Harrow COUNCIL LONDON

REPORT FOR: CABINET

Date of Meeting:	14 September 2017
Subject:	Variation and extension of the Health Visiting contract and response to the Scrutiny Review of the Health Visiting Service
Key Decision:	Yes
Responsible Officer:	Andrew Howe, Director of Public Health
Portfolio Holder:	Councillor Varsha Parmar, Portfolio Holder for Health, Equality and Community Safety Councillor Christine Robson, Portfolio Holder for Children, Young People and Schools Councillor Adam Swersky, Portfolio Holder for Finance and Commercialisation
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All
Enclosures:	Appendix 1 - Health Visiting Service performance 2015/16 to Q1 17/18 Appendix 2 - Comparative performance for mandated checks Q3 2016/17 Appendix 3 - Targets for current health visiting service as agreed for contract variation Appendix 4 - EqIA Appendix 5 - Health Visiting Report – London

North West Healthcare Trust (LNWHT)
Response

Section 1 – Summary and Recommendations

This report requests that Cabinet approve the variation and extension of term of the current Health Visiting contract with London North West Healthcare NHS Trust to take into consideration service changes and to cover the period until the commencement of the new contract currently being procured by the Council which is due to start on 1 July 2018. This extended timeframe will allow officers to facilitate the procurement process and achieve successful mobilisation of the new integrated 0-19 Health Visiting and School Nursing service.

The report also sets out the Cabinet's response to the recent Scrutiny Review of the Health Visiting Service.

Recommendations:

Cabinet is requested to:

- Approve the variation and extension of the novated contract for the Health Visiting Service with London North West Healthcare NHS Trust to run until 30 June 2018;
- Amend the delegated authority agreed at Cabinet in November 2016 to allow the Director of Public Health to approve the procurement of a new Health Visiting Service now to be implemented by **1 July 2018** (the delegated authority to be exercised following consultation with the Portfolio Holders for Health, Equality and Community Safety; Children, Young People & Schools; and Finance & Commercialisation, along with Corporate Director for People Services and Director of Finance;
- Approve the option to let the contract for 0-19 services for up to a total of seven (7) years (including all extension options);
- Note the response to recommendations of the Scrutiny Review of the Health Visiting Service.
- Note the proposed changes to the service delivery model for the new 0-19 Health Visiting and School Nursing service as set out at Section C.
- Note the possibilities to offset some of the expected increased service level demand due to projected increased 0-19 population and new statutory requirements through capital investment that has the potential for releasing service capacity and reducing the ongoing revenue cost of the contractual service. Some of the potential areas for capital investment are set out at Section D.

Reason: (For recommendations)

The procurement process for the new 0-19 Health Visiting and School Nursing service has had to be pushed back to allow sufficient time for the

development of the specification and consultation as well as the procurement process and mobilisation of the new service. It will not be possible to complete the process described above by 31 December 2017 as per the original request to Cabinet in November 2016.

The Executive is required to respond to the recommendations of the Scrutiny Review that were presented to the Overview and Scrutiny (O&S) Committee on 27 June 2017 and where O&S Committee noted and acknowledged that the substantive Cabinet response would be available in September. The original report and the minutes of the O&S Committee meeting of 27 June 2017 are available here:
http://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=276&MId=64281&Ver=4#AI108885

While the budget for the 0-19 Health Visiting and School Nursing service is not proposed to be reduced there are a number of financial pressures that we are expecting over the lifetime of the seven (7) year contract (there will be break clauses), particularly the statutory requirement to offer vision screening which is not being delivered by the current provider – as well as the projected increases in our 0-19 population. The needs analysis/refresh of the Joint Strategic Needs Assessment (JSNA) that has been carried out for this tender sets out that the Office for National Statistics (ONS) is predicting an increase in Harrow's 0-19 population to 67,000 by 2021 and 69,000 by 2026. A number of areas have been identified in the current services where resources could be released if there was capital investment in IT solutions.

Section 2 – Report

2.1. Introduction

2.1.1. The Health Visiting service is a key part of Harrow Council's drive to improve the health and wellbeing of local children and young people and their families. The transfer of the commissioning responsibility for Health Visiting to the Council from the NHSE (in October 2015) and the new School Nursing Service (which commenced in January 2016) will ensure a consistent and co-ordinated approach to the commissioning of a key public health services for children and young people from the age of 0 -19. It will also assist the council in meeting its priority to "protect the most vulnerable and support families." Harrow's Health and Wellbeing Strategy 2016-2020[1] sets out the Council's commitment to enabling children to "Start Well" so that "children from the womb to adulthood [can] be safe, happy and have every opportunity to reach their full potential."

2.1.2. Both Health Visiting and School Nursing enable the council to fulfil its statutory duties in regard to the Healthy Child Programme (0-5) and the Healthy Child Programme (5-19).

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[1]https://www.harrow.gov.uk/www2/documents/s130914/DRAFT%20Harrow%20Health%20and%20Wellbeing%20Strategy%202016-20%20FINAL%20UPDATED.pdf

2.2. A – Variation and Extension of the Health Visiting contract to 30 June 2018

2.2.1. The delay to the original timetable has been necessary to allow sufficient time for the development of the specification and consultation as well as the procurement process and mobilisation of the new service. It will not be possible to complete the process described above by 31 December 2017.

2.2.2. Harrow's historical comparatively small budget for these services (something which predates the transfer of the services from the old Primary Care Trusts to local authorities) means the only way this new service will be successful will be if all partners are engaged and have a shared vision and understanding of their roles in relation to the new service. It was felt that it was imperative that more time was invested in engaging with partners, something that has been recognised by them. (The range of stakeholders can be seen at Appendix 1 of the 0-19 Harrow Health Visiting & School Nursing Services Consultation Outcomes Report.) The feedback at the second all stakeholder event on 17 July 2017 was confirmation that this approach was appreciated and has set the foundation upon which a more integrated service can be built. We have also invested more time in engaging with the market. We have held three market engagement events which we hope will ensure that potential providers have the best possible understanding of our requirements and have had a chance to put their questions as far in advance of the issuing of the specification as possible.

2.2.3. Officers have undertaken extensive consultation to inform the redesign of the services and Cabinet is therefore requested to approve the variation and extension of the novated contract for the Health Visiting service until 30 June 2018.

2.2.4. The existing school nursing contract has a proposed service expiry date which is still within the time period for the current contract length.

2.3. Options considered

2.3.1. <u>Option A - Continuing with the original timetable</u>

Members agreed at Cabinet in November 2016 that the new contract would start on 1 January 2018. This is not a viable option as a mobilisation period ending June 2018 is required to allow commissioners time to procure and mobilise a transformed service that reflected the views of key stakeholders who were consulted on the proposed changes to the new service model. As a consequence of the significant diminution of the Public Health Commissioning function, there will be no capacity to review and develop this service in the future and therefore the approach we are taking will future-proof the service and ensure its success over the next seven years.

2.3.2. <u>Option B - Varying and extending the existing novated contract</u>

<u>This is the preferred option.</u> The delay to the original timetable has been necessary to allow sufficient time for the development of the specification and

consultation as well as the procurement process and mobilisation of the new service. This cannot be achieved by 31 December 2017. The indicative procurement timetable is as follows:

Event	Date
Full stakeholder event	30 Jan 2017
Consultation with stakeholders (for full list please see Appendix 1 of the 0-19 Harrow Health Visiting & School Nursing Services Consultation Outcomes Report)	January - June 2017
Consultation with potential bidders	12 Jun 2017
"You said, we did" full stakeholder feedback event	18 Jul 2017
Final market engagement event	8 Sept 2017
Publish tender documents	15 Sep 2017
Shortlist bidders	Oct 2017
Negotiation stage	Nov-Dec 2017
Evaluation of final tenders	Jan 2018
Supplier notification of outcomes	Feb 2018
Contract award	Mar 2018
Mobilisation	March - June 2018
Full service commencement	1 Jul 2018

2.4. B – Executive Response to Scrutiny Review of Health Visiting

2.4.1. Scrutiny

The Executive is grateful that Scrutiny members chose Health Visiting as a topic for an in-depth review which was conducted between January and March 2017.

2.4.2. The aims of the review as agreed by the scrutiny members were:

- Understanding the service on the ground through work-shadowing, meeting parents and meeting London North West service managers.
- Understanding how other boroughs' HV service works.
- Understanding how it fits with LBH Early Years Service
- Understanding the current budget
- Examination of the expenditure involved in provision of the service
- Meeting national representative of e.g. PHE or Institute of Health Visiting to understand the national picture.

2.4.3. The report and its recommendations include insights particularly around access for mothers whose first language is not English have been very useful and is something that will be addressed in the new

specification. The feedback from the Health Visitors themselves was that they very much appreciated elected members taking the time and effort to acquaint themselves with what they do.

2.4.4. The Review made sixteen recommendations of which two were for the Executive (recommendations 10 and 15) and fourteen recommendations were for the current provider. The recommendations that the Review made to the provider are very pertinent for the new specification and as such the Council is responding to them as well.

	Recommendation	**Executive response**
1.	To ensure the vacancy rate is filled across all the grades and not just the Health Visitors in order to meet the demand of the service, which will reduce the caseload per HV and improve the efficiency of the service.	In public health we collate the quarterly vacancy data and ask for assurances around the staffing vacancies. We will ensure that this is built in to the new contract performance reporting regime.
2.	To improve the level of skill-mix within the Health Visiting teams to deliver the Healthy Child Programme focusing mainly on the underperforming 12 months and 2-2.5 year developmental checks while maintaining performance levels for the other mandated checks.	This will be a requirement in the new service spec and potential bidders were informed of this at the market engagement event in June.
3.	To develop and implement a programme to recruit, develop and retain HV staff to meet the demand in service, which will reduce waiting times and deliver a more efficient service.	Harrow does have good staff retention rates. We are looking to incorporate a requirement in relation to clinical support and training into the new service spec. We would also expect providers to set out how they will grow their own staff as part of the social value requirements of the evaluation process.
4.	That Health Visitors (HVs) are trained to ensure information and advice provided to parents is consistent across the board including knowledge on Language Line and providing the service in various community languages	This is a very useful recommendation and has been shared with potential providers who attended the 0-19 market engagement event in June. We will be assessing how well the bidders for the new

	Recommendation	Executive response
		contract propose to meet these requirements around information and accessibility as part of the evaluation process.
5.	That HVs undergo diversity and cultural awareness training to develop an understanding of different cultures and how this impacts on their roles improving the quality of service being delivered.	We will ask the prospective providers during the procurement process how they will meet this requirement
6.	That HVs are trained to recognise cultural pressures and are able to provide the relevant support, information and advice in a confidential and safe environment to mothers/parent, which will help pick up and address potential issues such as depression and domestic violence.	The recommendation and the specifics of the issues that members picked up on when they carried out their visits are very useful. Prospective providers, during the procurement process, will be asked to demonstrate how they will ensure that this is dealt with under the new contract.
7.	To further promote appointments within dedicated Saturday clinics to address the low take up of Antenatal and 12 months and 2-2.5 year Health Reviews to reduce the number of parents not attending.	We recognise the importance of the Saturday clinics in increasing the numbers under the current contract. We will be asking providers what range of steps they will be adopting to ensure the maximum uptake of all the mandated child development checks.[2]
8.	To undertake a publicity campaign (including posters, social media, engaging with the voluntary and community sector, faith groups, schools and partners) to raise awareness and educate parents on the importance of the clinics, and could reduce the no shows.	We will be looking to have the most ambitious targets possible for attendance at the mandated child development checks and want to monitor these by ethnicity and other protected characteristic groups so

[2] There are five mandated child development checks that the local authority is required to ensure happens between the first antenatal contact and 2.5 years old: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407644/overview1-health-visit.pdf#page=2

	Recommendation	Executive response
		it will be possible to ensure more steps are undertaken if particular ethnic/language groups are underrepresented. We have also worked closely with partners such as early support hubs/children's centres, PVIs (Private, Voluntary and Independently run childcare settings), GPs, maternity/midwifery, vol sec orgs as part of the consultation in order to look at how this can be addressed collectively.
9.	To ensure adequate information (posters) is displayed at all clinics and also available to provide to parents, as lack of information was available at a number of clinics.	We support this recommendation and will be working with current provider as well as the successful bidder of the new contract to ensure this is improved.
10.	**[Council] To agree targets (comparative to neighbouring boroughs) and include these as Key Performance Indicators (KPIs) within the contract to be monitored on a regular basis, which will help to improve performance.**	**Accepted.** We have agreed variations to the contract that was novated from NHS England on 1 October 2015. This includes more challenging targets. It is important to note that performance has been improving significantly in the last two quarters. More details about current performance are set out below in Appendix 3. It should be noted that we will be requiring the service to report on new local indicators that will

	Recommendation	Executive response
		show the percentage of vulnerable[3] children who are seen at each of the mandated child developmental checks. There is the target that 100% of vulnerable children are seen.
11.	To change the way ethnicity and mother tongue/language competence are recorded on patient records. At the moment the Health Visiting patient record system records 132 different ethnicities. It is recommended that ethnicity is simplified and the Council's Diversity Monitoring categories (Appendix 4) are used and a separate record is kept of language and language proficiency.	Work has started on this recommendation. There was be a meeting on 25 July to start discussions around aligning data recording and it will be a requirement of the new contract.
12.	To review the contact material (letters) to ensure they are inclusive and incorporate a strap line offering the information in alternative formats and community languages, which will contribute to addressing the language barrier.	We support this recommendation and it will be a requirement of the new contract. We will also be working with the existing provider to improve this.
13.	To ensure all staff are aware of and trained to arrange for interpretation services if required to address the issue of language barrier.	We support this recommendation and it will be a requirement of the new contract. We will also be working with the existing provider to improve this..
14.	To undertake a review of the set-up of all clinics to ensure customer confidentiality is maintained at all times so that no more than one visit is conducted in the same room at any one time.	We support this recommendation and it will be a requirement of the new service. We will also be working with the existing provider to improve this before the commencement of the new contract.
15.	**[Council] That a fully comprehensive Equality Impact Assessment is undertaken to highlight potential barriers and identify ways to improve the service. The findings and requirements of this to be incorporated**	**Accepted.** This recommendation is accepted and the EqIA along with the refresh of

[3] Health Visiting nationally has two categories of 'vulnerable': Universal Partnership (UP) and Universal Partnership Plus (UPP). UP covers children/parents where there are long-term health issues and additional health needs, reassurance about a health worry, advice on sexual health, and support for emotional and mental health wellbeing. UPP covers LAC, CP, CIN children etc.

	Recommendation	Executive response
	in the service specification of the new contract.	the JSNA that was completed specifically for this tender reflects the most comprehensive EqIA that was possible. The Scrutiny Review report in itself forms part of this. As Scrutiny Members note at recommendation 11, the system of data recording is not adequate so there are gaps in our knowledge of the service users and their protected characteristics. We have started conversations with the current service and it will be part of the new specification.
16.	That the service develops and supports five groups for the five most common language groups. The purpose of these groups would be to act as a sounding board for translated documents and invitation letters etc., and be able to support other parents from those communities	There was extensive consultation with different community groups as part of the consultation process for this contract. We will be asking bidders to set out how they plan to engage effectively with the five most common ethnic groups in Harrow.

2.5. C – Proposed changes to the service delivery model for the new 0-19 Health Visiting and School Nursing service

2.5.1. The funding available to commissioning these services is significantly lower than our statistical neighbours and as a consequence, the challenge is to develop a service specification which is realistic and affordable. During the review of the service, we identified a number of gaps in provision and efficiencies that could be made to ensure high quality and good value for money services.

2.5.2. Members are requested to note the number of proposed changes for the new 0-19 Health Visiting and School Nursing service and the wider implications. See table below for details:

	Proposed Change	Rationale	Implications	Mitigation
1)	HVs will be required to ensure that the 6-8 week (developmental) checks are undertaken in collaboration with GPs.	At the moment both health visitors and GPs carry out a 6-8 week check. Parents have reported in our consultation being confused as to the difference between both checks. To avoid duplication, HVs will be expected to liaise with GPs on the completion of the 6-8 weeks checks and only undertake them where a gap has been identified.	This is a mandated requirement that the Council reports on nationally. There are risks that the council's performance for the 6-8 week check point drops and we don't retain met or meet our national target.	We will ensure greater co-operation between HVs and GPs and set a key performance indicator to monitor this. To encourage better data sharing between HVs and GPs.
2)	Introduce up to 2 new developmental checks: one at 4-5 months and another at 4-5 years.	Gaps have been identified by professionals and families in the required child developmental checks. 4-5 months is a key check point for weaning and introducing solid foods and healthy eating habits. 4-5 years is a key point for school-readiness i.e. ensuring children are toilet-trained, aware of dental health etc.	If we are to introduce the new checks at 4-5 months and 4-5 years capacity need to be released elsewhere.	As set elsewhere it is hoped that reducing health visitor involvement at the 6-8 week and 2-2.5 year checkpoints, capacity will be released to delivered these additional checks.

	Proposed Change	Rationale	Implications	Mitigation
3)	That the health visiting service ensure that the assessments at 2-2.5 years are carried out in collaboration with early years settings.	There is an overlap between the nationally required checks carried out separately by health visiting and early years currently. Other boroughs have introduced integrated checks. Duplication would be avoided. Such a change would also have the advantage of further upskilling and building the capacity of partners in early years settings.	It is hoped that health visiting service capacity will be released to carry out checks at other child developmental stages.	It is hoped that it will be supported by better data sharing as set out below, as well as improved joint working and training.
4)	To introduce vision screening	This is set out in PHE guidance documents as a commissioning responsibility of local authorities.	There is likely to be a cost implication for introducing this.	There are no mitigations as no additional funding has been identified to meet this requirement. As a consequence, the commissioner will need to remove certain aspects of the service to enable the provider to deliver this requirement.

	Proposed Change	Rationale	Implications	Mitigation
5)	Changing the delivery model for school nursing in special schools to bring it in line with the statutory guidance on Supporting pupils at school with medical conditions[4]	There is a need to ensure that the service is operating in line with statutory guidance and that roles and responsibilities are appropriately allocated and understood.	This will represent a significant change to the current operating model. It is proposed to reduce the provision to deliver services like the administrative functions around medicines in line with statutory guidance.	Affected schools will be consulted on these changes and would have till September 2018 to make the necessary changes.

2.6. D – Potential areas for capital investment in the new 0-19 Health Visiting and School Nursing service

While there have been a number of meetings with key stakeholders around the potential for much better data sharing systems and IT solutions, it is not possible to work up detailed business cases for new IT solutions until the new provider is in place. Capital investment in IT solutions would release limited resources and enable the provider to be efficient in the way they deliver services. A number of areas have been identified where digital solutions would be useful:

	Service area	Rationale
1)	Health questionnaires for Reception age and Year 6 pupils c.7,000 questionnaires each year.	These are currently all on paper. We are asking providers to propose secure web-based solutions for this.
2)	A+E notifications all on paper currently.	Around 500 notifications are triaged by the service every month on paper. There is currently no IT solution regarding the acute and community systems communicating with each other. This is costly in terms of staff time needed to process and scan

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484418/supporting-pupils-at-school-with-medical-conditions.pdf

	Service area	Rationale
		data. There are also greater risks around data going missing.
3)	Overlap between assessments carried out by health visitors at 2-2.5 years and those carried out by early years providers	We have had discussions with partners about the PVIs (Private, Voluntary and Independent childcare providers) carrying out the assessments currently carried out by health visitors at 2-2.5 years as PVIs are already carrying out similar assessments at the same time. Both are national requirements. Other boroughs have moved further in integrating both reviews and Ofsted has picked this up in some area inspections. An IT solution would assist with maintaining performance levels while managing risks and allowing health visiting capacity to be released for other requirements.
4)	Greater system interoperability between GPs (EMIS system) and 0-19 service (SystemOne)	If the GP and health visiting service IT systems were able to share data it would enable the new 0-19 service to check that the 6-8 week check currently delivered by health visitors had been delivered by the child’s GP.

2.7. Risk Management Implications

Risk included on Directorate risk register? No (0-19 is regularly discussed at the Children and Young People Commissioning Executive Group)
Separate risk register in place? Yes

2.7.1. The risks of not extending the current contract would be that the Council would then be in a position of not having any formal terms and conditions in place for the provision of the service and the Council would not be able to meet its statutory obligations. We do not have the scope to vary and extend the novated contract without Cabinet approval as the value of the contract is in excess of £500,000.

2.7.2. Roughly 4,000 children each quarter would not receive their mandated checks with all the concomitant reputational risks to the Council.

2.7.3. The risks associated with not doing as much as possible to make the health visiting service as accessible as possible are that the more vulnerable children do not get the best start in life and problems, be they health, development or safeguarding are not picked up in good time.

2.8. Legal Implications

2.8.1. Modification of this contract is permitted under the Public Contract Regulations 2015 (PCR) as a change of provider cannot be made for *"economic or technical reasons"* as it would result in *"significant inconvenience or substantial duplication of costs for the contracting authority"*. This change is permissible because it will not result in an increase in contract value of more than 50% of the original contract.

2.8.2. The provision of the current novated Health Visiting Service NHSE contract continues by way of conduct. There is scope within the Contract Procedure Rules (CPRs) to waive the Council's Contract Procedure Rules on the basis that it is in the Council's best interest to continue this contract until July 2018 and it is service imperative. This will allow for the public health commissioners to undertake a full procurement of a new School Nursing and Health Visiting Service incorporating changes in legislation and stakeholder consultation.

2.8.3. The changes to the contract will be reflected by way of a Deed of Variation and Extension drafted by the Legal Department

2.9. Financial Implications

2.9.1. The annual Public Health grant for 2017/18 is £11.094m. Within the grant amount the budget available for the integrated 0-19 service totals £3.572m for the current financial year. This reduces to £3.553m for 2018-19 and to £3.536m from April 2019 onwards (these reductions reflecting the efficiencies anticipated from the extension periods to the existing school nursing service contract).

2.9.2. These budgets indicated a financial envelope of £24.769m over the seven years from April 2018 to fund the proposed contract. This financial envelope will need to contain:

- The total contract price;
- Any increased costs should the Council be required to fund services not currently provided i.e. vision and hearing screening;
- Any increases in the 0-19 population over the contract term.

2.9.3. These mandated services are currently funded within the ring fenced Public Health grant, and delivered through the shared service with Barnet. The eventual award of this seven year contract will result in contractual obligations with the successful provider for services which are funded by external grant and which cannot be guaranteed in the longer term.

2.9.4. The Public Health grant is currently ring-fenced until March 2019, after which it is expected that the service will be funded by business rates. It is not clear what impact, if any, the changes to the funding will have on the level of available resource however the provision of statutory services will continue and will need to be funded by the Council.

2.9.5. The current MTFS does not assume any capital funding for Public Health projects. If it can be established through the evaluation process, that capital investment could reduce the ongoing revenue costs of this service, a cost benefit analysis would be required. If such analysis demonstrates the capital investment would realise revenue benefits, new capital funding would need to be identified within the Council.

2.9.6. It should be noted that in February 2016 Cabinet, as part of the Medium Term Financial Strategy, approved further significant reductions (totalling £2.265m) to the public health team and the services commissioned from April 2018

2.9.7. These savings include the staffing reduction of £0.610m which represent a reduction of 65% in the cost of the Public Health team compared with the staffing structure in April 2013 when the responsibility for Public Health transferred to local authorities from the Department of Health.

2.10. Equalities implications / Public Sector Equality Duty

A full Equalities Impact Assessment (EqIA) has been carried out. As set out in the assessment, there are a number of areas where there are data gaps – gaps we wish to close through the procurement process. We acknowledge the various equalities and access issues that were highlighted during the scrutiny review and which we are seeking to address in the specification as well as through working in the meantime with the current provider.

The EqIA is appended to this report.

2.11. Council Priorities

The 0-19 combined health visiting and school nursing service has a key role in delivering on three of the Council’s priorities:

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

Vulnerable families will be a key focus of the new service. We are going to increase the reporting requirements regarding vulnerable children. We intend to increase and improve joint working with early support hubs that play a key role in their communities. Improving families’ lives is at the heart of this service, whether that is about improving the bond between mother and child, father and child, supporting a mother with post natal depression, or working with a family whose child is on a child protection plan.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards Date: 4 August 2017	x	on behalf of the Chief Financial Officer
Name: Sarah Inverary Date: 7 August 2017	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**NO, as it impacts on all Wards**
EqIA carried out: **EqIA cleared by:**	**YES** Johanna Morgan, DETG Chair for People Directorate

Section 4 - Contact Details and Background Papers

Contact: Audrey Salmon, Head of Public Health Commissioning (Barnet and Harrow Joint Public Health Service) – audrey.salmon@harrow.gov.uk

Jonathan Hill-Brown – Public Health Commissioning Manager – (Barnet and Harrow Joint Public Health Service) – jonathan.hill-brown@harrow.gov.uk

Background Papers:

Report for Cabinet, 17 September 2015: Transfer of Public Health Commissioning Responsibilities for 0-5 year olds (Healthy Child Programme delivered by the Health Visiting service)

https://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=249&MID=62616#AI96852
Report for Cabinet, 17 November 2016: Procurement arrangements for public health services for children and families and Sexual and Reproductive Health Services:
https://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=249&MId=62839#AI103940
Scrutiny Review of Health Visiting, June 2017:
http://www.harrow.gov.uk/www2/ieListDocuments.aspx?CId=276&MId=64281&Ver=4#AI108885.

0-19 Harrow Health Visiting & School Nursing Services Consultation Outcomes Report

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

Appendix 1 – Health Visiting Service performance 2015/16 to Q1 17/18

See below for the table showing performance of the Harrow Health Visiting Service since Q1 15/16. It can be seen that overall the service is now improving.

KPI	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Number of mothers who received a first face to face antenatal contact with a Health Visitor.	13	17	18	5	94	163	243	254
Percentage of births that receive a face to face NBV* within 14 days by a Health Visitor	90.9%	90.0%	88.4%	91.0%	90%	96%	94%	95%
Percentage of children who received a 6-8 week review by the time they were 8 weeks.	3.2%	2.3%	64.9%	86.8%	63%	66%	70%	73%
Percentage of infants being breastfed at 6-8 weeks	*	*	*	79.0%	57%	60%	60%	65%
12 Month checks when child turns 12 months in that quarter	2.7%	2.3%	1.3%	6.0%	16%	18%	30%	75%
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months.	4.9%	14.9%	4.8%	7.6%	22%	40%	60%	60%
Percentage of children who received a 2-2½ year review	3.3%	3.2%	2.1%	8.4%	14%	25%	31%	39%
Percentage of children who received a 2-2½ review using ASQ 3	DK	DK	DK	13%	33%	49%	34%	42%

Appendix 2 – Comparative performance for mandated checks Q3 2016/17

The most recent figures are those from Q3 2016/17. There is always a lag of one quarter to obtain the national comparator statistics. It can be seen that Harrow is now much more in line with our statistical neighbours.

Health Visitor Service Delivery Metrics
2016/17 Quarter 3 (April 2017 release)
Source: Public Health England
Crown Copyright © 2017

	C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks	C4: Percentage of children who received a 12 month review by the time they turned 12 months	C5: Percentage of children who received a 12 month review by the time they turned 15 months	C6i: Percentage of children who received a 2-2½ year review
Area	%	%	%	%	%
England (aggregate value of local authorities passing Stage 1 validation)	88.7%	83.9%	74.8%	82.7%	78.2%
North East (aggregate value of local authorities passing Stage 1 validation)	91.0%	93.5%	88.4%	96.1%	91.2%
North West (aggregate value of local authorities passing Stage 1 validation)	89.2%	90.5%	84.5%	90.2%	88.0%
Yorkshire and The Humber (aggregate value of local authorities passing Stage 1 validation)	86.2%	87.7%	82.1%	86.8%	81.9%
East Midlands (aggregate value of local authorities passing Stage 1 validation)	90.1%	91.8%	82.7%	89.1%	84.0%
West Midlands (aggregate value of local authorities passing Stage 1 validation)	89.8%	87.5%	84.9%	86.0%	83.9%
East of England (aggregate value of local authorities passing Stage 1 validation)	93.5%	92.2%	86.8%	92.7%	85.7%
London (aggregate value of local authorities passing Stage 1 validation)	91.6%	60.8%	45.6%	62.3%	59.7%
South East (aggregate value of local authorities passing Stage 1 validation)	84.8%	85.4%	74.4%	81.4%	76.9%
South West (aggregate value of local authorities passing Stage 1 validation)	80.9%	82.9%	74.3%	81.7%	72.8%

	C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks	C4: Percentage of children who received a 12 month review by the time they turned 12 months	C5: Percentage of children who received a 12 month review by the time they turned 15 months	C6i: Percentage of children who received a 2-2½ year review
Barking and Dagenham	92.3%	53.4%	21.3%	60.5%	49.5%
Barnet	95.2%		23.0%	69.6%	69.6%
Bexley	92.5%	40.5%	8.3%	52.5%	64.1%
Brent	91.9%	73.7%	37.2%	37.3%	29.8%
Bromley	93.4%	89.6%	81.5%	89.1%	78.4%
Camden	93.7%	78.7%	75.9%	93.8%	
Croydon	61.3%	6.1%	2.3%	7.3%	21.8%
Ealing	93.8%	61.9%	53.8%	49.1%	47.9%
Enfield		86.0%	40.8%		78.3%
Greenwich	94.4%	71.5%	4.3%	65.4%	72.9%
Hackney and City of London*	95.5%	18.0%	93.6%	93.5%	83.6%
Hammersmith and Fulham	95.1%		78.5%	79.9%	72.7%
Haringey	91.8%	10.2%	36.2%	46.2%	51.5%
Harrow	94.3%	69.8%	30.0%	60.1%	31.4%
Havering	91.0%	38.4%	55.4%	82.5%	72.4%
Hillingdon	94.1%	94.7%	82.0%	78.2%	73.1%
Hounslow	97.1%	93.3%	13.3%	14.0%	50.4%
Islington	93.4%	29.3%	17.6%	62.6%	78.2%
Kensington and Chelsea	96.5%		69.5%	76.4%	68.5%
Kingston upon Thames	79.6%	91.5%	54.0%	67.2%	47.4%
Lambeth	97.3%		91.3%	93.9%	94.4%
Lewisham	94.9%	73.9%	76.1%	82.4%	78.0%
Merton	97.2%	95.5%	66.2%	63.8%	58.3%
Newham	95.3%	32.1%	29.6%	69.4%	54.6%
Redbridge	90.2%	77.5%	48.5%	40.5%	53.1%
Richmond upon Thames	98.4%	95.0%	52.3%	67.0%	49.8%
Southwark					
Sutton	92.3%	85.2%	74.0%	76.3%	66.5%
Tower Hamlets	83.4%		50.8%	50.7%	60.3%
Waltham Forest	89.9%		17.6%	62.9%	38.0%
Wandsworth	94.0%	80.6%	40.0%	76.0%	59.7%
Westminster	94.8%		81.0%	88.5%	81.9%
Slough	93.3%	93.9%	80.6%	81.6%	75.1%
	Harrow's statistical neighbours				

	C2: Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a Health Visitor	C8i: Percentage of infants who received a 6-8 week review by the time they were 8 weeks	C4: Percentage of children who received a 12 month review by the time they turned 12 months	C5: Percentage of children who received a 12 month review by the time they turned 15 months	C6i: Percentage of children who received a 2-2½ year review

Notes:	
	No submission
	Does not pass Stage 1 Validation
	Does not pass Stage 2 validation
DK	Local authority entered 'Don't know'
	Blank cells (with no colour highlight) where data does not meet validation criteria, therefore values cannot be published

Appendix 3 – Targets for current health visiting service as agreed for contract variation

As set out above, It should be noted that we will be requiring the service to report on new local indicators that will show the percentage of vulnerable children who are seen at each of the mandated checks. There is the target that 100% of vulnerable children are seen.

KPI	**Current performance (Q4 16/17)**	**Target agreed for contract variation**
Number of mothers who received a first face to face antenatal contact with a Health Visitor.*	30%	35%
Percentage of births that receive a face to face NBV** within 14 days by a Health Visitor	95%	95%
Percentage of children who received a 6-8 week review by the time they were 8 weeks.	73%	80%
Percentage of infants being breastfed at 6-8 weeks	65%	75%
12 Month checks when child turns 12 months in that quarter	75%	80%
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months.	60%	90%
Percentage of children who received a 2-2½ year review	39%	60%
Percentage of children who received a 2-2½ review using ASQ 3	42%	70%

* This indicator is national recorded as an absolute number as it is difficult to calculate the denominator. In terms of a proxy indicator the denominator has been agreed as a % of total number of infants who turned 30 days in the quarter with the numerator set at the number of mums who receive an antenatal contact then the England average for Q1 16/17 was 38%.

** New Birth Visits