NOTICE OF MEETING

ADULTS & HEALTH SCRUTINY PANEL

Monday, 5th October, 2015, 6.30 pm - Civic Centre, High Road, Wood Green, N22 8LE

MEMBERS: Councillors Pippa Connor (Chair), Gina Adamou, David Beacham, Clare Bull, Raj Sahota and Felicia Opoku

Quorum: 3

1. FILMING AT MEETINGS

Please note that 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.

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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. APOLOGIES FOR ABSENCE

3. ITEMS OF 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 as noted below).

4. DECLARATIONS OF INTEREST

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

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of 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 interest are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

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

6. MINUTES (PAGES 1 - 12)

To approve the minutes of the Adults and Health Scrutiny Panel meeting held on 29 June 2015.

7. CARE QUALITY COMMISSION (PAGES 13 - 14)

The Inspection Manager for the Adult Social Care Directorate of the Care Quality Commission, London Region, will be presenting an overview of inspections carried out in the borough and those planned for the future, drawing out key trends and lessons regarding the quality of care delivered in the borough.

8. QUALITY ASSURANCE AND DEVELOPING A PARTNERSHIP APPROACH IN HARINGEY (PAGES 15 - 206)

This report provides information on Haringey's approach to Quality Assurance and outlines Haringey's ambition to develop a community wide partnership approach to assuring quality across the Health and Social Care system.

9. HARINGEY BETTER CARE FUND PLAN UPDATE (PAGES 207 - 218)

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

10. WORK PROGRAMME UPDATE (PAGES 219 - 230)

This report gives details of the proposed scrutiny work programme for the remainder of the municipal year.

11. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted at item 3 above.

12. DATES OF FUTURE MEETINGS

The following dates are listed in the diary:

- 5 November 2015
- 18 January 2016
- 1 March 2016

Christian Scade
Principal Scrutiny Officer
Tel – 020 8489 2933
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Email: christian.scade@haringey.gov.uk

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

Friday, 25 September 2015

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Agenda Item 6

MINUTES OF THE ADULTS & HEALTH SCRUTINY PANEL
MONDAY, 29 JUNE 2015

Councillors Connor (Chair), Adamou, Beacham, Bull, Sahota and Opoku

AH33. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

AH34. APOLOGIES FOR ABSENCE

No apologies for absence were received.

AH35. URGENT BUSINESS

There were no items of urgent business put forward.

AH36. DECLARATIONS OF INTEREST

Cllr Connor declared a personal interest as her sister worked as a GP in Tottenham.

There were no disclosable pecuniary interests or prejudicial interests declared by members.

AH37. DEPUTATIONS/ PETITIONS/ PRESENTATIONS/ QUESTIONS

There were no deputations, petitions, presentations or questions.

AH38. MINUTES

AGREED: That the minutes of the meeting held on 18 March 2015 be approved as a correct record.

AH39. TERMS OF REFERENCE - ADULTS AND HEALTH SCRUTINY PANEL

AGREED: That the terms of reference for the Adults and Health Scrutiny Panel be noted.

AH40. PRIMARY CARE IN HARINGEY UPDATE

Cassie Williams, Assistant Director of Primary Care Quality and Development, Haringey Clinical Commissioning Group (CCG), provided the panel with an update on the work of the Premises Task and Finish Group (GP access); co-commissioning; and the development of new models of primary care in Haringey.

It was noted the Premises Task and Finish Group had been working to address GP access issues, particularly in the east of the borough and to ensure adequate future provision in regeneration areas, most notably the Tottenham and Wood Green areas.

During discussion, reference was made to the strategic development plan that had been commissioned by NHS England. It was noted that a draft report had been considered by the Health and Wellbeing Board on 23 June 2015. This had confirmed there was a shortfall in provision in Tottenham Hale and Northumberland Park.

Ms Williams informed the panel that NHS England had been working to resolve these issues in a number of ways. For example, an infrastructure fund had been released for extending GP premises to increase availability of access. In Haringey, six practices had been successful in bidding for this NHS England fund with five of the bids supporting increased access in Northumberland Park and Tottenham Hale. In addition, it was noted that NHS England had been working to commission a new practice in Tottenham Hale. This would offer additional GP and nurse appointments in Hale Village until completion of a new building in 3-5 years time. This provision was intended to be in place during Autumn of 2015 and the panel was informed that longer terms solutions had started to be considered with additional capacity being included in local regeneration plans.

In terms of co-commissioning, the panel was informed that during 2014 CCGs had been invited to become more involved in commissioning primary care in collaboration with NHS England. It was noted that this was managed at a north central London (NCL) level and that there were three levels of co-commissioning that CCGs could opt for:

- Level 1: Greater involvement – in decision making

- Level 2: Joint commissioning – joint decision making

- Level 3: Delegated authority – taking on delegated responsibilities

Ms Williams explained that from April 2015 NCL CCGs had entered co-commissioning at Level 1 and as a result NHS England had engaged the CCGs in discussion around decisions. It was noted that from October 2015 NCL would begin joint commissioning (Level 2).

Ms Williams concluded her presentation by providing an update on new models of Primary Care. It was explained that there was a need to increase Primary Care access and to provide more coordinated services. The panel was informed various pilots had been successfully initiated in Haringey where GPs had worked together in new ways. These included Saturday clinics, extended hours telephone consultations, a call centre and personalised care plans for over 75s with long term conditions.

During discussion, reference was made to the following:

- Standards of practice for confidentiality and patient consent to information / data sharing

- Workforce development, including GP recruitment

- Concerns about the numbers of non-registered patients in Tottenham Hale

- Premises development and building requirements

- Governance arrangements for co-commissioning and the role of the pan-NCL joint commissioning committee

- Issues in relation to the infrastructure fund and how this would be used to expand the premises at the Somerset Gardens Family Healthcare Centre.

- Ensuring members of the panel received a copy of the Strategic Premises Document Plan: Borough of Haringey, considered by the Health and Wellbeing Board on 23 June 2015.

The panel agreed an update on the Premises Task and Finish Group, with input from NHS England, should be prioritised for inclusion in the panel's future work programme (for Autumn 2015). In addition, Ms Williams confirmed she would be happy to return at the end of the 2015/16 to provide an update on co-commissioning, the strategic direction for Primary Care in Haringey, and New Models of Primary Care.

AGREED:

1. That the report be noted.

2. That a copy of the Strategic Premises Document Plan: Borough of Haringey, considered by the Health and Wellbeing Board on 23 June 2015, be circulated to members of the panel for information.

3. That an update on the Premises Task and Finish Group (Access to GPs) be prioritised for inclusion in the panel's future work programme (for Autumn 2015) and discussed further under item 11 on the agenda – Work Programme Development.

4. That an update on Co-Commissioning, the strategic direction for Primary Care in Haringey, and New Models of Primary Care be prioritised for inclusion in the panel's future work programme (for March 2016) and discussed further under item 11 on the agenda – Work Programme Development.

AH41. THE PRINCIPLES AND METHODOLOGY THAT WILL SUPPORT THE CONSULTATION AND CO-PRODUCTION PROCESS FOR PROPOSED CHANGES TO ADULT CARE SERVICES

Cllr Peter Morton, Cabinet Member for Health and Wellbeing, informed the panel that throughout the consultation for the Medium Term Financial Strategy (2015-2018), he had given a commitment to come back to service users and carers to consult on any detailed proposals for adult care services.

Cllr Morton commented that the current model for adult social care in Haringey did not do enough to prevent care and support needs escalating, and was unsustainable in the long-term. It was noted that in 2014/15, for every £3 the council spent, £1 went on adult social care. The panel was informed that while demand for services continued to rise, the money available to fund them had reduced. Cllr Morton advised that on 16 June 2015 Cabinet had agreed to carry out specific consultation and further engagement with residents and partners on issues including:

- Increasing the Council's capacity to deliver re-ablement and intermediate care service;

- Increasing the Council's capacity to provide Supported Living Accommodation and Shared Lives schemes;

- Increasing the availability and flexibility of specialist services within the borough meeting the individual needs of residents.

Beverley Tarka, Interim Director of Adult Social Services, explained that the consultation process would commence on 29 June 2015 and close after 90 days, reporting back to Cabinet in November 2015. The panel was informed that this process would be an opportunity to: (a) explain in detail specific proposals and the likely impact of the service offer and (b) seek views and understand concerns about how to shape and implement services for the future.

During the discussion, reference was made to the following:

- Lessons that had been learnt from the Medium Term Financial Strategy and Corporate Plan (2015-2018) consultation period.

- Ensuring information provided to service users and carers was accessible and provided in accessible formats.

- The Council's statutory responsibilities to provide services to meet the assessed needs of adults.

- The Council's commitment to safeguard adults at risk and commitment to work with service users and their families and carers in the design of services.

- Equality Impact Assessments that had been undertaken as part of the proposals for the Medium Term Financial Strategy (2015-2018). It was noted that these would be reviewed, updated and monitored.

- Risks, and concerns, associated with the transfer of social care services to social enterprises and ensuring any risks were managed.

- The importance of gathering information / insight on how social enterprises had been used to deliver health and social care in other parts of the country to ensure Haringey could benefit from any lessons learned.

- The implications of the Public Services (Social Value) Act (2012).

- The importance of contract monitoring and quality assurance when commissioning services.

In response to questions, Charlotte Pomery, Assistant Director Commissioning, informed the panel that the Council had set aside £20,000 for independent advocacy to help support individuals and carers to understand the proposals and ensure they could fully take part in the consultation process. The panel discussed the schedule of consultation meetings and it was agreed that once finalised this should be circulated to panel members. Anne Carswell, Interim Programme Manager, informed the panel that workshops and feedback sessions would be made available for users of the affected services, as well as their carers. It was noted that these sessions would be made available within the affected day centres and residential homes across the borough to ensure accessibility to all key stakeholders.

Ms Pomery informed the panel that independent facilitation would support service users and carers in the co design of new models for Older People dementia day opportunities, Learning disability day opportunities and alternative support for Linden residents. The co-production principles, outlined below, were noted by the panel:

- Improving outcomes for residents;

- Transparency about parameters;

- Respect for others' perspectives;

- Ability to test ideas and thinking;

- Trust and understanding;

- Space to acknowledge the challenge of working differently;

- Advocacy for users;

- Willingness to think through ideas and to change our minds, within the parameters; and

- Steadfast adherence to the values and principles of the Corporate plan

The panel was informed that a report on the co-production activity and outcomes would be provided as an appendix to the November (2015) Cabinet report. In addition, the panel agreed that an update on how the consultation and co-production process had been conducted, in relation to proposed changes to adult care services, should be prioritised in the panel's future work programme (for October 2015).

In response to questions, following a ruling by the Supreme Court in 2014 that Haringey's consultation on its Council Tax Reduction Scheme had been unlawful, Ms Tarka explained that the documents, to be used during the consultation and co-production process for proposed changes to adult care services, had been agreed with legal services and independently verified by a barrister.

AGREED:

1. That the principles and methodology to support the consultation and co-production process for proposed changes to adult care services, outlined in the report, be noted.

2. That an update on how the consultation and co-production process had been conducted, in relation to proposed changes to adult care services, be prioritised in the panel's future work programme (for October 2015) and discussed further under item 11 on the agenda – Work Programme Development.

3. That, once finalised, a copy of the schedule of consultation meetings with independent advocates be circulated to members of the panel.

AH42. QUALITY ASSURANCE AND THE CARE QUALITY COMMISSION IN HARINGEY

The panel considered the report of the Interim Director of Adult Services, and Assistant Director for Commissioning, setting out the Council's approach to quality assurance and its relationship with the Care Quality Commission (CQC).

During the discussion, reference was made to the following:

- Sections 5 and 48 of the Care Act 2014.

- The roles and responsibilities of the Safeguarding Adult Board.

- Ensuring links between quality assurance and safeguarding were made, understood and followed through when delivering value for money commissioned services.

- The Council's plans, set out in the Corporate Plan and Market Position Statement, for transforming adult social care that placed greater emphasis on supporting people to manage their own care through personalisation, early intervention and prevention.

- The need for effective quality assurance to be informed by good feedback and engagement, notably from users and cares, but also from wider stakeholders including the CQC, providers and staff, Healthwatch, the CCG and other agencies.

- Options for keeping scrutiny informed of CQC inspections. It was noted that nationally the CQC had indicated a keenness to work with the scrutiny function of local authorities in a more proactive and joined up way. It was proposed that the CQC should be invited to attend scrutiny on an annual basis to: set out their inspection programme; talk through any emerging themes; and to ensure awareness of the standards and approach being adopted.

- The progress that has been made in delivering an improvement plan (set out in Appendix A to the report) in relation to the CQC Inspection of Haringey's Community Reablement Service.

- Work that was underway with Sevacare in light of a recent CQC inspection that had found people using the service were at significant risk of receiving inappropriate or unsafe care.

Charlotte Pomery, Assistant Director for Commissioning, informed the panel that Sevacare, a large home care agency, had a block contract with the Council until 31 March 2011. It was noted that this contract had expired and the Council no longer had a contract with Sevacare. However, it was explained Sevacare had remained a high volume provider in the borough, albeit with diminishing volumes of work.

Beverley Tarka, Interim Director of Adult Services, advised that the most recent CQC inspection of Sevacare had taken place in December 2014. The CQC had found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. It was noted the CQC would take enforcement action against the registered persons and would report further on this once completed.

The following points were noted:

- Following the announcement of the inspection results, the Council's Establishment Concern Procedure had been instigated and as a

result an immediate suspension of new care packages with Sevacare had been put in place.

- Referrals to Sevacare would remain formally suspended for the foreseeable future.

- New referrals would be made to alternative providers.

- The roles and responsibilities of the Safeguarding Adults Team in relation to activity in respect of Sevacare.

- Haringey funded clients would be reviewed and if they wanted to change their contract to receive care from a different provider the Council would support them to do this. However, it was noted that not everyone using the Sevacare service may want to change, especially if they were satisfied with their individual carer(s).

- An Improvement Board had been established with senior managers from the Council and Sevacare as well as appropriate local branch officers, to implement a robust improvement plan.

- The senior management team of Sevacare had removed their local branch manager and had brought in a Quality Assurance manager and a Director of Operations to oversee implementation of the improvement plan.

In developing the 2015/16 scrutiny work programme the panel agreed that they should contribute to quality assurance activity of care providers operating across the borough. It was agreed that input from the CQC at their next meeting would help with this task.

AGREED:

1. That the Council's overall approach to Quality Assurance and specific updates regarding recent CQC inspections of Sevacare and of Haringey's Community Reablement Service, outlined in the report, be noted.

2. That the CQC be invited to attend scrutiny on an annual basis, to set out their inspection programme, and that this be discussed further under item 11 on the agenda – Work Programme Development.

AH43. WORK PROGRAMME DEVELOPMENT

The Chair informed the panel that throughout May and June a number of activities had been employed to support the development of the scrutiny work programme. This included a public survey, a Scrutiny Cafe event, and informal meetings with Cabinet Members and Senior Officers. In addition, Haringey's Obesity Conference, held on the 25 June 2015, had provided a

useful networking opportunity to discuss a number of issues raised in section 8 of the report.

Jeanelle de Gruchy, Director of Public Health, informed the panel that over 200 delegates had attended the conference. In addition a new Haringey Obesity Alliance had been formed by a wide range of partners including the Council, the local NHS, Homes for Haringey, the Tottenham Hotspur Foundation, and local schools. It was noted that the aim of this alliance was to help reduce obesity in Haringey by supporting more people to eat well and be physically active.

During the discussion on obesity, reference was made to the following:

- Looking at how scrutiny could engage and involve local communities in helping the Council to better understand the challenges and barriers to creating an environment where the healthiest choice was the easiest

- Looking at how scrutiny could support local community groups to help change behaviour, fostering interconnections between settings

- The role of schools and Children's Centres

- The influence of race, ethnicity, and culture on childhood obesity

- Asset based approaches within healthcare

- The work the council was doing to review all "No Ball Games" signs

- Enfield's use of Health Trainers to help people wanting to improve their general health and to make healthy choices

- Information from scrutiny work elsewhere, including Tackling Childhood Obesity in Birmingham (2014)

- The importance of any scrutiny work in Haringey being carefully scoped to ensure it was manageable and established clear questions to be investigated

The following issues were discussed in relation to themes that had emerged from the Scrutiny Cafe, outlined in section 8 of the report:

- The importance of prioritising and selecting issues for scrutiny involvement that complimented Corporate Priority 2 – "Enable all adults to live healthy, long and fulfilling lives"

- Access to GPs and looking at how scrutiny could engage and involve local GPs and other local healthcare providers in their work

- The importance of scrutiny monitoring the impact of proposed changes to adult care services

- Adult Safeguarding

- Haringey's Reablement Service

- Paediatric A&E attendances and admissions

- Suggestions in relation to loneliness and isolation. This included a suggestion that the panel should look at Neighbourhood Connects towards the end of 2015/16 to ensure it was delivering agreed objectives and tackling issues associated with loneliness and isolation across the borough.

In addition, it was agreed that the following items, discussed under items 8, 9 and 10 on the agenda, should be prioritised for inclusion in the panel's future work programme:

- An update on the Premises Task and Finish Group (Access to GPs) – with input from local GPs and NHS England (Autumn 2015)

- An update on Co-Commissioning, the strategic direction for Primary Care in Haringey, and New Models of Primary Care (March 2016)

- An update on how the consultation and co-production process had been conducted in relation to proposed changes to adult care services (October 2015)

- That the CQC be invited to attend scrutiny on an annual basis to set out their inspection programme

The panel agreed the suggestions above should be used to assist members of the panel to scope a potential scrutiny project for 2015/16.

AGREED:

1. That, subject to the additions, comments and amendments, referred to above, the items outlined in section 8 of the report be prioritised for inclusion in the 2015/16 scrutiny work programme and recommended for endorsement by the Overview and Scrutiny Committee on 27 July 2015;

2. That, as appropriate, the Chair of the Panel meet with appropriate Cabinet members and senior officers to further clarify the work programme.

3. That a briefing be arranged with panel members (during August / early September 2015) to: (a) discuss the Adults and Health Scrutiny Panel's

work programme, and (b) scope a potential scrutiny project for 2015/16 based on suggestions put forward by the panel including work relating to obesity, paediatric A&E attendances / admissions, and tackling issues associated with loneliness and isolation.

AH44. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

AH45. DATES OF FUTURE MEETINGS

The Chair referred Members present to agenda Item 13 as shown on the agenda in respect of future meeting dates, and Members noted the information contained therein'.

AH46. DURATION OF MEETING

18:31 hrs – 20:52 hrs

Cllr Pippa Connor

Chair

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Report for: Adults and Health Scrutiny Panel 5 October, 2015

Item number: **7**

Title: Care Quality Commission: presentation by the Care Quality Commission

Report authorised by : Charlotte Pomery, Assistant Director Commissioning

Lead Officer: Farzad Fazilat, Commissioning Manager

Ward(s) affected: All

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Its role is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

1.2 At its last meeting in June 2015, the Adults and Health Scrutiny Panel considered a paper on the Council's approach to quality assurance and its relationship with the CQC, including options for keeping Scrutiny informed of the work of the CQC locally. As a result of this, the Inspection Manager for the Adult Social Care Directorate of the CQC, London Region, will be presenting an overview of inspections carried out in the borough and those planned for the future, drawing out key trends and lessons regarding the quality of care delivered in the borough.

2. Cabinet Member Introduction

2.1 I am pleased that the Care Quality Commission is able to present to the Panel an overview of its current and planned activity in the borough, and that we are working together to ensure consistently high quality and effective care for local residents.

3. Recommendations

3.1 The Adults and Health Scrutiny Panel is asked to consider how the presentation made by the Care Quality Commission to the Panel can be used most effectively to inform future discussions and its future work programme.

4. Reasons for decision

N/A

5. Alternative options considered

N/A

6. Background information

N/A

7. Contribution to strategic outcomes

N/A

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

N/A

9. Use of Appendices

N/A

10. Local Government (Access to Information) Act 1985

N/A

Agenda Item 8

Report for: Adult and Health Scrutiny Panel 5th October 2015

Item number: 8

Title: **Quality Assurance and developing a partnership approach in Haringey.**

Report authorised by : Beverley Tarka Director of Adult Social Care

Lead Officer: Beverley Tarka Director of Adult Social Care

Ward(s) affected: All

Report for Key/ Non Key Decision: Non key Decision

1. Describe the issue under consideration

1.1 In June 2015 Adult Health and Scrutiny Panel received a report on Quality Assurance and the Care Quality Commission in Haringey. This report outlined the Care Quality Commission's new approach to regulating, inspecting and rating Adult Social Care Services.

1.2 The report set out the council's approach to quality assurance and its' relationship to the CQC and options for keeping Scrutiny informed of the CQC's inspections, and focussed on recent inspections with regards to Sevacare and the Council's reablement service.

1.3 At this meeting it was agreed that further information would be provided to scrutiny on the Quality Assurance and Safeguarding frameworks and approaches in place and in development in Haringey.

http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=804&MId=7412&Ver=4

2. Cabinet Member Introduction

2.1 Assuring the quality of health and social, care services provided in Haringey is a core aim for the Council and its partners. I welcome the opportunity to present to scrutiny detail around both the approach we are taking to assuring quality and the plans we have to further develop our capability and capacity to ensure Haringey residents receive services of the highest quality.

2.2 We are currently focussed on developing community wide partnership approach to assuring quality that will include in its' membership service users, carers, providers, commissioners, health practitioners, Safeguarding professionals, CQC and HealthWatch. We are bringing to scrutiny for discussion and comment detail on early progress in developing the partnership and an outline of next steps designed to see a partnership approach to quality in place by April 2016.

Haringey LONDON

3. Recommendations

It is recommended that Panel notes the content of the presentations which outline Haringey's approach to Quality Assurance and outlines Haringey's ambition to develop a community wide partnership approach to assuring quality across the Health and Social Care system.

4. Reasons for decision

Not Applicable

5. Alternative options considered

Not Applicable

6. Background information

6.1 Section 5 of the Care Act 2014 sets out new duties for Councils with regard to shaping and managing local care markets. There are new duties placed on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition as set out in the Care Act is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

6.2 Section 48 of the Care Act places new duties on local authorities to meet an adult's care and support needs and a carer's support needs when a registered care provider becomes unable to carry on a regulated activity because of business failure.

6.3 The Council recognises the changing landscape for adult social care both in terms of the Care Act and its own commissioning intentions as set out in the Corporate Plan and the Market Position Statement. The Council is therefore strengthening its approach to quality assurance and contract monitoring role across all provision we will 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.

6.4 Quality Assurance in Haringey is important to ensure that local services are safe and of a high standard. It is also about ensuring that the resources that are available are deployed effectively. There are a range of methodologies and measures that we and our partners use to assure the quality of our services, many of which are described in the appendix below. Previously our Quality Assurance has been largely inward looking and holding our providers to account but we are now looking to develop a new model where assuring the quality of our services is done in partnership with a range of stakeholders, to enable greater understanding and wider ownership of the process.

6.5 In this new model everyone including, people who use services, relatives, carers, providers, staff delivering the service, social care staff, health practitioners, Safeguarding professionals, regulatory bodies e.g. CQC and HealthWatch will have a role to play to contribute to the improvement in the quality of care provided in Haringey.

6.6 The accompanying presentations titled "Quality Assurance Summary Report for Scrutiny" details the mechanisms that are currently in place to assure quality in Haringey. The presentation summarise the governance approach in place and

provides detail on how quality is assured in respect of safeguarding, social work practice, provider services and commissioning.

6.7 The accompanying presentation titled “Developing a Partnership approach to Quality in Haringey” provides summary detail of a recent workshop to explore the opportunities and willingness to develop a partnership approach to assuring quality in Haringey.

7. Contribution to strategic outcomes

Priority 2

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

Finance and Procurement

8.1 This paper is for noting and there are no financial implications directly arising out of the report. The quality assurance approach outlined is carried out as part of the normal work of the Council from within its existing resources.

Legal

Not Applicable

Equality

Not Applicable

9. Use of Appendices

Appendix 1 Quality Assurance Summary Report for Scrutiny	Quality Assurance Summary Report for S
Appendix 2 Developing a Partnership approach to Quality in Haringey	Developing a partnership approach

10. Local Government (Access to Information) Act 1985

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Quality Assurance Summary Report for Scrutiny

5th October 2015

What do we mean by quality? Definition and current frameworks	
Fit for purpose	Effective
Safe	People's experience
People's expectations	Caring
Responsive	Well-led
Accessible	Clear communication
Focus on outcomes (personalisation)	Dignity and respect
Choice and control	Timeliness of service
Empowerment	Legal boundaries
Darzi definition - clinical effectiveness, patient safety and experience	
Care Quality Commission framework – safe, effective, caring, responsive and well-led	

How do we currently measure quality?	
Contract monitoring	Complaints, compliments and other feedback
Performance indicators, including safeguarding data	Audits and surveys
Quality assurance	Assessments and reviews
What joint quality outcomes do we want to achieve?	
Connections between health and social care around patient safety, safeguarding, commissioning for quality and assurance.	
Improved safeguarding quality	
Shared strategic focus through the Health & Wellbeing Board, SAB's Quality Assurance sub-group and future Quality Workshops	

Governance – Quality Assurance Board

- The Adult Social Services Quality Assurance Board ensures that quality assurance arrangements are in place 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 data and evidence is analysed and used to inform service delivery as well as strategic planning and commissioning.
- The Board meets quarterly and is chaired by the Director of Adults Services and attended by senior operational, strategy and commissioning officers responsible for ensuring and overseeing quality in service delivery.

Terms Of Reference Quality Assurance Board Adult Social Services	App 1a	 Microsoft Office Word Document

Governance – Quality Assurance Board (2)

- The Adult Social Services Quality Assurance Board has in place an Improvement and Quality Action Plan with actions against each of the 4 DoH ASCOF domains on which LA's are measured :
  - Enhancing quality of life for people with care and support needs.
  - Delaying and reducing the need for care and support.
  - Ensuring that People have a positive experience of care and support.
  - Safeguarding adults whose circumstances make them vulnerable.
- Each action has a lead officer from the relevant service area and the Action Plan is reviewed and updated at each Board meeting.

Quality Assurance Board Action Plan	App 1b	 Microsoft Office Word Document

Governance - Safeguarding Quality Assurance

- A quarterly update is provided from the Quality Assurance Board to the Safeguarding Adults Board. This report details progress against targeted areas of safeguarding work overseen by the Board. A copy of the latest report can be found below.
- Safeguarding Performance is summarised in a quarterly report that is presented at both the Quality Assurance and Safeguarding Adults Boards

Sub-group quarterly update	App 1c	 Microsoft Office Word Document
Adult Safeguarding Report	App 1d	 Microsoft Office Word Document

Governance - Safeguarding Quality Assurance (2)

- A multi agency quality sub-group (of the Safeguarding Adults Board) is currently in the process of being set up to support Haringey Safeguarding Adults Board to fulfil its remit of ensuring local safeguarding arrangements are effective and deliver the outcomes that people want.
- In addition to the actions in the Improvement and Quality plan the QA Board reviews performance in regards to safeguarding including the review of performance data and case-file audits.

Multi Agency Safeguarding Adults Board Quality Assurance sub-group	App 1e	 Microsoft Office Word Document
Adult Safeguarding Case File Audit Tool	App 1f	 Microsoft Office Excel Worksheet

Quality in Practice

- Monthly case file audits are completed across each service area with reports collated by the performance team and key findings summarised in a report to the Quality Assurance Board.
- A Quarterly Learning Report is also produced summarising feedback (including compliments, members enquiries and complaints)
- Upheld complaints are summarised and scrutinised at the Quality Assurance Board .

Adult Case File Audit Tool	App 1g	 Microsoft Office Excel Worksheet
Learning from feedback	App 1h	 Microsoft Office Word Document

Quality in the Market

- In June Haringey published its' first Market Position statement setting out Haringey's plans to work with providers to develop diverse high quality care locally which meets local need and the Council's strategic priorities whilst delivering value for money.
- A requirement of the Care Act the Market Position Statement will be reviewed and refreshed as Haringey delivers against the Corporate plan, to send key messages to existing and future providers about our plans, our values and the outcomes we want to see delivered for adults in Haringey.

Market position Statement	App 1i	Adobe Acrobat Document

Fundamental Standards

- In November 2014, the Government published the Fundamental Standards regulations. The regulations are a key part of the changes the Care Quality Commission (CQC) has made to the way it inspects health and care services.
- The Fundamental Standards, including a new "Duty of Candour" replace the 16 'essential standards' of quality and safety which were previously used to assess whether care had fallen below acceptable standards.
- Where the Council's provider services are inspected by CQC, the Quality Assurance Board receives inspection updates and oversees any improvement plans required.

CQC Fundamental Standards	App 1 j	Microsoft Office Word Document

Quality in Commissioning

- Haringey has drafted a framework that ill apply to all social care services that are commissioned for adults in Haringey, including services provided by Haringey Council. The framework sets out our expectation that all services are expected to meet or exceed quality standards and describes the way that we will measure quality.
- Everyone including, people who use services, relatives, carers, providers, staff delivering the service, social care staff, health practitioners, Safeguarding professionals, regulatory bodies e.g. CQC and HealthWatch will have a role to play to contribute to the improvement in the quality of care provided in Haringey.

Commissioning Quality Assessment Framework	App 1 k	 Microsoft Office Word Document

Quality in Commissioning (2)

- Haringey has taken a lead role, working with the LGA and other key partners to help develop Commissioning for Better Outcomes Standards.
- The standards (currently in draft) are designed to ensure that everyone shapes and shares the vision of excellent care and support for people in need of adult social care, challenging commissioners to embark on an ambitious journey.
- The standards support the development of a common focus and purpose across the system, driven by shared values and behaviors.

Commissioning for Better Outcomes draft standards	App 1l	 Microsoft Office Word Document

Quality Assurance sub-group
Draft Terms of Reference

PURPOSE OF THE BOARD

The purpose of the Adult Social Services Quality Assurance Board 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.

The Quality Assurance Board is responsible for overseeing quality assurance across Adult Social Services and will report on the safeguarding elements of its work to the Safeguarding Adults Board on a quarterly basis.

The oversight and governance of quality assurance will be provided by the Adult Social Services Quality Assurance Board through:

- Monitoring the impact and quality of service delivery to improve outcomes for service users and/or carers;
- Ensuring practice standards within Adult Social Services are being consistently delivered to a high level, identifying any areas for improvement, and ensuring that the workforce is appropriately trained to maintain these standards;
- Analysing information from customer feedback and turning this into tangible actions for service improvement;
- Establishing links between performance management and quality assurance such that these are informed by one another;
- Establishing a systematic learning culture across Adult Social Services;
- Ensuring that there is a systematic approach to addressing areas of improvement through the identification and allocation of resources to undertake activity to support sustainable improvements;
- Sharing information, best practice and experience;
- Ensuring robust monitoring and reporting on the quality of care delivered by external providers of adult social care across Haringey;

Quality Assurance sub-group
Draft Terms of Reference

- Providing assurance required by Adult Social Services' regulators and responding to new government initiatives, directives and legislation;
- Making sure that services to support people are provided without discrimination to people with the protected characteristics identified in the Equality Act 2010; and
- Producing an annual Local Account detailing Adult Social Services' performance and priorities for residents, service users and other local partners.

OPERATIONAL ARRANGEMENTS

The Adult Social Services Quality Assurance Board will meet on a quarterly basis. The Board will be chaired by the Director of Adult Social Services and will comprise the following attendees:

- Director of Adult Social Services;
- Strategic Lead Governance & Business Improvement Services;
- Business Improvement Officer, Business Improvement Services;
- Head of Service Assessment & Personalisation;
- Head of Haringey Learning Disability Partnership;
- Service Manager Adult Mental Health;
- Principal Social Worker;
- Commissioning Manager (Adults);
- Senior Performance Officer;
- Framework-i Business Analyst;
- Adult Social Care Workforce Development Manager;
- Assistant Head of Customer Services; and
- Any other officer who may be asked to join the Board to assist with specific pieces of work.

Quality Assurance sub-group
Draft Terms of Reference

Representatives are responsible for disseminating decisions and actions required back to their services, performing any actions needed and reporting back to the Quality Assurance Board.

Attendees are expected to make every effort to attend meetings. If representatives cannot attend a meeting, they should formally submit apologies to the Chair in advance of the meeting and make every effort to find a substitute or deputy to attend.

Members should not arrange for a Deputy to attend on their behalf on more than two occasions without notifying the Chair in advance of the meeting.

To make decisions, the meeting must be quorate. A quorum will be at least 5 of the members.

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Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
ASCOF DOMAIN 1 Enhancing quality of life for people with care and support needs • People live their own lives to the full and achieve the outcomes which matter to them by accessing and receiving high quality support and information. • Carers can balance their caring roles and maintain their desired quality of life. • People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. • People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.					
1.1	Continue to develop and support the Personal Budget Users' Forum to share information and improve the personal budget service, including enhancing the reconciliation process to ensure budgets meet support needs.	Sue Southgate	March 2015	There is an ongoing presence of a Personal Budget Support Services (PBSS) officer at the Haringey Personal Budget Users Forum. Joint work has been carried out between the PBSS Team and the Haringey Direct Payments User Forum around the set up of the volunteer advice line. The advice line up was set up in December 2013 by the Personal Budgets User Forum following a successful application to the Big Lottery Fund. The advice line was set up as a pilot scheme for 12 months but has continued to operate since, offering advice to people receiving direct payments and personal budgets. The PBSS Team are completing systematic reviews of DP users and are reconciling accounts within the body of the review. Should discrepancies or misappropriation occur, areas of concern or misuse are discussed with Line Managers on a case by case basis. The direct payment will not be stopped automatically but a reassessment is scheduled.	
1.2	Extend the local network of Dementia Friends to	Anne Carswell /	March 2015	The success of Dementia Friends Campaign, in	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
	help support people with dementia in the community.	Toby Kent		borough, was dependent on council employees learning more about dementia and turning understanding into action in the local community. Haringey's focus was twofold: 1. To provide formal training opportunities to social services staff likely to meet and work with Adults living with dementia. 2. To provide information sessions to a wider group of Haringey employees and local stakeholders, promoting the Dementia Friends Campaign and encouraging sign up to the project as a 'Friend' in the first instance and as a Champion if people felt they were able. There were drop in sessions attended by Heads of Service, Managing Directors (Homes for Haringey), Team Managers, key stakeholders from the Dementia Steering Group, Health representatives and Social Services staff. At each of these sessions attendees were provided with information:- • A short video produced by Dementia Friends/Public Health England. • A brief discussion about dementia. • Practical examples/tasks highlighting some of the difficulties people living with dementia may face in their community • Advice around what you can do in your local community	

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				• Information on how someone could become a Dementia Friend. In between these two events there was a more formal seminar/training session for Social Services staff (specifically from Older People's Day Services) around dementia awareness and the Dementia Friends Campaign. This event was facilitated by a local community based Dementia Friends Champion. Because this event was facilitated by a Dementia Friend Champion the attendees could sign up and register as Dementia Friends directly at the event. Subsequent to these events there have been further meetings with colleagues from Homes for Haringey with the intention of providing some more tailored training to front-line Housing workers. Finally the Dementia Steering Group have been asked to continue the work started with these events and promote both the Dementia Friends Campaign and dementia awareness within the council and with stakeholders on an ongoing basis.	
1.3	Tender a tri-borough contract for an advocacy service, linked to assessment and care planning.	Farzad Fazilat	January 2015	We have successfully awarded a tri-borough contract for an advocacy service to ensure that	

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				we fully comply with the requirements set out under the new Care Act legislation. The advocacy service contract has been awarded to Voiceability, who is also the provider of statutory (Independent Mental Capacity Act and Independent Mental Health Assessment) advocacy services in the borough. This new service will link advocacy provision with assessment and care planning services.	
1.4	Support people with severe mental health issues to access secure housing.	Jeni Plummer / Farzad Fazilat	August 2014	*A scheme was identified in Truro Road which was designed for people with MH conditions and as part of their recovery. The building is due to be completed by June 2014 and be in use by August 2014.*	

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Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
ASCOF DOMAIN 2 Delaying and reducing the need for care and support • Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help manage their care needs. • Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services. • When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.					
2.1	Continue to support the development of extra care housing as an alternative to residential care.	Farzad Fazilat	March 2016	Two new extra care schemes are being built in the borough. • Pretoria Road – 52 units with 8 units designated for people with dementia • Protheroe House – 50 Units also with a community / reablement focus An extra care working group has been established with representatives from the Council – Commissioning, Housing Related Support and Commissioning and Adult Social Care, the CCG, and One Housing (provider and developer). The group is developing the model of care and nominations process for the two extra care schemes. It is expected that residents will be able to move in June 2016 for Protheroe House and September 2016 for Pretoria Road. It is anticipated that the referral process for the schemes will commence in January 2016 for Protheroe and March 2016 for Pretoria. The next meeting of the working group is late July 2015.	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
2.2	In conjunction with the Haringey Clinical Commissioning Group, review the reablement service to consider options for extending service provision.	Eamonn Dillon / Sue Southgate	March 2015	Following a successful CQC inspection in 2014, an independent review of the Community Reablement Service was carried out in April 2015 to consider future options for the service. Proposals for redesigning the reablement service to extend the current service are being consulted on from July 2015.	
2.3	Develop the Neighbourhoods Connect project to provide a community-based service focused on improving health and wellbeing outcomes and community participation.	Farzad Fazilat	March 2015	Haringey Neighbourhoods Connect aims to reduce social isolation by connecting local people to social activities, hobbies, fitness, well-being, community groups and volunteering opportunities in Haringey. Following a series of evaluation meetings held with the providers and another interested voluntary and community sector organisation and statutory partners, it was agreed to commission a Neighbourhoods Connect service that focussed on the 18+ population, not just 50+. The new Neighbourhoods Connect service is a community based service that is focused on improving outcomes relating to health and wellbeing and community participation in Haringey residents. The service has a particular focus on adult population groups (18+), who are at increased risk of social isolation, including: • people with long-term physical and mental health conditions,	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				• unpaid carers, • people who are housebound, • people with dementia and their carers, • older people living alone or with an unpaid carer. The service was procured during December 2014 and January 2015, with the contracts being awarded in February 2015. Interested providers were asked to demonstrate how they would make a positive impact on the following outcomes amongst people accessing the service. 1. Improved self-reported wellbeing (as measured by the Warwick-Edinburgh Scale). 2. Increased participation in community groups, services and activities. 3. Increased participation in training, volunteering and employment (among service users, or people delivering the service). The interested providers were asked to demonstrate their own delivery model to achieve these outcomes. Four Neighbourhoods Connect Services have been commissioned. There is one service for each GP collaborative network. The four GP collaborative areas are as follows: 1. West Haringey – provided by Groundwork 2. Central Haringey – provided by HAGA	

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				3. North East Haringey – provided by HAGA 4. South East Haringey – provided by HAGA The providers are part of the BCF Promoting Independence Group which has been supporting the start up of the service and has been a helpful sounding and advice board, as well as a place for the providers to learn about new services, make connections and share information the service.	
2.4	Develop the Home from Hospital project into a winter pressures service to provide support to enable people to return home following hospital admission.	Sue Southgate / Farzad Fazilat	March 2015	Living Under One Sun were commissioned to provide the Home from Hospital service over the winter period 2014-15. The service is for Haringey residents over 50 years old on discharge from A&E and inpatient hospital beds at the Whittington and North Middlesex Hospitals. The Home from Hospital scheme enables vulnerable patients to be discharged promptly from hospital when their medical and nursing needs have been met. This is achieved by rapid access to a short term volunteer led service. The aim of the home from hospital scheme is to build confidence, help individuals to self-manage and return to their normal pattern of living. Volunteers and paid workers support people home and make a number of home visits and telephone calls to the service user and provide conversation, companionship and practical help with everyday tasks as required, tailored to their individual needs. These will	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				include activities such as ensuring basic items are available, that the home environment is warm, supporting with personal finances, and assistance navigating other support services. The service has successfully met and exceeded its contract requirements. 143 referrals were made to the service over the winter period in 2014-15. 78 patients were supported home on the day of discharge from hospital. The service also made 225 home visits and 615 supportive telephone calls with people referred to the service. The winter service was extended until the end of August 2015 to enable a continued service, whilst a year round service is commissioned. The year round service is currently out for Request for Quotation. It is anticipated the year round service will commence September 2015 and will continue until the end of March 2016.	
2.5	Introduce Purple Folders to store essential personalised health information and to promote equitable health care for people with learning disabilities.	Laura Gordon / Heather McKoy	March 2015	The Purple Folders were launched on 1st April 2014 and to date 267 Purple Folders have been issued. As a result the health action planning training has evolved to incorporate the Purple Folders and Health Equalities training. The training session on 9th July 2014 was attended by 23 people, a few carers but the majority were service providers i.e. residential homes and supported living staff.	

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Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				31 people have so far booked to attend the next session on 10th September 2014 with further training dates planned for approximately 6 weekly. Ad hoc training is also provided on request. Three blood pressure monitors have also been purchased. To date 6 carers have been trained to use them to support the Annual Health Check, with further cohorts of 6 planned for future training. This work is being done in partnership with Dr. Lionel Sherman (GP) with a focus on training family carers for those service users living at home but unwilling or unable to access health checks at their GP surgery.	
2.6	Publish an updated Care Directory guide to local services.	Farzad Fazilat	March 2015	Updated Care Directory for 2014/15 has been published.	

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Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
ASCOF DOMAIN 3 Ensuring that people have a positive experience of care and support • People who use social care and their carers are satisfied with their experience of care and support services. • Carers feel that they are respected as equal partners throughout the care process. • People know what choices are available to them locally, what they are entitled to, and who to contact when they need help. • People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.					
3.1	Identify gaps in services to deliver integrated health and social care through the Better Care Fund. Co-design new services with input from a broad range of stakeholders.	Sue Southgate / Claire Collins	March 2015	In September 2014 Haringey's Better Care Fund plan was signed off by the Council and the Clinical Commissioning Group. The Better Care Fund plan sets out Haringey's vision for health and social care services over the next five years as well as setting out the way forward for jointly developing and commissioning more integrated services. Two hundred local people have helped develop the following priorities. Integrated services will be: • Easy to access, through a single point of access • Well managed and provided by competent professionals and staff • Person Centred and personalised to the • experiences and views of people who use them • Provide good and timely information, from a • variety of sources including the voluntary and community sector	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				• Enable individuals to do things for themselves through prevention, self-management and reablement • Work together as one team, including the patient/service user, with clear and constant communication • Promote wellbeing and reduce loneliness through community capacity building. These priorities will inform the service's aims and objectives, delivery and outcomes. During 2014/5 stakeholders from health and the voluntary sector have come together with the Council to build on the integrated services already provided. Some of the new services are described below. During 2014/15, an integrated Locality Team comprising of GPs, nurses, social workers, therapy staff, pharmacists and mental health workers has been piloted in the North East of the borough (from November 2014). The Team have been showing good outcomes for Haringey residents, developing joint health and social care plans to minimise the risk of people being admitted to hospital. 71 people have gone through the locality team since its inception. The Team will be expanded across all GP collaboratives later this year.	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				As part of the Better Care Fund, social workers now work with the multidisciplinary teams at the North Middlesex Hospital seven days a week (from December 2014) to ensure that Haringey residents do not stay in hospital longer than they need to and that they have a good multidisciplinary approach to determining what support is needed at home.	
3.2	Monitor and oversee practice issues arising from health and social care integration	Sue Southgate / Claire Collins	March 2015	During 2014/15 the Council worked with the CCG to secure funding to develop a programme of joint health and social care training and listening events to support front line staff in Haringey develop the skills and knowledge in delivering integrated services. The Listening Events also gave health and social care workers the opportunity to understand each other's roles and talk about how they can work together so that we provide better outcomes for our residents. The Council are now part of a newly formed Haringey Community Education Providers Network linking health and social care service providers, community groups and education providers focused around learning with and from each other. This will ensure we have a competent workforce across social care and health able to deliver on the vision of the Better Care Fund Plan.	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
3.3	Carry out annual Adult Social Care Survey to monitor customer satisfaction and develop an action plan to address any issues identified.	ASS Heads of Service / Mark Grinham / Farzad Fazilat	March 2015	Adult Social Care Survey carried out in 2014/15 and data submitted in May 2015. 928 surveys were sent by post to social care users in Haringey, with 297 responding.	
3.4	Carry out Carers Survey and develop an action plan to address any issues identified.	ASS Heads of Service / Mark Grinham / Farzad Fazilat	March 2015	Carers Survey carried out between October and November 2014 and data submitted in April 2015. 850 surveys were sent by post to Haringey carers, with 354 responding.	
3.5	Monitor and oversee social work practice issues arising from implementation of the Care Act	Chris Atherton	March 2015	The Principal Social Worker holds social work forums which occur monthly for each service area where issues of practice and Care Act implementation are discussed. Within these sessions, staff look at changes in practice, good case examples and blockers that are stopping practitioners from providing services as outlined within the Act. The Principal Social Worker also holds workshops around specific practice aspects that are linked to the Act, such as Mental Capacity training, strengths based social work, etc. as well as case discussion sessions which draw on practice delivery from the Care Act. Specific training programmes have been carried out around the Care Act.	
Ref	**Key actions**	**Lead officer(s)**	**Completion date**	**Progress**	**Rag status**
ASCOF DOMAIN 4 Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm					

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
• Everyone enjoys physical safety and feels secure. • People are free from physical and emotional abuse, harassment, neglect and self-harm. • People are protected as far as possible from avoidable harm, disease and injuries. • People are supported to plan ahead and have the freedom to manage risks the way that they wish.					
4.1	Continue to monitor safeguarding referrals and introduce interactive 'heat maps' to target adult safeguarding prevention activity.	Sue Southgate / Mark Grinham	March 2015	Safeguarding referral data is reported to the Quality Assurance Board, Safeguarding Prevention Subgroup and Safeguarding Adults Board on a quarterly basis. This information has fed into work with the Commissioning Unit around establishment concerns to determine whether or not the Council should continue to use a service provider where there are concerns. Alerts raised against hospitals are also reviewed with health and CCG colleagues to identify learning. Safeguarding 'heat maps' were introduced in October 2014 to give a greater understanding of the geographical location of safeguarding referrals in the borough. It is intended that this information will be used in future to target safeguarding prevention activity.	
4.2	Continue to promote awareness of adult safeguarding, including a targeted safeguarding awareness campaign to raise knowledge and reporting of adult safeguarding concerns.	Sue Southgate / Helen Constantine	March 2015	To ensure that Safeguarding is Everyone's Business, this has been adopted as one of the five Improving Haringey themes. This means it is regularly promoted through the Council, is a part of everyone's performance appraisal and has significant senior support. All Council staff also receive safeguarding training on an annual	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				basis. The latest Safeguarding Campaign has focused on Child Sexual Exploitation. The aim of the campaign was to raise awareness amongst Haringey staff and the local community and business, highlighting some of the signs to look for and how to report it. A Safeguarding Prevention Subgroup elder abuse event was also held in February 2015 to raise awareness of safeguarding issues affecting older people.	
4.3	As part of Making Safeguarding Personal, introduce an adult safeguarding user survey to identify whether people's needs are met through the safeguarding investigation process.	Jeni Plummer / Mark Grinham	March 2015	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.	
4.4	Start to implement the Adult Safeguarding Prevention Strategy delivery plan.	Sue Southgate / Marco Bardetti	March 2015	Prevention Strategy being implemented by the Safeguarding Prevention Subgroup. In July 2015, the Safeguarding Prevention Subgroup and Training and Development Subgroup were merged and have considered rationalising the delivery plan.	
4.5	Recruit an independent chair for the Safeguarding Adults Board.	Beverley Tarka / Helen Constantine	March 2015	The Care Act requires that each local authority must set up a Safeguarding Adults Board. Although it is not a requirement, the local	

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				authority and its key statutory partners from the Clinical Commissioning Group and Metropolitan Police Service consider that the appointment of an independent chair to the Safeguarding Adults Board (SAB) who is not an employee, or a member of an agency that is a member of the SAB, will provide partners with the reassurance that the Board has some independence from the local authority and other partners. An independent chair has been in place since June 2015. A joint LSCB/SAB Business Manager has also been appointed to support the operation and development of both Boards, by overseeing and reviewing procedures, and checking that staff training is of the very highest standard.	
4.6	(SAAT action improvement plan): Ensure that commissioning contract services that can demonstrate Mental Capacity Act (MCA) are complied with.	Farzad Fazilat	April 2015	Provider Forum is used to raise awareness of MCA requirements. MCA compliance is built into contracts and service specifications. MCA compliance is embedded into Quality Assurance mechanisms. Where concerns have been identified, monitoring has been undertaken of providers' compliance with mental capacity requirements, and improvements have been made.	
4.7	(SAAT action improvement plan): Appropriate training for all staff: framework to assess competency and MCA integrated into supervision and appraisal systems to be developed and used.	Marianne Ecker / Sue Southgate	April 2015	Following the recent Cheshire-West supreme court judgement, Adults and Children's Services have received briefings from our Legal Department on the implications of potential	

Adult Social Care Improvement & Quality Action Plan 2014/15 and 2015/16

Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
	Development of a refreshed MCA/Deprivation of Liberty Safeguards (DOLS) policy in response to the Cheshire-West judgement.			Deprivation of Liberties/Court of Protection proceedings. A Deprivation of Liberty Safeguards (DoLS) Staff Procedure and Guidance has been drafted. Awaiting Legal comments. Training programme established and available for staff and partners. Extra MCA training courses commissioned and further courses being commissioned. Integration into appraisal will form part of the revamp of the corporate appraisal system which has been put back until April 2015. Meetings have taken place with regards to updating the policy and legal input. Further courses to be commissioned for new financial year, updates to be made to e-Learning to reflect local policy.	
4.8	(SAAT action improvement plan): Join up Borough response to safeguarding. Safeguarding Adults Information to be made more available and accessible.	Sue Southgate / Helen Constantine	April 2015	Work-plan in production. Paper written to be taken to LSCB board for agreement. Links with LSCB training subgroup strengthened to establish a common strategy to improve safeguarding awareness for all. Information cards re-printed, counter top holders procured.	

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Ref	Key actions	Lead officer(s)	Completion date	Progress	Rag status
				Review planned to be carried out as part of preparation for Care Act implementation. Considering joint purchase with other authorities of another e-learning suite of courses specifically designed to inform about the Care Act. Will have unlimited usage and therefore can be made available to all Haringey Partners.	
4.9	Monitor and oversee practice issues arising from the change in Deprivation of Liberty Safeguards (DoLS) legislation	Sue Southgate / Chris Atherton	March 2015	Issues around capacity and deprivation of liberty are discussion topics that have been addressed both through workshops and case discussion with frontline practitioners. Recently a proposal was taken to SOG and agreed to both develop our frontline BIA capacity and to manage the current backlog of cases.	

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Date of SAB:	13 July 2015

Title:	Sub-group quarterly update: Adult Social Services Quality Assurance Board (sub-group of SAB)

Purpose of briefing:	Quarterly update to inform the SAB of recent and current safeguarding work undertaken by the Adult Social Services Quality Assurance Board

Subgroup details:	Adult Social Services Quality Assurance Board: last meeting held on 16 June 2015

Lead Officer:	Helen Constantine Strategic Lead – Governance and Business Improvement

1. Introduction

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 (QAB) 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.

The sub-group meets quarterly and has recently seen the merger and adoption of the Safeguarding Practice sub-group workplan.

2. Summary

The Adult Social Services Quality Assurance Board last met on 16 June 2015. Relevant areas of safeguarding work discussed by the Board are described below.

3. Background

The Board's Improvement and Quality Action Plan (2014-2016)[1] has been developed to include key improvement projects identified in the 2013-14 Local Account, the three 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 for Q4 2014-2015 were presented to the Quality Assurance Board. There were no upheld complaints concerning adult safeguarding. In Q2 there were 3 Members' Enquiries in relation to adult safeguarding and 1 in Q3.

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 whistle blowing policies. Quality assurance reviews of all supported living provisions in Haringey are also being carried out. A risk register of care providers is being compiled to identify level of risks in provider failure.

A market position statement has been published, setting out commissioning intentions for the next 4 years (see report presented to Cabinet on 16 June 2015: http://www.minutes.haringey.gov.uk/documents/s79046/Market%20Position%20Statement%20with%20Signature.pdf.

Safeguarding adults' performance data for Q4 was presented to the Quality Assurance Board. This data will be presented to the Safeguarding Adults Board meeting on 13 July 2015.

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.

[1] Including areas for further improvement following the section 11 audit (Children Act 2004) in 2014

A draft children and adults' social care supervision policy was presented to QAB. The policy will ensure quality supervision is in place and is based on a reflective model.

Care Quality Commission's new fundamental standards replace the 16 'essential standards' of quality and safety. The fundamental standards include a requirement to have governance and auditing systems in place to ensure compliance with the standards, as well as 2 new regulations – the duty of candour and the fit and proper person requirement for directors. These standards will be tested through registration and inspections.

4. Conclusion

The work described above will continue to be monitored by the Quality Assurance Board.

Work is underway 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. These and a further quarterly update will be provided to the Safeguarding Adults Board at the next meeting.

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Adults Safeguarding Report

April 2015 - June 2015

Commentary

There have been a total of 801* **Safeguarding Concerns** raised between 1st April 2015 and 30th June 2015, Of which, 281 * **Section 42 enquiries** were sent to the Adult Protection Team for further investigation during the same period. Between 1st April 2014 and 30th June 2014 a total of 1033 Alerts had been raised, Of which,217* Referrals were sent to the Adult Protection Team for further investigation during the same period. This represents a 22.46%* decrease in the number of **Concerns** raised at the same point between each consecutive financial years, and an 29.49% increase in the number of **Referrals/Section 42 referrals** raised between the same time periods.

348 **Safeguarding Concerns** were raised in June 2015. Of which, 104 **Section 42 cases** were sent to the Adult Protection Team for further investigation. This is an increase from the 88 **Section 42 cases** raised in May 2015.

For clarification, **Alerts** and **Referrals** are determined as follows:

Safeguarding Concerns
A sign of suspected abuse or neglect that is reported to the council or identified by the council. Safeguarding concerns can include cases of sexual exploitation, modern slavery, domestic abuse and self-neglect.

Section 42 Safeguarding Enquiries
The enquiries where an adult meets ALL of the section 42 criteria. The criteria are: (a) The adult has needs for care AND support (whether or not the authority is meeting any of those needs) AND (b) The adult is experiencing, or is at risk of, abuse or neglect AND (c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Other Safeguarding Enquiries
The enquiries where an adult does not meet all of the section 42 criteria but the council considers it necessary and proportionate to have a safeguarding enquiry.

Neglect and acts of omission were the most common form of abuse between April and June 2015, whilst the alleged victim's own home remains the most common location where the abuse took place.

Referrals whereby the source was stated as "other" generated 57 referrals out of the total 281 received.

A total of 19 of the 281 referrals received, identified that Other Local Authorities were providing a service for the vulnerable adult within Haringey.

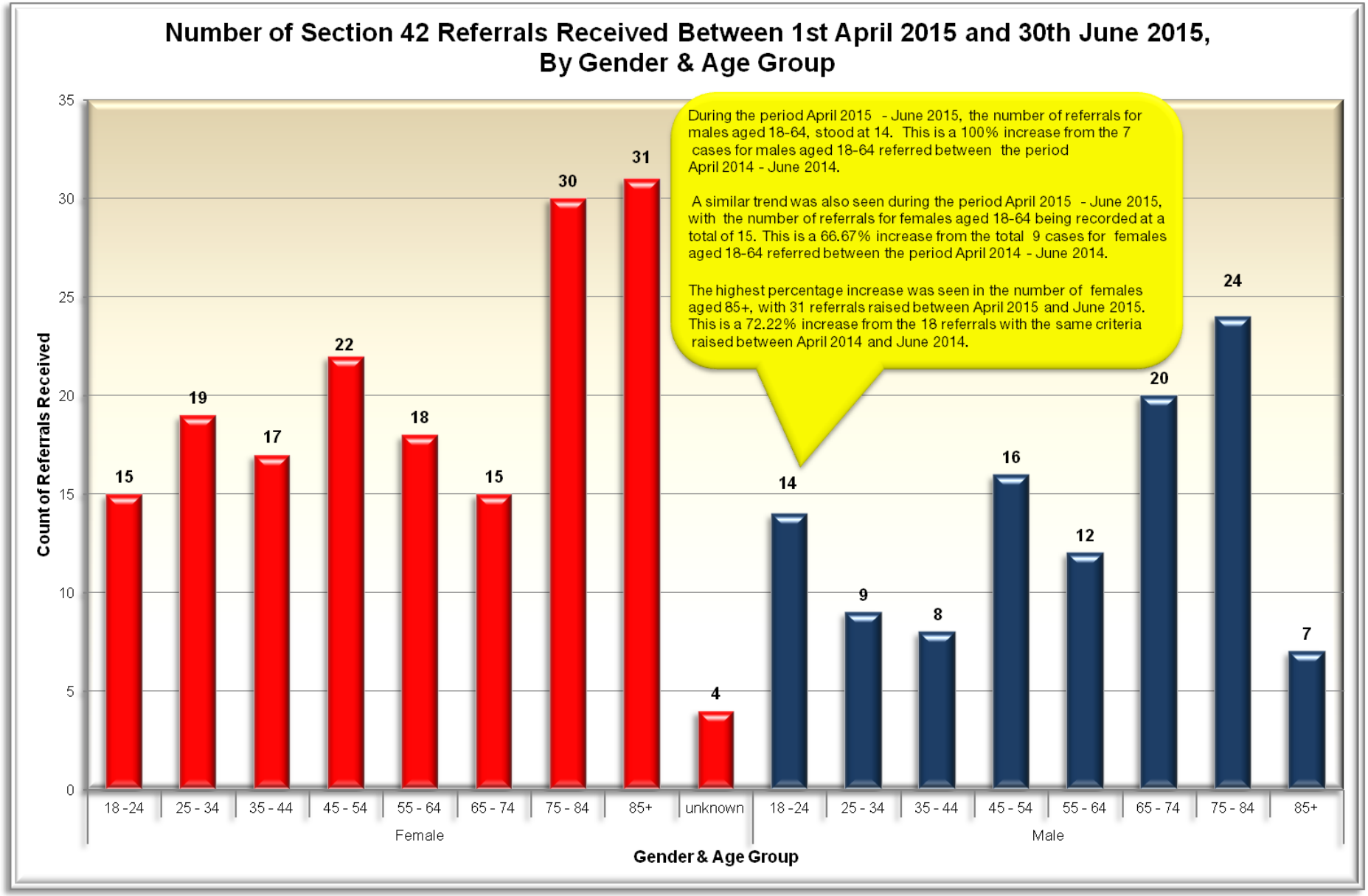
Vulnerable adults aged 75 - 84 with a primary support reason of "physical support", represent the highest proportion of referrals raised.

Those of Black Caribbean origin represent the highest proportion of BME SOVA alerts raised.

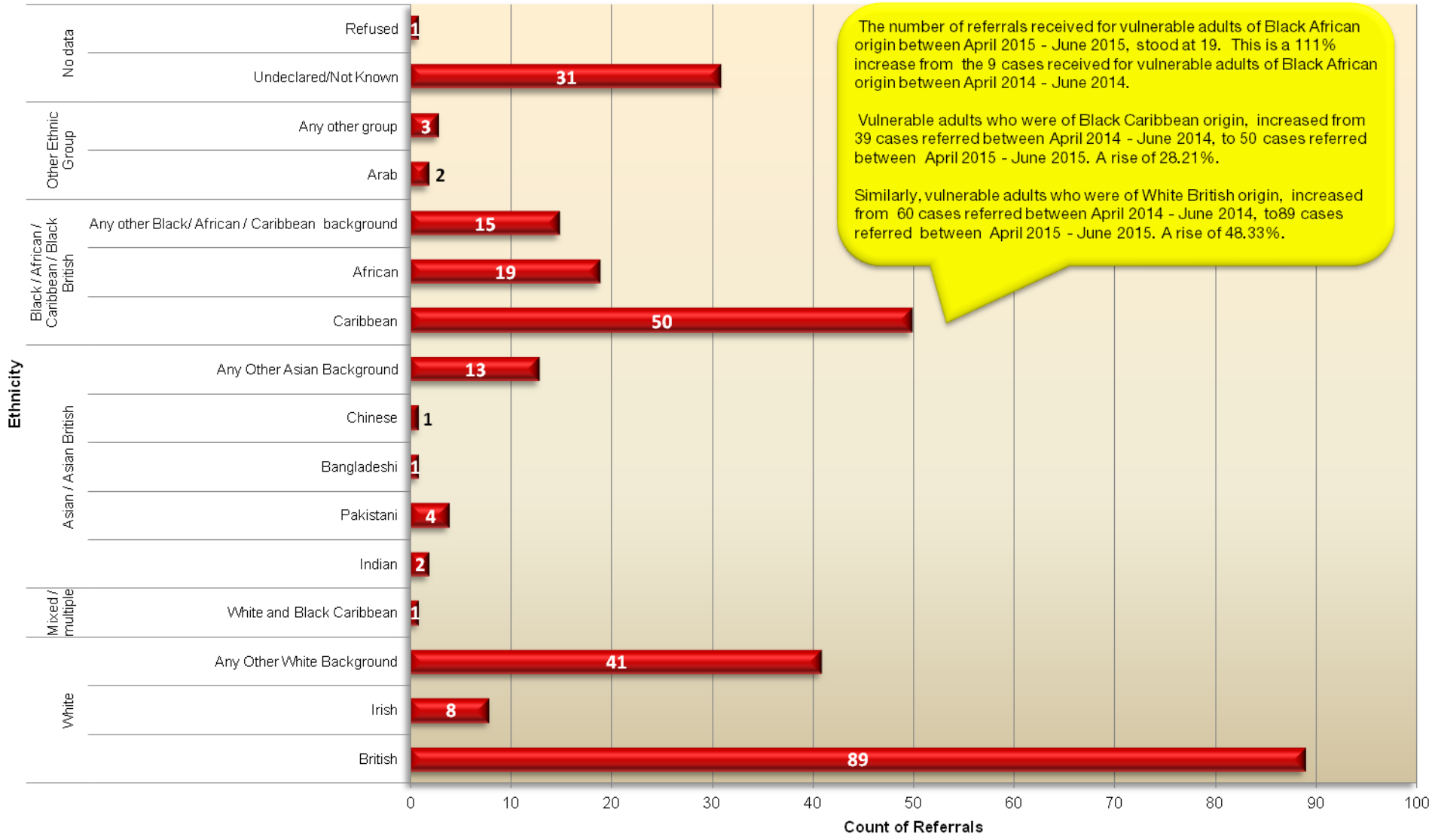
Of the 281 Referrals raised between April 2015 and June 2015, a total of 118 were closed.

Please be advised that the Domestic Violence And Hate Crime maps are only intended for relevant Council workers, and must NOT be distributed to the public or wider Community.

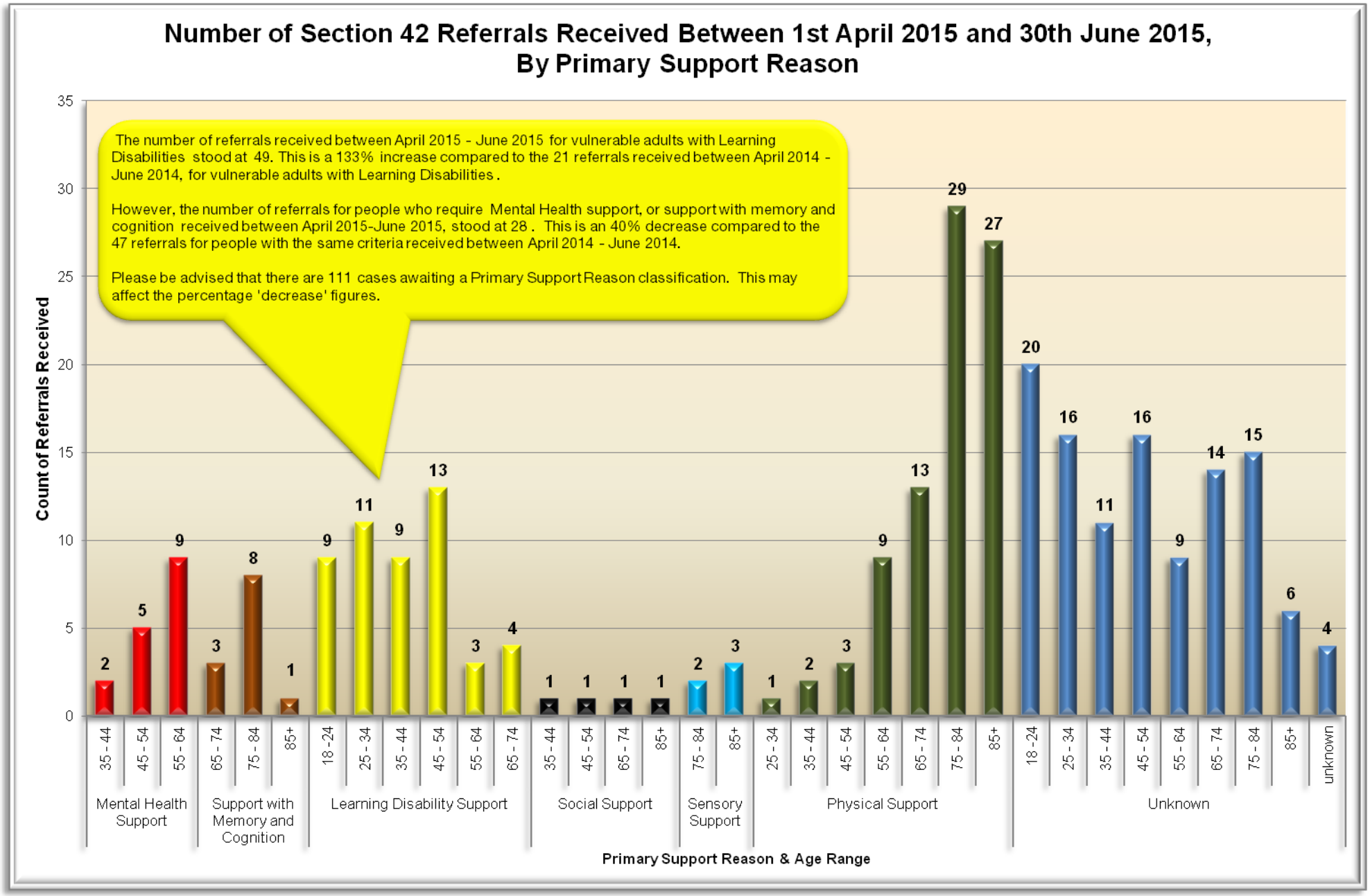
** Please be advised that these figures are provisional and are subject to validation, which may change as a result. The introduction of the Care Act 2014 has seen a change in the terminology used to determine the safeguarding processes used by Local Authorities. Comparrisons between financial years must take these changes into account.*


Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015, By Gender & Age Group
During the period April 2015 - June 2015, the number of referrals for males aged 18-64, stood at 14. This is a 100% increase from the 7 cases for males aged 18-64 referred between the period April 2014 - June 2014.
A similar trend was also seen during the period April 2015 - June 2015, with the number of referrals for females aged 18-64 being recorded at a total of 15. This is a 66.67% increase from the total 9 cases for females aged 18-64 referred between the period April 2014 - June 2014.
The highest percentage increase was seen in the number of females aged 85+, with 31 referrals raised between April 2015 and June 2015. This is a 72.22% increase from the 18 referrals with the same criteria raised between April 2014 and June 2014.
Count of Referrals Received
0
5
10
15
20
25
30
35
15
19
17
22
18
15
30
31
4
14
9
8
16
12
20
24
7
18 -24
25 - 34
35 - 44
45 - 54
55 - 64
65 - 74
75 - 84
85+
unknown
18 -24
25 - 34
35 - 44
45 - 54
55 - 64
65 - 74
75 - 84
85+
Female
Male
Gender & Age Group

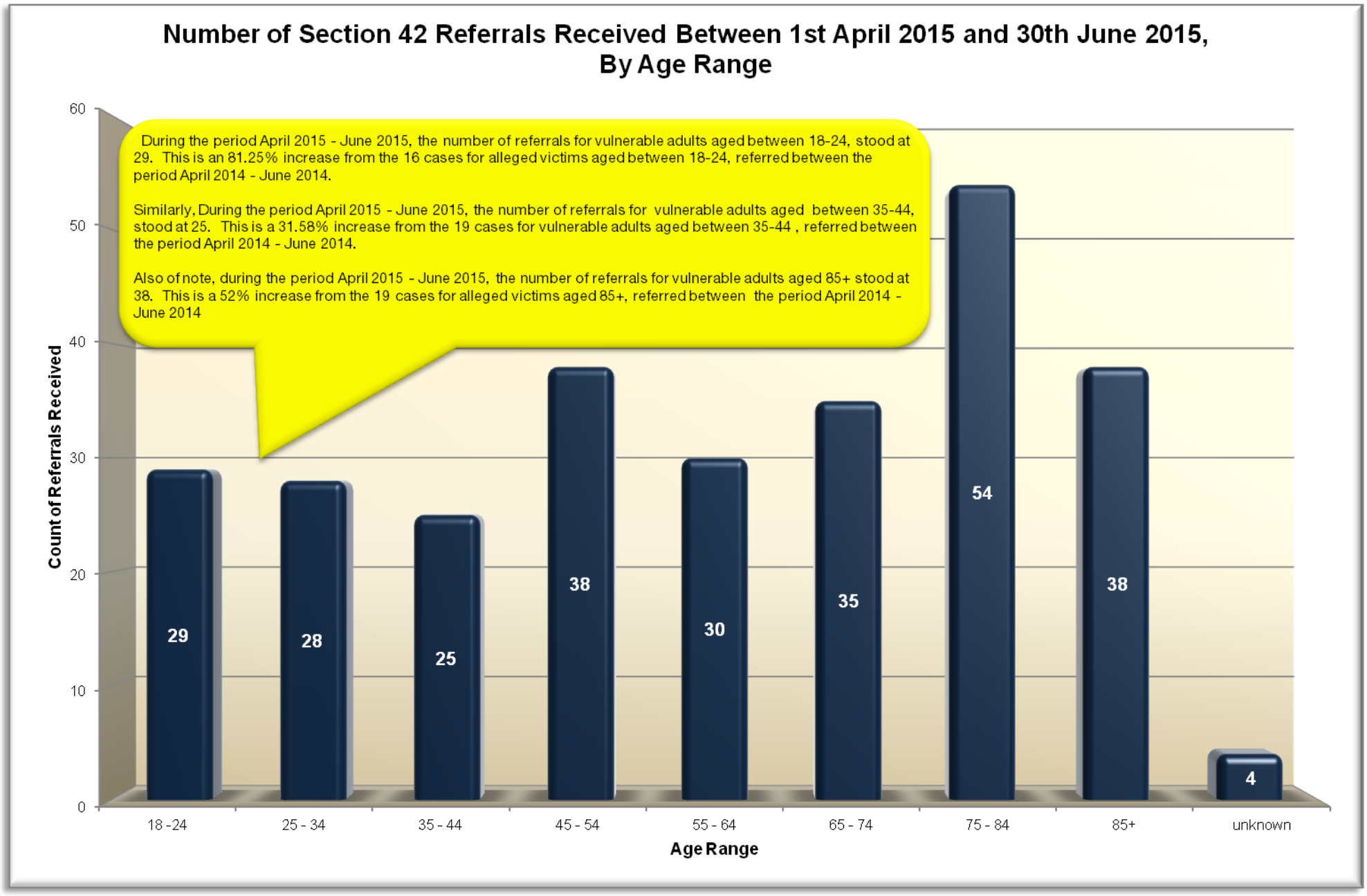
Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015, By Ethnicity Summary



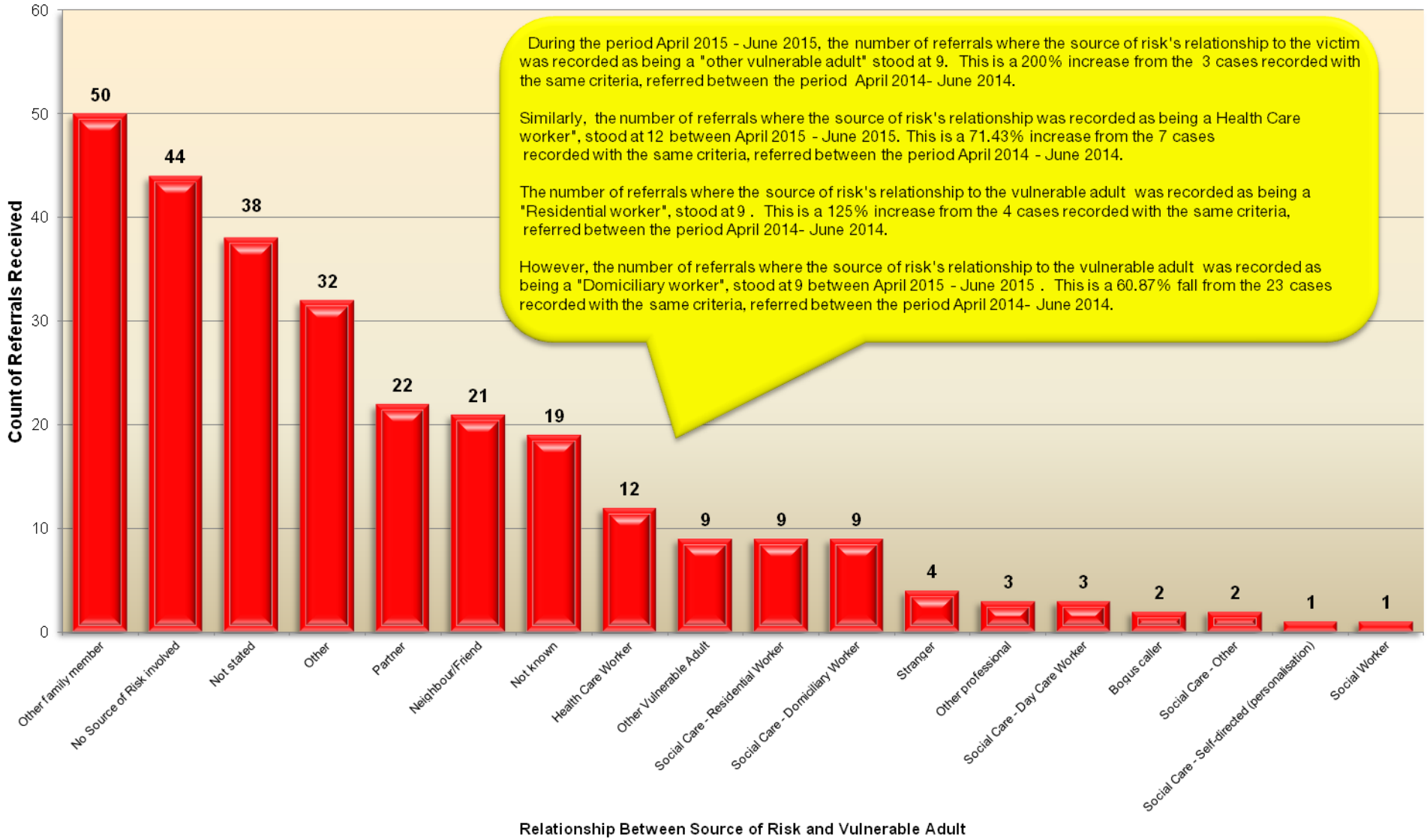
Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015, By Primary Support Reason



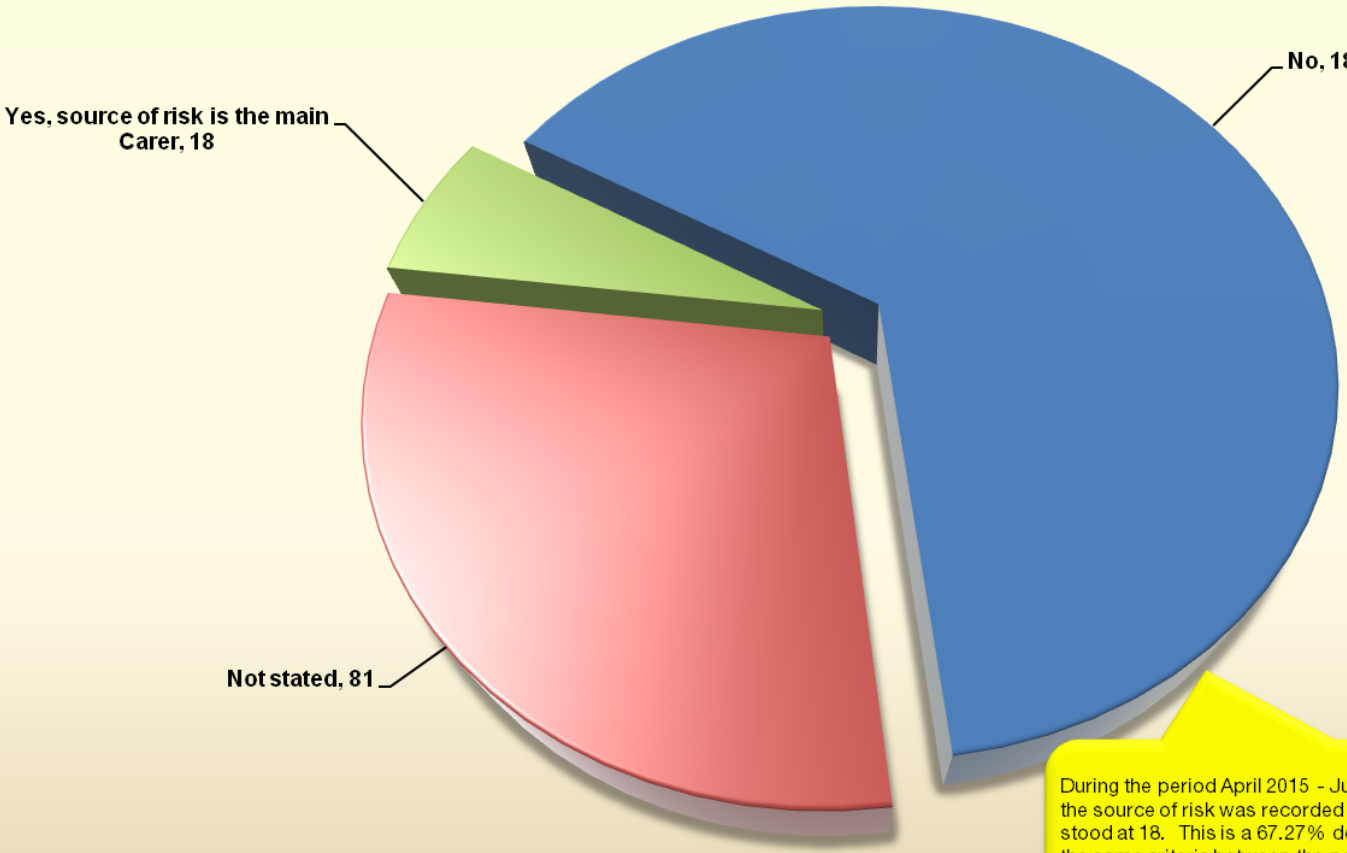
Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015, By Age Range



Number of Section 42 Cases Received Between 1st April 2015 and 30th June 2015 Which Record The Relationship Between the Source of Risk and Vulnerable Adult.

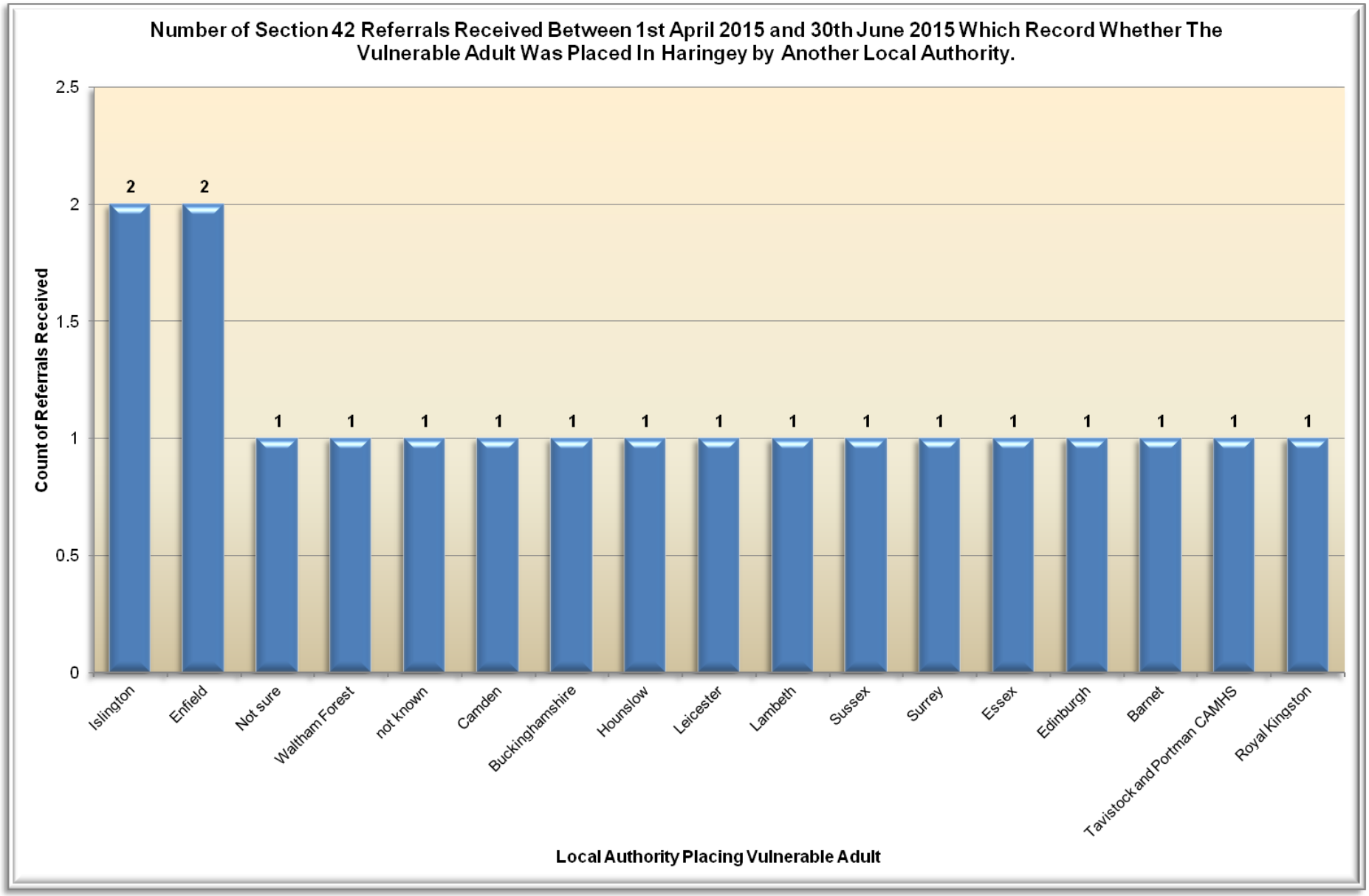


Number of Section 42 Referrals Received Between 1st April 2015 and 30th June2015 Which Record Whether The Source of Risk is the Vulnerable Adult's Main Carer.

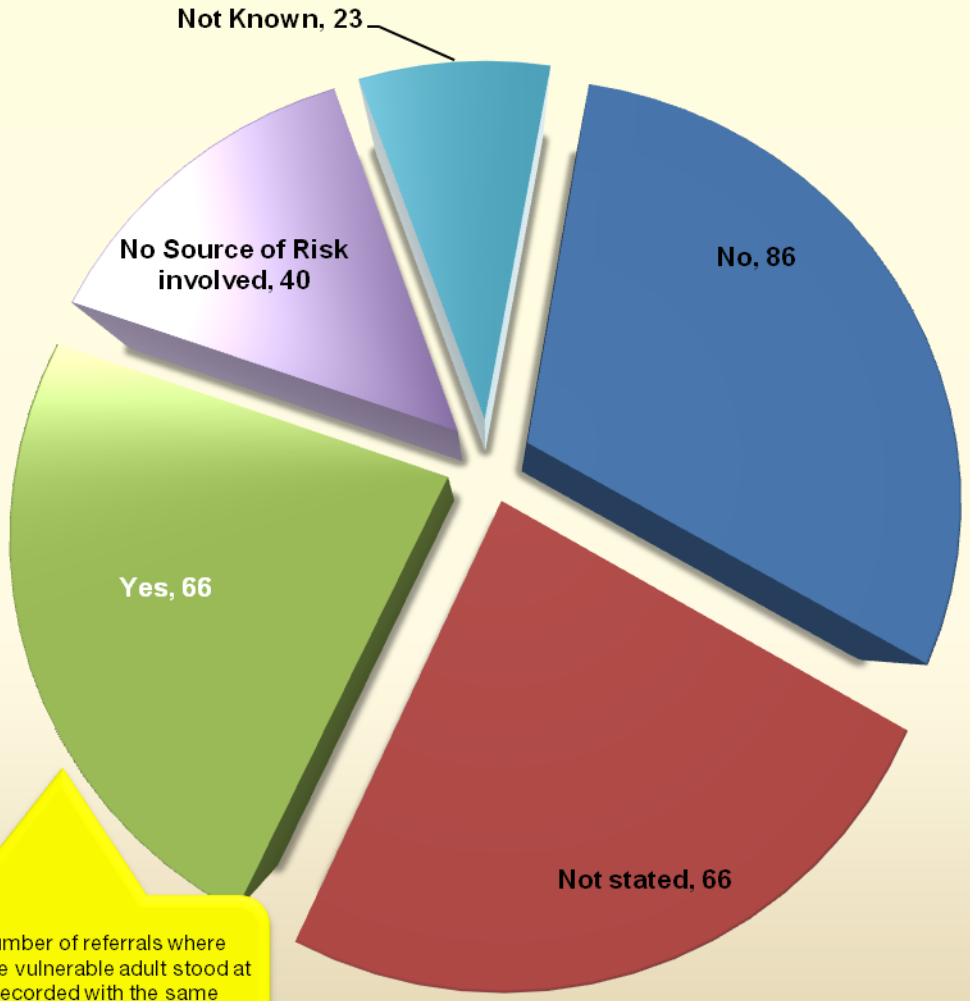


During the period April 2015 - June 2015, the number of referrals where the source of risk was recorded as being the vulnerable adult's main carer, stood at 18. This is a 67.27% decrease from the 55 cases recorded with the same criteria between the period April 2014- June 2014.

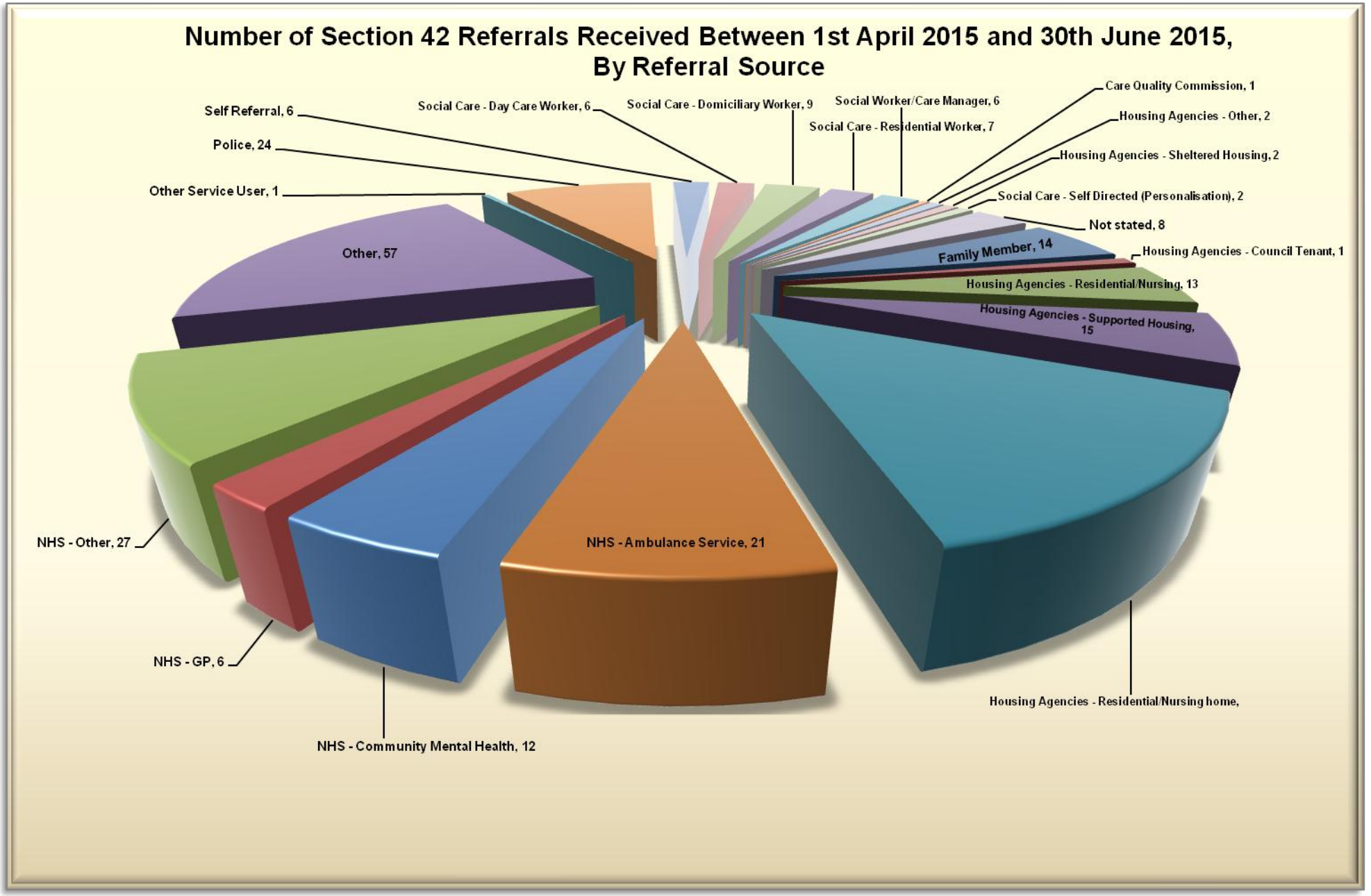
Please be advised that the 81 cases not recorded must be taken into consideration when calculating the variences.

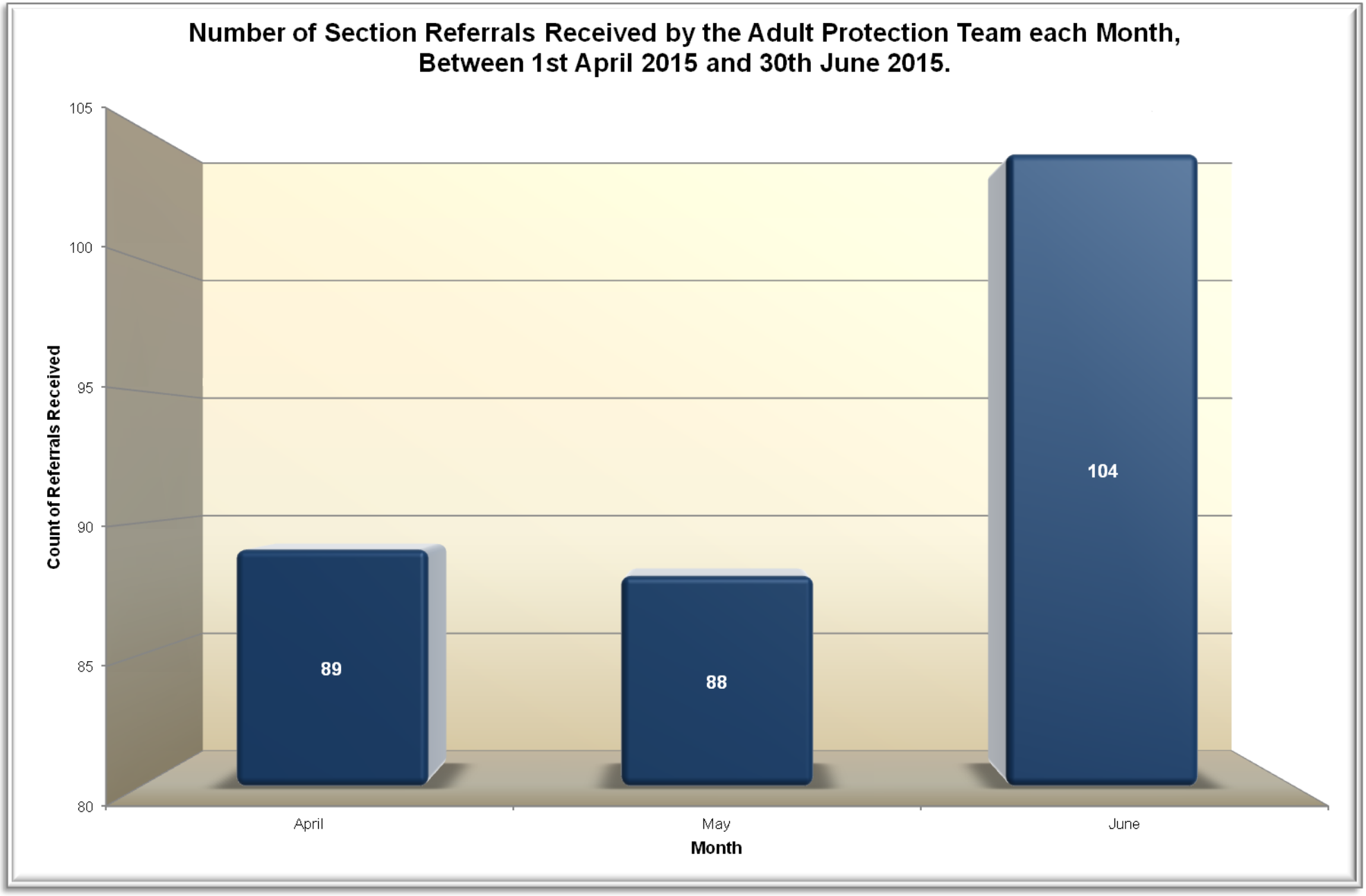

Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015 Which Record Whether The Vulnerable Adult Was Placed In Haringey by Another Local Authority.
Count of Referrals Received
2.5
2
1.5
1
0.5
0
2
2
1
1
1
1
1
1
1
1
1
1
1
1
1
1
Islington
Enfield
Not sure
Waltham Forest
not known
Camden
Buckinghamshire
Hounslow
Leicester
Lambeth
Sussex
Surrey
Essex
Edinburgh
Barnet
Tavistock and Portman CAMHS
Royal Kingston
Local Authority Placing Vulnerable Adult

Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015 Which Record Whether The Source of Risk lives With the Vulnerable Adult.

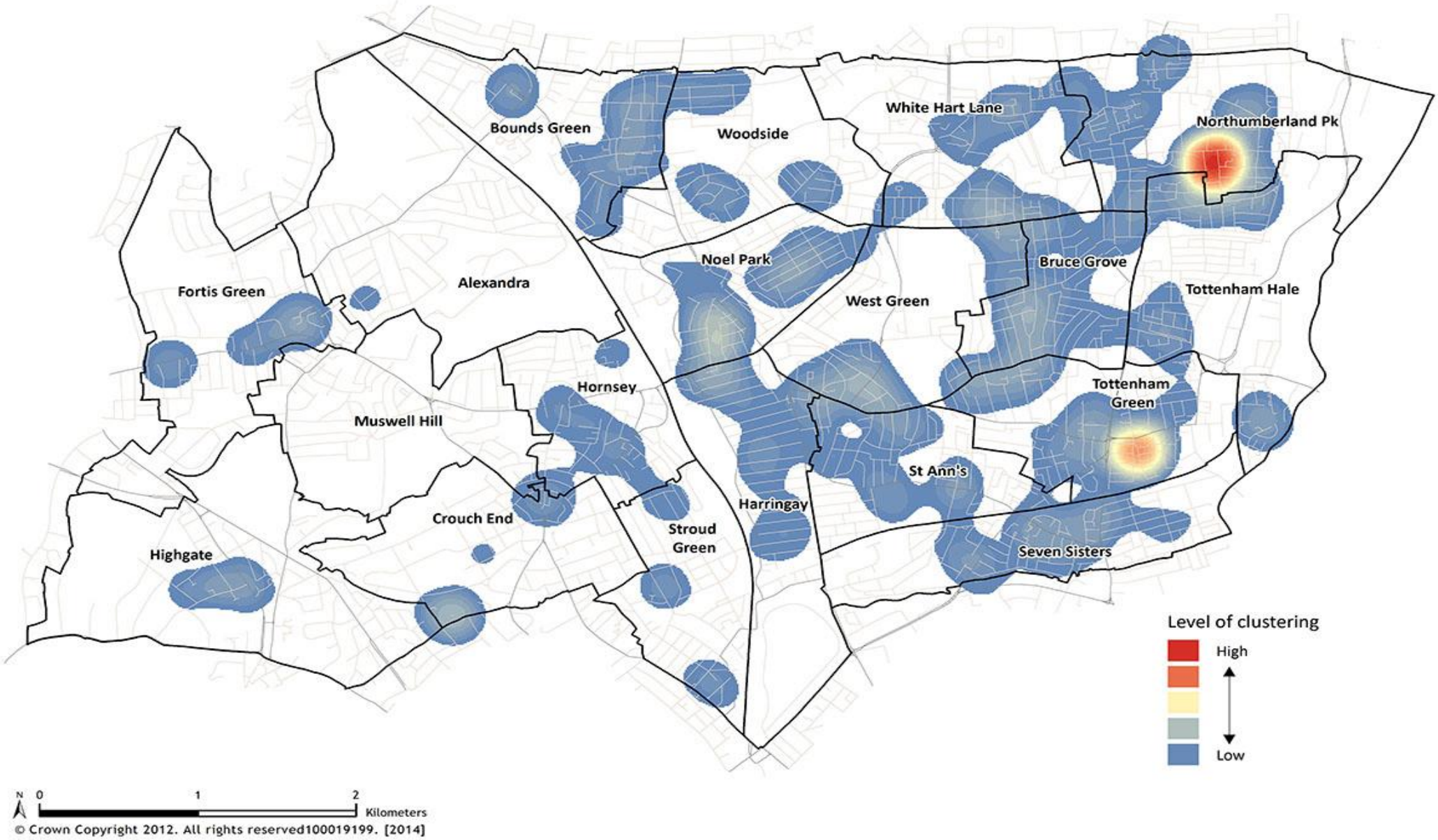


During the period April 2015 - June 2015, the number of referrals where the source of risk was recorded as living with the vulnerable adult stood at 66. This is a 35% decrease from the 49 cases recorded with the same criteria between the period April 2014- June 2014.

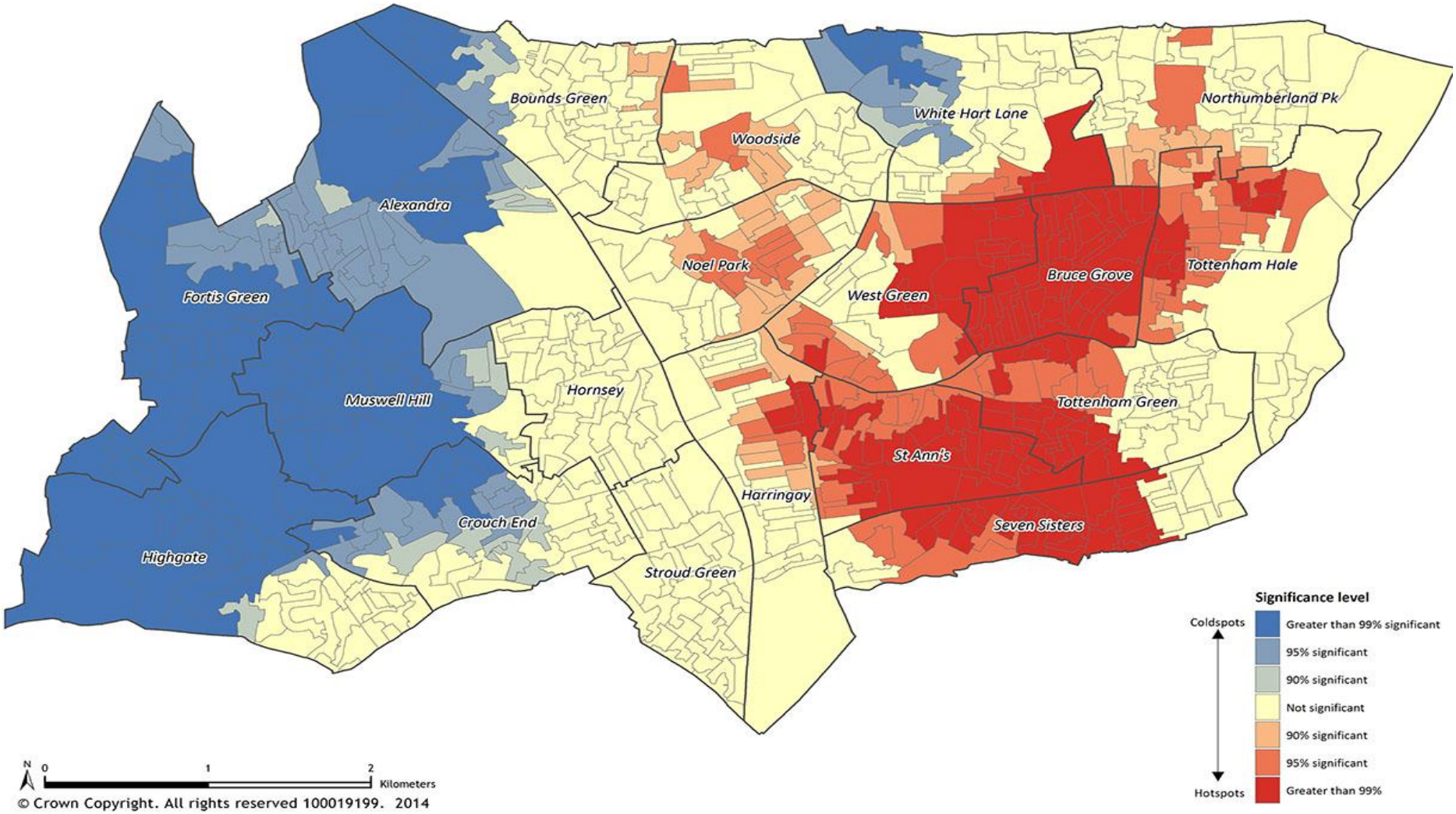

Number of Section 42 Referrals Received Between 1st April 2015 and 30th June 2015, By Referral Source
Self Referral, 6
Police, 24
Other Service User, 1
Other, 57
NHS - Other, 27
NHS - GP, 6
NHS - Community Mental Health, 12
NHS - Ambulance Service, 21
Housing Agencies - Residential/Nursing home,
Social Care - Day Care Worker, 6
Social Care - Domiciliary Worker, 9
Social Worker/Care Manager, 6
Social Care - Residential Worker, 7
Care Quality Commission, 1
Housing Agencies - Other, 2
Housing Agencies - Sheltered Housing, 2
Social Care - Self Directed (Personalisation), 2
Not stated, 8
Family Member, 14
Housing Agencies - Council Tenant, 1
Housing Agencies - Residential/Nursing, 13
Housing Agencies - Supported Housing, 15


Number of Section Referrals Received by the Adult Protection Team each Month, Between 1st April 2015 and 30th June 2015.
Count of Referrals Received
105
100
95
90
85
80
89
88
104
April
May
June
Month

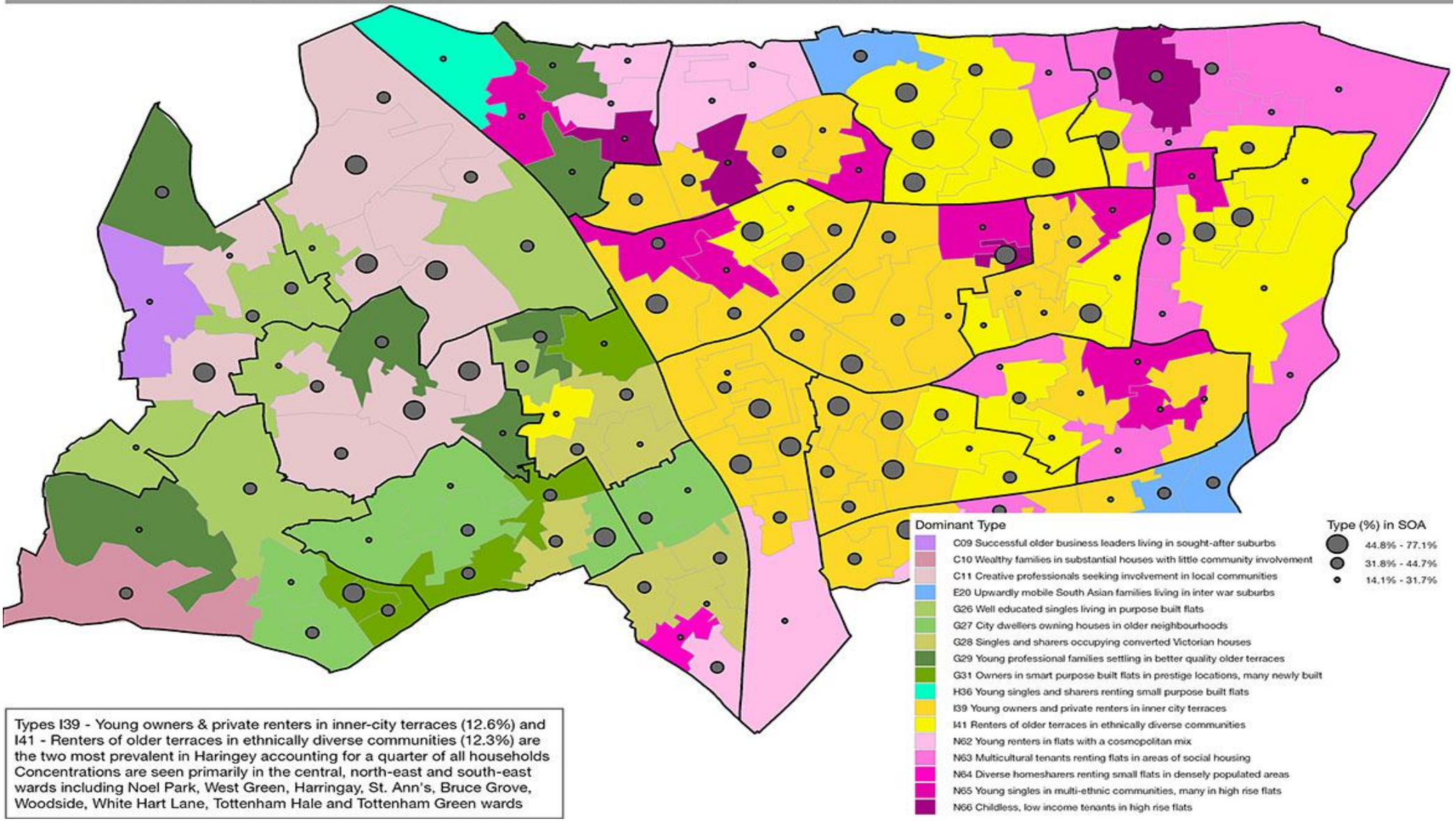
Adult safeguarding referrals hotspots: *April14 - March15*



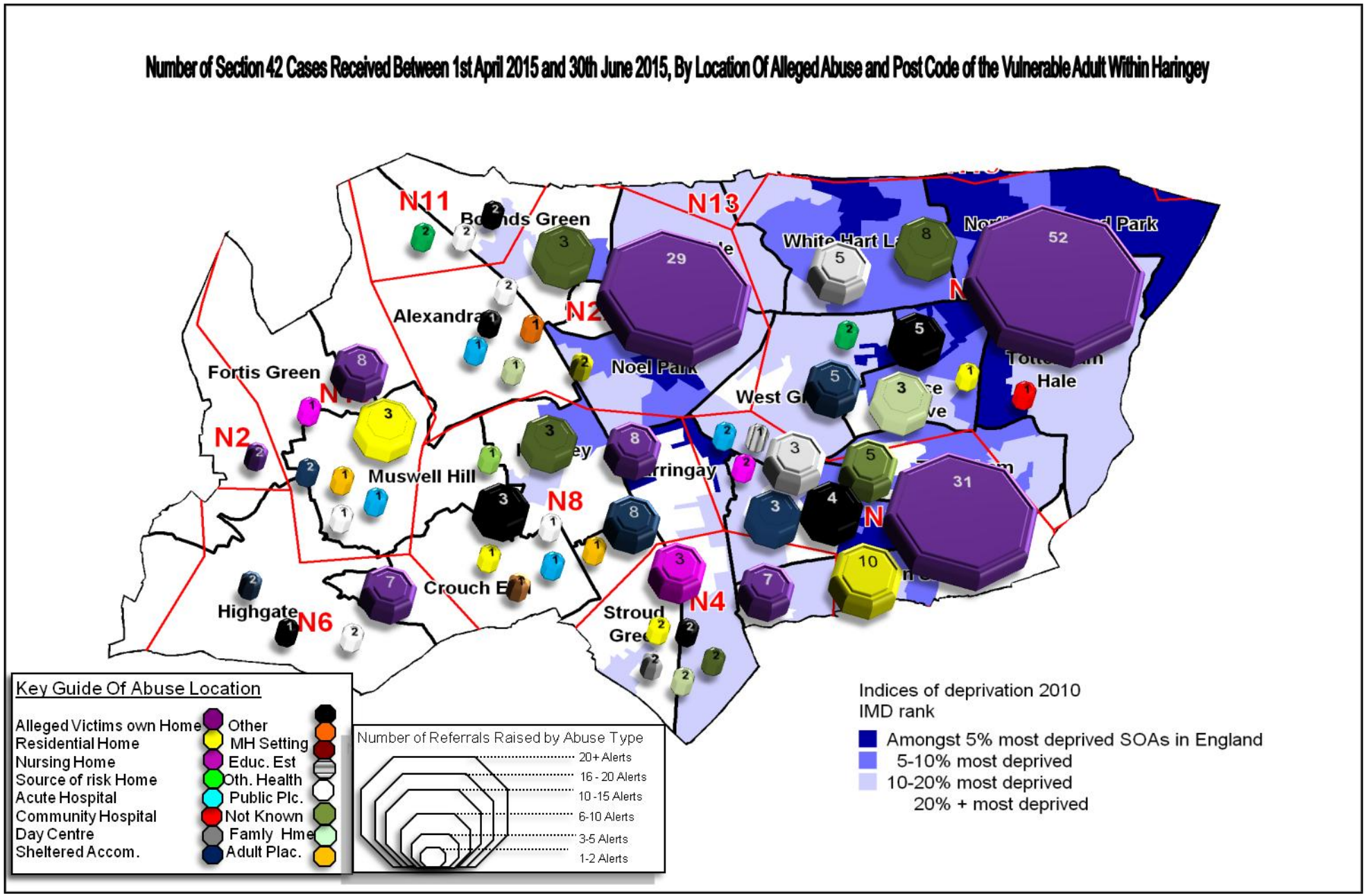
Population density hotspots and coldspots: Number of persons per hectare (10,000 sq metres) - 2011 Census



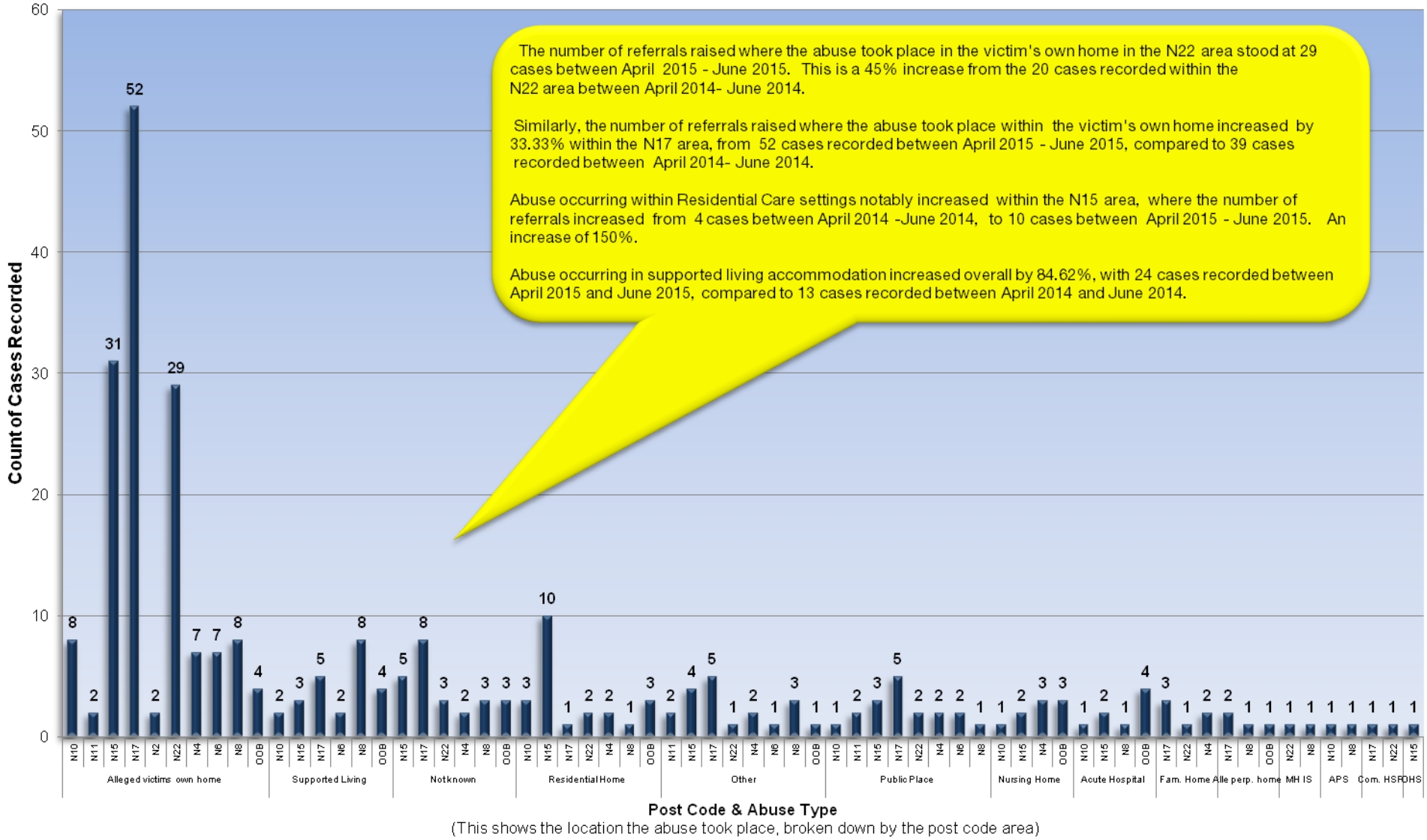
The map below illustrates the distribution of Mosaic Types across Haringey at Lower Super Output Area level. It is important to note that this represents the most frequent Mosaic Types within each area and may not even represent the majority of households in a given SOA*; there will be significant variations at household level. The size of the grey dot represents the dominance of that particular Type in the SOA.

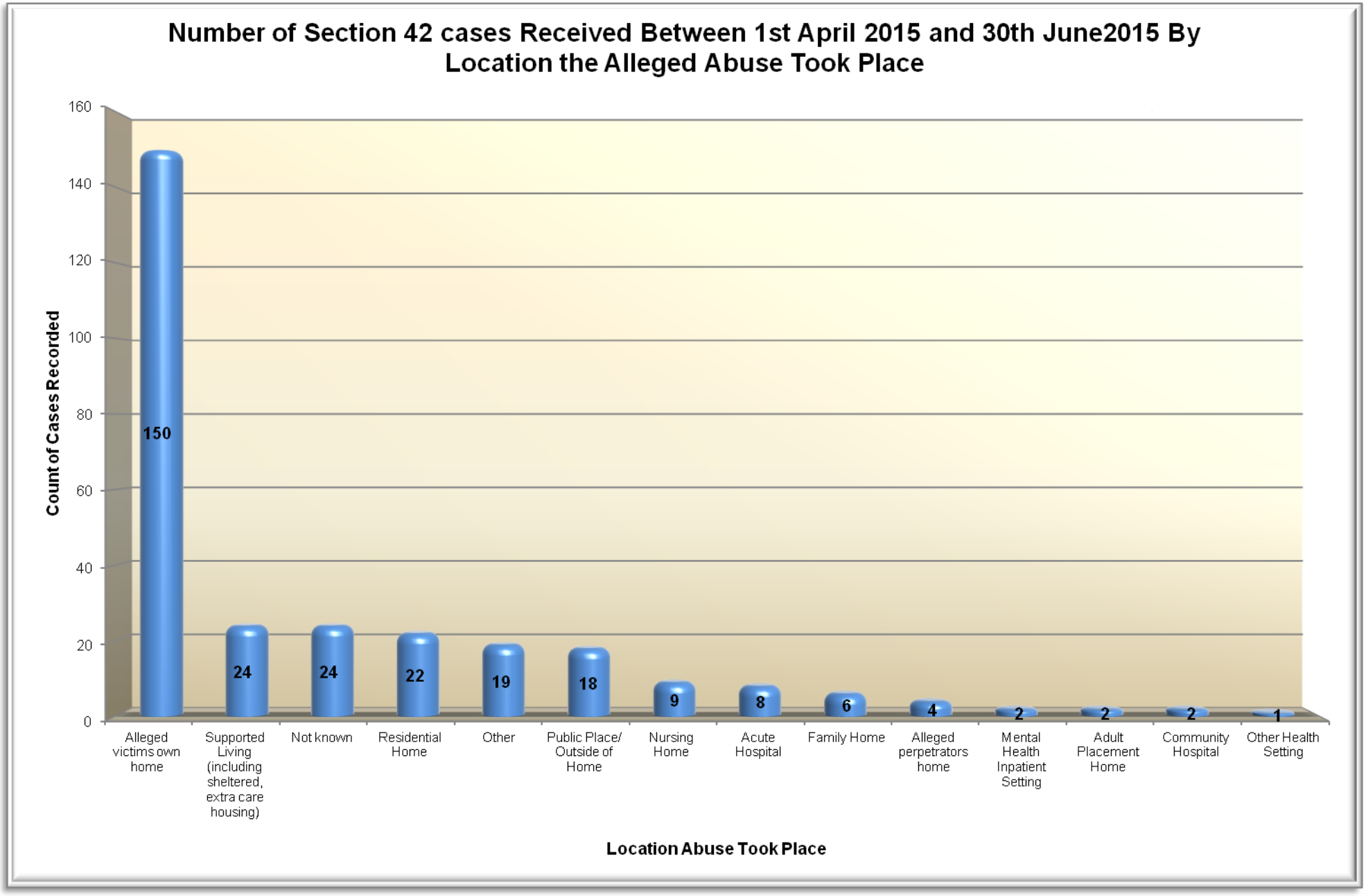


Types I39 - Young owners & private renters in inner-city terraces (12.6%) and I41 - Renters of older terraces in ethnically diverse communities (12.3%) are the two most prevalent in Haringey accounting for a quarter of all households Concentrations are seen primarily in the central, north-east and south-east wards including Noel Park, West Green, Harringay, St. Ann's, Bruce Grove, Woodside, White Hart Lane, Tottenham Hale and Tottenham Green wards

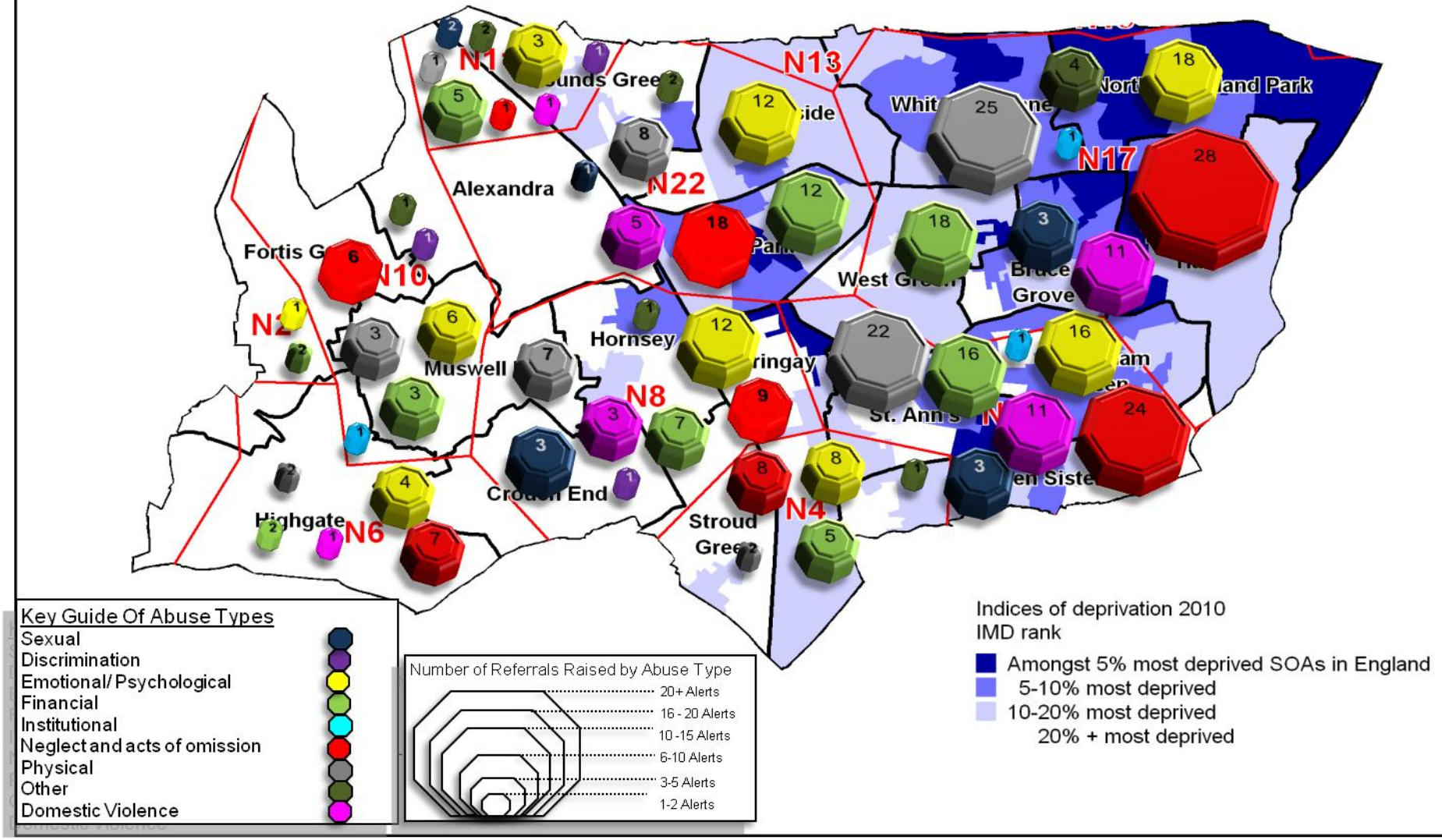

Number of Section 42 Cases Received Between 1st April 2015 and 30th June 2015, By Location Of Alleged Abuse and Post Code of the Vulnerable Adult Within Haringey
N11
N13
N2
N8
N4
N6
Alexandra
Noel Park
West Green
Muswell Hill
Fortis Green
Crouch End
Highgate
Stroud Green
Hale
Key Guide Of Abuse Location
Alleged Victims own Home
Residential Home
Nursing Home
Source of risk Home
Acute Hospital
Community Hospital
Day Centre
Sheltered Accom.
Other
MH Setting
Educ. Est
Oth. Health
Public Plc.
Not Known
Famly Hme
Adult Plac.
Number of Referrals Raised by Abuse Type
20+ Alerts
16 - 20 Alerts
10 -15 Alerts
6-10 Alerts
3-5 Alerts
1-2 Alerts
Indices of deprivation 2010
IMD rank
Amongst 5% most deprived SOAs in England
5-10% most deprived
10-20% most deprived
20% + most deprived

Number of Section 42 Cases Received Between 1st April 2015 and 30th June 2015 By Location of Alleged Abuse and Post Code of Vulnerable Adult

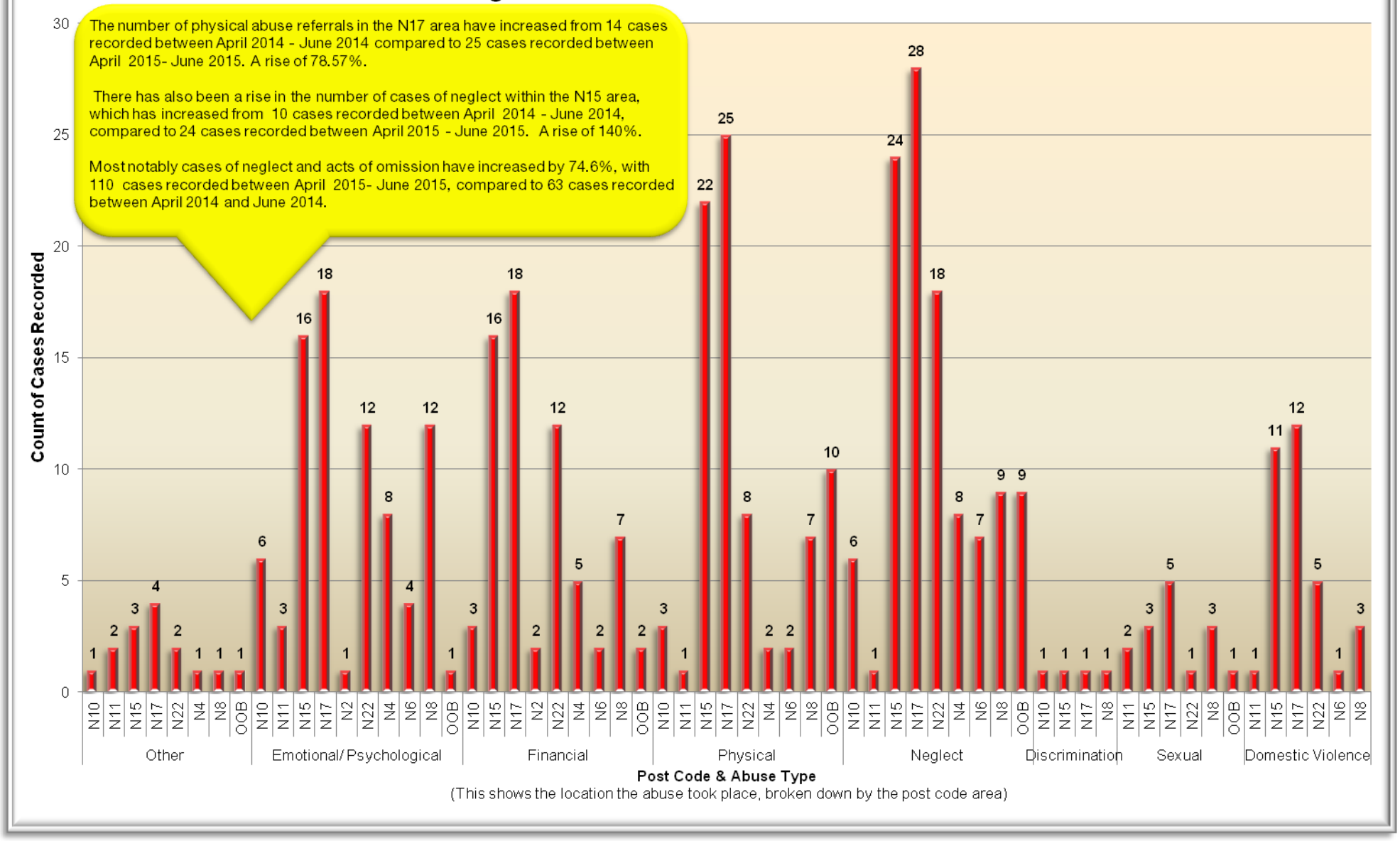


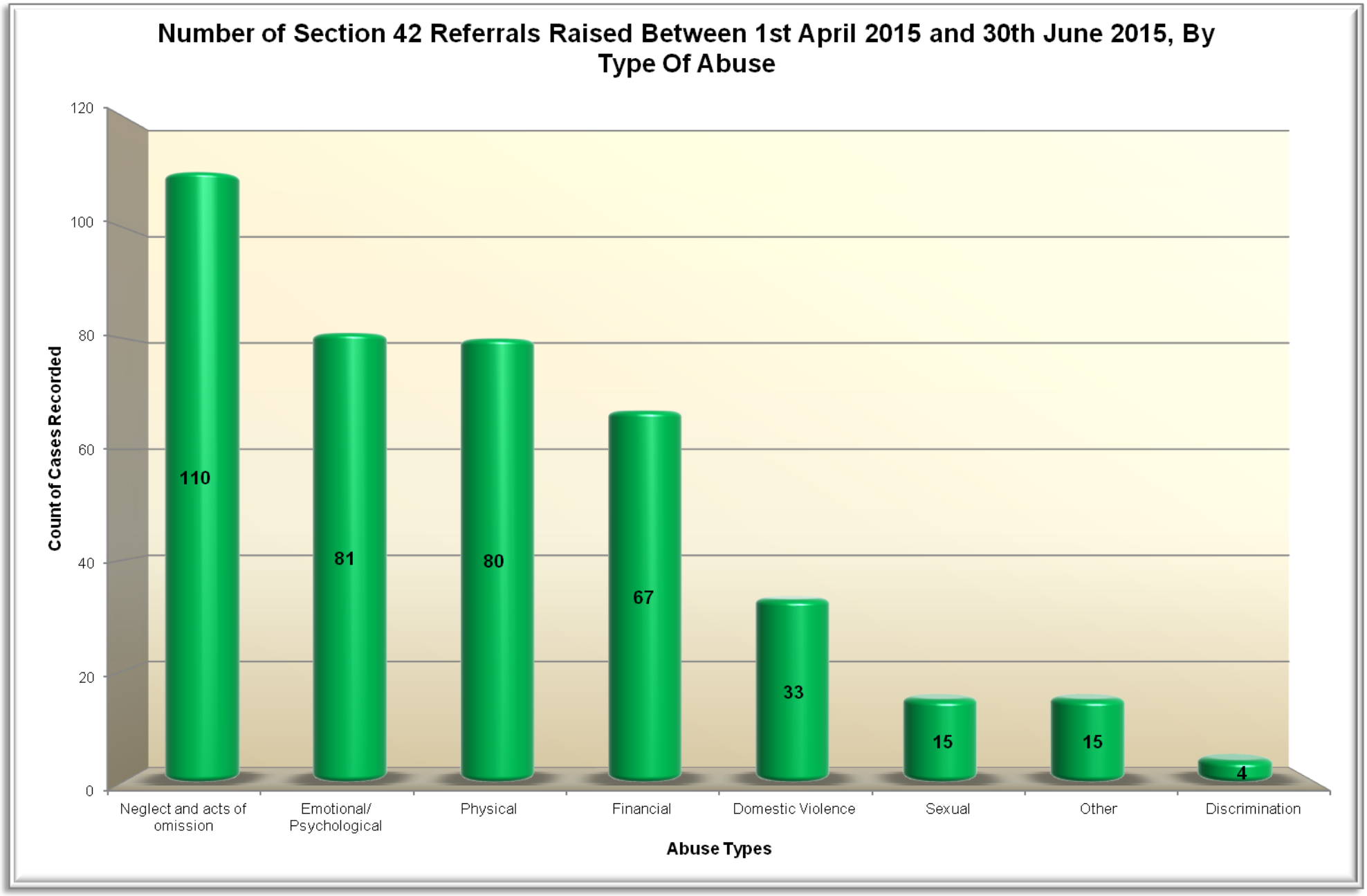

Number of Section 42 cases Received Between 1st April 2015 and 30th June2015 By Location the Alleged Abuse Took Place
Count of Cases Recorded
160
140
120
100
80
60
40
20
0
150
24
24
22
19
18
9
8
6
4
2
2
2
1
Alleged victims own home
Supported Living (including sheltered, extra care housing)
Not known
Residential Home
Other
Public Place/ Outside of Home
Nursing Home
Acute Hospital
Family Home
Alleged perpetrators home
Mental Health Inpatient Setting
Adult Placement Home
Community Hospital
Other Health Setting
Location Abuse Took Place

Number of Section 42 Cases Received Between 1st April 2015 and 30th June 2015, By Type Of Abuse and Post Code of Vulnerable Adult Within Haringey

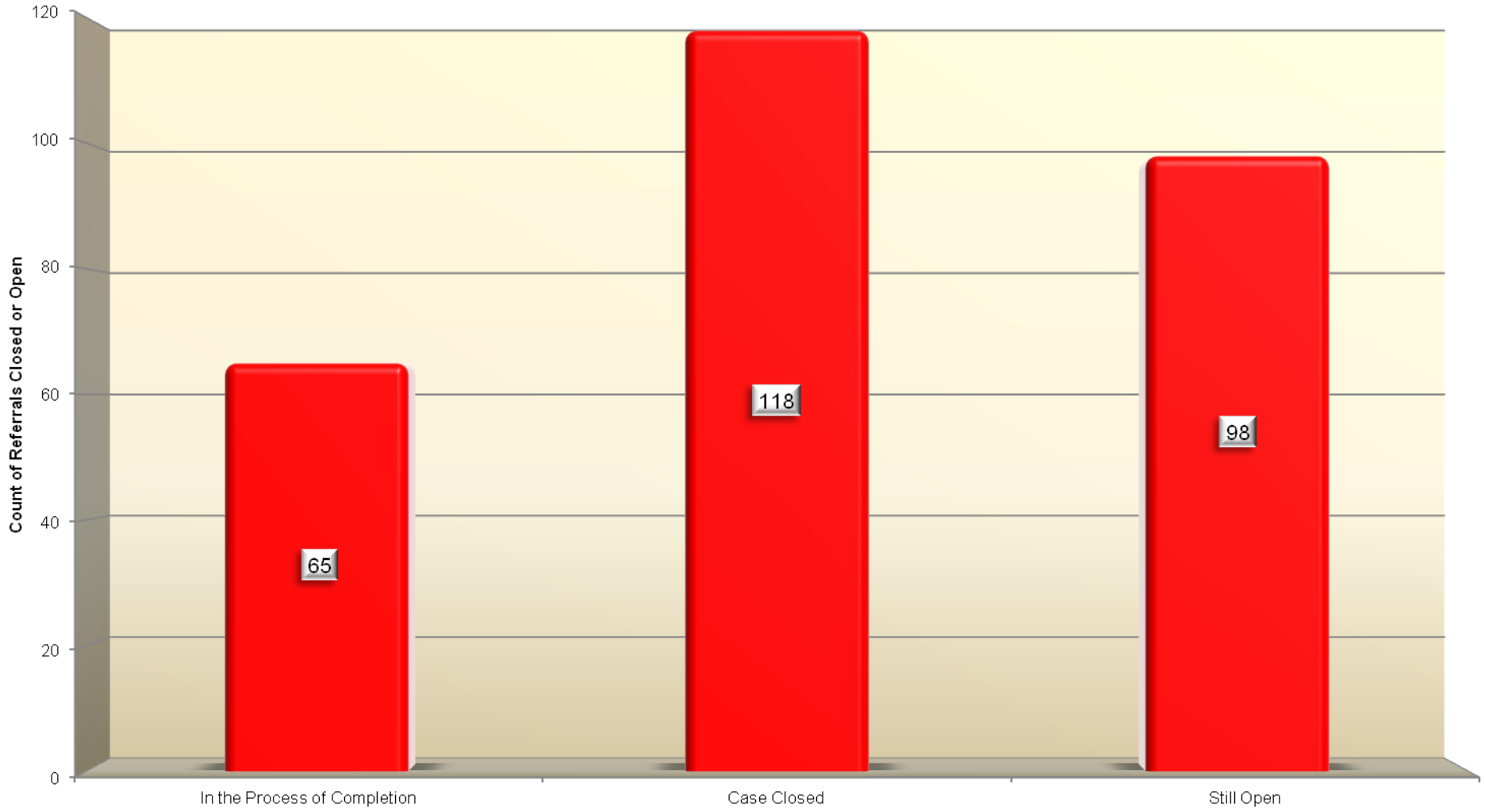


Number of Section 42 Cases Received Between 1st April 2015 and 30th June 2015,By Location of Alleged Abuse and Post Code of the Vulnerable Adult



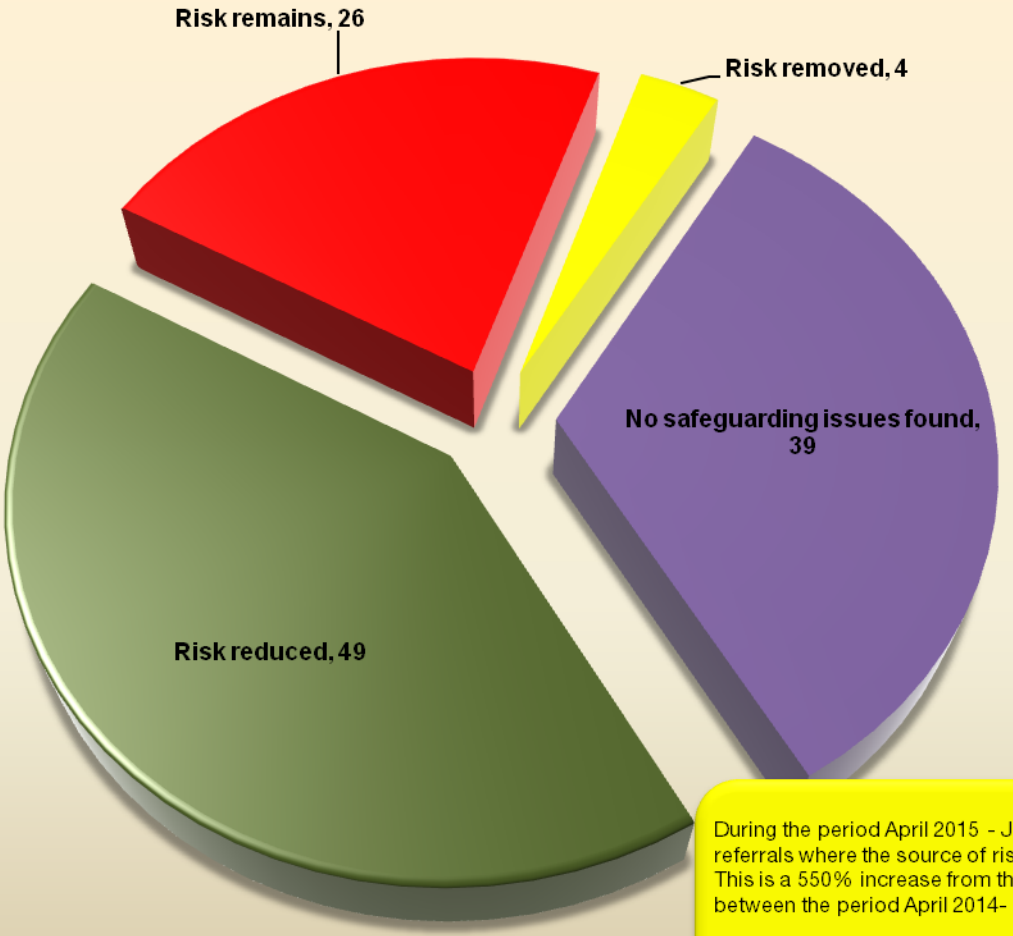

Number of Section 42 Referrals Raised Between 1st April 2015 and 30th June 2015, By Type Of Abuse
Count of Cases Recorded
120
100
80
60
40
20
0
110
81
80
67
33
15
15
4
Neglect and acts of omission
Emotional/ Psychological
Physical
Financial
Domestic Violence
Sexual
Other
Discrimination
Abuse Types

Number of Section 42 Referrals Which Have Been Closed Between 1st April 2015 and 30th June 2015



(All S42 referrals enter a screening process before they can be closed. "In the process of Completion" have been screened, and are awaiting authorisation to be closed. "Case Closed" are completed and closed).

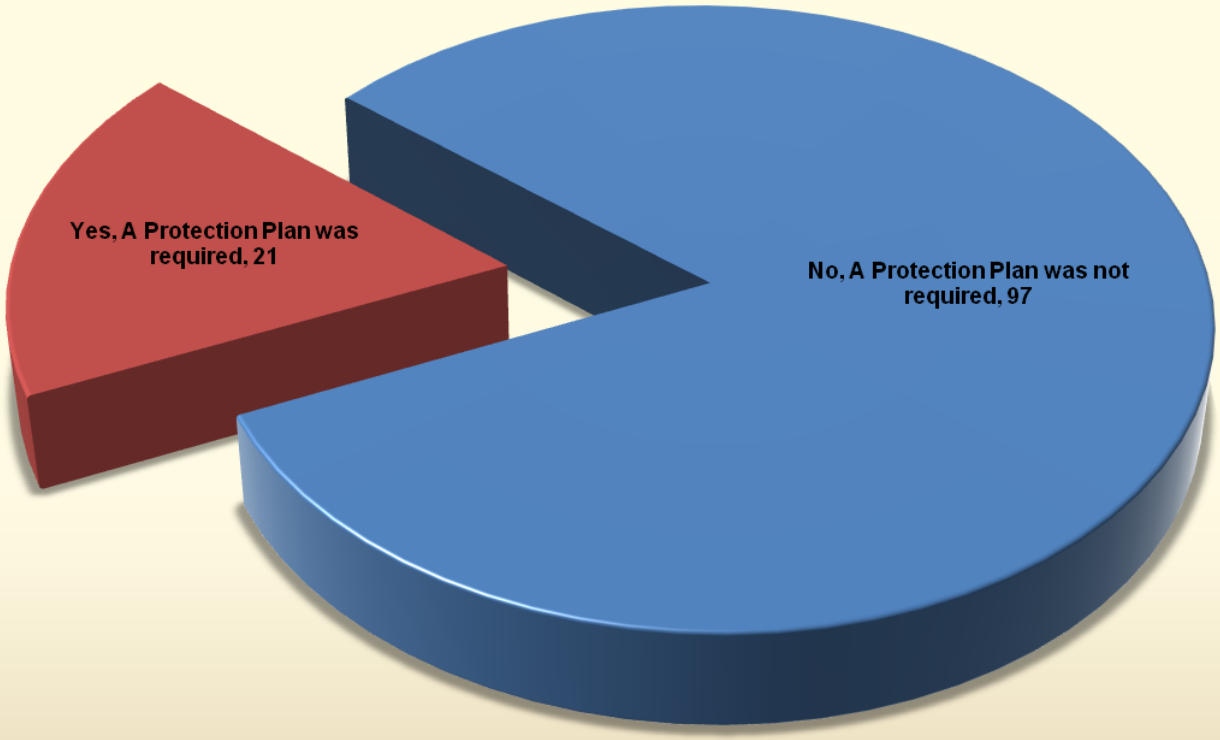
Final "Risk Status" Recorded at Case Conclusion, Between 1st April 2015 and 30th June 2015.



During the period April 2015 - June 2015, the number of concluded referrals where the source of risk was deemed to 'remain', stood at 26. This is a 550% increase from the 4 cases recorded with the same criteria between the period April 2014- June 2014.

Concluded cases where the 'risk reduced' decreased from 129 cases between April 2014 and June 2015, to 49 cases between April 2015 and June 2015. A fall of 62.02%.

How Many Of The Section 42 Referrals Closed Between 1st April 2015 and 30th June 2015 Required a Safeguarding/Protection Plan?



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Haringey Multi-Agency Safeguarding Adults Board
Quality Assurance sub-group
Draft Terms of Reference
(August 2015)

HARINGEY SAFEGUARDING ADULTS BOARD VISION

Haringey residents are able to live a life free from harm, where communities:

- Have a culture that does not tolerate abuse;
- Work together to prevent abuse; and
- Know what to do when abuse happens.

PURPOSE OF THE BOARD

The purpose of the Quality Assurance sub-group is to support Haringey Safeguarding Adults Board (the Board) to fulfil its remit of ensuring local safeguarding arrangements are effective and deliver the outcomes that people want. The Board's Quality Assurance Framework will act as the mechanism by which the Board will hold local agencies to account for their safeguarding work, including prevention and early intervention. This will be achieved through the delivery of an annual work plan developed in line with the Board's strategic priorities and objectives, and through the production of regular reports and information as required by the Board.

SPECIFIC RESPONISIBILTIES

1. To produce an annual programme of work in line with the Board's strategic priorities and objectives.

2. To develop a range of tools and methodologies to support the implementation of the Board's Quality Assurance Framework, including exception and performance reporting to the Board

3. To ensure the activities of the Quality Assurance sub-group reflect and promote the principles of Making Safeguarding Personal.

Haringey Multi-Agency Safeguarding Adults Board
Quality Assurance sub-group
Draft Terms of Reference
(August 2015)

4. To co-ordinate the implementation of the Board's Performance Framework and to present findings to the Board on a regular basis.

5. Identify themes, trends and gaps, and make recommendations to target the Board's work and gain the greatest improvement.

6. To ensure identified minimum standards in Board's safeguarding adults audit tool are in place and reflected in inter-agency policy and practice

7. To contribute to the review and monitor impact of the multi-agency Safeguarding Adults procedures.

8. To formulate an annual audit programme informed by the Board's strategic plan as well as findings from monitoring activities. This will include commissioning multi-agency themed audits and case file audits.

9. To monitor delivery of local safeguarding adult review / domestic homicide action plans and to ensure the implementation of these are assessed in terms of their impact on front line practice and outcomes for service users.

10. To monitor key outcomes of national reviews and inquiries advising the Board of any learning arising which could be applied in Haringey.

11. To maintain the Learning from Experience Database as a means of disseminating and promoting learning from serious cases.

12. To identify themes, trends and gaps arising from monitoring activity and to make recommendations about where to target the Board's work to gain greatest improvement.

13. To advise the Board of approaches to gain user feedback in order to ensure that the voice of the service users informs, influences and shapes the development of services.

14. To liaise with other subgroups and working groups to ensure a joined up and consistent approach to the work undertaken.

OPERATIONAL ARRANGEMENTS

Haringey Multi-Agency Safeguarding Adults Board
Quality Assurance sub-group
Draft Terms of Reference
(August 2015)

The Board's Quality Assurance sub-group will meet on a quarterly basis. To be considered quorate, meetings must have representatives from at least three agencies/organisations. The meeting agenda and papers will be circulated 5 working days in advance of the meeting.

The chair will be appointed by Haringey Safeguarding Adults Board. The vice-chair will be appointed the Quality Assurance sub-group.

Membership will be drawn from the partner agencies that have representatives on the Board and can make a significant professional contribution to the delivery of the Quality Assurance sub-group's main responsibilities.

When necessary, individuals from specialist areas of practice may be invited to take part in the work of the Quality Assurance sub-group.

Core Membership:

- Haringey Local Authority
- Haringey Metropolitan Police
- Haringey Clinical Commissioning Group
- Whittington Health
- North Middlesex University Hospital
- Barnet Enfield Haringey – Mental Health Trust
- London Fire Brigade
- London Ambulance

Review

These Terms of Reference will be reviewed annually and agreed by the Board.

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Adult Safeguarding Case File Audit Tool

Client ID:	
Person completing the Audit:	
Allocated Worker:	
Team:	
Date Audit Completed:	

Audit to be completed on all work carried out in the last 12 months.

SECTION 1 - Getting the basics right.

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Is the address on home page current and up to date?					
Are the demographic details for the person correct and up to date? (including gender, ethnicity, first language, and date of birth)					
The service user group field records the person's **Primary Support Reason**, (which is the main reason the person has approached the Council for care.) Is there **one current** primary support reason recorded and open?					
Has the case been clearly allocated or deallocated properly?					

SECTION 2 - Screening

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Does the screening episode clearly identify the vulnerable adult's desired goals or outcomes, and define what they wanted to achieve as part of the safeguarding intervention?					

Are the Action(s) already taken to protect victim clearly identified?					
Are the description of events clear and concise so that someone unfamiliar with the case could pick it up easily?					
Are the location(s) of abuse (tick box) identified and correct?					
Are the type(s) of abuse (tick box) identified and correct?					
Are any vulnerable adults and/or children who may be residing in the vulnerable adults' dwelling clearly identified? Have the appropriate team services been informed? (ie children's services)					
Have all the details of the 'source of harm' been clearly identified and recorded, so that someone unfamiliar with the case could pick it up easily? (ie name, address, or organisation the perpetrator works for)					
Have the referrer's (source) details been recorded accurately and fully?					
Were the person’s needs captured and is the evidence to support them clear?					
If the person lacks capacity, has a Mental Capacity Act Assessment been done?					
Has the 'risk level' been identified correctly?					
If applicable, if the case has been concluded at the screening stage is this decision correct?					
Were all major risks or concerns reasonably identified? were these responded to appropriately?					
Overall, is the Screening process clear, succinct and factually relevant?					

Is the rationale for decisions arising from the screening/discussion clear, accurate and provides detailed reasoning?					
Are you satisfied that the screening episode has been completed within a reasonable timeframe, based upon the merits of the case?					

SECTION 2 - Strategy Meeting

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Has a Strategy meeting been completed for this person? (if not please select "n/a" for all remaining questions)					
Is the description of the incident clear and concise so that someone unfamiliar with the case could pick it up easily?					
Are the summary of concerns clear and concise so that someone unfamiliar with the case could pick it up easily?					
Is the date of the Strategy Meeting recorded?					
Are all details within the Management Outcome and rationale section recorded?					
Is there sufficient detail in the Strategy meeting episode to enable someone who is unfamiliar with the case to pick it up easily?					
Are you satisfied that the strategy meeting episode has been completed within a reasonable timeframe, based upon the merits of the case?					

SECTION 3 - Case Conference & Reviews

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments

Has a Case Conference been completed for this person? (if not, please select "n/a" for all remaining questions)					
Is the description of the "actions taken" clear and concise so that someone unfamiliar to the case could pick it up easily?					
Have the risks/needs been clearly identified?					
Are all details within the Management Outcome and rationale section recorded?					
Is there sufficient detail in the Case Conference episode to enable someone who is unfamiliar with the case to pick it up easily?					
Are the outcomes of the Case Conference clear, detailed and concise?					

SECTION 4 - Case conclusion

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Is their evidence to show the case acheived 'meaningful improvement' for the individual? (ie protect them from harm, or improve their current situation)					
Did the case (from start to finish) clearly identify the vulnerable adult's desired goals or outcomes; define what they wanted to achieve as part of the safeguarding intervention, and detail why/how these were met?					
were we able to meet the vulnerable adult's desired outcome?					
Overall did the investigation identify the risks to the vulnerable adult, and detail the actions taken to protect them in a clear concise way?					

Were the Rationale/ reason for decision(s) clear, factual and concise?					
Is there evidence to show that the vulnerable adult was involved/ informed throughout their case?					
If there were any major risks or concerns identified, were these responded to appropriately?					
Looking at this case in hindsight. Should it have been raised for investigation at an earlier date? (ie should the alert have been raised sooner)					

Recommendations	Final Comments
Detail any good practice which could be shared to other practitioners	
Detail any recommendations to pass on to the practitioners. (ie what could have been done better.)	

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Adults Social Services Case File Audit Tool

Client ID:	
Person completing the Audit:	
Allocated Worker:	
Team:	
Date Audit Completed:	

Audit to be completed on all work carried out in the last 12 months.

SECTION 1 - Getting the basics right.

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Is the address on home page current and up to date?					
Are the demographic details for the person correct and up to date? (including gender, ethnicity, first language, and date of birth)					
The service user group field records the person's **Primary Support Reason**, (which is the main reason the person has approached the Council for care.) Is there **one current** primary support reason recorded and open?					
Are the details of the relevant carer/relative/person recorded in full, under the "relationships" field in the home page? Is their relationship description clearly identified?					
Has the case been clearly allocated or deallocated properly?					
Are you satisfied with the 'general upkeep' of the information on the 'home page'?					
Are all case notes concise, easy to read, easy to follow, and in chronological order?					

SECTION 2 - Assessments

SECTION 2 - Assessments

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Is there any evidence to suggest that the person was involved within their own assessment?					
Are the 'presenting issues' Under section 2 - "Presenting needs / diagnosis and medication" of the assessment recorded in sufficient detail, to enable someone who is unfamiliar with the case to pick it up easily?					
Have all risk factors been identified within the assessment in sufficient detail, so that someone who is unfamiliar with the case could pick it up easily?					
Was a reablement service offered to the person?					
If a Reablement service was not offered, should it have been?					
When deciding the outcomes, is there evidence that the practitioner used the person's existing support network to meet identified needs?					
Is there evidence that the practitioner was sensitive to the person's cultural needs or preferences?					
Were the person's needs captured and is the evidence to support them clear?					
If the person lacks capacity, has a Mental Capacity Act Assessment been done?					
If applicable, has the Health Condition been recorded correctly?					
If applicable, was an advocate offered or arranged for the person?					
Overall, is the Assessment clear, succinct and factually relevant?					
Does the Assessment clearly identify the person's desired goals or outcomes?					
Is the outcome recorded correct? (eg if the outcome recorded is "Early cessation of service due to life event - long term services needed" is this actually the case?					
Is it clear that the Care Act eligibility criteria was met?					

SECTION 2 - Carers

Case File Audit Questions	Fully	Partially	Not at all	N/A	Comments
Is there evidence that the practitioner tried to identify a main carer?					
If identified, is there evidence that the Carer was offered an assessment?					
If the Carer accepted is there evidence that a Carer Assessment was carried out?					
If the Carer declined the offer of an assessment are the reasons why recorded?					
Is there sufficient detail in the person's records to enable someone who is unfamiliar with the case to pick it up easily?					
If a carer has been identified have their details been recorded? (including gender, ethnicity, date of birth and contact details)					
Is the carer 'linked' correctly to the cared for person on Mosaic?					

SECTION 3 - Reviews

Case File Audit Questions				Answer	Comments
Has a review been completed within the last 12 months for this person? (if the person is new to the Council or did not require a review please select "n/a" for all remaining questions)					
Is the Review holistic i.e. does it take account of the person, their support network, their physical environment, their engagement with the community?					
Were Reablement services offered as part of the review?					
Did the review focus around delaying and reducing the need for long-term or complex care and support?					
Were the person’s needs captured and is the evidence to support them clear?					

If the person lacks capacity, has a Mental Capacity Act Assessment been done?					
Overall, is the Review clear, succinct and factually relevant?					
Does the Review clearly identify the person's desired goals or outcomes?					
Is the outcome recorded correct? (eg if the outcome recorded is "Change in setting - Move to nursing care," is this actually the case?					

SECTION 4 - Finance

Case File Audit Questions				Answer	Comments
Is there evidence that the person was advised that they would be financially assessed?					
Is there evidence that the option of a Direct Payment was discussed and offered?					
Has every effort been made to offer the most cost effective service, which also meets the person's needs fully?					

SECTION 5 - Safeguarding

Case File Audit Questions				Answer	Comments
Has a safeguarding referral already been raised for this person?					
If not, is there any evidence to suggest that a safeguarding referral should have been made, as a result of the person's assessment or review?					
If there were any major risks or concerns identified, were these responded to appropriately?					

Recommendations	Final Comments
Detail any good practice which could be shared to other practitioners	
Detail any recommendations to pass on to the practitioner. (ie what could have been done better.	

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Report for:	**Adult, Commissioning and Safeguarding Quality Board 16/06/15**	**Item Number:**	1.3

Title:	Adult Social Services Learning from Complaints: Quarter 4 (October - December 2014)

Lead Officer:	Helen Constantine, Head of Governance and Business Improvement Services

Report Author:	Rebecca Waggott, Business Improvement Officer, Governance and Business Improvement Services

1. Introduction

1.1 The Feedback & Information Governance Team record and monitor feedback received for all directorates across the Council. Learning reports about the feedback received by the Council are shared with each directorate on a quarterly basis. This enables directorates to monitor and learn from customer feedback to improve service delivery.

1.2 This report sets out details of the feedback received in relation to Adult Social Services in Quarter 4 (Q4) of 2014/15, comparing performance across 2014/15 and 2013/14 and highlighting the key issues arising. Details of the upheld complaints and compliments received in Q4 are included in Appendices 1 and 2.

1.3 The report recommends that details of the upheld complaints from Q4 are reviewed by the relevant service managers and discussed with staff teams, as appropriate, to identify learning points and areas for improvement.

1.4 The report also recommends that service managers remind their teams to submit all compliments received to Governance and Business Improvement Services to ensure all feedback for Adult Social Services is recorded and considered in this report.

2. Complaints

2.1 In Quarter 4 of 2014/15, 49 issues were raised in relation to Adult Social Services, of which 24 were Members' Enquiries (49%) and 25 were complaints (51%). The level of complaints is generally higher than previous quarters, although similar levels have been recorded previously. The number of Members' Enquiries has remained fairly consistent.

	2013/14				2014/15			
Case type	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Members' Enquiries	23	30	30	22	29	21	25	24
Adult social care complaints	9	17	11	19	0	17	7	18
Complaints (general)	4	3	3	8	7	7	3	7
Total	**36**	**50**	**44**	**49**	**36**	**45**	**35**	**49**

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2.2 The table below shows that the level of upheld complaints is slightly higher than previously recorded.

	2013/14				2014/15			
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Upheld	7	12	6	12	3	12	4	14
Partly upheld	1	-	-	-	-	-	-	-
Responded (Members' Enquiries)	23	29	30	22	29	21	25	24
Not upheld	2	7	6	12	2	10	2	5
Unable to reach a decision	2	2	0	0	1	2	1	3
Outcome not recorded	1	2	2	3	1	0	3	4
Withdrawn	0	0	0	0	0	0	0	1
Total	**36**	**52**	**44**	**49**	**36**	**45**	**35**	**51**

2.3 For the purpose of learning from complaints, our attention is focused on the 'upheld' and 'partly upheld' cases. The majority of upheld complaints in Q4 were for Service Assessment & Personalisation and Occupational Therapy.

	2013/14				2014/15			
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Service Assessment and Personalisation	5	6	5	8	0	7	1	6
Occupational Therapy	-	-	-	-	1	2	3	5
Learning Disabilities Partnership	1	4	0	2	1	2	0	2
Adult Commissioning	1	2	1	1	1	1	0	1
Safeguarding Services	1	0	0	0	0	0	0	0
Mental Health	0	0	0	1	0	0	0	1
Total	**8**	**12**	**6**	**12**	**3**	**12**	**4**	**15**

2.4 The table below shows upheld complaints by issue nature. In Q4, three complaints appear to be about inadequate communication and a further three relate to an incomplete service.

	2013/14				2014/15			
Issue nature	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Service of poor standard	5	3	1	7	2	3	3	1
Service delayed	2	1	0	0	0	0	0	2
Communication inadequate	1	2	2	3	1	1	0	3
No reply to emails/letters/call	0	3	0	2	0	1	0	1
Service incomplete	0	1	1	1	0	2	0	3
Decision was wrong	0	1	1	0	0	0	0	1
Employee behaviour	0	1	0	0	0	1	0	1
Difficulty accessing service	0	0	1	0	0	1	0	1
Service cost	0	0	0	0	0	1	0	1
Records inaccurate	0	0	0	0	0	2	0	0
Service request not actioned	0	0	0	0	0	1	1	0
Total	**8**	**12**	**6**	**13**	**3**	**13**	**4**	**14**

2.5 Details of the 14 upheld complaints from Q4 are included in Appendix 1. It is recommended that this information is reviewed by the relevant service managers and discussed with staff teams, as appropriate, to identify areas for learning and improvement.

3. Members' Enquiries

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3.1 The table below shows the breakdown of Members' Enquiries by service area. Adult Commissioning, Prevention and Provider Services, Service Assessment & Personalisation and Occupational Therapy received the largest number of enquiries in Q4.

	2013/14				2014/15			
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Service Assessment and Personalisation	9	14	12	8	6	8	7	4
Occupational Therapy	-	-	-	-	8	3	4	4
Adult Commissioning	6	13	12	8	7	5	6	9
Safeguarding Services	3	2	4	3	1	3	1	0
Prevention and Provider Services	3	0	2	1	7	2	6	6
Learning Disabilities Partnership	2	1	0	2	0	0	1	0
Business Management Services	0	0	0	0	0	0	0	1
Total	**23**	**30**	**30**	**22**	**29**	**21**	**25**	**24**

3.2 The table below shows that 12 Members' Enquiries (50%) in Q4 were requests for information or service enquiries. There was also a notable number of Members' Enquiries about inadequate communication, although it is not possible to determine whether the Members' Enquiries were 'upheld' as such.

	2013/14				2014/15			
Issue nature	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Member information request/service enquiry	19	15	8	9	8	5	9	12
Service of poor standard	1	3	6	2	2	2	0	1
Communication inadequate	0	5	6	7	9	8	4	8
Service incomplete	0	0	0	4	2	2	7	2
Decision was wrong	0	2	4	0	1	2	1	1
Difficulty assessing service	0	2	2	0	1	0	0	0
Policy or procedure not followed	0	2	0	0	0	0	0	0
Service delayed	0	1	1	0	2	1	1	0
Service removed	1	0	2	0	0	0	0	0
Service cost	1	0	0	0	0	1	0	0
No reply to emails/letters/call	1	0	0	0	2	0	0	0
Employee behaviour	0	0	1	0	0	0	1	0
Service request not actioned	0	0	0	0	2	0	0	0
Disagree with policy	0	0	0	0	0	0	2	0
Total	**23**	**30**	**30**	**22**	**29**	**21**	**25**	**24**

4. Compliments

4.1 In Q4, Adult Social Services received 2 compliments from service users or their representatives and 1 from other members of staff across the organisation. This represents a decrease from previous quarters, highlighting the importance of service managers ensuring that team managers are aware of the need to send all compliments to Governance and Business Improvement Services for recording. Details of the 3 compliments from Q4 are included in Appendix 2 for information. The table below shows the number of compliments by service area. In Q4, compliments were received for staff in the Mental Health Service and Assessment & Personalisation. A further compliment from staff was received for the Haven Day Centre.

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	2013/14				2014/15			
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Service Assessment and Personalisation	3	8	2	7	4	3	2	1
Provider Services	6	6	3	0	-	-	3	1
Learning Disabilities Partnership	0	1	1	0	1	0	0	0
Mental Health	0	0	0	0	0	0	0	1
Total	**9**	**15**	**6**	**7**	**5**	**3**	**5**	**3**

5. Recommendations

5.1 That the relevant service managers review the 14 complaints in Appendix 1 which were upheld in Q4. Service managers should discuss with staff teams, as appropriate, to identify areas for improvement. Feedback should be provided to Governance and Business Improvement Services by Friday 3 July 2015.

5.2 That service managers ensure complaints learning is a regular discussion item at team meetings to help improve services for residents.

5.3 That all service managers remind their team managers to send any compliments received to Governance and Business Improvement Services to ensure all compliments received by Adult Social Services are recorded and reviewed.

5.4 That the relevant service managers review the 3 compliments received in Q4 detailed in Appendix 2 and consider nominations for Haringey Stars Awards.

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Appendix 1: Quarter 4 Complaints Upheld or Partly Upheld

COMPLAINTS					
Service	**Issue Summary**	**Issue Nature**	**Outcome**	**Solution**	**Reference Number**
Occupational Therapy	Requested another OT assessment which has been refused, as has the provision of a shower.	Decision was wrong	Upheld	Re-Assessment/Review	LBH/3892715
Occupational Therapy	OT adaptations done- poor quality.	Service incomplete	Upheld	No Further Action Required	LBH/3905715
Occupational Therapy	Agreed adaptations have not commenced.	Service Delayed	Upheld	Apology	LBH/4148815
Occupational Therapy	Delays in the adaptation works in the property.	Service incomplete	Upheld	Provide Service	LBH/4165715
Mental Health / Occupational Therapy	Wants more help from Social Worker who has been offering advice not practical for her needs.	Service, difficulty accessing	Upheld	Provide Information Review Customer Information	LBH/3924615
Service Assessment Personalisation	Closure of nursing home and no physical assessment of Aunt.	Communication inadequate	Upheld	Apology	LBH/3901315
Service Assessment Personalisation	No response to request for financial assessment /assessment of needs. Lack of response to phone calls and telephone messages.	Service Delayed	Upheld	Apology Provide Service Review Customer Information	LBH/4006215
Service Assessment Personalisation	Not received medical reports, OT /community care assessment.	Service incomplete	Upheld	Apology Provide Service	LBH/4022715
Service Assessment Personalisation	Charge for care when he was advised that the first 6 weeks would be free.	Service Cost	Upheld	Refund	LBH/4086715
Service Assessment Personalisation	Employee was rude.	Employee Behaviour	Upheld	Apology Employee Training or Guidance	LBH/4124815
Service Assessment Personalisation	No response/decision on 3rd party top-up agreement.	Communication inadequate	Upheld	Refund Apology	LBH/4130215

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Service	Issue Summary	Issue Nature	Outcome	Solution	Reference Number
Joint Learning Disability Partnership	Service failure to answer enquiries relating to the care and maintenance of her relative.	Communication inadequate	Upheld	Apology Re-Assessment/Review	LBH/3945815
Joint Learning Disability Partnership	No response to correspondence.	No reply to emails/letters/call	Upheld	Apology Re-Assessment/Review	LBH/3947915
Adult Commissioning	Client's correspondence returned without postage by Performance Team.	Service of poor standard	Upheld	Review Customer Information Compensation Apology	LBH/3972515

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Appendix 2: Quarter 4 Compliments

Staff/Service	Extract from Comment
January 2015	
Eze Ihenacho, Mental Health Service	'He has acted in an efficient and highly professional manner and crucially, been very empathetic to me in an extremely complex and distressing long-term family situation'.
February 2015	
Dagnew Messele, Assessment and Personalisation	'... thank you very much for your support of [client] and the way you have supported us as a family - we really appreciate your kindness, and wish you well for the future too'.
March 2015	
Tanya Kenny-Parker and staff at the Haven Day Centre	*'I just want to express thanks and appreciation to Tanya and all of the staff at the Haven. I am currently working with a lady who has been neglecting herself for many years to the extent her hair was completely matted half way down her back. Her home is also in extreme state of neglect with limited facilities. She has been difficult to engage as she is very guarded but I approached Tanya to see if we could offer her a shower and cut her hair at the Haven. [The client] agreed to come with me yesterday, Tanya and I showered her and cut her hair- Vidal Sassoon would have been proud! The staff all made her very welcome and when I took her home she said she had a lovely day and was pleased to meet so many lovely people' (Elizabeth Blanche, Social Worker).*

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Agenda Item 19

Haringey Council

Report for:	**Cabinet - 16 June 2015**	**Item Number:**	

Title:	**Adult Services Market Position Statement**

Report Authorised by:	**Zina Etheridge Deputy Chief Executive** 

Lead Officer:	**Charlotte Pomery, Assistant Director of Commissioning**

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

1. Describe the issue under consideration

1.1. This report introduces the Market Position Statement for Adult Social Care, which is attached as Appendix 1.

1.2. The Market Position Statement, a national requirement reinforced in the implementation of the Care Act 2014 which puts market development on a statutory footing, supports the delivery of the objectives set out in Priority 2 of the Corporate Plan, Empower all adults to live healthy long and fulfilling lives, agreed by Cabinet in February 2015. It describes how we will work with providers to develop diverse, high quality care locally which meets local need and the Council's strategic priorities whilst delivering value for money.

2. Cabinet Member introduction

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2.1 Our ambitions for local residents are high and yet we know that our current system is not meeting the increasing demand we are seeing for adult social care. In order to make the changes in provision we need, focusing on prevention and early intervention, offering greater choice, control and independence and improving quality, we need to ensure that our providers – across sectors – deliver our objectives and improve outcomes for local residents.

2.2 This, Haringey's first Market Position Statement, which will be reviewed and refreshed as we continue to deliver the objectives set out in the Corporate Plan, sends key messages to existing and future providers about our plans, our values and the outcomes we want to see delivered for adults in Haringey.

3. Recommendations

3.1 Members are asked to approve the Council's Market Position Statement for Adult Social Care attached as Appendix 1 to this report.

4. Alternative options considered

4.1 The option of not producing a Market Position Statement was considered but discarded on the grounds that it usefully sets out for the market our commissioning intentions and is a core requirement of the Care Act 2014.

5. Background information

5.1 Section 5 of the Care Act 2014 sets out new duties for Councils with regard to shaping and managing their local care markets. There are new duties placed on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

5.2 Section 48 of the Care Act also places new duties on local authorities to meet an adult's care and support needs and a carer's support needs when a registered care provider becomes unable to carry on a regulated activity because of business failure.

5.3 The purpose, therefore, of Haringey's Market Position Statement is to describe how the Council will work with providers to ensure the development of a diverse, effective and high quality local adult care market which is geared more towards

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supporting people to manage their own care through personalisation, early intervention and prevention of needs escalating. The aim of this document is to support the local adult care market to plan which services it will need to develop, and how, in order meet the needs of the local population, including those most vulnerable. It sets out the direction of travel for adult social care enabling voluntary and community organisations and other providers to learn about future opportunities and to develop new activities and services. In addition, social care providers and organisations not currently operating in Haringey can use this position statement to find opportunities that use their expertise and skills to benefit local people.

5.4 The Market Position Statement highlights the roles of the Council, providers and other stakeholders in developing and sustaining high quality provision across the market. In light of the increasing role of the market in providing services, the Council will strengthen its quality assurance and contract monitoring role across provisions. In doing so, the Council will review the role of the Providers' Forum and ensure a principal focus on service improvement and quality standards as well as wider information sharing and market development issues. At the same time the proposed move to framework agreements for much of Haringey's adult social care provision will facilitate more targeted contract monitoring and quality assurance in the borough. Effective quality assurance is informed by good user and carer feedback and engagement and the Council is committed to collecting and responding to user and carer feedback in a more consistent way. The Council is reviewing its internal facing Quality Assurance Board, which, in light of the Care Act and the subsequent changes for the Safeguarding Adults Board, will develop a focus on quality assurance across partners. The Council will be working with other stakeholders, including Healthwatch, to ensure that their function responds to adult social care as well as health care issues.

5.5 In line with the Care and Support Statutory Guidance advice that the local authority should engage with providers and stakeholders in developing its Market Position Statement, the draft has been discussed with the Providers' Forum on a number of occasions and circulated for comment.

5.6 If approved, the Market Position Statement will be reformatted and widely circulated to providers and other stakeholders.

6. Comments of the Chief Finance Officer and financial implications

6.1 This report for Cabinet outlines the national requirements for the implementation of the Care Act 2014 which puts market development on a statutory footing, supports the delivery of the objectives set out in Priority 2 of the Corporate Plan and empowers all adults to live healthy, long and fulfilled lives as agreed by Cabinet in February 2015. As such there are no financial implications arising directly from this

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report. However, it is important to note the financial context in which the Market Position Statement will operate.

6.2 The 2015-16 net revenue budget for the Council is £276 million which includes budgets allocated to Adults Social Care of £83 million for Corporate Plan Priority Two - Empower all adults to live healthy, long and fulfilling lives. The Council's Medium Term Financial Strategy (MTFS) sets out actions to achieve overall Priority Two savings of at least £30 million by the end of the period to 2018.

6.3 In this challenging financial context the successful implementation of the Market Position Statement is a key component to supporting the financial position of the Borough in addition to the undoubted benefits that will accrue from the development of a diverse, effective and high quality local adult care market which is geared more towards supporting people to manage their own care through personalisation, early intervention and prevention of needs escalating.

7. Assistant Director of Corporate Governance Comments and legal implications

7.1 Section 5 of the Care Act 2014 places a duty on the Council to facilitate and promote a diverse and high quality market of care and support services (including prevention services) for all people in its area regardless of who arranges and pays for those services. In particular, the Council must act with a view to ensuring that there is a range of different services and providers to choose from.

7.2 There are certain factors the Council must consider when exercising this duty. These include the importance of ensuring the sustainability of the market and supporting continuous improvement in the quality of services; making available information about the services available to people in its area; facilitating the local market by maintaining awareness of the current and future demand for services in its area, and how this demand can be met by providers; the importance of carers and service users being able to undertake work, education and training; and the importance of fostering an effective workforce capable of delivering high quality services.

7.3 Section 48 of the Act places a temporary duty on the Council to ensure that adults' needs for care and support (or needs for support in the case of an adult who is a carer) continue to be met when there is a business failure of a provider of care and support in its area registered with the Care Quality Commission and the provider becomes unable to carry on the regulated care activity in question as a result.

7.4 The Care and Support Statutory Guidance 2014 advise that local authorities may discharge their market shaping and commissioning and provider failure duties by developing with providers and stakeholders a published Market Position Statement. The Guidance provides that:

4.82. A Market Position Statement should contain information on: the local authority's direction of travel and policy intent, key information and statistics on needs, demand

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and trends, (including for specialised services, personalisation, integration, housing, community services, information services and advocacy, and carers' services), information from consumer research and other sources about people's needs and wants, information to put the authority's needs in a national context, an indication of current and future authority resourcing and financial forecasts, a summary of supply and demand, the authority's ambitions for quality improvements and new types of services and innovations, and details or cross-references to the local authority's own commissioning intentions, strategies and practices.

There is a strong emphasis on engaging with providers and other stakeholders in developing a Market Position Statement.

8. Equalities and Community Cohesion Comments

8.1 This report sets out the Council's approach to ensuring that appropriate services are delivered to those people in the borough with care and support needs in ways which promote their independence, choice and control. This is in line with legislation to support greater personalisation and independence for disabled people in society and in line with the Care Act 2014.

9 Head of Procurement Comments

9.1 The Market Position Statement will bring about a better understanding of the needs of the community and the resources that exist to respond to these, as well as identifying where future demand may be met by introducing new resources and managing the market.

9.2 As the Market Position Statement is developed opportunities for providers will be raised through market engagement and publication on the council's web site where a procurement competition is possible. Alternatively, where a procurement competition is not needed, opportunities will be published on the the voluntary, community and social enterprise (VCSE) sector's website where a grant funding opportunity is possible.

9.3 The Market Position Statement will provide much needed focus on identifying where and applying for VCSE funding that will ease financial pressure on the Council to provide for Adult Social Care.

9.4 The aspect of stepping in when a provider as a business fails will require a more informed understanding of the way that businesses perform while delivering services and this will require an active risk management approach by Adult Social Services so that when a business fails the service continues to be provided with the minimum of disruption.

9.5 The contracts entered into between provider and Council will need to include terms and conditions that support step in and address the ambitions of the MPS, in

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particular how each party is to communicate and the responsibilities of each party on business failure of a provider.

9.6 The vision of alternative residential and nursing care provisions may mean re-negotiation of existing agreements with providers and will require a wider capacity from such providers to meet the Market Position Statement, (pp 33-34 refer).

9.7 The Market Position Statement will require a coordinated approach between procurement and Adult Social Care commissioners, with timelines of activities set out for meeting the Market Position Statement.

9 Policy Implication

10.1 There are no policy implications arising directly from this report.

11 Reasons for Decision

11.1 The Market Position Statement is a key statement of the direction of travel for adult social care within the local authority. It has been given added emphasis in the Care Act 2014 and is presented for the approval of Cabinet.

12. Use of Appendices

12.1 Market Position Statement attached as Appendix 1

13 Local Government (Access to Information) Act 1985

13.1

Appendix 1

Haringey Council

Market Position Statement

Adult Services

London Borough of Haringey

June 2015

Haringey Council

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1. Executive summary and key messages

Welcome to the London Borough of Haringey's first Adult Social Care Market Position Statement (MPS). The purpose of this document is to describe how the Council will work with providers to ensure the development of a diverse, effective and high quality local adult care market which is geared more towards supporting people to manage their own care through personalisation, early intervention and prevention of needs escalating. The aim of this document is to support the local adult care market to plan which services it will need to develop, and how, in order meet the needs of the local population, including those most vulnerable. It sets out the direction of travel for adult social care enabling voluntary and community organisations and other providers to learn about future opportunities and to develop new activities and services. In addition, social care providers and organisations not currently operating in Haringey can use this position statement to find opportunities that use their expertise and skills to benefit local people.

This document is based on information gained from a number of sources including the Joint Strategic Needs Assessment; the Corporate Plan Building a Stronger Haringey Together; the Medium Term Financial Strategy; the Workforce Strategy; market/customer surveys; consultation with a number of key stakeholders.

Importantly, feedback from users, carers and local residents has consistently focused on some key elements of service delivery, and we would wish to see these values reflected in the provision which we develop and commission:

- Respect and dignity
- Empowerment
- Inclusion
- Developing community resilience
- Reducing inequalities
- Ability to live healthy lives for longer
- Fulfilling lives with opportunity for growth

The pressure on local government finances since the Comprehensive Spending Review in 2010 has required Haringey, along with other Councils in the country, to reduce

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significantly its controllable budget – by £70 million between 2015/16, 2016/17 and 2017/18, on top of the £117 million reduction already made since 2010, representing approximately a quarter of the remaining budget. The challenge is to transform our offer, making better use of resources, targeting them more effectively and rethinking the way we meet needs, focusing much more on the outcomes we are trying to achieve, whilst delivering high quality and safe services. We are implementing a Commissioning Framework, aligned to a more commercial approach, which seeks to ensure that this transformation is based on evidence and best practice. We are also adopting a more strategic approach to the market, of which this position statement is an element, recognising that we need to work with providers at a number of levels in order to spend resources efficiently, derive the most impact and value from the services delivered for Haringey residents and maintain a focus on high quality.

This market position statement is produced at time when the council has published its Corporate Plan 'Building a Stronger Haringey Together', a three year budget (our 'Medium Term Financial Strategy) and a Workforce Strategy and is implementing the far-reaching Care Act 2014 which sets out particular requirements for market shaping and management. The market position statement is underpinned by the Council's five major priorities which set out the change we are looking for across service areas.

The Council sets out five strategic priorities in the Plan:

Priority 1: Enable every child and young person to have the best start in life, with high quality education

Priority 2: Empower all adults to live healthy, long and fulfilling lives

Priority 3: A clean, well maintained and safe borough where people are proud to live and work

Priority 4: Drive growth and employment from which everyone can benefit

Priority 5: Create homes and communities where people choose to live and are able to thrive

These strategic priorities will be delivered in line with six cross-cutting themes:

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1. Prevention and early intervention: *Providing support earlier to prevent problems from occurring or escalating*
2. A fair and equal borough: *Tackling the barriers facing the most disadvantaged and enabling them to reach their potential*
3. Working with our communities: *Building resilient communities where people are able to help themselves and support each other*
4. Value for money: *Achieving the best outcome from the investment made*
5. Customer focus: *Placing our customers at the heart of what we do*
6. Working in partnership: *Delivering with and through others*

The Corporate Plan signals a new approach for the Council where the focus is on achieving outcomes through our five strategic priorities and cross-cutting themes, rather than on delivering services through business units as previously. Whilst there is a focus on improving outcomes for adults with emerging or assessed needs across the Council and in other agencies, many services to adults will be delivered through the programme for Priority 2 and therefore through the following 5 objectives:

1. A borough where the healthier choice is the easier choice
2. Strong communities, where all residents are healthier and live independent, fulfilling lives.
3. Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing
4. Residents assessed as needing formal care and / or health support will receive responsive, high quality services
5. All vulnerable adults will be safeguarded from abuse

The focus on early intervention and prevention, building community capacity and enabling long term health and wellbeing links the Corporate Plan objectives with the requirements of the Care Act and the shift we are making in assessment, support planning and connecting to services. Increasing levels of integration – delivered through

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the Better Care Fund and the wider Health and Social Care Integration Programme – are fundamental to this agenda.

Specifically for adult social care services, our Commissioning Strategy identifies the following areas of activity:

1. Focus on prevention and early intervention through community based provision and support
2. Emphasis on reablement, enablement and recovery wherever possible so that where appropriate more people can retain and maintain their independence
3. Strong shift towards supported living and support in people's own homes
    a. Growth in the Shared Lives scheme to enable more people to live in family settings
    b. Expansion of extra care sheltered provision for all care groups
    c. Increase in supported living placements
    d. Less use of residential care
4. New model of day opportunities to move away from building based provision to accessing support and opportunities in the community
5. Changes to the way services are procured to establish a framework agreement for the provision of domiciliary, supported living and reablement in the borough
6. Greater integration with health services for all care groups leading to changes in screening, triage and assessment
7. Focus on high quality provision which safeguards service users and carers and enables outcomes to be achieved for all individuals

We are keen to deliver outcomes based commissioning in all areas of our activity. We want to work with service users to identify the outcomes which are important to them and then to co-produce solutions with them. We want to explore alternative models of delivery and to work with our residents, communities and other stakeholders to design and commission innovative services which deliver outcomes. We want to find ways of

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improving outcomes which move away from buildings based forms of care and towards maximising opportunities for all residents to participate in local life and to make the healthier choice the easier choice.

Haringey is committed to delivering social value through its commissioning activity and is implementing the Public Services (Social Value) Act 2012.. Sustainability indicators are built into our commissioning approach which measure to what extent social value is being delivered through specific contracts. Haringey defines social value, for the purposes of procurement, as a contractual benefit ancillary to end-user requirements that reduces carbon and/or waste, creates educational and employment opportunities for people in need, contributes to local regeneration/economic stability or saves money for the Council and the local tax payer.

We want to continue to engage with providers from all sectors to ensure that their expertise and perspective is incorporated into our commissioning processes and informs service design and implementation. By focusing on the achievement of outcomes, rather than on tightly defined inputs, we hope that we will foster innovation and genuinely improve the quality of life for all residents, focusing on those with emerging or established needs for care and support.

Future funding will be delivered through a commissioning and funding framework using a commissioning approach with clearly specified outcomes, and with the council seeking best and added value for money and high quality services for residents. This includes developing and enabling charities, social enterprises, mutuals, private and public sector companies and employee-owned co-operatives to compete to offer high quality services; and enablement of people from all walks of life to play a more active part in society. As part of the delivery of the Corporate Plan 2015-18, social enterprise models will be explored in the provision of services currently in-house delivered such as day opportunities, Shared Lives and Reablement.

We are mindful too that the market is vulnerable to wider economic forces and business breakdown, and in this position statement we set out both our preventative and our reactive approach to market failure within the context of Care Act requirements. We see this approach as building effective lines of communication with providers to enable early alerts to difficulties and to offer support and expertise to maintain quality and safe services for local residents.

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We are increasingly working in partnership with the Clinical Commissioning Group (CCG) and aligning our approaches through the Health and Care Integration Programme. This will result in a number of areas where we will jointly commission provision – seeking shared outcomes for local residents. There are other key partners too for adult social care, notably housing commissioners and providers, both within the Council and in partner agencies such as Registered Providers and care and support agencies. As we develop our focus on prevention and early intervention, we will continue to develop our partnerships with agencies such as JobCentre Plus, Further Education Colleges and Adult Learning.

We believe there are opportunities for us to work too at a regional and sub-regional level with both local government and health partners and we will seek to explore these opportunities as they arise, and within our commissioning strategies.

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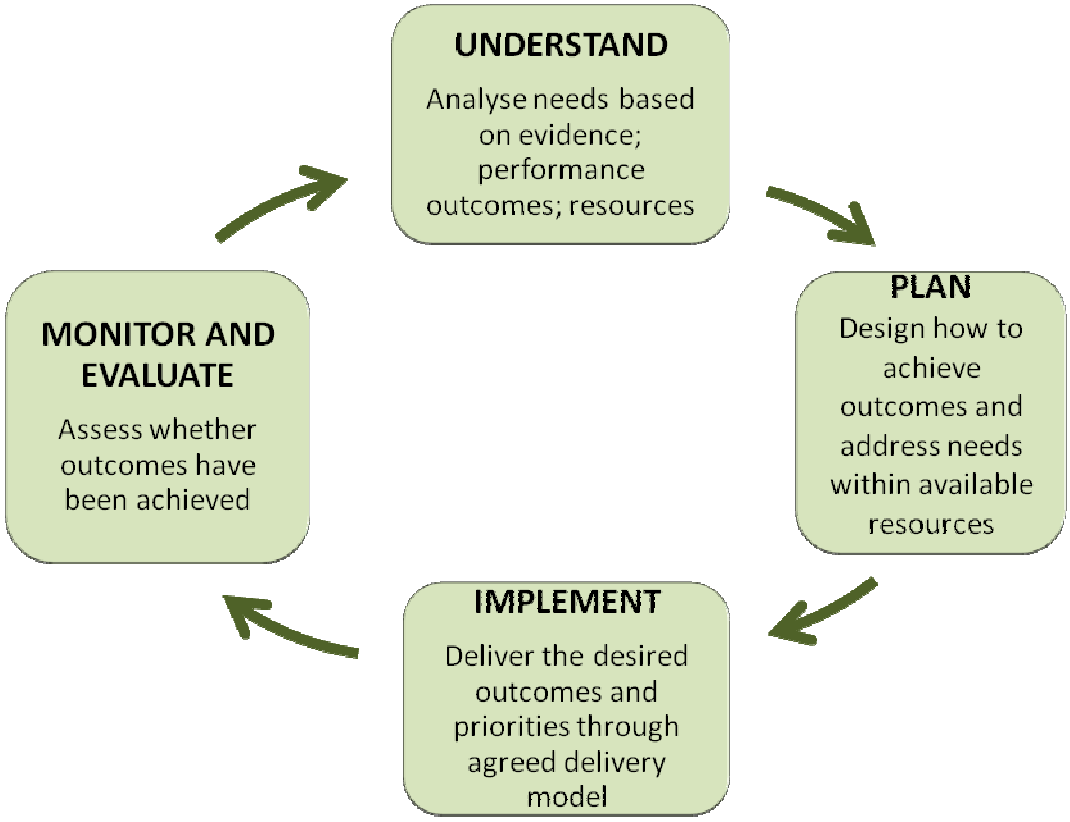
2. Commissioning approach

We are embedding our commissioning framework (please see appendix for more detail) into all our work across adult social care and in line with the Care Act. This includes adopting a more strategic approach to the market, building a focus on commerciality and value for money, to guide how decisions are taken on delivering outcomes for local residents.



Our approach as a local authority is to focus on our role as a commissioner and enabler, delivering value for money, accountability and empowerment. We want to take approaches which are:

1. Needs and evidence based
2. Outcomes focused – not targeted on detailed inputs
3. Customer and community centred
4. Ambitious for the outcomes our local residents can achieve
5. Value for money and attuned to the market

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We fully recognise the diversity and vibrancy of our local communities and seek to address inequalities in access, quality, outcomes and opportunity. We will work at service, community, infrastructure and population levels to enable individual, family and community resilience so that people, families and communities are empowered to meet their own needs. We know we need to facilitate prevention and early intervention and move resources to invest in these approaches. There are times when we will need to de-commission high cost, poor performing or low impact provision as well as building on the assets and strengths of local communities.

We want to engage meaningfully with individuals, families and communities to co-design and co-produce the solutions they need, listening to feedback on current provision. We know we need to continue to refine the need and evidence base before procuring services

We are particularly keen to bring innovation and investment into the borough whilst assessing and managing the market for services, embracing innovation. We want to work with the full range of providers in the borough in designing and commissioning services, to gain their insights and expertise as we deliver the Corporate Plan and our key objectives.

Our role under the Care Act to shape and stimulate the market for care so that it meets the needs of local residents, now and into the future, means that we will:

1. Continuously map and analyse our local markets, in the context of the wider provider landscape
2. Work closely with existing providers, help new ones to move into the market and work in partnership with people who use services and people who provide services to create as wide a range of support choices as possible
3. Develop a thriving, strong and diverse care market that is flexible and responsive to everyone in Haringey, not just those eligible for direct council support
4. Offer services that are fair, of good quality, offer value for money, change according to people's needs/wishes and promote well being, independence and dignity
5. Maintain a focus on personalised services whilst developing a presence in the market through procurement and contracting at a macro level

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6. Commission services which place an emphasis on prevention and early intervention to help people remain independent, to reduce the demand on acute services and have greater control of the services they receive

Information about all the Council's current contracts and end dates is available for all on the Contract Register on Haringey's website. The Register allows organisations to plan for future tender opportunities.

Improving the quality of care and safeguarding in the borough

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 will 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.

Despite the financial pressures on the Council, we will seek to 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. In this feedback to date, users and their carers have consistently told us that the following are important to them and these values guide our approach to quality:

- Respect and dignity
- Empowerment
- Inclusion
- Developing community resilience
- Reducing inequalities
- Ability to live healthy lives for longer
- Fulfilling lives with opportunity for growth

Our Quality Assurance (QA) and Safeguarding function covers all care services in the borough including residential care, supported living, services in the community, day services

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and personal budgets. 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. Our proposed move to framework agreements for much of Haringey's adult social care provision will facilitate more effective contract monitoring and quality assurance in the borough.

We believe everyone has a contribution to make to ensure a good and safe service including:

1. Service users
2. Family and carers
3. Care managers and social workers
4. Nurses and health workers
5. Commissioners and contract officers
6. Providers
7. Care workers
8. Advocates
9. CQC inspectors and
10. The public

Effective quality assurance is informed by good feedback and engagement, notably from users and carers, but also from wider stakeholders including the Care Quality Commission, providers and staff, Healthwatch and other agencies. We are committed to collecting and responding to this feedback in a consistent way which enables early identification of issues and an effective response. Our internal facing Quality Assurance Board, which, in light of the Care Act and the subsequent changes for the Safeguarding Adults Board, will develop a focus on quality assurance across all partners, will be reviewed.

A key aspect of our service is safeguarding. We take a risk management approach to safeguarding. We regularly review the information available regarding providers and update this from a range of sources, such as Care Quality Commission (CQC) reports, care management reviews, commissioning monitoring, review of incidents and safeguarding alerts. Where there are systemic concerns we have developed an 'Establishment Concern Procedure' to manage improvement plans and to ensure the safety of individuals affected.

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We also offer a range of support for providers to improve the quality of their service and we will continue to make available support and advice to providers operating for Haringey residents. We will review the role of the Providers' Forum and ensure a principal focus on service improvement and quality standards as well as wider information sharing and market development issues. We will offer providers a review of their Quality Assurance and Safeguarding Policy and Practice as well as support for embedding safeguarding practice and workforce development. We will continue to offer information, advice and guidance through the regular Providers' Forum and through training and development offered by the Council.

The Council will continue to maintain a good understanding of all regulated care provision operating in the borough and work with providers and have processes in place to ensure that there are good lines of communication between all providers and the Council. The Council will work with other local authorities to inform its work on risk assessment, risk management and the offer of support to providers and to build intelligence about the providers operating within the borough.

In addition, the Council will encourage active identification and early notification of any risks to business continuity by providers in order to carry out its duties under the Care Act and as part of annual Business Continuity Planning, the Council will identify and assess potential risks in Haringey with each of the local regulated care and other providers. The Council will keep a risk log of all providers in Haringey and regularly update the log. This would include financial risk management and organisational capacity as well as other service and care related risks. The Council will focus its activity on those providers where there is assessed to be greater risk of business failure to ensure a targeted approach and efficient use of resources.

Section 48 of the Care Act 2014 place a new temporary duty on local authorities to meet an adult's care and support needs and a carer's support needs when a registered care provider becomes unable to carry on a regulated activity because of business failure. Our Managing Provider Failure policy document explains what this duty means and Haringey Council's approach to ensuring that adults and carers are not left without the care or support they need if their care provider becomes unable to carry on providing because of business failure.

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Whilst the policy largely focuses on the Council's approach when there is business failure, Haringey's priority is to work with all registered care providers in the borough, to avoid the risk of business failure and to minimise the disruption and impact for service users of any such failure. We will proactively support providers and build relationships to ensure that the risk of business failure is identified and well understood and that steps are being taken in a planned way to mitigate this risk.

Delivering Social Value

Our approach to sustainable procurement is embedded in our commissioning framework and will be refreshed as part of a revised set of commissioning and procurement procedures. Haringey defines social value, for the purposes of procurement, as a contractual benefit ancillary to end-user requirements that reduces carbon and/or waste, creates educational and employment opportunities for people in need, contributes to local regeneration/economic stability or saves money for the Council (and hence the local tax payer).

Whilst the Public Services (Social Value) Act 2012 came into force earlier this year, Haringey Council has been operating a sustainable procurement programme since 2005 and we currently use a version of the prioritisation methodology that we have customised to suit Haringey. In essence, we have rationalised the 18 sustainability indicators which we could address through the procurement process and which could largely be defined as the components of Social Value.

We work with providers proactively to identify the impact of service delivery – and are particularly keen to ensure that some of our wider objectives, for example reduction in local unemployment, are met through our social care providers. The Corporate Plan identifies building stronger communities as well as individual and community capacity as core elements of the future service delivery and we recognise that building community and social capital is a central plank in the model of care and we actively promote:

- Mutual support and self-help
- Connections between individuals and resources
- Inclusion in community activities
- Community ownership and involvement in planning and reshaping services

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Prevention, Early Help and Intervention

Haringey's Prevention and Early Intervention approach is an important part of how we will achieve the vision and outcomes set out in the Council's Corporate Plan 2015-2018. By intervening earlier, before needs escalate, we believe we can have a more positive impact on outcomes across the activities of the Council.

Much of the focus for this Market Position Statement focuses on actions which will support the following two strategic priorities:

> *Enable every child and young person to have the best start in life, with high quality education*
>
> *Empower all adults to live healthy, long and fulfilling lives*

Early Help in Haringey is an emerging approach to practice, information giving, advice and intervention that is intended to enable children, families and adults to remain safely in their communities, improve their outcomes, reduce the need for more specialist support and sustain family and community cohesion by:

1. preventing needs arising;
2. intervening early to tackle emerging problems or;
3. targeting support on children, families and adults most at risk of becoming vulnerable.

This approach covers the age range from conception through to adulthood.

The Early Help Strategy already in place for children, young people and families will seek to deliver the following three outcomes:

1. Improve family and community resilience by increasing self-reliance, confidence and independence
2. Thriving children, young people, families and children - young people and families in the borough are healthy, learning and reaching their potential

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3. Strong partnerships making effective use of all resources - service delivery optimises community and partner resources and builds on the positive qualities and assets of organisations and people.

A parallel strategy will be developed to effect the transformation and focus needed across all services in the borough. Prevention and early help and intervention represent the sort of services that support people before they become ill or in the early stages of illness. They include provision such as the Haringey Neighbourhood Connects service delivered through local voluntary and community sector organisations that promotes increased participation of people in their neighbourhood communities, and NHS health checks and cancer screening programme and support people to manage their long term conditions (LTCs) themselves.

Prevention and early help and intervention objectives are concentrated on encouraging the development of a range of services that maximise community and voluntary sector involvement in preventing and/or delaying the need for social care support and sign-posting people appropriately in order to promote independence and resilience.

Future of Commissioning and Integrated work

As noted above, we are working in partnership with Haringey Clinical Commissioning Group, the CCG, led by GPs, which is made up of all 52 GP Practices in Haringey and is the responsible body for making sure the people of Haringey can access safe, well co-ordinated, high quality health services. Our Health and Care Integration Programme is becoming well established, with governance through the Health and Care Integration Steering Board reporting into the Health and Wellbeing Board. The scope of the programme is as follows:

1. The implementation of the shared vision of integrated care:

"*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.*"

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2. The identification of those services which are currently commissioned that will fall under the auspices of the integration projects associated with the Integration Programme.
3. The assurance of engagement and consultation with all key stakeholders in the local health and social care economy (e.g. NHS bodies, the local authorities, clinicians, social care professionals, service users / patients, and their informal carers) to access their opinions and ideas about the future shape of integrated health and social care in Haringey.
4. The development of a shared model of integration i.e. a description of what Haringey's integrated service offer will look like and why.
5. The development of a commercial framework that will drive the desired behaviours as well as the right outcomes.
6. The development and agreement of an approach for ongoing monitoring and reporting throughout the Integration Programme.
7. The development of protocols processes and procedures supporting integration, the replication of excellence, and the sharing of any lessons and experiences.
8. The construction of commissioning and implementation plans to support the delivery of Haringey's Integration Programme.

This means that where possible we will commission in a joined up way across the whole Council and the CCG and will develop alignment of budgets and approaches as the Programme develops.

The voluntary and not for profit sector

Haringey is fortunate in having a robust local not for profit and voluntary sector in the borough that provides services across a wide range of client groups. In 2013/14 Haringey Council spent £11.9 million across 117 individual organisations and 3 consortiums buying services from and supporting the work of the voluntary and not for profit sector.

Through our community investment and the development of infrastructure in the third sector, we aim to facilitate more individual choice, enterprise and less dependency on traditional services. We are taking forward an approach that is based on:

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1. Encouraging greater well being, self reliance, autonomy and personal responsibility
2. Co-production: building on existing community assets and unlocking social capital
3. Seeking innovation and supporting community led models that are alternatives to traditional social care options
4. Plurality in the market: exploring new models including partnership, micro-businesses, user led organisations, mutuals, charities and social enterprises
5. Considering overall value, including economic, environmental and social value
6. Localism and devolution – handing more power and responsibility back to communities
7. To enable people to run their affairs locally

As with all providers, Haringey Council welcomes dialogue with voluntary and not for profit sector providers who are developing and implementing innovative ways to ensure diversity and collaborative work with a view to supporting the Council in meeting its objectives. We are aware that the Corporate Plan signals a number of initiatives which will deliver opportunities for the voluntary and not for profit sectors.

We would foresee a role, for example, for the voluntary sector in the identification and development of social enterprises and social investors. We will, wherever possible, and within the contracting and tendering regulation framework, support smaller organisations and those operating in the voluntary and not for profit sectors to develop their capacity, skills and infrastructure in a way that will allow them to compete in the market. The Council also supports the development of consortia of providers – across sectors to build best practice and expertise – wherever possible.

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3. Haringey – a borough profile

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

The fastest growing population in Haringey is in age groups 30-34 and 45-49. Those aged 20 – 64 make up 66.3% of the total population whilst the number of people aged 65-69 and over 85 has decreased in the last 10 years. In relation to the population of London the proportion of people aged 25-39 in Haringey is significantly higher (31.1% vs. 28.1%) and the proportion of residents aged 65 and over is much lower, 8.8% to 11.1%.

Our population is growing and is projected to reach 286,700 by 2021. Population growth locally is mostly due to the increased birth rates, net gain from international migration and regeneration leading to increased number of housing units in the borough.

Below are some key facts in relation to services:

1. People with learning disabilities have lower levels of education and employment and supported housing
2. 1 in 13 residents are unpaid carers, 58% females; over 4000 provide up to 50 hours of unpaid care work a week. We know that our carers are on average younger than those across London.
3. Depression is under-detected in primary care but over-represented in acute settings
4. Haringey data identifies three times higher than expected levels of severe mental illness, disproportionately based in east of the borough
5. Low number of people with mental illness in employment
6. Number of people with dementia and long-term conditions is increasing (due to people living longer)
7. Men who live in the most deprived areas die, on average, 7.7 years younger than those living in the more affluent areas of the borough

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The Council is operating in an environment of unprecedented change as the levels of funding from central government reduces the Care Act is implemented and there is increasing demand for services.

Haringey Council is committed to supporting people to live away from residential care and remain in the community with support for as long as possible or to delay the needs for dependence on adult social care services. The overall direction for the future is less reliance on residential care and more emphasis on supporting residents to continue to live in their own home.

More detailed demographic data can be found on Haringey Council's web site: http://www.haringey.gov.uk/jsna

Personalisation

From 1st April 2015, everyone must have a personal budget – and the Care Act expectation is that direct payments will be the default way of delivering this. Already, people who have community care needs are encouraged to use direct payments to buy their own services with help from support staff. As more people take up this arrangement, providers of services will increasingly be selling directly to individuals rather than to the council and this is a major change in the way providers and commissioners do business. As a result of the above, the council is using a number of measures, including this document, to communicate and facilitate a dialogue with current and future providers to help the current market remain stable and to encourage the development of new, innovative ways of delivering support, stimulating new businesses and organisations.

There are now a total of 2, 053 people receiving either a Personal Budget or Direct Payment as at 31st March 2015.

There are now a total of 755 people with caring responsibilities in receipt of either a Personal Budget or Direct Payment between 1st April 2014 and 31st March 2015.

The number of people receiving long term support within the community stands at 2,355 as at 31st March 2015. This means that 87.10% of people receiving long term support also received either a Personal Budget or Direct Payment.

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The number of carers receiving a service stands at 719 between 1st April and 31st December 2014. This means that 83.73% of carers who receive a service also receive a direct payment or personal budget.

The Personal Budget Support and Service Finding Team help individuals to purchase services using their personal budget. Service users may choose to take this as a direct payment and purchase their own services themselves (with or without advice from the team). Alternatively, they may ask for advice about the choice of services available to them and request for these to be purchased on their behalf.

Self-funders

Self-funding operates at a wide variety of levels, from people who use family, friends, neighbours and local contacts to deliver low level domestic support such as assistance with household tasks such as shopping and gardening through to those who purchase residential care with nursing or buy live-in staff.

With the advent of the Care Act, the relationship between self-funders and the Council is changing and the Council's specific responsibilities to all those in potential needs of care and support, regardless of their means, are clearly set out in the detailed statutory guidance.

There is a steady increase in the numbers of people who are funding their own care and support due to:

- An increase in the local population
- Increased value of assets
- Increased charging
- Less state funding of community organisations
- Less emphasis on having families close by
- More people receiving direct payments
- People who are eligible topping up their provision from their own means

Haringey's own figures indicate 124 older people are self funders in a residential home and 100 older people are self-funders in a nursing home, a total of **224** older people. Applying the ELSA rates indicate that there are **440** older people paying for care in their own home.

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The average maximum weekly rate in 2014/15 paid by London councils (combining residential and nursing care) is £626.51.

Our data indicates that on average it will take 3.36 years for a self-funder to reach the £72,000 cap on care costs in Haringey. Given that the average length of stay for older people who self-fund in a care home is estimated to be between 1.66 and 1.73 years, there are unlikely to be a substantial number of self-funders who will reach the cap.

4. Information by care group

Older People

We will continue to focus on investing in early intervention and prevention to reduce people's need for longer term care. We recognise the economic and social value of supporting the growth of local and community initiatives that focus on care and support to increase independence and reduce isolation. Older People are defined as people who are 65+ years. Haringey's 65+ population is expected to increase to 26,923 by 2021[1]. The table below shows the population of older people living in Haringey with projections to 2025.

	2015	2020	% increase	2025	% increase
65-69	8,200	8,500	4%	10,100	23%
70-74	5,900	7,300	24%	7,700	31%
75-79	5,000	5,100	2%	6,400	28%
80-84	3,300	3,900	18%	4,000	21%
85-89	1,800	2,200	22%	2,700	50%
90-94	700	900	29%	1,300	86%
Total Population 65 and over	**24,900**	**28,000**	**12%**	**32,100**	**29%**

GLA data (Pop age 65 and over)

[1] Figure 1: 2011 ONS projections for Haringey, 65 and over

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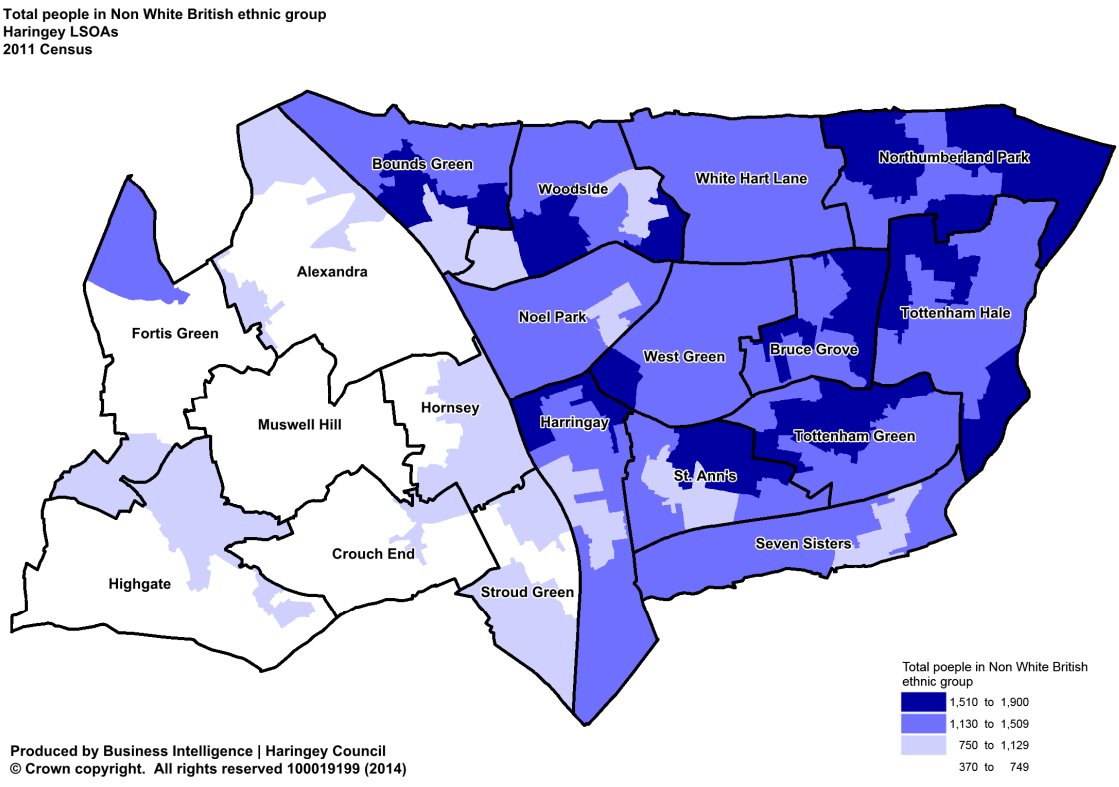
The 2001 Census showed that 58% of people aged over 50 in Haringey were owner-occupiers. This numbe be reducing and more 85 year olds live in private rented or LA accommodation.

- In Haringey 39% of adults aged over 55 reported a limiting long-term illness but is predicted to increase to 5,521 over the same period.[2]
- In 2013, it was estimated that there were about 1570 people living with dementia in Haringey.

More detailed demographic can be found here.

Black and Minority Ethnic Communities (BAME) in Haringey

Percentage of residents who are 65+ and non-White British in Haringey Wards



[2] Older People Needs Analysis 2010

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The majority of people over 65 from BAME communities live in the east of the borough (see Fig 2). 'Information is required to give an indication to providers of how services provided may need to be ethnically specific[3]

Registered care homes by provider and client group

Client type	Res./ with nursing	Number of homes	Number of places	Number of homes LA run	Number of LA places
Old age registered for dementia care	Residential	7	194	0	0
	With nursing	2	144	1	32
Old age only	Residential	12	133	0	0
	With nursing	2	144	1	32
Total					

Haringey ASC Commissioning Quality Team

Domiciliary Care – Older People and Adults with Physical Disabilities

The council provided the following amount of home care hours during 2013/14 – **15,400**

The private sector provided the following amount of home care hours during 2013/14 – **711,854**

Source: PSS EX1

Adults with Learning Disabilities

In Valuing People (2001) 'learning disability' is defined as a:

[3] Figure 2: Breakdown of residents who are 65+ and non-White British (includes categories beyond normal BME classification, for example, Polish, Turkish, Greek, Hispanic, Irish, etc) *from OP needs Ax 2010*

Haringey Council

- significantly reduced ability to understand new or complex information, to learn new skills
- reduced ability to cope independently which starts before adulthood with lasting effects on development.

(Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001).

Predicted population of people aged 18-64 with a Learning Disability

	2015 current figure	2020 population % increase	2025 population % increase	2030 population % increase
People with a moderate LD	763	819	858	887
People with a severe LD	282	300	313	323

Source: POPPI estimates

Approximately 1,045 people with a moderate and severe Learning Disability live in Haringey, that figure is projected to rise by 74, to 1,119 by the year 2020.

However, the future demand for adult services is mixed for two reasons:

Firstly the numbers of younger people (18 -24) with a Learning Disability needing support from adult services are going to decrease slightly between 2015 and 2020

Secondly, the numbers of adults with a Learning Disability who are living beyond 45 years of age is increasing.

What is certain is that as people with Learning Disabilities life expectancy rises, their physical and mental health support needs also increases. This change in the profile of needs impacts directly on the type of support that the Council needs to commission in the future.

Since the Winterbourne View Review, there has been a significant reduction in the number of people with challenging behaviour in hospitals or in large scale residential care -

Haringey Council

particularly those away from their home area. This remains work in progress locally.

The move to more personalised and independent services is influencing commissioning intentions. In Haringey there is an oversupply of residential care for the current resident population. Many residential services are operating with long term voids.
Registered Care Homes by type of Residential/Nursing care – Learning Disability

Client type	Residential /With nursing	No of homes	Spaces	No of LA homes run	No of LA spaces
Learning Disability	Residential	30	165	1	6
	With nursing	0	0	0	0

Adults with Mental Health

We want all residents to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

Significant change is underway in health and social care services. As mentioned earlier, the current financial climate is creating a challenge to all those involved in commissioning, providing and using services. Haringey has an aging population and younger people are surviving into adulthood with complex conditions. Haringey Council and Clinical Commissioning Group are placing significant emphasis and investment in prevention and early intervention as a way of helping people to live as independently as possible where they can manage as much of their care and support as they are able to

The chart below shows the range of services for people with mental health needs in Haringey.

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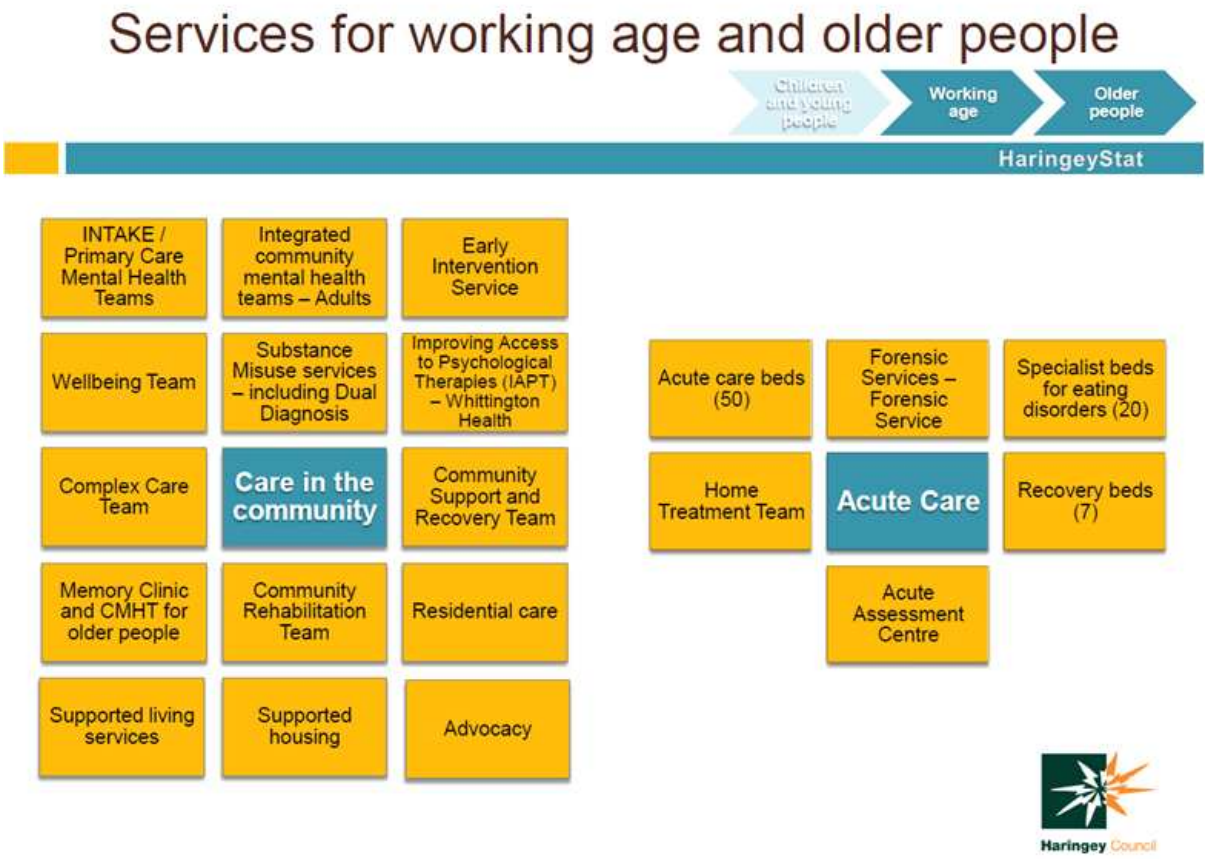

Access to services available across the Council and NHS

The pattern of demand in terms of admissions for psychosis and diagnosis of psychosis shows a considerable bias in terms of prevalence to the East of the Borough and higher rates of admission compared to London and National norms.

These diagnoses account for 80% of the admissions to BEHMHT in Haringey (Sept 2014 cluster report BEHMHT).

From the Barnet, Enfield and Haringey Mental Health Services FINANCIAL REVIEW – Final report from March 2014, BEHMHT has bed numbers per adjusted population just below the Median level nationally.

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People 18-65 with mental health needs. Rate per 10,000 pop

	Nursing and residential care	Supported and other accommodation	Supporting people
Haringey	195	105	105

People 18-65 with mental health needs. Rate per 10,000 pop

Comparative activity for Haringey - Adults under 65 with Mental Health Needs (From PSSEX1 return 2013/14) (Camden included for illustrative purposes)

Council	Cost	Per 10,000 Pop.
Barnet	2733	95
Enfield	1376	55
Camden	2613	140
Haringey	4030	195
London	N/A	110

Table 1. Res and Nursing home care

Council	Cost	Per 10,000 Pop.
Barnet	0	0
Enfield	725	30
Camden	1790	95
Haringey	2159	105
London	34116	50

Table 2 Supported and other Accommodation

The spend on Supporting people services reported in the PSSEX1 in 2013/14 shows 17 Authorities reporting a 0 return for Supporting People spend and activity. This is thought to be a reflection on the relevant sections of the return not being compulsory and Councils opting not to include them.

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Of the smaller group of comparators, Haringey spends more per head of population on Residential Care and on supported living services than others. To achieve London normative levels would mean an overall reduction in spend on the pathway of some 50%. To achieve comparable spend with Camden, often cited as an exemplar, a reduction in spend on residential and nursing care of 25% as well as a reduction in spend on supported living services of 10% would need to be made.

Given that the direction of travel as set out in commissioning priorities for the Council is to reduce reliance on Residential and Nursing care, the supply in Haringey is adequate if people are able to move into appropriate other support. There are 40 independent residential care homes in Haringey, the majority of which are in the east of the borough, for people with mental health issues (including forensic). In 2011, there were 225 beds across Haringey of which 100 placements are used by Haringey Council (Source: Haringey Adult Social Care).

What does Haringey need in the way of mental health support services?

The following services are currently in the process of being retendered.

Accommodation Type	*Commissioner*	*Current Provision*	*Required Provision*	*Gap*	*Comments*
Crisis Recovery House	BEHMHT	7	7	0	Needs to be moved to deliver the original intention if CCG agree to the model
Supported Living floating support	LBH HRS	92	117	25*	Should this be commissioned separately from ASC?

*includes services imminently on stream.

Supported living is an important step in the recovery pathway, providing a bridge between inpatient or temporary residential care and independent living. Supported living typically provides the service user with their own flat or shared housing within a warden controlled scheme with some schemes operate a 24 hour service, others a service that is 9-5 during the day, and others offer floating support to the scheme (or flat in the private sector rental market).

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Adults with Substance Misuse Concerns

Haringey intends to maintain a high standard of substance misuse prevention and treatment services available, ensuring they adapt to changes in our populations drug and alcohol use.

Predicted population of people with a substance misuse problem

	2015 current figure	2020 population % increase	2025 population % increase	2030 population % increase
People with a Substance misuse				

We recognise that residential services are critical for very complex substance misuse problems but we anticipate that demand will fall as more residents opt for community based services. The focus will be on supporting people into and through treatment into sustained recovery.

The majority of people who seek drug treatment in Haringey are using drugs such as crack cocaine or heroin. The prevalence data and estimate could be found here.

The overall demand for drug treatment remains fairly static. There has been a decrease in the number of heroin/crack users seeking treatment following a decrease in both local and national prevalence estimates. However, there has been an increase in the number of people coming to treatment with problems with legal highs/club drugs.

The current drug treatment system in Haringey has recently been improved by integrating services following a re-tender of provision. Three new contracts commenced in January 2014 for a period of 3-5 years for a recovery service, alcohol service and drug service.

Carers

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According to the 2011 census there are 18,887 people in Haringey who identify themselves as unpaid carers. This represents 7.4 % (1 in 13) of the usual resident population of the borough. 4,171 Haringey carers (22% of carers) provide care for 50 or more hours a week. 11,812 Haringey carers (63% of carers) provide care for 1-19 hours a week.

The Care Act definition of carers is

The changed status of carers within the Care Act, where there is a focus on their outcomes which is equivalent to that for the users for whom they provide care, is being reflected in the approach both to assessment and care management and to provision of services which achieve the outcomes they themselves identify as important.

Currently services for carers are primarily commissioned from voluntary sector providers and offer a range of support, information, advice advocacy services alongside some respite and peer support activities with some targeted at specific ethnic communities and illness specific conditions.

As we move to more preventative approaches, carers and the work they do becomes ever more crucial. Based on the principle where the overall wellbeing of the individual is at the forefront of their care and support, it will increase the rights of carers to access support and care.

Early in 2015, Haringey will be working with carers to commission a service to deliver improved outcomes for carers in the borough and will work with carers to improve their capacity for independent living through the provision of a range of person centred, co-ordinated and outcome focused services. This will include carers being able to say:

- I can care effectively and safely;
- I can look after my own health and wellbeing;
- I have realised and fulfilled my own potential and aspirations (including employment and training opportunities); and
- I can enjoy a life of my own alongside my caring responsibilities, including access to respite.

The service provider will be expected to have their own delivery model to achieve these outcomes. Innovative approaches are welcome.

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5. Commissioning Intentions

In line with the Care Act and with the Corporate Plan, the Council will be seeking to commission outcome-focused services for the local population which will improve people's quality of life and enable them to be as independent as possible, with appropriate levels of support and enablement.

Specifically for adult social care services, our Commissioning Strategy identifies the following areas of activity:

- Focus on prevention and early intervention through community based provision and support
- Emphasis on reablement, enablement and recovery wherever possible so that where appropriate more people can retain and maintain their independence
- Strong shift to supported living and support in people's own homes
    - Growth in the Shared Lives scheme to enable more people to live in family settings
    - Expansion of extra care sheltered provision for all care groups
    - Increase in supported living placements
    - Less use of residential care
- New model of day opportunities to move away from building based provision to accessing support and opportunities in the community
- Changes to the way services are procured to establish a framework agreement for the provision of domiciliary and reablement services in the borough
- Greater integration with health services for all care groups

For our commissioning intentions therefore

Haringey Council

1. Focus on prevention and early intervention through community based provision and support

The local authority will be tendering for:

a. providers of information, advice and guidance services which will build capacity and offer direct information, advice and guidance across a range of issues for all residents

b. provision of better financial advice and support for self-funders in order that they may capitalise on their investments and assets and ensure they are not over-charged or invest in high cost care packages unnecessarily

c. a service to improve outcomes for carers including provision of respite, to ensure that carers are able to enjoy a life beyond their caring responsibilities

d. preventative services for people with substance misuse needs

2. Emphasis on reablement, enablement and recovery wherever possible so that where appropriate more people can retain and maintain their independence

The local authority will be tendering for:

a. alternatives to residential and nursing care which promote reablement, enablement and independence for those able to benefit from such provision, will support all those with emerging or established needs in the borough

b. a reablement service through the independent sector and is exploring social enterprise models currently

c. a community reablement hub

d. a service for substance misuse which supports people into and through treatment into sustained recovery

e. recovery approach through all our services

3. Strong shift towards supported living and support in people's own homes

Haringey Council

a. Growth in the Shared Lives scheme to enable more people to live in family settings

b. Expansion of extra care sheltered provision for all care groups

c. Increase in supported living placements

d. Less use of residential care

The local authority will be developing a Supported Living Strategy for all adult care groups with opportunities for tendering for care and support as well as accommodation elements of such provision.

The local authority will also be seeking to expand extra care provision and would welcome dialogue with parties interested in developing such provision in Haringey.

We intend to continue exploring opportunities and choices for individuals who no longer choose to remain at home. We will be expanding extra care housing options for Haringey in the future.

We are developing new accommodation pathways across care groups, with work on mental health being the priority – commissioning for a pathway within the Housing Related Support programme is taking place in 2015.

The local authority signals its clear intention to commission fewer residential and nursing care placements in the future, as alternative provision comes on stream.

4. New model of day opportunities to move away from building based provision to accessing support and opportunities in the community

The local authority will be developing a new model of day opportunities provision for all care groups moving away from buildings based provision delivered through in-house services through an opportunities based approach delivered through the independent sector. There will be opportunities for service development and for social enterprise models which offer strong incentives for all care groups to access mainstream provision, develop their independence and skills and build social networks.

5. Changes to the way services are procured to establish a framework agreement for the provision of domiciliary and reablement services in the borough

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The local authority will be re-commissioning its domiciliary care services, which are currently all based on spot contracts, to a framework to enable greater consistency of approach and a stronger focus on quality and reablement. We will be working with providers as we move to the new approach in order to optimise their experience and expertise.

6. Greater integration with health services for all care groups

We will be working with the CCG as we implement our commissioning intentions and will seek to commission jointly wherever possible. The Better Care Fund covers services for older people with frailty, including dementia in the first year of operation, focusing in the second year on mental health services, through the adoption of the Mental Health and Wellbeing Framework across partners.

London Borough of Haringey's Budget/ Spend

It is predicted that demographic pressures will result in a steady rise in demand for Council funded services in the medium to long term. This will not be matched by an equivalent growth in public funding. Due to the government's austerity measures, LBH is planning to achieve a budget cut of £70 million over the next 3 years on top of the £117 million that has been saved since 2010. That is approximately a quarter of the remaining budget.

The Medium Term Financial Strategy sets out for the Council how it will achieve these budget reductions over the next three years, and should be read alongside this document.

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Appendix 1

Market Position Statement Survey

Tell us what you think

Please use these last pages of the Market, Position Statement to tell us what you think of this document and what would be useful to you in the future:

1. Have you found this Market Position Statement useful?

YES / NO

If no, please tell us how it could be improved

2. Did you find the information in the Market Position Statement useful?

YES / NO

If no, please tell us what would improve the level and type of information we could provide.

3. Did you find the structure of the Market Position Statement easy to follow?

YES / NO

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If no, please tell us how we could improve the structure to make it easier to follow.

4. Do you have any suggestions or ideas about how we could better support you to develop services in the borough?

Please send you completed survey forms to

Contact Name

Title

Address

Telephone

Email

Thank you for completing this survey. All feedback will be used to help us improve our services and future market position statements.

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Appendix 2 – Supplementary information

Personal Budgets

There are now a total of 3,577 service users receiving Personal Budget as at 31st December 2014. The community base stands at 4,910 as at 28th February 2014. This means that 73% of people receiving a community service have a Personal Budget.

The table below shows service areas by take up of Personal Payment

SERVICE	DIRECT PAYMENTS ONLY (*as at 31 Dec 2014)	PERSONAL BUDGETS (*as at 31 Dec 2014)			TOTAL SELF DIRECT SUPPORT FIGURE (Personal Budgets and Direct Payments as at *31 Dec 2014)
		TOTAL PERSONAL BUDGETS	Personal Budgets paid by Direct Payment	Personal Budgets with an arranged service (no DP)	
Older People	£9	£1316	£271	£1045	£1325
Physical disability	£12	£443	£235	£208	£455
Mental health	£3	£175	£15	£160	£178
Learning disability	£14	£419	£98	£321	£433
Sensory Support	£4	£50	£25	£25	£54
Social Support	£1	£10	£2	£8	£11
Carers (** Between April and Nov)	£5	£597	£597	£0	£602
Adult Service Total	£43	£2413	£646	£1767	£2456

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Carers Total	£5	£597	£597	£0	£602

Source: LBH ASC Client Information System

Table 5: Numbers of older people paying for home care based on ELSA Wave 5 and POPPI data

	Age 65-69	Age 70-74	Age 75-79	Age 80-84	Age 85-89	Age 90+	Sum of self-funders
Male	5	11	18	24	36	37	131
Female	16	45	45	64	65	76	309
Total	20	56	63	88	101	113	440

NB: Subject to rounding

Source: Haringey Partnership Draft Report February 2015

Attendance Allowance

Attendance Allowance is a needs-based benefit for people who need help in looking after themselves due to disability or illness (Table 6).

Table 6: Attendance Allowance claimants in Haringey (Feb 2014)

	People aged 65-69	People aged 70-74	People aged 75-79	People aged 80-84	People aged 85-89	People aged 90 +	Total
Attendance Allowance claimants	120	420	760	920	720	580	3,520

Source: DWP

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Using AA numbers to estimate the numbers of people who pay for care indicates there are **824** older people who pay for care in their own home in Haringey.

Levels of home ownership in 65+ households

	People aged 65-74	**People aged 75-84**	**People aged 85 and over**
Proportion of households aged 65 and over – owner occupiers	56.87%	57.92%	52.68%

Source: Census 2011

These data indicate that more than a half of all people aged 85 and over (2,500) in Haringey own a property worth a minimum £487,000.

Likely impact of Dilnot and Care Act 2014

Annual cost of care home place in 2016/17	**£33,431**
Hotel costs	£12,000 per annum
Annual costs minus hotel costs	£21,431
Weekly rate of care home place minus hotel costs (21,431/52)	£412.14
Number of weeks of care before self-funder will reach £72,000 cap (72,000/412.14)	175
Number of years and weeks before	3.36 years

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cap is reached (175/52)	

Source: Haringey Social Care Partnership Draft Report February 2015

In the table above the community based is defined as a snapshot date as at 31st December 2014, and consists of service users receiving "long term support" services only. Service users and carers will now be measured separately. However, carers will be measured by services received between April and December 2014, and not as a snapshot.

Both service users and carers will be measured by those receiving self directed support (personal budgets and direct payments), and those receiving direct payments only.

Distribution of older people by top [x number] wards compared with those in receipt of council support

Ranking	Ward by total population 2013-14	Ward by population aged over 65	Ward by number of council funded packages of Community based service in own home	Ward by number of council funded Nursing care	Ward by number of council funded Residential care
Seven Sisters	16263	1215	224	1	7
Tottenham Hale	15987	1200	244	4	11
Woodside	14998	1260	237	2	13
St Ann's	14871	1244	206	4	27
Bruce Grove	14864	1244	282	2	11
Northumberland Park	14729	1171	265	4	11
Tottenham	14671	1248	280	21	36

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Green					
Noel Park	14263	1193	236	3	21
Bounds Green	14060	1289	277	2	11
Harringay	13598	1018	167		16
White Hart Lane	13554	1160	241	1	3
West Green	13398	1311	234	2	9
Hornsey	12819	1073	185		3
Fortis Green	12484	1388	118	1	24
Crouch End	12483	1194	109		10
Stroud Green	11805	861	124	17	2
Alexandra	11767	1285	92	3	15
Highgate	11588	1441	104	3	6
Muswell Hill	10710	1339	132	1	10

POPPI

Haringey Council

Report for:	**Adult Social Services Quality Assurance Board** 16 June 2015	**Item Number:**	3.1

Title:	Fundamental Standards

Lead Officer:	Helen Constantine - Head of Business Management, Adult Social Services

Report Author:	Rebecca Waggott, Business Improvement Officer, Adult Social Services

1. Introduction

1.1 In November 2014, the Government published the Fundamental Standards regulations. The regulations are a key part of the changes the Care Quality Commission (CQC) has made to the way it inspects health and care services.

1.2 The Fundamental Standards replace the 16 'essential standards' of quality and safety which were previously used to assess whether care had fallen below acceptable standards.

1.3 All registered providers must show that they are meeting these regulatory requirements in order to register with CQC and then continue to deliver regulated services.

1.4 The Fundamental Standards include two new regulations – the duty of candour and the fit and proper person requirement for directors – as a direct response to the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust. These regulations are designed to ensure that providers have robust systems in place to be open and honest when things go wrong and to hold directors to account when care fails people.

1.5 This briefing outlines the new Fundamental Standards and the associated enforcement policy, as well as key aspects of the new regulations relating to the duty of candour and the fit and proper persons requirement for directors.

2. The fundamental standards

2.1 The Fundamental Standards are the standards below which a person's care must never fall. The Fundamental Standards are:

- care and treatment must be appropriate and reflect service users' needs and preferences.
- service users must be treated with dignity and respect.
- care and treatment must only be provided with consent.
- care and treatment must be provided in a safe way.
- service users must be protected from abuse and improper treatment.
- service users' nutritional and hydration needs must be met.

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- all premises and equipment used must be clean, secure, suitable and used properly.
- complaints must be appropriately investigated and appropriate action taken in response.
- systems and processes must be established to ensure compliance with the fundamental standards.
- sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
- persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
- registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

2.2 The new CQC inspection model for adult social care looks at five key questions: whether the service is safe; effective; caring; responsive to people's needs; and well-led. This enables inspection teams to identify good care.

2.3 When CQC inspectors identify poor care, the newly-established regulations guidance helps to determine whether there is a breach in the new regulations and if so, what action to take. In some cases, this will result in CQC using their powers to prosecute.

2.4 A new enforcement policy explains CQC's approach to taking action where poor care is identified, or where registered providers and managers do not meet the standards required in the regulations. The enforcement policy will be used to protect people who use services and to hold providers and, in some cases, individuals to account.

2.5 Enforcement action will often be used at the same time as placing a service in special measures. If a service is rated inadequate overall, it will be placed straight in special measures and inspected again within six months. If a service is rated inadequate for one of the five key questions it will usually have six months to improve. If insufficient improvements are made, CQC will take enforcement action to either cancel the provider's registration or vary the terms of registration.

2.6 The new fundamental standards require that systems and processes are in place to ensure compliance with the fundamental standards. This is set out in Regulation 17: Good governance, which aims to make sure that providers have systems and processes that ensure that they are able to meet the requirements in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

2.7 To meet this regulation, providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice.

3. Regulation 20: duty of candour

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3.1 From 1 April 2015, all registered providers must meet the new Regulation 20: Duty of candour. Meeting the duty of candour regulation will be central to both registration and inspection.

3.2 The aim of this regulation is to make sure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment.

3.3 It sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, giving reasonable support, providing truthful information and an apology.

3.4 The regulation requires that providers promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

3.5 In interpreting the duty of candour regulation, CQC use the following definitions used in the Francis Inquiry:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

3.6 Paragraph 9 of Regulation 20 defines what constitutes a notifiable safety incident, including the thresholds that trigger the duty of candour. The harm thresholds for adult social care are consistent with thresholds for the existing CQC notification system for reporting deaths and serious injuries.

3.7 To meet the requirements of Regulation 20, a registered provider has to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

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3.8 During the registration process, CQC will test with a provider that they understand the requirements of Regulation 20 and ask what systems they have in place to ensure they meet the requirements. This would include, but is not limited to, training for all staff on communicating with people who use services about notifiable safety incidents; incident reporting forms which support the recording of a duty of candour notification; support for staff when they notify people who use services when something has gone wrong; oversight and assurance.

3.9 During the inspection process, CQC will look at the following KLOEs under the safe and well-led questions which are relevant to the duty of candour in the inspection of all providers:

- Prompt: Are there plans for responding to any emergencies or untoward events, and are these understood by all staff?
- Prompt: Is there an emphasis on support, fairness, transparency and an open culture?

3.10 Regulation 20 applies to organisations rather than individual members of staff. It requires the provider to make sure that all their staff, regardless of seniority or permanency, understand the organisation's responsibility to be open and transparent in their communication with relevant persons in relation to a notifiable safety incident. It requires the provider to understand their own role, and to put policy and processes in place to ensure they are supported to deliver it.

3.11 Providers should also take action to tackle bullying, harassment and undermining, and investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.

3.12 When CQC identify a breach of Regulation 20, they will assess the impact on people and decide whether or not to take regulatory action, and what action to take, in accordance with the enforcement policy.

3.13 Illustrative examples of incidents that trigger the thresholds for duty of candour are set out in Appendix 1.

4. Regulation 5: Fit and proper persons: directors

4.1 From 1 April 2015, all registered providers must meet the new Regulation 5: Fit and proper persons: directors. Meeting the fit and proper person requirement for directors (FPPR) regulation will be central to both registration and inspection.

4.2 CQC is currently exploring mechanisms for how they can inspect and report on this regulation for organisations other than NHS bodies.

4.3 The aim of this regulation is to make sure that all directors of registered providers are responsible for the overall quality and safety of care, and for making sure that care meets the existing regulations and effective requirements of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This regulation is about ensuring that those individuals are fit and proper to carry out this important role.

4.4 The provider will have to ensure that it complies with the regulations by not having an unfit director in place. CQC will not expect local authority providers to apply the requirement to elected members as they are accountable through a different route. It will apply to the

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relevant management level local authority officers who are responsible for controlling and supervising the service.

4.5 It will be the ultimate responsibility of the chair of the provider to discharge the requirement placed on the provider to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

4.6 In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation extends to individuals who are prevented from holding the office (for example, under a director's disqualification order) and significantly, excluding people who:

> "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity".

4.7 To meet the requirements of Regulation 5, a provider has to:

- Provide evidence that appropriate systems and processes are in place to ensure that all new directors and existing directors are, and continue to be, fit, and that no appointments meet any of the unfitness criteria set out in Schedule 4, Part 2 of the regulations.
  This means that directors should be of good character, have the required skills, experience and knowledge and that their health enables them to fulfil the management function. None of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on barred lists and being prohibited from holding directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement or failure of care in carrying on a regulated activity.
- Make every reasonable effort to assure itself about an individual by all means available.
- Make specified information about directors available to CQC.
- Be aware of the various guidelines available and to have implemented procedures in line with this best practice.
- Where a Director no longer meets the fit and proper persons requirement and that individual is registered with a health or social care professional regulator, inform the regulator in question and take action to ensure the position is held by a person meeting the requirements.

4.8 The provider is responsible for the appointment, management and dismissal of its directors. The provider is responsible, as part of the recruitment and performance management processes, to ensure that the FPPR is met. CQC will not undertake a FPPR test of a director or determine what is serious mismanagement or misconduct, but they will examine how the provider has discharged its responsibility under the new regulation.

4.9 It is a breach of the regulation to have in place someone who does not satisfy the FPPR. Evidence of this could be if:

- A director is unfit on a 'mandatory' ground, such as a relevant conviction or bankruptcy. The provider will determine this.
- A provider does not have a proper process in place to enable it to make the assessments required by the FPPR.

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- On receipt of information about a director's fitness, a decision is reached on the fitness of the director that is not in the range of decisions that a reasonable person would make.

4.10 From April 2015, CQC has been able to take enforcement action for breaches of the FPPR, in accordance with their enforcement policy.

4.11 CQC will check and monitor the extent to which the provider meets the regulation at the point of registration, if concerns are identified during an inspection, on receipt of concerning information and where there is a serious failure of a provider.

4.12 During the registration process, CQC will test with the provider that they understand the requirements of the regulation and ask them what systems they have in place to ensure they will be able to meet these requirements.

4.13 CQC are currently exploring mechanisms for inspecting and reporting on FFPR for organisations other than NHS bodies. Arrangements are expected to be in place later in 2015.

4.14 In the interim, where concerns are raised during a CQC inspection, which may raise issues about the provider's application of the FPPR, the inspector will establish if the concerns relate to a director and their delivery in the quality and safety of care.

4.15 Where there is a serious failure of quality and safety of care of a provider, CQC will carry out a focused inspection including assessment of the FFPR aspects concerning recruitment and management of directors. This evidence will inform CQC's judgements about Regulation 5 and any breaches that may have taken place. Action taken will be proportionate to the concerns identified and the impact on people who use services.

4.16 There are some core public information sources about providers that CQC believe are relevant for providers to use as part of their FFPR due diligence, e.g. information from public inquiry reports, serious case reviews and Ombudsmen reports in our guidance.

4.17 As this is a new regulation, CQC expects to learn from what they find and will publish learning from the early stages of implementation once a sufficient body of information is available.

5. Key implications of the changes

5.1 It is important that CQC registered providers and registered managers are aware of the introduction of the Fundamental Standards as a replacement for the 16 'essential standards' of quality and safety. Local governance arrangements will now need to be framed in terms of the new Fundamental Standards and ensure compliance with these standards.

5.2 It is crucial that governance arrangements are in place to monitor compliance with the Fundamental Standards as this is a legal requirement. Registered services need to continue to use assurance and auditing systems to monitor and drive improvement in quality and safety. Registered services have also completed PIR assessments against the CQC Key Lines of Enquiry and must now progress the identified areas for improvement.

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5.3 The new regulations and enforcement policy mean that providers may be prosecuted and could face an unlimited fine for breaching the Fundamental Standards. This will make it even more important to monitor both internal and external service providers' compliance with the Fundamental Standards in order to prevent service failings, so that service continuity can be maintained and financial risk managed.

5.4 It is important that registered providers and managers understand the new requirements of Regulation 20: Duty of candour, and staff training is in place around communicating with people who use services about notifiable safety incidents.

5.5 Registered providers must also be aware of the requirements associated with Regulation 5: fit and proper persons: directors.

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Appendix 1: CQC adult social care illustrative examples of incidents that trigger duty of candour thresholds

Examples	Interpretation
An OT completed an assessment with a care home resident whose mobility was deteriorating. The OT advised that grab rails were needed in a person's bathroom before it was safe for them to use the bath and that in the meantime staff should assist the person to have a strip wash each morning. The manager failed to update the person's care plan or inform the care staff of this change, so staff supported the person to take a bath the following morning as usual. The person slipped when getting out of the bath and sustained a broken arm. The arm was put in a plaster cast and the person needed full assistance for all aspects of their care for 6 weeks until the cast was removed. The person made a full recovery.	This would be an example of an incident leading to a service user requiring further treatment to prevent the service user experiencing prolonged pain (regulation 20 (9)(b)(ii)
A new member of staff on induction was shadowing another care worker delivering care to a person who needed to be hoisted. Two trained members of staff were required to operate the hoist safely and the new member of staff had not yet been trained in moving and handling. The new care worker was asked to assist with the manoeuvre and did not attach one of the loops of the sling to the hoist properly. As a result, during the manoeuvre, the person slid out of the sling and onto the floor. The person sustained a broken hip requiring emergency surgery.	This would be an example of an incident leading to a service user experiencing changes to the structure to the body (regulation 20 (9) (b) (iii)
A person with a learning disability was prescribed antipsychotic medicines. They were assessed as needing full staff support in the management of their medicines. Over a period of two weeks they became increasingly anxious and distressed. When the person's medicines were checked it was discovered that their antipsychotic medicines had not been ordered the previous month and did not show on the MAR chart. This was because the correct procedure for ordering and the checking in of medicines had not been followed and the error had gone unnoticed for 18 days. This resulted in a prolonged deterioration in the person's mental health for more than 28 days.	This would be an example of an incident leading to prolonged psychological harm (regulation 20(9)(a)(iv)

DRAFT
Haringey Adult Service Quality Assurance Framework

Introduction

Haringey Council is committed to ensuring that the services people receive are of the high standard that we, our partners and the citizens of Haringey, expect. All providers that we commission are expected to deliver services that meet or exceed quality standards and the way that we measure those standards is outlined in this document.

The Framework will apply to all social care services that are commissioned for adults in Haringey, including services provided by Haringey Council. Services commissioned for children in Haringey are subject to separate, robust monitoring arrangements including Ofsted regulation and inspection.

We believe that everyone including, but are not limited to, people who use the service, relatives, carers, providers, staff delivering the service, social care staff, health practitioners, Safeguarding professionals, regulatory bodies e.g. Care Quality Commission (CQC), expert by experience assessors and HealthWatch has a role to play and will contribute to improvement in Quality of care provided in Haringey.

The Care Act 2015 has highlighted the duty of local authority to commission effective procurement, tendering and contract management, evaluation and decommissioning process that focus on providing appropriate high quality services to individuals to support their wellbeing and supporting the strategies for market shaping and commissioning.

Haringey Quality Assurance and Standards for Services

All social care and support services provided by Haringey Council will be assessed on how they deliver quality standards. Quality standards will be measured against the following outcomes:

- The service is always delivered in the best interests of the service user and is person centred
- People are treated with dignity and respect
- There is a clear pathway of access and move on from the service to more independent service
- There is management of the service users health and wellbeing needs
- The service works with the local community and the service user's support network
- The provider operates effectively and there is clear leadership and management of the organisation
- The provider has a clear method of measuring quality and internal management system in place to tackle any underperformance
- The provider works from an equalities perspective
- The provider has clear arrangement in place to deal with the service user's mental capacity issues and that any deprivation of their liberty is lawful

The following services will be covered by Haringey Quality Assurance Framework:

- Domiciliary care
- Supported Living Provisions
- Extra Care Housing
- Day Services
- Residential and Nursing Care Provisions

Quality Assurance and Contract Management
Services commissioned by HARINGEY are defined by a contract and specification detailing terms and conditions, including how the service should be provided and how quality and performance will be monitored. The Quality Assurance Framework will highlight the way Haringey monitors quality of the services.

When a service is assessed against standards under the Quality Assurance Framework, this will be considered in the context of contractual performance. Consideration will be given to whether the terms and conditions of the contract have been breached and based on this assessment appropriate action will be taken.

Quality Assurance and Care Quality Commission (CQC) Regulation and Healthwatch
CQC is the independent regulator of health and social care in England. They regulate and inspect many of the services that are commissioned by Haringey Council. In addition to CQC, Healthwatch have the power to 'Enter and View' providers so that their authorised representatives can observe matters relating to health and social care services.

The Council's relationship with the provider is **separate** to the role of the regulator, whereby the Council is responsible for monitoring how the provider is performing under its specific contract. However, where a commissioned service is regulated by the CQC, the Quality Assurance Framework aims to ensure a proportionate approach to performance monitoring by:

- Complimenting the inspection process conducted by the CQC
- Using intelligence gathered from CQC inspections to inform areas for further monitoring
- Avoiding duplication with CQC inspections & HealthWatch 'Enter & View' by sharing, coordinating with other agencies.

Quality Assurance Framework will be defined by systemic approach incorporating self - assessment and self - regulation by providers and underpinned by principal of proportionality, intelligence led action, collaboration between agencies and responsive to the needs of the service users and their families.

Haringey Quality Assurance Process will follow:

Risk Assessment and Prevention
Our Risk Assessment of all providers will be based on comprehensive Intelligence and information. Commissioning and Brokerage Officers will obtain and maintain accurate information about the quality of services from a wide range of sources. This enables our risk assessment and quality assurance to be an ongoing process. Furthermore, this will support our early identification and intervention approach in dealing with any concerns at earliest opportunity and offer support to address the concerns.

Information Gathering

The following Table shows the source of information and intelligence that feeds into our risk assessment of care provisions.

Source of Intelligence and intelligence	Type of Information	Frequency	By
CQC	CQC Inspection Report	Annual	Assessed Brokerage officers
HealthWatch	HealthWatch Inspection Report	Annual	Commissioning and Quality Assurance
Providers	Self –Assessment	Annual	Assessed and Audited by Brokerage Officers
Commissioning	Quality Assurance	Annual and As	Assessed by

and Quality Assurance Visit	Visit report	Required	Commissioning and Quality Assurance
Survey of Service Users and their Family Carers	Assessment of Service provision by service users and their family carers.	Annual and As Required	Performance / Commissioning and Quality Assurance
Complaint and Complement Records	Individual Statement and quality of the service	On going	Commissioning and Quality Assurance
Whistleblowing	Whistleblowing information	On going	Commissioning and Quality Assurance
Safeguarding	Safeguarding issues related to provider and provision of service	On going	Performance
Other Local Authorities and CCG	Information regarding quality of service from other commissioning agencies such as other LA and CCG	On Going	Commissioning and Quality Assurance
Care Management	Information from Review and individual care assessment	On going	Commissioning and Quality Assurance
Members of Public and Community	Information from Neighbours and Concerned members of the Public	On going	Commissioning and Quality Assurance

Commissioning and Quality Assurance will collate information regarding all care provisions in Haringey and record this information on Mosaic under provider's record.

Quality Assurance Visit

Quality Assurance visit to care provisions is essential part of our assessment and support to establish and maintain effective service delivery. The Quality Assurance visit will be undertaken by Commissioning and Brokerage Officers to assess the service whilst they are being provided. The visiting officers will speak with staff, service users and carers, inspect care records, check policy and procedures, recruitment, safeguarding and QA systems. The QA visit frequency will be determined by the size of the service, the nature of service provided and the level of risk identified by the QA assessment.

QA visit will normally be planned and coordinated with the provider, however Commissioning Team will undertake unannounced visit to provider's premises and care establishment as and when required. All visits will be authorised by the QA and Commissioning Manager. All providers will receive at least one QA visit per year.

The QA visit reports will be sent to QA and Commissioning Manager who will assess and feed the outcome to Haringey Risk Assessment and regular report to Head of Commissioning and directors of Adult Service.

Risk Assessment and Prevention

Our Risk Assessment of all providers will be based on comprehensive Intelligence and information. Commissioning and Brokerage Officers will obtain and maintain accurate information about the quality of services from a wide range of sources. This enables our risk assessment and quality assurance to be an ongoing process. Furthermore, this will support our early identification and intervention approach in dealing with any concerns at earliest opportunity and offer support to address the concerns.

The following table outlines the risk assessment method based on the category and complexity of the care provision.

	Risk Assessment					
		Complexity				
Category	Please specify	Care in the home provided to up to 50 residents or up to 6 residents in a residential care home	Care in the home provided to 50 or more residents or 6 or more residents in a residential care home or supporting up to 10 residents living in their own home who need two care workers at each visit	Care in the home provided to 100 or more residents or 10 or more residents in a residential care home or supporting 10 or more residents living in their own home who need two care workers at each visit	Care in the home provided to 200 or more residents or 20 or more residents in a residential care home or supporting 20 or more residents living in their own home who need two care workers at each visit	Supplier providing services to people in a care provision where one or more residents needs 1:1 or 2:1 or Supplier providing services in a care provision where one or more residents are subject to section 117 or 37/41 of the Mental Health Act
A	Substantiated safeguarding alert within the last two years where a person dies or is hospitalised and where the concern is linked to a failure in a supplier's services					
B	CQC taking Enforcement Action within the last two years					

C	Failing to meet one or more of CQC's essential standards within the last year, with a major impact					
D	Two of more of E to H applying to a supplier's services					
E	A service where there has been an establishment concern within the last two years					
F	Significant concerns arising from a monitoring visit of a care provision					
G	Failing to meet one or more of CQC's standards within the last year, with a moderate impact					
H	A single substantiated safeguarding concern within the last 12 months relating to a supplier's service where the risk level is high or three or more safeguarding concerns where the risk level is medium					
I	A review of a supplier quality of service determining that the supplier has not met one or more of the outcomes set by the council					
J	Concerns arising from a supplier's last financial evaluation					

Prevention
Haringey Commissioning and Quality Assurance team will draft a report on quality of service and share it with the provider. Based on the report and where appropriate, an improvement plan and monitoring arrangements will be agreed. The risk assessment will be updated accordingly.

The intelligence gathered may raise concerns about the quality of a service. These concerns will be judged as low, medium or high level and the provider will be asked to respond to these concerns accordingly.

Low level concerns – Haringey Commissioning and Quality Assurance Team received/stakeholder reports quality concerns that indicate an isolated issue impacting on an individual service user. Issue is drawn to the attention of the provider, who responds appropriately to resolve the situation and puts necessary steps in place to reduce likelihood of future occurrence.

Medium level concerns – Several reports received by Haringey Commissioning and Quality Assurance Team which indicate repeated quality concerns; issues impacting on a number of service users.

Provider will receive a formal notification that quality standards are not being met and asked to put an improvement plan in place. Haringey Commissioning and Quality Assurance Team may implement spot checks to ascertain the extent of the concerns and whether improvement plans are being followed.

High level concerns – Haringey Commissioning and Quality Assurance Team receives repeated and unresolved quality concerns;
safeguarding reports; potential contractual breaches; service continuity affected; concerns raised by regulatory bodies. Haringey Commissioning and Quality Assurance Team will immediately undertake visits and more intense and frequent quality monitoring until the matter is resolved. This level of concern may lead to Establishment Concern Procedure.

Reporting

Commissioning and Quality Assurance team will develop **Provider Risk and Quality Profile** which will include all relevant information relating to the quality of the service, including latest report, any improvement plan and any judgement on the quality of the service. The full report will be agreed with the provider in a fair and transparent way recognising both the need for accurate assessment of quality of service provided by individual providers.

The intelligence gathered may raise concerns about the quality of a service. These concerns will be judged as low, medium or high level and the provider will be asked to respond to these concerns accordingly.

Roles, Responsibilities & Resources
The Quality Assurance Team is part of the Commissioning Unit in Haringey. The team consists of:
Commissioning Manager who will oversee the Quality of care provisions in Haringey and reports to Assistant Director for Commissioning.

Brokerage and Quality Assurance Manager – responsible for brokerage service ensuring that the Quality Assurance Framework is implemented across all services; decides when to escalate quality assurance process; reports status of QUALITY ASSURANCE FRAMEWORK.

Brokerage and Quality Assurance Officer – responsible for service finding and assessing quality of care provisions by analysing the information gathered under the QUALITY ASSURANCE FRAMEWORK , undertaking visits and preparing Summary report and actions for improvement.

Expert by Experience – trained volunteers who assess quality of life outcomes for service users; responsible for reporting back to the **Brokerage and Quality Assurance Manager . This service needs to be developed**

Providers – responsible for delivering a high quality service; works in partnership with Haringey Commissioning and Quality Assurance team and regulatory bodies to improve quality where necessary

Social Care & Health Professionals – inform the QUALITY ASSURANCE FRAMEWORK intelligence gathering process by sharing relevant information about quality standards with Haringey Commissioning and Quality Assurance Team

Safeguarding Team – works in partnership with Haringey Commissioning and Quality Assurance team when quality issues lead to safeguarding concerns and vice versa.

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Introduction

The focus of high quality commissioning is on citizenship, health and wellbeing: achieving good outcomes with people using evidence, local knowledge, skills and resources to best effect. This means working in partnership across the health and social care system to promote health and wellbeing and prevent, as far as is possible, the need for health and social care. Every person using social care services deserves the highest quality care and support, and the maximum opportunity to influence how that support is arranged and managed. Effective commissioning plays a central role in driving up quality, enabling people to meaningfully direct their own care, facilitating integrated service delivery, and making the most effective use of the available resources. Commissioning is the local authority's cyclical activity to assess the needs of its local population for care and support services that will be arranged by the authority, then designing, delivering, monitoring and evaluating those services to ensure appropriate outcomes. Effective commissioning cannot be achieved in isolation and will be best delivered in close collaboration with others, such as children's services, public health, housing and NHS partners. In adult social care, the key outcomes are described by the Adult Social Care Outcomes Framework (ASCOF), Making It Real statements and Public Health Outcomes Framework, and build on the Association of Directors of Social Services (ADASS) Top Tips for Directors (see Appendix 1 for details). Together, they describe the care and support that will achieve what matters most to people - personalised, community-based support that promotes health and wellbeing.

What matters most to people?

- The person at the centre, rather than fitting them into services.
- People who use services and carers treated as individuals.
- Empowering choice and control for people who use services, and carers.
- Setting goals with people for care and support who use services, and carers.
- Having up to date, accessible information about services.
- Emphasising the importance of the relationship between people who use services, and providers and staff.
- Listening to people who use services and acting upon what they say.
- A positive approach, which highlights what people who use services can do and might be able to do with appropriate support, not what they cannot do.

Clenton Farquharson MBE
Co- Chair Think Local Act Personal

The standards are designed to ensure that everyone shapes and shares the vision of excellent care and support for people in need of adult social care, challenging commissioners to embark on an ambitious journey. They support the development of a common focus and purpose across the system, driven by shared values and behaviours. This includes commissioning for prevention; for both the care and support for people with assessed care needs, and for the overall health and wellbeing of all, thereby preventing, reducing or delaying the need for services in the future. There is a clear overlap with assuring the quality of CCG commissioning and, over time, we anticipate that there will be increasing alignment at a national level to support high quality integrated commissioning at a local level. For many Local Authorities, this will involve changes in commissioning and procurement practice in order to focus on promoting wellbeing and on outcomes, to be more responsive to community needs, to enable individuals as commissioners of their own care, and to actively promote collaboration across the whole system. These standards should be seen as a route map for that journey rather than the final destination - they are intended to be used to support development and improvement.

These standards have been developed from:

- A review of the available literature on effective commissioning.
- The engagement of a wide range of stakeholders to identify challenges in commissioning, to define what good looks like and to develop the content for the standards drawing on a wealth of experience and good practice.
- The input from a Project Steering Group coordinated by Think Local Act Personal (See Appendix 2).
- An expert review of a final draft of the standards by Local Authorities and other key organisations.
- A peer review of commissioning in three local authorities and lessons learned workshop.

The inclusivity of the approach reflects a commitment to coproduction and engagement. This work was funded by the Department of Health and undertaken by a team from the Health Services Management Centre at the University of Birmingham, commissioned by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

This is the updated version of the commissioning for better outcome standards and now reflects the views and revisions recommended by those involved in three pilot peer challenges.

Purpose of the standards

These standards are designed to support a dynamic process of continuous improvement and, through self-assessment and peer review, to challenge commissioners and their partners, to strengthen and innovate to achieve improved outcomes for adults using social care, their carers, families and communities. They are relevant to all aspects of commissioning and service redesign, including decommissioning. The standards have been designed to reflect the improvements that experience has shown are needed, to support the transformation of social care to meet people's reasonable aspirations, and to support the implementation of the Care Act. The overarching aim of the Care Act and related secondary legislation is to promote a whole system approach where strong local partnership arrangements for working with Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards are central to effective commissioning. It also means commissioning for the care and support needs of the whole population. The Act places a number of statutory duties on Local Authorities; particularly relevant are:

- A new statutory principle to promote health and wellbeing. This applies to commissioning, as well as care and support and safeguarding, and means that whenever a Local Authority makes a decision about an adult, they must promote that adult's wellbeing. The wellbeing principle applies equally to carers, and Local Authorities should similarly consider their health and wellbeing in assessing their eligible needs for support. The Act also requires Local Authorities to ensure the provision of preventative services - that is services which help prevent or delay the development of care and support needs, or reduce care and support needs (including carers' support needs). See more at: http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/5761381/ARTICLE#sthash.ix8yrQuI.dpuf.

- The Act introduces a new requirement to arrange independent advocacy for people who a) have substantial difficulty in being involved or engaged in care and support assessments, planning and reviews and b) where there is no one available to help facilitate this involvement and engagement.

- The duty to carry out their care and support functions with the aim of integrating services with those provided by health, housing and others. See more at: http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/6349034/ARTICLE#sthash.JInLArBH.dpuf. This has implications for the joint commissioning of services and ensuring a whole system approach.

- A new duty for Local Authorities to promote diversity and quality in the market of care and support for people in their local area. Local Authorities must act to ensure that there are a variety of different service providers available, that

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make available a wide range of appropriate, high quality services to meet the needs of the local population. See more at: http://www.local.gov.uk/web/guest/care-support-reform/-/journal_content/56/10180/5761381/ARTICLE#sthash.ix8yrQuI.dpuf.

The standards also build on other legislation relevant to commissioning – notably the Human Rights Act (2004) and duties under the Equality Act (2010), as well as duties on Local Authorities to promote social value under the Public Services (Social Value) Act (2013) and to undertake Joint Strategic Needs Assessments (JSNA) under the Local Government and Public Involvement in Health Act (2007). The standards articulate the ambitions of effective commissioning and are organised around four domains: person-centred and outcomes-focused commissioning, which lies at the heart of the commissioning endeavour, enabled by commissioning that is inclusive, well led, and promotes a sustainable and diverse market place. All Local Authorities should be able to demonstrate progress in all of the domains described here.

The standards

There are 9 standards grouped into three domains. There is considerable overlap between these and all elements need to be in place to achieve person-centred and outcomes-focused commissioning.

Domain	Description	Standards
Person-centred and outcome focused	This domain covers the quality of experience of people who use social care services, their families and carers and local communities. It considers the outcomes of social care at both an individual and population level.	1. Person-centred and focused on outcomes 2. Co-produced with service users, their carers and the wider local community
Well led	This domain covers how well led commissioning is by the Local Authority, including how commissioning of social care is supported by both the wider council and partner organisations	3. Well led 4. A whole system approach. 5. Uses evidence about what works
Promotes a sustainable and diverse	This domain covers the promotion of a vibrant, diverse and sustainable market, where improving quality and safety is integral to commissioning decisions.	6. A diverse and sustainable market 7. Provides value for money 8. Develops the workforce 9. Promotes positive engagement with Providers.

The 9 standards set out ambitions for what good commissioning is. There are set out below, under the three domains to provide a framework for self-assessment and peer challenge.

Good commissioning is:

Person-centred and outcomes-focused

1. Person-centred and focuses on outcomes

Good commissioning is person-centred and focuses on the outcomes that people say matter most to them. It empowers people to have choice and control in their lives and over their care and support.

2. Coproduced with people, their carers and their communities

Good commissioning starts from an understanding that people using services, and their carers and communities, are experts in their own lives and are therefore essential partners in the design and development of services. Good commissioning creates meaningful opportunities for the leadership and engagement of people, including carers and the wider community, in decisions that impact on the use of resources and the shape of local services.

Well led

3. Well led by Local Authorities

Good commissioning is well led within Local Authorities through the leadership, values and behaviour of elected members, senior leaders and commissioners of services and is underpinned by the principles of coproduction, personalisation, integration and the promotion of health and wellbeing.

4. Demonstrates a whole system approach

Good commissioning convenes and leads a whole system approach to ensure the best use of all resources in a local area through joint approaches between the public, voluntary and private sectors.

5. Uses evidence about what works

Good commissioning uses evidence about what works; it uses a wide range of information to promote quality outcomes for people, their carers and communities, and to support innovation.

Promotes a diverse and sustainable market

6. Ensures diversity, sustainability and quality of the market

Good commissioning ensures a vibrant, diverse and sustainable market to deliver positive outcomes for citizens and communities.

7. Provides value for money

Good commissioning provides value for money by identifying solutions that ensure a good balance of quality and cost to make the best use of resources and achieve the most positive outcomes for people and their communities.

8. Develops the commissioning and provider workforce

Good commissioning requires competent and effective commissioners and facilitates the development of an effective, sufficient, trained and motivated social care workforce. It is concerned with sustainability, including the financial stability of providers and the coordination of health and care workforce planning.

9. Promotes positive engagement with providers

Good commissioning promotes positive engagement with all providers of care and support. This means market shaping and commissioning should be shared endeavours, with commissioners working alongside providers and people with care and support needs, carers, family members and the public to find shared and agreed solutions.

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Using the standards

The standards are designed to be used by Local Authorities to engage with their commissioning partners in a dialogue about the quality of local commissioning in so far as it impacts on people who may be in need of care and support either now or in the future. Transparency in commissioning is fundamental to delivering better outcomes and it is intended that these standards can be used by local people using social care, carers, their communities and providers to reflect on and influence the quality of local commissioning.

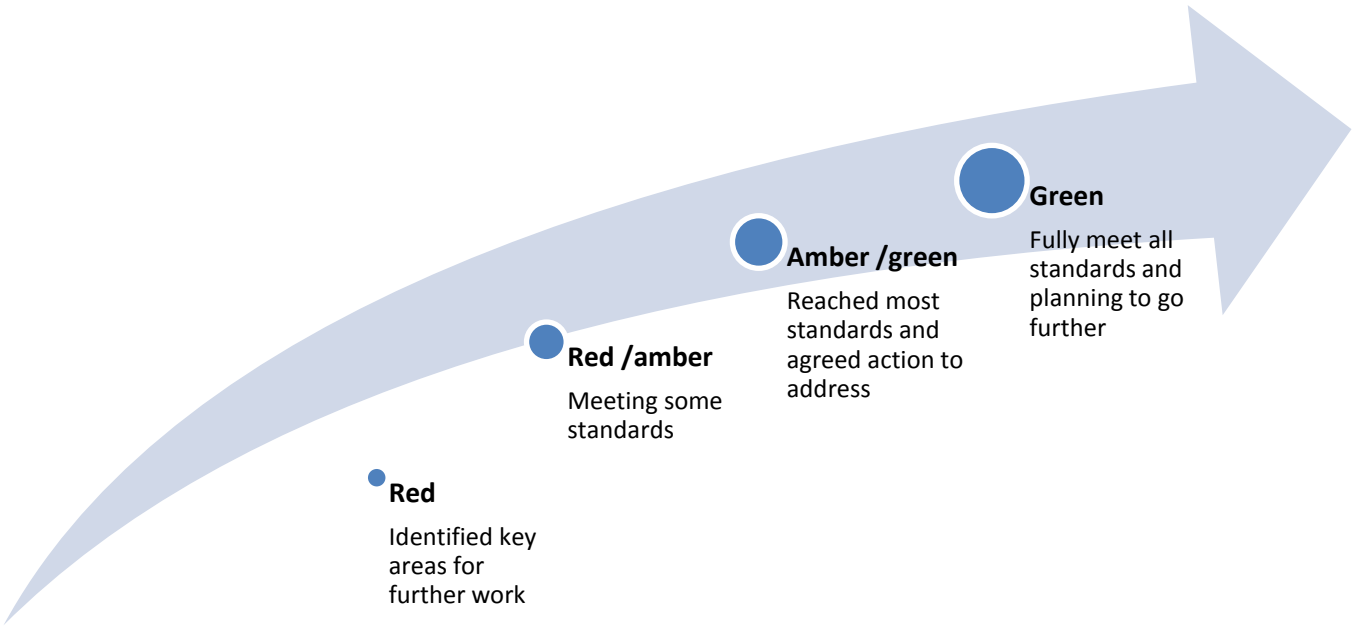
The first step is for Local Authorities to use these standards to critically examine the quality of their commissioning practice; they can then be used as a framework for the peer challenge process. Peer challenge is a constructive and supportive process, which has been found to be effective in enabling Local Authorities to take responsibility for their own improvement. It is not an inspection; rather it is delivered from the position of a 'critical friend' to promote sector led improvement. More information about peer challenge is available on the Local Government Association website: http://www.local.gov.uk/peer-challenge and a peer review methodology will be published in 2015.

It is expected that the relevant elected members, directors and commissioners within the Local Authority will lead the commissioning process, but this must also involve local people, and the Authority's strategic partners, who have a key role to play in ensuring that local people are able to access the care and support that they define as important to them. It is critical that these commissioning standards are used as part of a joined-up approach to commissioning involving Health and Wellbeing Boards, CCGs and with other Local Authority commissioning, and for all strategic partners to engage appropriately with this process and its outcomes. This includes:

- People who use adult social care
- Family members and carers
- Public and patient involvement forums and advocacy groups, including Healthwatch.
- Local community groups
- Other commissioners: Health and Wellbeing Boards, Clinical Commissioning Groups and Local Authority commissioners of housing, and other related services
- Providers of adult social care including voluntary sector organisations, community groups and independent sector providers
- Regulators

How well are you doing?

Each standard has several criteria that enable you to consider how well you are meeting the standards under each domain. At the end of this document there is a summary box for each domain for you to complete and an arrow to help assess progress.



In deciding on a score for each domain you will need to consider:

- What evidence do you have for the score you've decided on and how would you know if you were making progress in the future?
- To what extent is your view shared by others?
- How important is it to make progress against this standard?
- What do you need to do next?

Sources of evidence

In order to assess how well the Local Authority commissioning for better outcomes it will be necessary to draw on a wide range of evidence, and the same sources may be drawn on for different domains. As a minimum the following will need to be considered in terms of *what* they say and *how* they demonstrate good outcomes or other good practice in commissioning. Additional evidence will need to be considered in relation to commissioning with specific populations. Clearly, the most important source of evidence will be what matters to people who use social care and support services, their carers, advocates, and communities, and front line staff providing these services. Methods for gathering this evidence should be dynamic, ongoing and interactive so that it is possible to reflect the widest range of experiences and views.

Key documents and plans	**Local views**	**Reguation, monitoring and outcomes data**	**Good practice and innovation**
Local Authority strategies for finance, performance, care groups and other service strategies e.g. housing, culture and leisure, prevention Health and Wellbeing Board Strategies Joint commissioning strategies Pooled budget arrangements Safeguarding Board Annual Report and business plan Healthwatch Annual report Joint Strategic Needs Assessment Equality statements Local Accounts Making It Real Statements Market Position	Experiences of social care users, carers, advocates, families, communities, and front line staff, of social care provision Evidence from local people and commissioning partners on their views of commissioning Complaints/compliments Healthwatch reports Other reports or correspondence raising issues Map of engagement groups and methods of co-production with citizens and providers	ASCOF and related performance indicators Current, trend and benchmarked information Public Health Outcomes Framework and related indicators Personal Budgets and Outcomes Evaluation Tool (POET) Overview and scrutiny reports Qualitiative performance information on outcomes Contract monitoring outcomes Judicial reviews or other legal challenges	Evaluations of local services, including locally commissioned evaluations. Good practice promoted by ADASS, SCIE, LGA, NMDF and TLAP, NHS England, Skills for Care and other national bodies and how it is used locally NICE guidelines and quality standards Information about promising innovations from a range of sources including Local Authorities, local people, providers, think tanks and academic sources Enhanced integration of services and joint

Statements Top up agreements Think Local Act Personal (TLAP) partnerships at a local level Workforce Development Plans		Care Quality Commission (CQC) inspection reports on local providers Examples of learning from best practice Shared LA/NHS/CQC data on registered care Analysis of S4C workforce data (NMDS) Financial performance monitoring and evidence of fair fee levels and process.	monitoring of outcomes

The following sections set out the detail of the nine standards.

Good commissioning is person-centred and focuses on outcomes

Standard 1: Good commissioning is person-centred and focuses on outcomes Good commissioning is person-centred and focuses on the outcomes that people say matter most to them. It empowers people to have choice and control in their lives and over their care and support.	
What does good look like?	Draft questions to support peer challenge.
1.1 Commissioners ensure a focus across the system on personalisation and ensure commissioning decisions are informed by the desired outcomes of the people *who use local services.*	Is the council confident that its services users, their carers and the wider population are systematically, actively and meaningfully involved in shaping, designing and monitoring local care and support services?
1.2 Commissioners promote flexible, innovative person-centred models of care and ensure that there is a robust infrastructure in place to support micro-commissioning by people with an Individual Service Fund, personal budget or direct payment	
1.3 The Local Authority assures itself that its commissioning and contracting processes demonstrably lead to services which meet people's needs and *support them to achieve* their personal outcomes *and an improved quality of life*.	
1.4 Commissioners ensure that personal outcomes are being achieved through effective care management, good quality relationships with care and support staff and a strong focus on wellbeing.	
1.*5 The Local Authority recognises that building community and social capital is a central plank in the model of care and actively promotes:* *- Mutual support and self help* *- Connections between individuals and resources* *- Inclusion in community activities* *- Community ownership and involvement in planning ad reshaping services*	*What arrangements has the Council put in place to promote an asset based approach to commissioning care and support services?*

Standard 1: Good commissioning is person-centred and focuses on outcomes Good commissioning is person-centred and focuses on the outcomes that people say matter most to them. It empowers people to have choice and control in their lives and over their care and support.	
What does good look like?	Draft questions to support peer challenge.
What actions do we need to take to meet Standard 1	
Standard 2: Good Commissioning is coproduced with people, their carers and their communities Good commissioning starts from an understanding that people using services and their carers and communities are experts in their own lives and are, therefore essential partners in the design and development of services. Good commissioning creates meaningful opportunities for leadership and engagement of people, including carers and the wider community, in decisions that impact on the use of resources and shape of services locally.	
What does good look like?	Draft questions to support peer challenge.
2.1 The Local Authority demonstrates shared decision making with its *local population*, *including seldom heard groups*, actively engaging with them to shape priorities, specify population and personal outcomes and to maximise choice and control.	Is there evidence of a culture across social work teams, the wider councils and its partners that promotes care and support services focused on delivering outcomes and promoting the well-being of the local population?
2.2 Service specifications and contracts are designed with people who use services, their carers, advocates and providers to focus on outcomes, rather than outputs or time and task based activities.	
2.3 Commissioning processes are open and transparent and enable people who use services, and their carers, to hold services to	

Standard 1: Good commissioning is person-centred and focuses on outcomes Good commissioning is person-centred and focuses on the outcomes that people say matter most to them. It empowers people to have choice and control in their lives and over their care and support.	
What does good look like?	Draft questions to support peer challenge.
account.	
2.4 *Commissioners work collaboratively across service departments and organisations to ensure a smooth transition for young people with continuing care and support needs moving into adulthood*.	

What actions do we need to take to meet Standard 2

Good commissioning is well led

Standard 3 Good commissioning Is well led Good commissioning is well led within Local Authorities through the leadership, values and behaviours of elected members, senior leaders and commissioners of services and is underpinned by the principles of coproduction, personalisation, integration and the promotion of health and wellbeing *for all.*	
What does good look like?	Draft questions to support peer challenge.
3.1 The Local Authority is a local civic leader, improving the population's health and wellbeing by guiding the whole community including *public health*, local businesses, housing associations and voluntary sector organisations to improve outcomes. The Local Authority leads by example, demonstrating how other public services, such as transport and leisure, can play a role in achieving better wellbeing outcomes for the local population. This includes support for and active encouragement of innovation across the system.	Is the council recognised and respected as a strong civic leader working actively to promote the well-being of the local population? Are there strong, collaborative and trusting relationships and ways of working which ensure a range of preventative services for local people?
3.2 The Local Authority is able to articulate its vision and priorities for improving the health and well-being of the local population, based on a robust understanding of current and future needs. *Its commissioning intentions are well publicised and shared with local people.*	
3.3 *This shifts into Standard 4*	
3.4 Commissioning decisions are made on the basis of preventative outcomes which prevent, reduce or delay the need for social care services and promote physical, mental, emotional, social and economic wellbeing, as well as recognising individual and community assets.	

Standard 3 Good commissioning Is well led Good commissioning is well led within Local Authorities through the leadership, values and behaviours of elected members, senior leaders and commissioners of services and is underpinned by the principles of coproduction, personalisation, integration and the promotion of health and wellbeing *for all.*	
What does good look like?	Draft questions to support peer challenge.
3.5 There is a clear leadership role for people who use social care, and carers, to take an active and equal role in key commissioning decisions which impact on the use of resources and shape of services locally.	
3.6 The local authority places social, environmental and economic outcomes at the heart of good commissioning, reflecting its duties under the Public Services (Social Value) Act 2012	
3.7 Elected members are actively involved in commissioning decisions and understand the implications of those decisions on *the fair cost of care, the National Minimum Wage, the quality and effectiveness of local services and the sustainability of the local market.*	

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What actions do we need to take to meet Standard 3

Standard 4: Good commissioning demonstrates a whole system approach Good commissioning convenes and leads a whole system approach to ensure the best use of all resources in a local area through joint approaches between the public, voluntary and private sectors to improve outcomes for the local population	
What does good look like?	Draft questions to support peer challenge.
4.1 There is whole system approach to commissioning with joint (integrated) commissioning between health and social care apparent at every stage of the commissioning cycle and *overseen by the Health and Well Being Board*.	Do commissioners work collaboratively across organisational boundaries to share and align their plans and resources?
4.2 Commissioners work in partnership with other public services (including other Local Authorities), providers and community organisations to ensure the best use of resources, including ensuring that services can be de-commissioned, where appropriate, to reflect local needs and preferences.	
The Local Authority explicitly recognises wellbeing as the overarching goal of commissioning and plays a strategic role in leading, influencing and coordinating partners. This ensures a whole systems approach that drives transformation and prevents, reduces or delays the need for social care services and promotes the health and wellbeing of local people.	
4.3 The Local Authority promotes collaboration between different commissioning bodies *and the Regulator*, within and outside of the Local Authority boundaries, to ensure a joint strategic approach, seamless services and a smooth transition for people between services and localities and different funding streams.	
4.4 The overarching strategies of key partner organisations are aligned, outcomes-focused and promote integrated working.	

What actions do we need to take to meet Standard 4

Standard 5: Good commissioning uses a wide range of evidence about what works Good commissioning uses evidence about what works; using a wide range of information to achieve quality outcomes for people and communities.	
What does good look like?	Draft questions to support peer challenge.
5.1 There is demonstrable collaboration and sharing of qualitative and quantative data across the different agencies – social care, health, housing and education, which is used to establish a baseline and inform commissioning decisions in a clear and transparent way. The results are published and made available by the Local Authority.	Are commissioning decisions clearly underpinned by robust qualitative evidence and quantative data, as well as by the experience and views of local service users?
5.2 Commissioners employ a wide range of methods to collect, understand and analyse the views of people who use services and can demonstrate that this evidence strongly informs its commissioning priorities.	
5.3 There is capacity and capability to undertake the analysis necessary to interpret local data and wider evidence in a meaningful and relevant way.	

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What actions do we need to take to meet Standard 5

Good commissioning promotes a quality, sustainable and diverse market

Standard 6: Good commissioning promotes a diverse and sustainable market Good commissioning ensures a high quality, diverse and sustainable market able to support innovation and deliver services that promote positive outcomes for citizens and communities.	
What does good look like?	Draft questions to support peer challenge.
6.1 Commissioners demonstrate a full understanding of the local, regional and national market for relevant services to meet local need. They are clear about their commissioning priorities and strategic planning and market shaping functions ensure a vibrant, diverse and sustainable local market *that is able to deliver a range of high quality, appropriate, acceptable and equitable* services to meet identified care and support needs.	Do commissioners facilitate and promote systematic, comprehensive and open discussions with local Providers to help to ensure provision of local care and support services that meet the needs and aspirations of local people? *What evidence is there that the Council has a robust, evidence based understanding of the fair cost of care locally and that this informs its commissioning decisions?*
6.2 Commissioners actively encourage and promote investment and innovation in the market. They ensure *local contracting processes are proportionate and transparent,* promote long term relationships and accommodate the full range of care providers in order to deliver the best possible outcomes for local people.	
6.3 Commissioners have a good understanding of the Provider market and the fair cost of care. Their commissioning decisions take account of the commercial and financial context within which care providers operate and commissioners share risks and rewards appropriately with Providers	
6.4. Providers are encouraged and supported to consider the wider social, environmental and economic impact in the design and delivery of local services	
6.5 Commissioners have clear plans in place to prevent and manage provider failure, as appropriate	

Standard 6: Good commissioning promotes a diverse and sustainable market Good commissioning ensures a high quality, diverse and sustainable market able to support innovation and deliver services that promote positive outcomes for citizens and communities.	
What does good look like?	Draft questions to support peer challenge.
The commissioning and contracting approach encourages peer-led and other community based initiatives.	
Commissioning plans are underpinned by a robust understanding of the short and long term risks and sustainability of the local market and are responsive to fluctuating needs and demand.	
What actions do we need to take to meet Standard 6	

Standard 7: Good commissioning provides value for money Good commissioning ensures a good balance of quality and cost to make the best use of resources and achieve positive outcomes for people and their communities.	
What does good look like?	Draft questions to support peer challenge.
7.1 Commissioners understand the balance between the cost, quality and effectiveness of care and support services. Financial and quality data has a strong influence on contract specifications and costs.	Do commissioners use robust methodology and financial analysis to ensure the fair cost of care underpins locally commissioned care and support services? Are there robust and collaborative monitoring arrangements in place to ensure safe, good quality care and support services?
7.2 Commissioners effectively collect and monitor activity, cost and quality data and routinely share this information with providers, people who use services and the regulator.	
7.3 Commissioners use appropriate research methodologies to identify good practice and use this evidence to benchmark local services and drive improvement.	
7.4 Commissioners consider long-term economic benefits of using sustainable commissioning and procurement processes including preventative approaches and sustainable development.	
Strong, effective and transparent working between commissioners, the Regulator and safeguarding means that quality or safeguarding issues are addressed promptly	

and appropriately, with clarity around roles and responsibilities and a clear strategy for intervention. These arrangements are well publicised and shared with partners and local people.	

What actions do we have to take to meet Standard 7

Standard 8: Developing the commissioning and provider workforce Good commissioning requires competent and effective commissioners and facilitates the development of an effective, sufficient, trained and motivated social care workforce. It is concerned with sustainability, including the financial stability of providers and the coordination of health and care workforce planning.	
What does good look like?	Draft questions to support peer challenge
8.1 Commissioners have information and analysis of the local care workforce and work closely with partners to ensure there is a shared understanding of employment trends and risks. There are clear actions in place to ensure that the current and future workforce has the capacity, skills and knowledge to *lead,* commission, manage and deliver high quality social care and support.	*What evidence is there that the Council has taken steps to analyse and map the capacity and skills of the local care workforce and is working proactively to ensure a sufficient and skilled workforce is available to support local care and support needs in the short, medium and long term?*
8.2 Service contracts clearly specify the critical importance of a sufficient, skilled and motivated workforce and commissioners are confident and can evidence that fees and contracts allow providers to deliver staff terms and conditions that meet statutory obligations and reflect good practice including payment of at least the National Minimum Wage.	
8.3 Commissioners work collaboratively within the Local Authority and with key commissioning partners to develop job roles and skills that promote effective integration and improve outcomes.	
8.4 Commissioners use national and local workforce and other data to inform commissioning plans, contract specifications and local learning and development plans	
8.5 Commissioning roles are clearly described, with appropriate learning and development opportunities.	
8.6 There is a continuous culture of learning for all commissioners, the Executive Team and elected members, to ensure that the organisation is responsive and innovative.	

What actions do we need to take to meet Standard 8

Standard 9: (previously s.5) Good commissioning promotes positive engagement with all local providers of care Good commissioning promotes positive engagement with all providers of care and support. This means market shaping and commissioning should be shared endeavours, with commissioners working alongside people with care and support needs, carers, family members, providers and the public to find shared and agreed solutions.	
What does good look like?	Draft questions to support peer challenge.
9.1 Commissioners develop relationships with all local care providers to enable the design and delivery of services that meet the care and support needs and outcomes that local people want.	*Is there evidence that the Council supports local Providers to ensure their staff are well supported and trained and are able to deliver safe, personalised, quality services?*
9.2 Commissioners conduct open and transparent conversations with providers who are actively involved in the commissioning cycle and are able to plan and invest in local services.	
9.3 Relationships between commissioners and providers are open, respectful and honest. Providers share information about costs, profit margins and the terms and conditions of staff and Local Authorities share information about cost assumptions and the rationale for fee and contract decisions.	

at actions do we need to take to meet Standard 9

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"Developing a partnership approach to Quality in Haringey"

Workshop Summary 15th September 2015

Attendance

Attended by representatives from :

- Clinical Commissioning Group
- Healthwatch Haringey
- Local Authority
- Autism Working Group
- Homes for Haringey
- BEH Mental Health
- LD Partnership Board
- One Housing
- Safeguarding Adults Board (Chair)
- Older People's Forum
- Children's Safeguarding Board

Workshop Objectives

- Provide an opportunity to come together with other key stakeholders to share knowledge and identify areas of common interest.
- Identify and agree some key priorities that will benefit from a partnership approach.
- Agree next steps for a group that has as its focus a partnership approach to delivering quality outcomes to the people of Haringey

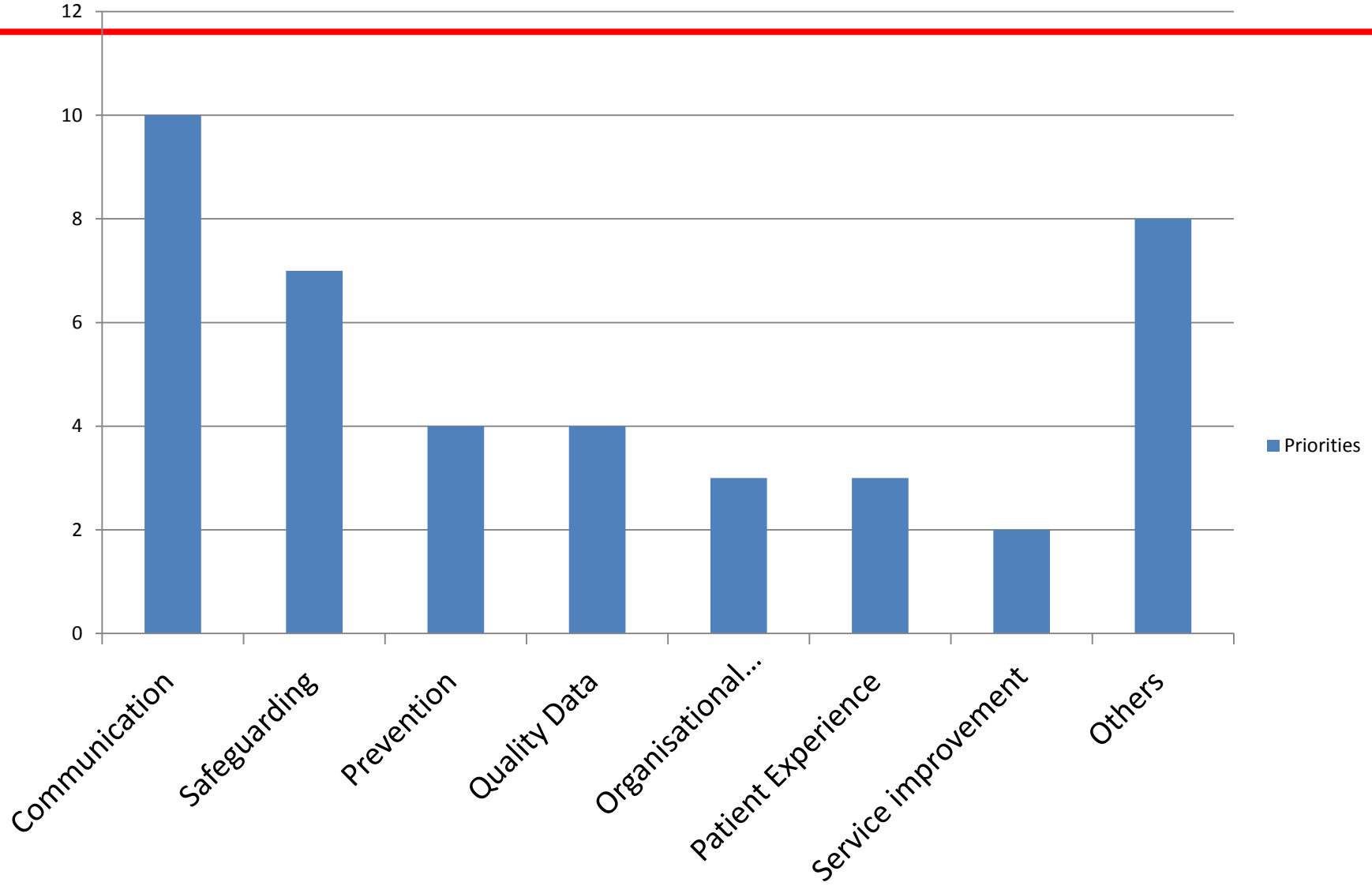
Workshop Outline

Time	Item
10:30 	Welcome and Introductions ➢ Agreeing Objectives ➢ Outline of the day
10:45	Speed Dating ➢ Sharing your priorities
11:10	Table Exercise ➢ "What do we mean by quality?"
11:55	Break
12:10	Group Discussion ➢ " How might we work together to improve Quality?"
12:50	Next Steps
12:55	Close

Priorities

Communication x 10 - Better relationship - Less silos - Improved pathways - Co-ordinated care - Service User Engagement - More streamlined processes	Safeguarding x 7 - Partnership approach - Improved services - Multi agency response
Prevention/enablement supporting independence x 4	Quality Data x 4
Organisational Development x 3	Patient experience x 3
Service improvement x 2	Process of recovery
Transitions	Sustainability of health
Advocacy and Support	Achieving Health status
Quality provision	Service user experience
Dignity Code	

Priorities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10
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Communication
Safeguarding
Prevention
Quality Data
Organisational...
Patient Experience
Service improvement
Others
Priorities

Next Steps

- To focus initially on better communication and safeguarding across the partnership.
- To look to develop quality champions in each organisation that can signpost people appropriately and facilitate better connections between organisations.
- To broaden the conversation to include providers (attend provider forum and extend invitation to include health and community organisations)
- Review current safeguarding intelligence to identify where more strategic interventions may improve quality across the system.
- To look to integrate safeguarding across the partnership, developing a multi-agency approach.
- To meet again before the end of the calendar year.

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Report for: Adults & Health Scrutiny Panel, 5 October 2015

Item number: **9**

Title: Haringey Better Care Fund (BCF) Plan Update

Report authorised by : Beverley Tarka, Director of Adult Social Services

Lead Officer: Marco Inzani, Commissioning Lead: Better Care Fund
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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 Adults Health & Scrutiny Panel 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 system integration. Progress has been made to develop collaborative working between the health and social care sector. The following paper outlines how: the BCF budget has been assigned; the main target of a reduction in emergency hospital admissions is progressing; outcomes are progressing; the public are being engaged; national conditions are being met; key milestones are being delivered; risks and issues have been identified; and the BCF programme is being governed. The information presented should give the Adults Health and Scrutiny Panel the assurance that the Haringey BCF is make 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:

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.	

Scheme	Service	2015/16
	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.	
	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	Service	2015/16
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**

5.6. 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.

5.7. 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)

5.8. 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)

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

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

5.10. 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.

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

NELs	Q1 15/16
Baseline	5934
Actual	5684
Variance	250
% Reduction	4.21%

5.12. From these figures Haringey is meeting both the Haringey Ambition and 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. However 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) to give assurance that the contingency fund could be released.

5.13. 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 growth in Total NELs.

Outcomes

5.14. 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+	Target	105.4
		Actual	136.5
Proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services.	65+	Target	
		Actual	
Delayed transfers of care (delayed days) from hospital per 100,000 population	All Ages	Target	1780
		Actual	1792
Injuries due to falls in older people per 100,000 population.	65+	Target	111
		Actual	136
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	Target	57.5%
		Actual	56.84%

5.15. 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. Delayed Transfers of Care is 1% over target (which is within a 10% tolerance). Both the Care Home Outcome (30% over target) and the Falls Outcome (23% over target) are significantly over target. The factors that can contribute to these outcomes are varied and complex and so it has been agreed to undertake a more thorough analysis (deep dive) to examine a range of supporting data to determine if an appropriate response can be explored.

Public and Service User Priorities

5.16. In addition to the BCF outcome measures, Haringey has surveyed over 200 local people and service users and has summarised their priorities as follows. Integrated services will (be):

- **Easy to access**, through a single point of access
- **Well managed** and provided by competent professionals and staff
- **Person Centred** and personalised to the experiences and views of people who use them
- **Provide good and timely information**, from a variety of sources including the voluntary and community sector
- **Enable individuals to do things for themselves** through prevention , self-management and reablement

- **Work together as one team**, including the patient/service user, with clear and constant communication
- **Promote wellbeing and reduce loneliness** through community capacity building.

5.17. 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.

5.18. 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 two months focused on a different theme connected to the BCF. The next event will be in November and will focus on the services in the Effective Hospital Discharge Scheme.

National Conditions

5.19. 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

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

Service	Progress
Locality Team	Implemented a Locality Team Test and Learn Pilot with two GP practices (Lawrence House and Morris House) 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 Worked with GP Collaboratives on initiatives to co-ordinate the care of older people with frailty Developed the Locality Team model based on evidence from the Value Based Commissioning (VBC) workshops Developed and agreed a Locality Team business case using local and national evidence for care co-ordination Launched the Locality Team Incentive Scheme for GPs to expand the coverage to all GP practices in Haringey
MDT	Continued the use of MDT Teleconferences Agreed to expand the MDT teleconferences to discuss Locality Team service users
Lymphedema	Continued to deliver and monitor these services 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 Initiated a review of these services as part of the LBH Transformation Programme Initiated the development of an Intermediate Care Strategy to develop options for the delivery of intermediate care including the Effective Hospital Discharge services.
Step Down	
Home From Hospital	Continued delivery of this service via Living Under One Sun up to 31 August 2015 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 service initiated to start from October 2015
Supported Self-Management (Diabetes)	Purchased diabetes DVD resources (in different community languages) and access for local people to a diabetes support website Procurement of self-management service initiated to start from October 2015

Service	Progress
Interoperable IT	Agreed to develop requirements for interoperable IT across adults, children's and mental health.
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 Delivered several workshops in response to the themes that emerged from the listening events: Understanding Professional Roles and Building Relationships Skills for Leading Change Joint Assessment & Care Planning 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 Agreed a Carers Business Case to support the assessment and support of carers

Risks and Issues

5.21. 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 the release of the contingency fund is dependent on this performance. To mitigate this risk modelling within the Haringey BCF has been used to determine the deliverability of 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.

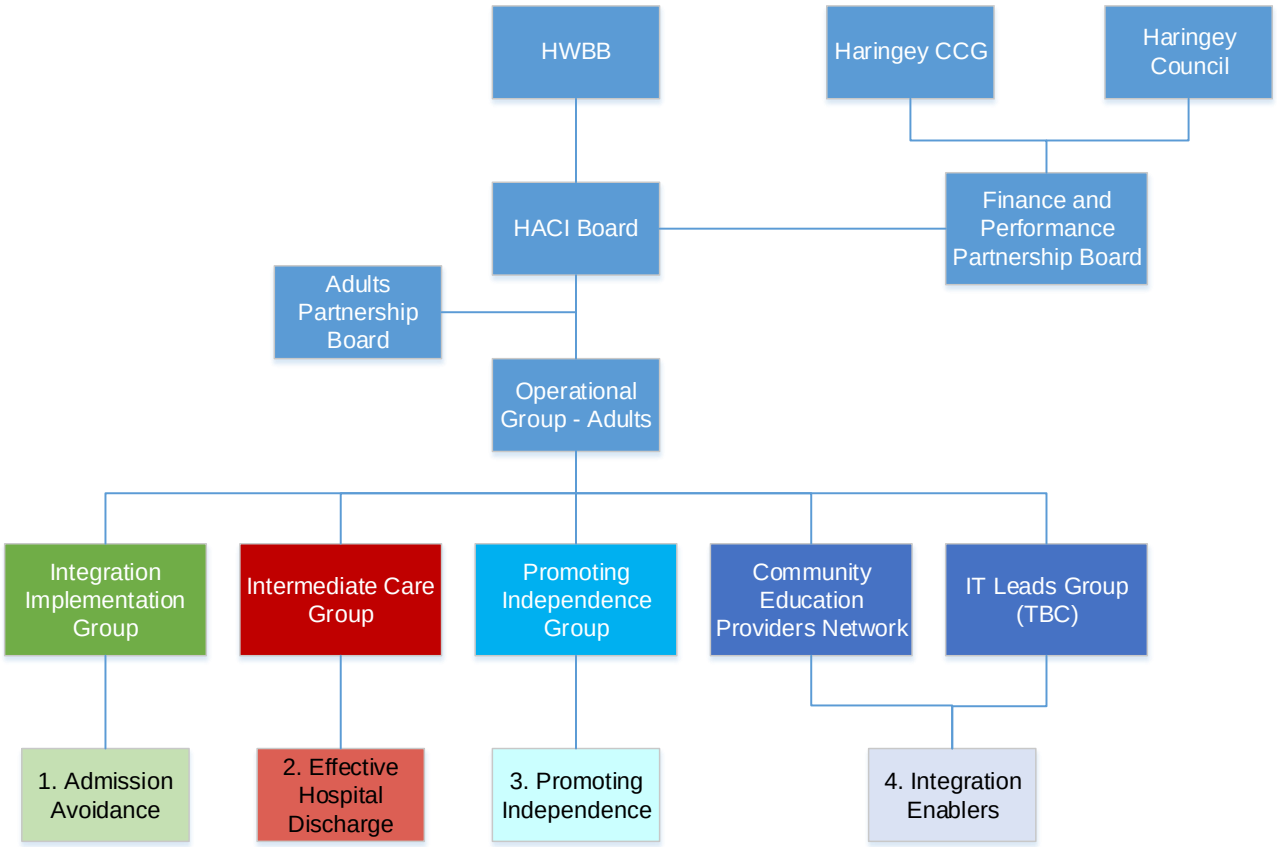
5.22. A number of the other risks identified have some shared cross cutting themes:

- 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 future budget and targets for the BCF have not been confirmed by NHS England beyond April 2016 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

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



5.24. 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. Once a quarter all finance and performance is overseen by the Finance and Performance Partnership Board. The HACI Board and the Finance and Performance Partnership Board are the only meetings that are exclusively for senior managers in LBH and Haringey CCG.

6. Contribution to strategic outcomes

6.1. 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

6.2. 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.

6.3. 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.

6.4. 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.

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

7.1. Finance and Procurement

7.1.1. 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.

7.1.2. 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.

7.2. Legal

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

7.3. Equality

7.3.1. 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.

8. Use of Appendices

8.1. Not Applicable

9. Local Government (Access to Information) Act 1985

9.1. 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

Report for: Adults and Health Scrutiny Panel – 5 October 2015

Item number: **10**

Title: Work Programme Update

Report authorised by : Bernie Ryan, Assistant Director of Corporate Governance

Lead Officer: Clifford Hart, Democratic Services Manager, 0208 489 2920, clifford.hart@haringey.gov.uk

Ward(s) affected: All

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 This report gives details of the proposed scrutiny work programme for the remainder of the municipal year.

2. Cabinet Member Introduction

N/A.

3. Recommendations

3.1 (a) That the Panel considers its future work programme, attached at **Appendix A**, and considers whether any amendments are required.

(b) That the Overview and Scrutiny Committee be asked to endorse any amendments, at (a) above, at its next meeting.

4. Reasons for decision

The work programme for Overview and Scrutiny was agreed by the Overview and Scrutiny Committee at its meeting on 27 July 2015. Arrangements for implementing the work programme have progressed and the latest plans for the Adults and Health Scrutiny Panel are outlined in **Appendix A**.

5. Alternative options considered

5.1 The Panel could choose not to review its work programme however this could diminish knowledge of the work of Overview and Scrutiny and would fail to keep the full membership updated on any changes to the work programme.

6. Background information

6.1 The careful selection and prioritisation of work is essential if the scrutiny function is to be successful, add value and retain credibility. At its first meeting of the municipal year, on 8 June 2015, the Overview and Scrutiny Committee agreed a process for developing the 2015/16 scrutiny work programme.

6.2 Following this meeting, a number of activities took place, including a public survey and Scrutiny Cafe, where over 90 suggestions, including a number from members of the public, were discussed by scrutiny members, council officers, partners, and community representatives. From these activities issues were prioritised and an indicative work programme agreed by the Overview and Scrutiny Committee in late July.

6.3 Whilst Scrutiny Panels are non-decision making bodies, i.e. work programmes must be approved by the Overview and Scrutiny Committee, this item gives the Panel an opportunity to oversee and monitor its work programme and to suggest amendments.

6.4 It had been agreed that the Adults and Health Scrutiny Panel would undertake a review on the issue of obesity. However, following an informal briefing on the Panel's work programme, held on 9 September 2015, it was agreed that time and resources, at this stage, should be prioritised by scrutinising, and preparing for, other items listed in the work programme attached at **Appendix A.**

Forward Plan

6.5 Since the implementation of the Local Government Act and the introduction of the Council's Forward Plan, scrutiny members have found the Plan to be a useful tool in planning the overview and scrutiny work programme. The Forward Plan is updated each month but sets out key decisions for a 3 month period.

6.6 To ensure the information provided to the Panel is up to date, a copy of the most recent Forward Plan can be viewed via the link below:

http://www.minutes.haringey.gov.uk/mgListPlans.aspx?RP=110&RD=0&J=1

6.7 The Panel may want to consider the Forward Plan and discuss whether any of these items require further investigation or monitoring via scrutiny.

Recommendations, Actions and Responses

6.8 The issue of making, and monitoring, recommendations/actions is an important part of the scrutiny process. A verbal update on actions completed since the last meeting will be provided by the Principal Scrutiny Officer.

7 Contribution to strategic outcomes

7.1 The individual issues included within the work plan were identified following consideration by relevant Members and officers of the priorities within the Corporate Plan. Their selection was specifically based on their potential to contribute to strategic outcomes.

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

Finance and Procurement

8.1 There are no financial implications arising from the recommendations set out in this report. Should any of the work undertaken by Overview and Scrutiny generate recommendations with financial implications then these will be highlighted at that time.

Legal

8.2 There are no immediate legal implications arising from this report.

8.3 Under Section 21 (6) of the Local Government Act 2000, an Overview and Scrutiny Committee has the power to appoint one or more sub-committees to discharge any of its functions.

8.4 In accordance with the Council's Constitution, the approval of the future scrutiny work programme and the appointment of Scrutiny Panels (to assist the scrutiny function) falls within the remit of the Overview and Scrutiny Committee.

8.5 Scrutiny Panels are non-decision making bodies and the work programme and any subsequent reports and recommendations that each scrutiny panel produces must be approved by the Overview and Scrutiny Committee. Such reports can then be referred to Cabinet or Council under agreed protocols.

Equality

8.6 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- Tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;
- Advance equality of opportunity between people who share those protected characteristics and people who do not;
- Foster good relations between people who share those characteristics and people who do not.

8.7 The Panel should ensure that it addresses these duties by considering them within its work plan, as well as individual pieces of work. This should include considering and clearly stating;

- How policy issues impact on different groups within the community, particularly those that share the nine protected characteristics;
- Whether the impact on particular groups is fair and proportionate;
- Whether there is equality of access to services and fair representation of all groups within Haringey;
- Whether any positive opportunities to advance equality of opportunity and/or good relations between people, are being realised.

8.8 The Panel should ensure that equalities comments are based on evidence. Wherever possible this should include demographic and service level data and evidence of residents/service-users views gathered through consultation.

9 Use of Appendices

Appendix A – Work Programme

10 Local Government (Access to Information) Act 1985

10.1 External web links have been provided in this report. Haringey Council is not responsible for the contents or reliability of linked websites and does not necessarily endorse any views expressed within them. Listings should not be taken as an endorsement of any kind. It is your responsibility to check the terms and conditions of any other web sites you may visit. We cannot guarantee that these links will work all of the time and we have no control over the availability of the linked pages.

Appendix A

Work Programme 2015/16 – Adults and Health Scrutiny Panel

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
29 June 2015	Primary Care in Haringey	An update on "Primary Care in Haringey" – including the Premises Task and Finish Group. Using the report from January 2015 as a template this item will provide an update on (a) Access to GPs/Buildings; (b) Primary Care Models moving forward; and (c) GP Co-Commissioning. In addition, this is an opportunity to look at options for scrutiny involvement moving forward, for example input from / questioning of NHS England.	Cassie Williams, Head of Quality and Performance, Haringey CCG Dr. Jeanelle de Gruchy Director of Public Health
	The principles and methodology that will support the consultation and co-production process for proposed changes to adult care services	An update on the redesign and re-provision of Adult Social Services – using the 16 June Cabinet report as a template. This paper informs Members of the principles and methodology that will support the consultation and co-production processes. The Cabinet Member for Health and Wellbeing will be in attendance for Q&As.	Cabinet Member for Health and Wellbeing Councillor Peter Morton Beverley Tarka, Interim Director Adult Social Services Charlotte Pomery, Assistant Director Commissioning
Cont...PTO			

Appendix A

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
29 June 2015	Quality Assurance and the Care Quality Commission in Haringey	To receive an update/info on: - The LBH improvement plan in relation to the CQC Sevacare – Haringey Inspection Report (May 2015) with information requested in relation to the strategic direction of the council as an enabler to support a diverse market place. - The progress that had been made in delivering the improvement plan for KLOE 5 – "*Is the service well led?*" in relation to the CQC Inspection of Haringey's Community Reablement Service (Update requested by the Scrutiny Panel in March 2015). - Options for keeping scrutiny informed of CQC inspections to ensure panel members are aware of, and are able to provide input to, trends emerging, especially in terms of safeguarding. This should include options for planned inspections and services where the inspections have already reported.	Beverley Tarka, Interim Director Adult Social Services Charlotte Pomery, Assistant Director Commissioning
	Scrutiny Work Programme Development	To set out some basic principles of good work programming and to provide an update on the public survey and Scrutiny Cafe.	Christian Scade, Principal Scrutiny Officer

Appendix A

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
5 October 2015	Care Quality Commission Inspection Programme	An opportunity for Members of the Panel to hear about the CQC's strategic approach to their regulatory and quality improvement work as well as to understand issues and trends arising from recent inspections locally as they affect Haringey residents. CQC to set out their future work programme and highlights from inspections already carried out. Martin Haines, Inspection Manager, CQC to attend.	Charlotte Pomery, Assistant Director Commissioning Martin Haines, Inspection Manager, CQC
	Quality Assurance and Safeguarding	Update report to include the following: - Draft QA Framework to be provided to the panel for comment before the framework is considered by SAB in October; - Case studies and information on roles and responsibilities; - Options for scrutiny involvement moving forward; - Report to outline how the framework will ensure links between quality assurance and safeguarding are understood and followed through.	Charlotte Pomery, AD Commissioning Beverley Tarka, Director Adult Social Services
Cont...PTO	Health and Social Care Integration	This item will provide an update on the corporate programme to set the scene but will focus on the Better Care Fund.	Beverley Tarka, Director Adult Social Services Marco Inzani Commissioning Lead for Better Care Fund

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
	Work Programme Update	A standing item to ensure the panel's work programme is kept under review throughout the year.	Christian Scade, Principal Scrutiny Officer
5 November 2015	The consultation and co-production process for proposed changes to adult care services (Title TBC)	To look at how the process was conducted	Beverley Tarka, Director Adult Social Services
	Mental Health and Wellbeing Updates	This item will cover: - Monitoring of actions outlined in the Joint Mental Health and Wellbeing Framework. For further information please see the minutes from the March 2015 AHSP meeting. - Monitoring of the recommendations made by the Transition from Child to Adult Mental Health Service Scrutiny Project. The Executive Response was considered by Cabinet in June 2015. Associated issues to be considered with the Chair as part of the agenda planning process.	Dr Tamara Djuretic, Assistant Director of Public Health
Cont...PTO	Access to GPs	Since the start of 2015 the Panel has received several updates concerning Primary Care in Haringey.	Jonathan Weaver, NHS England

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
		Moving forward, and in view of the plans for Tottenham Hale, the Scrutiny Panel have invited NHS England to attend their meeting on 5 November. With NHS England responsible for commissioning primary care (recognising there are now co-commissioning arrangements in place), and having already heard from Haringey CCG, the Panel would like an update from NHS England. The issues for discussion Include (a) plans for Tottenham Hale, (b) plans being developed out of the Strategic Premises Plan, and (c) an update on the premises infrastructure fund bid. Invitation to be sent to Haringey Healthwatch.	Cassie Williams, Head of Quality and Performance, Haringey CCG Dr. Jeanelle de Gruchy Director of Public Health
	Work Programme Update	A standing item to ensure the panel's work programme is kept under review throughout the year.	Christian Scade, Principal Scrutiny Officer
18 January 2016 **Cont...PTO**	Care Act Implementation	To include information on safeguarding following item scheduled for discussion on 5 October. What training and development opportunities, including site visits, do panel members require before this item is scrutinised? For further discussion.	Beverley Tarka, Director Adult Social Services

Appendix A

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
	LGA Peer Review *"Commissioning for Better Outcomes"*	An opportunity for scrutiny to focus on issues/actions relating to promoting a sustainable and diverse market place, and older people.	Beverley Tarka, Director Adult Social Services Charlotte Pomery, AD Commissioning
	Foot Care Update	Monitoring of previous scrutiny review recommendations plus consideration of issues discussed as part of the Scrutiny Cafe (June 2015) and Public Survey (May/June 2015). For further discussion, with consideration to be given to panel members taking part in other activities, such as site visits, to prepare for the item.	Beverley Tarka, Director Adult Social Services
	Alcohol and Tobacco	For further discussion based on priorities outlined in the Health and Wellbeing Strategy.	Dr. Jeanelle de Gruchy Director of Public Health
	Work Programme Update	A standing item to ensure the panel's work programme is kept under review throughout the year.	Christian Scade, Principal Scrutiny Officer
1 March 2016	Primary Care Update	To focus on Co-commissioning, the strategic direction for Primary Care in Haringey, and New Models of Primary Care with input from GPs.	Cassie Williams, Head of Quality and Performance, Haringey CCG
	Impact / monitoring of changes to adult care services	Q4 was suggested for this item to enable consideration of suitable data / insight. KLOE will focus on whether services are delivering the required standards and whether this is in accordance with the Council's commitments to local residents /	Beverley Tarka, Director Adult Social Services

Meeting Date	Agenda Item	Details and desired outcome	Lead Officer / Witnesses
		service users.	
	Cabinet Member Q&A	"Review of the Year" – similar format to be used as March 2015.	Cabinet Member for Health and Wellbeing Councillor Peter Morton
	Scrutiny Project Work	To consider any final project work and agree whether any reports should be considered for approval by the Overview and Scrutiny Committee on 8 March 2016.	Christian Scade, Principal Scrutiny Officer
	Work Programme Update	A standing item to ensure the panel's work programme is kept under review throughout the year.	Christian Scade, Principal Scrutiny Officer

Items still to be scoped / scheduled:

- Loneliness and isolation
    - On 29 June 2015 the Adults and Health Scrutiny Panel discussed a number of suggestions in relation to loneliness and isolation. Following further discussion, with the Panel Chair and officers, it's suggested the Panel carries out a "*deep dive*" on Neighbourhood Connects towards the end of 2015/16 (Q4) to ensure it is delivering agreed objectives / tackling issues associated with isolation and loneliness across the borough.

- Paediatric A&E attendances and admissions.
    - Following the Adults and Health Scrutiny Panel meeting on 29 June 2015 it was confirmed that:
        - "A&E attendances and admissions" would be picked up by the NCL JHOSC at their meeting in September 2015.
        - Scrutiny members would have an opportunity to look at some of these issues as part of the briefings that have taken place (and are planned – see below) with North Middlesex University Hospital NHS Trust concerning their Quality Account.
    - With this in mind it is suggested that any additional scrutiny wok by Haringey should only be considered after the September NCL JHOSC meeting, if appropriate.

- Men's Health Review – from 2011/12 – monitoring of previous recommendations

- Quality Accounts: North Middlesex University Hospital NHS Trust

- Following the joint briefing with LB Enfield in August 2015 the Trust suggested a follow up briefing could take place in January 2016 (TBC)

Items <u>not</u> to be taken forward:

- Obesity
  - Following an informal briefing on the panel's work programme, held on 9 September 2015, it was agreed that time and resources, at this stage, should be prioritised by scrutinising, and preparing for, other items listed on the work programme.