**NOTICE OF MEETING**

# HEALTH AND WELLBEING BOARD

## Tuesday, 24th November, 2015, 6.00 pm – Committee Rooms 1 & 2, Civic Centre, High Road Wood Green, N22 8LE

**Members**: See enclosed

Quorum: 3 voting members, including one local authority elected representative and one of either the Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes).

### 1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

### 2. WELCOME AND INTRODUCTIONS

The Chair will welcome those present to the meeting and introductions will be given.

### 3. APOLOGIES

To receive any apologies for absence.

### 4. 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 10).

## 5. 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.

## 6. QUESTIONS, DEPUTATIONS, PETITIONS

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

## 7. MINUTES (PAGES 1 - 16)

To consider and agree the minutes of the meeting of the Board held on 24th September 2015.

## 8. DISCUSSION ITEM: PRIORITY 2 INCREASING HEALTHY LIFE EXPECTANCY (PAGES 17 - 58)

## 9. BUSINESS ITEMS (PAGES 59 - 230)

1) Update on Ambition 8 of the Health and Wellbeing Strategy - Baseline and Target Measure
2) Clinical Commissioning Group Commissioning Intentions
3) Health and Care Integration Programme Update
4) Haringey Better Care Fund Plan Update
5) Annual Safeguarding Reports – Children's and Adults

## 10. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at Item 4 above.

## 11. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are as follows:

- 23rd February, 18:00 – 20:00

Philip Slawther
Principal Committee Coordinator
Tel – 020 8489 2957
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Email: philip.slawther2@haringey.gov.uk

Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
River Park House, 225 High Road, Wood Green, N22 8HQ

Date Published: 16th November 2015

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Agenda Item 2

**Membership of the Health and Wellbeing Board**

* Denotes voting Member of the 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 | Acting Director of Adult Social Services | Beverly Tarka |
| | | | Interim Director of Children's Services | Jon Abbey |
| | | | Director of Public Health | Dr Jeanelle de Gruchy |
| **NHS** | Haringey Clinical Commissioning Group (CCG) | 4 | *Chair | Dr Sherry Tang |
| | | | Vice Chair | Dr Dina Dhorajiwala |
| | | | Chief Officer | Sarah Price |
| | | | *Lay Member (confirmed as voting member by Full Council 23/02/15) | Cathy Herman |
| **Patient and Service User Representative** | Healthwatch Haringey | 1 | * Chair | Sharon Grant |
| **Voluntary Sector Representative** | HAVCO | 1 | CEO | Paul Leslie |
| **Haringey Local Safeguarding Board** | | 1 | Chair | Sir Paul Ennals |

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Agenda Item 7

**MINUTES OF THE HEALTH AND WELLBEING BOARD**
**THURSDAY 24 SEPTEMBER 2015**

**Board Members Present:** Dr Sherry Tang (Chair), Councillor Peter Morton (Cabinet Member for Health and Wellbeing), Dr Jeanelle de Gruchy (Director of Public Health), Sir Paul Ennals (Chair of Haringey LSCB), Mike Wilson (Director, Healthwatch Haringey – Substitute for Sharon Grant), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services LBOH), Paul Leslie (HAVCO - Interim CEO).

**Officers Present:** Zina Etheridge (Deputy Chief Executive LBOH), Philip Slawther (Principal Committee Coordinator LBOH), Stephen Lawrence-Orumwense (Assistant Head of Legal Services).

| MINUTE NO. | SUBJECT/DECISION | ACTION BY |
|---|---|---|
| **CNCL101.** | **WELCOME AND INTRODUCTIONS**<br><br>The Chair welcomed those present to the meeting. | |
| **CNCL102.** | **APOLOGIES**<br><br>The following apologies were noted:<br><br>• Cllr Claire Kober - Leader of the Council<br>• Cllr Ann Waters - Cabinet Member for Children<br>• Sharon Grant – Chair, Healthwatch Haringey (Mike Wilson attended as substitute).<br>• Cathy Herman (Lay Member, Haringey CCG) | |
| **CNCL103.** | **URGENT BUSINESS**<br><br>None. | |
| **CNCL104.** | **DECLARATIONS OF INTEREST**<br><br>None | |
| **CNCL105.** | **QUESTIONS, DEPUTATIONS, PETITIONS**<br><br>No Questions, Deputations or Petitions were tabled. | |
| **CNCL106.** | **MINUTES** | |

**MINUTES OF THE HEALTH AND WELLBEING BOARD**
**THURSDAY 24 SEPTEMBER 2015**

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| | **RESOLVED:**<br><br>That the minutes of the meeting held on 23rd June 2015 be confirmed as a correct record. | |
| **CNCL107.** | **DISCUSSION ITEM**<br><br>**UPDATE ON GP PROVISION IN TOTTENHAM HALE - HEALTH AND WELLBEING STRATEGY – AMBITION 5: PEOPLE CAN ACCESS THE RIGHT CARE AT THE RIGHT TIME**<br><br>The Board received a presentation from Mike de Coverley, NHS England, and Jill Webb, Head of Primary Care - NHS England which gave an overview of key developments related to the provision of additional Primary Care capacity in Tottenham Hale. Following the presentation the Board discussed the findings.<br><br>A copy of the presentation slides was included in the agenda pack and the Board noted some of the key points raised. The current progress to date was summarised as:<br><br>• NHS England Finance, Investment, Procurement & Audit Group (FIPA) ratified the findings and recommendations of the Strategic Premises Development Plan.<br>• NHS England, Haringey CCG and Haringey Council planners were developing a Delivery Plan which set out, in detail, proposed solutions to meet the challenges outlined in the Strategy Plan.<br>• NHS England Decision Making Group (DMG) approved a process for the selection of a provider to enter into competitive dialogue to establish the proposed pilot practice in Tottenham Hale.<br>• NHS England, in conjunction with colleagues from the London Borough of Haringey and Haringey CCG, undertook and completed the competitive process of pilot provider selection.<br>• A local practice partner was selected as the provider. The decision was then ratified by PCC DMG and the provider was notified.<br>• Lea Valley Estates confirmed that they would have builders on site until June 2016, who would be able to rapidly establish services to the facility.<br>• NHS England and Haringey CCG were working on an IT solution that would rapidly allow connectivity to the new temporary facility.<br><br>The next steps and upcoming milestones for the project were noted as: | |

- Completion of dialogue had been commenced with pilot provider to establish final costs and service specification
- Final Agreement of pilot costs and service specification required by DMG Primary Care Commissioning.
- NHSE had begun the process of drawing up the contract for services
- Preparation of business case for pilot premises
- Dialogue and agreement of co-commissioners on premise funding responsibilities (in progress). Ms. Webb advised that NHSE were undertaking a process to bring primary care medical services commissioning arrangements back within the CCG umbrella.
- Sourcing of temporary facility (commenced)
- Approval of business case for pilot premises by FIPA
- Site mobilisation with new Partner Practice
- Planned service commencement by early January 2016

Cllr Morton, the Cabinet Member for Health & Wellbeing, welcomed the commitment from NHSE and acknowledged that this was a significant step forward on something that partners had been working on for a long time to get it to the position that it was currently in. Cllr Morton advised that the process had taken 12 months and a resolution was at least another 6 months away. Cllr Morton emphasised that a resolution could not happen fast enough both for existing residents but also to meet the additional demand as a result of the area being a major regeneration zone for London. Cllr Morton observed that primary care was part of the wider investment in the area and offered an unprecedented opportunity to improve the borough and the lives of the people in it. Cllr Morton commented that it was refreshing to see a large public body being accountable to the public in such a clear way.

Sarah Price, Chief Operating Officer Haringey CCG, reiterated that going forward the arrangements for commissioning would change and that this would involve closer working with CCG colleagues in other areas to plan for primary care investment in the future. Ms. Price agreed that being very clear about what Haringey's commissioning priorities were would put us in a strong position to ensure that we get the sort of input required from partners. Ms. Price advised that the Board was absolutely committed to ensuring that a resolution was found to the primary care shortfall but also noted that some difficult decisions would need to be made about how things were taken forward. Ms. Price expressed a desire to work together with NHSE to prioritise some of the more difficult decisions and thanked NHSE for supporting the initial investment.

Zina Etheridge, the Deputy Chief Executive, recognised that there were a special and specific set of circumstances around this issue and expressed gratitude to colleagues in the CCG and NHSE for developing a solution. Ms. Etheridge emphasised the importance of local and

partnership working across this piece of work, and stated that the Board made a commitment to bring back local needs assessment for primary care at the last meeting. The Board noted that this evidence base would be crucial for accessing future public funding and would support collective evidence based decision making, at a local level, in a way that was transparent and accountable to local people.

Mike Wilson, Director of Healthwatch Haringey, acknowledged the challenges involved in the process and thanked NHSE colleagues for the work that had been undertaken. Mr. Wilson stated that he would like some assurances that the service provided was going to meet resident needs and that it would be a sustainable service that was adequately staffed. In response, Mr de Coverley recognised the concerns raised and advised that NHSE had identified a reliable local provider who would be able to provide experienced GP's from day one. The committee noted that adopting a local provider added a level of flexibility, and would allow NHSE to increase provision if required.

Ms. Webb advised the Board that it was unusual for primary care infrastructure to be funded by capital, but negotiations were ongoing nationally in order for NHSE to use capital funding within General Practice, as part of the Primary Care Infrastructure Fund. Ms. Webb advised that a move to a more commissioner led strategy by NHSE, around funding and infrastructure would potentially be an advantage as the commissioning structures were already in place in Haringey. This would potentially mitigate the impact and the pressure on revenue by virtue of the type of schemes that could be adopted.

Cllr Reith, thanked fellow members of the task and finish group for primary care for their efforts. Cllr Reith raised concerns with a lack of urgency and advised that many residents in Tottenham Hale Ward currently had no primary care services at all and were unable to register with a GP. Cllr Reith commented that one of the key learning points from this process should be for co-commissioning and NHSE to listen to what patients were saying. Cllr Reith urged that a solution to the funding issue needed to be found and emphasised the need to assure residents that the funding would be long term, in order to ensure that residents felt secure in registering at the new practice. Cllr Reith also urged NHSE to consider pressures resulting from regeneration schemes, such as in Tottenham and the migration of families to outer-London areas, when planning the future allocation of funding and primary care services.

The Chair thanked colleagues from NHSE coming and presenting to the Board and also thanked those present for their contributions.

**RESOLVED:**

That the progress to date around additional primary care capacity in Tottenham Hale be noted.

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| **CNCL108.** | **DISCUSSION ITEM**<br><br>**HEATH AND WELLBEING STRATEGY – AMBITION 9: PEOPLE WITH SEVERE MENTAL HEALTH NEEDS LIVING WELL IN THE COMMUNITY.**<br><br>A Presentation was circulated as part of the agenda pack. Dr Tamara Djuretic, Assistant Director of Public Health and Shelley Shenker, Assistant Director MH Commissioning – Haringey CCG, gave the first part of the presentation on Mental Health and Wellbeing. The second part of the presentation was delivered by colleagues from Barnet, Enfield and Haringey Mental Health Trust: Dr Jonathan Bindman - Medical Director; Maria Kane - Chief Executive and Katherine Edelman - Clinical Director of services for Haringey. Following the presentation the Board discussed the findings.<br><br>Some of the key points raised in the presentation were:<br><br>• The performance indicators for Ambition 9 were: Percentage of people aged 18-69 on Care Programme Approach in employment and percentage of people aged 18-69 on Care Programme Approach in settled employment.<br>• Current performance was noted as 76.8% of adults in contact with secondary mental health services were in stable accommodation which was similar to our statistical neighbours but was lower than the London average and higher than the England average. 5.1% of adults in secondary mental health services were in paid employment. 5.1% was lower than Haringey's statistical neighbours and both the London and national average.<br>• 5.7% of women in secondary mental health services were in paid employment, compared to only 3.3% of men.<br>• The aim for Ambition 9 was to increase the percentage of adults receiving coordinated care who were in employment to 9.85%, which would be top quartile nationally and to increase the percentage of adults receiving coordinated care who were in settled accommodation to 80%, which would be in line with Haringey's statistical neighbours.<br>• The joint CCG and LBH Mental Health and Wellbeing Framework was published in March 2015 following extensive engagement and consultation. A whole system approach was adopted in the definition of enablement adopted in the framework: *"...supporting people to meet their potential to live independently, to have meaningful social relationships, maintain good quality housing, find and/or maintain employment and live a* | |

*satisfying life."*

- The proposed enablement outcomes were divided between outcomes for the individual and outcomes for the system:

For the individual:

- Strong social networks and reduced isolation
- Sustained employment, meaningful activity
- Stable accommodation
- Improved resilience and self-confidence
- Resources are effective in achieving personal goals
- Improved physical health
- Positive service user experience

For the system:

- Reduced activity in intensive, high cost resources/increased activity in low intensity, lower cost resources
- Pathways to and availability of resources understood by all stakeholders
- Improved mental health awareness and reduced stigma
- There was a choice of readily accessible resources available that met a range of needs and preferences

- In order to deliver these outcomes, an integrated, personalised and goal orientated care approach would need to be adopted in order to facilitate a life beyond diagnosis.
- The delivery of more interventions at the earliest possible stage in order to keep people well and supporting people with community based services when they do become un-well was also a key aspect of delivering the above outcomes.
- The need to respond quickly and to deliver high quality interventions and in-patient care was also highlighted to the Board, in order to provide effective support and ensure early discharge.
- A shift in the balance of resources to lower tiers of care was required so that people were supported in a variety of settings.

Julie Proudly, Manger for the Twining Enterprise service gave an overview of the individual placement support model to the board, as an example of a successful highly evidenced model of supporting people with severe mental illness into employment. The key points were:

- Delivery in Haringey started in July 2015
- The model involved the integration of employment specialists within health teams so that employment became part of the health package and part of the recovery package
- One employment specialist was integrated into the Early Intervention Services and one employment specialist was integrated into Recovery Enablement Track which was in the process of being set up.
- To date, 35 clients had been engaged in the process and 6 had been offered jobs.

- The process was based on 8 evidence-based principles including; a client-centred approach to get patients the jobs that they want, a paid work focus, ongoing in work support and employer engagement.
- A similar project was established in Barnet in January which had been successful and Twining Enterprise hoped to be a centre of excellence by March 2017.
- The process involved an integrated approach involving a partnership between statutory partners and the voluntary sector.

Ms. Shenker gave a further example of successful enablement model, the accommodation pathway, to the Board. The key points were:

- The model was driven by a significant number of delayed discharges from Mental Health in-patient beds.
- The partnership identified multiple challenges including:
  - Lack of joined up approaches to early assessment ensuring that housing needs were being addressed early on.
  - Confusion about the range of available accommodation options and approvals routes for health and social care funding.
  - No clear escalation routes for when blockages occurred.
  - No regular multi-agency forum for resolving these issues proactively.
- A multi-agency steering group was established across health, social care, housing and BEH to clarify the accommodation pathway for people with mental health needs.
- This included the roles and responsibilities of key agencies involved in a person's care, and a guide for care co-ordinators which was being trialled.
- The aim was to ensure effective and timely assessment, access to least restrictive housing options which maximised independence for people with mental health needs.
- The group was also developing an accommodation pathway dashboard to outcomes.

The Board was advised that key implications of adopting an enablement approach were:

- Harnessing the role of communities in offering support and linking this to the primary care offer to maximise well-being.
- A need to pump prime to allow time for preventative, primary care and strengthened community based mental health services to be piloted and be shown to work with intent to release resources from secondary care to fund longer term developments.
- Need to consider investment, capacity and skills in voluntary sector organisations.
- Consensus about management of clinical risk would be vital as patients were empowered to manage their own care.

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| | • Roles and responsibilities would need to be clarified<br>• Patients lived in the community and interacted with others in a host of settings prior to presenting at mental health services and resources should be utilised across the system in order to keep people well.<br><br>In support of the enablement approach, the Board were asked to:<br><br>• Promote and support the whole system approach to developing and implementing integrated enablement service model<br>• Advocate integrated commissioning approach based on the outcomes and co-production models<br>• Hold the multiple stakeholders to account publicly to ensure a system wide response<br>• Have oversight of risks to the programme and support risk mitigation<br>• To monitor performance.<br><br>Dr Jonathon Bindman, Medical Director of BEH Mental Health Trust (BEH MHT), provided an update to the Board on the enablement approach from a clinical perspective.<br><br>• Dr. Bindman agreed with the enablement definition given in the presentation.<br>• Dr. Bindman reiterated that where people received their care and how that clinical risk was managed was a crucial factor.<br>• Significant improvements had been made in community mental care services but there were a number of cultural assumptions made around mental health that remained and were problematic: That mental health problems were lifelong; they were disabling and that those problems made it impossible for people to work or engage fully within the community.<br>• The existing community mental health system managed some aspects of clinical care but didn't do enough across the whole spectrum of people's lives, hence the notion that enablement was about a life beyond diagnosis.<br>• BEH MHT's official Enablement Programme launch was launched in 2015 and created a new vision for the organisation: *Live, Love, Do.*<br>• Enablement was an important transformation programme for BEH MHT and required a transformation across the whole health economy. Dr Bindman advocated that it was key that the programme was led by commissioning and had buy-in from both service users and the third sector.<br>• Dr. Bindman commented that a significantly higher percentage of people with severe mental illness who are on the Care Programme Approach could undertake meaningful activities and paid work, than the current levels of between 3-5%. The issue was that there were too many barriers that got in their way. | Board to note |

- Dr Bindman advised that enablement within secondary care was not just limited to recovery for people with the most severe mental illness, instead for BEH MHT this meant changing their approach right from the point they presented to their services and across a range of diagnoses and problems.
- Dr Bindman outlined a number of enablement projects that were being taken by BEH MHT. The aim of the projects was to challenge people's expectations and assumptions right from the point they came into contact with services and then providing them with a different model for their recovery and their support into independence.
- The name of the front end of the enablement intervention pathway was being changed from triage to assessment service. It was at this initial stage that the enablement principles needed to be rolled out in order to counter some of the negative assumptions about mental disorders that people may be exposed to at this early stage.
- Dr Bindman advocated that the existing pathway could sometimes encourage dependence and created unhelpful patient expectations and that the enablement approach sought to change this.

Ms Etheridge commented that she was pleased to see how much progress had been made on enablement model and stated that it was interesting to hear some of the different projects that were being developed to facilitate some of the service users to live the enablement model. Ms Etheridge commented that behind this was funding from number of sources, which demonstrated the importance of bringing budgets together.

Ms Etheridge asked what types of barriers needed to be overcome as a system in order to make a whole systems approach a reality for of the service users. In response, Ms Shenker stated that the enablement approach was in the process of being implemented and that the CCG would be working with partners to look at a wider array of projects that would deliver the outcomes that they were looking for. As the implementation of these projects progressed and as the shift in resources continued, it would be at this stage that barriers would start to emerge. Ms Shenker elaborated that barriers would likely emerge: At the point where people had anxieties or concerns about clinical risk; if there was a failure to develop a co-production model with service users and at the point at which movement of resources was discussed.

Dr. Djuretic elaborated that all of the relevant bodies were required to work together in order to provide holistic support, and that whilst currently the different bodies talked to each other they still delivered services individually instead of as one package of care. This would require a big cultural shift and for increased community involvement.

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| | Dr Bindman advised that there were a lot of barriers involved and that services users were heavily disadvantaged by changes to the welfare and benefits system. Dr Bindman further advised that any changes in the model and attempting to challenging dependence would be difficult and would take a lot of time and hard work to convince people of the advantages of this approach. The Board noted that there were also barriers in changes to the NHS work force and that this type of system transformation required a lot of changes to working practices, and in some cases would be contrary to some of the training that people had received.<br><br>Maria Kane, Chief Executive BEH MHT, advised that a further challenge would be how the primary care system was supported to become part of the enablement approach, particular when taking in to account the existing pressures facing GP's. Ms Kane also commented that some discussion would be required as to how the funding regime would be developed, to potentially create longer contracts and how funding would need to shift from secondary care to lower tiers.<br><br>Paul Leslie, Interim CEO HAVCO, commended the proposals. Mr Leslie also enquired as to what the training and communication processes were for voluntary sector organisations, and asked how some of those gaps would be filled. Dr Djuretic responded that the enablement approach would be taken to the voluntary sector forum on the 5th October to begin a dialogue on the role of the voluntary sector, and to establish what capacity there was within the community and where the gaps were.<br><br>The Board agreed to further consider its role in how it would contribute to the delivery of a whole system approach.<br><br>The chair thanked those present for their contributions.<br><br>**RESOLVED:**<br><br>I). That the progress to date of the enablement approach be noted. | Board |
| **CNCL110.** | **DISCUSSION ITEM**<br><br>**HEATH AND WELLBEING STRATEGY – AMBITION 7: MORE CHILDREN AND YOUNG PEOPLE WILL HAVE GOOD MENTAL HEALTH AND WELLBEING**<br><br>A Presentation was circulated as part of the agenda pack. Catherine Swaile, Vulnerable Children's Joint Commissioning Manager, gave the presentation to the Board on the review of Haringey Children's and Adolescent Mental Health Services (CAMHS). Following the presentation the Board discussed the findings. | |

Some of the key points raised in the presentation were:

- The review was linked to Ambition 7 of the Health and Wellbeing Strategy, more children and young people will have good mental health and wellbeing. The performance measure for this ambition was based on a survey that was being developed for school children, based on the Warwick-Edinburgh wellbeing score for children and young people. As the process was not finalised, a target had not yet been set for this ambition
- The Department of Health published a report earlier this year called Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. The report identified participation and collaboration as a core principle, promoting services designed in collaboration with children, young people and families to meet their needs. The report also contained 49 proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs
- Haringey's allocation of the £280m Transformation fund for CAMHS announced in the Autumn Budget was £515,302, recurrent for 5 years.
- CAMHS Review Project Board were leading the review of Haringey CAMHS, comprising representatives from the CCG, the Council, NHSE, CSU and Healthwatch. The process involved an engagement event for over 50 people in March and a follow up event was booked for 18th September to feedback on the review outcomes and to develop a transformation plan. Themed workshops were held on Looked after Children, Children with Learning Disabilities/ASD and Crisis.
- In addition, online surveys were conducted with feedback from 152 stakeholders including both children and young people and parents.
- Participation in the review was received from all providers to ascertain what the issues were in mental health and to see what improvements could be made.
- The latest estimated prevalence data showed that low level universal support was required by around 9000 children or young people in Haringey. No data was available for the numbers or Haringey's commissioned activity.
- Ms Swaile identified a significant gap at the next tier of support up, where a mental health professional was working with a family (but not as part of a multi disciplinary team) where Haringey commissioned around 300 services across health and social care but would expect about 4000 people requiring a response.
- Haringey's commissioned activity was around 1200 cases for multi- disciplinary specialist care services, against an estimated 1150 cases. Ms Swaile commented that this suggested an escalation of cases because need was not being met at the tier below.

- The number of cases at tier 4, which was classified as highly specialist inpatient services, was below what the estimated prevalence data would suggest with 17 cases against an estimate of around 50.
- Feedback was positive in terms of the quality of service. Feedback also indicated that improvements needed to be made in; crisis management, availability of choice, waiting times, inter-agency working, Looked After Children services IT infrastructure and concerns were raised about inadequate safeguarding training.

The Board noted that transformation plans needed to be submitted on 16th October and that these would require Chair sign-off. The transformation plans would be based on the outcomes of CAMHS review.

Catherine Swaile / Chair

Jon Abbey, the Director of Children's Services raised a query regarding the future model and transformation, requesting some further detail on the future operating model and where the prevalence scores suggested in the presentation might fit in with Early Help and schools. The Director of Children's Services also commented that the presentation highlighted the difficult transition for 16-18 year olds and raised concerns with the fragility of the workforce in regards to safeguarding training.

Ms Swaile responded that one of the key conclusions of the review were that there was a lack of support at tier 2, a lot of which could be developed in conjunction with schools, and that this required much more coherence in terms of planning. A further key conclusion identified by the review was that the lengths of interventions in CAHMS were longer than the national average. The concern therefore, was that dependencies were being built and the challenge was to ensure that people were getting useful interventions at the right time and that people were not being held in services. The Board noted that transition became difficult when children were held in services inappropriately, because they didn't meet the threshold for adult mental health services but discharge was equally unsuitable.

Sir Paul Ennals, Chair of Haringey LCSB, commended the presentation and commented that there were close links to the enablement model. Sir Paul agreed that the key concern seemed to be strengthening the links at tier 2 and identifying what the evidence showed were the key interventions that could reduce the flow of children and young people up into tier 3. Sir Paul added that in terms of the enablement model, there was evidence to suggest that intervening at the time of initial attachment was the most cost effective time of intervening and the most effective way of reducing the later flow of needs.

Ms Swaile agreed that developing a proper attachment pathway was key and was one of the main areas that had been identified to be taken

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| | forward. A lot of work already took place on working on attachment with families but it wasn't coordinated. The Board was advised that there was a high level of provision in Haringey, CAHMS spending was appropriate and a number of successful outcomes were achieved. The main issues revolved around coherence of planning and alignment. Sir Paul added that there were other conclusions to be drawn around the enablement link; namely more powerful use of the voluntary sector from within the community and shifting the focus of front line delivery away from highly trained mental health professionals to other providers who were much closer to home. There were a number of models within the voluntary sector that should be reviewed and considered.<br><br>Mr Wilson advised that the wider report that the CAHMS presentation was drawn from contained some equalities issues that were not reflected in the presentation. The equalities issue related to the number of referrals in the central and south east being lower than the west. Mr Wilson recommended that these issues needed to be flagged up as part of this work. Ms Swaile acknowledged the discrepancies outlined and suggested a possible correlation with lower referral rates for Black African and Black British African demographics and suggested that targeting certain areas with high proportions of certain communities may improve the referral rates. Ms Swaile advised that further work would need to be undertaken to look into this issue.<br><br>Sir Paul queried what the Board was being asked to do in relation to this paper. Ms Swaile responded that the paper was for information purposes and to update the Board on current progress. Ms Swaile stated that she would like to bring the more detailed transformation plan Back to the Board for approval prior to its publication on the Council and CCG website in November. Dr de Gruchy advised that the next meeting of the Board would fall too late to bring a subsequent paper back to board and reiterated that the purpose of this item was so that the Board could have a conversation about the review of CAMHS, particularly prior to it going to public consultation.<br><br>The Board agreed that any comments would have to be fed back outside of the Board on an individual basis to Catherine Swaile. It was noted that the timescales for the review were nationally driven with the planning guidance issued in August and a final submission deadline of October.<br><br>The Chair thanked those present for their contributions. | Catherine Swaile<br><br>Board |
| **CNCL111.** | **BUSINESS ITEM**<br><br>**PRIORITY 2 GOVERNANCE ARRANGEMENTS**<br><br>A report on the governance arrangements for Priority 2 of the Corporate Plan was included in the agenda pack. Charlotte Pomery, Assistant Director of Commissioning, presented the report to the Board. | |

The Council established governance arrangements to oversee delivery of each of the five priorities in the Council's Corporate Plan. The current arrangements consisted of internal boards focusing on delivery of both the outcomes in the Corporate Plan and the budget reductions required in the Medium Term Financial Strategy. The Healthy Lives Board was set up to focus on delivery of the second priority of the Corporate Plan: Empower all adults to live healthy, long and fulfilling lives with control over what was important to them.

In order to foster and enable the whole systems and collaborative working needed to deliver the Corporate Plan, the establishment of a partnership Outcome Board for each priority had been proposed. The paper set out the background to this requirement and requested that the Health and Wellbeing Board be ratified to take on this function for Priority 2, working across Haringey's health and social care system.

Dr Jeanelle de Gruchy, Director of Public Health requested more information around the Board's role in Priority 1 of the Corporate Plan: Enable every child and young person to have the best start in life, with high quality education. In response, Ms Pomery agreed that there was a significant synergy across health and wellbeing for both adults and children as shown by the CAMHS review. Ms Pomery advised that there was a proposal to establish a separate partnership Outcomes Board for Priority 1. The Board noted that there would need to be discussions on how the two partnership Outcomes Boards linked together in order to ensure that there were no gaps between the two priorities.

**RESOLVED:**

I). That the Health and Wellbeing Board, within the context of its functions, be ratified as the external Outcomes Board to oversee the delivery of Priority 2 of the Corporate Plan.

**NNS 111 AND GP OUT-OF-HOURS PROCUREMENT UPDATE**

A report on the NHS 111 service and the GP Out-of-Hours Procurement update was included in the agenda pack. Jill Shattock, Director of Commissioning – Haringey CCG, presented the report to the Board.

The Board noted that Haringey CCG was working with the other four CCGs in north central London (Barnet, Camden, Enfield, and Islington) to bring together the NHS 111 service and the GP out-of-hours service to enable them to work better together.

The CCG held a number of events over the preceding 8 months and received feedback from a wide range of members of the local

| | | |
|---|---|---|
| | community on the 111/OOH procurement proposals. The evidence gathered, including clinical evidence, showed that bringing the two services together across the five boroughs would meet local need for the service and provide a sustainable service. The procurement process was due to begin from 2nd October<br><br>**RESOLVED:**<br><br>I). That the report be noted. | |
| **CNCL112.** | **NEW ITEMS OF URGENT BUSINESS**<br><br>No new items of Urgent Business were tabled. | |
| **CNCL113.** | **FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS**<br><br>It was noted that the date of the next meeting was 24th November at 18:00.<br><br>The following agenda items were agreed for the next meeting:<br><br>• LSCB Annual Report.<br>• Remaining performance measures for Health & Wellbeing Strategy (From June HWB)<br><br>The Board agreed that future reports should more clearly define what was being asked of the Board in the recommendations and to ensure that a covering report was included in the agenda pack.<br><br>Cllr Morton observed that keeping future agendas tight and to as few agenda items as possible in order to review those items in detail seemed to work well and also agreed that focusing items on the ambitions in the Health and Wellbeing Strategy was useful. Cllr Morton suggested that the issue was maintaining the correct balance between accountability and policy making.<br><br>The Deputy Chief Executive commented that there were a number of areas were the Board had to make a decision due to the powers vested in it, such as approving the Pharmaceutical Needs Assessment. The Deputy Chief Executive suggested that the discussion items on future agendas should focus on what the barriers were to the system delivering the changes required. Sir Paul Ennals endorsed this approach.<br><br>The Board agreed to keep the main format of future meetings | Clerk<br>Clerk<br><br>Jeanelle de Gruchy / Sarah Price<br><br>Jeanelle de Gruchy / Sarah |

| | | |
|---|---|---|
| | to one or two strategic discussions, based on the ambitions of the HWB Strategy. The Board also agreed with tightening agendas and keeping the amount of time dedicated to presentations shorter in order to facilitate more discussion time.<br><br>Stephen Lawrence-Orumwense to be invited to future Health and Wellbeing agenda setting meetings.<br><br>The Board agreed to a start time of 18:00 for future meetings of the Board. | Price<br><br>Jeanelle de Gruchy / Clerk |

The meeting closed at 20.55pm.

Cllr Claire Kober

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Chair of the Health and Wellbeing Board

**Report for:** Health & Wellbeing Board 24th November 2015

**Item Number:** **8 - Discussion item**

**Title:** Increasing Healthy Life Expectancy (Priority 2)

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

**Lead Officer:** Marion Morris, Head of Health Improvement, Tel: 020 8489 6962
marion.morris@haringey.gov.uk

**Ward(s) affected:** ALL

**Report for Key/ Non Key Decision:** N/A – Report for noting

## 1. Describe the issue under consideration

1.1 This report introduces the annual public health report which this year focuses on increasing healthy life expectancy. This is Priority 2 of the Health and Wellbeing Strategy and the focus of the November Board meeting.

1.2 Performance against the ambitions which support Priority 2 will be outlined at the Board, along with a more detailed look at two of the risk factors for early death and unhealthy life expectancy, namely smoking and physical inactivity – with a particular focus on the improvements to health that can be achieved by increasing walking and stopping smoking. See appendix 1 for presentation.

## 2. Cabinet Member Introduction

2.1 I am pleased to note that residents in Haringey are now living longer but note that inequalities remain and that not all have benefited. There is still much for us to do as a Board to address these inequalities in health. For it is well known that unhealthy lifestyles, such as whether people smoke, how much they drink, what they eat, whether they take regular exercise, will have a negative impact on an individual's wellbeing and healthy life expectancy. There are also wider negative impacts, and costs of unhealthy lifestyles to families, communities and society as a whole, including avoidable pressures on the NHS.

2.2 The health of Haringey's population will only improve if we address the environmental factors that influence behaviour and choice, as well as individual level behaviour change. I welcome the publication of the Director of Public Health's report and the focus by the Health and Wellbeing Board on two major areas to tackle to increase prevention of unhealthy life expectancy – smoking and physical inactivity. Working with our partners and residents, we must ensure that we are ambitious and bold in our approach to increasing our prevention efforts.

## 3. Recommendations

3.1 The Health and Wellbeing Board is asked to:

3.1.1 Endorse the Local Government Declaration on Tobacco Control & the NHS Statement of Support for Tobacco Control.

3.1.2 Encourage the wide scale roll out of Making Every Contact Count Training.

3.1.3 Support the proposal for a dedicated & co-ordinated Walking programme & walk weekend in October 2016.

3.1.4 Champion the GLA's 'Ten Indicators of a Healthy Street' programme.

3.1.5 Champion 'walk to work week' and walking generally in the workplace.

## 4. Reasons for Decision

4.1 Endorsing the Tobacco Control Declaration, (para 3.1.1, see appendix 1 & 2) – will demonstrate a clear commitment on behalf of Haringey Council, Haringey CCG, And other members of the Health and Wellbeing Board to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence. This will involve: i) taking action to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to Haringey residents; and ii) developing plans with our partners and local communities to address the causes and impacts of tobacco use.

4.2 Championing the wide scale roll out of MECC for all front-line staff, (para 3.1.2, see appendix 4) - will ensure that we equip staff with the necessary competencies to have healthy conversations, deliver 'brief interventions', and skills to sign post recipients to support services where necessary. When done at scale this will have a large-scale prevention effect.

4.3 Developing a walking campaign in 2016, (para 3.1.3) will form part of a multi-faceted strategic approach to 'designing in' and promoting the benefits of walking for health in Haringey. Examples of this approach will include: firstly, working closely with the Greater London Authority (GLA) to promote the benefits of its 'Ten Indicators for a Healthy Street' programme[1]; (appendix 5) and secondly, Public Health and Environmental Services will undertake a review of the Smarter Travel Programme as part of the Local Implementation Plan (LIP)[2] for Transport, (Smarter Travel includes active travel projects run by community organisations which support walking and/or independent travel), in order to re-shape it to tackle obesity and explore how we could encourage walking among different age groups.

[1] Examples of the '10 Indicators' include: 'People choose to walk & cycle', 'People feel safe', 'Easy to cross', see appendix 4.

[2] Smarter Travel/Active travel programmes & targets are determined by the Mayor's Transport Strategy, Transport for London and the Council's Local Implementation Plan (LIP).

4.4 As part of the walking campaign, a 'walk-weekend' will be held in October 2016. Haringey residents will be provided with a book of maps of self-guided walks and also a folder of information on various guided walks organised by the Parks Friends Groups and/or the Historical and Civic Societies across the Borough.

## 5. Alternative options considered

Not applicable

## 6. Background information

6.1 Annual Public Health Reports

6.1.1 All directors of public health (DPH) have a statutory obligation to produce an Annual Public Health Report (APHR) for the population they serve. The APHR is the DPH's independent professional statement about the health of the population they serve. The Annual Public Health Report should be publicly accessible to view and will be available at the board meeting on the 24th November. Thereafter it will be published on line and hard copies will be available for distribution.

6.2 Poor diet, smoking, high blood pressure, obesity (due to inactivity and poor diet) and excess use of alcohol are the five top risk factors for long term conditions, poor health and early death in Haringey. These are health conditions that can be managed, but not always cured, such as heart disease, diabetes, and stroke. Not only do these conditions have a significant impact on individual health and wellbeing, but they also place a considerable burden on health and social care services.

6.2.1 Whilst progress has been made in achieving reductions in the overall prevalence of smoking in Haringey, data for routine and manual workers[3] shows an increase of 14% between 2011-14. Our ambition is to reduce the proportion of people smoking aged 18 and over in routine and manual professions to 19.3% in 2018, (from 39% in 2014), in line with projected London levels.

6.2.2 For physical activity, the proportion of adults participating in less than 30 minutes of physical exercise a week in Haringey is below the England and London average, with 26.4% of adults residents classified as inactive. One way of improving physical activity in Haringey will be to promote the benefits of active travel, and encourage more residents to walk and cycle during the week. Currently, 72% of Haringey residents walk five or more days a week. The aim is to increase this proportion so that Haringey is ranked in the top quartile in London by 2018, (see Appendix 7 for the benefits of physical activity for adults).

6.2.3 Stroke is part of the broader category of cardiovascular disease, a major contributor to unhealthy life expectancy and strongly associated with controllable lifestyle risk factors such as smoking, poor diet, alcohol and lack of physical exercise (see

[3] The ONS uses the National Statistics Socio-economic classification to measure the employment relations and conditions of occupations, central to showing the structure of socio-economic positions in modern societies and helping to explain variations in social behaviour and other social phenomena.

Appendix 6 Stroke : Act Fast, for the latest data summary on the impact of stroke in the UK). Early death from stroke is particularly high in Haringey, which is why we are using this as our performance measure for the Ambition 4 'Every resident enjoys long lasting good health.'

## 7. Contribution to strategic outcomes

7.1 'Increasing healthy life expectancy' is Priority 2 in the Haringey Health and Wellbeing Strategy; and objective 1 of Priority 2, 'Enable all adults to live healthy, long and fulfilling lives', in Haringey Council's Corporate Plan 2015-18.

## 8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

### 8.1 Finance and Procurement

8.1.1 The recommendations in this report do not have direct financial implications at this point.

### 8.2 Legal

8.2.1 The recommendations in this report do not have any direct legal implications at this point.

### 8.3 Equality

8.3.1 The publication of this Annual Public Health Report documents the chronic health inequalities and risks to health affecting Haringey residents, and the steps that Haringey Council is taking to mitigate those risks by firstly, continuing to support residents in routine and manual groups to stop smoking, and secondly, by encouraging more people to be physically active, through increased promotion of the health benefits associated with 'active travel, such as walking.

## 9. Appendices

Appendix 1 Presentation on Priority 2 – Increasing Healthy Life Expectancy

Appendix 2 Local Government Declaration on Tobacco Control (Appendix two)
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Appendix 3 NHS Statement of Support for Tobacco Control (Appendix three)

Appendix 4 Making Every Contact Count (MECC) – Training Brochure (Appendix 4)

Appendix 5 Ten Indicators for a Healthy Street.

Appendix 6 Stroke: Act Fast.

Appendix 7 Physical Activity benefits for adults & older adults

## 10. Local Government (Access to Information) Act 1985

Not applicable

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# Health and Wellbeing Strategy

## Priority 2: Increasing Healthy Life Expectancy



Health and Wellbeing Board – 24 November 2015

## Contents

1. Ambitions that support priority 2 – Haringey performance

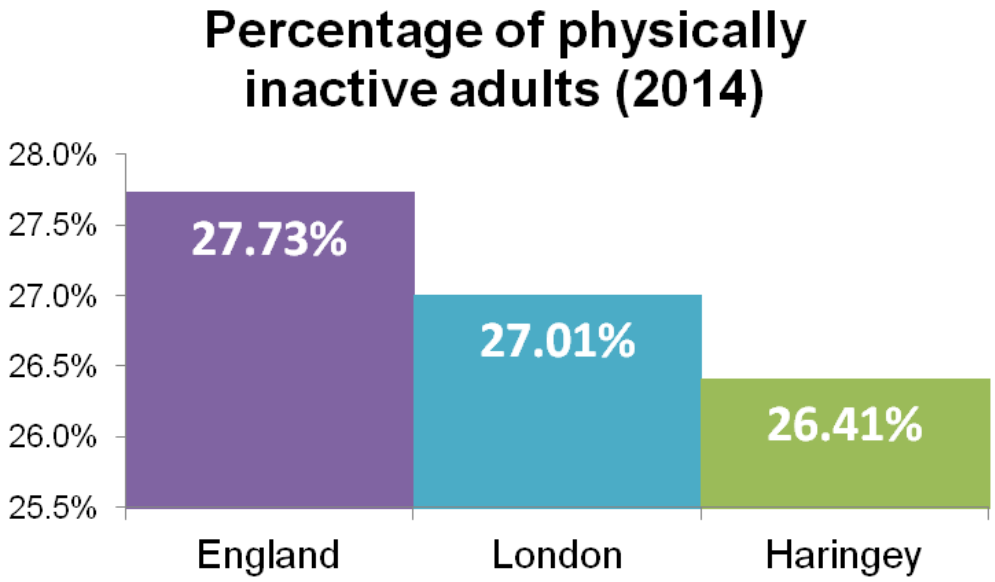
2. Focus on 2 risk factors for early death & unhealthy lifestyles:

    - smoking  &
    - lack of physical activity (walking)

3. Discuss what the Board can do to help

# Ambition 2 - More adults will be physically active

**Target: Reduction in inactive adults to 25% by 2018. On track to meet target. 0.35% reduction needed year on year from 2013 baseline which has been achieved in 2014.**




26.4% of Haringey adults are physically inactive (2014). Lower than London and England

If downward trend continues, on course to meet 25% target (2018)

22nd worst in London (2014)

## Measure

The proportion of adults participating in less than 30 minutes of physical exercise a week

*Source: PHOF (2014)*

# Ambition 3: Haringey is a healthy place to live

Target

Increase in the number of people who walk and cycle to the top quartile of our London Authorities by 2018

## London Rank:

12th

7th

72% walk 5 or more days a week

16% walk 2-4 days a week

7% walk 2-4 days a month

5% never walk



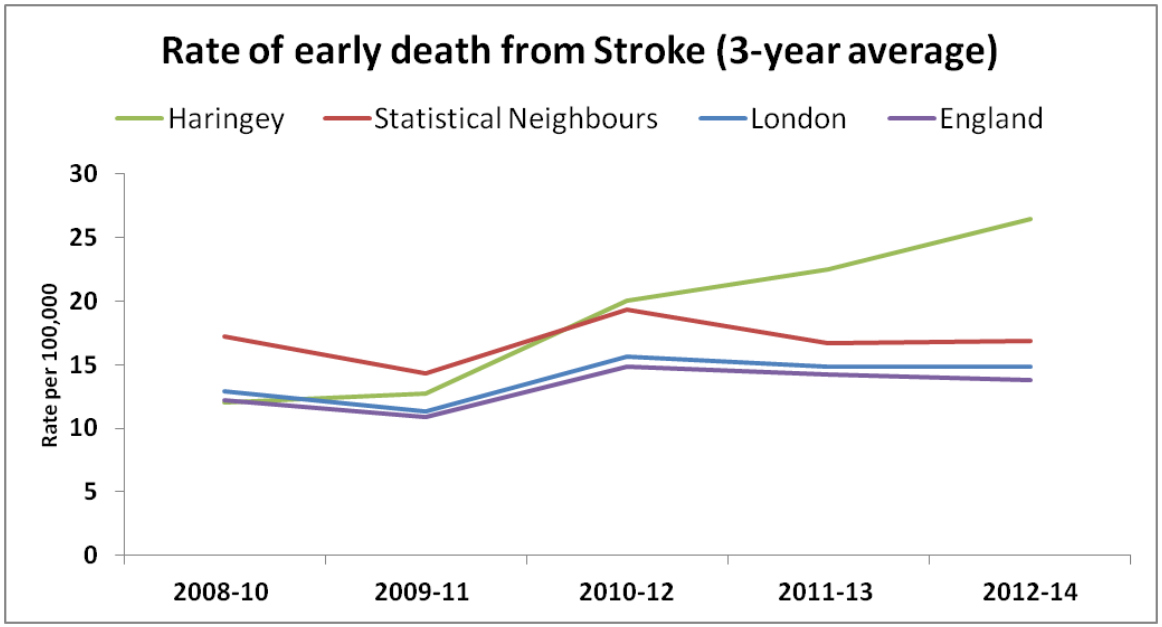
## Measure

Proportion of people who travel by bicycle in London where trip origin is Haringey
Proportion of people who travel by walking in London where trip origin is Haringey

*Source: Smarter Travel (2013)*

# Ambition 4 Every resident enjoys long lasting good health

Target : A 25% reduction from the (2011-13) mortality rate (22.5 per 100,000) to 16.9 deaths per 100,000 (2016-2018) or 68 deaths (2016-2018)




**Worst** in London

2nd worst early stroke mortality rate in England

22.34 deaths per 100,000 or 92 deaths (2012-2014) in Haringey from stroke

**Increase in upward trend** from 2011-2013

## Measure

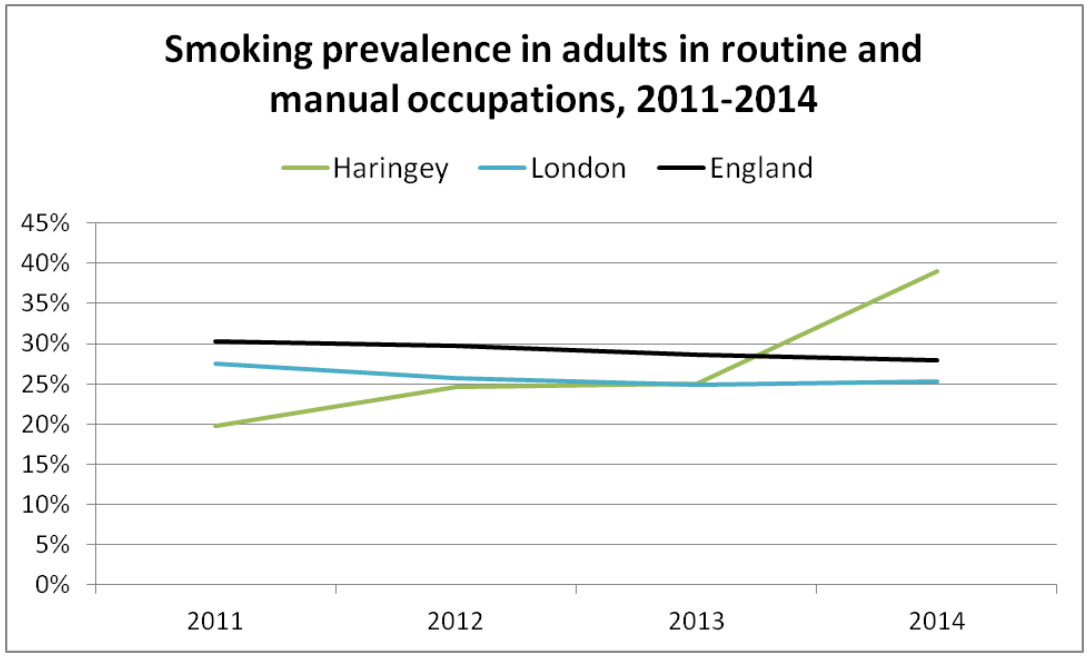
Age-standardised rate of mortality considered preventable from stroke in those aged 75 per 100,000 population

*Source: PHE (2014)*

# Smoking

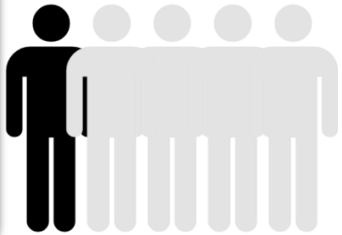
**One of the five** risk factors for early death & unhealthy life expectancy

# Smoking by Social Class

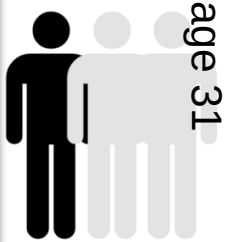



14% increase

1 in 5 residents smoke (21%)



1 in 3 Residents from routine & manual occupations smoke (39%) higher than London (25%) & England (28%



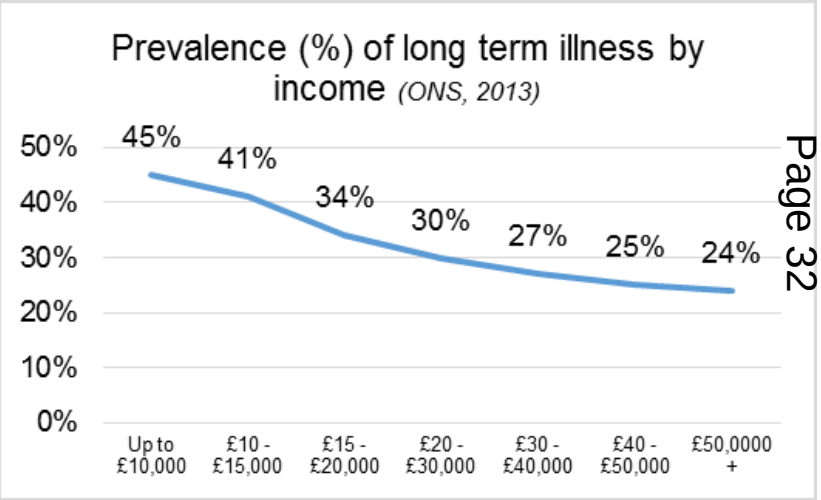
**Target**

reduce proportion of people smoking aged 18 and over in routine and manual professions to projected London levels by 2018 - 19.26%

*Source: PHE (2015)*

# Smoking: Long term conditions

- Smoking increases the risk of heart disease and stroke. Smokers are 2-4 times more likely to have a stroke (Shah, 2010).
- Smoking increases demand on services and doubles the risk of needing care.
- On average Smokers need care nine years earlier than non-smokers. (ASH, 2014)




**£1.8 million**
Current and ex-smokers requiring care cost Haringey Council

*Source: ONS (2013)*

# Smoking: Mental Health

- People with serious mental health conditions die between **8 and 17.5 years prematurely** - **most of this difference is attributable to smoking** (RCP, 2013)

- Prevalence of smoking in general population declined over past two decades but in those with mental health problems barely changed.

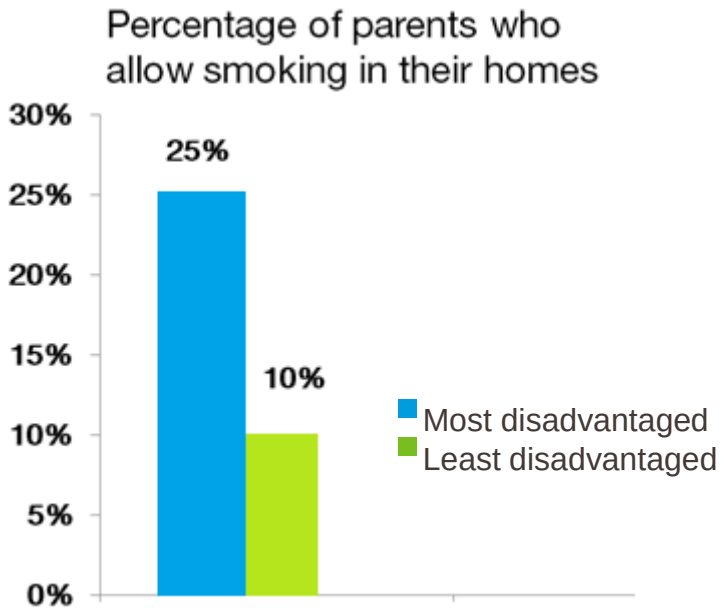
- **70%** of individuals in in-patient mental health settings smoke, compared with **20%** in the general population (RCP, 2013)

Over **40%** of UK tobacco is estimated to be consumed by people with mental health conditions

**£720m**

Cost to the NHS of treating smoking-related disease in people with mental health conditions (RCP and RCPsych, 2013)

# Smoking: Low income families




**Source:** 2015 YouGov Survey

Second hand smoke exposure increases rates of childhood asthma by **50%** (RCP, 2013)

- Smoking is responsible for **half** the difference in life expectancy between rich and poor (Statistics on Smoking - England, 2012 )
- Cheap illegal tobacco is more commonly used by people in disadvantaged communities.
- "the very lowest income families supporting young children, are at least twice as likely to smoke as similar families who could only just afford to smoke if they wanted to" (ASH, 2001)

# Health benefits of quitting Smoking

| Time since quitting | Health benefits of quitting |
|---|---|
| 20 minutes | Pulse returns to normal. |
| 8 Hours | Nicotine is reduced by 90% and carbon monoxide levels in blood reduce by 75%. Circulation improves. |
| 24 Hours | Carbon monoxide and nicotine almost eliminated from the body. |
| 2-12 weeks | Circulation improves. |
| 3-9 months | Coughing and wheezing is reduced. |
| 1 Year | Excess risk of a heart attack reduces by half. |
| 10 Years | Risk of lung cancer halved compared to continued smoking. |
| 15 Years | Risk of heart attack equal to never-smoker's. |

Source: NICE 2013

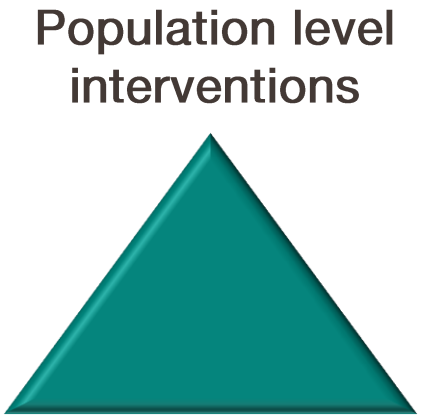
# Current action on smoking

## Population level interventions

Standard Packaging of tobacco products

Smoke free policies (work place, cars, work beginning with MHT is crucial)

Target illicit tobacco




## Interventions through communities

- Peer health champions
- Turkish community (engaging faith leaders)

## Intervention through services

Targeted stop smoking support to groups with highest prevalence is high (lower income, mental health) or where there is harm to others e.g. pregnant women & new mothers. From April 2016 support will be provided via an 'integrated wellness service.'

# What can the Health and Wellbeing Board do?

## Implement

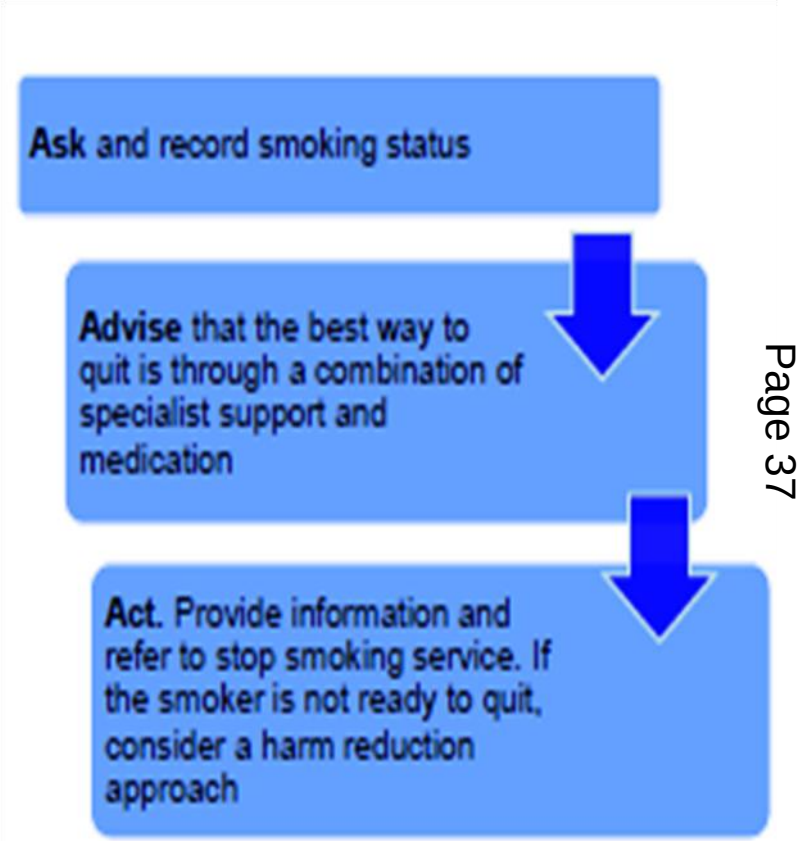
- Smokefree workplaces in Hospital & Mental Health Trusts
- NICE Guidance on Smoking & Secondary Care in Hospital & Mental Health sites (NICE:PH48).

## Sign & support

- the Declaration on Tobacco Control

## Champion

- the wide scale roll out of Making Every Contact Count (MECC) across the workforce in Haringey.



# Walking



The most equitable form of exercise

# Walking – most equitable form of exercise

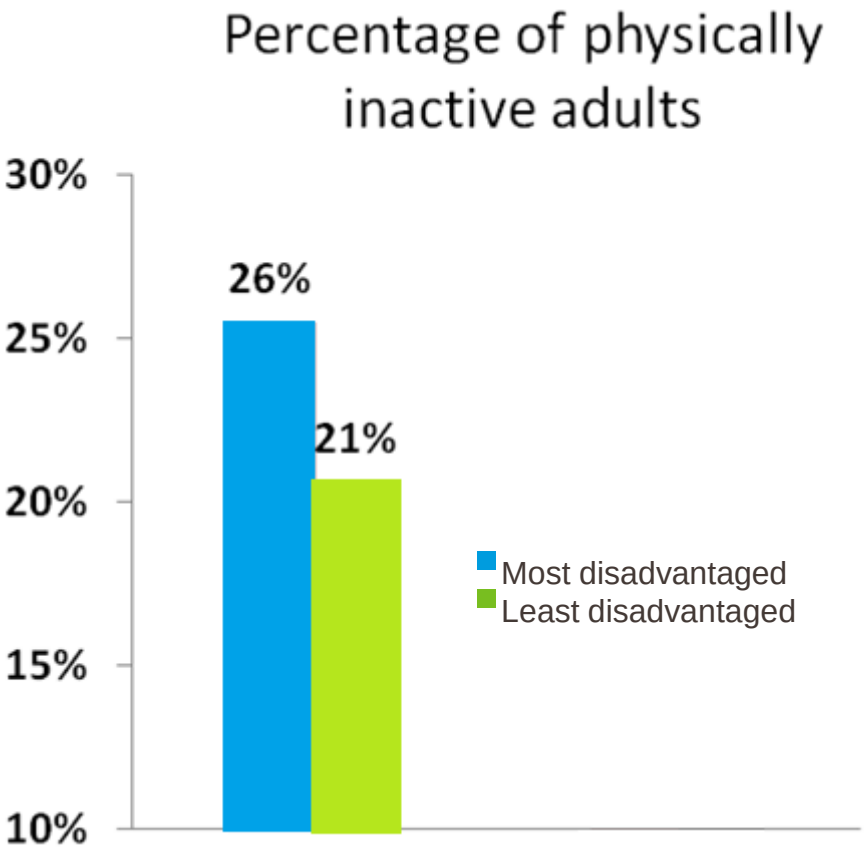
- Walking decreases the risk of obesity by **4.8%** for each additional km walked per day (PHE, 2010)
- Walking can be easy to do when factored into everyday activities (PHE, 2014)
- The Chief Medical Officer's 2011 report states walking for **30 minutes, 5 times a week** reduces the risk of many illnesses including:

  - Premature death - **30%** reduction
  - Heart attacks, stroke - **30%** reduction
  - Diabetes - **35%** reduction
  - Depression/dementia - **25%** reduction

Estimated direct cost of physical inactivity to the NHS in the UK is **£1.06 billion** (CMO Report, 2011)

**36%** of car trips in London could be walked in less than 25 minutes (Mayor of London, 2015)

# Walking: Socio-economic inequality




*Source: Sport England/PHOF (2014)*

- In Haringey, 26% of people in lower socio-economic groups are inactive compared to 21% of those in higher-socio economic groups.
- 'Communities with the lowest levels of physical activity often have the highest burden of disability & poor health.' (PHE 2013, 2014)
- The most successful agents of change will be people from the communities themselves.' (PHE 2014)

# Current action on walking

## Population level interventions

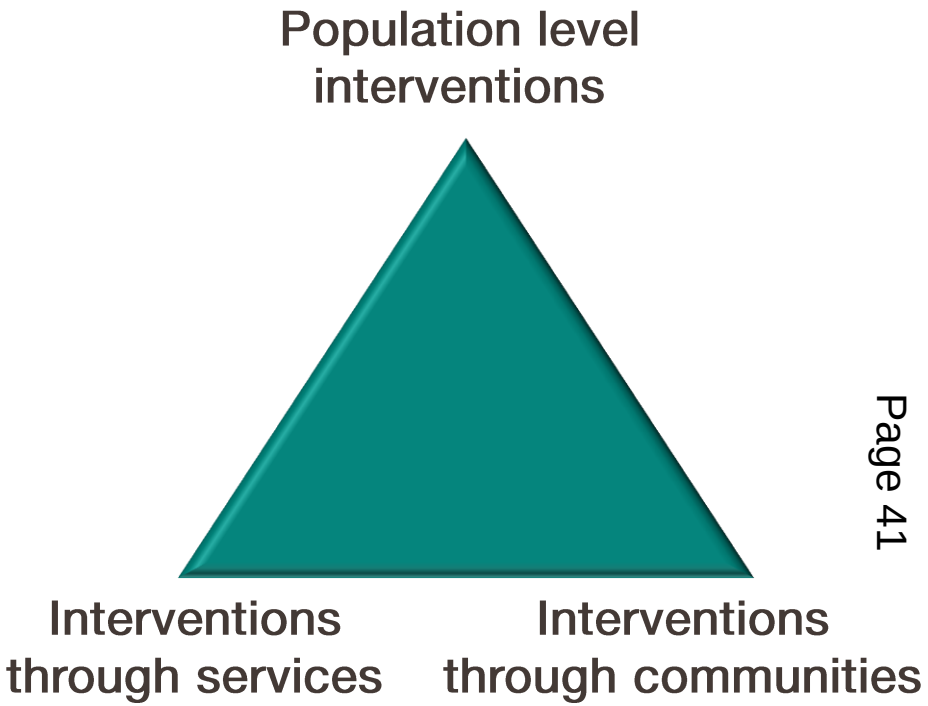
- Outdoor green space
- 20mph Speed limits
- Walking infrastructure i.e. Quietways

## Interventions through communities

- Independent resident led walks
- Smarter Travel programmes

## Intervention through services

- Targeted walk programmes – Active for Life
- Walking for Health - 'Health in Mind'
- https://www.walkingforhealth.org.uk/walkfinder/haringey-health-mind



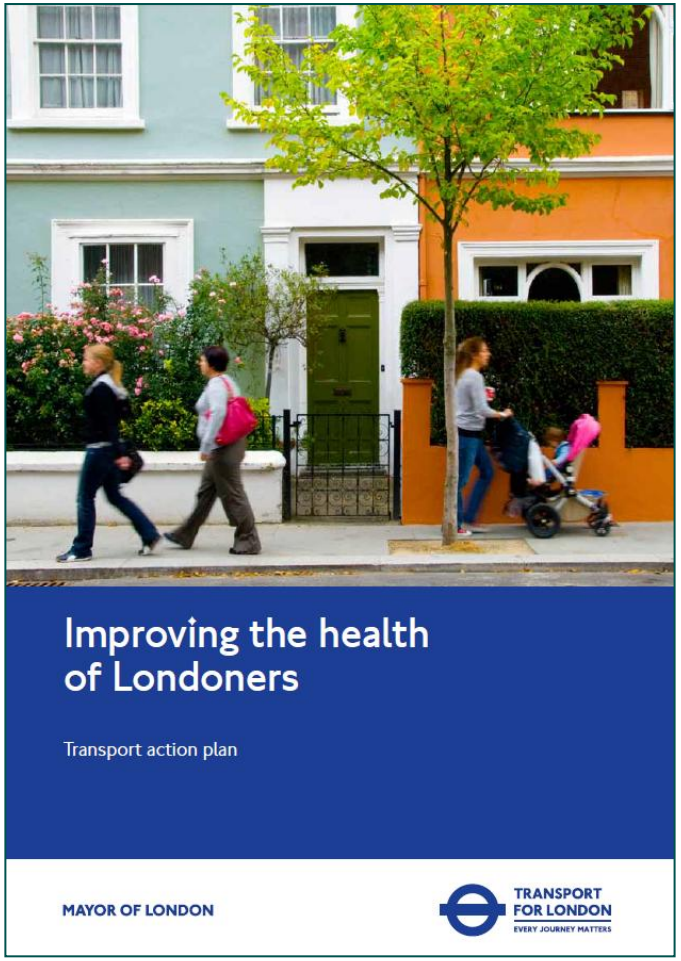
# Future action: Walking Campaign & Weekend - 1 & 2 October 2016

- Web pages on walking to be reviewed /refreshed
- Potential for dedicated website
- Promote awareness raising activities as build up to the weekend
- a resident group of walkers (from Friends of Parks groups) will design a booklet of Haringey Walks for the event
- high profile marketing campaign to publicise the Walk Weekend & encourage walking
- Campaign will link to other walking projects e.g. Walk to Work Week.

# Future proposals on Walking -1

## TfL's Health Action Plan

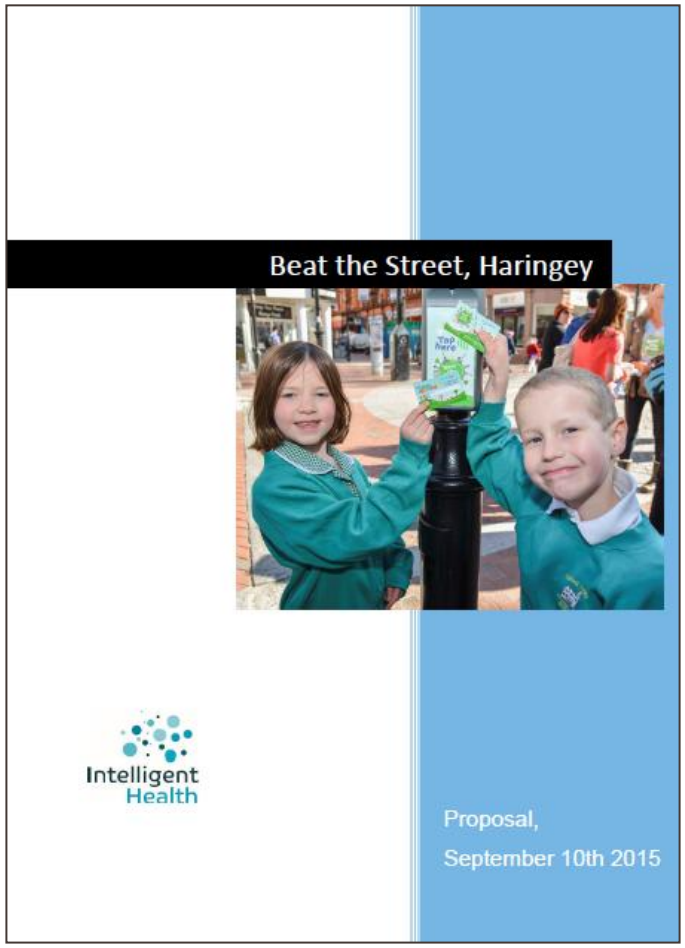
- Is a holistic evidence based approach to transport & health
- Sets out how TfL will embed health considerations into policy & practice
- Provides tools and resources for transport and health practitioners to use.



# Potential Future proposals on Walking – 2

## 'Beat the Streets' –

- **Haringey wide option**
- Involving 30,000 residents
- 15,000 adults and 15,000 children (<16) taking part
- 90% of the 60 primary schools engaged
- **12 month project** includes: a 6 month lead-in phase, a 6 week long live Beat the Street game (March-July) plus 4-5 months follow-up support.



# Delivering Beat the Streets

- 115 beat boxes outside every primary & secondary school, every key destination, in parks, footpaths & cycle ways linking these to residential areas
- 60,000 (8,000) RFID cards, branded as ‘Beat the Street Haringey’
- Banners for all participating schools
- A3 posters for schools, workplaces, Libraries and community centres
- Beat the Street website, Facebook & Twitter accounts.

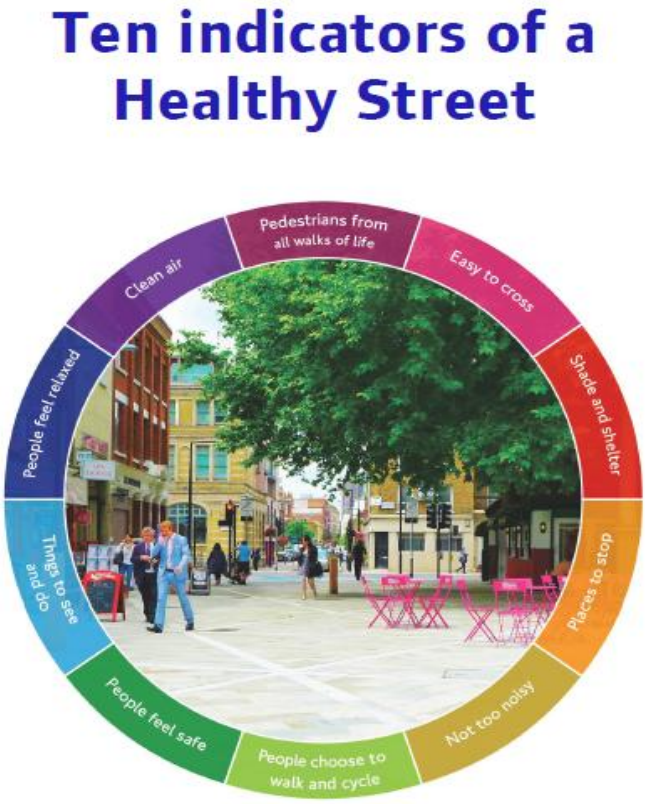


# What can the Health and Wellbeing Board do?

- Support the proposal for a 'dedicated & co-ordinated Walking programme' & walk weekend in October 2016

- Champion the GLA 'Ten indicators of a Healthy Street' programme

- Champion 'walk to work week' and
- walking generally in the workplace




MAYOR OF LONDON

TRANSPORT FOR LONDON
EVERY JOURNEY MATTERS

# Local Government Declaration on Tobacco Control

**We acknowledge that:**

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

**As local leaders in public health we welcome the:**

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

**We commit our Council from this date .....to:**

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

**Signatories**

**Leader of Council**

**Chief Executive**

**Director of Public Health**

Endorsed by

Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health

Dr Janet Atherton, President, Association of Directors of Public Health

Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute

Department of Health

Public Health England

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# NHS Statement of Support for Tobacco Control

**We acknowledge that:**

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

**We welcome the:**

- Commitment from local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Opportunity to support partnership working with local government as part of delivering local tobacco control in line with NICE guidance;
- Endorsement of this statement by central government, Public Health England, NHS England and others.

**We, ....., commit from the date ..... to:**

- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco;
- Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance on smoking and tobacco control;
- Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect our work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities; and
- Participate in local and regional networks for support.

**Signatories**

**Local NHS leader**

**Chair of the Health and Wellbeing Board**

**Director of Public Health**

Endorsed by

Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Simon Stevens, Chief Executive, NHS England

Sir Richard Thompson, President, Royal College of Physicians

Dr Hilary Cass, President, Royal College of Paediatrics and Child Health

Dr Janet Atherton, President, Association of Directors of Public Health

Professor John Ashton CBE, President, UK Faculty of Public Health

David Behan, Chief Executive, Care Quality Commission

Baroness Hollins, Chair, BMA Board of Science

Dr Maureen Baker, Chair, Royal College of General Practitioners

Department of Health | Public Health England | NHS England | Royal College of Physicians | BMA | Care Quality Commission | Royal College of General Practitioners | RCPCH

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Making Every Contact Count in Haringey

## Free training for ALL frontline Staff

## Making Every Contact Count (MECC)
## &
## Motivational Interviewing (MI)

**What you will learn**
Every day frontline workers across the public and voluntary sector have numerous interactions with local people dealing with range of issues – this training is about using those opportunities to:

- raise the issue of healthy lifestyles
- promote benefits of healthy living
- signpost to further support.

The main issues discussed include: **Alcohol, Healthy Eating, Healthy Weight, Physical activity, Smoking cessation and Mental health** promotion.
These behaviours are most closely linked to the development of long term conditions and/or contribute to the life expectancy gap in the borough.
By intervening early we can help people make a change and prevent the development of longer term problems.

**Learning outcomes**

- Overview and understanding of the definition of MECC
- Awareness of the economic, organisational and personal benefits of MECC
- Understanding of the underpinning principles of MECC (*and Motivational Interviewing where appropriate*) and its impact in Haringey
- Knowledge of the options and models of training (including 'direct provision' and 'train the trainer') which could be delivered in Haringey
- Awareness of the basic health components of MECC, including messages on smoking, healthy eating, physical activity, alcohol consumption and mental health awareness
- Ability to identify points of resident contact when and where to provide with health information, advice and guidance

## Venue

Lecture Room 2, Top Floor
Cypriot Community Centre, Earlham Grove, Wood Green, London N22 5HJ


## How to book

If you would like to register for a MECC or MI training session please contact Nadine Burton: nadine.burton@haringey.gov.uk with your full name and the session you would like to attend. For further information please contact Marion Morris

**Dates AM sessions – 9.30am to 12.30pm PM sessions – 1.30pm to 4.30pm**

### Making Every Contact Count

**October 2015**
Monday 5th – AM – MECC training
Wednesday 7th – PM – MECC Training
Friday 23rd – AM – MECC Training

**November 2015**
Tuesday 3rd – AM – MECC Training
Thursday 12th – PM – MECC Training
Wednesday 18th – AM – MECC Training

**December 2015**
Thursday 3rd – PM – MECC Training
Thursday 10th – AM – MECC Training

**January 2016**
Monday 11th – AM – MECC Training
Wednesday 13th – PM – MECC Training
Wednesday 20th – PM – MECC Training

**February 2016**
Thursday 4th – PM – MECC Training
Tuesday 9th – AM – MECC Training
Monday 22nd – PM – MECC Training

**March 2016**
Tuesday 15th – AM – MECC Training
Monday 21st – AM – MECC Training

### Motivational Interviewing

**December 2015**
Tuesday 1st (Motivational Interviewing)
FULL DAY

**January 2016**
Tuesday 12th (Motivational Interviewing)
FULL DAY

**February 2016**
Tuesday 2nd (Motivational Interviewing)
FULL DAY
Thursday 18th (Motivational Interviewing)
FULL DAY

**March 2016**
Thursday 3rd (Motivational Interviewing)
FULL DAY
Wednesday 30th (Motivational Interviewing)
FULL DAY

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Appendix 5

# Ten indicators of a Healthy Street


MAYOR OF LONDON

TRANSPORT FOR LONDON
EVERY JOURNEY MATTERS

Haringey LONDON healthwatch Haringey

HAVCO
HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

NHS Haringey Clinical Commissioning Group

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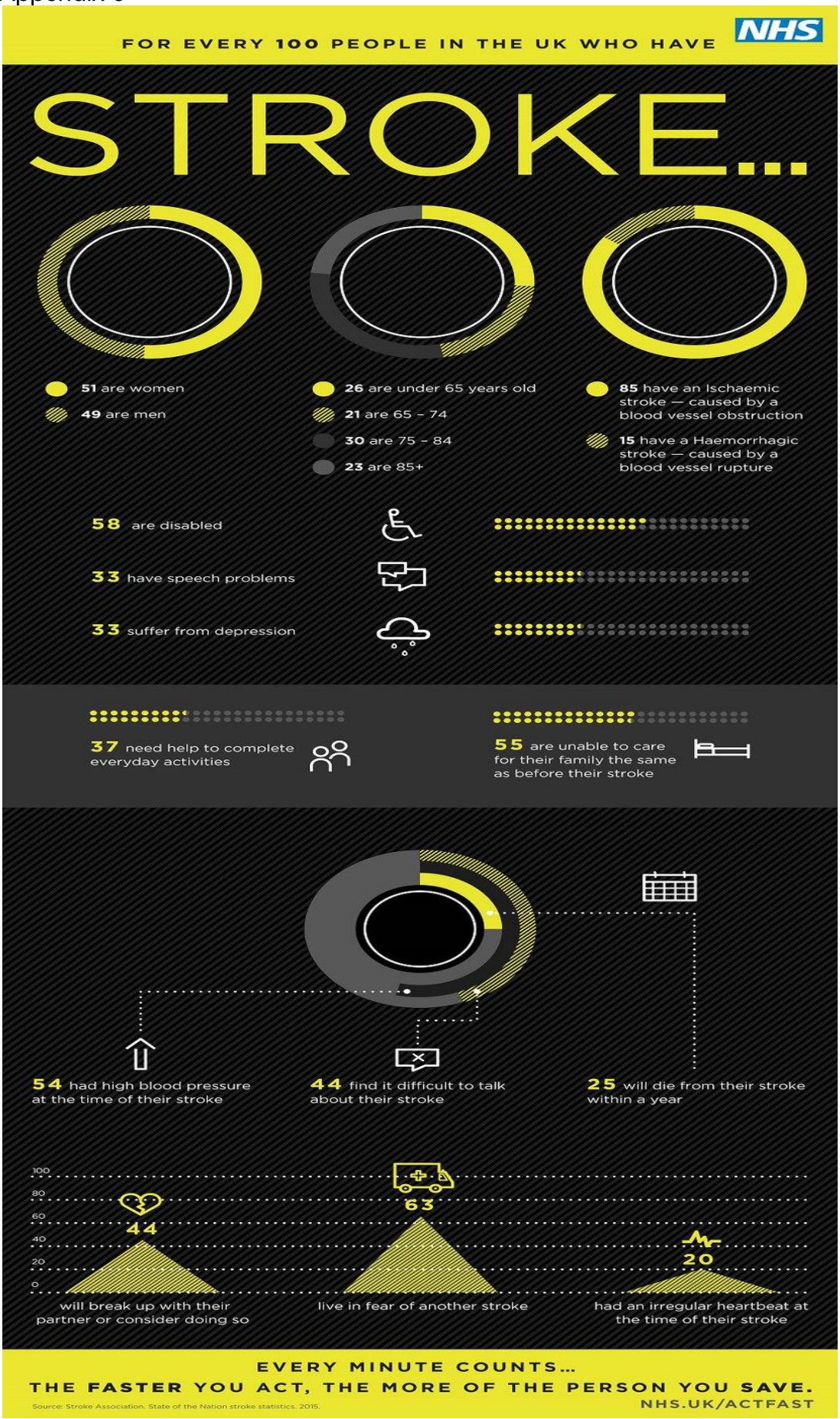
Appendix 6


FOR EVERY 100 PEOPLE IN THE UK WHO HAVE
NHS
STROKE...
51 are women
49 are men
26 are under 65 years old
21 are 65 – 74
30 are 75 – 84
23 are 85+
85 have an Ischaemic stroke — caused by a blood vessel obstruction
15 have a Haemorrhagic stroke — caused by a blood vessel rupture
58 are disabled
33 have speech problems
33 suffer from depression
37 need help to complete everyday activities
55 are unable to care for their family the same as before their stroke
54 had high blood pressure at the time of their stroke
44 find it difficult to talk about their stroke
25 will die from their stroke within a year
100
80
60
40
20
0
44
63
20
will break up with their partner or consider doing so
live in fear of another stroke
had an irregular heartbeat at the time of their stroke
EVERY MINUTE COUNTS...
THE FASTER YOU ACT, THE MORE OF THE PERSON YOU SAVE.
Source: Stroke Association. State of the Nation stroke statistics. 2015.
NHS.UK/ACTFAST

Appendix 7


Physical activity benefits for adults and older adults
BENEFITS HEALTH
IMPROVES SLEEP
MAINTAINS HEALTHY WEIGHT
MANAGES STRESS
IMPROVES QUALITY OF LIFE
REDUCES YOUR CHANCE OF
Type II Diabetes -40%
Cardiovascular Disease -35%
Falls, Depression and Dementia -30%
Joint and Back Pain -25%
Cancers (Colon and Breast) -20%
What should you do?
For a healthy heart and mind
To keep your muscles, bones and joints strong
To reduce your chance of falls
Be Active
Sit Less
Build Strength
Improve Balance
VIGOROUS
MODERATE
RUN
WALK
SPORT
CYCLE
STAIRS
SWIM
TV
SOFA
COMPUTER
GYM
YOGA
CARRY BAGS
DANCE
TAI CHI
BOWLS
MINUTES PER WEEK
75 OR 150
VIGOROUS INTENSITY
(BREATHING FAST DIFFICULTY TALKING)
MODERATE INTENSITY
(INCREASED BREATHING ABLE TO TALK)
OR A COMBINATION OF BOTH
BREAK UP SITTING TIME
2 DAYS PER WEEK
Something is better than nothing.
Start small and build up gradually:
just 10 minutes at a time provides benefit.
MAKE A START TODAY: it's never too late!
UK Chief Medical Officers' Guidelines 2011 Start Active, Stay Active: http:bit.ly/startactive

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**Report for:** Health and Wellbeing Board, 24th November 2015

**Title:** Update on Ambition 8, More Adults Will Have Good Mental Health and Wellbeing, Basline and Target Measure

**Report authorised by :** Jeanelle De Gruchy, Director of Public Health

**Lead Officer:** Tamara Djuretic, Assistant Director of Public Health, Tamara.djuretic@haringey.gov.uk 0208 4893265

**Ward(s) affected:** All

**Report for Key/ Non Key Decision:** Non key decision

## 1. Describe the issue under consideration

1.1 Priority 3 of Haringey's Health and Wellbeing Strategy focuses on improving mental health and wellbeing across the borough. Ambitions 7, 8 and 9 have been set in order to monitor progress of the implementation of Priority 3.

1.2 This paper describes the results of a baseline measure for Ambition 8 and proposes a trajectory and target for 2018.

## 2. Cabinet Member Introduction

2.1 Mental illness is a key priority for Haringey and one that we have recognised by making it a focus in the Haringey Health and Wellbeing Strategy.

2.2 Mental health and wellbeing in Haringey is at moderate levels and there are no significant differences between the overall borough score compared to the scores in the most deprived areas of the borough.

## 3. Recommendations

3.1 The Board is asked to note the overall findings of the borough-wide mental health and wellbeing survey and to agree the proposed trajectory for Ambition 8.

3.2 The Board is asked to agree to receive a full report on the survey at future meeting.

## 4. Reasons for decision

The mental health and wellbeing trajectory for Ambition 8 will allow the progress of the implementation of interventions supporting delivery of Ambition 8 to be monitored.

## 5. Alternative options considered

Not applicable.

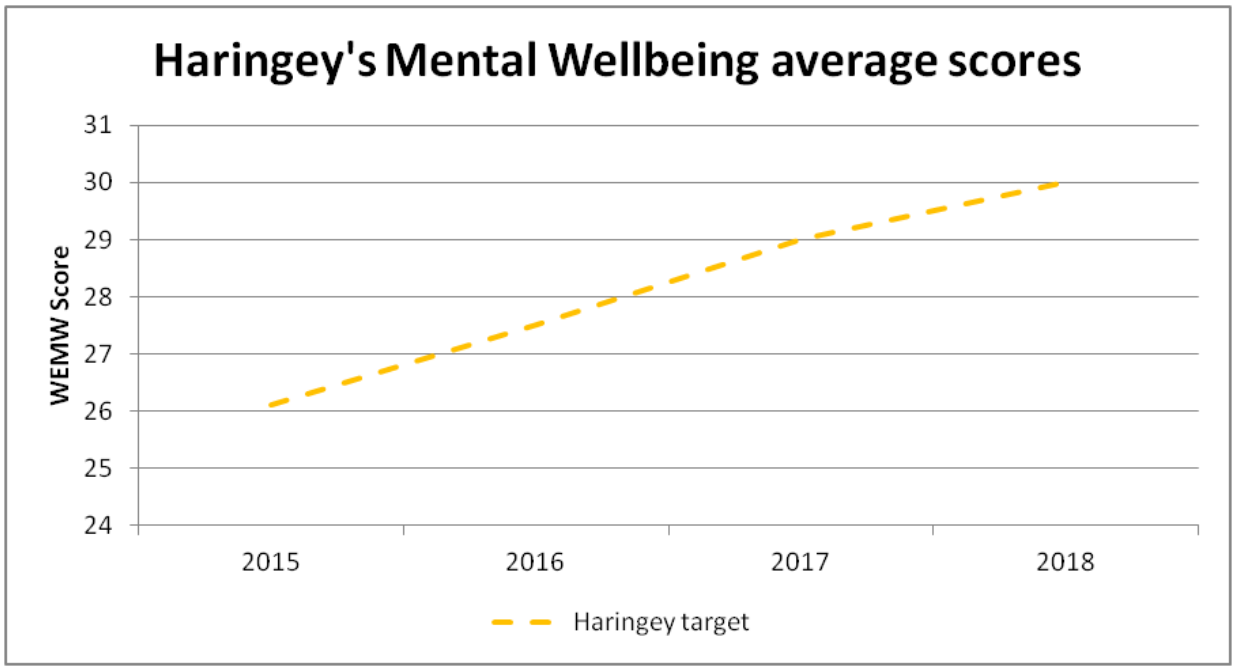
## 6. Background information

6.1 The first Haringey Mental Wellbeing Survey was undertaken in summer 2015 in order to gain a greater understanding of positive mental health and wellbeing across the local authority. Conducted by the Knowledge and Intelligence Liverpool Team at Public Health England, the survey provides a baseline measure of mental wellbeing across Haringey and within the most deprived population of the borough. The results will be used to support the ambitions and priorities set out in Haringey's Corporate Plan and Health and Wellbeing Strategy 2015-18.[i]

6.2 The results of the survey will provide the baseline, with the specific aim of increasing the average short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score by 2018. Methodology of the survey is described in details in Appendix I.

6.3 Average WEMWBS score for adults in Haringey measured by a survey across the borough was 26.10 and in the most deprived areas was 26.21. Any score of 21 or less was regarded as low in Haringey, scores between 22 and 29, or 30 for most deprived was moderate score and anything over 30 was regarded as high score.

It is proposed to increase borough average WEMWBS score to 30 (high) by 2018 (chart below).




6.4 Respondents between 16 and 24 years old were most likely to have low mental wellbeing in the cross area sample, whilst those aged 65 years and over were most likely to have low mental wellbeing in the most deprived sample. More men than women were categorised as having high mental wellbeing across both samples.

6.5 Good health and fewer medical conditions were associated with better mental wellbeing as well as having more time to do things people really enjoy and regularly spending leisure time outdoors. More days of exercise and spending less time being sedentary had a significant association with better mental wellbeing in the across area sample.

6.6 Satisfaction with personal relationships showed a strong association with mental wellbeing , as did levels of trust, being well supported, and feeling safe in a local area. Feelings of neighbourhood belonging, being satisfied with local area and social capital were significantly associated with better mental wellbeing.

6.7 Childhood experiences of unhappiness and violence were associated with worse mental wellbeing, however the only significant relationship was for childhood happiness and mental wellbeing level in the across area sample. Employment was associated with better mental wellbeing, whilst those unable to work due to sickness or disability were most likely to report low mental wellbeing. Poor educational attainment was associated with worse mental wellbeing, as were financial difficulties.

6.8 Full details of the survey will be communicated and discussed at various Senior Managers/Directorate meetings to understand full impact of the wider Council business on the overall mental health and wellbeing and to consider using some of the other measures as key performance indicators for specific services.

6.9 It is proposed that the survey will be repeated annually potentially using social media or other digital solutions.

## 7. Contribution to strategic outcomes

Priority 2 of the Corporate Plan and Health and Wellbeing Strategy Ambition 8.

## 8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

### Finance and Procurement

This is an update report for noting and as such there are no recommendations for action that have a direct financial implication.

### Legal

There are no legal issues arising from the recommendations in this report.

### Equality

The survey measures a number of protected characteristics such as age, sex, and disability and compares mental health and wellbeing scores between the whole borough and those people in the most deprived areas.

## 9. Use of Appendices

Appendix I – Measuring Mental Wellbeing methodology

## 10.Local Government (Access to Information) Act 1985

Mental Health and Wellbeing Framework
http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=771&MId=6848&Ver=4

Health and Wellbeing Strategy 2015-2018

Haringey's Corporate Plan 2015-2018
http://www.haringey.gov.uk/local-democracy/policies-and-strategies/corporate-plan-2015-18

[i] Haringey Council (2015) Haringey's Health and Wellbeing Strategy 2015-18 [Online]. Available at: www.haringey.gov.uk/

**Appendix I - Measuring mental wellbeing methodology**

The survey used the short Warwick-Edinburgh Mental Wellbeing Scale (sWEMWBS) to measure mental wellbeing. The full WEMWBS contains 14 items covering aspects of positive mental health that broadly involve perspectives on pleasure and happiness. The shorter, seven item version was developed as a more practical alternative to the full version of WEMWBS.[i] The seven items included in the sWEMWBS refer to participants' feelings over the past two weeks. They are:

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling close to other people
- I've been able to make up my own mind about things

Responses are scored on a five point Likert system, ranging from 1 meaning 'none of the time' through to 5 meaning 'all of the time'. Scores for each item are summed, meaning a respondent can score between 7 (lowest possible mental wellbeing) and 35 (highest possible mental wellbeing). In this report we refer to the results as WEMWBS, however it was the sWEMWBS questions that were used in the survey questionnaire.

**Sampling**

Sample size calculations were conducted to ensure a representative sample at local authority (LA) level, and these suggested that 500 participants would be sufficient for the size of the population in Haringey. In addition to the primary (across the whole LA population) sample of 500, Haringey Council opted to conduct an additional 500 'boost' sample of people living in the most deprived quintile of the population. This would allow comparison of survey responses from those in the most deprived areas with the primary sample. Within the results section of the report, the two samples are referred to as 'across area' (primary sample) and 'most deprived' (boost sample).

**Weighting**

A weighting variable was added to the survey dataset to equalise the sample characteristics with population characteristics, so that the resulting analysis more accurately reflects the population under study. Every respondent that had a valid gender, age group and national Index of Multiple Deprivation (IMD) 2010 quintile entered in the dataset was assigned a weighting value.

When performing analysis on the weighted dataset only the respondents that were assigned a weighting variable were included in the analysis.

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| **Report for:** | **Health and Wellbeing Board – 24th November 2015** |

| | |
|---|---|
| **Title:** | **Haringey CCG Commissioning Intentions 2016/17** |

| | |
|---|---|
| **Organisation:** | **Haringey Clinical Commissioning Group** |

| | |
|---|---|
| **Lead Officer:** | **Jill Shattock, Director of Commissioning** |

## 1. Describe the issue under consideration

In September of each year Haringey Clinical Commissioning Group (CCG) sends out its commissioning intentions for the forthcoming financial year. The Commissioning Intentions describe the areas of service improvement that the CCG plans to focus on for the forthcoming 12 months. These are set in the context of the Health and Wellbeing Strategy joint objectives, the CCG's Five Year Plan and are also reflected in the CCG's annual operating plan (a largely numeric document describing annual activity and financial plans).

The Commissioning Intentions are developed through the year in discussion with patients, stakeholders and clinicians in provider organisations and through the several service development groups which exist. The key themes included within the CCG's Commissioning Intentions are further discussed, in particular at an annual stakeholder event with representatives of many community groups, CCG member GP practices, Haringey councillors and a range of service providers and other stakeholders.

The CCG sends the Commissioning Intentions to its key service providers and these form part of the basis of contract negotiations for the forthcoming year.

The presentation for the Health and Wellbeing Board looks back at the main themes of the 2015/16 commissioning intentions and summarises the areas for focus for 2016/17. Members will recognise many common objectives and areas for joint working.

## 2. Recommendation

Health and Wellbeing Board members are asked to note the main themes in the 2016/17 Commissioning Intentions and to support collaborative working to deliver them during the year.

NHS
Haringey
Clinical Commissioning Group

# Commissioning Intentions 2016/17

Sarah Price
Chief Officer

NHS
Haringey
Clinical Commissioning Group

# Reminder - 2015/16

- End of life care pathway across multiple organisations, lead provider in place, significant improvements and 24/7 coverage.
- Mental Health Framework agreed with partners – DTOCs a big challenge last year– we now have an Accommodation pathway and Employment support service run by Twinings from a Dept. of Employment grant
- Primary Care Federations established (Haringey Health Connected and Central4Haringey)
- Bid for a CPEN successful
- Working at scale programme and GP Inter operability improvements

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Clinical Commissioning Group

# One Year On….

- Value Based Commissioning (VBC)Lead provider for Diabetes (with Islington CCG) and Older People with Frailty (OPwF)
- New community services and pathways for gynaecology, urology, gastro-enterology, paediatric allergy, CAMHS in primary care.
- Better Care Fund (BCF) authorised and Governance in place – Neighbourhood Connects Project and those of you that haven't met *HARRY GREY*.

# Meet Harry Gray

- 75 year old widower
- Has several health conditions: COPD, Dementia, Depression, Falls
- Visited A&E 32 times in last year, admitted 10 times.
- Cared for by his daughter

**Admission Avoidance**

Named Care Co-ordinator

Health and Social Care Plan

Referral for bereavement counselling

**Effective Hospital Discharge**

Less time in hospital

Support to return home

Regain confidence to prevent falls

**Promoting Independence**

Identification

Link to an ‘expert patient’ group

Link to a local gardening group

**Integration Enablers**

All relevant professionals know important information

Services in the evening

Support for Harry’s daughter

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Clinical Commissioning Group

# From 2015/16 to 2016/17

Mission

# Enabling the people of Haringey to live long and health lives with access to safe, well co-ordinated and high quality services

Values

Engagement
Efficiency
Innovation

Openness
Quality
Inclusiveness

Aims

High quality, valued and responsive services, working in partnership with the public to make the best use of available resources

To promote wellbeing, reduce health inequalities and improve health outcomes for local people

To improve the quality of life for people by commissioning integrated health and social care delivered closer to home

Objectives

Explore and commission alternative models of care

More partnership working and integration

Build capacity for populations to enhance their own health and wellbeing

Re-define the model for primary care

Projects

- Value Based Commissioning
- Urgent Care
- Vanguards
- End of life care
- QIPP
- Children's Pathways

- Better Care Fund
- strategy for North Central London
- Securing a future for mental health services
- London transformation
- Development of Health and Care Integration (HACI)
- Procurement of NHS 111 / GP out of hours service

- Value Based Commissioning
- End of Life Care
- Supported self management
- Childhood obesity
- Accomodation pathway
- Employment support

- Working at scale
- Federation development
- Workforce (CPEN)
- Co-commissioning
- 7x7 8-8 working
- Locality teams

| 1. Explore and commission new models of care | 2. More partnership working and integration | 3. Build population's ability to enhance health and wellbeing | 4. Re-define the model for primary care |
|---|---|---|---|
| **Value Based Commissioning**<br>• Diabetes<br>• Older People with Frailty<br>• Psychosis and depression, MSK , non stroke rehab | **Joint working with Local Authority**<br>• Joint budget for BCF<br>• Integrated governance in place<br>• BCF may be extended – Children, mental health ? | **Supported self-management training**<br>• For patients with long term conditions<br>• diabetes programmes | **Co-Commissioning for Primary Care**<br>• Participating in NCL wide arrangements for co-commissioning |
| **Urgent Care**<br>• Full review of short stay pathways (paediatric and adult)<br>• Ambulatory Care model at NMH being developed<br>• Alternative Conveyance Pathways with LAS | **Development of a strategy for North Central London**<br>• Significant financial challenge across health economy<br>• Establishing how and where CCGs work together at scale | **Joint commissioning on health life expectancy**<br>• Focus on case finding for atrial fibrillation and hypertension<br>• Reviewing integrated commissioning of all preventative services | **Access**<br>• Expanding 7/7 access to primary care and working at scale<br>• Working with NHS England on premises |
| **Facing the Future Together for Children**<br>• Focus on reducing unplanned admissions<br>• Strong focus for 16/17 on pathways and community nursing | **Procurement of NHS 111/OOHs**<br>• Procurement of combined 111/GP OoHs model across 5 CCGs | **Enablement model in mental health**<br>• Reviewing recovery houses and re-tendering<br>• Developing models of shared-care to support enablement | **Training and education**<br>• Programme of practice nurse training<br>• Focus on CPEN to deliver training within primary care |
| **QIPP Programme**<br>• Ophthalmology<br>• Medicines management<br>• Musculo-skeletal pathway<br>• Dermatology | **Securing a future for mental health services**<br>• Reviewing future of BEHMHT | **Neighbourhood connects and Integrated Advice and Guidance Service**<br>• Commissioned to build neighbourhood capacity<br>• Single service providing advice and guidance | **Federations**<br>• Development of GP Federations – within Collaborative areas and across Haringey |

NHS
Haringey
Clinical Commissioning Group

# Challenge Areas for Commissioning

- **Unscheduled care** – developing a more consistent and coherent approach
- **Paediatrics** – high rates of unplanned admissions, gaps particularly in community children's nursing and in communication/education exchanges with primary care **Mental health** – quality, access, GP training and education, awareness of services, quick and effective communication between primary care and MHT.
- **Planned care** – high referral rates for gastro-enterology, urology, gynaecology and dermatology
- **5YFV** and working differently
- Long term financial sustainability within the health economy

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# Focus Areas 2016/17

**Unscheduled Care**:

- Expanding ambulatory care, focus on improving short stay pathways – especially paediatrics
- Pursuing 111/OOH procurement – integrated service across NCL

**Community Services**

- Rapid response and District Nursing 24/7 now embedded and to be "joined up"
- Investment in lymphedema capacity
- Focus on quality of community services – data to support essential

**End of life care**

- 7 day service and development of bereavement service

**Primary Care**

- Commissioning responsibility for quality improvement and access to primary care services, education and training, premises review. "Co-Commissioning", Joint Committee across NCL.

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# Focus Areas 2016/17

**Integrated Care**

- Implementation of Locality Teams (MDTs based around practices to support care co-ordination), GP role in interacting with locality teams
- Integration of care for older people – making it happen, building community capacity and reducing unplanned admissions
- Focus on improved discharge process and on intermediate care: virtual wards or MDTs/hospital at home
- 7 day/wk therapy, pharmacy, phlebotomy at Trusts

**Paediatrics**

- Initiatives to support care out of hospital, email advice, reducing variation in primary care “Facing the Future Together”

**Planned care**

- QIPP schemes (ophthalmology, gynaecology, urology)
- Value based commissioning next phases
- Reducing variation in elective care
- MSK, dermatology

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# Focus Areas 2016/17

**Mental Health**

- Acting on review of acute psychiatric liaison service
- Equipping primary care management of people with mental health conditions
- Enablement approach across Health and Social Care
- CAMHS Review and transformation plan delivery.

**Increasing Healthy Life Expectancy -** joint programme with LBH colleagues

- Case finding and management of hypertension and Atrial Fibrillation
- Focus on pathways – CQUINs to support prevention
- Early detection and improving early diagnosis of breast and colorectal cancers
- Healthy life expectancy-key local drivers of reduced healthy life expectancy are CVD (stroke and hypertension); diabetes, COPD, outcomes for breast cancer and colorectal cancer
- Self Supported care

# Programme Structure

The Increasing Healthy Life Expectancy Work Programme is split into 4 key workstreams. Each workstream contains a range of projects / initiatives aimed at addressing both the clinical areas of concern in Haringey and the modifiable risk factors linked to disease progression.

In addition to overseeing the implementation of service developments and improvement, the Increasing Healthy Life Expectancy Work Programme will ensure that the mental health of patients with long term conditions is treated alongside their physical health needs.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Healthy Lifestyles<br>Promoting health and wellbeing enabling people to stay well for longer | Case Finding<br>Identifying people with illness earlier | Long Term Conditions and multi-morbidity<br>Improving outcomes and quality of life for people with diagnosed long term conditions | Cancer<br>Improving outcomes for people with breast and colon cancer |

Addressing mental health needs of patients with long term conditions

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|---|---|
| **Report for:** | **Health and Wellbeing Board – 24th November 2015** |

| | |
|---|---|
| **Title:** | **Health and Care Integration Programme Update** |

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

| | |
|---|---|
| **Lead Officer:** | **Tim Deeprose, Interim Joint Integration Programme Manager** |

## 1 Describe the issue under consideration

1.1 This paper provides an update on progress on the Health and Care Integration Programme report originally brought to the Health and Wellbeing Board on the 13th January 2015.

## 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 high level vision and approach is now agreed, with planning and implementation of the initial focus areas under way.

## 3 Recommendations

3.1 The Health and Wellbeing Board is asked to note progress.

## 4 Alternative options considered

4.1 There are no alternative options as this is a report updating the Board on the progress of the Health and Care Integration Programme.

## 5 Background information

### Detailed progress as at October 2015

| No | Project | DOT | Status | Comment |
|---|---|---|---|---|
| 1 | Adults | | | |
| 1.1 | Better Care Fund<br>BCF HR Oct 2015.docx | → | A | First Finance and Performance Partnership Board noted BCF performance and approved release of contingency. 100 residents attended the BCF 'Let's talk about Loneliness' Event. GP Locality Team Incentive Scheme launched. |
| 1.2 | Value Based Commissioning<br>VBC HR October.doc | → | A | Whittington Health has confirmed commitment to role of Lead Provider and intention to sign contracts. Terms of contracts to be agreed asap. A blended approach is being taken, working together to deliver:<br>1. signature of contract with Whittington Health<br>2. signature for all other providers<br>3. implementation – agreement of a delivery plan |
| 1.4 | *"healthy lifestyles" (promotion prevention)"* | | | The governance for this activity will be outside HACI |
| 2 | Children | | | |
| 2.2 | Link into Early Help Project | | | This project reached the implementation stage and is now being overseen by the Priority One Board |
| 2.3 | *"Facing the future together"* | | | Gap analysis, stakeholder engagement and benchmarking complete. Comments awaited from the CYP steering group before finalising the gap analysis. Scoping and definition underway, plan to come back to the HACI Board once feedback received from NHS England. |
| 2.4 | CAMHS Transformation Plan<br>CAHMS HR October.doc | | | Planning phase completed.<br><br>Transformation plan submitted to NHS England and now awaiting validation of the plan.<br><br>Next phase for implementation to be set out as project plan |
| 3 | Mental Health and Wellbeing | | | |
| 3.1 | Mental Health and Wellbeing Strategic Framework | | | Planning phase completed.<br>MH Framework approved by H&W Board and CCG Governing Body. |
| 3.2 | Enablement based on holistic outcomes | | | To be scoped Seeking Enablement Programme Champion – interviews in December. Implementation phase to commence in January 2016. |
| 3.2.1 | MH accommodation pathway | | | Accommodation Pathway completed and agreed. Implementation phase - thorny issues constructively surfaced and addressed. Cultural and practice change will be the real challenge. |

| | | | | |
|---|---|---|---|---|
| 3.2.2 | MH Employment support | | | Full funding agreed, contract in place and service commenced. |
| 4 | Cross theme/ Enablers | | | |
| 4.1 | Finance | | | BCF Section 75 agreed and in place. Monitoring by new Finance and Performance Partnership Board. Detailed work on a revised Section 75 for the Learning Disabilities Partnership is underway. |
| 4.2 | Information and technology | | | Further work required to seek progress or barriers since last working group report from May. "Held meetings to progress the collaborative working and case working components. We have a way forward for email sharing (end May) and will meet in June (after system upgrades) to review diaries and intranet access. Progressing tactical requirements and monitoring potential strategic solutions." |

## 6 Comments of the Chief Finance Officer and financial implications

6.1 This report is an update for noting about the progress of the Health and Care Integration Programme. The activity set out in this report is funded from various sources including Better Care Fund and the Council's Transformation reserve. There are no further financial implications as a result of this update report.

## 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).

7.3 There are no direct legal implications rising out of this report.

## 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 Integration of health and social care is a national policy arising 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 This paper provides an update on progress on the Health and Care Integration Programme report originally brought to the Health and Wellbeing Board on the 13th January 2015.

## 12 Use of Appendices

12.1 A separate report giving more detail of progress for the BCF project is included elsewhere on this meeting agenda.

**Report for:** Health and Wellbeing Board, Tuesday 24 November 2015

**Item number:**

**Title:** Haringey Better Care Fund (BCF) Plan Update

**Report authorised by :** Beverley Tarka, Director of Adult Social Services
Jill Shattock, Director of Commissioning, Haringey CCG

**Lead Officer:** Marco Inzani, Commissioning Lead: Better Care Fund
Marco.Inzani@haringeyccg.nhs.uk
Tel: 020 3688 2780

**Ward(s) affected:** All

**Report for Key/ Non Key Decision:** Non Key Decision

## 1. Describe the issue under consideration

1.1. This report is an update on progress with the implementation of the Better Care Fund in Haringey.

## 2. Recommendations

2.1. The Health and Wellbeing Board is asked to note the following updates on the Haringey Better Care Fund (BCF):

- The Haringey BCF, and its associated services, is making steady progress with implementation according to its assigned budget
- The governance of the Haringey BCF is established and includes a range of stakeholders in health and social care
- Quarter 1 (April – June 2015) data is available on a number of outcomes, however it is still too early to draw conclusions on the effectiveness of the Haringey BCF

## 3. Reasons for decision

3.1. The Better Care Fund (BCF) is a transformation programme for complex health and social care system integration. Progress has been made to develop collaborative working between the health and social care sector to focus on reducing emergency (non-elective) hospital admissions in adults and in particular older people (65+).

3.2. The following paper outlines:

- the BCF budget and how it has been assigned
- progress with the main target of a reduction in non-elective hospital admissions
- progress on other local and national outcomes and conditions
- the delivery of key milestones
- the identification of key risks and issues
- the governance of the BCF programme

3.3. The information presented should give the Health and Wellbeing Board the assurance that the Haringey BCF is making steady progress with implementation.

## 4. Alternative options considered

4.1. Not applicable

## 5. Background information

5.1. The vision for the Haringey Better Care Fund (BCF) is that by April 2019, 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.

5.2. This will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care). We will not define people by their disabilities, but by their abilities, their potential and what they can do for themselves, with and without support.

### Budget

5.3. The Haringey BCF Plan was submitted to NHS England on the 19th September 2014. Following a national assurance process the Haringey BCF plan was formally approved by NHS England on 7th January 2015. The pooled budget for the Haringey BCF in 2015/16 is £22m, with £16.4m from Haringey CCG and £5.6m from LBH.

5.4. The BCF is expected to deliver fewer emergency hospital admissions (Non-ELective admissions or NELs) over 2015/16. In order to deliver a reduction in this performance related target, the initial focus of the Haringey BCF is on services for older people (65+), as the group most at risk of a non-elective admission. £1.26m has been held back as a contingency fund in the event that the NEL target is not met. If the NEL target is met the contingency fund can be released to pay for any further out of hospital services that will contribute to reducing the number of emergency hospital admissions.

5.5. Haringey CCG and LBH have approved plans for the use of the £22m BCF budget (2015/16) to review and deliver up to 20 different services organised into four schemes. Some of these are existing schemes that are now funded from within the BCF. Others are schemes funded by additional investment:

| Scheme | Service | 2015/16 |
|---|---|---|
| **Scheme 1: Admission Avoidance** (this will deliver services that will prevent health conditions from escalating to a crisis where emergency services are needed) | **Locality Team** – Focused around GP practices, patients at risk of an emergency hospital admission will be supported by a multi-disciplinary team to identify health and social care goals that promote self-care and self-management to improve health and well-being. | **£13.5m** |
| | **MDT** - is a weekly Multi-Disciplinary Team (MDT) teleconference meeting involving representatives from primary, secondary, community, mental health and social care to discuss Haringey's most vulnerable patients (aged over 65) who are at risk of an emergency hospital admission. | |
| | **Lymphedema** - provides advice, treatment and support for patients with lymphedema/chronic oedema of any body part. | |
| | **Rapid Response** – determining a community health and social care response in people's homes, within 2 hours, to prevent a hospital attendance. | |
| | **Overnight District Nursing Service** – provides district nursing from 10pm to 8am. | |
| | **Dementia Day Centre** – provides social, intellectual and physical stimulation to aid the well-being of people with dementia. | |
| | **Recovery College (incl. MH Employment) -** Clarendon Recovery College offers social, educational and work opportunities for people who are recovering from severe and enduring mental illness. | |
| | **Falls Prevention** – provides a strength and balance exercise programme to prevent falls in older people. | |
| **Scheme 2: Effective Hospital Discharge** (this will deliver services that will facilitate discharge from hospital as quickly, safely and effectively as possible) | **Reablement -** provides health and social care expertise to help people learn or re-learn the skills necessary to self-manage in their own homes. | **£3.9m** |
| | **Step Down** – provides temporary, non-acute step-down placements made for patients who have received hospital treatment but cannot be discharged home due to a delayed transfer of care. | |

| Scheme | Service | 2015/16 |
|---|---|---|
| | **Home From Hospital – provides** a home accompaniment and visiting service to patients discharged from hospital. | |
| **Scheme 3: Promoting Independence** (this will deliver services that build community capacity to reduce isolation and improve health and wellbeing) | **Neighbourhood Connects (incl. Info & Advice)** – identifies residents who are socially isolated and through community development and motivational interviewing links them into the community. | **£0.6m** |
| | **Palliative Care** - increases access and advanced care planning for people at the end of life. | |
| | **Supported Self-Management (Generic)** – group support, such as the Expert Patient Programme, for people with Long Term Conditions to better manage their condition. | |
| | **Supported Self-Management (Diabetes)** – group support, such as the Expert Patient Programme, for people with Diabetes to better manage their condition. | |
| **Scheme 4: Integration Enablers** (this will deliver services that support the implementation of the first three schemes) | **Interoperable IT** – scoping the requirements that will support safe and confidential data sharing to improve patient care. | **£2.6m** |
| | **Workforce Development (incl some service delivery)** – developing the workforce culture to support health and social care integration and deliver 7 day provision. | |
| | **Disabled Facilities –** provides financial help for the cost of essential adaptation work to make a house suitable for a disabled person to live in. | |
| | **Care Act Responsibilities** – increases the assessment of carers and provides additional support and resources to improve health and well-being for carers. | |
| | **Contingency** – linked to achievement of NELs | **£1.26m** |
| | **TOTAL** | **£22m** |

6.6. The BCF services undergo a business case/service review process to ensure that BCF investment is being used on evidence based services that will deliver improvements to public and service user outcomes in the most efficient and cost effective way.

6.7. The BCF budget has a planned phasing according to the start date of the BCF services. The BCF budget is currently being spent according to plan with no overspends predicted.

**Non-elective admissions (NELs)**

6.8. Haringey CCG measures hospital activity on Non-ELective Admissions (NELs) using Secondary Uses Service (SUS) data which is the single, comprehensive repository for healthcare data in England. SUS data for Total NELs has approximately 1000 specialties (e.g. trauma and orthopaedics; neurosurgery; palliative medicine). NHS England recommended using a subset of NELs for the BCF. This recommended subset excludes a number of specialties including well-babies and oral surgery. Haringey CCG and LBH have decided to adopt this definition so that it more closely aligns to the BCF programme of work for 2015/16. This is summarised as follows:

| | | | | |
|---|---|---|---|---|
| Total NELs | = | BCF NELs | + | Additional NELs (additional specialties e.g. well-babies, oral surgery) |

6.9. Haringey has set its own ambition for the reduction in BCF NELs in 2015/16, which has been calculated as follows:

| | | | | |
|---|---|---|---|---|
| LBH/CCG Target<br>**Haringey Ambition**<br>3.4% Reduction<br>705 NELs | = | NHS England Target<br>**National Target**<br>1.5% Reduction<br>341 NELs | + | LBH/CCG Target<br>**Haringey Stretch Target**<br>1.9% Reduction<br>364 NELs |

6.10. The Haringey BCF reports on the Haringey Ambition and the National Target. NHS England measure the National Target from 1 January 2015 to 31 December 2015, the Haringey Ambition is measured from 1 April 2015 to 31 March 2016.

6.11. Performance for Quarter 1 (April – June 2015) on these targets is as follows:

| NELs | Q1 15/16 |
|---|---|
| Baseline | 5934 |
| Actual | 5820 |
| Variance | 114 |
| % Reduction | 1.92% |

6.12. From these figures Haringey is meeting the National Target, which should trigger the release of a portion of the contingency fund which can go towards out of hospital services that could further prevent emergency hospital admissions.

6.13. However Haringey is not meeting the Haringey Ambition target and there has been material growth in Total NELs in Haringey over 2015/16 combined with uncertainties in data quality with a number of acute providers for Haringey (largely Royal Free London and to a lesser extent Whittington Health).

6.14. Following a meeting of the Haringey BCF Finance and Performance Partnership Board (see Governance below) on 17 September 2015, both CCG and LBH members agreed that £315,000 would be released from the contingency to contribute to the cost generated by the overall growth in Total NELs.

**Outcomes**

6.15. In addition to Non Elective Admissions the Haringey BCF is measured according to the following five outcomes, which includes the data for Quarter 1 (April – June 2015):

| Performance Measure | Age | | Q1 15/16 |
|---|---|---|---|
| **Permanent admissions of older people to residential and nursing care homes per 100,000 population.** | 65+ | Baseline | 149 |
| | | Target | 151 |
| | | Actual | 225 |
| | | % Change | 49% |
| **Proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services.** | 65+ | Baseline | 76% |
| | | Target | 91% |
| | | Actual | - |
| | | % Change | - |
| **Delayed transfers of care (delayed days) from hospital per 100,000 population.** | All Ages | Baseline | 661 |
| | | Target | 661 |
| | | Actual | 835 |
| | | % Change | 26% |
| **Injuries due to falls in older people per 100,000 population.** | 65+ | Baseline | 628 |
| | | Target | 598 |
| | | Actual | 595 |
| | | % Change | -1% |
| **GP Patient Survey: In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)?** | All Ages | Baseline | 57.1% |
| | | Target | 57.5% |
| | | Actual | 56.8% |
| | | % Change | 0.7% |

6.16. The data for Q1 is not available for the Reablement Outcome as this is measured over January 2016 to March 2016 in line with national definitions.

6.17. Targets for each outcome were initially set on a projected baseline. Performance against these projected baselines highlighted poor performance on the care homes and falls outcomes. The factors that can contribute to these outcomes are varied and complex and so it was agreed to undertake a more thorough analysis (deep dive) to examine a range of supporting data to determine appropriate responses.

6.18. Following the deep dives, the baselines were recalibrated from actual data, which also reset the target. This changed the performance of Quarter 1. The Care Homes outcome is still performing poorly with a 49% increase in admissions. However the Falls outcome is now performing slightly better than the target, with a 1% reduction in falls. Delayed Transfers of Care (DTOCs) have now been highlighted as performing poorly with a 26% increase in delayed days. The GP patient Survey is near to target.

6.19. The deep dive on the care homes outcome has not yet drawn any conclusions but has already prompted some thoughts on developing an improved health service offer to care homes.

6.20. The falls deep dive has also not drawn any conclusions but will be used to shape the development of some of the existing BCF services.

6.21. An additional deep dive will now be created on DTOCs linked to the work being completed through the systems resilience group as part of winter planning.

**Public and Service User Priorities**

6.22. In addition to the BCF outcome measures, Haringey has surveyed over 200 local people and service users and has summarised their priorities into seven key themes. The following table lists the seven public priorities for integrated services and how the Haringey BCF will meet these priorities:

| **Haringey integrated services will (be):** | **How this will be met in the Haringey BCF 2015-16:** |
|---|---|
| 1. **Easy to access**, through a single point of access | Aiming for a single point of access for different levels of service delivery; patients at high risk of an emergency hospital admission will have a named care co-ordinator to guide them through services; there will be more evening/weekend services |
| 2. **Well managed** and provided by competent professionals and staff | Investing in integrated training and education |

| Haringey integrated services will (be): | How this will be met in the Haringey BCF 2015-16: |
|---|---|
| 3. **Person Centred** and personalised to the experiences and views of people who use them | Care co-ordinators will develop a person centred health and social care plan |
| 4. **Provide good and timely information**, from a variety of sources including the voluntary and community sector | Providing information, advice and guidance face to face in the community and online |
| 5. **Enable individuals to do things for themselves** through prevention , self-management and reablement | Implementing self-management support services; focusing on reablement to promote independence |
| 6. **Work together as one team**, including the patient/service user, with clear and constant communication | Care co-ordinators will work in a multi-disciplinary team, including the patients GP, and will meet regularly both face to face and via teleconferences |
| 7. **Promote wellbeing and reduce loneliness** through community capacity building. | Neighbourhoods Connect will target people who are isolated and link them into their community; more support will be given to carers to support their well-being |

6.23. BCF services will be expected to demonstrate progress against these public defined outcomes and will be supported by public health to use the most effective method for measurement.

6.24. Haringey continues to engage local people in the further development and implementation of the BCF. In 2015/16 there was a launch event on 4 June 2015 to detail how the Public and Service User Priorities were met by the BCF plans. This was followed on 16 September 2015 by an event focused on Loneliness in the community which linked to all the services in the Promoting Independence Scheme. Feedback was very positive from both events. Due to this positive feedback a public BCF event is planned for every quarter focused on a different theme connected to the BCF. The next event will be in December and will focus on the services in the Effective Hospital Discharge Scheme.

**National Conditions**

6.25. As well as setting a NEL Target and a further five outcomes, NHS England have also set six national conditions for the BCF. The following table summarises Haringey's progress according to these national conditions:

| National Condition | Progress |
|---|---|
| 1) Are the BCF plans jointly agreed between the CCG and Council? | Yes, as part of Integrated Governance (see below) |
| 2) Are Social Care Services (not spending) being protected? | Yes, Haringey CCG is meeting its financial commitment to invest in social services aligned to the NEL target |
| 3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering? | Yes, a number of BCF health and social care services operate 7 days a week |
| 4) In respect of data sharing - confirm that: | |
| i) Is the NHS Number being used as the primary identifier for health and care services? | Yes, including on social care systems |
| ii) Are you pursuing open APIs (i.e. systems that speak to each other)? | Yes, all providers are aware of plans regarding data sharing |
| iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2? | Yes, all providers operate under these controls |
| 5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional? | No – in progress. Moving from small pilots to a pan Haringey response as part of the Locality Team (see below) |
| 6) Is an agreement on the consequential impact of changes in the acute sector in place? | Yes, acute sector has been made fully aware of the BCF and are part of the BCF Governance (see below) |

**Milestones**

6.26. Up to October 2015 progress has been made on implementing the BCF services and programme:

| Service | Progress |
|---|---|
| **Locality Team** | • Supported implementation of the Unplanned Admissions Enhanced Service to identify and support the top 2% of patients in GP practices at risk of an emergency health admission<br>• Worked with GP Collaboratives on initiatives to co-ordinate the care of older people with frailty<br>• Developed the Locality Team model based on evidence from the Value Based Commissioning (VBC) workshops<br>• Implemented a Locality Team Test and Learn Pilot with two GP practices (Lawrence House and Morris House)<br>• Developed and agreed a Locality Team business case using local and national evidence for care co-ordination<br>• Launched the Locality Team Incentive Scheme for GPs to expand the coverage to all GP practices in Haringey, with a 40% take up so far<br>• Recruited two Locality Team Managers (East and West) to further develop the MDT teams |
| **MDT** | • Continued the use of MDT Teleconferences<br>• Agreed to expand the MDT teleconferences to discuss Locality Team service users |
| **Lymphedema** | • Continued to deliver and monitor these services<br>• Explored options for these services as part of community healthcare |
| **Rapid Response** | |
| **Overnight District Nursing Service** | |
| **Dementia Day Centre** | • Continued to deliver and monitor these services |
| **Recovery College (incl. MH Employment)** | |
| **Falls Prevention** | • Procured this service from Whittington Health from 1st April 2015 |
| **Reablement** | • Continued to deliver and monitor these services |
| **Step Down** | • Initiated a review of these services as part of the LBH Transformation Programme<br>• Initiated the development of an Intermediate Care Strategy to develop options for the delivery of intermediate care including the Effective Hospital Discharge services. |

| Service | Progress |
|---|---|
| **Home From Hospital** | • Continued delivery of this service via Living Under One Sun up to 31 August 2015<br>• Procured this service from the Bridge Renewal Trust from 1 September 2015 |
| **Neighbourhood Connects (incl. Info & Advice)** | • Procured this service from HAGA for the East and Central Haringey and Groundworks for the West Haringey from 1 January 2015 |
| **Palliative Care** | • Continued to deliver and monitor these services |
| **Supported Self-Management (Generic)** | • Procurement of self-management service from Whittington Health to start from November 2015 |
| **Supported Self-Management (Diabetes)** | • Purchased diabetes DVD resources (in different community languages) and access for local people to a diabetes support website<br>• Procurement of self-management service from Whittington Health to start from November 2015 |
| **Interoperable IT** | • Developing a scoping document of requirements for interoperable IT across adults, children's and mental health as part of the NHS Digital Roadmap |
| **Workforce Development (incl some service delivery)** | • Delivered 10 listening events to over 100 staff to understand what was needed to support the development of integrated health and social care<br>• Delivered several workshops in response to the themes that emerged from the listening events:<br>  ○ Understanding Professional Roles and Building Relationships<br>  ○ Skills for Leading Change<br>  ○ Joint Assessment & Care Planning<br>• Continued to deliver 7 day social working |
| **Disabled Facilities** | • Continued to deliver and monitor these grants |
| **Care Act Responsibilities** | • Delivered a number of engagement and co-production workshops with carers<br>• Agreed a Carers Business Case to support the assessment and support of carers |

**Service Focus**

6.27. The following two services have been highlighted for a more detailed update on their implementation:

***Locality Teams***

6.28. Locality teams are multi-disciplinary teams comprising of professionals

working across primary care, community health care, social care and mental health providing care that is co-ordinated and oriented towards enabling people to maintain their health, independence and wellbeing. Professionals working within the locality team will undertake care co-ordination. Care co-ordination involves the identification of people most at risk of a non-elective/emergency hospital admission and supports them to remain well and independent, and to prevent a hospital admission. Professionals within the locality team will develop and implement a care plan setting out the integrated package of support needed, either from self-care or from safe and effective services. Professionals undertaking care co-ordination will be working as 'care co-ordinators' however will be retaining their specific job title and specialism and incorporating the key tasks to their role.

6.29. Haringey has been piloting a Locality Team with two GP practices in North East Haringey (Morris House and Lawrence House) for almost a year. Within that time they have seen 75 patients. These patients have been selected by the GP practice as being at risk of an unplanned hospital admission and would benefit from care co-ordination. They have then been assigned to one of the Locality Team care co-ordinators (community matron, social worker, physiotherapist, mental health nurse or pharmacist) to develop a health and social care plan. The resulting actions have included:

- A 68 year old male, with chronic back pain was lying on his bed/sofa most of the day. He would not attend the mental health appointments as he could not sit for long enough. Due to low mood, he had previously not engaged with physiotherapy services. The Locality Team mental health nurse (CPN) used motivational interviewing to motivate him to engage with the Locality Team physiotherapist who started an exercise programme for him to start sitting up. The CPN liaised with the mental health clinic to help him access the clinic in his mobility scooter. Working together the CPN and the physiotherapist helped him to improve his mobility (his goal) and access his mental health clinic appointments.
- An 81 year old male, recently discharged from hospital with newly diagnosed diabetes was referred to the Locality Team at the MDT teleconference. There were concerns about depression, falls, self-neglect and diabetes management. A meals-on-wheels service was set up for him and he was given education and support to manage his diabetes including insulin administration. The Locality Team identified possible memory problems which resulted in a referral to the memory service. Telecare equipment was ordered due to the risk of falls. The team kept in touch with the patient to support him and his family through this period.
- One patient's goal was to be able to get upstairs to sleep. The social worker co-ordinated the services provided by physiotherapy and a rehabilitation assistant. His mobility has improved as he is now able to get upstairs. His care plan will be reviewed to incorporate this new level of function and to further improve his mobility.
- One patient repeatedly attends A&E for COPD exacerbation, claiming that she cannot get a GP appointment. She has been re-referred to pulmonary

rehabilitation and given information and advice on GP telephone consultations. She is otherwise independent and will be guided to book her appointments for ophthalmology and diabetes (referrals have been done).

- One patient is on multiple pain killers and has mobility problems. The team has rationalised her medication to reduce adverse effects and is working with her to improve mobility.

6.29. Further evaluation is being completed on the Locality Team with the support of public health. The evaluation will include an evaluation of patient experience (measured via a patient survey) and service usage (measured through tracking of the patients NHS number). This will determine the future of the service as part of integrated health and social care.

***Neighbourhoods Connect***

6.30. Neighbourhoods Connect is a service focused on identifying people who are alone and socially isolated and connecting them back into the community. From 1st April 2015 the two Neighbourhoods Connect service providers began delivering in Haringey: HAGA in the North East, South East and Central Collaborative areas and Groundworks in the West Collaborative area. HAGA has focused on brief and extended lifestyle interventions using techniques such as motivational interviewing. Groundworks have focused on community development and providing taster session activities.

6.31. From 1st April 2015 to 30th September 2015 HAGA have delivered interventions to 201 residents and Groundworks have delivered interventions to 62 residents. Residents have been supported to improve their wellbeing, connect with their community and to become active participants. Some examples of how this has worked include:

- A resident who was new to Haringey and feeling isolated was able to link to his residents association and volunteer his IT skills to support people into employment
- Establishing a Turkish speaking community group in supported housing which was able to support a Turkish unpaid carer in her seventies who was feeling depressed and isolated
- Supporting the development of a book group in another supported housing scheme following the interests of a 58 year old wheelchair user who rarely left her house
- Supporting an unpaid carer to identify the support she needed and to access a local dance class and potentially some bereavement counselling to address the loss of her mother

6.32. The next phase of implementation will be to try and target the truly isolated and housebound residents, who may need more than a brief intervention.

6.33. Further evaluation is being completed on the Neighbourhoods Connect service with the support of public health using validated well-being tools, such as Warwick Edinburgh Mental Well-Being Scale, to demonstrate whether there has been a positive impact on outcomes. This will determine the future of the service as part of integrated health and social care.

**Risks and Issues**

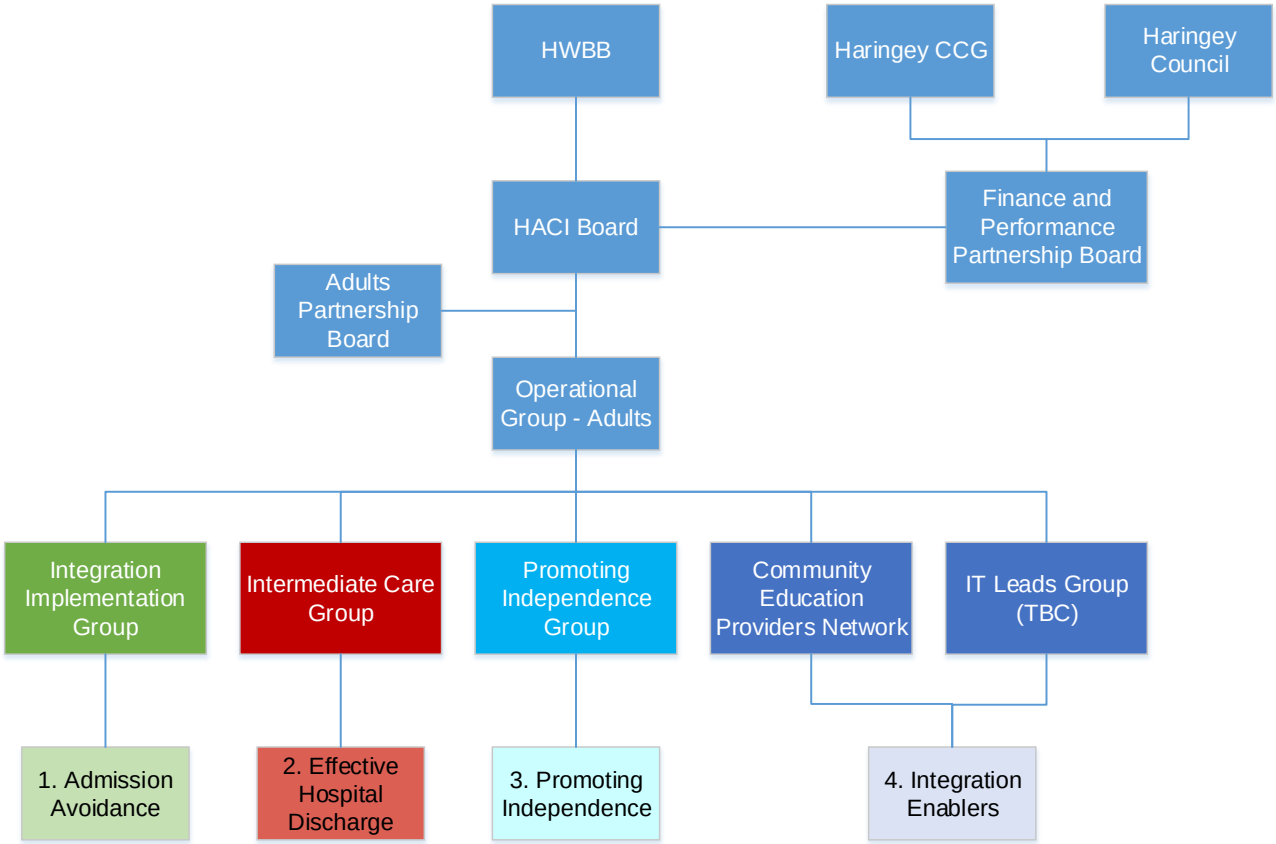
6.34. Several risks have been identified for the delivery of the BCF Plan. The highest risk is that emergency hospital admissions will not be reduced. This is the main target for the BCF and failure to deliver the target would indicate that schemes to avoid hospital admission are not succeeding and would limit scope for the CCG and Local Authority to target our resource into schemes to better promote and support independence. To mitigate this risk, modelling within the Haringey BCF has been used to determine which services are most likely to deliver the NEL targets. The best local and national evidence has been used in this modelling; however the modelling does come with a number of assumptions. The first year of implementation of the BCF will be to test a number of these assumptions as local circumstances can impact on the implementation of evidence based practice

6.35. A number of the other risks identified have some shared cross cutting themes:

- Joint working structures and arrangements are immature which may cause delays in implementation, reduce the effectiveness of partnerships and case duplication of effort. To mitigate this structures will need to be reviewed in six-months to ensure reporting is embedded and delivery is being clearly led.
- The continuation of the BCF into 2016-17 has been confirmed by NHS England however the scope of the budget and targets has not leading to short term contracts and uncertainty amongst providers. This is mitigated by Haringey CCG and LBH stating their commitment to the continued integration of health and social care, but being open with providers that the scope of these commitments may change in light of national announcements.
- Data quality and sharing issues are barriers to integration amongst providers. This is mitigated through the provision of some support by NHS England to Haringey to explore the issues and develop some potential solutions which can be implemented locally.
- The existing culture of the workforce in health and social care providers can be a barrier to integration and access of services. This will be mitigated through the development of frontline ‘integration champions’ to fully understand and co-produce local plans and services and be the bridge between strategy and delivery.

## Governance

6.36. The BCF has an established governance structure as follows:




6.37. Each BCF Scheme links to a working group. These working groups have membership from commissioners and BCF health and social care service providers including Haringey CCG and LBH. The working groups all report to the Operational Group – Adults which also has membership from: Haringey CCG; LBH; HAVCO; Healthwatch; North Middlesex Hospital Trust; and Whittington Hospital Trust. Any issues from this group are escalated to the Health and Care Integration (HACI) Board which reports to the Health and Well-being Board.

6.38. In line with national guidance, a Section 75 (S75) agreement has been signed by LBH and Haringey CCG. S75 of the NHS Act 2006 gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions. The Haringey BCF S75 Agreement establishes a pooled fund for the BCF and sets out the key principles and processes for any BCF budget changes and decisions.

6.39. As part of the S75 a Finance and Performance Partnership Board has been created to note the financial position of the BCF, with any underlying

rationale demonstrated by performance, raise any risks or issues relating to finance and performance and to make decisions on any under/over spend. This ensures that both partners are fully involved in and sighted on any decisions that affect integrated services.

## 7. Contribution to strategic outcomes

7.1. The BCF is one of the key plans for the London Borough of Haringey (LBH) and Haringey CCG. In particular it supports:

- 2014/19 North Central London 5-Year Plan
- 2014/19 Haringey CCG 5-Year Plan
- 2015/16 Haringey CCG Operating Plan
- LBH (2012) Joint Health and Well-being Strategy

7.2. The BCF is helping to deliver Priority 2 (Healthy Lives) of LBH's Priorities 2015/16 and Priority 2 (Integration) of Haringey CCG's Priorities 2015/16.

7.3. In line with national guidance, a Section 75 (S75) agreement has been signed by LBH and Haringey CCG. S75 of the NHS Act 2006 gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions. The Haringey BCF S75 Agreement establishes a pooled fund for the BCF and sets out the key principles and processes for any BCF budget changes and decisions.

7.4. As part of the S75 a Finance and Performance Partnership Board has been created to note the financial position of the BCF, with any underlying rationale demonstrated by performance, raise any risks or issues relating to finance and performance and to make decisions on any under/over spend. This ensures that both partners are fully involved in and sighted on any decisions that affect integrated services.

## 8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

### Finance and Procurement

8.1. This report is for noting only and there are no financial implications arising directly out of this report. There are also no procurement issues arising.

8.2. The expenditure plan for the Better Care Fund is set out above after paragraph 6.5. The plan is fully funded in this financial year. The contingency budget forms part of the allocation and so the release of one quarter's funding referred to in paragraph 6.13 does not create any new financial burdens. If performance improves in future months then the remaining fund will be available for investment in new services.

**Legal**

8.3. There are no legal implications arising from the recommendations in the report

**Equality**

8.4. An Equalities Impact Assessment (EIA) was completed for the whole BCF Programme in December 2014. The overall outcome was to continue with the programme as there were a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on older people (over 65), disability (including mental health), gender, religion/belief, marriage, human rights, socio-economic group, social inclusion and community cohesion. These positive impacts were mainly due to: the cohort of patients and services users that will be the main beneficiaries; the delivery of services in people's homes; working in a service user centred way to define health and social care goals; and the intention to improve health and well-being. No negative impacts were highlighted.

## 9. Use of Appendices

9.1. Not Applicable

## 10. Local Government (Access to Information) Act 1985

10.1. The original BCF plans and papers, including the equality impact assessment, can be found on the following web-link:

http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm

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| **Report for:** | **Health and Wellbeing Board -** Tuesday 24 November 2015 |

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|---|---|
| **Title:** | **Haringey Safeguarding Boards Annual Reports 2014/15** |

| | |
|---|---|
| **Organisation:** | **Haringey Safeguarding Adults Board (HSAB) & Haringey Safeguarding Children Board (HSCB)** |

| | |
|---|---|
| **Lead Officers:** | **Haringey Safeguarding Adults Board**<br>Beverley Tarka**,** Director of Adult Social Services (outgoing Chair)<br>Dr Adi Cooper**,** Independent Chair<br><br>**Haringey Safeguarding Children Board**<br>Sir Paul Ennals, Independent Chair |

## 1. Describe the issue under consideration

1.1 The annual reports are for the period 1st April 2014 to 31st March 2015 and are produced as part of the Boards' respective statutory duties:
- Section 43 and Schedule 2 of the Care Act 2014
- Section 14A of the Children Act 2004 and Chapter 3 of Working Together to Safeguard Children 2015.

1.2 The reports were ratified by the Boards at their respective meetings in October.

1.3 The reports should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner (in London the Mayor's Office for Policing & Crime), and the Health and Wellbeing Board.

1.4 The HSAB is reporting on its work prior to Care Act implementation. It provides an overview of Board activities and achievements to meet its objectives during 2014-15 and identifies key priorities which have formed strategic planning moving forward under the Care Act 2014 statutory requirements. The report includes a Chair's Foreword with message from both the outgoing Chair and incoming Independent Chair.

1.5 The HSCB report provides an overview of Board activities and achievements during 2014-2015; it summarises the effectiveness of safeguarding activity in Haringey; provides an overview of how well children in Haringey are protected, and fulfils the Board's statutory duties. The meeting's attention is explicitly drawn to the Chair's Foreword, especially the last paragraph; Section 6 on Board effectiveness, and the summary in Section 8.

## 2. Recommendations

The annual reports are noted for information purposes only.

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# Haringey Safeguarding Children Board

## Annual Report 2014 – 2015

Haringey Safeguarding Children Board
Annual Report 2014 – 2015

CONTENTS

# 1 Introduction

1.1 This annual report is for the period 1st April 2014 to 31st March 2015 and is produced as part of the Board's statutory duty under section 14A of *The Children Act 2004* and Chapter 3 of *Working Together to Safeguard Children 2015*. The Chair of the Board is required to publish an annual report in relation to the preceding financial year, on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

1.2 The report will be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner[1] and the Health and Wellbeing Board. The report provides an overview of LSCB activities and achievements during 2014 – 2015; it summarises the effectiveness of safeguarding activity in Haringey; provides an overview of how well children in Haringey are protected, and fulfils the Board's statutory duty to:

- provide an assessment of the performance and effectiveness of local services
- identify areas of weakness, the causes of those weaknesses and action being taken to address them as well as other proposals for action
- include lessons from reviews undertaken within the reporting period
- include assessment of Board partners' responses to child sexual exploitation
- include information on children missing from care, and how the LSCB is addressing the issue
- include contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training

1.3 More information about the statutory role and function of the LSCB can be found at *Appendix A*.

[1] In London this is the Mayor's Office for Policing and Crime

## 2 Foreword by the Chair

2.1 I am proud to present the annual report for Haringey's Safeguarding Children Board for 2014-15. I assumed the role of Chair in May 2014, and am most grateful for the support and engagement of partner agencies throughout the year. There is a strong collective commitment to working purposefully together in the task of keeping children and young people safe within Haringey, and this year has been one of real progress in many areas.

2.2 We are very conscious of the challenges that face all agencies working with children and young people. Budget pressures are real and increasing; all agencies have been required to reduce their budgets, whilst the demand for services has continued to rise in many areas. The world of child protection can be an unforgiving one, so it requires real maturity for agencies to find the necessary balance of strong support and strong challenge. I am proud of the way in which Haringey agencies have felt able to confront those areas where we know we need to improve, whilst seeking to identify examples of good practice that we see daily from staff on the front line.

2.3 The year began with an inspection visit from Ofsted, published in July (which I summarised in last year's report). The Board achieved a rating of "Requires Improvement", with Ofsted noting only four areas for improvement (see Section 2 below); we were encouraged that we nearly warranted a rating of "Good", and we are confident that should they return any time soon we would achieve that 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. They said that 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.

2.4 Early in the year we said goodbye to our Board Manager, Angela Bent. It took some time to replace her, but I was delighted recently to welcome Patricia Durr to the post. Patricia has brought vision, enthusiasm and great commitment to our work.

2.5 As the report indicates, all our subgroups have been active. We report here on two Serious Case Reviews (SCRs); we have continued work on a third, and we have just commenced a fourth one. We are now implementing our strategy for tackling Child Sexual Exploitation (CSE), and our Board has discussed some aspect of this issue at every meeting. We are looking more carefully at work across the borough to tackle Missing Children. We have contributed to the development of the Council's Early Help Strategy, and agreed our role in monitoring its delivery. We have increased our level of engagement with schools, and conducted a review of practice in the handling of cases of historic abuse.

2.6 We were pleased to host a major conference on Female Genital Mutilation, with previous Home Office Minister Lynne Featherstone, with over 150 delegates from across North London. Some pioneering work is taking place on this issue within some Haringey schools, and this is a great example of where young people themselves have helped to set the agenda and lead much of the campaigning.

2.7 The year ended with us receiving news of an Innovation Grant award from the Department for Education to support us in improving our collaboration with the neighbouring borough of Enfield in supporting vulnerable young people. In the years ahead we will need more such collaborations across geographical boundaries, so I am glad of the national recognition of our work.

2.8 In the coming year we intend to revisit our long-term strategy. We believe that every child should grow up in a loving and secure environment which is free from abuse, neglect and crime, enabling them to be safe and healthy and to enjoy life and fulfil their social and educational potential. I hope our new strategy will spell out the practical contribution that our Board can make to achieving this vision.

2.9 Safeguarding arrangements within Haringey are broadly robust and effective, and the partnership has demonstrated its willingness to confront and respond to issues which arise. |Resources available to all agencies are under severe pressure, and the years ahead require continued commitment from all agencies to maintain and further develop the safeguarding and other partnerships. We need to improve our sharing of data, so that we can become better at identifying any changes and emerging threats to the safety of children within Haringey. We need to improve our engagement of children and young people in our work. And we need to think radically about how the services provided by all agencies can work more effectively and efficiently together in the years ahead.

# 3 Progress on priorities, issues and challenges

3.1 The *LSCB Business Plan 2014 – 2016* (*Appendix B*) provides the framework of priorities for our work whilst allowing us to be responsive to emerging themes and challenges: it enables us to monitor and track progress on identified actions. The current Business Plan also takes into account areas of improvement as identified in the May 2014 Ofsted review of the LSCB, which have all been completed.

3.2 We review our priorities annually, and in last year's annual report we outlined 5 priorities within a two year business plan to the end of March 2016. Progress was achieved against each of these priorities, as set out below:

***3.3. 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*

3.3.1 This was also a particular focus for Ofsted recommendations, which we have responded to.

3.3.2 Ofsted recommended that we *review Haringey's Child Sexual Exploitation (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 co- ordinated response to this vulnerable group of young people*. They recommended that we *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 set out what success criteria will be used to measure and evaluate progress*

3.3.3 Additionally Ofsted recommended that we *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.* We should also *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*.

3.3.4 We have updated and re-issued the CSE guidance as suggested. We now know that the profile of CSE that emerges within Haringey is somewhat different to the high-profile cases in some English towns. Here much of CSE appears to be connected to gang activity within the borough, so Ofsted's recommendation was appropriate. We have begun implementing the strategy, and are bringing together all agencies on a regular basis to ensure we tackle and bear down upon the incidence of CSE. Our data processes now enable us to monitor changes in the occurrence of suspected CSE, and monitor rates of disruption and prosecution.

3.3.5 We have strengthened our reporting systems. We are currently undertaking a new review of how all agencies respond to missing children, in order to ensure that all

children are properly interviewed on their return, and that we learn any necessary lessons.

3.3.6 The CSE Sub-group is now overseeing this work and has a clear governance and accountability structure and agreed strategy, which includes connections and routes into the Violence Against Women and Girls Board, Gang Action Group Strategy and oversight of our work on Missing Children & Young People. The workflow into Multi-Agency Sexual Exploitation (MASE) meetings and Multi-Agency Safeguarding Hub (MASH) is developing, and the quality of contributions are strengthening significantly and being monitored via the CSE Sub-Group and the MASH Board. There is a clear action plan, with agreed accountabilities and reporting into the Board.

3.3.7 A Task & Finish Group chaired by the Metropolitan Police Borough Commander was convened this year to undertake a thorough review of the multi-agency response to Missing Children & Young People, and developing our local protocol.

3.3.8 Our Section 11 Audit this year included five additional strategic priorities to help achieve a better understanding of how services were responding, including a focus on working with children and young people affected by gangs and CSE. More information about the audit and its findings can be found at *Section 6.*

3.3.9 The Disabled Children's Sub-group undertook a review with the Gang Action Group of the engagement of disabled children during the reporting period and reported to the Board in May 2015 with the findings to be fed into the Gang Action Group Strategy.

3.3.10 There is work ongoing to make our performance data in this area more robust and to consider the impact of the Early Help offer on gang engagement.

### *3.4 PRIORITY TWO - Early Help*

*Scrutinise the move towards strengthening the 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.*

3.4.1 This year the Board considered the Council's Early Help Strategy and we have established regular reporting to the Board on progress and impact. Questions about Early Help were also a feature of our Section 11 Audit this year. There is still work to be done to review our training and we will be looking at Early Help in our 2015-16 audit cycle. We are committed to the importance of growing the borough's Early Help offer, so we can be confident that children and families receive support as early as possible, and fewer children need to rise up the tiers of need to receive a child protection plan.

### *3.5 PRIORITY THREE – Neglect*

*Improving effectiveness of all agencies in recognising and responding to neglect*

3.5.1 Neglect was a key focus of our Section 11 Audit this year to assess agencies safeguarding arrangements and more information about outcomes can be found at *Section 6.*

3.5.2 The MASH Board is looking in particular at the use of chronologies across the partnership to strengthen responses to cases of neglect. In 2015-16 the MASH Board is operating as a sub-group of the Board with a clear governance structure

3.5.3 The Board is reviewing the development of a Neglect Strategy.

### *3.6 PRIORITY FOUR - Promoting good practice*

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

3.6.1 Work began on developing a programme for disseminating examples of good practice in safeguarding through the partnership. Three examples of good practice went into the Board's Jan/Feb 2015 newsletter.

3.6.2 We developed our annual campaign programme this year and ran two highly successful campaigns including a very well received poster campaign focused on learning from SCRs. We also worked with the Council on a borough wide CSE Campaign towards the end of the year.

3.6.3 In 2015-16 we have ambitions to improve our communications and focus with a review of our training offer, branding, and development of our vision and 3-5 year strategy.

### *3.7 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.*

3.7.1 The Board remains committed to ensuring that children's real and lived experiences are the heart of our work. In 2014-15 we agreed a new annual audit cycle to include a multi-agency audit of how partners are considering the wishes and feelings of children in their direct work. Work also began on our engagement in the Office of the Children's Commissioner Takeover Day for November 2015. We have much more to do, though, in involving children in the work of the Board, and we aim to concentrate more on this in the coming year.

### 3.8 Working closer with Schools

*Ofsted also recommended that we "Ensure that schools are more 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".*

3.8.1 Our engagement with schools has improved considerably this year with established representation on our Board from both primary and secondary schools. The Chair has attended meetings with all head teachers to consider safeguarding priorities. During the summer of 2014 the Chair undertook a review of the procedures for handling cases of historical abuse within schools, following a high-profile case dating back to the 1980's which resulted in the conviction of the perpetrator for a 12 year sentence. The review identified examples of effective practice by the police, the school, the Local Authority Designated Officer (LADO) and the council, but also identified several learning points for all agencies. A small number of other allegations

have surfaced relating to historical abuse within Haringey schools from up to forty years ago, and the new procedures are now being followed.

3.8.2 This review provided an opportunity for schools to revisit their existing child protection policies, in particular their policies relating to whistle-blowing, disclosure, and Sex and Relationship Education, and a programme of work has been initiated with all schools in the borough in order to revise, improve and update policies. The board also reviewed all the most recent Ofsted reports of schools, receiving assurance that Ofsted ratings of safeguarding practice were consistently high, and that where any issues had been identified, appropriate action had been taken.

## 4 Local information and data

4.1 Haringey is an exceptionally diverse and fast-changing borough. We have a population of 267,451 according to the 2014 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.

4.2 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 with the 4th highest level of child poverty in London. Haringey is the most unequal borough in London, with over half of its wards being either very rich or very poor. Northumberland Park, a ward in the East, is the most widely deprived ward in London.

4.5 Haringey has high unemployment (9%) and the 2nd highest proportion of people living in temporary accommodation, which includes children and families. While three wards were in the top 25% for wellbeing in England in 2012, nine wards – mostly in the east of the borough – were in the bottom 25%.

4.6 There are approximately 63,400 children and young people under 20 living in Haringey (approximately one third of the total population). The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane and Tottenham Hale..

4.7 1 in 3 children live in poverty, 1 in 4 children live in household with no working adult (23% compared to 18% in London). Over 10, 000 households are with lone parents (34% compared to 28% in London). It is estimated that over 11, 000 children in Haringey live with some form of long-standing disability.

4.8 Over 9,000 children and young people have Special Educational Needs (SEN) in primary and secondary schools. Approximately 1,200 children have a Statement of SEN; of those, 35% had autism followed by moderate learning difficulties (21%) and emotional, behavioural and social difficulties (12%)

# 5 Governance and accountability

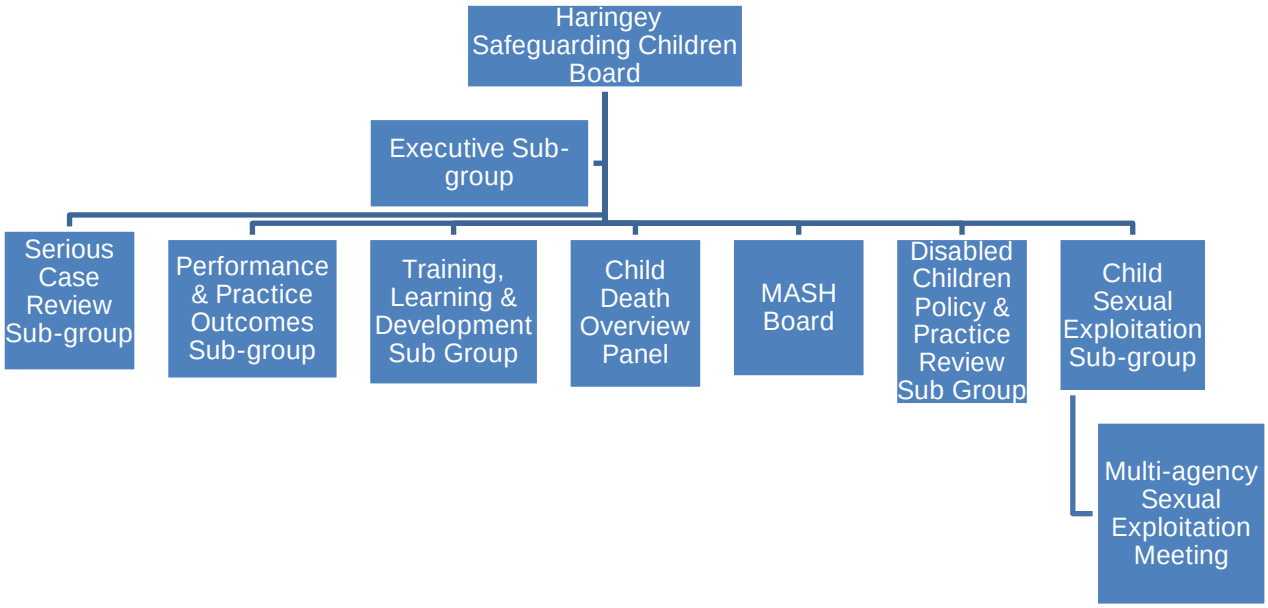
5.1 The LSCB has an independent chair and a number of subgroups chaired by a senior member from across the partner agencies. The Chair is accountable to the Chief Executive of the local authority in chairing the LSCB and overseeing its work programme. However, he is accountable only to the Board for the decisions he takes in that role. The role of Vice-Chair is undertaken by the Designated Nurse from the CCG.

5.2 The Board is attended by representatives from the partner agencies with a high level of engagement. Information about Board attendance can be found at *Appendix C.*

5.3 Governance continues to be strengthened with regular reporting from sub-groups through to the Executive and the Board; a range of task and finish group activity with clear reporting lines and the introduction of a member appraisal process this year.

5.4 During the year the structure of the Board changed to reflect priorities and efficiencies. We report on the business of each of the sub-groups operating during 2014-15 in this report and the structure below reflects the shape of the Board from April 2015.

**Board Structure 2015/16**




## 5.5 Relationship between the LSCB and other strategic boards

5.5.1 The Chair of the LSCB attends the Health and Well-Being Board and the Children's Trust. He meets regularly with the Chief Executive and Deputy Chief Executive, the

Director of Children's Services, the lead member for children and the Council Leader. 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 and this year greater links have been made with a number of other key strategic partnerships:

- The Violence Against Women & Girls Strategy Group which reports to the Community Safety Partnership
- The Preventing Radicalisation & Violent Extremism Strategy Group which reports to the Community Safety Partnership
- The Safeguarding Adults Board

## 5.6 Health

5.6.1 As the major commissioner of local health services across the borough Haringey Clinical Commissioning Group (CCG) is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. All health providers in Haringey are required to have effective arrangements in place to safeguard vulnerable children and to assure the CCG, as commissioners, that these were working. These arrangements included:

- safe recruitment;
- effective staff training;
- effective supervision arrangements;
- working in partnership with other agencies;
- all providers ensuring they have a Named Doctor and a Named Nurse for safeguarding Children (and a Named Midwife if the organisation provides maternity services);
- GP practices to have a lead for safeguarding, who should work closely with the Named GP and Designated Professionals.

5.6.2 The three main Provider Trusts are all also represented on the Board and hold internal bi-monthly safeguarding children committees attended by the Designated Doctor, Assistant Director Safeguarding / Designated Nurse Child Protection or Deputy Designated Nurse. The meetings provide an opportunity for information sharing and challenge regarding all aspects of safeguarding children. Any issues arising are discussed with the Executive Nurse/ Director of Quality and Integrated Governance and within the Haringey CCG Safeguarding Children Assurance meeting as appropriate. All Named Safeguarding Professionals in the Provider Trusts were up-to-date with safeguarding children training during 2014/15. More information is contained in the CCG Annual Safeguarding Report[2]

## 5.7 Financial arrangements

[2] Safeguarding Children Annual Report 2014/15, can be found on the Haringey Clinical Commissioning Group website

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 D.*

## 5.8 Reports from Sub-groups

### 5.8.1 Serious Case Review (SCR) Sub-group

***Chair:*** *Independent Board 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.*

5.8.2 During the year six sub-group meetings were held. Three cases were considered for possible initiation of a SCR. The first case concerned neglect of a severely disabled child, and a multi-agency review was commissioned. The second case concerned the non-accidental injury of a very young child known to agencies, and a single agency review was commissioned. The third concerned the death of a very young child, to be known as *Child R*; an SCR was commissioned in March 2015.

5.8.3 Five Panel meetings were held concerning the SCR for *Child O*. This complex case, involving the suicide of a 16 year old girl, involves many agencies, and is expected to report in the autumn of 2015.

5.8.4 One final Panel meeting was held in May 2014 for the SCR for *Child D.* Publication was then delayed pending court proceedings, in which the parents were found not guilty of harming their young child. The SCR was published in March 2015. Key areas of weakness identified through the SCR for *Child D* were the following:

- The quality of assessments of need of a mother, and a young child, by health visitors and social workers ;
- The process of planning for a new placement for children in care, taking account of the needs of the whole family ;
- The quality of post-natal checks in GP practice ;
- The importance of taking careful family histories, and understanding better the long-term impact on families of regular exposure to violence ;
- The need to improve the quality of supervision and management of staff who are dealing with challenging cases.

5.8.5 Action had been taken to address all these weaknesses by agencies following this case.

5.8.6 A further SCR, joint with the London Borough of Enfield regarding *Child CH*, also had delayed publication because of court proceedings. It was published in May 2015, after the end of the period covered by this report, and related mainly to practice from some years earlier. CH is a young man from a very violent background, who was found guilty of murdering another young man in a street fight. Key areas of weakness identified in this SCR are the following:

- the failure of Children's Social Care at the time to respond to the requests by a social worker and others for intervention with CH and his family;
- the failure of Children's Social Care at the time to follow safeguarding procedures and to ensure the safety of CH's nephew, after he was found to have suffered a large number of non-accidental injuries;
- the need to ensure Social Work assessments are used effectively to inform decisive action;
- the apparent normalisation and toleration by agencies of high levels of violence in CH's household, and failure to act on opportunities to remove CH from the household some time prior to Mr Z's death;
- the weaknesses in the processes of transferring case responsibility between the neighbouring boroughs.

5.8.7 Action had been taken to address all these weaknesses.

5.8.8 The group monitors action arising from SCR recommendations and ensures that learning from SCRs is embedded in the Board's multi-agency training offer. The sub-group oversaw a major dissemination programme reflecting on the learning from these SCRs, and others, through a well-regarded poster campaign involving all partner agencies and the addition of biannual SCR learning events.

5.8.9 The sub-group also considered the learning from a *Domestic Homicide Review*, and monitored the engagement with an SCR led by another London borough.

**5.9 QA & Best Practice Sub-group** – ***now Practice and Performance Outcomes Sub-group***
***Chair:*** *LB Haringey Assistant Director, Quality Assurance, Early Help & Prevention*
***Remit:*** *To monitor the effectiveness of multi-agency child protection and safeguarding 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.*

5.10 The Quality Assurance Subgroup and Best Practice Subgroups merged in January 2015 to form the Practice and Performance Outcomes (PPO) Sub Group, to reflect the broader remit. In 2014-15 both groups had a bimonthly cycle of six meetings per year. In 2015-16 the PPO Subgroup will meet on a quarterly cycle to enable partners to invest time in a meaningful audit process, leading to service improvement on a multi-agency basis.

**5.11 Audits**
During 2014/15 the group looked at both single agency auditing and a series of themed small scale multi-agency audits. Also during the period the statutory Section 11 audit was overseen by the sub group and included schools for the first time. The findings were presented to the LSCB in March 2015. More detailed information on this can be found in *Section 6.*

5.11.1 Some of the issues considered by the group through auditing were:

- **Supervision** – this is a key feature of a number of Serious Case Reviews and the exercise emphasised the importance of reflective supervision, action, timescales and follow up. CYPS looked at 30 cases over a 12 month period

and as a consequence reviewed and relaunched its supervision policy which is monitored through the monthly audit process.

- **Supervision Orders** – the review indicated that care plans were not always visible on children's files, internal policies were not consistently compliant with court orders, and supervision orders had not consistently had multi-agency input. This led to a review of policy, procedures and practice.
- **Family Group Conferencing** - the review led to a CYPS review and consideration of its use as part of the Early Help offer to promote family resilience and self-help.
- **Section 47 & Strategy discussions** – this highlighted concern about a lack of consistency with regard to multi-agency strategy discussions and timescales and the development of the use of conference calling, which the Board continues to pursue.
- **Child Protection Case Conferences** – Chairs' summaries were comprehensive, but lacked some evidence-based analysis that could be incorporated; the voice of the child was sometimes lacking in records; lack of parental input; risk assessments did not sufficiently evidence professional challenge.
- **Female Genital Mutilation** – audit following a challenge raised via Enfield LSCB on number of FGM referrals, leading to the development of and practice at North Middlesex Hospital

5.11.2 During the year, work to develop and agree an integrated multi-agency performance dataset for the Board began with all agencies agreeing to test out and populate a model dataset, with end of year figures for 2014/15 to be used as a baseline. This is being developed and refined into 2015-16 and includes indicators to underpin and monitor the CSE Strategy.

5.11.3 A Task and Finish Group was established reporting into this subgroup and to the CSE Subgroup, chaired by the Borough Commander and focused on Children and Young People Missing from Home, Care and Education. The remit of the group is to review and understand how partners respond to children 'missing' and to agree a joint protocol to recommend to the Board. This continues to be a focused priority in 2015-16.

5.11.4 The group is keen to ensure a strong iterative process between performance and practice across the partnership and will be developing and setting out a clear Performance Framework embedded in the Board's planning cycle. The group has agreed four priority areas to establish a genuine multi-agency approach to audits in 2015/2016, with a clear process including audit tools and moderation arrangements, to collectively identify issues and learning for all partners. The agreed audit themes for 2015/16 are:

- Quarter 1 Young Peoples Voice
- Quarter 2 Neglect
- Quarter 3 Child Sexual Exploitation
- Quarter 4 Child's Journey including referrals, MASH & Early Help

## 5.12 Child Death Overview Panel (CDOP)

***Chair:*** *AD Public Health*

***Remit:*** *To provide a review of all deaths of children who are under 18 and resident in the borough. and use the information gathered to develop interventions and recommendations to improve the health and safety of children in order to prevent future deaths*

5.12.1 The Child Death Overview Panel met on three occasions. During this period there were 18 child deaths and seven rapid response meetings (or strategy meetings that encompassed the functions of a rapid response meeting). Three of these meetings related to the same case. Bearing in mind the relatively small numbers involved, any observations must be tentative. The provisional main causes of death during the year broadly mirrored those of previous years with 12 out of 18 deaths being due to congenital anomalies or perinatal events, including prematurity. In one case, a child was hanged and the coroner gave a verdict of accidental death. One six month old child suffered severe head trauma and is the subject of a Serious Case Review. Another case involving the murder of a 10 month old was not felt to qualify for an SCR. Only six of the deaths in 2014-5 have been considered by the panel and closed, so no further conclusions can be drawn.

5.12.2 The panel closed a total of 20 cases over this period, of which only six were deaths in 2014-15. The delay was due to waiting for other statutory processes, such as inquests and police investigations, to be completed or to difficulties in obtaining post mortem reports or information from providers, such as discharge reports or Serious Incident reports. The pattern of deaths closed was similar to previous years with 13/20 deaths being due to congenital anomalies or perinatal events, including prematurity. There was also one death by fire and a death by drowning in the bath. Lessons from these had been disseminated to the relevant professionals, before the cases had been formally closed.

5.12.3 Over the next year it is planned to review "The Report of the Morecombe Bay Investigation" by Dr Bill Kirkup to see if there are any lessons for CDOP. We also hope to have a discussion with the London Ambulance Service and a presentation from one of the local providers on the Situation Awareness for Everyone (S.A.F.E) programme, a new £500k two year programme to trial care techniques to reduce preventable deaths and errors in England's paediatric departments (www.rcpch.ac.uk/safe).

## 5.13 Child Sexual Exploitation Sub-group

***Chair:*** *Designated Nurse, CCG*
***Remit:*** *To monitor and evaluate the effectiveness of the multi-agency approach to the identification and response to Child Sexual Exploitation in Haringey.*

5.13.1 The Child Sexual Exploitation (CSE) Task Group (set up in 2013/14 to review Haringey's guidance on CSE) became the LSCB Vulnerable Children sub-group in April 2014 and reviewed partnership processes in place across a range of areas, including female genital mutilation (FGM), domestic and gender based violence, and missing children.

5.13.2 Between November 2014 and January 2015 a partnership Task and Finish group chaired by the Deputy CEO of the Council oversaw the creation of Haringey's Child Sexual Exploitation strategy and this was ratified by the LSCB in January 2015.

5.13.3 The Vulnerable Children subgroup narrowed its remit in December 2014 to focus on Child Sexual Exploitation, including risks to missing/trafficked children and risks of CSE within gangs. The sub-group changed its name to the CSE sub-group to reflect this.

5.13.4 Oversight of the partnership response to some other aspects of the Vulnerable Children's sub-group - for example FGM and Honour-Based Violence - were transferred to the Violence Against Women and Girls strategic group.

5.13.5 The CSE sub-group then developed the action plan of the CSE strategy which will ensure the implementation of the strategy. This action plan was finally ratified by the LSCB in March 2015.

5.13.5 The creation of the strategy and action plan has resulted in more clarity regarding roles and responsibilities of partner agencies in prevention of and response to CSE. A decision was taken in February 2015 to use the London CSE Operating Protocol to identify and address CSE, providing a consistent response across the agencies. Subsequently Haringey's Multi Agency Sexual Exploitation (MASE) and Multi Agency Professionals (MAP) meetings have been reviewed and revised to develop strategic intelligence and case specific response respectively. Work will continue in 2015/16 to oversee the implementation of the CSE strategy, reporting progress regularly to Haringey's LSCB.

### 5.14 Disabled Children Policy & Practice Review Sub-group

***Chair:*** *LA Deputy Head of Service, Special Educational Needs & Disabilities*
***Remit:*** *To consider the Board's priorities in relation to how disabled children are safeguarded, and consider the specific vulnerabilities of this group of children in different circumstances*

5.14.1 This group was established in response to previous Government Practice Guidance for Disabled Children, which recommended that the LSCB consider the specific safeguarding needs of disabled children in a multi-agency group. The Board approved the disabled children's threshold document in January 2014.

5.14.2 **Disabled children's data:** There is a disabled children's data set which is being re-aligned to the new LSCB data set template, to identify trends, gaps and the impact on safeguarding Disabled children.

5.14.3 **Review engagement of Disabled children with gangs:** The Integrated Gang Unit (IGU) Manager presented the work of the Unit to the group and work was progressed on considering the prevalence of known gang-associated young people who have statements of SEN and Additional needs.

5.14.4 **Disabled children and neglect:** The Rosie 2 neglect programme was presented to the Disabled Children's group, providing a multi-agency look at the neglect of Disabled children. Rosie 2 is an e-learning interactive resource that allows

practitioners to consider and discuss a range of issues related to neglect, including joint working, disguised compliance, aggression, mentalisation and 'invisible' men.

5.14.5 **Over-Medication:** The Consultant Psychiatrist outlined an analysis of errors related to CAMHS-LD medication dispensation in the community over the last 3 months. The reason for the presentation was due to the unusual increase in issues not previously seen in 7 years. 5 cases were presented. Guidance for families has been drafted and is currently being written into a more accessible format.

5.14.6 **Review of child deaths and learning from legal issues relating to Disabled children nationally:** The group considered the Judgement and the learning from the case of Child AK, who was removed from the hospital in the UK against medical advice and sought medical intervention of Proton B treatment in Spain.

5.14.7 **Promoting good practice:** The group has discussed the qualitative impact of the use of multi-disciplinary teams In Special schools in de-escalating issues and to agreeing threshold for referral to social care has been met.

5.14.8 **Engaging the voices of Disabled children and Young People:** a joint Special Schools Council has been formed to support young people to present their issues and participate as citizens in their communities. Young Disabled people are now being supported to contribute their issues to the Disabled children's policy and practice review group via the special schools council and children's stories shall be presented to the group. The joint special school council is involved in the LSCB takeover day planned for November 2015.

5.14.9 **Curriculum Examples of Safeguarding Disabled Children:** Examples of materials and evidence of good practice regarding curriculum work on safeguarding disabled children was shared at the group from Haringey's Special schools. This material is now available electronically as a library of safeguarding disabled children school resources and is being updated as necessary.

5.14.10 **Case Presentation:** The group had a number of multi-agency case presentations regarding the following issues from which lessons were shared:

- CSE and young people with learning difficulties
- Home educated disabled child
- Autistic young people who are victims of crime – discussed police process, use of Police Intermediary and ABE process.
- Deprivation of Liberty – consideration of the recent court judgement for disabled young people.

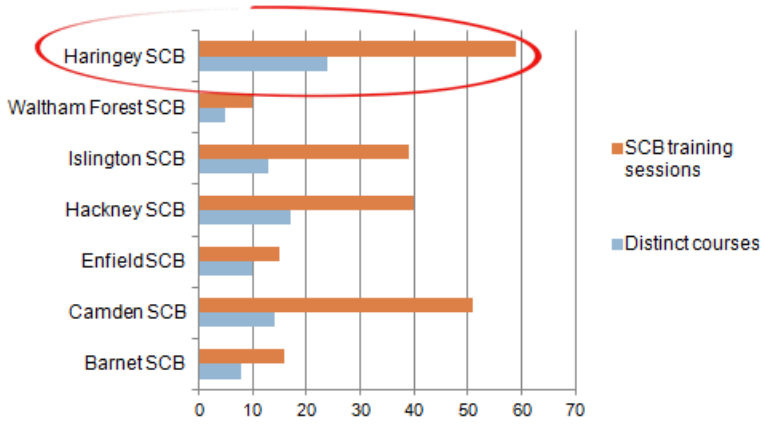
5.14.11 **Disability Hate crime:** The group received an update on the campaign which looks at the recognition and reporting of disability hate crime. There is a concern that incidents are not being reported.

### 5.15 Training, Learning & Development Sub-group

5.15.1 Haringey SCB's training subgroup is tasked with addressing the training needs of the partnership and is generally well-attended by most members, who are motivated and reflective partners and are deemed at the appropriate level of responsibility

within their organisations to make the decisions required by the subgroup. New members invited were representatives from Early Help and Public Health.

5.15.2 Haringey's large and complex population and level of need is reflected in the breadth of the Haringey SCB Training Programme. Compared to our six neighbouring boroughs, Haringey SCB delivered a broader and more plentiful training offer in 2014-15. Our offer is increasing whilst at the same time value for money is increasing as the cost of each session decreases.




5.15.3 In 2014-15, the LSCB multi-agency training team delivered 19 distinct training courses over 35 sessions, and 787 training places were offered to workers across the agencies, a similar number to the year before. Mean attendance figures have improved in the past couple of years, making courses increasingly better value for money.

5.15.4 The largest group attending was CYPS (176), followed closely by early years settings (161) and schools (149). We have seen a drop in other agencies' attendance over previous years.

5.15.5 Three 'bite-sized' learning lunches were also offered over the course of the year – open to all.

5.15.6 The LSCB ran an SCR Poster campaign in early 2015. Each poster represents a key lesson from serious case reviews across the country, and was accompanied by an information sheet. The issues covered were:

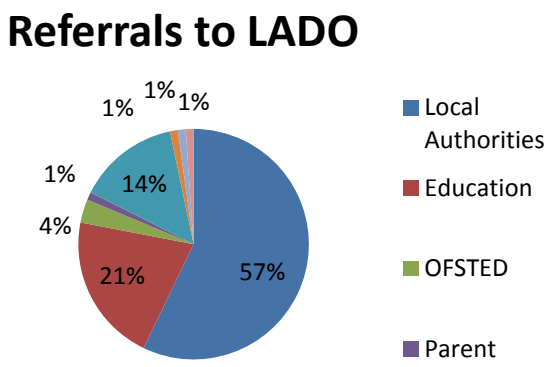
- Anti-social behaviour
- Mobile families
- Disabled children
- Neglect
- Domestic abuse
- Professional parents
- Information sharing
- English as an additional language
- Voice of the child
- Young people's mental health

## 5.16 Local Authority Designated Officer (LADO)Report

5.16.1 The LADO is responsible for the management and oversight of individual cases where allegations and concerns about the abuse and maltreatment of children have been made in respect of individuals working with children in an employed or voluntary capacity within the borough.

5.16.2 In 2014-15 there were 90 referrals to the LADO of which 63 resulted in strategy meetings, meeting the threshold for significant harm.

5.16.3 The LADO referrals for 2014 – 2015 originated from a broad range of partners with the majority coming from the education sector (schools and colleges). This is a trend that is consistent across other local authorities. Education is the biggest employment sector working with children and young people and generally speaking schools and colleges are familiar with the LADO role and function and use the service well. LADO referrals from police and health about their staff are relatively low, although this has increased from last year where there were no referrals about staff from either sector.




5.16.3 Awareness raising continues to be a challenge across the safeguarding partnership, also identified in the Council's Ofsted inspection (2014) as an area for improvement. In 2015/16 part of the awareness raising work will aim to increase identification, and improve and streamline the referral pathway, making it easier for partners to know when and how to contact the LADO.

5.16.4 Over half of all strategy meetings were convened to consider allegations of physical abuse by staff. Allegations of sexual abuse and neglect were next frequent. The number of substantiated referrals is significantly lower (6%) than in the previous reporting period where 56% of allegations were substantiated. A qualitative audit of the outcomes from 2014 – 15 has been scheduled to examine the evidence and identify any learning.

5.16.5 The successful recruitment of a new and experienced permanent LADO and the necessary ground work that was completed in the 2014 – 2015 year means that the resulting 2015 – 2016 LADO programme includes increased activity to raise awareness and promote the visibility of the LADO role and function within all employment sectors.

## 6 Board effectiveness and challenge

6.1 The Board has introduced a new system of annual appraisal of Board members. This provides a mechanism for monitoring the contribution of individuals, and allows for constructive feedback on the way in which the board is operating. Board members consider that it operates effectively overall, and demonstrates improvements in the efficiency and effectiveness of its reports, its meetings and its follow-up on decisions. Some suggestions are being considered for streamlining the work of some groups. We are exploring the potential for combining some of the work of the LSCB with the Safeguarding Adults Board, in order to improve the integration of our safeguarding work across the age ranges, and to increase the effectiveness of our work. We are also seeking to strengthen the quality and range of joint working across borough boundaries.

6.2 Board members also report positively upon the impact of the work of the Board on the practice and policies within their own agencies, citing numerous examples within the appraisal process of where policies have been changed and improves as a result of Board discussions. Feedback on the quality and range of the training offered by the Board continues to remain high.

6.3 The Chair provides regular challenge to individual agencies: such challenges are often made in accordance with the Board's agreed approach of identifying and praising positive practice and seeking to avoid publicly "naming and shaming" failures in practice. Examples of such challenge, include discussions with key partners regarding high levels of interim or temporary staff; discussions with one hospital trust regarding their A&E policy regarding young people; and discussions with some schools regarding the quality of their polices on SRE. On the Health and Well-Being Board, the Chair has played an active role in supporting the Board in challenging NHS England regarding the chronic shortages of primary care access in the poorest part of the Borough. The Chair has also actively engaged in the development of the Health and Well-Being Strategy.

6.4 Overall, the Board considers itself to be broadly effective, providing challenge and scrutiny across partners, and actively encouraging partnership working. The Board has more to do to engage the voices of children and young people effectively within its work. It has more to do to improve the collation and analysis of performance data across partners.

# 7 Quality and Performance

7.1 Our Performance and Practice Outcomes Sub-group takes the lead on our performance, audit and quality assurance work to monitor and scrutinise the effectiveness of multi-agency child protection and safeguarding work across the borough. Our Training, Learning and Development Sub-group works to support practice development and improvement.

## 7.2 Section 11 Audit

Section 11 (4) of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State, and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children.

7.2.1 One way in which the Board discharges this function is by carrying out a Section 11 Audit on a biennial basis. The audit enables the Board to identify gaps, strengths and weaknesses in safeguarding practice as well as identifying areas for improvement.

7.2.2 The audit was sent to a total of 42 agencies /schools across the borough and resulted in 31 returns within the original or revised time-scales. These included 9 (of 9) statutory services, 6 (of 12) secondary schools, 13 (of 15) primary schools, 3 (of 3) special schools and 0 (of 3) Children's Centres.

7.2.3 In addition to the 8 standards set out in the statutory guidance and the Safe Network Core Standards produced by the NSPCC, the Board included 5 other strategic priorities in the audit to help it achieve a better understanding of how services were responding. These were:

Working with children and young people affected by gangs

- Child Sexual Exploitation
- Female Genital Mutilation
- Domestic Violence
- Prevention of extremism/radicalisation

7.2.4 The audit provided assurance to the Board that agencies had policies and practices in place in order to keep children and young people safe. Some of the issues identified through the audit:

- Organisational change and budgetary pressures are affecting nearly all statutory agencies and the LSCB needs to be vigilant in seeking assurances from all partner agencies about the robustness of the processes they are putting in place to keep children safe.
- Recruitment and retention of staff remains a challenge in some areas
- Incorporating the views of children and young people into service planning and development needs to be strengthened

- Access to multi-agency training needs to be simplified
- Schools are confident that they are aware of and discharging their safeguarding duties
- Nearly all schools identified neglect, physical and emotional, as the most pervasive and challenging issue they faced and in light of SCR findings schools are acutely aware of not letting their tolerance levels in relation to neglect drop
- All schools have in place robust systems for monitoring children considered vulnerable/in need and to enable them to spot patterns across the school population.
- Domestic Violence remains a prevalent issue.
- All schools are working hard and creatively to respond to the rapidly changing challenges of social media.
- All secondary and primary schools have developed a range of in house provision - to manage a wide range of issues themselves before requiring additional support.
- A recurring theme was the need to cascade information or training to all staff
- Gang membership/influence was the most prevalent issue already affecting schools either directly or through its impact on younger siblings and families.
- Some schools have had direct experience of CSE and have developed strategies and services to identify and support those who may be vulnerable. All were extremely positive about the increased profile being given to CSE in the borough and saw themselves as playing a key role in the newly adopted LSCB CSE strategy.
- FGM was the issue to which responses by both schools and agencies was most underdeveloped.

**7.3** The Board is committed to securing sustained improvement in multi-agency safeguarding performance: it has a key role to play in scrutinising and challenging the performance of all partner agencies in keeping children safe. There is a commitment from across the partnership to fully understand the needs of children in Haringey and to plan in order to meet these needs. During this year the Board started work through a Task & Finish Group of the Quality Assurance Sub-group on developing an integrated multi-agency performance dashboard. The work to refine and finalise the dashboard will continue in 2015-16, building on the learning. The data we can provide for 2014-15 establishes a good baseline and moving forward it is important to the Board to ensure that we are able to make year on year comparisons of safeguarding in Haringey, and aligning with our priorities.

7.4 Haringey Council has focused its corporate strategy on three overarching outcomes which it works with partners across the borough to achieve. Under Outcome 1 Outstanding for All there are six objectives related directly to the lives of children and young people across the borough including:
*All children will be safeguarded from abuse*

7.5 Over the period there has been significant transformational work underway and a number of areas reported as performing well across the outcome:

- 86% of primary and 100% of secondary schools are judged as Good or Outstanding.
- Attainment at level 3 (A level) continues to rise with 63% of Haringey's 19 year olds achieving a qualification, a 4 percentage point increase from 2013, now in line with the average for London.
- 665 (78%) of families in phase one of Haringey's Families First Programme achieved an improvement in one or more outcome area (crime/anti-social behaviour, education, employment). Haringey has been put forward as early adopters of the expanded programme with 551 families eligible for phase 2 of the programme.
- There were 54 adoptions and special guardianship orders (SGO) in 2014/15 with an increase in special guardianship orders in Quarter 4 bringing the total to 32 for the year. The target was exceeded and permanency was secured for 22% of children that ceased to be looked after.

7.6 Targeted improvement work is underway in the following areas:

- The level of young people who are Not in Education, Employment or Training (NEETs), and young people whose status is Not Known, has been above the London average since the 2014 seasonal summer peak and at 4.5% the proportion of NEETs is higher than our statistical neighbours. A Young People's Strategy and a set of delivery options is being developed which will address delivery challenges in this area.
- A programme of work around permanency is underway including the development of a "fostering to adopt" scheme and concurrent planning with family finding methods deployed for children with more challenging needs. Haringey's current average of 589 days taken for looked after children to be placed for adoption for those children adopted in the period is 102 days above the national threshold of 487 days for 2012/15 but an improvement on the 778 days in 2013/14 and compares favourably with England's three year rolling average of 628 days.

### *7.7 Children in Need of Safeguarding and Support*

Through the year Children's Social Care report an increased pressure across the service with contacts increasing by 21% compared with the previous year, and a significant increase in the number of referrals at 2,262 and consequently assessments at 2,410.

7.7.1 Consistent with the picture nationally, the Police were the main source of referrals to CSC in 2014-15, followed by schools and health services respectively. See *Table 1 at Appendix E* for referral sources.

7.7.2 Of the 2,410 Child and Family Assessments completed last year, 82% were completed within 45 working days[3] against a target of 85%, although an

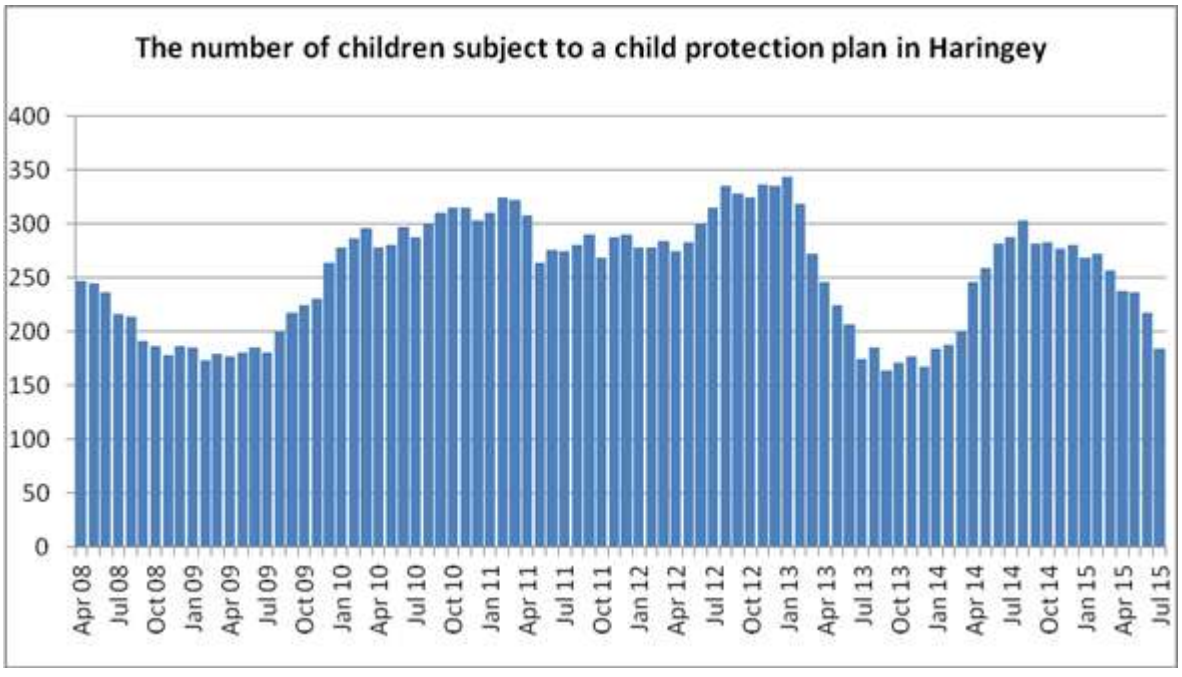
[3] Statutory guidance 'Working Together to Safeguard Children' was revised in 2013 giving local authorities more flexibility when assessing children. Previously, local authorities carried out an initial assessment within 10 working days and (where needed) a more in-depth core assessment within 35

improvement from the 76% achieved last year. Daily reporting to service managers and weekly performance meetings continue to play a role in tracking the timely completion of assessments. The factors identified through assessments are varied in Haringey, the most common being domestic violence, identified in just over a third of cases; the second most common is parental mental health, which was identified in one in ten cases. Abuse or neglect was identified in one in four assessed cases with physical abuse being the most common factor. See Table 2 at *Appendix E* for more information.

***7.7.3*** There were 2,385 Children in Need (CiN) – a significant increase on last year's end of year figure of 1280.

7.7.4 The number of children subject to a child protection plan (CPP) in Haringey in March 2015 was 257. This represents a 28% increase in the number of children subject to a child protection plan since March 2014, a rate of 44 per 10,000 children aged 0-17. This is higher than we reported last year (201 or 35 per 10,000) but is now more aligned with our statistical neighbours (257 or 42 per 10,000 in March 2014). In 2014/15 **2%** of all children subject to CPPs (**248**) were children with disabilities. Since 2009 the national trend for CPPs has been upwards but the picture in Haringey has been more variable *(Chart 1),*

*Chart 1*



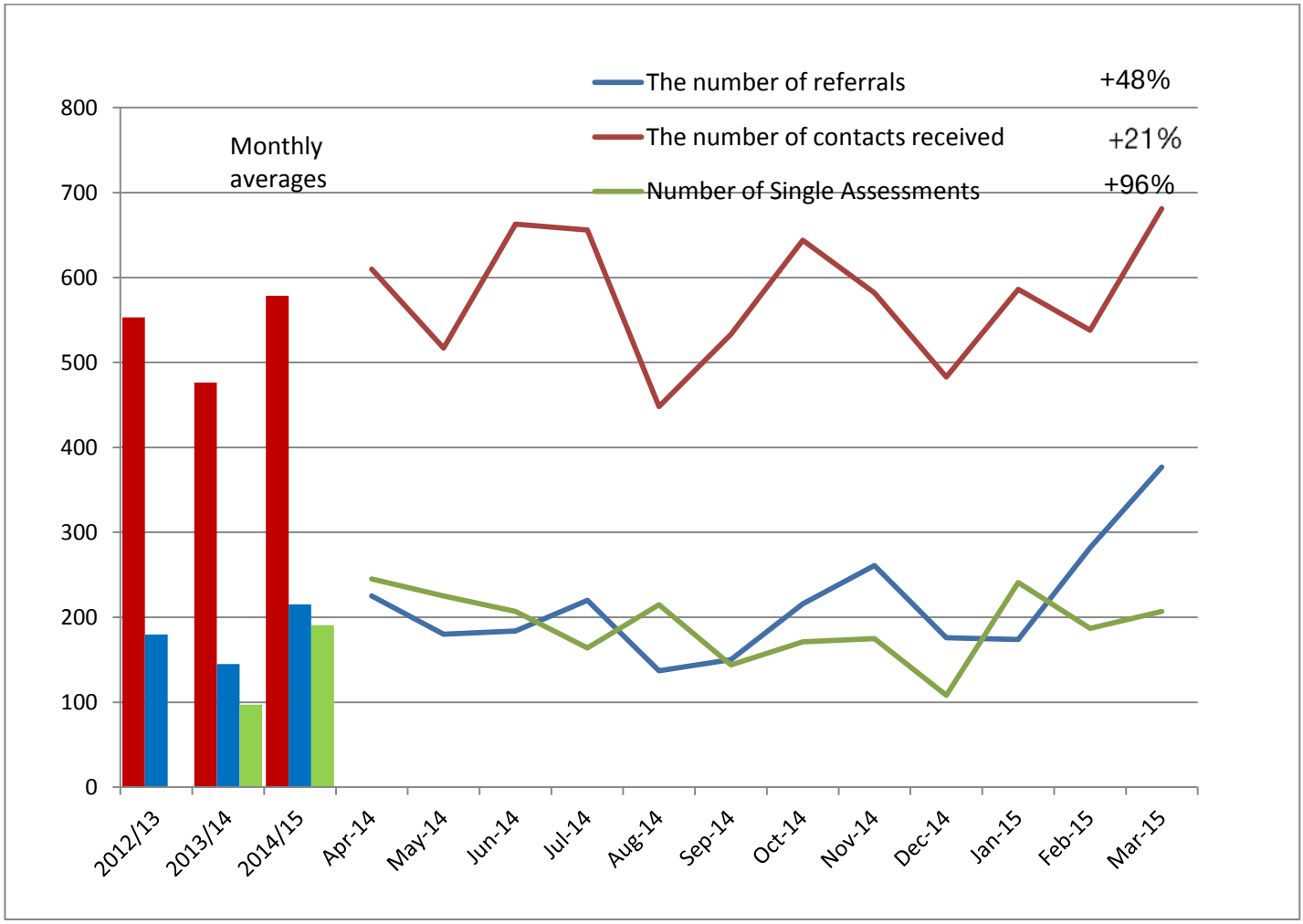

7.7.5 The reason for some significant increase in the numbers of contacts, referrals, assessments, CP plans and Children in Need is not clear but it does concur with a

working days. Local authorities now have the flexibility to carry out a single continuous assessment within 45 working days.

broader national upward trend as reported by the Department for Education[4]. Anecdotally we are aware that an increase in media attention on child protection such as we have seen over this period, can lead to increased referrals. A range of other factors also have an impact, including the quality of referrals, screening and assessment processes and the quality of decisions. One useful measure is that the number of children starting a protection plan as a proportion of referrals has remained around 8% or 9% for the last four years. Through 2015/16 arrangements for single point of contact, referrals, screening and assessment are being strengthened and re-launched, including the Multi-Agency Safeguarding Hub (MASH); and its governance through the Board.

*Table 2*

**Change in contacts, referrals and assessments in Children's Social Care since 2013/14**




[4] https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

7.7.6 Haringey has set a minimum requirement of home visits to children subject to child protection plans of every four weeks[5]. In 2014/15 84% of children were visited within this timeframe, down on the reported 95% last year. This is a matter of concern as it suggests that children at risk are not being seen in a timely way. Weekly monitoring highlights children with outstanding visits and there is a focus on proper recording. Visits to Children in Need at 73% are also below levels achieved in 2013/14 (93%)

7.7.7 21.5% (84) of children were subject to a child protection plan for a second or subsequent time, an increase from the 12.5% in 2013/14 and above target and statistical neighbour average of 14%. High levels of subsequent plans may suggest that the professionals responsible for the child's welfare are not intervening effectively either to bring about the required changes in the child's family situation, or to make alternative plans for the child's long term care. A quality assurance review of all cases which have ceased to be subject to plan was scheduled for early May and will report on the impact and outcome for these children.

### *7.8 Looked After Children*

451 children were in care on the last day of March 2015 or 77 per 10,000 population, including 29 unaccompanied asylum seeker children. This equates to a 10.6% reduction since March 2014, and although this closes the gap with our statistical neighbour rate (70), Haringey remains above the national average rate of 60 per 10,000 population.

7.8.1 Indicators around stability of placements for looked after children remain in line with statistical neighbours and targets. In 2014/15 7.5% of children had three or more placement moves; 77 children or 18% were placed 20 miles or more from Haringey at the end of March 2015, slightly more than the 16% target but on an improving trajectory.

7.8.2 In 2014/15, 92% (326 out of 355 children) of LAC children had an up to date health assessment, an improvement from the 88% reported last year, now in line with the 2013/14 London average and above the England position of 88%.

7.8.2 91% of LAC children had an up to date dental visit as at 31 March 2015, a significant improvement from the 71% achieved the previous year and exceeding the 2013/14 London average of 88% and national position of 84%.

7.8.3 78% of Children in Care visits were recorded as completed in the relevant timescales in this period, May. Performance in this area has dipped from levels of 95% achieved in previous years however it is reported that this is predominantly a system recording issue and that visits are happening in a timely way.

[5] The London Child Protection Procedures target for minimum standards on home visiting of children with a Child Protection Plan is 6 weekly

7.8.4 Performance on care leavers in suitable accommodation and in education, employment and training is below levels achieved last year albeit that the variation between Haringey and published national performance levels for 2013/14 in these areas is not significant. However benchmarking data around care leavers in education, employment and training shows that Haringey's position of 40% is below average for London in 2014/15 (57%).

7.8.5 Haringey's performance for care leavers aged 19-21 in higher education (16%) compares very favourably with the national position of 6%. An action plan to prioritise completion of Personal Education Plans (PEPs) is being implemented in 2015/16 and early signs are that this is improving results.

7.8.6 Up to date Care Planning remains a challenge with staffing pressures having an impact on both the consistency and timely completion of plans.

7.8.7 The average care proceedings duration in 2014/15 was 34 weeks (including cases commenced in 2013/14) significantly longer than the statutory 26 weeks time allowance for  and higher than the latest national comparator data which shows an average case duration of 30 weeks.

7.8.7 8.4% of looked after children (aged 10 and over) were convicted or subject to a final warning during the year 2014/15, a small increase on our 2013/14 figure and higher than the latest published England average rate of 5.6%.

7.8.8 The proportion of looked after children placed 20 miles or more from Haringey reduced to 77 children or 18% in Quarter 4. Some of this improvement is attributable to an increase in carers in the borough and the introduction of an Edge of Care panel to review all placements for children coming into care but some will be as a result of the overall reduction in the number of looked after children.

7.8.9 CSC report that a review of Looked After Children is underway to reshape the current approach to placements, sufficiency and to look at current policy and how this might be improved to better meet the needs of our young people.

### *7.9 Private Fostering*

During 2014-15 there were 13 new referrals to social care for potential private fostering arrangements. This is slightly above the England average of 12 (2011-12). 12 cases have closed since April 2014

7.9.1 As at the end of March 2015, there are 14 children and young people open to the private fostering team.

7.9.2 A private fostering arrangement is one that is made privately for the care of a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more. Private foster carers may be from the extended family, such as a cousin or great aunt; a friend of the family, the parent of a friend of the child, or someone previously unknown to the child's family who is willing to privately foster a child.

7.9.3 There are an estimated 10,000 children living in private fostering arrangements in England and Wales, but last year only just over 3,250 were reported as being cared for and accommodated in private fostering arrangements to local authorities[6]. While most of these children will be safe, others may be at risk of abuse and neglect at the hands of their private foster carers. (www.privatefostering.org.uk).

## 7.10 Missing Children and Young People

In 2014/15 Children's Social Care reported 47 looked after children going missing (95 episodes), an increase from 36 children reported the previous year. The cases of any missing children in care, or absent without authority, are reviewed on a weekly basis by the lead member.

7.10.1 During 2014-15, police data reports 582 episodes of children reported missing from home.

7.10.2 A key indicator for safeguarding is school attendance and the LSCB seeks to have oversight of the degree of absenteeism and missing from school referrals. Absence data is owned by schools, and school data is received via 3 yearly census returns. Full year attendance data is available in late autumn. We reported last year that average attendance at Haringey's schools compared well with the national average; persistent absence in Haringey's primary schools was higher (3.2%, compared with the national average of 2.7%); whilst in Haringey's secondary schools it was lower (5.2% compared with the national average of 6.5%). There were 512 missing from school referrals in 2014/15 including: 151 recorded missing from school; 150 poor school attendance referrals and 212 with no identified school place

7.10.3 There remain some issues around reconciling data between CSC and the police which are being looked at. A task and finish group is working on bringing together multi-agency datasets on children missing from home, care and education for matching and learning so that analysis and activity can be reported to the LSCB. A Haringey Runaway & Missing from Home & Care Protocol is being agreed by all agencies and this will strengthen our approach to supporting children who run away or go missing in the area.

## 7.11 Child Sexual Exploitation

In 2014-15 a total of 72 CSE referrals had been received by Children's Social Care; of these, 36 young people had been considered at MASE Meetings throughout the year. One was considered to be Category 3 – habitually subject to sexual exploitation, and 9 were considered to be in category 2 – being targeted for CSE. As noted previously, the profile of these young people suggests the activity has been

[6] https://www.gov.uk/government/statistics/notifications-of-private-fostering-arrangements-in-england-2015

largely gang-related, with the victims and the alleged perpetrators coming from mixed backgrounds.

### 7.12 Female Genital Mutilation (FGM)

Within Haringey, it is estimated that 2,772 girls have been born to women from countries where FGM is habitual between 2005 and 2013; of these, it is estimated that 1,187 were born to women with FGM, a rate of 6% of all girl births. Haringey is one of the boroughs with the highest perceived risk of FGM being administered to girls.

### 7.13 Gangs

Within the 11 active gangs operating within Haringey, there are an estimated 116 gang members; the very large majority of these are aged over 17

## 8 How safe are children & young people here?

What can be said in summary about how safe children and young people are in Haringey?

8.1 It is never possible to say categorically that all children are safe. External inspections suggest that our services across Haringey are at least as good as in most areas, not insignificant considering the very high rates of deprivation in parts of Haringey. Haringey is a complex urban authority, facing reductions in budgets in all its public services, and enduring much higher than average effects of the cuts in welfare benefits. The population within Haringey is under severe pressure.

8.2 We can be reassured that the quality of schools and education in Haringey is largely very high, and this provides a significant source of protection to children and young people. Some public health indicators – such as the comparatively low number of children attending hospital following accidents, give further assurance, though the data for obesity and teenage pregnancy continue to give concern.

8.3 The last year has seen a significant increase in the number of referrals to Children's Social Care, increases in the numbers of Children in Need, and increases in the number of children on Child Protection Plans (CPPs). Some of these rises are in line with national data, but we need to be vigilant to see whether services can respond effectively to this increase in demand. We have seen a reduction in the number of children on CPPs who receive the required regular visits, for example. Outcomes for children in care continue to be broadly satisfactory, though we have seen a reduction in some positive indicators.

8.4 We have improved the way in which we collectively tackle some of the biggest risks to children and young people, such as Child Sexual Exploitation and Gang membership and established the necessary focus on Children who Run Away or Go Missing from Home, Care and Education.

8.5 The Council and partners have invested in expanding Early Help services, to seek to meet the needs of children and families earlier. So far this process appears to be working well, though it will be vital that partners remain alert to services continue to respond more intensely where required.

8.6 2015-16 heralds many changes in safeguarding regarding Haringey's approach and response to safeguarding concerns: changes to the Early Help offer, the new Thresholds will be embedded in practice, MASH is being reviewed, the new 'front door' to children's social care will be launched, 'Signs of Safety' will be adopted by children's social care, impacting assessment and conferencing, and this will need to be understood by the partnership's frontline services

8.7 Our partnership is strong, but the challenges ahead require us to shift up another gear in our partnership working in the years ahead.

## *Appendix A :* Role, scope 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.

### Function

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCB:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- training of persons who work with children or in services affecting the safety and welfare of children;
- recruitment and supervision of persons who work with children;
- investigation of allegations concerning persons who work with children;
- safety and welfare of children who are privately fostered;
- cooperation with neighbouring children's services authorities and their Board partners;
- communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
- monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned

*Appendix B:* *Haringey Local Safeguarding Children Board Priorities and 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. The actions also take into account areas of improvement as identified in the May 2014 Ofsted review of the LSCB.

Priority High (H) Medium (M) Low (L)
Red (R )Action not started or behind schedule; Amber (A) Action in hand; Green (G) Action completed

| | |
|---|---|
| ❖ | ❖ **PRIORITY ONE Gangs**<br>❖ a) Strengthening the connections between work around 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 |

| P1 | Action | Lead group/person | By When | Evidence required | Progress/last updated | priority | RAG |
|---|---|---|---|---|---|---|---|
| 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 | CSE sub group | March 2015 | Work plans of existing groups<br>Statistical information from multi-agency partners<br>Risk assessments | The CSE Sub-group is now overseeing this work and has a clear governance and accountability structure and agreed strategy, which includes connections and routes into the VAWG, Gang Action Group Strategy and oversight of our work on Missing Children & Young People. The workflow into MASE and MASH is developing. There is a clear action plan and agreed | H | Green |

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|---|---|---|---|---|---|---|---|
| | **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 | | accountabilities and reporting into the Board.<br><br>Completed. | | |
| 2 | Complete Missing Children strategy, emphasising the links to gangs<br><br>**OFSTED 4 -** Ensure that the Board receives an annual report on children missing from home, missing from care and missing from | Vulnerable Children's Group | March2015<br>Date revised to July 2015<br><br>Nov 2014 | All agency local strategies to inform the multi-agency oversight by the LSCB | Missing Children Task & Finish Group is reporting in July 2015 and work is still to be done to develop the statutory Protocol.<br><br>Narrative included in LSCB Annual Report published Dec 2014. Work is underway with the T&F Group around reporting and | H | Amber |

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| | 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 | | | | data and it is hoped that this will be available for the Annual Report 2014/15 | | |
| 3 | Complete and implement CSE strategy<br>**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. | CSE Sub Group | December 2014 | Clear evidence of multi-agency systems | Strategy approved and being implemented via the CSE Sub-group | H | Green |
| 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 | The Disabled Children's Sub-group undertook the review with the Gang Action Group and reported to | M | Green |

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| | | | | findings with appropriate strategic leads to assure that the needs of disabled children affected by gangs is appropriate responded to. | the Board in May - the findings to be fed into the Gang Action Group Strategy in June. Five key areas were requested to be looked at in more detail for a further report to the Board in autumn 2015<br>*Check progress* | | |
| 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. | Model dataset is still being worked on with a need to iron out some particular issues for individual agencies. The end of year data will be included in the Annual Report 14/15 | M | Amber |
| 6 | Review the impact of the Early Help offer on future gangs engagement | Vulnerable Children's group / Best practice group | March 2015<br>Date revised to November 2015 | The findings will be presented to the LSCB and included in the annual report 14/15. | This action is being looked at within the process of monitoring the Early Help Strategy and the Board manager is discussing with GaG lead about the best way to take forward and will report back in November | M | Amber |

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| | | | | | 2015 | | |
| 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. | S11 Audit was completed and presented to the Board in March 2015 with questions regarding this priority summarised in the report. This will be ongoing moving forward | | Green |

❖ ❖ 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.
❖ The role of the LSCB in relation to the Early Help offer is to seek assurance that the introduction of the Early Help Offer does not inadvertently introduce new safeguarding risks.

| P2 | Action | Lead group/person | By When | Evidence required | Progress/last updated | | RAG |
|---|---|---|---|---|---|---|---|
| 1 | Consider the draft Early Help Strategy with particular focus on the safeguarding aspects of the strategy | LSCB Chair | November board meeting | The draft report | Happened at Board in November 2014 and is coming back to Board in July 2015 | M | GREEN |
| 2 | Request reports to the full Board initially every 6 months from the Early | LSCB Chair | First report to our May 2015 Board. | report | On track. First monitoring report due to board in July 2015. | L | Amber |

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| | Help Partnership Board, specifically seeking to answer the question as to whether the processes of step up and down are being undertaken safely and appropriately | | | | Specific issue relating to step down processes included within audit programme. | | |
| 3 | Review the training the LSCB currently undertakes, in order to consider whether any adjustments are required in the light of the changes. | LSCB Training Officer | May 15 following first report | | New Head of Early Help, Gareth Morgan is now a member of Training, Learning & Development Sub-group and the work is being progressed to ensure our courses reflect the EH offer. Meeting in June considered working together on a series of events. | L | Amber |
| 4 | 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. | S11 Audit was completed and presented to the Board in March 2015 with questions regarding this priority summarised in the report. This will be ongoing moving | M | Amber |

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| | | | | | forward | | |
| ❖ | ❖ PRIORITY THREE – Neglect<br>❖ Improving effectiveness of all agencies in recognising and responding to neglect | | | | | | |
| P3 | **Action** | **Lead group/person** | **By When** | **Evidence** | | | |
| 1 | Sign off Neglect Strategy | Performance & Best Practice Sub-group | July 2014 | The development and monitoring of the neglect strategy will be included in the work plan of the Performance and Practice Outcomes Sub-group. | This action was amended; the key element of the strategy was agreed to be the revised process of compiling chronologies which has now moved through to the MASH Board. Reference to strategy needs to be reviewed fully by the Board | | Green |
| 2 | Finalise delivery of the strategy | Performance & Best Practice Sub-group | November | | Neglect issue on agenda for September 2015 LSCB and agreed use of chronologies | M | Amber |
| 3 | Oversee delivery of Neglect Strategy | Performance & Best Practice Sub-group | March 2016 | | Check in March 2016 | L | Amber |
| 4 | Make this a feature of our Section 11 review | Quality Assurance Group | December 2014 | The S11 audit will have neglect as a themed | S11 Audit was completed and presented to the | M | Amber |

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|---|---|---|---|---|---|---|---|
| | | | | area to assess agencies safeguarding arrangements. | Board in March 2015 with questions regarding this priority summarised in the report. This will be ongoing moving forward | | |
| ❖ | ❖ PRIORITY FOUR - **Promoting good practice**<br>❖ Shift the overall balance of our activities more towards identifying and promoting elements of good practice. | | | | | | |
| P4 | **Action** | **Lead group/person** | **By When** | **Evidence** | | | |
| 1 | Create an annual Good practice in Safeguarding Award – perhaps as part of a wider Haringey Awards scheme; invite nominations for examples of effective multi-agency practice, create positive publicity around the awards | Chair/Board Manager | October 2015 | The LSCB will include the details of the award winners in their 2015/16 annual report. | Issues reviewed at the September 2014 best practice sub group and some criteria discussed. BM is pursuing funding options | L | Amber |
| 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, | Chair/Training Officer | November 2014 | Local and national safeguarding news will be available to all partners via the LSCB and their internal communications. | Three examples of good practice went into the Jan/Feb 2015 newsletter and next steps are to interview teams/individuals and include in the next newsletter. As of 18 March three responses | L | Amber |

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|---|---|---|---|---|---|---|---|
| | CCG newsletter etc). | | | | have been received for nominations but Training Officer feels that the approach needs to be reviewed | | |
| 3 | Design and deliver at least one specific campaign, in partnership with local agencies.<br><br>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. | SCR poster campaign was welcomed across the partnership.<br><br>CSE Safeguarding Campaign throughout March and beyond including learning lunches.<br><br>Full programme not yet agreed but should include the views and ideas of children and young people. | L | Amber |
| 4 | Review and update branding of LSCB. | Chair/Board Manager | March 2015 | The LSCB will re-launch its vision for safeguarding children in Haringey. | Work started on this with website refresh but needs development. | L | Amber |
| 5 | Develop a new vision for LSCB and 3-5 year | Chair/Board | July 2015 | Partners and the public will be | This is an ambitious action and will be | L | Amber |

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| | strategy | | | clear of the LSCB's ambitions for ensuring safeguarding arrangements in the borough | considered in light of the Board Development Day | | |
| 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. | Increased synergy between the boards in in the process of being formalised and will address this point in due course. A new SAB Chair is coming in to role in July | L | Amber |
| 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. | Primary and Secondary HT now members of the Board and attending. PE has addressed Primary and Secondary HT meetings. Key is how to formalise the wider engagement and also how to account for school contribution to the LSCB budget including private providers | M | Amber |

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| ❖ | ❖ **PRIORITY FIVE - Engaging the voices of children and young people**<br>❖ 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 | | | | | | |
| 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 | Work is now in place to develop this priority and increased focus will be given to this by the Business Manager to make the existing activity more meaningful. There is progress in relation to the Special School Council communication through the Disabled Children's Sub-group which could provide a good model | H | Amber |
| 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. | Delayed due to staffing issues but now being picked up by the Training sub group with a delivery date scheduled for November 2015 | M | Amber |

## *Appendix C:* Haringey LSCB Members attendance 2014-15

- representative attended on behalf of the member *post name changed

| Organisation | Job Title | Date of Meetings | | | | | | No: of meetings member attended/was represented |
|---|---|---|---|---|---|---|---|---|
| | | 28 May 14 | 16 July 14 | 30 Sept 14 | Nov 14 | 28 Jan 15 | 25 March 15 | |
| Independent | Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 / 6 |
| Independent | Lay Member | ✓ | ✓ | - | ✓ | ✓ | - | 5/6 |
| CAFCASS | Senior Service Manager | - | ✓ | - | - | - | ✓ | 2/6 |
| Local Authority | Deputy CEO | ✓ | - | ✓ | - | ✓ | ✓ | 4/6 |
| | Director of Children's Services, Safeguarding | ✓ | ✓ | ● | ✓ | ✓ | ✓ | 6/6 |
| | *Assistant Director, QA & Safeguarding | ✓ | - | ✓ | ✓ | ✓ | - | 5/6 |
| | Deputy Head of Service, Special Educational Needs and Disabilities | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |
| Health | Executive Nurse & Director of Quality and integrated governance (NHS Haringey CCG) | ● | - | - | - | ✓ | - | 2/6 |
| | Assistant Director for Safeguarding & Designated Nurse for CP (NHS Haringey CCG) | ● | ✓ | - | ✓ | ✓ | ✓ | 5/6 |
| | Consultant Paediatrician, Designated Doctor (Haringey CCG) | ✓ | ✓ | ● | ● | ✓ | ✓ | 6/6 |
| | Named GP NHS England London | ✓ | ✓ | - | ✓ | ✓ | ✓ | 5/6 |
| | Director of Nursing NHS England London) | ✓ | ✓ | - | - | - | - | 2/6 |
| | Deputy Director of Nursing (NMUH) | ● | ● | - | ✓ | - | - | 3/6 |
| | *Assistant Director, Universal and Safeguarding Children's Services (Whittington) | | - | ✓ | ✓ | ✓ | ✓ | 4/6 |
| | Director of Nursing & Exec Lead for Safeguarding Children (CAMHS- BEH-MHS)) | ● | ● | ✓ | - | - | ● | 4/6 |
| | Named Doctor for Child Protection (BEH-MHS) | - | - | ✓ | - | - | ● | 2/6 |
| Local Authority | Drug and Alcohol Partnership Manager | | | | | | | |
| Public Health | Assistant Director | - | ✓ | ✓ | ● | - | ✓ | 4/6 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Housing | Head of Housing Support and Options | ✓ | ✓ | - | ✓ | ✓ | - | 4/6 |
| Legal Services | Assistant Head of Legal Services; Social Care) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |
| Police | Borough Commander | ✓ | ✓ | - | ✓ | ✓ | ● | 6/6 |
| | DI, CAIT | ● | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |
| | DCI, CAIT | ✓ | ✓ | ✓ | ● | ✓ | ● | 6/6 |
| Probation | ACO (Haringey Probation Service) | - | ✓ | ✓ | - | ✓ | ● | 4/6 |
| | ACO (Probation Community Rehabilitation Company) | - | ✓ | ✓ | ● | - | ✓ | 4/6 |
| Voluntary | HAVCO | | | | | ✓ | ✓ | 2/2 |
| Lead Member | Councillor | ✓ | ✓ | ✓ | ✓ | ✓ | - | 5/6 |
| Primary School | Head Teacher | - | ✓ | - | ✓ | ✓ | ✓ | 4/6 |
| Secondary School | Head Teacher | - | - | - | ✓ | - | - | 1/6 |
| London Ambulance Service | Ambulance Operations Manager | ✓ | ● | - | ✓ | - | - | 3/6 |
| Adults Safeguarding | *Strategic Lead, Governance & Business Improvement Servs | - | ✓ | ● | ✓ | ✓ | - | 4/6 |
| YOS | YOS Interim Head of Service | ✓ | ✓ | ✓ | - | ✓ | - | 4/6 |
| LSCB | LSCB Business Manager | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |

## *Appendix D: Haringey Safeguarding Children Board Budget 2014-15*

| HARINGEY LSCB POOLED BUDGET 2014 - 15 | |
|---|---|
| **Contributing Agency** | **Amount** |
| Metropolitan Police | £5,000.00 |
| Haringey Council, CYPS | £151,100.00 |
| Cafcass | £550.00 |
| Probation | £2,000.00 |
| Tottenham Hotspur FC | £2,000.00 |
| North Middlesex Hospital | £5,000.00 |
| Whittington Health | £5,000.00 |
| Barnet, Enfield & Haringey MHT | £5,000.00 |
| Haringey CCG | £5,000.00 |
| **Sub Total** | **£180,650.00** |
| Budget carry forward 2013 – 14 | £37,000.00 |
| Enfield LSCB (SCR CH) | £11,785.15 |
| **Grand Total** | **£229,435.15** |

2.2 The budget commitments for 2014 – 15 are outlined below:

| Item | Budget allocation | Variance |
|---|---|---|
| Salaries | £172,200 | £14,350 |
| Training | £11,300 | £942 |
| Hire of premises | £8,600 | £717 |
| Travel | £1,400 | £117 |
| Catering | £2,200 | £183 |
| Stationery | £9,200 | £767 |
| Consultant fees | £39,900 | £3,325 |
| Project management | £20,800 | £1,733 |
| Staff subsistence | £800 | £67 |
| **Total** | **£227,100** | **£18,925** |

## Appendix E: Referrals to Children's Social Care

*Table 1*

| Source of Referral to Children's Social Care | Number of Referrals |
|---|---|
| Individual – family member/relative/carer | 40 |
| Individual – acquaintance | 17 |
| Individual – self | 76 |
| Individual – other | 9 |
| Schools | 385 |
| Education services | 0 |
| Health services - GP | 50 |
| Health services – health visitor | 56 |
| Health services – school nurse | 6 |
| Health services – other primary health services | 234 |
| Health services – A&E | 53 |
| Health services – other | 0 |
| Housing | 20 |
| LA services – social care | 13 |
| LA services – other internal | 130 |
| LA services – external | 172 |
| Police | 735 |
| Other legal agency | 60 |
| Other | 140 |
| Anonymous | 21 |
| Unknown | 45 |
| Total number of referrals | 2262 |

*Table 2*

| Factors Identified at the end of Children's Social Care Assessment | Number of Completed Assessments |
|---|---|
| Alcohol misuse: child | 0 |
| Alcohol misuse: parent/carer | 23 |
| Alcohol misuse: another person | 14 |
| Drug misuse: child | 12 |
| Drug misuse: parent/carer | 42 |
| Drug misuse: another person | 10 |
| Domestic violence: child subject | 81 |
| Domestic violence: parent/carer subject | 457 |
| Domestic violence: another person subject | 126 |
| Mental health: child | 36 |
| Mental health: parent/carer | 239 |
| Mental health: another person | 39 |
| Learning disability: child | 71 |
| Learning disability: parent/carer | 24 |
| Learning disability: another person | 6 |
| Physical disability or illness: child | 49 |
| Physical disability or illness: parent/carer | 48 |
| Physical disability or illness: another person | 10 |
| Young carer | 14 |
| Privately fostered | 13 |
| Unaccompanied Asylum Seeking Child | 16 |
| Missing | 44 |
| Child Sexual Exploitation | 18 |
| Trafficking | 5 |
| Gangs | 17 |
| Socially unacceptable behaviour | 41 |
| Self-harm | 10 |
| Abuse or neglect - neglect | 133 |
| Abuse or neglect - emotional abuse | 108 |
| Abuse or neglect - physical abuse | 273 |
| Abuse or neglect - sexual abuse | 66 |
| Other | 289 |
| No factors identified | 88 |
| Total number of completed assessments | 2410 |

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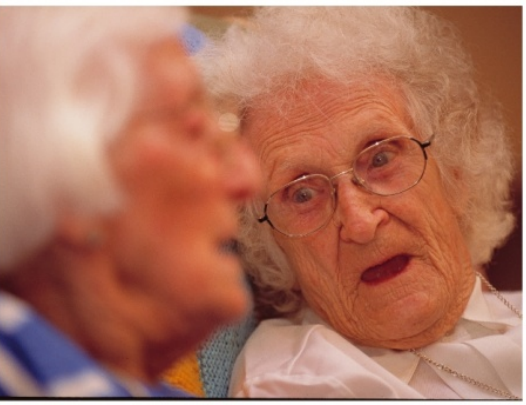
Haringey LONDON



# Haringey Safeguarding Adults Board

# Annual Report 2014/15

Safeguarding Adults Board SAB Haringey
Whittington Health NHS
North Middlesex University Hospital NHS
London Ambulance Service NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
NHS Haringey Clinical Commissioning Group
LFB London Fire Brigade
Metropolitan Police
HAVCO
Homes for Haringey

# What should I do if I think someone is being abused?

**Everybody can help adults to live free from harm and abuse. You play an important part in preventing and identifying neglect and abuse.**

If you or the person you have concerns about, you can make a referral to Adult Social Care via the Integrated Access Team.

- **Tel**: 020 8489 1400
  Opening Hours 9am - 5pm, Monday - Friday
- **Fax**: 020 8489 4900
- **Email**: IAT@haringey.gov.uk
- **Text**: IAT to 80818
  (charged at standard rate depending on provider and subscriber's package)

**Write to:**

**Integrated Access Team**
London Borough of Haringey
2nd Floor, 10 Station Road
Wood Green
London N22 7TR

Alternatively, you can raise your concerns by contacting one of the following:

- Safeguarding Adults Referral and Advice Line (out of hours) **020 8489 0000**
- Community Safety Unit (24 hours) **020 8345 1939**
- Police - Criminal Investigation Department (CID) (evenings and weekends) **020 8345 0832**
- You can complete the Safeguarding Adult Referral Form from our website: http://www.haringey.gov.uk/sites/haringeygovuk/files/safeguarding_alert_form_final.doc

If the danger is immediate, always call the police on:
**999**

# SAFEGUARDING ADULTS IS EVERYONES BUSINESS!

Contents

# 1. FOREWORD

## Message from Beverley Tarka
## Director of Haringey Adult Social Services,
## Chair of Haringey Safeguarding Adults Board 2014/15

As former Chair of the Haringey Safeguarding Adults Board (SAB), I am please to introduce our annual report for 2014/15. The Annual Report seeks to demonstrate how the Haringey SAB is working to improve the lives of people who need our support most. The report is published on behalf of the multi-agency Board and provides partners with an opportunity to celebrate their achievements in 2014-15, identify challenges and plan for the year ahead.

This is my final report on behalf of the Haringey SAB, as I stepped down at the end of the year to make way for an independent chair. The Haringey SAB needs an independent chair to reinvigorate its performance to ensure that all the organisations involved are delivering high quality services and safeguarding adults who are at risk. At the time of writing this report, we have already appointed an independent chair and a joint Business Manager to take the Haringey SAB forward in 2015.

The Care Act came in to force in April 2015. This legislation puts Safeguarding Adults Boards on a strong statutory basis, better equipped both to prevent abuse and to respond when it occurs. In Haringey the Board has spent time this year preparing for the introduction of the Care Act. To do this, the Board has reviewed its membership, statement of principles, terms of reference and are working together with the multi agency partnership to agree our strategic priorities for the next 3 years, to further improve the safeguarding of adults at risk, quality of services, provide more focus on prevention and to roll out the Making Safeguarding Personal (MSP) approach.

Over the past 12 months, the achievements of the Haringey SAB have been significant and reflect the strength of commitment and quality across the partnership. Important milestones have been achieved in each area of the identified work streams reflecting significant efforts on the part of both individuals and organisations across the Board.

Our partnership working continues to strengthen our ability to safeguard vulnerable adults to enable people to live in a place where everyone feels safe and has a good quality of life, this is underpinned by the principles and values outlined in this report.

Over the next 3 years, there is a lot to do. We are committed to continuous improvement and to learning from both national and local experience of safeguarding adults who are at risk. We will continue to work together in a supportive and collaborative way, whilst ensuring that we challenge ourselves and each other in assessing our effectiveness in safeguarding people in Haringey.

I would like to take this opportunity to acknowledge the commitment of all of you including the statutory, independent, and voluntary community sector, who have helped us to achieve all that we have in the last twelve months.

## Message from Dr Adi Cooper,
## Haringey Safeguarding Adults Board Independent Chair 2015/16

I am very pleased to be able to introduce the Annual Report 2014/15, as the new independent chair of the Haringey Safeguarding Adults Board. Having taken on this role, and meeting the partners who are members of the Board, I am impressed by their commitment to the shared principles and values, the work that has been undertaken, and those objectives achieved during this year of transition. With the introduction of the Care Act (2014) in April 2015, my challenge is to make it an ongoing reality and provide leadership to take the Board forward into the next phase. I bring a wealth of experience and knowledge of adult safeguarding policy and practice to Haringey, and I welcome the opportunity to apply what I have learnt in this new role.

I am grateful to Beverley Tarka as the outgoing chair of the Board, for getting the Haringey partnership onto a firm footing. I would also like to thank the Haringey officers who have provided support during the time I have been working with them.

Looking ahead, I am looking forward to strengthening the partnership, and consulting on the draft safeguarding adults strategy, which will provide a framework for the delivery of work in the future. As an independent chair, my role is to provide leadership, and constructive challenge to all, in order that we can best safeguard adults in Haringey at risk of harm or neglect. When intervention is necessary and enquiries are undertaken, we need to ensure that their outcomes are articulated and met wherever possible through a 'making safeguarding personal' approach.

Prevention is critical: raising awareness of safeguarding risks, improving the quality of services and supporting carers can reduce risks of harm and abuse. We also need to learn from what happens when things don't quite work out, from experiences elsewhere in London and England, and particularly where there is good practice. These are some of the themes that will be developed through the strategy, and I welcome the imminent consultation process in order to discuss with the community what local priorities are and how best to take the strategic aims forward together.

# 2. Haringey Safeguarding Adults Board Statement of Principles

In this section:

- Definition of the Haringey SAB Statement of Principles
- Aims of the Statement of Principles

Haringey Safeguarding Adults Board is committed to safeguarding all children, young people and adults at risk that come into contact with our work. We believe that all children, young people and vulnerable adults have an equal right to protection from abuse, regardless of their age, race, religion, gender, ability, background or sexual identity and consider the welfare of the child, young person or vulnerable adult is paramount. Children, young people and vulnerable adults with autism will be supported in particular to their individual need.

We take every reasonable step to ensure that children, young people and vulnerable adults are protected where our staff and partners/associates are involved in the delivery of our work. All concerns and allegations of abuse will be taken seriously and responded to promptly and appropriately by senior officers.

We enable all our staff and those who work with us to make informed and confident decisions regarding safeguarding. All staff receive training in basic awareness of safeguarding matters. Training is then undertaken commensurate with responsibilities in this area.

We expect everyone (including staff, partner agencies, associates and, volunteers) to understand and adhere to this policy.

### Aims of the Statement of Principles

We will endeavour to safeguard children, young people and vulnerable adults by:

- Valuing them, listening to and respecting them;
- Responding immediately and effectively to all concerns;
- Adopting this policy and adhering to our associated procedures and code of conduct for staff;
- Recruiting all staff, volunteers and associates safely by ensuring that all the necessary checks are made;
- Sharing immediately and effectively any concerns where children are involved in Children's Services; and
- Providing effective management of staff and associates through supervision, support and training.

The following measures ensure that safeguarding and promoting the welfare

of children, young people and vulnerable adults is given priority and is discharged effectively across Adult and Children's Services through commissioning arrangements:

- Haringey Adult Social Services is the responsible lead agency for providing care services for people in need, including those at risk of abuse. The SAB has given direction, support, guidance and quality assurance to safeguarding adults' policies, procedures and practice in Haringey. It is a Multi-Agency Board established to promote, inform and support safeguarding adults work. We ensure that priority is given to the prevention of abuse, and adult safeguarding is integrated into other community initiatives as well as links to other relevant inter-agency and community partnerships.
- Ensuring that safeguarding children and adult strategies and associated policies are in place, including safe recruitment of staff, a whistle-blowing policy and safeguarding training and supervision policies.
- Ensuring that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes.
- Designated NHS Safeguarding Nurse has been a member of the Haringey SAB and offers professional expertise and advice around safeguarding matters.

All organisations in Haringey and individuals working with adults who are vulnerable have a duty to protect them from abuse.

# 3. What is Safeguarding?

**In this section:**

- What is safeguarding
- What constitutes abuse and neglect
- Other types of abuse

Safeguarding adults is about working with adults with care and support needs to keep themselves safe from abuse or neglect. It is about people and organisations working together to prevent abuse.

Safeguarding Adults will help anyone who is:

> *"over 18 years old and is or may be in need of community care services by reason of mental or other disability, age or illness, **and** who is or may be unable to take care of him or herself, **or is** unable to protect him or herself against significant harm or exploitation"*[1]

The Care Act came into force on 1 April 2015 and has introduced a definition of who safeguarding adults will help:

> *"Anyone who has a need for care and support and is experiencing, or is at risk of, abuse and neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect"*

More information on the Care Act 2014 can be found on *page 23* Care Act and Safeguarding. Further information can be found on the Haringey website http://www.haringey.gov.uk/social-care-and-health/social-care-policy-and-practice/care-act-2014

Safeguarding adults should:

- Stop abuse or neglect wherever possible;
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- Safeguard adults in a way that supports them in making choices and having control over their lives;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities as a whole play their part in preventing, identifying and responding to abuse and neglect;

[1] This definition comes from the safeguarding adults policy guidance, No Secrets, published in 2000.

- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse or neglect.

To achieve these aims we must:

- Ensure individuals and organisations are clear about their roles and responsibilities;
- Create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect;
- Support the development of a positive learning environment across these partnerships and at all levels to help break down cultures that are risk-averse and seek to scapegoat or blame practitioners;
- Enable access to mainstream community resources such as accessible leisure facilities, safe town centers and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse or neglect; and
- Clarify how safeguarding concerns arising from poor quality and inadequate services, including patient safety in the health sector, should be responded to.

## What constitutes abuse and neglect?

Abuse may be:

- A single act or repeated acts. Abuse may take the form of a single act that has abusive consequences for the vulnerable adult or may comprise a series of acts, large or small, whose cumulative impact adversely affects the individual.

- Unintentional. Sometimes the abusive act was wilful on the part of the perpetrator but sometimes it may be unintentional. Causing harm may be unintentional but nevertheless harm was caused and therefore abuse has taken place, requiring a response under the safeguarding adults procedures. The nature of the response is likely to depend on whether the act was intentional or not.

- An act of neglect or a failure to act. Abuse may be caused as a result of a person with caring responsibilities acting in a way that is harmful to a dependent person. Failure to act so as to provide the level of care a reasonable person would be expected to provide, which results in harm to an adult at risk, is also abuse and requires a response under the safeguarding procedures.

- Multiple acts. An adult may experience several types of abuse simultaneously. Although the different forms of abuse are presented below as though they are discreet categories, there is often a lot of overlap between them.

Abuse and neglect can include:

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions;
- **Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence;
- **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting;
- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks;
- **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude;
- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion;
- **Organisational abuse** – including neglect and poor care practice within an institution care setting such as a hospital or care home, or in one's own home;
- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and
- **Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Other types of abuse

The **Domestic Abuse** definition includes **coercive control** which is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

**Hate crime** - A crime motivated by racial, sexual, or other prejudice.

**Female Genital Mutilation** – also known as female circumcision or female genital cutting, is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons

# 4. Who we are and what do we do?

**In this section:**

- Who we are and what do we do
- Haringey SAB Independent Chair
- Safeguarding Principles
- Haringey SAB Business Plan

The Local Authority through ASS is the responsible lead agency for providing care services for people in need, including those at risk of abuse. The Haringey SAB provides direction, support, guidance and quality assurance to safeguarding adults' policies, procedures and practice in Haringey. It is a multi-agency Board established to lead, promote, inform and support safeguarding adults work. We ensure that priority is given to the prevention of abuse, and adult safeguarding is integrated into other community initiatives as well as links to other relevant inter-agency and community partnerships.

Haringey SAB believes that living a life free from abuse is a fundamental right for each person, that safeguarding is everybody's business and that measures need to be in place to protect those least able to protect themselves.

Its membership includes statutory and independent agencies engaged in adult social care, community organisations and groups, including people who use services and carers.

The Haringey SAB meets four times a year. The Haringey SAB must make sure that there are arrangements for preventing harm and reacting to allegations of abuse in all agencies who work with potential adults at risk in Haringey. The Haringey SAB holds partner agencies to account to ensure they are protecting people who may be vulnerable to abuse.

Minutes of meetings are published on the Safeguarding section of the Haringey website; see Haringey SAB minutes of meetings[2].

## Haringey SAB Independent Chair

One of our key functions of the Haringey SAB membership is the position and role of the chair. With the high political focus on safeguarding adults has had and with significant changes happening across the partnership, it remains crucial for London-wide assurance that organisations continue to have robust governance and processes in place that lead to positive outcomes for adults as risk.

[2] Haringey Safeguarding adults Board minutes of Meeting - http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab

With this in mind, Haringey SAB has appointed an independent chair to provide robust and clear leadership to all partner agencies of the Haringey SAB. This leadership will present itself through challenge and influence, resulting in transparency and accountability amongst partner agencies.

## The Safeguarding Principles

The work of the Haringey SAB is underpinned by the safeguarding principles which were set out by the government in the statutory guidance accompanying the Care Act 2014. You can download this guidance by clicking here: Care and Support Statutory guidance[3]. The following six principles apply to all sectors and settings including care and support services. The principles inform the ways in which we work with adults.

1. **Empowerment –** The presumption of person-led decisions and informed consent, supporting the rights of the individual to lead an independent life based on self-determination.
2. **Prevention -** It is better to take action before harm occurs, including access to information on how to prevent or stop abuse, neglect and concerns about care quality or dignity.
3. **Proportionality -** Proportionate and least intrusive response appropriate to the risk presented.
4. **Protection -** Support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions, or to protect themselves or their assets.
5. **Partnership -** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability -** Accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

These six principles form the basis of our Safeguarding Adults Strategy, in which we set ourselves, the partnership and community specific actions to prevent and respond to abuse.

You can you view the Haringey Safeguarding Adults Board Strategic Plan 2015-18 in detail on our website at: http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab

## Haringey SAB Business Plan

The Board works to a Business Plan which identified five priority areas for action for the forthcoming year. The Business Plan assists the Haringey SAB to support,

[3] Care Act 2014: Statutory guidance for implementation - https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

monitor and review what partner agencies do individually and collectively to fulfil their safeguarding duties. The plan also serves to aid the development of future work for the Board and its partner agencies.

The five keys priorities:

1. **Strategy and Leadership** – Shared values, aims and objectives of safeguarding that provides people with expertise across the Council and with its partners.
2. **Safeguarding Practice –** Practice will reflect the strategic objectives to deliver an accessible, responsive, quality service to people at risk.
3. **Prevention –** There are Strategic plans to promote awareness, use information to focus resources where it is needed the most and work collegially with statutory, voluntary, carers and service users to prevent abuse.
4. **Training and Workforce Development –** All staff will be equipped to safeguard adults at risk and enhance their knowledge and skills through a multi-agency training and development programme.
5. **Communication –** there are strategic plans to promote awareness.

The Business Plan articulates the timescales and accountability for action in these areas, to which the work of subgroups is vital.

# 5. The work of the Safeguarding Adults Board during 2014/15

## Haringey SAB Subgroups

Each subgroup is led by a Haringey SAB member and provides a quarterly progress update to the Haringey SAB. In 2014, the three subgroups were:

| Prevention | Training & Workforce Development | Safeguarding Adults Practice Board (SAPB) |
|---|---|---|
| • Responsible for the development and implementation of the Prevention Strategy | • Responsible for the strategy, development and coordination of multi-agency safeguarding adults training provision. | • Coordinate and support the development of safeguarding adults work in Haringey with particular emphasis on developing best practice in safeguarding adults work and learning from experience. |

## Safeguarding Adults Practice Board (SAPB)

The Safeguarding Adults Practice Board (SAPB) was one of three sub-groups of the SAB. The SAPB developed as a response to the implementation of the Pan London Safeguarding Adults Policy and Procedures.

At the Haringey SAB meeting in July 2014, it was agreed that the subgroup would be dissolved and the SAPB Action Improvement plan would be merged in to the Quality Assurance (QA) Subgroup delivery plan and the QA Board becoming a subgroup of the Haringey SAB.

## Prevention Subgroup

The aim of the Prevention Sub-group is to oversee the delivery of the Haringey Safeguarding Adults Prevention Strategy 2014-17, approved by the SAB on 13 January 2014.

The Prevention Strategy (2014-17) outlines the strategic direction and the main priority areas for the different agencies, and represents the collaboration between

the agencies to provide a joint framework by which they will work in partnership to safeguard adults at risk.

The strategy describes the national and local policy framework and identifies nine priorities for adult safeguarding prevention work. These nine priorities cover a wide range of safeguarding prevention activities, which are incorporated in a delivery plan.

The Prevention Delivery Plan is discussed at the subgroup meetings and updates are provided to the Haringey SAB.

## Elder Abuse Fraud Prevention Training Awareness

The Safeguarding Prevention sub group held an event on "Elder Abuse Fraud Prevention Training Awareness" in February at Wood Green Cineworld Cinema. The purpose of the event was to find out about preventing fraud based on crimes against the elderly in Haringey. Professional speakers included the Metropolitan Police, Trading Standards, Nat West Fraud Prevention, external provider and Victim Support.

The scheme of the day was to get stakeholders involved who are in the provision of care for the elderly communities of Haringey. People who are in attendance can then take the information they have learned from the presentations and disseminate this amongst their community/group/company to raise awareness of abuse affecting older people.

The feedback was positive and it was proposed that this event is re-run in 2016 with an ambition to locate at other smaller locations across the Borough in order to harness local attendance.

*"I found the session informative, particularly with the many kinds of scams around. Good to know the banks are now coming together to tackle the issue. More awareness should be given to the many different communities living in Haringey, e.g. Voluntary organisations"*

*"A good variety of speakers from different areas of business"*

*"Very explanatory, clear and well educative"*

## Independent Domestic Violence Advocates

Independent Domestic Violence Advocates (IDVA) has been introduced to the Haringey Police Station environment from January 2015 to work alongside the Police Community Safety Unit (CSU) and Integrated Gangs Unit (IGU) at Wood Green Police Station. The Police have been invited to be part of the re-commissioning of the IDVA Provision which is proposed to be expanded.

The establishment of the IGU [which includes representation from the Local Authority Community Safety Partnership Strand and London Probation Service] at

Wood Green Police Station has been further developed to include a further check and balance for Safeguarding victims who fall within the Prevention Strand of the Ending Serious Youth and Gang Violence (EGYV) Strategy.

## Training and Workforce Development Sub group

The Training and Workforce Development subgroup has the responsibility for the development, planning and coordination of multi-agency safeguarding adults training provision. This includes making recommendations regarding the facilitation and commissioning of appropriate training resources and the regular review and evaluation of the training provision in line with the Haringey SAB Business Plan.

Haringey is committed to providing high quality multi agency safeguarding adults training that supports staff in carrying out their duties and to ensure compliance against a number of Care Quality Commission (CQC) requirements outlined within Essential Standards of Quality and Safety, (March 2010).

We have developed a safeguarding Development and Learning Opportunities work programme for all staff and partners. All the courses are designed in accordance with the National Minimum Standards implemented by the Care Standards Act 2000, and where possible linked to the Qualification Credit Framework.

Much has now been done to support the implementation of the Care Act through workshops, courses, briefings and the e-learning modules.

Some of the training courses being offered:

- Safeguarding Adults: Raising an Alert and immediate steps
  This training develops and builds on the competencies participants will have gained through undertaking the Basic Awareness
- Domestic abuse of Older People by their family members
  To help those who work with older people and who may also lead, investigate or manage Safeguarding Adult case work to understand, and to feel more confident in their practise
- Essential standards for Quality and Safety New for 2014
  To gain a clear understanding of the CQC essential standards and how they should be embedded within day to day work
- Mental Capacity Act and DoLS Awareness
  To build delegates knowledge and skills on Mental Capacity Act 2005 and DoLS
- Protecting against Institutional Abuse and Neglect
  To enable all staff and managers working within any provided services for adults to understand the crucial importance of every person's role and duty of care in keeping vulnerable adults safer
- Safeguarding those living with dementia or a mental illness
  To help those who work with these service user groups and who may also lead, investigate or manage Safeguarding Adult case work to understand, and to feel more confident in their practise
- Introduction to Financial Abuse - To develop abilities in dealing with concerns/ allegations of financial or material abuse.

- **Financial and Material abuse – Level 2**
  This second stage course is aimed at professionals who are likely to have a deeper involvement in an investigation, both criminal and non-criminal which require a deeper understanding of the complex processes and legislation involved within their professional role
- **Undertaking s42 enquiries – for social work practitioners and other professionals**
  Housing officers, Probation, community psychiatric nurses and other NHS staff must undertake this training to comply with the Care Act
- **Chairing and Leading the safeguarding meeting**
  Updating for those fulfilling the role of the Safeguarding Adults Manager and practical skills to be an effective Chair

E-learning courses available:

- Safeguarding Awareness for Adult service workers
- Introduction to adult safeguarding for Social Workers
- Legislation and Partnership working in the protection of adults at risk
- Safeguarding Adults at Risk: The role of the social worker in adult safeguarding
- Deprivation of Liberty Safeguards (DoLS)
- Mental Capacity Act
- Safeguarding children and adults at risk: basic awareness
- Care Act - Safeguarding

Safeguarding awareness is a mandatory requirement for all and training courses continues to be well received and feedback is generally very positive.

In 2014/15, over **350** Haringey staff and over **100** people from external providers attended one or more training sessions in Haringey.

## Training- CSE Safeguarding Awareness Campaign

A campaign to raise awareness of the potential signs of Child Sexual Exploitation (CSE) and encourage people to *"say something if they see something"* was launched in Haringey in March 2015.

The joint Haringey Council (Haringey SAB), Haringey Borough Police and Haringey LSCB campaign, calls on local residents and businesses to lookout for the warning signs of child sexual exploitation and to report any concerns.

As part of the campaign people working in local hospitality, transport, leisure and licensed businesses have been provided with bespoke CSE awareness training to help them identify scenarios in which children might be at risk of sexual exploitation.

Council and police officers are also working with teachers and community leaders to raise awareness of the issue and to agree what action should be taken if they suspect a child is at risk.

Tackling child sexual exploitation requires real cooperation and collaboration between professionals and the public to keep Haringey's young people safe. This campaign will help raise awareness amongst local residents and businesses of the potential signs of abuse and encourage people to raise any concerns they may have, detection and safeguarding of those at risk.

We have developed a mandatory e-Learning CSE training for all staff in the Council.

## Subgroups going forward 2015/16

| Safeguarding Adults Prevention and Training and Development Subgroup | Adult Social Services Quality Assurance Board Subgroup | Haringey Multi Agency Mental Capacity Act and Deprivation of Liberty Safeguards Subgroup |
|---|---|---|
| •Responsibility for the strategy, development and co-ordination of multiagency safeguarding adults training provision.<br>•Oversee the delivery of the Haringey Safeguarding Adults Prevention Strategy 2014 - 2017 | •Ensure that quality assurance arrangements are in place across Adult Social Services (ASS) to gather information on the quality of services provided, service user feedback and data on the outcomes achieved for people using ASS. | •Strengthen inter agency relationships and facilitate the ongoing implementation of the MCA including the Safeguards in addition to providing assurances around governance and quality, sharing practice and improving DoLS compliance. |

## Safeguarding Adults Prevention and Training and Development Subgroup

In January 2015, Haringey SAB agreed that the Prevention sub-group and the Training and Workforce Development subgroup be merged as there is synergy in the work plans and so we can make better use of resources. The terms of reference for the new subgroup was agreed at the April 2015 Meeting.

## Adult Social Services Quality Assurance Board Subgroup

The purpose of the Adult Social Services Quality Assurance Board (QAB) is to ensure that QA arrangements are in place across ASS to gather information on the quality of services provided, service user feedback and data on the outcomes achieved for people using Adult Social Services. The Board ensures that this information is analysed and used to inform service delivery as well as strategic planning and commissioning.

Haringey Council takes quality assurance and safeguarding seriously and recognises that quality and safeguarding is everyone's business. We recognise the impact of poor quality care on safeguarding, and also recognise that we need a

differentiated approach to quality and safeguarding concerns. In managing the market, we ensure a continued focus on quality of provision to ensure that people's quality of life is maintained and the wider outcomes they seek are achieved.

We have continued to work in partnership with our external care providers, Haringey CCG and the CQC around the monitoring of adult social care services for residents in Haringey. We have developed a close working relationship with the CQC, the independent regulator of health and adult social care in England, enabling us to share information and intelligence about the quality of care provision in the local area. This approach enables concerns to be identified at an early stage and appropriate action to be taken to keep people safe. Where there have been major safeguarding concerns regarding a provider, we have used the Joint Establishment Concerns Procedure [4]to work in partnership to investigate concerns and to take action where necessary, such as increased provider monitoring.

Despite the financial pressures on the Council, we ensure high quality services are delivered to Haringey residents and to continue to improve quality in line with national and local requirements. We recognise that service users and their families and carers are often best placed to assess the quality of the care they receive and we will continue to listen to and act on feedback from users and other stakeholders in holding providers to account.

The Board's Improvement and Quality Action Plan is currently being developed to include key improvement projects identified in the 2013-14 Local Account, local authority priorities from the Safeguarding Adult Audit Tool improvement plan, and practice issues around Deprivation of Liberty Safeguards (DoLS), the Care Act and health and social care integration. This enables key projects across ASS to be monitored by the QAB on a quarterly basis.

Adult Commissioning is continuing to work with external providers to improve their safeguarding practice and whistleblowing policies. QA reviews of all supported living provisions in Haringey are also being carried out.

## What will we do?

- Work is under way to move to a multi-agency QA sub-group and widen the remit to include partnership working. The focus will be on partnership issues, predominantly good practice, performance and quality assurance. The terms of reference and membership of the QAB will be revisited in order to take this forward.
- New case file audit templates will be introduced in July 2015 to reflect new Department of Health (DH) and Care Act requirements. This will include adult safeguarding case file audits.

[4] http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/safeguarding-adults-policies-and-procedures

- We will continue to support providers to strengthen their safeguarding and quality practice in Haringey and strengthen our quality assurance and contract monitoring role across provisions.
- Continue to promote awareness of adult safeguarding, including a targeted safeguarding awareness campaign to raise knowledge and reporting of adult safeguarding concerns.
- Fully embed adult safeguarding user survey to identify whether people's needs are met through the safeguarding investigation process.
- Continue to implement the Adult Safeguarding Prevention Strategy delivery plan.
- Embed DoLS procedure and guidance for staff.
- Review and consolidate methods for monitoring safeguarding referral data.

## Haringey Multi-Agency Mental Capacity Act and Deprivation of Liberty Safeguards Subgroup

In January 2015, it was proposed that the Haringey SAB establish a new Multi–agency Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS) subgroup. At the time of writing this report, the subgroup has been established and the terms of reference have been approved by the Haringey SAB.

The Multi–agency MCA/DoLS sub-group will help to strengthen inter agency relationships and facilitate the ongoing implementation of the MCA including the Safeguards in addition to providing assurances around governance and quality, sharing practice and improving DoLS compliance. The sub-group supports the aim of Government to embed rights and responsibilities of the MCA in mainstream work. The key message is that the MCA applies to everyone who works with and/or cares for an adult who may lack capacity to make specific decisions.

The subgroup will have the following responsibilities:

- To lead the implementation of the MCA in Haringey ensuring good practice and a coherent approach across all organisations;
- To support multi-agency, partnership work in ongoing implementation and governance of the MCA/DoLS through nominated Lead Officers;
- To identify training and workforce development needs for a range of staff and agree a Training Strategy to meet these needs;
- To develop and support the relevant elements and work streams in order to put the requirements of the MCA including DoLS in place;
- To provide collaborative leadership across Social Care, Health, Police, Fire Service, Provider and other relevant sectors;
- To encourage participation and contribution from key partnerships and relevant organisations;
- To facilitate dissemination of advice, guidance, materials and training information;
- To benchmark DoLS data set against similar LA demographic profiles to inform training strategies within Haringey for commissioners and providers;
- To review multi agency policy and operational guidance, as required;
- To ensure that the MCA strategy is implemented within partner organisations;

- To audit and evaluate how organisations are embedding MCA and share learning from audit process;
- To promote learning, through the consideration of the implications of relevant case law, recommendations from domestic homicide reviews and safeguarding adults reviews;
- To develop community strategies to raise awareness of MCA to Haringey residents; and
- To report as a forum to the SAB quarterly.

## Healthwatch

Healthwatch Haringey is independent from the Health and Social Care Services you use. Their job is to ensure that local people's views are heard in order to improve the experience and outcomes for people who use these services. Healthwatch Haringey works on behalf of all our communities: for children, young people and adults.

In developing the Haringey Safeguarding Strategic Plan, Haringey SAB will engage and consult with Healthwatch Haringey

Up until 31 March 2015 Healthwatch Haringey was run and led by Haringey Citizen's Advice Bureaux (HCAB) with support from Haringey Race and Equality Council (HREC).

## Health and Well-being Agenda

Improving health and wellbeing in the borough is not the sole responsibility of one or two organisations; the responsibility is shared amongst us all including the Haringey SAB.

The Health and Wellbeing Board (HWB) takes the lead in promoting a healthier Haringey. It has a general duty to promote the individual well-being of all local residents (Care Act 2014).

The **Health and Wellbeing Strategy 2015-18** will continue to emphasise the importance of partnership working and joint commissioning to achieve a focused use of resources and better value for money. Activities incorporate prevention and early intervention, community resilience and citizen empowerment, and reducing inequalities.

Healthwatch Haringey is an active participant of the HWB and has actively been involved in the preparation of the **Health and Wellbeing Strategy 2015-18.**

# Care Act 2014 and Safeguarding

## Background

In July 2012 the government introduced a white paper 'Caring for our Future: Reforming Care and Support' and a draft Care and Support Bill. The government's stated aims in reforming the law around care and support are to:

- Modernise the legal basis to reflect the government's ambitions for personalised adult social care;
- Simplify the law into one single statute for adult social care; and
- Consolidate all existing legislation and repeal old statute dating back over 60 years.

The Bill received royal assent and came into force on 1 April 2015.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Local authorities have new safeguarding duties. They must:

- **lead a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens
- **make enquiries, or request others to make them,** when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- **establish a SAB**, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
- **carry out Safeguarding Adults Reviews** when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them
- **arrange for an independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

## What have we done for preparation?

The Care Act Implementation programme, in collaboration with a wide range of colleagues, has paid full attention to helping Haringey prepare for the recent implementation of those parts of the Act relating to Adult Safeguarding. This undertaking brought into its scope staff, from different professions and agencies reflecting a commitment to partnership working as a key contributor to effective safeguarding.

A checklist has been devised to ensure compliance with statutory requirements for the SAB outlining our current position and any action required to ensure compliance with the Care Act.

Much work has taken place to ensure that Haringey will be compliant. This is a large and complex undertaking that is being delivered through a programme management approach consisting of 7 work-streams which includes commissioning, safeguarding, advice and information etc.

ASS staff have been provided with a rolling programme of briefings about the Care Act and specialised legal training. In 2014/15, over 500 staff, partner agencies, carers, service users and providers had attended meetings to find out more about the Act.

In summary, the SAB's attention is drawn to the following key features of this work:

i) **Briefings, Seminars, Workshops and Reports:** Briefings and reports on the safeguarding implications of the Act have been provided to a diverse group of stakeholders which include the SAB, officers from across the Council, Members of the Council, the Health Scrutiny Panel, partner agencies, service users and carers;
ii) **Training:** Adult Social Services has provided mandatory training for its staff on the Act and safeguarding. This has been very well attended and, as a result, our confidence about staffs' ability to discharge their safeguarding responsibilities under the Act is high; and
iii) **Networking:** Liaising with local authorities across London on a regular basis (monthly) to share experiences and learn lessons from other places. Networking indicates that safeguarding practice in Haringey compares well with that found in other local authorities.

As a result of the Care Act, ASS is producing a new suite of staff procedures. In so doing, every effort has been made to ensure that safeguarding is properly covered, as appropriate, by each new procedure.

Our Haringey SAB Strategy is being developed to ensure that the requirements of the Care Act 2014 will be implemented with the support of the partnership and the local community.

## Serious Case Review Refresh

The Haringey Serious Case Review (SCR) was revised in September 2014 and it sets out the policy and procedure for commissioning and undertaking a SCR relating to an adult at risk living in the London Borough of Haringey (LBH).

The policy and procedure will be further revised in line with Care Act guidance and the revised Pan London Procedures in early 2015.

We are required, under the Care Act to make enquiries, or ask others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect in their area and to find out what, if any, action may be needed. Safeguarding Adults Reviews (SARs) will be replacing SCRs, and must be arranged if an adult with care and support needs dies, or sustains a serious life threatening injury, as a result of abuse or neglect and there is concern about how one of the members (agency or organisation) of the SAB acted.

The purpose of SARs is described very clearly in the statutory guidance as to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

Haringey SAB has not been involved in any Serious Case Reviews in the last 12 months.

## Deprivation of Liberty Safeguards

The DoLS are for people in a hospital or care home, who for their own safety and in their own best interests, need to receive care and treatment that may have the effect of depriving them of their liberty, but who lack the capacity to consent to these arrangements.

DoLS are the way to give people the protection they need when they are being cared for or treated in ways that deprive them of their liberty.
The deprivation of a person's liberty is a serious matter and should not happen unless it is absolutely necessary. These safeguards have been created to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

We are in the process of developing a DoLS strategy to ensure not only compliancy with DoLS, but that we can go further to prevent abuse and harm through identifying those who lack capacity and may be at risk.

DoLS legislation has been in force since 2009. Initially, there were relatively few DoLS applications. However, since the Cheshire-West Judgement last year, the number of applications in Haringey has risen dramatically.

**What is the 'Cheshire West' judgement?**
In March 2014, the Supreme Court made a long awaited decision in a case about three people who lacked the mental capacity to make decisions about their living arrangements. The Court decided that all three were subject to a deprivation of their liberty. The judgement was important because it made the law on DoLS clearer and brought in an 'acid test' to work out whether or not a deprivation of someone's liberty was taking place.

The effect of the Court ruling has been that far more people in residential care and hospitals are now entitled to the DoL Safeguards.

In Haringey, the Council processed 119 DOL applications (although 345 applications received) during 2014/15. 30 applications were accompanied by urgent applications and 90 requests were for standard authorisation only. There were 15 authorisation requests assessed and not granted, as no deprivation was deemed to be occurring and 80 requests were granted and the remaining requests were withdrawn

Below is the yearly comparison since 2010/11.

| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|---|---|
| DoLS Applications | 10 | 22 | 20 | 32 | 119 |

There were 4 times as many DoLS applications progressed and almost 10 times as many DoLs applications received as opposed to the previous 12 months. On

average 30 DoLs applications were received per month which peaked at over 60 referrals some given month. There has also been an increase in the number of DoLS cases being considered via the court of protection

### Funding

On 27 March 2014, Minister Norman Lamb announced that he would make a £25 million one off payment for 2015-2016 to local authorities to use in managing the deprivation of liberty cases. This is in recognition of the huge task that local authorities face.

Haringey, like most other local authorities, is in the difficult position of having to meet the huge demand with very limited supply. In order to address the significant increase in DoLS assessments, immediate short term solutions are being pursued such as increasing the number of independent Best Interest Assessor (BIA)'s being used, using qualified social workers within Haringey to complete BIA assessments where appropriate.

ASS has received confirmation of funding from the DH as a one off payment for 2015-2016 for the management of DoLS cases. ASS is looking at utilising this to clear a large majority of the backlog by bringing in additional resources and with the rest being reinvested to train our adult staff team as BIA assessors. This will help us deal with the more immediate risk and allow us time to develop our in-house BIA provision.

Future work: Review the Haringey DoLS practice and procedure to ensure compliance with guidance from the Supreme Court judgement and code of practice.

## Safeguarding Adults at Risk Audit Tool

The Safeguarding Adults Audit Tool was developed based on elements of the NHS Safeguarding Adult Assurance Framework (SAAF) and other Safeguarding Adult Board Audits. The Independent Chairs network developed a framework for improving the effectiveness of Boards (March 2013) which was agreed by ADASS. One of the four areas that Chairs of Safeguarding Adult Boards believed to be central was, 'an audit tool to be completed each year by each partner to the Board with actions taken during the following year to remedy any deficits'.

Haringey SAB agreed to adopt the tool and members of the Board participated in a 'Challenge and Support' event in July 2014 to identify best practice and areas for improvement.

The SAB gained an overview of the safeguarding arrangements that are in place across the locality identifying strengths - so good practice can be shared; and common areas for improvement where organisations can work together with support from the Board.

The 3 key actions for improvement were identified for the SAB:

1. Ensure that commissioning contract services that can demonstrate MCA are complied with;
2. Appropriate training for all staff: framework to assess competency and MCA integrated into supervision and appraisal systems to be developed and used. Development of a refreshed MCA/DoLS policy in response to the Cheshire judgement; and
3. Join up Borough response to Safeguarding. Safeguarding Adults Information to be made more available and accessible

An Improvement Action Plan was developed and is reported to the Haringey SAB on a quarterly basis.

## Multi-Agency Risk Assessment Conference and Operating Information Sharing Protocol

The Multi Agency Risk Assessment Conference (MARAC) is a multi-agency approach to reducing the risk of serious harm or homicide, faced by high risk victims of domestic violence.

A MARAC takes place once a month and involves partner agencies sharing information on the highest risk cases of domestic violence and creating a coordinated action plan to reduce the risk to the victims/survivors and their families. Referrals are made using the Coordinated Action Against Domestic Violence (CAADA) risk identification tool which helps referring agencies determine the level of risk, or based on professional judgment.

The Multi Agency Operational Information Sharing Protocol (MOISP) is to establish accountability, responsibility and reporting structures for the MARAC and to outline the process of the MARAC. The MOISP also sets out the legal grounds for information sharing between all agencies who have agreed to work together within the MARAC framework in accordance with the relevant legislation[5] in order to: increase the safety of all victims, including children; enable the protection of vulnerable people; and reduce crime and disorder locally. The MOISP is designed to enhance existing arrangements rather than replace them. The protocol is reviewed every two years to ensure it is fit for purpose and up to date with best practice guidance.

The MOISP was revised in October 2014 and signed up by all MARAC representatives.

## Internal Audit Haringey SAB

[5] The Data Protection Act (1998), The Children Act (1989 and 2004), Human Rights Act (2000

In 2014/15, ASS commissioned an internal audit of Haringey SAB. The overall objective of the internal audit was to provide the Council, SAB Members, and partner agencies with reasonable, but not absolute, assurance as to the adequacy and effectiveness of the key controls relating to the management functions of the SAB.

ASS requested focus on key controls including:

- Governance - clear and documented terms of reference. The membership of the SAB is in line with the statutory requirements. The SAB meets in accordance with the requirements of its own terms of reference. The SAB has developed a Prevention Strategy and delivery plan and with regard to the management of safeguarding adults.
- Self Assessment - arrangements are in place for the SAB to complete a self assessment of its own work, performance and relations with partner organisations and from this develop an action plan with those partner organisations.
- Risk Management - there is an effective process in place by which the risks which could impact on the achievement of the SAB objectives are identified, evaluated and mitigated, and then kept under periodic review.
- Outcomes - the SAB has developed clear and achievable outcomes which are consistent with the aims and objectives of the Council.
- Liaison with other bodies and agencies - there is a clear protocol in place by which the SAB will co-operate and share information with other bodies to achieve its objectives, and is signed up to by all appropriate bodies.
- Performance and reporting - clear and specific targets and time scales are set which are linked to the agreed outcomes, with the actual achievement of the targets is compared to plan. Where there is a variance from plan, the cause of the variance is identified and remedial action developed where appropriate. Periodic and timely reporting is undertaken to the SAB.

Following the conclusion of the audit, Haringey SAB attained Substantial Assurance with no major issues for management or audit committee being raised.

## Haringey Multi Disciplinary High Risk Panel

The High Risk Panel (HRP) has been established to provide a multi-agency way of supporting work on complex and high risk cases, including but not limited to hoarding, fire risk, and self-neglect. The HRP support agencies in their work to lower and manage risk for both customers and their immediate neighbours, where risk might remain at a high threshold without collaboration available through a multi-agency approach. The panel has a consultative and advisory role and adheres to the confidentiality policy which governs the Haringey SAB.

The process for submitting a case to the High risk Panel is contained in the High Risk Panel protocols.

The HRP is collaboratively owned by participating agencies in Haringey. It is administered on behalf of the participating agencies by ASS

## Violence against Women and Girls Strategy Group

In September 2014, the Violence against Women and Girls Strategy group agreed to adopt the terminology of 'violence against women and girls'. The group have adopted the United Nations (UN) definition of violence against women and girls as featured in the government's strategy 'Call to End Violence Against Women and Girls (2010)' and The Mayor's Office for Policing And Crime (MOPAC) updated 'Violence Against Women and Girls Strategy (2013-17)'.

The Strategy group are now able to keep violence against women and girls visible, better understand the issue and are able to develop more effective responses. This also means it supports the development of a more integrated approach to the problem in Haringey, which has largely focused previously on domestic and sexual violence and abuse.

## Winterbourne View Action Plan

Together with our partners, a joint Action Plan was developed in response to the Winterbourne View SCR. This was monitored through regular project group meetings which have now been dissolved. However, the Learning Disabilities Executive Board continues to monitor progress on an operational level.

The Department for Health developed a national response looking at issues affecting people with learning disabilities residing in hospitals. NHS England then made a Transforming Care commitment, which includes the delivery of Care and Treatment Reviews (CTRs) for patients.

CTRs assess the needs of people with learning disabilities and how their future care needs can best be met – including the most appropriate setting. The CTR process also supports the action planning required to deliver the required discharges or transfers into the appropriate care.

Each CTR is scheduled over the course of a day and takes place at the current residence of the person with learning disabilities. It is structured as a round-table discussion of the personal and clinical needs of the person with learning disabilities and involves representatives of the person's voice (family, advocacy, etc), the care providers, the multidisciplinary team (Haringey Learning Disability Partnership (HLDP)), the CCG, and independent reviewers (representing NHS England).

**Future Work:** Ensure that the care ASS commission on behalf of people with a learning disability is outcome focused to protect those most vulnerable in society, based upon the learning for the Winterbourne View SCR.

## Advocacy

Haringey ASS must involve people in their assessments and in planning and checking their care and support.

Under the Care Act, individuals who experience substantial difficulty in being involved in care assessments, care planning, care reviews, safeguarding enquiries, safeguarding adult review; and where there is not an appropriate individual to support them, are entitled to access an independent advocate from Voiceability via a referral to the service from the Council.

Haringey ASS have re-tendered the provision of an advocacy service to ensure full compliance with requirements set out under the new legislation. The advocacy service contract has been awarded to Voiceability, who is also the provider of statutory (Independent Mental Capacity Act (IMCA) and Independent Mental Health Assessment) advocacy services in the borough.

## Community Safety Partnerships (CSP)

Haringey SAB has an important contribution to broader issues of community safety. This includes working at a local and regional level with other agencies who are working to reduce risk and tackle and prevent violence and harassment in our communities. The Haringey SAB has regional and local input to Multi Agency Public Protection Meetings (MAPPA), to manage the risk posed by violent and sexual offenders and MARAC which focus on the needs of victims of domestic violence.

The vision of the Community Safety Partnership (CSP) is to make Haringey one of the **safest boroughs** in London. The CSP works closely with health and safeguarding partners (member of the Haringey SAB) to address alcohol, drugs and mental disabilities as critical drivers of offending, disorder and ill health across all crime types. An effective community safety programme makes a significant contribution to good health and well-being, evident in the activities supporting outcomes such as; prevent and minimise gang-related activity and victimisation, and end violence against women and girls by working in partnership and promote healthy and safe relationships.

## Haringey Borough Multi-Agency Hoarding Protocol

In February 2014 at the Haringey HRP, the London Fire Brigade (LFB) took forward discussion and progression in the setting up of a Haringey Multi-Agency Hoarding Protocol. The panel consisted of representatives from the LFB, Homes for Haringey, Mental Health, and LBH. This was further discussed at the Haringey SAB meeting in July 2014 were partner agencies had the opportunity to comment and provide feedback.

In early July 2015, the Haringey Borough Multi-Agency Hoarding Protocol was approved and published by the SAB.

To view the protocol, you can download from the Haringey Website: http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/safeguarding-adults-policies-and-procedures

## Making Safeguarding Personal

The Making Safeguarding Personal (MSP) programme, led by the Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA), with funding from the DH, has gained widespread momentum.

Since 2010, the national MSP programme has aimed to promote a shift in culture and practice in response to what we know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. MSP is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them with the aim of enabling them to reach better resolution of their circumstances and recovery. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process.

Haringey SAB is committed to engaging with the MSP programme and has signed up to silver level to ensure that the achievement of personal outcomes is at the centre of the safeguarding arrangements.

Work has been undertaken as part of the MSP initiative to prepare for the introduction of an adult safeguarding user survey looking at the outcomes of safeguarding investigations. DH guidelines require 10% of safeguarding referrals to be surveyed and the survey must be carried out by qualified professionals. In ASS, we are currently identifying the resources needed to implement the survey in 2015.

## Safeguarding Threshold Guidance

Haringey SAB has drafted a SAB Threshold Guidance. The guidance explains the processes involved in making a decision about whether an "alert", regarding an adult who appears to be at risk of harm or is being harmed, is progressed through the safeguarding adults' procedures. Such "threshold decisions" are crucial in ensuring that members of the population who meet the definition of "vulnerable adult" (No Secrets 2000 and Care Act 2014 guidance) are able to receive the assistance they need. By definition, these adults are not able to protect themselves or claim their civil or human rights without assistance.

Discussions have taken place at SAB meetings and partner agencies invited to provide comments and feedback. It is anticipated that the final Threshold Guidance will be ratified by the SAB and to be published in latter 2015.

# 6. Haringey Safeguarding Adults Strategy (2015/18)

Haringey SAB members are jointly responsible for ensuring that key partners work together effectively to protect adults with care and support needs from abuse or neglect. The Haringey SAB aims to achieve this through our strategic plan which highlights our priorities for safeguarding adults for the next 3 years.

The strategy is in the process of being finalised and will be discussed at the SAB in 2015. Once the Strategy receives ratification from the Board, we will publish on the Haringey website at the following location:

http://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab

# 7. SAB Partner Statements - Achievements in 2014/15

The agencies that make up the Haringey SAB are all committed to improving their ability to prevent harm as well as to identify and react to allegations of abuse towards the people they work with. Every year, we ask our partners to write up their SAB partner statements which highlights their key achievements throughout the year and what are the plans for the coming year.

Full partner statements reports can be found in **Appendix A**. Below are excerpts from the reports:

## Whittington Health

Executive Leadership for Safeguarding is provided by the Director of Nursing and patient Experience. A review of Safeguarding practices was carried out by an external reviewer in early 2015. The actions from the review have been incorporated into the Trust Safeguarding work plan.

The Care Act came on to the statue books on the 1st April 2015, and training materials have been reviewed to reflect the changes.

Policy review is ongoing this includes Pressure Ulcer policy, Recruitment and Retention, Restraint in Care, Information sharing, Being Open, Safeguarding Adults at Risk, PREVENT, MCA, Serious incident, Disciplinary and Safer Recruitment, Patient Experience, Complaints and Privacy and Dignity.

The Trust is using the National guidance for the reporting and management of Pressure Ulcers.

Haringey CCG funded training for staff to undertake the role of MCA champions, this will allow them to support staff in practice and undertake MCA training.

The Trust Domestic Abuse Coordinator delivers training to staff across the Trust; and has developed a Domestic Abuse policy that was ratified in 2015.

## North Middlesex Hospital NHS Trust

The Trust has an up to date Safeguarding Adult's Policy that sets out responsibilities, reporting and investigating procedures for the protection of adults at risk. This policy supports and encourages staff to immediately report any concerns that they may have about possible abuse to a person at risk whilst the patient is receiving treatment or care at the hospital.

Over the last year, the Trust has continued the focus on raising awareness of its safeguarding adults procedures and policies. This approach enables staff to

recognise abuse situations and report or escalate in order for them to be investigated by the appropriate agencies.

The Trust continues to work with the Enfield and Haringey Social Services Safeguarding Adult Teams to comply with requirements for following up Safeguarding Adult alerts. Trust staff attends Safeguarding Adult Strategy Meetings and Case Conferences as required.

The Care Act requirements for Making Safeguarding Person requires us to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices. Family or representatives are now routinely invited to Safeguarding Adult Strategy meetings and Case Conferences to ensure their early involvement in decisions made and Protection Plans.

The Trust is committed to making improvements in response to lessons learned from the findings from Safeguarding adult investigations. Examples to changes in practice that have taken place in the Trust over the previous year include:

- Review of handover information about the patient's condition on discharge, including a discharge letter with a body map and description of any injuries and pressure ulcer management required;
- discharge checklists for discharge procedures in order to ensure that patients are discharged with relevant and up to date information;
- The Trust has developed a Missing and Absconding Persons Policy;
- Staff have been reminded to ensure that Mental capacity assessments (Mental Capacity Act 2005) and rationale for Best Interest Decisions are fully completed and discussed with family members;
- Staff are required to document Best Interest Assessments in the patient's medical file, in the event that treatment is withheld;
- Increase focus on requirements for Deprivation of Liberties Safeguard applications for patients who lack capacity and are provided with one to one supervision;
- the Mental Capacity Act and Deprivation of Liberty Safeguards Policy has been updated to reflect the guidance provided following the Cheshire West Case Law issued in April 2014;
- updated Deprivation of Liberty Safeguard application forms issued by ADASS in January 2015;
- developed a Domestic Violence Policy which is available on the hospital intranet;
- Ward Managers and Matrons were invited to attend a Mental Capacity Act and DoLS training update on 25th June 2014;
- a DOLS briefing sheet / flowchart has been circulated to all Consultant Medical Staff, Matrons and Ward Managers;
- Trust Safeguarding Adult Lead working with the Care of the Elderly Consultants to undertake sample ward audits to identify patients who might potentially meet the criteria for Deprivation of Liberty Safeguards referrals; and

- The number of DoLS applications progressed by the Trust has gradually increased over the previous year as ward staff are now more aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguard requirements.

## Haringey Association of Voluntary and Community Organisations (HAVCO)

HAVCO, a small umbrella organisation, supports a diverse range of groups, organisations, charities, Not-for-Profit companies and individuals with voluntary and community working as their core business and purpose.

Providing information and guidance is a key role, which includes assisting the development of new and existing organisations to meet good standards of safeguarding practice across all ages.

HAVCO's Board of Trustees, many of whom lead VCS organisations, committed to responding to future local and national safeguarding guidance when approving HAVCO's updated Safeguarding Policy.

As the Council's Strategic Partner representing the VCS, HAVCO committed to being represented at the Safeguarding Adults Board (SAB) at CEO level, in line with the new Care Act 2014 requirements. Being a small organisation, this was identified as a key statutory meeting. Therefore agreement was reached by all parties for a Board Trustee member to represent HAVCO at the SAB. This matched the existing HAVCO/VCS arrangements at the Local Safeguarding Children's Board, also introduced during this year. Attendance at both Boards was supported by HAVCO's Interim CEO.

Information has been made widely available to over 900 member organisations through HAVCO's E-Voice newsletter, which includes safeguarding information.

The Volunteer Centre and Supported Volunteering Project, hosted by HAVCO, provided access to safeguarding information in respect of working with volunteers. Direct work with member organisations included completing Disclosure and Barring Service applications to ensure ongoing compliance; and advice and guidance on policies and procedures covering Volunteer Management and best practice for safeguarding.

HAVCO's volunteering leads are members of Haringey's Mental Health Stigma Group and the End of Life Forum, which have synergy with safeguarding matters.

## Haringey Community Safety Partnership (CSP)

One of the CSP's 6 strategic objectives is the prevent violent extremism. There is a high level delivery group for this area, chaired by the Deputy Chief Executive. Many of those affected are vulnerable young adults and there are close links to the SAB, MASH and the LSCB.

A further strategic priority is addressing 'violence against women and girls' including domestic violence and this is a shared responsibility across services with common links to the MACE.

Community Safety has strengthened approaches such as joint enforcement; strategic licensing; tackling problem premises inclding gambling establishments and poorly managed pubs which is aimed at increasing the safety of vulnerable adults.

- Established regular information sharing with A&E hospital departments for the first time;
- Increased referrals from schools and colleges for those at risk/vulnerable to extremism and extremist views for the first time. This was facilitated by and by the statutory PREVENT duty and inclusion in OFSTED inspections;
- Achieved agreement across the Council and its partners to widen the remit from domestic violence to incorporate all strands of violence against women and girls;
- Strengthened the outcomes from the ASB Action Group for repeat and vulnerable victims and expanded the remit to include hate crime victims;
- Trading standards undertakes test purchasing to protect young adults from the harm of unregulated alcohol, tobacco etc; and
- Fully established the integrated offender way of working for top nominal's and gang-related offenders, many of whom are young adults. This team pools resources and expertise to improve the life outcomes and re-offending rates of a specific cohort.

## Community Housing (Homes for Haringey)

Community Housing Services unified with Homes for Haringey (HfH) in September 2014. HfH have taken this opportunity to review the HfH Safeguarding processes and procedures and have set up a HfH Safeguarding Group, which includes representatives from all areas of the business.

- Full review of processes and procedures and setting up of HfH Safeguarding Group;
- Implementation of the Housing Related Support funded pathway;
- Delivery of a further programme of supported living schemes; and
- Rolled out a new safeguarding training programme for frontline staff.

## Haringey Clinical Commissioning Group

Safeguarding, promoting and improving the health of Haringey's vulnerable adults are public health priorities and these are reflected in NHS Haringey's Clinical Commissioning Group's (HCCG) strategic objectives and those agreed with partners. HCCG plays an active role in the work of the Haringey SAB and works with strategic partners to demonstrate that as a core member of the SAB, HCCG is

committed to embedding the fundamental principles for the prevention and protection of vulnerable adults.

HCCG responsibilities as commissioners is to promote the safety and welfare of adults in all of the services it commissions and provide assurance of HCCG's commitment to prevent and reduce the risk of abuse and neglect of adults and of continuing to improve safeguarding practice in the NHS. Our other key achievements include:

- Mental Capacity Act (MCA) project funds were secured to deliver a programme of training and awareness raising including;
- MCA and DoLS champions training delivered to 30 Acute and Care home Managers;
- Patient engagement and awareness raising events on Lasting Power of Attorney and Advance Decisions for patients and carers;
- Patient information leaflets have been developed on Advance Decisions, Preferred Priorities for Care and Lasting Power of Attorney for GP practices and acute trusts;
- Provider Trust MCA compliance audit rolled out;
- Initiation of the multi-agency MCA and DoLS SAB sub group to embed MCA, share key work areas and find practical solutions to well-established challenges;
- Reviewed the Continuing Health Care safeguarding referral pathway; and
- North Central London Safeguarding Adults Lead network developed a Key Performance Indicators (KPI) for Safeguarding Adults to complement the existing governance. Alongside the KPIs, an annual audit and quarterly dashboard has been developed to monitor safeguarding compliance within provider organisations. The framework will assist providers to focus on essential safeguarding areas in order to collect data that can be used to inform the organisations Safeguarding Adults Framework and action plans.

## Barnet, Enfield and Haringey Mental Health Trust

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) understands and acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all BEHMHT patients remains a priority for the Trust as it is a fundamental component of all care provided.

Over the past year, the safeguarding arrangements across all Trust services has continued to be strengthened, with a particular focus on ensuring our staff receives an appropriate level of safeguarding training.

The Trust has in place a Safeguarding Surgery. The surgery was developed in 2014 and has been well received and utilised by staff. The forum promote patient-centred approach; Making Safeguarding Personnel (MSP), collaborative working with our partners and bringing new legislation to staff awareness.

The Trust has a safeguarding audit that is completed on a monthly basis by managers. Strengths, areas for improvement and actions plans are agreed and delivered. The Trust's safeguarding committee has oversight of the process and improvements. Our other key achievements include:

- Review the DoLS and MCA policies and frameworks in light of Cheshire West ruling;
- The pressure ulcer forum now meets monthly and is attended by clinicians from across services, the protocol has been agreed and a plan for roll out is being implemented;
- Datix Incident Reporting to link with safeguarding team enabling automatically generated alerts when incidents with a safeguarding element are reported;
- A restraint in care protocol has been developed for our older adults services;
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC's regulatory framework on all inpatient units and Community Teams. The Trust is fully compliant;
- The Safeguarding Team have been delivering bespoke training to teams which has led to an increase in awareness that safeguarding is everyone business to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity;
- BEHMHT have developed safeguarding champions in different areas to support staff. Issues where processes are not understood or where there are performance issues these are brought to the attention of the champions and staff are supported to address issues/concerns;
- MCA/DoLs lead for the Trust has led on the delivery bespoke training to teams. Subsequently awareness in IMCA and Advocacy services has improved; and
- Adult Safeguarding training level 1 is part of the mandatory training programme for all staff of which compliance is monitored through the Electronic Staff Record. Attendance record achieved above 85% throughout the year.

## London Ambulance Service

The Trust has a commitment and a duty to safeguard adults at risk as stipulated in Outcome 7 of the Care Quality Commission Regulations. To achieve this goal the organisation has to ensure robust systems and policies are in place and are followed consistently, to provide training and supervision to enable staff to recognise and report incidents of adult abuse, to provide expert advice and to reduce the risks to vulnerable adults at risk of being abused.

The Trust has safeguarding action plans for both children and adults which are reviewed by the Safeguarding Committee

The Trust has provided a range of face to face safeguarding training this year, including; all new staff receive safeguarding training on induction course. All new clinical staff A&E and PTS receives safeguarding level 2 training on the core training

course. All clinical staff including EOC also receives level 2 safeguarding refresher training on the Core Skills Refresher (CSR) course. In addition local leads, EBS, Medical Directorate and Clinical Hub staff who provided support to staff have also received level 3 safeguarding children training.

The number of staff who have received the full NHS Prevent training is approximately 60. LAS have now appointed a Prevent lead for the Trust and a plan to train all staff is being developed.

- The Safeguarding Adult policy has been amended to comply with the Care Act 2014;
- The guidance for staff on mental health patients and Safeguarding was reviewed and amended to provide greater clarity for staff on when to refer to social care;
- The Trust has introduced a new HR policy for Managing Allegations Against Staff;
- Several safeguarding updates have been produced throughout the year providing guidance to safeguarding on safeguarding procedures; and
- The Trust implemented the NHS guidance on Female Genital Mutilation (FGM); this now requires all staff to record on clinical records and evidence of FGM. LAS also introduced the guidance on when to make a safeguarding referral for an unborn child, child and adult.

# 8. Safeguarding Adults Performance Information

## What the statistics are telling us

Source: Haringey Performance Data return 01/04/2014 to 31/03/2015*
**These figures are provisional and are subject to validation which may change as a result.*

The Council collects information about safeguarding adults work in Haringey, so we know how well the Council is safeguarding people. This information helps the Haringey SAB decide what their next steps should be.

Data in relation to all safeguarding issues is monitored both locally and nationally. All safeguarding, alerts and referrals are recorded and co-ordinated by Haringey Council. Progress from initial alert through to conclusion is monitored for timeliness and quality across a wide variety of measures including the nature and location of harm, service user groups, outcomes, age, gender, ethnicity etc. This information is scrutinised by the QAB who report key issues quarterly to the SAB.

Haringey Council submits returns annually to the DH for collation and comparison of the key data across all authorities. The following commentary includes extracts from the data, trends and areas for improvement and development in Haringey.

## Alerts and Referrals

**Update**
From April 2015 onwards, some of the terms we use, such as 'referral; will be changing. This is because the Care Act has introduced new terms for us to use. The term 'safeguarding referral' will be replaced with the term 'safeguarding concern'. 'Safeguarding investigations/referrals' will be known as 'safeguarding enquiries'.

**There are two different types of safeguarding enquiries**

The type of safeguarding enquiry depends on the characteristics of the adult at risk. If the adult fits the criteria outlined in Section 42 of the Care Act, then local authorities are required by law to conduct enquiries. These will be referred to as **'Statutory Safeguarding Enquiries'.**
Local authorities will sometimes decide to make safeguarding enquiries for adults who do not fit the Section 42 criteria. These enquiries are not required by law and therefore will be referred to as **'Non Statutory Enquiries'**.

Every year, the number of safeguarding referrals is increasing as people become more aware of adult safeguarding and how to report it. The Adult Social Care Integrated Access team (IAT) provides a single point of access for reporting adults safeguarding concerns

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a 'safeguarding alert'.

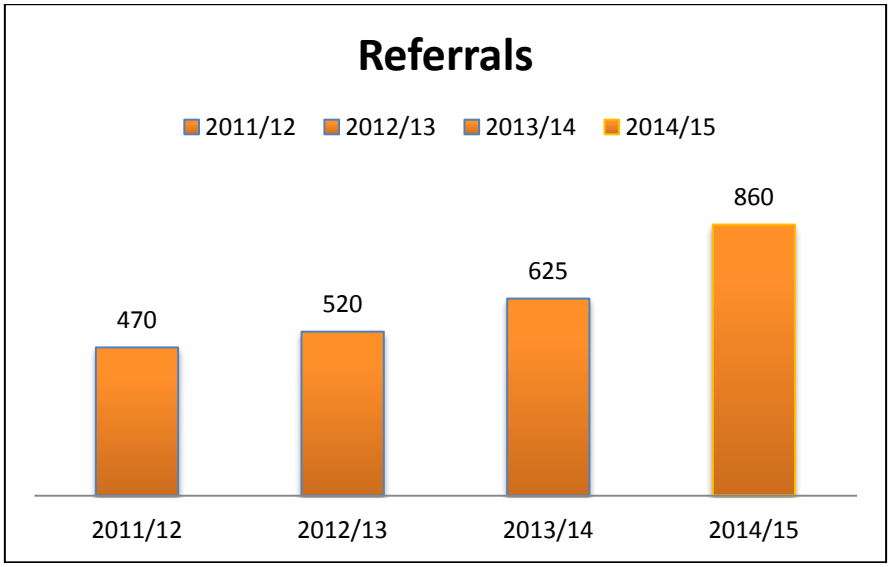
After an alert has been received, IAT then gather more information about the person and the concern. Once this has been done, we decide

whether the case needs to be referred for investigation. A case that went on to be investigated is known as a 'referral'.

In April–March **2013/14** the Council had **3019** alerts about possible abuse of which **625** were actually referred.

In April-March **2014/15**, the Council received **4009** alerts of which **860** safeguarding referrals, an increase of about **38%** on the previous year.

The graph below compares the numbers of referrals and shows a continuous increase.

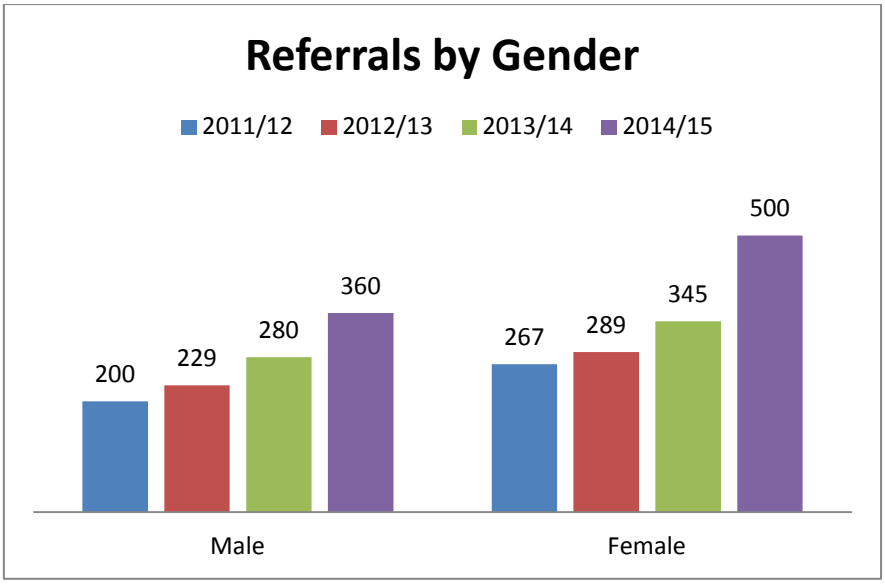



**People affected: Gender and Age Group**

During the period April 2014-March 2015, the number of referrals for males aged **55-64,** stood at **49**. This is a **63.33%** increase from the **30** cases for males aged **55-64** referred between the period April 2013 - March 2014.

A similar trend was also seen during the period April 2014-March 2015, with the number of referrals for females aged **35-44** being recorded at a total of **58**. This is a **48.71%** increase from the total **39** cases for females aged **35-44** referred between the period April 2013 - March 2014.

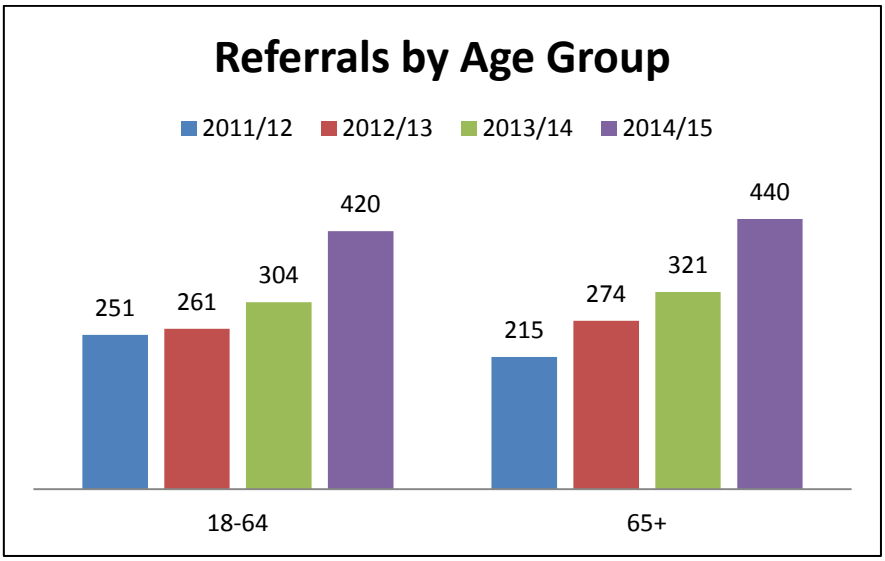
The highest percentage increase was seen in the number of males aged 18-24, with **31** referrals raised between April 2014 and March 2015. This is a **121%** increase from the **14** referrals with the same criteria raised between April 2013 and March 2014.




During the period April 2014-March 2015, the number of referrals for alleged victims aged between **18-24**, stood at **63**. This is a **40%** increase from the **45** cases for alleged victims aged between **18-24**, referred between the period April 2013-March 2014.

Similarly, during the period April 2014-March 2015, the number of referrals for alleged victims aged between **35-44**, stood at **83**. This is a **45.61%** increase from the **57** cases for alleged victims aged between 35-44, referred between the period April 2013-March 2014.

Also of note, during the period April 2014-March 2015, the number of referrals for alleged victims aged **55-64** stood at **91**. This is a **46.77%** increase from the **62** cases for alleged victims aged **55-64**, referred between the period April 2013-March 2014.

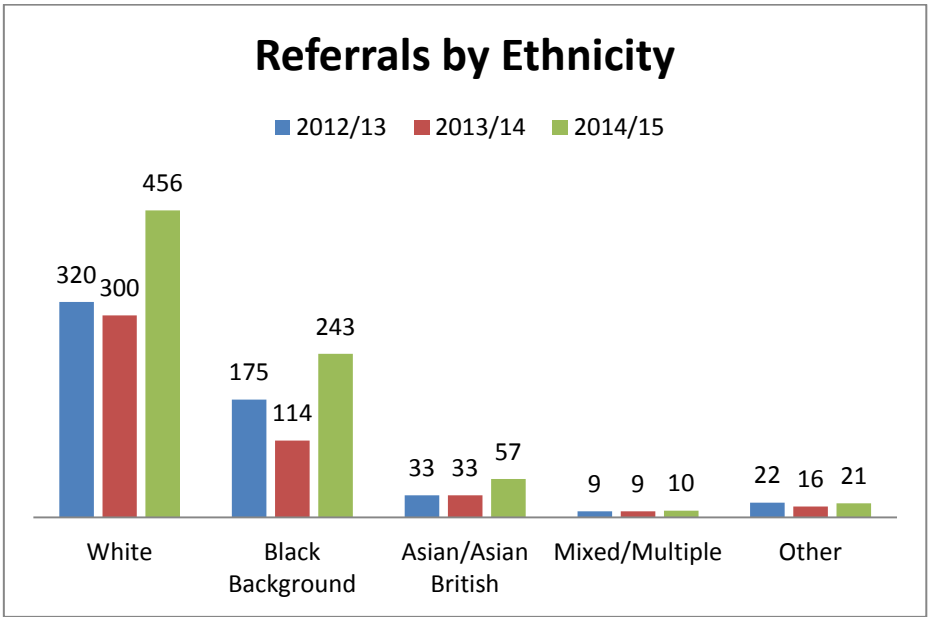


## Ethnicity

Ethnicity was recorded for **787** of **860** referrals received (**73** not declared/unknown). Of these, approximately **58%** were from a 'White' ethnic group (same percentage as last year, but an increase of **156** referrals), **30%** were from 'Black African/Caribbean/Black British' background (down from **32%** last year), and **7%** were from an 'Asian or Asian British' background.

The number of referrals received for alleged victims of White (non British) origin between April 2014-March 2015, stood at **116**, this is a **52.63%** increase from the **76** cases received for alleged victims of White (non British) origin between April 2013-March 2014.

Alleged victims who were of Indian origin, also increased from 13 cases referred between April 2013-March 2014, to **23** cases referred between April 2014-March 2015, a rise of **76.92%**.




## Primary Support Reason

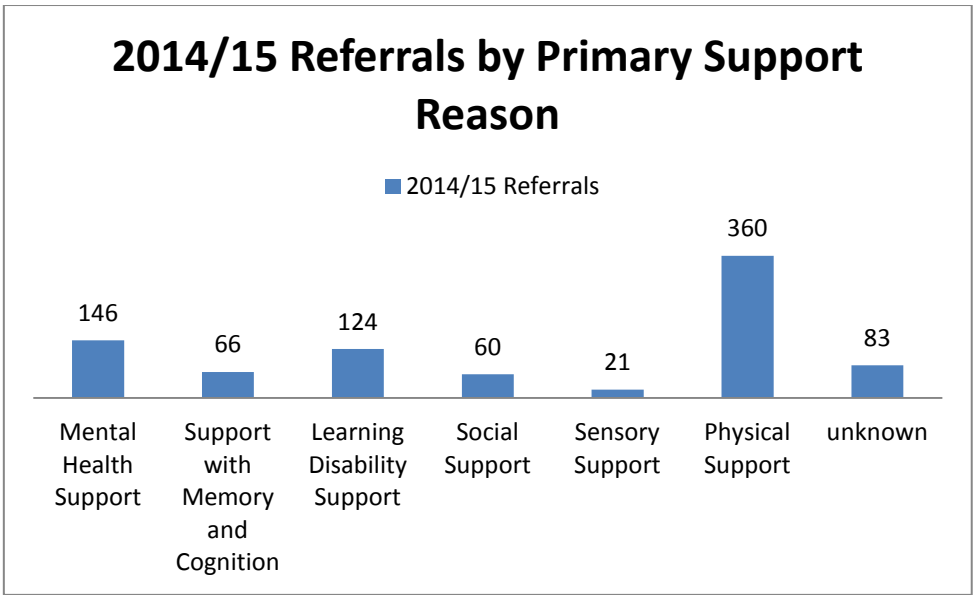
As from 1st April 2014, all Local Authorities no longer collect 'Service User Group' data, and instead collect information relating to the alleged victim's 'Primary Support Reason'. That is the main 'reason' they require support or care.

The number of referrals received between April 2014-March 2015 for alleged victims with Learning Disabilities stood at **212**, this is a **30.53%** increase compared to the **95** referrals received between April 2013-March 2014, for alleged victims with Learning Disabilities.

Similarly, the number of referrals for people who require Mental Health support, or support with memory and cognition aged **18-44** received between April 2014-March 2015, stood at **81**, this is a **52.83%** increase compared to the **53** referrals for

people with Mental Health issues aged **18-44** received between April 2013-March 2014.

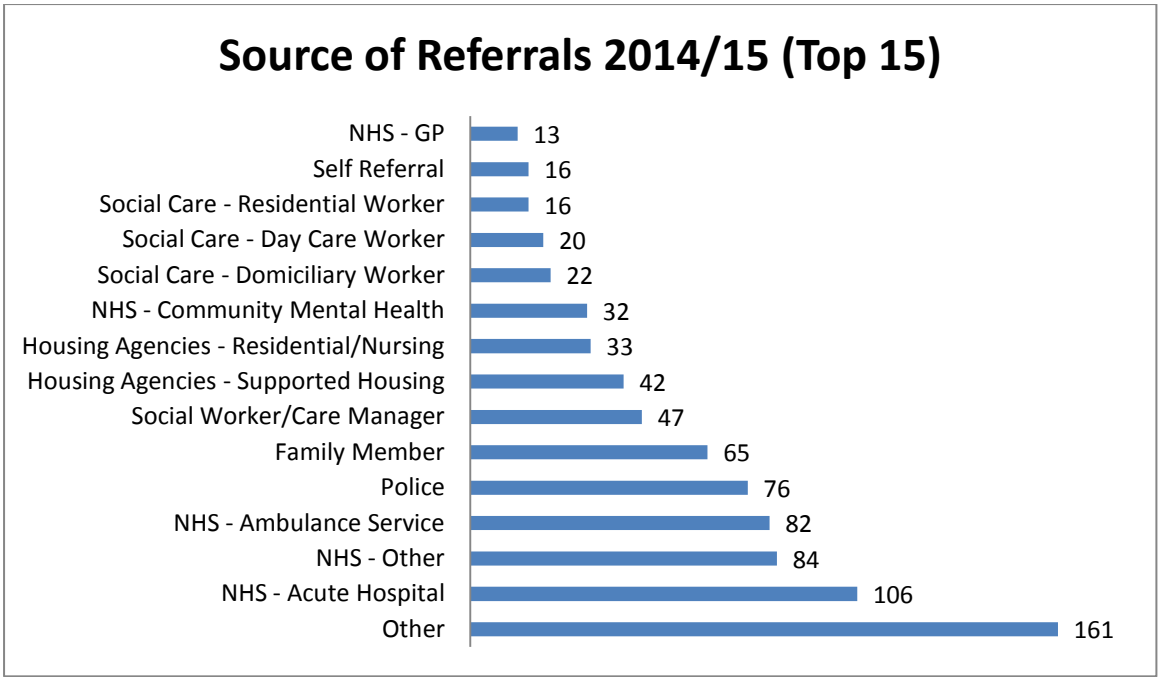
Overall Mental Health referrals for adults aged **18+** increased by **8.72%** between the two subsequent financial years.




## Sources of Referrals

The people who are most likely to report concerns about abuse and neglect are health* and social care staff. This is not surprising because health and social care staff get a lot of training and advice on spotting abuse and neglect. Also, adults with care and support needs are likely to be visited or monitored regularly by health and social care staff.

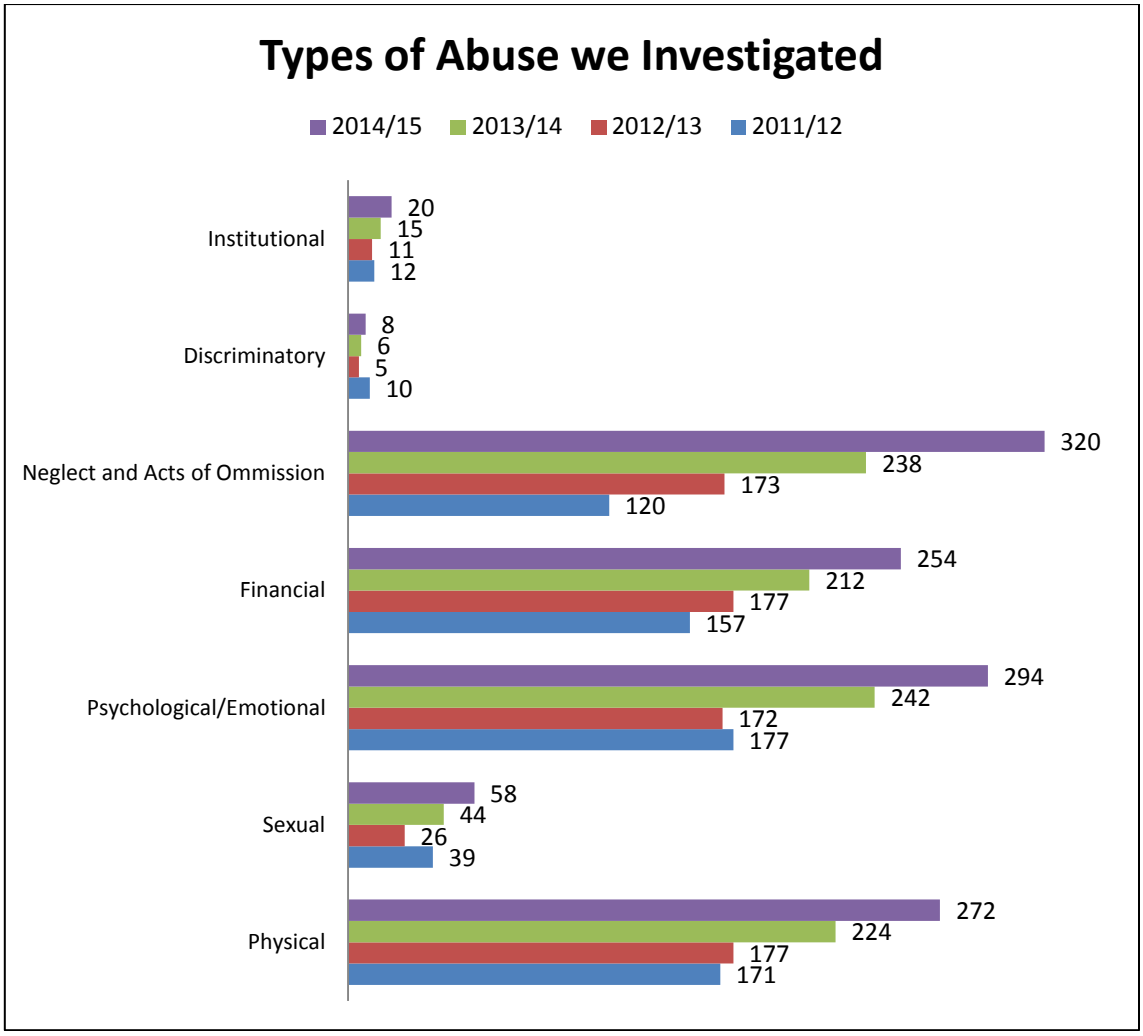
*Health Services includes referrals from acute hospitals, ambulance service, community mental health team, GP, CCG etc. Social care staff includes day care, domiciliary, residential workers and Care Managers.



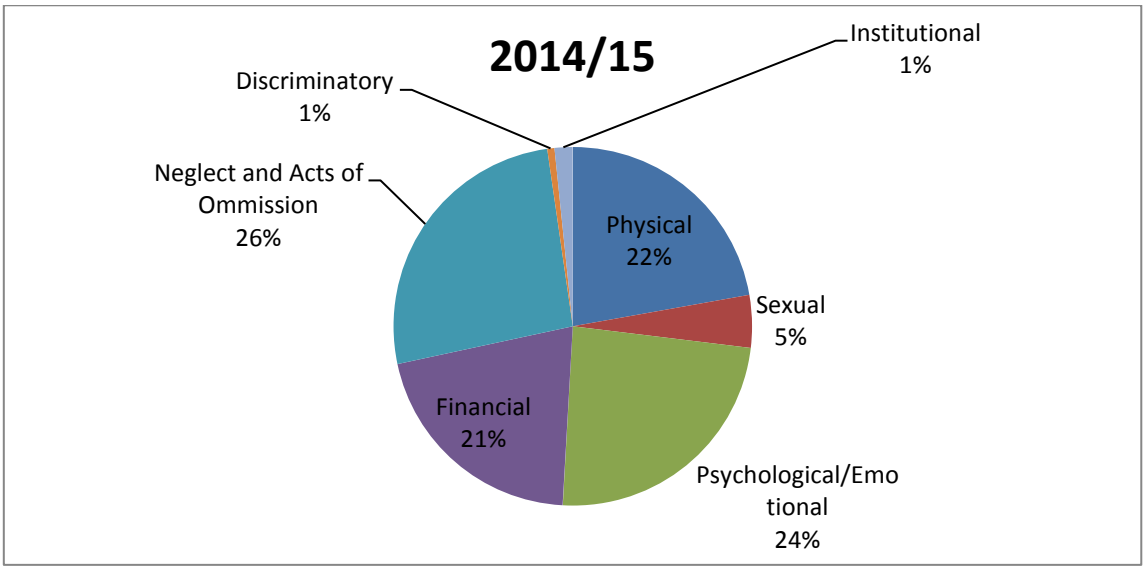

## Types of Abuse

In 2012/13, the majority of safeguarding referrals were reported and recorded as 'Physical' abuse and 'Emotional/Psychological' abuse, both with 177 cases compared to 171 and 177 in 2011/12. In 2013/14, the most notable increase is the number of referrals for 'Psychological/Emotional' abuse 242 (25%), and 'Neglect and Acts of Omission' 238 (24%).

The chart below shows that over the course of 2014/15, the most common types of abuse investigated were 'Neglect and Acts of Omission'. As previously mentioned, with the introduction of the Care Act 2015 we now have a duty to investigate additional types of abuse; domestic violence, modern slavery and self-neglect in future. We will report on these in our next annual report.


Types of Abuse we Investigated
2014/15
2013/14
2012/13
2011/12
Institutional
20
15
11
12
Discriminatory
8
6
5
10
Neglect and Acts of Ommission
320
238
173
120
Financial
254
212
177
157
Psychological/Emotional
294
242
172
177
Sexual
58
44
26
39
Physical
272
224
177
171

The following pie chart shows the percentage breakdown of the nature of the alleged abuse reported in 2014/15.




## Financial Abuse Case Study Example

Mr X's case demonstrates effective joint working between social care staff, our fraud team and the Police to take action to protect an adult with care and support needs from financial abuse.

Another local authority notified Haringey Adult Social Services of an individual living in Haringey following concerns from a neighbour that items were being removed from his property in West Sussex. Upon investigation, the Police found that Mr X had changed his Will to leave all of his estate to his live-in carer, and that large amounts of cash had been withdrawn from his bank account by the carer. Over £16,000 in cash was also seized during the investigation.

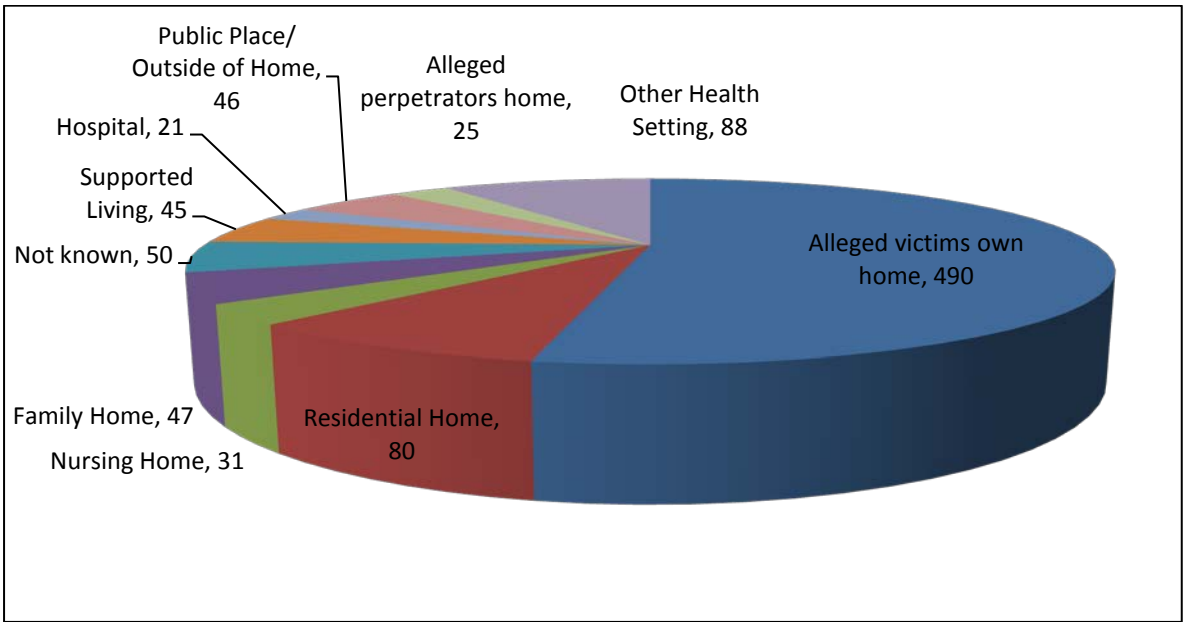
Social care staff supported Mr X to move into a residential home as a place of safety, to stop the planned transfer of his home and to write a new Will. Mr X was also helped to appoint his solicitor as a Lasting Power of Attorney for property and financial affairs.

In June 2015, the live-in carer and her partner were given prison sentences after pleading guilty to theft and fraud by false representation. By working in partnership with the Police, the Council successfully ended the financial abuse of Mr X and helped to bring the perpetrators to justice.

## Location of abuse investigated

Abuse can happen anywhere: for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can happen when someone lives alone or with others. It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

Abuse and neglect in care homes and hospital often make media headlines. The abuse at Winterbourne View Care Home and the neglect at Mid-Staffordshire NHS Trust got a lot of media coverage. The chart below shows the real story, more than half of all cases of abuse and neglect take place in the adult's own home.




## Safeguarding Outcomes

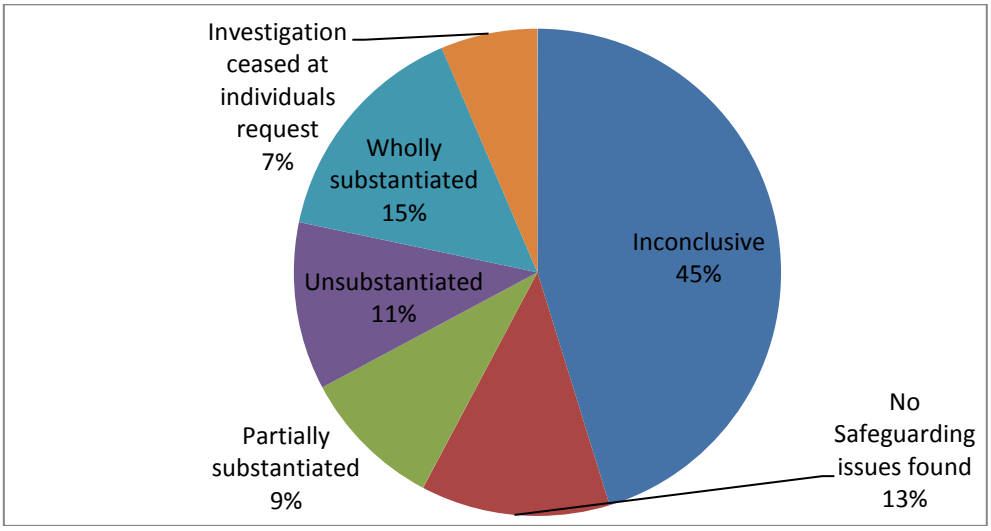
For every case investigated and it is determined that abuse has happened it is substantiated: evidence presented supports the allegation of abuse. Where there is more than one type abuse reported and it is considered that it partly happened, it is partially substantiated). For example, in a case of alleged physical abuse and financial abuse, the evidence supports the allegation of physical abuse but the evidence does not support the allegation of financial abuse therefore the overall outcome is partially substantiated.

If the evidence presented disproves the allegation of abuse, then we determine the abuse did not happen - unsubstantiated). If a decision cannot be made due to lack of evidence or some evidence does not support the allegation, it is therefore inconclusive.

In 2013/14, **680** safeguarding investigations were concluded (including investigations started the previous year). In **116 (17%)** of cases the abuse was confirmed as substantiated and in additional **50 (8%)** cases, where there was more than one allegation, partially substantiated.

In 2014/15, the number of cases concluded as "inconclusive" has increased by **40.89%,** from **225** cases recorded April 2013-March 2014, compared to **317** cases recorded between April 2014-March 2015.

In addition, the number of cases concluded as "partially substantiated" has increased by **60.98%,** from **41** cases recorded April 2013-March 2014, compared to 66 cases recorded between April 2014-March 2015.




This chart refers to investigations which were completed during the year. These include some cases which were started in the 2013-14 year, but completed in 2014-15.

In **45** cases the investigation was ceased at the request of the adult; as the adult's wishes need to be respected. However, in circumstances where there are serious risks to other adults or children an investigation will be instigated.

In all safeguarding investigations the adult at risk will be helped to stay safe from harm. If necessary, monitoring of the adult at risk will be increased, and changing the frequency, type or location of their care. Action will be taken against the person who caused the harm. This might include removal from a service, further training or disciplinary action if they were a paid carer.

# 9. Responding to the Safeguarding Statistics

Referrals and alerts are increasing every year; this demonstrates that our safeguarding awareness programme is working and that the message is reaching to members of the public. However, the work does not stop here. We need to continue to increase safeguarding awareness, and this will be done through the Training and Prevention Subgroup.

Only **21%** of all alerts received were investigated, this means that **79%** of the alerts did not meet the safeguarding investigation threshold. Alerts that do not meet the threshold are signposted to the appropriate team in ASS or partner organisations for information and advice.

In light of the above, we will be working closely with partner agencies to ensure that only appropriate alerts are sent to ASS, this will be done by providing training and briefing sessions on what constitutes abuse and how to see the signs. Increasing awareness of what constitutes abuse will reduce the number of alerts that we receive so we can concentrate more on actual safeguarding investigations.

As previously mentioned, the most common type of abuse in 2014/15 was Neglect and Act of Omission. Our priority in this area is to reduce the numbers. We need to ensure that good quality care services are provided and also providers are registered with the CQC. We will do this by ensuring our monitoring procedures and preventative measures (through our providers) are in place to ensure that individuals have:

- Choice from making their own decisions;
- Appropriate privacy and dignity;
- Access to food, shelter, clothing, heating, stimulation and activity, personal or medical care; and
- Freedom to practice individuals' cultural, religious or ethnic needs.

The Statistics will help us plan ahead and set ourselves priorities for our Safeguarding Strategic Plan and Prevention Delivery Action Plan for the coming year. Some of the areas that we will wish the Board to consider us working with are highlighted below:

- Use data collection to target under reporting in Asian and non white BME groups;
- Work with care home providers to run sessions on signs of abuse/ neglect for staff, families and residents;
- Continue to raise awareness of fraud and financial abuse including leafleting and newspaper articles;

- Training events across the Borough to capture greater local participation by the Elder Community - supported by voluntary organisation and charities such as Help the Aged;
- Continued roll out of Safeguarding e-learning including the CSE course and 2015 basic Safeguarding to ensure employees up to date with Safeguarding training;
- The Met Police to provide Safeguarding Adults awareness training to the Police Independent Advisory Group (IAG) to achieve greater education within Haringey's communities but also to harness critical friends to the Partnership Panel; and
- Harnessing support of the Haringey Business Community through the Responsible Retailer Scheme (RRS) and the newly established Licensees Forum to encourage responsible retailing and health awareness.

# 10. Appendix A – Full Partner Statements

## Haringey Adult Social Services

### Overview 2014-15

The Adult Social Services Quality Assurance Board ensures that quality assurance arrangements are in place across Adult Social Services to gather information on the quality of services provided, service user feedback and data on the outcomes achieved for people using Adult Social Services. The Board ensures that this information is analysed and used to inform service delivery as well as strategic planning and commissioning.

Haringey's Adult Social Services continues to make great strides in terms of further enhancing its safeguarding practice. Cases such as Winterbourne View, The Francis Report and recent evidence for national Care Quality Commission findings into home care and dementia care have highlighted poor and variable safeguarding practice. With such care quality concerns we have to assure ourselves that we have good care quality standards.

Perhaps the most fundamental change facing the Council arose from the implementation of the Care Act which received Royal Assent in May 2014 - to bring all care and support legislation into a single statute and address many of the recommendations made by the Dilnot Commission into the funding of adult social care.

Implementation is in two phases, with the main impact of the funding reform starting from April 2016; however from 2015/16 there will be a range of implementation issues and associated costs.

The changes taking effect from April 2015 can be broadly summarised as follows:
- New duty to arrange care for self-funders, including for residential care;
- New duty to provide deferred payments (currently discretionary);
- New duty of prevention and wellbeing to prevent or delay the need for care;
- New duty to provide information and advice, including about paying for care;
- Introduction of national eligibility criteria for adult social care;
- Extension of eligibility criteria to include carers;
- New duty to provide personal budgets for people with eligible needs;
- The introduction of statutory Adult Safeguarding Boards and associated responsibilities for adult protection; and,
- New duty to shape local care and support the market.

Making Safeguarding Personal is a key component of the improvement work that is being led by ADASS and LGA.
- In 2011-12, 'Making Safeguarding Personal: A Toolkit of Responses' was developed.
- For 2013-14, the Making Safeguarding Personal programme invited Councils to support both the implementation of the Care Bill and its associated statutory

guidance and safeguarding improvement.
Haringey has signed up to take this forward and will participate at 'silver' level – to support the realisation of the outcomes people want.

## Internal safeguarding adult's governance arrangements

Safeguarding adults at risk of abuse remains a priority for the Council. The *Corporate Plan 2013-15* sets out 'Safety and wellbeing for all' as one of four key Council priorities. Adult Social Services has an important role to play in delivering this priority through its work around adult safeguarding.

The Adult Social Services Quality Assurance Board involves a wide cross-section of Haringey's Adult Services staff to ensure a high level of ownership and to embed good practice right across Adult Social Services. The purpose of the QAB is to ensure that quality assurance arrangements are in place across Adult Social Services to gather information on the quality of services provided, service user feedback and data on the outcomes achieved for people using Adult Social Services. The Board ensures that this information is analysed and used to inform service delivery as well as strategic planning and commissioning.

## Safeguarding adults work undertaken and key achievements in 2014-2015

The Board's Improvement and Quality Action Plan is currently being developed to include key improvement projects identified in the Adult Social Services Local Account (2013-14), local authority priorities from the Safeguarding Adult Audit Tool improvement plan, and practice issues around Deprivation of Liberty Safeguards, the Care Act and health and social care integration. This enables key projects across Adult Social Services to be monitored by the Quality Assurance Board on a quarterly basis.

Work has been undertaken as part of the Making Safeguarding Personal initiative to prepare for the introduction of an adult safeguarding user survey looking at the outcomes of safeguarding investigations. Department of Health guidelines require 10% of safeguarding referrals to be surveyed and the survey must be carried out by qualified professionals. Adult Social Services are currently identifying the resources needed to implement the survey in 2015.

Complaints learning reports are presented to the QAB. There were no upheld complaints concerning adult safeguarding in 2014-15.

New case file audit templates will be introduced in July 2015 to reflect new Department of Health and Care Act requirements. This will include adult safeguarding case file audits.

Adult Commissioning is continuing to work with external providers to improve their safeguarding practice and whistleblowing policies. Quality assurance reviews of all supported living provisions in Haringey are also being carried out.

Safeguarding adults' performance data for is presented and analysed at the Quality

Assurance Board, prior to presentation to the Safeguarding Adults Board.

An update was provided to the Quality Assurance Board on how Adult Social Services have been managing the huge increase in Deprivation of Liberty Safeguards (DoLS) cases that have arisen following the Cheshire-West ruling.

We extended the local network of Dementia Friends to help support people with dementia in the community.

We tendered a tri-borough contract for an advocacy service. The new service links to assessment and care planning and will ensure the Council meets its new statutory duties arising from the Care Act 2014.

## Key challenges

Work is under way to move to a multi-agency Quality Assurance sub-group and widen the remit to include partnership working. The focus will be on partnership issues, predominantly good practice, performance and quality assurance. The terms of reference and membership of the QAB will be revisited in order to take this forward.

## Safeguarding adults work planned for 2015-2016

Safeguarding adults at risk of abuse remains a priority for the Council. It is a key objective of Priority 2 of the Council's *Corporate Plan 2015-18*. Adult Social Services has an important role to play in delivering this priority through its work around adult safeguarding.

Continue to promote awareness of adult safeguarding, including a targeted safeguarding awareness campaign to raise knowledge and reporting of adult safeguarding concerns.

Fully embed adult safeguarding user survey to identify whether people's needs are met through the safeguarding investigation process.

Continue to implement the Adult Safeguarding Prevention Strategy delivery plan. Embed Deprivation of Liberty Safeguards (DoLS) procedure and guidance for staff.

Review and consolidate methods for monitoring safeguarding referral data.

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

The Council ran a targeted safeguarding awareness campaign to raise knowledge and reporting of safeguarding concerns.

## WHITTINGTON HEALTH

### Overview 2014-15

Executive Leadership for Safeguarding is provided by the Director of Nursing and patient Experience.

Despite having a gap in the recruitment of a substantive Safeguarding lead the Trust continued to keep Safeguarding at the forefront of its work.

A review of Safeguarding practices was carried out by an external reviewer in early 2015. The actions from the review have been incorporated into the Trust Safeguarding work plan.

### Internal safeguarding adult's governance arrangements

The Safeguarding Lead attends the Safeguarding Adults Board and Board sub groups.

Whittington Health hosts a quarterly Safeguarding Committee attended by staff and partners from the CCG and Local Authorities.

Reports are prepared for the safeguarding adults committee and the Trust Quality and safety committee.

Invitations to the attend the Trust Safeguarding Adults Committee are extended to the Local Authority Safeguarding Team and the Clinical Commissioning Group

### Safeguarding adults work undertaken and key achievements in 2014-2015

The Care Act came on to the statue books on the 1st April 2015, training materials have been reviewed to reflect the changes.

Policy review is ongoing this includes Pressure Ulcer policy, Recruitment and Retention, Restraint in Care, Information sharing, Being Open, Safeguarding Adults at Risk, PREVENT, MCA, Serious incident, Disciplinary and Safer Recruitment, Patient Experience, Complaints and Privacy and Dignity. The Trust is using the National guidance for the reporting and management of Pressure Ulcers.

Haringey CCG funded training for staff to undertake the role of MCA champions, this will allow them to support staff in practice and undertake MCA training.

The Trust Domestic Abuse Coordinator delivers training to staff across the Trust; she has developed a Domestic Abuse policy that was ratified in 2015.

The Safeguarding Adults Lead in conjunction with the Domestic abuse Coordinator and the practice development lead in ED established a complex case meeting; this

occurs weekly and is attended by clinicians from ED, Ambulatory care and Older adults. Cases are triangulated with the Children's complex case meeting.

## Key challenges

The Trust had experienced challenges maintaining level 2 Safeguarding adults training figures. A plan is in place to deliver training to staff from across the organisation in order to achieve the required level by July 2015.

## Safeguarding adults work planned for 2015-2016

- To appoint a named Dr for Safeguarding Adults;
- Review the Safeguarding Adults Policy to reflect the PAN London Guidance 2015 ;
- To ensure that staff understand the Making Safeguarding Personal agenda (MSP) ensuring that patients voices are heard and listened to;
- To continue to deliver Mental Capacity Act and DoLs training;
- To deliver training to and raise awareness of the PREVENT agenda as part of the Governments strategy;
- To continue to work in collaboration with partner organisations to safeguard people;
- To ensure that lessons learned are imbedded into practice, evidence through governance meetings;
- To develop systems to establish the impact of safeguarding training on practice; and
- Participate in the Self-Assessment Framework (SAF) reviewing the outcomes on a 6 monthly basis linking the outcomes to the Trust work-plan.

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

- The Safeguarding Adults lead is delivering level 1 and 2 safeguarding training to staff across sites and at the Whittington Education Centre, these sessions have all been well attended and the feedback positive;
- There is a monthly session delivered to all new employees as part of the induction course;
- Training has also been delivered to the organisations volunteers.
- The Trust has developed an induction booklet for all new staff that contains key information on Safeguarding, including recognising abuse and what action to take; and
- The Trust level 2 Safeguarding Adults training has been attended by the CCG designated professional and the Safeguarding lead of a neighbouring Trust, this peer feedback was helpful.

## NORTH MIDDLESEX HOSPITAL NHS TRUST

### Overview 2014-15

The Trust has an up to date Safeguarding Adult's Policy that sets out responsibilities, reporting and investigating procedures for the protection of adults at risk. This policy supports and encourages staff to immediately report any concerns that they may have about possible abuse to a person at risk whilst the patient is receiving treatment or care at the hospital.

Over the last year, the Trust has continued the focus on raising awareness of its safeguarding adults procedures and policies. This approach enables staff to recognise abuse situations and report or escalate in order for them to be investigated by the appropriate agencies.

The Trust continues to work with the Enfield and Haringey Social Services Safeguarding Adult Teams to comply with requirements for following up Safeguarding Adult alerts. Trust staff attend Safeguarding Adult Strategy Meetings and Case Conferences as required.

### Internal safeguarding adult's governance arrangements

As part of the Trust's adult safeguarding responsibilities, it is required to provide trust representation at the local multi agency Safeguarding Adult Boards. The Trust is currently represented on both the Enfield and Haringey Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust has maintained an active participation in the Safeguarding Adults Boards undertaking work streams as required throughout the year.

The Trust has an established Safeguarding Adults Group which has representation from our inter professional and inter agency groups. It provides the strategic direction to safeguarding adult activities across the Trust and ensures that all safeguarding commitments and responsibilities are met. Its purpose is to promote engagement with all agencies and to gain assurance that standards set out in the 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' are met.

The Safeguarding Adults Group is chaired by the Deputy Director of Nursing and reports to the Trust Risk and Quality Committee. This ensures that scrutiny can be achieved at several levels which also involve Trust Non Executive Directors. The Safeguarding Adults Group also maintains an organisational overview of the implementation of the legal requirements of the Mental Capacity Act and the associated Deprivation of Liberty Safeguards (DOLS).

The Trust Board receives an Annual Report and work plan on the Trust's Safeguarding Adults arrangements.

## Safeguarding adults work undertaken and key achievements in 2014-2015

The Care Act requirements for Making Safeguarding Person requires us to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices. Family or representatives are now routinely invited to Safeguarding Adult Strategy meetings and Case Conferences to ensure their early involvement in decisions made and Protection Plans.

The Trust is committed to making improvements in response to lessons learned from the findings from Safeguarding adult investigations. Examples to changes in practice that have taken place in the Trust over the previous year include:

- Review of handover information about the patient's condition on discharge, including a discharge letter with a body map and description of any injuries and pressure ulcer management required
- discharge checklists for discharge procedures in order to ensure that patients are discharged with relevant and up to date information
- The Trust has developed a Missing and Absconding Persons Policy
- Staff have been reminded to ensure that Mental capacity assessments (Mental Capacity Act 2005) and rationale for Best Interest Decisions are fully completed and discussed with family members
- Staff are required to document Best Interest Assessments in the patient's medical file, in the event that treatment is withheld
- Increase focus on requirements for Deprivation of Liberties Safeguard applications for patients who lack capacity and are provided with one to one supervision
- the Mental Capacity Act and Deprivation of Liberty Safeguards Policy has been updated to reflect the guidance provided following the Cheshire West Case Law issued in April 2014
- updated Deprivation of Liberty Safeguard application forms issued by ADASS in January 2015
- developed a Domestic Violence Policy which is available on the hospital intranet
- Ward Managers and Matrons were invited to attend a Mental Capacity Act and DoLS training update on 25th June 2014,
- a DOLS briefing sheet / flowchart has been circulated to all Consultant Medical Staff, Matrons and Ward Managers
- Trust Safeguarding Adult Lead working with the Care of the Elderly Consultants to undertake sample ward audits to identify patients who might potentially meet the criteria for Deprivation of Liberty Safeguards referrals
- The number of DoLS applications progressed by the Trust has gradually increased over the previous year as ward staff are now more aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguard requirements.

## Key challenges

Ongoing Mental Capacity Act, Best Interest decisions and Deprivation of Liberty Safeguards training

## Safeguarding adults work planned for 2015-2016

The Trust needs to update its Safeguarding Adults Strategy in line with the recommendations from the Department of Health, Care Act 2014: statutory guidance for implementation and in response to national directives arising from the Supreme Court judgement on the Cheshire West case.

### Key priorities for the Trust in 2015/16

- ensure that Trust Safeguarding Adults Policies and procedures are up to date and comply with current legislation and implications of the Care Act 2014
- progress further work on the 'Making Safeguarding Personal' programme, to ensure that the adult, their families and carers are supported and informed about choices available to them for ongoing protection
- further work to develop a training plan for Mental Capacity, Best Interest Decisions and Deprivation of Liberty Safeguards
- ensure that reasonable adjustments are made as necessary for those with Learning Disabilities
- improve Domestic Violence support available to patients
- further Prevent Wrap training for all staff
- strengthen links for Safeguarding Adults and Child Protection work
- develop our work with patients who may need to have restrictions and restraints on their behaviours in their best interests
- ensure that Deprivation of Liberty Safeguard applications are progressed as required
- ensure that Mental Capacity Assessments and Best Interest decisions are formally recorded in patient medical records as required

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

A significant amount of work has been done to ensure that staff are trained to the correct level for level 1 and level 2 Safeguarding Adult training. Trust e-learning programmes included in training options available for staff

We continue to train staff through face-to-face training and e-learning packages. Safeguarding Adult Level 1 training is mandatory in the Trust for all new staff at induction. At end March 2015:

- 80% of all staff had completed their Safeguarding Adult level 1- training (compared with 56% at the start of the year).

Safeguarding Adult Level 2 training is provided as face to face training for relevant groups of staff and covers the Mental Capacity Act and Deprivation of Liberty Safeguards. The training figures are presented to the Trust Risk and Quality Committee on a quarterly basis. At the end of March 2015:

- 70% of relevant staff had completed their level 2 Safeguarding Adult training (compared with 40% compliance at the start of the year).

There is also ongoing training programme to raise staff awareness on the Government PREVENT programme which teaches them how to recognise vulnerable individuals who may be at risk of being drawn into terrorist activity.

## HARINGEY ASSOCIATION OF VOLUNTARY & COMMUNITY ORGANISATIONS (HAVCO)

### Overview 2014-15

HAVCO, a small umbrella organisation, supports a diverse range of groups, organisations, charities, Not-for-Profit companies and individuals with voluntary and community working as their core business and purpose.

Providing information and guidance is a key role, which includes assisting the development of new and existing organisations to meet good standards of safeguarding practice across all ages.

HAVCO's Board of Trustees, many of whom lead VCS organisations, committed to responding to future local and national safeguarding guidance when approving HAVCO's updated Safeguarding Policy.

As the Council's Strategic Partner representing the VCS, HAVCO committed to being represented at the Safeguarding Adults Board (SAB) at CEO level, in line with the new Care Act 2014 requirements. Being a small organisation, this was identified as a key statutory meeting. Therefore agreement was reached by all parties for a Board Trustee member to represent HAVCO at the SAB. This matched the existing HAVCO/VCS arrangements at the Local Safeguarding Children's Board, also introduced during this year. Attendance at both Boards was supported by HAVCO's Interim CEO.

### Internal safeguarding adult's governance arrangements

HAVCO's Safeguarding Policy, updated in 2014 was ratified by the Board of Trustees.

HAVCO's Personnel and Strategy Sub Committee considers matters related to safeguarding.

### Safeguarding adults work undertaken and key achievements in 2014-2015

Although HAVCO is not a statutory partner, we fully participated in the SAB's Peer Challenge and Support Event held in June 2014.

Information has been made widely available to over 900 member organisations through HAVCO's E-Voice newsletter, which includes safeguarding information.

The Volunteer Centre and Supported Volunteering Project, hosted by HAVCO, provided access to safeguarding information in respect of working with volunteers. Direct work with member organisations included completing Disclosure and Barring Service applications to ensure ongoing compliance; and advice and guidance on policies and procedures covering Volunteer Management and best practice for

safeguarding.

HAVCO's volunteering leads are members of Haringey's Mental Health Stigma Group and the End of Life Forum, which have synergy with safeguarding matters.

As part of our supporting volunteer work, where residents that face barriers to volunteering are matched to volunteer opportunities; many of the clients are adults with complex needs such as unemployment, mental health, learning difficulties, ex-offender etc. We have exceeded set targets as a significant number of our clients have successfully gained employment.

## Key challenges

The rate at which established VCS providers change and the continuous development of new groups and organisations is significant in Haringey. HAVCO's knowledge of and involvement with them, is entirely at the choice of each group or organisation. This is particularly challenging for those providing frontline services which have not been commissioned by Haringey Council or Clinical Commissioning Group (NHS), as there is no systemic external monitoring or scrutiny of their practice.

## Safeguarding adults work planned for 2015-2016

HAVCO does not directly provide safeguarding services. Our leadership and support role is underpinned by our strategic priorities. These have recently been revised for the next three years;

- **Strategic Priority 1:** Support communities to increase resilience.
- **Strategic Priority 2:** Encourage greater partnership working and better sharing of resources.
- **Strategic Priority 3:** Strengthen influence and leadership role to benefit communities.
- **Strategic Priority 4:** Improve and change HAVCO so that provision better meets the needs of local communities.

We are also at the early the early stages of scoping out what specific support we can offer people with early onset of Dementia as part of our Supported Volunteering work.

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

As a member of the SAB, staff at HAVCO have access to Haringey's online safeguarding training. Safeguarding training for supported volunteering officers is mandatory. HAVCO also promotes safeguarding resources as part of our regular communication with groups and organisations.

## BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (BEHMHT) AND ENFIELD COMMUNITY SERVICES (ECS)

### Overview 2014-15

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) understands and acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all our patients remains a priority for the Trust as we see it as a fundamental component of all care provided. Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust is essential. Over the past year, the safeguarding arrangements across all Trust services has continued to be strengthened, with a particular focus on ensuring our staff receives an appropriate level of safeguarding training.

The Executive Director of Nursing, Quality and Governance is the Executive Lead for Safeguarding Adults in the Trust. The Trust has a Safeguarding Team consisting of the Head of Safeguarding People, the Safeguarding Adults Lead and Safeguarding Children's lead.

The Trust's Safeguarding Annual Report and work plan continues to be developed on a yearly basis, for consideration and approval at the Governance and Risk Management Committee (GRMC) and is ratified by the Trust Board. The executive lead represents the Trust at the three Safeguarding Adults Boards. The management of safeguarding cases in Haringey is co-ordinated by Haringey Council. In Barnet, the management of safeguarding cases is co-ordinated by the Community Mental Health Team Managers and Team Managers within the integrated teams. This is similar to Enfield for the year 2014/15.

As part of our integrated governance structure, the Board receives an Annual Report and work plan on the Trust's Safeguarding Adults activities. At each public Board meeting the Trust Board receives an update on the number of alerts, investigations and related activities.

The Trust ensures the Safeguarding Adult Committee meets on a quarterly basis. The Committee is chaired by the Executive Director of Nursing, Quality and Governance. Other members of the committee are assistant directors from each service line or their representatives and safeguarding leads from the local authorities and CCGs. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults. The function of the Trust Safeguarding Adults Committee is to direct and ensure an overview of the safeguarding adult work programme and practice in the Trust. The Committee ensures that national and local practices are adhered to within the organisation and the sharing of learning.

There is a bi monthly practice development group co-ordinated by the Enfield Safeguarding Adults Team of which the Trust is a member. This forum allows for sharing of best practice and learning across all agencies.

The Trust has in place a Safeguarding Surgery. The surgery was developed in 2014

and has been well received and utilised by staff. The forum promote patient-centred approach; Making Safeguarding Personnel (MSP), collaborative working with our partners and bringing new legislation to staff awareness.

The Trust has a safeguarding audit that is completed on a monthly basis by managers. Strengths, areas for improvement and actions plans are agreed and delivered. The Trust's safeguarding committee has oversight of the process and improvements.

## Safeguarding adults work undertaken and key achievements in 2014-2015

- The Safeguarding team has been working closely with the local authority and the various teams in driving the MSP agenda.

- Strong multi-agency partnership working, including internal and external partners.
- Review the DoLS and MCA policies and frameworks in light of Cheshire West ruling
- There are monthly safeguarding surgeries in the trust, attended by clinicians from across the organisation. Presentation includes the Care Act- (MSP), domestic violence / abuse, Child Protection and opportunity to discuss complex issues concern to staff.
- The pressure ulcer forum now meets monthly and is attended by clinicians from across services, the protocol has been agreed and a plan for roll out is being implemented.
- Datix Incident Reporting to link with safeguarding team enabling automatically generated alerts when incidents with a safeguarding element are reported.
- A restraint in care protocol has been developed for our older adults services.
- The Trust took part in the Oaks learning event. Areas for improvement / development have been fully implemented.
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC's regulatory framework on all inpatient units and Community Teams. The Trust is fully compliant
- The Safeguarding Team have been delivering bespoke training to teams which has led to an increase in awareness that safeguarding is everyone business to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity.
- We have developed safeguarding champions in different areas to support staff. Issues where processes are not understood or where there are performance issues these are brought to the attention of the champions and staff are supported to address issues/concerns.
- MCA / DoLs lead for the Trust has led on the delivery bespoke training to teams. Subsequently awareness in IMCA and Advocacy services has improved.
- Adult Safeguarding training level 1 is part of the mandatory training programme for all staff of which compliance is monitored through the

Electronic Staff Record. Attendance record achieved above 85% throughout the year.

- There has been an increase in referrals for MARAC by the Trust as compared to last year. This is due to domestic violence training through the Safeguarding surgery.
- Safeguarding training have included the following; Female Genital Mutilation, Prevent and whistleblowing. This ensures staff are trained and understand the issues and know how to report concerns.

## Safeguarding adults work planned for 2015-2016

- Have a continued programme of level 1 Safeguarding Adults training with 85% compliance achieved.
- Review of the Trust Self-Assessment using the Safeguarding Adults Assurance Framework for Healthcare Services.
- BEHMHT recognises the importance of people's voices being heard and listened to within the safeguarding adult's procedures, staff to be compliant with the Care Act in relation to Making Safeguarding Personal (MSP) and the use of Advocacy services.
- Ensure learning from safeguarding cases is embedded into practice, via supervision and Trust training programmes.
- Remain responsive and reactive to changes as they occur in policy directives or good practice guidance.
- Continue to raise awareness of the PREVENT agenda and support staff to raise concerns.
- Raise awareness and promote the system of reporting Mental Capacity Assessments (MCA) and Deprivation of Liberty (DoLS) applications amongst staff.
- As part of a quality measure, team managers to audit one case file per month on Meridian. Action plans, recommendations and lesson learnt for followed up to improve practice.
- The Trust will be strengthening the links between safeguarding and complaints and/or incident investigations.

## HARINGEY CLINICAL COMMISSIONING GROUP

### Overview 2014-15

Safeguarding, promoting and improving the health of Haringey's vulnerable adults are public health priorities and these are reflected in NHS Haringey's Clinical Commissioning Group's strategic objectives and those agreed with partners. HCCG plays an active role in the work of the Haringey Safeguarding Adult Board (SAB) and works with strategic partners to demonstrate that as a core member of the SAB, HCCG is committed to embedding the fundamental principles for the prevention and protection of vulnerable adults.

### Internal safeguarding adult's governance arrangements

Within Haringey CCG's organisational structure safeguarding is positioned within the Quality and Integrated Governance Directorate under the leadership of the Executive Nurse and Director of Quality and Integrated Governance. This clearly embeds safeguarding as a patient safety service with robust clinical governance reporting arrangements via the Quality Committee.

HCCG's Chief Officer is the executive lead for HCCG's Safeguarding Adults' agenda and has the responsibility for ensuring the effective contribution by health services to safeguarding and promoting the safety of adults at risk and vulnerable people. The Chief Officer is a member of HCCG's Governing Body.

HCCG Director of Quality and Integrated Governance is responsible for ensuring that the monitoring of
Safeguarding Adults work across Haringey takes place through the Quality Committee of the Haringey CCG's Governing Body and the Haringey Safeguarding Adults Board (SAB).

The Assistant Director of Safeguarding oversees the Safeguarding Adults at risk Agenda in the CCG. This role also ensures that all health organisations with whom HCCG has commissioning arrangements with have links with their SAB and is responsible for ensuring Safeguarding Adults systems are in place and monitored.

The Adult Safeguarding Lead provides expertise, a point of contact for advice, and intelligence regarding adult safeguarding across the health economy. This role ensures that HCCG fulfils its statutory functions for safeguarding as detailed in statutory and national guidance, providing assurance to executive leads for safeguarding, that there is a systematic approach to safeguarding across HCCG.

HCCG Safeguarding Adults Lead is a member of Whittington Health, North Middlesex Hospital and Barnet, Enfield and Haringey Mental Health Trusts Safeguarding Committees. The Safeguarding Adults Lead utilises attendance at the committees as one way of gaining assurance that Provider Trusts are ensuring high quality Safeguarding Adults practice is embedded within their organisations. The Safeguarding Adult Lead monitors compliance with the Trusts respective safeguarding adult training strategies through representation on the committees and

takes action as required. Information obtained from these meetings is included in the Quality Committee Safeguarding Briefings.

Safeguarding is a standing agenda item at HCCGs Quality Committee. A monthly briefing is discussed with a more detailed report being submitted 6 monthly. The Quality Committee minutes go to the Bi-monthly Governing Body meetings.

HCCG participates in the Training and Prevent sub-group of the SAB via the Safeguarding Adults Lead or Assistant Director for Safeguarding.

An Annual Report is submitted to HCCG Governing Body.

HCCG's Governing Body General Practitioner (GP) Lead for Adults has specific responsibility for Safeguarding Adults within their portfolio of responsibilities when considering commissioning services for the residents of Haringey

## Safeguarding adults work undertaken and key achievements in 2014-2015

HCCG responsibilities as commissioners is to promote the safety and welfare of adults in all of the services it commissions and provide assurance of HCCG's commitment to prevent and reduce the risk of abuse and neglect of adults and of continuing to improve safeguarding practice in the NHS.

- Mental Capacity Act (MCA) project funds were secured to deliver a programme of training and awareness raising including:
- MCA and DoLS champions training delivered to 30 Acute and Care home Managers.
- Patient engagement and awareness raising events on Lasting Power of Attorney and Advance Decisions for patients and carers.
- Patient information leaflets have been developed on Advance Decisions, Preferred Priorities for Care and Lasting Power of Attorney for GP practices and acute trusts.
- Provider Trust MCA compliance audit rolled out.
- Initiation of the multi-agency MCA and DoLS SAB sub group to embed MCA, share key work areas and find practical solutions to well-established challenges.
- Developed the Key Performance Indicator for contract monitoring, through completion of annual audit and quarterly dashboard for provider trusts.
- Reviewed the Continuing Health Care safeguarding referral pathway

### Safeguarding Provider Monitoring Framework

North Central London Safeguarding Adults Lead network developed a Key Performance Indicators (KPI) for Safeguarding Adults to complement the existing governance. Alongside the KPIs, an annual audit and quarterly dashboard has been developed to monitor safeguarding compliance within provider organisations. The framework will assist providers to focus on essential safeguarding areas in order to collect data that can be used to inform the organisations Safeguarding Adults

Framework and action plans.

**Awareness Raising on Lasting Power of Attorney and Advance Decisions for Patients and Carers**

Awareness raising events have been held for patients and carers on Lasting Power of Attorneys (LPA) and Advanced Decisions To Refuse Treatment (ADRT) with speakers from the Public Guardian Office and Compassion in Dying. Incorporated into this event was a patient engagement exercise evaluating work undertaken to develop patient information leaflets for GPs and Acute Trusts on LPA and ADRT, both capturing whether they thought the information provided addressed their questions and concerns.

## Key challenges

The challenges for safeguarding over the coming year are to continue to develop, expand and embed safeguarding practice within the core work of the CCG; and to continue to build up partnership working with the local authority, local health providers and NHS England (London).

## Safeguarding adults work planned for 2015-2016

- Contractually incorporating Safeguarding Standards in all Provider Contracts.
- Conduct a baseline assessment of HCCG's position against the NHSE Revised Accountability and Assurance Framework to ensure compliancy.
- Support Safeguarding Adults Leads in provider organisations to implement the requirements of the safeguarding adults KPI.
- Update safeguarding adults at risk policy and training competency framework for HCCG to ensure its compliance with the Care Act 2014, revised Accountability and Assurance Framework.
- Develop a MCA and DoLS operational policy, competency framework and assessment tool for the Continuing Health Care Team (CHC) to ensure the CHC team are compliant with MCA legislation.
- To support the development and implement a localised SI and Safeguarding pathway to reduce duplication of effort and to enable timescales to be met and learning recorded/shared as required.
- HCCG Safeguarding Adult Lead will represent HCCG at the newly established MCA multiagency SAB sub group.
- Strengthen governance arrangements with provider organisations by holding 1:1 meetings on a Bi Monthly basis with the lead for safeguarding adults.
- Deliver the Mental Capacity and Deprivation of Liberty Safeguards key projects within 2015; General Practitioner (GP) MCA and DoLS bespoke training, shared learning event for acute providers, GP, MCA and DoLS audit, Lasting Power of Attorney (LPA), Advanced Directive (AD) and Mental Capacity public awareness sessions.
- Develop and roll out MCA, LPA Leaflets to General Practitioners and acute providers. Develop and roll out MCA and DoLS operational policy for care homes, develop and provide MCA and DoLS flash cards for the acute.

- Develop and implement a safeguarding supervision policy to ensure Safeguarding Adults supervision is integral to commissioning and providing effective person centred services that prevent abuse and neglect and that promote the well-being of the individual.
- Develop localised Multi Agency Safeguarding Adults Pressure Ulcer Protocol to ensure a proportionate response to the investigation of Pressure Ulcer care.
- Update the Safeguarding Adults Internet page: To reflect the changes in legislation, national and local policy and guidance.

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

HCCG have implemented the Bournemouth University (National Competence Framework for Safeguarding Adults 2010) which is a national framework that provides consistency and standardisation across practice settings in measuring competence leading to greater accountability.

HCCG's mandatory training programmes encompasses the five core standards of the Bournemouth Framework and expects that staff should be trained to:

- Understand what adult safeguarding is and their role in safeguarding adults;
- Recognise an adult potentially in need of safeguarding and take action;
- Understand procedures for making a "safeguarding alert";
- Understand dignity and respect when working with individuals; and
- Have knowledge of policy, procedures, and legislation that supports safeguarding adults' activity.

All HCCG staff have been allocated a training level according to their contact with adults at risk and any subsequent role in the safeguarding adults process.

Training compliance is monitored monthly by the Senior Management Team and reported Bi monthly at the Quality Committee.

## HOMES FOR HARINGEY

### Overview 2014-15

Community Housing Services unified with Homes for Haringey (HfH) in September 2014. We have taken this opportunity to review our Safeguarding processes and procedures and have set up a Homes for Haringey Safeguarding Group, which includes representatives from all areas of the business.

### Internal safeguarding adult's governance arrangements

The Director of Housing Demand has been the HfH representative on the Safeguarding Adults Board. Safeguarding is a standing item on the Executive Leadership Team (ELT) agenda and accountability extends through the ELT to the HfH Board.

### Safeguarding adults work undertaken and key achievements in 2014-2015

- Full review of processes and procedures and setting up of HfH Safeguarding Group.
- Implementation of the Housing Related Support funded pathway.
- Delivery of a further programme of supported living schemes.
- Rolled out a new safeguarding training programme for frontline staff

### Key challenges

- Meeting the housing needs of vulnerable households in a difficult market with a decreasing level of supply.
- Impact of welfare changes on households.
- Accessing help and support for residents with mental health problems to try and avoid crisis.

### Safeguarding adults work planned for 2015-2016

- Further roll out of training to concierges, estates staff and repairs operatives.
- Additional training linked to the Care Act and housing responsibilities.
- HfH have signed up as a partner to the Haringey Suicide Prevent initiative and will be part of the group developing this work.
- Further development of work to offer support and interventions to households who are experiencing financial difficulties leading to rent arrears.
- Participation in the review of supported housing.

### Details of internal arrangements for providing staff (and others) with safeguarding adults training

- E-learning available to all staff.
- Tailored training offered to frontline staff – phase 1 in 2014/15 and further phase in 2015/16.
- Access to specialist training for Safeguarding leads, if required.

## COMMUNITY SAFETY PARTNERSHIP

### Overview 2014-15

The Director of Adult Safeguarding and the DCS are both members of the Community Safety Partnership. Section 17 of the Crime and Disorder Act requires all parts of the Council and its key statutory partners to consider the prevention and reduction of crime, substance misuse, and reoffending in all that they do.
One of the CSP's 6 strategic objectives is the prevent violent extremism. There is a high level delivery group for this area, chaired by the Deputy Chief Executive. Many of those affected are vulnerable young adults and there are close links to the SAB, MASH and the LSCB.

A further strategic priority is addressing 'violence against women and girls' including domestic violence and this is a shared responsibility across services with common links to the MACE. The Director of Adult Services in on the VAWG Strategic Group and attends any local DV homicide reviews.

Community Safety has joined with Regulatory Services into one unit and this has strengthened approaches such as joint enforcement; strategic licensing; tackling problem premises inc gambling establishments and poorly managed pubs which is aimed at increasing the safety of vulnerable adults.

### Safeguarding adults work undertaken and key achievements in 2014-2015

- Established regular information sharing with A&E hospital departments for the first time
- Increased referrals from schools and colleges for those at risk/vulnerable to extremism and extremist views for the first time. This was facilitated by and by the statutory PREVENT duty and inclusion in OFSTED inspections
- Achieved agreement across the Council and its partners to widen the remit from domestic violence to incorporate all strands of violence against women and girls
- Strengthened the outcomes from the ASB Action Group for repeat and vulnerable victims and expanded the remit to include hate crime victims
- Trading standards undertakes test purchasing to protect young adults from the harm of unregulated alcohol, tobacco etc.
- Fully established the integrated offender way of working for top nominals and gang-related offenders, many of whom are young adults. This team pools resources and expertise to improve the life outcomes and re-offending rates of a specific cohort.

### Safeguarding adults work planned for 2015-2016

- Haringey is a pilot (one of 3 London boroughs) for the gang exit project which is an innovative model based around community support; face to face dialogue with known members of a chosen gang and a carrot and stick

approach to support and enforcement

- Preparing all business units and key partners to comply with the new PREVENT duty including pulling together risk assessments
- Working towards a Business Crime Reduction Partnership for Wood Green and later Tottenham High Road
- Securing resources to continue Victim Support services to young victims and to expand use of restorative justice in adult prisons (now confirmed as successful)
- Support delivery of the innovative MAC UK project which provides forensic mental health outreach services to youths and young adults at risk of gang affiliation
- Develop a whole family approach to the offender management cohort with structured links to Families First
- Re-commission a full service to deliver independent domestic advocacy to high risk clients
- Ensure full application of all new ASB tools and powers and assess their effectiveness
- Continue to raise awareness around Stop and Search and hold the police to account for their performance in this area
- Establish a multi-agency harmful practices group to start understanding and addressing complex issues such as FGB, forced marriage and other forms of violence against women and girls
- Commission highly professional DV homicide reviews, where relevant, ensuring that lessons are learnt, disseminated and monitored to help prevent future tragedies

## HARINGEY CHILDREN SERVICES / LOCAL SAFEGUARDING CHILDREN BOARD (LSCB).

### Internal safeguarding adult's governance arrangements

The Safeguarding Adults Board (SAB) has established strategic and functional links with Haringey's Local Safeguarding Children Board (LSCB).

The Assistant Director for Children and Families is a member of the SAB. Equally, the Joint Head of Governance, Business Management and Improvement Services is a member of LSCB and links across the Directorate and LSCB sub Groups. Two Boards now have a joint Business Manager.

There are also links through the local domestic and gender based violence partnership. The borough's domestic and gender based violence coordinator (for adults and children) operates out of the children's service, and the strategic commissioner is based in our public health service.

Information is shared between the LSCB and the Health and Wellbeing Board. A child sexual exploitation (CSE) themed audit was undertaken to have an overview of multi-agency practice in identifying and responding to allegations of CSE. The Health and Wellbeing Strategy includes consideration of CSE, as well as continuing to focus as a partnership on ensuring that: *Every child has the best start in life*. Following a restructure of the Council's senior management responsibility, the new strategic post of Assistant Director, Commissioning, has been created. The postholder oversees commissioning of services both for adults and children.

### Safeguarding adults work undertaken and key achievements in 2014-2015

*Safeguarding: it's everybody's business* was the focus of the Council's *Improving Haringey* campaign for staff 2015. This year the focus was recognising and reporting CSE. Led jointly by Assistant Directors in Children's and in Public Health Services the campaign was run in collaboration with LSCB partners and it included an awareness raising survey, master classes, e-learning and workshops as well as distributing information packs to statutory and voluntary sector partners and licensed traders like pubs, restaurants, take away outlets and taxis.

The LSCB provides information for parents, families and professionals and has a dedicated website www.haringeylscb.org.uk. Specific guidance published on the site includes:

- Alcohol and substance misuse
- Domestic violence
- Female genital mutilation
- Gangs and serious youth violence
- Neglect
- Parental mental illness
- Sexual exploitation
- Young carers

The LSCB sub-groups continue to focus on specific areas, as well as task and finish groups where these are required. Current sub-groups are:

- Best practice delivery
- Child death overview panel
- Training development and communication
- Quality assurance
- Serious case review
- Disabled children policy and practice review group
- Child sexual exploitation

The Multi-Agency Safeguarding Hub (MASH) has allowed greater opportunities for communication. A workflow has been agreed between the SOVA Team and the MASH for any cases of concern to be discussed, both ways, in the MASH context.

### Domestic and gender based violence

- We have continued to build on achievements of our Domestic and Gender Based Violence Partnership in 2015
- Expert, single strategic lead is now well established for domestic and gender based violence.
- Joint responsibility continues to work well across Community Safety and Public Health.
- Much higher numbers of women at risk continue to be referred to problem solving panel (MARAC).
- High numbers of women are reporting domestic violence to the Police.
- Improved working relations are in place across the Council and partnership.
- We have achieved an increased focus on our response to perpetrators.

## Safeguarding adults work planned for 2015-2016

The CYPS has re launched the strategic MASH Board with a wide ranging partner representation to oversee the contribution to and an effective functioning of MASH. Screening for domestic abuse in children's services: The domestic and gender based violence coordinator will work much more closely with MASH to offer appropriate advice and support to staff to access appropriate services for victims of DV.

The service is also in the process of re commissioning a programme for working with perpetrators of DV as the previous contract expired a few months ago.
We have a dedicated domestic and gender based violence practitioner who works with adults and children.

Along with majority of London Boroughs, Haringey CYPS and LSCB partners have decided to adopt Signs of Safety – Strengthening families practice framework model. Senior managers from LSCB partners have already attended an information session and plans are now in place to roll out training to staff to use this practice framework.

## Details of internal arrangements for providing staff (and others) with safeguarding adults training

There is a joint Learning and Development Board across adults and children services co chaired by the Director of Adults Services and AD for children Safeguarding and Support. The Board focuses on workforce development issues and areas of joint training and development.

LSCB has developed a programme of learning lunches - “bite-sized” learning opportunities for professionals across all agencies. These have included:

- An opportunity for local workers shared their experience of working with CSE in the area and informing agencies
- A focus on the links between safeguarding, gangs and child sexual exploitation.

The LSCB has now published its 2015/16training programme which includes a range of domestic and gender based violence topics and child protection for families with no recourse to public funds.

You can view the LSCB Annual report 2014/15 by clicking on the following link: http://www.haringeylscb.org/lscb.