Health and Wellbeing Board

AGENDA

DATE: Thursday 20 July 2017

TIME: 12.30 pm

VENUE: Committee Rooms 1 & 2, Harrow Civic Centre, Station Road, Harrow, HA1 2XY

MEMBERSHIP (Quorum 3)

Chair: Councillor Sachin Shah

Board Members:

Councillor Simon Brown	**Harrow Council**
Dr Shaheen Jinah	**Harrow Clinical Commissioning Group**
Dr Amol Kelshiker (VC)	**Chair, Harrow Clinical Commissioning Group**
Dr Genevieve Small	**Harrow Clinical Commissioning Group**
Councillor Varsha Parmar	**Harrow Council**
Councillor Mrs Christine Robson	**Harrow Council**
Councillor Janet Mote	**Harrow Council**
Mina Kakaiya	**Healthwatch Harrow**

Reserve Members

Councillor Ms Pamela Fitzpatrick	Harrow Council
Councillor Antonio Weiss	Harrow Council
Councillor Anne Whitehead	Harrow Council
Councillor Susan Hall	Harrow Council
Dr Shahla Ahmad	Harrow Clinical Commissioning Group
Julian Maw	Healthwatch Harrow

Non Voting Members:

Chris Spencer, Corporate Director, People, Harrow Council
Bernie Flaherty, Director Adult Social Services, Harrow Council
Andrew Howe, Director of Public Health, Harrow Council
Rob Larkman, Accountable Officer, Harrow Commissioning Group
Jo Ohlson, NW London NHS England
Simon Ovens, Borough Commander, Harrow Police
Carol Foyle, Representative of the Voluntary and Community Sector
Paul Jenkins, Interim Chief Operating Officer, Harrow Clinical Commissioning Group

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

Useful Information

Meeting details:

This meeting is open to the press and public.

Directions to the Civic Centre can be found at:
http://www.harrow.gov.uk/site/scripts/location.php.

Filming / recording of meetings

The Council will audio record Public and Councillor Questions. The audio recording will be placed on the Council's website.

Please note that proceedings at this meeting may be photographed, recorded or filmed. If you choose to attend, you will be deemed to have consented to being photographed, recorded and/or filmed.

When present in the meeting room, silent mode should be enabled for all mobile devices.

Meeting access / special requirements.

The Civic Centre is accessible to people with special needs. There are accessible toilets and lifts to meeting rooms. If you have special requirements, please contact the officer listed on the front page of this agenda.

An induction loop system for people with hearing difficulties is available. Please ask at the Security Desk on the Middlesex Floor.

Agenda publication date: Wednesday 12 July 2017

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. APPOINTMENT OF VICE-CHAIR

To note the appointment of the Chair of the Harrow Clinical Commissioning Group as Vice-Chair of the Board for the 2017-18 Municipal Year.

3. DECLARATIONS OF INTEREST

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

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

4. MINUTES (Pages 7 - 10)

That the minutes of the meeting held on 11 May 2017 be taken as read and signed as a correct record.

5. PUBLIC QUESTIONS, PETITIONS AND DEPUTATIONS

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

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

[The deadline for receipt of public questions is 3.00 pm, 17 July 2017. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

6. PETITIONS

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

7. DEPUTATIONS

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

8. INFORMATION REPORT - OVERVIEW OF SECTION 7A IMMUNISATION PROGRAMMES IN HARROW 2016/17 (Pages 11 - 80)

Report of NHS England

9. INFORMATION REPORT - A REVIEW OF FEMALE GENITAL MUTILATION IN HARROW (Pages 81 - 108)

Report of the Director of Public Health

10. TERMS OF REFERENCE FOR HEALTH AND WELLBEING BOARD (Pages 109 - 118)

Report of the Director of Legal and Governance Services

11. INFORMATION REPORT - OFSTED REPORT ON THE INSPECTION OF SERVICES FOR CHILDREN IN NEED OF PROTECTION, LOOKED AFTER CHILDREN AND CARE LEAVERS (Pages 119 - 176)

Report of the Corporate Director People.

12. INFORMATION REPORT - SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE (Pages 177 - 192)

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

13. INFORMATION REPORT - BETTER CARE FUND (BCF) UPDATE QUARTER 4 2016/17 AND 2017/18 (Pages 193 - 204)

Joint report of Corporate Director People, Harrow Council, and Interim Chief Operating Officer, Harrow Clinical Commissioning Group

14. INFORMATION REPORT - HARROW CLINICAL COMMISSIONING GROUP ANNUAL REPORT AND ANNUAL ACCOUNTS 2016/17 (Pages 205 - 330)

Report of the Harrow Clinical Commissioning Group

15. INFORMATION REPORT - REVENUE AND CAPITAL OUTTURN 2016/17 (Pages 331 - 398)

Report of the Corporate Director People

16. ANY OTHER BUSINESS

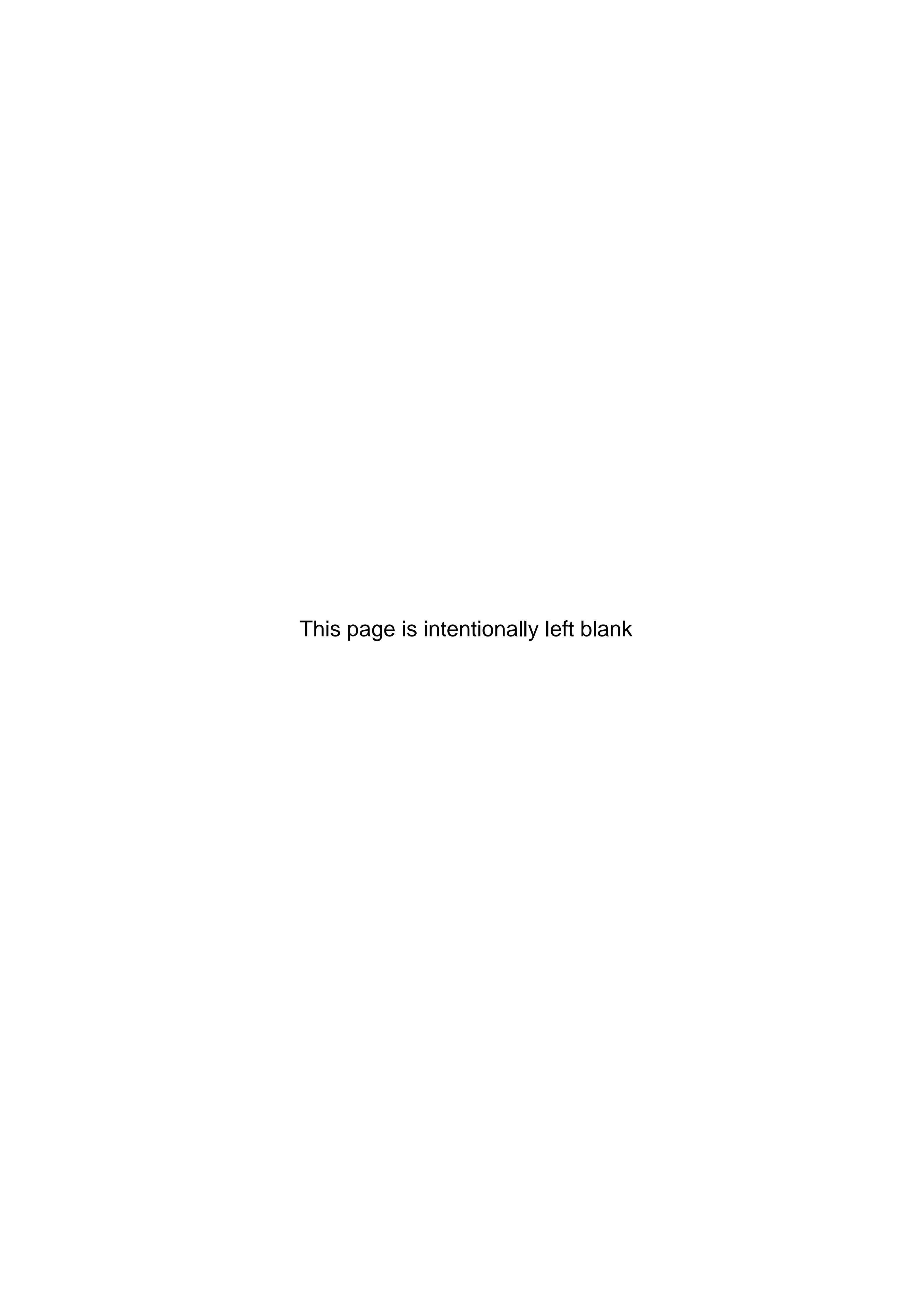
Which cannot otherwise be dealt with.

AGENDA - PART II - NIL

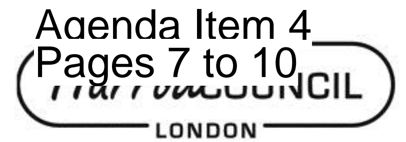
* DATA PROTECTION ACT NOTICE

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.]



This page is intentionally left blank



HEALTH AND WELLBEING BOARD

MINUTES

11 MAY 2017

Chair:	*	Councillor Sachin Shah	
Board Members:	*	Councillor Simon Brown	Harrow Council
	*	Councillor Janet Mote	Harrow Council
	*	Councillor Varsha Parmar	Harrow Council
	*	Councillor Mrs Christine Robson	Harrow Council
		Dr Amol Kelshiker (VC)	Chair of Harrow CCG
	*	Dr Shahla Ahmad	Harrow Clinical Commissioning Group
	*	Julian Maw	Healthwatch Harrow
	*	Dr Genevieve Small	Clinical Commissioning Group

Non Voting Members:	†	Bernie Flaherty	Director of Adult Social Services	Harrow Council
	*	Carol Foyle	Representative of the Voluntary and Community Sector	Voluntary and Community Sector
	*	Andrew Howe	Director of Public Health	Harrow Council
	*	Paul Jenkins	Interim Chief Operating Officer	Harrow Clinical Commissioning Group
	†	Rob Larkman	Accountable Officer	Harrow Clinical Commissioning Group
		Jo Ohlson	Director of Commissioning Operations	NW London NHS England

		Name	Title	Organisation
		Chief Superintendent Simon Ovens	Borough Commander, Harrow Police	Metropolitan Police
	†	Chris Spencer	Corporate Director, People	Harrow Council
In attendance: (Officers)	*	Sarah Crouch	Public Health Consultant	Harrow Council
	*	Carole Furlong	Public Health Consultant	Harrow Council
	*	Gary Griffiths	Deputy Chief Operating Officer	Harrow Clinical Commissioning Group
	*	Visva Sathasivam	Head of Adult Social Care	Harrow Council

204. Attendance by Reserve Members

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

Ordinary Member	Reserve Member
Dr Shaheen Jinah	Dr Shahla Ahmad
Mina Kakaiya	Julian Maw

205. Declarations of Interest

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

206. Minutes

RESOLVED: That the minutes of the meeting held on 2 March 2017, be taken as read and signed as a correct record.

207. Public Questions, Petitions and Deputations

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

RESOLVED ITEMS

208. Future Joint Strategic Needs Assessments (JSNA) in Harrow

The Board received a report on the Joint Strategic Needs Assessment which proposed changes on how it could be delivered in the future so that it was responsive and more easily managed.

An officer introduced the report, detailing the three options: a single JSNA produced once every three to five years, a thematic annual report, or a virtual JSNA.

In response to questions arising from the requirement for the webpage to become more functional in order to achieve a virtual JSNA, it was noted that:

- the date of posting for each item and for any subsequent update would be displayed;
- the ability to respond to requests for further information would be dependant on officer capacity. Responses to previous questions would be available in a separate section;
- a matrix would track progress and the Board would periodically receive updated information. Each report would have a key messages section to enable the capture of issues;
- the JSNA and Health and Wellbeing Strategy had been funded by Public Health. However, its funding had been reduced and any funding opportunities from the CCG would be welcomed to take the initiative forward;
- the need for all reports to be downloadable and with the opportunity to bring in manageable links was recognised.

RESOLVED: That option 3, a rolling virtual JSNA, be supported.

209. INFORMATION REPORT - Health and Wellbeing Strategy Update

Consideration was given to a report which set out progress made against the nine actions which the Board had committed to for 2016/17 to implement the Harrow Health and Wellbeing Strategy.

An officer introduced the report and drew particular attention to the good progress in the Children and Adolescent Mental Health Service transformation plan. It was noted that the Council had signed the 'Time to Change' Employer Pledge at a public event earlier that day.

A Member referred to the review of the Early Intervention Service and suggested a review after a year of implementation of the redesigned model of service delivery.

It was noted that there would be no further updates in relation to a specific Harrow Health and Wellbeing Strategy action plan. Instead it was proposed that the updates would come as a result of collaborative discussion around local implementation of the North West London Sustainability and Transformation Plan.

A CCG representative informed the Board that the Harrow Health app would have a second phase of publicity in May. Approximately 14,000 people had used the app to date including a significant number of people aged over 50.

RESOLVED: That the report be noted.

210. Child Poverty and Life Chances Strategy and Action Plan

The Board received the Child Poverty and Life Chances Strategy which brought together the actions currently being undertaken by Harrow Council and partners that would help mitigate the impact of child poverty in Harrow.

It was noted that the strategy for Harrow was to focus support and interventions on the eight areas in the borough where the disparity between income and health was higher compared to other ward counterparts.

Members were informed that officers were trying to identify funding opportunities and opportunities to work with partner organisations. A Capable Communities Grant had been obtained.

RESOLVED: That

(1) the Child Poverty and Life Chances Strategy and action plan be supported;

(2) a verbal report on key issues be presented to the Board in six months and an annual report be submitted.

211. INFORMATION REPORT - Better Care Fund (BCF) Update Quarter 3 2016/17 and 2017/18 Planning

A report was received which set out progress on the Better Care Fund (BCF) in the third quarter of 2016/17. Extracts from the Quarter 3 report indicated Harrow's position in relation to the plan and supplied data in narrative form to provide an indication of the estimated end position. It was noted that NSE England feedback on progress was positive

A CCG officer drew particular attention to additional resources for extended primary care access to primary care which was currently 8 am to 8 pm weekdays and access at weekends, and that April 2017 had seen the first time in twelve months that there were zero delay transfers of care related to health..

The Board was informed that the Council and CCG were making progress on the negotiation on the 2017/18 plan and an update would be submitted to the Board meeting in July.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 12.35 pm, closed at 1.20 pm).

(Signed) COUNCILLOR SACHIN SHAH
Chair

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	20 July 2017
Subject:	**INFORMATION REPORT –** Overview of Section 7A Immunisation Programmes in Harrow 2016/17
Responsible Officer:	Kenny Gibson, Head of Public Health Commissioning, NHS England London Region
Exempt:	No
Wards affected:	All

Enclosures:

Immunisation programmes in Harrow 2016/17, June 2017
Public Health : Screening External Assurance Report, June 2017

Section 1 – Summary

This report sets out the 2016/17 position with coverage and uptake within Harrow for the following programmes ~

1. NHS immunisation uptake
2. Cervical, bowel and breast cancer screening
3. Diabetic eye & abdominal aneurysm screening
4. Antenatal & new born screening

Each report will contextualise Harrow's position against national targets and aspirations. The reports will then go on to note local actions plans and recommendations for improvement for Harrow residents.

FOR INFORMATION

Section 2 – Report

As per the two listed reports.

Section 3 – Further Information

No further relevant information

Section 4 – Financial Implications

There are no financial implications for LB Harrow

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out?
No, since there is no requirement under the term of NHS England's commission of these programmes.

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
- Making a difference for communities
- Making a difference for families

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Not required

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Kenny.Gibson@nhs.net

Background Papers: None

Report to Health and Well-Being Board on Section 7a Immunisation Programmes in Harrow 2016/17

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

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

Classification: OFFICIAL

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

Contents

Contents 3
1 Aim 4
2 Headlines for London 4
3 Antenatal and New-born Vaccinations 4
3.1 Pertussis (Whooping Cough) vaccination for Pregnant Women 4
3.2 Universal BCG vaccination 6
3.3 Neonatal Hep B vaccination 7
4 Routine Childhood Immunisation Programme (0-5 years) 8
4.1 'COVER' 8
4.2 Rotavirus 12
4.3 Meningococcal B vaccination 12
5 School Age Vaccinations 13
5.1 HPV vaccination 13
5.2 Men ACWY 15
6 Adult Vaccinations 15
6.1 Shingles 15
6.2 PPV 16
6.3 Seasonal 'Flu 17
7 Next Steps 18

1 Aim

- The purpose of this paper is to provide an overview of Section 7a immunisation programmes in the London Borough of Harrow for 2016/17. The paper covers the vaccine coverage and uptake for each programme along with an account of what NHS England (NHSE) London Region are doing to improve uptake and coverage.
- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and the 17 programmes include:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal 'flu vaccination
- Members of the Health and Well-Being Board are asked to note and support the work NHSE (London) and its partners such as Public Health England (PHE) and the local authority are doing to increase vaccination coverage and immunisation uptake in Harrow.

2 Headlines for London

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

3 Antenatal and New-born Vaccinations

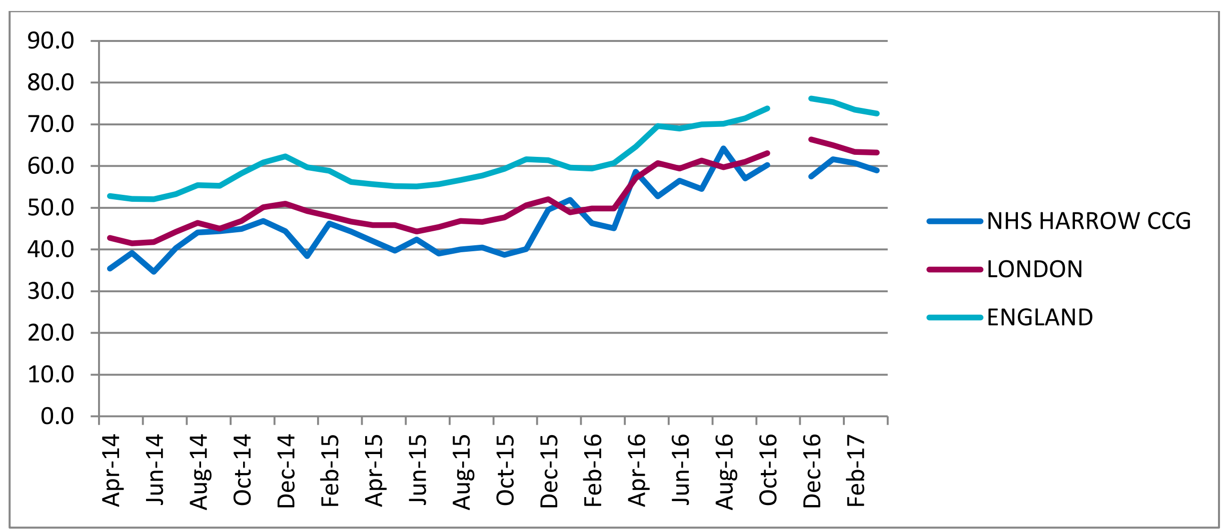
3.1 Pertussis (Whooping Cough) vaccination for Pregnant Women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. In 2012, pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt in the increase of confirmed pertussis (whooping cough) cases. This programme was extended for another 5 years

by the Department of Health (DH) in 2014. Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.

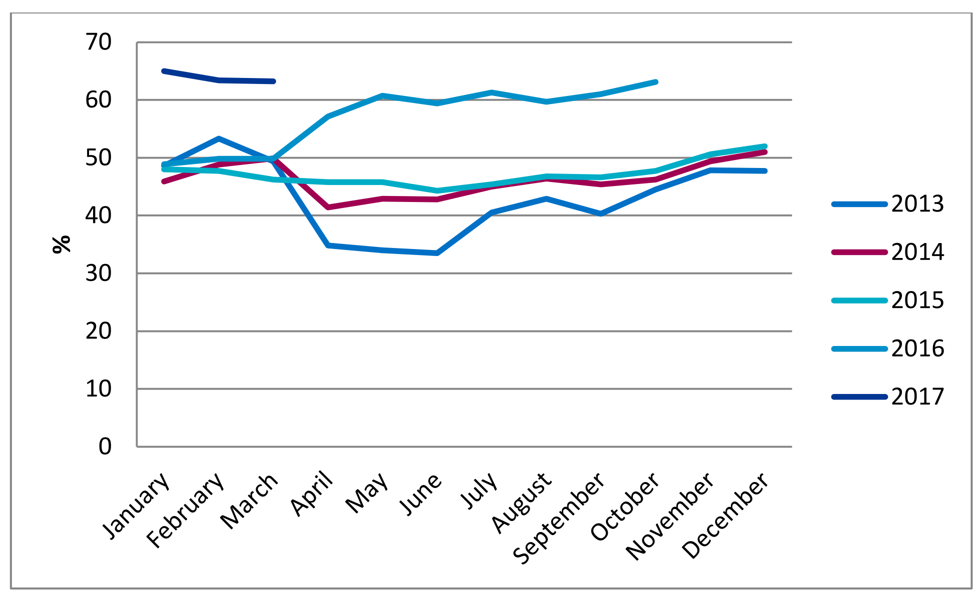
- There are seasonal patterns with the winter months of November and December each year reporting the highest proportion vaccinated whilst there's a drop between April and July
    - Difference attributed to pertussis given with seasonal 'flu vaccination during November and December
- Whooping cough vaccine uptake is reported monthly by PHE. The latest available data for Harrow is March 2017. It can be seen Harrow performs below London and England averages – 58.9% in March 2017 compared to London's 61%. The gap in the graph is due to data not being calculated nationally for November 2016.
- However, the first three months of 2017 demonstrate higher percentage uptake than any other year (see figure 2). This has been replicated in Harrow.

Figure 1
Monthly uptake rates of pertussis vaccine during pregnancy for Harrow CCG compared to London and England for April 2014 – March 2017



Source: PHE (2017)

Figure 2
Comparison of annual update rates of pertussis vaccination for London



Source: PHE (2017)

What are we doing to improve uptake?

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

3.2 Universal BCG vaccination

- The BCG vaccine is offered to neonates (up to one year) to protect them against progression to severe disease if exposed to TB.
- Since April 2015, NHSE (London) has been rolling out a 100% offer of BCG vaccine to all babies up to the age of one year across London. This action had been recommended by the London TB Board and the London Immunisation Board in 2014. This offer is commissioned to be given in all maternity units in London with a community offer for those parents who missed out on the vaccine in maternity hospitals or who have recently moved into London.
- However, in April 2015, a global shortage of the BCG vaccine resulted in vaccine supply issues within Europe. As a result, the roll-out of the universal offer of BCG was temporarily stalled in London. Once stock was made available again in October 2015, NHSE (London) continued to work with

providers across London to deliver the universal offer. A catch up programme was also implemented for those infants who missed out on a vaccine due to the shortage. As per PHE guidance, infants most at risk were prioritised.

- The global shortage has continued into 2016 and in June 2016, PHE national team procured InterVax, a BCG vaccine from Canada. This vaccine is unlicensed in the UK and as a result has to be offered under a Patient Specific Directive (PSD), i.e. to named patients. Stock supplies are also restricted. Within London about 20 maternity and community providers are able to order one box of vaccine per fortnight (each box contains about 200 doses). Throughout July and August, NHSE (London) team have held fortnightly teleconference calls with these providers to support them to deliver BCG vaccine to those babies up to the age of 3 months who are most at risk of TB meningitis, i.e. those babies living with parents or grandparents from high risk countries.
- At the end of August 2016, NHSE (London) team audited the stock situation and delivery process and developed an interim London Intervax BCG protocol that has been in operation in London since November 2016. This sets out the referral process and eligibility criteria for BCG, mainly a universal offer in maternity units with a targeted follow up by community providers covering the named priority groups in the Section 7a BCG service specification.
- Harrow babies who are birthed at London North West, Barnet and Imperial hospitals should all be offered BCG vaccination at birth. For those babies who fit the criteria as set out in the London Intervax BCG protocol and not immunised at birth, Central London Community Healthcare NHS Trust (CLCH) are providing a community clinic.
- The shortage of BCG vaccine is likely to continue for some time and NHSE (London) would like to thank the HWBB for their continued support of providers.

3.3 Neonatal Hep B vaccination

- The aim of the immunisation is to prevent babies born to mothers with hepatitis B, from contracting the disease at delivery or in the first year of life.
- Babies born to mother who are Hepatitis B positive should receive a course of 4 doses of Hepatitis B vaccine and a serology/dried blood test by 12 months of age. Mothers are identified through the antenatal screening programme and babies are followed up through primary care in Harrow. At risk babies are monitored by the London Immunisation Team with monthly reports to the NHSE Quality, Safety and Performance Group.
- Since April 2017, delivery of neonatal Hep B immunisation programme is provided through GP practices. Work has been ongoing with the Harrow CCG to have Harrow practices enabled to deliver the 2nd, 3rd and 4th doses with dried blood spot (DBS) testing or serology. From August 2017, GP practices will only need to focus on the 2nd dose and 4th as the new 6-in- 1 programme that is replacing the 5-in -1 vaccine in routine childhood immunisation programme will mean all children will receive Hep B vaccine.
- There is no available data for Harrow as the numbers are too small and so the data has been suppressed (usually when numbers are less than 5).

What are we doing to ensure protection?

- Prior to 2017, London had five models of Hepatitis B vaccine delivery - GP, hospital based, community based or combination models and following the inclusion of payment for delivery in GMS contract of neonatal Hep B immunisations, NHSE has been working to mobilise the 11 boroughs who do not have a primary care model onto GP practice delivery. Failsafes have been commissioned from the CHIS hubs to track infants, including the unregistered, and to ensure completion of the course are being commissioned to support this model of delivery. The new pathway and model is in line with national guidance and directives and its development being monitored by the internal Quality, Safety and Performance Committee in NHS England (London) and by the London Immunisation Board. Following the agreement of a pharmacy with a wholesale licence ordering and stocking the DBS kits for GP practices, the protocol will be released on July 1st 2017 for consultation.

4 Routine Childhood Immunisation Programme (0-5 years)

4.1 'COVER'

- The routine vaccinations in COVER protect against:
  - Diphtheria, Tetanus, Pertussis (whooping cough), Polio, Haemophilus influenza type b (give as the '5 in 1' DTaP/IPV/Hib vaccine)
  - Pneumococcal disease, (PCV)
  - Meningococcal group C disease (Men C) and
  - Measles, mumps and rubella (MMR)

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

- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection particularly as there is no real incentive for GPs to submit data for COVER statistics and large numbers of deprived or vulnerable groups. In addition, there is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Harrow's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Harrow has not achieved the required 95%

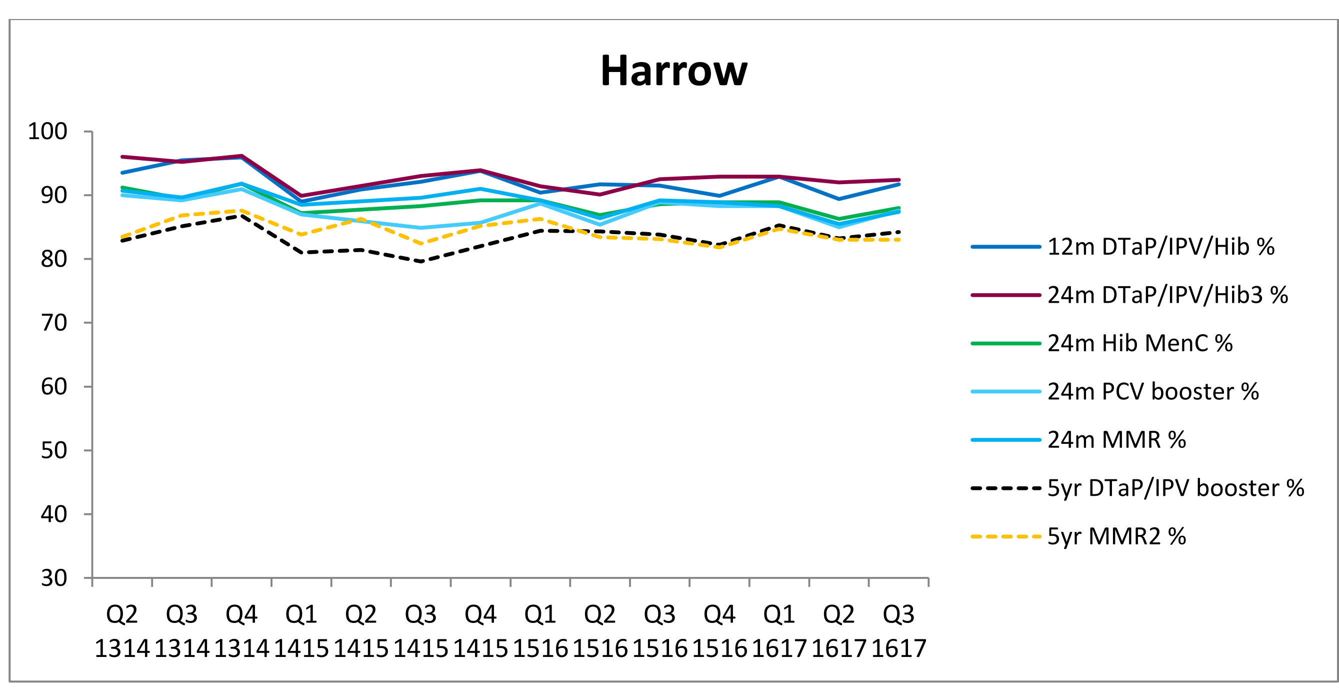
herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).

- Figure 3 illustrates the comparison of Harrow to other North West London boroughs using quarterly COVER statistics for the uptake of the six COVER indicators for uptake. The primaries (i.e. completed three doses of DTaP/IPV/Hib) are used to indicate age one immunisations, PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2 and preschool booster and second dose of MMR for age 5. Quarterly rates vary considerably more than annual rates but are used here so that Quarter 3 data from 2016/17 (the latest available data) could be included.

- Unfortunately due to changes to the business analytics system within NHSE, the usual time trend graphs for Harrow versus London and England averages could not be computed for this report but will be available again in the future. However, throughout 2011/12 to 2015/16, London has consistently performed below national on all COVER indicators by ~4% for the age 1 vaccinations, ~6% for age 2 vaccinations and ~10% for the age 5 vaccinations. Like for Harrow, the rates dipped at the start of 2013/14 but have since increased to the pre-dip levels.

- When looking at 'COVER' rates, it is important to look at coverage and drop out rates. Vaccine coverage is the proportion of eligible children receiving all doses of the recommended schedule – e.g. both doses of MMR. Drop-out rate measures the perceived quality of services. For Harrow, 83% of 5 year children had both doses of MMR with a drop out rate of 10.8%

Figure 3
COVER rates for Age 1, Age 2 and Age 5 cohorts in Harrow (2011-2016)



Source: PHE (2017)

What are we doing to increase uptake of COVER?

- Harrow like other London boroughs performs below England averages for completed routine childhood immunisations as indicated by MMR 2nd dose and preschool booster. This is also below the recommended WHO 95% recommended uptake levels. Improving uptake rates in Harrow is being undertaken by pan London endeavours as well as local borough partnership work between CCG, local authority, PHE and NHSE London.
- Increasing coverage and uptake of the COVER reported vaccinations to the recommended 95% levels is a complex task. Under the London Immunisation Board, PHE and NHSE (London) have been working together to improve quality of vaccination services, increasing access, managing vaccine incidents and improving information management, such as better data linkages between Child Health Information Systems (CHIS) and GP systems. As well as these pan London approaches, NHSE (London) have been working locally with PHE health protection teams, CCGs and local public health teams in local authorities to identify local barriers and vulnerable or underserved groups (e.g. travelling community) and to work together to improve public acceptability and access and thereby increase vaccine uptake. These actions take the form of local immunisation steering groups with local annual action plans and are accountable to local governance structures.
- In June 2016, NHSE (London) and PHE (London) hosted a 'deep dive' into 0-5s immunisations and agreed a nine point action plan to be imbedded over the next year (see Figure 3 for the infographic).
- The London wide Immunisation Plan for 2016/17 included sub-sets of plans such as improving parental reminders across London, which the evidence repeatedly states as the main contributor to improving uptake of 0-5s vaccinations. This resulted in the production of 0-5s best practice pathway (currently out for consultation) and a call/recall best practice pathway, which is just about to be released. The London Immunisation Board will be monitoring the impact of these pathways over the next year.
- An evaluation of the 300 practices in London last year in relation to improving uptake of COVER reported vaccinations, also concluded that practices need support around information materials to discuss with parents which the NHSE (London) immunisation team are addressing in conjunction with our PHE colleagues.
- Since April 2017, London's child health information systems (CHIS) are being provided by four hubs which feed a single data platform. This has simplified the barriers previously experienced by London have a large number of different data systems 'talking to each other'. Now all CHIS information is on one system fed by three data linkage systems from GP practices, which in turn are now on one of three systems. This change should remove many of the data errors in the past that had led to an overestimation of unvaccinated children. However, London continues to have a large proportion of children vaccinated overseas which often means that children are reported as unvaccinated when they have been vaccinated but on a different schedule. Work is underway to help GPs code the vaccinations of these new patients.

Figure 4
Infographic of action plan for improving 0-5s immunisation uptake in London

Actions from London's 0-5s Immunisation Deep Dive June 2016

1. We will start computing regular GP-to-CHIS RAG risk assessments

2. We will implement WHO toolkit to find underserved populations and use peer-groups

3. We will provide information, data and intelligence in different formats

4. We will implement a best practice immunisation pathway across London

5. We will tackle the GP practices that are not performing

6. We will continue to use the Borough Plans to work in partnership to improve local uptake

7. We will push the eRedbook as a single health record, accessible to parent, accessible to all providers inc. pharmacy, A&E and OPD

8. We will continue to commission alternative providers and increase patient choice for vaccines

9. We will utilise social media campaigns, particularly for the underserved peer groups

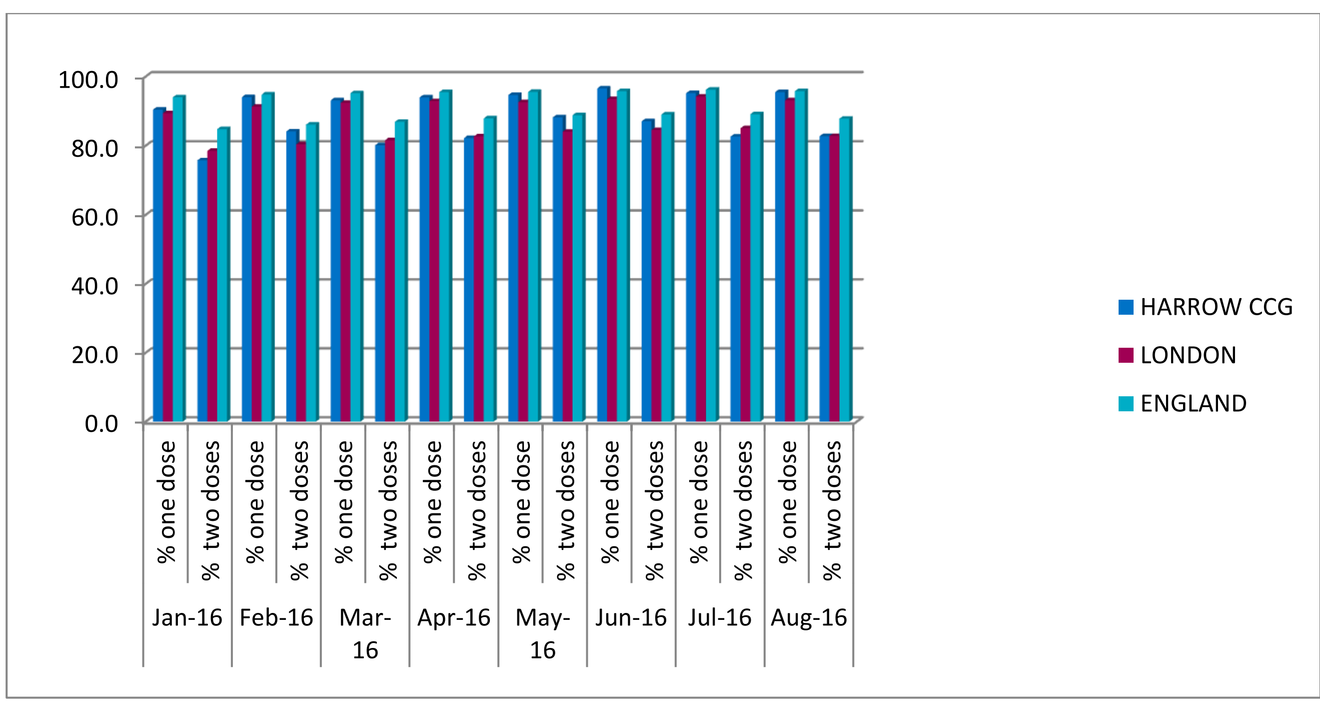
4.2 Rotavirus

- Rotavirus is a contagious virus that causes gastroenteritis.
- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages for 1st dose have been 90% or over. There is a slight drop of ~1% for 2nd dose (completed course) for England, whilst London drops to the mid 80s.
- The programme has been very successful in reducing incidences of rotavirus with laboratory reports of rotavirus for July 2013 – June 2014 being 67% lower than the ten season average for the same period in the seasons 2003/04 to 2012/13.
- In Harrow uptake of Rotavirus has consistently been 90% or higher.

4.3 Meningococcal B vaccination

- Since September 2015, all infants are offered a course of meningococcal B (men B) vaccine as part of the Routine Childhood Schedule. Eligible infants were those babies born on or after 1st July 2015 with a small catch up programme for babies born on or after 1st May 2015.
- There are preliminary data for babies aged 26 weeks for the months of January - August 2016 (Figure 5). It can be seen that Harrow performs similarly to London averages. Rates do drop at second dose from 92.7% of Harrow 12 month olds having had one dose of Men B compared to 87.7% with two doses.

Figure 5
Uptake of 1st and 2nd dose for Harrow CCG for babies aged 52 weeks compared to London and England 2016



Source: PHE (2016)

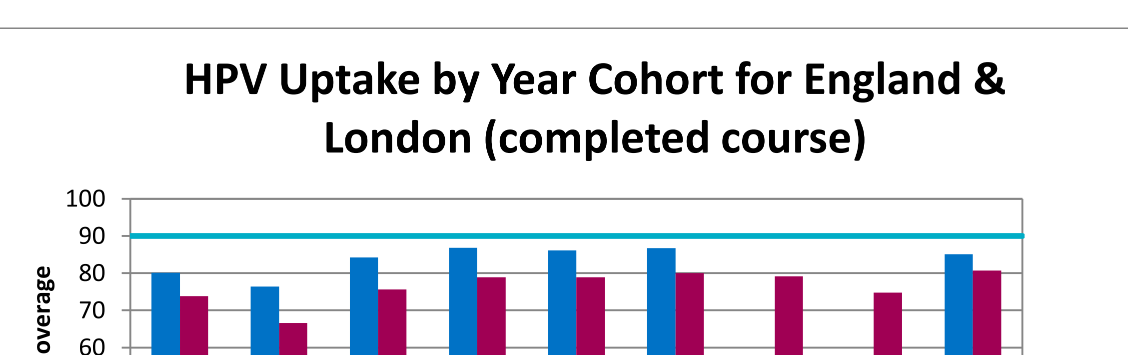
5 School Age Vaccinations

School age vaccinations are 1) HPV vaccine for 12-13 year old girls and 2) tetanus, diphtheria, polio booster at age 14 for boys and girls and 3) Meningitis ACWY

5.1 HPV vaccination

- Human papillomavirus (HPV) vaccination protects against viruses that are linked to the development of cervical cancer
- HPV vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 is that two doses are adequate.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. However the introduction of a two course programme instead of a three course programme meant that many providers didn't offer the second dose until the next academic year. As a result a national average could not be computed for 2014/15. For 2015/16, London was the only region to commission both doses to be given within one academic year (hence why there are two year groups displayed in Figure 6). It can be seen that London' completed dose schedule has remained stable at 80% since 2013/14, despite the re-procurement of school age vaccination services across London.
- For Harrow, rates have remained stable around 85% uptake for completed schedule of HPV for the last two years until end 2015/16. Since then the provision of these immunisations has been moved from London North West Healthcare NHS Trust to CLCH.

Figure 6



Source: PHE (2016)

Figure 7

Table of completed HPV courses for 2013/14 – 2015/16 for London boroughs

Name of Organisation	% 2015/16	% 2014/15	%2013/14
BARKING AND DAGENHAM	49.8	83.5	79.2
BARNET	74.3	72.6	69.5
BEXLEY	81.3	80.5	76.6
BRENT	68.4	81.0	81.1
BROMLEY	80.8	84.5	86.8
CAMDEN	65.2	73.5	77.0
CITY OF LONDON	77.4	85.1	85.4
CROYDON	73.1	79.2	76.4
EALING	67.3	81.3	77.0
ENFIELD	65.7	72.7	68.3
GREENWICH TEACHING	72	79.7	77.6
HACKNEY	78.1	64.1	68.2
HAMMERSMITH AND FULHAM	48.8	75.1	73.3
HARINGEY	77	80.5	76.4
HARROW	76.5	77.6	83.2
HAVERING	75	86.3	86.2
HILLINGDON	87.6	86.7	86.5
HOUNSLOW	77.5	83.5	86.2
ISLINGTON	71.3	84.1	87.1
KENSINGTON AND CHELSEA	47.4	62.6	78.9
KINGSTON	85.1	85.3	81.6
LAMBETH	79.2	78.9	80.9
LEWISHAM	66.7	73.4	82.9
MERTON	84.5	85.4	87.6
NEWHAM	83.5	90.9	92.3
REDBRIDGE	75.9	79.2	69.2
RICHMOND	76	76.0	81.8
SOUTHWARK	84.2	77.3	85.7
SUTTON	88.3	87.7	90.4
TOWER HAMLETS	76.8	74.1	75.6
WALTHAM FOREST	65.6	73.3	86.8
WANDSWORTH	91.9	82.7	79.1
WESTMINSTER	63.1	74.7	77.9

Source: PHE (2017)

5.2 Men ACWY

- This vaccination protects against four types of Meningitis
- This is the first year that statistics have been gathered on Men ACWY uptake in schools. In London, 63.1% of the routine cohort Year 10 were vaccinated (compared to England's 77.2%), 76% of routine cohort Year 9 (England had 84.1%) and 55.9% of the catch up Year 11 (compared to England's 71.8%).
- In Harrow the uptake rate was 75.6% for Year 10 and 74.7% for Year 11.

What are we doing to improve uptake?

- During 2016/17, NHSE immunisation team are monitoring performance monthly and there is a deep dive into performance scheduled for June 2017.
- The team are also undertaking a study into the service factors impacting upon school vaccinations uptake in London as well as organising a 'Hackathon' for school age vaccinations to take place in the summer.
- In Harrow the school age vaccination service was re-procured in 2016, when the contract moved from LNW to CLCH.

6 Adult Vaccinations

6.1 Shingles

- The Shingles vaccination programme commenced in September 2013. Shingles vaccine is offered to people who are 70 years or 78 years old on 1st September in the given year (or who were 70 years in 2013/14, 2014/15 and 2015/16). Data on vaccine coverage is collected between 1st September and 31st August. London has excellent reporting rates with 95.8% of GP practices submitting data returns for 2014/15 (Harrow CCG had returns of 93.1%).
- Figure 8 illustrates the percentage uptake by CCG in London for three years of the programme for the routine age 70 cohort. It can be seen that Harrow CCG reports uptake rates that are slightly higher than London averages but lower than England averages.
- Nationally and within London, there is no difference between ethnic groups in terms of uptake.

Figure 8
Table displaying % of shingles uptake for age 70 cohort by CCG in London

	% of 70 years age cohort		
CCG	2013/14	2014/15	2015/16
Barking and Dagenham CCG	51.9	50.2	47.4
Barnet CCG	56.1	55.9	54.4
Bexley CCG	47	53.1	45.8
Brent	51.8	53.1	52.0
Bromley CCG	55.6	52.5	48.8

Camden CCG	50.3	47.6	46.4
Central London (Westminster) CCG	34.6	33.5	40.2
City and Hackney CCG	43	40.6	35.4
Croydon CCG	55.6	53.6	47.0
Ealing CCG	49.8	42.9	45.7
Enfield CCG	52	51.2	50.2
Greenwich CCG	51.4	46.2	38.4
Hammersmith & Fulham CCG	36.6	33	28.6
Haringey CCG	47.7	47.5	48.2
Harrow CCG	51	50.8	50.8
Havering CCG	54.6	50.8	47.5
Hillingdon CCG	62	55.8	54.9
Hounslow CCG	44.6	43.2	44.1
Islington CCG	51.2	48	45.3
Kingston CCG	52.6	57.5	50.9
Lambeth CCG	51.2	42.7	41.7
Lewisham CCG	49	48	48.0
Merton CCG	51.1	48.8	48.2
Newham CCG	60.7	56	51.6
Redbridge CCG	51.2	47.6	46.2
Richmond CCG	61.8	53.7	50.5
Southwark CCG	45.5	40.7	42.3
Sutton CCG	56.2	58	58.0
Tower Hamlets CCG	50.9	49.9	46.2
Waltham Forrest CCG	48.7	46.4	48.1
Wandsworth CCG	52	51.1	48.4
West London (K&C & QPP) CCG	42.1	25.6	28.1
London	**51.3**	**48.8**	**47.1**
England	**61.8**	**59**	**54.9**

Source: PHE (2016)

What are we doing to increase uptake?

- Shingles continues to be promoted as part of our London Immunisation Plan. For 2017/18, we are working with CCGs and GP practices to improve call/recall as the evaluation of the 2015/16 shingles promotion plan found that this activity may bring about higher uptake rates.

6.2 PPV

- Pneumococcal Polysachride Vaccine (PPV) is offered to all those aged 65 and older to protect against 23 strains of pneumococcal bacterium. It is a one off vaccine which protects for life. This vaccination tends to be given

alongside the flu vaccination during the flu season as the patient is usually present at the flu appointment.

- Reporting coverage rates are good – 98.1% of London GP practices report their rates, 96.7% for England and 100% returns in Harrow. Vaccine uptake and reporting coverage is published cumulatively. The latest published data is for 2015/16. Up to and including 31st March 2016, 66.7% of those aged 65 years and older were vaccinated with PPV in Harrow. This is higher than London's average of 65.3% and lower than England's average of 70.1%. There is no target for this vaccine as we are aiming for individual protection not population protection.
- It is worth noting that the over 65s population are largely protected against pneumococcal invasive disease and pneumonia from the PCV-13 programme given as part of the 0 to 5s routine childhood immunisation schedule, because young children are the main source of spread of these infections. PPV23 is an additional vaccine to help protect this population from the remaining 13 strains not covered in the PCV-13 vaccine.

6.3 Seasonal 'Flu

- Figure 9 illustrates the uptake of seasonal 'flu vaccine for each of the identified 'at risk' groups for Harrow CCG compared to London and England averages for the winter 2016/17 (September 1st 2016 to January 31st 2017). It can be seen that London performs lower than England across the groups but that Harrow CCG performs better than London averages for Over 65's, at risk groups and school aged children.
- The child 'flu vaccine (Fluenz) programme for 2-4 year olds is given in general practice whilst the school age programme is delivered by community providers for Years 1-3.
- Uptake of flu vaccine increased this season across the at risk groups including child 'flu vaccine groups with London, England and Harrow exceeding the lower threshold of 40% for uptake for children in the school programmes. Uptake in preschool children remain low but after a huge audit of poor performing practices during the summer of 2016 in London with follow up action plans, London demonstrated a big increase on the previous year.

Figure 9

Uptake of the 'at risk' Groups of Seasonal 'flu for Harrow CCG compared to London and England for Winter 2016/17 (September 1st 2016 – January 31st 2017)

CCG	% of uptake 65 +	% of at risk patients (6 months - 64 years)	% of pregnant women	% of 2 year olds	% of 3 year olds	% of 4 year olds	% of year 1	% of year 2	% of Year 3
Harrow	68.7	47.9	36.5	27.4	29.5	21.6	54	47.6	46.2

London	65.1	47.1	39.6	30.3	32.6	24.9	45.8	43.6	42
England	70.4	48.1	44.8	38.8	41.6	33.8	57.6	55.3	53.3

Source: PHE (2017)

What are we doing to improve uptake?

- Following the decline in 'flu uptake in London during the 2015/16 season and the continual fall in uptake amongst 2, 3 and 4 year olds, NHSE carried a large number of evaluations which fed into the London Influenza Vaccination Plan for 2016/17. This plan was signed off by the London Immunisation Board and was delivered through a weekly Immunisation business group co-chaired by PHE London and NHSE London. This group monitored progress against the plan and operated remedial plans when necessary.
- 2016/17 also saw the consolidation of the delivery of school age vaccinations by community providers and the second year of delivery of the child 'flu programme has seen increases in uptake across the city.
- NHSE London have now commenced the evaluation of this plan with the intention to improve uptake rates again next 'flu season (2017/18).

7 Next Steps

- A new regional Immunisation Plan was signed off by the London Immunisation Board in May 2017. This includes closer partnership working across London.
- A new immunisation steering group was recently set up and the first meeting held on the 6th June. It involves a number of stakeholders including the CCG, NHS England, PHE Health Protection team, the local maternity unit and school aged vaccination team.
- An evaluation of local partnership arrangements for immunisations is under way with initial findings presented to the London Immunisation Board and a final report due in July 2017. NHSE looks forward to implementing the recommendations with local partners in tackling health inequalities pertaining to immunisations and new ways of working together as STPs on the preventive agenda, which includes immunisations.

NHS England

Public Health:
Screening
External assurance report

Harrow Health & Wellbeing Board Screening

June 2017

An introduction outlining the services and our partnership requirements

Operating Model

From 'Immunisation and Screening National Delivery Framework & Local Operating Model', April 2013

- The Health and Social Care Act 2012 creates a new set of responsibilities for the delivery of public health services. In England, although the local leadership for improving and protecting the public's health will sit with local government, the reforms provide specific roles for the National Health Service England (NHS England) and Public Heath England (PHE) for the commissioning and system leadership of the national screening and immunisation programmes.
- NHS England's Area Teams will commission these services. Specialist public health staff employed by PHE are embedded in these teams to provide accountability and leadership for the commissioning of the programmes and to provide system leadership.
- All the arrangements in the Immunisation and Screening National Delivery Framework and local operating framework are set in the context of accountability to Ministers and Parliament. This is set out in the agreements between the Department of Health (DH) and NHS England, especially the section 7A agreement on public health functions to be exercised the NHS England, and the partnership agreement between the NHS England and PHE.
- The national delivery framework and local operating model have been agreed jointly by DH, NHS England, local government and PHE. They set out how, after 1 April 2013, national, regional, and local operational and governance arrangements for national screening and immunisation programmes in England will be coordinated.
- Each of the partners (DH, NHS England, Local Government and PHE) has its own responsibilities for which it is accountable. The national delivery framework and local operating model sets out how effective co-ordination for national screening and immunisation programmes will operate, addressing coordination at all stages along the delivery chain – formulation of policy, implementation, delivery, monitoring, reporting and review
- The national delivery framework operationalises these agreements in relation to the roles of DH, NHS England, and PHE for national immunisation and screening programmes in England.
- The local operating model is a parallel document and sets out the local arrangements by which the NHS England, PHE and local government will work together to commission and provide system leadership for screening and immunisation services.

Scope of National Screening Programmes

Each year nationally approximately 11 million newborns and adults will be invited to participate in an NHS England commissioned screening programme

Antenatal and Newborn Screening Programmes

- NHS Fetal Anomaly Screening Programme
- NHS Infectious Diseases in Pregnancy Screening Programme
- NHS Newborn and Infant Physical Examination Programme
- NHS Newborn Blood Spot Screening Programme
- NHS Newborn Hearing Screening Programme
- NHS Sickle Cell and Thalassaemia Screening Programme

Adult Non-Cancer Screening Programmes:

- NHS Abdominal Aortic Aneurysm Screening Programme
- NHS Diabetic Eye Screening Programme

Cancer Screening Programmes:

- NHS Cervical Screening Programme
- NHS Breast Screening Programme
- NHS Bowel Cancer Screening Programme

Partnerships

- NHS England, through its Area Teams will be responsible for the commissioning of all National Immunisation and Screening Programmes described in Section 7A of the Mandate. In this capacity, NHS England will be accountable for ensuring that local providers of services will deliver against the national service specifications and meet agreed population uptake & coverage levels as specified in Public Health Outcome Indicators and KPIs. NHS England will be responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
- PHE Specialist National Teams, in addition to the national role as has been described in the national framework, will support national professional networks for PHE embedded staff in Area Team Screening and Immunisation Teams.
- Local Authorities will provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers. This function may be carried out through agreed local mechanisms e.g. local programme boards for screening and immunisation programmes or using established health protection sub-committees of the Health and Wellbeing Boards.
- CCGs will have a duty of quality improvement and this extends to primary medical care services delivered by GP practices such as immunisation and screening services. As commissioners of treatment services that receive screen positive patients, CCGs will have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen positive patients and meet quality standards. CCGs will also hold the contracts for maternity services, which are providers of antenatal & newborn screening.

Cancer Screening

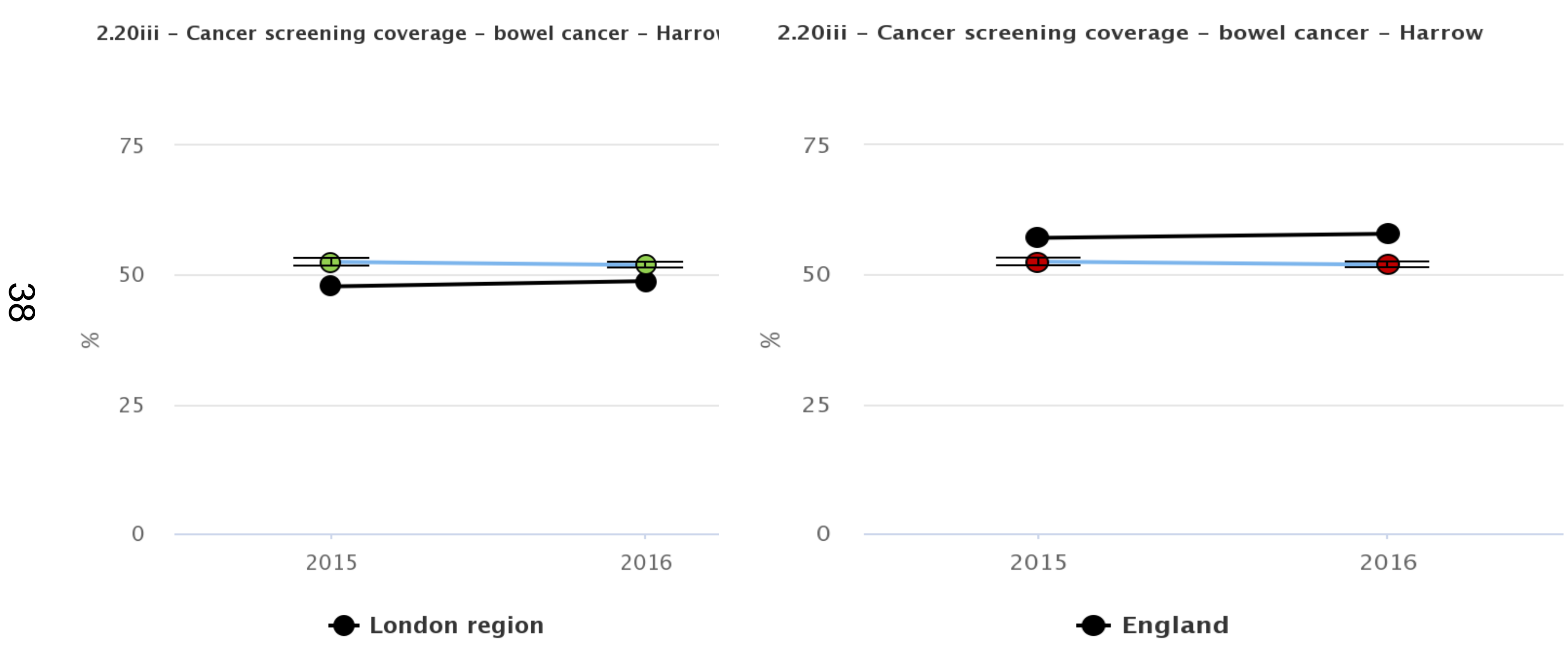
Bowel Cancer Screening

Describe the plan, trajectory, aim	Describe performance against plan, trajectory, aim
Reduction in morbidity and mortality from bowel cancer through adequately screening a minimum of 52% of the eligible population. Men and women aged 60-74 years invited every two years. Coverage is the proportion of the eligible population screened within the last 2.5 years. For the Harrow population the commissioned provider for clinical bowel screening services (assessment and treatment) is London Northwest Healthcare NHS Trust. Administration and analysis of samples is also provided by North West London NHS Trust who are commissioned to deliver this service pan London. North West London Healthcare NHS Trust is also commissioned to provide one off bowel scope screening for all 55 year olds to the Harrow population in line with the national programme.	Latest published data for coverage demonstrates performance in Harrow is better than the London average but worse than the England average (see next slide). In 2016 coverage for Harrow was at 51.9% compared to 57.9% for England and 48.8% for London for the same time period. Bowel scope has been fully rolled out to the entire eligible Harrow population since xx . This compare with only 33% of the entire London population having access to this service by the end of Quarter 4 2017/18. There are currently no nationally agreed targets for bowel scope uptake or coverage as the programme is only part rolled out.

Activities/impact since last report	Future Activities/Reviews
London Northwest Healthcare NHS Trust has signed up to contractual quality improvement schemes to reduce the number of DNAs at assessment appointments and to improve participation rates in bowel scope screening.	Future activities: text reminders to non attenders; continuation of GP endorsement on invitation letters and enhanced reminder letters;

Escalation for action/information	RAG rating
None	Green

Coverage 2015 and 2016

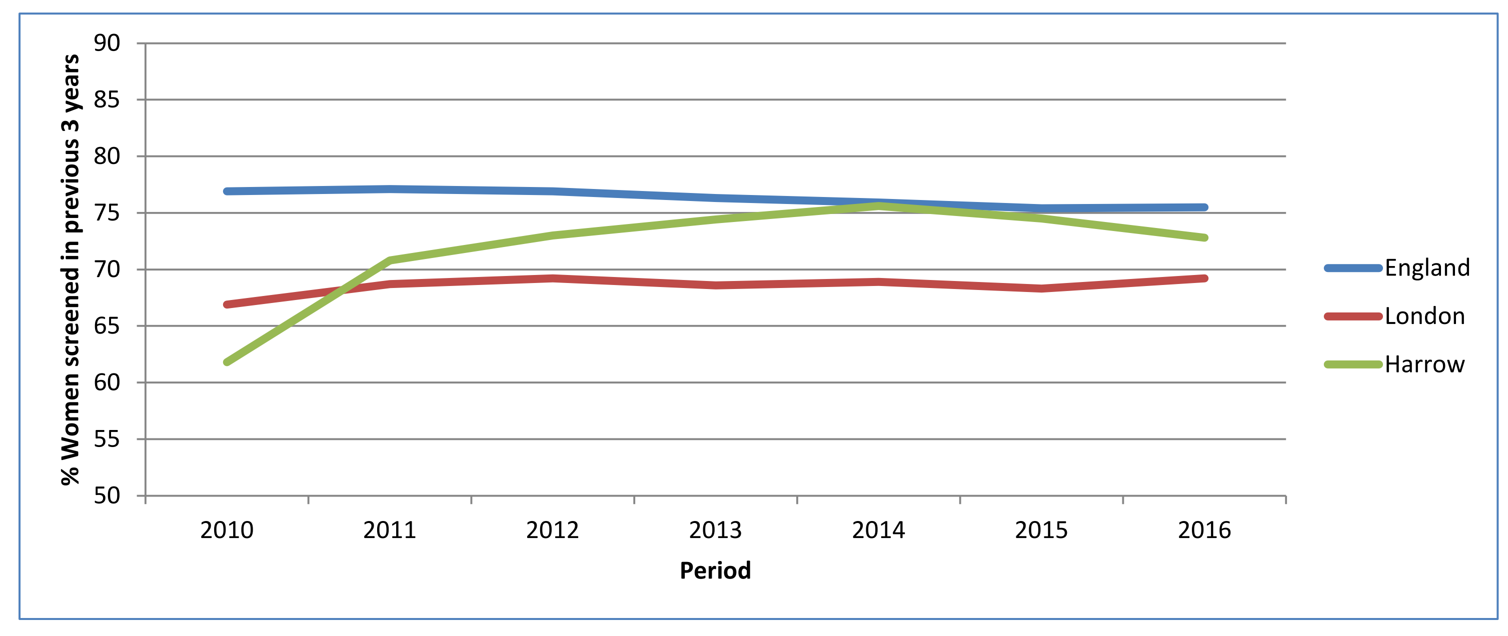


Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Breast Screening

Aim	Performance See slide 26 for data illustrations
To reduce morbidity and mortality caused by breast cancer through adequately screening a minimum of 70% of the eligible population. Women aged 50 – 70 years old are invited every three years. For the Harrow population the commissioned provider for clinical breast screening services is the North London Breast Screening Service hosted by the Royal Free NHS Trust. Administration is provided by the London Hub (Royal Free NHS Trust)..	Harrow CCG meets the national standard for breast screening coverage (70% of eligible population screened within the previous 36 months). Coverage as at November 2016 in Harrow CCG was 70.78% (PHOF), higher than the NWL and London averages but lower than the national average of 58.82% Twelve practices within the borough achieved the national target, while 14 practices achieved less than 60% (10% below target
Activities/impact since last report	**Future Activities/Reviews**
- Since early 2015 work has been continuing on procuring and mobilising a new service delivery model with a focus primarily on maintaining business as usual. - All breast screening administration now transferred to the London Administration Hub: to standardise process and practices including but not limited to round-planning and Quality Management Systems. - CQINs: Every Contact Counts – promoting all screening programmes throughout NHSE public health commissioned services. Impact is unknown though a 1-3% increase, coupled with other promotional activities and standardised practice, could be realised.	- London Hub Website (Phase 1) - Communication and Health Promotion Strategies: Identifying stakeholders and new ways of working together (practice, CCG, STP level) to improve women's experience's, service performance and health outcomes - London-wide GP Information Pack: sent to all practices 6 weeks prior to women being invited (Health promotion)
Escalation for action/information	**RAG rating**
None	- Current RAG rating '**Green'**

Breast screening Coverage 2010 – 20016



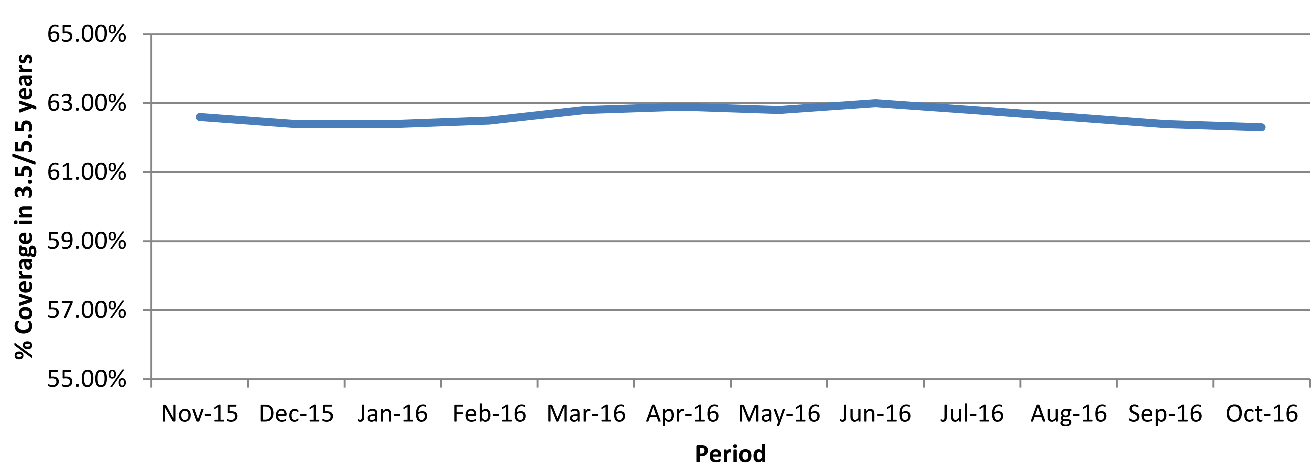
	2010	2011	2012	2013	2014	2015	2016
England	76.9	77.1	76.9	76.3	75.9	75.4	75.5
London	66.9	68.7	69.2	68.6	68.9	68.3	69.2
Harrow	61.8	70.8	73	74.4	75.6	74.5	72.8
Lower CI	61.1	70.2	72.4	73.9	75	73.9	72.3
Upper CI	62.4	71.3	73.5	75	76.1	75	73.4
Count	13,675	15,905	16,738	17,532	17,876	18,120	18,069

Cervical Cancer Screening

Aim	(65%)
The cervical cancer screening programme screens women aged 25-49 years every 3 years and women aged 50-64 every 5 years. For Harrow populations the call / recall function is managed centrally by Primary Care Support England (PCSE) and women are invited to attend their GP surgery for a cervical cancer screen. Laboratory and colposcopy services for Harrow patients are provided by Northwick Park.	Harrow is consistently below the national and London standard for screening coverage at 62.3%. Performance in Harrow ranges from 54.6% in Headstone Lane Medical Practice to 100% at the Brent and Harrow Safe Haven Unit. A full breakdown of practice performance is provided on the next slide.
Activities/impact since last report	**Future Activities/Reviews**
- Centralised call /recall transferred to PCSE (Capita) from local screening managers, transition issues and a backlog on adding GP newly registered patient uploads may have had an adverse impact on coverage. - Funding and service specification for pan-London GP endorsed text reminder service approved, evidence shows text reminders can improve uptake by up to 6%. - Link with Jo's Trust cervical cancer screening roadshows to improve uptake. - Commissioner primary care working with practice staff around sample taker training and competence.	- Roll out of GP-endorsed text reminder project to at least 80% of all London general practices. - Improving screening pathways for forensic inpatient units. - Specific focus on people living with serious mental illness to improve screening rates among this population, evidence shows people with mental illness are three times more likely to die once they receive a cancer diagnosis and late presentation is a key factor.

Escalation for action/information	RAG rating
TATs for all CCGs has declined due to increased workload meaning women are waiting longer for results. This is worsened by shortage of cytoscreeners due to planned introduction of HPV primary screening and consequent reduction in cytology workload. Conversion of some work to HPV primary screening early to reduce backlog planned. Introduction of HPV primary screening for all by April 2019 Potential courier issues leading to lost samples between TDL and North Mid being investigated.	- Current RAG rating '**RED'** Local Authority, CCG and Practice Performance Dashboards can be accessed at: http://digital.nhs.uk/pubs/cervical_screen_coverage_quarterly

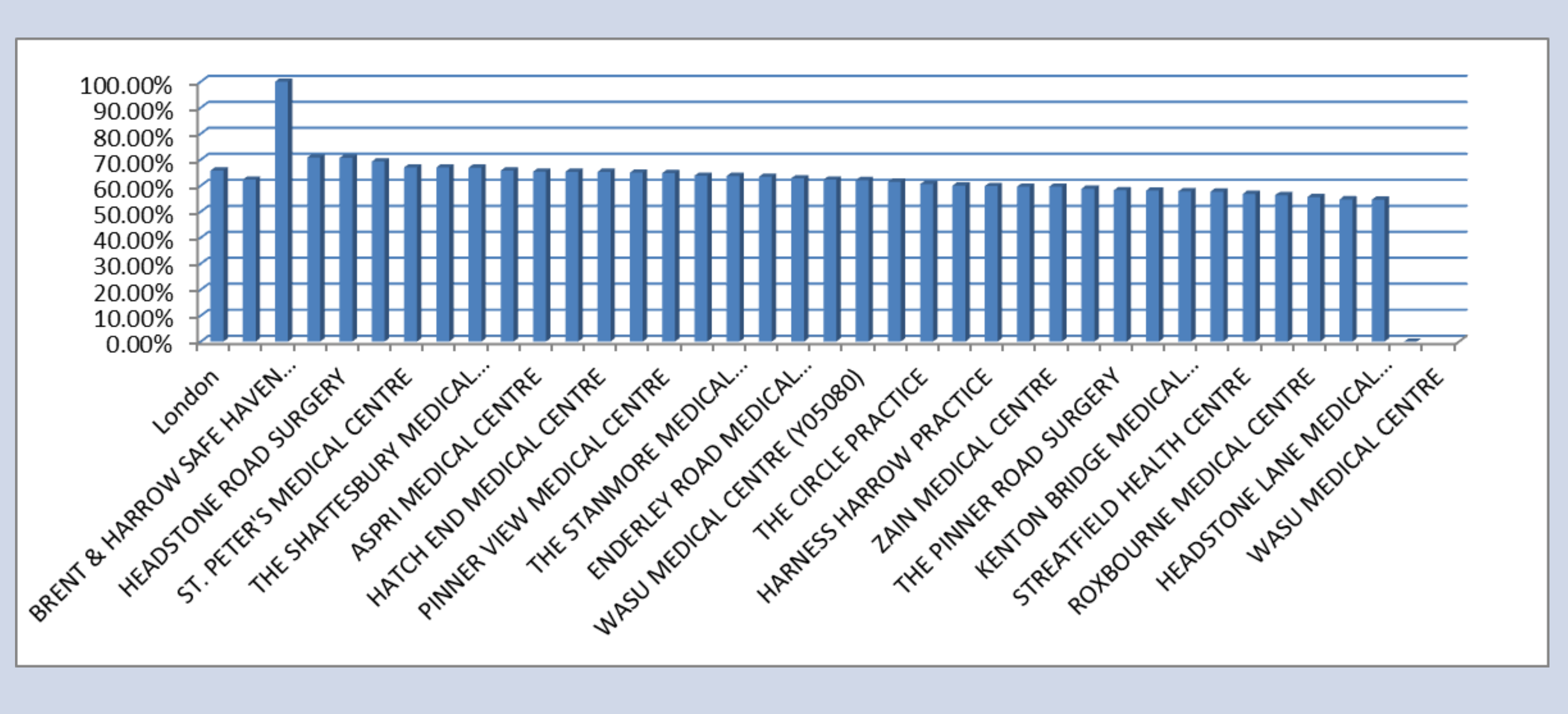
Cervical Screening Coverage



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
NHS HARROW C	62.60%	62.40%	62.40%	62.50%	62.80%	62.90%	62.80%	63.00%	62.80%	62.60%	62.40%	62.30%

Coverage by Practice: Harrow CCG

Coverage by General Practice (November 2016)



Data available on request

Area	Report name	Detail	Frequency
Screening & Imms	SAM (Section 7a Assurance Meeting) Report	S7a Public Health report with latest published data for indicators covered in the S7a Framework, used for the quarterly S7a assurance meetings	Quarterly
	Local Authority Assurance Dashboard	Dashboard bringing together the published data for immunisations, screening and cancer screening programmes to provide assurance for Local Authorities	Every 1-2 months
	CCG and Practice Profile Tool	Provides DCO, CCG and GP practice level data for cancer screening, PHE immunisation and Unify immunisation data, with timeseries, interactive views and comparison to similar CCGs.	Quarterly
Cancer screening	Cancer Screening Coverage and Uptake	Breast, bowel and cervical screening uptake/coverage with: - 12 month rolling timeseries - gap of number of people needing to be screening to meet the standard (by CCG and practice level)	Monthly (16th of month)
	Cancer Screening 62 Day Waiting Times	Performance against the 62 day waiting times target for treatment after referral from breast/bowel/cervical cancer screening programme, by provider.	Monthly (2nd Thursday of month)
	Cervical Screening Turnaround Times	Cervical cancer turnaround times for screening test results (KPI # CS4a) with 12 month rolling timeseries	Monthly
	Bowel Scope Screening	National bowel scope screening uptake, activity and percentage requiring colonoscopy, including provider performance against trajectories	Monthly
	Breast Screening KPIs	Summary of monthly and quarterly breast screening KPI data measures, by screening centre	Monthly / Quarterly
	Bowel Screening KPIs	Summary of monthly and quarterly bowel screening KPI data measures, by screening centre (note: quarterly data is London region only until national data received)	Monthly / Quarterly
	Cervical Screening KPIs	Summary of quarterly cervical screening KPI data measures, by local authority (coverage data) and screening centre	Quarterly
Screening	Screening KPI Dashboard - Non Confidential	Provides a high level overview of the quality of screening programmes at key points on the screening pathway. Covers: - Antenatal and newborn screening KPIs (ANNB) - Abdominal aortic aneurysm screening KPIs (AAA) - Diabetic eye screening KPIs (DESP)	Quarterly
	Screening KPI Dashboard - Confidential	Same as non confidential dashboard above, but includes KPIs with small numbers that are supressed in published data	Quarterly

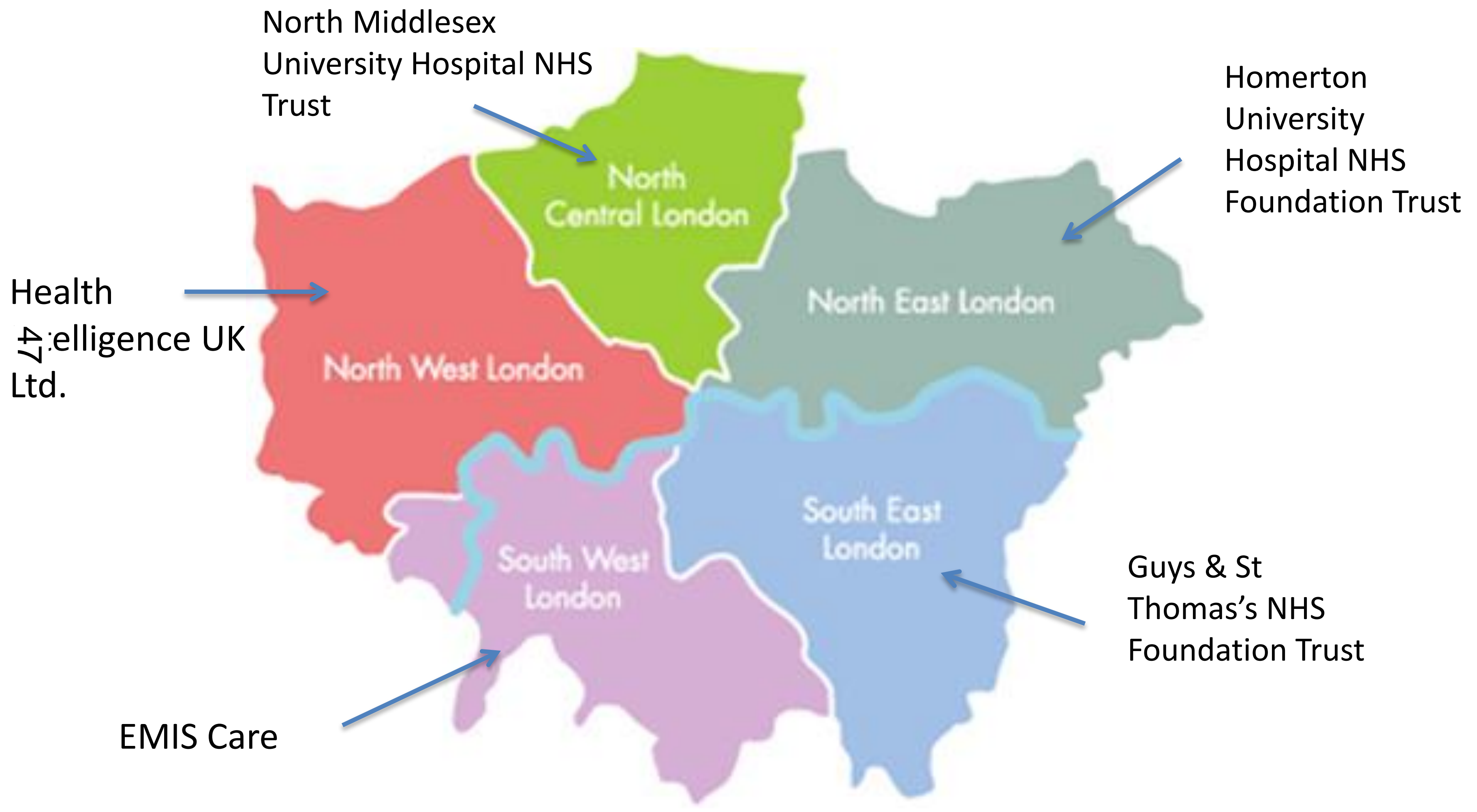
Adult and young person's screening programmes (non cancer)

Abdominal Aortic Aneurysm Screening

Diabetic Eye Screening

Diabetic Eye Screening

Service Provision – Programme Geography: Diabetic Eye Screening (DES)



Diabetic Eye Screening Programme Exceptions

Exceptions	Improvement Actions
Borough is meeting the achievable standard for screening uptake Concern about the time taken to assess and treat screen detected abnormality	Programme audit schedule plans include a Did not Attend (DNA) audit, to ascertain why people do not attend when invited, during 2017/18 to try to improve this further

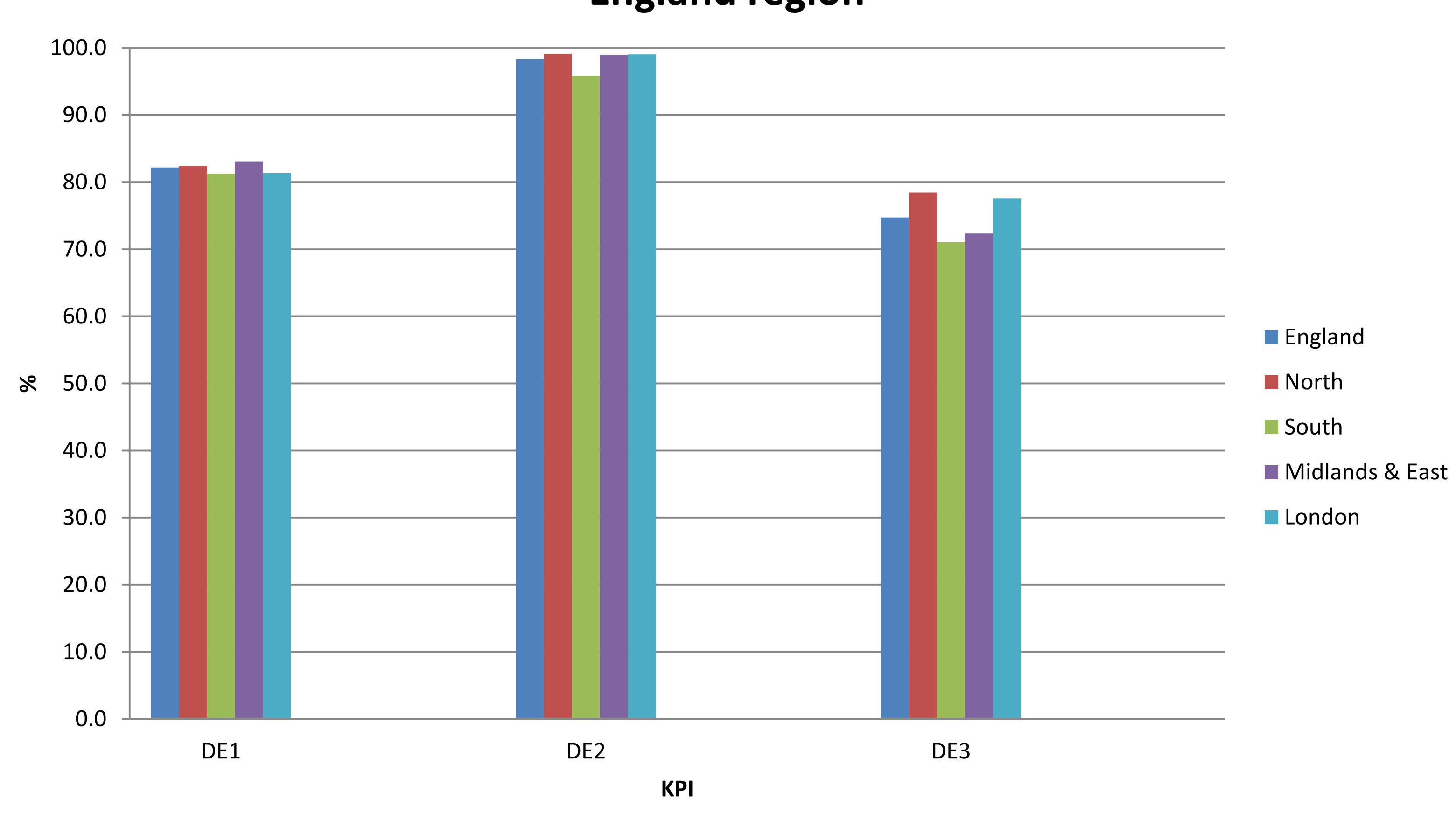
Activities/impact since last report	Actions Required
• All GP practices have signed up and participating in monthly data extraction to ensure we know about every person living with diabetes in the borough • GPs uptake ranges from 79 - 92.5%. Average participation in annual screening, by GP practice, is 85.5%	Linked treatment centre: Moorfields Northwick Park site, patients incurring delay to consultation following referral, due to 'severe capacity issues' Escalated through Programme Board to local CCG commissioner

Escalation for action/information	RAG rating
Timely assessment for treatment needs improving. NHS England commissioners leading transformation agenda for low risk patients with screen-detected retinopathy as part of 2017/18 CQUIN, reducing the referral rate from DESP to hospital by up to 80%	Amber/Green

DES Key Performance Indicators: Descriptors

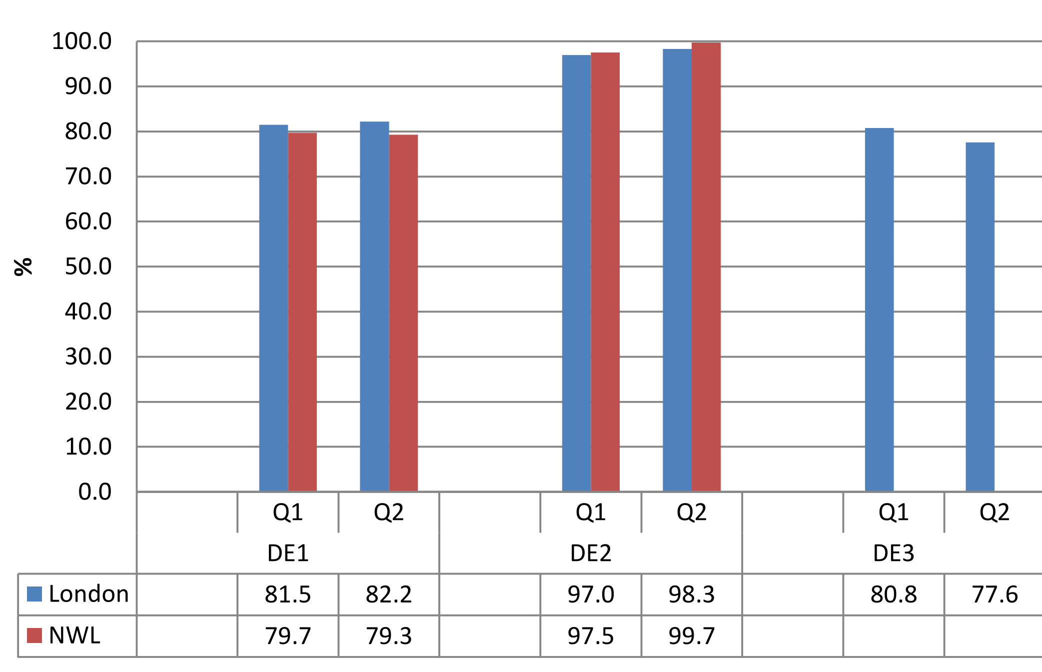
KPI	Description	Minimum Standard (%)	Achievable Standard (%)
DE1	Uptake of routine digital screening event	≥ 70.0%	≥ 80.0%
DE2	Results issued within 3 weeks of screening	≥ 70.0%	≥ 95.0%
DE3	Timely assessment for R3A screen positive		≥ 80.0%

Key Performance Indicators (National): DES



Key Performance Indicators (London): DES

- In 2015/16, a national project ran to standardise the delivery of the screening pathway and the methodology for reporting
- As such accurate, validated performance data is only available for quarters 1 & 2 or 2016/17
- Prior to this, NHSE commissioners were discharging their responsibilities through local multi-disciplinary performance boards, ensuring national KPIs and quality standards were being adhered to, in order to receive the assurance required.



	DE1 Q1	DE1 Q2	DE2 Q1	DE2 Q2	DE3 Q1	DE3 Q2
London	81.5	82.2	97.0	98.3	80.8	77.6
NWL	79.7	79.3	97.5	99.7		

- The National Diabetic Eye Screening programme advised against sharing of locally produced performance data until the common pathway had been fully rolled out, due to lack of data quality assurance processes
- Q4 data was published but has since been recognised as containing major flaws, caused by database issues during the period of merger, following London procurement

Harrow: Summary of External Quality Assurance visit, 2017

In February 2017, Public Health England's (PHE) Quality Assurance (QA) team undertook a formal quality assurance visit and assessment of the North West London Diabetic Eye Screening Programme (NWL DESP). The visit is peer led and reviews the quality of the service in accordance with both national Key performance indicators and the nationally defined quality assurance standards.

As a result of the visit, 17 recommendations were made. An action plan has been developed to ensure each recommendation is addressed and commissioners will hold the Provider to account for delivering the described actions, in full and to time.

Visit highlights

Areas of good practice	Opportunities for improvement (themes)
Enthusiasm and commitment of all parties during a period of major change which led to the successful mobilisation of a new service	Ensure clinical and programme governance is clearly documented, both within the Provider organisation but also across linked Providers
Recognition of strengths and weaknesses by the service provider and co-working with the commissioners to develop and improve the service	Ensure failsafe responsibilities are up to date and documented in both a policy and within memorandum's of understanding, where pathways cross organisational boundaries
effective organisational structure with a clear local identity	Formalise audit plans and strategies for improving access and uptake
innovative approaches such as the failsafe model	Review policies for management of populations in specific 'sub-groups- (e.g. those in secure settings and pregnant patients)
good engagement from the hospital eye service leads	Risk assessments to ne undertaken for some elements of service infrastructure (e.g. suitability of grading facilities)

Abdominal Aortic Aneurysm Screening

Abdominal Aortic Aneurysm Programme Exceptions

Exceptions	Improvement Actions
While uptake is anticipated to fall across NWL for 2017/18, by approximately 10%. Harrow is expected to improve its uptake rate.	Harrow is a part of the London wide re-procurement of AAA services

Activities/impact since last report	Actions Required
In 2016/17, significant gains were made due to a programme of promotional work that was deemed excessive and outside of the scope of the NAAASP, by the national team. Consequently a return to 2015/16 performance is anticipated	Further actions considered to strengthen uptake and increase participation in the programme following the re-procurement of the service
Escalation for action/information	**RAG rating**
Confirmed full year uptake data will be available in September 2017 Practice level uptake performance in Harrow currently ranges from 62.5 to 100% Average GP practice uptake rate in 2016/17 was 70.67%. Despite trends elsewhere in NWL, uptake in Harrow has improved in 2017/18 and is forecast to close at approx. 79%	Amber

Service Provision – Programme Geography: AAA

AAA Key Performance Indicators: Descriptors

KPI	Description	Acceptable Standard (%)	Achievable Standard (%)
AA1	**Completeness of offer**	45	50
AA2	**Coverage of initial screen**	38	42
AA3	**Coverage of annual surveillance screen**	85	95
AA4	**Coverage of quarterly surveillance screen**	85	95

Key Performance Indicators (National): AAA

%

100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

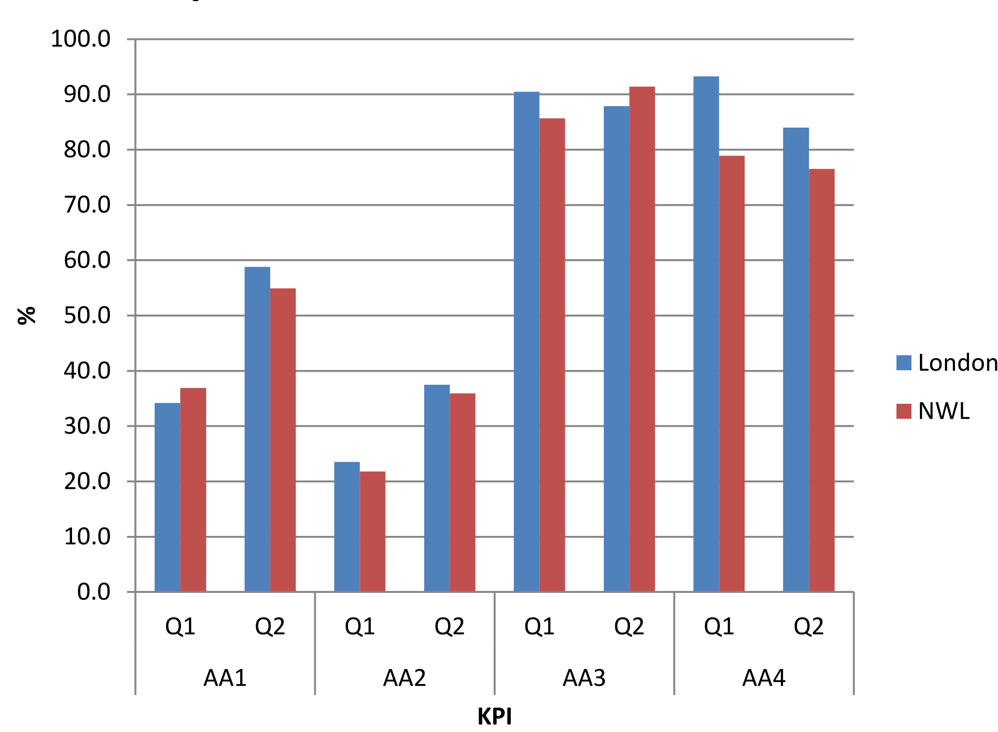
KPI

AA1
AA2
AA3
AA4

England
North
South
Midlands & East
London

Key Performance Indicators (London): DES

- National AAA Screening Programme (NAAASP) introduced 3 new KPIs from Q1 2016/17. Only 2 quarters of currently reported KPI indicators is available
- AAA is a one off screen for the majority of the population, as such performance is measured cumulatively, throughout the year (see AA1 and 2)
- Attendance at surveillance appointments falls below achievable standard for reported periods available. As result:
    - Screening office now call every man before appointment as a reminder
    - If they fail to attend, the Vascular Surgeon and Clinical Director write directly to each man and their GP, urging them to attend when invited
    - As a result, performance is improving against these two KPIs



Antenatal and Newborn
Screening programmes

ANNB Screening Programmes

There are six Antenatal and Newborn (ANNB) screening programmes, screening for a total of 30 conditions:

Foetal Anomaly Screening Programme (FASP, includes Down's Syndrome, Edwards' Syndrome and Patau's Syndrome screening)

Infectious Diseases in Pregnancy Screening Programme (IDPS)

Newborn and Infant Physical Examination Screening Programme (NIPE)

Newborn Bloodspot Screening Programme (NBBS)

Newborn Hearing Screening Programme (NHSP)

Sickle Cell and Thalassaemia Screening Programme (SCT)

Commissioning arrangements for ANNB Screening

- Most elements of ANNB screening programmes are funded wholly or partly within the Maternity Pathway Payment (MPP) and contracts are within CCGs and CSU contracts with local providers. Some programme elements are sub-contracted by maternity units.

- NHSE directly commission newborn bloodspot laboratory services in London with samples from the Harrow population being sent to Great Ormond Street Laboratory

- Quarterly ANNB Screening Performance and Quality Programme Boards are held, aligned with STP footprints. The scope of these boards are developing to include antenatal and newborn immunisations.

- The next North West London Board is to be held 22nd June 2017 between 1pm and 3pm

Commissioning arrangements for ANNB Screening

- Most elements of ANNB screening programmes are funded wholly or partly within the Maternity Pathway Payment (MPP) and contracts are within CCGs and CSU contracts with local providers. Some programme elements are sub-contracted by maternity units.

- NHSE directly commission newborn bloodspot laboratory services in London with samples from the Harrow population being sent to Great Ormond Street Laboratory

- Quarterly ANNB Screening Performance and Quality Programme Boards are held, aligned with STP footprints. The scope of these boards are developing to include antenatal and newborn immunisations.

- The next North West London Board is to be held 22nd June 2017 between 1pm and 3pm

ANNB Programme Exceptions

Exceptions

ST2: London North West Healthcare NHS Trust has improved their performance with this indicator, although they do not yet meet the acceptable standard.
ID2: Due to small numbers there is greater variation in performance in this KPI
NB1 / NB4: Data quality and completeness has generally improved over the last 4 quarters
NP1 / NP2: LNWHT has been unable to provide data for this KPI

Improvement Actions

ST2: Improvement plans have been requested and trajectories for Improving Performance in this KPI have been set for 2017-18, these will be monitored via the NWL programme Board
ID2: The common theme for reduced performance is non attendance at appointments and NHS E L is working with providers to produce detailed exception reporting to further understand this in order to improve performance
NB1 / NB4: NHS E L worked with LNWHT CHRD to improve understanding of KPI definitions and detailed exception reporting in order to account for 100% of the eligible population. The eligible population for Harrow will be reported on from Q1 2017-18 by the recently implemented NWL CHIS Hub and quality of data is expected to improve
NP2: Reporting the NIPE KPIs is now mandatory, and overall for England there is now 90.3% completeness of reporting. These are new indicators and data quality is improving.

Activities/impact since last report

NB2: LNWHT performs consistently within this indicator and has achieved the acceptable level for the last 4 quarters. This is a challenging KPI as although reported by maternity includes the avoidable repeats sample data for eligible babies up to 1 years of age and therefore is impacted by quality of those samples taken in other services.

Actions Required

NHS E L ANNB commissioning team is planning to undertake some Pan London work reviewing the NBBS pathway for older babies and those who move into London and will work with commissioning colleagues and those providing care to ensure they have robust pathways in place for this cohort of babies in line with standards and service specifications for newborn screening

Escalation for action/information

The most common ANNB screening incident theme in Harrow has been related to the pathway for repeating NBBS samples in older babies (>28 days – 1 year of age). These are minor in terms of impact but have been repetitive. LNWHT did hold a task and finish group to address this and developed a joint SOP between maternity and community services for the NBBS programme however Health visiting services are now undergoing procurement.

RAG rating

Current RAG rating:

- Green – high confidence in improvement – please see above planned work for the older baby pathway.

Data: ANNB KPIs

About — This is an overview of the data for 13 ANNB KPIs for the five London STPs, at provider level. Regional and national summary data is also provided for comparison.

Latest update — Quarterly data for 4 quarters up to 2016/17 Q3 (produced 31 May 2017)

Data source — PHE Screening

All KPI data has been submitted by local services via the regional Screening Quality Assurance Service (SQAS)

Aggregated totals have been calculated by the National Screening Data and Information Team, PHE Screening

Data sharing — This data is covered by the Memorandum of Understanding between PHE and NHSE. Data can be shared for management purposes only, for the enhancement of NHS screening programmes. MUST NOT be put in the public domain (this includes communications and minutes of meetings that may end up in the public domain).

Data caveats — Prior to Q1 2016/17 data for Imperial College Healthcare Trust (QCCH) and Imperial College Healthcare Trust (St Mary's) were reported together as Imperial College Healthcare Trust. For this reason, KPI data for QCCH is identical to that for St Mary's prior to this point. (See "Provider Changes" below.)

Provider changes — Changes to providers from Q1 2016/17:

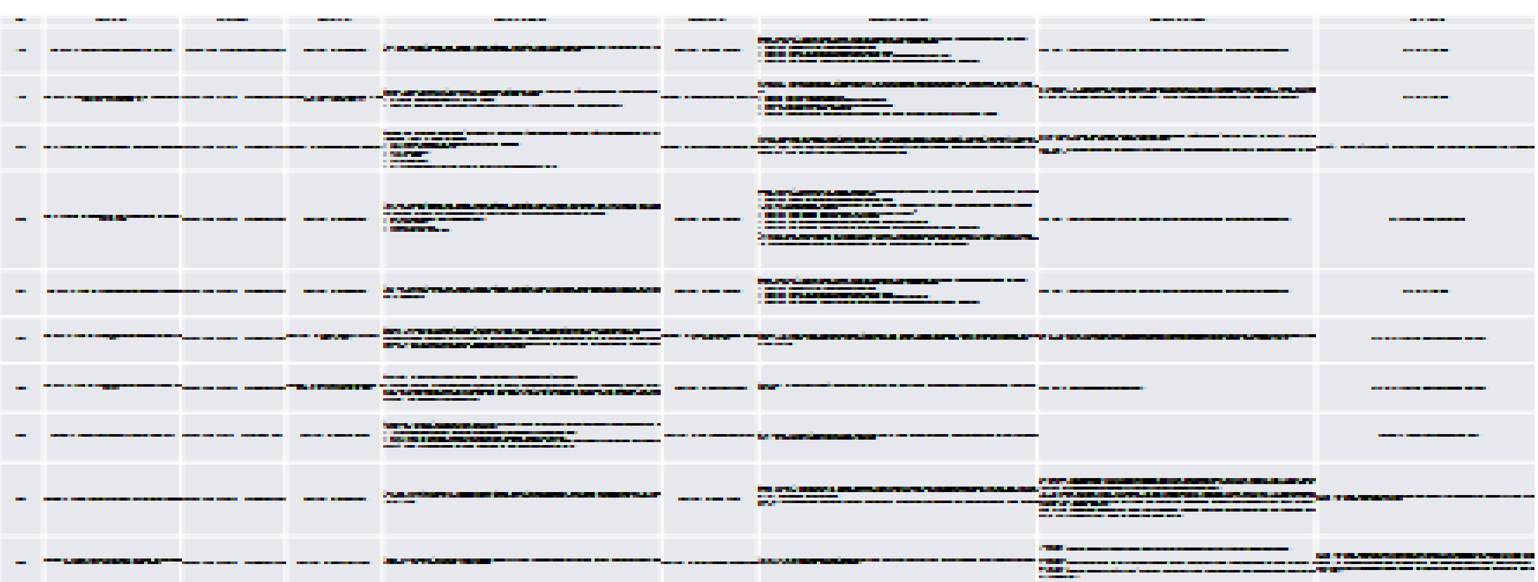
Old code and unit name	New code and unit name
RYJ - Imperial College Healthcare NHS Trust	RYJ - Imperial College Healthcare NHS Trust (QCCH)
	RYJ - Imperial College Healthcare NHS Trust (St Mary's)

Further information

Minimum threshold	Minimum level of performance which programmes are expected to attain to ensure patient safety and programme effectiveness. Programmes not meeting the minimum standard are expected to implement recovery plans to ensure rapid and sustained improvement. All programmes are expected to exceed the minimum standard and should aspire towards performance above this level
Achievable standard	Level at which the programme is likely to be running effectively; screening programmes should aspire towards attaining and maintaining performance at this level

Contact — OIC Public Health Matrix Group, NHS England — England.PublicHealth-Analysis@nhs.net

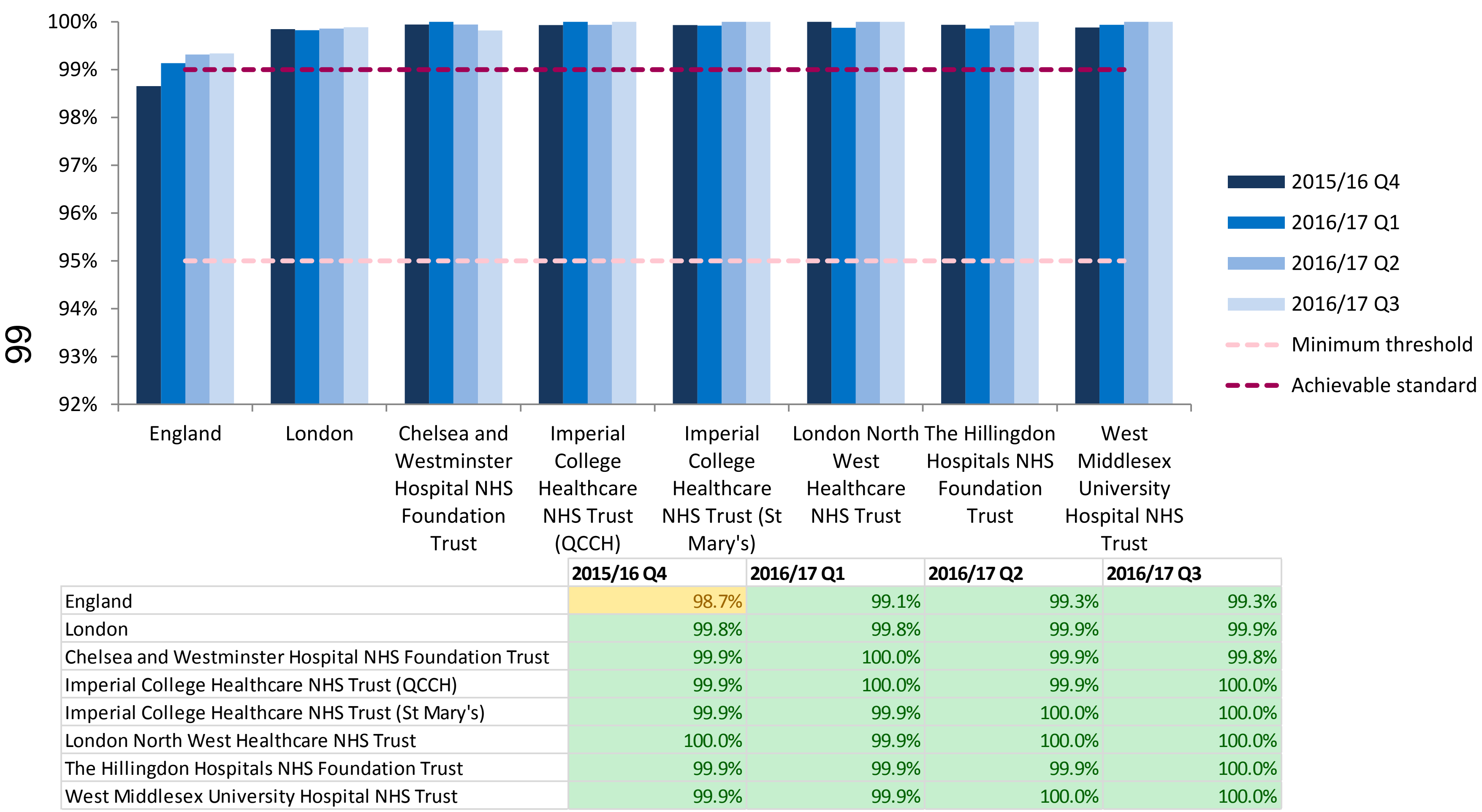
KPI Defintions



NHSP KPI 1 (by CCG) - Screens Complete by 4 weeks (Well Babies, Hospital Sites)/ 4 Weeks (NICU babies) for births in Q3 - 2016/17. Report compiled on 28-03-2017

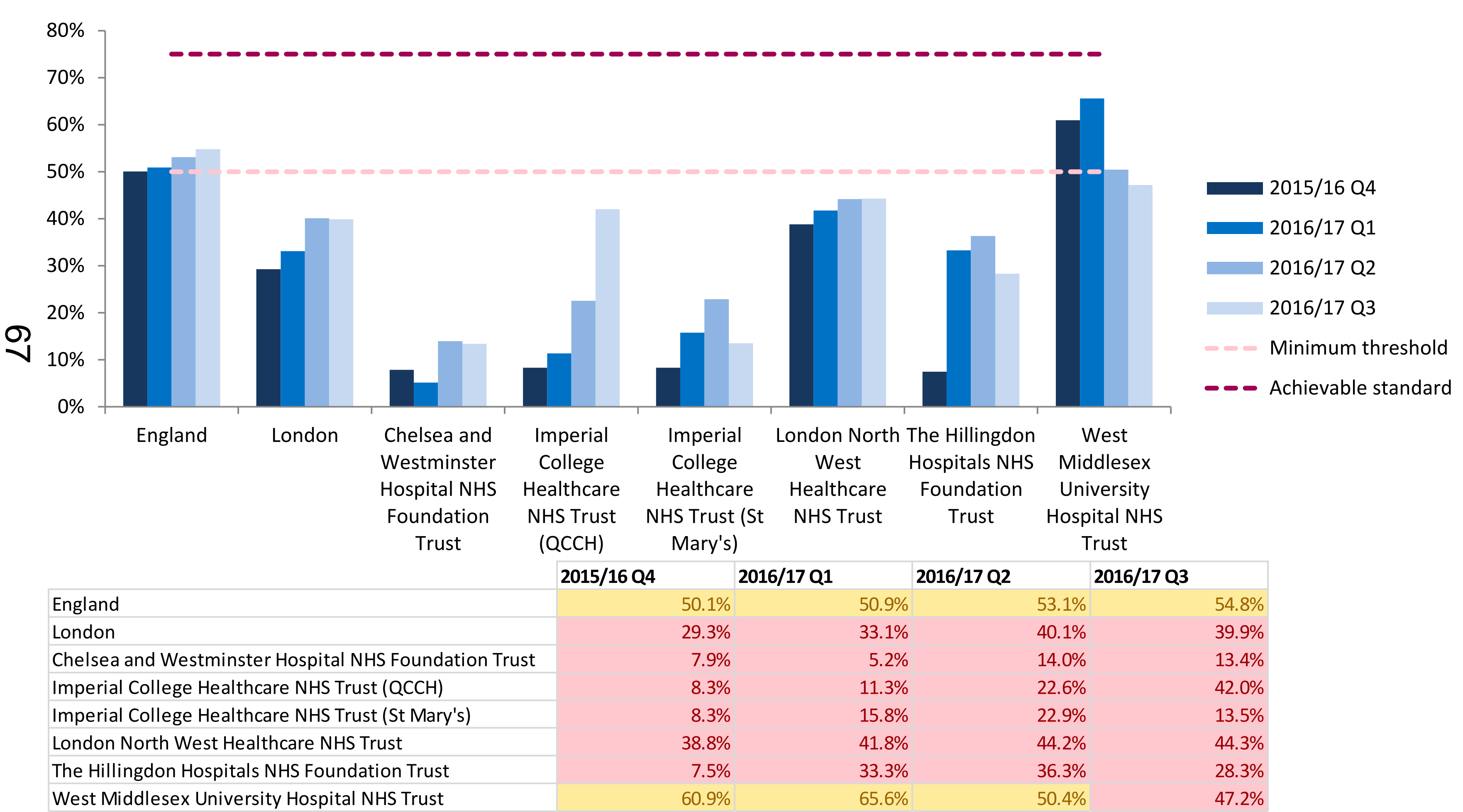
NHSP KPI 2 - Screen Completion to Attended Assessment within 4 weeks (28 days) or by 44 weeks GA, for births in Q3 - 2016/17. Report compiled on 28-03-2017

ST1: Antenatal sickle cell and thalassaemia screening – coverage



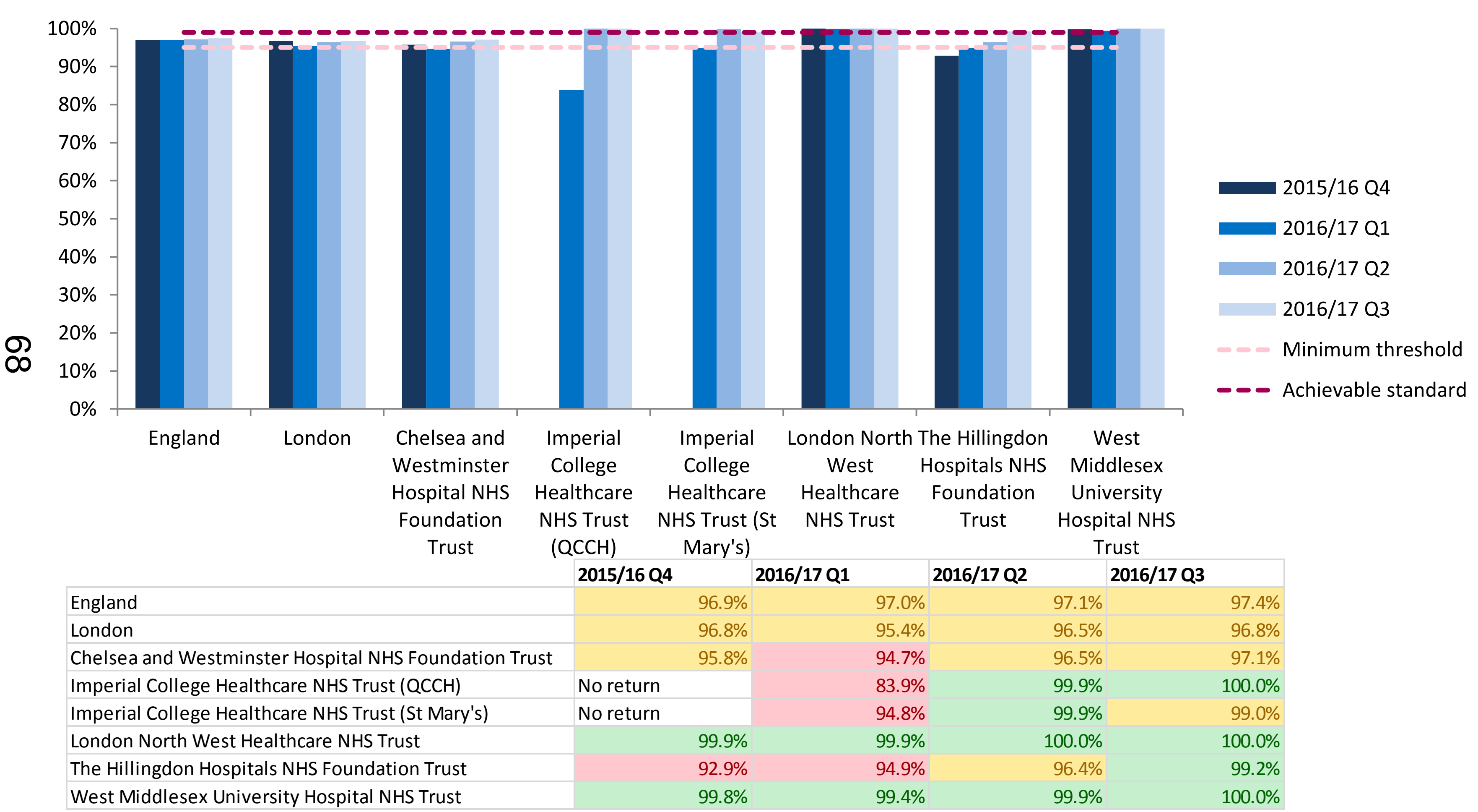
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	98.7%	99.1%	99.3%	99.3%
London	99.8%	99.8%	99.9%	99.9%
Chelsea and Westminster Hospital NHS Foundation Trust	99.9%	100.0%	99.9%	99.8%
Imperial College Healthcare NHS Trust (QCCH)	99.9%	100.0%	99.9%	100.0%
Imperial College Healthcare NHS Trust (St Mary's)	99.9%	99.9%	100.0%	100.0%
London North West Healthcare NHS Trust	100.0%	99.9%	100.0%	100.0%
The Hillingdon Hospitals NHS Foundation Trust	99.9%	99.9%	99.9%	100.0%
West Middlesex University Hospital NHS Trust	99.9%	99.9%	100.0%	100.0%

ST2: Antenatal sickle cell and thalassaemia screening – timeliness of test



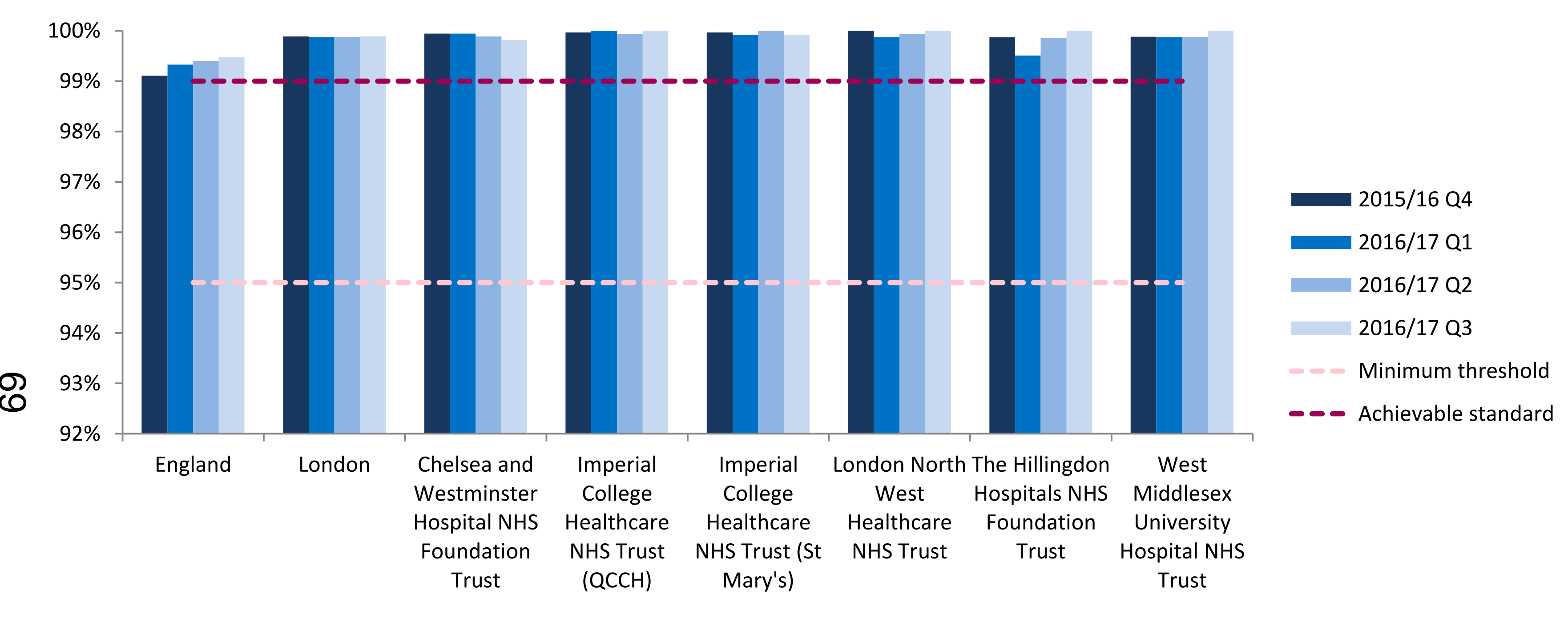
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	50.1%	50.9%	53.1%	54.8%
London	29.3%	33.1%	40.1%	39.9%
Chelsea and Westminster Hospital NHS Foundation Trust	7.9%	5.2%	14.0%	13.4%
Imperial College Healthcare NHS Trust (QCCH)	8.3%	11.3%	22.6%	42.0%
Imperial College Healthcare NHS Trust (St Mary's)	8.3%	15.8%	22.9%	13.5%
London North West Healthcare NHS Trust	38.8%	41.8%	44.2%	44.3%
The Hillingdon Hospitals NHS Foundation Trust	7.5%	33.3%	36.3%	28.3%
West Middlesex University Hospital NHS Trust	60.9%	65.6%	50.4%	47.2%

ST3: Antenatal sickle cell and thalassaemia screening – completion of FOQ



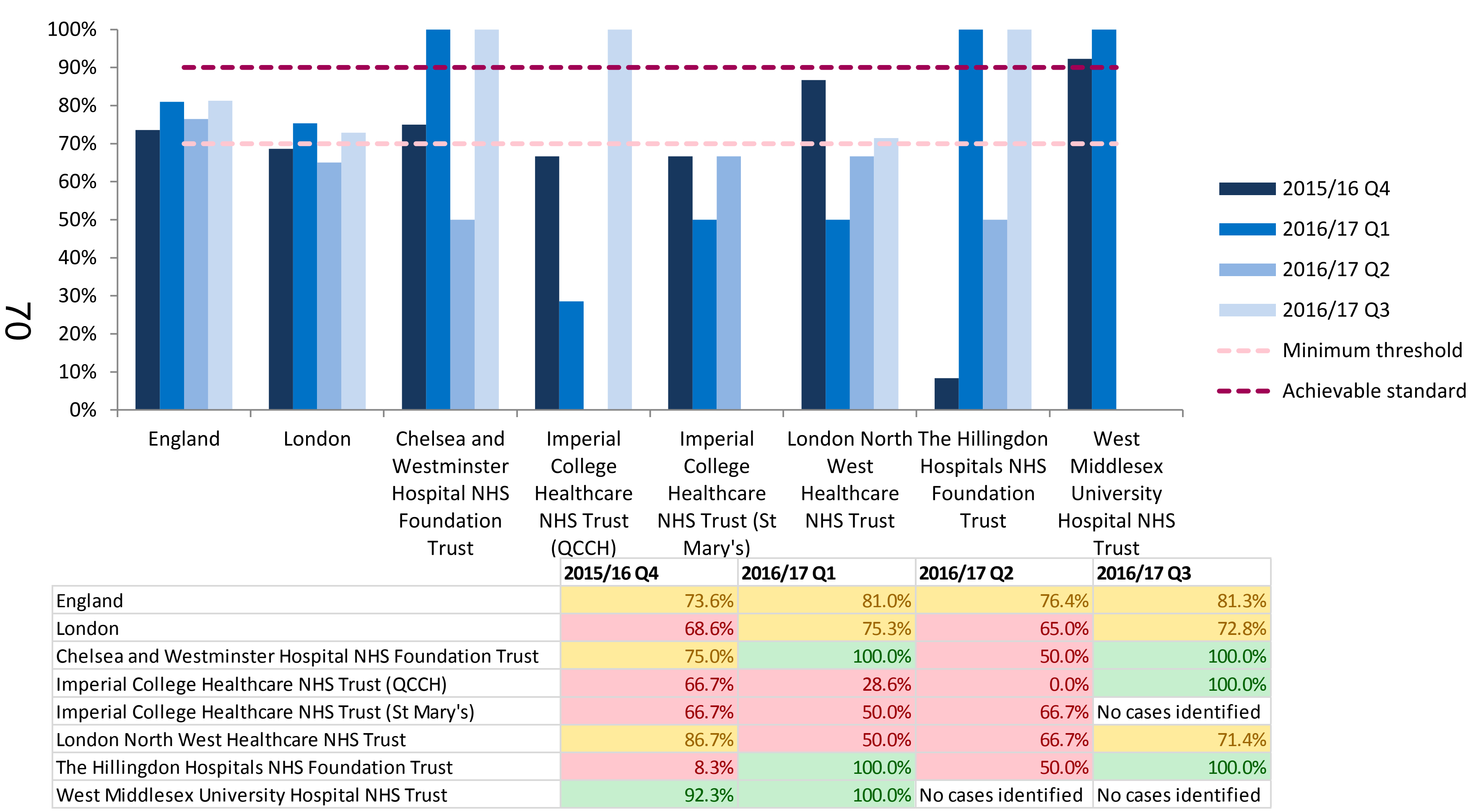
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	96.9%	97.0%	97.1%	97.4%
London	96.8%	95.4%	96.5%	96.8%
Chelsea and Westminster Hospital NHS Foundation Trust	95.8%	94.7%	96.5%	97.1%
Imperial College Healthcare NHS Trust (QCCH)	No return	83.9%	99.9%	100.0%
Imperial College Healthcare NHS Trust (St Mary's)	No return	94.8%	99.9%	99.0%
London North West Healthcare NHS Trust	99.9%	99.9%	100.0%	100.0%
The Hillingdon Hospitals NHS Foundation Trust	92.9%	94.9%	96.4%	99.2%
West Middlesex University Hospital NHS Trust	99.8%	99.4%	99.9%	100.0%

ID1: Antenatal infectious disease screening – HIV coverage



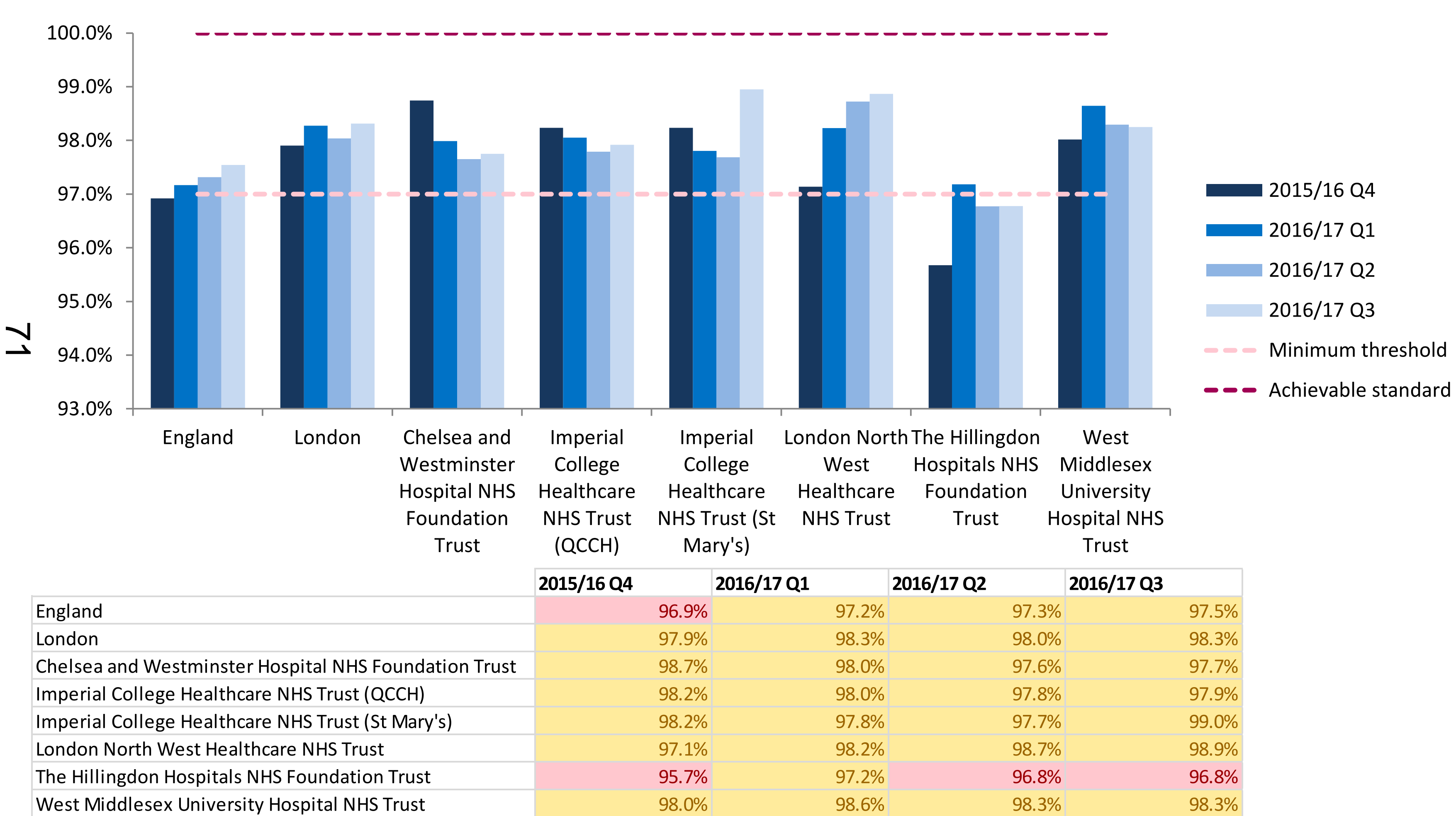
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	99.1%	99.3%	99.4%	99.5%
London	99.9%	99.9%	99.9%	99.9%
Chelsea and Westminster Hospital NHS Foundation Trust	99.9%	99.9%	99.9%	99.8%
Imperial College Healthcare NHS Trust (QCCH)	100.0%	100.0%	99.9%	100.0%
Imperial College Healthcare NHS Trust (St Mary's)	100.0%	99.9%	100.0%	99.9%
London North West Healthcare NHS Trust	100.0%	99.9%	99.9%	100.0%
The Hillingdon Hospitals NHS Foundation Trust	99.9%	99.5%	99.9%	100.0%
West Middlesex University Hospital NHS Trust	99.9%	99.9%	99.9%	100.0%

ID2: Antenatal infectious disease screening – timely referral of hepatitis B positive women for specialist assessment



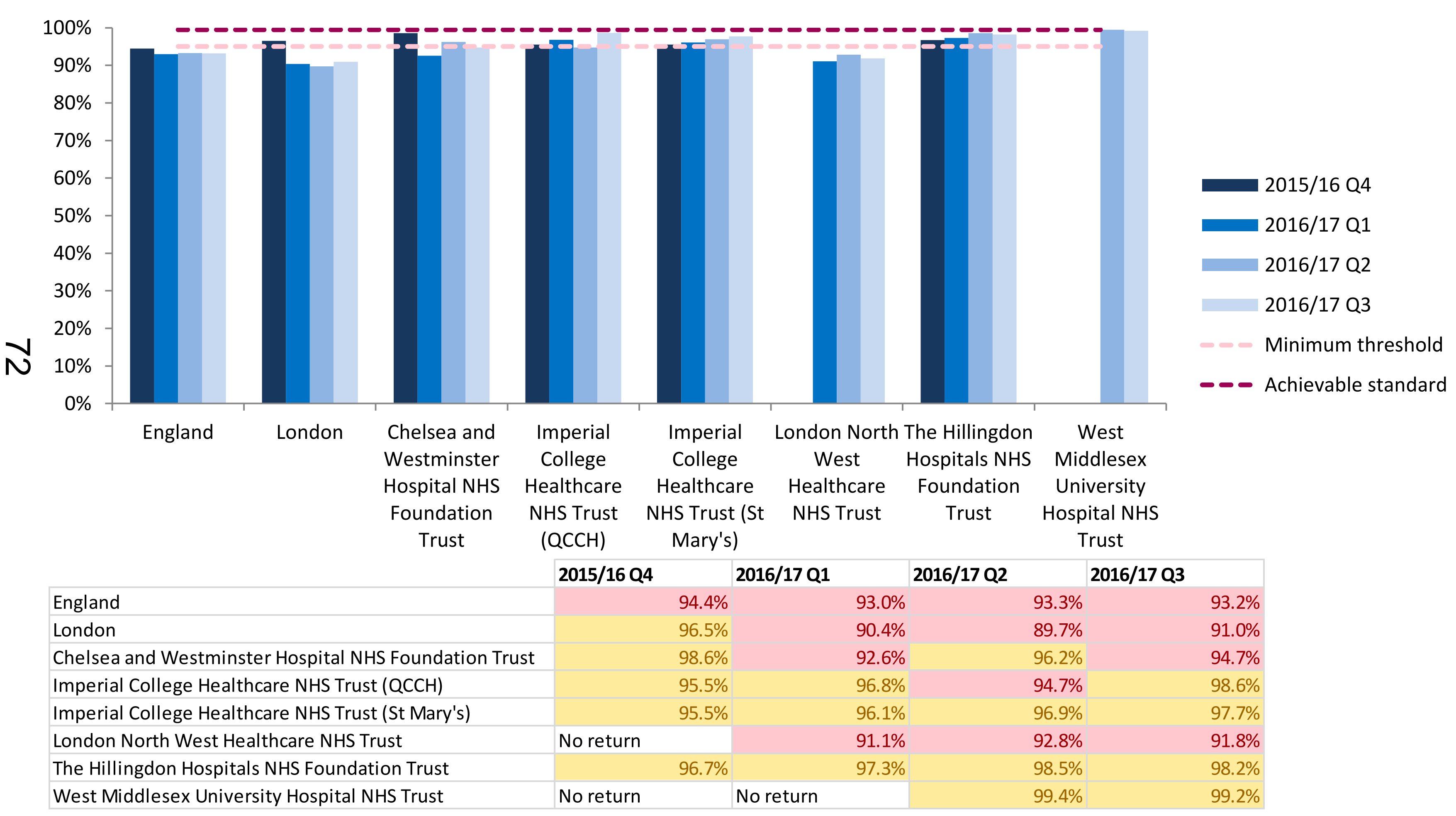
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	73.6%	81.0%	76.4%	81.3%
London	68.6%	75.3%	65.0%	72.8%
Chelsea and Westminster Hospital NHS Foundation Trust	75.0%	100.0%	50.0%	100.0%
Imperial College Healthcare NHS Trust (QCCH)	66.7%	28.6%	0.0%	100.0%
Imperial College Healthcare NHS Trust (St Mary's)	66.7%	50.0%	66.7%	No cases identified
London North West Healthcare NHS Trust	86.7%	50.0%	66.7%	71.4%
The Hillingdon Hospitals NHS Foundation Trust	8.3%	100.0%	50.0%	100.0%
West Middlesex University Hospital NHS Trust	92.3%	100.0%	No cases identified	No cases identified

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



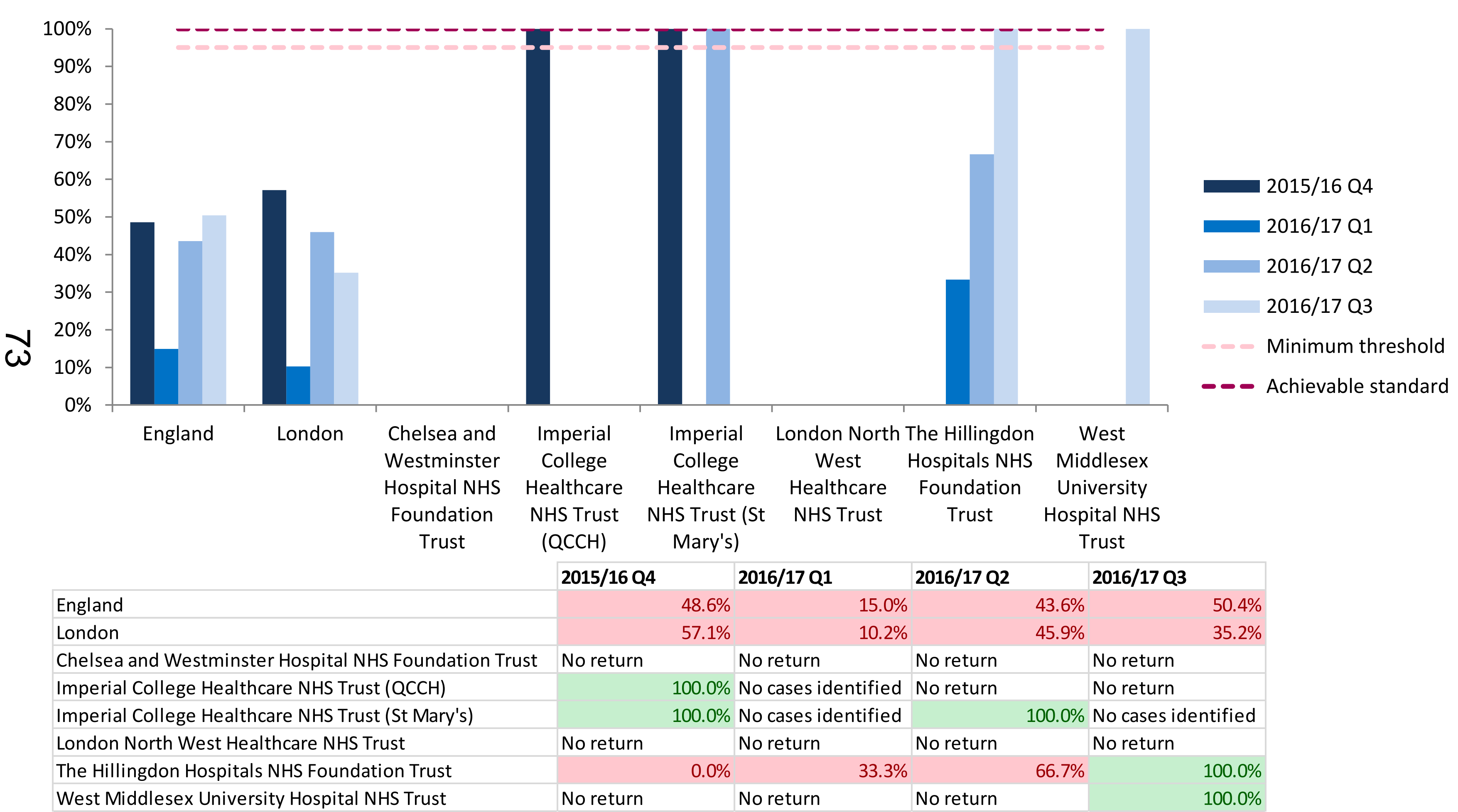
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	96.9%	97.2%	97.3%	97.5%
London	97.9%	98.3%	98.0%	98.3%
Chelsea and Westminster Hospital NHS Foundation Trust	98.7%	98.0%	97.6%	97.7%
Imperial College Healthcare NHS Trust (QCCH)	98.2%	98.0%	97.8%	97.9%
Imperial College Healthcare NHS Trust (St Mary's)	98.2%	97.8%	97.7%	99.0%
London North West Healthcare NHS Trust	97.1%	98.2%	98.7%	98.9%
The Hillingdon Hospitals NHS Foundation Trust	95.7%	97.2%	96.8%	96.8%
West Middlesex University Hospital NHS Trust	98.0%	98.6%	98.3%	98.3%

NP1: Newborn and Infant Physical Examination – coverage (newborn)



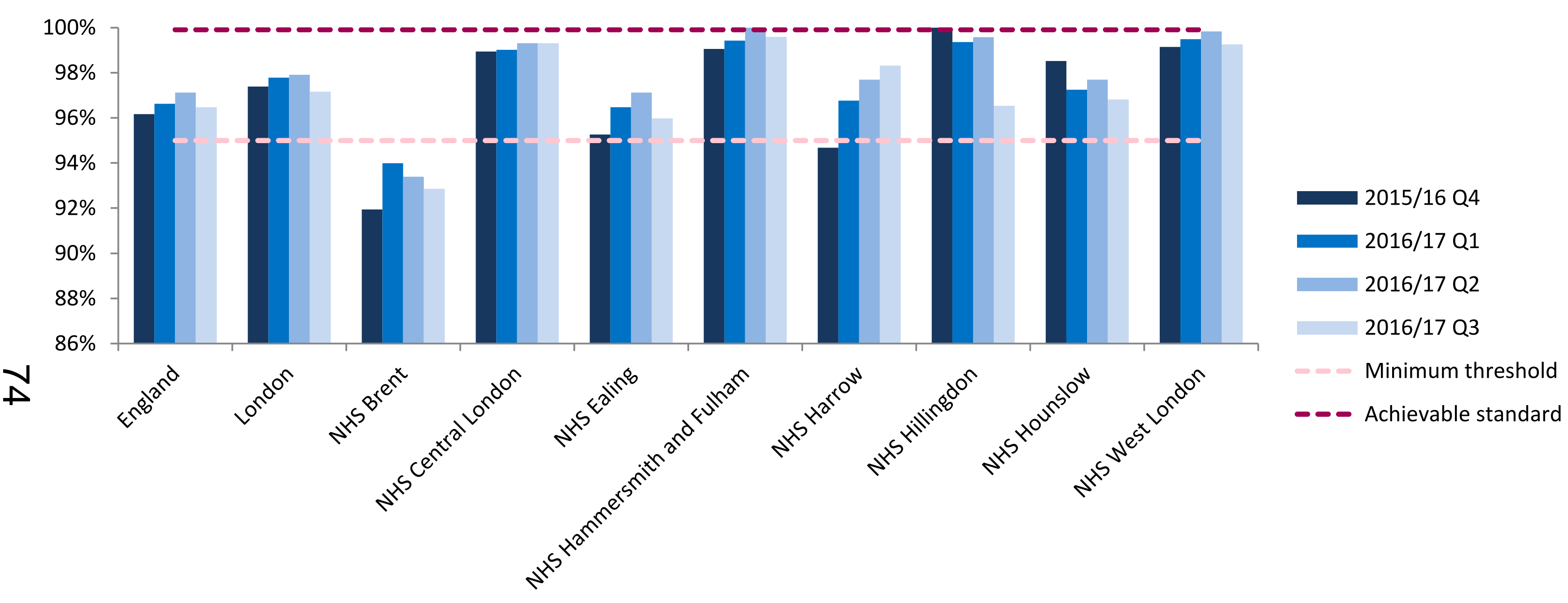
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	94.4%	93.0%	93.3%	93.2%
London	96.5%	90.4%	89.7%	91.0%
Chelsea and Westminster Hospital NHS Foundation Trust	98.6%	92.6%	96.2%	94.7%
Imperial College Healthcare NHS Trust (QCCH)	95.5%	96.8%	94.7%	98.6%
Imperial College Healthcare NHS Trust (St Mary's)	95.5%	96.1%	96.9%	97.7%
London North West Healthcare NHS Trust	No return	91.1%	92.8%	91.8%
The Hillingdon Hospitals NHS Foundation Trust	96.7%	97.3%	98.5%	98.2%
West Middlesex University Hospital NHS Trust	No return	No return	99.4%	99.2%

NP2: Newborn and Infant Physical Examination – timely assessment of DDH



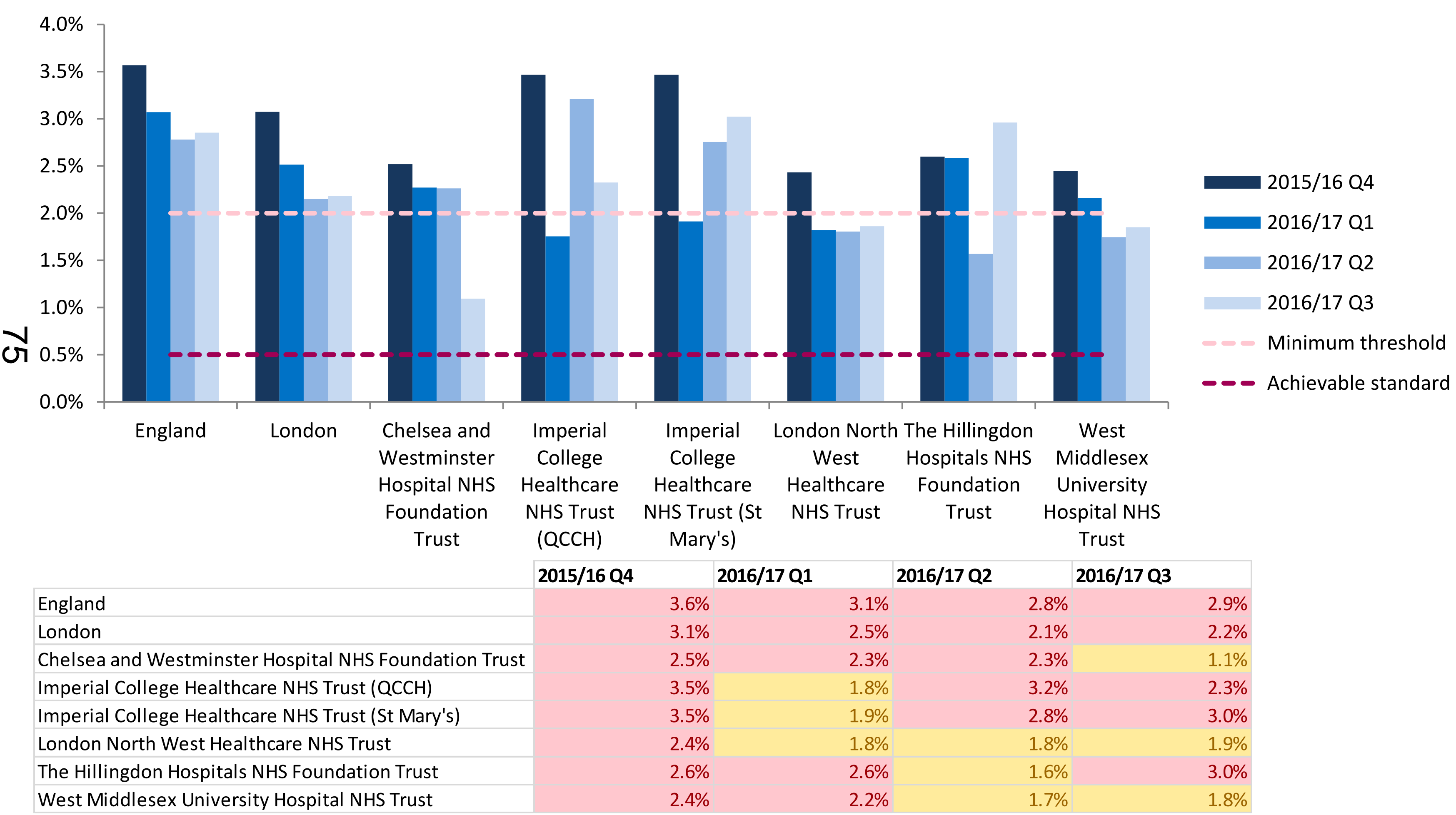
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	48.6%	15.0%	43.6%	50.4%
London	57.1%	10.2%	45.9%	35.2%
Chelsea and Westminster Hospital NHS Foundation Trust	No return	No return	No return	No return
Imperial College Healthcare NHS Trust (QCCH)	100.0%	No cases identified	No return	No return
Imperial College Healthcare NHS Trust (St Mary's)	100.0%	No cases identified	100.0%	No cases identified
London North West Healthcare NHS Trust	No return	No return	No return	No return
The Hillingdon Hospitals NHS Foundation Trust	0.0%	33.3%	66.7%	100.0%
West Middlesex University Hospital NHS Trust	No return	No return	No return	100.0%

NB1: Newborn blood spot screening – coverage (CCG responsibility at birth)



	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	96.2%	96.6%	97.1%	96.5%
London	97.4%	97.8%	97.9%	97.2%
NHS Brent	91.9%	94.0%	93.4%	92.9%
NHS Central London	98.9%	99.0%	99.3%	99.3%
NHS Ealing	95.3%	96.5%	97.1%	96.0%
NHS Hammersmith and Fulham	99.1%	99.4%	100.0%	99.6%
NHS Harrow	94.7%	96.8%	97.7%	98.3%
NHS Hillingdon	100.0%	99.4%	99.6%	96.5%
NHS Hounslow	98.5%	97.2%	97.7%	96.8%
NHS West London	99.1%	99.5%	99.8%	99.3%

NB2: Newborn blood spot screening – avoidable repeat tests

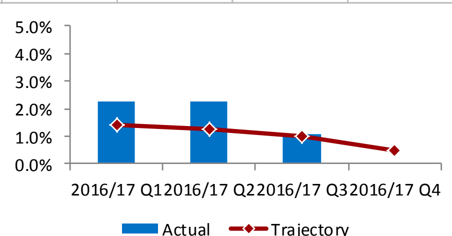


	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	3.6%	3.1%	2.8%	2.9%
London	3.1%	2.5%	2.1%	2.2%
Chelsea and Westminster Hospital NHS Foundation Trust	2.5%	2.3%	2.3%	1.1%
Imperial College Healthcare NHS Trust (QCCH)	3.5%	1.8%	3.2%	2.3%
Imperial College Healthcare NHS Trust (St Mary's)	3.5%	1.9%	2.8%	3.0%
London North West Healthcare NHS Trust	2.4%	1.8%	1.8%	1.9%
The Hillingdon Hospitals NHS Foundation Trust	2.6%	2.6%	1.6%	3.0%
West Middlesex University Hospital NHS Trust	2.4%	2.2%	1.7%	1.8%

NB2: Trajectories

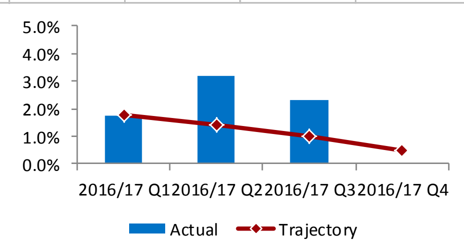
Chelsea and Westminster Hospital NHS Foundation Trust

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	1.4%	1.3%	1.0%	0.5%
Actual	2.3%	2.3%	1.1%	



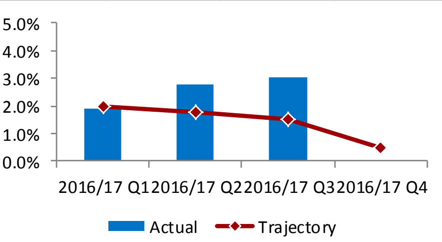
Imperial College Healthcare NHS Trust (QCCH)

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	1.8%	1.4%	1.0%	0.5%
Actual	1.8%	3.2%	2.3%	



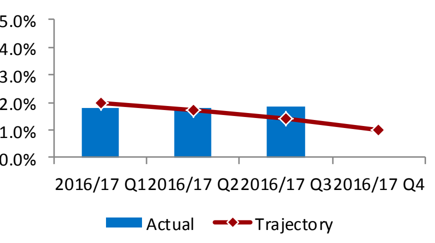
Imperial College Healthcare NHS Trust (St Mary's)

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	2.0%	1.8%	1.5%	0.5%
Actual	1.9%	2.8%	3.0%	



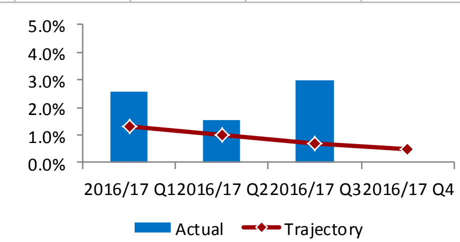
London North West Healthcare NHS Trust

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	2.0%	1.7%	1.4%	1.0%
Actual	1.8%	1.8%	1.9%	



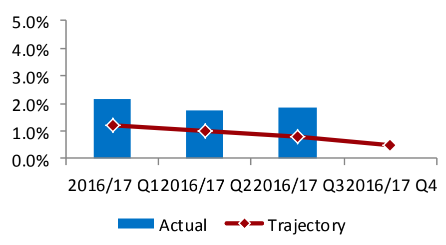
The Hillingdon Hospitals NHS Foundation Trust

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	1.3%	1.0%	0.7%	0.5%
Actual	2.6%	1.6%	3.0%	

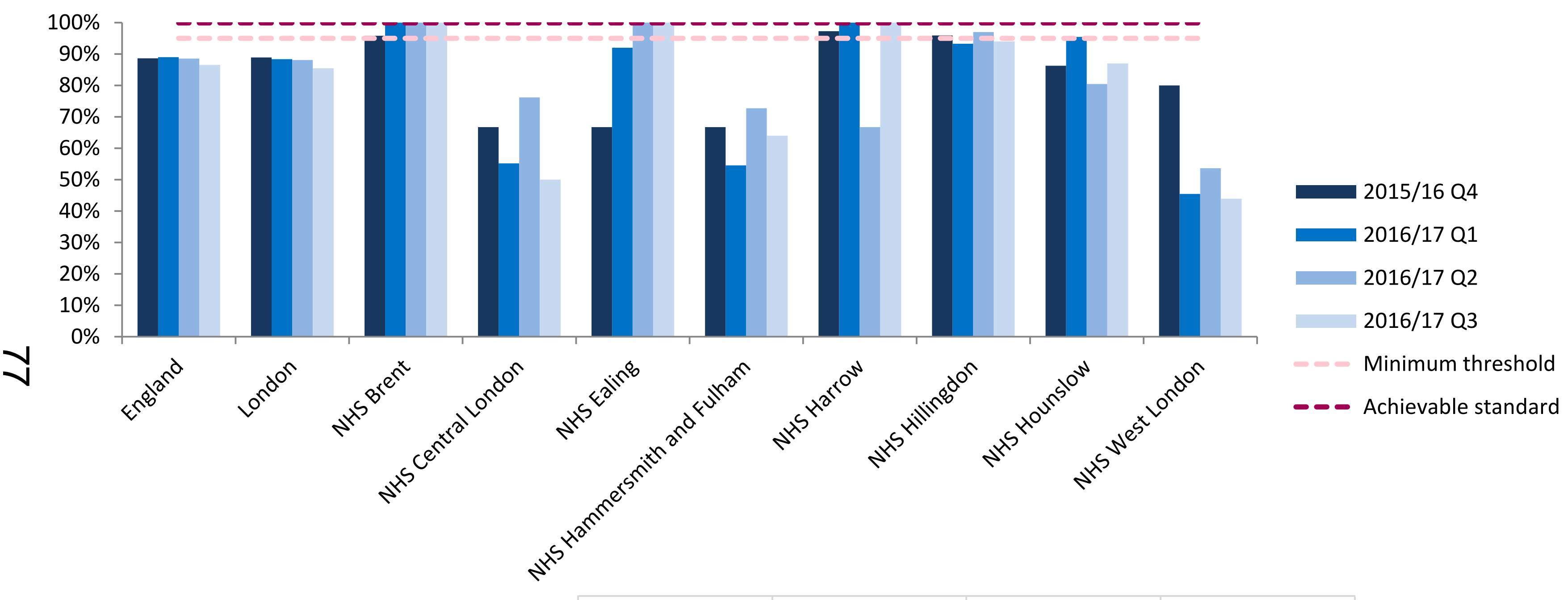


West Middlesex University Hospital NHS Trust

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Trajectory	1.2%	1.0%	0.8%	0.5%
Actual	2.2%	1.7%	1.8%	

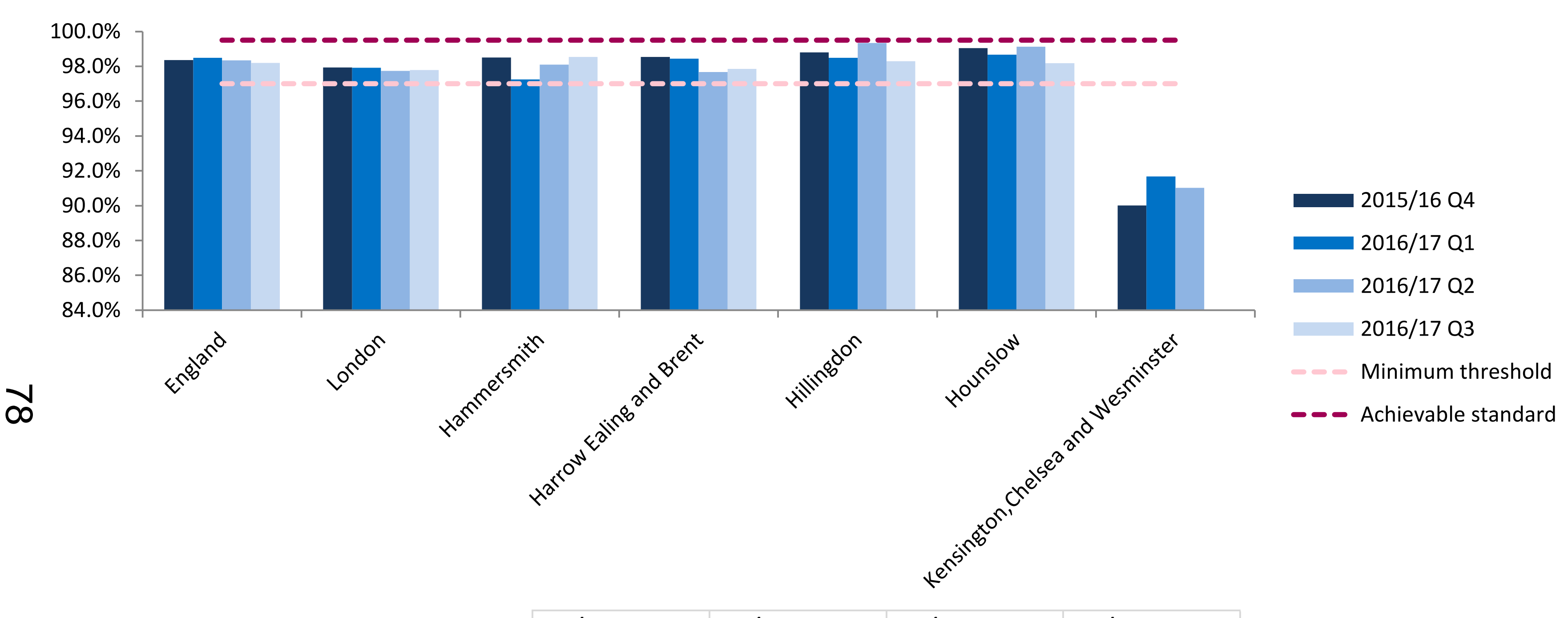


NB4: Newborn blood spot screening – coverage (movers in)



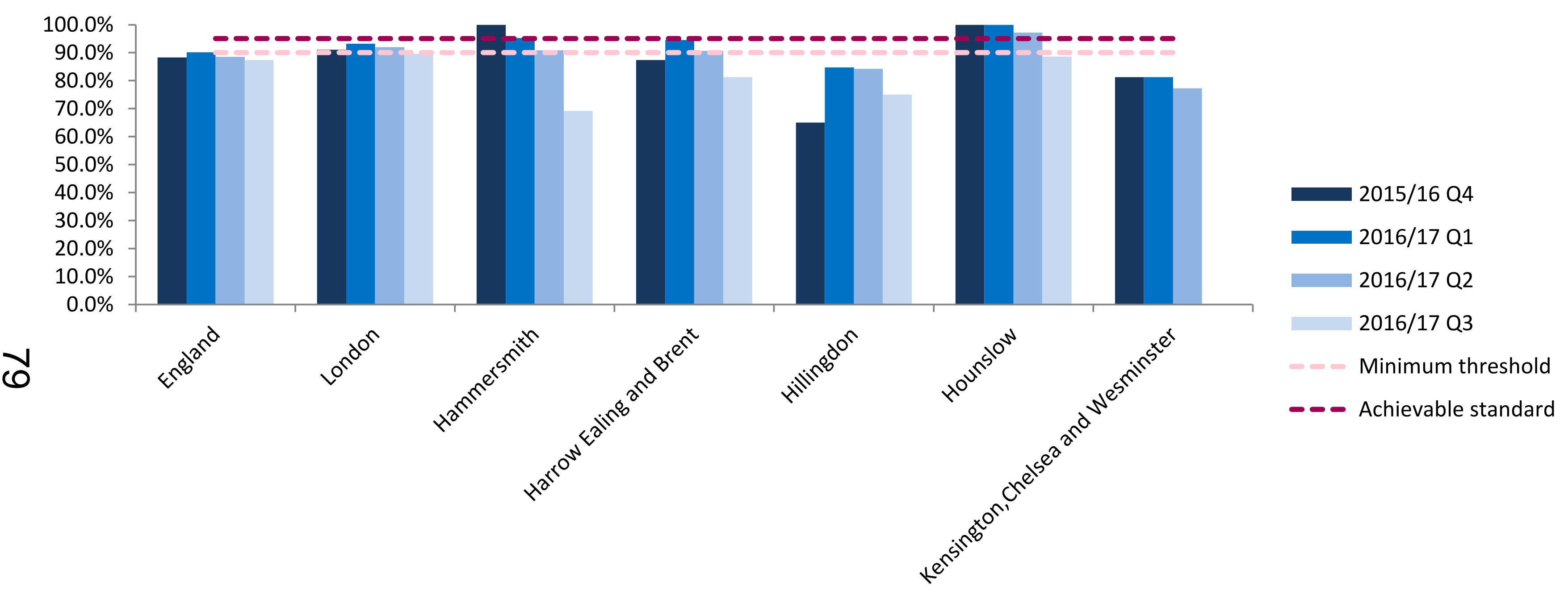
	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	88.6%	88.9%	88.5%	86.5%
London	88.9%	88.4%	88.0%	85.5%
NHS Brent	95.8%	100.0%	100.0%	100.0%
NHS Central London	66.7%	55.2%	76.2%	50.0%
NHS Ealing	66.7%	92.0%	100.0%	100.0%
NHS Hammersmith and Fulham	66.7%	54.5%	72.7%	64.0%
NHS Harrow	97.2%	100.0%	66.7%	100.0%
NHS Hillingdon	95.8%	93.3%	97.0%	94.0%
NHS Hounslow	86.2%	95.5%	80.4%	87.0%
NHS West London	80.0%	45.5%	53.6%	43.9%

NH1: Newborn hearing screening – coverage



	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	98.4%	98.5%	98.3%	98.2%
London	97.9%	97.9%	97.7%	97.8%
Hammersmith	98.5%	97.2%	98.1%	98.5%
Harrow Ealing and Brent	98.5%	98.4%	97.7%	97.8%
Hillingdon	98.8%	98.5%	99.3%	98.3%
Hounslow	99.0%	98.7%	99.1%	98.2%
Kensington,Chelsea and Wesminster	90.0%	91.7%	91.0%	

NH2: Newborn hearing – timely assessment for screen referrals



	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
England	88.3%	90.1%	88.5%	87.3%
London	91.1%	93.2%	92.0%	89.6%
Hammersmith	100.0%	95.2%	90.9%	69.2%
Harrow Ealing and Brent	87.4%	94.6%	90.6%	81.3%
Hillingdon	65.0%	84.7%	84.2%	75.0%
Hounslow	100.0%	100.0%	97.2%	88.6%
Kensington,Chelsea and Wesminster	81.3%	81.3%	77.3%	

This page is intentionally left blank

REPORT FOR: **Harrow Health and Wellbeing Board**

Date of Meeting:	20 July 2017
Subject:	**INFORMATION REPORT** – A review of Female Genital Mutilation in Harrow
Responsible Officer:	Dr Andrew Howe, Director of Public Health
Exempt:	No
Wards affected:	All
Enclosures:	A review of Female Genital Mutilation in Harrow

Section 1 – Summary

This report sets out the current intelligence on female genital mutilation for Harrow. It covers prevalence and a range of issues to identify and to reduce the risk of FGM in young women and girls in Harrow.

FOR INFORMATION

Section 2 – Report

Female genital mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. FGM has been illegal in the UK since 1985, with the law being strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad.

The attached report will
- Define FGM;
- Identify the law and guidance on FGM in England;
- Present data on what we know about FGM in Harrow;
- Identify local actions to raise awareness of FGM;
- Identify local actions to protect and safeguard those at risk of FGM;
- Identify local actions to support those who have undergone FGM;
- Describe the reporting pathways; and
- Describe the governance arrangements.

Section 3 – Further Information
None

Section 4 Financial Implications
This report includes actions being taken by the council and by partner organisations. Funding for different elements of the activity is from a variety of sources including LA children's services budgets; LA community safety budget; LA education budget and individual schools' budgets; the CCG and provider health organisations primarily London Northwest Healthcare Trust.

Performance Issues
FGM notification is mandatory but there are no targets associated with it. The reporting system is to address the paucity of knowledge about the rate of FGM in England.

Ofsted and CQC both take an interest in the work on FGM. The recent Ofsted report for Harrow children's services recognised the local work on FGM as being "well integrated into broader safeguarding work" and there being "an understanding of the complex dynamics when there are concerns about abuse or neglect in a particular cultural context. This is apparent in a clear, effective and well-joined-up approach to the issue of female genital mutilation".

Environmental Impact
Not applicable

Risk Management Implications
The identification of young women and girls at risk of FGM is an area of concern for the council and is part of the safeguarding arrangements. We have not currently identified specific risks on this topic but will be continuing

to monitor the number of referrals coming through to MASH to ensure that those at high risk are identified and supported, if necessary through FGM prevention orders.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out?
No. An EQIA will be carried out on the action plan in due course.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report directly impacts on the health and wellbeing of female children, young women and adult women from specific ethnic communities. It therefore contributes to the council priorities

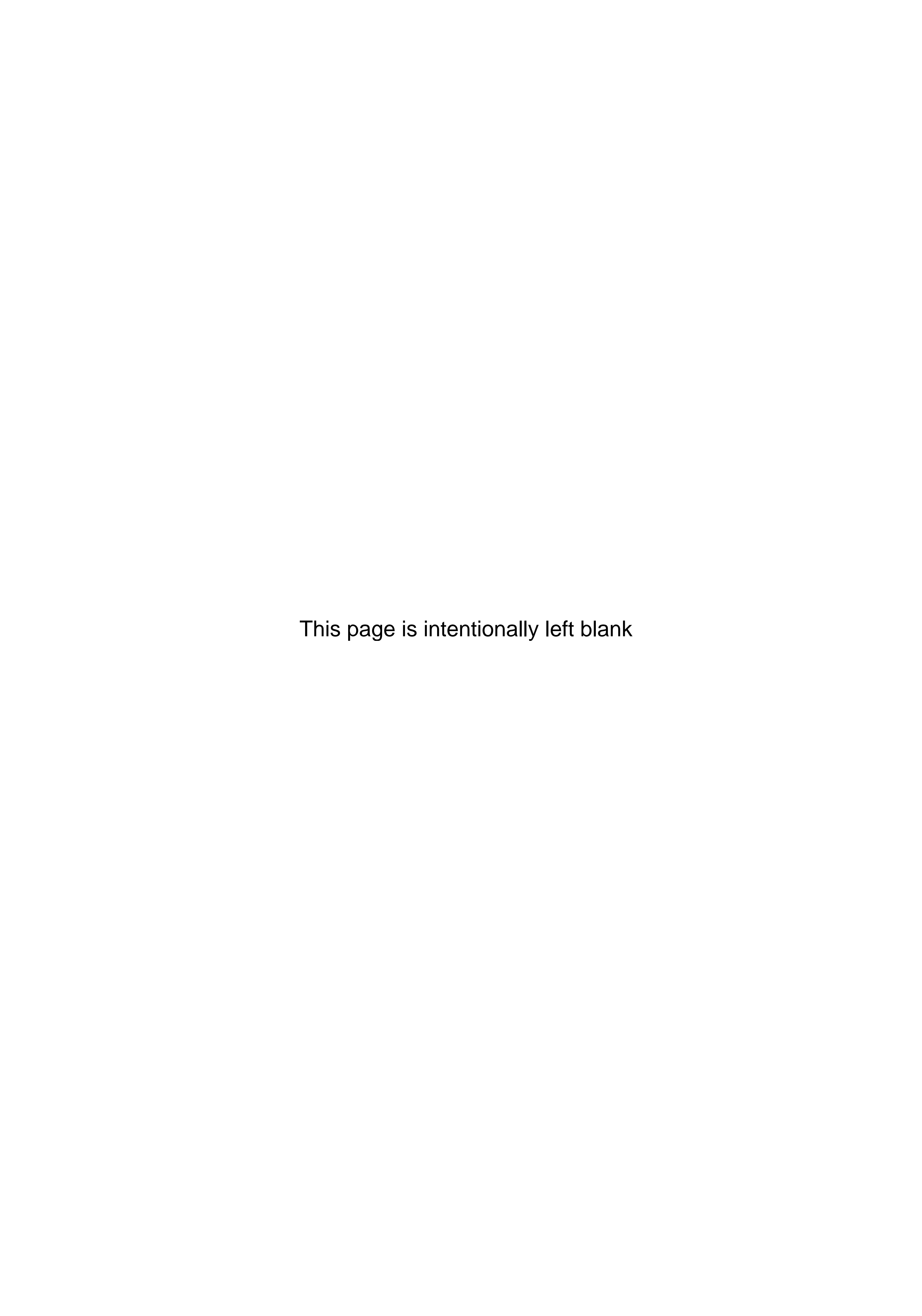
- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for families

Name: Anthony Lineker	✓	on behalf of the Chief Financial Officer
Date: 4 July 2017		

Ward Councillors notified: NO

Section 7 - Contact Details and Background Papers

Contact: Carole Furlong, Consultant in Public Health, 020 8420 9508


This page is intentionally left blank

A Review of Female Genital Mutilation in Harrow

Contents

Introduction 2
Principles underpinning work on FGM 2
What is Female Genital Mutilation? (FGM) 3
Types of FGM 3
Prevalence of FGM - Who is at risk of FGM? 6
The Law in England and Wales 8
Female Genital Mutilation Act 8
The Serious Crime Act 8
Working together to safeguard children 9
Multi-Agency Guidance 9
What do we know about FGM Locally? 10
FGM Prevention Programme 10
FGM Data collection 11
Data Definitions 11
Data Quality 11
FGM: New cases 12
FGM: Attendances within the year 13
Referrals to MASH 14
Local actions to protect and safeguard those at risk of FGM 18
Reporting Pathway 18
Harrow FGM Reporting Pathway 19
Local actions to support those who have undergone FGM 20
Monitoring and governance of FGM in Harrow 21
Appendix : Risk assessment templates 22

INTRODUCTION

Female genital mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. FGM has been illegal in the UK since 1985, with the law being strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad.

This report will

- Describe FGM
- Identify the law and guidance on FGM in England
- Present data on the prevalence of FGM in Harrow
- Identify local actions to raise awareness of FGM;
- Identify local actions to protect and safeguard those at risk of FGM
- Identify local actions to support those who have undergone FGM
- Describe the reporting pathways

PRINCIPLES UNDERPINNING WORK ON FGM

The following principles have been adopted by all agencies in relation to identifying and responding to those at risk of, or who have undergone FGM, and their parent(s) or guardians:

- the safety and welfare of the child is paramount;
- all agencies should act in the interests of the rights of the child, as stated in the United Nations Convention on the Rights of the Child (1989);
- FGM is illegal in the UK;
- FGM is an extremely harmful practice - responding to it cannot be left to personal choice;
- accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin all interventions;
- as FGM is often an embedded social norm, engagement with families and communities plays an important role in contributing to ending it; and
- all decisions or plans should be based on high quality assessments (in accordance with Working Together to Safeguard Children (2015)5 statutory guidance in England, and the Framework for the Assessment of Children in Need and their Families in Wales (2001)6).

WHAT IS FEMALE GENITAL MUTILATION? (FGM)

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for victims and can cause harm in many ways the practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in child birth, causing danger to the child and mother and/or death.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

TYPES OF FGM

FGM has been classified by the World Health Organisation (WHO) into four types:

- **Type 1 – Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);

- **Type 2 – Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina);

- **Type 3 – Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris; and is the most severe type

- **Type 4 – Other:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

FGM is a deeply embedded social norm, practised by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman and to be marriageable. FGM is believed to be a way of ensuring virginity and chastity. It is used to safeguard girls from sex outside marriage and from having sexual feelings. Although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. FGM is not supported by any religious doctrine.

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. Generally speaking, risks increase with increasing severity of the procedure.

Immediate/short term health problems include severe pain, difficulty passing urine, excessive bleeding, infection due to the instrument being used in multiple procedures, wound healing problems, shock and death.

In the long term, women who have suffered FGM may also have some or all of the following problems:

- **Pain**: due to tissue damage and scarring that may result in trapped or unprotected nerve endings.
- **Infections**:
    - **Chronic genital infections**: with consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear.
    - **Chronic reproductive tract infections**: May cause chronic back and pelvic pain.
    - **Urinary tract infections**: If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.
- **Painful urination**: due to obstruction of the urethra and recurrent urinary tract infections.
- **Menstrual problems**: result from the obstruction of the vaginal opening. This may lead to painful menstruation (dysmenorrhea), irregular menses and difficulty in passing menstrual blood, particularly among women with Type III FGM.
- **Keloid scarring** where excessive scar tissue forms at the site of the cutting. Keloid scars grow lumpy and larger than the wound they're healing
- **Human immunodeficiency virus (HIV)**: given that the transmission of HIV is facilitated through trauma of the vaginal epithelium which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM.
- **Female sexual health problems**: removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems.
- **Obstetric complications**: FGM is associated with an increased risk of Caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult labour, obstetric tears/lacerations, instrumental delivery, prolonged labour, and extended maternal hospital stay. The risks increase with the severity of FGM.
- **Obstetric fistula**: a direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with prolonged and obstructed labour it is reasonable to presume that both conditions could be linked in women living with FGM.
- **Need for later surgeries**: for example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse

and childbirth (known as deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks;

- **Perinatal risks**: obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death.
- **Psychological consequences**: some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD), anxiety disorders and depression. The cultural significance of FGM might not protect against psychological complications.

FGM is a complex issue – despite the harm it causes, many women and men from practicing communities consider it to be normal to protect their cultural identity.

Terms used for FGM in other languages can be found in the multi-agency statutory guidance on female genital mutilation.

FIGURE 1 COMMON TERMS FOR FGM

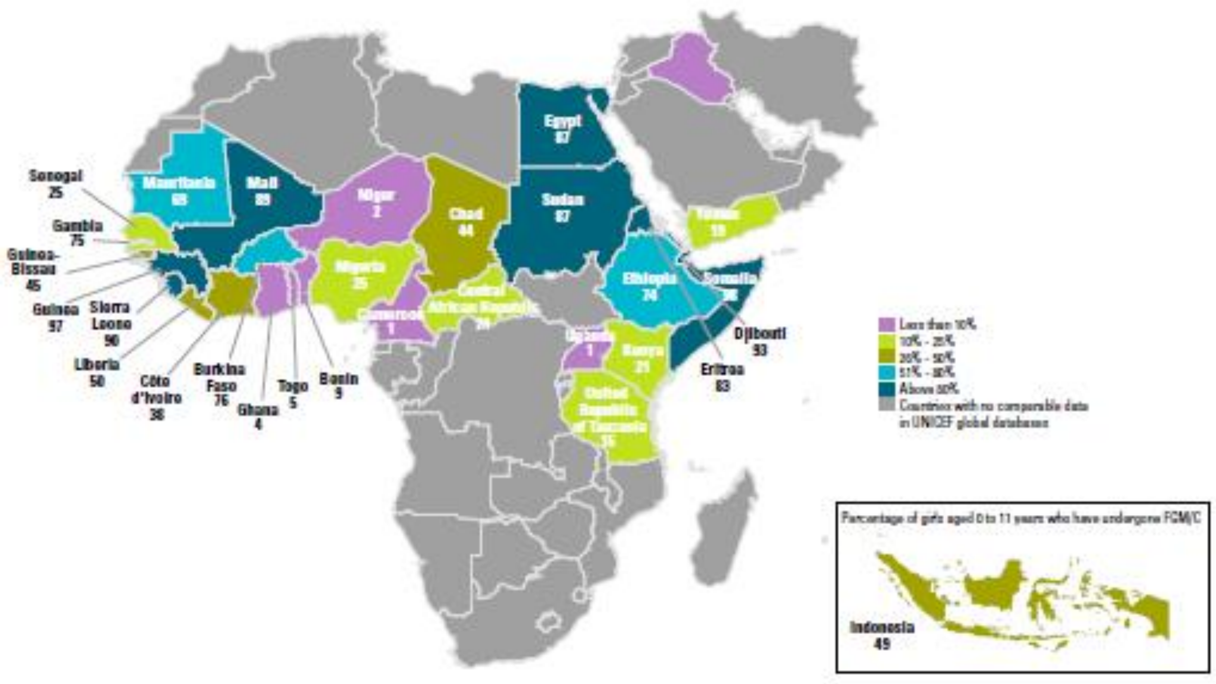
Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Believed to be a religious tradition/obligation by some Muslims
SIERRA LEONE	Sunna	Soussou	Believed to be a religious tradition/obligation by some Muslims
	Bondo	Temenee/ Mandingo/Limba	Integral part of an initiation rite into adulthood
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood
SOMALIA	Gudiniin	Somali	Circumcision – used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
CHAD – the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
GAMBIA	Niaka	Mandinka	Literally to 'cut /weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

Source: Female genital Mutilation Risk and Safeguarding: Guidance for Professionals

PREVALENCE OF FGM - WHO IS AT RISK OF FGM?

FGM is practiced in a swath of African countries from the Atlantic coast to the Horn of Africa, in parts of the Middle East, and in some Asian countries like Indonesia.

FIGURE 2. PERCENTAGE OF YOUNG AND ADULT WOMEN AGED 15-49 WHO HAVE UNDERGONE FGM.

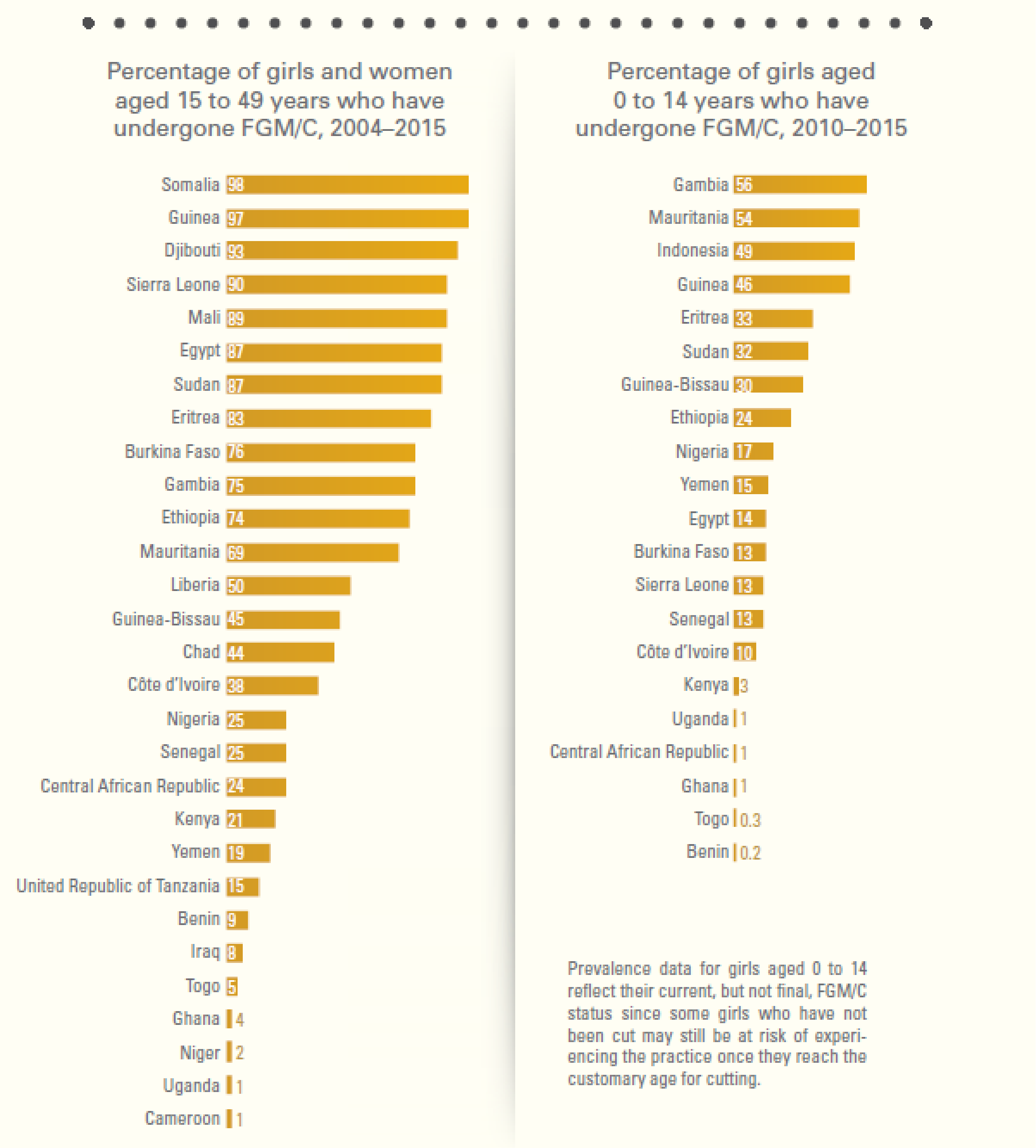


Source: Female genital Mutilation Risk and Safeguarding: Guidance for Professionals

Figure 3 shows the estimated prevalence of FGM in young and adult women aged 15-49 and amongst girls under 15 in different countries. This data is not complete and has been gathered from various household surveys in different countries but it illustrates the extent of the issue and that it is a global problem. Over the past 30 years, there have been huge efforts to reduce the prevalence of FGM. In many countries, there has been a movement against FGM and in some countries there have been significant reductions in prevalence – although not in the countries with the highest prevalence.

Female children and young people from these countries living in the UK are therefore at risk of FGM. FORWARD UK (Foundation for Women's Health Research and Development) estimates that as many as 6,500 girls are at risk of FGM within the UK. Estimating the numbers of girls and young women are at risk in Harrow is not possible as we have no data on the attitudes of the local communities who have their origins in high prevalence countries. In the school census, we are able to see that there are over 500 girls and young women attending schools in Harrow who speak languages of East African countries with FGM rates of over 80%.

FIGURE 3 PREVALENCE OF FGM/C AROUND THE WORLD



SOURCE: UNICEF

THE LAW IN ENGLAND AND WALES

There are a number of relevant pieces of legislation and guidance that consider FGM.

FEMALE GENITAL MUTILATION ACT

FGM is child abuse and illegal in England and Wales under the Female Genital Mutilation Act 2003[1]. Under section 1(1) of the 2003 Act, a person is guilty of an offence it they excise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris. Section 6(1) of the 2003 Act provides that the term "girl" includes "woman" so the offences in section 1 to 3 apply to victims of any age.

Other than in the excepted circumstances set out in section 1(2) and (3), it is an offence for any person (regardless of their nationality or residence status) to:

- Perform FGM in England or Wales (section 1 of the 2003 Act);
- Assist a girl to carry out FGM on herself in England or Wales (section 2 of the 2003 Act); and
- Assist (from England or Wales) a non-UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident (section 3 of the 2003 Act.)

Any person found guilty of an offence under section 1, 2 or 3 of the 2003 Act is liable to a maximum penalty of 14 years' imprisonment or a fine (or both).

THE SERIOUS CRIME ACT

The Serious Crime Act 2015 strengthened the legislative framework around tackling FGM. One of the new measures introduced through Section 5B of the 2003 Act[2] requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police (the mandatory reporting duty). However, healthcare professionals are not expected to investigate or make decisions upon whether a case of FGM was a crime or not, under the legislation. All cases should be dealt with under existing safeguarding frameworks, which for children under 18 who have undergone FGM would mean a referral to Children's Social Care and the police.

Health professionals and organisations can access a range of support materials, including 2-page process guide. These can be found at www.gov.uk/dh/fgm.

Other measures were introduced through the Serious Crime Act 2015. This now includes:

- An offence of failing to protect a girl from the risk of FGM;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Lifelong anonymity for victims of FGM; and

[1] http://www.legislation.gov.uk/ukpga/2003/31/contents

[2] http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation

- FGM Protection Orders which can be used to protect girls at risk.

Working together to safeguard children

The Department for Education published statutory guidance in 2013 (updated in March 2015) titled Working together to safeguard children[3]. This guidance covers:

- the legislative requirements and expectations on individual local authority and school services to safeguard and promote the welfare of children; and
- a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services Whilst the guidance does not make specific provision for safeguarding activities relating to FGM, it sets out requirements around information sharing which are needed to effectively safeguard against FGM and all forms of child abuse.

Multi-Agency Guidance

No single agency can adequately meet the multiple needs of someone affected by FGM. In 2016, the government launched statutory multi-agency guidance on FGM.[4] This guidance encourages agencies to cooperate and work together to protect and support those at risk of, or who have undergone, FGM. The guidance provides information on:

- Identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them.
- Identifying when a girl or young woman has had FGM and responding appropriately to support them, and
- Measures that can be implemented to prevent and ultimately help end the practice of FGM.

The guidelines make clear that FGM is child abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/protection structures, policies and procedures.

[3] www.workingtogetheronline.co.uk

[4] www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

What do we know about FGM Locally?

Prior to 2014/15 there was no collection of data on the prevalence of FGM and so, although FGM was known to occur, the scale of the issue was unknown. The FGM Prevention Programme is a programme of work led by the Department of Health to improve the NHS response to FGM; this includes projects to improve awareness, provision of services and management of FGM, and the safeguarding of girls at risk. One of the first actions was to find out the scale of the issue so that the scale of response could be more accurately measured. It is important to note in all of these datasets, that if a patient is identified through the delivery of care from the NHS as having had FGM, this does not mean that she had FGM either recently or that the FGM was carried out in the UK or while she was resident in the UK.

In 2015, Macfarlane et al estimated the prevalence of FGM in two age groups 0-14 and 15-49. The data was only calculated for 2011. It has been extrapolated to give current (2016) estimates and estimates for the number of cases in 2021. This extrapolation assumes that in the absence of any change in FGM, the prevalence grows as the population grows, which is a solid and reliable assumption. It shows that for Harrow, the number of cases in under 14s and in 15-49 year olds not expected to change over the next five years but it is expected to increase in the over 50s. This type of prediction of future prevalence also assumes that nothing is being done to address FGM so that can be a very reliable benchmark to measure potential interventions against.

	Estimated number of cases of FGM in	
Age	2016	2021
0-14 years	109	107
15-49 years	1190	1087
50+	511	642

From Macfarland et al (2015)

FGM Prevention Programme

Between September 2014 and March 2015, FGM Prevalence Dataset was collected and published at the level of acute trusts only. The data was non-identifiable aggregate data about the prevalence of FGM within the female population as treated by acute NHS trusts in England. As data was not identifiable, it could not be disaggregated to give numbers at a local authority level. In this period, 10 cases of FGM were identified at Northwick Park Hospital and 88 health contacts took place with women identified as having FGM (either within this year or previously). National data showed that these contacts were most commonly due to obstetrics, maternity and gynaecology. Due to the lack of personal identifiers in the data, it was possible for a woman to be identified as a 'new' case in more than one hospital causing over estimation of the number of cases.

An Enhanced Dataset has been introduced which contains a much wider range of data and is at an individual level. It has also been extended beyond acute trusts and now includes

mental health trusts, GP practices and community health services. Although it was initially discretionary, it became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. The full dataset contains 30 data items including: patient demographic data, specific FGM information and referral and treatment information. Disclosure control measures are taken so that individuals cannot be identified. This means that small numbers are suppressed although zero returns and blank returns are identified.

The women and girls newly recorded in the FGM Enhanced Dataset may have been previously identified and included in the FGM Prevalence Dataset. However, they will now be identified as 'newly recorded' on their first contact with a health provider. This will happen only once regardless of how many other health providers they see.

FGM Data collection

The data collection records the first time a woman or girl is recorded in the FGM Enhanced Dataset during the reporting period. They may have FGM and be having treatment related to their FGM or they may be having treatment for something unrelated to it. In practice, the vast majority of women identified as having FGM are those accessing antenatal care.

As this information has not been collected previously, the first few years of collection will be predominantly identifying the prevalent cases in the community.

The second set of data is every subsequent contact that a woman or girl who has FGM has with the NHS – this includes new and previously recorded cases and women or girls may have more than one attendance within the data collection period at any number of NHS organisations. Again, this may be related or unrelated to FGM.

Data Definitions

Newly Recorded: women and girls with FGM are those who have had their FGM information collected in the FGM Enhanced Dataset for the first time. This will include those identified as having FGM and those having treatment for their FGM. 'Newly recorded' does not necessarily mean that the attendance is the woman or girl's first attendance for FGM and it does not mean that the FGM is a recent occurrence for her.

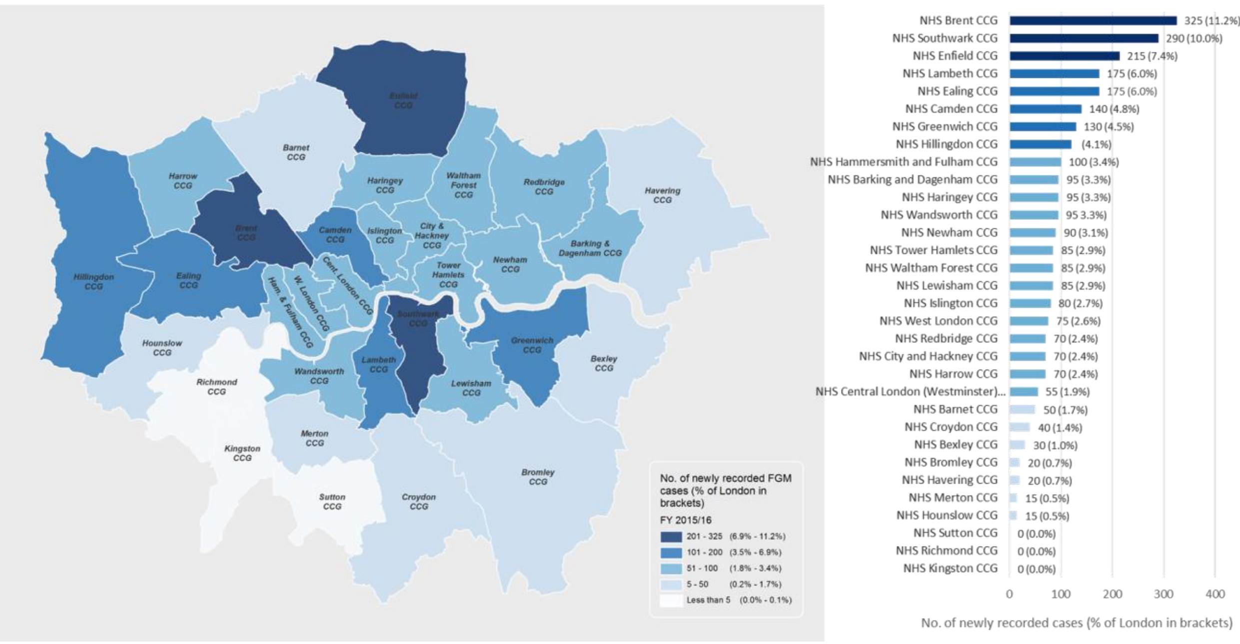
Total Attendances: refers to all attendances in the reporting period where FGM was identified or a procedure for 'reversal' of FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.

Data Quality

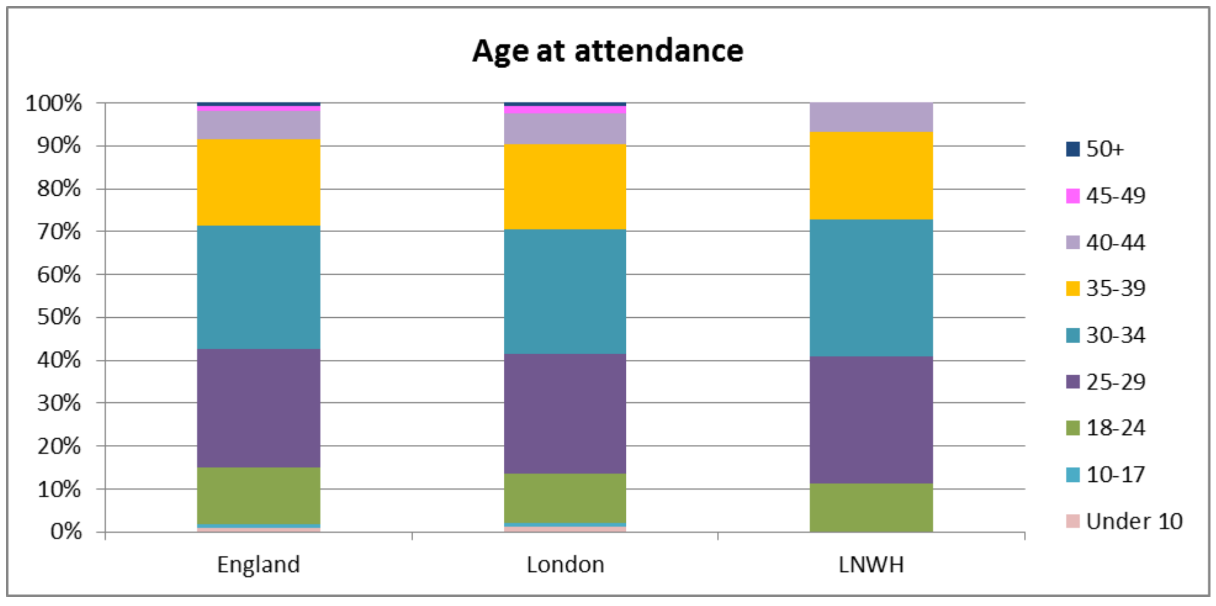
Although the collection of data is now mandatory, the quality and completeness of the data across the country is far from good. The FGM dataset is a relatively new one with only one year of data so far and, due to missing data and inconsistencies in recording across the country there are many caveats that must be heeded when trying to interpret the data.

FGM: NEW CASES

The number of newly recorded cases has been rounded to the closest 5 to prevent disclosure. Between April 2015 and March 2016, 70 women or girls (i.e. under 18) in Harrow were identified as having had FGM at some point in their lives. Compared to the rest of the local authorities in England, Harrow ranks joint 27th highest and joint 19th highest in London. Nationally, the highest numbers identified were seen in Birmingham, Bristol and Brent. In London, the highest numbers were seen in Brent and Southwark. Harrow identified 2.4% of the cases that were identified in London.

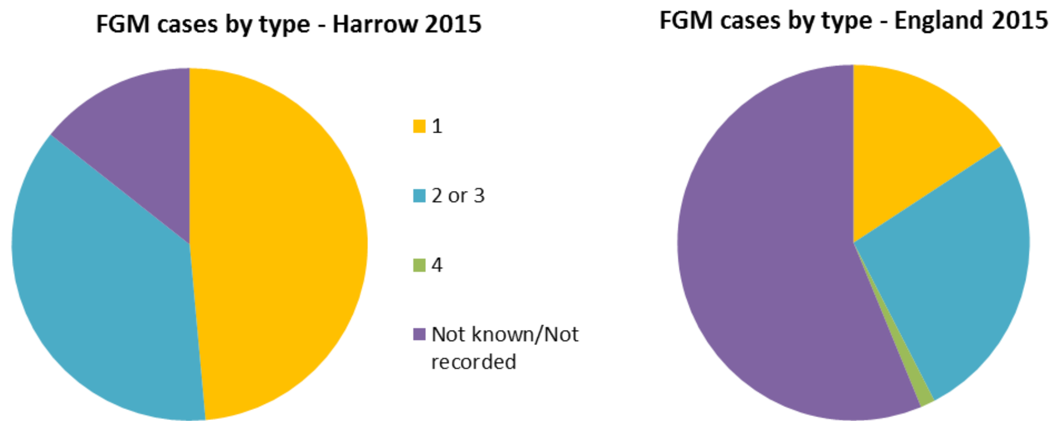


The small numbers do not allow us to divide the cases into age categories for Harrow but data is available at Trust level. The data shows that there was a slightly higher proportion of women in 25-39 age groups than nationally. There were no under 18s identified locally.



The recording of age at which FGM took place is very poorly recorded nationally and is not recorded on any cases at London Northwest NHS Trust, so it is not currently possible to say how many are recent cases, or indeed, if any of them are.

The majority of cases identified in Harrow were Type 1 FGM and 14% were either unknown or unrecorded. Across England the figure for unknown and unrecorded was significantly higher and accounted for more than half of all cases.

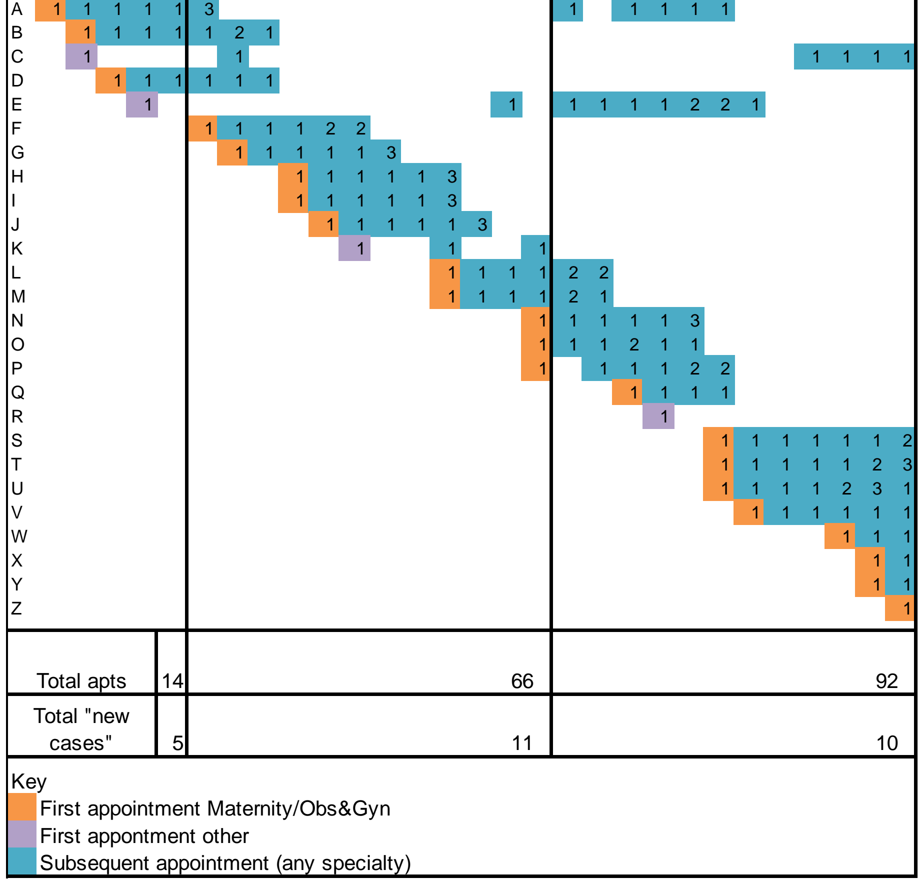


FGM: ATTENDANCES WITHIN THE YEAR

Harrow ranks 4th highest nationally in the rate of attendances for women or girls with FGM i.e. the number of contacts with the health services that any woman previously or concurrently identified as having FGM.

We do not have data on the reasons for these attendances as again, the data quality is poor nationally and the attendance type is not recorded in the LNWH dataset. We know anecdotally, that some/most are maternity cases and will be receiving a number of antenatal attendances while others may be having treatment for their FGM and other attendances could be completely unrelated to their FGM. What is clear is that LNWH are recording all attendances which may not be the cases in other Trusts. As a result, the number of attendances per new cases identified in LNWH is over 6 compared to only 1 or 2 attendances elsewhere. These figures do not however represent those women newly identified but also include those previously identified who have attended the hospital. The following figure attempts to illustrate this in a hypothetical population and their hospital attendance. It illustrates how the number of appointments can increase despite the number of “new” cases remaining static or even decreasing.

FIGURE 4 ILLUSTRATION OF APPOINTMENTS VS NEW CASES

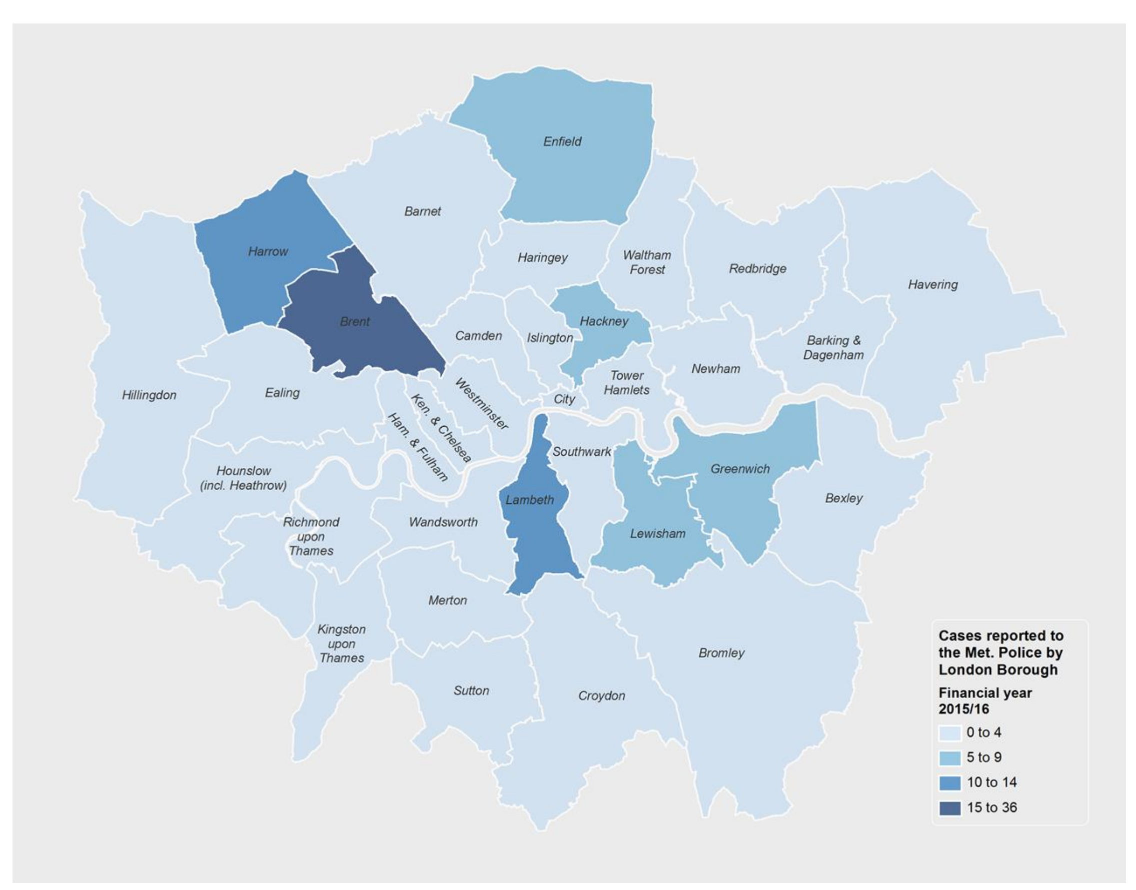


Although caution is advised on interpretation of current data released from the Department of Health, the current position would indicate that health staff in LNWH are complying with recording responsibilities. We know that LNWH are a good example of where recording of FGM has been integrated into hospital services. The safeguarding nurses have ensured that questions about FGM are routinely asked as part of the Trust's safeguarding policy. These questions are asked regardless of whether the child or mother are attending accident and emergency, paediatrics, maternity or a surgical ward. However, the incompleteness of the data records still needs to be addressed.

Referrals to MASH

Since the introduction of mandatory reporting for certain professions, combined with the local awareness raising activity, referral figures are increasing. The increased awareness and emphasis on FGM in Harrow have resulted in more cases being identified and reported than in other areas of London, with the exception of Brent.

Referral figures to the MASH have risen from an average of 3-4 per year prior to 2015 to 14 in 2015-6. While most of these cases were children identified as potentially "at risk" of FGM, one case was of a young woman who had already had FGM. This case was investigated and it was established that she had undergone FGM prior to arriving in the UK.


Enfield
Barnet
Harrow
Haringey
Waltham Forest
Redbridge
Havering
Brent
Hackney
Camden
Islington
Barking & Dagenham
Newham
Tower Hamlets
Hillingdon
Ealing
Westminster
Ken. & Chelsea
City
Ham. & Fulham
Southwark
Greenwich
Hounslow (incl. Heathrow)
Lambeth
Bexley
Richmond upon Thames
Wandsworth
Lewisham
Merton
Kingston upon Thames
Bromley
Sutton
Croydon
Cases reported to the Met. Police by London Borough
Financial year 2015/16
0 to 4
5 to 9
10 to 14
15 to 36

FGM Awareness and Training

As part of its on-going commitment to protect young girls from the practice of FGM, the HSCB ran briefings for staff on the new duties and to reinforce understanding about the harmful initial and long term effects of FGM. The lead outreach officer from the Home Office presented at a HSCB event to help embed an understanding of the new duties across the partnership.

Harrow has two named safeguarding health professionals who also lead on FGM. They are based at Northwick Park Hospital within London North West Healthcare Trust (LNWHT). They provide training, advice, and support to health professionals within the hospital community; to other health providers such as the mental health trust; and in general practice settings. In addition LNWHT run hospital based dedicated clinics for FGM. They have a recognised national profile, and contributed to the development of the Department of Health video “FGM: The Facts” on NHS choices: www.nhs.uk/fgm.

All GP practices have a safeguarding lead who has attended training on FGM. Further training has been provided for other practice staff and CCG Board members including non-executive members. This increased awareness has improved the quality and timeliness of GP referrals and their action plans. In turn, the GPs report that responses from MASH have improved so they know what is happening with their patients.

As part of the HSCB, colleagues in Public Health have FORWARD trained FGM trainers who deliver a cross agency session as part of our race, culture, faith and diversity implications for safeguarding children effectively course. These trainers work as part of our voluntary community and faith child safeguarding engagement.

Schools in Harrow have been working with NSPCC and FORWARD on FGM. Norbury School is the leading primary school in the NSPCC Talk PANTS programme and lead in Female Genital Mutilation education, working alongside the Azure Project with the Metropolitan Police. The school had six months of regular meetings with stakeholders including health services, children’s services, their parent group, the voluntary sector, the police, cluster schools and charities to understand the facts, the various educational approaches, training and engagement with communities.

FIGURE 5 NSPCC TALK PANTS POSTER

Following these meetings the school created their own FGM lesson plans, resources and approaches which they were shared with their stakeholders and modified as required. All Year 5 & 6 pupils’ parents met the school and reviewed the resources before the lessons were piloted

and INSETs were held for their staff, governors and parents. Under the slogan My Body My Rules, Norbury has specific FGM lessons from year 3-year 6

Norbury School has also delivered CPD Online seminar lessons and has participated in three conferences, a radio programme and has developed a video. They are also a case study championed by the Home Office and have shared the approach and learning with other schools. Their role in raising awareness of FGM has also been recognised by the United Nations, within the Big Bro Movement.

In a number of Harrow schools and colleges, lesson plans are being created and resources for schools to use in partnership with their community, under the support and guidance of Norbury Primary School. Norbury is also working with older students from a high school to train as providers in lessons. As local education champions on FGM, Norbury has developed the lesson plans for PANTS from Nursery through to year 6. Their staff have trained and facilitated assemblies, seminar lessons and taught across 10 different boroughs in London. Norbury is now a facilitator for a national training provider speaking at Conferences in Bristol, Manchester and London. The school has now introduced the Talk PANTS programme to Year 2.

Harrow High School met with KS3 parents to share Harrow High's Talk PANTS and FGM vision with the plan to deliver lessons. Elmgrove has received staff training and is working with Community Ambassadors to deliver Talk PANTS/FGM lessons. Grange have completely adopted the programme working with Norbury on a weekly basis in the Autumn Term. HASVO (Harrow Association of Somali Voluntary Organisations) are working with Rooks Heath School to support the FGM agenda and developing an FGM film. Harrow College has included FGM awareness in its health fair.

LOCAL ACTIONS TO PROTECT AND SAFEGUARD THOSE AT RISK OF FGM

The Harrow Domestic and Sexual Violence Forum has identified FGM as a priority area. In line with this, a series of posters and communication plan have been produced to raise the profile of this critical issue. They were distributed throughout the Borough at 26 on street sites and in council publications, with the design options distributed to local sites for display at their discretion.

FIGURE 6 HARROW FGM POSTER

The Department of Health launched a campaign at the start of the 2016 summer school holidays when the numbers of girls taken outside of the UK to be cut increases, to raise awareness of the severe health implications of FGM for those living in UK who are members of communities affected by FGM. We have promoted the campaign locally. http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx

Harrow LSCB has a page on the website on FGM which gives background information for those with concerns as well as End FGM campaign materials. http://www.harrowlscb.co.uk/guidance-for-practitioners/female-genital-mutilation/

REPORTING PATHWAY

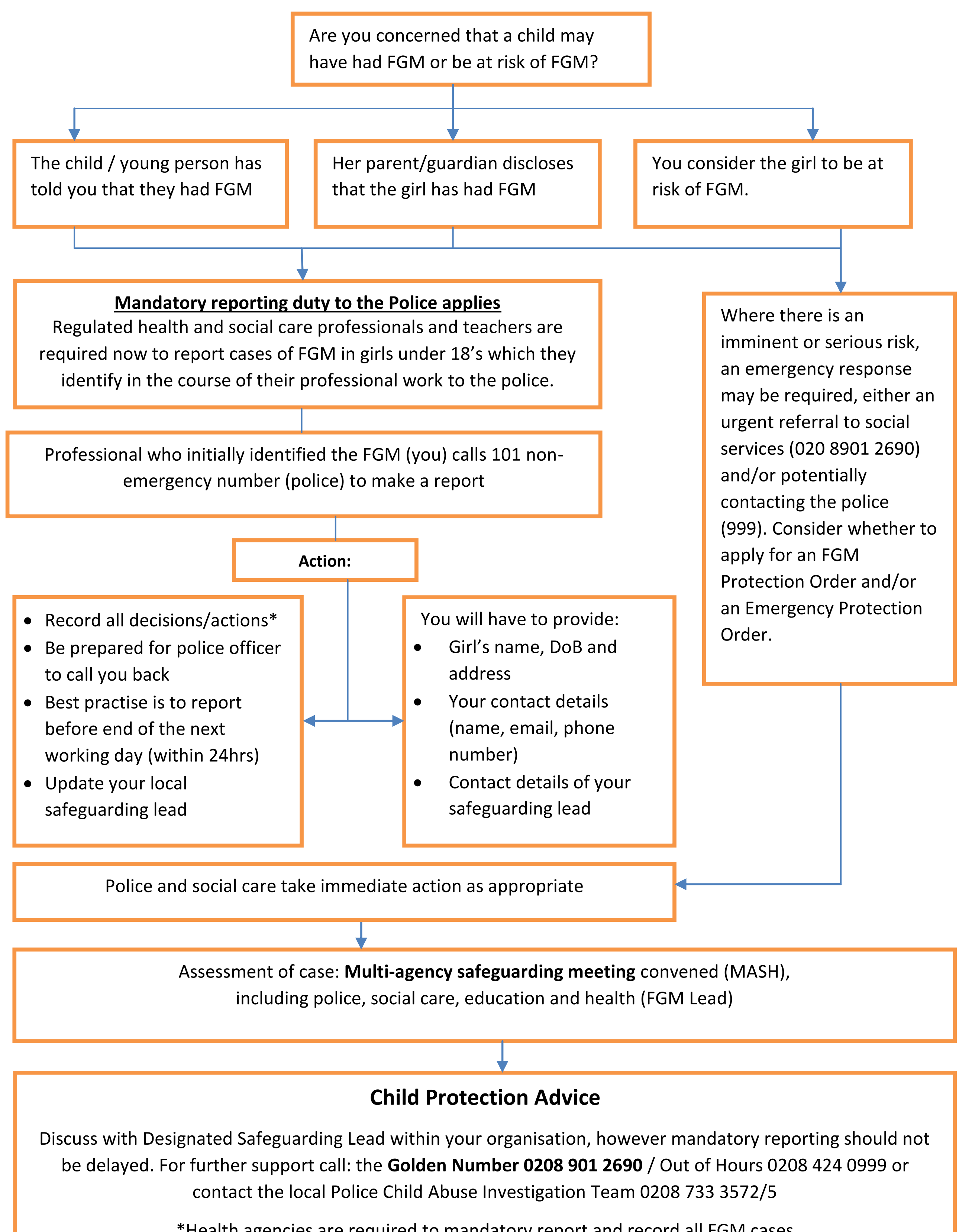
Using national examples of best practice and utilising the considerable local expertise in Harrow, the LSCB has developed a pathway for FGM reporting. If anyone is concerned that there is FGM occurring or that a woman or girl is in danger, they should follow the Harrow FGM pathway. Although this is strictly confidential, some people may not be comfortable reporting locally and so In addition, we also promote a national helpline: fgmhelp@nspcc.org.uk telephone: 0800 028 3550. The risk assessment templates are presented in the appendix.

Contact details for the lead health professionals in Harrow (based in Northwick Park Hospital)

Grace Nartey (gracenartey@nhs.net Tel: 020 8869 5046 or mobile 07825606008) and

Florence Acquah (florence.acquah@nhs.net Tel: 0208 869 3692/3695 or Mobile: 07879444682)

HARROW FGM REPORTING PATHWAY



LOCAL ACTIONS TO SUPPORT THOSE WHO HAVE UNDERGONE FGM

Supporting women who have undergone FGM can take many forms – from treating complications arising from their FGM to surgical interventions to emotional and psychological support.

Small procedures to open the scar -to de-infibulate - are possible. These interventions are also known as reversal but they cannot put back tissue that has been cut away. The procedure is done in a specialist clinic usually with a local anaesthetic and a nurse, doctor or midwife will perform it. The skin will be stitched at either side of the scar to keep it from healing together again and it will usually heal very quickly. This small operation can reduce symptoms such as painful or slow urination, painful periods (dysmenorrhoea), urinary tract infections and pain during sex. Although the procedure can be done any time, some women will chose to have the procedure when they are pregnant while others wait until they are in labour.

The closest FGM clinic is the African Well Women's Clinic at Northwick Park Hospital Antenatal Clinic Watford Rd. Harrow Middlesex, HA1 3UJ. This clinic is held on Friday mornings. It is run by specialist midwives who will refer to a consultant if necessary. (Contact number for Northwick Park Hospital Harrow Antenatal clinic 020 8869 2880). http://www.nwlh.nhs.uk/services/antenatal-care/.

Traumatic experiences can often have psychological repercussions. Undergoing FGM can be one of those experiences -feelings of low self esteem, depression, anxiety and anger are commonly reported – even if at the time the girl shared the community expectations that this is what happens to all girls. Symptoms of post traumatic stress disorder such as flashbacks, panic attacks and nightmares which can be triggered by a smell, a sound or a situation are also common. Assessment and support is available from the local mental health services through the Single Point of Access for North West London Adult Community Mental Health Services. (contact: 0800 0234 650 or cnw-tr.spa@nhs.net http://www.cnwl.nhs.uk/service/single-point-of-access-north-west-london-adult-community-mental-health-services/)

MONITORING AND GOVERNANCE OF FGM IN HARROW

The Violence, Vulnerability and Exploitation (VVE) subgroup (formerly Child Sexual Exploitation subgroup) of the Community Safety Partnership has recently expanded its remit to encompass all aspects of VVE including FGM. A new VVE strategy and an action plan are in development. A new FGM action group will be established which will report into the VVE subgroup. The membership and frequency of this group are not yet agreed but it is hoped that this group will meet for the first time before schools break up in July.

Because of its relationship to the health and wellbeing of children and young people, FGM is also included in the Harrow Safeguarding Children's Board's data set and is scrutinised by the HSCB's Quality Assurance sub committee.

CCGs also have a responsibility in ensuring that all of the Acute and Mental Health Trusts they commission from have policies in place to report FGM cases. This is in place in Harrow.

Harrow Council's Ofsted inspection in February 2017, noted the local work on FGM as being "well integrated into broader safeguarding work" and there being "an understanding of the complex dynamics when there are concerns about abuse or neglect in a particular cultural context. This is apparent in a clear, effective and well-joined-up approach to the issue of female genital mutilation".

APPENDIX : RISK ASSESSMENT TEMPLATES

Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

Date: ______________ Completed by: ______________
Assessment: Initial/On-going

This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law			
Woman's nieces, siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM			
Woman or woman's partner/family requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part One (b): NON-PREGNANT ADULT WOMAN (over 18)

Date: ______________ Completed by: ______________
Assessment: Initial/On-going

This is to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
A female family elder (maternal or paternal) is influential in family or is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Part 2: CHILD/YOUNG ADULT (under 18 years old)

Date: _______________ Completed by: _______________
Assessment: Initial/On-going

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required

Indicator	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A female family elder is very influential within the family and is/will be involved in the care of the girl			
Mother/family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc.			
Girl withdrawn from PHSE lessons or from learning about FGM – School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the family			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Part 3: CHILD/YOUNG ADULT (under 18 years old)

Date: _______________ Completed by: _______________

Assessment: Initial/On-going

This is to help when considering whether a child HAS HAD FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs e.g. withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/ another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

If you suspect but do not know that a girl has undergone FGM based on risk factors presenting, you should look to refer to Social Services / CAIT Team / police / MASH, in accordance with your local safeguarding procedures.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	20 July 2017
Subject:	Terms of Reference for Health and Wellbeing Board
Responsible Officer:	Hugh Peart, Director of Legal and Governance Services
Public:	Yes
Wards affected:	All Wards
Enclosures:	Current Terms of Reference with tracked changes

Section 1 – Summary and Recommendations

This report informs the Board of the request by the Harrow Clinical Commissioning Group for an increase in its voting representation on the Board. It also seeks approval to amend the terms of reference in relation to sub groups.

Recommendations:
The Board is requested to:
1. Consider the request from the Harrow Clinical Commissioning Group to amend its membership by the inclusion of the Accountable Officer as a Voting Board Member;
2. Agree, subject to Council approval, that the paragraph on Sub Groups be deleted from the terms of reference as these groups are not in operation;
3. Recommend to the Constitutional Review Working Group that Council be requested to approve the revised Terms of Reference for inclusion in the Council's Constitution.

Section 2 – Report

At its first meeting on 19 June 2013 the Board received a report which set out its terms of reference and procedural rules. The voting membership comprised four Members of the Council nominated by the Leader of the Council, three representatives from Harrow Clinical Commissioning Group and one representative from Harrow Healthwatch. At the meeting on 30 June 2016, it was noted that the number of Members of the Council nominated by the Leader of the Council had been increased from 4 to 5. This was to enable the Leader of the Council to take a place on the Board and to enable the continued attendance of an opposition Member.

Current situation

Harrow Clinical Commissioning Group has requested that the CCG Accountable Officer or his/her nominee becomes an additional voting member on the Board. The officer is currently a non-voting member. If this is approved, there would be an equality of votes between the Members of the Council and the CCG/Healthwatch with the casting vote in the event of an equality of votes falling to the Leader of the Council or in his absence the Vice-Chair who is the Chair of the Harrow Clinical Commissioning Group. This is in accordance with the balance between the organisations as when the Board was first set up. As the CCG Accountable Officer is currently a non-voting member, the bullet point in section 4.3 would be deleted if it is agreed for this member to become a voting member. The total number of CCG Board members would remain the same.

It was envisaged that the Health and Wellbeing Board would establish sub groups. These would be informal officer level groups and would be reviewed annually. As Sub groups are no longer appointed, and no minutes or issues have been submitted to the Board, it is suggested that they be deleted from the terms of reference.

Why a change is needed

The current terms of reference for the Health and Wellbeing Board are attached with suggested amendments in track changes with regard to a revised voting membership and the deletion of the paragraph on sub groups.

Financial Implications/Comments

No additional costs have been identified as a result of the proposed changes to voting representation. However, in the event that any costs arise from these changes, such costs would need to be contained within existing partner organisation budgets as appropriate

Legal Implications/Comments

Under s.194 of the Health and Social Care Act, a local authority must establish a Health and Wellbeing Board. The core membership is set out

under that section and may include ‘such other persons, or representatives of such other persons, as the local authority thinks appropriate.’ The Board itself can appoint additional members. As the member in question was originally appointed by the local authority it is appropriate for the change in their status to be approved by Council, particularly as it is a change to the constitution.

The usual practice is for proposed changes to the constitution to be considered by the Constitution Review Working Group prior to a report going to Council..

Risk Management Implications

There are no additional risks identified.

Equalities implications

The purpose of the Board is to improve health and wellbeing for the residents of Harrow and reduce inequalities in outcomes.

Council Priorities

The Council’s vision:

Working Together to Make a Difference for Harrow

The report incorporates the administration’s priorities by improving health and wellbeing for the residents of Harrow and reduce inequalities in outcomes.

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

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

Name: Donna Edwards Date: 14 June 2017	x	on behalf of the Chief Financial Officer
Name: Caroline Eccles Date: 27 June 2017	X	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Miriam Wearing, Senior Democratic Services Officer
Email: Miriam.wearing@harrow.gov.uk
Tel: 020 8424 1542

Background Papers: Terms of reference of Health and Wellbeing Board

HEALTH AND WELLBEING BOARD

1. Accountability

The Health and Wellbeing Board is set up in accordance with section 102 of the Health and Social Care Act 2012. The Council can choose to delegate decision making powers to the Health and Wellbeing Board. Any recommendations are subject to the agreement of the Leader of the Council if they are not covered by the delegated authority.

Members of the Board will be required to abide by the Code of Conduct.

2. Purpose of the Board

2.1. The Government proposes that statutory health and wellbeing boards will have 3 main functions:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across NHS, social care and public health
- to support joint commissioning and pooled arrangements, where all parties agree this makes sense

The Board will cover both adult and children's issues.

2.2. The purpose of the Board is to improve health and wellbeing for the residents of Harrow and reduce inequalities in outcomes. The Board will hold partner agencies to account for delivering improvements to the provision of health, adult and children's services social care and housing services.

3. Key Responsibilities

3.1. The key responsibilities of the Health and Wellbeing Board shall be:

3.1.1. To agree health and wellbeing priorities for Harrow

3.1.2. To develop the joint strategic needs assessment

3.1.3. To develop a joint health and wellbeing strategy

3.1.4. To promote joint commissioning

3.1.5. To ensure that Harrow Council and the CCG commissioning plans have had sufficient regard to the Joint Health and Wellbeing strategy

3.1.6. To have a role in agreeing the commissioning arrangements for local Healthwatch

3.1.7. To consider how to best use the totality of resources available for health and wellbeing.

3.1.8. To oversee the quality of commissioned health services

3.1.9. To provide a forum for public accountability of NHS, public health, social care and other health and wellbeing services

3.1.10. To monitor the outcomes of the public health framework, social care framework and NHS framework introduced from April 2013)

3.1.11. To authorise Harrow's Clinical Commissioning Group annual assessment

3.1.12. To produce a Pharmaceutical Needs Assessment and revise every three years

3.1.13. Undertake additional responsibilities as delegated by the local authority or the Clinical Commissioning Group e.g. considering wider health determinants such as housing, or be the vehicle for lead commissioning of learning disabilities services.

4. Membership

4.1. The Chair of the Board will be nominated by the Leader of Harrow Council.

4.2. The voting membership will be:

- Members of the Council nominated by the Leader of the Council (5)
- Chair of the Harrow Clinical Commissioning Group (vice chair)
- GP representative of the Harrow Clinical Commissioning Group
- A further representative of the Harrow Clinical Commissioning Group
- CCG Accountable Officer or nominee
- Chair of Healthwatch

4.3. The following Advisors will be non-voting members:

- Director of Public Health
- Chief Officer, Voluntary and Community Sector
- Senior Officer of Harrow Police
- ~~Accountable Officer – CCG~~
- Chief Operating Officer – CCG

Comment [MW1]: This bullet point is to be deleted if it is agreed for this member to become a voting member (as referenced in 4.2 above)

- Corporate Director, People
- Director Adult Social Services

4.4. The voluntary and community sector representative shall be nominated by the Voluntary Community Sector Forum on an annual basis.

4.5. Members are appointed annually. Members of the Board shall each name a reserve who will have the authority to make decisions in the event that they are unable to attend a meeting.

4.6. Board members shall sign a register of attendance at each meeting and should not normally miss more than one meeting within a financial year.

4.7. The chair of the Clinical Commissioning Group will serve as the vice chair of the Health and Wellbeing Board.

4.8. Providers will be invited to attend meetings as required depending on the subject under discussion.

4.9. Participation of the NHS England

4.9.1. NHS England must appoint a representative to join Harrow's Health and Wellbeing Board for the purpose of participating in the Boards preparation of the JSNA and JHWS.

4.9.2. The Health and Wellbeing Board can request the participation of the NHS England representative when the Health and Wellbeing Board is considering a matter that relates to the exercise or proposed exercise of the commissioning functions of NHS England in relation to Harrow.

4.10. Meeting Frequency

4.10.1. The Board shall meet bi monthly subject to review

4.10.2. An extraordinary meeting will be called when the Chair considers this necessary and/or in the circumstances where the Chair receives a request in writing by 50% of the voting membership of the Board

4.11. Health and Wellbeing Board Executive

4.11.1. The purpose of the Health and Wellbeing Board Executive is to:

- Develop and deliver a programme of work based on the Joint Commissioning priorities and the Joint Health and Wellbeing Strategy
- Shape future years joint commissioning
- Shape the agenda for future HWB meetings

- Engage and understand the views of different organisations (including providers)
- Bring together a collective view of partners and providers to the bi-monthly Health and Wellbeing Board
- Share Commissioning Intentions and common priorities
- Govern and quality assure the Health and Wellbeing Board work programme
- Be aware and discuss emerging policy and strategy
- Problem Solving

4.11.2. The meetings of the Executive will be scheduled to meet before the Board.

4.11.3. Membership will consist of senior representatives from both the Council and Clinical Commissioning Group, including the Directors of Adults, Children's, and Public Health services, the Chair of Harrow Clinical Commissioning Group, Accountable Officer, Chief Operating Officer, GP Clinical Directors, and finance officers.

4.11.4. The chairing of the Executive will alternate between the council's Corporate Director of People Services and the Chief Operating Officer, Harrow CCG.

4.12. Local Safeguarding Boards

4.12.1. The Council's two Local Safeguarding Boards have a horizontal link to the Health and Wellbeing Board and include:

4.12.1.1. Local Safeguarding Adults Board

4.12.1.2. Harrow Local Children's Safeguarding Board

~~**4.13. Sub Groups**~~

~~4.13.1. The Board will review each year which sub groups are to be established based on the Boards priority areas~~

~~4.13.2. The Sub Groups will ensure that the views of patients and service users are included.~~

~~4.13.3. Sub groups will be informal officer level groups.~~

~~4.13.4. Sub groups should provide a copy of their previous minutes or a list of issues for discussion at alternate Health and Wellbeing Board meetings to be considered by members.~~

~~4.14.~~4.13. **Conduct of Meetings**

Comment [MW2]: Sub groups are no longer appointed and no minutes or issues have been submitted to the Board.

~~4.14.1.~~4.13.1. Meetings of the Board will be held in public except where the public are excluded from the meeting by resolution in accordance with Access to Information Act.

~~4.14.2.~~4.13.2. The quorum of the Board shall be 50% of the voting membership – however there must be attendance of at least one voting member from both the Council and the Clinical Commissioning Group. Should the quorum not be secured the meeting will not take place.

~~4.14.3.~~4.13.3. Decisions shall be made on the basis of a show of hands of a majority of voting members present. The Chairman will have a second or casting vote.

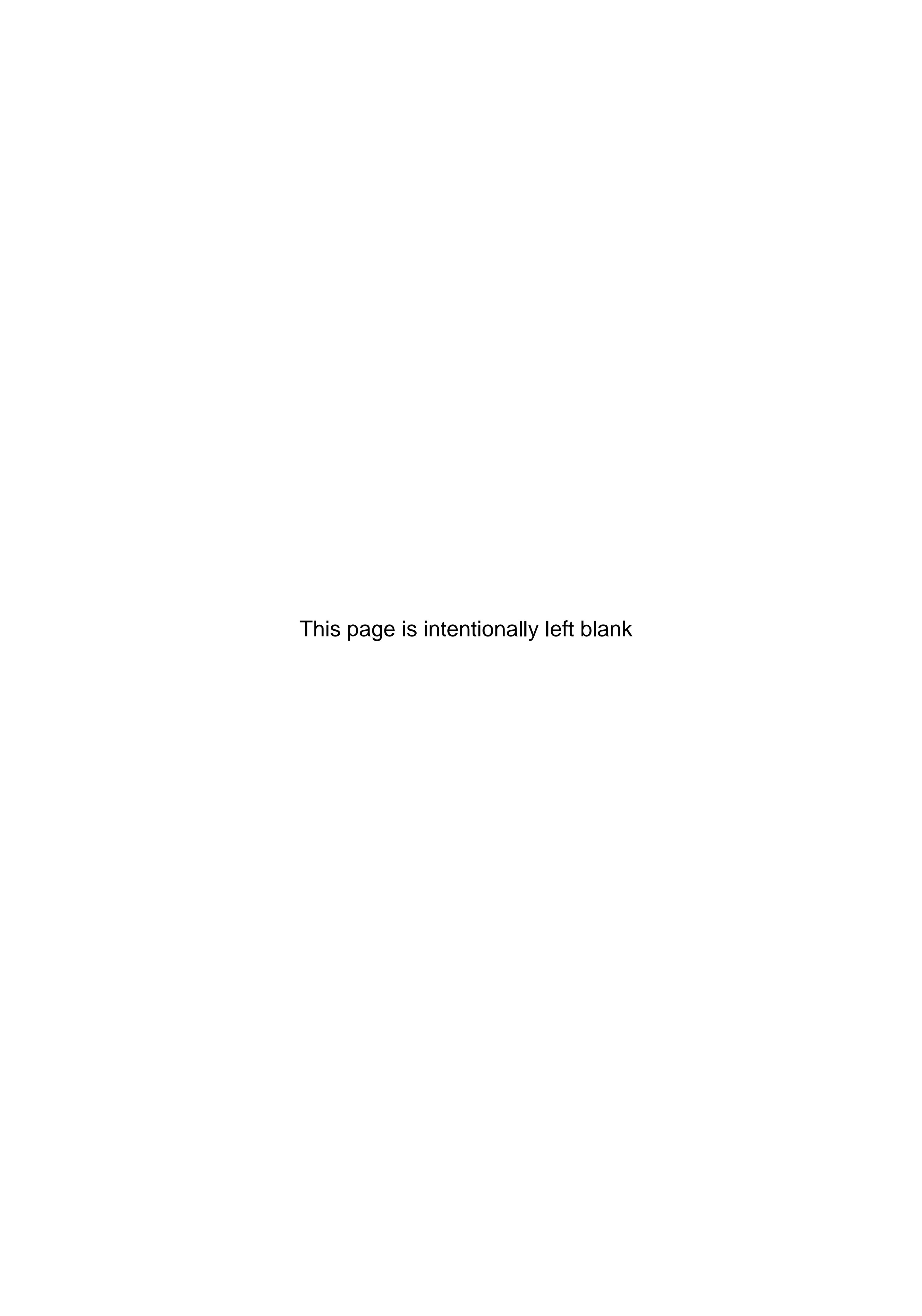
~~4.14.4.~~4.13.4. Each meeting will have provision for the public to ask questions. There will be a total limit of 15 minutes for the asking and answering of public questions.

~~4.14.5.~~4.13.5. Harrow Council Democratic Services will service the meetings including the preparation and circulation of agenda and the production of minutes.

~~4.14.6.~~4.13.6. Minutes of the meetings will be available on the website of the council.

~~4.14.7.~~4.13.7. The chair shall sign off the minutes as a true and accurate record of the meeting.

~~4.14.8.~~4.13.8. Agendas and supporting papers will be available on the website of the council at least five working days before the meeting.


This page is intentionally left blank

REPORT FOR:	HEALTH AND WELLBEING BOARD
Date of Meeting:	20 July 2017
Subject:	Ofsted Report on the Inspection of services for children in need of protection, looked after children and care leavers.
Responsible Officer:	Chris Spencer, Corporate Director of People services
Public:	Yes
Wards affected:	All wards
Enclosures:	Appendix 1: Ofsted Report on Harrow published 31.03.17 https://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/harrow/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf Appendix 2: Harrow Children's Post Inspection Action Plan April 2017

Section 1 – Summary and Recommendations

The attached Ofsted report follows the recent statutory Inspection of services for children in need of protection, looked after children and care leavers, with the action plan required within 70 working days.

Recommendations:
Health and Well-being Board is requested to note the inspection report and

comment on the action plan.

- Ofsted is the independent regulator of children's services.
- Addressing the recommendations in the inspection report is not optional.
- The Local Authority is required to provide an action plan to Ofsted within 70 working days of the published inspection report.

Section 2 – Report

This statutory inspection of Children's Services supports delivery of the Heath and Well-being strategy; especially ensuring that Children *start well* in life and *stay well*.

The related action plan identifies how the report recommendations will be implemented across Children's Services with the help of partner agencies to further support children, young people and their families in Harrow to achieve positive life outcomes. The Health and well-being partnership is ambitious to ensure that good outcomes are embedded across the whole community and that future activity is focussed on achieving an outstanding service.

Current situation

1.The previous full inspection of children's services was in May 2012, under a different Ofsted framework, with both safeguarding arrangements and services to children looked after judged to be 'Adequate overall', with some elements of Good. It is widely recognised that the current framework is a tougher test than the previous inspection framework.

2. Statutory inspection of local authority functions is carried out by Ofsted under section 136 of the Education and Inspections Act 2006.

3. Re-inspection was expected within a 3 year cycle under a revised Ofsted Framework introduced in 2013, which was expanded subsequently in to a 5 year programme. The current Ofsted inspection Framework uses a grading system of: Inadequate; Requires Improvement; Good; Outstanding.

4. Harrow's judgement outcome as 'Good' has achieved one grade higher than previously, and demonstrates the continuing journey of improvement being achieved.This outcome places Harrow in the top performance quartile of local authorities nationally, while maintaining Harrow's reputation for value for money, while demonstrating value for money as evidenced by local

authority comparator data which places Harrow as spending lower per child than the average of its statistical neighbours.

5. The Single Inspection Framework [SIF] inspection considers the following:
• children who need help and protection, including early help
• children looked after, including: adoption, fostering, the use of residential care, children who return home, and achieving permanent homes and families for children and young people
• young people leaving care or preparing to leave care
• management and leadership

6. During the four week inspection, up to 11 inspectors focused on a wide range of issues:
• the experiences of children and young people
• the thresholds for providing help, care and protection to children and young people
• evaluating the quality and impact of the help, care and protection given to children and young people and families
• evaluating the quality and impact of the support to young people looked after, and routes out of the care system through adoption, and statutory care leavers provision
• evaluating the quality and impact of leadership and governance arrangements
• meeting with children, young people, parents and their carers
• shadowing social workers in their daily activities
• observing a wide range of meetings, including child protection conferences and looked after children reviews

7. Inspectors looked closely at the experiences of children and young people who have needed or still need help and/or protection, as well as children and young people who are looked after and those leaving care as young adults. They tracked in the region of 200 individual cases and spoke with many social work staff, several children and young people,parents/carers, foster carers and adoptive parents and other professionals involved such as Health and Police. They considered how well the local authority knows itself and the difference being made to the life chances of vulnerable children and young people resident in Harrow.

8. The local authority is required to prepare and publish a written statement of the action it intends to take in response to the report. It should send a copy of this statement to Ofsted at ProtectionOfChildren@ofsted.gov.uk within 70 working days of receiving the final report. [The Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007 www.legislation.gov.uk/uksi/2007/462/contents/made]

9. Harrow's short notice full inspection of Children's Service started 16 January 2017 and completed onsite 09 February 2017. The inspection team involved 11 inspectors. Ofsted published their combined Harrow Local Authority and Local Safeguarding Children Board report 31 March 2017.

10. Harrow Local Authority was judged 'Good' overall, with services well

matched to the needs of children and young people and their families in Harrow, which effectively reduced risk and improve their life outcomes. Inspectors identified strong and effective leadership having a positive impact on service design, development and delivery. Harrow was judged to know itself well, with a clear understanding of strengths and areas for development.

11. At the time of inspection, Early Support Service transformation was in progress but still at an initial phase, following an extended consultation period. Inspectors acknowledged this and recognised the strong foundations underlying the restructure and relocation to community hubs, while identifying Early Support as a priority for continuing progress. Early Support implementation continues to be rolled out, and during the inspection an Early Support Project Board was convened to oversee progress towards full operation from September 2017.

12. Inspectors recognised the investment made by the Council in creating additional social work posts to meet increasing demand. As a result, the report judged social work caseloads as manageable, enabling social workers to visit children regularly. Inspectors also recognised the positive impact of Harrow's 'joined-up approach' to recruitment, retention and development and the importance of a sufficient, skilled and stable workforce to drive improvement, with appropriate management time and focus.

13. Commitment to performance management and quality assurance activity was identified across the organisation, which had enabled improvements to be achieved and sustained. The proposed action plan will further embed strong performance and address areas for development identified thorough the inspection process.Failure to address these areas for development effectively risks future
inspection adverse impact.

Implications of the Recommendation

The delivery of the action plan to meet the Ofsted recommendations will require ownership and support from all the statutory partners.

Financial Implications/Comments

The risk of failing an Ofsted inspection is recognised to have considerable financial implications to the council and its partners. However, this inspection found all statutory requirements were met in full and the judgement on the Local Authority delivery of children's services was 'Good'. There are no additional implications arising from this inspection, as detailed in the published report..

Legal Implications/Comments

This and future Ofsted inspection of Children's Services lay the regulatory

foundations for meeting the statutory requirements for Harrow Council and its partners . No other specific legal implications flow from this inspection & report to the Health and Well-Being Board.

Risk Management Implications

Statutory inspections carry considerable reputational and financial risk Implications for the Council and statutory partners. As a consequence this has been a significant element of the Council risk register and senior management priorities across the Heath and Well-being partnership.

The outcome of this inspection demonstrates this was a well considered and proportionate response. The future inspection regime under the new ILACS (Inspection of Local Authority Children's Services) will continue to form a significant feature of senior manager risk management attention across statutory partners and corporate support across the council.

Equalities implications

Was an Equality Impact Assessment carried out? No

This report sets out the actions we are taking to secure further improvements, which when achieved will have a positive impact on all vulnerable residents in Harrow; and therefore no equalities impact assessment is needed.

Council Priorities

This statutory inspection of Children's Services and the related action plan support delivery of the Council's vision:

Working Together to Make a Difference for Harrow

and meets the Ambition Plan theme:

Protect the Most Vulnerable and Support Families.

It helps to fulfil the HWB strategy around starting well, and staying well, and living well.

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

Name:Jo Frost	x	on behalf of the Chief Financial Officer
Date: 4 July 2017		

Ward Councillors notified: **NO**

Section 4 - Contact Details and Background Papers

Contact: Paul Hewitt

Background Papers: List only **public** documents (ie not Private and Confidential/Part II documents) relied on to a material extent in preparing the report (eg previous reports). Where possible also include a web link to the documents.

noderngov\Data\AgendaItemDocs\2\6\1\AI00109162\$xyiaj11o.doc

REPORT FOR: CABINET

Date of Meeting:	23 May 2017
Subject:	Ofsted Report on the Inspection of services for children in need of protection, looked after children and care leavers
Key Decision:	No
Responsible Officer:	Chris Spencer, Corporate Director of People
Portfolio Holder:	Cllr Christine Robson Portfolio Holder for Children, Schools and Young People
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All
Enclosures:	Appendix 1: Ofsted Report on Harrow published 31.03.17 https://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/harrow/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf Appendix 2: Harrow Children's Post Inspection Action Plan April 2017

Section 1 – Summary and Recommendations

The attached Ofsted report follows the recent statutory Inspection of services for children in need of protection, looked after children and care leavers, with the action plan required within 70 working days.

Recommendations:

Cabinet is requested to note the inspection report and approve the action plan.

Reason: (For recommendations)

- Ofsted is the independent regulator of children's services.
- Addressing the recommendations in the inspection report is not optional.
- The Local Authority is required to provide an action plan to Ofsted within 70 working days of the published inspection report.

Section 2 – Report

Introductory paragraph

This statutory inspection of Children's Services supports delivery of the Council's vision: **Working Together to Make a Difference for Harrow**, and the Ambition Plan theme: **Protect the Most Vulnerable and Support Families**.
The related action plan identifies how the report recommendations will be implemented across Children's Services to further support children, young people and their families in Harrow achieve positive life outcomes. The People Services Directorate is ambitious to ensure that good outcomes are embedded across the whole directorate and that future activity is focussed on achieving an outstanding service.

Background

1. The previous full inspection of children's services was in May 2012, under a different Ofsted framework, with both safeguarding arrangements and services to children looked after judged to be 'Adequate overall', with some elements of Good. It is widely recognised that the current framework is a tougher test than the previous inspection framework.

2. Statutory inspection of local authority functions is carried out by Ofsted under section 136 of the Education and Inspections Act 2006.

3. Re-inspection was expected within a 3 year cycle under a revised Ofsted Framework introduced in 2013, which was expanded subsequently in to a 5 year programme. The current Ofsted inspection Framework uses a

grading system of: Inadequate; Requires Improvement; Good; Outstanding.

4. Harrow's judgement outcome as 'Good' has achieved one grade higher than previously, and demonstrates the continuing journey of improvement being achieved.

   This outcome places Harrow in the top performance quartile of local authorities nationally, while maintaining Harrow's reputation for value for money, while demonstrating value for money as evidenced by local authority comparator data which places Harrow as spending lower per child than the average of its statistical neighbours.

5. The Single Inspection Framework [SIF] inspection considers the following:
   - children who need help and protection, including early help
   - children looked after, including: adoption, fostering, the use of residential care, children who return home, and achieving permanent homes and families for children and young people
   - young people leaving care or preparing to leave care
   - management and leadership

6. During the four week inspection, up to 11 inspectors focused on a wide range of issues:
   - the experiences of children and young people
   - the thresholds for providing help, care and protection to children and young people
   - evaluating the quality and impact of the help, care and protection given to children and young people and families
   - evaluating the quality and impact of the support to young people looked after, and routes out of the care system through adoption, and statutory care leavers provision
   - evaluating the quality and impact of leadership and governance arrangements
   - meeting with children, young people, parents and their carers
   - shadowing social workers in their daily activities
   - observing a wide range of meetings, including child protection conferences and looked after children reviews

7. Inspectors looked closely at the experiences of children and young people who have needed or still need help and/or protection, as well as children and young people who are looked after and those leaving care as young adults. They tracked in the region of 200 individual cases and spoke with many social work staff, several children and young people, parents/carers, foster carers and adoptive parents and other professionals involved such as Health and Police. They considered how well the local authority knows itself and the difference being made to the life chances of vulnerable children and young people resident in Harrow.

8. The local authority is required to prepare and publish a written statement of the action it intends to take in response to the report. It should send a

copy of this statement to Ofsted at ProtectionOfChildren@ofsted.gov.uk within 70 working days of receiving the final report. [The Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007 www.legislation.gov.uk/uksi/2007/462/contents/made]

Current situation

9. Harrow's short notice full inspection of Children's Service started 16 January 2017 and completed onsite 09 February 2017. The inspection team involved 11 inspectors. Ofsted published their combined Harrow Local Authority and Local Safeguarding Children Board report 31 March 2017.

10. Harrow Local Authority was judged 'Good' overall, with services well matched to the needs of children and young people and their families in Harrow, which effectively reduced risk and improve their life outcomes. Inspectors identified strong and effective leadership having a positive impact on service design, development and delivery. Harrow was judged to know itself well, with a clear understanding of strengths and areas for development.

11. At the time of inspection, Early Support Service transformation was in progress but still at an initial phase, following an extended consultation period. Inspectors acknowledged this and recognised the strong foundations underlying the restructure and relocation to community hubs, while identifying Early Support as a priority for continuing progress.

    Early Support implementation continues to be rolled out, and during the inspection an Early Support Project Board was convened to oversee progress towards full operation from September 2017.

12. Inspectors recognised the investment made by the Council in creating additional social work posts to meet increasing demand. As a result, the report judged social work caseloads as manageable, enabling social workers to visit children regularly. Inspectors also recognised the positive impact of Harrow's 'joined-up approach' to recruitment, retention and development and the importance of a sufficient, skilled and stable workforce to drive improvement, with appropriate management time and focus.

13. Commitment to performance management and quality assurance activity was identified across the organisation, which had enabled improvements to be achieved and sustained. The proposed action plan will further embed strong performance and address areas for development identified thorough the inspection process.

    Failure to address these areas for development effectively risks future inspection adverse impact.

14. Environmental Implications:
There are no environmental impact considerations in this report.

15. Risk Management Implications
Risk included on Directorate risk register? Yes

Statutory inspections carry considerable reputational and financial risk implications for the Council. As a consequence this has been a significant element of the directorate risk register and senior management priorities. The outcome of this inspection demonstrates this was a well considered and proportionate response. The future inspection regime under the new ILACS (Inspection of Local Authority Children's Services) will continue to form a significant feature of senior manager risk management attention and corporate support across the whole council.

16. Legal Implications
This and future Ofsted inspection of Children's Services lay the regulatory foundations for meeting the statutory requirements for Harrow Council. No other specific legal implications flow from this inspection & report to Cabinet.

17. Financial Implications
The risk of failing an Ofsted inspection is recognised to have considerable financial implications to the council. However, this inspection found all statutory requirements were met in full and the judgement on the Local Authority delivery of children's services was 'Good'. There are no additional implications arising from this inspection, as detailed in the published report.

18. Equalities implications / Public Sector Equality Duty
This report sets out the actions we are taking to secure further improvements, which when achieved will have a positive impact on all residents in Harrow.

18. Council Priorities
This statutory inspection of Children's Services and the related action plan support delivery of the Council's vision:

Working Together to Make a Difference for Harrow
and meets the Ambition Plan theme:
Protect the Most Vulnerable and Support Families.

Section 3 - Statutory Officer Clearance

Name: Jo Frost Date: 11 April 2017	x	on behalf of the Chief Financial Officer
Name: Sarah Wilson Date: 07 April 2017	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO, as it impacts on all Wards**.
EqIA carried out: **EqIA cleared by:**	**NO** No new or changed policy or service Not applicable

Section 4 - Contact Details and Background Papers

Contact: **Paul Hewitt**
Divisional Director, Children and Young People Services
Paul.hewitt@harrow.gov.uk, 020 8736 6978

Background Papers:

- Ofsted Framework and Evaluation Schedule: children in need of help and protection and care leavers and Local Safeguarding Children Boards [Feb 2017]
  NOTE: Aug 2016 was the current edition at the inspection.
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590899/Framework_and_evaluation_schedule_-_Inspection_of_local_authority_children_s_services.doc

Call-In Waived by the Chair of Overview and Scrutiny Committee	**NOT APPLICABLE** *[Call-in applies]*

London Borough of Harrow

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection dates: 16 January 2017 to 9 February 2017

Report published: 31 March 2017

Children's services in Harrow are good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Good

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children in Harrow receive services that are well matched to their needs, reduce risk and improve their outcomes. This is because senior leaders and elected members provide strong and effective leadership, which has a positive impact on the way that services are designed, developed and delivered. The director of children's services, divisional director and chief executive have a clear understanding of both strengths and areas for development. They make good use of performance information and learning from audits to address shortfalls and raise standards, for example in their ongoing focus on improving the functioning of the multi-agency safeguarding hub (MASH). They recognise that greater use of feedback from children is needed to strengthen audits further. The local authority's overview and scrutiny panel lacks sufficient focus on children and is not consistently effective.

Social workers see children regularly. They use good direct work to come to know them well and build relationships of trust with them. This helps to improve the outcomes that children achieve. Social workers are able to do this because they have manageable caseloads. A strong focus on, and investment in, recruiting sufficient social workers makes this possible. This is also having a positive impact on reducing both a reliance on agency staff and the staff turnover. The professional development of social workers is supported by a well-planned and resourced training offer.

When children are referred to the local authority with a presenting risk of significant harm, action is quickly taken to ensure their safety. Thresholds are well understood and consistently applied. When children's level of need is lower, the MASH does not always handle these referrals as quickly as it should. While inspectors did not see any examples of children suffering harm as a result of this, some children do experience delay in receiving further assessment and services. Child protection strategy discussions take place promptly, but do not routinely involve key agencies beyond the police and local authority. There are a number of well-established and effective targeted early-help services to support children in Harrow. However, the number of children with additional needs who could benefit from an assessment and coordinated early-help response and are receiving one are low. The local authority is aware of this. The steps that it has taken to restructure and relocate its early-help services into community hubs, such as youth centres and children's centres, are well considered, but are at too early a stage to have had an impact.

Services for children and young people who go missing and those at risk of sexual exploitation are good and improving. Help and protection is effective and well coordinated for these children and young people. There is an effective structure of both strategic and operational meetings to develop services and track performance, and to monitor and intervene in the cases of individual children. A specialist team, includinga child sexual exploitation coordinator, missing person's worker and gang worker, helps to ensure a focused and joined-up service for children. This work, in common with that to tackle female genital mutilation and radicalisation, is well integrated into broader safeguarding work. Disabled children receive a good service that considers their needs and manages transitions to adult services effectively.

Assessments of children’s circumstances are almost all completed to a timescale that matches the seriousness and urgency of their needs, and identifies key-risk and protective factors. However, assessments for children in need and those on child protection plans are not always updated to reflect children’s current circumstances and some assessments lack sufficient analysis, for example in consideration of culture and ethnicity. This makes it more difficult to ensure that plans reflect children’s current circumstances and can be used to drive and measure progress.

Decisions for children to become looked after are made quickly and in their best interests. Children only become looked after when it is absolutely necessary. When legal proceedings are needed to secure their safety, assessments and support to children and their families are good and the progress swift. When the plan is for children to return home, most do so successfully. However, a few experience delay and a lack of clarity in the delivery of services to support their return home.

Children looked after receive a good service from social workers, who have high aspirations for them. Social workers help young children to understand difficult and complicated decisions about their lives, and demonstrate a real commitment to engaging young people who have ongoing high-risk behaviours. Children participate well in their reviews, and this means that plans and decisions are rooted in their wishes and feelings. In a few cases, social workers and independent reviewing officers (IROs) need to be better prepared for reviews and make sure that agreed actions are always tracked between review meetings. The health needs of children looked after, including those living outside the borough, are generally well considered, with very timely initial and review health assessments. However, some children do not receive therapeutic or emotional health services quickly enough.

When children cannot return to their birth families, new permanent homes are found as quickly as possible. Social workers pay close attention to getting this right for older children, disabled children, children from particular ethnic groups, and those with brothers and sisters. Children needing a range of possible alternative permanent families benefit from early parallel planning, careful matching with carers or adopters and good support plans. Adoption work is very strong. Children’s arrangements are secure, and placement and adoption breakdowns are rare.

A large majority of care leavers receive good support that helps them to achieve well in their education and career aspirations, and in developing the skills that they need to live independently. Many achieve well and make a successful transition to adulthood. However, for a small minority there are delays in providing the support that they need in key areas, such as their emotional well-being, education, employment and training.

Children looked after and care leavers have a good understanding of their entitlements. They also receive helpful and clear information about advocacy and the independent visitors scheme. Alongside unaccompanied asylum-seeking children, they benefit from an impressive range of creative and innovative participation and engagement opportunities and an active Children in Care Council, ‘Beyond limits’.

Contents

Executive summary 2

The local authority 5

Information about this local authority area 5

Recommendations 8

Summary for children and young people 9

The experiences and progress of children who need help and protection 10

The experiences and progress of children looked after and achieving permanence 16

Leadership, management and governance 27

The Local Safeguarding Children Board (LSCB) 33

Executive summary 33

Recommendations 34

Inspection findings – the Local Safeguarding Children Board 34

Information about this inspection 40

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one short-break children's residential home. It was judged to be outstanding at its most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in May 2012. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was in May 2012. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since March 2014.
- The DCS is also responsible for adult services and public health services.
- The chief executive has been in post since November 2014.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since December 2016.

Children living in this area

- Approximately 57,000 children and young people under the age of 18 years live in Harrow. This is 23% of the total population in the area.
- Approximately 15% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 9% (the national average is 15%)
  - in secondary schools is 12% (the national average is 13%).
- Children and young people from minority ethnic groups account for 69% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Indian and other Asian.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 66% (the national average is 20%)
  - in secondary schools is 60% (the national average is 16%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- 87% of the school population is classified as belonging to an ethnic group other than White British. The top five most recorded community languages spoken in the borough are English, Gujarati, Tamil, Romanian and Arabic.

Child protection in this area

- At 31 December 2016, 1,753 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,827 at 31 March 2016.
- At 31 December 2016, 228 children and young people were the subject of a child protection plan (a rate of 40 per 10,000 children). This is an increase from 195 (34 per 10,000 children) at 31 March 2016.
- At 31 March 2016, six children lived in a privately arranged fostering placement. This is a small increase from a low number at 31 March 2015.
- In the two years before inspection, three serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed.
- No serious case reviews are currently ongoing.

Children looked after in this area

- At 31 December 2016, 200 children were being looked after by the local authority (a rate of 35 per 10,000 children). This is an increase from 180 (32 per 10,000 children) at 31 March 2016. Of this number:
  - 68 (34%) live outside the local authority area
  - 17 live in residential children's homes, all of whom live out of the authority area
  - a very small number live in residential special schools[3] which are out of the authority area
  - 136 live with foster families, of whom 36% live out of the authority area
  - a very small number live with their parents in the authority area
  - 23 children are unaccompanied asylum-seeking children.
- In the past 12 months:
  - there have been nine adoptions
  - 18 children became the subject of special guardianship orders
  - 144 children ceased to be looked after, of whom 6% subsequently returned to be looked after
  - 16 children and young people ceased to be looked after and moved on to independent living

[3] These are residential special schools that look after children for 295 days or less per year.

- 53 children and young people ceased to be looked after and are now living in houses in multiple occupation. In all cases, providers who specialise in accommodation for young people supply this accommodation, and appropriate on-site or floating support is provided.

Recommendations

1. Ensure that all children and families who need an early-help assessment and a package of support coordinated by a lead professional are able to receive these.

2. Ensure that decision making within the multi-agency safeguarding hub is consistently timely, so that all children who are the subject of a referral receive assessment and support in a timely manner.

3. Ensure that assessments and plans are consistently up to date, reflective of children's views and clear about what is expected of families.

4. Ensure that strategy discussions involve the full range of relevant agencies, so that the full range of relevant information informs the assessment of risk.

5. Ensure that children looked after receive timely therapeutic support when they need it.

6. Improve the quality of plans when children return to their families from care, so that there is clarity about what services will be provided, who will provide them, by when and what they are aimed at achieving.

7. Ensure that professionals consistently implement actions required between review meetings for children looked after.

8. Ensure that the good support experienced by the vast majority of care leavers is extended to all care leavers, so that their needs are better met.

9. Strengthen the quality of learning from audits through better involvement and use of feedback from children and their families.

10. Improve the functioning of the overview and scrutiny panel to ensure that it is more sharply focused on children and that its work has an impact on improving both services for children and the outcomes that they achieve.

Summary for children and young people

- Services for children and young people in Harrow are good. Most children and young people have the support that they need when they need it.
- Social workers work hard to make sure that children and young people are safe. They visit children regularly and come to know them well. This helps them to know what type of support will be most helpful. There are plenty of different services that give good support to children and their families to help them to overcome their difficulties.
- There are some parts of the service that could do better. Managers and council leaders recognise this and are determined to improve services for children and families. Overall, they are doing a good job.
- When children are at immediate risk, social workers and other adults, such as police officers and teachers, work together well. They act quickly to protect children.
- Good support is provided to help to keep children and young people safe when they have been at risk of sexual exploitation or going missing, or have become involved with gangs.
- Sometimes, when children need help but are not at immediate risk, they do not have the assessments or help that they need quite as quickly as they could. The council knows this and is working hard to do better.
- Plans about how to make things better for children are not always as clear as they could be. It is important that everybody understands what has to change and what they are expected to do.
- Social workers work hard to find the right place for children to live if they cannot live with their own families. They want children looked after to be happy, to do well at school and to make successful moves into adulthood. They try hard to do this and to make sure that children's experiences of being looked after are positive.
- Foster carers and adopters are very positive about the support that they receive to help to make sure that children and young people are settled in their homes. Social workers pay good attention to things that may help children to settle in, like the religion of foster carers, the languages they speak and how near they live to children's schools.
- Young people leaving care receive a good service. Staff keep in touch with them and provide support to help them to keep healthy and be happy with where they live, and in education, training or a job. There is good support for those young people who choose to go to college or university, and they have practical and financial support to help them to succeed.
- There is a good range of different types of places to live that are available for young people who are ready to leave care. They have good help in learning how to live independently and manage their own lives.

The experiences and progress of children who need help and protection	Requires improvement

Summary

When children in Harrow are at risk of significant harm, the local authority acts quickly and effectively to address their needs and reduce risk. The multi-agency safeguarding hub provides an effective single point of contact that transfers child protection concerns promptly to the first response team (FRT) for assessment and intervention. Thresholds are well understood and are consistently applied. The vast majority of strategy discussions are timely, but rarely involve agencies other than the police and children's social care. This limited involvement from other key agencies, such as health, means that decisions are not always informed by the full range of relevant information available.

Children with lower levels of need do not routinely receive such a prompt response. Most decisions to transfer children's cases to the FRT for a child in need assessment or to early-help services take longer than 24 hours. This means that some children do not have their needs assessed or receive services as quickly as they could. Performance management systems in the multi-agency safeguarding hub do not provide enough information to accurately track the progress of children's cases to ensure the timeliness of assessments and service provision.

There are a number of well-established and effective targeted early-help services to support children in Harrow. However, the number of children with additional needs who could benefit from an assessment and a coordinated early-help response from the local authority and partner agencies, and who are receiving one, are low. At the time of the inspection, a substantial redesign and reorganisation of these services were in the process of implementation, but were at too early a stage to have had an impact.

Social workers see children regularly and know them well. Good direct work with children is used to gain an understanding of their wishes and feelings. This is a real strength of the service. This good knowledge of children's wishes and feelings is not always fully reflected in written assessments. Although assessments identify risk factors and strengths, some lack sufficient depth and analysis, for example in the consideration of culture and ethnicity. Some assessments do not accurately identify all concerns or take enough account of historic factors. Plans, following assessment, are of variable quality. Poorer examples are not always sufficiently specific or clear about the outcomes that they aim to achieve, or about what is expected of families. This makes it more difficult to use plans to drive and measure progress.

Work to protect children and young people from the risks associated with going missing, sexual exploitation and related concerns, such as gang affiliation, is good

and improving. Most children and young people receive a service that is well coordinated between agencies and reduces risk.

Inspection findings

11. The local authority acts quickly and effectively to protect children when they are at risk of significant harm. The multi-agency safeguarding hub (MASH) provides an effective single point of contact that transfers child protection concerns promptly to the first response team (FRT). This team holds strategy discussions and undertakes child protection enquiries when this is appropriate. Thresholds of need are well understood and consistently applied. However, children with lower levels of need do not always receive such a prompt response. Decisions to transfer children's cases to the FRT for a child in need assessment or to early-help service are appropriate, but most take longer than 24 hours. This means that some children do not have their needs fully assessed or receive services as quickly as they could. Delays in progressing referrals promptly are a long-standing concern identified by the Local Safeguarding Children Board (LSCB) case audits. Progress in improving this deficit is hampered by the existing performance systems in the MASH, as these do not give managers full or timely information to track the progress of children's cases accurately. (Recommendation)

12. Out of office hours, the emergency duty team provides an effective social work service. Timely and well-considered responses by this team ensure that children are kept safe. Effective on-call and management arrangements ensure that additional staffing can quickly be put in place to manage times of increased demand. Good communication with daytime teams ensures that children are quickly linked to services that match their needs.

13. Social workers visit children regularly and know them well. This means that children and their parents can build relationships of trust with social workers. This enables social workers to have a more accurate understanding of children's needs and to focus help appropriately, leading to improved outcomes for most children. Social workers have a strong focus on children, whose wishes and feelings are captured well through good direct work, observation and engagement in the majority of work with families. Children are sometimes taken out of lessons to facilitate direct work, despite feedback from children that they do not like it and that it has a negative impact on their relationships with friends and classmates. While there will be occasions on which this practice is unfortunately unavoidable, as standard practice it is unacceptable.

14. The number of children with additional needs who could benefit from an assessment and coordinated early-help response from the local authority and partner agencies and who are receiving this is low. It is of concern that no partner agencies, such as health organisations or schools, are undertaking the role of lead professional following those common assessment framework assessments that have been completed. Although early intervention workers

are quickly allocated to families and do undertake some good work, most assessments seen by inspectors were poor. Consequently, much early-help work lacks focus or a clear benchmark against which to measure progress. This means that help to some children and their families is not as effective as it could be. (Recommendation)

15. The local authority has carried out a detailed review of early-help services and is aware of these areas for development. At the time of the inspection, a substantial redesign and reorganisation of these services was in the process of implementation. The steps that the local authority has taken to restructure and relocate its early-help services into community hubs, such as youth centres and children's centres, are well considered, but at too early a stage to have had a measurable impact.

16. Although early-help services to children with multiple or more complex additional needs are not consistently well coordinated, the local authority does provide a number of well-established and successfully targeted early-help services. These include a domestic abuse group work programme for victims and their children, direct work with young people who are involved with gangs, and a volunteering scheme which increases young people's skills and confidence and enables them to mentor other young people. These services complement a strong children's centres offer and are leading to improved outcomes for children.

17. The threshold between children who could benefit from early-help services and those who need a statutory social work response is well understood and applied. This is also the case for the threshold between children who are in need and those at risk of significant harm who require a child protection response. However, the rationale for decision making is not always recorded clearly enough, particularly when strategy discussions lead to a decision not to proceed with child protection enquiries. Child protection strategy discussions are timely, but rarely involve agencies other than the police and the local authority. This limited involvement from other key agencies, such as health, means that decisions are not always informed by the full range of relevant information available. (Recommendation)

18. The quality of assessments is not consistently good. Although assessments routinely identify risk factors and strengths, many lack sufficient breadth of consideration and depth of analysis, for example in their consideration of the important role that culture and religion can play in children's sense of identity and belonging. Some do not accurately identify all concerns or take full account of historic factors. Chronologies are not consistently used to understand children's stories and the impact of patterns of risk. Although there is a new chronology template to support improved practice in this area, it is too new to have had an impact on all children's cases. (Recommendation)

19. While social workers have a strong focus on listening to children and understanding their wishes and feelings through strong direct work,

observation and engagement, messages from children do not always inform assessments and plans directly enough. When assessments are commissioned for children recently referred to the local authority, a sharp focus on timeliness is ensuring that almost all assessments are completed to a timescale that matches the seriousness and urgency of their needs. However, assessments for children in need and those on child protection plans are not always updated and so, in some cases, do not reflect children's current circumstances. This, in turn, means that plans do not always reflect their current needs. Plans are not always clear and specific enough. The outcomes that they are aimed at achieving are not always defined clearly enough, nor is it always clear what is expected of families. Most plans do not include contingency arrangements. (Recommendation)

20. Child in need meetings and child protection core groups are almost always held regularly, but discussions in these meetings do not always focus on agreed actions. As a consequence, plans are not used as well as they could be to either drive or measure progress. Good agency attendance at these meetings and social workers' sound knowledge of the families that they are working with help to limit the impact of these areas of weakness and ensure that, for most children, the involvement of the local authority in their lives is leading to improved outcomes.

21. Child protection conferences are well chaired. Although they are child centred and sensitive to families, they keep an appropriate focus on risk. Children have access to support from an advocate to attend these meetings, and inspectors saw evidence of this service being used to good effect. While the local authority has a systemic approach to monitoring children's attendance and engagement in conferences, it recognises that there are some children who are not benefiting from being as involved in their conferences as they could be. Child protection chairs add value, because of their ability to offer independent advice and improve practice. Multi-agency engagement in child protection conferences is a strength. When there has been poor attendance by any particular agency, this has been identified and escalated by chairs, leading to improved attendance.

22. Children in need and subject to child protection plans receive effective help from a range of targeted support services. Multi-agency engagement is strong and services work well together, particularly when responding to the impact on children of domestic abuse, drug and alcohol misuse and parental mental il health. Pre-birth assessments of babies who may go on to be in need or at risk after they are born are good. This was an area for priority action identified at the time of Ofsted's last inspection, and continued to be an issue of concern identified by the 'Baby F' serious case review published in 2015. A sharpenedfocus on this work and the introduction of a pre-birth assessment toolkit have supported improved inter-agency communication, particularly with midwifery, and timelier and clearer assessments for these babies. A well-used 'neglect toolkit' has had a similar positive impact on improving the identification of risk when it stems from a chronic pattern of concern.

23. When children are at risk through living in homes where there is domestic abuse, drug or alcohol misuse or parental mental ill health, meetings designed to coordinate support services work well. The multi-agency public protection arrangements and multi-agency risk assessment conferences (MARAC) share information and coordinate services effectively. Good information sharing and engagement in the MARAC process by social workers is successfully reducing the risks to which children are exposed. Discussion between agencies at MARAC achieves tangible improvements to the lives of children who are exposed to domestic abuse.

24. Work to identify and to protect children and young people from the risk of sexual exploitation is good and improving. Most children and young people receive a service that is well coordinated between agencies, identifies the harm that they have suffered or are at risk of suffering and reduces risk. The multi-agency sexual exploitation panel is effective. A risk assessment tool is routinely well used to assess risks when they first come to light, but is not yet consistently used to reassess risk. This means that social workers are not always absolutely clear about how successful the actions taken have been in reducing risk. A specialist team, including a child sexual exploitation coordinator, a missing person's worker and a gangs worker, is important in ensuring a joined-up approach to these closely related areas of risk, and has been central to the improvements that have been achieved in the past six months, particularly with regard to the timeliness of return home interviews.

25. A children at risk meeting, chaired by the divisional director of children and young people services, is used effectively to track the circumstances and progress of those children who are currently missing or who have been missing in the previous week. Strategy meetings are held appropriately when risks escalate. Although over two thirds of children and young people receive a return home interview within 72 hours of being found, this means that nearly a third are waiting too long to have the opportunity for an interview. Copies of return home interviews are included in children's and young people's electronic case files, but the information that they contain is not used consistently enough to inform planning about how to keep them safe or to reduce the likelihood of them going missing again.

26. Effective work is undertaken to identify and track children missing education. An up-to-date list of children missing education is maintained by the children missing education officer. The children missing education policy and procedures provide clear guidance to professionals. Information sharing within the local authority and partners is effective. Staff have a sound overview of the welfare of children who are electively home educated. Good liaison with families and information sharing with schools, families and other services has contributed to a decrease in the number of families who are choosing home education when it may not be in the individual best interests of their children.

27. Disabled children receive a good service in Harrow. Experienced social workers consider the full range of children's needs, whether these relate to disability or

their broader welfare concerns. Transitions to adult services are well managed. When there are child protection concerns, these are addressed promptly and effectively.

28. Social workers in Harrow know their communities well. They make good use of interpreters when this is necessary, and have an understanding of the complex dynamics when there are concerns about abuse or neglect in a particular cultural context. This is apparent in a clear, effective and well-joined-up approach to the issue of female genital mutilation, in links with community resources such as an Asian women's resource centre and in positive work with families who have no recourse to public funds.

29. Work to tackle the risks to children and young people from radicalisation through Harrow's 'Prevent' partnership is well established. Counter-radicalisation work with children and young people is aligned with wider child protection, child in need and early-help work, so that children benefit from a broad consideration of their needs and a joined-up approach to meeting them. Awareness-raising and engagement work has successfully increased the understanding by professionals and the local community. An integrated response to children at risk of radicalisation, gang affiliation, going missing and child sexual exploitation has resulted in a stronger and more effective approach. Harrow's gangs worker operates at both a strategic and operational level, and his work is valued by young people. The carefully designed gangs direct work programme ensures that young people have the opportunity to think about their gang affiliations, to share their worries and fears in a safe environment, and to work towards making choices that will help to keep them safer. Young people value the individualised approach provided by the Harrow gangs worker.

The experiences and progress of children looked after and achieving permanence	Good

Summary

When children need to be looked after in Harrow, the response is swift and child centred. Children only become looked after when this is necessary and in their best interests. Social workers visit children looked after regularly, know them well and build strong relationships with them. They have high aspirations for them. Children receive a good service, and timely and effective decisions are made so that they move to permanent homes as quickly as possible. Social workers demonstrate a proactive approach and work hard to secure homes for children with brothers and sisters, older children and disabled children. When legal proceedings are necessary to secure children's safety, assessments and support to children and their families are timely and appropriate. When the plan is for children to return home, most do so successfully. However, a few children experience delay and a lack of clarity in the delivery of services to support their return home.

Good participation and engagement by children means that their views are used well to inform planning and decisions made about their care plans. Reviews are regular and are held within appropriate timescales. Improvements are needed in some children's reviews, including better organisation and preparation by social workers and independent reviewing officers. Actions are not always progressed quickly enough between review meetings, causing delays in care planning for a few children. An effective and committed children looked after health service is improving health outcomes for children, including significant progress in the timeliness of initial and review health assessments. However, some children do not receive appropriate therapeutic and emotional health support services quickly enough. Children looked after benefit from an impressive range of creative and innovative participation and engagement opportunities, and an active Children in Care Council, 'Beyond limits'.

Children needing a range of alternative permanent families benefit from early parallel planning, careful matching with carers and adopters, and good support plans. Adoption work is very strong. Children's arrangements are secure, and placement and adoption breakdowns are rare. 'Together or apart' assessments are mostly good, but some variation in the depth of analysis and the clarity with which children's voices are recorded means that they do not always add the value that they could to the decision-making process.

A large majority of care leavers receive good support that helps them to achieve well in their education and career aspirations, and in developing the skills that they need to live independently. Many achieve well and make a successful transition to adulthood. However, for a small minority, there are delays in providing support in key areas, such as their emotional well-being, education, employment and training.

Inspection findings

30. When children need to be looked after in Harrow, the response is swift and child-centred. When legal proceedings are necessary to secure children's safety, assessments and support to children and their families are timely and appropriate. Permanence, including through return to birth families, is considered at the earliest opportunity. Children are not looked after unnecessarily.

31. The Public Law Outline (PLO) process is used well to ensure that there is no drift or delay in planning for children, either within court proceedings or at the pre-proceedings stage. Regular management oversight and tracking systems help to prevent drift for children needing permanence. When delays are identified, reasons for this are clearly recorded in children's case files, and actions are quickly agreed and implemented to address them. Pre-proceedings letters are of high quality, so families understand exactly what is expected of them. They are encouraged to seek legal advice and are helped to access interpreting and translation support services, when needed. When children do need to be the subject of care proceedings, the local authority ensures that these are completed quickly to avoid delay and uncertainty for children.

32. The majority of children who return home do so successfully, with low numbers of children experiencing a subsequent looked-after episode. Appropriate decisions are made when children do need to become looked after for a second time or when their circumstances change. For some children returning home, there is a delay in the provision of the appropriate support services needed to reduce continued disruption to children's lives. Plans in place to support children who have returned home need to be implemented more quickly. Support for children on the edge of care is not consistently well targeted, coordinated or monitored. The local authority is aware of this deficit, but the plans to improve services through a 'reunification local offer' are at too early a stage to have had an impact on improving practice. (Recommendation)

33. The Children and Family Court Advisory and Support Service and social work teams, including the emergency duty service and independent reviewing officers (IROs), link together at an early stage to share information and consider viable permanence options for children. Strong professional relationships and the sharing of key information about risks to children support effective communication between partners and early identification of children's needs. This continues for children whose journey to permanence is through the PLO process. Low numbers of emergency and urgent care applications are indicative of good planning for children and early anticipation of their needs.

34. There is a strong commitment and expectation in Harrow that children live with their extended family and with their brothers and sisters when it is safe

and appropriate for them to do so. This is demonstrated by the 15% who left care due to special guardianship orders (SGOs) made during 2015–16, ensuring that children achieve early permanence while continuing to live with their families. There is a wide range of service provision and extensive support available to families undergoing SGO assessments. This includes effective use of family group conferences in identifying viable options for where children will live. Direct work with children prepares them well for permanent moves to special guardians, long-term foster carers or adopters.

35. Social workers develop strong, open relationships with children and their families, and have a good understanding of children's individual needs. Cultural heritage is well considered. Social workers know children well and talk about them positively, including those who find engagement difficult and experience challenges in managing their behaviour. Visits to see children are regular, and children are mostly seen alone. Inspectors saw evidence that social workers help young children to understand difficult and complicated decisions about their lives and demonstrate a real commitment to engaging older young people who have ongoing high-risk behaviours. Children told inspectors: 'my social worker is very helpful', 'she tells me what's going on' and 'my social worker helped me to stay with my gran.'

36. Assessments to decide applicants' suitability for fostering roles are almost always comprehensive, with careful analysis of issues relating to their life experiences, ethnicity, faith and values. For a small number of carers, discussion at fostering panel could be more searching about how their personal values may affect them in their fostering role. Supervising social workers visit foster carers regularly and record detailed discussions. Areas for development are explored alongside warm and positive feedback about the difference that carers have made for children. During these visits, fostering social workers explore missing from home incidents and check whether all important meetings and assessments have happened, such as personal education plans (PEPs) and health reviews. This supports children's progress. Foster carers' annual reviews are timely, clear and help them to reflect on their practice and develop their skills.

37. Foster carers told inspectors that, overall, they appreciate the quality of the training and support that they receive, including the advice and involvement of a play therapist. They say that they are well supported by the managers in the fostering service. One foster carer said, 'They definitely make you feel valued' and another 'They recognise that we have a challenging job and stand shoulder to shoulder with us, treating us like fellow professionals.' Some expressed frustration about too many changes in fostering and children's social workers, saying that this is unsettling for them and for the children in their care. They reported that they cannot always get through to social workers on the phone.

38. Children are generally well matched with foster carers, including in relation to cultural and ethnic factors. This is true for both short- and long-term foster

care arrangements. When this is not possible, consideration is given to the emotional impact and risks to children of moving to an alternative home. Decisions are made in children's best interests. Workers are proactive in their approaches to foster carers and, as a result, children with care plans for long-term fostering secure permanence quickly, reducing disruption and enabling them to maintain close relationships with carers.

39. An appropriate range of recruitment activity for foster carers takes place, including high-quality features in local publications with diverse and inclusive images. Despite this, the local authority has not met its own targets for the recruitment of foster carers. Eleven new carers have been approved since April 2016, but this is still seven short of the ambitious target set by the local authority. The local authority commissions placements from a range of independent providers to ensure that, despite this shortfall, it has a sufficient range of placements for children and young people. Short-term placement stability is in line with similar authorities, while long-term stability, although improving, continues to fluctuate and remains a challenge for the local authority. A small number of children continue to experience a high number of moves. For these children, the local authority has taken appropriate steps to find alternative homes that can best meet their highly complex needs. This particular sufficiency challenge is being addressed through a range of provision, both 'in-house' and commissioned through an independent framework agreement across the West London Alliance. A recent rise in the number of children living in foster homes is positive, but has not led to any reduction in the local authority's use of residential children's homes for teenagers with complex needs.

40. Strategy meetings held to plan responses to children and young people who go missing from care, and those who are at risk of sexual exploitation, are timely and are supported by good information sharing from partner agencies. This is helping to keep children and young people safe. The great majority of children receive timely return home interviews. While intelligence gathered is used to inform some children's risk assessments and decisions about where it is safe for them to live, the cumulative impact of repeat incidents is not always well understood or analysed to help to keep children safe. Workers and carers do make consistent attempts to engage with young people so that support plans can be progressed.

41. All children looked after attend registered provision, with a small number in alternative provision or missing education. While the majority of children and young people attend school regularly, a high proportion of children looked after have been persistently absent from school. Although this number has reduced recently, action to return children to education swiftly is not always effective, and a small minority of children continue to remain out of education for too long.

42. Managers have accurately identified the key improvements needed to better support the attainment and progress of children looked after. As a result, the

virtual school is taking steps to improve outcomes for children, and these are beginning to make a difference to them. The virtual school monitors the attendance and progress of children regularly. This enhances the oversight of those who experience disruption to their learning and those at risk of not achieving, including those children who are placed out of the area. This results in targeted actions that better support those children who are at risk of not succeeding. Often the virtual school team acts as an effective advocate for children and young people, and is persistent in offering support to them when they experience problems at school or at home.

43. The virtual school team has made good progress in improving the proportion of children with up-to-date PEPs, and staff have a good understanding of when further improvements are needed. Staff are working hard with schools and social workers to improve the quality of PEPs. However, too many PEPs are not fully completed. When this is the case, important information is missing, such as children's views and details of how the pupil premium grant is being used to address the specific needs of individual children.

44. Children looked after achieve at around the national rate for children looked after at key stages 1 and 2. Historically, attainment at key stage 4 has been comparatively poor, but, as a result of better targeting of practical support to pupils in key stage 4 last year, the attainment of these pupils improved to the national rate for children looked after. Data shows that this year, as a result of improved support, a greater proportion of pupils are on track to achieve well at key stage 4. However, the gap between the attainment of children looked after and their peers remains wide. The good support provided to young people by schools, the virtual school and partners ensures that a high proportion of young people, many of whom have few qualifications, remain in education, employment and training when they complete Year 11 through to Year 13.

45. Children's health needs receive significant oversight and monitoring from the children looked after health service and, as a result, their health outcomes continue to improve. Strong relationships between the service, social work teams and partners, complemented by effective tracking systems, help with effective communication and information sharing. As a consequence, children's health needs are identified quickly, and timescales for initial and review health assessments are improving rapidly. Children's involvement in and feedback of their experience are pivotal to this recent success and have helped to inform improvements to the service. A sharp focus on improving the completion rate of strengths and difficulties questionnaires by children looked after has seen the rate rise from only 41% during 2015–16 to 75% at the end of December 2016. This is positive, although further work is required to meet the 81% average figure for similar local authorities.

46. The health needs of children placed out of the local authority area are actively monitored. The children looked after health nurse challenges any delays effectively to ensure that children receive a timely service. A small number of

children were seen by inspectors to experience delays in receiving timely therapeutic support. Children needing specialist support from the child and adolescent mental health services often have to wait for help. This is also reported by children's foster carers. (Recommendation)

47. Children benefit from an impressive range of creative and innovative participation and engagement opportunities. All children receive information about advocacy, the independent visitors scheme and their entitlements from the children's pledge. Workers show a continuous commitment to attending engagement activities that help to gain children's views and wishes. Workers have high aspirations for children and support them to try new experiences to develop their social, emotional and educational skills. Engagement activity includes unaccompanied asylum-seeking children and those who may not want to be actively involved in Harrow's very active Children in Care Council, 'Beyond limits'. A number of annual activities are arranged specifically to encourage the participation of children living outside of the local authority. The local authority does well in engaging local businesses and sports clubs to provide both work and wider social opportunities for children looked after. For example, the local authority involved Queens Park Rangers football club in a recent football development activity for children looked after.

48. Children benefit from regular, timely reviews, and have an opportunity to meet with their IRO prior to meetings. If children do not attend, their views and wishes are represented in a variety of formats and are used to inform appropriate decisions. When instability or significant changes occur in children's lives, reviews are brought forward to make appropriate changes to their care plans. The IRO service is generally effective in identifying and challenging delays to ensure that children receive the right help. However, foster carers did share some frustrations with inspectors about a lack of consistency. These include some actions not being followed up between reviews, leading to delays in support for children, and that IROs and children's social workers are, on occasion, insufficiently prepared for meetings (Recommendation).

49. Sixteen- and 17-year-olds who are homeless or in danger of homelessness are quickly and accurately assessed to decide whether they should become looked after by the local authority or if it is more appropriate to provide support in other ways. These young people are provided with support and accommodation that meets their needs. Bed and breakfast accommodation is not used, and careful attention is paid to their vulnerabilities.

The graded judgement for adoption performance is that it is good

50. In Harrow, all children are considered for adoption when they are unable to live within their birth family. Careful matching and good post-adoption support

have resulted in no children experiencing an adoption breakdown in recent years.

51. A combination of a drop in the number of placement orders being granted and decisions being moved away from adoption has led to a reduction in the number of children leaving care to be adopted, in Harrow. This has fallen from 10 children in 2015–16 to a projected six children being adopted by the end of March 2017. There are currently four children in adoptive families. Harrow has a lower rate of children looked after than similar areas, and fewer children in care aged under 10 years. Decisions which have been changed away from adoption are typically due to the availability of wider family members to care permanently for children. The number of children leaving care for special guardianship arrangements went up to 15% in 2015–16, with a similar rise seen in recent in-year figures. Evidence shows that this resulted in good outcomes for children, and disruptions to special guardianship arrangements are rare in Harrow. Therefore, the current rates of adoption appear appropriate in the context of the wider children looked after population.

52. Children's journeys to adoption are very timely for almost all children, with performance against national thresholds being well above the average in England. Local in-year data shows a very slight slowing down of performance, but it is still very timely for children. Managers know individual children well and can account for delays in a small number of complex cases.

53. Children's progress is closely monitored to avoid any unnecessary delay. Regular permanence planning meetings and legal planning meetings are attended by the adoption manager. A tracking manager is partly based with 'front-door' social work teams to ensure that all social workers 'think permanence' at the earliest opportunity. As a result, early parallel planning is well embedded and is particularly effective in securing adoption for very young children, allowing secure attachments to be made. Early family finding ahead of a placement order being granted means that some children can, at the appropriate point, move quickly to prospective adopters. However, this is slowed down for a few children by avoidable external causes, such as delays in police checks. In a very small number of cases, children's adoption could have been secured even sooner.

54. Children's permanence records are of a good standard. Social workers prepare life-story books for children. These give extensive information about their birth family and journey to their new family. Later-life letters are well written, giving young people a sensitive but straightforward account of their life story. However, social workers currently make limited use of learning from research. The profile of children being adopted, although small in number, has become more ethnically diverse than in previous years and there have been recent adoptions of children with disabilities and groups of brothers and sisters. 'Together or apart' assessments are mostly of a high standard. Variations in the depth of analysis and the clarity with which children's voices are recorded

mean that a minority do not add the full value that they could to the decision-making process.

55. Decisions made by the agency decision maker (ADM) are timely and detail a clear rationale for plans for adoption. The combined fostering and adoption panel is constituted of highly experienced and committed individuals who reflect the range and diversity of Harrow’s community. Regular feedback to social workers has contributed to improvement in the quality of reports coming to panel. Feedback from adopters who have attended the panel is positive. Adopters value the face-to-face meeting with the panel’s medical adviser, because it helps them to understand the current and future health needs of their child. However, links between the ADM and the panel chair have been limited, to date, and managers have already recognised this as an area for improvement.

56. Harrow’s partnership arrangement with a voluntary adoption agency (VAA) gives access to a broad range of approved adopters across the country, as well as the national adoption register and local consortia. A diverse range of adopters have been matched to children, including single parents and same-sex couples. Children are carefully matched and many benefit from being adopted by families that reflect their own culture and ethnicity. Prospective adopter records completed by the VAA are very detailed, and reflect a thorough assessment process and clear analysis of the parenting capacity of the applicants.

57. Adopters are positive about their experiences of the assessment process, and preparation days have helped them to relate to their child’s experience and the experience of the birth family. They receive detailed information about their child and value the support from social workers. As one said, ‘Nothing is too much trouble.’

58. There has been just one foster for adoption placement, to date, in Harrow. However, foster for adoption and concurrent care are discussed with all prospective adopters during assessment and are promoted during preparation. A number of concurrent placements have meant that very young children have a minimal number of placement moves and attach at an early stage to their prospective adopters. Children are well prepared for moving in with their adoptive families. Foster carers are highly skilled in preparing children for adoption, and have completed specialist training.

59. Adoption support plans are sensitive and detailed. Contact arrangements are carefully considered for children moving to adoption, and a letterbox contact coordinator works within the adoption team. When it has been important for children to maintain some direct contact with key people, careful matching has secured adopters who understand and will support this contact.

60. Post-adoption support for families is a strength in Harrow. An experienced adoption team, including a play therapist, provides easy-to-access help when

it is needed. There are strong links with the virtual school, and this results in targeted support for children at risk of exclusion. Therapeutic support is frequently funded through the adoption support fund, with 13 children receiving grants since April 2016, and all applications to date have been successful. In addition, a commissioned service provides bespoke therapeutic work with birth families, adopters and their children. Many Harrow adopters use a variety of support groups provided by the partner VAA, such as groups for same-sex adopters. This means that families benefit from open-ended support through the VAA. As one adopter put it, 'knowing you can come back in one, two or 20 years is key' to choosing to adopt with Harrow.

The graded judgement about the experience and progress of care leavers is that it is good

61. Care leavers in Harrow receive good support which helps many to achieve good outcomes. These include making good progress in further and higher education, and living in safe and secure accommodation. They develop their skills to live independently well. However, the good support that the majority of those leaving care receive is not experienced by all. For a small minority, there are delays in receiving the support and help that they need in key areas of their lives, such as support for their education, training and employment, their mental health and in accessing sexual health services. (Recommendation)

62. Social workers and social work assistants form positive and productive relationships with care leavers. They encourage them to aim high and achieve their goals. This leads to the good outcomes that the majority achieve. Staff and managers know care leavers well. They understand their needs and circumstances, and see them regularly. This includes those who are at risk of sexual exploitation, are parents themselves or are in custody. In the majority of cases, when care leavers' needs become more acute or their circumstances change, staff increase their contact and take effective action to mitigate the risks that they face, such as the breakdown of their tenancy.

63. When care leavers lose touch with the leaving care team, staff almost always take all reasonable steps to engage with them, including via text, phone, through family and known friends, and by unannounced visits. Care leavers told inspectors that they trust staff, whom they can readily turn to when they need help. One comment, 'he's like family', was typical of the high regard in which staff from the leaving care team are held.

64. Staff plan well to meet care leavers' needs, with many good examples of them receiving effective practical help that supports both their immediate and longer-term needs. Nearly all care leavers have an up-to-date pathway plan.

Typically, plans are clear, focus well on the needs of care leavers and capture their views effectively.

65. Managers and staff have high aspirations for all care leavers, including those who arrive in the United Kingdom as unaccompanied asylum-seeking children. This is reflected in the very good support that they receive with regard to their accommodation, health, education and career aspirations. Many young people who have sought asylum have high aspirations for themselves, such as to become architects, lawyers, chefs or entrepreneurs. With very well-tailored individual support, many are making excellent progress towards these goals. The help that they receive enables them to settle well and engage with the wider community.

66. Managers ensure that there is an appropriate range of accommodation available to care leavers. There are a small number of care leavers who remain with their foster carers when they reach 18 years of age or live in supported lodgings. Most live in semi-independent accommodation. Staff and managers never use bed and breakfast accommodation as an option for care leavers, even in an emergency.

67. Care leavers receive good support from the leaving care team and housing providers to develop the skills that they need to live independently. All those who move into independent accommodation take a two-day course in preparation. Managers and staff make accurate assessments of care leavers' readiness to live independently and provide support accordingly. Such support ranges from such everyday matters, such as advice on managing a budget, up to help in saving for and securing a mortgage. As a result, over the past year all but one care leaver have successfully maintained their tenancy.

68. Care leavers receive good guidance from their social worker, social work assistant and the specialist careers adviser to help them to achieve well in their education. There are a good number of care leavers at university, many of whom are making excellent progress. While at university, care leavers receive additional funding that helps them successfully to complete their studies, for example through payment for accommodation during holiday periods.

69. The number of care leavers who are in education, training or employment is good. Published data for 19- to 21-year-olds shows that a higher proportion of care leavers are in education, training and employment than in similar local authorities and in England overall. More recent local data shows that approximately three quarters of all those supported by the leaving care team have an education, training or employment place, including a small number who are undertaking apprenticeships.

70. Staff provide good, practical assistance to maintain good health. Most care leavers register with their local doctor and dentist, and attend medical appointments that meet their specific health needs. Staff accompany

sometimes quite nervous care leavers to their appointments. Care leavers told inspectors how much they value the practical assistance that they receive. Additional health screening for tuberculosis for asylum-seeking young people meets their health needs well. Managers have recently introduced a health passport that brings together care leavers’ health histories so that they are better placed to manage their own health as they gain greater independence.

71. Staff promote care leavers’ entitlements effectively through, for example, a regular and very well-attended forum for care leavers and a widely circulated charter that outlines the local authority’s commitment to them. As a result, care leavers know whom to turn to should they wish to complain about any aspect of the support that they are receiving. The leaving care team responds effectively when care leavers raise concerns about the help that they are receiving.

Leadership, management and governance	Good

Summary

A strong and energetic senior management team with a sense of direction, robust governance arrangements and clear lines of accountability is having a positive impact on the way in which services are designed, developed and delivered. This is helping children to achieve good outcomes.

The local authority knows itself well. Senior leaders have a clear understanding of strengths and areas for development, and are making intelligent use of qualitative and quantitative data to address shortfalls and raise standards. Learning from audits is acted on and the quality of practice is improving. With greater use of feedback from children and families, the impact of audits would be further strengthened.

A strong focus on and investment in social worker recruitment are having a positive impact on reducing both a reliance on agency staff and staff turnover. A low level of exit interviews limits the gathering of information in order to develop the recruitment and retention strategy further, and is an area of development in an otherwise thorough approach. Workforce development is a significant priority in Harrow, and social workers' professional development is supported by a well-planned and resourced offer of training. Investment in staffing has ensured that social workers have manageable caseloads, and this means that they are able to visit children regularly to come to know them and their families well and build relationships of trust. This supports the achievement of improved outcomes for children.

The local authority, through its corporate parenting panel, demonstrates a clear commitment to improving the life chances of children looked after. The sufficiency strategy is clear and coherent, with relevant priorities linked to present and future need. Appropriate commissioning arrangements are in place to ensure that there is a range of placements to meet the needs of children looked after.

Services for children who go missing and those at risk of sexual exploitation are good and improving. Most receive effective and well-coordinated help and protection. There is an effective structure of both strategic and operational meetings to develop services and track performance, and to monitor and intervene in the cases of individual children. The timeliness of return home interviews has improved significantly, but remains a priority, given that almost a third take over 72 hours to complete.

The local authority's overview and scrutiny panel is not consistently effective. There is no stand-alone children's scrutiny committee and, while some important issues affecting children's outcomes have been discussed at the scrutiny committee, there is still insufficient focus or challenge on matters affecting children.

Inspection findings

72. The director of children's services and the divisional director for children and young people's services provide highly visible and strong leadership, with a clear focus on improving the quality of services for local children. Effective communication between senior officers and elected members, combined with clear governance arrangements, ensures that there is a sharp focus on improving outcomes for children. Regular face-to-face meetings between the chief executive, the director of children's services, the lead member and the chair of the Local Safeguarding Children Board (LSCB) facilitate a shared understanding of the key challenges for children's social care. Senior leaders understand the scale of the challenges that they and their staff face, and are realistic about strengths and areas for development, such as the need to implement planned improvements to early-help services and to further improve the timeliness and quality of the multi-agency safeguarding hub (MASH).

73. The role of director of children's services also has a strategic statutory responsibility for adult social care services, children's social care and public health. Although this is a wide span of control, a clear line of sight to frontline practice is maintained. An appropriate statement of assurance has been undertaken to ensure that there is sufficient capacity to fulfil these roles.

74. There is a strong commitment to performance management at all levels of the organisation. Meetings involving elected members, including the leader, senior managers and the LSCB chair, ensure that a determined focus is kept on performance. The business analysis function collects a wide range of relevant up-to-date performance data, helping to create a culture in which performance is seen as everybody's business. This data enables all managers to drill down to individual, team and service performance, and provides a direct line of sight to what is happening at the frontline. Performance monitoring reports are routinely scrutinised, and information is used well to understand causes and identify possible solutions to any areas of poor performance. This grip on performance has enabled a focus on achieving and sustaining improvements in the timeliness of initial health assessments for children looked after and for single assessments, and continues to drive the development of the MASH.

75. The local authority makes good use of external reviews from relevant specialist bodies, such as the Local Government Association. This is reflective of a culture of openness to learning and improvement at all levels throughout

the organisation. A number of such reviews have been commissioned to help to evaluate the effectiveness of current provision. External audits of child sexual exploitation provision have helped to identify gaps, with the recommendations clearly acted upon. An external audit in December 2016 looked at placement provision for children looked after, and has made a number of recommendations to help Harrow to focus further on the sufficiency of placements.

76. Audits are used well to quality assure social work practice and gain an insight into how effectively services are improving the outcomes that children achieve. A clear audit programme, including senior leaders undertaking audits, is in place. Lessons learned from audits are used well to identify and address areas for improvement, including routine individual and team feedback. As part of this programme, observations of social work practice are undertaken to enhance the understanding of the service that children and families receive. The local authority recognises that more needs to be done to involve children and families, including seeking their views as part of the audit programme. However, this remains underdeveloped. (Recommendation)

77. Significant improvements have been made in the provision of services to children missing from home and care, and those at risk of sexual and gang exploitation. Most receive well-coordinated help and protection. Improvements in intelligence sharing, mapping of trends and disruption activity, along with more effective use of the multi-agency sexual exploitation meetings, have helped to keep Harrow children better protected. In particular, effective multi-agency mapping, coupled with proactive use of legislation, has been decisive in keeping some children safe. There is an effective structure of both strategic and operational meetings in place to develop services and track performance, and to monitor and intervene in the cases of individual children. The development of a specialist co-located team, including a child sexual exploitation coordinator, missing persons' worker and gang worker, has ensured a more focused and joined-up service for children.

78. While inspectors saw an improving picture, there is still further work to be done in ensuring the consistent use of the child sexual exploitation risk assessment tool. This is about ensuring that it is always used to assess risk, and is more particularly about ensuring that it is also used to assess how risk has reduced or increased over time and in response to the help provided. While the timeliness of return home interviews has improved significantly as a result of effective performance and contact management, almost a third of children and young people are still having to wait more than 72 hours to be seen.

79. A joined-up approach to recruitment, retention and development is having a positive impact in terms of making Harrow a more attractive place to work. Senior leaders have understood the importance of having a sufficient, skilled and stable workforce in order to drive improvement. They have invested both financially and in management time and focus to achieve this. Substantial

efforts are being made to recruit staff, such as the recruitment of qualified and appropriately experienced overseas workers and investing in the 'Step up' and 'Frontline' programmes. These are showing signs of fruition, with both the dependency on agency staff and the level of staff turnover reducing. A low level of exit interviews hampers the gathering of important information to further develop the social worker recruitment and retention strategy. The local authority's commitment to children's social work in Harrow is seen in the funding of extra social work provision in response to increasing demand in order to keep social work caseloads at a manageable level. This enables social workers to visit children regularly. (Recommendation)

80. The vast majority of social workers spoken to by inspectors were very positive about working for Harrow, and particularly mentioned visible and supportive leadership and management. The pod system of small groups of social workers, each supported by a skilled pod manager, is a strength which social workers almost universally report as supportive and which assists them in delivering a service to vulnerable children and families. Use of a systemic approach to practice is well embedded and adds value, enabling reflection and a holistic approach to the work with families. Most social workers are tenacious in their efforts to engage with children and families, and they speak with genuine warmth and knowledge about the children whom they are helping.

81. Managers pay careful attention to non-casework supervision areas, particularly training and development and workload management. In a small minority of cases, although both supervision and management oversight are regular, social workers do not receive clear enough direction to support fully effective practice with children. The vast majority of social workers have an up-to-date annual appraisal which clearly identifies their achievements and areas for development in the future. Social workers have access to a wide range of training and development opportunities, and are actively encouraged to participate.

82. The local authority's overview and scrutiny panel is not consistently effective. There is no stand-alone children's scrutiny committee and, while some important issues affecting children's outcomes have been discussed at the scrutiny committee, there is still insufficient focus and challenge on matters affecting children. For example, there has been little consideration of the effectiveness of services for children at risk of sexual exploitation. Recognition of the limitations of scrutiny prompted Harrow, in late 2016, to commission an external review focusing on how scrutiny can be better exercised. This review is ongoing, so is too recent to have had an impact. (Recommendation)

83. Elected members of the corporate parenting panel demonstrate a clear commitment to improving the life chances of children looked after. They have oversight of detailed performance information and analysis, with a range of professionals presenting reports. This helps them to clarify, challenge and question activity. Mandatory training enhances their understanding. The

corporate parenting strategy is detailed, and it sets clear priorities and the areas for improvement. There is an appropriate focus on monitoring action completion, but the lack of sufficient outcome information limits the ability to fully understand if completed actions have improved outcomes for children.

84. The Health and Wellbeing Board, chaired by the leader of the council, takes a 'whole life journey' approach to identifying priorities, and this includes a number relevant to the lives of children and young people. This 'high-level' vision is translated into a clear and well-focused commissioning plan by the multi-agency children's commissioning group. Through this group, the local authority, including public health, works closely and effectively with the clinical commissioning group and schools to ensure that there is an appropriate range of commissioned services to meet children's needs. Children and young people are being successfully involved in the design of service specifications and the commissioning process. Active contract management ensures an ongoing focus on the quality of services and, through this, the outcomes achieved by children. Children and young people are well involved in this process, leading to more sharply targeted services, including the development of sexual health services and the recent 'Future in mind' recommissioning of emotional well-being services for children and young people. Effective use of data and contract management is leading to the recommissioning of services, which are producing better outcomes. The cancellation of a previous contract to provide return home interviews led to the creation of a new in-house service, with subsequent improvements in timeliness of completion.

85. The sufficiency strategy 2015–17 is clear and coherent, with relevant priorities linked to present and future need. Appropriate commissioning arrangements are in place to ensure that there is a range of placements to meet the needs of children looked after. Steps are being taken to address gaps, such as the use of positive contracts through the West London Alliance, including innovative recommissioning of the framework for the provision of independent foster placements. The local authority has seen an increasing number of young people placed in private sector residential accommodation in the past year. The quality of such provision is overseen by the access to resources panel, which is chaired by the divisional director, and the use of such accommodation is continually reviewed to ensure that it is meeting need. For some young people, the decision to place outside of Harrow in such accommodation has been on the basis of well-evidenced assessments to address particular issues of risk.

86. The local authority responds to complaints in a well-organised and open way, with an increasing number being resolved at an early stage. When it identifies wider practice concerns, it takes steps to address and improve practice. Overall, numbers of complaints are reducing, and those that are made are being resolved increasingly quickly. However, the local authority's own audits from April to September 2016 show that in over half of children's case files audited there was no evidence of parents, carers or children being given information relating to access to records, complaints or advocacy. This means

that the local authority cannot be certain that it is actively seeking feedback from children and their families or making sure that they are aware of their entitlements.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Local Safeguarding Children Board in Harrow fulfils all of its statutory functions, as defined in 'Working together to safeguard children' 2015, and has made considerable progress in work to safeguard vulnerable children. Following the appointment of an experienced and knowledgeable chair, it remains well positioned to enhance the effectiveness and coordination of local safeguarding arrangements further. Key partner agencies are represented, and the board benefits from two highly effective lay members who offer exceptional levels of knowledgeable support and challenge.

The board demonstrates open and candid challenge between board members, and this has been effective in some areas, such as improving safeguarding practice within the multi-agency safeguarding hub. However, the board is insufficiently informed about the quality of all frontline services and practice. As a result of limited performance information supplied by some partner agencies, the board's data set does not fully reflect the range of services responsible for safeguarding children in Harrow, and analysis is limited. This inhibits the board's ability to monitor and understand the overall effectiveness of services and to challenge agencies when they fall short.

The board has coordinated effective multi-agency arrangements for responding to young people at risk of child sexual exploitation at both operational and strategic levels. Some of this area of work is still in development, but overall the arrangements to tackle child sexual exploitation are robust. Some children and young people have benefited from schools providing awareness-raising sessions regarding female genital mutilation, including one primary school.

The board's annual report provides helpful information on a wide range of issues. For example, there is a commentary on the Home Office review in Harrow of gangs and youth violence. This noted the effective operational partnership work, but identified the need for an overarching strategy, now led by the Safer Harrow Partnership.

The influence and participation of children and young people in aiding understanding and informing board priorities and providing ongoing feedback are in their infancy. The board is not yet systematically evaluating the effectiveness of the newly formed early-help services.

The board has a comprehensive range of training events and e-learning courses that have increased the number of practitioners who have received training. The training events include lessons learned from serious case reviews, including a

nationally recognised and highly regarded 'cartoon' account of a young person's experience of living in a neglectful home environment.

Recommendations

87. Work with the Local Safeguarding Children Board's (LSCB)'s constituent agencies to ensure that the board receives a sufficient breadth and quality of performance information to support rigorous monitoring, analysis and challenge of the full range of safeguarding work with children in Harrow.

88. Strengthen the board's scrutiny of the quality and impact of early-help services.

89. Review the capacity and functioning of the board's sub-groups to ensure that they are all as effective as the best.

90. Engage children and young people more effectively in contributing to and developing the board's work and priorities.

91. Continue work with schools to significantly improve their engagement with the section 11 audit process.

92. Update the LSCB threshold document so that it is fully compliant with statutory guidance, and is as effective a document as it can be to support decision making by those working with children and their families.

Inspection findings – the Local Safeguarding Children Board

93. Governance arrangements are well established. The newly appointed independent chair of the board intends to retain the existing pattern of regular meetings with the chief executive, director of children's services, leader of the council and lead member, as well as senior managers from partner agencies. The detailed minutes of these meetings evidence that key priorities and issues of concern for children are shared at the most senior level. The chair of the board attends the Health and Wellbeing Board, at which the Local Safeguarding Children Board's (LSCB's) annual report is considered. The chair provides appropriate challenge to partners, ensuring that children's issues are prioritised. The board maintains a challenge log as a record of actions taken on a number of issues. In 2016, there were 15 challenges made. However, as the impact of these challenges is not recorded, it is difficult to assess the effectiveness of the board's challenge to agencies.

94. Key areas of the board's work are appropriately aligned with other relevant boards and multi-agency bodies. Work to prevent child sexual exploitation is

aligned with the Safer Harrow Partnership, and the board works in conjunction with the Harrow Safeguarding Adults Board to promote a 'think family approach' in relation to vulnerable adults. This ensures that the board has a pivotal role in coordinating work across the partnership to raise awareness of important issues. One example is work following a Home Office peer review initiative to end gang and youth violence, which resulted in a Harrow-specific preventative strategy on gangs, knife crime and violence.

95. The newly appointed chair has current, relevant experience. He is also the chair of another LSCB and contributes to work on pan-London LSCB work-streams. Further involvement in and work for a domestic abuse charity and as safeguarding adviser to the diocese of London give him an extensive understanding of board business and priorities. The board is financially sound, but is due to have a reduction in funding in the next budgetary year. The board plans to manage this by reducing the use of external auditors, and has confidence that there is the capacity in the partner organisations to complete more audits in-house. The board's auditing activity has been crucial in identifying practice weaknesses, for example within the multi-agency safeguarding hub (MASH) and in relation to section 47 processes. The board has the agreement of all partners that, in the event of any unforeseen expenses, such as serious case reviews (SCRs), all partners will share the cost.

96. The board has appropriate multi-agency membership and is attended by sufficiently senior officers from a wide variety of relevant agencies. Board members are committed to improving the life chances of children. The two lay members involved at board level contribute very effectively, including one acting as a vice-chair for one of the sub-groups and for the board itself. The relationship between the board and the lead member is strong and effective, despite the lead member being newly appointed.

97. In the past two years, the board has moved forward significantly in its commitment to driving up the standard of safeguarding services provided by partner agencies. The board has had success in raising practice standards, but the extent of this has been hampered by a lack of available performance information from partner agencies and a consequent lack of analysis. This means that the board does not have a full or accurate picture of the differences that agencies are making for children, or of gaps and shortfalls in service delivery. For example, the waiting times for child and adolescent mental health services often are not provided as part of the data set for the board, and the opportunity is missed for this to be an area of challenge to health partners. Weakness in data provision therefore reduces the board's influence on the planning and commissioning of services, as it cannot systematically monitor or evaluate quality. (Recommendation)

98. Data and performance information sharing works better within the board when partners are able to share concerns, develop a shared understanding and take action to improve service provision. For example, the identification of a lack of proactive antenatal and midwifery engagement with vulnerable

pregnant women led to practice changes which now ensure earlier targeted engagement with these mothers. This promotes better support and more effective relationship building with the most vulnerable at the earliest possible stage. The board has worked effectively to influence the staffing provision in the MASH and the location of the police interview suite, in order to support and improve the assessments of all children.

99. Early-help provision has been subject to a series of scrutiny exercises by the board, but as yet has not highlighted effectively the factors that have held back progress. The board has focused on linking the respective priorities of partner agencies, but this has not provided the necessary challenge and focus. The engagement of agencies in the common assessment framework process is weak, with no professionals from any agency other than the local authority currently undertaking the lead professional role with families. The LSCB has not sufficiently challenged partner agencies, such as health and schools, about this shortfall. (Recommendation)

100. The threshold document has been subject to two revisions in the past year following learning from the board's section 47 and MASH audits. It requires further modification, as it lacks sufficient clarity about key service pathways, such as those for children at risk of sexual exploitation, and does not provide guidance about the thresholds for voluntary accommodation or care proceedings, under sections 20 and 31 of the Children Act 1989, as required by statutory guidance. It also contains some language that is unclear or confusing for professionals using the document as a guide to decision making. (Recommendation)

101. The board has been effective in promoting awareness of child sexual exploitation among young people, having supported the delivery of 'Chelsea's Choice' across Harrow to 16 schools. The board has overseen and been influential in ensuring an appropriate local response to the 'Prevent' duty and female genital mutilation. This includes ensuring the provision of training and awareness raising, and supporting some innovative projects such as the 'Pants' video. This initiative is an example of good practice.

102. The LSCB undertakes annual section 11 audits of partners' effectiveness in carrying out their safeguarding responsibilities. These have been jointly completed with a neighbouring authority, enabling efficiencies. All statutory partners complete this audit, but less than 50% of schools do so. There is evidence that more schools are now engaging positively with the board following the setting up of a safeguarding in education termly seminar group, led by the board business manager. The seminar group has addressed such issues as bullying, female genital mutilation and the role of the MASH. To date, 55 out of a possible 60 schools and colleges are reported as attending this group, and teaching staff spoke positively regarding the initiative.

103. The board recognises that its current structure of six sub-groups requires revision. Not all sub-groups have sufficient capacity or the active engagement

of all partners, so cannot fully achieve their planned work. The minutes of some sub-groups do not provide a concise record of activity. This has been recognised. When sub-groups have been working effectively, such as the quality assurance sub-group, there are measurable improvements in practice. The multi-agency audits undertaken are focused on relevant issues of concern, and lead to clear action plans and evidence of improvement, for example the recent audit of services for disabled children. Positively, the practice of this sub-group is that audit activity continues until measurable improvements have been seen in practice. A good example is the audits carried out of the section 47 process, which led to tangible improvements in the quality and impact of practice with children at risk of significant harm. (Recommendation)

104. The child death overview panel (CDOP) is effective in analysing local information on child deaths, identifying patterns and trends. None of the small number of deaths during the past year were linked to safeguarding issues or concerns about professional practice, so were not referred to the board. There are plans in place to improve the CDOP annual report by linking findings to the wider population in order to improve the quality of the information provided. The CDOP has developed and rolled out good awareness-raising programmes linked to the use of baby slings, safer sleeping, smoking cessation and the availability of support for bereaved parents. Harrow has high rates of breastfeeding, and the CDOP challenged the council successfully when there was a proposed plan to cut funding to a successful peer breastfeeding programme.

105. Processes for making decisions about and undertaking SCRs or management reviews are clearly set out in the terms of reference of the SCR sub-group and are well established. This group also monitors and challenges the progress of SCR action plans. The board has been undertaking work relating to three SCRs in the past year, as well as multi-agency learning reviews of children's cases that do not meet the criteria for an SCR. A programme of training sessions ensures that lessons learned are cascaded out by all agencies quickly via e-bulletins, training events, sub-group members and the children's services management team. This sub-group holds agencies to account effectively in implementing recommendations.

106. The quality assurance sub-group is responsible for a wide range of tasks, including analysis of data sets and coordinating the six-monthly multi-agency case audits. These case audits are an effective mechanism for increasing understanding of the quality of frontline practice and identifying areas for improvement. This has enabled the board to identify a number of priorities and put action plans in place to further strengthen practice.

107. The child sexual exploitation sub-group has a wide work programme following the areas identified for improvement by the second child sexual exploitation review in spring 2016. There are some key improvements which the sub-group is progressing, such as awareness-raising activity with staff in sexual

health clinics. Areas for development include evidence of challenge. For example, there is lack of analysis of return home interviews. The return home interviews are frequently a verbatim account of the young person's words, instead of an analysis of the push and pull factors or the cumulative risk of multiple 'missing' episodes.

108. Social workers and foster carers who spoke to inspectors value the multi-agency training provided by the board. Training activity has increased significantly, with 1,702 sessions delivered in 2015–16 against 1,194 in 2014–15. The creation of 60 child sexual exploitation champions, who have been trained to cascade face-to-face courses within partnership agencies, has been effective. This means that all partner agencies are supported to share good practice within their workforce. Some training sessions for local GPs have been specifically designed and led by the general practitioner who sits on the board. All training is evaluated, but the low feedback response on individuals' practice three months after training hampers the evaluation in its effectiveness. Training is responsive to changing need, as it combines learning from the LSCB's own audits and SCRs, as well as nationally published SCRs and research findings, into current training programmes. A small community organisation is commissioned to deliver training to a large number of voluntary and faith organisations. This is ensuring that safeguarding issues are far better understood. An increasing number of the organisations that have attended these sessions have nominated a designated safeguarding lead for their organisation.

109. The board has an accessible and informative website with links to relevant good-quality information about a range of safeguarding issues. A focus group of children looked after was involved in its development and one young person was directly involved in the design. It includes helpful information on SCRs. The LSCB produced an 'outstandingly good' cartoon, in the words of a child living in a family of neglectful and abusive parents. This is used routinely in induction and other training. It has a useful site for young people that includes information on the NSPCC 'Pants' campaign, female genital mutilation, bullying, child sexual exploitation and 'what to do if you are worried'. The website also holds the pan-London LSCB policies and procedures, which the board has adopted.

110. Young people have recently been involved in presenting a session at the board's annual conference, and in a series of positive and effective sessions undertaken with other young people seeking their views on safety in Harrow. However, children and young people are not routinely or sufficiently engaged in the quality assurance and priority-setting work of the board (Recommendation)

111. The LSCB annual report 2015–16 is a comprehensive document. It is detailed as a record of performance, but it is not sufficiently rigorous in its analysis. It has helpful summary key findings and some suggestions on what needs to be focused on in the future. The business plan is linked to the annual report, but

it lacks a sharpness and a framework to measure impact. The business plan priorities are too broad and lack specificity, so cannot be readily achievable or measurable. As a result of this, the business plan is not a sufficiently effective tool for the board to understand whether it is making a positive difference for children and young people. Overall, there is a lack of alignment between the business plan, the challenge log and action plans. These all need to be kept up to date so that board members always have a clear understanding of the board's position, and can measure impact and ensure sufficient challenge. (Recommendation)

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) and one Social Care Regulatory Inspector from Ofsted.

The inspection team

Lead inspector: Dominic Stevens

Deputy lead inspector: Andy Whippey

Team inspectors: Alison Smale, Julie Knight, Brenda McInerney, Jon Bowman, Stephanie Murray, Linda Bond, Joy Howick

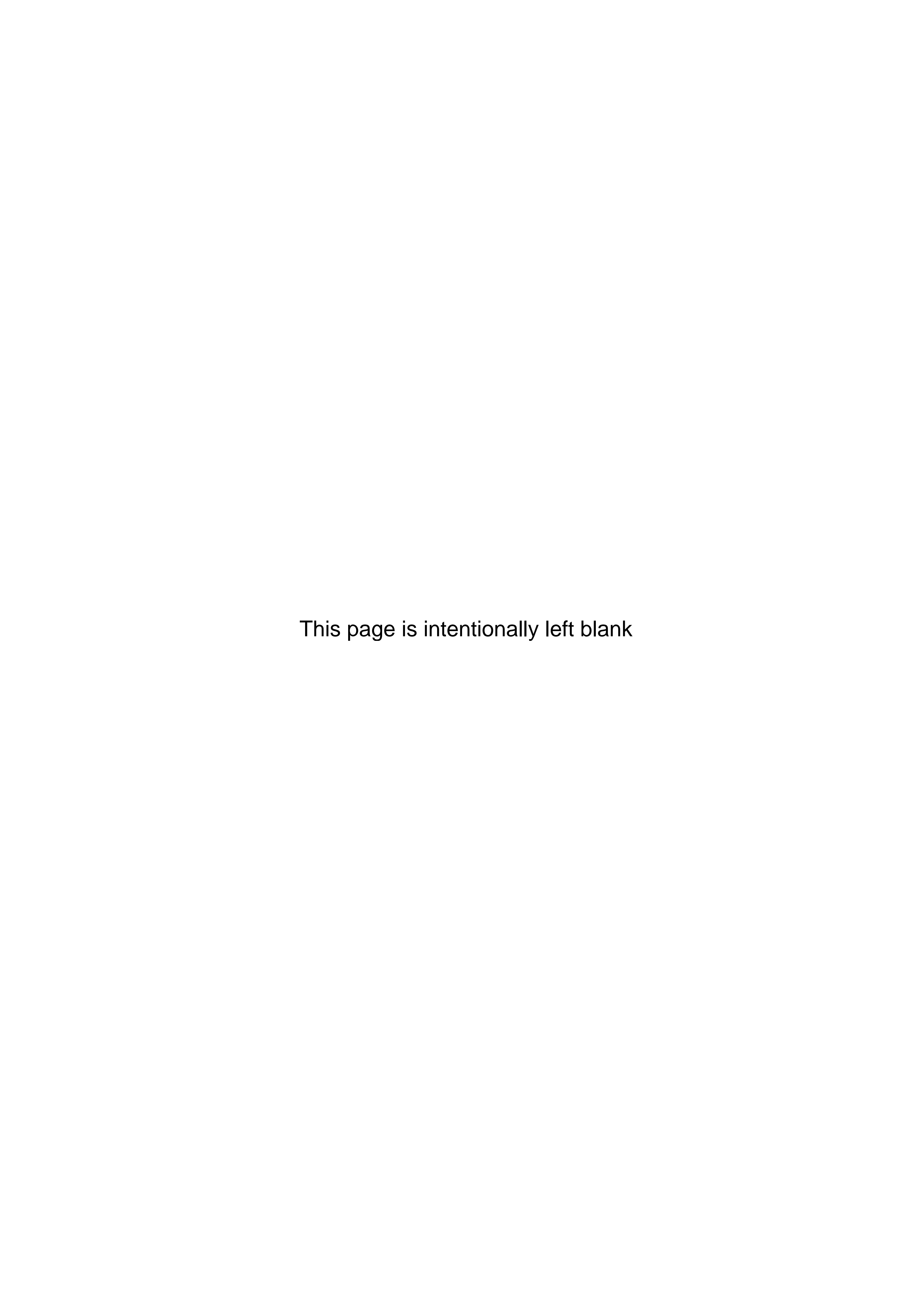
Senior data analyst: Patrick Thomson

Quality assurance manager: Sean Tarpey

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.
If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.
You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.
This publication is available at www.gov.uk/government/organisations/ofsted.
Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsgov.uk/ofsted
© Crown copyright 2017


This page is intentionally left blank

2017 London Borough of Harrow OFSTED Single Inspection Framework Action Plan				
Report Recommendations	**What will be done?**	**Who will do this and by when?**	**What will be different?**	**Progress**
1. Ensure that all children and families who need an early-help assessment and a package of support coordinated by a lead professional are able to receive this.	LA in partnership with key agencies in the HSCB will fully implement an agreed Early Support Pathway following the re-organisation of Early Support Services.	Head of Service Early Support and Youth Offending. By 30.09.17	i) Increase in targeted Early Support assessments for young people and their families ii) Increase in targeted Early Support packages for young people and their families iii) Suite of performance management data to track and evidence impact of effectiveness of Early Support services.	
2. Ensure that decision-making within the MASH is consistently timely, so that all children who are the subject of a referral receive assessment and support in a timely manner.	The performance management system in MASH will be revised in order to improve the timeliness of the Section 17 referral pathway to the First Response Team.	Head of Service Children's Access Service. By 30.09.17	i) Performance management data will demonstrate that targets are achieved and maintained for referral and assessment timeliness	
3 Ensure that assessments and plans are consistently up to date, reflective of children's views and clear about what is expected of families.	Young people and their families receiving Section 17 child protection and looked after services will benefit from SMART plans that reflect their changing needs.	Head of Service Children in Need Service. By 30.09.17	i) Data will demonstrate that assessments are updated in line with CIN, CP, & LAC Reviews. ii) Monitoring and audit analysis demonstrate that YP views actively contribute to revised assessments and that plans are SMART.	

4. Ensure that strategy discussions involve the full range of relevant agencies, so that the full range of relevant information informs assessment of risk.	The Local Authority in partnership with key agencies will increase multi-agency participation in child protection strategy discussions and during Section 47 investigations.	Head of Service Children's Access / Head of Service Children in Need Service. By 30.09.17	i) Section 47 strategy discussions will demonstrate improved contribution of relevant agencies, particularly Health.	
5. Ensure that children looked after receive timely therapeutic support when they need it.	All Children Looked After will receive appropriate and timely Tier 2/3 therapeutic services in line with their assessed needs.	Divisional Director Children and Young People Service By 30.09.17	i) The LA & Health partners performance data will demonstrate that targets are met and consistently achieved for the provision of therapeutic support and outcomes for CLA.	.
6. Improve the quality of plans when children return to their families from care, so that there is clarity about what services will be provided, who will provide them, by when and what they are aimed at achieving.	Final CLA Review meetings for young people returning to the care of their parents will confirm the appropriate package of support services and that contingency arrangements are agreed.	Head of Service Children in Need Service / Head of Service Quality Assurance and Service Improvement. By 30.09.17	i) The LA performance data for CLA demonstrates effective delivery of care planning for young people to be reunited with their birth families.	.
7. Ensure professionals consistently implement actions required between review meetings for children looked after.	Social Workers and Independent Reviewing Officers will ensure that all young people and their carers are prepared and supported to participate in CLA Review Meetings.	Head of Service Quality Assurance and Service Improvement. By 30.09.17	i) Supervising Social Workers will confirm foster carers have been adequately supported to contribute to Review meetings that are effective. ii) Monitoring and Dispute Resolution data demonstrate	

	Social Worker line managers will ensure that agreed actions are progressed between Review meetings.		that care planning decisions are delivered in a timely manner.	
8. Ensure that the good support experienced by the vast majority of care leavers is extended to all care leavers, so that their needs are better met.	Effective pathway planning will ensure that all care leavers receive timely support for their emotional well-being, education, employment and training.	Head of Service Corporate Parenting. By 30.09.17	i) Data will demonstrate that targets are consistently met for care leavers in relation to their accommodation, education, employment and training status.	
9. Strengthen the quality of learning from audits through better involvement and use of feedback from children and their families.	The Local Authority Quality Assurance Framework will be revised to strengthen the voice and participation of young people and their families.	Head of Service Quality Assurance and Service Improvement. By 30.09.17	i) Audit processes will be specifically revised to include feedback from young people and their families. ii) Quality Assurance quarterly reporting will analyse the themes of feedback and participation of YP and their families through audit and review mechanisms.	
10. Improve the functioning of the overview and scrutiny panel, to ensure that it is more sharply focused on children and that its work has an impact on improving both services for children and the outcomes they achieve.	Overview and Scrutiny Panel activity in LA will ensure there is sufficient focus and challenge on strategic planning and delivery for the children and young people's population of Harrow.	Harrow Council CEO / Harrow Council DCS. By 31.03.18	i) Overview & Scrutiny Panel agenda items and recommendations demonstrate sufficient focus on the key strategic plans for the children and young people's population in Harrow.	

This page is intentionally left blank

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	20 July 2017
Subject:	**Sustainability and Transformation Plan (STP)**
Responsible Officer:	Joint Report by Paul Jenkins - Interim Chief Operating Officer Chris Spencer - Corporate Director of People Services
Exempt:	No
Wards affected:	Harrow
Enclosures:	Harrow Sustainability and Transformation Plan (STP) Summary April 2017

Section 1 – Summary

This report presents the ‘Harrow’s Chapter’ of the Sustainability and Transformation Plan (STP) which was reviewed at the Health and Wellbeing Board Seminar.

FOR INFORMATION

Section 2 – Report

The report provides an update on Harrow's Sustainability and Transformation Plan and how the nine priorities developed by Harrow will enable us to achieve our vision and fundamentally transform our system.

Section 3 – Further Information

There may be an update report brought to the meeting in the future.

Section 4 – Financial Implications

There are no immediate or direct financial impacts arising from this paper, and the development of the priorities are expected to be delivered within the existing financial envelope for partner organisations. In the event that changes to delivery models result in additional costs (either one-off or ongoing) the financial implications would need to be assessed and agreed by the relevant organisation as part of the respective annual financial planning process.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? Not required

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

- Please refer to the attached document to understand how the proposed changes will make a difference for older people, families, and communities.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

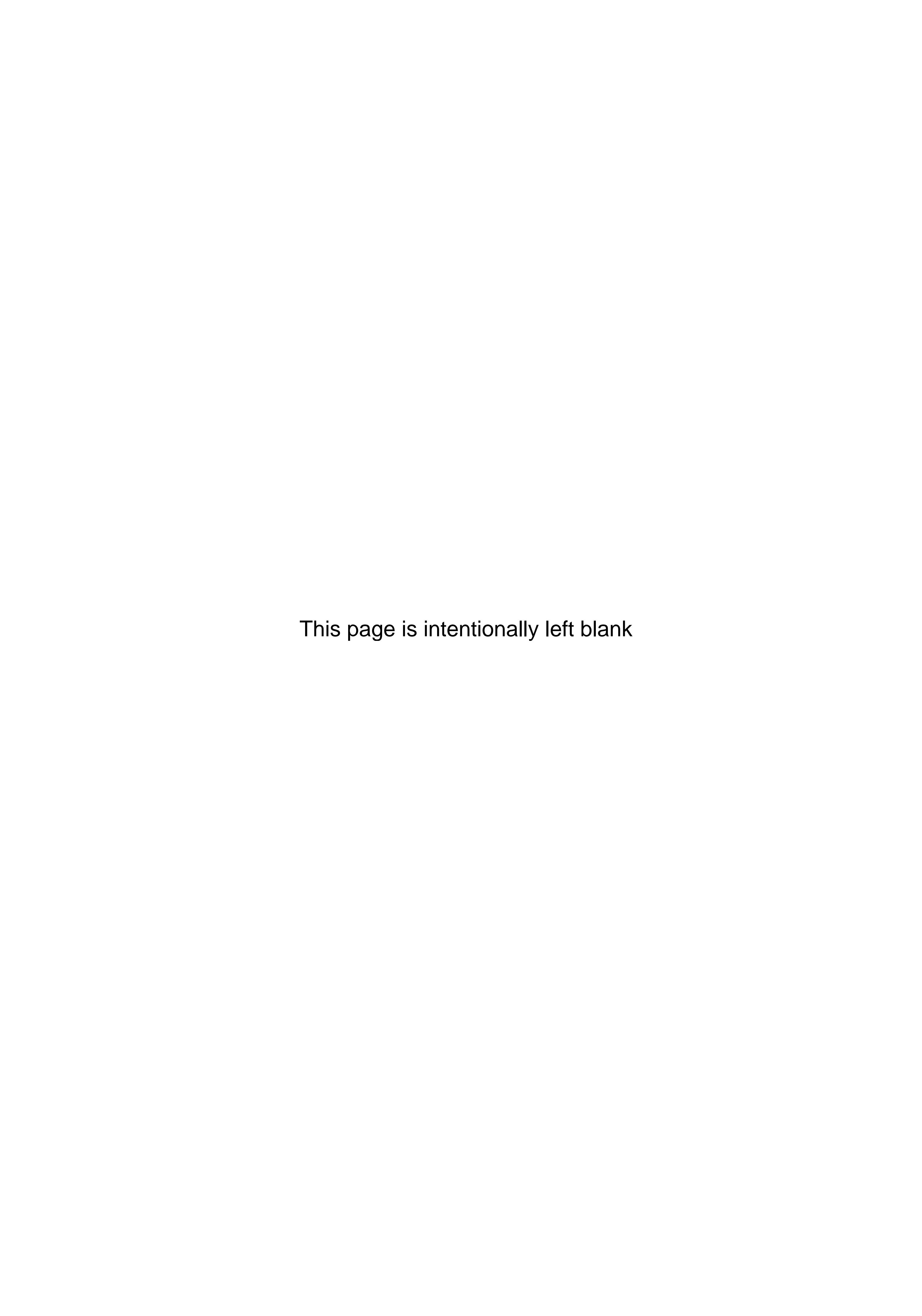
Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 6 July 2017		

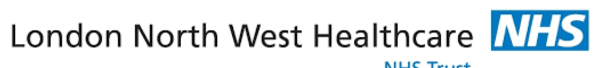
Ward Councillors notified: **NO**

Section 7 - Contact Details and Background Papers

Contact: Gary Griffiths, Assistant Chief Operating Officer, Harrow CCG
0208 966 1067

Background Papers: STP Summary

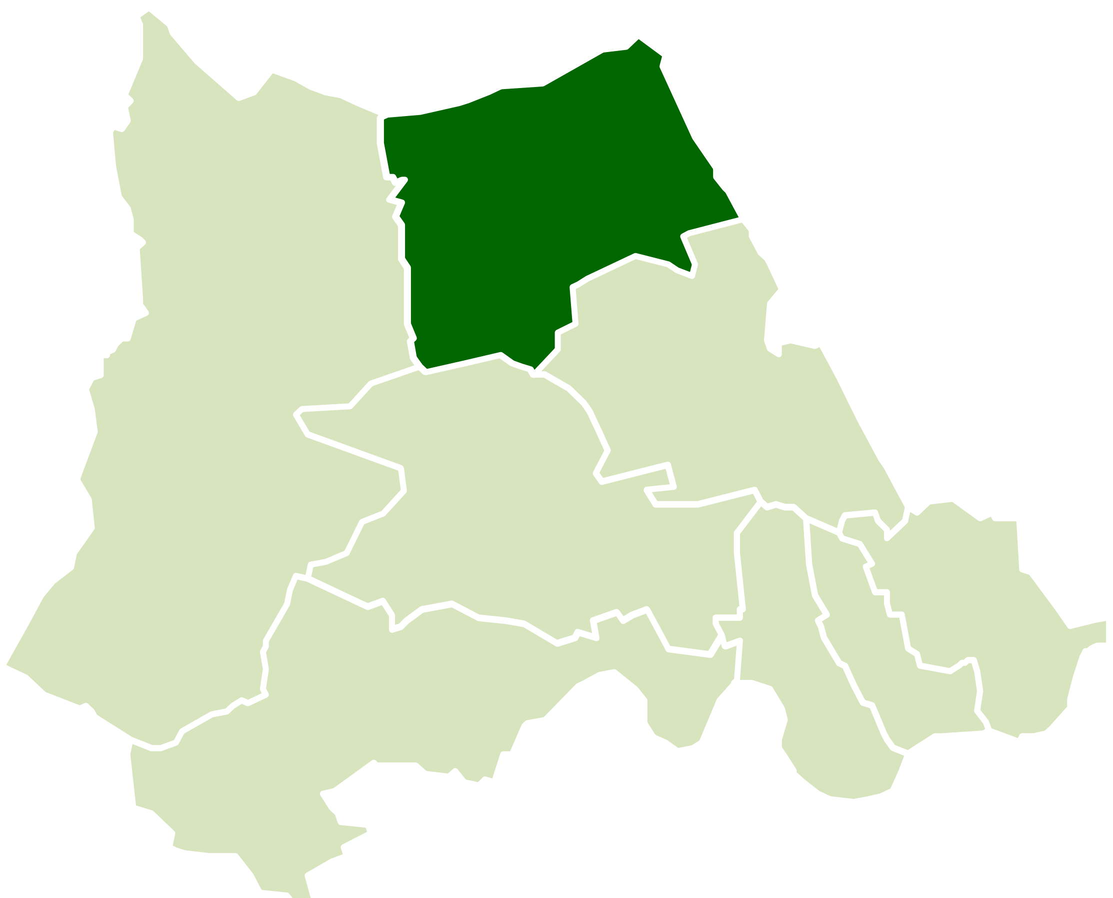

This page is intentionally left blank



Harrow Sustainability and Transformation Plan (STP) Summary

April 2017

181



Contents

- The purpose of the Sustainability and Transformation Plan … pg. 3
- Understanding our population – the health and wellbeing of Harrow … pg. 4
- NWL priorities and Delivery Areas (DAs) … pg. 5
- Detailed slides on each Delivery Area … pg. 6-10
- Enablers to support the five Delivery Areas … pg. 11
- Timeline for Harrow … pg. 12

Glossary of Terms

- **Accountable Care Systems (ACS)**: brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. ACS take many different forms ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers.
- **App:** is short for application - this can be any type of computer program**.** Applications have been around for as long as computers, but the term 'app' is associated with the software that runs on a smartphone or tablet device.
- **Discharge to Assess (D2A):** is where people no longer require an acute hospital bed but may still require care services, are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- **Joint Strategic Needs Assessment (JSNA):** is the means by which CCGs and local authorities describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs.
- **My Community ePurse:** is a personal budget and support planning tool that enables you to receive a personal budget and purchase services using this allocation all in one place using a PayPal electronic e-purse.
- **Patient Activation Measure (PAM)**: is a tool that enables healthcare professionals to understand a patient's activation level, or their level of knowledge, skills and confidence to manage their Long Term Condition.
- **Primary Care Hub(s):** have the key characteristic of an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care.
- **Risk Stratification:** The process of separating patient populations into high-risk, low-risk, and rising-risk groups.
- **Social Prescribing:** is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.
- **Whole System Care**: recognises the contribution that all partners make to the delivery of high quality care.

The purpose of the Sustainability and Transformation Plan

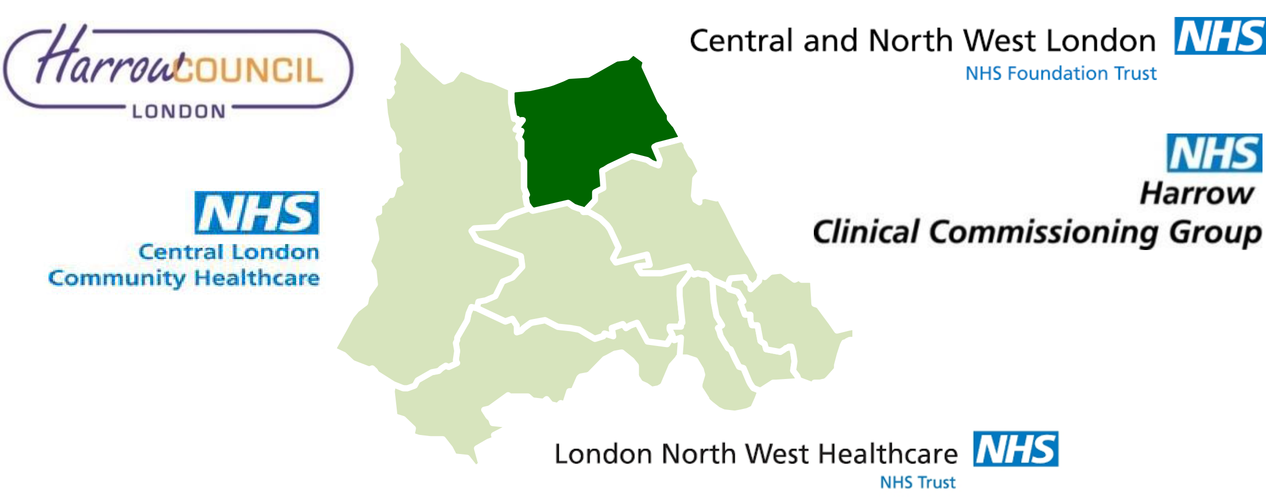
- NHS England's Five Year Forward View (FYFV) sets out a vision for the future of the NHS.
- Local areas have developed a **Sustainability and Transformation Plan (STP)** to help local organisations plan how to deliver a better health and care service that will address the FYFV 'Triple Aims' of:

  1. **Improving people's health and well being**
  2. **Improving the quality of care that people receive**
  3. **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.**

- This provides us in NW London with a unique 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 is 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.

- Harrow providers and commissioners (both local government and NHS) contributed to the development of the NWL STP, to deliver a genuine place based plan for the borough, with a strong focus on Primary Care Transformation as a key enabler for sustainable system change.
- Existing Harrow plans have been built on within the STP, including the:
  - Harrow Health & Wellbeing Strategy 2016-20
  - Harrow JSNA 2015-20
  - Harrow 2016/17 Better Care Fund Plan
  - Harrow CCG 2016/17 Operational Plans
  - The Harrow Ambition Plan 16/17 – 18/19
  - Harrow Out of Hospital strategy
- This document is a summary of what the NWL STP means for Harrow, capturing work that is in-progress and work that is aspirational over the coming years.



Understanding our population – the health and wellbeing of Harrow

Children

- Nearly 1 in 5 of Harrow children live in poverty, which can lead to poor health outcomes as an adult.
- Children in Harrow have similar levels of obesity as the England average (21% of 10 and 11 year olds), which increases the risk of cardiovascular disease and diabetes in later life.
- About 3,100 children (5.5% of children) were in need of a service from Social Care in 13/14. These children are vulnerable and many have poor mental and physical health.
- In Harrow there are many babies born with low birth weights, who are more vulnerable to infection, developmental problems and even death in infancy.

Cancer

- Incidence for all cancers is lower in Harrow than the England average.
- Early diagnosis is important for improving survival rates, however rates of bowel and breast cancer screening are lower in Harrow than the national minimum standard.
- Cervical screening rates are also low, and are declining in young women. In addition, vaccination against Human Papilloma Virus (HPV) – which causes almost all cervical cancer – is lower than the England average.
- There is increased risk of certain cancers in Asian and Black ethnic groups, which is particularly relevant in Harrow. Women from these groups have a lower under-65 survival rate for breast cancer and higher risk of cervical cancer in those over 65 years.

Serious and long term mental health needs

- One in 7 adults in Harrow have a mental health problem.
- Over 97% of people referred to Talking therapies, are seen within 6 weeks.
- Hospital admissions due to drug-related mental health and behavioural disorder are amongst highest in London, with higher prevalence of schizophrenia, bipolar affective disorder and other psychoses.
- About one fifth of people accessing substance misuse services are having concurrent contact with mental health services.
- Rates of unemployment are higher in those with mental health conditions. Unemployment is directly associated with poor mental and physical health including cardiovascular disease, depression and suicide plus those out of work are more likely to smoke, drink alcohol and be physically inactive.

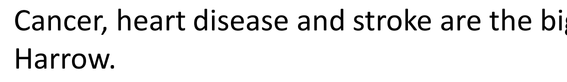
Older People

- Harrow has a higher proportion of those aged over 65 compared to other NWL boroughs, and a third of those aged over 65 have at least one long term health problem or disability.
- People in Harrow are living longer with ill health (approx. 20 year gap in healthy life expectancy and life expectancy).
- These is a shortage of appropriately trained health care professionals to meet the care needs of our growing elderly population.
- Older people are at greater risk of falls and associated injury, such as hip fractures, which is associated with a greater need for institutional care.
- There will be increased NHS & social care costs due to the ageing population and increasing dementia prevalence.

Mostly healthy

- There are high rates of obesity in Harrow, and many residents don't take enough exercise (31% of adults are physically inactive). A physically inactive person is likely to spend more time in hospital and visit the doctor more often than an active person.
- Those living in the most deprived areas of the borough are less likely to live near green space, and these areas have the lowest rates of physical activity and higher rates of obesity and cardiovascular disease.
- There are low amounts of fruit and vegetables eaten, which impacts on health and obesity levels.

One or more long-term conditions



- Cancer, heart disease and stroke are the biggest causes of death in Harrow.
- One in ten people in Harrow have Type 2 Diabetes, which one of the highest rates in England. We also have the highest rate of 'pre-diabetes'.
- Many people (15%) with a long-term condition or disability feel that their day-to-day activities are limited in some way.

Other

- More deprived areas in Harrow have poorer health outcomes; we need to urgently address this inequality and ensure that everyone in Harrow has an opportunity to start, work, live and age well.
- Harrow is an ethnically diverse borough; over half of our residents are black or an ethnic minority. This means that rates of some conditions such as diabetes and heart disease is greater; there is a 3-fold increased risk of diabetes among people of South Asian origin compared with white people and risk increases at a younger age and lower weight.

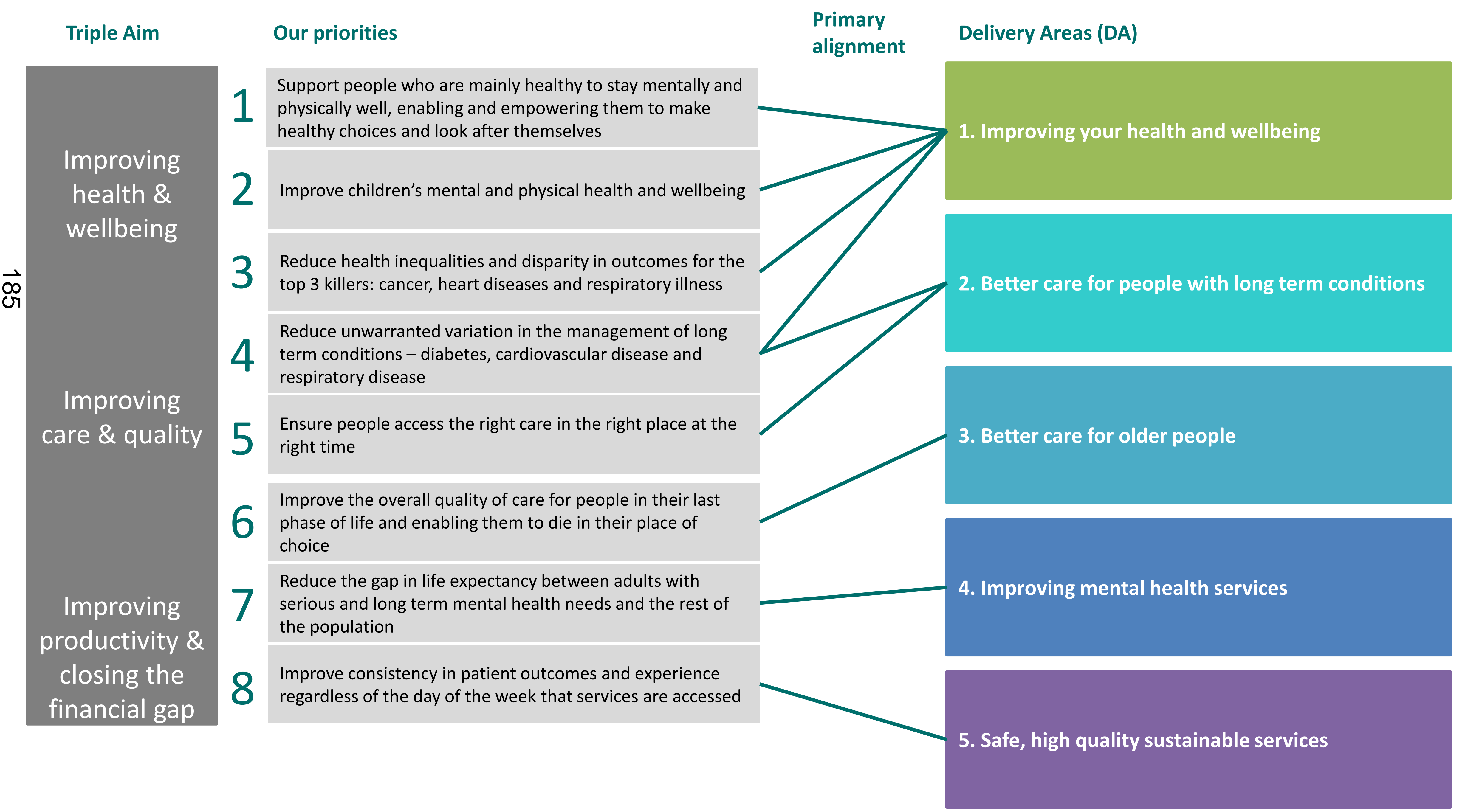
Other

- A quarter of adult social care users do not have as much social contact as they would like, leading to social isolation. Feeling lonely and socially isolated in older age has been suggested to be as harmful to health as smoking 15 cigarettes a day.
- There are high rates of fuel poverty (over 10%), implying that many Harrow residents are living in cold homes, which may be having a knock-on impact on their health (e.g. cardiovascular and respiratory diseases).
- There are high rates of TB (the fifth highest rate in London) and high rates of statutory homeless.

NWL priorities and Delivery Areas (DAs)

Harrow, as part of North West London, has developed **a set of nine priorities** that will enable us to achieve our vision and **fundamentally transform our system.**

We will focus on **five delivery areas** in order to deliver against these priorities at scale and pace.



DA1: Improving your health and wellbeing

We are 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.

What we are going to do	How we are going to do it in Harrow	17/18	18/19	2019>
We are **reducing loneliness** by encouraging everyone to be part of our local community	• We are increasing community networking and provide opportunities for residents to help each other through Harrow Communities Click.	★	★	★
	• We are integrating more with voluntary services and using social prescribing more (e.g. the 'Age of Loneliness' app) to improve community networks.	★	★	★
We are **increasing self-care** We are working to **prevent cancer** We want to **reduce the stigma** of mental health problems	• We are using technology (including apps), expert patient programmes and personal health budgets (My Community ePurse) to increase self-care provision.	★		
	• We are working in partnership to improve cancer screening uptake, particularly in marginalised and seldom heard groups in Harrow.	★		
	• We are promoting the Time to Talk campaign to reduce mental health stigma.	★		
We are **encouraging employment** for people with a learning disability or mental health problem	• We are providing an employment mental health service that is linked to existing talking therapies, which aims to support people with mental health conditions into employment.	★		
	• We have signed the NHS Learning Disabilities Employment Pledge and are developing an action plan to increase employment for people with a Learning Disability.	★		
We are **enabling and supporting healthier living**.	• We are developing new, and promoting existing ways of signposting residents to facilities, information, advice and services which promote health and wellbeing.	★	★	★
	• We are promoting the NWL People's Health and Wellbeing Charter which aims to manage and reduce demand in health and care services through encouraging behavioural change in residents and staff.	★	★	★
	• We will begin a pilot at Northwick Park hospital to reduce emergency activity caused by alcohol.	★		
We are **addressing issues that affect health** such as housing, employment, schools and the environment.	• We are developing a healthy workplace programme across health and care staff and encouraging other large employers in Harrow to do the same. We will achieve commitment to the Healthy Workplace Charter before 2018-19.	★		
	• This year, we will will conduct health impact assessments on redevelopment areas (e.g. Grange Farm, Civic Centre) and make recommendations to promote health and wellbeing.	★		
We are **supporting children to get the best start in life** *[see also DA4: Improving mental health services]*	• We are redesigning early help & the 0-19 public health nursing health visiting services to better meet the needs of our population.	★	★	★
	• We will ensure that diagnostic, assessment and integrated care pathways are in place for people with a Learning Disability, autism and complex and challenging behaviour.	★		
	• We will improve the availability of Long Acting Reversible Contraceptives (i.e. implants, injections and intrauterine devices), maternity and abortion services and services for early pregnancy loss.	★	★	★
	• We will reduce childhood obesity through nutrition education and physical activity.	★		
	• We will work with our population to increase immunisation rates.	★	★	★

NHS Trust

DA2: Better care for people with long term conditions

Every patient with a long term condition (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 long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are **improving quality and access** in primary care. *[See also DA5: Safe, high quality sustainable services]*	• We are increasing access to primary care (aligned with GP Access Fund) so that residents can see a GP when they need to, rather than going to an urgent care centre or A&E.	★		
	• We will ensure that referrals to our specialists are necessary and appropriate, through the Referral Optimisation Service.	★		
	• We will standardise treatment of asthma and diabetes patients in GP practices, to improve care.	★		
	• We are educating primary and community clinicians in insulin initiation for diabetes patients, providing care closer to home and at lower cost than in a hospital setting.	★		
	• We are supporting integrated care teams and primary care to proactively monitor patients at risk of hospital admission through the Risk Stratification Dashboard, and intervene as necessary.	★		
	• We are supporting the development of GP federations, enabling delivery of primary care at scale (to around 50,000 people), which should improve access for patients.	★		
We are **increasing early cancer diagnosis** We are **enabling faster treatment** of cancer	• We will learn from the Healthy London Partnerships Transforming Cancer Programme to improve diagnostic capacity, patient information and inter-Trust referrals for our residents with cancer.	★		
	• We are improving access to cancer treatment through providing enhanced local acute oncology services, and a new straight to test endoscopy service at Northwick Park, which will reduce the time to treatment and minimise unnecessary outpatient appointments.	★		
We are **improving outcomes and support** for people with common mental health needs. We are **addressing the mental health needs** of people with long-term physical health conditions. *[See also DA4: Improving Mental Health Services]*	• We are improving the mental health of people with diabetes by providing talking therapies to diabetics with depression and / or anxiety.	★		
	• We are increasing access to, and availability of, early intervention mental health services, such as psychosis services, psychological therapies and community perinatal services. Like Minded	★		
We are **improving people's health and outcomes** We are developing new ways of **preventing and managing long term conditions**.	• We are implementing an Integrated Diabetes strategy so that diabetic patients can be managed in community clinics with consultant and GP led support.	★		
	• We are enhancing community respiratory services, so that patients can be treated closer to home. This will be through acute consultant input to community clinics, and a new pulmonary rehabilitation service.	★	★	★
	• We will develop a community cardiology service to provide care closer to home. NHS RightCare	★		
	• We are improving our falls prevention service that will provide support to nursing homes. This should avoid falls and their subsequent admission to hospital.	★		
We are **promoting self-management** and 'patient activation'	• We are implementing a joined up approach to new technologies, developing local and regional apps to signpost self care tools and information.	★		
	• We are deploying a Patient Activation Measure pilot with patients engaged in Whole Systems Care, with a view to improving their knowledge, skills and confidence in managing their own health.	★		
	• We are helping the voluntary sector to support self-care through access to expert patient programmes and personal health budgets.	★		
	• We are providing self-help training for diabetes patients.	★		

DA3: Better care for older people

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

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.

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are taking a **whole systems** approach to commissioning and delivery of local services	• We will continue to progress local innovative delivery of Whole Systems Integrated Care (WSIC) and Primary Care Transformation	★		
	• We will take action following a NWL-wide market analysis of older people's care homes to ensure Harrow has enough quality provision to meet the needs of our population. (North West London Whole Systems Integrated Care)	★		
We are **implementing an Accountable Care System**	• We will develop and procure an Accountable Care System(ACS) business model. This will support our services through working across the care pathway, removing boundaries and supporting an efficient and effective care service.	★		
We are **upgrading rapid response and intermediate care services**	• We will accelerate deployment of the Integrated Urgent Care Pathway in Harrow, aligned with the NWL plans and Better Care Fund (BCF) developments, to provide residents with an alternative to A&E.	★		
	• We are providing a rapid response in-reach service to our nursing homes so that residents can be treated within their nursing home, rather than being admitted to hospital.			★
	• We are extending the virtual wards initiative, where people are provided with intensive nursing and social care within their own homes, rather than in hospital.	★	★	★
We are creating an integrated and consistent **transfer of care approach** across Harrow	• We are improving alignment, information sharing and joint delivery between services e.g. Improving Access to Psychological Therapies (IAPT) and the local authority re-ablement team.	★		
	• We are rolling out a Harrow Integrated Health and Social Care single assessment process to support early interventions and accelerate discharge to appropriate non-hospital care settings. (The Better Care Fund)			★
	• We will protect adult social care activity levels through Better Care Fund funding.	★		
	• We are exploring new models of care including Discharge to Assess and Hospital at Home to support our resident to get the right care in the right place..	★		
We are **improving care in the last phase of life**	• We are identifying patients who are potentially in their last phase of life through advanced care plans and risk stratification, which will improve management of those patients in their preferred setting (usually in their own homes).	★		
	• We are increasing staff training on managing End of Life Care across all Harrow providers, to ensure patients are managed according to their wishes.	★		
	• We are improving and implement proactive signposting to last phase of life resources for both patients and carers, to increase care in the community and reduce dependence on acute hospitals.	★		
	• We are streamlining processes to improve access to palliative care funding to enable people to make choices and have a degree of control over their own End of Life care pathways.	★		
	• We are reviewing how to integrate the Palliative Care nursing team with other End of Life services, so that care provided to patients is seamless.	★		
	• We are redesigning the End of Life pathway in partnership with Brent CCG and London North West Health	★		

DA4: Improving mental health services

No health without mental health

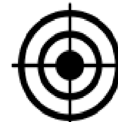
I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My 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.

What we are going to do

We are **implementing the new model of care** for people with serious and long term mental health needs

We are **improving physical and mental health** and increasing life expectancy
[See also DA2: Better care for people with long term conditions]

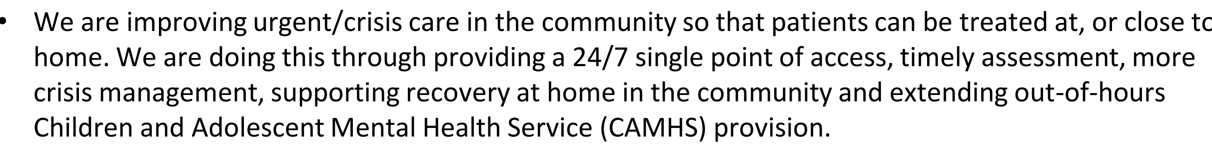
How we are going to do it in Harrow	17/18	18/19	2019>
We will improve specialist community-based support through opening up Early Intervention in Psychosis team access to all age patients - specifically for patients who are over 35 – and embedding a link worker model for delivery of interventions to patients who are over 35.	★		
We will embed physical health check assessments within inpatients and Early Intervention in Psychosis community teams, ensuring outcomes are factored into care plan management.	★		
We will improve pathways between the mental health Single Point of Access and Local Teams.	★		
We will provide different types of accommodation for mental health patients - moving towards independent living with floating support. We will also implement a Supported Housing Strategy, to improve access for people with mental health issues to access good quality, affordable housing with tenure options.			★
We will implement Community Based Packages to provide mental health care closer to people's homes.	★		
We will improve the efficiency and responsiveness of community teams through using data analytics to centrally schedule community team visits and minimise the time spent on non-face-to-face activities. We will also install hard/software infrastructure to allow for video conferencing with patients.			★
We are enhancing our investment in Primary Care Mental Health services, to improve access to mental health services.	★		
We are providing mental health training to GPs (through an Advanced Diploma in MH Care), peer support, and other treatment types in line with proposed Like-Minded model.			

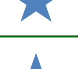


We are focussing **interventions for target populations**

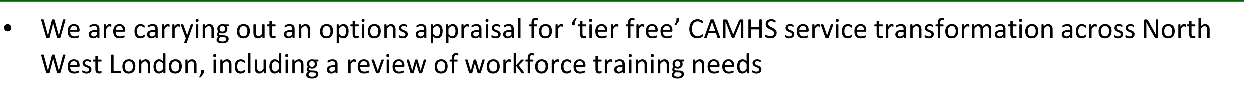
How we are going to do it in Harrow	17/18	18/19	2019>
We are providing specialist perinatal mental health community services.	★		
We are promoting the 'Five ways to wellbeing' amongst older people to improve their mental health	★		
We are supporting the 'Work and Health Programme', which provides work placements for people with common mental health needs	★		

We are **improving crisis support services**
We are delivering the '**Crisis Care Concordat**'



How we are going to do it in Harrow	17/18	18/19	2019>
We are improving urgent/crisis care in the community so that patients can be treated at, or close to, home. We are doing this through providing a 24/7 single point of access, timely assessment, more crisis management, supporting recovery at home in the community and extending out-of-hours Children and Adolescent Mental Health Service (CAMHS) provision.			
We are also exploring alternatives to inpatient admissions, such as crisis houses/recovery houses.			

We are implementing 'Future in Mind' to **improve children's mental health and wellbeing**



How we are going to do it in Harrow	17/18	18/19	2019>
We are carrying out an options appraisal for 'tier free' CAMHS service transformation across North West London, including a review of workforce training needs			
We are improving access to local care and support for carers and patients through developing an emotional health and wellbeing service offer , ensuring links to Primary Care Transformation			
We are providing a new community eating disorder service for children & young people			

DA5: Safe, high quality sustainable services

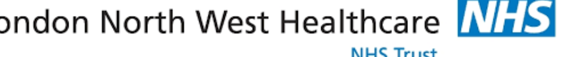
High quality specialist services at the time you need them

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

What we are going to do	How we are going to do it in Harrow	When are we going to do it: 17/18	18/19	2019>
We are **improving quality and access** in primary care. *[See also DA2: Better care for people with long term conditions]*	• We will implement care models for three Primary Care Hubs which will provide integrated delivery for identified pathways.	★		
	• We will open an East Harrow Hub in 2018/19 which will include a walk-in centre. This will improve access to primary care and reduce pressure on urgent care and A&E, and will support our Integrated Urgent Care model.			★
	• We will implement an integrated patient information solution which will provide real time integration between GP Practices and Harrow's Community Services provider.	★		
We are delivering the **7 day services standards**	• We are supporting enhanced access to primary care through the establishment of GP Network hubs to deliver primary care services, especially at evenings and weekends.	★		
	• We will support development of a 7-day inpatient emergency service with increased consultant input.			★
We are **reconfiguring acute services**	• We will implement the ongoing programme to improve the quality of services through restructuring and consolidating services (Shaping a Healthier Future).	★		
	• We will introduce a paediatric assessment unit at Northwick Park. and work to achieve London Quality Standards on e.g. consultant cover.	★		
We are using specialised commissioning to **improve pathways from primary care** We are supporting **consolidation of specialised services**	• We will use CQUIN and QIPP levers to improve the efficiency and quality of care for patients, focussing on: innovation (increasing tele-medicine), improved bed utilisation by implementing a Clinical Utilisation Review, initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life.	★		
	• We will establish a Renal Clinical Improvement Network to build on existing centre of excellence.	★		
	• We are implementing the national Hepatitis C programme to reduce the likelihood of liver disease resulting from Hepatitis C infection.	★		
	• We are contributing to NWL-wide reviews CAMHS, radiology, imaging, HIV, paediatric transport and neuro-rehabilitation services and will implement the recommendations arising from these.	★		

Shaping a healthier future

Central and North West London



Enablers to support the 5 Delivery Areas

There are three enablers to support delivery of the 9 priorities and 5 delivery areas. These enablers cut across all areas, and will support the STP plans to make them effective, efficient and delivered on time.

The below figure is taken from the NW London Strategy and Transformation Plan and provides an overview of how the enablers will change the landscape for health and social care in NW London.

Delivery Areas

1. Improving your health and wellbeing
2. Better care for people with long term conditions
3. Better care for older people
4. Improving mental health services
5. Safe, high quality sustainable services

Estates will…

- Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale. In Harrow this will be through the East Harrow Hub.
- 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

Digital will…

- **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

Workforce will…

- **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

This page is intentionally left blank

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	20 July 2017
Subject:	**INFORMATION REPORT – Better Care Fund (BCF) Update Quarter 4 2016/17 and 2017/18 Plan**
Responsible Officer:	Chris Spencer, Corporate Director People Services & Paul Jenkins, Chief Operating Officer, Harrow CCG (Interim).
Exempt:	No
Wards affected:	All
Enclosures:	N/A

Section 1 – Summary

This report sets out progress on the BCF, Better Care Fund in the fourth quarter – Q4 of 2016/17.

(Report submitted to NHSE 31st May 2017 in accordance with prescribed deadlines).

FOR INFORMATION

Section 2 – Report

The Harrow BCF annual plan 2016/17 was originally submitted to NHS England on June 17th 2016. The agreed value of the Better Care Fund in Harrow is £16.258m, £1.181m of which reflects the capital funding in relation to Disabled Facility (the Community Capacity Grant having been discontinued).

The balance of £15.077m allocated to revenue funding supports two agreed schemes.

NHS England subsequently made a number of changes to the reporting format for the plan which was re-submitted on September 8th 2016 along with the S75 agreement between Harrow CCG and Harrow Council.

As a result of the changes to the plan format a number of changes were made to the reporting template which was released later than anticipated incurring a delay in reporting timelines.

This report covers the Q4 report of the 2016/17 plan.

The BCF agreed schemes within the 2016/17 plan include:

- **Protecting Social Care - £ 6.558m.**

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

  These schemes are a continuation of schemes established in the 2015/16 BCF plan.

- **Whole Systems & Transforming Community Services - £8.519m.**

  Harrow CCG re-tendered its community service contract late summer 2015. The new contract award was made in December 2015 and the new service became operational in May of 2016 with the Community Rapids Discharge service following on October 4th 2016.

  Through the re-commissioning and re-configuration of community services Harrow CCG has better aligned its community service provision with primary and social care towards establishing a Single Point of Access to community services. The new community service provider transferred its IT operating system to EMIS Community, the system used by Harrow GP's on November 7th 2016.

This development will support the CCG and partners to deliver more integrated and joined up services that will support reducing admissions into acute care and delivery of care in community settings.

The community services model underpins the vision for an ‘Accountable Care Organisation – ACO’ for Harrow which will improve access to care and IMPROVE the patient experience for Harrow registered patients.

Section 3 – Further Information

The 2016/17 BCF plan also agreed a plan to deliver the national conditions as set out by NHS England.

The conditions are as follows:

- Protection of social care services.
- 7 day services to support patients being discharged
- Data sharing – NHS number being used as the primary identifier for health and social care services and appropriate agreements in place
- Joint assessments and lead professionals in place for high risk populations
- Agreement on the impact of changes with the acute sector.

The following are extracts from the Q4 report that indicate our position in relation to the plan. This version also has an additional section which includes the summary of year end performance as submitted on May 31st 2017.

We have supplied data in narrative form in key areas to give an indication of where we estimate our end position.

National Conditions – Table 3.

Condition (please refer to the detailed definition below)	Please select “Yes” “No” or “No - in progress”	If the answer is “No” or “No –in progress” please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is “No” or “No – in progress” please provide an explanation as to why the condition was not met within the quarter and how this is being addressed
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services – please confirm:			
(i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically	No – in progress		Discussions on going but have progressed significantly.

appropriate			
(ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No – in progress		As above.
4) In respect of Data Sharing – please confirm:			
(i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
(ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
(iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
(iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No		Agreement underway with good progress made.
6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.	Yes		
7. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care.	Yes		

8. Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan.	Yes		

National and locally defined metrics – Table 5.

Non-Elective Admission	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	690 above plan (2579 last month) which is entirely attributable to increased short stay admissions. This is however offset by some decrease in the numbers of long LoS. The increase is being reviewed via joint audit with initial results indicating inappropriate use of beds and chairs in observation areas for patients to either wait for 'path' results or admission. The acute Trust is also validating a potential double count of some of the short/long stay admissions, audit finding due w/e 19th May. This work is likely to trigger an audit/review of GP heralded admissions.

Delay Transfers of Care [DToC]	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target.
Commentary on progress:	We have experienced increases in our DToC numbers over the year but have in place robust processes to monitor the position on a daily basis with partners. As a result we have seen a decrease in Q4, utilising our community beds capacity. We had our 1st week of 0 DToC's in April 2017 since we started monitoring the data and activity in April 2016. The annual DToC report will be circulated by the end of Q1 2017

Local performance metric as described in your approved BCF plan	Social Care User Satisfaction was identified in the BCF as the local performance metric. This is measured annually
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	There was a drop in reported satisfaction from 58% to 53% (NB only 'extremely' or 'very' satisfied responses are included) but this is within the survey margin of error. There are no targets for this survey measure. Analysis of last year’s data showed that feeling in control of daily life, good nutrition and being treated well by staff were the strongest drovers of satisfaction with services. The survey recently closed, so analysis work will continue to work out what accounts for the

	results and what follow up actions might be included.

Local defined patient experience metric as described in your approved BCF plan If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	Overall GP experience
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	As anticipated we maintained the previous years performance but did not fully meet the target. The July 2016 Ipsos Mori survey results are 46% of patient reported good levels of GP satisfaction and 32% reported fairly good - consistent with the previous quarters position.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The indicator has slightly improved in 2016 -17 with fewer admissions to residential care made for older people in year, down from 190 - 182 people, with a modest population increase estimated (exact figures not available at the time of writing). The target is being achieved despite pressure from hospital discharges and 'complex cases' in the community. Increasingly, community based solutions are more expensive than residential options.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	The result this year of 76.4% is slightly lower than last year (77.6%) against a target of 80%. The result follows a familiar pattern with rehabilitation/reablement services offered widely (3rd highest in London last year) but success rates relatively lower as a consequence.

Year End feedback.

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

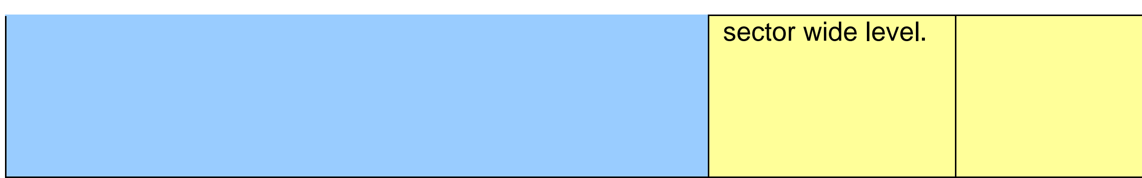
Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Developing and implementing the plan has supported both the CCG and LA to gain greater understanding of each other's business and operating challenges. Through continued joint working both partners have been able to provide a unified and supportive response to the wider health and care economy at peak times.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	All plans were realised with the exception of 7/7 working and Single Assessment as set out in the guidance. Both partners face significant financial pressure in the face of increasing demand and more complex needs. The partners have flexed existing services to provide an enhanced service, some delivered 24/7 and both will continue to work towards 7/7 working. The single assessment form development has moved significantly but is affected by the fact that there is not full interoperability across providers.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The fund has given all partners increased flexibility to develop services and to transform existing ways of working and pathways. This has been done through shared working of the Systems Resilience Operational Group working across BHH.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Neither agree nor disagree	Harrow did not fully meet its NEL target due to a number of pressures that we are looking at in order to learn from the experience going forward. A large portion of the plans in Harrow CCG's 2017 QIPP will be aimed at reducing NEL's aligned with the BCF plan and other initiatives.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Strongly Agree	2016/17 has been the most positive in Harrow CCG's DToC performance with numbers in single figures for the bulk of the year. Similarly the LA's DToC performance has been positive with larger numbers of people being discharged home with reabling care packages.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and	Neither agree nor disagree	The proportion of older people still at home has fallen very slightly in the past year (and is short of target) but the high volume of support provided (as a proportion of live discharges) has been maintained.

over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services		
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	The number of care home admissions had been rising but in 2016-17 fewer admissions have been recorded. Notably more existing clients were supported to remain living in the community following a change in circumstances, rather than being placed in care homes.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Development and on-going monitoring of the plan has enabled the partners to better understand the pressures facing the respective partner organisation at a time of increasing and often unprecedented demand for services. This has helped to strengthen our shared responses at times of peak activity and has helped greatly to shape shared thinking around the future vision for Harrow.	1. Shared vision and commitment
Success 2	The plan and its implementation is a substantive item at a monthly Health & Wellbeing Board sub group - HWBB Joint	2. Shared leadership and governance

	Executive, which is attended by senior leaders from both organisations. This has helped all partners to understand the finer details of the plan and the interdependencies between the various elements of the plan. This has helped to enhance discussion with the wider Health & Wellbeing Board membership demonstrating a joined up approach to delivery of the plan through a shared leadership approach.	
Success 3	Relationships between the partners are at their strongest and this has been demonstrated through successful joined up responses to increasing pressure facing the system. This happens at a number of levels, operationally in acute and community services most notably demonstrated by the steady state of our DToC performance at its best for some years in 2016/17. The collaboration continues at a more strategic level with a wide range of partner supporting strategic operational resilience at a borough and	3. Collaborative working relationships



Section 4 – Financial Implications

Both the Council and CCG continue to face financial challenges and optimising the allocation of BCF resources remains a key priority of the plan. The national picture for the finances of the public sector continues to remain very challenging. Projections by London councils based on the government spending plans are for additional reductions of over 30% over the next two years. As a result this is likely to translate into further significant grant cuts in the coming years although projections show on–going pressures on the Councils budgets driven largely by the statutory responsibility on the council to meet the increase in demand relates to individual with complex care needs requiring higher intensity care provision. This national picture is reflected locally as the outturn (Q4) position reported to Cabinet in June reported an overspend of £2.7m on the Adult Social Care budget.

The CCG has developed a recovery plan that has been submitted to NHSE. For 2017/18 the CCG is planning for £21.2m in year deficit ((6.5)% of recurrent resource limit). To deliver this plan the CCG will need to deliver a £17.5m QIPP (savings) plan.

In February, Council approved the budget for 2017/18, which included growth of £4.629m for Adult social care (funded by the 3% precept) to fund these underlying pressures and the budget assumed the continuation of the BCF funding for the protection of social care at £6.558m. The NHS planning guidance, issued at the end of March, prescribed inflationary uplifts of 1.79% on the 16/17 allocations, although the 2017-18 BCF has yet to be agreed.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

The BCF will improve the following priorities:

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

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

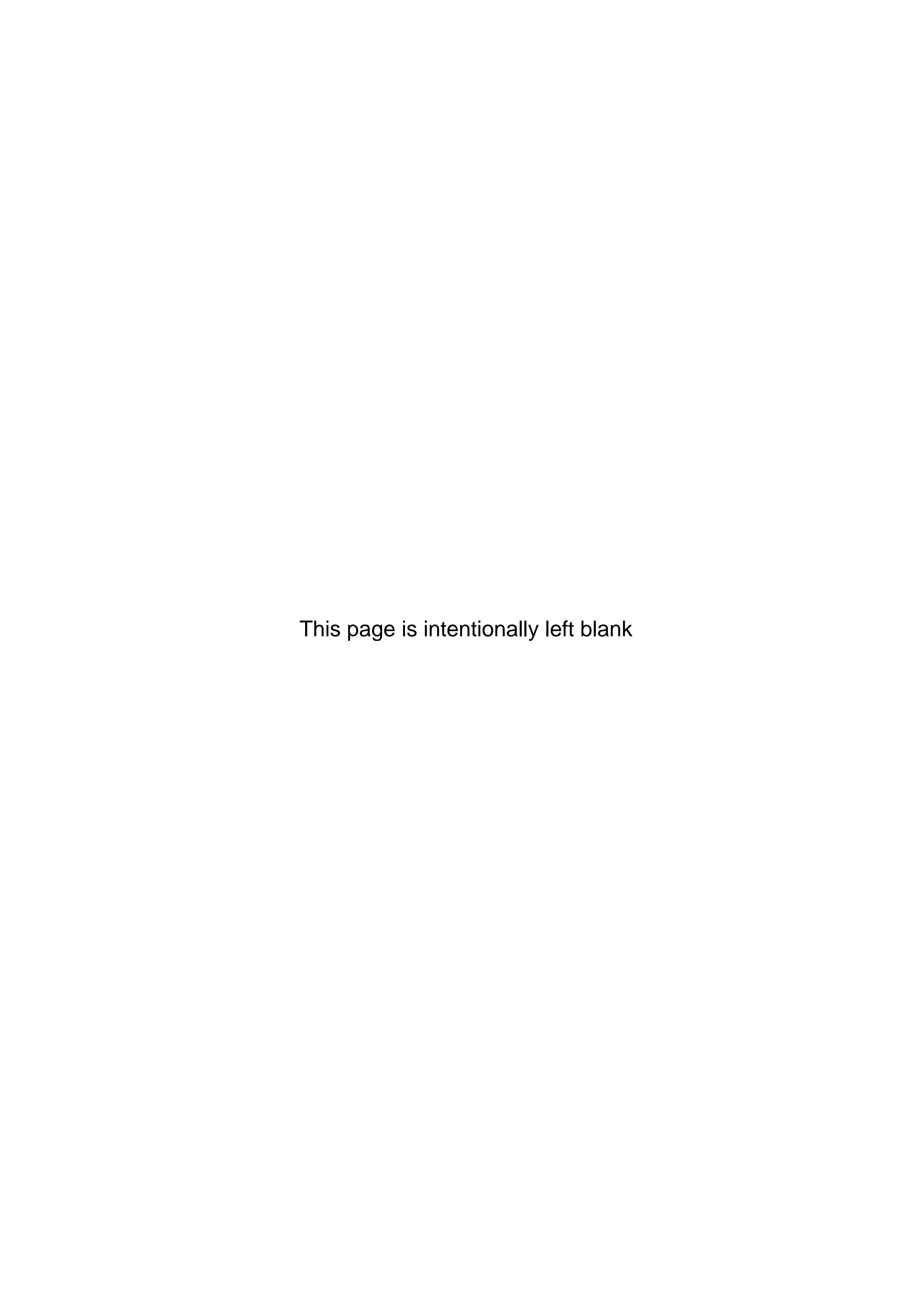
Name: Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 27 June 2017		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Garry Griffiths, Assistant Chief Operating Officer, 0208 966 1067

Background Papers: List **only non-exempt** documents relied on to a material extent in preparing the report. (eg previous reports) Where possible also include electronic link.


This page is intentionally left blank

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	20 July 2017
Subject:	**INFORMATION REPORT - Harrow CCG Annual Report and Annual Account 2016/17**
Responsible Officer:	Paul Jenkins - Interim Chief Operating Officer
Exempt:	No
Wards affected:	All
Enclosures:	Annual Report and Accounts 2016-17

Section 1 – Summary

CCG's annual report for 2016/17 provides an overview of performance and our achievements during the past 12 months along with how we spent the money allocated to us and how we delivered our services.

FOR INFORMATION

Section 2 – Report

The report provides Harrow CCG's performance and achievements during the past 12 months.

Section 3 – Further Information

Not applicable

Section 4 – Financial Implications

Not applicable

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? Not required

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

- Please refer to the attached document to understand how the proposed changes will make a difference for older people, families, and communities.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

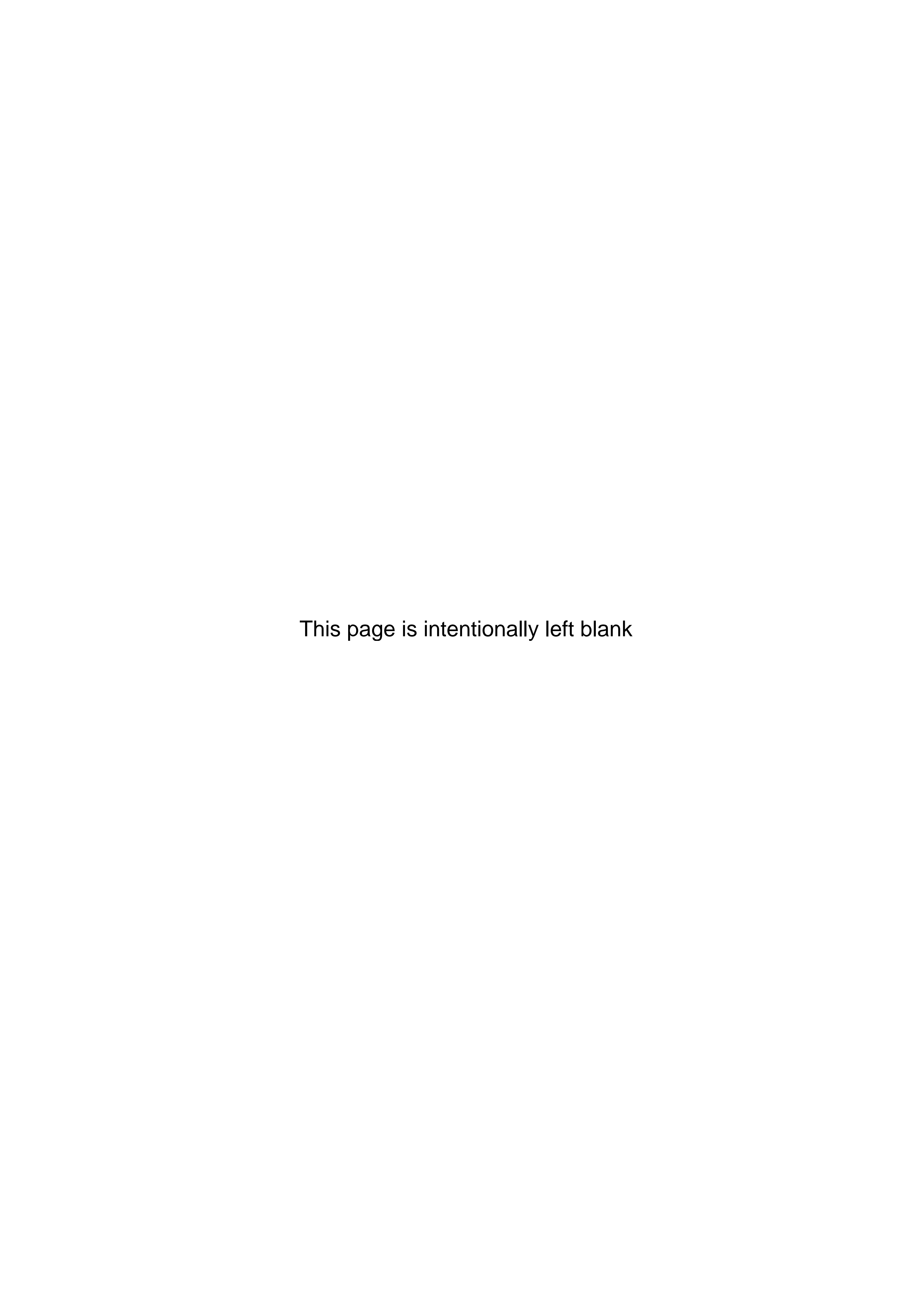
Not required

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Gary Griffiths, Assistant Chief Operating Officer, Harrow CCG
0208 966 1067

Background Papers: Annual Report and Accounts 2016-17


This page is intentionally left blank

NHS Harrow Clinical Commissioning Group

Annual Report and Accounts 2016/17

Performance Report 1

1 Performance Overview 2

1.1 Statement from the Chair and Accountable Officer 2

1.2 Our vision and who we are 3

1.3 How the CCG works and its activities 3
1.3.1 Taking forward devolution in health and care for London 6

1.4 Health of the borough 6

1.5 Achievements 8

1.6 Priorities 10

1.7 Health and Wellbeing Strategy 11

1.8 Key issues and risks 12
1.8.1 Issues 12
1.8.2 Risks 13

1.9 Going Concern 13

1.10 Performance summary 13

1.11 How we spent your money 15

2 Performance Analysis 16

2.1 How the CCG measures performance 16

2.2 Development and performance during the year 16
2.2.1 Financial targets 16
2.2.2 Funding allocations 17
2.2.3 Accident and Emergency (A&E) department 17
2.2.4 Referral to Treatment (RTT) 18
2.2.5 Diagnostic waiting times 18
2.2.6 Cancer waiting times 19
2.2.7 Improved Access to Psychological Therapies (IAPT) 20
2.2.8 Dementia diagnosis 21
2.2.9 Health Care Associated Infections (HCAIs) such as MRSA and C.difficile 22

2.3 Sustainable Development 23

2.4 Improve quality 23
2.4.1 Continuing HealthCare (CHC) 25
2.4.2 Quality and safety monitoring and assurance 25
2.4.3 Clinical effectiveness 26

2.4.4 Quality assurance visits 26
2.4.5 Mortality 26
2.4.6 Patient safety 27
2.4.7 Pressure ulcers 27
2.4.8 Safeguarding 27
2.4.9 Infection control 28
2.4.10 Patient experience 29
2.4.11 Leadership/Responsiveness (Well-Led) 30

2.5 Patient and public involvement 30

2.6 Reducing health inequality 32

Accountability Report 35

Corporate Governance Report 36

3 Members' Report 36

3.1 Member profiles 36

3.2 Member practices 41

3.3 Composition of Governing Body 42

3.4 Committees, including Audit Committee 43
3.4.1 Audit Committee 43
3.4.2 Executive Committee 43

3.5 Register of Interests 44

3.6 Raising concerns – whistleblowing arrangements 44

3.7 Personal data related incidents 44

3.8 Statement of disclosure to Auditors 45

3.9 Modern Slavery Act 45

4 Statement of the Accountable Officer's Responsibilities 46

5 Governance Statement 48

5.1 Introduction and context 48

5.2 Scope of responsibility 48

5.3 Governance arrangements and effectiveness 48
5.3.1 CCG Constitution and structure 48

5.3.2 Governing Body 49
5.3.3 Audit Committee 51
5.3.4 Executive Committee 52
5.3.5 Procurement Panel 54
5.3.6 Other Governing Body committees 55
5.3.7 Joint committees with delegated decision making authority 57
5.3.8 Other Joint Committees 58
5.3.9 Clinical Board 59
5.3.10 Shaping a Healthier Future (SaHF) Implementation Programme Board 59

5.4 UK Corporate Governance Code 60

5.5 Discharge of statutory functions 60

5.6 Risk management arrangements and effectiveness 60
5.6.1 Risk management strategy 60
5.6.2 Capacity to handle risk 64
5.6.3 Risk assessment 65

5.7 Other sources of assurance 67
5.7.1 Internal control framework 67
5.7.2 Annual audit of conflicts of interest management 67
5.7.3 Data quality 68
5.7.4 Information Governance 68
5.7.5 Business critical models 69
5.7.6 Third party assurances 69
5.7.7 Health and safety 69
5.7.8 Complaints 69
5.7.9 Freedom of Information (FOI) 70
5.7.10 Emergency planning preparedness and resilience 70

5.8 Control issues 71

5.9 Review of economy, efficiency and effectiveness of the use of resources 71
5.9.1 In-year and underlying financial position 72
5.9.2 Delegation of functions 73
5.9.3 Counter fraud arrangements 73

5.10 Head of Internal Audit Opinion 73

5.11 Review of the effectiveness of governance, risk management and internal control 77

5.12 Conclusion 77

Remuneration and Staff Report 78

6 Remuneration Report 78

6.1 Remuneration committee 78

6.2 Policy on the remuneration of senior managers 78
6.2.1 Chair and Clinical Directors 78
6.2.2 Lay Members 79
6.2.3 Executive Directors 79
6.2.4 Executive Directors performance related pay 80

6.3 Remuneration of very senior managers 80

6.4 Senior Managers remuneration (salary and pension entitlements) 80
6.4.1 Senior Managers definition 80
6.4.2 Senior Managers: salaries and allowances (has been subject to audit) 81
6.4.3 Senior Managers: Salaries and allowances – joint appointments (has been subject to audit) 82
6.4.4 Senior Managers: pension benefits (has been subject to audit) 84

6.5 Compensation on early retirement or for loss of office (has been subject to audit) 86

6.6 Payments to past senior managers (has been subject to audit) 86

6.7 Fair pay disclosure (has been subject to audit) 86

7 Staff Report 87

7.1 Number of senior managers by band 87

7.2 Staff numbers and costs 87

7.3 Staff composition 88

7.4 Sickness absence data 88

7.5 Staff policies 88
7.5.1 Equality 88

7.6 Expenditure on consultancy 89

7.7 Off-payroll engagements 89

7.8 Exit packages (has been subject to audit) 90

8 Parliamentary Accountability and Audit Report 91

Independent Auditor's Report and Financial Statements 92

9 INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE

GOVERNING BODY OF NHS HARROW CLINICAL COMMISSIONING GROUP 93

10 Financial Statements 97

Performance Report

Staff from the Drug and Alcohol Service at a NHS Harrow CCG event

The Performance Report comprises of the:

- Performance Overview
- Performance Analysis

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

1 Performance Overview

1.1 Statement from the Chair and Accountable Officer

Welcome to the 2016/17 annual report for NHS Harrow Clinical Commissioning Group (CCG). This performance overview gives a summary of our achievements during the past 12 months, how we spent the money allocated to us and how we delivered our services.

It also sets out how we discharged our functions, our strategic vision, the key risks to achieving our objectives, our activities during the 2016/17 financial year and includes an outline of the overall health of the borough.

In the past year, the main focus of our work has been to work with neighbouring CCGs, the public, voluntary and third sector groups, NHS providers and the London Borough of Harrow to put together a five year plan for health and care in North West (NW) London.

The plan, called the North West London Sustainability and Transformation Plan (STP), is designed to maintain and improve the quality of care while making sure that services stay on an even financial keel.

You can read about the STP here. We've produced a second document which has more information about the specific plans for Harrow.

While much of the focus has been on the future, we have achieved a great deal this year too. You can read more in section 1.5 but some of the highlights include:

- Opening a third walk-in centre in the borough at Belmont Practice in East Harrow. Harrow residents now have access to 1,100 extra appointments a week at walk-in centres should they need to see a clinician urgently and they are unable to wait for a slot at their local GP practice,
- Launching the Health Help Now app – this is a portal for smart phones and tablets which delivers self-care tools and information with the details of local health services that are available.
- An integrated diabetes strategy is in place which includes acute, community, primary and social care services.

We're also committed to delivering extra investment for local health services. In December 2016, NHS Harrow CCG's Governing Body agreed to support a bid for over £500m of investment across North West London to improve NHS buildings and facilities in the next ten years. The bid will now be subject to approval by NHS England and central government.

For residents in Harrow, such an investment will bring many benefits including:

- improved GP practice buildings and facilities, making them accessible and enabling the delivery of many more services,
- a new out of hospital hub in Belmont/Kenmore (North East Harrow),

- developing more out of hospital services, creating out of hospital hubs at the Pinn Medical Centre and the Alexandra Avenue Health and Social Care Centre and
- improving buildings at Northwick Park Hospital and increasing the scope of post-surgery recovery and critical care beds.

You can find out more about the work we are prioritising for the future in section 1.6 and our Commissioning Intentions document , which sets out our plans for the next two years.

If you want to find out more about our work, please visit our website, where you can also find out dates, times and locations for our regular meetings of the Governing Body, which are held in public. We welcome the contributions of all our partners in planning and driving forward improvements in health and care services across Harrow.

Dr. Amol Kelshiker
Chair
NHS Harrow CCG

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs

1.2 Our vision and who we are

NHS Harrow CCG was established in April 2013 under Section 1H of the National Health Service Act 2006, as amended by Section 11 Health and Social Care Act 2012.

It is a GP-led organisation, responsible for planning, buying (commissioning) and designing many of the health services needed by the approximately 260,000 people registered with GPs in Harrow.

The CCG is one of more than 200 CCGs in the UK, whose collective challenge is to meet the demands of a population that is growing in size, getting older and living with increasingly complex conditions.

NHS Harrow CCG's vision is to work in partnership with local residents to ensure they receive high quality, modern, sustainable, needs-led and cost effective care, within the financial budgets available.

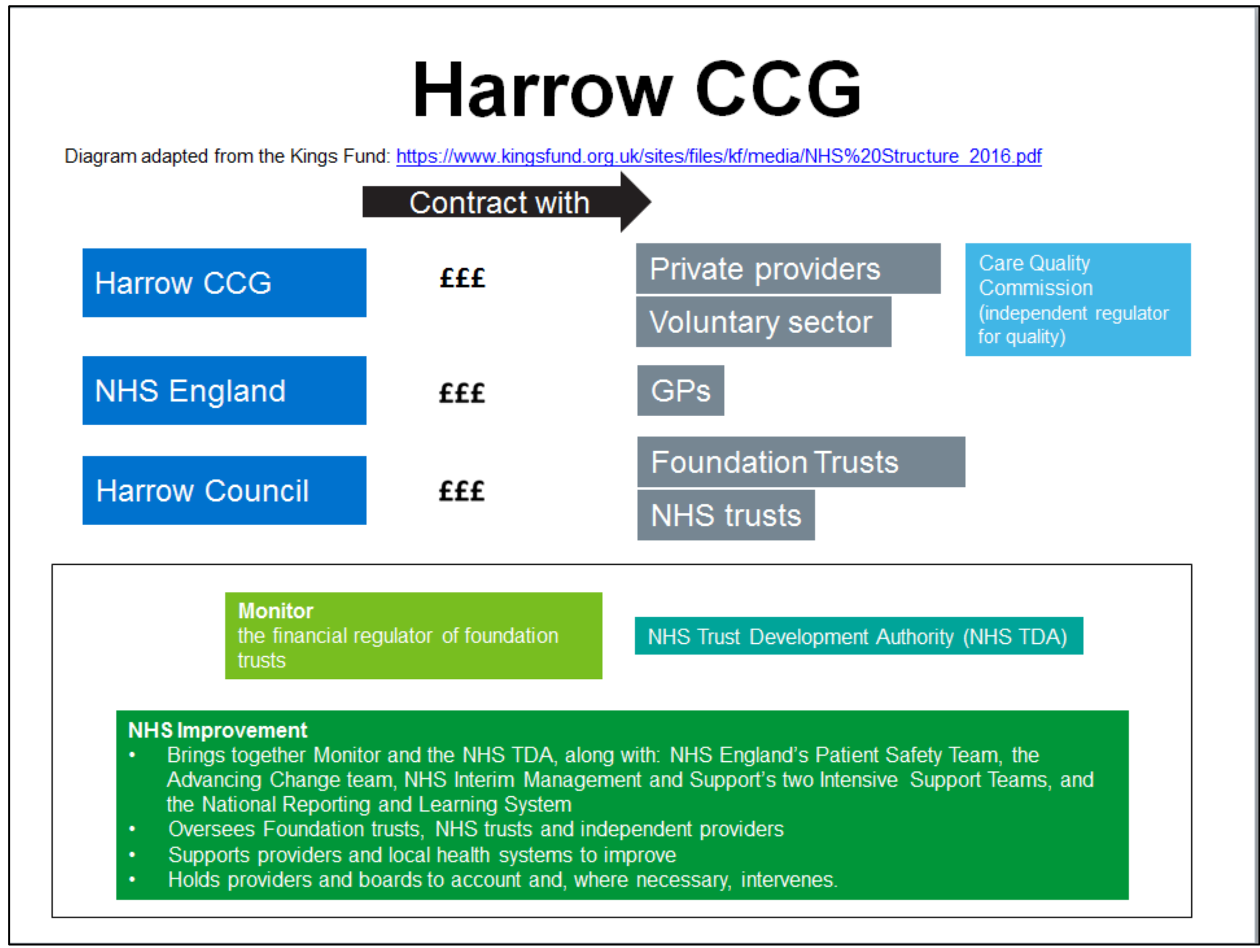
Our guiding principles are to deliver care that is personalised, localised, integrated (more joined up) and centralised, where it benefits patients.

1.3 How the CCG works and its activities

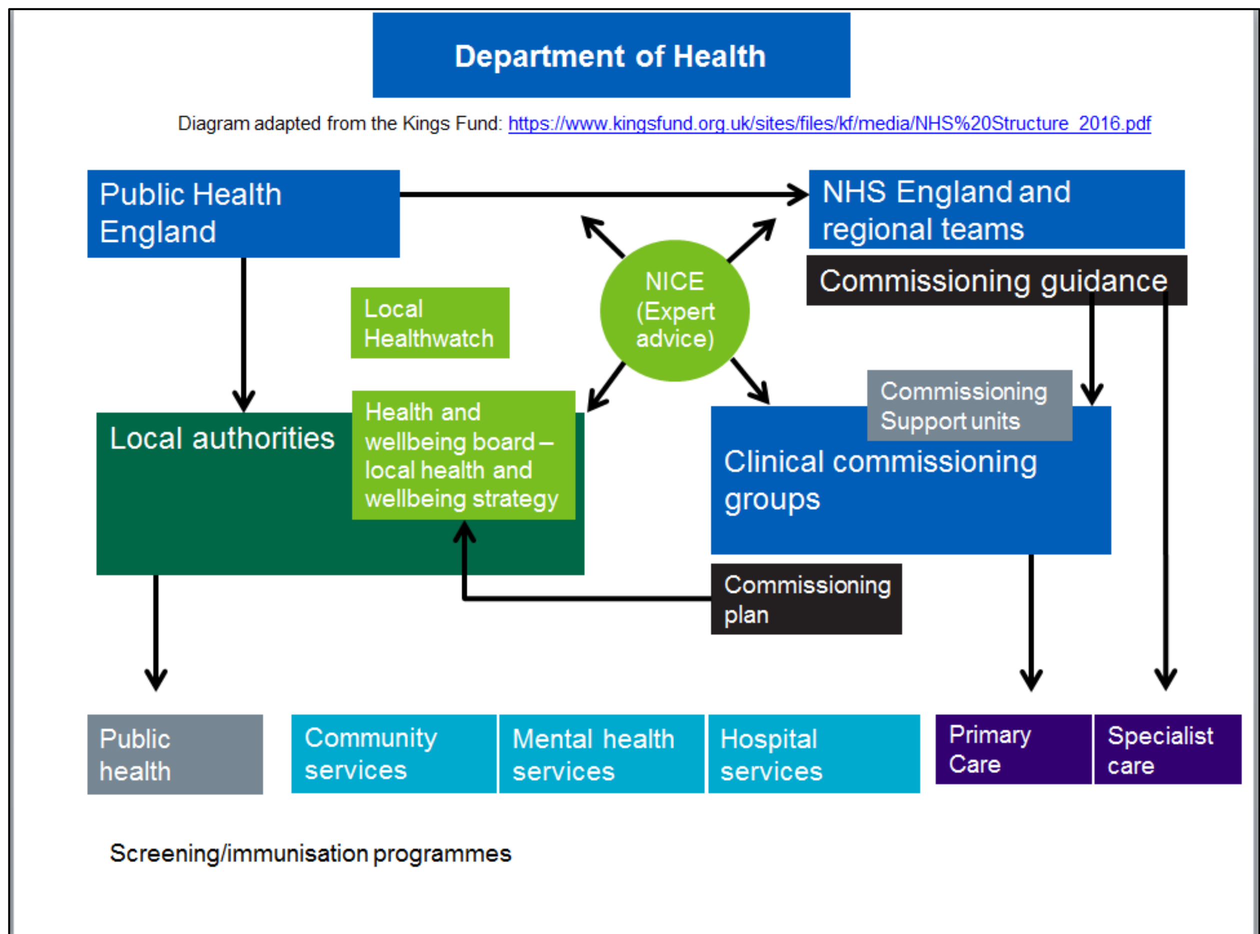
We are a membership organisation, made up of the 34 GP practices in the borough. Our vision is to work in partnership with our members to ensure that local residents receive high quality, modern, sustainable, needs-led and cost effective care within the financial budgets that are

available to us.

The diagrams below set out how NHS Harrow CCG works in the context of the roles of other health and social care providers. We also explain how public funding is used and the governance arrangements that are in place to ensure that public money is accounted for while maintaining priorities of delivering high quality care.



Harrow Healthwatch attends NHS Harrow CCG's Governing Body meetings.



- Primary care is commissioned jointly with NHSE who have the majority vote in decision making.
- Shared services operate in-house within North West London (NW London) CCGs, rather than through a separate Commissioning Support Unit (CSU).

Patients are always at the heart of everything we do. We make decisions about health services that take account of the feedback from patients, carers and local patient representative organisations to ensure services we purchase and re-design are those services that our residents need and are able to access.

The work of NHS Harrow CCG is overseen by its Governing Body, which ensures NHS Harrow CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. We continue to work with other CCGs in NW London to improve healthcare services for Harrow's residents.

By working together with patients and the public and other partners, we want to ensure that Harrow's patients get better access to care around the clock. This means:

- being able to get appointments with a GP quickly and conveniently,
- making sure that more specialist doctors are available, no matter the day of the week,
- ensuring that mental health is considered at the same time as physical health,
- facilitating one single, coordinated approach being taken by health and voluntary sector organisations and
- where longer term care from different people is needed, it is joined up so that a patient does not need to keep repeating their history to a range of different people across a number of services.

We make sure that the public helps us to shape care, and we involved them from the early stages in designing our services. We continue to listen to their feedback along the way.

Please visit our website for more information about NHS Harrow CCG and the work it does, including our constitution.

1.3.1 Taking forward devolution in health and care for London

London faces significant population, health, organisational and financial challenges which must be addressed if we are to support Londoners to be as healthy as they can be and for services to be sustainable. London partners, including London CCGs, have committed to work more closely together to support those who live and work in London to lead healthier, independent lives, prevent ill-health, and to make the best use of health and care assets. London health and care leaders have worked closely together at local, sub-regional and regional level over a number of years to develop a clear vision for better health and care, built on the views of Londoners, and central government and national bodies backed this commitment through the 2015 London Health Devolution Agreement.

Throughout 2016, local, multi-borough and sub-regional (STP) areas in London have worked hard to plan rapid improvements to health and care within existing powers. Five London devolution 'pilots' have also explored how more local powers, resources and decision making could accelerate the improvements that Londoners want to see. Our devolution work has underscored the importance of working at different levels in London under the three themes of prevention, integration and estates. We are clear that transformation must be locally led and that many services can only be delivered at the borough or smaller locality level, whereas others are more appropriately aggregated across boroughs or London-wide.

The forthcoming London Health and Care Devolution Memorandum of Understanding (MoU) will express commitments by national bodies to enable these improvements to go further and faster, based on the different ambition and appetite of local areas. We have also been working to commence delivery of more collaborative health and care governance and delivery capability at London-level working within the London Health Board arrangements. This aims to complement and support local areas in their transformation ambitions. As an example, the London Estates board has started to meet in shadow form, looking at what projects need help at a London level to progress more speedily and how NHS buildings are best utilised. This work will help to deliver the modern buildings which London's health service needs, use them as intensively as possible and potentially free up the land for much needed new housing.

1.4 Health of the borough

A comprehensive picture of Harrow’s health was captured in the Joint Strategic Needs Assessment (JSNA) document that was compiled by Harrow Council. What follows in this section is based on Harrow Council’s 2015/2020 JSNA.

Health and wellbeing is not just about health services alone. The biggest impacts on an individual’s health and wellbeing derive from the environments that people were born in, live or work in, their education, wealth and relationships with others.

Tackling the determinants of health is required across the full life cycle, using a life course approach (rather than an overview being considered at any single point in time). This uses the Marmot approach based on the Marmot Review published in 2010 which set out key areas that needed to be improved to make a significant impact in reducing health inequalities and addressing the health inequalities between the vulnerable and non-vulnerable populations. This approach helps to focus on people of all ages and stages of life.

The aim of Harrow's JSNA is to identify the inequalities in health and wellbeing and other associated factors in Harrow. Strategies and action plans are aimed at addressing such issues to improve the lives of people who live in the borough.

Around 260,268 people live in Harrow and just over half of this total population is female. 7% of the total population are under the age of 5 years and 7% of the population are people aged over 75 years. Compared to the average rates across London, the population of Harrow has a higher proportion of older people (those aged over 60 years) and a lower proportion of people that are in their 20s and 30s. The age structure of the population varies across the borough.

Ethnic diversity

Harrow is one of the most ethnically diverse boroughs in the country. In 2011, 43% of Harrow's population came from an Asian or Asian-British background. The percentage from a white ethnic background is almost equal at 42%.

A further 8% of the population comes from a Black/African/Caribbean or Black-British ethnic background. In the next 10 years, it is predicted that the local Black, Asian and minority ethnic (BAME) populations in Harrow will increase from 51% to 68% of the total population.

Every year, Harrow welcomes over 2,000 new British citizens in citizenship ceremonies. Demographics based on the age structure of the population and ethnic mix varies across Harrow. In Pinner and Pinner South wards, BAME groups make up around 40% of the total population, while in Queensbury, Kenton West and Kenton East, BAME groups make up over 70% of the population (this data was extracted from Census 2011). An increase in the BAME population will result in different patterns of health and illness than in previous years. For example, higher rates of diabetes and heart disease in BAME groups may require a different and culturally appropriate approach being taken when planning their prevention and treatment.

Religious diversity

Alongside ethnic diversity, Harrow has great religious diversity. Harrow is home to one of the largest Hindu communities in the country where 26% of the population are Hindu. There is also a greater proportion of people from Muslim and Jewish faiths than is the national average for England.

Gender/Sexual orientation

Although gender and sexual orientation is a protected characteristic under equalities legislation, robust data does not exist on numbers of people that classify themselves as lesbian, gay, bisexual or transgender.

On sexual orientation, data from the National Survey of Sexual Attitudes and Lifestyle, the Treasury and Stonewall (a UK charity supporting the rights of Lesbian, Gay, Bisexual and Transgender – LGBT – people) broadly agrees that approximately 5-7% of the population in Harrow classify themselves as lesbian, gay or bisexual.

It is also worth noting that, between December 2005 (when the Civil Partnership Act came into force) and the end of 2013, there have been 71 civil partnerships in Harrow. Since 29 March 2014, same sex marriages were permitted, but no local data is yet available to provide statistics.

Deprivation

Deprivation is most commonly measured by using the Index of Multiple Deprivation (IMD). This

index incorporates a number of factors and includes varied dimensions such as housing, employment and income to deliver a single deprivation score. Harrow is ranked 203 out of 354 districts in England where the first score relates to the most deprived district. Most deprivation can be found in the center of the borough, with some pockets of deprivation located in the south and east. Harrow's least deprived areas are likely to be found to the west of the borough. Not all disadvantaged people live in deprived areas and conversely, not everyone who lives in a deprived area could be classified as disadvantaged.

Vulnerable groups

In terms of children and young people, Harrow is home to 55,800 children aged between 0 to 17. About 3,100 children were in need of a social care service between April 2013 and the end of March 2014. This includes the 'Children Looked After' (CLA) categories, those supported in their families or independently, and children that were the subject of a child protection plan (CPP).

Key issues and challenges

Nearly two-thirds of Harrow's under 18 Children in Need (CiN) populations are from BAME groups. The proportion of children in need from Asian or Asian British origins was over one quarter (higher than the figures for our statistical neighbours). Harrow has a rate of 19.8%, the average figure for London is 13.1% and the average figure for England is 6.2%. As at 31 March 2014, approximately 54.8% of those in the CiN category were male children compared to 43.7% female children in Harrow. This percentage is consistent with London, England and Harrow's statistical neighbours.

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

- **Children with learning disabilities**
  The estimated prevalence of special educational needs in Harrow has remained consistent over time at 2.6%. This is lower than the average for London, at 2.7% and England's average of 2.8%. The number per 1,000 of children with moderate learning disabilities in Harrow is lower than London's average but is higher for children with severe learning disabilities.

- **Children with sensory impairments**
  For sensory impairments, approximately 180 children are reported to be deaf in Harrow and we have achieved a rate of 99% of regular hearing aid checks for these groups of children.

1.5 Achievements

Some of the achievements by NHS Harrow CCG are listed below:

- Opening a third walk-in centre in the borough at Belmont Practice in East Harrow. Harrow residents now have access to 1,100 extra appointments a week at walk-in centres should they need to see a clinician urgently and they are unable to wait for a slot at their local GP practice.
- With Harrow Council, setting up a new service targeting Children and Young Peoples' Emotional Health and Wellbeing Service. The service works with children having special

educational needs, disabilities and various disorders along the autism spectrum, CLA groups, young carers, and children or young people displaying challenging behaviours (and/or those who are experiencing life events from bereavement, self-harm, school exclusions and obsessive compulsive disorders or OCD).

- Launching the Health Help Now app – this is a portal for smart phones and tablets which delivers self-care tools and details of local health services that are available,
- Putting an integrated diabetes strategy in place which includes acute, community, primary and social care services.
- Working collaboratively with Harrow Council to improve the Children Looked After (CLA) service. The new service is in place following a successful two year pilot. It has become an integral and valued resource in Harrow and has been recognised as an example of good practice by NHSE, Ofsted and neighbouring CCGs.

Changes to maternity and childrens' services across North West London

In maternity services, we improved care and ensured the delivery of many new standards that were set out in the National Maternity Review 'Better Births' released in 2016. These improvements included:

- Meeting London's standard for the numbers of midwifes to births (100 new midwives were recruited).
- More consultants are available day and night.
- There is better continuity in care available through post-natal and ante-natal care in the same hospital.

We tested a range of new ways of working to transform maternity services. These improvements were recognised nationally.

Changes to children's services in NW London improved care

- Better access was made available day and night, seven days a week to more senior children's doctors in five hospitals across NW London.
- More inpatient and paediatric assessment beds were provided at West Middlesex, Hillingdon, Northwick Park hospitals.
- Four new paediatric assessment units provide same day care in a purpose-built environment for patients needing treatment, but where they do not need to be in A&E or be admitted to hospital. This reduces the average length of stay in hospital by 12 hours.
- An extra 48 paediatric nurses and 10 paediatric consultants have been introduced.

Mental Health in NW London

In 2016/17 new mental health services were launched including:

- a new 24/7, year round service providing support, advice and information for those who experience mental health illness, their carers and professionals which has helped reduce A&E attendances for people in mental health crisis by 300-400 a year,
- a new specialist assessment, treatment and support service for pregnant women or women who have given birth within the past year and
- a new service for children and young people affected by eating disorders which accepts self-referrals from young people and children, parents, as well as GPs, health and other professionals, including teachers. It aims to reduce 200 crisis visits per year.

1.6 Priorities

NHS Harrow CCG has a clear organisational vision to work in partnership to ensure that Harrow residents receive high quality, modern, sustainable, needs-led and cost-effective care within the financial budgets available.

CCG Chair Dr. Kelshiker reviewing how the Health Help Now app works

Priority 1 – Personalised services

- We are working with patients and other key stakeholders to ensure that we meet the diverse needs of Harrow residents.
- We will promote self-care and better healthcare education. By focusing on prevention, we will develop better patient pathways for diabetes and services that are related to musculo-skeletal conditions (MSK).

Priority 2 – Localised services

- We aim to reduce hospital attendance by commissioning more elective procedures outside hospitals, by investing more in building community and primary care capacity across the borough.
- We will work with GP Practices to increase the access to primary care services and provide more services out of hours.

Priority 3 – Integrated services

- We will transform services to deliver whole-systems community based care. This is focused on providing joined-up support for people who are at risk of hospital admissions or those who have Long-Term Conditions (LTCs).
- We will leverage the benefits of technology to provide more timely, joined up services

and better, more consistent treatments that make optimum use of resources.

- We will work with our partners in NW London to improve urgent care and out-of-hours care pathways to ensure that more responsive care and reduced pressures on A&E and the London Ambulance Services (LAS) are achieved.
- We will partner with other service commissioners and providers to develop better and more integrated mental health and children's services.

Priority 4 – Centralised services

- Where appropriate, people can get better care when services are centralised so all the specialist care they might need is in one place.
- At the same time, we want to reduce the amount of time patients spend in hospital by increasing the availability of community beds. We are also developing better, efficient care pathways for out-of-hospital care within community settings.

1.7 Health and Wellbeing Strategy

Under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, CCGs must, in exercising their functions, have regard to the most recent joint health and wellbeing strategy prepared by the local council.

Our vision of the local Harrow Health and Wellbeing Strategy is to help each other to start, live, work and age well. This is explained below:

- Starting well: we want children from the womb to adulthood to be safe, happy and able to receive every opportunity to reach their full potential.
- Living well: we want high quality, easily accessible health and care services when and where needed, sufficient and good quality housing, green spaces and spaces for activity, healthy high streets and neighbourhoods.
- Work well: we want to help people to be financially secure through finding good jobs and staying in work in organisations that will promote their overall health and wellbeing.
- Age well: we want to enable older people to remain well and connected to others while being able to live independently in their own homes for longer. We want to enable more dignified deaths.

The key priorities are to:

- use every opportunity to promote mental well-being,
- empower the community and voluntary sector to collaborate to deliver alternate delivery models and funding solutions and
- provide integrated health and care services.

The Health and Wellbeing partners in Harrow will focus on how they can contribute towards making Harrow a better place to live and reduce differences in life expectancy and healthy life expectancies between local communities.

Measuring Progress in 2016/17

For the purposes of this report, the primary means by which the CCG and the Council monitor the strategy is via the Health and Wellbeing Board Executive and a review of progress and contributions across the borough – one of many regular reviews through the year – took place in March 2017.

We also measured progress against the delivery of our Commissioning Intentions in 2016/17 through:

- presenting a review of progress against each of the ten key priorities at each meeting of NHS Harrow CCG's Governing Body and Harrow's Health and Wellbeing Board,
- engaging with GP Practices through Peer Group Meetings and the GP Forum on the progress with implementing our Commissioning Intentions on a quarterly basis,
- facilitating a patient and stakeholder Commissioning Intentions 'stock-take' event in March 2016,
- working with Harrow Healthwatch and the Harrow Patient Participation Network and other affiliate groups to review progress updates – helping us to focus on particular priority areas – and
- engaging with NHS England on the progress regarding delivery of our Commissioning Intentions and the Sustainability Transformation Plan (STP) through building in an on-going assurance process.

1.8 Key issues and risks

1.8.1 Issues

Governance

Following the outcome of an in-depth governance review, the CCG recognised the need to improve governance effectiveness to support improved organisational agility, better use of resources and delivery capability. This warranted establishing committees in common, having proactive risk escalation processes, establishing a shared secretariat function across Brent, Harrow and Hillingdon (BHH) CGGs and revising constitutions and standing orders.

To enact the above, we developed a BHH CCGs governance improvement plan. Implementation of the plan started in the third quarter of the financial year. The full tangible benefits will be manifested in the 2017/18 financial year.

In October 2016, NHS Harrow CCG adopted an initial Improvement Plan to address known and perceived weaknesses in its governance and decision-making. This incorporated the outcomes of the in-depth governance review, work from Smarter Working Awaydays and themes identified by the recently-appointed Interim Director of Compliance. This plan has been regularly reviewed, extended and refined. Assurance on its delivery is being obtained through the Audit Committee.

The majority of the items have been achieved, and there is good progress on all the others. However, there is still work to do in continuing to strengthen the CCG's governance and decision-making, building on the groundwork done so far. A new plan has been drawn up for continuing improvement in the next stage of the CCG's development, reflecting particularly its emphasis on recovery.

Organisational Development

We developed a shared strategic direction for organisational development (OD) across the eight CCGs in NW London (NWL) which was published in the NW London People Strategy. This strategy sets out our ambition to develop a more collaborative, integrated and innovative workforce.

Over the past year, the central Organisational Develoment (OD) team has supported the CCGs, including NHS Harrow CCG, in the following programmes of work:

- delivering our Learning and Development programme,
- staff engagement and surveys,
- promoting health and wellbeing,
- improving our organisational culture and behaviours,
- developing our leadership development offer,
- delivery of a corporate induction programme and
- development of a coaching and mentoring programme.

1.8.2 Risks

Financial Position

The key risk for the CCG has been its in-year deficit and underlying deficit position. The CCG finished the financial year with a £1.3m in-year deficit. The underlying position, which takes into account all non-recurrent items of expenditure, is a deficit of £9.9 million. See section 5.9.1 for more information.

Quality, Innovation, Productivity and Prevention (QIPP) Schemes

Delays in realising efficiency savings, leading to a forecast under-delivery of QIPP savings in 2016/17 with the risk of an escalating burden on future years, remained the primary risk to NHS Harrow CCG's objectives - namely, managing resources effectively to ensure best value and the delivery of financial targets.

The outcome of contract negotiations and reduction in the planned level of financial support from the NW London strategy increased the required QIPP savings to be found in the year. Following on from a review of the position, budget adjustments were actioned in the month to close the majority of the gaps.

However, there has been a deterioration in the reported position, predominately around acute performance, prescribing and continuing care, which increased the QIPP 'stretch requirement'. Control arrangements and assurances around QIPP delivery have been closely examined by the Governing Body.

1.9 Going Concern

The CCG accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by the inclusion of financial provision for that service in published documents.

1.10 Performance summary

The CCG's full annual accounts have been prepared under a direction as issued by NHS England (NHSE), under the National Health Service Act 2006 (as amended). NHSE directed that the financial statements of CCGs shall meet the accounting requirements of the Manual for Accounts that was issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

From 1 April 2013, NHS Harrow CCG has been responsible for commissioning (planning and

purchasing) of local health services - excluding primary care and specialised services that are commissioned by NHSE. Previously primary care trusts (PCTs) had the responsibility for the full range of services.

Financial position

The CCG financial position was a deficit of £1.3m in 2016/17 and an underlying deficit (after taking into account non-recurrent items) of £9.9m.

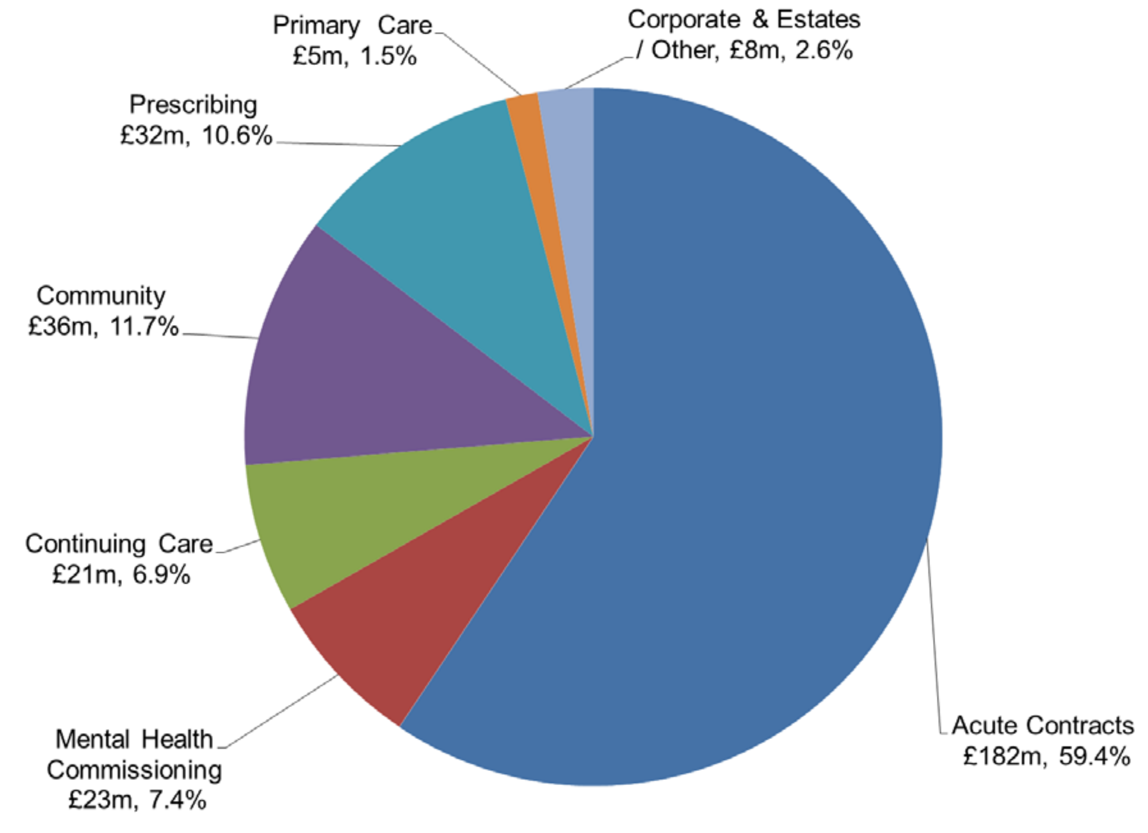
Uncommitted reserve requirement

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Harrow CCG has released its uncommitted reserve to the bottom line, resulting in a reduction to the in year deficit of £1.1m. This has been offset against other cost pressures from the current financial year.

1.11 How we spent your money

The chart below gives a breakdown by service of the CCG's total net expenditure of £303.4m.



2 Performance Analysis

2.1 How the CCG measures performance

NHS Harrow CCG has a statutory duty to report on the performance of a number of services defined nationally within the NHS Constitution, Everyone Counts Guidance from 2014/15 to 2018/19 (Operating Framework) and the NHS Mandated Outcomes Framework.

Performance of the CCG is monitored by the senior management team, and is regularly reviewed at key system and operational meetings with providers and other commissioners. Performance of the CCG is also routinely (and as requested) reported to NHSE as part of the quarterly assurance cycle.

As part of the Improvement and Assessment Framework CCGs work under, you can keep up to date with the performance of the CCG and the wider local NHS by typing your postcode into the new My NHS website.

2.2 Development and performance during the year

Although there have been areas of improvement in NHS Harrow CCG's performance in 2016/17, there remain areas where NHS Harrow CCG needs to improve performance in collaboration with providers.

A summary of performance across the range of NHS Constitution Standards is provided in the subsequent paragraphs.

2.2.1 Financial targets (see note 18 of the Financial Statements)

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended) regarding the use of its resources. For 2016/17, NHS Harrow CCG's performance against each is summarised below:

- **Expenditure not to exceed its income**
  For 2016/17 NHS Harrow CCG had an overall target of £306m and actual performance of £307.3m and so achieved a deficit of £1.3m
- **Capital resource use not to exceed the amount specified in directions**
  For 2016/17 NHS Harrow CCG did not have a capital allocation
- **Revenue resource use not to exceed the amount specified in directions**
  For 2016/17 NHS Harrow CCG net revenue expenditure totalled £303.7m against a revenue resource allocation of £302.4m.

In addition, NHSE has placed the following additional controls on clinical commissioning groups' use of resources:

- **Capital resource use on specified matters not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG did not have a capital allocation
- **Revenue resource use on specified matters not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG did not have any resources allocated with specific directions
- **Revenue administration resource use not to exceed the amount specified in directions**
  For 2016/17 Harrow CCG had a target of £5.2m and actual performance of £4.5m an so achieved a surplus of £0.7m (running costs).

A deficit on programme of £2m and a surplus on running costs of £0.7m together equal Harrow CCG's deficit of £1.3m.

2.2.2 Funding allocations

NHS England published CCG allocations for three years with indicative allocations for the following two years in January 2016.

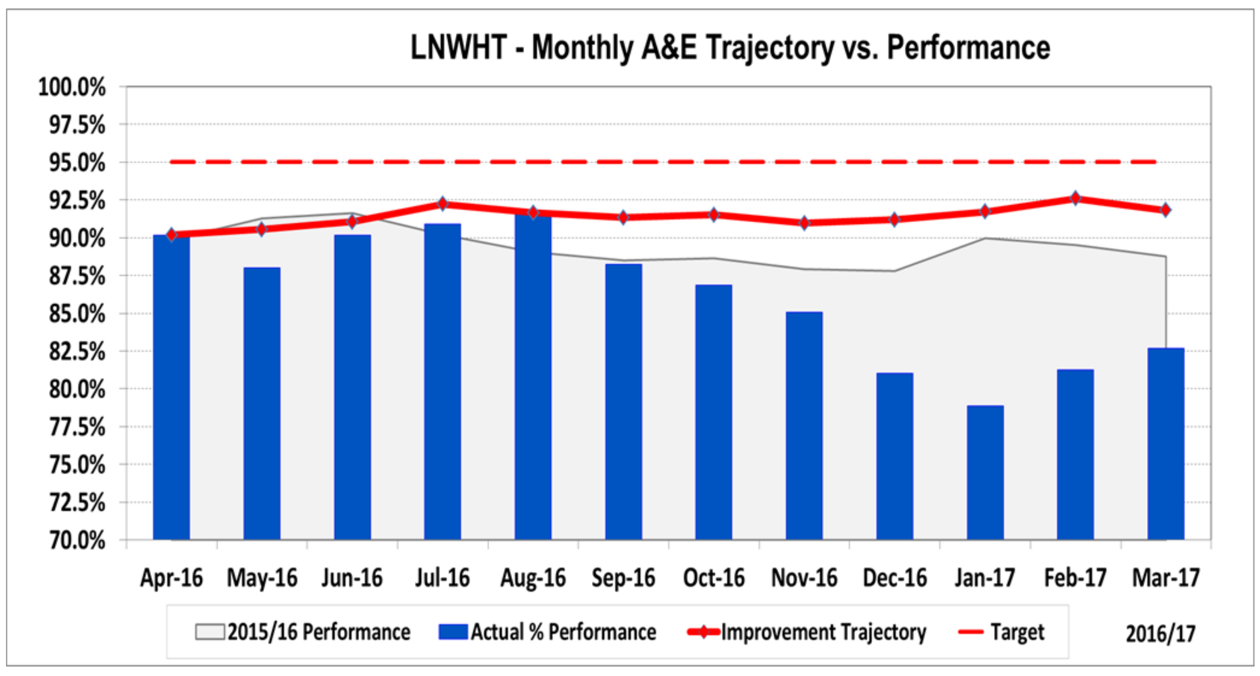
For 2016/17, the CCG received an increase in allocation of 6.0% on the funding received in 2015/16, equivalent to £15.9m.

In 2017/18, the CCG receives an increase in allocation of 2.9% on the funding received in 2016/17, equivalent to £8.0m. In 2018/19, the CCG will receive an allocation increase of 2.9%, equivalent to £8.3m. By the end of 2018/19, the CCG is calculated to be 2.2% below its funding capitation target.

In 2017/18, the CCG takes on delegated responsibility for commissioning primary care medical services. The additional allocation received for commissioning these services will be £30.8m. In 2018/19 the allocation for primary medical services will increase by 3.5%, equivalent to £1.1m. By the end of 2018/19, the allocation received by the CCG for primary medical services is calculated to be 4.4% below its funding capitation target.

2.2.3 Accident and Emergency (A&E) department

Achievement of the A&E 4-hour wait target continues to be challenging for NHS Harrow CCG with the year end position at 86.2%. Work has been on-going throughout the year with London North West Healthcare Trust (LNWHT) to improve patient flow and reduce delayed transfers of care.

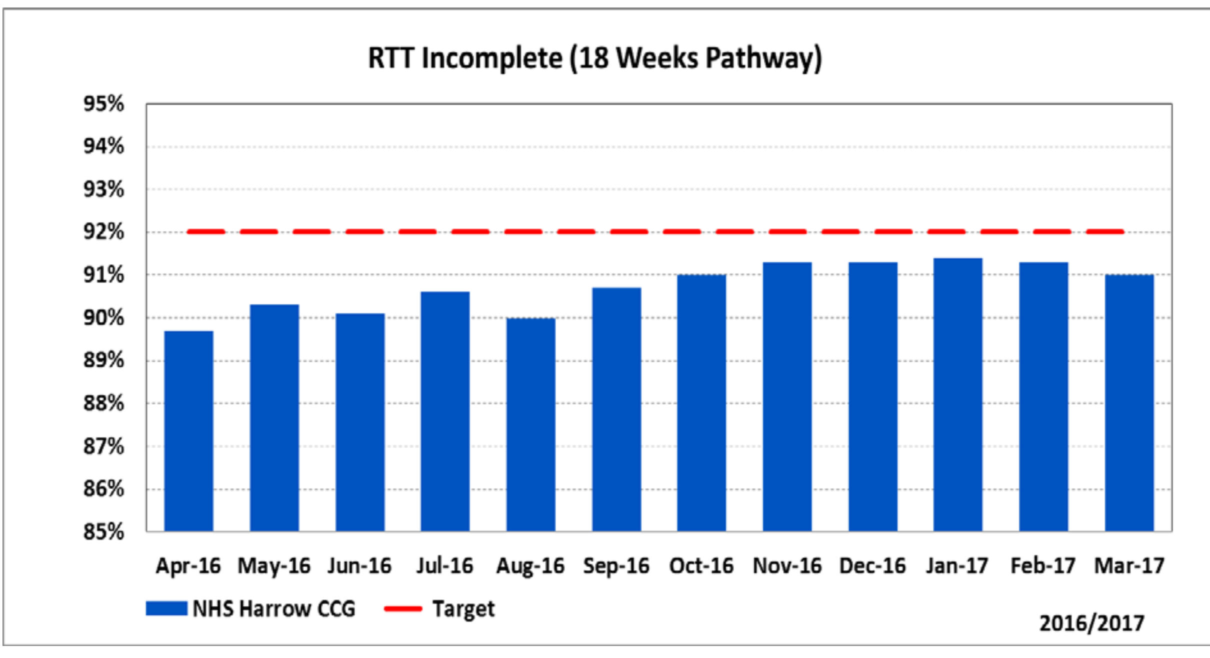


The trajectory represents the path agreed by the CCG, the Trust and our partners to support consistent achievement of the A&E target.

2.2.4 Referral to Treatment (RTT)

The Referral to Treatment incomplete target (percentage of incomplete patients seen within 18 weeks) is the main national access performance indicator.

NHS Harrow CCG year end performance is 90.7%. Performance against the standard was not achieved this year due to the need to prioritise non-elective admissions and cancer procedures. NHS Harrow CCG performance has also been impacted by Imperial College Healthcare Trust and the CCG is working closely with the Trust to ensure sufficient capacity within specialties with high demand. In October 2016, LNWHT met the 92% RTT Incomplete pathway national standard and, along with a sustainability plan, measures are in place to sustain performance.

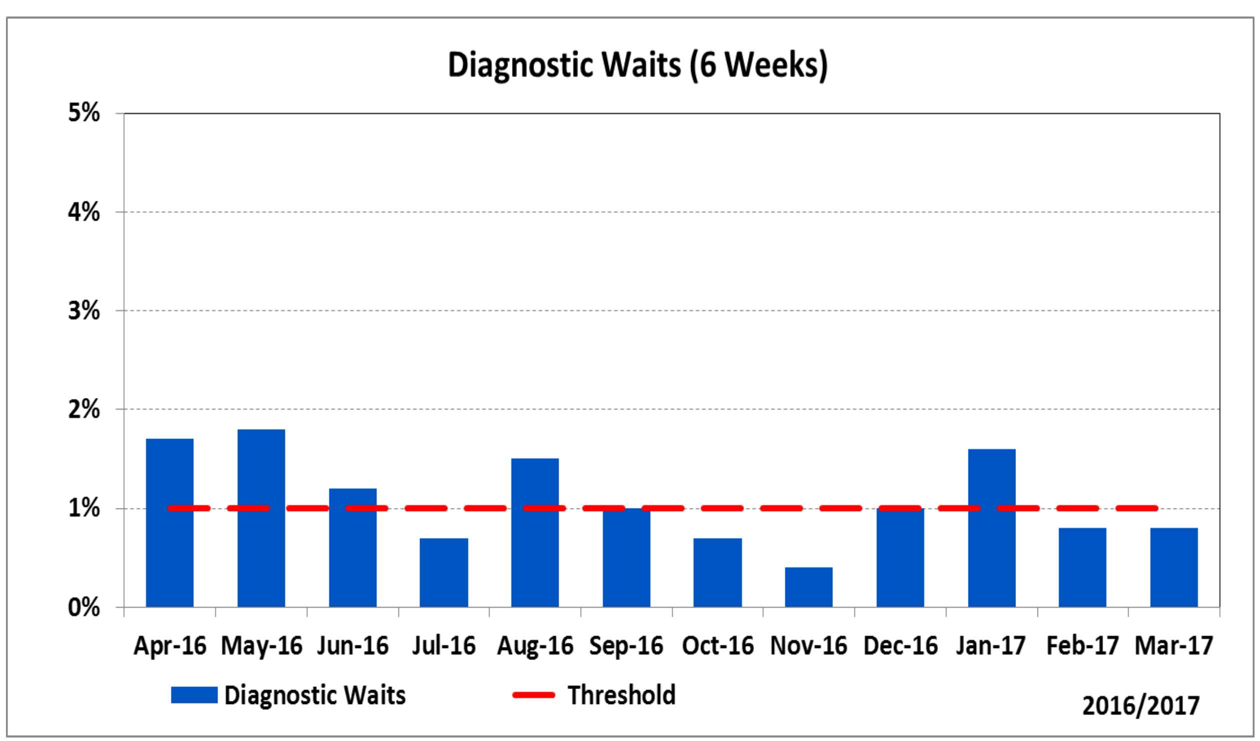


2.2.5 Diagnostic waiting times

The diagnostic waiting times target (for 15 key diagnostic tests and procedures) states that 99% of all patients should wait no more than 6 weeks for their diagnostic test.

Year end performance is 98.9% which is slightly below the 99% target. Overall performance has remained stable and NHS Harrow CCG is working with LNWHT to monitor compliance against this standard.

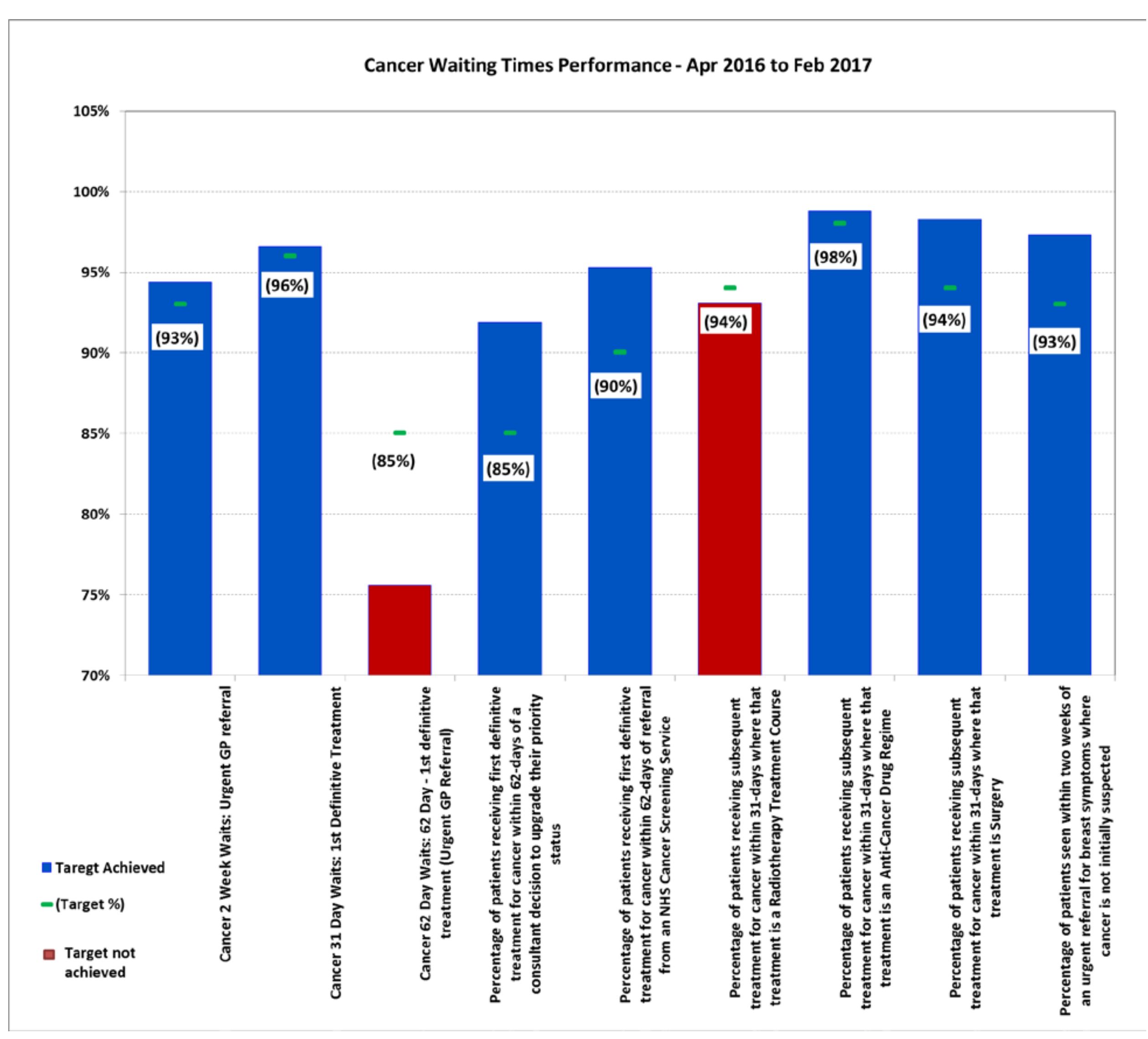
The graph below measures the percentage of patients waiting longer than 6 weeks so the target line is therefore set at 1%.



2.2.6 Cancer waiting times

NHS Harrow CCG is currently achieving seven of the nine cancer waiting time standards on a year end basis. Performance has been stable through 2016/17 with the exception of the 62 day waits for first definitive treatment standard which is currently at 75.6% for year end performance. Further improvements are being supported thought the NHSE Cancer Taskforce.

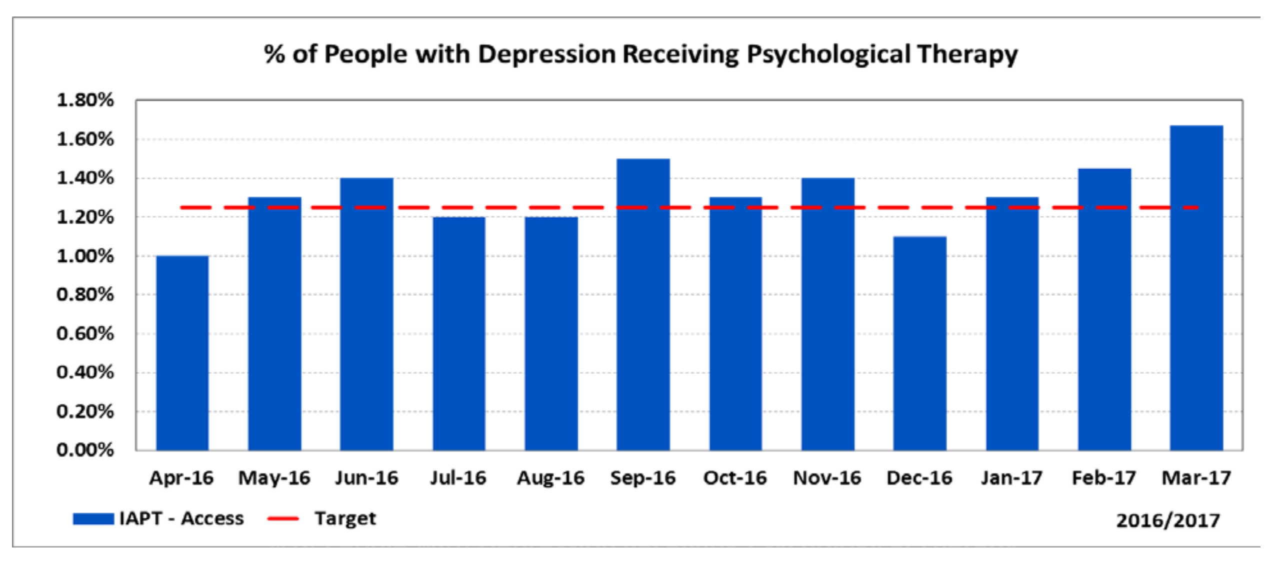
Initiatives to improve performance include the implementation of surveillance lists to reduce backlog numbers, weekly patient list review and capacity analysis across high demand specialties.

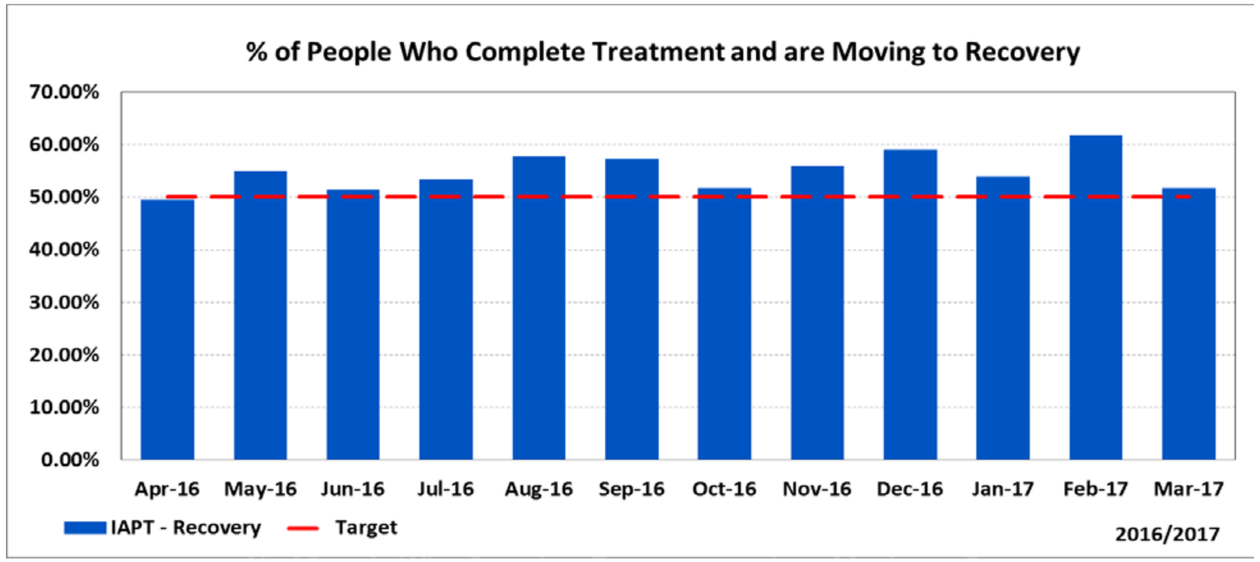


2.2.7 Improved Access to Psychological Therapies (IAPT)

NHS Harrow CCG has seen an increase in access and recovery rates throughout 2016/17. The year end positions for both IAPT Access and Recovery have met the national standards at 1.32% and 54.9% respectively.

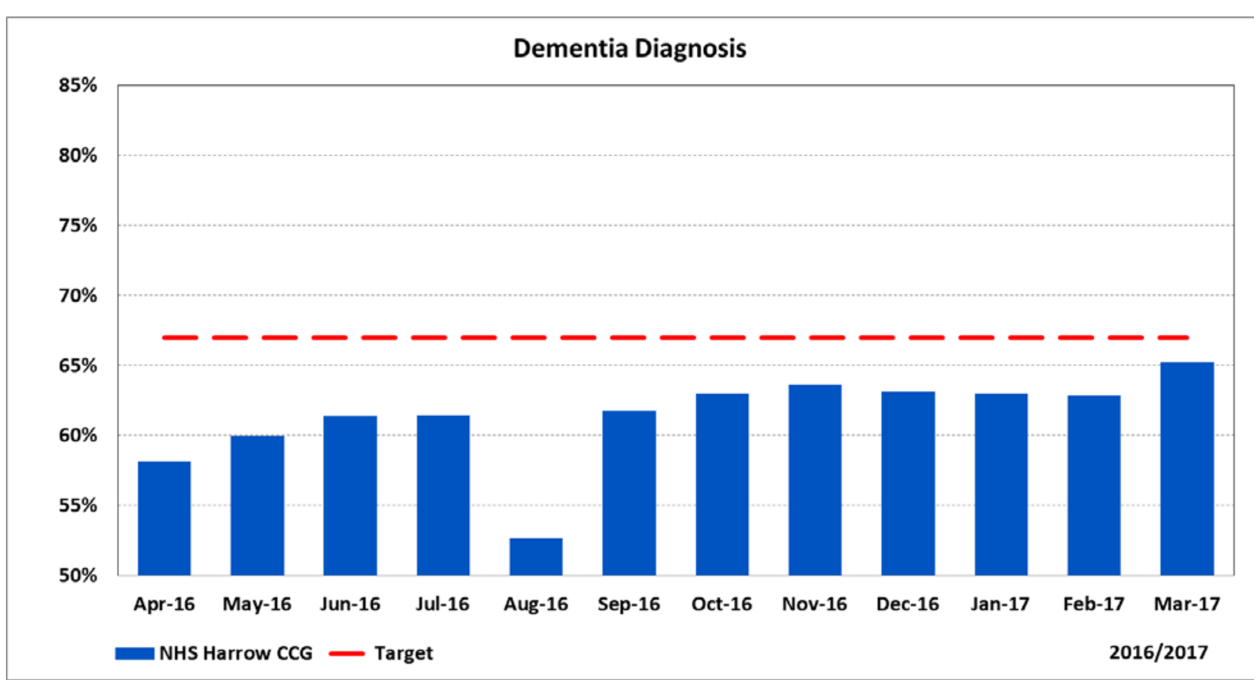
Providers have worked closely with primary care to improve GP referrals. In addition, the service has improved community outreach by partnering with local voluntary sector organisations. There is also a programme in place to increase numbers of self-referrals which is expected to improve recovery. These efforts have enabled the CCG to deliver above its access targets for 2016/17.





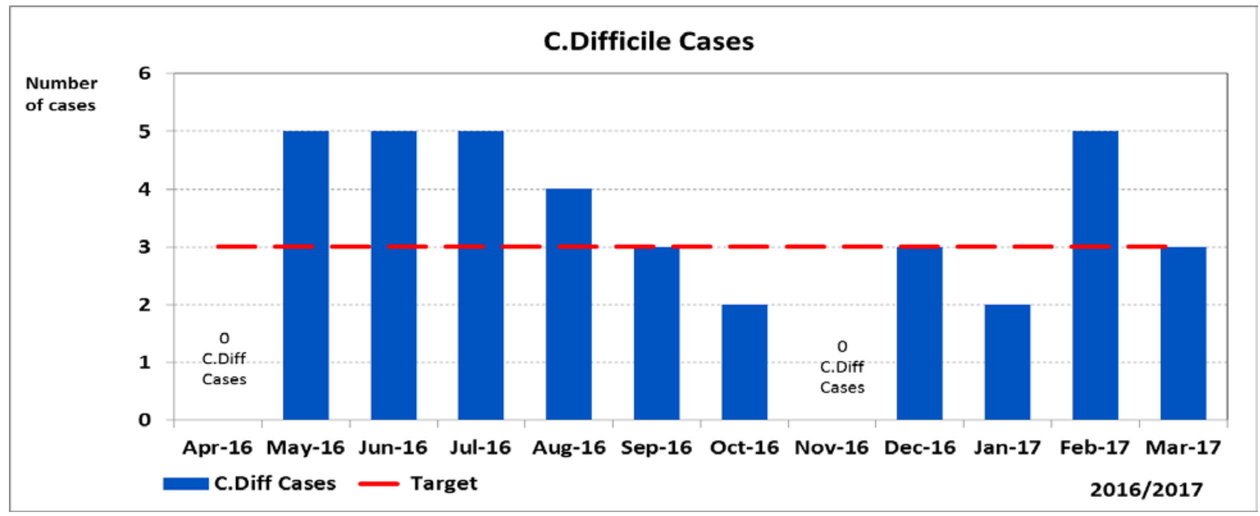
2.2.8 Dementia diagnosis

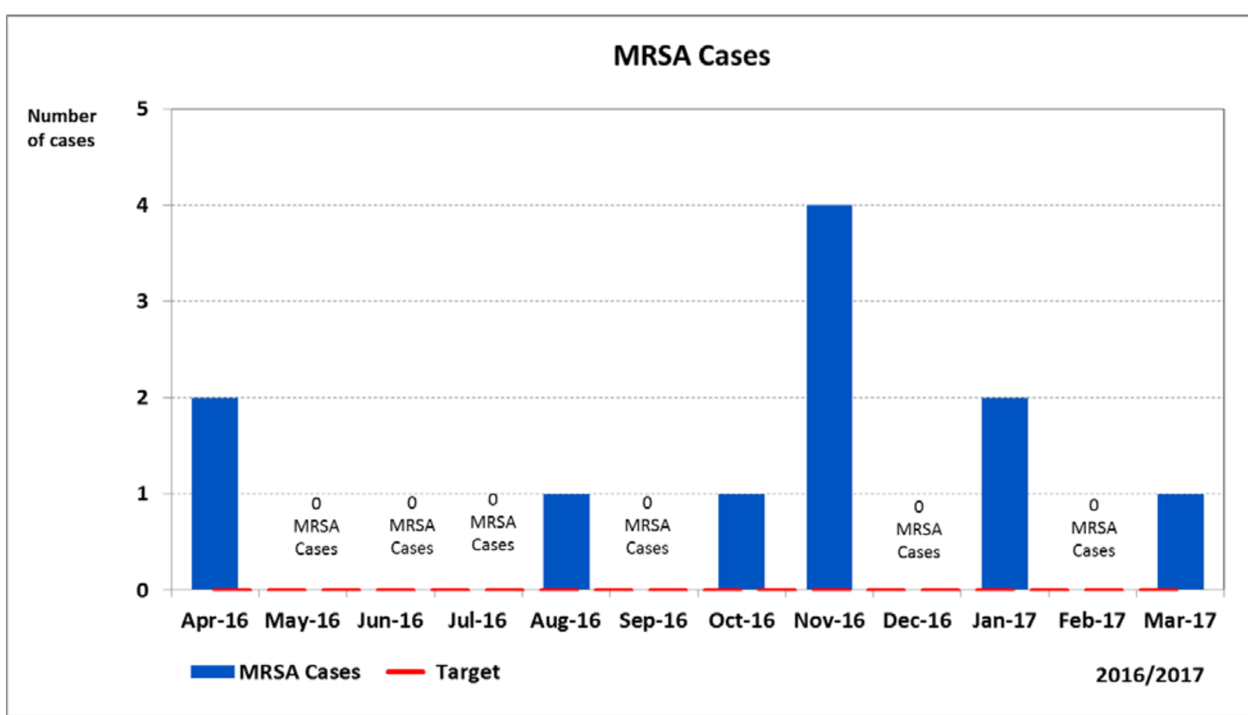
The numbers of patients aged 65 and over who have been diagnosed with dementia has increased significantly during 2016/17. However, the CCG remains under the national target of 66.7%. Actions include increased local engagement and encouragement with GPs and practice managers through peer group meetings and realignment of current resources to deliver a Dementia Intensive Support Team.



2.2.9 Health Care Associated Infections (HCAIs) such as MRSA and C.difficile

Both C.difficile and MRSA targets are not being met by NHS Harrow CCG. The CCG quality team is undertaking a review of HCAI cases across providers including a full post infection review specifically for MRSA cases. A revised assessment form has also been developed to help support the identification of areas of improvement in C. difficile lapses of care.





2.3 Sustainable Development

As an NHS organisation, utilising public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets, we can improve health in the immediate and long term, even in the context of the rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline).

The majority of the environmental and social impacts are through the services we commission. We work with our providers through the contracting process to make sure sustainability is factored into the services they offer local people.

2.4 Improve quality

NHS Harrow CCG has a statutory duty under Section 14R of the National Health Service Act 2006 (as amended) to report on the performance of a number of services defined nationally within the NHS Constitution, Everyone Counts Guidance for 2015/16 to 2018/19 (Operating Framework) and the NHS Mandated Outcomes Framework.

The Quality and Safety Team works across BHH CCGs to enable effective sharing of resources to focus in on the quality challenges across the three boroughs as well as within the individual CCG area.

Throughout 2016/17, the Quality and Safety Team has provided monthly and quarterly quality

reports to the Quality and Safety and Integrated Governance Committees. These have fed into the Governing Bodies to ensure that CCGs have sufficient information to gain assurance regarding the services they commission. The reports provide an overview of Quality and Safety for the CCGs focusing on the main health providers across BHH CCGs, highlighting good practice and areas for improvement.

The CCGs commit to commissioning quality health services for their patient population. To achieve this, the CCGs hold providers to account through contractual monitoring. To gain assurance regarding the quality of services, the Quality and Safety Team monitor the work of the providers through the Clinical Quality Review Groups (CQRGs) which focus on clinical effectiveness, patient safety, patient experience and leadership.

BHH CCGs work with the other CCGs in NW London with each taking a lead commissioning role for the main contracts. The table below illustrates the current structure for lead and associate commissioning arrangements.

Trust/Provider	Abbreviation	Lead CCG	Used by CCG
Central London Community Health	CLHC	Harrow	Harrow
Central and North West London Mental Health Foundation Trust (Mental Health)	CNWL	Harrow	Brent Harrow Hillingdon
Central and North West London Mental Health Foundation Trust (Community)	CNWL	Hillingdon	Hillingdon
Imperial College Healthcare NHS Trust	ICHT	Hammersmith and Fulham	Brent
London Ambulance Service	LAS	Brent	All of London
London North West Healthcare NHS Trust (Acute)	LNWHT or LNWH	Brent	Brent Harrow
London North West Healthcare NHS Trust Community Services	LNWHT or LNWH	Ealing	Brent Harrow
Royal Brompton Hospitals NHS Foundation Trust	RBHT	NHSE (80%) Hillingdon (20%)	All of England
The Hillingdon Hospitals NHS Foundation Trust	THHFT or THH	Hillingdon	Hillingdon
Urgent Care – Greenbrook at Northwick Park Hospital	N/A	Harrow	Harrow Brent
Urgent Care – Greenbrook at The Hillingdon Hospital	N/A	Hillingdon	Hillingdon
Urgent Care – Care UK at Central Middlesex Hospital	N/A	Brent	Brent
111 – Care UK	N/A	Hounslow	Brent Harrow
111 – Care UK	N/A	Hillingdon	Hillingdon

In addition, there are contracts with other acute Trusts and a number of smaller contracts providing a range of health care including:

- Walk-In Centre service,
- end of life care,
- mental health services,

- dementia support,
- carer support,
- bereavement and counseling,
- interpreting services,
- dermatology,
- termination of pregnancy,
- wheelchairs and
- various community services.

These contracts are managed by the Central Contracts Team for the whole of NW London. To strengthen the monitoring of the quality of these services, BHH CCGs, in 2016, established a substantive quality leadership role for central contracts, working as part of the wider BHH Quality and Safety Team.

This has enabled the development and implementation of a quality monitoring system that satisfies the high expectations BHH CCGs have in gaining quality assurance of all providers they commission services from. This has included regular contract meetings to, among other tasks, review the quality indicators set out in the North West London Core Quality Requirements document (which all providers are expected to adhere to) alongside quality assurance visits, so that concerns or issues regarding quality can be identified at an early stage and dealt with appropriately, in order to mitigate any potential risk to patients.

A summary of performance across the range of NHS Constitution standards is provided in the subsequent paragraphs.

2.4.1 Continuing HealthCare (CHC)

CHC sits in the Quality and Safety Directorate. The service ensures that the BHH CCGs adhered to their statutory responsibilities and that they are discharged in accordance with relevant standing rules and guidance, including the National Framework. The care for those patients eligible for CHC or Children's Continuing Care (CCC) is assessed in collaboration with the patient and their representatives and is deemed appropriate to meet all of the individual's health and associated social care needs. The care commissioned is provided either within or outside the person's home, as appropriate to their assessed needs with regular reviews to ensure that the care package continues to meet their needs.

In 2016/17 the CCG continued to ensure that patients eligible for Continuing Healthcare and Children's Continuing Care have had the right to have a Personal Health Budget. We also started to plan for Personal Health Budgets to be offered more widely, where evidence has indicated an individual could benefit.

2.4.2 Quality and safety monitoring and assurance

The BHH Quality and Safety Team uses four domains to monitor the services commissioned by the CCGs:

- Clinical effectiveness.
- Patient safety.
- Patient experience.
- Leadership and responsiveness.

These domains are aligned to the Care Quality Commission's (CQC's) Key Lines of Enquiry, i.e. Safe, Caring, Responsive, Effective and Well-Led. This enables the team to support providers in measuring themselves against the CQC requirements.

2.4.3 Clinical effectiveness

During 2016/17, the team continued to work with providers to encourage an open and transparent culture. The main providers have shared their Quality Accounts with the CCGs to identify areas for improvement.

The providers submit data on a monthly or quarterly basis to the CCGs which is monitored via a quality dashboard by the Quality and Safety and Clinical Risk/Integrated Governance Committees.

The team has developed a quality alert system to provide an early warning system of themes arising across the health services commissioned by the CCGs. During 2016/17, this system has been implemented in NHS Harrow CCG. This has enabled the team to prompt discussions with providers to ensure improvements are made.

The team has worked with other CCGs across North West London to develop core requirements for quality as well as specific indicators relating to the type of service being provided. These indicators are tracked through the use of a quality and performance dashboard, provider led audits and thematic reviews. These are reviewed by the Clinical Review Quality Groups (CQRGs) which also receive regular reports for clinical audit and assurance of compliance with NICE Guidance by the providers.

2.4.4 Quality assurance visits

The Quality Team has developed a programme of quality assurance visits to services serving the BHH CCGs' patient population across NW London. This has not only enabled concerns to be raised with providers early, but also to enhance the relationship between commissioner and provider, ensuring that patients receive a constantly improving service. The intelligence gained from these visits is triangulated with Serious Incidents (SIs) and complaints and the data and information provided through the CQRGs with the providers.

Visits include:

- **London Ambulance Service (LAS) –** The team has conducted three assurance visits to LAS to review medicines management, operational systems and distribution. These have been documented as part of the CCG assurance reporting programme. The next assurance visits will be shadowing the operational teams and crews and a new pilot for handover breaches in Emergency Departments (EDs).
- **Care Homes –** There are regular visits by the Continuing Health Care Team to homes supporting CCG-funded patients to ensure that our patients are receiving safe, good care. There have also been ad hoc visits to providers by the Quality Team to gain a broader perspective of the quality of care.
- **Main Trusts –** During 2016/17, the BHH Quality Team has undertaken quality visits to a variety of services to gain assurance regarding the quality and safety of the care being delivered by our main commissioned services. This has informed commissioners about the quality of care and enabled the team to work with providers to identify and support service improvement areas.

2.4.5 Mortality

During 2016/17, the BHH Quality and Safety Team has been working with our lead mental health and learning disability trust (CNWL) to strengthen the approach taken to review the deaths of service users with learning disabilities or mental health problems. This has been effective in improving practice for monitoring the physical health of service users with mental health problems. This will be developed in line with the CQC requirements.

Following the CQC publication of its review in December 2016, Learning, Candor and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England, NHS Improvement set out the governance framework that is required for all NHS Trusts to improve how they collect data and publish information on deaths.

The BHH Quality and Safety Team will monitor the development of the framework in each of the Trusts and support the sharing of the learning across NW London.

2.4.6 Patient safety

The Quality and Safety Team manages the SI process for BHH CCGs' main providers. Investigations of SIs are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again. The quality of SIs reports from our providers has been under continual scrutiny and assurances have been provided in respect of training of staff in Root Cause Analysis (RCA) investigations.

Investigations of SIs include Never Events, which are key indicators that there have been failures to put in place the required systemic barriers to error. Their occurrence can tell commissioners something fundamental about the quality, care and safety processes in an organisation.

During 2016/17, the team has been able to build and implement an improved system for monitoring the compliance of providers to meet the timescales for reporting of SIs and submission of the investigative reports, as well as enabling the team to draw better intelligence regarding the themes arising from the incidents and measure the impact of the learning of the providers from SIs. This approach has resulted in improved reporting and improved compliance with the National Framework.

2.4.7 Pressure ulcers

A significant aspect of patient safety continues to be in relation to pressure ulcers. A NW London Pressure Ulcer Clinical Network has been revitalised to engage all of the main acute and community NHS Trusts in NW London to work with the CCGs to share good practice and initiatives to reduce the risk of pressure ulcers. It takes a collaborative approach between acute and community providers to implement education and practice improvements across NW London.

2.4.8 Safeguarding

NHS Harrow CCG continues to ensure that all services commissioned for the population of Harrow safeguard children, young people and adults at risk. It has a responsibility to commission services that can support children, young people and adults at risk of harm or neglect, ensuring access is a priority for those most in need. NHS Harrow CCG has policies for Safeguarding Children, Safeguarding Adults and Prevent in place and the commissioning team ensures they are embedded in all contracts with service providers.

The CCG has a dedicated team for safeguarding children and adults and it remains a high priority across all aspects of CCG work. The Safeguarding Team works closely with the Quality Team to ensure the quality of services is good. A Quality Outcomes Framework for Safeguarding Children and Adults has been included in all contracts since April 2016 and this ensures a reporting matrix of Key Performance Indicators (KPI's). KPIs set the standard for safeguarding children and adults within a service and enable the Designated Professionals to review the information and be assured service provision safeguards vulnerable service users.

Through the KPIs, all commissioned services are monitored for their compliance and commitment to safeguarding those at risk and this will include monitoring of training levels in accordance with the Inter-collegiate Document for both children and adults at risk. Use of these documents ensures all health staff working with children or adults at risk are trained to recognise and respond to abuse or neglect at the appropriate level for their role.

KPIs also provide assurance that appropriate safeguarding professionals are in post, as well as help tackle national priorities such as child sexual exploitation, domestic abuse, female genital mutilation, modern slavery and preventing and reducing the incidence of pressure ulcers. The Designated Nurse from the CCG lead commissioner will attend the monthly Clinical Quality Group (CQG) meetings to review the information submitted by the provider. The safeguarding professionals also perform inspections with the quality leads where there have been concerns about safeguarding, safety and quality standards. These visits allow for improved scrutiny while also supporting the provider to make the necessary improvements to the service.

The Designated Professionals support the CCG with service specifications to ensure all commissioned services have safeguarding embedded in service provision. They provide a source of expertise where there are issues about the safeguarding of patients. The Designated Professionals also support and attend the contract monitoring meetings with Harrow Public Health who commission health visiting, school nursing, sexual health services and drug and alcohol services. They also provide advice and support with safeguarding concerns.

The Designated Professionals for safeguarding children and adults provide training for all CCG staff and support training with the Named GPs for GP practices in Harrow. They are also a source of information and support to the GP practices. The Designated Professionals work closely with the Named Professionals/Leads from the provider services and provide supervision on a regular basis.

The Designated Professionals for Safeguarding Children also support the Child Death Overview Panel (CDOP) and cover the rapid response when a child dies unexpectedly. Safeguarding issues are always considered, shared when appropriate with the Local Safeguarding Children Board (LSCB) or NHS Harrow CCG.

NHS Harrow CCG is committed to supporting and working with both the LSCB and the Safeguarding Adult Board (SAB), with representation from the Designated Professionals for Safeguarding, Clinical Leads for Safeguarding and the Assistant Chief Operating Officer Leads for Safeguarding. Annual Reports are produced for both Safeguarding Children and Safeguarding Adults. These reports are reviewed and agreed at the Quality Safety and Clinical Risk Committee and then presented at the Governing Body.

2.4.9 Infection control

Cases of Methicillin Resistant Staphylococcus Aureus (MRSA) Blood Stream Infections (BSIs) are reported and reviewed in line with the national reporting requirements.

All 23 cases across the BHH CCGs – of which seven were in Harrow – were subject to a Post Infection Review (PIR). Outcomes of the PIR are aimed at attributing responsibility for the learning actions and are shared across the health economy. Not all cases have a clear source and set of learning actions for prevention and as such are attributed to a third party. Below is the table of 2016/17 MRSA BSIs.

Methicillin Sensitive Staphylococcus Aureus (MSSA) BSI

While MRSA has been the principle S.aureus of concern, nationally it is recognised that MSSA is on the increase and is now reported on. Although there are no national targets for MSSA BSIs, cases identified in acute settings are reviewed while there are no investigations undertaken for community-acquired cases.

Escherichia coli (E.coli) BSIs

E Coli BSIs have also been on the increase nationally. Currently, there are no investigations undertaken for these cases in the community. Since a significant number of cases are linked to urinary sepsis, action plans are in place to reduce risks of urinary tract infections.

Clostridium difficile Infections (CDIs)

BHH CCGs continue to make progress in reducing the number of CDIs.

Cases in acute settings are subject to a Root Cause Analysis (RCA) to try and identify lapses in care. Any such lapse is followed up with individual remedial actions aimed at preventing similar cases. CDI cases are classified as avoidable or unavoidable.

CCG	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Harrow	0	5	5	5	4	3	2	4	3	2	5

2.4.10 Patient experience

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS.

NHS Harrow CCG uses a number of measures to monitor patient experience and these are set out below.

Complaints and principles for remedy

BHH CCGs work together to manage complaints and concerns, recognising that complaints, expressions of concern and compliments from the users of health services provide insight into the performance and efficiency of the services they commission. The CCGs use this valuable first-hand intelligence concerning the services they commission to ensure quality, patient-focused services are at the heart of their work. Every person's experience counts.

The CCGs aim to be compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

We are committed to the key principles in the Francis and Keogh reports:

- Openness, transparency and candor throughout the system.
- Importance of narrative as well as numbers within the data.
- Visibility of themes at board level and evidence of response to both individuals and themes.

BHH CCGs aim to ensure complaints are dealt with efficiently and that they are risk assessed in line with the NHS national complaints procedure. The NHS complaints procedure adheres to the principles for remedy published by the Parliamentary and Health Service Ombudsman and its Principles of Good Complaints Handling 2009.

The aim is to ensure a consistent approach is taken concerning the management and investigation of complaints, regardless of issues raised. It is imperative that investigations take into account the views and wishes of the complainant. Each complaint response is prepared in order to identify areas for improvement and to implement procedures to ensure clarity of roles and responsibilities in the CCG and between organisations.

Friends and Family

The Team monitors the compliance of the main providers to the Friends and Family framework at the Clinical Quality Review Groups (CQRGs). This enables the CCGs to gain an understanding of the level of confidence that patients and relatives have in commissioned services. Where insufficient responses are gained, the Quality Team discuss with the provider what other methods of gaining patient engagement are being undertaken to ensure that there is a commitment to constantly improve patient experience.

Quality Impact Assessments

During 2016/17, a quality impact assessment framework has been developed to support the CCGs in evaluating the impact of any changes to the commissioning of services. This will be used, in addition to equality impact assessments, to ensure that there is full consideration of the impact of CCG decisions regarding the commissioning, or decommissioning, of services on patient experience.

2.4.11 Leadership/Responsiveness (Well-Led)

The Quality and Safety Team monitor the quality of the leadership and responsiveness of providers to engage with CCGs and partners to constantly improve services for patients.

A significant way the team gathers this intelligence is from the CQC to monitor the progress of improvements of services and respond to clinical risks that could impact on the safety of patients.

In the year, the CCG was assessed by NHS England under its Improvement and Assurance Framework. The CCG was rated as “Requires Improvement”. Following this, the CCG has put in place a number of measures to improve governance and leadership for 2017/18.

CQC Assurance

Each provider has undergone a CQC inspection under the commission’s new regulatory regime. All providers are supported by their respective BHH Associate Directors for Quality and Safety in the assurance and oversight of CQC action plans. These CQC action plans are captured locally and managed via the individual provider CQRG process. In addition, action plans are shared as part of local quality and safety monitoring.

2.5 Patient and public involvement

This section explains how the CCG has discharged its duty under Section 14Z2 of The NHS Act 2006 (as amended) to involve the public in commissioning (planning, decision-making and proposals for change that will impact on individual or groups and how health services are provided to them).

NHS Harrow CCG is committed to involving, consulting and listening to patients, carers, members of the public and other stakeholders to help us understand the needs, preferences and experiences of our residents so that health services meet their needs.

The CCG's Equality and Engagement Committee oversees and provides assurance of its engagement work. It includes representatives from Healthwatch Harrow and the voluntary sector and is chaired by the governing body lay member for public and patient involvement.

Engagement takes place through a number of approaches that include targeted outreach to stakeholder groups, public events, partnership working with our voluntary sector, and the use of social media so patients and members of the public can have their say about the design and development of local services.

As a result, the CCG provided a range of opportunities for involvement by the public, clinicians and community organisations, with this demonstrated through its engagement with them on the following:

Obtaining views on the CCG's health plans and services

The CCG's 'Healthcare in Harrow' public event in April 2016 provided an update to 94 participants on its health plans and obtained their views on local healthcare services. This included obtaining feedback on BHH CCG's vision and plans for a 24/7 integrated urgent care access, treatment and clinical advice service.

Sustainability Transformation Plan priorities and the CCG's plans to deliver them through its Commissioning Intentions for 2017/18

Members of the public, community organisations and stakeholders such as Public Health, Young Harrow, and Healthwatch, provided feedback on the CCG's STP and Commissioning Intentions at a public event in October 2016.

Further engagement on the STP and Commissioning Intentions took place through an online survey, and with target stakeholder groups – carers, Health and Social Care Voluntary Sector Group, Inter-faith Network, MIND user group and Harrow Patients' Participation Network.

Developing new service models through co-design and empowerment

150 children and young people and over 130 parents and professionals were engaged through workshops and discussions with the CCG to identify and design a user-led model for a health and well-being service for 0 – 18 year olds (up to 25 for young people with additional needs). The engagement work undertaken has informed the CCG and its partners to shape the specification for this service and provide an input into the procurement process.

Helping people to access the right care for them and to self-manage

The CCG engaged with members of the Gorkha, Somali and Middle Eastern communities to provide information on how to access the right NHS services and to improve their understanding of services available.

The Gorkhas were supported to engage with Diabetes UK to help them understand the condition better and how they can help themselves through diet and exercise.

Harrow Health Help Now App provides advice and information, and directs people to the nearest available service. Available on smartphones and PCs, the App was promoted through outreach to community groups, via Harrow Patients' Participation Network and health fairs to patients, at stalls located in public settings and through the CCG's social media channels. Over 5,000 downloads of the App by Harrow residents were completed.

Improving healthcare pathways and quality of services

The Right Care programme initiative involved service users, carers, Harrow Council, providers and clinicians coming together with the CCG at a number of workshops covering dementia, MSK, cancer and respiratory disease. These focused on developing together patient-centred approaches to achieve better outcomes for those affected by the aforementioned, which have been used to develop project proposals.

Understanding the benefits and challenges of delegated commissioning of primary care in Harrow

Engagement activities have been part of an on-going programme of work to ensure that not only Members (GP practices) are kept informed on what's entailed in the move to delegated commissioning, but also patient groups through Harrow Patients Participation Network (HPPN), and the public through the CCG's website.

Patients' preferences on engagement to improve local NHS building and facilities

As part of the NW London-wide information gathering survey to develop a better understanding of how patients want to be engaged on the development of hubs and GP practices, the CCG engaged with the Somali and Afghani community to obtain their input.

Obtaining perspectives on the CCG's engagement and communications

Discussions with a variety of community organisations and representatives helped to obtain a range of perspectives to inform the CCG's approach to engagement and its current communications, including from migrant community, young people, Somali women and Voluntary Action Harrow. These will be used to develop the CCG's Engagement and Communications Strategy for 2017 to 2020 to further strengthen public and stakeholder involvement in its work.

Developing the patients' voice

The CCG worked with HPPN, which it funds, to develop the patients' voice through Patients Participation Groups (PPGs) comprising the network. This included joint HPPN and CCG meetings to provide information and develop dialogue on areas of work, such as proposed health plans and delegated commissioning.

2.6 Reducing health inequality

This section explains how the CCG discharged its duty under Section 14T of the National Health Service Act (as amended), having regard to the need to reduce inequalities.

The CCG also publishes a Public Sector Equality Duty Report annually which can be found on our website.

The Equality Act 2010 provides a framework for NHS Harrow CCG to work towards eliminating discrimination and reducing inequalities in the heath of local people. The Act sets out the 'personal nine' characteristics protected by legislation. This effectively ensures that everyone is protected from discrimination as one or more characteristic will apply to all as they include age, race and ethnicity, pregnancy and maternity, marriage and civil partnership, disability, gender re-assignment, religion or belief, gender and sexual orientation.

NHS Harrow CCG is committed to meeting its equality and diversity duties across all its work,

policies and functions. Each year it provides a performance update on our progress, working towards reducing inequalities.

Equality objectives

The CCG collaborated with Healthwatch Harrow, Public Health, Mencap and Shaping a Healthier Future (SaHF) programme staff to take a partnership approach towards establishing a number of equality objectives that focus on driving improvements in the local community's health. The objectives are aligned to the four overarching themes of the NHS equalities framework (Equalities Delivery System 2), and are delivered through a range of activities including commissioning, workforce development, provider contracts monitoring, engagement and communications within Harrow's communities. We will be working with our stakeholders in the next year to review and revise our current equality objectives and to develop new ones for 2017 to 2021.

Equality Delivery System (EDS2)

The NHS' equalities reporting framework helped us to identify what we are doing well, what we need to improve on and the equality gaps and risks that we will need to address. The CCG's approach to date has been to self-assess its progress against the EDS2 framework, which highlighted gaps in our work. We are addressing this by working towards developing a partnership approach to improving and assessing our performance.

NHS Workforce Race Equality Standard (WRES)

The WRES helps NHS organisations to address race equality issues in a range of staffing areas and report on this against nine indicators. The CCG workforce is too small for the WRES indicators to be applied properly, so it collaborated with its neighbouring CCGs (Brent and Hillingdon) to submit a jointly co-ordinated WRES report in May 2016. Some of the key data on workforce race equality indicators is highlighted below.

- BME workforce representation increased, including in Agenda for Change bands 8-9 and Very Senior Management posts
- White staff are 1.28 times relatively more likely to be appointed from shortlisting across all posts compared to the rate of 2.48 times greater, which was the case in the previous year and
- Access to non-mandatory training and CPD is 1.89 times relatively greater for BME staff, compared to 0 times previously.

Equality Analysis

As part of ensuring that the CCG gives 'due regard' to equalities in its commissioning plans, policy development and any proposed service changes, Equality Impact Assessments (EIAs) are undertaken. These help to ensure that there is no negative or disproportionate effect on any particular protected group, and that all measures to eliminate or minimise any such effect have been considered.

EIAs were reported to the Equality and Engagement Committee for scrutiny, with these including on the QiPP schemes and Future in Mind Business Case.

To ensure that EIAs are embedded as integral to the CCG delivering service improvements, guidance on undertaking EIAs has been developed for implementation in 2017 onwards.

Partnership working

A key part of the CCG's work on tackling health inequalities has been to collaborate with its partners on the Health and Wellbeing Board to agree priorities to address key health challenges in the borough, as detailed in Harrow's Health and Well-being Strategy 2016/20.

As a commissioner of healthcare, the CCG has a duty to ensure that NHS providers are meeting their statutory duties under the Public Sector Equality Duty. The CCG regularly monitors the providers' performance, patient experience and service access, as well as work with them to gauge their progress on meeting their equality duties, including on implementation of the Accessible Information Standard. Our providers publish their equality compliance reports annually on their websites.

Workforce training

One of the key ways the CCG can foster inclusion and reduce health inequalities is through training of its staff to be 'equality-aware' in their work. All staff and governing body members were mandated to either complete or refresh their knowledge on diversity through in-house training. Training on reflecting social value in procurement processes was provided to commissioners, which will help the CCG to consider and address some of the social determinants of poor health through its procurement of services.

Communications

The CCG significantly grew its digital presence to reach diverse audiences by extending its communications channels across key social media platforms – website, Twitter, Facebook, YouTube and Instagram. The CCG continued to fine-tune its website for accessibility, and increased its twitter following with this being the largest across North West London CCGs. It actively used social media to communicate health messages in an appropriate, accessible way to local people – most importantly via the Harrow Health Help Now App.

Accountability Report

Cllr. Shah (Harrow's Mayoress) cuts the ribbon at the opening of a new Walk-in-Centre

The Accountability Report comprises of the:

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

Corporate Governance Report

The Corporate Governance Report outlines the composition and organisation of the CCG governance structures and how they support the achievement of the CCG's objectives.

This report comprises of the:

- Members' Report
- Statement of the Accountable Officer's Responsibillities
- Governance Statement

3 Members' Report

NHS Harrow CCG is responsible for planning and commissioning health services for the people of the London Borough of Harrow. Set up in 2013, the CCG operates in accordance with its Constitution with a governing body made up of lay members, clinicians and executive directors.

3.1 Member profiles

		Biography
	Dr Amol Kelshiker Chair and Clinical Director	Amol works at The Pinn Medical Centre and has a special interest in diabetes and cardiology. A Harrow resident for more than 40 years, Amol has worked in the borough as a GP for more than half of that time and passionately believes in reducing dependence on hospitals, allowing more patients to be treated in their GP practice and ensuring continuity of care.
	Dr Kaushik Karia Vice Chair and Clinical Director	Kaushik is a GP with a special interest in gynaecology, working at the Aspri Medical Centre. He has worked in the area for more than 20 years. Kaushik would like to see the delivery of quality clinical care to our patients closer to their homes and believes that access to the health care system in Harrow needs to improve, something that can be done by enhancing resources in primary care.
	Dr Dilip Patel Clinical Director Resigned 31 March 2017	Dilip has been involved with the local health system for 30 years as a clinician and a member of various health related committees. Based at the Civic Medical Centre, he's a GP with a diverse range of interests including diabetes, ischemic heart disease and urology.

	Dr Genevieve Small Clinical Director	Genevieve is the Named GP for Safeguarding Children for NHS Harrow. She was brought up in Harrow and has worked in the borough for more than ten years. She is currently at The Ridgeway Surgery and is passionate about strong community services enabling patients to access services that are more responsive to their day-to-day needs.
	Dr Shahla Ahmad Clinical Director Appointed 20 June 2016	Shahla has been a dedicated partner for over 16 years at the GP Direct practice in Harrow. She has a specialist interest in mental health, paediatrics and prevention. Shahla is dedicated to making robust and efficient pathway changes to improve experiences for all patients in Harrow. She has lived in Harrow for most of her life and would like to see the best possible provision of Harrow services for her patients.
	Dr Shaheen Jinah Clinical Director Appointed 6 June 2016	Shaheen is currently a sessional GP at Roxbourne Medical Centre and The Pinn Medical Centre where she has worked since 2003. She grew up in Harrow and completed her medical degree at University College London (UCL) and GP training in Reading as part of the South Oxfordshire GP training scheme. Shaheen has a special interest in mental health, gynaecology and reproductive healthcare. In June 2013, she moved to Alberta, Canada for two years where she worked as a Rural Physician, helping to set up maternity and teenage health clinics.
	Dr Sharanjit Takher Clinical Director Appointed 1 September 2015	Sharanjit is a GP with a special interest in paediatrics, working at the Enderley Road Medical Centre. He worked at the practice as a trainee doctor and was inspired to become a GP by his time there. Among his many clinical interests and roles, Sharanjit is involved in the care of residents at a nursing home for neuro-disability, performs minor surgery and joint injections and teaches local medical students.

	Dr Sandy Gupta Secondary Care Consultant	Sandy is the Consultant Cardiologist at Whipps Cross and St Bartholomew's Hospitals since 1999. He has a keen interest in research concerning inflammation and heart disease and was awarded a British Heart Foundation (BHF) research fellowship.
	Ian Holder BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees Appointed 21 July 2016	Ian previously held roles as a Non-Executive Director (NED) and Deputy Chair for an NHS Foundation Trust providing mental health and community services where he also went on to chair the Audit Committee. He is a chartered accountant with extensive experience as a director of multinational companies and formerly a mentor for the Institute of Chartered Accountants (ICAEW) Financial Leaders of the Future Programme. Ian's specialities include being an organisational consultant, executive coach and senior accredited BACP registered counselling psychotherapist.
	Gerald Zeidman Deputy Chair and Lay Member Contract completed 31 March 2017	Gerald is a pharmacist and a Fellow of the Royal Pharmaceutical Society. Gerald has been a Non-Executive Director of a number of former NHS health authorities. Currently Gerald is Chief Officer of Bedfordshire Local Pharmaceutical Committee.
	Richard Smith Lay Member Appointed 18 July 2016	Richard has spent his career helping organisations to get the best from the people who work for them and where people give their best to their organisations. Specialising in leadership development, managing change, and the effectiveness of senior teams, he held senior posts in retail, manufacturing, IT and banking industries. Richard now leads an international consulting practice, and is an author on change management. He has been a Harrow resident for over 30 years.

	Sanjay Dighe Lay Member	Sanjay is responsible for Patient and Public Engagement. He is also the principal of a company specialising in financial risk management. He is an honorary director of Third Sector Potential, a social enterprise supporting the voluntary sector. Sanjay is the Chair of the BBC Trust's London Audience Panel.
	Rob Larkman Accountable Officer	Rob Larkman has been an NHS Chief Executive for over 20 years in both provider and commissioning organisations. He has a background in financial management and has worked in advertising and management consultancy before joining the NHS in 1993. He was Chief Executive of NHS Camden between 2002 and 2009 and, more recently, was the Chief Executive of the Whittington Hospital before moving to North West London.
	Paul Jenkins Interim Chief Operating Officer Appointed 11 January 2017	In a career in the NHS spanning 28 years, Paul is an experienced health and social care system commissioner. He has held a range of board-level management positions in NHS commissioning and hospital provider roles. Throughout his career Paul has led major programmes of service redesign across primary, secondary care and mental health and has experience of commissioning in all dimensions of health care and primary care contracting. Paul also has held director portfolios covering information management and technology and performance improvement. He joined NHS Harrow CCG in January 2017, but has worked previously in NW London as deputy chief executive at Westminster Primary Care Trust and managing director with NW London's acute commissioning partnership. Paul has held a number of trustee appointments with charitable not-for-profit organisations focused on health promotion, HIV and sexual health, and supporting people with and alcohol and drug addictions.

	Javina Sehgal Chief Operating Officer Seconded out from 23 January 2017	Javina has been chief operating officer for NHS Harrow CCG since April 2013. Previous to this she has been the acting borough director and borough director of NHS Harrow PCT, as well as the deputy borough director. Previous to this she had senior roles in the social services departments of Brent, Hammersmith and Fulham councils.
	Neil Ferrelly Chief Finance Officer	Neil has worked in NHS Finance for more than 35 years and has experience from both acute trusts and in NHS commissioning roles. Before coming to NW London CCGs, Neil was the director of finance at North West Surrey CCG. Before that, he was Primary Care Trust (PCT) Director of Finance at Harrow, West Sussex and Kingston and the Joint Chief Finance Officer of both NHS Richmond CCG and NHS Kingston CCG. Neil has a vital role supporting clinical commissioners to ensure that the CCGs' resources are used to provide the best health outcomes for people in Brent, Harrow and Hillingdon.
	Alex Faulkes Director of Delivery and Performance Appointed 1 April 2016	Alex has over 16 years of experience working in the NHS, spanning acute hospitals, mental health trusts and specialist providers. He joined BHH CCGs from Croydon Health Services NHS Trust, where he was Associate Director of Performance, Contracting and Planning. Before that he headed up the performance and planning team at Great Ormond Street Hospital and has also held a general management role at King's College Hospital. His portfolio includes performance monitoring and management across the three BHH CCGs as well the London Ambulance Service on behalf of CCGs across London.

	Diane Jones Director of Quality and Safety Appointed 1 March 2017	Diane has worked in the NHS for over 25 years and is a trained midwife. She joined BHH CCGs from NHS Greenwich CCG where she was the Director of Integrated Governance, and took up her new role in March 2017. Diane has significant leadership experience, having worked at senior management level for the past 10 years. Prior to her role at NHS Greenwich CCG, Diane was Deputy Nurse Director with NHS Redbridge CCG.
	Andrew Howe Director of Public Health, Harrow Council	Andrew is the jointly appointed Director of Public Health for Barnet and Harrow Councils. He moved to Harrow in 2008 and previously worked as the Director of Public Health for NHS Blackpool and Blackpool Council.
	Mina Kakaiya Representative, Healthwatch Harrow	Mina has over twenty years of working in the health and social care sector, especially within the NHS mental health field, and has a proven track record of working in social work and community development. Mina was part of a team that helped guide the improvement of East London NHS Foundation Trust's translation services and in developing culturally responsive wellbeing services in Hackney.

3.2 Member practices

Our population is served by 34 GP practices that make up NHS Harrow CCG's membership.

NHS Harrow CCG member practices	
Aspri Medical Centre	Kenton Clinic
Bacon Lane Surgery	Kings Road Surgery
Belmont Health Centre	Northwick Surgery
Circle Practice	Pinn Medical Centre
Civic Medical Centre	Pinner Road Surgery
Elliott Hall Medical Centre	Pinner View Medical Centre
Enderley Medical Centre	Ridgeway Surgery
Enterprise Practice	Roxbourne Medical Centre
First Choice Medical Care	Savita Medical Centre
GP Direct	Shaftesbury Medical Centre
Mollison Way Surgery	Simpson House
Hatch End Medical Centre	St Peters Medical Centre
Headstone Lane Medical Centre	Stanmore Medical Centre

Headstone Road Surgery Honeypot Medical Centre Kenton Bridge Medical Centre (Dr Golden) Kenton Bridge Medical Centre (Dr Raja)	Stanmore Surgery Streatfield Health Centre Streatfield Medical Centre Zain Medical Centre

3.3 Composition of Governing Body

The main function of the Governing Body is to ensure that the CCG has appropriate arrangements in place to ensure it exercises its functions effectively, efficiently and economically, and in accordance with any generally accepted principles of good governance that are relevant to it.

The Governing Body leads on setting the vision and strategy, approves commissioning plans, monitors performance against plan, and provides assurance of strategic risks.

Governing Body members		
Name	**Title**	**Voting/ non-voting**
Dr Amol Kelshiker	Chair and Clinical Director	voting
Dr Kaushik Karia	Vice Chair and Clinical Director	voting
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	voting
Dr Genevieve Small	Clinical Director	voting
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	voting
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	voting
Dr Sharanjit Takher	Clinical Director	voting
Dr Sandy Gupta	Secondary Care Consultant	voting
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	voting
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	voting
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	voting
Richard Smith Appointed 18 July 2016	Lay Member	voting
Sanjay Dighe	Lay Member	voting
Rob Larkman	Accountable Officer	voting
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	non-voting
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	non-voting
Neil Ferrelly	Chief Finance Officer	voting
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	non-voting
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	voting
Ann Jackson Appointed 1 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	voting

Jan Norman Resigned 31 December 2016	Director of Quality and Safety	voting
Andrew Howe	Director of Public Health, Harrow Council	non-voting
Mina Kakaiya	Representative, Healthwatch Harrow	non-voting

More information on the Governing Body members can be found in the Governance Statement.

3.4 Committees, including Audit Committee

3.4.1 Audit Committee

NHS Harrow CCG holds meetings in common with Brent and Hillingdon CCGs. The main purpose of the Audit Committee is to scrutinise the governance, risk management and internal control arrangements put in place to ensure the achievement of organisational objectives. It also ensures the adoption of best practice in the conduct of public business and stewardship of public funds.

Its membership comprises:

Audit Committee members	
Name	**Title**
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees
Dr Dilip Patel Resigned 31 March 2017	Clinical Director
Gerald Zeidman Contract completed 31 March 2017	Lay Member

3.4.2 Executive Committee

The purpose of the CCG Executive Committee is to ensure the strategic and operational arrangements of the CCG are effective and enable the CCG to achieve the objectives and performance.

The Executive Committee is authorised through the scheme of delegation and standing financial instructions, among others, to undertake a range of duties.

These include ensuring the strategic and operational arrangements of the CCG and enabling the CCG to achieve the objectives and performance requirements within capital and resource limits set out in the Secretary of State's mandate during the period specified.

Executive Committee members		
Name	**Title**	**Voting/ non-voting**
Dr Amol Kelshiker	Chair and Clinical Director	voting
Dr Kaushik Karia	Vice Chair and Clinical Director	voting
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	voting
Dr Genevieve Small	Clinical Director	voting
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	voting

Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	voting
Dr Sharanjit Takher	Clinical Director	voting
Rob Larkman	Accountable Officer	voting
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	non-voting
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	non-voting
Neil Ferrelly	Chief Finance Officer	voting
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	non-voting
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	voting
Ann Jackson Appointed 1 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	voting
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	voting
Gilbert George	Interim Head of Governance	non-voting

3.5 Register of Interests

NHS Harrow CCG maintains a register of interests that details names of individuals and details of their interest. Individuals will declare any interest they have, which may lead to a conflict with the interests of the CCG in relation to any decision to be made by the CCG.

The CCG has developed proactive mechanisms for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the CCG decision-making.

The Register of Interests and our Conflicts of Interest Policy is available on the CCG website.

3.6 Raising concerns – whistleblowing arrangements

The CCG has a policy and procedure in place for staff and external parties to raise concerns without fear of reprisal or victimization which demonstrates the CCG's commitment and support to those who may need to come forward.

Concerns may relate to unlawful conduct, financial malpractice or malpractice related to patients, employees, the public or the environment.

Where concerns have been raised, the CCG has carried out an investigation following the due process outlined in our Raising Concerns (Whistleblowing) Policy and reported the outcomes as appropriate.

3.7 Personal data related incidents

In 2016/17, NHS Harrow CCG reported no personal data related incidents to the Information Commissioner's Office.

3.8 Statement of disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report.
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

3.9 Modern Slavery Act

NHS Harrow CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

4 Statement of the Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHSE). NHSE has appointed the Accountable Officer of NHS Harrow CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money, and in the CCG Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable,
- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- for safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities). The relevant responsibilities of accounting officers under Managing Public Money.
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHSE has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction.

The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- observe the Accounts Direction issued by NHSE, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter, except that the CCG did not meet the following statutory financial duties:

- For expenditure not to exceed income: as expenditure exceeded income by £1.3million
- For revenue resource use not to exceed the amount specified in Directions: as the amount was exceeded by £1.3million

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

5 Governance Statement

5.1 Introduction and context

NHS Harrow CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended).

The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

NHS England is supported by legislation in exercising formal powers of direction if it is satisfied that a CCG is (a) failing or (b) is at risk of failing to discharge its functions. Formal intervention action would be proposed, as laid out in section 14Z21 of the NHS Act 2006 (as amended).

As of 1 April 2016, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. A full list of formal powers of direction can be viewed on the NHSE website.

5.2 Scope of responsibility

The Accountable Officer has responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which he is personally responsible, in accordance with the responsibilities assigned to him in Managing Public Money. He also acknowledges his responsibilities as set out under the National Health Service Act 2006 (as amended) and in his Clinical Commissioning Group Accountable Officer Appointment Letter.

The Accountable Officer is responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. He also has responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

5.3 Governance arrangements and effectiveness

5.3.1 CCG Constitution and structure

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The above is set out in The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b).

The overarching governance arrangements are set out in the Constitution which includes standing orders, prime financial policies, instructions and the scheme of reservation and delegation. The CCG has delegated to the Governing Body decision making and responsibility for the delivery of all its duties with certain exceptions:

- Determination of the arrangements by which the members of the CCG approve those decisions that are reserved for the membership.

- Consideration and approval of applications to NHSE on any matter concerning changes to the CCG's constitution, including terms of reference for the CCG's Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.
- Approval of the arrangements for identifying practice members to represent practices in matters concerning the work of the CCG and appointing clinical leaders to represent the CCG's membership on the CCG's Governing Body, for example through election (if desired).
- Approval of the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.

The Governing Body has supplemented the governance framework by the formal adoption of the Nolan Principles on Standards in Public Life, the Code of Conduct and Accountability for NHS Boards, the CCG Code of Conduct, Standards of Business Conduct (incorporating gifts, hospitality and sponsorship) Policy, Anti-Bribery Policy, and a Conflicts of Interest Policy.

In addition, jointly with NHS Brent and Hillingdon CCGs, the CCG has appointed two associate lay members whose primary role is to enable clearly independent decision making in relation to procurement choices where otherwise a conflict of interest could be perceived.

Using the NHSE guidance, The Functions of Clinical Commissioning Groups, and published legal guidance, the CCG has reviewed its statutory duties and is satisfied that it has in place all the necessary complete and lawful arrangements to ensure the proper discharge of those functions.

5.3.2 Governing Body

To undertake and ensure the systematic discharge of its functions and duties, the CCG established a Governing Body and committees. Details of their roles are set out below.

The functions of the Governing Body are:

- Commissioning community and secondary healthcare services (including mental health services) for:
  - all patients registered with its member GP practices and
  - all individuals who are resident within the London Borough of Harrow who are not registered with a member GP practice of any CCG (e.g. unregistered)
- Commissioning emergency care for anyone present in London Borough of Harrow.
- Paying its employees' remuneration, fees and allowances in accordance with the determinations made by NHS Harrow CCG Governing Body and determining any other terms and conditions of service of the CCG's employees.
- Determining the remuneration and travelling or other allowance of members of its Governing Body via the Joint Remuneration Committee.

The main areas of work undertaken during 2016/17 included oversight of the work of the committees that report to the Governing Body, establishing CCG objectives for 2016/17. Other areas include:

- Oversight of the work of the committees that report to the Governing Body and supporting a review of the governance structures and member participation,
- Governing Body members led a number of the CCG's events this year and presented at local community groups. These events gave local residents an opportunity to learn about key health initiatives and to give them a chance to feedback on local services.
- Further refined risk registers and closely monitored of strategic risks facing the CCG through the Board Assurance Framework (BAF).

- Governing Body members took part in a dedicated procurement workshop refreshing knowledge on procurement panel processes, the overall procurement process, flexibility and exceptionality and transparency work.
- Reviewed and approved of various business cases to shape service pathways/delivery and improve patient outcomes.
- Directly supported the development of the CCG's Commissioning Intentions.

Performance of the Governing Body

The Governing Body has considered the means by which it can review its effectiveness and has adopted an annual programme of self-assessment. The outcome of the self-assessment is formally reported at a meeting of the Governing Body and an associated action plan developed.

Governing Body committees will follow a similar process from 2017/18 with the outcomes considered by the Governing Body as part of a wider annual review of performance. In addition, with the assistance of an external consultant, the CCG has conducted organisational development seminars.

To discharge these duties, it has met on six occasions during the year with attendance as follows:

[Note: For voting/non-voting status, refer to table in section 3.3]

Governing Body Members			
Name	**Title**	**Present/ deputy**	**Absent**
Dr Amol Kelshiker	Chair and Clinical Director	6	0
Dr Kaushik Karia	Vice Chair and Clinical Director	6	0
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	6	0
Dr Genevieve Small	Clinical Director	4	2
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	5	1
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	5	1
Dr Sharanjit Takher	Clinical Director	4	2
Dr Sandy Gupta	Secondary Care Consultant	5	1
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	2	4
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	6	0
Richard Smith Appointed 18 July 2016	Lay Member	4	2
Sanjay Dighe	Lay Member	5	1
Rob Larkman	Accountable Officer	1	5
Paul Jenkins Appointed 11 January 2017	Interim Chief Operating Officer	2	4
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	4	2

Neil Ferrelly	Chief Finance Officer	5	1
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	3	3
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	1	0
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	1
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	3	3
Andrew Howe	Director of Public Health, Harrow Council	6	0
Mina Kakaiya	Representative, Healthwatch Harrow	4	2

5.3.3 Audit Committee

The Committee reviews the establishment and maintenance of effective systems of integrated governance, risk management and internal control across the whole of NHS Harrow CCG's activities, designed to support the achievement of the CCG's objectives. Its work dovetails with that of NHS Harrow CCG's Integrated Governance and Finance, QIPP and Performance committees, which it has established to seek assurance that robust clinical quality is in place.

The Audit Committee reviews the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by NHS Harrow CCG's Governing Body,
- the underlying assurance processes that indicate the degree of achievement of each of NHS Harrow CCG's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements,
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification and
- the policies and procedures for all work related to fraud, bribery and corruption as set out in the NHS Protect Standards for Commissioners and as required by NHS Protect.

In carrying out this work, the Audit Committee primarily uses the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It also seeks reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This is evidenced through the Audit Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

In discharging these responsibilities, the Audit Committee has focused on the establishment of effective policies and procedures to control financial performance and to ensure compliance with relevant regulatory and legal requirements.

This work has included overseeing counter fraud arrangements, reviewing the financial control environment assessments, closely monitoring the contracting database developments, monitoring the refinement of risk management and overseeing the extension of internal audit and counter fraud contracts.

The Committee was appointed as the Audit Panel (approved by BHH CCGs Governing Bodies) to oversee the procurement, and recommend appointment of, external auditors to undertake external audit services across the eight NWL CCGs, from 1 April 2017.

At each meeting, the committee also reviewed the risk management and assurance framework arrangements to ensure effective management of the CCG's strategic, operational and collaboration risks.

The Committee recognised that conflicts of interest perceived or real, posed a particular challenge for NHS Harrow CCG. To ensure that all dealings were beyond reproach, it oversaw the ongoing development of the conflicts of interest policy, specific arrangements to oversee the co-commissioning of primary care services with NHSE and transparency in the management of conflicts of interest. In so doing, the Committee met on six occasions with attendance as follows:

Audit Committee Members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	3	1
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	2	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	5	1
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	1	5

5.3.4 Executive Committee

The purpose of the CCG Executive Committee is to ensure the strategic and operational arrangements of the CCG enable it to achieve the objectives and performance requirements within the capital and resource limits set out in the Secretary of State's mandate during the period specified. It:

- ensures the CCG has arrangements in place to comply with the processes to review and measure performance set out in the mandate,
- works in partnership with its local authority to develop joint strategic needs assessments and joint health and well-being strategies,
- ensures that health services are provided in a way that promotes awareness of, and has regard to, the NHS Constitution
- acts with a view to securing continuous improvement to the quality of services,
- assists and supports NHSE in relation to its duty to improve the quality of primary medical services,
- promotes the involvement of patients, their carers and representatives in decisions about their healthcare,
- secures continuous improvement to the quality of services,
- promotes innovation, research and the use of research and
- acts with a view to promoting integration of both health services with other health services and health services with health-related and social care services where the CCG
- considers that this would improve the quality of services or reduce inequalities.

Areas reviewed by the Committee included:

- draft Annual Governance Statement,
- QIPP governance processes,

- GP practice budget setting,
- operating plan activity and narrative,
- managing the conflict of interest process for the Chairs and Clinical Director election process,
- access to phlebotomy services in Harrow,
- improving access to primary care through walk-in centres,
- primary care co-commissioning model,
- improving early diagnosis of dementia,
- improving Access to Psychological Therapies (IAPT),
- Board Assurance Framework (BAF) summary reports,
- Harrow quality strategy and work plan,
- Healthy London Partnership,
- LNWHT Recovery Plan,
- primary care ICT and interoperability,
- terms of reference of the BHH CCGs Education Forum,
- Harrow Better Care Fund – BCF plan,
- NWL STP – Strategic Transformation Plan and
- Tier 3 primary care delegation application to NHSE.

To discharge these duties, it has met on 10 occasions during the year with attendance as follows:

Executive Committee Members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Dr Amol Kelshiker	Chair and Clinical Director	10	0
Dr Kaushik Karia	Vice Chair and Clinical Director	9	1
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	8	2
Dr Genevieve Small	Clinical Director	10	0
Dr Shahla Ahmad Appointed 20 June 2016	Clinical Director	7	3
Dr Shaheen Jinah Appointed 6 June 2016	Clinical Director	3	5
Dr Sharanjit Takher	Clinical Director	9	1
Rob Larkman	Accountable Officer	6	4
Paul Jenkins Appointed from 11 January 2017	Interim Chief Operating Officer	2	0
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	8	2
Neil Ferrelly	Chief Finance Officer	10	0
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	3 (2)	5
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	1	0
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	0
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	7	0
Gilbert George	Interim Head of Governance	10	0

5.3.5 Procurement Panel

The role of the panel is, if requested by the Governing Body, to undertake any or all of the following tasks:

- Receive proposals for service change and scrutinise rather than query them.
- Review service specifications.
- Identify the best sourcing route.
- Consider pricing and costing issues for Any Qualified Provider and propose single tender sourcing.
- Oversee the sourcing and implementation of any new service.
- Establish the rationale for selecting any given procurement route and provider.
- Make recommendations to the Governing Body on procurement routes for contracts
- Approve the administrative arrangements for procurement, where authority has been delegated, to make decisions on behalf of the Governing Body.

Membership of the panel is determined on a case-by-case basis, by the Governing Body and must include non-conflicted members of the Governing Body. Other non-conflicted individuals of the CCG, Local Authority and NHS organisations may be invited to the panel, as voting or non-voting members, at the discretion of the Governing Body. During the past year the Panel has met on 10 occasions. In these meetings, items for discussion included:

- phlebotomy,
- cardiology,
- Walk-in centres,
- Harrow Health Limited contract,
- care management LIS (Local Improvement Scheme) and
- medicines optimisation support

Procurement Panel members			
Name	**Title**	**Present/ (deputy)**	**Absent**
Gerald Zeidman Contract completed 31 March 2017	Lay Member	10	0
Sanjay Dighe	Lay Member	7	3
Mukesh Panchal	Associate Lay Member	6	4
Dr Sandy Gupta	Secondary Care Consultant	8	2
Rob Larkman	Accountable Officer	2	8
Paul Jenkins Appointed from 11 January 2017	Interim Chief Operating Officer	3	0
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	6	2
Neil Ferrelly	Chief Finance Officer	(7)	3
Alex Faulkes Appointed 1 April 2016	Director of Delivery and Performance	0	10
Diane Jones Appointed 1 March 2017	Director of Quality and Safety	0	1
Ann Jackson Appointed 10 January 2017 Resigned 28 February 2017	Interim Director of Quality and Safety	0	0
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	5	0

Gilbert George	Interim Head of Governance	2	8

5.3.6 Other Governing Body committees

Finance, Research and Quality, Innovation, Prevention and Productivity (QIPP) Committee

The purpose of the Finance, Research and Quality, Innovation, Prevention and Productivity (QIPP) Committee is to:

- promote innovation and promote research and the use of research by providing assurance and oversight against this duty,
- promote collaborative working,
- continuously assess financial and non-financial risks relating to the QIPP plans and ensure measures and mitigation to manage risk,
- ensure the QIPP plan is supported by robust financial planning,
- review annual budget and medium term financial plans,
- review performance of key objectives and targets as set in the annual outcomes
- framework and
- receive and review business cases and procurement procedures as required.

Over the year, items for discussion included:

- 2016/17 initial budgets and financial plan
- Performance reports
- Finance reports
- QIPP Project Management Office reports
- Draft NWL financial strategy
- Interim community beds procurement
- End of life single point of access.

To discharge these responsibilities, the Committee met on 12 occasions during the year.

Quality Safety and Risk Committee

The Quality, Safety and Clinical Risk Committee works to provide assurance that the CCG and its committees and subcommittees have in place the proper process for monitoring quality, safety, risk and driving improvement.

The general areas of responsibility for the committee are to:

- seek assurance that the Commissioning Plan and strategy for the CCG fully reflects all elements of quality (patient experience, effectiveness and patient safety), keeping in mind that the strategy and response may need to adapt and change,
- provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the CCG does and continuously support the improvement of quality in primary care services (this includes jointly commissioned services),
- provide oversight and assurance of the process and compliance issues concerning SIs,
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans,
- ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern,
- review annual provider Quality Accounts,

- review patient experience through surveys and complaints and make recommendations for improvement and
- have responsibility for CCG information governance compliance and monitoring provider information governance compliance.

During 2016/17 the committee has:

- monitored the quality and safety risks of commissioned services,
- reviewed monthly integrated performance and quality reports, focusing on the exceptions regarding quality risks and mitigating actions,
- embedded quarterly reports which have provided the committee with an overview of quality and safety risks and priorities,
- considered key areas in more depth including themes and learning from SIs, pressure ulcers,
- received annual reports in relation to both adults and children's safeguarding,
- monitored and discussed the challenges faced by the CCG in relation to continuing and complex care,
- examined the Quality Account for CNWL, the mental health trust, as the lead commissioner, to enable the CCG to submit a statement on behalf of NW London CCGs,
- reviewed the priorities within the Quality Accounts of those providers for which the CCG is an associate commissioner or those out of area to ensure that the CCG is sighted on the quality of their commissioned services and
- scrutinised the quality impact of changes to commissioning of services such as medicines management.

To discharge these responsibilities, the Committee met on 12 occasions during the year.

Equality and Engagement Committee

The purpose of the Equality and Engagement Committee is to meet the public sector equality duty. It does this by:

- providing oversight and assurance that the CCG is eliminating unlawful discrimination harassment, victimisation and conduct prohibited in the 2010 Act,
- advancing equality of opportunity between people who share a protected characteristic and those who do not,
- foster good relations between people who share a protected characteristic and those who do not,
- making arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements,
- have regard to the need to reduce inequalities by:
    - providing oversight and assurance that the CCG acts in accordance with the CCG's equality and diversity engagement policy which specifies the CCG's approach to reducing inequalities and states how this will be reflected in the CCG's planning and delivery of services,
    - receive an annual assessment of performance against these objectives from the CCG and
- promote the involvement of patients, their carers and representatives in decisions about their healthcare.

To discharge these responsibilities, the Committee met on four occasions during the year.

During 2016/17 the Committee focused on:

- assuring that the CCG is responsive to the needs of deaf people or those with hearing impairments through the services it commissions,
- ensuring the public and patients are engaged on proposed service development, procurement and commissioning, with feedback acted upon,
- improving representation by the voluntary sector on the Committee, with this extended to the Voluntary Sector Forum and
- making sure the Equality Impact Assessment process is applied through screening, with a full assessment undertaken where required, and the outcomes of either reported to the Committee

5.3.7 Joint committees with delegated decision making authority

Local Primary care co-commissioning and eight Joint Committees in North West London

The CCG has entered into joint arrangements known as primary care co-commissioning with NHSE which are designed to enable the CCG to better influence the development of local primary care. Primary care co-commissioning will enable the CCG to ensure that primary care acts as a driver for ambitious plans to transform the local health and care economy, both locally and across NW London.

The local Primary Care Co-Commissioning Committee meets monthly. A meeting in common of the eight joint committees in North West London takes place quarterly (NHS Brent, Harrow, Hillingdon, Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs).

The shared vision for primary care co-commissioning places GPs at the centre of organising and coordinating care for people, seven days a week, through both individual practices and practice networks. By aligning this work with transformation work across NW London, co-commissioning is designed to achieve the following:

- Services that are joined up, coordinated, and easily navigated, with more services available closer to people's homes,
- High quality out-of-hospital care and improved access to services,
- Improved health outcomes, equity of access, reduced inequalities, and better patient experiences
- Enhanced local patient and public involvement in developing services, with a greater focus on prevention, staying healthy, and patient empowerment.

The meetings held in common have focused on devising a coordinated NW London approach to key strategic issues, such as the implementation of the Strategic Commissioning Framework and strategic approaches to estates development and the Personal Medical Services (PMS) review.

Harrow's local joint committee has focused on formulating CCG-specific Commissioning Intentions for the reinvestment of the local PMS premiums, the development of local estates strategies, and the deployment of funds through the Primary Care Transformation Fund. It has also considered the commissioning of APMS contracts. The private sections of the local meetings have considered confidential practice issues, including contract performance issues and have had oversight of action plans to address these.

The joint committees have also worked hard to engage local stakeholders (including Healthwatch Harrow and the Health and Wellbeing Boards) in co-commissioning. Through

the NW London primary care transformation team, the joint committees have also supported lay member co-commissioning education sessions, including on the local primary care landscape, primary care finance, and the methodologies of the PMS review.

In December 2016, NHS Harrow CCG applied to become a level three delegated CCG taking full responsibility for the commissioning of primary medical services, subject to members agreement. On 15 February 2015, members of the CCG voted in favour of level three delegation, there was a turnout of 88% of practices. 78% of practices voted in favour.

NHS Harrow CCG will take on responsibility for commissioning primary care medical services from 1 April 2017. NHS Harrow CCG will establish a committee of the Governing Body in order to carry out these functions. The final terms of reference will be adopted into the CCG's constitution and these will have effect from 1 April 2017. With full delegation, NHS Harrow CCG expects to be able to commission services in a more integrated way, be more responsive to patients and to general practitioners.

5.3.8 Other Joint Committees

North West London (NWL) CCGs' collaboration board (a non-statutory joint committee for consultation and for decision making in limited areas)

This committee brings together eight CCG chairs, two Accountable Officers and shared directors, together with lay members and Healthwatch Harrow representation, to discuss joint strategic objectives and proposals. This allows the NW London CCGs to seek a consensus view, taking into account the needs of local health populations, before proposals and recommendations are discussed in each CCG.

The board serves to guide the CCGs' overall approach to the annual contracts rounds and to develop a business intelligence and informatics strategy. In limited areas, the board has delegated authority from the CCGs in which it can take joint decisions. For instance, it takes decisions in response to the recommendations of NWL CCGs' Policy Development Group on Individual Funding Requests (IFRs) and Planned Procedures with a Threshold (PPwTs). In all cases regarding financial investment, the CCGs' Standing Financial Instructions are adhered to and the local decision making routes are followed.

North West London (NWL) CCGs' collaboration board (a non-statutory joint committee for consultation and for decision making in limited areas)

The collaboration board serves to guide the CCGs' approach to developing joint strategy, including business intelligence and informatics strategy, and also spends time at the beginning of the contracts round providing feedback on the approach to be taken, led by the NW London CCGs' director of contracting, performance and procurement. In limited areas, the board has delegated authority from the CCGs in which it can take joint decisions. For instance, it takes decisions in response to the recommendations of NWL CCGs' Policy Development Group on Individual Funding Requests (IFRs) and Planned Procedures with a Threshold (PPwTs) as to what healthcare treatment may be funded in the boroughs and against which criteria. In all other cases regarding financial investment, the CCGs' respective local Standing Financial Instructions are adhered to and the local decision making routes are followed.

A key focus of collaboration during 2016/17 was to accelerate and deepen the development of the NW London STP, with a large contingent of the board's membership also meeting regularly together with a range of stakeholders via the Strategic Planning Group for NW London. Since the publication of the STP, the board's strategy meetings have been re-orientated to ensure that health commissioners explore in depth the progress within and across the five 'delivery areas' and three 'enablers' of the STP, and provide rigorous challenge to the executive arm of the sector.

5.3.9 Clinical Board

The Clinical Board provides clinical advice for the Shaping a Healthier Future (SaHF) re-configuration programme, ensuring that the approach to implementation across primary and secondary care is clinically sound and that clinical safety and quality are protected during the implementation period.

Its responsibilities include:

- Monitor and manage clinical risk to patients and the clinical delivery of services across NWL during reconfiguration implementation, agreeing collective action to address any issues.
- Lead clinical implementation planning, in particular advising on safe sequencing of change and readiness for change.
- Provide expert clinical advice on other programme deliverables if needed, including local workstream deliverables.
- Seek advice, where necessary, from:
  - the NW London Clinical Senate (once established),
  - the Governing Body and
  - the Clinical Networks – expert advisory groups of clinicians in the key areas of maternity, paediatrics and emergency and urgent care.
- Commission the Clinical Networks/Clinical Implementation Groups to provide advice on any specialty-specific implementation issues.

5.3.10 Shaping a Healthier Future (SaHF) Implementation Programme Board

The Implementation Programme Board oversees the implementation of the Shaping a Healthier Future reconfiguration programme in line with decisions taken by the NW London Joint Committee of Primary Care Trusts (NW London JCPCT, formed in 2012 and then comprised the eight NW London PCTs and three neighbouring PCTs – Camden, Richmond, Wandsworth).

The Programme Board has responsibilities to:

- bring together local commissioners and local providers to jointly manage reconfiguration implementation,
- plan, manage progress, resolve issues and manage risks and interdependencies,
- receive and discuss progress reports from workstream leads,
- track system-wide delivery of QIPP and Cost Improvement Plans and enabling projects as they pertain to the delivery of Shaping a Healthier Future reconfiguration by, for example, delivery of admissions avoidance and reductions in length of stay,
- receive and discuss key programme deliverables, in particular:
  - system-wide deliverables such as common modelling assumptions,
  - Outline Business Case (OBC) and Final Business Cases (FBCs) for capital expenditure,
- ensure the different parts of the programme maintain sufficient focus on issues relating to clinical risk, workforce, travel and access, equalities and carers and that appropriate patient engagement continues,
- ensure appropriate links are made with other strategic programmes and organisations outside NW London and
- ensure the CCG complies with information governance requirements to new and emerging priorities and risks.

5.4 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Corporate Governance Code.

However, the CCG draws on best practice from the code in the areas of:

- Leadership – members having collective responsibility for the long term planning of the CCG
- Effectiveness – committee members having the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively.
- Accountability – members determining the nature and extent of the significant risks they are willing to take to achieve the CCG strategic objectives

5.5 Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, the Accountable Officer can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

5.6 Risk management arrangements and effectiveness

5.6.1 Risk management strategy

The Risk Management and Assurance Strategy published in 2015 outlines NHS Harrow CCG's approach to risk management and its vision in relation to assurance systems. NHS Harrow CCG has a responsibility to ensure that it is effectively governed in accordance with best practice across corporate, clinical and financial governance.

Every activity that NHS Harrow CCG undertakes, or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives.

Risk management aims to draw attention to actual or potential problems and to encourage the appropriate response to them. Risks are managed by the people who have the greatest ability to control them.

Successful risk management involves:

- identifying and assessing risks,
- taking action to anticipate or manage them,
- monitoring them and reviewing progress in order to establish whether further action is necessary or not and
- ensuring effective contingency plans are in place.

Through the management of risk, NHS Harrow CCG seeks to minimise, though not necessarily eliminate, threats and maximise opportunities. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Governing Body and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety and reduce our financial, operational and reputational risks through awareness, competence and management.

NHS Harrow CCG risk management processes ensure that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- clarifying objectives,
- identifying threats to the objectives,
- defining and recording risks,
- completion of the risk register and identifying actions and
- escalation of risks.

The risks NHS Harrow CCG is specifically exposed to are identified by:

- Internal methods – such as complaints, claims, identification of trends, audits, QIPP related risks, project risks, patient satisfaction surveys, whistle-blowing and monitoring the quality of commissioned services.
- External methods – HM Coroner reports, media, national reports, new legislation, surveys, reports from assessments/inspections by external bodies (e.g. CQC), reviews of partnership working, horizon scanning.
- Liaison – through practice visits, locality meetings, GP Forums, patient engagement forums, practice feedback forms and practice manager meetings.

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. For example, from a directorate (workstream) risk register to the corporate register, or from the team risk register to the directorate risk register. Risks are reviewed according to assigned domains by the appropriate CCG committee.

The Governing Body is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. By articulating its appetite for risk taking, the Governing Body makes clear that:

- some element of risk taking is necessary to allow the CCG to seize important opportunities,
- risk taking is more acceptable in some areas than in others and
- there is a point at which the management of a risk should be immediately escalated to the direct oversight of the Senior Management Team.

A formal risk appetite statement sets a clear process for the management of risk and enhances the reporting of any instances where the appetite and specific risk thresholds are reached.

The Governing Body will review its risk appetite on an annual basis or during times of increased uncertainty or adverse changes. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the Governing Body to determine the organisational capacity to control risk.

The Governing Body has a risk appetite matrix, which uses specific risk domains, it scores each risk against the national risk scoring matrix, determining a category of low, moderate, high or significant.

In the review and monitoring process, there is particular focus on the controls that have been applied to each risk and the extent of the assurances that the actions are proving effective.

Embedding risk management

Our processes for embedding risk management include:

Raising awareness

Staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.

- Risk identification – line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.
- Accountability – staff will be identified to own the actions to tackle risks.
- Communication – there will be active and frequent communication between staff, stakeholders and partners.

Competence

Staff will be competent at managing risk.

- Training – staff will have access to comprehensive risk guidance and advice. Those who are identified as requiring more specialist training to enable them to fulfil their responsibilities relevant to their roles will have this provided internally
- Behaviour and culture – senior management will lead change by example, ensuring risks are identified, assessed and managed. All staff are encouraged to identify risks.

Management

Activities will be controlled using the risk management process and staff are empowered to tackle risks.

- Risk assessment and management – risks will be assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans will be put in place where required.
- Process – the process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.
- Measuring performance – exposure to risk will be measured with the aim of reducing this over time. The culture of risk management will also be measured and improved during the lifetime of this strategy.

Public stakeholder engagement

NHS Harrow CCG actively promotes patient and public involvement via partnership working and effective external and internal communication, website and intranet. The process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.

Control mechanism

There are different operational levels of risk governance in the CCG:

- Governing Bodies,
- Audit Committee,
- Finance and Performance Committee,
- Quality Safety and Clinical Risk Committee,
- Equality and Engagement Committee,
- Procurement Panel,
- The Executive (management) and
- workstream forums.

Risk management by the Governing Body is underpinned by a number of interlocking systems of control:

- Board Assurance Framework (BAF) sets out the strategic objectives, identifies risks inrelation to each strategic objective along with the controls in place and assurances available on their operation
- Corporate Risk Register (informed by Team, Work Stream Directorate risks) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly, it demonstrates that an effective risk management approach is in operation within the organisation
- Audit and other committees exist to provide scrutiny and assurance of the robustness of risk processes and to support the Governing Body.

Prevention of risk

Best practice says each work-stream, team and directorate will have a forum where risk is discussed, including the risk register, actions, and any required escalation.

The CCG has both formal and informal mechanisms for identifying risks to achieving its objectives. One element of pro-active risk management is prevention. Prevention is embedded within the operation of the CCG through:

- an incident reporting policy which recognises that the vast majority of NHS patients receive high standards of care but acknowledges that incidents do occur and encourages prompt reporting as a key part of risk management,
- the risk evaluation of every decision the Governing Body and its committees are asked to make and
- the impact assessment of all policies, practices, procedures and decisions to ensure equality and diversity compliance.

Horizon scanning can identify positive areas for NHS Harrow CCG to develop its business and services, taking opportunities where these arise. NHS Harrow CCG will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scan, NHS Harrow CCG is better able to respond to changes or emerging issues in a planned structured coordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach, it should consider on-going risks to commissioned services.

NHS Harrow CCG's Governing Body has the responsibility to horizon scan and formally communicates matters in the appropriate forum relating to their areas of accountability.

Deterrent to risks arising

Although internal controls are in place, reliance on external organisations to perform key functions exposes NHS Harrow CCG to some risk of fraud and bribery. Measures to mitigate these risks are included in the Anti-Fraud and Anti-Bribery Policy and addressed as part of the Local Counter Fraud Specialist Work-plan 2016/17.

Operational risks are recorded and managed through the corporate risk register or through the BAF if it is deemed that they could impact on the achievement of strategic objectives. The risks in both documents record the risk, its causes and the effects, and are rated according to severity, which is calculated using weighted values for the likelihood of the risk occurring and the consequences if it does occur. Risks are categorised as either low, moderate, high or extreme.

5.6.2 Capacity to handle risk

The Accountable Officer has overall responsibility for risk management and discharges this by:

- continually promoting risk management and demonstrating leadership, involvement and support,
- ensuring an appropriate committee structure is in place and ensuring each receives regular risk reports and
- ensuring that the Governing Body, executive team, clinical directors and senior managers are appointed with managerial responsibility for risk management.

All risk owners have been trained in the risk management process and this has been supplemented with written guidance. In addition, on a regular basis, the Head of Governance assists risk owners to review controls and assurances in respect of each risk. This means good practice is shared between all BHH CCGs.

The Governing Body is responsible for the performance management of the integrated risk management strategy and systems of clinical, financial and organisational control. It oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and is supported in that function by its committees:

- The Audit Committee, in line with the NHS Audit Committee Handbook, ensures the CCG has an effective process in place with regards to risk management and monitors the quality of the assurance framework, referring significant issues to the Governing Body.
- The Quality, Safety and Clinical Risk Committee has overarching responsibility for clinical risk management, information governance and health and safety risks.
- The Finance, Research and Quality, Innovation, Prevention and Productivity Committee (QIPP) Committee continuously assesses financial and non-financial risks relating to the QIPP plans and ensures the CCG has in place measures and mitigations to manage risk.
- The Executive Committee monitors, in detail, risks to achieving individual corporate objectives including action plans with a particular focus on risks rated amber and red.

Each committee reports its findings on risk management to the next Governing Body meeting. In this way, the CCG is assured that risk is effectively controlled and that its governance statement is valid.

In addition to the leadership of the risk management process, each strategic risk is owned by both a clinical member of the Governing Body and an executive member of the Governing Body.

It is overseen by the Director of Quality and Safety in respect of clinical risks, the Chief Finance Officer in respect of financial risks and by the Chief Operating Officer in respect of all other risks. In this way, leadership of, and commitment to, the risk management process is demonstrated at the highest level.

To ensure continued progress in the implementation of effective risk management, as outlined in the risk management and assurance strategy, the CCG has developed a risk training programme plan for different levels of risk management responsibilities and accountabilities:

- Operational.
- Management.
- Executive.

Review of effectiveness

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. This draws on performance information available. The review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

The CCG has been advised on the implications of the result of the review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, Finance and Performance Committee and Quality Safety and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

5.6.3 Risk assessment

Using the risk and control framework, risk assessment is conducted in a systematic manner across all aspects of the CCG's strategic and operational goals.

The risks and the controls applied to them are actively scrutinised throughout the year by the Governing Body, responsible committees and the Senior Management Team.

Each risk is assigned a target risk rating and, if the Governing Body is satisfied that the level of risk has reduced to that level and is fully mitigated, it may direct that the risk be removed from the assurance framework.

Risks to governance, compliance, management and internal control

As part of the approved internal audit plan for 2016/17, internal auditors were asked to undertake an audit of the CCG's BAF and risk management and information governance.

The internal auditors concluded that the CCG has adequate and effective framework for risk management, governance, internal control and information governance. They have identified further enhancements to the framework of risk management, governance, internal control and information governance to ensure that it remains adequate and effective.

The BHH CCGs have detailed a governance improvement plan informed by the findings and recommendations of a jointly commissioned independent review.

Using the risk and control framework described above, risk assessment is conducted in a

systematic manner across all aspects of the CCG's strategic and operational goals. The major risks confronting the organisation are set out below. The risks and the controls applied to them are actively scrutinised throughout the year by the Governing Body, responsible committees and the senior management team. Each risk is assigned a target risk rating and if the Governing Body is satisfied that the level of risk has reduced to that level, it may direct that the risk be removed from the assurance framework.

Ref	Strategic Objectives	Summary Descriptor
1a	Improve the health and wellbeing of people in Harrow by commissioning high quality and safe services	Failure to deliver the Harrow Health and Wellbeing Strategy
2a	Involve and empower the people of Harrow in shaping of local services	Failure to actively engage public in an effective manner to support the shaping of local services
3a	Manage resources effectively ensuring best value and deliver financial balance	There is a risk that financial pressures lead to the CCG not achieving the financial plan, causing the statutory duty not to be met and an inability to improve services for the local population
3b	Manage resources effectively ensuring best value and deliver financial balance	There is a risk that unplanned provider activity results in the CCG not achieving the required efficiency savings while improving service quality which would lead to increased financial pressure in future years
4a	Implement our Local Services Strategy – primary care driving development and delivery of integrated care	There is a risk that delayed moves of services into the community will cause local QIPP programmes not to be achieved, reducing delivery against commissioning outcomes
5a	Develop robust and collaborative commissioning arrangements	There is a risk that silo working on individual organisations' priorities lead to the CCG and its partners not innovating to jointly commission services
5b	Develop robust and collaborative commissioning arrangements	Providers may fail to deliver services to the required standard within contracts without the CCG being aware or able to take timely action which could lead to avoidable harm to patients and the CCG not meeting its statutory responsibilities
6a	Improving performance in line with the NHS Constitution	There is a risk that pressures on provider services impacts on their ability to achieve national standards while maintaining patient care
7a	Empowering people of Harrow to keep well and have a positive experience of care when they require it	There is a risk that the CCG does not communicate sufficient information and clarity (with recognition of inequalities) to facilitate understanding, enabling people to make the right choices

Principal risks to compliance

The principal risks to compliance with NHS Harrow CCG's continued authorisation are identified through the review of four domains, each of which is assessed on a broad range of performance measures:

- Are local people getting good quality care?
- Are patient rights under the NHS Constitution being promoted?
- Are health outcomes improving for local people?
- Are CCGs commissioning services within their financial allocations?

A named director is accountable for the risks in each domain and the process is overseen through the CCG governance arrangements. Every month, the senior management team, responsible committee and the Governing Body receive and scrutinise performance in this area. Further assurance on the effective management of risks to compliance with the CCG's authorisation is obtained from the NHSE self-assessment process and regular review meetings with NHSE.

Governing Body oversight

The main function of the Governing Body is to ensure that the CCG has arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant.

The Governing Body has responsibility for:

- assurance, including audit and remuneration,
- assuring the decision-making arrangements,
- oversight of arrangements for dealing with conflict of interest,
- agreeing the vision and strategy,
- formal approval of commissioning plans on behalf of the CCG,
- oversight of performance and
- providing assurance of strategic risks.

The Governing Body is responsible for the strategic direction of the CCG and for assuring the achievement of key health, wellbeing, financial, performance and service targets. It is directly accountable to the public, GP member practices of the CCG and NHSE.

5.7 Other sources of assurance

5.7.1 Internal control framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk. It can therefore only provide reasonable and not absolute assurance of effectiveness.

5.7.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHSE published a template audit framework in September

2016.

An internal audit on conflicts of interest management was conducted in line with the scope and approach contained within the NHSE framework. The internal audit review covered the five domain areas totalling 27 controls.

- Governance arrangements.
- Declarations of interests and gifts and hospitality.
- Registers of interests, gifts and hospitality and procurement decisions.
- Decision making processes and contract monitoring.
- Reporting concerns and identifying and managing breaches/ non-compliance.

The internal audit concluded with a Reasonable Assurance on compliance. The CCG was fully compliant on 70% of the 27 standards whilst the remaining 30% were either partially or non-compliant and management is agreeing actions to improve compliance in these areas.

5.7.3 Data quality

The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by the membership body and Governing Body is accurate and fit for purpose. All data that is forwarded to the Governing Body has been discussed, and analysed at a minuted committee meeting prior to being submitted for discussion, noting or a formal decision at the Governing Body.

5.7.4 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG submitted level two satisfactory compliance on their annual Information Governance Toolkit. As part of the compliance process, a cyber-security and information governance internal audit was completed. The governance audit concentrated on the process of the Registration Authority, information governance training and the information governance framework. The cyber security audit focused on network security, malware prevention and system configurations.

As a result of this work, the CCG is undertaking a range of actions in 2017/18. This includes updating its cyber security policy.

The CCG's continuing commitment is as follows:

- We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.
- We have established an information governance management framework and have developed information governance processes and procedures in line with the information Governance Toolkit.
- We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.
- There are processes in place for incident reporting and investigation of SIs. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

The Director of Informatics has given assurance that the IT operating model, which includes backup and disaster recovery mechanisms, is in place and embedded in the operations of the informatics team. The model is supported by the terms of the service level agreements that underpin the service.

5.7.5 Business critical models

The CCG has an appropriate framework and environment in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson Report.

All business critical models have been identified and that information about quality assurance processes for those models has been provided to the Shaping a Healthier Future (SaHF) Implementation Programme Board.

5.7.6 Third party assurances

The CCG requests service auditor's reports from its third party providers for those providers it engages with directly. Where contracts are managed nationally by NHS England the Service Auditor's Reports are made available to CCGs via the NHS England SharePoint site. The Service Auditor's Reports are also made available to the CCGs external auditors as part of the year end audit.

5.7.7 Health and safety

The CCG recognises its responsibility to ensure that reasonable precautions are taken to provide a safe working environment and to prevent or minimise the causes of fires or other health and safety issues, in compliance with relevant statutes and codes of practice.

During the year, improvements were implemented following risk assessments with respect to the working environment, the systems in place including fire precautions and response arrangements and the information and training provided to staff.

NHS Brent, Harrow and Hillingdon CCGs have received professional health and safety and fire safety support to fulfil the role of the Competent Person throughout 2016/17 (i.e. an individual with the appropriate skills and training). Advice, support and training is available for all staff, including those volunteering for specific roles in the event of an emergency. A health and safety working group examines and coordinates the CCG's health and safety arrangements, described in a framework, and the response to incidents and near misses. A training needs analysis was undertaken with the HR department and specified health and safety training is mandatory, the completion of which is monitored by the working group and included in reports received by Governing Body's committees.

The CCGs have a work-plan for the Health and Safety group's activities through 2017/18 and priorities include the implementation of policy arrangements in identified risk areas, ensuring expert advice arrangements and ensuring appropriate training to staff.

5.7.8 Complaints

NHS Harrow CCG aims to ensure that complaints are dealt with efficiently and that they are risk assessed in line with the NHS National complaints procedure. The NHS complaints procedure adheres to the principles for remedy published by the Parliamentary and Health Service Ombudsman and its Principles of Good Complaints Handling 2009.

The aim is to ensure that a consistent approach is taken concerning the management and investigation of complaints, regardless of issues raised. It is imperative that investigations take into

account the views and wishes of the complainant. Each complaint response is prepared in order to identify areas for improvement and to implement procedures to ensure clarity of roles and responsibilities in the CCG and between organisations.

From 1 April 2016 to 31 March 2017, the CCG received a total of 24 complaints:

13 of these related to commissioning decisions taken by the CCG, of these, three related to the individual funding request process and five concerned NHS Funded healthcare. All were investigated and responded to under the NHS complaints procedure.

One complaint concerned primary care contractors and was forwarded to NHSE for investigation and response.

10 complaints were about other providers and were forwarded to the appropriate organisations for investigation and response. Where appropriate, the CCG requests a copy of the final response for monitoring purposes.

Complaints referred to Parliamentary and Health Service Ombudsman

During the 2016/17 financial year, the CCG received two requests by the Parliamentary and Health Service Ombudsman (PHSO) for independent review.

The first matter related to CHC and the recovery of costs following a retrospective review. This was partly upheld by the PHSO.

The second matter related to the treatment of a patient received in a care home and is still subject to PHSO review.

The CCG acted on recommendations made by the PHSO and implemented actions within the requested timelines.

As a matter of policy, PHSO reports are shared with the relevant CCG staff in order to ensure that the relevant procedures and processes are embedded.

5.7.9 Freedom of Information (FOI)

The CCG, as statutory body for the purposes of the FOI Act, is required to respond to requests for information within 20 working days. It must either confirm that it does not hold the information or provide the information requested. The Act allows the CCG to exempt disclosure of some types of information where it is correct to do so and that it is in the public interest. The requester can refer the case to the Information Commissioner’s Office (ICO) which has the regulatory duty to ensure public authorities comply with the Act and can investigate the CCG’s decision and handling of requests.

In 2016/17, NHS Harrow CCG received 305 requests. This is a 16% increase on the 2015/2016 volume.

The CCG responded to 83% of requests within 20 working days. This is compared to 80% achieved in the previous year. The ICO has set an expectation for public authorities to aspire to 85% of all requests to be responded to in 20 working days.

5.7.10 Emergency planning preparedness and resilience

Emergency preparedness, resilience and response is defined by a series of statutory responsibilities under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 which require NHS organisations to maintain a robust capability to plan for, and respond to

incidents or emergencies that could impact on their communities.

In accordance with this legislation, NHS Harrow CCG collaborates with NHS Brent and Hillingdon CCGs to develop incident response and threat-specific plans (e.g. cold weather and severe weather plans) to ensure we continue to deliver our critical business operations and support our partners in the event of a major incident or emergency.

Furthermore, the CCG operates a robust on-call system 24 hours a day, seven days a week, 365 days a year to further ensure resilience across the local health economy. Our organisation is fully part of the local and regional emergency planning structure with regular representation at Borough Resilience Forums and participates in multi-agency exercises, ensuring a proactive and coordinated approach to emergency preparedness.

BHH CCGs are committed to collaboratively implementing an integrated and dynamic business continuity management system which is aligned to ISO 22301, and an emergency preparedness and response capability to ensure the continued delivery of safe and effective healthcare commissioning and management across outer North West London.

NHS Harrow CCG has incident response plans and procedures in place, which are fully compliant with NHS England's, Emergency Preparedness 2015 Guidance. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing and exercising this plan, the results of which are reported to the Governing Body.

5.8 Control issues

Control issues – specifically the in-year deficit position, underlying financial position and mitigating actions – are set out in more detail in section 5.9.1.

5.9 Review of economy, efficiency and effectiveness of the use of resources

The role of the Governing Body

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance.

The Governing Body receives regular reports summarising the financial performance of the CCG. In addition, its committees, including the Audit Committee, have important roles to play in assuring the Governing Body on the arrangements in place to secure economic, efficient and effective use of resources.

The Audit Committee provides the CCG's Governing Body with an independent and objective view of the CCG's efficiency and effectiveness, use of resources financial and control systems, financial and business information.

Jointly with NHS Brent and Hillingdon CCGs, we have established a collaborative arrangement to share a leadership team and work together to become effective commissioners. This collaborative agreement enables:

- the joint commissioning of high quality care,
- the CCG to tackle cross borough issues,
- maximum influence in negotiating and managing contracts with key providers,
- shaping of the provider landscape in NW London and
- economies of scale.

In addition, the CCG is one of eight NW London CCGs working collaboratively to deliver improvements to services across the area. Initiatives have included joint approaches on:

- the NW London STP,
- primary care co-commissioning with NHS and
- a common financial strategy to deliver Shaping a Healthier Future.

Quality of leadership indicator

NHSE carry out an assessment based on four key lines of enquiry to determine how robustly the leaders of a CCG are performing their role. The indicator is based on four key lines of enquiry, concerning:

- robust culture and leadership sustainability,
- quality,
- governance, including financial governance and
- engagement and involvement.

Evidence-based assessments are made by NHS England local teams and moderated regionally and nationally in a process overseen by regional directors and the director of NHS operations and delivery.

There are four levels of assessment - Green Star (highest), Green, Amber, Red (lowest).

Harrow were rated Amber (based on latest assessment 2016/17 Q2). An action plan is now in place to address these issues.

5.9.1 In-year and underlying financial position

In-year financial position

The CCG's planned surplus in 2016/17 was £0.1m (0.03% of recurrent Revenue Resource Limit). The outturn position for 2016/17 is a deficit of £1.3m. The deficit was the result of overspends on acute contracts, continuing care and prescribing costs. These were partly off-set by underspends on community and primary care budgets as well as additional in-year support from the risk share arrangement across NHS Brent, Hillingdon and Harrow CCGs.

Underlying financial position

The CCG had an underlying deficit of £9.9m at the end of 2016/17. The difference between the in-year deficit of £1.3m and the underlying position of is accounted for by a combination of additional in-year allocations and other non-recurrent underspends.

Financial plans going forward

In 2017/18, the CCG's resource allocation has increased by £38.6m. £30.6m relates to the CCG taking on responsibility for commissioning primary medical services. The remaining £8.0m increase relates to growth applied to the CCG core allocation. The CCG is planning for an in-year deficit of £21.2m (£6.5% of recurrent Revenue Resource Limit) and an underlying deficit of £9.1m (2.8% of recurrent Revenue Resource Limit).

A two year recovery programme of work is in place to ensure that the CCG is financially sustainable going forward.

5.9.2 Delegation of functions

The CCG has not delegated any of its functions (no delegated chains) during the 2016/17 financial year.

5.9.3 Counter fraud arrangements

NHS Harrow CCG does not tolerate fraud and bribery within the NHS. The intention is to eliminate all NHS fraud and bribery as far as possible. The aim of the anti-fraud and anti-bribery policy is to protect the property and finances of the NHS and of patients in our care.

NHS Harrow CCG has adopted the seven-stage approach developed by NHS Protect:

- Creation of an anti-fraud culture.
- Maximum deterrence of fraud.
- Successful prevention of fraud which cannot be deterred.
- Prompt detection of fraud which cannot be prevented.
- Professional investigation of detected fraud.
- Effective sanctions, including appropriate legal action against people committing fraud and bribery and
- Effective methods of seeking redress in respect of money defrauded.

NHS Harrow CCG will take all necessary steps to counter fraud and bribery in accordance with this policy, the NHS Protect Standards for Commissioners, the policy statement, Applying Appropriate Sanctions Consistently, published by NHS Protect and any other relevant guidance or advice issued by NHS Protect. NHS Harrow CCG also has a Standards of Business Conduct (gifts, hospitality and commercial sponsorship) Policy.

RSM Risk Assurance Services LLP provides the counter fraud provision on behalf of the CCG and appoints an Accredited Local Counter Fraud Specialist to undertake the counter fraud work proportionate to identified risks.

The CCG Audit Committee receives a report against each of the Standards for Commissioners on an annual basis demonstrating executive support and direction for a proportionate proactive work plan to address identified risks.

5.10 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

> In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement. Our list of opinions is provided in Appendix A.

The head of internal audit opinion

For the 12 months ended 31 March 2017, the head of internal audit opinion for NHS Harrow Clinical Commissioning Group is as follows:

Head of internal audit opinion 2016/2017
The organisation has an adequate and effective framework for risk management, governance and internal control. **However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.**

Factors and findings which have informed our opinion

The **Cyber Security** review was given a PARTIAL ASSURANCE opinion. It confirmed the CCG's known risks and the need for Security Improvement Projects (SIP) that will bring enhanced technologies to manage cyber threats. A number of control deficiencies were found across various cyber security themes including Firewalls and Internet Gateways; Secure Configuration; User Access Control; Malware Protection and Patch Management. Management has agreed an action plan and is in the process of implementing the agreed actions.

The **Continuing Healthcare** review was given a PARTIAL ASSURANCE opinion. An increase in demand, particularly around high cost cases such as fast track palliative care, meant that the duration of care was longer than expected. This strong demand for Continuing Healthcare had resulted in increased and substantial overspends against planned budgets. Additional work by the Value Care Organisation recently brought in to conduct some analysis on demand and patient activity should help the CCGs to assess demand more accurately moving forwards, which in turn will inform the budget setting process.

Following on from our work in 2015/16 on a complaint to NHS England regarding a procurement exercise conducted by the CCG we undertook a follow up exercise to review the implementation of actions. We found that overall the quality of the procurement processes examined as part of this review was considerably stronger than those which we had previously reviewed and there was a clearer process which added considerable rigour and transparency to the procurement process.

We have issued SUBSTANTIAL ASSURANCE opinions on the following reports:

- Budget Setting, Budgetary Control and Financial Reporting
- Financial Feeder Systems
- Primary Care Co – Commissioning
- Payroll Feeder Systems

We have issued REASONABLE ASSURANCE opinions on the following reports:

- Clinical Governance
- Procurement and Conflicts of Interest
- Quality, Innovation, Productivity and Prevention (QIPP)
- Conflicts of Interest

We have also issued one ADVISORY report relating to the Board Assurance Framework Review – Deep Dive Review.

Agreed action plans are in place for the above reports and we will follow up on the implementation of actions and provide updates to the Audit Committee as part of our Progress Report.

Further issues relevant to this opinion

We have also reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services, who via a contract with NHS England, provide services to the CCG. The Service Auditor Report did not raise any significant control issues which impacted on this opinion.

Issues judged relevant to the preparation of the annual governance statement

Based on the work we have undertaken on the CCG's system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). However, the CCG may wish to consider whether any other issues have arisen, including the results of any external reviews which it might want to consider for inclusion in the Annual Governance Statement.

Scope of the opinion

The opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS).

As a practising member firm of the Institute of Chartered Accountants in England and Wales (ICAEW), we are subject to its ethical and other professional requirements which are detailed at http://www.icaew.com/en/members/regulations-standards-and-guidance.

The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

Recommendations for improvements should be assessed by you for their full impact before they are implemented.

This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

This report is supplied on the understanding that it is solely for the use of the persons to whom it is addressed and for the purposes set out herein. Our work has been undertaken solely to prepare this report and state those matters that we have agreed to state to them.

This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM Risk Assurance Services LLP for any purpose or in any context. Any party other than the Board which obtains access to this report or a copy and chooses to rely on this report (or any part of it) will do so at its own risk. To the

fullest extent permitted by law, RSM Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

RSM Risk Assurance Services LLP is a limited liability partnership registered in England and Wales no. OC389499 at 6th floor, 25 Farringdon Street, London EC4A 4AB.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your internal audit opinion.

Annual opinions

- The organisation has an adequate and effective framework for risk management, governance and internal control.

- The organisation has an adequate and effective framework for risk management,governance and internal control.
  However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

- There are weaknesses in the framework of governance, risk management and control such that it could be, or could become, inadequate and ineffective.

- The organisation does not have an adequate framework of risk management, governance or internal control

5.11 Review of the effectiveness of governance, risk management and internal control

This review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. It draws on the performance information available. It is also informed by comments made by the external auditors in their annual audit letter and other reports.

The assurance framework provides evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the result of this review by:

* the Governing Body,
* the Audit Committee,
* if relevant, the Risk/Clinical Governance/Quality Committee,
* internal audit and
* other explicit review/assurance mechanisms.

5.12 Conclusion

The role and conclusions of each of the above was that the CCG had adequate and effective framework for risk management, governance and internal control.

However, as stated in section 1.8.1, the CCG recognises it has had weaknesses in its governance and decision-making. It has implemented an action plan to address these weaknesses which is monitored by the Audit Committee on behalf of the Governing Body.

An updated plan is being drawn up for 2017/18 to help the CCG build on the range of work undertaken so far.

Remuneration and Staff Report

6 Remuneration Report

6.1 Remuneration committee

The remuneration committee meets in common across BHH CCGs. Membership comprises the Chair of each CCG and a lay member from each CCG. The committee met once during 2016/17 with attendance as follows:

Member	Title	Present	Absent
Dr Amol Kelshiker	Chair and Clinical Director	1	0
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	0	0
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	1	0
Sanjay Dighe	Lay Member	1	0

The committee advises the Governing Body on appropriate remuneration and terms of service for the Accountable Officer, senior managers and members of the Governing Body.

The committee reported the basis for its recommendations to the Governing Body which used the committee's report as the basis for its decisions on remuneration. However, the board remained accountable for taking final decisions on the remuneration and terms of service for the Accountable Officer and senior managers.

6.2 Policy on the remuneration of senior managers

This remuneration policy includes clinicians, Lay Members and Executive Directors.

6.2.1 Chair and Clinical Directors

The Chair and Clinical Directors have a fixed-term Governing Body contract, and there is a three year rolling programme of elections to the Governing Body. Once elected for a term, they are subject to a three month notice period. There is no provision in their contract for compensation for early termination upon the expiry of the initial period or after re-election. Details of the Clinical Directors are stated below:

Name	Title	Contract start date	Contract end date
Dr Amol Kelshiker	Chair and Clinical Director	1 April 2013	1 August 2018
Dr Kaushik Karia	Vice Chair and Clinical Director	1 October 2013	1 August 2018
Dr Dilip Patel Resigned 31 March 2017	Clinical Director	1 October 2013	1 August 2018
Dr Genevieve Small	Clinical Director	1 October 2013	1 August 2018
Dr Shahla Ahmad	Clinical Director	20 June 2016	31 August 2018
Dr Shaheen Jinah	Clinical Director	6 June 2016	4 August 2018
Dr Sharanjit Takher	Clinical Director	1 September 2015	31 August 2018
Dr Sandy Gupta	Secondary Care Consultant	1 October 2013	4 August 2018

6.2.2 Lay Members

The Lay Members listed below have a Letter of Engagement stating the duties and accountabilities of the organisation and themselves.

The Lay Members are subject to a four week notice period. On termination of the appointment, they are only entitled to accrued fees as at the date of termination, together with reimbursement of any expenses properly incurred prior to that date.

Name	Title	Contract start date	Contract end date
Ian Holder Appointed 21 July 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	21 July 2016	20 July 2018
Tom Challenor Resigned 31 May 2016	BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees	1 July 2014	31 May 2016
Sanjay Dighe	Lay Member	1 April 2013	31 May 2019
Gerald Zeidman Contract completed 31 March 2017	Deputy Chair and Lay Member	1 August 2013	31 March 2017
Richard Smith Appointed 18 July 2016	Lay Member	18 July 2016	17 July 2019
Joanna Brown Appointed 1 August 2016	Associate Lay Member	1 August 2016	31 July 2018
Mukesh Panchal	Associate Lay Member	1 August 2014	31 July 2018
Hilary Ruth Barnes Resigned 29 July 2016	Associate Lay Member	1 August 2014	31 July 2016

6.2.3 Executive Directors

Executive Directors are on the senior managers pay framework, have a permanent contract and are subject to a six month notice period except in the case of summary or immediate dismissal. Compensation for loss of office is based on the terms and conditions laid out under Agenda for Change.

Details of the substantive Executive Directors are stated below.

Name	Title	Contract start date
Rob Larkman	Accountable Officer	1 April 2013
Neil Ferrelly	Chief Finance Officer	1 March 2016
Alex Faulkes	Director of Performance and Delivery	1 April 2016
Diane Jones	Director of Quality and Safety	1 March 2017
Javina Sehgal Seconded out from 23 January 2017	Chief Operating Officer	1 April 2013
Jan Norman Resigned 31 December 2016	Director of Quality and Safety	19 August 2015

6.2.4 Executive Directors performance related pay

The performance of all CCG staff, including directors and senior managers, is reviewed between April and March of each year in accordance with the CCG's annual performance review process.

The CCG established a process for a consolidated pay increase, as well as a mechanism for a non-consolidated performance related pay bonus for employees on the senior managers pay framework. The non-consolidated element of the performance related pay has been replaced and the revised Senior Manager Pay and Reward Policy came into effect from 1 April 2016.

All pay progression payments for directors and senior managers employed on the Senior Manager Pay framework are linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay and Reward Policy. Performance awards for 2016/17 will be determined in the first quarter of 2017/18.

The performance of the Chief Operating Officer is appraised by the Accountable Officer and the Accountable Officer is appraised by the Chair. The performance of CCG directors is appraised by the Accountable Officer.

6.3 Remuneration of very senior managers

The Accountable Officer of NHS Harrow CCG is paid in excess of £142,500 per annum. However it should be noted that this remuneration is for services provided across the three CCGs – NHS Brent, Harrow and Hillingdon CCGs.

The Remuneration Committee advises the Governing Body of an appropriate remuneration for the Accountable Officer based on services provided to the three CCGs. In addition, the CCG Chair, who is part time, would be paid in excess of £142,500 per annum on a pro rata basis and this remuneration has been advised by the Remuneration Committee to the Governing Body who remain accountable for taking decisions on the remuneration and terms of service for senior managers.

6.4 Senior Managers remuneration (salary and pension entitlements)

6.4.1 Senior Managers definition

The Department of Health Group Manual for Accounts 2016/17 defines Senior Managers as:

> "Those persons in senior positions having authority or responsibility for directing or controlling the majority activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

6.4.2 Senior Managers: salaries and allowances (has been subject to audit)

Name	Title	Dates	Note	2016/17					2015/16			
				Salary & Fees	Expense Payments (taxable)	Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary & Fees	Expense Payments (taxable)	All Pension Related Benefits	Total
				(bands of £5,000) £000	(nearest £100) £00	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(nearest £00) £00	(bands of £2,500) £000	(bands of £5,000) £000
Dr Amol Kelshiker	Chair and Clinical Director			80 - 85	-	-	12.5 - 15	95 - 100	80 - 85	-	7.5 - 10	90 - 95
Dr Kaushik Karia	Vice Chair and Clinical Director			40 - 45	-	-	-	40 - 45	45 - 50	-	-	45 - 50
Dr Dilip Patel	Clinical Director	Resigned 31.03.2017		35 - 40	-	-	7.5 - 10	45 - 50	40 - 45	-	10 - 12.5	55 - 60
Dr Genevieve Small	Clinical Director		1	70 - 75	-	-	12.5 - 15	85 - 90	80 - 85	-	7.5 - 10	90 - 95
Dr Kanesh Rajani	Clinical Director	Resigned 31.03.16		-	-	-	-	-	40 - 45	-	0 - 2.5	45 - 50
Dr Lawrence Gould	Clinical Director	Resigned 31.08.2015		-	-	-	-	-	20 - 25	-	-	20 - 25
Dr Shahla Ahmad	Clinical Director	Appointed 20.06.2016		30 - 35	-	-	157.5 - 160*	185 - 190	-	-	-	-
Dr Shaheen Jinah	Clinical Director	Appointed 6.06.2016		30 - 35	-	-	137.5 - 140*	170 - 175	-	-	-	-
Dr Sharanjit Takher	Clinical Director	Appointed 1.09.2015		35 - 40	-	-	75 - 77.5	115 - 120	20 - 25	-	297.5-300*	320 - 325*
Dr Sandy Gupta	Secondary Care Consultant			0 - 5	1	-	47.5 - 50	50 - 55	0 - 5	-	-	0 - 5
Ian Holder	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Appointed 21.07.2016	2	0 - 5	-	-	-	0 - 5	-	-	-	-
Tom Challenor	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Resigned 31.05.2016	2	0 - 5	-	-	-	0 - 5	5 - 10	-	-	5 - 10
Gerald Zeidman	Deputy Chair and Lay Member	Resigned 31.03.2017		15 - 20	-	-	-	15 - 20	10 - 15	-	-	10 - 15
Richard Smith	Lay Member	Appointed 18.07.2016		5 - 10	-	-	-	5 - 10	-	-	-	-
Sanjay Dighe	Lay Member			10 - 15	-	-	-	10 - 15	10 - 15	-	-	10 - 15
Hilary Ruth Barnes	Associate Lay Member	Resigned 29.07.2016	2	0 - 5	-	-	-	0 - 5	0 - 5	-	-	0 - 5
Joanna Brown	Associate Lay Member	Appointed 1.08.2016	2	0 - 5	-	-	-	0 - 5	-	-	-	-
Mukesh Panchal	Associate Lay Member		2	0 - 5	-	-	-	0 - 5	0 - 5	-	-	0 - 5
Rob Larkman	Accountable Officer		2	45 - 50	-	0 - 5	7.5 - 10	55 - 60	45 - 50	-	7.5 - 10	50 - 55
Paul Jenkins	Interim Chief Operating Officer	Appointed 11.01.17	3	45 - 50	-	-	-	45 - 50	-	-	-	-
Javina Sehgal	Chief Operating Officer	Seconded out 23.01.2017		85 - 90	-	0 - 5	27.5 - 30	115 - 120	105 - 110	-	27.5 - 30	135 - 140
Neil Ferrelly	Chief Finance Officer	Appointed 1.03.2016	2	30 - 35	-	-	45 - 47.5	80 - 85	0 - 5	-	5 - 7.5	5 - 10
Alex Stiles	Acting Chief Finance Officer	Acting 1.01.2016 to 29.02.2016		-	-	-	-	-	0 - 5	-	25 - 27.5	25 - 30
Jonathan Wise	Chief Finance Officer	Resigned 31.12.2015	2	-	-	-	-	-	30 - 35	-	15 - 17.5	45 - 50
Alex Faulkes	Director of Delivery and Performance	Appointed 1.04.2016	2	25 - 30	-	-	-	25 - 30				
Jeff Boateng	Acting Director of Delivery and Performance	Acting 1.02.2016 to 31.03.2016	2	-	-	-	-	-	0 - 5	-	-	0 - 5
Bernard Quinn	Director of Delivery and Performance	Resigned 31.01.2016	2	-	-	0 - 5	-	0 - 5	20 - 25	-	0 - 2.5	20 - 25
Diane Jones	Director Of Quality and Safety	Appointed 1.03.2017	2	0 - 5	-	-	20 - 22.5	20 - 25	-	-	-	-
Ann Jackson	Interim Director of Quality and Safety	Appointed 1.01.2017, Resigned 28.02.2017	2,3	0 - 5	-	-	-	0 - 5	-	-	-	-
Jan Norman	Director of Quality and Safety	Appointed 19.08.2015, Resigned 31.12.2016	2	20 - 25	-	-	20 - 22.5	40 - 45	15 - 20	-	17.5 - 20	35 - 40
Carole Matlock	Joint Interim Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	2,3	-	-	-	-	-	5 - 10	-	-	5 - 10
Pauline Johnson	Joint Interim Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	2,3	-	-	-	-	-	5 - 10	-	-	5 - 10
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	Resigned 1.05.2015	2	-	-	-	-	-	0 - 5	-	7.5 - 10	10 - 15
Andrew Howe	Director of Public Health, Harrow Council		4	-	-	-	-	-	-	-	-	-
Mina Kakaiya	Representative, Healthwatch Ltd		5	-	-	-	-	-	-	-	-	-

6.4.3 Senior Managers: Salaries and allowances – joint appointments (has been subject to audit)

The following Senior Managers work across Brent, Harrow and Hillingdon CCGs and their costs have been shared across these CCGs. This table gives their total salaries and allowances. The "salaries and allowances" table 6.4.2 only shows Brent CCG's share of their costs.

			2016/17					2015/16			
Name	Title	Dates	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (nearest £00) £00	Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary & Fees (bands of £5,000) £000	Expense Payments (taxable) (nearest £00) £00	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Rob Larkman	Accountable Officer		160 - 165	-	0 - 5	30 - 32.5	195 - 200	160 - 165	-	25 - 27.5	185 - 190
Neil Ferrelly	Chief Finance Officer	Appointed 1.03.2016	120 - 125	-	-	162.5 - 165	285 - 290	10 - 15	-	22.5 - 25	30 - 35
Jonathan Wise	Chief Finance Officer	Resigned 31.12.2015	-	-	-	-	-	105 - 110	-	60 - 62.5	170 - 175
Alex Faulkes	Director of Delivery and Performance	Appointed 1.04.2016	95 - 100	-	-	-	95 - 100				
Jeff Boateng	Acting Director of Delivery and Performance	Acting 1.02.2016 to 31.03.2016	-	-	-	-	-	15 - 20	-	-	15 - 20
Bernard Quinn	Director of Delivery and Performance	Resigned 31.01.2016	-	-	0 - 5	-	0 - 5	85 - 90	1	0 - 2.5	85 - 90
Diane Jones	Director of Quality and Safety	Appointed 1.03.2017	5 - 10	-	-	75 - 77.5	80 - 85	-	-	-	-
Ann Jackson	Interim Director of Quality and Safety	Appointed 1.01.2017, Resigned 28.02.2017	5 - 10	-	-	-	5 - 10	-	-	-	-
Jan Norman	Director of Quality and Safety	Appointed 19.08.2015, Resigned 31.12.2016	85 - 90	-	-	72.5 - 75	155 - 160	65 - 70	-	67.5 - 70	135 - 140
Carole Mattock	Interim Joint Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	-	-	-	-	-	30 - 35	-	-	30 - 35
Pauline Johnson	Interim Joint Director of Quality & Safety	Appointed 1.05.2015, Resigned 18.08.2015	-	-	-	-	-	25 - 30	-	-	25 - 30
Professor Ursula Gallagher	Nurse Consultant and Director of Patient Quality & Safety	Resigned 1.05.2015	-	-	-	-	-	5 - 10	-	32.5 - 35	40 - 45
Ian Holder	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Appointed 21.07.2016	10 - 15	-	-	-	10 - 15	-	-	-	-
Tom Challenor	BHH Lay Member (Governance), Chair of BHH Audit & Remuneration Committees	Resigned 31.05.2016	0 - 5	-	-	-	0 - 5	15 - 20	-	-	15 - 20
Hilary Ruth Barnes	Associate Lay Member	Resigned 29.06.2016	0 - 5	-	-	-	0 - 5	5 - 10	-	-	5 - 10
Joanna Brown	Associate Lay Member	Appointed 1.08.2016	5 - 10	-	-	-	5 - 10	-	-	-	-
Mukesh Panchal	Associate Lay Member		5 - 10	-	-	-	5 - 10	5 - 10	-	-	5 - 10

Notes to Salaries and allowances and joint arrangements table

1. Salary and fees includes £20k (2015/16: £30k) in respect of other services provided to the CCG.
2. Joint appointments – a number of Senior Managers work across NHS Brent, Harrow and Hillingdon CCGs and their share is calculated on the relative population of each CCG. These costs were shared as follows: 38% NHS Brent CCG, 28% NHS Harrow CCG and 34% NHS Hillingdon CCG.
   The "Senior Managers – salaries and allowances" table 6.4.2 shows NHS Harrow CCGs share of the costs of such staff and the "Senior Managers - Salaries and allowances – Joint arrangements" table 6.4.3 shows their total salaries and allowances.
3. Paid through agency or consultancy company and includes agency commission but excludes VAT.
4. Paid by Harrow Council/Non voting member.
5. Paid by Healthwatch Harrow/Non voting member.

* The pension figures supplied by NHS Pensions Agency are based on their current salary compared to that of their last officer employment (which could have been many years ago) uplifted for inflation. Therefore this does not necessarily reflect the increase in pension benefits during 2016/17 only.

Performance Pay and Bonuses
With effect from 1 April 2015, the CCG established performance related pay and bonuses for Senior Managers linked to annual appraisal of performance and the CCG achieving its strategic objectives in line with the Senior Manager Pay and Reward Policy. The performance pay and bonus included in the table above relates to the financial year 2015/16 which was agreed and paid in 2016/17. For 2016/17, any performance related pay has yet to be assessed and agreed. If awarded, they will be shown in 2017/18.

Long Term Performance Pay and Bonuses
There were no "long term performance pay and bonus" awards during 2016/17 and 2015/16.

Definitions

Salary and fees – All amounts paid or payable by the clinical commissioning group, including recharges from any other health body but excluding recharges to other health bodies.
Expense payments (taxable) – This is the gross value of taxable expenses and benefits before tax.
Performance pay and bonuses – These comprise money or other assets received or receivable for the financial year as a result of achieving performance measures and targets relating to a period ending in the relevant financial year.
Long term performance pay and bonuses – These comprise money or other assets received or receivable for periods of more than one year as a result of achievement of performance measures or targets.
All pension related benefits – This figure includes those benefits accruing to Senior Managers from membership of the NHS Pensions Scheme which is a defined benefit scheme (although accounted for by NHS bodies as if it were a defined contribution scheme). In summary, for defined benefit schemes, the amount included here is the annual increase in pension entitlement. Zero amounts are shown for individuals for whom:
The CCG does not pay into a pension scheme, or
The all pension benefit figure is a negative number.
Total – This is the total of all the above columns and does not necessarily represent the total the individual personally received from the CCG.

6.4.4 Senior Managers: pension benefits (has been subject to audit)

Name	Title	Dates	Note	Real increase / (decrease) in pension at pension age (bands of £2,500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000 £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Employer's contribution to stakeholder pension £00
Dr Amol Kelshiker	Chair and Clinical Director		1	0 - 2.5	2.5 - 5	10 - 15	35 - 40	246	38	284	-
Dr Dilip Patel	Clinical Director	Resigned 31.03.2017	1	0 - 2.5	0 - 2.5	5 - 10	25 - 30	-	-	-	*
Dr Genevieve Small	Clinical Director		1	0 - 2.5	0 - 2.5	10 - 15	30 - 35	173	24	198	-
Dr Shahla Ahmad	Clinical Director	Appointed 20.06.2016	1	5 - 7.5	15 - 17.5	5 - 10	15 - 20	-	93	120	-
Shaheen Jinah	Clinical Director	Appointed 6.06.2016	1	5 - 7.5	12.5 - 15	5 - 10	15 - 20	-	85	103	-
Dr Sharanjit Takher	Clinical Director		1	2.5 - 5	5 - 7.5	5 - 10	20 - 25	66	44	110	-
Dr Sandeep Gupta	Secondary Care Consultant		1	0 - 2.5	5 - 7.5	40 - 45	125 - 130	774	61	835	-
Rob Larkman	Accountable Officer		2	0 - 2.5	5 - 7.5	45 - 50	140 - 145	1,016	-	-	*
Javina Sehgal	Chief Operating Officer	Seconded out 23.01.2017		0 - 2.5	-	15 - 20	-	164	23	193	-
Neil Ferrelly	Chief Finance Officer		2	7.5 - 10	22.5 - 25	50 - 55	160 - 165	924	181	1,105	-
Diane Jones	Director of Quality and Safety	Appointed 1.03.2017	2	0 - 2.5	0 - 2.5	15 - 20	40 - 45	217	5	276	-
Jan Norman	Director of Quality and Safety	Resigned 31.12.2016	2	0 - 2.5	0 - 2.5	50 - 55	150 - 155	1,051	-	-	*

Notes to Pension benefits table:

1. Figures are supplied by the NHS Pensions Agency and are based on their employment as Governing Body Members of the CCG only. Pension relation to Practitioner employments are not included.
2. The disclosure for these individuals who are shared across Brent, Harrow and Hillingdon CCGs is their total amount and not their share applicable to each individual CCG

* There is no cash equivalent transfer value as at 31 March 2017 as these members have reached normal retirement age.

Certain members, including interims, do not receive pensionable remuneration or have opted out of the pension scheme and therefore there are no entries in respect of pensions for these Members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

6.5 Compensation on early retirement or for loss of office (has been subject to audit)

There have been no compensation on early retirement or loss of office payments.

6.6 Payments to past senior managers (has been subject to audit)

There have been no payments made to past senior managers.

6.7 Fair pay disclosure (has been subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Governing Body member in NHS Harrow CCG during the financial year 2016/17 was £105k - £110k (2015/16: £105k – £110k). This was 2.53 (2015/16: 2.45) times the median remuneration of the workforce, which was £42.4k (2015/16: £44.1k). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In 2016/17, no employees received remuneration in excess of the highest-paid member.

The workforce median calculation is based on the average cost of staff on the NHS Harrow CCG payroll. This includes full costs for staff directly working for NHS Harrow CCG, as well as a small number of Commissioning Support Service staff.

7 Staff Report

7.1 Number of senior managers by band

Number	Band
19	VSM

7.2 Staff numbers and costs

The average number of people in the CCG's workforce is as follows and includes staff recharged to and from the CCG:

Staff numbers (has been subject to audit)	2016/17	2015/16
	No.	No.
Permanently Employed	79	68
Other	21	20
Total	100	88

Included within the above whole time equivalent staff numbers are 28.5 (2015/16: 26.5) relating to commissioning support services.

These figures include staff which NHS Brent CCG hosts the employment of but are shared across the Brent, Harrow and Hillingdon federation, and commissioning support functions shared across all eight NW London CCGs.

Workforce benefits (has been subject to audit)

2016/17

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,276	1,398	2,674	1,128	1,441	2,569	2,404	2,839	5,243
Social security costs	171	59	230	135	43	178	306	102	408
Employer Contributions to NHS Pension Scheme	195	80	275	140	58	198	335	138	473
Workforce benefits expenditure	**1,642**	**1,537**	**3,179**	**1,403**	**1,542**	**2,945**	**3,045**	**3,079**	**6,124**

2015/16

	Admin			Programme			Total		
	Employees	Other	Total	Employees	Other	Total	Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,390	1,269	2,659	945	1,954	2,899	2,335	3,223	5,558
Social security costs	133	42	175	89	32	121	222	74	296
Employer Contributions to NHS Pension Scheme	183	55	238	116	43	159	299	98	397
Workforce benefits expenditure	**1,706**	**1,366**	**3,072**	**1,150**	**2,029**	**3,179**	**2,856**	**3,395**	**6,251**

7.3 Staff composition

Staff numbers	Female	Male
Governing Body	4	8
Other senior managers and clinical leads (not included in Governing Body figures)	0	1
CCG staff	23	12

These figures show all staff on NHS Harrow CCG's payroll which includes staff shared across the BHH CCGs Federation, and commissioning support functions shared across all eight North West London CCGs.

The membership body of the CCG is made up of its individual member practices whose staff are not employed by the CCG. As such, we do not record information on the gender of staff in general practices.

7.4 Sickness absence data

With a relatively small office-based workforce, sickness absence is not a significant issue for the CCG. The management and reporting of sickness is supported by a comprehensive absence management policy and advice from the Human Resources Team which covers the eight NW London CCGs. Human Resources has undertaken process training for CCG managers, including the efficient use of sickness absence management protocols to refresh knowledge and reminding mangers of their role in the management of absence.

A table is included in the workforce benefits note 3.4 of the Financial Statements with sickness absence data.

7.5 Staff policies

The CCG has a number people management policies in place to ensure effective recruitment and employment of its staff. The people management policies promote best practice and a non-discriminatory approach to all aspects of employment within the organisation. These policies recognise the importance of a good employment relationships and commitment to employee engagement.

These robust people management policies are reviewed regularly and Equality Impact Assessments undertaken. The policies are approved through the CCGs' HR Committee that meets on a monthly basis and thereafter agreed by the Remuneration Committee before implementation.

All staff policies are accessible to all staff via an internal intranet site and the HR Staff Handbook.

7.5.1 Equality

The CCGs is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of sex, race, ethnic or national origin, sexual orientation, marriage and civil partnership, religion or belief, age, pregnancy and maternity, trade union membership, disability, offending background, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or any other personal characteristic.

Diversity is viewed positively and, in recognising that everyone is different, the unique

contribution that each individual's experience, knowledge and skills can make is valued equally.

The promotion of equality and diversity is actively pursued through policies and ensures that employees receive fair, equitable and consistent treatment. It also ensures that employees, and potential employees, are not subject to direct or indirect discrimination.

The CCG works with Access to Work, when appropriate, and abides by the principles of the 'Disability Confident Scheme' in relation to recruitment, whereby disabled applicants get a guaranteed interview.

It is a condition of employment that all employees respect and act in accordance with our equality and diversity policy. Failure to do so will result in the disciplinary procedure being instigated, which could result in termination of employment.

7.6 Expenditure on consultancy

During the year, NHS Harrow CCG incurred £234.5k on consultancy services. This was largely attributed to QIPP consultancy.

7.7 Off-payroll engagements

Table 1 – Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2017	7
of which, the number that have existed:	
For less than 1 year at the time of reporting	6
For between 1 and 2 years at the time of reporting	1
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	0
For 4 or more years at the time of reporting	0

The CCG confirms that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2 – New off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	11
Number of new engagements which include contractual clauses giving Harrow CCG the right to request assurance in relation to Income Tax and National Insurance obligations	11
Number for whom assurance has been requested	9
of which:	
Assurance has been received	8
Assurance has not been received	1
Engagements terminated as a result of assurance not being received	0

Table 3 – Off-payroll engagements / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

	Number
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	24

The substantive Chief Operating officer was seconded out on 23 January 2017. Therefore, to cover this position, an interim has been appointed from 11 January 2017 to 11 July 2017.

7.8 Exit packages (has been subject to audit)

Please refer to note 3.3 of the Financial Statements for details on exit packages.

8 Parliamentary Accountability and Audit Report

NHS Harrow CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on contingent liabilities are included in note 11 of the Financial Statements within this report. An audit certificate and report is also included in this Annual Report.

Independent Auditor's Report and Financial Statements

Involving patients in planning future healthcare in Harrow

Rob Larkman
Accountable Officer
NHS Brent, Harrow and Hillingdon CCGs
Date: 24 May 2017

9 INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS HARROW CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Harrow Clinical Commissioning Group (the CCG) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 (the 2016-17 GAM) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the "Code of Audit Practice").

As explained in the Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Direction issued thereunder.

Qualified opinion on regularity arising from non-compliance with governing authorities

The CCG has reported the following breaches in its financial performance targets in note 18 to the financial statements.

Financial duty	Target £000s	Performance £000's	Excess £000's
Expenditure not to exceed income	305,988	307,310	£1,322
Revenue resource use does not exceed the amount specified in Directions	302,371	303,693	£1,322

Except for the incurrence of expenditure in excess of total income and also in excess of the specified resource limit, in our opinion, in all material respects the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Annual Report Directions made under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception - Use of resources

Auditor's responsibilities
We report to you if we are not satisfied that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Our assessment of arrangements is made by reference to the overall criterion: In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Basis for qualified conclusion
The CCG has reported a deficit of £1.322 million in the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £21.2 million for 2017/18.

Consequently, there remain material uncertainties in the CCG's financial position and ability to return to financial balance in the medium term. This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified Conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Matters on which we are required to report by exception - Referral to the Secretary of State under section 30(a) and 30(b) of the Local Audit and Accountability Act 2014

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure (section 30(a)), or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency (section 30(b)).

On 26 May 2017 we referred the breaches of the CCG's financial performance targets for 2016/17 to the Secretary of State under section 30(a) and that the CCG had set a deficit budget for 2017/18 under section 30(b) of the Local Audit and Accountability Act 2014.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Harrow Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

BDO LLP

Leigh Lloyd-Thomas
For and on behalf of BDO LLP, Appointed Auditor
London, UK
26 May 2017

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

10

NHS Harrow CCG
Financial Statements
2016-17

This year ended: 31 March 2016
This year commencing: 1 May 2017

CONTENTS

	Page Number
The Primary Statements:	
Statement of Comprehensive Net Expenditure for the year ended 31 March 2017	1
Statement of Financial Position as at 31 March 2017	2
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017	3
Statement of Cash Flows for the year ended 31 March 2017	4
Notes to the Accounts	
Accounting policies	5
Other operating revenue	9
Workforce benefits and numbers	9
Operating expenses	11
Better payment practice code	12
Operating leases - as lessee	12
Current trade and other receivables	13
Cash and cash equivalents	13
Current trade and other payables	14
Current provisions	14
Contingent liabilities	14
Financial instruments	15
Operating segments	15
Pooled budgets	16
Related party transactions	16
Events after the end of the reporting period	18
Losses	18
Financial performance targets	18

NHS Harrow CCG - Annual Accounts 2016/17

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2017

	Note	2016/17 £'000	2015/16 £'000
Income from sale of services	2	(576)	(634)
Other operating income	2	(3,041)	(1,626)
Total operating income		**(3,617)**	**(2,260)**
Workforce costs	3	6,124	6,251
Purchase of services	4	300,718	280,203
Provision expense	4	20	(30)
Other Operating Expenditure	4	448	435
Total operating expenditure		**307,310**	**286,859**
Net Operating Expenditure		**303,693**	**284,599**
Total Comprehensive Expenditure for the Year		**303,693**	**284,599**

The notes on pages 5 to 18 form part of this statement.

NHS Harrow CCG - Annual Accounts 2016/17

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Current assets			
Trade and other receivables	7	3,627	3,842
Cash and cash equivalents	8	86	122
Total current assets		**3,713**	3,964
Current liabilities			
Trade and other payables	9	(34,092)	(34,959)
Provisions	10	(57)	(37)
Total current liabilities		**(34,149)**	(34,996)
Assets less Liabilities		**(30,436)**	(31,032)
Financed by Taxpayers' Equity			
General fund		(30,436)	(31,032)
Total taxpayers' equity		**(30,436)**	(31,032)

The balance sheet movement of £0.6m on the general fund reflects the difference between the cash funding and net operating costs for the financial year.

The notes on pages 5 to 18 form part of this statement.

The financial statements on pages 1 to 18 were approved by the Governing Body on 23 May 2017 and signed on its behalf by:

Rob Larkman
Accountable Officer

Statement of Changes In Taxpayers Equity for the Year Ended 31 March 2017

2016/17 Changes in taxpayers’ equity

	General fund £000
Balance as at 1 April 2016	**(31,032)**
2016/17 Changes in Clinical Commissioning Group taxpayers’ equity	
Net operating expenditure for the financial year	(303,693)
Cash funding	304,289
Balance as at 31 March 2017	**(30,436)**

The cash funding of £304.3m represents the drawing of cash the CCG made during the year from the Department of Health.

2015/16 Changes in taxpayers’ equity

	General fund £000
Balance as at 1 April 2015	**(34,245)**
2015/16 Changes in Clinical Commissioning Group taxpayers’ equity	
Net operating costs for the financial year	(284,599)
Cash funding	287,812
Balance as at 31 March 2016	**(31,032)**

The notes on pages 5 to 18 form part of this statement.

Statement of Cash Flows for the Year Ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(303,693)	(284,599)
Decrease / (increase) in trade & other receivables	7	215	(1,187)
Decrease in trade & other payables	9	(867)	(1,889)
Increase / (decrease) in provisions	10	20	(30)
Net Cash Outflow from Operating Activities		**(304,325)**	(287,705)
Cash Flows from Financing Activities			
Cash funding received		304,289	287,812
Net Cash Inflow from Financing Activities		**304,289**	287,812
Net (Decrease) / increase in Cash	8	**(36)**	107
Cash at the Beginning of the Financial Year		**122**	15
Cash at the End of the Financial Year		**86**	122

The notes on pages 5 to 18 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016/17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
The clinical commissioning group accounts for this as a joint operation and recognises its share of:

- assets the clinical commissioning group controls;
- liabilities the clinical commissioning group incurs;
- expenses the clinical commissioning group incurs; and,
- clinical commissioning group's share of the income from the pooled budget activities.

1.4 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 *Critical Judgements in Applying Accounting Policies*

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.4.1.1 *Brent CCG Federation Recharge to Harrow and Hillingdon CCGs*

Certain functions such as Quality and Safety are delivered across all three CCG's using a federation model. Each CCG is responsible for its proportionate share of total costs. All federation costs are

initially paid by NHS Brent CCG with an appropriate proportion recharged to the other CCG's on a net accounting basis. The share of costs for the CCG are shown in operating expenses, note 4. The split for the period 1 April 2016 to 31 March 2017 has been determined as 38% for NHS Brent CCG, 28% for NHS Harrow CCG and 34% for NHS Hillingdon CCG. This is based on the relative running cost allocation for each CCG and has been updated for a small change in 2016/17.

1.4.1.2 ***Accounting for Commissioning Support Services (CSS)***

The CSS service is managed by NHS Brent CCG for the CCGs in North West London and NHS Brent CCG charges the other CCGs for the costs of providing the service. NHS Brent CCG is currently subject to a greater degree of financial and operational risk for managing this service than the other CCGs, therefore NHS Brent CCG acts as a principal and accounts on a gross basis for all expenditure incurred including workforce, consultancy and other costs. These are shown as revenue amounts charged to the other CCGs within 'recoveries in respect of workforce benefits' and 'non-patient care services to other bodies'. The other CCGs show their costs charged by NHS Brent CCG as either 'workforce benefits – other staff' and 'Services from other CCGs and NHS England'.

1.4.1.3 ***NHS 111 Shared Commissioning Arrangement***

NHS Hounslow CCG commissions 111 service from Care UK on behalf of NHS Brent CCG, NHS Harrow CCG and NHS Ealing CCG. NHS Hounslow CCG acts as an agent and each CCG is responsible for its proportion share of the total costs. The share of costs for NHS Brent CCG are shown in operating expenses, note 4. The service cost is recharged out to CCGs based on the population size on a net accounting basis in the following proportions: NHS Hounslow 23%, NHS Ealing CCG 29%, NHS Brent CCG 27% and NHS Harrow CCG 21%.

1.4.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.4.2.1 ***Prescription Pricing Authority Expenditure***

The Prescription Pricing Authority (PPA) currently provides details of the monthly expenditure incurred by independent contractors in respect of pharmacy contract payments and drug costs for the CCG. There is a two month delay in notifying the CCG of its expenditure for a particular month. Actual costs for February are available in April and therefore used, however the CCG accrues its estimated prescribing costs for March based on the annual PPA profile.

1.4.2.2 ***Acute Contracts Expenditure***

Healthcare services from acute NHS providers are commissioned under service level agreements. Providers use the monthly activity data to inform their monthly Service Level Agreement Monitoring (SLAM) reports and to charge the CCG for activity provided. The latest available SLAM information covers February (Month 11) data and this is available at the beginning of April. Providers estimate the activity delivered in March to forecast the full year activity levels and amounts to be charged to the CCG. The CCG will review this un-validated March activity for reasonableness before estimating the expenditure for that month at various points. Throughout the year, the CCG may issue contract challenges against invoiced activity and, where these have yet to be resolved, will make an estimate of the amounts that it believes will not need to be paid. The CCG also estimate amounts recoverable against payments to date where activity has fallen below contracted levels or additional amounts payable where activity exceeds contracted activity.

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Notes to the financial statements

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.7 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Operating Leases

1.8.1 The Clinical Commissioning Group as Lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

1.9 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.
In the Statement of Cash Flows, cash is shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group’s cash management.

1.10 Provisions

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.11 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.12 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group

pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.13 **Continuing Healthcare Risk Pooling**

In 2014/15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the clinical commissioning group contributed annually to a pooled fund, which is used to settle the claims. 2016/17 is the final year that clinical commissioning groups will contribute into this scheme.

1.14 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
The CCGs financial assets are classified as:

- Loans and receivables.

They are measured at amortised cost less any impairment.
At the end of the reporting period, the clinical commissioning group assesses whether these are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
The amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.15 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. The CCGs financial liabilities are classified as other financial liabilities and are measured at amortised cost.

1.16 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 **Accounting Standards that have been issued but have not yet been adopted**

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016/17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016/17, were they applied in that year.

2. Other Operating Revenue

	2016/17 Admin	2016/17 Programme	2016/17 Total	2015/16 Total
	£000	£000	£000	£000
Education, training and research	-	323	323	208
Charitable and other contributions to revenue expenditure: non-NHS	-	18	18	18
Non-patient care services to other bodies	-	253	253	426
Other revenue	7	3,016	3,023	1,608
Total other operating revenue	**7**	**3,610**	**3,617**	**2,260**

Notes:

1) Programme Revenue
Programme revenue is revenue received that is relating to the provision of healthcare or healthcare services.

2) Cash drawdown from NHS England
Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3. Workforce benefits and numbers

3.1 2016/17 Workforce benefits

	Admin Employees	Admin Other	Admin Total	Programme Employees	Programme Other	Programme Total	Total Employees	Total Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,276	1,398	2,674	1,128	1,441	2,569	2,404	2,839	5,243
Social security costs	171	59	230	135	43	178	306	102	408
Employer Contributions to NHS Pension Scheme	195	80	275	140	58	198	335	138	473
Workforce benefits expenditure	**1,642**	**1,537**	**3,179**	**1,403**	**1,542**	**2,945**	**3,045**	**3,079**	**6,124**

2015/16 Workforce benefits

	Admin Employees	Admin Other	Admin Total	Programme Employees	Programme Other	Programme Total	Total Employees	Total Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	1,390	1,269	2,659	945	1,954	2,899	2,335	3,223	5,558
Social security costs	133	42	175	89	32	121	222	74	296
Employer Contributions to NHS Pension Scheme	183	55	238	116	43	159	299	98	397
Workforce benefits expenditure	**1,706**	**1,366**	**3,072**	**1,150**	**2,029**	**3,179**	**2,856**	**3,395**	**6,251**

3.2 Average number of workforce

	2016/17 Employees	2016/17 Other	2016/17 Total	2015/16 Total
	No.	No.	No.	No.
Total	79	20	**99**	88

3.3 Exit packages agreed

The clinical commissioning group has not agreed any exit packages during 2016/17 (2015/16: None).

3. Workforce benefits and numbers (contd.)

3.4 Staff sickness absence

	2016/17 Number	2015/16 Number
Total Days Lost	138	35
Total Staff Years	34	28
Average working Days Lost	**4.1**	**1.3**

Staff sickness absence figures are provided by the Department of Health and cover the calendar year.

3.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

4. Operating expenses

	2016/17			2015/16
	Admin	Programme	Total	Total
	£000	£000	£000	£000
Gross workforce benefits				
Workforce benefits excluding Governing Body members	2,935	2,852	5,787	5,921
Executive Governing Body members	244	93	337	330
Total gross workforce benefits	**3,179**	**2,945**	**6,124**	**6,251**
Other costs				
Services from other CCGs and NHS England	357	406	763	2,351
Services from foundation trusts	-	57,045	57,045	57,217
Services from other NHS trusts	-	158,071	158,071	144,360
Services from other NHS bodies	-	-	-	5
Purchase of healthcare from non-NHS bodies	-	42,429	42,429	35,827
Chair, GP Members and Lay Members	428	21	449	421
Supplies and services – clinical	-	544	544	2,331
Supplies and services – general	66	2,351	2,417	928
Consultancy services	77	157	234	90
Establishment	67	136	203	292
Transport	1	-	1	1
Premises	152	815	967	1,034
Impairments and reversals of receivables	-	24	24	8
External audit fees	62	-	62	62
Prescribing costs	-	32,110	32,110	31,827
GMS, PMS and APMS	-	3,827	3,827	1,754
Other professional fees incl. internal audit fees	112	877	989	324
Clinical negligence	-	6	6	6
Education and training	25	401	426	224
Provisions	-	20	20	(30)
CHC Risk Pool contributions	-	630	630	1,576
Other expenditure	-	(31)	(31)	-
Total other costs	**1,347**	**299,839**	**301,186**	**280,608**
Total operating expenses	**4,526**	**302,784**	**307,310**	**286,859**

Notes:

1) Admin Expenditure
Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

2) Programme Expenditure
Programme expenditure is revenue expenditure that is relating to the provision of healthcare or healthcare services.

3) Acronyms
GMS - General Medical Services, PMS - Personal Medical Services, APMS - Alternative Provider Medical Services and CHC - Continuing Health Care.

4) External Audit Fees
The External Audit fees net of VAT is £52k. The figure above is inclusive of VAT as not recoverable by the CCG.

5. Better Payment Practice Code

Measure of compliance	2016/17	
	Number	£000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Period	9,925	51,990
Total Non-NHS Trade Invoices paid within target	9,386	47,700
Percentage of Non-NHS Trade invoices paid within target	**94.6%**	**91.7%**
NHS Payables		
Total NHS Trade Invoices Paid in the Period	3,276	224,557
Total NHS Trade Invoices Paid within target	3,188	219,549
Percentage of NHS Trade Invoices paid within target	**97.3%**	**97.8%**

	2015/16	
	Number	£000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	8,294	43,999
Total Non-NHS Trade Invoices paid within target	8,026	41,325
Percentage of Non-NHS Trade invoices paid within target	**96.8%**	**93.9%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,124	213,462
Total NHS Trade Invoices Paid within target	3,086	212,552
Percentage of NHS Trade Invoices paid within target	**98.8%**	**99.6%**

The Better Payment Practice Code requires NHS organisations to aim to pay 95% of all valid invoices, by value and volume, within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

6. Operating Leases - as lessee

6.1 Payments recognised as an Expense

2016/17	Buildings	Other	Total
	£000	£000	£000
Minimum lease payments	635	1	**636**
Total	**635**	**1**	**636**

2015/16	Buildings	Other	Total
	£000	£000	£000
Minimum lease payments	985	-	**985**
Contingent rents	-	-	**-**
Sub-lease payments	-	-	**-**
Total	**985**	**-**	**985**

The clinical commissioning group is charged for property owned or managed by NHS Property Services Ltd, Community Health Partnerships Ltd and NHS Brent CCG for NHS Harrow CCG's share of BHH Federation and CSS charges for their headquarters at The Heights. Other payments relate to a photocopier lease.

6.2 Future minimum lease payments

2016/17	Other	Total
	£000	£000
Payable:		
No later than one year	2	**2**
Between one and five years	3	**3**
Total	**5**	**5**

6.2 Future minimum lease payments (contd.)

The future minimum lease payments shown in the table above are in respect of a lease with Xerox (UK) Ltd. for rental of a photocopier.

There were no future minimum lease payments in respect of Other payments during 2015/16.

Whilst our arrangements with NHS Property Services Ltd and Community Health Partnerships Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

7. Current trade and other receivables

	31 March 2017	31 March 2016
	£000	£000
NHS receivables: Revenue	1,184	1,278
NHS prepayments	1,711	1,243
NHS accrued income	90	324
Non-NHS receivables: Revenue	226	261
Non-NHS prepayments	160	41
Non-NHS accrued income	206	729
Provision for the impairment of receivables	(140)	(147)
VAT	190	113
Total current trade and other receivables	**3,627**	**3,842**

The great majority of trade is with NHS England and other CCGs. As NHS England and CCGs are funded by the Government, no credit scoring of them is considered necessary.

7.1 Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000	£000
By up to three months	-	320
By three to six months	17	8
By more than six months	21	-
Total	**38**	**328**

7.2 Provision for impairment of receivables

	2016/17	2015/16
	£000	£000
Balance at 1 April 2016	**(147)**	**(139)**
Amounts recovered during the year	31	-
Increase in receivables impaired	(24)	(8)
Balance at 31 March 2017	**(140)**	**(147)**

8. Cash and cash equivalents

	2016/17	2015/16
	£000	£000
Balance at 1 April 2016	**122**	**15**
Net change in year	(36)	107
Balance at 31 March 2017	**86**	**122**
Made up of:		
Cash with the Government Banking Service	86	122

9. Current trade and other payables

	31 March 2017	31 March 2016
	£000	£000
NHS payables: revenue	5,450	11,244
NHS accruals	10,562	7,995
Non-NHS payables: revenue	7,682	7,650
Non-NHS accruals	9,389	7,552
Non-NHS deferred income	-	167
Social security costs	34	22
Tax	29	22
Other payables	946	307
Total current trade and other payables	**34,092**	**34,959**

Other payables include £40k outstanding pension contributions at 31 March 2017 (31 March 2016: £32k).

10. Current provisions

	31 March 2017	31 March 2016
	£000	£000
Continuing care	57	37
Total	**57**	**37**

	Total Continuing Care
	£000
Balance at 1 April 2016	**37**
Arising during the period	57
Reversed unused	(37)
Balance at 31 March 2017	**57**
Expected timing of cash flows:	
Within one year	57
Balance at 31 March 2017	**57**

The clinical commissioning group had a provision of £57k relating to 4 continuing care claims as at 31 March 2017 (31 March 2016: £37k relates to 1 case).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £40k (31 March 2016: £769k). NHSE also hold a contingent liability of £53k relating to 2 cases.

11. Contingent liabilities

	31 March 2017	31 March 2016
	£000	£000
Continuing Healthcare (6 cases)	114	-
Net value of contingent liabilities	114	-

12. Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.
Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group and internal auditors.

12.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with all transactions, assets and liabilities being in the UK and sterling based.

12.1.2 Credit risk

Because the majority of the clinical commissioning group's revenue comes from parliamentary funding, it has low exposure to credit risk. The maximum exposures as at the end of the period are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

12.2 Financial assets

	31 March 2017 Loans and Receivables £000	31 March 2016 Loans and Receivables £000
Receivables: NHS	1,274	1,602
Non-NHS	432	990
Cash at bank and in hand	86	122
Total	**1,792**	**2,714**

12.3 Financial liabilities

	31 March 2017 Other £000	31 March 2016 Other £000
Payables: NHS	16,012	19,239
Non-NHS	18,017	15,509
Total	**34,029**	**34,748**

13. Operating segments

The clinical commissioning group has one operating segment, which is the commissioning of healthcare.

14. Pooled budgets

The clinical commissioning group has a Pooled Budget under Section 75 of the NHS Act 2006 with the London Borough of Harrow in respect of the Better Care Fund (BCF) which it entered into during 2015/16.

The BCF is hosted by The London Borough of Harrow and was announced by the Government in the June 2013 spending round to drive the transformation of local services to ensure that the people receive better and more integrated care and support. The fund is to be deployed locally on health and social care through pooled budget arrangements between local authorities and clinical commissioning groups.

The clinical commissioning group's share of the income and expenditure handled by the BCF pooled budget was:

	2016/17 £000	2015/16 £000
Income	(8,519)	(7,772)
Expenditure	8,519	7,814

15. Related party transactions

Members of the Governing Body are required to declare any interests that they hold, either directly or through family members, in organisations other than the clinical commissioning group. Where the CCG incurs expenditure with or receives income from those organisations, the organisations are known as related parties and the transactions must be reported. Those transactions, together with the nature of the interest and the nature of the transaction, are shown below.

During the year none of the Executive or Lay Members, or parties related to them, have undertaken any material transactions with the clinical commissioning group.

Details of related party transactions with GP Members are as follows (payments shown below are in respect of services provided to the clinical commissioning group by the practice which the member is a partner rather than payments to members themselves, and comprise payments made during 2016/17 and outstanding invoices):

GP Member	GP Practice	2016/17 Expenditure with Related Party £000	Amounts owed to Related Party £000
Dr Amol Kelshiker	Pinn Medical Centre	680	-
Dr Kaushik Karia	Aspri Medical Centre	70	-
Dr Dilip Patel	Civic Medical Centre	47	-
Dr Shahla Ahmad	GP Direct	3	-
Dr Genevieve Small	Ridgeway Surgery	1,466	82
Dr Sharanjit Takher	Endley Road Medical Centre	24	-

Dr Amol Kelshiker, Dr Kaushik Karia and Dr Shahla Ahmad are shareholders in Harrow Health CIC.
For Dr Dilip Patel, Dr Genevieve Small and Dr Sharanjit Takher, their practices hold shares in Harrow Health CIC.

GP Network	2016/17 Expenditure with Related Party £000	2016/17 Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Harrow Health CIC	3,072	51	80	51

NHS Brent, Harrow and Hillingdon CCGs are related parties of each other due to the BHH Federation arrangements whereby the management have joint control.

15. Related party transactions (contd.)

NHS Brent CCG incurred £7k expenditure with the Good Governance Institute, of which Ian Holder, BHH Lay Member (Governance), Chair of BHH Audit and Remuneration Committees, is a Senior Associate. This was in respect of professional services provided across BHH CCGs, and therefore these costs were shared across the three CCGs.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as their Parent. Details of related party transactions with such entities is as follows:

	2016/17 Expenditure with Related Party	2016/17 Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
NHS England including CCG's:				
NHS England	730	-	-	569
NHS Brent CCG	2,036	234	-	129
NHS Hillingdon CCG	60	424	6	143
NHS Central London (Westminster) CCG	478	4	460	1
NHS Foundation Trusts:				
Central And North West London MH NHS Foundation Trust	23,332	-	1,209	-
Chelsea And Westminster Hospital NHS Foundation Trust	1,377	-	468	8
Great Ormond Street Hospital for Children NHS Foundation Trust	438	-	-	36
Guys And St Thomas NHS Foundation Trust	1,318	-	167	13
King's College Hospital NHS Foundation Trust	273	-	-	-
Moorfields Eye Hospital NHS Foundation Trust	7,459	-	282	-
Royal Brompton And Harefield NHS Foundation Trust	2,613	-	349	-
Royal Free London NHS Foundation Trust	9,415	-	40	189
The Hillingdon Hospital NHS Foundation Trust	6,089	-	466	-
University College London NHS Foundation Trust	3,632	-	197	33
NHS Trusts:				
Barts Health NHS Trust	721	-	92	-
Central London Community Healthcare NHS Trust	10,900	-	730	-
East And North Hertfordshire NHS Trust	725	-	21	-
Imperial College Healthcare NHS Trust	12,251	-	670	124
London Ambulance Service NHS Trust	7,368	-	286	-
London North West Healthcare NHS Trust	116,608	-	5,635	1,356
Royal National Orthopaedic Hospital NHS Trust	3,500	-	186	-
West Hertfordshire Hospitals NHS Trust	2,798	-	-	233

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

Community Health Partnerships Ltd	437	-	820	-
Health Education England	-	469	22	-
London Borough of Harrow	9,000	1,015	731	206
NHS Property Services Ltd	506	-	634	-
HMRC [1]	306	-	63	190
NHS Pensions Agency [1]	335	-	40	-

[1] Transactions with HMRC and NHS Pensions Agency are in respect of receipts and payments relating to 2016/17.

16. Events after the end of the reporting period

Delegated primary care responsibilities

NHS England recently announced details of the clinical commissioning groups approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2017. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Harrow CCG has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2017.

17. Losses

The total number of clinical commissioning group losses, and their total value, was as follows:

	2016/17	
	Total Number of cases Number	Total Value of Cases £'000
Administrative write-offs	4	24
Total	**4**	**24**

There were no losses during 2015/16.

18. Financial performance targets

The clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).

Performance against those duties was as follows:

	2016/17		2015/16	
	Target £000	Performance £000	Target £000	Performance £000
Expenditure not to exceed income	305,988	307,310	288,947	286,859
Revenue resource use does not exceed the amount specified in Directions	302,371	303,693	286,687	284,599
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	5,237	4,519	5,674	4,423

A deficit on programme costs of (£2m) and a surplus on running costs of £0.7m together equal NHS Harrow CCG's in-year deficit of (£1.3m).

Agenda Item 15
Pages 331 to 398

REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	20 July 2017
Subject:	**INFORMATION REPORT –** Revenue & Capital Outturn 2016/17
Responsible Officer:	Chris Spencer, Corporate Director People, Harrow Council
Exempt:	No
Wards affected:	All
Enclosures:	June 2017 Cabinet Report and Appendices

Section 1 – Summary

The Board is requested to note the report detailing Harrow Council's Revenue and Capital Outturn 2016/17, as reported to the Council's Cabinet on 15 June 2017.

FOR INFORMATION

Section 2 – Report

Revenue
The revenue outturn position of the Council at the end of the financial year 2016/17 year (as attached in the appendices) is showing a balanced position before transfers to and from reserves.

The gross Directorate spend shows an overspend of £10.982m and includes carry forwards into 2017/18 of £2.336m and net contributions to reserves of £745k.

The balanced position is arrived at as follows:

	£m
• Inflation and Corporate Items	(3.882)
• Contingency	(1.329)
• Capital Financing and Interest Charges	(1.589)
• Government Grants	(0.805)
• Corporate Reserves	(1.000)
• Use of Capital Receipts Flexibility	(2.377)
	(10.982)

2016/17 has remained a very challenging financial environment with continuing demand pressures on the budget, with gross savings included within the 2016/17 budget totalling £17.553m.

All outturn positions detailed in this report are provisional until agreed by Cabinet and are subject to minor technical changes, prior to the finalisation of the Statement of Accounts.

Capital
Total spend on the capital programme for the year is £89.751m (53%) against a budget of £167.438m, giving a variance of £77.686m. The variance of £77.686m is made up of total slippage of £70.839m which will be carried forward into 2017/18 and underspends of £6.847m. More detail is included in table 6, including the split between the general fund and the HRA. The draft budget set out in the attached report shows a refreshed Medium Term Financial Strategy (MTFS) with a number of changes which Cabinet were asked to note.

Section 3 – Further Information

See attached report.

Section 4 – Financial Implications

Financial implications are integral to the attached report.

Section 5 - Equalities implications

See attached report.

Section 6 – Council Priorities

See attached report.

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports)

Name: Sharon Daniels	x	on behalf of the Chief Financial Officer
Date: 28 June 2017		

Ward Councillors notified:	**NO, as it impacts on all wards**

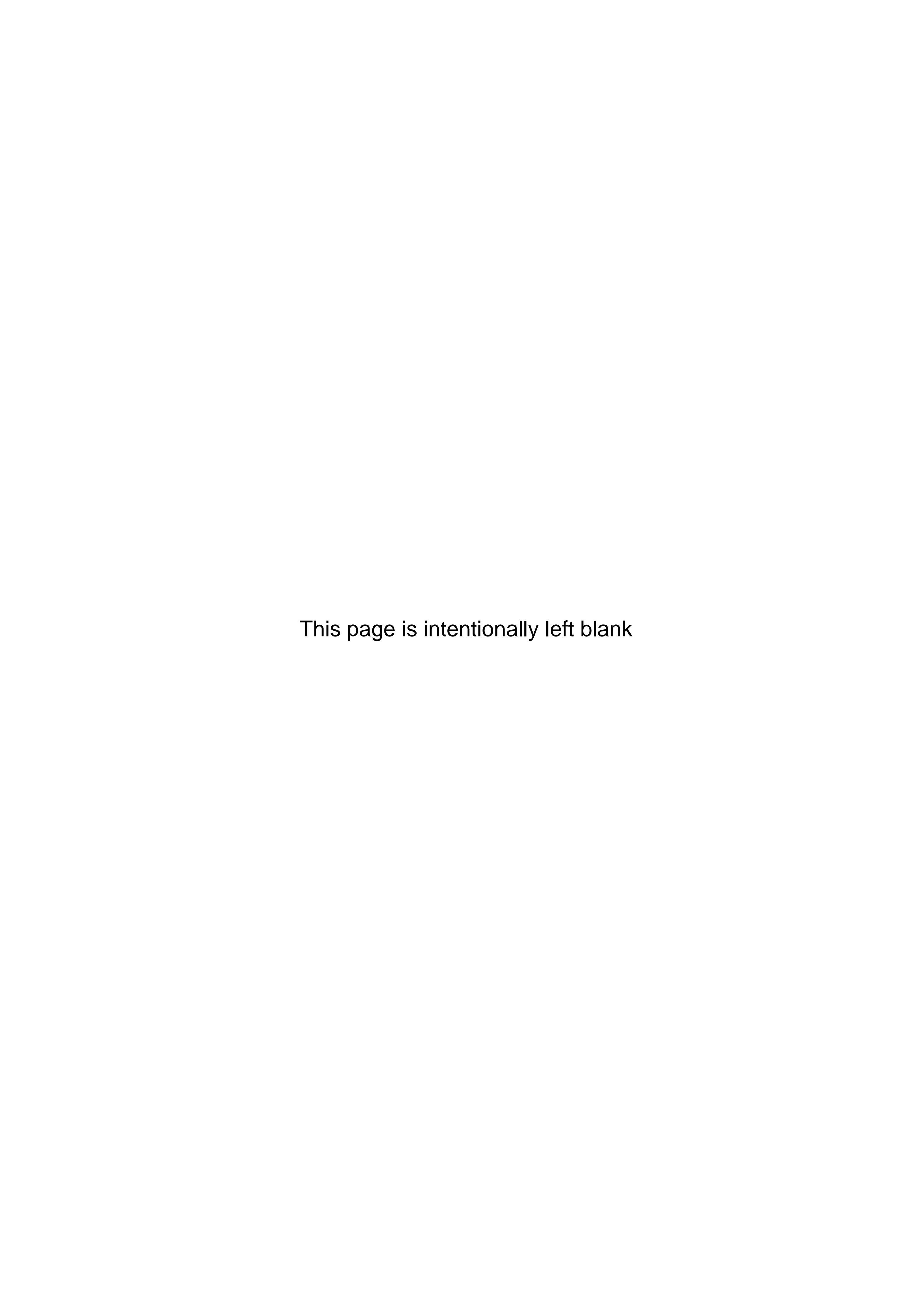
Section 7 - Contact Details and Background Papers

Contact:

Donna Edwards
Finance Business Partner – Adults & Public Health
Email: donna.edwards@harrow.gov.uk

Background Papers:

None


This page is intentionally left blank

REPORT FOR:	CABINET
Date of meeting:	15 June 2017
Subject:	Revenue and Capital Outturn 2016/17
Key Decision:	Yes
Responsible Officer:	Dawn Calvert, Director of Finance
Portfolio Holder:	Councillor Adam Swersky, Portfolio Holder for Finance and Commercialisation
Exempt:	No, except for Appendix 7, which is exempt on the grounds that it contains “exempt information” under paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (as amended) in that it contains information relating to the financial or business affairs of any particular person (including the authority holding that information
Decision subject to Call-in:	Yes
Wards affected:	All wards
Enclosures:	Appendix 1 - Revenue Carry forward Schedule Appendix 1a- Contributions to/Draw Downs from Reserves (Departmental). Appendix 2 – MTFS - 2016/17 to 2019/20 Savings Tracker Appendix 3 – Capital Monitoring Appendix 4 – Reserves Movements 2016/17 Appendix 5 – Capital Receipts Flexibility Appendix 6 – HRA Revenue Outturn Appendix 7 – Concilium Business Services Performance Report (Part II – Exempt)

Section 1 – Summary and Recommendations

This report sets out the Council's revenue and capital outturn position for 2016/17

Recommendations:

1. That Cabinet notes the revenue and capital outturn position for 2016/17
2. Cabinet to note the additional grant for Adult Social Care as detailed in paragraph 11, 12 and 13.
3. That Cabinet notes the movement between reserves outlined in paragraph 24 to 36.
4. That Cabinet notes the revenue carry forwards outlined at paragraphs 35 and 36 and detailed in Appendix 1.
5. That Cabinet notes the carry forwards on the capital programme outlined in table 6 (paragraph 54) and set out at Appendix 3 that have been approved under delegated authority by the Director of Finance.
6. That Cabinet approve the virement in the 2016/17 capital programme detailed in paragraph 54 and delegate Authority to the Director of Finance and Portfolio Holder for Finance and Commercialisation to reallocate the Capital to alternative projects.
7. That Cabinet notes the timetable for preparation of draft statement of account and external audit review as outlined in paragraphs 77 and 78.

Reason (for recommendation)

To report the financial position as at 31 March 2017

Section 2 – Report

EXECUTIVE SUMMARY

1. The revenue outturn position of the Council at the end of the financial year 2016/17 year is showing a balanced position before transfers to and from reserves. The gross Directorate spend shows an overspend of £10.982m. The £10.982m includes carry forwards into 2017/18 of £2.336m and net contributions to reserves of £745k. The balanced position is arrived at as follows:

	£m
• Inflation and Corporate Items	(3.882)
• Contingency	(1.329)
• Capital Financing and Interest Charges	(1.589)
• Government Grants	(0.805)
• Corporate Reserves	(1.000)
• Use of Capital Receipts Flexibility	(2.377)
	(10.982)

2. 2016/17 has remained a very challenging financial environment with continuing demand pressures on the budget, with gross savings included within the 2016/17 budget totalling £17.553m.

3. It is recommended that the carry forward of £2.336m is added to reserves in 2016/17 for use in 2017/18 and there will be a further net contribution into reserves of £745k.

4. All outturn positions detailed in this report are provisional until agreed by Cabinet and are subject to minor technical changes, prior to the finalisation of the Statement of Accounts.

5. Total spend on the capital programme for the year is £89.751m (53%) against a budget of £167.438m, giving a variance of £77.686m. The variance of £77.686m is made up of total slippage of £70.839m which will be carried forward into 2017/18 and underspends of £6.847m. More detail is included in table 6, including the split between the general fund and the HRA.

REVENUE OUTTURN

6. The revenue outturn on General Fund for the Council after transfers to ear marked reserves for the financial year 2016/17 is showing a nil variance against the approved budget of £164.987m, and there is no addition or reduction to general Fund balances of £10.008m. Table 1 sets out the Revenue Outturn position.

Table 1: Revenue Outturn 2016/17 Summary

2016/17 Original Budget		Latest Budget	Provisional Outturn	2016/17 Outturn Variance	Draw down from / contribution to reserve	Carry Fwd	Variance adj for draww down and carry Fwd
£'000	Directorate	£'000	£'000		£'000	£'000	£'000
21,798	**Resources & Commercial**	**21,581**	**22,520**	**939**	**-1,110**	**60**	**-111**
33,272	Environment & Community	34,493	35,208	715	-363	296	648
6,758	Housing General Fund	6,474	8,712	2,238	-51	86	2,273
40,030	**Community Total**	**40,967**	**43,920**	**2,953**	**-414**	**382**	**2,921**
58,191	Adult & Public Health Service	63,129	63,608	479	-428	1761	1,812
37,120	Children & Family	35,135	43,337	8,202	-2,310		5,892
95,311	**People Total**	**98,264**	**106,945**	**8,681**	**-2,738**	**1,761**	**7,704**
2,014	**Regeneration**	**2,192**	**-2,480**	**-4,672**	**5,007**	**133**	**468**
159,153	**Sub Total Directorate**	**163,004**	**170,905**	7,901	**745**	**2,336**	**10,982**
7,625	Inflation and Corporate Items	7,725	3,843	-3,882			
1,248	Contingency	1,329	0	-1,329			
-49	Capital Financing and Interest	-40	-1,871	-1,831			
-1,768	Interest on Balances	-1,768	-1,526	242			
-7,551	Grants	-8,423	-9,228	-805			
0	Carry Forwards from 2016/17	-1,794	-1,794	0			
6329	Corporate Reserves Contribution	4954	3954	-1,000			
	Use of Capital Receipt		-2377	-2,377			
164,987	**Sub Total**	**164,987**	**161,906**	**-3,081**	**745**	**2,336**	**0**
	Other adjustments , addition /Reduction to/From Reserves						
	Departmental Reserves	0	745	745			
	Carry Forwards to 2017/18		2,336	2,336			
164,987	**Total Budget Requirement**	**164,987**	**164,987**	**0**			

Directorates' Position

The outturn for the Directorates is a net over spend of £10.982m after taking into consideration the net contribution to reserves of £745k and a carry forward assumed of £2.336m. The £745k net contribution into reserves was made up of draw downs from reserves of £5.407m and contributions into reserves of £6.152m. Of the £6.152m contribution into reserves, £5.521m relates to Community Infrastructure Levy (CIL) income. Excluding this the contribution into reserves was £631k. The

breakdown is set out at Appendix 1a. The position for each directorate is summarised as follows:

Resources

7. The outturn position for Resources is an under spend of (£111k) after allowing for a net contribution from reserves of £1.110m and a carry forward of £60k. The key reasons for the under spend are detailed below:

   - Customer Services is reporting an under spend of (£799k). The under spend predominately relates to the recovery of Housing Benefits overpayments, coupled with receipt of Government subsidy. In addition, the Business Transformation Partnerships team has delivered spending reductions from previous identified savings opportunities relating to negotiated service credits and IT support costs.

   - Legal and Governance is reporting an under spend of (£368k) due to the receipt of an unbudgeted £208k from Central Government for the costs of European Elections incurred in 2015-16 alongside an over achievement of income within the Registration service.

   - HRD & Shared Services is reporting an under spend of (£414k) mainly due to the phase 1 implementation of the shared services with Buckinghamshire County Council.

   - There are other minor underspend across the service totalling (£77k).

   The above is offset by over spends listed below

   - In Procurement, Pan Organisational savings were not fully achieved and a service budgetary pressure relating to West London Alliance membership fees resulted in an over spend of £197k.

   - Strategic Commissioning report an over spend of £127k for the financial year due the under achievement of income which the service has reported throughout the financial year would not be received. This pressure has been mitigated going forward.

   - An over spend of £81k accrued in the Finance division. This overspend relates to the increased cost of agency staff covering key roles within the service.

   - Business Support is reporting an over spend of £1.153m. The majority of the over spend relates to increased demand within Children’s services impacting on Business Support staffing requirements. The on-going pressure has been accounted for within the MTFS for the 2017/18 financial year, with growth funding provided to help remove the existing pressure.

The recommended carry forward requests of £60k are set out at Appendix 1

Community

8. The outturn position for Community is an over spend of £2.921m after taking into consideration a net draw down from reserves of £414k and carry forward of £382k. The key reasons for the net over spend are detailed below:

   - Housing General Fund services are over spent by £2.273m, due mainly to the cost of homelessness partially offset by net rental income from the Council's Property Acquisition Programme and increased fees in respect of the disabled adaptations programme

   - The MTFS saving associated with the changes of garden and food waste collection system was partially achieved, resulting in a pressure of £1.3m (income shortfall of £0.5m against the original target for garden waste and additional operational costs of £0.8m).

   - A pressure of £1.15m on the Arts and Heritage service arose in relation to the non transfer to Cultura. This takes into account a drawdown from TPIF of £170k to meet some of the transition costs and a carry forward request of £270k in relation to grant funding that is no longer available for the Headstone Manor project.

   - There is a £92k overspend on Leisure & Libraries in relation to the contract indexation price increase.

   - A pressure of £90k on car park income due to the closure of Gayton Road Car Park for regeneration activity. This is allowed for within the Regeneration funding model.

The pressures are partially offset by:

- £0.870m savings on waste disposal costs.

- £0.607m income from parking as a result of a change in accounting policy from cash accounting to accrual accounting.

- £94k directorate management savings in relation to computer software costs, which form part of future MTFS savings and a recharge to HRA for 25% of the Corporate Director salary costs.

- £418k one off in year savings delivered as part of the spending protocol.

The recommended carry forward requests of £382k are set out at Appendix 1

People Services

9. People Services is reporting an over spend of £7.704m after taking into consideration a net draw down from reserve of £2.738m and a carry forward of £1.761m (in relation to specific unspent external funding for commitments in 2017-18) . The net over spend of £7.704m is made up of an under spend of (£911k) on Public Health, an over spend of £2.723m on Adults and an over spend of £5.892m on Children's Services. The key reasons for the over spends are detailed below:

Public Health

Public Health is reporting an under spend of (£911k), £184k of which was budgeted to fund wider public health outcomes. The key variances are as below;

- A lower level of spend on wider health improvement as a result of the cessation of planned projects (£375k).

- An underspend against contracted activity (£290k)

- An underspend against the sexual health budget (£332k) reflecting a lower of activity in relation to statutory demand led open access services.

- Additional underspends have been offset by various additional pressures of £86k.

The under spend above represents grant capacity, against which, increased expenditure for wider public health outcomes incurred across the Council will be charged.

Adult Services

10. Adult Services is reporting an over spend of £2.723m. The key reasons for the over spend are detailed below:

- A net overspend of £3.062m in relation to Adult Social Care. This comprises gross pressures of £3.269m, representing largely placement costs but also includes £203k in relation to Deprivation of Liberties (DoLs) and £198k for the Mental Health services managed by Central North West London (CNWL). These pressures are offset by underspends across a range of budget heads, including Children and Young Adults(CYAD), of £61k.

- An overspend of £0.722m on in-house provided services. This is largely due to pressures of £1.025m in relation to delays in achieving MTFS proposals (including Kenmore of £420k), offset by underspends over a range of budgets, including reductions in staffing costs.

- Safeguarding quality assurance net underspend of £20k – this includes reductions in staffing costs.

- Strategic Management underspend of £1.041m – this relates to the impact of spending control reductions across the division held centrally to mitigate wider pressures.

Adult Social Care Budget in 17/18

11. The March 2017 Budget announced that Councils would receive an extra £2bn to fund adult social care over the next three years to help stabilise the social care system. One off funding of £3.628m will be allocated to Harrow in 2017-18 (£2.743 2018-19 and 1.367m 2019-20). This additional one off funding is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

12. The grant will be pooled into, and agreed as part of the Better Care Fund, although the funding will be paid directly to Councils. The grant includes a small number of conditions to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface.

13. The government has committed to setting out proposals for future social care funding in a green paper later this year and it is hoped that this will deliver the reforms that are necessary to put social care systems on a stable footing and provide longer term sustainable solutions.

Children's Services

14. At outturn the over spend for the Directorate is £5.892m, this is after taking into consideration a net draw down from reserves of £2.310m.

    The majority of Children's budgets are demand led and the Council has a statutory duty to meet vulnerable children's needs. It is therefore challenging to balance the budget. The total headline pressures are £8.202m. The main areas of over spend are detailed below:

    - **Special Needs Transport £1.182m overspend**. Special Needs Transport underwent a significant review in 2014/15 with a view to achieving a £0.570m savings target. It was only possible to meet approximately half of this savings target due in main to contract prices being higher than anticipated. This contributes to part of the over spend. There has also been an increase in demand, particularly for transport from home to colleges as the SEND reforms that extends special educational provision to age 25 years has led to an increased number of young adults with complex needs continuing in education. The revised transport policy required for the 2016/17 MTFS savings target was approved by Cabinet in September but minimal savings resulted from this. This saving line has subsequently been reversed by growth agreed in the 2017/18 MTFS.

    - **Placements £3.673m overspend -** The overspend mainly resulted from an increase in the number of children in high cost residential placements. A number of these placements have been needed in response to significant risks relating to child sexual exploitation and gangs involvement. Any high cost residential placement now requires the agreement of two heads of service to ensure that it is needed, and that no lower cost alternative would be suitable. The Divisional Director is now chairing the access to resources panel to ensure that tight time limits are agreed for any such high cost residential placement .Only the Divisional Director can now agree a high cost residential placement to be used in an emergency, outside of the access to resources panel.

    - **Children and Young People's Service staffing £1.666m overspend** - Approximately half of this pressure resulted from around 19 FTE supernumery staff being employed, the majority of which to tackle a large backlog of casework and increased demand. Going forward these posts will be funded by MTFS growth agreed in the 2017/18 budget. The volume of referrals from the police to the Multi Agency Safeguarding Hub increased by 37%, many of these referrals are about domestic abuse and risk. In addition the volume of referrals linked to homelessness increased significantly meaning that children are particularly vulnerable in temporary housing. The number of children on child protection plans increased by

12% and this included all forms of child abuse especially neglect and court proceedings increased by 30% compared to 2015/16. The remainder of the pressure mainly results from agency cover for sickness, maternity and vacant posts together with additional staffing costs related to the recent Ofsted inspection.

- **Families with no Recourse to Public Funds (NRPF) overspend £0.814m** - These are families being supported by the Council because they have no recourse to public funds (NRPF). The welfare reforms, along with stricter enforcement of Asylum Legislation are the main causal factors for this demand, which is unpredictable in terms of volume and costs. The exit routes for ceasing funding are dependent on variable factors, many of which cannot be controlled by the Council. 1.5 FTE bespoke workers have been recruited to focus specifically on these families to help reduce costs and mitigate the financial pressures on this budget. One recent case of NRPF was closed to the Department with a saving of £70k per year for that one family as a direct result of intervention from the NRPF worker and fraud team.

- **Business Support Staffing in Children's Services £304k overspend**
The model of practice within Children's Services is to integrate business support throughout the children's pathway. These are specialist posts supporting social work pods, and the specialist panels e.g. Adoption Panel which supports the multiple statutory functions throughout Children's Services. The rise in demand in Children's Services which has resulted in additional social workers as set out above has also increased the requirement for additional business support staff. Growth for these posts has now been agreed in the 2017/18 MTFS.

- **Early Intervention Service Transformation £358k overspend**
The re modelling of the Youth Development, Early Intervention and Children Centre's teams was scheduled to be completed by 1st October 2016. This transformation process encountered significant delays and many redundancies didn't take place until the end of March. The full year saving is anticipated in 2017-18.

- **Other directorate wide net overspends £207k** of which £105k relates to legal costs that are funded from the litigation budget that sits within the corporate budget.

These over spends were offset by:

- Use of one off children's social care reserve of £219k.
- Other net draw down from reserve of £2.091m

The recommended carry forward for People Services of £1.761m which is mainly related to Public Health is set out in Appendix 1.

Regeneration, Enterprise and Planning

15. The outturn position for Regeneration, Enterprise and Planning division is an over spend of £468k, after taking into consideration the net contribution to reserves of £5.007m. (This sum consists of a contribution of £5.521m into the reserve in relation to CIL income, offset by a drawdown of £514k from reserves in relation to the New Homes Bonus). The key reasons for the net over spend are detailed below:

- Overspend of £564k relating to the revenue costs of regeneration activity, this will be met from the Minimum Revenue Provision that sits within the corporate budget.

- Underspend in operating costs of £21k for Economic Development

- A net underspend of £75k in Planning & Building Control due mainly to additional income achieved.

The recommended carry forward requests of £133k are set out at Appendix 1.

CORPORATE ITEMS

Inflation and other Corporate Items

16. The net underspend for 2016/17 for inflation and corporate items is £3.882m. There are a number of items that make up this underspend, these include:

    - £1.037m relates to the Utility Inflation and other inflation provisions against which no draw downs were made.

    - £1m homelessness budget, the related expenditure for this budget is included in the Housing outturn position.

    - £650k was written back on the Good Received /Invoice Received suspense account.

    - £236k – legal provision that is no longer required.

    - £375k relates to litigation against which £106k legal cost in children is funded from.

    - £296k in relation to over recovery of employer's pension contribution.

    - £129k relates to reduction is the subscription charges paid in the year.

Contingency

17. There have been no calls on the contingency for unforeseen items therefore an under spend of £1.329m is contributing to the overall underspend position.

Capital Financing and Interest on Balances

18. The net underspend of £1.831m is mainly as a result of a reduction in Minimum Revenue Provision charge. There was also a small adverse variance of £242k on Interest on Balances.

Government Grants

19. Additional grant income of £805k was received during 2016/17 which contributes towards the under spend.

Capital Receipts Flexibility 2016/17

20. In the Spending Review 2015, it was announced that to support local authorities to deliver more efficient and sustainable services, the government will allow local authorities to spend up to 100% of their Capital receipts on the revenue costs of reform projects. This flexibility is being offered to the sector for the three financial years 2016/17 to 2018/19. Qualifying expenditure is expenditure on any project that is designed to generate on-going revenue savings in the delivery of public services and/or transform service delivery to reduce costs and/or transform service delivery in a way that reduces costs or demand for services in future years for any of the public sector delivery partners.

21. The Council signified its intent to make use of this flexibility in its final budget report to Cabinet and Council in February 2016 and February 2017.

22. The actual sum identified as qualifying expenditure in 2016/17 was £2.377m as attached at Appendix 5.

23. Capital receipts have been received in 2016/17 totalling £6.7m in respect of a number of asset disposals. After the application of £2.377m in 2016/17, there will be in excess of £4.3m capital receipts remaining which can be used for future capital receipts flexibility applications in 2017/18 and 2018/19 or they can be applied to fund future capital expenditure.

RESERVES

24. The movement on the main reserves is set out in the following table, supported by narrative. A more detailed analysis of the movement in reserves is set out in Appendix 4.

Table 2: Main movement in Reserves

	Balance B/F 1.4.16	Drawdown From Reserve	Contribution to Reserve	Balance c/f 31.03.17
Revenue grant reserve	1,304,511	-902,649	506,770	908,632
Revenue Carryforwards	1,793,000	-1,793,000	2,336,000	2,336,000
Business Risk	2,109,000			2,109,000
MTFS Implementation cost	875,054	-1,286,349	3,268,000	2,856,705
TPIF	3,188,928	-654,519		2,534,409
Commercialisation	520,620	-116,000		404,620
IT reserve	1,854,000	-1,176,000		678,000
Welfare Reform Reserve	1,000,000	-1,000,000		0
Budget Planning Reserve			2,000,000	2,000,000
Harrow and Mayor CIL	766,965		5,521,000	6,287,965
General Fund Balances	10,008,000			10,008,000

25. **Revenue Grant Reserve** – This reserve contains revenue grants to be used for specific purposes or which may be subject to claw back if conditions of the grant are not met. The opening balance was £1.304m, with a £903k draw down in year and additions of £507k in year to bring the total to be carried forward to £909k. The £909k closing balance relates to the following grants:

- £60k - Anti Fraud Grant
- £138k - Planning Delivery Grant
- £204k - New Homes Bonus grant
- £111k - High Need Strategic Planning
- £10k - London Fire Brigade hoarders project
- £38k - Community Housing Fund
- £348k - Estate Regeneration

26. **Business Risk Reserve -** This reserve was established as part of the 2012/13 outturn to provide for a number of identified business risks. £2.109m was available at the start of 2016/17 with no drawdowns during the year.

27. **Medium Term Financial Strategy Implementation Reserve** – This reserve was established to facilitate the achievement of MTFS savings. The balance at the start of the year was £875k, to which £3.268m has been added (this includes the £314k IT reserve that is no longer required and the planned contribution of £2.954m as agreed as part of the 2016/17 Budget), £1.286m has been drawn down in the year, which leaves a balance of £2.857m. The £1.286m of draw downs were as follows:

- Severance costs £936k
- The bridge £350k

28. **Transformation and Priority Initiatives Fund** - The balance at 1 April 2016 was £3.189m. During the year £654k was drawn down from the reserve, which leaves a balance of £2.534m. There were a number of draw downs totalling the £654k but the main items that were funded are as follows:

- Project Infinity £152k
- Arts Centre £170k
- Improving the street scene (Fly tipping) £100k
- Community Click £96k
- Fighting Domestic Violence £45k

29. **Commercialisation Reserve** – The balance at the beginning of the year 1 April 2016 was £521k. During the year £116k was drawn down which leaves a balance of £405k, the main items of drawn down are as follows:

- Project infinity - £95k
- Oxygen Finance - £21k

30. **IT Implementation Reserve** – The reserve was established as a result of Cabinet agreeing to fund £2.854m of transformation and transition costs arising from the ICT Procurement award of contract in March 2015. The balance at the beginning to 1 April 2016 was £1.854m. During the year £862k was drawn down to cover the transition and transformation cost. There was also a review of the amount that is required going forward it was agreed that £314k is no longer required. It is recommended that this sum be added to the MTFS Implementation reserve, which will bring the closing balance to £678k.

31. **Welfare Reform Reserve** – The balance at the start of 1 April 2016 was £1m , this has now been drawn down to cover the homelessness cost in the Housing General Fund as previously reported to Cabinet in the budget monitoring reports.

32. **Budget Planning Reserve** - £2m has been added to this reserve, £1m is assumed used as part of the 2017/18 budget setting, the other £1m will be held as a contingency should it be required.

33. **Harrow and Mayor CIL Reserve** – The **Community Infrastructure Levy** is a planning charge, introduced by the Planning Act 2008 as a tool for local authorities in England and Wales to help deliver infrastructure to support the development of their area.

34. Harrow has £767k in the reserve as at 31st March 2016 and £5.521m has been added during the year, giving a closing balance of £6.288m. £4.8m of this funding is earmarked to fund Highways Improvements in the Capital Programme in 2017/18 and 2018/19.

35. **Revenue Carry forward requests** were received, mainly in relation to projects not completed and government grants not yet spent. The carry forward requests are summarised below and listed in appendix 1:-

Table 3 Summary of Revenue Carry Forwards

	Council Funding	Grant Funding	Total
	£'000	£'000	£'000
Resources	-	60	60
Community	270	112	382
People Services	-	1,761	1,761
Regeneration	-	133	133
Carry Fwd Total	**270**	**2,067**	**2,336**

36. It is recommended that £2.336m is added to reserves in respect of these carry forwards. Carry Forward requests have been agreed in line with the criteria set out in the Financial Regulations.

GENERAL RESERVES

37. Harrow's level of General Reserves is towards the lower end of what is considered prudent at £10.008m, but is considered adequate given the level of earmarked reserves. It is not recommended to increase the level of General Reserve at this point.

MTFS Implementation Tracker

38. The 2016/17 budget includes approved MTFS savings of £17.553m. The progress on implementation is summarised in table 4 below and shown in more detail in Appendix 2:

Table 4 Summary of MTFS Tracker

	Resources	Community	People	Regeneration	Pan Organisation	Total at outturn	Percentage	Total at Period 11	Movement
	£000	£000	£000	£000	£000	£000		£000	£000
Red	774	207	2,588	30	0	3,599	21%	3,405	194
Amber	944	1,911	1,116	0	220	4,191	24%	4,753	-562
Green	288	2,080	1,108	50	0	3,526	20%	3,028	498
Blue	2,558	776	2,893	10	0	6,237	36%	6,367	-130
Purple	0	0	0	0	0	0		0	0
Total	**4,564**	**4,974**	**7,705**	**90**	**220**	**17,553**	**1**	**17,553**	**0**

39. Of the £17.553m of savings in 2016/17, a total of £3.599m have been categorised as red savings which means they were not achieved in 2016/17. Some of these savings are red as the implementation was delayed and so although not achieved in 2016/17, the saving will be progressed in 2017/18. Others relate to savings which will not be progressed at all and have been reversed as part of the 2017/18 Budget setting process. The detail of the red savings is as follows:

Analysis of the Red Savings

40. In the Resources directorate £774k of savings were not achieved and therefore classified as red. Detail of these savings are detailed as follows:

    - Business Support savings of £649k was not achieved due to the additional demand from Children's Services relating to increased activity at the front door. The saving has been reversed as part of the 2017/18 budget setting.

    - Strategic Commissioning highlighted risk of £125k relating to the profit share gain agreement with LamCo as part of the contract for the running of the Communications team. The service was aware that this level of income was unlikely to be achieved. A report has been approved by cabinet to bring the Communications service back in house. The report proposes changes to the service which will enable financial stability.

41. In Community the red savings of £207k relates to the following;

    - Harrow Art Centre £173k – this savings has now been reversed as part of 2017/18 budget setting process as the service remains as an in-house provision.

    - £59k relates to the review of management savings in Housing and will be achieved in 2017/18. There was an offsetting growth on Watkins House of £25k included which brings the figure to a net £34k.

42. People Services savings of £2.588m were rated as red as they were not achieved this year, details of these savings are as follows;

    Children Services - £387k

    - SEN transport savings £257k - this has been reversed as part of 2017/18 budget setting.

- Harrow Schools Improvement Partnership savings £130k was delayed due to a significant reduction to income achieved in 2016/17. A new operating model for HSIP is being developed to ensure this saving is achieved in 2017/18.

43. Adult Services - £2.2m
    - Supporting people savings of £276k in relation to services at the Bridge. Following consultation Members decided to continue to fund these services from the TPIF in 2016-17 and with funding of £490k over the next three years as the service moves to a fully self financed model.

      The Kenmore NRC Savings of £609k was not achieved this year as it was not possible to establish a community model as anticipated through the procurement process. This is expected to be partially delivered in 2017-18 through the revised Sancroft local authority trading company as a Phoenix project. Any shortfall in 2017-18 is expected to be mitigated by the Adult Social Care grant allocation.

    - Reduce Commissioning team of £150k has been delayed; a restructure is currently being consulted on and as a result this saving is expected to be be fully achieved in 2017/18.

    - Demography savings of £1m have not been achieved. The Adult Social Care placement growth of £4.353m allocated in 2017/18 is expected to mitigate any ongoing placement pressures.

    - Sancroft savings of £166k - These savings were expected to be delivered from contractual renegotiations around the provision of day care services which are currently underutilised. The legal review of the contract has confirmed that it is not possible to renegotiate the contract to deliver the planned savings, and given the further savings anticipated in 2017/18 (of £334k), alternative options are now being explored under the banner of project Phoenix and the new Sancroft model. Any shortfall in 2017-18 is expected to be mitigated by the Adult Social Care grant allocation.

44. Regeneration – Savings from development and management building control service of £30k has been delayed due to resource constraints. The income target will be fully achieved in 2017/18.

45. Of the £220k Pan Organisation savings, £120k was achieved and the rest of the £100k is delayed, a number of projects are in the pipeline to deliver this in 2017/18.

Analysis of the Amber Savings

46. The amber rating indicates that a saving was partially achieved in the year but not fully achieved. Therefore, the £4.191m of amber savings (in Table 4) have been further analysed as follows:

Table 5: Analysis of 2016/17 Amber Savings

	Resources	Community	People		Regeneration	Pan Organisation	Total	% Split
			Adult	Children				
	£000	£000	£000	£000	£000	£000	£000	£000
Amber	944	1,911	0	1,116	0	220	4191	
Red	237	1420	0	547	0	100	2304	55%
Green	707	491	0	569	0	120	1887	45%
Total	**944**	**1911**	**0**	**1116**	**0**	**220**	**4191**	**100%**

47. **Resources –** of the £944k of Amber savings, the element that was achieved and would therefore be green is £707k and the element not achieved and therefore would be shows as red is £237k. The £237k is explained below:

    - In addition the Division reported additional saving risks of £87k related to Commissioning Capacity in the Council. This will be fully achieved next year.

    - Finance reported a risk of £100k following the restructure of the service. 3 key posts remained covered by agency staff but have now been recruited to. The cost of agency cover to back fill staff and absence due to sickness created the pressure.

    - Legal & Governance reported a risk of £50k after the proposal of a shared Registrars service with Brent Council did not proceed.

48. **Community –** of the £1.911m of amber savings, £1.420m were not achieved in year as follows:

    - Of the £2.68m garden waste savings (of which £1.7m being profiled in 2016/17), £1.3m was not achieved. The directorate continues to review the scheme and take mitigating actions to address the on-going pressure.

    - £120k was not achieved from the £200k contractual/commissioned/SLA savings this year; various contractual agreements are now put in place to achieve the rest of the £120k savings in 2017/18.

49. **People's Services** – of the £1.116m of Amber savings, £547k savings were not achieved as follows:

    - Early intervention and Youth Development savings £358k - delayed due to some Human Resources issues which have now been resolved and savings are expected to be fully achieved in 2017/18.

    - Placement savings £700k - of the total saving of £700k, the bulk has been achieved with £189k of savings not achieved this year. There has been a significant increase in demand for children's placements, in particular for high cost residential placements which has caused pressures on this budget.

50. **Pan Organisation Savings** – of the £200k amber savings, £100k is delayed, a number of projects are in the pipeline to deliver this in 2017/18.

HOUSING REVENUE ACCOUNT (HRA)

51. Provisional results for the HRA indicate a surplus of £157k against a budgeted surplus of £144k. This includes higher than expected repair costs due mainly to unforeseen repairs expenditure required to meet legislative requirements and discharge mandatory health and safety obligations, costs of compulsory upgrade of IT systems, and unbudgeted Depot bin hire recharges, offset by underspends in operating expenditure and reduced contributions to the bad debt provision. The outturn also includes reduced depreciation charges which result in only a transfer of resources to the Major Repairs Reserve which is used to finance capital expenditure. A more detailed analysis of the HRA Outturn position is set out at Appendix 6.

Concilium Business Services

52. The Quarter 2 performance of Concilium Business Services was reported to Cabinet in December 2017. The December Cabinet report set out the principle that any profits generated from trading companies can be used to support the general fund, subject to agreement with the respective Board of Directors. Any retained losses must be held against Council reserves in light of potential realisation. The Quarter 4 performance of the Company is set out in Confidential Appendix 7.

CAPITAL

53. Total spend on the capital programme for the year is £89.751m, which is 53% of the approved budget. (£78.148m General Fund and £11.603m HRA). This compares to an approved budget of £167.438m (£137.616m General Fund and £29.822m HRA). The variance of £77.687m comprises of slippage of £53.621m General Fund and £17.219m HRA with underspends of £5.847m General Fund and £1m HRA. The summary position and funding of the programme is shown in table 6. The slippage identified in Table 6 and detailed in Appendix 3 has been approved under delegated authority as carry forwards by the Chief Finance Officer.

Table 6: Summary Capital Outturn 2016/17

Directorate	Original Programme	CFWD's	Adjust ments	External	LBH	Total Budget	Actual	Variance	Slippag e	Under spend
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Community	38,980	8,438	-23	5,851	41,544	47,395	38,475	-8,920	4,837	-4,083
People	17,920	19,287	1,650	34,871	3,986	38,857	17,017	-21,840	20,533	-1,307
Resources	20,525	10,344	-931	0	29,938	29,938	12,200	-17,738	17,738	0
Regeneration	19,058	3,264	-896	1,547	19,879	21,426	10,456	-10,970	10,513	-457
Cross Cutting Investment in Infrastructure	5,000	0	-5,000	0	0	0	0	0	0	0
TOTAL GENERAL FUND	**101,483**	**41,333**	**-5,200**	**42,269**	**95,347**	**137,616**	**78,148**	**-59,468**	**53,621**	**-5,847**
HRA	25,550	16,684	-12,412	0	29,823	29,822	11,603	-18,219	17,219	-1,000
TOTAL GENERAL FUND & HRA	**127,033**	**58,017**	**-17,612**	**42,269**	**125,170**	**167,438**	**89,751**	**-77,687**	**70,840**	**-6,847**
TOTAL CAPITAL PROGRAMME	**127,033**	**58,017**	**-17,612**	**42,269**	**125,170**	**167,438**	**89,751**	**-77,687**	**70,840**	**-6,847**
NOTE:										
General Fund Funding:										
Grant	-23,616	-15,647	-2,558	-41,821		-41,821	22,160	-19,661	-19,231	430
Section 106	-143	-1,109	804	-448		-448	401	-47	-47	0
RCCO	0	0	0	0		0	0	0	0	0
Borrow ing	-77,724	-24,577	6,954		-95,347	-95,347	55,587	-39,760	-34,343	5,417
TOTAL GENERAL FUND	**-101,483**	**-41,333**	**5,200**	**-42,269**	**-95,347**	**-137,616**	**78,148**	**-59,468**	**-53,621**	**5,847**
HRA Funding:										
Revenue (MMR)	-22,285	-2,546	13,872	0	-10,959	-10,959	6,448	-4,511	-3,254	1,257
Grant	0	0	0	0	0	0	48	48	0	-48
Contribution	-70	0	70	0	0	0	209	209	0	-209
Main Programme	**-22,355**	**-2,546**	**13,942**	**0**	**-10,959**	**-10,959**	**6,705**	**-4,254**	**-3,254**	**1,000**
Affordable Housing (Sec 106)	-1,495	0	1,495	0	0	0	1,046	1,046	1,046	0
Contribution	0	0	0	0	0	0	0	0	0	0
Capital Receipt - Right to buy	-1,700	-14,138	-3,025	0	-18,864	-18,864	3,013	-15,851	-15,851	0
Capital Receipt - Others	0	0	0	0	0	0	0	0	0	0
Borrow ing	0	0	0	0	0	0	0	0	0	0
Revenue (MRR)	0	0	0	0	0	0	839	839	839	0
Affordable Housing	**-3,195**	**-14,138**	**-1,530**	**0**	**-18,864**	**-18,864**	**4,898**	**-13,966**	**-13,966**	**0**
TOTAL HRA	**-25,550**	**-16,684**	**12,412**	**0**	**-29,823**	**-29,823**	**11,603**	**-18,220**	**-17,220**	**1,000**
TOTAL CAPITAL PROGRAMME	**-127,033**	**-58,017**	**17,612**	**-42,269**	**-125,170**	**-167,438**	**89,751**	**-77,687**	**-70,840**	**6,847**

54. Virements in the Capital Programme

The following virements in relation to General Fund underspends are recommended for approval by Cabinet. This underspend will be carried forward to 2017/18 for future use.

Table 7: Virements in the Capital Programme 2016/17

Directorate	Underspend
From	£'000
Community	-4,083
People	-1,307
Regeneration	-457
	-5,847
To	
Unused Capital Budget	**5,847**

DIRECTORATE PERFORMANCE ON CAPITAL

55. The capital programme by directorate is included at Appendix 3 showing performance against the latest approved budget for each programme line. Set out below is narrative to explain the capital outturn and the major variances:

RESOURCES

The directorate spent £12.2m against a budget of £29.937m, a 41% spend. The balance of £17.7m under spend has been slipped to 2017/18 as set out in Appendix 3. The key reason for slippage is as follows;

56. Property Investment Portfolio – £5.401m of the £15m budget has been spent in 2016/17 and the remaining £9.629m will be slipped to 2017/18 whilst the search for appropriate investment opportunities continues.

57. The majority of the slippage relates to the transition of the ICT service (£2.005M) and the on-going refresh and enhancement of ICT (£1.956M) to fund the on-going transformation of ICT within the authority. A number of projects included in the transformation programme - Middleware Replacement, Enterprise Portfolio Assessment and Microsoft Exchange Upgrade - have been delayed resulting in related capital payments moving into subsequent financial year(s).

58. The on-going refreshment and enhancement projects have slipped due to significant issues coping with the volume of work and pipeline of requests, Sopra Steria were unable to define solutions and cost projects for delivery within the 2015/16 and 2016/17 financial years. Headway has now been made and the pipeline of work is now beginning to filter into deliverable projects.

COMMUNITY DIRECTORATE

The net variance for the Community Directorate is an outturn of £38.5m against the budget of £47.4m, a variance of £8.9m. (£4.8m of slippage and £4.1m underspend).

Commissioning and Environmental Services

59. The services spent £19.586m against a budget of £19.289m, so a total of £297k above the budget. The negative slippage means that £297k will be deducted from the 2017/18 budget.

60. The capital funding has been invested in the Boroughs infrastructure in order to improve the Borough, both for residents and staff. Some of these improvements have led to the generation of additional income, particularly from disused parks buildings that were brought back into use. Others, such as the rationalisation of accommodation have yielded savings both on maintenance and utilities. Likewise, investment on the highways network including additional capital on street lighting to accelerate the replacement of old lamp columns will reduce both reactive maintenance and electricity costs in the future. Some projects contributed significantly to social regeneration by making available more facilities for community use.

61. Some of the key projects and outcomes were;

- Highways: Re-surfaced 23km of Harrow's 460km road network and carried out 1,718 repairs to carriageways including potholes related work. Reconstructed 18,701 linear meters of footways and carried out 3,416 repairs to footways to improve safety to residents and visitors.

- Street Lights: Replaced around 2,000 lighting columns with LED technology to improve safety and energy efficiency. Additionally completed the removal of lit bollards and replaced with highly reflective units, circa 800 no.

- Parking Management Programme: A number of schemes agreed by Traffic and Road Safety Advisory Panel (TARSAP) have been completed. These include Headstone Lane Station Area, Somerset Road Area, West Avenue, Bethecar Road, CPZs at Wealdstone, South Harrow and Hatch End, extension of existing CPZ on Pangbourne Drive, and the installation of P&D parking in Kenton Land and Kingshill Drive car parks.

- Harrow Weald Cemetery – refurbishment works to building housing public and staff facilities, addressing structural issues and ensuring provision of suitable, working, facilities within one of our operational cemeteries.

- Parks Infrastructure: Improvements made to a number of buildings including
  - ➢ Installation of new playground at Weald Village and a borough wide programme of works for the replacement and upgrade of deteriorating playground surfacing, to ensure continued provision of a safe environment for our children to enjoy a range of play equipment
  - ➢ Centenary Park improvement works to football pitches to provide improved and additional 3G pitches to meet demand and generate additional income for the Council as well as the provision of a new café.
  - ➢ Headstone Manor and Kenton Rec pavilions, redecoration of changing rooms and works to make pavilions DDA compliant
  - ➢ Refurbishment work on tennis Courts at Pinner Village Gardens and Rayners Mead to bring them back into use and encourage increased participation in sports.

Cultural Services

62. The service spent £2.1m against a budget of £4.3m, a 49% spend. £1.186m of the variance has been slipped to 2017/18. The capital grant of £1m originally assigned to the Harrow Art Centre will now no longer be required. The spend related to the following projects:

- Libraries: Refurbishment work at Stanmore Library was completed, including the provision of open + technology. 14 self-service kiosks were replaced as part of the refresh programme.
- Leisure: Installation of new lockers at Harrow Leisure Centre and improvement to the changing rooms at Hatch End pool as well as roofing work to weather proof the building in advance of internal redecoration.
- Headstone Manor project is on-going. A new visitors centre and café is now open.

Housing General Fund

63. The service spent £23.8m against a budget of £16.8m, 71% of the budget was spent. This includes the property purchase initiative and if excluded the spend on the remaining Housing General Fund projects was £1.968m against a budget of £2.477m, a 79% spend. Of this variance of £509k, £435k of the variance has been slipped to 2017/18, with a net underspend of £74k on Empty Property Grants. The external funded element of Empty Property Grants not spent will be carried forward.

Property Purchase Initiative

64. £14.794m was spent against a budget of £21.3m, a 69% spend. £3.513m of the variance has been slipped to 2017/18. This will result in a net underspend of £3.0m. Fifty eight have been purchased to 31 March 2017, with a further forty two dwellings to complete in 2017/18.

PEOPLE SERVICES

The net variance for People Service is an outturn of £17.017m against the budget of £38.857m, a variance of £21.840m. (£20.533m of slippage and £1.307m underspend).

Children's Service

65. The final outturn in 2016-17 for the schools capital programme is spend of £16.403m against a total budget of £36.046m. This represented expenditure of 46% against the budget. £19.643m of the variance has been slipped to 2017/18. This is slightly changed position from Q3 which anticipated spend of 54% due to the on-going work to close the final accounts on the SEP2 programme including some aspects of secondary and SEN expansion. In addition to this £4.2m of funding in relation to SEN expansion was agreed to be rephased into 2017-18 and this is now shown as slippage on the 2016-17 outturn

Secondary Expansion Programme 1 and 2 including Secondary and SEN

66. The Council employs cost consultants to provide valuations of the works carried out by the contractors. However, the account valuations provided by the contractor vary significantly to those provided by the council's cost consultants and this could be a further pressure, and may require council borrowing to fund.

67. The forecasts continue to be monitored and updated as projects are completed and the accounts clarified and agreed with the contractors. Work is being undertaken with Legal Services to support the process of closing the programme with Keepmoat.

Secondary Expansion Programme 3

68. Three schemes are complete and Welldon Park Junior School is still going through the value engineering process and this scheme is still subject to planning approval there could be further works or redesigns required to meet any additional planning conditions which could put further financial pressure on this programme. Any

pressure on this programme will result in an overspend which would have to be funded from Council borrowing.

69. Weald Rise Primary School, also part of SEP3, is being rebuilt as part of the Priority School Building Programme. However the expansion of the school is in addition to the works being provided by the EFA. Therefore the council has funded a top up fee in order to deliver the expansion element of this programme, totalling £2.28m. This is included in the overall outturn for the programme.

SLIPPAGE

The reported slippage for 2016-17 is £19.643m. The majority of these items are set out as follows;

School Expansion Programme 3

70. Slippage relates to Stag Lane and Welldon Park Junior Schools which are part of phase 3 of the expansion programme for which the majority of the work will be undertaken in 2017-18. There is minimal impact to the schools as a result of these delays since the expanded year group at Welldon Park is still working its way through the infants (which is on a separate site and whose building works were completed for September 2016). There will be sufficient capacity in the junior school until building works are completed for September 2017. In relation to Stag Lane the school expanded its pupil numbers from September 2016 and there will also be sufficient capacity within the school to accommodate the increased numbers until the building works are completed for September 2017**.**

Secondary School Expansion 1 and 2

71. Slippage relates to work is being undertaken with Legal Services to support the process of closing the programme with contractor. There is no impact on school provision as a result of the slippage as buildings have been handed over and schools are operational.

Secondary

72. The position with the school projections reported to Cabinet in July 2016, indicate that the demand for secondary school places is lower than previously expected and there will be a shortfall at a later stage than anticipated, from 2022. It is therefore proposed to slip secondary provision funding into 2017-18.

Special Education Needs

73. The specification for SEN provision is still being scoped and the LA is working closely with the existing special schools and the EFA to look at possible free school and the outcome of this will determine the need for SEN provision in the borough**.**

Amalgamations, bulge classes and capital maintenance

These are rolling programmes.

Adult Services

74. The service spent £614k against a budget of £2.811m, a 22% spend. £3.351m of the £890k variance has been slipped to 2017/18 with an underspend on the programme of £1.307m. There have been delays on a number of schemes within the programme resulting in slippage. The most significant ones are:

a. MOSAIC (£272k) - The project has been delayed by Sopra Steria capacity issues – the carry forward is required for the project to go live .
b. Bedford House reconfiguration (£284k). Delays with planning and contractor procurement have delayed the project so the remaining budget will be spent in 17/18 to assist in delivering the planned MTFS savings.
c. Integrated Health Model (£85k) Other capital projects have taken priority this year (MOSAIC) but there is still a requirement to have 95% NHS Numbers so work will carry on into 17/18 .
d. Maintenance of Adult Properties (£149k) This work had been hoped to be part of reconfiguration of Adult day centre properties before end of year but work has been delayed.
e. In - House Residential (£100k) Original plans for improvements against in - house residential properties did not take place, reviews are to take place as to requirements for 2017/18 and budget has been slipped .

Regeneration, Enterprise and Planning
The net variance for the Regeneration, Enterprise and Planning Directorate is an outturn of £10.456m against the budget of £21.426m, a variance of £10.970m. (£10.513m of slippage and £457k underspend).

75. The division has continued the major regeneration programme and associated Town Centre improvements in line with the Regeneration Strategy which will see a new civic centre and some 5,500 new homes within the Heart of Harrow Opportunity Area and Mayor of London Housing Zone and will provide a major impetus for business development, creating around 3,000 new jobs overall.
The division spent £9.660m against a budget of £19.754m, a 49% spend. £9.641m of the variance has been slipped to 2017/18.

Some of key projects and outcomes were:

- Regeneration Programme: planning and design work has commenced on all key sites. A design team has been appointed for Poets' Corner (existing Civic Centre site), Byron Quarter (leisure centre site) and Wealdstone Project/New Civic to take forward the schemes and scope initial phases for detailed delivery. Feasibility studies for Greenhill Way and Waxwell Lane completed and engagement activities led on all sites including Vaughan Road, which is due to be submitted for planning Qtr 1.
- Works have started at the Haslam House site which will complete in 17/18 and deliver the first pilot of build to rent units for the private market Fairview commenced capital works at Gayton Road site towards delivering social and build to rent for the Council
- Exchange of contract for purchase of social club in Poets Corner site
- Regeneration Unit capacity and skills built up to service current workload planning and delivery
- £1.5m grant funding was secured in 2016/17 through the GLA's London Regeneration Fund. This is for a 2 year capital programme, the funding is allocated between the creation of artists studios / workspace and a gallery at Whitefiriars Studios (formerly known as Artisan Studios and Wealdstone Square (formerly known as Trinity Square). Funding allocated to Whitefriars Studios is £660k, and £850k to Wealdstone Square. The artists studios are near to completion and £109,394 GLA funding will be carried forward into 2017/18. The

Square is at RIBA Stag 3 and £762,732 will be carried forward and spent to complete the work in 2017/18.

Housing Revenue Account

76. HRA spent £11.604m against a budget of £29.823m, including Homes-4-Harrow, a spend of 39%. £17.219m will be carried forward to 2017-18 leaving £1m underspend against the planned investment programme to assist with achieving the savings targets in the HRA. £3.254m will be carried forward for the main planned investment programme with the full variance of £13.965m carried forward in respect of the Homes-4-Harrow programme. With regard to Homes-4-Harrow, planning objections for the Grange Farm Estate regeneration scheme are being addressed and demolition notices have been served with right to buy applications suspended. The scheme is in the design phase and we continue to buy back properties owned by leaseholders. Council's Infill programme, aimed at developing under-utilised pockets of Council land in and around the Borough is in build phase and properties will start to become available during 2017-18.

TIMETABLE FOR PREPARATION OF DRAFT STATEMENT AND EXTERNAL AUDIT REVIEW

77. New regulations bringing forward publication dates for the production and audit of Local Authority Statement of Account's comes into effect for the 2017/18 financial year. Harrow along with many other Councils have amended their closure of accounts timetables to allow practice runs of issuing the draft accounts by 31st May (previous deadline was 30th June each year).

78. Work is progressing on the production of the draft accounts (including Pension Fund) with the aim of them being completed by 31st May. In future years the audit of the Statement of Accounts will have to be completed by 31st July (currently 30th September).

LEGAL IMPLICATIONS

79. Section 151 of the Local Government Act 1972 states that, "without prejudice to section 111, every local authority shall make arrangements for the proper administration of their financial affairs and shall secure that one of their officers has responsibility for the administration of those affairs"

80. Section 28 of the Local government Act 2003 imposes a statutory duty on a billing or major precepting authority to monitor, during the financial year, its income and expenditure against budget calculations.

FINANCIAL IMPLICATIONS

81. Financial implications are contained within the body of the report.

PERFORMANCE

82. Good financial monitoring is essential to ensuring that there are adequate and appropriately directed resources to support delivery and achievement of Council priorities and targets as set out in the Corporate Plan. In addition, adherence to the Prudential Framework ensures capital expenditure plans remain affordable in the longer term and that capital resources are maximised.

83. Financial performance is considered quarterly at Cabinet.

RISK MANAGEMENT IMPLICATIONS

84. The risks to the council and how they are being managed are clearly set out in the report:

    Risks included on Directorate risk registers? Yes

EQUALITIES IMPLICATIONS

85. There are no direct equalities impacts arising from the decisions within this report.

CORPORATE PRIORITIES

The Council's vision is:

Working Together to Make a Difference for Harrow

The administrations priorities are:

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

Section 3 - Statutory Officer Clearance

Name: Dawn Calvert Date: 2 June 2017	x	Director of Finance
Name: Jessica Farmer Date: 5 June 2017	x	on behalf of the Monitoring Officer

Ward Councillors notified:	NO
EqIA carried out: **EqIA cleared by:**	NO N/A

Section 4 - Contact Details and Background Papers

Contact: Sharon Daniels, Head of Strategic and Technical Finance (Deputy Section 151 Officer)
(Sharon.daniels@harrow.gov.uk)

Background Papers:
..\..\..\..\..\BUDGET\Budget 2017-18\February Cabinet\Final report\Final Report Appendices for Daksha\V4 Final Budget Report 070217.doc

..\..\..\..\..\BUDGET\Budget 2016-17\Feb Cabinet\Final version for Cabinet\report and Final appendices to Daksha\Final Budget report 18 February 2016 v4.doc

..\..\..\Period 6\Final Cabinet Report\Cabinet Report Template Q2 (Autosaved).xlsx

Call-In Waived by the Chairman of Overview and Scrutiny Committee	**NOT APPLICABLE** *[Call –in applies]*

Revenue Carry Forward Schedule Appendix 1

Services	Description	Council Funding	Ring Fenced Grant Funding	Non Ring Fenced Grant Funding	Total	Reason for Carry Forward & Consequences of not carrying forward.
		£000	£000	£000	£000	
Resources and Commercial Directorate						
Legal and Governance	Carry Forward Request 2016-17 Individual Electoral Registration		60		60	Continuation of investment into the Individual Electronic Registration. Grant ring fenced for the project.
Total Resources and Commercial	**Total 2016-17**	**0**	**60**	**0**	**60**	
Community Directorate	**Description**	**Council Funding**	**Ring Fenced Grant Funding**	**Non Ring Fenced Grant Funding**	**Total**	**Reason for Carry Forward & Consequences of not carrying forward.**
		£000	**£000**	**£000**	**£000**	
	Carry Forward Request 2016-17					
Environment and Culture [Museum]	Arts Council Resilience Grant		10		10	This project is not due for completion until August 2017. If this funding is not carried forward grant in full must be repaid
Environment and Culture [Museum]	HLF Young Roots Grant		16		16	This project is not due for completion until September 2018. If this funding is not carried forward grant in full must be repaid
Environment and Culture [Museum]	HLF Match funding	270			270	The John Lyon Trust is no longer providing £270k revenue match funding for Museum project. HLF Funding of £548k would be lost if match funding is not available
Housing General Fund	London Fire Brigade, Hoarders project		80		80	This funding is for combating dangers of fire by residents hoarding possessions in their homes. Grant was given late in 2016-17 therefore no opportunity to spend hence request for carry forward.
Housing General Fund	Gas Safety		6		6	To be able to use the money given to the Council by Foundations (FILT) to carry out Gas safe inspections in Harrow. Consequences if we don't carry forward would be that we would not be able to do anymore Gas safe inspections and have to return the money.
Total Community	**Total 2016-17**	**270**	**113**	**0**	**383**	
Peoples Directorate	**Description**	**Council Funding**	**Ring Fenced Grant Funding**	**Non Ring Fenced Grant Funding**	**Total**	
		£000	**£000**	**£000**	**£000**	
Public Health	obesity		50		50	Ring fenced PH projects to be carried forward
Public Health	Staffing		65		65	Ring fenced PH projects to be carried forward
Public Health	MH and Wellbeing		130		130	Ring fenced PH projects to be carried forward

Services	Description	Council Funding	Ring Fenced Grant Funding	Non Ring Fenced Grant Funding	Total	Reason for Carry Forward & Consequences of not carrying forward.
		£000	£000	£000	£000	
Public Health	AofPHE project		1,008		1,008	Monies from Health Education England for PH team to commission PH projects
Public Health	HEE project		508		508	Monies from Health Education England for PH team to commission PH projects
Total Peoples Directorate	**Total 2016-17**	**0**	**1761**	**0**	**1761**	

Regen Ent Planning Directorate	Description	Council Funding	Ring Fenced Grant Funding	Non Ring Fenced Grant Funding	Total	Reason for Carry Forward & Consequences of not carrying forward.
		£000	£000	£000	£000	
Planning	Communities and Local Government – Self-build		21		21	This was received in March 2017 and relates to work we are required to undertake to meet our statutory responsibilities to deliver self-build housing within the borough. If not spent / or not spent in accordance with the grant, it would be repayable.
Planning	(former) Department of Energy and Climate Change – District heating		97		97	This grant is ring-fenced, with Harrow match-funding 33%. It is the Harrow match funding / underspend that costs to date will be paid (circa £37k), so the full grant amount should be carried forward. If not spent / or not spent in accordance with the grant, it would be repayable.
Planning	The Town and Country Planning (Permission in Principle) Order 2017 ('the PiP Order') and The Town and Country Planning (Brownfield Land Register) Regs 2017 ('the BR Regs').		15		15	Planning Policy will be leading on the brownfield register, so when received it should be coded to 5570 so as to be available in 17/18 (we have to have a register in place by end of December 2017). If not spent / or not spent in accordance with the grant, it would be repayable.
Total Regeneration Enterprise & Planning Directorate	**Total 2016-17**	**0**	**133**	**0**	**133**	
2016-17 Revenue Carry Forward Total		**270**	**2,066**	**0**	**2,336**	

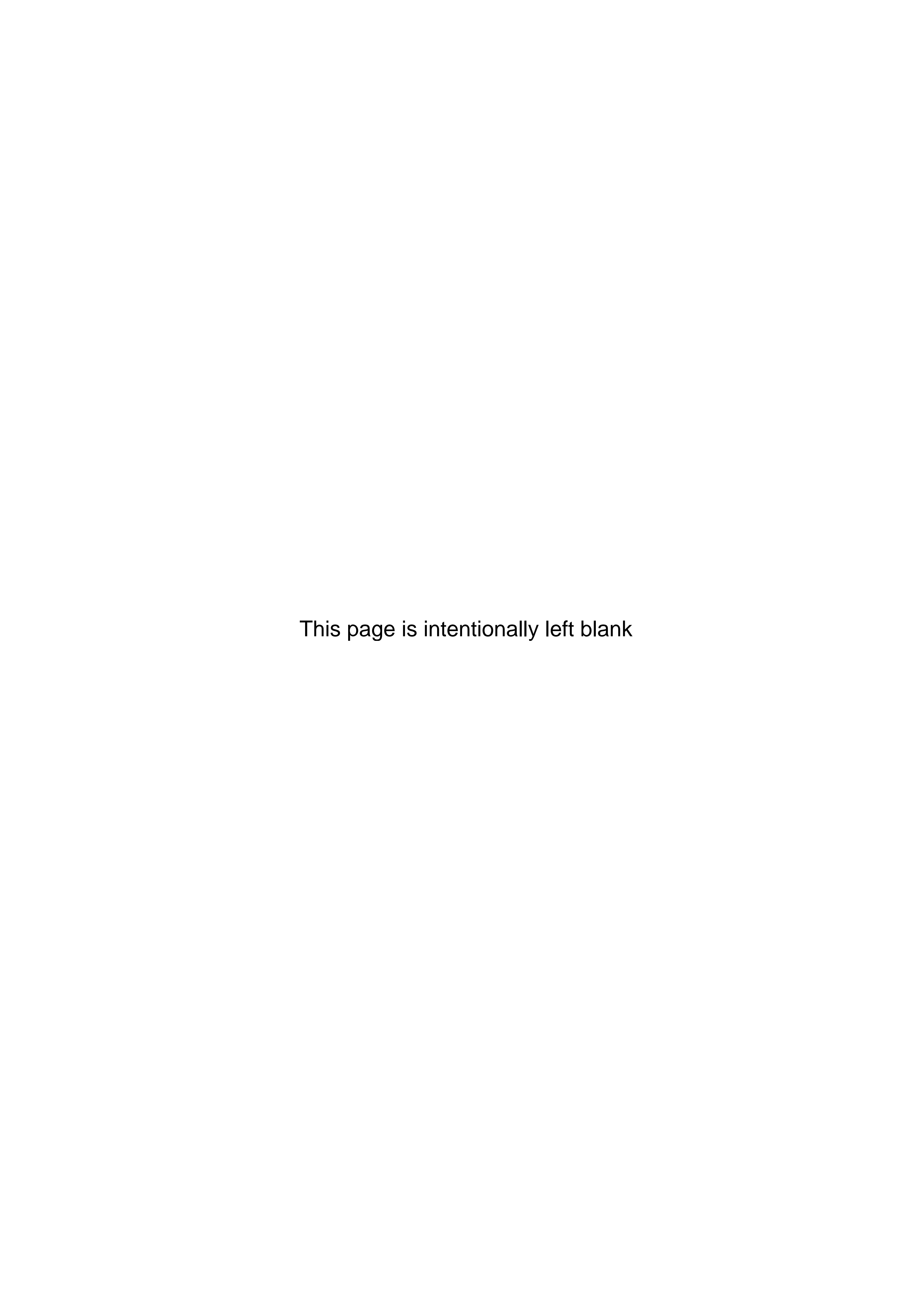
Contributions to/Draw Down from Reserves (Directorate) Appendix 1a

Directorate	Description		£'000
Resources	Transformation and Priority Initiatives Fund	-	140,600
Resources	MTFS Implementation Reserve	-	259,271
Resources	IT Draw Down	-	862,000
Resources	Commercialisation	-	21,000
Resources	Election - Contribution to reserve		105,930
Resources	Legal Reserve		67,000
	Resources Total	**-**	**1,109,941**

Community			
Community	TPIF	-	270,000
Community	MTFS Implementation Reserve	-	93,000
Community	Repossession reserve	-	51,000
	Community Total	**-**	**414,000**

People			
Adult	Transformation and Priority Initiatives Fund	-	171,919
Adult	MTFS Implementation Reserve	-	162,958
Adult	MTFS Implementation Reserve (The Bridge)	-	347,000
Adult	Commercialisation	-	95,000
Adult	Neighbourhood Resource Centre sinking fund reserve		123,970
Adult	*Adult Total*	*-*	*652,907*
Public Health	Public Health Grant		*225,000*
	Adult and Public Health Total	**-**	**427,907**
Children	Transformation and Priority Initiatives Fund	-	72,000
Children	MTFS Implementation Reserve	-	424,120
Children	HSIP	-	1,141,000
Children	Children Social Care Reserve	-	218,865
Children	Troubled families grant	-	287,648
Children	Special Schools Private Funding Initiatives	-	277,520
Children	Revenue Grant Reserve		111,000
Children	**Children's Total**	***-***	***2,310,153***
	People's Total	**-**	**2,738,060**

Regeneration	New Home Bonus Grant	-	514,000
Regeneration	Harrow and Mayor CIL		5,521,000
	Regeneration Total		**5,007,000**
	Total Contributions to/Draw Down from Reserves		**744,999**


This page is intentionally left blank

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
Resources & Commercial									
RES_SC01	**Strategic Commissioning**	**Income from Communications Through Gain Share Model**	125	25	13		163	**Red**	Work continues to be undertaken to establish whether this saving can be achieved and is sustainable into 2017/18 as income targets will increase in this year. To date the underachievement is being covered through the Resources and Commercial Directorate underspend position
RES_SC02	**Strategic Commissioning**	**Additional Income from Communications Provider and Further Savings**			107		107	**Purple**	Future Year saving, still in development
RES_SC03	**Strategic Commissioning**	**Domestic Violence Budget Reduction Based on Alternative Funding**		21	61		82	**Purple**	Future Year saving, still in development
RES_SC04	**Strategic Commissioning**	**Proposed savings in Healthwatch Funding**	13		50		63	**Green**	2016/17 Savings target achieved
RES_SC05	**Strategic Commissioning**	**SIMS Team Contribution to Overheads and Additional Income**	30	20	20		70	**Green**	2016/17 Savings target achieved
RES_SC06	**Strategic Commissioning**	**Commissioning Capacity in the Council**	371	10	50		431	**Amber**	All staff savings have been delivered and integrated into budgets for 2016/17. The majority of this saving is achieved, with further work taking place to deliver the full saving by the end of the year. Around £87k of the 2016/17 target is at risk. There are plans to mitigate this by looking to underspend in other parts of the Division.
RES_HR01	**HR**	**Shared HR Service with Buckinghamshire County Council - Business Case Under Development**		140	110		250	**Green**	The shared HR Service went live on 1 August 16 and all the MTFS savings are built in to the fees and charges for the shared Service. There is sufficient budget provision to meet the service charges for 16/17 and the implementation costs.
RES_HR03	**HR**	**Organisational Development -** Review existing shared OD service provision		155			155	**Purple**	The OD Service has been subsumed within the new shared HR Service and the MTFS savings built in to the fees and charges.
RES_F01	**Finance & Assurance**	**Reduction in Contribution to Insurance Fund due to improved claims performance**	200				200	**Blue**	Contribution reduction built into 16/17 budget. Savings achieved

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
RES_F02	Finance & Assurance	Improved Treasury investment return from increased Risk appetite (Primarily lending for longer and to institutions with lower credit ratings)	180	595	625		1,400	Green	Harrow remains in the upper quartile for rates received on its short term treasury investments. Although performance remains high, a lower level of balances means that investment income will not increase significantly, however a review of borrowing to support the Capital Programme achieve the 2016/17 savings.
RES03	Finance and Assurance	Review of the Finance structure 2015/16 and 2016/17 proposals	415				415	Amber	Team re-structure completed to delete 7fte. New structure in place from 01/05/16. 3 posts remain covered by agency staff and are currently being recruited to. Agency cover to back fill staff absence due to sickness is also creating a pressure. Estimated pressure in 2016/17 is £100k.
RES_F03b	Finance & Assurance	Audit and Fraud - staffing reductions	30	15			45	Blue	Corporate Fraud Investigator post deleted - £30k removed from budget therefore saving achieved
RES_F04	Finance & Assurance	Investment Portfolio		350	350		700	Purple	Future Year saving, still in development
RES_LG02	Legal & Governance	Committees		100			100	Purple	Future Year saving, still in development. There is no plan or political support to deliver these savings.
RES_LG03	Legal & Governance	Shared Registrars Service	50				50	Amber	Reports to effect a shared registrars service with Brent are scheduled for both Council's and Cabinets in the Autumn. This plan has now been abandon.
RES_LG04	Legal & Governance	Expansion of the Legal Practice 15/16 and 16/17 proposals	384	354	354		1,092	Blue	2016/17 savings achieved . Achievement of future savings will become cleaer as the year progress.
RES_CP01	Commercial, Contracts & Procurement	Selling services through shared procurement arrangements. 15/16 and 16/17 proposals	108	182	180	-	470	Amber	The delay to the establishment of the Procurement Shared Service by the withdrawal of Bucks has made the delivery of savings for 2016/17 difficult but everything is being done to ensure delivery. 2017/18 savings are subject to a revised staffing structure and consultation with Unions. Plans for 2018/19 not yet developed.
RES_CS02	Customer Services and IT	Revenues and Benefits - Domestic and NNDR Site Review and Collection Rate			250		250	Purple	Future Year saving, still in development

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
RES_CS06	**Customer Services and IT**	**Assumed savings from the completion of the roll out of universal credit and the opportunity this provides to simplify the CTS scheme**			300		300	**Purple**	Future Year saving still in development, and at risk as full HB caseload migration to Universal Credit (UC) still many years away which means administration savings by simplifying local Council Tax Support Scheme is unachievable. Progression to UC extremely slow. Saving unachiavable and should be removed until DWP gives time lines for migration of HB Working Age caseload.
RES_CS07	**Customer Services and IT**	**IT Maintenance Savings**	67				67	**Blue**	Savings target achieved
RES_CS09	**Customer Services and IT**	**IT Contract.** Reduced costs assuming reduction of 100 IT users across the Council	31				31	**Blue**	Savings target achieved
RES_CS10	**Customer Services and IT**	**IT - reduce colour printing across the organisation by 50%**	50				50	**Blue**	Savings target achieved
RES_CS12	**Customer Services and IT**	**Customer Services - review Helpline charging and commercialisation**	65				65	**Green**	Savings target achieved
RES_CS15	**Customer Services and IT**	**Capital financing savings from IT contract being less than in the capital programme**	260				260	**Blue**	Savings target achieved
BSS 01	**BSS**	**Business Support Review**.	649	352	320		1,321	**Red**	Additional demand from Childrens Services due to increased activity at the front door. Deep Dive review carried out with Members and options on reducing costs presented to Commissioning Panel.The saving was subesquently reversed as part of the 2017/18 Budget Setting process.
RES16	**Strategic Commissioning**	Retender of the Communications Service to take account of reductions in spend phased in the following way: 2016/17 - 10% reduction, 2017/18 - 10% reduction. **15/16 MTFS**	57	57			114	**Blue**	2016/17 savings achieved . Achievement of future savings will become clearer as the year progresses.
RES21	**Directorate Wide**	Management Savings **15/16 MTFS**	150				150	**Blue**	Savings on track to be achieved.
RES25	**Customer Services & IT**	Procurement savings across the contracts managed within the division. **15/16 MTFS**	949				949	**Blue**	Savings achieved.
RESG01	**Customer Services & IT**	**Welfare Reform contingency utilisation-** 6FTE Revenues and benefits £215k - reversal of one off growth **15/16 MTFS**	215				215	**Blue**	Savings achieved - Temporary staff contract terminated
RES082	**Collections and Benefits**	Revenues Staffing Reductions **14/15 MTFS**	40				40	**Blue**	Achieved and monies already taken from budget as at 1/4/2016

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
RES083	**Collections and Benefits**	Housing Benefits Staffing Reductions as Benefits moves to DWP. Reduced staffing required as Housing Benefits transfers to Universal Credit and is no longer administered by Harrow. **14/15 MTFS**	125				125	**Blue**	Achieved and monies already taken from budget as at 1/4/2016
			4,564	**2,376**	**2,790**	**-**	**9,730**		
Children & Families									
PC01	**Education & Commissioning**	**Schools Strategy** Education & Professional Lead - Early Years. Change funding to maximise use of grants	91				91	**Blue**	Achieved
PC02	**Education & Commissioning**	**Capital Team** **Delete Senior Professional after postholder retires £73k and increase capitalisation £70k** **Post vacant**	143				143	**Blue**	Post Holder retired September 2015 and the 2016-17 budgeted establishment was adjusted to reflect the saving. Capitalisation was built into the capital programme. Savings achieved.
PC03	**Special Educational Needs**	**Residential School Placements** Maximise use of grants	500				500	**Blue**	Funding streams were adjusted and 2016-17 budget was reduced to reflect saving.
PC04	**Special Educational Needs**	**Educational Psychology** Income generation	50				50	**Blue**	Achieved
PC05	**Children & Young People**	**The Firs** Selling bed spaces, providing training to other LAs, renting out rooms/garden for activities	52				52	**Green**	Achieved through a combination of income generation and efficiencies
PC06	**Children & Young People**	**Children's Placements - Care Leavers** Efficiencies in procurement	200				200	**Amber**	Partly achieved through increasing the number of housing benefit claimants, moving young people into independent living at an earlier stage and improved contractual and commissioning arrangements to drive down costs. Confirmed cost reductions in 2016/17 totalled £23k. Demand and complexity, particularly in relation to gangs and exploitations, continued to increase throughout the year meaning that savings were offset by pressures from demand.
PC07	**Children & Young People**	**Children's Placements - Looked After Children** **N**egotiate price reductions and review packages of support	500				500	**Amber**	Robust monitoring and regular review of high cost placements at panels chaired by Divisional Director took place throughout 2016/17 resulting in confirmed reductions of £488k. Improved contractual and commissioning arrangements drove down costs. Improved care planning so children and young people were moved from expensive residential placements in a more timely manner. Demand and complexity continued to increase, particularly in relation to gangs and exploitation, meaning that savings were offset by pressures from demand.
PC08	**Children & Young People**	**Emergency Duty Team** Full cost recovery	50				50	**Blue**	Achieved.

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
PC12	Children & Young People	**Review of posts in Quality Assurance & Improvement Service**			223		223	Purple	Future Year saving, still in development
PC13	Children & Young People	**Early Intervention & Youth Development** Integration and restructure of childrens centres, early intervention and youth development service	416	266			682	Amber	The target implementation date of 01/10/16 slipped with the majority of redundancies taking place at the end of March. The HR issues linked to the transformation proved to be challenging. 37 job descriptions being reduced to 4 was complex and meant that agency staff had to stay in post for longer than had been expected.
PC14	Children & Young People	**Review of Adoption Contract**			86		86	Purple	Future Year saving, still in development
PC15	Children & Young People	**Review of posts in MASH**			100		100	Purple	Future Year saving, still in development
PC16	Children & Young People	**Review of posts in Family Information Service**			61		61	Purple	Future Year saving, still in development
PC17	Children & Young People	**Review of posts in Access to Resources**			57		57	Purple	Future Year saving, still in development
PC19	Children & Young People	**Review of Leaving Care, Children Looked After & Unaccompanied Asylum Seeking Children Teams**			173		173	Purple	Future Year saving, still in development
PC20	Education & Commissioning	**Commissioning** Reduction by 2.6FTE vacant posts	184				184	Blue	2.6FTE post holders left in 2015. 2016-17 budgeted establishment was adjusted to reflect the achievement of savings
PC21	Education & Commissioning	**Governor Services** Governor Support Officer post	44				44	Blue	Post holder left March 2016. 2016-17 budgeted establishment was adjusted to reflect the achievement of savings.
PC22	Education & Commissioning	**Schools Strategy** Non staffing budgets	35				35	Blue	2016-17 budgets were adjusted to reflect saving
PC23	Education & Commissioning	**Harrow School Improvement Partnership** HSIP Full Cost recovery including Support Service Costs	130				130	Red	Significant reductions to income in 2016/17 meant that this saving was not achieved. A new operating model for HSIP is being developed to ensure that the service is financially sustainable going forward.
PC24	Education & Commissioning	**Enhancing Achievement within Education Strategy** Post should be 75% funded by grant management fees from April 2016, post holder redundant from August 2016	61	8			69	Blue	Post holder left August 2016. 2016-17 budget establishment was adjusted to reflect the savings
PC25	Contracts	**Review of Young Carers Contract** Contractual efficiencies	20				20	Blue	New contract arrangements commenced Sept 15. 2016-17 budgets were adjusted to reflect saving
PC28	Cross Service	**Non-pay inflation**	150	150	150	150	600	Blue	Funding was retained centrally and therefore not included in 2016-17 budgets

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	**£000**	**£000**	**£000**	**£000**		
PC29	**Management**	**Review of Management**	449				449	**Blue**	Posts deleted, post holders left and 2016-17 budgeted establishments were adjusted to reflect the savings
PC31	**Special Needs Service**	**Children with Disabilities** Efficiences as service seeks to merge with adults	50				50	**Blue**	The CWD service has been merged with the adults with disability service to create a 0-25 children & young people with disailities service. Part of this restructure has deleted one vacant senior social worker post.
PC32	**Special Needs Service**	**Educational Psychology** Income generation	50				50	**Blue**	Achieved.
PC33	**Special Needs Service**	**Review of Special Educational Needs Transport**	257	257			514	**Red**	This saving was due to be met by the implementation of a revised transport policy to ensure only service users who were eligible continued to receive transport. However the review resulted in only limited reductions of service users and in addition demand continued to grow. This saving has now been offset by growth in the 2017/18 budget.
PC36	**Children & Young People**	**Review of posts in Quality Assurance & Service Improvement**			248		248	**Purple**	Future Year saving, still in development
PC38	**Children & Young People**	**Review of Children Looked After & Placements Service**			1,000		1,000	**Purple**	Future Year saving, still in development
PC39	**Education & Commissioning**	**Education Strategy & Capital** Capitalise 2fte	137				137	**Blue**	Capitalisation was built into capital programme
PC42	**Special Needs Service**	**Review of Special Needs Service**			1,164		1,164	**Purple**	Future Year saving, still in development. £651k was reversed as part of the 2017/18 Budget setting process.
			3,569	**681**	**3,262**	**150**	**7,662**		
Adults									
PA_1	**Adults**	**Supporting People -** renegotiation of existing statutory contracts	150				150	**Green**	Savings target achieved
PA_2	**Adults**	**Supporting People** - review of provision Care Act eligible service users (Bridge / Wiseworks Day Service), and consideration of alternative provision for non eligible service users	276				276	**Red**	Following consultation Members have decided that the contract at the Bridge will not cease. 2016/17 financial implications have been addressed through the 2015/16 Revenue Outturn position. Future years funding will need to be addressed as part of the budget setting process.
PA_3	**Adults**	**Wiseworks -** commercialisation opportunities and to be self financing by end of MTFS period	50	69	56		175	**Green**	2016/17 Savings target achieved
PA_4	**Adults**	**Milmans** Community tender		175	184		359	**Purple**	Future year saving in development
PA_5	**Adults**	**New Bentley [formerly Byron NRC]** Community Tender		446			446	**Purple**	Future year saving. This saving was reversed as part of the 2017/18 Budget Setting process.
PA_6A	**Adults**	**Vaughan NRC** - service review to identify efficiencies in supporting the most complex		100			100	**Purple**	Future year saving in development

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
PA_7	Adults	**Kenmore NRC** - Community Tender	609				609	Red	Community Model being taken forward, and risk of a significantly reduced saving.
PA_9	Adults	**Sancroft** - contract management and service renegotiation	166	334			500	Red	The savings in 2016/17 were expected to be delivered from contractual renegotiations around the day care services provided which are currently under utilised. The legal review of the contract has identified that it is not possible to renegotiate the contract to deliver the planned savings, and given the further savings anticipated in 2017/18, alternative options are now being explored. As a result, this reduction in expenditure cannot be achieved in the current financial year
PA_10A	Adults	**Transport -** review transport provision	200	200	350		750	Green	Will be delivered through wider mitigation
PA_11A	Adults	**MOW/Catering Service** - review of service		65			65	Purple	Future year saving in development
PA_12	Adults	**Southdown -** review service through shared lives	139				139	Green	2016/17 savings achieved through other mitigated action.
PA_13	Adults	**Welldon/Harrow View -** review service through shared lives	106				106	Green	2016/17 savings achieved through other mitigated action.
PA_14	Adults	**Shared Lives -** commercialisation through selling model to neighbouring boroughs	50	150			200	Green	2016/17 Savings target achieved
PA_15	Adults	**Bedford House / Roxborough Park -** review provision within Bedford House	150	650			800	Green	2016/17 savings achieved through other mitigated action. £400k of the saving has been reversed as part of the 2017/18 Budget Setting process.
PA_16	Adults	**7 Kenton Road** - review provision through supporting living and shared lives		228			228	Purple	Future year saving in development
PA_17	Adults	**Hospital / STARRS Discharge** - social care assessments through reablement in line with Care Act guidance	70				70	Green	2016/17 Savings target achieved
PA_19	Adults	**Reduce Commissioning Team** - restructure to reduce the team by 2FTE	150				150	Red	Restructure proposals halted pending decision around 17/18 MTFS which proposes deletion of the team.
PA_20	Adults	**Demography -** reduce remaining MTFS annual demographic growth provision to the Adult Social Care purchasing budget in 2016/17	1,000				1,000	Red	The underlying pressures within ASC from 2015/16 together with the potential impact of the National Living Wage, delivery of MTFS including the reduction in demography indicates that this year will be more financially challenged than in recent years, with an overspend predicted.
PA_21	Adults	**CHW Senior Management Restructure** - savings from senior management restructure following consultation	261				261	Blue	Delivered budget reduced

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
PA_25	Adults	**Maintenance team** - services provided within existing staffing resources	165				165	Blue	Delivered budget reduced
PA_26	Adults	**My Community ePurse -** commercialisation of My Community ePurse		1,000	600		1,600	Purple	Future year saving in development. Procurement of commercial partner in progress. Competitive dialogue will indicate ability to deliver savings. This saving has been reprofiled into 2018/19 and 2019/20 as part of the 2017/18 budget setting process.
PA_27	Adults	**Our Community ePurse** - explore new commercialisation opportunities		998	1,250		2,248	Purple	Future year saving in development. Procurement of commercial partner in progress. Competitive dialogue will indicate ability to deliver savings. This saving has been reprofiled into 2018/19 and 2019/20 as part of the 2017/18 budget setting process.
PA_28	Adults	**Community Wrap** - explore new commercialisation opportunities			640		640	Purple	Future year saving in development
PA_29B	Adults	**Total Community ePurse** - explore new commercialisation opportunities			2250		2,250	Purple	Future year saving in development. Procurement of commercial partner in progress. Competitive dialogue will indicate ability to deliver savings. This saving has been reprofiled into 2019/20 as part of the 2017/18 budget setting process.
CHW09	Adults	Reduced funding following review of WLA programme **2015/16 MTFS**	50				50	Blue	2016/17 Savings target achieved
		Total	**3,592**	**4,415**	**5,330**	**-**	**13,337**		
Public Health									
PH_1	PH	**Health Checks** - reduction in activity	100				100	Blue	2016/17 Savings target achieved
PH_2	PH	**Sexual Health -** reduction of activity in projects & non contracted activity 16-17.	153				153	Blue	Delivered, budget reduced
PH_3	PH	**Sexual Health -** consolidation of activity within new contract efficiency 17-18		105			105	Purple	Pan London collaborative commissioning has delivered savings, however the current Contraceptive and Sexual Health services block contract is over delivering. This is likely to result in increased cost post reprocurement. This saving was replaced by an alternative on Health visiting contract efficiencies as part of the 2017/18 Budget setting process.
PH_4	PH	**Tobacco Control & Smoking Cessation -** reduction in promotional activities	20				20	Blue	Delivered, budget reduced
PH_5	PH	**Tobacco Control & Smoking Cessation -** reduction of service		279			279	Purple	On target to be delivered following consultation to cease the service.
PH_6	PH	**Physical Activity -** reduction of service	76				76	Blue	2016/17 Savings target achieved
PH_7	PH	**Young Peoples Public Health -** reduction of Schools Programme	100				100	Green	2016/17 Savings target achieved
PH_9	PH	**Health intelligence & Knowledge -** reduction in staff costs		48			48	Blue	On target to be delivered
PH_10	PH	**Staffing & Support -** reduction in budget & deletion of additional procurement support	54	30			84	Blue	2016/17 Savings target achieved

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
PH_11	PH	**Drug and Alcohol** - reduction in service (contract related costs. Employee costs included in PH_12)			1,500		1,500	Purple	Targetted reduction to be considered in consultation with contracted provider
PH_12	PH	**Reduction to service** - staffing reductions	41		795		836	Green	2016/17 Savings target achieved
			544	**462**	**2,295**	**-**	**3,301**		
Community									
CE_1	ESD - Public Protection	**Cessation of subsidy to Metropolitan Police**	158				158	Blue	Achieved. Agreement with Met Police already terminated.
CE_2	Commissioning Services	**Highways Services** - Efficiencies in advance of the retendering of the Highways Contract (restructure Traffic to delete 2 engineer posts). Early approval in July 15 required in order to commence staff consultation and selection process. Part year saving from December 15 onwards.	80				80	Blue	2016/17 Savings target achieved
CE_3	Commissioning Services	**Mortuary Services -** Reduction in costs as a result of Barnet joining the partnership with Brent.	14				14	Blue	2016/17 Savings target achieved
CE_4	Commissioning Services	**Staff efficiencies in Parking and Network Teams -** deletion of Parking Manager post and reduction in team leaders and inspectors. This management saving relates to the deletion of parking manager post. The post has been vacant since April 15 and therefore full year saving can be achieved in 15/16.	75				75	Blue	2016/17 Savings target achieved
CE_5	Directorate Wide	**Reduction of supplies & services budget**	100	50	50		200	Blue	2016/17 Savings target achieved
CE_7	ESD - Waste Services	**Alternative funding for recycling officer post** - post to be commercially funded or deleted.	29				29	Blue	2016/17 Savings target achieved
CE_8	ESD - Technical Services	**Staff efficiency once Towards Excellence fully embedded -** Deletion of 2 posts.		34	34		68	Green	This savings was achieved as part of division-wide restructure taking place during 16/17.
CE_9	ESD - Public Protection	**Efficiencies arising from Selective Licensing -** Through full cost recovery and reduction in failure demand. Net income.	200	35			235	Green	2016/17 Savings target achieved
CE_10.1	ESD - Management	**Management savings** Savings on **team leader posts** across the Environmental Service Delivery division.	86				86	Green	This will be achieved as part of division-wide restructure taking place during 16/17. Commercial activities within the division (e.g. grounds maintenance service under Project Phoenix) will ensure that full saving is met in 16/17.
CE_10.2	ESD - Management	**Management savings** Savings on a **management post** across the Environmental Service Delivery division.		75			75	Green	This will be achieved as part of division-wide restructure taking place during 16/17.
CE_12	Commissioning Services	**Project Phoenix** - Commercialisation projects	115	-	1,525		1,640	Green	2016/17 Savings target achieved

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
CE_13	ESD - Harrow Pride	**Contract savings** Roll out the successful trial of wider parks bins provision and move to a fully in house dog waste collection service.	35				35	Blue	Savings target achieved
CE_14	Commissioning Services	**Highways Services** - revenue savings on utilities and maintenance costs due to acceleration of the Street Lighting replacement programme and extension of the variable lighting regime.	70	10			80	Green	2016/17 Savings target achieved
CE_15	Commissioning Services	**Highways Services -** Reduction in revenue budget for reactive maintenance due to accelerated capital investment from 2014/15.	60	20	20		100	Green	2016/17 Savings target achieved
CE_16	Commissioning Services	**Staff efficiencies in Parking and Network Teams -** reduction in team leader and inspector posts. Staff consultation completed in June 15. The reduction in posts will be phased over the next 2 years to ensure minimal impact on service level.	75	80	20		175	Green	2016/17 Savings target achieved
CE_17	Commissioning Services	**General efficiencies across the Division (Policy, Community Engagement, Facilities Management and Contracts Management)** - including capitalisation of senior contracts officer post, removal of some supplies & services budget	12	9	80		101	Green	16/17 savings achieved by reducing Supplies & Services budget
CE_18	Commissioning Services	**Income Generation** - Facilities Management Service Level Agreements (SLAs) and Energy SLAs to schools	46	20	20		86	Green	2016/17 Savings achived . Additional schools buy-back as part of SLA renewal.
CE_19	Commissioning Services	**Road safety officer post** - externally funded by Transport for London (TfL)		40			40	Purple	To include this salary recharges in the funding bid to TfL on road safety activities.
CE_20	Commissioning Services	**Further contract efficiencies following the re-procurement of Facilities Management contract.**		80			80	Purple	To secure reduced costs through gain share mechanism on commercial opportunities.
CE_21	NIS	**Neighbourhood Investment Scheme (NIS) -** a base budget of £210K is available for all 21 wards. A one-off saving has been offered as part of the early year saving. It is now proposed that the full budget is removed from 16/17 onwards.			210		210	Green	Savings target achieved
CE_22.1	ESD - Environmental Health	**Environmental Health team -** Introduction of Street Trading, Fixed Penalty receipts and other internal efficiencies	210				210	Green	Savings target achieved
CE_22.2	ESD - Environmental Health	**Environmental Health team -** Introduction of Street Trading, Fixed Penalty receipts and other internal efficiencies	30				30	Green	Savings target achieved
E&E_01	Commissioning Services	**Trading Standards** - Further cost reduction in Trading Standards service by re-negotiating the Service Level Agreement with London Borough of Brent. **15/16 MTFS**	40	40			80	Green	2016/17 Savings target achieved
E&E_03	Commissioning Services - Community Engagement	**School Crossing Patrols -** service to be funded directly by schools via Service Level Agreement (SLA). If any school chooses not to enter into a SLA, the service for that school will cease. **15/16 MTFS**	64				64	Blue	SCP service included in the 16/17 School SLA pack. 12 schools have bought into the service.

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
E&E_05	**Commissioning Services - Contract Mgt & Policy**	**Staff Efficiencies across the Division -** Deletion of 3 posts 15/16 MTFS		86			86	**Green**	1 post has been deleted in 15-16 and the deletion of the other 2 posts is a 17/18 saving, for which a plan will be provided.
E&E_06	**Commissioning Services - Facilities Mgt**	**Reduction in Facilities Management costs -** reduce the controllable budget by 20% in the first 2 years through re-structuring and changing ways of service delivery and a further 5% over Years 3 & 4 through additional efficiencies post re-structuring. Consultation with staff already underway and it is proposed to delete 8 posts, 3 of these are currently vacant. **15/16 MTFS**	44	44	22		110	**Green**	2016/17 Savings target achieved
E&E_07	**Commissioning Services - Facilities Mgt**	Introduction of staff car parking charges. **15/16 MTFS**	30	-	-		30	**Green**	Savings target achieved
E&E_08	**Commissioning Services - Highway Services**	**Reduce highways maintenance budget** - Changes to the response times on non urgent works i.e. respond to these in 48 hours instead of existing 24 hours. **15/16 MTFS**	84	45			129	**Green**	This is being achieved through changes in response times and accelerated capital investment which reduces the need for responsive repairs.
E&E_09	**Commissioning Services - Highways**	**Highways Contract** - Extend the scope of the Highways Contract to include scheme design and / or inspection services when the contract is re-procured (current contract will expire in 16/17). **15/16 MTFS**		120	120		240	**Purple**	To be incorporated into contract re-negotiation by securing savings through contract extension. Alternatively, reducing staff.
E&E_10	**Commissioning Services - Highways**	**Review salary capitalisation of highway programme & TfL funded projects. 15/16 MTFS**	100	50	50		200	**Green**	2016-17, however increasing this level of capitalisation will require some planning. Making efficiencies from reviewing the highways contract and outsourcing some design work could reduce staff numbers further and therefore the proportion of staff time working on capital will reduce. The balance between staff reductions and salary capitalisation needs careful consideration.
E&E_11	**Commissioning Services - Network Mgt**	**Additional income** - from street works. 15/16 MTFS	20	10			30	**Green**	16/17 Savings achieved
E&E_12	**Commissioning Services - Street Lighting**	**Changes in Street Lighting Policy to include variable lighting solutions. 15/16 MTFS**	68	10	12		90	**Green**	Additional capital budget agreed to implement CMS dimming solution. Agreed policy for dimming is up to 50%. Currently doing 66%, so further dimming within the parameters is possible thereby generating energy savings.
E&E_13	**Commissioning Services - Street Lighting and Drainage**	**Street lighting and Drainage budgets -** capital investment allows for lower maintenance costs. **15/16 MTFS**	25	40			65	**Green**	2016/17 Savings target achieved

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
E&E_14	Commissioning Services - Winter Gritting	**Reduction in winter gritting budgets** - renegotiation of winter gritting contract - adopt a risk sharing approach and move away from the current fixed pricing for the service. **15/16 MTFS**	20		10		30	Green	2016/17 Savings target achieved
E&E_18	Directorate wide	**Staff Efficiencies following the merger of the Business & Service Development and Commissioning Services Divisions** - Delete one performance management officer post and a cemetery superintendent post as of 31 March 2015. In addition, further efficiencies to be achieved in Environmental Services Delivery and Commissioning Divisions in 17/18. **15/16 MTFS**		30	50		80	Purple	Plan to be developed to ensure that savings in 17/18 and 18/19 will be met.
E&E_20	Directorate-wide	**Contractual/commissioned/SLA savings -** To seek maximum value in savings from existing contracts, Service Level Agreements and all services commissioned, from third parties by re-negotiating terms that will yield cashable savings. To secure on-going cashable benefits from gain share and third party income arrangements. **15/16 MTFS**	200	200			400	Amber	16/17 target is planned to be met from TFM contract subject to the demand on responsive works and commercial agreements with neighbouring boroughs.
E&E_26	Environmental Services - Harrow Pride	**Reduce Parks service to statutory minimum:** Delete parks locking service, naturalise parks (except paid for fine turf), no green flag parks, litter picking reduced to once per week from 1st April 2015. Reduction of 4 Driver posts, 2 Operative posts and 5 Grounds Maintenance Specialist posts One-off vehicle early termination cost (2 tippers) is estimated at £23K. **Parks Management.** Through implementation of the previous savings proposal of reducing parks maintenance standards to the statutory minimum, there can be a further reduction in management and supervisory posts from the existing parks structure of 1 team leader and 2 charge-hands from 1st April 2015. **15/16 MTFS**	23				23	Blue	Saving already achieved during 15/16.
E&E_27	Environmental Services - Harrow Pride	**Highways verge grass cutting, moving from a three weekly to a six weekly cycle.** Reduce quality of service from 1st April 2015. One-off vehicle de-hire cost (1 tipper) is estimated at £11K. **15/16 MTFS**	11				11	Blue	Saving already achieved during 15/16.

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
E&E_34	**Environmental Services -Waste Services**	**Change mixed organic waste collection system with separate collection of food waste and introduce charges for garden waste from 1st October 2015.** **Food Waste** - Each household on 3 wheeled bin system will be provided with a new 23L food waste bin and a kitchen caddy which will be emptied weekly. **Garden Waste** - Garden waste will be collected fortnightly on a chargeable basis. Households that subscribe to the service will receive 25 lifts per year at a price of **£75.** Concessions will be provided to residents on means tested benefits. Introductory offer - £75 to cover the period between 1st oct 15 and 31st Mar 17. **The saving figure assumes 40% of households will take up the chargeable service.** One-off implementation costs are estimated as follows: Revenue costs of approx £430K, and Capital costs for new food waste bins and kitchen caddies (£720K); the construction of a bulking facility for food waste at the depot (£250K). **2015/16 MTFS**	1,711				1,711	**Amber**	Revised service offer, charging regime and actual participation rate suggest a net saving in the region of £1.3m. The difference is being mitigated by a one-off saving on waste disposal costs as part of WLWA levy arrangements for 16/17.
		Sub Total	3,835	1,128	2,223	-	7,186		
CC_1	**Community & Culture**	**Senior Management Restructure** - Deletion of Divisional Director Community & Culture post	137				137	**Blue**	Achieved. Post deleted as part of senior management restructure.
CC_2	**Community & Culture**	**Library Strategy Phase 2 - delivery of** network of libraries and library regeneration	180	108	209		497	**Green**	16/17 saving have been met in part. 17/18 and 18/19 savings - a delay in the timetable for the new Town Centre library means that the full MTFS saving in 2018/19 is currently unlikely to be achieved. Alternative savings / mitigations are being formulated.
CC_3	**Community & Culture**	**Reduction in library and leisure contract management function costs**	40				40	**Blue**	Saving made from a reduction in maintenance budget.
CHW12	**Community & Culture**	Redevelopment Harrow Leisure Centre Site **15/16 MTFS**		100			100	**Purple**	A decision regarding a new leisure centre or refurbishment of the existing leisure centre has yet to be made. Saving in 17/18 to be mitigated by the importation of environmentally approved soil to Bannister Sports Centre. Saving in 18/19 may be mitigated by a further one-off income from the importation of environmentally approved soil to other sites in Harrow (subject to viability studies).

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
CC_4	**Community & Culture**	**Arts & Heritage -** delivery of business plan (reallocation of savings based on Cabinet report May 2015)	(342)	282			(60)	**Red**	The service was originally planned to be transferred to Cultura on 1st April 16, but is no longer taking place. The saving has been reversed as part of the 2017/18 Budget Setting Process.
CHW15	**Community & Culture**	Reduce council subsidy to the Harrow Arts Centre & Museum, whilst developing business plan to eliminate subsidy in the longer term. In 2015/16 saving achieved by additional income and staff re-structure in 2014/15 (resulting in 2 redundancies) . **15/16 MTFS**	515				515	**Red**	The service was originally planned to be transferred to Cultura on 1st April 16, but is no longer taking place. The saving has been reversed as part of the 2017/18 Budget Setting Process.
		Sub Total Cultural Services	530	490	209	-	1,229		
CH_1	**HGF**	**Salaries recharges to HRA and capital** - increase proportion of salaries charged to HRA and capital projects to reflect current working arrangements	163				163	**Green**	Savings target achieved
CH_2	**HGF**	**Supporting People** - savings assumed to result from contract renegotiation or possible cessation of support in later years	68				68	**Green**	Savings target achieved
CH_3	**HGF**	**Supporting People** - cessation of funding for Handyperson Scheme, which is intended to become self-supporting through commercialisation	10	25			35	**Green**	2016/17 Savings target achieved
CH_4	**HGF**	**Supporting People - Sheltered Housing floating support** - savings assumed to result from contract renegotiation or review of service delivery		60			60	**Green**	2016/17 Savings target achieved
CH_5	**HGF**	**Miscellaneous minor budgets -** minor budget savings	10				10	**Blue**	Savings target achieved
CH_7	**HGF**	**Watkins House -** Options review	(25)	100	100		175	**Red**	It is not clear whether this is now deliverable in the light of the additional short term cost of managing the scheme to achieve compliance. Future costs of care provision are being assessed. This saving has been reversed as part of the 2017/18 Budget setting process.
CH_8	**HGF**	**Private lettings agency -** projected income from establishing a lettings agency		130	174	120	424	**Purple**	The Private Lettings Agengy has now been established and has commenced operation. It is still developing as a business, and there is a possibility that the savings may not be entirely delivered due to combination of delay in becoming operational and increased costs from those originally assumed. This saving has been reversed as part of the 2017/18 Budget setting process.

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
CH_9	HGF	**Property purchase initiative -** net benefit to Council of proposals to purchase 100 homes, per Cabinet report appendix. Homelessness savings are part of the equation.	230	31	(2)	42	301	Green	2016/17 Savings target achieved
CH_10	HGF	**Home Improvement Agency -** savings arising from a combination of reducing the service and increasing the charge to the HRA in respect of the Occupational Therapist service	(10)	130			120	Green	2016/17 Savings target achieved
CH_11	HGF	**Salary recharges to HRA -** management charge in respect of HRA property used as Temporary Accommodation - cost to HRA covered by property service charges. Charge will cease when HRA property ceases to be used as TA, and savings will be required to replace this item at that point.	104				104	Green	Savings target achieved
CHW18	HGF	CHW Management savings -1 fte in Housing 2016/17, **15/16 MTFS**	59				59	Red	Expected to be achieved by alternative route; replaced by recharge of 25% Corporate Director Community's salary to HRA, and increasing the proportion of Director of Housing's salary charged to the HRA from 70% to 80% to reflect current patterns of work.
Housing subtotal			609	476	272	162	1,519		
Community subtotal			**4,974**	**2,094**	**2,704**	**162**	**9,934**		
Regeneration									
REG_1	Regeneration and Planning	**Increase in planning income -** more planning applications are anticipated in coming years following the successful Housing Zone bid and the implementation of regeneration strategy.	50				50	Green	Savings target achieved
REG_3	Regeneration and Planning	**Additional income from Development Management and Building Control services** - develop and provide party wall agreement and plan drawing service.	30				30	Amber	Details of new service offers are being drawn up. There may be a delay of implementing this due to resource constraints, however this will be mitigated by additional building control income anticipated following the review of current fees & charges.
REG_4	Regeneration and Planning	**Reduction of supplies & services budget in Planning Division**	10				10	Blue	Achieved.
REG_6	Economic Development	**Commercialisation of work space, subject to agreement with St Edwards** (income net of running costs)		50			50	Purple	This saving is not achievable as the opportunity to acquire Stanmore Place no longer exists.This saving has been reversed as part of the 2017/18 Budget setting process.

MTFS Tracker Savings Tracker

Unique Reference No.	Specific Service Area	Description	2016/17	2017/18	2018/19	2019/20	Total	RAG Rating	Comment
			£000	£000	£000	£000	£000		
E&E_36	**Planning - Development Mgt**	**Planning Fees**: following an increase in 2013, the government may increase the statutory planning fees at some point over the next four years. **2015/16 MTFS.**		100			100	**Amber**	DCLG undertook a public consultation recently to seek views on the proposed approach to implementing the planning provisions in the Housing and Planning Bill, and this covered the area of changes to planning application fees. Responses are awaited. It is currently uncertain if there will be a national increase in fees, and if so, when this will be implemented.
			90	**150**	**-**	**-**	**240**		
Pan Organisation									
PO 01	**Pan Organisation**	**Using the Market -** A package of saving proposals around total facilities management, supplier negotiations, revenue generation and consultancy have been identified which will provide better VFM to residents and reduce costs to the Council. **2015/16 MTFS**	220				220	**Amber**	A number of projects are in the pipeline to deliver this saving but at this stage it is felt that some may slip into 2017/18 and therefore will not all be delivered for 2016/17.
PO 03	**Pan Organisation**	**Regeneration -** Indicative net income realised from a long term regeneration strategy for the borough, to be formalised following consultation launched in early 2015. **2015/16 MTFS**	-	350	2,000		2,350	**Purple**	Future Year saving, still in development
PO 04	**Pan Organisation**	Additional Commercialisation savings from projects in the pipeline		1,100			1,100	**Purple**	Future Year saving, still in development. Reversed as part of the 2017/18 Budget Setting Process.
Total savings			**220**	**1,450**	**2,000**	**-**	**3,670**		
Total Savings			**17,553**	**11,628**	**18,381**	**312**	**47,874**		

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
	£000	£000	£000	£000	£000	£000	£000	£000	
Resources									
BTP - Public Realms	0	1,373	0	**1,373**	734	-639	639	0	
Capital cost of transition and transformation of ICT service	1,500	2,206	100	**3,806**	1,801	-2,005	2,005	0	A number of projects included in the transformation programme - Middleware Replacement, Enterprise Portfolio Assessment and Microsoft Exchange Upgrade - have been delayed resulting in related capital payments moving into subsequent financial year(s). ~£1m is already committed. Balance is needed to fund remaining contractual transformation projects with Sopra Steria. The transformation programme will result in the Authority's ICT being brought under manufacturers' support. This is required for PSN and PCI compliance. The impact on the community/organisation is low.
ITO Transformation	0	370	-175	**195**	77	-118	118	0	This programme is used to fund activities delivered under the Web Services Upgrade programme - remaining funds are transferred to that programme as needed. It is a controlling mechanism to ensure the web services upgrade does not overspend. Balance will be needed to fund web services upgrade work already identified and carried forward into 2017/18. There will be no impact of the above on community/organisation
My Harrow Services Account Dev Prog	0	8	0	**8**	2	-6	6	0	Due to a change in the requirements from the business, the requirements for this piece of work were changed. This has not created any change in costs, but has meant that delivery of the project has slipped back by 3 months
IT Improvement Project	0	200	-200	**0**	0	0	0	0	

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Web Upgrade Project	0	0	91	**91**	66	-25	25	0	This programme is used to fund development work on the Authority's inward and outward facing web services (such as Intranet, Internet Payment System and Jadu upgrades). Funds were transferred from the ITO Transformation programme to cover this upgrade activity but due to delays with delivery some of these transferred funds were not used. £4.5k is already committed. The balance will be used on web service upgrades in the pipeline. Web services upgrades are required to support MyHarrow and other outward facing services
SAP: Financial Leger/Systems Control Imp	270	172	0	**442**	6	-436	436	0	Why the project has slipped: Projects put on pause due to performance issues with SAP server. No CR progressed until performance issues were resolved Over/ underspend after slippages: £0, the projects have been rephased and pending approval at a strategic level for upgrade of SAP The impact of the above on community/organisation: The delays due to performance issues and approvals means issues experienced by users will not be resolved and efficiencies not delivered
BTP - Mobile & Flex	0	1,068	0	**1,068**	347	-721	721	0	This programme is used to fund the Authority's transformation towards mobile and flexible working. The majority of work has been focused on SharePoint. Developments in this area have been delayed following Capita's exit in 2015 and a series of requests to Sopra Steria which have been hit design and technical problems. These requests are being conslidated into a strategic improvement plan for the SharePoint infrastructure which will need funding in 2017/18. None. Any balance will contribute towards the necessary upgrade. No impact on the community, but organisational flexibility including full facilitation of mobile and flexible working are at risk.

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
ICT Infrastructure & Corporate Applications	0	55	35	**90**	4	-86	86	0	The funds for this project are for the implementation of Policy and Compliance software - MetaCompliance. This project was delayed while the evaluation and selection of a software took place and the project costs were agreed with Sopra Steria. The project commenced towards the end of 2016/17 and so the remaining funds are needed to complete the project, which is now in delivery. The balance to be used on essential pipeline projects including Gandlake and Bartec. No impact on the community. The project will ensure and assure the Authority is compliant with its regulatory and legislative requirements specific to directorates and wrt Information Security & Governance (ultimately avoiding heavy fines for non-compliance)
IT Corporate System Refresh	0	829	0	**828**	78	-750	750	0	The funds for this programme are put aside for the upgrade of SAP CRM and the Customer Contact Portal. These have been the subject of protracted discussions with Sopra Steria around the scope and commercials of the upgrade solutions. These were agreed late in 2016/17 and work is now due to start in 2017/18. The balance to be used on essential pipeline projects including Gandlake and Bartec. Minimum impact on the community, though some improvements in customer contact might result. Organisational change will focus on the ability of the Contact Centre staff to respond efficiently to resident's queries at first point of contact.
LAA Performance Reward Grant	0	124	0	**124**	35	-89	89	0	
BTP - Hardware Refresh	0	35	-35	**0**	0	0	0	0	
Loan Payment - Capital	915	2,159	0	**3,074**	2,848	-226	226	0	

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Ongoing refresh & enhancement of ICT	2,000	1,196	-698	**2,498**	542	-1,956	1,956	0	projects to refresh the ICT infrastructure which were not included in the contracted programme of IT transformation projects with Sopra Steria. Due to significant issues coping with the volume of work and pipeline of requests, Sopra Steria were unable to define solutions and cost projects for delivery within the 2015/16 and 2016/17 financial years. Headway has now been made and the pipeline of work is now beginning to filter into deliverable projects - major initiatives being the replacement of Gandlake and upgrade of Bartec. ~£850k has been committed. The balance to be used on essential pipeline projects including Gandlake and Bartec. Impact on community will be minimal though the necessary replacement of the Gandlake system will enable environment services to continue to offer IT enabled services to residents. The organisation will benefit from reliability and performanc
Small Schemes (Council wide)	0	49	-49	**0**	0	0	0	0	
FM Minor Work	0	500	0	**500**	0	-500	500	0	
IER Grant	0	0	0	**0**	-12	-12	12	0	
My Harrow Service Account	740	0	0	**740**	271	-469	469	0	This budget covers the delivery of authority wide IT solutions. A variety of facotors has resulted in the delivery of these projects being pushed back into 2017/18. These have included the nesesity to upgrade further IT systems, extended periods of the discovery phase of some projects due to complications of business requirements and competing priorities within the organisation. The moving of the delivery date to next financial year will not cause any additional capital costs
Property Investment	15,000	0	0	**15,000**	5,401	-9,599	9,599	0	The balance of this budget will be slipped to 2017/18 whilst the search for adequate investment opportunities continues

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
HR Shared Service	100	0	0	**100**	0	-100	100	0	The Shared Service phase 2 went live in April 2017. IT development was planned prior to April and therefore the spend was forecasted for last year. The IT work had external dependencies such as fibre optic telephone line, Buckinghamshire development work which has been timetabled and is on track but will now be delivered in 2017-18 and therefore the slippage. This has had no impact on the community as it was an internal HR Service and the also no impact on the organisation as we had a plan B in place for this and that plan has been implemented and work and service has continued as normal.
			0						
Resources Total	**20,525**	**10,344**	**-931**	**29,937**	**12,200**	**-17,737**	**17,737**	**0**	
Regeneration Programme									
Harrow Card	0	26	0	**26**	24	-2	0	-2	
Station Road Highway and Environmental Improvements	0	514	-378	**136**	134	-2	0	-2	
Artisan Studios	0	0	660	**660**	551	-109	109	0	This is a 2 year project funded from London Regeneration Fund. Fit-out works will be completed in early 2017/18 to utilise the remaining GLA funding.
Trinity Square	0	0	850	**850**	87	-763	763	0	Regeneration Fund. The unspent fund will be utilised for design and to complete the project in 17/18.
Regeneration Programme	19,058	2,724	-2,028	**19,754**	9,660	-10,094	9,641	-453	Slippage due to unavoidable delays, relating to land assembly, commercial finance review, planning outcomes and unpredictable approval delays to procurement processes. Expected to result in deferral of financing costs and possible delays to completion. Programme is being reviewed in light of refined delivery approach, which will assist accurate forecasting this financial year.
Regeneration Total	**19,058**	**3,264**	**-896**	**21,426**	**10,456**	**-10,970**	**10,513**	**-457**	
Community									

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Carbon Reduction Programme 2015/16	300	0	0	**300**	124	-176	176	0	Some of the Corporate Accommodation work delivers energy efficiency and it is proposed that the slippage for both Carbon Reduction and Corporate Accommodation projects be considered together.
Corporate Accommodation Maintenance	231	0	0	**231**	636	405	-405	0	Additional spend due to increase in refurbishment work to deliver office relocation into Civic Centre as well as other capital work to meet statutory requirements. Some of the spend related to work that delivers energy efficiency and can be met from Carbon Reduction budget above.
High Priority Plan Maintenance Corporate Property	575	0	0	**575**	657	82	-82	0	Additional spend on building works that require urgent repairs.
Car Park Infrastructure	20	0	52	**72**	68	-4	4	0	
City Farm/Pinner Park Farm	0	514	-414	**100**	9	-91	91	0	Delay in completing procurement process in 16/17 means that the works will now be delivered in early 17/18.
Harrow On Hill Station	2,000	0	-2,000	**0**	0	0	0	0	
Highway Drainage Improvements & Flood Defence Infrastructure	500	0	0	**500**	504	4	-4	0	
Highway Improvement Programme	4,750	-471	3,703	**7,982**	8,095	113	-113	0	The highway programme was accelerated to complete some road schemes by taking advantage of dry weather in March.
Parking Management Programme	300	0	0	**300**	294	-6	6	0	
Public Realm Services – Parks, Open Spaces & Cemeteries	0	0	0	**0**	28	28	-28	0	This is part of Park Infrastructure project (see below).
Public realm Services – Waste and Recycling	200	16	0	**216**	269	53	-53	0	Additional spend due to demand for new bins from developers as well as the replacement of old / borken bins.
Section 106 Schemes	0	105	50	**155**	148	-7	7	0	
Street Lighting Improvement Programme	3,000	-83	1,100	**4,017**	3,930	-87	87	0	Small underspend to be carried forward to complete the on-going lighting replacement programme.
TfL Principal Roads	923	0	0	**923**	923	0	0	0	
TfL Transport Capital	1,088	191	219	**1,498**	1,548	50	-50	0	The overspend will be met from 17/18 LIP allocation.
Trade Waste	400	0	0	**400**	101	-299	299	0	The purchase of refurbished bins help reduce the costs in 16/17. Increasing number of trade waste customers means that the capital budget needs to be carried forward to meet the demand.

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Harrow Green Grid	293	128	100	**521**	461	-60	60	0	Delay in completing the projects due to a sub-contractor being withdrawn from the highway work contract. Alternative supplier will need to be identified to complete the work. The delivery of the Newton Park project had to be put back due to the delay in the confirmation of EA funding for a larger project at the same site which would compliment the green grid work and drainage infrastructure improvement.
CCTV cameras and equipment at the depot	150	0	0	**150**	313	163	-163	0	Additional spend on CCTV cameras to address flytipping and parking issues. In addition, a number of tools and equipment were replaced / newly purchased for the depot.
Park Infastructue	675	0	611	**1,286**	1,413	127	-127	0	Additional spend on parks infrastructure to secure a competitive price from contractors, achieving best value for the capital work undertaken.
Parks Litter Bins	65	0	-52	**13**	11	-2	2	0	
Green Gym	50	0	0	**50**	50	0	0	0	
Enviroment Total	**15,520**	**400**	**3,369**	**19,289**	**19,586**	**297**	**-297**	**0**	
Housing									
Disabled Facilities Grants	1,500	31	0	**1,531**	1,619	88	**0**	88	Overspend caused by higher than expected recharges from Adult Services.
Empty Property Grant	400	391	0	**791**	334	-457	**307**	-150	Underspend £457k of which £307k requested for carry fwd Slippage caused by less landlords expressing an interest in available grants and the requirement to provide nomination rights for temporary accommodation
Funding	0	0	0	**0**	0	0	**0**	0	
Improvement grant	70	60	0	**130**	7	-123	**128**	5	See below, Renovation grants.
Housing Property Purchase	15,000	6,307	0	**21,307**	14,794	-6,513	**3,513**	-3,000	Slippage of £6.5m required to fund purchase of remaining 42 properties of Council's Property Acquisition Prgramme which will make 100 properties available for use as temporary accommodation to alleviate Homelessness pressures on General Fund or for use in private rented sector. Slippage caused by slower than anticipated start in acquisition of suitable properties in target areas but terms now agreed on the remaining properties.

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Renovation Grants	0	25	0	**25**	8	-17	**0**	-17	Discretionary grants to carry out disabled adaptations on private homes, related to improvement grants (above).
Total Housing	**16,970**	**6,814**	**0**	**23,784**	**16,762**	**-7,022**	**3,948**	**-3,074**	
Culture									
Sec 106 Banister Sport Pitch	0	1,004	-954	**50**	10	-40	40	0	Options are being explored on how best to utilise the S106 funding to achieve best value.
Harrow Arts Centre	1,000	0	0	**1,000**	0	-1,000	0	-1,000	This relates to a capital grant to Cultura but is no longer required as a result of the non transfer of the arts & heritage service.
Headstone Manor	5,190	0	-2,438	**2,752**	1,742	-1,010	1,010	0	This project is largely funded from HLF over a number of years. There is a delay in the installation of the heating system to Manor House as a result of poor performance of the sub-contractor, and archaeological discoveries beside the Small Barn and to the Northwest of the Manor House.
Leisure Centre Capital Infrastructure	300	220	0	**520**	375	-145	136	-9	Project completion delayed due to the need for listed building consent for Kenton Library.
Culture Total	**6,490**	**1,224**	**-3,392**	**4,322**	**2,127**	**-2,195**	**1,186**	**-1,009**	
Community and Culture Total	**38,980**	**8,438**	**-23**	**47,395**	**38,475**	**-8,920**	**4,837**	**-4,083**	
People									
Adults Social Care-Framework-I & IT Integration	0	130	-130	**0**	0	0	0	0	Budget given up as part of savings against Adults capital programme
MOSAIC Implementation - Adults & Children's Services	0	605	0	**605**	333	-272	272	0	MOSAIC project is still ongoing - Project delayed by Sopra Steria capacity issues - carry forward to fund go live.
Adults Personal Social Services - Community Capacity Grant	0	157	0	**157**	0	-157	0	-157	2015-16 carry forward ultimately not required
Capital Strategic Reviews	0	508	-108	**400**	116	-284	284	0	Delays with planning and contractor procurement has delayed the project so the remaining budget will be spent in 17/18
Quality Outcome for People With Dementia	0	150	-150	**0**	0	0	0	0	Budget given up as part of savings against Adults capital programme

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Reform Of Social Care Funding	0	800	-800	**0**	40	40	0	40	Budget given up as part of savings against Adults capital programme. £40k overspend relates to a commitment that had been overlooked when budget had been reduced to zero.
Market Shaping And Development	0	250	-250	**0**	0	0	0	0	Budget given up as part of savings against Adults capital programme
Integrated Health Model	0	422	-322	**100**	15	-85	85	0	Other capital projects have taken priority this year (MOSAIC) but there is still a requirement to have 95% NHS Numbers so work will carry on into 17/18
Maintenance of Adults Properties	0	149	0	**149**	0	-149	149	0	This work had been hoped to be part of reconfiguation of Adult day centre properties before end of year but has been delayed.
Safeguarding Quality Assurance Quadrants (QAQ)	0	168	-118	**50**	0	-50	0	-50	Budget given up as part of savings against Adults capital programme, remaining £50k budget was no longer required.
Project Infinity	1,650	0	-400	**1,250**	110	-1,140	0	-1,140	Spend of £110k relates to IT project work salaries on the infinity project, no further spend has taken place on the project for this year. As there are adequate budgets in place for future years, no carry forward is required and this has resulted in the £1m underspend as shown.
In-House Residential	100	0	0	**100**	0	-100	100	0	Original plans for improvements against in house residential properties did not take place, reviews are to take place as to requirements for 2017/18 and budget has been slipped.
Adults	**1,750**	**3,339**	**-2,278**	**2,811**	**614**	**-2,197**	**890**	**-1,307**	
Schools Expansion Programme - Phase 1	0	186	60	**246**	80	-166	219	53	Slippage relates to work is being undertaken with Legal Services to support the process of closing the programme with contractor. No impact on school provision. Buildings handed over and schools operational

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Schools Expansion Programme - Phase 2	0	1,840	2,239	**4,079**	1,150	-2,929	2,929	0	Slippage relates to work is being undertaken with Legal Services to support the process of closing the programme with contractor. No impact on school provision. Buildings handed over and schools operational
Schools Expansion Programme Phase 3	9,555	9,017	186	**18,758**	12,268	-6,490	6,490	0	Slippage relates to Stag Lane and Welldon Park Junior Schools which are part of phase 3 of the expansion programme for which the majority of the work will be undertaken in 2017-18. There is minimal impact to the schools as a result of these delays since the expanded year group at Welldon Park is still working its way through the infants (which is on a separate site and whose building works were completed for September 2016). There will be sufficient capacity in the junior school until building works are completed for September 2017. In relation to Stag Lane the school expanded its pupil numbers from September 2016 and there will also be sufficient capacity within the school to accommodate the increased numbers until the building works are completed for September 2017.
Schools Expansion Programme - Phase 4	0	420	0	**420**	92	-328	0	-328	This funding has been transferred to the secondary budget
SEN Provision	4,200	459	502	**5,161**	662	-4,499	4,505	6	The specification for SEN provision is still being scoped and the LA is working closely with the existing special schools and the EFA to look at possible free school and the outcome of this will determine the need for SEN provision in the borough
Secondary Expansions	525	728	969	**2,222**	533	-1,689	2,017	328	The position with the school projections reported to Cabinet in July 2016, indicate that the demand for secondary school places is lower than previously expected and there will be a shortfall at a later stage than anticipated, from 2022. It is therefore proposed to slip Secondary provision funding into 2017-18.
School Amalgamation	0	733	200	**933**	333	-600	600	0	Rolling programme - needs to be slipped to fund maintenance in future years
Bulge Classes	150	209	-150	**209**	71	-138	138	0	Rolling programme - needs to be slipped to fund bulge classes in future years
Free School Meals	0	6	0	**6**	0	-6	6	0	This funding is committed in 2017-18.

Appendix 3 Capital monitoring

Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
Hatch End MUGA	0	0	0	**0**	0	0	0	0	
Schools Capital Maintenance	1,350	1,012	-78	**2,284**	293	-1,991	1,932	-59	Rolling programme - needs to be slipped to fund maintenance in future years
Devolved Formula Non VA Schools	390	504	0	**894**	841	-53	53	0	Funding to be passported directly to schools in 2017-18
IT Development	0	799	0	**799**	56	-743	743	0	This funding relates to the tools for the trade for social workers
Whitmore School	0	35	0	**35**	24	-11	11	0	Slippage relates to work is being undertaken with Legal Services to support the process of closing the programme with contractor. No impact on school provision. Buildings handed over and schools operational
Total School and Children	**16,170**	**15,948**	**3,928**	**36,046**	**16,403**	**-19,643**	**19,643**	**0**	
PeopleTotal	**17,920**	**19,287**	**1,650**	**38,857**	**17,017**	**-21,840**	**20,533**	**-1,307**	
Cross Cutting Investment in Infrastructure	**5,000**	**0**	**-5,000**	**0**	**0**	0	0	**0**	
Total General Fund	**101,483**	**41,333**	**-5,200**	**137,615**	**78,148**	**-59,467**	**53,620**	**-5,847**	
HRA									
Housing Programme	22,285	2,547	-13,873	**10,959**	6,705	-4,254	3,254	-1,000	Slippage is due to reprofiling of external and internal works on Councils housing stock, underspend of £1m contributes to the savings required in HRA as a result of ongoing reforms required by Government. Slippage will not impact on residents as works are delivered as part of a planned investment programme aimed at acheiving tenant and leaseholder satisfaction.
Housing Programme - S106	1,495	0	-1,495	**0**	0	0	0	0	
Housing Programme - S20	70	0	-70	**0**	0	0	0	0	
Grange Farm Redevelopment	0	5,554	4,616	**10,170**	2,928	-7,242	7,150	-92	Slippage due to planning delays following a statutory objection to the planning application from the MOD which the Council is addressing, and will result in deferral of delivery date. Impact on tenants and leaseholders is being mitigated by regular communications and consultation events
HRA Affordable Housing	1,700	8,584	-1,590	**8,694**	1,971	-6,723	6,815	92	Slippage as result of planning and procurement issues resulting in delays in delivery of new build dwellings for use as social housing for eligible persons / families.

Appendix 3 Capital monitoring

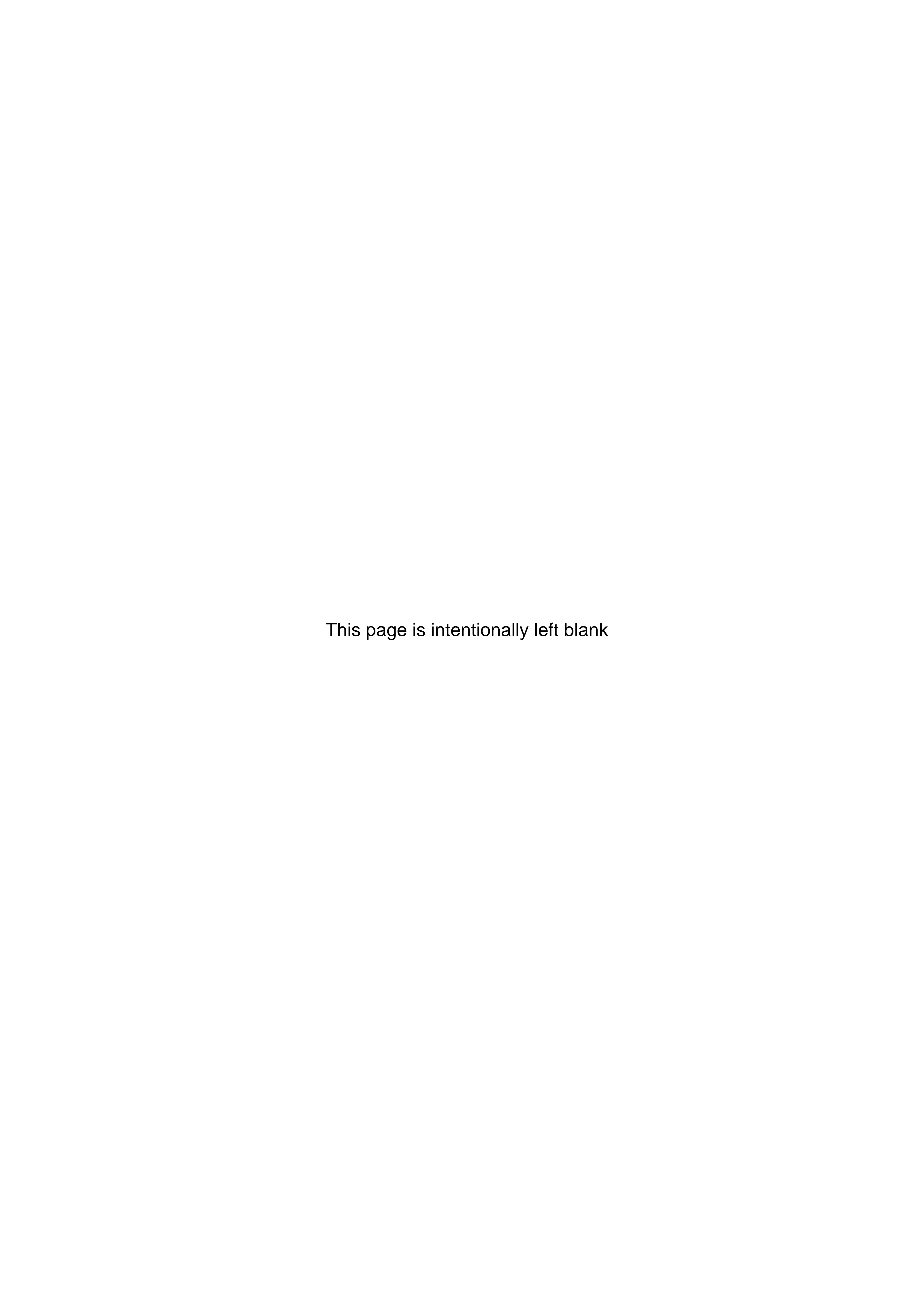
Capital Programme Outturn 2016-17

	Original Budget	Carry Forward	Changes in Q1-Q4	Revised Budget	Outturn	Variance	Slippage to 2017-18	Over / Underspend	Reason for Variance
TOTAL HRA	**25,550**	**16,685**	**-12,412**	**29,823**	**11,604**	**-18,219**	**17,219**	**-1,000**	HRA Capital expenditure financed entirely from HRA resources, therefore slippage had no impact on General Fund financial resources.
Total Council Capital Programme	**127,033**	**58,018**	**-17,612**	**167,438**	**89,752**	**-77,686**	**70,839**	**-6,847**	

Movement in Reserves 2016/17

Appendix 4

	Balance b/f 1.4.16 £	Drawndown £	Contribution £	Balance c/f 31.3.17 £
Revenue grant reserve	-1,304,511	902,649	-506,770	-908,632
Projects in progress (c/fwds)	-1,793,000	1,793,000	-2,336,000	-2,336,000
Business Risk	-2,109,000			-2,109,000
MTFS Implementation cost	-875,054	1,286,349	-3,268,000	-2,856,705
TPIF	-3,188,928	654,519		-2,534,409
Public Health (cfwd)	-898,195		-225,000	-1,123,195
CIL Harrow	-727,569		-5,405,000	-6,132,569
CIL Mayor	-39,396		-116,000	-155,396
POCA	-285,000			-285,000
Libraries	-250,000			-250,000
Legal expansion reserve	-351,639	0	-67,000	-418,639
Children's Social Care Reserve	-218,865	218,865		0
Insurance reserve	-500,000			-500,000
Borough Elections	-105,930		-105,930	-211,860
Harvist reserve Harrow Share	-19,495			-19,495
NW London Education Business Partnership	0			0
Personal Injury Reserve	-110,147			-110,147
Standing up for those in need	-800,000			-800,000
Rapid response	-75,000			-75,000
IT reserve	-1,854,000	1,176,000		-678,000
Compensatory Added Years	-642,782	80,000		-562,782
PFI Schools Sinking Fund	-2,790,490	277,520		-2,512,970
PFI NRC Sinking Fund	-1,290,065		-123,970	-1,414,035
HSIP	-1,153,324	1,141,000		-12,324
Commercialisation Reserve	-520,620	116,000		-404,620
Welfare Reform Reserve	-1,000,000	1,000,000		0
Budget Planning Reserve	0		-2,000,000	-2,000,000
Total	-22,903,011	8,645,902	-14,153,670	-28,410,779



This page is intentionally left blank

Capital Receipts Flexibility Strategy Appendix 5

Directorate	Description of expenditure	Savings Reference in MTFS	Cost
			£000
Community			
	Project management and review of processes	E&E 18,CE 8, CE10.1 &.2	123
		E & E 18 - staff efficiencies following the merger of the Business and Service development and commissioning services divisions	
		CE 8 - Staff efficiencies in Directorate	
		CE10.1 and CE10.2 - Staff Management savings	
	Business Commercialisation Team and Marketing cost	CE12 - Project Pheonix commercialisation projects and COM S01 - Commercial projects under project Phoenix	325
	Redundancy	CE10.2 - Staff management savings	54
	Redundancy	CH_10 - Home Improvement Agency	11
		Total	**513**

Directorate	Description of expenditure	Savings Reference in MTFS	Cost
Regeneration			
	Regen - Staff and admin	PO03 Regeneration - indicative net income to be realised from a long term Regeneration Strategy for the Borough.	564
	Parking loss of Income	PO03 Regeneration - indicative net income to be realised from a long term Regeneration Strategy for the Borough.	90
	Data Centre cost	PO03 Regeneration - indicative net income to be realised from a long term Regeneration Strategy for the Borough.	82
		Total	**736**

Resources

	Redundancy Costs	RES HR 01 - shared HR service with Bucks	97
	Redundancy Costs	RES HR 03 - review of Organisational Development	62
	Redundancy Costs	RES 23	59
	Redundancy Costs	BSS 01 Review of Business Support	46
			264

Adults

	Redundancy	PC 31 -Children with Disabilities Efficiences as service seeks to merge with adults	39
	Redundancy	PA 05 New Bentley Community Tender	61
	Redundancy	PA 12- Southdown - review service through shared lives	63
	Project management for project Infinity	PA 29B - Total Community ePurse-commercialisation opportunities	152
	Project management for project Infinity	PA 29B - Total Community ePurse-commercialisation opportunities	95
		Total	410

Children's

	Redundancy	PC13 Early Intervention and Youth Development	375
	Redundancy	PC24 - Enhancing acheivement within Education Strategy	49
	Project management costs	PC13 Early Intervention and Youth Development	30
			454
		Total	**2377**

Housing Revenue Account (HRA)

Provisional results for the HRA indicate a surplus of £157k against a budgeted surplus of £144k. This includes higher than expected repairs costs due mainly to unforeseen repairs expenditure required to meet legislative requirements and discharge mandatory health & safety obligations, costs of compulsory upgrade of IT systems, and unbudgeted Depot bin hire recharges, offset by underspends in operating expenditure and reduced contributions to the bad debt provision. The outturn also includes reduced depreciation charges which result in only a transfer of resources to the Major Repairs Reserve which is used to finance capital expenditure.

A summary of the HRA position is provided below which includes estimated balances.

HRA revenue balances £'000	**Outturn 2015-16**	**Revised Budget**	**Outturn**	**Variance**
Balance b/fwd	-4,584	-5,296	-6,736	-1,440
Net (surplus) deficit	-2,152	-144	-157	-13
Balance c/fwd	-6,736	-5,440	-6,893	-1,453

Housing Revenue Account (£'000s) 2016-17	Outturn 2015-16	Original budget	Revised Budget	Outturn	Variance	Variance	Reason for variation
Operating Expenditure : Employee costs, Estates & sheltered, Utilities & other	6,346	7,058	7,219	6,304	-915	-13%	Includes recharges to achieve General Fund MTFS savings together with £145k recharges from depot for bin hire not included in budget off set by unbudgetted grant income for regeneration programme and capacities on utilities.
Repairs Expenditure : Response, void, cyclical, other	7,263	7,108	7,108	8,418	1,310	18%	Increased void costs including units becoming vacant as a result of regen programme, used as temporary accommodation, cyclical & preventative maintenance for compliance with applicable legislation.
Other Expenditure : Impairment allowance, Grants to Move, Affordable Housing, Other expenditure	272	1,220	1,065	633	-432	-41%	Capacities on Investment in Services, Bad Debt provision and Grants to Move together with increased proportion of costs for regeneration qualifying as capital
Income : Dwelling rents, Leasehold charges	-32,071	-32,224	-32,234	-32,280	-46	0%	Lower dwellings rents due to suspension of property acquisition programme offset by additional income from non-secure service charges levied on dwellings used as temporary accommodation to alleviate pressures on General Fund.
Controllable	**-18,190**	**-16,838**	**-16,841**	**-16,924**	**-83**	**0%**	
Non controllable (SSC, depreciation, financing costs)	9,773	16,548	16,598	16,365	-233	-1%	Lower interest payable due to deferral of additional borrowing for Infill programme
Transfer to earmarked reserves	6,265	100	100	403	303	303%	Transfer unused grants for Grange Farm to reserves
Net (surplus) deficit	**-2,152**	**-190**	**-144**	**-157**	**-13**	**9%**	
Balance b/fwd	**-4,584**	**-5,296**	**-5,296**	**-6,736**	**-6,736**		
Balance c/fwd	**-6,736**	**-5,486**	**-5,440**	**-6,893**	**-6,749**		