Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Thursday 15 December 2016**

TIME: **7.30 pm**

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

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Michael Borio**

Councillors:

Niraj Dattani	Mrs Vina Mithani (VC)
Margaret Davine	Chris Mote

Reserve Members:

1. Jo Dooley	1. Lynda Seymour
2. Ajay Maru	2. Jean Lammiman
3. Sasi Suresh	

Advisers:

Julian Maw	Healthwatch Harrow
Dr N Merali	Harrow Local Medical Committee

Contact: **Manize Talukdar, Democratic & Electoral Services Officer**
Tel: 020 8424 1323 E-mail: manize.talukdar@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. 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 Sub-Committee;
(b) all other Members present.

3. MINUTES (Pages 5 - 12)

That the minutes of the meeting held on 27 June 2016 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

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 12 December 2016. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

7. HARROW SAFEGUARDING ADULTS BOARD (HSAB) ANNUAL REPORT 2015/2016 (Pages 13 - 72)

Report of the Assistant Director, Adult Social Services.

8. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016 (Pages 73 - 226)

Report of the Director of Public Health.

9. CQC INSPECTION REPORT FOR LNWHT AND ACTION PLAN & UPDATE (Pages 227 - 234)

Report of the Chief Nurse, London North West Healthcare NHS Trust.

10. INFORMATION REPORT: NORTH WEST LONDON (NWL) SUSTAINABILITY & TRANSFORMATION PLAN (STP) (Pages 235 - 312)

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

11. INFORMATION REPORT: DIABETES UPDATE (Pages 313 - 318)

Report of Chief Operating Officer, Harrow Clinical Commissioning Group.

12. VERBAL UPDATE ON THE NEW WALK IN CENTRE LOCATED AT THE BELMONT HEALTH CENTRE (Verbal Report)

Verbal update of the Chief Operating Officer, Harrow Clinical Commissioning Group.

13. SHAPING A HEALTHIER FUTURE - UPDATE FROM NW LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 319 - 324)

Report of the Divisional Director, Strategic Commissioning.

14. ANY OTHER BUSINESS

Which the Chairman 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.]

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HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

27 JUNE 2016

Chair:	*	Councillor Michael Borio		
Councillors:	†	Niraj Dattani	*	Mrs Vina Mithani
	*	Margaret Davine	*	Chris Mote
Advisers:	*	Julian Maw	-	Harrow Healthwatch
		Dr N Merali	-	Harrow Local Medical Committee

* Denotes Member present

70. Attendance by Reserve Members

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

71. Declarations of Interest

RESOLVED: To note that there were no declarations of interests made by Members.

72. Minutes

RESOLVED: That the minutes of the meeting held on 1 March 2016, be taken as read and signed as a correct record.

73. Appointment of Vice-Chair

RESOLVED: To appoint Councillor Mrs Vina Mithani as Vice-Chair of the Sub-Committee for the 2016/2017 Municipal Year.

74. Public Questions and Petitions

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

75. References from Council and Other Committees/Panels

There were none.

RESOLVED ITEMS

76. Appointment of Advisers

The Committee received a report which recommended the appointment of two non-voting advisers to the Sub-Committee for the 2016/17 Municipal Year.

RESOLVED: That Mr Julian Maw of HealthWatch Harrow and Dr Nizar Merali of the Local Medical Committee be appointed as advisers to the Sub-Committee for the 2016/17 municipal year.

77. Royal National Orthopaedic Hospital Draft Quality Accounts

The Committee received a report which contained the final draft of the 2015/16 Quality Account for the Royal National Orthopaedic Hospital (RNOH).

The representative from RNOH introduced the report and explained that the version provided to the Committee would be formatted into a professional format once finalised. The representative explained that the Quality Account reviewed the Trust's performance across a range of indicators as well as setting out quality improvement priorities for 2016/17.

The following questions were made by Members and responded to accordingly:

- How does the Trust expand on issues raised in patient experiences to ensure that it was responsive?

  The Trust collected data from inpatient surveys to identify key issues identified. Friends and family were also asked for their views and patients were additionally asked if they would recommend the hospital to other patients. The Trust was fortunate that it had a good response rate to these surveys.

  In terms of statistics, RNOH was ranked in the top 8 nationally for its response rates to the surveys. Additionally 96% of patients had responded that they would recommend RNOH and in terms of Health and Social Care were ranked in the top 10 nationally.

- Are there any plans to address the physical state of the buildings of RNOH?

The buildings did require some maintenance works but it had to be recognised that RNOH was one of the leading orthopaedic hospitals in the UK, had very high standards and had good infection control measures.

There were building works proposed which would improve its condition.

- How does the RNOH perceive it would develop its relationship with the Council?

  It was important to consider that RNOH received referrals for care on a national basis. However RNOH wanted to have a greater presence in the borough and ensure that residents and the Council were involved in patient groups, audits and inspections to ensure continuous quality improvement.

- Are there any issues with staffing levels at RNOH?

  Nursing staffing levels was a challenge. RNOH had 5 patients to every nursing staff which was a good ratio and were trying to recruit nurses locally. However RNOH had to compete with other London Trusts for nursing staff and it had to be appreciated that transport links were not as favourable as other locations.

  In relation to medical staff, approximately 20% of orthopaedic surgeons went through RNOH so there was an excellent level of expertise.

  The adviser representing HealthWatch Harrow commented that they had also been presented with the draft quality accounts and had endorsed them.

RESOLVED: That

(1) the Royal National Orthopaedic Hospital Draft Quality Accounts be endorsed; and

(2) a written statement of assurance be provided to the Trust for inclusion in the final published account.

78. Shaping a Healthier Future - Joint Overview and Health Scrutiny Committee Update Report

The Committee received a report which provided an update on the discussions at the last meeting of the North West London Joint Health Overview and Scrutiny Committee for the Shaping a Healthier future Programme.

An officer presented the report and explained that the key headlines from the last meeting revolved around NHS collaboration, the pressure on Accident and Emergency services, hospital based activities and local services.

An update was also provided on the Implementation Business Case and the Sustainability and TransformationPlan. Members of the Sub-Committee were asked to provide any subject areas which they believed required discussion at the next Joint Committee meeting.

Members of the Sub-Committee made the following comments:

- there needed to be more focus on the Harrow East drop in medical centre. This was essential for residents in the eastern parts of Harrow;

- there needed to be more thought given to combating the waiting time for those using the Accident and Emergency services at Northwick Park Hospital;

- the Urgent Care Contract was due to end on March 2017. More information was required on what plans would be put in place after this and its impact on residents in Harrow.

RESOLVED: That the report be noted.

79. HH Operational Plan 2016-17 April 2016 Final

The Committee received a report from HealthWatch Harrow which provided information about its work which had been commissioned by the Council and which was managed by Harrow in Business.

The Chair of Harrow in Business introduced the item and made the following points:

There were two key headlines and successes. Firstly HealthWatch Harrow had held five public engagement forums which were attended by increasing levels of community groups. This led to them contributing towards the whole system and providing valuable information. Secondly a clear programme of focusing on Care Homes had been established. Eight care homes had been visited and lessons were still being absorbed;

HealthWatch Harrow was now focusing on what they were delivering this year. Their priorities were contained in its operational plan and there would be a continued focus on engagement particularly in innovative ways and in raising its profile;

HealthWatch Harrow had adopted an objective to help people to work in organisations which support Health and Well-being. It would therefore be focusing on engaging with local businesses and had already commenced researching into the difficulties faced by them;

The following questions were made by Members and responded to accordingly:

There is a 43% reduction in HealthWatch Harrow's budget. How would its impact be mitigated to ensure sustainability?

More volunteers were being utilised and closer working relationships were being developed with the business community. One of its ambitions was to develop the Health and Wellbeing Investment Fund to see how these could best be utilised.

In addition to these expenditure had been reduced. HealthWatch Harrow had moved premises which had helped to save a significant amount of money.

How was HealthWatch Harrow working with the voluntary and community sector in signposting patients to involvement forms?

HealthWatch Harrow had been joining events arranged by the voluntary and community sector to raise awareness of this.

Type 2 diabetes could be better controlled if residents were engaged regarding diet and nutrition. This would then lead to significant financial savings for the NHS. What was being done to get the message through?

Prevention was a key message that HealthWatch Harrow tried to communicate. Some pilot work had taken place on this subject and a key point was to ensure that children were educated in schools to better control their diet and nutrition.

How would HealthWatch Harrow get the link between clinical and social care right?

There was no immediate solution and effective discharge policies and procedures were still being considered by the advisory board of HealthWatch. Specialist knowledge would be required to address this link.

Was there any information about the outcomes reached in visiting 8 care homes over 70 days?

There had been some delays in obtaining relevant information. The analysis from these visits had nearly been concluded and its findings would emerge accordingly. An action plan would then be developed accordingly.

RESOLVED: That the report be noted.

80. Integrated Urgent Care Programme

The Committee received a report which provided information on the progress and plans for the design and delivery of a functionally integrated Urgent Care System for Harrow residents.

The Chief Operating Officer of the Harrow Clinical Commissioning Group (CCG) introduced the report and made the following points:

- When representatives of the CCG had last attended the Sub-Committee's meeting, it had talked about plans in creating an urgent

care system to meet the needs to Harrow residents. The progress in relation to this was now being reported;

- The North West London Collaboration of CCGs were currently re-shaping their NHS 111, GP Out of Hours and wider urgent care services with the aim of an integrated urgent care service;

- The integrated urgent care service would be based on 4 elements: 111 services, GP out of hours service, wider urgent care services programme and urgent care and walk-in centres;

- Every CCG would have some form of urgent care system. Following an open and competitive procurement process, two walk in centres had been commissioned to deliver services from August 2016. These were the Pinn Medical Centre and the Ridgeway Surgery from Alexandra Avenue;

- The CCG were unsuccessful in selecting a preferred provider for a third new walk in centre in the East of the borough as the minimum criteria of the service specification had not been met;

- A further procurement to commission a walk in centre in the East of the borough was currently underway. This was planned to be delivered from the Belmont Health Centre and would replicate the service specification for The Pinn and Alexandra Avenue Walk in centres. The implementation date for this service would remain as November 2016;

- The CCG were confident that a preferred provider would be identified as part of the new procurement process for a Walk in centre from Belmont Health Centre;

- The North West London Collaboration for Clinical Commissioning Groups was leading on a central procurement process to re-commission NHS 111 services for the 8 CCGs across North West London. The original date for the new contract to take effect had been delayed until June 2017 due to a significant programme of patient, stakeholder and CCG engagement;

- Brent, Harrow and Hillingdon were scoping the benefits of what a single model for NHS 111 would look like for their residents if the majority of clinical telephone assessment and navigation to appropriate services was delivered by a local Clinical Hub called a Clinical Advice and Treatment Service (CATS).

- The current contract for Harrow CCG for the delivery of Urgent Care Services to be delivered at Northwick Park Hospital expired at the end of March 2017. The model would continue to be primary care led and would work to replicate the CATS model in a physical environment;

- A Sustainability and Transformation Plan was being developed. This would be a 5 year plan and would focus on three key areas: health and well-being, care & quality and finance & efficiency;

- The STP would be a place based plan and required a partnership approach to deliver better outcomes and a sustainable model of care. The CCG had received a clear commitment from all of its partners on this and would be leading on its development;

- There would be a lot of engagement on the STP including with the Council, the voluntary and community sector and HealthWatch Harrow. This would include events where ideas and feedback would be collated and reflected upon.

The following questions were made by Members and responded to accordingly:

- Could more detail be provided on the plans for a Hub at Belmont Medical Centre in addition to the Walk-in centre?

  As part of the Shaping a Healthier Future Programme and the funding proposed, a hub identified for Harrow was located at the Belmont Medical Centre. The Hub was distinct from the Walk-in centre and would deliver wider services relating to out of hospital, diagnostics, MRIs and X-rays;

- What would a single model of the 111 service look like?

  In the proposed single model for the 8 CCGs across North West London, this would drive efficiencies and how outcomes were delivered to patients. It essentially would act as a Triage service. Another model would be to shift clinical resources to CATS to care plan patients.

- When the urgent care contract ended in March 2017, what were the implications for Northwick Park Hospital and the Shaping a Healthier Future Programme more broadly?

  There had always been an intention to revisit the specification and enhance it and the CCG were currently liaising with Northwick Park Hospital on developing this. It presented a good opportunity to have a good urgent care centre.

- Would the Belmont Medical Centre have enough space physically for a Walk-in centre and acting as a Hub for other services?

  There would be some re-arrangement of the space used in Belmont Medical Centres. Some services would move out and there was a lot of space which was currently unused.

RESOLVED: That the report be noted and the CCG and Council's Policy Team liaise to arrange for members to visit the borough's walk in centres.

81. Royal National Orthopaedic Hospital Quality Account 2015-16

RESOLVED: That the exempt appendix be noted.

(Note: The meeting, having commenced at 7.35 pm, closed at 9.14 pm).

(Signed) COUNCILLOR MICHAEL BORIO
Chair

REPORT FOR: Health & Social Care Scrutiny Sub-Committee

Date of Meeting:	15 December 2016
Subject:	Harrow Safeguarding Adults Board (HSAB) Annual Report 2015/2016
Responsible Officer:	Visva Sathasivam Assistant Director, Adult Social Services
Scrutiny Lead Member area:	Policy Lead Member, Councillor Chris Mote Performance Lead Member, Councillor Mrs Chika Amadi
Exempt:	No
Wards affected:	All
Enclosures:	Appendix 1 - Harrow Safeguarding Adults Board Annual Report 2015/2016

Section 1 – Summary and Recommendations

This report provides Scrutiny Committee Members with an overview of the Harrow Safeguarding Adults Board (HSAB) Annual Report for 2015/2016 which summarises safeguarding activity undertaken in that year by the Council and its key partners. It sets out the progress made against priorities, analyses the referrals received and outlines priorities for the current year (2016/2017).

Recommendations:
Scrutiny Committee is requested to note the work that has taken place in 2015/2016 and the action plan for 2016/2017.

Section 2 – Report

2.1 Introduction

This is the ninth Annual Report of the Harrow Safeguarding Adults Board (HSAB) and a copy is attached as an appendix for information.

2.2 The Care Act 2014

Under the Care Act 2014 the local Safeguarding Adults Board has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- *the Harrow SAB has a 3 year strategic plan for 2014 – 2017 which will be updated for 2017/2020*

ii. publish an annual report

- *Harrow LSAB's 8th Annual Report (for 2014/2015) was presented to the Council's Scrutiny Committee in October 2015. This 9th report covers the financial year 2015/2016*

- *each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent*

- *as in previous years, the Board's annual report for 2015/16 has been produced in "Executive Summary", "key messages for staff" and "easy to read" formats and is available to a wider audience through the Council and partner agencies websites*

iii. conduct any Safeguarding Adults Reviews (SARs)

- *these will be carried out as required and there were none required for 2015/16 in Harrow*

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- *the membership of Harrow's SAB (as at 31st March 2016) is shown in Appendix 3 and their attendance record is shown at Appendix 4*

2.3 Management Information/statistics

The full set of statistical information is at Appendix 1 of the attached report.

Headline messages – safeguarding adults

This section outlines the Harrow position last year with commentary based on the last available set of national data and local intelligence:

- 1,690 concerns (previously called “alerts”) compared to 1,227 in 2014/15, represented a growth of 38% locally. This year the growth in numbers is likely to be related to implementation of the Care Act 2014 which widened the remit for safeguarding adults and lowered the threshold for making enquiries

- 40% of Harrow concerns (680 cases) were taken forward as enquiries (previously called “referrals”), compared to 51% in 2013/14. It is difficult to be sure what percentage of concerns should meet the threshold for enquiries, although it certainly would not be 100%. Given another high increase in concerns it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or “root cause analysis” for pressure sores. As previously, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage

- repeat enquiries in Harrow increased very slightly from 18% in 2014/2015 to 19% in 2015/2016. The last known national figure was 18%, so Harrow is closely aligned with the performance in other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board wants to continue to monitor closely. Independent file audit always looks at repeat referrals and to date (with one exception) found that they were all for a new concern, which is reassuring

- completed enquiries in Harrow (100%) is significantly better than the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully against the indicative timescales to ensure that there is no “drift”, however the introduction of Making Safeguarding Personal has slowed down the process because the user is in control of dates and venues for meetings etc

- in Harrow the female: male ratio at the end of 2015/2016 was 63:37 for enquiries, which is very close to the last known national position of 61:39

- numbers for older people decreased again last year from 363 in 2014/15 to 314, even so they remain the highest “at risk” group

- for adults with a physical disability the figure in Harrow last year was 40% of concerns. As indicated in last year's annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory

- mental health numbers improved significantly last year from 16% of enquiries (103 users) in 2014/15 to 31% (210 users). This is now higher than the last national figure of 24% and is very positive given the large amount of focused work done by CNWL Mental Health NHS Trust in 2015/16

- in Harrow the number of enquiries for people with a learning disability in 2015/2016 was exactly the same (88 cases) as the previous year and at 13% is lower than the last available national figure of 19%

- it is very pleasing to note that the concerns from "BME" communities rose again last year to 51% from 45% in 2015/2016 – which is in line with the makeup of the Harrow population.

  The enquiries figure was 48% which is also positive, as it suggests that a proportionate number of concerns are progressed and people from "minority" communities are not being disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow remain broadly similar to 2015/16, with the highest percentage being in the service user's own home (61%) and 20% in care homes (long term and temporary placements). This is almost exactly the same figures as in 2014/15

  Figures in other settings remain small e.g. 1% in an acute hospital (10 cases); 4% in mental health in-patient units (25 cases) and 4% in supported accommodation (26 cases)

- allegations of physical abuse (23%) and neglect (at 21%) remained the most common referral reasons last year. Concerns about sexual abuse rose from 42 cases in 2014/2015 to 65 last year. It is the first year for cases of self-neglect to be reported under the safeguarding adults' statistics and there were 11 concerns dealt with under the local arrangements

- financial abuse (17%) and emotional/psychological abuse (20%) are the other significant figures and both have reduced very slightly – by 3% and 2% respectively

- in Harrow, social care staff e.g. “domiciliary care workers” (22%); “other family members” (25%) and “partner” (10%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2014/2015

- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of concerns and this is the second time that year on year comparison has been possible for the HSAB to carry out. Last year the highest numbers (16%) were from social workers/care managers and mental health staff. The increase in concerns (from 55 in 2014/15 to 112 last year) raised by the latter is very positive given the significant focus on this work by managers in the Trust. The other sources were: primary health care staff (10% - a small decrease from the previous year); residential care staff (10% - a small increase from 2014/2015); family (8% - a small decrease on the last 2 years); secondary health care staff (a 7% decrease [40 less cases] than in 2014/15); Police (6% - a 2% increase) and friend/neighbour (3 more cases [12 cases] than the previous year)

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2014/2015 statistics of 89 cases have increased to 105 – which is positive. The safeguarding adults team, supported by the Police, continue to give this area a high priority

- outcomes for the adult at risk include: increased monitoring (13%); community care assessment and services (13%); management of access to perpetrator (5%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (1%); application to Court of Protection (1%).

  All figures are broadly similar to 2014/2015 and although the percentage is the same as the previous year there were 9 cases (an increase of 5) taken to the Court of Protection which is positive.

Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the fourth year that the HSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board’s oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services

(including those that are placed out of borough), the HSAB needs to be reassured that they are carefully applied and monitored.

There were 798 requests for authorisations last year (an increase of 414 on the previous year) of which 644 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 122 requests from hospitals compared to 16 in 2014/2015 – an increase of 13%.

It is also positive that more cases were referred from hospitals suggesting that staff in those settings are becoming clearer about their responsibilities as managing authorities.

There are also good case examples of the involvement of a Best Interest Assessor or independent section 12 doctor highlighting ways in which restrictions on individual's can be reduced e.g. picking up where sedative medication has not been reviewed and could be reduced.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2014/2015 position. In some important areas e.g. mental health referrals and concerns from BME communities, there was significant improvement. There was also a small improvement in the numbers of cases subject to Police action/prosecution. Given that these were areas prioritised by the HSAB for 2015/16 this is a very positive outcome. Areas for focus in 2016/17 include the reduction for the 3rd year of cases being referred from secondary care and the need to ensure that self-neglect concerns are being recorded correctly - as the numbers in year 1 appear lower than the research suggests they might have been. The HSAB would also like to be reassured that the numbers of concerns received from family/friends are as high as they should be.

The action plan in the attached report (year three of the HSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 Making a Difference – (progress on objectives for 2015/2016)

This section of the attached annual report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2015/2016, as set out in the annual report for 2014/2015. There are some very positive examples of positive outcomes for Scrutiny to note.

Section 3 - Performance Issues

The report is primarily concerned with performance and contains analysis of the Harrow Safeguarding Adults Board statistics, both as they relate to the previous year and also to national data.

Section 4 - Environmental Impact

There is no environmental impact arising from this report.

Section 5 - Risk Management Implications

Risk included on Directorate risk register? Yes

Separate risk register in place? No

Potential risks:
Failure to ensure local safeguarding adults' arrangements are robust could lead to a serious untoward incident e.g. death of a vulnerable person. Failure to implement the statutory DoLS guidance could lead to a legal challenge about unlawful deprivation of a vulnerable person in a care home, hospice, or hospital.

Section 6 - Equalities implications

The HSAB considers local safeguarding adults statistics at each Business Meeting and at its annual review/business planning event, with particular emphasis on ensuring that concerns (referrals) are being received from all sections of the community. The Strategic Plan for 2014/17 was developed such that the HSAB monitors the impact of abuse in all parts of Harrow's community and the new version for 2017/2020 will continue that focus. Safeguarding adults' work is already focused on some of the most vulnerable and marginalised residents of the local community and the 2015/2016 statistics demonstrate that concerns are coming from all sections of the Harrow community.

Section 7 - Corporate Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report primarily relates to the Corporate priorities of:

- making a difference for the vulnerable
- making a difference for communities

Ward Councillors notified:	No - the report affects all Wards

Section 9 - Contact Details/Background Papers

Contact: Visva Sathasivam (Head of Adult Social Care)
(Direct Dial: 0208 736 6012)

Background Papers: Harrow Safeguarding Adults Annual Report 2015/2016

Harrow COUNCIL LONDON

& our Partners,

Committed to Safeguarding Adults

Harrow Safeguarding Adults Board (HSAB)

Annual Report 2015 - 2016

Harrow COUNCIL LONDON

in partnership with:

HAD Harrow Association of Disabled People

Harrow age UK

mind For better mental health

Harrow mencap Providing opportunity : promoting change

harrow carers supporting family & friends

LFB LONDON FIRE BRIGADE

METROPOLITAN POLICE Working together for a safer London

NHS

Harrow Safeguarding HSCB Children Board

Index **Page**

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (HSAB Vision)

Foreword

This is the 9th Annual Report published on behalf of Harrow's Safeguarding Adults Board (HSAB) and contains contributions from its member agencies. The Board coordinates local partnership arrangements to safeguard adults at risk of harm. This report details the work carried out by the HSAB last year (2015/2016) and highlights the priorities for 2016/2017.

Nationally, the Care Act 2014 has placed Local Safeguarding Adults Boards on a statutory basis in primary legislation for the first time. This meant that by 1st April 2015 the Board had to meet the requirements of the Act and I can confirm that the Harrow Board is compliant with those requirements, which include having as core partners the Local Authority, the Clinical Commissioning Group and the Police. The Board has always published an annual report, which is now a statutory requirement.

The Board has taken the opportunity provided by the Care Act 2014 to review its policies and procedures and to introduce new ones where required. The Board has also been aware of the introduction into adult safeguarding arrangements of self-neglect, modern slavery and institutional abuse, alongside sexual exploitation and hate crime.

There was a lot of excellent work done last year on the priorities that the HSAB had agreed were important and I think that once again this annual report demonstrates the difference that the Board's work has made to the lives of the most vulnerable people in the borough (see section 3) and trust you agree once you have read it.

A key priority for the HSAB in the coming year will be specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety).

As ever, everything the HSAB does is to achieve its vision – "*that Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business".*

I am delighted to present this report to you and hope you will use it to raise awareness of adult safeguarding and to identify issues that you can take forward in your own organisation.

Bernie Flaherty (Chair of the HSAB)

SECTION 1 - INTRODUCTION

1. Introduction to the annual report

This Annual Report describes the activities carried out by the partnership organisations that form the Harrow Safeguarding Adults Board (HSAB) during 2015/16 and it also looks ahead to the priorities for 2016/17.

1.1 The Harrow Safeguarding Adults Board (HSAB)

The Harrow Safeguarding Adults Board (HSAB) is chaired by Bernie Flaherty (Director – Adult Social Services, Harrow Council) and is the body that oversees how organisations across Harrow work together to safeguard or protect adults who may be at risk of significant harm, or who have been abused or harmed.

The HSAB takes its leadership role very seriously with appropriate senior management attendance from member organisations and the active involvement of the elected Councillor who is the Council's Portfolio holder for adult social care, health and well-being. The list of members (as at March 31st 2016) is at Appendix 3, with their attendance record at Appendix 4.

1.2 Acknowledgments

The Board would like to thank staff, volunteers, users and carers from all agencies who have contributed to safeguarding and dignity/respect work in Harrow over the last year.

1.3 HSAB Accountability

Under the Care Act 2014 the HSAB has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- the HSAB has a 3 year strategic plan for 2014 – 2017 which is updated each year after production of the annual report

ii. publish an annual report

- the HSAB's 8th Annual Report (for 2014/2015) was presented to the Council's Scrutiny Committee on 26th October 2015. This 9th report for 2015/2016 will go to the Health and Wellbeing Board on 8th September 2016 and a Scrutiny meeting on 21st November 2016
- consultation on the 2014/15 annual report as well as the 2015/16 draft version was done with Healthwatch in Harrow as well as the Local Account Group
- each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent

- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- these will be carried out as required, but there were none that needed to be done in 2015/16

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow's HSAB (as at 31st March 2016) is shown in Appendix 3 and their attendance record is shown at Appendix 4

1.4 "London Multi-Agency Adult Safeguarding Policy and Procedures"

The final version of the London Multi-Agency Adult Safeguarding Policy and Procedures was produced in December 2015 and formally launched on 9th February 2016. An update was required to ensure that the procedures were compliant with the Care Act 2014. As required, the Harrow Safeguarding Adults Board formally adopted the procedures at its meeting on 16th March 2016 and will implement them from 1st April 2016. The main points from the new procedures are:

- the process is now 4 stages: concerns; enquiry; safeguarding plan and review; and closure;
- Section 75 agreements continue to allow for Mental Health Trusts to act on behalf of the Local Authority to undertake safeguarding adult duties;
- the Safeguarding Adults Manager (SAM) who oversees the enquiries is allocated in the Local Authority or (where Section 75 agreements are in place), the relevant Mental Health Trust;
- there are no definitive timescales, (however indicative ones similar to the previous pan London procedures are given), as the focus has become more about user led processes in line with Making Safeguarding Personal;
- there is more focus on outcomes than process;
- the initial lead actions in response to a safeguarding concern should always be taken by the Local Authority for the area where the incident occurred. The "placing Local Authority" continues to hold the overall responsibility for the individual;
- the new areas introduced under the Care Act 2014 are referenced e.g. modern slavery; and
- HSAB partners are required to ensure the widest possible dissemination amongst staff

There will be a formal review in one year's time.

SECTION 2

HSAB Work Programme in 2015/2016

2.1 Harrow HSAB business meetings – work areas covered

The HSAB met on 4 occasions in 2015/2016 – three Business Meetings and an Annual Review/Business Planning Day. The following table lists the main topics discussed by the Board at those meetings – some being standing items (e.g. quarterly statistics); some were items for a decision (e.g. the new London multi-agency procedures); some were for information/discussion (e.g. training); others were aimed at Board development (e.g. Prevent/radicalisation), and there were also specific items providing challenge to the Board (e.g. user input to the annual review/business planning day). Some items (e.g. Making Safeguarding Personal) were discussed at more than one meeting.

Prevention and Community Engagement (including user involvement)

- Prevent and radicalisation – presentation/discussion (item for Board development)
- User Engagement - feedback on progress with the Harrow Safe Place Scheme development and from the discussions with the Local Account Group about the HSAB Annual Report 2014/15 (items for challenge; information and discussion)
- Mystery Shopping exercise – year 2 (item for information and decision)
- "Safeguarding is all about us" – user input to annual review/business planning day (item for challenge)
- World Elder Abuse Awareness Day 2015 in Harrow – local arrangements agreed (item for decision)
- Harrow Safe Place Scheme (item for information)
- Budget cuts and any impact on vulnerable people – (item for challenge)
- CSE; FGM and gangs – adult social care perspective (item for information)
- User outcomes – feedback from independent file audits and interviews with users (item for information)

Training and Workforce Development

- Formal review of the Safeguarding Adults (multi-agency) training programme (item for decision)
- HSAB Training programme for 2016/2017 (item for information and decision)
- Feedback from Best Practice Forums e.g. self-neglect (item for information)
- HSAB conference 25th November 2015 (item for discussion and information)

Quality and Performance Review

- Peer Review action plan monitoring (item for decision)
- Quality assurance framework for safeguarding adults' work (standing item)
- File audits – confirmation of each Board member organisation's audit processes (item for information)
- Mystery Shopping exercise – year 2 (item for information and decision)
- Quarterly statistics – discussed and findings used by the HSAB to inform changes to the training programme and local practice (standing item at every meeting)
- Home Office Inspection of Vulnerable People in Custody (item for decision)

Policies and Procedures/Governance

- HSAB Strategic Plan 2014/17 – exception reports (standing item)
- The HSAB Annual Report 2013/2014 - discussed and formally signed off (item for decision)
- Care Act 2014 implementation (items for decision)
- HSAB membership and revised Terms of Reference (item for decision)
- Safeguarding Adults Reviews (SAR) Policy – (item for decision)
- London multi-agency policy/procedures 2016 (item for decision)
- Making Safeguarding Personal – action plan agreed (items for discussion and decision)
- Metropolitan Police information sharing agreement (item for discussion)
- Self-neglect protocol (item for decision)

Joint work with the Harrow Safeguarding Children's Board (HSCB)

- HSCB independent audit (item for information)
- HSCB Annual Report 2014/2015 (item for information)
- Transition protocol for safeguarding work (item for decision)
- Child Sexual Exploitation – HSCB feedback (item for information)
- Female Genital Mutilation (FGM) – update on local arrangements (item for information)
- Learning from serious case reviews - (item for information)

Safeguarding Adults Reviews (SARs)

There were no cases for the HSAB to commission a SAR or review in 2015/2016.

2.2 Management information (statistics)

The Board collates multi agency information on a range of adult safeguarding statistics in order to produce a management report. The report which is available at each business meeting is overseen by and discussed at the HSAB.

It attempts to identify trends in referral data and to provide accessible and useful statistics to Board members which can then be used to inform decisions e.g. identifying where awareness campaigns or training should be focussed.

The statistical information for safeguarding adults services in 2015/2016 is shown at Appendix 2.

Headline messages – safeguarding adults

This section outlines the Harrow position last year with commentary based on the last available set of national data and local intelligence:

- 1,690 concerns (previously called "alerts") compared to 1,227 in 2014/15, represented a growth of 38% locally. This year the growth in numbers is likely to be related to implementation of the Care Act 2014 which widened the remit for safeguarding adults and lowered the threshold for making enquiries

- 40% of Harrow concerns (680 cases) were taken forward as enquiries (previously called “referrals”), compared to 51% in 2013/14. It is difficult to be sure what percentage of concerns should meet the threshold for enquiries, although it certainly would not be 100%. Given another high increase in concerns it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or “root cause analysis” for pressure sores. As previously, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage
- repeat enquiries in Harrow increased very slightly from 18% in 2014/2015 to 19% in 2015/2016. The last known national figure was 18%, so Harrow is closely aligned with the performance in other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board wants to continue to monitor closely. The most recent independent file audit (for cases completed between March 2015 and September 2015) looked at repeat referrals and with one exception found that they were all for a new concern, which is reassuring
- completed enquiries in Harrow (100%) is significantly better than the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully against the indicative timescales to ensure that there is no “drift”, however the introduction of Making Safeguarding Personal has slowed down the process because the user is in control of dates and venues for meetings etc
- in Harrow the female: male ratio at the end of 2015/2016 was 63:37 for enquiries, which is very close to the last known national position of 61:39
- numbers for older people decreased again last year from 363 in 2014/15 to 314, even so they remain the highest “at risk” group
- for adults with a physical disability the figure in Harrow last year was 40% of concerns. As indicated in last year’s annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory
- mental health numbers improved significantly last year from 16% of enquiries (103 users) in 2014/15 to 31% (210 users). This is now higher than the last national figure of 24% and is very positive given the large amount of focused work done by CNWL Mental Health NHS Trust in 2015/16
- in Harrow the number of enquiries for people with a learning disability in 2015/2016 was exactly the same (88 cases) as the previous year and at 13% is lower than the last available national figure of 19%

- it is very pleasing to note that the concerns from "BME" communities rose again last year to 51% from 45% in 2015/2016 – which is in line with the makeup of the Harrow population. The enquiries figure was 48% which is also positive, as it suggests that a proportionate number of concerns are progressed and people from "minority" communities are not being disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow remain broadly similar to 2015/16, with the highest percentage being in the service user's own home (61%) and 20% in care homes (long term and temporary placements). This is almost exactly the same figures as in 2014/15

  Figures in other settings remain small e.g. 1% in an acute hospital (10 cases); 4% in mental health in-patient units (25 cases) and 4% in supported accommodation (26 cases)

- allegations of physical abuse (23%) and neglect (at 21%) remained the most common referral reasons last year. Concerns about sexual abuse rose from 42 cases in 2014/2015 to 65 last year. It is the first year for cases of self-neglect to be reported under the safeguarding adults' statistics and there were 11 concerns dealt with under the local arrangements

- financial abuse (17%) and emotional/psychological abuse (20%) are the other significant figures and both have reduced very slightly – by 3% and 2% respectively
- in Harrow, social care staff e.g. "domiciliary care workers" (22%); "other family members" (25%) and "partner" (10%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2014/2015
- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of concerns and this is the second time that year on year comparison has been possible for the HSAB to carry out. Last year the highest numbers (16%) were from social workers/care managers and mental health staff. The increase in concerns (from 55 in 2014/15 to 112 last year) raised by the latter is very positive given the significant focus on this work by managers in the Trust. The other sources were: primary health care staff (10% - a small decrease from the previous year); residential care staff (10% - a small increase from 2014/2015); family (8% - a small decrease on the last 2 years); secondary health care staff (a 7% decrease [40 less cases] than in 2014/15); Police (6% - a 2% increase) and friend/neighbour (3 more cases [12 cases] than the previous year)

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2014/2015 statistics of 89 cases have increased to 105 – which is positive. The safeguarding adults team supported by the Police continue to give this area a high priority
- outcomes for the adult at risk include: increased monitoring (13%); community care assessment and services (13%); management of access to perpetrator (5%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (1%); application to Court of Protection (1%)

  All figures are broadly similar to 2014/2015 and although the percentage is the same as the previous year there were 9 cases (an increase of 5) taken to the Court of Protection which is positive.

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Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the fourth year that the HSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (including those that are placed out of borough), the HSAB needs to be reassured that they are carefully applied and monitored.

There were 798 requests for authorisations last year (an increase of 414 on the previous year) of which 644 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 122 requests from hospitals compared to 16 in 2014/2015 – an increase of 13%.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2014/2015 position. In some important areas e.g. mental health referrals and concerns from BME communities, there was significant improvement. There was also a small improvement in the numbers of cases subject to Police action/prosecution. Given that these were areas prioritised by the HSAB for 2015/16 this is a very positive outcome. Areas for focus in 2016/17 include the reduction for the 3rd year of cases being referred from secondary care and the need to ensure that self-neglect concerns are being recorded correctly - as the numbers in year 1 appear lower than the research suggests they might have been. The HSAB would also like to be reassured that the numbers of concerns received from family/friends are as high as they should be.

The action plan in this report (year three of the HSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 HSAB Resources

As at 31st March 2016, the staffing of the dedicated Safeguarding Adults Service located in the Council is as follows:-

1 Service Manager (Safeguarding Adults and DoLS)

1 DoLS Co-ordinator

1 Safeguarding Adults Co-ordinator

1 Team Manager

2 wte Safeguarding Adults Senior Practitioners

7 wte qualified Social Workers

Under the formal Section 75 agreement there are also a number of trained Safeguarding Adults Managers with a dedicated Lead located in Central and North West London Mental Health NHS Foundation Trust (CNWL). The nature of the work carried out is included in CNWL's statement at Appendix 1.

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In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit and administrative support to the HSAB etc.

The costs of these services are primarily borne by the People Services Department within Harrow Council, with contributions totalling circa £20,500 p.a. from three of the four local NHS partner agencies (Harrow Clinical Commissioning Group; North West London Hospitals Trust; and the Royal National Orthopaedic Hospital Trust) and also the London Fire Service. In 2016/2017 there will be an additional contribution from the Metropolitan Police of £5,000 p.a.

Costs related to the time spent by partner agencies on HSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual organisations.

SECTION 3 – MAKING A DIFFERENCE

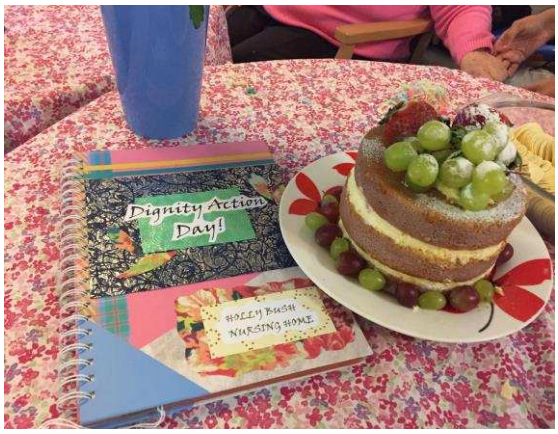
(PROGRESS ON OBJECTIVES 2015/2016)

This section of the report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2015/2016, as set out in the annual report for 2014/2015.

Theme 1 - Prevention and Community Involvement

The HSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

The HSAB's prevention strategy 2014 – 2017 ("Promoting Dignity and Prevention of Abuse") was formally agreed at the Board meeting in March 2014. 2015/2016 was the second year of implementation which built on the work done from the previous year. Examples of work in this area include:



Care providers ran events to mark Dignity Awareness Day (1st February 2016). Some poignant quotes from older people who took part at Princess Alexandra Home included: "*dignity is about choice"; "dignity is being there for me, coming to me to have a conversation"; "dignity is simply being nice and pleasant to people - treating them the way you'd like to be treated*".
Other events included: pancakes at College Hill Care home; a resident singing West End favourite songs at Grove House; a "digni tea" at Primrose House; celebrations and reminiscence at Holly Bush Nursing Home.

To mark the 10th World Elder Abuse Awareness Day (June 2015) the HSAB organised a Best Practice Forum on self-neglect which was attended by 55 staff from a range of local organisations. Up to date research was presented by Michael Preston-Shoot (Professor of Social Work at University of Bedfordshire) which focused on how best to work with people who were reluctant to accept care or support.

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The Safeguarding Adults Services continues to promote distribution of "The Little Book of Big Scams" produced by the Metropolitan Police and the Home Office which is extremely popular with members of the general public.

Ensure effective communication by the HSAB with its target audiences

A formal Communications Plan for the HSAB was approved by the Board at the March 2015 business meeting. It aims to ensure that its target audiences across the whole community know about abuse and how to report it and that resources are used for publicity and awareness related events in the most time/cost efficient ways.

The HSAB's newsletter which commenced in 2013 continued throughout last year aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The editions published (July and October 2015 and January 2016) included topics such as: statistical information; Law Commission consultation on possible DoLS reforms; scams (e.g. door step crime); Dignity Action Day 2016; Home Office report on inspection of custody arrangements for vulnerable people; the new "pan London" procedures; Prevent; and training information.

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Articles were also written for "News and Views" which is produced for people with a learning disability with a particular focus on keeping safe including e-safety on-line.

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Contributions continued from the Safeguarding Adults Service to the Multi-agency Risk Assessment Conference (MARAC – domestic violence focus); Multi-agency Public Protection Arrangements (MAPPA – public safety focus); Prevent (prevention of terrorism focus), and Anti-social Behaviour Group (ASBAG – anti social behaviour focus) - ensuring effective information sharing and communication where vulnerable adults are victims or perpetrators.

There is evidence that the Harrow HSAB's work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding enquiry is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that all the users interviewed were very happy with the outcome of the enquiry and (an important change from her previous findings) had felt in control of the process. It is believed that new approaches introduced under the "Making Safeguarding Personal" project e.g. holding strategy meetings at user's own homes have been major factors in this improvement.

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Service users attended the HSAB Annual Review Day again last year (June 2015). They told the HSAB about what was important to them in keeping safe and provided challenge to Board members:

“people come to the front door and ask for our Bank information – this is scary”; “lots of people are worried about door step crime”; “my house was burgled when I was in hospital – I was scared to go back”; “carers should not tell other people what the key safe number at the front door is”; ”we would like more leaflets about keeping safe”; “taxi drivers should be told not to speak on their mobile phone when they drive us anywhere”; “tell head teachers at the end of term not to let students be rude to us”; “we don’t think that the Police know much about mental health problems”; “we would like to know which staff in mental health services know about what to do if we tell them about abuse”; “who are the CNWL champions for keeping safe?”

The HSAB Annual Report for 2014/15 was presented to the Local Account Group and discussed in detail. There was a request that more awareness raising was done in local mental health services which has been implemented by CNWL.

Outcomes for prevention work included:

More work has been done to set up a Harrow Safe Place scheme. Choices For All students and users at Creative Support are helping by visiting shops, churches and cafes near the Bus Station (as the first priority area) asking them to sign up.

At its meeting in September 2015, the HSAB formally approved a protocol for working with people who self-neglect based in large part on the research presented by Professor Preston-Shoot. The effectiveness of the new approach was reviewed at the HSAB meeting in March 2016 and was assessed as working well.

The referrals from “BME” communities increased last year to 51% which is very much in line with the local demographic makeup of the borough and suggests that the HSAB’s messages are reaching a wider audience.

The very positive arrangements between the Safeguarding Adults Service and the local Fire Service continued last year with 83 referrals for free home fire safety checks.

As requested by users and the Local Account Group, more awareness raising and focus was given to safeguarding adults work by CNWL with a very significant improvement in numbers of concerns dealt with in that area.

The “champion” information was displayed at relevant units by CNWL.

Mental health concerns rose by 15% (107 more people) suggesting that (as requested by users and the Local Account Group) a greater number of staff in these services know what to do about allegations of abuse.

Theme 2 – Quality and Performance Review

The HSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the HSAB at all of its meetings in 2015/2016. See 2.2 above for detailed analysis.

A second "mystery shopping" exercise was commissioned by the HSAB which was carried out by users (supported by Mind in Harrow) in November 2015. The areas contacted were: 101 – Police non-emergency service; SPA (Single Point of Access for CNWL) and 3 GP practices. The findings were presented to the Board in December 2015 and feedback has been given to the agencies contacted in the exercise.

File Audit

Both internal and external (independent) audits of casework continued in the Council's Safeguarding Adults and DoLS Service during 2015/2016 with headline massages presented to the HSAB. A total of 96 cases were reviewed with the key focus being on areas highlighted from performance reports e.g. checking that repeat referrals were for different concerns. The audit findings were fed back to relevant front-line staff and managers as a way of informing continuous improvement.

In May 2015, in CNWL Mental Health Trust, an audit of procedures and recording of safeguarding adults enquiries was undertaken by an external auditor. One outcome was the creation of a specific role 'Lead Safeguarding Adults Manager' (Lead SAM) to undertake reform of policies and procedures for raising a concern, verifying if a further enquiry was required and organising a Safeguarding Adults Manager to conduct this.
A further very positive outcome was a marked improvement in the number of concerns raised/reported. In Quarter 1 of 2015/16 the average was 10 a month, in Quarter 4 it was 35 a month.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The HSAB has received statistical reports at each of its meetings, including the full year position for 2014/2015 at its Annual Review Day. In addition, the new Strategic Plan for 2014 – 2017 included trend analysis looking back over the previous 3 years and all reports included comparison with the national position wherever possible.

Outcomes:

Ongoing analysis by the HSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with areas identified for future work covered in the action plan at section 4

Changes were made to the multi-agency training programme and also to the specific sessions for front-line staff. For example, a bespoke course on "pressure sore prevention and management" was delivered by a local Tissue Viability Nurse.

Theme 3 –Training and Workforce Development

The HSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

Multi-agency training remains a high priority for the HSAB. The existing programme is competency based. This ensures that all staff know about the competencies required to meet their safeguarding adults' responsibilities within the workplace.

As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Some targeted briefing sessions took place: Pubwatch landlords (with a focus on the sexual exploitation of vulnerable adults and done in partnership with the HSCB); Enhanced Practice Nurses; the Wiseworks Centre for people with mental health difficulties; MIND in Harrow users and volunteers; St Luke's Hospice and care providers (primarily about DoLS).

Attendees by sector (multi-agency training programme)		**2015-16**
Harrow Council Internal		187
Health		49
Statutory (other)		1
Private		373
Voluntary		85
Sub-total:		**695**
SGA Team Briefing Sessions		
Age UK Harrow Volunteers		10
Deprivation of Liberty Safeguards (DoLS) Briefings		72
Housing Team		15
Members Briefings		12
Pubwatch		50
HSAB annual conference (focus on the Mental Capacity Act)		107
Pressure Area Care		29
Self-Neglect & Hoarding (learning from research)		55
Kenmore NRC		19
Marlborough Hill Day Centre / Wiseworks		9
Milmans Service User Briefings		20
MIND in Harrow Service Users & Volunteers		5
Carers Briefing		14
Enhanced Practice Nurses		19
GP Surgeries (Clinical & Non-Clinical Staff)		17
St Luke's Hospice		25
	Sub-total	**478**
Total Attending (all sessions)		**1173**

Funding was also received from the Department of Health which enabled the HSAB to hold its first conference. The focus was on use of the Mental Capacity Act, sessions were run by Edge Training and included input from Alex Ruck-Keene a leading barrister in the field. Evaluation was almost 100% positive from the 107 multi-agency staff that attended.

Outcomes

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions.

Last year there was a focus on ensuring that the requirements of the Care Act 2014 were addressed in both formal and briefing sessions. This included self-neglect and the other new areas of work e.g. modern slavery.

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DOLS arrangements (including for health funded services and facilities) are effective

The Deprivation of Liberty Safeguards (DoLS) statistics are at section 2.2 of this report.

The statutory timescales were met in all the cases assessed last year in Harrow which in comparison to many other Councils across the country where there are significant waiting lists is excellent. This may not be sustainable in 2016/17 given withdrawal of the Government grant, pressure on Council finances and a continuing growth in referral numbers.

Outcomes:

The HSAB can be reassured that for the 789 cases where a DoLS was authorised, some of the most vulnerable people they are responsible for have been protected. It is also positive that more cases were referred from hospitals suggesting that staff in those settings are becoming clearer about their responsibilities as managing authorities.

There are also good case examples of the involvement of a Best Interest Assessor or independent section 12 doctor highlighting ways in which restrictions on individual's can be reduced e.g. picking up where sedative medication has not been reviewed and could be reduced.

Theme 4 - Policies and Procedures/Governance

Ensure production of the HSAB Annual Report and presentation to all relevant accountable bodies

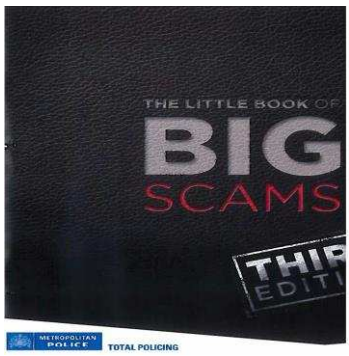
The HSAB Annual Report 2014/2015 was agreed formally by the Board at its annual review day in June 2015. This report for 2015/2016 will be discussed at the same event in June 2016. Following its formal agreement by the HSAB, the report was presented to the Health and Wellbeing Board (14th October 2015), the Council's Scrutiny Committee (26th October 2015) and subsequently to all partner agencies' Executive meetings or equivalent.

Outcomes:

As in previous years, following the decision to sign off the annual report by the HSAB last June a "key messages for staff" version of the report was produced for the third time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

The general public is aware of safeguarding issues and the work of the HSAB

The safeguarding adults' website was kept up to date and has a section for easy to read information.



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As stated above the Safeguarding Adults Service finds that the "little book of big scams" produced by the Metropolitan Police is popular with the general public and is therefore actively promoting it as widely as possible across Harrow.

The HSAB (jointly with the Safeguarding Children's Board) takes a "family first" approach to its work

Joint common meetings continued again last year e.g. bi-annually with the Multi-agency [children's] Safeguarding Hub (MASH) and London Ambulance Service.

Joint briefing sessions are run wherever possible e.g. with Pubwatch/pub landlords about sexual exploitation.

Outcomes:

Independent file audits continue to show growing confidence in this area of work by staff in Adult Services. These audit findings were fed back to and discussed with the Children's Safeguarding Board (HSCB) quality assurance sub-group meeting.

The HSAB has strategic oversight of local safeguarding adults work

Year two actions from the HSAB Strategic Plan 2014 – 2017 were implemented with an exception report at each Board meeting. This section of the annual report covers the work carried out and some of the outcomes achieved as a result.

Theme 5 – Partnership with the Local Safeguarding Children's Board (HSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Independent file audit last year again reviewed cases where domestic violence was a factor. The HSAB was reassured by the finding that referrals were being routinely made to MARAC and it is becoming much more common for a worker or manager from the Safeguarding Adults/DOLS Service to attend the meetings for specific cases.

Some audited cases also recognised work done with both the Looked After Children's and Children with Disability Teams.

Outcomes:

Better outcomes for young adults in specific cases where joint work was effective.

The HSAB (jointly with the HSCB) takes a "family first" approach to its work

See above. In addition, a practitioner representative from the Council's Safeguarding Adults/DoLS Service and relevant NHS staff provide information to MASH (Multi-agency Safeguarding Hub) where threshold decisions about referred children are discussed. This ensures appropriate information sharing and therefore decisions are taken in the most informed way possible.

Section 4: Action Plan (objectives 2016/2017)

NB. There are a range of actions for all partner agencies that will be taken forward in 2016/17 not reflected below as the HSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

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Theme 1 – Prevention and Community Engagement

Overall objective

All the agencies represented at the HSAB have agreed to take a "zero tolerance" approach to the abuse of adults at risk from harm. The vision for the Board adopted in 2011 states "Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business". As such the HSAB has agreed that prevention of abuse (in both domestic and institutional settings), publicity campaigns and information which reaches all sections of the community should be a high priority.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow Source: PR; WV; CA and ADASS	Implement the Prevention Strategy 2014 – 2017 Updates on progress presented at Board business meetings (user outcomes)	March/April 2017 Quarterly at Board Meetings
Ensure effective communication by the HSAB with its target audiences Source: ADASS and CA	Implement the HSAB Communications Policy as agreed at the March 2015 Board meeting (service delivery and effective practice)/(user outcomes)	End March 2017

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence Source: HPS and CA	Specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety) are taken forward over the 3 years of the HSAB Strategic Plan – and users report feeling safer in annual surveys and in focus group discussions (user outcomes); (leadership); (strategy)	End March 2017
There is evidence that the Harrow HSAB's work is influenced by user feedback and priorities Source: CA; MSP	Demonstrable changes in policy and practice are evident following annual evaluation of user feedback and presentation at the HSAB Review Day; Local Account Group and similar (user outcomes); (people's experiences of safeguarding)	End July 2017

Theme 2 – Training and Workforce Development

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the HSAB has signed up to a multi-agency workforce development/training strategy. In addition, the main messages drawn from the Bournemouth University/Learn To Care research (May 2010) "Towards a National Competence Framework for Safeguarding Adults" suggests that there needs to be better coordination, quality and breadth of multi-agency staff training.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act Source: BU; file audit; HPR and CA	Update the training programme implementing the results from the 2015/16 formal evaluation and recognising any learning from file audit and user interviews Run Best Practice Forums as appropriate to supplement the formal training programme in order to cover specific topics of interest (service delivery and effective practice)	End July 2016 End March 2017
DOLS arrangements (including for health funded services and facilities) are effective Source: HWB and WV	HSAB receives DoLS performance information at each Board Meeting (people's experiences of safeguarding)	Quarterly

Theme 3 – Quality and Performance Review

Overall objective

The HSAB has agreed to oversee robust performance management frameworks for monitoring the quality and effectiveness of safeguarding work across all sectors. The existing QA framework for the HSAB has user/carer challenge at its centre.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB oversees effective practice and ensures continuous improvement Source: HPR; NHS; ADASS and CA	Commission the 3rd "mystery shopping" exercise ensuring feedback is given to providers and learning is implemented Develop an action plan to address relevant recommendations from the inspection of vulnerable people in custody report (performance and resource management)	End March 2017 End October 2016
Statistical data improves understanding of local patterns enabling improved planning of responses to allegations Source: HPR; SAR; CA and AR	Ensure presentation of statistics at each HSAB Board Meeting and at the Annual Review/Business Planning Day, including comparisons with any available national data (performance and resource management)	Quarterly
The HSAB is confident that safeguarding adults work is person centred Source: HPR; MSP	HSAB receives reports on the findings of the user interviews conducted by the independent social worker at the end of the safeguarding adults process – ensuring that any learning is implemented (service delivery and effective practice)	End March 2017

Theme 4 – Policies, Procedures and Governance

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the HSAB has signed up to a multi agency partnership, oversight by each organisation's executive body to the work and the London Multi-agency Policy & Procedures that describe the framework for responding to concerns/enquiries.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Ensure production of the HSAB Annual Report Source: HPR and CA	HSAB receives the draft Annual Report within 3 months of the end of the financial year – with a focus on outcomes wherever possible (Local Safeguarding Adults Board)	End June 2016
Ensure that the HSAB Annual Report is presented to all relevant accountable bodies Source: PR; AR; CA	Presentation is made to Scrutiny Committee to include progress against the previous year's action plan and objectives for the coming year Feedback is obtained from Healthwatch in Harrow All partner agencies present the Annual Report to their Board (or equivalent) within 3 months of the agreement by the HSAB	First available Scrutiny meeting after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016) First available Board meeting (or equivalent) after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016)

	Presentation is made to Health and Wellbeing Board with particular reference to progress on agreed joint priorities and recommendations for the coming year (leadership); (Local Safeguarding Adults Board); (Strategy)	First available Health and Wellbeing Board meeting after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016)
The general public is aware of safeguarding issues and the work of the HSAB Source: ADASS and PR	Implement the HSAB Communications Policy as agreed by the Board at its March 2015 Board meeting The HSAB Annual Report is published in an easy to read format and posted on all partner websites (service delivery and effective practice)	End March 2017 End October 2016
The statutory HSAB is effective; Care Act compliant and has strategic oversight of local safeguarding adults work Source: ADASS; CA and HPR	The HSAB Strategic Plan is monitored at Board meetings and updated at the Annual Review/Business Planning Day (leadership)	Quarterly and end of June 2017
Ensure local arrangements are London multiagency Policy/Procedures compliant and cover the new safeguarding areas e.g. human trafficking Source: CA	The HSAB formally adopts the new London multiagency Policy/Procedures when available	As determined by relevant guidance when the new procedures are issued

Theme 5 – Partnership with the Harrow Safeguarding Children's Board (HSCB)

The HSAB and HSCB have agreed to work in collaboration to ensure sharing of information, learning and ideas such that effective and safe services are offered with a "family first" approach. This ensures that staff working in Children's Services recognise any vulnerable adults in the family and staff working with adults recognise any risks to children.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC. Source: PR and ADASS	Consider all possible areas for joint approaches e.g. in relation to safeguarding training, work with schools and sexual exploitation (working together)	End March 2017
The HSAB (jointly with the HSCB) takes a "think whole family" approach to its work Source: WV and NHS	Audit processes in both Adults and Children's Services across all HSAB partner agencies look at the whole family (working together)	End March 2017

Source Documents:

AR – Harrow Safeguarding Adults Board Annual Reports

HPR – Harrow formal Peer Review recommendations

PR – Peer Review (incorporating Association of Directors of Adult Social Services – National Framework for Good Practice Standards; Care Quality Commission (CQC) reports and the reviews of “No Secrets” and “Putting People First”)

NHS – National Health Service audit tool (local priorities)

BU - Bournemouth University/Learn To Care research “Towards A National Competence Framework For Safeguarding Adults” (May 2010) and Harrow (Safeguarding Adults Board) Training Strategy

FA - File Audit learning/recommendations

WV – Winterbourne View or Francis report findings and Government response

HWB – Health and Wellbeing Board priority

SAR – national statistics (Harrow data)

UES – Harrow (Safeguarding Adults Board) User Engagement Strategy

HPS - Harrow (Safeguarding Adults Board) Prevention Strategy 2014 - 2017

ADASS – Advice and guidance to Directors of Adult Social Services

CA – Care Act 2014

MSP – Making Safeguarding Personal

Appendix 1

Statements from key HSAB partners

The following statements have been provided by some of the key agencies represented on the HSAB. The reports cover adult safeguarding issues from each organisation's perspective and some identify key priorities for 2016/17.

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healthwatch Harrow

28th July 2016

Mr Seamus Doherty
Safeguarding Adults Co-ordinator
2nd Floor, East Wing
Harrow Council
Civic Centre
Station Road
Harrow HA1 2XF

Dear Seamus
Re: SAB Annual Report

Thank you for inviting Healthwatch Harrow to make a formal response to your annual report, which is as follows:
As the manager of the Healthwatch Harrow service, Harrow in Business and its staff, volunteers and networks, look forward to supporting the work of the Harrow Safeguarding Adults Board during 2016/17, especially by communicating key priorities and actions as outlined in the 2015/16 Annual Report, through our range of business and community engagement activities and social media channels to the local people, businesses and others. Wherever possible, we will look to support each other at key events and community engagement forums and via our regular e-bulletins and e-newsletters.
Yours sincerely
Ash Verma
Chair (HiB)

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Harrow Mencap

Harrow Mencap continues to support a zero tolerance approach to safeguarding and feels the best way to show its commitment is to actively promote the rights of people with learning disabilities and be working in partnership with other agencies and individuals to actively raise awareness.

Outcomes for prevention and community development

- through a contracted service we have provided advocacy support for 33 individuals who were subject to safeguarding alerts ensuring their voice was heard in the process of protecting them. And the safeguarding process was focussed on the outcomes they wished to achieve
- provided staying safe workshops for young people (aged 18-25) with learning disabilities. This has included keeping safe on line
- as part of our partnership with other NWL Mencaps we have delivered quality checks on services for older and disabled people and have worked with providers to improve services
- safeguarding is an integral part of all person centred support plans

Outcomes for Training and Workforce Development

- 3 members of staff have undertaken safeguarding and advocacy training
- all Care and Support staff undertake DOLS training
- all staff receive basic awareness training for Children & Adults as part of their induction and these are refreshed annually
- safeguarding is discussed at every team meeting
- safeguarding incidents are critically reviewed so staff can learn from the process

Outcomes for Quality and Performance Review

- safeguarding leads meet regularly to review incidents and the response to incidents so any barriers are identified and addressed

Outcomes for Governance

- safeguarding is on the agenda for every board meeting so the board is aware of issues and develop appropriate and responsive plans and policies
- we continue to ensure that that there is a designated trustee with responsibility for safeguarding

Priorities for 2016-17

- continue to ensure that all staff are aware of their responsibilities under the Care Act (2014)
- to hold a learning disability Forum to explore what being safe means to individuals and how to keep safe whilst having active lives
- to continue to campaign to ensure that the rights of people with learning disabilities are upheld

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Royal National Orthopaedic Hospital (RNOH)

Outcomes for Prevention and Community Engagement:

- An FGM leaflet has been developed for staff and visitors which raise awareness of FGM, the support available and our legal responsibilities.

Outcomes for Training and Workforce Development:

- Staff trained to level 2 currently at 85.86%. Staff trained to level 1 currently at 91.33%.
- The effect of this is an increased awareness amongst all levels of staff resulting in safeguarding concerns being raised by a variety of staff/departments such as administrators in the appointment booking department.
- The Trust Induction programme now contains MCA and DoLS training for all new starters.
- The mandatory training programme includes awareness of self-neglect and it's complexities in relation to patients who have mental capacity to make 'unwise' decisions. Modern slavery is now also covered in all mandatory training. Sexual exploitation is discussed in both the Adult and Children's Safeguarding training.
- RNOH has revised the Adult Safeguarding workforce. Adult Safeguarding now has a 0.8 WTE Named Nurse and a full time Learning Disability nurse.

Outcomes for Quality and Performance Review:

- Bi-monthly meetings of the Safeguarding Adult Committee are held with attendance from named professionals, operational leads from nursing, Allied Health Professional, social work and patient representative.

Outcomes for Policies and Procedures/Governance:

- HSAB Annual Report 2014/2015 was presented to the organisation's Trust Board

Outcomes for joint work with the HSCB - "think family":

- Domestic violence is now incorporated in all Adult Safeguarding training as well as Children's Safeguarding training.
- The Adult Safeguarding Named Nurse and Children's Safeguarding Named Nurse are working closely together to facilitate cross learning in light of the 'think family' initiative.

Priorities for 2016/17:

- Undertake regular audit of knowledge and skills and corresponding outcomes.
- Engage service users to provide feedback and lessons learnt.
- Complete FGM policy and leaflet.

- Review all Adult Safeguarding documentation: SG referral, MCA/BID in order to make them more user friendly and incorporate the 'making safeguarding personal' agenda.
- Complete Prevent policy.
- Implement training strategy for the soon to be finalised Intercollegiate Document for adult Safeguarding.
- Newsletter to include lessons learnt from staff and patient feedback in order to disseminate learning widely across the organisation.
- Implement Safeguarding Champions in all departments to engage and feedback to staff on a local level any new developments/recommendations and to ensure Safeguarding is at the forefront of each department's agenda.
- Implement staff supervision programme.
- Update the Trusts Adult Safeguarding webpage to make it more user friendly so as to encourage staff to utilise the resources available to them.
- Continue to raise the profile of all Adult Safeguarding issues and embed best practice across all aspects of the organisation.

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Age UK Harrow (AUKH)

Age UK Harrow is firmly committed to Safeguarding Adults and believes that all have the right to live free from abuse of any kind. Age or circumstances should not have any bearing or effect on this basic right

Outcomes for Prevention and Community Engagement

- WEAAD: 16th June 2015;

  AUKH led on this day and this year organised an all day drop in sessions in the office. This enabled people to come in and speak to the staff on a one to one basis as well as collect information. Staff and volunteers gave out information on the subject and how to report it. Although the numbers attending were not great, those who did come had no idea of elder abuse and AUKH staff were able to raise the awareness on the subject. This did not generate a huge number of people coming in but the message did get to those who had no awareness on the subject.

  On-going articles on safeguarding in the newsletter to remind members about scams.

- Outcomes have been that a number of clients have been signposted to Safeguarding and are aware of how the service operates. Some have been clients who have called on behalf of someone else etc.
- Made 2 direct safeguarding referrals.

Outcomes for Training and Workforce Development

- Staff continue to attend basic awareness course. Refresher training is also offered where appropriate.
- Volunteers are offered in house training delivered by Council staff or AUKH staff.
- Induction of new staff/volunteers/trustees – now includes presentation on safeguarding that was developed by the Council Safeguarding team.
- All support group meetings and staff meeting have Safeguarding as a standing agenda item where issues relating to this are discussed.

Due to all the above, the outcomes have been:-

- Staff and volunteers are more aware of safeguarding issues and the signs to look out for.
- Are more aware of how to report any safeguarding issues and staff knows how to deal with the issues if volunteers raise any alerts.
- Through the annual review of volunteers and clients to find out any safeguarding problems – outcome was to have Boundary training and this was accessed.

Outcomes for Quality and Performance Review

- Attained quality marks for our Advice and Advocacy service and both had safeguarding reviewed as part of the audit.
- AUKH has contributed to quality and performance review through our Chief Executive, Avani Modasia, attendance at HSAB meetings, HSAB away day in 2015.
- All staff now more aware of procedures internally on reporting safeguarding issues.

Outcomes for Policies and Procedures/Governance

The work done over the years on Safeguarding has resulted in the outcomes below:-

- Safeguarding is standing agenda item at AUKH Board meetings which includes feedback from the HSAB Board is given.
- The annual HSAB report was tabled at the board meeting.
- We have continued to implement pan London Procedures.
- Worked to ensure production of the HSAB Annual Report
- Reviewed the safeguarding policy to reflect the changes under the care act.
- Reviewed our internal the safeguarding reporting system for the organisation.

Our priorities for 2016/17 are:-

- As a result of incidents, work to introduce extensive volunteer safeguarding training with practical examples.
- Organise 11th annual World Elder Abuse Awareness Day event in partnership with the Council and other partners.
- Continue training staff and volunteers to spot risk/harm and take appropriate action,

- Raise awareness about safeguarding issues especially for vulnerable elderly and encourage more people to get help. Outcome same as above
- Continue working with Health watch in doing enter and view sessions and thus raise awareness about safeguarding.

Personal Pledges made at HSAB 2015 planning day

- Update all Safeguarding policies to include the Care Act
- Develop internal procedures on what referrals to be sent to Safeguarding Team. (Work on both the pledges has been started)

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Mind in Harrow

Mind in Harrow is firmly committed to Safeguarding Adults in partnership with Harrow Council, NHS, police and independent sector organisations with a particular focus on adults at risk owing to their mental health.

Outcomes for Prevention and Community Engagement:

- Contributed to safeguarding prevention by offering support and information through our Care Act Information & Advice Service (SWiSH), in conjunction with Harrow Council Safeguarding Team and CNWL NHS Foundation Trust, to people with mental health needs who have reported to us that they may be at risk of abuse or mistreatment.
- Increased community engagement and contributed to safeguarding prevention through the Chief Executive being a Trustee of Harrow Equalities Centre, which runs a Hate Crime project.
- Increased awareness of the need for improved coordination between the police and NHS mental health services for BMER community members who are arrested and detained and could be at risk owing to their mental health problems through our Somali Olole Isbedel project campaign.

Outcomes for Training and Workforce Development:

- Increased our staff awareness of safeguarding procedures through implementation of our policy that all our new employees are required to undertake the Harrow Council introduction to safeguarding training course.
- Increased our volunteer and mental health service user representatives' awareness of safeguarding procedures through training delivered by the Harrow Safeguarding Team/Freelance trainer three times a year.
- Increased our staff awareness of Prevent programme through attendance at Harrow Council training, resulting in one referral being made in May 2016.

Outcomes for Quality and Performance Review:

- Increased awareness of mental health safeguarding issues from a voluntary sector perspective through our Chief Executive's attendance at Harrow Multi-Agency Safeguarding Adults Board meetings 2015-16, the Harrow LSAB away day in 2015.
- Contributed to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a 'Mystery Shopping' exercise with 111 number, CNWL NHS Foundation Trust Single Point of Access (SPA) and a sample of GP practices in the autumn of 2015, which has resulted in learning reported to the Safeguarding Board.

Outcomes for Policies and Procedures/Governance:

- Improved Child Protection Policy through our annual review.
- Improved our Safeguarding Adults at Risk Policy by incorporating the new Pan-London Multi-Agency Procedures reviewed as a result of Care Act 2014 implementation.
- Improved our Board of Trustees awareness of current local safeguarding issues through our Chief Executive's presentation of the new Pan-London Multi-Agency Procedures and other safeguarding changes introduced as a result of the Care Act 2014 to a May 2016 meeting.
- Improved awareness of the need for a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, from local evidence and the Home Office inspection report for Brent and Harrow 'The welfare of vulnerable people in police custody' (March 2015).

Outcomes for joint work with the LSCB ("think family"):

- Increased our staff awareness of safeguarding procedures by our policy that all new senior staff and casework staff are required to undertake Harrow Council introduction to safeguarding children training session.
- Encouraged improved coordination between Harrow adult mental health safeguarding service lead and child protection services for situations raised with us where the alleged perpetrator is someone experiencing mental health problems.

Priorities for 2016/2017:

In addition to continuation of Mind in Harrow's actions and outcomes for 2015-16:

- Contribute to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a new 'Mystery Shopping' exercise 2016-17 and repeat the exercise for 2015-16 for improved responses.
- Contribute to a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, through the new working group to be convened from June 2016.

- Contribute to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a new 'Mystery Shopping' exercise 2016-17 and repeat the exercise for 2015-16 for improved responses.
- Contribute to a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, through the new working group to be convened from June 2016

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HARROW Clinical Commissioning Group (CCG)

Outcomes for Prevention and Community Engagement

Harrow CCG is committed to engaging with the community about health services for patients. We make decisions based on the feedback we get to ensure that the services we commission and redesign are services that residents need and can access.

We hold regular events so that patients can have their say in the design and development of local services.

In 2015/16 we consulted with patients, carers, stakeholders and the wider general public on a number of issues including:

- The Harrow spinal multi-disciplinary team (MDT) triage service
- NHS 111
- Procurement of the IAPT (Improving Access to Psychological Therapies Programme) service
- Review and redesign for paediatric pathways
- Wheelchair services

We also consulted on our commissioning intentions 2016/17 by holding a large public event. 181 people attended and were given an overview of our vision and our priorities for the year ahead.

For commissioning intentions 2016/17 the CCG also facilitated discussions with:

- GPs
- Mind in Harrow
- Age UK Harrow
- Harrow Patients' Participation Network (HPPN)
- Patient participation groups (PPGs)
- Local Medical Committee
- Healthwatch Harrow
- Existing and prospective providers

This year Harrow CCG developed an agreement with the Harrow Patients' Participation Network (HPPN) which brings together patient participation groups (PPGs) from surgeries across the borough.

This agreement will ensure a successful working partnership that helps improve services. The CCG also worked closely with partner organisations (Harrow Council and Healthwatch Harrow) to ensure engagement relating to health in the borough is more joined up.

The CCG continues to use its patient newsletter (Patients First), its website and social media to connect and share healthcare messages with local people.

We have an Equality and Engagement Committee which includes representatives from Healthwatch and the voluntary sector, and is chaired by our Governing Body lay member for public and patient engagement. It meets bi-monthly and oversees the engagement work carried out by the CCG to ensure it is open and inclusive.

NHSE Deep Dive

CCG Harrow participated in the NHS England deep dive review of Safeguarding Adults as part of the assurance process for CCGs in 2015/2016

Overall, Harrow CCG was assured as good.

An action plan has been drawn up following the Designated Safeguarding Professionals meeting held on the 4th April, 2016 to address areas where there was limited assurance.

NHS England commended CCG Harrow for good quality framework for undertaking provider assurance clinical visits

Outcomes for Training and Workforce Development

Currently 97% of the Harrow CCG staff have received Safeguarding Adults training.

The new categories of abuse have been embedded into the training materials.

Prevent training is also on-going. Harrow CCG and its providers are currently above the trajectory set by NHS ENGLAND

Outcomes of Quality and Performance Review:

Harrow CCG has works closely with other CCGs to commission high quality health services and monitor the effectiveness of the providers in delivering safe care.

Harrow CCG take the lead for undertaking this for the CNWL mental health services across NWL and are associate commissioners for the London North West Hospital Trust (LNWHT) contract and Imperial College HealthCare NHS Trust.

During 2015/16 the Brent, Harrow and Hillingdon CCGs Federation Quality and Safety Team underwent significant changes since July 2015. Jan Norman joined the organisation as the Director for Quality and Safety, Sandra Corry, the Deputy Director for Quality and Safety and Nicky Brown John, the Assistant Director for Quality and Safety. Safeguarding Adults within the CCG has since been delegated to the Quality and Safety Team.

For 2016/17 quality indicators for safeguarding adults are firmly included within the core requirements for North West London and an outcomes framework is being developed in collaboration with providers who will be required to submit quarterly reports to the CCGs.

Outcomes of Policies and procedures/Governance

Updates from the Safeguarding Adults Board Meeting and from national guidelines and legislation have been shared with staff of the CCG during team meetings.

Outcomes for Joint work with Children Safeguarding:

The Designated Nurse Safeguarding Children and the Lead Nurse Safeguarding Adults have attended various work streams be work streams within the CCG. The aim is to give updates on Safeguarding and to ensure the work streams have embedded Safeguarding correctly in their processes

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Central & North West London (CNWL) NHS Foundation Trust

Outcomes for Quality and Performance Review:

- The Board had previously formed a view there was a possible under-reporting of Concerns within Trust's services.
- In May an Audit of Procedures and Recording of Safeguarding Adults Enquiries was undertaken by an External Auditor.
- One outcome was the creation of a specific role 'Lead Safeguarding Adults Manager' (Lead SAM) to undertake reform of policies and procedures for raising a Concern, verifying if Further Enquiry was required and organizing a Safeguarding Adults Manager to conduct this.
- A further Outcome was a marked improvement in the number of Concerns raised/reported. In Quarter 1 of 2015/16 the average was 10 a month, in Quarter 4 it was 35 a month.
- The HSAB Annual Report 2014/2015 was presented to CNWL's Executive Board in September 2015.
- In December 2015 the new Single Point of Access for CNWL was a participant in a Mystery Shopper exercise. Following feedback further training was undertaken with the staff of the SPA by the Lead SAM about how to responded to a Concern raised by third parties.

Outcomes for Policies and Procedures/Governance:

- In September 2015 the following email account is launched for all to make enquiries to: cnw-tr.mentalhealthsafeguardingharrow@nhs.net
- In November 2015 the Trust launched the Single Point of Access (SPA) to receive referral for people professionals hold concerns that their wellbeing is suffering due to mental health difficulties (cnw-tr.SPA@nhs.net)

- In March 2016, the Trust's Care Quality Meeting for its Harrow Service, ratified a new Operational Policy in regard to the Allocation of Safeguarding Adults Manager to conduct Enquiries
- Also in March 2016 the reconfiguration of community services for mental health was completed. The 4 teams are now all based in a single site: Bentley House

Outcomes for Training and Workforce Development:

- Training entitled "Safeguarding Adults: Developments due to the Implementation of the Care Act 2014" was provided by the Lead SAM. Staff from the following services areas attended: the Single Point of Access, Liaison Psychiatry, Home Treatment Team, Ellington, Eastlake & Ferneley Wards; and those formerly of the Community Recovery Team, Assertive Outreach Team, Personal Budget Team and Community Rehabilitation Team.
- This covered the new categories of abuse, FGM, as well as good practice in regard to when and how to raise a Concern.
- Training on when and how to raise a Concern was also provided to staff of partner agencies RETHINK Bridge Centre & Look Ahead Support.

Priorities for 2016/17:

- To engage Patients and Carers
- To engage Staff

Personal pledges made at the Annual Review/business planning day 2015:

- Photographs of each Champion for Learning Disabilities is now displayed on the Wards at Northwick Park Hospital Mental Health Centre. This has achieved a personal pledge of the Trust.

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Harrow Police

Outcomes for Prevention and Engagement

Harrow Police incorporate measures to ensure the continuation of quality outcomes and support for vulnerable members of the community, in particular:

- increasing staffing levels in MASH and incorporating updated MPS operational models around Protecting Vulnerable Persons
- ensuring early identification of vulnerable victims and increasing referrals to services through MASH where appropriate.
- early engagement from Neighbourhood Policing Teams to provide re-assurance and crime prevention advice.
- enforcing a positive action response against those committing crime against vulnerable victims

- daily review of crimes with a focus upon Domestic Abuse, Hate Crime and crime involving vulnerable victims
- joint community engagement work with Partners, including Secure streets, Action Days and ward-based Street Briefings

Outcomes for training and Workforce Development

All front-line officers receive corporate in-house training around Mental Health, Safeguarding issues and dealing with Vulnerable persons. This includes referral thresholds and Merlin minimum standards and supporting partner training to ensure wider awareness of roles, responsibilities and available services. This is an integral part of induction training for new officers and is also delivered to the existing workforce. Additional bespoke training is provided to staff in specialist roles on an on-going basis.

Outcomes for Quality and Performance Review

The internal MPS Quality Assurance framework drives minimum standards for cases involving vulnerable victims, including elderly persons and situations involving Mental Health issues. Domestic Abuse now includes cases of coercive control and Honour Based Violence and there is an increasing focus on a wider variety of investigative outcomes, including Criminal Behaviour Orders, Victimless Prosecutions and Domestic Violence Protection Notices/Orders.

Outcomes for Policies and Procedure/Governance

Harrow Police are fully engaged with the strategic partnerships for Safeguarding adults and children and is represented on the appropriate boards and executive groups. Harrow Police are fully engaged with internal and external auditing of case management and referrals. MPS structures, including around Protecting Vulnerable Persons, are currently being reviewed at an organisational level and this may include an uplift in officers deployed in this portfolio and a redesign of central delivery around the policing response to Safeguarding Adults. All changes will be communicated to strategic partners in sufficient time to ensure continuity of service delivery. Any actions arising from the LSAB annual report have been dealt with and completed.

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Harrow Council – Adult Services

Harrow Council's Safeguarding Adults and DoLS Service takes the lead coordinating role for safeguarding vulnerable adults at risk from harm. This role is both in relation to multi-agency strategic development of the work as well as enquiries into individual cases of abuse and instances of institutional abuse. The Service also supports the HSAB arrangements; organises a range of public awareness campaigns; oversees the multi-agency training programme and runs briefing sessions. In 2015/2016 as with the previous year, the Safeguarding Adults and DoLS Service had a work programme which supported the overall objectives and priorities in the HSAB Business Plan and progress is monitored at a regular meetings. The work of the Service and any outcomes, including the numbers of referrals handled are covered in the body of this report.

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Safeguarding Adults Concern & Enquiry Data - 1st April 2015 - 31st March 2016

Summary Statistics

No. of Concerns: -	**1690**	**%**
Taken forward as Enquiries: -	680	40%
Dealt with at Concern Stage: -	1010	60%
No. of Repeat Enquiries: -	132	19%
No. of Completed Enquiries: -	677	100%
Concerns Female	1041	62%
Concerns Male	642	38%
Not Stated / Recorded	7	0%
	1690	**100%**
Enquiries Female	430	63%
Enquiries Male	249	37%
Not Stated / Recorded	1	0%
	680	**100%**

Concerns

From different Ethnic Backgrounds (non white UK): -	**863**	**51%**
Female	523	61%
Male	335	39%
(ethnicity) Not Stated / Recorded	49	6%
	863	**99%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	827	863
White UK	49%	51%

Enquiries

From different Ethnic Backgrounds (non white UK): -	**323**	**48%**
Female	197	61%
Male	126	39%
(ethnicity) Not Stated / Recorded	23	7%
	323	**100%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	357	323
White UK	53%	48%

Where Abuse / Harm took Place: -

Own Home	423	61%
Care Home - Permanent	57	8%
Care Home with Nursing - Permanent	52	8%
Care Home - Temporary	11	2%
Care Home with Nursing - Temporary	11	2%
Alleged Perpetrators Home	15	2%
Mental Health Inpatient Setting	25	4%
Acute Hospital	10	1%
Community Hospital	3	0%
Other Health Setting	2	0%
Supported Accommodation	26	4%
Day Centre/Service	6	1%
Public Place	27	4%
Education/Training/Workplace Establishment	4	1%
Other	11	2%
Not Known / Not Recorded	7	1%
	690	**100%**

Many cases involve multiple locations of abuse and this is highlighted in these figures

Service User Group: -

Older People	314	46%
Learning Disability	88	13%
Physical Disability Support	269	40%
Mental Health	210	31%
Support with Memory and Cognotion	35	5%
Sensory Support	18	3%
Substance Misuse		0%
Other Adult at Risk / Social Support	50	7%
Not Stated / Recorded	10	1%
Total No. of Service Users	**680**	**146%**
No. of Multiple Service User Groups	**314**	**46%**

Some Service Users have multiple conditions e.g. older person with a physical disability and mental health issue and this is highlighted in these figures

Type of Abuse / Harm: -

Physical	201	23%
Sexual	65	7%
Emotional/Psychological	179	20%
Financial	154	17%
Neglect	190	21%
Self-Neglect	11	1%
Discriminatory	6	1%
Organisational / Institutional	24	3%
Domestice Abuse	55	6%
Modern Slavery		0%
Not Stated / Recorded		0%
Multiple Abuses	217	25%
	885	**125%**

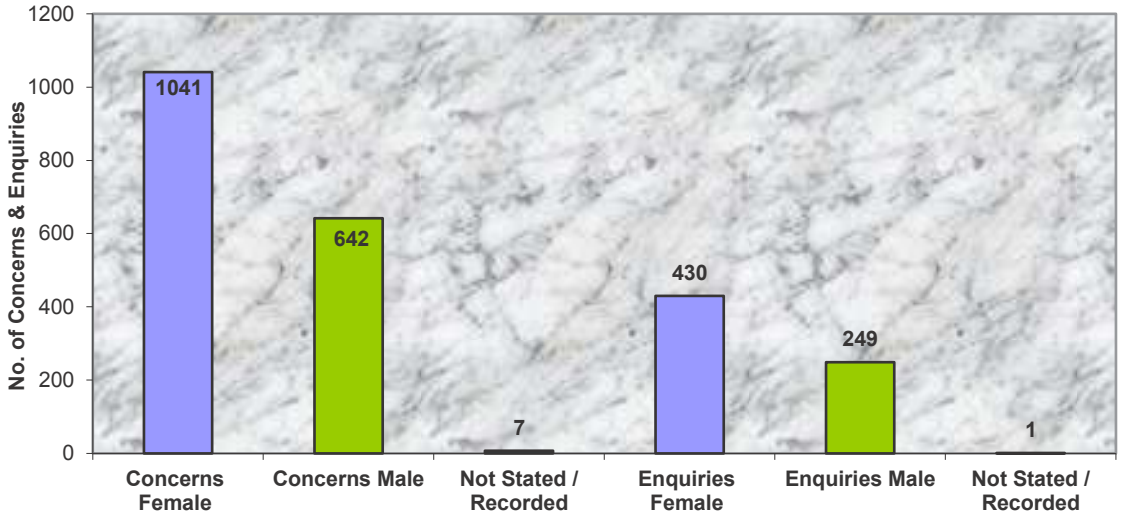
Many cases involve multiple abuses and this is highlighted in these figures

Person Alleged to have caused Abuse / Harm:-			
	Health Care Worker	39	6%
	Neighbour or Friend	33	5%
	Main Family Carer / Other Family Member	173	25%
	Other Professional	26	4%
	Other Vulnerable Adult	25	4%
	Partner	71	10%
	Social Care Staff	151	22%
	Stranger	55	8%
	Volunteer or Befriender	3	0%
	Other	104	15%
	Not Known/Stated/Recorded	0	0%
		680	**100%**
	Source of Referral		
Social Care Staff	Domiciliary Staff	23	3%
	Residential Care Staff	68	10%
	Day Care Staff	17	3%
	Social Worker/Care Manager	106	16%
	Self -Directed Care Staff	6	1%
	Other Social Care Worker	37	5%
Health Staff	Primary/Community Health Staff	70	10%
	Secondary Health Staff	59	9%
	Mental Health Staff	112	16%
	Other Health Care Worker		0%
Other Sources of Referral	Self-Referral	10	1%
	Family member	54	8%
	Friend/neighbour	12	2%
	Other Service User	3	0%
	Care Quality Commission	1	0%
	Education/Training/Workplace Establishment	5	1%
	Housing	21	3%
	Police	44	6%
	Other (anon, probation, contracts, MAPPA, MARAC, etc	32	5%
	Not Recorded	0	0%
		680	**100%**

Outcomes for Adult at Risk (completed cases) :-				
	Increased Monitoring	116	13%	**Many cases allow for multiple outcomes and this is highlighted in these figures**
	Removed from property or service	27	3%	
	Community Care Assessment & Services	122	13%	
	Civil Action		0%	
	Apllication to Court of Protection	9	1%	
	Application to change appointee-ship	2	0%	
	Referral to advocacy scheme	18	2%	
	Referral to Counselling/Training	22	2%	
	Moved to increase/Different Care	48	5%	
	Management of access to finances	13	1%	
	Guardianship/Use of Mental Health Act	8	1%	
	Review of Self Directed Support (IB)	15	2%	
	Management of access to Perpetrator	45	5%	
	Referral to MARAC	15	2%	
	Other	382	42%	
	No Further Action	11	1%	
	Not Recorded	66	7%	
		919	**100%**	

Outcomes for Person Alleged to have caused the Abuse / Harm (completed cases) :-				
	Criminal Prosecution/Formal Caution	10	1%	**Many cases allow for multiple outcomes and this is highlighted in these figures**
	Police Action	95	11%	
	Community Care Assessment	46	6%	
	Removal from Property or Service	30	4%	
	Management of Access to Adult at Risk	46	6%	
	Referred to ISA / DBS	1	0%	
	Referral to Registration Body	12	1%	
	Disciplinary Action	27	3%	
	Action By Care Quality Commission	16	2%	
	Continued Monitoring	56	7%	
	Counselling/Training/Treatment	36	4%	
	Referral to Court Mandated Treatment	1	0%	
	Referral to MAPPA	2	0%	
	Action under Mental Health Act	8	1%	
	Action by Contract Compliance	27	3%	
	Exoneration	84	10%	
	No Further Action	37	4%	
	Not Known	232	28%	
	Not Recorded	66	8%	
		832	**100%**	

Safeguarding Adults Concern & Enquiry Data - 1st April 2015 - 31st March 2016
Male / Female Ratio

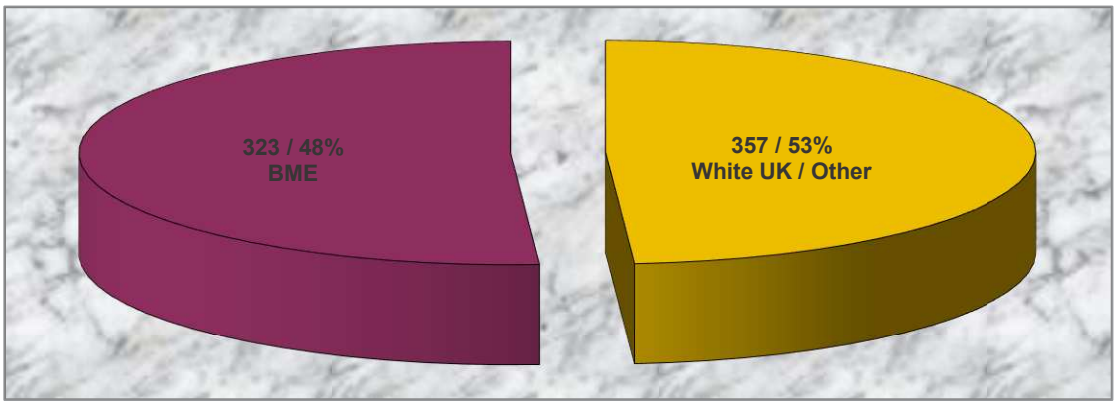


Total No. of Concerns - 1690
Proceeding to Enquiry - 680

Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Male / Female Ratio
(from different ethnic backgrounds)

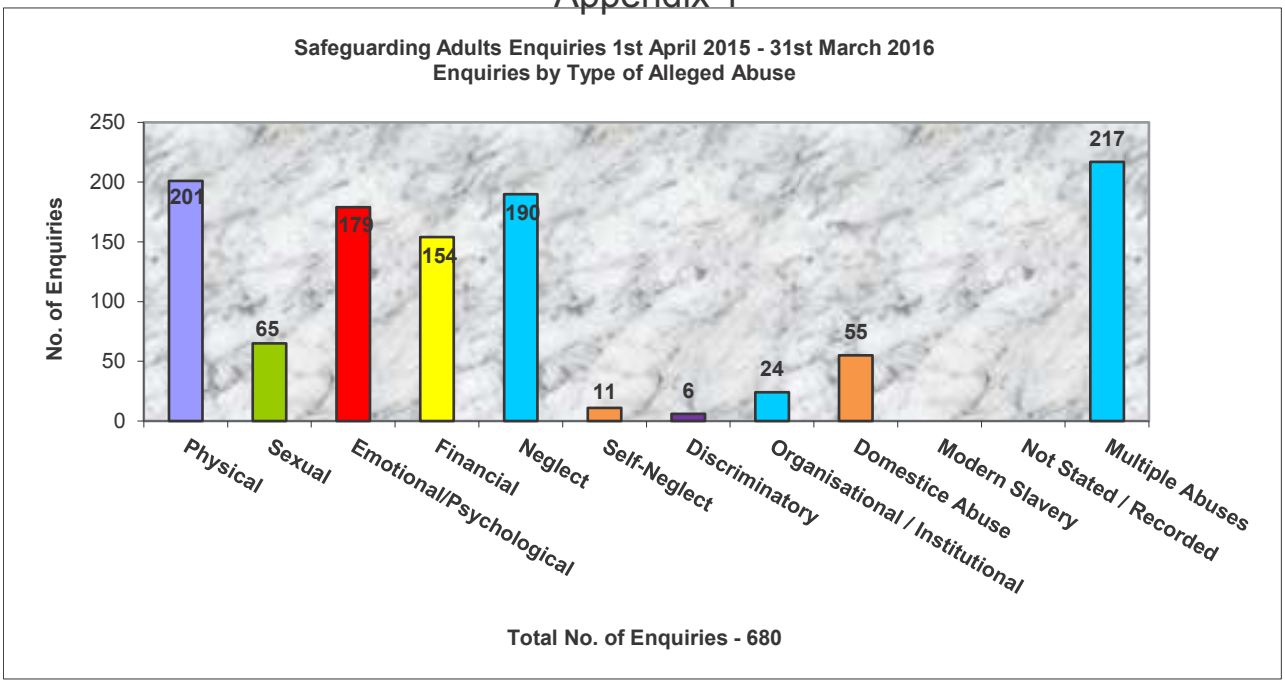
Total No. of Enquiries - 680 (23 did not state / record ethnicity but did record gender)
% of overall Enquiries - 48%

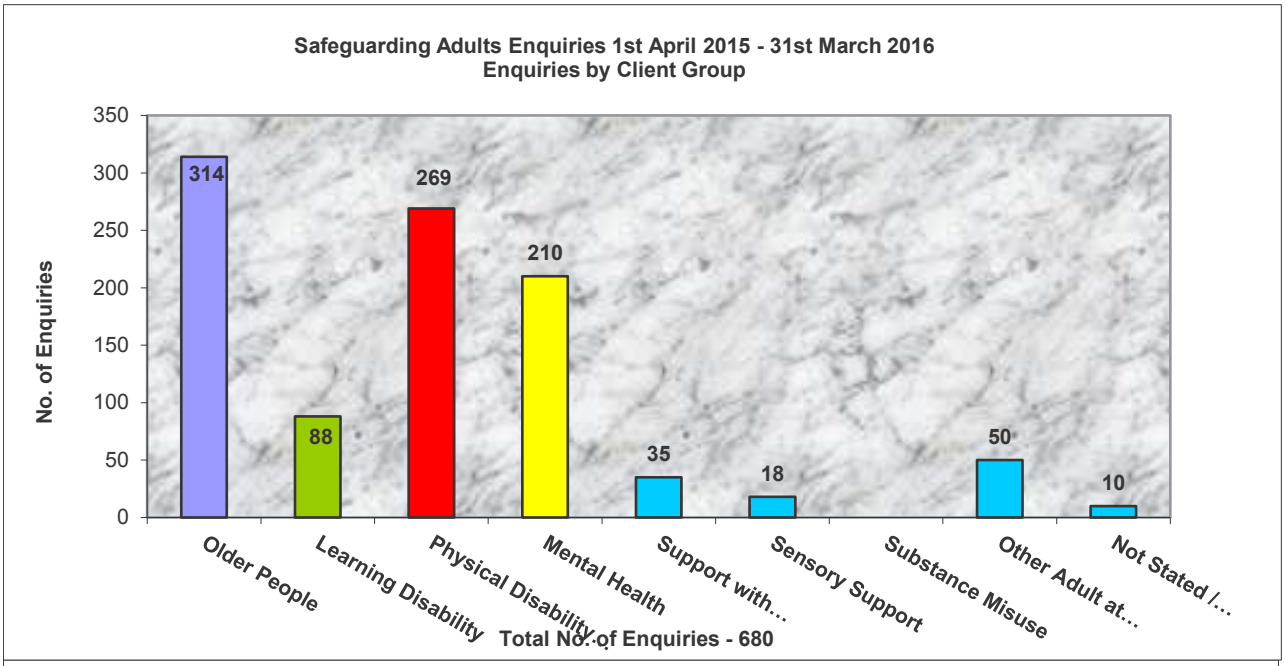
Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
W/UK / BME Ratio

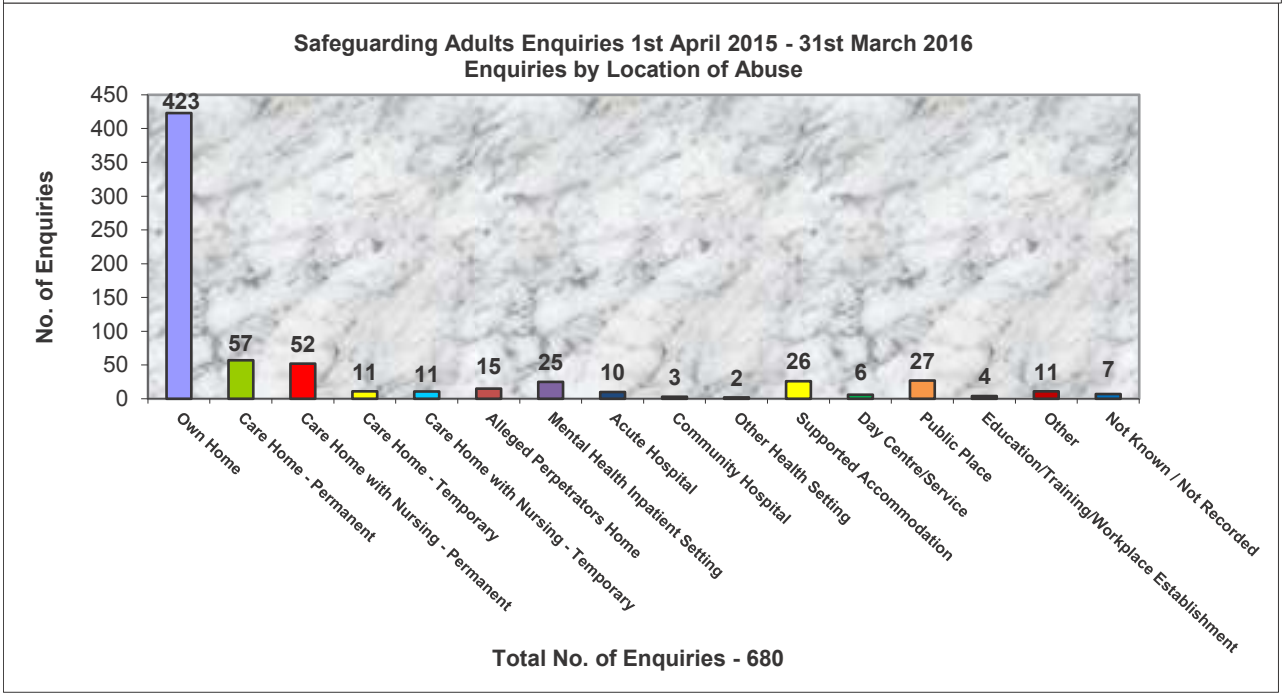


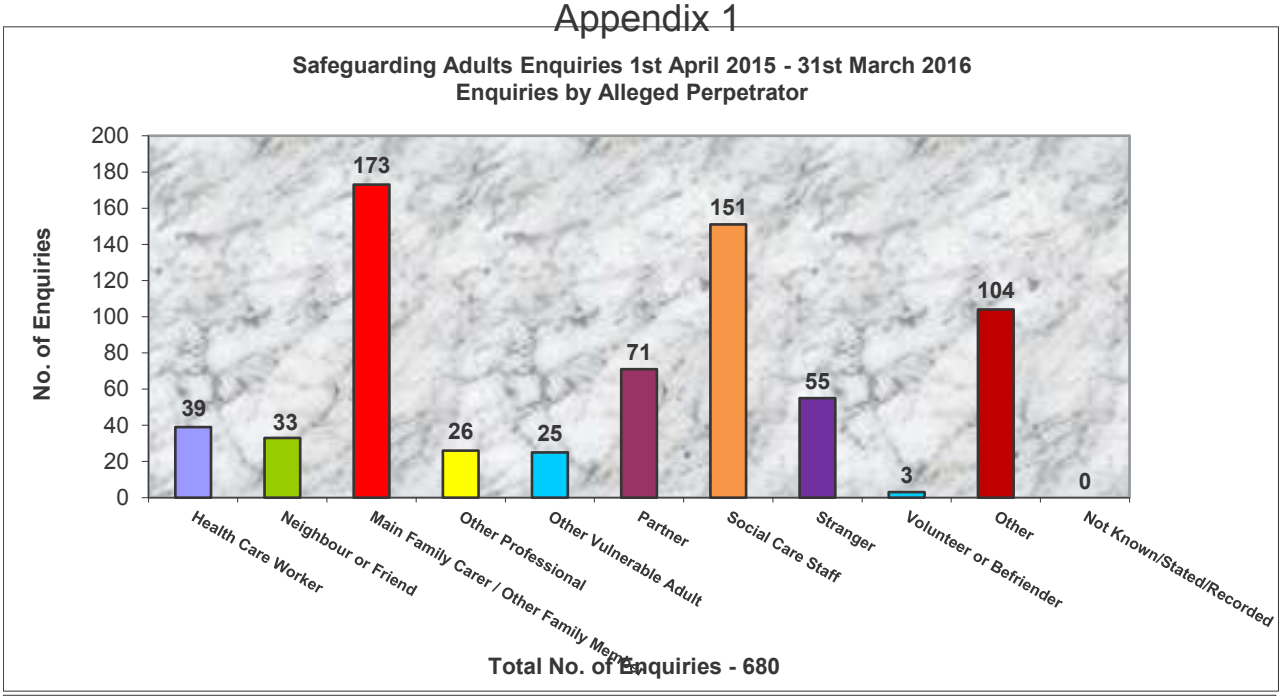
% Adult BAME Community in Harrow
(from 2011 Census) - 42%

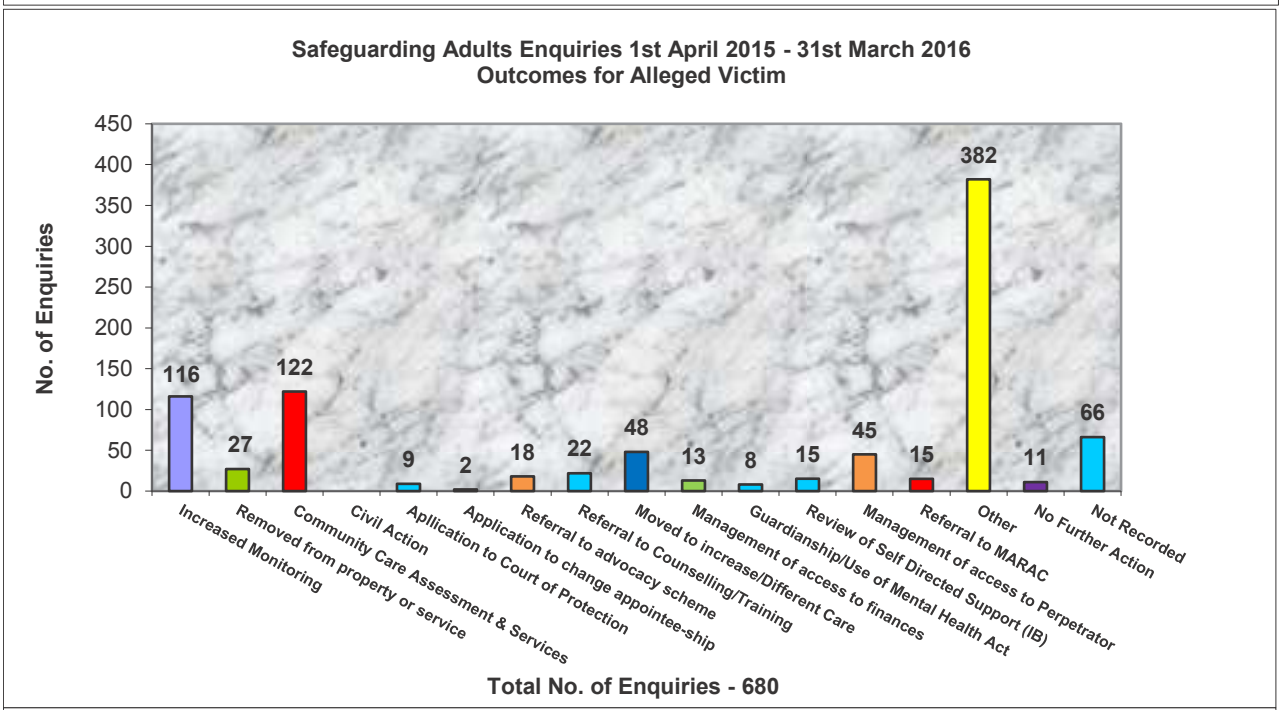
% BME Safeguarding Concerns - 51%
% BME Safeguarding Enquiries - 48%

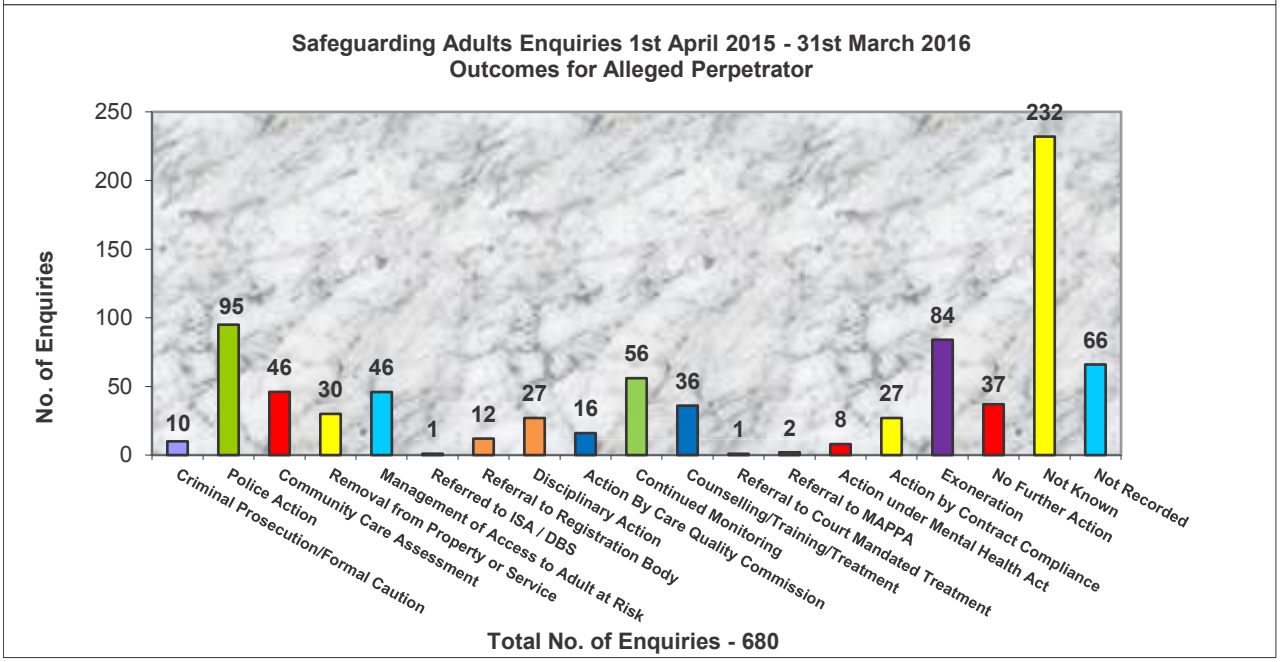

Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Type of Alleged Abuse
No. of Enquiries
250
200
150
100
50
0
201
65
179
154
190
11
6
24
55
217
Physical
Sexual
Emotional/Psychological
Financial
Neglect
Self-Neglect
Discriminatory
Organisational / Institutional
Domestic Abuse
Modern Slavery
Not Stated / Recorded
Multiple Abuses
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Client Group
No. of Enquiries
350
300
250
200
150
100
50
0
314
88
269
210
35
18
50
10
Older People
Learning Disability
Physical Disability
Mental Health
Support with...
Sensory Support
Substance Misuse
Other Adult at...
Not Stated /...
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Location of Abuse
No. of Enquiries
450
400
350
300
250
200
150
100
50
0
423
57
52
11
11
15
25
10
3
2
26
6
27
4
11
7
Own Home
Care Home - Permanent
Care Home with Nursing - Permanent
Care Home - Temporary
Care Home with Nursing - Temporary
Alleged Perpetrators Home
Mental Health Inpatient Setting
Acute Hospital
Community Hospital
Other Health Setting
Supported Accommodation
Day Centre/Service
Public Place
Education/Training/Workplace Establishment
Other
Not Known / Not Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Alleged Perpetrator
No. of Enquiries
200
180
160
140
120
100
80
60
40
20
0
39
33
173
26
25
71
151
55
3
104
0
Health Care Worker
Neighbour or Friend
Main Family Carer / Other Family Member
Other Professional
Other Vulnerable Adult
Partner
Social Care Staff
Stranger
Volunteer or Befriender
Other
Not Known/Stated/Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Outcomes for Alleged Victim
No. of Enquiries
450
400
350
300
250
200
150
100
50
0
116
27
122
9
2
18
22
48
13
8
15
45
15
382
11
66
Increased Monitoring
Removed from property or service
Community Care Assessment & Services
Civil Action
Aplication to Court of Protection
Application to change appointee-ship
Referral to advocacy scheme
Moved to Counselling/Training
Management of access to finances
Guardianship/Use of Mental Health Act
Review of Self Directed Support (IB)
Management of access to Perpetrator
Referral to MARAC
Other
No Further Action
Not Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Outcomes for Alleged Perpetrator
No. of Enquiries
250
200
150
100
50
0
10
95
46
30
46
1
12
27
16
56
36
1
2
8
27
84
37
232
66
Criminal Prosecution/Formal Caution
Police Action
Community Care Assessment
Removal from Property or Service
Management of Access to Adult at Risk
Referred to ISA / DBS
Referral to Registration Body
Disciplinary Action
Action By Care Quality Commission
Continued Monitoring
Counselling/Training/Treatment
Referral to Court Mandated Treatment
Referral to MAPPA
Action under Mental Health Act
Action by Contract Compliance
Exoneration
No Further Action
Not Known
Not Recorded
Total No. of Enquiries - 680

Appendix 3

HSAB Membership (as at 31st March 2016)

HSAB Member	Organisation
Christine-Asare-Bosompem	Harrow Clinical Commissioning Group (CCG)
Karen Connell	Harrow Council Housing Department
Sarah Crouch	Public Health, Harrow Council
Jonathan Davies	London North West Healthcare NHS Trust (hospital services)
Julie-Anne Dowie	Royal National Orthopaedic Hospital (RNOH)
Andrew Faulkner	Brent and Harrow Trading Standards
Bernie Flaherty (Chair)	Adult Social Services, Harrow Council
Mark Gillham	Mind in Harrow
Garry Griffiths	Harrow Clinical Commissioning Group (CCG)
Sherin Hart	Private sector care home provider representative
Vicki Hurst	London Ambulance Service
Patrick Laffey	London North West Healthcare NHS Trust (Provider Organisation)
Jules Lloyd	London Fire Service
Nigel Long	Harrow Association of Disability
Coral McGookin	Harrow Local Safeguarding Children's Board (HSCB)
Avani Modasia	Age UK Harrow
Cllr Chris Mote	Elected Councillor, Harrow Council
Mike Paterson	Metropolitan Police – Harrow
Tanya Paxton	CNWL Mental Health NHS Foundation Trust
Deven Pillay	Harrow Mencap
Visva Sathasivam	Adult Social Care, Harrow Council

Chris Spencer	People Services, Harrow Council
Karen Tiquet	Westminster Drug Project
Cllr Anne Whitehead	Elected Councillor (Portfolio Holder), Harrow Council
In attendance	
Arvind Sharma	Healthwatch Harrow
Officers supporting the work of the HSAB	
Sue Spurlock	Manager Safeguarding Adults and DoLS Services – Harrow Council
Seamus Doherty	Safeguarding Adults Co-ordinator - Harrow Council

Appendix 4

Harrow Safeguarding Adults Board Attendance Record 2015/2016

Organisation	26/6/2015	16/9/2015	9/12/2015	16/3/2016	Total meetings attended
Brent and Harrow Trading Standards	x	x	x	✓	1
Harrow Council - Housing Department	✓	✓	✓	✓	4
London Ambulance Service	x	x	✓	✓	2
London Fire Service	x	x	x	x	0
Westminster Drug Project	x	x	✓	x	1
Harrow Council - Adult Social Services	✓	✓	✓	✓	4
Harrow Council - elected portfolio holder	✓	✓	✓	✓	4
Harrow Council - shadow portfolio holder	x	✓	✓	✓	3
Mind in Harrow	✓	✓	✓	✓	4
NHS Harrow (Harrow CCG)	✓	✓	✓	✓	4
Ealing Hospitals Trust (Harrow Provider Organisation)	✓	✓	✓	✓	4
North West London Hospitals Trust	✓	x	x	✓	2

Harrow CCG – clinician	x	x	x	x	0
Local Safeguarding Children Board (HSCB)	✓	✓	✓	x	3
Royal National Orthopaedic Hospital	✓	x	✓	✓	3
Metropolitan Police – Harrow	✓	x	x	✓	2
Age UK Harrow	✓	✓	x	✓	3
Harrow Mencap	✓	✓	✓	✓	4
CNWL	✓	✓	✓	✓	4
Harrow Association of Disabled People	✓	✓	x	x	2
Private sector provider representative (elected June 2013)	x	✓	x	x	1
Public Health	x	✓	x	x	1
Department of Work and Pensions	x	x	x	x	0
In attendance					
Care Quality Commission (CQC)	x	x	x	x	0
Healthwatch Harrow	x	x	x	x	0
Safeguarding Adults & DoLS Service – to support the Board	✓	✓	✓	✓	4

Further information/contact details

For further information about this report or any aspect of safeguarding vulnerable adults at risk of harm in Harrow, the website is:

www.harrow.gov.uk/safeguardingadults

If you would like information or advice (including how to access the multi-agency training programme) the Safeguarding Adults Service can be contacted on the telephone number below or via e-mail at:

safeguarding.adults@harrow.gov.uk

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for an older person or an adult with a disability, this can be done through Access Harrow on: 020 8901 2680
(ahadultsservices@harrow.gov.uk)

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for a younger person with mental health difficulties, this can be done through 0800 023 4650 (CNWL single point of access).

(cnw-tr.mentalhealthsafeguardingharrow@nhs.net)

Any enquiries about the Deprivation of Liberty Safeguards (DoLS) including requests for authorisations can be e-mailed to: DOLS@harrow.gov.uk

DoLS requests can also be sent to the safe haven fax: 020 8416 8269.

The address for written correspondence (to either Access Harrow or the Safeguarding Adults and DoLS Service) is:

Civic Centre
PO Box 7,
Station Road,
Harrow, Middx. HA1 2UH

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REPORT FOR: **HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	15 December 2016
Subject:	Annual Report of the Director of Public Health 2016
Responsible Officer:	Dr Andrew Howe Director of Public Health
Scrutiny Lead Member area:	Councillor Richard Almond, Policy Lead Member, Children & Families Councillor Janet Mote, Performance Lead Member, Children & Families
Exempt:	No
Wards affected:	All
Enclosures:	Appendix 1 - A Hand Up, Not A Hand Out: Annual Report Of The Director Of Public Health 2016 Appendix 2 - Child Poverty And Health Inequality Needs Assessment

Section 1 – Summary and Recommendations

This report is the Annual Report of the Director of Public Health for 2016. The topic of the report is child poverty. The report considers the factors affecting child poverty, looks at what this means for us in Harrow and suggests a way forward.

Recommendations:
The HOSC is asked to note the report.

Section 2 – Report

Each year, the Director of Public Health must publish an independent report on health in the borough. The annual report is the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be publicly accessible.

The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action.

Director of Public Health annual reports should:

- Contribute to improving the health and well-being of local populations
- Reduce health inequalities
- Promote action for better health, through measuring progress towards health targets
- Assist with the planning and monitoring of local programmes and services that impact on health over time

This report sets out to raise the issue of Child Poverty in Harrow. It is based on a health needs assessment on child poverty undertaken by my team earlier this year.

Child poverty is defined by the experience of material deprivation and lack of financial resources which can be driven by factors such as low pay, changes to in-work benefits, problem debt and worklessness. Growing up in poverty can seriously impact a child's emotional wellbeing, physical health and educational attainment with long lasting effects into adulthood.

Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty. Harrow's housing, transport and childcare costs make it harder for low income families and many low skilled workers to survive on their incomes. Tackling child poverty needs to be a priority because of its short and long term consequences for children and for local areas. Tackling poverty is a key strategy to achieving successes in areas such as better health, education and economic development. Research estimates that poverty costs the UK £25 billion every year in reduced educational opportunities, lower taxes and higher service costs[1]

There are persistent pockets of deprivation and child poverty in Harrow. We know from our services that work with vulnerable children and young people across Harrow, and our research and policy work, that it is often a

[1] Joseph Rowntree Foundation, Estimating the Cost of Child Poverty (2008)

combination of factors combined that have cause child poverty resulting in detrimental effects on a child's long term outcomes and life chances. Poor housing, unemployment, language barriers, debt and rent arrears, are all associated with poverty in Harrow.

As well as highlighting this issue, I have proposed developing a child poverty strategy and action plan for Harrow; one that all partners buy into so that together we agree what we need do to mitigate child poverty and ensure that every child in Harrow has the best opportunity to meet and fulfil their full potential.

Following on from this report, my team will undertake further research and gather case studies to illustrate what child poverty means for Harrow. A workshop on 9th November brought together local partners in the statutory and the voluntary / community sector to begin to develop the priorities and actions that we need to take over the next 5 years.

Legal Implications/Comments

Under Section 73B(5) of the National Health Service Act 2006 The director of public health for a local authority must prepare an annual report on the health of the people in the area of the local authority.

Financial Implications

Whilst this report does not have any specific recommendations with financial implications, it highlights the need for further partnership work to address child poverty. It does recognise the unprecedented financial challenges faced by the council and partner organisations and the need to work differently and sustainably within available resources.

Performance Issues

Performance indicators will be agreed as part of the development of the strategy.

Environmental Impact

Not applicable

Risk Management Implications

Risk included on Directorate risk register? No
Separate risk register in place? No

Equalities implications

Was an Equality Impact Assessment carried out? No

The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 advance equality of opportunity between people from different groups foster good relations between people from different groups

The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services

The report considers the impact of poverty on children and an accompanying needs assessment document covers the aspects of equalities legislation that affect or are affected by poverty.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

The report incorporates the following of the administration's priorities.

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

Section 3 - Statutory Officer Clearance

Not required

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Carole Furlong, Consultant in Public Health, 020 8420 9508 (ext 5508)

Background Papers: Health Needs Assessment on child poverty.

Harrow Public Health Team

A HAND UP, NOT A HAND OUT.

CHILD POVERTY IN HARROW.

Annual Report from the Director of Public Health, 2016


We cannot say we have fair competition when some people have to run a 100 metre race with sandbags attached to their legs.
– Ha Joon Chang

Table of Contents

FOREWORD
Dr. Andrew Howe

Each year, as the Director of Public Health, I have a responsibility to deliver a report that looks at the health and wellbeing of the people in Harrow. Coming up with a report that doesn't just churn out the same old data is important because I want the my annual reports stimulate readers and make them want to take action. This year my annual report focuses on the topic of child poverty and is accompanied by a short film that illustrates the issues.

Poverty is damaging to children's health. Children living in poverty are at a significant health disadvantage because being poor negatively affects developing physiological systems.

We know from research that living in poverty can have detrimental health consequences that are severe and lifelong. This is linked to multiple health problems that can be costly to treat and cause outcomes that can limit economic potential. And that's not all, it feeds into an unremitting cycle affecting generations.

Giving children a healthy start pays off in health and well-being. This is not just important for children and their families, but for society as a whole.

But what has this to do with Harrow? We are fortunate to live and work in a place that is, on the whole, healthy and compares well with other boroughs on many indicators. However, this hides some stark differences that make it difficult for some Harrow children to thrive. In this report, I want to show you some of the issues that lead to children living in poverty and some of it's impacts. I also want to show you that there are things that, collectively, we are doing to help our residents get out of the poverty trap but as ever, we could do more.

I have asked my team to work with our partners, and with the people and the organisations in Harrow to look at what we can do that will make a difference. We are facing unprecedented pressure on our budgets and so it won't be a case of giving money or grants. We need creative, sustainable solutions to help people help themselves. As one local resident said "we need a hand up, not a hand out!"

I hope you enjoy reading this report and watching the short film that accompanies it and I hope you will join with us to make a difference to children living in poverty in Harrow.

What is child poverty and how does it relate to inequality?

Child poverty is defined by the experience of material deprivation and lack of financial resources which can be driven by factors such as low pay, changes to in-work benefits, problem debt and worklessness.

With poverty affecting one in four children in the UK - about 600,000 children in London – that's a whole lot of missed opportunity for them and us.

We all have images of what poverty looks like: it might be the pre- welfare state poverty of the 1930s; Victorian era poverty, or the numerous nameless faces of starving children in developing countries. But in a affluent society as modern day Britain and a borough such as Harrow, what does poverty really look like?

Sociologist Peter Townsend summed it up when he wrote "Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong."

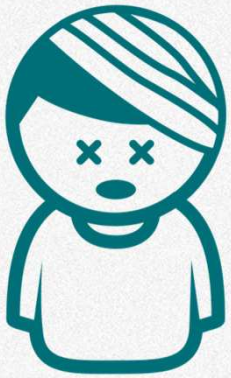
In affluent societies, therefore, poverty is about a lack of resources. Poor people lack capital: physical capital (property ownership); human capital (education and skills) and social capital (connections among individuals). However the defining characteristic of poverty is financial capital, since money allows people to compensate for the other shortfalls in their lives.

A number of social and health problems, including, lower life expectancy, reduced social mobility, higher rates of obesity, mental illness and infant mortality and lower levels of trust, have been shown to worsen in unequal societies.

This ensures that not only do children living in poverty not achieve their potential, society as a whole misses out too.

What does this mean in reality?

Families at the poverty line have £79 less per week than families on average income.



Three-year-olds in households with incomes below about £10,000 are 2.5 times more likely to suffer chronic illness than children in households with incomes above £52,000

In 2015-6, the Trussell Trust gave out 1,109,309 three-day emergency food supplies given to people in crisis. Over 110,000 were given out in London – almost 40% to children.

Drivers of child poverty

There are a number of factors that are driving child poverty now. Many of these have a long term impact and drive poor children to grow up into poor adults. Thus the cycle continues. Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty. These are the difficult issues we need to tackle if we are going to make a difference.

Child poverty drivers

The main driver for child poverty is a lack of sufficient income from parental employment, which restrict the amount of earnings a household..

Long term worklessness can cause difficulties in returning to work. For many the longer the lack of employment continues, the lower the confidence levels drop. Add to this skill loss and possible employer bias makes it difficult to get back into the work routine.

Unemployment isn't the only issue. Working insufficient hours and/or for low pay is a particular problem in Harrow. Harrow residents earn less than the average salary of their counterparts in London and the UK as a whole. As a result, many people work out of the borough, incurring high transport costs which may then negate their higher salaries.

Leaving school with no or low qualification levels limit the range of employment opportunities and the wages that could be expected. It can also make adults less likely to want to return to adult education and skills development opportunities which could facilitate them into better paid work.

Larger families require higher levels of income to avoid poverty. They have a need for larger housing which is both difficult to find and much more expensive in Harrow. The welfare reforms have exacerbated this leading to high levels of residents becoming homeless.

The costs of childcare can also restrict parental employment due to the expense. A lack of awareness about in-work benefits perpetuates this belief.

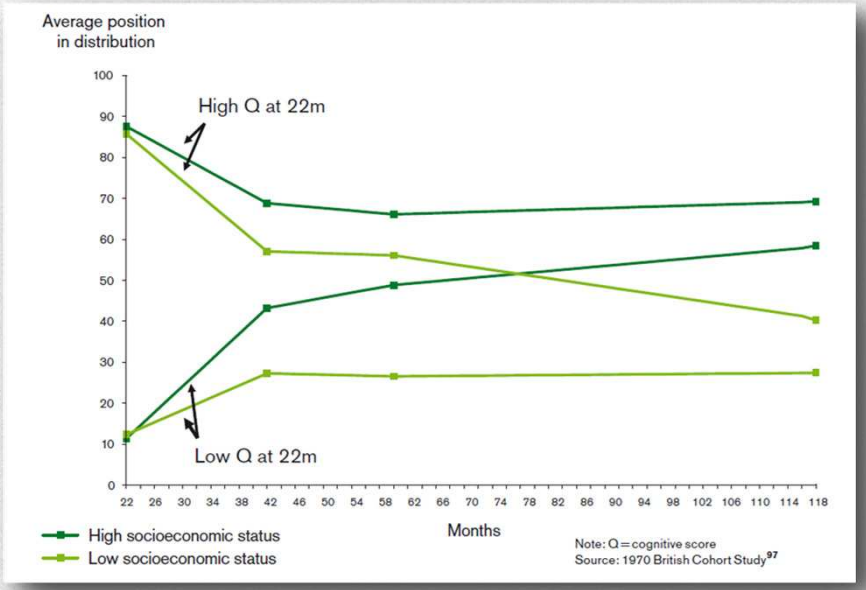
Drug & alcohol dependency, although affecting only a small proportion of the children in poverty, will have a profound impact on both parents and children.

Parental ill health or family instability which can both reduce the number of parents whose earnings contribute to income, and also mean the remaining parent's employment options are more restricted due to caring responsibilities either for the child or the disabled family member.

How does growing up in poverty affect children?

Undoubtedly, there will be children who thrive despite the poverty in which they have grown up. But for many others poverty means a childhood of insecurity, educational underachievement and isolation from their peers

Inequality in early cognitive development in the 1970 British Cohort study at age 22months to 10 years



Source: 1970 British Cohort Study

The graph illustrates the impact of social inequality on the cognitive development of children.

The British Cohort Study followed the lives of people born in a single week in 1970. Children's cognitive development was measured at different time periods beginning at 22 months and proceeding for 10 years.

By the age of six (74 months), the 'less bright' children from higher socio-economic groups performed better in tests of cognitive-ability than 'bright' children from lower socio-economic groups.

This early disadvantage for children in lower socioeconomic groups went on to predict final educational outcomes and therefore future life chances.

Poverty is like punishment for a crime you didn't commit.

— Eli Khamarov, writer

What does child poverty look like in Harrow

Case study: Family A

Mrs A is a lone parent with 6 children ranging from 16 to 5 years old. Her eldest children have been in contact with the criminal justice system and all of the children had poor school attendance.

Mrs A came to Harrow 17 years ago and had been a housewife and mother and had never worked. Her husband left her to return to his homeland and she had been unable to work due her youngest children being under school age and she had no childcare help.

She was in receipt of Child Benefits, Child Tax Credits, Housing Benefits, and Income Support & Council Tax Support. The family were referred to the Together with Families programme and worked with Xcite, Reed and Harrow in Business.

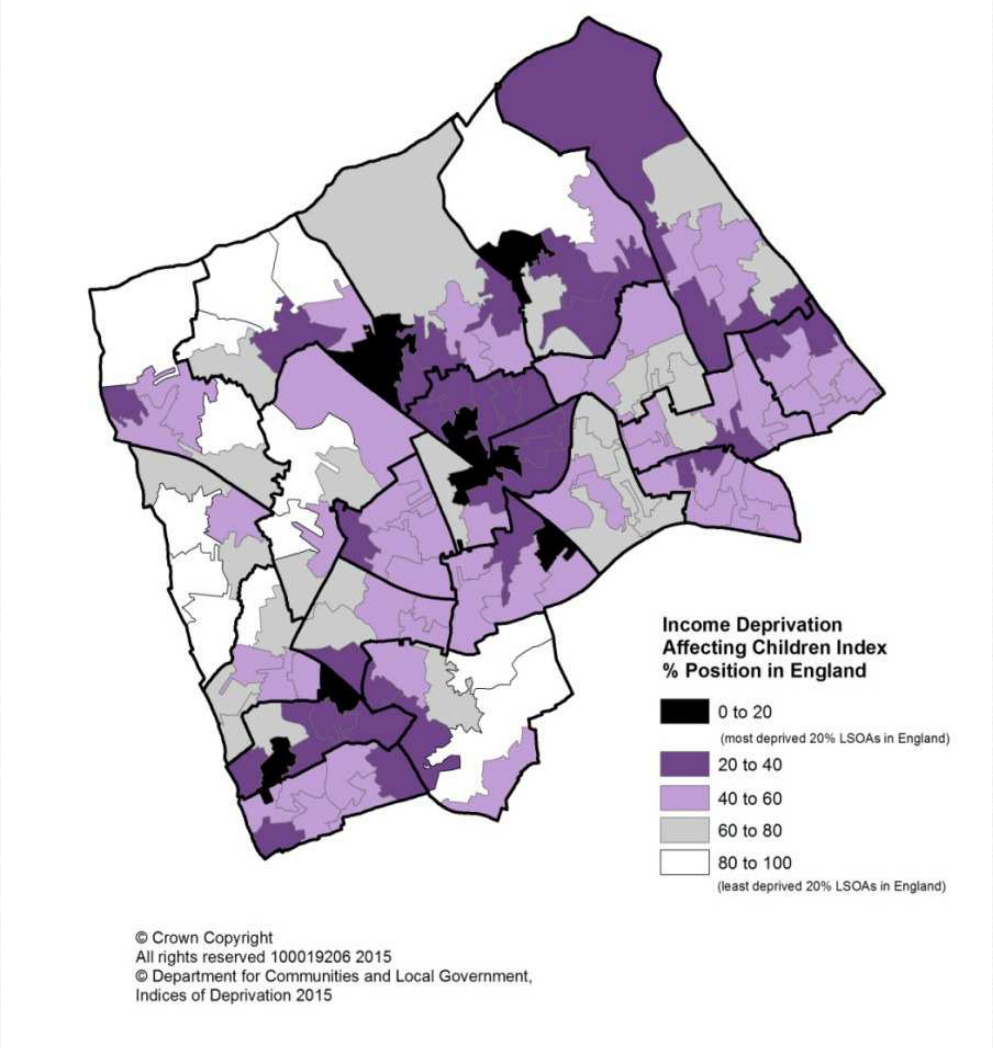
She was helped to boost her confidence and improve her mental health. She was helped with job applications and CV writing and to write a business case to start a garment-making business which would allow her to work from home.

She is now growing her business through word of mouth.

Child poverty drivers in Harrow: Income deprivation

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0-15 years living in income deprived families. Income deprivation affecting children follows a similar pattern to income deprivation in general. Overall the picture of income deprivation affecting children is varied, with LSOAs in each of the quintile bands.

Seventeen percent of children in Harrow live in families experiencing income deprivation. The highest concentrations of deprivation are in central and south-west parts of the borough, Harrow's most deprived LSOAs for income deprivation affecting children, which are in the 10% most deprived in England, are in Marlborough and Wealdstone and Roxbourne wards.

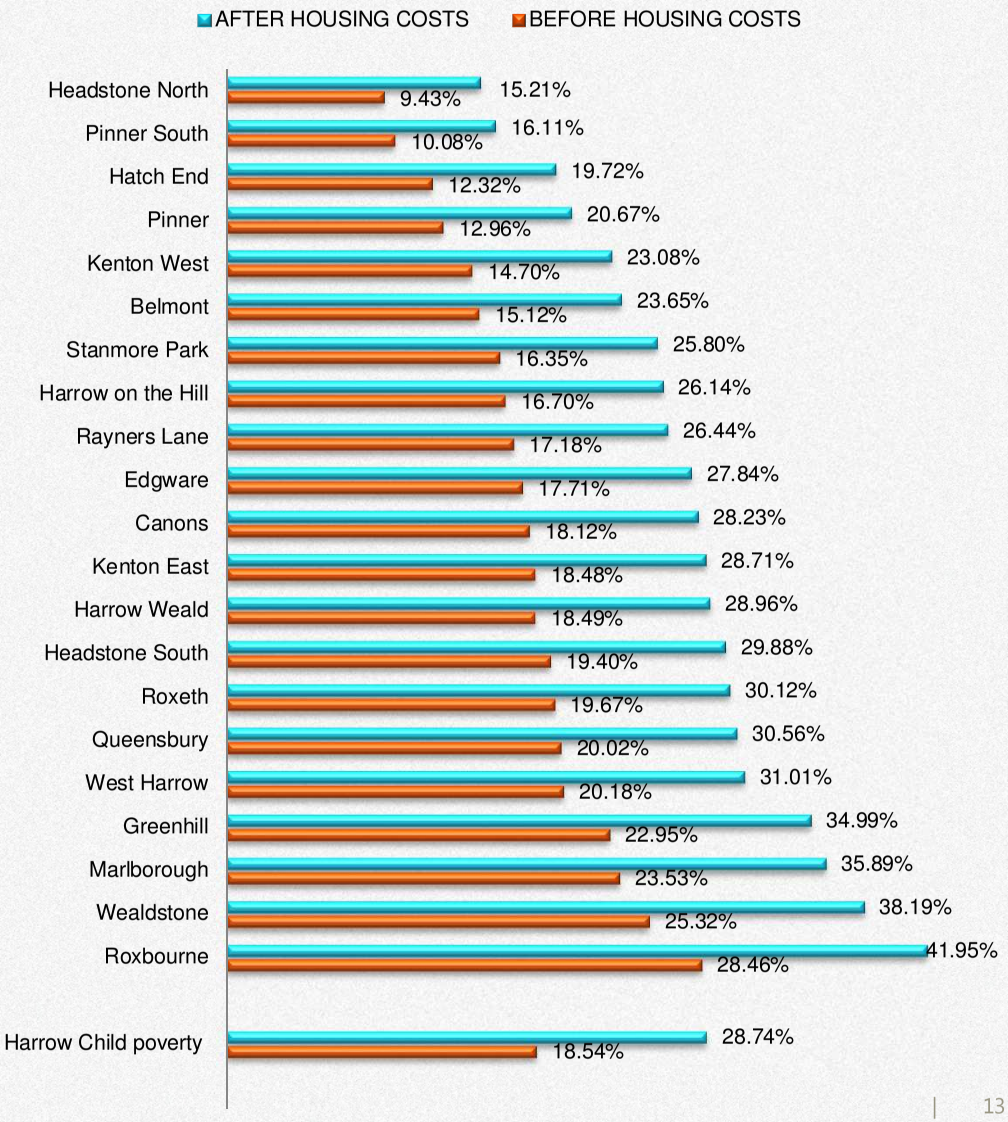


Child poverty drivers in Harrow: Housing costs

As with the rest of London, private sector accommodation – both to rent and buy – is unaffordable to Harrow residents on average or lower incomes. For many households private sector rents are only affordable with Housing Benefit (HB) support and for some (larger families and young singles) are facing stark choices: move to smaller affordable housing in the borough (if available) and/or cut household expenditure on other items or move outside London to a property that meets their actual needs.

For those who can afford to live in Harrow, the cost of housing itself can also push children and families into poverty as see on the graph opposite. On average, there is a 10.2% increase in the proportion of children pushed into poverty after housing costs have been met. However, in Roxbourne, Wealdstone and Marlborough where child poverty is already highest in the borough, the increase is even greater.

Percentage of children in poverty in Harrow before and after housing costs, Oct-Dec 2013

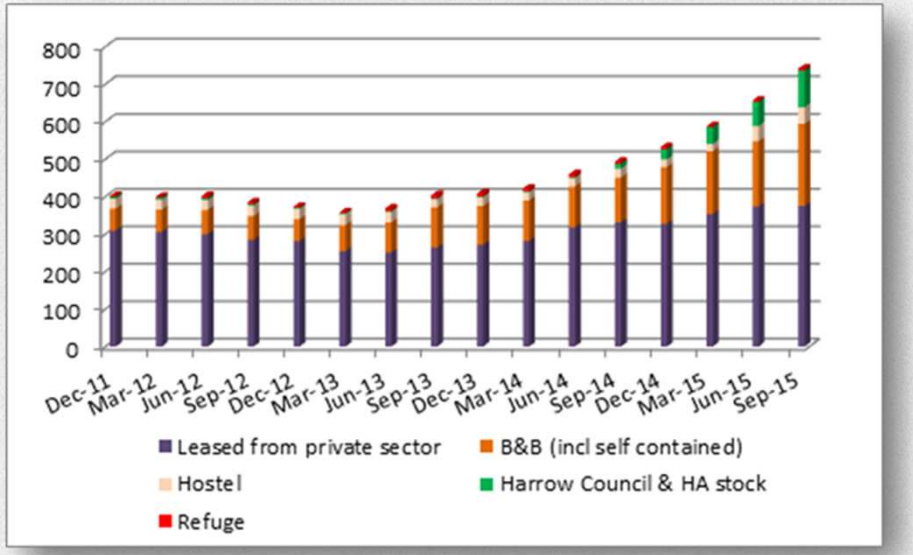


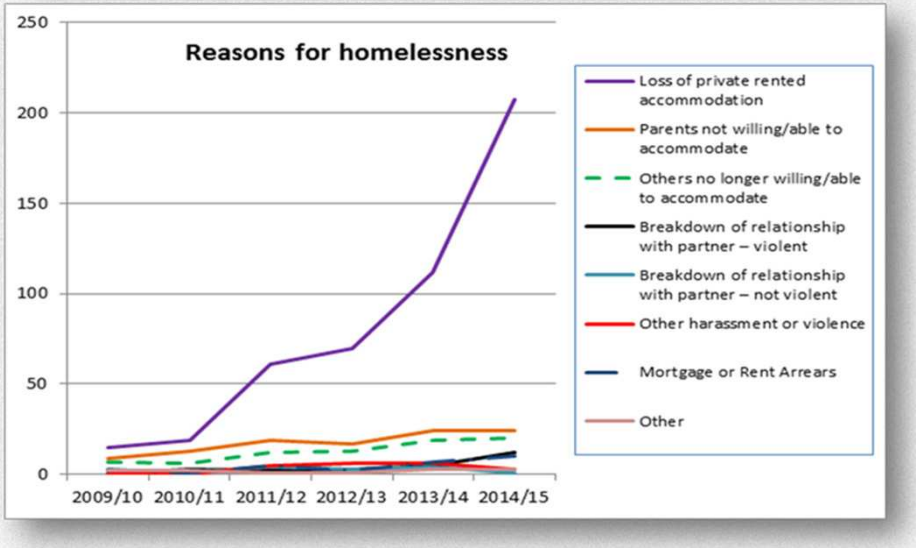
Child poverty drivers in Harrow: Housing and homelessness

Unlike the rest of London, Harrow has a very limited social housing stock . The number of social housing properties becoming available for letting each year are small and, this means that the options of social housing are currently only available to those deemed to be most in need. These are households who are generally on very low incomes i.e. welfare dependent.

There has been a significant rise in the number of people needing temporary accommodation in Harrow largely due to loss of private rented sector housing. This has resulted in unprecedented numbers being placed in bed and breakfast accommodation .

Of the 1,100 children in temporary accommodation at the end of 2015 who were in households in receipt of housing benefit, more than half were in households where parents were in work.



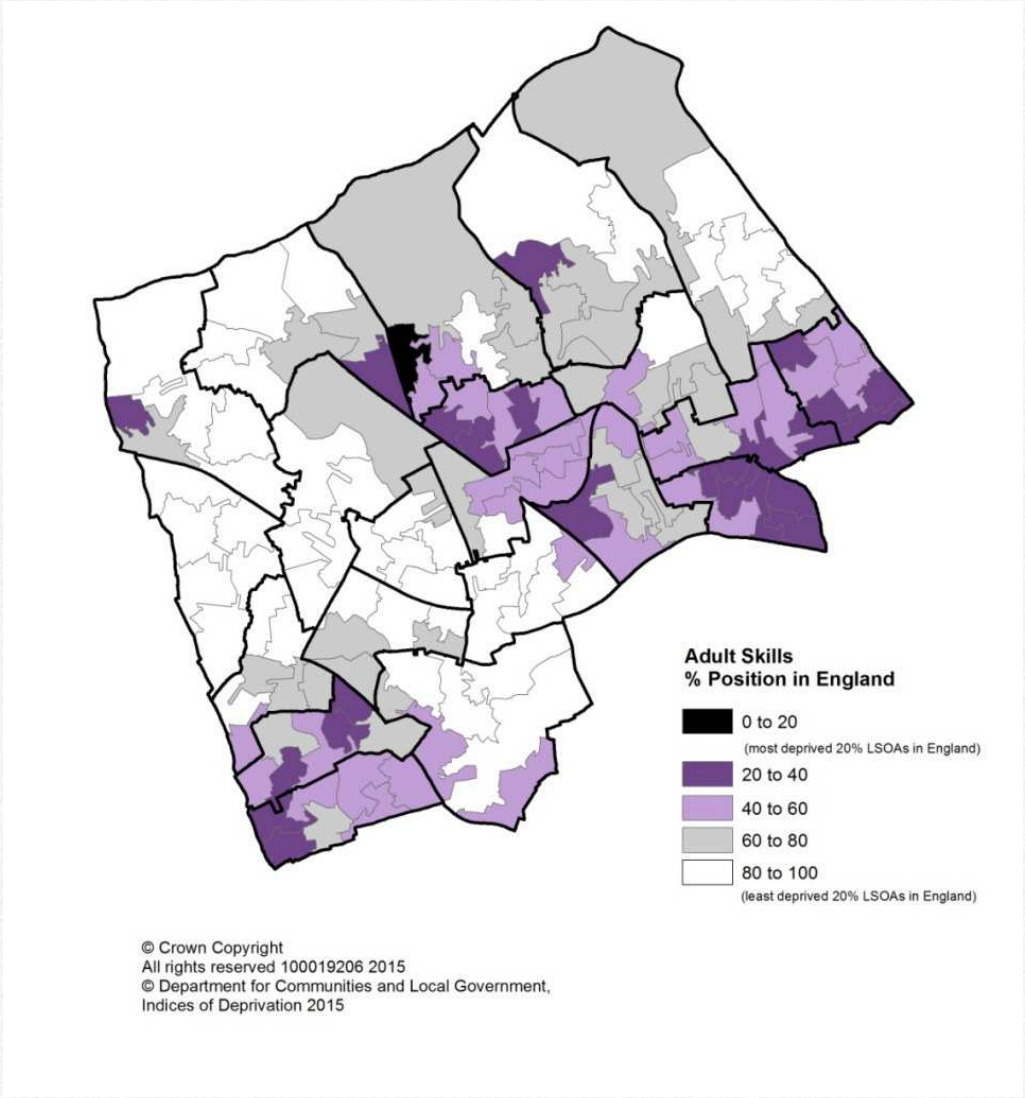


Child Poverty Drivers in Harrow: Language and skills barriers

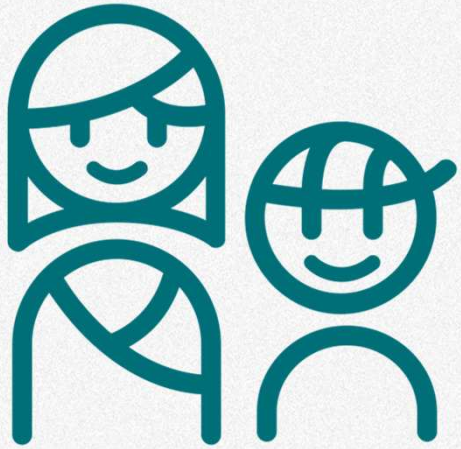
Having no or low qualifications and /or poor English language skills can block paths to higher paying employment.

Wards in the east of the borough such as Kenton West, Kenton East and Queensbury wards have higher levels of residents who cannot speak English and as a result score high for this measure.

Harrow's worst ranked LSOA for adult skills is also on of England's most deprived 20% and is in the Harrow Weald ward – the area covering part of the Headstone Estate. Three of Harrow's top ten ranked LSOAs for low levels of adult skills are in Roxbourne ward. Adult skills levels are worse in the centre, southeast and south-west of the borough.



What does child poverty look like in Harrow



Case study: Mrs Z

Mrs Z is a lone parent with a son who is at primary school. She receives housing benefits, child tax credits and child benefit. She had been unable to find work due to child care issues.

As a previous volunteer at her son's school, she wanted to get a job there which would allow her to work during school hours.

The Xcite advisor helped Mrs Z write a speculative letter to the school's head teacher and create a new CV.

At first she heard nothing but when some jobs were advertised, the excite advisor called the school to inquire about her speculative application.

After tough interview, Mrs Z got the job she wanted and is now happily working near her son.

Poverty is an opportunity to provide an opportunity. It's an opportunity to kill the worm that eats away at children's hearts, minds and self-esteem.

Compassion.com

Some examples that support the child poverty agenda

*Harrow's **Together with Families programme** began in April 2015 and helps families resolve complex issues and implements earlier interventions that can prevent families problems from escalating.*

***Children's Centres** provide universal, targeted and specialist services tailored to the needs of the local community. They play a big role in supporting the lives of children in the borough to have the best possible start in life.*

***Harrow's voluntary sector** provide advice and support on a wide range of topics to people in Harrow.*

***Healthy Start** is an important means-tested scheme providing vouchers for pregnant women or parents with a child under four. The vouchers can be spent with local retailers.*

***Xcite** is an employment programme, providing a full range of support to help Harrow residents back into work by identifying and overcoming any barriers*

***Foodbanks give** clients three day's nutritionally balanced, non-perishable food but they offer a lot more than food. Volunteers give a listening ear and signpost to other charities and agencies to help resolve the underlying causes of their crisis.*

***Child and Adolescent Mental Health Service (CAMHS) Transformation project** aims to improve emotional, behavioural and mental health outcomes for children and young people of all ages, and all levels of need.*

What next?

In this report, I have set out to raise the issue of Child Poverty in Harrow. Growing up in poverty can seriously impact a child's emotional wellbeing, physical health and educational attainment with long lasting effects into adulthood.

Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty. Harrow's housing, transport and childcare costs make it harder for low income families and many low skilled workers to survive on their incomes. Tackling child poverty needs to be a priority because of its short and long term consequences for children and for local areas.

There are persistent pockets of deprivation and child poverty in Harrow. We know from our services that work with vulnerable children and young people across Harrow, and our research and policy work, that it is often a combination of factors combined that have cause child poverty resulting in detrimental effects on a child's long term outcomes and life chances. Poor housing, unemployment, language barriers, debt and rent arrears, are all associated with poverty in Harrow.

Our next step has to be to develop a child poverty strategy and action plan for Harrow; one that all partners buy into so that together we agree what we need do to mitigate child poverty and ensure that every child in Harrow has the best opportunity to meet and fulfil their full potential.

My team has organised a workshop to explore the issues locally. We need to look at the ways we can break the cycle of child poverty to give children in Harrow a better chance.

Acknowledgements and picture credits

I would like to thank following contributors for help in compiling this report.

Carole Furlong
Leah de Souza-Thomas
Andrea Lagos
Victoria Isaacs
Helen Spillane
Su Kaminska
Alex Dewsnap
David Harrington
Mark Billington
Kuljit Kaur Bisal
Charisse Monero

References:

1. Child Poverty Action Group. Child Poverty facts and figures. Available from http://www.cpag.org.uk/child-poverty-facts-and-figures (accessed 5th September 2016)

2. London Borough of Harrow. Child Poverty and Health inequality review. May 2016

3. Department for Education. Child poverty strategy 2014 to 2017. Ref: ISBN 9781474108287

Pictures are from the Noun Project. (www.thenounproject.com)

Designs by Javier Cabezas, Jaime Carrion, Natapon Chantabutr, Combinedesign, Sergey Demushkin, Fx Pedron, Ed Harrison, Irene Hoffman, Krisada, Martha Ormiston, Luis Prado, Christoph Robausch, Denis Sazhin, Tuktuk Design, Marie Van den Broeck, Gerald Wildmoser

Overcoming poverty is not a gesture of charity. It is the protection of a fundamental human right, the right to dignity and a decent life."

— Nelson Mandela,
Former President of South Africa

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Appendix 2

Harrow Public Health 2016

Child poverty and health inequality needs assessment

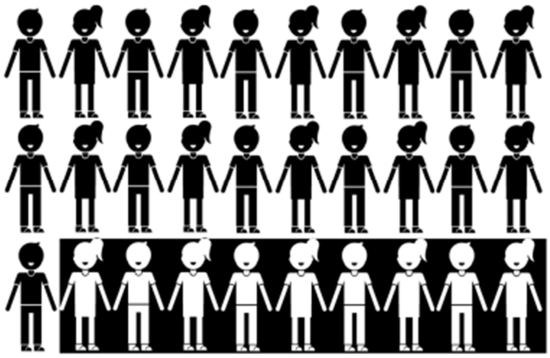
Andrea Lagos, Public health strategist Harrow

TABLE OF CONTENTS

Executive summary

Action on child poverty took place in 2010 when the Child Poverty Act was introduced in the UK. The Act required the government to produce a child poverty strategy and this was published in 2011 and renewed in June 2014 committing the government to ending child poverty by 2020[1]. When children grow up poor, this can impact on their immediate and long term life chances. Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty. The Department for Work and Pensions estimate that there were 3.9 million children living in poverty in the UK in 2014-15. That's 28 per cent of children or 9 in a classroom of 30 as depicted below.[2]

Figure 1: **9 in a class of 30 in poverty**



Mitigating child poverty is a priority for local authorities and is already reflected in the Harrow corporate plan 2016-2019 and also the health and wellbeing strategy. Harrow is generally better than other London boroughs when looking at the index of multiple deprivation (IMD) and child poverty levels. However this report shows that there are children and families in the borough who are experiencing poverty. For example Harrow's high housing and childcare costs can make it harder for low income families and low skilled workers to survive on their incomes.

The word cloud below has captured some of the key words associated with poverty in Harrow and demonstrates that child poverty is a complex multi-dimensional issue that can only be addressed through collaborative working. The local authority is in a unique position

[1] The Child Poverty Unit is jointly sponsored by the Department for Work and Pensions, the Department of Education and HM Treasury. The unit works to reduce poverty and improve social justice and supports ministers in meeting their child poverty reduction targets by 2020.
[2] Households Below Average Income, An analysis of the income distribution 1994/95 – 2015/16, Tables 4a and 4b. Department for Work and Pensions, 2016.

to make this happen and the needs assessment highlights some of the key challenges we face.

Figure 2: **Word cloud showing key indicators and risk factors for poverty**

Local authorities have a large part to play to address child poverty and break the inter-generational cycles of poverty that exists in some of the more deprived areas of the borough. Harrow does not have a child poverty strategy but will aim to have a strategy in place by 2017. This needs assessment will provide an evidence base giving a picture of the risk factors associated with child poverty locally and will support the development of the strategy. Below is a summary of 21 compelling reasons why we need a child poverty strategy in Harrow.

Key findings

1. **London's poverty profile report[3] shows** 27% of people in London were in poverty, 7 percentage points higher than the rest of England which was 20% in 2015. The cost of housing is the main factor explaining London's higher poverty rate.
2. **Child poverty levels in Harrow are 18.54% before housing costs (BHC) and rise to 28.74% after housing costs (AHC).** Poverty rises in some of the more deprived areas of the borough, Roxbourne has the highest percentage of child

[3] www.londonspovertyprofile.org.uk

poverty levels with 28.5% BHC rising to 42% after (AHC). Wealdstone, Marlborough, Greenhill, West Harrow, Queensbury and Roxeth have the next highest child poverty levels in the borough

3. **Families experience poverty for many reasons, but its fundamental cause is not having enough money to cope with the circumstances in which they are living**. A family might move into poverty because of a rise in living costs, a drop in earnings through job loss or benefit changes. Childcare and housing are two of the costs that take the biggest toll on families' budgets. The data recorded enquiries at the CAB suggest that the number of enquiries on fuel debt has increased.

4. **17.0% of pupils in Harrow's high schools were eligible for free school meals (FSM) as at January 2014.** FSM is also used as a proxy indicator for child poverty levels.

5. **Child poverty has long-lasting effects. By GCSE, there is a 28 per cent gap between children receiving free school meals and their wealthier peers in terms of the number achieving at least 5 A*-C GCSE grades.** The inequality gap in achievement in Harrow continues to narrow, however is still above national averages. Of Harrow's schools, 87 percent were good or outstanding as at October 2014, only 12 percent of schools required improvement whilst 2 percent judged inadequate. Whilst pupils in Harrow have performed above national averages overall, particular ethnic groups within Harrow do not fare as well as others. Inequalities in education exist in Harrow, particularly amongst children with special educational needs (SEN), those eligible for FSM and ethnic groups.

6. **Population projections for the 4-10 year age group are expected to increase from 20,864 children mid-year 2012 to 25,567 children mid- year 2024**.Children in large families are at a far greater risk of living in poverty – 34% of children in poverty live in families with three or more children. Children and young people under the age of 20 years make up 25.1% of the population of Harrow.

7. **The average spend on childcare per week is £153. This increases to £199 in the North East of the borough and decreases to £86 in the South East Area.** The acquisition of childcare is an important parameter which determines the employability status of a parent. Essentially, the take up of formal childcare is lower

in Harrow at only 9 percent compared with London (14 percent) and England (15 percent) averages.

8. **At 2.3% (August 2014), the unemployment rate in Harrow was below the rates for West London, London and England. However, unemployment in Wealdstone and Marlborough wards (at 4.1% and 3.9% respectively) was above the London average of 3.7%.** The number of residents of working age on key out-of-work benefits has been falling since August 2009, but worklessness rates in 24 of Harrow's 137 LSOAs exceeded the London average of 9.6% in May 2014

9. **Wealdstone, followed by Roxbourne are the most deprived wards in Harrow for income deprivation affecting children**. Harrow's ranking for income deprivation affecting children has improved considerably since 2010 where five LSOAs (Lower Super Output Areas) are in the country's least deprived 10 percent, these LSOAs are situated in Harrow on the Hill, Hatch End, Headstone North, Pinner and Pinner South wards.

10. **Kenton East scores highest in relation to those adults who experience barriers to learning and disadvantage in the labour market due to lack of English proficiency.** Overall, adult skills levels are worse in the centre, south-east and south-west of Harrow. An LSOA in Harrow Weald, in England's most deprived 20 percent, is the borough's worst ranked for adult skills.

11. **Wages paid in Harrow (£489) in 2014 were below the national average of £523.30 and considerably lower than London's average of £660.50**. Boroughs with the largest increase in low-paid jobs since 2010 were Harrow (from 21% to 37%), Waltham Forest (from 21% to 35%) and Newham (from 17% to 29%). Research shows when households are faced with financial difficulties, one of the first areas where cuts are made are in relation to household food brought per week, most frequently, healthier foods including fruits and vegetables. However, such cutbacks bring about consequences towards health and wellbeing.

12. **Lack of work can be associated to a number of factors including, poverty, crime, substance abuse, poor health, low education levels and family breakdowns.** In August 2014, there were 2,490 individuals in Harrow claiming Jobseeker's Allowance, a rate of 2.3% which was the lowest level of unemployment of all West London boroughs. According to research, in addition to

various other life adjustments, unemployment can hinder a family's ability to purchase less fresh foods and eat a balanced meal due to the high prices of healthy foods.

13. **Proficiency in English language can be a barrier to work leading to low paid low skills jobs.** School census data shows that in 2013-14 there were 168 languages spoken in Harrow schools representing the richness and diversity in the borough. In January 2014 English as a first language dropped to 38.8%. English along with Gujarati, Tamil, Somali, Arabic and Urdu continue to be the main languages spoken by Harrow's pupils. In line with the changing ethnic groups Middle Eastern and Eastern European languages are increasing significantly year on year.

14. **Poverty is also related to more complicated health histories over the course of a lifetime, again influencing earnings as well as the overall quality and length of life.** Men in the most deprived areas of England have a life expectancy 9.2 years shorter than men in the least deprived areas. They also spend 14% less of their life in good health.

15. **Poor health indicators are, most frequently, found in the more deprived areas of Harrow whilst better health outcomes, in the more affluent parts. For women in the most deprived parts of the borough, life expectancy was 4 years lower than in the most affluent areas. For men, however, the gap is much wider, with a difference in life expectancy to be over 8 years.** Although Harrow, as a borough, is generally a healthy place, there are a few measures where Harrow performs worse in than the England average, this includes; high rates of fuel poverty and statutory homelessness, high rates of excess weight in 10-11 year olds, low amount of fruit and vegetables eaten, high rates of TB and low rates of health checks.

16. **Concerning health and wellbeing factors for children includes poor mental and emotional wellbeing, tooth decay, obesity, increase in type 2 diabetes in children and low physical activity is worse in areas with higher child poverty levels**. In 2011/12, 35.1% of five year olds had one or more decayed, filled or missing teeth. This was worse than the England average.

17. **Referrals to the Multi Agency Safeguarding Hub in Harrow show that the most commonly found presenting needs were domestic violence, accounting**

for just over 34% of all needs identified, followed by parental substance abuse, accounting for nearly 19% of needs identified. Referrals have also come from some of the areas in the borough where child poverty levels are highest.

18. **Poor housing, overcrowding and rising rent in private rented sector coupled with very low availability of social housing sector and increase in temporary accommodation are all associated with poverty.** High average house prices in Harrow indicate home ownership to also be out of reach for those on lower incomes. Out of all London boroughs, Harrow has the lowest proportion of social housing. Approximately, 10 percent of Harrow's household live in social rented housing. Despite prevention efforts made from the housing team, there are still a high number of families dwelling in temporary accommodation. Harrow is nationally ranked 24th for overcrowding, where 1st is the most overcrowded. Harrow wards with the highest rates of overcrowding are Greenhill, Edgware and Marlborough. In Harrow, approximately, 6,100 children aged 0-5 years live in the 30% most deprived areas.

19. **There are more private renters in poverty than social renters or owners in London.** A decade ago it was the least common tenure among those in poverty. Most children in poverty are in rented housing (more than 530,000), half with a registered social landlord and half with a private landlord. The number of children in poverty in private rented housing has more than doubled in ten years.

20. **The wards with the highest rates of overcrowding are Greenhill, Edgware and Marlborough. 400 cases accepted as eligible and unintentionally homeless in 2014/15, more than double since 2013/14 (180) and a huge increase since 2010/11 (45).** Loss of private rented accommodation now accounts for nearly 75% acceptances, up from under 40% in 2009/10. There is a huge focus on homelessness prevention through mediation/conciliation, debt and Housing Benefit advice, rent & mortgage intervention, emergency support, negotiation/legal advocacy and sanctuary as well as other private rented sector assistance.

21. **Housing reforms plus welfare benefit changes since 2011 have led to an increase in homelessness applications and acceptances in Harrow, resulting in more families being placed in bed and breakfast at an average cost to the council of £7,000 per family per year.** Whilst Harrow is a top performer in terms of managing and preventing homelessness (one of the lowest acceptances in

London, lowest number in B&B in West London) there are no signs that the upward trend is going to reduce in the near future.

1.0 Introduction

1.1 The need for a child poverty strategy

1.1.1 The aim of this report is to present the latest picture of Child Poverty in Harrow by providing analysis of data from various departments in Harrow council, national context on child poverty reference to reports that exist relating to child poverty. The report aims to give a detailed overview of some of the key issues relating to child poverty in Harrow.

1.1.2 In March 2010 the Child Poverty Act 2010 was passed, compelling action to be taken on local and national levels to meet the target of eradicating child poverty by 2020 in the UK. The Act requires the government to publish a child poverty strategy.

1.1.3 In 2011 a national strategy was published[4], then renewed in June 2014[5]. The government commissioned independent reviews by Frank Field[6] and Graham Allen[7] which focused on children's life chances and the importance of early intervention. Both reviews are referenced in the governments' national strategies. The Marmot review[8] published in 2010 is also a key player in assessing health inequalities and the impact on poverty.

1.1.4 The Child Poverty Act also requires local authorities and their partners to cooperate to tackle child poverty in their local areas; including the duty to publish a local child poverty needs assessment and a child poverty strategy for their area. This document will provide the underlying knowledge and intelligence that assesses poverty and health inequalities that impact on child poverty in Harrow.

1.1.5 Even though the UK is a relatively rich country, many children live in poverty, it is estimated that over 600,000 of London's children live in poverty alone. Whilst some children thrive despite the poverty they grow up in, for many children growing up in poverty can mean a childhood of insecurity, under-achievement at school and

[4] Government child poverty strategy April 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/177031/CM-8061.pdf
[5] Government child poverty strategy 2014-17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324103/Child_poverty_strategy.pdf
[6] Frank Field The foundation years: preventing poor children becoming poor adults, December 2010 http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf
[7] Graham Allen report on early intervention: next steps, Jan 2011 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf
[8] Marmot Review, Fair society Healthy lives 2010, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

isolation from their peers. Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty.London's high housing, transport and childcare costs make it harder for low income families and many low skilled workers to survive on their incomes.

1.2 Why is child poverty an issue for local authorities?

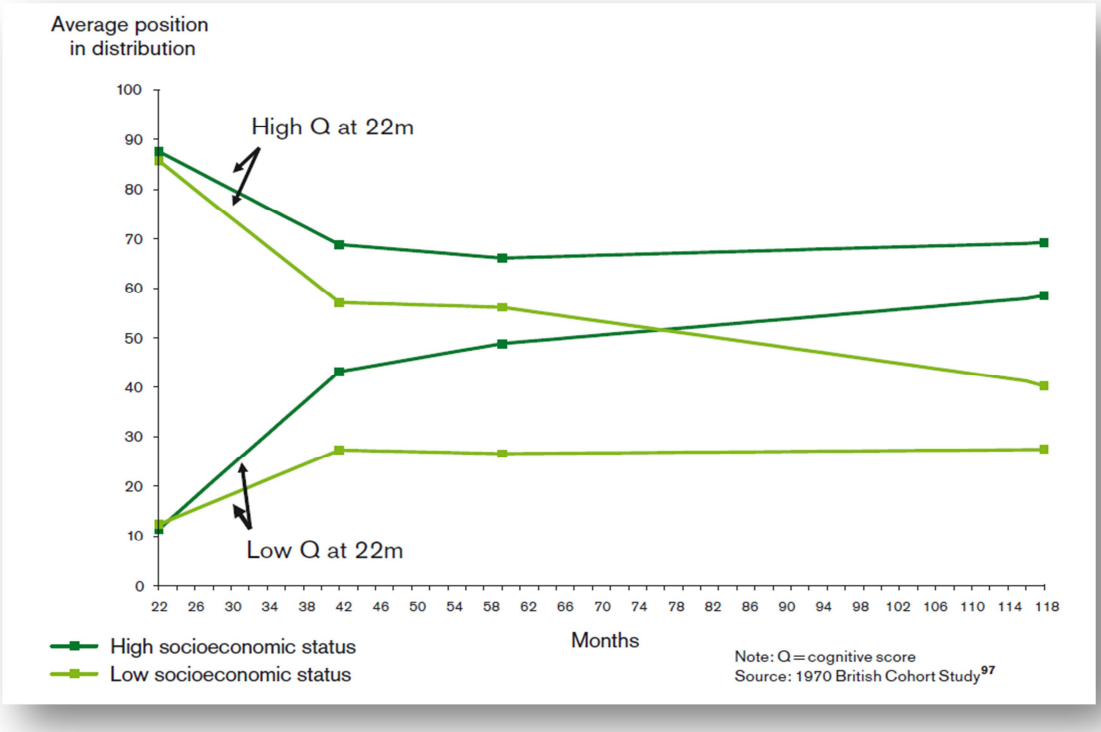
1.2.1 Tackling child poverty is a priority because of its short and long term consequences for children and for local areas. Tackling poverty is a key strategy to achieving successes in areas such as better health, education and economic development. Research estimates that poverty costs the UK £25 billion every year in reduced educational opportunities, lower taxes and higher service costs[9]

"Poverty affects different aspects of people's lives, existing when people are denied opportunities to work, to learn, to live healthy and fulfilling lives, and to live out their retirement years in security. Lack of income, access to good-quality health, education and housing, and the quality of the local environment all affect people's well-being." (DSS, 1999a: 23)[1]

1.2.2 More importantly, inequality can have an impact on the cognitive development and therefore future life chances of children as reported in the Marmot review. The 1970 British Cohort Study (BCS70) follows the lives of more than 17,000 people born in England, Scotland and Wales in a single week of 1970. Over the course of cohort members lives, the BCS70 has collected information on health, physical, educational and social development, and economic circumstances among other factors. Figure 4 shows inequality in cognitive development of children in the BCS at 22 months and 10 years. The following groups of 2 year olds at either end of the cognitive ability scale, significant gaps in cognitive ability opened up between 2 and 10 years dependent on socio economic status. And in fact, by around age 6 the 'less bright' group with higher socio economic status had caught up with the 'bright' group with lower socio economic status. Thus the socio economic environment in which the child is developing would seem to have a huge impact on cognitive development, far greater than any 'raw material' that the child is born with.

[9] Joseph Rowntree Foundation, Estimating the Cost of Child Poverty (2008)

Figure 3: **Inequality in early cognitive development of children in the 1970 British Cohort Study, at 22 months to 10 years**



1.2.3 Local authorities and their delivery partners have a vital role in delivering many of the building blocks to tackle child poverty. As providers of services to children, young people and families, they have a major part to play in narrowing the gaps in outcomes between children from low income families and their peers, and breaking inter-generational cycles of deprivation. Through driving regional economic performance and sustainable growth they also create prosperity and employment. Local authorities can provide strategic leadership in tackling child poverty and facilitate creative local solutions tailored to local circumstances.

1.2.4 The child poverty basket of indicators[10] brings together indicators of child poverty as identified by the Child Poverty Unit. It is designed to allow the comparison and analysis of data from different local authorities (LAs) and regions in England.

1.3 Defining poverty

1.3.1 When we talk about poverty in the UK today we rarely mean malnutrition or the levels of squalor of previous centuries or even the hardships of the 1930s before the

[10] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators

welfare state. It is a relative concept. 'Poor' people are those who are considerably worse off than the majority of the population – a level of deprivation heavily out of line with the general living standards enjoyed by the majority of the population in one of the most affluent countries in the world. Professor Peter Townsend[11], a leading authority on UK poverty, defines poverty as when someone's

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"Resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities"

Poverty is about the conditions people face. A study on poverty and social exclusion showed for example, out of 58 million people in Britain today:

- Roughly 9.5 million people in Britain cannot afford adequate housing conditions as perceived by the majority of the population. That is, they cannot afford to keep their home adequately heated, free from damp or in a decent state of decoration.
- About 8 million people cannot afford one or more essential household goods, such as a fridge, a telephone or carpets for living areas, or to repair electrical goods or furniture when they break or wear out.
- Almost 7.5 million people are too poor to be able to engage in those common social activities considered necessary: visiting friends and family, attending weddings and funerals, or having celebrations on special occasions.
- A third of British children go without at least one of the things they need, like three meals a day, toys, out of school activities or adequate clothing. Eighteen per cent of children go without two or more items or activities defined as necessities by the majority of the population.
- About 6.5 million adults go without essential clothing, such as a warm waterproof coat, because of lack of money.
- Around 4 million people are not properly fed by today's standards. They do not have enough money to afford fresh fruit and vegetables, or two meals a day, for example.

[11] Peter Townsend, report on poverty https://www.jrf.org.uk/report/reporting-poverty-uk-practical-guide-journalists

- Over 10.5 million people suffer from financial insecurity. They cannot afford to save, insure their house contents or spend even small amounts of money on themselves.

1.3.2 The general public holds ideas about the necessities of life that are more wide-ranging, or multidimensional, than is ordinarily represented in expert or political assessments. People of all ages and walks of life do not restrict their interpretation of 'necessities' to the basic material needs of a subsistence diet, shelter, clothing and fuel. There are social customs, obligations and activities that substantial majorities of the population also identify as among the top necessities of life. People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantages through unemployment, low income, poor housing, inadequate health care and barriers to lifelong learning, culture, sport and recreation. They are often excluded and marginalised from participating in activities (economic, social and cultural) that are the norm for other people.

1.3.3 Parental income has also often been identified as one of the best predictors of a child's future life chances. In the UK, someone in poverty as a teenager in the mid 1980s was almost four times as likely to be in poverty as an adult compared to those who were not in poverty as teenagers. The evidence suggests that the impact of parental income on future poverty acts mainly through impacting on the child's educational attainment.

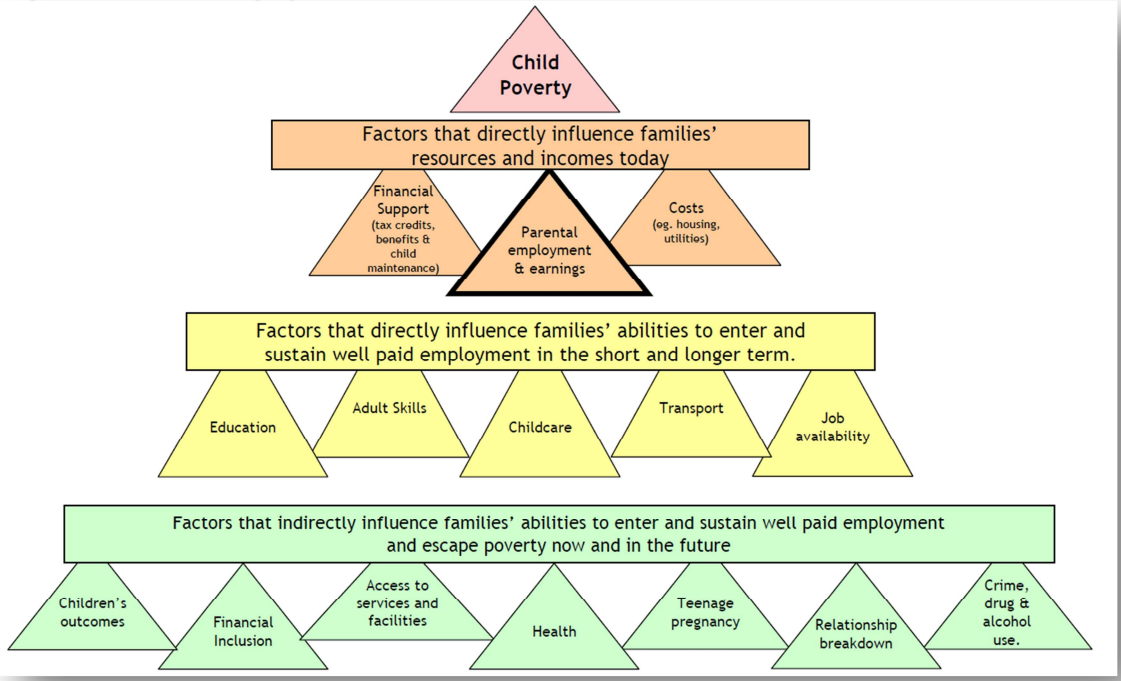
The current government definition of child poverty is "children living in households with incomes below 60 per cent of the median income" Children in households with low incomes, are families either in receipt of out-of-work benefits or in receipt of tax credits with a reported income which is less than 60 per cent of national median income. This measure provides a broad proxy for the relative low-income measure as used in the Child Poverty Act 2010 and enables analysis at a local level. Administrative data sources on benefits and tax credits from the Department for Work and Pensions (DWP) and Her Majesty's Revenue and Customs (HMRC) are used in the calculation of the Children in Low-Income Families Local Measure.

1.3.4 The government are currently reviewing the definition to propose a new way of measuring child poverty, suggesting that the new system would focus on the "root causes" of poverty and make a "meaningful change to children's life chances". The new measures will include factors such as educational achievement and living in workless households as well as income. They plan to scrap measures introduced in 2010 - which define a child as being poor when it lives in a household with an income below 60% of the UK's average. New legislation would introduce a "statutory duty to report on worklessness and levels of educational attainment", focused on changes in the number of long-term workless households and GCSE attainment for all pupils. For this reason, the report focusses on areas other than parental income.

1.3.5 The government propose to develop a range of other indicators to measure other causes of poverty, including family breakdown, debt and drug and alcohol dependency, reporting annually on how these indicators affect life chances. Poverty can also extend to those that are “asset rich and income poor” and many people in this position own their own homes. Many people in this situation have very small incomes and cannot afford the upkeep, resulting in deteriorating homes, which may well be losing value. It is not just older people, though. Increasingly in an economic downturn it is likely to be affecting other people who have lost their jobs and have mortgages on their homes. People who spend more than 10 per cent of their net income on fuel are defined as living in fuel poverty.

1.3.6 The child poverty pyramid below represents the Child Poverty Unit’s understanding of the factors that impact on child poverty.. To be effective an area needs to focus attention on the factors which have largest and most direct impact on child poverty. To reflect this, the factors are prioritised into a hierarchy of three tiers to show their impact on reducing child poverty.

Figure 4: **Pyramid of factors affecting child poverty**



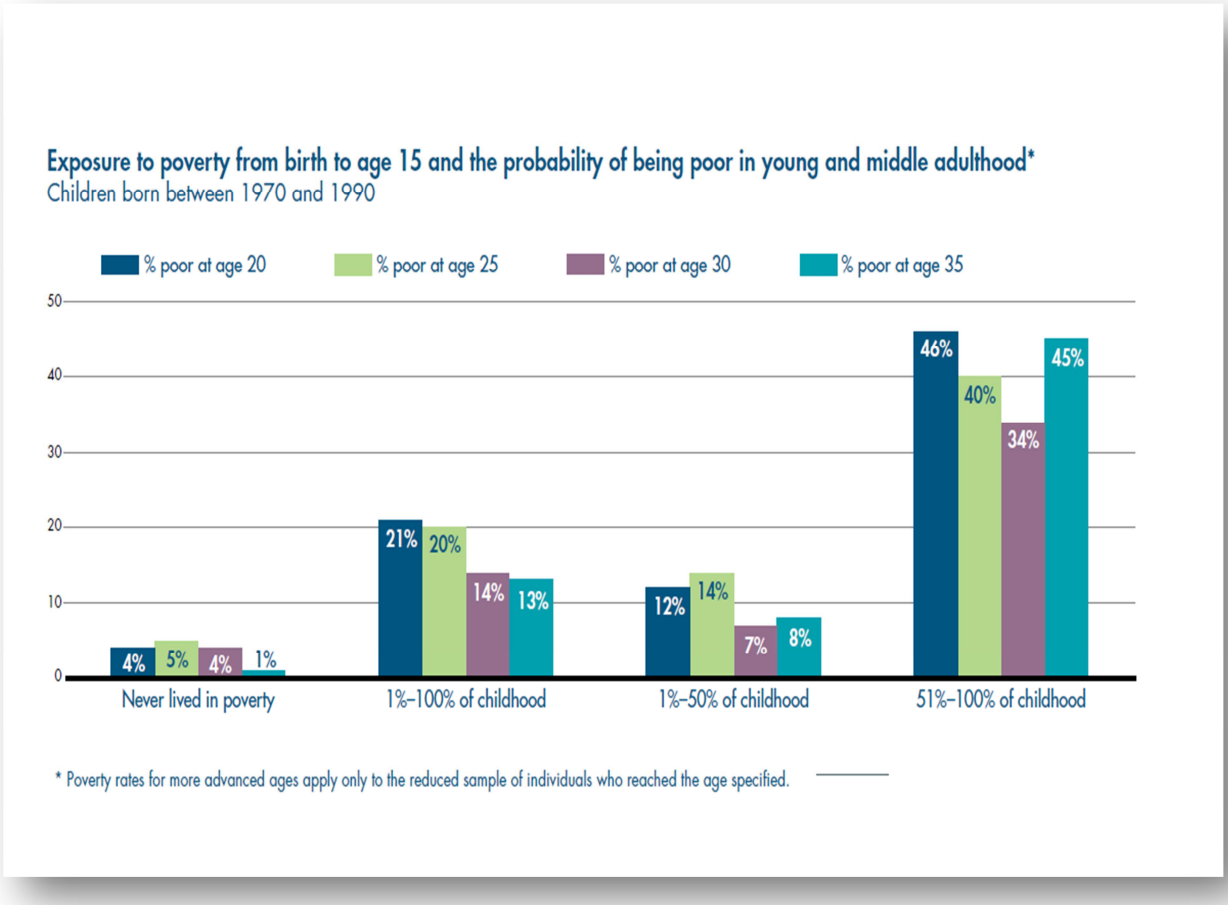
1.3.7 Evidence suggests that different aspects of poverty have different effects on various aspects of well-being. A poor physical environment, resulting from bad housing and/or neighbourhood, results in a detrimental home life, more depressive symptoms and more risky behaviour. The psycho-social strain on parents associated with poverty independently reduces a child's quality of home life, increases the likelihood of low self-worth and the chances of engaging in risky behaviour. Different dimensions of poverty and their effects on childhood wellbeing.

Intergenerational poverty

1.3.8 Research shows that children who grow up in poverty are more likely to be poor as adults, while those who grow up in more affluent families are more likely to be affluent later in life. While even a few years in poverty can have a significant impact on children's economic trajectories, the risks are particularly severe for the small number who experience many years of poverty. The graph below shows children born between 1970 and 1990 and the probability of them being poor into adulthood.[12]

[12] http://academiccommons.columbia.edu/download/fedora_content/download/ac:126228/CONTENT/text_911.pdf

Figure 1: **Exposure to poverty from birth to age 15 and the probability of being poor in young and middle adulthood.**



1.3.9 As well as making for a fairer society, improving intergenerational mobility has a number of potential additional outcomes of interest to policymakers: It has been argued that greater equality of opportunity could reduce the need for welfare support, encourage greater social cohesion and make use of the potential of all individuals, increasing economic efficiency.

1.4 Poverty in London

1.4.1 London's poverty profile report[13] shows 27% of Londoners live in poverty after housing costs are taken into account, compared with 20% in the rest of England. The cost of housing is the main factor explaining London's higher poverty rate. Figure 2 shows how London performs across a range of indicators.

[13] http://www.londonspovertyprofile.org.uk/2015_LPP_Document_01.7-web%255b2%255d.pdf

Figure 2: **Table showing poverty profile in London (London poverty profile 2015)**

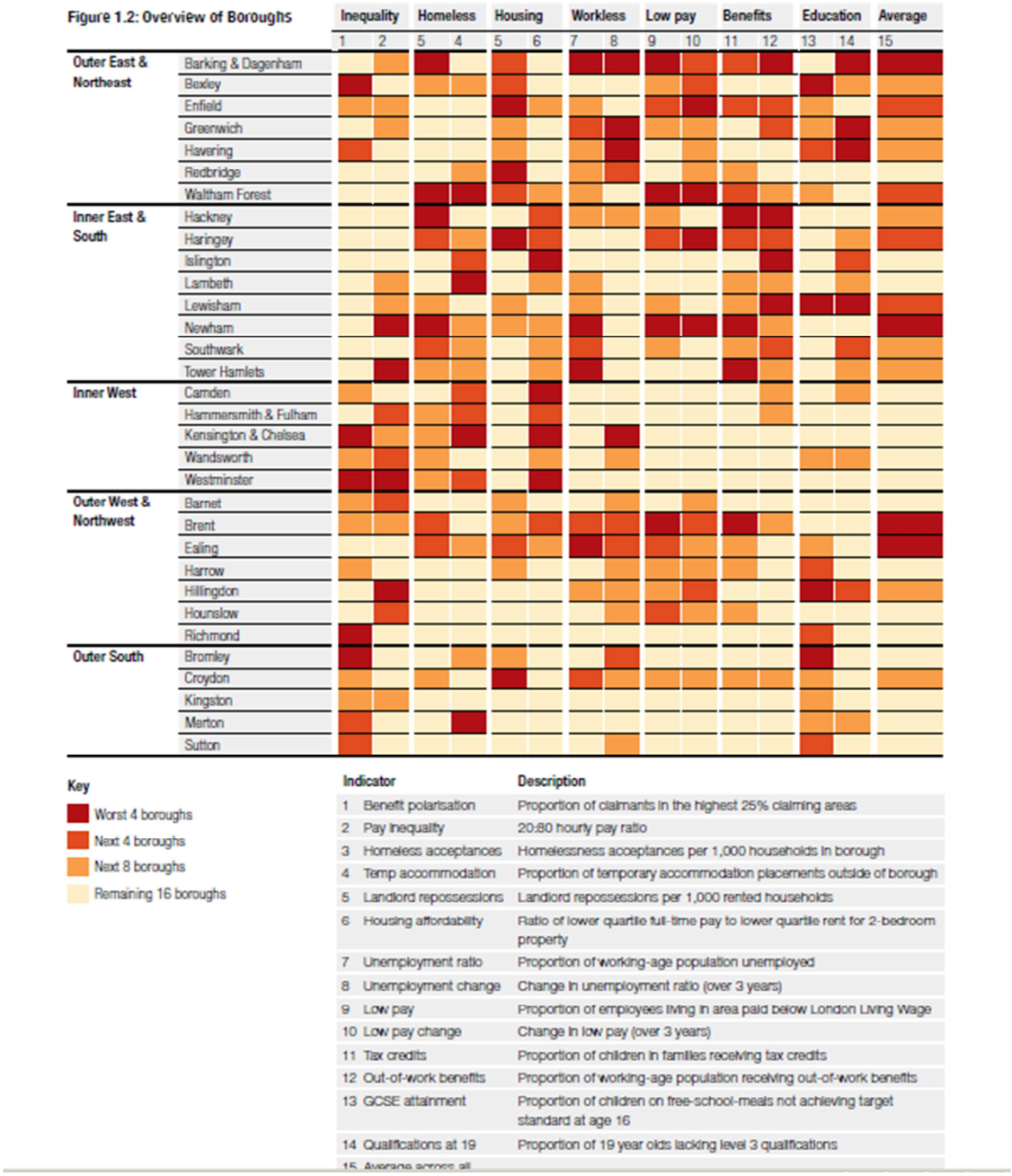


Figure 1.2: Overview of Boroughs

		Inequality		Homeless		Housing		Workless		Low pay		Benefits		Education		Average
		1	2	5	4	5	6	7	8	9	10	11	12	13	14	15
Outer East & Northeast	Barking & Dagenham															
	Bexley															
	Enfield															
	Greenwich															
	Havering															
	Redbridge															
	Waltham Forest															
Inner East & South	Hackney															
	Haringey															
	Islington															
	Lambeth															
	Lewisham															
	Newham															
	Southwark															
	Tower Hamlets															
Inner West	Camden															
	Hammersmith & Fulham															
	Kensington & Chelsea															
	Wandsworth															
	Westminster															
Outer West & Northwest	Barnet															
	Brent															
	Ealing															
	Harrow															
	Hillingdon															
	Hounslow															
	Richmond															
Outer South	Bromley															
	Croydon															
	Kingston															
	Merton															
	Sutton															

Key

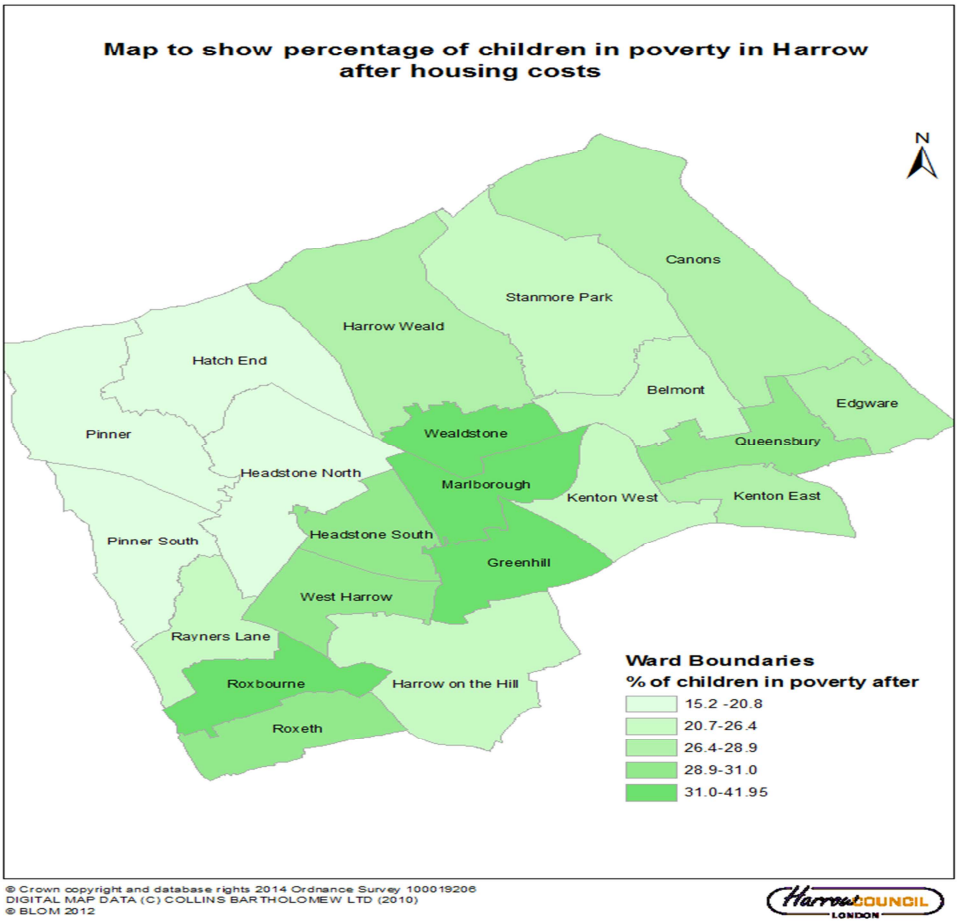
- Worst 4 boroughs
- Next 4 boroughs
- Next 8 boroughs
- Remaining 16 boroughs

	Indicator	Description
1	Benefit polarisation	Proportion of claimants in the highest 25% claiming areas
2	Pay inequality	20:80 hourly pay ratio
3	Homeless acceptances	Homelessness acceptances per 1,000 households in borough
4	Temp accommodation	Proportion of temporary accommodation placements outside of borough
5	Landlord repossessions	Landlord repossessions per 1,000 rented households
6	Housing affordability	Ratio of lower quartile full-time pay to lower quartile rent for 2-bedroom property
7	Unemployment ratio	Proportion of working-age population unemployed
8	Unemployment change	Change in unemployment ratio (over 3 years)
9	Low pay	Proportion of employees living in area paid below London Living Wage
10	Low pay change	Change in low pay (over 3 years)
11	Tax credits	Proportion of children in families receiving tax credits
12	Out-of-work benefits	Proportion of working-age population receiving out-of-work benefits
13	GCSE attainment	Proportion of children on free-school-meals not achieving target standard at age 16
14	Qualifications at 19	Proportion of 19 year olds lacking level 3 qualifications
15	Average across all	

1.5 Poverty in Harrow

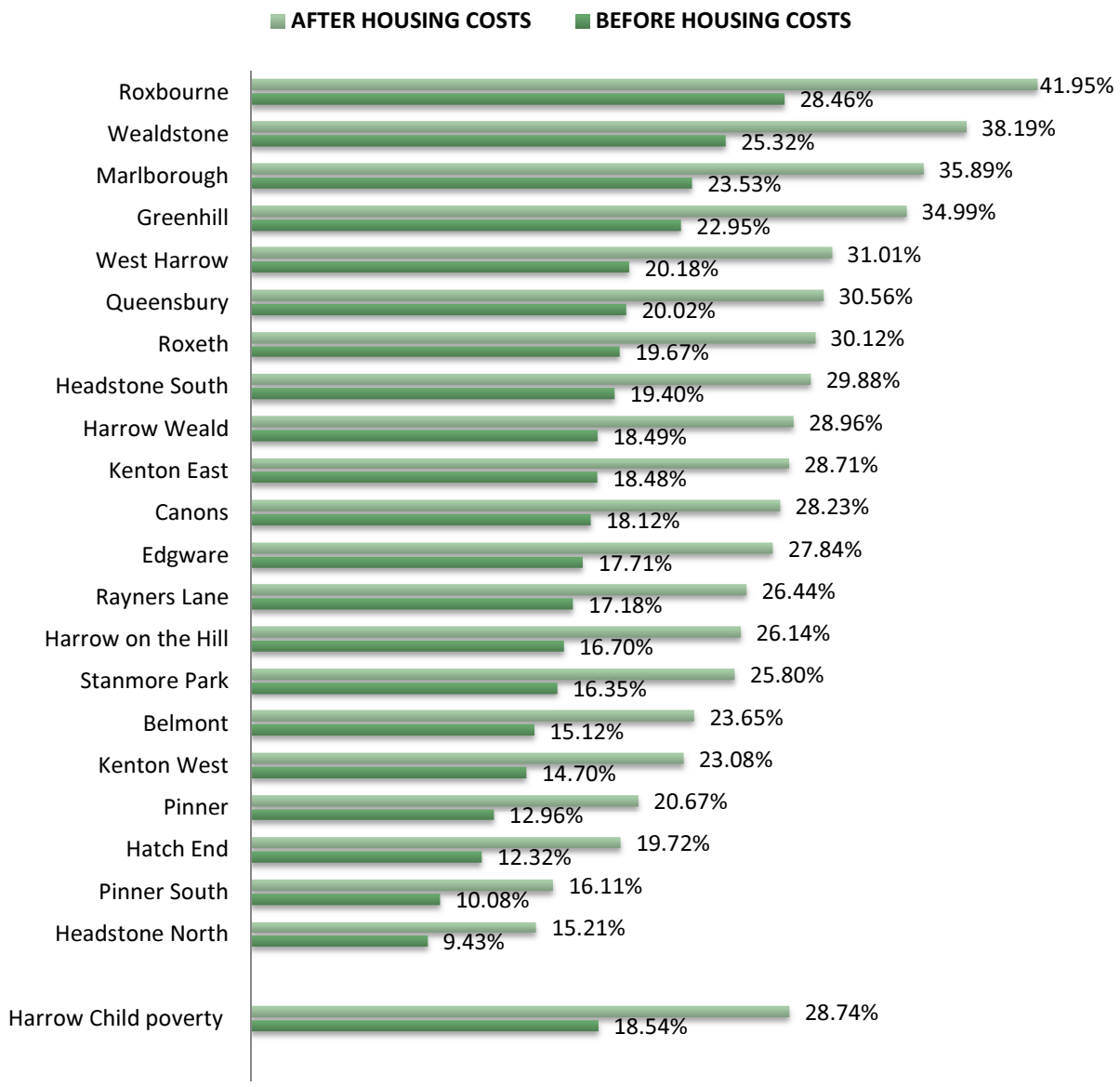
1.5.1 Figures 3 and 4 below show income before and after housing costs. Overall, the child poverty levels in Harrow are 18.5% before housing costs (BHC) and rise to 28.7% after housing costs (AHC). Poverty rises in some of the more deprived areas of the borough, Roxbourne has the highest percentage of child poverty levels with 28.5% BHC rising to 42% after (AHC). Wealdstone, Marlborough, Greenhill, West Harrow, Queensbury and Roxeth have the highest child poverty levels in the borough as shown in the map below. .

Figure 3: **Map showing the percentage of children in poverty, Oct – Dec 2013 in Harrow**[14]



[14]End child poverty.co.uk, data available from: http://webcache.googleusercontent.com/search?q=cache:MmzF3HSQCf4J:http://www.endchildpoverty.org.uk/images/ecp/London_LA%2520and%2520ward%2520data.xlsx%2BChildren+in+poverty,+Oct-Dec+2013+estimates&safe=active&hl=en-GB&gbv=2&ct=clnk

Figure 4: **Percentage of children in poverty, Oct – Dec 2013 in Harrow**



1.5.2 Marmot's *Fair Society Healthy Lives*[15]*, 2008*, shows that there is a direct correlation between socioeconomic status and health outcomes is highlighted. The report proposed the most effective evidence-based strategies for reducing health inequalities in England from 2010. Marmot's work on inequalities stressed that there was a social gradient in health – the lower a person's position the worse his or health. Action should focus on reducing the gradient. Child poverty is exacerbated by inequalities and so tackling these inequalities means that we can mitigate child poverty and poor outcomes for children and their families.

[15] Marmot Fair Society Healthy Lives, Feb 2010: http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE

1.5.3 The Marmot Review (2010) was a strategic review of health inequalities in England. It recommended six key areas of action that were required across all of society, to reduce health inequality:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

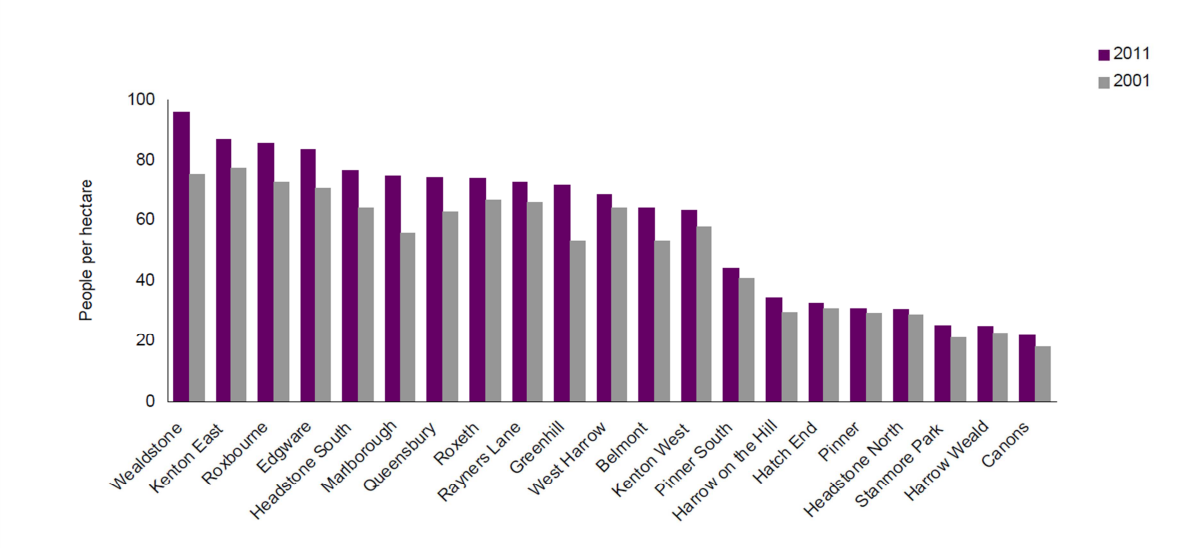
2.0 Harrow in Context

2.1 Population

2.1.1 Harrow has 137 Lower Super Output Areas (LSOAs), within the borough's 21 wards. Harrow is the 12th largest borough in London in terms of area, covering 5,047 hectares (50 square kms).

2.1.2 With an estimated overall usual resident population of 239,056 in the 2011 Census the borough is the 20th largest in London in terms of population. Typically there are either six or seven LSOAs in each ward. The average sized LSOA in Harrow has 1,745 residents and 615 households. The least densely populated wards are Canons, Harrow Weald, and Stanmore Park. These wards are all in the north of the borough and have large swathes of green belt land. At the LSOA level, the area to the south of Locket Road in Marlborough; part of West Harrow (Honeybun Estate, Vaughan Road and Butler Avenue); and the Byron Road/Church Lane area in Wealdstone ward have higher population densities than other inner London areas

Figure 5: **Population density in Harrow**[16]



[16] *Source: 2011 Census, ONS, cited Harrow Vitality profiles*

2.1.3 Harrow is home to 55,800 children aged 0-17[17]. Key children population stats based on 2011 census child population data shows:

- The ONS live births for Harrow have substantially increased from 2,581 in 2001, to 3,088 in 2007 and to 3,559 in 2013 which is an increase of 38% since 2001.
- Of the 3,559 live births in 2013, 68.5% were to non-UK born mothers. Of the 69% non-UK born mothers 49.9% were born in the Middle East & Asia, 30.8% in the European Union and 13.4% in Africa.
- A quarter of the mothers from the European Union were born in the 'New EU', which constitutes the twelve countries which joined the European Union (EU) between 2004 and 2012. Birth rates among British-born mothers have fallen from 1,307 births in 2001 to 1,122 in 2013.
- Harrow is ranked in the top quartile nationally for 0-4 year olds, 6.7 per cent (15,916) of Harrow's residents are children aged four and under in 2011.
- There has been a 32% (+3,900) increase in 0-4 year olds since 2001, 6.7 per cent (15,916) of Harrow's residents are children aged four and under, compared to 5.8% (12,019) in 2001
- 81.6 per cent (12,991) of all children aged 0 to 4 in Harrow are from minority ethnic groups (all groups excluding White British). 44.8 per cent (7,134) of all Harrow's young children are of Asian/Asian British ethnic origin, the largest ethnic grouping.
- There are pockets of high concentration of 0-4 year olds in central and south-west Harrow.
- Approximately, 6,100 children (Age 0-5) live in the 30% most deprived areas of Harrow (based on the Index of Deprivation affecting Children)

2.1.4 Wealdstone ward has the highest percentage of residents aged four and under, followed by Roxbourne. Greenhill has seen the largest percentage increase in 0-4 year olds since 2001, followed by Canons and Wealdstone ward. Canons is generally characterised by its high proportion of elderly residents, although over the decade

[17] ONS mid-year estimates 2013

Canons has seen a significant increase in its housing stock, which may have brought in more families with young children to this area. Likewise Greenhill, Wealdstone, Marlborough and Harrow on the Hill wards have also experienced substantial housing development over the decade to 2011.

2.1.5 In 2013/14 there were approximately 5,770 NINo registrations in Harrow, 40% higher than the number of registrations in 2012/13 (4,120). In West London 54,900 NINos were issued in 2013/14, 23.7% of London's overall total of 231,830. 2010/11 was West London's and London's peak year for NINos. The rate of NINos per 1,000 working age population in Harrow in 2013 was 28, below the West London rate of 49 and London's rate at 43 (per 1,000 residents aged 16-64).

2.1.6 21% (13,447) of Harrow's NINo registrations have been issued to Indian workers since 2002/03, the largest national group overall and perhaps reflecting the fact that Harrow has a large settled Indian community, which attracts migrant Indian workers to the area. Romania, Sri Lanka and Poland are ranked 2nd, 3rd and 4th respectively, with between 5,540 and 9,860 registrations, per country, in total over the past eleven years. In 2013/14 the number of Romanian workers issued with NINos in Harrow, more than doubled compared to the previous year, rising from 940 registrations in 2012/13 to over 2,470 registrations in 2013/14 and the largest influx of Romanian workers recorded in the borough. This large increase may partly be due to the lifting of restrictions on Bulgarian and Romanian nationals' rights to work in the UK on 1st January 2014.

Figure 6: **GP and National Insurance Registrations to Overseas Nationals (NINo)**

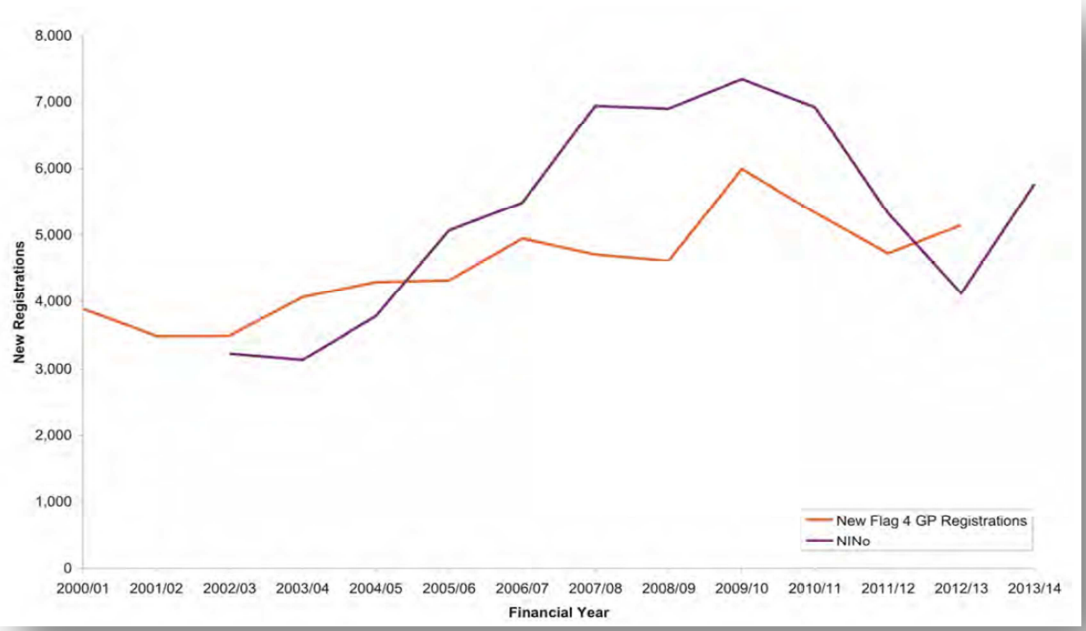
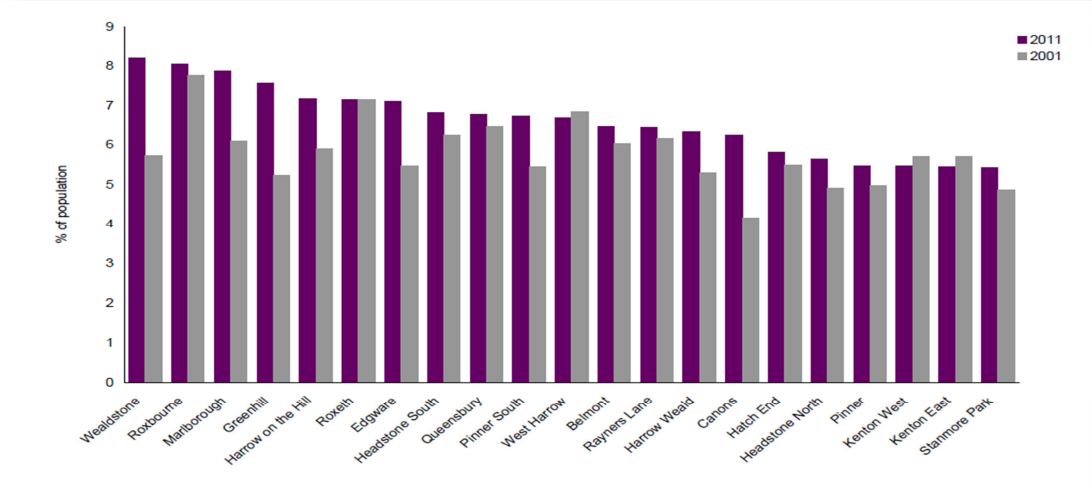


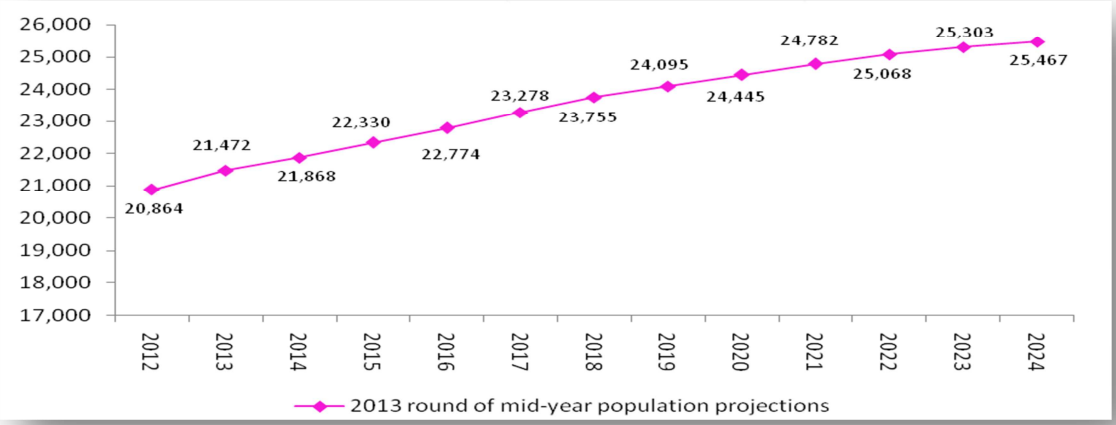
Figure 7: **Children aged 0-4 in Harrow**[18]



2.1.7 The 2013 round mid-year population projections are represented in the charts below. The 4-10 year old population projections suggest that this group will continue to rise with a projected increase of 22.1% from 20,864 children mid-year 2012 to 25,467 children mid-year 2024.

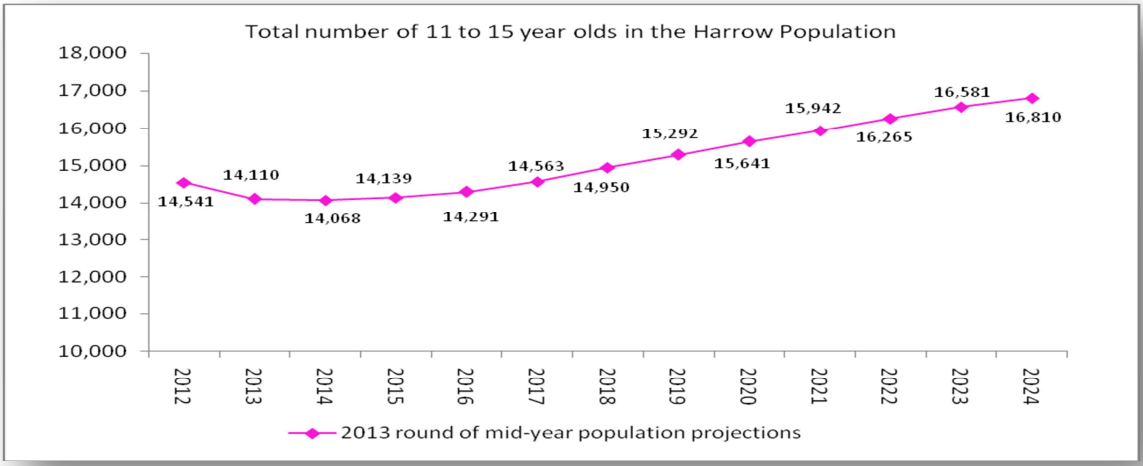
[18] *Source 2011 Census, ONS, cited in Harrow vitality profiles*

Figure 8: **Harrow's 4 to 10 year old population projections**[19]



2.1.8 The number of 11-15 year olds in the population is projected to increase from 2015 (14,139) and will continue rising to 16,810 in 2024 and beyond. There is a projected increase of 15.6% from 2012 to 2024. The timing of this increase reflects the current surge in Reception numbers.

Figure 9: **Harrow's 11 to 15 year old population projections**[20]



2.1.9 As a result of the increase in the birth rate, the school population has increased and is projected to continue this upward trend. The number of primary aged pupils on roll has risen from 16,633 in January 2006 to 19,347 in January 2014. The pressure on

[19] *Source: Harrow 2013rnd trend BPO borough, GLA*
[20] *Source: Harrow 2013, GLA*

school places is particularly acute in the reception year groups where there has been an increase from 2,224 in January 2006 to 3,030 in January 2014. Although the secondary school population has remained more stable during this period, the growth is expected to progress through the year groups and to impact Harrow's high schools from 2016/17.

2.2 Ethnicity

2.2.1 The ethnicity profile of Harrow's school pupils reflects the general diversity changes within Harrow's population. In January 2011 Indian and White British pupils were the largest ethnic groups in Harrow's schools however as at January 2014 the Asian other pupils are the majority. The fall in White British pupils from 28% in 2006 to 19% in 2011 has dropped even further in January 2014 with only 14.5% White British pupils attending Harrow's schools. The increase in pupils from Asian other backgrounds has gone from 13.1% in 2006 to 19.5% in 2011 and now 21.0%, and this is followed by an increase in the White other backgrounds group from 4.2% in 2006 to 7.3% in 2011 and 11.0% in 2014. The chart below shows the percentage of pupils in each ethnic group in Harrow schools as at January 2014.

2.2.2 Harrow school census data shows that the percentage change in the number of pupils in the ethnic groups in Harrow's schools from 2009-10 to 2013-14. Whilst the Asian other group has increased significantly over the last 5 years it is the White other group that has had the largest increase of 89.1% from 1,940 in January 2010 to 3,669 in January 2014.

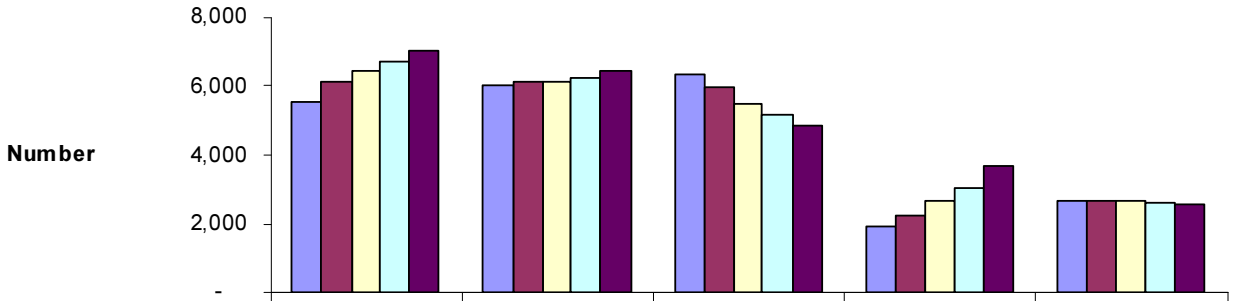
Table 1: Table showing percentage change in the number of pupils in the ethnic groups in Harrow schools

Ethnicity	January 2010		January 2011		January 2012		January 2013		January 2014		% change 2010 to 2014
	Number	%	Number	%	Number	%	Number	%	Number	%	

Asian other	5572	18.2%	6091	19.5%	6450	20.3%	6737	20.9%	7013	21.0%	25.9%
Indian	6026	19.7%	6097	19.5%	6125	19.3%	6221	19.3%	6483	19.4%	7.6%
White British	6356	20.8%	5952	19.1%	5480	17.3%	5188	16.1%	4846	14.5%	-23.8%
White other	1940	6.3%	2224	7.1%	2628	8.3%	3037	9.4%	3669	11.0%	89.1%
Black African	2649	8.7%	2669	8.6%	2664	8.4%	2620	8.1%	2567	7.7%	-3.1%
Pakistani	1344	4.4%	1407	4.5%	1503	4.7%	1577	4.9%	1632	4.9%	21.4%
Any other ethnic group	1039	3.4%	1143	3.7%	1192	3.8%	1276	3.9%	1411	4.2%	35.8%
Black Caribbean	1316	4.3%	1285	4.1%	1271	4.0%	1219	3.8%	1180	3.5%	-10.3%
Mixed other	897	2.9%	917	2.9%	950	3.0%	990	3.1%	1044	3.1%	16.4%
Mixed White Asian	622	2.0%	679	2.2%	710	2.2%	753	2.3%	767	2.3%	23.3%
Mixed White Black Caribbean	642	2.1%	645	2.1%	644	2.0%	638	2.0%	644	1.9%	0.3%
White Irish	570	1.9%	562	1.8%	550	1.7%	561	1.7%	523	1.6%	-8.2%
Black other	452	1.5%	447	1.4%	420	1.3%	426	1.3%	416	1.2%	-8.0%
Unclassified	310	1.0%	319	1.0%	273	0.9%	287	0.9%	340	1.0%	9.7%
Mixed White Black African	262	0.9%	276	0.9%	289	0.9%	306	0.9%	319	1.0%	21.8%
Bangladeshi	265	0.9%	280	0.9%	289	0.9%	297	0.9%	287	0.9%	8.3%
Chinese	194	0.6%	177	0.6%	178	0.6%	170	0.5%	185	0.6%	-4.6%
White Irish Traveller	96	0.3%	94	0.3%	91	0.3%	79	0.2%	78	0.2%	-18.8%
White Gypsy Roma	8	0.0%	8	0.0%	10	0.0%	8	0.0%	10	0.0%	25.0%
Grand Total	**30560**	**100%**	**31204**	**100%**	**31717**	**100%**	**32308**	**100%**	**33414**	**100%**	**9.3%**

2.2.3 Figure 10 below shows the increases within the 5 largest ethnic groups in Harrow schools from January 2010 to January 2014.

Figure 10: **Number of pupils in the 5 major ethnic groups in Harrow schools from 2010 to 2014**



	Asian other	Indian	White British	White other	Black African
January 2010	5,572	6,026	6,356	1,940	2,649
January 2011	6,091	6,097	5,952	2,224	2,669
January 2012	6,450	6,125	5,480	2,628	2,664
January 2013	6,737	6,221	5,188	3,037	2,620
January 2014	7,013	6,483	4,846	3,669	2,567

Ethnic group

2.3 Proficiency in English

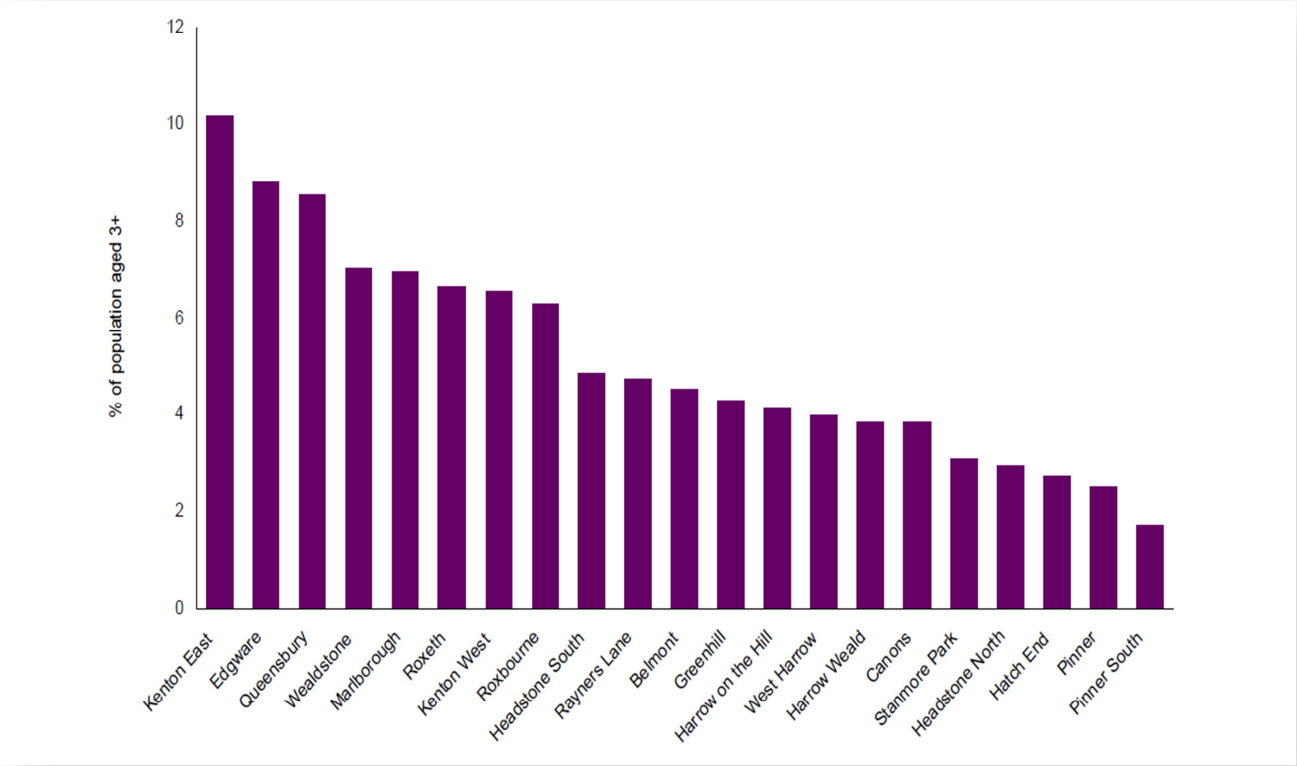
2.3.1 The school census data shows that in 2009-10 159 languages were spoken by pupils in Harrow schools and in 2013-14 there were 168. As at 2010 less than half the children at Harrow schools spoke English as a first language (47.1%) and as at January 2014 this percentage has dropped to 38.8%. English along with Gujarati, Tamil, Somali, Arabic and Urdu continue to be the main languages spoken by Harrow's pupils. In line with the changing ethnic groups Middle Eastern and Eastern European languages (particularly Romanian) are increasing significantly year on year. Over two-thirds (69.6%, 6,890) of Harrow's residents who do not speak English well are aged 16 to 64. 23.8% (2,353) are aged 65 and over, with the remaining 6.7% (659) being children.

2.3.2 There are three distinct areas in the borough where there are relatively high numbers of residents who either do not speak English or do not speak English well. These areas are: in the south-east, clustered around Kenton East, Queensbury and Edgware wards; in Marlborough and Wealdstone wards; and in a third cluster in South Harrow.

2.3.3 Kenton East has the highest percentage of residents who cannot speak English, followed by Marlborough, Queensbury, Edgware and Kenton West wards. Kenton East also has the highest percentage of residents who cannot speak English well.

The north-west of Harrow has the lowest numbers of people who either cannot speak English or do not speak English well. Very low numbers of residents in Pinner South cannot speak English.

Figure 11: **Residents who cannot speak English well**[21]



2.3.4 In line with the demographic changes in Harrow's population in recent years, the number of pupils whose first language is other than English has increased from 54.7% in 2010 to 62.7% in 2014. Harrow's averages are substantially above both the statistical neighbour and England averages.

Table 2: Percentage of pupils stating other than English as their first language in primary schools

Primary Schools	January 2010	January 2011	January 2012	January 2013	January 2014

[21] *2011 Census cited in Harrow Vitality profiles*

Harrow	**54.7%**	**55.7%**	**58.2%**	**59.4%**	**62.7%**
Statistical Neighbours	46.5%	47.9%	49.3%	50.1%	51.1%
England	16.0%	16.8%	17.5%	18.1%	18.7%

2.3.5 The table below shows that 56.9% of pupils in Harrow's high schools stated a language other than English as their first language in 2014. Harrow's average has increased over the last five years by nearly 10% from 47.7% in 2010.

Table 3: Percentage of pupils stating other than English as their first language in secondary schools

Secondary Schools	January 2010	January 2011	January 2012	January 2013	January 2014
Harrow	**47.7%**	**51.0%**	**53.2%**	**55.9%**	**56.9%**
Statistical Neighbours	38.1%	38.9%	39.9%	41.2%	42.1%
England	11.6%	12.3%	12.9%	13.6%	14.3%

2.4 Local economy

2.4.1 Harrow's economic activity rate shows a general upward trend and, at 76.9% (year ending June 2014), is very similar to London's rate. Harrow's overall employment rate was 70.4%, the second lowest rate in West London, and just below national and London rates.

2.4.2 In 2013/4 (July to June) the employment rate (66%) for those from minority ethnic groups in Harrow was lower than the rate for the overall population, but higher than the comparator rates for London, England and West London generally.

2.4.3 Wages in Harrow are generally lower than in West London and London, leading to a high proportion of residents commuting to other areas for better paid jobs. The average weekly wage paid to women working full-time in Harrow in 2014 was the third lowest level in London. At 2.3% (August 2014), the unemployment rate in Harrow was below the rates for West London, London and England. However,

unemployment in Wealdstone and Marlborough wards (at 4.1% and 3.9% respectively) was above the London average of 3.7%. The number of residents of working age on key out-of-work benefits has been falling since August 2009, but worklessness rates in 24 of Harrow's 137 LSOAs exceeded the London average of 9.6% in May 2014

2.4.4 The 2013 Business Register and Employment Survey shows that Harrow provides employment for over 69,000 people. This is the smallest employment base of all the West London boroughs. In terms of employment sectors, the most dominant sectors in Harrow are:

- Public administration, education & health (32%), Finance, IT, property and other business surveys (23%); and Wholesale/retail trade and vehicle repairs (16%)
- The local authority is the largest employer in Harrow, but over 57% of local government jobs in Harrow are part-time jobs
- A high proportion of Harrow's employed residents (26%) are engaged in 'Professional Occupations'. This compares to 22% in West London and 24% in London overall.
- In 2013/14 just over 20% of Harrow's workers (aged 16+) were self-employed, above the levels for West London, London and England Business and Enterprise
- Small businesses (0-4 people) in the borough represent nearly 80% of the total number of Harrow's businesses. Harrow has the highest proportion of small businesses compared to the other West London boroughs.
- There are relatively few very large businesses in the borough and the number employing 100 or more people is slowly declining. However, the number of medium-sized businesses, employing between 11-24 and 25-49 people, has been growing in recent years. Those businesses employing over 100 people provide a third of the total number of jobs in the borough.

2.5 Housing and temporary accomodation

2.5.1 As with the rest of London, private sector accommodation – both to rent and buy - is unaffordable to Harrow residents on average or lower incomes. For many households private sector rents are only affordable with Housing Benefit (HB)

support and for some (larger families and young singles) they will soon face a stark choice: either to move to smaller affordable housing locally (if available) and/or to cut household expenditure on other items, or to move outside London to a property that meets their actual needs.

2.5.2 Private rents are increasing as fewer people are able to move into home ownership. This is further squeezing the availability of homes at the lower end of the market – this is the market which the council uses to provide housing for those in housing need, because of the lack of availability of affordable housing. HB support is also reducing, further restricting availability at the lower end of the private rented market.

2.5.3 The majority of people in Harrow own their own homes (70%). Unlike the rest of London, Harrow has a very small social housing stock (10%). The number of social housing properties becoming available for letting each year is small and means that options of social housing are currently only available to those deemed to be most in need. These are households who are in the highest priority need e.g. for health or social reasons.

2.5.4 Over the last 10 years housing tenure has changed with owner occupation declining by 6% and private rental increasing by 6%. At an estimated 20% the private rented sector is now nearly twice the size of the social housing sector (10%). Most people who are unable to buy their own home are likely to have their housing needs met through renting privately. Social housing will continue to be an option for the minority of residents. Harrow has high average house prices meaning home ownership is also out of reach for those on average or lower incomes.

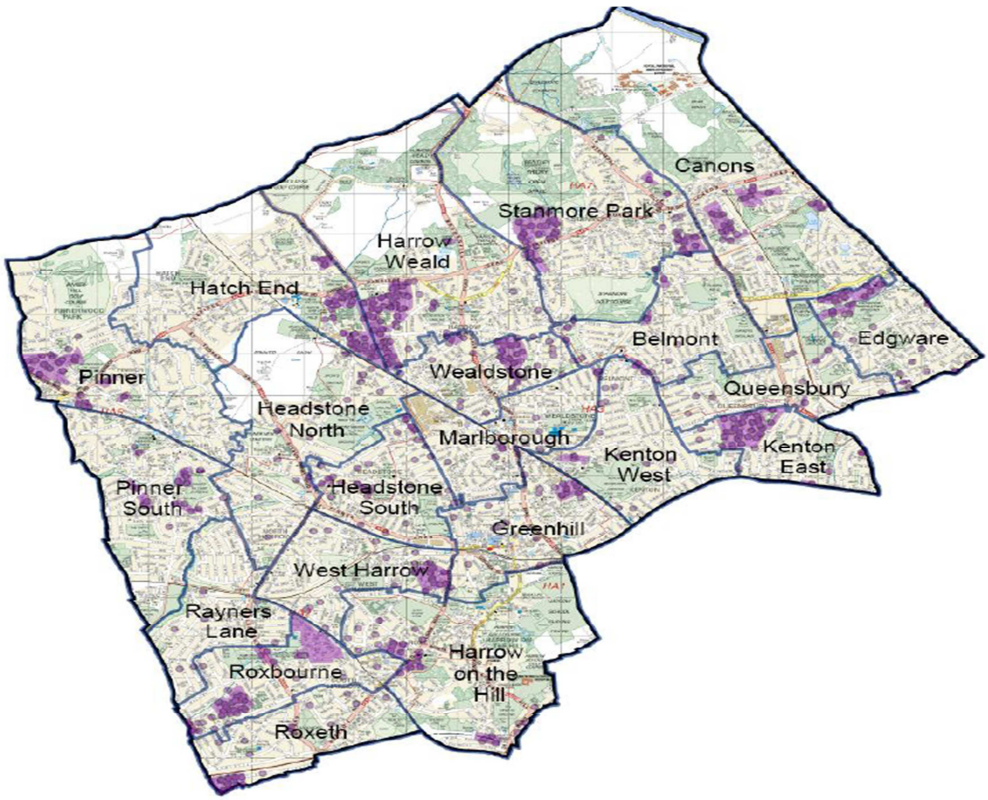
2.5.5 All of the above factors, plus welfare benefit changes since 2011 have led to an increase in homelessness applications and acceptances in Harrow, resulting in more families being placed in B&B at an average cost to the council of £10,000 per family per year. Whilst Harrow is a top performer in terms of managing and preventing homelessness (one of the lowest acceptances in London) there are no signs that the upward trend is going to reduce in the near future.

2.5.6 Supported housing meets the needs of vulnerable people, and this includes sheltered/extra care housing (as an alternative to residential care) and supported accommodation or housing support services to meet the needs of people e.g. with

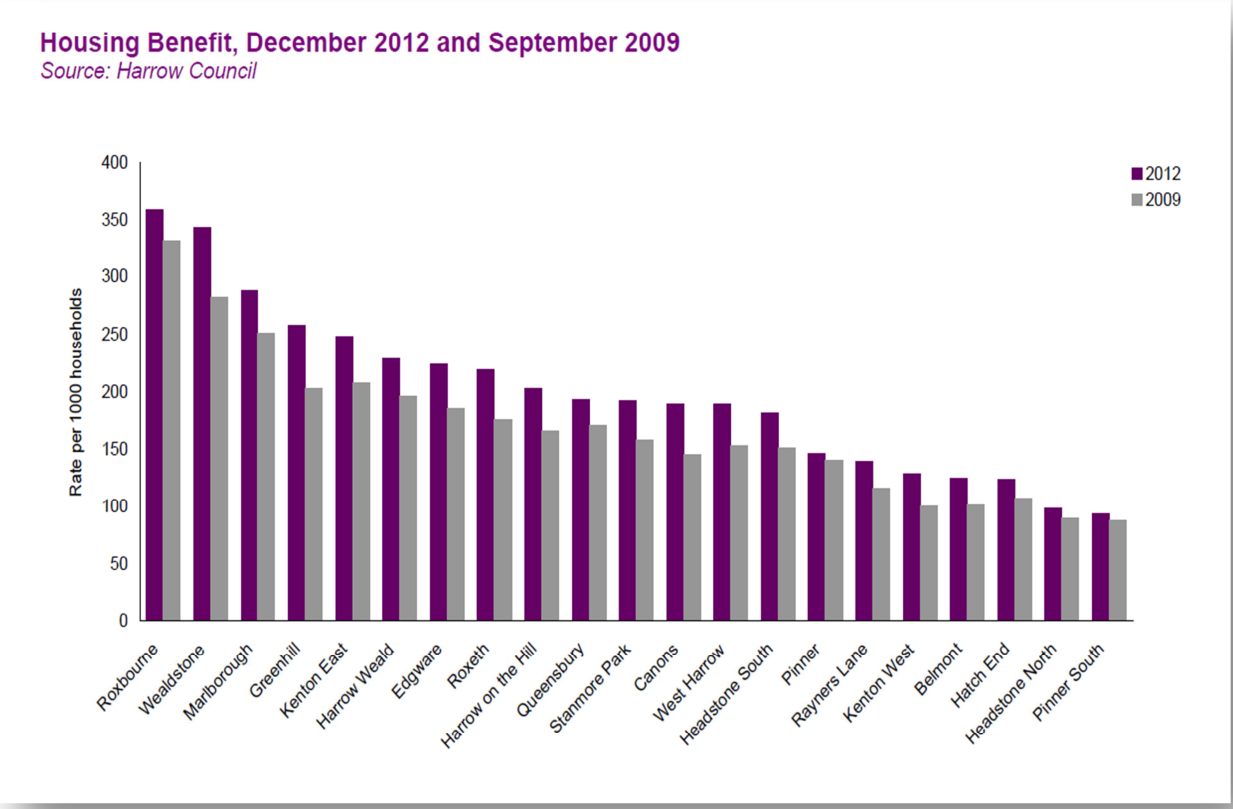
learning disabilities, mental health needs or experience of domestic abuse, offending or substance misuse. This will be predominantly in the social housing sector. Private housing providers are expected to provide new opportunities within this area in the future as an alternative way of meeting demand, however this is counter balanced by a policy drive for new affordable housing products to be predominantly home ownership.

2.5.7 Harrow has some pockets of multiple deprivation which closely correlate to social housing estates. The council has done much to tackle this through specific regeneration schemes such as at Rayners Lane and Mill Farm, and are currently embarking on the regeneration of the Grange Farm estate. Outside of these, Harrow's social housing estates contain no tower blocks, are generally small, mixed tenure and well integrated with the wider community, and therefore do not suffer to the same extent with physical and social deprivation as seen in other London boroughs. Current allocation policies have the potential to undermine this position as generally only those who are dependent on benefits and have particular needs are housed.

Figure 12: **Harrow Council Housing Stock Concentrations by Ward, 2011**



- 16,994 households received Housing Benefit in December 2012, a rate of 201.7 per 1,000 households
- 19.7% (+2,795) more households were claiming Housing Benefit compared to September 2009
- Over 1,600 households in Roxbourne claimed Housing Benefit - the highest number per ward, with 36% of households claiming housing benefit
- Pinner South had the lowest rate of Housing Benefit claimants at 94.2 per 1,000 households, just over a quarter of the rate of Roxbourne
- Households receiving Housing Benefit are mainly concentrated in the east, centre, and south-west of the borough. Smaller concentrations are also found in the west and north-east of the borough.

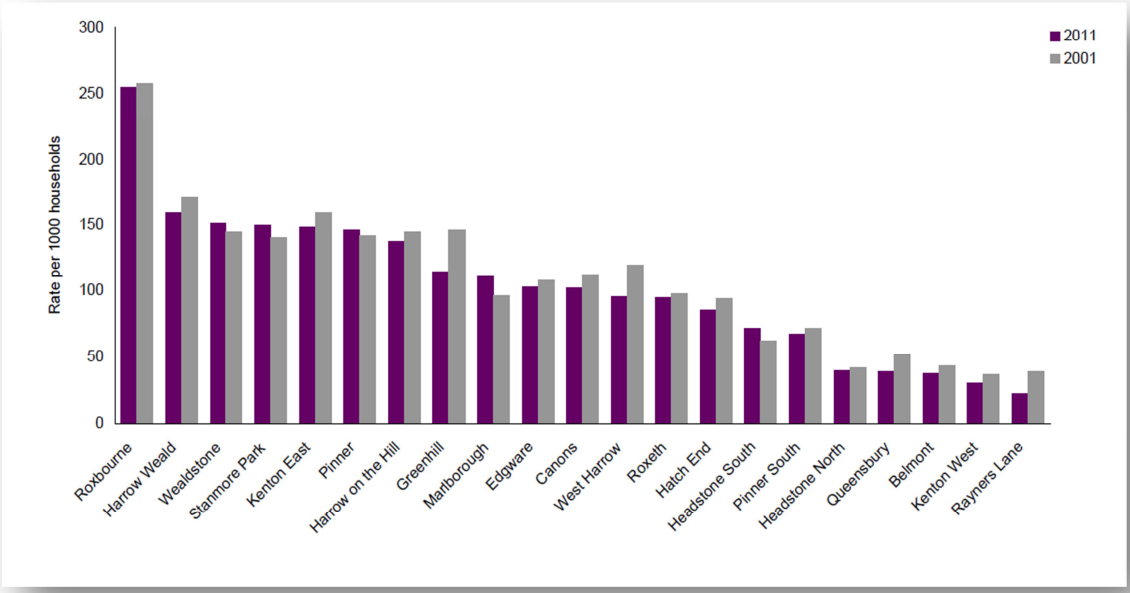


2.5.8 Marlborough has seen the highest increase in social rented households since 2001, an increase of 128 properties (29.7 per 1,000 households). Roxbourne (which contains the Rayners Lane Estate) has the highest rate of social rented properties at

254.4 per 1,000 households, a total of 1,148 households. The LSOA with the highest rate of social rented properties is in Roxbourne, with 684.8 per 1,000 households.

- 10.6% of Harrow's households live in social rented housing
- Areas of high concentration reveal where some of the larger council or housing association estates are located
- Harrow is ranked 281st out of 326 national districts, where 1st has the highest percentage of social rented stock
- Harrow has the lowest proportion of social housing of any of the London boroughs

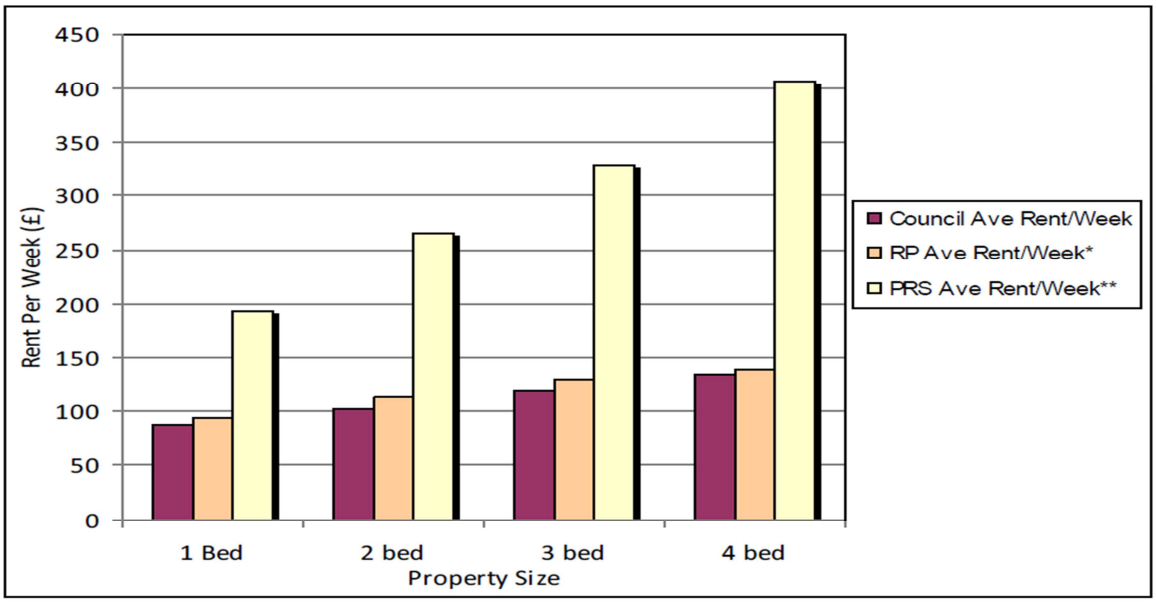
Figure 13: **Social rented housing**[22]



2.5.9 Rents in the social housing sector are less than half of those in the private rented sector (PRS) for all property sizes. This is because social housing is subsidised and rent levels are subject to a national formula.

[22] Source, Census, 2011, Harrow Vitality profiles

Figure 14: **Average rents for social housing and private rented**



2.5.10 London as a whole has approximately 50,000 families in temporary accommodation all competing for the same temporary accommodation. There are approximately 1000 people in and awaiting Temporary accommodation in Harrow as of 2015 despite prevention efforts through the housing team. The highest concentrations of residents in temporary accommodation are in locations with hostels, which are traditionally used to house those in need. Wealdstone ward has the highest rate followed by Marlborough and Belmont. The lowest rates are in Canons, Headstone North, Pinner South and Stanmore Park. There has been a significant rise in the number of people needing temporary accommodation; key stats for 2015 show:

- Unprecedented B&B figures – typical Bailiffs day will yield 20 families needing emergency accom, and only a few Harrow rooms will be available to meet need
- 90 families with children in breach of 6 week limit at end Nov 15 – Harrow's figure is 15% of the London total over 6 weeks
- 805 in TA including 250 in B&B plus 125 pending accommodation in PSLs and HALS. With an estimated further 70 families we are working with who are threatened with homelessness and likely to be homeless soon. So a total of 1000.
- Of the 1,100 children in temporary accommodation who are in households in receipt of HB, 500 of these children are in households which are not in work.600 of these children are in households which are in work.

Figure 15: **Temporary accommodation numbers over time, Dec 2012, May 2009 and Sept 2005**[23]

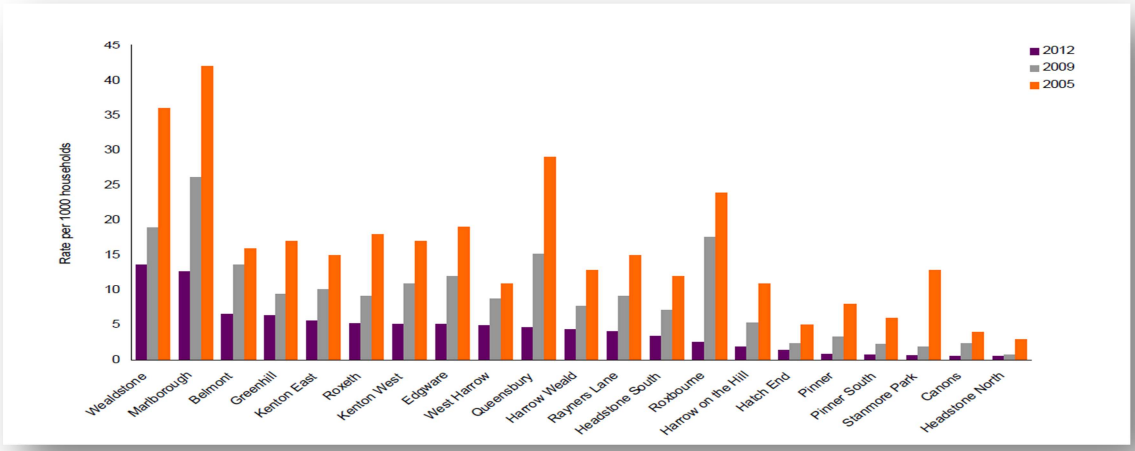
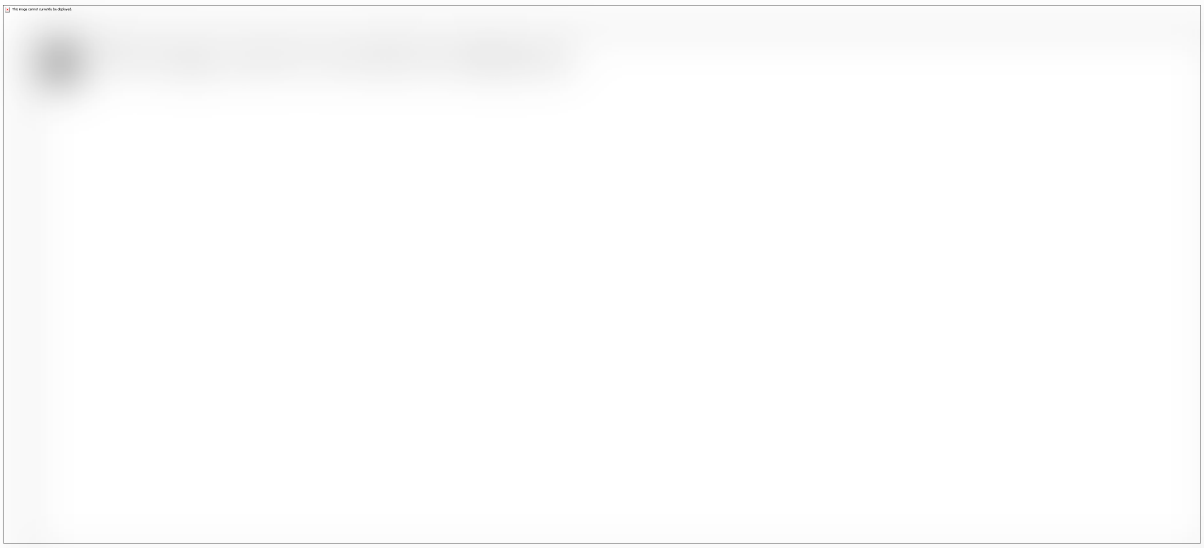
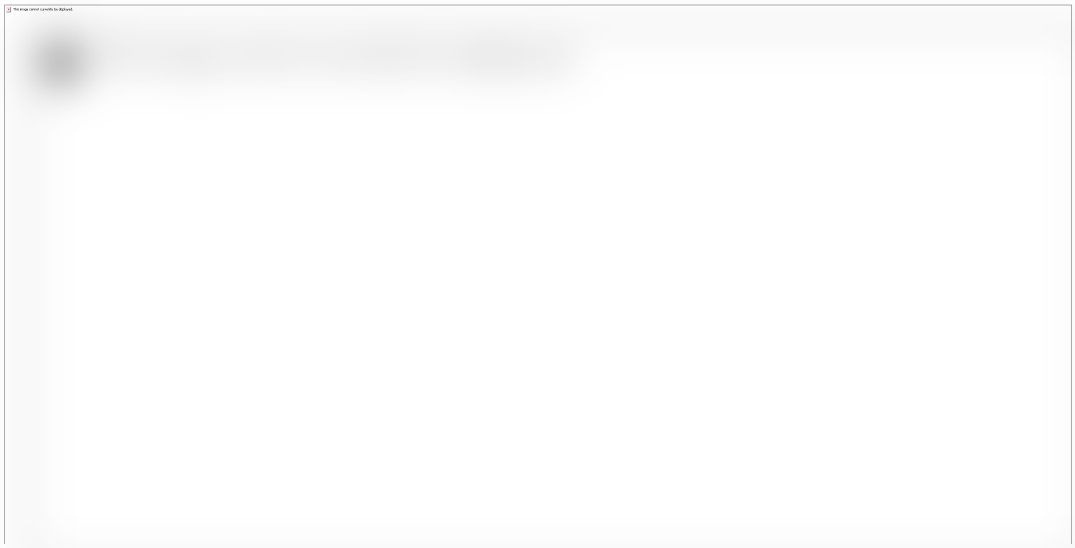


Figure 16: **Number of households in temporary accommodation, 2015**



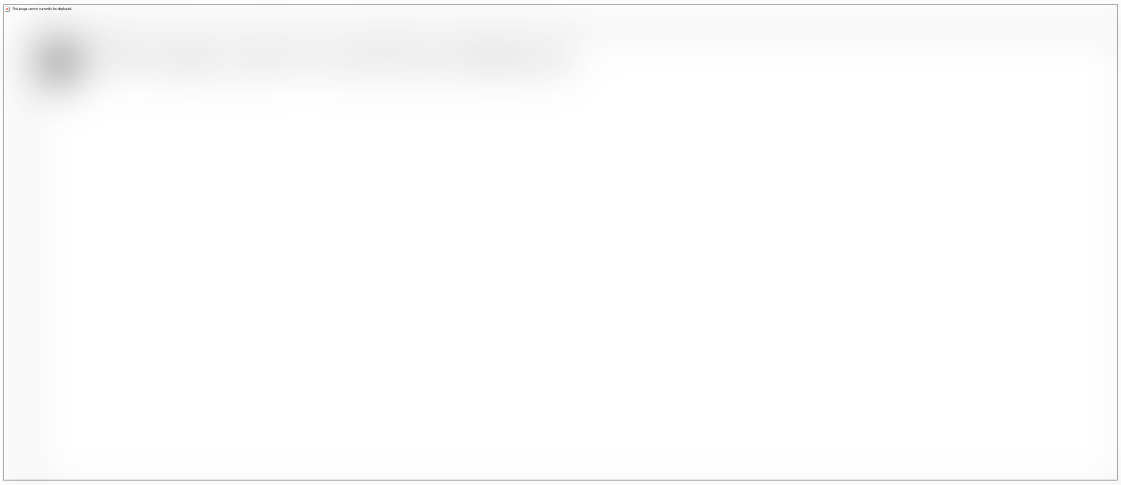
[23] *Source Harrow Council Housing team*

Figure 17: **Number of households in Bed & Breakfast accommodation**



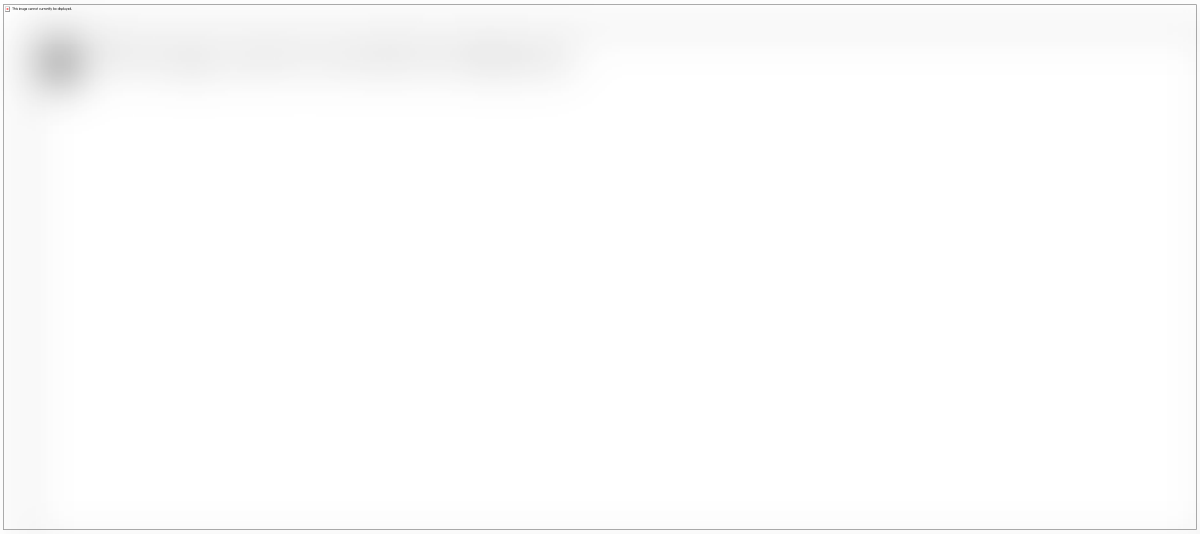
2.5.12 As of September 2015, 219 families were in B&B, numbers have nearly doubled since September 2013 (107).

Figure 18: **Number of households accepted as eligible, unintentionally homeless and in priority need**



2.5.13 400 cases accepted as eligible and unintentionally homeless in 2014/15, more than double since 2013/14 (180) and a huge increase since 2010/11 (45). Loss of private rented accommodation now accounts for nearly ¾ of acceptances, up from under 40% in 2009/10.

Figure 19: **Reasons for homelessness acceptance**



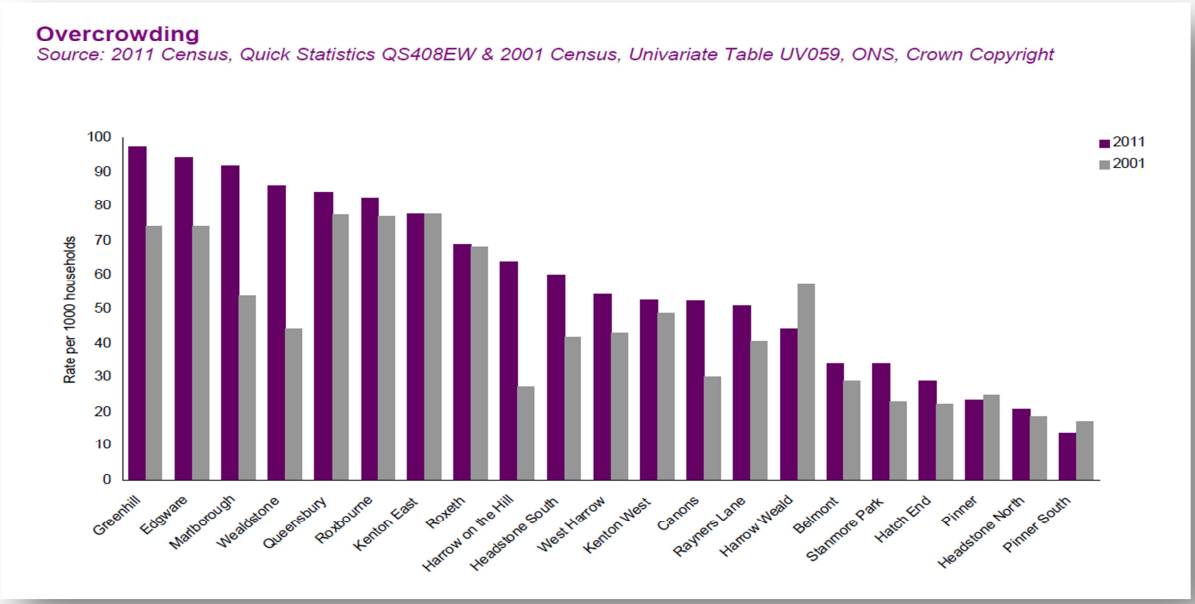
2.5.14 There is a huge focus on **homelessness prevention** through mediation/conciliation, debt and Housing Benefit advice, rent & mortgage intervention, emergency support, negotiation/legal advocacy and sanctuary protection measures as well as other private rented sector assistance. Whilst the Housing Needs Service? record statistics on this work (below), much more is offered in the form of advice via leaflets, telephone calls and emails, which are not necessarily recorded.

Figure 20: **Table showing statistics for homelessness prevention in Harrow in the last six years**

Homeless Prevention	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Households able to remain in existing home	367	719	861	936	823	802
Households assisted to find alternative accommodation	454	400	329	518	494	602

2.5.11 The wards with the highest rates of overcrowding are Greenhill, Edgware and Marlborough. The most overcrowded LSOA is in Queensbury with a rate of 148.9 per 1,000, this is followed by a LSOA in Harrow on the Hill.

Figure 21: **Overcrowding in Harrow by ward**



- In Harrow 5.8% of all households are overcrowded; a total of 4,923 17 of 21 wards experienced an increase in overcrowding since 2001
- There is a concentration of over overcrowded households in the central wards as well as to the south-east and south-west of the borough
- Harrow is nationally ranked 24th for overcrowding, where 1st is the most overcrowded

2.6 Parental education and skills

2.6.1 This sub-domain of the Education, Skills & Training index includes: the proportion of working-age adults (women aged 25 to 59 and men aged 25 to 64) with no or low qualifications; and an English language proficiency indicator, which is the proportion of the working-age population (women aged 25 to 59 and men aged 25 to 64) who cannot speak English or cannot speak English 'well'. The latter is a new indicator to include those adults who experience barriers to learning and disadvantage in the labour market as a result of lack of proficiency in English. These are non-overlapping counts in order to eliminate double counting of people within domains.

2.6.2 At ward level Kenton East scores highest for this measure. This is perhaps to be expected as the 2011 Census showed that Kenton East ward has the highest

percentage of residents who cannot speak English, at 1.8 per cent (193 residents). According to the 2011 Census question on main language spoken at home, Gujarati speakers predominate in the wards to the east of Harrow. Around 20 per cent of residents in Kenton West, Kenton East and Queensbury wards speak largely Gujarati. Similarly the 2011 showed that Harrow's Romanian speakers are also largely concentrated in the wards to the east of the borough.

2.6.3 The wards to the west of the borough have much higher levels of adult skills, with Pinner South and Headstone North the best ranked wards for this measure, Greenhill ward just following.

2.6.4 Harrow's worst ranked LSOA for adult skills is in England's most deprived 20 per cent and is in Harrow Weald ward - the area covering part of the Headstone Estate. Three of Harrow's top ten ranked LSOAs for low levels of adult skills are in Roxbourne ward.

- Adults skills levels are worse in the centre, south-east and south-west of the borough
- Kenton East is Harrow's top ranked ward for this measure
- Only one of Harrow's LSOAs is in England's most deprived 20 per cent for this indicator, whilst 35 per cent are in England's least deprived 20 per cent

Figure 22: **Harrow's top ten ranked LSOAs in the Adult Skills Sub-Domain**[24]

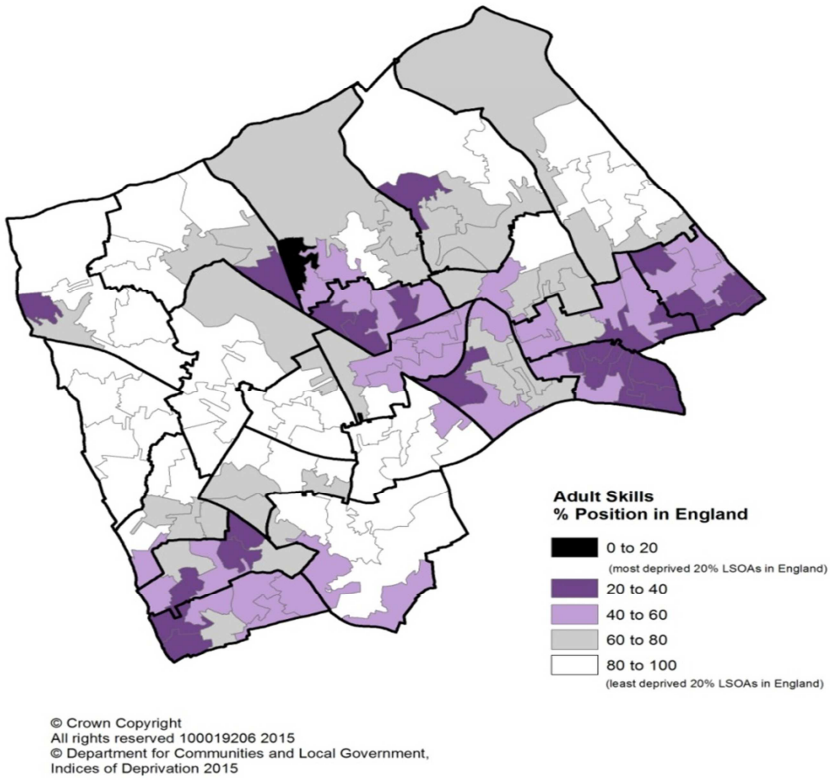


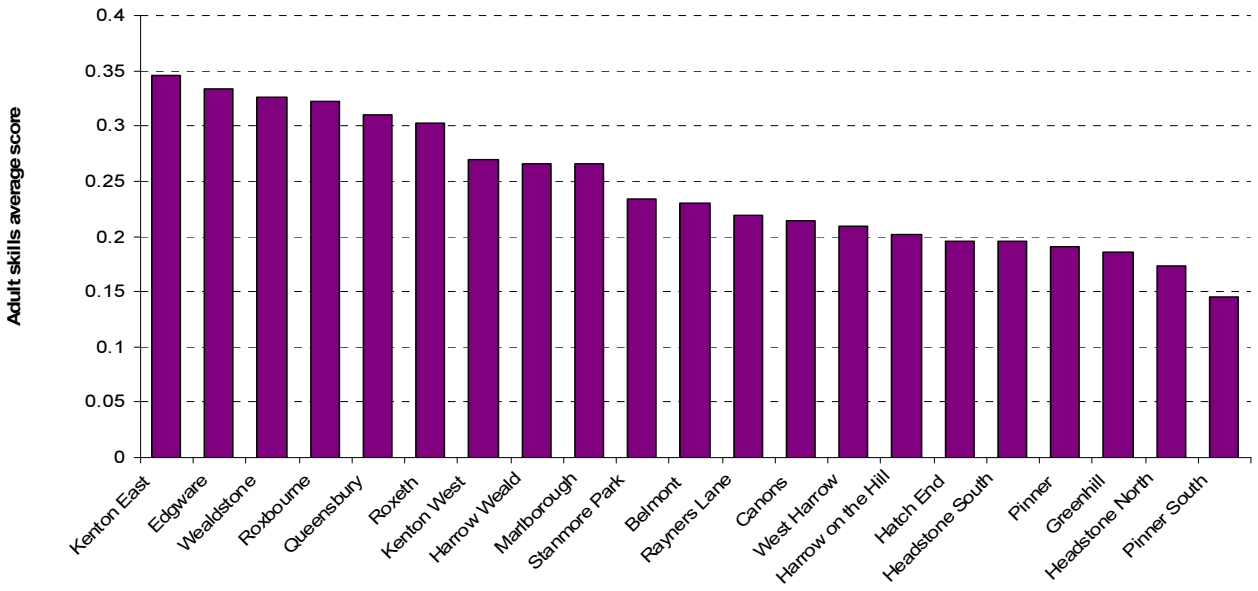
Figure 23: **CLG, Indices of Deprivation 2015, Crown Copyright**

LSOA code	Ward	National rank	National Decile
139	Harrow Weald	5626	20%
167	Kenton East	6652	30%
215	Roxbourne	6850	30%
124	Edgware	7200	30%
235	Wealdstone	7248	30%
217	Roxbourne	8172	30%
211	Roxbourne	8702	30%
168	Kenton East	9101	30%
151	Hatch End	9876	40%
120	Edgware	10168	40%

** All neighbourhoods (LSOAs) in England are ranked between 1 and 32,844, with '1' the most deprived nationally*

[24] CLG indices of deprivation. 2015

Figure 24: **Adult skills in Harrow by ward, higher scores equates to lower skill levels**



2.7 Unemployment

2.7.1 The Government pays money to individuals in order to support them financially under various circumstances. Most of these benefits are administered by DWP. The exceptions are Housing Benefit and Council Tax Reduction, which are administered by local authorities. Means tested benefits include:

- Jobseekers allowance
- Income support
- Employment and Support Allowance
- Pension Credit
- Housing Benefit
- Child and working tax credits

Figure 25: **Economic Activity and Inactivity in Harrow, July 2013 - June 2014**

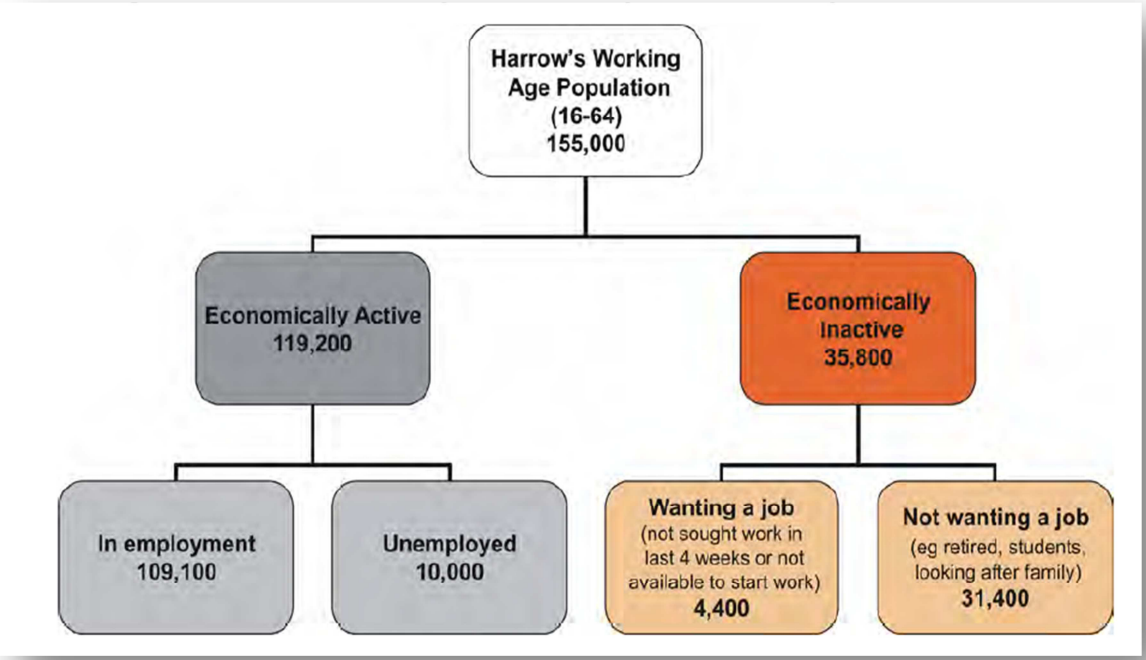
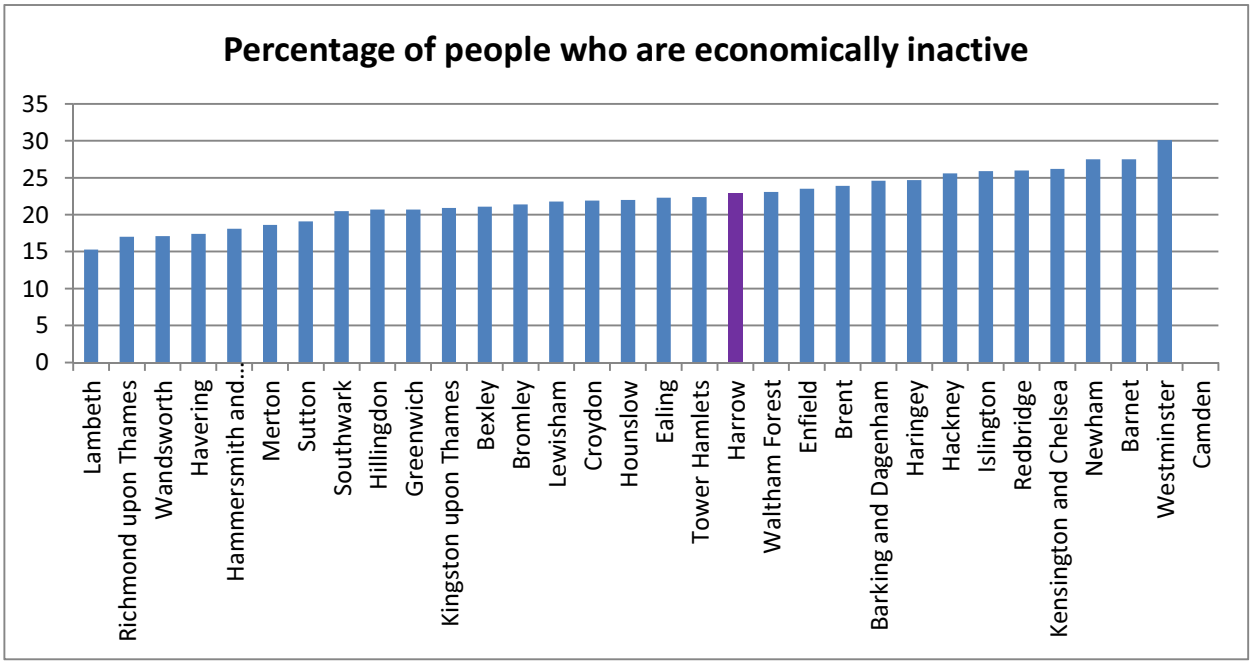


Figure 26: **Percentage of people who are economically inactive in Harrow compared with London boroughs**[25]



2.7.2 In August 2014 there were 2,490 people in Harrow claiming Jobseeker's Allowance, a rate of 2.3%, based on the percentage of the economically active population,

[25] Source, office for national statistics

excluding economically active students. This was the lowest level of unemployment of all the West London boroughs (a rate which averaged 3.3%) and lower than London's rate of 3.7% and the national rate of 3.2%. Trends are watched closely as unemployment levels in the borough can be affected by the wider economic landscape.

Figure 1: **Graph showing JSA claims in Harrow from 2007 to 2015**

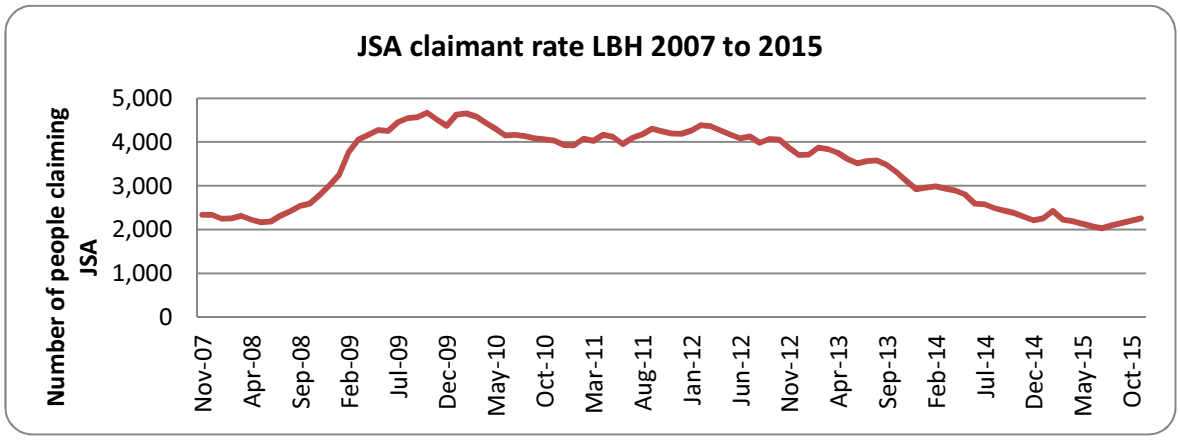


Figure 2: **Graph showing JSA claims for 19-24 year olds**

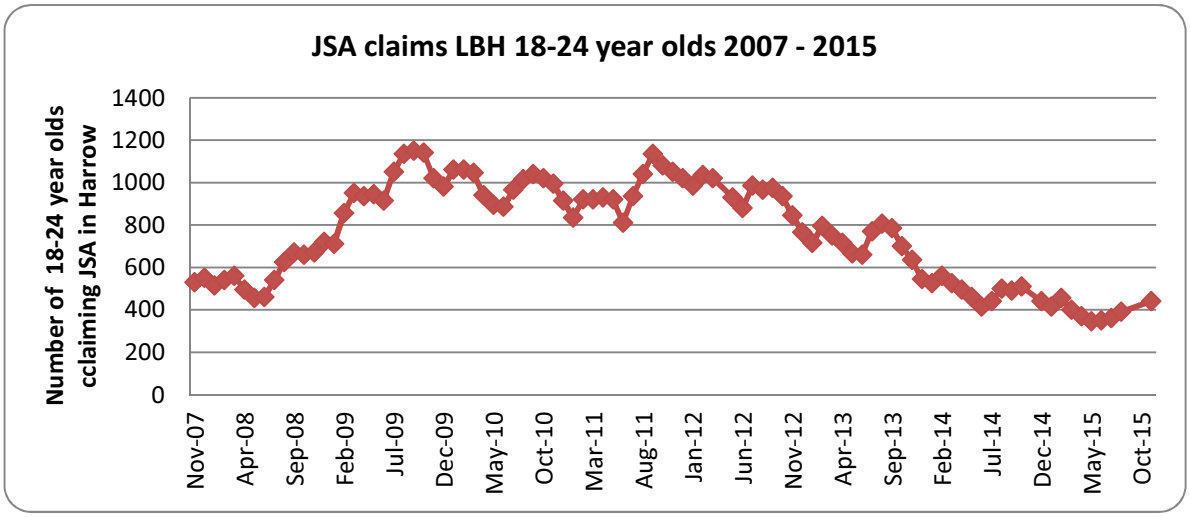
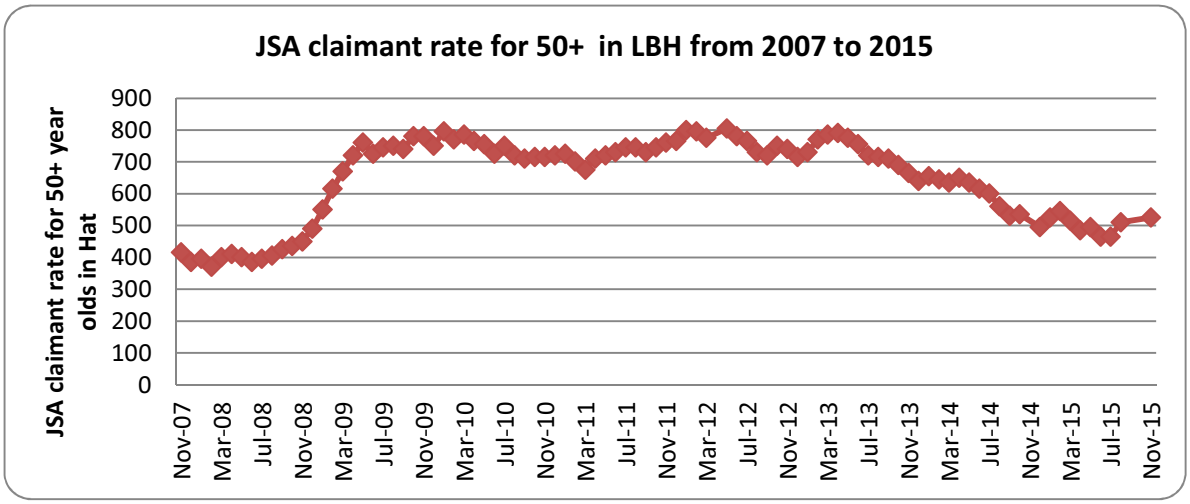


Figure 3: **Graph showing JSA claimant rate for 50+**



Harrow emergency relief scheme

2.7.3 The council currently administers the emergency relief scheme for those facing hardship. Those eligible are able to access white goods, food, fuel, clothes, emergency travel. Many referrals are made through the voluntary sector and from internal council departments. From April 2016 to 30th September 2016, 261 applications were made of which about 39% had children in the home. The council are currently consulting on the changes in light of the significant reduction in the budget and are proposing how the new hardship fund will work. Proposals state furniture, white goods and carpets may no longer be awarded under this scheme which may have an impact on some of the families who are experiencing financial challenges. The new hardship scheme can be accessed via application where staff will review the applicant against primary criteria but would not be able to exceed £100. To improve the applicants long term outlook advice, support and referrals to other agencies would be made.

2.7.4 Universal Credit is rolling out across the country. Universal Credit ensures that claimants are better off in work than they are on benefits. It is available to people who are on a low income or out of work. It is replacing 6 former benefits with a single monthly payment. Harrow will roll out UC from November 2016.

2.7.5 There here is currently a benefit cap in place in England, Scotland and Wales restricting the amount in certain benefits that a working age household can receive.

Any household receiving more than the cap has their Housing Benefit reduced to bring them back within the limit. From 7th November 2016 the cap which is currently up to £26,000 per year is to be reduced to £23,000 for households living in London and to £20,000 for those outside London. The current Benefit Cap is:

- £500 a week for couples (with or without children living with them)
- £500 a week for single parents whose children live with them
- £350 a week for single adults who don't have children, or whose children don't live with them

From November 2016 it will be:

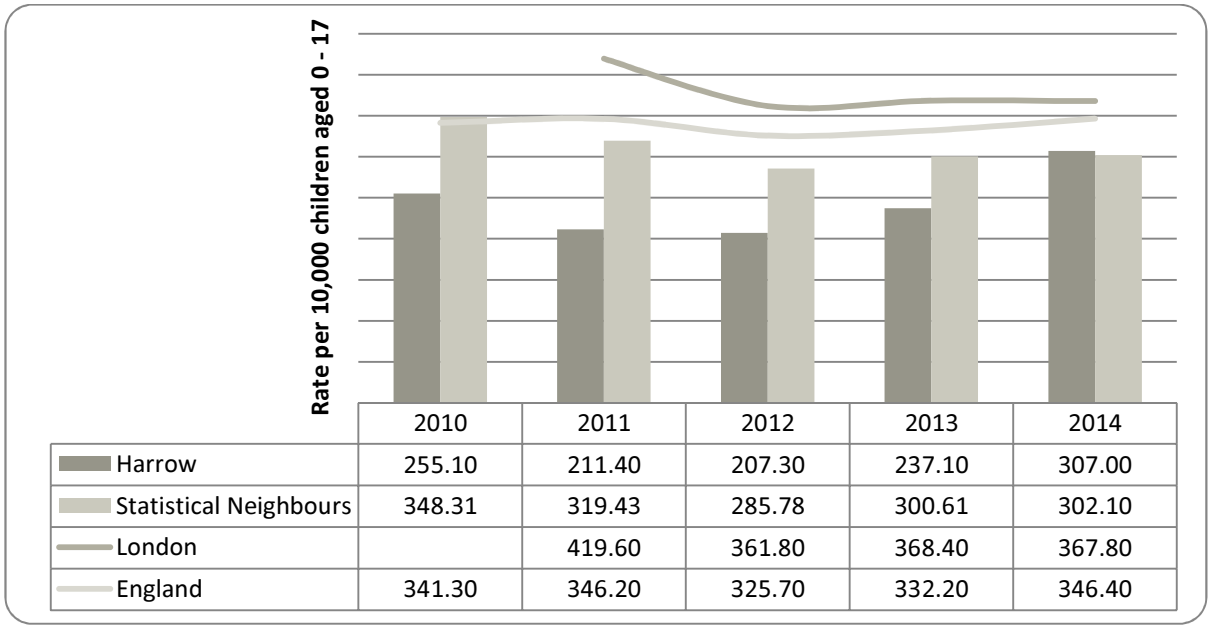
- £442.31 a week for couples (with or without children living with them)
- £442.31 a week for single parents whose children live with them
- £296.35 a week for single adults who do not have children, or whose children do not live with them

2.8 Children in Need[26]

2.8.1 As seen in the chart below, Harrow now has a similar proportion (rate per 10,000 children aged 0 -17) of children 'in need' (CiN) compared to our statistical neighbours[27]; Harrow's CiN rate has increased recently following a revision of thresholds for eligibility of social care services, moreover the demography is also changing, the 2011 National Census revealed that Harrow's population is estimated to have increased to 239,100; this figure is 15.6% higher than the 2001 Census, the recently published ONS (Office for National Statistics) 2013 mid-year estimates show a further increase to 243,372. With the increase in population, the child population is also growing & there is an additional demand on universal and specialist services.

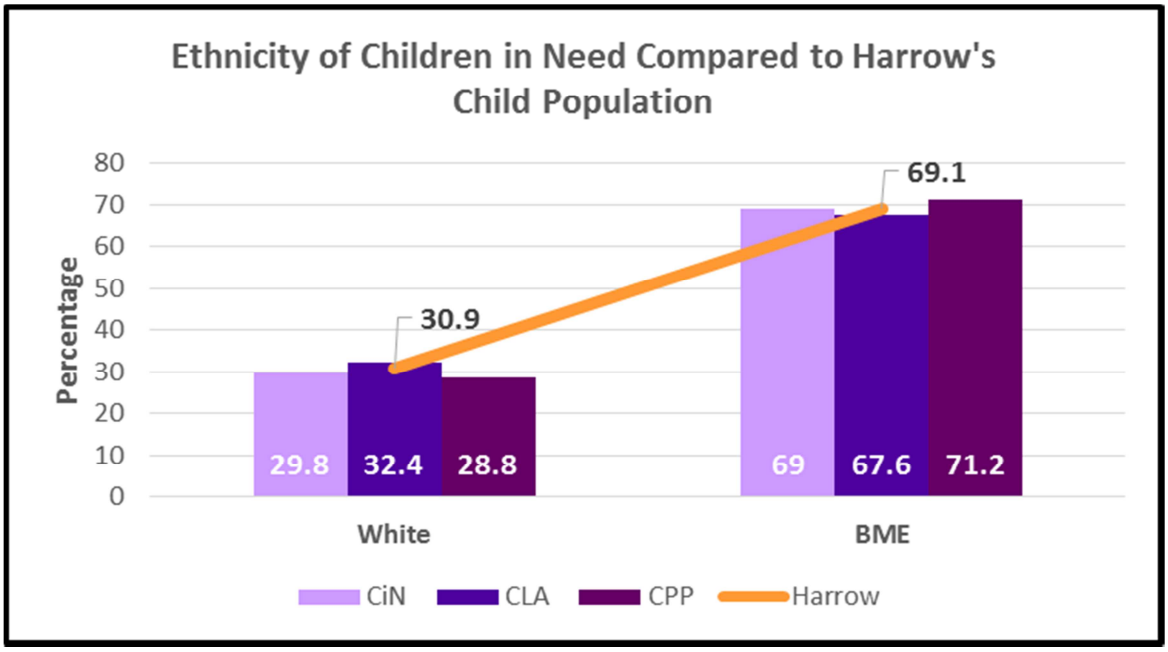
[26] *Source: DfE Characteristics of children in need in England*
[3] In line with the DfE, this indicator is derived from 2010 deprivation data and 2008 population data
[4] Harrow's statistical neighbours are: Barnet, Brent, Ealing, Hillingdon, Hounslow, Kingston, Merton, Redbridge, Surrey, Sutton

Figure 4: **Children in need rate per 10,000 aged 0-17**



	2010	2011	2012	2013	2014
Harrow	255.10	211.40	207.30	237.10	307.00
Statistical Neighbours	348.31	319.43	285.78	300.61	302.10
London		419.60	361.80	368.40	367.80
England	341.30	346.20	325.70	332.20	346.40

Figure 5: **Ethnicity of children in need compared to Harrows Child population**[28]



2.8.2 Key stats for children social care

- 2,241 children and young people were provided with care services in Harrow (34.3 per 1,000 population aged 21 and under), in the twelve month period from 1st April 2012 to 31st March 2013

[28] *Source: ONS 2011 Census, DfE Children looked after in England & DfE Characteristics of children in need in England*

- 88.8% of support for children and young people is provided within the borough
- The rate of children and young people provided with social care services in Harrow continues to be below both the national and London averages
- Children and young people provided with services are concentrated in the centre of the borough and in the south of the borough.

2.8.3 In line with the rest of the country, the proportion of males receiving a social care service is higher than the proportion of females.

Table 4: Percentage of children in need at 31 March 2014 by gender[29]

	Unborn or unknown	Male	Female
Harrow	**1.5**	**54.8**	**43.7**
London	1.7	53.3	45.0
England	2.0	52.7	45.3
Statistical neighbours average	1.8	53.0	45.2

2.8.4 Nearly 50% of children in need in Harrow are aged 10 -17 and a further 25% are aged 5 to 9. In general in Harrow, the age group splits for these children are broadly in line with the rest of the country, and particularly with Harrow's statistical neighbours.

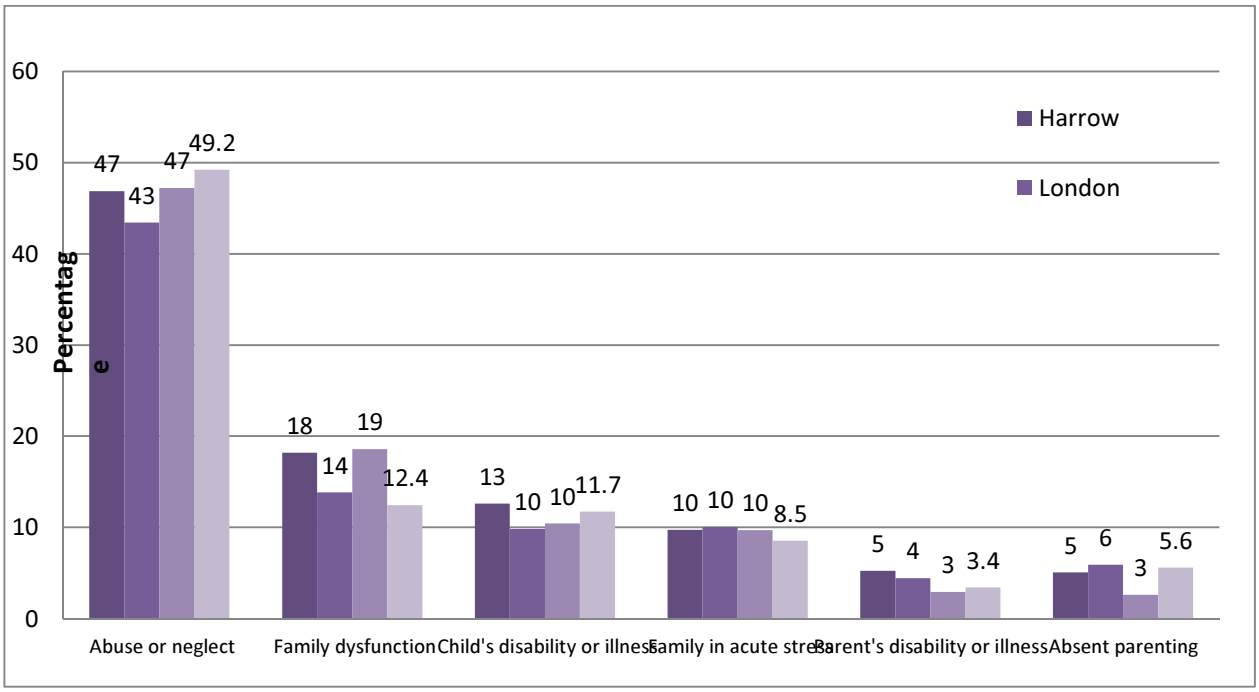
2.8.5 The main reasons why children received a service from social care helps identify what kinds of pressures are placed on the services. The top five most frequent reasons why children required a service are shown below, abuse or neglect and family dysfunction constitute the two most frequent reasons for providing a service; other reasons are socially unacceptable behaviour or low income. In most

[29] *Source: DfE Characteristics of children in need in England*

circumstances there are multiple reasons, e.g. family dysfunction may also be a feature with the category of abuse and neglect.

2.8.6 Though there are some variations, Harrow is in line with either statistical neighbours or England averages for most categories, service provision is slightly higher in Harrow where the primary reason for a request for service is due to child's disabilities or illness or parental disabilities compared to Statistical neighbours and England averages. Harrow has slightly lesser proportion of service users where the primary reason is socially unacceptable behavior, nationally and locally a very small proportion of families receive a service mainly due to low income though this may change with more families having no recourse to public funds.

Figure 6: **Primary reason for service**[30]



2.8.7 The Multi-Agency Safeguarding Hub (MASH) sits within the Children's Access Team and aims to improve the safeguarding response for children through better information sharing and high-quality and timely safeguarding responses. This innovative way of working emphasises the importance of collaboration and co-location of partners (Social care, Early Intervention, Health, Police, Probation,

[30] Source: DfE Characteristics of children in need in England

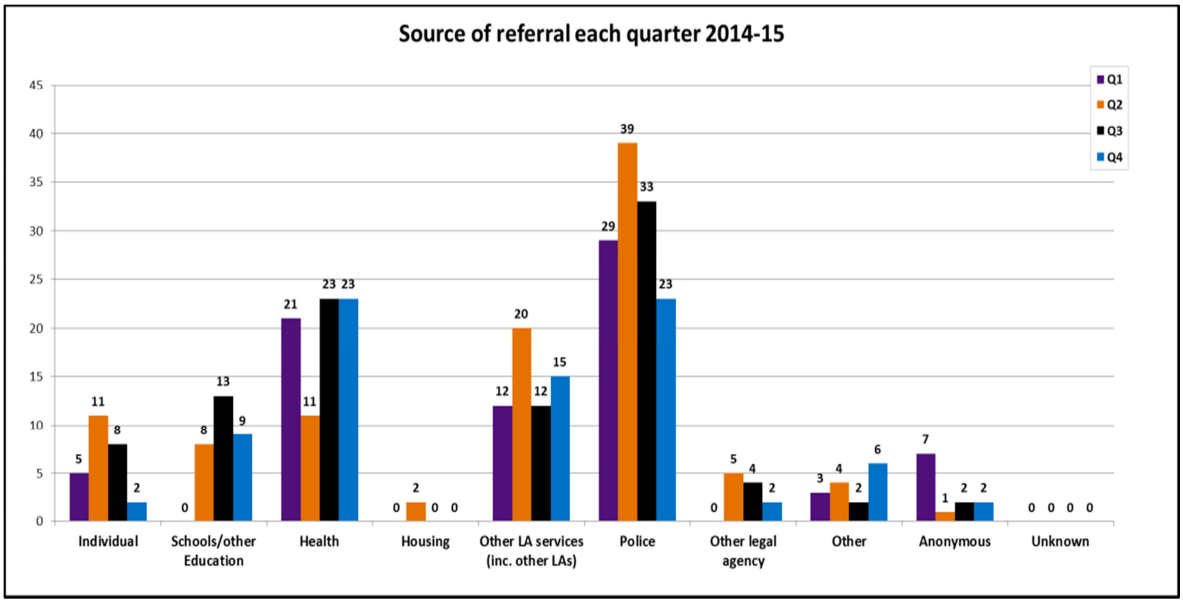
Education), sharing information on cases causing concern in order to risk assess and make decisions with a strong information base.

Table 5: No of cases that were processed by the MASH Team during 2014-15

	April - June	July to Sept	Oct. - Dec	Jan - March
No of clients	86	101	97	82

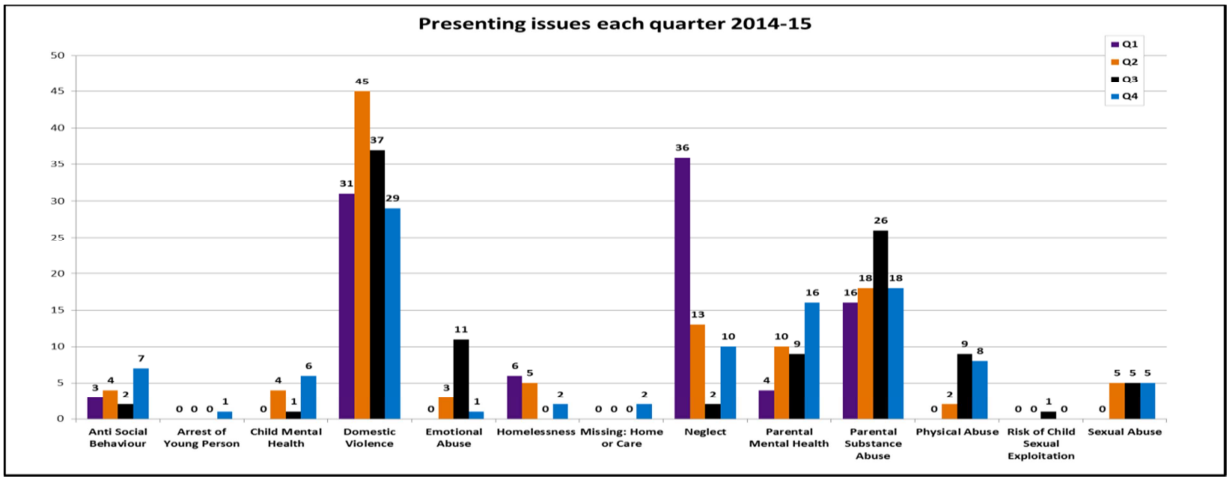
2.8.8 The most frequent sources of referral to the MASH are the police, accounting for nearly 34% of referrals over the year, followed by Health, accounting for just over 21%; however, the proportion from the police has been decreasing since quarter two. The third most frequent source is other local authority services (including other local authorities), accounting for 16% of all referrals.

Figure 7: **Source of referrals to MASH**[31]



2.8.9 The most commonly found presenting needs over the year were domestic violence, accounting for just over 34% of all needs identified, followed by parental substance abuse, accounting for nearly 19% of needs identified. The third most frequent need was neglect at nearly 15%.

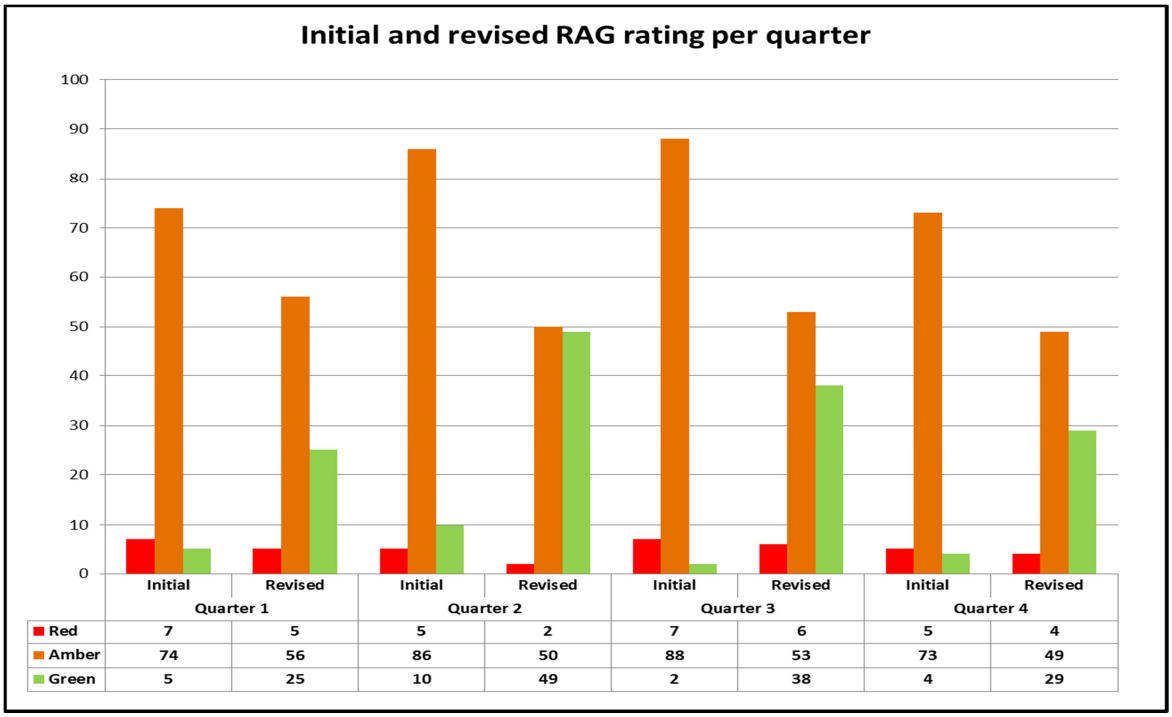
Figure 8: **presenting issues quarter 2014-15**[32]



2.8.10 All the referrals to the MASH are rated as red, amber or green on referral and then again on assessment, once all relevant information has been gathered, in order to assess the level of risk to the child. The chart below shows that the number rated as red (i.e. high risk) is low over each quarter at both referral and assessment; the number rated as amber (medium risk) is high at referral but lower at assessment, suggesting that after information gathering the risk for a significant number of children is lowered to green (i.e. found to be low risk).

[32] *Source: : Harrow local data (Frameworki)*

Figure 9: **Referrals to MASH by RAG rating**[33]



2.8.11 Harrow carried out 2178 assessments during 2013-14 compared to a total of 1,399 in the previous year; comparator data is not fully available as local authorities moved to continuous assessments at different times of the year.

2.8.11 If a referral leads to a further assessment of the child and their circumstances then additional factors are identified during the assessment, the two most frequent factors identified during the assessment process are domestic violence (which could include the child as a subject) and abuse or neglect. There is always an element of emotional abuse implicit in domestic violence that is not always recorded separately.

Table 6: Factors identified at the end of assessment[34]

Factors identified at the end of assessment	No.	%
Domestic violence	871	27.7
abuse or neglect	609	19.4
Other	573	18.2
Substance misuse: parent/carer/another person	280	8.9
Mental health: parent/carer/another person	274	8.7
Socially unacceptable behaviour	95	3.0

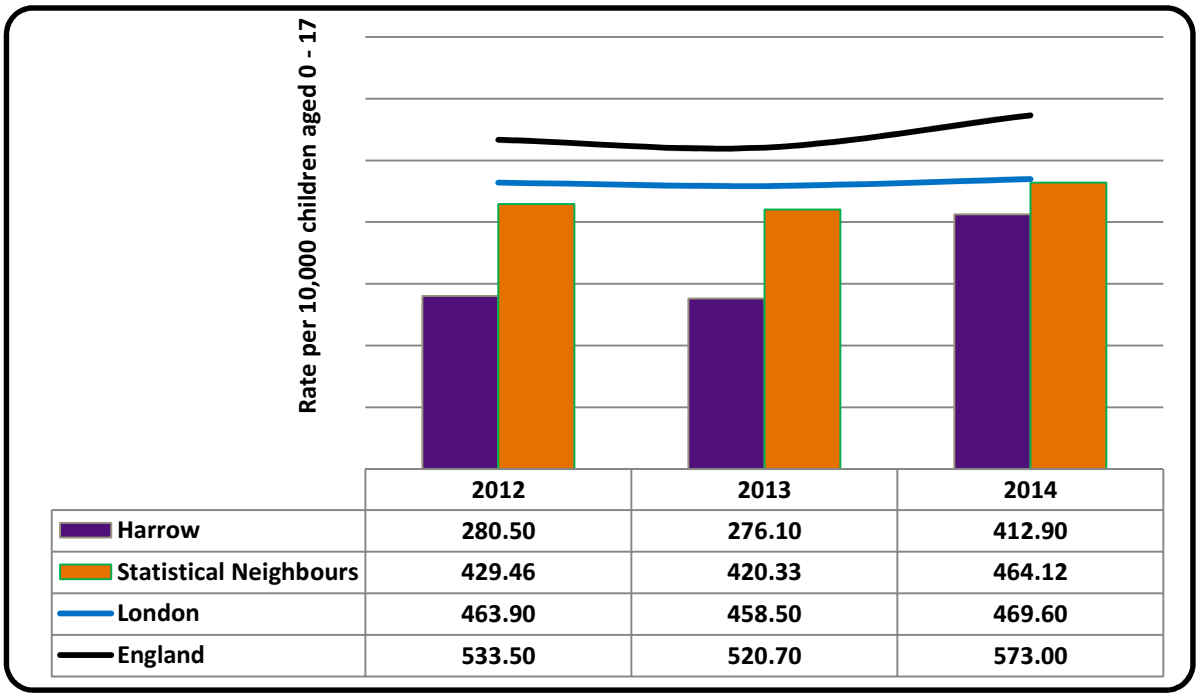
[33] *Source: Harrow local data (Frameworki)*
[34] *Source: Harrow local data (Frameworki) NB: more than one factor can be identified during assessment.*

Learning disability: child	60	1.9
Mental health: child	57	1.8
Physical disability: child	55	1.7
Self-harm	55	1.7
No factors identified	44	1.4
Physical disability: parent/carer/another person	41	1.3
Substance misuse: child	35	1.1
Missing	28	0.9
Child sexual exploitation	29	0.9
Young carer	14	0.4
Learning disability: parent/carer/another person	11	0.3
Trafficking	7	0.2
Gangs	7	0.2
UASC	2	0.1
Total number of completed assessments	**2178**	

2.9 Referrals to social services

2.9.1 The number and rate of referrals per 10,000 children in Harrow had historically been low compared to national averages, but 2013 -14 saw a rise due to revised thresholds & the changing demography. There were 2,305 referrals made to children's social care services during 2013-14 compared to 1,529 in the previous year. Nationally there has been a rise in referrals by approximately 11%.

Figure 10: **Rates of referrals to children's social services**



	2012	2013	2014
Harrow	280.50	276.10	412.90
Statistical Neighbours	429.46	420.33	464.12
London	463.90	458.50	469.60
England	533.50	520.70	573.00

2.9.2 Possible abuse or neglect is the most frequent reason for referral to social care services (31%), followed by domestic violence and family dysfunction. The presenting issues categories are designed to identify what kinds of pressures are placed on social services to support service planning. Roxbourne has the highest concentration of referrals followed by Wealdstone.

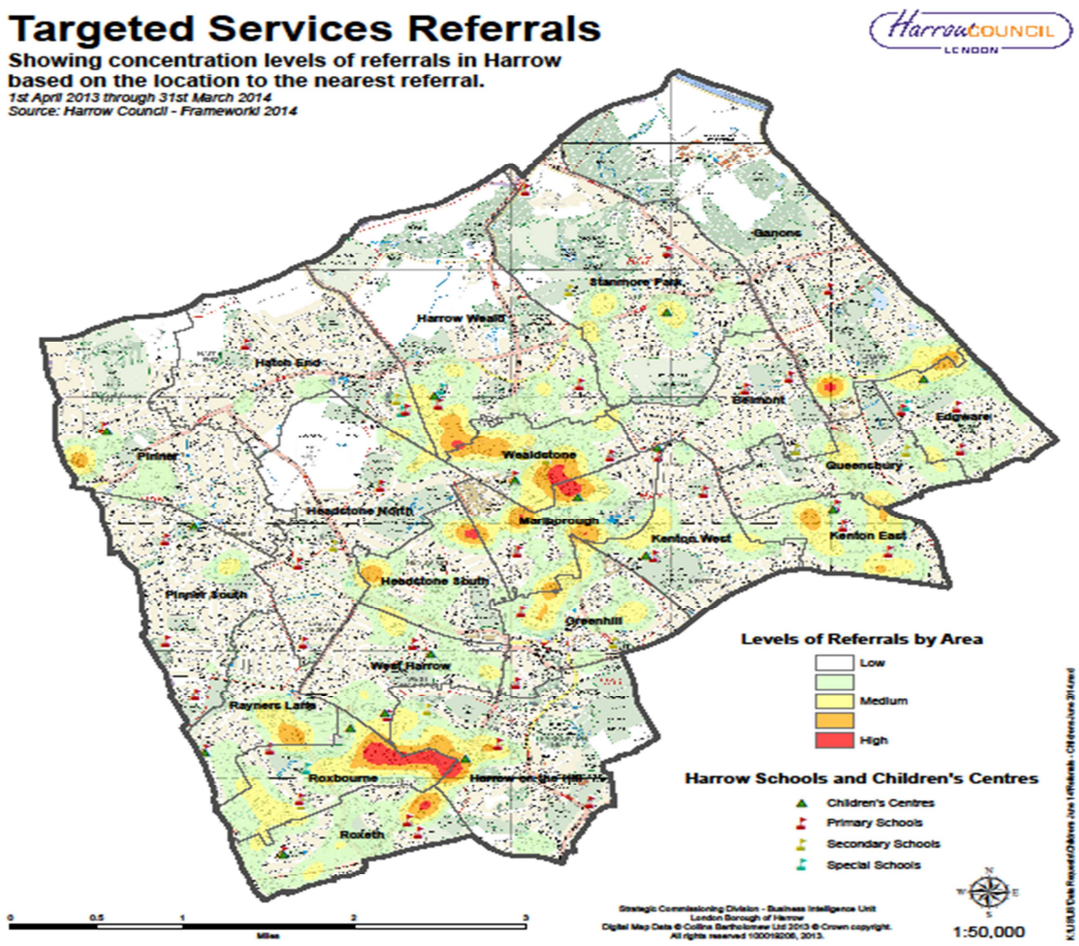
Figure 11: **Presenting issues at referral** [35]

Presenting Issues at referral	No.	%
Possible abuse or neglect	744	31.1
Domestic violence	572	23.9
Family dysfunction	233	9.7
Mental health concerns (parent/child)	154	6.4

[35] *Source: Harrow local data (Frameworki)*

Parenting support	117	4.9
Substance misuse (parent)	94	3.9
Child's disability	66	2.8
Family in acute stress	53	2.2
Socially unacceptable behaviour	52	2.2
Housing issues	38	1.6
Other*	270	11.3
Total	2393	100.0

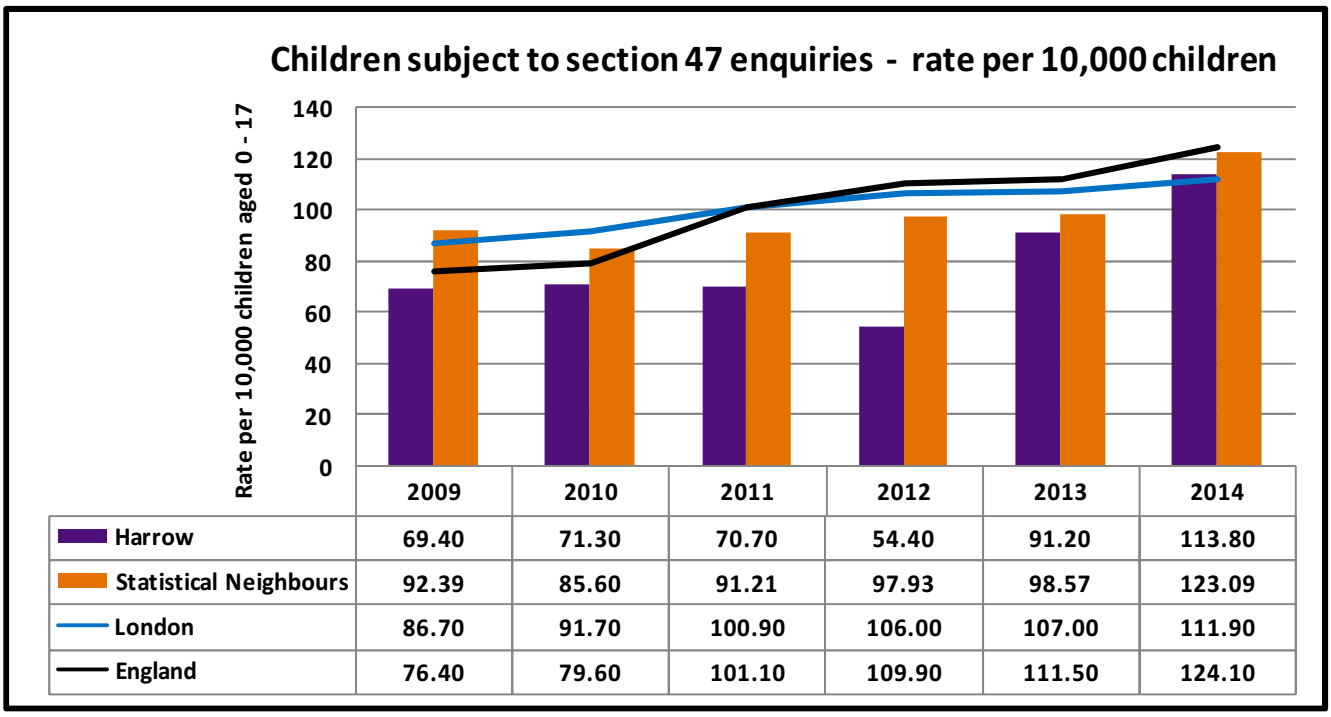
Figure 12: **Map showing concentration levels of referrals in Harrow based on location to the nearest referral.**



2.9.4 It is the Local Safeguarding Children Board's (LSCB) responsibility to ensure effective multi-agency arrangements to promote and safeguard the welfare of children and young people. '*Working together to Safeguard Children'* (2013) sets out

how organizations should work together to safeguard and promote the welfare of children and young people.

Figure 13: **Child protection investigations**[36]



	2009	2010	2011	2012	2013	2014
Harrow	69.40	71.30	70.70	54.40	91.20	113.80
Statistical Neighbours	92.39	85.60	91.21	97.93	98.57	123.09
London	86.70	91.70	100.90	106.00	107.00	111.90
England	76.40	79.60	101.10	109.90	111.50	124.10

2.9.6 The rate of children subject to child protection investigations under s47 of the Children Act has fluctuated over the past 5 years and the highest was during 2014. However, the rate has remained slightly below our statistical neighbours; lowered thresholds and the increasing child population has had an impact across all activities in the department.

2.9.7 Children are made the subject of a child protection plan (CPP) when they are considered to be at risk of physical, sexual, emotional harm or neglect. An Initial Child Protection Conference is convened and all professionals involved with the child are invited. Parents and children of an appropriate age attend the conference as well, a decision is made at the conference whether a child protection plan is required.

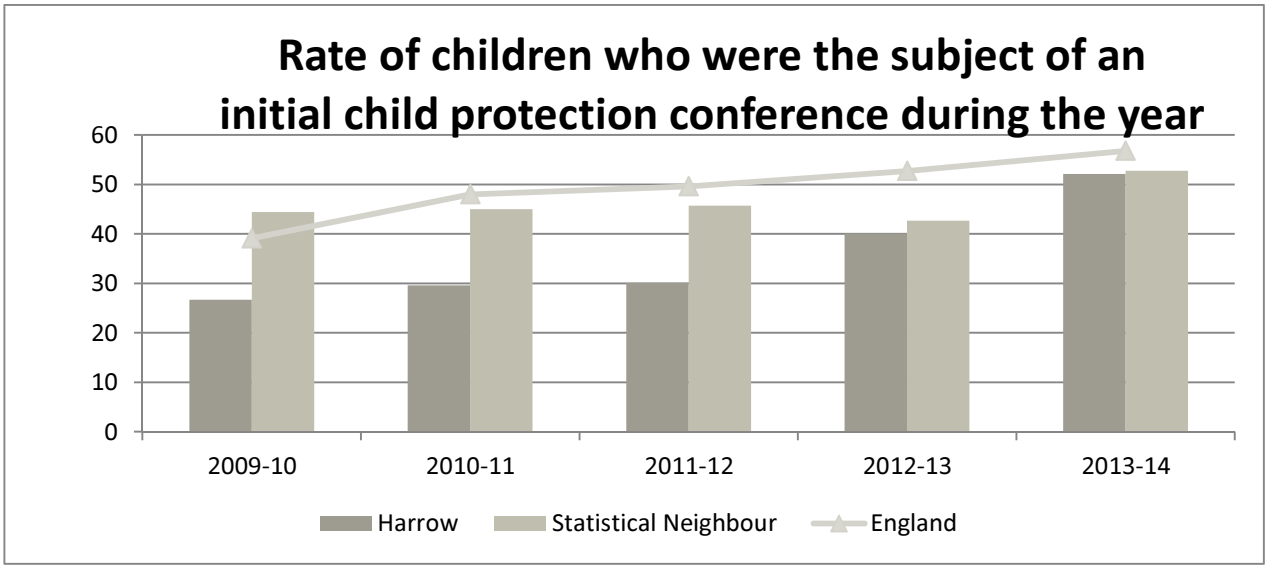
[36] *Source: DfE Characteristics of children in need in England; Local Authority Interactive Tool (LAIT)*

2.9.8 The number of children subject of an initial child protection conference during the year have increased year on year

Table 7: Child protection conference[37]

	2009-10	2010-11	2011-12	2012-13	2013-14
Harrow	133	150	165	222	291

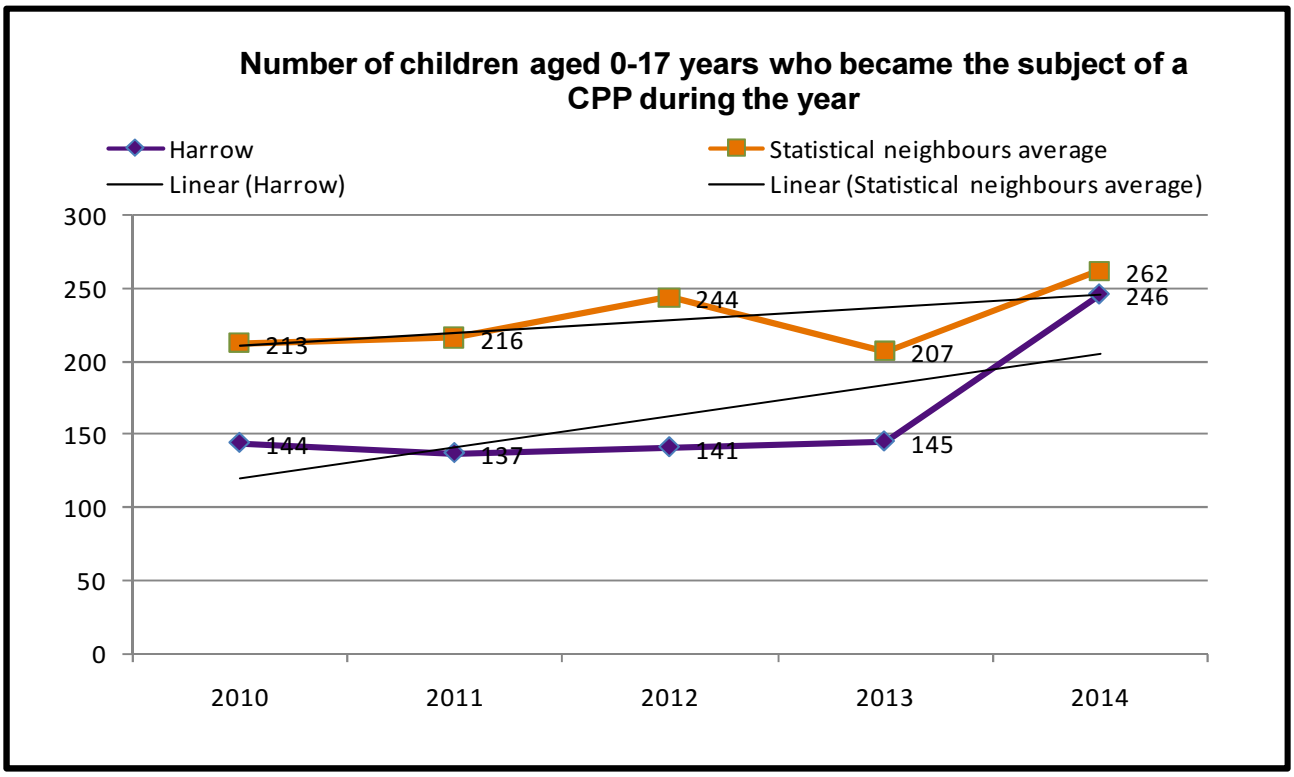
Figure 14: **Rate of children who were the subject of an initial child protection conference**



2.9.9 Between 2010 and 2014, there has been a 71% increase in Harrow in the number of children who became subject of a CPP during the year, increasing from 144 to 246. The number was stable for the first three years of this period and then rose sharply in 2013-14. This rise is mirrored by our statistical neighbours. There has been a considerable rise of 13.5% in the overall numbers of children starting a CPP in England in 2013-14; in comparison, the increase from 2011-12 to 2012-13 was 1.2%. The rise in numbers could be due to changes in the thresholds, increased awareness and referrals to social care due to the media coverage of high profile cases or whether there has been an increase in the neglect, abuse or other issues that impact adversely on the welfare of children

[37] *Source: DfE Characteristics of children in need in England*

Figure 15: **Number of children who became the subject of a CPP**[38]



2.9.11 Over 70% of children who are subject of a CPP were of a BME background which is reflective of the ethnic diversity of the local population. The proportions of males and females subject to a child protection plan at any one time are broadly similar, although in Harrow there are slightly more females than males while for our statistical neighbours, London and England there are slightly more males than females. Harrow has fewer children aged between 1 and 4 years on a CPP compared to statistical neighbours, London and England and slightly more children aged 5 to 9 years. In common with most other authorities, the most frequent types of abuse in Harrow are emotional abuse or neglect, together accounting for nearly 9 out of 10 cases. Practice in Harrow is to record a primary category and additional categories and hence multiple appears lower than comparators.

2.10 Children looked after (CLA)

2.10.1 Under s.17.1 (a) of the Children Act 1989, local authorities have a duty to 'safeguard and promote the welfare of children within their area who are in need'. The Act is

[38] *Source: DfE Characteristics of children in need in England; Local Authority Interactive Tool (LAIT)*

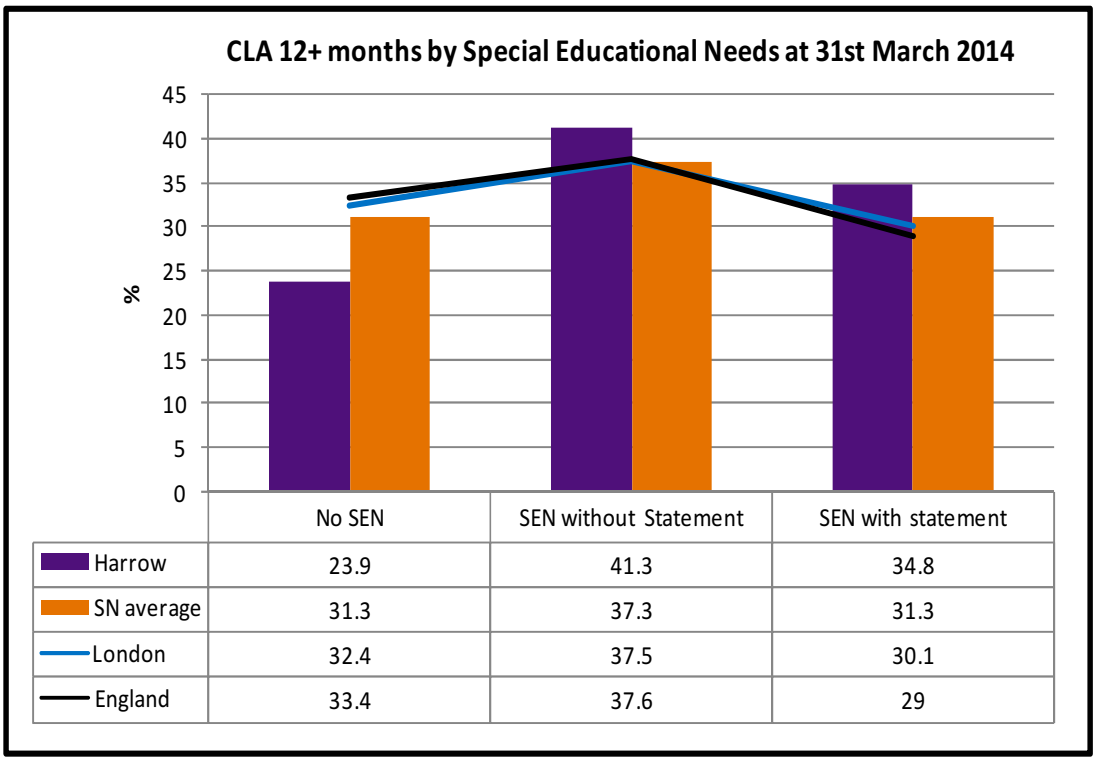
designed to ensure the safety and wellbeing of a child and if appropriate provide services that will allow the child to stay with their family.

2.10.2 Where there are serious concerns that a child is at risk of harm if she/he remains at home, the local authority may apply for a court order to remove the child. If this request is granted the child becomes a 'looked after' child. The term 'looked after' includes all children being looked after by a local authority, i.e. those subject to court orders and those looked after on a voluntary basis through an agreement with their parents under Section 20 of the Act.

- At the end of March 2014, almost 69,000 children were looked after in England, an increase of 1% on the previous year and 7% compared to March 2010. This number has been increasing steadily over the past five years and is now at its highest point since 1985.
- Nationally, the rate of looked after children per 10,000 is 60; in Harrow this rate is 30.
- The majority of looked after children in England – 62% in 2014 – are provided with a service due to abuse or neglect.
- Compared to national figures for all children in England, a far high proportion of looked after children have special educational needs: just under 18% of all school children in England had SEN as at March 2014; this was 67% for CLA. Harrow has a higher proportion of CLA with SEN both with and without a statement compared to statistical neighbours, London and England.

Figure 16: **Graph showing children looked after with SEN.**[39]

[39] Source: DfE Outcomes for children looked after



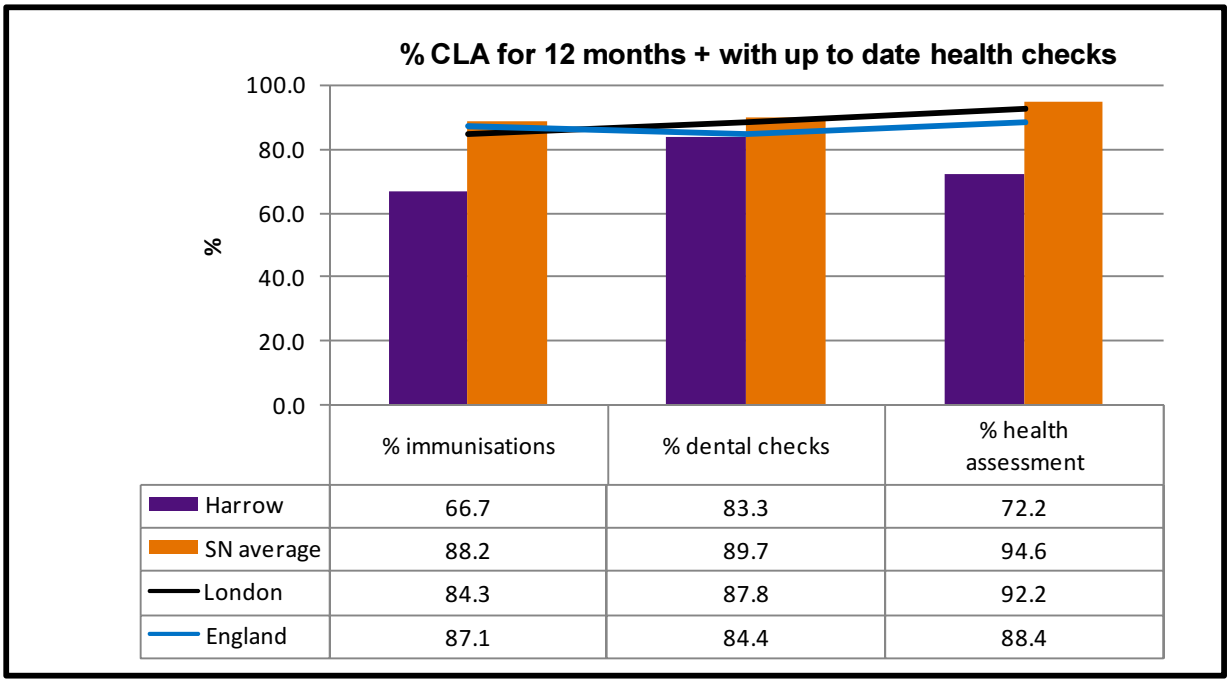
	No SEN	SEN without Statement	SEN with statement
Harrow	23.9	41.3	34.8
SN average	31.3	37.3	31.3
London	32.4	37.5	30.1
England	33.4	37.6	29

2.10.3 Harrow's number and rate of looked after children are generally fairly stable and have historically been substantially lower than England, London and statistical neighbours (there was a temporary dip in the numbers during 2010-11). At 31st March 2014 there were 165 children looked after. Historically, and in line with all but eight authorities in England, Harrow has more males than females looked after. Compared to statistical neighbours and London, Harrow's proportion of males to females is higher still.

2.10.4 Health checks for children who were being looked after for 12 months or more are a key tool in ensuring the health needs of all looked after children are identified. Initial and annual health assessments are important to ensure prompt identification of pre-existing, emerging and changing health needs. This is particularly important given the turnover of the CLA cohort, the need to maintain an overview for children placed in and outside of the borough, the developmental needs of babies and young children and the specialist health needs of older children.

2.10.5 Harrow is performing significantly less well in immunizations and dental and health checks than statistical neighbours, London and England, and this has decreased since last year, when 94% of all LAC for 12 or more months had all three of these.

Figure 17: **Percentage of children looked after for twelve months plus with up to date health checks**[40]



	% immunisations	% dental checks	% health assessment
Harrow	66.7	83.3	72.2
SN average	88.2	89.7	94.6
London	84.3	87.8	92.2
England	87.1	84.4	88.4

2.10.6 Evidence suggests that mental health problems are over four times more likely for looked after children compared to their non-looked after peers. This data item covers the emotional and behavioural health of children looked after, as recorded by a main carer in the Strengths and Difficulties Questionnaire (SDQ). A higher score on the SDQ indicates more emotional difficulties, with a score of 0 to 13 being considered normal, a score of 14 to 16 considered borderline cause for concern, and 17 or more a cause for concern. Across the country, looked after boys score higher than looked after girls at all ages (data on gender split not available at LA level). Harrow's rate of collecting SDQ questionnaires has fallen during 2013-14, the average score per child has also fallen.

2.10.7 In 2013-14, 10 out of 90 (11%) children/young people looked after for more than 1 year were identified as using alcohol or substances, compared to 6% across London. Referral pathways are in place between CLA and substance misuse services. Due to small numbers of looked after children Harrow's proportion of looked after children who misuse alcohol or substance appear higher.

[40] *Source: DfE Characteristics of children in need in England; Local Authority Interactive Tool (LAIT)*

2.10.8 Children in the care of local authorities are one of the most vulnerable groups in society and children who have been looked after continuously have a significantly lower level of educational attainment than other children. In England in 2013-14, 12% of looked-after children achieved five or more A*-C grades at GCSE or equivalent level; this constitutes an attainment gap of 40.1% when compared to non-looked after children. Many 'looked after' children face considerable challenges in achieving high standards in school, and yet education is fundamentally their pathway to future success.

2.10.9 The instability of placement arrangements, high school absentee rates, insufficient educational support, insufficient support and encouragement at home for learning and development and the need for help with their emotional, mental and physical health have been cited by the Social Exclusion Unit as the reasons why children in care fail to thrive.

2.11 Early intervention

2.11.1 The Early Intervention Services (EIS) division encompasses four 'Team around the Family' (TAF) teams, the Youth Development Team and ten Children Centres. The Team around the Family' (TAF) teams, the Youth Development Team provides integrated support for children and families as soon as a concern starts to emerge. EIS aims to prevent escalation to specialist and statutory services; improve outcomes for our most vulnerable children and families; and to build family resilience so families can sustain progress and positive outcomes. The work is based around a 'Team around the Family' approach, with designated lead professionals responsible for the co-ordination of case work and multi-agency support.

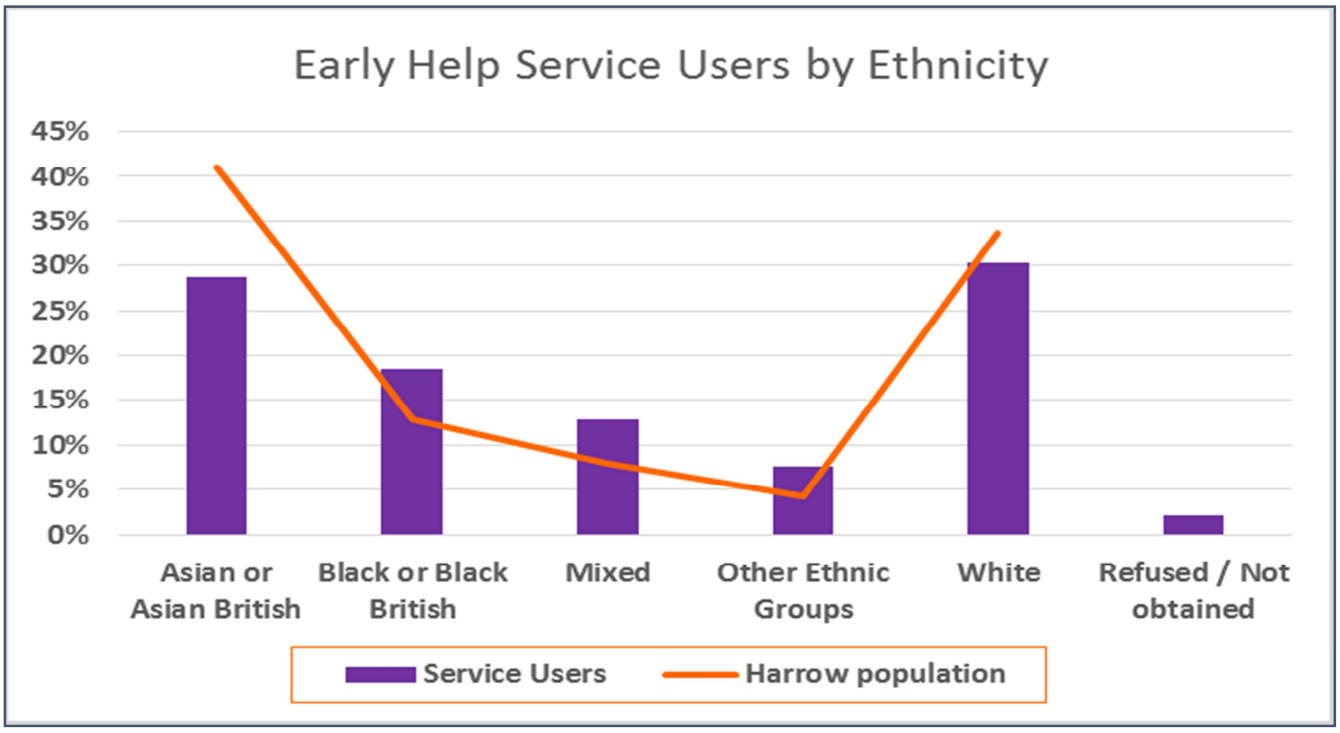
2.11.2 The Division works with children & young people from conception to their nineteenth birthday and up to 24 years old for young people with a disability or engaged in specific young adult projects.

Priority groups or Early Help Assessments are undertaken for:

- Children in Need not meeting the Social Care threshold
- Children and parents that have experienced domestic violence
- Children suffering poor outcomes as a result of parental mental health difficulties

- Children suffering poor outcomes through parental alcohol or substance misuse or the negative effects of parental alcohol / substance misuse
- Children or young people not in education, employment or training (NEET)
- Children whose attendance falls below 85% and those at risk of exclusion from schools
- Children at the edge of care

Figure 18: **Ethnicity of Service Users 2013-14**



2.11.3 The largest group of service users are from Asian (28%) & White backgrounds (31%). However compared to the general child population of Harrow, service users are slightly over represented from the Black or Black British, Mixed and Other ethnic backgrounds and under-represented from Asian background (41%). A detailed breakdown of service users by ethnicities is provided in the table below.

2.12 Young carers[41]

[41] Carers strategy

2.12.1 Young carers are children and young people under the age of 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances.

2.12.2 The Children and Families Act (2014) has introduced changes in the way in which young carers are identified and supported. The changes include a general duty on local authorities to improve the wellbeing of young carers who are ordinary residents, the identification of any children who may be involved in providing care, the provision of medical services to patients who are young carers, schools must have a process in place for the identification of young carers. Schools must put in place a mechanism for the provision of appropriate support to promote the wellbeing and improve the educational attainment of young carers within their school.

2.12.3 The 2011 Census found that in London there are a total of 26,231 young carers aged 5 – 17.

- Of these, 20,636 (79%) provide 0 – 19 hours care per week.
- 2,944 (11%) provide 20 – 49 hours care per week, and
- 2,650 (10%) provide over 50 hours care per week, 556 (21%) are aged 5 – 9.

However, it is thought that this is an under-estimate as:

- 1 in 12 secondary school age children were providing personal care in a 2010 study & almost a third were providing emotional care (BBC & Univesity of Nottingham)
- The average age that Young Carers start caring is 10 – meaning that there will be a lot of Young Carers in primary schools too.

There are an estimated 250,000 young people living with parental substance misuse in the UK.

2.12.4 Of the 24,620 carers in Harrow identified in the 2011 Census.

- 2,272 are young carers aged 5 – 24

- If we are to apply the London percentages to those in Harrow, we can estimate that there are 863 young carers aged 5 – 17.
- Of these 863 it is estimated that 113 (13%) are aged 5 – 9.
- The number of young carers aged 5 – 18 currently recorded as receiving support within a Harrow School is 212. The majority of who are over the age of 11.
- The majority of schools felt that there were a significant number of 'hidden' young carers on role.

2.12.5 Young carers have needs and for a number of reasons,

- Young carers are 1.5x more likely than peers to have a special educational need/ disability.
- Male young and young adult carers are twice as likely as peers to report 'not good health'; girls are 2.5 times as likely.
- One local authority found 11% young carers sustained an injury due to caring, under half told their GP they were caring, 35% thought their health had worsened due to caring, 35% also experienced eating disorder symptoms.
- Just 37% of known Young Carers in Harrow were meeting National Standards in both Maths and English.
- Over 2/3 of Young Carers aged 8-16 say they have been bullied.
- Young Carers are twice as likely to be not in Education, Employment or Training.

3.0 Risk factors associated with poverty

3.1 Debt and rent arrears

3.1.1 The data records all enquiries at the bureau, previously only unique client enquiries were recorded. There are again high levels of enquiries regarding housing benefit, employment support allowance and threatened homelessness. There appears to be no enquiries regarding domestic violence, which may reflect a problem with recording rather than no incidence of this occurring.

3.1.2 The number of enquiries appear to have dramatically increased on fuel debt in the last month, but may be explained by the demands of meeting a project deadline rather than a specific problem. In addition, there has been an increase in water debt in the last month for which there does not appear to be an obvious explanation.

Table 8: Table showing the number of CAB enquiries in Harrow by enquiry[42]

CAB Enquiries (volume)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Travel
Mortgage & Secured Loan Arrears	3	2	2	7	4	5	8	5	2	2	5	4	3	▽ ☺
Rent Arrears (local authority)	19	12	19	9	18	11	12	15	12	19	11	7	19	△ ☹
Rent Arrears (Housing Associations)	5	8	6	7	8	8	7	7	9	9	7	2	5	△ ☹
Rent Arrears (Private Landlords)	8	13	10	7	15	5	11	11	9	9	10	6	6	◁▷ 😐
Council Tax Arrears	62	59	56	39	47	49	44	50	44	20	58	48	53	△ ☹
Other Debts	78	58	57	47	72	69	66	73	64	75	59	48	65	△ ☹
Council Tax Benefit	31	23	25	36	36	20	27	29	33	45	32	17	20	△ ☹
Housing Benefit	106	100	99	72	98	65	88	87	115	138	140	83	95	△ ☹
Job Seekers Allowance	27	32	26	20	31	19	20	29	23	20	17	12	12	◁▷ 😐
Incapacity Benefit / Employment Support Allowance	58	63	63	48	40	52	46	61	43	56	66	60	68	△ ☹
Redundancy & Dismissal	13	23	22	15	13	15	14	20	25	22	29	19	17	▽ ☺
Actual Homelessness	9	10	6	8	6	5	4	13	10	9	9	11	3	▽ ☺
Threatened Homelessness	21	11	21	13	20	17	11	24	28	24	27	24	13	▽ ☺
Domestic Violence Incidence	6	1	4	0	1	0	2	2	2	2	0	0	0	◁▷ 😐
Divorce and Separation	17	18	16	7	21	18	16	23	17	17	10	9	17	△ ☹
Fuel Debt	27	18	21	12	15	14	13	16	13	15	17	15	47	△ ☹
Telephone & Broadband Debt	8	4	4	5	9	3	4	5	7	8	5	3	5	△ ☹
Bank and Building Society Arrears	10	7	7	7	12	7	5	7	6	4	9	3	5	△ ☹
Credit, Store & Charge Card Arrears	29	22	14	17	16	21	16	16	13	11	13	10	14	△ ☹
Unsecured Personal Loan Debts	10	10	6	10	17	15	12	11	8	11	8	8	11	△ ☹
Water Supply Sewerage Debts	8	8	8	4	7	8	12	9	7	6	8	2	18	△ ☹
Access To + Provision of Accommodation	14	21	20	14	8	20	12	24	9	8	23	21	8	▽ ☺
Local Authority Housing	6	6	10	4	13	11	11	18	11	14	13	6	4	▽ ☺
Total for Month	**575**	**529**	**522**	**408**	**527**	**457**	**461**	**555**	**510**	**544**	**576**	**418**	**508**	△ ☹

3.2 Parental income

[42] *Source: CASE - Citizens Advice Management Information System - From April 2015*

3.2.1 Wages in Harrow are generally lower than in London and in West London as a whole, leading to a high proportion of residents commuting to other areas for better paid jobs. People working in Harrow earn, on average, less than the average weekly pay for Harrow residents. These lower wages could reflect lower level activities undertaken by businesses in the borough or a low demand for labour.

3.2.2 Figure 19 looks at low pay by boroughs. It is included because there are two ways of looking at the geography of low pay: by where the jobs are located, and by where the people who work in those jobs live. In a city of commuting like London, these two measures can vary substantially. The line in this graph shows the proportion of jobs that are low paid by where the workplace is. Boroughs further away from the centre of London tend to have a higher proportion of low-paid jobs. Nine of the ten boroughs with the highest proportion of low-paid jobs are in Outer London, and are also spread fairly evenly, with for example Bexley in the Outer East & Northeast sub-region and Harrow in the Outer West & Northwest. The borough with the worst low pay rate is Harrow, with 37% of jobs paid below the London Living Wage, followed by Waltham Forest (35%) and Bexley (33%

Figure 19: **Low-paid jobs in London by borough of work and borough of residence**

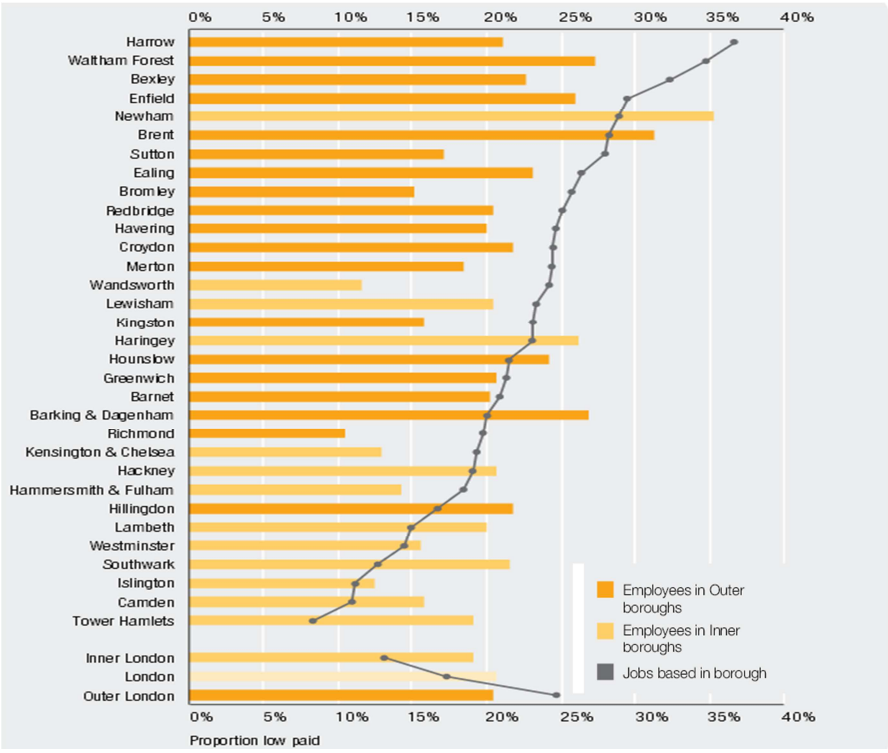


Figure 20: **Earning and parental income in Harrow compared to London and nationally**[43]

Earnings by Workplace (2015)

	Harrow (pounds)	London (pounds)	Great Britain (pounds)
Gross weekly pay			
Full-time workers	508.0	659.9	529.0
Male full-time workers	584.1	715.4	569.9
Female full-time workers	435.3	595.8	471.5
Hourly pay - excluding overtime			
Full-time workers	12.81	17.13	13.32
Male full-time workers	13.78	18.20	13.91
Female full-time workers	11.29	16.05	12.56

Source: ONS annual survey of hours and earnings - workplace analysis

Note: Median earnings in pounds for employees working in the area. From 15/04/2014 all the data in the hourly pay table (including time series data) has been amended to show "Hourly pay excluding overtime" instead of total hourly pay.

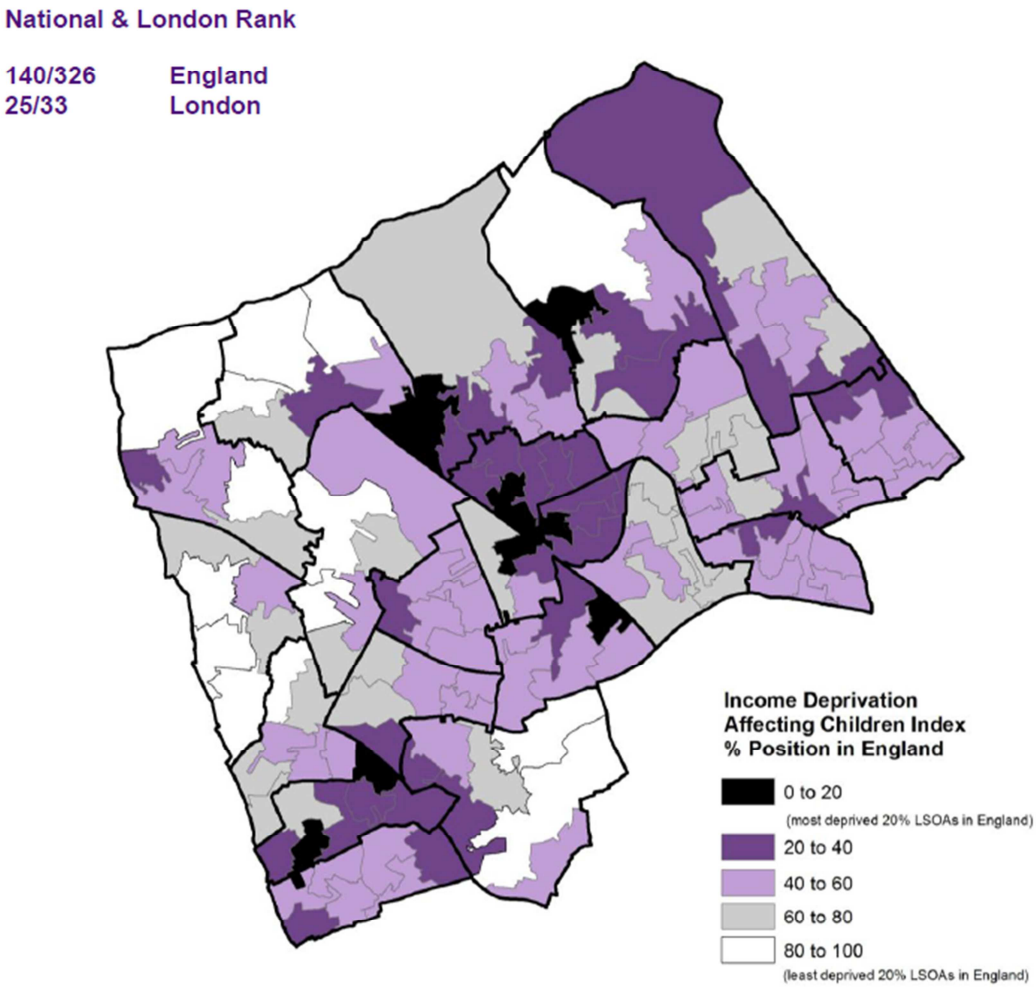
3.2.3 The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families3. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain. Income deprivation affecting children follows a similar pattern to income deprivation in general. Overall the picture of income deprivation affecting children is varied, with LSOAs in each of the quintile bands. The 2015 ID shows that 16.9 per cent of children in Harrow live in families experiencing income deprivation. Based on the 2010 ID, the Greater London Authority (GLA) estimated that Harrow's corresponding level for 2010 was 24.4 per cent4.

3.2.4 Eight of Harrow's LSOAs feature in the most deprived 20 per cent of LSOAs in England, compared to 25 LSOAs in 2010. Three LSOAS are amongst the country's most deprived 10 per cent, down from eight in the 2010 ID. None of Harrow's LSOAs are in the most deprived 5 per cent of LSOAs, an improved position from 2010, when four of the borough's LSOAs were identified in the most deprived 5 per cent nationally. Overall far fewer of Harrows LSOAs are in the four most deprived

[43] Source: ONS annual survey of hours and earnings - workplace analysis, 2014

quintiles, compared to 2010. Harrow's most deprived LSOAs for income deprivation affecting children are adjoining LSOAs in Marlborough and Wealdstone wards, and the LSOA in Roxbourne ward covering the Rayners Lane Estate - these LSOAs are in the country's most deprived 10 per cent. The wards of Stanmore Park, Harrow Weald, Hatch End and Greenhill also have LSOAs featuring in the 20 per cent most deprived in England. There are 14 LSOAs in the least deprived 20 per cent in the country, up from nine in 2010. Five. LSOAs are in the country's least deprived 10 per cent and these are all to the west of the borough - in Harrow on the Hill, Hatch End, Headstone North, Pinner and Pinner South wards.

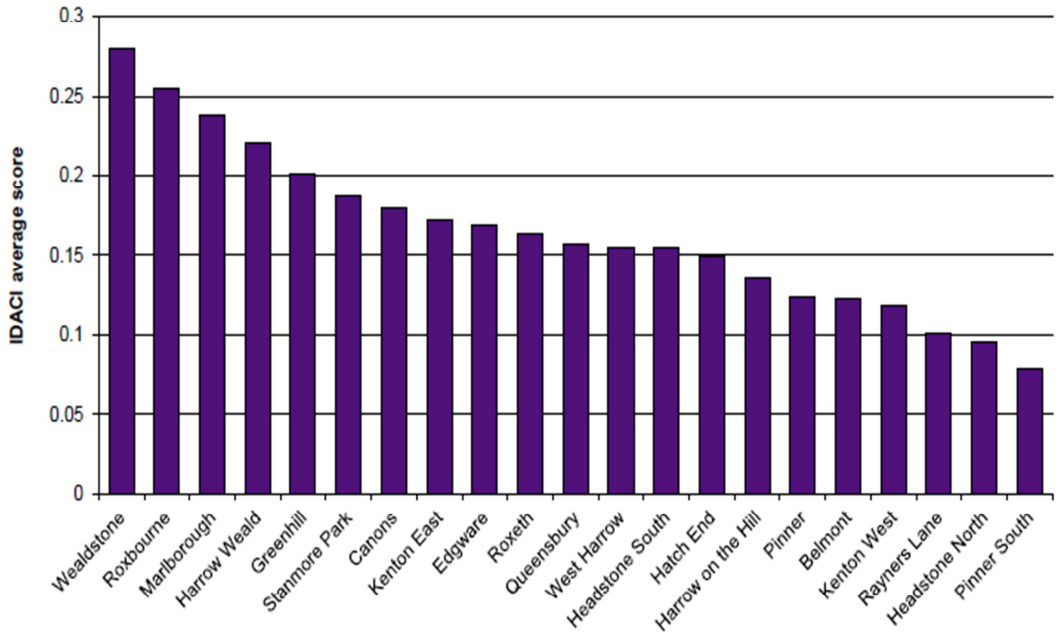
Figure 21: **Income deprivation affecting children (IDACI)**



Income Deprivation Affecting Children by ward

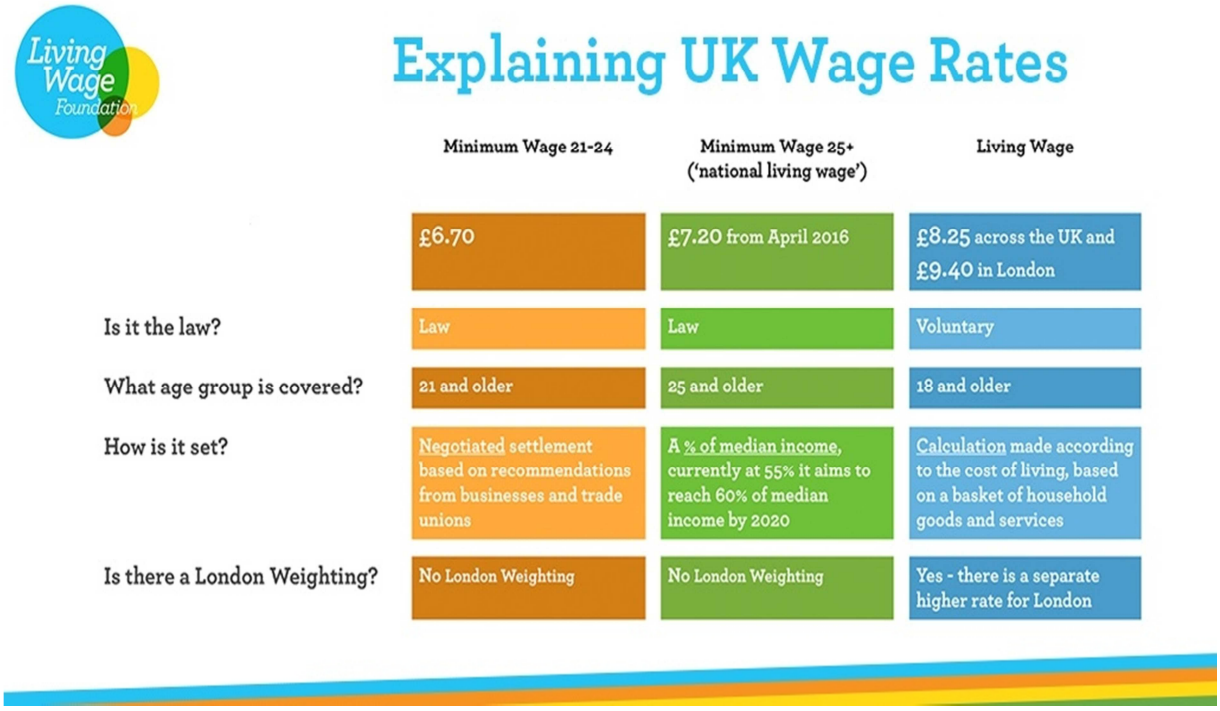
Source: CLG, Indices of Deprivation 2015, Crown Copyright

Note: Ward level data has been calculated from LSOA average IDACI scores



3.2.5 The Living Wage commitment sees everyone working at an employer, regardless of whether they are permanent employees or third-party contractors; receive a minimum hourly wage of £8.25, and £9.40 in London - significantly higher than the national minimum wage of £6.70. The Living Wage is an hourly rate, set independently and is based on the cost of living. The Living Wage is for all employees over the age of 18, whereas the new enhanced minimum wage rate is for over 25s only. New rates are announced in Living Wage Week in November every year. The Living Wage Foundation has 2,300 accredited Living Wage employers across the UK. These are employers who commit to paying their staff at least the voluntary Living Wage. Harrow council is not signed up to the living wage.

Figure 22: **Explaining the UK wage rates**[44]



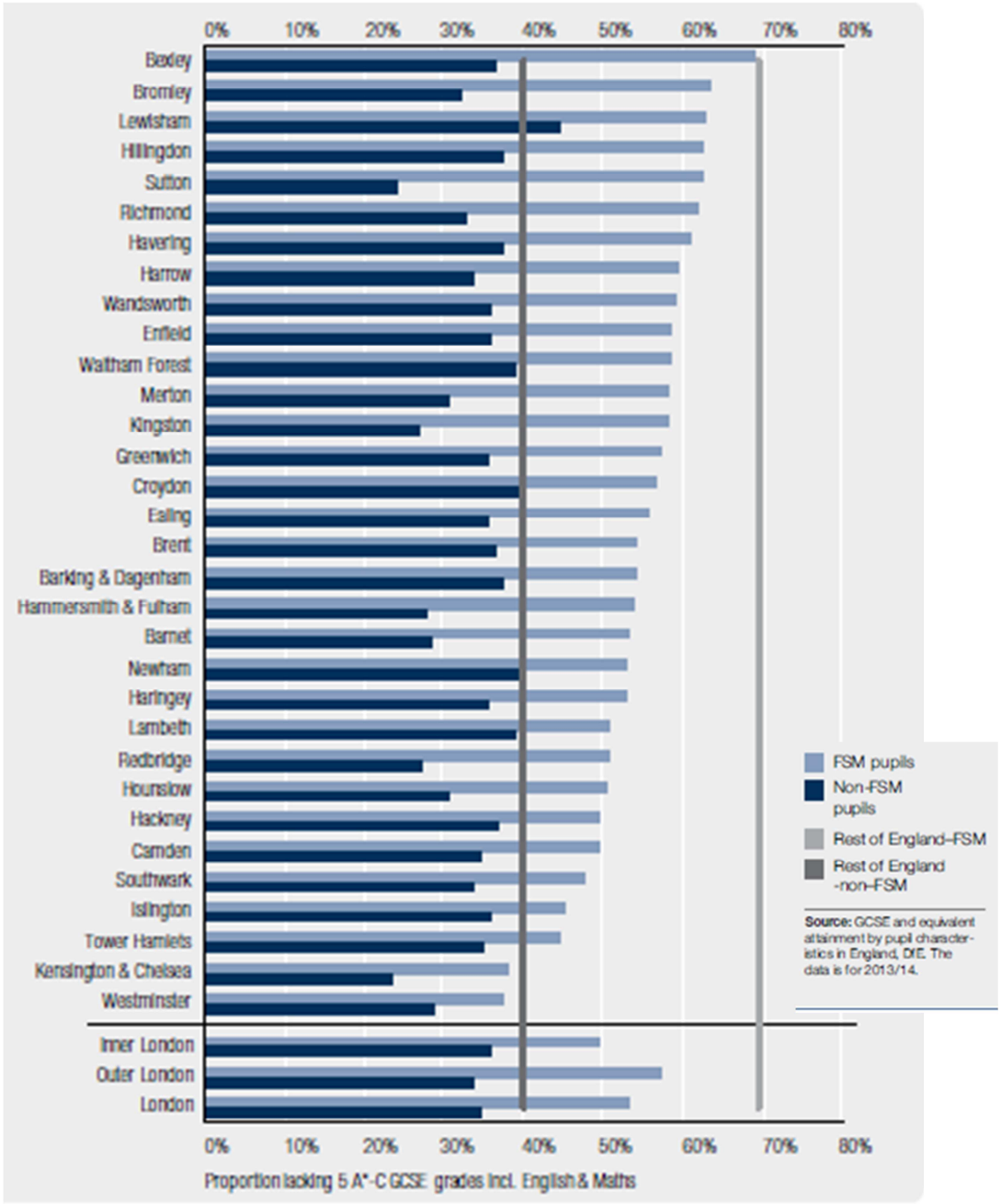
3.3 Children on free school meals

3.3.1 Free school meals are available to all full-time pupils (including full-day nursery children and sixth form students) who are still at school and whose parents receive the following:

- Income Support
- Income based JSA and ESA
- Child Tax Credit
- Support under part VI of the Immigration and Asylum Act 1999
- Child Tax Credit, provided they are not entitled to Working Tax Credit and have an annual income, as assessed by HM Revenue and Customs (HMRC), that does not exceed £16,190
- The guaranteed element of State Pension Credit.

[44] http://www.livingwage.org.uk/news/briefing-april-1st-introduction-national-living-wage

Figure 23: **Students on FSM in Harrow lacking 5 A-C GCSEs compared with London**



3.3.2 As a proxy for socio economic change, 13.8% of children in Harrow's primary schools were eligible for free school meals as at January 2014. The table below shows that FSM eligibility remained steady from 2010 until 2013, dropping in 2014. This drop may be attributable to the changes in the Welfare Benefit system, which is now known as Universal Credit.

Figure 24: **Percentage of pupils eligible for Free School Meals in primary schools**

Primary Schools	January 2010	January 2011	January 2012	January 2013	January 2014
Harrow	**16.5%**	**17.1%**	**16.2%**	**16.2%**	**13.8%**
Statistical Neighbours	17.2%	17.8%	17.5%	16.9%	15.0%
England	17.3%	18.0%	18.1%	18.1%	17.0%

3.3.3 The table below shows that 17.0% of pupils in Harrow's high schools were eligible for free school meals as at January 2014. FSM eligibility has overall remained steady over the last 5 years with a slight increase in 2011.

Table 9: Percentage of pupils eligible for Free School Meals in secondary schools

Secondary Schools	January 2010	January 2011	January 2012	January 2013	January 2014
Harrow	**17.6%**	**20.4%**	**18.1%**	**18.6%**	**17.0%**
Statistical Neighbours	15.9%	16.4%	16.6%	16.7%	15.5%
England	14.2%	14.6%	14.8%	15.1%	14.6%

3.4 Childcare

3.4.1 In Harrow, the take up of formal childcare is lower at 9% compared with London 14% and England averages 15%[45] The recent childcare sufficiency assessment produced by the local authority to assess the landscape and identify any needs and gaps in childcare in the borough.

3.4.2 There is likely increasing demand for childcare as a result of a growing population of children aged 0-4 years and the growing number of parents in work. Much of this demand is likely to arise in the growth wards of Canons, Marlborough, Wealdstone

[45] Source: basket of indicators CPU : https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators

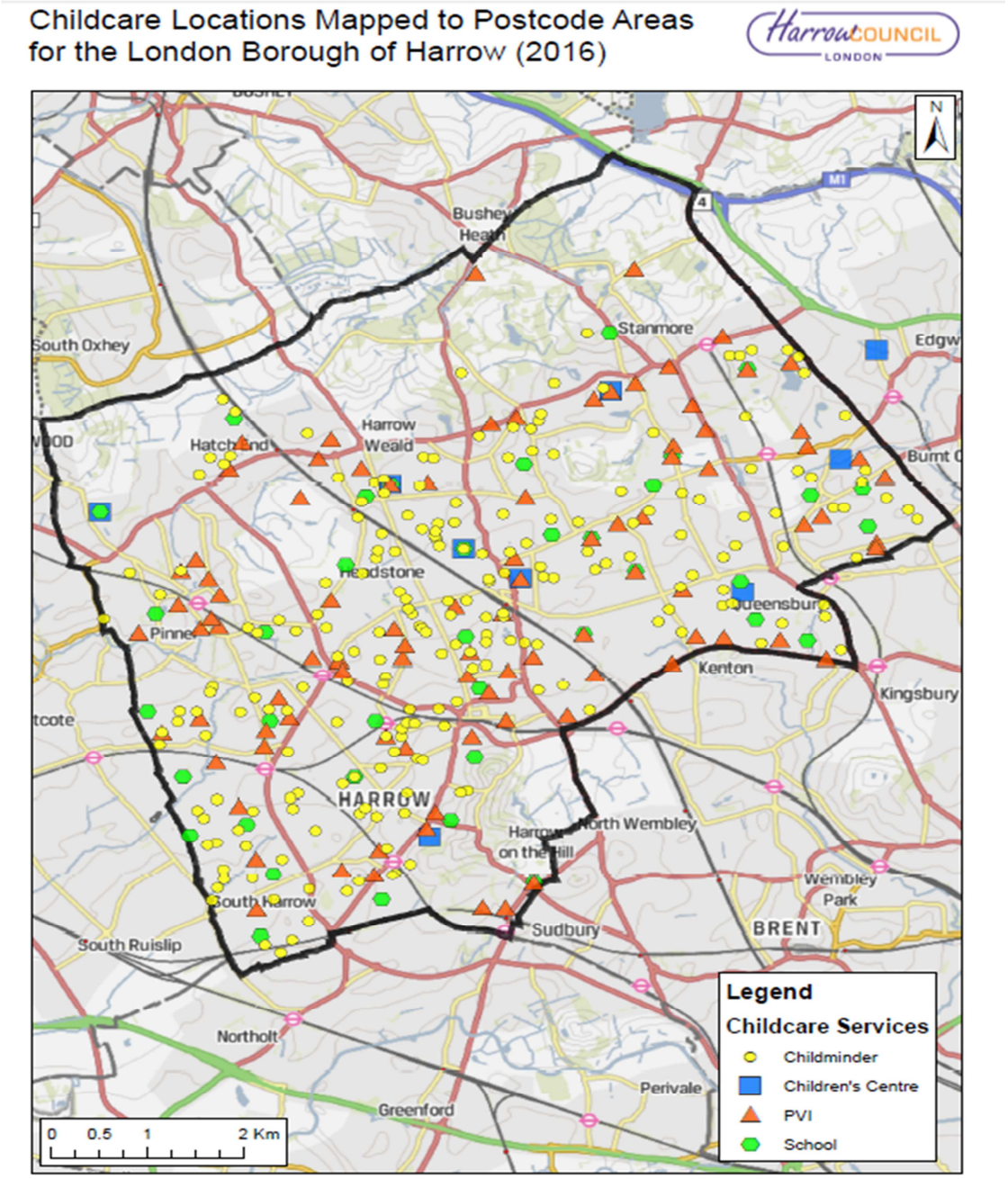
and Roxbourne. Marlborough, Wealdstone and Roxbourne, together with Harrow Weald, are also expected to require increased childcare provision particularly for eligible 2 year olds reflecting the relative deprivation of these wards to the rest of the borough.

3.4.2 Overall, most children aged 3 and 4 years are taking up early education entitlements in good quality provision in Harrow where approximately 17 in every 20 early years settings in Harrow have Ofsted ratings of 'good' or 'outstanding' (in line with all England averages). At the same time, 65% of parents report being satisfied/very satisfied with the childcare in 2016. In addition, half of parents/carers feel that there is a good choice of childcare locally and that it is available where and when they need it and half of parents/carers feel that the quality of childcare is high.

3.4.4 Key considerations for any childcare planners in encouraging greater take-up include:

- A changing ethnic profile of Harrow requires childcare provision that is sensitive to religious, cultural and language needs. Some new communities such as from Somalia tend to have lower rates of take-up of childcare for children aged 0-4 years for example.
- A higher proportion of children in Harrow have a Statement of Educational Need (SEN) who are eligible for the 2 year old entitlement and 3 and 4 year old entitlements than is the case in outer London and England. This points to demand for childcare that is equipped at meeting the needs of children with additional needs. Most early years settings report they need help to improve their ability to meet the needs of these children.

Figure 25: **Map showing the location of childcare locations in Harrow**



White British families were more likely to use childcare vouchers (22%) compared to other ethnicities (14%). This reflects the higher percentage of White British ethnicities that have both partners working full time (22% of White British compared to 14% of other ethnicities).[46]

3.4.5 Affordability is identified by parents and all types of early years settings as a key priority:

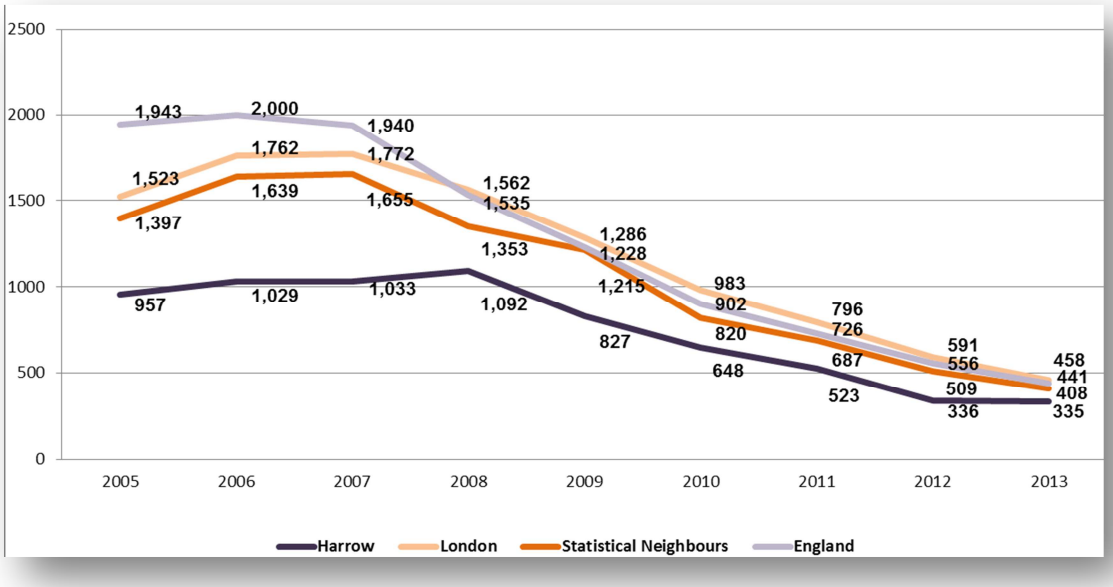
[46] Harrow Childcare sufficiency assessment 2016

- 3 in every 4 families report that childcare costs are not affordable. This is particularly so for families on lower incomes (less than £40,000 per annum) and lone parents.
- The average spend on childcare per week is £153. This increases to £199 in the North East of the borough and decreases to £86 in the South East Area. Costs tend to be less for lone parents, households that are less economically active, lower income households and families with children with SEN/ additional needs.
- Harrow childminders tend to charge a little less than London averages for children aged 2-5 years. Nursery costs tend to be higher than London averages.
- Early years settings raise concerns about the levels of funding to enable funded places particularly and 21% of early years settings report that they intend increasing fees by more than £10 per week for local families in the coming 18 months.

3.5 Youth offending and exclusions

3.5.1 Since 2007 the national trend has been a year on year decrease in the number of first time entrants to the youth justice system. The national trend is reflected in Harrow's figures which decreased from 1,092 in 2008 to 335 in 2013. Harrow has consistently performed well against National, London and Statistical Neighbour averages. There has been only a slight decrease between 2012 (336) and 2013 (335) which may suggest that numbers are levelling out.

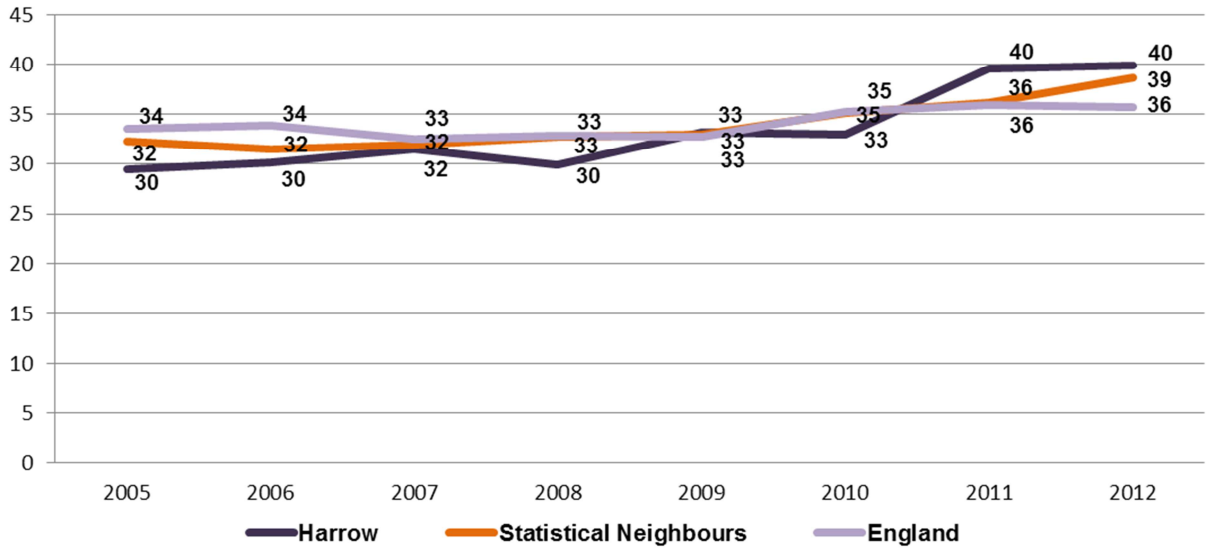
Figure 26: **First time entrants to the youth justice system in Harrow**



3.5.2 On a national scale re-offending has seen a steady increase in the proportion of re-offenders between 2005 and 2012. However, the size of the cohort from which re-offending has been measured has been decreasing year on year with particular reductions among those young people who have had no previous offences. This has left a smaller, more challenging group within the youth justice system which is reflected in a higher rate of re-offending.[47] Harrow has followed the national trend with the proportion of re-offenders increasing steadily since 2005. Although, since 2010 harrow's rate of re-offending has moved above national and statistical neighbours for the first time. This is likely due to harrow's levels of first time offenders reducing at a faster rate during those periods.

[47] YJB/MOJ - Youth Justice Annual statistics 12-13 https://www.gov.uk/government/statistics/youth-justice-statistics

Figure 27: **Proportion of young offenders who re-offend 2005 – 2012**[3]



3.5.3 Harrow's 2012 figure for re-offending was 30.95% (63 re-offenders out of a cohort of 158 offenders) which is in line with the 2011 figure of 39.50% (85 re-offenders out of a cohort of 215 offenders). Although the proportion of re-offenders has remained stable between 2011 and 2012, the 2012 figure represents a smaller cohort with 63 re-offenders compared to 85 in 2011.

Table 10: Overall absence in primary schools

% Overall Absence	2009-10	2010-11	2011-12	2012-13
Harrow	**5.66%**	**5.2%**	**4.5%**	**4.6%**
Statistical Neighbours	5.42%	5.1%	4.3%	4.5%
England	5.21%	5.0%	4.4%	4.7%

3.5.4 The rate of overall absence in Harrow's primary schools has improved from 5.66% in 2009-10 to 4.6% in 2012-13. In outer London overall absence ranged from 4.1% to 4.9%, Harrow ranked joint 5th out of the 7 rankings alongside 5 other local authorities. Overall absence in London ranged from 3.5% to 4.9% and of the 9 rankings Harrow ranked 6th alongside 6 other local authorities. Nationally overall absence ranged from 3.5% to 5.3%, Harrow ranked joint 8th alongside 18 other local authorities. The 2013-14 data is yet to be published.

Table 11: Persistent Absence in primary schools

% Persistent Absence	2009-10	2010-11	2011-12	2012-13
Harrow	**1.4%**	**3.7%**	**3.1%**	**2.9%**
Statistical Neighbour	1.3%	3.8%	2.7%	2.5%
England Average	1.4%	3.9%	3.1%	3.0%

3.5.5 The definition of persistent absence changed from 20% or more absence in 2009-10 to 15% or more absence in 2010-11. Persistent absence (PA) has improved in primary schools from 3.7% in 2010-11 to 2.9% in 2012-13. Harrow's PA has been better than the national average. In outer London persistent absence ranged from 1.9% to 3.4%, Harrow ranked joint 7th out of the 10 rankings alongside 3 other local authorities. Persistent absence in London ranged from 1.9% to 3.9% and of the 14 rankings Harrow ranked 9th alongside 5 other local authorities. Nationally persistent absence ranged from 1.6% to 5.2%, Harrow ranked joint 12th alongside 15 other local authorities out of 27 rankings. The 2013-14 data is yet to be published.

Table 12: Overall absence in high schools

% Overall Absence	2009-10	2010-11	2011-12	2012-13
Harrow	**6.06%**	**5.7%**	**5.2%**	**5.2%**
Statistical Neighbours	6.28%	6.0%	5.2%	5.1%
England	6.80%	6.5%	5.9%	5.8%

3.5.6 The rate of overall absence in Harrow's high schools has improved from 6.06% in 2009-10 to 5.2% in 2012-13, and has overall been better than the statistical neighbour and national averages, as can be seen in the table above. Overall absence in high schools in outer London ranged from 4.5% to 5.7% and Harrow ranked joint 6th with 3 other boroughs out of 11 rankings. The range in London was 4.3% to 5.7% and Harrow ranked joint 8th with 3 other boroughs out of a total of 13 rankings. The range nationally was 4.3% to 7.7% and Harrow ranked joint 8th with 6 other local authorities out of 31 ranks.

Table 13: Persistent Absence in high schools

% Persistent Absence	2009-10	2010-11	2011-12	2012-13
Harrow	**3.3%**	**6.3%**	**5.6%**	**4.8%**
Statistical Neighbour	3.2%	6.6%	5.7%	4.5%
England Average	4.2%	8.4%	7.4%	6.4%

3.5.7 Persistent absence in Harrow's high schools has improved from 6.3% in 2010-11 to 4.8% in 2012-13. Harrow's PA is significantly lower than the national averages, as well as better than the statistical neighbour average. In outer London persistent absence in the secondary sector ranged from 3.7% to 6.2%, Harrow ranked joint 6th out of the 14 rankings alongside 2 other local authorities. In London the range was 3.0% to 6.4% and of the 17 rankings Harrow ranked 7th alongside 4 other boroughs. Nationally the range was 3.0% to 12.1%; Harrow ranked joint 10th alongside 5 other local authorities out of 54 rankings. The 2013-14 data is yet to be published.

3.5.8 Permanent exclusions in Harrow's primary schools have fluctuated over the last few years, with a low of 3 permanent exclusions in 2013-14 (0.01% of the school population). However in 2012-13 Harrow's low percentage (0.04%) of permanent exclusions is still higher than the national average (0.02%) as well as the statistical neighbour average (0.01%).

3.5.9 Permanent exclusions in Harrow's high schools have dropped over the last few years from 35 in 2009-10 to 19 in 2013-14 (0.16% of the school population). However Harrow's percentage of permanent exclusions in 2012-13 remains above the national average (0.12%).

3.6 Substance misuse[48]

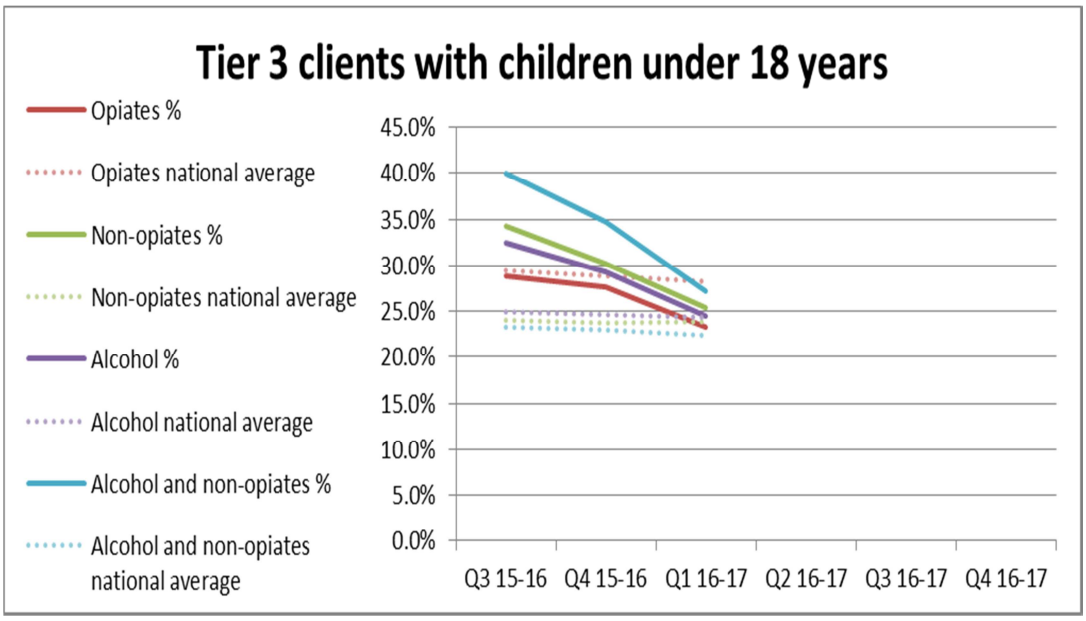
3.6.1 Parental substance use can and does cause serious harm to children at every age from conception to adulthood. Adverse effects on children encompass a wide range of emotional, cognitive, behavioural and other psychological problems, and they are potentially exposed to many sustained and intermittent hazards as a result of parental substance use, including:

[48] Data from Harrow substance misuse service , public health

- increased likelihood of early substance misuse (up to seven times more likely) and offending behaviour
- inadequate supervision
- inappropriate parenting practices/separation
- inadequate accommodation or instability of residence
- dangerous substances in the home
- interrupted or otherwise unsatisfactory education/attainment and socialisation
- threats to physical safety/exposure to criminal or inappropriate behaviour

3.6.2 It is also noted that mothers with drug dependencies, whilst trying to manage their own difficulties, are not always aware of the child's needs and can be less engaged with the child - arousing issues of neglect. The Harrow Substance Misuse Service delivers a Hidden Harm Service to support parents with drug or alcohol problems to engage with treatment services and reduce risks to their children.

Figure 28: **Harrow substance misusers with children under 18 years**



3.6.3 The above data shows that in respect of:

- The proportion of adult Opiate Users living with children, Harrow is slightly lower than the national average

- The proportion of all other categories of substance misuse adult clients living with children, Harrow is higher than the than the national average
- Overall the proportion of adult substance misuse clients living with children in Harrow has decreased between 2015/16 Q3 and 2016/17 Q1.

3.7 Food poverty

3.7.1 Food poverty is also a significant issue in London. In a recent report, Beyond the Foodbank[49] it is reported that more than 100,000 Londoners turned to food banks for an emergency food parcel. In addition to this:

- 32,000 eligible children not getting free school meals
- 28% eligible families not receiving Health start vouchers
- 592,000 London kids at risk of hunger during holidays

The report defines food poverty as

> *"the absence of 'physical, social and economic access to sufficient, safe and nutritious food to meet people's dietary needs and food preferences for an active and healthy life, and the confidence that access can be assured in the immediate and long-term future" (Beyond the Foodbank 2015)*

3.7.2 Many of those living in poverty are in employment, a consequence of low wages and the proliferation of exploitative zero hours contracts, some can't find work at all. No official measurement for food poverty or food insecurity exists in the UK.

3.7.3 Households in London spend, on average, £57.90 on food per week. When faced with financial difficulties, this is one of the first areas where cut backs are made. Such cutbacks, however, come with consequences for health and wellbeing. The Department of Health defines food poverty as "the inability to afford, or to have access to, food to make up a healthy diet"5, suggesting that the key drivers of it are a low income, combined with high and rising food prices. Given the number of children in London living in low-income households, a high proportion are therefore vulnerable

[49] Beyond the food bank 2015

to food poverty. This work seeks to explore the experiences of these and other families across London.

3.7.4 The report suggests that families have changed their food purchasing behaviour. Around two in five parents (42%) in London say they have cut back on the amount of food they buy or the amount they spend on food on a daily/weekly/monthly basis. This can take various forms, such as buying less meat or restricting snacks, but our research shows that a significant proportion of families are cutting back on fruit and vegetables.

3.7.5 Close to one in ten (8%) parents reported that, at some point, their children have had to skip meals because they cannot afford to buy food. Overall, 15% of parents in London reported that their children always or often tell them they are hungry, with a further quarter (28%) reporting that they do so less regularly. Related research in London has highlighted teachers' concerns about children going to school hungry. It is not just parents and teachers who say that children are going hungry; children themselves also report going without food.

3.7.6 There were a reported 198 people supported by the Harrow food bank in September 2015, the last data recorded, data from the housing benefit team in Harrow[50]

Table showing the number of people accessing emergency relief schemes in Harrow

Help Scheme	Mar -15	Apr -15	May- 15	Jun -15	Jul- 15	Aug- 15	Sep- 15	Oct -15	Nov- 15	Dec- 15	Jan- 16	Feb -16	Mar- 16	Travel
Number of Emergency Relief Scheme awards	26	24	24	37	26	22	19	12	21	13	14	21	18	▽
Number of Discretionary Housing Payments	160	54	58	63	67	61	73	67	101	563	97	154	193	△
Number of people supported by Foodbank	271	156	183	160	169	64	198							△

4.0 Health inequalities and poverty

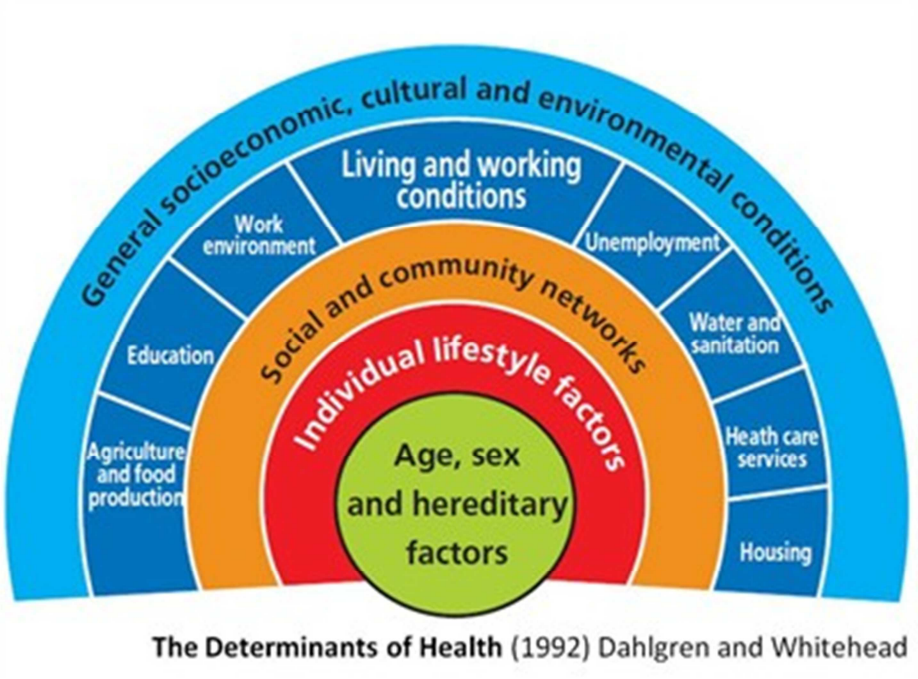
4.1 Health Inequalities

4.1.1 The social or "wider" determinants of health are summarised in the widely used Dahlgren and Whitehead's Determinants of Health model as shown below. The

[50] Harrow Economic and welfare reform impact dashboard

model depicts the many layers affecting a person's health which can also impact on a child's health and wellbeing.

Figure 29: **Determinants of Health Model**[51]



4.1.2 The social determinants of health which are the collective set of conditions in which people are born, grow up, live and work include housing, education, financial security, and the built environment as well as the health system. There is a close correlation between the social determinants of health, the pyramid of factors relating to child poverty and as we will see later the index of multiple deprivation, particularly

4.1.3 Evidence shows that inequalities in health largely reflect inequalities in society. There is considerable evidence connecting health outcomes with these social determinants and emphasising the importance of prevention of ill health which make it clear that:

- Action on health inequalities requires action across all the social determinants of health
- People in higher socio-economic groups generally experience better health. there is a social gradient in health , and work should focus on reducing this gradient

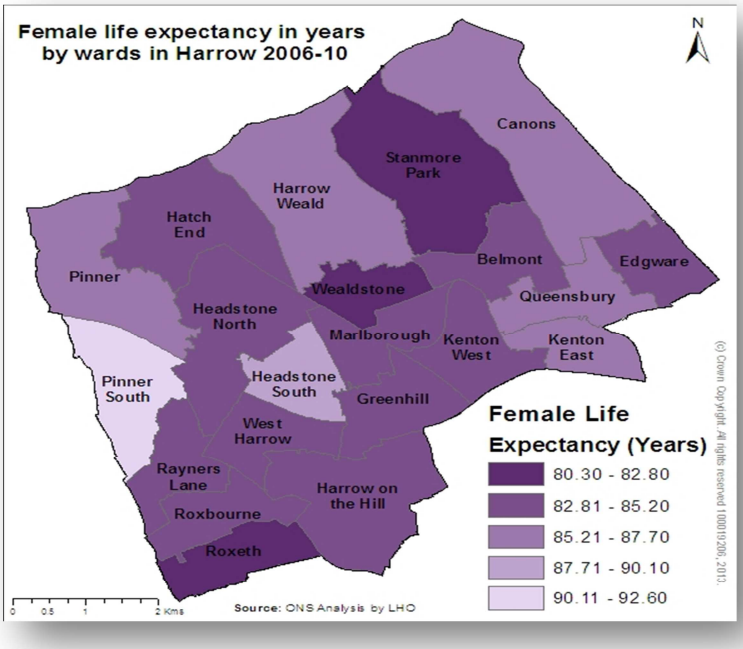
[51] *Source: G Dahlgren and M Whitehead*

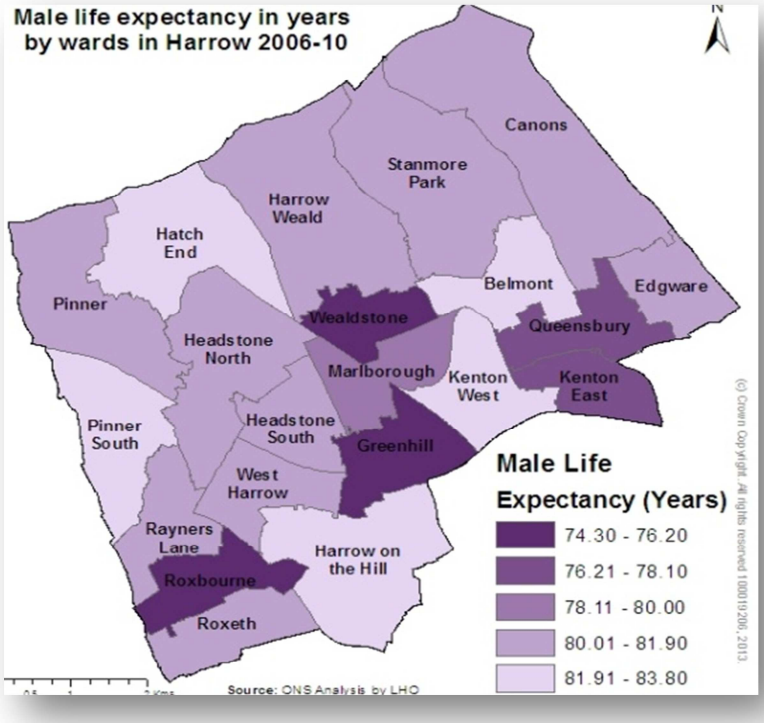
- Necessary to take action across all groups , albeit with a scale and intensity that is proportionate to the level of disadvantage
- Action to reduce health inequalities will have economic benefits in reducing losses from illness associated with health inequalities which currently account for productivity loses, reduced tax revenue , higher welfare payments and increased treatment costs- this is in addition to improving people's sense of wellbeing
- Effective local delivery of this requires empowerment of individual and local community

4.2 Link between deprivation and poor health

4.2.1 The difference in life expectancy in women in the most deprived areas in Harrow was 6 years lower then in the most affluent areas, but has decreased to 4 years. For men the gap started at less than 7 years but has widened to over 8 years. This change over time and the difference between male and females living in Harrow can be seen in the graph below.

Figure 30: **Map to show male and female life expectancy**





4.2.2 Evidence from Harrows JSNA suggests that Harrow is generally a healthy place and we perform better or similar to national levels for many health indicators although there are a few indicators where Harrow performs worse than the England average such as:

- High rate of statutory homelessness
- High rate of fuel poverty
- High percentage of adult social care users who do not have as much social contact as they would like
- High rates of low birthweight babies
- High rates of excess weight in 10-11 year olds
- Low amount of fruit and vegetables eaten
- Low amount of exercise taken
- People entering prison with substance misuse problems who are not already known to community services
- Low rates of cervical cancer screening
- Low rates of health checks
- Low rates for HPV, PPV and flu vaccination
- High rates of late diagnosis of HIV
- High rates of TB
- High rates of tooth decay in children

4.2.3 There is a close correlation between deprivation and poor health. In general, poor health indicators are found in the more deprived parts of the borough and better outcomes in the more affluent parts. On average, baby girls born in Pinner South can expect to live more than nine years longer than baby girls born in Wealdstone. Baby boys born in Headstone North can expect to live for more than eight years longer than baby boys in Wealdstone. It's no coincidence, given our income and financial security are important determinants of health and wellbeing, that we find poverty is linked to this inequality; we know 42% of children in Wealdstone are living in poverty compared to 9.3% in Pinner South. We need to urgently address this inequality and ensure that **everyone** in Harrow has an opportunity to start, work, live and age well – the Health and Wellbeing Board vision for Harrow.

4.2.4 The table below shows how children's health and wellbeing in Harrow compared with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average.

Table 1: Child Health public health profiles summary for 2016

Harrow Child Health Profile — March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	15	4.2	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	4	6.6	12.0	19.3	5.0
Health protection	3 MMR vaccination for one dose (2 years) >=90% <90%	2,909	91.3	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	2,969	93.2	95.7	79.2	99.2
	5 Children in care immunisations	65	68.4	87.8	64.9	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	2,301	70.4	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,588	65.3	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	120	1.5	4.7	9.0	1.5
	10 First time entrants to the youth justice system	81	346.1	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	7,040	14.7	18.6	34.4	6.1
	12 Family homelessness	255	2.9	1.8	8.9	0.2
	13 Children in care	165	29	60	158	20
	14 Children killed or seriously injured in road traffic accidents	7	14.1	17.9	51.5	5.5
Health improvement	15 Low birthweight of term babies	138	4.3	2.9	5.8	1.6
	16 Obese children (4-5 years)	267	9.2	9.1	13.6	4.2
	17 Obese children (10-11 years)	511	21.2	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	35.1	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	75	557.5	322.0	1,406.8	11.7
	20 Under 18 conceptions	62	14.3	24.3	43.9	9.2
	21 Teenage mothers	8	0.2	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	10	17.5	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	15	50.2	88.8	278.2	24.7
Prevention of ill health	24 Smoking status at time of delivery	144	4.7	11.4	27.2	2.1
	25 Breastfeeding initiation	2,690	88.7	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	-	-	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	13,957	798.6	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	332	70.1	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	207	73.0	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	151	253.5	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	35	61.8	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	72	168.7	398.8	1,388.4	105.2

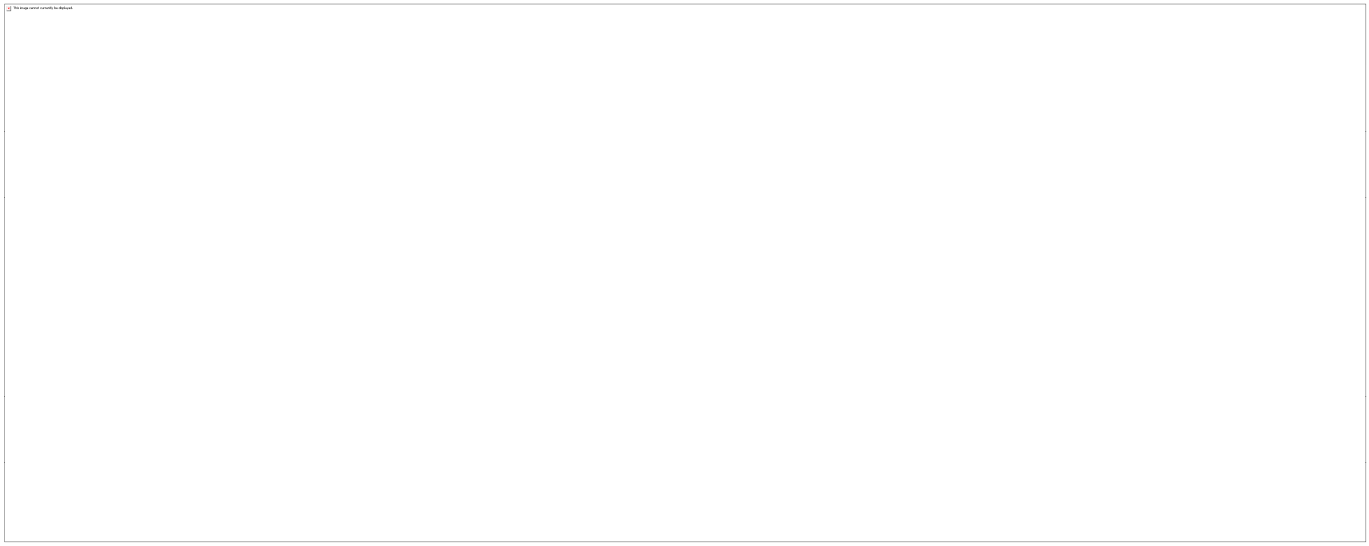
Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

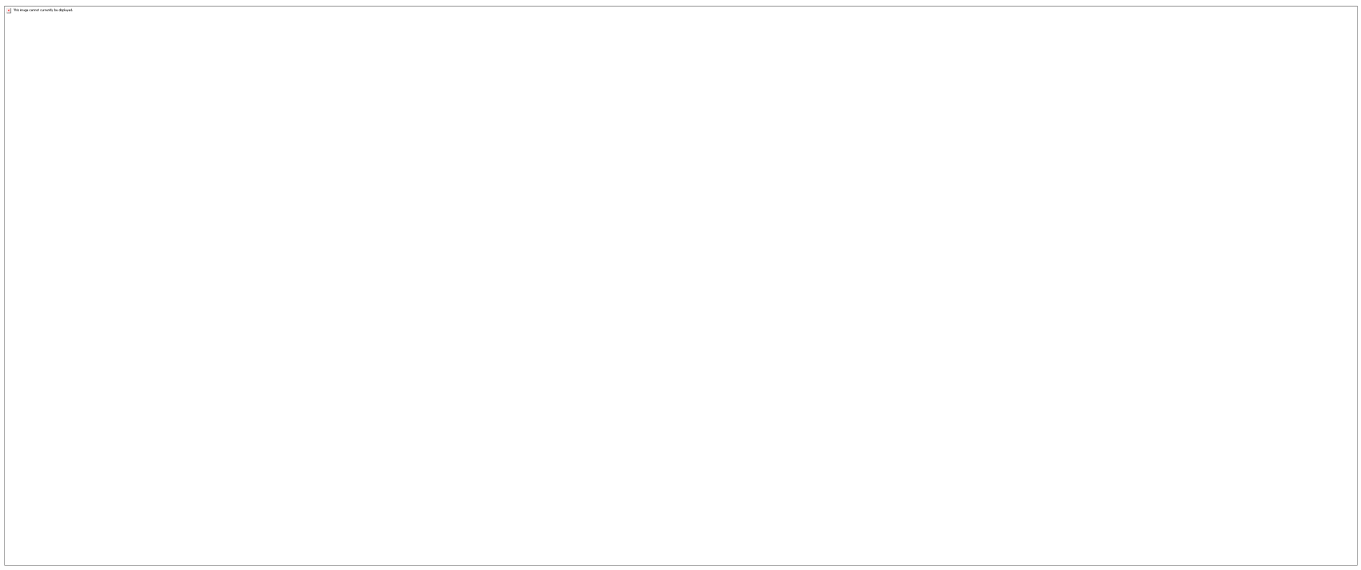
4.2.5 Harrow shows worse outcomes across six areas, for immunisations for children in care, low birth weight babies, tooth decay, childhood obesity, hospital admissions and A&E attendances for 0-4 year olds.

4.2.6 Analysis of tooth decay following the dental public health epidemiology programme for oral health for 5 year olds shows that Harrow children have very bad teeth, with 34.2% of children with decayed or missing filled teeth (dmft) worse than Brent (30.8%) and Hounslow (30.5%) . Ealing is the worst in West London with 39%.

4.2.7 In terms of comparing with the UK we are still pretty bad, the worst in the country is Blackburn and Darwen with 55.7% and the LA with the best teeth in the country are South Gloucestershire with only 14.1%.

Figure 31: **Children with decayed or missing teeth**





4.3 Obesity

4.3.1 Obesity is a global epidemic. For adults and children overweight and obesity are assessed by body mass index (BMI) and this is reflected in both the Public Health Outcomes Framework 2013-6 indicators on excess weight. Obesity is a major contributory factor towards ill health and premature death in Harrow and in England. The four most common health problems related to obesity are:

- High blood pressure
- Coronary heart disease
- Type 2 diabetes
- The risk of several cancers is higher in obese people, including endometrial, breast and colon cancer[52]

4.3.2 Analysis of the Health Survey for England data shows then some wards particularly in the South and East of the borough had higher prevalence of obesity[53]. For example there exists up to a 6% more obesity in wards such as Roxeth, Roxbourne and Wealdstone when compared to Harrow on the Hill or Canons[54]. An important factor in reducing and preventing obesity is being physically active. Harrow has a similar proportion of adults that are physically active* (54.5%) than the England average (56.0%)[55].

4.3.3 Childhood obesity increases the risk of cardiovascular disease and diabetes in later life. In Harrow childhood obesity rates are increasing with 9.3% of Reception aged children being overweight or obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6. Low levels of physical activity and high levels of fat and sugar in children's diet are a significant cause, the sugar also leading now to a significant amount of preventable tooth decay in children as young as five years old.

4.3.4 Children's weight is measured by the National Child Measurement Programme (NCMP) at Reception (age 4-5) and Year 6 (age 10-11). Public Health England

[52] National Obesity Observatory – The Health Risks of Obesity www.noo.org.uk accessed online 18/2/14
[53] Harrow Health Profile 2012, Website www.apho.org.uk accessed online 10/9/13
[54] Harrow Obesity Needs Assessment 2014, Barnet and Harrow Public Health Team, Harrow Council, p26
* Physically active is defined as adults achieving at least 150 minutes of physical activity per week (Harrow Health Profile 2013, APHO)
[55] Harrow Health Profile 2012, Website www.apho.org.uk accessed online 10/9/13

compared NCMP obesity data to the 'benchmark' for England and rated Local Authorities as better, similar or worse. Harrow has similar obesity prevalence to England for both Reception (9.3% England, 10.2% Harrow), and Year 6 (18.9% England, 20.4% Harrow)[56]. In terms of excess weight (obese and overweight) Harrow also has a similar prevalence to England for Year 6 (England 33.3%, Harrow 34.2%) and Reception (England 22.2%, Harrow 21.2%)[57]. The risk of obesity doubles between age 4 and 11 in Harrow.

Harrow has **similar** obesity prevalence to England for Reception and significantly **worse** than the England average for Year 6. When all children who are above a healthy weight (obese and overweight) are considered, Harrow is **better** than the England average for Reception Children and **similar** to the England average for Year 6 children.

Figure 32: **Prevalence of obesity & excess weight for Reception and Year 6 children in Harrow (2014/15)**

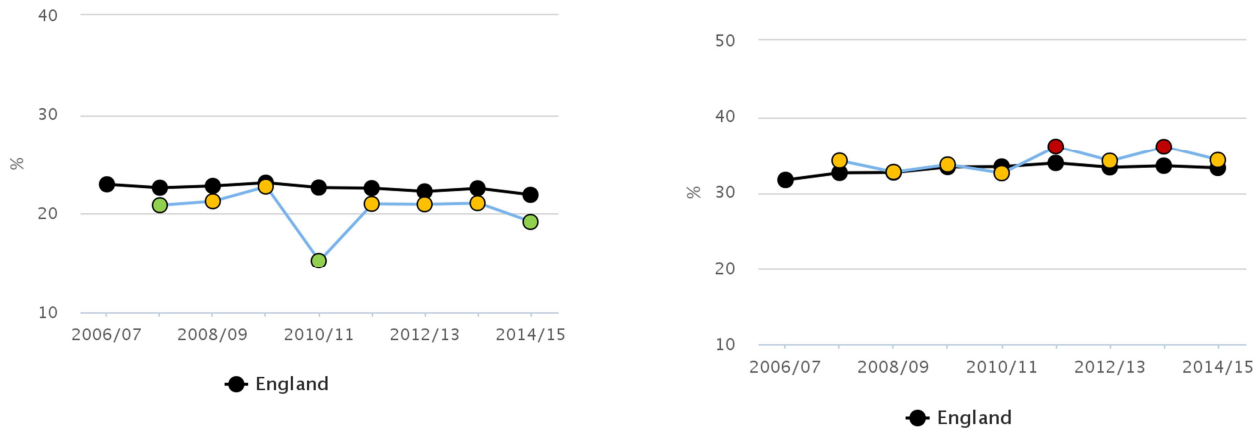
		England	London	Harrow
Reception	Obese	9.1%	10.1%	9.2%
	Excess weight*	21.9%	22.2%	19.2%
Year 6	Obese	19.1%	22.6%	21.2%
	Excess weight	33.2%	37.2%	34.3%

Worse than the England Average | Similar to the England Average | Better than the England Average

*The term 'excess weight' is applied when an adult or child is classified as overweight **or** obese. Sometimes this is also known as 'above a healthy weight'.

[56] Public Health England NCMP Local Authority Profiles 2012/13 http://fingertips.phe.org.uk accessed online 11/2/14/
[57] Public Health England NCMP Local Authority Profile 2012/13 http://fingertips.phe.org.uk accessed online 10/02/14

Figure 33: **Harrow's prevalence of overweight (including obese) from 2006/7-2012/13 for Reception and Yr 6**

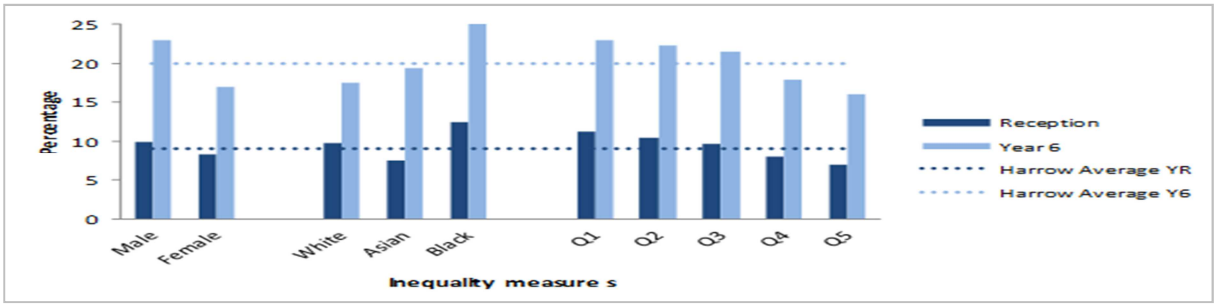


In reception obesity (including overweight) rates have fallen slightly, in line with the national average apart from in 2011 when Reception obesity levels fell significantly below the England average to 6.9%. In Year 6 rates are rising gradually, in line with the national average. Apart from in 2011/12 and 2013/14 where levels rose to 36.1%.

Prevalence of obesity was found to be higher among boys than girls in both school years. In reception, 9.9 per cent of boys and 8.2 per cent of girls were classified as obese. In year 6 the percentages were 23 per cent and 16.9 per cent respectively.

Obesity prevalence was higher than the national average for children in both school years in the ethnic groups 'Asian or Asian British' (7.4% in reception and 23.8% in year 6) and 'Black or Black British' (19.1% and 25.1%).

Figure 34: **Prevalence of obesity among children in Year 6 and Reception, 5 years data combined**

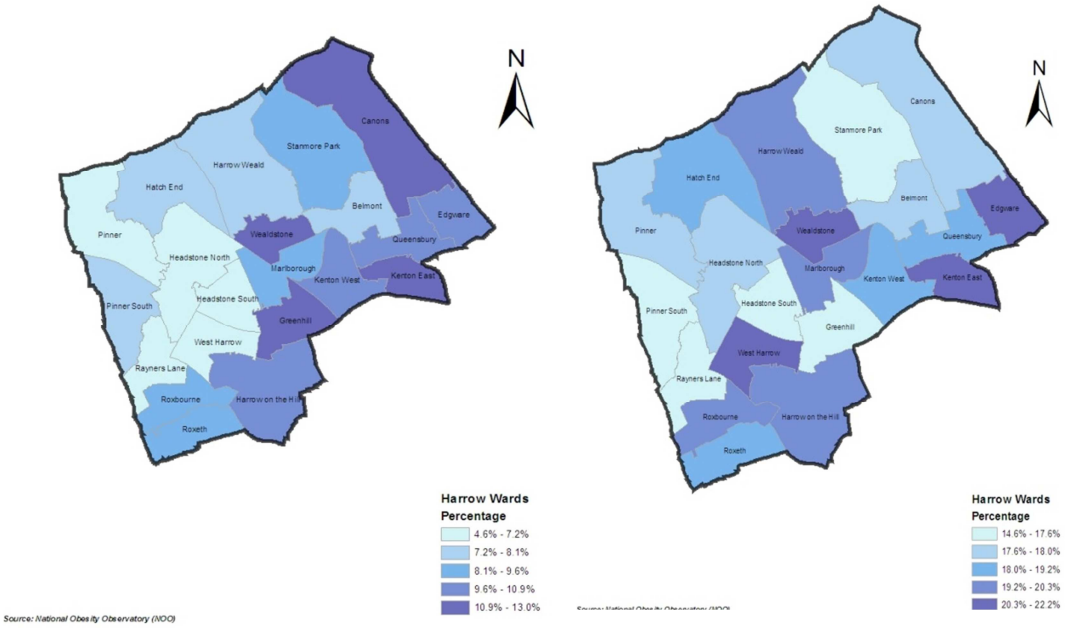


As in previous years, a strong positive relationship exists between deprivation and obesity prevalence for children in each school year. The obesity prevalence among reception year

children attending schools in areas in the most deprived decile (Q1) was 11.9 per cent compared with 6.5 per cent among those attending schools in areas in the least deprived decile. Similarly, obesity prevalence among year 6 children attending schools in areas in the most deprived decile was 24.7 per cent compared with 13.1 per cent among those attending schools in areas in the least deprived decile.

Below is the mapped prevalence of obesity in the electoral wards in Harrow for both Reception and Year 6. Over both age groups there is higher prevalence in wards in the South and East of Harrow.

Figure 35: **Harrow's prevalence of obesity by ward from 2009/10- 2011/1 for Reception and Yr 6**



4.3.5 The Harrow Breastfeeding service is exemplary, with a dedicated team of volunteers and real improvements in breastfeeding initiation demonstrated, Harrow is one of 3 London Boroughs to receive reaccreditation from UNICEF Baby Friendly Initiative.

4.3.6 Challenges include the absence of a tier two weight management services for children, issues regarding NCMP data sharing between partners and the absence of a clear pathway for NCMP follow up. There are similar issues with BMI data sharing between midwifery and Health Visiting services.

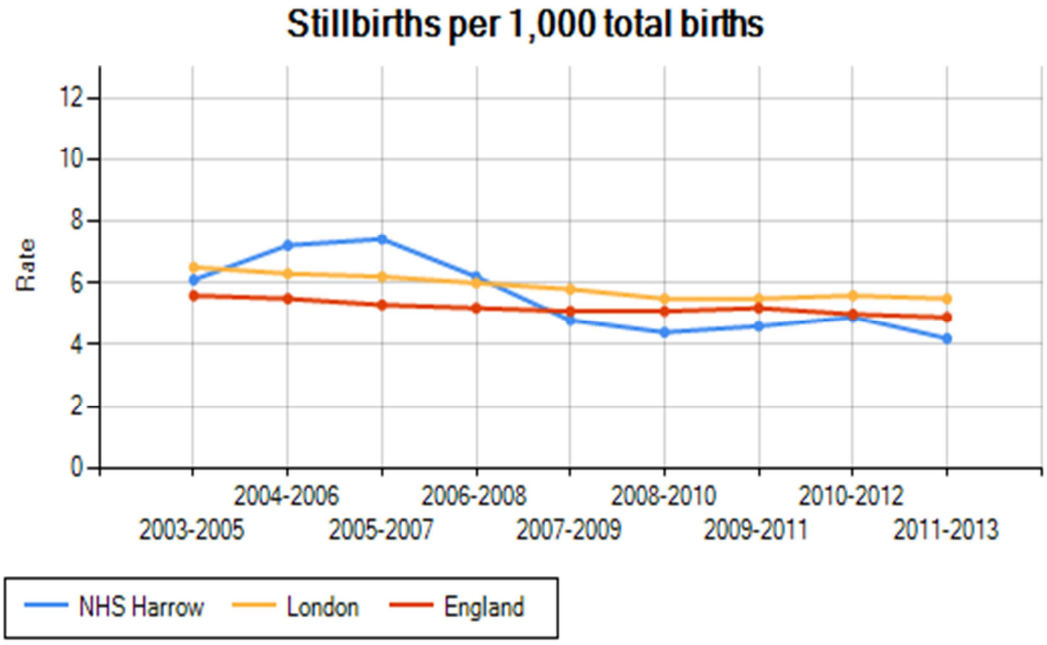
Schools are engaged with healthy eating, active travel and physical activity with many interventions happening. The removal of the funded Public Health programmes for Healthy Eating and Healthy School London next year may be a blow but a legacy of information will remain. Continual areas of difficulty include the lack of central coordination of school catering and the absence of nutritional support available which is due to pressures on the community dieticians.

4.4 Low birth weight and infant mortality

4.4.1 Babies born below normal birth weight are more vulnerable to infection, developmental problems and even death in infancy as well as longer term consequences such as cardiovascular disease and diabetes in later life[i]. Low birth weight can be caused by a variety of factors but there is particular concern to eliminate smoking and substance use in pregnancy as a cause. Childhood poverty leads to premature mortality and poor health outcomes for adults[ii]. Children from poorer backgrounds are also at more risk of poorer development.

4.4.2 Stillbirth rates in the UK are higher than might be expected in a high income country: approximately one in 200 babies is still born (4.9 stillbirths per 1,000 births). There have been approximately 3,300 stillbirths per year in recent years.

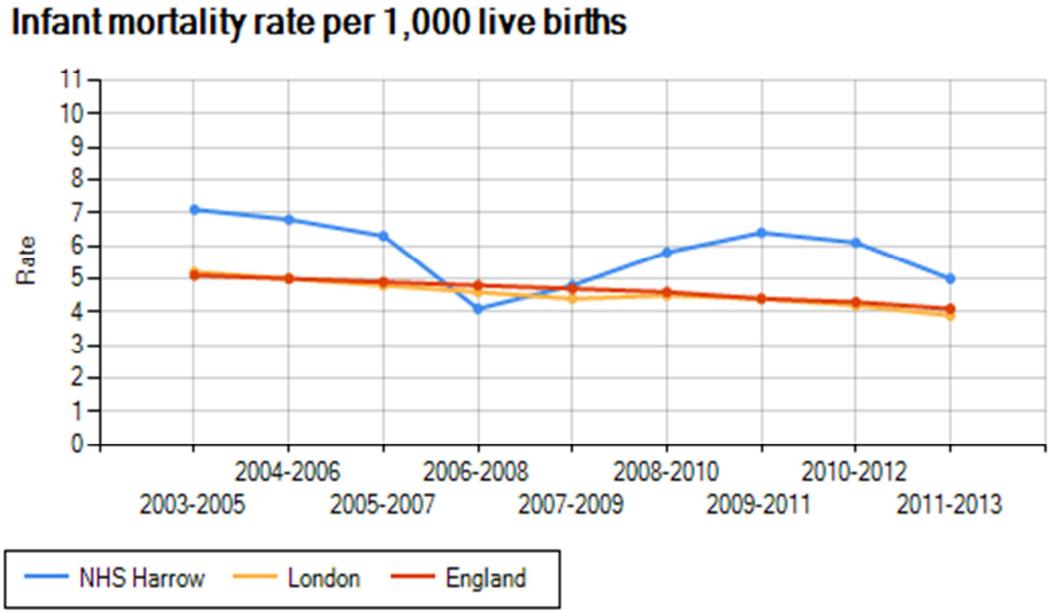
4.4.3 A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. The **stillbirth rate** is the number of stillbirths per 1,000 total (live and still) births. There were 45 stillbirths in NHS Harrow in the period 2011-2013: a stillbirth rate of 4.2 stillbirths per 1,000 births. The London rate was 5.5, and nationally the rate was 4.9.



4.4.4 Infant mortality is also high, with one in 250 (4.1 in every 1,000) infants dying in their first year of life. There have been approximately 2,800 infant deaths per year in recent years. Infant mortality is a significant factor in overall life expectancy, with 61% of all deaths in children (0-19 years) being infant deaths1.

4.4.5 The **infant mortality rate** is the number of infants dying before their first birthday per 1,000 live births. There were 18 infant deaths in NHS Harrow in the period 2011-2013: an infant mortality rate of 5.0 per 1,000 births. The London rate was 3.9, and nationally the rate was 4.1.[58]

[58] Source: Public Health Outcomes Framework: www.phoutcomes.info/public-health-outcomes-framework

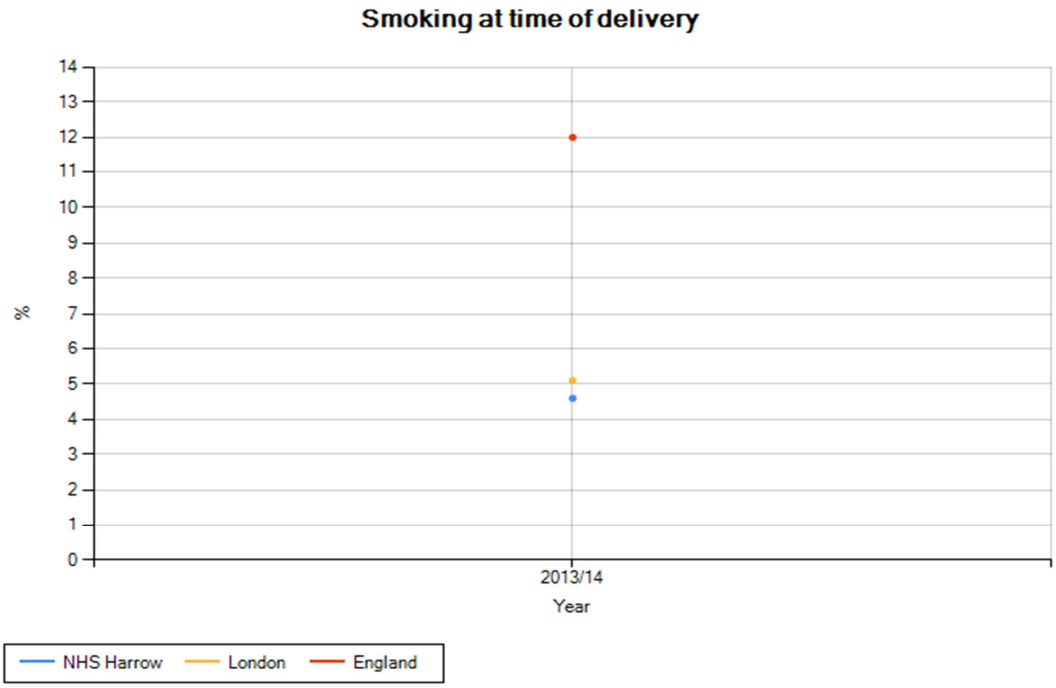


4.4.6 More than 300 babies die per year in the UK from unexplained causes. The rate has been falling since the late 1980s. Risk factors include parental smoking (during pregnancy and in the home), low birthweight, late antenatal care and babies born to younger mothers. Most of these deaths occur within the first six months of life. Many of these stillbirths and deaths are preventable. Reducing infant deaths and stillbirths is a priority for the NHS and government, captured in the NHS2 and Public Health Outcomes Frameworks.

There was considerable variation within England in the period 2011-2013, with more than a three-fold difference in local stillbirth rates from the lowest to the highest; for infant mortality there was more than a four-fold difference from the lowest to the highest. Although the causes of stillbirths are often unclear, there are associated risk factors1,5. These include, but are not limited to:

- Maternal age
- Smoking in pregnancy
- Maternal obesity
- Socioeconomic position
- Multiple births
- Influenza

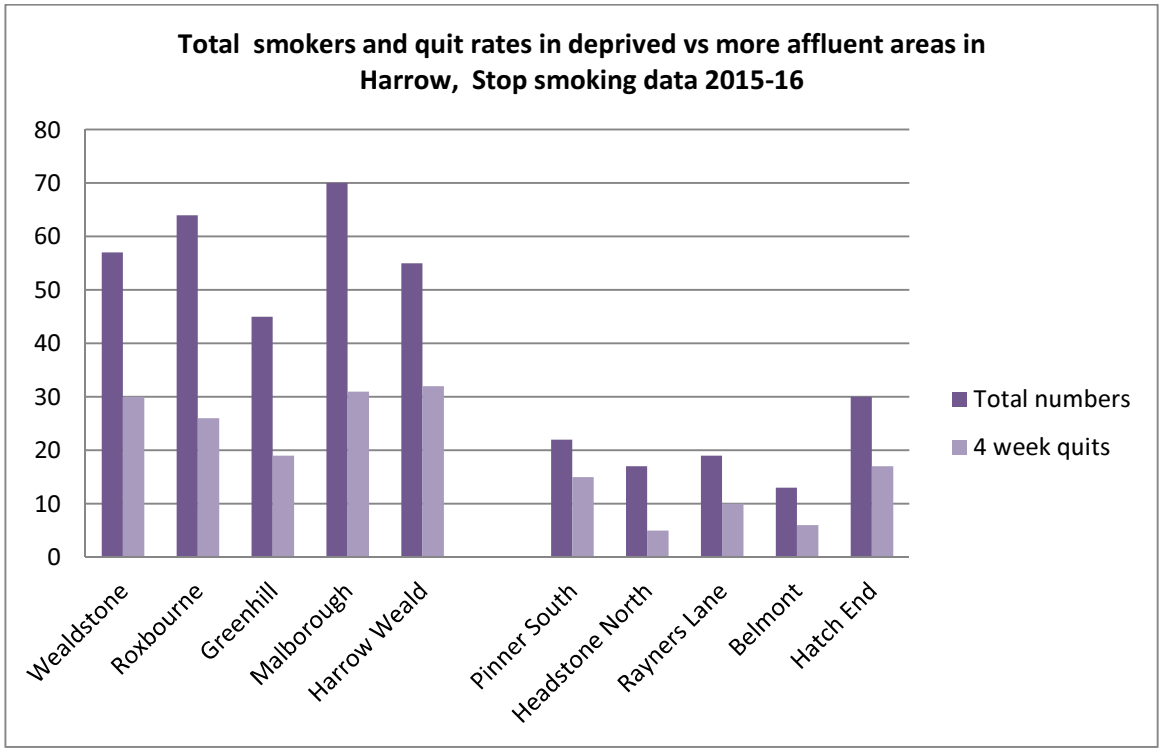
4.4.7 Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. There is also an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy7.



4.4.8 Poor mental health in children and young people is linked to self-harm and suicide, poorer educational attainment and employment prospects, antisocial behaviour and offending, social relationship difficulties and health risk behaviour (smoking, substance misuse, sexual risk, poor nutrition and physical activity). Half of adult mental health problems start before the age of 14. Child adversity of all forms accounts for 30% of adult mental disorder. Looked after children are therefore more vulnerable to poor mental health. Youth offending could be a consequence and cause of unmet health needs.

4.4.9 The graph below shows data taken from the stop smoking service in Harrow. The graph shows that there is a significant difference between the deprived areas and the number of smokers. Wealdstone, Roxbourne, Greenhill, Marlborough and Harrow Weald show higher numbers of smokers than there are in Pinner South, Rayners Lane, Belmont and Hatch End.

Figure 36: **Total smokers and quit rates in Harrow's deprived areas**



4.5 Speech and Language

4.5.1 Disadvantage, poor socio-economic factors and a language poor early environment have been shown to correlate with Speech and Language Communication Needs (SLCN) in terms of early language development which, whilst not necessarily a result of a long term underlying impairment, can result in poorer learning outcomes and children not achieving their potential. In the most disadvantaged areas of England, up to 50% of children at school entry present with communication skills that are below those expected for their age.

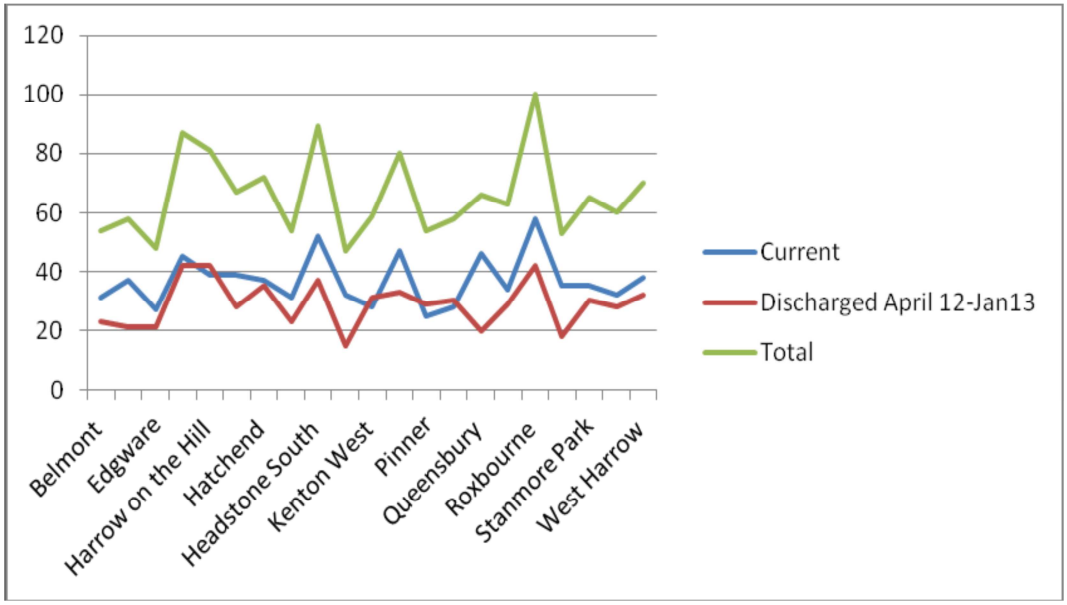
4.5.2 Socially disadvantaged children are much more likely than other children to be identified as having SLCN, i.e. that there is a strong 'social gradient'. Pupils entitled to free school meals, i.e. children whose parents are receiving any of a number of state benefits, are 1.8 times more likely than other pupils to be identified as having SLCN. Pupils living in a more deprived neighbourhood are 1.3 times more likely than other pupils to be identified as having SLCN. This means that pupils entitled to free school

meals and living in a more deprived neighbourhood are 2.3 times more likely to be identified as having SLCN than those not so socially disadvantaged.[59]

4.5.3 The Marmot review points out that reducing social and health inequalities requires a focus on improving educational outcomes. It also identifies communication skills as being necessary for 'school readiness' .Improving the communication development of socially disadvantaged children would therefore have an important wider benefit in terms of promoting social equity

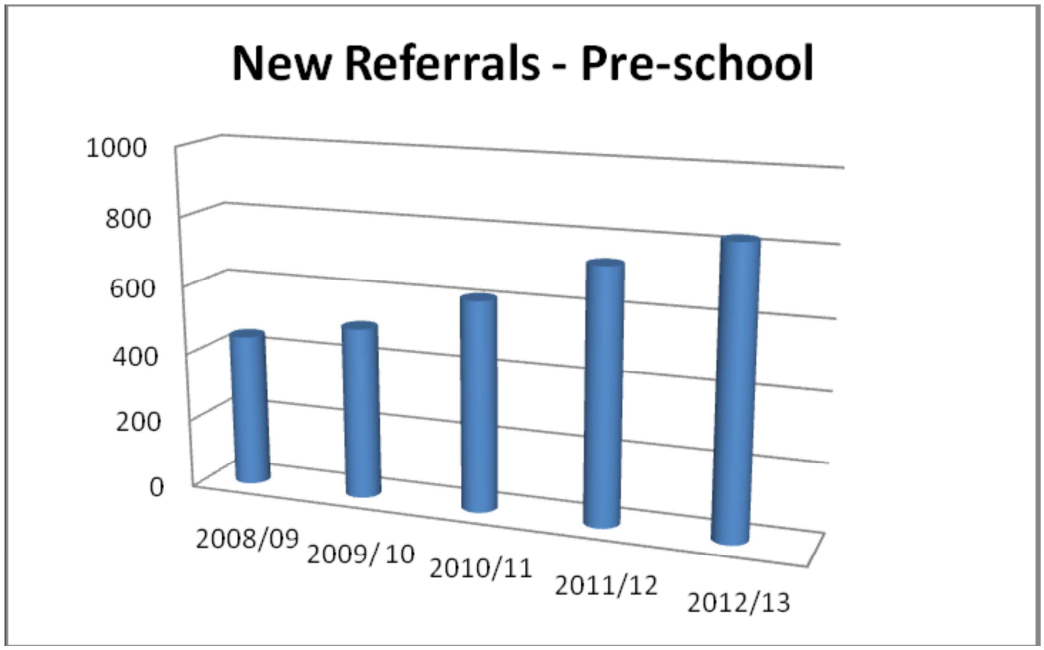
4.5.4 An analysis in January 2013 of children aged 0-4 years, accessing SLT services mirror LSOA with the wards of Roxbourne, Marlborough, Greenhill, Headstone South and Queensbury having significantly higher numbers of children with SLCN.

Figure 37: **Children accessing SLT services**



4.5.5 Reviewing trends of new referrals of pre-school children over a five year period indicates almost 100% rise in demand with 445 children receiving an assessment in 2008/9 compared with 824 children in 2012/13.

[59] http://www.dcsf.gov.uk/bercowreview/docs/7771-DCSF-BERCOW.PDF cited in 'Report of Speech, Language and Communication Needs – Task and Finish Group'



4.5.6 Caseloads reveal growing numbers of pre-school children with special needs and persistent SLCN with an increase of approximately 35% from 200 to 290. This is also reflected in the growing caseloads of children with SLCN across Harrow's primary schools.

4.5.7 The support provided for children's SLCN is normally understood in terms of three levels:

- Universal provision (for all children), i.e. high quality inclusive provision with a language rich environment which promotes all children's speech language and communication development.

- Targeted provision for children who are at risk of speech, language or communication difficulties or who need additional support that can be provided by skilled early years practitioners (EYP) or parents and guided by specialists such as SLT's within mainstream settings

- Specialist provision for children with severe and specific SLCN who require specialist interventions provided or supported by a speech and language therapist in collaboration with EYP and parents.

4.6 Conduct disorder

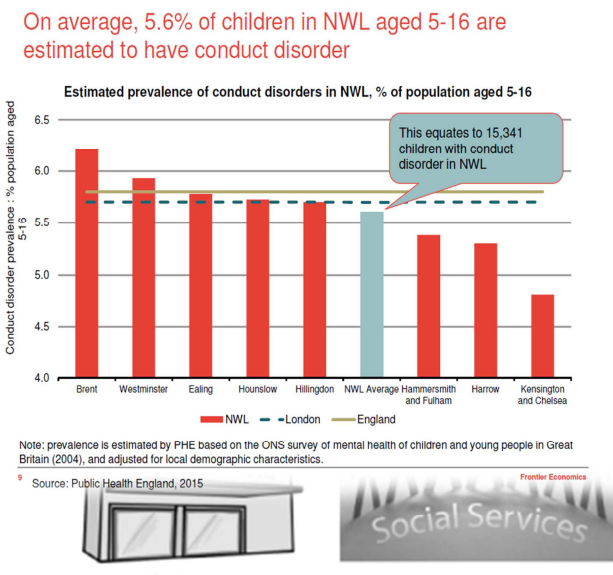
4.6.1 Conduct disorders are “characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age appropriate social expectations.” (National Institute for Health and Care Excellence, 2013)

4.6.2 There are a number of different types of conduct disorder, including ‘oppositional defiant disorder,’ which characterises the anti-social behaviour more commonly observed amongst those aged 10 and younger such as disobedience, hostility towards authoritative figures, and difficulty forming relationships.

4.6.3 Conduct disorders frequently exist alongside other mental health problems, particularly Attention-deficit hyperactivity disorder, which characterises a group of behavioral symptoms that includes inattentiveness, hyperactivity, and impulsiveness. (NHS conditions)

Figure 38: **A) Estimated prevalence of conduct disorders in NWL aged 5-16 and B) impact on health, education, crime and employment into adulthood C) estimated cost to public purse**

A



B

C

4.7 Domestic violence

4.7.1 The number of recorded domestic abuse incidents in all forces of England and Wales has been increasing in recent years.

4.7.2 Since 2010/11 the total domestic incidents recorded across the 32 boroughs that the MPS cover have increased by 22%; domestic offences, on the other hand, have increased at a higher rate with 2015/16 seeing an increase of 53% compared to 2010/11. When considering the long term trend for both domestic incidents and recorded domestic abuse offences since the inception of the Police and Crime Plan, this upward trajectory is still apparent, with increasing recording in all categories except domestic abuse homicide offences. This increase is believed to be caused, in part, by police forces improving recording practices.

4.7.3 Harrow compares favourably with other London Boroughs in terms of levels of DV recorded. In terms of domestic incidents per 1,000 population, Harrow has 12.5, the second lowest. This compares to a high of 27.2 in Barking and Dagenham; 17 in Ealing and 16.2 in Brent. There is a high correlation between population size and recorded notifiable domestic abuse offences. Harrow has a low “volume” of domestic incidents, but more importantly, has the second lowest number of domestic incidents per 1000 population, when compared to other London Boroughs.

4.7.4 We have an IDVA based in NWP hospital and although the referrals for this post are low, they are in line with the other hospital placed IDVAs across London. This service deals with domestic violence cases as well as sexual violence, honour based violence, forced marriage and female genital mutilation. The IDVA deals with high risk cases, and has supported clients through the criminal justice system, housing and other various matters with monthly MARAC referrals.

4.8 Tuberculosis rates

TB can be seen as a barometer of health inequalities and tackling it will play a key role in enabling local authorities and the NHS to successfully reduce health

inequalities across England. Certain groups are disproportionately affected by TB and this under-served population includes:

- ethnic minority groups
- refugees and asylum seekers
- those with a history of or current homelessness
- those with a history of or current imprisonment
- those with drug or alcohol misuse issues

4.8.1 People with a past or current social risk factor are at increased risk of TB and in 2015 there was an increase in the number of TB cases with these social risk factors. Most of the cases are from people who were not born in the UK. Harrow has seen a large increase in the number of migrants from eastern Europe where there is a higher prevalence of TB and many are in the private rented sector.

5.0 Education and attainment of children

5.1 Early years foundation stage educational attainment levels

5.1.1 The EYFS Profile is a teacher assessment of children's development at the end of the EYFS (the end of the academic year in which the child turns five). It should support a smooth transition to Key Stage 1 (KS1) by informing the professional dialogue between EYFS and KS1 teachers. This information should help Year 1 teachers plan an effective, responsive and appropriate curriculum that will meet the needs of all children. The Profile is also designed to inform parents or carers about their child's development against the early learning goals (ELGs).

5.1.2 Following an independent review of the EYFS by Dame Clare Tickell, a new Profile was published in March 2012. The new profile and revised EYFS have a stronger emphasis on the three prime areas which are most essential for children's healthy development**.** These three areas are: communication and language; physical; and personal, social and emotional development**.** The new profile made changes to the way in which children are assessed at the end of the EYFS. The new profile requires practitioners to make a best-fit assessment of whether children are emerging, expected or exceeding against each of the new 17 ELGs.

5.1.3 Standards have continued to rise in the EYFS in response to the priority given by schools and the LA to this area. Whilst standards have risen, the gap between the lowest attaining 20% of pupils and the rest of the cohort has continued to narrow (2013/14 – 34.9%) but is still above the national average of 33.9%. At the same time the key indicator of a good level of development has shown a significant improvement from 45% in 2012-13 to 61% in 2013-14. Demographic changes are having an impact on assessments at entry level.

Figure 39: **Early Years Foundation Stage outcomes**

Good level of development (1)	2011-12	2012-13	2013-14
Harrow	**60%**	**45%**	**61%**
Statistical Neighbours	65%	50%	60%
England	64%	52%	60%

Table 2: The percentage inequality gap in achievement across all the Early Learning Goals

The percentage inequality gap in achievement across all the Early Learning Goals	2011-12	2012-13	2013-14
Harrow	**30.8%**	**37.9%**	**34.9%**
Statistical Neighbours	30.9%	34.4%	33.3%
England	30.1%	36.6%	33.9%

5.1.4 The percentage gap in achievement between the lowest 20 per cent of achieving children in a local authority (mean score), and the score of the median. The pupil characteristics of the 2013-14 EYFS cohort help to better understand Harrow's 2013-14 results. Of the 3,070 pupils in Harrow's schools at the end of Reception a majority came from the following ethnic groups . 61.1% of the 2013-14 cohort stated a language other than English as their first language, with a substantial majority of the pupils of the main ethnic groups not stating English as their first language

Table 3: Number of EYFS pupils with English as a second language

Ethnic Group	Total Pupils	% Other
Indian	683	75%
Asian other	577	88%
White other	437	94%
Any Other Ethnic Group	130	90%
Pakistani	148	73%
Black African	156	67%
Mixed other	97	37%
Mixed White Asian	68	44%
White British	377	7%
Unclassified	128	13%
Chinese	20	65%
Bangladeshi	18	72%
Black other	25	48%
Mixed White Black African	30	37%
Mixed White Black Caribbean	54	6%
Black Caribbean	80	1%
White Gypsy Roma	1	100%
White Irish	31	0%
White Irish Traveller	10	0%
Total 2013-14 EYFS Pupils	**3070**	**63%**

5.2 School years education and attainment levels

5.2.2 There are 61 schools in Harrow, 44 primary schools with nursery classes in 26 of these schools, 11 high schools, 1 all-through free school, 2 primary special schools, 2 high special schools and 1 pupil referral unit. 8 high schools in Harrow have acquired academy status. A high proportion of Harrow's schools are judged good or outstanding. As at October 2014 87% (51 schools) of Harrow's schools were good or outstanding, with 51% (30 schools) judged outstanding, 36% (21 schools) judged good, 12% (7 schools) requiring improvement and 2% (1 school) judged inadequate.

5.2.4 The table below shows that a majority of Harrow's high school pupils reside in the borough of Harrow. More pupils reside in the Roxbourne (6.2%) and Wealdstone (5.9%) wards, and less than 250 pupils reside in Pinner (1.9%). A significant number of secondary age pupils reside in boroughs outside of Harrow.

Table 4: Harrow schools' Year 7 to Year 13 pupils Harrow ward of residence[60]

Ward	Number of pupils	Percentage of pupils
Roxbourne	785	6.2%
Wealdstone	745	5.9%
Marlborough	673	5.3%
Queensbury	662	5.3%
Harrow Weald	590	4.7%
Headstone South	579	4.6%
West Harrow	555	4.4%
Rayners Lane	542	4.3%
Roxeth	528	4.2%
Headstone North	517	4.1%
Belmont	516	4.1%
Kenton West	504	4.0%
Edgware	492	3.9%
Kenton East	453	3.6%
Harrow on the Hill	445	3.5%
Greenhill	376	3.0%
Stanmore Park	346	2.7%
Hatch End	303	2.4%
Canons	291	2.3%
Pinner South	275	2.2%
Pinner	238	1.9%
Harrow wards total	**10,415**	**82.7%**
Out of borough/Unknown	**2,186**	**17.3%**
Grand total	**12,601**	**100%**

5.2.5 Schools in Harrow are amongst the best performing in the country and this has, on

[60] *Source – January 2014 School Census*

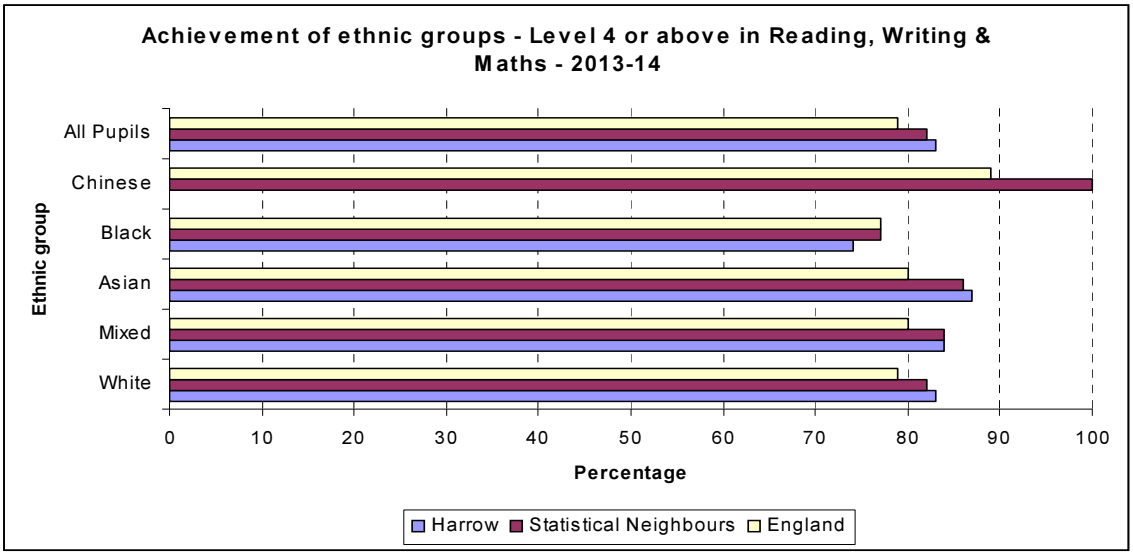
the whole, been maintained over a number of years. The Performance and Standards report provides a summary analysis for all LA maintained and Academy schools' performance for 2014, as well as trends over the past three years. The information is based on the Department for Education data (DfE), EYFS performance data. However there are some inequalities in education and attainment amongst ethnic groups, children with SEN, those eligible for FSM and those whose first language is not English.

5.2.6 Despite the strong profile of performance in Harrow, there are significant groups of pupils that do not attain as well as their peers. These groups often attain in line with their group nationally but do not attain as well as their peers in Harrow. These underachieving groups within Harrow are as follows:

- specific ethnic groups, especially black pupil groups, at Key Stage 2 and 4.
- those with Special Educational Needs (SEN)
- those eligible for Free School Meals (FSM)
- those speaking a language other than English as their first language

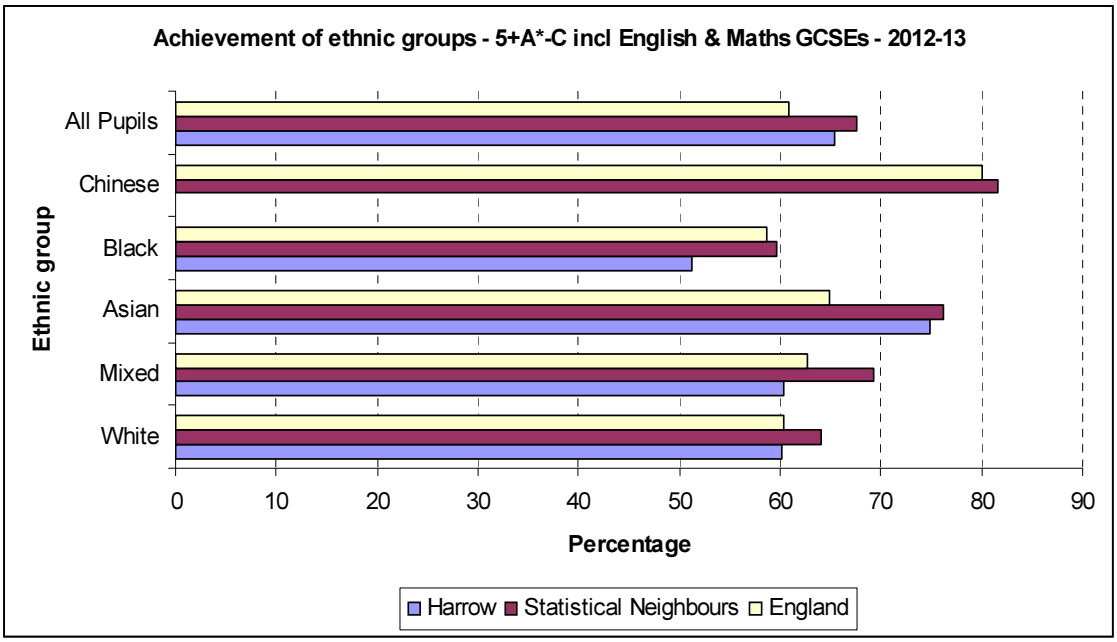
5.2.7 The chart below for 2013-2014 shows that whilst all pupils in Harrow have performed above both the national and Harrow's statistical neighbour averages particular ethnic groups within Harrow do not fare so well. The achievement of Harrow's black pupils is not only below both the national average as well as the statistical neighbour average; it is also the lowest in all of the ethnic groups included in the chart. The results of Harrow's Asian and White British pupils are significantly above the national average as well as above the statistical neighbour average.

Figure 40: **Graph showing the attainment of ethnic groups in Harrow schools, for 2013-14**



5.2.8 No comparative data for 2013-14 has been published; the chart below shows that Harrow's 2012-13 results. These showed performance below statistical neighbours for every ethnic group included, with the Black pupils performing well below all of the other ethnic groups, as well as the statistical neighbour and national averages.

Figure 41: **Achievement of ethnic groups in Harrow schools, 2012-13**



5.3 Children with special educational needs (SEN)

5.3.1 Children have special educational needs (SEN) if they have a learning difficulty which calls for special educational provision to be made for them. Further definitional and background information is provided in the *Special Educational Needs Code of Practice.*

5.3.2 Overall the attainment of pupils with Special Educational Needs (SEN), at Key Stage 2 relative to this group nationally, compares well with both national and statistical neighbour averages as can be seen in the tables below. However, the gap in Harrow has increased over the last three years. The most recent results have shown an increase in the gap of 52.1, which is higher than that of Harrow's statistical neighbours (46.2%) and in-line with the national gap (51.9%).

Table 5: The SEN/non-SEN gap – achieving Level 4 or above in Reading, Writing & Maths in Key Stage 2 tests[61]

The SEN/non-SEN gap – achieving Level 4 or above in Reading, Writing & Maths in Key Stage 2 tests	2011-12 %	2012-13 %	2013-14 %
Harrow	47.5	48.8	52.1
Statistical Neighbours	51.0	49.9	46.2
England	55.0	53.3	51.9

5.3.3 For young people with a Special Educational Need, the gap at GCSE has fluctuated over the last three years. In 2012-13 Harrow's gap (49.1%) was higher than both its statistical neighbours (46.5%) and the national average (47.2%).

Table 6: The SEN/non-SEN gap – achieving 5 A*- C GCSE inc. English and Maths[62]

The SEN/non-SEN gap – achieving 5 A*- C GCSE inc. English and Maths	2010-11 %	2011-12 %	2012-13 %
Harrow	51.0	46.3	49.1
Statistical Neighbours	49.8	46.5	46.5
England	47.6	47.0	47.2

5.3.4 There has been an increase in the number of children in Harrow's high schools with the primary need:

[61] *Source: DfE Statistical First Release*
[62] *Source DfE Statistical First Release*

- Autistic Spectrum Disorder - this has consistently increased over the last few years, with a 86.8% increase from 38 pupils in January 2009 to 72 pupils in January 2014;
- Speech, Language & Communication Needs has had a 36.6% increase from 71 pupils in January 2009 to 95 pupils in January 2014;
- Moderate Learning Difficulty has fluctuated over the last few years, with the highest number of pupils – 208 pupils - in January 2011;
- Visual Impairment has increased year on year from 8 pupils in January 2009 to 24 pupils in January 2014.

5.3.5 The number of pupils with the following primary needs have decreased in Harrow's high schools:

- Behaviour, Emotional & Social Difficulties has fluctuated over the last few years, with the lowest number of pupils – 272 pupils – in January 2014;
- Specific Learning Difficulty has fluctuated over the last few years, with one of the lowest number of pupils – 166 pupils – in January 2014;
- Hearing Impairment has had a 21% decrease from January 2009, with the lowest number of pupils – 33 pupils – in January 2014.

5.4 Attainment of FSM eligible pupils

5.4.1 At present children who receive free school meals show substantially less progress across all subjects between Key Stage 1 and Key Stage 2 than their more affluent peers, and young people leaving school at the age of 16 without any or with only very limited qualifications are disproportionately from disadvantaged backgrounds.

5.4.2 Harrow's gap between pupils eligible for free school meals and non-fsm pupils at Key Stage 2 has been closing over the last five years, with a gap of 14% in 2013-14. This gap is in-line with the statistical neighbours but narrower than the national gap.

Table 7: Key Stage 2 results by Free School Meal eligibility

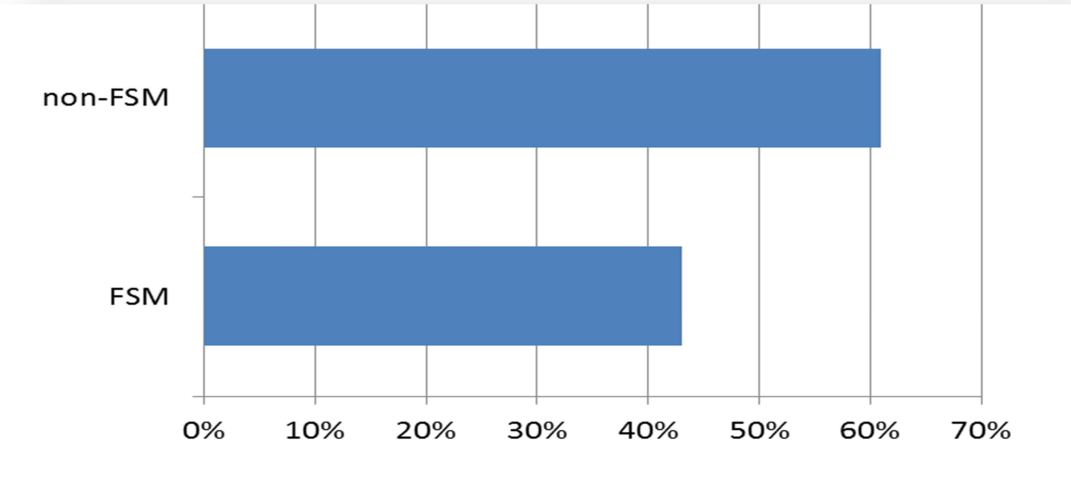
The FSM eligibility/non-FSM gap – achieving Level 4 or above in both English & maths in Key Stage 2 tests	2009-10 %	2010-11 %
Harrow	**25**	**20**
Statistical Neighbours	19	19
England	21	20

The FSM eligibility/non-FSM gap – achieving Level 4 or above in Reading, Writing & maths in Key Stage 2 tests	2011-12 %	2012-13 %	2013-14 %
Harrow	**19**	**17**	**14**
Statistical Neighbours	18	17	14
England	19	19	18

5.4.3 The achievement of Harrow's young people eligible for Free School Meals at the end of Key Stage 4 was significantly better than both the statistical neighbour and national averages. In 2012-13, Harrow achieved a further reduction in the gap between FSM and non-FSM, which was down to the lowest in the last few years 19.9%.

5.4.4 Children in Harrow on FSM who go on to achieve a level 2 at 19 is 81% compared with 81% and 71%. The gap in progression to higher education for children in Harrow on FSM is higher in Harrow at 18 percentage points compared with London at 12 pp, but the same as national figures at 18pp.

Figure 42: **Estimated percentage of pupils aged 15 on FSM and non-FSM who entered HE by 19 In Harrow**



5.5 Performance of pupils with English as a second language

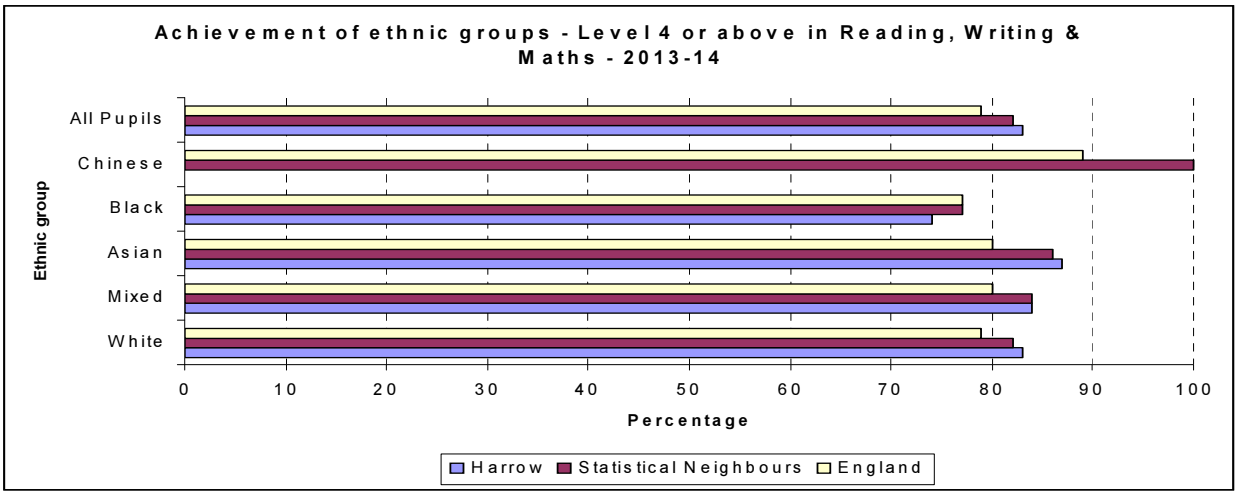
5.5.1 In 2013-14 pupils whose first language is English (85%) performed better than the pupils whose first language is other than English (82%). The attainment of Harrow's pupils whose first language is not English has overall stayed in line with the statistical neighbour averages and above the national averages over the last three years

5.5.2 Harrow is in the top 10 authorities nationally for the successful progression after GCSE of young people entitled to free school meals. Seven others are also London authorities. Harrow is also among the highest performing authorities in the country for the percentage of young people who are in Education, Employment or Training (EET) after the age of 16. In 2013 Harrow was ranked 1st in London for the participation of young people at ages 16 and 17. Harrow has been recognised for these achievements and recently hosted a 'best practice' visit by OFSTED and London Councils with respect to EET.

5.5.3 The chart below shows that whilst all pupils in Harrow have performed above both the national and Harrow's statistical neighbour averages particular ethnic groups within Harrow do not fare so well. The achievement of Harrow's black pupils is not only below both the national average as well as the statistical neighbour average; it is also the lowest in all of the ethnic groups included in the chart. The results of

Harrow's Asian and White pupils are significantly above the national average as well as above the statistical neighbour average.

Figure 43: **Key Stage 2 Results by Ethnic Origin**



5.5.4 Only the results of the Asian and Chinese pupils have been both consistently and significantly above Harrow's average results over the last five years. In contrast the results of Harrow's White, mixed and Black pupils have consistently remained below the Harrow, statistical neighbour and national averages, with the Black pupils' results being significantly below. The provisional 2013-14 5 A*-C GCSEs including English and mathematics of Black African (47.9%), Black Caribbean (51.1%) and Black Other (59.5%) groups were significantly below the Harrow average of 61.3%.

6.0 Existing services

6.1 Children's Centre's

6.1.1 Harrows Children's Centre's provide universal and targeted / specialist services tailored to the needs of the local community & play a big role in supporting the lives of children and their families in the borough to have the best possible start in life. There are 10 Children's Centres located all around Harrow organised into two hubs; Hillview Hub and Cedars Hub.:

The ethos of Children's Centre's is to

- Keep the well-being of children, young people and their families at the heart
- Work together with parents to give children and their families the best possible start in life
- Employ and develop a multi-skilled, talented, trained and committed workforce
- Ensure services reflect on and respond to the changing needs of the local communities
- Build enabling and effective services through professional partnerships and considered business planning

Children's Centres offer a range of services, drop in sessions, activities and workshops

- 2 year old progress checks & school readiness support for children aged 3+
- Adult education classes and training, including ESOL & Family Learning
- Health visiting services, Midwifery services, Breastfeeding support groups
- Child development workshops & childhood safety
- Citizens Advice Bureau
- Counseling
- Fathers' groups
- Food Bank
- HARO (Harrow acting for relatives of offenders)

- Short breaks
- Stay and play sessions, including: music and movement; arts and crafts
- Toy libraries
- Volunteering opportunities
- Behaviour management

6.2 Troubled Families Expanded Programme:

6.2.1 The Troubled Families Expanded Programme (TFEP) began in April 2015 and is a significant opportunity to achieve lasting change for families, and help map out future savings for local services. It offers a unique opportunity to bring together key partners at a local level, and demonstrate the benefits of integrated service delivery.

6.2.5 In Harrow , the troubled families is called the **Together with Families** and was launched in July 2016. We are expected to work with 1330 families over the next 5 years, with a strong emphasis on developing a strategic approach with key partners and working together to reform services with a focus on savings and early help.

6.2.6 Each local authority and its partners needs to set out what they consider to be successful outcomes on a family by family level against the programme's six headline problems:

1. Parents and children involved in crime or anti-social behaviour;
2. Children who have not been attending school regularly;
3. Children who need help;
4. Adults out of work or at risk of financial exclusion and young people at risk of worklessness;
5. Families affected by domestic violence and abuse;
6. Parents and children with a range of health problems.

6.3 Breastfeeding support and health start

6.3.1 Breastfeeding is one of health visiting's 6 high impact changes because of its many health benefits. Babies who breastfeed have a lower risk of gastroenteritis, respiratory infections, sudden infant death syndrome, obesity, Type 1 & 2 diabetes and allergies (e.g. asthma, lactose intolerance). There are huge benefits to mothers too, the longer mothers breastfeed, the greater their protection against breast and ovarian cancer, and hip fractures in later life.

6.3.2 The breastfeeding support groups span the borough and offer women many opportunities for support. There are five regular, reliable breastfeeding support groups running Monday – Friday, most are run in Children's Centres and one runs in a community café with the intention of supporting women to breastfeed in public. To increase referrals and facilitate partnership working, most groups run at the same time as the Health Visiting Team running Healthy Child clinics. The Edgware and Stanmore groups are well situated to support women who live in Harrow yet delivered their babies at non-fully accredited UNICEF Baby Friendly hospitals outside the borough and may be thus may be more likely to face breastfeeding challenges. The Infant Feeding Team continues to support the 'Baby Buddy App' which has just won a coveted award from the Royal College of midwives – 'Best Online Resource for Mums and Mums To Be'. Information on accessing this' App' is included on the flyers and website and at the breastfeeding Support Groups.

6.3.3 The Healthy Start benefit incorporates a food voucher scheme and a vitamin coupon. Food vouchers can be spent on fresh or frozen fruit and vegetables, plain cows' milk and first infant formula. Pregnant women and children under four years old receive one £3.10 voucher per week. Babies receive two £3.10 vouchers (£6.20) per week. Healthy Start vitamins are available through children's centres and at pharmacies. Healthy Start vouchers provide a valuable financial support for low-income families.

For a two parent household with a baby and toddler, Healthy Start food vouchers could increase the weekly food spend by 14%. For a single mother with a baby and toddler, Healthy Start boosts purchasing power by almost 25%.Although child poverty rates have increased, Healthy Start uptake has decreased recently due to problems with service delivery and lack of awareness about the benefit. The national average uptake is 75% - meaning that 1 in 4 eligible participants does not receive the benefit.

Local authorities are best placed to increase uptake through health professionals in direct contact with those who may be eligible.

6.4 CAMHS Transformation project

6.4.1 Harrow's Emotional, Behavioural and Mental Health Service Partnership Group was established in October 2013 for 18 months to provide systemic overview of the commissioning of comprehensive CAMHS services on all tiers. Within this time, in March 2015 the government published Future in Mind, their strategy for promoting, protecting and improving our children and young people's mental health.

6.4.2 The delivery of the recommendations presented in the strategy are the responsibility of a number of agencies, NHS England expect that the leadership for the Local Transformation Plans will be led by Clinical Commissioning Groups (CCG) and in partnership with the Local Authority, Schools, Public Health, Voluntary Sector and Health Providers over a 5 year period. The groups aim is to improve emotional, behavioural and mental health outcomes for children and young people of all ages, and all levels of need. There is an emphasis on outcomes being delivered as efficiently, effectively and sustainably as possible, so that limited resources help as many users as possible.

6.5 Support into work

6.5.1 The Xcite programme is an employment programme providing a full range of support to help Harrow residents back into work. They help by overcoming barriers to work including by supporting with confidence, writing application forms, telephone skills, interview skills and jobsearch techniques and 1:1 coaching. Anyone who is claiming benefits and would like support to find work can contact the team in Harrow.

6.6 Parent Champions

6.6.1 Parent Champions are defined as those that have positive experiences of using childcare and/ or supporting their child's early learning, who act as advocates and peer advisers to other parents in their community. The family and Childcare Trust have a track record of supporting local authorities meet their strategic priorities through the parent champion model.

6.6.2 Research shows that parents trust other parents to provide honest and user-friendly information. The scheme has proved to be an invaluable way of giving messages to parents in the community, reducing isolation and social exclusion.

6.6.3 Following the experience of the FCT running the parent champion scheme up and down the country. It is a light touch approach to giving information and advice to other parents in the community. The type of information will be led by children's services and public health. The aim of the scheme will be to recruit at least 10 parents from the Harrow community who will:

1. Advocate children's services through outreach
2. Give key health messages

6.6.4 In addition to the learning and social benefits for parents and children, a detailed analysis of the Social Return on Investment (SROI) shows that any investment pays for itself many times over. The final calculation of how Parent Champions worked in one area in the UK showed that the total monetary benefit to society was £1,075,567 - more than 12 times the original investment of £84,092.

6.7 Voluntary and community sector

The voluntary and community organisations play a key part in supporting some of the vulnerable families in Harrow. Voluntary Action Harrow Co-operative work with the voluntary and community sector providing information, training and guidance to help them achieve their objectives. They also help to co-ordinate the Voluntary and Community Sector Forum which brings together local groups, organisations, community workers and partners to identify local issues of mutual interest and need, and work collaboratively to find solutions. The voluntary sector play a crucial part in supporting people in the community. We know that there are over 150 voluntary organisations operating in Harrow who have a wealth of knowledge about the needs of the community in which they operate. The young Harrow foundation work with a host of organisations in Harrow set up to support some of the most vulnerable in the community. For example, Watford FC, Ignite, Young Carers project, Compass and Hope.

Figure 44: **Snapshot from Young Harrow Foundation website**[63]

6.8 Harrow Help scheme and Citizens Advice Bureau (CAB)

6.8.1 Harrow have a help scheme that is available for people that are in a desperate situation and need access to funds to support them with purchasing white goods through the emergency relief scheme, food banks and discretionary housing payments. The DHP was fully spent in 2014/15 but has been reduced for this year.

6.8.2 The CAB continue to provide support and advice to people facing an array of difficulties including as listed below:

[63] https://youngharrowfoundation.org/portfolio-2/

6.9 Regeneration programmes

6.9.1 Harrows regeneration strategy over the period to 2026 aims to deliver three core objectives:

- Place – Providing the homes, schools and other infrastructure needed to meet the demands of our growing population and business base, with high quality town and district centres that attract business investment and foster community engagement
- Communities – Creating new jobs, breaking down barriers to employment, tackling overcrowding and fuel poverty in our homes and working alongside other services to address health and welfare issues

- Business – Reinforcing our commercial centres, promoting Harrow as an investment location, addressing skills shortages and supporting new business start ups, developing local supply chains through procurement.

6.9.2 The Grange Farm estate in South Harrow is tucked away between Northolt Road and Shaftesbury Avenue. The estate has 282 properties mainly made up of Resiform flats which are a unique type of building involving use of fiberglass panels for external walls. These flats are expensive to maintain and difficult to keep warm. Working closely with local residents and a specialist design team, the Housing Services department has submitted a planning application to replace all of the properties on the estate with 549 new houses and apartments of mixed sizes.

6.9.3 A new Harrow Civic Centre will be built in Harrow and Wealdstone. The proposed new Civic Centre would be built on the site of the Peel House car park in Wealdstone by 2019. The proposals for the three sites include the creation of more than 300 jobs and 1,100 homes – including hundreds of affordable homes. They form part of the council's "Building a Better Harrow" regeneration strategy, which over the coming years aims to deliver a total of 3,000 jobs, 5,500 new homes and £1.75 billion of investment to the borough

6.9.4 Harrow Council were successful in a bid o the GLA for a 1.5 million pound regeneration programme in Wealdstone. Wealdstone has seen a decline and is in one of the most deprived areas where child poverty levels are high. 9.37% retail vacancy rate in June 2015, (nearly double the percentage for other district centres in Harrow). From 1981 to 2013 there has been an estimated loss of 6100 jobs (55%).(Census 2011, BRES 2013) This has includes the closure of Winsor and Newton (ColArt), Whitefriars Glass, and the Hamilton Brush Company, and the reduction of Kodak to less than 5% of its former staffing levels. Nearly a third of residents are aged under 25. Residents have a lower level of skills than other Harrow areas. Wealdstone suffers from a high fear of crime, drug dealing and is frequented by one of Harrow's largest street gangs. Residents say they see it as a no go area after dark. The aims of the regeneration programme will be to

- Creating a town square, engaging community and business in design and delivery; providing young people with design skills; developing partnerships
- 3. "Work Labs"; a workspace development and marketing strategy

- 4. Support business survival and growth

6.9.5 The Government has announced proposals for a new High Speed 2 (HS2) and Crossrail station at Old Oak by 2026, potentially making it one of the best connected railway stations in the UK. This will give rise to significant potential for economic development, jobs growth and new homes. Harrow will also benefit from this as there is an opportunity to regenerate the wider area. Based around the new HS2 and Crossrail station at Old Oak, the Mayor, Transport for London (TfL), plus the London Boroughs of Hammersmith & Fulham, Brent and Ealing, have been considering the potential for regenerating the area and are seeking views on a 30-year Vision for Old Oak. This would transform the area with up to 90,000 jobs and up to 19,000 new homes, schools, open spaces, shops and leisure facilities.

6.10 Discussion

This report highlights child poverty as a multidimensional, multi-faceted issue that poses many challenges in light of the cuts faced by local authorities. The needs assessment shows that poverty is not just based on income alone as is the current measure for child poverty. Housing, educational attainment, employment, language barriers, mental health all exacerbate child poverty in Harrow and each of these areas brings together multiple agencies including local authorities and key stakeholders including the voluntary and community sector.

The opportunity to mitigate child poverty in Harrow, brings with it the prospect to work in a smarter, more efficient and more effective way to cross departmentally, with external partners and the voluntary and community sector to think about and agree key priorities for tackling child poverty in Harrow over the next 5 years. Further analysis through in depth qualitative assessment and interviews, a planned workshop in November will enable us to have a better understanding of what poverty means for Harrow. In an age of fewer resources and shrinking budgets we need to think more creatively and work more collaboratively to mitigate child poverty to improve children's life chances and health outcomes focusing on areas where there is need.

7.0 References and acknowledgements

We would like to acknowledge colleagues at the council from the following departments who have supported the child poverty needs assessment through providing vital data and statistics that have helped to compile this report.

With thanks to:

- Housing
- Economic development and employment and regeneration teams
- Benefits
- Early Intervention
- Education business intelligence
- Early years education team
- Together with Families
- Children's social Care
- Public health knowledge and Intelligence
- Children's social services

Also thanks to external organisations including:

- Voluntary Action Harrow
- Young Harrow Foundation
- Citizens Advise Bureau
- Jobcentre Plus
- Food Bank
- Paediatric Therapy - Chaucer Unit Level 3 | Northwick Park & St. Mark's Hospital
- Child Poverty Action Group http://www.cpag.org.uk/

Internal reports such as:

- Vitality Profiles
- Childcare sufficiency assessment, 2016
- Harrow Mental Health Needs Assessment
- Joint strategic needs assessment
- Health and Wellbeing Strategy

- Housing Strategy 2013-2018
- Harrow Carers Strategy (note not to be published until 2017)
- Harrow Economic and welfare reform impact dashboard
- Domestic Violence strategy
- Obesity Strategy
- Framework I data

External reports have been referenced throughout the document as footnotes. Some key documents referenced include:

- Frank Field The foundation years: preventing poor children becoming poor adults, December 2010 http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf
- Marmot Review, Fair society Healthy lives 2010, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report
- Beyond the food bank, 2015 https://www.trustforlondon.org.uk/research/publication/beyond-the-food-bank-london-food-poverty-profile/
- Graham Allen report on early intervention: next steps, Jan 2011 http://grahamallenmp.co.uk/static/pdf/early-intervention-7th.pdf
- Government child poverty strategy April 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/177031/CM-8061.pdf
- Government child poverty strategy 2014-17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324103/Child_poverty_strategy.pdf

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BOARD REPORT SUMMARY

Date of Meeting: 30th November 2016		☐ Private	☒ Public
Item No. **Board Report No.**	9 16/11/06	☐ Approval ☒ Discussion ☐ Noting ☐ Confidential	

Subject: CQC Action Plan Update

Director Responsible: **Amanda Pye** Chief Nurse	**Author:** Marian O'Connor Operational Head of Nursing, Midwifery & AHP Standards

Summary:

The CQC Action Plan Tracker has been established (see attached) to track the progress of all of the CQC Actions, and is sorted according to the board committees and indexed accordingly. The Tracker provides an overview of the monthly progress of all of the CQC Actions using the established colour legend and a brief overview of the evidence available currently.

Currently there are ten completed actions (grey), thirty eight actions which are progressing 'On track' (green), ten actions which are 'Off track but expected to deliver on time' (yellow) and 10 actions which are 'Off track' (red). The Master CQC Action plan (also attached) provides full details and the evidence for each action.

Areas of risk/concern:

The 'Off track' Actions are being address within the respective board committees and requests made from the executive leads to provide revised date of expected completion of these actions and revised plans.

Recommendations:

The Trust Board is requested to:

- Receive and note this report
- Decide if any further actions and/or information are required, particularly in relation to the 'Off track' actions
- Support the recommendations stated in this report.

Board Assurance Framework Reference(s) (if applicable):
1.8

Financial Implications (specify any additional costs or loss of income and how this will

be resourced):

None

Has an Equality Impact Assessment been carried out on this issue or proposal?
☐ Yes
☐ No
☐ Not applicable

If yes, are there any further actions required? ☐ Yes ☐ No

Workforce Issues (including training and education implications):

N/A

Has an Equality Impact Assessment been carried out?
☐ Yes
☐ No
☐ Not applicable

If yes, are there any further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public?
N/A

Paper respects the rights, values and commitments within the NHS Constitution.
☐ Yes
☐ No
☒ N/A

Action Plan Tracker

				Month										Target Date		
Monitoring Board Committee	Action Index	MUST DO action	Executive Lead	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	mm/yy	Evidence presented	Evidence yet to be presented
1. Integrated Gorvernance Committee	1.01/	Ensure that risks are managed appropriately and in a timely manner in all services including Dental	CN			3	3	3	3					Dec-16	New Governance report identifies all risks of >15 presented to IGC. Risk register updated with new policy guidance.	
	1.02/	Duty of candour Notifications in person and in writing have not been provided to the relevant person for some incidents triggering the duty or recorded: referenced in warning notice	CN	3	3	3	3	3	3					Sep-16	1. Learning sessions arranged for Nov & Dec 2016 (across the trust) 2. Monthly audit of compliance of DATIX reports by Governance dept.	**Nov 2016** Re-audit of compliance by CCG's (TBA Likely Feb 2017)
	1.03/	Improve consultant cover on eHDU to include out of hours and weekend working. (WARNING NOTICE)	COO	4	4	4	4	4	4					Jan-16		
	1.04/	Implement WHO patient safety checklists in all surgery settings	CMO				1	1	1					Sep-16		**Nov 2016** Update pending from leads
	1.05/	Ensure medical care on eHDU follows Faculty of Intensive Care Medicine guidelines. Warning Notice	CMO	4	4	4	4	4	4					Jan-16		
	1.06/	Ensure appropriate medical staffing and competency of staff in the Elective High Dependency Unit (eHDU) (WARNING NOTICE)	CMO	4	4	4	4	4	4					Jan-16		
	1.07/	Ensure incidents in OPD are reported, escalated, investigated with learning derived and shared.	CN	3	3	3	1	1	1					Sep-16	Audit of OPD Datix reports (2015/2016) shows low reporting in OPD	**Nov 2016** Targetted teaching in OPD areas of low reporting TBA with Governance team
	1.08	Review IPC and improve cleanliness of equipment and fixtures on Ealing medical wards.	CN			3	3	3	3					Apr-18	**Nov 2016** Request by CN with focus for Dec 2016 with ICT reviewing the medical wards with the HoN and Matron/Ward sister - report to be presented at TICC Jan 2017 meeting	**Nov 2016** TICC Meeting Minutes to be included once available
	1.09	Improve hand hygiene to show audits resulting in above 90% compliance and leading to 100%.	CN			3	2	2	2					Dec-16	**Nov 2016** Hand Hygiene report (Oct 16) presented at TICC Meeting (Nov 16)	
	1.1	Review drug round timings to minimise medicines errors	CN	3	3	3	3	3	3					Jun-16		**Nov 2016** Monitoring trend of DATIX reports related to Medication at night (Report due for Jan 17 IGC)
	1.11	Review infection prevention and control (IPC) practice and ensure correct IPC dress protocols are observed for all staff.	CN	3	3	3	3	3	3					Dec-16	Revised Dress Code Policy (Sept 2016)	**Nov 2016** Spot check of staff compliance planned for Dec 2016 - Report to be provided Jan 2017 TICC)
	1.12	In maternity and gynecology address safety concerns in relation to midwife shortages	CN	3	3	3	3	3	3					Aug-16	**Nov 2016 Maternity dashboard.** Vacancy rate of 10.3% with a midwife to birth ratio 1:31.	**Nov 2016** Recuitment into vacant posts (17 in total) pending
	1.13	In Maternity lack of safety thermometers displayed	CN	4	4	4	4	4	4					Jan-16	EAT Assessment demonstrates compliance	**Nov 2016** Spot checks of ward display of safety thermometers planned for Dec 16 & reported to be provided
	1.14	Due to this being highlighted the Trust will Ensure Safety thermometer is displayed in every area	CN	3	3	3	3	3	3					Sept-16 Ongoing		**Nov 2016** Spot checks of ward display of safety thermometers planned for Dec 16 & report to be provided
	1.15	Monitor required checks and cleaning of equipment including epidural trolleys.	CN		3	3	3	3	3					Aug-16 Ongoing	TICC Report (spot check of facilities & equipment) presented at TICC Nov 2016	**Nov 2016** Update pending from Matron/ward sister to provide Epidural Trolley Checklist
	1.16	Ensure reportable incidents are reported in Surgical services Warning Notice Ensure all medical and nursing staff are reporting all reportable incidents on Datix.	CN/CMO	3	3	3	3	3	3					Jan-17	**Nov 2016** Governance dashboard shows significant improvement in reporting in surgical division	

1.17	Ensure robust protocols are in place for the transfer of necessary communication between midwifery and health visiting services	COO					3	3					Mar-17	**Nov 2016** Handover document in use between midwifes & healthvisitors	**Nov 2016** New lead Nurse for Quality in community to undertake audit in Q4
1.18	Review service level agreements related to the provision of surgical instruments.	COO					2	2					Mar-17		**Nov 2016** Update pending from divisional leads
1.19	Ensure adequate emergency evacuation procedures in outpatients and diagnostic imaging (OPD	COO	3	3	3	3	3	3	0				Sep-16	**Nov 2016** Minutes of emergency management steering committee (Sept 2016), October cover sheet & TOR for the group. Fire evacuation plan available for staff on intranet with Annual Fire safety report & Annual Fire Audit attached.	
1.2	Harmonise adult's community health services and systems used across various locations to ensure continuity and allow for shared learning from complaints and incidents across the organisation	COO	3	3	3	3	3	3					Oct-16 Ongoing	Learning sessions arranged for Nov & Dec 2016 (across the trust)	
1.21	Review the maternity risk register to include missing issues such as lack of soundproofing in the bereavement room.	COO	3	3	3	3	3	3					Jun-16		**Nov 2016** Estates have been instructed to undertaken a feasibility exercise re: sound proofing a room on delivery suite - Review of Risk registry pending.
1.22	Address items on the OPD risk register including lack of capacity, lack of complete medical records, overbooking of clinics,	COO	3	3	3	2	2	2					Mar-17		**Nov 2016** Update pending from divisional leads
1.23	Ensure the secure storage of all patient records at all service locations.	Director of Strategy	3	3	3	3	3	3					Oct-16 Ongoing	**Nov 2016** Currently reviewing all storage (1) Recruitment to vacant Health Records Programme Manager post: recruited by end December 2016, person in post Q1 2017. (2) Restructure of Health Records department in November/December 2016 resulting in a centralisation of prepping services bringing most Health Records activities under single management	**Nov 2016** Evidence pending (1) Advert posted on NHS Jobs (2) Minutes of Outpatient Improvement Steering Group and Restructure Consultation Paper.
1.24	Set up a system to ensure that nitrous oxide and oxygen cylinders are taken out of use once they have passed their expiry date	Director of Estates and Facilities	3	3									Oct-16 Ongoing	**Nov 2016** Medical Gas policy (2016)	**Nov 2016** AP Audit remains outstanding
1.25	Ensure COSHH assessments and arrangements are up to date and maintained. In all wards and departments	Director of Estates and Facilities	3										Oct-16	**Nov 2016** Lack of divisional staff attending training, lack of risk assessments in place. Generic COSHH templates provided by H&S.	**Nov 2016** Audit of selected areas by H&S team
2.01	Improve provision of equipment for surgery.	COO	1	1	1	1	1	1					June-16 Ongoing		**Nov 2016** Update pending from leads
2.02	1. Instigate and continue an improvement plan in the emergency department to achieve mandatory targets including the 4 hour treatment target. 2. Improve access to services and patients flow through the ED at Northwick Park to wards on the hospital	COO	3	3	2	2	2	2					01/04/2017		**Nov 2016** Monthly meeting TBA with DGM's & COO to review progress
2.03	Take action to reduce caseloads pediatrics therapy services.	COO	3	3	3	2	2	1					Dec-16		**Nov 2016** Update pending from leads
2.04	Improve referral to treatment times in surgery.	Director of Improvement	3	3	3	2	2	1					Oct-16		**Nov 2016** Update pending from leads
2.05	Improve theatre utilisation and efficiencies related to start and finish times.	Director of Improvement/COO	3	3	2	1	1	1					Oct-16		**Nov 2016** Update pending from leads

2. Finance and Performance

Committee	2.06	Engage staff in the community adult's health services development and reconfiguration so they can influence changes within the organisation.	COO	3	3	3	2	2	2					Dec-16		**Nov 2016** Update pending from leads
	2.07	Address items on the OPD risk register including overbooking of clinics.	Director of Improvement/COO	3	3	2	1	1	1					Oct-16		**Nov 2016** Update pending from leads
	2.08	Ensure prompt access to adult's community health services including tissue viability service, speech and language therapy and continence services among others.	COO					3	3					Sep-17	**Nov 2016** Update pending from leads	
3. Clinical Excellence	3.01	Ensure all eHDU handovers are consultant led.	COO	4	4	4	4	4	4					Mar-16		
	3.02	Set an action plan to address poor performance against College of Emergency Medicine audit measures on pain relief, renal colic, fractured neck of femur and consultant sign off.	CMO	3	3	3	3	3	3					Mar-17		**Nov 2016** Emergency Medicine are currently re-auditing within the areas detailed and will formulate a new action plan when completed.
	3.03	Ensure improvement in data completeness for patients having major bowel cancer surgery in line with the England average of 87% and up from the hospital performance of 30%.	CMO	3	3	3	2	2	1					Dec-16	National Bowel Cancer Audit Report (2015)	**Nov 2016** Infoflex implementation (go-live 28 November) which will support data capture. However a permanent solution to complete data entry has not been identified yet.
	3.04	Formally define care pathways in surgery. Inadequate	CMO/COO	3	3	3	2	2	1					Dec-16		**Nov 2016** Update pending from leads
	3.05	Ensure MRSA screening and medicines management checked at handover	CN		3	3	3	3	3					Dec-16	Matron's Documentation Group laucnhed (Oct 2016)	**Nov 2016** Evidence pending of revised Handover document and then a plan for audit of compliance (Q4)
	3.06	Develop care plans which enable individualised information to be reflected and acted upon by staff.	CN/CMO						3					Mar-17	Matron's Documentation Group laucnhed (Oct 2016)	
	3.07	Develop a single vision and set of operating Procedures across the three community hospitals.	COO	3	3	3	2	2	2					Dec-2016		**Nov 2016** Update pending from leads
	3.08	Set up a formal escalation process for deteriorating patients on eHDU.	COO	4	4	4	4	4	4					Jan-16		
	3.09	Ensure improvements in handovers between ED and the wards at Northwick Park	COO		3	3	3	3	3					Dec-16		**Nov 2016** Handover document to be reviewed at Matron's & Sisters meeting (launch handover document Dec 2016)
	4.01	Implement a hospital wide training programme to ensure ward staff understanding of end of life care and the Last Days of Life Care Agreement (LDLCA).	CMO?CN		3	3	3	3	3					Jul-17	**Nov 2016** EoL leading on CQUIN	**Nov 2016** Plan and Trajectory in place and monitored
	4.02	Ensure patients with memory need are identified and they receive personalized care according to their needs.	CN			3	3	3	3					Aug-17	**Nov 2016** Confusion Care Pathways (CCP) Identifiers have been implemented trust wide with the use of bedside magnets and stickers for medical notes. In addition, patients on the confusion pathway are monitored via the Daily Safety Brief (see evidence) on every acute ward (trust wide) and within the community bedded units.	

	4.03	Ensure patients' nutrition and hydration is monitored with fully completed records on wards across the organisation	CN			3	3	3	3					Dec-16	**Nov 2016** Full EAT assessments pending this month. Nutrition Matron's group launched with first meeting planned for Nov 2016 with a key focus on MUST tool and hydration audit	**Nov 2016** Nutrition Group Meeting Minutes Enter & View Vist by HealthWatch Brent (Nov 16) pending (likely Jan 17)
	4.04	Ensure that the Denham Unit has sufficient nursing staff to keep patients safe at all times.	CN	3	3	4	4	4	4					Jul-16		**Nov 2016** Safer Staffing Report to be included (Aug 2016)
	4.05	Take action to reduce caseloads of staff in health visiting	CN	3	3	3	3	3	3					Dec-16		**Nov 2016** Safer Staffing report each month includes reference to HV caseload and as published benchmarked against it. Monitoring of Datix incidents related to staffing by the Division
	4.06	Review and improve consultant cover in hematology.	COO	3	3	3	3	2	2					Dec-16		**Nov 2016** Another round of substantive recruitment is planned with interviews in February 2017 to recruit to 2 vacant post plus to replace a consultant who tendered her resignation in October 2016 (leaving in January 2017).
	4.07	Improve signage for patients in outpatient clinics.	Director of Estates and Facilities					3	3					Oct-18	**Nov 2016** Meeting with key stakeholders around scope delayed, but some funding provided for Outpatient areas in charitable fund Sept 16	**Nov 2016** Capital project bid pending
	4.08	Improve the environment of the stroke wards at Northwick Park Hospital.	Director of Estates and Facilities		3	3	3	3	3					Jun-17	**Nov 2016** External Survey highlighted only minor issues around decor. Work to be prioritised in capital allocati	
	4.09	Develop a workforce strategy and business development plans to ensure adults community health and acute services are not reliant on use on bank and agency staff and actual employed	Director of HR/OD	3	3	3	3	3	3						**Nov 2016** The People Strategy document	**Nov 2016** Continiously monitored with Safer Staffing Report
	4.1	Review and improve facilities for patients living with dementia Review the surgical environment with respect to the needs of individuals living with dementia.	CN			3	3	3	3					Mar-18	**Nov 2016** Hardy Ward (NPH) updated to be dementia friendly	**Nov 2016** Plan to reassessment updated wards against the Kinds Fund Ward Environmental Assessment Tool.
4. Patient and Staff Committee	4.11	Develop an end of life link nurse or champion role within each community team and ward area to raise awareness of end of life issues and act as a resource for the team.	CN	3	3	3	3	3	3					Jun-17	**Nov 2016** Lead Nurse for EoL is working within the Senior Nurses End of Life Group	
	4.12	Provide mandatory EOLC training for all nurses across all three borough and the Divisions s to promote equity of knowledge, not only in syringe drivers and symptom control, but also in the understanding of the Gold Standards	CN				3	3	3					Sep-17	**Nov 2016** Sage & Thyme Training in progress already	**Nov 2016** Training review & progress report pending
	4.13	Ensure appropriate staffing competency out of hours in radiology (WARNING NOTICE)	CMO	4	4	4	4	4	4					Jan-16		
	4.14	Review therapy visits on wards to prevent and minimise patients missing therapy	CN	0	0	3	3	3	3					Apr-17	**Nov 2016** AHP included in Safer Staffing and monthly workforce report	**Nov 2016** Workforce report (Dec 2016) pending
	4.15	Improve record keeping with respect to fluid balance charts.	CN	3	3	3	3	3	3					Mar-17	**Nov 2016** Revised Fluid balance policy for in-patients and fluid chart (Nov 16)	**Nov 2016** Audit & EAT Compliance

	4.16	Ensure staffs receive training and have their knowledge assessed in Mental Capacity and Deprivation of Liberty safeguards.	CN			3	3	3	3					Mar-17	**Nov 2016** Lessions Learnt sessions (drop in) arrange weekly for month of October 2016	**Nov 2016** DOLS Training Compliance 57%, MCA L2 78% & MCA L3 66% Compliance with trajectory pending
	4.17	Ensure all staff working within the community health and acute services receives adequate training.	COO	3	3	3	3	2	2					Mar-17	**Nov 2016** MAST Trainign report (Aug/Sept 16)	
	4.18	Improve facilities in the hematology day care clinic.	Director of Estates and Facilities	3	3	3	3	4	4					Oct-16		
	4.19	Remove inconsistencies of care in Dementia	CN			3	3	3	3					Apr-17	**Nov 2016** 56% of eligable staff trained in October 2016	
	4.2	In Maternity and Gynae pressures on single staff covering more than one area, for example triage and observations simultaneously	COO	3	3	3	3	2	2					Dec-2016	**Nov 2016** Redesign of the triage pathway. Observation bay to be closed and a new post (front of house midwife)	**Nov 2016** Quality Impact Assessment & Outcome measures pending
	4.22	Improve mandatory training levels and support for all staff to reach trust targets of 95%.	Director of HR/OD	3	3	3	3	2	2					Apr-17	**Nov 2016** Workforce Report (sept 16) embedded	
	4.23	Review and improve facilities for patients living with dementia and remove inconsistencies of care.	CN			3	3	3	3					Mar-18	**Nov 2016** Dementia Strategy launched attached	
	4.24	Take action to ensure community staff are integrated and feel part of the organisation	Director of HR/OD	3	3	3	3	2	2					Nov-16		**Nov 2016** Update pending from divisional leads
	4.25	Review and improve the post-operative environment in which children recover following surgery	COO											Jul-17		**Nov 2016** Update pending from divisional leads
5. Strategy Committee	5.1	Ensure consistent availability and use of computers and software across all service locations	DoS/Deputy CEO											Mar-17		**Nov 2016** Update pending from divisional leads
	5.2	Improve ventilation in the endoscopy department	Director of Estates and Facilities	3	3	3	3	3	3					Mar-18	**Nov 2016** Business case pending. Floorplans & Quotations available	
6. Board	6.01	Review all arrangements and processes for the care and treatment of children at Ealing ED.	CN/CMO	4	4	4	4	4	4					Jun-16		
	6.02	Ensure improvements in handovers between ED and the wards at Northwick Park	COO	3	3	2	2	2	2					Dec-16		**Nov 2016** Board paper to be included from Oct 2016
	6.03	Review and raise checks and practices to the necessary standard under Fit and Proper Persons (FPPR) requirements for existing and future senior staff.	Dir. of HR & OD	4	4	4	4	4	4					Feb-16		

1. Off track

2. Off Track but expected to be delivered on time

3. On track

4. Completed

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REPORT FOR: **HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	15th December 2016
Subject:	North West London (NWL) Sustainability & Transformation Plan (STP)
Responsible Officer:	Javina Sehgal, Chief Operating Officer Harrow CCG Chris Spencer, Corporate Director People Services, Harrow Council
Scrutiny Lead Member area:	Councillor Kairul Kareema Marikar, Policy Lead Member Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All wards
Enclosures:	Appendix A - Summary of North West London Sustainability And Transformation Plan November 2016 Appendix B - North West London Sustainability And Transformation Plan 21 October Final Submission to NHSE

Section 1 – Summary and Recommendations

This report accompanies the final North West London (NWL) Sustainability & Transformation Plan (STP) submitted to NHSE on 21st October 2016.

The quality of health and social care collaboration in support of the NWL STP will be one determining factor in the eventual allocation of a national fund of up to £3.8 billion over the next 5 years.

Recommendation: The Committee is asked to note the plan.

Section 2 – Report

Background

Sustainability and Transformation Plans (STPs) are a key element of the local implementation of the Five Year Forward View including delivery of the health and care 'gaps' described in the Five Year Forward View:

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

North West London, which includes the 8 boroughs and CCGs, is one of the designated 44 footprints required to submit a STP.

To support delivery of the STP the boroughs in NW London are required to collaborate as 'place based systems' across health and local government to address the ambition set out in the FYFV.

To support delivery of the FYFV a nominal additional fund allocation of up to £3.8 billion will be available across the five year period. Access to a portion of the funds to support delivery of the NWL STP will be largely determined by the content and local system-wide (Council, Commissioners, Providers, 3rd sector) support for and commitment to the local STP.

The NWL STP will describe plans at different levels of 'place'– across the whole system in North West London, from the local to the sub-regional, as appropriate. Local plans, including those jointly developed for Harrow, form the building blocks of the NWL STP.

Harrow Response to the STP

The care commissioning and delivery organisations serving the Harrow population have come together to form the Harrow Sustainability and Transformation Plan Group (HSTPG). Harrow CCG is acting as the convenor of the HSTPG and also acts as the conduit across the sub-regional and regional arrangements to coordinate the STP process.

The HSTPG has members from the London Borough of Harrow, London North West Hospitals Trust, Central London Community Health Services, Central and North West London Mental Health Trust, patient groups and 3rd sector providers.

An initial high level draft submission was agreed by the HSTPG and made to the NWL STP team in mid-April, and contributed to the NWL draft submission on 15th April 2016.

A further draft was submitted in June.

These iterations of the plan were discussed at the Harrow Health and Wellbeing Board meetings in May and August and at the Overview and Scrutiny Committee in June.

The final version of the North West London Sustainability and Transformation Plan was submitted to NHSE on 21st October 2016.

The HSTPG will meet in December 2016 to agree a process for the development of a local STP implementation plan by March 2017.

Stakeholder Engagement

The Harrow STP partners have prioritised local stakeholder engagement in the development of the plan including presentations to:

- Harrow Voluntary and Community Services Forum
- HealthWatch Harrow
- Harrow Mind Service User Group (HUG)
- Interfaith Network meeting
- Carers (Carers Harrow and Mencap)
- Harrow Patients Participation Network
- Voluntary Sector Forum Health & Well-being Subgroup

- A public event in October, incorporating our draft commissioning intentions, attended by individuals, representatives of local community groups and stakeholders

- An online survey for members of the public to provide feedback on the STP and commissioning intentions

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

A final draft of the plan was circulated to member organisations of the STP for comment to the North West London Strategy and Transformation team by Wednesday 7th September.

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.

The content of the regional STP submissions, including NWL, will be a determining factor in the allocation decisions nationally.

Performance Issues

The STP's delivery will be coordinated across the Harrow health and care economy.

It is anticipated that there will be a positive impact on resident outcomes that are delivered either by partners or by joint working with partners.

These anticipated benefits will be quantified for each programme or project as they are developed in detail. The benefits will be linked to existing or new measures or outcomes, quality, access and productivity as they evolve.

Environmental Impact

At this point in time there is no anticipated environmental impact of the STP.

This will be reviewed on an ongoing basis at a programme and project level as the evolving strategies and plans are further developed into change and delivery action plans.

Risk Management Implications

To date no formal risk assessment has been undertaken on the potential local impact of the STP. This will be reviewed on an ongoing basis at a programme and project level as the evolving strategies and plans are further developed into change and delivery action plans.

Equalities implications

A key focus of the STP for Harrow is to address inequalities in both provision and outcomes over the 5 year period.

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

Council Priorities

The Council's vision: ***Working Together to Make a Difference for Harrow.***

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

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

Section 3 - Statutory Officer Clearance

Not Required

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Hugh Caslake, Harrow CCG Head of QIPP and Delivery, 07958 196271

Background Papers: None

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North West London

Sustainability and Transformation Plan Summary

Being well, living well: a sustainability and transformation plan for North West London

November 2016

Have your say

We want to hear your views as we develop this plan. We welcome your comments on any aspect of this plan.

You can send us your comments either online at www.healthiernwlondon.commonplace.is or email healthiernwl@nw.london.nhs.uk.

This document is a summary. More details are available on our website www.healthiernorthwestlondon.nhs.uk.

Our vision

Everyone living, working and visiting North West (NW) London should have the opportunity **to be well and live well** – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers.

For this to happen, the health service needs to turn the current model, which directs most resources into caring for people when they become ill, on its head. The new model must support patients to stay well and take more control of their own health and wellbeing, as close to home as possible.

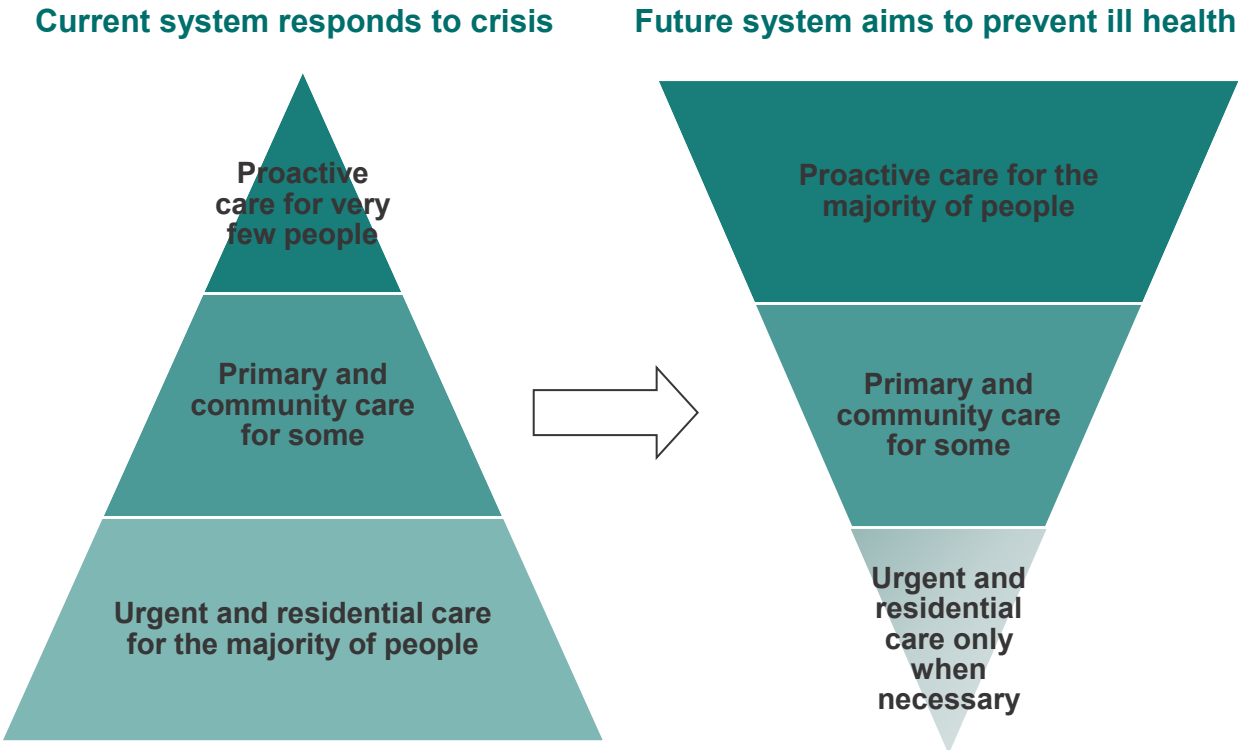
Sustainability
Using resources to meet the needs of people today without causing problems for future generations.

The NHS and councils of NW London have developed this draft Sustainability and Transformation Plan (STP). The STP takes its starting point from the ambitions and knowledge in the national **NHS Five Year Forward View** strategy and translates it for our local situation.

NHS Five Year Forward View

The NHS Five Year Forward View is a strategy for the NHS in England. It describes the gaps in health and social care; how the quality of NHS care can be variable; with widespread health inequalities and preventable illnesses. People's needs are changing, new treatments are emerging every day, and there are challenges in areas such as mental health, cancer and support for frail older patients.

The NHS Five Year Forward View also sets out the benefits of new ways of delivering care; the critical importance of better public health and preventing ill health; how services across health and social care need to be joined up and patients and communities need to be empowered; why primary care needs to be strengthened; and the need for further efficiencies in the health service.



Working together to achieve change

Over four billion pounds a year is spent on providing NW London's health and care services for our two million residents. There are 400 GP practices, ten hospitals and four mental health and community health trusts across the eight boroughs.

Doctors, nurses and other clinicians have worked with key stakeholders to propose how care should evolve to provide a high quality and sustainable system that meets your needs. The STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well and has involved over 30 organisations:

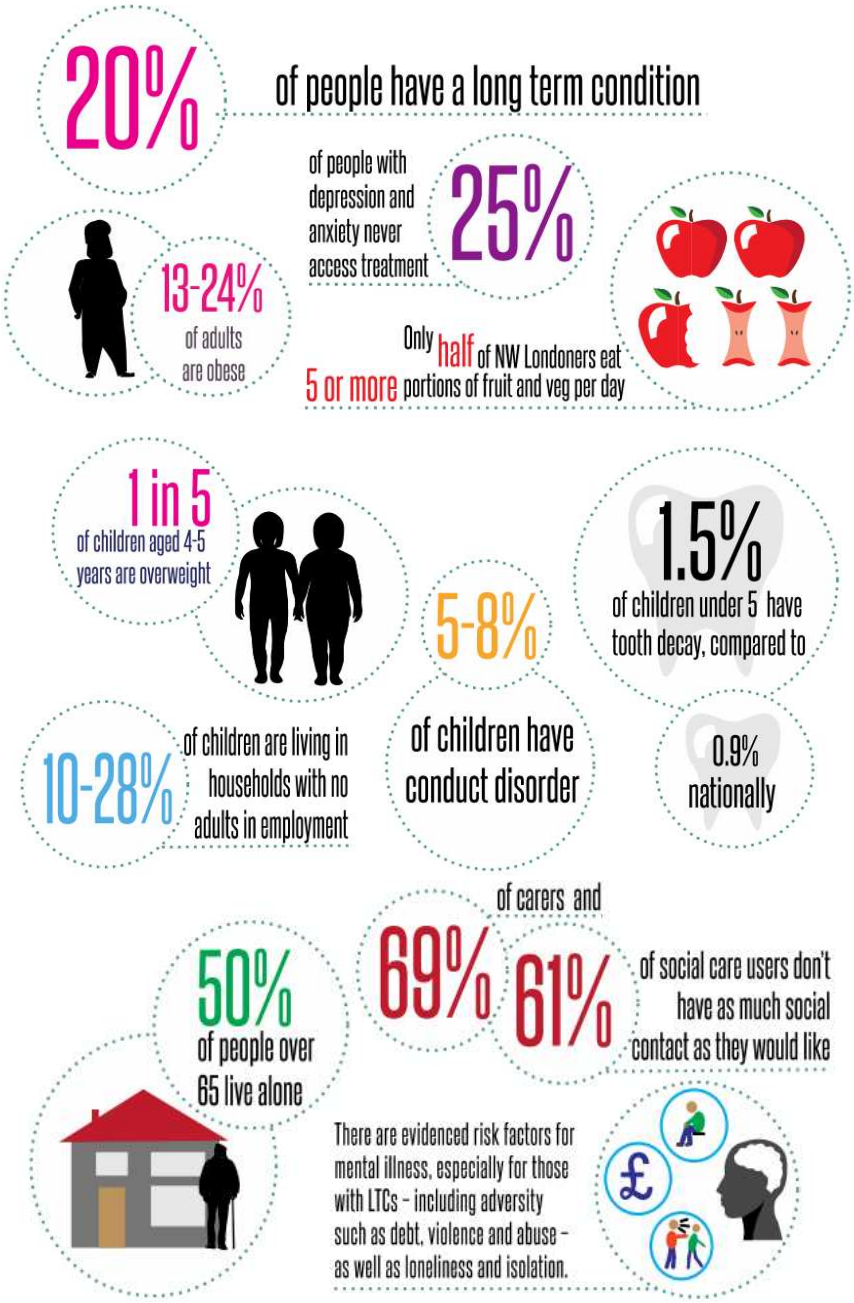
- **Clinical commissioning groups (GP-led groups responsible for planning and buying NHS services):** Brent; Central London; Ealing; Hammersmith and Fulham; Harrow; Hillingdon; Hounslow; and West London.
- **Local authorities:** Brent; Hammersmith & Fulham, Harrow; Hillingdon; Hounslow; Kensington and Chelsea; and the City of Westminster.
- **NHS providers (hospitals, community services and mental health services):** West London Mental Health NHS Trust; Central and North West London NHS Foundation Trust; Chelsea and Westminster Hospital NHS Foundation Trust; London North West Healthcare NHS Trust; The Hillingdon Hospitals NHS Foundation Trust; Hounslow and Richmond Community Healthcare NHS Trust; The Royal Marsden NHS Foundation Trust; Royal Brompton and Harefield NHS Foundation Trust; London Ambulance Service NHS Trust; Imperial College Healthcare NHS Trust; Central London Community Healthcare NHS Trust

We are also working with colleagues from a range of regional and national health and care organisations.

Why we need an STP

Many people live in an unhealthy situation and make unhealthy choices:

- Only half of our population is physically active
- half of over-65s live alone and over 60 per cent of adult social care users want more social contact
- many people are living in poverty
- people with serious long-term mental health needs live 20 years less than those without.



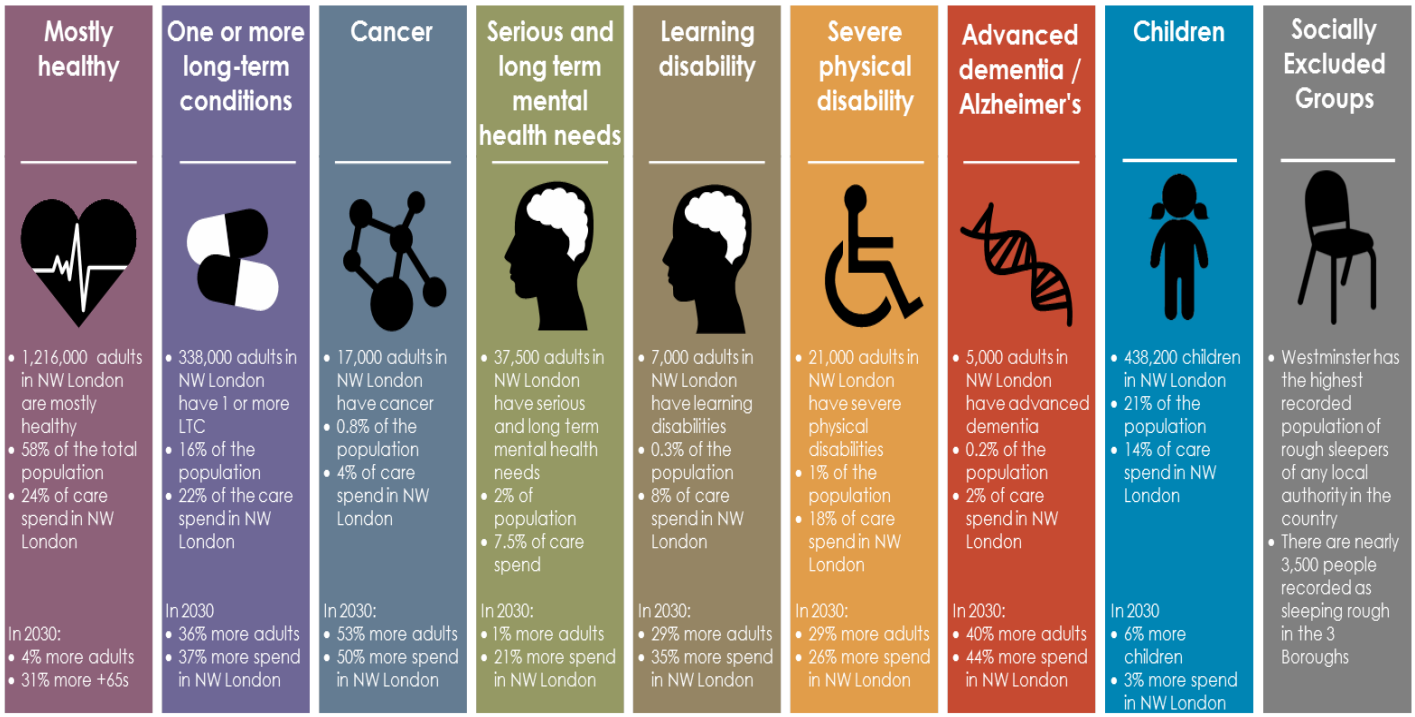
Some of our services are of poor quality and inefficient

- Over 30 per cent of patients in acute hospitals do not need to be there, and could be treated in or nearer to home
- 1,500 people under 75 die each year from cancer, heart diseases and respiratory illness. If we were to reach the national average, we would save 200 people a year
- over 80 per cent of people want to die at home, but only 22 per cent do so.

The cost of health and social care is outstripping the budget

- Despite a growing NHS budget, if we don't take action, there will be a £1.3billion shortfall by 2021. Local authorities have faced cuts in adult social care budgets.

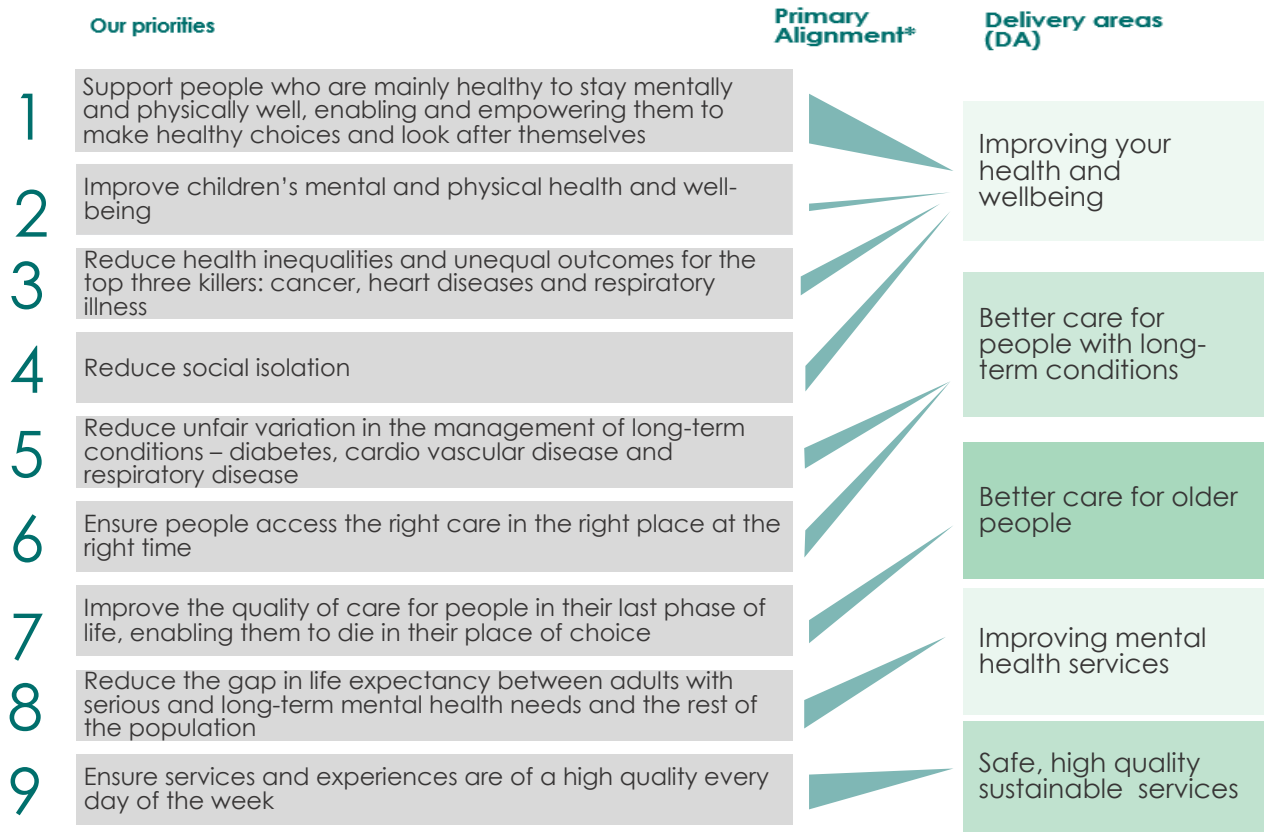
Our population and some likely changes over the next 15 years if we don't take action now



Our aims and priorities

We aim to improve:

1. health and wellbeing
2. care and quality
3. efficiency, to balance the budget



Delivery areas

Delivery area 1: Improving your health and wellbeing

Your health is affected by the environment and communities you live and work in and the choices you make. Your local NHS and councils want to support you to have a healthy life by:

- Reducing loneliness by encouraging everyone to be part of their local community
- supporting campaigns to increase self-care; to prevent cancer; and to reduce the stigma of mental health problems
- encouraging exercise and healthier eating; and reducing smoking and drinking
- encouraging employment for people with a learning disability or mental health problem
- tackling issues that affect health such as housing, employment, schools and the environment
- supporting children to get the best start in life by increasing immunisation rates, tackling childhood obesity and providing more mental health care and support.

Delivery area 2: Better care for people with long-term conditions

With many different organisations involved in care for people with health conditions, services can be confusing and vary in quality. We want to coordinate services better, and help every patient with a long-term mental or physical condition to get the care and support they need to manage their condition by:

- Catching cancers earlier and starting treatment more quickly
- developing new ways of preventing and managing long-term conditions, like diabetes
- improving access to mental health services
- helping the voluntary sector to support self-care; for instance offering people with long-term conditions access to expert patient programmes; and increasing the availability of personal health budgets.

Delivery area 3: Better care for older people

We are pleased that so many of our residents are living longer than previous generations thanks to better medicines, new treatments and cures. We want to improve care for our older people by:

- Tackling the lack of nursing and care homes
- providing specialist teams which can react quickly when there is a problem
- commissioning all services for older people with local government and coordinating care between the NHS, social care and other organisations
- improving end of life care, supporting people to die in the place of their choice.

Delivery area 4: Improving mental health services

We all have mental health. Most of us have a difficulty with our mental health at some point in our lives. Poor mental health has the potential to affect our physical health. We want to support people with serious and long-term mental health problems, learning disabilities, autism or challenging behaviour by:

- Providing a more proactive service focused on recovery
- supporting more GPs to become experts in mental health care
- improving early intervention services and crisis support services; and introduce 24/7 mental health A&E teams
- improving child and adolescent services - particularly in the evenings and weekends.

Delivery area 5: Safe, high quality and sustainable services

Whilst the vast majority of care in NW London is of a high quality, we know there is more to do and we can make services more efficient. Our buildings and ways of working make it difficult to take advantage of new technology. This means the health service is not as efficient or patient-focused as other public or high street services. We want to:

- Provide more services at night and weekends - particularly assessments by a consultant and access to vital tests

- introduce specialist children's assessment units and improve children's services, for example by recruiting more children's nurses
- make the most of new technology to save everyone time and worry, and improve services
- concentrate our skills and experience where they make the biggest difference for patients.

What will primary, intermediate and hospital care look like?

Primary care

- There will be a greater focus on keeping people healthy, like more health screening and better management of long-term conditions
- there will be more appointments earlier in the day, later at night, and at weekends. Already 280,000 patients can use online consultations and 60,000 can use video consultations. We want everyone to be able to use online advice if they wish.
- GP practices will work together and in partnership with other services. Patients won't have to go to lots of different places to get simple treatments. Other health professionals will take on some responsibilities from GPs, like treating coughs, colds and minor injuries.

Our residents' responsibilities

Our plans are dependent on people recognising their responsibility to:

- Look after themselves
- ask for help when necessary
- use services sensibly and fairly
- be an active part of their own community.

In 2016/17 we will produce a People's Health and Wellbeing Charter so that people can understand their responsibilities and access the right care in the right place at the right time.

Intermediate care

- Intermediate health and social care will respond more quickly when people become ill
- to help people get home as soon as they are medically fit, more services will be available in, or close to people's homes; in GP practices; in local services hubs or in hospitals.

Hospital services

- Concentrating specialist doctors, teams and equipment in 24/7 units leads to better outcomes for patients. In 2012 the NHS agreed to reduce the number of major hospitals in north west London from nine to five. This will improve urgent care, planned surgery, maternity services and children's care.

- major hospitals at Chelsea and Westminster, Hammersmith, Hillingdon, Northwick Park, St Mary's and West Middlesex, will be supported by local hospitals at Charing Cross, Central Middlesex and Ealing.
- all three local hospitals will have a local A&E and a range of services to meet the needs of the vast majority of the local population e.g. services for elderly people; access to appropriate beds; and a range of outpatient and test facilities. No substantive changes to A&Es in Ealing or at Charing Cross will be made until there are sufficient alternatives in place through local services or in other major hospitals.

Supporting the transformation

To transform services and make them sustainable, we need to invest in our workforce and digital technology, improve our buildings and make services more efficient.

Workforce

- We need to **recruit and retaining a permanent workforce** that works in multi-disciplinary teams with new roles and careers
- invest £15million in **developing, educating and training staff**, to support changing population needs
- establish **leadership development forums** to drive transformation and share good practice and learning.

Digital

- Increase the use of technology to **reduce unnecessary trips to and from hospital**
- reduce paper and **share electronic care records** across the NHS to make sure patients are properly cared for at all times
- **patient records, online information and support** should be readily available and understood by patients and carers so they can become more involved in their own care
- use **population care data** to make better decisions about future services and to support integrated health and social care.

Buildings and facilities

- **Share facilities** between health, social care and local government and develop local services hubs to maximise the use of space, be more efficient and make services more integrated
- use an investment fund of up to £100million **to improve the condition of primary care buildings and facilities**
- improve hospital buildings and facilities and introduce new ways of working which will **reduce the £625million we need to maintain outdated buildings.**

Make every contact count

Everyone in the NHS who comes into contact with members of the public has the opportunity to have a conversation to improve their health, whether they are a receptionist, heart surgeon or GP. We want to help those staff in having (sometimes difficult) conversations with people.

We welcome your comments on any aspect of this plan but in particular:

- Do you think we have chosen the right priorities and overall vision?
- Are there specific ideas that you agree or disagree with?
- Are there bits missing?

You can send us your comments either online at www.healthiernwlondon.commonplace.is or email healthiernwl@nw.london.nhs.uk

We look forward to hearing from you.

Appendix 2

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

V01

21 October 2016

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

N ngland has published the Five Year Forward View (FYFV), setting out a vision f e future of the NHS. Local areas have been asked to develop a Sustainability c ransformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.4bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful. We have listened to the feedback we have received so far from our patients and residents and updated our plan in particular around access to primary care and the delivery of mental health services. We will continue to engage throughout the lifetime of the plan.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group and NW London STP System Leader

Carolyn Downs
Chief Executive of Brent Council

Clare Parker
Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

Contents Page

i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs (e.g. schizophrenia) have a life expectancy up to 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.4bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

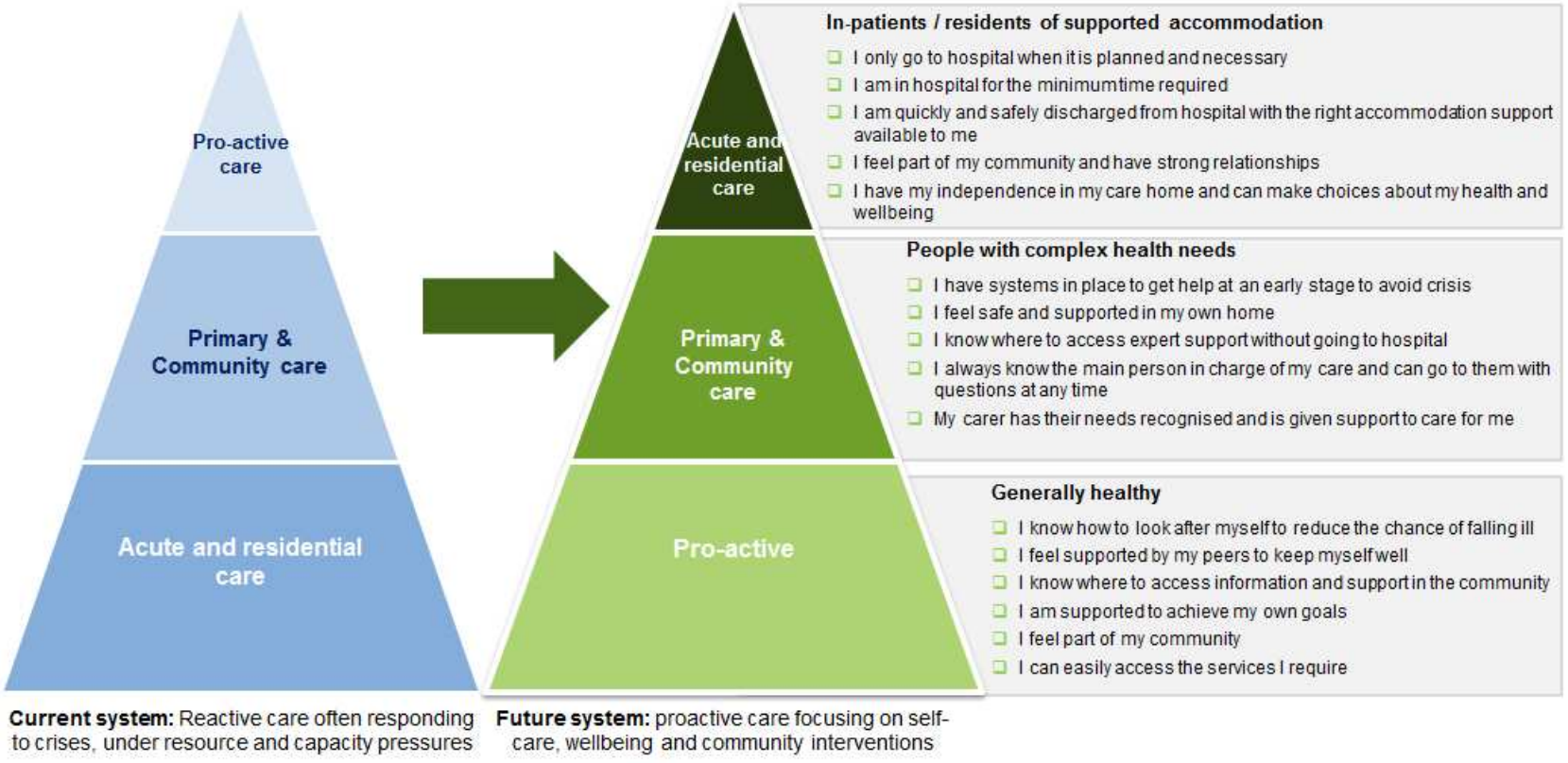
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,000	458,000	26,000	43,300	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	16%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
256 roving lth & being	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children the get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole ulation ensuring proactive, co-ordinated and accessible care. We will deliver this ugh primary care operating at scale through networks, federations of practices or er-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves, it benefits from specialisation and innovation. The benefits of senior clinical advice available at most parts of the day are now well documented to improve outcomes as it enables the right treatment to be s delivered to the patient at the right time We know from our London wide work on stroke and major trauma that better outcomes can be achieved by consolidating specialist doctors into a smaller number of units that can deliver consistently high quality, well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our STP sets out how we will meet the needs of our population more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also allow us to deliver primary care to scale with an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs. Due to the on-going uncertainty of the future of Ealing Hospital the vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. As Ealing currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

A joint statement from six boroughs is at Appendix A. Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute services in the two respective boroughs. Both councils remain fully committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

There is a similar vision for Charing Cross Hospital. Here, again, we plan to deliver ambulatory care, primary care to scale and an extensive range of diagnostic services. However at Charing Cross, during this STP period, there are no planned changes to the A&E services currently being provided.

i. Executive Summary: Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £298m gap in social care, giving a system wide shortfall of £1,410m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the health sector is a £15.1m surplus, and the social care deficit is £35m, giving an overall sector deficit of £19.9m.

Table: North West London Footprint position in 20/21

£'m	CCGs	Acute	Non-Acute	Spec. Comm	Primary Care	STF Investment	Sub-total (Health)	Social Care	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Do Nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	**-**	**(1,112.4)**	**(297.5)**	**(1,409.9)**
Business as usual savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	**108.5**	**680.6**
A 1-5 - Investment	(118.3)	-	-	-	-	-	**(118.3)**	**-**	**(118.3)**
A1-5 - Savings	302.9	120.4	23.0	-	-	-	**446.3**	62.5	**508.8**
dditional costs of delivering 5YFV	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	**-**	**1,127.5**	**262.5**	**1,390.0**
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	**-**	**-**	**-**	**15.1**	**(35.0)**	**(19.9)**

Schemes have been identified which support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the areas of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes These schemes, as well as improving patient outcomes, are expected to cost less – requiring £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings.

In addition, the solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, mainly attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for most providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing, once it can be demonstrated that reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.

The remaining deficit is due to London Ambulance Service (NWL only) and Royal Brompton & Harefield, who are within the NWL footprint but primarily commissioned by NHS England.

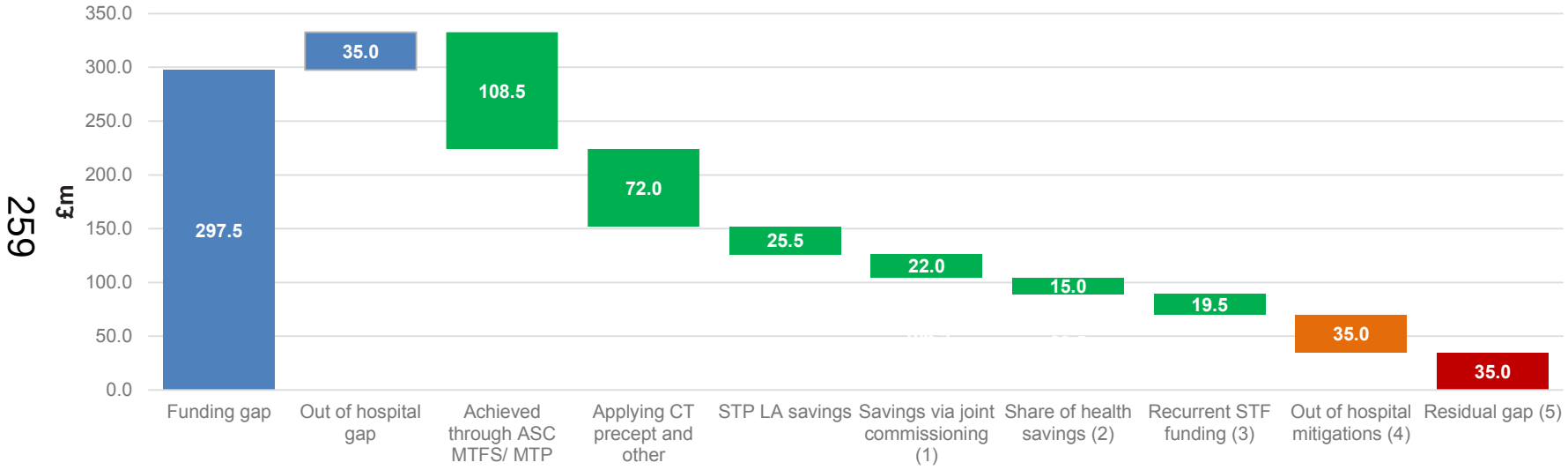
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances (I)

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. In addition to this there continues to be a significant level of service and demographic pressures putting further strain on the service. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The chart below sets out below the projected gap and how this will be addressed. The savings are further broken down on the following slide.



The following assumptions and caveats apply:
The residual gap of £35m by 20/21 will be addressed through further joint working between health and social care. An initial estimated cost pressure of £35m illustrates the likely shift from hospital activity into adult social care, which is to be addressed through a robust business case process. £19.5m is assumed to be funded by STF on a recurrent basis, leaving an unresolved recurrent gap of £35m.

(1) Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3;
(2) The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;
(3) Assumed that £19.5m will be recurrent funding from 2020/21through the STF fund;
(4) Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;
(5) The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.
NB Confirmation of what the final on-going sources of funding will be from 2020/21 is being sought.

i. Executive Summary:
Social Care Finances (2)

The table below sets out how the savings accruing to local authorities from joint work with Health on the Delivery Area business cases will be delivered through the investment of transformation funding:

Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health** (£M)
Public Health & prevention	DA1	**-**	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	**-**	**-**	**-**	**6.1**
Caring for people with complex needs	DA3	**-**	**-**	**-**	**5.1**
Accommodation based care	DA3	**7.7**	**-**	**7.7**	**2.0**
Discharge	DA3	**3.4**	**-**	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	**-**
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	**-**	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:
To deliver the savings requires non-recurrent transformational investment from the NHS Sustainability and Transformation Fund of an estimated £110m over 3 years (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services. The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary: 16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA1	i. Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery ii. Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	i. A shared understanding of public and professional responsibility for use of services ii. Maximising opportunities working jointly to support people with mental health problems, resulting in benefits to the health system and wider local economy
DA2	i. Increased accessibility to primary care through extended hours and via a variety of channels (e.g. digital, phone, face-to-face) ii. Enhanced primary care with focus on providing more proactive and co-ordinated care to patients iii. Comprehensive diabetes performance dashboard at practice and CCG level iv. Delivery of Patient Activation Measure Year 1 targets as part of the self care framework	i. Delivering extended access for Primary Care, 8am – 8pm, 7 days a week, leading to additional appointments available for patients out of hours, every week, as well as a reduction in NELs and A&E attendances ii. Unique, convenient , efficient and better care for patients as well as supporting sustainability and delivering accountable care for patients iii. Improve health and wellbeing of local diabetic population iv. Enable more patients with an LTC to self-manage
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint safer staffing programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.4bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

1. Case for Change:
Understanding our population

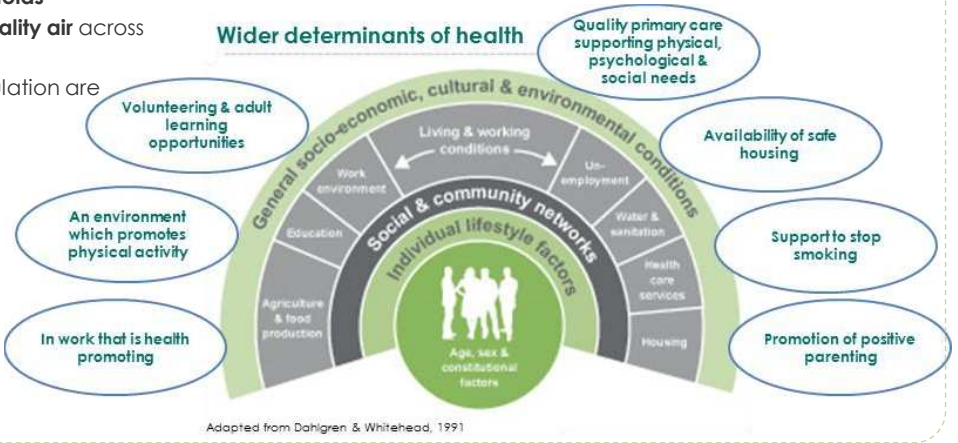
In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of** **n decay** in children aged 5 (50% higher than and average)
- e primary school **children with high levels of obesity**

264

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Adapted from Dahlgren & Whitehead, 1991

Population Segmentation for NW London 2015–30[3]

Mostly healthy

- 1,216,000 adults in NW London are mostly healthy
- 58% of the total population
- 24% of care spend in NW London

In 2030:
- 4% more adults
- 31% more +65s

One or more long-term conditions

- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030:
- 35% more adults
- 37% more spend in NW London

Cancer

- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4.5% of care spend in NW London

In 2030:
- 53% more adults
- 50% more spend in NW London

Serious and long term mental health needs

- 37,500 adults in NW London have serious and long term mental health needs
- 2% of population
- 7.5% of care spend

In 2030:
- 16% more adults
- 21% more spend in NW London

Learning disability

- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8% of care spend in NW London

In 2030:
- 29% more adults
- 35% more spend in NW London

Severe physical disability

- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults
- 26% more spend in NW London

Advanced dementia / Alzheimer's

- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults
- 44% more spend in NW London

Children

- 438,200 children in NW London
- 21% of the population
- 14% of care spend in NW London

In 2030:
- 6% more children
- 3% more spend in NW London

Socially Excluded Groups

- Westminster has the highest recorded population of rough sleepers of any local authority in the country
- There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

Please note that segment numbers are for adults only with the exception of the children segment

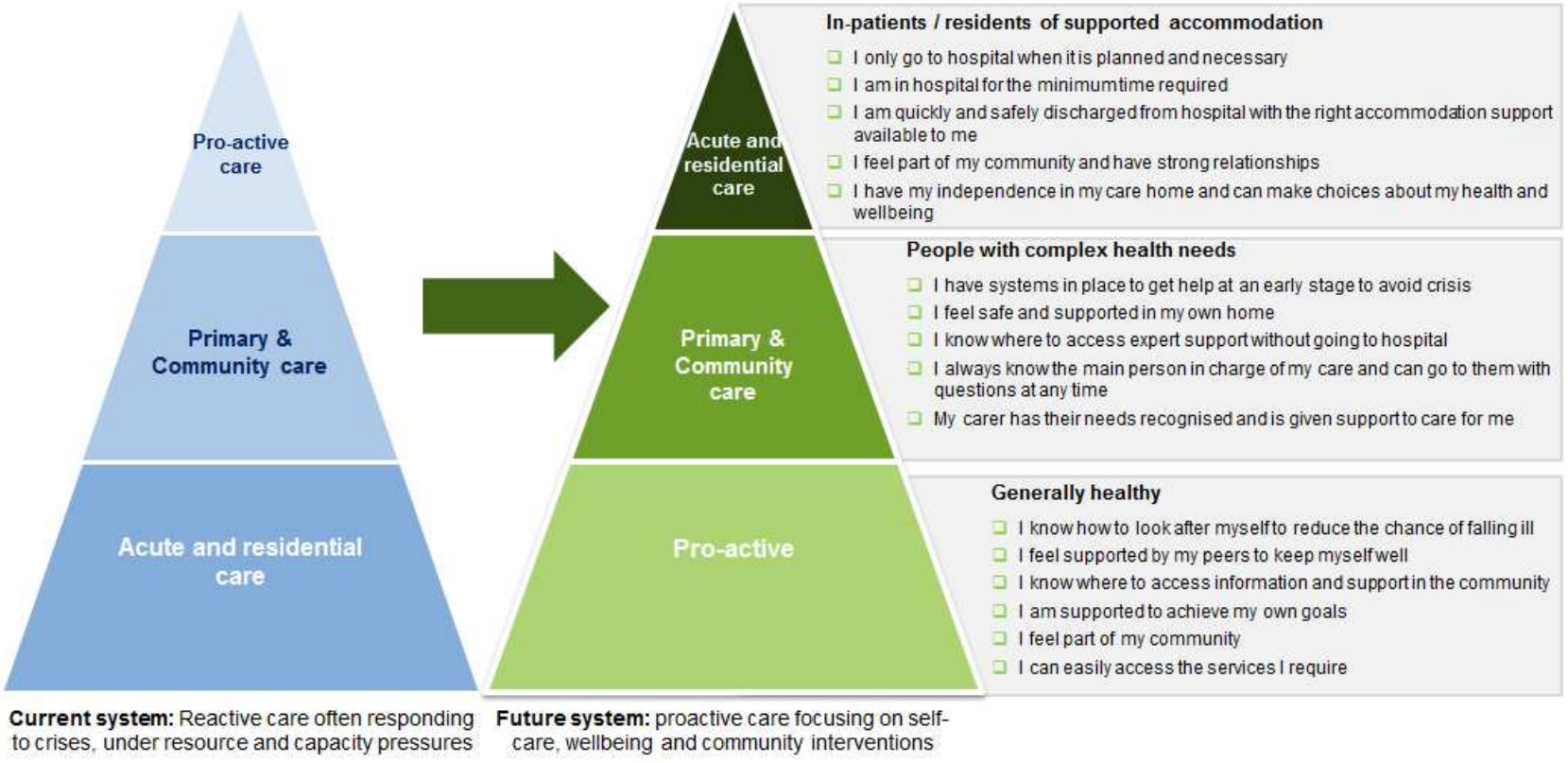
1. Case for Change:

The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

1. Case for Change:
Understanding people's needs

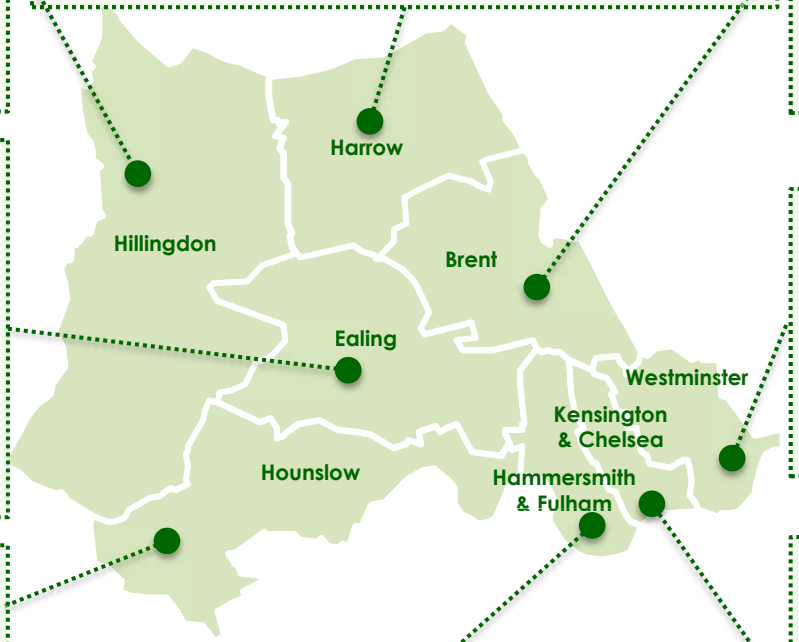
While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6

- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a [illegible]% rise in the number of people over [illegible] years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)



- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

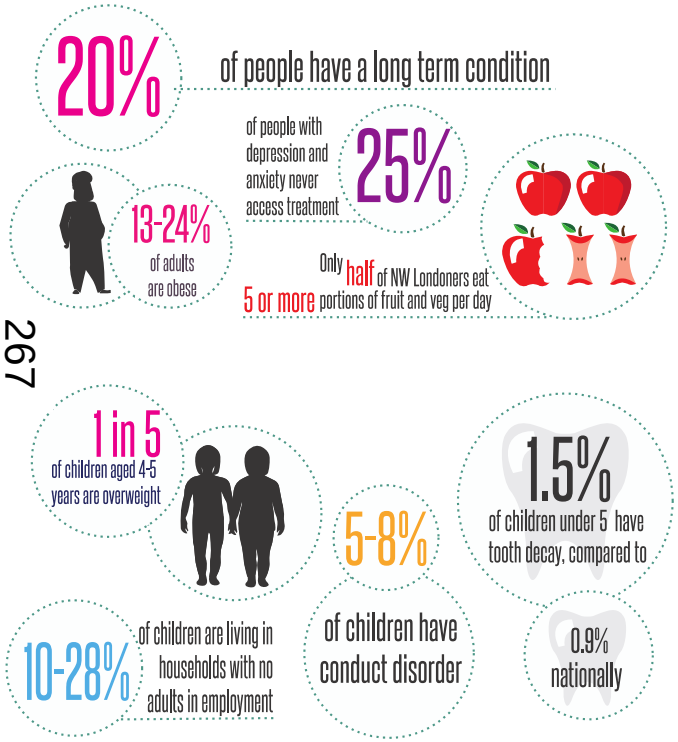
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…



1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

Our Priorities

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

1 Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

2 Improve children's mental and physical health and well-being

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

3 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

"My life is important, I am part of my community and I have opportunity, choice and control"

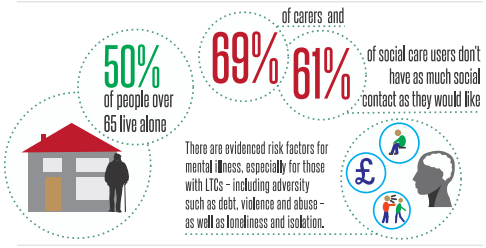
"As soon as I am struggling, appropriate and timely help is available"

"The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me"

"My wellbeing and happiness is valued and I am supported to stay well and thrive"

"I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing"

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health and preventing escalation of mental health needs	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
268 r 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy circa 20 years less than the average and the number of people in this group in NW London is double the national average.	People are supported holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

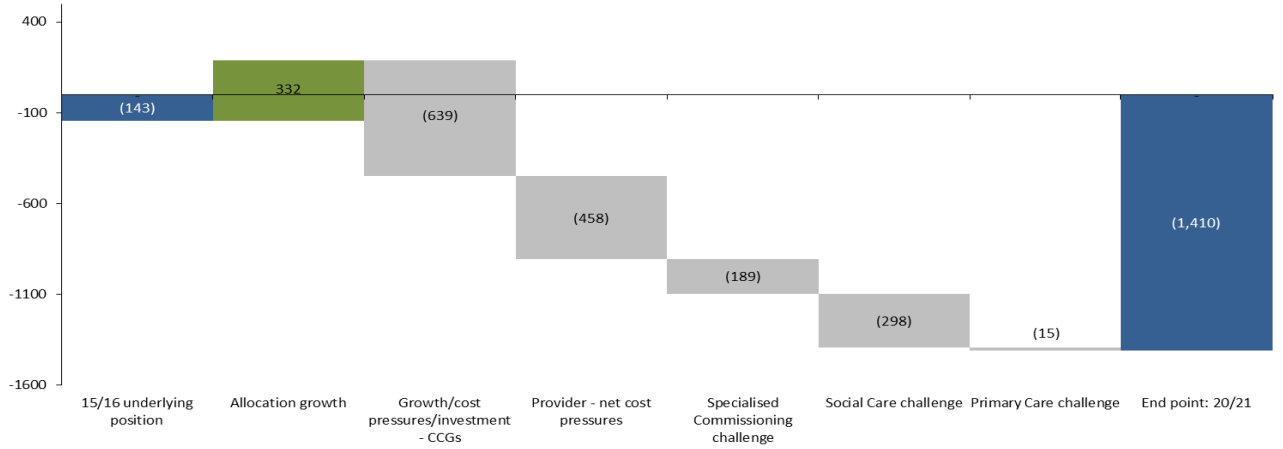
Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £297m gap in social care, giving a system wide shortfall of £1,410m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

Profile of the 'Do nothing' movement in financial position 2015/16 to 2020/21



Profile of the 'Do Nothing' financial challenge by organisation outturn 17/18 to 20/21

Sector	17/18	18/19	19/20	20/21
	£'m	£'m	£'m	£'m
Providers	(403)	(493)	(579)	(661)
CCGs	(77)	(140)	(198)	(248)
Spec Comm	(44)	(90)	(138)	(189)
Primary Care	(1)	(12)	(19)	(15)
Total NHS	**(525)**	**(735)**	**(934)**	**(1,113)**
Social Care	(74)	(148)	(223)	(297)
Total Health & Social Care	**(599)**	**(883)**	**(1,157)**	**(1,410)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
270 roving lth & being	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children to get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1: Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

2020/2021

271

Target Population:

All adults: 1,641,500

Mostly Healthy Adults at risk of developing a LTC: 121,680

All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is <u>important</u> for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. We will support positive choices through sexual health service transformation. Our residents who have a learning disability are also sometimes not receiving the full support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Developing a number of cross cutting approaches which will amplify the interventions described below and overleaf – embedding Making Every Contact Count and supporting national campaigns being 2 such examples.
- Interventions that are focused on **keeping our whole population well** and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Targeted work with the population who **need mental health support** – the mortality gap is driven largely through unhealthy lifestyles and barriers to accessing the right support. We will work to address the wider determinants of health, such as employment and housing, where there is good evidence of impact. Social isolation, whether older people, single parents, or people how need mental health support affects around 200,000 people in NW London and can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].
- Enabling **children to get the best start in life,** by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].

2. Delivery Area 1: Radically upgrading prevention and wellbeing

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A number of cross cutting approaches and new ways of working will support activity in this area and through working across health and social care, with public health leadership will help increase our ability to deliver the interventions and outcomes described below: **- Embedding principles of Making Every Contact Count in all services commissioned across Delivery Areas 1-5** **- Supporting and publicising national campaigns and work such as on cancer prevention, mental health stigma and self care**				
A **Enabling and supporting healthier living – for the population of NWL**	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London • Implement NW London wide programmes for physical activity for adults • Widespread availability of Long Acting Reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss	3.5	9
B **Keeping People Mentally Well and avoiding Social Isolation**	The healthy living programme plans will also cover how Boroughs will address social isolation, building on current local work: In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda Provide digitally enabled support to people , including Patient Reported Outcome Measures (PROMs), online communities, digital engagement via online and apps (especially for young people), social prescribing and sign posting to relevant support Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities Target smoking cessation activities at people with mental illness to support reducing ill-health as a consequence of tobacco usage.	0.5	6.6
C **Helping children to get the best start in life**	• Implement the prevention priorities within the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services – especially in schools – as part of a wider new model of care • Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough	• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work • Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity	TBC	TBC

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my g term condition. As person living with this dition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is <u>important</u> for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas. Improving the strength and sustainability of primary care is critical in tackling unwarranted variations and improving LTC management and outcomes. Taking action on the key SCF areas of proactive and co-ordination will equip primary care to do so.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1)[7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].
- Children and young people with special education needs and disabilities are a vulnerable group that can require access to specialist support, often delivered by multi-agency services. Implementing CCG responsibilities for SEND under the Children & Families Act 2014 is therefore a NW London priority.

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A
274
Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care
	• For Accessible care:
	  • provide extended access specs with quantification of reduced attendances and admissions
	  • Deliver affordable access solutions for the 8-8, 7 day requirements
	  • Create minimum standards for appointment requirements
	  • Achieve accessible read/write patient records
	  • Deliver operational access and a communications programme for patients, key providers and stakeholders
	  • Align extended access provision with urgent care and 111
	• For Co-ordinated care:
	  • define key features for primary and integrated care teams and deliver consistent outcomes for care team models across NW London
	  • Deliver consistent outcomes for care team models across NW London
	  • Agree targeted population within CCG as priority for co-ordinate care management across NWL
	  • Design standard approach to risk stratification and case finding across NWL. Maximise use of WSIC dashboard to monitor patients and case find
	  • Define core intervention for care teams for core population
	  • Define roles that the care team will carry out daily with patients
	• For Proactive care:
	  • finalise key outcome measures for preventive care in LTC
	  • Develop two clinical pathways (including diabetes) and test against provider-models and outcome-measures
	  • Define key outcome measures for needs-based client groups (adults) and explore gap-analysis locally
	  • All eight CCGs supported in implementation of Patient Activation Measure (PAM) programme with target patients receiving PAM assessment and tailored approach to self-care
	• Support CCGs to deliver their GP Access Fund objectives with a consistent and systematic approach, including delivery of the Extended Primary Care Service providing significantly higher levels of access to NW London residents
	• Continue to support the development of federations, enabling the delivery of primary care at scale
	• Host workshops and service-user survey in key geographical areas, building on existing Healthwatch, Patient Participation Group and Lay Partner Advisory Group priorities (e.g. to review I-statements and test outcome measures)
	• Develop two clinical pathways (diabetes, atrial fibrillation) and test against provider-models and outcome-measures
	• Identify four to eight geographical areas to test the draft pathways against the defined outcomes with pilot clinical teams
	• Review of key pressure-points in clinical working day
		• Fully implement the primary care outcomes within the SCF in each of the eight boroughs and across NW London
		• Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working
		• Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers
		• Deliver this range of co-ordinated and population-based care through a system of networked hubs, with facility for both physical and digital access by patients, including services for people with dementia
		• Enable general practices and multi-disciplinary hubs to access and share digital patient records, including crisis care-plans and LTC pathway management
		• Provide access to a spectrum of care, for appropriate population-based interventions for urgent LTC and on-going care needs
		• Ambulatory and emergency care schemes in place
		• Develop relevant LTC clinical pathways in light of co-ordinated and proactive care experience
			18	26.4

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
Improve cancer screening to increase early diagnosis and faster treatment	Our Primary Care Cancer Board will take the learning from Healthy London Partnership's (HLP) Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will: • Share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. • Align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18 to ensure sufficient capacity within NW London. • Roll out improved information regarding patient choice and 2 week wait to support patients referred from primary care with suspected cancer • Implement straight to test endoscopy at Imperial, Ealing, Northwick Park and Hillingdon hospitals. • Begin to work with the voluntary sector to research primary care learning from Significant Event Audits • Work with Trusts to create more effective and efficient inter Trust referrals to support the delivery of national standards.	In partnership with Healthy London Partnership' s Transforming Cancer Programme and the Royal Marsden and Partners Cancer Vanguard, we will develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, These actions will reduce variation in acute care and ensure that patients have effective, high quality cancer care wherever they are treated in NW London.	TBC	TBC
…er outcomes and support …people with common mental health needs **(with an initial focus on people with long term physical health conditions)**	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC

Reduce variation by focusing on 'Right Care' priority areas	• Three key areas identified to be the largest priority to focus on at sector-wide level: diabetes prevention, atrial fibrillation and reducing hypertension
	• Identified and/or commenced work in 2016/17 in following areas:
	  • Mobilisation of National Diabetes Prevention Programme
	  • Comprehensive diabetes performance dashboard at practice and CCG level
	  • Comprehensive referral process for patients with non-diabetic hyperglycaemia into the National Diabetes Programme
	• Aside from these three deliverables, each CCG will be addressing the issues that cause the most unwarranted variation in care in their locality
	• The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care. Brent and Harrow have are also national 1st wave delivery sites and are focussing on diabetes and MSK.
		• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools
		• Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes
		• Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations
		• Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors
		• Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs
		• Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.
			2	12.4

B

C

275

D

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
Improve self-management and 'patient activation'	• Develop protocols for approved health apps to support self-care in collaboration with Digital Health London • Develop a package of evidence and case studies to support local areas to adopt innovative approaches such as AliveCor, a digital device being rolled out by Hounslow GPs which uses smartphones to detect Atrial Fibrillation in patients Develop best practice approaches to online-management solutions • Host NW London symposium series, commencing with Activating the Workforce in November • Support delivery of IG Governance toolkit L2 compliance within targeted CCG and develop case study for wider support. • Development of Third sector programme framework, supporting development of the voluntary sector infrastructure to support self-care • Patient Activation Measurement (PAM) programme implemented across NW London with target patients receiving assessment and tailored approach to self-care (target 43,920 patients). Self-Care programmes delivered in NW London to be aligned to PAM levels, supporting a tailored approach to self-care and a NW London mental health and wellbeing guidance to PAM levels to be developed.	• Full delivery of Self-Care framework across NW London • NW London workforce supported by embedded self-care training programmes • Technology, including online management solutions, in place to support self-management and health education for people with LTCs • PAM embedded across health and social care supporting tailoring of care for all people with LTC (target 428,700 patients) • Third Sector fully integrated within Accountable Care Partnerships with single point of access and geographically based consortiums • Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from co-ordinated care and continuity with a named clinician to support them with LTCs • Increase availability of, and access to, personal health budgets, taking on integrated personal commissioning approach, including building on good practice from within and outside NW London around the use of brokerage to manage access to such personalised services	3.4	6.2

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

2020/2021

277

Contribution to Closing the Financial Gap

£72.1m

Target Population:

311,500

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is important for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Improve market management and take a whole systems approach to commissioning**	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	**Implement accountable care partnerships**	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnerships • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnerships, with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	**Upgraded rapid response and intermediate care services**	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible by identifying opportunities and agreeing transformational improvements to NW London models, either locally or NW London-wide • Improve the rate of return on existing services, reducing NEL admissions and reducing length of stay • Enhance integration with other service providers • Establish an older people's reference group to guide this work • Agreed the older person's pathway across community, acute and last phase of life • Agreed areas for standardisation across NW London for IC/RR and acute frailty • Agreed outcomes and standards for intermediate care function and acute frailty	• Use best practice model across all eight boroughs, creating standardisation wherever possible to enable additional capacity to decrease the inappropriate time that a person is cared for in an institutional setting • Operate rapid response and integrated care as part of a fully integrated ACP model	20.2	64.9
D	**Create an integrated and consistent transfer of care approach across NW London**	• Agree an integrated health and social care model to improve transfer of care • Implement a single needs-based assessment to support appropriate transfer of care via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and transfer of care across NW London	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • Transfer of care correspondence is electronic with the single assessment process built into the shared care records across NW London • Fully integrated health and social care transfer of care process for all patients in NW London	7.4	9.6
E	**Improve care in the last phase of life**	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

2020/2021

279

Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is <u>important</u> for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. The NW London STP has mental health threaded throughout our delivery areas – within prevention and within work on long term conditions. But we know that focus is also required as poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact – and the outcomes described in the implementation guidance are reflected in our plans[2].

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially impacted by their condition and **10% will commit suicide**
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before the age of 18 .
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – thresholds to access services can be barriers to access care – and stigma remains a challenge for many people – and in particular within some communities,

Our aim in NW London is to improve outcomes for children and for adults with mental health needs, we will do this by:

- Implementing a new model of care for adults which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing the very specific needs that relate to some of our populations – such as for people with learning disabilities (through the Transforming Care Partnership) and for new mothers
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need – building on current Early Intervention in Psychosis and Liaison Psychiatry services.
- Implementing 'Future in Mind' Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home[3].

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4: Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	**Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy**	• More support available in primary care through locally commissioned services – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
		• More support available in primary care through locally commissioned services
			• Full roll out of the new model across NW London providing tailored evidence based support available closer to home to service users and carers, which will include:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			 
				11	16

B	**Focussed interventions for target populations**	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Provide vulnerable individuals and their families with best practice support • Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care	TBC	5

C	**Crisis support services, including delivering the 'Crisis Care Concordat'**	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS), Metropolitan police and other services – meeting access targets
		• Round the clock mental health teams in our A&Es and support on wards, progress towards 'core 24'
		• Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)
			• Ensure care will be available for service users and carers when they most need it through:
			  • Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery
			  • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis
				TBC	TBC

D	**Implementing 'Future in Mind' to improve children's mental health and wellbeing**	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Digital enablement to share information between care settings to support new care models • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

281

2020/2021

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is important for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Ensure all patients receive prompt treatment in accordance with the national referral to treatment (RTT) standards,
- Consolidate acute services onto five sites (the local government position on proposed acute changes is set out in Appendix A)
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Specialised Commissioning**	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	**Deliver the 7 day services standards**	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C **Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites Fully deliver on the vision for maternity set out in *Better Births* national maternity review – through our 15/16 reconfiguration programme we have already made significant progress delivering this vision for maternity. In 16/17 we will focus on providing continuity of care for women, so that maternity care is provided by a small team of midwives during the antenatal, intrapartum and postnatal period.	Reduce demand for acute services through investment in the pro active out of hospital care model, enabled by investment in the Hubs. Develop the hospital in Ealing and jointly shape the delivery of health and social care provision of services from that site, including: • a network of ambulatory care pathways • a centre of excellence for elderly services including access to appropriate beds • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists. Deliver on the full recommendations set out in *Better Births* national maternity review, in order to achieve joined-up, sustainable continuity of care for women in NW London.	33.6	89.6
D **NW London Productivity Programme**	A Chief Transformation Officer has been appointed to lead a collaborative transformation programme across all NHS Trusts in NW London and a team of interim senior programme directors have been appointed. By the end of 16/17 we will agree and resource a sustainable team to ensure these priorities are delivered. This is a big ticket cost reduction transformation programme within the STP and we should secure investment proportionate to the costs savings. Implement and embed the NW London productivity programme across all provider NHS trusts, focusing on the following four areas: • **Orthopaedics**: mobilise a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT) to reduce unwarranted variation and increase efficiency, thus generating both quality improvements and financial savings. Ensure all Acute Providers in North West London have agreed Best In Sector Performance Metrics and establish a NW London dashboard. Agree priorities and interventions and commence delivery. • **Procurement**: deliver £3m of immediate tactical non-pay savings. Agree plan to reduce unwarranted variation in NHS supplies prices, and make £15.2m savings in non-pay spend. Develop options and agree a NW London operating model, in line with best practice and Carter and identify any structural changes required to the way procurement is currently delivered. , Establish common procurement competencies and staff development plan. Ensure robust plans in place with ownership from Procurement leads, CFOs and clinical lead and identify any investment required. • **Safer Staffing**: Agree a three year delivery plan with trajectory of benefits and any required investment identified. Agree detailed proposal for reduction in agency costs via more effective staff bank, supported by technology. All e-nursing rosters agreed six weeks in advance and plan for medical roster implementation, benchmark and share all data. • **Back Office**: this is **new and additional priority** agreed in September 2016. Deliver additional collaborative productivity opportunities. Agree priorities, geographic clusters and three year delivery plan with trajectory of benefits and any required investment identified. Integrated Procurement and Safer Staffing work within the wider Back Office plans.	Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together to deliver added value. **Rolling programme of pathway redesign and quality improvement initiatives to ensure trusts are consistently in the top quartile of efficiency (Getting It Right First Time principles).** Shared records is a key enabler of all pathway redesign. • **Orthopaedics:** Implement plan agreed in 16/17. Agree a consolidated service model for a NWL collaborative elective Orthopaedic centre, agree a business case and implement subject to investment. • **Identify and implement priorities for rolling programme following Orthopaedics.** • **Procurement:** Implement a pan-NWL procurement operating model which is compliant with the National Interim Future Operating Model, Deliver Carter compliant Procurement Transformation Plans with quantified (and delivered) financial savings which all leads to Collaborative and shared service models in place for NWL procurement operating within a sustainable financial footprint assessed by improving year on year saving: cost ratios. • **Safer Staffing:** build on work from 2016/17 such that rostering is optimised, bank fill rates are maximised and reliance on agency is minimised. (quantified benefits will emerge from 16/17 business case) Developed a workforce plan summarising the total workforce numbers and competencies required across NWL. Collective workforce planning and collaborative resourcing to include recruitment, development and retention with the right balance of permanent and flexible workers . • **Back Office**: Implement priorities as described in business case.	4.1*	143.4

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas	By 2020/21, Enablers will change the landscape for health and social care:		
	Estates will…	**Digital will…**	**Workforce will…**
1. Radically upgrading prevention and wellbeing	• Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality • **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital • **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care • **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care • **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence	• **Target recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
iminating unwarranted ation and improving Long n Conditions (LTC) anagement			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers: Estates

Context

The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.

Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings

Our model requires investment in the development of local hubs to enable the provision of integrated, co-located health care, social care and voluntary support across the eight local authority/CCG areas, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care.

285 London has developed and submitted a joint 'One Public Estate' bid to rage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.

A joint health and council estates group has been established to oversee the work and minimise gross spend through aligning health and local authority plans for regeneration and seeking innovative financial solutions to provide estate cost-effectively, realising value from surplus assets.

There has been significant local progress towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £614m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs
  - The hub strategy and plans include community Mental Health services, such as IAPT
  - Hubs will support delivery of the GP 5 Year Forward View and are critical in enabling reconfiguration of acute services
  - Hubs will also help deliver the access and coordinated care aspects of the Strategic Commissioning Framework
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local Population
  - Trusts have developed proposals with the resultant capital requirement being presented in the Shaping a Healthier Future business case which is due to go to the NHSE investment committee for approval

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:

- Local services hubs will provide the physical location to support integrated public health, prevention and out-of-hospital care delivered by health , social care and voluntary organisations.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:

Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7 day access to all residents

Delivery Area 3 - Outcomes for older people:

- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of appropriate bedded care

Delivery Area 4 - Supporting those with mental health needs:

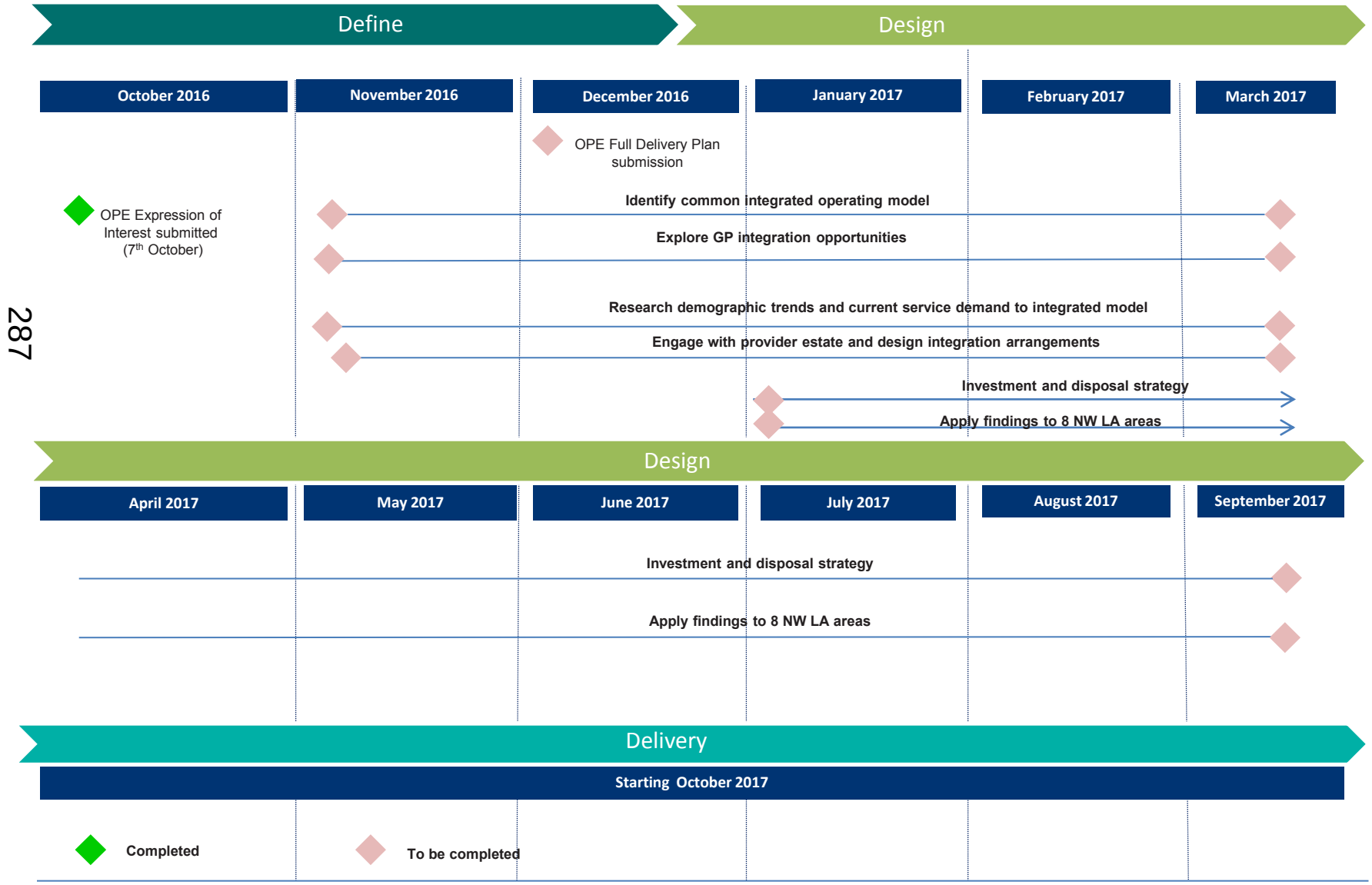
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

Delivery Area 5 – Providing high quality, sustainable acute services:

- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

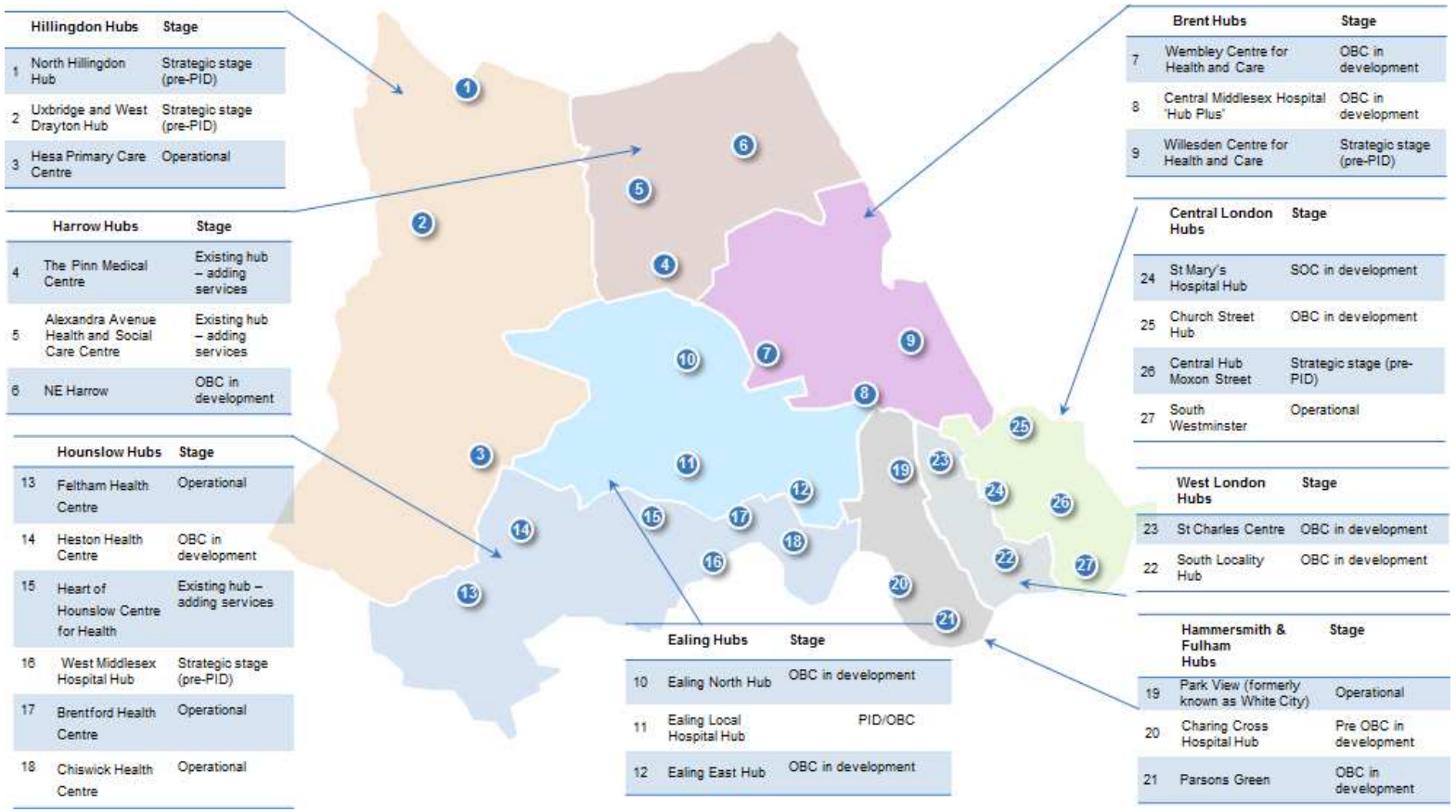
3. Enablers: Estates

Estates Strategy to deliver Out of Hospital through One Public Estate (OPE) – High level timeline to Oct 2017



3. Enablers:
Estates

Proposed Local Services Hubs map



	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage (pre-PID)
2	Uxbridge and West Drayton Hub	Strategic stage (pre-PID)
3	Hesa Primary Care Centre	Operational

	Harrow Hubs	Stage
4	The Pinn Medical Centre	Existing hub – adding services
5	Alexandra Avenue Health and Social Care Centre	Existing hub – adding services
6	NE Harrow	OBC in development

	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	OBC in development
15	Heart of Hounslow Centre for Health	Existing hub – adding services
16	West Middlesex Hospital Hub	Strategic stage (pre-PID)
17	Brentford Health Centre	Operational
18	Chiswick Health Centre	Operational

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	PID/OBC
12	Ealing East Hub	OBC in development

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	OBC in development
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Strategic stage (pre-PID)

	Central London Hubs	Stage
24	St Mary's Hospital Hub	SOC in development
25	Church Street Hub	OBC in development
26	Central Hub Moxon Street	Strategic stage (pre-PID)
27	South Westminster	Operational

	West London Hubs	Stage
23	St Charles Centre	OBC in development
22	South Locality Hub	OBC in development

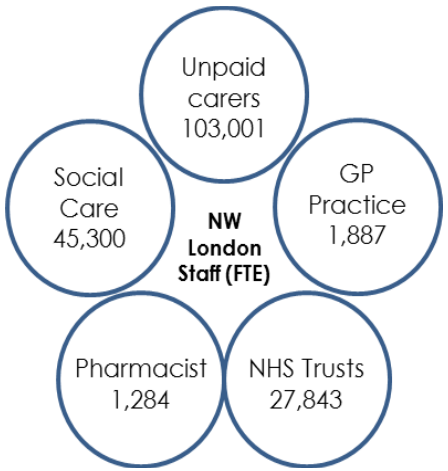
	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	Pre OBC in development
21	Parsons Green	OBC in development

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work. It will also be key to achieving our collective vision of improved quality of care through delivering sustainable new models of care that meet our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly to expand work across social care[1].
- Carers are also a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial to achieving our vision.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Appropriate workforce planning and actively addressing workforce issues will, however, be instrumental in addressing the five delivery areas in the STP.

The NW London workforce



The challenges our workforce strategy will address to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Achievements to date

Workforce planning and addressing workforce shortages

- Developed Infrastructure for workforce planning and analytics
- Established annual workforce planning processes for acute healthcare professionals
- Extended workforce planning to cover primary care including new models of care such as the Cancer Vanguard
- Worked with Skills for Care and engaged with national project work to ensure integrated workforce planning for Social Care
- Invested in a team of 4 workforce planners to support primary care and integration. Work includes the Day of Care Audit designed to improve efficiency in General Practice
- Worked with the Healthy London Partnership to understand the demand and supply of staff in primary care and identified opportunities to close the gaps.
- Led a centralised Pan-London placement management and workforce development programme for paramedics with an investment of over £1.5m, contributing to increasing workforce supply and staff retention
- Utilised health education funding to ensure high quality education for medical trainees on-going.

Improving recruitment and retention

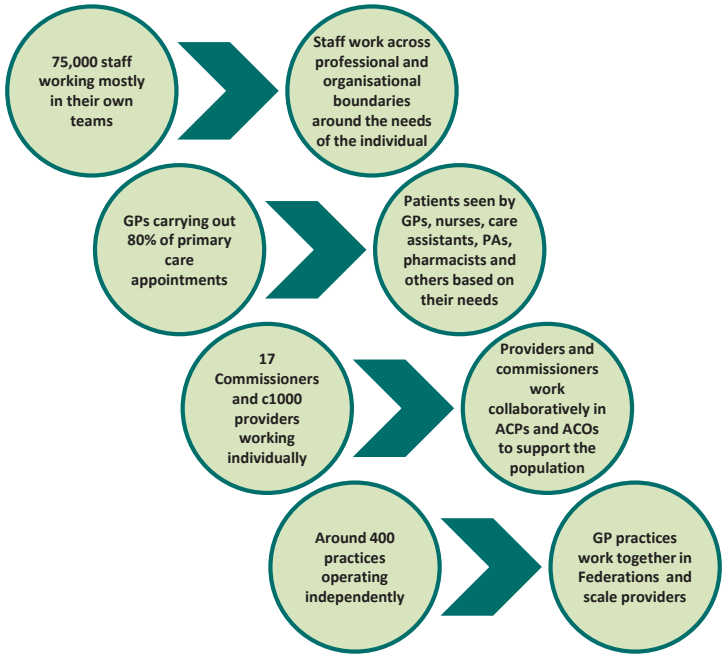
- With Capital Nurse we have started recruitment of 350 newly qualified nurses onto a rotational programme with educational and development support, this covers all NHS trusts in NW London as well as primary care. This investment will demonstrate the benefits of a rotational programme in improving retention rates and developing nurses within NW London to move on from their training to more senior nursing posts.
- We have programmes to improve the recruitment of nurses in general practice including a funded course with placements for nurse from outside of practice nursing to develop skills and experience to move into the sector. In 16/17 we have recruited 26 nurses across NW London.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care. Nine physician associates currently work in NW London, 31started training in September, a further 15 will start in February 2017. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 95 paediatric nurses and 9 consultants paediatricians.

Governance

Governance has been improved to deliver a comprehensive STP workforce strategy. This is supported by a strengthened collaboration between Health Education England and the CCG collaborative, local councils and other stakeholders. A CCG and HEE joint STP workforce team reports to a newly established Board that is co-chaired by the CCG, Social Care and HEE is a **key enabler** to delivery. This approach encompasses critical experience and expertise. It also maximises efficiency and ensures clinically led decision making and input from key stakeholders including health and social care providers, CEPNs (Community Education Providers Network) and the Healthy London Partnership.

A new robust governance structure to deliver the STP workforce strategy

What will be different in 2020[6]?



3. Enablers: Workforce

Current Transformation Plans and Benefits

Workforce planning and addressing workforce shortages

Effective workforce planning is essential for securing our future workforce, it underpins all further interventional activity and investment to support the workforce. We have the infrastructure in place to forecast shortages and develop plans to address them. This includes Primary Care and work is underway to ensure it covers new models of care such as the Cancer Vanguard. Critically this work will also include social care working with Skills for Care and through engagement and national project work.

Improving recruitment and retention

Improving recruitment and retention across health and social care will be critical to closing the financial gap and addressing workforce shortages. Modelling in London and the south east shows £100.7 million could be saved in the next 10 years by retaining new staff for 1 extra year. Recruitment and retention issues lead to high use of agency staff costing £172m.

To reduce spend on agency we will control demand for bank shifts by improving rostering and encourage more staff to work through banks instead of agencies to reduce agency costs.

Delivering the improvements in CAMHS Eating Disorder services will require an increase in numbers of staff with these specialist skills , we know we will face competition for these staff. We will work with our Like Minded programme to make sure NW London is an attractive place to come and work to retain cu staff and improve recruitment

W rce Transformation across health and social care workforce to support integrated care

Care in NW London will be delivered differently in 2021. Building on existing work we will support staff to work in new ways. To deliver the Strategic Commissioning Framework and the 10 point plan for Primary Care we will support workforce to improve productivity and build capacity in general practice and develop the whole care team. We will work with the Time for Care programme at an NW London level and develop local CCG plans based on local priorities and areas where the 10 High Impact Actions will have the greatest effect.

We have established the Change Academy. This is a collaborative programme across NW London to address workforce transformation, organisational development between providers and systems leadership. Through Change Academy High Performing Care programme we will support system change through high performing teams and improvement methodology underpinned by data enabled evidence-based decision-making. The scope of this programme will be multi-organisational change teams charged with delivery of STP on actual delivery issues in real time.

Leadership and Organisational Development to support future services

We understand that effective leadership underpins the transformation we need to achieve in NW London. As part of the Change Academy there are programmes targeted at supporting leaders across health and care:

I. STP/SPG systems leadership

II. Joint commissioning skills development

III. Emerging GP leaders network

IV. Practice manager development programme

This work will support staff and carers across all settings through the changes required by the STP and to develop the right culture to make sure changes are successfully delivered.

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- Using **£1.5m HEE funding** to support new models of care, self-care and LTCs
- Train up to 180 health and care professionals **to support self-care**
- Supporting 24 professionals to become **health coach trainers** to enable patients to take greater responsibility for their health
- Expand the programme in 2017/18 to develop carers as health trainers.
- Embed the NW London **Healthy Workplace Charter** to promote staff health and wellbeing initiatives and ambassadorship

Delivery Area 2 - Reducing variation:

- The seven day services programme is receiving an additional investment of £750K to trial new models of care and to further support the Radiography workforce.
- The Cancer Vanguard is being supported through instigating new project leads to drive evidence based service design

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- Delivery of the SCF and 10-pont plan for Primary Care through workforce transformation
- Consultant outreach into primary care
- CEPNs focused on developing the primary care and community workforce
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

- GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs were supported through an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.
- Using £600k of HEE funding to support the transformation of Serious and long term mental health and children and young people's mental health

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses by improving recruitment and more effective rostering and thereby the cost of service

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London CCGs, with good progress with Information Governance across care settings.
- Each of the eight CCGs has a single IT system across their practices, and six of the eight CCGs are implementing common systems across primary and community care.
- In the acute space, Imperial and Chelsea & Westminster have a strong track record with digital clinical systems and are working together on a common Electronic Patient Record. Imperial (with Chelwest) is expected to be nominated by NHS England as a Global Digital Exemplar and will provide leadership to the rest of the footprint in the provision of improved patient outcomes and enhanced business efficiencies.
- Digital technology will support Primary Care transformation with new models of care that support out of hospital Local Services, through shared records across care settings, including new GP provider networks/hubs and ultimately via Accountable Care Partnerships. Potential funding from the Estates & Technology Transformation Fund (ETTF) will help upskill the primary care workforce and encourage patients to use new digital channels to access care, and use digital tools to become more involved in their own care.
- The footprint has a good track record in delivery of shared records, e.g. the NW London Diagnostic Cloud. The NW London Care Information Exchange is under way, funded by the Imperial College Healthcare charity, to give patients and clinicians a single view of care across providers and platforms, and provide tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne in primary and community care. In the longer term, it is our ambition for the NWL Exchange to interface with the wider London Health and Care Information Exchange.
- There is good support from the NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London information exchange, record locator, and IG register.
- Imperial College Health Partners (ICHP), Academic Health Science Network (AHSN) for NW London, is working closely with local health and care partners to ensure that innovation plays a major part in achieving the goals set out in our STP. One example of this is the roll-out of the Intrapreneur programme which to date has enabled over 100 local executives and frontline clinicians to integrate innovation with their everyday role.

Key Challenges

- re is a significant challenge for digital to transform current delivery models and enable new, integrated models of health and social care, shifting care out of hospitals through red information between care settings and a reduced emphasis on traditional face-to-face care delivery.
- er 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access information about the patient[1]. This will be mitigated by sharing care records and converging with other footprints via national and pan-London NHS systems and capabilities (e.g. Summary Care Record, e-Referrals, Co-ordinate My Care, electronic discharges); and in the longer term addressed through the NW London Care Information Exchange and (for the 16% outside the footprint) a pan-London information exchange.
- Due to different services running multiple systems, achieving shared records is dependent on open interfaces, which primary and community IT suppliers have not yet delivered. This will require continued pressure on suppliers to resolve – in particular TPP and EMIS.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is requested from NHSE to define and fund interfaces nationally.
- Clinical transformation projects are invariably costly and time consuming, which needs to be allowed for in the LDR plans
- Some citizens and care professionals have rising expectations for digital healthcare which we cannot deliver; for others, there is a lack of digital awareness and enthusiasm, requiring a greater push for communication around the benefits of digital solutions and education on how best to use them.

Strategic Local Digital Roadmap (LDR) Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality
2. **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital
3. **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care
5. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence

Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education.
- **Digital Health** to leverage innovations such as remote monitoring, point of care and self-testing, mobile applications, interoperability of IT systems, big data analytics and AI.

The NW London Digital Programme Board will oversee delivery of the LDR, integrated with the governance of the STP.

3. Enablers: Digital

STP Delivery Area	LDR Work Stream	Key Digital Enablers for Sustainability & Transformation Plan
1. Radically upgrading prevention and wellbeing	• Tools for self-management and self-care • Enable Patient Access • Build a shared care record	**Deliver digital empowerment to enhance self-care and wellbeing:** • Easier access for citizens to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • Innovation programme to find the right **digital tools** to: help people **manage their health and** wellbeing through digital apps of their choice, connected to clinical IT systems; **create online communities** of patients and carers; get children and young people involved in health and wellness • **New digital channels** (e.g. online and video consultations) to help people engage more quickly and easily with primary care **Embed prevention and wellbeing into the 'whole systems' model:** • Support for integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care plans that are shared with patients and carers)
2. Eliminating unwarranted variation and improving LTC management	• Automate clinical workflows and records • Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Deliver digital empowerment by increasing patient engagement to better self-manage their LTCs:** • Delivery of Patient Activation Measures (PAM) tool for every patient with an LTC to develop health literacy and informed patients • Innovation programme to help people **manage their LTCs (conditions and interventions)** through digital apps of their choice, extending clinical systems to involve patients (e.g. SystmOne for diabetes) and potentially telehealth (e.g. wearable technology) **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience • Support for new models of multi-disciplinary care, delivered consistently across localities, through shared care records • **Automation of clinical workflows and records**, particularly in secondary care settings, and support for new pathways and transfers of care through interoperability and development of a shared care record to deliver **integrated health and care records and plans**
3. Achieving better outcomes and experiences for older people	• Enable Patient Access • Build a shared care record • Use dynamic data analytics	**Provide fully integrated service delivery of care for older people** • **Shared clinical information and infrastructure** to support new primary care and wellbeing hubs and ACPs with clinical solutions • Citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange, new digital channels** (e.g. online and video consultations) • Support for a **single transfer of care** approach, and **new models** of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care (NW London and pan-London CIEs) • **Integration of Co-ordinate My Care (CMC) for last phase of life plans** with acute, community and primary care systems; and promote its use in CCGs. through education and training and support care planning and management • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care **dashboards** across 350 GP practices will deliver direct, integrated patient care
4. Improving outcomes for children and adults with mental health needs	• Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Enable people to live full and healthy lives with the help of digital technology** • Innovation programme supported by the AHSN and industry leaders to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities – for example Patient Reported Outcome Measures (PROMs); **create online communities** of patients and carers; get children and young people involved through apps **Implement new models of care and 24/7 services where required** • Support for **new models** for out-of-hours and inter-disciplinary care, such as **24x7 crisis support services** and **shared crisis care plans** to deliver the objectives of the Crisis Care Concordat, through shared care records **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience
5. Ensuring we have safe, high quality, sustainable acute services	• Automate clinical workflows and records • Enable Patient Access • Build a shared care record	**Invest in digital technology in Hospitals** • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Support new models for out-of-hours care through **shared care records and the NWL diagnostic cloud**, such as 24x7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks • Better digital tools to ensure **optimisation of acute resources**, e.g. radiology Clinical Decision Support, referral wizards and decision support tools, greater use of NHS e-Referrals including Advice & Guidance capability • Integrated **discharge planning and management**, and support for **acute-to-acute transfers**. through shared care records • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • **Dynamic analytics** to track consistency and outcomes of out-of-hours care • **Partnership model for informatics delivery** that makes best use of specialist technology skills across organisations

4. Primary Care

Primary Care in the context of out of hospital transformation

The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (FYFV). In NW London, our STP sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans.

Our plans are for the development of integrated out of hospital care – Local Services – that will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be enabled to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. This will improve health and wellbeing and care and quality for patients.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London.

294

We will transform General Practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all, as set out in the Transforming Primary Care in London: a Strategic Commissioning Framework.

We will implement a substantial up scaling of intermediate care services, available to people locally, offering integrated health and social care teams outside an acute hospital setting.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP. Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

'There is arguably no more important job in modern Britain than that of the family doctor'

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

We are determined that NW London succeeds.

Enhanced Primary Care: Locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care, and co-ordination across key parts of the system against a single shared care-plan

Self-Care: Embedding the self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

Upgrading Rapid Response and Intermediate Care Services: delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

Transfer of Care: implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

4. Primary Care

The local services landscape including primary care

Achieving an effective model of integrated out of hospital services is key to the delivery of the NW London STP. Within NW London, we have a highly diverse population, which is supported within Primary and Community Care by a mix of out of hospital services with varying levels of capacity.

We have achieved much since we began implementing Primary Care transformation across NW London in 2015, and Whole Systems Integrated Care in 2014, but we do not underestimate the remaining challenges. We now have Primary Care operating at-scale across NW London (diagram, bottom right). Our current plans for further transformation are underpinned by national and local policies and initiatives:

- **The 5 Year Forward View (5YFV)**

As part of our Local Services Transformation, we aim to tackle the triple gap identified in the 5YFV: Finance, Sustainability and Quality. All of our initiatives have had these priorities in the forefront of our planning, and are key components of London's STP.

- **The General Practice Forward View (GPFV)**

The GPFV sets out a plan, backed by a multi-billion pound investment, to stabilise and transform General Practice. The focus of the plan centres around workforce (incentivisation for recruitment and retention), workload (practice resilience) , infrastructure (estates and technology) and care redesign.

- **The Strategic Commissioning Framework (SCF)**

This is London's agreed approach to supporting the focus on Accessible, Proactive and Co-ordinated Care within Primary Care. Self-care is an integral part of proactive care contributing towards Enhanced Primary Care offer.

- **The GP Access Fund (GPAF)**

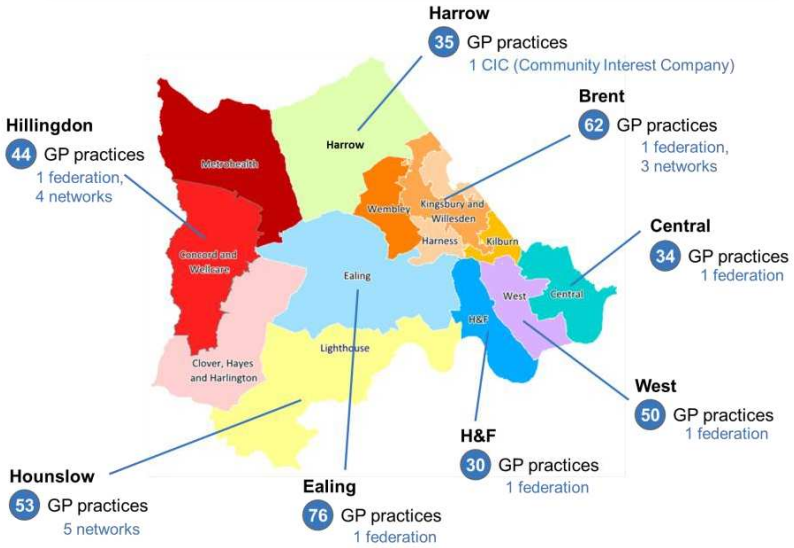
As part of the extended access aspects of Accessible Care, NW London will meet the extended access specifications by the end of Mach 2017, in order to better support our population to access Primary Care services more efficiently, at a time and place that suits them.

- **King's Fund and related reports**

Evidence based, national reports have indicated areas of focus for NW London. We have also utilised local knowledge from reviews and evaluation to assess our current status quo (blue box) and areas for development.

In NW London, we have:

- 1,093 GPs
- 473 practice nurses
- 273 clinical support staff
- Average list size 5,560
- GP and nurse workforce supply is the lowest in London
- 392 GP practices with 31 sites open at weekends
- 17 groups of GP providers
- 388 dental care practices
- 1,284 pharmacists
- Pharmacy and dental practice supply one of the best in London
- 5 different IC/RR services
- Multiple Single Points of Access (SPAs)
- Many care homes, often in disparate locations
- Differing provision of bedded and non-bedded care across NW London



4. Primary Care: CCGs have agreed to support Primary Care providers in delivering a clear set of standards over the next five years, in support of our vision

Proactive care	
Co-design	Work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve health and wellbeing
Developing assets and resources to improve health and wellbeing	Work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected and supported
Conversations focused on individual health goals	Where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	Enable and assist people to access (inc. in schools, community and workplaces) information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing.
Patients not accessing Primary Care services	Design ways to reach people who do not routinely access services and may be at higher risk of ill health.

Accessible care	
Patient choice	Patients have a choice of access (e.g. face-to-face, email, telephone, video)
Contacting the practice	Patients make one call, click, or contact to make an appointment. Primary care teams will actively promote online services to patients (inc. appointment booking, viewing records, prescription ordering and email consultations)
Routine opening hours	Patients can access pre-bookable appointments with a primary health professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	Patients can access a GP or other Primary Care health professional 7days a week, 12 hours per day (8am -8pm or alternative equivalent based on local need), for unscheduled and pre-bookable appointments
Same-day access	Patients can have a consultation (inc. virtually) with a GP or skilled nurse on the same day, in their local network
Urgent and emergency care	Patients can be clinically assessed rapidly. Practices will have systems and skilled staff to ensure patients are properly identified and responded to
Continuity of care	Patients are registered with a named team member, responsible for providing coordination and continuity, with practices offering flexible appointment lengths

Co-ordinated care	
Case finding and review	Practices identify patients, through data analytics, who would benefit from coordinated care and continuity with a named clinician, regularly and proactively reviewing those patients
Named professional	Patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	Each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in care
Patients supported to manage their health and wellbeing	Primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing. including the use of digital tools and education, such as health coaching.
Multi-disciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving. Care will be coordinated via shared electronic care records.

4. Primary Care: A whole population approach to delivering integrated out of hospital care in NW London

We have developed a whole population approach to delivering integrated out of hospital care in NW London.

Majority of activity

Population segments

Service needs	Mostly healthy people	People with complex conditions
Planned	**Prevention measures as per defined protocols** • Lifestyle interventions, health education in schools, smoking cessation, screening • Choice of access options and centralized scheduling across multiple channels • Services are available at convenient times (e.g. evenings and weekends) • Prevention programs in collaboration with Local Authorities, e.g. walk-in classes	**Care by the same team in core hours** • Support with adhering to a care plan under the guidance of a care-coordinator • Tailored advice and support with self-management that includes social interventions and support • Preferred service and a named clinician are available for pre-planned appointments • Discharge coordination with hospital services • Infrastructure to support home-monitoring
Unplanned	**Easy access and information sharing** • Walk-in, telephone and tele-consultation options available, including out of hours • Support for self-care (e.g. online advice) • Advanced information sharing between services and professionals exclusively through Electronic Health Records (EHR), also accessible to the patient	**Rapid access, preferably to the core team** • Single telephone line to direct patients out of hours; otherwise care coordinator is main point of contact • Core team keeps sufficient capacity for unplanned appointments • All professionals use EHR; feed back most important events to the core team

Episodic Care[1]

- Main emphasis on ease of access
- Episodic care, overseen by a qualified GP on duty during normal and extended hours at a hub / dedicated practice or call centre
- Patient-self management of limiting illnesses

Continuous Care[1]

- Main emphasis on continuity
- Continuous care provided mainly during core hours by the same team, according to a care plan
- Care coordinator to serve as the first point of contact for the patient, and all other providers

1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)

4. Primary Care: Primary care and Intermediate Care transformation is the foundation for Local Services Transformation

The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP.

Our challenges

- **Demand for health and care services is increasing.**
- **There is unwarranted variation in care, quality and outcomes across NW London.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

How Local Services areas of focus fit within STP delivery areas

DA2 — **Improve quality and reducing variation across Primary Care (for LTC management)**

DA3 — **Achieving better outcomes and experiences with a focus on older people**

What are the ways of working

- **Developing sustainable services**
- **Changing how we work together to deliver the transformation required**

Our areas of focus

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

- Joint commissioning and delivery models across CCGs and providers
- Evolving **Primary Care at-scale**
- Managing demand across boundaries through pathway redesign
- **Strengthening care teams** to provide effective care

- Effective **joint governance** able to address difficult issues
- Working **cross-boundary**; across acute and social care
- Collaborating to improve quality and efficiency, e.g., through the Virtual Primary Care Team
- Building upon **Whole Systems Integrated Care**

The impact of our plans

A healthier NW London

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care.

More productive care:

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

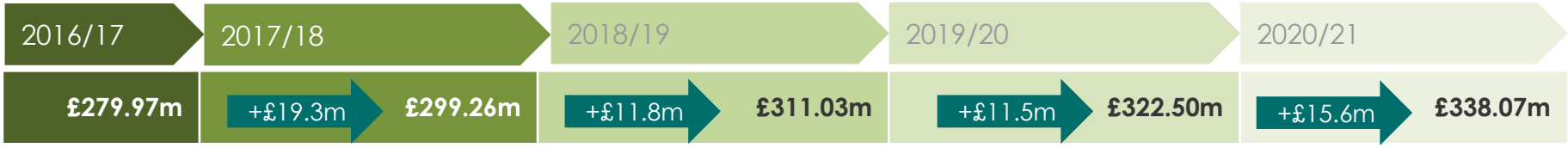
More effective system:

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

4. Primary Care: There will be significant investment in General Practice within NW London

This diagram shows NW London's:

- Efficiency targets
- Increases in primary care medical allocations (blue arrows)
- The planned delivery of the Strategic Commissioning Framework and the Strategy and Transformation Plan



299

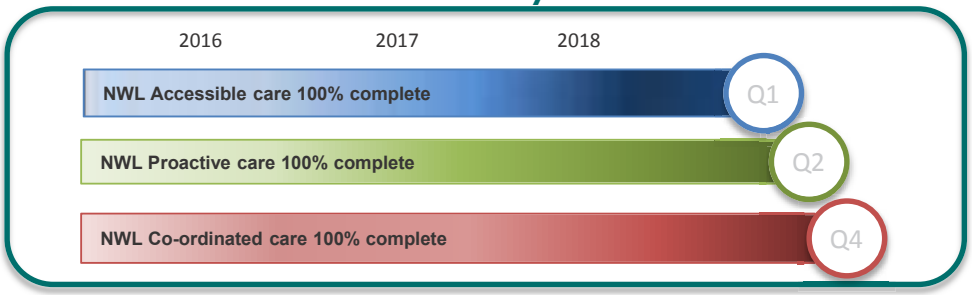
Key

Increases in Primary Care medical allocations

The diagram does not show funding from national programmes (such as the General Practice Access Fund) from which NW London is aiming to access approximately £4.5m in 2016/17 – announced in the GP Forward View.

Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. Transforming general practice in line with the standards set out in the Strategic Commissioning Framework is critical to delivery of the ambitions set out in the STP. The diagram below shows the milestones to full delivery.

Milestones for SCF delivery across NW London



5. Finance:

Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue, with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that overall the footprint including social care has a small deficit of £19.9m.

£'m	CCGs	Acute	Non-Acute	Specialised Commissioning	Primary Care	STF Investment	Sub-total	Social Care	Total	
Do nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	-	**(1,112.4)**	**(297.5)**	**(1,409.9)**	**Note 1**
BAU Savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	108.5	**680.6**	**Note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	**(4.0)**	-	**(4.0)**	
[illegible]ry Area 1 - Savings	15.6	-	-	-	-	-	**15.6**	8.0	**23.6**	
[illegible]ry Area 2 - Investment	(5.4)	-	-	-	-	-	**(5.4)**	-	**(5.4)**	
[illegible]ry Area 2 - Savings	18.5	-	-	-	-	-	**18.5**	-	**18.5**	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	**(52.3)**	-	**(52.3)**	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	**134.9**	33.1	**168.0**	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	**(11.0)**	-	**(11.0)**	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	**22.8**	6.4	**29.2**	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	**(45.6)**	-	**(45.6)**	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	**254.5**	15.0	**269.5**	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**	**Note 4**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**	**Note 4**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**	
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	-	**1,127.5**	262.5	**1,390.0**	
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	-	-	-	**15.1**	**(35.0)**	**(19.9)**	
				Note 5				**Note 3**		

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since Jun '16 STP due to changes in the underlying position of social care, and inclusion of the Royal Brompton & Harefield and the London Ambulance Service deficit attributable to NWL.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc.

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable).

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated.

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

Note 6: As we have developed our project plans we have more clearly articulated the focus of our delivery areas. This has resulted in 'Delivering the SCF' moving from DA3 to DA2. The individual DA totals have therefore changed although overall investment and saving totals remain constant.

5. Finance:

Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a break even position .

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

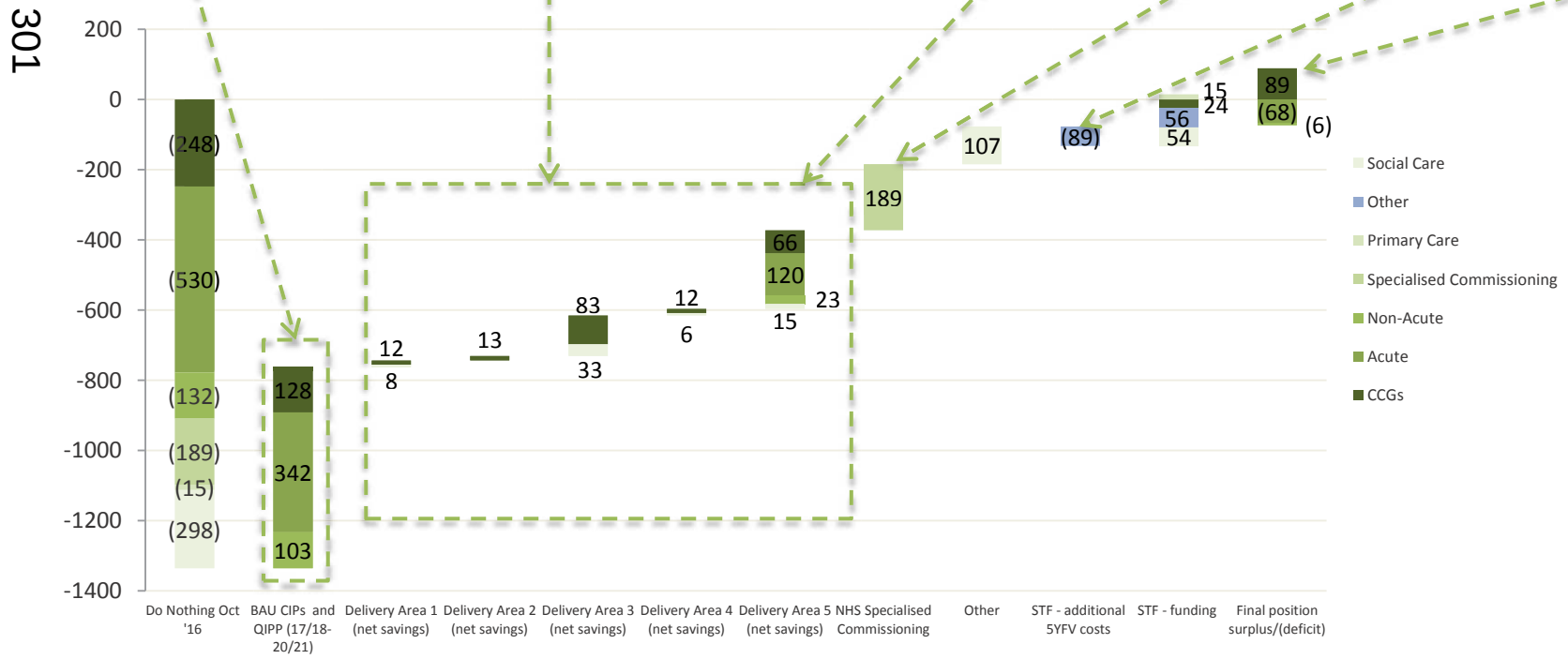
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

Final position CCG Surplus (£89m) Acute deficit (£68m) Non-acute deficit (£6m)



5. Finance: Next steps

Financial risks to delivery of the STP

There are a number of risks facing NWL commissioners and providers which are inherent in the STP. These are:

- Delivery of business as usual efficiency savings
- Delivery of the service transformations set out in the five delivery areas, and the realisation of the associated savings
- Financial challenges on the provider side that remain at the end of the STP period
- Plans to close the specialist commissioning gap are not yet available
- Deterioration in underlying organisational financial positions since 2016/17 plans were agreed
- Closing the remaining social care funding gap
- Accelerating delivery of transformation plans to enable recently notified NHS financial control totals to be achieved.

The key risk to achieving sector balance is the delivery of the savings, both business as usual efficiency savings and those associated with the service transformations described in the five delivery areas.

There are also particular challenges in relation to:

- The deficit on the Ealing Hospital site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging;
- The deficit at the Royal Brompton and Harefield, which although mostly commissioned by NHSE Specialised Commissioning, is included in the NWL footprint;
- The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution.

The plans to close the Specialised Commissioning gap are not yet available in enough detail to allow an assessment of the level of risk facing the NWL Specialised service providers. This may pose a significant risk to the viability of some providers.

Next steps to address the risks

There are a number of processes in place to quantify and mitigate the risks set out above. These include:

- A robust process of business case development to validate the investments and savings that have been identified so far, and the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered
- A portfolio management approach with clear governance to ensure that project directors are held accountable for delivering agreed savings, with a change control process to close projects and agree new ones as required to deliver the planned patient outcomes and associated savings
- The work through DA5d on productivity will support the development of trust internal infrastructures to support the business as usual efficiency savings
- The acceleration of the changes relating to Ealing hospital, once out of hospital capacity is in place
- Joint pathway planning with specialist commissioning and other CCGs across London to confirm the plans to reduce demand and to quantify the impact on providers
- Quantification of changes in underlying financial positions and differences between the STP financial assumptions and notified control totals, feeding into a sector approach to the 2 year contracting round to ensure that effective risk management processes are in place.

This work will be developed and will continue over the next few months.

5. Finance:

STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. The STF funding being use to support provider deficits has already been notified to Trusts for 17/18 and 18/19, and is not included below. The funding below is being sought **in addition** to provider STF funding.

Sustainability and Transformation funding requirement for North West London

Investment Area	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Investment in Prevention & Social Care	21.0	25.0	30.0	34.0
Social Care funding gap	-	-	-	19.5
Total Social Care and prevention	**21.0**	**25.0**	**30.0**	**53.5**
Seven Day services roll out through to 2019/20	4.0	7.0	12.0	24.0
General Practice Forward View and Extended GP Access	10.0	10.0	5.0	5.0
Increasing capacity in Child and Adolescent mental health services and reducing waiting times in Eating Disorders services	5.0	5.0	8.0	10.0
Implementing recommendations of mental health task force	10.0	10.0	10.0	5.0
Cancer taskforce Strategy	3.0	5.0	10.0	3.0
National Maternity Review	7.0	7.0	2.0	2.0
Local Digital Roadmaps supporting paper free at the point of care and electronic health records	3.0	10.0	10.0	6.7
Total Health	**42.0**	**54.0**	**57.0**	**55.7**
Improvement Resources	2.0	2.0	-	-
Additional Investment in Primary Care services	1.0	12.0	19.0	14.8
System support funding	-	-	-	24.0
Total	**66.0**	**93.0**	**106.0**	**148.0**

5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £978m (funded by £713m from internal resources, £37m from disposals and £228m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

The table below details the 'Do something' capital for the 5 year STP period.

Table : Do Something Capital

Key Capital Schemes	17/18-20/21 £m	Less: disposals £m	Other funding sources £m	Total £m
	Gross Capital			Net capital
Outer NWL (SOC1)[1]	385	(9)		375
Inner NWL (SOC2)[2]	222	(222)		-
IT Digital Roadmap[3]	60			60
CNWL - strategic investments	79	(53)	(26)	-
Royal Brompton	100	(100)		-
Total	**845**	**(384)**	**(26)**	**435**

Note 1 – The Outer NWL business case (SOC1) is modelled on an 'accelerated' approval timeline in order to address the sustainability issue at Ealing Hospital;
Note 2 – The Inner NWL Business Case (SOC2) is funded through the disposal of a charitable asset, thus placing a restriction on the use of the sale proceeds;
Note 3 - IT digital roadmap funding is expected to be funded via the Estates and Technology Transformation Fund (ETTF).

6. Risks and Mitigations: Strategic Risks

Appendix 2

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	• Maintain system attention on importance of delivery over the next five years through focus on Delivery Areas 1, 2 and 3 • Continue to develop delivery plans using learning from vanguards and other areas • Establishment of robust governance process across NW London system focussing on both delivery and assurance • Clear metrics agreed to monitor progress	
There is insufficient capacity or capability in primary care to deliver the model of care	Quality and sustainability	• Support development of GP federations • Early investment in primary care through joint commissioning • Identification and support to vulnerable practices • Digital solutions to reduce primary care workloads	• Support in developing a reliable understanding of sector demand and capacity for primary care
Can't get people to own the responsibility for their own health	Self care and empowerment	• Development of a 'People's Charter' • Closer working with local government to engage residents in the conversation, primarily through DA1	• National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints, and the sustainability issues at Ealing Hospital	Finance and estates	• Submit a business case for capital to NHS England • Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment • Identification of further opportunities through One Public Estate • Submit a business case for capital to NHS England that sets out the clinical and financial rationale for an accelerated timeline	• Support for retention of land receipts for reinvestment, and potential devolution asks • Support for an accelerated timeline for the capital business cases
Information Technology systems are not in place to enable seamless integrated care and a shift towards out of hospital activity.	Information and technology	• Work within new national standards on data sharing to support the delivery of integrated services and systems. • Keep pressure on primary and community IT system providers to deliver open interfaces which will enable record sharing	• NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. • Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality • Continued focus at a national level on open API

6. Risks and Mitigations: Other Risks

Appendix 2

Risks	Category	Proposed mitigations	Support from NHSE
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	• On-going quality surveillance to reduce risk • Contingency plans developed should a service be flagged as *fragile* • Strengthened governance structure with clear joint leadership maintaining focus on delivery and enabling more rapid and effective responses to a situation	
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	• Development of a joint market management strategy lead by the Joint Health and Care Transformation Group • Specific project of work in this area through DA3 • On-going support to homes to address quality issues	
Provider and system sustainability targets result in competing local priorities	Quality and sustainability	• Joint Health and Care Transformation Group provides forum for system wide discussion.	• Alignment of NHS England and NHS Improvement positions on provider sustainability versus system sustainability
...are unable to recruit or retain ...force to support the old model ... training and transforming to the new model of care	People and workforce	• Establishment of Workforce Transformation Delivery Board to provide system leadership and focus • Development of cross-sector workforce strategy • Close working with HEENWL	
There is resistance to change from existing staff	People and workforce	• OD support and training for front line staff and system leaders • Wide staff engagement in the design and delivery of new models through project delivery groups.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	• Work closely with partners to understand the implications of 'Brexit' • Provide staff with support to ensure they feel valued and secure.	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	• Developing relationships between health and local authority organisations, supported by joint governance via the Joint Health and Care Transformation Group • Joint statement agreed and areas of commonality identified to enable progress	

7. References

Appendix 2

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
Case for Change	12-19	[1] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea. [2] NOMIS profiles, data from Office for National Statistics [3] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [4] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs

7. References

Appendix 2

Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) Management	23-26	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] Cancer Research UK [3] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf [4] Fund Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund [5] Pan-London Atrial Fibrillation Programme [6] NHS London Health Programmes, NHS Commission Board, JSNA Ealing [7] Kings Fund, 2010 [8] Initial analysis following review of self-care literature [9] http://dvr.sagepub.com/content/13/4/268

7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	27-28	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
Delivery Area 4: Improving outcomes for children and adults with mental health needs	29-30	[1] Tulloch et al., 2008 [2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf [4] Royal College of Psychiatrists, 2012 [5] http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spmin1
Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	31-33	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
Enablers: Estates	35-38	[1] ERIC Returns 2015/16 published 11 October 2016 [2] NHSE London Estate Database Version 5 [3] NW London CCGs condition surveys [4] Oxford University's School of Primary Care Research of general practices across England, published in The Lancet in April 2016 [5] Lord Carter Report: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/http://qna.files.parliament.uk/ws-attachments/450921/original/Operational%20productivity%20and%20performance%20in%20English%20NHS%20acute%20hospitals%20-%20Unwarranted%20variations.pdf

7. References

Section	Slides	References
Enablers: Workforce	39-41	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
…nablers: Digital	42-43	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

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REPORT FOR: **HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	15th December 2016
Subject:	**INFORMATION REPORT – Diabetes update**
Responsible Officer:	Javina Sehgal, Chief Operating Officer Harrow Clinical Commissioning Group
Scrutiny Lead Member area:	Councillor Kairul Kareema Marikar, Policy Lead Member Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All wards
Enclosures:	None

Section 1 – Summary and Recommendations

FOR INFORMATION

This report provides the Overview and Scrutiny Committee an update on the development of the Harrow Diabetes Strategy, the lead responsibility for which sits with the Clinical Commissioning Group.

Section 2 – Report

Harrow has one of the highest rates of type 2 diabetes in the country, with current prevalence estimated to be around 10% with a rise in projection to 13% by 2020. These rates are largely driven by increasing levels of overweight/obesity, changing ethnic composition, and an ageing population. 605 of are overweight or obese, and approximately 50% are Asian or African-Caribbean ethic background (associated with relatively high disease risk).

In Harrow, these ethnic groups, older people, and lower socio-economic status groups are all likely to experience disproportionately high rates of the disease. The data also reveals a huge variation in access to the right care and management for diabetes across different geographic locations and between the GP practices as well, which we would like to reduce.

Given the national burden of disease due to type 2 diabetes, and incidence trends, recent national strategy documents and the All Party Parliamentary Group report on diabetes, note that, in addition to early detection, offer of the NICE recommended 8/9 key care processes and the comprehensive management of disease through the treatment targets, there is a particular need for improving access to the structured education and the preventative action.

There is increasing recognition of diabetes prevention and early recognition. All 34 practices in Harrow are undertaking clinical audits in order to set up pre-diabetes registers and health checks are also helping with the registers.

Public health developed a rapid diabetes needs assessment, using best practice transformational work from other areas of similar demographics like Slough and other London boroughs. Aligned to this Harrow CCG in collaboration with stakeholders are developing a diabetes strategy that will evaluate the whole pathway from prevention to tertiary care.

To help with the understanding for commissioning requirements, Harrow CCG

facilitated a stakeholder workshop in collaboration with NHS Rightcare, public health, Diabetes UK and the patient groups to gain some formal feedback to current services and gaps within current services within the borough.

A clinical reference group is going to be established in December 2016 with the aim that it will develop, agree and deliver on the required outcomes of the strategy. It will also be required to ensure best practice and local reviews/evaluations are taken into consideration with any recommendations being made.

The CCG will also establish a sub-group that will evaluate 1) type 1 diabetes, 2) diabetes in children/pregnant women and 3) those that require specialist provision of CGM or Insulin pumps. The final actions will be agreed through the clinical reference group and the strategy updated with the latest NDA (National diabetes Audit) data and published both on the Harrow CCG and the Harrow council websites.

The CCG is committed to ensuring that its strategy and commissioning intentions are aligned to the public health plans on prevention and awareness, the local and NWL STP footprints plans, and will also reflect the core principles of the HWBB.

Section 3 – Further Information

The final strategy will be completed by January 2017 in time for a detailed discussion at the March 2017 H&WBB meeting.

Section 4 – Financial Implications

None at this stage.

The financial and procurement route/s for services to be considered has not been agreed as the strategy is still in development stage.

Section 5 - Equalities implications

N/A

Section 6 – 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**

Patients will be identified through proactive case finding at general practice , working with stakeholders to identify groups for targeted interventions.

- **Making a difference for communities**

The diabetes strategy aims to provide integrated services that are coordinated for the patient and their careers, including social prescribing, prevention and self-care.

- **Making a difference for families**

Families and carers will be better informed about diabetes through Patient Activation Measures (PAMs) and self-care working groups, to facilitate an increased quality of life.

Harrow Health and Wellbeing Strategy

'*local priority of reducing unwarranted variation in the management of long term conditions*'

Clinical audits in general practice lead by Clinical experts, will provide training and development of the management of Diabetes in general practice. Training and education events have been on-going throughout the year with patients diagnosed with diabetes.

Harrow CCG Corporate Objectives

'Objective 1: Improve the health and wellbeing of the local residents of Harrow'

The self-care and PAMs programmes will help patients to self-manage.

'Objective 2: Engage patients and the public in decision-making'

In collaboration with NHS Right Care, Harrow CCG have held a workshop (more to follow) with local residents to understand the commissioning needs based on service user feedback. Harrow patient participation group have also been involved in discussions around the strategy.

'Objective 3: Manage resources effectively'

Training for clinicians, training and education for patients to self-manage, and a review of the current pathways will enable resources to be managed more effectively through the development of integrative working arrangements

Statutory Officer Clearance

Not required.

Ward Councillors notified:	**YES**

Section 7 - Contact Details and Background Papers

Contact: Angela Ward (Harrow CCG), Email: angela.ward1@nhs.net
Tel: 020 8966 1163

Background Papers: None

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REPORT FOR: HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	15 December 2016
Subject:	Shaping a Healthier Future – Update from NW London Joint Health Overview and Scrutiny Committee
Responsible Officer:	Alex Dewsnap, Divisional Director, Strategic Commissioning
Scrutiny Lead Member area:	Health: Policy Lead – Councillor Kairul Kareema Marikar Performance Lead – Councillor Vina Mithani
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides an update on the discussions at the latest meeting of the NW London Joint Health Overview and Scrutiny Committee for the Shaping a Healthier Future programme.

Recommendations:
The Sub-Committee is asked to:

- Consider the update and provide any comments/issues that are to be raised in advance of the next JHOSC meeting.

Section 2 – Report

The North West London Joint Health Overview and Scrutiny Committee (JHOSC) comprises elected members drawn from the boroughs geographically covered by the NHS NW London Shaping a Healthier Future (SaHF) programme and was set up to consider the proposals and consultation process formally between the period of 2 July and 8 October 2012. The proposals set out the reconfiguration of the accident and emergency provision in North West London. This included changes to emergency maternity and paediatric care with clear implications for out-of-hospital care.

The JHOSC published its final report in October 2012, making recommendations on how the SaHF proposals could be developed and implemented, including the risks that needed to be explored. The JHOSC also recommended that the committee continue to meet beyond the original consultation period to provide ongoing strategic scrutiny of the development and implementation of Shaping a Healthier Future.

Harrow's ongoing participation in the JHOSC examining the implementation of the SaHF ensures that scrutiny of the issues is maintained at a regional level and that Harrow residents' perspectives are put forward to the NHS as it implements the SaHF programme. The Health and Social Care Scrutiny Sub-Committee receives regular update reports on the JHOSC so that it can pick up any local issues in its own work programme as well as feed into the JHOSC's agenda planning and deliberations. As confirmed at Annual Council on 19 May 2016, Harrow's member representatives on the JHOSC for 2016/17 are Councillors Michael Borio and Vina Mithani.

JHOSC meeting on 14 October 2016

The latest meeting of the JHOSC was held on 14 October 2016. Neither Harrow member representative could attend, however there was officer attendance. Detailed below are key headlines from those discussions, which centred on the development of the Sustainability and Transformation Plan (STP) for NW London:

Consultation and engagement – the NHS is holding local public events around the STP, working with council communications teams and talking to Healthwatchs in devising engagement plans for the 5-year course of the STP. The JHOSC expressed its disappointment that it had not been presented the STP whilst it was being developed. There was concern from the JHOSC over engagement with the public, partners and NHS staff.

Demographics - population growth remains a concern of the JHOSC, for example the Old Oak Common development, and whether NHS plans are adequately taking account of population growth in the health services being developed for areas.

Acute services – the JHOSC expressed the view that the plans represented cuts to services, not efficiencies, and that vital health services will be closed down as a consequence. It was noted however that the changes to maternity services had been independently reviewed and approved.

A key concern of the JHOSC that was reiterated at this meeting was around the capacity of the acute services that do remain open and that will be required to take on the additional patient flow, e.g. Northwick Park Hospital, West Middlesex Hospital.

Out of hospital strategy – the SaHF programme relies heavily on robust out of hospital strategies being in place to relieve the pressure on acute services. It was noted that the STP makes no reference to community pharmacies, key to out of hospital provision yet funding for these are proposed to be cut in recent government consultation. Furthermore it was noted that whilst GPs are a central plank of primary care, the commissioning of GPs and the quality of their services sit outside CCGs responsibility as they are the responsibility of NHS England.

ImBC/STP interface – the SaHF Implementation Business Case is now not expected to be presented to the JHOSC until December or the new year. The STP is due to be signed off in December. The two need to be developed and informed in tandem.

The STP will allow areas to know their funding allocations for health for a 5-year period for the first time. This level of funding transformation will necessitate a change in the way the NHS and councils deliver health and social care services. The STP should clearly model the social care funding gap as the STP asks councils to do more with the NHS, however increased activity is not necessarily reflected in council budgets which are under enormous strain.

Correspondence following JHOSC meeting
Following on from the JHOSC discussions, the Chair of the JHOSC Councillor Mel Collins (Hounslow) wrote to the chair of the CCG Collaborative (Dr Mohini Parmar) which oversees the SaHF programme to submit the views of the JHOSC. In this (letter dated 19 October 2016), he stated the committee's disappointment that the "JHOSC was omitted from the plan of engagement of the STP…We also remain concerned at the continued absence of the Implementation Business Case". The letter also provided JHOSC comments on the draft STP that had been submitted to NHS England on 30 June regarding:

- Future of Ealing Hospital
- Consultation with NHS staff
- Lack of risk assessment within the STP especially given the speed/ scale of change envisaged in the STP, reduction in acute services, meeting demographic changes, out of hospital services
- Social care funding gap

Dr Parmar in her response (1 November 2016) noted that the tight nationally-set deadlines did not allow for detailed work on the latest STP and JHOSC dates to align. She gave the JHOSC the reassurance that there was significant engagement throughout this period with local council colleagues as well as events for the public to attend.

The ImBC will be shared with JHOSC councillors after it has been ensured that the ImBC fully aligns with the STP and that the latest position on NHS capital funding is taken properly into account.

Dr Parmar's letter finishes by saying "Much of the further STP detail will be developed and discussed at local level through CCG commissioning intentions, but we will of course continue to engage with you on aggregated plans".

Other JHOSC related activity
The next meeting of the JHOSC is still to be arranged and will be the annual meeting where chairing arrangements for the year are confirmed. The agenda will focus on: hospital transport, CQC report on London Ambulance Service, performance of A&E in NW London, the SaHF Implementation Business Case.

On 24 November 2016 there was a pan-London JHOSC forum which brought together representatives from all of London's JHOSCs to discuss the scrutiny of STPs by JHOSCs going forward and opportunities to work together across London and strategically. The number of places allocated to each JHOSC was limited and neither Harrow member representative was able to attend.

Financial Implications
The costs of delivering the health scrutiny work programme will be met from within existing resources.

Performance Issues
There is no specific performance issues associated with this report.

Environmental Impact
There is no specific environmental impact associated with this report.

Risk Management Implications
There are none specific to this report.

Equalities Implications
There are a number of equalities implications that relate to the reconfiguration of health services in North West London as a whole. These implications form part of the on-going considerations of the JHOSC.

Council Priorities
- Protect the most vulnerable and support families

Section 3 - Statutory Officer Clearance
Statutory clearances not required.

Ward Councillors notified:	N/A

Section 4 - Contact Details and Background Papers

Contact:
Nahreen Matlib, Senior Policy Officer, 020 8420 9204 (ext 5204)

Background Papers:
Agenda papers for the JHOSC meeting on 14 October 2016:
http://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=1102&MId=6408 7&Ver=4

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