Health and Wellbeing Board

TUESDAY, 13TH JANUARY, 2015 at 13:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: See attached

AGENDA

1. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

The Chair welcome those present to the meetings and introductions will then be made.

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 - 14)

To consider and agree the minutes of the meeting of the Board held on 30 September 2014.

7. STRATEGIC COMMISSIONING FRAMEWORK FOR PRIMARY CARE TRANSFORMATION IN LONDON (PAGES 15 - 16)

8. PRIMARY CARE TASK AND FINISH REPORT (PAGES 17 - 22)

9. HEALTH AND WELLBEING STRATEGY 2015-2018 - LAUNCH OF CONSULTATION (PAGES 23 - 28)

10. HEALTH AND CARE INTEGRATION UPDATE (PAGES 29 - 36)

11. LSCB ANNUAL REPORT 2013-14 (PAGES 37 - 88)

12. MENTAL HEALTH CRISIS CARE CONCORDAT (PAGES 89 - 94)

13. HWB GOVERNANCE: BOARD MEMBERSHIP APPOINTMENT AND CHANGE TO VOTING RIGHTS (PAGES 95 - 98)

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 next meeting is scheduled for 19 March 2015 but is subject to confirmation and possible rescheduling.

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Monday, 05 January 2015

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Agenda Item 1

Membership of the Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	Leader of the Council	Cllr Claire Kober
			Cabinet Member for Children and Young People	Cllr Ann Waters
			Cabinet Member for Health and Wellbeing	Cllr Peter Morton
	Officers' Representatives	3	Director of Adult Social Services	Beverly Tarka
			Interim Director of Children and Young People's Services	Jon Abbey
			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

Haringey Council | healthwatch Haringey | HAVCO Haringey Association of Voluntary and Community Organisations | NHS Haringey Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 30 SEPTEMBER 2014

Board Members Present: Councillor Claire Kober (Chair), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Zina Etheridge (Deputy Chief Executive LBOH), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey), Gill Hawken (HAVCO), Cathy Herman (Lay Member, Haringey CCG), Councillor Peter Morton (Cabinet Member for Health and Wellbeing), Dr Helen Pelendrides (Chair, Haringey CCG), Sarah Price (Chief Office, Haringey CCG), Lisa Redfern (Director of Children's Services), Dr Sherry Tang (GP Board Member, Haringey CCG), Beverley Tarka (Interim Director Adult Social Care) and Cllr Ann Waters (Cabinet Member for Children, LBOH).

Officers Present: Xanthe Barker (Principal Committee Coordinator LBOH), Stephen Lawrence Orumwense (Assistant Head of Legal Services), Neil Roberts (Head of Primary Care NHS England), Mike Wilson (Director Healthwatch Haringey).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** The Chair welcomed those present to the meeting and noted that there was a deputation and two public questions in relation to Item 10: 'GP Access in Tottenham Hale: Capacity Study'. Therefore, with the Board's agreement, as soon as representatives from NHS England were present to respond to questions, this report would be brought forward.	
CNCL102.	**APOLOGIES** There were no apologies for absence.	
CNCL103.	**MINUTES** **RESOLVED:** That the minutes of the meeting held on 1 July 2014 be confirmed as a correct record.	
CNCL104.	**URGENT BUSINESS** The Chair noted that there was one item of urgent business, 'Implications of	

	the New Care Act 2014'. This report was for information only and would be taken under Item 13 *(the report had been circulated to members of the Board on 24 September 2014).*	
CNCL105.	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
CNCL106.	**FIVE BOROUGH FIVE YEAR PLAN 2014/15 - 2018/19 - BARNET, ENFIELD, HARINGEY, CAMDEN AND ISLINGTON CLINICAL COMMISSIONING GROUPS (CCGS)** The Board considered a report, previously circulated, which provided an update on the strategic planning undertaken by the NHS and progress towards the next submission of the North Central London (NCL) Strategic Planning Group (SPG) Five Year Plan, which aligned plans across Barnet, Camden, Enfield and Islington CCGs, Public Health and NHS England. The submission was due to be submitted to NHS England in late October. In response to points made with regard to need to ensure that Haringey was not placed at any disadvantage, given that other boroughs within the group may have different priorities and needs and different levels of resourcing; the Board was advised that individual borough's priorities could not be altered. With regard to resourcing the Board was assured that Haringey would not be placed at any disadvantage. **RESOLVED:** i. That the content of the report, the progress made to date and the next steps outline in the report, be noted. ii. That the Board placed on record its support for the North Central London Plan.	
CNCL107.	**QUESTIONS, DEPUTATIONS, PETITIONS** As set out above the Chair noted that a deputation and two public questions had been accepted in relation to Item 10: 'GP Access in Tottenham Hale: Capacity Study'. These had been received from: <u>Deputation</u> From Ms Vicky Ladizhinskaya <u>Public Questions</u> Michael Polledri, Chairman of Lee Valley Estates *(represented by Chris Shellard)* Nuala Kiely, Service User Engagement Coordinator, Mental Health Support Association **Deputation**	

Ms Ladizhinskaya began by thanking the Board for hearing her deputation and noted that in addition to the people that had signed the original deputation request, over seventy additional people had also signed her deputation statement noting their support for this. For residents living in Bream Close, Hale Village and Ferry Lane, the difficulties attached to obtaining a GP appointment and the quality of the service provided by the local practice had become acute.

Ms Ladizhinskaya stated that new developments, including the Hale Village scheme, had seen the population of Tottenham Hale rise by 32% in the last three years and during this time there had been no increase in the provision of GP practices. In addition, the area's largest practice, Tynemouth Road, was, by the NHS's own admission, in the bottom ten practices in the country according to a survey undertaken in 2014. The same survey also showed that 42% of patients were unable to make an appointment when they telephoned the practice.

Ms Ladizhinskaya noted that prior to the new development at Hale Village being built there was an existing problem with the quality and provision of GP services in Tottenham Hale and that this had been compounded by a significant rise in the local population. It was noted that as part of the original planning permission granted by the Council for the Hale Village development it had been specified that a GP practice should be included within the scheme and that Lea Valley Estates had worked with the NHS to secure this. However, it had not been possible to find GPs willing to set up a practice in the area and as a consequence the space allocated for health care had been used for a kidney dialysis unit serving the wider north London area rather than addressing the primary care needs of the local community. Given the likelihood of further significant development in the area in medium to long term Ms Ladizhinskaya argued that it was essential that provision for primary care was properly considered and reflected in the plans currently being developed in order to prevent the problem worsening.

Ms Ladizhinskaya recounted her own experiences of attempting to obtain a GP appointment at the Tynemouth Road practice and a series of errors that had led to her test results being delayed by six weeks. She noted that many of her neighbours had experienced similar difficulties in obtaining a GP appointment and delays in hospital referrals. There was a general lack of communication and follow up from the Tynemouth Road practice and that was putting patients at unacceptable risk. She noted that the recent Healthwatch report had highlighted the issues at the Tynemouth Road practice, the lack of GP practices and quality of primary health care in Tottenham Hale. In conclusion Ms Ladizhinskaya noted that residents did not want preferential treatment and that they simply wanted GP provision across the borough to be equal and of the standard enjoyed by the majority of people living in the UK.

The Chair thanked Ms Ladizhinskaya for her deputation and for sharing her personal experiences with the Board and invited Councillor Reith, one of the

local Ward Members, to set out her concerns.

Councillor Reith began by noting that the lack of GP services and the quality of existing GP services had been an issue that pre-dated the development of Hale Village. In her previous role as Deputy Leader of the Council she had attended meetings with the former Primary Care Trust (PCT) where the need for improved services in the area had been discussed along with the specific provision of a GP practice within the Hale Village development.

Councillor Reith reminded the Board that NHS England was responsible for commissioning GPs and ensuring that there were adequate GP services in place. This was a challenge that NHS England had to resolve both in the short and longer term. She contended that NHS England and the Clinical Commissioning Group (CCG) should, as a matter of urgency, map need in the area and put together proposals around how they intended to meet this. She underlined that although the Local Authority could lobby for this work to be undertaken it had no power to require this to happen.

Councillor Reith noted that her own experience of obtaining an appointment at the Tynemouth Road practice echoed that of Ms Ladizhinskaya's and the issues highlighted within the Healthwatch report. She noted that poor primary care significantly impacted on people's health and advised that there had been cases where people had presented at Accident and Emergency (A&E) in the advanced stages of cancer because their symptoms had either not been picked up by their GP or because of a failure to obtain an appointment with their GP. There had also been instances where women had received no ante-natal care and had presented at A&E in labour.

In conclusion Councillor Reith noted that without the necessary provision of primary health care services in the area the expected growth in population and regeneration of the Tottenham would be impaired. She underlined the need for partners to work together to resolve this issue and suggested that a Working Group ought to be established as soon as possible to address the immediate lack of GP facilities.

The Chair formally responded to the deputation and noted that this was an issue that was of concern to her both in terms of the impact this was currently having upon residents and in the medium to long term as the population of the area was likely to grow significantly. The success of the Council's aspirations for the regeneration and development of the area would rely upon services of this type being in place to serve residents and the Council's planning policy documents reflected this; however, the commissioning of GP services was not in the gift of the Council or the Clinical Commissioning Group (CCG). The power and responsibility to resolve these issues lay with NHS England and the Council would support residents in their calls for action.

As set out above two questions (set out in Appendix 1) had been formally submitted to the Board from Mr Michael Polledri, Chairman of Lea Valley Estates (represented by Mr Chris Shellard) and Ms Nuala Kiely, Service User

	Engagement Coordinator, Mental Health Support Association. The Chair asked both Mr Shellard and Ms Kiely to read their questions to the Board and members of the public present. In response to the first question from Mr Polledri the Chairman of Lea Valley Estates, the Chair reiterated that NHS England held the power to commission GP practices and that the Council had no authority to compel them to do so. She noted that NHS England had agreed to explore the feasibility of establishing a GP practice at Hale Village; however, this would take between twelve and fifteen months and, given the acute need for GP services in the area, this was not satisfactory. In response to the second question from Ms Kiely the Chair noted that as suggested by the question there was a postcode dimension to the discharge of patients from secondary to primary health care; however, this was a complex issue that primarily needed to be addressed by the relevant health care providers.	
CNCL108.	**GP ACCESS IN TOTTENHAM HALE: CAPACITY STUDY** The Board received a presentation, previously circulated within the agenda pack, from Sharon Grant, Chair of Healthwatch Haringey. Following the presentation the Board discussed the group's findings. The Cabinet Member for Health and Wellbeing, Councillor Morton, began by noting that this issue had been discussed by the Council's Overview and Scrutiny Committee and that it also shared the concerns outlined above with regard to GP services in Tottenham. He noted that he strongly supported proposals to establish a Task and Finish group to look how these issues might be resolved. There was agreement that the provision of adequate GP services was essential to the community and particularly in relation to children and families. The Cabinet Member for Children and Families, Councillor Waters, noted that the Council's approach to supporting families focussed heavily on the importance of ensuring that all children received the best start in life and this was reflected in its focus on children aged from nought to five years of age. She noted that GPs played a crucial role in the development and wellbeing of children in this age group and added that it was essential that they had access to good quality GP services. In response to a question, the Chair of Healthwatch Haringey confirmed that it was the organisation's view that immediate action was required to address the lack of GP services in Tottenham Hale. Waiting for twelve to fifteen months for a feasibility study to be undertaken was not a viable option given the acute need in the area. It was noted that Neil Roberts of NHS England would respond to the points made under the next item.	

RESOLVED:

i. That the findings outlined in the Healthwatch report relating to poor access to GP services for residents in the Tottenham Hale area, highlighted in both qualitative and quantitative evidence, be noted;

ii. That the findings outlined in the report relating to the poor access to GP services for residents in the North East GP collaborative area, highlighted in both qualitative and quantitative evidence, be noted;

iii. That the findings outlined in the Healthwatch report relating to the relatively poor access to GP services in Haringey compared to the national benchmark and in comparison with Camden, reflected in the number of actual GP appointments per week, be noted;

iv. That Healthwatch's call for immediate steps to be taken to supplement the GP capacity in Tottenham Hale, pending the proposals arising from the recommendation below, be endorsed;

v. That Healthwatch's call for a working group to be set up as a matter of urgency to review the evidence and to make recommendations to the Health and Wellbeing Board, within three months, for immediate action to improve access to GP services in the short term for the residents in Tottenham Hale and surrounding Wards be endorsed (the membership should include NHS England, Haringey CCG, Public Health, patient representatives and other partners that that the Health and Wellbeing Board may wish to nominate); and

vi. That Healthwatch's call for a planning group to be established to develop a strategy and plan for GP services in Haringey over the next five years, with priority being given to the North East and South East GP collaborative areas, be endorsed (the membership should include NHS England, Haringey CCG, Public Health, patient representatives and other partners that that the Health and Wellbeing Board may wish to nominate).

CNCL109. GP SERVICES IN HARINGEY

The Board received a verbal update from Neil Roberts, Head of Primary Care at NHS England, on the provision of GP services in Haringey and particularly in Tottenham Hale. Mr Roberts also responded on points made as part of the deputation and formal questions submitted under Item 6 in relation to the lack of GP services in Tottenham Hale.

Mr Roberts began by noting that the issue of access to GP services was of concern to many people across the UK and that this was not particular to Haringey. He noted that the Healthwatch report on the capacity of GPs in Tottenham Hale was alarming and he accepted that the position appeared to be worsening based on the Healthwatch report and the experiences that had

been shared by residents with the Board that evening. Mr Roberts advised that GP's could not be compelled to establish practices and noted that the funding arrangements in place for GP practices were based on population rather than an analysis of the needs of an area. As a consequence establishing a practice in an area of significant need was likely to be less 'profitable' and more demanding and therefore was less attractive to GPs.

With regard to specific criticism of the Tynemouth Road Practice Mr Roberts noted that NHS England had been working with the practice to improve the quality of the services it offered and the systems in place there. Though it was disappointing that the impact of this improvement work did not appear to have taken full affect NHS England would continue to work with the practice to improve standards.

In terms of the regeneration work being undertaken in Tottenham Hale and the impact of additional population of Hale Village, Mr Roberts noted that NHS England had only been in place since April 2013 and that discussion around Hale Village and the regeneration of Tottenham Hale pre dated its existence. Therefore work was required to assess how the regeneration work and needs of a growing population would be addressed and it was proposed that this could be done in part by a Task and Finish group chaired by Mr Roberts and including representatives from the CCG, Council and Healthwatch.

In relation to the twelve to fifteen month period referred to in terms of procuring a new GP practice Mr Roberts noted that there were procurement rules that NHS England were required to follow and that this timescale was based on the need to adhere to these. Therefore 'growing' existing practices was an important alternative and NHS England was working closely with practices in the area to achieve more capacity and improve the quality of services. Mr Roberts also made reference to the average number of patients on a GP practice list and the importance of having sufficient nursing capacity and skills mix within a practice.

The Chair thanked Mr Roberts for attending and responding to the points made earlier. She opened discussion by noting that the average number of patients on a GP's list was a misleading measure of their capacity; for example there may be a larger than average population of elderly people or high levels of social deprivation meaning that there were likely to be more demanding health needs and this would not be detected by looking at the average number of patients on a GPs list. The Chair also noted that if the provision of GP services were to be discussed using private sector terminology then the lack of adequate GP services in Tottenham Hale could be seen as market failure on the part of NHS England.

In response to a question with regard to what action NHS England intended to take as a matter of urgency, in order to respond to the acute problems residents were experiencing in registering with GPs and obtaining GP appointments; Mr Roberts advised that NHS England was putting measures in

place to address the immediate problems. These included discussion with the CCG around solutions that would provide quick action; however, simply providing cash injection to address the problems in the short term was not a viable option and would set a precedent that could not be met.

The Board was in agreement that new and innovative approaches had to be adopted in order to address the acute need that was evident in the area. There was a general consensus that as a matter of urgency examples elsewhere in the country where this type of scenario had been successfully addressed should be identified and looked at. It was also noted that it would be important that the proposed Task and Finish Group considered and quickly identified measures that could be quickly put in place as well as considering the long term healthcare needs of the area over the next twenty years.

In response to concerns expressed with regard to the need to plan for the wider healthcare needs in the north east of Haringey, as these were likely to significantly increase over the next decade; Mr Roberts agreed that a clear strategy for recruiting GPs in the medium to long term was required and that improving the viability of existing practices and planning with GPs would form an important part of this.

At the conclusion of discussion there was a general consensus that the Board should escalate this issue and formally write to NHS England outlining its concerns with regard to GP services in Tottenham Hale and the Tynemouth Road clinic. There was agreement that the letter should call for immediate action to be taken by NHS England and for the proposed Task and Finish group to commence as soon as possible.

RESOLVED:

i. That the information and proposed actions presented by NHS England be noted;

ii. That a Task and Finish Group be established as soon as possible to look at how the immediate and long term health care needs of Tottenham should be met.

iii. That a letter should be sent by the Chair, on behalf of the Board, to NHS England formally setting out its concerns with regard to the provision and quality of GP services in Tottenham Hale and the Tynemouth Road practice, calling for immediate action to be taken and for it to outline how it intended to do this.

CNCL110. HEALTH AND CARE INTEGRATION

The Board considered a report, previously circulated, which set out proposals with regard to the establishment of a Health Care Integration Programme in order to enable the Council and the Clinical Commissioning Group (CCG) to jointly achieve better outcomes for local residents, improve the user

experience and to deliver efficiencies and value for money.

There were five appendices included within the report, as set out below and these were considered in turn:

Appendix 1 – Healthcare Integration Programme (presentation)
Appendix 2 – Value Based Commissioning for Older People with Frailty
Appendix 3 – Mental Health Framework
Appendix 4 – Better Care Fund Re-Submission
Appendix 5 – Scrutiny Review and Response Report

Healthcare Integration Programme (presentation)
The Board received a presentation setting out the vision and scope of the Integrated Care Programme and the Board then discussed this. In response to a question the Board was advised that one of the principles that underpinned the work around the programme had been to focus on building and developing existing structures and relationships rather than using time and resources to create a new set of structures.

There was agreement that the proposals formed a good example of multi-agency working and that in order to support the work and ensure that it was properly embedded training across the various organisations would be needed.

Value Based Commissioning for Older People with Frailty
The Board considered a report that provided an update on progress in developing an outline business case for Value Based Commissioning (VBC). The Board was advised that VBC was an important part of delivering integrated care and that Haringey was leading in the development of work in this area.

RESOLVED:

That the proposals set out in the report be noted.

Mental Health Framework
The Board was advised that the Mental Health and Wellbeing Framework (MHWF) was being devised in order to bring together all of the existing strategies and to set out a clear vision for improving the mental health and wellbeing of Haringey's residents from early years throughout adulthood and into older age.

RESOLVED:

That the Mental Health and Wellbeing Framework scoping document be noted and that approval be given to the process for developing the MHWF outlined in the report.

Better Care Fund Re-Submission

The Board considered a report seeking endorsement of the revised Better Care Fund (BCF) Plan, which was submitted on 19 September, as the agreed vision for improving the health, wellbeing and the independence of Haringey's residents, through the delivery of integrated health and social care services. It was also noted that the Lead of the Council would formally note the revised BCF Plan on 3 November.

RESOLVED:

i. That the revised BCF Plan, submitted on 19 September 2014, be endorsed as the agreed vision to improve health, wellbeing and the independence of Haringey's residents, through the delivery of integrated health and social care services.

ii. That it be noted that revisions made to the Plan, as required by NHS England, were set out in Appendix 3 of the report.

Scrutiny Review and Response Report

The Board received a report setting out the proposed responses to recommendations made by the Overview and Scrutiny Panels on Mental and Physical Health and Mental Health and Accommodation.

RESOLVED:

i. That the responses to the recommendations made by the Overview and Scrutiny Panel's, as set out in Appendices 1 and 2 of the report, be noted.

ii. That it be noted that the report and Appendices 1 and 2 would be presented to Cabinet on 14 October 2014 and that any proposals for change would be taken to Cabinet at a future date as necessary for adoption and agreement, after further work to identify resources, costs and risks.

Following discussion of the five Appendices to the report the Board agreed the recommendations set out in the substantive report:

RESOLVED:

i. That the proposal for the Health and Care Integration Programme, as set out in Appendix 1 of the report, be noted;

ii. That it be noted that some of the existing integration initiatives would be incorporated into the Programme – updates for key integration initiatives currently in progress were set out in Appendices 2 to 6 of the report;

iii. That it be agreed that the Health and Wellbeing Board would provide strategic oversight of the programme, although key decisions would

	be made through the Council or CCGs respective decision making structure; and iv. That it be agreed that a follow up report would be submitted to the next meeting, which would also include a proposals around how the Health and Wellbeing Board would be involved in this Programme.	
CNCL111.	**ANNUAL PUBLIC HEALTH REPORT** The Board considered a report, previously circulated, which presented the Annual Public Health Report and planned local anti-stigma and Mental Health and Wellbeing campaign for October 2014. The Board was advised that the 2014 report focused on the Health and Wellbeing Strategy outcome 'Improving Mental Health and Wellbeing' and that it explored what was meant by 'wellbeing' and how this was linked to both physical and mental health. The Annual Public Health Report focussed on communicating messages that would engage all residents in Haringey regardless of their mental health and wellbeing state. It was envisaged that the report would initiate and open discussions about people's own mental health and wellbeing, promote early recognition of signs and symptoms and encourage people who required help to access the appropriate services. **RESOLVED:** That the Annual Public Health Report and planned local anti-stigma and mental health and wellbeing campaign for October 2014 be noted.	
CNCL112.	**PHARMACEUTICAL NEEDS ASSESSMENT** The Board considered a report, previously circulated, which set out the progress made to date with respect to the development of a new Pharmaceutical Needs Assessment (PNA) and the timetable for this. **RESOLVED:** i. That progress made to date with respect to developing the PNA be noted; ii. That development of the PNA be delegated to the Director of Public Health; iii. That approval be given to PNA Steering Group's Terms of Reference and membership; and iv. That the timetable, as outlined in paragraph 5.9 of the report for consulting on, approving and publishing the PNA be noted and agreed.	
CNCL113.	**NEW ITEMS OF URGENT BUSINESS**	

	As set out under CNCL104 above an information report entitled 'Implications of the New Care Act 2014' was considered as a new item of urgent business. **RESOLVED:** That the report be noted.	
CNCL114.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 13 January 2015 and that the meeting currently scheduled for 21 April 2015 may need to be rescheduled.	

The meeting closed at 9.15pm.

COUNCILLOR CLAIRE KOBER

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Chair

Report for:	**Health and Wellbeing Board – 13 January 2015**

Title:	**Primary Care – A Strategic View**

Organisation:	**Haringey Clinical Commissioning Group**

Lead Officer:	**Cassie Williams, Assistant Director of Primary Care Quality and Development**

1. Describe the issue under consideration

In October 2014 Healthwatch provided a report to the Health and Wellbeing Board which described concerns in terms of access to GP appointments and patient satisfaction in the east of the borough. NHS England have provided a report to this Board describing the actions which have been taken as a result. A presentation will be given to the Board to give an overarching summary view of the current strategic direction of primary care nationally, in North Central London as well as our local strategy. The Board is being asked to give its views on this strategic approach.

A number of significant documents have been published recently which provide an indication of the future direction of Primary Care. In addition there are organisational changes, such as the introduction of co-commissioning, which will potentially have an impact on how primary care is commissioned. This presentation will provide an overview of these reports and re-organisations and their implications for Haringey. The main areas of focus will be as follows:

- **Five Year Forward View**: published by Simon Stevens of NHS England in October 2014. This document highlights how far the NHS has progressed in 10 years and describes possible ways of moving forward in the next 5 years. It highlights the need to stabilise funding for general practice and provide new funding for innovation and improved access. It suggests that new models of care will be important to consider in future including multi-service providers.

- **Strategic Commissioning Framework for Primary Care Transformation in London**: is being developed by the London Primary Care Transformation Programme chaired by Dr Clare Gerada. This document provides a vision for primary care in London and highlights the need to improve access and make care more coordinated and proactive.

- **Co-commissioning:** CCGs have been invited to make expressions of interest in relation to having a more collaborative role in commissioning primary care with NHS England. The goal is to create a more joined up, clinically led commissioning system which delivers seamless, integrated primary care services based around the needs of the local population. This will be managed at a north central London level. The goal is to produce more consistency and efficiency and a more collaborative approach to meeting the challenges of the next few years.

This presentation will finally describe the strategic approach of Haringey CCG. The mission is to make primary care and care closer to home effective for Haringey residents, focusing on improving health outcomes. The focus is on actively promoting self-management, integration and looking for innovative ways of providing health care. It will aim to ensure that healthcare is more joined up and holistic and that GPs have an overall responsibility for health in Haringey.

2. Recommendations

The Board is asked to give its views on the strategic view of the CC to developing primary care in the borough.

Report for:	**Health and Wellbeing Board – 13th January 2015**
Title:	**Primary Care Task and Finish Group**
Organisation:	**Neil Roberts, NHS England**
Lead Officer:	**Sarah Barron, NHS England**

1. Describe the issue under consideration

1.1. Following discussion at the Health and Wellbeing Board of 30th September 2014, it was recommended that a Primary Care Task and Finish Group be established. Its key aims were to address primary care provision in specific regeneration areas of Haringey and to look at ways of improving the quality of primary care access across the borough. The Task and Finish Group was asked to report its interim findings at this January Board. The attached paper sets out progress that has been made in this period.

1.2. Haringey has a number of significant regeneration schemes and housing developments which have been planned, particularly for the East of the borough. Schemes of various sizes are planned in a number of areas and it is predicted that the schemes will deliver an increased population of circa 15,000 people by 2020 increasing to circa 28,000 by 2025 and the potential of continuing increased demand in capacity. About half of this increased population will be in the Tottenham area and the other half spread across the borough.

1.3. In order to fully assess what primary care capacity is required within these regeneration and development schemes, and to understand the various options available to meet this requirement, an options appraisal will be undertaken through the NHS Strategic Partnering Agreement (SPA). A partner has been appointed to undertake the options appraisal, GB Partnerships Ltd, who will attend the Health and Wellbeing Board on 13th January 2015 to provide an update on progress.

1.4. Next Steps

1.4.1. To provide a further progress report in the form of a presentation by GB Partnerships Ltd, at the January Health and Well-being Board meeting

1.4.2. To work with GB Partnerships Ltd, to complete an options appraisal by April 2015
1.4.3. To report back to the Health and Wellbeing Board at their next meeting in April 2015 on progress and recommendations as a result of the options appraisal

2. Recommendations

2.1. To be assured on the progress of the Task and Finish Group, and comment on the identified next steps.

HARINGEY PRIMARY CARE TASK AND FINISH GROUP
REPORT TO HEALTH AND WELLBEING BOARD DECEMBER 2014

1. INTRODUCTION

Following discussion at the Health and Wellbeing Board of 30th September 2014, it was recommended that a Primary Care Task and Finish Group be established. Its key aims were to address primary care provision in specific regeneration areas of Haringey and to look at ways of improving the quality of primary care access across the borough. The Task and Finish Group was asked to report its interim findings at this January Board. This paper sets out progress that has been made in this period.
A presentation will accompany this report.

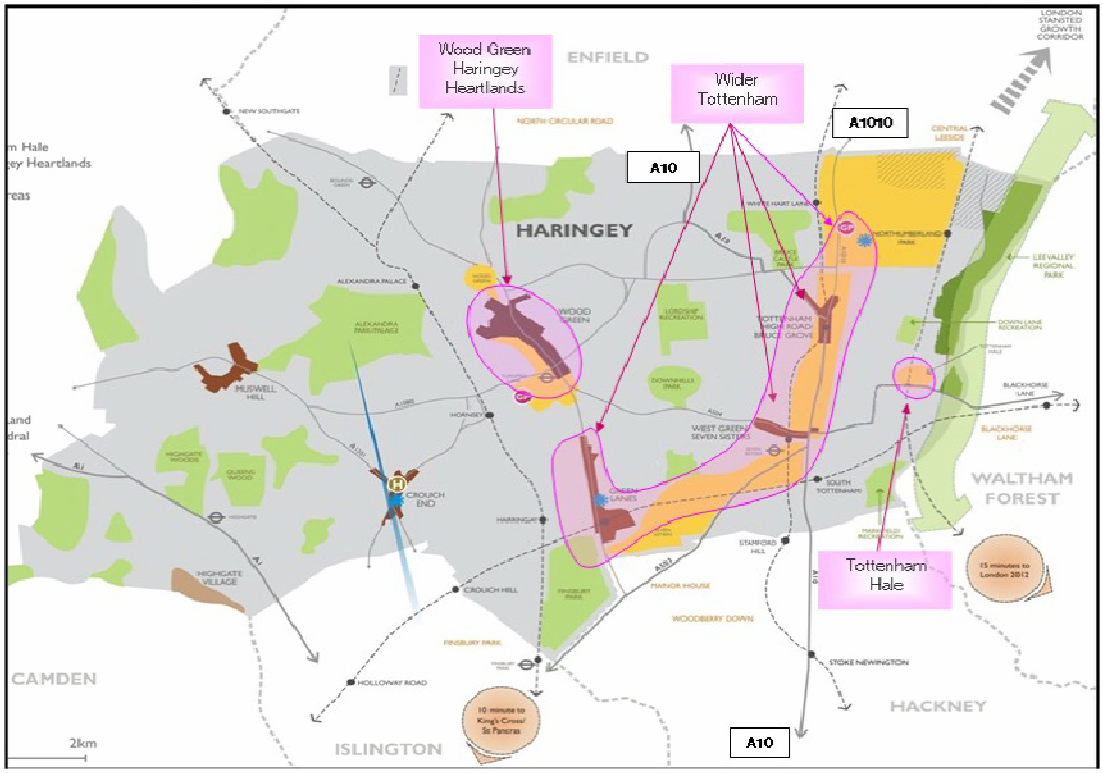
2. BACKGROUND

Haringey has a number of significant regeneration schemes and housing developments which have been planned, particularly for the east of the borough. Schemes of various sizes are planned in a number of areas and it is predicted that the schemes will deliver an increased population of circa 15,000 people by 2020 increasing to circa 28,000 by 2025 and the potential of continuing increased demand in capacity. About half of this increased population will be in the Tottenham area and the other half spread across the borough.

Each will have a significant impact on population and will therefore place significant additional pressure on Primary Care which cannot be managed within the current resource. The Task and Finish Group has decided to consider Primary Care premises in the context of all of these areas, but with specific emphasis on the Tottenham area, and Wood Green.

Figure 1 below shows the key areas of development opportunity in Haringey as identified in the 2010 Borough Investment Plan.

Figure 1



It is acknowledged that Primary Care already faces significant capacity challenges in the east of the Borough. A recent Healthwatch report raised concerns that there was a shortfall in patient appointments in the Tottenham Hale area in the larger context of an overall shortfall in the east of the borough. It highlighted low patient satisfaction in relation to access in this area on the basis of the GP survey. It also identified that 32% of GPs in Haringey were over 60 years in age and a significant percentage were likely to retire within the next 10 years.

Haringey CCG further highlighted that a number of the current practice premises would not be viable in the future. There are various reasons for this, including leases expiring, some buildings which are not suitable for modernising, a building which is not currently CQC compliant and a number of practices being housed in small buildings which would not allow expansion of patient lists.

3. DIRECTION OF TRAVEL

It was recognised that immediate primary care issues need to be addressed but that it was also important to plan for the future. The following timescales were agreed to address:

- Long-term: The need for increased primary care capacity and premises due to growth in population
- Medium-term: The need for increased primary care capacity and premises due to poor premises, practice closure and ongoing deficit in primary care provision
- Short-term: Immediate access problems either due to lack of capacity or poor quality of access

4 PROGRESS TO DATE

- **Long-term**

The Task and Finish Group initially focused on how to ensure that there is sufficient capacity to meet the needs of residents in the future, with particular regard to the regeneration in Tottenham.

NHS England has a clear process for capital developments, which commences with the development of a Project Initiation Document (PID), which is submitted to their Finance, Investment, Procurement and Audit Committee (FIPA) for approval. The Haringey PID was submitted to FIPA in November 2014. The PID provides evidence to support the funding of an options appraisal.

This options appraisal will be undertaken through the NHS Strategic Partnering Agreement (SPA) and a partner has been appointed to undertake the options appraisal, GB Partnerships Ltd. At the time of writing this report the options appraisal was being commenced.

The options appraisal will do the following:

- Undertake an assessment of current primary care premises and provision
- Assess the likely future changes in primary care provision, such as retirement, practice closure, practice mergers
- Assess the need for primary care provision due to development and regeneration schemes
- Explore all possible options for future provision, having regard to the above
- Examine the services provided by other healthcare providers in the area, such as Whittington Health, to understand the nature of their premises and explore any scope for utilisation and integrated working
- Assess the pharmacy need in view of future population growth (drawing on the local Pharmacy Needs Assessment)

- Explore the need for temporary solutions until longer-term premises are completed

- **Medium-term**

As referred to in 4.1 above, the options appraisal will include the consideration of temporary solutions whilst primary care premises are being built within development areas. The Task and Finish Group is clear that there is a requirement to look at how primary care provision is both increased and improved in the medium term. The options appraisal will both assess this need and provide physical premises options to consider.

- **Short-term**

An Access Taskforce has been set up to consider current access issues and look at how to maximise current provision. This Taskforce reports into the Task and Finish Group. At the first meeting, it was acknowledged that access issues were significantly impacted by a lack of current premises provision and therefore these needed to be considered as part of the current premises work. It was agreed that the options appraisal would therefore include proposals for short to medium term solutions to offer additional space for primary care provision in the east of the borough.

5 NEXT STEPS

- To work with GB Partnerships Ltd, to complete an options appraisal by April 2015
- To report back to the Health and Wellbeing Board at their next meeting after April 2015 on progress and recommendations as a result of the options appraisal

Haringey Council

healthwatch Haringey

HAVCO Haringey Association of Voluntary and Community Organisations

NHS Haringey Clinical Commissioning Group

Report for:	Health and Wellbeing Board – 13 January 2015

Title:	Health and Wellbeing Strategy 2015-2018: launch of consultation

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

Lead Officer:	Dr. Jeanelle de Gruchy, Director of Public Health

1. Describe the issue under consideration

1.1. Haringey's current Health and Wellbeing Strategy comes to an end in 2015. In July 2014, the Health and Wellbeing Board (HWB) launched a programme of activity to review and refresh the strategy for 2015 to 2018.

1.2. The HWB is now asked to consider the draft strategy at its meeting on 13 January and approve it for public consultation.

2. Cabinet Member introduction

2.1. Everyone has the right to enjoy good health and wellbeing. However, in Haringey there are large inequalities across the borough. Residents in the poorest parts of the borough are not only more likely to die early, but they will also spend a greater proportion of their shorter lives unwell. This inequality is often established from birth (or even before) and develops further through life.

2.2. In the current economic climate for the public sector, the challenge is to find new and different ways to build more resilient communities supported by services that make an evidenced and sustained improvement.

2.3. Haringey already has a significant and ambitious programme of change which includes regeneration, children's and adults' services, housing and education. National legislation is introducing greater integration of health and social care, new ways for adults to fund their care, and welfare reform to name but a few.

2.4. Against this backdrop, the new Health and Wellbeing Strategy will focus on some of the issues requiring system leadership if we are to deliver a real and sustainable difference.

3. Recommendation

3.1. That the HWB:
- agrees the draft strategy and
- endorses the start of a 3 month public consultation.

4. Alternative options considered

4.1. No other options are being considered. The Health and Wellbeing Board has a statutory duty to bring together bodies from the NHS, public health and local government, including Healthwatch as the patient's voice, to plan how best to meet local health and care needs. These needs must be set out through a joint health and wellbeing strategy that offers a strategic framework in which the clinical commissioning group, council and NHS England can make their own commissioning decisions.

5. Background information

5.1. It is the statutory responsibility of the Health and Wellbeing Board to publish a Health and Wellbeing Strategy and a Joint Strategy Needs Assessment (JSNA).

5.2. Haringey's current Health and Wellbeing Strategy is for 2012 to 2015. In July 2014, the Health and Wellbeing Board (HWB) launched a programme of activity to review and refresh the strategy for 2015 to 2018. An analysis of current need in Haringey (ie the Joint Strategic Needs Assessment) was undertaken as well as a review of the current strategy through a series of meetings with key stakeholder groups, and a workshop, survey and focus groups of the voluntary sector and residents organised by HealthWatch and HAVCO.

5.3. The review highlighted in particular that residents in Haringey are:
- becoming overweight and obese from an early age,
- developing long term health conditions at a relatively young age, and
- there are significant numbers of people with mental health issues

This contributes to significant health inequalities in the borough.

5.4. This review informed the development of the draft strategy and its three priorities:
1) Reducing obesity
2) Increasing healthy life expectancy
3) Improving mental health

5.5. The strategy will enable:

- all partners to be clear about our agreed priorities for the next three years
- all members of the HWB to embed these priorities within their own organisations and ensure that these are reflected in their commissioning and delivery plans
- key agencies to develop joined-up or integrated commissioning and delivery plans to address these priorities

- the HWB to hold member organisations to account for their actions towards achieving the priorities within the strategy
- members of the board to work with and influence partner organisations to contribute to the priorities and the approaches for working agreed within this strategy

5.6. The draft strategy acknowledges the importance of, and is aligned with, other closely related frameworks and programmes, including the CCG's 5 year strategy; NHS North Central London's 5-year strategy; health and social care integration; Haringey 54,000; improving the quality of primary care.

5.7. The draft strategy also acknowledges the key wider determinants of health and wellbeing including regeneration, housing, employment and education. This strategy complements the strategies and programmes that address these areas. In addition, the Health and Wellbeing Board will work to influence these policy areas, where appropriate, to support delivery of its new health and wellbeing strategy.

5.8. The strategy will have strong synergy with the council's Corporate plan, both in its priorities and through integrating the cross-cutting principles of: developing a preventative and early intervention approach; reducing inequalities; working with communities and developing partnerships.

5.9. The purpose of this statutory consultation is to obtain views on:

- the proposed priorities
- the focus of the three priorities and ideas of how to deliver these outcomes
- how organisations and individuals could contribute to the delivery of the outcomes, either by themselves or in partnership with others

5.10. In addition, there will be more detailed engagement with residents and service users on the priorities to shape the development of the delivery plans. This consultation activity will vary for the respective priorities to ensure that we can most usefully inform the plans.

5.11. The consultation will engage with:

- residents and users of relevant council and NHS services
- community groups and the voluntary sector
- partner organisations and partnership boards
- NHS and Social Care providers

5.12. The consultation will last for 3 months. The strategy and delivery plans will be brought to the June/July HWB.

6. Comments of the Chief Finance Officer and financial implications

6.1. There are no new financial implications directly arising from this report. The Health and Wellbeing strategy will be implemented using Public Health Grant and Council budgets and the budgets of other partners such as Health.

6.2. The costs of the consultation will be met from within existing resources.

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

7.1. Section 196 of the Health and Social Care Act 2012 provides for the Health and Wellbeing Board to exercise the functions of the local authority and the clinically commissioning group to prepare a joint health and wellbeing strategy (JHWS). The Statutory Guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy 2013 provides that "Local authorities and clinical commissioning groups have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process. Success will not be achieved if a few members of the board assume ownership, or conversely do not bring their area of expertise and knowledge to the process. As the duties apply across the health and wellbeing board as a whole, boards will need to discuss and agree their own arrangements for signing off the process and outputs. What is important is that the duties are discharged by the board as a whole" (Paragraph 3.1).

In preparing the JHWS, the Board must involve the local Healthwatch organisation and the local community. The Guidance provides that when involving the local community, the Board "should consider inclusive ways to involve people from different parts of the community including people with particular communication needs to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. This should recognise the need to engage with parts of the community that are socially excluded and vulnerable48. Involvement should aim to allow active participation of the community throughout the process – enabling people to input their views and experiences of local services, needs and assets as part of qualitative evidence; and to have a genuine voice and influence over the planning of their services" (Paragraph 5).

8. Equalities and Community Cohesion Comments

8.1. An Equalities Impact Assessment (EqIA) is currently being undertaken. The findings will be analysed and will inform the final strategy.

9. Head of Procurement Comments

9.1. The Procurement Service has been consulted about this report, and has confirmed that no comment is required.

10. Policy Implication

10.1. This strategy enables the HWB to fulfil its statutory duty to bring together bodies from the NHS, public health, local government and Healthwatch to plan how best to meet local health and care needs. These needs must be set out through a joint health and wellbeing strategy that offers a strategic framework in which the clinical

commissioning group, council and NHS England can make their own commissioning decisions.

10.2. Key strategies and plans are:
- 10.2.1. Joint Strategic Needs Assessment
- 10.2.2. Council's Corporate Plan
- 10.2.3. NHS North Central London 5 year plan
- 10.2.4. Haringey Clinical Commissioning Group 5 year plan
- 10.2.5. Health and social care integration
- 10.2.6. Haringey 54,000 programme
- 10.2.7. Tottenham Strategic Regeneration Framework
- 10.2.8. Housing and welfare reforms

11. Reasons for Decision

11.1. The HWB takes the lead in promoting a healthier Haringey and this strategy provides its direction over the next four years. It is therefore vital that partners are involved in formulating and committed to commissioning and delivery in line with the proposed strategic approach.

12. Use of Appendices

12.1. Appendix 1: The Health and Wellbeing Strategy consultation draft will be tabled at the HWB on 13 January 2015.

13. Local Government (Access to Information) Act 1985

13.1. None

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Report for:	**Health and Wellbeing Board – 13th January 2015**

Title:	**Health and Care Integration Update**

Report Authorised by:	**Zina Etheridge – Deputy Chief Executive, Haringey Council and Sarah Price – Chief Officer, Haringey CCG**

Lead Officer:	**Asad Butt, Integration interim programme manager**

1 Describe the issue under consideration

1.1 This paper provides an update to the report brought to the Health and Wellbeing Board of the 30th September 2014 and proposes a governance structure for the programme.

2 Cabinet Member introduction

2.1 Supporting everyone to be healthy and have a high quality of life for as long as possible is a core aim for the Council and its partners. Integrating health and social care so that care is person centred, joined up and meets their needs is core to that vision. The establishment of the health and social care programme is an important step towards delivering that integration. The proposed governance model set out in this paper will ensure that the programme is effectively governed and has strong strategic input from the HWB.

3 Recommendations

3.1 The HWB is asked to note progress made to date.

3.2 The HWB is asked to note and approve the proposed governance structure in Appendix A

4 Alternative options considered

4.1 None

5 Background information

5.1 The Health and Social Care Integration Programme has been established to support Haringey in meeting its vision for Integrated Care, i.e.:

- We want people in Haringey to be healthier and to have a higher quality of life for longer.
- We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible. This means:
    - The individual's perspective should be at the heart of any discussions about integrated care
    - When planning and providing integrated care services the individual's perspective should be the organising principle of service delivery

5.2 The programme has agreed three key priorities (themes), integrated care for adults, children, and people with mental ill health as the focus for the first phase. These themes align with the outcomes set out in Haringey's Health and Wellbeing Strategy, the Council's Corporate Plan and the 5 year strategy for CCGs in North Central London.

5.3 Within each theme, a number of projects / programmes have been identified to deliver the agreed integrated care vision, for that theme. Additionally, the Integration Programme includes cross cutting themes in the areas of technology and finance that will enable and support integration.

5.4 Projects/programmes underway in the Adults theme are:

- Better Care Fund: encompassing actions to tackle health inequalities and the life expectancy gap, through a focus on early interventions in long term conditions, and improving mental health and wellbeing, through a focus on choice, control and empowerment. For the first year, focusing on integrated service for frail older people (65+) to enable them live independently.
- Value Based Commissioning: establishing models and approaches to commission services based on values / outcomes rather than activity; working in partnership with Enfield CCG.

5.5 Projects/programmes underway in the Childrens theme are:

- SEND reforms Programme: implementing the changes set out in the Children and Families Act regarding special educational needs and disabilities (SEND) which came into effect from September 2014.

- Early Help Project (input): Providing input into the Childrens project considering the range of provision often described as prevention, early intervention and targeted early help, which may be delivered by universal services or by commissioned services.

5.6 Projects/programmes underway in the Mental Health theme are:

- Mental Health Strategic Framework: setting the strategic direction and implementation approach for integrated mental health services in Haringey, covering both adults and children (CAMHS).
- Mental Health and accommodation: Creating a revised pathway for people with mental ill health who require housing support, supported housing or Residential Care.

5.7 The theme leads are working to define the outcomes and outputs at the next level of detail and this progress will be included in the next update to the board.

5.8 The Health and Care Integration Programme has consolidated existing Integration projects and proposes the governance framework (Appendix A) to enable greater collaboration and effectiveness across Haringey.

5.9 The breadth and depth of the Integration Programme is such that it requires different levels of specialist and detailed attention and steer. To ensure the appropriate people are involved, the governance structure consists of three layers,

- Strategic
  - Set the vision and ambition for integration in Haringey
  - Provide guidance and strategic direction
  - Make strategic decisions (impacting vision and direction of travel) within the agreed scope and principles
- Steering
  - Have the ultimate oversight of the Integration Programme
  - Steer the Integration Programme and associated projects
  - Ensure progress on track to achieve the agreed vision and goals set out for integration in Haringey
  - Make management decisions (enabling the programmes and projects to continue) within the agreed scope and principles
- Operational
  - Manage and direct projects (at an operational level)
  - Agree proposals for operationalisation of the integration plan which are developed through the projects
  - Ensure the projects are on track and progressing as expected

- Make operational project decisions, within the agreed scope and plan, enabling the project to continue to deliver

5.10 This layered governance structure aligns with the existing governance that is already in place within the Council and the CCG.

5.11 The governance structure will be supported by quarterly updates via presentation or paper to the Health and Wellbeing board

6 Comments of the Chief Finance Officer and financial implications

6.1 Not applicable at this stage. As a next step further work will be completed to scope the Programme and associated projects, as well as to determine any financial implications. This scope and financial implications will be discussed and agreed with the appropriate stakeholders in the respective organisations.

6.2 The result of this scoping work with any comments from the Chief Finance Officer(s) will be included in the follow up presentation/ paper to the next meeting.

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

7.1 The Council's Assistant Director of Corporate Governance has been consulted about this report.

7.2 The Health and Care Integration programme is conducive to the Board's statutory duty to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population (Section 195 of the Health and Social Care Act 2012). The Integration Programme is also conducive to the Council's and the CCG's statutory powers to promote integrated commissioning and provision of services in health and social care. These powers are set out in Sections 75 of the National Health Services (NHS) Act 2006 (as amended) (arrangements between NHS bodies and local authorities for the delegation of functions), Sections 13N and 14Z1 of the NHS Act 2006 (14Z1 Duty as to promoting integration), Sections 25 and 26 of the Children and families Act 2014 (Education, health and care provision: integration and joint commissioning) and Section 3 of the Care Act 2014 (Promoting integration of care and support with health services etc)

8 Equalities and Community Cohesion Comments

8.1 The proposed Health and Care Integration Programme is designed to provide health and social care services that produce better outcomes and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities.

8.2 Equality impact assessments will be carried out as part of the project planning and delivery process.

9 Head of Procurement Comments

9.1 N/A There are no direct procurement implications arising out of this report however as and when the projects identify procurement requirements the appropriate processes will be followed.

10 Policy Implication

10.1 There are no direct policy implications arising out of this report however national policy is a key driver of integration especially from the Better Care Fund and Care Act Implementation and this programme of work will complement and add value to work under this remit.

11 Reasons for Decision

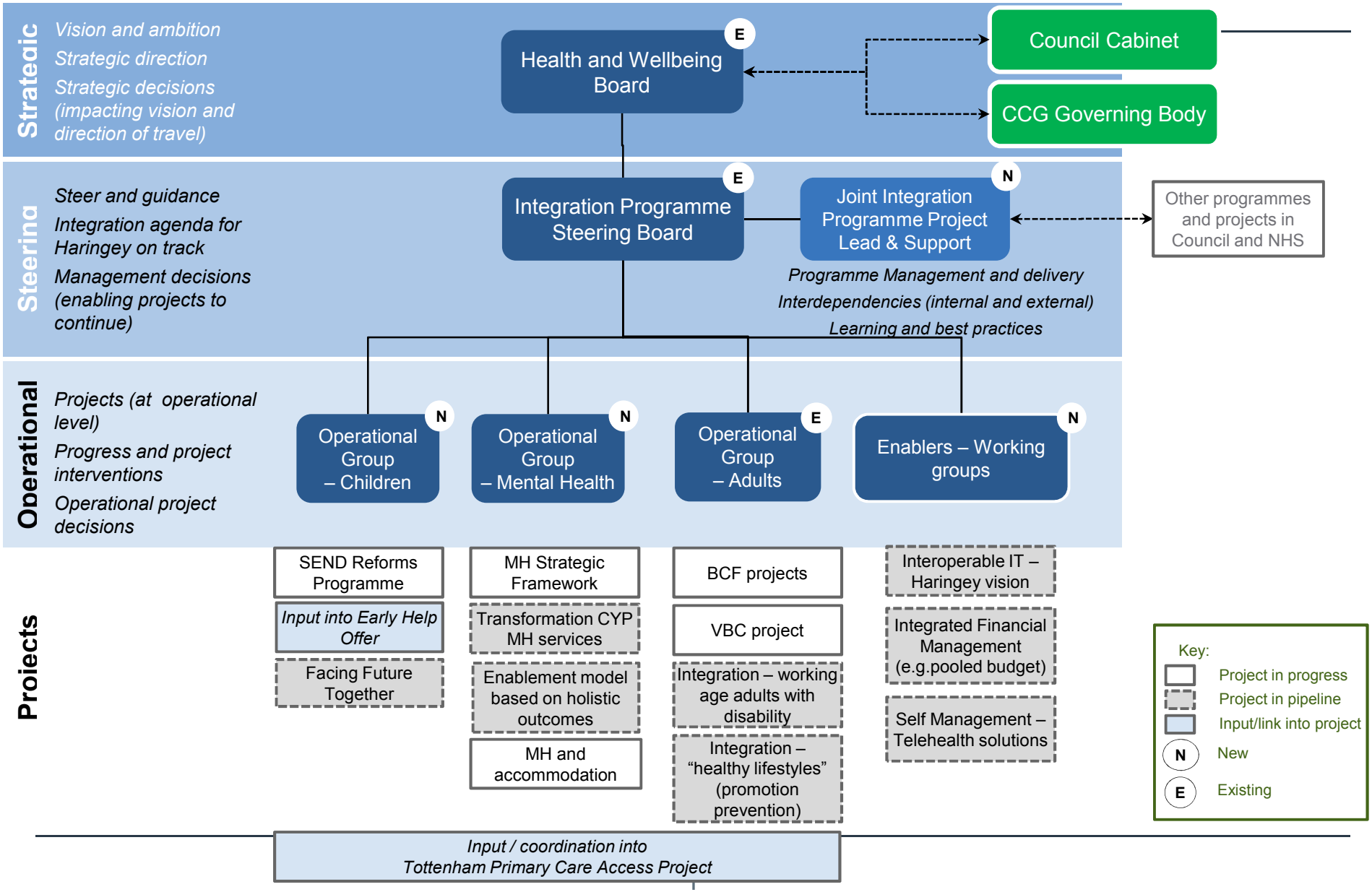
11.1 The proposed governance process provides clarity as to how the Health and Wellbeing Board will provide strategic direction and decisions for the Health and Care Integration Programme.

12 Use of Appendices

Appendix A: Proposed Governance Structure

13 Local Government (Access to Information) Act 1985

Overall governance layers (Use existing meetings / forums where possible)



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Haringey Safeguarding Children Board

Annual Report on the Effectiveness of Safeguarding Children in Haringey 2013 -14 and Business Plan 2014-15

Foreword from the Independent Chair

During the year under review, the Board was ably chaired by Graham Badman. I had the honour of taking over from him in May 2014. During Graham's five years of service, Haringey's LSCB developed a powerful ethos of teamwork and challenge, and forged strong relationships between the agencies working in Haringey. His wisdom, humour and tenacity are all much missed.

2013-14 was a year of change and challenge within Haringey. New organisational structures emerged, and many faces changed. The new commissioning arrangements in health were led by the Clinical Commissioning Group, which established its ways of working rapidly, at a time of budget pressure and constant change. The Health and Well-Being Board brought together agencies from across the Borough, and a strategy was agreed which focussed strongly on children and young people. The council's children's services were restructured, with many familiar faces moving on, and there was a period where several posts were held by interim managers. The probation service underwent preparation for fundamental change. Throughout these changes the Board remained a stable point where partnership working was strong.

Nationally, the new version of Government guidance on safeguarding, "Working Together", was issued. It set out new accountabilities for the LSCB independent chair, with the local authority chief executive assuming responsibility for ensuring that the Board is effectively managed. This change was smoothly negotiated; the relationship between Chair and Chief Executive has been positive. Any anxieties that this change might involve a reduction in the rightful independence of the LSCB and Chair have been dispelled, through the open and transparent way in which the relationship has been handled. "Working Together" also made explicit a new responsibility for LSCB's to scrutinise the Early Help offer, which is a relatively new area of focus for the Board.

Before I assumed the chair of the Board, I had been invited during the autumn of 2013 to review the work of the LSCB. I found an effective group of agencies, working well together, with a clear commitment to partnership working and to safeguarding children, and an openness to consider different ways of working. Together we identified some changes to the governance and operation of the Board, to the use of performance data, and to the degree of priority given to Early Help, which are now being incorporated into the running of the Board.

Shortly after the end of 2013-14, in May 2014, Ofsted visited, to inspect LB Haringey and to review the work of the LSCB. Although the review fell just outside the year in question, it was reflecting on work undertaken during that year, so perhaps the best way to reflect on our work last year is to highlight the conclusions of Ofsted. We were the ninth LSCB to be reviewed, so the inspectors and ourselves were learning from the process as much as from the outcome. They judged our work to be "Requiring Improvement - RI" (as with the council). In their feedback, they noted that they had found just 4 areas for improvement, none urgent – a lower number than any other board who had received the RI rating. As they said to us, it was easy for any observer to see that we were just on the borders of a "good" judgement, though at present Ofsted do not have the licence to comment publicly beyond the headline rating. To enable comparison, RI is the most common rating so far delivered by Ofsted, with more than half of Boards so far reviewed gaining this rating.

Ofsted confirmed that we were compliant with the new Working Together arrangements, our governance was effective, we had effective business planning, and we paid attention to the voice of the child. We demonstrated challenge to partners, and supported partners in holding each other to account. Our range of audit activity was noted, with support for our Learning and Improvement Framework and our approach to Serious Case Reviews. Our training programme, our policies, and our website, were all commended.

Ofsted did however identify four areas for improvement, all of which already had appeared within our priorities, and on which we have been working. Our work with schools required further strengthening, to ensure that schools are more fully involved at Board level. Our guidance on Child Sexual Exploitation (CSE) required further review, to ensure that the issue of girls' involvement with gangs was properly reflected. Our strategy on CSE, which was being developed on a London-wide basis, needed accelerating. And Ofsted wanted us to be more rigorous in our reviews of work with missing children, and those in private fostering.

Our Business Plan for 2014-16 is set out in section 6. It shows how we are responding to these comments, and responding to the priorities that the agencies within Haringey have jointly agreed upon. The years ahead promise as much challenge as the last ones; the budget reductions that almost all statutory agencies have faced so far are just a prelude to the reductions that most agencies face in the next two years. Achieving more with less is a constant theme, and it is one which challenges us all. Partnership working has never been more important than now.

Sir Paul Ennals
Independent Chair,
Haringey LSCB

Contents

Approved on: 4th December 2014

Haringey Local Safeguarding Children Board, River Park House, Wood Green, Haringey, N22 8HQ www.haringeylscb.org Tel: 020 8489 1470

1. Introduction

This is the Fourth Annual report of Haringey LSCB. It has been compiled by representatives of the LSCB and safeguarding lead officers. Its purpose is to:

- provide an overview of LSCB activities and achievements during 2013/14
- provide a summary of the effectiveness of safeguarding activity in Haringey,
- provide the public, practitioners and main stakeholders with an overview of how well children in Haringey are protected, and
- include proposals for action and lessons from reviews undertaken.

Haringey is an exceptionally diverse and fast-changing borough. We have a population of 263,386 according to the 2013 Office for National Statistics Mid Year Estimates. Almost two-thirds of our population, and over 70% of our young people, are from ethnic minority backgrounds, and over 100 languages are spoken in the borough. Our population is the fifth most ethnically diverse in the country.

The borough ranks as one of the most deprived in the country with pockets of extreme deprivation in the east. Haringey is the 13th most deprived borough in England and the 4th most deprived in London.

The population of Haringey is growing. The previous 2011 ONS census population estimate of 255,540 is projected to reach 286,700 by 2021. This would be a 12.2% increase compared to the actually observed increase of 17.7% (according to the comparison between 2001 and 2011 Census figures). The fastest growing population locally is in age groups 30-34 and 45-49. The number of people aged 65-69 and over 85 decreased since 2001.

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, 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.

Functions

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

- *Training*
- *Safe workforce:* Safe recruitment, management and supervision of people who work with children:
- *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:* Participating in local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account:.
- *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 that gives rise to the need for a Serious Case Review.
    - Identifying any general public health or safety concerns arising from the deaths of children

2. Summary of key areas of progress and achievements in 2013-14

In last year's annual report Haringey LSCB outlined 6 priorities. Progress was achieved against each of these priorities, as set out below.

- *Priority 1: Engaging children, young people and their families*

An on-line survey was undertaken of the views of children and young people, with limited responses. A set of standards was produced on how best to secure views, and all agencies now report on their engagement with children and young people in their annual reports. An audit of the current consultation methodologies used by member agencies threw up a very wide range of structures and systems; it was agreed that the key issue for the LSCB is how to ensure that this wide learning is appropriately fed into our work.

- *Priority 2: Strengthening governance and accountability arrangements between the LSCB and other partnership boards*

LSCG governance has been strengthened through a review of the membership of the Board and sub-groups, a review of the induction and development pack for members, successful recruitment of an effective and motivated lay member, and an independent review of the Board's effectiveness. LSCB's involvement with their partnerships has been strengthened through the involvement of the Chair on the Health and Well-Being board and the Children's Trust, and regular meetings between the Chair and key external officers

- *Priority 3: Monitoring the effectiveness of the MASH and Early Help intervention*

An external review of MASH effectiveness provided encouraging feedback. The Board has approved a threshold document, and confirmed the effective use of the Common Assessment Framework to support disabled children.

- *Priority 4: Ensuring the link between schools and safeguarding*

Board membership has been strengthened through the AD for Schools, through the effective engagement of two key head teachers, and work with schools has been increased.

- *Priority 5: The identification and response to children and young people at risk of child sexual exploitation including where there is gang and group violence*

The Board worked with the Gang Action Group to agree their strategy. The CSE task group evolved into the Vulnerable Children's Group, and worked intensively on developing guidance and a strategy, which approached completion at the year end.

- *Priority 6: Identification of missing, unknown or opted out young people*

Guidance was reviewed, and a performance indicator included in the Board's Performance dataset.

Key areas of progress and achievements in 2013-14

- Developed a Learning and improvement framework
- Conducted multi agency audits
    - Policy and procedures audit
    - Schools s175/157
    - Threshold review
- SCR published October 2013
- Continued to deliver and develop high quality and up to date multi-agency training
- Held a safeguarding conference – Child Sexual Exploitation September 2013
- Reviewed 5 years of child death in Haringey

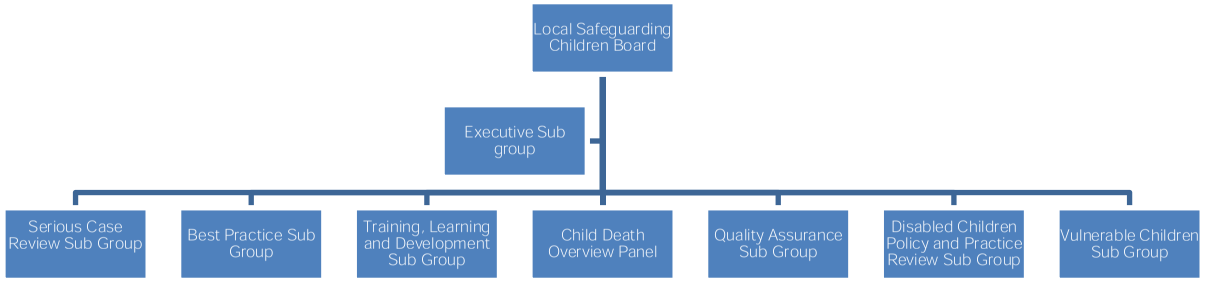
Section 4 includes more detail on the work of the LSCB and its partners.

3. Effectiveness of the LSCB - Governance and accountability arrangements

Chairing and membership arrangement

The LSCB has an independent chair and each subgroup is chaired by a senior member from across the partner agencies. The board is attended by representatives from the partner agencies with a high level of engagement - See appendices Two & Three

Structure chart



Relationship between the LSCB and other strategic boards

- From April 2013 the arrangements for planning and providing health and social care changed. Two new bodies - the Haringey Clinical Commissioning Group (CCG) and the Health and Wellbeing Board (HWB) - were established. The Children's Trust was re-established.

- The CCG is a new NHS organisation that is responsible for planning and commissioning some of the hospital, mental health and community care services for Haringey residents.
- The HWB includes officers from Haringey council and the CCG who work together to understand Haringey's health and social care needs, agree priorities and ensure that services are offered in a more joined up way.
- The Chair of the LSCB attends the HWB and the Children's Trust. He meets regularly with the Chief Executive and Deputy Chief Executive, the Director of Children's Services and the lead member for children. He meets annually with the Chief Executives of the key partner agencies. He meets annually with the Council's Scrutiny Committee. Several board members sit on the Community Safety Partnership.

Accountability

The LSCB chair is accountable to the Chief Executive of the borough for his role in chairing the LSCB and overseeing its work programme. However, he is accountable only to the Board for the decisions he takes in that role.

Financial arrangements

The work of the Board is financed by contributions from partner agencies, of which currently over 80% comes from the council. In addition to financial contributions, partner agencies contribute significant amounts of staff time to support the delivery of the board's work programme, and to support training delivery. Full budget information is contained within Appendix One.

Haringey LSCB communication

A key method of communication is the LSCB website. The analysis of usage shows an increase of 122% over the last 4 years, to a level for 2013-14 of over 85,000 page views. Appendix Four gives further details.

In May 2014, OFSTED commented *'the LSCB website is well constructed and provides up to date information on Board activities, policy and practice guidelines, threshold documents and Serious Case Review and case management review reports'*.

Haringey LSCB continues to communicate with local people via the telephone, in emails and by sign posting to services – directing local people who are looking for information and advice about services or who want to make complaints.

Voice of a LSCB partner

"I applied for the volunteer lay member position because I am committed to promoting children's welfare and safeguarding them. This position also relates to my studies and work experiences within the borough.

My experience with LSCB so far is very exciting and also very demanding. My personal aim for LSCB is to understand the needs of the children and young people within the borough and to remain focused on challenging the overall quality of safeguarding work by local agencies so that practice continues to improve.

I found the meetings extremely useful and effective. Only by being there even if I only observing and listening makes me understand how the organisation is working and its priorities. Since being part of LSCB, my perception about Haringey social agencies has radically changed.

Now I honestly can argue that media and also local people are misjudging social services and most probably I would have fallen in the same category if this chance to actually see LSCB's efforts on making sure that all the agencies is working efficient together to protect children and young people.

My overall experience with LSCB, is a life changing for me not only because I have the chance to listen/meet the highest leaders and managers from local agencies but also to learn from their experience."

Anamaria, Lay Member 2014

Voice of a LSCB partner

"Safeguarding children is of paramount importance to Tottenham Hotspur and liaison with Haringey LSCB is part of our continued drive for better awareness and standards in this field." Angela Seymour, Head of Safeguarding, Tottenham Hotspur, 2014

4. LSCB subgroup activities

4.1 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 deaths that are unexpected. This is a statutory obligation and is intended to ascertain any lessons that may be learnt for the future.

During the year 2013/14, we published a report covering the experience of the first five years of Haringey CDOP from 2008 to 2013. It revealed that most deaths in children are the result of perinatal and congenital, including inherited, conditions. The Haringey CDOP has identified few modifiable factors except in cases of trauma, Sudden Infant Death Syndrome and intra-partum deaths. These modifiable factors have been highlighted to relevant healthcare professionals. Even though the report spans five years, the numbers are small, which makes most comparisons with national data difficult. However Haringey's experience does reflect national experience that deaths are much more common in some groups of society, those who are socially disadvantaged and those from Black and Ethnic minority groups. As has been stated in a number of recent national reports, including "Why Children Died" (Why Children Die: death in infants, children and young people in the UK. May 2014. Wolfe I, MacFarlane A, Donkin A, Marmot M on behalf of the Royal College of Paediatrics and Child Health, the National Children's Bureau and the British Association for Child and Adolescent Public Health.), action by health services acting alone will have a limited effect.

Experience in 2013/14 followed the same pattern. During this period, 46 cases were closed, mostly from previous years, and there were 21 deaths. Unusually, there were two young people who committed suicide and one died in a fire. One of the cases of suicide had a long psychiatric history and was referred to the SCR Panel and a SCR was instituted. The other case is still being investigated. A preschool child died in a house fire while in the care of her disabled grandmother. The fire was caused by clothing catching fire from a stand-alone gas heater. Escape from the home was hampered by the fact that the door, through which the occupants would escape, opened inwards and would be difficult to open as the grandmother was in a wheelchair. With the rise in numbers of people having difficulty in paying fuel bills, the risk of this sort of fire will be greater. These learning points are being shared with the relevant agencies.

4.2 Quality Assurance (QA) 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. To monitor and scrutinise the effectiveness of local arrangements to safeguard children and through this, to ensure a demonstrable impact on services.

The QA sub group adopted a new performance framework (Eastern region model), built around the LSCB's priorities and enables data and narrative to evidence safeguarding in Haringey, taking indicators from across the partnership. However further work has now been commissioned with a view to simplifying the data sets.

In September 2013, the Multi-agency Child Sexual Exploitation (CSE) protocol was launched at the LSCB annual safeguarding conference. Copies were circulated to agencies for dissemination and also uploaded on to the LSCB website.

A review of CSE prevalence was undertaken by the CSE task group. It was noted that there had been an increase in referrals on CSE and this data is captured in the LSCB performance framework. The CSE task group ceased and has now evolved into a Vulnerable Children and young people sub group.

A number of indicators were identified across the partnership and have been embedded into the performance framework

4.3 Serious Case Review Sub Group. Chair - LSCB independent chair

Remit: To consider when to undertake a review on the death of a child where abuse or neglect are factors, or where there are serious concerns regarding inter-agency working where a child suffers potentially life threatening concerns, serious impairment of health or development, and to monitor implementation of action plans.

Regulation 5 of the Local Safeguarding Children Board (LSCB) regulations 2006 requires LSCBs to undertake reviews of serious cases

All new SCRs commenced in 2013/14 have been actioned in line with the Working Together guidance. SCR processes have been revised to enable flexibility as recommended in WT 2013.

- *Child T*

Child T Serious Case Review was published on 10th October 2013. A LSCB response was also published and is being monitored by the SCR subgroup. The review highlighted important learning for many agencies, including the health visitor service, GPs and children's social care. Learning from the review has led to improvements in strategy meetings, strengthening of the Early Help offer, expectation of all New Birth visits being undertaken within national timescales, and improved information sharing between agencies. A pathway to guide GP's in their assessment and referral of minor injuries was developed. Haringey level 3 training 2011-12 focused on non-accidental injury, and child protection guidance for GP trainers was developed: this was adopted by the London Deanery and used at trainer workshops

- *Child CH*

Child CH Serious case report has now been completed, April 2014. A LSCB response is being put together and publication will take place when current court action is completed.

- *Child D*

Child D Serious Case report has now been completed, April 2014. A sign off meeting is due to take place in May 2014 and a LSCB response will be developed and publication should take place after court proceedings are concluded late 2014.

4.4 Best Practice Sub Group (BP). Chair - Designated Nurse for Child Protection, Haringey CCG

The remit of the Best Practice Sub–group is to improve safeguarding practice by translating national and local policy, procedures and guidance into effective practice arrangements. The group can propose operational changes to improve multi-agency training.

It was the multi-agency forum for agreeing process and practice changes that relate to the LSCB's core business.

The 2013/14 work plan had 4 priorities:

a) *Review of cases which did not meet the Serious Case Review threshold* – one case was reviewed, a second was delayed due to single agency processes taking priority

b) *Engaging children, young people and their families* – a scoping exercise was undertaken to review national best practice and research. Localised practice guidance will be developed in 2014/15

c) *Review of guidance on missing children* – this work was not completed as the group was awaiting the publication of the Pan London Procedures to ensure alignment.

d) Monitoring of the effectiveness of the Multi-Agency Safeguarding Hub (MASH) and Early Help Intervention – This was achieved: see below

A report of the work of the Multiagency Safeguarding Hub (MASH) was received. In light of the finding that large numbers of cases involved risk from domestic abuse, consideration was given by Whittington Health to a Domestic Violence lead to be a source of expertise.

Following discussions regarding domestic and gender based violence across the borough and the strategic drive to improve the response to it, the mental health Trust adapted their electronic patient record to include a field for Domestic Abuse as part of their risk assessment.

A case review was undertaken which identified current effective practice and made recommendations for improvement in some areas. One of the areas identified as a concern was the capacity of the health visiting service, particularly in the east of the Borough, to work in a proactive, preventative way. This was due to the high level of need in the area and the difficulty in recruiting to vacant posts. It should be noted the challenge in HV recruitment was a national issue not only specific to Haringey. The challenge was further debated at the main board with Whittington Health leading on a response.

The action plan developed in response to the recommendations from the case review will be taken forward through 2014/15 and implementation monitored via the LSCB.

The LSCB professional disagreement protocol was reviewed and refreshed in response to the Child T serious case review. The protocol was re-launched and all agencies were encouraged to use it as required.

One of the challenges for the sub group was the limited capacity of members to carry out the work required between the meetings, which sometimes delayed progress on specific items.

The other main challenge was developing a proportionate case review model which allowed for maximum learning relevant to current practice. It was agreed to use the 'principles for learning and improvement' in Working Together 2013. It was acknowledged the group was likely to need to limit the number of cases reviewed.

There were also challenges in terms of membership and regular attendance as all agencies went through significant internal re-organisation.

The sub group provides opportunities for agencies to be held to account for practice which requires improvement and for agencies to share best practice.

4.5 Disabled children's policy and review sub group. Chair – Interim Head of Disabled Children's Services

Remit: This working group was established in response to the DCSF Practice Guidance for Disabled Children, which recommended that the LSCB consider the specific safeguarding needs of Disabled children in a Multi-agency group. In November 2012 the working group was accepted as a sub group.

The group considers the Board's priorities in relation to how Disabled children are safeguarded and considers the specific vulnerabilities of this group of children in different circumstances.

There is a developing Disabled children's data set that will increase the understanding of the experience of disabled children within the borough. The group is building data from comparative neighbours and across agency and shall be used to identify trends, gaps and impact on safeguarding Disabled children. The group has considered the issue of the masking of abuse for disabled children by the use of authorised / non authorised absences, and has looked at attendance figures for all Special Schools in Haringey, patterns and trends and explanations. Learning was disseminated through the group.

Multi-agency audits have been undertaken to consider threshold criteria and this information will feed into the development of the service. This included disabled children in child protection conferences.

There has been a focus on increasing participation of disabled children in the borough, including inclusion in the young inspectors programme. In addition work commenced on reporting arrangements for Disabled children into the Disabled children's policy and practice review group and to the Youth Council. The group hopes to continue to develop accessible ways for Disabled children to input their views into these forums and to be able to feedback the difference their views have made to the outcomes/decisions.

4.6 Training and Development 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

The training sub group have completed a training needs analysis considering the needs from different services, local and national reviews and evaluations of courses. New courses have been identified for the new year including bespoke courses for managers.

As well as one day training, the LSCB is delivering training on line and in bite sized seminars. The LSCB jointly with Haringey council have bought an interactive package of training that can be disseminated through agencies and used by managers with their teams to support and build confidence when responding to child protection and safeguarding matters.

An impact report was completed in the beginning of 2013. Due to the absence of a training manager for much of the year, this has not as of yet been updated. 3 months post evaluation of training began in 2013/14; this information will need to be collated and compiled in an impact report.

The sub group undertook a range of tasks aimed at ensuring that there is an up to date multi-agency training program in place.

5. Learning and Improvement Framework

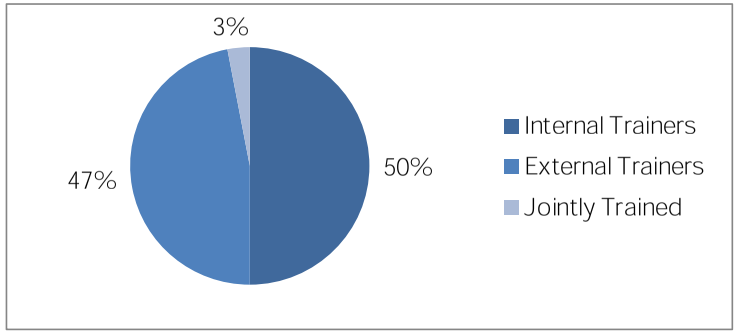
A key role for the LSCB is to ensure that there is a positive learning and improvement framework, some of which is detailed in this section.

5.1 Multi –agency training 2013/14

The LSCB scheduled 20 multi-agency training courses over 48 sessions. In comparison to some of Haringey's geographically neighbouring boroughs, the LSCB scheduled the second highest number of courses, suggesting there is a high demand for multi-agency training across the borough.

In 2013-14 70% of the total trainers were internal. Internal trainers trained 50% of the total trained (388).

Proportion of total trained, 2013-14



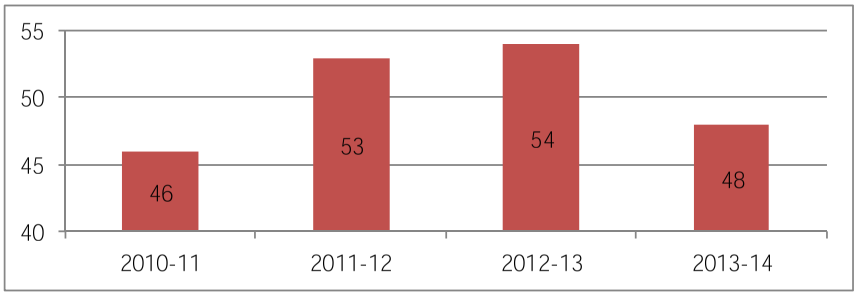
The use of internal trainers gives training a feel for local issues and services, encourages networking across the services and maximises the opportunity for trainers to develop their skills.

Home Grown Trainers - Haringey LSCB tenders the 'Training for Trainers' course where single agencies are offered the opportunity to up-skill agencies' senior workers with child protection responsibilities to deliver basic Child Protection awareness training within their own setting (and where appropriate for the LSCB). All candidates for the course are required to deliver a minimum of two basic awareness Child Protection sessions per financial year and to complete an annual training return.

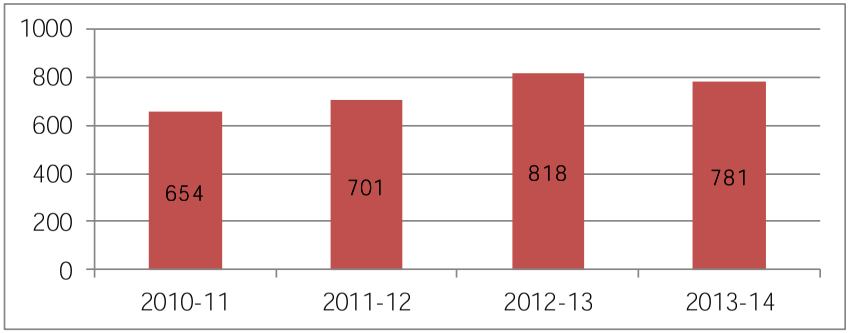
Haringey LSCB trained 17 new single agency trainers in 2013-14 (decrease of 43% since 2011-12); 23 places were offered (decrease of 36% since 2011-12). In terms of value for money, 8.5 people were trained per two-day course session.

Training Uptake - The number of course sessions scheduled in 2013-14 has decreased by 11% since 2012-13. However the overall numbers trained has only decreased by 5% suggesting there is a continuous demand for training.

Number of course sessions scheduled by financial years

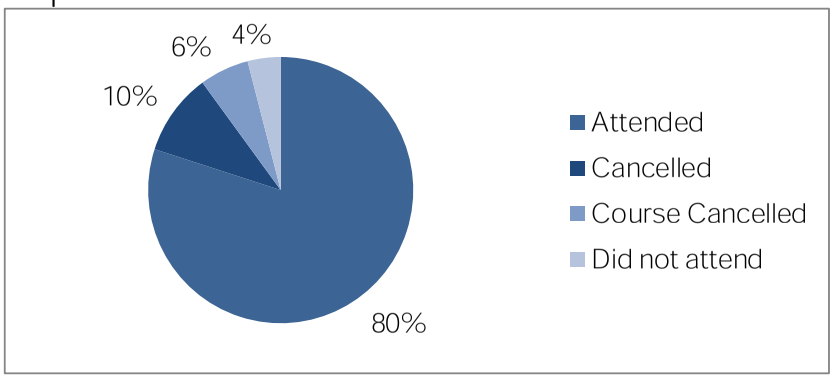


Overall numbers trained via LSCB multi-agency courses

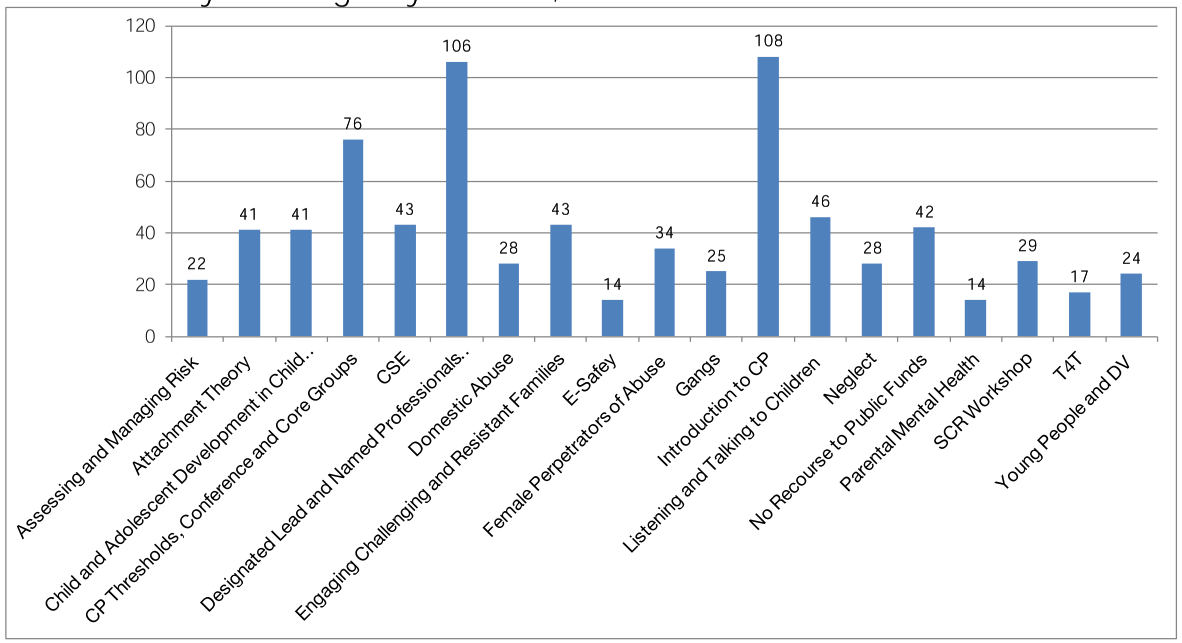


Attendance Statistics - In 2013-14 978 applications were received of whom 781 people (80%) attended (compared to 77% in 2012-13). Attendance was over 44 training sessions from 17 agencies. 10% cancelled their place leaving opportunities for the LSCB to offer these to others. 6% were affected by the 4 sessions which were cancelled and 4% of applicants did not attend overall.

Proportion of attendance and non-attendance rates



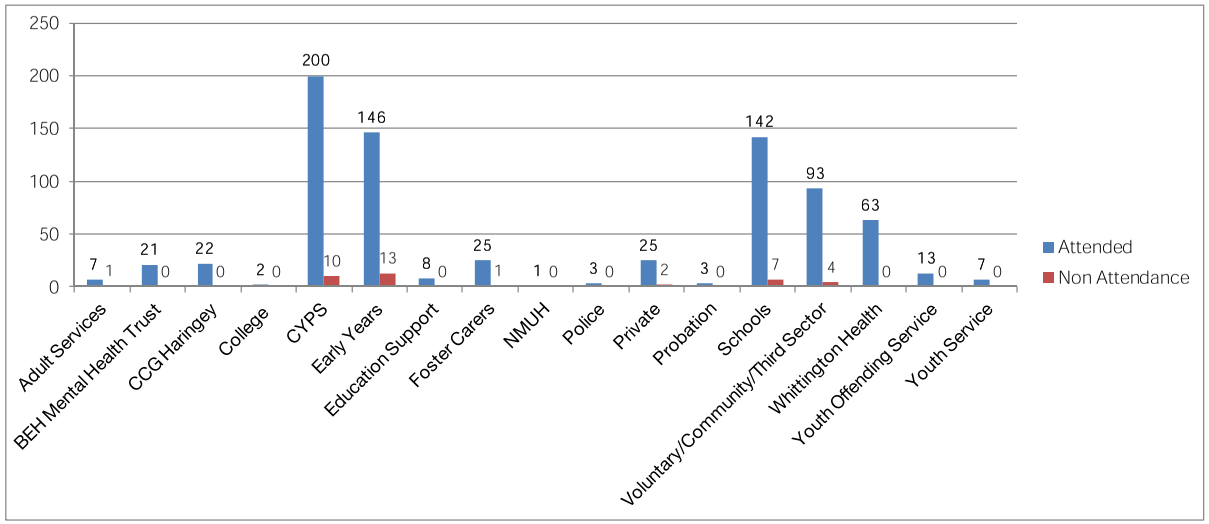
Attendance by multi-agency courses, 2013-14



The highest attendance to multi-agency courses was for Introduction to Child Protection (13.8%) and Designated Lead and Named Professionals (13.6%).

Attendance by Individual Agency - Attendance to courses was across 17 multi-agencies. The highest attendance by an individual agency was by CYPS (26% of total attendees), followed by early years (19%) and schools (18%).

Attendance by Individual Agency (2013-14)



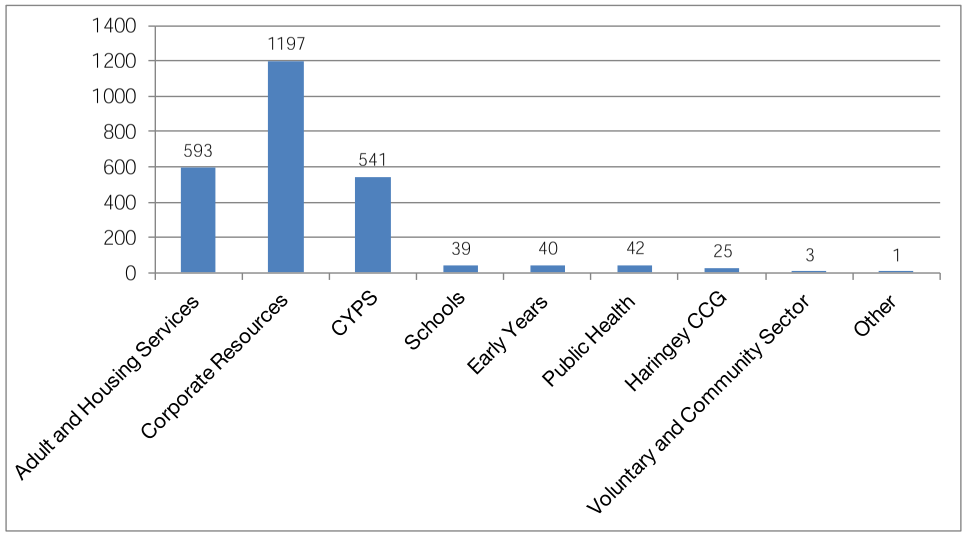
CYPS and Early years showed the highest rates of non attendance, followed by schools and the voluntary and community sector.

Since 2011-12 there has been an increase of 78% in school attendance on courses.

E-Learning - In November 2013, the Introduction to Child Protection e-learning was changed to **'Safeguarding Children and Adults: Basic Awareness'** e-learning. This was to support the Safeguarding theme of the *Improving Haringey Campaign*. For the first time, this e-learning resource covered both children and vulnerable adults safeguarding issues.

Between April 2013 and March 2014 2398 online courses were completed, an increase of 1021% since 2012-13 where 214 candidates completed Introduction to Child Protection.

Uptake e-learning by agency, 2013-14



Evaluation to Training Courses - Evaluating the effectiveness of training on practice is a core part of the Training, Learning & Development Subgroup. LSCB courses are evaluated using evaluation forms as well as verbal feedback to trainers on the day.

- Courses met the expectations of 98% of candidates
- The content of the course was about right for 90% of candidates
- 98% felt the training provided a safe forum for discussion
- Following the training sessions, 99% felt confident to undertake multi-agency child protection work
- 99% were likely to recommend courses to colleagues

5.2 Allegations against professionals – LADO

A report is produced annually which provides an overview and analysis of the work of the Local Authority Designated Officer (LADO). The LADO is responsible for the management and oversight of individual cases where allegations of abuse and maltreatment of children have been made against individuals working with children in an employed or voluntary capacity. The report outlines key developments, provides an overview of allegations which have been investigated, and provides a summary of consultation and advice offered by the LADO.

During the twelve month period from April 2013 there are records that the LADO was consulted on a total of 33 occasions. There may have been further instances of consultation where advice and guidance was given on safeguarding and welfare issues but these are not recorded. Thirty three referrals resulted in convening a strategy meeting or discussion.

This makes for an average of less than two contacts a week, which is lower than the overall referral rate in the last 6 months of 2012-13.

In the 12 months between April 2013 and March 2014, 45% (15) of the allegations taken to strategy meeting were substantiated, six led to disciplinary action, five to investigation by the police - one of which is waiting on a decision regarding prosecution. One foster carer was referred to the Fostering Panel to determine whether they should continue fostering. The number of substantiated referrals is slightly lower than in the previous reporting period where 56% of allegations were substantiated. 39% (6) were not substantiated, 2 were deemed not to have met the threshold at the strategy meeting and 2 remain open. The numbers involved are small and slight changes are not seen as particularly significant, what is important is the quality of investigation and decision making on each individual case.

The number of referrals to the LADO for 2013-2014 as recorded appears quite low. These are in fact those that led to strategy meetings being convened. The records of advice and consultation are not available and this might indicate a much higher number of enquiries that were deemed not to have met the threshold for LADO intervention. This has been rectified since April 2014 where all referrals are recorded on the database and the Framework-i system regardless of outcome.

6 Effectiveness of Safeguarding in Haringey

6.1 Council data

The Council reports on a range of performance targets for 2013-14, of which several are relevant to the work of the LSCB.

The following areas are performing well:

- The number of schools rated good or outstanding by Ofsted (all 11 secondary schools, and 49 out of 60 inspected primaries, are judged good or outstanding)
- The number of eligible families receiving services from Haringey Families First (on target to achieve targeted numbers of families)
- Number of successful adoptions and special guardianship orders. (64, against a target of 45).
- Number of cases dealt with by the offender management unit (255 against a target of 150)
- Number of gang members supported in the Gang Exit Programme (74 against a target of 70)

The Council reports the following areas as requiring further focus:

- Number of children's centres judged good or outstanding (of 14 centres, 9 were judged good, and 5 were judged requiring improvement)
- Early access to maternity services
- Rate of children subject to a child protection plan
- Timeliness of adoption placements (reducing from 778 days to 540, but still above the national targets)
- Timeliness of Child and Family assessments (83% of referrals seen within 10 days, against a target of 95%).

6.2 Children's Social Care Data.

- There has been a downward trend in the number of children subject to a child protection plan. Children on a plan have reduced by 30% since the end of March 2013, 80 fewer children. At the end of March there were 201 children on child protection plans, a rate of 35 per 10,000 population, below the 2012/13 rate for our statistical neighbours (40), the 2012/13 rate of 47 and the target rate of 43. The main issue to be concerned with here is ensuring the threshold is set at the right level.

- A children and families single assessment went live from 1 July and initial and core assessments were replaced with simple and complex assessments. 1091 of these assessments have been completed in the year so far, 77% in 45 working days against a target of 85%. New assessments are being undertaken in a timely manner due to tighter management and systems changes.
- 83% of children assessed were seen within 10 days in the year below the 95% target but more children have been seen in 10 days in recent months (87% in February).
- 9.9% of child protection plans that ceased this year lasted 2 years or more, close to statistical neighbour position of 9%. The target is 7%.
- 10% of children have become the subject of a Child Protection Plan for a second or subsequent time, in line with 10% target.
- There have been 5181 Child contacts recorded in the year, around 1,000 fewer contacts in 2013/14 compared with 2012/13
- Referrals are also reducing, 20% reduction forecast in addition to a 14% reduction on numbers in 2011/12. This is equivalent to a referral rate of 300 per 10,000 population.
- The rate of re-referrals within 12 months of the previous referral at 14% is in line with target (16%) and statistical neighbours.
- 90% of child protection cases have been reviewed within timescale for the current cohort, below the 100% target and below levels achieved by statistical neighbours.
- There has been a 3% reduction in the number of children in care since the end of March 2013. 523 children were in care on the last day of February or 91 per 10,000 population, which remains higher than the level in similar boroughs although a significant reduction on this point last year (rate 93).

6.3 Police Data

The Metropolitan Police issues quarterly summaries of performance across London, segregated into each local authority area, covering violent offences, sexual offences robberies, and common assault, and the rate of "sanction detection" (crime clear-up). Throughout 2013-14 the data showed that the numbers of crimes recorded as committed against children under the age of 18 was broadly consistent with rates in comparable London authorities, and detection rates were broadly higher than in comparable authorities. The LSCB is exploring ways of improving the ways of analysing this regular police data.

6.4 Health Reports

Haringey Clinical Commissioning Group published their annual safeguarding report in November 2014, covering 2013-14. It provides an overview of safeguarding arrangements across the health services in Haringey, including a summary of the performance of health providers against their training targets.

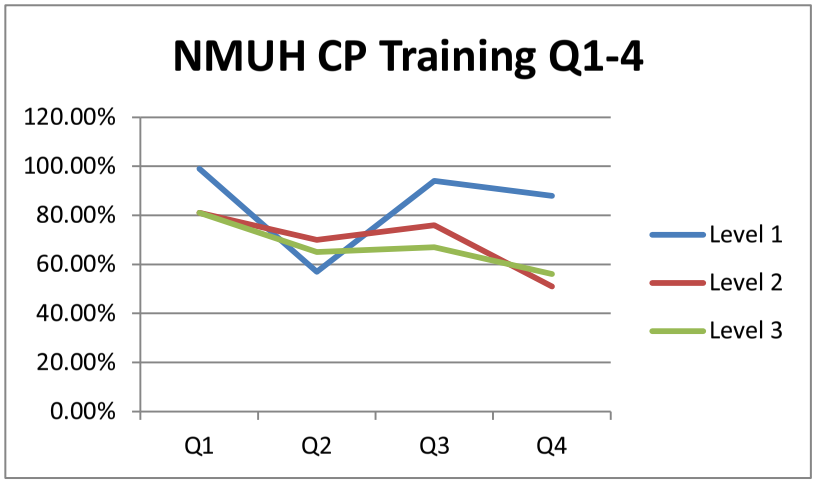
All Named safeguarding professionals in the Provider Trusts were up-to-date with safeguarding children training during 2013/14. Training compliance for all employers was set at 80% or above with the exception of BEH-MHT who set theirs at 85%. In addition to each Trust

having specifically tailored training there are several sources of more general and subject specific child protection (CP) training available for Haringey health professionals:

- E-learning via HSCB
- E-learning via NHS Skills for Health Core Learning Unit
- Multi-agency day courses via HSCB
- Lunch time learning sessions via HSCB
- E-learning produced by the Royal College of Paediatrics and Child Health

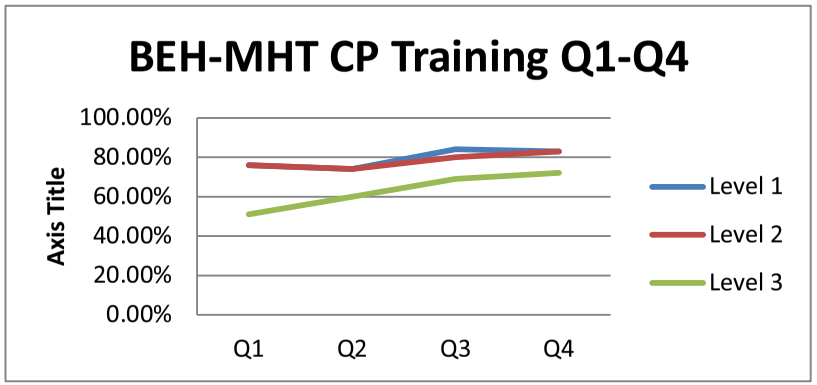
The tables below show the performance of each provider against their child protection training targets in 2013-14.

North Middlesex University Hospital NHS Trust



The Trust undertook a number of actions to try to address the low compliance with safeguarding training. These included commissioning additional capacity for level 2 & level 3 training, ensuring staff were aware of all training dates, sending email alerts to individual staff members and their manager when non-attendance occurred and proactively booking staff onto future sessions. The issue of low training compliance rates was discussed at the Contract and Quality Review Meetings (CQRG).

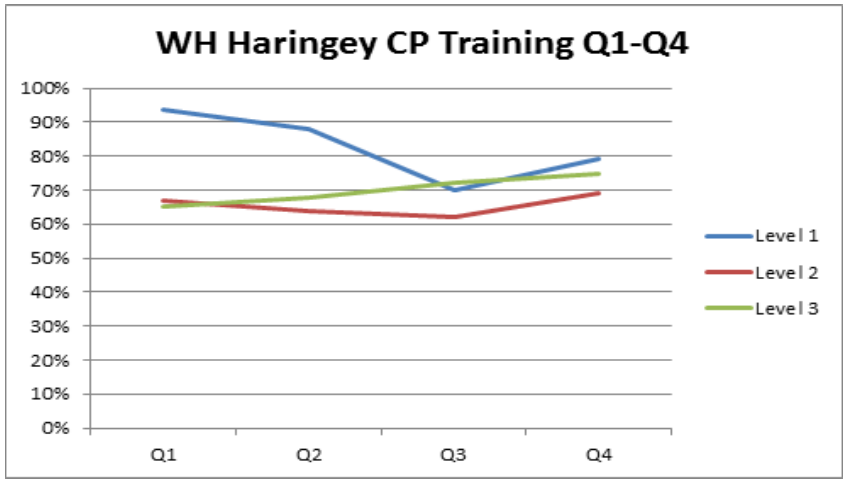
Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT)



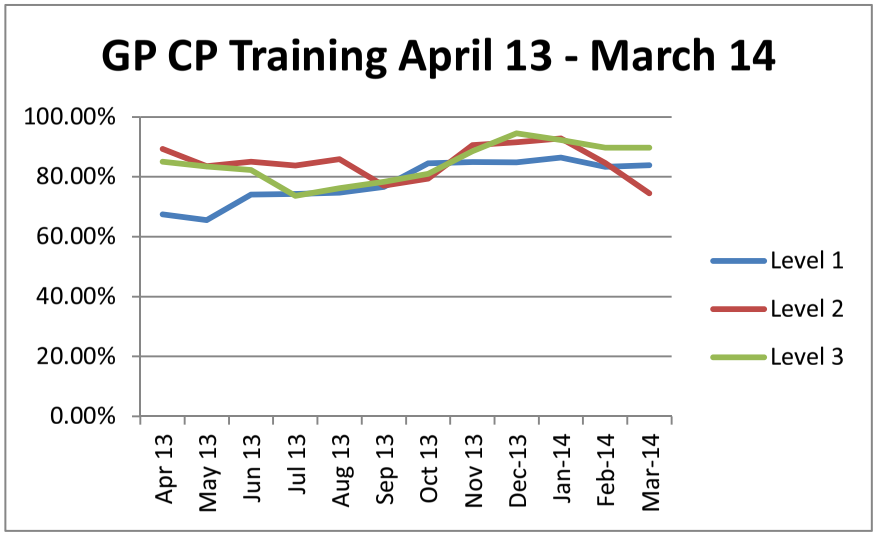
BEH-MHT reported that Level 1&2 compliance was lower than expected despite considerable training having taken place. Large numbers of staff became non-compliant at the end of the three yearly training cycle. To increase compliance additional sessions were commissioned and individuals given a date to attend.

Level 3 showed some improvement and increasing accuracy although attendance at courses was still thought likely to be under-reported due to historical issues of limited LSCB and staff feedback systems. Individual staff who were non-compliant were identified and names circulated to managers to chase submission of evidence or attendance at training.

Whittington Hospital NHS Trust (Whittington Health) (WH)



General Practice Staff



Haringey Looked After Children (LAC)

In 2013/14 there were 208 Haringey children new into care. 67% of children received their initial health assessments within the statutory 4 weeks' timeframe. The Children in Care (CIC) Team had not been receiving timely referrals from the Local Authority which then prevented the children being seen within timescales.

Work was done between the CiC team and local authority colleagues supported by the CCG - for example regular meetings and the creation of a care pathway flow chart - and the system demonstrated improvement by quarter 4.

6.5 Missing Children Missing from Care

During the course of 2013-14, 24 children in care were reported as missing from their placement, in a total of 32 episodes. The cases of any missing children in care, or absent without authority, are reviewed on a weekly basis by the lead member. Work has commenced to review the ways in which these cases are recorded, in order to synchronise records with the case management systems, and a more reliable process should be in place during the coming year.

Children Missing Education

A key indicator for safeguarding is school attendance and the LSCB seeks to have oversight of the degree of absenteeism

- Average attendance at Haringey's primary schools is 95.2%, compared with the national average of 95.3%. Average attendance at Haringey's secondary schools is 94.7%, compared with the national average of 94.1% (academic year 2012-2013). Persistent absence in Haringey's primary schools is 3.2%, compared with the national average of 2.7%. Persistent absence at Haringey's secondary schools is 5.2% compared with the national average of 6.5% (academic year 2012-2013).

- The cohort whose attendance raises the most concern is the Gypsy, Roma and Traveller (GRT) population. Attendance of GRT pupils is poor throughout their time at school but seriously deteriorates in secondary school. Parents will often state that their child has left home/is travelling with family/has returned to their country of origin etc. School staff and Educational Welfare Officers will work with all GRT families as they would the parents of any pupil whose attendance is a concern, and will undertake to locate any children claimed to have moved away. Unfortunately some children are involved in criminal activities and school will become aware of this through the work of the Youth Offending Service and the Police.

- In March 2014 16 children in care were reported to have been missing from school. The Virtual School has effective mechanisms for monitoring the attendance, and performance, of children in care in school settings.

A further concern is children who are not registered at a school and therefore may be missing education.

- The data for this cohort of children and young people is taken from cases referred between 1 September 2013 and 18 July 2014. During this period there were 590 referrals recorded; 452 have been located, 12 unable to trace and 124 of those remain open for casework.

- Of those children and young people to have been located 74% were supported to enrol at school, 17% were tracked and their whereabouts confirmed by the new local authority, 3.5% elected to home educate, 0.5% were above statutory school age and referred to Youth Community and Participation Service, 2.5% were given advice. The 2.5% that could not be located were closed following extensive investigations.

- The main source of all referrals are from out of borough education departments (30%) and Haringey School Admissions (28%). Health Services comprising of General Practitioners, Health Visitors/Clinics, Hospitals, Speech and Language Therapy, and School Nursing Service take up 11% of all the referrals received. Social Care liaises closely referring 11% of all cases. Schools from within Haringey and outside Haringey refer children and young people these account for 7.5% and 3.5% respectively. The remaining referrals are from the Benefits Agency, Housing, members of the public, other agencies such as those working with domestic violence, Police and Probation Services, self referrals, UK Border/Home Office/Immigration Agency, in borough and out of borough Youth Offending Services.

The largest group within the referral set is year one children at 14% with year eights and tens at 10% each. Nursery 2%, reception 7%, year two 9%, year three 7%, year four 4%, year five 5%, year six, seven and eight at 8% each, year eleven 6% and year twelve 2%.

Children Missing from Home

During 2013-14, police data reports 319 children as having been reported missing from home. Children are tracked in relation to risk of engagement with gangs, and potential risk of CSE. Data recording systems are currently being reviewed, in the light of Ofsted recommendations.

6.6 Reviews

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 included:

6.6.1 Policy and Procedures Audit 2013/14

A key role of the LSCB as outlined in Working Together to Safeguard Children 2013 is to develop local policy and guidance and ensure that this is accessible to the multi-agency network.

The audit involved a tick box survey whereby respondents were asked whether they were aware of a document, had used it and if so, how useful it was. This was confined to local guidance rather than London or national guidance. Returns were largely from health professionals. The results provided some reassurance concerning the degree to which current policies were known and understood, but also identified some policies which required greater emphasis. The audit also highlighted some areas of overlap or duplication, which have been addressed.

6.6.2 Schools audit 2013/14

During the year an audit was undertaken of how all Haringey schools are undertaking their safeguarding duties, as described under Sections 157 and 175 of the Education Act 2002. We used a self-audit tool which has been developed to allow schools to review their own practice.

Although not all schools completed the audit, the results were broadly consistent and encouraging.

- All returns identified clear arrangements in relation to the Designated Safeguarding Lead and Deputy and training for this role
- There was compliance with staff training and all had been trained at least every 3 years and in many cases more frequently. Various methods of delivery were used including on line training, cascade by the Designated Lead and externally commissioned training.
- All returns evidenced compliance with Child Protection policies and procedures which are clearly communicated to staff
- One school identified the need to review the policy on staff conduct to ensure it included behaviour outside of the school
- Schools are using varied and creative means of promoting communication with children and young people and providing support. These include initiatives such as Circle Time and workshops on topics such as bullying
- All respondents identified arrangements for counselling and pastoral support where needed and pupil voice was reflected via surveys and questionnaires
- E safety policy and awareness was universally mentioned
- All schools are using the CAF and report that staff have received appropriate training
- All schools gave examples of how they maintain contact with parents and provided information and advice on issues such as e safety
- There were many examples given of how the school has used the curriculum to promote safeguarding, for example, through PHSE and initiatives such as anti bullying week, assemblies and visits from organisations such as Stonewall
- The Designated Child Protection lead is evidenced as playing an active role in attending relevant meetings, CP conferences, core groups etc or in some cases delegating where they are unable to attend
- Recruitment and Selection demonstrated compliance

Areas for Development

- Role of Governing Body : Several schools in the sample identified that this was an area for review or further development, for example, in relation to training and monitoring CP arrangements
- Many schools had used this to identify a need for updating some of their policies and procedures

Conclusions

This is the first time that schools have been involved in a safeguarding audit, and feedback suggests that this has been a useful experience in highlighting areas for development and review. Some schools have undertaken this in partnership with a representative of the Governing Body which has enabled a coherent review of safeguarding practice and compliance.
The findings indicate a strong safeguarding ethos in those schools that responded, with many examples of how the curriculum can be used to promote protection. There is evidence of robust arrangements for Designated Leads, the delivery of training and dissemination of guidance. However, currently it is not possible to determine whether the responding schools are a representative sample of schools, or whether those schools most committed to safeguarding where more likely to respond. The board agreed a set of actions for 2014-15 to further strengthen the engagement of schools in the work of the Board.

6.6.3 Private Fostering Data:

As at 31/03/14 there are 15 children and young people open to the private fostering team, and one sibling who is not considered as privately fostered due to his age.

There have been 10 enquiries/notifications since November 2013 (no data available from the period April – November 2013) – 5 led to referrals and are now open cases.

12 cases have closed since April 2013

Child and Family Assessments are currently being carried out on 9 of the 14 open cases to assess thresholds for Child in Need and whether CIN plans are required in addition to support/monitoring under privately fostering regulations

6.6.4 Voice of the Child

It was agreed that a survey would be developed using the Viewpoint system to directly communicate with children and young people about a range of safeguarding issues. Viewpoint is an on line resource that enables direct survey work with participants. It is already in use in Haringey to gauge the views of particular cohorts of young people, for example, young people who are looked after. Schools were invited to participate in this work, asking questions about their safety and welfare at school, at home and travelling out and about in Haringey. The survey produced a limited amount of useful information to inform the work of the LSCB.

Work has been under way to disseminate guidance to all partners on effective ways of ensuring that the views of children and young people inform the work of each agency. Each agency has their own methods of capturing the views of children and young people, and the Board commissioned an audit of the range of methodologies currently employed. Given the wide-ranging consultation systems in place, it was decided that establishing a further mechanism specifically for the LSCB would be disproportionate. All agencies now include summaries of the views of children and young people within their annual safeguarding reports that the Board considers.

6.7 Agency Inspections

Thematic Neglect inspection

LB Haringey was one of the authorities involved in Ofsted's thematic inspection of the work of Children's Social Care Departments in the area of neglect. The inspection resulted in a wide-ranging set of recommendations for authorities and for LSCBs. Children's Social Care drafted a comprehensive action plan, which the Board agreed in May 2014, which has been incorporated into the LSCB's priorities for 2014-16.

Probation

London Probation Trust was inspected in January 2014 by HMI Probation. This Inspection of Adult Offending Work (IAOW) also had a thematic component focused on safeguarding children.

The report was published in May 2014 and in relation to safeguarding children Inspectors acknowledged that statutory relationships with partners were strong and effective; most staff had appropriate training in relation to child protection in the last 2 years and Multi-Agency Safeguarding Hub (MASH) arrangements worked really well. However, more was needed to be done in terms of ensuring MAPPA and child protection outcomes are fully reflected in sentence planning, follow through with home visits and repeat where appropriate, carry out periodic checks with CSC and Police during the Order or Licence, record decisions from child protection conferences and follow through on any actions and, effective management oversight in all cases involving safeguarding children issues.

Despite the identified areas for improvement the Inspectors were 'impressed by the commitment of staff and managers to improvement, which augurs well for the future'. These Areas for Improvement will be taken forward into the two new probation organisations in 2014/15; the National Probation Service and the Community Rehabilitation Company and monitored through continued internal case auditing.

Children's Social Care Ofsted inspection

In May 2014 Ofsted inspected the local authority's safeguarding arrangements, and judged the authority as Requiring Improvement. Ofsted noted evidence of real progress within children's social care, noting that the referral rates were reducing safely. Eleven areas for improvement were identified, including the need to accelerate the roll-out of a comprehensive early help offer, further improve performance around the timeliness and rigour of assessments, and ensure that strategy meetings appropriately engage all relevant agencies. The LSCB reviewed the authority's Action Plan for addressing the issues raised, and is supporting its delivery. Fourteen strengths were noted and commented on. The full Ofsted report is available on Ofsted's website.

6.8 Summary and Conclusions

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 are 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 during the year including:

- Information sharing
- Support to children experiencing neglect
- School safeguarding practice
- Missing children checks
- Support to children in care
- Role of child protection advisers
- Role of MASH
- Thresholds
- Structure changes within CYPS

- Early help pathways
- Gangs strategy

External inspections have suggested that the quality of safeguarding provision in all partner agencies meets statutory requirements, and the key lessons are summarised above. However, a number of common factors can present challenges to the quality of practice on the ground.

The financial pressures faced by all agencies have had an impact on the services that children and families receive. Some partners faced enormous challenges in recruiting sufficient staff to fill available posts, particularly in the east of the borough where many social problems are at their most severe. Haringey continues to target the offer of healthy child programme to those children most in need.

Many services have introduced changes in management structures, as part of their response to financial pressures, with consequent lack of continuity in approach. Good quality safeguarding practice depends upon continuities at all levels of the system, and frequent changes in personnel can impact on the quality of care that children and families receive, and on the quality of multi-agency partnership.

The high levels of children within the child protection system within Haringey continue to make it challenging for the authority to afford the desired range of Early Help services. Partners are clear about the importance of seeking to transfer resources towards early help and away from supporting children on child protection plans or in care; but the process of managing such a change is challenging for all services.

7. Priorities for 2014- 2015

These priorities include priorities chosen as a result of local issues and demands and will be addressed over 2014-16 by the Board. They will be incorporated into work plans aimed at improving outcomes progressed through the Board's agenda, or addressed more specifically by sub groups or task groups.

- PRIORITY ONE Gangs

Strengthening the connections between work around a) missing children, CSE and gangs, b) supporting and monitoring the development of a multi-agency response, and c) assessing the effectiveness of early intervention in reducing gang membership

- PRIORITY TWO - Early Help

Scrutinise the move towards strengthening early help offer across Haringey, seeking assurance on the common understanding of definitions, on the impact on child protection services, and on appropriate multi-agency engagement.

- PRIORITY THREE – Neglect

Improving effectiveness of all agencies in recognising and responding to neglect

- PRIORITY FOUR - Promoting good practice

Shift the overall balance of our activities more towards identifying and promoting elements of good practice.

- PRIORITY FIVE - Engaging the voices of children and young people

Identify an effective and proportionate way of tapping into the already available views of children and young people, to inform the work of the LSCB

Section 8 Business Plan 2014 – 2016

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.

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. The actions also take into account areas of improvement as identified in the May 2014 Ofsted review of the LSCB.

P1	Action	Lead group/person	By When	Evidence required
1	Review the current range of multi-agency groups working with highly vulnerable groups of young people (gangs, CSE, missing children, violence against women & girls, etc) & recommend (if appropriate) more functional & proportionate systems	Vulnerable Children's Group	March 2015	Work plans of existing groups Statistical information from multi-agency partners Risk assessments
	OFSTED 2 - Review Haringey's CSE multi-agency guidance and consider whether the involvement or association with gangs by young women should be included as a risk factor to strengthen arrangements to provide a coordinated response to this vulnerable group of young people.		Sep 14	

2	Complete Missing Children strategy, emphasising the links to gangs OFSTED 4 - Ensure that the Board receives an annual report on children missing from home, missing from care and missing from education to assure itself that appropriate processes and practice are in place to safeguard this vulnerable group of children and young people. Strengthen the existing Board's annual report arrangements to include an evaluation of service responses for missing children, to support multi-agency actions and reduce risks posed to children	Vulnerable Children's Group	March 2015 Nov 2014	All agency local strategies to inform the multi-agency oversight by the LSCB
3	Complete and implement CSE strategy OFSTED 3 - Accelerate plans to formally agree the draft CSE strategy and ensure it is clearly linked to the gang action plan. Make clear how the strategy will link to front-line practice, and what success criteria will be used to measure and evaluate progress.	Vulnerable Children's group	December 2014	Clear evidence of multi-agency systems
4	Review engagement of disabled children with gangs	Disabled children policy and review group	March 2015	The LSCB will have the findings of the review presented to the LSCB board and the Chair or representative will discuss findings

				with appropriate strategic leads to assure that the needs of disabled children affected by gangs is appropriate responded to.
5	Review relevant performance data and information-sharing systems	Quality Assurance Sub group	March 2015	The LSCB performance management report. This will incorporate the findings of this review.
6	Review the impact of the Early Help offer on future gangs engagement	Vulnerable Children's group / Best practice group	March 2015	The findings will be presented to the LSCB and included in the annual report 14/15.
7	Make this a feature of our Section 11 review	Quality Assurance group	December 2014	The S11 audit will have gangs as a themed area to assess agency's safeguarding arrangements.
P2	Action	Lead group/person	By When	Evidence required
1	Agree process of LSCB regular engagement in early help strategy	Best Practice Group/Chair	March 2015	A completed detailed plan on how the LSCB will engage with the early help strategy will be included in the Annual report 2014/15.
2	Review the definitions used by partners in relation to early help	Best Practice Group	March 2015	The LSCB will ensure the partnership have a clear understanding of the definition of early help, plus list of current definitions
3	Seek assurance that proposals to expand the early help offer do not impact negatively on child	Chair	March 2015	Tbd – agree key performance indicators with Early Help

	protection services			Partnership Board, & agree regular reporting to Board
4	Review suitability of LSCB's current training offer	Training and learning group	September 2015	All LSCB commissioned and delivered training will be reviewed to ensure early help is appropriately included. Courses will be quality assured.
5	Make this a feature of our Section 11 review	Quality Assurance Group	December 2014	The S11 audit will have early help as a themed area to assess agencies safeguarding arrangements.
P3	Action	Lead group/person	By When	Evidence
1	Sign off Neglect Strategy	Best Practice Group	September 2014	The development and monitoring of the neglect strategy will be included in the work plan of the Best Practice group.
2	Oversee delivery of Neglect Strategy	Best Practice	March 2016	
3	Make this a feature of our Section 11 review	Quality Assurance Group	December 2014	The S11 audit will have neglect as a themed area to assess agencies safeguarding arrangements.
P4	Action	Lead group/person	By When	Evidence
1	Create an annual Good practice in Safeguarding Award – perhaps as part of a wider	Chair/Board Manager	October 2015	The LSCB will include the details of the award winners in their 2015/16 annual report.

	Haringey Awards scheme; invite nominations for examples of effective multi-agency practice, create positive publicity around the awards			
2	Develop a programme for disseminating examples of good practice in safeguarding through existing agency newsletters. Have regular slots in agency e-bulletins (for example, HAVCO's e-bulletin, CCG newsletter etc).	Chair/Training Officer	November 2014	Local and national safeguarding news will be available to all partners via the LSCB and their internal communications.
3	Design and deliver at least one specific campaign, in partnership with local agencies. These will include SCR learning, FGM in schools and the community, promoting positive parenting and involving children and young people.	Chair/Board Manager/Training Officer	July 2015	The LSCB will have agreed a one year campaign programme – first to run Jan/April 15 on learning from SCRs.
4	Review and update branding of LSCB.	Chair/Board Manager	March 2015	The LSCB will re-launch its vision for safeguarding children in Haringey.
5	Develop a new vision for LSCB and 3-5 year strategy	Chair/Board	July 2015	Partners and the public will be clear of the LSCB's ambitions for

				ensuring safeguarding arrangements in the borough
6	Explore potential for "Community Champions" – a proposal from the voluntary sector to actively engage local people in specific safeguarding activities.	Chair/Board Manager	September 2015	The children and adults safeguarding boards with the third sector will discuss the viability of this proposal.
7	OFSTED 1- Ensure that schools are fully involved at Board level so that their representations are known, understood and considered and their contribution fully harnessed to influence the shape of services.	Chair/Board Manager	March 2015	The board will be able to evidence clear dialogue and influence from schools on the safeguarding agenda which will be outlined in the annual report.
P5	Action	Lead group/person	By When	Evidence
1	Explore potential for focus groups of young people to discuss particular issues based around our priorities	Chair/Board Manager	March 2015	Engagement of young people and participation team
2	Explore possible ways of engaging with "Takeover Day" in November.	Chair/Board Manager	November 2014	The LSCB will have engaged young people in new creative ways.

Appendix 1

Income 2013/14

Agency Contribution	Amount £
METROPOLITAN POLICE	5,000.00
LOCAL AUTHORITY *(including staffing costs and council employer contribution NI & Pension)*	180,064.00
BEH Mental Health services	5,000.00
CAFCASS	550.00
Whittington Health	5,000.00
North Middlesex Hospital Health	5,000.00
Probation	2,000.00
Tottenham Hotspur	2,000.00
Haringey CCG – Health	5,000.00
DCS funding	15,000.00
Budget carried over from	47,000.00
	271,614.00

Expenditure 2013/14

Expenditure - 1st April to 31st March 2014		
		Amount £
Administration/staffing	Staff wages (*2.5 including staffing costs and council employer contribution NI & Pension),* *phone, stationary, equipment excluding HE*	108,055.69
Catering	Refreshments: training and extended meetings	523.10
Independent consultants	Chairs, 3 x overview writers, auditors including HE	115,810.95
Trainers	External trainers	14,569.00
Venue	Meetings and training	4,645.00
	Overall Total	243,603.74

Budget 2013-14	£ 271,614.00	1st April 2013 to 31st March 2014
Expenditure 2013-14	£ 243,603.74	1st April 2013 to 31st March 2014
Income 2013-14		1st April 2013 to 31st March 2014
Balance remaining	£ 28,010.26	1st April 2014

APPENDIX 2

LSCB current Membership 14/15	
Chair	Sir Paul Ennals (Independent)
Local Authority	Lisa Redfern (Director CYPS) Myra O'Farrell (Interim AD of Quality Assurance and Safeguarding, CYPS) Susan Otiti (Assistant Director, Public Health)
Police	DCI John Foulkes (CAIT- North Sector) DCI Victor Olissa (Borough Commander) DI Simon Webb (CAIT – Haringey)
Probation	Andrew Blight (ACO Haringey) Douglas Charlton
Health Services	Jennie Williams (Executive Nurse and Director of Quality and Governance, NHS Haringey CCG) David Elliman (Designated Doctor for Child Protection and Child Death, NHS Haringey CCG) Karen Baggaley (Assistant Director for Safeguarding and Designated nurse for Child Protection, NHS Haringey CCG) Mary Sexton Director of Nursing and Executive Lead for Safeguarding Children BEH-MHT Geoff Isaac (Named Doctor for Child Protection BEH-MHT) Julie Thomas (Named GP for Child Protection , Haringey) Alison Kett (Deputy Director of Nursing Whittington Health) Julie Firth (Deputy Director of Nursing North Middlesex Hospital
Lead Member	Cllr Ann Waters, Lead Member for Children
Cafcass	Phyllis Dyer (Service Manager)
Voluntary Sector	(Chief Executive, HAVCO)
Housing	Denise Gandy (Head of Housing Support & Options)
Schools	Joan McVittie, Head Teacher - Woodside High Angela Ryan, Primary Head Teacher – Campsbourne
Adults Safeguarding	Helen Constantin (Head of Joint Governance and Business Improvement Services)
Legal Services	Stephen Lawrence (Assistant Head of Legal Services: Social Care)

Appendix 3

Haringey LSCB Members attendance 2013-14

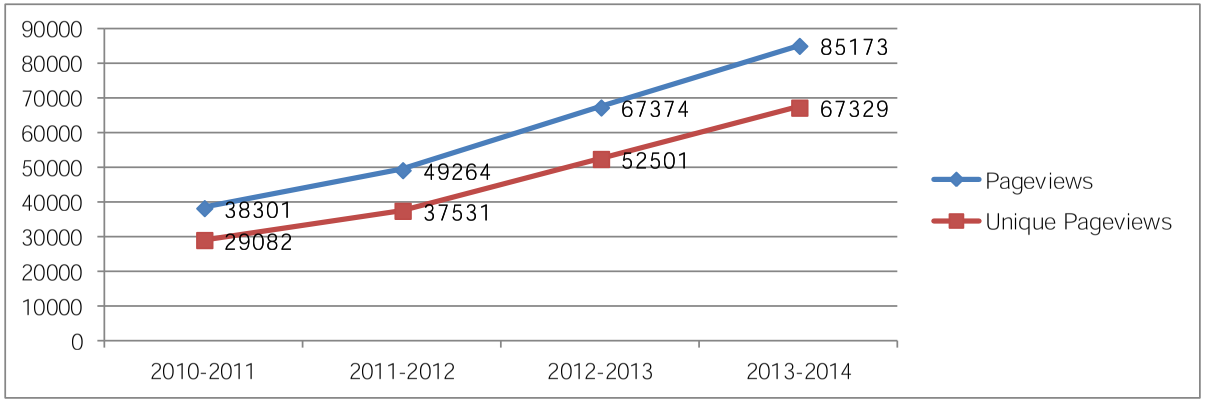
- Denotes representative attended on behalf of the member

Organisation	Job Title	Date of Meetings						No: of meetings member attended/was represented
		29/5/2013	31/7/2013	2/10/2013	27/11/2013	29/1/2014	26/3/14	
Independent	Chair	√	√	√	√	√	√	6 / 6
Independent	Lay Member		-	√	√	√	-	3 / 4
CAFCASS	Senior Service Manager	√	-	√	√	-	-	3 / 6
Local Authority	Director of Children's Services, Safeguarding	-	√	-	-	√	√	3 / 6
	Assistant Director, Safeguarding	-	√*	-	√			2 / 4
	Head of Service, QA and Safeguarding	-	√	√	√		√	4 /5
	Head of Service, Additional Needs and Disabilities	-	√*	√*	√*	√*	-	4 / 6
Health	Director of Quality and integrated governance (CCG)	-	-	√*	√	-	√	3 / 6
	Designated Nurse for CP (CCG)	√	√	√	√	√	√	6 /6
	Consultant Paediatrician, Designated Doctor (CCG)	√	√	√	√	√	√	6 /6
	Named GP NHS England London	√	√	√	√	√	√	6 /6
	Director of Nursing (NMUH)	√*	√*	-	-	-	-	2 / 6
	Assistant Director, Universal and Safeguarding Children's Services (Whittington)	√	√	√	√	√	√	6 /6
	Assistant Director (CAMHS- BEH-MHS))	-	-	-	-	-	-	0 /6
	Consultant Psychiatrist (BEH-MHS)	-	√	√	-	√	√	4 /6
	Director of Nursing Quality and Safety (BEH-MHS)	√	√*	√*	√*	-	-	4 / 6
	Director of Nursing NHS England London)					√	√	2 / 2
Local Authority	Drug and Alcohol Partnership Manager	-	-	√	-	√	√	3 / 6
Public Health	Assistant Director	√	√	√	√	√	√	6 / 6
Housing	Head of Housing Support and Options	-	√	√	√	-	-	3 / 6

Legal Services	Assistant Head of Legal	√	√	√	√	√	√	6 / 6
Police	Borough Commander	√	√*	-	√*	√*	√*	5 / 6
	DI, CAIT	√	-	√	√*	√	√	5 / 6
	DCI, CAIT	√	√	-	-		-	2 / 6
Probation	Senior Probation Officer	√	-	√	√	√	-	4 / 6
Voluntary	HAVCO	-	√	-	-	[redacted]		1 / 4
Lead Member	Councillor	√	-	√	√	√	√	5 / 6
Primary School	Head Teacher	-	-	√	-	-	-	1 / 6
Secondary School	Head Teacher	-	√	√	-	√	-	3 / 6
London Ambulance Service	Ambulance Operations Manager	√	√*	√*	√*	√	√	6 / 6
Adult and Housing Services	Deputy Director	√*	√	√*	-	-	√*	4 / 6
YOS	YOS Head of Service	-	√	-	-	-	√	2 / 6
LSCB	LSCB Business Manager	√	√	√	√	√	√	6 / 6

Appendix 4

Website Traffic Yearly Breakdown



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

Report for:	**Health and Wellbeing Board – 13 January 2015**

Title:	**LSCB Annual Report 2013-14**

Organisation:	**Haringey LSCB**

Lead Officer:	**Sir Paul Ennals - Chair**

1. Describe the issue under consideration

1.1 The Haringey Local Safeguarding Board is set up under statute, to coordinate what is done by each partner agency to safeguard and promote the welfare of children in the area, and to ensure the effectiveness of those services. All key statutory agencies are members.

1.2 DfE guidance "Working Together 2013" sets out the duties and responsibilities of the LSCB. One specific responsibility relates to the publishing of an annual report. The guidance states the following:

1.3 *"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.*

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

1.5 This report constitutes fulfilment of that responsibility. It covers the period 2013-14, prior to my appointment in May 2014. It has been published later than we had intended, owing to the current vacancy in the post of Board Business Manager

1.6 I would draw to the attention of the Health and Well-Being Board the following sections in particular, though I am happy to respond to comments or questions on any section:

1.6.1 My foreword pages 2-3
1.6.2 Summary of safeguarding, page 36-37
1.6.3 Board priorities page 38.

2. Recommendations

2.1 Note the Annual Report of the Haringey LSCB 2013-14
2.2 Note the priorities for 2014-16.

Haringey Council

healthwatch Haringey

HAVCO Haringey Association of Voluntary and Community Organisations

NHS Haringey Clinical Commissioning Group

Report for:	**Health and Wellbeing Board – 13th January 2015**

Title:	**Mental Health Crisis Care Concordat**

Organisation:	**Haringey Clinical Commissioning Group**

Lead Officer:	**Sarah Price, Chief Officer**

1. Describe the issue under consideration

The Mental Health Crisis Concordat was published in February 2014 by the Department of Health and the Home Office. Twenty two national organisations signed the concordat. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

There is a requirement to achieve local sign up and to develop an action plan to deliver the aims of the concordat. Following a London workshop in October local organisations signed the concordat before the 31st December deadline. Project support has been secured to develop a multi-agency action plan by March 2015.

Progress is being publicised via the Crisis Concordat website which colour codes current status; Haringey is currently coded amber (signed the concordat but action plan to be produced). When the action plan is submitted the website map will show Haringey as green.

2. Recommendations

That the Health and Wellbeing Board notes and endorses the Concordat.

Introduction

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat**.** It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. The Concordat builds on and does not replace existing guidance. Current service provision should continue while the Action Plan is being devised.

Mental Health Crisis Care Concordat: the joint statement

We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.

Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England.

Signatories to the Concordat

Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
NHS Clinical Commissioners
NHS Confederation
NHS England
NHS Providers
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

Third sector and charity supporters of the Concordat

Centre for Mental Health
Mental Health Foundation
Mental Health Providers Forum
National Housing Federation
National Survivor User Network
Rethink Mental Illness
Richmond Fellowship
Stonewall
Together for mental wellbeing
Turning Point
Young Minds

London Implementation

A London workshop was held on 27th October 2014 to prompt further work to deliver the concordat. Following the workshop, all London agencies agreed to sign the concordat, individually or through ADASS, London Councils and the London Office of CCGs, before the target date of 31 December 2014. This has been completed and the London declaration is attached as Appendix A. There is a Crisis Concordat website (http://www.crisiscareconcordat.org.uk/explore-the-map/) which shows amber for the Borough of Haringey. This will move to green when our action plan is submitted before 31 March 2015.

The action plan will require us to agree processes and timelines to work towards the best practice models of service described in the Crisis Concordat supporting commissioning documentation. The Barnet, Enfield and Haringey CCGs have been successful in a bid for additional 2014/15 mental health early access funding recently announced by Norman Lamb, Minister for Care Services. This includes £30k for project management costs to help develop the action plan. The majority of the funding, a further £600k, is being used to increase early access to mental health services in the three boroughs over the winter period.

Multi Agency Collaboration

At the London conference the metropolitan police gave an example of the success of multiagency collaborative working to positively impact upon people in mental health crisis and detained in police cells under section 136 of the mental health act. Through implementation of the Mental Health Partnership Board section 136 protocol, people are detained at an NHS place of safety, resulting in the numbers detained in police cells falling from more than 80 in 2013 to less than 20 in 2014. The MHPB ambition is that no one should be detained under a section136 in a police cell in London.

Further information

A full copy of the Mental Health Crisis Care Concordat can be found at:

http://www.crisiscareconcordat.org.uk/about/

A map showing national progress to adoption and implementation of the Concordat can be found at:

http://www.crisiscareconcordat.org.uk/explore-the-map/

Appendix A – 2014 London Declaration on next page

The 2014 London Declaration on improving outcomes for people experiencing mental health crisis, 27th October 2014.

We, as partner organisations in **London**, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work to improve the system of care and support that is provided for such people in **London** before, during and after the crisis itself.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in **London** by putting in place local action plans which reflect the new crisis care commissioning standards and which are regularly reviewed and updated.

This declaration supports 'parity of esteem' between physical and mental health care in the following ways:

- Through adopting the new crisis care commissioning standards in **London**
- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in **London** for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there are safe and effective services in **London** with clear and agreed policies and procedures in place for people in crisis.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to service users, patients, carers and staff, or the wider community and to support people's recovery and wellbeing.

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Agenda Item 13

Report for:	**Health and Wellbeing Board – 13 January 2015**

Title:	**Board Member Appointment and Change to Voting Rights**

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

Lead Officer:	**Stephen Lawrence-Orumwense Assistant Head of Legal Services Social Care and Contract**

1. Describe the issue under consideration

1.1 The Health and Wellbeing Board ('Board') is being asked to consider appointing the Chair of the Haringey Local Safeguarding Children Board as a member of the Board. Also, following the appointment by Full Council of an additional elected member to the Board, there has been an in-balance in the voting rights between Council and non-Council members of the Board. Therefore, the Board is also being asked to consider recommending to Full Council to alter the voting rights of the Lay Board Member Clinical Commissioning Group to restore the balance.

2. Cabinet Member introduction

2.1 This is not applicable (N/A)

3. Recommendation

3.1 It is recommended that:

a) The Board appoint the Chair of the Haringey Local Safeguarding Children Board as a non-voting member of the Board;

b) The Board request that Full Council alter the voting rights of the Lay Board Member of the Clinical Commissioning Group to a voting member; and

c) The Board accept this report as consultation by Full Council for the purpose of altering the voting rights of the Board member.

4. Alternative options considered

N/A

5. Background information

5.1 The Board is a Committee of the Council. The Council's Constitution (at Part 3 Section B Paragraph 8) sets out the governance arrangement for the Board. The Constitution provides for the following persons to be a member of the Board:

- The Leader of the Council
- The Cabinet Member for Children and Families
- The Cabinet Member for Health and Wellbeing
- Chair, Clinical Commissioning Group (Vice Chair of HWB)
- Chair of Healthwatch
- Director of Adult and Housing Services
- Director of Children and Young People's Services
- Director of Public Health
- Chief Officer, Clinical Commissioning Group
- Lay Board Member, Clinical Commissioning Group
- GP Board Member, Clinical Commissioning Group
- HAVCO representative
- Representative for the NHSCB (when requried)

The Council and the Board can appoint additional members as they deem appropriate. But the Council must consult with the Board prior to such appointment.

5.2 The Constitution restricts voting rights in the Board to the following members;

a) Local authority councillors (Leader of the Council, Cabinet Member for Children and Families and Cabinet Member for Health and Wellbeing);

b) Chair, Clinical Commissioning Group (Vice Chair of HWB); and

c) Chair, Healthwatch.

Any additional member appointed to the Board by the Council or by the Board are non-voting members. However, Full Council can make a direction to alter the voting right of Board members following consultation with the Board.

5.3 The recent Ofsted Inspection of Haringey Children Services (July 2014) flagged up the need to ensure that the Board's priorities are sufficiently linked to the children social care priorities. As a consequence, the Independent Chair of the LSCB has been attending and participating in the meeting of the Board to ensure a strategic focus on the agenda for promoting and safeguarding the welfare of children. The recommendation that the Board appoint the Chair of the LSCB is intended to confirm this existing arrangement. The Chair of the LSCB will be a non-voting member.

5.4 There is an underlying principle of consensus, equality and parity in decision making in the Board. This is reflected in parts in the balance between the voting

rights of Council members and non-Council members of the Board. In the last municipal year (2013/14), there were two Council members with voting rights and two non-Council members with voting rights. In this municipal year (2014/15), this position has altered with the appointment by Full Council of an additional elected member to the Board. The recommendation to Full Council to alter the non-voting right of the Lay Board Member of the Clinical Commissioning Group is intended to restore this voting balance in decision making between Council and non-Council members of the Board.

6. Comments of the Chief Finance Officer and financial implications

N/A

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

7.1 Section 194 of the Health and Social Care Act 2014 provides for the establishment and membership of the Health and Wellbeing Board. This section (*subsection (2)*) sets out that the Board's membership must include the director of children's services, the director of adult social services and the director of public health. There must be at least one elected representative, which may be the leader of the local authority and/or councillors nominated by the Leader (*subsections (3) and (4)*). The Local Healthwatch organisation and each relevant CCG must also appoint representatives (*subsections (5) and (6)*). The section (*subsection (8)*) enables the Board to appoint additional persons as members. The local authority is also able to invite other persons (other than councillors) or representatives of other persons to become members *(subsection (2)(g)).* The local authority must consult the Health and Wellbeing Board before appointing additional persons after the Board has been established (*Subsection (9)).*

7.2 Regulation 6 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provides that a person who is a member of a Health and Wellbeing Board shall not be treated as a non-voting member of that Board unless the local authority which established the Board otherwise directs. Before making such a direction, the local authority must consult the Health and Wellbeing Board. At the Full Council meeting on 20th May 2013, following consultation with the Board, it was directed that the then local authority elected members of the Board, the Chair of the Clinical Commissioning Group and the Chair of Healthwatch will have voting rights. That any additional persons appointed to the HWB either by the Local Authority or the HWB will be appointed on a non-voting basis. This direction is reflected in the Council's Constitution.

7.3 All voting members of the Board are required to comply both with the Members' Code of Conduct and the provisions of the Localism Act 2011 relating to Standards. In particular, voting members will be required to complete a register of interests which must be kept up to date. Voting members must also declare any disclosable pecuniary interest or prejudicial interest in any matter being considered and must not take part in any discussion or decision with respect to these items.

8. **Equalities and Community Cohesion Comments**

N/A

9. Head of Procurement Comments

N/A

10. Policy Implication

N/A

11. Reasons for Decision

This is dealt with above.

12. Use of Appendices

N/A

13. Local Government (Access to Information) Act 1985