haringey strategic partnership

NOTICE OF MEETING

Well Being Strategic Partnership Board

TUESDAY, 11TH JANUARY, 2011 at 19:00 HRS – COMMITTEE ROOMS 1 & TWO, CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see membership list below.

AGENDA

1. APOLOGIES

To receive any apologies for absence.

2. MINUTES (PAGES 1 - 8)

To confirm the minutes of the meeting held on 5 October 2010 as a correct record.

3. URGENT BUSINESS

To consider the admission of any items of Urgent Business. (Late items of Urgent Business will be considered under the agenda item where they appear. New items of Urgent Business will be considered under Item 12 below).

4. DECLARATIONS OF INTEREST

Members of the Board must declare any personal and or prejudicial interests with respect to agenda items and must not take part in any decision made with respect to those items.

DISCUSSION ITEMS:

5. RESPONDING TO THE NHS AND PUBLIC HEALTH WHITE PAPERS (PAGES 9 - 26)

6. FUTURE CHALLENGES AND IMPACT FOLLOWING COMPREHENSIVE SPENDING REVIEW ANNOUNCEMENT

This report will be sent to follow.

INFORMATION ITEMS:

7. QUARTERLY UPDATE ON SAFEGUARDING ADULTS

This report will be sent to follow.

8. EXPERIENCE STILL COUNTS UPDATE (PAGES 27 - 28)

9. NHS HARINGEY: APPROACH TO PERFORMANCE MANAGEMENT (PAGES 29 - 36)

10. PERFORMANCE REPORT (PAGES 37 - 50)

11. UPDATES FROM PARTNERSHIP SUB GROUPS (PAGES 51 - 54)

12. NEW ITEMS OF URGENT BUSINESS

To consider any new items of Urgent Business admitted under Item 2 above.

13. ANY OTHER BUSINESS

To consider any items of AOB.

14. DATES OF FUTURE MEETINGS

The next meeting will be held at 7pm, on 7 April, 2011 at the Civic Centre, High Road, Wood Green, N22 8LE.

Dates for 2011/12 are being scheduled as part of the Council's Calendar of Meetings. Once this has been set members of the Board will be advised.

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Published: 22 December 2010

SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	9	Mun Thong Phung Councillor Dilek Dogus (Chair) Councillor John Bevan Councillor Ann Waters Margaret Allen Jeanelle De Gruchy* John Morris Lisa Redfern
Health	Haringey Teaching Primary Care Trust	6	Stephen Deitch Fiona Eldridge Cathy Herman Marion Morris Richard Sumray (Vice-Chair) Ian Wilson
	North Middlesex Hospital trust	1	Claire Panniker
	BEH Mental Health Trust	1	Michael Fox
	Whittington Hospital Trust	1	Rob Larkman
Community Representatives	Community Link Forum	3	Margaret Fowler Faiza Rizvi Stephen Wish
	HAVCO	1	Naeem Sheikh
Education	College of North East London	1	Paul Head
	Middlesex University	1	Dr Gina Taylor
Other agencies	Haringey Probation Service	1	Kate Gilbert
	Metropolitan Police	1	Chris Barclay
	Total	**27**	

** Jointly appointed by the Council and Primary Care Trust*

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Agenda Item 2

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 5 OCTOBER 2010

Present: Councillor Dilek Dogus, (Chair), Margaret Allen, Councillor John Bevan, Margaret Fowler, Michael Fox, Cathy Herman, Richard Milner, Marion Morris, Susan Otiti, Mun Thong Phung, Lisa Redfern, Naeem Sheikh, Richard Sumray, Councillor Ann Waters, Stephen Wish.

In Attendance: Xanthe Barker, Olivia Darby, Carmel Keeley, Sima Khiroya, Melanie Ponomarenko, Leks Omiteru, Barbara Nicholls, Helena Pugh.

MINUTE NO.	SUBJECT/DECISION	ACTON BY
WB001	**APOLOGIES** Apologies for absence were received from the following: Stephen Deitch Paul Head - Howard Jeffrey substituted Claire Pannicker Bronagh Scott Dr. Gina Taylor	
WB002	**URGENT BUSINESS** There were no items of Urgent Business.	
WB003	**DECLARATIONS OF INTEREST** No declarations of interest were made.	
WB004	**MINUTES** **RESOLVED:** That the minutes of the meeting held on 10 June 2010 be confirmed as a correct record.	
WB005	**FINANCIAL PLANNING / CHALLENGES 2010/11** The Board received a report on the funding cuts and financial challenges facing Public Sector organisations. The Chair noted that the report had been brought to the Board in order to draw together all of the issues that would impact upon the financial resources available to Public Sector organisations. The restricted timetable around the implementation of funding cuts and new legislation meant that consultation with partners and local residents would not be as extensive as the Council would like and therefore providing a 'snap shot' of the current picture had been considered essential at this juncture. More detailed reports would be submitted to the Board in January setting out the implications of the CSR and the various White Papers being published during the autumn and their impact upon health and wellbeing.	

	The Vice-Chair noted that the proposed changes were the most significant since the NHS's conception and represented a conceptual change to the way in which services would be delivered. In order to address the challenges, and to ensure that the Borough was as well placed as possible to deal with them, it was essential that work began swiftly to plan for how these would be implemented now. Given the scale of the financial challenges ahead all options would have to be considered and this would inevitably result in redundancies and a change in the role the VCS may play in delivery services. Establishing clear principals and priorities at the outset would be essential in order to plan the best use of resources around these. Large Public Sector organisations such as the Council and NHS Haringey would need to work together to form these principals and priorities to ensure that the funding available to the Public Sector was used as effectively as possible. **RESOLVED:** That the report be noted.	
WB006	**'EQUITY AND EXCELLENCE: LIBERATING THE NHS' - WHITE PAPER 12 JULY 2010** The Board received a report that provided a briefing on the White Paper published on 12 July 2010 entitled 'Equity and Excellence: Liberating the NHS'. The one of the key changes arising from this was the abolition of Primary Care Trusts (PCTs) and the creation of an NHS Commissioning Board and GP collaboratives. The new GP collaboratives would take over responsibility for the commissioning of services by 2013. Other significant changes included allowing patients to register with the GP of their choice, rather than restricting them to their local GP and opening up health provision to allow private providers to compete to deliver services. In terms of performance and strategic priorities the White Paper proposed that a new outcome focused framework should be established for health and social care to replace existing targets. The Secretary of State would be responsible for setting national objectives for health improvement. The Care Quality Commission (CQC) would regulate the quality of health and social care and the National Institute for Clinical Excellence (NICE) would set standards. Local Authorities would take over responsibility for Public Health and as part of this would be required to appoint a Director of Public Heath and a ring fenced budget for 'Health Improvement' would be allocated to Local Authorities to support this function. As part of this shift in responsibilities Local Authorities would be required to establish Health and Well Being Boards by April 2012 and these would have four key functions:	

- Leading on a Joint Strategic Needs Assessment (JSNA) to assess local needs
- Promoting integration and partnership working (including joint commissioning)
- Supporting joint commissioning and pooled budget arrangements
- Overview and Scrutiny

Following the presentation the Chair noted that the scale of change made it difficult to visualise how health and social care would be delivered once all of the changes had bedded in. However, certain aspects, such as the shift in responsibility for Public Health from PCTs to Local Authorities were welcomed, provided the necessary funding was attached.

In response to concerns as to whether there would be a merger of the five North London Boroughs, in order to reduce management costs, the Board was advised that Primary Care Trusts (PCTs) were being required to make a 50% reduction to management costs, which meant that a range of options to achieve this were being considered at present.

In addition to reducing management costs the PCT would also need to provide support to Local Authorities and GPs in preparation for the hand over of responsibilities for Public Health and Commissioning. Therefore the organisation's capacity to support other functions would diminish.

It was noted that whilst many of the changes had the potential to have a positive impact upon the delivery of health care, particularly moving towards a more outcome based approach; the speed with which changes were being implemented may lead to good aspects of the current system being lost. This, combined with heavy redundancies and lack of capacity, meant that the support the PCT could give to additional work would be minimal. The PCT would need to focus much of its remaining capacity assisting with the implementation of the new arrangements.

The Board was advised that emerging proposals suggested that GP commissioning bodies were likely to be responsible for commissioning 40% of the total budget, rather than 80% as previously suggested. Therefore the national NHS Commissioning Board would hold the majority of the budget.

It was noted that proposals to transfer health scrutiny to statutory Health and Wellbeing Boards would have an impact on the way Overview and Scrutiny operated. New mechanisms would need to be established to ensure that there was effective scrutiny in place.

In response to concern raised that the speed with which changes were being implemented would result in the Voluntary and Community Sector (VCS) being sidelined; the Chair advised that the Council recognised and valued the expertise and the skills within the VCS. However, the magnitude of the changes proposed meant that there may need to be patience while the new plans were worked through.

There was discussion around how the issues arising from the White Paper should be taken forward and the implications for partnership working. There was agreement that the Board had a key role to play in providing leadership around these issues moving forward and that retaining the good aspects of partnership working was vital.

It was noted that work would be required to ensure that GPs with commissioning skills understood the role of Local Authorities in public health and service provision. There was agreement that the Board should consider hosting a workshop for GPs on Local Authorities and health and social care issues (including Total Place agenda). As GPs leading on collaboratives had many demands placed on their time at present it was suggested that the invitation should be issued to all GPs.

Lisa Redfern

The Board was advised that officers would also look at other areas where it could provide leadership locally.

Concern was raised that services provided on a 'block contract' basis by Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) may be more vulnerable to cuts than acute services (paid based on activity) if services were too rapidly.

The Board was advised that guidance from the Department of Health noted that the children's agenda would form an important part of the new Health and Wellbeing Board and that therefore the Board would need to consult with the Children's Trust as the new arrangements were implemented.

Mun Thong Phung

The Chair concluded by noting that there would be a further report on this topic in January by which point the CSR would have taken place and further information would have been received with respect to the White Paper.

There was agreement that officers should look at options for establishing a Health and Wellbeing Board and the implications for the existing Well Being Strategic Partnership Board.

RESOLVED:

i. That the report be noted.

ii. That a report setting out the options for establishing a Health and Wellbeing Board and the implications for the existing Well Being Strategic Partnership Board should be submitted to the January meeting.

Lisa Redfern

iii. That a workshop session, hosted by the Board, should be considered for GPs to provide an overview of how Local Authorities operated with respect to health and social care issues (including 'shared services' agenda).

All

WB007	**NHS HARINGEY AND COUNCIL: APPROACH TO PERFORMANCE MANAGEMENT** The Vice-Chair apologised for the absence of an appropriately briefed officer to present this report and it was agreed that the item should be deferred until the next meeting. **RESOLVED:** That the report be included within the agenda for the next meeting.	Xanthe Barker
WB008	**SAFEGUARDING ADULTS: UPDATE ON IMPLEMENTATION PLAN** The Board received a tabled report that provided an update on the Safeguarding Adults Implementation Plan (SAIP). It was noted that the permanent Head of Safeguarding and (DoLS) had been in place since August and that a new Safeguarding Panel, had been established, which was Chaired by Councillor Gina Adamou and attended by Councillor Joanna Christophides and Councillor David Winskill. In addition the Cross Borough Peer Challenge Group, which was comprised of representatives from the following London Boroughs; Camden, Hackney, Haringey and Sutton, was near to completing its work on Risk Assessment and Screening and the Case file Audit Tool and these had now been piloted. In terms of implementation the group would meet and agree recommendations around the adoption on 11 October. The Board was advised that the number of alerts being received by the Safeguarding and DoLS team had increased more than was anticipated during the last year. Analysis of the alerts indicated that there was confusion around the terms Safety and Safeguarding. In order to assist people to determine when it was appropriate to raise an alert and what information should be provided a 'How To' guide was being compiled. It was noted that the guide would be particularly useful to the Ambulance Service as staff routinely attended situations where Safeguarding issues became apparent. The Board was advised that training specifically for Ambulance Service staff was being planned. **RESOLVED:** That the report be noted.	
WB010	**QUARTER 1 PERFORMANCE SUMMARY / EXCEPTION REPORT** The Board received a report that provided an overview of performance against Local Area Agreement (LAA) National and Local Performance Indicators (PIs) within the Boards responsibility during the first quarter of 2010/11.	

	An overview of the report was provided and it was noted that despite the turbulent political and financial backdrop overall performance during the first quarter of 2010/11 had been good. It was noted that NI 39, which related to hospital admission rates for alcohol related harm, continued to be a challenging. These had risen across London and Haringey was particularly affected due to the number of dependent drinkers resident in the Borough. The Board was advised that NI 40, which related to the number of drug users recorded as being in effective treatment against a 2007/08 baseline, was comprised of two components; the number of people entering and the number completing treatment. Therefore this measure of performance did not fully reflect the effectiveness of the treatment systems in place. In response to concerns that there was insufficient dialogue with people receiving treatment around how the service could be improved, the Board was advised that there were mechanisms in place to facilitate this. The Drug and Alcohol Action Strategic Manager advised that she would discuss this issue with the manager of the integrated service and it was also agreed that this should be discussed by the Mental Health Partnership Board. The Board placed on record its thanks to all of the people that had contributed to the work that had been undertaken in partnership during the last year. **RESOLVED:** That the report be noted.	Marion Morris / Lisa Redfern
WB011	**WELL-BEING PARTNERSHIP BOARD RISK REGISTER (AS AT 30 JUNE 2010)** The Board received a report that presented the status of risks associated with its running and against the achievement of key LAA targets as measured within the Well Being Risk Register as of 30 June 2010. Due to the political climate and the pace with which new policies and legislation were being implemented, unknown areas of risk, such as the Comprehensive Spending Review (CSR) and two White Papers, could not be measured at present. It was noted that the Joint Leadership Team (JLT) was in the process of agreeing three key principals going forward and there was agreement that the Risk Register should be redrafted based around these priorities and presented to the Board at the January meeting. **RESOLVED:** i. That the report be noted. ii. That the risk register should be redrafted as set out above and submitted to the January meeting for discussion.	Margaret Allen / Helen Constantine Margaret Allen / Helen Constanti

		ne
WB012	**THEME BOARD PRIORITIES 2011/12 - RESOURCING AND SUSTAINABLE COMMUNITY STRATEGY REFRESH** The Board received a briefing note setting out the process that would be followed with respect to tackling reductions to the Area Based Grant (ABG) and the refresh of the Sustainable Community Strategy (SCS). As part of the process the Joint Leadership Team (JLT) been asked to identify three key priorities going forward and the following had been agreed in principal: 1. Developing locality based commissioning 2. Joint working on priority areas with measurable outcomes 3. Early intervention and prevention The Board discussed the priorities set out above and it was suggested that the first priority should be amended to GP locality based commissioning and the priorities reviewed to ensure they are aligned with the new NHS White Paper. It was noted that the process required Theme Boards leads to work up proposals based on a 25%, 50% and 100% reduction to the ABG. The Chair noted that there was still a great deal of uncertainty at present with respect to the ABG and arrangements in place around the Board moving forward. The Board would receive more detailed information and proposals at its next meeting in January. **RESOLVED:** That the paper be noted.	
WB013	**MINUTES OF SUB GROUPS** The Board was advised that the minutes of each of the subordinate Partnerships Boards had been included within the agenda for governance purposes and to provide an overview of the work they were undertaking and the issues of concern to each Board. The Chair noted that the Partnership Boards played an important role in shaping policy, influencing the health and wellbeing agenda and demonstrating good engagement. It was requested that a summary of the key issues for each Partnership Board was also provided. **RESOLVED:** i. That the minutes of the sub groups appended to the agenda be noted. ii. That in future it would be helpful to just give the Board key highlights from each Partnership Board.	Lisa Redfern Lisa Redfern

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 5 OCTOBER 2010

WB014	**NEW ITEMS OF URGENT BUSINESS** No new items of Urgent Business were admitted.	
WB015	**ANY OTHER BUSINESS** It was noted that the Overview and Scrutiny Committee would be setting up a Scrutiny Review of the implications of the new White Paper and that anyone was interested in participating should contact Melanie Ponomarenko, Principal Scrutiny Support Officer.	All to note
WB016	**DATES OF FUTURE MEETINGS** The dates of future meetings, set out below, were noted: • 11 January 2011, 7pm, Council Chamber, Civic Centre • 7 April 2011, 7pm, Council Chamber, Civic Centre *Once the Council's Calendar of Meetings for 2011/12 (which runs from 1 May – 30 April) has been agreed members of the Board will be advised.*	

The meeting closed at 9pm.

COUNCILLOR DILEK DOGUS

Chair

haringey strategic partnership

Meeting: **Well Being Strategic Partnership Board**

Date: **11 January 2011**

Report Title: **Responding to the NHS and Public Health White Papers**

Report of: **Mun Thong Phung,** Director, Adult, Culture and Community Services
Peter Lewis, Director, Children and Young People's Service
Dr. Jeanelle de Gruchy, Director of Public Health

Purpose

This report is the first in a suite of papers addressing Haringey's response to the following White Papers: **Equity and Excellence: Liberating the NHS;** and **Healthy Lives, Healthy People: Our strategy for public health in England**. It covers:

1) **Setting the strategic direction for health and wellbeing in Haringey**
2) **Establishing shadow arrangements for the Health and Wellbeing Board**
3) **Changes to the NHS (including proposed new public health system, setting up GP consortia, creating HealthWatch)**

Summary

The NHS White Paper represents possibly the most radical restructuring of the NHS since its inception. The changes will have major implications for local authorities which will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

This report proposes the **strategic direction** for health and wellbeing locally with the following vision for health and wellbeing:
'**Every child, young person and adult in Haringey will have an equal chance of having a healthy, safe and fulfilling life.'**

We are proposing **three outcomes**:

i. improved health and wellbeing
ii. reduced health inequalities
iii. children and adults safeguarded

To achieve our vision and deliver our outcomes we will:

- Develop strong partnership working between commissioning organisations
- Prioritise early intervention and prevention
- Offer residents increased choice and control over their lives through the personalisation of health and social care services
- Use evidence from our joint strategic needs assessment (JSNA) to commission cost-effective services and interventions
- Recognise that local residents, statutory, voluntary, community and commercial

organisations all have a role to play in delivering health and wellbeing improvements

What we are proposing to do next:

i. set up a **shadow Health and Wellbeing Board** from April 2011
ii. develop a new **health and wellbeing strategy** with associated delivery plans
iii. establish **health and social care commissioning arrangements**
iv. **transfer the public health function** to the council by March 2011

To aid discussion of these proposals **a list of questions** is included in section 4.

List of appendices
Appendix 1: Policy background
Appendix 2: Remit of existing Well-being Partnership Board and Children's Trust
Appendix 3: Future key public health roles

Legal/Financial Implications

The recommendation to set up a shadow Health and Wellbeing Board (H&WBB) from April 2011 is not expected to have new financial implications as it is expected to work within existing resources. As outlined in the summary above, there are likely to be significant financial implications moving forward. These will be picked up in future reports following receipt of the final legislation as a result of the NHS White Paper and associated publications.

The principal legislative reforms will include transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health. Within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need.

Recommendations

That, in readiness for the establishment of the statutory Health and Wellbeing Board from April 2012, members of the Well-being Partnership Board (WBPB) discuss the questions set out in Section 4 and:

1) Discuss the proposed vision and outcomes to be finalised at the inaugural meeting of the shadow Health and Wellbeing Board

2) Endorse the creation of a shadow Health and Wellbeing Board from April 2011 with an immediate focus on:
   - developing a health and wellbeing strategy
   - establishing health and social care commissioning arrangements
   - transferring the public health team from NHS Haringey to the council

3) Note the proposals for the transfer of the public health function to the council, establishment of GP consortia and HealthWatch, and associated timescale.

For more information contact:

Name: **Title:**	Lisa Redfern Assistant Director, Adult, Culture & Community Services	Debbie Haith Deputy Director, Children & Families	Dr. Jeanelle de Gruchy Director of Public Health, NHS Haringey
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1 Setting the strategic direction for health and wellbeing

1.1 The national context

The **Equity and Excellence: Liberating the NHS** White Paper, published in July 2010, outlines a series of changes to the NHS. It introduces additional responsibilities and new statutory functions which build on the power of local authorities to promote wellbeing; notably that local public health functions will be transferred from the NHS to the local authority. Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement which includes positive promotion of the adoption of 'healthy' lifestyles, as well as tackling inequalities in health and addressing the wider social influences of health.

The Department of Health's plan is that new statutory Health and Wellbeing Boards will be in place by April 2012 to ensure that:

- joint working takes place when commissioning NHS, public health, and social care services
- there is strategic oversight of health and care services
- GP consortia are responsive to the needs of patients

In November 2010, the government published **Healthy Lives, Healthy People**, the White Paper setting out its strategy for public health in England. It describes a framework and principles to:

- protect the population from serious health threats
- help people live longer, healthier and more fulfilling lives, and
- improve the health of the poorest, fastest

Further relevant policy background is described in Appendix 1.

1.2 The local context: a strategic vision for health and wellbeing in Haringey

Haringey has long been committed to ending health inequalities and improving health and wellbeing locally (see Appendix 2 for details); a summary of our current commitments is set out below.

Document	Commitment
Sustainable Community Strategy 2007-16	**Healthier people with a better quality of life**
Children and Young People's Plan 2009-20	We want every child and young person in Haringey to be **happy, healthy, safe and confident about the future.**
Well-being Strategic Framework 2010 (revised draft)	**A healthy and caring Haringey**: *All people in Haringey have the best possible chance of enjoyable, long, healthy lives***.**

In response to the recent national developments outlined above we are proposing bringing our local commitments together to promote a **Healthier Haringey** where people of all ages are able to benefit from improvements. Our vision[1] is that:

Vision
'Every child, young person and adult in Haringey will

[1] To be finalised at the inaugural meeting of the Shadow Health and Wellbeing Board.

have an equal chance of having a healthy, safe and fulfilling life.'

We are proposing **three outcomes**:

i. improved health and wellbeing
ii. reduced health inequalities
iii. children and adults safeguarded

1.3 Implementing our vision

To achieve this we will:

- Develop strong partnership working between commissioning organisations
- Prioritise early intervention and prevention
- Offer residents increased choice and control over their lives through the personalisation of health and social care services
- Use evidence from our joint strategic needs assessment (JSNA) to commission value for money services and interventions
- Recognise that local residents, statutory, voluntary, community and commercial organisations all have a role to play in delivering health and wellbeing improvements

2 Establishing a shadow Health and Wellbeing Board

2.1 We are recommending that we set up a shadow Health and Wellbeing Board from April 2011 – the structure would need to be able to be modified once legislation has been passed - subject to approval by the HSP Executive, Well-being Partnership Board and the Children's Trust. The shadow Board will operate until the new statutory board is in place in April 2012.

2.1.1 The shadow Health and Wellbeing Board will have a broader remit than the current Well-being Partnership Board, shifting to whole system commissioning for children ***and*** adults to enhance partnership work. It will have increasing authority as its statutory functions become clearer. Its membership will be wider than the current Well-being Partnership Board as it will also cover services to children.

2.1.2 The shadow Board will prepare partners for the establishment of the statutory Health and Wellbeing Board by developing a Health and Wellbeing Strategy initiating focused work programmes to:

- *lead the statutory JSNA programme*, planning and commissioning services based on evidence from JSNA findings
- *reduce health inequalities*, ensuring a focus on public health during the transition to the local authority leadership for health improvement
- *oversee the commissioning function* identifying areas and priorities for joint commissioning and pooled budget arrangements for NHS, children's and adults' social care including safeguarding, public health and other local services (a group will be set up to lead this work)
- *promote integration and partnership working*
- *promote engagement with GPs* through the development of the GP consortia
- *enhance public and patient engagement* establishing a local *HealthWatch*
- *monitor and review health and wellbeing improvements and outcomes* (using the NHS, Public Health and Social Care Outcomes Frameworks).

2.1.3 The Health and Wellbeing Strategy will be the mechanism for delivering the Health and Wellbeing Board's outcomes.

2.2 Local Authority/NHS Integrated Working Board

2.2.1 In Haringey, we have already set up an Integrated Working Board to manage the implementation of the White Paper. It is responsible for:

- Establishing our local Health and Wellbeing Board (including a shadow Board)
- Engaging with GP collaboratives
- Establishing a health and wellbeing commissioning group
- Transferring the public health function to the council

2.2.2 The Integrated Working Board will also have a comprehensive communications plan to help manage the change. We have begun establishing links between the council, NHS Haringey and GPs, and have produced a short guide for GPs on the role of local authorities in improving health and wellbeing outcomes.

2.2.3 Membership of the Integrated Working Board includes representatives from: Haringey Council's Adults' and Children's Services, the Chief Executive's Service; Public Health; NHS Haringey's commissioning function; and a Clinical Director representing the GP collaboratives.

2.2.4 The Board will meet fortnightly for the next few months and will provide progress updates to the council's management board, Haringey Strategic Partnership Executive, Well-being Partnership Board and Children's Trust.

2.2.5 There is potential for the Integrated Working Board will become the executive group of the shadow Health and Wellbeing Board.

3 Changes to the NHS

3.1 Consultation on changes to NHS Haringey

3.1.1 A staff consultation on the implementation of a Single Management Team for the five Primary Care Trusts (PCTs) in North Central London (NCL) started on Monday 22 November 2010 and ends on Monday 21 February 2011. These changes will be effective from 1 April 2011. The proposal is to create a single, central transitional organisation across the NCL sector, while retaining a local presence within each of the five boroughs. The proposal is deemed necessary to meet the national requirement to make significant management cost savings by 2012/13; approximately 54% management cost savings across the NCL sector, which equates to £28 million.

3.1.2 The proposal is for Haringey's local NHS presence to be provided largely by joint commissioning posts with Enfield's as well as joint commissioning posts with Haringey Council for adults' and children's social care.

3.2 Proposed new public health system in Haringey

3.2.1 The PCT public health teams are part of the above process. Although public health has been relatively protected, there will be a reduction in the public health workforce. The proposed structure is for teams to be based locally with

the local authority, led by the Director of Public Health (DPH), who will be jointly accountable to their local authority chief executives and to the sector DPH who will be accountable to the sector chief executive.

3.2.2 Arrangements to deliver certain public health functions at a sector level – with public health expertise from the borough teams – are under discussion by the five PCT DsPH in the sector.

3.2.3 Throughout the transition, staff will remain NHS Haringey employees until employment is either transferred to the national Public Health Service, or other agencies or providers or the council.

3.2.4 It is proposed that the public health function is transferred from NHS Haringey to the council by March 2011 and a project plan to support the transfer is in development. A detailed description of future public health functions is given in Appendix 3.

3.3 Funding for public health

3.3.1 The NHS White Paper proposed that the Department of Health would create a ring-fenced public health budget, and with this local DsPH will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for these funds will include a 'health premium' designed to promote action to improve population-wide health and reduce health inequalities.

3.3.2 At this time of high financial challenge, there is a considerable risk of a reduction in funding for public health. Currently the baseline funding for public health requires further clarification – as well as where reductions have recently occurred, or where they are proposed.

3.3.3 Health improvement and health protection issues are currently largely commissioned by the public health team through existing NHS commissioning budgets and it is envisaged that this will continue and be transferred as part of a ring-fencing public health function; clarification of commissioning lead and budget responsibility for certain areas is required.

3.3.4 In addition, current community NHS providers deliver substantial parts of what is required to improve public health, and provide substantial preventative as opposed to care and treatment activity – health visiting and school nursing being obvious examples. How we identify and safeguard those activities commissioned for public health action is still to be clarified.

3.3.5 Currently the extent of local authority funding for public health, particularly health improvement, is unclear; a considerable proportion of this is likely to be from area-based grants, which are to be discontinued, which fund the delivery of many public health functions.

3.4 GP Consortia in Haringey

3.4.1 The NHS White Paper proposed a fundamental shift in responsibilities and budgets for commissioning NHS healthcare and services, with GPs working in 'consortia' at the centre of this.

3.4.2 Haringey GP practices have been organised into four collaboratives for the last three years: West Haringey, Central Haringey, North East Haringey and South East Haringey. A GP Clinical Director leads the work of each respective collaborative. The four collaboratives recently agreed to form a pan-Haringey Consortium that would cover a population of approximately 250,000.

3.4.3 NHS London's GP consortia development programme (designed with the national programme) will make funds available from April 2011 for GP consortia to boost their progress.

3.4.4 The four Haringey GP collaboratives have expressed their interest to be one of the first groups to take part in the NHS London pathfinder programme and NHS Haringey is supporting them through their application process. A joint statement of intent to work in partnership with the local authority is a key part of the application. It is hoped that Haringey GPs will be in a position to apply for pathfinder status by 24 December 2010.

3.5 HealthWatch

During 2011/12 we will be preparing for the creation of Haringey HealthWatch, which will replace the Local Involvement Network. It will be an independent body with the power to monitor the NHS and to refer patients' concerns to a wide range of authorities and be in place by April 2012.

4 Next steps

4.1 An updated version of this report will be presented to the Children's Trust in February 2011; we will provide regular updates on progress to the council's management board, NHS Haringey and to the HSP and thematic boards.

4.2 Below are the timescales for implementation of the national and local changes.

No.	National activity	Timescale
1.	NHS White Paper (and other related papers) published	July 2010
2.	DH Vision for Adult Social Care and outcomes framework consultation published	November 2010
3.	Public Health White paper published	November 2010
4.	Publications on information strategy, patient choice, provider led education and data returns	December 2010
5.	NHS Commissioning Board established in shadow form	April 2011
6.	Haringey shadow Health and Wellbeing Board established	April 2011
7.	Phased transfer of public health team to the local authority	April 2011
8.	Shadow GP consortia set up	2011-12
9.	NHS Commissioning Board with Regional Offices established	April 2012
10.	Public Health England, the new national Public Health Service, established	April 2012
11.	Strategic Health Authorities abolished	2012-13
12.	GP consortia commissioning the majority of local NHS services – contracts held with providers	April 2013
13.	Primary Care Trusts abolished	April 2013

No.	Local activity in Haringey	Timescale
1.	LA/ NHS Integrated Working Board established	October 2010
2.	Information to GPs on LA	December 2010
3.	• Establish Integrated Working Board sub group to manage the transfer, subject to agreed financial arrangements, of the NHS public health team to the council • Project brief /PID to be developed	December 2010
4.	• Director of Public Health to establish the baseline of funding for public health within Haringey, both within NHS Haringey and Haringey Council • DPH to be made aware of all proposals for reduction in budgets considered to be for public health	End of December 2010
5.	As part of the new responsibilities of the DPH: • Agree the public health elements of all community provider services • Begin establishing accountable joint commissioning arrangements with the GP collaboratives.	End of January 2011
6.	Haringey shadow Health and Wellbeing Board established	April 2011
7.	Phased transfer of public health team to the local authority	April 2011
8.	Haringey shadow GP consortia set up	2011-12
9.	NHS Haringey abolished	April 2013

4.3 To start discussion at the Well-being Partnership Board **a list of questions** is presented below for consideration. These cover the vision for improving health and wellbeing locally, setting up of a shadow Health and Wellbeing Board and proposals for developing the Health and Wellbeing strategy.

Questions for discussion

Section 1: Setting the strategic direction for health and wellbeing

Vision
'Every child, young person and adult in Haringey will have an equal chance of having a healthy, safe and fulfilling life.'

Outcomes

i. **improved health and wellbeing**
i. **reduced health inequalities**
ii. **children and adults safeguarded**

1. **Do you agree with the proposed vision for health and wellbeing?**
(The vision will be finalised at the inaugural meeting of the shadow Health and Wellbeing Board.)

2. **Could it be worded differently? If so how?**

3. **Do you agree with the proposed outcomes?**

Section 2: Establishing a shadow Health and Wellbeing Board

Recommendation 2 of this report:
Endorse the creation of a shadow Health and Wellbeing Board from April 2011 with an immediate focus on:

- establishing health and social care commissioning arrangements
- the transfer of the public health unit to Haringey Council
- developing a Health and Wellbeing Strategy

4. **Do you agree with the creation of a shadow Health and Wellbeing Board which will include adults' and children's services and safeguarding from April 2011?**

5. **What, if any, other areas of immediate focus should the Health and Wellbeing Board have?**

6. **What are the implications of the creation of the Health and Wellbeing Board for the other thematic boards under the HSP?**
   - What are the key relationships and how should they be developed?
   - How should the Health and Wellbeing Board operate to carry out the oversight role effectively?
   - How should the shadow Health and Wellbeing Board manage potential conflicts and not prejudice possible future statutory positions?
   - How might the Health and Wellbeing Board facilitate the integration of care pathways so that client/ patients receive seamless care even when different commissioners contribute to the care pathway?

Section 3: Developing the Health and Wellbeing Strategy

It is proposed that the Health and Wellbeing strategy will include the following themes:

- **Empowering Haringey's people and communities**
- **Enabling the best start in life**
- **Primary and social care equity**
- **Health, work and wellbeing**
- **Maintaining healthy and sustainable places**
- **Preventing ill-health and supporting lifestyle changes**

7. **Do you agree with inclusion of the above themes?**

8. **Which health improvement issues should the Health and Wellbeing Strategy focus on as priorities?**

9. **What information will the Health and Wellbeing Board need in order to assess the effectiveness of health improvement programmes and their impact on health?**

Appendix 1: Policy background

Equity and Excellence: Liberating the NHS
The above White Paper, published on 13 July 2010, outlines a series of changes to the NHS. It introduces additional responsibilities and new statutory functions which build on the power of local authorities to promote local wellbeing. It states that each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement. Health improvement includes positive promotion of the adoption of 'healthy' lifestyles, as well as inequalities in health and the wider social influences of health.

The Local Government Information Unit described the White Paper as representing "possibly the most radical restructuring of the NHS since its inception". The Paper sets out three key principles:

- Patients at the centre of the NHS
- Changing the emphasis of measurements to clinical outcomes
- Empowering health professionals, in particular GPs

The legislative framework following the public consultation on the White Paper was published in December 2010. It sets out how the government will legislate and implement the proposed reforms, drawing on the insights and experience contributed by those who responded to the consultation.

A fuller briefing on this White Paper is available on request.

Achieving Equity and Excellence for Children
In addition to the NHS White Paper, in September 2010, a consultation on the above was launched to consider how to ensure high-quality services for children and young people. It recognises that, although children and young people are mostly healthy, illness and injury can have a long-lasting impact on a young person and ultimately on their life chances and overall wellbeing; the implementation of proposals from this consultation will be the responsibility of the Health and Wellbeing Board.

Healthy Lives, Healthy People
In November 2010, the government published its Public Health White Paper setting out a framework and a set of principles to:

- protect the population from serious health threats
- help people live longer, healthier and more fulfilling lives, and
- improve the health of the poorest, fastest.

Subject to Parliament, the government has set out its intention to put local government and communities at the heart of improving health and wellbeing for their populations and tackling inequalities. The government has promised a ring-fenced budget of £4bn, part of which will go to local authorities, while the rest will be spent by a new central body, **Public Health England**, which will organise national programmes such as immunisation and screening. Details of the public health outcomes framework and funding will be consulted on separately in the next few weeks.

NHS White Paper Transparency in Outcomes (A framework for the NHS)

The above consultation document (section 2.2 of the DH document) states that the current performance regime will be replaced with separate frameworks for outcomes that set direction for the NHS, public health and social care, and provide for clear and unambiguous accountability thus enabling better joint working.

Capable communities and active citizens (A vision for adult social care)
In November, the DH published its vision for adult social care, setting out a new agenda for adult social care based on a power shift from the state to the citizen. The vision will feed into the development of a White Paper on social care in autumn 2011, and future legislation. The DH also launched a consultation**, Transparency in Outcomes: a framework for adult social care**, setting out a new strategic approach to quality and outcomes in adult social care. Responses are due by February 2011.

All's well that ends well – Local Government Information Unit (LGIU) study
An independent study, commissioned by the LGIU and published in October 2010, focuses on the role of local government in supporting health improvement and tackling health inequalities, and analyses the structure of support needed locally to deliver effective action for communities.

- The new Health and Wellbeing Boards need real teeth – they have to be statutory bodies with effective powers, able to make decisions and to bring reluctant partners into line, but there should not be a government blueprint – they need flexibility to adapt different types of structure to respond to local circumstances.
- The new boards should be subject to independent and robust scrutiny.
- Support is needed to get the new system right – local government needs to take the lead here.
- There needs to be much more robust evaluation of what works – nationally and locally; programmes should not be rolled out with no prior evidence and no funding built in for evaluation.
- Clarity is needed over spending on health improvement and tackling health inequalities; no-one knows what is currently spent – resources need to be better targeted with ongoing effective evaluation.
- There is an urgent need to make the business and policy case for early intervention and preventative action – with new models which incentivise different parts of the public sector to invest up-front.

Appendix 2: Remit of existing Well-being Partnership Board and Children's Trust

	Existing Well-being Partnership Board	Children's Trust
Vision	'A Healthy and Caring Haringey: *All people in Haringey have the best possible chance of enjoyable, long, healthy lives*.' *(Draft revised Wellbeing Strategic Framework)*	*We want every child and young person in Haringey to be happy, healthy and safe with a bright future. (Children's Trust Terms of Reference)* We want every child and young person in Haringey to be **happy, healthy, safe and confident about the future.** *(Children and Young People's Plan)*
Purpose (taken from ToR)	To lead in promoting and delivering a Healthier Haringey for all people aged 18 years and over in Haringey by: 1. improving the health and quality of life of people who live and work in Haringey and reducing health inequalities 2. setting a strategic framework, including outcomes and objectives, through which joint priorities can be delivered and through which statutory responsibilities can be carried out 3. agreeing joint, overarching priorities for the wider well-being agenda	1. To develop and publish a child and family-centred outcome led vision for all children and young people in a Children and Young People's Plan which incorporates all partners' strategies related to children and young people. 2. To put in place robust arrangements for inter-agency governance and performance measurement of all the Every Child Matters outcomes for children and young people. 3. To develop integrated strategy, joint planning and commissioning and pooled and aligned budgets to deliver the Children and Young People's Plan. 4. To deliver child safeguarding services through integrated processes, and effective multi-agency working underpinned by shared language and shared processes. 5. To develop and promote integrated frontline delivery of services organised around the needs of the child, young person or family rather than professional or institutional boundaries.
Outcomes	**From draft revised Wellbeing Strategic Framework:** • Reduced health inequalities (see below) • Adults safeguarded from abuse wherever possible and dealt with appropriately and effectively if it does occur • Choice and control offered through the personalisation of services	**From Children and Young People's Plan** • Be Healthy • Stay safe • Make a positive contribution • Enjoy and achieve • Achieve Economic well-being

	Existing Well-being Partnership Board	Children's Trust
	• Care closer to home **From the draft Health Inequalities Strategy:** • Empowering Haringey's People and Communities • Primary and Social Care Equity • Health, Work and Wellbeing • Maintaining Healthy and Sustainable Places • Preventing Ill-Health and Supporting Lifestyle Changes	**From the draft Health Inequalities Strategy:** Enabling the Best Start in Life

Appendix 3: Key public health roles

This appendix sets out the key roles likely to be required to deliver improved health and reduce health inequalities locally.

1. Health improvement commissioning and strategic development

Key roles
- Ensure all health improvement activity has 'strategic fit' with the newly constituted Health and Wellbeing Board
- Commission health improvement services and health promotion activity to encourage healthier lifestyles
- Influence GP consortia to commission services to encompass prevention and early intervention as well as disease treatment
- Develop partnership working to impact on the wider determinants of health and health inequalities

The new public health function will have significant responsibilities for commissioning of health improvement services, for example, smoking cessation services. For some areas where prevention, screening and treatment are closely linked, such as sexual health, some form of joint commissioning approach with our GP consortia may be most effective. Likewise, there will be benefits in ensuring we capitalize on the expertise and experience of primary care trust and local authority commissioners working on the adults' and children's social care and drug and alcohol agendas.

Many functions within the local authority contribute to the health improvement agenda and we need to ensure that integration will deliver the required functions but avoid duplication and that the focus remains on early intervention and prevention. We need to aim to ensure best practice and value for money inform our commissioning and that the delivery of commissioned services is performance managed and evaluated appropriately.

2. Public health intelligence

Key roles
- Leading the Joint Strategic Needs Assessment (JSNA)
- Adding value to the existing 'intelligence function' within the council

Intelligence supports all public health functions. JSNAs will form the foundation of priority setting and inform a range of commissioning strategies and plans; they will help local people to hold providers and commissioners to account. The public health team has a number of specialists skilled in intelligence who currently support the JSNA programme as part of their roles; they will bring valuable expertise to the council's intelligence function. Some intelligence is being provided at a sector level.

3. Health protection

Key roles
- Ensuring effective infectious disease surveillance and outbreak management
- Ensuring effective infection prevention and control in NHS premises and non-NHS community settings (e.g. schools, care homes)
- Ensuring effective commissioning of immunization and screening programmes
- Contributing to effective emergency planning and ensuring NHS emergency resilience
- Contributing to partnership working on environmental health issues, community safety and injury prevention

North East and North Central London Health Protection Unit (NE&NCL HPU) currently provides expert advice to each local authority as well as surveillance of infectious diseases and health protection incidents to inform local action; timely investigation of incidents and trends of disease; and leading or contributing to prevention and control programmes. While clarity on the role of Public Health England in health protection provision at the local level is required, integration of the public health team into the local authority provides a real opportunity to develop multi-disciplinary environmental protection and emergency planning functions locally

We provide public health leadership for screening and immunisation programmes at sector level. The DsPH across the sector are currently identifying other areas for sector joint working, such as emergency planning and response.

4. Public health support for health and social care commissioning

Key roles
- Developing information solutions to assist joint commissioning
- Supporting health care (acute and community) and social care commissioning
- Ensuring that all components of clinical effectiveness and best practice are supporting commissioning process
- Contributing to a strong joint commissioning function between the GP consortia and local authority

The need for local organisations to work together in partnership more closely and effectively than ever before is integral to providing effective and targeted services to local people. The powers that enable joint working between the NHS and local authorities will be extended and new statutory Health and Wellbeing Boards will be expected to be in place by April 2012 to ensure that there is strategic oversight of health and care services and that joint working takes place when commissioning NHS, public health, and social care services.

The NHS makes a large (about 40% and relatively rapid) contribution to some conditions – such as cardiovascular disease – that are major contributors to health inequalities. Influencing NHS commissioning to reduce inequality is therefore important. Public health has considerable technical expertise and experience for health care commissioning; locally we have prioritised this with senior public health support and will continue to do so, proactively and as required.

Existing local NHS service providers include substantial health improvement roles, from health promotion to elements of more major services which deliver public health outcomes such as school nursing and health visiting. Arrangements for the

commissioning of these services are likely to need a strong joint commissioning function between GP consortia, public health and the local authority.

Decisions will also be needed about key joint commissioning arrangements for mental health and learning disabilities; children's and young people's services (including CAHMS) and long term conditions.

haringey strategic partnership

Meeting: **Well Being Strategic Partnership Board**

Date: **11 January 2011**

Report Title: **Experience Still Counts 2009-2012**

Report of: **Barbara Nicholls, Head of Adult Commissioning, Mental health and the Voluntary Sector Adult Culture & Community Services**

Purpose

To provide Board members with update on Experience Still Counts the quality of life strategy for older people.

Summary

Experience Still Counts is the Haringey Strategic Partnership's quality of life strategy for older people in the borough, including and involving all statutory partners, the third sector and older people themselves. It was widely consulted on with older people.

The delivery of the strategy is now monitored by the Older People's Partnership Board, and a sub-group was established to review the plan and develop a set of priorities.

I view of the fundamental changes that are happening in the Public Sector, particularly in the NHS, the Older People's Partnership Board has agreed that a Commissioning sub-group is established to drive, steer and contribute to service planning once the full details of the Comprehensive Spending Review are understood, using Experience Still Counts and its delivery plan re-prioritisation as a platform for discussion. The first meeting of this sub-group is in January 2011

Legal/Financial Implications

Public sector finances are reducing, and the role of the NHS and Adult Social Care in the delivery of public services will change. Budgets for 2011/12 have not yet been finalised for the key statutory partners – i.e. the Council and NHS Haringey. Delivery of the strategy will be dependent on working with older people in setting priorities over the next two financial years in the context of reducing public finances, whilst maintaining quality service delivery within the available resources.

Recommendations

That the WBPB notes the contents of the report, and the approach to ensuring

that older people's priorities are incorporated into commissioning plans
For more information contact: Name: Barbara Nicholls Title: Head of Adult Commissioning, Adult Culture & Community Services, Haringey Council. Tel: 020 8489 3328 Email address: barbara.nicholls@haringey.gov.uk

Background

The strategy was presented to the Well-being Partnership Board in May 2009, and was agreed at Council Cabinet in June 2009.

The delivery plan sets out ten outcomes, with a number of key initiatives under each of the outcomes, with progress achieved on the delivery of a significant number of the initiatives. However in order to ensure progress is maintained, agreed priorities for the next two financial years (for the remaining life of the strategy) is critical.

The strategy and delivery plan provide the platform with work against the outcomes progressing in other arenas. This includes for example, a completed review of the Older People's Partnership Board, increased engagement of Older People in personalisation (including using the innovative 'Reaching Out' programme to consult with older people on their domiciliary care needs and comment on the impact on of the transforming social care agenda), commissioning of a foot care service, development of a commissioning framework for the delivery of older people's mental health services, review and strengthening of the Safeguarding Adults Service, and the development of a volunteering strategy. Within this context of work being undertaken across the partnership, the Older People's Partnership sub-group's initial work plan considered achievements to date and areas where progress has been limited. From the latter the priorities for action for the remainder of Experience Still Counts 2009-2012 have been drafted, and will be considered in a newly established Commissioning Subgroup to the Older People's Partnership Board in January 2011.

Well-being Partnership Board members, including statutory and third sector partners are key to the successful delivery of the quality of life strategy, which is dependent on ownership from all stakeholders across the partnership. Engagement from statutory sector partners is particularly critical in terms of planning for the use of available resources in the coming financial years.

Use of Appendices

None

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Meeting: **Well Being Strategic Partnership Board**

Date: **11 January 2010**

Report Title: **NHS Haringey and Council: Approach to Performance Management**

Report of: **Arshiya Khan, Director of Professional Standards, NHS Haringey.**

Purpose: To update the Board on the approach to performance management taken by NHS Haringey and the Council.
Legal/Financial Implications N/A
Recommendations: That the report be noted.
For more information contact: Name: Arshiya Khan Title: Director of Professional Standards Tel: 020 8442 6697 Email address: arshiya.khan@haringey.nhs.uk

Background

NHS Haringey is responsible for managing independent contractors (General Practitioners, Dentists, Pharmacists and Optometrists) against their contracts. This is carried out through a number of established methods: regular contract review visits, audits and dashboards.

Queries have been raised about access to general practitioners (GPs) so this paper focuses on performance management of general practice.

Access and Targets

There have been well established targets around access to GPs which all practices in Haringey were meeting. These were:

- access to a GP within 48 hours, and
- access to a primary care professional within 24 hours.

Since June 2010 these are no longer targets for GP practices following the revisions to the Operating Framework for the NHS in England 2010/11 published by the Department of Health. These revisions are to reflect the government's ambition to move towards a health service focusing on quality and outcomes not processes, and with more devolved responsibilities.

Under access, the revised NHS Operating Framework for 2010/11 states:

"We intend to remove some process targets. This is not a signal that clinically unjustified waits are acceptable. Patients should still be able to expect the NHS to continue to deliver improvements in access and quality. It will remain important, for example, for patients with cancer or its symptoms, to be seen by the right person, with appropriate expertise, within the current performance standard timescales.

The Vital Sign and Existing Commitment relating to access to primary care will no longer be performance managed. This is not a signal that a deterioration of patients' experiences is acceptable and commissioners must ensure access reflects local need. "

Whilst there is no longer a target for access against which practices are being monitored, information on access is still being collected via the national GP Patient Survey. Practices who underachieve on the patient survey are monitored against individual action plans to demonstrate improvements.

Practices also have the opportunity to participate in a directed enhanced service for extended hours opening; this means that if they open additional hours outside the core hours of 8.30am – 6.30pm they can receive additional payments. The majority of practices in Haringey have opted in to this scheme.

Performance Monitoring

As referred to above there are a number of tools used for monitoring performance of practices.

All practices in Haringey have signed up to the General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contracts. There are certain standards in the contracts to which the contract holder must adhere, and these are reviewed through contract review meetings with the contract holder (usually a GP at the practice). If a practice is not meeting their contractual obligations they may be service a breach or remedial notice, or in severe situations a contract may be terminated.

A number of practices each year are audited against points claimed for their Quality and Outcomes Framework (QOF) by the North Central London Audit Service. If practices cannot produce evidence of points claimed then monies paid to them may be clawed back.

A dashboard has been developed to show how each practice is performing against national targets and local priorities. These are produced each quarter and shared with practices. They may be used as the basis for discussions with practices where NHS Haringey has concerns about performance, and support the contract review visits. Information from these dashboards will be published by NHS Haringey on our internet.

NHS Haringey has an escalation process for primary care performance where issues have been raised or concerns identified through any route, including the above routes. This is attached at Appendix 1.

APPENDIX 1

NHS Haringey Primary Care Escalation Process

NHS Haringey has developed a Primary Care Escalation Process as follows:

Identifying Under Performance:

- Regular monitoring and active contract management should allow NHS Haringey and Primary Care providers to work together and identify early signs of underperformance and consequently target where remedial action is required.
- Any concerning outcomes from contract reviews should be reported to the Independent Contract Performers Review Group (ICGRP) in the first instance, unless they are serious enough to warrant reporting to the Reference Committee (Ref Com).
- When a provider underperforms systematically or persistently then it may be appropriate for intervention under the contract.

Intervening to Support Recovery:

- Interventions should firstly be aimed at supporting recovery and actions taken should be proportionate to the risk presented.
- The main aim of intervention is to achieve recovery and it is assumed that with the correct level and method of intervention that this can be achieved in the majority of cases.
- If there is a repeated failure to meet targets or co-operate with the PCT, then intervention may be aimed at safeguarding patient safety and/or initiating action to procure services from elsewhere.
- The actions and measures taken should be proportionate to the scale of the underperformance.
- The type of interventions will vary, dependent upon the type of contract held with the provider, such GMS, PMS, APMS. However, common themes throughout are likely to include:
-
    - Meetings with Practice Managers/ all relevant staff to discuss targets and appropriate dispute resolution/escalation methods to adopt such as development and monitoring of action plans
    - Serving of a contract remedial notice and the required steps to take within a specified time period
    - Service of a breach notice; and
    - In more extreme circumstances a suspension or termination of all or part of the contract may be invoked.

- The appropriate type of intervention will also be dependant upon the level of underperformance. If a provider is underperforming in one area or against a specific target then the root of the issue is likely to be at a service level. However, if the underperformance is persistent or

systematic then this is likely to be as a result of a problem at an organisational level.

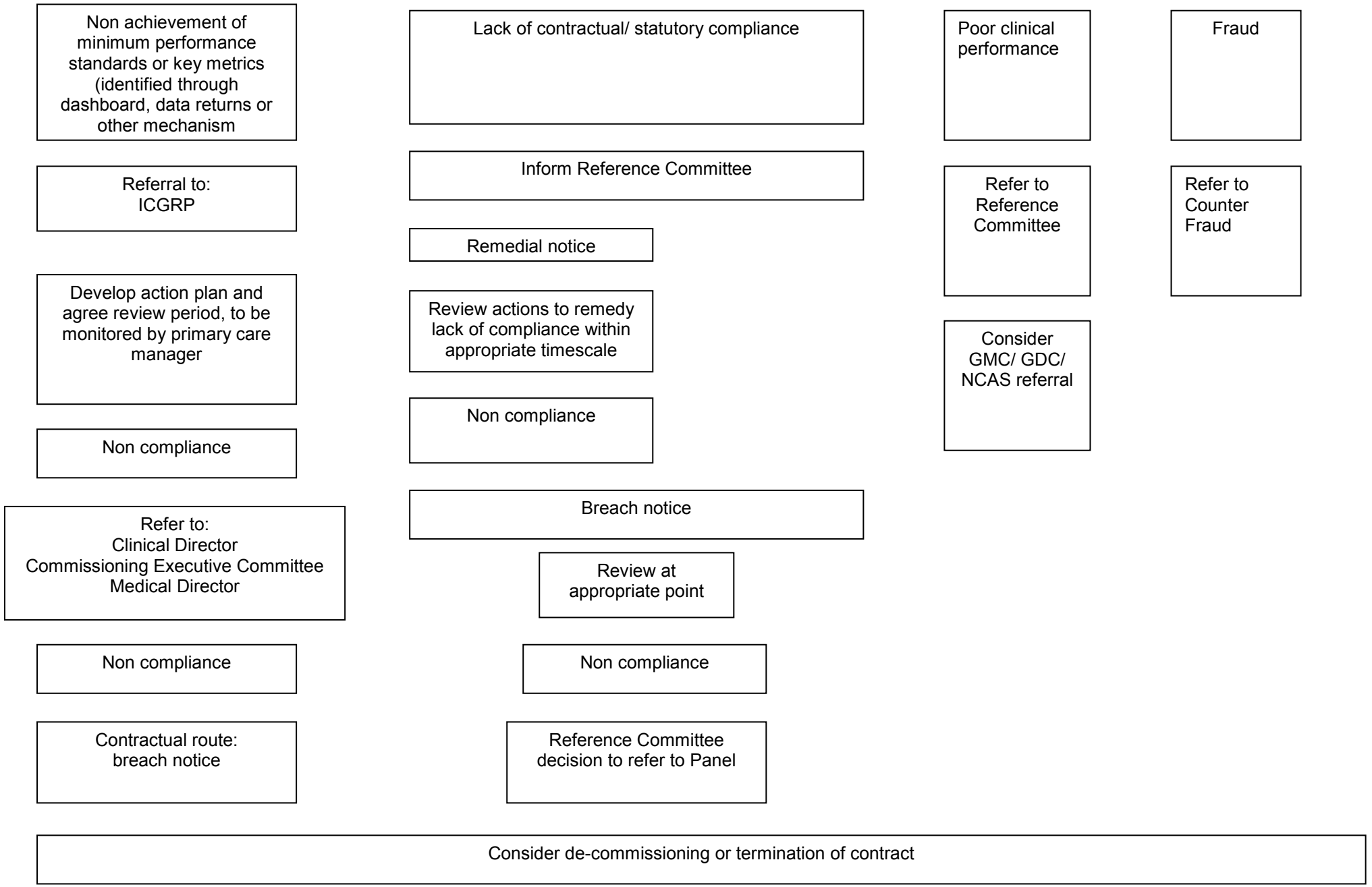
- A contract remedial notice will detail the improvements the PCT expects the Practice to make, sets out clear timelines for this to happen and details any contractual sanctions. An effective remedial plan may include responsibilities for both the provider and the commissioner. The plan could look to include offering external support organisations to address specific areas of underperformance concerning a provider.

Identifying and Recognising High Performance:

- NHS Haringey will place an emphasis on recognising and celebrating high performers who consistently reach standards across the dashboard.
- High performance providers may be asked to be role models and can provide peer support to other primary care providers.

Managing Provider Failure:

- In line with the recurrent theme throughout this framework NHS Haringey will develop a more consistent and transparent approach to managing failure through the performance management process.
- This will be supported by the PCT developing defined clear thresholds for intervention and taking action against providers that fail to address underperformance within a reasonable time frame.
- As part of the process the PCT will consider a range of options to ensure that patients are able to access high quality primary care services.
- Where a provider is unable to demonstrate recovery, the commissioner will need to consider disinvesting.


Non achievement of minimum performance standards or key metrics (identified through dashboard, data returns or other mechanism
Referral to: ICGRP
Develop action plan and agree review period, to be monitored by primary care manager
Non compliance
Refer to: Clinical Director Commissioning Executive Committee Medical Director
Non compliance
Contractual route: breach notice
Lack of contractual/ statutory compliance
Inform Reference Committee
Remedial notice
Review actions to remedy lack of compliance within appropriate timescale
Non compliance
Breach notice
Review at appropriate point
Non compliance
Reference Committee decision to refer to Panel
Poor clinical performance
Refer to Reference Committee
Consider GMC/ GDC/ NCAS referral
Fraud
Refer to Counter Fraud
Consider de-commissioning or termination of contract

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haringey strategic partnership

Meeting: **Well Being Strategic Partnership Board**

Date: **11 January 2011**

Report Title: **Performance Report**

Report of: **Director of ACCS & Director of Public Health**

Purpose

To provide the 2010/11 quarter two performance on national and local indicators within the Well-Being Scorecard.

Summary

This report shows that of the 14 PIs where data was available for Q2, 57.2% (8) were reported as green, 14.2% (2) as amber, 28.6% (4) as red and 51.7% (15) could not be reported as data was not available at the time of writing this report.

The Appendix 1 shows performance against all the indicators that the thematic board has agreed to overview**.**

The Appendix 2 provides an exception report focusing on those indicators that are performing below the target. These are:

- Drug users in effective treatment
- Immunisation rate for children aged 2 for MMR
- Percentage change in under-18 conceptions
- Temporary Accommodation

Legal/Financial Implications

None identified.

Recommendations

To note the report.

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1. Background

The Well-being Partnership Board (WBPB) is a strategic body forming part of the Haringey Strategic Partnership (HSP). The HSP has established six priority outcomes which are set out in the Sustainable Community Strategy. The WBPB is responsible for making sure that these outcomes and our LAA targets are achieved. This report provides the quarter 2 position of performance against 2010/11 targets and noting areas of concern.

2. 2010/11 Performance - Quarter 2 position

- Performance in the Number of adults permanently admitted into residential and nursing care indicator is very good as low number signifies good performance. As at end of quarter 2, 4 adults were placed permanently into a care home against a target of 8.

- 49 older people admitted into residential and nursing care as at end of quarter 2. Performance continues to be strong as this is below target of 57, putting us in a very good position to achieve the end of year target of 113. Again a low number of permanent admissions equals good in performance terms.

- Both the prevalence (NI 53a) and recording (NI 53b) of breastfeeding are performing well. In quarter 2, prevalence was 73.5% against a target of 68.1% and breastfeeding status at 95.3% against a target of 92.7%.

- 81.8% of vulnerable people achieved independent living as at end of quarter 2 against target of 79%.

- 11.9% of carers receiving a needs assessment or review (NI 135) for quarter 2 compared to 8.2% in quarter 1. Progress on this target has slowed in the last quarter, however due to problems experienced with Corelogic, (Adult Social Carer's database provider) the denominator figure is based on August's community figure and is inaccurate and performance unable to be accurately measured.

3. Appendices

3.1 Q2 Well-being scorecard – Appendix 1
Q2 Well-being Exception report – Appendix 2

Well-Being Board scorecard 2010-11 APPENDIX 1

PI Code	Performance Indicator	2009/10				Q1 2010/11				Q2 2010/11				2010/11				Latest Note
		Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	
L0114 LAA	Improved living conditions for vulnerable people ii) Number of older people permanently admitted into residential and nursing care - YTD (2007 -2010 LAA local stretch target)	114	115			27	28			49	57			62	75			
L0115 LAA	Improved living conditions for vulnerable people iii) Number of adults permanently admitted into residential and nursing care - YTD (2007 -2010 LAA local stretch target)	13	20			0	4			4	8			10	10			
L0221(LAA local)	% of HIV infected patients with CD4 count less than 200 cells per mm3 diagnosed (LAA local)		40.1%			Not measured for Quarters									27.95%			The latest data available is from 2009/10.
L0222 (LAA)	Immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella (MMR) (LAA local)	85.3%	85%			63.2%	85%			54.5%	85%				90%			Exception report available.
NI 7	Environment for a thriving third sector (LAA local)		21.9%			Not measured for Quarters									24.9%			Baseline measurement was conducted during Autumn 2008, and a follow up commences in Autumn 2010.
NI 08	Adult participation in sport and active recreation (2007-2010 LAA stretch target)		26.9%			Not measured for Quarters									27.9%			09/10 survey runs from Oct 09 - Sep 10 with results being published in Dec 10.

PI Code	Performance Indicator	2009/10				Q1 2010/11				Q2 2010/11				2010/11				Latest Note
		Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	
NI 35	Building resilience to violent extremism (LAA)	3	3			Not measured for Quarters									3			
NI 39	Rate of Hospital Admissions per 100,000 for Alcohol Related Harm (LAA)	1969	1224															Data for Q1 will be published in January 2011 and Q2 in March 2011. See: www.nwph.net/alcohol/lape/nationalindicator.htm
NI 40	Number of drug users recorded as being in effective treatment against 2007/08 baseline. (LAA)	39	135			26	135				135			35	135			Exception report available.
NI 51	Effectiveness of child and adolescent mental health (CAMHS) services (LAA)	15	15			Not measured for Quarters								16	16			
NI 53a	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants being breastfed at 6-8 weeks (LAA local)	70.3%	64.8%			75.46%	68.1%			73.5%	68.1%			73.5%	68.1%			
NI 53b	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants for whom breastfeeding status is recorded (as being totally or partially breastfed at 6-8 weeks that quarter) (LAA local)	92.8%	90%			96.2%	91.3%			95.3%	92.7%			95.3%	92.7%			
NI 56(x)	Obesity in primary school age children in Year 6: Line 10 (LAA)		24.0%			Not measured for Quarters									23.8%			
NI 112	Percentage change in under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline) (LAA)	-15.1%	-18.1%			-13.3%	-55.0%			-15.9%	-55.0%			-15.9%	-55.0%			Exception report available.

PI Code	Performance Indicator	2009/10				Q1 2010/11				Q2 2010/11				2010/11				Latest Note
		Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	
NI 113a	Prevalence of Chlamydia in under 25 year olds - Part 1 - Chlamydia screens/tests (LAA)	26.4 %	25.0 %			8.0 %	5.6 %			15.6 %	5.6 %			15.6 %	5.6 %			
NI 116	Proportion of children in poverty (LAA)		32.5 %			Not measured for Quarters									30.5 %			
NI 121	Mortality rate from all circulatory diseases at ages under 75 per 100,000 population (LAA)	86.42	94.00			Not measured for Quarters									93.00			The Final Mortality rate for 2009-10 as ratified by the CQC is 86.42. This is the average of the directly standardised death rate per 100,000 population for 2007, 2008 and 2009. NHS Haringey's target is 89
NI 123	Number of 4-week smoking quitters who attended NHS Stop Smoking Services	2103	2000			304	205							304	205			The latest data available is from Q1.
NI 125	Achieving independence for older people through rehabilitation/intermediate care (LAA)	82.6 %	82%							92.9 %	85%			94.1 %	85%			
NI 126	Early Access for Women to Maternity Services (LAA)	73.9 %	80.0 %			79.5 %	81.0 %			80.8 %	81.0 %			80.2 %	81.0 %			
NI 127	Self reported experience of social care users (measured by survey every 3 years)		66.1 %			Not measured for Quarters												The result from 2009-10 Equipment survey shows that 66.1% of service users felt that their equipment / minor adaptations made their life much better compared to 59.2% in 2007/08 survey, an increase 6.9%.
NI 135	% of carers receiving needs assessment or review and a specific carer's service, or advice and information - YTD (LAA)	21.2 %	19.2 %			8.2 %	5.8 %			11.9 %	11.6 %			14.9 %	15.5 %			The denominator figures have been changed for the months from April 2010 to October 2010, to match the PI definition by reflecting the number of service users receiving a community based service (4460). The previous figure provided was for the client base (5262).
NI 141	Percentage of vulnerable people achieving independent living (LAA)	77.4 %	77%			89.5 %	79%			81.8 %	79%			84.6 %	82%			

PI Code	Performance Indicator	2009/10				Q1 2010/11				Q2 2010/11				2010/11				Latest Note
		Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	
NI 149	% of Adults receiving secondary mental health services in settled accommodation (LAA)	88.0%	85.0%			83.0%	86.0%			85.0%	86.0%			88.0%	86.0%			
NI 153	% of working age people claiming out of work benefits in the worst performing neighbourhoods (LAA)		26.3%												23.7%			This target has been renegoatiated with GOL and is now based on maintaining the baseline gap between the Haringey and London rates - 0.6 percentage points. The latest data (four quarters to November 2009) show that the gap is currently 0.8 percentage points. Data for 2010/11 Q1 will not be available from the DWP until 2011.
NI 156	Number of households living in temporary accommodation (LAA)	3,547	3,552			3,454	3,310			3,341	3,073			3,305	2,915			Exception report available.
NI 175	Access to services and facilities by public transport, walking and cycling					Not measured for Quarters												Data not yet received from Transport for London.
NI 187a	Tackling fuel poverty – % of people receiving income based benefits living in homes with: (i) Low energy efficiency (LAA)	13.42%	12.53%			Not measured for Quarters									11.53%			This Indicator relates to the SAP ratings of homes occupied by vulnerable households. Data for the indicator was obtained from a postal survey form sent to 7,500 residents in the borough who were identified as being in receipt of either council tax benefit or housing benefit. The postal survey form used was that approved by DECC and is submitted with this form. Out of 7,500 survey forms sent out 462 were returned. The returned survey forms were then analysed using NHER Auto Assessor software, which calculates the SAP rating of each individual dwelling based on NHER Level O methodology and using between 15 and 25 data items. A small table is then produced detailing how many properties fell within the SAP bandings of interest, with this number then being expressed as a percentage. The entire exercise was undertaken for us by Creative Environmental Networks. The results for 2009/10 showed that 13.4% of vulnerable

PI Code	Performance Indicator	2009/10				Q1 2010/11				Q2 2010/11				2010/11				Latest Note
		Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	Value	Target	Status	Short Trend	
																		residents were living in homes with a poor SAP rating of less than 35 (compared to this year's target of 12.5%). The Affordable Warmth Strategy was launched in November 2009 and provides details on how we intend to reduce the incidence of fuel poverty in the borough. The four central tenets of the Action Plan are: 1) Engage with people to improve awareness and understanding of energy efficiency and fuel poverty 2) Increase the energy efficiency of Haringey's housing 3) Maximise resources and opportunities for tackling fuel poverty 4) Link to other strategies We have also secured a small amount (£42,500) of funding from the North London sub Region to enable us to survey and carry out such improvements as we can to the properties reported as having the lowest SAP ratings.
NI 187b	Tackling fuel poverty – % of people receiving income based benefits living in homes with: (ii) High energy efficiency (LAA)	16.23%	14%			Not measured for Quarters									15%			

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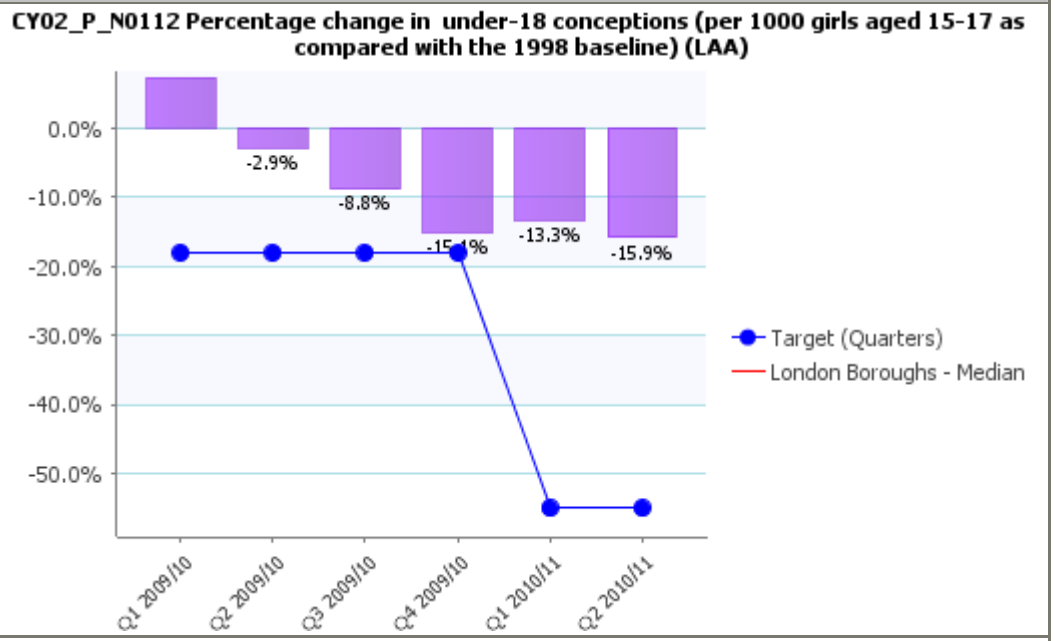
Wellbeing Theme Board Exception Report APPENDIX 2

NI 112	Percentage change in under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline) (LAA)

The change in the rate of under-18 conceptions per 1,000 girls aged 15-17 years resident in the area for the current calendar year, as compared with the 1998 baseline rate, shown as a percentage of the 1998 rate.

2009 - 2010			
	Value	Target	Status
2009/10	-15.1%	-18.1%	
	Value	Target	Status
Q1 2010/11	-13.3%	-55.0%	
Q2 2010/11	-15.9%	-55.0%	
2010/11	-15.9%	-55.0%	

Red



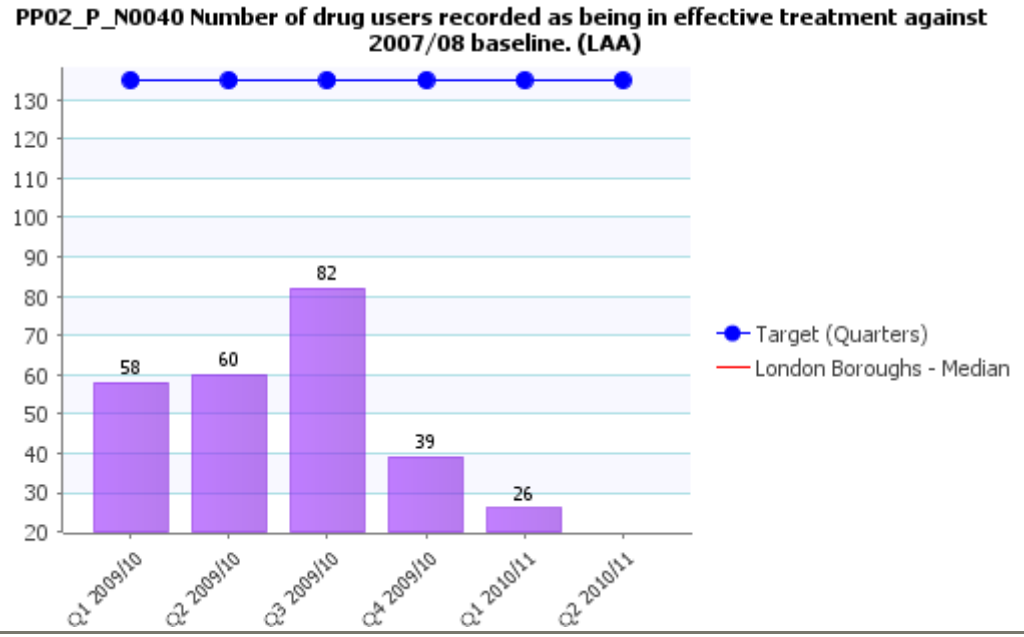
-15.9% is based on 2008 actual data. There were 52.4 conceptions per 1,000 in 2008 compared to 62.3 in 1998, the baseline year. This decrease was greater than the England average of -13%. The target for 2010 (2011-12) is to reduce the number of conceptions from the 1998 baseline rate by -55% (28 per 1,000 conceptions). Work on reducing teenage conceptions and teenage pregnancies and supporting teenage parents is overseen by the Teenage Pregnancy Executive Board. A Teenage Pregnancy Prevention and Support Strategy 2010 – 2013 is under development.

NI 40	Number of drug users recorded as being in effective treatment against 2007/08 baseline. (LAA)

This indicator shows the change in the total number of drug users, using crack and/or opiates recorded as being in effective treatment, when compared with the number of drug users using crack and/or opiates recorded as being in effective treatment in the baseline year of 2007/8.

2009 - 2010			
	Value	Target	Status
2009/10	39	135	
	Value	Target	Status
Q1 2010/11	26	135	
Q2 2010/11		135	
2010/11	35	135	

Red



Performance relates to the 12 month period between July 2009 and June 2010.

Although there was a short surge of new clients in Q1, the projection show only 26 more clients in effective treatment by Sept (YTD) in comparison to same time last year.

The projection for Q2 shows Haringey is 33 clients below the YTD target. The projection is done by looking at the number of new clients in Q2 and applying the percentage in effective treatment in Q1 to the Q2 cohort. Considering we are starting from a lower baseline for missing the target last year, the end of year performance for 2010-11 will be a challenge.

In the monthly performance meetings with the treatment agencies it has become apparent that most new clients are using cannabis and not crack or opiates, including clients reached through Probation and Mental Health services. Those who do use crack or opiates are already familiar with drug treatment services in Haringey. In this context it should be also be noted that the number of new clients in contact with drug treatment rose from the baseline 807 in 2003-4 to 1468 in 2008-9 (82%) But the increase has stalled since 2009-10 (1418 during last year). This can be expected since many more would have received treatment whilst the sector grew in size and funding. The National Drug Treatment Agency also reports that nationally the number of younger people coming to treatment are no longer using crack or opiates to the same extent.

Conversely, the percentage of clients in effective treatment has continuously improved (from 83% in Sept 2009 to 86% in Sept 2010). Clients completing treatment successfully (ie drug free) YTD is at 49% in comparison to 32% in London (and up from 41% from the same time last year).

DAAT and the commissioned agencies are working hard to find new clients eg. by:

* Engagement and access steering group (chaired by Eban, treatment agency in the North East of Haringey)
* CRI (agency who diverts drug using offenders into drug treatment) is working closely with Probation to engage more clients, however most use cannabis and are also reluctant to disclose drug use.
* BUBIC extended outreach in the evenings but they report that the last two months have been very quiet
* A worker at A & E in North Middlesex is doing outreach to refer clients to both alcohol and drug treatment
* Training sessions with GPs so that they can better identify drug and alcohol use (eg. related to depression) and refer to appropriate services
* Dual is doing outreach with mental health teams

Also, the performance is monitored monthly and actions discussed at the performance monitoring group chaired by the DAAT.

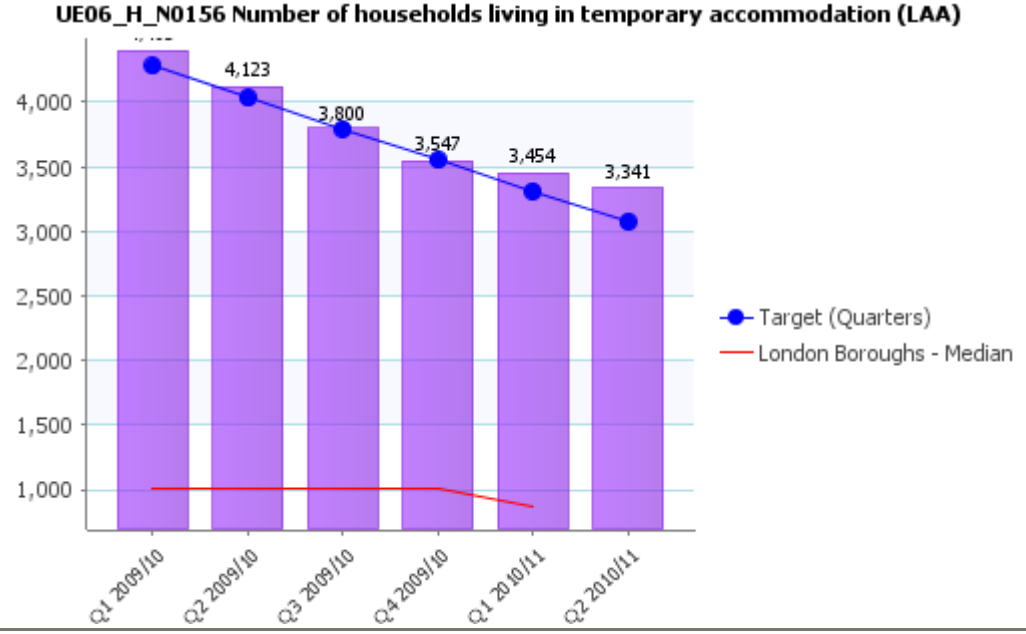
Figure accurate as at October 2010 report (Published on www.ndtms.net. This is a live dataset therefore figures may change month by month if there are any subsequent corrections to data).

NI 156	Number of households living in temporary accommodation (LAA)

This indicator measures the numbers of households living in temporary accommodation provided under the homelessness legislation.

2009 - 2010			
	Value	Target	Status
2009/10	3,547	3,552	
	Value	Target	Status
Q1 2010/11	3,454	3,310	
Q2 2010/11	3,341	3,073	
2010/11	3,305	2,915	

Red



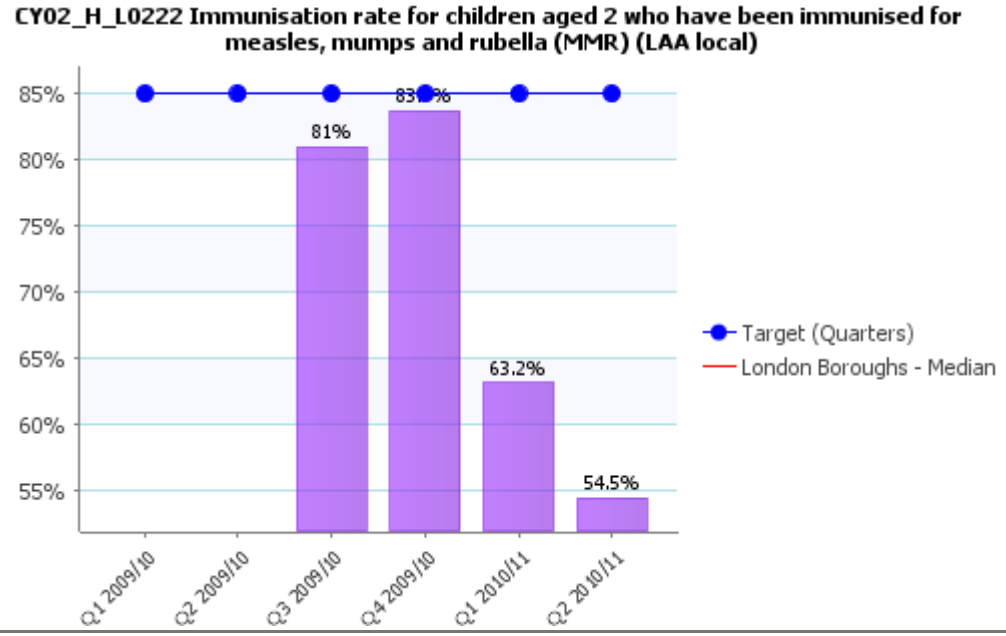
Work to reduce numbers in TA continues. There have been particular problems in the last quarter in securing alternative supply in the private sector. This has meant that more households have had to remain in temporary accommodation. Efforts are continuing to secure alternative supply which will assist the continued drive to reduce numbers, although this is becoming increasingly difficult as suppliers continue to explore the market for a range of options.

L0222 (LAA)	Immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella (MMR) (LAA local)

2009 - 2010			
	Value	Target	Status
2009/10	85.3%	85%	

	Value	Target	Status
Q1 2010/11	63.2%	85%	
Q2 2010/11	54.5%	85%	
2010/11		90%	

Red



Due to the existing manual data collection process not all immunisation records were collected in Q1 or Q2 which resulted in the drop in performance seen in the graph above. A automated data extraction tool is being purchased to ensure 100% data collection which will improve rates and provide mechanism to monitor and drive improvement through targeted performance management and support.

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haringey strategic partnership

Meeting: **Well Being Strategic Partnership Board**

Date: **11 January 2011**

Report Title: **Update from Partnership Board Subgroups**

Report of: **Lisa Redfern, AD Adult Services & Commissioning**

Purpose To provide an update the Well Being Partnership Board about key highlights and activities for each of the Adult partnership boards over the last quarter.
Summary Haringey has well established Adult Partnership Boards. The purpose of this report is to summarise the key issues and highlights form the five boards over the last quarter.
Legal/Financial Implications Not applicable.
Recommendations That the Well Being Partnership Board notes the contents of the report.
For more information contact: Name: Lisa Redfern Title: Assistant Director, Adult Services & Commissioning Tel: 020 8489 2324 Email address: lisa.redfern@haringey.gov.uk

1. Background

There are five Partnership Boards (or Steering Groups) that meeting regularly including:

- Mental Health Partnership Board
- Older People's Partnership Board
- Carers Partnership Board
- Learning Disabilities Partnership Board
- Autism Spectrum Disorder Steering Group

2. Mental Health Partnership Board key highlights

At the last meeting of the Mental Health Partnership Board (MHPB) in November, the Board discussed the following key items:

- Barnet Enfield Haringey Mental Health Trust (BEHMHT) Transformation programme: a presentation was received about nine areas of the programme including: forensic services, CAMHS, Community Mental Health Teams, Continuing Care, Eating Disorders, Crisis Houses, Substance Misuse, Dementia Care Pathways and Brain Injury Recovery;
- Implementation of personalised care in mental health services – the board noted the development of a pilot scheme;
- Progress report on the actions within the Delivery Plan of the Joint Strategic Mental Health Strategy was tabled and noted; and
- The celebration of World Mental Health Day in Haringey was noted.

Older People's Partnership Board key highlights

The Older People Partnership Board (OPPB), most recently meet on 15th December 2010.

- The Council and NHS Haringey Joint Older People's Mental Health and Dementia Commissioning Framework was received at the meeting, agreed and formally launched;
- NHS Haringey provided a general update about changes affecting them, including the centralisation of many PCT functions into North Central London NHS;
- An update report was received from and OPPB member who is also on Haringey LINk, including concerns about the breadth of responsibilities that the new HealthWatch will have from 2012;
- Adult Social Care advised that the Council is still analysing the Comprehensive Spending Review (CSR) implications, following the detailed announcements made on 13th December about the Council's actual cash settlement. A subgroup to the OPPB is to be established in early January 2010 to look at the implications of the CSR on commissioning for older people, including working through older people's key priorities from Experience Still Counts.

There was also a special meeting convened in November for the OPPB to consider the implications of the Coalition Government's NHS White Paper on changes to the NHS and what it can do to look after the interests of older people the new NHS arrangements.

The key points from the discussion and for the OPPB to consider include:

- Create a mechanism by which, through the OPPB, the voices of older people are heard by GP commissioning consortia, HealthWatch and the Health and Wellbeing Board;
- Identify what is key, what is working well now, what should we hold on to and how we can build on these areas across Health and Local Authority services and agencies; and

- How best we can support older people in Haringey and work with / benefit from new policies and arrangements once the new structure for Health and Haringey Council becomes clearer?

Carers Partnership Board key highlights

In August 2010, the Carers Partnership Board (CPB) had an away day to identify its top four priorities for the next year. Carers and other members of the CPB identified the following areas as its priorities: Carers Assessments, Respite Care (planned and emergency), Carer Awareness and Community and Publicity and Engagement.

At the away day, the carers on the CPB elected Marylyn Duncan as Carer Co-Chair to chair meetings alongside Lisa Redfern. The Board also reviewed its membership and has invited representatives from Adult Learning, Leisure Services, PALS – Whittington and North Middlesex Hospitals, Housing and Haringey Guarantee to attend future CPB meetings.

At the last meeting of the CPB in November, the Board was updated on the following areas of work:

- Carers assessment and carers awareness training for social workers, care managers and care coordinators and importance of carers being part of the training to help build relationships and breakdown barriers between carers and professionals:
- Members of the Board from CYPS – Young Carers Service, the DAAT and Adults Commissioning have also been involved in developing a presentation on to raise awareness of carers within the community and health services. The Board will receive a draft copy of the presentation at the January meeting; and
- The development of branding for the CPB. The Board agreed that *Supporting and recognising the contribution of carers in our community* was a suitable strap line for the CPB. This will be used on publicity material from the New Year.

Learning Disabilities Partnership Board (LDPB) key highlights

There is ongoing work to ensure the LDPB is accessible to all people and to increase the number of carer and champion representatives. The format of the meeting have been developed to increase accessibility and to enable all participants to have their say.

Delivery groups under the LDPB include: Our Rights, My Service @18, 'Where I live', 'Getting Older', 'What I do during the day and evening', and 'Keeping Healthy'.

Other areas of work that the LDPB has been working on include:

- Hate Crime - significant progress has been made this year with the campaign initiated and driven by our rights delivery group against Hate Crime;
- Carer's respite - consultation on a range of respite options for users and carers. This is to support choice and control re personalisation;

- Day opportunities Re-provision **-** This year a large day service at the Keston site has been modernised and re-provided in keeping with objectives of Valuing People Now. There has been considerable capital investment in developing small community bases;
- Transition of young people - Work in this area has focused on improving transition pathways for young people. A transition policy, protocols have been developed through engagement and consultation with young people and their families; and
- Keeping Healthy – development of a health framework aimed at improving health outcomes for people with learning disabilities, complex health needs and autistic spectrum disorders. Significant progress to-date has included and more than 100% increase in the number of people with learning disabilities who have an annual heath check. Research is currently on-going to determine the outcomes for people.

Autism Spectrum Disorder (ASD) Steering Group key highlights

The Autism Steering Group has signalled a preferred model of care that would be acceptable to service-users and carers;

The partners concerned in establishing a model for ASD include: service-users, carers, parents, Local Authority staff, staff of health trusts, education providers, and independent providers of accommodation; and

Consultation of members of the ASD Steering Group in Haringey took place in September 2009. The consultation reported in December 2009 that carers and statutory agencies staff preferred a model of a stand-alone service. Work is currently on-going to develop these proposals.

Other areas of work that the Steering Group have been working on include:

- Specialist ASD training - ASD specialist training is well underway with very positive feedback to date from attendees;
- Specialist Housing **-** Work I ongoing to develop specialist ASD and LD housing in borough. Housing and Adult social care submitted a paper to the capital assets ad strategy board which outlined the proposal to develop LD and autism specific housing on the Keston site;
- Personalisation and social Inclusion **-** The Haringey Autism new Thursday adult autism/Aspergers drop in service at the Bounds Green Scout Park starts on March 2011. This development has been spearheaded by development of an autism consortium, which is aiming to develop in borough social opportunities; and
- Keeping Healthy - The Haringey Assessment and intervention Team part of an outreach community health development has now started to take referrals. The primary role of the team is to work with people at serious risk of mental health breakdown or at risk of serious breakdown of services because of behaviours that people find challenging.

Use of Appendices

None