LONDON BOROUGH OF HARROW

Health and Wellbeing Board Agenda

Date: **Thursday 25 January 2024**

Time: **10.00 am**

Venue: **The Auditorium - Harrow Council Hub, Kenmore Avenue, Harrow, HA3 8LU**

Membership (Quorum 5)

Chair:	**Councillor Paul Osborn**
Voting Members:	
Members of Council Nominated by the Leader of the Council:	**Councillor Ghazanfar Ali** **Councillor Hitesh Karia** **Councillor Pritesh Patel** **Councillor Norman Stevenson**
Reserve Members:	Councillor David Ashton Councillor Marilyn Ashton Councillor Chetna Halai Councillor Anjana Patel Councillor Simon Brown
Representatives of North West London Integrated Care Board:	**Dr Radhika Balu (VC)** **Isha Coombes** **Vacancy** **Reserve:** Hugh Caslake
Representative of Healthwatch Harrow:	**Yaa Asamany** **Reserve:** Marie Pate
Representatives from the NHS:	**James Benson** **Simon Crawford** **Reserves:** Jackie Allain James Walters

Non Voting Members:

Director of Public Health	Carole Furlong
Chief Officer, Voluntary and Community Sector	John Higgins
Senior Officer of Harrow Police	Inspector Edward Baildon
Chair of the Harrow Safeguarding Children and Adult Board	Chris Miller
Managing Director of Harrow Borough Based Partnership	Lisa Henschen
Corporate Director People / Director of Adult Social Services, Harrow Council	Senel Arkut
Director of Children's Services, Harrow Council	Parmjit Chahal

Contact: Alison Atherton, Senior Professional - Democratic Services
Tel: 07825 726493 E-mail: alison.atherton@harrow.gov.uk

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You will be admitted on a first-come-first basis and directed to seats.

Please:

(1) Stay seated.

(2) Access the meeting agenda online at [Browse meetings - Health and Wellbeing Board – Harrow Council]

(3) Put mobile devices on silent.

(4) Follow instructions of the Security Officers.

(5) Advise Security on your arrival if you are a registered speaker.

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Agenda publication date: Wednesday 17 January 2024

Agenda - Part I

1. **Attendance by Reserve Members**
   To note the attendance at this meeting of any duly appointed Reserve Members.

2. **Declarations of Interest**
   To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from all Members present.

3. **Minutes** (Pages 7 - 12)
   That the minutes of the meeting held on 2 November 2023 be taken as read and signed as a correct record.

4. **Public Questions**
   To receive any public questions received.

   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 22 January 2024. 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.

6. **Deputations**
   To receive deputations (if any).

7. **Harrow Borough Partnership Winter Improvement Plan and System Pressures Metrics Report** (Pages 13 - 52)
   Report of the Managing Director, Harrow Borough Based Partnership

8. **North Central London Start Well Programme Consultation** (Pages 53 - 94)
   Report of North Central London Start Well Programme Director

9. **Health and Wellbeing strategy Update: Healthy People - start well** (Pages 95 - 122)
   Report of the Director of Public Health

10. **North West London Child Death Review (CDR) Annual Report 2022/23** (Pages 123 - 164)
    Report of the Chief Executive Officer of Integrated Care System

11. **Any Other Business**
    Which cannot otherwise be dealt with.

Agenda - Part II - Nil

Data Protection Act Notice

The Council will record the meeting and will place the recording on the Council's website.

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

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LONDON BOROUGH OF HARROW

Health and Wellbeing Board

Minutes

2 November 2023

Present:

Chair:	Councillor Paul Osborn		
Board Members:	Councillor Marilyn Ashton		Harrow Council
	Councillor Simon Brown		Harrow Council
	Councillor Pritesh Patel		Harrow Council
	Councillor Norman Stevenson		Harrow Council
	Dr Radhika Balu (VC)		North West London Integrated Care Board
	Jackie Allain		NHS (Reserve)
	Isha Coombes		North West London Integrated Care Board
Non Voting Members:	Senel Arkut	Corporate Director, People	Harrow Council
	Carole Furlong	Director of Public Health	Harrow Council
	Lisa Henschen		Harrow Borough Based Partnership
	John Higgins	Voluntary Sector Representative	Voluntary and Community Sector
	Chris Miller	Chair, Harrow Safeguarding Boards	Harrow Council
In attendance: (Officers)	Sebastien Baugh	Consultant in Public Health	
	Nahreen Matlib	Senior Scrutiny Officer	

David McNulty	Director of Housing
Dipti Patel	Corporate Director Place
Meghan Zinkewich-Peotti	Project Manager-Housing Strategy

Apologies received: Parmjit Chahal

Absent: Inspector Edward Baildon

60. Attendance by Reserve Members

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

Ordinary Member	Reserve Member
Councillor Ghazanfar Ali	Councillor Simon Brown
Councillor Hitesh Karia	Councillor Marilyn Ashton
James Benson	Jackie Allain

61. Declarations of Interest

RESOLVED: To note that the following interest was declared:-

All agenda items
Councillor Simon Brown declared a non pecuniary interest in that his daughter was employed by Central and Northwest London NHS Trust. He would remain in the meeting room whilst the items were considered and voted upon.

62. Minutes

RESOLVED: That the minutes of the meeting held on 13 September 2023 be taken as read and signed as a correct record.

63. Public Questions, Petitions and Deputations

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

Resolved Items

64. Harrow System Pressures Metrics Report

The Board received a report and tabled presentation which set out a draft schedule of an expanded set of system metrics that were designed to indicate demand pressure on the Harrow health and care system and the effectiveness of the system's response to that demand.

During the presentation, the Board were informed of the impact of the strikes on winter pressures at London North West University Hospitals Trust and advised that details in terms of the number of cancelled procedures and increase in numbers on the waiting list since the start of the year could be provided. Further, data for the following four key indicators was being collated, validated and would be included in future reports:-

- Success of prevention measures;
- Pathway improvement;
- Demand pressure; and
- Utilisation of community resources.

The Board made the following comments on the tabled presentation:-

- It was important to contextualise the statistics so that the Board could assess whether performance was good, bad or average and gauge what was 'normal';
- An explanatory note should appear alongside Hospital Capacity Status;
- It should be clarified that FCP was an abbreviation for Full Capacity Protocol. The Board was advised that the Integrated Management Board had previewed the public health report and that consideration was being given to the possible early work that could be done in order to prevent patients becoming 'critical';
- The impact of the strikes was on the social care sector as a whole so the report should reflect that.

The Board was advised that there was a good post discharge support offer but that there were two rehabilitation units in the borough where delays were being seen. Due to the increased complexity of needs it could be challenging sourcing the appropriate placement which led to delay. This year, a bridging service on hospital wards to facilitate the discharge of patients home by working with clinical staff had been introduced.

In response to a Member's suggestion that the extension of admission times to care homes to include weekends could assist with the discharge of patients from hospital, the Board was advised that whilst some homes would accept a Saturday admission it was whether the time of day was appropriate. There was a forum of care providers and it was clear which establishments would accept weekend admissions. The Board was further advised that safety of the patient was paramount and that some care providers did not feel confident to take patients at the weekend due to clinical capacity. Home care capacity was not an issue in Harrow.

It was requested that the next report include both discharge and re-admission figures and also the impact on voluntary sector resources. Social care funding was being increasingly impacted by discharges.

RESOLVED: That the report and presentation be noted.

65. Annual Director of Public Health Report (ADPHR)

The Board received the Annual Report of the Director of Public Health which was an independent report from the Director of Public Health which reflected the local population's health and wellbeing needs.

The Director of Public Health introduced the report and explained how it should be used and navigated and undertook to respond to any detailed questions following the meeting. In response to a question in relation to the work on poverty, she advised that this would take some months and that it was necessary to understand and improve the inequalities across the borough.

In terms of those residents with learning disabilities, the Vice Chair stated that the report showed that this group were living 19 years less in Harrow and that this information was important for GPs to be aware of. She urged that this information be communicated on.

The Board welcomed the report which would underpin the strategies moving forward. It was commented that working with London Councils, comparative data might be useful in order to both learn from other boroughs and share Harrow's good practice with them. The Director of Public Health confirmed that the data had been shared with the Integrated Care Board as part of the joint needs assessment.

RESOLVED: That the report be noted and the recommendations within the Annual Report be supported.

66. Health and Wellbeing strategy Update: Healthy Places

The Board received a report and presentation which set out the work and commitments being taken forward as part of the healthy place domain of the health and wellbeing strategy, which included community safety and housing.

The Board were informed that the Community Safety Strategy had been approved by Council in September and was an ambitious plan to ensure that Harrow remained one of the safest boroughs in London. The strategy included six key community safety priorities and each priority area had a sub-group led by a senior officer. In response to a question, the officer advised that the delivery planned would be informed by workstreams and be reported to the Safer Harrow Partnership on a quarterly basis.

The Board received a presentation on the Housing element of the report and noted that the information provided in the Director of Public Health's Annual report would be useful in terms of condition of housing and areas where language might be a barrier. In considering the report and presentation in relation to housing, the following comments were made:-

- The Chair commented that the Grange Farm re-development would make a significant difference to residents' lives and health and he requested that data/improvements be monitored.

- The Vice Chair praised the Rough Sleeper service.

- In terms of damp and mould in properties, a leaflet outlining where residents could go for assistance, in different languages if possible, would be helpful, particularly for GPs who were seeing patients who might be in poor health as a result.

- Clarity on the extent of the voluntary sector involvement in promoting the initiatives was sought and the Board was advised that the Council was working with West London Alliance to track funding.

- In response to a question in relation to households moving from long term to short term leasing arrangements, the officer advised that landlords found it more financially viable to lease on a longer term basis, although these had fallen due to the market. The Chair advised that this issue was being considered as part of the budget setting process as there could potentially be a significant cost pressure in two years' time.

In response to the positive feedback in terms of the move to neighbourhood working in relation to Environmental Health, the Chair indicated that it would be useful to set out to government, as a good example, how this had impacted on demand for services.

RESOLVED: That

(1) the work underway and planned to support the delivery of the health and wellbeing strategy be noted;

(2) the approach being taken to improve the health and wellbeing of Harrow be endorsed.

67. Harrow Safeguarding Partners' Annual Report

The Board received the Harrow Safeguarding Partners' Annual Report, a joint report which covered the work of the partnership to safeguard both adults and children.

In considering the report, the Chair stated that the borough needed to be in a good place in light of the potentially imminent OFSTED and Care Quality Commission (CQC) inspections and that it was important for Harrow to receive its fair share of funding. The contribution from the Police was also an issue and needed to be addressed as the police were key in terms of safeguarding. Another member of the Board added that equitable funding was a long standing issue and that the Integrated Care Board was reviewing its out of hospital spend. It was hoped that the financial position would be clearer by April 2024.

The Corporate Director, People, sought to reassure the Board that work on the recommendations set out in report was underway. The Partnership had decided to separate the Board arrangements for Children and Adults due to inspection arrangements. In response to the comment that funding was a significant issue and that each of the three statutory partners should contribute their share as the burden often fell on the Council, the Corporate Director advised that back office arrangements were important and that partners would be asked to contribute too. Safeguarding was everybody's responsibility and the correct resource should be dedicated to the sub-group.

In response to the question as to who the recommendations of the report were addressed to, the Board was advised that it was to the statutory leads of the three main partners. The regulations stated that the Safeguarding Children Partnership must report annually but also have independent scrutiny. In terms of the Safeguarding Adults Partnership, each of the three partners were required to report what they had done against the strategic plan.

RESOLVED: That the Harrow Safeguarding Partners' Annual Report be endorsed.

68. Creating a smokefree generation and tackling youth vaping

This item had been withdrawn from the agenda.

(Note: The meeting, having commenced at 10.00 am, closed at 11.44 am).

(Signed) Councillor Paul Osborn
Chair

LONDON BOROUGH OF HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	25th January 2024
Subject:	Harrow Borough Partnership Winter Improvement Plan and System Pressures Metrics Report
Responsible Officer:	Lisa Henschen, Managing Director, Harrow Borough Based Partnership
Public:	Yes
Wards affected:	All
Enclosures:	Winter Improvement Plan Update and System Pressures Metrics

Section 1 – Summary and Recommendations

The Winter Improvement Plan was developed by the Harrow Borough Based Partnership to prepare the system for the Winter Period.

The planned actions aim to support the provision of high quality care in the community, the prevention of admission to hospital and safe and efficient discharge to the community once patients' acute needs have been met.

The report provides an update on delivery of those actions.

The second part of the report contains system pressures metrics that are designed to indicate:

- Demand pressure on the Harrow health and care system;
- The effectiveness of the system's response to that demand.

The data in the report reflects the system position just prior to Christmas, a time when demand on health and care services is usually relatively low.

Further data will become available between the submission of this report and the meeting of the Health and Wellbeing Board, which will cover the first week after New Year, when the health and care system usually experiences a surge in demand.

Early indications (Wednesday 3rd January) are that the combination of a surge in demand and the impact of the Junior Doctors' Strike is having a severe impact on services.

A briefing on the latest position will be prepared for discussion by the Board.

Recommendations:

The Board is requested to note the contents of the report.

Section 2 – Report

The Harrow Partnership's 2023/24 winter planning included a Winter Improvement Plan and the development of an expanded list of metrics that inform the system's response to increased demand during the winter period.

The Winter Improvement Plan actions that the system committed to complete in 2023 have been delivered and it is expected that those scheduled for January will also be completed as planned.

The System Pressures Metrics are now established and are used to inform discussion at the System response Group and Health and Care Executive as well as the Health and Wellbeing Board.

Financial Implications/Comments

The winter improvement plan is funded by a range of sources including grant funding from the Department for Health and Social Care to support Discharges and core service funding. In Harrow this grant totals £2.246m (of which £934k allocated to the Council and £1.312m allocated to the Council via the ICB funding) and is pooled within the Better Care Fund, and built into the Adult Social Care forecast and budget for 2024-25 on an ongoing basis. These resources underpin a number of the metrics being reported.

The table below details the additional NWL funding totalling £29.1m across the 8 local authorities to provide additional winter capacity. Some of this funding has been passported to Councils through the agreed BCF such as the bridging service where in Harrow £650k has been provided within the ICB funding of £1.312m.

Delivery of 182 General and Acute Beds (all Trusts)	**£14.5m**
Bridging services (Local Authorities)	**£5.1m**
Complex Care Local Authority Bedded Capacity	**£5.1m**
Discharge Hubs (all Trusts)	**£3.1m**
Single Point of Access / Urgent Community Response (part funded by Community Provider Collaborative)	**£0.2m**
Admission Avoidance – (THH & LNWH – Frailty)	**£1.1m**
Total	**£29.1m**

Legal Implications/Comments

The Health and Wellbeing Board's responsibilities include
3.1.5. To ensure that Harrow Council and the Integrated Care Board’s commissioning plans have had sufficient regard to the Joint Health and Wellbeing strategy
3.1.6. To consider how to best use the totality of resources available for health and wellbeing, subject to the governance processes of the respective partner organisations as appropriate.

Risk Management Implications

The indicators will support the monitoring of potential risks relating to increased demand for services during the winter period.

Risks included on corporate or directorate risk register? **N/A**

Separate risk register in place? **N/A**

The relevant risks contained in the register are attached/summarised below. **N/A**

The following key risks should be taken into account when agreeing the recommendations in this report: N/A

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? **N/A**

Council Priorities

Please identify how the decision sought delivers this priority.

1. **A council that puts residents first**

2. **A borough that is clean and safe**

3. **A place where those in need are supported x**

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

Statutory Officer: Donna Edwards
Signed on *behalf of/by the Chief Financial Officer
Date: 11/01/2024

Statutory Officer: Sharon Clarke
Signed on *behalf of/by the Monitoring Officer
Date: 09/01/2024

Chief Officer: Carole Furlong on behalf of Senel Arkut

Signed on behalf of the Corporate Director/by Director of Public Health
Date: 05/01/2024

Mandatory Checks

Ward Councillors notified: NO*, as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Hugh Caslake: AD Integration and Delivery (07958 196271)

Background Papers:

- Winter Improvement Plan and Winter System Pressures Metrics

If appropriate, does the report include the following considerations?

1.	Consultation	NO
2.	Priorities	NO

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Harrow Winter Improvement Plan and System Pressures Metrics

January 2024

Harrow Borough Based Partnership

Supporting better care and healthier lives

Winter Improvement Plan

The action plan on the three following slides was developed by the Harrow Borough Based Partnership to prepare the system for the Winter Period.

The planned actions aim to support the provision of high quality care in the community, the prevention of admission to hospital and safe and efficient discharge to the community once patients' acute needs have been met.

The actions that the system committed to complete in 2023 have been delivered and it is expected that those scheduled for January will also be completed as planned.

Winter Improvement Plan Actions (1/3)

Action	Target impacted	Status	30 Nov	31 Dec	31 Jan	28 Feb	31 Mar
Implement Harrow Bridging Service	Reduce % of patients without C2R, not discharged	• Spec and procurement complete. • Service commenced 16/11/23. • Service accepting all referrals from MDT but spare capacity – review of potential to manage wider cohort of patients.	Commenced				
Harrow Multi-Agency Admission Avoidance Summit	Reduce ASC NEL admissions	Multi-agency summit took place 09/11/23.	Action plan agreed.				
Action plan to improve review of children attending hospital due to asthma	Reduce ASC NEL admissions	Task and finish group established. Data analysis complete.	Action plan agreed.				
Implement local escalation processes for discharge delays as described in the winter plan	Reduce % of patients without C2R, not discharged	• Twice daily Discharge Hub / ASC MDTs established 09/10/23. • Three times weekly PL DTOC reporting to Partnership Leaders,	In place				
Launch 'Radar' function of Harrow Frailty Dashboard to identify rising risk patients	Reduce ASC NEL admissions	Risk stratification radar launched 02/11 for use by primary care to identify patients with rising risk of deterioration.	Complete				

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Winter Improvement Plan Actions (2/3)

Action	Target impacted	31 October	30 November	31 December	31 January	28 February
Implement 2023/24 winter wellness scheme: Deliver Make Every Contact Count winter programme	Reduce ASC NEL admissions	**Public Health and Voluntary Action Harrow training programme started 06/11**	**Ongoing**			
Review pathway for discharge of patients in rehabilitation units	Reduce % of patients without C2R, not discharged	**MDT established.** **P2 NCTRs reducing.**	**In place.**			
Review processes for admissions from and discharge to care homes	Reduce % of patients without C2R, not discharged Reduce ASC NEL admissions		**Review complete 30/11**	**Finalise pathway between care homes and LNW virtual wards.**	Draft discharge pathway and SOP TBC 08/01/23.	Trusted assessor model to be developed.
Improve process for discharging patients from CNWL mental health beds to reduce delays	Reduce % of patients without No Criteria to Remain, not discharged	**Adult social care review pathway accelerated, Currently no patients whose discharge is delayed (03/01/23)**				
Secure access to clinical records across CNWL and Drug and Alcohol service provider.	Prevent admissions to secondary inpatient care	**CNWL data available to D&A team.** Further work to resolve IG issues for sharing of Drug and Alcohol Service data.				

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Winter Improvement Plan Actions (3/3)

Action	Target impacted	31 October	30 November	31 December	31 January	28 February	31 March
LNWHT winter inpatient beds Phase 1: open 33 beds up across NPH and EH from October Phase 2: open NPH SAU level 4 from November Phase 3: open 32 NPH AMU modular beds from March		Phase 1: 23 of 33 beds open	Phase 2: open 14 NPH SAU level 4 trollies		Phase 1: 33 of 33 beds open		Phase 3: 32 NPH AMU modular beds open
Digital solutions to support flow and discharges to improve monitoring of patient flow actions through Timely Care Hub and Optica	Reduce % of patients without C2R, not discharged	Continued working with CCS to develop the digital tools to interface with Cerner					
Increase daily discharges via NPH and EH Discharge Lounges	Reduce % of patients without C2R, not discharged	Daily process in place to review all discharges for suitability Daily review of confirmed and potential discharges with Divisional Teams					
REACH: 12 week pilot for ED Consultant to triage LAS call-in anticipation of preventing conveyance by offering A&G or diverting call to SPA for SDEC/other specialty alternatives. REACH will operate M-F, 1000-1800	Reduce ASC NEL admissions	12 week pilot commenced as of 11 Oct					
Increase conversion NPH	Same day emergency care: Reduced waits to be seen in ED Rapid Access Unit NPH		Converting NPH CDU D Bay to increase access to non-specific chest pain, needlestick injuries, hyperkalaemia and post CT KUB				

Harrow System Pressures Metrics

The data in the following slides reflects the system position just prior to Christmas, a time when demand on health and care services is usually relatively low.

Further data will become available between the submission of this report and the meeting of the Health and Wellbeing Board, which will cover the first week after New Year, when the health and care system usually experiences a surge in demand.

Early indications (Wednesday 3rd January) are that the combination of a surge in demand and the impact of the Junior Doctors' Strike is having a severe impact on services.

A briefing on the latest position will be prepared for discussion by the Board.

The final slide contains a summary of some longer term trends that have emerged in 2023. These include a significant increase in the number of A&E attendances and a very large increase in the number of people receiving social care support after discharge from hospital.

Harrow System Pressures Metrics (1/2)

	System Indicators	Cohort	Frequency	Data Period	Current Period	Previous Period	Context	
Success of Prevention Measures								
1	Autumn Campaign - Covid vacc uptake	Harrow	Weekly	WE 24/12	34.84%	34.85%	NWL uptake	27.0%
2	Autumn Campaign - Flu vacc uptake	Harrow	Weekly	WE 21/12	38.15%	37.85%	NWL uptake	33.3%
Demand pressure								
6	AED Attends	NPH	Weekly	WE 24/12	2248	2246	Avg over last winter (Oct 22 - Apr 23)	2,139
7	AED Attends Paeds	NPH	Weekly	WE 24/12	409	444	Avg over last winter (Oct 22 - Apr 23)	546
8	UTC Attends	NPH	Weekly	WE 24/12	1432	1582	3 mth avg	1,314
9	AED Emergency Admissions	NPH	Weekly	WE 24/12	667	711	Avg over last winter (Oct 22 - Apr 23)	642
10	Community/District Nursing - Visits completed (in hours)	Harrow	Weekly	WE 23/12	1,673	1,654	Avg over last winter (Oct 22 - Apr 23)	2,321
11	Community/District Nursing - Rostered staff (in hours)	Harrow	Weekly	WE 23/12	1,558	1,455	Avg over last winter (Oct 22 - Apr 23)	1,843
12	No hospital discharges in month that required social care input	Harrow	Monthly	Oct-23	147	147	Mar '20 Avg	178
13	No of patients being worked with by social care	Harrow	Monthly	Oct-23	337	337	Mar '20 Avg	91
14	MH Liaison AED Referrals	Harrow	Weekly	WE 24/12	63	73	Avg over last winter (Oct 22 - Apr 23)	33
15	MH Liaison AED Referrals - 1 hour response	Harrow	Weekly	WE 24/12	90.2%	83.3%	Avg over last winter (Oct 22 - Apr 23)	62%
16	MH Liaison Ward referrals	Harrow	Weekly	WE 24/12	34	33	Avg over last winter (Oct 22 - Apr 23)	60
17	MH Liaison Ward referrals - 24 hour response	Harrow	Weekly	WE 24/12	72.2%	63.6%	Avg over last winter (Oct 22 - Apr 23)	85%
18	Rapid Response - Visits completed (in hours)	Harrow	Weekly	WE 23/12	200	360	Avg over last winter (Oct 22 - Apr 23)	330
19	Rapid Response - Rostered staff (in hours)	Harrow	Weekly	WE 23/12	147.75	391	Avg over last winter (Oct 22 - Apr 23)	390
20	No of referrals to drug and alcohol service							
21	Urgent referrals to drug and alcohol service							
22	No of referrals to Housing for homeless patients with MH issues							
23	Urgent referrals to Housing for homeless patients with MH issues							
24	People contacting LA about Damp / Mould	Harrow	Monthly	Nov-23	104	69	3 mth avg	76
26	Covid Related 111 Calls	Harrow	Weekly	WE 24/12	147	110	Avg over last winter (Oct 22 - Apr 23)	69

Harrow Borough Based Partnership
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Harrow System Pressures Metrics (1/2)

	System Indicators	Cohort	Frequency	Data Period	Current Period	Previous Period	Context	
Pathway Efficiency								
27	Delayed Transfers of Care – Community Beds (P2)	Harrow	Weekly	WE 26/12	11	10	4 wk avg	9
28a	Delayed Transfers of Care - Pathway 0	NPH - Harrow	Weekly	WE 26/12	7	7	4 wk avg	15
28b	Delayed Transfers of Care - Pathway 1	NPH - Harrow	Weekly	WE 26/12	12	16	4 wk avg	8
28c	Delayed Transfers of Care - Pathway 2	NPH - Harrow	Weekly	WE 26/12	8	8	4 wk avg	5
28d	Delayed Transfers of Care - Pathway 3	NPH - Harrow	Weekly	WE 26/12	5	2	4 wk avg	4
	Delayed Transfers of Care Total	NPH - Harrow	Weekly	WE 26/12	32	33	4 wk avg	37
28e	Delayed Transfers of Care - Unstated Pathway	NPH - Harrow	Weekly	WE 26/12	3	2	4 wk avg	11
39	Community Equipment Delays	Harrow	Monthly					
40	Enhanced Frailty service - Current Caseload	Harrow	Monthly	Nov-23	189	195	6 mth avg	192
41	Enhanced Frailty service - Step ups	Harrow	Monthly	Nov-23	76	65	6 mth avg	69
42	Enhanced Frailty service - Step down	Harrow	Monthly	Nov-23	64	72	6 mth avg	66
System Stress								
56	Hospital Capacity Status	NPH	Weekly	WE -26/12	Green	FCP	% of weeks FCP over last winter (Oct 22 - Apr 23)	83%
57	12 Hour AED Waits	NPH	Weekly	WE -24/12	187	198	Avg over last winter (Oct 22 - Apr 23)	313
58	LAS Handovers - No. of 60 min Breaches	NPH	Weekly	WE -24/12	1	18	Avg over last winter (Oct 22 - Apr 23)	103
59	Community/District Nursing - No. of visits deferred once	Harrow	Weekly	WE -23/12	15	60	Avg over last winter (Oct 22 - Apr 23)	4
60	Community/District Nursing - No. of visits deferred more than once	Harrow	Weekly	WE -23/12	0	0	Avg over last winter (Oct 22 - Apr 23)	1
61	Rapid Response - No. of referrals with a 2 hour response time	CLCH	Weekly	WE -23/12	58	80	Avg over last winter (Oct 22 - Apr 23)	69
62	Rapid Response - Initial visits not completed within 2 hours	CLCH	Weekly	WE -23/12	2	10	Avg over last winter (Oct 22 - Apr 23)	2
63	Rapid Response - No. of referrals rejected due to capacity	CLCH	Weekly	WE -23/12	0	0	Avg over last winter (Oct 22 - Apr 23)	0
64	Community Services Sickness Absence	Harrow	Weekly	WE -23/12	1.1%	2.3%	Avg over last winter (Oct 22 - Apr 23)	3.9%

Summary of Key Issues in Longer Term Trends

System	Indicator (s)	Lead Provider	Current Position (See metrics schedues for details)	Longer-term Trend
Demand for Unscheduled Care	Accident and Emergency Department Attendances / Non-elective admissions at NPH	Northwick Park Hospital (LNWUHT)	Both A&E attendances and non-emective admissions are currenty above /the average for ast winter.	A&E admissions now average 2,100 per week, a level that, pre-Covid woud have been a peak in activity. Non-elective admissions average approximately 600 per week.
Demand for Unscheduled Care	12 Hour A&E waits v LAS 60 minute Handover Delays	Northwick Park Hospital (LNWUHT)	There were 397 12 Hour A&E waits last week compared to an average last winter of 313. There were no 60 minute LAS handover delays compared to an average last winter of 103.	LAS managing patients at the hospital in stationary ambulances when capacity was not available in A&E resulted in long handover delays and poor LAS response times. This approach changed in June 2023 and the result has been very few handover delays and a sharp increase in 12 hour waits in A&E.
Hosp Discharge	Hospital Discharges	Northwick Park Hospital (LNWUHT)	Discharges in most recent week from NOPW ere 655 against an average over the last year of 503.	Since August discharges have been above 600, compared to an average for 12 months of 503, peaking at 746 earlier in December.
Social Care Demand	Patients discharged needing social care support v those remaining on social care caseload	LB Harrow Adult Social Care	The number of patients leaving hospital requiring social care support in October (147) was lower than last year's winter average (178). Thr average number of discharged patients in September and October receiving support from social care was 425, compared to last winter's average of 298.	Although the number of patients discharged from hospital requiring social care support has not increased since 2019/20, the number continuing to receive support in 2022/23 and 2023/24 has increased from fewer than 100 to approximately 300. Although the full explanation of this change will be complex, the move to earlier discharge is a significant factor in this increase in demand for social care.

Harrow Borough Based Partnership
Supporting better care and healthier lives

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Harrow Borough Partnership Winter Plan

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Winter 2023/24

Draft 3 - FINAL

Harrow Borough Based Partnership

Supporting better care and healthier lives

The Harrow Borough Based Partnership

Harrow Borough Based Partnership brings together our NHS organisations, Harrow Council, our GPs, and local Voluntary & Community Sector.

We strive to support each other and our communities as equal partners focussing on better health and wellbeing for all.

NHS North West London Integrated Care System	Harrow Council	Harrow's Primary Care Networks
NHS Central London Community Healthcare NHS Trust	NHS Central and North West London NHS Foundation Trust	NHS London North West University Healthcare
Harrow Together	Harrow Health Community Interest Company	St Luke's Hospice

Harrow Borough Based Partnership
Supporting better care and healthier lives

Introduction

It is the ambition of the Borough Based Partnership in Harrow that our winter plan is a plan for the Place for Harrow and its citizens and carers. We are seeking to achieve, through a collaborative planning process led by our Health and Care Executive, that we move away from a focus on individual organisational capacity planning towards a Place Plan. This winter plan for 23/24 will build on our system learning and evaluation of the Partnership's winter response in 22/23.

The Place plan for Harrow will focus on:

- Taking preventative action to mitigate where possible, the impact of illness of individuals, families and the health and care system, through our flu and COVID immunisation delivery, particularly amongst groups experiencing the highest levels of health inequalities;
- Harnessing our local assets in Harrow; our building and community spaces to provide a warm and safe places within our communities, where people can come together for company, extending this where possible to a range of community activities to support health and wellbeing of our citizens;
- Communication with local citizens to support them to navigate the local health and care offer, so care can be provided by the right service and/or individual in the right place;
- Addressing the wider determinants of health that will impact our local population over the winter, through a robust information, advice and support offer to support income maximisation, support home adaptations to create energy efficiencies and action to reduce the risks of homelessness.
- Continuing to strengthen our support and capacity in primary and community teams to prevent admissions to hospital and ensure a robust discharge pathway out of hospital to maintain effective care for people who need the support of hospital services;
- Deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place for in and out of hospital care;
- Securing a strong discharge pathway to reduce the length of time our citizens spend in hospital once medically fit to leave, delivering the best outcomes for our citizens and the wider functioning of our urgent and emergency care services.

Overview of the Harrow Winter Plan

Prevention and community winter wellness

- Health and wellbeing support through the Warm Hub programme
- Robust flu and COVID vaccination programme across all cohorts
- Addressing the wider determinants of health and admission risks
- Communication and engagement campaign with local communities, to include information about Talking Therapies and mental health perinatal services

Community based admission avoidance

- Securing primary care access and capacity
- Enhanced Frailty Service
- Rapid response and care home support
- Mental health – crisis alternative- Coves, stepdown beds, Home Treatment Team

In hospital care

Discharge Hub and Discharge Support Service

- SDEC
- Acute Hospital Flow and increased bed capacity
- Community rehab bedded care flow
- Mental Health- in-reach to medical wards for people with alcohol problems from Substance Misuse provider

Discharge pathways

- Enhanced on-site social care
- Increased provision of step down beds
- Integrated intermediate care service, including reablement
- Increased provision for same day equipment
- Increased home care provision, including weekends
- Mental Health- need access to hospital discharge team, to improve flow

Winter demand and capacity modelling (1/3)

This will be reviewed fortnightly by the Harrow Health and Care Executive for oversight and risk management.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Success of Prevention Measures									
1	Autumn Campaign - Covid vaccination uptake by cohort	Green	Foundry	Harrow	Weekly	0.05%	0.05%		
2	Autumn Campaign - Flu vaccination uptake by cohort (including years 7 and 11)	Green	WSIC/Immform	Harrow	Weekly	5.90%			
3	Paediatric Asthma Reviews within 48 hrs of AED attendance	Amber	Public Health	Harrow	Monthly				
4	Paediatric Asthma Reviews within 48 hrs of ED Admissions	Amber	Public Health	Harrow	Monthly				
5	Winter Wellness MECC sessions uptake	Red	Voluntary Action Harrow - To be Scoped	Harrow	Monthly				
Demand pressure									
6	AED Attends	Green	NWL BI	NPH	Weekly	2,062	1,776		
7	AED Attends Paeds - Harrow	Green	NWL BI	NPH	Weekly	160	160		
8	UTC Attends	Green	NWL BI	NPH	Weekly	1,359	1,359		
9	UTC Attends Paeds - Harrow	Green	NWL BI	NPH	Weekly	161	161		
10	Community/District Nursing - Number of visits completed (in hours)	Green	CLCH	Harrow	Weekly	1,616	1,577		
11	Community/District Nursing - Number of rostered staff (in hours)	Green	CLCH	Harrow	Weekly	1,455	1,471		
12	LA Demand Pressure	Red	LA	Harrow	Weekly				
13	MH Liaison AED Referrals	Green	CNWL	Harrow	Weekly	57	30		
14	MH Liaison AED Referrals - 1 hour response	Green	CNWL	Harrow	Weekly	66.7%	72.7%		
15	MH Liaison Ward referrals	Green	CNWL	Harrow	Weekly	20	73		
16	MH Liaison Ward referrals - 24 hour response	Green	CNWL	Harrow	Weekly	83.3%	94.1%		
17	Rapid Response - Number of visits completed (in hours)	Green	CLCH	Harrow	Weekly	272	332		
18	Rapid Response - Number of rostered staff (in hours)	Green	CLCH	Harrow	Weekly	345	368		
19	Number of referrals to drug and alcohol service	Red	CNWL	Harrow	Monthly				
20	Number of urgent referrals to drug and alcohol service	Red	CNWL	Harrow	Monthly				
21	Number of referrals to Harrow Housing pathway for homeless patients with mental health issues	Red	LA Housing	Harrow	Monthly				
22	Number of urgent referrals to Harrow Housing pathway for homeless patients with mental health issues	Red	LA Housing	Harrow	Monthly				
23	People contacting LA about Damp / Mould	Red	LA Housing	Harrow	Monthly				
24	Primary Care Patches Use / Availability	Red	Primary Care	Harrow	Weekly				

- Red: **Need confirmation that data is collected and reported.**
- Amber: **Data is reported. Process not yet in place for regular submission to PMO.**
- Green: **Data received regularly by PMO**

Harrow Borough Based Partnership
Supporting better care and healthier lives

Winter demand and capacity modelling (2/3)

This will be reviewed fortnightly by the Harrow Health and Care Executive for oversight and risk management.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Pathway Efficiency									
25	Community Bed DTOCs		Local Care	Harrow	Weekly				
26	DTOCs by pathway @ NPH as % discharges vs NWL Boroughs		Local Care: Optica / NWL BI	Harrow	Weekly				
27	NPH DTOCs: Awaiting equipment		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
28	NPH DTOCs: Awaiting long term placement		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
29	NPH DTOCs: Awaiting rehab bed		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
30	NPH DTOCs: Homeless		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
31	NPH DTOCs: Patient / family choice delays.		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
32	NPH DTOCs: POC start / restart		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
33	Number of pts waiting more than 48 hours on a P1 pathway escalated		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
34	Number of pts waiting more than 5 days on a P1 pathways escalated		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
35	Number of pts waiting more than 5 days on a P3 pathway escalated		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
36	Number of pts waiting more than 7 days on a P3 pathway escalated		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
37	Bridging Service Indicators		LA	Harrow	Fortnightly				
38	Community Equipment Delays		Borough Team	Harrow	Monthly				
39	Enhanced Frailty service - Current Caseload - Aug & July		Borough Team	Harrow	Monthly	191	207		
40	Enhanced Frailty service - Step ups - Aug & July		Borough Team	Harrow	Monthly	69	82		
41	Enhanced Frailty service - Step down - Aug & July		Borough Team	Harrow	Monthly	47	76		
Pathway improvement									
42	Complete FIT notes in secondary care		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
43	Discharges to Care Homes at Weekends		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
44	Onward referrals (C2C referrals)		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				
45	Discharge Letters sent to GP Practices		NPH Discharge Hub / Optica / NWL BI	Harrow	Weekly				

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Winter demand and capacity modelling (3/3)

This will be reviewed fortnightly by the Harrow Health and Care Executive for oversight and risk management.

Line No	System Indicators	Status	Source	Cohort	Frequency	Current Week	Previous Week	Current Trend	Previous Trend
Utilisation of community resources									
46	Capacity Access Improvement Plans - Additional capacity per site and number of redirections from UTC and 111		Borough Team	Harrow	Monthly				
47	Community Rehab bedded care flow / Intermediate Care Beds - Utilisation and LOS		Local Care	Harrow	Monthly				
48	Number of contacts at Community Pharmacy Consultation Service not requiring redirection		Borough Team	Harrow	Monthly				
49	Uptake / Utilisation of: Enhanced Access Services		Borough Team	Harrow	Monthly				
50	Virtual Ward contacts for Cardiology (Heart Failure and AF), Respiratory and Diabetes		Local Care	Harrow	Monthly				
51	Uptake / Utilisation of: Care Home Support Service		Borough Team	Harrow	Quarterly				
52	Uptake / Utilisation of: Childhood Asthma Clinics		Borough Team	Harrow	Quarterly				
53	Uptake / Utilisation of: CYP Health Inequalities Clinics		Borough Team	Harrow	Quarterly				
54	Uptake / Utilisation of: Additional Care for Complex Patients		Borough Team	Harrow	Quarterly				
System Stress									
55	Hospital Capacity Status		NPH	NPH	Weekly on Tuesday	Full Capacity Protocol	Black		
56	12 Hour AED Waits		NWL BI	NPH	Weekly	340	356		
57	LAS Handovers - Average number of 60 min Breaches per day		NWL BI	NPH	Weekly	0	2		
58	Community/District Nursing - Total number of visits deferred once		CLCH	Harrow	Weekly	0	1		
59	Community/District Nursing - Total number of visits deferred more than once		CLCH	Harrow	Weekly	0	0		
60	Rapid Response - Number of referrals with a 2 hour response time		CLCH	CLCH	Weekly	56	59		
61	Rapid Response - Total number of initial visits triaged for a 2 hour response that were not completed within 2 hours of acceptance into service		CLCH	CLCH	Weekly	4	14		
62	Rapid Response - Total number of referrals rejected due to capacity		CLCH	CLCH	Weekly	0	0		

Need confirmation that data is collected and reported.

Data is reported. Process not yet in place for regular submission to PMO.

Data received regularly by PMO

Harrow Borough Based Partnership

Supporting better care and healthier lives

Management of interface for system efficiency

There is work being done at both local and NWL level to manage system efficiency. Following the 'Delivery plan for improving access to primary care' being published, there are three priorities that will be reviewed:

1. Onward referrals (C2C referrals),
2. Complete FIT notes in secondary care. Call and recall of patients to be done by trusts ,
3. GPs should have access to single email / primary care liaison officers in each trust. Clear points of contact at point of referral for GPs and patients to access secondary care and working GP bypass numbers for the trust to hold in their systems.

The above work is being picked up through 3 working groups which will be reporting to NWL System interface group. Data sharing between primary care and LNWHT; this will be through CIE and LCR. With the trust now switched to Cerner, this should become more seamless.

Over the coming period work will be done to ensure there is an updated contact list that includes bypass numbers for Harrow practices, community services and hospital services. This list will then be made available to health and care services within Harrow. LNWHT will be looking at amending templates for outpatient letters so that service contact details are available for patients and GPs. We are picking this up at Local interface group.

Work will be done with primary care colleagues to ensure referrals are sent through on the correct forms especially when referring to SDEC. Work is taking place within NWL to improve quality of discharge summaries with the possibility of an inclusion of a contact number for the pharmacy team that practices, and community pharmacies can use to discuss medication queries.

A letter will be drafted to be sent to clinical teams in LNWHT and GPs across Brent, Harrow and Ealing. The letter will be like that sent last year but with a refreshed set of priority areas for focus for primary care and LNWHT.

Sharing of performance data and agreed escalation processes

The Northwick Park discharge hub coordinates the patient level daily calls for system coordination of individual issues and barriers to discharge.

As part of our plan for winter, it is proposed that a more robust system of escalation is introduced to provide senior input for challenges to discharge.

Daily prioritisation of discharges is taking place involving the discharge hub and social care services. The nationally commissioned Optica system is being implemented in NWL ICB and will provide a common source of analysis on the discharge pathway.

Briefings will be circulated to the DASS and Managing Director Harrow BBP three times each week on patients that are delayed, using the following criteria:

- Patients waiting more than 48 hours on a P1 pathway
- Patients waiting more than 5 days on a P1 pathway
- Patients waiting more than 48 hours on a P2 pathway
- Patients waiting more than 5 days on a P3 pathway
- Patients waiting more than 7 days on a P3 pathway

To ensure parity briefing will also be established once a week for Mental Health and Learning Disability patients at NPH Mental Health Unit or on medical wards clinically ready for discharge but delayed in line as follows:

- Patients waiting more than 72 hours on any pathways

The system flow and winter planning workstream will take strategic oversight of delays in the system, beyond individual patient delays to focus on themes and system issues that are factors in delay, for a collective partnership response to support in addressing them.

Prevention and community winter wellness

Health and wellbeing support to warm hubs

Following the successful delivery and evaluation of the Harrow Winter Wellness programme in 22/23, the London Borough of Harrow will be supporting the scheme for the 23/24 winter, running from November 2023 until March 2024. This will be funded from the Public Health grant and BBP inequalities funds. Warm hubs will deliver the following interventions as part of the winter wellness scheme:

- Support the delivery of a number of activities aligned with specific priorities e.g. Making Everyone Contact Count, physical activity, healthy cooking and eating, reducing falls risk, smoking cessation.
- Targeted clinical outreach for specific priority areas through health checks for residents attending warm hubs.
- Distribute warm packs provided by public health.
- Support the community-based Conversation Café model delivery.
- Support the provision of information and advice services delivering from warm hubs.

We have built on last years evaluation through: focusing on expanding the proactive health checks in warm hubs; encouraging collaborative & innovative approaches to engaging with communities; developing an enhanced evaluation offer that will strengthen the evaluation of the programme this year.

Addressing the wider determinant of ill health and admission risk

MECC:

Voluntary Action Harrow have been commissioned to deliver the Winter Wellness MECC sessions this winter. The session will focus on how to eat better, stay warm and find the best health help. The session will be open to all colleagues including frontline staff.

Cost of Living Support and Housing:

Local Authority have set up a support page for residents to seek support with the cost of living crisis (Help with the cost of living – London Borough of Harrow). A working group has been set up to oversee this.

Housing-related support services including; EACH Counselling & Support, Age UK Hillingdon, Harrow & Brent. Fuel Poverty and Energy Advice; Seasonal Health Intervention Network (SHINE) run by Islington Council for Londoners and Green Doctor (Groundwork)

Damp and Mould work- working group, set up to work together on responding to the regulator/government on damp and mould, developing a comms plan, monitoring trends in the number of cases, developing a strategy.

Prevention and community winter wellness

Flu and COVID vaccination

- The Autumn campaign will commence on around early to mid October. The cohorts will be the same as Autumn 2022. All Harrow PCNs will be participating.
- Autumn flu plans to be jointly developed with COVID to reflect the need for co-administration wherever possible.
- Pathway for Newly severely immunosuppressed patients now available.
- The National Flu immunisation programme 2023/2024 has been published. It sets out which groups are eligible for flu vaccinations this coming flu season. 50-64 year olds are not part of the eligible groups.
- Secondary school children in years 7 and 11 are entitled to free flu jab but all school-based delivery will have a hard stop of 15th December to align with the Christmas break.
- Frontline H&SCWs are included in this year's flu programme and vaccinations should be delivered through occupational health schemes.
- Targets for flu will be 100% offer to all eligible and ambition to meet or exceed last year's position.
- All plans must have a strong emphasis on tackling inequalities and focus on groups not coming forward.
- The Immunisation and Flu Task & Finish Group will continue to meet on a monthly basis, moving to 2weekly as we near September (flu season) - Representation of the group is from Borough Team, Public Health, Local authority PCN management leads, Immunisation champions and community pharmacy representation.

Prevention and community winter wellness

Communication and engagement with local communities

NW London-wide communications and engagement winter plan I in place to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan will use data from previous winter campaigns and the Whole Systems Integrated Care Dashboard to target and support the right areas and communities. A local working group has been established across the NWL communication leads and Local Authority communication and BBP team to ensure coordination of efforts and a dynamic response based on vaccination uptake data and urgent care activity.

Specific areas of focus include:

- Full winter messaging flyers launching in October, with Flu campaign, Children and young people campaign and Self-care campaign launching and continuing throughout winter period, with focus on Urgent and emergency care - Vaccination (flu/*Covid booster) - Children and young people - Primary care.
- Harrow Health Citizen Forum [online] in September, December, March with focus on Winter Wellness messaging.
- ‘Town hall’ style in person forum at prominent locations such as St. Peter’s Church with a focus on winter messaging.
- Regular ‘drop-in’ sessions with specific local communities, engagement and information, including co-ordination with local communities on immunisations i.e., Romanian - RCCT, Somalian - HASVO, Gujarati - SKLPC, as well as rhyme time library sessions targeting under 5s and young mothers.
- Local schools link-in to target under 18s and parent/guardians
- EOI process for commissioning local VCS groups to engage resident networks on winter wellness campaigns. This will be live until September, with community grants to be issued for roll-out September/October

Community based admission avoidance

Securing Primary Care Access and Capacity

- Care Home Support as a key focus for preventing winter admissions: a review will commence 02/10/23 of the support provided to care homes to minimise the avoidable use of the UEC system and ensure safe, timely discharges from hospital to care homes
- An action plan for improving reviews and follow up of Children with asthma is in development, which will include increasing training to expand capacity for asthma reviews across the Primary Care workforce, a focused mapping of the discharge and notification pathway for children attending or being admitted to A&E following asthma attack and regular data reporting and review at PCN level
- Two Initial Accommodation Centres established for asylum seekers providing health screening and GP registration
- Enhanced Access now fully embedded (commenced October 2022): additional GP appointments from 6.30pm to 8pm weekdays and 9am to 5pm on Saturday
- Capacity Access Improvement Plans being implemented through practice action plans to create more capacity and increase access, and GP Access Centre operating at the Pinn Medical Centre, targeting 90% utilisation, 7 days a week and bank holidays
- CYP Health Inequalities Clinics and Additional Care for Complex Patients (extended appointments) were implemented in June
- Additional services commissioned through NWL Standard offer implemented from June includes: spirometry; wound care; ABPM; ECG; ring pessaries.
- ehubs implementation improving across Harrow utilising ARRs clinicians. We are seeing high levels of e-consultation in Harrow.
- Community Pharmacy Minor Ailment Service to be rolled out Q3/Q4 once NHSE have resolved prescribing and liability issues
- Community Pharmacy Consultation Scheme: uptake to be improved through software to facilitate referral that will be purchased and implemented across NWL

Community based admission avoidance

Harrow Rapid Response

- The Harrow Rapid Response Team will maintain business as usual levels of activity for winter 2023/24 of 1000 patient contacts per month (inc Follow up visits).
- The service averaged 288 referrals per month for winter 2022/23.
- Current service performance is 97.6% against its KPI of a 2-hour response time for all referrals and it is anticipated that this will be maintained in line with performance over winter 2022/23

	Nov-22	Dec-22	Jan-23	Feb-23
Referrals	214	342	325	273

Care Home Support Team:

- The Harrow Care Home Support Team will be supported by Harrow Rapid Response if they see and increase referrals and if they meet Rapid Response criteria.
- Weekends and OOH will be covered by Harrow Rapid Response.
- Activity data for the Care Home support Team is not currently reported, however this will be established for winter 23/24.

Proactive frailty management

The Enhanced Frailty service operates all throughout the year and will be carrying on business as usual:

- Systematic proactive identification of frail patients and with escalating risks
- Timely triage
- Step-up to the service and provide appropriate interventions including integrated multi-agency teams bringing skills and capacity together based on the need of the individual
- Step-down and maintenance as appropriate.
- Work with wider system partners i.e. acute, social care etc. for seamless integrated service i.e. work towards a resilient system especially during winter.

Overall ensuring patient benefit from specific interventions and have better care and experience and avoiding non-elective admissions.

Additional Social Care

Increased social work capacity to be put in place to work with primary care to support people in the home to avoid hospital admission.

High Impact Area 2: Frailty - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
High Impact Area 8: Urgent Community Response - increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission

In-hospital care

Say Day Emergency Care (SDEC)

- SDEC
  - 7 day service that runs for 12 hours of the day.
  - The capacity is to see 75 appointments per day, this includes new and follow up appointments.
- Frailty service
  - Service that runs 5 days a week, from 9am-5pm.
  - The capacity of this service is to see 8 patients a day.
  - Inclusion criteria:
    - CFS ≥ 6
    - ≥ 65 years
    - NEWS ≤ 3

Acute Hospital Flow and increased bed capacity

- Modular unit comprising 32 additional beds for opening late Feb 24
- Recruitment commenced to build staffing capacity ahead of this
- 4 additional elderly care and 2 stroke beds opened winter 22/23 remain open
- TBC scoping of SAU capacity to convert 4-8 trolley spaces to overnight beds
- Virtual ward programs for
  - Cardiology - heart failure and atrial fibrillation (45 pts in each)
  - Respiratory (30 pts)
  - Diabetes (20 pts)
- Move of 10 gastroenterology beds in spring 23 to Central Middlesex Hospital (CMH) to facilitate increased GIM beds at Northwick Park Hospital (NPH).

High impact area 1: Same Day Emergency Care - reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
High Impact area 2: Frailty - reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
High impact area 3: Inpatient flow and length of stay (acute): reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

In-hospital care

Community Rehab bedded care flow / Intermediate Care Beds

CNWL has open and locked adult rehab beds across the system which Harrow patients can access if required. Current access to open is immediate, locked rehab can take some time, in which case private providers are sourced to avoid delays.

CNWL has 7 stepdown houses with 40 beds, which Harrow patients can access for up to 2 weeks to support bed flow.

Starting in August 2023, there will be an increased focus on discharge from community rehab beds to ensure robust productivity and flow. This process is commencing with fortnightly meetings with the community rehab providers, social care, discharge hub and Borough Partnership team.

Mental Health

The core components of the approach for winter for mental health services are:

- Addressing the growth in delays for patients clinically ready for discharge but waiting for social care support. Exploring the potential for the hospital discharge team to oversee the discharge of patients from MH beds on the NPH site when the team is at full capacity
- Improve flow through housing pathway for patients with mental health issues. Seeking to broker a fast track pathway with housing services.
- CNWL referrals from mental health and learning disability inpatients to ASC with escalation of delays beyond 72hrs
- Improved access to drug and alcohol service through in-reach to medical wards and ED is now well established and effective. The next step is to support access to clinical records across CNWL and Drug and Alcohol service provider.
- Active promotion across the public and health and care professionals of crisis alternative services with capacity: Maternity and mental health perinatal services, IAPT and Coves

High impact area 4: Community bed productivity and flow: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes

In-hospital care / Discharge Pathway

Discharge Hub

- The overall aim is to relieve acute pressures by identifying patients to be managed with community support, instead of requiring an acute bed. This is achieved by clinical assessments undertaken by clinical screeners to share community knowledge of services and avoid any delay to discharge.
- NPH discharge hub, remains understaffed and has been supported and managed by LNW to continue to sustain flow.
- The hub is responsible for confirming discharge plans for patients across pathways 1-3 who have new or additional care needs on discharge.
- The NPH discharge team confirms the most daily discharges across the sector and receives on average 40 referrals daily to screening and processing for discharge.
- In advance of the winter, the focus will be on recruiting to the full team establishment, particularly the screeners to identify patients for the community.

Discharge Support Service

The discharge support service is an essential component of the discharge pathway in Harrow, focusing on both timely discharge for patients on the P0 and P1 pathways as well as focusing on avoiding readmissions through securing community based support for people at the point of discharge.

Over a 6 month winter period, the service will have the capacity to support 500 patients at discharge and 300 post discharge support.

The discharge element will include provision of accompanied taxi service or accompanying patient in Hospital transport if appropriate. There is a standard cohort of 4 staff with coordinator on site Monday to Friday who liaise with the Discharge team to receive referrals but also take direct referrals from other routes if these can be accommodated.

Post Discharge intervention can include telephone calls, referring and signposting onwards to suitable services, home visits and practical support that helps a discharge be successful, thus reducing the risk of readmissions.

High impact area 5: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed

Discharge pathways

Enhanced on-site social care

Seven-day hospital SW cover funded for the winter period.

Increased social work and OT staff to support hospital discharge process.

Provision of step-down care

Step down beds have to be purchased on a block rather than spot basis.

Current plans to mitigate additional pressure:

- 5 step down beds currently purchased, which will be increased to 8 from October.
- Funds available for 6 additional residential care beds (currently 558 LD / other)

Additional more complex step down beds (EMI) might be available in the market if additional funding were available.

Same day community equipment

Same day equipment delivery service (MRS) has been made available, at greater cost to reduce the longer lead times.

To be used as required to achieve planned discharge date.

Prescribers instructed in use of same day delivery.

Further work to review prescribing process to maximise efficiency of resource use while achieving fastest delivery of equipment.

Data will be made available on use of same day delivery services.

Home care provision, including weekends

Development of local bridging services, through the Autumn in advance of the critical winter period, tailored to relieve pressure in the local discharge pathway, to allow eligible P1 patients to be supported with packages of care following relevant assessments for onward support where necessary.

Increased provision of 72 hour domiciliary care or reablement as needed but a follow up or further assessment is needed to support patient recovery at home

High impact area 6: Intermediate care demand and capacity: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

Discharge pathways

Integrated Intermediate Care service, and reablement provision

The delivery of the Integrated Intermediate Care Service discharge pathway for facilitation of discharge and prevention of admission for the Winter of 23/24 will be supported through the following developments:

- **Discharge to Assess (D2A) and Short-term Rehabilitation:** CLCH will maintain Discharge to Assess (D2A) and short-term Rehabilitation Pathways in support of discharge delivering 1100 contacts per month over the winter of 23/24.
- **Northwick Park Discharge Hub:** The discharge hub lead post has been recruited to and the post holder starts in September 2023. Discharge hub Clinical screener post recruitment is ongoing with a view to these being fully recruited to by October 2023.
- **Carers Lead role:** Has been recruited to and will support service users and carer needs under the integrated pathway.
- **Training:** Has been implemented in support of the for the delivery of the integrated pathway for the winter of 23/24. Follow up training is planned for September or October 2023.
- **Single Referral Form:** Discharge 2 Assess (D2A) referral form used across NWL and will remain in use, however, CLCH has requested changes to make this form consistent with the single merged referral form for ICCS.
- **ICCS End-to-end patient pathway:** Pathway is complete following face to face sessions with leads.
- **SOP:** A draft SOP has been developed and is being reviewed by stakeholders for implementation for winter of 23/24.
- **Information sharing:** An interim solution to data sharing has been agreed with ICCS partners. Information sharing between Acute, Community and Primary Care Health Services will be facilitated with the go live of the Cerner Patient Administration and Records System in August 2023 at LNWHT using the London Care Record. A virtual desktop solution is proposed for access of across health and social care systems.

High impact area 6: Intermediate care demand and capacity: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

Additional winter schemes

We are currently working on the basis that all additional winter funding coming into the system is known and we will not be expecting additional funding allocations.

However, if this position changes, acknowledging that funding is likely to be focused on specific pressure areas, priorities for investment for Harrow, based on our evaluation of Winter 22/23, would be:

- Additional reablement schemes;
- Expanding the Discharge Support Service, including the addition of handyman services;
- Home First and Trusted Assessors to support patient flow.

Harrow system risks to the delivery of the winter plan 23/24

Risk	Risk Owner	Mitigations	Date for review
If CLCH are not commissioned to provide discharge to assess community rehabilitation provision, there is a risk to system flow through increased bed days for medically fit patients.	Jane Wheeler and Jackie Allain	Exploring how this service can be funded non-recurrently this year. Meeting with CLCH/Jane Wheeler soon to work out the details.	September 2023
If we do not address under-utilisation and delayed discharges of Harrow patients within the rehab beds, particularly at Woodlands Hall, there are financial risks to the system, and potential loss of Harrow provision	Melissa Mellett, Lisa Henschen, Shaun Riley Jackie Allain	Bi-weekly discharge group being established. Potential to increase scope of discharge hub to cover P2 beds (through integrated intermediate care team) but discharge hub needs full staffing to achieve. Stakeholder briefing to be held with NWL ICB	September 2023
If agreements for managing cross NWL and NCL arrangements for discharge support cannot be made in advance of winter pressures (for Harrow residents registered with Barnet GPs) we risk unnecessary delays at Northwick Park	Ian Robinson? Senel Arkut	TBC	TBC
If we are unable to secure a stoma care pathway for Harrow residents, we risk hospital delays	ICB (TBD) Senel Arkut	Explore with other London Boroughs how they are working with care providers to deliver stoma care	October 2023

Action Plan

Action	Lead	Delivery date
Domain: interface		
Update contact list and by-pass numbers for Harrow GPs. Share widely across acute and community providers	Rahul Bhagvat	9/10/2023
Update outpatient letter details to include names and telephone numbers of clinical teams	TBC	TBC
Ensuring Primary Care are using correct SDEC referral forms	Rahul Bhagvat	9/10/2023
System letter to support efficient ways of working to support winter pressures	Radhika Balu and Jon Baker	October 2023
Domain: data and escalation		
Implement local escalation processes for discharge delays as described in the winter plan	Natasha Harmsworth-Blythe, Shaun Riley, Santokh Dalal, Senel Arkut, Lisa Henschen	9/10/2023
Address any outstanding issues with local data collection for winter performance monitoring	Bharat Gami	9/10/2023

Action Plan

Action	Lead	Delivery date
Domain: prevention		
Implement 2023/24 winter wellness scheme for Harrow	Seb Baugh	November 2023
Deliver MECC winter programme	Laurence Gibson	November 2023
Domain: community based admission avoidance		
Secure our pathways of support to care homes for admission avoidance and timely discussion – including Care Home Support Team and Primary Care Enhanced Service. Action plan to be developed.	Sandra Arinze Jenny Gorasia Patrick Laffey	20/10/2023
Domain: in-hospital care		
Secure robust discharge flow for patients in rehabilitation units	Lisa Henschen, Bharat Gami, Natasha Harmsworth-Blythe	09/10/2023

Action Plan

Action	Lead	Delivery date
Domain: discharge pathway		
Establish bridging service for Harrow	Senel Arkut, Johanna Morgan, Shaun Riley	October 2023
Explore closer alignment between PATCH (children's virtual ward service) and children's community health teams	Philomena Bouzemada and Claire Eves	October 2023
Implementation of the integrated intermediate care service	Jackie Allain and Shaun Riley	November 2023
Agree pathways for Harrow residents registered with Barnet GP (joint meeting between Harrow, Brent and Barnet)	Shaun Riley, Lisa Henschen	November 2023
Explore options for stoma patients through homecare providers	TBC	October 2023
Active promotion of mental health crisis alternatives to front line staff and the public	James Connell, supported by Mental Health workstream	October 2023
Explore potential for discharge hub supporting mental health discharges across health and social care – dependent on hub staffing	Gail Burrell, Natasha Harmsworth-Blythe, Lisa Henschen	December 2023
Implement regular briefings and escalation across discharge pathways for physical and mental health	Shaun Riley, Santokh Dalal, Lisa Henschen	September 2023
Seek to establish data sharing of clinical records across CNWL and Drug and Alcohol service provider	Seb Baugh, Gail Burrell, Deepti Shah-Armon	December 2023

LONDON BOROUGH OF
HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	25th January 2024
Subject:	North Central London Start Well Programme Consultation
Responsible Officer:	Anna Stewart - North Central London Start Well Programme Director
Public:	Yes
Wards affected:	N/A
Enclosures:	Harrow Health and Wellbeing Board – Start Well programme slides

Section 1 – Summary and Recommendations

North Central London Integrated Care Board and NHS England (London) Specialised Commissioning are consulting on proposed changes to maternity, neonatal, and children's surgical services in North Central London. The report sets out the options being consulted on, and the possible impact of these on residents of Harrow. It outlines the approach to consultation and how residents, staff and stakeholders can give their feedback on the proposals.

One aspect of the detailed proposals includes the proposal to close a hospital-based maternity and neonatal unit. There are two proposed options being consulted on around this:
Option A where maternity and neonatal services are provided at: UCLH, North Midd, Barnet Hospital and Whittington Hospital
Option B where maternity and neonatal services are provided at: UCLH, North Midd, Barnet Hospital and Royal Free Hospital

There are small numbers of Harrow residents who access maternity services in NCL and should changes be implemented there is a small impact for residents of Harrow – around 120 residents under option A and 1 under option B.

Recommendations:

The Board is requested to:

- Note the update on the programme and provide feedback as to how to raise awareness with of the consultation with Harrow residents and encourage participation.

Section 2 – Report

The Start Well Programme was initiated in November 2021 to ensure that hospital-based maternity, neonatal and children and young people's services are best set up to meet the needs of our population. The Start Well programme is part of wider strategic planning for health and care across the NCL Integrated Care System aiming to deliver our population health strategy and reduce inequalities amongst our residents.

North Central London Integrated Care Board and NHS England (London) Specialised Commissioning are consulting on proposed changes to maternity, neonatal, and children's surgical services in North Central London. The proposals being consulted on are underpinned by a case for change, the development of new future facing care models and an extensive options appraisal process involving clinicians and members of the public.

The details of the proposals are outlined in the report attached, as well as our approach to consultation and engagement with residents. More information about the proposals, including how to give feedback can be found on our website: nclhealthandcare.org.uk/get-involved/start-well

Financial Implications/Comments

At this stage, proposals are out to public consultation. There have been no changes agreed to change services which would have an impact on Harrow.

Following public consultation, NCL ICB and NHSE London Region specialised commissioning would take a decision if any service changes should be implemented. This is not anticipated to be until late 2024/25.

This programme of work is focused on improving quality of care and improving outcomes for our local population. During the options appraisal process we considered the affordability and value for money options put forward for consultation however this was not a deciding factor on the options for consultation. Our proposals involve prioritising significant additional investment, around £40 million in either option for maternity and neonatal to improve and expand the current estate and facilities.

Legal Implications/Comments

One of the Health and Wellbeing Board's key responsibilities is:
To provide a forum for public accountability of NHS, public health, social care and other health and wellbeing services

Risk Management Implications

There are no risks for the Council.

Risks included on corporate or directorate risk register? **No**

Separate risk register in place? **Yes** (programme held risk register that feeds into NCL ICB's risk register)

The relevant risks contained in the register are attached/summarised below.
N/A

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? **Yes**

An extensive interim Integrated Impact Assessment (IIA) (including development of mitigations) was undertaken as part of developing the proposals, which can be found on our website. High level findings from the maternity and neonatal services IIA are outlined in the attached report. The link to the full documents are here: https://nclhealthandcare.org.uk/get-involved/start-well-2/additional-documents/ There were no significant findings for Harrow residents as part of this interim impact assessment, however this would be reviewed following consultation.

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

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 11/01/2024

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 11/01/2024

Chief Officer: Carole Furlong on behalf of Senel Arkut
Signed on behalf of the Corporate Director/by the Director of Public Health
Date: 05/01/2024

Mandatory Checks

Ward Councillors notified: N/A

Section 4 - Contact Details and Background Papers

Contact: Anna Stewart, Programme Director – NCL Start Well Programme, NCL Integrated Care Board anna.stewart3@nhs.net

Background Papers: nclhealthandcare.org.uk/get-involved/start-well

If appropriate, does the report include the following considerations?

1. Consultation YES / NO
2. Priorities YES / NO

North Central London
Integrated Care System

NCL Start Well Programme

Harrow Health and Wellbeing Board

25 January 2024

Context and objectives

North Central London Integrated Care System

- Today's session is an opportunity to brief you on the proposals that have been developed as part of the Start Well Programme. This Programme of work was initiated in 2021 to ensure maternity, neonatal, children and young people's services are set up to meet population needs and improve outcomes. The drivers for starting the work demonstrate that the programme is key to delivering against our duties around population health improvement and tackling inequalities.
- This is a long programme of work, and no decision has been made on the changes. The ICB Board agreed at its meeting on Tuesday 5 December 2023 to initiate a 14-week consultation period, from 11 December 2023 until 17 March 2024. A decision on the proposals is not expected to be made until Autumn/Winter 2024/25.
- The programme has developed a set of proposals to improve maternity and neonatal and children's surgical services in NCL. The purpose of the briefing today is to:
  - Provide some context on the programme, outline the rationale for change and how the options have been developed
  - Describe the options being put forward for public consultation
  - Outline the potential impact these proposals may have on different populations, including Harrow
  - Capture your views and feedback on the approach to consultation and how best to engage with the populations in Harrow who may be potentially impacted
- The link to the consultation website where you can find more information and details about the programme is: nclhealthandcare.org.uk/start-well

Background and context

The drivers for this programme and the need for change are rooted in our relentless focus on improving outcomes and reducing inequalities within our population

North Central London Integrated Care System

North Central London ICS has an ambition to provide services that support the best start in life, both for our residents and for people from neighbouring boroughs and beyond who choose to use our services.

We know that care received at the beginning of life is a powerful force against health inequalities and a catalyst for improved life chances which is why Start Well is a key priority in our Population Health and Integrated Care Strategy.

Central to the Start Well programme are the needs of pregnant women and people and their babies. We want to ensure our services are in the best position to support families through the life changing journey of pregnancy and birth.

We have ten principles which will guide our new ways of working

North Central London Integrated Care System

To make our transition to a population health and integrated care system that is needs-driven, holistic and integrated, we have identified 10 principles to guide us and given examples of what that looks like in terms of changed ways of working.

Trust the strengths of individuals and our communities
We listen to our communities and develop care models that are strengths-based and focussed on what communities need, not just what services have always delivered

Break down barriers and make brave decisions that demonstrate our collective accountability for population health
We understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions

Build from insights
We create digital partnerships and use integrated qualitative and quantitative data to understand need

Strengthen our Borough Partnerships
We build a system approach for local decision making and accountability to support local action on physical and mental health inequalities and wider determinants

Mobilise our system's world class improvement and academic expertise for innovation and learning
We build the evidence base for population health improvement and innovative approaches to improve integrated working

Break new ground in system finance for population health and inequalities
We shift our investment toward prevention and proactive care models and create payment models based on outcomes.

Build 'one workforce' to deliver sustainable, integrated health and care services
We maximise our workforce skills, efficiencies and capabilities across the system

Support hyper-local delivery to tackle health inequalities and address wider determinants
We make care more sustainable by creating local integrated teams that coordinate care around the communities they serve

Relentlessly focus on communities with the greatest needs
We embed Core20PLUS5 in all our programmes with a particular focus on inclusion health to make sure no-one is left behind

Deliver more environmentally sustainable health and care services
We prioritise activity which impacts our communities' health and environment, such as transport

Source: North Central London ICS Population Health and Integrated Care Strategy

The Start Well programme will support us to tackle inequalities and improve population health outcomes

North Central London Integrated Care System

The Start Well programme was initiated to ensure services are set up to meet population needs and improve outcomes. The drivers for starting the work demonstrate that the programme is key to delivering against our duties around population health improvement and tackling inequalities

- **Improving care at the start of life has the potential to have far reaching impacts on overall population health and life outcomes**
- **There is longstanding inequity in service provision across maternity, neonatal and paediatric services – with not everyone having access to the same care as others**
- **The quality of services could be improved, and some service users face differential outcomes and experience**
- **Our workforce is constrained and, in some instances, our people are working in environments that are not set up for them to provide the best possible patient care**
- **Ensuring we are in a position to respond to national reviews and best practice guidance such as the Three Year Delivery Plan for Maternity and Neonatal Care**

The ICS also has a number of other programmes which are aiming to achieve population health improvements and integration of care such as a review into community services, mental health services and the implementation of a Long Term Conditions Locally Commissioned Service for Primary Care.

Start Well is a collaborative programme involving a wide range of patients, carers, community representatives, clinical leaders and ICS partners

North Central London Integrated Care System

Start of review
November 21

Agreement across all organisations to commence the programme following Trust Board engagement.

Case for change development
November 21 – May 22

The clinical case for change was co-developed through significant clinical engagement, including: 60 interviews, 12 reference group meetings, 2 large clinical workshops and 5 surgical deep dive sessions

New care models
July – September 21

Future facing best practice care models were developed. This involved **over 100 clinicians** through workshops and task and finish groups

Case for change engagement
July – September 22

Engagement with patients and the public on the case for change, including:

- 207 in depth discussions
- 389 questionnaire responses
- 16 stakeholder meetings
- 2 youth summits

Over **75% of respondents agreed or strongly agreed with opportunities identified**

Options appraisal
November 22 – May 23

Evaluation of options was undertaken through **10** clinical reference group meetings, **8** finance group meetings and **3** patient and public engagement group meetings

Options appraisal workshop
May 23

Programme board workshop where options were narrowed involving local authority partners, Trust reps as well as NEL, NWL and Herts.

Pre-consultation business case development
May 23 – September 23

Drafting of pre-consultation cases that outline proposals and new clinical model to be implemented

IIA engagement
May – June 23

Engagement with **over 120 service users** about their experiences of maternity and neonatal care to build up an understanding of the impact of implementing changes

Clinical senate review
July 23

A panel of over 30 senate panel members reviewed and feedback on proposals. Lead clinicians from NCL represented the programme

Finance assurance
August 23 – September 23

Assurance of capital assumptions for each option through 1:1 assurance meetings with CFOs

Further assurance of wider finance case through CFO group, and sign off in September

NHSE Assurance
November 23

Assurance of proposals by NHSE, a requirement in advance of commencing a consultation. Trust Board sign up to proposals is needed for this

ICB Board
December 5th 23

Seeking approval to commence consultation on proposals

Public consultation
December 23 – March 24

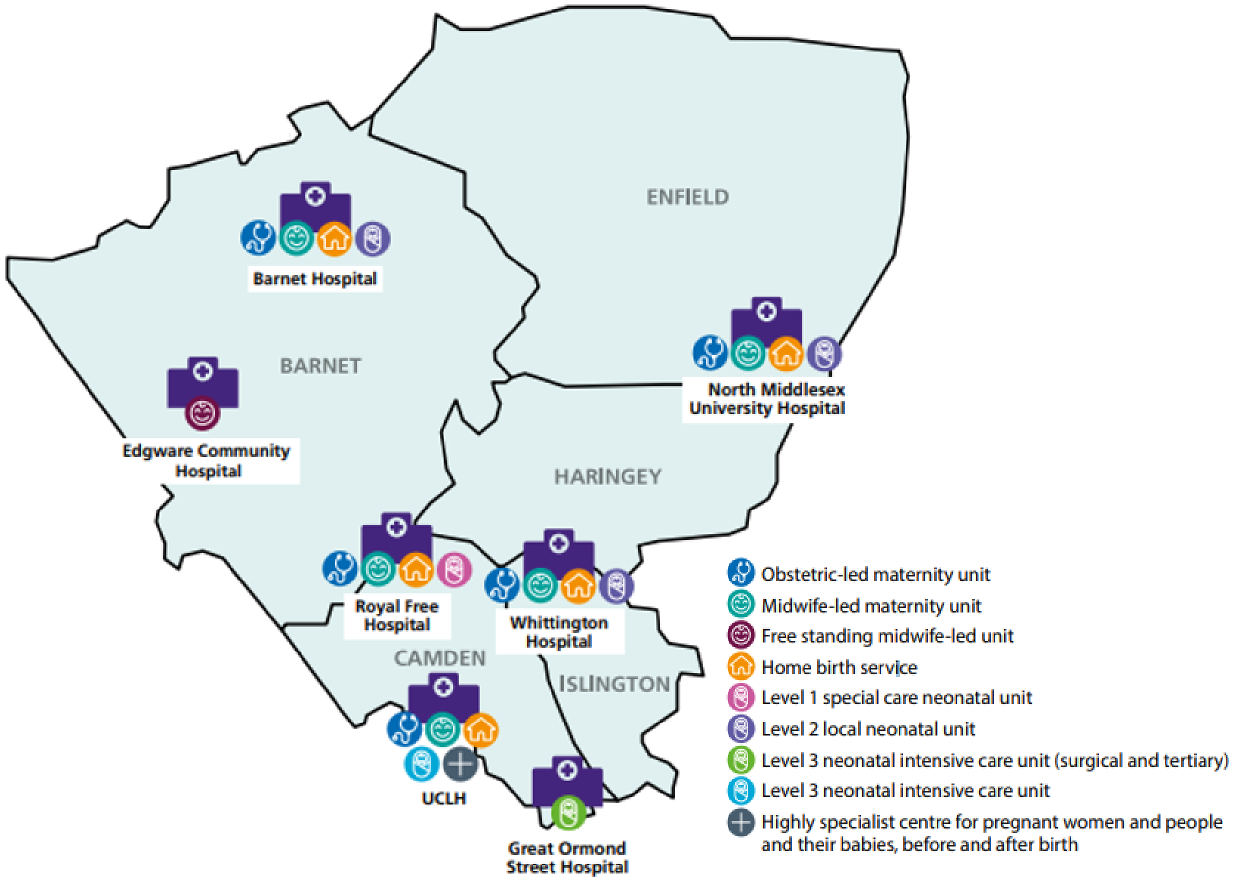
Seeking feedback on proposals which will inform subsequent decision making

The programme, which began in November 2021, has benefited from extensive clinical and service user input.

Maternity and neonatal services proposals

How maternity and neonatal care is currently organised in North Central London

North Central London Integrated Care System



In our five boroughs we have **five maternity and neonatal units** and a **standalone midwifery led birth centre**:

- Five obstetric units
- Five alongside midwifery-led units
- One standalone midwifery-led unit at Edgware Community Hospital
- One special care neonatal unit (level 1)
- Two local neonatal units (level 2)
- Two NICUs (level 3 – one of which is at GOSH and out of scope of the proposals)

Pregnant women and people can access maternity care at their unit of choice. This means people who live within Barnet, Camden, Haringey, Enfield or Islington may choose a hospital outside of these area and those who live outside the NCL boroughs can access maternity care at a hospital within NCL

There are important clinical drivers for change in our maternity and neonatal services

North Central London Integrated Care System

NCL has a declining birth rate, with increasing complexity of service users. There is insufficient activity and staff to sustain five maternity and neonatal units in the long term

Staffing levels do not always meet best practice guidance and there are high vacancy rates which frequently compromise service provision. This often leads to the inability to staff birth centres – meaning the choice of midwifery-led care is often compromised

The level 1 unit at the Royal Free Hospital was only 37% occupied in 2021/22. The number of admissions to the unit have been falling and there are expensive and complex mitigations in place to maintain its safety. This unit does not provide equitable care to service users and it represents a clinical risk, which requires a long-term solution as identified by the London Neonatal Operational Delivery Network and the Trust

The maternity and neonatal estate at the Whittington Hospital does not meet with modern best practice building standards. It has no ensuite bathrooms in its labour ward, its neonatal unit is cramped with risks around infection control. These risks are actively mitigated by excellent staff and clinical processes; however, this does create increased pressure on staff to safely deliver the service

Maternity CQC re-inspections has identified challenges with maternity services in NCL and there are opportunities to improve their quality

Edgware Birth Centre supports an ever-decreasing number of women to give birth – in 22/23 only 34 women gave birth there. Given the declining birth rate and increasing complexity of births it is unlikely this will increase in the future

Our vision for maternity and neonatal care is delivered through our new care model

North Central London Integrated Care System

66

The new care model proposes:

- **Bringing together maternity and neonatal care into four units as opposed to our current five**
- **Three level 2 neonatal units as well as the specialist NICU at UCLH**
- **No longer having a level 1 neonatal unit**
- **No longer having a standalone midwifery-led birth centre**

Our vision for maternity and neonatal services

Provision of high-quality equitable care: all units being able to provide the same level of neonatal care will address the current inequity of having a level 1 neonatal unit as local provision for those closest to that level 1 unit is less comprehensive than the local provision for those closer to any of the level 2 centres

Units that provide sustainable activity numbers: through consolidation, we will have larger units which are more clinically sustainable in the long term given the declining NCL birth rate and the need to make best use of our scarce workforce

Workforce resilience: units staffed in line with best practice, supporting our teams to deliver high quality care. Delivering this over four units as opposed to five means increased workforce resilience and units will be less vulnerable to short term closures – ensuring that choice of birth setting can be facilitated in a more consistent way. This may also help deliver greater continuity of care to parents, which is currently a challenge to deliver as our workforce are spread thinly

The right capacity to meet demand: ensuring that NCL has access to the right level of capacity to meet changing needs of our population – including access to specialist care where it may be needed

Environment that provides a positive patient experience: investing in our estate and making improvements that will address current issues. We will invest in making sure we have optimally sized units, meaning better value for money and wider benefits of adopting the new care model

Options for consultation – maternity and neonates

North Central London Integrated Care System

Our preferred option

Option A: *UCLH, North Mid, Barnet, Whittington*

Site	Service
UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service
North Mid	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Barnet	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Whittington Hospital	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Royal Free Hospital	Maternity and neonatal services would cease to be provided

Option B: *UCLH, North Mid, Barnet, Royal Free*

Site	Service
UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service
North Mid	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Barnet	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Royal Free Hospital	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Whittington Hospital	Maternity and neonatal services would cease to be provided

Closure of the birthing suites at Edgware Birth Centre

Both options being put forward for consultation are deemed to be implementable

North Central London Integrated Care System

The status quo is not an option for consultation because:

- The way services are currently set up won't meet the long-term needs of our population and doesn't resolve the challenges identified in our case for change
- Staffing services across five sites as opposed to four would continue to be a challenge and not make best use of our skilled workforce
- The neonatal unit at the Royal Free Hospital would continue to need support to maintain the skills of staff and this does not represent a long term, sustainable solution

Both proposed options being put forward for consultation have been deemed to be implementable and we are consulting on both options.

Option A has been identified as the preferred option for consultation because:

- it would mean fewer staff needing to move to a new location
- option B would mean some people would need to go to hospitals in North East London that would struggle to have capacity for this because of rising birth rates in some parts of North East London
- while option A would mean some people would need to go to hospitals in North West London, those hospitals have confirmed they have capacity for this as the number of births in North West London is falling

Future flows have been projected for each option, using an approach which considers choice

North Central London Integrated Care System

Note: LSOA is a Lower Super Output Area and is the smallest granularity of geography that is used for travel time analysis. Typically, there are 1,000-2,000 residents within an LSOA.

Approach	Description
1 For each LSOA identify the closest hospital for the catchment population	• The catchment population for the patient flow analysis has been defined as all LSOAs in NCL where there was activity in the 2021/22 baseline year and any LSOAs for whom an NCL site is the closest hospital, this includes any populations living in neighbouring boroughs. • The neighbouring ICSs have been defined as all London ICSs plus Hertfordshire and West Essex ICS • The closest hospital is found using the Travel Time API (Google), calculating the travel time in minutes at peak time
2 Calculate the number of deliveries at each in scope hospital in 21/22 by LSOA	• The volume of activity at each of the in-scope hospitals has been calculated for each of the LSOAs in the catchment population • The hospitals that are in scope of this work are all acute NCL hospitals and the following neighbouring units: St Mary's, Chelsea and Westminster, Northwick Park, Homerton, Whipps Cross, Royal London, Princess Alexandra, Watford General, Newham, Luton and Lister Hospitals
3 Understand in each LSOA the number of people giving birth at their closest unit or choosing to give birth elsewhere	• It is modelled that **everyone in an LSOA flows to their nearest unit by travel time (car/driving at peak times)**. If this unit is modelled as closed, then the population will be modelled as flowing to the next nearest. • However, if over 80% of people in any LSOA are currently choosing to go to a unit further away than their nearest by travel time, then everyone in that LSOA is modelled to travel further to the unit of choice. • In each option, when a unit closes, everyone who was modelled to go to that unit is then modelled to **go to their nearest hospital instead**

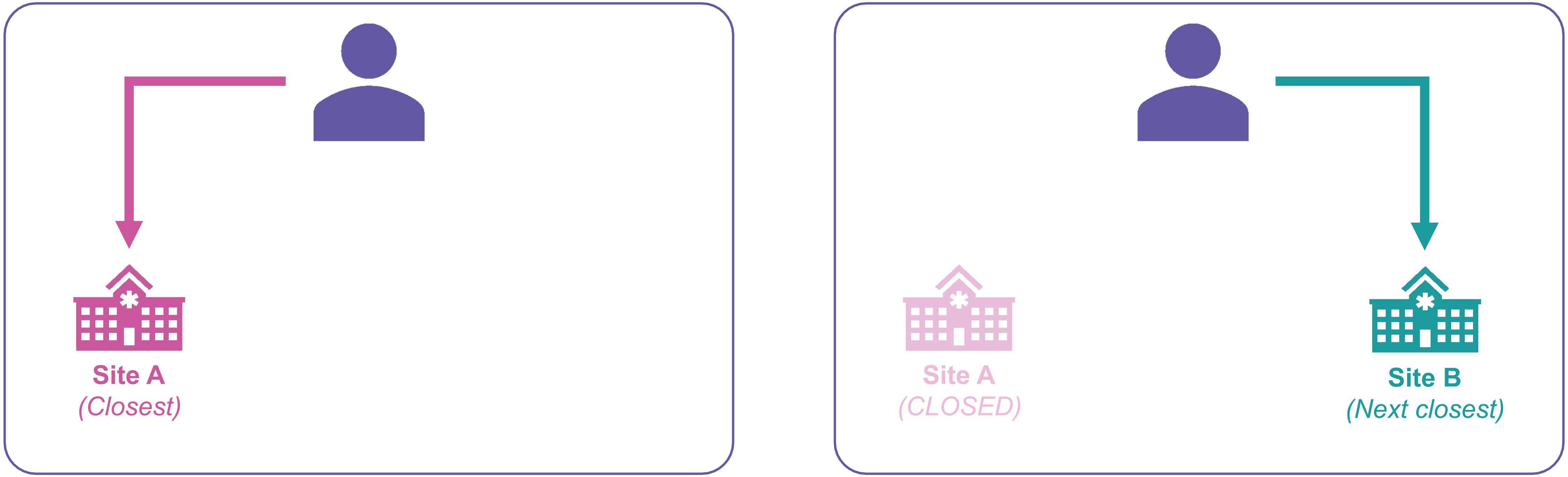
We identified the people who may be impacted by the proposals

North Central London Integrated Care System

- We looked at where people currently live and identified geographies whose closest hospital is Royal Free (option A) or Whittington (option B)
- For the impacted populations we looked at what the next closest hospital would be and projected the activity to the next nearest unit. All activity in that LSOA is flowed to this hospital.
- This modelling is based on historic activity and a set of assumptions and therefore is indicative. Whilst the modelling approach has factored in choice there may be individuals within the impacted LSOAs who choose a hospital that is further away than the closest.

Currently: where people go now (the closest)

Future: Predicted flow if maternity unit at Site A closed

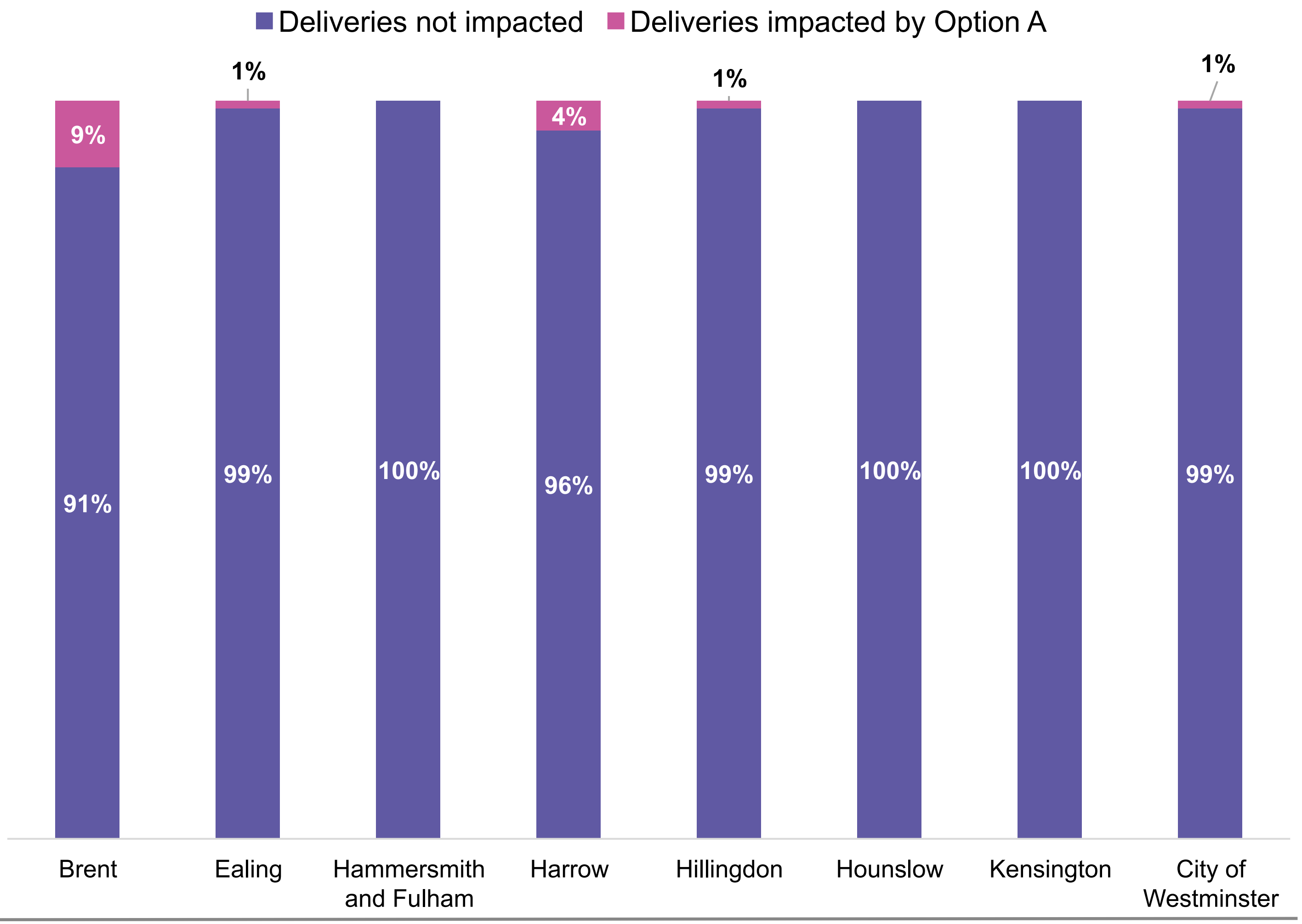


North Central London Integrated Care System

The proposals in option A would result in 2,560 deliveries being being moved to another unit

- Based on future activity modelling, in option A, 2,560 deliveries are would be moved from the Royal Free Hospital to another unit. This includes units that may be outside of NCL.
- Of the 2,560, 73% (1,860) are NCL residents and the remaining 27% (700) are non-NCL residents.
- Of the non-NCL residents impacted 558 are NWL residents
- Of the NWL residents impacted:
  - Brent: 380
  - Ealing: 18
  - Harrow: 124
  - Hillingdon: 8
  - Hounslow: 1
  - Westminster: 27
- The proportion of total deliveries impacted by NWL borough is set out in the graph to the right

Proportion of activity which may being impacted by borough

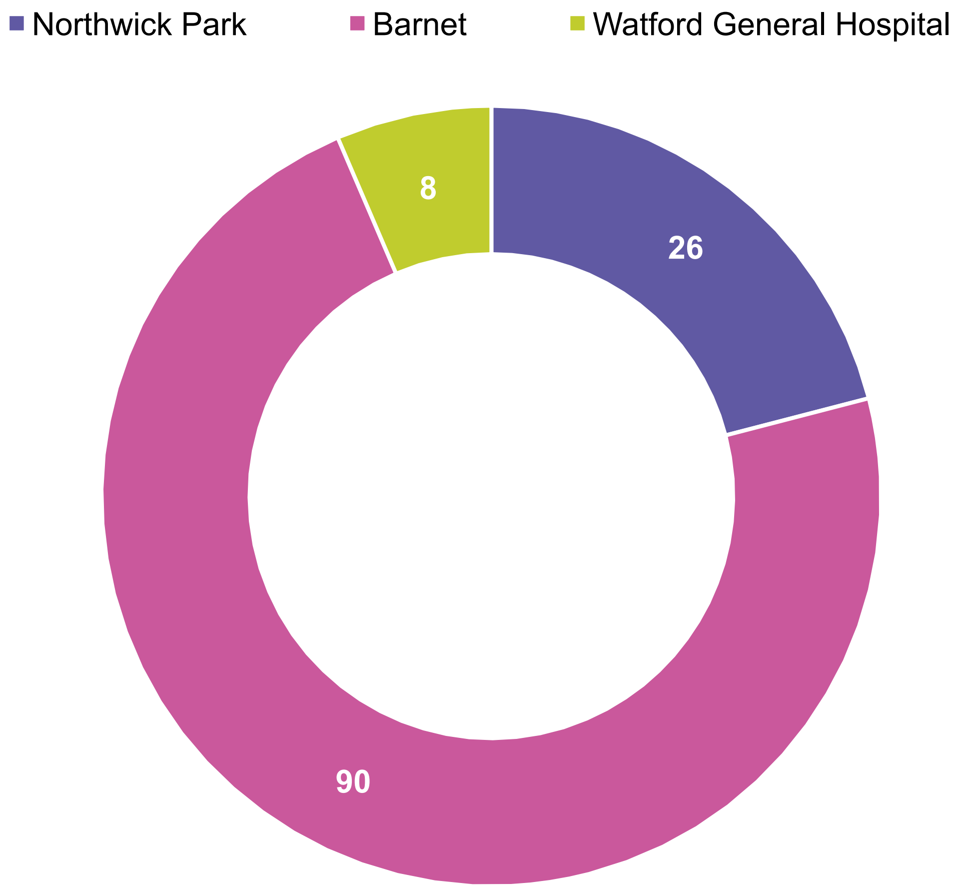


In option A, the majority of impacted residents in Harrow are projected to flow to Barnet Hospital

North Central London Integrated Care System

- Based on future activity modelling, in option A, 2,560 deliveries would be moved from the Royal Free Hospital to another unit. This includes units that may be outside of NCL.
- Of the 2,560, 73% (1,860) are NCL residents and the remaining 27% (700) are non-NCL residents.
- Of the non-NCL residents impacted 558 are NWL residents
- Of the NWL residents impacted **124 are Harrow residents**
- Based on the modelling the impacted residents have been modelled to flow to the next nearest hospital by driving at peak times as follows:
    - Barnet: 90
    - Northwick park: 26
    - Watford General Hospital: 8

Option A: Projected deliveries by site for all impacted Harrow residents

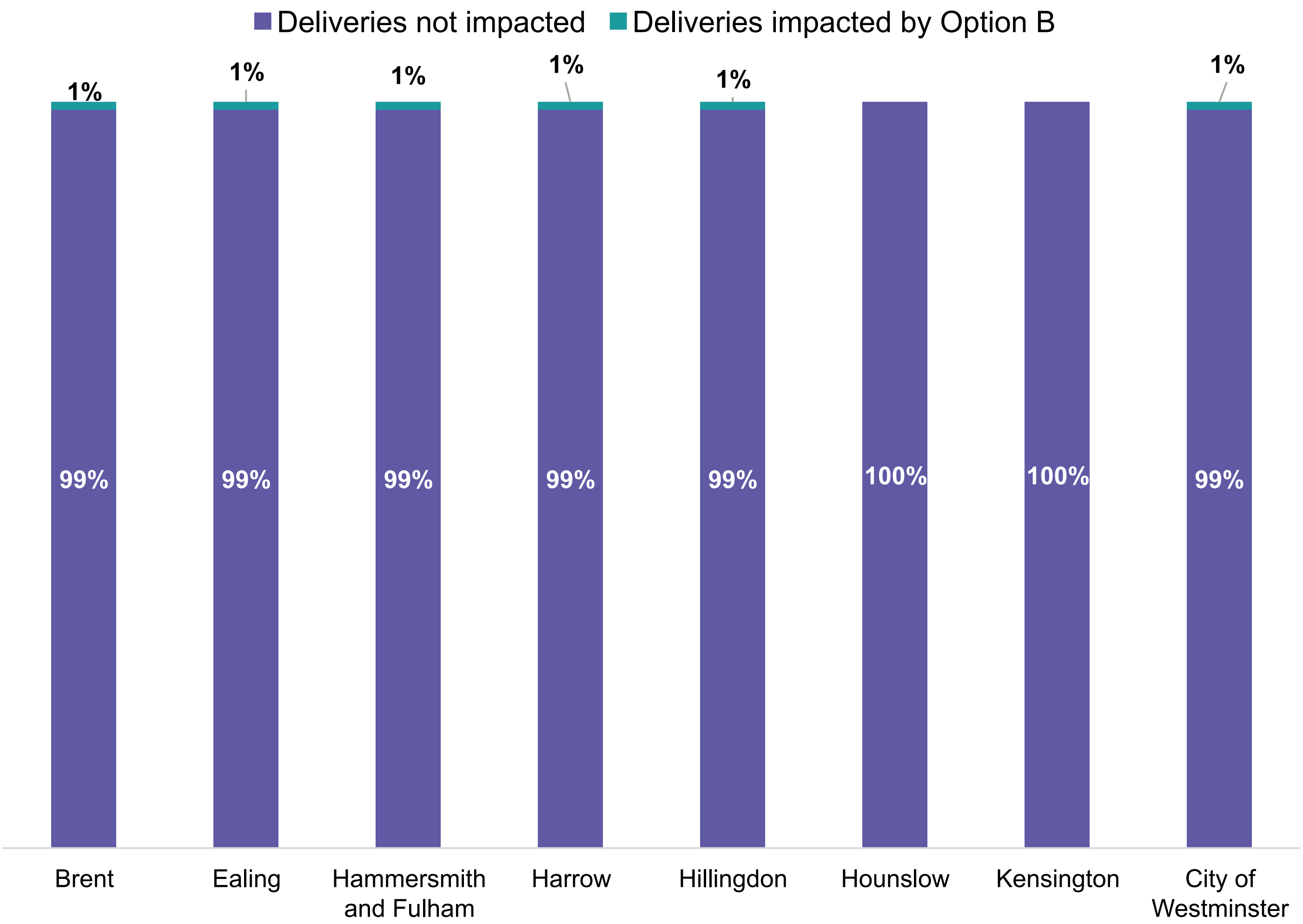


The proposals in option B would result in 3,391 deliveries being being moved to another unit

North Central London Integrated Care System

- Based on future activity modelling, in option B, 3,391 deliveries would be moved from the Whittington Hospital to another unit. This includes units that may be outside of NCL.
- Of the 3,391, 88% (2,978) are NCL residents and the remaining 11% (413) are non-NCL residents.
- Of the non-NCL residents impacted 39 are NWL residents
- Of the NWL residents impacted:
  - Brent: 27
  - Ealing: 2
  - Hammersmith and Fulham: 1
  - Harrow: 1
  - Hillingdon: 2
  - Westminster: 6
- The proportion of total deliveries impacted by borough is set out in the graph to the right

Proportion of activity which may being impacted by borough



We have built up an understanding of the impact of our proposals through our Interim Integrated Impact Assessment

North Central London Integrated Care System

Our IIA draws on multiple strands of work which has supported us to build a picture of what the impact of our proposals could be, and who may be impacted:

1. Our case for change took a population health approach and identified service users with characteristics who may be at risk of health inequalities
2. We undertook a supplementary literature Review to identify inequalities in maternal and neonatal outcomes undertaken by public health professionals
3. We engaged with potentially impacted groups to understand their views on the possible impact of proposals
4. We have undertaken extensive analysis on:
   - Accessibility (travel time, cost, parking, public transport access, car ownership)
   - Population demographics
   - Sustainability impact by looking at carbon emissions

We have identified the following impacts of our proposals:

- **Accessibility**: relatively small average increases in travel time across both options (both by public transport and car)
- **Cost of travel:** additional expenses when travelling by taxi on average of £4, but close to the closing sites up to £11
- **Accessing an unfamiliar hospital site:** changes may mean people having to travel to and navigate around a hospital site which they are unfamiliar with
- **Understanding changes:** service users need to be able to understand their choices of maternity care and what change could mean for them

1 **Understand proposed service changes**
- Understand current services and where they are delivered
- Review the proposed changes to the model of care
- Understand where services will be delivered for each potential option

2 **Identify potentially impacted populations**
- Assess which local people may be impacted by the proposals

3 **Understand the potentially impacted groups**
- Understand the demographics and location of the population
- Understand populations who might be disproportionally impacted by the proposals or who are vulnerable

4 **Assess impact of proposals on populations**
- Understand the overall potential impact on moving services on quality, outcomes, patient experience, access, sustainability and geographical areas
- Assess this impact for those populations who may be disproportionally impacted or who are vulnerable

5 **Agree mitigations**
- Agree steps to mitigate against any negative impacts and enhance any benefits

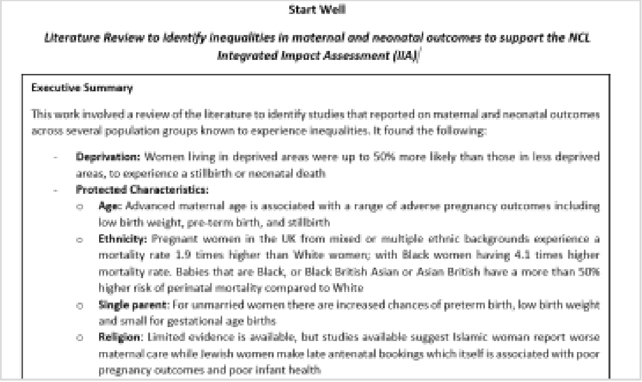
IIA engagement reach

38 engagement meetings facilitated

124 patients, residents and staff have been involved

9 sessions with parents who have recent experience of neonatal care

5 meetings with specialist midwives supporting women with complex needs



Start Well

Literature Review to identify inequalities in maternal and neonatal outcomes to support the NCL Integrated Impact Assessment (IIA)

Executive Summary

This work involved a review of the literature to identify studies that reported on maternal and neonatal outcomes across several population groups known to experience inequalities. It found the following:

- **Deprivation:** Women living in deprived areas were up to 50% more likely than those in less deprived areas, to experience a stillbirth or neonatal death
- **Protected Characteristics:**
  - **Age:** Advanced maternal age is associated with a range of adverse pregnancy outcomes including low birth weight, pre-term birth, and stillbirth
  - **Ethnicity:** Pregnant women in the UK from mixed or multiple ethnic backgrounds experience a mortality rate 1.9 times higher than White women; with Black women having 4.1 times higher mortality rate. Babies that are Black, or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality compared to White
  - **Single parent:** For unmarried women there are increased chances of preterm birth, low birth weight and small for gestational age births
  - **Religion:** Limited evidence is available, but studies available suggest Islamic woman report worse maternal care while Jewish women make late antenatal bookings which itself is associated with poor pregnancy outcomes and poor infant health

Two specific geographical areas were identified as being more vulnerable to the impact of our proposals

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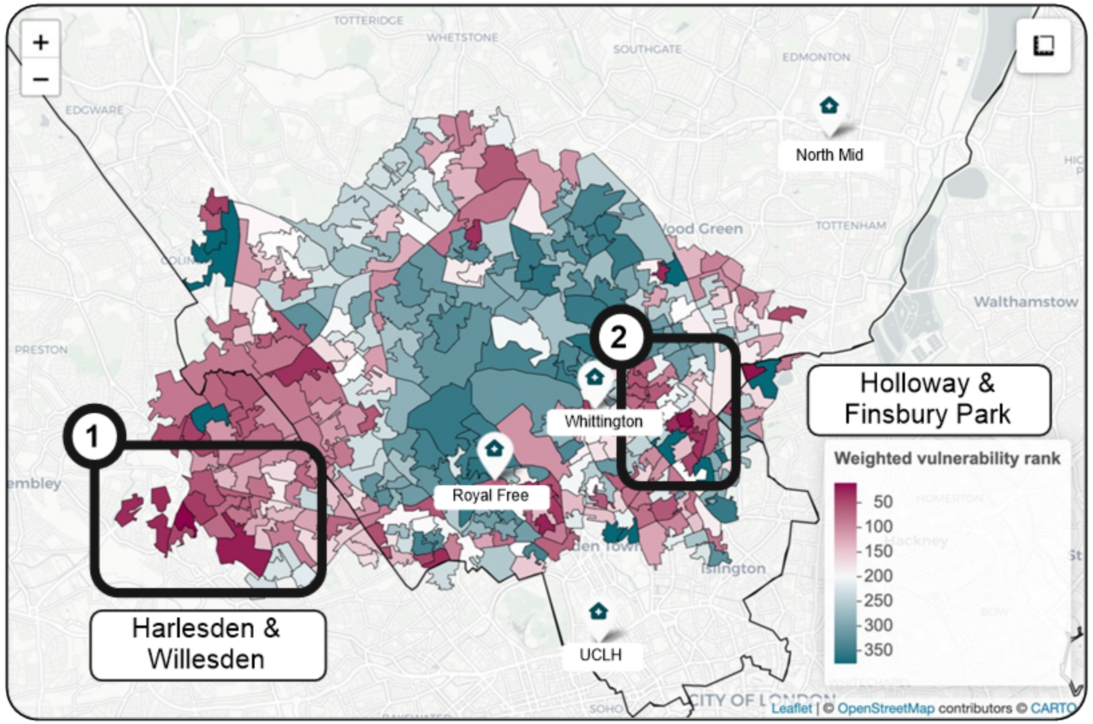

Weightings were used to ranks all LSOAs from highest to lowest against a range of metrics including ethnic minorities, deprivation and poor health outcomes where 1 = worst, 400 = best. A weighted average was then developed for each LSOA and used to identify populations who may be more vulnerable to the impact of our proposals

- **Two geographical areas** were identified as having residents who may be more vulnerable to the impact of our proposals because they face barriers to accessing services due to living in areas of deprivation and having high levels of poor general health
- As a result of the proposals, people in **Harlesden and Willesden** (option A), and **Holloway and Finsbury Park** (option B) may need additional support to:
  - **Access the hospital site** if they are disabled/in poor health or are not proficient in English
  - **Travel to hospital by taxi**, if required, as it will cost an additional £4-£5 per journey
  - **Access services online** as they may have lower digital proficiency
  - **Care for other family members** as they may be a lone parent
- **Black African and Black Caribbean** populations are concentrated in these geographies and have poorer maternity outcomes
- Harlesden has a large proportion of **Bangladeshi and Pakistani** populations, who are more likely to have worse maternal health outcomes

There are a range of population groups who may be impacted if we were to implement either option A or B

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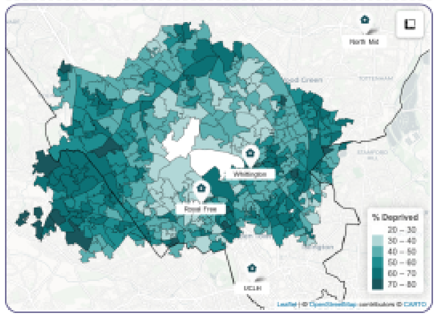
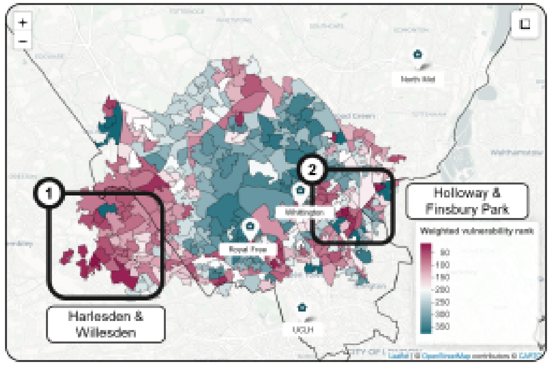
Women and people who live in deprived areas: there is a link between people living in deprivation and adverse outcomes from maternity and neonatal care. People living in these areas may be particularly impacted by increased taxi costs if either option A or B were to be implemented.

Deprived population
Rate (%) of deprived population

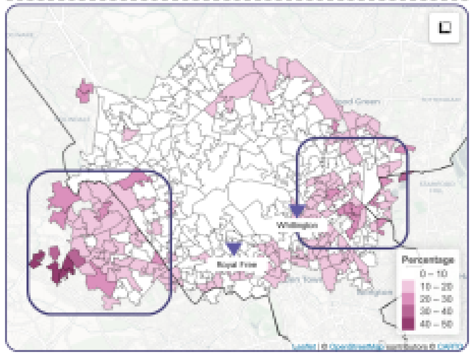


People living in geographic areas who may have vulnerabilities: we identified two neighbouring areas with a higher concentration of people who may be vulnerable to service changes. **Harlesden and Willesden** would be more impacted by option A and **Holloway and Finsbury Park** would be more impacted by option B. The reason that these areas have been identified is due to their higher concentration of people who belong to an ethnic minority, people with poorer English proficiency and areas of higher deprivation. Mitigations for these populations include a focus on continuity of care and ensuring there is integration with other local services



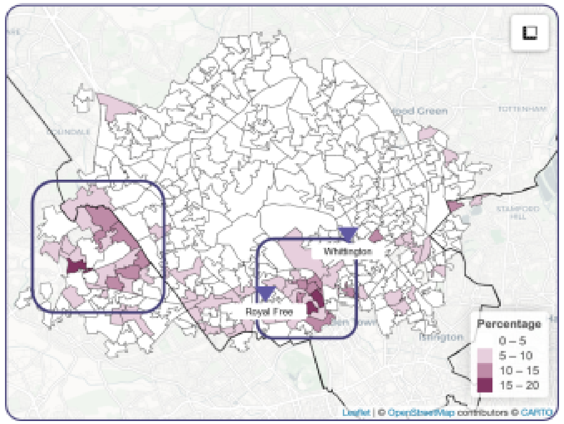
Black African (including Somali) and Black Caribbean women and people of childbearing age: there is evidence that Black African and Black Caribbean women and people may experience poorer maternity outcomes. The impact on Black African and Black Caribbean women of proposed changes may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of their wider health needs during pregnancy.

Black African and Black Caribbean populations
Proportion of Black African and Black Caribbean populations



Asian women and people of childbearing age: there is evidence that Asian (particularly Bangladeshi and Pakistani) women and people may experience worse outcomes from maternity care. The impact for them may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of wider health needs given evidence of higher prevalence of conditions such as diabetes.

Asian (Bangladeshi and Pakistani) populations
Proportion of Bangladeshi and Pakistani populations



There are a range of population groups who may be impacted if we were to implement either option A or B

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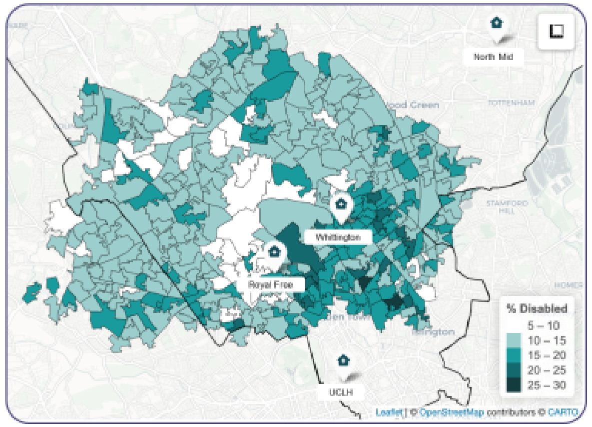
Women and people of childbearing age with disabilities (including learning disabilities): people with disabilities may be more impacted by proposed changes due to challenges navigating to an unfamiliar hospital site, taxi costs due to lower car ownership and the physical accessibility of hospital sites.

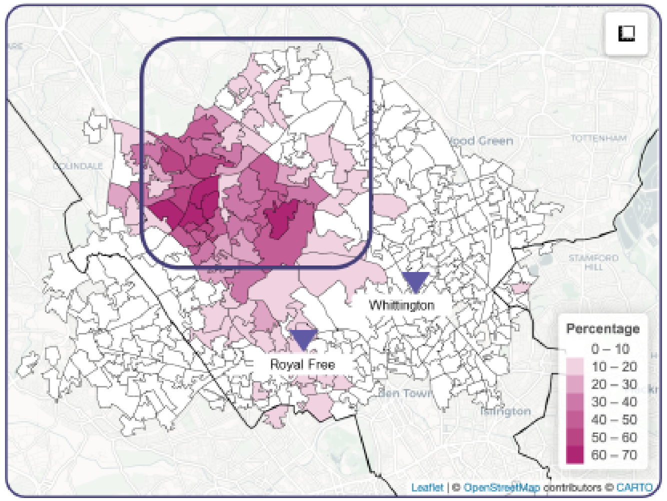
People with a disability
Rate (%) of people with a disability



Through engagement with service users to date, we have developed mitigations that may need to be put in place to support service users with a range of different needs should a decision be taken to implement proposals. This covers areas such as:

- Communication and information sharing
- Travel and transport
- Ongoing engagement with communities

Jewish Population
Proportion of Jewish populations



Women and people from the orthodox Jewish community: Orthodox Jewish people may be impacted by the proposed changes, particularly around Option A. Consideration may need to be given for the specific needs of this group around maternity care. This includes requirements around Kosher food, observance of Shabbat and the impact on travel and ability to access online or digital materials.

There are a number of other service users who have characteristics that make them potentially more impacted should we implement option A or B which our IIA identifies. This includes older and younger pregnant women and people, people with poor literacy and women and people in inclusion health groups.

We would seek as a priority to engage with all of these groups during the consultation period.

The birthing suites at Edgware Birth Centre

We are also proposing closing the birthing suites at Edgware Birth Centre

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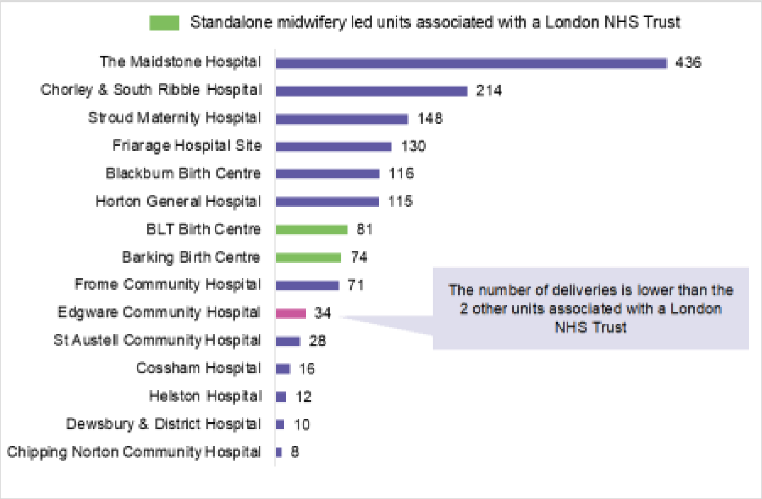
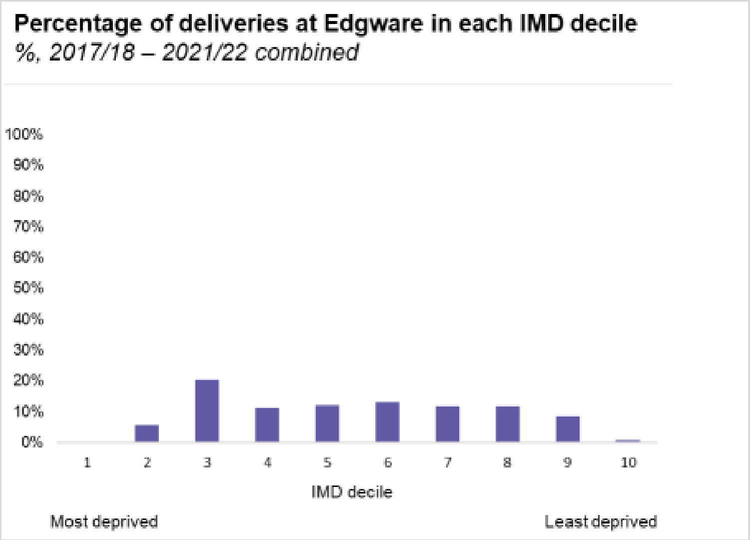
Case for change for Edgware Birth Centre

- Edgware Birth Centre does not provide the right type of capacity for our population, with analysis suggesting only 30% of women across NCL would be clinically appropriate to give birth there and an even smaller number of this 30% would be within close travelling distance of the unit
- Births are becoming more complex and anticipated to decline over the next 10 years, meaning it would be very difficult to increase activity numbers at the unit
- The number of births at the unit has been declining every year since 2017 and it is one of units with the smallest number of births in the country, with only 34 births in the last financial year
- We do not have the workforce to support the unit as well as our other alongside midwifery-led units which leads to short term closures of the service
- There are opportunities to use the space at the site in a more efficient way and provide antenatal and post natal services for our local population there that are more in line with their needs





We are consulting on this as a separate proposal alongside the maternity and neonatal proposals. They are not dependent on one another.

Surgery for babies and children

There are several important clinical drivers for change in our paediatric surgical services

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There is currently a lack of defined emergency surgical pathways for young children meaning that clinicians in emergency departments make multiple enquires to secure the right pathway for individual children.

Some children are transferred up to three times before receiving emergency surgical treatment in the right setting. From April 2020 to March 2021, 144 children and young people were transferred from an NCL provider to other hospitals for an emergency surgical procedure

Access to surgical and anaesthetic workforce to deliver care for young children is limited at local sites and scarce nationally, with the ability to undertake an operation often dependent on the skills of the individual staff on duty that day

There are some operations being undertaken in very low volumes at local sites which raises questions about the ability of staff to maintain their skills

There is lack of clarity on the role of Great Ormond Street Hospital in caring for local NCL children and young people requiring surgery, alongside its tertiary and quaternary work

Children are not always looked after in age-appropriate environments, or on child-only lists which does not represent a high-quality patient experience

There are long waits for planned operations, particularly in ENT and Dentistry, and there are opportunities to consider how these high-volume specialties better manage demand and capacity

There were broader opportunities to improve identified through the case for change which are being addressed through other programmes of work.

Our proposals will improve quality outcomes and patient experience for paediatric surgical care

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Paediatric surgery care model benefits

Access
Paediatric surgical care will be delivered in the appropriate setting to ensure that all patients receive the care they require as quickly as possible

Workforce
Make best use of paediatric surgeons and consultant paediatric anaesthetists to deliver planned and emergency surgical care to children at a fewer number of sites

Sustainable services
Consolidating low volume specialties and ensuring staff maintain competencies will ensure that surgical services remain sustainable

Environment
Ensure all children receive care in a child friendly environment where possible, on dedicated children's surgical lists

Surgical pathways
Providing clarity on surgical pathways reduces time taken to find a bed at local units or transfer children

Option for consultation – paediatric surgery

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- We developed and appraised options for the location of planned and emergency surgical services for children and young people in NCL
- Following our options appraisal, there is one option for consultation for the location of the 'Centre of expertise: day case' and 'Centre of expertise: emergency and planned inpatient'

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Option for consultation

Centre of Expertise: emergency & planned inpatient		Centre of Expertise: day case	
GOSH	**Would deliver majority of surgical care for children under 3 years and under 5 years (general surgery and urology). Would provide planned inpatient surgery for children age 1 years and over for low volume specialties.**	**UCLH**	**Would delivers all day case surgery for children age 1 and 2 years. Would provide day case activity for all children age 3 years and over for low volume specialties.**

The proposed care model would move less than 10% of paediatric surgical care in NCL

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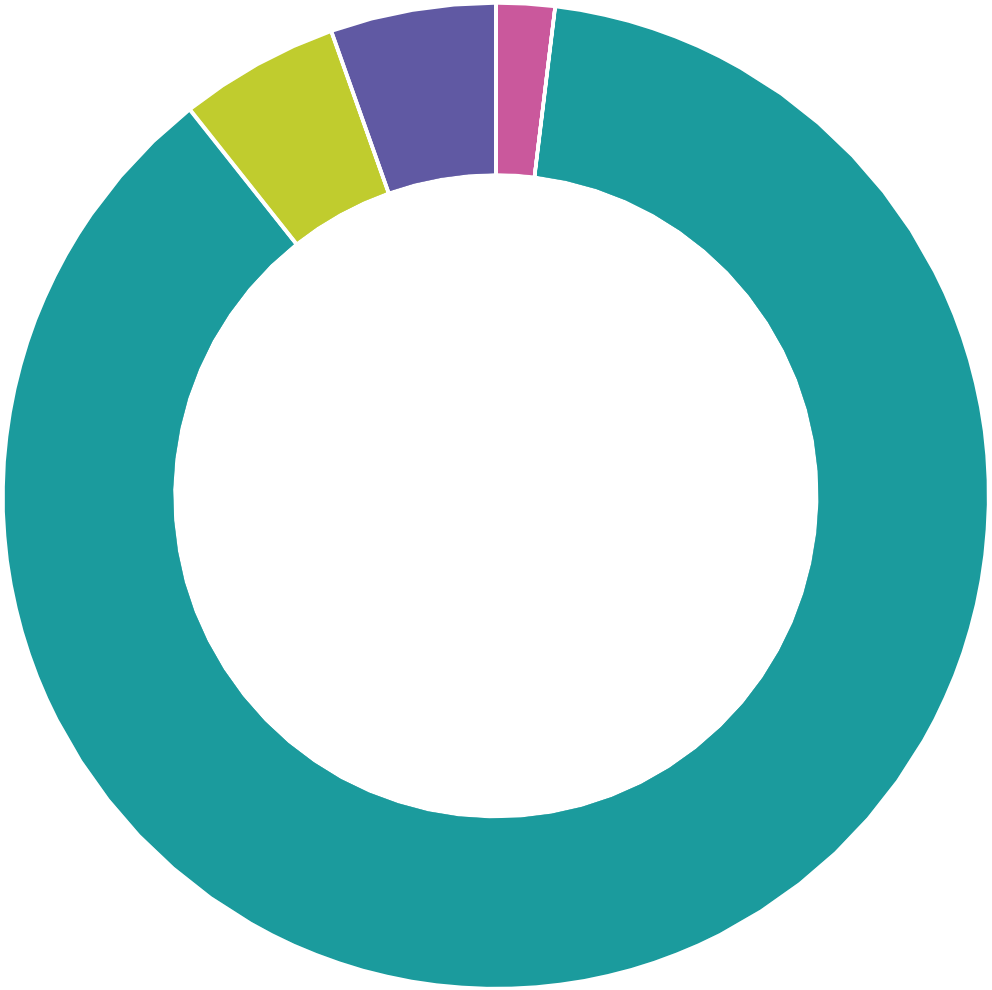
Centre of Expertise: Daycase – c.300 children
Bringing together planned daycase activity

Centre of Expertise: Emergency & planned inpatient – c. 300 children for surgical care and c.1,000 children for surgical assessment
Bringing together emergency for very young children and planned inpatient care



Out of area
Emergency paediatric surgical activity that would continue to be delivered outside NCL (e.g., major trauma)

Local and specialist units
Most of the emergency and planned activity would remain at local units or at specialist units. This means that children and young people are seen at the place best suited to their needs.

The consultation

The programme has benefited from substantial input from service users and local communities and public consultation will expand the reach of the engagement to date

Case for change development

- Review of existing patient experience insights data from 11 different sources
- Establishment of a youth mentoring scheme and youth summits
- Targeted engagement with a small number of patient groups

Case for change engagement

- A 10-week engagement programme
- 43 engagement events
- 207 in-depth conversations
- 389 questionnaires completed

Care model development

- Establishment of the Patient and Public Engagement Group (PPEG) to review and input into care models
- Feedback from case for change engagement informed their development
- Two youth summits involving 35 young people

Options appraisal

- PPEG responsible for development and initial evaluation of access criteria
- PPEG Chair a member of the programme board and participated in the programme board workshop for the options appraisal

IIA Engagement

- 11-week targeted engagement period focussing on those with protected characteristics and at risk of poorer outcomes
- 38 sessions held, reaching 124 patients

Public Consultation

- Widely promoted high volume engagement with all staff, stakeholders and residents
- Some in-depth conversations with targeted groups
- A formal part of our statutory duties around major service change and ongoing involvement of people and communities

14-week public consultation from mid-December 2023

North Central London Integrated Care System

Approval given to commence a 14-week consultation to gather views from service users, stakeholders, residents and staff, running from **11 December – 17 March 2024.**

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Development of the consultation plan

The Consultation Plan is a working document which details the purpose, scope and plan of how we will deliver this public consultation.

The consultation is being jointly run by NCL Integrated Care Board, on behalf of the Integrated Care System and its partner organisations, and NHS England as the commissioner of some specialised neonatal and surgical services.

The plan has been reviewed by our Programme Board, NHSE at a formal assurance meeting, and Healthwatch representatives. The plan will be iterative, and we will monitor progress throughout the consultation to ensure we are meeting our objectives.

The consultation will be overseen by the Start Well Programme Board, and we will provide regular updates on planning and delivery. Responses will be independently collected and analysed by an external organisation in line with best practice.

At the end of the consultation period, we will have an independently drafted report detailing the feedback received during the 14-week period.

Key Legal Duties
This consultation will fulfil our duty under the

- **NHS Act 2006** (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022)
  - to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way services are provided and decisions about how they operate
  - to consult local authorities
  - To regard the need to reduce health inequalities in access and outcomes
  - consider the 'triple aim' with regard to the health and wellbeing of people, quality of services and efficient and sustainable use of resources
- **Equality Act 2010** (Public Sector Equality Duty) to demonstrate how we have taken account of the nine protected characteristics and given regard to:
  - Eliminate discrimination, harassment and victimisation
  - Advance equality of opportunity
  - Foster good relations
- **The Gunning Principles for a fair consultation**

Through consultation we are seeking to gather views from a diverse range of voices

North Central London Integrated Care System

We will deliver a 14-week formal public consultation, in line with best practice that complies with our legal requirements and duties. Our aims are:

- To inform stakeholders about how proposals have been developed in a clear, simple and accessible way that allows for 'intelligent consideration'
- Provide adequate time and opportunities for staff, residents and stakeholders to give their views on proposals, and the potential impacts
- Ensure a diverse range of voices are heard
- Seek alternative proposals or evidence not yet considered
- Understand the advantages and disadvantages of the proposed change and any unintended consequences
- Explore what mitigations might be used to reduce the impact of disadvantages
- Find out what matters most to patients and how this might affect implementation
- Provide analysis of responses to enable conscientious consideration before a decision is made

Consultation aims

- Raise awareness of consultation with staff, patients, service users and residents and encourage to participate
- Remind people that their views matter and encourage them to share feedback through direct engagement
- Encourage participation from a diverse range of voices by providing adequate time and opportunities for people to respond
- Focus resources on hearing from people with protected characteristics and more impacted groups
- Provide staff engagement mechanisms all for health and care staff in NCL during the consultation period.
- Capture stakeholder attitudes of key groups and influencers on the proposals and the consultation process

Consultation materials and promotion

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Consultation materials

We have developed materials that explain the proposals and rationale in a clear and accessible way.

Information is available on our website and in hard copy, with an easy read, different formats and translated versions

In line with best practice, we have commissioned an experienced independent organisation to collate and analyse responses to the consultation.

This includes a questionnaire that will cover the three components of our proposals:

- Maternity and neonatal services proposals
- Edgware birthing suites proposals
- Surgery for babies and children

We are asking for each of these elements:

- To what extent do you agree/disagree with our proposals
- What are the main disadvantages and how could we address these?
- Are there any other solutions or information we should consider?

We will promote and encourage participation in the consultation in several ways:

Displays: in key locations we will promote the opportunity to respond to the consultation such as in NCL hospitals and clinics and other healthcare settings such as GP surgeries and pharmacies

Online promotion: social media channels, such as Facebook, Instagram, X and Linkedin, will be used to reach out to potential participants in the consultation. Branded graphics will be produced that are aligned with the look and feel of printed materials

Partner channels: all providers and partners such as councils will be asked to profile the consultation on their websites and through newsletters and other public facing channels and drive traffic to the NCL ICB website.

VCSE networks: we will provide content including information and visual materials and ask colleagues in voluntary and community sector organisations to use their channels to promote the consultation.

Media: We will seek to promote the consultation through earned (free) or paid-for content in local newspapers, newsletters and local radio.

Our consultation approach includes a focus on the groups identified through our IIA

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Our approach does the following:

- Build on previous engagement contacts, over 300 VCSE organisations will be contacted to take part in the consultation
- Work with partners, including councils and VCSE organisations, ICBs in neighbouring areas
- Prioritising groups identified by the interim IIA or with protected characteristics or at greater risk of health inequality
- Targeted engagement in geographical areas where there may be particular impact drawn out in the interim IIA, including areas outside of North Central London
- Identify the best ways of reaching and engaging priority groups ie. through third parties and trusted partners
- Ensure we develop a range of opportunities for stakeholders to respond to the consultation
- Arrange any events and meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Make sure there is equality monitoring of participants to ensure the views received reflect the local population

Resident groups we will be targeting through the consultation

- Black African (including Somali) and Black Caribbean women
- Asian women and people of childbearing age who (with a particular focus on Pakistani and Bangladeshi women)
- People living in areas of deprivation
- Orthodox Jewish women
- People with disabilities
- People living in Harlesden and Willesden
- People living in Holloway and Finsbury Park
- Older women of childbearing age (40+)
- Younger women of childbearing age (under 20)
- Women with mental health problems
- People from LGBTQ+ communities
- People who are carers
- People with poor English proficiency
- People with poor literacy
- People belonging to inclusion health groups such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller

We will tailor our engagement techniques during the consultation period

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- Broad range of techniques will be used, tailored to each audience and their level of interest.
- Opportunities online and face to face
- Working with third-party advocates (VCSE) to reach communities who may not engage directly
- Materials in accessible formats including Easy Read and translations
- Mechanisms in place to capture and analyse outputs.

Light engagement → **Deeper engagement**

Survey distributed on email	Drop in event/stall: face to face	Attendance at meeting: short agenda slot	Presentation and feedback: Start Well Team	Presentation and feedback: commissioned	Small group discussion online	Small group discussion: face to face	Interactive workshop: Start Well Team	Interactive workshop: commissioned	Telephone / online interviews

This type of engagement will be **promoted widely** to allow **a range of people to participate** in the consultation and give their views

This type of engagement will **focus on groups with protected characteristics and those identified by the IIA as potentially being more impacted** to understand their views and impact of the options in a meaningful way

North Central London Integrated Care System

Next steps

Next Steps

North Central London Integrated Care System

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Consultation input	• We would welcome your support and suggestions in terms of who we should reach out to and are very happy to come along to meetings and events • Please share the opportunity to take part in the consultation with your networks
Evaluating responses to the consultation	• We are working with an independent partner to evaluate consultation responses. • At our mid-way review we will assess our approach and review demographic information on responses to date. • Following the consultation period, we will publish an evaluation of the responses, in a report produced by this independent organisation, this will include who we reached during the consultation.
After consultation	• Feedback will inform future decision-making, the next steps and how plans would be implemented. • Following consultation, we expect NCL ICB Board, on behalf of NCL Integrated Care System and alongside NHS England who commission neonatal and specialist surgical services for children, after consideration of the consultation outcome, to make a decision by the end of 2024 or early 2025.

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LONDON BOROUGH OF
HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	25 January 2024
Subject:	Health and Wellbeing strategy Update: Healthy People – start well
Responsible Officer:	Carole Furlong Director of Public Health
Public:	Yes
Wards affected:	All
Enclosures:	Presentation

Section 1 – Summary and Recommendations

This report sets out the work and commitments being taken forward as part of the healthy people domain of the health and wellbeing strategy, with a particular focus on children and young people & starting well in life.

Recommendations:
The Board is requested to:

- Note the work that has been completed to date to support the delivery of more integrated services for children, young people and families in Harrow, in addition to promoting and supporting healthy early years and school settings in the borough; enabling the delivery of the Start Well elements of the Health and Wellbeing Strategy.
- Endorse the integrated CYP model and roadmap to implementation.

Section 2 – Report

This update of the health and wellbeing strategy will cover aspects of the healthy places domain of the strategy. At this meeting, there will be a presentation of the community safety strategy and an update on housing including: homelessness, damp and mould, increasing the quality of existing council homes, and new affordable homes, with reference to partnership working.

They are being presented to the health and wellbeing board because each has an impact on the health and wellbeing of residents and those working and visiting the borough.

CYP integration and family hubs

There has been recognition locally that although there are many excellent service offers for children, young people and families in Harrow, these are often not joined up to provide the most effective care to families.

Following the Covid Pandemic and with the growing cost of living crisis, existing areas of concern in children and young people (CYP) services seem to have been exacerbated, and inequalities in the delivery of those services have potentially deepened.

For families to receive the best help, services need to be joined up and integrated in their approaches. There is a strong case for supporting families during the early years of a child's life (conception to age 5) as this is a critical period that determines the lifelong effects of physical, cognitive, social and emotional, and behavioural development. The right support for families during this time can fundamentally change lives. At present, family members often have to tell their stories again and again, do not know where to go to get help, and are often not met with the right support at the right time. Family members need to know who to turn to when they need help, and trusted relationships sit at the heart of this. We also know that we need to adapt our services to reach our underserved populations.

Our frontline practitioners need to understand the system that they work in and who to contact when they want to intervene proactively to support a family member. They need to be able to share information easily so that they can work seamlessly with other professionals and the families under their care. They also need to feel supported and empowered to work collaboratively across the system, and make decisions that enable them to offer the best care they can.

With the financial pressures currently being felt by the system, the urgent need to tackle health inequalities, and the growth in the demand for many of our services, we need to make better use of our current resources and develop offers that are sustainable and adaptable.

In response, the borough-based partnership in Harrow set out a mission to support better care and healthier lives for CYP and families, by transforming and integrating CYP services, and taking a family-centred approach to doing so. Our engagement and co-production work has helped us to determine four key programmes of work that will help deliver our ambition, namely:

1. Early Help for the Under 5s in the central integrated neighbourhood.
2. Family Hub Networks.
3. Harrow Family Front Door.
4. Team Around the Family (“TAF”) and Lead Professional Model.

These programmes of work are in progress and we are seeking investment from Harrow’s health and care partners to establish three TAF coordinator roles, a digital tool for the Family Front Door and a communications campaign.

Healthy Early Years London & Health Schools London

Healthy Schools London (HSL) and Healthy Early Years London (HEYL) are award schemes sponsored by the Mayor of London, which recognise and celebrate schools/settings that are making a difference to children and young people’s health. It underpins public health’s health and wellbeing strategy ‘start well’. HSL is school focussed and HEYL is tailored for early years and children under 5. Evidence shows that embedding good behaviours and practices from an early age stays with the child into adulthood.

HSL is an evidence-based “whole school approach” to improve the health and wellbeing of children and young people. The aim of HSL is to encourage schools to improve their health-promoting environments, reduce health inequalities, improve educational achievement and supports; pupils, staff and the wider community to develop health and wellbeing behaviours. The programme seeks to help schools develop their health and wellbeing policies and procedures and recognise and reward health promoting activities through accreditation.

The evidence-base for improving health within school settings is clear and supports a multitude of cross governmental strategies and statutory guidance. It supports local education providers to optimise health outcomes; contributing to the success of our own local health and education strategies and provides demonstratable evidence toward achieving Ofsted goals. Taking part in Healthy Schools will enable schools in Harrow to directly support the health and wellbeing of their pupils and staff and work toward reducing inequality within their communities and reflect the ‘start well’ in the Health and Wellbeing Strategy.

Public health has a built an excellent partnership with schools/settings over the last 5 years. The Fit4Life group was set up comprising key stakeholders, including schools, to look at the progress of the awards and responds to the HAY Harrow findings. This partnership and collaborative working has not only promoted core health improvement messages but has developed real tangible actions. Each school and early years provider is given a HSL and HEYL pack which outlines what is required to participate in the award.

The HSL and HEYL awards are not just about achieving a certificate. They take a whole school/setting approach to improving health and wellbeing for children and young people. They make schools/settings think about what food and snacks they provide, how they encourage physical activity and reduce obesity, how they help to improve children's mental health, etc.

Healthy Schools London awards to date:
- 41 Bronze
- 34 Silver
- 21 Gold

Healthy Early Years London awards to date:
- 21 Bronze
- 11 Silver
- 8 Gold

Harrow are the second highest scoring borough for achieving HEYL Gold awards across London.

Link to main site for HSL: https://www.london.gov.uk/what-we-do/health/healthy-schools-london/awards/home
Link to HEYL site : https://www.london.gov.uk/programmes-strategies/health-and-wellbeing/healthy-early-years-london

Both programmes are well embedded but depend on the close collaborative working with colleagues in education and early years teams. In order to be compliant, the awards need to be quality assured. We are in discussions with the teams to ensure ongoing commitment as HSL and HEYL meet both health and education priorities.

Financial Implications/Comments

There are no direct costs associated with delivering the health and wellbeing strategy.

However, to be able to deliver the full integrated CYP model, including family hubs, additional recurrent and non-recurrent funding is required. A business case is being taken to the next Harrow Joint Management Board (JMB) in February. As a partnership board, if the business case is approved, JMB will be responsible for agreeing the contributions from each of the partners. The additional funding will be funding:

- TAF coordinator roles (£60K per role – recurrent funding). Work is currently being undertaken to confirm whether the requirement is for two or three roles. TAF coordinators will coordinate trusted, preventative, multi-agency support for families who have an unmet or emerging need. This can currently not be offered to families due to capacity constraints, which in turn increases the risk of escalations to late-stage crisis management.

- branding and communications for the TAFs and Family Hubs Networks (£10K sought – non-recurrent funding) The launching of the new family hub networks will require a rebranding of the current children's centres and early support sites, as well as a communications campaign to inform wider practitioners and the public about the new networks.

If the business case is not approved, the CYP integration programme will not be able to deliver the TAF model, and the rebranding of the current children's centres and early support sites, as well as wider communications to the public, would be impacted.

Legal Implications/Comments

Section 116A of the Local Government and Public Involvement in Health Act 2007, stipulates that it is the responsibility of the local authority and integrated care boards to prepare a local health and wellbeing strategy.

The Health and Social Care Act 2012 provides responsibility to the Health and Wellbeing Board for the oversight of the local health and wellbeing strategy. The purpose of the Board is to improve health and wellbeing for the residents of Harrow and reduce inequalities in outcomes. The Board will hold partner agencies to account for delivering improvements to the provision of health, adult and children's services social care and housing services.

A key responsibility is to consider how to best use the totality of resources available for health and wellbeing, subject to the governance processes of the respective partner organisations as appropriate

.

Risk Management Implications

The health and wellbeing strategy does not present any risks, or suggest any mitigation

Risks included on corporate or directorate risk register? **No**

Separate risk register in place? **No**

The relevant risks contained in the register are attached/summarised below.
n/a

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? No

Harrow's Health and Wellbeing strategy plays a crucial role in advancing the equality, diversity, and inclusion agenda across the borough. By addressing the unique health needs of a diverse population, committing to addressing the building blocks of good health as a priority, as well as ensuring that health and care services are accessible and tailored to different demographics, this therefore reduces health disparities and promotes equality. It also fosters inclusivity by actively engaging with underrepresented groups and involving them in the planning and implementation of initiatives - a key priority for this strategy. This strategy can help create an environment where all residents, regardless of their background or circumstances, feel valued, supported, and empowered to lead healthier lives, ultimately contributing to a more inclusive and equitable society.

Council Priorities

A council that puts residents first

A place where those in need are supported

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

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 11/01/2024

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 10/01/2024

Chief Officer: Carole Furlong on behalf of Senel Arkut
Signed on behalf of the Corporate Director by Director of Public Health
Date: 10/01/2024

Mandatory Checks

Ward Councillors notified: NO as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Carole Furlong, Director of Public Health, Carole.Furlong@harrow.gov.uk

Background Papers:

Harrow Health and Wellbeing Strategy

If appropriate, does the report include the following considerations?

1.	Consultation	NO
2.	Priorities	NO

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CYP Service Integration
HWB Update

103

January 2024

***Ayo Adekoya**, Associate Director of Integration, Harrow Borough-based Partnership*

Harrow Borough
Based Partnership
Supporting better care and healthier lives

Brief on the Case for Change

Despite having a plethora of excellent services in Harrow, family members have had to tell their stories again and again, not knowing where to go to get help, and often not being met with the right support at the right time. For families to receive the best help:

- **Services need to be joined up and integrated in their approaches**. Family members need to know who to turn to when they need help, and trusted relationships sit at the heart of this. We also know that **we need to adapt our services to reach our underserved populations**.
- **Practitioners need to understand the system that they work in and who to contact when they want to intervene proactively to support a family member**. They need to be able to **share information easily** so that they can work seamlessly with other professionals and the families under their care. They also need to **feel supported and empowered to work collaboratively across the system**, and make decisions that enable them to offer the best care they can.

With the **financial pressures currently being felt by the system**, the urgent **need to tackle health inequalities**, and the **growth in the demand for many of our services**, we need to **make better use of our current resources and develop offers that are sustainable and adaptable**.

Our Approach

Building Consensus
(Feb ‘23 – Apr ‘23)

- ✓Away-day 1
- ✓Agree the vision and shared purpose
- ✓Agree key design principles
- ✓Agree the high-level outcomes
- ✓Confirm emerging priorities
- ✓Identify the risks and barriers

Developing the Model
(May ‘23 – Aug ‘23)

- ✓Away-day 2
- ✓Confirm the case for change
- ✓Start unblocking barriers
- ✓Co-production
- ✓Prioritise changes; start immediate
- ✓Align with neighbourhood footprints
- ✓Start the business case

Implementation Planning
(Sept ‘23 – Mar ‘24)

- ✓Away-day 3
- ✓Finalise model
- ✓Describe what will change
- ❑Finalise plans for operationalisation and training
- ❑Develop evaluation plan
- ❑Business case sign-off
- ❑Start baselining, tracking and reporting outcomes
- ❑Implementation (Test and Learn)

The Integrated Offer

Four priority areas were identified for the integrated model of care following a short needs assessment, stakeholder engagement and learning from other boroughs across England. These have evolved into **four programmes of work**:

1. **Early Help for the Under 5s in the Central Integrated Neighbourhood** (Hillview Children's Centre and outreach spokes, GP Direct and Shaftesbury GP Practices)**.** This is an NHS England-funded pilot, running until March 2025, to develop a hyperlocal preventive care team approach to improving life chances for children and families living in disadvantaged circumstances.

2. **Family Hub Networks**. **The development of family hubs is one of the 2023/24 flagship actions for Harrow Council.** There will be three hub networks, aligned to the three integrated neighbourhood teams in Harrow.

3. **Harrow Family Front Door.** This is a digital non-stigmatising single point of contact for services that support and provide guidance for parents, carers, young people and professionals. Behind the front door sits a multi-agency panel with different areas of expertise, working together to decide and coordinate the best way to support children, young people and their families.

4. **Team Around the Family ("TAF") and Lead Professional Model.** The TAF is a flexible multi-agency team working together to offer supportive, early and preventative interventions to children and their families to prevent escalation of issues and reduce the need for late-stage statutory interventions. The Lead Professional will lead the TAF, advocate for the CYP family, help coordinate onward referrals and hand-hold the child/young person/parent/carer through the process of obtaining support.

Start Well by Giving Every Child the Best Start in Life

What we have committed to do	The integrated offer supports this commitment in the following ways	The programme of work that will support the delivery of this commitment
Work together to ensure that children and families are safe	The **early identification of unmet or emerging needs** across the system and **proactively supporting families before crises happen**. Training of relevant multi-agency staff around where to access information, signpost and conduct TAFs.	• Family Hub Networks • Team Around the Family and Lead Professional • Family Front Door
Develop models of care for children and young people that meet their needs and focuses on early support and prevention	The integrated offer is primarily a **preventative and early intervention offer**.	• Team Around the Family and Lead Professional • Family Front Door • Optivita (Early Help for the Under 5s)
Ensure that schools, health and social care develop stronger working partnerships	We are holding **listening events in schools** and **working with schools, health and care partners in developing TAFs**. Holding **communities of practice** to share learning, solve issues and build expertise. The first Community of Practice takes place on 17.01.23.	• Team Around the Family and Lead Professional (including Communities of Practice)
Ensure that physical activity is promoted in all children and young people's settings	Where the need has been identified through data or engagement, we are **working with partners to bring their physical activity offers to the relevant family hub networks** (e.g. parents using The Beacon Centre have requested this).	• Family Hub Networks • Optivita (for Under 5 settings in the pilot area)
Address challenges that families in Harrow are experiencing through closer working with families and communities in Harrow.	**Co-production** with parents and young people in our underserved communities (with VCS support) and **listening events** in schools. **TAFs will include family members.**	• Family Hub Networks • Team Around the Family and Lead Professional • Optivita (for Under 5 settings in the pilot area)

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Supporting better care and healthier lives

Family Hub Networks

What are the Family Hub Networks?

- A network of family hubs in each neighbourhood that **reach into our communities with early help and preventative interventions**, and help children, young people and families build their resilience to crises and feel well supported by the system.
- The Family Hubs are **not about physical buildings**, but about adapting how and where information, advice and help are delivered, to ensure families get the right support, at the right time, in the right place.
- The family hub networks **will map to the footprints of the three integrated neighbourhood teams (INTs) in Harrow** (East, West and Central). The current early support sites and children's centres will be aligned as follows:
    - **East:** **Kenmore Park** + Chandos + Stanmore Park
    - **Central:** **Hillview** + Elmgrove + Gange + Wealdstone Youth Hub
    - **West:** **Cedars** + Pinner + Whitefriars

What will be different?

- **Taking offers out into our communities** e.g. community centres, warm hubs, schools. This will also allow for extending operational hours for activities and services.
- Enhancing the current provision by **joining up support where practitioners in the hub network are seeing the same families** (and between multi-disciplinary teams working for CYP).
- **Identifying C/YP/families** who attend the network sites and have an **unmet or emerging need, and introducing them to the *Harrow Family Front Door*** so they can access timely support to prevent escalation
- **Broadening the age range for support**.
- Doing more to **promote the current early help offers**.

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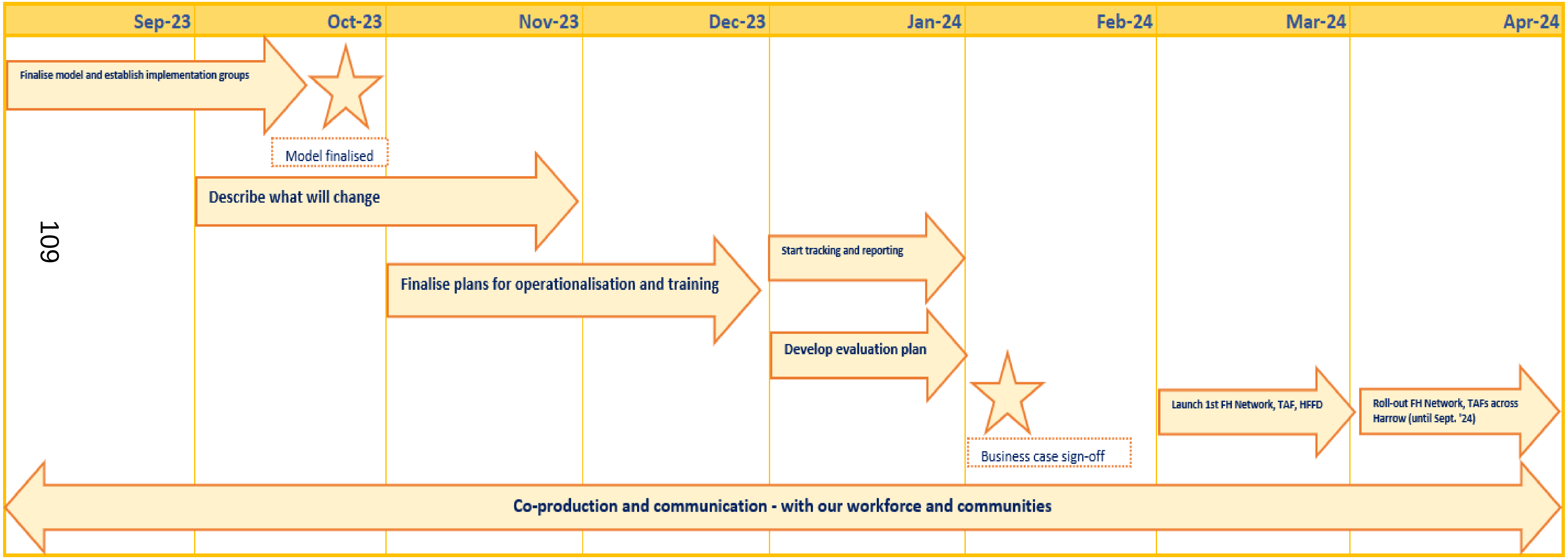
Supporting better care and healthier lives

Roadmap to Implementation: Next 5 Months



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What Else is Required to Deliver the Model?

- We are making best use of the current resources in the system and have sourced funding from other avenues to bolster the delivery of the integrated model e.g. inequalities funding for an additional health and wellbeing worker; partnership transformation funding for co-production and for OD support; partnership Comms Equity Role to support with the communications campaign.
- There is however a need to secure additional recurrent and non-recurrent funding to be able to deliver the full integrated model and ensure the success of the programme.
- We will be taking a business case to the next Harrow Joint Management Board in February, to secure some additional funding for three TAF coordinator roles, branding and comms for the TAFs and Family Hubs Networks, and a digital tool for the Harrow Family Front Door.

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Risks

	Description	Mitigation
1.	Competing and conflicting agendas (e.g. for health visitors around SEN and a high demand for statutory work), as well as the amount of change currently occurring in the system (e.g. Children's Services restructure and alignment of management structure to support the new integrated model). **The risk is that teams will not have the scope to engage with the implementation and embed the changes into BAU.**	• Protected time for change • Allowing for delays in responding to waiting lists when change is required whilst balancing impact of change with statutory work • Managing the pace of change • Organisational development (OD) support from external OD experts.
2.	A number of interventions have been identified to ensure the delivery of an integrated model. There is currently no funding allocated to allow for operational delivery of the model. Any investment committed will need to be recurrent to ensure the model is sustained. **The delivery of the full integrated model is at risk without sustained investment.**	• Wherever possible we are optimising current resources to deliver the new integrated model • Recommending a business case for required additional investment to go to the Harrow Joint Management Board in February.
3.	**Significant organisational/structural changes within NW London ICB and Local Authority Children's Services may have an impact on engagement in the programme and on implementation timelines.** The move to consultation within the ICB will impact on capacity to attend meetings, as engagement meetings have already begun which ICB colleagues are attending.	• Keep comms open about timelines for organisational changes. If impact is significant, agree a slow-down on non-urgent elements of the implementation. Map out what can be predicted in terms of impact and agree a clear line of escalation.
4.	A number of interventions have been identified to ensure the delivery of an integrated model. There is currently no funding allocated to allow for operational delivery of the model. Any investment committed will need to be recurrent to ensure the model is sustained. **The delivery of the full integrated model is at risk without sustained investment.**	• Wherever possible we are optimising current resources to deliver the new integrated model. • A business case for the required additional investment to go to the Harrow Joint Management Board in February.
5.	New Children's Services structure is not a straight map of the three INTs/FH network areas. The are no 'family hub manager' posts in the new structure although there will be some management capacity for the LA elements of delivery. **This could have an impact on capacity to deliver the overarching integrated model.**	• Workshop taking place on 08.01.23 to discuss and mitigate.

Asks of the HWB …

- Note the work that has been completed to date to support the delivery of more integrated services for children, young people and families in Harrow, and support the delivery of the Start Well elements of the Health and Wellbeing Strategy.
- Endorse the integrated model.
- Endorse the roadmap to implementation.

Harrow Borough Based Partnership
Supporting better care and healthier lives

HEALTHY EARLY YEARS LONDON

HEALTHY SCHOOLS LONDON

Healthy Schools London (HSL) and Healthy Early Years London (HEYL) are award schemes sponsored by the Mayor of London, which support, recognise and celebrate schools/EY providers that are making a difference to children and young people's health.

PH Support for HEYL and HSL

1. Dedicated HEYL/HSL officer time
2. HEYL/HSL welcome packs
3. Free training on SS4E
4. Access to PH funding e.g. Daily Mile tracks, water fountains
5. Public Health CYP newsletter

LONDON BOROUGH OF HARROW

Example of resulting action in relation to Oral Health:

Healthy Schools London: Gold Award

St Bernadette's Primary School

David O'Farrell, Headteacher

Preach the Gospel at all times
and when necessary use words.

Outcomes

Reception

1) To increase the % of reception children who brush their teeth twice a day from 66% to 80%
Outcome: 84% - target exceeded

2) To increase % of reception children who are registered with a dentist from 60% to 80%
Outcome: 95.5% - target exceeded

3) To decrease the % of reception pupils consuming sugary foods and drinks often from 66% to 50%
Outcome: 5% - target exceeded

Reception & Y5

4) To increase parents' understanding of healthy eating and oral health from 66%
Outcome: 95.5% - target exceeded

Example of resulting action in relation to Sexual Health:

HEALTHY SCHOOLS LONDON
GOLD AWARD

HEALTHY SCHOOLS GOLD AWARD

Jubilee Academy

Sukhi Cooper, School Business Manager

HEALTHY SCHOOLS LONDON

LONDON BOROUGH OF HARROW

OUTCOMES OF THE PROJECT

1) To decrease the % of students that do not know how to access local sexual health services, from baseline 58% to target of 40%

Final outcome – 43% IMPROVED BUT NOT MET

2) To increase the % of students who know how to report a concern if they see something online or in school that is upsetting or makes them feel safe online or at school, from baseline 75% to target of 90%

Final outcome – 100% EXCEEDED

3) To decrease the % of students who did not feel able to say 'no' to something they didn't want to do, from baseline 16% to target of 10%

Final outcome – 9% EXCEEDED

4) To decrease the % of students that do not understand what a heathy teenage relationship looks like, from baseline 15% to target of 10%

Final outcome – 0% EXCEEDED

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Healthy People

Theme	Commitment in the Health and Wellbeing Strategy	Action area	Key performance indicators - how will progress be measured?	Programmes of work that support the delivery of this commitment	Current progress & next steps	Lead	Funding status
Start well: giving every child the best start in life	work together to ensure that children and families are safe	Ensure that our children and young people are safe, including those that are more vulnerable, through early identification, and engagement with key services	• No. of referrals from health visiting to MASH • Rate of child protection plan at any point during the year • Rate of children looked after at any point in the year	• Maternal Early Childhood Sustained Home-visiting • Early Support • Together with families programme • Family Hub Networks • Team Around the Family and Lead Professional	The Harrow 0-19 service will continue to deliver the MECSH programme. Over 50 families have been enrolled on this 2 year intensive support programme since the soft rollout started in Autumn 2022. Families can join the programme up to the child reaching 8 weeks of age. The Children, Young People and Families integration programme is establishing a lead professional model to enable robust coordination of multi-agency working, and the right early support	Director of Childrens Services	business case being developed for TAF coordinator roles, branding & comms, and digital tool for Harrow Family Front door - to be presented at JMB
	develop models of care for children and young people that meet their needs and focuses on early support and prevention	Develop the family hubs model to strengthen early support and prevention including partnership working with schools and other partnership commissioned services (e.g. substance misuse)	*indicators under development* *- family surveys focussed on experience of care, and empowered and resilient families* *- workforce surveys focussed on collaborative working, workforce development and satisfaction*	• Family Hub Networks • Commissioned services (e.g. substance misuse services)	This integrated model is currently in the final stages of planning for operationalising the offer and developing training for the workforce. It is expected that the first family hub network will launch before the end of March, with a roll-out of other family hub networks through March / April .	Director of Childrens Services / Service Director for Outer London Services	as above and funded within existing resources
	address challenges that families in Harrow are experiencing through closer working with families & communities in Harrow	Develop programmes that enable closer working with families in Harrow & connections with voluntary and community sector groups supporting those families, alongside high-quality maternity, health visiting services and social care services.	• No. of maternity community champions recruited *indicators under development* *• Reach of the programme into the community* *• No. of mothers and families engaged with*	• Maternity community champions programme • Family Hub Networks • Optivita programme (under 5s)	52 maternity champions have been recruited, with over half of those having been trained. Outreach activities have commenced, and over 150 families have been engaged with, and 0ver 50 women supported through various focus groups or peer support sessions.	BBP	funded by the borough based partnership until October 2024
	ensure that schools, health and social care develop stronger working partnerships	Developing stronger strategic links and partnerships between schools, health and social care, using the partnerships forums and workstreams as an enabler, and continuing the implement the Healthy Schools London and Health Early Years London across settings in Harrow to deliver (evidence- based) proven health and wellbeing programmes for children	• No. of early years settings that have achieved bronze, silver or gold status • No. of schools that at have achieved bronze, silver or gold status *indicators under development focussed on listening events held and communities of practice developed*	• Healthy Schools London and Healthy Early Years London	Harrow is the 2nd highest perfromer in London, with 21 schools achieving the highest level of certification. Schools are supported to address issues that concern them most. Current projects have detialed measurable outcomes in dental health, and sexual health at individual schools. The programme is well engaged with the schools and it is intended to use the programme as a continued communication channel with the schools to achieve a workable dialogue in light of increased integrated services between health and care.	DPH AD for Integration	Funded within existing resources by public health grant
	ensure that physical activity is promoted in all children and young people's settings	Physical activity is promoted in all settings, especially under- fives, where 180 minutes is the recommended daily amount, promoting initiatives such as the Daily Mile in schools	• prevalence of obesity in reception and year 6 aged children • physical activity levels for children and young people	• Healthy Schools London and Healthy Early Years London • Harrow's year of Physical Activity programme	Street tag / promotion through schools PH are leading a focus on physical activity in 2024, responding to community needs and running pilot programmes to assess acceptbility and demand.	DPH Communities Directorate	Funded within existing resources by public health grant

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Overarching metrics for the health and wellbeing strategy

Indicator	Unit	Period	Harrow					NWL value	Source
			Latest (January 2024)	Latest trend	Count	Value	Compared to NWL		
Overarching metrics for the health and wellbeing strategy									
Infant mortality rate	Rate per 1,000	2019-21	**3.8**	→	39			3.7	ONS
Child mortality rate (1-17)	Rate per 1,000	2018-2020	**11.4**	→	19			10.5	ONS
Life expectancy (female)	Years	2018-2020	**85.7**	→				85.1	ONS
Life expectancy (male)	Years	2018-2020	**82.2**	→				81.2	ONS
Healthy life expectancy (female)	Years	2018-2020	**60.9**	→				64.8	ONS
Healthy life expectancy (male)	Years	2018-2020	**64.8**	→				64.5	ONS
Slope index of inequality (female)	Years	2018-2020	**6.3**	→				6.6	DHSC
Slope index of inequality (male)	Years	2018-2020	**6.6**	→				8.7	DHSC
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Indirectly Standardised Rate per 100,000	2020/21	**550.9**	↓	1,375			372.9	ONS
Under 75 mortality rate from causes considered preventable	DSR per 100,000	2021	**154.4**	n/a	317			183.0	DHSC
Under 75 mortality rate from cardiovascular causes considered preventable	DSR per 100,000	2021	**25.2**	n/a	50			28.0	DHSC
Under 75 mortality rate from cancer causes considered preventable	DSR per 100,000	2021	**27.9**	n/a	56			39.1	DHSC
Under 75 mortality rate from liver disease causes considered preventable	DSR per 100,000	2021	**17.6**	n/a	37			17.7	DHSC
Under 75 mortality rate from respiratory causes considered preventable	DSR per 100,000	2021	**n/a**	n/a	8		n/a	11.7	DHSC

Children and Young People specific metrics

Indicator	Unit	Period	Harrow Latest (January 2024)	Harrow Latest trend	Harrow Count	Harrow Value	Harrow Compared to NWL	NWL value	Source
Children and Young People specific metrics									
Maternity champions trained	People	2022/23	**30**	↑	30		n/a	n/a	Harrow BBP
Healthy Early Years (HEY) Combined First Steps, Bronze, Silver, Gold	Number	Q2 2022/23	**98**	→	98		n/a	n/a	LB Harrow
Healthy Schools London (HSL) Number achieving Bronze, Silver, Gold	Number	Q2 2022/23	**94**	→	94		n/a	n/a	LB Harrow
Children who received a 6-8 week review by the time they were 8 weeks.	Percentage	Q2 2022/23	**85.0%**		648		n/a	n/a	LB Harrow
Children who received a 12 month review	Percentage	Q2 2022/23	**86.1%**		758		n/a	n/a	LB Harrow
Life satisfaction (age 10-17)	Score	2022	**7.17**	↓			n/a	n/a	HAY Harrow
Vaccination coverage: MMR for one dose (2 years old)	Percentage	2022/23	**84.6%**	↑	2,723			84.0%	NHS Digital
% of children achieving a good level of development at the end of Reception	Percentage	2021/22	**70.4%**	n/a	2,158			66.70%	DfE
Average Attainment 8 score (15-16 years)	Score	2021/22	**56.7**	→				53.9	DfE
Smoking at time of birth delivery	Percentage	2022/23	n/a	n/a	n/a			3.4%	DHSC
Rate of Self Harm hospital admissions (under 18)	Rate per 1,000	July 2022-23	**1.58**		528				WSIC
Percentage of 5 year olds with experience of visually obvious dentinal decay	Percentage	2021/22	**35.8%**	→	134			33.1%	Dental Epi Survey
Reception prevalence of obesity	Percentage	2022/23	**8.3%**	→	245			9.0%	DHSC
Year 6 prevalence of obesity	Percentage	2022/23	**23.7%**	→	690			24.4%	DHSC
Age 16/17 not in education, employment or training (NEET) or not known	Percentage	2022/23	**1.7%**	→	99			3.6%	DfE
Rate of episodes of Children in need of at any point during the year	Rate per 10,000 (0-18)	2022/23	**606.5**	↓	3,522			599.3 (Statistical Neighbours)	DfE
Rate of Referrals	Rate per 10,000 (0-18)	2022/23	**534**	↑	3,102			509 (Statistical Neighbours)	DfE
Rate of child protection plan at any point during the year	Rate per 10,000 (0-18)	2022/23	**105**	↓	609			84 (Statistical Neighbours)	DfE
Rate of children looked after at any point in the year	Rate per 10,000 (0-18)	2022/23	**49.6**	↑	292			65.3 (Statistical Neighbours)	DfE

LONDON BOROUGH OF
HARROW

Report for:	**Health and Wellbeing Board**
Date of Meeting:	25th January 2024
Subject:	North West London Child Death Review (CDR) Annual Report 2022-3
Responsible Officer:	Rob Hurd, Chief Executive Officer of Integrated Care System
Public:	Yes
Wards affected:	All
Enclosures:	NWL CDR Annual Report 2022-23

Section 1 – Summary and Recommendations

This report describes the work of the NWL Child Review Team for year 2023-4 and highlights some issues relating to child mortality that relate to NWL as a whole and are also applicable to Harrow

Recommendations:

The Board is requested to:
Receive the contents of the report and to particularly note the information on pages 31 and 35 as potentially assisting with the HWB strategic objective of reducing child mortality.

Section 2 – Report

Background

In 2019 the Child Death Review Process (The CDR Process) was significantly altered. The previous single borough process was replaced with the NWL process. This move enables larger case-loads to be considered by multi agency professionals ensuring trends and themes relating to child mortality to be better identified and actioned.

This is the report of the NWL ICB for 2023 – 24.

This report describes the work of the CDR team and reports some of its findings. It also shows how the analysis of child death data over a large population aggregated over the four years since the NWL CDR Process began allows for the identification of small populations where child mortality is significantly higher than in other areas. Some small population areas in Harrow are identified as having higher child mortality.

LSOA no	Ward
2213-	Roxbourne
2117-	Canons
2118-	Edgware
2238-	West Harrow
2234-	Wealdstone
2203-	Queensbury
2181-	Marlborough
2126-	Rayners Lane

This provides Harrow partners with an opportunity to take focused action.

Considerations

The Office for Health Inequalities and Disparities has identified how focusing on small communities where child mortality is high could enable progress to be made towards Local Partners' goals to reduce child mortality.

Applying such a focus may require little additional resource, but long -term progress should be monitored.

Equalities Impact

Black and Asian women have well documented poorer outcomes in relation to child birth than other ethnicities, however in NWL that is not the case. Nor is the link between deprivation and poor outcomes, also well documented elsewhere, so clear in NWL. The data at pages 31 and 35 of the report represent a challenge and an opportunity to Harrow partners.

Financial Implications/Comments

Taking action to understand the reasons for enhanced child mortality in the LSOAs highlighted in the report may have some financial implications.

The financial impact of any actions would need to be considered as part of the annual budget setting process for all and contained within the annual Public Health grant or partner organisation budgets as appropriate.

Legal Implications/Comments

The Children Act 2004 imposes a statutory duty to carry out Child Death Reviews and the relevant Guidance is the Child Death Review Statutory and Operational Guidance (England)
The terms of the Health and Wellbeing Board include
. To consider how to best use the totality of resources available for health and wellbeing, subject to the governance processes of the respective partner organisations as appropriate.
. To provide a forum for public accountability of NHS, public health, social care and other health and wellbeing services

(https://www.harrow.gov.uk/downloads/file/31683/HAR_PH_HEALTH_AND_WELLBEING_STRATEGY_web_v2.pdf)

Risk Management Implications

Risks included on corporate or directorate risk register? **No**

Separate risk register in place? **No**

The relevant risks contained in the register are attached/summarised below. **/n/a**

The following key risks should be taken into account when agreeing the recommendations in this report:

Risk Description	Mitigations	RAG Status
Insufficient resource or analysis to impact child mortality in identified LSOAs	Working with partners we will be able to take appropriate action without requiring more resource ▪ ▪	Amber

Equalities implications / Public Sector Equality Duty

Was an Equality Impact Assessment carried out? No

If No. At this stage no change of policy or delivery or service is suggested. However, should action be taken to understand and address child mortality in the identified LSOAs then an EIA will be required.

Council Priorities

1. **A council that puts residents first**

2. **A place where those in need are supported**

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

Statutory Officer: Donna Edwards
Signed on behalf of the Chief Financial Officer
Date: 11/01/2024

Statutory Officer: Sharon Clarke
Signed on behalf of the Monitoring Officer
Date: 11/01/2024

Chief Officer: Carole Furlong on behalf of Corporate Director
Signed on behalf of the Corporate Director by the Director of Public Health
Date: 10/01/2024

Mandatory Checks

Ward Councillors notified: No, as it impacts on all Wards

Section 4 - Contact Details and Background Papers

Contact: Tanya Nanauwan, North West London Child Death Review Team Manager, t.nanuwan@nhs.net

If appropriate, does the report include the following considerations?

1.	Consultation	YES / NO
2.	Priorities	YES / NO

North West London

Child Death Review

Annual Report 2022/2023

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North West London Child Death Review Team

Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, Westminster

NHS North West London

North West London (NWL) Child Death Review (CDR) Annual Report 2022/2023

Introduction

This report provides an overview of the work done by the NWL Child Death Review (CDR) Service, which coordinates the statutory CDR process for children who are usually resident in NWL. The service works closely with a range of partner organisations across NWL including, London Ambulance service, children's social care, the police, primary and secondary healthcare agencies, education and local safeguarding children partnerships.

Reviews are carried out on the deaths[1] of any child normally resident in the area by collecting and analysing information about each death with a view to identifying:

- any case giving rise to the need for a serious incident notification[2],
- any matters of concern affecting the safety and welfare of children in the area of the relevant local authority,
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.

<u>The NWL Services that Contribute to the CDR Process</u>
Table 1 illustrates the NHS and local council services that contribute to the CDR process.

The NHS and local councils are the statutory agencies, responsible for the CDR process, but schools, London Ambulance Service, the Metropolitan Police and a range of third sector bodies also make a very important contribution.

---

[1] It does not review cases of stillborn or the planned termination of pregnancies which happen when healthcare staff are present.

[2] When a child dies (or is seriously harmed) and there is neglect or abuse known or suspected to be part of the child or family history the relevant local authority is required to send a serious incident notification to the Department for Education. Occasionally a baby might die in circumstances of neglect or abuse which prior to the CDR process were unknown to the local authority.

Figure 1

We are:

- **65,000** NHS employees
- **1,500** Adult social care staff
- **1,500** Voluntary organisations
- **1,300** (FTE) GPs
- **350** GP practices
- **276** Care homes
- **45** Primary Care Networks
- **9** NHS Trusts – four acute trusts, **4** community and mental health trusts, **1** ambulance trust
- **8** London Councils
- **8** Boroughs
- **1** NHS Clinical Commissioning Group (until ICS/ICB established)

Brent
Ealing www.ealing.gov.uk
Harrow COUNCIL LONDON
HILLINGDON LONDON
h&f hammersmith & fulham
IMPERIAL COLLEGE HEALTH PARTNERS
THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA
London Borough of Hounslow
Supported by City of Westminster
West London Alliance IMPROVING OUTCOMES FOR WEST LONDON

NHS

Acute trusts
Chelsea and Westminster NHS Foundation Trust

Imperial College Health Care NHS Trust

London North West University Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Community and mental health trusts
Central and North West London NHS Foundation Trust

Central London Community Health Care NHS Trust

Hounslow and Richmond Community Healthcare NHS Trust

West London NHS Trust

Other NHS organisations
London Ambulance Service NHS Trust

National Institute of Clinical Research Network North West London

NHS England/London

NHS Health Education North West London

NHS North West London Clinical Commissioning Group

Table 1

The Geography and the People of NWL

The service covers the eight boroughs of NWL: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. (Figure 1). NW London is a diverse area with a population[3] of 2.1 m people from many different ethnicities.

[3] ONS 2021

Health Inequalities

There are significant health challenges and inequalities in health status and life expectancy across NWL.

- 1 in 10 people have diabetes or non-diabetic hyperglycaemia (NDH) (1 in 16 nationally).
- 1 in 5 adults (18+) has two or more long-term conditions compared to 1 in 4 nationally.
- Alcohol admissions in Ealing are above the average in England, with 2,200 admissions a year per 100,000 people (England 1,815).
- Rates of emergency hospital admissions for self-harm are twice as high in Hounslow as they are Harrow.
- 1 in 4 of our 10-11 year-olds are obese (1 in 5 nationally).
- 17.1% of people in Hillingdon smoke, versus 9.2% in Ealing (13% across NW London - 14% nationally).
- 38,000+ (11%) children and young people aged between 5 and 18 years have a mental health disorder (12% nationally).

Social and Economic Inequalities

There are wide differentials in the economic circumstances and available social support experienced in various families and communities in NWL.

- 28.6% of people do not have English as first language (8% nationally).
- 8.7% households are overcrowded (3.5% nationally).

Variation Within and Between Boroughs

- Kensington and Chelsea has the greatest income inequality in London.
- While 13.9% of children in Harrow are in low income families 29% of children in Westminster are (16% nationally).
- Nearly four times as many children live in poverty in Hammersmith and Fulham’s poorest ward 45% as in the richest ward 12.2% (30% nationally).
- On the index of multiple deprivation (where 1 is the most deprived) Brent numbers 65 and Harrow 156 (out of 317 local authorities).

The Diversity and Age Profiles of NWL’s Children

The table below shows the breakdown in the ethnicity, gender and age of children 0-17 years across NWL.

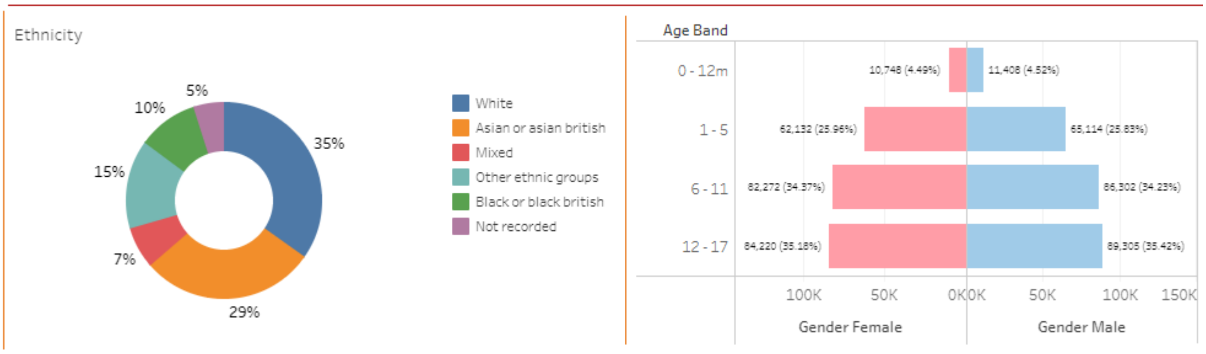

Table 2

Aim of NWL CDR Team

The aim of the Service is to ensure families are appropriately supported following the death of their child and that any learning to prevent future child deaths is identified and actioned both locally and nationally. We also seek to work with partner agencies across NWL to ensure the statutory guidelines are adhered to in a systematic way.

Objectives

The service objectives are to:

- Ensure a key worker is allocated to all families normally resident in NWL whose child has died.
- Ensure families are signposted to specialist bereavement support and are fully informed of the CDR process.
- Support staff responding to the death of a child within NWL.
- Develop staff training around child death and bereavement support.
- Promote local and national learning following child deaths.

Staffing

The NWL CDR team comprises five full time staff. They coordinate and manage the CDR process and work closely with NWL designated doctors for child death who have a statutory responsibility for child deaths.
The CDR team provide expertise in Joint Agency Response[4] meetings (JAR) and Child Death Review Meetings[5] (CDRMs). The team also supports the final stage of the process at the monthly Child Death Overview Panels (CDOP).

[4] These are multi agency meetings which respond to unexpected child deaths
[5] These are multi agency meetings which are attended by staff with knowledge of the child which discuss the circumstances of every child death.

In April 2022 during normal office hours in cases involving unexpected deaths the team began supporting multi agency joint home visits as part of the Key worker role to ensure bereaved parents and families have a single point of contact.

<u>NWL CDR Team Structure (See Figure 2 Below)</u>

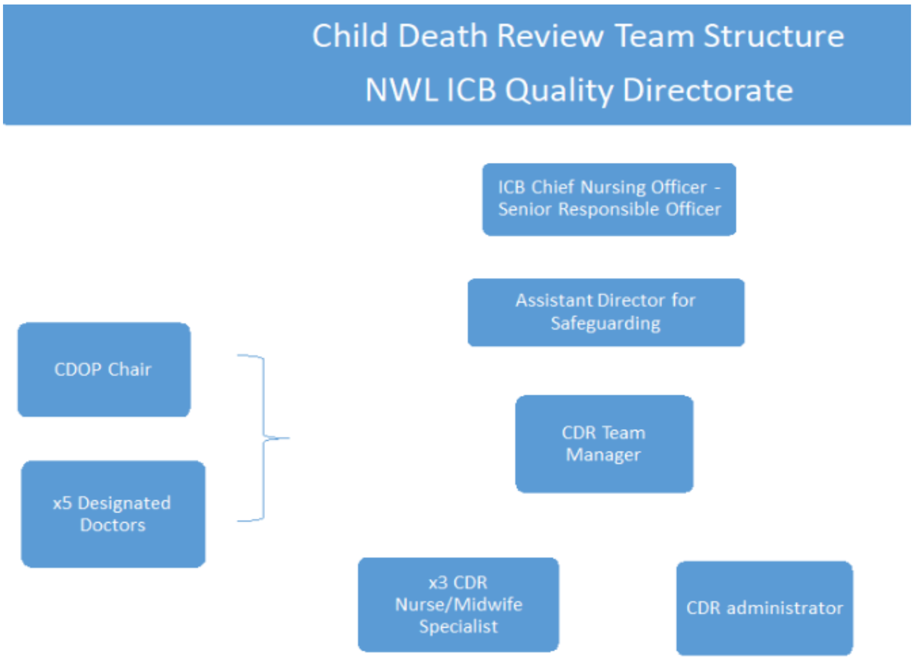

Figure 2

The CDR Team Achievements for 2022/23

As well as running an effective service, we seek also to spread learning, improve practice and raise understanding of how professionals and the public can contribute to reducing child mortality. Over the past year we have

- Developed a CDR website which publicises upcoming training events, contains informative newsletters, and provides learning from deaths with seven minute briefings. It also explains how the service works and provides contact information. This can be accessed at:

  https://www.nwlondonicb.nhs.uk/professionals/children-and-young-people/child-death-reviews

- Run a London learning event focusing on falls from heights – See seven-minute briefing on our website.

- Delivered a range of multi-agency events. One of NWL's designated doctors for child death, the police and a bereavement charity help us deliver wide ranging and in-depth learning. We intend to include children's social care and a coroner in sessions where their expertise will prove invaluable and we continue to develop the content as a result of attendee feedback.

- Supported acute trusts to deliver effective and timely Child Death Review Meetings. Our staff attend this hospital led meetings and provide feedback to ensure consistency and improvement.

- Reduced a backlog of aging cases. Some cases get "stuck" for a number of reasons and we have focused on ensuring that the oldest cases in the system receive additional attention.

- Worked with a donor charity to enable community health teams to have access to cooling blankets so that families can spend time at home with their child after they have died. Three cooling blankets have been funded by the Stefanou Foundation[6] and now are available for use in NWL.

- Worked with local bereavement charities across NWL to ensure that CDR staff and partners understand what is available for families.

- Highlighted to NCMD and to England's Chief Medical Officer a cluster of deaths linked to the failure of central venous catheters. This is now being investigated by the Deputy Chief Medical Officer for Patient Safety.

- Published a quarterly newsletter.

- Strengthened our relationships with partner agencies by having quarterly meetings with the police, local safeguarding children partnerships, community health teams and local authority children's social care teams.

<u>Child Death Notifications</u>

NWL received 145 notifications of child deaths in the past year. Table 3 shows these by borough and how this year's figure compares with the previous three years.

[6] More details can be found at http://www.stefanoufoundation.org

Death notifications by LSCB and year

LSCB name	2019-20	2020-21	2021-22	2022-23
Brent	17	32	21	18
Ealing	23	29	24	23
Hammersmith and Fulham	8	7	10	13
Harrow	26	13	22	25
Hillingdon	19	24	14	25
Hounslow	28	18	11	16
Kensington & Chelsea	9	4	4	9
Westminster	20	4	11	16
Total	**150**	**131**	**117**	**145**

Table 3 (taken from the National Child Mortality Database)

There were fewer deaths in the Covid pandemic years 2020/2022 but numbers have returned to where they were before the pandemic. The situation in NWL was similar to what was reported nationally.

Ealing has the largest population of the eight NWL boroughs and also the highest population of 0-17 year olds and Ealing consistently has the highest number of deaths.

Borough Specific Issues

These points of note are issues to be kept under review. The numbers for each borough remain relatively small and therefore it takes time before it is possible to discern trends of note as opposed to normal statistical variations.

- Westminster has seen a rise in child deaths since mid-2021
- Hammersmith and Fulham previously had a downward trend between April 2019 and February 2022 but since then has seen an upturn
- Brent, Ealing and Hounslow have experienced a downward trend since 2019-2020.
- Kensington and Chelsea, had no reported child deaths in Quarter 4 January-March 2023
- Hillingdon has only had two child deaths in the first four months of 2023, compared with 13 in the same period in 2022
- Child deaths in Hounslow in 2023 are more than double for the same period in 2022.

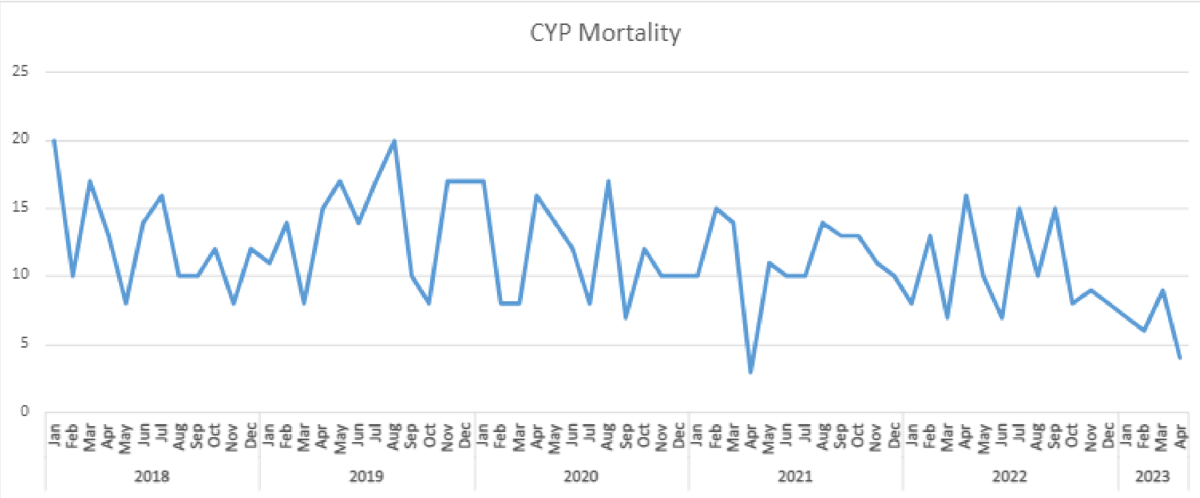

Figure 3

<u>Child Deaths in NWL</u>

Figure 3 shows the wide fluctuations in child death reports month by month. In some months 20 are reported and in others 3. The median is 12.

There are seven CDOPs in London. North West London, which has the largest resident population also has the highest number of child deaths in all age categories (Table 4).

1.3.2: Total child deaths by age group - 3 years

CDOP	0 - 27 days	28 - 364 days	1 - 4 years	5 - 9 years	10 - 14 years	15 - 17 years
North Central London	86	62	30	19	19	33
North East London (Barking, Dagenham, Havering & Redbridge)	63	40	25	5	14	16
North East London (Waltham Forest, East London & the City)	129	56	28	14	18	28
North West London	188	67	45	21	40	36
South East London (Bexley, Greenwich & Lewisham)	104	41	26	10	10	17
South East London (Bromley, Lambeth & Southwark)	72	37	12	11	11	13
South West London	91	53	29	20	14	32
Total	**733**	**356**	**195**	**100**	**126**	**175**

Table 4 (three years of child death in London)

Joint Agency Response (JAR)

A JAR is a multi-agency meeting attended by any agency that has been involved with a child in a meaningful way prior to their death and it takes place if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (incl. SUDI/C);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Occurs in such a way that the initial circumstances raise suspicions that the death may not have been natural; or
- (In the case of a stillbirth) takes place with no healthcare professional in attendance.

In 2022/23 the CDR Team held and chaired 58 JAR meetings. Figure 4 shows how over four years, while the number of notifications are now back to pre-pandemic levels, the number of JARs has doubled suggesting an increase in unexpected deaths. It is also possible that some of this increase is due to better reporting and a more responsive system.

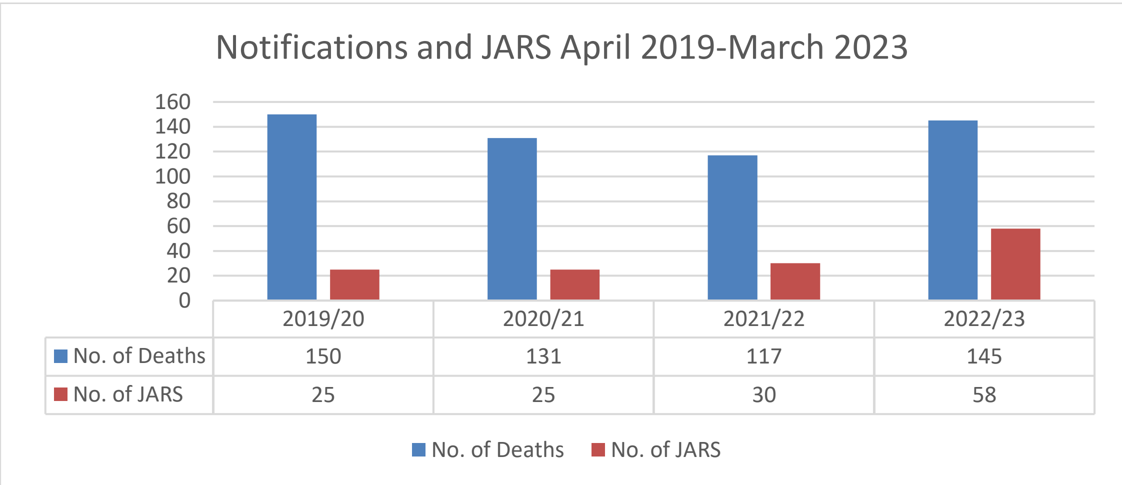

Figure 4

<u>Unexpected and Expected Deaths Yearly Comparison 2019-2023</u>

Of 543 death notifications received over the last four years, 25% of them are unexpected. These have doubled since 2019. Expected deaths are mainly neonatal or happen among children with chronic health needs like cancer or with chromosomal or congenital anomalies. These expected deaths have declined since 2019. This is shown by Figure 5.

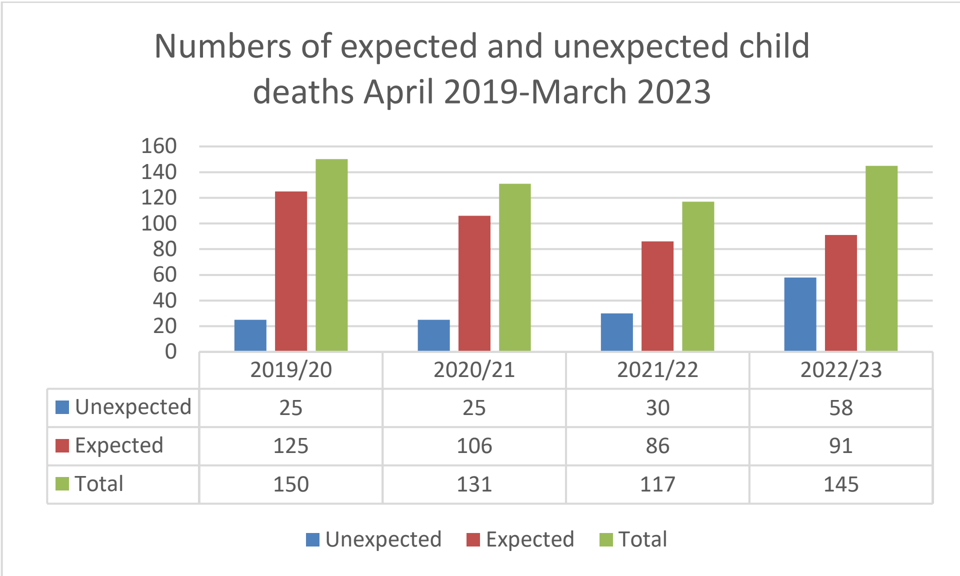

Figure 5

Age

The highest number of deaths occur among children aged 0-27 days (36%) and 28-364 days (22%). Table 4 above shows that this pattern is similar across London. NWL's pattern of death by age of child is broadly similar to the national picture. The Tables below (copied from NCMD reports) show how NWL compares with England as a whole. Neonatal and infant mortality are close to the England average, while mortality among children aged 1-17 is slightly higher in NWL than in England.

1. Neonatal mortality

Deaths of children aged under 28 days. Mortality rates are presented per 1,000 infant population.

Table 1. Number and rate of neonatal deaths, by year

ICB: NHS North West London *Data source: NCMD, ONS Census (2021)*

Comparison with England average ● Over 5% higher ● Within 5% ● 5 - 15% lower ● Over 15% lower

	Your ICB		England
	Neonatal deaths	Rate per 1,000 infants	Rate per 1,000 infants
2019-20	62	2.6 ●	2.5
2020-21	70	3.0 ●	2.4
2021-22	54	2.3 ●	2.5
2022-23	54	2.3 ●	2.7
Total	**240**	**2.6 ●**	**2.5**

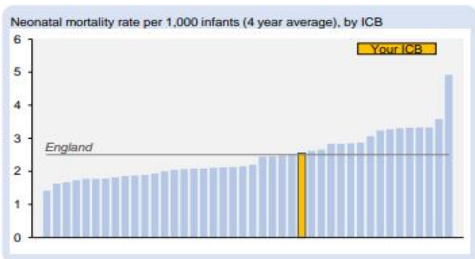

Table Showing Neonatal Mortality

2. Infant mortality

Deaths of children aged under 1 year. Mortality rates are presented per 1,000 infant population.

Table 5. Number and rate of infant deaths, by year

ICB: NHS North West London *Data source: NCMD, ONS Census (2021)*

Comparison with England average Over 5% higher Within 5% 5 - 15% lower Over 15% lower

	Your ICB		England
	Infant deaths	Rate per 1,000 infants	Rate per 1,000 infants
2019-20	90	3.8	3.7
2020-21	89	3.8	3.4
2021-22	73	3.1	3.7
2022-23	85	3.6	3.8
Total	**337**	**3.6**	**3.7**

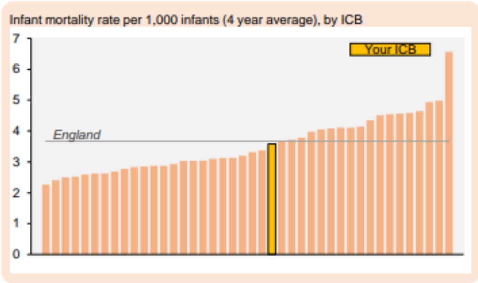

Table Showing Infant Mortality

3. Mortality rate of children aged 1 - 17 years

Deaths of children aged between 1 and 17 years. Mortality rates are presented per 100,000 population of children the same age.

Table 9. Number and rate of deaths of 1-17 year olds, by year

ICB: NHS North West London *Data source: NCMD, ONS Census (2021)*

Comparison with England average Over 5% higher Within 5% 5 - 15% lower Over 15% lower

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
2019-20	56	13.6	11.3
2020-21	42	10.2	9.6
2021-22	45	10.9	11.7
2022-23	60	14.6	13.6
Total	**203**	**12.3**	**11.5**

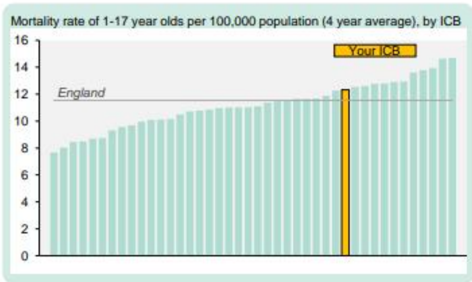

Table Showing Child Mortality

Sex

Of the 145 notifications received 78 (53%) were Male and 64 (44%) were Female. Three notifications were received where the sex of the child was not determined. These were babies born under 23 weeks with no post mortem carried out.

. Number and rate of deaths of 1-17 year olds between 01/04/2019-31/03/2023 (4 years), by sex

rth West London *Data source: NCMD, ONS Census (2021)*

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
Female	88	11.0	9.8
Male	113	13.4	13.1

The table above shows that the proportion of male deaths at 56% involving children aged 1-17 and at the rate of 13.1 per 100,000 is higher than the National average.

National Reports

A recent National Child Mortality Database's (NCMD) report[7] on sudden and unexpected deaths in infancy and childhood (SUDIC) highlighted that in 27% of cases where a SUDIC occurs with a child aged 1 - 17 there is often a family history of convulsions (27%).
Even when their deaths are fully explained by an underlying medical condition the same family history is often found. The NWL CDR Team is reviewing these deaths across NWL to see whether this issue is found in NWL. This could have an impact on how children attending GPs and Accident and Emergency following febrile convulsion are assessed. The NCMD report recommends that research on sudden unexpected and unexplained deaths of children over one year of age be prioritised to identify modifiable factors so professionals can work to prevent these deaths.

The report also highlights that more deaths occur in males and among vulnerable infants with lower birth weight.

The Lullaby Trust[8] has identified that 63% of unexplained deaths were among boys in 2020. This could be for biological reasons [9].

Other Investigations

There are a number of different ways in which learning is obtained from child deaths; some mandatory, others not. The CDR process is mandatory. From time to time the CDR process runs in parallel with other investigations.

Learning Disabilities Mortality Review (LeDeR)

Every child over the age of four, who has a learning disability and who dies should have their case referred for a LeDeR. In the past year ten cases have been referred.

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[7] Accessed at https://www.ncmd.info/wp-content/uploads/2022/12/SUDIC-Thematic-report_FINAL.pdf
[8] https://www.lullabytrust.org.uk
[9] Gender bias in under-five mortality in low/middle-income countries | BMJ Global Health Costa et al 2017

Main Issues that have Arisen from LeDeR from NWL Cases

- A child with Learning Disabilities (LD) was managed by an adult resuscitation team which was not aware of the child's complex background.
- The LAS should consider coding as high priority addresses occupied by children with LD and complex needs in view of their potential for rapid deterioration.
- The impact of COVID and the effect the Visiting Policy had on a family who could not be with their child at time of death.
- COVID made services less accessible for children with complex needs
- There are issues with communication from hospital trusts to community health teams on the child's or young person's discharge.
- Best practice would always be the use of interpreters.
- Importance of supporting the LeDeR programme by reporting the death of child aged four and above with a learning disability.

As of 1st July 2023, LeDeR policy relating to the deaths of children and young people under the age of 18 is changing. There will no longer be any requirement for deaths of children with a learning disability to also be notified to LeDeR.

LeDeR are making this change because it is important that the deaths of children with a learning disability are reviewed by the national mandated processes that look at the deaths of all children.

Previous or Current Social Care Involvement

In 42 cases there had been prior to death some involvement of children's social care with either the deceased child or a sibling. In 14 of these cases modifiable factors were identified:

- Safe Sleeping Concerns.
- Better understanding of CAMHS and the neurodiversity pathway.
- Alcohol and smoking around a new born baby.
- Mother's mental health needs not assessed with the father being invisible to the case.
- Out of date EpiPen and importance of schools knowing how to use them.
- Clear child allergy plans to be shared between Health and School.
- Supportive mechanisms for parents where child has a mental health condition without a diagnosis.
- Education on using additional unsuitable aids to sleep; e.g. battery powered sleep aids.

- Unbooked pregnancy/missed opportunities in pregnancy e.g. attending Emergency Department when pregnant, mother had no GP, Maternity services involved and attended child protection conference but mother remained unbooked for pregnancy.

London Ambulance Service (LAS) Learning from JARS/CDRM/CDOP

- LAS now have paediatric saturation probes on all ambulances and body worn cameras are being rolled out across London. The LAS Hazardous Area Response Team now have longer reach poles following learning raised at the CDRM related to the death of a child by drowning.
- LAS have revised their mapping system so that children with particular needs are taken to the right hospital. Through this system LAS crews can ensure that children receive the specialist treatment they need.

NWL Child Death Review Process

Child Death Review Meetings (CDRM)

These meetings precede the CDOP and focus on the operational delivery of services to the deceased child and family prior to death, identifying areas of good practice and opportunities for improvement. The CDR team have worked hard to ensure CDRMs have been carried out where possible in a timely manner.

The Child Death Overview Panel (CDOP)

NWL convenes three different CDOPs:

- A neo natal panel for all babies under 28 days old (neonates)
- Flute panel which reviews children resident in Brent, Harrow, Hammersmith and Fulham, Kensington and Chelsea and the City of Westminster.
- Triangle panel which reviews children resident in Hounslow, Ealing and Hillingdon.

Last year the three panels closed 117 cases (compared with 65 in the previous year).

Panel members consist of paediatricians, public health experts, social care representatives, police officers, and a Designated Nurse for Safeguarding Children. Recently we have added a bereavement charity representative.

For neonatal panels we have an obstetrician, a neonatologist and a midwife. We plan to hold themed panels in the future where specialist services can offer specific expert advice in cases involving SUDI, suicide, trauma and cancer.

Delays to the CDOP panel

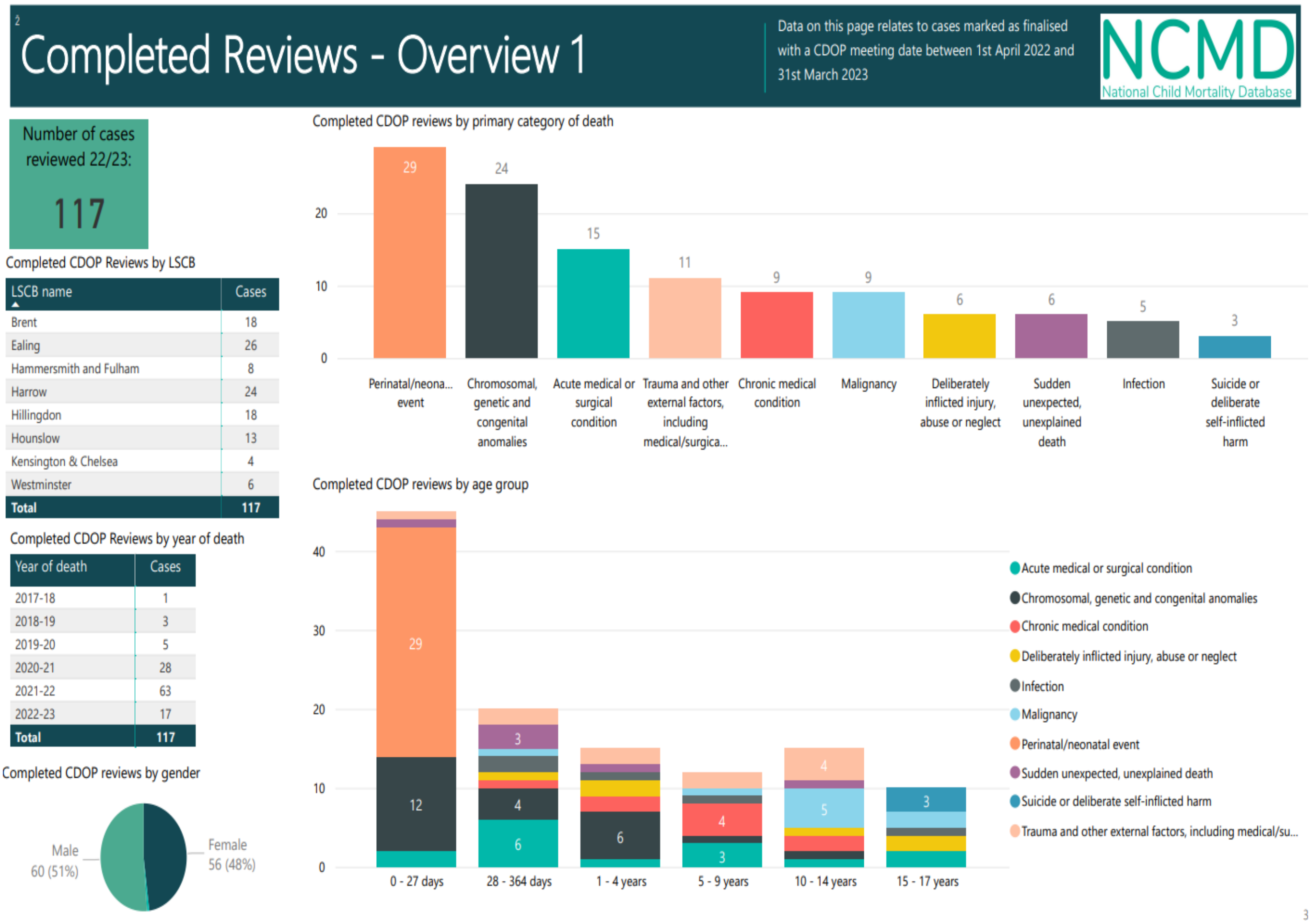
Cases being presented at CDOP can have delays due to outstanding investigations such as post mortem reports, police investigations, PMRT[10] reports, serious incident reports [11], HSIB[12] reports.

Last year's report had an objective to ensure the CDR team worked with partner agencies to enable cases to progress. This was done by carrying out teaching on the CDR process, supporting trusts with CDRMs, and building relationships with the coronial services to ensure timely reports are shared and by attending PMRT meetings.

[10] The Perinatal Mortality Review tool; this is the review of every baby death from 22 weeks' gestation up to death 28 days after birth.
[11] These are commissioned and completed by hospital trusts when any serious safety incident occurs
[12] These are reports conducted by the Healthcare Safety Investigation Branch into the deaths of babies up to 6 days after birth born as a result of labour, which began on or after 37 weeks' gestation.

Cases by Borough

Table 9 shows completed cases by borough, age, category of death and gender.



Completed CDOP Reviews by LSCB

LSCB name	Cases
Brent	18
Ealing	26
Hammersmith and Fulham	8
Harrow	24
Hillingdon	18
Hounslow	13
Kensington & Chelsea	4
Westminster	6
Total	**117**

Completed CDOP Reviews by year of death

Year of death	Cases
2017-18	1
2018-19	3
2019-20	5
2020-21	28
2021-22	63
2022-23	17
Total	**117**

Figure 6

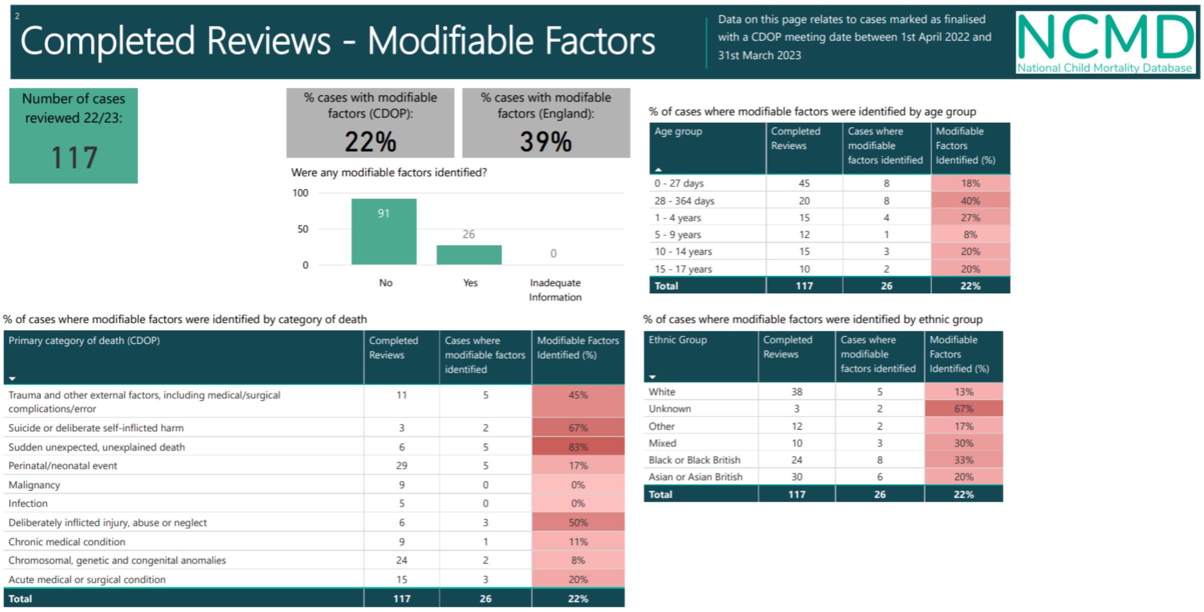
Modifiable Factors

Modifiable factors are things that could be done differently to prevent future child deaths. Figure 7 highlights that during 2022/23, 22% of cases (26/117) had modifiable factors. The national average is 39%. Modifiable factors were found in a higher proportion of cases involving families from minority ethnic communities (although our data needs to be improved as a high % of cases were unknown). Modifiable factors were also present in deaths relating to trauma, Suicide, SUDI, and deliberately inflicted abuse and neglect cases.

Across all boroughs modifiable factors included:

- Communication between agencies especially on discharge of children with complex/chronic illnesses.

- Use of interpreters to ensure the family understand what is being told and advised.
- Accident prevention information when giving advice on weaning (the risk of choking from sweetcorn kernels and the like).
- Basic life support in the community and
- Parent's knowledge on where and how to call for medical help.
- Missing documentation on ethnicity and family dynamics, especially invisibility of the father.



2

Completed Reviews - Modifiable Factors

Data on this page relates to cases marked as finalised with a CDOP meeting date between 1st April 2022 and 31st March 2023

NCMD National Child Mortality Database

Number of cases reviewed 22/23: 117

% cases with modifiable factors (CDOP): 22%

% cases with modifiable factors (England): 39%

Were any modifiable factors identified?

No	91
Yes	26
Inadequate Information	0

% of cases where modifiable factors were identified by age group

Age group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
0 - 27 days	45	8	18%
28 - 364 days	20	8	40%
1 - 4 years	15	4	27%
5 - 9 years	12	1	8%
10 - 14 years	15	3	20%
15 - 17 years	10	2	20%
Total	**117**	**26**	**22%**

% of cases where modifiable factors were identified by category of death

Primary category of death (CDOP)	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
Trauma and other external factors, including medical/surgical complications/error	11	5	45%
Suicide or deliberate self-inflicted harm	3	2	67%
Sudden unexpected, unexplained death	6	5	83%
Perinatal/neonatal event	29	5	17%
Malignancy	9	0	0%
Infection	5	0	0%
Deliberately inflicted injury, abuse or neglect	6	3	50%
Chronic medical condition	9	1	11%
Chromosomal, genetic and congenital anomalies	24	2	8%
Acute medical or surgical condition	15	3	20%
Total	**117**	**26**	**22%**

% of cases where modifiable factors were identified by ethnic group

Ethnic Group	Completed Reviews	Cases where modifiable factors identified	Modifiable Factors Identified (%)
White	38	5	13%
Unknown	3	2	67%
Other	12	2	17%
Mixed	10	3	30%
Black or Black British	24	8	33%
Asian or Asian British	30	6	20%
Total	**117**	**26**	**22%**

Figure 7

<u>Case Reviewed at CDOP: Category of Death Over the Last 3 Years 2020-2023</u>

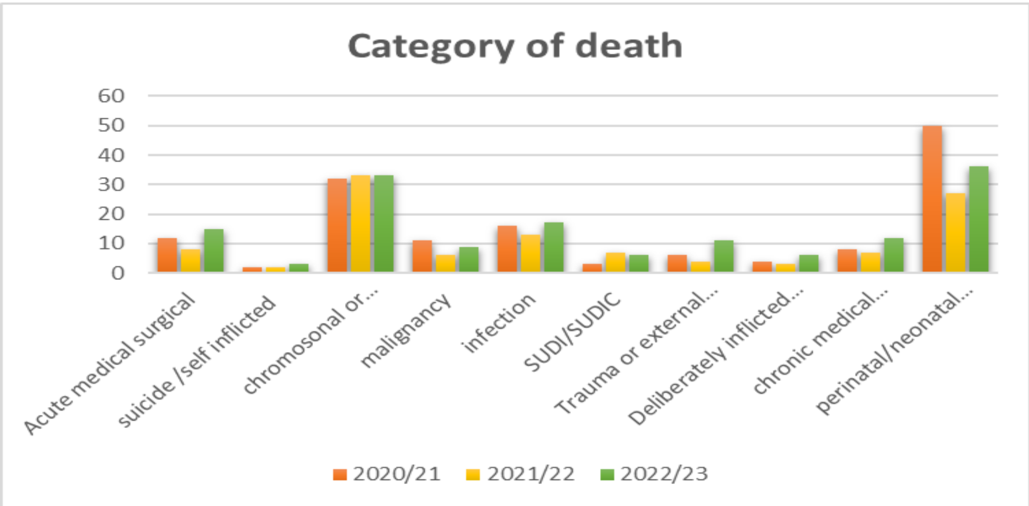


Figure 8

With unexpected deaths, we have noted an increase in acute medical/surgical and trauma/external deaths. The incidence of sudden unexpected deaths in infants (SUDI) declined in 2020/21 and has since risen 2021/22. (Figure 5).

Below is a summary of some themes we have collated from cases reviewed at CDOP over the past three years.

Significant Issues:

Consanguinity

Numerous studies have shown that higher rates of consanguinity in communities' correlates to higher rates of infant mortality. We notice high numbers of baby deaths born to consanguineous parents; significantly in excess of the rate of consanguineous partnerships in the community.

There is a need for preconception counselling within communities e.g. from religious leaders, consistency of interpreting services and a way of engaging missing fathers.

NWL CDR Proposal:
Collaborate with community and acute trusts as well as children's centres and pharmacies for QR codes and leaflets that have consistent information on use of interpreters and inclusion of fathers.

Action at community level may help people to understand and act on this advice; but this is only acceptable if information is balanced, non-stigmatising and offers families and communities realistic choices. NCMD suggests that pre-conception genetic counselling might prepare people for choices.

Asthma

No child should die as a result of asthma, but in NWL we have had four asthma deaths since 2020. A key theme is the need for consistency in follow up from GP and acute trusts as well as clinical nurse support via a core pathway across NWL.

NWL CDR Proposal:
Work is already commenced on ensuring consistent services are commissioned across NWL in terms of clinical nurse specialists and developing a collaborative core pathway.

Infection

46 cases identified the primary cause of death as Covid 19, sepsis, respiratory syncytial virus bronchiolitis. A key theme from the 46 deaths was the need to recognise an unwell child – and to ensure that parents knew who to contact when their child was unwell.

NWL CDR Proposal:
Undertake engagement with at risk cohorts across NWL; coproduce and deliver tailored services to address risk.

Sudden Unexplained Deaths of Infants/Children

16 cases, mostly aged between 28-364 days.

NWL CDR Proposal:
Consistent Safe Sleep advice from all agencies - Every Contact Counts especially when families are not in their usual environment or if they are attending a party or event with their child and there may be alcohol involved.

Suicides

7 cases; with the ingestion of sodium nitrate being the cause of death of two 17year olds and with two deaths by strangulation/hanging. Three of these cases have been reviewed at CDOP.

Key themes from the seven deaths over the last three years; low mood reported, but not all were known to CAMHS. All were still in education.

NWL CDR Proposal:
To work with the Children and Young People (CYP) Mental Health team to develop key messages and better communication approaches.

Trauma

21 deaths including two where children had choking episodes at home, two knife/ pointed instrument deaths, injuries from falls and car accidents and drownings.
Key issues - In one case of choking episode the parents did not commence basic life support. In another case a child choked during feeding. Three cases involved falls from height and in one case two children died abroad in a car accident.

NWL CDR Proposal:
Feeding advice leaflets/videos concerning giving babies solids which include foods that have hard skin like grapes, sweetcorn, peas.
Basic life support in the community for parents/public.
Charity and local authorities offering swimming lessons to high school ages/ children who have arrived here from abroad.
Early intervention activities to reduce and prevent serious youth violence
Consistent information sharing from all agencies.

From the thematic review that the CDR Team conducted, it is clear that we need to collaborate with system partners to share these emerging themes. From these themes we can achieve change and reduce child deaths in our eight NW London boroughs.

<u>Categories of Death by Borough</u>

Table 11 shows completed reviews over a period of four years 2019-2023 by borough and by category of death.

Number of child death reviews where the death was reviewed between 01/04/2019 - 31/03/2023 (4 years)

	Deliberately inflicted injury, abuse or neglect	Suicide or deliberate self-inflicted harm	Trauma and other external factors	Malignancy	Acute medical or surgical condition	Chronic medical condition	Chromosomal, genetic and congenital anomalies	Perinatal/neonatal event	Infection	Sudden unexpected, unexplained death	Total
Brent	5	3	0	4	3	2	26	15	5	3	66
Ealing	2	1	7	8	5	4	18	20	7	4	76
Hammersmith and Fulham	1	0	2	3	2	4	6	4	1	2	25
Harrow	1	0	4	2	6	5	15	24	3	1	61
Hillingdon	1	1	5	6	5	5	15	19	4	9	70
Hounslow	1	0	5	4	6	5	15	22	5	3	66
Kensington & Chelsea	1	3	0	1	2	2	3	7	2	0	21
Westminster	1	2	4	6	1	7	4	5	2	5	37
North West London	13	10	27	34	30	34	102	116	29	27	422
%	3%	2%	6%	8%	7%	8%	24%	27%	7%	6%	100%

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Data represents completed reviews between 01/04/2019 and 31/03/2023. The actual date of death may be before these dates.

Table 5

Ealing and Hillingdon have had the most deaths over the four-year period, Brent and Hounslow having the same number of deaths. Hillingdon have had the highest number of sudden unexpected, unexplained deaths with nine over the four-year period. Brent have had the highest number of deliberately inflicted deaths including, abuse or neglect (5) and Kensington and Chelsea and Brent have had the highest number of suicide/deliberate self-inflicted harm (3).

In each borough the highest number of deaths are due to chromosomal, genetic and congenital anomalies and perinatal/neonatal events.

Learning from Neonatal Panels – 2022/2023

NWL CDR team hold six neonatal panels a year. They consist of specialists in the childbirth continuum and the neonatal period including midwives, obstetricians and neonatologists. To ensure we capture the perspective of parents, we also have a representative from a baby loss charity as well as public health professionals. The cases reviewed at the neonatal panel are those where there are no safeguarding concerns.

According to the NICE guidelines, the neonatal period is from birth to 28 days of age, however the NCMD defines the neonatal period as being up to 27 days of age. The NCDM is the source of our data and so this report will include babies who have died up to 27 days old. The CDR Guidance[13] requires all babies who are born with signs of life to be reviewed, unless born after a medical termination of pregnancy. This may also include babies who were stillborn in the absence of a medical professional.

In 2022/2023, the cases of 45 neonatal deaths were reviewed, 38% of all child deaths in NWL. Three had JAR meetings due to either birth trauma or SUDI. The majority of babies were female. There was one baby documented as indeterminate sex due to gestation at birth (Figure 9).

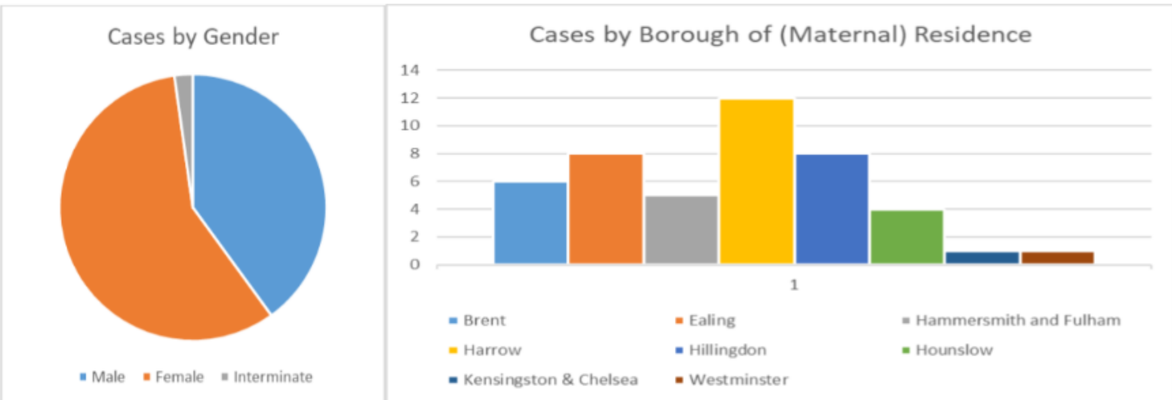


Figure 9

The largest number of babies who die in the neo natal period are black and Asian (Figure 10). The NWL CDR team have frequently flagged this to NCMD for further action. For example, it is known that Black African women are more likely to develop

[13] Accessed at https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

hypertension in pregnancy, leading to an increase of morbidity and mortality for both mother and baby. These women could be offered more frequent blood pressure monitoring during pregnancy to identify hypertensive complications at the earliest opportunity.

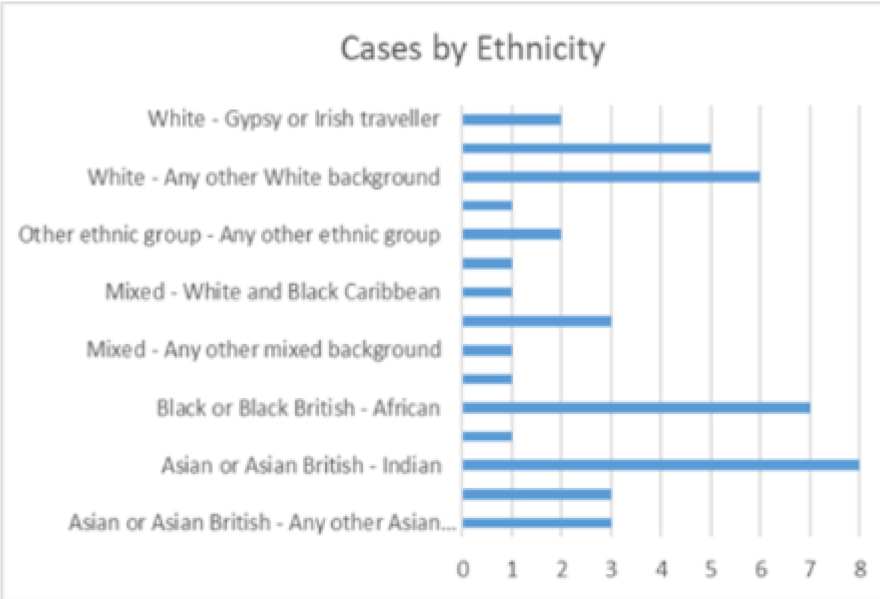


Figure 10

44% of the baby deaths were due to prematurity or as a result of the complications that arise from immaturity, whereas 8% died from infection. In the cases reviewed in 2022/2023, one neonate is recorded as having died as a result of Group B Streptococcus. The GBS3 trial[14] may lead to changes to the prevalence of screening in the antenatal period.

We have noticed a trend where babies are being delivered earlier with signs of life. (Figure 11 and 12).

[14] 71 hospitals in England and Wales are taking part in a randomised control trial; offering pregnant women GBS screening. This will report in 2024

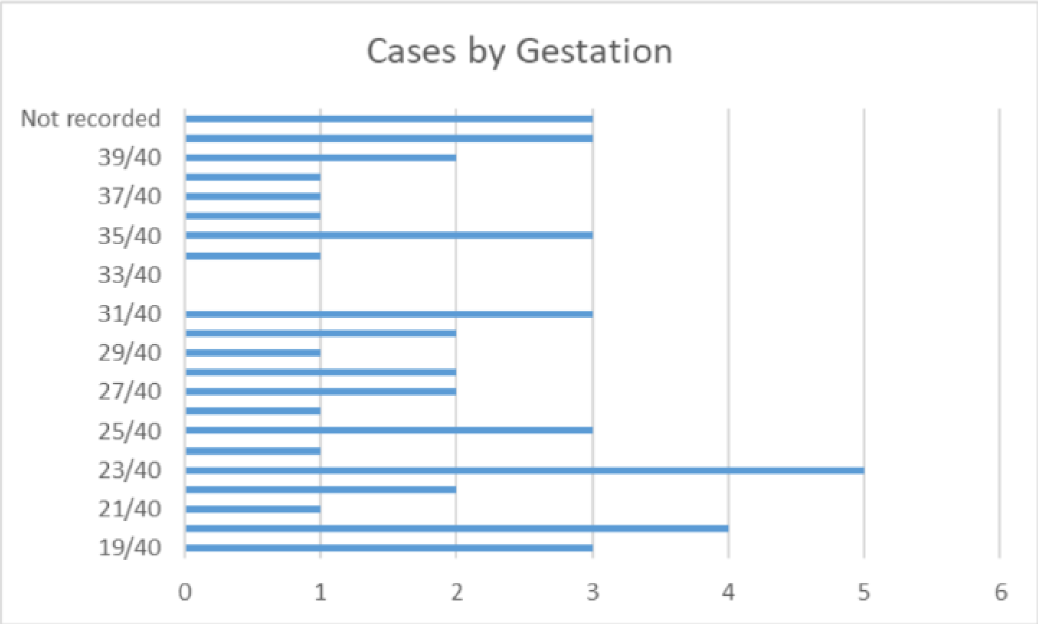


Figure 11

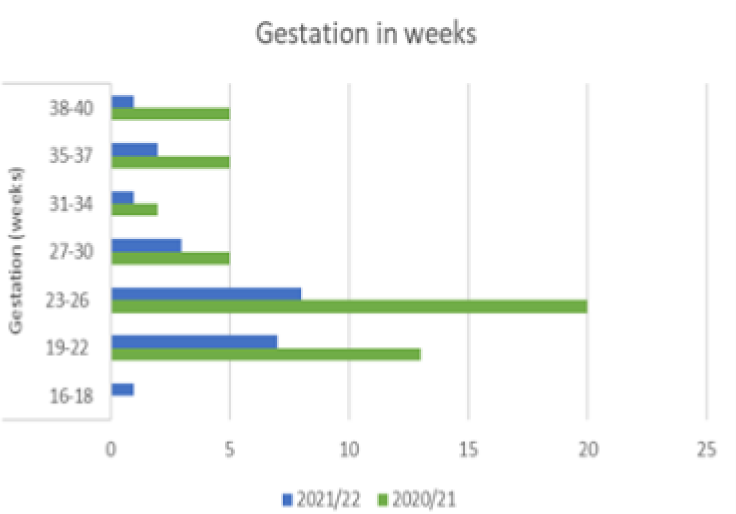


Figure 12

Some repeat themes arose during the Neonatal CDOPs. Interpreters were not used as often as they should have been and often family members were used. To address this, we have requested that all Trusts providing maternity care audit the use of interpreters.

We have also found there are a significant number of babies born to consanguineous parents. This data is currently collected by the maternity units, however greater understanding as to the degree of relationship is required. Work with religious leaders and public health could provide communities with information about this risk.

The Neonatal CDOP has identified that a number of women whose babies have died, have undergone IVF abroad. However, data collection on this is poor. Next year we will work with Trusts to improve data collection about this.

The Neonatal CDOPs have gone from strength to strength in reviewing and understanding neonatal deaths, with invaluable insights from highly specialised experts.

Ethnicity and Deprivation

<u>Child Mortality and Ethnicity</u>

We want to understand better the link between ethnicity, deprivation and child mortality. Table 6 shows how over a four-year period the child mortality rate among black and Asian populations is higher in all eight NWL boroughs than it is for other ethnic groups.

	Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)					Child death rate per 100,000 population of the same ethnic group per year				
	Asian or Asian British	Black or Black British	Mixed	White	Other	Asian or Asian British	Black or Black British	Mixed	White	Other
Brent	27	20	5	22	10	29.9	33.3	18.4	28.3	26.9
Ealing	43	14	6	22	10	43.5	33.6	16.9	20.7	25.3
Hammersmith and Fulham	5	8	5	12	4	46.6	36.8	26.3	18.5	36.4
Harrow	39	12	8	22	4	35.7	63.7	42.4	33.5	19.2
Hillingdon	36	8	5	24	4	34.1	27.6	18.9	23.1	19.3
Hounslow	30	13	3	17	5	30.3	49.7	11.5	18.1	25.1
Kensington & Chelsea	3	4	3	11	2	34.7	43.8	23.0	21.3	21.0
Westminster	9	7	1	12	20	42.2	53.0	5.8	24.9	87.9
North West London	192	86	36	142	59	35.3	39.1	19.6	23.2	32.5

Source: NCMD, ONS mid-year population estimates

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out within the law.
2. Population estimates for 2021 (census data) were used for all years. These data are available at https://www.ons.gov.uk/datasets/create

Table 6[15]

Table 7 compares child (age 1-17) mortality rates over four years by ethnicity within NWL ICB and contrasts them with rates in England over the same period. This shows that in NWL

[15] When looking at Ethnicity and Deprivation we have used data from NCMD from notifications received as well as completed reviews over a period of 4 years (01/04/19-31/03/23). We have also used valuable data from the NWL ICB Analytics team.

Asian/ Asian British mortality rates are significantly below the English average and Black/ Black British mortality rates are slightly higher. The most significant discrepancy is among those children described as "other" This requires more research.

Table 12. Number and rate of deaths of 1-17 year olds between 01/04/2019-31/03/2023 (4 years), by ethnicity

ICB: NHS North West London   Data source: NCMD, ONS Census (2021)

	Your ICB		England
	Deaths of 1 - 17 year olds	Rate per 100,000 population	Rate per 100,000 population
Asian or Asian British	66	12.8	16.4
Black or Black British	32	15.2	14.8
Mixed	14	8.2	9.0
White	46	8.0	10.0
Other	33	19.0	13.5

Table 7

	Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)					Child death rate per 100,000 population of the same deprivation quintile per year				
	1 (most deprived)	2	3	4	5 (least deprived)	1 (most deprived)	2	3	4	5 (least deprived)
Brent	17	34	31	6	0	26.0	28.7	35.3	29.1	0.0
Ealing	17	44	22	12	5	27.3	37.4	28.8	25.4	28.0
Hammersmith and Fulham	11	11	13	2	1	40.1	31.0	39.3	7.3	25.3
Harrow	1	9	34	31	11	26.3	28.1	39.1	43.2	28.2
Hillingdon	6	33	25	9	9	43.8	29.6	36.8	20.1	18.9
Hounslow	4	39	27	3	0	15.6	35.6	28.0	9.5	0.0
Kensington & Chelsea	5	7	4	9	1	20.9	50.2	20.3	29.8	23.7
Westminster	8	11	6	9	13	31.5	30.4	27.7	36.4	91.5
North West London	69	188	162	81	40	27.9	32.7	33.0	27.2	31.0

Source: NCMD, ONS mid-year population estimates

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths and planned terminations of pregnancy carried out
2. Population estimates for 2021 (census data) were used for all years. These data are available at https://www.ons.gov.uk/datasets/create

Table 8

Child Mortality and Deprivation

Table 8 provides some surprising data on the link between child mortality and deprivation. It appears to show that across NWL as a whole deprivation and child mortality do not correlate in the same way as is seen at UK level[16]. The index of multiple deprivation provides us with a map of where communities collectively are deprived but we do not know if a family, who may live in a deprived community, is in fact deprived, or indeed if a family in a wealthy community is wealthy. This is an area to be explored further.

Table 9 shows how the different causes of death correlate with deprivation data and there is no clear link between any cause of death and deprivation, save for the fact that there are fewer deaths, of any type by number in the least deprived locations in NWL. This runs counter to the national picture and requires more analysis.

	Number of child death notifications received where the death occurred between 01/04/2019 - 31/03/2023 (4 years)						
	1 (most deprived)	**2**	**3**	**4**	**5 (least deprived)**	**Total**	
Insufficient Info	2	0	1	1	1	**5**	**1%**
Infection	3	4	6	9	5	**27**	**5%**
Intrapartum or pre-natal event	2	5	12	4	1	**24**	**4%**
Malignancy	2	13	17	5	1	**38**	**7%**
Preterm	17	64	42	19	7	**149**	**28%**
SUDIC	8	23	11	13	2	**57**	**11%**
Suicide or Self Harm	0	5	3	2	0	**10**	**2%**
Trauma	6	10	12	4	3	**35**	**6%**
Underlying Health Condition	29	64	58	24	20	**195**	**36%**
Total	**69**	**188**	**162**	**81**	**40**	**540**	**100%**

Source: NCMD

1. A child for these purposes is defined as a child aged 0 up to their 18th birthday, excluding stillbirths a

Table 9

<u>The NWL Map of Child Death</u>

Figure 13 shows where child deaths have occurred in NWL over the past four years, and the deprivation decile[17] for each Lower Super Output Areas (LSOA) which the deaths occurred in.   There are 1103 lower super output areas in NWL, each representing a community of about 2000 people. In the past four years there have been 515 child deaths in NWL. These are not spread evenly across the NWL footprint. Some small communities

[16] See key findings from NCMD report on deprivation and child mortality – which headlines; ‘There is a clear association between risk of death and deprivation (except for malignancy)”; accessed at https://ncmd.info/wp-content/uploads/2021/05/NCMD-Deprivation-2019_20-Key-findings.pdf

[17] The Index of multiple deprivation grades communities on a score of 1-10, where 1 means most deprived.

have experienced 8-10 deaths and others 1-2. By focusing on the few small areas that have a high number of deaths, we hope to improve child mortality in NWL in the future.

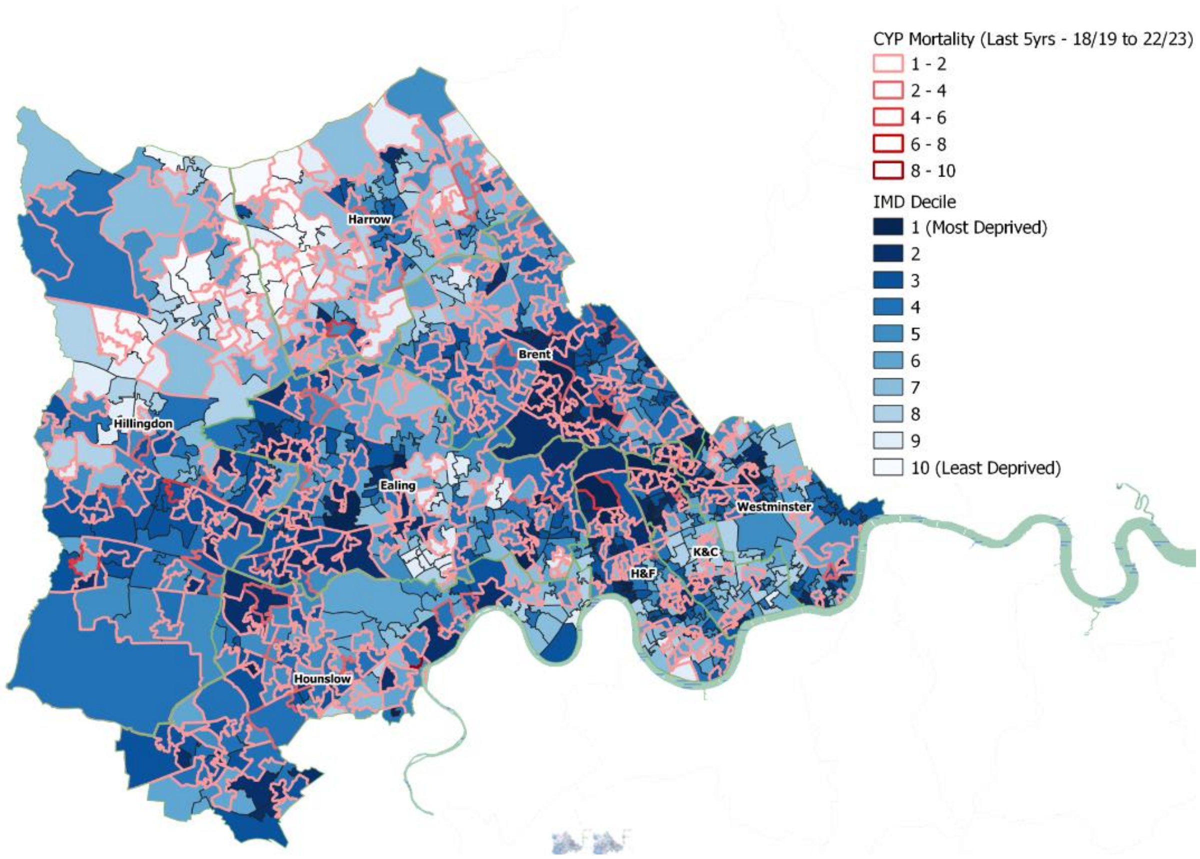


Figure 13

<u>Deprivation by Borough</u>

The tables below show the Lower Super Output Areas (LSOA) in each borough with the deprivation score and total number of deaths over the last 4 years 2018-2023. The CDR team would suggest the individual boroughs look in to these areas to see what health promotion/interventions may help in these areas to reduce infant mortality. Please see appendix 1 for the causes of death in each area which may help when considering what services are needed.

Brent

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01000498	Brent	4	4
E01000596	Brent	1	3
E01000497	Brent	4	3
E01000622	Brent	3	3
E01000640	Brent	3	3
E01000642	Brent	3	3
E01000643	Brent	1	3
E01000590	Brent	6	3
E01000587	Brent	6	3

Ealing

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01001366	Ealing	3	4
E01001238	Ealing	3	4
E01001336	Ealing	4	3
E01001337	Ealing	2	3
E01001356	Ealing	1	3
E01001294	Ealing	5	3
E01001369	Ealing	3	3
E01001322	Ealing	5	3
E01001195	Ealing	6	3

Hammersmith and Fulham

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01001876	Hammersmith and Fulham	1	7
E01001938	Hammersmith and Fulham	3	3
E01001852	Hammersmith and Fulham	5	3

Harrow

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002238	Harrow	8	5
E01002213	Harrow	5	5
E01002126	Harrow	6	5
E01002181	Harrow	8	4
E01002203	Harrow	7	3
E01002118	Harrow	5	3
E01002117	Harrow	6	3
E01002234	Harrow	5	3

Hillingdon

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002525	Hillingdon	6	5
E01002401	Hillingdon	3	5
E01002457	Hillingdon	3	4
E01002397	Hillingdon	3	4
E01002492	Hillingdon	5	3
E01033724	Hillingdon	8	3
E01002394	Hillingdon	5	3
E01002407	Hillingdon	3	3
E01002551	Hillingdon	4	3

Hounslow

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002681	Hounslow	4	10
E01002650	Hounslow	4	5
E01002642	Hounslow	4	5
E01002568	Hounslow	3	4
E01002664	Hounslow	2	4
E01002684	Hounslow	4	3
E01002591	Hounslow	5	3
E01002622	Hounslow	5	3
E01002638	Hounslow	2	3
E01002626	Hounslow	5	3

Kensington & Chelsea

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01002830	Kensington and Chelsea	2	3

Westminster

Sum of Patients			
LSOA_OF_RESIDE	LSOA_Name	Deprivation	Total
E01004744	Westminster	3	3
E01004718	Westminster	2	3

Working with Bereaved Families Across NWL

From April 2023, the CDR Team will be acting as key workers for bereaved families, helping them navigate the many procedures that follow on from the death of a child and keeping them informed of developments. The CDR team will also during normal office hours be completing joint home visits This entails working with police colleagues from the very beginning of an unexpected death. As well as helping families understand the coronial process the CDR team will signpost them to bereavement care.

Along with this work the Shooting Star Hospice have been able to set up a project where they will be supporting all bereaved families whose child has died for long term support. This is an exciting project that will be monitored and assessed over the coming year. The aim is to ensure all families have the appropriate support required following the death of their child and includes family therapy as well as supported visits. The pilot will start with all child deaths apart from trauma and suicide deaths. This joined up working will also help when we are collecting data in terms of the child's lived experience, ethnicity, family situation.

Work for 2023/24

- Re introduce key working from April 2023 including letters to all parents explaining the CDOP process.
- Increase training events including teaching alongside police/trusts/community teams as well as our own events.
- Serious Youth Violence - Knife crime event in June 2023 with Pan London CDOP.
- Suicide and SUDI event planned for Q3/4.

- Increase awareness and collaboration within the ICB including Children and Young People transformation service (CYP).
- Better working relationships with our partner agencies.
- NWL CDR Team more visible in Trusts and Community settings.
- Collaborative working with hospice to provide bereavement support for families across NWL – for both expected and unexpected deaths including neonatal deaths.
- Work with public health and data analysts to further explore child deaths across NWL.
- Work with NCMD to improve our data collection.

Appendix A

Brent

Sum of Patients			
LSOA name	**LSOA - Residence**	**Diagnosis**	**Total**
Brent	**E01000498**	#N/A	1
		Sudden infant death syndrome without mention of autopsy	1
		Arthrogryposis multiplex congenita	1
		Heart disease, unspecified	1
	E01000640	Disorders of tyrosine metabolism	1
		Other bacterial sepsis of newborn	1
		Intentional self-harm by unspecified means	1
	E01000497	Fetus and newborn affected by multiple pregnancy	2
		Metabolic disorder, unspecified	1
	E01000642	Other ill-defined and unspecified causes of mortality	1
		Unspecified pulmonary haemorrhage originating in the perinatal period	1
		Status asthmaticus	1
	E01000643	Other sphingolipidosis	1
		#N/A	1
		Sepsis, unspecified	1
	E01000587	Extreme immaturity	2
		Congenital diaphragmatic hernia	1
	E01000622	Extreme immaturity	1
		Malignant neoplasm: Cortex of adrenal gland	1
		Fetus and newborn affected by oligohydramnios	1

Ealing

Ealing	E01001238	Sudden infant death syndrome without mention of autopsy	1
		Pedestrian injured in collision with railway train or railway vehicle	1
		Exposure to unspecified electric current	1
		Other cardiomyopathies	1
	E01001366	Sudden infant death syndrome without mention of autopsy	1
		Pneumonia, unspecified	1
		Motorcycle rider injured in collision with fixed or stationary object	1
		Persistent fetal circulation	1
	E01001356	Fetus and newborn affected by other forms of placental separation and haemorrh	1
		Surgical operation with transplant of whole organ	1
		Fetus and newborn affected by placental transfusion syndromes	1
	E01001336	Acidosis	1
		Immunodeficiency, unspecified	1
		Extreme immaturity	1
	E01001195	Fetus and newborn affected by chorioamnionitis	1
		Neonatal cerebral leukomalacia	1
		Fetus and newborn affected by maternal hypertensive disorders	1
	E01001294	Malignant neoplasm: Pineal gland	1
		Persistent fetal circulation	1
		Necrotizing enterocolitis of fetus and newborn	1
	E01001322	Asthma, unspecified	1
		#N/A	1

Hammersmith and Fulham

Hammersmith and Fulham	E01001876	Other bacterial sepsis of newborn	2
		Unspecified intraventricular (nontraumatic) haemorrhage of fetus and newborn	1
		Sudden infant death syndrome without mention of autopsy	1
		Edwards' syndrome, unspecified	1
		Cerebral palsy, unspecified	1
		Lymphoedema, not elsewhere classified	1
	E01001852	Fetus and newborn affected by multiple pregnancy	2
		Respiratory distress syndrome of newborn	1

Harrow

Harrow	E01002213	Extreme immaturity	2
		Other and unspecified convulsions	1
		Unspecified diabetes mellitus	1
		Fall from, out of or through building or structure	1
	E01002238	Extreme immaturity	3
		Malignant neoplasm: Adrenal gland, unspecified	1
		Fetus and newborn affected by chorioamnionitis	1
	E01002126	Other specified degenerative diseases of nervous system	1
		Other specified chronic obstructive pulmonary disease	1
		Extreme immaturity	1
		Malignant neoplasm: Brain, unspecified	1
	E01002234	Fetus and newborn affected by chorioamnionitis	1
		Other disorders of nervous system, not elsewhere classified	1
		Fetus and newborn affected by oligohydramnios	1
	E01002117	Bronchopneumonia, unspecified	1
		Encephalopathy, unspecified	1
		Congenital malformation of lung, unspecified	1
	E01002181	Extreme immaturity	2
		Glycogen storage disease	1
	E01002203	Down syndrome, unspecified	1
		Other specified cerebrovascular diseases	1
		Hypoxic ischaemic encephalopathy of newborn	1

Hillingdon

Hillingdon	E01002525	Other secondary pulmonary hypertension	1
		Extreme immaturity	1
		#N/A	1
		Malignant neoplasm: Spinal cord	1
		Other bacterial sepsis of newborn	1
	E01002457	Respiratory distress syndrome of newborn	2
		Slow fetal growth, unspecified	1
		Necrotizing enterocolitis of fetus and newborn	1
	E01002397	Malignant neoplasm: Adrenal gland, unspecified	2
		Pneumonia, unspecified	1
		Bacterial sepsis of newborn, unspecified	1
	E01002401	Toxic shock syndrome	1
		Fetus and newborn affected by other forms of placental separation and haemorrh	1
		Fetus and newborn affected by multiple pregnancy	1
		Fetus and newborn affected by oligohydramnios	1
	E01002492	Fetus and newborn affected by prolapsed cord	1
		Muscular dystrophy	1
		Malignant neoplasm: Connective and soft tissue of pelvis	1
	E01002551	Fetus and newborn affected by multiple pregnancy	1
		Hypoplasia and dysplasia of lung	1
		Fetus and newborn affected by placental transfusion syndromes	1
	E01002394	Malformation of coronary vessels	1
		Other medical procedures	1
		Metabolic disorder, unspecified	1
	E01002407	Congenital malformation syndromes predominantly associated with short stature	1
		Other disorders of branched-chain amino-acid metabolism	1
		Necrotizing enterocolitis of fetus and newborn	1

Hounslow

Hounslow	E01002681	Extreme immaturity	3
		Termination of pregnancy, affecting fetus and newborn	2
		Other specified congenital malformations of brain	1
		Other preterm infants	1
		Edwards' syndrome, unspecified	1
		Down syndrome, unspecified	1
		Fetus and newborn affected by premature rupture of membranes	1
	E01002650	Fetus and newborn affected by chorioamnionitis	2
		Congenital diaphragmatic hernia	1
		Other accidental hanging and strangulation	1
		Fetus and newborn affected by multiple pregnancy	1
	E01002568	Metabolic disorder, unspecified	1
		Congenital malformation of heart, unspecified	1
		Assault by hanging, strangulation and suffocation	1
		Bronchopneumonia, unspecified	1
	E01002642	Intentional self-harm by hanging, strangulation and suffocation	1
		Fall from, out of or through building or structure	1
		Assault by drugs, medicaments and biological substances	1
		Extreme immaturity	1
	E01002684	Coarctation of aorta	1
		Pneumococcal meningitis	1
		Malignant neoplasm: Adrenal gland, unspecified	1
	E01002622	Congenital diaphragmatic hernia	1
		Unspecified intraventricular (nontraumatic) haemorrhage of fetus and newborn	1
		Extreme immaturity	1
	E01002638	Birth asphyxia, unspecified	1
		Wegener granulomatosis	1
		Ebstein anomaly	1
	E01002664	Cerebral palsy, unspecified	1
		Fetus and newborn affected by chorioamnionitis	1
		Extreme immaturity	1

Kensington and Chelsea/Westminster

Kensington and Chelsea	E01002830	Cardiomyopathy, unspecified	1
		#N/A	1
		Pneumonia, unspecified	1
Westminster	E01004744	Fetus and newborn affected by chorioamnionitis	1
		Unspecified drowning and submersion	1
		Hypoxic ischaemic encephalopathy of newborn	1
	E01004718	Fetus and newborn affected by maternal infectious and parasitic diseases	2
		Fetus and newborn affected by placenta praevia	1

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