Haringey Council

Health and Wellbeing Board

TUESDAY, 8TH APRIL, 2014 at 13:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE.

MEMBERS: Please see attached Membership list.

AGENDA

1. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

2. APOLOGIES

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 14).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. QUESTIONS, DEPUTATIONS, PETITIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

6. MINUTES (PAGES 3 - 20)

To consider and agree the minutes of the meeting of the Board held on 7 January and the special meeting of the Board on 11 February.

7. OUTCOME 3 DELIVERY GROUP UPDATE (PAGES 21 - 24)

Report of the Director of Public Health to provide an update to the Board with regards to progress from the outcome 3 delivery group.

8. HEALTH AND WELLBEING BOARD STRATEGY 2015-19 (PAGES 25 - 32)

Report of the Director of Public Health for the Board to agree the plan to refresh the current Health and Wellbeing Board Strategy (2012-2015).

9. EARLY ACCESS TO MATERNITY SERVICES (PAGES 33 - 52)

Report of the Director of Public Health to provide the Board with information about the profile of women who book late for maternity services and highlight the significance of early access to the health of mothers and infants.

10. PRESENTATION OF THE IMMUNISATION AND SCREENING DATA FROM NHSE

Report of NHS England to update the Health and Wellbeing Board on performance of Immunisation and Screening programmes in Haringey.

TO FOLLOW

11. HEALTHWATCH PROGRAMMES (PAGES 53 - 78)

Report of HealthWatch Haringey, setting out the Strategy and Work Programme for 2014/15.

12. LSCB ANNUAL REPORT (PAGES 79 - 130)

Report of the Interim Director of Children's Services.

13. AUTISM INCLUDING SELF-ASSESSMENT (PAGES 131 - 148)

Report of the Director of Adult and Housing Services to brief the Health and Wellbeing Board on Haringey's response to the Autism Strategy 2010 and to monitor the planning, commissioning and review of services for people with autism.

14. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at item 3 above.

15. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

Members of the Board are invited to suggest future agenda items.

The dates of future meetings are as follows:

- 8 July 2014, 1.30pm
- 30 September 2014, 6.30pm
- 13 January 2015, 1.30pm
- 21 April 2015, 6.30pm

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Monday, 31 March 2014

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Agenda Item 1

Membership of the Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	2	Cabinet Member for Health and Adult Services	Cllr Bernice Vanier (Chair)
			Cabinet Member for Children and Young People	Cllr Ann Waters
	Officers' Representatives	3	Director of Adult social Services	Mun Thong Phung
			Interim Director of Children and Young People's Services	Lisa Redfern
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	Chair	Dr Sherry Tang
			GP Board Member	Dr Helen Pelendrides
			Chief Officer	Sarah Price
			Lay Member	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	Interim Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	Interim Representative	Gill Hawken

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Agenda Item 6

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 7 JANUARY 2014

Members Fitzroy Andrew (Chief Executive, HAVCO), Libby Blake (Director of CYPS, LBOH), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Sharon Grant (Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Dr Helen Pelendrides (Chair, Haringey CCG), Mun Thong Phung (Director of Adults and Housing, LBOH), Sarah Price (Chief Office, Haringey CCG), Dr Sherry Tang (GP Board Member, Haringey CCG), Cllr Bernice Vanier (Chair - Cabinet Member for Health and Adult Services, LBOH) and Cllr Ann Waters (Cabinet Member for Children, LBOH)

Apologies Councillor Helen

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL56.	**APOLOGIES** Apologies for absence were received from Helen Pelendrides. The Board thanked Fitzroy Andrew for all his work on the Board as the HAVCO representative, and wished him the best of luck for his future work. Confirmation of the new HAVCO representative on the Board was awaited.	
CNCL57.	**URGENT BUSINESS** The Chair admitted two new items of business for discussion under agenda item 13.	
CNCL58.	**DECLARATIONS OF INTEREST** There were no declarations of interest.	
CNCL59.	**QUESTIONS, DEPUTATIONS, PETITIONS** There were no such items.	
CNCL60.	**MINUTES** **RESOLVED** That the minutes of the meeting held on 8 October 2013 be approved and signed by the Chair. It was agreed that Lisa Redfern and Sharon Grant would pick up the action from the previous meeting for a discussion of Healthwatch support for safeguarding work outside the meeting. Jeanelle de Gruchy would also look into the arrangements for inviting Healthwatch to future Haringey Stat sessions – it was confirmed that no	LR/SG JdeG

	Haringey Stat sessions relating specifically to health matters had been held since the previous meeting, although other topics had been covered.	
CNCL61.	**PERFORMANCE HIGHLIGHT REPORT** The Board considered the report and a tabled briefing note on Childhood Obesity in Haringey – 2013, as presented by Jeanelle de Gruchy, which covered the following issues: • It was noted that the relatively small numbers in Haringey meant that there was greater fluctuation in the figures for year to year. • The Board noted the close link between childhood obesity and deprivation in Haringey, which was also reflected in the geographical variations for the borough. Links between childhood obesity, ethnicity and gender were also noted. • Childhood obesity remained a priority area for action, and it was noted that there had been significant media attention on this issue since the publication of the last annual public health report. • The briefing note gave an overview of current activity aimed at reducing childhood obesity in Haringey. The following points were raised by the Board in discussion of this issue: • It was confirmed that headline findings from the research into fast food were now available, and that a launch event for the findings was scheduled to take place in June 2014 and would involve Haringey schools. Work was also taking place with schools on implementing the actions arising from this research. It was noted that planning and environmental services within the Council were also undertaking work regarding the proliferation of fast food outlets in the borough. • With regard to school meals, it was felt that there was an opportunity to influence what was provided and to drive towards a healthy meals policy in all Haringey schools. Cllr Waters advised that there had been proposals to commission out the school meals service, but this had been withdrawn following the Government's announcement on expanding free school meals until more was known about the funding that would be provided. In the meantime, a working group had been established to support schools in delivering the changes with free school meals. • The Board agreed that it was important for health and lifestyle issues to be factored into the Council's regeneration strategy. • Emotional health and wellbeing needed to be acknowledged as an important factor in considering childhood and adult obesity, and this was something that was often overlooked. It was noted that emotional health and wellbeing, including issues such as anxiety and bullying, formed a part of the work with schools around the issue of obesity. • It was emphasised that a whole family approach was essential, and this was supported by the important work taking place with Early Years and Children's Centres.	

	With regard to the overall performance summary report, the Board asked about the additional red mark on the figure for those successfully completing drug treatment, and it was agreed that Jeanelle de Gruchy would clarify whether this was an error on the report. It was suggested that the report to the next meeting of the Board should focus on this measure. A query was also raised regarding the mortality rate for suicide and undetermined injury, and it was agreed that this should also be followed up.	JdeG
CNCL62.	**DELIVERY GROUPS UPDATE REPORT** The Board considered the update report on the work of the delivery groups, as presented by Jeanelle de Gruchy, and noted the dates of the forthcoming seminar for Outcome 2 on 21 January 2014 and for Outcome 3 on 5 March 2014.	
CNCL63.	**PRIMARY CARE DEVELOPMENT - UPDATE** The Board considered the update report on primary care development, as presented by Sarah Price. It was noted that the CCG was working with GP practices as partners within this process, and adopting a developmental approach. Update on progress was contained within section 5 of the report, and it was reported that the aim was to move towards more integrated models of care. There was a need to protect and retain what was good about the current GP practice model, but to make improvements where possible; the progress made in respect of IT and pilot programmes for increasing access were working towards these changes. Sherry Tang added that another key issue for GP practices was the constraint of their existing physical premises, and that developmental work with GP practices needed to address the issues of premises. The Board covered the following points in discussion of the report: • The Board asked whether patients had been involved in trialling initiatives such as the Minor Ailments Scheme and Doctor First, and whether they had had the opportunity to be involved in evaluation of the schemes. It was noted that Minor Ailments was an established scheme, but that Doctor First was just starting in those practices that had chosen to use it, and evaluation had yet to take place. It was felt that patients should have a role in any evaluation of the scheme, and Sharon Grant advised that Healthwatch may be able to assist in facilitating this. • With regard to the way in which these schemes were promoted, it was reported that there had been a campaign and publicity materials produced, however further work was taking place to spread information via community groups in order to reach those who would not necessarily respond to a standard publicity campaign. The importance of communicating changes and initiatives to all patients equally, in order to ensure that no groups were disadvantaged as a consequence, was emphasised.	

	• The Board noted that different groups wanted to access health services in a wide variety of ways, and that it was important to offer a diverse range of options. • Concern was expressed that it may be the most vulnerable patients who ended up using channels such as the Minor Ailments Scheme and Doctor First, rather than receiving a full face to face consultation with a GP, and asked whether there were associated risks. With regard to Minor Ailments, it was reported that pharmacists worked to a set protocol and would always refer a patient to their GP for matters that were beyond their competency. With Doctor First, GPs recognised that there was the potential for increased risk from telephone consultations and adopted a cautious approach, particularly where patients were not fluent in English, were elderly or had learning difficulties; different thresholds were therefore adopted for vulnerable groups. • The CCG had developed a local quality dashboard, to be updated quarterly, in order to help practices monitor their performance and compare it against targets and peer performance. The CCG locality directors and clinical leads were working with practices to support their development, and to facilitate joint working and learning opportunities between different practices. • It was reported that National Health Service England (NHSE) were attending the special meeting of the Board in February, and it was agreed that this would be a good opportunity to ask them about their perspective on this work, and their current and future role. • In response to a question from the Committee, it was confirmed that the £5m identified for primary care development as set out in the report was for Haringey only, but was spread over the three-year period 2013-15.	
CNCL64.	**HARINGEY ADULT SOCIAL CARE LOCAL ACCOUNT 2012-13** The Board considered the report on the 2012/13 Haringey Adult Social Care Local Account, as presented by Mun Thong Phung. It was a requirement that the Council publish its local account annually, in an easy to read format accessible to all residents, and this was the third such document produced. The report outlined the Council's adult social care activities during 2012/13, and included lots of feedback from service users. For the coming year, it was noted that there would be closer work between the Council and health partners with the introduction of the Better Care Fund (BCF) – a report on this would be brought to the next meeting of the Board on 11 February. The Board welcomed the content and readability of this year's local account.	
CNCL65.	**HOMELESSNESS AND HEALTH** The Board received a presentation on the health needs assessment of homeless in Haringey (Appendix A), delivered by Sarah Hart.	

	The following points were raised by the Board in discussion following the presentation: • The Board asked whether there was scope for a pan-London specialist team model to be explored, such that boroughs with less demand could buy in from a specialist unit such as the one operated in Westminster. • The Board noted that the requirement to provide photographic ID was a barrier for homeless people seeking to register with a GP, and asked how this issue could be addressed. It was noted that GPs would require approval from NHSE to accept alternative forms of ID, such as a letter from a hostel, and it was suggested that this was an issue that could be asked of NHSE directly. • Queenswood Practice, located on Park Road, Hornsey was known as being particularly good with regard to services for homeless patients and it was suggested that they be contacted regarding how they resolved the problem of patients requiring photographic ID to register. It was noted that Queenswood might operate a walk-in model that was more suited to homeless patients, rather than registering them on an ongoing basis. • The Board discussed the complex issues around those without recourse to public funds, and the current status of migrants from the EU. It was agreed that greater clarity was required in order to fully understand this issue and that further information on this should be brought back to the Board. • It was suggested that other north London boroughs be asked how they handled commissioning in relation to health services for the homeless, and that this question could be raised through the North London Strategic Alliance. • In addition to the work reported with the London Fire Brigade, it was suggested that Network Rail and the Canal and River Trust be approached for possible information on the location of rough sleepers. • It was agreed that there was a need for further discussion on this issue, and that a further report should be brought back to the Board. It was also suggested that a workshop session involving all stakeholders involved in this issue would be useful, with one of the outcomes to focus on the advice and information that all partners were providing to the homeless. It was further suggested that there should be a link between this work and the current scrutiny review on mental health. The Board welcomed the quality of the presentation and research in this area.	JdeG
CNCL66.	**NHS SCREENING AND IMMUNISATION PROGRAMMES** The Board considered the report on NHS screening and immunisation programmes, as presented by Tamara Djuretic. It was noted that commissioning responsibility for screening and immunisation programmes had transferred to NHSE, with Public Health England (PHE) taking an advisory role. It was further noted that performance in	

	this area had not been negatively affected during the transition of responsibilities. The following points were raised by the Board in discussion of the report: • In response to a question from the Board regarding whether there were any screening programmes that were not currently operated locally that may be of benefit to the local population, it was reported that all screening programmes that were currently available nationally were also available in Haringey. • The Board asked about the scope to target programmes according to local need. As programmes had previously been managed locally, there had been significant scope to target programmes according to the needs of the local population; while most of these programmes had continued as before since the transition to NHSE, it was important to receive assurance on an ongoing basis that programmes continued to run in a suitable format that met the needs of the population in Haringey. • In response to concern raised regarding the absence of data on screening programmes since the transition, it was reported that it was now necessary for data to be validated before it could be published publicly (for example in a report to the Board) although that data could be accessed. The Board was asked how regularly performance data should be reported up, and it was agreed that it would be appropriate for data to be provided to the Board on a quarterly basis. The CCG and GPs would require information more frequently, for example on a monthly basis, depending on the programme being reported on. It was noted that a key factor in the usefulness of the data was that it be updated and provided in a timely manner. It was suggested that these points could be fed back to NHSE when they attended the Board in February, and it was reported that ongoing discussions were being held with NHSE at a London-wide level in order to keep this issue live. • It was agreed that the first formal performance report from NHSE should be requested for the 8 April 2014 meeting of the Board, with quarterly updates thereafter.	JdeG
CNCL67.	**NEW ITEMS OF URGENT BUSINESS** The Chair admitted two new items of urgent business. <u>2014/15 NHS Planning Briefing</u> Sarah Price advised the Board of the guidance around CCG planning, with CCGs to produce 5 year strategic and 2 year operational plans. The 2 year CCG funding allocations had been published on 18 December 2013, and a timetable for the development of strategic and operational plans was proposed as follows: • Draft 2 year plan to HWB for approval 11 February 2014 • CCG to submit draft 2 year plan to NHSE 14 February 2014 • BCF plan to be submitted 15 February 2014 • Final 2 year plan and draft 5 year plan to be circulated by email to	

HWB Members for approval/information 1 – 15 March 2014
- CCG GB to approve draft 5 year plan and final 2 year plan 26 March 2014
- CCG to submit draft 5 year plan and final 2 year plan 4 April 2014
- HWB to discuss the submitted draft of the 5 year plan 8 April
- CCG to submit final 5 year plan 20 June 2014

The Board noted the proposed timetable.

Strategic Regeneration for Tottenham

The Chair advised that this would be an item on the agenda for the special meeting on 11 February, but asked the Board to approve the establishment of a working group to consider the proposed response in advance of the meeting. The Board agreed to this approach.

Steve Hitchins, new Chair of Whittington Health, was introduced to the meeting and was welcomed to his new post by the Board.

The meeting closed at 15:25hrs.

Councillor Bernice Vanier

Chair

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MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 11 FEBRUARY 2014

Members — Robin Charnley (Partnership and Policy officer, HAVCO – substituting for Pamela Pemberton), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Sharon Grant (Interim Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Mun Thong Phung (Director of Adults and Housing, LBOH), Sarah Price (Chief Officer, Haringey CCG), Lisa Redfern (Interim Director of CYPS, LBOH), Cllr Bernice Vanier (Chair - Cabinet Member for Health and Adult Services, LBOH) and Cllr Ann Waters (Cabinet Member for Children, LBOH)

Apologies — Dr Helen Pelendrides (GP Member, Haringey CCG), Pamela Pemberton (Interim Chief Executive, HAVCO), Dr Sherry Tang (Chair, Haringey CCG)

Also present — Helen Chapman (Principal Committee Coordinator, LBOH), Zina Etheridge (Interim Deputy Chief Executive, LBOH), Victoria Wyatt (Senior Lawyer, LBOH).

MINUTE NO.	SUBJECT/ DECISION	ACTION BY
HWB68.	**APOLOGIES** Apologies for absence were received from Sherry Tang, Helen Pelendrides and from Pamela Pemberton, for whom Robin Charnley was acting as substitute.	
HWB69.	**URGENT BUSINESS** There were no new items of urgent business.	
HWB70.	**DECLARATIONS OF INTEREST** There were no declarations of interest.	
HWB71.	**BETTER CARE FUND (BCF): LOCAL HEALTH AND SOCIAL CARE INTEGRATION PLAN** Sarah Price and Mun Thong Phung introduced the report on the proposed Better Care Fund (BCF) Health and Social Care Integration Plan, developed jointly by the Council and CCG, as set out in the report circulated. • The BCF would consist of a pooled budget, worth £3.8bn nationally, to be deployed locally on health and social care, and would aim to deliver transformational change towards more integrated health and social care services. • It had been determined that the initial focus of the work in 2014/15 would be older adults, with priority for those who were frail or suffering from dementia. From 2015/16, it was the intention to extend the focus of the work to all adults with mental health	

issues.

- For 2014/15, Haringey's allocation of the BCF would be £957k, in the form of a transfer from the CCG to the Council.
- For 2015/16, the value of the BCF would rise to £18m as a pooled budget, the precise nature of which was still to be set out in guidance. It was emphasised that this money was not new funding, but represented existing commissioned services.
- One of the aims of improving integration was to prevent service users having to repeat their stories to a range of different professionals by working in a joined up manner. It was also noted that there would be an increased role for the third sector.
- A successful event had been held with service users, and it was noted that continuing to engage with residents and service users was an essential part of the work. A reference group had already been established to continue the commitment to user engagement.

The following points were raised by the Board in discussion of the item:

- The Chair noted that this work was critical for Haringey, where work had already begun on moving towards greater integration of services. It was noted that a report on the BCF would be considered by the Council's Cabinet on the evening of 11 February, and that the Integration Plan would then be submitted to the Department of Health.
- It was felt that this was exactly the type of work that the Board should be looking at in terms of strategic direction, and the report was broadly welcomed and supported by Board members.
- It was noted that Healthwatch were very supportive of the proposals, but it was requested that consideration be given to having a separate identified workstream for patient / user engagement set out under ways of working for April 2014 – March 2015 (paragraph 6.20 of the report) and also to Healthwatch forming part of the Integrated Management Board as set out in paragraph 6.30. It was agreed that both of these issues would be looked into. — SP / MTP
- In response to a question regarding Outcome 5 of the contingency plan – patient / service user experience – and how this would be measured, it was agreed that local, deliverable measures around this area would be developed.
- It was suggested that engagement with Healthwatch could help to reduce some of the risks as identified in the risk log at paragraph 6.46 of the report, and it was agreed that consideration would be given to this point. — SP / MTP
- In response to a question regarding value-based commissioning, it was agreed that it was intended that there be a strong focus on this, and that elements of the Plan could be reworded if it was not felt that this was coming through with sufficient emphasis. — SP / MTP
- It was noted that, at paragraph 6.31 of the report, reference was made to the Chief Executive of Healthwatch being a member of the Health and Wellbeing Board, whereas this should read the Chair of Healthwatch. It was agreed that this would be corrected. — SP /

	• In response to a question from the Board, it was confirmed that the BCF funding would be ring-fenced. **RESOLVED** That the Health and Wellbeing Board: i) Approve the Integration Plan, as set out in Appendix 1 to the report, in readiness for its submission to NHS England on 14 February 2014. ii) Note that Haringey Clinical Commissioning Group's Governing Body considered and agreed the Integration Plan as set out at Appendix 1 to the report on 30th January 2014. iii) Note that Cabinet will consider the final Plan as agreed by the Health and Wellbeing Board at its meeting on 11th February 2014. Cllr Waters left the meeting at 2pm, at which point the Chair advised that the meeting was no longer quorate and could not therefore proceed formally. The meeting continued on an informal basis only after this point. The notes of the informal part of the meeting are appended.	MTP

Councillor Bernice Vanier

Chair

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Notes of the informal Health and Wellbeing Board – Tuesday 11 February 2014

Members of the HWB: Robin Charnley (Partnership and Policy officer, HAVCO – substituting for Pamela Pemberton), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Sharon Grant (Interim Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Mun Thong Phung (Director of Adults and Housing, LBOH), Sarah Price (Chief Officer, Haringey CCG), Lisa Redfern (Interim Director of CYPS, LBOH), Cllr Bernice Vanier (Chair - Cabinet Member for Health and Adult Services, LBOH) and Cllr Ann Waters (Cabinet Member for Children, LBOH)

Also present: Helen Chapman (Principal Committee Coordinator, LBOH), Zina Etheridge (Interim Deputy Chief Executive, LBOH), Victoria Wyatt (Senior Lawyer, LBOH).

Tottenham Strategic Regeneration Framework

Malcolm Smith (Interim Programme Director, Tottenham – LBOH), introduced the emerging Tottenham Strategic Regeneration Framework and sought feedback on the draft document.

- The Framework would be going to Cabinet for approval in March 2014 and, if approved, the intention would be to start working on the priority areas straight after the May elections.
- Mr Smith indicated that the main area where more focus was needed was the 'people' aspect. The health inequalities issues across different areas of Haringey was known, and this document should focus on addressing key underlying issues such as improving wellbeing and raising aspirations.
- Physical regeneration also had significant role to play in health and wellbeing issues, and the sense of 'place', how spaces were looked after and managed, all needed to be looked at.
- Mr Smith advised that colleagues working in health and social care both within the Council and partners were being asked what they felt the toughest areas to get right were, within the framework.

The following points were raised during the discussion of the item, and in response to questions:

- It was noted that every aspect of regeneration had an impact on health and wellbeing, for example housing, employment, health services, GPs and developing resilient communities.
- It was suggested that the draft Framework was currently a bit light on health and wellbeing aspects at the moment, and the fact that health partners were being consulted about the developing draft was welcomed. In response to concerns that health issues were not yet strongly represented in the draft, Mr Smith advised that a key challenge was to identify key deliverable targets for strategic outcome 1 'Build a strong, safe and healthy community' so that the final document did contain a detailed plan for how this would be achieved.
- Mr Smith advised that he did not feel it would be easy to achieve strategic outcome 1, but that the Council would be looking for 3 to 6 key interventions that would have the best chance of having an impact on some of the social

issues identified. These key interventions had not yet been identified, and the intention was for the advice of colleagues and partners to help guide towards those that could have the greatest impact. It was noted that there was a complicated network of issues that needed to be addressed – it was not possible to pinpoint a concern such as 'health' and try to tackle this in isolation.

- It was suggested that health impact assessments should be carried out on key policies and programmes to assess their health and wellbeing impact.
- Officers from the Council and CCG confirmed that they intended to work with the Council's Regeneration team as part of the Better Care Fund work.
- It was suggested that the Health and Wellbeing Board should have a role within the governance structure for the Tottenham regeneration programme, and it was agreed that this should be the case, although further discussions would be needed outside the meeting regarding what form this should take.
- It was agreed that the Health and Wellbeing Board needed a clear outline of the process for developing this framework, and a timetable setting out where the document was going, and the points at which the Board would have the opportunity to have input. It was felt that the Board needed to be involved in the development of the document, and was in a position to offer robust challenge around health and wellbeing aspects. The way forward on this would be discussed outside the meeting.

Action: Cllr Vanier, Jeanelle de Gruchy, Malcolm Smith

NHS Planning – draft 2 year plan

Sarah Price (Chief Officer, Haringey CCG) presented a tabled report on the CCG's draft 2 year operating plan, covering the first 2 years of the 5 year strategic plan for 2014/15 – 2018/19.

- It was noted that it was important for the draft plan to align with the Council's Health and Wellbeing Strategy. The aim was to increase the focus and effectiveness of primary care services for residents, and to transform services particularly around mental health, life expectancy and services for young people.
- As part of the transformation of services and the move towards integrated working arrangements, consideration needed to be given to questions such as who else the CCG needed to be working with, and how they could work differently.
- It was important to look at how to engage communities in a more innovative way, for example making use of new technologies.
- There was a need to look at new models for primary care, for example with GP practices working together in new ways to deliver services jointly.
- The 2-year plan needed to deliver services to NHS standards, with a focus on quality. Outcomes included reducing emergency hospital admissions, addressing mental health needs and increasing levels of patient satisfaction.

The following points were covered in discussion, and in response to questions:

- In response to a question submitted by the public: *'What assessments have been made of the other health facilities (e.g. child health clinics, dental care, urgent/out of hours care, mental health clinics and beds) which will be needed by the additional population and where will these be provided?'* it was reported that this would be addressed by a combination of physical use of buildings, and different ways of working. GPs were keen to work in a more networked way, which would mean access to primary care in a different way, and there was also the potential to use children's centres, etc, in order to deliver primary care services, rather than just traditional GP surgeries.
- It was suggested that the wording around integration and joint working could be strengthened in the Plan, in order to convey a stronger sense of partnership working.
- It was noted that one of the benefits of working in a more integrated way was that it gave the ability to identify areas where earlier intervention would be beneficial; Sarah Price advised that this was a key driver of the Plan, and that the wording would be reviewed to see how this could be brought out more.

Action: Sarah Price

NHSE Performance in Primary Care

Vanessa Lodge, Director of Nursing, Central and North East London, NHS England, spoke about NHSE performance in primary care. A copy of the presentation was attached to the agenda for the HWB meeting.

- It was noted that NHS England was now a national organisation, which was a significant change from the previous model of local PCTs; performance lists were now held nationally, and there was also now a requirement for all GP practices to be compliant with the CQC.
- There was a need for all GPs to undertake an appraisal for revalidation, and a mechanism was in place to undertake the appraisals.

The following points were raised in discussion and in response to questions:

- There was concern that the CCG had responsibility for improving quality in primary care, but that NHSE held the information regarding GP performance. Information around concerns or complaints about GP performance was felt to be held by NHSE until such time as this could be made public. Ms Lodge advised that there was a need for NHSE to discuss with the CCG how best to share information related to concerns related to the concerns.
- Four questions had been received from the public as follows:
  a) Would you agree that the planned development of around 10,000 extra homes in Tottenham under the current regeneration plans will require between 14 and 19 GPs, or between 3 and 5 average sized GP practices, to serve the additional population?
  b) What steps are being taken, and by whom, to ensure that adequate premises will be available for the new GPs who will be needed?

c) How will the HWB and/or the CCG ensure that additional GPs actually do come and practice in the area to serve the additional population?
d) What assessments have been made of the other health facilities (e.g. child health clinics, dental care, urgent/out of hours care, mental health clinics and beds) which will be needed by the additional population and where will these be provided?

- In response to question a) it was reported that this was not an uncommon situation, and that processes were in place regarding the way in which patients would register with GPs.
- In response to question b), it was noted that this was a question of capital allocations, and that information on this would be provided after the meeting.

Action: Vanessa Lodge

- In response to question c), it was noted that there had not historically been a problem encouraging GPs to work in London, but that there was a need to ensure that the right people were performing the right roles for them, and this was being addressed as part of the performance framework.
- In response to question d), it was reported that there was a need to make the most of existing facilities for the local population, and that additional detail on this point could be provided after the meeting.

Action: Vanessa Lodge

- A question was raised around what happened if problems were identified in respect of a GP practice by the CQC. It was reported that the CQC would advise NHSE immediately, and would then prepare a report for the GP practice concerned, which would also be published online. CQC would undertake a follow-up visit within three months of the last-dated action identified in the report to ensure that required actions had been implemented. It was noted that there was no formal system in place for liaising with the CCG. It was suggested that Vanessa Lodge speak to the NHSE about ensuring that there was some mechanism in place for the CQC to advise the CCG of issues more routinely.
- In response to a question around how the CQC chose practices to visit, it was reported that this was random, except for where specific concerns had been raised about a practice. Before planning where to visit, all available intelligence was taken into consideration.
- The system for making complaints about a GP was felt to be very complex, and Ms Lodge was asked whether it would be possible to feed back to NHSE and/or the CQC that there was a need to make the system easier for the public to understand. Ms Lodge advised that training with GP practices had been arranged to improve local capacity for dealing with complaints, but agreed that she would feed this back.

Action: Vanessa Lodge

- With regard to complaints, it was further suggested that there be a specific NHSE workstream around getting information out to the public about how to make feedback about the services they received, and informing people about the revalidation programme and it was agreed that this suggestion would be fed back to NHSE.

Action: Vanessa Lodge

- In response to a question regarding the connection between information held by Healthwatch, NHSE and the CQC, it was reported that Healthwatch was a member of NHSE's quality surveillance groups, and would raise issues via this route. It was not known what form of relationship there was between Healthwatch and the CQC. Concern was expressed that Healthwatch was not listed in the presentation as one of NHSE's sources of information when it should be. It was confirmed that Healthwatch would be gathering information regarding GP performance, and would feed this directly through to NHSE.
- In response to a question regarding where the responsibility for strategic planning for primary care lay, it was reported that this was something that needed to be looked at further.
- The member of the public who had submitted questions in advance of the meeting, spoke to express concern regarding the mechanisms in place to ensure that there were sufficient premises for GP practices to meet the demand from new homes being built, and also for making GPs aware of the new opportunities being developed. Ms Lodge advised she would take these concerns back to NHSE, and then report back on the mechanisms to address these issues. It was felt that the way in which services was delivered was as important as delivering the right level of services.

  Action: Vanessa Lodge
- It was suggested that there should be an NHSE representative on the Health and Wellbeing Board, as primary care commissioning was not currently represented. It was agreed that this would be looked into.

  Action: Cllr Vanier, Jeanelle de Gruchy
- Cllr Vanier thanked Vanessa Lodge for attending the meeting, and for agreeing to come back for a future meeting.

The informal meeting closed at 3.30pm.

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Agenda Item 7

Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	

Title:	DELIVERY GROUP OUTCOME 3 - UPDATE REPORT

Report Authorised by:	Jeanelle de Gruchy, Director of Public Health

Lead Officer:	Jill Shattock, Director of Commissioning, Haringey CCG

Ward(s) affected: ALL	Report for Key/Non Key Decisions: N/A

1. **Describe the issue under consideration**

   Three Health and Wellbeing Board Delivery Groups have been set up to cover each of the specific outcomes from the Health and Wellbeing Board's Strategy 2012-2015. These are:

   - Outcome 1: Giving every child the best start in life.
   - Outcome 2: Reducing the life expectancy gap.
   - Outcome 3: Improving mental health and wellbeing.

   This report provides an update to the board with regards to the progress from the outcome 3 delivery group.

2. **Cabinet Member introduction**

   N/A

3. **Recommendations**

   Members are asked to note, discuss and comment on the key points that arose from the recent HWB seminar.

   Multiple barriers to recovery were identified from the patient perspective mainly due to the fragmentation and communication issues between partner agencies and it is

Haringey Council

important that HWB members continue to support all partners to contribute to the improvements necessary.

4. Alternative options considered

N/A

5. Background

5.1 Mental health and recovery

The aim of outcome 3 is to support all residents in Haringey to enjoy the best possible mental health and wellbeing and have a good quality of life. Improved treatment and support techniques now mean a much more positive, independent; outlook for many people with mental health conditions can be achieved.

Recovery focussed care means that the emphasis is on enabling people to live as independently as possible with more control over their care and less reliance on services. The key tenets of this model are to support people to:

- manage their own lives
- maintain stronger social relationships
- achieve a greater sense of purpose
- acquire the skills they need for living and working
- improve their chances in education
- achieve better employment rates
- maintain a suitable and stable place to live.

5.2 Highlight report

i. Most actions from the outcome 3 delivery plan have now been completed.
ii. The group has met to scope out commissioning arrangements across health and social care and a full mapping exercise is well underway.
iii. Discussions have commenced concerning the potential to revise commissioning arrangements in light of new organisation structures.

Priorities for 14/15

iv. Full refresh and update of the delivery plan to ensure patient “flow” issues are highlighted and action plans are in place to resolve.
v. Development of a joint CCG and LBH Mental Health Framework to set the longer term vision and strategy for commissioning mental health services; the Public health team are leading on developing the framework that will then form the basis for the HWBB strategy refresh.
vi. Discussions to conclude concerning strengthening commissioning arrangements.

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The HWB Outcome 3 seminar was held on 5th March 2014; this built on the initial "gap analysis" seminar in September and focussed on gaining the strategic sign up from partner organisations to the progress towards a recovery model of care and shared the work to date around value based commissioning for mental health .

A wide range of partners attended including health, social care and housing, providing good contributions from all participating organisations/directorates.

The workshop consisted of a mix of presentations and group discussions, including very powerful messages from service users past and present and many ideas for how to improve services on the ground.

Key points:

- A self-assessment will be carried out to assess current progress against the "ImROC Ten Challenges Tool", this will provide an opportunity to clearly assess and prioritise development needed locally towards a recovery model.
- Staff training and organisational leadership are necessary and important at all levels to embed a recovery model of care across all organisations.
- The importance of looking at the full patient pathway to identify "flow" problems, e.g. the presentation from the recovery house identified significant issues with moving people on successfully as per protocol due to lack of onward options.
- Forward planning for ongoing housing stock and the lead in times for the creation and development of sustainable supported housing options.
- Forward planning at a patient level and the importance of care co-ordinators being appointed quickly and planning for discharge from the day of admission.
- Better communication between all agencies, in particular between the Trusts and benefits/housing when patients are admitted.
- Resources are needed for self -support and prevention, voluntary and third sector organisations are key partners for this.
- Commitment to strengthening future commissioning arrangements and supporting the value based outcomes work.

All the discussions reinforced that mental health issues become fragmented very easily due to the number of organisations involved and contributing, this increasingly leads to the risk of people falling between the cracks unnecessarily and patient pathways becoming blocked through "flow".

Detailed work has already begun to address the rising levels of delayed transfers of care (DTOC); Haringey, as a borough, has the highest number and a group meets weekly to action at patient level. Additional housing officers are being appointed to assist with the case work needed.

6. Comments of the Chief Finance Officer and financial implications

There are no financial implications arising directly from this paper.

Haringey Council

7. **Comments of the Assistant Director of Corporate Governance and legal implications**

   The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications arising out of this report

8. **Equalities and Community Cohesion Comments**

   N/A

9. **Head of Procurement Comments**

   N/A

10. **Policy Implication**

    The Health and wellbeing strategy aims to improve the health and wellbeing of children and adults in our borough and reduce health inequalities between the east and west of the borough. The main objective of this Delivery Group is to delivery Outcome 3 of the strategy: 'to improve mental health and wellbeing'.

11. **Reasons for Decision**

    For Information only

12. **Use of Appendices**

    N/A

13. **Local Government (Access to Information) Act 1985**

    None

Agenda Item 8

Haringey Council

Report for:	**Health and Wellbeing Board**	**Item Number:**	

Title:	**HEALTH AND WELLBEING STRATEGY (2015 – 2018)**

Report Authorised by:	**Jeanelle de Gruchy, Director of Public Health**

Lead Officer:	**Andrew James, Public Health**

Ward(s) affected: ALL	**Report for Key/Non Key Decisions:** **Non Key**

1. Describe the issue under consideration

The current Health and Wellbeing Strategy is for 2012– 2015. The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish a Health and Wellbeing strategy and therefore needs to agree a plan to develop a further strategy for the period 2015 – 2018. The Health and Wellbeing Board is asked to agree an indicative timetable for work on the 2015 – 2018 strategy to commence.

2. Cabinet Member introduction

Inequalities in health typify Haringey. With some exceptions, Haringey is divided east to west by enormous differences in wealth, opportunity and life expectancy. Some of the richest wards in the UK are located in the west, while the east contains several of the country's most deprived communities. Haringey's Health and Wellbeing Strategy, with its three priorities of giving every child the best start in life; tackling the life expectancy gap; and improving mental health and wellbeing, has been a key strategy in delivering the Health and Wellbeing Board's overarching objective to improve the health and wellbeing of residents and tackle the profound health inequalities in the borough.

We have the opportunity through the next year, to not only continue to deliver our strategy, but also to evaluate what we have achieved to date and, with residents and other key stakeholders, consider and plan our priorities from 2015.

Haringey Council

3. Recommendations

The Health and Wellbeing Board is asked to approve the draft timetable as set out at section 6 and Appendix 1 to this report and commence project work.

4. Alternative options considered

No other alternatives have been considered. The production of the Health and Wellbeing Strategy is a legal requirement.

5. Background

5.1 The current Health and Wellbeing Strategy is for 2012 – 2015. The Board is clear in its roles and responsibilities and how their duties interrelate to improve the health and wellbeing of Haringey's residents. The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy.

5.2 The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment (JSNA) and other related needs assessments. Although the HWB Strategy and JSNA are separate work streams, with the latter updated on a rolling basis, it is in the devising, upgrading and publishing of the strategy, based on the JSNA, that the board has the biggest impact in fulfilling its roles and responsibilities including:

- The Board has a responsibility to set a strategic framework for its statutory duties and have a key role in promoting and co-ordinating joint commissioning and integrated provision between the NHS, social care and related children's and public health services in Haringey.

- The Board will advise on effective evidence based strategic commissioning and decommissioning intentions for children and adults based on the JSNA's robust analysis of their needs. It will ensure that commissioning plans are in place to address local need and priorities, in line with the Health and Wellbeing Strategy, and will deliver an integrated approach to the planning and delivery of services.

- There is a requirement for residents and those working in the borough to participate in the JSNA and Health and Wellbeing Strategy development.

- To review how far the Clinical Commissioning Group has contributed to the delivery of any Health and Wellbeing Strategy to which it was required to have regard.

- The Board will oversee the delivery of our strategic outcomes for local health and wellbeing targets, holding those responsible to account.

Haringey Council

- The Board work with the local health scrutiny process and the local Healthwatch to improve outcomes for communities and people who use services.

5.3 The new strategy should build on the current Health and Wellbeing Strategy (2012 – 2015) as continuity of delivery is important in managing long term issues. It is important to measure its impact by comparing what we knew about Haringey in 2012 against the same information in 2014/15. There are lessons to be learnt in terms of what works and what did not work so well which require to be reflected in the new strategy. In 2013/2014 the HWB established Delivery Groups to deliver on its outcomes which can deliver part of the review.

5.4 The strategy will also need to take into account current developments that impact on residents' health and wellbeing, such as the effects of austerity and in particular, how this strategy could support delivery of the socio-economic regeneration of Tottenham and health and social care integration.

5.5 The steps related to strategy development and management are:[1]

1. Identification and justification
2. Development of strategy
3. Approval of strategy
4. Implementation and Delivery
5. Communication
6. Monitoring and review.

6. Draft Plan

6.1. April – July 2014

6.1.1. Project Commencement

6.1.1.1. To identify and develop a Health and Wellbeing Strategy Steering Group

6.1.2. JSNA Stage

6.1.2.1. To instruct the JSNA steering group to produce a report by 31st July 2014 on the issues facing Haringey today.

6.1.2.2. To develop and undertake a consultation programme, via HealthWatch, with the residents and citizens of Haringey to identify their concerns and ideas on what should be in the strategy to report back by 31st July 2014.

[1] Guide to policy and strategy development in Haringey, Policy and Equalities Team, London Borough of Haringey. Feb 2013

Haringey Council

6.1.3. The Review Stage

6.1.3.1. To develop an information group to produce a report by 31st July 2014 on how the data compares between 2012 and today from the strategy.

6.1.3.2. To instruct each delivery group to produce a report by 31st July 2014 on the lessons learnt, the successes and what did not work.

6.1.3.3. To develop a consultation programme, via health Watch, that captures the views of children, adults and their carers about the services they receive to report back by 31st July 2014

6.2. August 2014. - September 2014

6.2.1. The Compilation stage

6.2.1.1. To hold a workshop in September with stakeholders to assemble the draft strategy

6.2.1.2. To identify outcome delivery work streams in early September 2014

6.3. October 2014 – January 2015

6.3.1. The Development Stage

6.3.1.1. To develop outcome delivery plans by 15th November

6.3.1.2. To complete assembled draft of the strategy by 30th November 2014

6.3.2. Communication Stage

6.3.2.1. An Equalities Impact Assessment of the proposals in the strategy is required which will be completed by 31st January 2014

6.3.2.2. There will be required a further public consultation requirement on the draft strategy to be completed by 31st January 2014

6.3.3. Approval Stage

6.3.3.1. During December 2014 comments will sought on the draft strategy from HWB, CCG Board and other stakeholder boards. Members of the Local Authority (Directors' Group, Cabinet and Full Council) will be involved in the development of the strategy.

6.4. February 2015 – March 2015

6.4.1. Approval Stage

6.4.1.1. Approval for final strategy with plan required from HWB, CCG Board, Local Authority (Directors' Group, Cabinet and Full Council) and other stakeholder boards

6.5. April 2014 – July 2015

6.5.1. Communication Stage

6.5.1.1. Communication will be on going throughout the project.

6.5.1.2. Public involvement will be in the Review Stage and Development stage

Haringey Council

6.5.1.3. There will be required communication of the final agreed strategy to residents, citizens and stakeholders April 2015 – July 2015.

7. Comments of the Chief Finance Officer and financial implications

There are no financial implications arising directly from this paper. All activities and services delivered under the Health and Wellbeing Strategy will be funded from existing Public Health, Social care and Health Resources.

8. Comments of the Assistant Director of Corporate Governance and legal implications

8.1 The Assistant Director Corporate Governance has been consulted in the preparation of this report.

8.2 In accordance with section 196 Health and Social Care Act 2012 and sections 116 and 116A Local Government and Public Involvement in Health Act 2007, the Health and Wellbeing Board is required to prepare and agree the Joint Strategic Needs Assessment (JSNA) and joint Health Wellbeing Strategy (HWB Strategy). There are no specific legal implications arising out of this report.

9. Equalities and Community Cohesion Comments

9.1 The main areas of the board's work relating to the Public Sector Equality Duty under the Equality Act 2010 are the JSNA and the development of our Health and Wellbeing Strategy which will be subject to an Equalities Impact Assessment.

9.2 The needs of people and communities, particularly those most vulnerable will continue to be made explicit in our updates of the JSNA and Health and Wellbeing Strategy as well as prioritised in the council's Corporate Equality Objectives. Equality Impact Assessments will be undertaken on specific thematic, condition or population based health and wellbeing related strategies.

9.3 It will be important for the HWB to consider all individuals in shaping policy and have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out its activities.

9.4 To help the HWB do this, mechanisms to ensure the views of children, adults and their carers about the services they need are taken into account in the delivery of those services must be put in place. This should be in addition to ensuring that the views of patients and the public have a voice through HealthWatch.

10. Head of Procurement Comments

N/A

Haringey Council

11. Policy Implication

The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy.

12. Reasons for Decision

The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy.

13. Use of Appendices

Appendix 1: Prospective Timetable for Health and Wellbeing Board Strategy

14. Local Government (Access to Information) Act 1985

None

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Appendix 1

Appendix 1: Prospective Timetable for Health and Wellbeing Board Strategy

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
JSNA Stage															
Review Stage															
Compilation Stage															
Development Stage															
Approval Stage															
Communication Stage															
Implementation Stage															

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Agenda Item 9

Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	

Title:	Performance report: Early access to maternity services

Report Authorised by:	Jeanelle De Gruchy, Director of Public Health

Lead Officer:	Sheena Carr/Mia Moilanen, Public Health Directorate

Ward(s) affected:	Report for Key/Non Key Decisions:
All	N/A

1. Describe the issue under consideration

Booking late for antenatal care is a significant public health issue as maternal and perinatal deaths and complications are higher in women who book late.[i] Early access predicts, prevents and manages problems with women and/or the unborn babies. Encouraging women to book for antenatal care within 13 weeks of pregnancy is therefore a focus for the priority to reduce infant mortality within the Haringey Health and wellbeing strategy.

This paper and the enclosed presentation outline the latest local performance, which is below London and England averages. The purpose is to provide information about the profile of women who book late and highlight the significance of early access to the health of mothers and infants.

2. Cabinet Member introduction

N/A

3. Recommendations

The HWB is asked to:

- note current performance against the target

Haringey Council

- support the promotion of early access to maternity services particularly amongst women from groups previously identified as booking late.

4. Alternative options considered

N/A

5. Background information

The NICE guideline for antenatal care[ii] recommends that pregnant women should receive a complete assessment (booking appointment) by 12 weeks gestation (12 weeks and 6 days), but ideally by the 10th week.

The aim of this appointment is to ensure:

- an early assessment of the physical, psychological and social status of the pregnant women in order to reduce the risk of complications
- that women have access to the full range of screening programmes, and
- planning of care throughout pregnancy.

Performance summary

- Despite improvements since 2010/11, Haringey's early access rate is still behind London and England, and below the national target (at 77% in 2012/13 against 90% target).
- There are strong links between late bookings and deprivation.
- Half of young women under 20 are still booking after 13 weeks.
- Timely data is lacking with some inconsistencies in methodologies.

Research with local Black African communities, commissioned by public health, identified faith and superstition as key barriers to early access. Work is currently underway with the voluntary and community sector to identify innovative approaches to promote early access to maternity services.

The public health grant in 2014/15 will be used to develop an early years community champions service to work with local community organisations, faith groups and children's centres to promote early maternity access and to signpost to maternity services. Materials have been produced in specific community languages based on findings from health equity audits which can support the community health champion role. In addition, a DVD will shortly be available, targeted at Black African women, to promote the importance of early antenatal care.

The CCG Board considered its role as commissioners at their March Board meeting. They focused on their ability to influence early access through monitoring:

- the quality of care and facilities by acute hospitals
- practice level data, incl. GP referrals to booking times.
- that pregnant women with complex social factors are provided for. in accordance to best practice[iii].

6. Financial Implications and comments of the Chief Finance Officer

Haringey Council

There are no new financial implications arising directly from this report. The ongoing work to improve early access to maternity services is funded from the public health grant and by CCGs commissioning arrangements.

7. Comments of the Assistant Director of Corporate Governance and legal implications

The Assistant Director Corporate Governance has been consulted on this report. There are no specific legal implications arising from this report.

8. Equalities and Community Cohesion Comments

This paper and the enclosed presentation address inequalities in early access to maternity services with reference to research on black African women commissioned by Haringey Public Health[iv]. No Equalities Impact Assessment has been undertaken, but public health have undertaken health equity audits to understand inequities in access to maternity services.

9. Head of Procurement Comments

N/A

10. Policy Implication

This paper and the enclosed presentation supplement the information in Haringey JSNA (Joint Strategic Needs Assessment) Maternity section and link with the following national evidence base and guidelines:

- The Confidential Enquiry into maternal and Child Health (CEMACH). Perinatal Mortality 2007. London: CEMACH, 2009
- NICE guideline for antenatal care (external link)
- NICE Clinical Guideline 62. Antenatal Care: routine care for the healthy pregnant woman. NICE March 2008

Encouraging women to book for antenatal care within 13 weeks of pregnancy is therefore a focus for the priority to reduce infant mortality within the Haringey Health and wellbeing strategy.

11. Reasons for Decision

N/A

12. Use of Appendices

Appendix 1: Early access to maternity services - Performance update presentation

13. Local Government (Access to Information) Act 1985

Haringey Council

N/A

[i] Confidential Enquiry into maternal and Child Health (CEMACH). Perinatal Mortality 2007. London: CEMACH, 2009
[ii] NICE Clinical Guideline 62. Antenatal Care: routine care for the healthy pregnant woman. NICE March 2008
[iii] CG110 Pregnancy and complex social factors: full guideline

[iv] (Chinouya M., Madziva C., (2012) Black African women and the antenatal booking appointment in Haringey)

Early access to maternity services



Haringey performance – HWB meeting 8 April 2014

Haringey Public Health

Haringey Council

“What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.” *(Marmot, 2010)*

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Giving every child the best start in life

To reduce the risk of complications, it is important that women have access to:

- an early assessment of their physical, psychological and social status
- full range of screening programmes, and
- planning of care throughout pregnancy

Early access to maternity services is a key indicator for reducing infant mortality in Haringey's Health and Wellbeing Strategy

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Women at risk

Generally, women at risk of poor obstetric and neonatal outcomes:

- are obese
- smoke
- misuse drugs and/or alcohol
- are recent migrants, refugees, asylum seekers, and with little or no English
- are aged under 20
- are experiencing domestic abuse

Early access predicts, prevents and manages problems with women and/or the unborn babies

Source: *Saving Mothers' Lives*

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The target and performance

90%

of women to see a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices before 12 weeks 6 days of pregnancy but ideally by the 10th week.

Current full year performance (Haringey 2012-13):

77%

Source: NHS England, Maternity Data (last accessed 13 March 2014)

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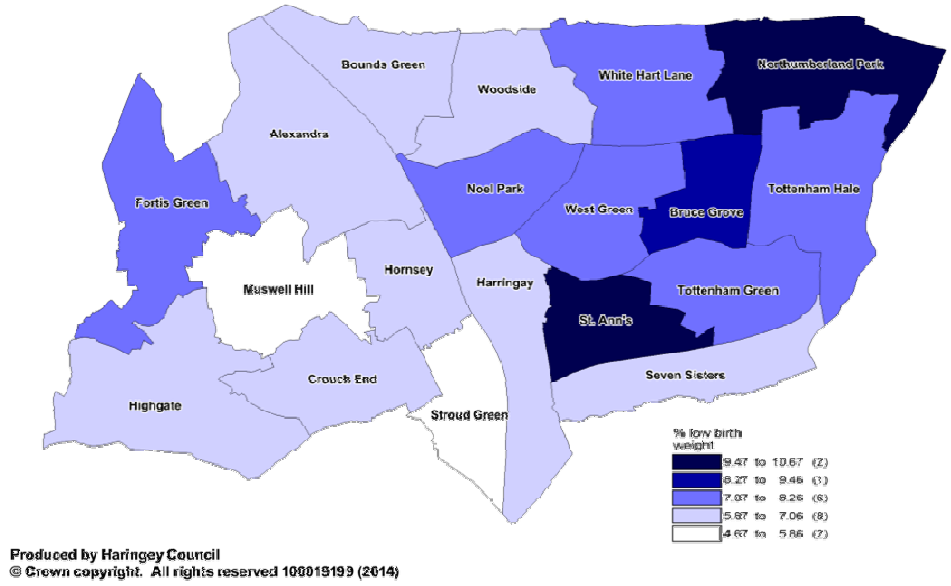
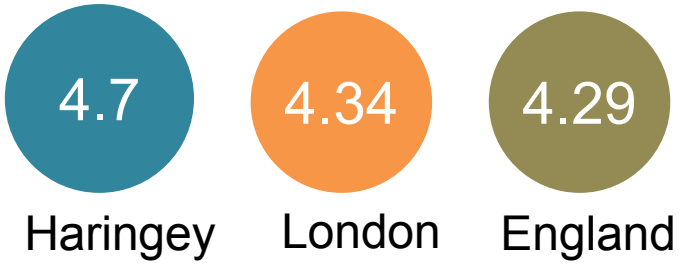
Impact of late access

Low birth weight – babies born <2500g



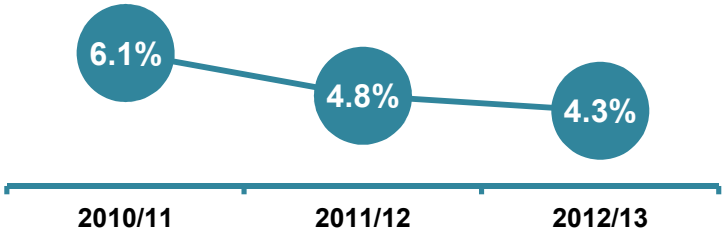
Source: ONS Public Health birth files 2010-2012

Infant mortality
(per 1000 births 2009/11)



Source: Public Health Outcome Framework (2014)

Smoking status at the time of delivery (Haringey 2012/13)



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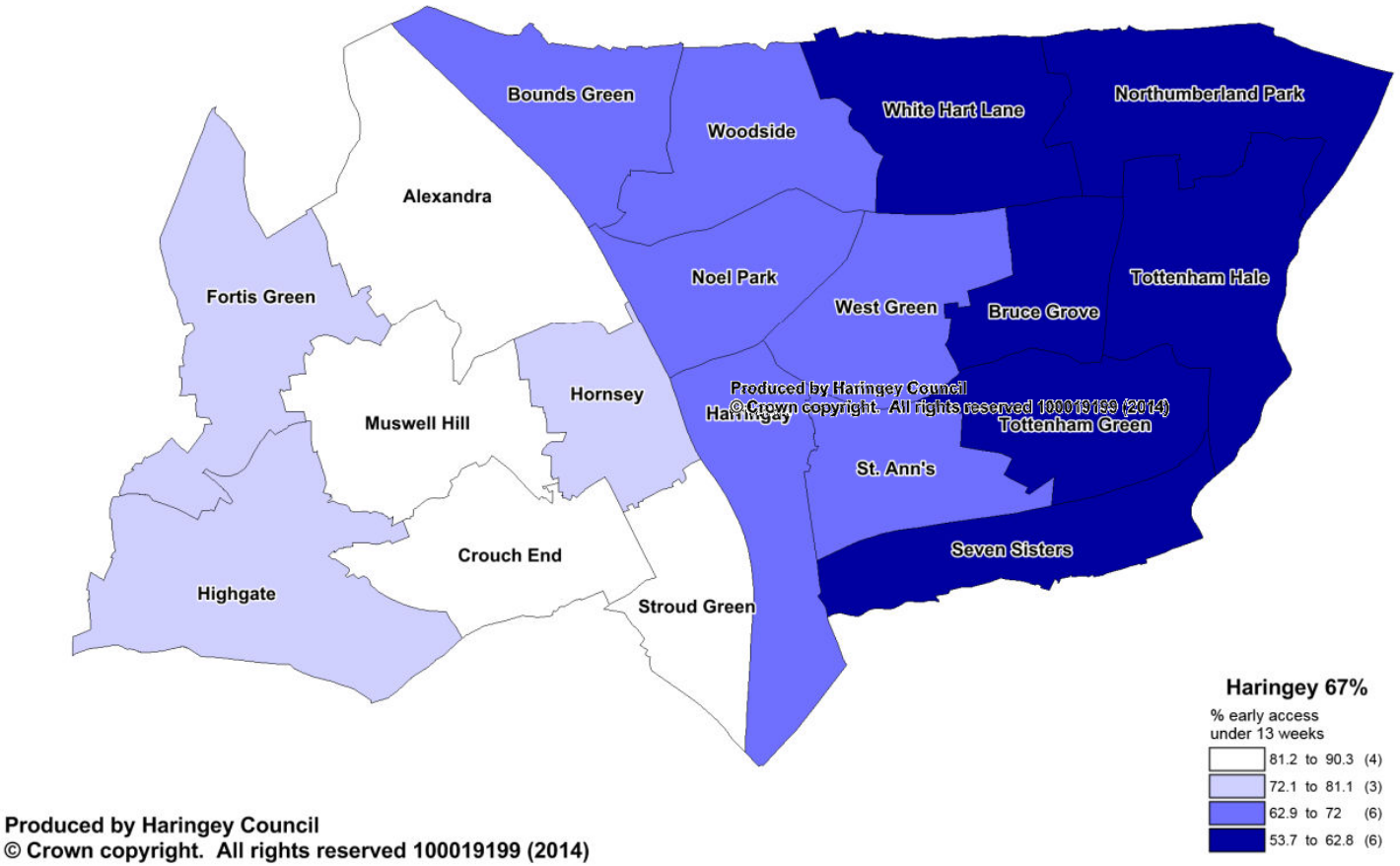
Early access to maternity services by ward

Haringey (2012)



Source: Annual Audit 2012. Whittington and North Middlesex Hospital.

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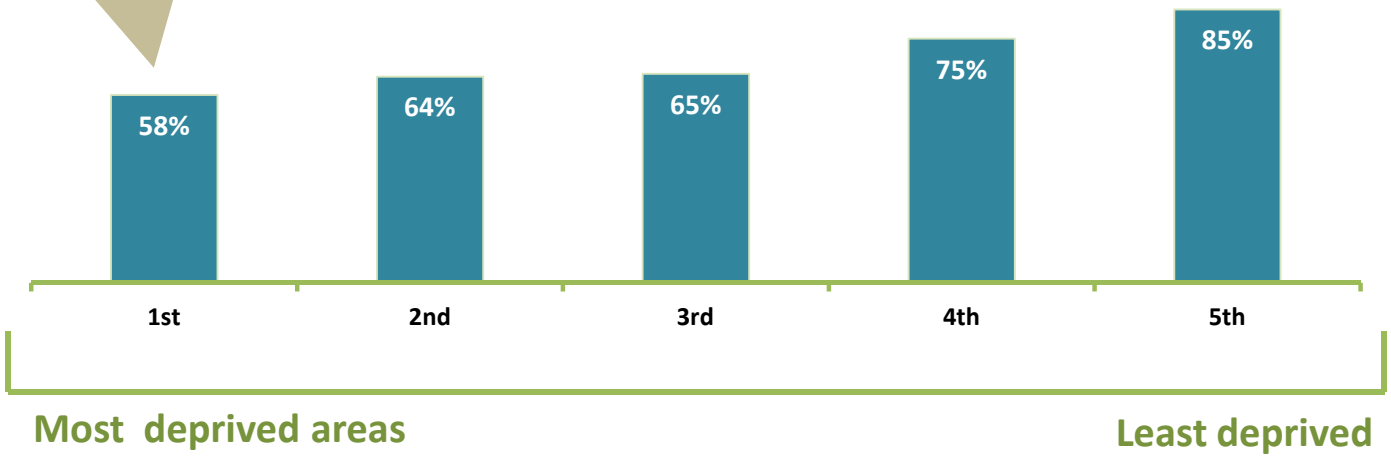
Maternity bookings in Haringey by deprivation quintile

58%

of women in the most deprived areas book early (2012)

85%

of women in the least deprived areas book early (2012)



Source: Annual Audit 2012. Whittington and North Middlesex Hospital.

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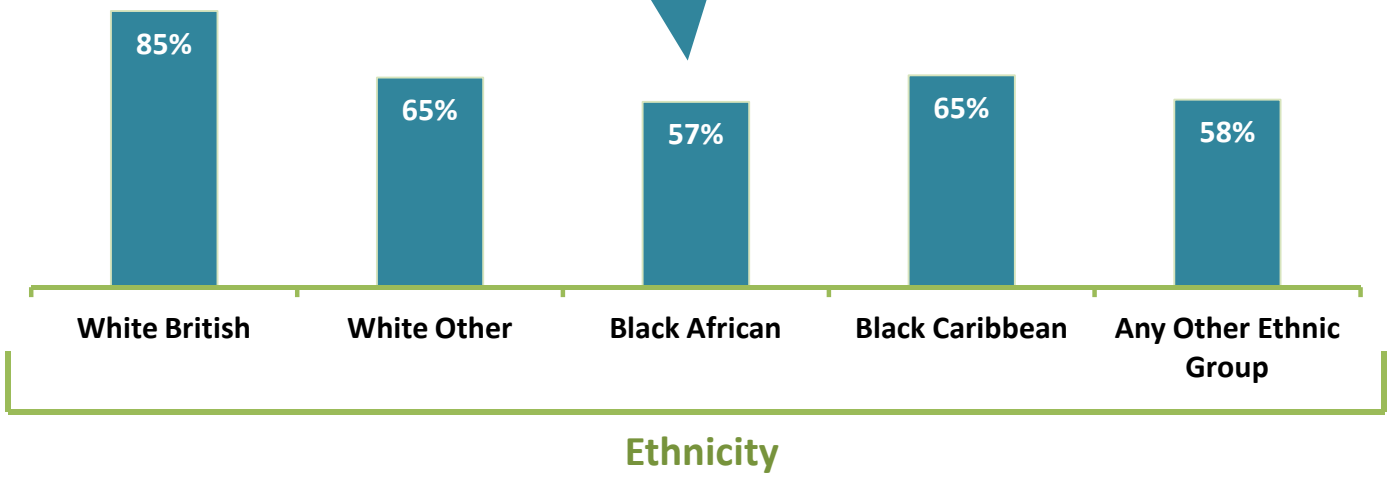
Maternity bookings in Haringey by ethnicity

85%

of white British women book early (2012)

57%

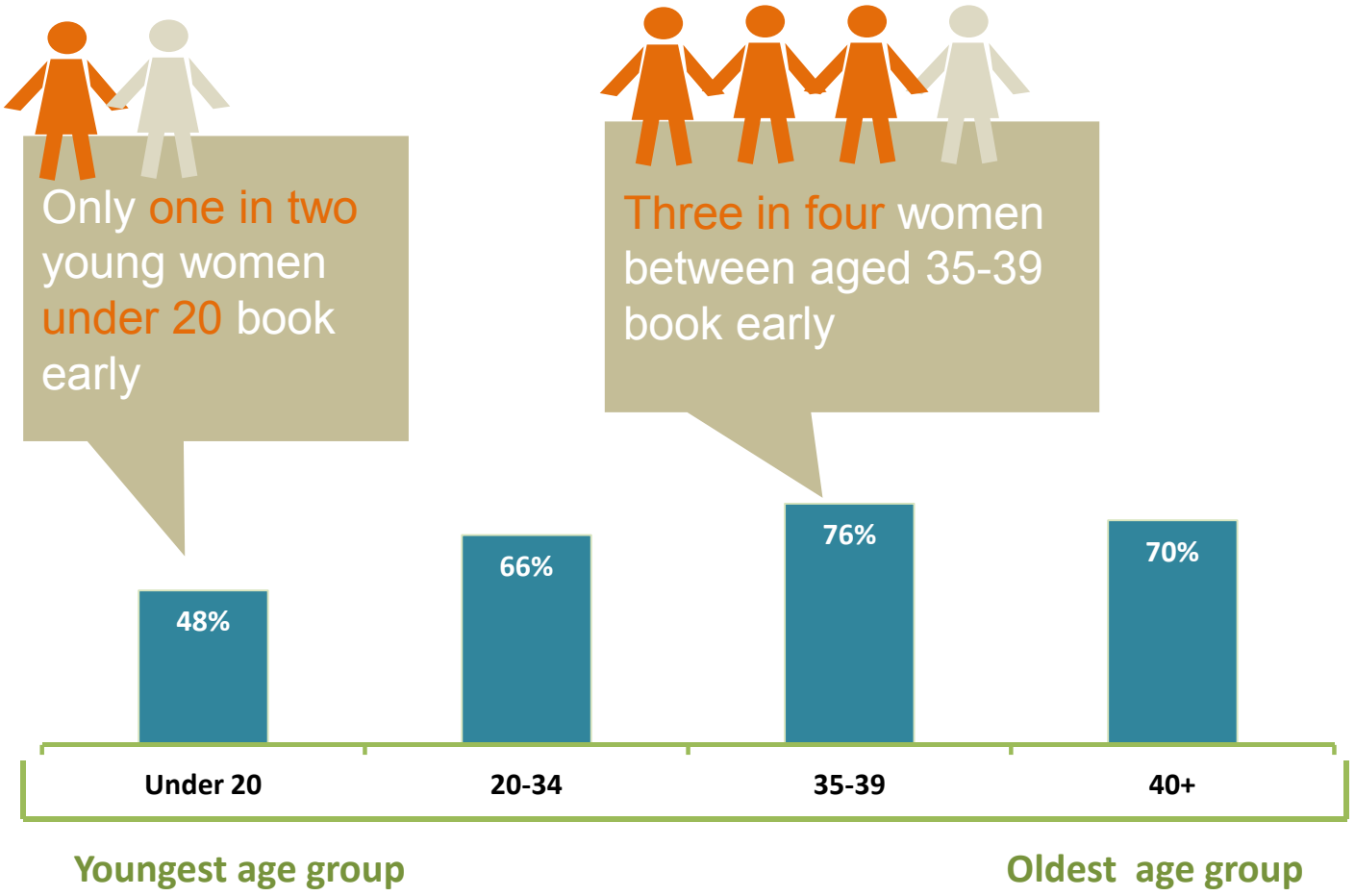
of black African women book early (2012)



Source: Annual Audit 2012. Whittington and North Middlesex Hospital.

Haringey Council

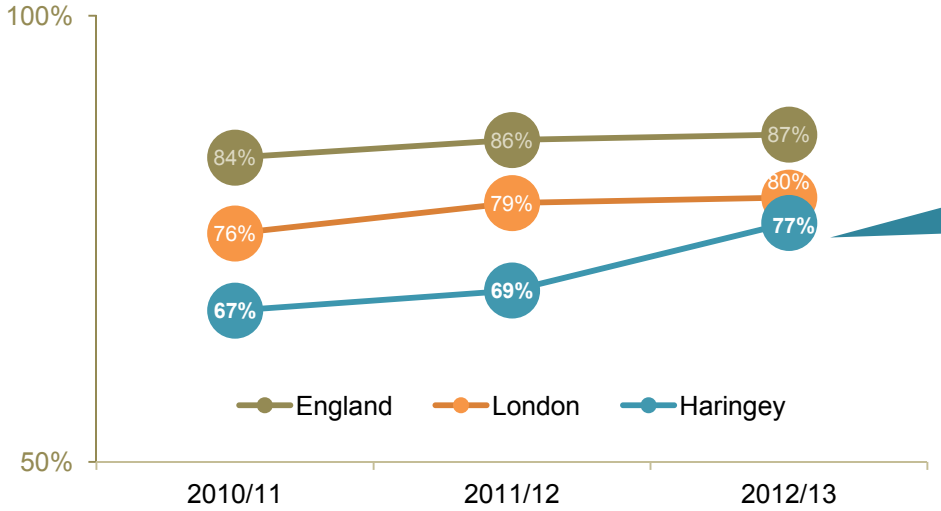
Maternity bookings in Haringey by age



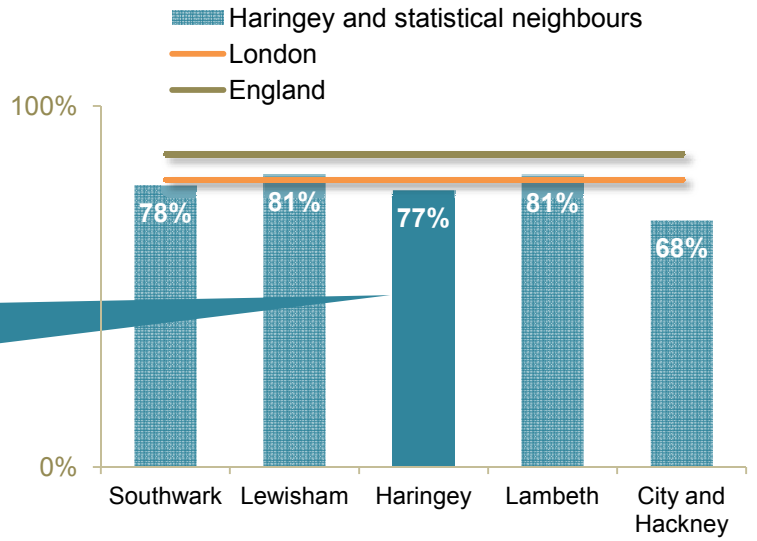
Source: Annual Audit 2012. Whittington and North Middlesex Hospital.

Haringey Council

How Haringey compares (2010/11-2012/13)



Fewer women in Haringey access early than in London and England but trend is up



Similar to Haringey statistical neighbours

Source: [NHS England, Maternity Data (last accessed 13 March 2014)]

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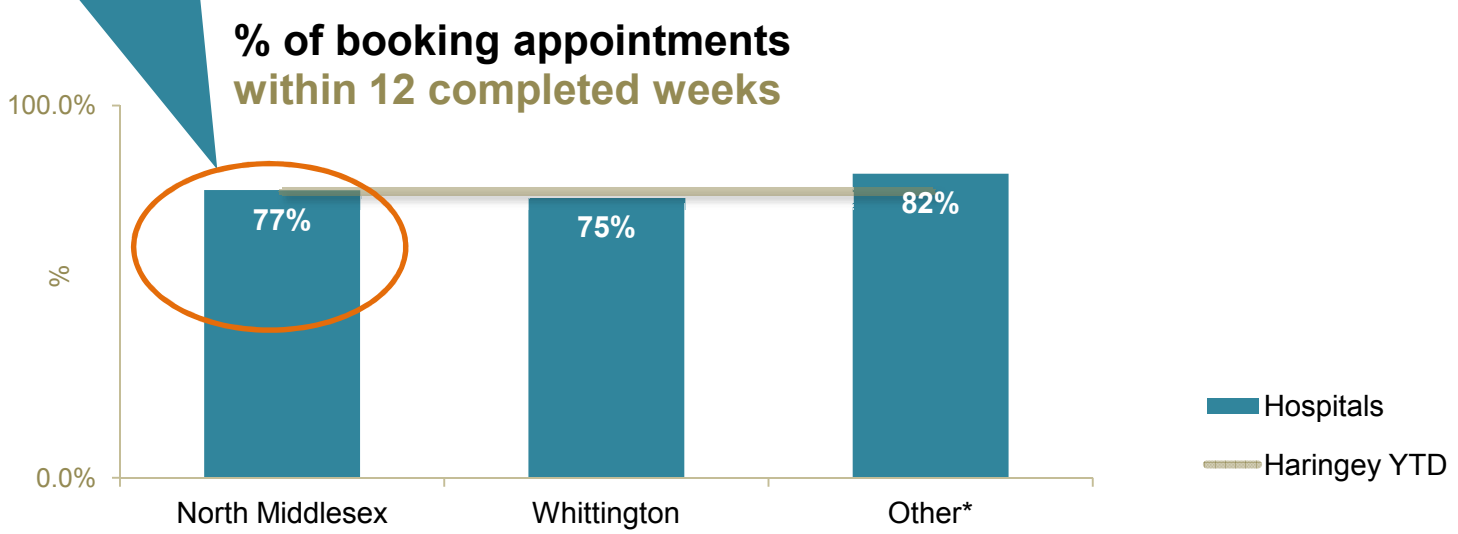
How hospitals compare (YTD)

Early bookings slightly higher in North Middlesex Hospital than in Whittington



Source: Haringey CCG, 2014. (Data covers March-November 2013)

** Other includes UCLH, Royal Free and Barnet & Chase Hospitals*

Haringey Council

Local research on African communities

- Lack of awareness: *'I have never seen anywhere where it says you must go at 12 weeks*' (Kenyan mother)
- Unresolved immigration issues: '*I left mine for 4 months as I did not have papers*' [immigration papers] (Nigerian mother)
- Cultural reasons: *'you do not talk about pregnancy before 3 months as someone may do juju on you [the evil eye] and harm the baby*'

The research project in 2012 included clinic data combined with qualitative methods: face to face interviews and focus groups with 29 community representatives

Source: Chinouya M., Madziva C., (2012) Black African women and the antenatal booking appointment in Haringey

Haringey Council

Local public health activity to improve early access

- Community health champions
- Engagement and education work at children's centres
- Promoting early referral to the Family Nurse Partnership for first time young parents
- Raising awareness of the importance of early bookings in local pharmacies, libraries etc.
- Increase the number of women self referring directly to hospitals

Haringey Council

In summary

Key issues

- Despite improvements since 2010/11, Haringey significantly below the national target
- Strong links between late bookings and deprivation
- Half of young women under 20 are still booking after 13 weeks.
- Timely data lacking with inconsistencies in methodologies

Recommendations

- Increase awareness of early booking targeting those areas and communities where late booking is highest
- Raise awareness at GPs, community and voluntary organisations, Children Centres and hospitals
- Utilise community health champions
- Monitor practice level data, incl. time from referral to booking
- Joint working with NCL Maternity commissioner (based in Haringey CCG) to increase early access and monitor actions in maternity specification

Haringey Council

Reference and guidance

- Confidential Enquiry into maternal and Child Health (CEMACH). Perinatal Mortality 2007. London: CEMACH, 2009
- Chinouya M., Madziva C., (2012) Black African women and the antenatal booking appointment in Haringey
- Haringey JSNA: Maternity
- Marmot (2010) Fair Society Healthy Lives' (The Marmot Review 2010)
- NICE guideline for antenatal care (external link)
- NICE Clinical Guideline 62. Antenatal Care: routine care for the healthy pregnant woman. NICE March 2008

For further information email: sheena.carr@haringey.gov.uk

Haringey Council

Agenda Item 11

Haringey Council

Report for:	**Health and Wellbeing Board**	**Item Number:**	

Title:	**Healthwatch Haringey Work Programme Draft 2014/15**

Report Authorised by:	**Sharon Grant, Interim Chair Healthwatch Haringey**

Lead Officer:	**Mike Wilson, Director Healthwatch Haringey**

Ward(s) affected: ALL	**Report for Key/Non Key Decisions:** **N/A**

1. Describe the issue under consideration

Healthwatch Haringey has prepared a Strategy and Work Programme for 2014/15, the second year of the contract with Haringey Council. The Healthwatch contract for year two, unlike year one, does not include a detailed specification although the objectives and outcomes remain the same. This draft report includes a strategic context, a review of year one, proposals for year two and a detailed work plan.

2. Recommendations

The Health and Wellbeing Board:

(a) Note and comment on the overall proposals for 2014/15 and the detailed work plan attached.

(b) Note that any comments will be referred to the Council's contract manager responsible for managing the Healthwatch contract for consideration.

Haringey Council

3. Background information

The Council awarded a two year contract in March 2013 to the Haringey Citizens Advice Bureau, in partnership with the Haringey Race Equality Council, to deliver the Healthwatch contract in Haringey.

Healthwatch is the independent consumer watchdog set up to collect information and represent the views of the public on health and social care. Healthwatch is here to give patients, service users and local people an opportunity to influence and challenge decision making about local health and social care services. From April 2014 our remit will also include children and young people.

This draft work programme has been sent to our Healthwatch network of service user groups, volunteers, “friends” and recently appointed board members and at the time of writing we have received a number of comments. Most of the comments refer to a “very ambitious programme” for a small organisation and related to this a “need to agree priorities” and focus on the “hard to reach”. There is general consensus that mental health should be a top priority.

4. Financial Implications and comments of the Chief Finance Officer

There are no direct financial implications for the Council arising from this report as the two year Healthwatch Contract is funded through non ring fenced grant from the Government. The level of funding for 2014/15 at £198,787 is included in the Contract and is the same as year one with no uplift.

5. Comments of the Assistant Director Corporate Governance and legal implications

The Assistant Director Corporate Governance has been consulted on this report. There are no specific legal implications arising from this report.

6. Equalities and Community Cohesion Comments

Haringey Healthwatch is subject to the public sector body duties in the Equalities Act (2010). The Strategy attached includes reference to a number of groups with Protected Characteristics whose interests we will represent and to a cross cutting priority to contribute to the reduction in health inequalities. We have a specific responsibility to ensure that “hidden communities” and those whose voice is seldom heard in the commissioning and delivery of health and social care services are given a voice. The independent evaluation of our work in year one includes an Equalities Impact Assessment screening to identify gaps in our outreach and engagement.

Haringey Council

7. Policy Implication

The Healthwatch Strategy and priorities are required to reflect the JSNA and Health and Wellbeing Strategy priorities. Our activities are focussed on the three HWB Strategy outcomes: giving every child the best start in life; reducing the gap in life expectancy; and improving mental health and wellbeing. We will contribute to these outcomes by using consumer expectations, patient experience and active engagement to improve the design and delivery of health and social care services.

8. Use of Appendices

N/A

9. Local Government (Access to Information) Act 1985

N/A

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healthwatch Haringey

Healthwatch Haringey Strategy

Work Programme 2014/15

citizens advice bureau

Haringey Race and Equality Council

Haringey Citizens Advice Bureau charity registration: 1069301. Company limited by guarantee registration: 3501846

Healthwatch Haringey Strategy and Work Programme 2014/15

Summary Review of Year One (2013/14)

We end year one in a strong position with our Board, staff and volunteer team in place; having built positive relationships with our partners and stakeholders and raised awareness of our role. However, we are only at the beginning of our service development and recognise that we need to increase our engagement with social care providers and start to develop a service offer for children and young people. We will have commissioned an independent evaluation report by the end of March which will identify our strengths and weaknesses to date and will inform our service development in year two.

Active project delivery was delayed due to late recruitment of the staff team and the need to complete the start-up processes required in any new organisation. This delay was reflected in the Contract performance traffic light reports, which were substantially red in the first two quarters moving to amber / green in Q3 and to green in Q4.

A significant factor contributing to our red traffic light was the difficulty recruiting to the Board; our first attempt did not generate the number of applicants we had anticipated and we failed to appoint any directors. However, our recruitment advertisement in February attracted a larger number of applicants and following interviews in March five board members have been appointed. A further round of recruitment will take place in May / June to increase the skill base of the board to provide the appropriate range of skills and governance for the new social enterprise.

Delays in recruiting volunteers impacted on our ability to undertake a range of monitoring activities including mystery shopping and enter and view visits but we now have a cohort of sixteen volunteers most of whom have had the relevant training relating to their area of interest. We have a list of other people with significant knowledge of health and social care keen to sign up as volunteers and they will be a valuable addition to our team in year two.

One of the highlights of the year was our “launch” in January with Dr Katherine Rake, chief executive of Healthwatch England, giving the keynote speech and Jeff Schumann hosting the event and keeping everyone amused. Over 80 people attended from a diverse range of backgrounds and organisations; a number of whom have since signed up to be Healthwatch volunteers. The evaluation of the event was positive with 90% saying the event was useful and informative and that Healthwatch had an important role to play in improving health and social care services. At the workshop session participants told us that the key priorities for Healthwatch in year two should be mental health, complaints systems, GP access, hospital transport and increasing the awareness of Healthwatch and what we provide.

Challenges and Priorities Year Two (2014/15)

Year two priorities are those identified at our launch event plus developing a delivery strategy and delivery plan for working with young people and engaging more actively in the social care sector. We also need to establish effective communication channels with what we call the “spokes” in our “hub and spoke” model. In addition to service user group “spokes” there are also a number of cross cutting themes such as health inequalities, personal budgets and commissioning processes which we will need to engage with. The “spokes” are stated in general terms and we will need to prioritise our focus within each spoke to avoid diluting our impact and failing to make a difference.

We will be operating in a policy and delivery environment that will be changing significantly with new legislation and more integrated care delivered by multi professional teams in the community. Arguably the scale of the changes planned in 2014/16 in the commissioning and delivery of health and social care services is unprecedented as it is a whole systems change; keeping the consumer/service user at the centre of these changes will be a challenge for all those involved. The complexity of the challenge is illustrated in the diagram below, which identifies our proposed hub and spoke arrangements and the complex environment that provides a policy context for our work in the foreseeable future.

This is a very ambitious programme; Healthwatch has limited resources but can make a significant difference to the patient experience if we focus on the key levers of change and our priorities, which may change in future years. We need to deploy our staff team, volunteers and board members strategically in order to achieve the wide reach that we are proposing. We are guided by the JSNA and Health and Wellbeing Strategies and our priorities will reflect those in these documents. We will be actively engaged in the refresh of the Health and Wellbeing Strategy over the course of the next twelve months and ensure that service users and consumers are also actively engaged in the process.

To meet our statutory and contractual objectives Healthwatch must have effective communication channels into the community to be able to represent the views of service users and consumers. We also need to understand the nature of the changes taking place in health and social care and the impact these may have on service users. At a time of change involving new pathways of care and service redesign Healthwatch must ensure that patients and service users are actively engaged as an equal partner in developing these changes and in the commissioning or re-commissioning of services. Service commissioners have a statutory duty to involve service users and patients in developing and commissioning new service models and are keen to do so; it is Healthwatch’s role to help facilitate these engagement process and to check with service users that they feel they have been engaged and involved.

With our team of volunteers, we can start to reach out to service users and build a network of health and social care champions to work with their communities. We will be able to start a programme of “Enter and View” to monitor and evaluate patient experience in a variety of residential settings and our “mystery shoppers” will be reporting on service standards in public areas and the quality of customer service. Social care services must be on our agenda in year two given that in year one our focus was more on NHS services. This will include children and young people and young

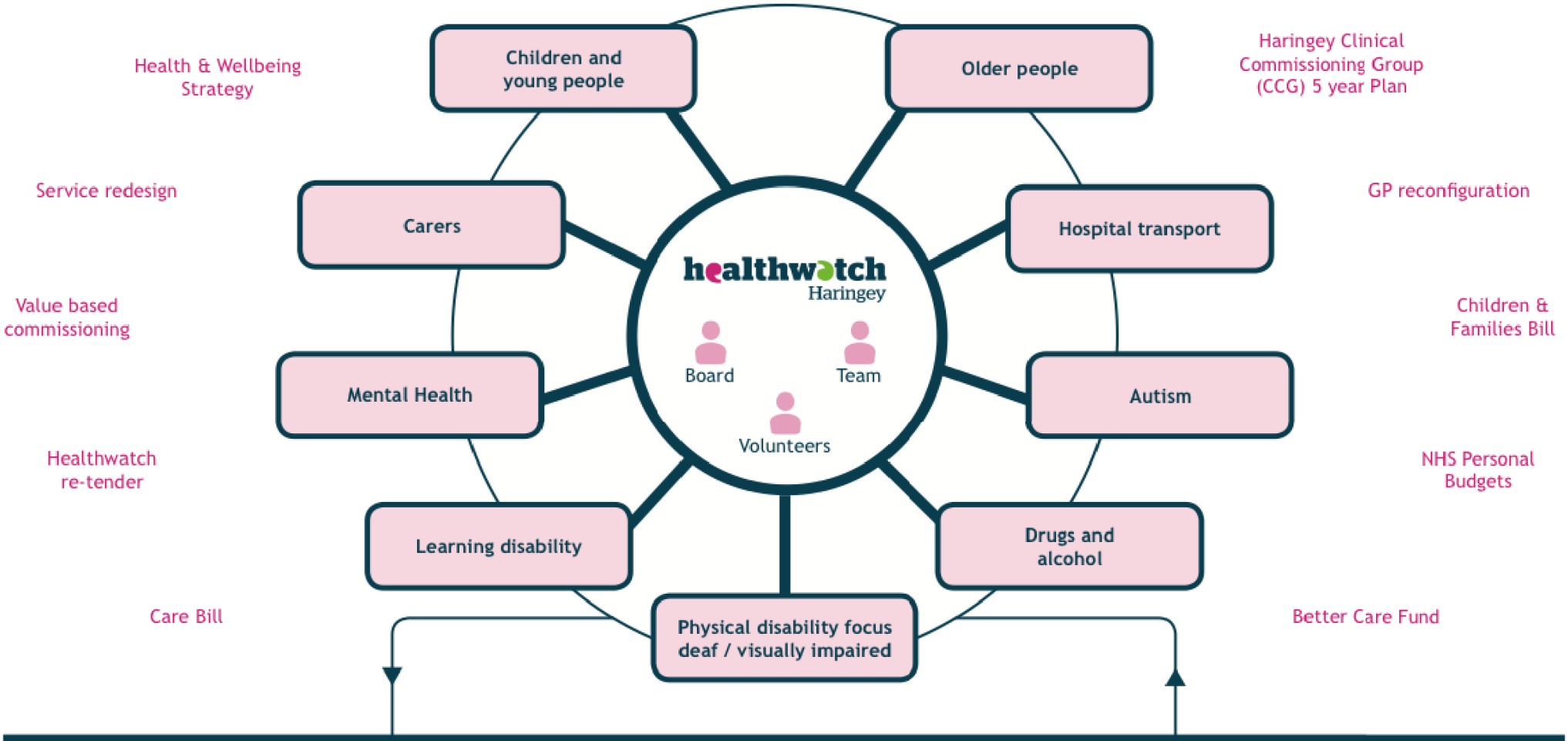
carers, a group whose voice is seldom heard and whose own life chances are frequently damaged by their caring responsibilities.

We will continue to identify and engage with “hidden communities” whose voice is seldom heard. In year one our engagement and focus group activities included the Homeless and we will continue to work with this group in year two. Our partnership with the Haringey Race Equality Council and the Muslim Network will develop over the year and we will focus on access to health services in the Muslim communities, including women’s health. We had some initial engagement with young carers in year one and we will develop this focus over the coming year raising awareness and working with other agencies to give young carers a voice. Our newly appointed Board will bring their own experience and interests to the discussion on priorities and “hidden communities” and therefore we need to build some flexibility into the detail of the work programme to make best use of this valuable resource.

This year is a significant one for the organisation as it develops into an independent social enterprise and meets the challenges that this will involve. We will be gearing up to bid for the Healthwatch contract post March 2015 and seeking to develop other income streams to support our work in health and social care in Haringey. The work plan attached reflects these organisational changes as well as the activities required to successfully deliver year two of the Healthwatch Haringey Contract.

healthwatch Haringey

Hub & Spoke Model



CROSS CUTTING:

- Personal budgets
- Inequalities
- Commissioning process
- Patient Participation Groups
- BME communities
- Lesbian, Gay, Bi-sexual, Transgender (LGBT) groups
- Male health
- Public health

Healthwatch Haringey Objectives

The objectives are clearly stated in the Contract with the Council which covers the two years 2013/15…. "Healthwatch Haringey will help improve the experience of residents using local health and social care services by":

- providing information;
- offering signposting;
- engaging and influencing;
- being the local consumer champion;
- employing the 'enter and view' power to observe and assess the quality of publicly funded health and social care services;
- providing evidence based data analysis and intelligence feedback to providers and commissioners of health and social care services to inform their continuous improvement of services;
- being the voice of the user, patient and the community on the Health and Wellbeing Board and actively taking part in the preparation of the statutory Joint Strategic Needs Assessment;
- building strong and effective working relationships both strategically and operationally across Haringey, including Haringey Council as commissioner of Healthwatch, the Adult and Health Scrutiny Committee, local people, local health and social care commissioners service providers, and regulators;
- carrying out regular self-assessments of its performance in partnership working, service provision, value for money, workforce effectiveness and human resource management.

Contract Outcomes

The Contract identifies four broad outcomes related to which are a number of performance indicators, measures and deadlines.

1. To be a Consumer Champion representing the voice of users, patients and the public. Healthwatch Haringey has influenced the planning, commissioning, design and scrutiny of local health and social care services. Healthwatch Haringey's Consumer Champion role has made a positive difference by improving people's experience of local health and social care services.

2. To recruit and deploy an active volunteer workforce within Healthwatch Haringey.

3. Haringey residents know what health and social care services are available and how to access them and are able to make more informed choices about services. Haringey residents are clear about and know how to make a complaint to health and social care providers.

4. The public and local stakeholders view Healthwatch Haringey as a model of good practice.

These outcomes are delivered through the activities that Healthwatch Haringey is required to deliver under the Contract. These are listed below with a cross reference to the outcomes they relate to in brackets [ ].

The Provider of the Healthwatch Haringey service shall ensure that:

- it carries out Haringey Council's statutory Healthwatch functions in accordance with the Health and Social Care Act 2012 (or any subsequent legislation) [2,4]

- the model delivers accessible Healthwatch functions to Haringey's diverse communities, including the prioritisation of hard-to-reach-communities and preference should be given to the development of a highly visible Haringey Healthwatch hub and spoke model [1, 2]

- it will become a legal entity that is a social enterprise by the end of year 2 of this contract [4]

- it acts as local consumer champion representing the collective voice of Haringey's people on the statutory Health and Wellbeing (H&WB) Board [1]

- it participates in the preparation of the statutory Joint Strategic Needs Assessments (JSNA) and joint health and wellbeing strategies to influence the local commissioning of health and social care services [1]

- it works with health and social care commissioners, providers, regulators and Healthwatch England to bring about improvements in people's experience of using local health and social care services, using the .information gathered from their Healthwatch consumer champion role to influence the HWH agenda and that of its partners [1,2]

- it provides information to help people access and make choices about local health and social care services [2,3]

- it supports individuals to access information and independent advocacy when and if they need help to complain about NHS services, and/or social care

services [3]

- it is responsible for keeping up to date with any further advice and other best practice guidelines on Healthwatch as they are issued by the Department of Health (DH), Local Government Association (LGA) or HWE and to implement them accordingly. This will be a standing agenda item in the quarterly contract monitoring meetings [3,4]

- it is responsible for keeping up to date with developments in adult and children's health and social care and integrate them into the role and functions of the Healthwatch Haringey role as required by the Council's Authorised Officer (as defined in the Contract Conditions) [3,4]

HEALTHWATCH HARINGEY (HWH) WORK PLAN 2014/15

OBJECTIVE / KPI	MEASURE	Q1	Q2	Q3	Q4
CARRY OUT FUNCTIONS (2012 ACT)					
Appoint appropriately qualified and trained Board members	Induction training plan by early March, delivered in Q1	X			
	Minimum of three Board workshops in the year		X	X	X
	Further round of Board recruitment	X			
Recruit competent and trained volunteers to support staff team. Training needs identified and met	Volunteers /staff trained by end Q1 to include Safeguarding	X			
	Gaps identified and targeted recruitment		X		
	Minimum of 20 volunteers recruited and trained				X
	Continuous monitoring of Guidance and Regulations	→	→	→	→
Familiarisation with Act and Regulations	Monthly briefings for Board and Staff	X	X	X	X
Brief Chair, Board and staff **Maintain record of Healthwatch England (HWE) briefings**	Record and brief as necessary	→	→	→	→

Annual report meets requirements of Directive	Annual Report fully compliant Regarded as an exemplar by HWE	X			
HWH MODEL TO DELIVER ACCESSIBLE FUNCTIONS TO DIVERSE COMMUNITY					
Map and identify diverse communities and in particular those with Protected Characteristics	Comprehensive mapping of community / voluntary groups completed Identify 'gaps' in relation to our agreed "spokes"	X X			
Identify communication networks / channels to reach individual members of these communities and highlight gaps	Communications Strategy agreed which highlights "gaps" and potential channels of communication Channels of communication in place with 360 feedback	X	 X		
PRIORITISE HARD-TO-REACH COMMUNITIES					
Specific focus on the East of the Borough where health inequalities are the greatest	Communication and Engagement strategies reflect this Volunteer deployment reflects this priority	X			
Monitor use of translation services in primary / secondary care and promote uptake	Monitor through survey and mystery shopping. Starting with those in the east of the Borough	X	X		

Work with Registered Providers (RP's) to access social housing tenants	Work with Newlon Housing and Homes for Haringey in Q1 Work with six other RP's in Haringey	X			X
Work with Muslim Network outreach worker/s	Project with Haringey Clinical Commissioning Group started with focus on diabetes and safe fasting Expand project include other issues - women's health	X	 X		
Use Equality Impact Assessment (EqIA) screening evaluation to identify 'gaps' and inform year 2 priorities	Adopt the Action Plan Integrate Action Plan into Work Plan as necessary		X		
DEVELOP HIGHLY VISIBLE HUB AND SPOKE MODEL					
Develop the 'Hub' and ensure that the Board members bring knowledge and skills to support the 'Spokes'	Complete skills / interests analysis for Board members and give them portfolios Profile volunteers and do skills / interest analysis and give them portfolios	X X			
Agree the 'Spokes' and start to develop effective communication channels early in year 2; informed by Joint strategic needs assessment (JSNA) priorities	'Spokes' defined and interest groups clustered to provide a critical mass Workshop and focus group sessions with all groups by Q4	X X	 X	 X	 X

Publicise the model to raise awareness and ensure that views of service users, carers and other consumers are captured effectively	Establish effective feedback mechanisms with all 'Spokes' Work with the 'Spokes' to ensure that they are inclusive and representative of their user group. Develop a code of practice. Promote a Healthwatch Standard?		X X		
Add further 'Spokes' to the system as priorities change and existing 'Spokes' become embedded	Keep under review quarterly and make recommendations to the Board		→	→	→
HWH TO BECOME SOCIAL ENTERPRISE BY JUNE					
Board in place with the appropriate skills and experience to provide effective governance to a social enterprise	Agree Memorandum and Articles of Association and Constitution Appoint additional board members / co-optees as required to fill skills gap Board members training on Governance issues	X	 X X		
Framework of relevant policies and procedures to comply with legal requirements and good practice	Policies and procedures in place / staff manual		X		
Business Plan which is viable and identifies income generation opportunities for 2015/16 onwards	Viable business plan produced 2015 / 18 Identify additional income streams and achieve two new contracts outside HWH by Q3 and two more by Q4		X	X	X

Project Plan to ensure that HWH is in a strong position to submit a credible bid for the HW Contract which meets the Council's detailed specification		X			
Bid successfully for the HWH contract post 2014/15 in a competitive tender situation	Prepare high quality bid for on-going contract by end Q3			X	
Existing contract novated to social enterprise	Submit proposal to Council and HCAB and prepare legal documentation Contract novated	X	 X		
Clarify implications for staff including *Transfer of Undertakings (Protection of Employment*) Regulations (TUPE) rights, pension provision and other terms and conditions. Use of existing systems and assets including office accommodation	Clarify the legal position re staff Transfer of assets to social enterprise	X	 X		
Staff have skills and capacity to transition to a social enterprise	Training needs identified and appropriate training provided	→			

Retain staff during this period of uncertainty	Keep staff updated regularly and manage risks Encourage an early tender exercise early in Q3 to reduce uncertainty	→	X	→	→
REPRESENT COLLECTIVE VOICE OF LONDON BOROUGH OF HARINGEY PEOPLE ON THE HEALTH & WELLBEING BOARD AS THE LOCAL CONSUMER CHAMPION					
Capture large amount of feedback data and present in a professional style using Healthwatch Haringey's Customer Relationship System (HWH-CRM) database **Capture information from outreach meetings, focus groups, mystery shopping and surveys by volunteers**	HWH-CRM to be working effectively and producing high quality reports HWH-CRM updated on a weekly basis Volunteers managed effectively and producing high quality feedback	X → →		→	→
Capture complaints from a variety of sources including: advocacy service provider; direct to HWH, HCAB, NHS Direct and other websites, NHS Trusts, CQC, NHS England	Systematic process in place for capturing complaints and up loading to HWH-CRM Work with providers to improve their complaints recording and reporting Evidence of improved complaints systems in place. Provide report	X X	X	X	

Develop a panel, 'Friends of Healthwatch', to provide a source of information and feedback	Target an additional 100 'Friends' each quarter				
Use existing service user panels for targeted surveys	A minimum of one targeted survey each Q				
Ensure that the voices of all consumers are heard including those in 'hidden communities'	Complete 'gap' analysis and informed by EqIA Identify hidden communities for engagement in year 3		X 		 X
Encourage Health & Wellbeing (H&WB) Board members to consult with service users and other consumers on any changes to policy, practice, service delivery arrangements and budget profile	Active involvement and regular attendance at H&WB Board Regularly highlight user / consumer feedback at Board	 			
Ensure that health inequalities are highlighted and addressed in policy reports and area strategies e.g. Tottenham Regeneration	Encourage service users to be involved in Tottenham Regeneration Be a champion for reducing health inequalities	 			

Attend relevant Haringey and NCL Scrutiny Committee meetings and support service user groups to attend when invited to do so	Regular HWH attendance Involve volunteers and other service users to attend				
INPUT INTO THE JSNA & HWB STRATEGY TO INFLUENCE THE HEALTH AND SOCIAL CARE SERVICE COMMISSIONING					
Need to engage with those responsible for developing the JSNA and H&WB Strategies	The JSNA is not being refreshed in 2014/15. Active involvement in updating the H&WB Strategy for 2015/16				
Involvement in the Better Care Fund Strategy which will involve 'new' community based services and decommissioning of some existing services	Active engagement in the process to quality assure patient/service user engagement in addition to seat on H&WB Board Ensure a project plan is in place to capture patient experience at an early stage	 X			
Need to ensure that consultation with service users and consumers is meaningful and reflected in the final strategies	Consult with service users to seek their views about the level of engagement / involvement				

WORKS WITH THE HEALTH AND SOCIAL CARE PROVIDERS TO IMPROVE PATIENT EXPERIENCE OF SERVICES					
Ensure providers understand the role of HW	Effective and on-going communications to ensure meaningful engagement				
Active members of the Whittington Patient Experience steering group and engagement in their forward strategy	Regular meeting attendance and input into Quality Reports				
Work in partnership with Healthwatch Islington to improve patient engagement / experience at Whittington Hospital	Joint working and co-ordination to agree priorities				
Work in partnership with North Middlesex University Hospital (NMUH) and Barnet, Enfield and Haringey Mental Health Trust (BEH MHT)	Regular attendance at the Care Quality Research Group (CQRG) meetings – we have 'lead' for NMUH and 'lead' for Healthwatch Enfield on BEH MHT. Regular involvement in the Patient Experience groups				
Develop relationships with the newly formed Patient Consultation Groups (PCGs) linked to GP practices	Strategy in place for setting up a PCG network Network meetings each Quarter	X 			

Work with care providers / forums to improve services	Attend Forum meetings				
Use 'Enter and View', Mystery Shopping and surveys of service users to help providers improve the patient experience	Effective volunteer deployment and robust reports				
Promote the use of complaints as a tool for service improvement and identify best practice	Work with providers to improve their complaints recording and reporting Evidence of improved complaints systems in place – Report	X	X 	 X	
WORKS WITH HWE AND OTHER REGULATORS TO IMPROVE THE PATIENT EXPERIENCE OF SERVICE					
Establish positive, on-going relationships with the local Care Quality Commission (CQC) rep	Quarterly review meetings				
Read CQC reports and record outcomes in the HWH-CRM	Read weekly updates and standing item on HWH team agenda				
Co-ordinate 'Enter and View' and Mystery Shopping with CQC when appropriate	Always contact in advance and seek suggestions for visits				

Notify HWE of any local concerns that need resolution at a higher level	As required				
Use the HWE 'Hub' as a resource to learn from and share best practice	Regular use as a resource				
INFORMATION TO PEOPLE TO ACCESS AND CHOOSE HEALTH AND SOCIAL CARE SERVICES					
Promote the HWH brand widely in the community to increase knowledge of HWH role. Use outreach, newsletters, posters, website, feedback cards etc.	Detailed Communications strategy and plan in place				
Maintain an up to date database of services that are available and information on consumers' rights to access these services	Consolidate database on HWH-CRM and regularly update				
Promote and offer an effective telephone signposting service	Publicise and monitor uptake				

Use outreach to provide information on access and choice	A minimum of 4 outreach sessions each Quarter utilising staff and volunteers	X	X	X	X
Work with volunteers and user groups to increase their knowledge so they can signpost people	Train those volunteers who wish to deliver signposting services		X		
Develop a web based signposting system			X		
HELP INDIVIDUALS TO ACCESS INFORMATION/ ADVOCACY TO MAKE COMPLAINT RE HEALTH AND SOCIAL CARE SERVICES					
Have a good understanding of the complaints channels in relation to the various providers and commissioners	Ensure all staff and volunteers have access to the Information	X			
Make appropriate referrals to the local advocacy services contracted by the local authority	Monitor number and nature of referrals to the Advocacy service	→			

KEEP UP TO DATE ON ADVICE / BEST PRACTICE FROM: LOCAL GOVERNMENT ASSOCIATION (LGA), DEPARTMENT OF HEALTH (DH) AND HEALTHWATCH ENGLAND (HWE) AND IMPLEMENT					
Ensure that all guidance and best practice is disseminated through the organisation, including the Board, and appropriate action taken to implement changes in policy, practice or procedure	Regular briefing updates; e-bulletins fortnightly and bi-monthly (every second month) newsletters				
Membership of the LGA information network ensures that we receive all relevant correspondence and reports and attendance at meetings highlights issues currently under review	LGA briefings				
Attendance at relevant DH and HWE meetings gives an early warning of issues under consideration and future directions of travel	Regular attendance and HW network Work with HWE on their priorities	 			

KEEP UP TO DATE WITH DEVELOPMENTS IN ADULT AND CHILD HEALTH AND SOCIAL CARE AND INTEGRATE INTO ROLE AND FUNCTIONS OF HWH					
Regular liaison with local authority commissioners to identify new developments	Meetings each Quarter				
Have prioritised NHS Personal Budgets as a new development for communication to service users in 2014/15	Network with user groups with an interest in personal care and NHS budgets				
Need to develop and deliver a programme in relation to child health and social care	Engagement strategy in place Agreed priorities for 2014/15 Robust patient experience / feedback available	X X 			
TO BE REGARDED AS AN ORGANISATION THAT DELIVERS CONTRACTS TO TIME, BUDGET AND QUALITY STANDARD					
To exceed the expectations of the CCG in delivering both the Muslim Network and Five Year Strategy engagement projects **To generate repeat commissions from the CCG and other clients**		X			

END

Agenda Item 12

Haringey Council

Report for:	**Health and Wellbeing Board** **8 April 2014**	**Item Number:**	

Title:	**Haringey LSCB Annual Report**

Report Authorised by:	**Lisa Redfern** **Interim Director of Children's Services**

Lead Officer:	**Myra O'Farrell, Assistant Director (Interim) Quality Assurance CYPS**

Ward(s) affected: All	**Report for Non Key Decisions:**

1. Describe the issue under consideration

Under the Children Act 2004, at least once in every 12 month period, a Local Safeguarding Children Board must prepare and publish a report about safeguarding and promoting the welfare of children in its local area. The Local Safeguarding Children Board is required to submit the annual report to the Health and Wellbeing Board. This is important in strengthening the links between the Local Safeguarding Children Board and the Health and Wellbeing Board in co-ordinating the arrangements for safeguarding and promoting the welfare of children in Haringey.

2. Recommendations

That the Health and Wellbeing Board note the content of Haringey's LSCB Annual Report 2012-13 and Business Plan 2013-14.

Haringey Council

3. Alternative options considered

Statutory guidance provides for the Annual Report to be reported up to the Board, and therefore no alternative options have been considered.

4. Background information

Haringey Safeguarding Children Board is a multi-agency strategic partnership that exists to promote the safety and welfare of all children in their home, in school and in the community. It is an independent body with a statutory requirement under the Children Act 2004 to oversee the work of Haringey's Children's Service and partner agencies in Haringey to ensure safeguarding practice is effective on the ground to keep children safe from harm.

The Annual report provides detail about the work of the LSCB and offers comment and assurance on the effectiveness of the arrangements for early intervention and safeguarding of children and young people in Haringey, as well as documenting the achievements of the LSCB and partners over the last 12 months, LSCB membership, what has worked well and what the focus will be over the year ahead.

5. Comments of the Chief Finance Officer and financial implications

The expenditure of the LSCB for the year covered by the annual report was £195k. Most of this cost was covered by Haringey Children's services budget with £9,550 total contributions from partner organisations (Police, Probation, Cafcass and Tottenham Hotspur.)

The estimated expenditure in 2013/14 is £282k – this includes around £62k additional one off funding. The planned expenditure budget for 14/15 is £229k.

6. Comments of the Assistant Director of Corporate Governance and legal implications

The Assistant Director of Corporate Governance has been consulted about the content of this Report.

Section 14A of the Children Act 2014 requires the Local Safeguarding Children Board to prepare and publish an annual report about safeguarding and promoting the welfare of children in its local area. The Working Together to Safeguard Children (2013) statutory guidance requires the annual report to be submitted to the Chair of the Health and Wellbeing Board.

The guidance further provides that the report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action

Haringey Council

being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.

The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

7. Equalities and Community Cohesion Comments

N/A

8. Head of Procurement Comments

N/A

9. Policy Implication

N/A

10. Reasons for Decision

Report is for noting only

11. Use of Appendices

Appendix 1 – Haringey LSCB Annual Report on the Effectiveness of Safeguarding Children in Haringey 2012-13 and Business Plan 2013-14

12. Local Government (Access to Information) Act 1985

N/A

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Haringey Safeguarding Children Board

Annual Report on the Effectiveness of Safeguarding Children in Haringey 2012-13 and Business Plan 2013-14

Foreword from the Independent Chair

In writing this foreword to the Annual Report, my last, having been in post for five years. I first wish to pay tribute and offer my thanks to the staff of all those agencies and organisations represented on the Board for their support and commitment to Child Protection.

The London Borough of Haringey is not an easy place to work in as the data contained in this report illustrates. It presents challenges to health, police, housing and social care staff alike. There is a need for constant vigilance and a willingness to challenge assumptions and seek new ways to solve old and persistent problems. Mistakes have occurred illustrated tragically by the death of Peter Connelly and later Serious Case Reviews.

However, within those Reviews positive change is discernible and the resilience of staff in the face of challenges by the LSCB and others is commendable. What no one should doubt is the commitment of the staff I have worked with to meet children's needs and defend their rights. Every child death or injury is tragic and regrettable but it must be remembered that hundreds of children thrive and grow as a consequence of the intervention of those agencies represented on the board – individually and collectively.

This report details achievement over the last year and does not shy away from the challenges of the future. A future set against the background of legislative change, new demands and a new audit regime led by Ofsted. Much is expected of LSCBs – (a far cry from the days of Child Protection Committees) in terms of analysis, liaison, training and joint working. Quite often good Child Protection is derived from doing simple things well, supervision being authoritative in practice, communication and so on. It remains to be seen if LSCBs nationwide are sufficiently well resourced to 'hold the ring' and ensure a climate of mutual accountability.

It has been a privilege to work here.

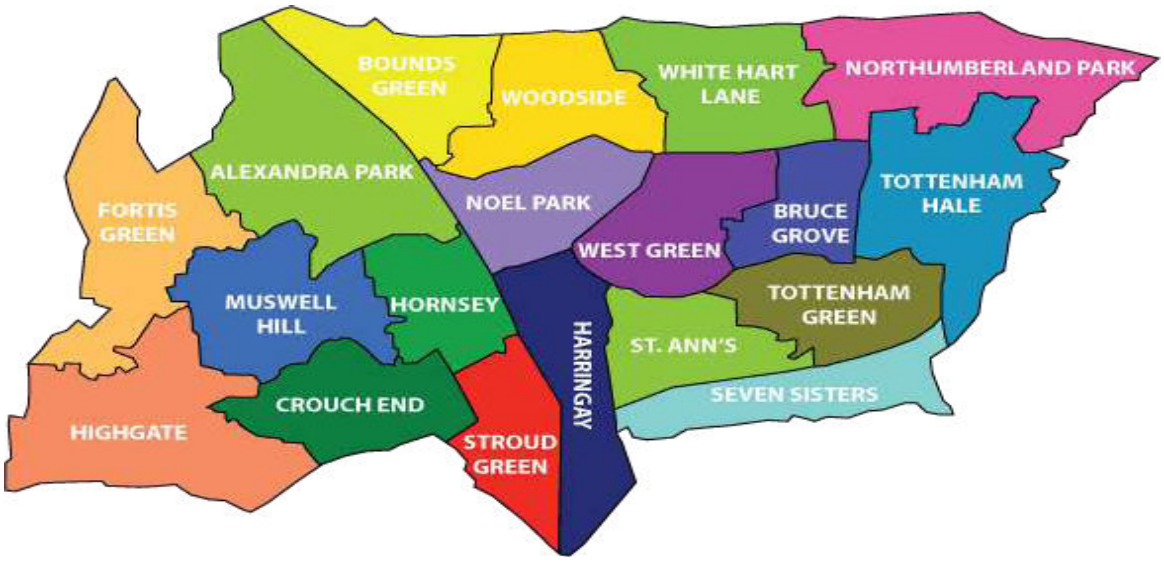
Graham Badman, Independent Chair

Contents

Approved on: 27th November 2013

Haringey Local Safeguarding Children Board, 48 Station Road, Wood Green, Haringey, N22 7TY www.haringeylscb.org Tel: 020 8489 1470

Section one - Introduction



- Haringey is an exceptionally diverse and fast-changing borough with a population of about 225,000 residents (ONS). There are approximately 53,800 children and young people under 20 living in Haringey. The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane and Tottenham Hale. Haringey has a relatively young population with almost a quarter of the population under the age of 20[1].

- Haringey is the 5th most ethnically diverse borough in the country. Nearly half of the residents and nearly 81% of our school children come from Black and minority ethnic (BME) communities; 190 different languages are spoken in our schools. The proportion of children from BME communities varies from 30% in Muswell Hill to 78% in Northumberland Park. Haringey is the 4th most deprived borough in London and the 13th most deprived in the country.[2]

- An estimated 21,595 (36.4%) children live in poverty, largely in the east of the borough. There are significant levels of homelessness; more than 3,000 households are officially in temporary accommodation, the highest in London. Just over 30% of households live in social housing with high concentrations in the east of the borough. The east of the borough is more densely populated than the west[3]

- This is the third Annual report of Haringey LSCB and this report builds upon the previous annual reports and business plans published by Haringey LSCB.

[1] Haringey JSNA, 2012 summary
[2] Haringey JSNA, 2012 summary
[3] Haringey JSNA, 2012 summary

It has been compiled by representatives of the LSCB and safeguarding lead officers. The purpose of this report is to:

- provide an overview of LSCB activities and achievements during 2012/13
- provide an summary of the effectiveness of safeguarding activity in Haringey, including areas of weakness, the causes of those weaknesses and action being undertaken to address them,
- provide the public, practitioners and main stakeholders with an overview of how well children in Haringey are protected and,
- include proposals for action, lessons from reviews undertaken, and recommendations to strategic partners

Role and function of the LSCB

The LSCB is the statutory body for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in the London Borough of Haringey.

The objectives of the Board are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
- To ensure the effectiveness of what is done by each such person or body for that purpose

Scope

The scope of the LSCB role falls into three categories:

1. To engage in activities that safeguard all children and aim to identify and prevent abuse and ensure that children grow up in circumstances consistent with safe care.
2. To lead and co-ordinate pro-active work that aims to target particular groups.
3. To lead and co-ordinate responsive work to protect children who are suffering or likely to suffer significant harm.

Function

Thresholds, policies and procedures

Developing policies and procedures for safeguarding and promoting the welfare of children, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.

Training

Training of people who work with children or services affecting the safety and welfare of children:

- LSCB has a responsibility to ensure that single-agency and interagency training on safeguarding and promoting welfare is provided in order to meet local needs.
- LSCBs are required to evaluate the quality of training, and ensure that relevant training is provided. This covers both the training provided by single-agencies to their own staff and multi-agency training organisation.
- Haringey develops, organises and delivers multi- agency training although this is not a core requirement for LSCBs

Safe workforce

Safe recruitment, management and supervision of people who work with children:

- Establishing effective safe workforce policies and procedures based on national guidance.
- Ensuring that robust quality assurance processes are in place to monitor compliance, e.g. audits of vetting practice.
- Investigating allegations concerning people working with children:
- Producing policies and procedures to ensure that allegations are dealt with properly and quickly.
- Monitoring the Safety and welfare of children who are privately fostered:
- Ensuring the co-ordination and effective implementation of measures designed to strengthen private fostering notification arrangements

Communication and raising awareness

Communicating the need to safeguard and promote the welfare of children, raising their awareness of how this can be best done, and encouraging individuals and partners to do so. This should involve listening to and consulting children and young people and ensuring their views are taken into account in planning and delivering services.

Monitoring and evaluation

Monitoring and evaluating the effectiveness of what is done by the Local Authority and Board partners (individually and collectively) to safeguard and promote the welfare of children and advise them on ways to improve.

Participating in planning and commissioning

The LSCB must participate in local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account:

- This is achieved to a large extent by contributing to the Children and Young People's Plan, and ensuring in discussion with The Children Trust and agency leaders that planning and commissioning of services for children takes account of their responsibility to safeguard and promote the welfare of children.

- The LSCB is the responsible authority for matters relating to the protection of children from harm.

Child Death Review Function

The LSCB holds responsibility for the compulsory functions regarding all child deaths. These include:

- Collecting and analysing information about the deaths of all children normally resident in Haringey with a view to:

    - Identifying any matters of concern including any case giving rise to the need for a Serious Case Review.

    - Identifying any general public health or safety concerns arising from the deaths of children

The Board's scope is wide and covers universal, targeted and responsive safeguarding. The Board aims to address all areas, but remains focussed on its core business of ensuring that children who are suspected or know to be at risk of significant harm are being protected effectively.

Section two – Summary of key areas of progress and achievements in 2012-13

In last year's annual report Haringey LSCB outlined 7 priorities in its role in co-ordinating local work to safeguard and promote the welfare of children. These were:

- *The engagement of Children, young People and their families to influence the work of the LSCB*
- *Strengthen governance and accountability arrangements between the LSCB and other partnership Boards*
- *Implement and review response to identified local safeguarding issues*
- *Implementation of the New Working Together to Safeguarding Children Guidance*
- *Developing a co-ordinated link between Schools and safeguarding*
- *Identification of Children at risk of Sexual Exploitation*
- *Supporting and monitoring organisations in the identification and response to Neglect in the borough.*

Whilst a lot of work has been done on every priority, work remains. National Research (Local Safeguarding Children Boards, a review of progress DCSF 2008) has shown that more effective Boards are those who concentrate on a few clearly articulated priorities which are continually reviewed and updated to meet changing needs and pressures.

The engagement of Children, young People and their families to influence the work of the LSCB

- This year the board initiated links with children and young people's groups, most notably Haringey's youth council who have worked alongside the LSCB to develop key questions to ask young people on how safe they feel.

Strengthen governance and accountability arrangements between the LSCB and other partnership Boards

- Haringey's Children Trust Board has been reinstated and the chair of the LSCB is a member, strengthening links and accountability.
- The director of Public health attended the board to inform partners of the priorities of the Health and Wellbeing Board.
- In February 2013 the 2011/12 LSCB annual report was presented to the Health and Wellbeing board.

Implement and review response to identified local safeguarding issues

- A review of Haringey's safeguarding action plan took place and all areas have now been addressed.

Implementation of the New Working Together to Safeguarding Children Guidance

- The partnership responded to the government Working Together consultation. There were variety of views to the changes and the New Working Together statutory guidance came in to effect on 15th April 2013.

Developing a co-ordinated link between Schools and safeguarding

- The designated teacher's forum was refreshed and reinstated facilitated by the LSCB and now includes the involvement of other partner agencies including health.

- The board welcomed 2 new Head teachers who joined the board from primary and secondary schools

- A newly designed designated Child Protection training course offers Designated Child Protection Officers an opportunity to develop their skills; this should also improve the quality and timeliness of referrals.

- The vacant LADO post has now been filled.

- The LSCB provided joint training with the Local Authorities Human Resource team on safer recruitment for schools.

Identification of Children at risk of Sexual Exploitation

- The LSCB has responded to the national issue of children and young people at risk of sexual exploitation through a strategic multi-agency group tasked with reviewing the local multi-agency protocols, mapping out the prevalence of CSE and identifying the intervention resources in the borough.

- The local authority reviewed how they collate information and have imbedded changes into the ICS system, enabling easy and clear access to known cases of concern.

- A CSE themed audit was undertaken to have an overview of multi-agency practice in identifying and responding to allegations of CSE.

- Multi-agency training with Barnados was delivered by the LSCB as well as a learning lunch where local workers shared their experience of working with CSE in the area and informing agencies to the services in the borough.

- In recognition of the link between group and gangs and child sexual exploitation, a learning lunch workshop was held in February and

safeguarding and gangs has been included in the 2013/14 multi-agency training programme.

Supporting and monitoring organisations in the identification and response to Neglect in the borough.

- In April 2012, the LSCB published a SCIE review of a family where neglect was a key issue. It raised a number of concerns over agencies ability to identify and respond to Neglect.

- Neglect was the theme of the LSCB's 2nd Annual Safeguarding conference with National and local speakers including Action for Children.

Key areas of progress and achievements in 2012-13

- Completion of Section 11 audit of safeguarding arrangements in eight agencies; including the police service, housing and children services.

- The development of a bi monthly LSCB newsletter to facilitate communication of local and national safeguarding issues

- Development of Learning lunches providing bite-size learning opportunities for professionals across all agencies, sharing local experience

- Building on 3rd sector's (voluntary services) involvement with safeguarding by holding two joint 3rd sector safeguarding events which included the involvement of adult safeguarding leads

- Revised multi-agency pre-birth guidance document with the aim of :

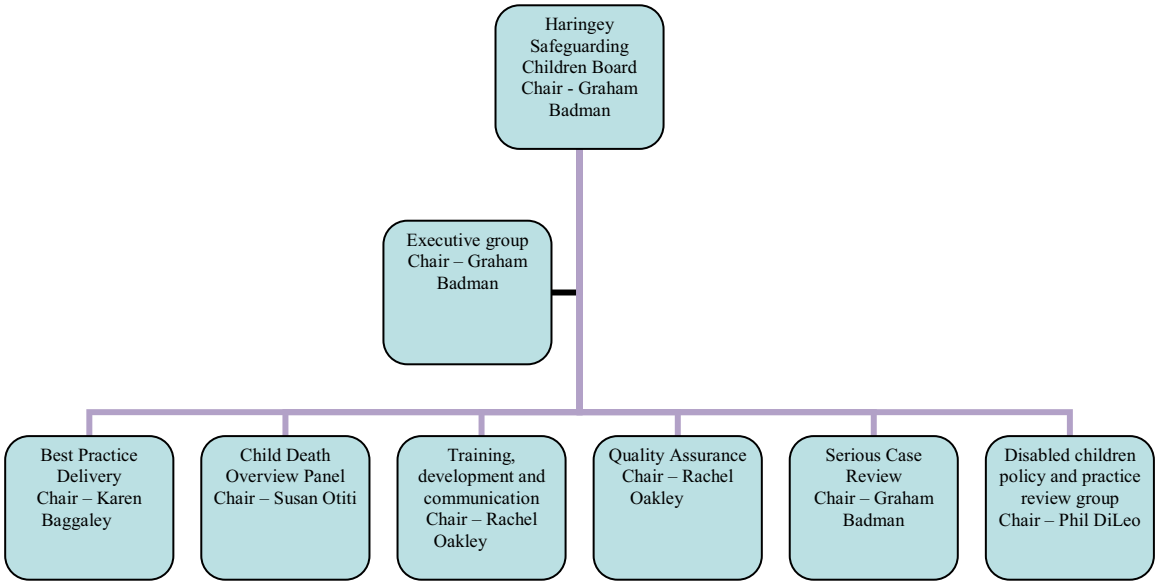
  - Increasing awareness across the partnership
  - Increasing referrals to the Family Nurse Partnership (FNP)
  - Increasing use of pre-discharge planning meetings
  - Reducing late referrals to the Safeguarding panel.
  - Increasing pre-birth planning and support for young people previously Looked After or those currently Looked After.

- Continued to deliver and develop high quality and up to date multi-agency training

Section 4 includes more detail on the work of the LSCB and its partners.

Section three – Effectiveness of the LSCB - Governance and accountability arrangements

Structure chart



Chairing and membership arrangements

- Graham Badman continues to be the Independent chair of the board, a post he has held since 2009.
- The board met every two months throughout the year, a total of 6 times.
- The work of the board is progressed through its sub groups and time limited working groups. Haringey has six subgroups - each has an annual work plan that is agreed by the board.
- There is also a task group which reports to the board on Child Sexual Exploitation.
- As of October 2012, the working group that focuses on disabled children, which previously reported into the Quality Assurance sub group, was recognised as a sub group in itself and now reports directly to the LSCB.
- There is also an executive group of the LSCB Board, which comprises leads from each of the key statutory agencies, together with the Independent chair and Business manager. Changes are being made to include the chairs of all the sub groups; this will strengthen the board's oversight of its own

performance and effectiveness as well as provide sharper focus on evaluating the improvements of the help, care and protection being provided to children and young people in Haringey.

- The board will become even more transparent and have further scrutiny and challenge with the inclusion of the newly appointed lay member. The Lay person will be in post summer 2013.

- The board regularly reviews its priorities and the work of its groups through the board and executive group. It takes into account learning from other boards and national research.

- The board work will continue to review how it can demonstrate the impact of safeguarding activity on the outcomes for children and young people

Engagement of partners

- To ensure that safeguarding work is co-ordinated and monitored effectively it is important the board has the right representatives and that they have a clear understanding of their roles and responsibilities. There is always a balance between needing the right people and the optimum size for a meeting to progress business effectively. The current board has 35 members.

- Member's attendance is good for a Board of this size. A full schedule on attendance can be found in appendix 2

- There were changes in representation from schools, but in late 2012 the board welcomed Head teachers from both primary and secondary who have added much value.

- This year has seen the joining of the London Ambulance Service and the re-joining of the voluntary sector to the board.

Relationship between the LSCB and the Children Trust and other strategic boards

- The Children's Trust was re-established this year and the chair of the LSCB is a member and is there to provide challenge and share the views of the LSCB so consideration can be given when commissioning and developing services. In addition the lead member for children services chairs the Children Trust and is a member of the LSCB

- Haringey has a Shadow Health and Wellbeing board. Boards will take on their statutory functions from April 2013 and will be a forum for key personnel from health and care systems to work together to improve the health and wellbeing of their local population and reduce health inequalities. In February 2013, the LSCB annual report was presented to the Shadow board.

- In addition health will have significant changes with the establishment of the clinical commissioning group. The lead doctor has been invited to join the LSCB.

Role of elected members and directors of children services

- In May 2012, Councillor Lorna Reith left her post as lead member for children. New lead Member for children Councillor Ann Waters, who took up her place on the LSCB as a participant observer.

- The DCS continued to work closely with the LSCB chair and hold the chair to account for the effectiveness of the LSCB.

Financial arrangements

Income 2012/13

Agency	Contributions (£)
Children Services	£189,697.02
Metropolitan Police	£5,000
Whittington Health	NIL
North Middlesex University Hospital	NIL
BEH –MHT	NIL
Cafcass	£550
Probation	£2000
Tottenham Hotspur	£2000
Total	£199,247.02

Expenditure 2012/13

Narrative	Budget (£)
Salaries	132,879.12
Trainers	14,410
Administration/Equipment	1341.15

Catering	2021.82
Consultancy	35,208.09
Other (LSCB expenses)	550.92
Publicity	1901.70
Venues	5150
Total	193,462.80

- Contributions to the board are both financial and non-financial. Due to the changes around the administration of the board, 2012/13 demonstrated some of the challenges that can arise when financial contributions are not agreed in the preceding year. Although in 2012-13 the financial contributions were highly dependent upon Children's Services, other agencies (particularly health) have made notable contributions in terms of release of staff time.

- As some agencies cover other boroughs there can also be variations in the amounts contributed.

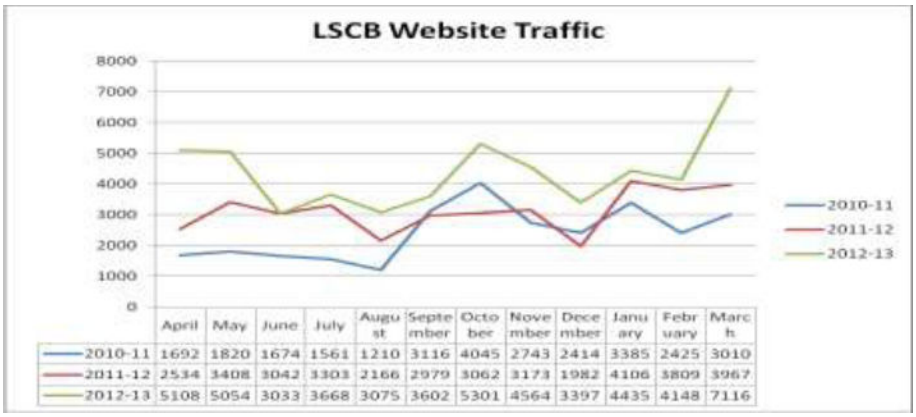
- For the year coming contribution amounts have been agreed in advance, which will lead to more effective planning and moving tasks forward.

Haringey LSCB Website and communication

- Over the year the LSCB has made attempts to improve how it communicates information and feeds back progress to practitioners across all organisations.

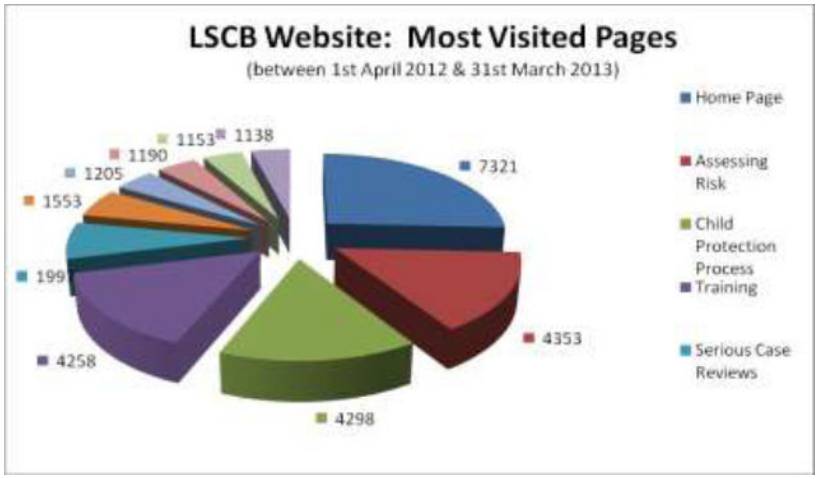
- The introduction of a regular newsletter and the improvement of the News website page enable's the LSCB to detail local and national safeguarding activity. This in turns enables professionals and the public to have an understanding of what work is been carried out.

- The regular "inside story" feature in the newsletter has been very welcomed and allows practitioners to share their child protection experiences from their view and has included stories from; a GP, teaching assistant and youth offending officer.



	April	May	June	July	August	September	October	November	December	January	February	March
2010-11	1692	1820	1674	1561	1210	3116	4045	2743	2414	3385	2425	3010
2011-12	2534	3408	3042	3303	2166	2979	3062	3173	1982	4106	3809	3967
2012-13	5108	5054	3033	3668	3075	3602	5301	4564	3397	4435	4148	7116

- There has been a significant increase in people accessing the LSCB website this year



- The chart above shows the top 10 most visited pages with number of hits.
- The LSCB training programme 2012-13 was downloaded 688 times between April 2012 and March 2013.
- The Scie Review on our Serious Case Review page was downloaded 741 times between April 2012 and March 2013 and had the longest page view of 8minutes 3 seconds.

Section four –LSCB subgroup activities

The key aim of the work of Haringey's LSCB sub groups and working groups is to impact on local arrangements and outcomes for children.

This section provides a summary of each sub group's work this year.

LSCB Sub groups

Child Death Overview Panel (CDOP) Chair - Assistant Director, Public Health

Remit: To review the circumstances surrounding all child deaths and make preventative recommendations where possible; to ensure a rapid response to any that are unexpected.

Over the year:

- There were 3 Child Death Overview panel meetings and 1 rapid response meeting.
- There were 20 deaths notified; a decrease on last year.
- The panel closed 15 cases, though none were for the current year.
    - Two children were known to the social services disability team and one child had a child protection plan due to parental mental health. This was unrelated to the death of the baby at four days old.
    - There were no suspicious deaths and no particular patterns of disease.
- An analysis of a single year's deaths, because of the small numbers involved, would be limited in its value. As the CDOP process has now been in place for five years (2008-2013) a review of this period is being carried out with the local authority public health department."

Quality Assurance Sub Group Chair - Head of Safeguarding, quality assurance and development, CYPS

Remit: To monitor the effectiveness of multi-agency child protection work through data analysis and audit processes

- The Quality Assurance sub group met 5 times and had a change of chair towards the end of 2012. As the LSCB's key group to oversee the performance of agencies, this years has been a challenge and has involved a review of the dataset and its effectiveness. As a result, the LSCB QA Sub-Group has undertaken a commitment to develop a new performance framework, based on a model developed by LSCBs in the Eastern Region as

part of the region's sector-led improvement work. The model is based on linking vision to performance, and understanding "what good looks like". It identifies priority outcomes and asks the question 'how will we know?' that these are achieved.

- The aim is to base this on the current priorities already agreed by LSCB, and to use the framework to provide a clear view of progress on the journey to realising them. If used successfully it is hoped that the framework will help to focus the board's attention on measuring achievement against its ambition, and reduce duplication of 'in agency' monitoring which can commonly be a distraction for LSCBs. It is also the intention that the framework will make more visible the contribution of partners, who will need to be fully engaged with its development.

- The framework gathers together a range of types of evidence including data and statistics, messages from audit, the voice of the customer and of staff, and professional expertise or other evidence. It is expected that the process of identifying the necessary evidence will include a range of existing measures and material, but will also highlight where development of further evidence sources may be necessary, or where new insights might be gained by bringing together information held by partners. It will also be necessary to define a tightly focused set of data which is required to monitor the core functions of the LSCB. The approach is both mindful of, and supports, the new requirements of the DfE Safeguarding Performance Information Framework[4] [born of the recommendations of the Munro Review], and some of the more soft-edged local information requirements it contains. Many of the "How do you know…?" questions which are a large part of the local information component [i.e. those which should be monitored in local areas, but which are not reported to central government] fit closely with the framework's use of customer and staff feedback.

The development of the framework is scheduled to begin during the first quarter of the 2013/14 financial year.

Serious Case Review Sub Group Chair - LSCB independent chair

Remit: To decide when to undertake a review and to monitor implementation of action plans.

- When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a Serious Case Review. The LSCB should consider undertaking a review whenever a child has been seriously harmed and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the welfare of the child.

[4] http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/b00209694/perf-info

- The LSCB undertook 2 management reviews during the year, one of which became a Serious Case review.
    - 1 review involved a SUDI (sudden unexplained death of an infant) – this raised learning over co-sleeping and the advice given by professionals to parents.
    - 1 review involved a child under 5 and concerns over physical harm, the findings resulted in the SCR sub group agreeing a Serious Case Review should be undertaken. This is now underway and should be completed Summer 2013
- There were no SCR's completed during this year.
- The learning from reviews conducted during this year will be published in next year's Annual Report.
- Professor Eileen Munro recommends that LSCBs adopt 'system' methodology in conducting Serious Case Reviews in order to move beyond identifying what happened to explain why it happened. In their response the Government has clearly agreed that such approaches should inform further consideration. Haringey LSCB took the opportunity as part of the pan London pilots to trial a SCIE methodology review on a case
- This review was completed in 2012/13 and looked at the neglect of children in a family.
- The process engaged both frontline practitioners and managers in a reflective process of learning and action planning. The response from those directly involved in the process has continued to be very positive. The report can be found on our website. Details of the learning from this review are in section five.
- A session was held on the findings of the SCIE and involved staff and managers in the learning process. It is the responsibility of each partner agency to ensure that lessons from Serious Case Reviews are disseminated to both managers and frontline staff.
- There have been changes to raise the standards to the process of referring cases to the SCR sub group with the introduction of a referral form as well as guidance notes being provided to assist agencies with the completion of their Individual Management Review reports (IMRs).

Best Practice Delivery Sub Group (BPD) Chair - Designated Nurse for Child Protection, North Central London

Remit: To turn the learning from serious and other forms of case review into effective operational practice

- There were six meetings held this year and a range of safeguarding issues were reviewed including:

  - Early Years provided a report of safeguarding arrangements for child-minders, children centres and are now members of the sub group. The report set out the approaches being taken which include the Haringey Quality Improvement and Accreditation Scheme in use across all private, voluntary and independent providers (PVIs) who deliver the 3&4 year old free entitlement and the requirement of all designated Child Protection officers to attend a termly safeguarding forum to support their expertise.

  - A similar scheme has been developed and is now in place for child minders. Support is available for child-minders regarding Ofsted registration. All child-minders are required to attend basic safeguarding children training with updates every three years. This training is specifically tailored to meet the needs of child-minders and since 2012 an advanced training is also available.

  - The Safeguarding Forums held for children's centres led by children's social care and each centre has an identified Family Support Worker. All children's centres receive an updated list of children subject to a child protection plan each month.

  - Child Protection Conference Process pilot was reviewed. This was a large scale piece of work which began in November 2011 whereby all the reports for the conference are read in the 30 minutes available prior to the start of the conference leaving more time for discussion and analysis of risk and need by participants and family. Each attendee of the conference records his/her analysis and view as to whether a child protection plan is required before each person is asked. A plan is then made to address the needs and reduce the risk.

  - The final evaluation report was discussed at the sub group in February and circulated to agencies.

  - Parents, carers and, where appropriate, children informed the evaluation report of the child protection process.

  - An audit on the involvement of GPs in the child protection process was discussed in the sub group which highlighted a number of issues: significant number of incorrect GPs being invited to the initial conference (this was largely resolved by the review conference), number of reports from GPs recorded on the minutes, and quality of the reports. Joint work is currently underway between Haringey Clinical Commissioning Group and Children and Young People Service (CYPS) to address these issues.

Training, Development and Communications Sub Group Chair - Head of Safeguarding, Quality Assurance and Practice Development (CYPS)

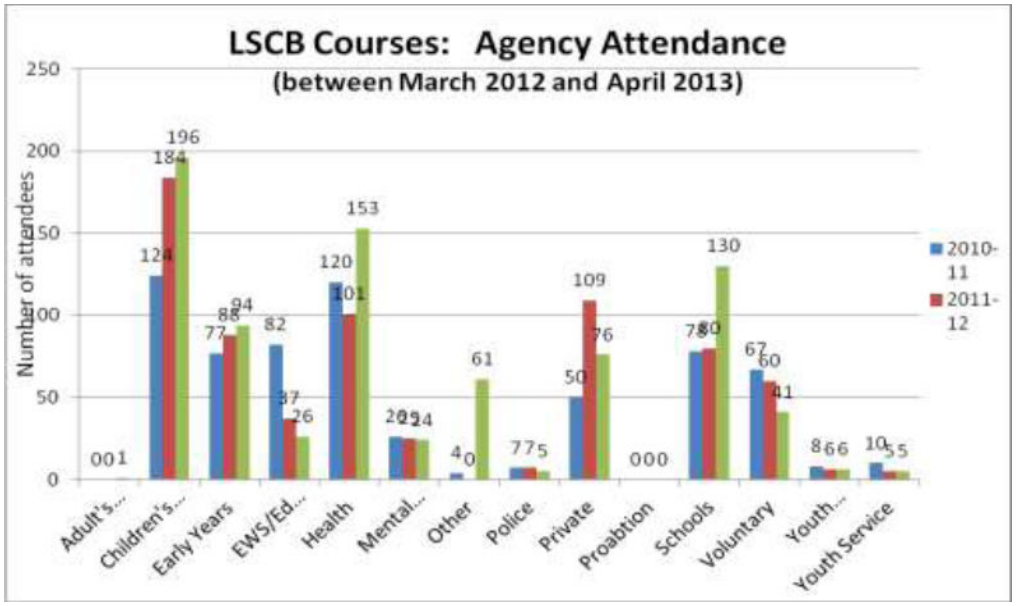
Remit: To oversee the delivery and evaluation of a multi-agency training programme and monitor the degree to which partner organisations are ensuring a 'safeguarding-aware' workforce

- There were 6 meetings held of the training, development and communication sub group.
- This year there were significant changes in the training programme which included the introduction of courses such as E-safety, to support professionals around safeguarding children in the digital world.
- The programme also had the inclusion of learning lunches, an opportunity for agencies to get bite size learning during their lunch hour. These sessions have been a great success seeing numbers of participants exceed 60 for some sessions. These sessions provided a local context to a variety of issues raising awareness of the local picture and the local response. Sessions have included Child Sexual Exploitation and Female Genital Mutilation.
- As part of the ongoing evaluation of training the LSCB training officer carried out a review of the impact of training, producing a report for the board.

Impact of training

- Haringey LSCB uses a range of approaches to ensure the quality of single and multi-agency training, including the Annual Training Return (that seeks to identify quality and quantity of single agency training as well as multi-agency training received across agencies), using a tendering process to commission trainers, employing clear contracts for internal and external trainers, course evaluations, and quality assurance of courses offered.
- A moderate review of the literature to research others' learning on linking training to practice and outcomes for children and young people was conducted.
- In order to explore further the link between training, practice and outcomes for children and young people, an Evaluation Pilot was carried out, to see whether other methods of evaluation might be preferable to, or might supplement, the current 'happy sheet' evaluation and quality assurance of courses.
- The purpose of the evaluation pilot was to evidence the impact of training on practice and on outcomes for children and families. Although the evaluation pilot did bring up some interesting data, the response rates were so low as to make an effective analysis of the data difficult.

Agencies attending multi-agency training



- 1059 (966 last year) applications were received throughout the year
- 818 (701 last year) of those attended the course, 182 did not attend and 59 cancelled- (17 courses were run throughout the year by external trainers)
- The agency with highest attendance is Children's Social Care with 196 applicants

Agency Attendance	2010-11	2011-12	2012-13
Adult's Social Care	0	0	1
Children's Social Care	124	184	196
Early Years	77	88	94
EWS/Ed Support	82	37	26
Health	120	101	153
Mental Health	26	25	24
Other	4	0	61
Police	7	7	5
Private	50	109	76
Probation	0	0	0
Schools	78	80	130
Voluntary	67	60	41
Youth Offending Service	8	6	6
Youth Service	10	5	5
Totals	653	702	818

Disabled children's policy and practice review group Chair - Head of service to children and young people of additional needs and disability

Remit: This group took recommendations from DCSF Guidance 2009 on Safeguarding Disabled children to provide its work plan and framework for the year.

The Disabled Children's Policy and Practice Review group became a formal subgroup to the LSCB in November 2012. The priorities for the group were:

- Domestic Violence and Disabled children,
- poor attendance at school masking CP issues for Disabled children,
- home educated Disabled children,
- Multi-agency audits, review of children who have SEN, at school action plus and one additional external service and on the threshold of CP.
- The effectiveness of Multi disciplinary team meetings in Special schools was reviewed.
- The impact of short breaks services on improving family's resilience was reviewed.
- Haringey's Threshold for continuum of need and intervention has been developed to include a more detailed definition of the threshold as it applies to Disabled children.
- Role of transport / escorts in safeguarding
- Lines of enquiry listed above has challenged professionals' practice in authorising absences, monitoring home education programmes; screening for DV etc
- Work informed development of new descriptors;
- Head teacher from Independent special school and who works with different LAs has shared practice with those LAs and applied lessons learned;
- Number of disabled CIC placed in residential schools has reduced and slowed the rate of disabled children requiring care;
- Further work underway as to how all services can maintain and share chronologies
- Special schools report that MDT meetings have demonstrated efficient and effective use of professional's time; improved working together and sharing of information; increased management of risk at school level; improved referrals enabling clear decisions to be made against thresholds.

The group also:

- Raised awareness of complexities involved in safeguarding disabled children across social care, education and health professionals;
- Detailed case reviews subject to evaluative and reflective multi agency discussions;

- Shared and tested Special school safeguarding policies to ensure fit for purpose;

- Gained clearer information from children during CP investigations and medicals using communication packs.

Participation of children and their families

- All permanent positions in the Additional Needs and Disability (AND) service involve parents of Disabled children and a youth panel of Disabled YP as part of our safer recruitment process.

- Regular meetings with parents / carers / providers including developing short breaks, personal budgets, transition, secondary transfer, starting school, preparing for changes in legislation. Attendance at all sessions has been from 60 – 100 parents on each occasion which has contributed to parents being well informed and there is evidence of how this has directly influenced decision making.

- Children within one of our Special schools are being consulted on the Threshold document regarding the descriptors of abuse for Disabled children.

Task groups

Child Sexual Exploitation Task group

- Child Sexual Exploitation (CSE) has been high profile nationally most notably due to cases in Oxford, Derby and Rochdale as well as the Children Commissioner's office review of CSE.

- Haringey set up a CSE group a year ago and have gone through a change of chair this year with the departure of the previous chair who had been leading on the work. Over the latter part of the year the group has re-established itself and has completed the multi-agency CSE protocol and will launch the protocol in the summer.

- A multi-agency themed audit was undertaken looking at the identification and response to CSE. The key findings were that CSE was identified appropriately and the initial response was appropriate. There was concern over the response from the agencies working with the families after the initial identification. As CSE awareness is raised future audits will take place to see if there is an improvement.

- Work is underway on mapping out the prevalence of CSE in the borough and what services are currently available. This will be captured in a report and made available to the board later in the year.

Allegations against professionals – LADO

Key development work completed in 2012/13[5]

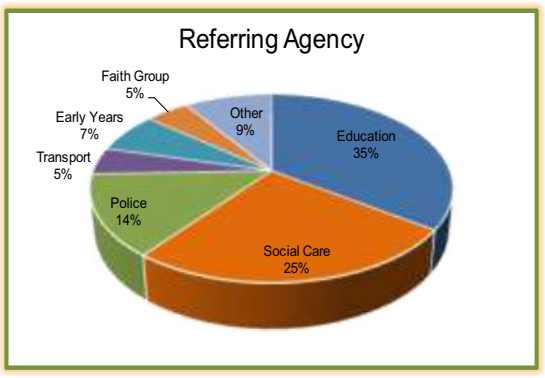
- Review of the thresholds for progressing referrals to strategy meeting stage – to ensure referrals receive the appropriate level of response.
- New workflow designed resulting in a process that is explicit to all
- The documentation and guidance has been reviewed and updated
- Development of confidential electronic recording system (on framework-i) for LADO referrals, improving recording and reporting capability significantly, resulting in following improvements operational from 1st April 2013:
  - service able to record and report in detail on all consultations and allegations which meet threshold
  - capture and reporting of all performance related data such as nature of referral, referring agency, setting of employment
  - capture and reporting of diversity data of alleged perpetrator(s) and alleged victim(s)
  - ability to compare and contrast data with allegations made within perpetrators own families or outside work
  - reporting of outcomes
  - reporting of length of time to resolve cases
- Development of system for recording and monitoring consultations.
- The LADO attends forums for Designated Teachers of primary and secondary schools and Children Centre meetings.
- The LADO action plan was updated in line with the last OFSTED recommendations and implemented.

Defined and communicated clear respective responsibilities of the referrer, HR and the LADO. This includes defining the criteria and boundaries in the process for a range of outcomes e.g. cases that meet the criteria for suspension.

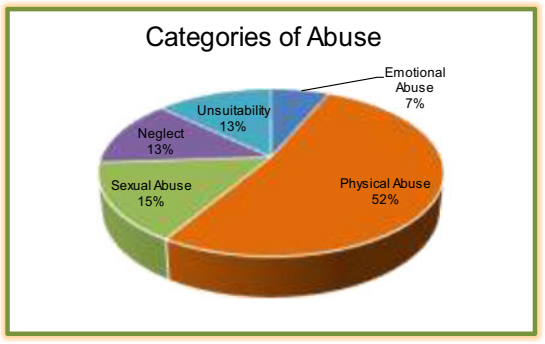
Referrals that met threshold - There were 46 referrals to the LADO that met the threshold for involvement. This figure is broadly in line with our neighbouring boroughs.

[5] *Reported activity is limited to quarter 3 and 4. Appointment of LADO and transfer of oversight of work to Head of Service for Safeguarding, Quality Assurance and Practice Development, made at the end of September 2012.*

The following charts illustrate the breakdown of referrals by referring agency and by categories of abuse



Referring Agencies - The large majority of contacts with the LADO came directly from the educational setting itself and account for 35% of referrals in total. The remaining educational referrals came via CYPS staff or the police after parents had approached them.



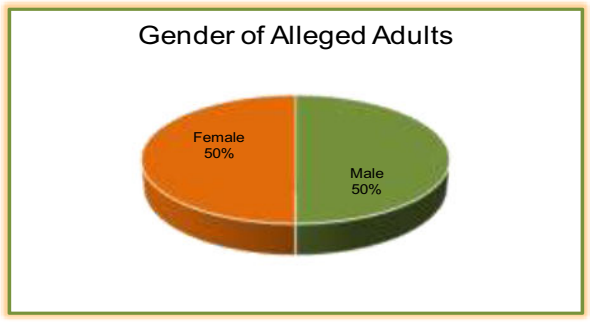
Categories of abuse - The largest category of allegations by type was physical abuse this primarily occurred in educational settings and accounted for 52% of allegations that met threshold and 59% of all allegations received.

- The majority of these allegations relate to teachers and support staff having trouble in managing challenging behaviour and the use of restraint regarded as being unlawful or contrary to guidance.

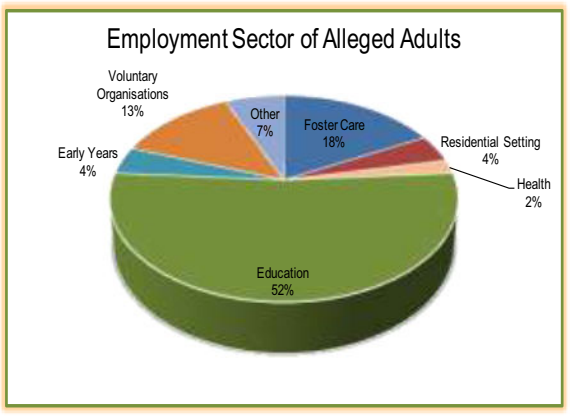
- In particular, the issue of appropriate restraint and personal protection by teachers when a child is out of control was a feature of a significant number of the allegations investigated. Analysis highlighted a positive correlation with a lack of understanding and interpretation, of the relevant legislation.

- Although there was a predominance of allegations in relation to physical and sexual abuse, it was notable that the individual circumstances of the allegations varied significantly. This demonstrates the need for designated professionals and senior staff responsible for safeguarding to have an awareness of the range of situations in which children could be harmed and how what meets the threshold for intervention by the LADO.

Profile of adults that allegations have been made against



Of the 46 referrals to the LADO, there were an equal number of women and men referred.



The majority of referrals came from state schools, with only one by an Independent Academy. There are a low number of referrals from other sections, such as Early Years and children's residential provision. The lowest reported sector was Health. There have yet to be any referrals from Police[1].

Comparative Data

- The number of allegations (46) investigated in the year 2012/13 represents a considerable decrease from the 87 allegation deemed to have met the threshold in 2011/12. This reduction is a result of successful changes in application of the thresholds, LADO consultation and advice resulting in addressing issues through more appropriate channels such as HR procedures or through focused learning and development.

- During 2012/13, the largest numbers of allegations were made in respect of foster carers, the majority of these allegations subsequently being withdrawn or found to be unsubstantiated. The reduction in referrals that have been converted into investigations represents further improvement in the appropriate application of thresholds and focus on situations that meet the criteria for statutory intervention. Analysis of referrals since October 2012 that have led to investigation and those that did not meet the threshold has shown that the appropriate decisions have been made. Feedback from partner agencies including schools and children's centres indicate an increasingly high level of satisfaction and understanding of the process and thresholds.

Substantiation of Referrals

- In six months between October and March 2013, 56% of allegations taken to strategy meeting were substantiated (25% of these led to a criminal prosecution, with half of this number being convicted and other awaiting the outcome of the proceedings) and 25% of allegations were unsubstantiated of which one was found to be malicious.

- It should be noted that when an allegation is deemed to be unsubstantiated this does not necessarily equate to it being unfounded, but rather there is insufficient evidence to substantiate the allegation.

Community Partnership - Pamela Pemberton, HAVCO

- There are some 1000 Voluntary and Community Sector (VCS) organisations working in Haringey and a large proportion of them provide services to children, young people and their families.

- At the height of Haringey's Strategic Partnership (HSP) there had been organised engagement with voluntary sector partners operating in the children and young people's sector. Since the demise of the HSP the Local Children's Safeguarding Board has filled this gap by working closely with HAVCO late last year to ensure that voluntary sector providers are aware of their safeguarding responsibilities and to seek better ways of cross-working.

- The first important change that occurred is that HAVCO joined the LSCB in October 2012. Since this time the organisation, in conjunction with the LSCB and Children England, held two important events; the *Safeguarding Today Seminar* in December 2012 and *Core Standards Training* in March 2013. Approximately 90 VCS organisations in total, participated in these events.

- Through this engagement and support the VCS have: a) become more aware of how to access key resources to help them navigate their way through vetting and barring changes via the Safer Network website, b) consolidated a safeguarding priority list and c) developed two reports from the consultation and training as reference for future developments.

- Key partners need to maintain and build upon this momentum and the LCSB, Children England and HAVCO are currently looking at what we can put in place, given limited resources, to ensure that engagement between statutory leads and children and young people voluntary sector providers are held regularly, enabling the VCS to influence policy and service developments whilst developing and strengthening the VCS workforce to manage safeguarding issues effectively.

- Our ultimate goal is that ongoing engagement between partners improves and protects the lives of children, young people and their families living in the Borough.

Section Five – Local Safeguarding performance data

Quality assurance monitoring

In 2012/13 the LSCB has continued to challenge the performance of partner agencies to ensure the effectiveness of arrangements to keep children safe. This has been done by:
undertaking a multi-partnership Section 11 audit on agencies' safeguarding arrangements including on-site visits to confirm the evidence detailed in the self assessment returns. There is more detail later in this section.

Safeguarding data

Long term trend	2009/10	2010/11	2011/12	2012/13
The Number of child contacts received	14,355	9,556	6,722	6,637
The number of referrals to children social care	3324	2658	2509	2045
The percentage of referrals to children social care going on to initial assessment	-	84%	99%	87%
Percentages of re-referrals within 12 months of the previous referral		19%	17%	15%

- There has been a small reduction in contacts and a significant reduction in referrals to children social care in 2012/13.
- There is a continued reduction in referrals to children social care
- The percentage of re-referrals continues to reduce

Long term trend	2009/10	2010/11	2011/12	2012/13
Percentage of initial assessments for children's social care carried out within 10 working days of referral	-	66%	71%	70%
Percentage of core assessments for children's social care that were carried out within 35 working days	47%	63%	66%	70%

Long term trend	2009/10	2010/11	2011/12	2012/13
Children subject to a child protection plan	294	320	284	275
Children becoming Subject to a child protection plan in the period		334	277	354
Children ceasing Subject to a child protection plan in the period		-308	-313	-363
Haringey Net Change		*26*	*-36*	*-9*

Long term trend	2009/10	2010/11	2011/12	2012/13
Children moving to Haringey on a child protection plan	-	-	11	25
Children moving out of Haringey on a child protection plan	-	-	-32	-27
Haringey Net Change	-	-	*-21*	*-2*

Long term trend	2009/10	2010/11	2011/12	2012/13
Child Protection Plans lasting 2 years or more	16.9%	5.8%	6.4%	7.0%
Percentage of children becoming the subject of Child Protection Plan for a second or subsequent time	-	9.0%	10.5%	4.8%
Percentage of child protection cases which were reviewed within required timescales	96%	98%	97%	95%

Long term trend	2009/10	2010/11	2011/12	2012/13
Child Protection Visits	-	92%	95%	94%
Children in Need Visits	-	69%	81%	85%

Long term trend	2009/10	2010/11	2011/12	2012/13
Care Proceedings Initiated– (No. of children)	-	243	137	117

Key headlines:

- There has been a reduction in contacts to Children Services over the past 12 months. This could be due to the efforts by the screening team to develop stronger relationships with referrers and providing clear advice around thresholds and information sharing.
- There has been a pro-active effort to have discussions with referrers to ensure that only those contacts that require statutory assessment are progressed and alternative strategies such as the use of CAF and the voluntary sector that do not meet the criteria.

- The low re-referral rate is an indicator that referrals to children social care and the work of the first response team is effective and resulting in low referral back into Children services
- The % of IA's completed in 10 days is below that of statistical neighbours. As of 2013/14 there will be the introduction of the single assessment, which will set targets of seeing a child within 10days.
- There has been an improvement in the completion of core assessments. Children services managers will need to be more focused in 2013/14 with the changes to a single assessment and management oversight to ensure targets on completion dates are met.
- There has been a 58% reduction of children with disabilities being subject to a CPP.
- There has been a decrease in the number of care proceedings initiated.

AUDITS, REVIEWS and EVALUATIONS

The partnership undertakes audits, reviews and evaluations throughout the year both multi-agency and single agency to provide assurance of the safeguarding practices and arrangements in Haringey and to improve single and multi-agency practices.

In the past year these include:

- 7 - Audits carried out by Barnet, Enfield and Haringey Mental Health Services
- 2 - Multi-agency carried out by LSCB
- 2 – Audits by the disabled children policy group
- 1 – Audit by health in respect to GPs
- 1 – Audit on core groups
- 1 – Audit by NMUH
- 1 – Audit on conference attendance by CYPS

An audit of Child Protection cases held in the safeguarding and support team was completed – identified issues of thresholds and effectiveness of CP plans. This team have actively looked at the findings. The audit also raised the issue on transfer between teams in Children social care and changes are taking place from April 2013 which involves the inclusion of the new social worker at the initial conference which allows CP plans to be progressed more quickly and less drift.

Child Protection Conference Pilot

An evaluation has taken place on the new child protection conference model which was piloted in Haringey Council in October 2011. The model was developed by the

Child Protection Chairs, who based it loosely on the Strengthening Families model of conferencing.

Section 11

- Section 11 (s11) of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others are provided having regard to that need. Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children.

- *Working Together to Safeguard Children* (2010) requires Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of organisations' implementation of their duties under s11 of the Children Act 2004. The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through co-ordinating services but also through evaluation and continuous improvement. For example, by asking individual organisations to self-evaluate under an agreed framework of benchmarks or indicators and then sharing results with the Board.[6]

- This is the first s11 Audit commissioned by Haringey LSCB

- The key requirements from the statutory s11 guidance are as follows:

    - senior management commitment to the importance of safeguarding and promoting children's welfare;

    - a clear statement of the agency's responsibilities towards children, available for all staff;

    - a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children;

    - service development that takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families;

    - staff training on safeguarding and promoting the welfare of children for all staff working with or (depending on the agency's primary functions) in contact with children and families;

    - safe recruitment procedures in place;

    - effective inter-agency working to safeguard and promote the welfare of children; and,

[6] *Working Together to Safeguard Children (2010), 3.28*

- effective information sharing.

- The Haringey LSCB s11 audit incorporates the standards for the areas of 'child protection' and 'safer staff and volunteers' with the addition of Ofsted standards for the effective functioning of an LSCB and in Section 12 of the audit, outstanding actions arising from Ofsted/CQC inspections in Haringey in early 2011. These relate almost entirely to Children's Social Services (CSC) only.

  - Adult Social Care – Haringey Council
  - Children's Social Care including Children with Disabilities Team– Haringey Council
  - Metropolitan Police - CAIT
  - Probation Service
  - North Middlesex University Hospital Trust
  - Whittington Health
  - Barnet, Enfield and Haringey Mental Health Trust
  - Haringey Housing (incorporating both Homes for Haringey and Community Housing) (H4H)

- Compliance with, and commitment to, the process was high across all agencies. Based on discussions at site visits it was evident to the Assessment Team that all agencies took their safeguarding responsibilities very seriously and saw the s11 audit process as a valuable opportunity to reflect on and improve standards. In this respect the process itself has a real value in raising awareness of what still needs to be done as well as highlighting where things are going well. The Assessment Team felt that this was particularly the case in those agencies where the primary focus of the work is providing services to adults – Probation, Housing and Adults Services, who all saw the audit as a vehicle for strengthening how they respond to the needs of children who may be at risk.

- Individual agency action plans will not be presented in this report. All agencies are responsible for monitoring their own action plans. Statutory agencies are also responsible for monitoring the action plans of commissioned agencies and ensuring that any areas of non- or part-compliance are addressed... Areas identified for improvement will be collated by agency and used as the basis for their action planning. The Board asked for progress reports from statutory agencies at the end of the year

Cross cutting themes

- These themes emerged as significant across a number of agencies but do not necessarily apply to all. Nevertheless they are issues which all agencies

need to keep consistently in mind when reviewing their arrangements under s11

- Processes for ratification of single agency policies and procedures by the LSCB need to be clarified and strengthened
- All agencies need to review and strengthen internal communication processes for making staff aware of policies and procedures and organisational and professional accountability frameworks. This is particularly the case in Adult focussed services for whom embedding staff awareness of safeguarding children is a priority action
- All agencies need to strengthen processes for disseminating learning and data in relation to safeguarding to staff
- All agencies need to strengthen arrangements for listening to children at a practice level
- All agencies need to strengthen arrangements for incorporating the views of children and families into service and business planning
- All agencies need to ensure that all staff are subject to a robust induction process
- All agencies need to ensure that all staff receive the appropriate level of supervision commensurate with their roles and responsibilities
- More opportunities should be afforded for staff and managers from all agencies to discuss issues of mutual concern and to share good practice
- Where sub-contractors are used to deliver services to children all agencies need to ensure that they are fully compliant with s11 standards
- Work needs to continue in strengthening the use of the Common Assessment Framework (CAF)
- All agencies need to strengthen their relationship with the Local Authority Designated Officer (LADO)

Inspections

- In January 2013, the LSCB were presented with the results of the Safeguarding Practice Peer Challenge (SPPC) pilot undertaken by the Local Government Association (LGA) and the Children's Improvement Board in November 2012. As a first step in responding to the recommendations presented to the LSCB, they have agreed to commission an independent reviewer to conduct structured interviews with key agencies and staff nominated by the board. The interviews are to determine practitioner's views on thresholds and early help as above and to confirm whether agencies are content that they have both the correct protocols and sufficient resources in place when concerns about children are escalating and urgent information

sharing is required. These views will be presented to the board along with the review of the application of thresholds and early help by social workers so that partners can determine whether any further action is needed.

- The findings of this review will be commented on in next year's report.

Learning from case reviews - Neglect

Neglect is the most common reason for children being on child protection plans.

- In April 2012 the LSCB made public a report of professional's involvement with a family where neglect was a concern. The report highlights the failings to identify and respond to Neglect. The SCR sub group agreed to pilot a systems methodology developed by the Social Care Institute for Excellence (SCIE).

- The review looked at the chronic neglect of a number of children – both boys and girls - who were removed from home by the police under powers of Police Protection and placed in local authority care at the end of April 2009. Both parents were arrested, charged and convicted and both have served custodial sentences. At the point that the children were taken into care they were known to a range of agencies and had been known to children's social care since 2002.

- The report provides a clear narrative of what a lack of understanding of the nature and causation and impact of Neglect can have on a child's emotional and physical development

> ***"..because without an understanding of the causation, manifestation and cumulative impact of chronic neglect, responses in the future will inevitably, be generally wanting" SCIE Learning Together, Haringey LSCB , Report of the Review of Family Z, 2012, p18***

- The systems approach requires the review team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the 'local rationality'. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

- There were limitations to the review; for example some staff had left the borough and the family were not involved and therefore their view on professional's involvement was not captured. However, using the methodology the review team identified eight underlying issues in 3 areas.

Management systems

1. The absence of a coherence between family support services and emergency response

2. Autocratic management style creates fear, paralyses thinking and prevents

constructive case work challenge

Long term work

3. Inadequate understanding of the causation and impact of neglect across agencies

leaves professional efforts misdirected

4. No shared culture of authoritative challenge amongst professionals allowing for the

exploration of disagreements

Tools

5. Design of work processes and procedures makes it difficult to respond *as effectively* to neglect as to incidents/injuries

6. Computer systems can make it difficult

Cognitive and emotional biases

7. Absence of systems to promote review of professional judgements

Family-professional interaction

8. No effective challenge to, or ability to work with, non-engaging families

Section Six Effectiveness of safeguarding in Haringey and Key recommendations

This report aims to reflect the current state of safeguarding activity across Haringey and some of the work that has gone on in the last year. Many areas of the work the LSCB and its partners conduct is concerned with activity or output. It is not always easy to identify the outcome, or the result of the actions we take but our aim is to try and maintain a focus on what is happening on the frontline for practitioners and the actions that make a difference to a child or young person. The board will continue to ask the questions on how well are children and young people helped, cared for and protected. This will sometimes involve making informed judgements about likely impact, for example, the effectiveness of training in helping professionals take action if they are concerned about a child. The Board has knowledge of many of the services that the partners offer around early help and child protection, both individually and collectively. In many areas the board can say that partnership working is good, for example: the MASH.

The board has collectively challenged and assured itself around the effectiveness of safeguarding in a number of areas over the year including:

- Ensuring that there were clear local arrangements in place for safeguarding in health whilst the NHS reforms of moving towards Clinical Commissioning Groups. There was recognition that potential risks associated with reforms would be mitigated in part due to the continuity of key professionals within the arrangements, as well as the establishment of the Health and Wellbeing Board to ensure services communicate with each other.

- A year on from the London Riots, receiving updates on agencies' response to the riots, which included the work of Troubled Families which is part of a wider programme of early intervention and prevention measures. The local authority had invested money toward Youth Services, which had produced a summer programme to ensure there were opportunities for children and young people in the borough to take part in positive activities. Residential provision over the summer period would also be introduced and there had also been a move toward a more targeted youth work offer which hoped to target 180 young people over the year.

- Whittington Health was asked to provide assurance around their safeguarding training provision, following a decision to withdrawal from the LSCB mandatory induction training programme. It was clarified that the proposal would impact on Level 1 & 2 staff but there would be no change to staff training at level 3 who would still access the LSCB programme. All Whittington health staff would also be signposted to the LSCB training programme and encouraged to access multi-agency courses to update their knowledge.

- Establishing the local picture of Home Education children and safeguarding. Data provided indicated:
    - 108 pupils are registered as home educated.
    - 13 are known to special needs.
    - 5 known to social care.
    - 5 known to traveller's team.
    - None are on a subject plan.

Overall the reviews and audits the board and partners have carried out reflect that there is good work across agencies but there are improvements and challenges to the delivery of services.

- The voice of the child is often still missing; more work is needed to capture how CYP feel they are safe as well as whether CYP know how to keep safe.
- The link between early help, thresholds and child protection needs developing to ensure professionals and the community understand.
- Agencies will need to share regularly their safeguarding audits to provide a clearer overview of safeguarding to be included in the LSCB annual report 2013/14
- single agency annual reports should be presented to the board
- Representatives attending the LSCB should improve the quality of dissemination within their organisations of lessons learned and relevant information
- All agencies should review the cross cutting themes as identified in the Section 11 audit
- The issue of CSE should be addressed within in the Children and Young People's Plan and considered in the JSNA

Key recommendations

- All senior officers should ensure that their service has had sight of the recommendations from the SCIE review and monitor any specific action plans for their service
- All senior officers should ensure their service reviews the S11 cross cutting themes to assure themselves their safeguarding standards are robust and fit for purpose.

How will we know whether we are achieving what we want?

The Board has discussed the need to become sharper at determining the impact of our work, and whether we are achieving our ambitions. We are reviewing our current performance indicators, with a view to improving the range and quality of performance data that we receive, and enabling us to know whether we are achieving our ambitions. Next year's report will capture the result of this work.

Section Seven Priorities for 2013- 2014

These priorities include priorities chosen as a result of local issues and demands and will be addressed over 2013-14 by the Board. They will be incorporated into work plans aimed at improving outcomes progressed through the Boards agenda, or addressed more specifically by either sub groups or task groups.

Priority one	Engaging children, young people and their families
Priority two	Strengthening governance and accountability arrangements between the LSCB and other partnership boards
Priority three	Monitoring the effectiveness of the MASH and Early Help intervention (new)
Priority four	Ensuring the link between schools and safeguarding
Priority five	The identification and response to children and young people at risk of child sexual exploitation including where there is gang and group violence (amended)
Priority six	Identification of missing, unknown or opted out young people (new)

Section Eight Business Plan 2013 – 2014

This business plan outlines the agreed priorities and actions to be undertaken by the Board and its partners to deliver this year's safeguarding priorities.

P1	Engaging children, young people and their families			
	Action	Lead group/person	By When	Evidence
	Develop/revise guidance on engaging CYP and their families	Best Practice	March 2014	Guidance tool will be available to detail best practice on ensuring the voice of the child and their families
	Develop a performance indicator around engaging with children and young people	Quality Assurance Sub group	December 2013	It will be embedded in the LSCB Dataset
	Undertake a survey of CYP voices around how safe they feel in their area?	LSCB	March 2014	A report to be presented to board end of year and evidence of CYP voices in future business planning
	All agencies to include in their end of year reports evidence of how they engaged with CYP and their families	All members	March 2014	Views will be in end of year reports
P2	Strengthening governance and accountability arrangements between the LSCB and other partnership boards			
	Action	Lead group/person	By When	Evidence
	Development of LSCB members packs to show clear roles/responsibilities	Business Manager	October 2013	All members will sign agreement stating they understand their respective roles/responsibilities on the board

	Review of the membership and role of the Executive sub group	LSCB chair	October 2013	Revised Terms of Reference will outline role and membership of group
	Recruitment of second Lay member	LSCB	December 2013	The board will have 2 lay members
P3	Monitoring the effectiveness of the MASH and Early Help intervention (new)			
	Action	Lead group/person	By When	Evidence
	Develop a performance indicator around early help provision	Quality Assurance sub group	March 2014	It will be embedded in the LSCB Dataset
	Review impact of MASH's first 12mths	Best Practice sub group	March 2014	LSCB will have an understanding on the strengths and challenges to MASH
	Review findings of peer review challenge response	LSCB	October 2013	LSCB will have an overview of partners perception of thresholds and early intervention
P4	Ensuring the link between schools and safeguarding			
	Action	Lead group/person	By When	Evidence
	Undertake audit of statutory duties and responsibilities for schools (under s157/175 Education act)	Quality Assurance sub group	March 2014	LSCB will be able to form a view on safeguarding practices in schools
P5	The identification and response to children and young people at risk of child sexual exploitation including where there is gang and group violence (amended)			
	Action	Lead group/person	By When	Evidence
	Launch the multi-agency CSE guidance	CSE task group	September 2013	Copy of guidance will be sent to all agencies
	Monitor the GAG strategy	LSCB	March 2014	Representative from GAG to attend board
	Review known prevalence of CSE and provisions in borough	CSE task group	December 2013	Report to be made available to the Board

	Develop a performance indicator around CSE and gangs	Quality assurance sub group	December 2013	It will be embedded in the LSCB Dataset
P6	Identification of missing, unknown or opted out young people (new)			
	Action	Lead group/person	By When	Evidence
	Review missing from home and care guidance	Best practice	December 2013	Ensure document is fit for purpose and includes pathways for early help
	Develop a performance indicator around missing from care and home	Quality Assurance	December 2013	It will be embedded in the LSCB Dataset

Appendix 1

LSCB current Membership	
Chair	Graham Badman (Independent)
CYPS	Libby Blake (Director CYPS) Marion Wheeler (AD of Safeguarding) Rachel Oakley (Head of Safeguarding, Quality Assurance & Practice Development) Linda James (Strategic Manager, YOS)
Police	DCI Graham Grant (CAIT- North Sector) DCI Victor Olissa (Borough Commander) DI Keith Paterson (CAIT – Haringey)
Probation	Andrew Blight (ACO Haringey)
Health Services	Jennie Williams (Director of Quality and Integrated Governance, NHS Haringey CCG) David Elliman (Designated Doctor for Child Protection and Child Death, NHS Haringey CCG) Karen Baggaley (Designated nurse for child Protection, NHS Haringey CCG) Geoff Isaac (Consultant Psychiatrist, BEH-MHT) Julie Thomas (Named GP, Haringey) Dee Hackett (Director of Operations, Whittington Health Shaun Colins (Assistant Director, BEH MHT/CAMHS) Susan Otiti (Assistant Director, Public Health)
Lead Member	Cllr Ann Waters, Lead Member for Children
Cafcass	Phyllis Dyer (Service Manager)
Voluntary Sector	Fitzroy Andrews (Chief Executive, HAVCO)
Housing	Denise Gandy (Head of Housing Support & Options)
Schools	Joan McVittie, Head Teacher Jane Flynn, Head Teacher)
Adults Safeguarding	Lisa Redfern (Deputy Director, Adult & Community Services)
Legal Services	Stephen Lawrence (Assistant Head of Legal Services: Social Care)
LSCB officers	Angela Bent, Business Manager Shauna McAllister, Training Officer Naomi Foreman, Executive Officer

Appendix 2

Attendance

Organisation	Job Title	Date of Meetings						% of attendance
		30/05/2012	18/07/2012	26/09/2012	28/11/2012	30/01/2013	27/03/2013	
Independent	Chair	√	√	√	√	√	√	100%
Independent	Independent	√	√	√	Apologies	Apologies	√	67%
LSCB	LSCB Business Manager	√	√	√	√	√	√	100%
Health	Designated Nurse for CP	√	√	Apologies	√	√	√	83%
Health	Consultant Paediatrician, Designated Doctor	√	√	Apologies	√	√	√	83%
Health	Named GP NHS London	√	√	√	√	√	√	100%
Health, NMUH	Director of Nursing NMUH	Apologies	Apologies	√	√	√	√	67%
Health, NCL London	Chief Officer	Apologies	√	√		√	Apologies	100%
Health, Whittington	Assistant Director, Universal and Safeguarding Children's Services	√	√	√	√	√	√	100%
LBH/NHS NCL	Drug and Alcohol Strategy Manager	√	√	√	Apologies	Apologies	Apologies	67%
BEH-MHT	Consultant Psychiatrist BEH-MHT	Apologies	√	√		Apologies	√	50%
BEH-MHT	Executive Director of Nursing Quality and Governance	√	Apologies	√	√	√	√	83%
CAMHS	Assistant Director	√	Apologies	Apologies	Apologies	Apologies		17%
CYPS	Assistant Director	Apologies	Apologies	√	√	√	√	67%
CYPS - Prevention and Early Years	Deputy Director, Prevention and Early Intervention	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	0%
CYPS	Deputy Director Children and Families	Apologies	Apologies	Apologies	Post deleted	Post deleted	Post deleted	0%
CYPS	Director of Children's Services	Apologies	Apologies	Apologies	√	√	Apologies	33%

CYPS	Head of Service	Apologies	√	√	√	√	√	83%
CYPS - Prevention and Early Years	Head of Integrated Working and Family Support			Apologies	√		√	33%
Adult and Community Services	Deputy Director	√	√	√	√		Apologies	67%
CAFCASS	Senior Service Manager	Apologies	√	√	√	Apologies	Apologies	50%
Police, Borough Commander	Borough Commander	Apologies	√	√		√	√	67%
Police, Haringey CAIT	DI, CAIT	√	√	√	√	√	Apologies	83%
Police, CAIT	DCI, CAIT	Apologies	Apologies	Apologies	√	Apologies	√	40%
Education		√	√	Left	vacant	vacant	vacant	100%
Public Health	Assistant Director	√	Apologies	√	√	Apologies	Apologies	50%
Housing	Head of Housing Support and Options	√	Apologies	√	√	Apologies	√	67%
Legal Services	Assistant Head of Legal	√	Apologies	√	√	√	Apologies	67%
Probation	Senior Probation Officer	√	Apologies	√	√	√	Apologies	67%
YOS	YOS Strategic Manager	Apologies	√	√	√	√	Apologies	67%
Voluntary	HAVCO	Apologies	Apologies	√	Apologies	√	√	50%
Lead Member	Councillor	√	Apologies	√	√	√	√	83%
Primary School	Head Teacher	vacant	vacant	vacant	√	√	√	100%
Secondary School	Head Teacher	vacant	vacant	vacant	Apologies	√	Apologies	33%
London Ambulance Service	Ambulance Operations Manager	vacant	vacant	vacant	vacant	√	√	100%
CYPS	Head of Service, Additional Needs and Disabilities	-	-	-	-	-	√	100%

Contacts
For more information about the work of Haringey Local Safeguarding Children Board, please contact the LSCB Team: 020 8489 1470 or email lscb@haringey.gov.uk

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Agenda Item 13

Haringey Council

Report for:	Health and Wellbeing Board on 8th April 2014	Item Number:	

Title:	Autism, including self assessment

Report Authorised by:	Mun Thong Phung, Director of Adult Social Services pp B. J Tarka.

Lead Officer:	Beverley Tarka, Acting Deputy Director, Adult Social Services Tel: 020 8489 3353, Email: beverley.tarka@haringey.gov.uk

Ward(s) affected: All	Report for Key/Non Key Decision: N/A

1. Describe the issue under consideration

1.1 To enable the Health and Wellbeing Board to be briefed on Haringey' response to the Autism Strategy 2010, and to monitor the planning, commissioning and review of services for people with autism.

2. Cabinet Member introduction

2.1 The statutory guidance accompanying the Autism Strategy, Fulfilling and Rewarding Lives, states that Health and Wellbeing Boards will play a key part in the planning, commissioning and reviewing of services for people with autism. The Department of Health is undertaking a formal review of the Strategy, and a recent national self assessment exercise was initiated at the end of last year. I am pleased to introduce a summary of Haringey's self assessment, which highlights development locally and, more importantly, has helped us to focus on areas for further development.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to note the progress made in Haringey's response to the Autism Strategy, and to ensure that outcomes for people with autism are actively monitored and reviewed. It is proposed that progress reports will be made to the Health and Well Being Board annually.

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Haringey Council

4. Alternative options considered

4.1 Not applicable. The statutory guidance accompanying the Autism Strategy states that Health and Wellbeing Boards will play a key part in the planning, commissioning and reviewing of services for people with autism.

5. Background information

5.1 Following the Autism Act 2009, Fulfilling and Rewarding Lives (2010), a strategy aimed at improving outcomes for adults with autism, was launched. In 2013, Haringey was asked to submit a self assessment evaluation outlining progress on the implementation of the Strategy. This self assessment is attached as Appendix 1. Key areas covered are planning, training, diagnosis, care and support, housing and accommodation, employment, and engagement with the criminal justice system.

5.2 A summary of key developments in Haringey is also given below:

- There is a specific chapter on autism in the local Joint Strategic Needs Assessment (JSNA);
- Haringey's local Housing Strategy specifically identifies autism;
- Specialist Autistic Spectrum Condition (ASC) Training Programme developed with the National Autistic Society (NAS) and delivered to staff in Haringey's Learning Disabilities (LD) Partnership;
- Improvements in transition planning to support people with ASC;
- Projects to support housing for people with ASC (Autism in Haringey Housing
- Strategy);
- Running of a pilot tri-borough ASC diagnostic service;
- JSNA includes a chapter on autism;
- Advocacy for personalisation: Haringey Association for Independent Living (HAIL) commissioned;
- Supported living options, which support people with autism and a learning disability including people in the Winterbourne cohort; and
- For people with autism and a learning disability, there is a single pathway in terms of initial assessment, with specialist multi-disciplinary input from the LD Partnership.

5.3 As importantly, the self assessment has highlighted areas for future focus:

- Database of all people with a diagnosis of autism to be developed;
- The need to address the needs of people with autism who are high functioning;
- It is also acknowledged that in order to address the needs of high functioning autism (HFA)/Aspergers, there is the need for improved working with Mental Health Services;
- The requirement is for the mainstream Mental Health Trust (MHT) to be skilled to respond to these needs;

- Consideration for the particular needs of older people with autism;
- Use the learning form the local autism assessment pilot project to establish an assessment pathway;
- Promotion of employment opportunities;
- Engagement with the criminal justice system in support for people with autism; and
- The Autism Self Assessment Evaluation 2013 provided an opportunity to rethink and reinvigorate the borough's response to implementation of the Autism Strategy. To this end, an Autism Working Group has been set up with a clear remit to develop and inaugurate an Autism Partnership Board, with clear aims and objectives which are aimed at improving outcomes for people with autism. This Working Group, which is made up of representatives from NAS, Haringey Autism, CCG commissioning, Local Authority commissioning, parent and carer, has met regularly since submission of the self assessment and, to date, has developed a Terms of Reference for an Autism Partnership Board, and is developing plans which will allow for user representation.

6. Comments of the Chief Finance Officer and financial implications

6.1 There is no specific budget for services for people with autism; services are funded from within the Learning Disability budget. There are no financial implications arising directly from this report which describes the current provision. If new or expanded services are put in place in future, funding will need to be identified for them.

7. Assistant Director of Corporate Governance Comments and legal implications

7.1 The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications arising out of this report.

8. Equalities and Community Cohesion Comments

8.1 There are no specific equalities implications arising out of this report.

9. Head of Procurement Comments

9.1 Head of Procurement notes the contents of this report. At this stage there no are procurement issues identified within this strategy.

10. Policy Implication

10.1 Please see Autism Strategy 2010 for further policy details.

10.2 Please see Statutory Guidance for the Autism Strategy.

11. Reasons for Decision

11.1 This is a non-key decision. However, as the Autism Strategy guidance is statutory, local Councils and local health bodies have a legal duty to implement it.

12. Use of Appendices

12.1 Appendix 1 - Autism Self Assessment.

Haringey Council

13. Local Government (Access to Information) Act 1985

13.1 N/A.

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Public Health England

Improving Health and Lives:
Learning Disabilities Observatory

Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

3

Comment

We are currently working with Haringey Clinical Commissioning Group, Barnet Clinical Commissioning Group and Enfield Commissioning group especially around the needs of non-LD clients with autism. This allows us to share resources

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

⊗ *Yes*
◯ *No*

If yes, how are you doing this?

There is a tri-borough working group with Enfield and Barnet - initial discussions have taken place to date in terms of working more collaboratively on this area.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

⊗ *Yes*
◯ *No*

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

Tristan Brice - Adult Commissioning Manager (LD, MH & CHC) - responsibilities include commissioning of services for LD, MH and CHC eligible clients registered with a Haringey GP. Report to the CCG Director of Commissioning and relevant CCG committees and Boards

**Peter White Commissioning Manager for Adult Social Care, reporting to the Assistant Director for Adult Social Care.*

At present, there is not a robust process for engagement with those with autism and family members and carers. Locally we are seeking to re-establish the Autism Partnership Board.

4. Is Autism included in the local JSNA?

◯ *Red*
◯ *Amber*
◯ *Green*

Comment

See JSNA

http://www.haringey.gov.uk/index/social_care_and_health/health/jsna/jsna-adults-and-older-people/jsna-autism.htm

5. Have you started to collect data on people with a diagnosis of autism?

⊗ *Red*
○ *Amber*
○ *Green*

Comment

The JSNA has a chapter on autism. The data is better on people with ASD in the LD service.

Locally need to develop more robust mechanisms to ensure data is captured systematically and comprehensively across the population.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

⊗ *Yes*
○ *No*

If yes, what is

the total number of people?

77

the number who are also identified as having a learning disability?

77

the number who are identified as also having mental health problems?

48

Comment

We have some data available since April 2013 for all the new referrals and since November 2012 for all transition referrals.

We have set up a new single care pathway of initial assessments. All the new referrals to the service will have a joint assessment between a health and a social care professional. All the assessments would include establishing eligibility, assessment of needs, autism screening assessment, risk assessment checklist. Those eligible will have further autism diagnostic assessment where appropriate and Health Equalities Framework assessment

We aim to complete all the transition assessment before the age of 16 years 6months with transition plan to adult services in place.

7. Does your commissioning plan reflect local data and needs of people with autism?

⊗ *Yes*
○ *No*

If yes, how is this demonstrated?

The draft commissioning plan references the JSNA - available upon request

8. What data collection sources do you use?

- ◯ Red
- ◯ Red/Amber
- ⊗ Amber
- ◯ Amber/Green
- ◯ Green

Comment

Locally we have robust data on individual service users with LD collected from a range of sources

We need to develop more robust processes for collecting data on the wider population (GP registers; education registers).

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ⊗ Red
- Amber
- Green

Comment

We are looking to re-establish the Autism Partnership Board as a means of ensuring collaboration across the borough in implementing the Autism Strategy.

Joint commissioning and partnership development - in partnership with community housing are developing supported housing for people with learning disabilities. This is linked to Winterbourne View programme of reviews and repatriation to appropriate care facilities in borough. This work supports the movement of people from inpatient units to community placements.

We have developed a project with the Local Authorities Housing Related Support Commissioners and Haringey's housing related support provider market, who have been tasked with including an Autistic Assessment tool in all assessments of people presenting to the Vulnerable Adults Team for assessment and referral into housing related support funded provision. This will enable data to be collected on people who present with an Autism and Autistic related behaviours who would otherwise fall outside the Council's Fair Access to Care Services criteria.

The LA and CCG have been working closely on developing Section 75 agreement for integrated LD services. This will be signed off in October 2013. Both organisations are committed to then focussing on implementing the autism strategy over the next year (refer to Q5)

10. How have you and your partners engaged people with autism and their carers in planning?

- ⊗ Red
- Amber
- Green

Please give an example to demonstrate your score.

We do not have robust mechanisms for autism specific consultation work. Our first priority is to re-establish the Autism Partnership Board.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- ◯ Red
- Amber
- Green

Please give an example.

The Autism project developed with and between Adult Social Care, Housing Related Support Commissioning and the non-statutory provider market in Haringey will through screening for Autism increase priority access to preventative services like supported and sheltered housing and community interventions linked to the Criminal Justice System, homelessness and substance misuse.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- [x] *Yes*
- [ ] *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

Young people (14 years and above) are screened using an assessment tool that is designed for young people, who may, or may not be eligible to access adult services. A dedicated transition team is based within the local authority, and there is a dedicated transition panel that reviews, and plans for children from 14 onwards to ensure their transition planning begins early. Transition is supported by a range of disciplines based in children's services, inducing education and looked after children's services; who leads the transition process is dependent on the young person's needs and primary diagnosis.

13. Does your planning consider the particular needs of older people with Autism?

- [x] *Red*
- [ ] *Amber*
- [ ] *Green*

Comment

All the new referrals to the service are assessed jointly by health and social care professionals. Training within generic older people services needs to be undertaken.

Training

14. Have you got a multi-agency autism training plan?

- [x] *Yes*
- [ ] *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

- [ ] *Red*
- [ ] *Amber*
- [ ] *Green*

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

We have a training plan developed by National Autism Society. Levels range from basic to level 4

We have incorporated autism screening as part of all the assessments. Autism related training was provided by local authority for all the staff from community team. There is autism training available for all the provider staff.

To bring our autism care pathway in line with NICE guidelines, we are currently rolling out training in Autism Diagnostic assessment using ADOS.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Comments

Communication training available and provided by Speech and Language Therapists. It covers general communication issues in LD population and is also relevant for autism specific communications.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- ⊗ *Yes*
- ◯ *No*

Please comment further on any developments and challenges.

Consultant psychiatrist, consultant nurse (LD) and GPs were involved in the training programme delivered to GPs for the LD DES.

18. Have local Criminal Justice services engaged in the training agenda?

- ◯ *Yes*
- ⊗ *No*

Please comment further on any developments and challenges.

This area will be progressed over the coming year.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- ◯ *Red*
- ◯ *Amber*
- ◯ *Green*

Please provide further comment.

We have diagnostic pathways based on NICE guidelines for those with autism and learning disabilities and lead to a multidisciplinary care plans.

Currently we use SLAM as the assessment centre. We have asked our local MH Trust to provide a business case for a local autism assessment centre following the results of a local autism assessment pilot project.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

11

Year (Four figures, e.g. 2013)

2012

Comment

The service went live in November 2012 for LD transition services and April 2013 for LD services.

We (in collaboration with Barnet and Enfield) ran a pilot local diagnostic pathway from April 2012 - January 2013. 13 people assessed the service from across the three boroughs.

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

10

Comment

We are currently looking to commission a local based service for non LD autism.

22. How many people have completed the pathway in the last year?

2

Comment

We have started capturing this data from April 2013 for those with LD where autism care pathway is established

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

⊗ *Yes*
◯ *No*

Comment

Haringey has taken the lead (working with Barnet and Enfield CCGs) in liaising with BEH-MHT at developing a local assessment clinic.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

◯ *a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis*
⊗ *b. Specialist autism specific service*

Please comment further

At present it is a specialist service. We are aiming to deliver training to generic services so that they can support clients effectively

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

◯ *Yes*
⊗ *No*

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

The GP receives the notification for those diagnosed with autism that are not eligible for LD services. This should be resolved with the establishment of a local diagnostic service for this cohort.

This is not an issue for those who meet the eligibility criteria for LD services.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

Advice and Information

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

Comment

Haringey Learning Disability Partnership is currently working on a systematic way of recording this information on our social services and health service user database. Currently it is difficult to ascertain an accurate total number of adults with autistic spectrum condition in the Borough as this would include adults who are not eligible for a service from the local authority under FACs criteria. Some adults on the autistic spectrum would also not be eligible for a service from the Learning Disabilities Partnership (combined health and social care team) in Haringey and may be known to the mainstream adult services. The historic information cannot currently be made available without extensive officer time to glean the information from individual health and social care records

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

◯ *Yes*
⊗ *No*

If yes, please give details

Not at present

*The Integrated Access Team has been set up in Haringey Council to provide: * A first point of contact for new users of Adult Social Care services, their carers and families * A simple screening process aimed at resolving local resident's social care needs as quickly as possible * Where needs are more complex, speedy referral to the most appropriate Service Team * Better information and advice on a range of services and activities locally * Help, through signposting, to find advice and support outside of the Council*

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

◯ *Yes*
⊗ *No*

If yes, please give details

This area will be developed over the coming year

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment

See Q33 for list of services

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment

See Q33 for list of services

Clients have access to advocacy and the voluntary sector who will support them with support planning, reviews and safeguarding.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- ⊗ *Yes*
- ○ *No*

Provide an example of the type of support that is available in your area.

See Q33 for list of services

We commission a number of services that are available to both people who are eligible under care access to services and those who may not be entitled and self funders.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- ○ *Red*
- ⊗ *Amber*
- ○ *Green*

Comment

The Council fund through personal budgets/social care budget through fees to private and voluntary providers and autistic specific services that are commissioned include the following:

** Haringey Learning Disabilities Partnership supports patients and carers with ASC through a range of interventions.*
** Area 51 (external link) - Further education opportunities for people with ASC.*
** Edward Marcus (external link) - supported living and residential accommodation for people ASC*
** Residential and day opportunities for people with ASC Hoffmann Foundation - Autism Hub*
** Liza Dresner and Dom Fisher - information support and advice for people with ASC. Resources for autism*
** Email: liza@resourcesforautism.org.uk*
** TreeHouse - the national charity for autism education-educational provision for children/ young people with ASC*
** Email: gbierschenk@treehouse.org.uk*

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- ◯ Red
- Amber
- Green

Comment

http://www.haringey.gov.uk/index/housing_and_planning/housing/housingstrategy/housing_strategy.htm

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- ◯ Red
- Amber
- Green

Comment

Utilising the services identified in Q33

36. Do transition processes to adult services have an employment focus?

- ◯ Red
- Amber
- Green

Comment

Young people referred for adult care are screened as indicated in question 12 using an eligibility screening tool. Employment is part of this process as is education and training needs.

As part of transition from childhood to adulthood holistic assessments explore the person's potential for employment and the support they might need. Haringey Council provide a range of services both directly and indirectly through personal budgets to support for young adults with learning into work. For example there are regular groups which young adults attend in our in house day centres which support people into work. The Council also refer young adults to Haringey Association for Independent Living who have a number of schemes such as Worky Worky scheme (an employment agency for people with autism, learning disabilities and/or physical disabilities) as well as Spotless (a social enterprise which employs people with learning disabilities). HAVCO is a voluntary and support network which also provides support to young adults to assist them into employment.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ⊗ Red
- Amber
- Green

Comment

More robust mechanisms are required for integrating the CJS within the autism pathway.

Currently, the CCG commission Catch 22 (voluntary organisation) to support vulnerable adults who come into contact with the CJS. When an arrested person is brought into a police station they are asked questions about their health issues....'do you have any mental health or learning difficulty issues, are you on any form of medication' etc. This of course is done before Catch 22 would arrive, then a FME (police doctor) would be called to examine the person to determine state of mind, any issues or problems they feel they may need to relay to the FME. In some cases a Mental Health assessment team may be required to examine the person.

Catch 22 would therefore see clients with autism as part of their work.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

31

Comment

A is a 40 year old male with a diagnosis of autism and severe short-term memory loss. He also cannot read or understand documents. He has been unhappy with the voluntary organisation who are contracted to provide his day to day care on 3 days a week. This should include doing some housework, opening and reading correspondence and ensuring that any signs of stress or mental illness are addressed. He also has family in another part of the country who want to move him to their house and claim carers allowance.

A also attends an art and drama class and has made friends there. He finds it difficult to go to his art class when he has to wait in for the carer, who can come at any time during the course of a day. One of his friends is worried about him and approaches an Advocate. It is established that the carer told A he was going to be evicted from his flat. The advocate contacts his landlord whilst A is present and establishes that there are no plans to evict A.

The advocate also requests a meeting between A's care provider, care co-ordinator and the advocate at which A confirms that he is not happy with his care provider. They restrict his life by expecting him to wait in. They don't explain what letters and bills are about and they blame him when tenants in his block make complaints.

He is very stressed and it is agreed that a personal budget will be obtained with which to obtain a care provider who will be able to meet A's individual needs. It also emerges that A worked for a large supermarket for 9 years. It is agreed that suitable adult literacy classes should be included in the care plan as he expresses a desire to go back to work which he enjoyed.

Self-advocate story two

Question number

11

Comment

What is a rewarding and fulfilling life for someone with autism? G is a 19 year-old mixed race male with a diagnosis of asperger's and ADHD who was placed in several schools or residential establishments before adulthood. His mother is his carer, however he has had to move out of the family home because she and his brother cannot cope with his challenging behaviour. G is also having problems because when he is in public places people mistake his ADHD for aggression and this brings him into contact with the Police.

Since reaching the age of 18 he has been placed in a bedsit in a part of London he does not know and has to walk everywhere as he has no money for fares. This has also meant that he has become prey to a post-code gang who regard him as trespassing on "their Manor".

An MHSA Advocate worked closely with this young man and his GP, first of all to obtain a Disabled Person's Freedom Pass so he doesn't have to walk everywhere. This also enables him to keep in touch with his family. We also argued on his behalf for a move to supported living in an area where he will not be vulnerable to gangs. We have also found a course at college for him to do.

The local Police Community Safety Team were also approached so that if G is agitated in public and the Police are involved a flag on the system indicates his diagnosis and that he is vulnerable - not a criminal. G's mother has noticed that since the intervention by the advocacy service G is much happier and hasn't been in trouble with the Police. G says it's fantastic being able to travel to college without being victimised, and he hopes one day to find a fulfilling job.

Self-advocate story three

Question number

26

Comment

Resources for Autism provide an evening group in Haringey for higher need adults.

All RfA services focus on relationship building (we only use our own staff and have a key worker system) and on making sure we meet any sensory and communication needs.

An example is TH who is 20 with very high needs. He has been excluded from a range of services due to his behaviour and has had a large turnover of carers. He successfully attended RfA play and youth provision and his parents requested that he transition into our adult group.

We undertake as many home visits as necessary to gain a picture of an individual's likes and dislikes and any triggers as well indentifying preferred communication methods. We try to create 2 or three 'goals' for each participant and these are reviewed at the end of every session by the key worker to ensure we are meeting the individuals needs. With TH the goal was to help him to have more appropriate interactions, to see a reduction in aggressive behaviour and to enable him to remain focused on an activity for 2 minutes. Over the past year we have seen incidents involving TH reduce from at least 3 a session to almost none and there have been no attacks on other service users for the past year. Recently his key worker reported him focusing for 10 minutes on a chosen activity, far above our original goal. In addition TH has now joined a second group with us which is a 12 week horticulture project and this is his third week and it has been extremely successful. We will develop the goals with him to include him participating in other groups and continue to work on his ability to focus happily.

RfA services are individually tailored to meet the needs of each of our users.

Self-advocate story four.

Question number

35

Comment

J who is 19 and had hardly left his room for 2 years. Initially we worked with him at home and linked him to a support worker to help him leave the house and travel without too much anxiety. His support worker went with him to the confidence group for the first few weeks. J really enjoyed the group and meeting others who had similar difficulties. He is keen to work eventually but was terrified of the prospect having been badly bullied at school and because he understands that other people find him 'odd'. He expressed a wish to volunteer in a small friendly office base working with some form of design.

We were able to offer him some work in our office creating staff ID cards and labels for collecting tins. He loved this work and found the office environment friendly and welcoming. He is now doing similar work for another local charity with weekly phone calls with his support worker and he attends the confidence group independently, travelling by himself. Although we do not say that this is a step towards paid employment as this can be very hard to find it clearly puts J in a much better position to gain paid work as time goes on and his confidence and social skills grow.

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

7

Month

1

Year

2014