with mental health problems, BME and refugee groups, women, older people, people with long term conditions. Over 200 people benefited from weekly hour long dance classes. Plan is in progress to train front line staff in Exercise to Music Skills to sustain the dance and exercise program.

Outdoor adventurous activity: In schools teachers have the opportunity to attend Outdoor Adventurous Activity CPD where they learn about developing children's skills through team challenges. Teachers are encouraged to share this information with parents for them to do at home. There will be OAA CPD for primary schools in February 2016. The idea of engaging parents is one that could be explored by HSIP and shared with teachers.

Park user groups: Increasing numbers of Park User Groups and consequent events and improvements to the park which will encourage greater use and appeal. Harrow Council have just established a Borough Parks Forum to spread best practice and support. There is also a programme of pavilion refurbishments in parks to enable potential use by nurseries.

Schools Travel Plan program: Harrow has an extensive school travel plan. 33 out of 62 schools have a plan in place which is set to increase. However a larger number of schools have initiatives in place to increase active travel. Schools take part in walk to school week/month and bike week. Harrow Council supports schools regarding parking and congestion issues. This includes helping them to increase active travel. Some schools have park and stride initiatives where parents park further away and walk to the school. All maintained schools will have access to active travel maps with information on walking/cycling journey times and routes. *Bikeability* maps are being refreshed and will be available for the whole of the borough. There is an audit being completed to assess cycling

permeability through the borough at present. This will help plan future cycling infrastructure. Walking and cycling are part of all regeneration work.

Walk to school week: Most schools participate in walk to school week/month and bike week which helps families to incorporate active travel into their every day commute.

Bikeability: Harrow Council runs cycle clubs for women and school children and organises guided tours to promote cycling within a safer environment. *Bikeability* is available to children and free cycle training is available to anyone who works and lives in the borough. 68% of schools are engaged with *Bikeability*. In addition the council offer balance bike training. Schools are engaging with children regarding scooters and providing safe places to store them.

Exercise on Referral: Exercise on referral is a program of tailored exercise sessions offered to meet a person's need. The program introduces people to the benefits of physical activity. Individuals are referred onto the program by their health professional (GP, practice nurse, physiotherapist etc.). The program is open to adults aged 16 years and over who have an existing health condition, meeting the referral criteria and are considered inactive (not currently participating in at least 30 minutes of moderate intensity activity on three or more days a week).

Health Checks: NHS Health Checks are for 40-74 year olds who presently do not have an existing cardiovascular risk factor. Follow-up programs have been put in place to support those who have been identified as needing to increase their physical activity levels. These include HealthWise (gym based exercise program), weight management program (gym and dietary advice), Let's Get Moving (motivational interviewing and signposting program) and resources highlighting local opportunities.

Sportivate: The Sportivate programme gives 11-25 year-olds access to six-to-eight weeks' of free or subsidised coaching in a range of sports. During the six-to-eight weeks those taking part can work towards an event or personal challenge and when the free or low-cost coaching has finished they will be supported to continue playing sport. Sportivate launched in June 2011 as a four-year programme aimed at 14-25 year-olds but, due to its success, additional funding of £10m per year has been invested allowing the programme to run until March 2017. Sportivate is inclusive and targets a variety of young people including those who have a disability and people from black and minority ethnic groups. In 2014/15 approximately 942 14-25 year old to access sport and physical activity, with 598 of those people retained in the programme through participating in a minimum of 6 hours of coaching. A minimum of 168 coaching hours have been delivered across the Borough.

London Youth Games: 300 young people from across borough aged 7 - 18 represent Harrow annually in the Balfour Beatty London Youth Games held at Crystal Palace National Sports Centre, with a further 250 young people taking part in pre – squad trials, training and selection for the borough representative squads. In Harrow, the games is used to support the work of local voluntary sports clubs, many of whom use the games as a means of recruiting new members. Teams representing Harrow can be classed into three categories, the first being young people who come directly from a local sports club, are regularly playing at a high level and are keen to represent the Borough at the London Youth Games. The second category is from an open trial system, where young people from all over the Borough

that are encouraged to turn up for a trial and a team are then picked based on qualified sports coaches' recommendations. The 3rd is from a school representative team, and are generally supported by schoolteachers and the school sport system.

School Games [formerly known as the Sainsbury's School Games]: The School Games is a unique opportunity to motivate and inspire millions of young people across the country to take part in more competitive school sport. The Games are made up of four levels of activity: competition in schools, between schools, at county/area level and a national event for the most talented school age athletes. Intra-school competition - sporting competition for all students held within their school, culminating in a School Games Day. Inter-school competition - individuals and teams are selected to represent their schools against other local schools in competitions run by School Games Organisers, with the winning teams progressing to a School Games Festival. Sainsbury's School Games Festival - regional or countywide festivals and competitions are usually held twice a year to find the best performers in the area as a culmination of school sport competition. National multi-sport event - the 2015 School Games saw the most talented young people in the UK selected to compete in high-performance venues.

Satellite Clubs: Satellite Club funding has been invested into 10 schools in Harrow. Over 340 11-18 year old are expected to access sport and physical activity.

Get Active Harrow: All sport & physical activity opportunities in Harrow are promoted via the Get Active London page –www.getactivelondon/getactiveharrow - one stop shop for everyone to access. We successfully engaged with all partners and in 2014/2015 Harrow had 244 page views. There are currently 88 clubs, 141 venues and activities in Harrow promoted to Londoners via the website.

Change4Life Clubs: The national Change4Life School Sport Clubs program launched in March 2012. One member of staff per school runs before school, lunch time or after school clubs which encourage young people to have fun while being physically active and learn about how to eat healthily and live a healthy life-style. The hours of activity are recorded on wrist bands and in log books which encourage parents to get involved in their child's progress. Nearly two-thirds (61%) of primary schools run C4L clubs based on increasing physical activity amongst those most in need. HSIP are currently working with schools to encourage them to put links to C4L on their websites for families to access.

Harrow Primary Schools Athletics Championships: [aka Borough Sports] was in 2015 an inclusive competition. Categories taken from the Paralympics were included with wheelchair races, visually and hearing disabled, statemented children. A Paralympian attended as guest of honor and Aspire also supported the event with a wheelchair basketballer. This will be repeated in 2016 with particular reference to the Olympics in Rio. A Mini Olympics will also be held for KS1. A number of competitions are held in the borough targeting those children who may not make the elite team to represent their school.

Clubs providing a range of activity sessions for different age groups: *The Cedars Youth and Community Centre; Harrow leisure centre;* Beacon Centre

Appendix 2 - Glossary of terms:

Moderate-intensity physical activity leads to faster breathing, increased heart rate and feeling warmer. Moderate-intensity physical activity could include walking at 3–4 mph, and household tasks such as vacuum cleaning or mowing the lawn.
As a rough estimate, most people experience moderate intensity activity when they walk at 3mph, or walking uphill, or when they are carrying a lot of shopping. This also applies to cycling at 10mph or cycling uphill. However, the fitter you are, the more activity you have to do for it to be of moderate intensity. Fit individuals may want to engage in more vigorous activity as it brings extra health benefit and also allows the benefit to come from shorter sessions.

Vigorous-intensity physical activity leads to very hard breathing, shortness of breath, rapid heartbeat and should leave a person unable to maintain a conversation comfortably. Vigorous-intensity activity could include running at 6–8 mph, cycling at 12–14 mph or swimming slow front crawl (50 yards per minute).

Mode Share: This indicator will measure the proportion of personal travel made by each mode by the borough of origin of the trip. This gives a broad indication of the general travel behaviour of households within a given borough. If a trip is made by more than one mode then the main mode is the one which is used to cover the greatest distance.

National recommendations for being physically active: The CMOs' current recommendations for physical activity (see UK physical activity guidelines) state that:
Under 5s: Children capable of walking unaided should be physically active for at least 180 minutes (3hours) daily.
Children & Young people (5-18 years): Should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours daily.
Adults (19-64 years): Should aim to be active daily with moderate intensity activity adding up to 150 minutes (2.5 hours) per week or 75 minutes of vigorous activity per week.
Older adults (65+ years): Should aim to be active daily, a week of moderate intensity activity should add up to 150 minutes (2.5 hours). Regular exercisers should aim for 75 minutes of vigorous activity per week

Physically inactive: The Chief Medical Officer defines physical inactivity as participation in less than 30 minutes of moderate intensity physical activity per week within a 28-day period[liii].

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	30th June 2016
Subject:	**INFORMATION REPORT – Update on the Health & Wellbeing Action Plan**
Responsible Officer:	Javina Seghal, Chief Operating Officer, Harrow CCG and Dr. Andrew Howe, Director of Public Health. This is a joint report in that it notes actions taken by both the Council and the Clinical Commissioning Group.
Exempt:	No
Wards affected:	All Wards.
Enclosures:	Appendix setting out the detail of the actions completed.

Section 1 – Summary

This report sets out progress made on Health and Wellbeing Strategy actions, as of May 31st 2016.

FOR INFORMATION

Section 2 – Report

The Harrow Health and Wellbeing Board committed to monitoring actions agreed to implement the Harrow Health and Wellbeing Strategy, on a quarterly basis with a view to understanding how to celebrate and improve partnership working. Progress is reported against all action in the accompanying appendix 1. There is notable achievement in all areas. Issues the Board may wish to consider include:

- how to further engage with the voluntary sector in order that they can strategically collaborate with the Harrow Health and Wellbeing Board.
- increase engagement with the Police given mental health is an area of joint interest.

Section 3 – Further Information

Progress on the action plan will be provided to each Health and Wellbeing Board for the financial year 2016-2017.

Section 4 – Financial Implications

There are no direct financial implications arising from this report; as it only sets out a record of progress on actions agreed which will be contained within the existing budgets.

Section 5 - Equalities implications

The Harrow Health and Wellbeing Strategy sets out an approach to improve the health and wellbeing of the whole population concentrating particularly on those with the greatest need. It explicitly highlights health inequalities associated with deprivation but also equalities groups (based upon the evidence presented in the Joint Strategic Needs Assessment) and reinforces the need for approaches which target and reach these groups.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

The main categories within the Health and Wellbeing Action Plan support the Council's vision in the following areas:

Making a difference for the vulnerable
The strategy highlights the unacceptable differences between people living in different parts of Harrow and the Health and Wellbeing Board's desire to reduce inequality in a number of areas

- Pilot integrated employment/ mental health support and ensure that Harrow residents are signposted to talking therapies available

Making a difference for communities
The Strategy addresses helping people to live well, a large component of which is about community cohesion and also about how important the environment people live in – housing, high streets and green spaces – are to resident's health.

- Explore new models to empower Harrow residents to do more for each other
- Improve joint communications and promote effective engagement with all Harrow residents
- Assess the health impact of Harrow regeneration schemes

Making a difference for local businesses
One element of the Strategy is to support Harrow residents to 'work well'. The Harrow Health and Wellbeing Board is keen to find opportunities to help people in Harrow to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing. Engaging with local businesses will be key to successful achievement of this objective.

- Commit to London Healthy Workplace Charter (The Charter is a set of standards which if met, will enable getting the best from the health and wellbeing workforce in Harrow and position the Health and Wellbeing Board members as exemplary employers, inspiring other local businesses and organisations)

Making a difference for families
The strategy highlights the need to support children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential. Children need to be loved and nurtured if they are to achieve long term physical, mental and emotional wellbeing. Good attachment with parents and carers in early life are important and so a family focused approach is critical to help children have the best start in life.

- Transforming children and young people's mental health and wellbeing and Transforming early help for children and young people

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

Name: Sharon Daniels	x	on behalf of the Chief Financial Officer
Date: 31 May 2016		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Sarah Crouch, Consultant in Public Health, 020 8736 6834

Background Papers:
Joint HWB Strategy 2016-2020
http://www.harrow.gov.uk/download/downloads/id/8376/joint_health_and_wellbeing_strategy_for_harrow_2016-2020

Action Plan
http://www.harrow.gov.uk/download/downloads/id/8377/health_and_wellbeing_board_action_plan_appendix_1

Appendix 1: Harrow Health and Wellbeing Board 2016/17 action plan – Update report 30 June 2016

The table below outlines the actions which the Health and Wellbeing Board have committed to in 2016 and an update on progress to date.

	Objective	Explanation	Actions	HWB sponsor/ executive lead	Please provide update for HWB on 30 June 2016 focusing on achievements against actions and any barriers to success. At end of summary, please comment on whether you are on track to achieve all actions. Next review will be Sept 2016.
Start well					
1.	Transforming children and young people's mental health and wellbeing	In Harrow Children and young people currently have an inconsistent approach to services depending on the area, school, and GP they have. We want an integrated solution which provides a different sort of service for children and young people and their parents. We plan to deliver this through our Children and Adolescent Mental Health Service (CAMHS) transformation plan over the next 5 years and the Future in Mind programme.	- To identify additional resources to support the pilot of the new model of service delivery without impacting on existing services - To provide additional services for unaccompanied asylum seeking children - To commission a new eating disorder service across 5 boroughs - To develop an options appraisal for CAMHS service transformation across West London - To review workforce training needs	Dr Genevieve Small Jessica Thom	The key millstones achieved to date are: • Harrow Project Manager- to implement local priorities • Harrow Engagement Lead- to implement local priorities and engage with local stakeholders and population • Local Pilot project to support the joint Emotional Health and Wellbeing Targeted Service consisting of 3.5 wte delivering in selected Harrow schools. • New Community Eating disorder service- Joint Harrow, Brent, Hillingdon, Central and West London CCG commissioned- CNWL providing

2.	Transforming early help for children and young people	In Harrow, the services available for early help have been identified as having a degree of duplication and fragmentation. In order to make the services providing early help more effective and efficient we will review the current services with a view to developing an integrated offer of early help for children and young people that need it. Giving every child a good start means ensuring that the pre-natal and early years services identify and address problems in children and their families as early as possible. This means we will also need to review the health visiting services to ensure that they coordinate with the new integrated early help service.	- To establish a project Board to review the current services - To agree the outcomes for the early help services - To redesign the early help service in collaboration with staff and users - To review the Health visiting service against the needs of the local population	Chris Spencer	The formal Staff Consultation regarding the EIS redesign commenced 8th June 2016. The proposed model will be adjusted as part of the formal consultation. The aim is to provide an integrated service for children's centres, youth development team, and early intervention service that maintains an offer of early help in the Borough. The timeline for implementation is end of September 2016 Currently the specification (the service came with the national specification in October 2015) is being reviewed with a view to making any necessary adaptations for Harrow, including specifying not just what will be measured but levels of performance expected. A seminar was held on 20 May to which stakeholders (LBH Early Years, CIN, LNW Maternity Services/Midwifery, the service (LNW) and the CCG (Designated Safeguarding Nurse, Chair and COO) were invited. A further session is planned to be held in July.
Live well					
3.	Explore new	Harrow Communities Click (HCC) is	- Harrow Communities Click to	Andrew	Presentation to be made to

	models to empower Harrow residents to do more for each other	a membership organisation aiming to promote and facilitate mutual networks and time banking to improve the quality of life for people living in Harrow. Harrow Communities Click is different to volunteering as you gain a one hour time credit per hour that you give, which you can use when you need support. In addition to this, Harrow Council is currently reviewing all the Council's approach to volunteering, considering best practice (including digital means of engagement). The Health and Wellbeing Board will promote Harrow Communities Click and review further opportunities for joint working with the Voluntary sector in Harrow to empower residents to support each other.	present to the Health and Wellbeing Board - Health and Wellbeing Board to promote the Harrow Communities Click model and support integrated working - Share Harrow Council's review of best practice in relation to empowering the community and resident's preferences - Support the VCS to consider how they would like to engage with the Health and Wellbeing Board and how to link up work across the Harrow	Howe Carol Yarde	H&WBB on a date to be agreed. Following the above presentation the H&WBB will be asked to endorse Communities Click. The Council has just launched two pilots in Wealdstone and the south of the borough (Roxeth ward) on the MyHarrow Fund. These pilots are based on ethnographic research ran during 2015 to understand how residents act and what type of community engagement scheme residents would engage with (especially those who do not normally engage with the Council). The pilots will run for 3 months with the results being available in September with a view to then rolling out a borough wide scheme for 2017/18. The best practice elements of this are more about the more innovative ways the Council has tried to engage with local residents on the development of the scheme and the application of 'design principles' in the development of the schemes. The Council's work on developing a strategy for Information, Advice and Advocacy has just completed consultation and as part of the next steps we will co-ordinate co-

					design/production workshops with the VCS to develop the strategy. This process will be carried out over June and July and will be facilitated by the New Local Government Network, which has recently published a national report on better commissioning with the VCS, so we will draw on their expertise.
4.	Improve joint communications and promote effective engagement with all Harrow residents	The Health and Wellbeing Board has committed to provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing. As part of this, it is important that there is joined up approach to engaging with residents and for new ways of working to be explored to ensure a two way dialogue is established between a representative cross section of the Harrow population and the Health and Wellbeing Board. In particular it is acknowledged that the population of Harrow is extremely diverse and there is a need for a working group to highlight inequalities in Harrow and the needs of marginalised groups to ensure that the vision to improve the health and wellbeing of all, with particularly concentrated focus on those with the greatest need is addressed.	- Set up an engagement working group tasked with developing an integrated plan for communications - To develop a shared planner which outlines all planned engagement events in 2016 and look for synergies between planned activities of partners to increase efficiency and integration of messages - To develop a shared list of stakeholders and channels of communication with them - To incorporate into the planner key messages that Health and Wellbeing Board partners will be disseminating to residents at specific points in 2016 - To agree shared mechanisms to communicate the mission, vision and objectives of the Harrow Health and Wellbeing Board to residents and progress against these objectives	Arvind Sharma Melissa Allison-Forbes/Carol Yarde	The engagement working group will meet on the 3rd June for the first time, and will look to take this set of actions forward. This will also need to link with the new Sustainable Transformation Plan so that joint consultations and engagements are developed and delivered where there is benefit to do so.

		An integrated approach to communication and engagement will enable health and wellbeing messages to be more co-ordinated, targeted and powerful; culminating in residents feeling more informed about progress and future developments.	- To share learning in relation to engaging with seldom heard groups and improving access to services and facilities which promote health and wellbeing		
5.	Assess the health impact of Harrow regeneration schemes	Regeneration of Harrow is a major priority for the years ahead. The Kodak site, College Road, sites in Wealdstone and major council sites, such as the Civic Centre, will be redeveloped with new affordable housing being a particular feature. There is an opportunity to consider how to enhance the positive impact this regeneration scheme will have on health, wellbeing and health inequalities and to minimise any possible negative impacts.	- Pilot the use of a Health Impact Assessment framework on Grange Farm re-development and make recommendations to promote health and wellbeing - Evaluate the effectiveness of the piloted HIA framework - Conduct an HIA on Civic Centre redevelopment - Planning and Public Health to participate in joint training with a view to mainstreaming the HIA approach within the Council - Consider a strategic approach to estates	Andrew Howe Sarah Crouch	The Grange Farm Rapid HIA (led by Public Health) and Civic Centre redevelopment Rapid HIA (led by Planning) are in final draft form and have an extensive list of recommendations. A paper and the draft is being taken to the Regeneration Board in July 2016 which will outline the proposed process for future HIAs Training attended by council officers from both Public Health Planning The HIAs have been taken to the CCG Strategic Estates Board for their comment with particular reference to the impact on primary care services
Work well					
6.	Pilot integrated employment/ mental health support and ensure that Harrow residents are signposted to talking therapies available	We know that mental health problems such as depression and anxiety are common in Harrow but many don't get the help and support they need. It is estimated only 25% of those experiencing common mental health problems receive help compared to 90% of those with diabetes. Talking Therapies are effective	- Increase uptake of Talking Therapies amongst Harrow residents - Secure external funding to initiate the employment/mental health pilot - Consult with stakeholders to develop a service specification for integrated employment/mental health	Andrew Howe Sarah Crouch	Harrow Employment and Mental Health Task and Finish group Funding secured and specification drafted and procurement ran from Nov-Dec 2015 The trailblazer has experienced significant delays in the official contract signing despite the preferred provider being identified in January. The delays are

		psychological treatments available for free and through self-referral for Harrow residents but take-up of this service is below target. The Health and Wellbeing Board partners will champion the service and improve signposting to increase uptake of the service. Common mental health problems are also major reasons for unemployment in Harrow. An estimated 28% of people claiming Employment Support Allowance (ESA) and Jobseekers' Allowance (JSA) have a common mental health problem and 95% of these people will continue to be out of work for more than 12 months. While unemployment in Harrow is reducing, there has not been a commensurate reduction in the number of people with mental health conditions getting back to work. A programme will be launched in 2016 which will trial the impact of joining up employment and mental health support with a view to helping residents back to sustained employment.	service which meets needs and is integrated with current local provision - Develop targets for the employment/mental health service for 2016 - Procure a provider for the service and ensure the service fits well with other related local services such as Talking Therapies - Launch and promote the service - Monitor outcomes in line with targets set		between the GLA and WLA sign off. The provider has begun mobilisation plans and engagement locally Harrow Employment and Mental Health Task and Finish group has met and reviewed the TORs and attendance to reflect a close monitoring role which will inform the quarterly meetings held by the GLA with the provider on the mobilisation and service activity when it begins Launch has been ear marked for July Targets will be set in light of delayed start and the Task and Finish group has all relevant stakeholders engaged.
7.	Commit to London Healthy Workplace Charter	Each Health and Wellbeing Board member organisation will demonstrate that they take the health of their staff seriously by signing up to and implementing the London Healthy Workplace Charter.	Harrow Council will take action in 2016 to attain 'achievement' status of GLA Healthy Workplace Charter	Andrew Howe Sarah Crouch/	**Harrow Council will take action in 2016 to attain 'achievement' status of GLA Healthy Workplace Charter** Public Health have undertaken review of workplace health needs

		The Charter is a set of standards which if met, will enable us to get the best from the health and wellbeing workforce in Harrow and position the Health and Wellbeing Board members as exemplary employers, inspiring other local businesses and organisations. Harrow Council has already signed up to the Charter achieving 'commitment' grade but should now work towards 'excellence' grade.	Harrow CCG will take action in 2016 to attain 'Commitment' level of the GLA Healthy Workplace Charter	Jason Parker and Bashir Arif	for Harrow Council, and mapped current service provision against this and the standards set out in the LHWC. Our self-assessment record suggests that we have achieved approx. 26% of the full charter (i.e. of standards required to meet 'excellence' level). Continued progress on initiatives underway will help us score higher but this requires systematic and high level corporate and councillor support that it must be a priority, even in a difficult financial climate if we are to retain a productive and resilient workforce. A 2016-17 workplace health plan has been developed for the Council and a paper is being taken to Corporate Equalities Board and Corporate H&S group (probable steering group). Progress is being made on mental health components of charter particularly. - Public Health has engaged departmental health champions, and the Making a Difference Group who have actively contributed to development of the plans. As a result of Harrow CCG action, LNWHT have registered their interest in the Charter, CLCH are engaged in discussions about the Charter and there are intentions to include a staff health and

			A plan for engaging other local organisations will be developed		wellbeing CQUIN in the CLCH contract **A plan for engaging other local organisations will be developed** Limits on capacity mean focus is currently on Council workforce and PH will produce a plan later in year for engaging other organisation
Age well					
8.	Roll out virtual wards ensuring an integrated approach to health and social care is adopted	Virtual wards are a team of health and social care professionals who work together to provide integrated health and social care to Harrow residents aged 65 and above with one or more long term condition. The Virtual Wards will provide hands on care to the patient, either in a GP Practice or the person's home and give support to their GP / social worker in managing their conditions. The group of professionals come together to provide treatment to patients with complex conditions as if they were on a hospital ward - intensive but proactive treatment. It will mean people will be better for longer, it will mean that when people become ill, their experience of being cared for will be more integrated (and thus better), it will mean people will avoid	- Three virtual wards presently established - Six virtual wards to be operational by 31 March 2016 - Virtual Wards to be supported by multi disciplinary team consisting of social care, community and specialist nursing staff, case manager and dedicated GP	Amol Kelshiker/ Bernie Flaherty Jon Manzoni/ Garry Griffiths	The full Business case for WSIC was presented to the CCG Governing Body and gained approval. This further development will support the expansion of the model across Harrow. The 7 key priorities for the expanded service are: • Improving End of Life Care • Reducing Non Elective Admissions • Improving Hospital Discharge and Reducing Readmission • Identifying Dementia • Reducing the risk of falls. • Improving patient activation • Improving patient satisfaction

		unnecessary visits to hospitals and GPs when they can be better cared for at home. The Health and Wellbeing Board will support full roll out of virtual wards and ensure an integrated approach to health and social care is adopted.			In addition an f/t project lead has been appointed to take the work forward.
9.	Join up approaches and signposting which enable residents to keep themselves healthy and well	Harrow has one of the highest older people populations in London and this is set to rise by around 12% by 2020. One of the key priorities for all Health and Wellbeing Board partners is to 'add life to years' and enable older people to remain well and independent in their own homes for longer. Enabling people to care for themselves for longer means signposting people and their carers – many of whom are over 65 as well - to facilities and sources of information and support which keep them healthy. It is particularly important to consider mental wellbeing in older age groups, given they may be more vulnerable to social isolation and loneliness due to the loss of friends and family, mobility or income. A one size fits all approach will not work in a community as diverse as Harrow and special consideration should be given to engaging with seldom heard groups of older people. The Health and Wellbeing Board can help to improve signposting to appropriate facilities and sources of	- Promote 5 ways to wellbeing - to connect, be active, keep learning, take notice and give - amongst older people - Explore what mechanisms are already in place to signpost residents to facilities, information, advice and services which promote health and wellbeing. - Promote existing mechanisms for signposting residents to facilities, information, advice and services which promote health and wellbeing. - Identify gaps and opportunities to improve signposting, particularly for seldom heard groups and those who do not have access to digital information.	Andrew Howe Carole Furlong	Harrow PH has been actively contributing to the North West London working group discussions in empowering residents to self-care & manage better. Now that a NWL approach to self-care has been developed, PH is keen to use this & the current work, as the basis for engaging with all local stakeholders in developing a holistic self-care strategy for Harrow. In other boroughs this has been successfully led by the voluntary sector. As part of this approach, Harrow CCG is investigating piloting a system to assess patient's motivation and readiness to self-care. If we know this then we can direct patients to the most useful source of support. The annual Public Health report in 2015 covered the topic of social isolation and loneliness. The report promoted the 5 ways to well-being – plus a sixth on creativity

		support and campaign to promote wellbeing. This does not necessarily mean having a single point of access to information but ensuring that at every point a resident may seek out information, they find the same high quality comprehensive information and support.		Rachel Gap	Six guides were produced and distributed across the borough that brought together the various activities to promote wellbeing across Harrow ranging from mindfulness sessions to dance classes. The Warm Homes Healthy People Project has supported almost 600 people over the past two years. The project's main aim is to help people who live in cold homes. As well as dealing with fuel poverty issues, the advisors also signpost people to social activities and befriending schemes to reduce social isolation. The council is undertaking a review of all of the advice and advocacy services it commissions with a view to identifying gaps and duplications and commissioning these services more effectively in the future The Council is developing an Information, Advice and Advocacy Strategy for the borough, and is in discussions with the CCG on how such services they commission can be integrated in the strategy. Following the development of strategy this will lead to a new commissioning approach with related services in place by April 2017. One clear aspect that has arisen during the consultation is

					around join-up of services and also join-up with those services provided in the community but not commissioned by public sector organisations. Co-production workshops on the strategy development will take place in June and July.

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	30 June 2016
Subject:	**Sustainability & Transformation Plan (STP) Update**
Responsible Officer:	Javina Sehgal, Chief Operating Officer Harrow CCG Chris Spencer, Corporate Director People, Harrow Council
Exempt:	No
Enclosures:	None

Section 1 – Summary and Recommendation

This report provides an update on the previous report presented to the HWB on 11th May 2016. The report focuses on local work in two main areas: stakeholder engagement and the emerging local themes for the nine NWL priorities of work.

Recommendation: The HWB is asked to note the report and endorse the actions taken to progress the Harrow contribution to the NWL STP. The NWL submission made on 30th June will be positioned as a checkpoint submission as development of the local STPs will continue beyond that date. The previous report stated the intention to bring the NWL June submission to the HWB meeting on 30th June 2016. The final NWL submission date has been deferred and the proposed content now includes a Harrow STP Executive Summary. The Harrow Exec Summary will be presented to the Board at the meeting on 30 June 2016, and the final NWL checkpoint submission to NHSE will be presented at the next HWB meeting on 8th September 2016.

Section 2 – Report

Background

The NHS Five Year Forward View (FYFV), published in October 2014, set out a shared vision for the future of the NHS, which aligns to the strategic objectives in North West London (NWL) and Harrow. Planning Guidance released in December 2015 set the requirement to develop a shared five-year plan. Forty four STP footprints have been established nationally. The STP plans for each should describe how areas will locally deliver the requirements of the Five Year Forward View.

Boroughs in NWL, including Harrow, have been collaborating as 'place based systems' across health and local government to address the ambition set out in the FYFV. The NWL STP will describe plans at different levels of 'place'– across the whole system in NWL, from the local to the sub-regional, as appropriate. The local plans jointly developed for Harrow will form the building blocks of the NWL STP. This STP will be an umbrella plan and will bring together local place-based plans to address the health and care 'gaps' described in the Five Year Forward View:

- The health and wellbeing gap;
- The care and quality gap; and
- The funding and efficiency gap.

Harrow Response to the STP

The members of the Harrow Sustainability and Transformation Planning Group (HSTPG) have been continuing to work together to develop local plans to feed into the NWL STP document. Harrow CCG is still acting currently as the convenor for the HSTPG which meets bi-weekly, and also acts as the conduit across the sub-regional and regional arrangements as NWL work together to coordinate the STP process. The HSTPG membership still includes other stakeholders including patient groups and 3rd sector providers.

Building on the high level work done in March and April for the agreed mid-April high level draft submission, the HSTPG have been applying principles of co-design and joint ownership for delivery to ensure that the local plans deliver step change for the three care gaps over the next 5 years.

The local work has been structured around the 9 emerging priorities for NWL as presented at the May meeting of the HWB, closely aligned with the HWB strategy developed earlier in 2016.

Plan and priorities

The April to June timescales for the development of the plan remain tight and have been determined by the national programme established by NHS England.

Development of our local draft plan has been facilitated by:

- Resourcing the STP with external support from GE Healthcare Finnamore, funded by the NWL Strategy and Transformation team.
- Identification of key individuals within each organisation who have been working together to build the local plans in response the 9 priorities of NWL
- Bi weekly meetings of the HSTPG to review progress and inform the local plan content, while identifying priorities unique to the Health & Wellbeing vision and care needs of Harrow.
- Specific working group sessions with the CCG, Council and providers to focus on developing plans and strategies for the four years beyond 2016/17.

The HSTPG is still taking note of the work and processes of the neighbouring SPGs to ensure that a consistent approach is taken across NWL, and also to identify key learning which can be applied to facilitate the development of the Harrow plans. An example of this is the ongoing joint STP work with Brent and London Northwest Hospitals on End of Life care.

Examples of some of the emerging themes for Harrow are shown below. The HSTPG and the various workgroups will continue to develop these and other themes into proposed actions and strategies for the STP

Triple aims	NW London's emerging priorities	Examples of Harrow's emerging local themes
Health & Well-Being	1. Support people who are mainly healthy to stay mentally & physically well 2. Reduce social Isolation 3. Improve children's mental and physical health and well-being	1. Improving sign-posting for people and carers, including enabled by Project Infinity and Personal Budgets 2. Reviewing scope and scale of day services, mental health employment opportunities and a broader supported housing strategy 3. Options appraisal for the CAMHS service transformation, early help and eating disorders
Care & Quality	4. Ensure people access the right care in the right place at the right time 5. Reduce the gap in life expectancy between adults with severe & enduring mental illness and the rest of the population 6. Improve the overall quality of care for people in their last phase of life 7. Improve consistency in patient outcomes and experience every day of the week 8. Reduce unwarranted variation in the management of LTCs – diabetes, cardiovascular disease and respiratory disease 9. Reduce health inequalities and outcomes disparity for top 3 killers, inc. cancer	4. Walk-in centres, Hubs and Heart of Harrow strategies 5. Ensuring Mental Health is included in local Integrated Care plans, holistic health assessments, Single Point of Access 6. Co-design and aligning of strategies and actions across Harrow and Brent in partnership with acute hospitals 7. Develop Health and Social Care discharge pathway into Community Services 8. Targeted and ongoing investment in whole systems integrated care transformation focussing on how to provide personalised care for people with 1 or more Long Term Condition. 9. Reducing health inequalities through local, accessible "closer to home" services, improving early diagnosis capability.
Finance & Efficiency	All of the above will contribute to achieving and maintaining financial balance	All of the above will contribute to achieving and maintaining financial balance

Stakeholder Engagement

In light of the national planning guidance on producing a Sustainability and Transformation Plan (STP), the Harrow STP partners have been progressing with local stakeholder engagement.

Presentations have been given to the Harrow Voluntary and Community Services Forum at the end of May and Healthwatch Harrow in early June. The focus of the sessions was to raise awareness of the STP and the local Harrow process.

- The VCS event was attended by ~12 leaders from voluntary sector organisations across Harrow. The presentation was jointly delivered by the CCG, Harrow Council and a CCG Lay member. Ideas discussed included simplifying the language used to improve understanding of priorities and strategies and voluntary organisations should be seen as equal partners in STP development and delivery. The VCS also emphasised that the building of capacity in the third sector should be included as a Harrow priority.
- The Healthwatch Harrow event was attended by ~31 members. The presentation was jointly delivered by the CCG, Harrow Council and a CCG Lay member. Views from the audience on possible content for the local STP included looking at holistic approaches to care (health and care plans for the whole person), and improving systems to better track patients and improve communications (including signposting) through digitization.

The development of at least one joint public event is ongoing, however timing of the event has been considered in the context of Harrow's already comprehensive engagement activities planned for June.

A STP-specific event is now likely to be run in July 2016. Ideally this should be followed by a second event sometime in Quarter 3 of 2016/17 to share the further developed plans for both NWL and Harrow.

The prime focus of the events will be to provide members of the public, voluntary sector, front line staff and key stakeholders from each organisation with an understanding of the STP and understand local implications for Harrow's health and social care economy.

Governance and Sign Off of the Local Plan
A key factor in the Harrow submission is the joint Governance and sign-off of the final Harrow submission at the end of June.

As discussed in May, governance of the local process will be managed through the structure of the HSTPG whose members represent the various organisations and who are tasked to raise any issues and concerned with their respective Executive Boards. The regular feedback and updates given to the HWB are to enable them in their oversight role for the Harrow STP.

Recommendation
The HWB is asked to note this report and endorse the priorities set out within it. The Board is also requested to note that the 30 June 2016 NWL STP checkpoint submission will be now be presented to the Board at the meeting in July 2016. The 30 June 2016 meeting will be asked to consider the Harrow STP Executive Summary which will be included in the NWL submission.

Section 3 – Further Information

Further updates will be given at the next meeting of the Harrow H&WB.

Section 4 – Financial Implications

The national £1.8 billion Sustainability and Transformation Fund resources are part of the recurrent real-terms uplift for the NHS in 2016/17 of £3.8 billion[1]. The content of the regional STP submissions, including NWL, will be a determining factor in the allocation decisions nationally. Indicative allocations suggest that the NWL STP CCG allocation will be in the region of £3,643m for 2016/17 rising to £4,093m by 2020/21. Additional transformation funding may be allocated and will be assessed as part of the STP submission.

Both the Council and CCG continue to face significant financial challenges.

In July 2015, Cabinet received a budget planning process update report which reaffirmed the total budget gap of £52.4m over the three year period 2016/17 to 2018/19. In February 2016 the Council approved the final revenue budget for 2016/17 and Medium Term Financial Strategy (MTFS) for 2016/17 to 2019/20, which included a significant level of savings to deliver a balanced budget over the MTFS term.

The CCG submitted the final version of the operating plan at the beginning of April, which indicated that the CCG would achieve recurrent balance by the end of 2016/17. However the CCG would not be compliant with NHS business rules (namely a deterioration in the year on year position and achieving a 1% cumulative reserve).

The financial models to support the development of the local and NWL STP are being jointly developed by CCG CFOs. These plans are expected to assist in contributing to and achieving financial balance for health budgets. These plans will be presented as they are developed for consideration and approval through the relevant governance processes (CCG & LA), to ensure that any proposals can be delivered within the existing MTFS and financial plans.

Any considerations around the potential to pool resources across health and social care will be reported in due course and to seek the relevant approvals.

Section 5 - Equalities implications

No Equality Impact Assessment has been carried out at this stage. This will be reviewed as the plans develop.

Section 6 – Corporate Priorities

By its nature and intent the STP supports the following corporate priorities:

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

[1] The Sustainability and Transformation Fund and financial control totals for 2016/17: your questions answered, March 2016.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/506565/STF_FAQ_-_9_march_FINAL.pdf

- Supporting and protecting people who are most in need.

STATUTORY OFFICER CLEARANCE

Name: Donna Edwards Date: 10 June 2016	x	on behalf of the Chief Financial Officer
Name: Caroline Eccles Date: 10 June 2016	x	on behalf of the Monitoring Officer

Section 7 - Contact Details and Background Papers

Contact: David Bowen-Cassie, Harrow STP Lead, 07741 249 235

Background documents: None

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	**30 June 2016**
Subject:	Harrow and Brent System Resilience Group (SRG)
Responsible Officer:	Sue Whiting, Assistant Chief Operating Officer, Harrow CCG
Public:	Yes
Wards affected:	N/A
Enclosures:	None

Section 1 – Summary and Recommendations

This report gives an overview of the Brent and Harrow System Resilience Group (SRG), focused on Harrow. The SRG is an opportunity to work together collaboratively, bringing key organisations together to deliver timely access to care for the residents of Harrow Borough. The report summarises what an SRG is, and presents the work of the Brent and Harrow SRG in terms of key programmes and initiatives, and sets out the benefits of the SRG and other related programmes to the patients and population of Harrow.

Recommendations:
The Board is requested to:
(1) Note the report.
(2) Confirm the Harrow Council representative (and deputising arrangements) for the Brent & Harrow SRG

Section 2 – Report

2.1 System Resilience Groups (SRGs)

Professor Sir Bruce Keogh outlined NHS England's vision for change in his *Review of Urgent and Emergency Care (the Review) End of Phase One Report*, published in November 2013[(1)].

Under this new care model outlined in the *NHS Five Year Forward View* [(2)], the urgent and emergency care system would be simplified to provide better integration between A&E departments and other services that provide and support urgent treatments.

Urgent and Emergency Care Networks (U&EC – see Figure 1) will be based on the geographies required to give strategic oversight of urgent and emergency care on a regional footprint, ensuring that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise, whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible.

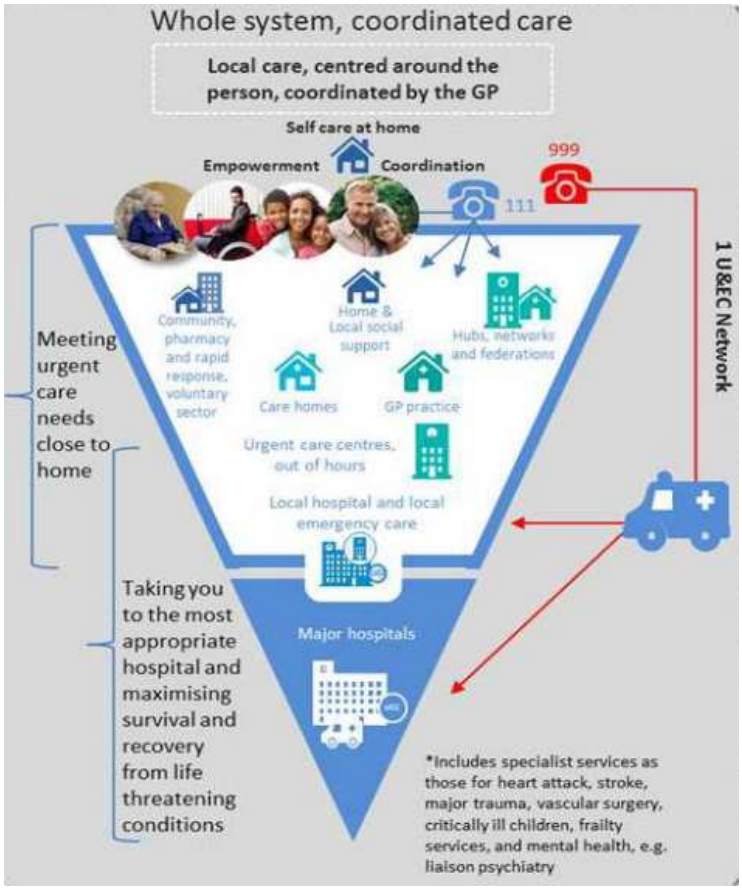


Figure 1: North West London Strategy [(3),] based on Professor Sir Bruce Keogh NHS England's vision for change [(4)]

System Resilience Groups (SRGs) have evolved to undertake the operational leadership of those local services fulfilling the role anticipated of the "operational networks" described in Sir Keogh's report.

SRGs retain responsibility for ensuring the effective delivery of urgent care in their area, in co-ordination with an overall urgent and emergency care strategy agreed through the regional Urgent and Emergency Care Network.

2.1.1 Important Operational Objectives for SRGs

For SRGs, important operational objectives include:

- The translation and delivery of network service designations and standards to match the local provision of services
- Ensuring a high level of clinical assessment for the patient, in or close to their home, and ready access to diagnostics where required
- The development and utilisation of "clinical decision-support hubs" to support the timely and effective delivery of community-based care
- Establishing effective communication, information technology and data sharing systems, including real-time access to an electronic patient record containing information relevant to the patient's urgent care needs
- The delivery of local mental health crisis care action plans to ensure early and effective intervention to prevent crisis and support people who experience mental health crisis
- Ensuring the effective development and configuration of primary and community care to underpin the provision of urgent care outside hospital settings 24/7 and
- Achieving accurate data capture and performance monitoring

2.2 Brent and Harrow SRG

SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. SRGs plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). SRGs have helped to establish more patient-centred care and are encouraging shared learning across health and social care communities by working in partnership.

Appendix 1 shows the membership of the Brent and Harrow SRG.

One of the principle purposes of the SRG is to drive the delivery of the Operational Resilience Plan by:

- Ensuring determination of need across the Harrow and Brent geographical footprint
- Initiating local change as identified
- Eliminating barriers to whole system improvement

- Ensuring all relevant perspectives as to both unplanned and planned care within the local health and social care system are adequately considered
- Enabling the management of Accident & Emergency 4-hour performance and referral to treatment times, including all of the contributing factors to achieving these targets
- Improving patient experience
- Assurance that appropriate systems and structures are in place and managed on a day-to-day basis
- Taking community pressures into consideration
- Monitoring progress against the required metrics of the Better Care Fund

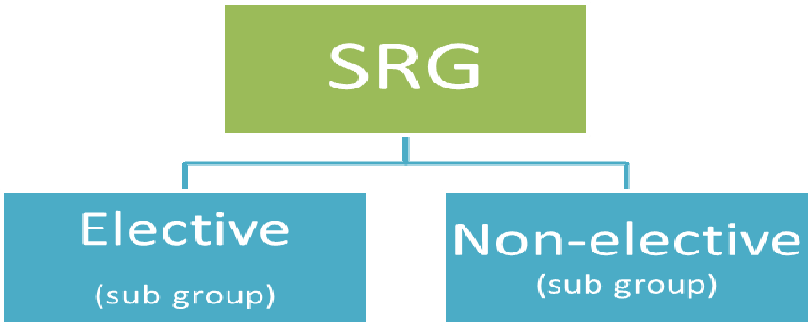
Key roles and functions of the SRG

- Provide an opportunity for all parts of the local health and social care system to co-develop strategy
- Collaboratively plan safe and efficient services for patients
- Provide the forum for system wide planning of service delivery

The SRG will measure its progress mainly through:

- Its ability to meet nationally prescribed planning requirements
- Working together to ensure that the Operational Resilience Plans and updates are supported and assured
- Demonstrable ability to flex or otherwise vary the ORP to incorporate actions required to meet specific identified challenges, including periods of likely heightened demand (e.g. over Winter)
- Ensure adequate testing of system wide escalation planning occurs
- Oversee monitoring of application of resilience funding to optimise outcomes

2.2.1 Composition of the Brent and Harrow SRG Sub-Groups



2.2.1.1 Elective Sub-Group

This sub-group facilitates the delivery of elective (an admission to hospital that has been arranged in advance: it is not an emergency admission, nor a maternity admission nor a transfer from a hospital bed to another health care provider) projects that have been clinically agreed by members of the SRG.

The sub-group also oversees the performance management and quality assurance of elective schemes. In doing so, the elective sub-group identifies gaps in the delivery of target outcomes and initiates collaborative Task and Finish Groups. Risks are managed collaboratively through an agreed risk mitigation plan, and significant risks are escalated to the SRG.

Current work streams include:

- Referral to treatment initiatives (RTT)
- Cancer
- Diagnostics

2.2.1.2 Non-Elective Sub-Group

This Sub-Group facilitates the delivery of non-elective (for unplanned, frequently urgent hospital admissions via A&E in most cases) projects that have been clinically agreed by members of the SRG.

Workstreams include:

- Winter Plan
- Better Care Fund

2.3 Benefits of the SRG to the Harrow Population

The Harrow-wide vision for whole systems integrated care is to improve the quality of health and social care for individuals, carers and families, empowering and supporting people to maintain independence and lead full lives as active participants in their community.

Partners across Harrow believe that truly empowering people to help themselves requires support to be provided around people, and not around existing organisational arrangements.

By working in this way through the BCF and the SRG, the benefits for the patients and population of Harrow will be:

- Improvements in the quality of life for everybody in our Borough by providing proactive, joined-up services
- Stakeholder organisations working together, sharing information, expertise and experience better
- Delivering co-ordinated seamless care, in particular to those with the most complex health needs, including those with multiple long-term conditions
- Improving the efficiency of the existing system by reducing inter-agency referrals
- Reducing the utilisation of acute care resources to support our residents
- Making it easier for everybody, however sick or frail, to continue to live happily and safely at home.

2.4 Progress and Update Against 2015/16 Objectives

2.4.1 Elective Sub-Group

2.4.1.1 RTT

The London North West Hospital Healthcare (LNWHT) Trust's RTT position is currently not achieving the target for incomplete pathways. Most specialities are under pressure as all urgent requests are being prioritised. The focus is on driving efficiency, and a plan is in place to improve performance which will take time to embed.

2.4.1.2 Cancer

Cancer performance with regards to the 62 Day Cancer Waits has been challenging for the Trust to achieve in previous months. New for 2016/17 is the Cancer Remedial Action Plan (RAP) agreed between the LNWHT and Commissioners, and measures are being put in place to make improvements.

2.4.1.3 Diagnostics

Diagnostic performance has dipped since September 2015 in regards to the 6 week diagnostic wait. An improvement trajectory is in place along with an improvement plan focusing on patient booking, imaging, physiological measurement and endoscopy.

2.4.2 Non-Elective Sub-Group

2.4.2.1 A&E performance

Achievement of the A&E 4-hour wait target continues to be challenging. Work has been on-going throughout 2015/16 with London North West Healthcare NHS Trust (LNWHT) to improve patient flow and reduce delayed transfers of care. 43 new modular beds were opened in January 2016 to meet additional demand. LNWHT has submitted a revised action plan and trajectory to commissioners which has been agreed. Additional staffing has been brought into A&E and Surgical capacity continues to be utilised to ensure that bed breaches are minimised.

2.4.2.2 Emergency Care Improvement (ECIP)

Brent & Harrow SRG are working closely with ECIP (previously called Emergency Care Intensive Support Team - ECIST) to review and improve emergency care processes at LNWHT and support improvements to patient flow through the trust. This will improve both the 4 hour wait A&E target achievement and discharges from ED and Inpatients.

2.4.2.3 Delayed Transfers of Care (DToC)

The non-elective sub group actively reviews DToC numbers including the number of DToC patients and the number of Days lost due to DToCs. The top breach reasons across providers is also reviewed. Bottlenecks across the system are then removed to enable patient flow to be improved.

2.4.2.4 Discharge pathway

As well as the ECIP discharge work, Brent & Harrow is working with partners across North West London to review and implement a universal discharge protocol. This work involves discussions with key stakeholders to review and compare current discharge policies for gaps and best practice and develop a unified protocol accepted across agencies.

2.4.2.1 Winter Planning

Harrow CCG Winter Schemes for 2015/16 are shown in the table below.

Table 1: Winter Schemes – Harrow CCG 2015/16

Harrow CCG Local Winter Schemes 2015/16
Winter / Emergency Planning (Willow Ward)
Mount Vernon Beds – Edmund Ward (Step Down bed reserve) / CLCH
NH W16 Additional Beds in Willesden (Furness)
3 Neuro Beds
10 Nursing Beds
NH W7 Acute Psychiatric Unit – Co-located (transit Lounge)
Winter Resilience – Continuing Health Care Assessment (Staff Cost)
3 Occupational Therapists (Band 5)
STARRS Social Worker
Social Care Harrow
Reablement
Care UK Green Ambulance (111 Resilience Scheme)
Winter Pressure campaign advertising cost
Additional Winter Pressure
111 Pharmacy Hub

2.4.2.2 Better Care Fund

The Better Care Fund [5] (BCF) is a Programme spanning both the NHS and Local Government in each footprint area. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wrap-around' fully integrated health and social care, resulting in an improved experience and better quality of life.

Working with Harrow Local Authority, the agreed BCF schemes for 2016/17 will be Protection of Social Care Services (provided by the Local Authority) and Whole Systems & Transformation of Community Services (provided by Harrow CCG).

The funding will be supported by a Section 75 agreement between the CCG and the Local Authority (such a S75 agreement allows the two bodies to enter into partnership agreements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised).

2.4.2.1 Protection of Social Care

In 2015/16, the Protection of Social Care Programme focused on the implementation of the Health and Social Care Act (2012) to support people with eligible levels of need, and to deliver high quality reablement and rehabilitation.

In 2015/16, the work looked at delivering:

a) Swift access and assessment, either from the acute sector or from a community setting, fully aligned with integrated teams wrapped around GP services
b) Reablement at the 'front of house' when people present to social care
c) A diverse range of available services for those eligible, purchasable through 'personal budgets'
d) Comprehensive and effective safeguarding of vulnerable adults and diligent quality assurance to ensure services are of a good standard

In 2016/17, the aim of this programme of work will be to ensure that the social care provision essential to the delivery of a safe, effective, supportive whole system of care is sustained and the same level and quality of service.

2.4.2.2 Whole Systems Integrated Care and Transformation of Community Services

In 2015/16, 2 new initiatives were developed, both of which - though at an early stage of development - are already delivering significant positive benefits to Harrow patients:

- *Virtual Ward Project:* In order to provide more intensive support in the community for patients at high risk of hospital admission (but not requiring the short term crisis level support provided by the Rapid Response Team), network based Virtual Wards have been established. These are led by dedicated GPs with Special Interest (GPwSI) and supported by a multi-disciplinary team (MDT), which also incorporates a Virtual Ward Case Manager.

- *Enhanced Practice Nurse (EPN) Project:* In partnership with the CCG, GP Practices across Harrow have employed EPNs to provide rapid and high level support for house-bound patients at high risk of hospital admission. By 31st December 2015, over 724 patients whose average age was 84 had been supported, and all of whom were at risk of hospital admissions.

A key innovation in 2015/16 was the development of the Anticipatory Care Plan element of the Care Plan which pro-actively sets out future goals and actions for each patient.

Another key area of work in 2015/16 was the measurements of benefits achieved through the delivery of the Whole Systems (WS) Programme.

This focused on the avoidance of non-elective, elective, and accident and emergency admissions.
Monthly monitoring indicated that by November 2015, 435 non-elective admissions were avoided, which was ahead of a target of 384.

In 2016/17, the primary objective of the WS Programme is to demonstrate the sustainability of a multi-disciplinary and collaborative approach for the provision of

anticipatory care in the community to support a cohort of patients at high risk of hospital admission.

In particular, the aim of the WS Programme is to support patients who are over 65 years of age, and have one or more long-term conditions. In total, there are 28,400 patients within the Borough that are over 65, with one or more long-term conditions and these currently account for 5,960 unplanned hospital admissions each year at an average cost of £2,628 each, and a total cost of £16 million per year.

2.4.2.2 BCF Future Plans for 2016/17

In 2016/17, the WS Programme will focus on providing anticipatory, multi-disciplinary care for those 5,000 people within the cohort who, through a systematic approach to case identification, are identified as most likely to benefit from the support available.

In particular, the following 3 patient groups have been identified as those that will be supported through the WS Programme in 2016/17:

- People over 65, with one or more long-term conditions, and an EMIS IQ Risk Score of 40 or over
- People over 65, with one or more long-term conditions, recently discharged from hospital and who have had 3 or more hospital admissions in the last 12 months
- People over 65, with one or more long-term conditions, currently living in a residential or nursing care home in the Borough

By focusing support on a proportion (approximately 20%) of the over 65s with one or more long-term conditions cohort it is anticipated that through multi-disciplinary working, partners will have a bigger overall impact on health outcomes and hospital admissions than if the resources available were spread over a larger cohort of people.

The target for the programme is that within the cohort of 5,000 people, 500 fewer hospital admissions will be recorded in the six months following referral compared to the six months prior to referral.

If this is achieved, then this would be equivalent to a saving of £1,314,000. 7 further outcome measures have also been developed for the WS Programme in 2016/17 and performance against each will be measured throughout the year. These measures are:

- Falls
- Dementia
- End of Life Care
- Non-Elective Admissions
- Hospital Discharge Support
- Patient Activation
- Patient Satisfaction

2.5 New Developments / Models for Brent and Harrow SRG - The High Impact 8 Change Model

Brent and Harrow CCG are working towards using the High Impact 8 Change Model as a framework for delivering health and social care improvements to Brent and Harrow patients (see Figure 2).

The Model was produced by several organisations: the Department of Health, the Local Government Association; NHS England; Monitor; Trust Development Agency (TDA); and ADASS, the Association of Directors of Adult Social Services.

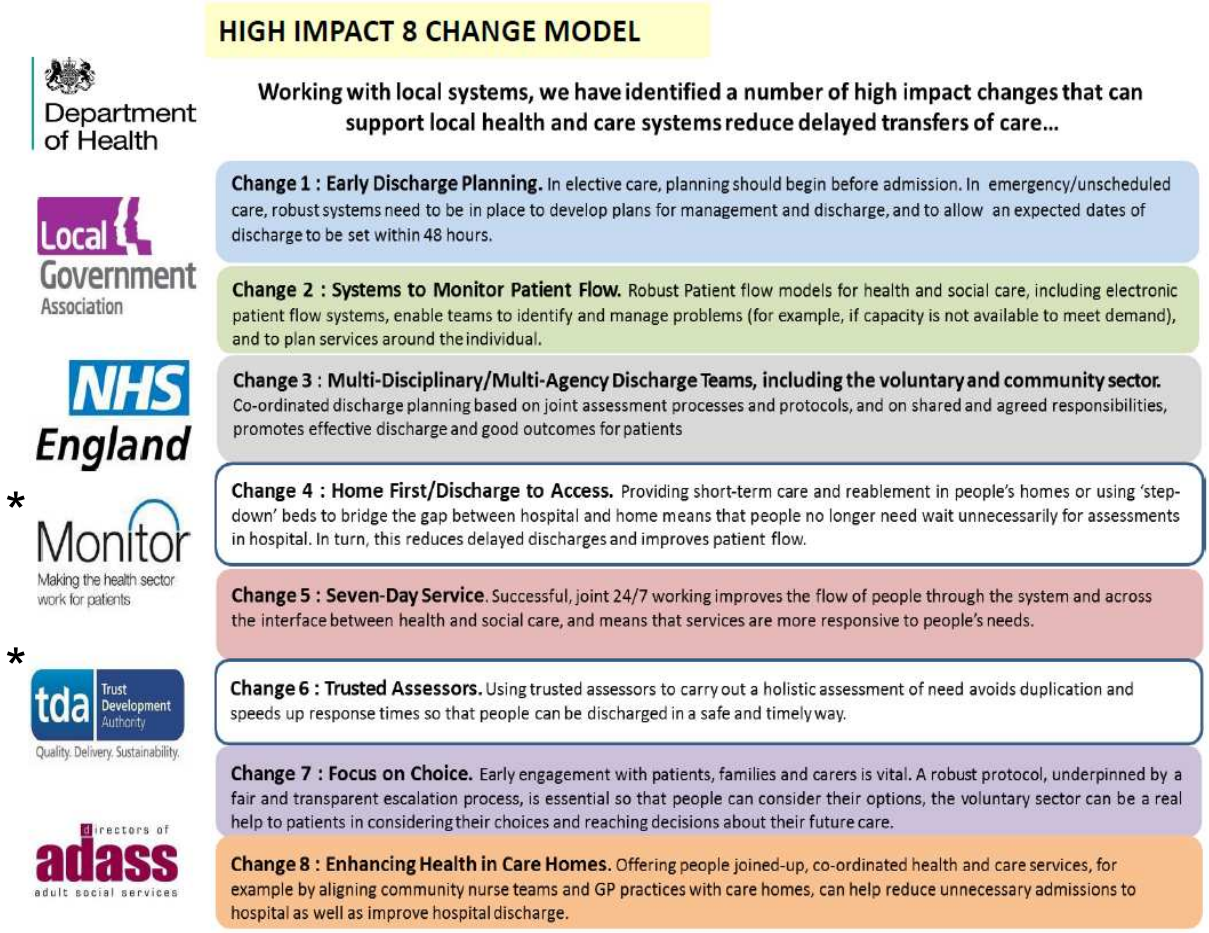


Figure 2: High 8 Impact and Change Model

* Note: The TDA and Monitor are now part of NHS Improvement.

At present, the Brent and Harrow SRG is undertaking a gap analysis and working towards incorporating the NHS Constitution and Outcomes Framework targets with the recently released *"CCG Improvement and Assessment Framework 2016/17"* [6] into a revised suit of indicators for the Brent and Harrow SRG.

These indicators will help drive performance improvement of the High Impact 8.

2.5.1 Current self-assessment against the High Impact Change Model

Ensuring people do not stay in hospital for longer than they need to is an important issue – maintaining patient flow, having access to responsive health and care services and supporting families are essential.

Valuable lessons were learnt from the health and social care system across the country last winter about what works well, and these lessons have been built into the High Impact Change model.

We have reviewed Brent and Harrow SRG's current maturity against the High Impact Changes assessment criteria which supports each change in the model. The evidence used is a base position of what is currently available to the Brent Harrow and Hillingdon CCGs Delivery and Performance Team.

Current assessment position.

	Not yet Established	Plans in place	Established	Mature	Exemplary
RAG RATING	Rating 1/5	Rating 2/5	Rating 3/5	Rating 4/5	Rating 5/5

Impact Change	Current assessment Position	Evidence link
Early discharge planning	Rating 2 - Plans in Place	One version of the truth. ED Action Plan. BCF
Systems to monitor patient flow	Rating 2 - Plans in Place	One version of the truth. ED Action Plan. BCF
Multi disciplinary / multi agency discharge teams	Rating 2 - Plans in Place	Brent & Harrow BCF plans
Home first / Discharge to Access	Rating 2 - Plans in Place	Brent & Harrow BCF plans
Seven Day Service	Rating 2/3 - Plans in Place / Established	Brent & Harrow BCF plans
Trusted Assessors	Rating 2 - Plans in Place	Brent & Harrow BCF plans
Focus on Choice	Rating 2 - Plans in Place	Brent & Harrow BCF plans
Enhancing Health in Care Homes	Rating 2 - Plans in Place	Brent & Harrow BCF plans

Figure 3: High 8 Impact and Change Model – Brent and Harrow SRG self-assessment rating

2.5.2 Conclusion of assessment

The first run of the self-assessment found that Brent and Harrow SRG is currently rated as 'Plans in Place' (Figure 3) for the High Impact Change Model.

A prudent view has been taken in making the assessment due to the materials at hand. For this reason, we could anticipate that assessment of each change could in effect move up one position.

It is also expected that the assessment position will move up in ratings once leads have been identified to give comprehensive updates - specifically against the

assessment criteria, and once further documents and evidence are interrogated further.

2.5.3 Next steps

Further work will be done to progress the self-assessment of Brent and Harrow SRG against the High Impact Change model, which will result in a firm baseline position of rating for each change on, which to build and improve towards higher ratings and plug gaps in assessment assurance.

Gaps in assurance of assessment will be targeted and filled, while actions will be addressed to increase rating standards.

It is suggested that a position of 'Established' (see Figure 3) is aimed for in the first instance for each module in the High Impact Change Model.

A performance dashboard will be developed with robust metrics which will monitor both the High Impact Changes and their progress to moving up to the next rating step, and system improvement to delivering patient care.

The ultimate conclusion of this work will see SRG meetings using the High Impact Change model to assess, interrogate and improve key workstreams.

This would be conducted under the guidance and with the assistance of a comprehensive virtual PMO from the newly configured BHH Delivery and Performance team.

2.6 Summary

The Brent and Harrow SRG is a senior leaders' group that is tasked with ensuring that the different organisations and stakeholders – including the voluntary sector – all work together to ensure that, operationally, patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise, whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible.

APPENDIX 1

Membership of Brent and Harrow SRG

Name	Title/Role	Organisation
Dame Jacqueline Docherty	Chief Executive	London North West Hospital Trust (LNWHT)
Dr Charles Cayley	Medical Director	LNWHT
Lee Martin	Chief Operating Officer	LNWHT
Yvonne Leese	Director of Community Services	LNWHT
Maeve O'Callaghan-Harrington	Deputy Director of Operations	LNWHT
Vince Baxter	General Manager – Adult Services	LNWHT
Jason Antrobus	Head of Performance	LNWHT
Jo Ohlson	Director of Commissioning Operations NWL	NHS England
Matthew Bailey	Deputy Head of Assurance NWL	NHS England
Pauline Cranmer	Assistant Director of Operations	London Ambulance Service (LAS)
Dr Etheldreda Kong	Clinical Chair	Brent CCG
Dr Sami Ansari	Clinical Lead for Acute & Urgent Care	Brent CCG
Sarah Mansuralli	Chief Operating Officer	Brent CCG
Isha Coombes	Assistant Director - Out of Hospital Services	Brent CCG
Dr Amol Kelshiker	Clinical Chair	Harrow CCG
Javina Sehgal	Chief Operating Officer	Harrow CCG
Sue Whiting	Assistant Chief Operating Officer	Harrow CCG
Phil Porter	Strategic Director – Community Wellbeing	Brent Local Authority
Yolanda Dennehy	Adult Social Care Lead	Brent Local Authority
Bernie Flaherty	Director of Adult Social Services	Harrow Local Authority
Sean Riley	Social Care Service Manager	Harrow Local Authority
Rob Larkman	Accountable Officer	Brent Harrow and Hillingdon CCGs
Jan Norman	Director of Quality & Strategy	Brent Harrow and Hillingdon CCGs
Alex Faulkes	Director of Delivery & Performance	Brent Harrow and Hillingdon CCGs
Jeff Boateng	Deputy Director of Delivery & Performance	Brent Harrow and Hillingdon CCGs

REFERENCES:

1. *"Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report";* NHS England; http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf
2. *"NHS Five Year Forward View";* NHS England; https://www.england.nhs.uk/ourwork/futurenhs/
3. *"NHS 111/GP Out of Hours Integrated Services - A key role in the redesign of urgent and emergency care";* North West London Collaboration of CCGs; https://www.harrow.gov.uk/www2/documents/s130336/151014%20NWL%20JHOSC%20-%20paper%202%20-%20Update%20on%20NHS%20111%20service.pdf
4. *"Role and Establishment of Urgent and Emergency Care Networks";* NHS England; http://www.nhs.uk/NHSEngland/keogh-review/Documents/Role-Networks-advice-RDs%201.1FV.pdf
5. *"Better Care Fund";* NHS England; https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
6. *"CCG Improvement and Assessment Framework 2016/17*", NHS England; https://www.england.nhs.uk/commissioning/ccg-auth/

Financial Implications/Comments

No direct implications.

Legal Implications/Comments

https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

Risk Management Implications

Lack of collaboration may cause delays in access to care, and/or failure to utilize resources most appropriately.

Equalities implications

Was an Equality Impact Assessment carried out? EIAs are be carried out under each individual Programme of work

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

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

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Sue Whiting,
Assistant Chief Operating Officer, Harrow CCG
020 8966 1006

Background Papers None.

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