Health and Wellbeing Board

AGENDA

DATE: **Thursday 7 March 2019**

TIME: **12.00 pm**

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

MEMBERSHIP (Quorum 5)

Chair: **Councillor Graham Henson**

Board Members:

Councillor Ghazanfar Ali	**Harrow Council**
Councillor Simon Brown	**Harrow Council**
Councillor Janet Mote	**Harrow Council**
Marie Pate	**Healthwatch Harrow**
Councillor Christine Robson	**Harrow Council**
Javina Sehgal	**Managing Director, Harrow Clinical Commissioning Group**
Dr Muhammad Shahzad	**Harrow Clinical Commissioning Group**
Dr Genevieve Small	**Chair, Harrow Clinical Commissioning Group**
1 Vacancy	**Harrow Clinical Commissioning Group**

Reserve Members

Councillor Dean Gilligan	Harrow Council
Councillor Maxine Henson	Harrow Council
Councillor Dr Lesline Lewinson	Harrow Council
Councillor Krishna Suresh	Harrow Council
Dr Himagauri Kelshiker	Harrow Clinical Commissioning Group
1 vacancy	Harrow Clinical Commissioning Group

Non Voting Members:

Varsha Dodhia, Representative of the Voluntary and Community Sector
Carole Furlong, Director of Public Health, Harrow Council
Paul Hewitt, Interim Corporate Director - People, Harrow Council
Chris Miller, Chair, Harrow Safeguarding Children Board
Vacancy, NW London NHS England
Simon Rose, Borough Commander, Harrow & Brent Police
Vacancy, Harrow Clinical Commissioning Group
Visva Sathasivam, Interim Director Adult Social Services, Harrow Council

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

Harrow COUNCIL LONDON

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 27 February 2019

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

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

Reserve Members may attend meetings:-

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

2. DECLARATIONS OF INTEREST

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

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

3. MINUTES (Pages 5 - 14)

That the minutes of the meeting held on 10 January 2019 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS *

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

Questions will be asked in the order in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, Monday 4 March 2019. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. PETITIONS

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

6. DEPUTATIONS

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

7. INFORMATION REPORT - LEARNING DISABILITY INTEGRATED SERVICES (Pages 15 - 48)

Report of the Interim Director of Adult Social Services, Harrow Council, Interim Associate Director of Contracts, Harrow Clinical Commissioning Group and Jameson Divisional Director, CNWL.

8. INFORMATION REPORT - DISABLED FACILITIES GRANT (To Follow)

Report of the Corporate Director Community and Interim Corporate Director People

9. SOCIAL PRESCRIBING - UPDATE

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

10. FUTURE KEY PRIORITIES FOR HEALTH AND WELLBEING BOARD

Verbal discussion led by Interim Corporate Director People, Harrow Council, and Managing Director, Harrow Clinical Commissioning Group

11. INFORMATION REPORT - UPDATE ON THE NEW 0-19 HEALTH VISITING AND SCHOOL NURSING SERVICE (Pages 49 - 56)

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

12. FEEDBACK REGARDING VISIT FROM DUNCAN SELBIE, CHIEF EXECUTIVE PUBLIC HEALTH ENGLAND

Verbal report from Interim Corporate Director People Services and Director of Public Health

13. 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.]

HEALTH AND WELLBEING BOARD

MINUTES

10 JANUARY 2019

Chair:	*	Councillor Graham Henson		
Board Members:	*	Councillor Ghazanfar Ali		
	*	Councillor Simon Brown		
	*	Councillor Janet Mote		
	*	Councillor Christine Robson		
	*	Javina Sehgal (VC)	Managing Director	
		Dr Himagauri Kelshiker	Clinical Commissioning Group (Reserve)	
	*	Marie Pate	Healthwatch Harrow	
	*	Dr Muhammad Shahzad	Clinical Commissioning Group	
	*	Dr Genevieve Small	Clinical Commissioning Group	
Non Voting Members:	*	Carole Furlong	Director of Public Health	Harrow Council
	*	Paul Hewitt	Corporate Director, People (Interim)	Harrow Council
	*	Chris Miller	Chair, Harrow Safeguarding Children Board	Harrow Council
	*	Tajinder Nijjar	Chief Executive Officer, Harrow Citizens' Advice Bureau	Voluntary and Community Sector
	†	Detective Chief Superintendent Simon Rose	Borough Commander, Harrow, Brent & Barnet Police	Metropolitan Police Service

	†	Visva Sathasivam	Interim Director of Adult Social Services	Harrow Council
In attendance: (Officers)		Matthew Cruice	Deputy Team Leader, Adult Screening Programmes	NHS England
		Donna Edwards	Finance Business Partner, Adults and Public Health	Harrow Council
		Priya Ganatra	Children's Commissioner, Peoples Directorate	Harrow Council
		Anita Harris	Head of Children's Services	Harrow Clinical Commissioning Group
		Catherine Heffernan	Principal Adviser for Commissioning Immunisations and Vaccination Services	NHS England
		Lisa Henschen	Assistant Managing Director	Harrow Clinical Commissioning Group
		Seth Mills	Head of Service for Specialist Learning, Disability Care and Children and Young Adults Disabilities Services and Client and Finance Brokerage, People Services	Harrow Council
		Lucy Rumbellow	Immunisation Commissioning Manager	Harrow Clinical Commissioning Group
		Peter Tolley	Divisional Director Children and Young People Services	Harrow Council

* Denotes Member present
† Denotes apologies received

35. Attendance by Reserve Members

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

36. Change to Membership

The Board was advised that Tajinder Nijjar had been appointed as the Deputy representative of the Voluntary and Community Sector and that Dr Sharanjit Takher was no longer a CCG Reserve representative.

37. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 10 – Section 117 of the Mental Health Act 1983
Councillor Graham Henson declared a non pecuniary interest in that his wife was employed by Rethink Mental Illness. He would remain in the room whilst the matter was considered and voted upon.

All Agenda Items
Councillors Chris and Janet Mote declared a non-pecuniary interest in that their daughter worked at Northwick Park Hospital. They would remain in the room whilst the matter was considered and voted upon

Dr Muhammad Shahzad declared a non-pecuniary interest in that he was a GP in Harrow, part of the Harrow Clinical Commissioning Group. He would remain in the room whilst the matter was considered and voted upon.

38. Minutes

RESOLVED: That the minutes of the meeting held on 1 November 2018, be taken as read and signed as a correct record.

39. Public Questions, Petitions and Deputations

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

40. Clinical Commission Group (CCG) Commissioning Intentions Update

Subsequent to detailed discussion at the last meeting, the Board received a report on the final version of the 2019/21 Clinical Commissioning Group Commissioning Intentions. The Board was informed that the Commissioning Intentions had been approved by the CCG. It was noted that any significant change would be reported back to the Board.

The CCG Managing Director introduced the report and outlined the areas updated since the last meeting of the Board:

- Inclusion of the themes from the finalised Primary Care Strategy
- Reflection of the expected Harrow population growth, infrastructure and planning
- Inclusion of additional feedback from engagement events
- Strengthening of the commitment to support homelessness in Harrow
- Outlining the assumed outcomes expected as a result of the Commissioning Intentions

In response to a question the Board was informed that CCG support for the Child Death Overview Panel would continue as at present pending the outcome of consultations, subsequent to which some functions would transfer to the Sustainability and Transformation Partnership (STP).

RESOLVED: That the report be noted.

41. Primary Care Strategy

The Board received a report which set out the Primary Care Strategy for Harrow CCG and set out the current position and challenges faced within General Practice in Harrow and the transformational programme that would be delivered to respond to them.

A CCG Assistant Managing Director introduced the report and expressed appreciation to partners who had contributed to the strategy. She outlined the six objectives to deliver the vision for primary care in Harrow. The Board was informed that population growth was shown to be of particular concern to Harrow residents.

The Board asked questions regarding the provision of data in the strategy and noted the inclusion of information from the latest public health annual report. Annual data was available for childhood obesity and it was hoped that access to the General Practice database could more accurately provide information on adult obesity. Estimates had been included for ethnicity population but accurate measurement were available in census data.

A Board Member sought assurances that the NHS health checks were available for all adults in the borough. The Director of Public Health informed the Board that although the number of invitations issued was still too low in Harrow, uptake for those who had been invited was about 55% which was in line with national uptake. Whilst Harrow Council, through the Public Health team, commissioned NHS Health checks, not all practices signed up to deliver them. It was noted that in line with the primary care at scale that was part of the strategy, health checks could take place at an alternative practice or clinic within a locality in order to deliver greater population coverage. Public Health and Primary Care Commissioners agreed to work together to facilitate this.

In response to a questions the Board was informed that:

- the findings from the National GP Patient Survey 2018 indicated that Harrow was above national benchmark for some of these access indicators, but below in overall access to GP services. This was a key reason why it was a central objective within the Strategy;

- there was a range of workforce initiatives to encourage recruitment to fill gaps in the Harrow workforce including the First Fives programme for newly registered GPs and the Last Fives for succession planning which included mentoring;

- the CCG was aware of the need to support the homeless and non-registered to access services;

- consideration would be given to the provision of annual checks for those with needs although they were not part of the Continuing Care programme.

RESOLVED: That the report be noted.

42. Social Prescribing

The Board received a report on the engagement events and work on developing resilient communities within the context of a wider Community Based Asset Development approach.

The Director of Public Health introduced the report and informed the Board that the scheme being delivered by Capable Communities, which was funded by a grant from the Department for Communities and Local Government, had finished in December 2018. The officer confirmed that the CCG and Harrow Council had agreed to fund the continuation of the scheme on a 50/50 basis until the end of March 2019.

The Director of Public Health informed the Board that contrary to the proposal in the report, the work was not ready for a decision on an options appraisal. Particular mention was made of the need for feedback and evaluation from any social prescribing scheme. It was noted that GPs had not been receiving feedback on whether people had taken up the opportunities offered and, if so, what they had done and what were the outcomes.

Support was sought for consideration of the possible options as outlined in the report. Officers of the Council and CCG would look at these options and see how well they fitted in with the aspiration for a scheme that could be evaluated; that could target interventions to priority groups; and that would provide a good return on investment. The officers would continue to build on Lateral work on community resilience with the voluntary sector and consultation would include Board Members. A progress report would be submitted to the Board at its March or May meeting.

RESOLVED: That the report be noted and the direction of travel endorsed.

43. Section 117 of the Mental Health Act 1983

Subsequent to an initial discussion at the last meeting, the Board received a report which set out the agreed approach including procedures and terms of reference and implementation plan to support people in receipt of Section 117 support (Mental Health Act 1983) in the form of after hospital health and/or social care support. The report was considered as urgent in accordance with the Local Government (Access to Information) Act 1985.

A CCG officer introduced the report outlining work undertaken, in conjunction with Harrow officers, to manage those in receipt of Section 117 care who had an individual care package. It was noted that a new matrix would determine the funding split for new and review cases and make clearer where and how the costs would be apportioned. Members were informed that it would be implemented once training was in place.

RESOLVED: That the report be noted.

44. INFORMATION REPORT - Draft Revenue Budget 2019/20 and Medium Term Financial Strategy 2019/20 to 2021/22

The Board received a report which detailed Harrow Council's Draft Revenue Budget 2019/20 and Medium Term Financial Strategy 2019/20 to 2021/22 as reported to the Council's Cabinet on 6 December 2018. It was noted that the budget and MTFS would return to Cabinet in February 2019 for final approval and recommendation to Council.

An officer introduced the report and drew particular attention to the key points relevant to the Health and Wellbeing Board including the continued financial challenges to the health and social care sector. The additional funding for social care had not been confirmed beyond 2020. The continuation of the Improved Better Care Fund of approximately £5.5m had been assumed although confirmation had not yet been received. The appendix contained information on savings. With regard to adult services savings there were no new savings beyond those in the 2017/18 budget. Whilst a balanced budget was forecast, significant challenge was anticipated in the next few years.

The Vice-Chair indicated that the CCG recognised the financial difficulties that the Council was experiencing and commended the work undertaken. She stated that, as the health service was also demand led, the opportunities for integrated and innovative work should be taken for the benefit of Harrow residents. An assurance that population growth was modelled into the budget was sought and a question was asked as to the size of the public health reserve.

The officer stated that the public health reserve was carried forward as it was ring fenced. Work continued to analyse population growth and the budget implications.

The Chair stated that the consultation enabled openness and transparency. He made particular reference to the business rates consultation pilot under which £2.6m had been allocated to Harrow but it was not known whether it would continue.

RESOLVED: That the report be noted.

45. Harrow CAMHS Transformation Refresh 2018 Report to NHS England

The Board received a report which set out the progress and plans for mental health services for Harrow young people in line with the expectations of the government's Future in Mind initiative. Consideration was given to the North West London (NWL) CAMHS Transformation Plan and the Harrow CAMHS Transformation Plan Refresh.

The CCG Managing Director introduced the report, informing the Board that due to the timing of the meeting the draft NWL CAMHS Transformation Plan had been submitted to NHS England prior to consideration by the Board.

Feedback from NHS England could result in some further amendment ahead of a resubmission date of 4 February 2019.

A CCG officer outlined the five priorities and three enabling work streams and drew particular attention to:

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- waiting times for CAMHS had shown steady improvement when compared to 2016/17 data, with the numbers of children and young people waiting, both for referral to assessment and referral to treatment, showing a reduction;

- Harrow Horizons assessment to treatment target for quarter 2 was also achieved;

- waiting time from referral to assessment would continue to be a priority, so that children and young people were able to access services and support in a timely way;

- the Plan included an explanation of the support available for young people with Autism, Learning Disabilities and Challenging Behaviour as well as services for looked after children and young offenders;

- the improved transition to adult services for the 18-25 age group and the aspiration for a 0-25 service.

In response to a question from the Chair of the Harrow Safeguarding Children Board, the Managing Director undertook to speak to NWL colleagues with regard to an update on the data for self harm hospital admissions and circulate to the Board.

RESOLVED: That the NWL CAMHS Transformation Plan and the Harrow CAMHS Transformation Refresh be endorsed.

46. Harrow Safeguarding Children Board (HSCB) Annual Report

The Board received the Harrow Safeguarding Children's Board (HSCB) Annual Report 2017-18. The Chair of the HSCB introduced the report and drew particular attention to the following:

- as indicated in appendix 2 to the annual report, there was an inequality of funding with Harrow Council contributing more than a fair share;

- the need to better understand how the data from each agency contributed to the overall picture;

- there was good reason to have confidence in the new future arrangements.

Members of the Board spoke in support of the work of the HSCB and one stated that, although not a requirement, the Board had maintained its natural

partnership with education and schools in planning for the future. A Member stated that she had been impressed during her visit to the MESH.

In response to a question as to the affect of childhood poverty, the Board was informed that the remit to ensure cooperation to protect children from harm could have reference to circumstances arising from poverty.

RESOLVED: That the Harrow Safeguarding Children Board Annual Report be endorsed.

47. Annual Report on Immunisation

The Board received an update on the delivery of the NHS (London) commissioned Childhood and School Age Immunisation Programmes. Members were informed of the uptake of the different programmes against nationally set targets, exception reports and actions being taken to improve performance or manage any serious incidents affecting Harrow residents.

A representative from NHSE (London) introduced the report stating that Harrow's immunisation rates were similar to or slightly higher than the national rates. A survey indicated that a third of children in London had moved at least once by age one resulting in difficulty in tracking families. NHSE was investigating digital analysis to overcome this problem.

Particular mention was made of:

- only one case of measles in Harrow in the last year indicated that vaccination was at a good level;

- HPV vaccinations would be provided in Year 9 in the future;

- evaluating the pilot of delivery of maternal vaccinations in maternity units across London.

In response to questions regarding BCG immunisations, it was noted that babies born at Northwick Park Hospital were routinely vaccinated against BCG. BCG immunisation was targeted to high risk areas only or high risk households with health visitors referring cases if appropriate. There was now sufficient licensed vaccine to include a mop up session for the cohort who had missed out due to the previous shortage.

With regard to flu immunisation in schools, the officer undertook to inform the Director of Public Health of the outcome of discussions with the London immunisation Board representatives. For immunisations where there was no alternative to animal based vaccine it was a personal decision for those groups affected and a guide was available to support them.

RESOLVED: That the report be noted.

48. Adult Non-Cancer Screening Update

The Board received a report that set out the performance of the adult non-cancer screening programmes commissioned by NHS England for the Harrow population. The two programmes were the Abdominal Aortic Aneurysm Screening Programme (AAASP) and Diabetic Eye Screening Programme (DESP).

A NHS England representative introduced the report and advised of a lack of Harrow specific data for AAASP as it was included within the national data for NWL and North London. AAASP performance had fallen the previous year due to the London-wide procurement programme which sought to improve resilience. All men had now been invited and screening invitations were back on track.

It was noted that for DESP the London region had the highest uptake in the country and that Harrow had the highest uptake in London. The Board was informed of the development of DESP screening programme software which would enable a targeted health inequalities strategy to be delivered. It was hoped that the strategy would be available in six to nine months and information submitted in the next report to the Board.

RESOLVED: That the report be noted

49. Any Other Business

NHS Long Term Plan
It was agreed that the Plan be discussed at the next meeting.

(Note: The meeting, having commenced at 12.00 pm, closed at 2.05 pm).

(Signed) COUNCILLOR GRAHAM HENSON
Chair

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	7 March 2019
Subject:	**INFORMATION REPORT** – Learning Disability Integrated Services
Responsible Officers:	Visva Sathasivam, Director of Adult Social Services, People Services, Harrow Council Angela Neblett, Interim Associate Director of Contracts – Mental Health, NHS Harrow CCG Ade Odunlade, Jameson Divisional Director, CNWL
Exempt:	No
Wards affected:	All
Enclosures:	Appendix 1 – Project Initiation Document: Creating an Integrated Learning Disability Team

Section 1 – Summary

Building on the Community Resilience vision for Harrow Adult Social Care, the Council approached NHS Harrow CCG to develop an integrated team for learning disability community services across social care and the NHS under a single operational management structure. This joint management approach will enable better outcomes for people with learning disabilities and their families, improved satisfaction for professionals working in the teams and in the longer term, more effective and sustainable services.

FOR INFORMATION

Section 2 – Report

A Project Initiation Document has been agreed between the Council, Harrow CCG and Central and North West London NHS Foundation Trust (CNWL). The agreement is to develop a single operational management structure for the Council's specialist LD staff and the CNWL LD Community Team currently based at Kingswood Hospital (commissioned by the CCG). The model will be very similar to that recently implemented in Brent and operational in other NW London boroughs.

This builds on the national aspiration to develop integrated care services across Health and Care.
'Local NHS organisations will increasingly focus on population health and local partnerships with local authority funded services, through new Integrated Care systems (ICS) everywhere' Long Term Plan January 2019.

The team will be co-located. Clinical staff will continue to receive supervision from NHS colleagues and all staff will continue with their current employment arrangements and terms and conditions.

A single team will have more flexibility in deciding on the right interventions at the right time and tThis will be particularly important at times of crisis and will therefore lead to better outcomes for people with LD and their families. In the medium term, it is expected that this will relieve pressure on the local health and care economy through reduced hospital admissions and fewer long term residential placements.

The target is to achieve co-location and the single structure by November 2019. However, this will depend on available locations for the 42 staff involved.

This project represents the first step towards integrated service delivery. In the longer term the CCG and Council aspire to build on this with further integration service delivery proposals, potentially supported by the integration of budgets and contracts, working in collaboration with wider partners, carers and citizens.

Section 3 – Further Information

A tri-partite Project Board is meeting at least monthly reporting to the Health & Wellbeing Board and chaired in rotation by the three Project Sponsors, the DASS, the CCG Associate Director of Contracts and the CNWL Divisional Director.

Section 4 – Financial Implications

The estimated total costs of commissioned care for people with learning disabilities in Harrow are:

Council funded	£21million	Total gross expenditure from Adult Social Care - Finance Return (ASC-FR) 2017-2018
NHS funded	£4.4million	£3.7million Continuing Healthcare; £0.7million s117 aftercare and Funded Nursing Care – Forecasts for 2018-19

These costs do not include staff costs for the Council, the CCG or CNWL. It is expected that over time average per person care costs to the local health and care economy will reduce by ensuring the right help, at the right time, in the right place, for example, avoiding unnecessary hospital admissions or long term residential care. The 2019-20 Adult Social Care budget does not assume any savings will be delivered through this integration project, however, any reductions in the future care costs arising will help in managing down the overall underlying level of expenditure.

These costs are not currently shared costs and at this time there is no intention to pool resources across the health and social care economy, although this may change in the longer term, subject to the development and approval of appropriate business cases by partner organisations.

This project has been supported, in 2018-19, through the Council funding the costs (£75k) of an Integration Programme Manager, who is also delivering two other integration projects. These costs will require funding during 2019-20 and form part of the overall Adults transformation programme costs that will be agreed as part of the 2019-20 Council budget.

The project has yet to establish any additional cost requirements, although costs associated with new premises, relocation of staff, IT and HR are likely. When identified, such costs will be reported to the project board and would be expected to be managed within the existing budgets for all partner organisations.

Section 5 - Equalities implications

An Equality Impact Assessment will be completed by the end of April 2019.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

- The project is expected to address all of the Council priorities. In particular, the project will improve services for vulnerable people with a Learning Disability across both health and social care services, helping to alleviate the stress that their families bear as carers. This will make the Harrow community more resilient and there are expected to be opportunities for local business by offering a wider variety of services to learning disabled people.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Name: 22 February 2019	x	on behalf of the Chief Financial Officer
Date: Donna Edwards		

Ward Councillors notified:	**NO (affects all wards)**

Section 7 - Contact Details and Background Papers

Contact: Seth Mills, Head of Service, Children and Young People with Disabilities and Specialist LD - 020 8966 6450 and Richard Pantlin, Integration Programme Manager - richard.pantlin@harrow.gov.uk

Background Papers:
Project Initiation Document: Creating an Integrated Community Learning Disability Team – Version 1.0 Final dated 4 February 2019

PROJECT INITIATION DOCUMENT:

Creating an Integrated Community Learning Disability Team

Version: 1.0 Final
Date: 4 February 2019

Author:
Richard Pantlin, Programme Manager, Integrated Service Delivery

Senior Responsible Officers:
Visva Sathasivam, Director of Adult Social Services, Harrow Council
Angela Neblett, Interim Associate Director of Contracts – Mental Health, NHS Harrow CCG
Ade Odunlade, Jameson Divisional Director, CNWL

Project Owners:
Seth Mills, Head of Service for Children, Young People & Adults with Disabilities (CYAD), Harrow Council
Lennie Dick, Commissioning Manager for LD and MH, NHS Harrow CCG
Jo Carroll, Interim Service Director for Learning Disability, CNWL

Revision History

Date Issued:	Version No.	Summary of Changes	Author
21/08/18	0.1	First Draft	RP
16/09/18	0.2	Updated following discussions with CCG, SM, LD, AN	RP
06/11/18	0.3	Significantly revised following meetings with Brent & Ealing Integrated LD Community Team managers & former Oxfordshire Head of ASC	RP
12/11/18	0.4	Updated following comments from Seth Mills – circulated to Council's ASC Programme Board	RP
14/11/18	0.5	Updated following ASC Programme Board	RP
11/12/18	0.6	Updates following meeting with AN & LD	AN, RP
14/12/18	0.7	Updates following HWB Exec	RP
4/02/19	1.0	Finalised after first Project Board	

Distribution List

The final draft of this document will be issued to the following people for information (I) or review (R):

Name:	Role/Position:	I / R
Visva Sathasiva	Senior Responsible Officer & Director of Adult Social Services, Harrow Council	**R**
Javina Seghal	Managing Director, NHS Harrow CCG	**R**
Angela Neblett	Senior Responsible Officer & Interim Associate Director Contracts – Mental Health, NHS Harrow CCG	**R**
Ade Odunlade	Senior Responsible Officer & Jameson Divisional Director, CNWL	**R**
Lennie Dick	Project Owner & Head of Commissioning for Mental Health, Learning Disabilities and Carers, NHS Harrow CCG	**R**
Seth Mills	Project Owner & Head of Service for Chlidren Young People and Adults with Disabilities (CYAD), Harrow Council	**R**
Jo Carroll	Project Owner & Interim Service Director for Learning Disability, CNWL	**R**
Mike Bibby	ASC Programme Manager, Harrow Council	**I**
Dr Himagauri Kelshiker and Dr Hannah Bundock	Mental Health and LD Clinical Leads, NHS Harrow CCG	**I**
Donna Edwards	Business Finance Lead, Harrow Council	I
Alex Stiles	Deputy Chief Finance Officer, NHS Harrow CCG	I

Contents

1. Executive Summary

This document sets out the terms of reference and the structure of the project for creating an Integrated Community Team for people with a Learning Disability. It will be a joint project between Harrow Council, NHS Harrow CCG and Central and North West London NHS Foundation Trust (CNWL). Its objectives are to:

1. Assess the feasibility and benefits of creating an integrated multi-disciplinary community service for adults with a learning disability
2. Engage with all stakeholders regarding the establishment of an integrated team consisting of Harrow Council and NHS staff under a single operational management structure with shared values and priorities
3. Develop an implementation plan for setting up such an integrated team – to be co-located (with the social care Children and Young People with Disabilities team)
4. Execution of the plan.

Section 2 sets out the national, regional and local background to LD services and current issues. Integrated community LD teams with NHS and Council staff under a single operational manager are NHS England policy, in line with recent NICE guidance and increasingly the norm, for example in Brent and Ealing.

Expected benefits include:

- Develop greater community resilience
- Better outcomes for people with LD and families
- Improved assessment
- Faster assessments
- Preventing deterioration
    - better quality of life outcomes
    - reduced costs eg of residential placements
    - hospital avoidance
- Targeted and co-ordinated support
- Promote access to mainstream services
- The right help, at the right time, in the right place
- Support for families and informal carers
- More people living at home (not institutional care)
- Improved quality of life
- Reduction in behaviours that challenge
- More expertise, sharing information, sharing best practice
- Reduction in waste, reduce duplication = savings
- Impact on whole system – better health, least expensive support options
- Meeting government policy

Governance: as a tri-partite Council / CCG / CNWL project, there will be a dedicated monthly Project Board composed of the SRO's and Project Owners, chaired by an SRO from each of the participating organisations on a rotating basis. The project manager will attend and submit a draft Highlight Report. Agreed Highlight Reports will be issued to the Health & Wellbeing Executive Board. There will also be regular project team meetings.

Key milestones are:

Month	Deliverable
November	Agree PID with Council & CCG Managers
December	Engage with CNWL management and clinical leads re feasibility Formal approval of PID at HWB Exec on 13th Engage with LBH LD Team Managers re feasibility

	Engage with local third sector bodies (Mencap, etc)
January 2019	Established clarity on total Harrow budget for LD, cohort size, current staffing profile and current IT systems. Research co-location options
February	First Project Board meeting (1st Feb – tbc) Quantitative survey of people with learning disabilities and their families (jointly with Mencap) – subject to Project Board agreement Model options for staffing & budgets
March	Develop medium to long-term outcome benefits model Analyse survey results for customer satisfaction baseline
April	Assess HR implications Engage with people with LD and families (jointly with Mencap)
May	Meetings with all affected LBH & CNWL staff Workshops with people with LD and families
June	Address IT implications for new integrated team
July	Decide on preferred location(s) for integrated team Staff consultation process begins
August	Draft formal agreement between LBH, CCG & CNWL Staff consultation process ends
September	Appoint integrated team manager(s) Develop protocols for integrated working Implement new IT arrangements
October	Prepare new location(s) - if necessary Formal agreement signed between LBH, CCG & CNWL Staff training
November	Go live

Important note re go live date: It was agreed at the first Project Board meeting that the priority is to achieve a single integrated operational management structure and that this should happen before November 2019 if possible. It is recognised that identification and preparation of suitable premises for up to 42 staff could take longer than November.

A wide range of staff across Harrow Council, Harrow CCG and CNWL as well as external stakeholders will need to contribute to the project in order to meet these milestones, including relevant managers and representatives of frontline staff, NHS providers, other local health and care providers, patients / service users / informal carers.

No high risks or issues requiring Project Sponsor involvement have been identified at this stage.

2. Background

2.1 The national context

The prevailing policy direction for adults with learning disabilities is towards empowerment, self-determination and support to live at home. There is widespread recognition that people with a learning disability should be fully included in their communities and that they aspire to citizenship, good health, friendship, employment and independent accommodation just like everyone else.

Since the closure of the large institutions in the 1980s, and the acceptance that disabled people's needs are primarily social as opposed to medical, health authorities have largely transferred their responsibilities for caring for learning disabled people to local authorities. There has been an attendant transfer of funds, sometimes resulting in the establishment of pooled budgets. In many cases the pooling of funds initiated the pooling of manpower and hence integrated joint NHS and social care teams are increasingly the norm, operating in a number of locations.

Policy

Since the publication of Valuing People[1] in 2001 policy development has mirrored that of social care for adults generally. Learning disabled people are supported to live at home (or in the least restrictive environment), encouraged to make use of main stream services, to participate in education and to engage in employment if they can. An asset-based approach (focusing on what people can do for themselves, not just on what they need) is promoted. Informal and family carers have a right to be supported at all stages, but especially through the transition from childhood to adulthood. Mental Capacity for individuals should be assumed, unless indicated otherwise, and the involvement of people who use services in co-production is encouraged. 'Person-centred' working, where services are constructed for the benefit of people who use them (not the other way around) and respecting individual preferences, has its origins in learning disability policy. Where possible, autonomy should be supported by the use of Direct Payments.

Additionally, the special characteristics that pertain to learning disability should be positively addressed. For example, poor health outcomes and shortened life expectancy, increased frailty at the end of life, people experiencing dual diagnosis such as mental health and learning disability, dual discrimination such as being a member of BME group with a learning disability, vulnerability to bullying, harassment and abuse. Many of the issues that are faced by people with a learning disability are societal, such as poor health outcomes, with the most pressing currently being the inappropriate detention of people whose behaviour challenges in Assessment and Treatment Units (in-patient services). The Transforming Care programme is designed to address this.

Definition and prevalence

A learning disability affects the way that someone communicates and understands information. This means that someone may have difficulties in understanding new or complex information, learning new skills and coping independently. The underlying condition or reason for the disability is evidenced before adulthood, with a lasting effect on development.

An estimated 1.2 million adults, children and young people (2.3% of the English population) have a learning disability and an estimated 10-17% of these display behaviour that challenges. There are an estimated 40,000 children with learning disabilities and challenging behaviour.[2]

[1] Valuing People White Paper. A New Strategy for Learning Disability for the 21st Century 2001 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf

[2] NICE Guildeline: "Learning disabilities and behavior that challenges: service design and delivery" – 28 March 2018

Around 350,000 people have a severe learning disability. The broad term 'learning disability' can cover a spectrum of conditions, from a mild learning disability where someone can manage independently but might take longer to learn new skills, to a profound and severe learning disability where an individual may need substantial care and support with every aspect of their life.

Autism spectrum disorder (ASD) is the name for a range of similar conditions, including Asperger syndrome, that affect a person's social interaction, communication, interests and behaviour.

It is estimated that about 1 in every 100 people has ASD, i.e. over 700,000 people in the UK. More boys are diagnosed with the condition than girls. Around 70% of people with ASD have a non-verbal IQ of below 70 and will fall under the remit of learning disability services. Up to 50% of people with severe learning disability have an autistic spectrum disorder. An increase in prevalence of ASD over time is likely to be due to a broadening of the diagnostic criteria.[3]

Challenging behaviour, or behaviours that challenge, can be defined as those which put an individual or those around them at risk, including self-harm, hurting others, destructive behaviour, eating inedible objects, smearing and running away. These behaviours cause particular strain on families and staff alike and can be ameliorated by positive behaviour strategies and support networks.

Current issues[4]

- Premature mortality

There is evidence that people with a learning disability experience inequalities in healthcare. Men with a learning disability die on average 13 years sooner, and women with a learning disability 20 years sooner, compared to those without learning disabilities. The most common reason is delays or problems with diagnosis or treatment and delays in providing appropriate care in response to changing needs. There needs to be better identification of people with learning disability within the NHS, better training for staff and increased collaboration between professionals. Regular Health Checks are another mechanism by which health inequalities can be addressed.

- Ageing

People with a learning disability are living longer. Problems of frailty and early onset dementia are consequently increasing in prevalence and services should to be geared up to meeting those needs.

- Employment

There are 3.7 million people with disabilities in employment but only 100,000 of them have a learning disability. The government is committed to increasing employment opportunities for people with a learning disability.

- Welfare benefits

[3] https://www.autism.org.uk/about/what-is/myths-facts-stats.aspx#

[4] Learning Disability - policy and services. Briefing Paper. House of Commons Library 2018 http://researchbriefings.files.parliament.uk/documents/SN07058/SN07058.pdf

Disability advocacy bodies have long voiced concerns about the assessment processes for both incapacity and disability benefits and the particular issues faced by people with learning disabilities claiming benefits.

- Criminal justice

The creation of liaison and diversion services intended to divert people with mental health needs and learning disabilities away from the criminal justice system has been successful and will be rolled out nationally by 2021.

- Integration between health and social care

Integration continues to be a broad goal in order to create a seamless service for people with learning disabilities and their families. In particular families express concern at the maze of services and professionals with whom they come in to contact and providing a single key worker is one solution to address this issue.

- Advocacy

A long-standing tradition of self-advocacy in learning disability services has been expressed as 'Nothing About Us Without Us' and is enhanced by easy read documents and circles of support. The intention of this approach is to provide good opportunities for consultation, involvement and co-production.

- Transforming Care

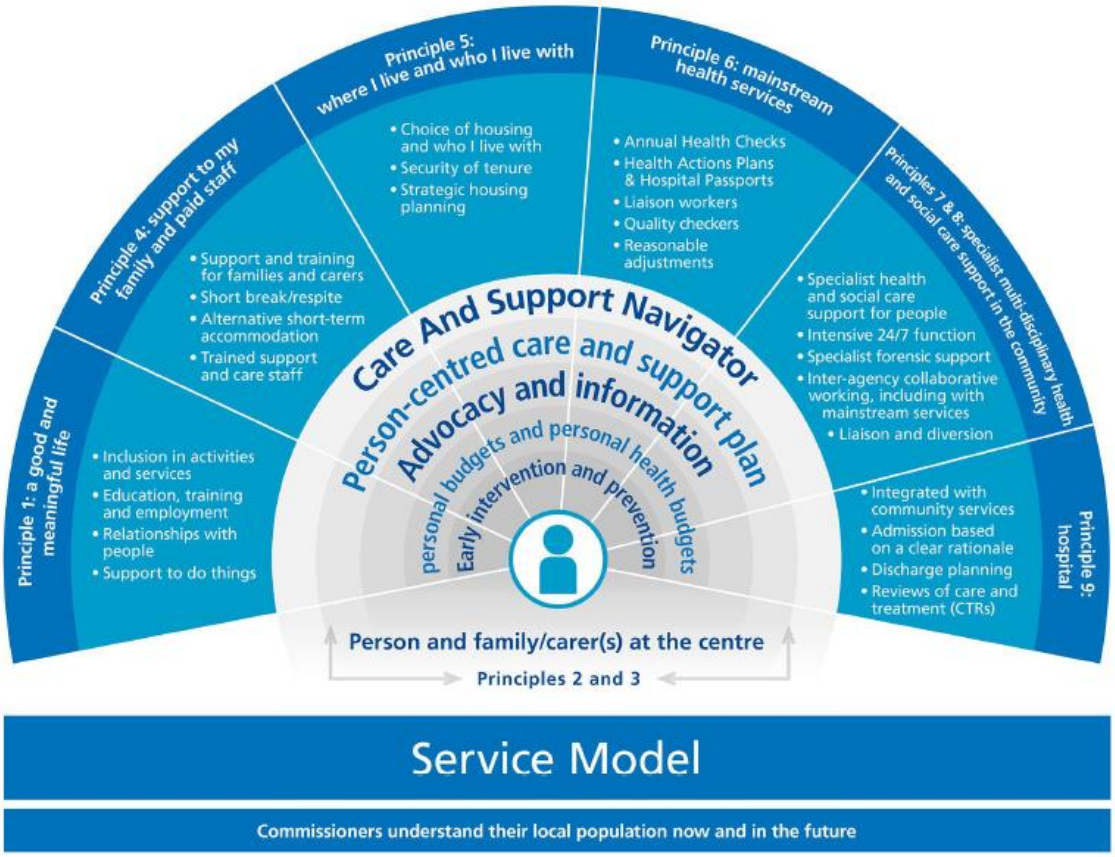
Inappropriate placement in a hospital environment of people with a learning disability, coupled with early deaths of people detained, has led to the government's stated ambition that everyone living in a (specialist) hospital should move to a community setting as quickly as possible.

More specifically, the exposure of widespread abuse at Winterbourne View private hospital in 2011 led to a review of care provided in this hospital, and across England more widely, for people with a learning disability and behaviour that challenges. The resulting report **"Transforming care: a national response to Winterbourne View hospital"** (Department of Health) started a programme of work to improve services for people with a learning disability or autism who also have mental health conditions or behaviours described as challenging. In particular, this aimed to shift emphasis from inpatient care in mental health hospitals towards care based on people's individual needs and wishes and those of their families, provided by general and specialist services in the community. The programme did not meet its original targets and was reconfigured in 2015.

A new national plan **"Building the right support"** (2015)[5] included plans for 48 'transforming care partnerships' to pilot new arrangements of services. The national plan was followed by NHS England's "**national service model"** (October 2015) that set out the range of support that should be in place no later than March 2019.

The national service model was summed up in this diagram:

[5] https://www.england.nhs.uk/learning-disabilities/natplan/



Note Principle 7 in particular:

"People with a learning disability and/or autism should be able to access ***specialist health and social care support in the community*** *– via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary."*

The most recent national publication is the NICE Guideline of 28 March 2018: "**Learning disabilities and behaviour that challenges: service design and delivery"[6].** It is designed to "*help local areas shift their focus towards prevention and early intervention, enabling children, young people and adults to live in their communities, and increasing support for families and carers. This should reduce the need for people to move away from their home or community for care, education or treatment."*

Its recommendations are relevant to this project. They start with these (emphasis added):

"1.1.1 Local authorities and clinical commissioning groups should jointly designate a ***lead commissioner*** *to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing, behaviour that challenges. …*

1.1.3 The lead commissioner should ensure that ***budgets and other resources are pooled*** *to develop local and regional services for children, young people and adults with a learning disability and behaviour that challenges. These should be pooled:*

- ***across health, social care and education****"*

[6] https://www.nice.org.uk/guidance/ng93

2.2 North West London Context

Harrow is one of eight boroughs and eight CCGs within the North West London Sustainability and Transformation Plan (STP) area. This is one of five STP areas across London. The CCGs collaborate under the brand "healthiernorthwestlondon" with a corresponding website.

A Sustainablity and Transformation Plan was published in October 2016[7]. It includes a forecast that the number of adults with a Learning Disability will increase by 29% from 7,000 to 9,000 by 2030 across the area. They currently account for 0.8% of the population and 8% of the health and care expenditure.

The CCGs are currently also moving towards becoming an "Integrated Care System" (ICS) by April 2019 and are focused on patients over 65 to trial the ICS approach.

Two examples of integrated specialist LD service delivery teams in London were included in the NHS England "Model Service Specifications". These are summarized in Appendix C and include Ealing in the NW London STP area.

Ealing and Brent have also set up integrated community LD teams. As part of the initiation of this project, meetings have been held with their managers. In both cases, operational management is the responsibility of a joint-funded Head of Disability Services and a joint funded integrated team manager. Team members continue to be employed and funded by either the NHS Trust or the local authority according to their role. Clinical oversight for health professionals is provided by the NHS Trust.

In Ealing's case, the team has been established for over 15 years and is co-located. In Brent's case, the integrated team has only been established in September 2018 and is working towards co-location.

Both team managers are clear that an integrated service offers greater flexibility in responding to issues that clients encounter with the appropriate intervention leading to better outcomes.

The Ealing managers identified these benefits:

- Culture that all adult LD cases are "our people" and therefore they all have care plans (usually written by a social worker). There is a clear ethos in the team that the preferred option is for people to be living at home and to return there as soon as possible after any hospital episode and that, if home is not feasible, then the best outcome for the person is arranged collaboratively.
- More people supported to live in the community.
- Reduced numbers and durations of psychiatric hospital admissions. (Zero in the last 12 months. A major reason for this is that people with mild LD would not normally receive any NHS interventions but these are the individuals who are out and about in the community and can get themselves into difficult situations such as involvement in gangs / criminal behaviour. A social worker would have limited options for intervention such as a care package of some sort but, with the resources of the integrated team, input from other staff is available, eg a Positive Behavioural Support therapist. It is these individuals who can often end up in secure hospitals or forensic services at great expense.)
- More efficient transition from children's services.
- Better hospital pathways and personalised support for mainstream health services

[7] https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

- Better engagement with local providers and market modelling, eg recent training for providers in PBS models and the STOMP agenda.

2.3 Local Harrow Context

Harrow has a population of around 251,960 covering 20 square miles. Harrow is an Outer London Borough in North West London and borders Hertfordshire to the north and four London Boroughs: Barnet to the east, Brent to the south east, Ealing to the south and Hillingdon to the west.

Based on the average estimated English population, Harrow would expect to have approximately:

- 5,795 adults, children and young people with learning disabilities
- 580 – 985 of these with behaviours that challenge
- 190 children with learning disabilities and challenging behaviour
- 570 - 750 adults with ASD and NO learning disability.

Harrow Council's service for people of all ages with Learning Disabilities are managed in three teams under Seth Mills:

- For ages 0 – 18 years: c 8 fte Social Work and SW Assistant staff
- For ages 18 – 25 years: c 7 fte Social Work and SW Assistant staff with 104 clients (as at August 2018)
- For ages 26+
- In addition, services are brokered by one team for residential care and supported living and another team for domiciliary care.

Harrow has a set of distinct challenges coming from a unique profile in North West London with an older than average population.

Harrow is also one of the most ethnically diverse boroughs in the country. In 2011, 43% of the Harrow population were from an Asian/ Asian British background, the percentage from a white ethnic background was almost equal at 42%, and a further 8% were from Black/ African/ Caribbean/ Black British background. Over the next ten years it is predicted that the local Black, Asian and minority (BAME) population in Harrow will increase from almost 54% to over 60%.

Alongside ethnic diversity, Harrow has great religious diversity. Harrow is home to one of the largest Hindu communities in the country, making up 26% of the population. There is also a greater proportion of people of Muslim and Jewish faith than the national average.

The Harrow Health & Wellbeing Board agreed a new Vision for Adult Social Care in March 2018. This project is in line with its key messages:

- *To pave the way for seamless health and social care integration.*
- *To respond to the continuing rise in demand for health and social care.*
- *To transform the offer of care.*
- *To enhance health, wellbeing and resilience with a preventative approach that embodies the 'wellbeing principle'.*
- *Delivering the right level and type of support at the right time and in the right place to keep people independent for longer.*
- *Manage customer expectation and increase customer satisfaction.*

The LD project will include co-production with staff in the Council and CNWL, patients, service users, carers and the voluntary and community led organisations in Harrow.

Harrow CCG has included in its Commissioning Intentions for 2019-21:

- *"Review the opportunity of integrating the Community Learning Disabilities Team with the Local Authority Learning Disabilities Team"*

3. Project Definition

3.1 Business Mandate

The project mandate was agreed by Visva Sathasivam and Garry Griffiths in May 2018 as follows:

"Harrow Council currently provides social work input and commissioned care for people with Learning Disabilities. Harrow CCG funds Central North West London Trust (CNWL) for LD health services including the commissioning of residential and domiciliary care. This project will explore the feasibility of the Council taking on management responsibility for some or all of the functions currently delivered by CNWL in order to deliver integrated specialist LD services. This may include co-location of staff. This has the potential of improving the quality of service delivery through a more integrated arrangement and releasing efficiencies."

3.2 Project Approach

PRINCE2[8] principles will be used to manage the project. PRINCE2 provides a structured project management methodology to ensure that projects are managed on time and to budget. Every project is assigned a Project Sponsor with the responsibility for ensuring that the project is a success and for commissioning Quality Assurance of the 'deliverables' arising from the project.

The project is initiated by developing this project initiation document (PID). The PID sets out the agreed Business Mandate, the terms of reference and states the different roles, responsibilities, risks, milestones and products to be delivered. In addition, the PID clarifies the process for change control and escalation procedures.

A Highlight Report is produced each month for the Project Board. It identifies all tasks, which have been completed during the reporting month and all those still outstanding for the following month. Overall project status is provided and a clear statement of risks.

All project control documents are available in electronic format and are usually delivered by email.

See Appendix A for PRINCE2 roles and responsibilities.

3.3 Project Scope

The overall project scope includes:

- Assessment of feasibility and benefits of creating an integrated community support service for adults with a learning disability
- Engagement with all stakeholders regarding the establishment of an integrated team under a single operational management structure consisting of Harrow Council and NHS staff
- Development of an implementation plan for setting up such an integrated team – ideally to be co-located
- Execution of the plan.

3.3.1 Exclusions

The scope of the project excludes:

[8] PRINCE stands for Projects in a Controlled Environment

- Services for people resident outside the London Borough of Harrow unless they are registered with a GP Practice within Harrow.
- Services for people whose primary diagnosis is not a learning disability.
- Services for children with a learning disability.

3.4 Project Plan

See separate plan for details. Key milestones are:

Month	Deliverable
November	Agree PID with Council & CCG Managers
December	Engage with CNWL management and clinical leads re feasibility Formal approval of PID at HWB Exec on 13th Engage with LBH LD Team Managers re feasibility Engage with local third sector bodies (Mencap, etc)
January 2019	Established clarity on total Harrow budget for LD, cohort size, current staffing profile and current IT systems. Research co-location options
February	First Project Board meeting (1st Feb – tbc) Quantitative survey of people with learning disabilities and their families (jointly with Mencap) – subject to Project Board agreement Model options for staffing & budgets
March	Develop medium to long-term outcome benefits model Analyse survey results for customer satisfaction baseline
April	Assess HR implications Engage with people with LD and families (jointly with Mencap)
May	Meetings with all affected LBH & CNWL staff Workshops with people with LD and families
June	Address IT implications for new integrated team
July	Decide on preferred location(s) for integrated team Staff consultation process begins
August	Draft formal agreement between LBH, CCG & CNWL Staff consultation process ends
September	Appoint integrated team manager(s) Develop protocols for integrated working Implement new IT arrangements
October	Prepare new location(s) - if necessary Formal agreement signed between LBH, CCG & CNWL Staff training
November	Go live

Important note re go live date: It was agreed at the first Project Board meeting that the priority is to achieve a single integrated operational management structure and that this should happen before November 2019 if possible. It is recognised that identification and preparation of suitable premises for up to 42 staff could take longer than November.

A wide range of staff across Harrow Council, Harrow CCG and CNWL as well as external stakeholders will need to contribute to the project in order to make it a success including relevant managers and representatives of frontline staff, NHS providers, other local health and care providers, patients / service users / informal carers.

3.5 Constraints

- Time is a significant constraint and target projections will need to be monitored carefully through governance.
- Resources are a major constraint both financial and capacity of existing staff to carry out project activities without additional resources. Currently, only one part-time resource has been identified as dedicated to this project. Other staff input from Harrow Council, CNWL and Harrow CCG will have to be absorbed alongside existing priorities.
- Availability and engagement with practitioners to assist the mapping of current processes and identification of future processes.
- The culture of the different organisations is an important constraint.

3.6 Risks and issues

The Project Risks and Issues will be identified in a Risk Register. At this early stage there are no high level risks or issues requiring Project Sponsor oversight.

3.7 Highlight Reports

These will be produced monthly for discussion at Project Board meetings and form part of a formal reporting procedure to the Health & Wellbeing Exec. Each Highlight Report will state:

- Tasks completed this month
- Tasks to be completed next month
- Budget and Timescale status
- Issues to resolve and decisions to be made
- Risks and mitigations

4. Business case and costs

4.1 Expected Benefits

- Develop greater community resilience
- Better outcomes for people with LD and families
- Improved assessment
- Faster assessments
- Preventing deterioration
    - better quality of life outcomes
    - reduced costs eg of residential placements
    - hospital avoidance
- Targeted and co-ordinated support
- Promote access to mainstream services
- The right help, at the right time, in the right place
- Support for families and informal carers
- More people living at home (not institutional care)
- Improved quality of life
- Reduction in challenging behaviour
- More expertise, sharing information, sharing best practice
- Reduction in waste, reduce duplication = savings
- Impact on whole system – better health, least expensive support options
- Meeting government policy

- Better co-ordination and planning
- Help reduce health inequalities for people with LD
- Joint emergency care plans

4.2 Sustainability

Harrow Council and Harrow CCG are both under severe financial pressure. In order to improve sustainability, there are expected to be some savings in part from reduced management overheads and from earlier, more appropriate joint interventions in order to avoid situations escalating with associated long-term costs and from improved commissioning.

There are likely to be wider savings to the local health and care economy in the medium term from reduced costs of long term placements and a reduction in inappropriate hospital admissions and forensic services.

4.3 Project costs

There is a direct Council Integration Programme cost of £75,000 during 2018-19, which is shared between this project and the following:

- Integrated Brokerage
- GP Co-location
- Project Infinity / Watson Care Manager.

Costs of management and operational staff time during 2018-19 is expected to be absorbed within normal working arrangements.

Implementation costs for 2019-20 are to be established.

5. Project Governance

Governance will be provided through a dedicated tri-partite Project Board meeting monthly and reporting to the Harrow Health & Wellbeing Executive Board. The Project Board will consist of the following and will be chaired on a rotating basis by one of the Project Sponsors / Senior Responsible Officers.

Project Role	Name	Business Area
Project Sponsors / SROs	Visva Sathisivam Angela Neblett Ade Odunlade	Director of Adult Social Services, Council Interim Associate Director of Contracts – Mental Health, NHS Harrow CCG Jameson Divisional Director, CNWL
Project Owners	Seth Mills Lennie Dick Jo Carroll	Head of Service, Specialist Learning Disability Care & CYAD (Children & Young People with Disabilities, LD Team, MH, Long Term Placements), Harrow Council Commissioning Manager for LD and MH, NHS Harrow CCG Interim Service Director for Learning Disability, CNWL

Project Manager	Richard Pantlin	Contracted through the Council for the joint project

In addition to a report to the Health & Wellbeing Board, there may be a report to the NW London Care & Health Partnership Board as required.

There will also be regular project team meetings with the Project Owners, team managers and other staff such as HR, IT and Estates as required.

The roles of participants in the project are outlined in Appendix B.

Appendix A – PRINCE2 Project Roles

A. The Sponsor / Senior Responsible Officer

The Sponsor has full authority for the project and together with the Project Board will provide overall direction and final authorisation of the budget. The Sponsor will make arrangements to keep Directors, Chief Executives, the Leader, Cabinet and other Members informed on progress with the project and of any critical issues.

The Sponsor is responsible for overall business assurance of the project, (i.e. that it remains on target to deliver the projects products which will achieve the expected business benefits and the project will complete within its agreed tolerances for budget and schedule).

The Sponsor is final arbitrator if the Project Board disagree or cannot come to a consensus decision.

Sponsor Responsibilities:

- ensure the existence of a viable Business Case, the approval of the Business Case, and the responsibility for the Business Case throughout the lifetime of the project.
- ensure tolerances are set for the project.
- authorise budget expenditure and set stage tolerances.
- brief Joint Exec Board and Corporate Management Teams (CMT) and Health & Wellbeing Board about project progress.
- recommend future action on the project to Joint Exec Board and Corporate Management Teams (CMT) and Health & Wellbeing Board if tolerances are exceeded.
- chair Project Board Meetings.
- approve the Project Closure Report. This is to include the Lessons Learned from this project.
- provide overall Business Assurance.
- validate and monitor the Business Case against external events and against project progress.
- keep the project in-line with Customer Strategies.
- monitor overall Project Finance.
- monitor overall Business Risks to ensure they are controlled.
- authorise Supplier and Contractor Payments.
- review Strategic Changes and their impact on the Business Case.
- assess impact of potential changes to the business case and project plan.
- monitor for any Corporate Programme changes that could impact on the project.
- review Stage and Project Progress against the agreed tolerances set.

B. The Project Board / Health & Wellbeing Exec Board

The Project Board will exercise the main control over the project on a “management by exception basis”. The Project Board will be accountable for the overall success of the project, will approve all major plans and will authorise any major deviation from the plans. It will be the authority that signs off the completion of each stage of the Project and will authorise the start of the Project, will arbitrate on any conflicts within the Project and will negotiate solutions to any

problems between the Project and internal or external bodies. In addition, it will approve the appointment and responsibilities of the Project Manager and the delegation of any of its Project assurance responsibilities.

The Project Board responsibilities include the following tasks, (broken down across Project Start, Running and Closure).

At the beginning of the Project to:

- agree the scope, objectives and constraints of the project.
- authorise commitment of project resources.
- review and approve the Project Initiation Document with respect to its accuracy and suitability for purpose.
- ensure compliance with local and regional standards including DoH expectations under STP, Five Year Forward View and any other relevant initiatives.
- agree with the Project Manager his responsibilities, objectives and the limits of the Project Managers authority.
- delegate any project assurance roles.
- commit to the project, resources required by the various Stages of the Project.
- ensure that the Scope of the project correctly reflects the Patients/Service Users, Carers requirements.
- confirm Project tolerances
- specify any External Constraints – E.g. Quality Assurance.
- agree the overall project plan.
- take “cabinet” responsibility for the success of the project.
- represent the project to their staff in a positive way throughout the project.
- authorising project expenditure against budget
- co-ordinating priorities
- representing the project to external bodies
- ensuring the interests of the staff or section they represent are met, when not in conflict with the project’s objectives
- ensuring that business and technical integrity is maintained
- reviewing the status of the project each month
- approving plans which deviate from the agreed overall project plan
- providing top level decision making and problem resolution

As the Project progresses:

- **ensure staff are available** for project tasks.
- provide overall guidance and direction to the Project, ensuring that it remains within any specified scope.
- review each completed Stage and approve progress to the next.
- review and approve any Stage Plans and Exception Plans.
- provide “ownership” of one or more of any identified project risks as allocated at plan approval time.

- monitor any such risk, advise the Project Manager of any change in status and take action where appropriate, to minimise the risk.
- approve changes.
- ensure that appropriate resources remain committed to the Project.
- ensure continued compliance with local, regional and national standards and expectations.
- attend Monthly Project Board Meetings.
- review the status of the project each month.
- provide top level decision making and problem resolution.
- ensure the interests of the staff or section they represent are met, when not in conflict with the project's objectives.
- ensure compliance with Departmental, Corporate Management Team or Investment Board directives.

At the end of the project:

- provide assurance that all products have been delivered satisfactorily.
- provide assurance that all Acceptance Criteria have been met.
- decide on the recommendation for any follow-on actions and ensure the passage of these to the appropriate group including Health & Wellbeing Board.
- arrange for a Post Implementation Review.
- approve the Project Closure Report.
- provide a Project Closure Notification to the Health & Wellbeing Board.

C. The Project Owners

Develop and implement, in co-operation with the project manager, the project activities as detailed in the Project Plan. This will include:

- assist end users reviewing and/or adjusting business practices to achieve business objectives.

Other responsibilities include:

- develop, in co-operation with the project manager, the necessary working relationships and co-operative activities with the various Task Group staff members engaged in the Project's activities.
- assist Implementation Staff with Project Planning and Reporting Tools.
- advising of changes in organisation structures and operational delivery
- analyse Budget Needs and Monitor Expenditures.
- identify and assist the acquisition of Project resources.
- act as Liaison Between Project and Officer staff across organisations.
- monitor Task Group issues and resolutions.
- assist with the development and administration of End User Training Programs.
- develop and promote communication between Task Groups.
- provide status reporting.

- assist the project manager to draw up an achievable project plan and managing the progress of the Project Team against plan
- taking responsibility for quality and performance particularly in terms of meeting project objectives, time-scales, budget and sponsor satisfaction
- liaison where necessary with progress updates to NHS England, Department of Health (DoH)
- providing top-level briefings and reports to the Sponsor, Senior Officers and Members
- helping specify and agree any changes or modifications to the project plan
- ensuring that safety and security standards are maintained throughout the project
- contributing to risk assessment and monitoring

D. Project Leaders

The Project Leaders may be appointed at various stages of the project by the project manager to carry out a work package. Project Leaders in this role have overall responsibility for the day to day management of their portion of the project as described in the work package. Project Leaders will report on a weekly basis to the Project Manager at a Checkpoint Meeting to review progress. The main tasks undertaken by Project Leaders are to:

- develop detailed product descriptions including purpose, composition, derivation and quality.
- prepare sub-project implementation plans
- ensure their portion of the project is delivered to time and meets all the required tasks as set out in the Project Plan
- understand the tolerance levels and alert the Project Manager to any deviation from the plan or timescale
- prepare progress reports for the progress meetings and other relevant progress or Project Board meetings as required by the Project Manager
- liaise with related projects to ensure that common areas of interest are identified and kept under consideration with no conflict of resources or objectives
- help specify and agree any changes or modifications to the project plan
- ensure selected individuals are trained as required
- contribute to risk assessment and monitoring
- deal with team issues as they arise

E. Project Assurance

These people are responsible for monitoring all aspects of the project's performance and products independent of the project manager. They may represent the business, user, audit, and financial, legal, and/or technical aspects of the project delivered.

Responsibilities include:

- ensuring user needs and expectations are being met and managed
- ensuring service risks are identified and controlled
- monitoring expenditure and time schedule

- ensuring the products delivered meet the required Business Case
- constantly reassessing the value-for-money solution
- ensuring a fit with the overall programme or service strategy
- ensuring the right people (users) are being involved in specifying and testing the systems
- ensuring an acceptable solution is being developed
- ensuring the project remains viable
- ensuring the scope of the project is not “creeping up” unnoticed
- ensuring the focus on business need is maintained
- ensuring internal and external communications are working effectively
- ensuring adherence to quality assurance standards (e.g. conformance to specification)

i. Finance Assurance

Finance Assurance ensures that suitable financial standards and procedures are defined and followed throughout the project.

ii. Clinical Assurance

Clinical Assurance ensures that the project conforms to all relevant clinical requirements.

F. Project Manager

The Project Manager has the authority and responsibility for the project on a day-to-day basis, on behalf of the Project Sponsors and Owners. The Project Manager’s responsibility is to ensure that the project produces the required products, to the required standard of quality and within the constraints set for time and cost; and for the project producing a result which achieves the benefits defined in the Business Case.

Project Manager Responsibilities:

- Manage the production of the required project products and controls.
- Direct and motivate the Task Groups.
- Plan and monitor the project.
- Agree any delegation and use of project assurance roles required by the Sponsor/Project Board.
- Produce the Project Initiation Document.
- Prepare Project Stage, (and where necessary), Exception Plans in conjunction with project staff, and agree them with the Project Board.
- Manage Project Risks, including the development of Contingency Plans.
- Liaise with other projects/programmes as is necessary.
- Take responsibility for overall progress and use of resources, and initiate corrective action where necessary.
- Report to the Project Board through Highlight Reports.
- Liaise with the Project Owners or the appointed Project Assurance roles to ensure the overall direction and integrity of the Project.
- Agree technical and quality strategy with the Project Owners.

- Prepare the Closure Report for approval by the Sponsor/Project Board.
- Prepare any Project Follow-On Recommendations.
- Identify and obtain any support and advice required for the management, planning and control of the project.
- Take responsibility for project administration.

G. Project Support

Senior manager personal assistants in the Council and the CCG will provide support with booking appointments and meeting rooms, printing and other administrative arrangements.

Appendix B – Project team & project assurance roles

In addition to Senior Responsible Officers / Project Sponsors (Visva Sathasivam, Ade Odunlade and Angela Neblett), the following represent the core project team:

Project Role	Name	Business Area
Project Owner – Council	Seth Mills	Head of Service, Specialist Learning Disability Care & CYAD (Children & Young People with Disabilities, LD Team, MH, Long Term Placements)
Project Owner – CCG	Lennie Dick	Commissioning Manager for LD and MH, NHS Harrow CCG
Project Owner - CNWL	Josephine Carroll	Interim Service Director for Learning Disability, CNWL
Project Manager	Richard Pantlin	Integration Programme Manager, Harrow Council
LBH Project Leaders	Allan Meachim Mario Casiero LD Team Managers HR adviser Estates	IT Project Support & Community Engagement, Harrow Council
CCG Project Leader	Adeola Adeleke	Patient & Public Engagement
CNWL Project Leaders	Senior LD HR adviser Estates IT staff	
Local health and care providers / service user representatives	Deven Pillay Mike Coker LD Partnership Forum	Chief Exec, Harrow Mencap & Community Solutions Chief Exec, Harrow Carers

The following will provide an assurance / advisory role to the project:

Project Role	Name	Business Area
Project Assurance - Clinical	Dr Himagauri Kelshiker and Dr Hannah	Mental Health and LD Clinical Leads, NHS Harrow CCG

	Bundock	
Project Assurance – Finance LBH	Donna Edwards	Business Finance Lead, Harrow Council
Project Assurance – Finance CCG	Alex Stiles	Deputy Chief Finance Officer, Harrow CCG

Appendix C – Examples of integrated service delivery teams

C.1 Ealing Intensive Therapeutic Short Break Service[9]

For a population of 345,000, the team consists of a Clinical Psychologist (Band 8) and an Assistant Psychologist (Band 5) who specialize in learning disability.

The Ealing Intensive Therapeutic Short Break Service (ITSBS) is for young people with a learning disability who display behaviour described as challenging at imminent risk of residential placement.The aim is to enable the young person to remain within their family home and community settings longer term. The ITSBS provides families with intensive interventions and follow-up support, combining a carefully tailored package of additional short breaks and intensive clinical psychology therapy to reduce challenging behaviours and provide a break for the parents/young person.

The team is co-located in the Ealing Service for Children with Additional Needs (ESCAN) which consists of multi-agency services. They work very closely with allocated social workers from the Children with Disabilities Social Care Team. The clinical psychologist post is a job share post with each coming from the CAMHs Learning Disability team. The team is managed by the Ealing local authority, Social Care manager for children with disabilities.

As of November 2016, the team's caseload has ranged from 5-8 children and young people at any one time on the active caseload, (with an average of 2-3 years on caseload with intensity of support varying by individual and circumstances at time).

C.2 Southwark Enhanced Intervention Service[10]

For a population of 300,000, Southwark Enhanced Intervention Service (EIS) supports adults with a learning disability, or both a learning disability and autism, who display significant behaviour that challenges.

Community learning disability services in Southwark are provided by three services: the Adults with Learning Disability Team (Southwark Social Care); Community Team for Adults with Learning Disabilities (Guys and St Thomas' Foundation NHS Trust) and Mental Health and Mental Health Learning Disabilities Team (South London and Maudsley NHS Trust, SLaM). All three services contribute to the membership of the Enhanced Intervention Service (EIS), whose team members are also members of their respective services.

The EIS is led by SLaM. It has discrete functions and team members' EIS time is ring-fenced, but its clients are also the clients of the three contributing services and its staff are full members of the staff of their respective services and maintain close links with their colleagues in these services; this ensures smooth transfer of care to these services when EIS input is no longer required.

During 2016 the team's caseload has ranged from 10 – 15 adults at any one time as follows:

- 6-10 people on active caseload, depending on intensity of work
- 2-4 people on monitoring caseload (e.g. period of monitoring prior to discharge)
- Collaborative support averages 1-2 people at any point in time (e.g. direct support to other

[9] Example from the Model Service Specifications document

[10] Example from the Model Service Specifications document

services to work with an individual)

In addition, the team also provides 'population' level work, including:

• Training and consultation to Child & Adolescent Mental Health Service - Learning Disability (CAMHs-LD) and local providers

• Supporting local service developments for people presenting with more significant and complex behaviours that challenge through training and consultation

• Strategic developments around enhanced provision and Transforming Care within the local borough and TCP.

The Enhanced Intervention Service is in addition to services provided by the specialist community learning disabilities teams but with a focus on the Transforming Care group, with an explicit aim of avoiding more restrictive, out of area environments and with capacity to respond intensively and rapidly.

Staffing:

- 1 wte 8b clinical psychologist and lead for EIS
- 1 wte band 6 behaviour support practitioner
- 0.6 wte senior practitioner – Southwark social care
- 0.5 wte band 7 community nurse
- 0.5 wte band 7 Speech and Language Therapy

Access to psychiatry, CPNs and OT within CLDTs as required.

The key functions of support provided by the Enhanced Intervention Service are:

• Working preventatively with local services to increase their capacity to create capable environments through training and consultation

• Rapid, flexible, intensive MDT multi-element assessments and interventions at point of crisis or potential service/family breakdown to help avoid hospital admission/ placement breakdown/out of area placement

• Service design, planning and strengthening services for people returning to Southwark; additional clinical expertise to support step-down back from more restrictive environments

The service works with adult mental health, child and forensic services around interface issues, as and when it is needed.

Appendix D – Selected recommendations from NICE Guideline March 2018

The following recommendations have been extracted from the NICE Guideline : "**Learning disabilities and behaviour that challenges: service design and delivery"[11].** These are deemed the most pertinent for this project (**emphasis** added). Other recommendations are also very important for detailed design of services and practitioners.

*"1.1.1 Local authorities and clinical commissioning groups should jointly designate a **lead commissioner** to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing, behaviour that challenges.*

*1.1.3 The lead commissioner should ensure that **budgets and other resources are pooled** to develop local and regional services for children, young people and adults with a learning disability and behaviour that challenges. These should be pooled:*

- *across health, social care and education and*
- *with neighbouring authorities.*

*1.1.5 Ensure that funding mechanisms for service providers support **creative and flexible community-based responses, for example, a contingency fund** that service providers can draw on quickly if there is a crisis.*

1.1.7 Ensure that services are planned and delivered in a way that:

- *is **co-produced** with children, young people and adults using services and their families, carers and independent advocates …*

*1.1.9 Take joint responsibility with service providers and other organisations for **managing risk** when developing and delivering care and support for children, young people and adults with a learning disability and behaviour that challenges. Aim to manage risks and difficulties without resorting to changing placements or putting greater restrictions on the person.*

*1.1.12 Commissioners should **establish a multi-agency group**, or make use of an existing group, including experts by experience and service providers, to monitor the quality of services and the outcomes achieved.*

*1.2.10 Local authorities working in partnership with healthcare professionals should assign a single practitioner, for example, a social worker (in a disabled children's team or community learning disability team) or community psychiatric nurse, to be the person's **'named worker'**. The named worker should get to know the person and coordinate support to meet their needs over the long term.*

*1.2.19 Ensure that a range of funding arrangements are available, including **direct payments, personal budgets or individual service funds**, depending on children, young people and adults' needs and preferences.*

1.4.1 The lead commissioner should commission services in the community for people with a learning disability and behaviour that challenges (including for people in contact with, or at risk of contact with, the criminal justice system). These services:

- *should be able to cater for lower-level needs up to intensive, complex or fluctuating needs*

[11] https://www.nice.org.uk/guidance/ng93

- *could be set up either as 1 large team with different subteams or as several separate teams*
- *should be provided wherever possible as an alternative to, and to reduce the potential need for:*
    - *inpatient care for children, young people and adults or*
    - *residential placements for children and young people.*

1.4.2 Services in the community should fulfill the following core functions:

- *specialist prevention and early intervention*
- *developing capacity in non-specialist community services to prevent unnecessary inpatient admissions*
- *giving support and training to families and carers (by following the recommendations on support and interventions for family members or carers in NICE's guideline on challenging behaviour and learning disabilities: prevention and interventions)*
- *quality assurance and service development*
- *short-term assessment and intervention*
- *longer-term complex intervention*
- *crisis response and intervention.*

1.4.3 Ensure that children, young people and adults with a learning disability can get specialist support through their community learning disability team that meets their needs, for example, in relation to:

- *behaviour*
- *communication*
- *social care and support needs*
- *physical health*
- *mental health*
- *education*
- *offending behaviour.*

This could be achieved by employing relevant practitioners within the community learning disability team or by developing close links with practitioners in other relevant services.

1.4.4 Services who provide support through the community learning disability team should work together and provide consultancy and support to each other.

1.4.5 If a child, young person or adult develops, or is at risk of developing, ***offending behaviour****, community learning disability teams should refer them to appropriate specialists, such as community forensic or youth justice services, as soon as possible (see recommendations 1.4.12 to 1.4.16). These services should:*

- *provide evidence-based early interventions that are adapted for people with a learning disability and address the specific behaviour*
- *work in an ongoing partnership with each other and with the community learning disability team whenever needed.*

1.4.6 Community learning disability teams should maintain good communication and ***links with the police and liaison and diversion teams*** *so that:*

- *they can advise on assessments of vulnerability, particularly for people with mild or borderline learning disabilities who may otherwise not be identified as vulnerable*
- *people who need support can be diverted from the criminal justice service to community learning disability teams.*

1.4.7 Ensure that ***specialist assessment and behavioural*** *support are available in the community so that children, young people and adults can stay where they currently live and avoid moving.*

*1.4.10 Provide a local, personalised response to children, young people and adults who need **intensive support during a crisis**. This response should:*

- *focus on keeping people in their own home*
- *have an out-of-hours helpline as a first option with the capacity to respond rapidly (within 1 hour or in line with local mental health crisis response times), staffed by people with skills and knowledge in learning disabilities and behaviour that challenges, and specialist skills in mental health problems*
- *provide face-to-face support within 4 hours if needed, based on initial triage*
- *involve partnership with other commissioners, service providers and family members and carers*
- *include giving staff access to the person's information if they are already in contact with services*
- *provide short-term support to achieve aims that are agreed with the person*
- *include clear contact details for children's services (as set out in the Local Offer) and adults' services.*

*1.4.12 Commission local **community forensic services** for children, young people and adults with a learning disability and behaviour that challenges who are in contact with, or at risk of contact with, the criminal justice system to prevent out-of-area hospital placement. These could be provided as stand-alone teams, or as a specialism within an existing team, for example, a community learning disability team, or a learning disability specialism within a community forensic team.*

*1.5.1 Commissioners should work with local **housing** and social care providers to identify the specific housing needs of adults with a learning disability and behaviour that challenges. They should ensure areas have a range of housing and care options available that meet these needs and cater for different preferences and person-centred support needs."*

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	7 March 2019
Subject:	**INFORMATION REPORT -**Update on the new 0-19 Health Visiting and School Nursing Service
Responsible Officer:	Carole Furlong, Director of Public Health, Harrow Council Javina Sehgal, Managing Director, Harrow Clinical Commissioning
Public:	Yes
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides the Health and Well-Being Board with an update on the 0-19 Health Visiting and School Nursing service contract since it commenced on 1 July 2018.

FOR INFORMATION

Section 2 – Report

Background

The background to the new 0-19 Health Visiting and School Nursing Contract was set out in the previous paper that was taken to the Health and Well-Being Board on 5 July 2018.[1]

This report will look at the key achievements of the last six months as well as some of the challenges.

Achievements

CNWL as the new provider – in conjunction with LNWUH and CLCH as the previous providers – worked very hard to successfully transfer all the staff and data to the new service, in a new venue with functioning IT systems on the first day of work, Monday 2 July 2019. It is a testament to all involved that this happened without a hitch and was no small undertaking with 75 staff involved.

As part of mobilisation CNWL needed to recruit a number of staff. All key posts were filled by the beginning of October 2018.

Official launch of the new service was on 2 October 2018. Shortly afterwards visits to the fully refurbished office / clinic space at Milman's in Pinner were arranged for any Councillor who wished to attend. It was a useful opportunity for the lead / shadow members as well as the members of the Health Visiting Scrutiny Review to see for themselves how the service is operating from the new combined site.

The service has carried out an in-depth audit of SEN cases and held a consultation with parents / carers of children with SEN in order to make sure it is supporting this group of vulnerable young people. Overall practice was found to be good but there were a number of areas that the service will be focussing on over the coming months, including the service offer for home-schooled pupils. This is an important focus for the service currently.

As previously set out in Cabinet reports, the introduction of the new check at 4-5 months is dependent on health visiting resources being freed up through GPs sending through additional information from their existing 6-8 week check. Dr Small has assisted greatly with the technical solution and support for the project. Her successor as Lead GP for Children and Young People, Dr Bundock, is now taking over the work and has led on the work to identify the pilot GP practices for the data flow tests. The pilots will be starting shortly.

Significant amounts of work are being carried out to work in a different way at the 2 year check points with early years settings. The fuller introduction of the new check at 3.5 years is dependent on this project.

Work is being undertaken with LNWUH to clarify the responsibilities in terms of safeguarding and the post formerly called the Paediatric Liaison Health

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1 http://www.harrow.gov.uk/www2/documents/s151264/Health_and_Wellbeing_Board_Information_Report_0-19_Update.pdf

Visitor, as well as to redefine the responsibilities of that post in regards to the 0-19 service itself.

There was a delay in starting with the NCMP (National Child Measurement Programme) while the new staff in the school nursing team were recruited. The opportunity was also taken to revise and refresh all the letter templates for parents / carers and schools.

The new vision screening service started in January 2019 and was preceded by meetings with ophthalmology at Northwick Park Hospital to ensure that the pathways were appropriate and only appropriate referrals were made. It was agreed that there would be a research project undertaken to assess the impact of the programme. The Brent 0-19 Service have been included in order to ensure that the same referral processes are used by both Brent and Harrow 0-19 services. The engagement was very much welcomed by the ophthalmology consultant who believes it will be of great benefit to the young people in Harrow and hopefully prevent later referrals at a point when treatment is much more difficult.

The processes for supporting school-aged children who have child protection plans has been rolled out. After some initial difficulties this is now working well. It will be reviewed over the next 12 months and the HSCB kept informed of how this is working.

Contact has been made with the Romanian community group as a first step to setting up more regular feedback processes with the five most spoken language groups in the borough. Romanian is now the second widest-spoken language in Harrow after English.

At the request of the HSCB the 0-19 Service has made FGM a priority given the low numbers of referrals from health services. The service has ensured that all its staff have been trained or had their training refreshed.

The service has been working closely with public health and LNWUH paediatricians to scope a project to improve breast-feeding rates in Harrow. The drivers for this are the numbers of avoidable admissions in babies under 28 days to Northwick Park Hospital A&E as well the problems with childhood obesity and poor oral health.

The Breast-Feeding Peer Supporters won the award for Volunteers of the year Award at the Harrow Heroes 2018 Award ceremony.

Safeguarding service
All posts are now recruited to. There is a full-time MASH Health Visitor based at the Civic Centre and full-time administrative support for the team.

Performance

Overall high levels of performance have been maintained.

The number of **antenatal checks** has fallen quite significantly as the service is still working on data flows from the main maternity units in order to have the

information to target the antenatal checks at the mothers specified in the service specification i.e.

- those categorised as vulnerable by maternity/midwifery services;
- those referred by GP as vulnerable;
- late bookers for maternity services i.e. those who register their pregnancy after 20 weeks ;
- first-time mothers (primips);
- those for whom there is no information e.g. they have just arrived in the country.

The percentage **of 6-8 week reviews** has fallen slightly but the figure for 6-8 week reviews carried out before 10 weeks is 76%.

The performance for the **2 year reviews** remains strong. There were some issues with the way the data was calculated previously for the **12 month** reviews which is why there has been a significant drop. This will start improving and the figure for **12 month reviews by the age of 15 months** has remained high.

National KPI	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Total number of infants who turned 30 days within the quarter	938	914	931	828	916	906	894
Number of mothers who received a first face to face antenatal contact with a Health Visitor.	284	276	255	248	263	26	23
Percentage of births that receive a face to face NBV* within 14 days by a Health Visitor	93%	93%	94%	96%	94%	92%	95%
Percentage of children who received a 6-8 week review by the time they were 8 weeks.	72%	70%	79%	76%	81%	70%	65%
12 Month checks when child turns 12 months in that quarter	84%	80%	86%	86%	34%	19%	14%
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months.	85%	89%	86%	90%	85%	81%	82%
Percentage of children who received a 2-2½ year review	41%	61%	63%	71%	75%	76%	74%
Percentage of children who received a 2-2½ review using ASQ 3	41%	16%	86%	81%	97%	95%	96%

Priorities for the next phase of transformation

There are a number of significant projects which will require a concerted investment of time on the part of the 0-19 Service as well as Public Health and other partners in order to implement the service specification as planned:

- Continued work on new processes for 6-8 week review and 2 year old reviews
- Implementation of action plan following SEN audit and review
- Review of paediatric liaison role
- New online health questionnaires for secondary aged pupils
- More work to set up feedback groups for 5 most commonly spoken languages in Harrow
- Review of nursery nurse role at Woodlands and Kingsley
- Data flows (there are a number of projects relating to this and needing to ensure that the data can be transferred safely and within all data protection legislation).
- Data reporting: all the key data is being reported on but the new service specification went much further in its data requirements. It is going to take some time before this is all reported as required by the service specification.

Financial Implications/Comments

There are no financial implications arising from this report updating the progress since the start of the contract in July 2018.proposed changes to the budget.

The contract value totals approx. £3.7m pa, and represents school nursing and health visiting services (funded by the Public Health grant) and the children's safeguarding service (funded by Harrow CCG).

It should be noted that the award of this contract included the provision of breast feeding services (previously commissioned separately) as well as vision and screening services which were not previously funded.
The contract was awarded for an initial term of 3 years, with the potential to extend for a further 4 years.

Legal Implications/Comments

Not applicable

Risk Management Implications

Risks	**Mitigations**
Dip in performance	This is always a risk and will be closely monitored as always. The service has been set performance targets which they are working towards.
Risks of vulnerable children not being seen due to changes in processes e.g. to the school nurse involvement in CP processes.	This is always a risk and was carefully considered as part of the procurement and service design stage. Children's social care and the HSCB were consulted on the changes prior to procurement.

Risks	Mitigations
	There is always a strong focus on the part of the service and LA/CCG commissioners re. the most vulnerable children i.e. it is always checked that the service is regularly seeing those known as vulnerable; those transferring into Harrow from another local authority or country. In addition, reviews have been built into the process so that it can be ensured that the changes are not having a negative impact on vulnerable children and families. The intention behind the changes is to *reduce* risks overall by ensuring that e.g. children who are not in an early years setting are seen at 3.5 years.

Equalities implications

Yes. All set out in previous reports and published with Cabinet papers.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

The 0-19 Health Visiting and School Nursing service will positively impact all of these areas with most immediate impact on the vulnerable and families.

- 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	[x]	on behalf of the Chief Financial Officer
Date: 11 February 2019		

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact:

Jonathan Hill-Brown, Public Health Commissioning Manager, LB Harrow, 020 8424 7613
Anita Harris, Head of Children's Commissioning, Harrow CCG, 020 8966 1048

Background Papers:

Reports to Cabinet, 17.11.16:
https://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=249&MId=6283 9&Ver=4#AI103940

Reports to Cabinet, 14.9.17:
https://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=249&MId=6413 4&Ver=4#AI110550

Reports to Health and Wellbeing Board, 5.7.18:
http://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=1280&MId=6440 6&Ver=4#AI113708

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