NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Thursday, 8th December, 2016, 6.00 pm - Haringey Civic Centre

Members: See enclosed.

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

1. FILMING AT MEETINGS

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

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

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

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

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda Item 15).

5. DECLARATIONS OF INTEREST

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

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

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

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

6. QUESTIONS, DEPUTATIONS, PETITIONS

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

7. MINUTES (PAGES 3 - 20)

To consider and agree the minutes of the meeting of the Board held on 12 September 2016.

STRATEGIC DISCUSSION ITEMS

8. HEALTH AND WELLBEING STRATEGY UPDATE (PAGES 21 - 48)

9. PRIMARY CARE ESTATES UPDATE (PAGES 49 - 56)

BUSINESS ITEMS

10. DEVELOPING AN ACCOUNTABLE CARE PARTNERSHIP ACROSS HARINGEY AND ISLINGTON (PAGES 57 - 64)

11. SECTION 75 AGREEMENT - LEAD COMMISSIONING ARRANGEMENTS (PAGES 65 - 68)

12. HARINGEY SAFEGUARDING CHILDREN'S BOARD (HSCB) AND HARINGEY SAFEGUARDING ADULTS BOARD (HSAB): ANNUAL REPORTS (PAGES 69 - 212)

13. CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN (PAGES 213 - 316)

14. NORTH MIDDLESEX UPDATE (PAGES 317 - 318)

15. NEW ITEMS OF URGENT BUSINESS

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

16. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The next meeting of the Board is 2nd March 2017 18:00-20:00.

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Wednesday, 30 November 2016

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	*Leader of the Council	Cllr Claire Kober
			*Cabinet Member for Children and Young People	Cllr Elin Weston
			*Cabinet Member for Finance and Health	Cllr Jason Arthur
	Officers' Representatives	3	Acting Director of Adult Social Services	Beverly Tarka
			Interim Director of Children's Services	Jon Abbey
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	*Chair	Dr Peter Christian
			Vice Chair	Dr Dina Dhorajiwala
			Chief Officer	Sarah Price
			*Lay Member (confirmed as voting member by Full Council 23/02/15)	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Chair	Sir Paul Ennals

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Agenda Item 7

MINUTES OF THE HEALTH AND WELLBEING BOARD
MONDAY 12 SEPTEMBER 2016

Board Members Present: Cllr Claire Kober (Chair), Councillor Jason Arthur (Cabinet Member for Finance and Health), Cllr Elin Weston (Cabinet Member for Children & Families), Dr Jeanelle de Gruchy (Director of Public Health), Sharon Grant (Chair, Healthwatch Haringey), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Peter Christian (Chair Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Cathy Herman (Lay Member, Haringey CCG) Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services) Geoffrey Ocen (Bridge Renewal Trust – Chief Executive).

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

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** The Chair welcomed those present to the meeting and the Board introduced themselves.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Sir Paul Ennals.	
CNCL103.	**URGENT BUSINESS** There were no items of Urgent Business.	
CNCL104.	**DECLARATIONS OF INTEREST** Dr Christian informed the Board that, in respect of commissioning primary care, one of the applications for central funding for new premises involved the Muswell Hill practice where he worked.	
CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** No Questions, Deputations or Petitions were tabled.	

CNCL106.	**MINUTES** The Board commented that there was a typographical error on page 2 of the minutes; the heading should read 'Intermediate Care and Integration.' The Board also noted that, on page 17 of the pack, the 4th paragraph should refer to the Chair of Healthwatch, not the Director. **RESOLVED:** That the minutes of the meeting held on 19th May 2016 be confirmed as a correct record.	
CNCL107.	**DISCUSSION ITEM** **FUTURE HEALTH AND WELLBEING OF THE POPULATION** A cover report was included in the agenda pack (pages 21-22), which updated the board on the work being undertaken at a local level around health and social care within Haringey; jointly between Haringey and Islington through the Wellbeing Partnership and, across North Central London through the Sustainable Transformation Plan. Zina Etheridge, Deputy Chief Executive introduced the report. A presentation was also given jointly to the Board by the Deputy Chief Executive and Sarah Price, Chair Haringey CCG. Hard copies of the presentation were tabled at the meeting. The Board were advised that together, Haringey & Islington were best placed to tackle local issues and lead transformational change at pace. However, the Board needed to start considering next steps to ensure the right structures were in place to work with communities to deliver better health and care over the long term. Some of the key considerations outlined in the presentation included: Whether there was a need for a more formal, shared governance structure with shared accountabilities, risks and incentives; should there be a more radical approach to pooling financial resources; how to improve the commissioner/provider relationships; and how to embed incentive structures aligned to outcomes rather than processes. The Board considered that any new approach would need to enable the Wellbeing Partnership to deliver improvements for residents, front-line change and financial efficiencies faster and more effectively. In summary, the Deputy Chief Executive advised that development of the STP for North Central London led to a series of questions about how best to deliver ongoing improvements to health and care in Haringey. The Board was informed that the next step was to start exploring	

whether a more formal arrangement for the Wellbeing Partnership could help achieve these improvements. The Deputy Chief Executive acknowledged that there was a significant amount of information to consider and suggested that the Board might want to consider and discuss its initial findings, and that subsequent conversations could be held either on a one-to-one basis or potentially at the next Joint Health and Wellbeing Board with Islington.

Cllr Weston, Cabinet Member for Children and Families commented that the increasingly formalised nature of joint working with both Islington and across NCL created the need for an overarching structure in place in order to ensure successful delivery. This was especially apparent given the resources already invested and the risks involved. The Chief Officer, Haringey CCG agreed that the process needed to be embedded and become more formalised, and advised that the focus was very much on the population as opposed to the organisations that sat within them. It was advocated that that this was crucial in making sure the services delivered met local needs.

The Deputy Chief Executive outlined that the initial emphasis for forming the Wellbeing Partnership was the application to become a vanguard organisation for the NHS's New Models of Care programme which, whilst unsuccessful, elicited further discussions around developing a new model of care that brought in Islington and a host of new providers and led to the establishment of the Wellbeing Partnership. The Deputy Chief Executive suggested to the Board that there was a spectrum of different models that could be used; from developing an Accountable Care Partnership to a much looser coalition governed by a Memorandum of Understanding. The Board noted that an Accountable Care Partnership tended to have budgets based on a per-head of population basis and that as a system, there would be a focus on what was the best way of spending that money to achieve the objectives required. Separate arrangements were likely to be required for specialist commissioning.

The Chair suggested that it was probable that there could be a significant devolution deal for London on the table around the time of the Autumn Statement, which would include aspects on fiscal devolution and also aspects of public service reform to make it more accountable and responsive. The Chair advised that part of the process would involve scaling up from working on a borough wide basis to a sub-regional or regional basis, and that there were clear synergies between this and the work being undertaken around further integrating health and care in Haringey. The Chief Officer, Haringey CCG suggested that there would also likely be further opportunities to apply for vanguard status and some of the pump priming funds to help get some of these new models up and running.

The Chair requested that members of the Board give further

	consideration to whether a more formal arrangement for the Wellbeing Partnership should be developed and also consider the potential models involved. Further consideration to be given outside of the meeting and in the run up to the joint Health and Wellbeing Board meeting on 3rd October. Geoffrey Ocen, Chief Executive of the Bridge Renewal Trust emphasised the need to agree a governance structure going forward, particularly in terms of the need to safeguard localised decision making. The Deputy Chief Executive acknowledged that there would be certain aspects that were best suited to being undertaken on pan-London or regional basis, some on an NCL basis and those that would be much more suited to a local basis. The Cabinet Member for Children and Families urged that an agreement would also need to contain the flexibility to allow other partners to come in when required. The Cabinet Member elaborated that as well as facilitating localised decision making, the agreement would also need to support further integration of health and care across the NCL region. Sharon Grant, Chair Healthwatch Haringey raised concerns about accountability and advocated the need to continue to make it clear to user groups where decisions were made. The Chair of Healthwatch Haringey also raised concerns around the potential for further broadening of collaborative working to harden the inequalities around the north-east of the borough and urged focusing on collaboration that tackled some of the significant health inequalities in this area. The Chief Officer, Haringey CCG agreed that a key challenge was to find how to broaden work with other partners, commissioning services together in order to deliver the range of services required for the population, including working with Enfield. The Chair advised that there had been a great deal of partnership working undertaken in recent months with Enfield around North Middlesex Hospital, which had also led to a number of discussions around the underpinning issues relating to primary care and the clear similarities between north Tottenham and Edmonton. The Chair noted the point about accountability and commented that this would be particularly important given that the STP process seemed to have taken place across the country with very little political oversight and suggested there was a clear need for transparency. **RESOLVED:** I). That the HWB notes developments on health and social care locally, with Islington and across North Central London.	All
CNCL110.	**DISCUSSION ITEM** **DEVOLUTION AND PREVENTION**	

A report was included in the agenda pack at page 25. Jeanelle de Gruchy, the Director of Public Health introduced the report to the Board. There was also a presentation which was included in the agenda pack at page 33. The report and presentation provided an update to the Board on progress of the Healthy Environment Strand of the Haringey Prevention Pilot. Following the presentation the Board discussed the findings.

The Board was advised that a business case outlining the proposals for the devolution pilot was presented to the London Health and Care Devolution Programme Board at the end of July. Haringey would continue to work with London partners and national government over the coming months to refine those proposals. A final business case was due to be submitted to the London Prevention Board by December 2016.

The Director of Public Health circulated three handouts which provided a conceptual approach to prevention, using a pyramid diagram to outline the primary, secondary and tertiary prevention approaches. The approaches to prevention were broken down into three types of intervention; population level, community development and personal services. The three diagrams represented the separate approaches for children and young people and for adults, as well as a version with 'I' statements i.e. how residents would experience the outcome of interventions.

The Chair enquired whether the empty boxes represented the absence of population level interventions at the secondary prevention stage or whether it suggested that there was an intervention that did not currently take place, but which might be developed in the future. The Director of Public Health advised that population level interventions also impacted as secondary and tertiary interventions. The Director of Public Health advised that this would be better illustrated in future versions of the diagram. The Board was given an example of someone recovering from a heart attack that utilised parks or council leisure services which were available to the whole population.

The Chair of Healthwatch Haringey suggested that one possibility in this area would be measures that were aimed at the whole population which increased understanding of certain conditions particularly within certain groups of the population. The Director of Public Health acknowledged that there was a cross cutting aspect of prevention around information advice and guidance and also stated that this was where the 'I' statements contained in the overview diagram were relevant.

The Lay Member Haringey CCG commented that the fuel poverty and work intervention captured on the adults diagram appeared to be

marooned between secondary and tertiary areas of prevention but could be considered to be more of a counterbalance to the whole of the population level activities. The Director of Public Health responded that the fuel poverty work tended to be targeted more toward older people. The Lay Member Haringey CCG elaborated that her concern was that by looking at specific interventions at the secondary and tertiary levels there was a risk of missing some of the wider determinants at a primary prevention level. The Lay Member Haringey CCG also commented that there were some issues around mental health that may not have been captured and that domestic violence was missing from the adults strand. The Director of Public Health acknowledged that the diagram was not comprehensive and agreed that the domestic violence strand could be added into the adults model. The Director of Public Health agreed that the broader point around work and employment could be captured under the existing intervention on place shaping through regeneration and planning; and done in way that reflected the overlap across primary, secondary and tertiary levels of intervention.

Jeanelle de Gruchy

The Director of Public Health went through the presentation with the Board. The devolution 'asks' were summarised as:

- Powers to address areas of problem gambling through greater local control of Fixed Odd Betting Terminals and devolved funding for local solutions to tackle problem gambling.
- Establish health as a 5th licensing objective to enable local authorities to take all health impacts into account when considering licensing applications.
- Tobacco control powers: Extending smokefree areas to smokefree outdoor restaurants, cafes and pubs; and introducing positive licensing of tobacco products.

The Board was reminded that Priority 2 of the Health and Wellbeing Strategy was to increase healthy life expectancy. The two ambitions that sat underneath this priority were: Ambition 3 - Haringey as a healthy place to live; and Ambition 4 – every resident enjoys long lasting good health. The Board considered that the Healthy Environment strand of the Prevention Pilot had clear links to Priority 2; particularly the performance measure for Ambition 4 around achieving a 25% reduction in early death from stroke by 2016-2018. The Board were invited to have a discussion, focusing particularly on the tobacco and smoke free outdoor restaurants, cafes and pubs 'ask'.

The Lay Member, Haringey CCG asked whether, in light of changing attitudes to smoking more generally, there was any information on how attitudes had changed to people smoking outside. The Director of Public Health responded that she didn't possess any specific information, but that she was aware of similar schemes which would have gathered significant feedback such as, Brighton's smoke free beaches scheme. The Director of Public Health agreed that some work

needed to be undertaken to gather all of that information together. The Lay Member, Haringey CCG commented that it would be a shame to have moved public opinion so far on smoking generally only to lose it with smoking outside, particularly as people may be equally concerned with air pollution caused by motor vehicles, for instance.

The Chair suggested that it would also be interesting to understand perception levels across different parts of the borough, as there could be parts of the borough or particular communities where smoking was much more prevalent and there would be an increased likelihood of push back to this type of intervention. The Chair also suggested that attitudes to smokefree restaurants may be different to say smokefree beaches or outdoor spaces more generally, as it was a defined space.

The Chair, Haringey CCG commented that the issue of perception was an interesting one and that Highgate and Muswell Hill had high levels of alcohol related illness, but that this was less obvious than in other less affluent areas of the borough. The Chair of Haringey CCG also suggested that the provision of alcohol for sale had become easier to access in recent years not harder, and that this was in stark contrast to tobacco.

The Director of Public Health advised that the business case was being further developed and that dialogue was ongoing with various government departments, therefore this piece of work was evolving quickly. The Director of Public Health suggested that she would keep Board members involved via email and welcomed any further feedback on the devolution feedback.

The Chair enquired whether there was any way of looking at licensing decisions that had been taken in the last two or three years for instance, to ascertain whether the presence of a fifth licensing objective around the health impact would have had a significant influence on determining those applications. The Director of Public Health responded that there was a piece of work underway looking into this, and that as part of this process Public Health had been challenged to look at what powers the local authority already had and whether these were being fully exercised.

The Chief Executive of the Bridge Renewal Trust sought clarification on the legal position of these powers and whether the Council had the power to carry out the proposed regulatory changes. Officers responded that this was part of the negotiation process with the DCLG and other government departments, and that any additional powers would need to be conveyed as part of the proposed Bill.

RESOLVED:

I). That the Board note the development of the Haringey devolution

	prevention pilot.	
CNCL111.	DISCUSSION ITEM VIOLENCE AGAINST WOMEN AND GIRLS The Board received a report and the Violence Against Women and Girls (VAWG) draft strategy as part of the agenda pack at pages 45 and 51 respectively. The strategy was out for public consultation and the Board were asked to give its views with a particular focus on the impact of VAWG on children and young people. The report was introduced by Fiona Dwyer, the Strategic Lead for Violence Against Women and Girls. The Board also received a presentation from the Strategic Lead for Violence Against Women and Girls with additional input received from Emily Sayer from the Highgate Woods Young Feminist Group. Ms Sayer outlined the role of the organisation and their experience of engaging schools around VAWG. Sean Thrasher and Celina Guler, two young people who had undergone training through the council-funded VAWG prevention project called Protect Our Women, also spoke to the Board as part of the presentation. Ms Sayer advised the Board that she had recently taken over responsibility for the Highgate Woods Young Feminist Group and that the group was established to provide a space for the girls at the school to discuss issues that were affecting them and to also make them aware that the issues involved affected society as a whole. Ms Sayer commented that discussions during meetings were often quite advanced and that examples of topics ranged from the school's uniform policy to casual sexism and cat-calling in the street. The students who attended the meetings ranged from years 7-13 and Ms Sayer considered that the students' awareness of, and ability to engage around, those issues was clearly beneficial. However, it was also worrying that students at such a young age were so affected by these issues and this demonstrated the need for a group of this type. The group was in the process of arranging for a workshop session with the Strategic Lead for Violence Against Women to come to the school and speak to pupils. The Deputy Chief Executive asked what the impact was on the children of being able to have these discussions. Ms Sayer responded that the Head Teacher had spoken to staff on the first day of term around the way in which the uniform policy was enforced and that this was a tangible demonstration that the discussions had had an effect. Less tangible impacts were around offering them advice on how to deal with particular situations and creating a sense of community; reassuring them that other people were feeling the same way as them.	

The Cabinet Member for Children and Families asked whether boys were able to and encouraged to join the group. Cllr Weston elaborated that part of the proposed strategy around VAWG was to focus on perpetrators and that in the instance of cat-calling most perpetrators would be boys and young men. Ms Sayer responded that some of their sessions were targeted at particular groups and that some of these sessions were open to both boys and girls but that it was a case of seeing what the students felt most comfortable with.

The Strategic Lead for Violence Against Women and Girls introduced Sean Thrasher and Celina Guler and advised that the Protect our Women programme was a 12 week programme funded by Public Health looking at the whole spectrum of VAWG and supporting young people to become champions around prevention work, which was one of the four key priorities contained in the VAWG Strategy. The Board was advised that whilst undertaking the programme, Mr Thrasher realised how much he was unaware of the issues surrounding VAWG. The first lesson incorporated a TED talk on domestic abuse by an author named Lesley Steiner and it was noted that what was striking was that despite being very intelligent and successful she was completely oblivious to the fact that she was a victim of domestic abuse. Complete ignorance about the subject was typical of the experience of most people living with domestic abuse. As well as introducing the young people to a variety of topics that they may not have otherwise had exposure to, the programme also offered practical advice about what to do and where to go if the students suffered from domestic violence or abuse.

Ms Guler reiterated that undertaking the programme had helped her to come in to contact with and explore a number of issues, such as FGM and forced marriage that she had previously known nothing about. The topics discussed were very important and the programme offered a forum to engage with these issues in an environment that the young people were comfortable with. In response to a question, the Board was advised that the course was a voluntary course based after school with around 10-20 people in each group. Approximately 200 young people in Haringey had been through the programme; across a number of schools and sixth form, and the take up was around 55% girls and 45% boys.

The Director of Public Health asked whether the POW programme had had an effect on challenging or changing behaviour. The Board were advised that there had been a noticeable impact on students and that the course had allowed the students to learn significant life skills. In addition, it was noted that although 200 students had undertaken the programme, they were also discussing it with their wider social groups and that the cumulative impact would be much greater than just those who attended the programme. In response to a question about whether there would be an appetite for groups targeted specifically at

	males, the Board was advised that this would be useful in certain topics but that maintaining the overall format of mixed groups was preferred. The Lay Member Haringey CCG, asked whether during discussions, the students had identified areas where there wasn't enough being done, especially in terms of some of the agencies who were present at the Board. Mr Thrasher responded that he was unaware of any specific areas but suggested that there was always scope to do more. The Director of Public Health drew the Boards' attention to Appendix 2 of the report which set out the health impacts of violence on young people and the scale involved. The Director of Public Health emphasised that this was a key link for the Health and Wellbeing board to consider. The Board noted that the consultation on the strategy was due to run from 1st August to 30th September 2016. The Chair, Healthwatch Haringey asked whether the consultation period could be extended; particularly given that it was due to take place over the summer holidays and the need to fully engage with the voluntary and community sector. The Board was advised that this consultation was a top level strategic approach to VAWG and that there would be subsequent opportunities to engage with a variety of groups around implementation and delivery plans. Future engagement exercises would be done on a community level basis. It was planned that there would be seven survivor focus groups based around each of the key areas of VAWG, as well as working closely with children's centres and community engagement teams to access smaller groups that council services may not necessarily come into contact with. The Chair requested that the Clerk circulated the VAWG Strategy consultation plan to the Board, including details of the different survivor focus groups proposed. The Board to consider whether there were any other groups that should specifically be targeted as part of the consultation process. The Chief Officer, Haringey CCG enquired how the consultation would fit in with the Community Safety Partnership and what their engagement with the process was. The Director of Public Health responded that the Community Safety Partnership had ownership of the strategy and the VAWG strategic group fed into the Community Safety Partnership. The Director of Children's Services advised that an independent diagnostic evaluation was undertaken in July with police, health, social care, early help and other strategic leads. The Board considered that the lines of enquiry included: how services responded to domestic abuse, what the quality and impact of assessment and decision making was, whether there was effective leadership and management	Clerk/ Board

	across partners, and a number of cases were also reviewed. There were ongoing challenges identified around the need for better joining up of services and the need to strengthen the strategic focus on domestic abuse, as well as the need to put in place an alternative service model to undertake first response. The Board considered that there was significant amounts of work being done on an operational as well as strategic level, and the need to join up the two levels. The Cabinet Member for Finance and Health commended the strategy and suggested that the strategy would be developed further, with further engagement undertaken on delivery of the overarching principles and an action plan. The Cabinet Member for Finance and Health advised that the strategy seemed to omit faith groups from the consultation progress. The Chair acknowledged that the Cabinet Member for Communities had already picked up on this point and that faith groups would be included in the consultation. RESOLVED: I). To note the VAWG Strategy, and how the Board could contribute to the delivery of the Strategy.	
CNCL112.	BUSINESS ITEMS REVIEW OF MEMBERSHIP AND TERMS OF REFERENCE The Board received a report which outlined proposed changes to the Board's membership and terms of reference following a review undertaken, as agreed at the Board meeting of 26th February 2016. The report was introduced by Stephen Lawrence-Orumwense, Assistant Head of Legal and was included in the agenda pack at page 77. The aim of the review was to ensure the right level of representation to provide system leadership for Haringey and its residents, and to take account of wider developments across the local health and care system. The developments mentioned in the review included the introduction of five year Sustainability and Transformation Plans, the increasing collaboration between Haringey and Islington health and care economies, and the statutory footing of the Safeguarding Adults Board under the Care Act 2014. The review also considered the Board's terms of reference to ensure that they reflected current operations and supported its future ambitions. The Board was advised that following consideration of the paper, any revisions to membership would go forward to Full Council for approval. The Board was advised that one of the key findings of the review was that the Board should consider maintaining its existing terms of reference as they provided clear mechanisms for engagement, but that	

	the board should seek to utilise these frameworks in order to engage with other stakeholders. Furthermore, the review also identified some minor changes in order to better reflect its current way of working; including formalising the inclusion of the Deputy Chief Executive to the Board and the inclusion of the Independent Chair of the SAB. The review further proposed that the terms of reference should be amended to reflect the Board's ambition to collaborate across borough boundaries and to enter into joint working arrangements with other HWB's. The Chair of Healthwatch Haringey suggested that the review raised questions about the role of the Health and Wellbeing Board and advocated that there was a serious problem of local accountability in terms of Health and Social Care. The Chair of Healthwatch Haringey commented that the recent review of the workings of the partnership boards was fairly critical of the way those boards represented the users of health and social care services and suggested that the Health and Wellbeing Board had minimal representation of patients and service users in its current format. The Chair of Healthwatch Haringey suggested that one solution might be to undertake supplementary activities under the auspices of the Health and Wellbeing Board to enable further patient and user engagement. The Board was advised that there had been significant changes to health and social care in the last year, particularly around the closure of residential homes and services for people suffering from conditions such as autism and dementia. The Board considered that the relatives and families of those affected had to go through a very stressful process, addressing a number of different forums to voice their disapproval. The Cabinet Member for Health and Finance commented that in relation to the recommendations contained in the above mentioned report there was a cafe meeting planned in order to discuss the best way to ensure the voice of residents was heard through the partnership board process. The Cabinet Member for Health and Finance acknowledged the need to engage with users and residents more broadly but suggested that inclusion of a further representative on the Board could be tokenistic and suggested that engagement might be best done outside of the confines of Board meetings. The Leader commented that she was concerned about where the strategic partnership space would be if it wasn't through this Board. In addition, the Leader responded that those who had objections to the closure of services were now involved in the process, as well as having given a number of deputations to Council bodies such as Cabinet, Full Council and Overview & Scrutiny, as well as numerous other informal groups. The Lay Member, Haringey CCG advocated that the role of the Board was to challenge all of the organisations to consult and engage with	

residents and to ensure that they did it well. It was also suggested that it was undesirable to get one or two people to fully represent a diverse range of service users and that instead the Board as a whole should be responsible for facilitating engagement across different levels and holding each other to account for this.

The Director of Adults Social Services advised that the review of the workings of the partnership boards was commissioned by the Council in recognition of the need to make partnership boards operate more effectively. A co-production steering group had been established where users had been encouraged to engage and have a meaningful voice in terms of design and delivery of service. In response to a question around how residents accessed the Board, the Chair advised that there was the ability for residents to come and give deputations, bring petitions or ask questions of the Board. The Board noted the presentation on primary care capacity in Tottenham Hale, in response to the Healthwatch report, by way of an example which demonstrated a clear outcome.

RESOLVED:

I. That the existing framework in the Board's terms of reference should be used to engage other partners or stakeholders to contribute to the workings of the Board as systems leaders;

II. That the HWB reviews reporting links between the Board and other relevant partnerships or forums and considers ways in which these links could be strengthened to contribute to the workings of the Board;

III. That the current Local Authority membership of the HWB should be amended to include the Deputy Chief Executive who has the strategic oversight of children and adult social care and public health;

IV. That the current membership of the HWB should be amended to include the Independent Chair of the Safeguarding Adult Board (with attendance at meetings when appropriate) and the membership of the Independent Chair of the Local Safeguarding Children Board should be on the same footing; and

V. That the HWB terms of reference should be amended to reflect the Board's ambition to collaborate across borough boundaries and pan London and to enter into joint working arrangements in its area of responsibility with other HWBs and for the benefit of residents of the borough.

COMMISSIONING PRIMARY CARE

The Board received a report which set out the ongoing work in Haringey in relation to Primary Care, specifically around General Practice. The report was introduced by Cassie Williams AD Primary Care Quality and Development, Haringey CCG and was included in the agenda pack at page 91 and the Haringey General Practice Development Programme 2016-17 was also included in the agenda pack as an appendix to the report at page 97.

The report included an update on Primary Care premises development, particularly in relation to the new zero list practice in Tottenham Hale, which opened on 31st August, and additional work being progressed to secure adequate and appropriate premises for general practice in Haringey. This work was developed out of the Haringey Strategic Premises Development Plan which was presented to the Health and Wellbeing Board on 23rd June 2015. The report further detailed the current and future options for Haringey in relation to primary care commissioning. Haringey CCG, in collaboration with the other 4 CCGs of North Central London, currently jointly commissioned General Practice together with NHS England but was being invited to consider whether to submit an expression of interest to take on Level 3, delegated commissioning from April 2017.

The Chair of Healthwatch Haringey raised concerns about maintaining adequate levels of accountability in General Practice going forwards and enquired what mechanisms were in place to ensure that any future gaps in primary care capacity would be addressed. The AD Primary Care Quality and Development responded that there was significant work underway in the development and use of dashboards to produce high-level data and to flag up any quality concerns in relation to practices. The CCG and partners were increasingly developing their evidence base to ensure that they had a firm understanding of the health care situation in Haringey. The Deputy Chief Executive advised that the Board had previously agreed that an assessment of primary care in the borough would come back to the Board at an appropriate point in the cycle, to ensure strategic oversight was maintained. In response to a question, the AD Primary Care Quality and Development responded that the dashboard data was reviewed through internal governance routes, such as the primary care transformation boards and was also disseminated to GP practices, and was part of the peer review process.

The Board considered the report and noted its contents.

COMMISSIONING INTENTIONS

The Board received a report which set out the Haringey CCG and local authority draft commissioning intentions for 2017/18. The report was introduced by Sarah Price, Chief Officer Haringey CCG and was

	included in the agenda pack at page 103. The Health and Wellbeing Board were advised that organisations' Commissioning Intentions were developed each year in order to signal changes to contractual process, any services to undergo procurement or any changes to strategy. For the purposes of NHS organisations formal notice of contractual changes needed to be issued to providers by 30 September. The Board considered that Haringey (LBH and CCG) had been developing joint Commissioning Intentions for 2017-2020. The Board was advised that the Commissioning Intentions would fall under the STP going forwards and that broader intentions would be developed across the five boroughs. RESOLVED: I). To note the progress on the Commissioning Intentions. SECTION 75 A report was included in the agenda pack at pages 109-220, which proposed the implementation of a model of commissioning and pooled budgets supported by a partnership agreement under S.75 of the National Health Services Act 2006. The partnership agreement set out the shared outcomes and objectives sought, and contained detailed schedules which enabled; lead commissioning and pooled budgets for specified care groups. Whilst the initial focus was on adult services, the partnership agreement would act as a framework and was designed to enable schedules to be added for other care groups, including Children's Services, as required. The partnership agreement was due to be presented to Cabinet for approval on 13th September 2016 and to the CCG's Governing Body for approval on 23rd September 2016. The implementation of pooled budgets was due to be in place by April 2016. In response to a request from the Cabinet Member for Children and Families, the Board agreed that the Cabinet Member and Director of Children's Services would be added to the oversight body at the point in which any pooling of budgets was undertaken for Children's Services; in order to ensure the requisite oversight mechanisms were in place. The Chair of Haringey CCG agreed to feed back this request. RESOLVED: The Health and Wellbeing Board was asked to consider and endorse the proposed S.75 Partnership Agreement between the Council and the CCG which provides for: I. Lead commissioning and the establishment and maintenance of	Sarah Price

	pooled fund for the commissioning of learning disability services for eligible adults resident in Haringey; II. Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of mental health services for eligible adults resident in Haringey; III. Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of older people's services, including those services identified in the Better Care Fund 2016/17, for eligible adults resident; IV. Joint commissioning and the establishment and maintenance of a pooled fund for the commissioning of children and adolescent mental health services for the residents of the London Borough of Haringey; V. Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for eligible adults resident in Haringey: and VI. which is attached as Appendix 1 of the report and is due to be considered by the Cabinet and the CCG's Governing Body in September.	
CNCL113.	ACTION LOG The Board noted the action log.	
CNCL114.	NEW ITEMS OF URGENT BUSINESS No new items of Urgent Business were tabled.	
CNCL115.	FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS It was noted that the future meeting dates were: • 8th December 2016 at 18:00 • 2nd March 2017 at 18:00	

The meeting closed at 20.05pm.

Cllr Claire Kober

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Chair of the Health and Wellbeing Board

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Report for: Health and Wellbeing Board – 8 December 2016

Title: Haringey Health and Wellbeing Strategy 2015-18 update

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

Lead Officers: Dr Tamara Djuretic, Assistant Director of Public Health, Haringey Council
Deborah Millward, Healthy Public Policy Officer, Haringey Council
Rachel Lissauer, Acting Director of Commissioning Haringey Clinical Commissioning Group
Dr Will Maimaris, Consultant in Public Health Haringey Council

1. Describe the issue under consideration

1.1 This report describes progress in delivering Haringey's Health and Wellbeing Strategy 2015-18 (appendix 1). The report also presents the challenges in delivering the ambitions and areas of focus for the next 18 months.

2 Recommendations

2.1 The board is asked to note progress in implementing the health and wellbeing strategy over the last 18 months and agree the key areas of focus for the next 18 months.

3 Background information

3.1 Haringey's 2015-18 Health and Wellbeing Strategy was approved by the Health and Wellbeing Board following a consultation with residents and partners in 2015.

3.2 The vision is to work with communities and residents to reduce health inequalities and improve the opportunities for adults and children so that they can enjoy a healthy, safe and fulfilling life.

3.3 Nine ambitions for the strategy were identified with three priority areas where we need to make the most significant and sustainable improvements:

1. Reducing obesity
2. Increasing healthy life expectancy
3. Improving mental health and wellbeing.

3.4 In order to deliver improvements in these areas, the Health and Wellbeing Strategy has been implemented through 3 complementary approaches:

1. A **population health** approach to make Haringey a healthier place to live through ensuring that policies developed by all sectors contribute to health-promoting conditions and to create supportive environments that impact positively on people's health

2. A **community health** approach that will build capacity to support improved health and wellbeing in our communities and to enable people to have the knowledge and skills to meet life's challenges and to contribute to society

3. A **personal health** approach which is about developing joined up services which prevent and respond to individual health and care needs.

3.5 These approaches operate at 3 levels of prevention:

1. **Primary prevention** includes health promotion and requires action on the determinants of health to prevent disease occurring. It has been described as refocusing upstream to stop people falling in to the waters of disease.
2. **Secondary prevention** is essentially the early detection of disease, followed by appropriate intervention, such as health promotion or treatment.
3. **Tertiary prevention** aims to reduce the impact of the disease and promote quality of life through active rehabilitation.

3.6 Haringey's Prevention Pyramid provides a diagrammatic presentation of these approaches (Appendix 2).

3.7 In the first 18 months of delivering the Health and Wellbeing Strategy we have made progess in the following areas:

1. Establishing strategic frameworks for delivery, such as the mental health framework, Health in All policies and the Community Wellbeing Framework.
2. Establishing partnerships and govecrnance to deliver improvements in health and wellbeing at population level, such as the Haringey Obesity Alliance and the Haringey and Islington Wellbeing Partnership.
3. Initiating key interventions (see table below):

	HWB Strategy priority areas		
Examples of initiatives contributing to delivering the health and wellbeing strategy	**Reducing obesity**	**Increasing healthy life expectancy**	**Improving mental health and wellbeing**
Population Health approaches			
Using planning policy to create a	✓	✓	✓

borough where it is easy and safe to play, walk and cycle: • E.g. Embedding health promoting planning principles into High Road West and Haringey Development Vehicle • Removal of no ball games signs			
Healthier catering commitment	✓	✓	
Healthy schools	✓	✓	✓
Haringey Obesity Alliance	✓	✓	
Community health approaches			
Haringey walks	✓	✓	✓
Time banking for substance misuse and mental health cohorts		✓	✓
Development of social prescribing and local co-ordination model		✓	✓
Personal health – health and care services			
Delivery of Making Every Contact Count (MECC) training	✓	✓	✓
Integrated wellness service commissioned	✓	✓	✓
Expansion of integrated care teams and hospital admission avoidance services		✓	✓
Case finding for stroke risk factors in primary care – over 2000 cases of high blood pressure and over 280 cases of atrial fibrillation identified.		✓	
Roll out of healthy child programme	✓	✓	✓

3.8 While we have made significant progress in the areas described above, we have yet to see improvements against many of the long-term high level ambitions (outcome indicators) set out in the Health and Wellbeing Strategy (see appendix 3).

3.9 Achieving our ambitions will require sustained long-term action. For example, interventions which impact on the wider determinants of health, such as education, planning policy and regeneration can take many years for their full benefits to be realised.

3.10 There are also significant challenges to shifting resources towards prevention and early intervention while demand management pressures continue to increase across all statutory providers of health and care services.

3.11 For the remaining period covered by the Health and Wellbeing Strategy (the next18-24 months) we have outlined priority areas for continuing to deliver the strategy in the accompanying slide pack.

3.12 We are exploring new opportunities to deliver improved outcomes through working together across Haringey and Islington, as part of the Haringey and Islington Wellbeing Partnership.

3.13 We will ensure local leadership and delivery of those components of the North Central London Sustainability and Transformation Plan (STP) that support delivery of our Health and Wellbeing Strategy, such as those relating to prevention and integrated care.

4 Statutory Officers comments (Chief Finance Officer, Assistant Director of Corporate Governance, Equalities)

4.1 Finance

4.2 There are no financial implications arising from this report.

4.3 Legal

4.4 There are no legal implicatsion arising from this report.

4.5 Equalities

4.6 The Council has a public sector equality duty under the Equality 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.

4.7 Tackling health inequalities is at the heart of the Health and Wellbeing strategy 2015-18. We know that there are significant divegences in obesity levels, life expectancy and mental health prevalence among those that share different protected characteristics and between different areas of the borough.

4.8 Progress towards reducing health inequalities should be monitored and evaluated as part of this update on implementation of the Health and Wellbeing Strategy.

5. Use of Appendices

1. Haringey's Health and Wellbeing Strategy 2015-18
2. Haringey Prevention Pyramid
3. Slide set: Update on Haringey's Health and Wellbeing Strategy (2015-18)

6. Local Government (Access to Information) Act 1985

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Update on Haringey's Health and Wellbeing Strategy 2015-18

Dr Jeanelle de Gruchy

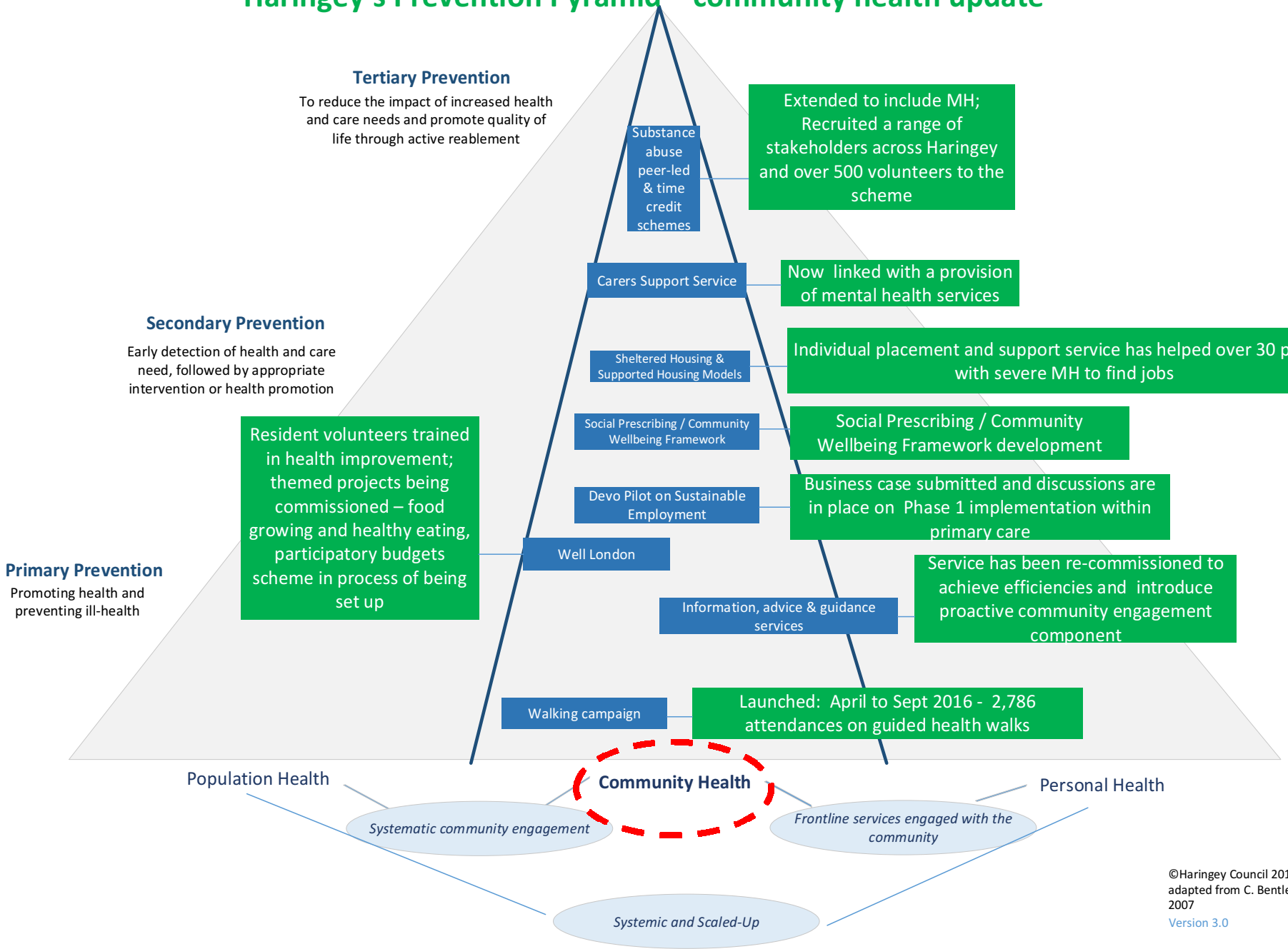
Director of Public Health, Haringey

HWB Strategy – Progress over 18 months

- Setting strategic frameworks (Health in All Policy, Mental Health Framework);
- Focus on governance, relationships and partnership building (Obesity Alliance, H&I Wellbeing Partnership);
- Focus on commissioning and implementing contracts (Integrated Wellness Service);

Haringey's Prevention Pyramid – Population health update
Key Achievements

Haringey's Prevention Pyramid – community health update



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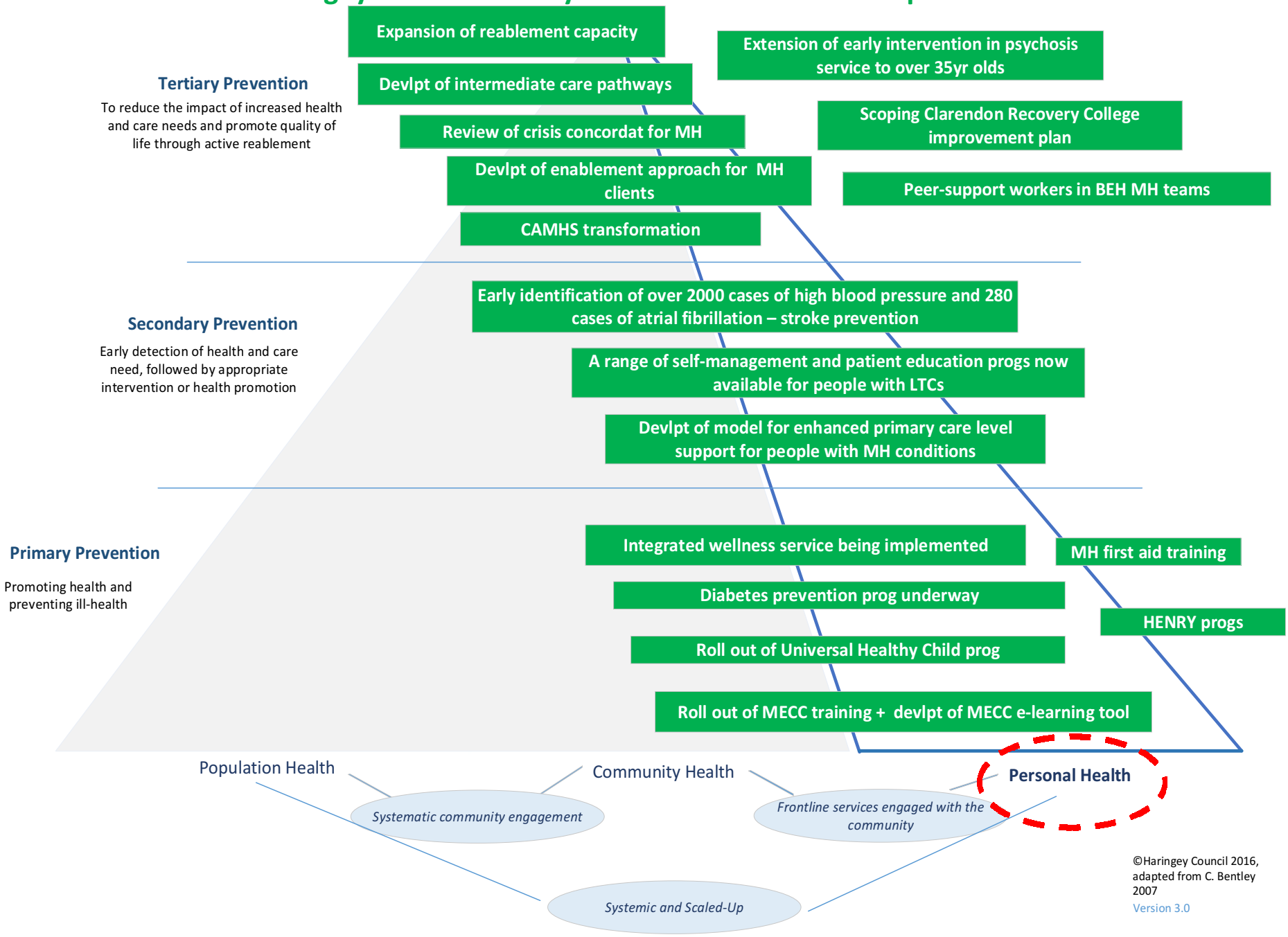
Haringey's Prevention Pyramid – Personal health update



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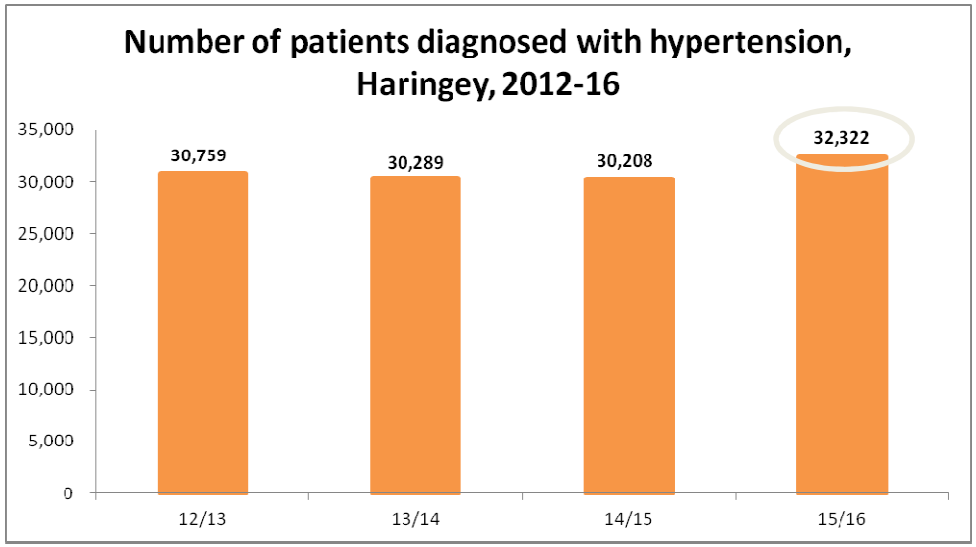
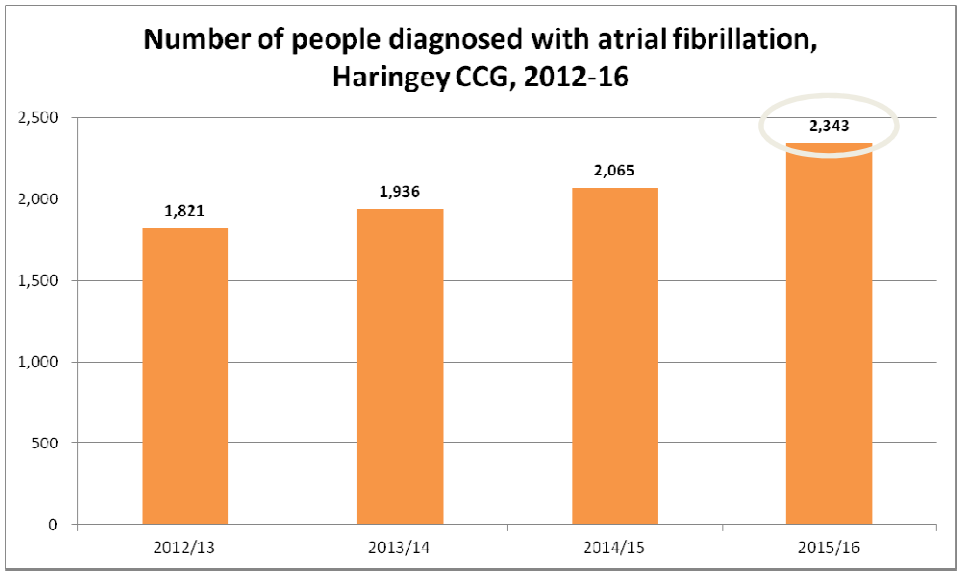
Recent successes – stroke prevention initiatives in primary care have increased diagnosis of AF and Hypertension





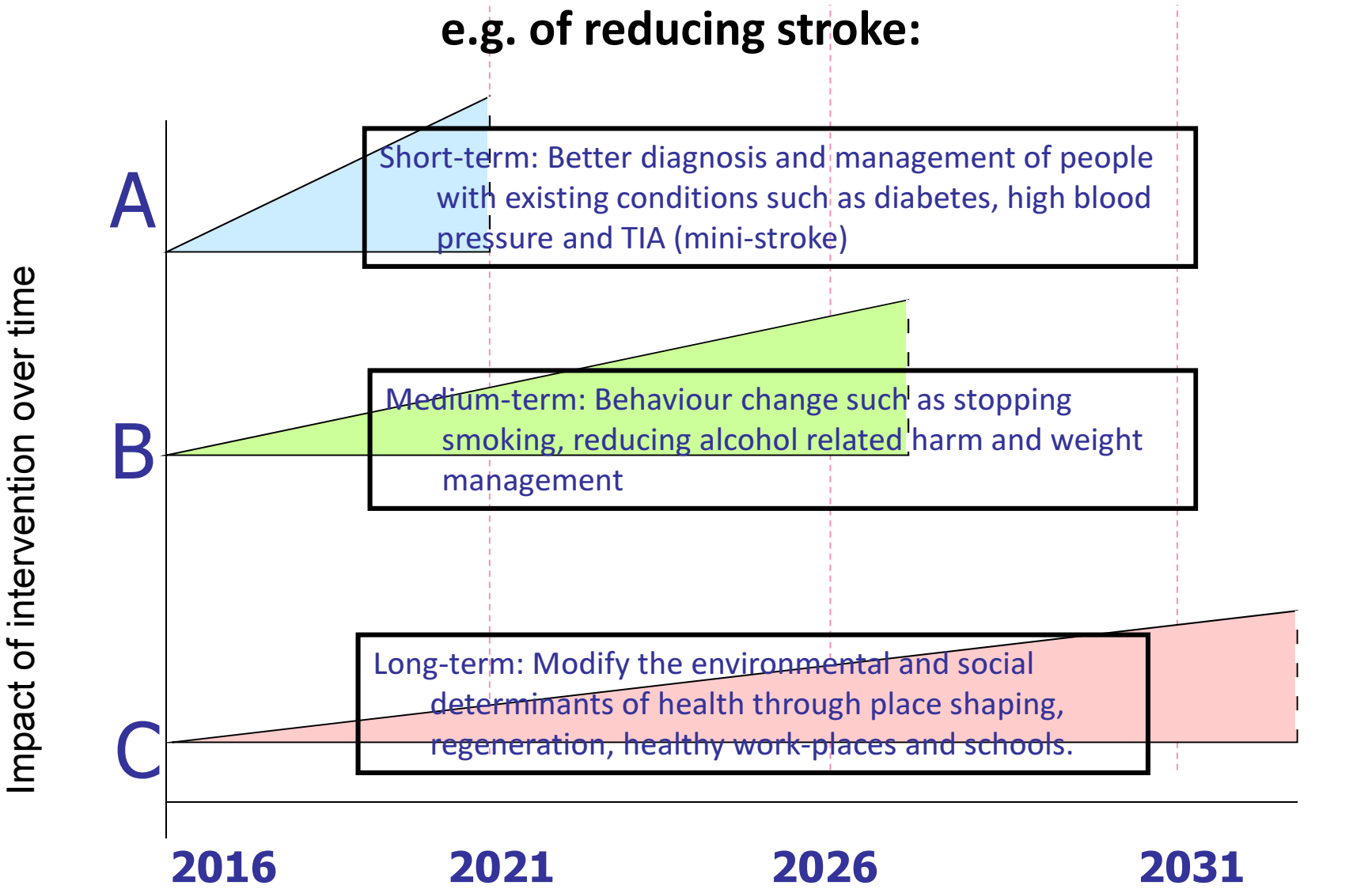
Haringey stroke prevention initiative promotes opportunistic pulse checks (for AF) and blood pressure checks in primary care

7% increase in the number of people diagnosed with hypertension from 2014/15 to 2015/16 – more than 2,000 additional diagnoses

13% increase in the number of people diagnosed with atrial fibrillation from 2014/15 to 2015/16 – nearly 300 additional diagnoses.

Source: Quality Outcomes Framework, 2015/16

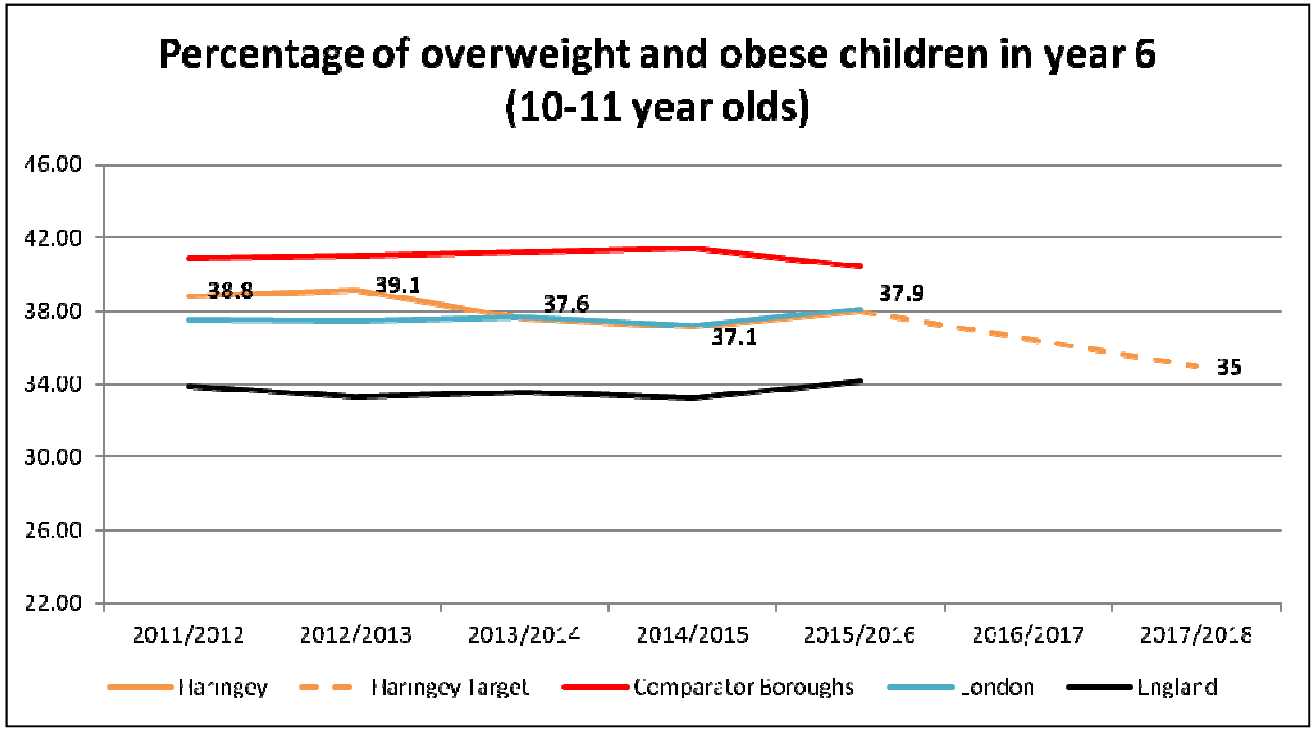
Timescales for impact of key interventions – e.g. of reducing stroke:



Adapted from Bentley 2007

Ambition 1: Fewer children and young people will be overweight or obese

2018 Target: Reduce the % of overweight and obese children at year 6 (age 10-11) to 35%



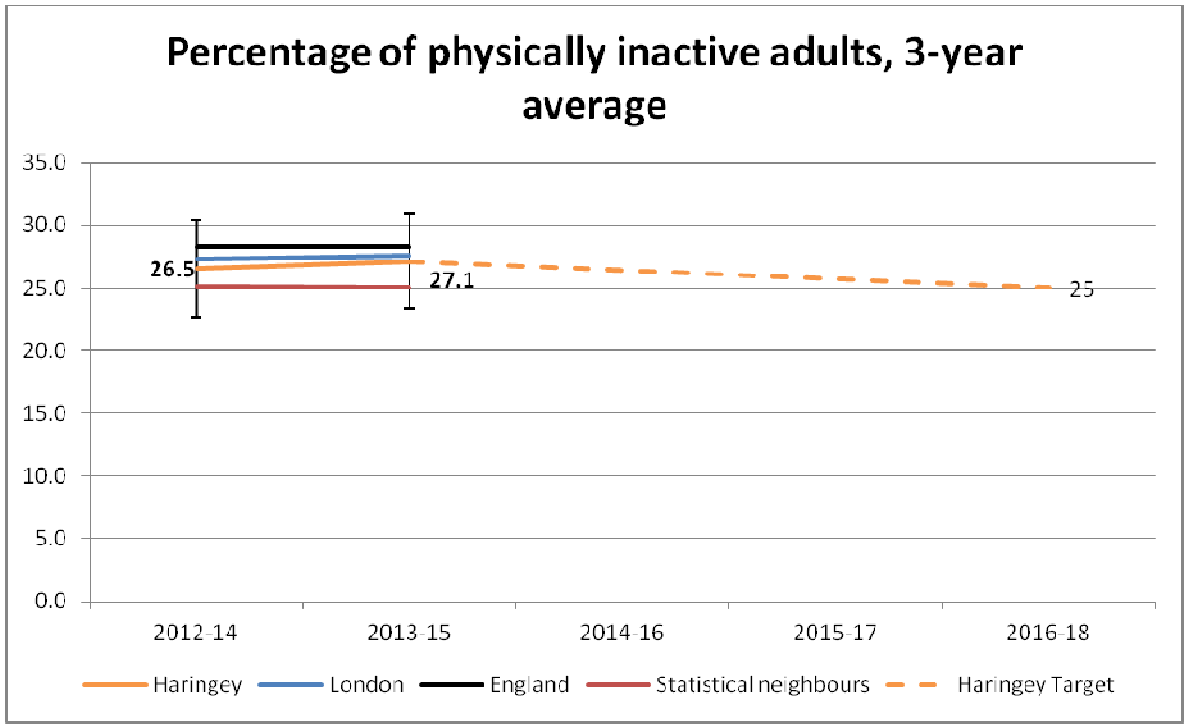
2015/2016 update:

- Prevalence has increased by 0.8% in 2015/2016 to 37.9%
- Haringey needs a **1.5% year on year** decrease in child obesity to reach our 2018 target

Source: NCMP (2016) – Updated annually – also reported for Corporate Plan P1 board

Ambition 2: More adults will be physically active

2018 Target: Reduction in inactive adults to 25%



2016 update:

- Haringey's proportion of physically inactive adults has increased to **27.1%** for 2013-15, above our comparator boroughs
- Haringey is currently above its 2018 target of 25%

Source: PHOF (2015) – Updated annually, also reported for Corporate Plan P2 board

Ambition 3: Haringey is a healthy place to live

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

London Rank 2013/2014:

12th  **3%** **2nd Quartile**

7th  **38%** **2nd Quartile**

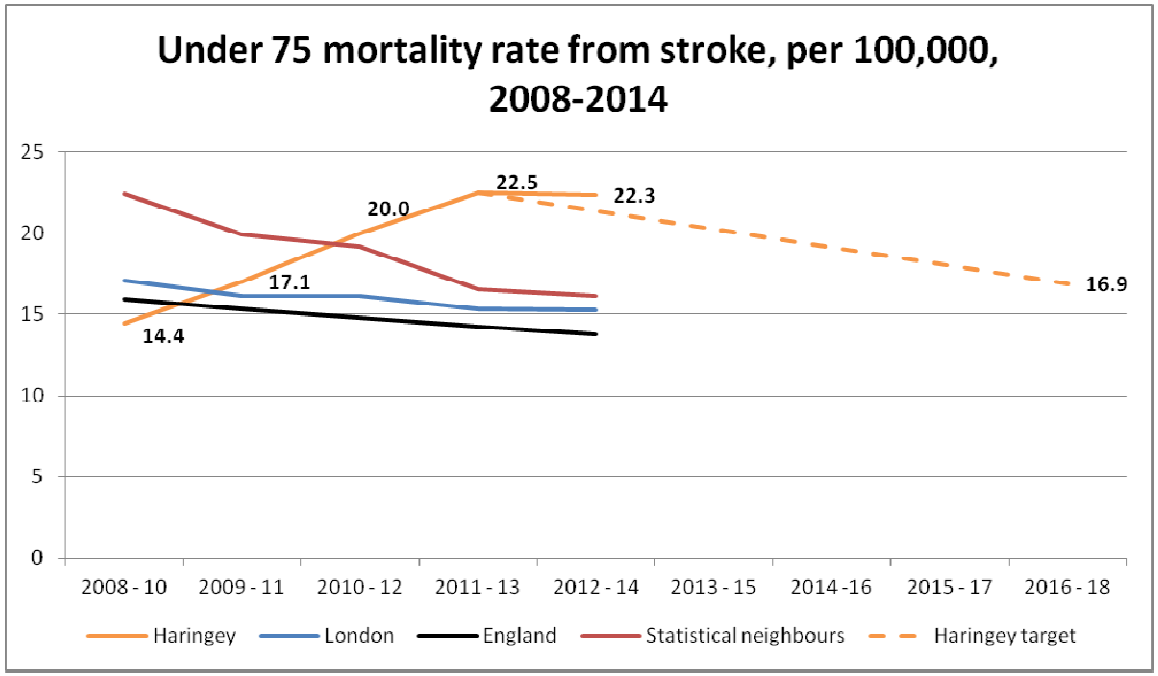
No new update

- Haringey needs a **1.3%** increase in cycling year on year to meet the London quartile target of 7% by 2018
- Haringey needs a **1.7%** year on year increase in walking to meet the London top quartile target of 42% by 2018

Source: Smarter Travel London (2013/2014) – No new update in 2016

Ambition 4: Every resident enjoys long lasting good health

2018 Target: Reduction in the rate of early death by stroke by 25%



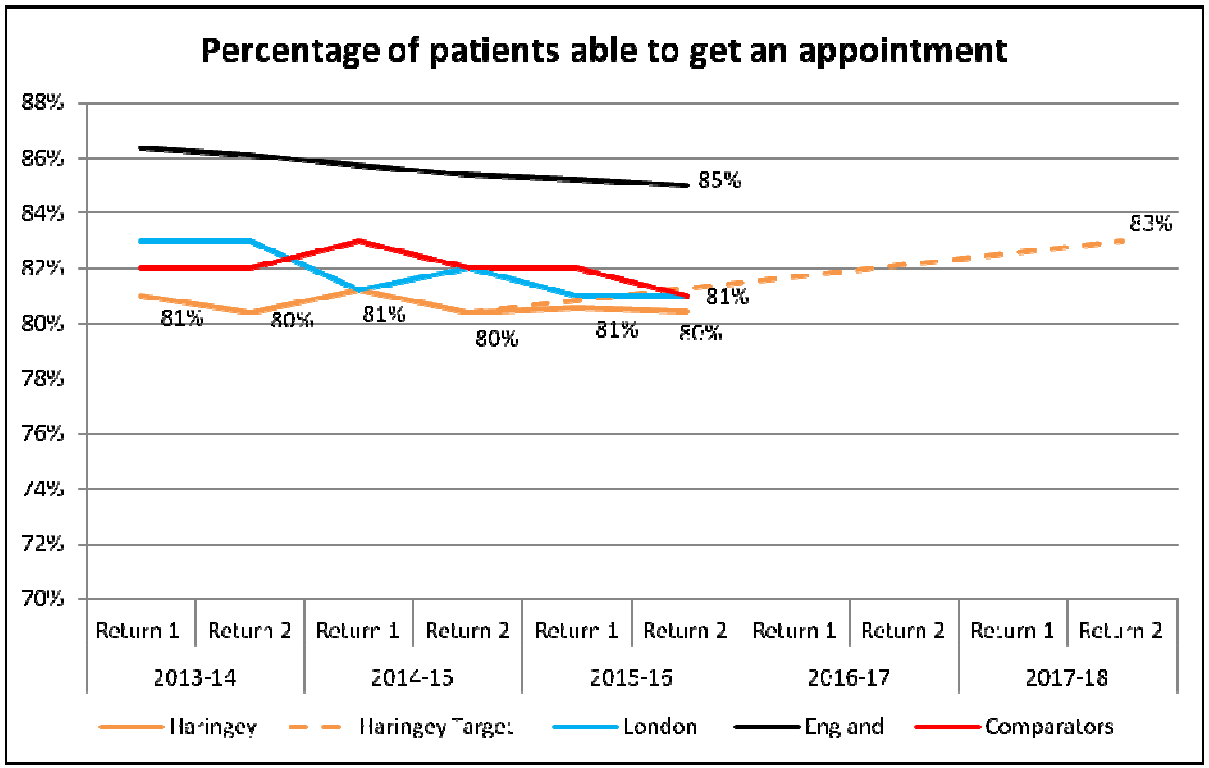
2015 update:

- Haringey's stroke rate currently stands at **22.3** compared to 16.3 for similar boroughs
- **1st out of 32** London boroughs for early death from stroke
- In 2014/15, **23.1%** of stroke patients were left severely disabled compared to just 11.0% for London (SSNAP, 2016) – approximately 60 people a year

Source: PHOF (2015) – Updated annually in 3 year averages, also reported for Corporate Plan P2 board

Ambition 5: People can access the right care at the right time

2018 Target: Increase in patients reporting they are able to get a GP appointment to see or speak to someone to 83%



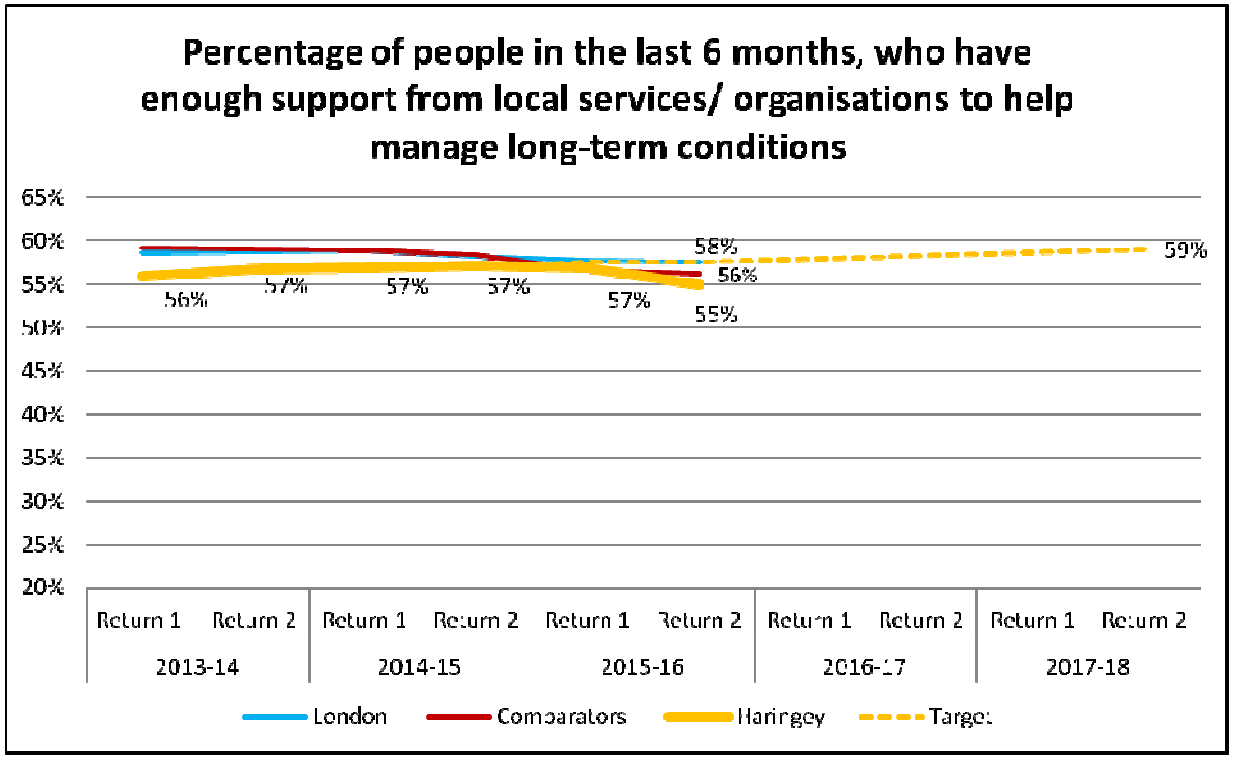
No update:

- Percentage of patients able to get a GP appointment is fluctuating around **80-81%**
- This is 1% lower than London and comparator borough averages and 4% lower than the England average

Source: GP Patient Survey (2016) – Updated bi-annually (Jan and July)

Ambition 6: More people will do more to look after themselves

2018 Target: Increase in adults who feel supported to manage their long term conditions to 59%



No update:

- **2%** decrease in the latest return for 2015/2016
- Numbers have remained similar since 2013/2014, need to see if reduction is sustained in the next returns

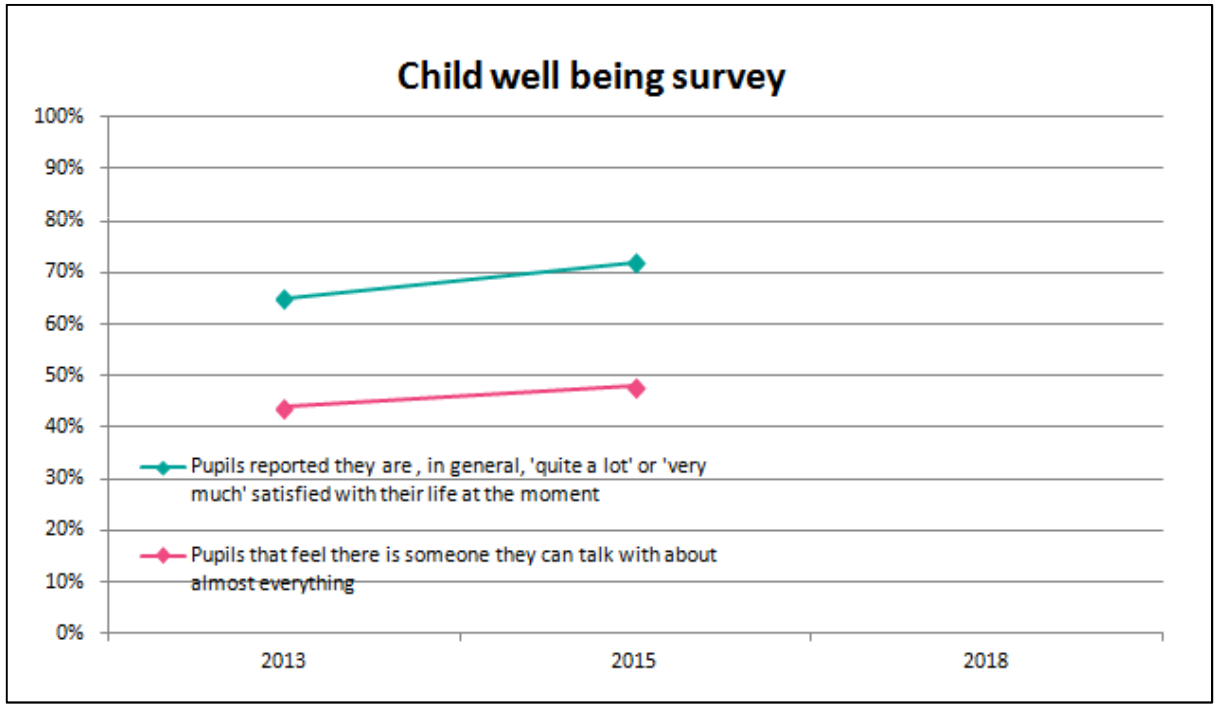
Source: GP Patient Survey (2016) – Updated bi-annually – also reported for P2 board

Ambition 7: More children and young people will have good mental health and well-being

2018 Target: To show substantial improvement on the 2 questions

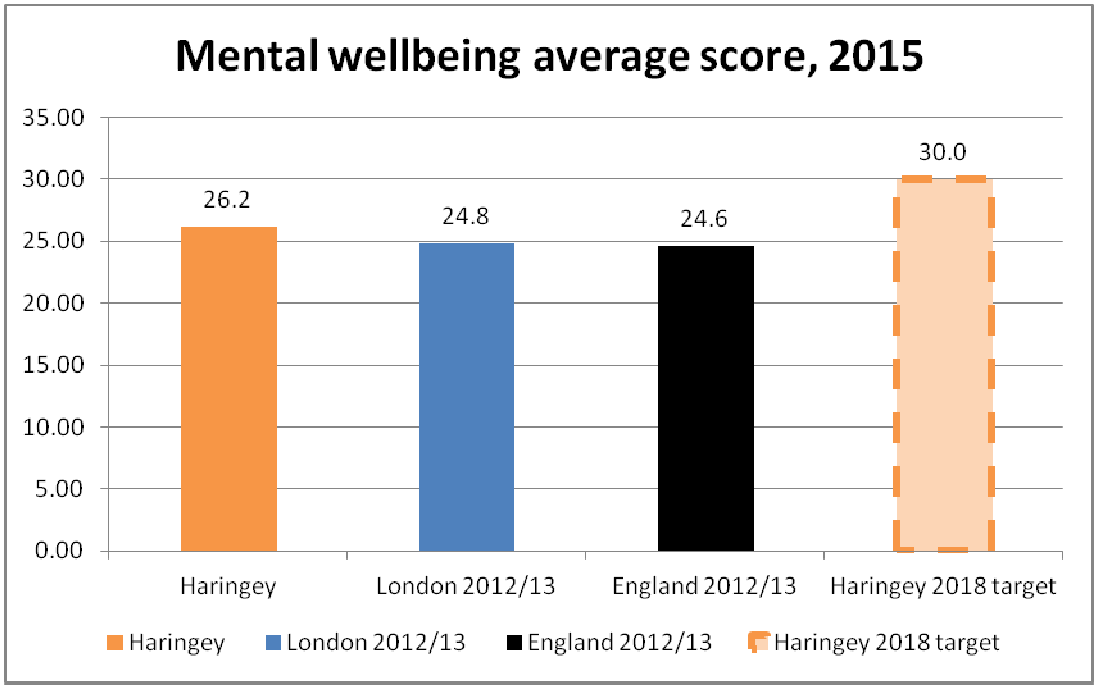
No update:

- School Health Education Unit (SHEU) survey for child wellbeing – commissioned every two years
- Life satisfaction increased from 65% in 2013 to **72%** in 2015
- Proportion of pupils that feel there is someone they can talk to about problems increased from 42% to **59%** in 2015



Ambition 8: More adults will have good mental health and wellbeing

2018 Target: Increase the average score of adults on the short Warwick-Edinburgh mental wellbeing scale by 2018



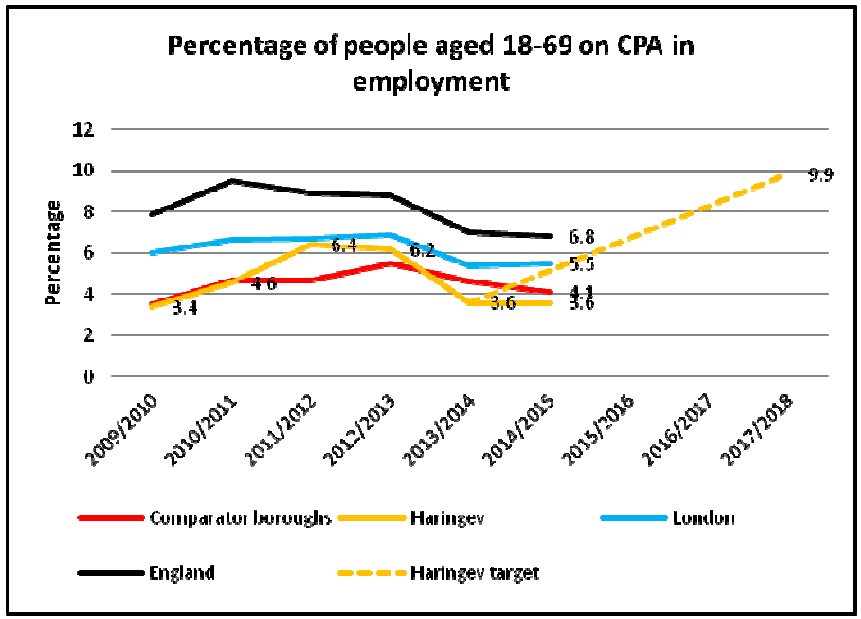
- Haringey in 2015 had a higher wellbeing average score than London and England in 2012/13. More recent data is currently unavailable
- Average Mental Wellbeing score for adults in Haringey measured by a survey across the borough was **26.1**. This is a moderate score (highest possible is 36)

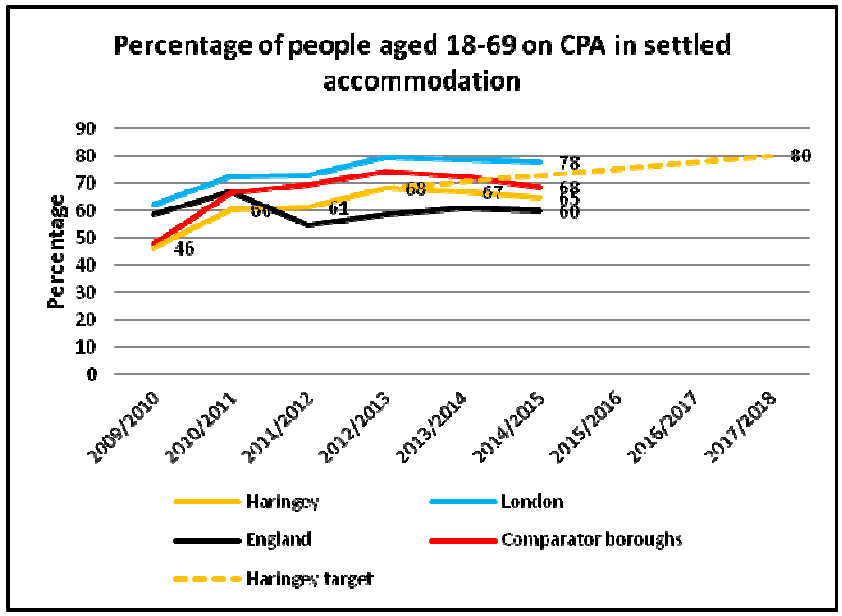
Source: 2016 Haringey Mental Health survey – commissioned in 2015, updated every 2 years

Ambition 9: People with severe mental health needs live well in the community

2018 Target: Increase the proportion of adults receiving Care Programme Approach who are in employment to maintain top quartile position (9.8%)

Increase the proportion of adults receiving Care Programme Approach who are in settled accommodation to 80%





- Haringey's performance has remained at 3.6% which is currently in-line with similar boroughs, **5.2%** below target

- Haringey's performance is broadly following the trends observed for London and similar boroughs but remains **11%** below target

Source: PHOF (2015) – Updated annually – also reported for Corporate Plan P2 board

Challenges

- Attempting to shift towards prevention and early intervention at a community level as demand management pressures become more acute in specialist providers
- Joining up of children's and adults work into a whole population approach
- Ensuring engagement and involvement of residents and voluntary and community sector groups
- Ensuring that a health in all policies approach is embedded across the council and partner organisations.
- Challenges in delivering devolution projects without additional funding.
- Delivery of ambitions requires sustained long-term focus

Population health – key focus areas

- Continued focus on getting the best population health outcome through the procurement of the Haringey Development Vehicle and High Road West
- Expanding and strengthening Haringey's Obesity Alliance to ensure it delivers at pace and scale
- Develop and implement workplace policies including Food Standards Policy and Smoking Policy
- Expanding and strengthening tobacco control e.g. increasing smoke-free places
- Looking for opportunities to further embed health into policy making, strategy development and programmes.

Opportunities through Haringey and Islington Wellbeing Partnership

- Identify key areas where work across the Haringey and Islington level will add value to our whole systems delivery plan to reduce obesity
- Exploring opportunities to tackle the health impact of poor quality housing e.g. fuel poverty.

Community Health – Key focus areas

- Secure funding, commission and implement local area co-ordination and build social prescription/social referral component with primary and community care; increase score to children, young people and families; ensure engagement of carers
- Implement community information system which supports community resilience, knowledge and self-reliance
- Start Phase 1 implementation of health and employment pilot (linked to devolution)

Opportunities through the Haringey and Islington Wellbeing Partnership

- Development of community hubs across Haringey and Islington (including social prescribing and local co-ordination components) – linked to integrated care networks (CHINs) proposal in the North Central London STP
- Looking for opportunities of aligning health and employment work across the partnership and explore potential for external funding from Shaw Trust

Personal Health – key focus areas

- Integrated out of hospital project – simplifying and scaling up services that support people to avoid hospital admission and maintain independence after hospital admissions.
- Development of primary care mental health hubs as part of an integrated multi-disciplinary model for mental health.
- Continued focus on case finding and improved management of high blood pressure and atrial fibrillation, with new focus on diabetes and kidney disease.

Opportunities through Haringey and Islington Wellbeing Partnership

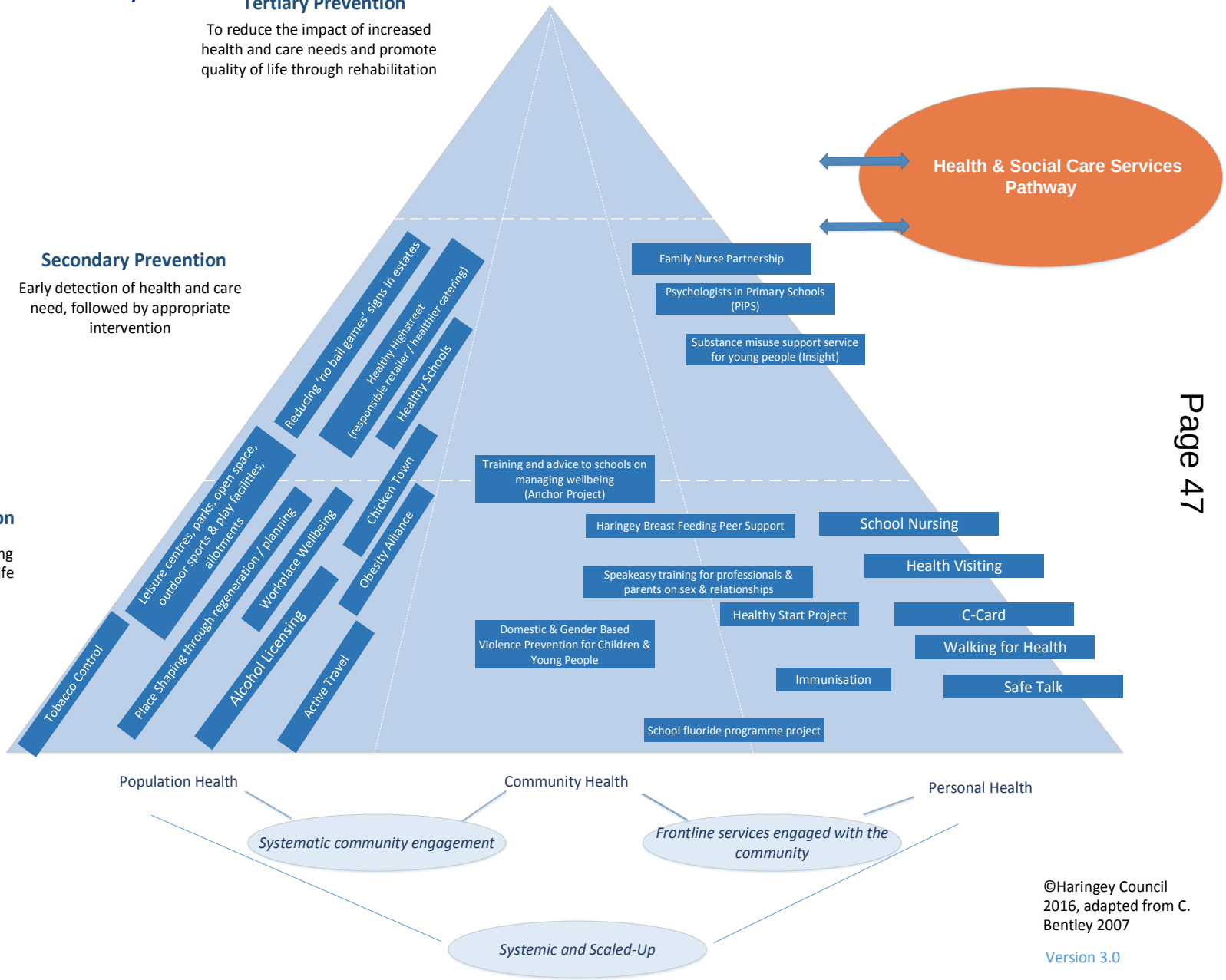
- Implementation of prevention and care closer to home elements of the North Central London Sustainability and Transformation Plan including
  - Development of more effective care models for diabetes and cardiovascular disease, musculoskeletal conditions, learning disabilities and older people
- Scoping of Children and Young People's Work-stream
- Looking for opportunities of aligning intermediate care services.

<u>NCL level</u>

- Development of community perinatal mental health service

Haringey's Prevention Pyramid: Children and Young People

(Children & Young People focused)



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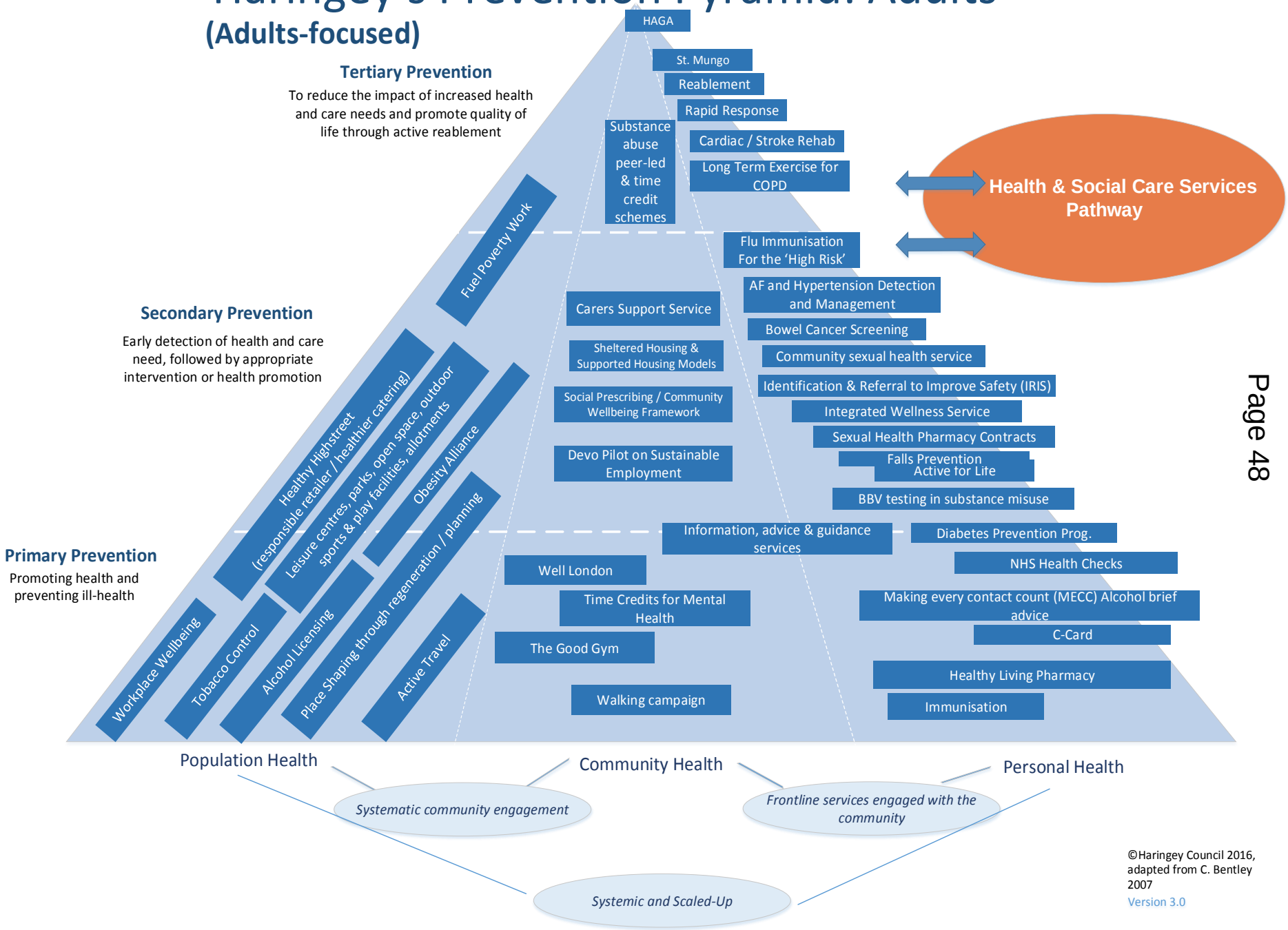
Haringey's Prevention Pyramid: Adults

(Adults-focused)



Report for: Health and Wellbeing Board – 8 December 2016

Title: Primary Care Estates Update

Organisation: Haringey Clinical Commissioning Group (CCG)

Lead Officer: Cassie Williams – Assistant Director of Primary Care Quality and Development, Haringey CCG

1. Describe the issue under consideration

1.1 On 24 September 2015, it was agreed that the Health and Wellbeing Board would review Primary Care capacity in the borough on an annual basis. This paper provides an update to the Board and describes progress which has been made during the year in meeting capacity demands. It finally describes the required actions for the following year to maintain a proactive approach.

1.2 Of particular note is the opening of the Hale Village temporary site in August 2016. At the time of writing this report the practice, which opened with no patients on its list, now has over 800 patients. In addition, Haringey CCG has been provisionally awarded £11.6 million for three estates developments in areas previously identified as having particular capacity needs; Tottenham Hale, Wood Green and Green Lanes. Whilst there is still a long process to successfully access these funds, it is extremely positive for Haringey that provisional approval has been given.

2. Recommendations

2.1 That the Health and Wellbeing Board:

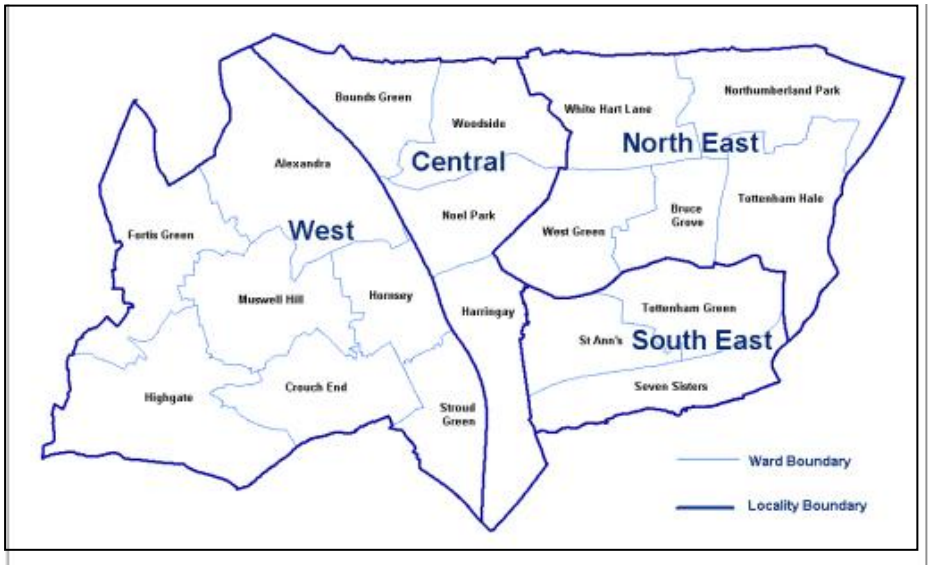
a) Notes and comments on the progress of primary care capacity and developments.

b) Provide feedback in relation to the Draft Guiding Principles document.

3. Background

The Area's current need, progress to meet that need and ongoing challenges

3.1 This information is described by CCG Collaborative. Wards within each collaborative are shown in the map below (a practice map is included in Appendix 1):



3.2 **North East Collaborative**

3.3 Current need: there are 10 GP surgeries within the NE collaborative, with a total registered patient list size of 87,432. Of the 10 practices, 8 are rated red/high or amber/significant non-statutory property compliance. Four out of the five wards in the area exceed the average list size (1,800) per GP.

3.4 The Haringey Strategic Development Plan (HSDP) presented to Health and Wellbeing Board in June 2015, identified Tottenham Hale as having a current shortfall of 10.4 GPs (2015 >9,700 patients shortfall) and future shortfall in capacity in 2020 of 17,234 and in 2025 of 19,895. It further identified Northumberland Park as having a current shortfall in capacity of 3850, expanding to 6190 by 2020 and to 17,880 by 2026.

3.5 Other pressures in the system include that Tottenham Health Centre will soon be under a compulsory purchase order which will require a move within the next 5 years. Charlton House has a limited lease (2 years) and will require a move at that time. Dowsett Road's premises are not CQC compliant but it would not be practical or cost effective to improve this small practice.

3.6 **Progress and Ongoing Challenges**

3.7 <u>Tottenham Hale</u>

3.8 A new zero list practice was opened in Hale Village in August 2016. The practice now has over 800 patients and is continuing to expand. Due to the small list size they currently have limited opening hours but patients are able to access GP appointments at Lawrence House who manage this temporary GP contract. This was agreed as part of the negotiated contract. As the list size increases, the opening hours will be extended.

3.10 The estates and technology transformation fund (ETTF) bid for a new health facility at the Welbourne Centre which would accommodate the temporary practice was provisionally successful. It has the capacity to provide GP provision for up to 20,000 patients and also provide flexible space for a range of health and care services. Funding is currently identified of £3,790,080. All bids are now subject to a lengthy approval process. Quotes have been submitted to NHSE to secure a PID, Outline and Full Business Case writer. At the same time work is progressing with the developer to outline the needs of the site in relation to facilitating a GP practice.

3.10 Northumberland Park

3.11 A partial, shorter term solution for Northumberland Park was an ETTF bid to expand Somerset Gardens Medical Practice. Unfortunately, this was not successful. Discussions have been initiated with the practice to consider other options for progressing the work. Part of the purpose of ETTF bids was to mitigate the ongoing increases to revenue costs for the CCG with new or expanded buildings in order to maximise what is affordable. The next step for the CCG is to consider whether an increase in practice capacity on this site would be affordable in terms of rental reimbursements.

3.12 As much of the population increase in Northumberland Park is after 2020, there have been limited plans for future expansion at this stage, however, the CCG is part of discussions with the Tottenham Regeneration Team to ensure that adequate provision for health is part of the planned developments.

3.13 South East Collaborative

3.14 Current Need: There are 9 practices within this collaborative, with a registered patient list data of 59,411. Of the 9 practices, 8 are in red/high or amber/significant rated properties for non-statutory property compliance, the highest percentage across the four collaboratives at 82%. One of the three wards exceeds the average list size (1,800) per GP.

3.15 In addition one small practice has closed, St John's in this financial year and another, Philip Lane, is due to close at the end of the financial year. West Green Surgery is a practice which is expanding quickly and is now struggling with capacity.

3.16 Progress and Ongoing Challenges

3.17 Two medium sized practices, Chestnuts Park and Laurels came up for re-procurement in the last year and are currently under caretaking arrangements. Both practices are in the same location (Laurels Healthy Living Centre) and, as a result, there is an opportunity to re-procure these 2 practices as one new practice. This

provides an opportunity to secure better use of space and expanded capacity. The new contract will be re-procured in July 2017.

3.18 This area is also likely to benefit from the developments at Tottenham Hale, Wood Green and Green Lanes, described below.

3.19 Central Collaborative

3.20 Current Need: There are 10 practices within this collaborative, with a registered patient list data of 64,725. Of the 10 practices, 7 are in red/high or amber/significant rated properties for non-statutory property compliance. One of the four wards exceeds the average list size (1,800) per GP.

3.21 The HSDP identified that Wood Green/Noel Park had a current shortfall of GP capacity for 5500 patients and expected future shortfall in capacity in 2020 of 11,000 rising to 14,500 in 2025. This did not account for the current practice closures.

3.22 This year, three small practices have closed with a combined list size of c.3500 patients with another of c.2000 patients considering their future options as they have outgrown the current premises. The West Green Surgery is also close to Green Lanes. On the north side of the area one branch practice has requested closure due to the challenges of managing a small site. Westbury Medical Centre is experiencing lease issues and has been considering options to relocate.

3.23 The Collaborative also has the highest growth projection, within the Noel Park ward, from across the Borough with an anticipated 7,944 additional people between 2011 – 2026.

3.24 Progress and Ongoing Challenges

3.25 The ETTF bid for a new health facility on the Hawes and Curtis site was provisionally successful. This can provide capacity for around 15,000 patients but would also accommodate a current practice list. Funding is currently identified of £2,683,676 but is subject to the approval processes described above.

3.26 An additional ETTF bid for the Iceland site in Wood Green was also successful to the value of £5,161,200 which can provide GP provision for around 15,000 patients.

3.27 Two improvement grants, supported by the CCG, were submitted to expand the capacity of Hornsey Park surgery by 1 consulting room and Bounds Green Group Practice by 3 consulting rooms. The CCG is awaiting the outcome of these bids.

3.28 The ETTF bid for Westbury Medical Centre to move to Waltheof Gardens was not successful. Work is now ongoing to consider whether this move can be supported without ETTF funding.

3.29 West Collaborative

3.30 Current Need: There are 11 practices within this collaborative, with a registered patient list data of 85,100. Of the 11 practices, 8 are in red/high or amber/significant rated properties for non-statutory property compliance. Across the seven wards within the west collaborative there is a planned 5,785 population increase from 2011 – 2026. However, there is a modern, fit-for-purpose LIFT development at Hornsey Central Neighbourhood Health Centre, located in Muswell Hill ward; the site of the second highest population increase within this Collaborative.

3.31 In Muswell Hill, there are current capacity challenges and the population is understood to be likely to increase by at least 2000 in the next few years. There are 3 practices which are wishing to merge, with 2 of these who may choose to retire with their buildings going out of the system within the next 5 years. No site has currently been confirmed for the potential merger and expansion which would need to accommodate at least 25,000 patients.

3.32 A small practice has closed in Crouch End and another has expressed a wish to retire, however this area currently has adequate capacity and it is likely that these practices would not be re-procured as individual practices.

3.33 Progress and Ongoing Challenges

The ETTF bid for a site at Muswell Hill was not successful. Ongoing work is now required with the council to identify an appropriate site and consider what would be financial viable.

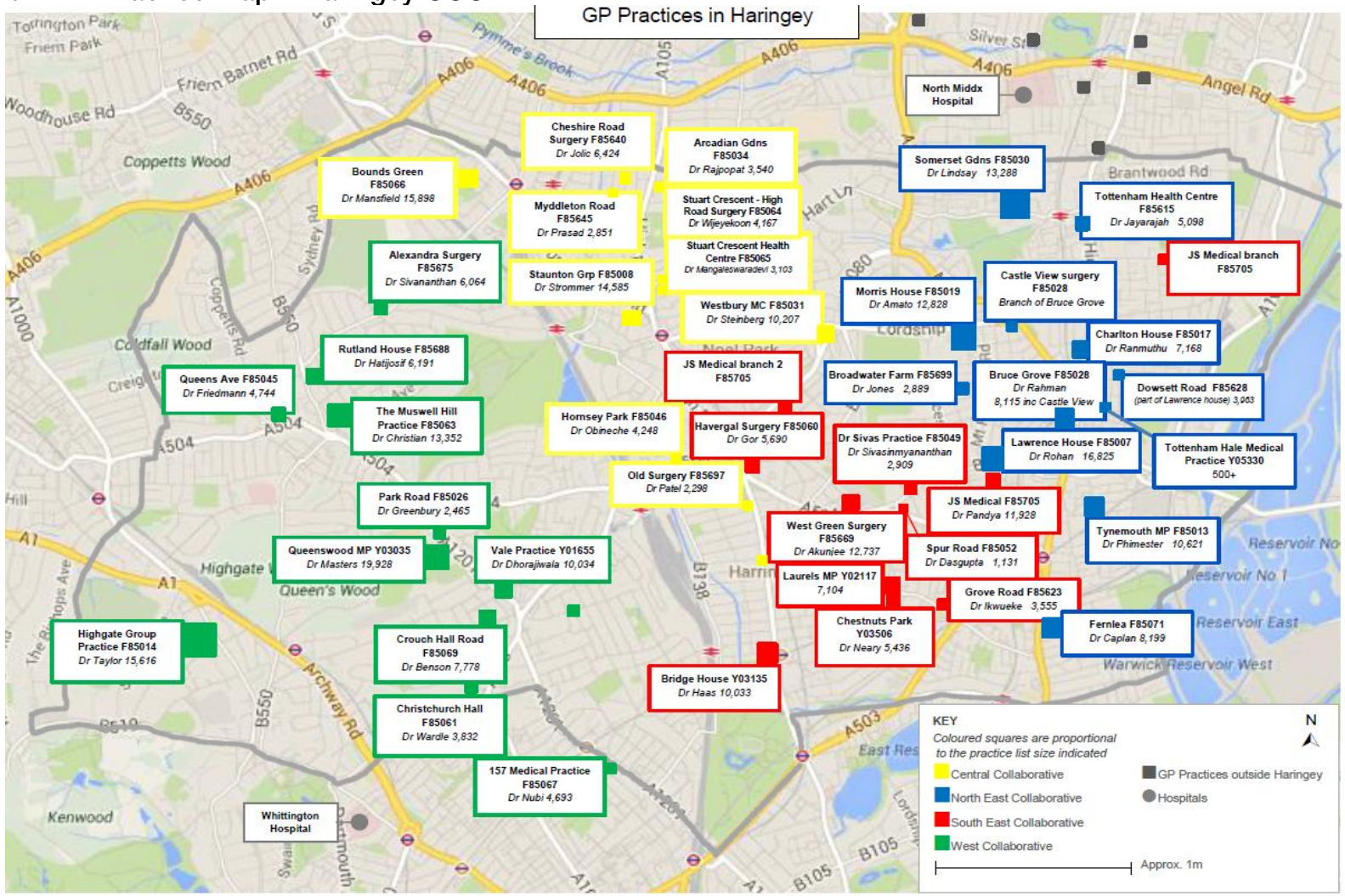
4 Other ongoing work

4.1 As part of the successful bids which were submitted by Haringey CCG, it is now necessary to conduct a process to identify which practices will move into new sites. These GPs will also need to support the design process. A draft document is attached in Appendix 2 which describes the principles considered when prioritising practice developments. This includes a description of the sort of practice which would be likely to be successful in moving into a site. It is important to note that these are guiding principles rather than firm rules and will help secure the best type of premises for Haringey with the most sustainable practices working within them. This draft document has been discussed with local GPs and will be subject to further community engagement. HWBB are asked to comment on these principles and provide any comments.

5 Timings

5.1 It is proposed that Primary Care Estates work continues to be reviewed annually by the Health and Wellbeing Board.

Appendix 1 – Practice Map – Haringey CCG



November 2016

Appendix 2 – Guiding Principles for Premises Development Draft

Haringey CCG is committed to ensuring that every patient has access to high quality primary care. In order to achieve this we believe that it is necessary to support the further development of larger practices which can offer a range of services provided by a group of clinicians with different skills. This document describes the type of estate which Haringey CCG proposes to prioritise for premises development and the sort of practice which is most likely to be able to support for Primary Care provision as part of the Primary Care Estates Strategy.

- A building which is fit for purpose as set out in CQC guidance (including fully DDA compliant). This is likely to be purpose built. New estate would not be supported in a converted terraced house.

- A building that meets a specific need (significant improvement from existing estate or supports development of a strategic goal, such as multidisciplinary working, at scale service provision, offering a wider range of services) or meets a capacity need in the local area, including where there are new housing developments.

- The building is in a location that is well served for transport (described as having a high PTAL score)

- The building is of an appropriate size to house a 'viable' practice. A viable practice is defined as:
    - A practice (or combined merged practices) going into a new building should have or be actively moving towards a list size of at least 6,000 patients.[1]
    - Where more than one practice plans to move into a new site, they would become a single practice.[2]
    - A practice which is able to demonstrate positive patient experience, GP Outcome Standards and meeting CQC standards, and is able to demonstrate a positive approach to making improvements.
    - A group practice: to reduce the risk of retirement leading to practice closure and ensuring continuity of patient care.
    - A practice able to deliver a range of services consistent with the STP Vision
    - A training practice or actively moving towards being a training practice

- The building is able to accommodate new ways of working including 7 days 8am-8pm, offering a range of services and a flexible use of space.

- The building is in a location which maintains or increases the number of patients who have a practice within a reasonable distance from their house. It is recognised that a reasonable distance may be different for the area under consideration, but at the least, it should be within a mile and require only an easy travel journey on one mode of

[1] A 6,000 list size is the figure used by NHS England in their standard London APMS contract to denote financial viability

[2] Where contractual rules prevent two contracts being formally merged – practices would operate a one practice, having one staff team, one reception and one waiting room etc.

transport. Consideration would be given to shorter distances for areas of high deprivation (IMD score within highest 20% nationally).

Report for: Health and Wellbeing Board – 8 December 2016

Title: Developing an Accountable Care Partnership across Haringey and Islington

Organisation: Haringey Clinical Commissioning Group, on behalf of the Wellbeing Partnership

Lead Officer: Charlotte Pomery, Assistant Director, Haringey Council
Rachel Lissauer, Acting Director of Commissioning, Haringey CCG

1. Describe the issue under consideration

1.1 On the 3 October the Haringey and Islington Joint Health and Wellbeing Board endorsed further work to consider the development of an Accountable Care Partnership (ACP) that supports the outcomes sought by the Haringey and Islington Wellbeing Partnership.

1.2 This report provides an update to the Haringey Health and Wellbeing Board. It outlines how an Accountable Care Partnership could support delivery of our aims for the Partnership as well as providing a vehicle for delivery of the North Central London Strategic Transformation Plan (STP). It then reviews the key options and decisions that need to be made on organisational form and on the scale and pace of change.

2. Recommendations

2.1 The Haringey Health and Wellbeing Board is asked to:

a) Note progress with the Wellbeing Programme and the continued work to explore how an Accountable Care Partnership can support the Wellbeing Partnership's aims of taking a preventative approach to maintaining population health and wellbeing.

b) Discuss options on organisational form, governance and pace of change and consider what arrangements are most likely to enable the Partnership to drive efficiency and improve outcomes in the long term.

c) Discuss the role of the Health and Wellbeing Board in shaping the Wellbeing Partnership.

3. Timings

3.1 Work is underway to further explore the different aspects of developing an Accountable Care Partnership: finances; governance; pace of change and level of contractual formality.

3.2 A further update will be taken to the next Joint Health and Wellbeing Board in January. The Joint Health and Wellbeing Board will be asked to make recommendations which will be taken to statutory decision-making boards before April 2017.

4. Background information

4.1 Nationally and internationally health and care economies are challenging payment systems and organisational structures that present barriers to co-ordinated care; create a tendency towards treatment in expensive settings and prevent recognition of the inter-dependencies of health, mental health and social care. Across Haringey and Islington, there is an acknowledgement that these issues are shared and the organisations involved in the Wellbeing Partnership have already committed to a set of principles which begin to set out the basis for a new way of working.

- Partner organisations will work together for the benefit of local people;
- We will involve local people in our design, planning and decision-making;
- Partner organisations will find innovative ways to cede current powers and controls to explore new ways of working together;
- We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates;
- Partner organisations have agreed to find ways to 'risk share' during transformational change;
- We will find ways to share joint incentives and rewards;
- Partner organisations will make improvement by striving to be the best, together;
- We will be rigorous in ensuring value for money and financial sustainability

4.2 Our goal in designing an Accountable Care Partnership is to move to a position where councils, healthcare commissioners and providers take collective responsibility for meeting the health (physical and mental) and care needs of our population across the two boroughs in the long term.

4.3 The Wellbeing Partnership has established a set of workstreams to explore the costs and opportunities of working together for particular high need population groups: children and young people; people with mental health needs; older people with frailty; people with learning disabilities; people with cardio-vascular disease and diabetes and people with muskelo-skeletal conditions (MSK). We are also looking at cross-cutting issues such as prevention and tackling the wider determinants of health.

4.4 These workstreams have begun to identify ways in which Islington and Haringey might work together to improve outcomes and value in our health and care system.

We are using this as the basis from which to consider whether a different organisational form is required to support delivery. We have also considered the emerging evidence from Accountable Care entities and vanguard sites nationally and internationally.

4.5 These lessons, together with our emerging priorities from the workstreams, are informing our priorities for developing an Accountable Care Partnership. However, there remain some key decisions to be taken which will influence the pace and nature of our work.

5. Lessons from Accountable Care Partnerships

5.1 The joint work that we have undertaken within North Central London, as part of the Sustainability and Transformation Plan, indicates that we face a significant affordability gap in the provision of health and social care now and over the next five years. We know that we need to work together systemically and systematically to improve efficiency and effectiveness. However, integrated care interventions such as multi-professional teams or case management, do not on their own improve outcomes and improve value. So, under strong leadership and mindful of our local needs, demand and resources, we need to be in a position to learn from other areas, to apply the lessons to our local landscape and to build on the characteristics observed in successful accountable care partnerships:

- Taking responsibility for the full budget associated with a population, with a risk / gain share in place to create incentives to address need, manage demand and share the risks of population growth or activity increases
- Using information and analysis about the population to predict health and care need and inform planning
- Developing strong and clear links between primary care physicians who can co-ordinate all medical care for high-risk patients and community services and specialist teams
- Focusing on the small proportion of people who account for a high proportion of use and targeting interventions
- Developing case management programmes for people with multiple chronic illnesses
- Sharing access to the clinical information about the patient, regardless of where previous treatments and care was delivered.

6. Learning from the workstreams

6.1 The way we organise health and social care across the system going forward needs to position us to respond to some of the very real pressures we face. The fragility of the care market, for example, is putting considerable pressure on the availability and affordability of high quality domiciliary, residential and nursing care. This in turn is having a significant impact on some of the most vulnerable people within the population and is particularly affecting those at risk of requiring hospital care or

needing to be safely discharged from a stay in hospital or an inpatient mental health unit.

6.2 Workstreams within the Wellbeing Partnership are considering how we best respond to these present and growing pressures. Overall our approach must be to work together to build strong communities; focus on prevention; improve sign-posting to and availability of non-statutory services and to improve the pathway into high quality, efficient services for those who need them.

6.3 **Building strong communities through taking a whole population approach:** We are adding further strands of work to the outcomes identified in the Sustainability and Transformation Plan for children and young people, notably Reducing Childhood Obesity and Achieving a Good Level of Development, to create a programme focused on ensuring that our work with children and young people both supports better outcomes for families in the short term and builds a healthier population for the longer term. This work will engage with early years providers and schools, for example, to strengthen health and wellbeing for all children and young people.

6.4 **Managing demand by building communities around practices:** In 'vanguard' sites and internationally there is an emerging tendency to focus on relatively small populations (c 50,000) as the basis of planning and as the locus for multi-professional teams. This is reflected as a strong ambition within the North Central London STP through the plan to establish 'Care Closer to Home Integrated Networks'. These are designed both to 'house' and coordinate multi-professional community services and to provide a practical locus of support for individual GP practices to support the delivery of a consistent quality standard and offer to all patients.

6.5 The emerging thinking from our work-streams for diabetes/CVD, for frailty and for mental health is that a key goal of the Wellbeing Partnership would be to test and learn from the establishment of hubs. These hubs would be responsive to the particular requirements and demographics of the population served. They would have a focus on supporting the delivery of a common standard of care across general practice. They would carefully test the impact of a more pro-active; preventative and co-ordinated offer for patients. The costs of care and outcomes for the population within the network would need to be managed carefully and monitored over a number of years to evaluate impact.

6.6 **Consolidating the services available outside hospital:** Haringey and Islington would work together to maximise the availability of our care for people who are at risk of admission to residential care or hospital, both mental health and acute. This is likely to involve extending services (such as rapid response) that are effective and considering scope for efficiencies in how they are provided. It will involve sharing capacity to manage and develop the market for domiciliary and residential care. Together we will take a strategic and joined up approach to Intermediate Care, to improve the resources we have for assessment and to share access to

step down and rehabilitative facilities. This common approach would apply across a range of population groups, for people with learning disabilities as well as for people with mental health needs and the frail elderly.

6.7 **Prevention**: A shared approach towards prevention could allow us to scale up the work that is happening across both Boroughs. We would look to work together on mental health and employment; extending the scope of the obesity alliance and working jointly on case finding and preventative approaches towards cardio-vascular disease and diabetes. Working together could involve public health teams working together to deliver shared schemes and combining analytical resources and expertise where appropriate.

7. Emerging points for discussion

Formalising the partnership

7.1 The Wellbeing Partnership is currently based on a community of interest and agreement between organisations of a set of principles and common approaches. It has grown out of a shared understanding of local need, demand and the impact of increasingly pressured resources. It constitutes a programme of work that has been approved by the Health and Wellbeing Boards as well as Governing Bodies and Trust Boards. The programme is overseen by the Chief Executives of the organisations involved.

7.2 If we are to move towards taking responsibility for population health and for the overall budget associated with health and care, we are likely to need to formalise this relationship and the roles and responsibilities within the Partnership.

7.3 The Wellbeing Partnership has a number of options before it about the degree of formality with which organisations come together and the timescales for any new developments. If organisations wanted to achieve a degree of shared accountability and responsibility whilst taking a 'light touch' approach and leaving existing contractual arrangements largely intact, we might look towards a 'virtual' alliance. Here, organisations would agree a shared vision; shared commitment to how we use resources together; agreements of how service delivery will be implemented and shared governance. New contracts could set out which services and budgets would be approached together and could define common outcomes that we are working towards. However, we would not be setting up a 'new' or distinct organisation or entity.

7.4 There are more radical approaches. Some vanguard sites are now moving towards establishing an Accountable Care Partnership as a distinct entity, taking on a contract for the management of the budget associated with health and care, with responsibility for delivering improved outcomes. This has implications across the board and would require significant input from statutory boards, residents and stakeholders who would need to be able to shape and influence this over time. It has advantages of conceptual and contractual clarity and may well be the clearest

way of achieving impact. However, it carries risk of failure due to complexity, particularly the difficulty of agreeing budgets, outcomes and how to apportion risk. It also puts a focus on the task of defining contracts and roles rather than working together on delivery.

Governance

7.5 If organisations were prepared to move from a programme approach into working together in a more formal way on implementation and delivery as well as making shared decisions about spending, then decision-making and accountability structures need to support this approach.

7.6 If the Wellbeing Programme were to start functioning like an Accountable Care Partnership, consideration would need to be given to an executive structure that could take responsibility for any shared functions, such as the delivery of 'care closer to home networks' or consolidation of out of hospital services. This might require the formation of a board which would be likely to need non-executive, independent as well as clinical or professional input. It would need to be clear whether a board had any areas of delegated responsibility or whether it was advisory and remained accountable to statutory bodies in all decisions.

7.7 Over time, certain budgets might be identified to be aligned (managed alongside each other transparently) or pooled (fully merged). If budgets were to be brought more closely together, roles are responsibilities for budget managers would need to be set out. In all cases it would need to be clear exactly how decision-making would be scrutinised.

Engagement

7.8 Residents, stakeholders and service users must be able to influence the shape and direction that is taken with this work. There have been several events held with clinical staff to discuss the Wellbeing Partnership and it has been discussed within the Haringey patient forum, the Haringey Voluntary and Community Sector Forum and the Co-Production Steering Group. There has also been stakeholder involvement through the workstreams. However, further discussion and engagement would be needed around any plans to alter structures for delivery; budgets or routes for decision-making.

7.9 Communication leads from all organisations involved in the Wellbeing Partnership are now meeting regularly to plan and structure this engagement

Health and Wellbeing Board Role

7.10 It is key that the Health and Wellbeing Board, as the statutory body that brings together health and council decision-makers, continues to influence and steer the path of the Partnership.

7.11 The Wellbeing Partnership has a potentially significant role to play in supporting delivery of the Haringey Health and Wellbeing Strategy. It is important that the Haringey Health and Wellbeing Board is assured that any Accountable Care Partnership is shaped so that it increases the pace and degree to which the strategy can be delivered.

8. Conclusion

8.1 Between January and April 2017 there are some key decisions to be made about the degree of ambition for the Wellbeing Partnership. Organisations would need a clear mandate to move towards becoming 'accountable' for health and care outcomes and spend.

8.2 The views of the Haringey Health and Wellbeing Board are sought on the degree of ambition and the pace of change that is required.

8.3 To date, work on organisational form and structure has been undertaken by the Strategy Leads from organisations represented in the partnership. Sub-groups are now being established to work in December and January on the detailed proposals around governance, finance and engagement.

8.4 The Health and Wellbeing Board is asked to discuss its priorities and to consider its role in relation to the Wellbeing Partnership.

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Report for: Health and Wellbeing Board – 8 December 2016

Title: Section 75 Agreement – Lead Commissioning Arrangements

Organisation: Haringey Clinical Commissioning Group and Haringey Council

Lead Officer: Rachel Lissauer (Director of Commissioning Haringey Clinical Commissioning Group) and Charlotte Pomery (Assistant Director Commissioning Haringey Council)

1. Describe the issue under consideration

1.1 At its September meeting, the Health and Wellbeing Board received a report on the proposal by Haringey Council (the Council) and Haringey Clinical Commissioning Group (the CCG) to implement a model of commissioning and pooled budgets supported by a partnership agreement under S.75 of the National Health Services Act 2006. The Cabinet of the Council and the Governing Body of the CCG agreed the partnership agreement later that month and partners have been working on the detail to enable lead commissioning and pooled budgets for specified care groups to be in place by April 2017.

1.2 As previously notified, the partnership agreement will act as a framework and is designed to enable schedules to be added for other care groups, across all areas of the Council and CCG's activities, as required.

1.3 The Health and Wellbeing Board will maintain its statutory role and have strategic oversight of the integration and partnership arrangements delivered through the s. 75 Partnership Agreement and this report is brought to the Board for an update on the development of these arrangements.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to note the work underway to ensure the following arrangements can be in place from April 2017:

2.1.1 Lead commissioning and the establishment and maintenance of pooled fund for the commissioning of learning disability services for eligible adults resident in Haringey;

2.1.2 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of mental health services for eligible adults resident in Haringey;

2.1.3 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of long term conditions and older people's services, including those services identified in the Better Care Fund 2016/17, for eligible adults resident in Haringey;

2.1.4 Joint commissioning and the establishment and maintenance of a pooled fund for the commissioning of children and adolescent mental health services for the residents of the London Borough of Haringey;

2.1.5 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for eligible adults resident in Haringey.

3. Timings

3.1 The Council and the CCG are carrying out significant work in order to set in place lead commissioning and pooled budgets arrangements by April 2017.

3.2 Lead commissioning

3.3 The Council and the CCG are together working up a commissioning structure to support lead commissioning arrangements in Haringey as agreed from April 2017. This structure is being developed by partners mindful of the thinking shaping other areas of joined up working between health and local government, such as the Accountable Care Partnership across Haringey and Islington and the implementation of the Sustainability and Transformation Plan across North Central London.

3.3 The lead commissioning arrangements will be supported by commissioning specifications for each care group areas which have been developed jointly in light of both national and local policy requirements and in light of the demand and financial pressures facing local provision.

3.4 The roles of the lead commissioners are to:

a) Understand and respond to the need and demand in the local health and care economy
b) Lead on the development of the strategic commissioning intentions of the Council and the CCG, reflecting these in all service specifications
c) Ensure the sufficiency and quality of market provisions to meet need
d) Contribute to the transformation and re-design of services in line with the agreed strategic commissioning intentions
e) As pooled fund manager, manage the pooled budget to support and enable the strategic commissioning intentions
f) Deliver savings as set out in the Council's Medium Term Financial Strategy and the CCG's Quality Improvement and Performance Plans.

3.5 Pooled budgets

3.3.1 Since agreement in September to pool budgets between the CCG and the Council, work has been underway to put in place the required arrangements and

assurances. This work is being undertaken jointly by finance and commissioning officers from both the CCG and the Council in full cognisance of the financial pressures facing both the NHS and local government. It is fully aligned with the budget setting and savings preparation processes for each organisation.

3.3.2 As previously notified, the scope of the pooled budget is all spend in the area whether preventative and community based or secondary and acute based, whether for public health, social care or continuing health care. The agreement is that, rather than gradually pooling different elements of budget, all spend on a particular care group is included in a pooled budget and that ring fences and aligned budgets continue to exist within the overall pool until it is possible to lift the ring fences and to create genuinely pooled budgets with fluid spend on health, public health and social care interventions as required by need and demand.

3.3.2 Partners are working within the risk share agreement which forms part of the body of the s. 75 Partnership Agreement and covers how the CCG and the Council will set the initial budgets to be pooled, deal with over and under spends and specify how any savings or cost efficiencies will be achieved.

3.3.3 Aligned to this process, partners are building their budgets for 2017/2018 (and beyond) and their savings proposals in light of demand and resource constraints over the coming years. It is acknowledged that whilst pooling budgets between the CCG and the Council enables greater flexibility in meeting health and care needs in a joined up way, it also reduces the scope for the CCG and the Council to manage their own budgets autonomously as risks are mitigated and action is taken to reduce spend within the partnership and any savings generated are applied first to the pooled budget arrangements.

3.3.4 The endorsement needed to move from an aligned budget to a fully pooled budget sits with the Joint Finance and Performance Partnership Board (the Partnership Board). The draft baseline budgets for pooling and the draft Joint Savings and Investment Plan are being presented to the Partnership Board in December, as agreed, based on a clear and accurate understanding of activity, performance, costs and demand over the previous period.

3.3.5 The first issue for consideration is the baseline for the budgets to be pooled and it will be necessary to demonstrate to the Partnership Board both that demand and upward cost pressures on budgets in the pooled arrangements have been adequately reflected in the budget setting process where possible and that outstanding pressures are quantified, do not create cross-subsidy via the risk share, and have robust savings plans in place.

3.3.6 The second issue for consideration is the Joint Savings and Investment Plan which sets out not only how savings led by each of the CCG and the Council previously will be brought together but also how the pooled budget will deliver further savings by operating more efficiently and effectively to address need and manage demand.

3.3.6 The Partnership Board will review plans and will recommend the budgets and joint savings plans to the Cabinet and Governing Body for their approval as part of the budget setting process.

3.4 This report offers a brief insight into the work being undertaken by the CCG and the Council to deliver lead commissioning and pooled budget arrangements by April 2017. Whilst significant progress has been made, there is a lot of detail to work through together and a programme of actions yet to be concluded to ensure all assurances and processes are in place for both organisations as set out in the s. 75 Partnership Agreement. Further updates can be furnished to the Health and Wellbeing Board as required.

Report for: Health and Wellbeing Board - 8 December 2016

Title: Haringey Safeguarding Boards' Annual Reports 2015/16

Organisation: Haringey Safeguarding Children Board (HSCB) and Haringey Safeguarding Adults Board (HSAB)

Lead Officer: Patricia Durr, LSCB and SAB Business Manager

1. Describe the issue under consideration

1.1 The annual reports are for the period 1st April 2015 to 31st March 2016 and are produced as part of the Boards' respective statutory duties:

- Section 14A of the Children Act 2004 and Chapter 3 of Working Together to Safeguard Children 2015.
- Section 43 and Schedule 2 of the Care Act 2014

1.2 The reports were ratified by the Safeguarding Boards at their respective meetings in September and November 2016.

1.3 It is a requirement that the reports are submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner (in London the Mayor's Office for Policing and Crime), and the Health and Wellbeing Board.

1.4 The HSCB report provides an overview of Board activities and achievements during 2015-2016; it summarises the effectiveness of safeguarding activity in Haringey; provides an overview of how well children in Haringey are protected, reports on progress on issues and priorities and the Board's Strategic Plan 2016-21. The meeting's attention is explicitly drawn to the Chair's Foreword, especially the last paragraph; Section 6 on Board effectiveness, and the summary in Section 8.

1.5 The HSAB report is for the period 1st April 2015 to 31st March 2016 and is produced as part of the Board's statutory duty under The Care Act 2014 and Chapter 14 of the Care & Support Guidance. The Annual Report gives details of progress on priorities and Strategic Plan 2015-18; sets out how effective the HSAB has been over the 2015/16 year; provides detail on the SARs that it has commissioned, and describes how its partners have contributed to the work of the Board to promote effective adult safeguarding.

2. Recommendations

2.1 That the Health and Wellbeing Board notes the HSCB and HSAB Annual Reports.

3. Appendices

Appendix 1: HSCB Annual Report 2015/16
Appendix 2: HSAB Annual Report 2015/16

Haringey Safeguarding Children Board

Annual Report 2015 – 2016

Haringey Safeguarding Children Board
Annual Report 2015-16

CONTENTS

1 Foreword by the Chair

1.1 Welcome to my second annual report as the Independent Chair of Haringey's Safeguarding Children Board for 2015-16. I am most grateful for the strong support and engagement of partner agencies throughout the year, and the sterling contributions of the Board manager Patricia Durr and Assistant Eliese Gray. The partnership displays a real drive to work purposefully together in the task of keeping children and young people safe within Haringey, and this year has been one of real progress in many areas.

1.2 The external challenges have not become any less on all partners; indeed, in many respects the challenges have increased further. Budget pressures continue to ratchet up amongst all agencies, and in particular the financial and workforce pressures have been becoming more apparent amongst health agencies. Demand has continued to increase; the child population in Haringey has increased markedly in recent years, perhaps as a result of Government welfare changes leading many poor families to leave inner London boroughs and move into Haringey. We see evidence daily of families under increasing pressure, and front-line staff in all partner agencies have had to show real courage and determination in the face of increasing referrals. The world of child protection can be an unforgiving one, so it requires real maturity for agencies to find the necessary balance of strong support and strong challenge. I remain proud of the way in which Haringey agencies confront those areas where we know we need to improve, whilst seeking to identify examples of good practice that we see daily from staff on the front line.

1.3 Resources available to the Board itself have also been under severe pressure. At times we have been over-ambitious in setting out objectives for ourselves, even when we have known that the central coordinating resources are slimmer, and that each partner is under-staffed. As the report will show, although we have achieved much within the year, we have also left undone some of our ambitions. It is the message of the times that we have to find ways of doing more with less, and we have had to be mature and realistic about what is achievable. For example, we would all like to have strengthened further the direct engagement of the Board with children and young people; and our aspirations to begin to recognise good practice more formally and regularly have had to be put on hold. We have streamlined our ways of operating, to maximise on the valuable time that partners make available and to sharpen our approaches to audit, review and decision-making.

1.4 In the previous year we had been inspected by Ofsted, so part of the story of 2015-16 has been one of ensuring that we have responded fully to the recommendations that they produced. Other partners in turn have been inspected by the various regulators; as a Board we consider all external inspection reports, and satisfy ourselves that partners are addressing any issues that relate to child protection.

1.5 As is common within London, we have seen many changes of personnel in key positions across all agencies, and some real challenges for partners to fill some vacant posts. I am pleased that overall the proportions of agency and temporary staff have been reducing, but in the process we have been getting to know many new faces in a multitude of roles. I believe there has been insufficient attention paid by Government Departments to the needs of workforce development across many key sectors; our

challenges in recruiting and retaining health visitors, experienced social workers and senior managers in all agencies is mirrored across London.

1.6 We have initiated some major changes across the partnership in our approaches to working with children and families. The introduction of the "Signs of Safety" approach signals our commitment to strengthening our commitment to "appreciative enquiry", engaging more positively with children and families, and placing trust in front-line professionals to reach conclusions about the families with whom they are working.

1.7 During the year we have focussed closely on Missing Children (with a task group led by the Borough Commander), and on ensuring that our strategy for Child Sexual Exploitation is robust. The calendar year ended with an independent diagnostic assessment of this area of work, a process which engaged all partners in intensive joint work. We were pleased with the endorsements that emerged, whilst also clear on the importance of the further improvements which we have committed to implementing.

1.8 I reported last year on our successful application to the Department for Education for an Innovation Grant to strengthen the quality and range of our joint working to support vulnerable young people across the borough boundaries with our neighbours in Enfield. The project has been highly successful, and provides us with some strong evidence of the importance of finding ways of working flexibly in response to the flexible lives of so many young people.

1.9 In January 2016 the Government commissioned Alan Wood to review the future of LSCBs, and our Board submitted thoughts to this process. The report, and the Government's response, came out this Spring, and we are engaged in thinking about how we can respond as a partnership to the challenges it sets out. Most of the themes identified chime with proposals we had put forward, so I expect our Board to be well positioned for the legislation that is currently working its way through Parliament.

1.10 Safeguarding arrangements within Haringey remain broadly robust and effective, and the partnership continues to demonstrate its willingness to confront and respond to issues which arise. The year ahead looks ever more challenging in relation to resources, and we need to be ready to consider radical different ways of undertaking our key roles. We still need to improve our sharing and analysis of data, so that we can become better at identifying any changes and emerging threats to the safety of children within Haringey. We still need to improve our engagement of children and young people in our work. But as a partnership we are ready for the next set of challenges.

2 Introduction

2.1 This annual report is for the period 1st April 2015 to 31st March 2016 and is produced as part of the Board's statutory duty under section 14A of *The Children Act 2004* and Chapter 3 of *Working Together to Safeguard Children 2015*. The Chair of the Board is required to publish an annual report in relation to the preceding financial year, on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

2.2 The report will be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner[1] and the Health and Wellbeing Board. The report provides an overview of LSCB activities and achievements during 2015 – 2016; it summarises the effectiveness of safeguarding activity in Haringey; provides an overview of how well children in Haringey are protected, and fulfils the Board's statutory duty to:

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

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

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

3 Progress on priorities, issues and challenges

3.1 The *LSCB Business Plan 2014 – 2016* (*Appendix C*) has continued to provide the framework of priorities for our work whilst allowing us to be responsive to emerging themes and challenges: it enables us to monitor and track progress on identified actions.

3.2 We review our priorities annually and in 2015-16 we laid the groundwork for a longer term five year Strategy 2016-21 which is outlined at Appendix D. A new Business Plan is being developed to take us forward in 2016-17 to address priorities outlined in the strategy, which are:

- Priority One: Overhaul the ways in which agencies tackle chronic neglect
- Priority Two: Improve outcomes for children with particular vulnerabilities and those subject to particular risks
- Priority Three: Strengthen cross-borough partnership
- Priority Four: Develop high quality partnership working at all levels between our agencies

The strategy also identifies a couple of enabling priorities:

- Enabling Priority One: Meaningfully engage children and young people in our work
- Enabling Priority Two: Promote and develop the children's workforce to better safeguard children and promote their welfare

3.3 In May 2016, the Wood Review of LSCBs was published with recommendations for changing the statutory arrangements for local safeguarding arrangements. The recommendations have been accepted by Government and are currently being taken forward in the Adoption and Social Work Bill. The Board is therefore reviewing its priorities in light of this. In this section we set out progress achieved in 2015-16.

3.3. PRIORITY ONE Gangs, Child Sexual Expoloitation (CSE) and Missing
Strengthening the connections between work around a) missing children, CSE and gangs, b) supporting and monitoring the development of a multi-agency response, and c) assessing the effectiveness of early intervention in reducing gang membership

3.3.1 We have made good progress in this area underpinned by the following:

- Bi-borough CSE & Vulnerable Children Project funded by the DfE LSCB Innovation Fund in partnership with our neighbouring borough Enfield;
- a multi-agency diagnostic on CSE, recommendations and partnership action plan;
- review of progress against CSE strategy and development of an integrated refreshed action plan with clear accountability;
- developed our reporting cycle to ensure that we received regular reports on CSE, gangs and missing children;
- developed our performance monitoring with a focus on these issues;
- commissioned a Serious Case Review which considered gang association and harmful sexual behaviour to be published in 2016 with learning about approach;
- completed engagement in the MsUnderstood Project looking at CSE, serious youth violence and harmful sexual behaviour;

- Represented on the London Safeguarding Children Board CSE Task & Finish Group
- Strengthened representation of Violence Against Women & Girls (Lead in Public Health) and Gangs and Offender Management (Lead in Community Safety)
- Developed both CSE and Children who run away or go missing from home, care or education pathways and local protocols. Missing Children and Young People protocols
- Developed integrated approaches to considering the links between gangs, missing children and young people and CSE through the Multi-agency Child Sexual Exploitation (MASE) meetings co-chaired by the Borough Police and Children's Social Care.

3.3.2 The sub-group has responded to developments with clear governance and accountability structure and agreed strategy and action plan, which includes connections and routes into the Violence Against Women and Girls Board, Gang Action Group Strategy and oversight of our work on Missing Children & Young People. It has embedded learning about the wider connections to additional vulnerabilities through revision of its remit and role for 2016-17. There is an integrated action plan, with agreed accountabilities and reporting into the Board, which encompasses the recommendations and learning from the multi-agency CSE Diagnostic Report.

3.3.3 The CSE Bi-borough CSE & Vulnerable Children Project enabled us to build on the priority both Boards had committed to the issue. The Project led to the development of a number of joint initiatives including:

- A communication pilot project via North Middlesex University Hospital to provide information to our hardest to reach young people that includes information on a range of vulnerabilities and includes links to our respective youth websites.
- Bi-borough MASH to MASH checks for cases where there is a concern of CSE/ Gang activity
- Aligning the CSE Central Logs across Haringey and Enfield and to introduce a system for gathering intelligence on persons of concern
- Periodic Bi-borough Peer Networking Seminars sharing information about alliances, sexual relationships, tensions places of education and any known gang links to better safeguard children at risk.
- Sharing learning about models of best practice across the bi-borough partnership and to align resources to improve information sharing and safeguarding responses to vulnerable children and young people which included aligning arrangements for Single Points of Contact for CSE across both boroughs in Children's Social Care, Health and the Police and improving MASE arrangements
- Joint CSE and harmful sexual behaviour training targeted at particular professional groups including foster carers, pupil referral units and MASH teams, semi-independent accommodation providers and children's homes

3.3.4 This project demonstrates that where there is an appetite to collaborate in the best interest of our most vulnerable children and young people, much can be achieved

both in terms of best practice and cost efficiencies through sharing resources. A number of recommendations are being taken forward by the Boards to embed the work and continue the collaboration.

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3.4 PRIORITY TWO - Early Help

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

3.4.1 A new strategic approach to enabling early help and intervention for children, young people and their families was launched this year focussed on delivery of integrated, flexible and responsive services with a greater emphasis on prevention and early intervention with the aim of reducing, in the longer term, the need for specialist and more expensive provision. The approach seeks to empower parents, families and children to be resilient and effective in developing a supportive environment for their children. The Strategy seeks to deliver the following three outcomes:

- Improved family and community resilience
- Thriving children, young people and families
- Strong partnerships making effective use of all resources

3.4.2 The Strategy is delivered through the Haringey's Early Help Partnership Board and monitored and reviewed through the Board's governance arrangements. This Board identified that the key risk contained within the strategy is the immediate impact on safeguarding as resources shift to Early Help.

3.5 PRIORITY THREE – Neglect

Improving effectiveness of all agencies in recognising and responding to neglect

3.5.1 The Board is reviewing the development of a Neglect Strategy and has taken this forward in its developing 5 year strategy 2016-21 as a key priority.

3.5.2 Our audit cycle for this year included a multi-agency audit focused on neglect which took place in two stages over Q2 and Q4. Compliance rate was 100% collectively although not all of the children were known to all services within the timescale. A common challenge in multi-agency auditing is the differences in the way in which the audit was undertaken and moderated and an acknowledgement of the different skills levels and approaches within and between agencies. Some good practice showed evidence of a real commitment to hearing the child's wishes and feelings but overall there is work to do to improve engagement with children. Some good evidence of partnership working but some concerns around reporting and recording. All cases evidenced that CP case conferences, initial and reviews, are held in a timely manner and that core groups are regularly being held.

5.2.3 A number of recommendations are being taken forward including the development of documents, training and tools to support and deepen understanding of neglect; improve the use of hypothesis and analysis in neglect cases; embed Signs of Safety

to enable a more robust multi-agency approach to identify risk and expressing and owning the level of concern; review the suitability and availability of direct work tools and resources to improve and support direct work with children and young people; and increase understanding of the impact of neglect and attachment theory and neuroscience through the multi-agency training programme.

5.2.4 Additionally our new Board Strategy commits us to:

- develop a LSCB neglect strategy ensuring that prevention and Early Help is at the centre of response
- develop understanding across the partnership of attachment theory
- develop and roll out a training programme to ensure thresholds are correctly applied
- get messages out into communities through information and other campaigns
- support early intervention and parenting programmes such as Family Nurse Partnership and Parent-Infant Programme.

3.6 Progressing Priority Four ***Promoting good practice*** **and** Priority Five, ***Engaging the voices of children and young people*** has proven to be a real challenge this year. Capacity and resources have not allowed for the necessary development time for the Board Manager to build the infrastructure needed. The number of Serious Case Reviews has diverted attention away from appreciative inquiry. We have continued to improve engagement with schools through representative Primary and Secondary HTs now members of the Board. The Board Manager now works with the School Improvement Safeguarding Lead to develop the Designated Safeguarding Lead Forum.

3.6.1 Engaging children and young people remains a firm enabling priority in our new strategy which commits us to:

- Establish a robust, proportionate system for securing the views of children and young people on key issues concerning the Board, including CYP who are themselves at risk.
- Build on the extensive existing mechanisms for capturing CYP's views, to allow for key issues to surface for consideration by the Board.
- Establish a system for CYP to present periodically to the Board on key issues.
- Ensure annual audit cycle and performance framework consistently includes attention to children's lived experiences and journeys

3.7 **Signs of Safety (SoS)**

3.7.1 In Q1 the Board took the formal partnership decision to support the adoption of the SoS model of approach to working with children and families and confirmed funding for an accredited training programme across the partnership. SoS puts children, parents and everyone connected to the children at the heart of assessments and decision-making and gives them every opportunity to come up with their own ideas on how to make their children safe before we offer/impose our own solutions. Clear leadership provides workers with the confidence to make the right decisions at the right time to support families to stay together.

3.7.2 The three main principles of the SoS model are:

- Developing positive and constructive working relationships with families, children and between professionals.
- Working with families from a stance of appreciative inquiry and being professionally curious, applying a questioning approach.
- Promoting the direct involvement of practitioners and service users in the research and development of SoS so that the model is informed by what complex case work and child practice actually looks and feels like.

3.7.3 An implementation plan has been agreed by the Executive running through four phases and involving training and strategic development. Phases 1 and 2 were completed this year. Phase 1 was about leadership and the development of the plan and the alignment with practice across the partnership. A workshop was held on 29th July and involved the Executive membership and other key partnership representatives. Phase 2 was about rollout across the partnership and includes introductory training. Phases 3 and 4 involve further practice development and practice leadership.

4 Local Context

4.1 Haringey is an exceptionally diverse and fast-changing borough. We have a population of 267,540 according to 2014 Office for National Statistics Mid Year Estimates. Almost half of our population and three-quarters of our young people are from ethnic minority backgrounds, and around 200 languages are spoken. Our population is the fifth most ethnically diverse in the country.

4.2 The borough still ranks among the most deprived in the country but has seen improvement in its ranking over the past six years - with the exception of Education and Living Environment, Haringey has seen an improvement in rankings for all domains in the English Indices of Deprivation 2015. Haringey is the 30th most deprived borough in England and the 6th most deprived in London with the 10th highest level of child poverty in London. 7 of Haringey's 19 wards are within the most deprived 10% nationally. All of these wards are in the east of the borough where Northumberland Park remains the most deprived.

In terms of crime, Haringey is ranked 8th most deprived in England out of 326 local authorities and 8th in London out of 33 local authorities.

4.5 There are approximately 63,400 children and young people under 20 living in Haringey (approximately one third of the total population). The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane and Tottenham Hale. There are more children in the east of Haringey, which has higher levels of deprivation than the west.

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

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

4.9 Haringey's Joint Strategic Needs Assessment (JSNA) 2014/2015 describes the health, care and wellbeing needs of the local population. This helps the CCG and Haringey Council commission the best services to meet those needs

5 Governance and accountability

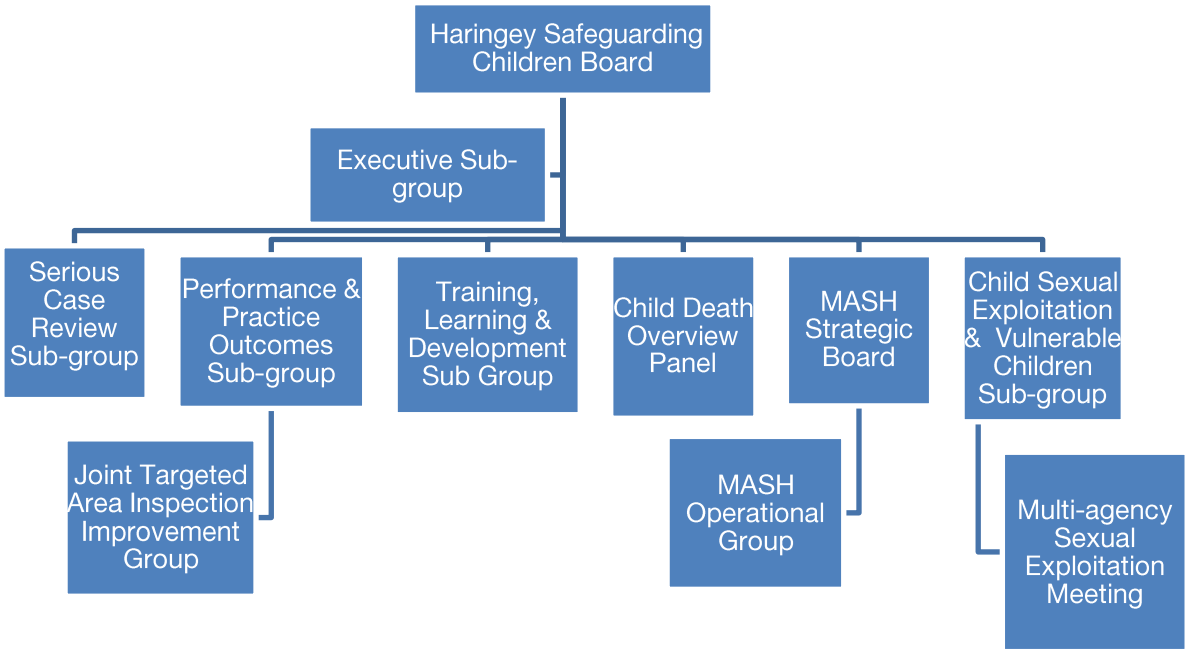
5.1 The LSCB has an independent chair and a number of subgroups chaired by a senior member from across the partner agencies. The Chair is accountable to the Chief Executive of the local authority in chairing the LSCB and overseeing its work programme. However, he is accountable only to the Board for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

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

5.3 Governance continues to be strengthened with regular reporting from sub-groups through to the Executive and the Board; a range of task and finish group activity with clear reporting lines the continuation of our member appraisal process, and the introduction of 360degree appraisal of the Chair..

5.4 During the year the structure of the Board changed to reflect priorities and efficiencies. We report on the business of each of the sub-groups operating during 2015-16 in this report and the structure below reflects the shape of the Board from April 2016.

Board Structure 2016/17



5.5 Relationship between the LSCB and other strategic boards

5.5.1 The Chair of the LSCB attends the Health and Well-Being Board. He meets regularly with the Chief Executive and Deputy Chief Executive, the Director of Children's Services, the lead member for children, the Council Leader, and the Chair of the Adult Safeguarding Board. He meets annually with the Chief Executives of the key

partner agencies. He meets annually with the Council's Scrutiny Committee. Links are maintained through representation on key strategic partnerships:

- Community Safety Partnership
- The Health & Wellbeing Board
- The Safeguarding Adults Board
- The Violence Against Women & Girls Strategy Group
- The Preventing Radicalisation & Violent Extremism (Prevent) Delivery Group

This year, the Board has developed a Prevent Action Plan and the Board Manager sits on the borough Prevent Delivery Group.

5.6 **The Local Authority**

5.6.1 Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, and statutory guidance Working Together to Safeguard Children sets these out in detail. This includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm, regardless of where they are found, under sections 17 and 47 of the Children Act 1989. The Director of Children's Services and Lead Member for Children's Services in local authorities are the key points of professional and political accountability, with responsibility for the effective delivery of these functions.

5.6.2 The Local Authority - lead by the Director of Children's Services and the Deputy CEO - is represented at all levels of the LSCB and plays a lead role in the partnership.

5.5.7 **The Partnership**

5.7.1 Safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play.

5.7.2 A range of local agencies, including the council, the police and health services, have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. Under section 10 of the same Act, a similar range of agencies are required to cooperate with local authorities to promote the well-being of children in each local authority area (see chapter 1). This cooperation should exist and be effective at all levels of the organisation, from strategic level through to operational delivery
More information about these statutory duties can be found at Appendix B.
In addition to these section 11 duties, which apply to a number of named organisations, further safeguarding duties are also placed on individual organisations through other statutes.

5.8 Health

5.8.1 Haringey CCG is the major commissioner of local health services across the borough and is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. All health providers in Haringey are required to have effective arrangements in place to safeguard vulnerable children and to assure the CCG, as commissioners, that these are working. Designated Professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the Local Authority and the Haringey Local Safeguarding Children Board (HSCB). They also provide advice and support to multi-agency health professionals.

5.8.2 *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015)* defines the safeguarding responsibility and duty of Clinical Commissioning Groups (CCGs). CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding children.

5.8.3 Haringey CCG fulfils and is compliant with these safeguarding children responsibilities and duties during the period of 01/04/15 to 31/03/16 as outlined in its Safeguarding Children Annual Report 2015-16 within its own organisation and across the organisations from which it commissions. Additionally NHS England conducted a series of deep-dive exercises across CCGs' arrangements and in 2015, one of the areas of focus was safeguarding. The results of this process were reported in February 2015 and they acknowledged the extent of focus and commitment to safeguarding within Haringey CCG.

5.8.4 The Assistant Director Safeguarding/Designated Nurse Safeguarding Children, Designated Doctor, and Named GP were full and active members of the HSCB in 2015/16; regularly attending and contributing to the bi-monthly meetings. The Assistant Director Safeguarding / Designated Nurse Safeguarding Children and Designated Doctor were also full and active members of the HSCB Executive. The Assistant Director Safeguarding / Designated Nurse for Safeguarding Children continued in the capacity of Vice Chair of the HSCB throughout this period, as well as chairing the CSE Subgroup (which developed the borough's CSE Strategy and Action Plan) and Vice Chairing the Violence Against Women and Girls (VAWG) Strategic Group; with the Interim Assistant Designated Nurse and latterly the Deputy Designated Nurse attending the VAWG Commissioning and Harmful Practices Groups.

5.8.5 The three main Provider Trusts are all also represented on the Board and hold internal bi-monthly safeguarding children committees attended by the Designated Doctor, Assistant Director Safeguarding / Designated Nurse Child Protection or

Deputy Designated Nurse. The meetings provide an opportunity for information sharing and challenge regarding all aspects of safeguarding children. Any issues arising are discussed with the Executive Nurse/ Director of Quality and Integrated Governance and within the Haringey CCG Safeguarding Children Assurance meeting as appropriate. All Named Safeguarding Professionals in the Provider Trusts were up-to-date with safeguarding children training during 2015/16. More information is contained in the CCG Annual Safeguarding Report[2]

5.9 **The Metropolitan Police**

5.9.1 The Metropolitan Police is represented on the Board across a number of different commands and teams including the Haringey Borough Command and its Public Protection Unit; the Sexual Offences, Exploitation and Child Abuse Investigation Command (Specialist Crime and Operations 17) and the local Child Abuse Investigation Team and regional Sexual Exploitation Team. Additionally Serious Case Reviews are supported by the Specialist Crime Review Group.

5.9.2 SC&O17 teams investigate allegations of abuse against children, under 18 years of age, involving family members, carers or people in a position of trust. This includes allegations of physical abuse, sexual abuse, emotional abuse and neglect. They also investigate historical allegations where the offence took place when the person was under 18 but is now an adult. All children are considered vulnerable to crime and abuse by adults and other children and young people. All offences against the child are governed by legislation which determines differing ages for specific offences.

5.10 **Financial arrangements**

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

5.10.2 The guidelines which we adhere to (Working Together 2015) make it clear that funding arrangements for Safeguarding should not fall disproportionately and unfairly on one or more partner to the benefit of others. In London this burden does fall unfairly on Local Authorities because the Metropolitan Police continues to choose to fund partnership safeguarding in London at a level 45% below all the other large urban Metropolitan Police Forces in England. This is not negotiable at a local borough level.

5.10.3 The safeguarding structures in London are changing but there will still be a need to resource whatever arrangements are put in place.

[2] Safeguarding Children Annual Report 2015/16, can be found on the Haringey Clinical Commissioning Group website

5.11 Reports from Sub-groups

5.11.1 Serious Case Review (SCR) Sub-group

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

5.11.2 The group met 5 times during the course of 2015-16. Attendance was good at all these events, although the Chair missed one meeting through illness (chaired by the LSCB Vice-Chair).

5.11.3 During the course of the year the following issues were discussed and actions taken:

a. Monitoring of Action plan in respect of Child T
b. Agreeing publication of SCR on CH, in partnership with LB Enfield, agreeing communications strategy and monitoring Action Plan
c. Agreeing publication of Child O, and agreeing dissemination
d. Commissioning, and monitoring production of, SCR on Child R (due for publication in June 16)
e. Commissioning SCR on Child S
f. Considering the learning from SCRs published in Haringey over recent years, identifying common themes and agreeing a communications strategy
g. Considering – but not completing – production of a Haringey protocol on undertaking SCRs

5.11.4 The **SCR on CH** concerned a troubled young man who, at the age of 15, murdered another young man in a knife attack. The report highlighted the depth of CH's experiences with violence throughout his life, the complexity of the his mother's actions to hinder effective agency engagement, the problems encountered in transferring the case from Haringey to Enfield, and some clear occasions where more effective and direct involvement could have been expected by agencies. From the publication of CH, the key areas of learning arose from the need to address the following issues, all of which have been addressed in the action plan:

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

5.11.5 The **SCR on Child O** concerned a deeply troubled young woman with long-standing mental health problems who took her own life at the age of 16. She had received intensive input from several agencies over a prolonged period, but no one had succeeded in building a sufficiently trusting relationship to understand the cause of her distress or find a way of helping her. The report highlighted some failures to respond appropriately to regular unspecific allegations from O regarding sexual offences against her; recent changes in policy and practice in all agencies would hopefully have produced a more appropriate response today. The report found some failings in the formal child protection arrangements undertaken by several of the agencies. The process of agreeing the joint funding of place at the residential therapeutic placement from where O took her own life was prolonged and not well managed. When Ofsted rated the placement inadequate on safeguarding, whilst the council was right to review the placement, the review judged it to have done so insensitively and in too much haste. All these issues have been addressed within the action plan.

5.11.6 **Protocol** – whilst the plan to produce a protocol setting out Haringey's processes for SCRs has not been completed, the two new SCRs which have been commissioned are testing out different approaches to engagement with staff, and use of a Panel. Creation of a protocol has been deferred whilst the Government itself reviews its arrangements for SCRs.

5.11.7 **The review of key learning from previous Haringey SCRs** threw up a series of recurring themes, and focus groups are being established to discuss each of these issues with staff:

- Weaknesses in professional challenge
- Failures to assess the wider family, environment and case history
- Poor inter-agency communication
- The need to intervene earlier
- Lack of professional awareness over emotional harm inflicted on the child
- Organisational, planning and process failures.

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5.11.8 We held three learning events across the year, including a joint event with Enfield Board to disseminate learning from the SCR on Child CH, and two SCR workshops looking at the SCRs for Child CH and Child O as part of the Board Training Programme.

5.12 **QA & Best Practice Sub-group** – ***now Practice and Performance Outcomes (PPO) Sub-group***
Chair: *LB Haringey Assistant Director, Quality Assurance, Early Help & Prevention*
Remit: *To monitor the effectiveness of multi-agency child protection and safeguarding work through data analysis and audit processes. To monitor and scrutinise the effectiveness of local arrangements to safeguard children and, through this, to ensure a demonstrable impact on services.*

5.12.1 The PPO sub group met in May and September 2015 and January 2016. There has been good attendance from CYPS, Schools and Learning, LA Performance, CAIT, Commissioning, Legal and Health - Haringey Clinical Commissioning Group (HCCG), Whittington Hospital NHS Trust (Whittington), North Middlesex University

Hospital Trust (NMUH) and Barnet Enfield and Haringey Mental Health Trust (BEH-MHT). The Group is chaired by the Assistant Director Safeguarding and Social Care.

5.12.2 **Activity, Progress and Achievements 2015/16**

- Audit cycle has continued with Voice of the Child in Q1, Neglect in Q2/Q4 and the CSE Evaluation carried out independently in Q3. All these audit reports have been presented to the LSCB board along with action plans.
- Development of a model data set has been much more challenging and time consuming. As a number of agencies found it difficult to provide data requested in the initial data set model, and it was revised to overcome these difficulties.
- Submission of data has been quite variable in that some agencies have submitted comprehensive data on time whereas others have had to be chased and even then submitted only incomplete data. Efforts are continuing to bring about improvements both in the timeliness and quality of data.
- Work has taken place to develop a Performance Framework with an appropriate score card.
- Threshold guidance was updated to incorporate the latest government guidance in relation to CSE, Prevent and LADO along with the associated indicators.
- "Learning from SCRs" seminars have continued. A cross border joint seminar in relation to CH SCR was held with Enfield LSCB.

5.12.3 **Planned Next Steps:**

- A Joint Targeted Area Inspection (JTAI) Improvement Group has been established reporting to the Board via the PPO Sub-group.
- An independent multi agency evaluation on the theme of Domestic Violence has taken place recently, reflecting the criteria established for us by the JTAI process. Recommendations will be considered to decide what improvements need to be made both in terms of data and practice.
- Consideration has been given to amalgamating the JTAI and PPO subgroups; however, this matter needs to be examined further to ensure that important aspects of PPO's work are not overlooked.
- Monitor the consistent use of the Performance framework by all agencies.
- Improve communication about performance across the partnership including the outcomes and learning from audits and reviews.

5.13 Child Death Overview Panel (CDOP)

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

5.13.1 As the year in question has only just closed, this is a preliminary report and, as such, subject to change. The system was piloted in 2007/8 and has been fully functional from 2008/9. A full report on the scheme from 2008/9 will be prepared later in the year. In 2015/16, there were 24 deaths of children normally resident in Haringey. For many of these, final post mortem reports, inquests or other proceedings are still in

progress. The table below describes the children who died by their age and provisional diagnosis. These have not yet been confirmed by the CDOP.

Age	**<28 days**	**28 days <1 year**	**1 year <5 years**	**5 years <18 years**
Cause of Death				
Deliberately inflicted injury, abuse or neglect				1[1]
Malignancy		1		2
Acute medical or surgical condition				
Chronic medical condition		1[2]		1[3]
Chromosomal, genetic and congenital anomalies	1	2		1
Perinatal/neonatal event[4]	6	2		
Sudden Unexplained Infant Death		2[4]		
As yet unascertained	1	2		1
TOTAL	**8**	**10**		**6**

1. This youth was fatally stabbed just short of his 18th birthday. He was known to social services and the youth justice system. A serious case review is being undertaken.
2. This infant died from cardiac disease secondary to unrecognised vitamin D deficiency. His older sister had already been treated for this condition. His mother misunderstood information given about vitamin D deficiency and only took supplements herself. The importance of vitamin D deficiency and the availability of free supplements, to those who need them, is being emphasised to healthcare professionals and the leaflet for parents has been revised. Coincidentally, national information is being put in all red books (Personal Child health Records). The Public Health Department of the Local Authority will organise a symposium.
3. A young person ingested a constituent of food to which she was known to be allergic and subsequently died. The exact circumstances are yet to be made clear.
4. In one instance the mother was known to have taken up smoking after delivery, having ceased during the pregnancy.

5.13.2 During the year, there were eight rapid response meetings in relation to unexpected deaths, as well as three meetings of the CDOP panel itself. The work of the CDOP was significantly hampered by the absence on long term sick leave of the Health Services Single Point of Contact, demonstrating the great value of her contribution.

5.14 Child Sexual Exploitation (CSE) & Vulnerable Children Sub-group

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

5.14.1 The CSE sub-group is made up of a wide range of relevant partners. During 2015/16 the group met five times and has largely been working on monitoring the implementation of the Haringey CSE strategy. The CSE Strategy was ratified by Haringey LSCB in January 2015. The action plan was developed by the CSE sub-group and ratified by the board in March 2015.

5.11.2 The CSE Action Plan consists of five objectives, beneath which a number of actions have been taken and a number are planned:

- Prevention and Early Identification
- Data Collection and Analysis
- Providing effective services and support
- Prosecution and disruption
- Governance and Scrutiny

5.11.3 **Activity and progress during 2015/16:**

- All agencies had access to e-learning on CSE and face-to-face courses via the LSCB and via internal organisational training. Safer London delivered training sessions to a variety of staff within schools and health agencies.
- Haringey had a CSE Single Point of Contact (SPOC) in place within Whittington Health, CYPS and the Metropolitan Police. These people were the conduit for information flow into and out from the Multi-Agency Planning (MAP) and Multi-Agency Sexual Exploitation (MASE) meetings.
- All the care and support provision used by Haringey for looked-after-children located both in and out of the borough was mapped. Requirements with regard to CSE including expectations of staff working with children and young people has been included as part of the contract specification for the planned procurement of semi-independent provision.
- Haringey Public Health team undertook a review of Haringey schools Sex and Relationships Education (SRE) policies during the spring and summer term of 2015 and found that specific information about CSE and Female Genital Mutilation (FGM) was not included in the SRE policies but was sometimes mentioned in the Child Protection, or safeguarding policy. Advice was offered and suggestions made for improvement.
- A key aspect of the CSE strategy was to collect and analyse a range of data to inform the response to the CSE within Haringey. The work of the MASE meetings informs the borough's CSE profile and a first report for quarter 1 was presented to the LSCB in September 2015. The CSE profile was discussed at each CSE Sub-group meeting. The Profile is compliant with the London CSE Operating Protocol identifying needs of children and young people, details of offenders; details of problem locations and themes arising.
- Haringey was successful in a joint bid with Enfield LSCB for Department for Education Innovation funding which enabled a project lead to be commissioned to develop closer joint working across Haringey and Enfield to meet the needs of young people at risk of or experiencing CSE.
- During 2015 the London CSE Operating Protocol was adopted for all MAP and MASE meetings within Haringey with the aim of facilitating the use of standardised criteria, agreed risk assessment tools and ensuring young people received a consistent and appropriate response.

- In November 2015 the HLSCB Child Sexual Exploitation Pathway & Governance was published. It had been developed in consultation with safeguarding partners in Haringey to ensure that staff from all services are well informed about local CSE arrangements. The guidance aimed to ensure that professionals are able to understand how to identify and assess risk, share information, work well together, form professional judgements and make informed decisions to help vulnerable children and young people and safeguard and protect those in need of support, protection and care.
- Also in November a multi-agency diagnostic of services for Children and Young people at risk of CSE was commenced which considered a number of key themes and made a number of recommendations to further improve the partnership response to CSE. These recommendations have been added to the CSE action plan for consideration and implementation during 20167/17.
- Two data bases – an offender/suspect profile and a victim profile - were created to inform and populate a CSE profile in a standardised way, whilst enabling professionals to identify the most vulnerable children and track themes locations and trends.
- In early January 2016 The London Safeguarding Children Board issued revised guidance on CSE with significant changes which the partnership responded to.

5.11.4 **Planned next steps for 2016/17:**

Much progress had been made since March 2015. However there remains much to do to ensure that the work already achieved has a positive impact on children and young people. The frequency of the meetings will be reviewed with a view to using task and finish groups to drive the implementation of the strategy forward. Actions planned include:

- Revision of the HLSCB Child Sexual Exploitation Pathway & Governance in light of the London SCB revised guidance
- Development and dissemination of Local CSE publicity materials
- Consideration of the CSE Champions model within a broad range of agencies and providers.
- Develop a high level, targeted disruption and prosecution strategy.
- Development of the group into scrutiny and accountability for a range of vulnerabilities.

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5.12 **MASH Strategic Board**

Chair: *Assistant Director Safeguarding and Social Care. LB Haringey*
Remit: *To improve safeguarding arrangements and promote the welfare of children through the successful implementation of a Multi Agency Safeguarding Hub in Haringey.*

5.12.1 The MASH Strategic Board (MSB) was revived this year and has met regularly every two months since the first meeting in May 2015. The group has enjoyed good attendance from partners, namely, CYPS, police, health (CCG, North Midds, Whittington, CAMHS and MH Trust), probation, education, Mosaic support staff and performance.

5.12.2 **Activity and Progress 2015/16**

The main focus of the MSB has been:

- to oversee the development and launch of Single Point of Access (SPA) and Multi Agency Safeguarding Hub.
- to ensure there is an appropriate level of presence of staff from key MASH partner agencies.
- holding the MASH Operational Group to account and that the operational protocol is being implemented effectively.
- to agree MASH IT solutions and the data set to measure the activity and the effectiveness of the MASH.
- development and implementation of Information Sharing Protocol.
- oversee the implementation of the MASH Improvement Action Plan focusing on information sharing, governance, staffing, I.T., premises, operational protocol, training, performance reporting and PR/Comms.

5.12.3 **Achievements to Date**

- Four well attended multi agency briefing sessions held to launch SPA and MASH with positive feedback from partner agencies.
- MASH Improvement Action Plan has been implemented and signed off.
- Issues of staffing levels have been discussed and resolved although clarity is still being sought about the level of health staffing commissioned for the MASH by CCG.
- Presence of Early Help personnel in the SPA taking work directly from SPA to Early Help.
- Clear separation of contacts and referrals and the respective pathways for both.
- The Operational MASH Group operating effectively to drive the business of MASH and also interrogating data to develop a better understanding of performance.

5.12.4 **Planned Next Steps**

- Embedding the consistent use of thresholds across all partner agencies as well as in SPA and MASH.
- Interrogation of the MASH data set more systematically to explore why so many contacts and S47s lead to no further action.
- Responding to the recommendations from the SCR Child R to review the MASH

5.13 Training, Learning & Development Sub-group

Chair: *LSCB Training Co-ordinator (until July 2015)*
Named Nurse for Safeguarding, Whittington Health (July 2015- Feb 2016)
Vacant (since Feb 2016)

Remit: *To monitor and evaluate the effectiveness of safeguarding children training, learning and development across the partnership.*

5.13.1 The Training, Learning and Development Sub-group is tasked with addressing the training needs of the partnership and is generally well-attended by most members, who are motivated and reflective partners and are deemed at the appropriate level of responsibility within their organisations to make the decisions required. Unfortunately the group has struggled in 2015-16 to be as effective as it might due

to problems with chairing the group and a vacancy within the Board Business Unit for the training lead. This has meant that plans around quality assuring training across the partnership, adopting a new approach to single agency training oversight and communication with children and young people and the wider community and partnership have not been progressed.

5.13.2 The group oversaw the 2015-16 LSCB multi agency training programme which delivered 19 training courses over 36 sessions; approximately 700 training places were offered to workers across the agencies, similar to the previous year and covering a full range of levels 1-4, skills and knowledge areas. Learning lunches on CSE and Preventing Radicalisation were also offered.

5.13.3 The largest take up of the multi-agency LSCB training offer was from CYPS staff and schools, followed closely by early years settings. There has been a drop in attendance from other agencies over previous years. Training for Designated Safeguarding Leads has been the most popular course and as a result of increased demand from schools across the borough and anticipated further increase following the review of the statutory guidance Keeping Children Safe in Education, Schools and Learning Traded Services are now providing this course for schools as part of their wider training offer in addition to the LSCB multi-agency offer.

5.13.4 New this year was Signs of Safety training and briefings following agreement by the Board in May 2015 to adopt and implement this approach to safeguarding and child protection. Phase 1 implementation involved five 2 day training session for social workers and Early Help staff and six half day partnership briefings to introduce the model. Also this year, the DfE funded bi-borough CSE & Vulnerable Children Project allowed us to explore and develop greater collaboration and a joint training offer with our Enfield neighbours around CSE and harmful sexual behaviour. A number of targeted courses were offered in the last quarter of the year and through in to Q1 2016-17. The Board Managers are continuing to develop this collaborative approach to training.

5.13.5 The group had plans to explore ways of reaching more staff across the partnership and ensuring that the learning is effectively and usefully disseminated by diversifying the training offer. This is in part prompted by some concern about dips in applications and attendances for full day training courses which is thought to be at least in part due to diminishing capacities of the multi-agency workforce to engage in whole day training. Further consultation with the workforce was planned and will be carried forward through 2016-17 as the Board also considers the potential impact of the Government's new proposals for safeguarding arrangements through the Adoption and Social Work Bill.

5.13.6 In December 2015 FUSE - a new learning platform - was launched which enables participants to access all available training and book themselves onto courses. There were some problems for partners to access and register with the service – some of which are ongoing and we are keeping it under review. The Business Unit has worked hard to ensure that this was not a barrier to people accessing the training courses.

5.14 **Local Authority Designated Officer (LADO)**

5.14.1 The Local Authority Designated Officer is a statutory role; the role and its remit are clearly defined in Chapter 7 of the London Child Protection Procedures as well as in the Government guidance "Keeping Children Safe in Education". Contact is made with the LADO when there are concerns that a professional or volunteer working with children has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against a child
- Behaved towards a child/children in a way that would indicate they may pose a risk of harm to children.

This concern includes behaviour or an incident in the home life of a professional or volunteer where the procedures may apply.

5.14.2 Following the appointment of a permanent LADO in April 2015, it has been possible to develop a more consistent approach to data collection and analysis regarding contacts and referrals made to the LADO. This year there were a total of 276 consultations with the LADO, an average of 5.3 per week. The first quarter showed 59 contacts with the LADO; the last quarter had 76, showing a steady increase over the year. This can be explained in part by the consistency of having a permanent LADO who has been building links with partner agencies and staff within Children's Services, and partly by a greater understanding of the role within the borough. Comparable data obtained from neighbouring boroughs would suggest the current levels of activity are about what would be expected.

5.14.3 In 2015-16 out of a total 276 contacts for advice, consultation or referral from various partner agencies:

- 69 were from the education sector (25%) - usually from Head Teachers or Designated Safeguarding Leads;
- 94 contacts from social workers either within the London Borough of Haringey, or in other neighbouring authorities (34%);
- 15 from the Early Years Service (5%);
- 17 formal contacts from Ofsted (6%); and one from the Department for Education;
- 23 from the police, either the Child Abuse Team or from other parts of the police service (8%);
- the remainder of contacts were from a number of partners both statutory agencies and within the community.

5.14.4 The largest number of consultations were about, rather than from, those working in the education sector. These amounted to 122 of all the 276 contacts; this is 44%. 73 (26%) of consultations with the LADO were about qualified teachers.

5.14.5 55 of the referrals were sufficiently serious to require a formal investigation. Of these, 10 cases were found to be substantiated. This figure remains broadly constant, and is consistent with figures in neighbouring authorities.

5.14.6 It is expected that work will continue to embed and promote understanding of the LADO role across partner agencies. It is hoped that by raising the profile of the role within the borough concerns and allegations about staff who work with children and young people can be dealt with firmly, fairly and consistently. Actions should be agreed with understanding of the implications for both the children involved and the professional or volunteer.

6 Board effectiveness and challenge

6.1 During the year all Board members were appraised by the Chair or Vice-Chair, reviewing the contribution they had made to the work of the board and securing their views on the board's strengths and weaknesses, and the conclusions from the appraisals were considered by the Executive and the full Board. Board members are largely positive about the efficiency and effectiveness of the Board – the quality of its reports, its minutes, and its decision-making - whilst noting the need for further strengthening of the Board's direct engagement with children and young people. Those agencies which operate across more than one authority boundary are supportive of identifying ways in which the number of meetings can be reduced, and supportive of increasing further collaboration with the Safeguarding Adults Board and with neighbouring LSCBs.

6.2 In response, the Board has agreed to streamline its work into quarterly meetings, with consequent reductions in the frequency of some sub-committees. Links with the Safeguarding Adults Board has been further strengthened, with joint work planned and collaboration in particular with the Enfield LSCB has become significant and influential.

6.3 The Board continues to provide an opportunity for rigorous challenge of the work of partners. Much of the necessary challenge rightly occurs outside the public setting of a full Board meeting, and the Chair's regular challenges to partners reflect the Board's commitment to avoiding the "naming and shaming" which has characterised much child protection practice nationally. The Serious Case Reviews provided many opportunities for challenge – summarised in Section 5.11. The Board has also focussed in some detail on the work of the front door and the MASH, seeking assurance on the engagement by all partners, the delivery of objectives, and the understanding of thresholds. The board has also provided consistent challenge to improve the practice of Strategy Meetings, in particular to ensure appropriate invitations to and engagement of health professionals, to ensure that meetings always take place when required, and to increase the capability of carrying out some such meetings "virtually".

6.4 During the year there has been a significant improvement in the frequency and quality of strategic joint working across the agencies regarding high risk young people. A pattern of monthly breakfast meetings has been established, which in turn spawned the creation of a new strategic group (reporting to the LSCB) to review practice in areas covered by Joint targeted Area Inspections. These processes have injected some vigour and pace to the processes of joint working.

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

6.4 Overall, the Board considers itself to be broadly effective, providing rigorous challenge and scrutiny across partners, combined with increased levels of support. The Board still has more to do to engage the voices of children and young people,

and lay members, effectively within its work. Whilst the quality of its performance data has improved, and the regular interrogation of the data has become regular, in line with neighbouring authorities there remains a real challenge to securing relevant multi-agency data in a timely manner.

6.5 The shortage of resources available to the Board has become more apparent. Appropriate levels of funding have been hard to secure from some partners, in particular from the Metropolitan Police, and the budgets are increasingly dependent upon the council's contributions, at a time when council budgets are under severe pressure. The Board has had to be realistic in tempering some of its aspirations, in the light of inadequate resources available to the board itself or to partners.

6.6 In the coming year, as the Board responds to the recommendations of the Wood Report, there will be many further changes. Many of the Government's proposed changes chime with the views of the Board – processes of simplifying arrangements, streamlining meetings and membership, reviewing the coordination of Child death Reviews, simplifying processes of Serious Case Reviews, and looking imaginatively at cross-borough arrangements, are all consistent with Board thinking. But times of change bring risks of disruption and further resource pressures. The year ahead will be one of high risk for the strength and sustainability of LSCBs. As a partnership I want us to remain faithful to our vision for all children to be safe and healthy, to enjoy life and to fulfil their social and educational potential.

Quality and Performance

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

7.2 **Audits**

Our agreed audit cycle this year included four agreed priority areas to establish a genuine multi-agency approach to audits in 2015/2016:

- Q1 – Children's wishes, feelings and experiences
- Q2 – Neglect
- Q3 – CSE and other additional vulnerabilities
- Q4 - Child's journey – pathway from identified need

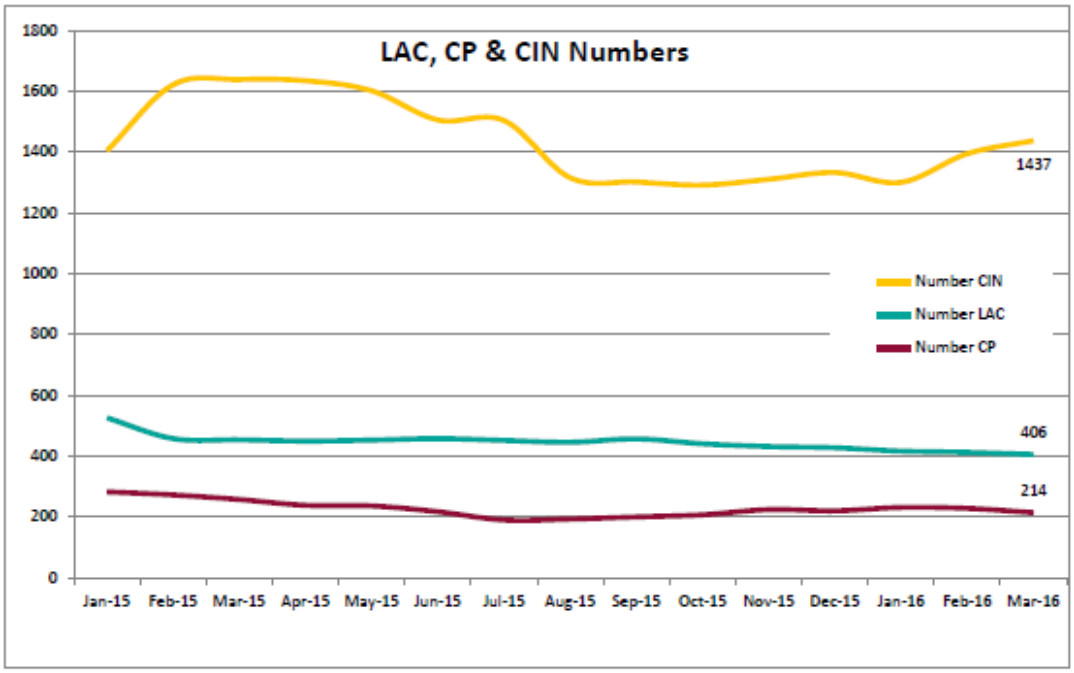
7.2.1 As a partnership we were able to complete three audits this year, instead of the planned four, partly due to the intensity of the Q3 CSE evaluation which involved an external evaluator in a process which was akin to a mock inspection and provided a rich feedback tool for the partnership.

7.2.2 Outcomes of the audits on Children's wishes, feelings and experiences, CSE and neglect are discussed elsewhere in this report. Moving forward into 2016-17 we have established a Joint Targeted Area Inspection Improvement Group which will provide the framework and expertise to undertake multi-agency audits and improve our approach.

7.3 **Children in Need of Safeguarding and Support**

This year saw significant changes to the management of the multi-agency front door in Haringey with the full launch of Single Point of Access and Multi-agency Safeguarding Hub arrangements from 1st February 2016. The new process for recording each individual child's contact and referral episodes has meant some settling in.

There has been a 6.2% increase in contacts compared with 2014-15, most notably in the last 2 months of the year. The number of recorded contacts in March at 907 is 60% higher than the number received in December and January. Referrals and assessments have also increased substantially in the same period. It is thought that this change may well be related to implementation of new SPA arrangements


LAC, CP & CIN Numbers
1800
1600
1400
1200
1000
800
600
400
200
0
1437
406
214
Number CIN
Number LAC
Number CP
Jan-15
Feb-15
Mar-15
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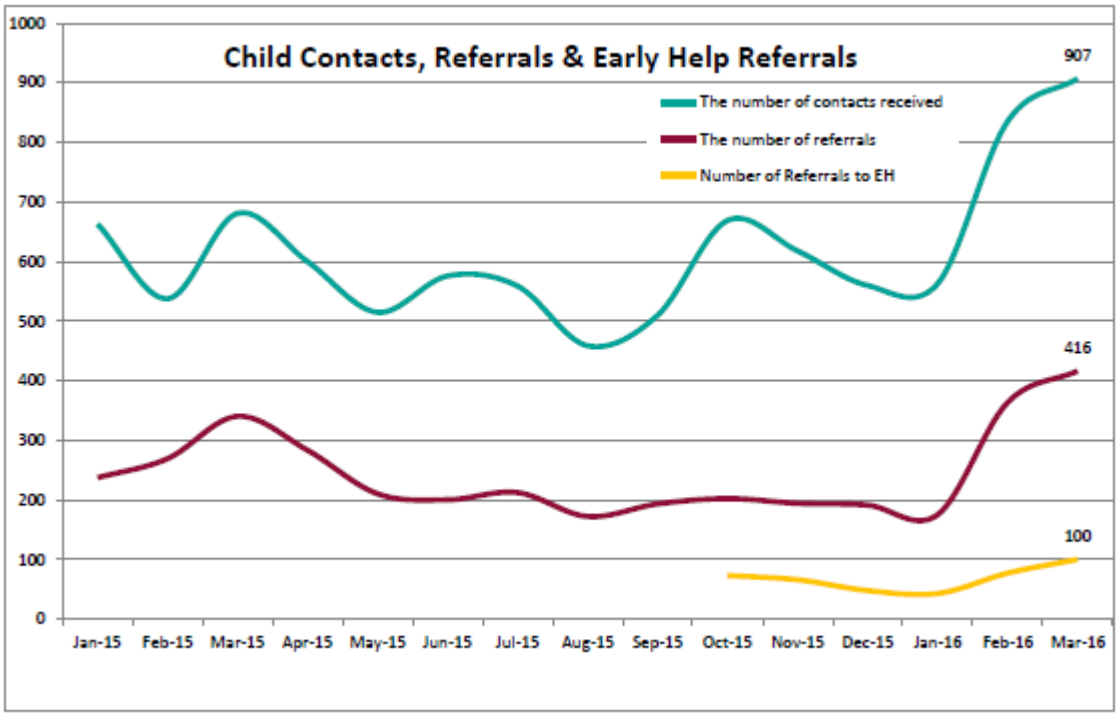
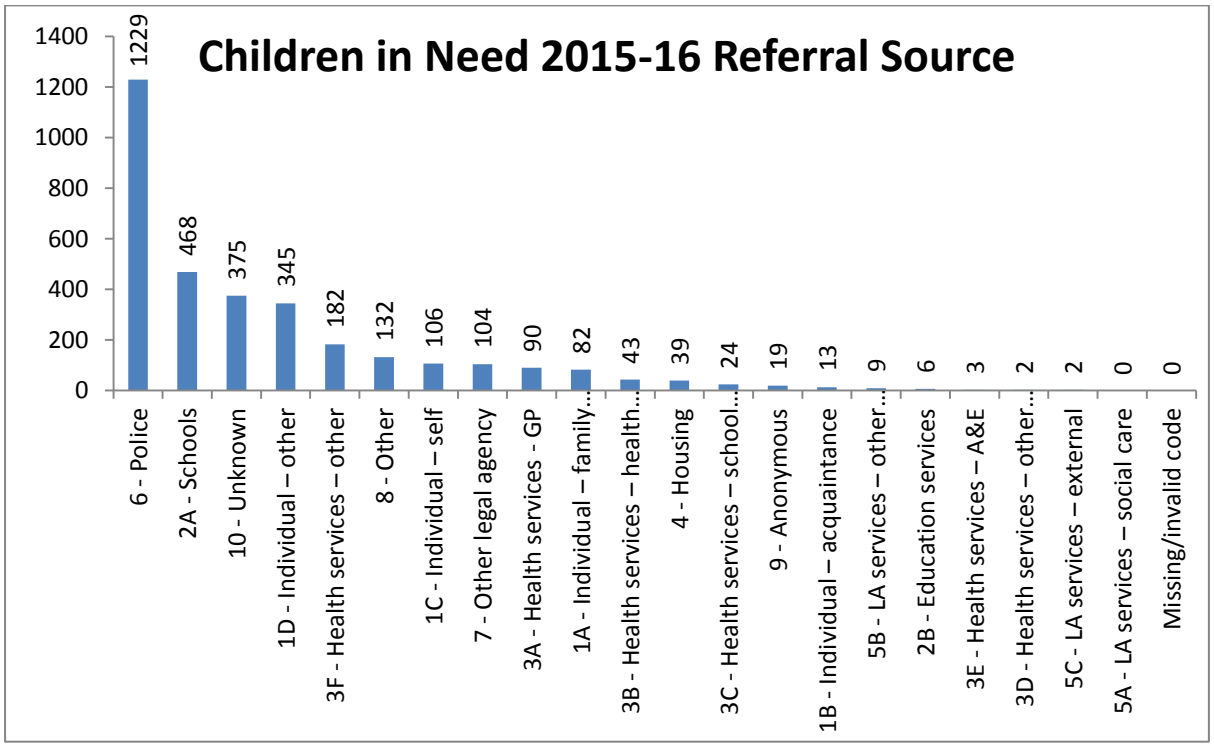
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16


Child Contacts, Referrals & Early Help Referrals
1000
900
800
700
600
500
400
300
200
100
0
907
416
100
The number of contacts received
The number of referrals
Number of Referrals to EH
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16

Bold – P1 indicator	2014/15			2015/16										
	Haringey	England 2013/14	SNs 2014/15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	H or L		YTD	*Target*	Traffic Light
The number of contacts received	6,941			669	618	560	563	835	907	L	↓	7,371	-	Data Only
Referrals	2,262	657,800	3,804	202	194	191	175	363	416	L	↓	2,811	*2,403*	Red
The rate of referrals to children's social care per 10,000 pop	383	470	506	34	33	32	30	62	71	L	↓	476	*407*	Red
Re-referrals within 12 months of the previous referral	12%	23%	14%	16%	10%	13%	15%	8%	8%	L	↑	15%	*14%*	Amber
Percentage of referrals with outcome NFA	5%	14%	4%	N/A	N/A	N/A	N/A	16%	18%	L	↓	9%	-	Data Only

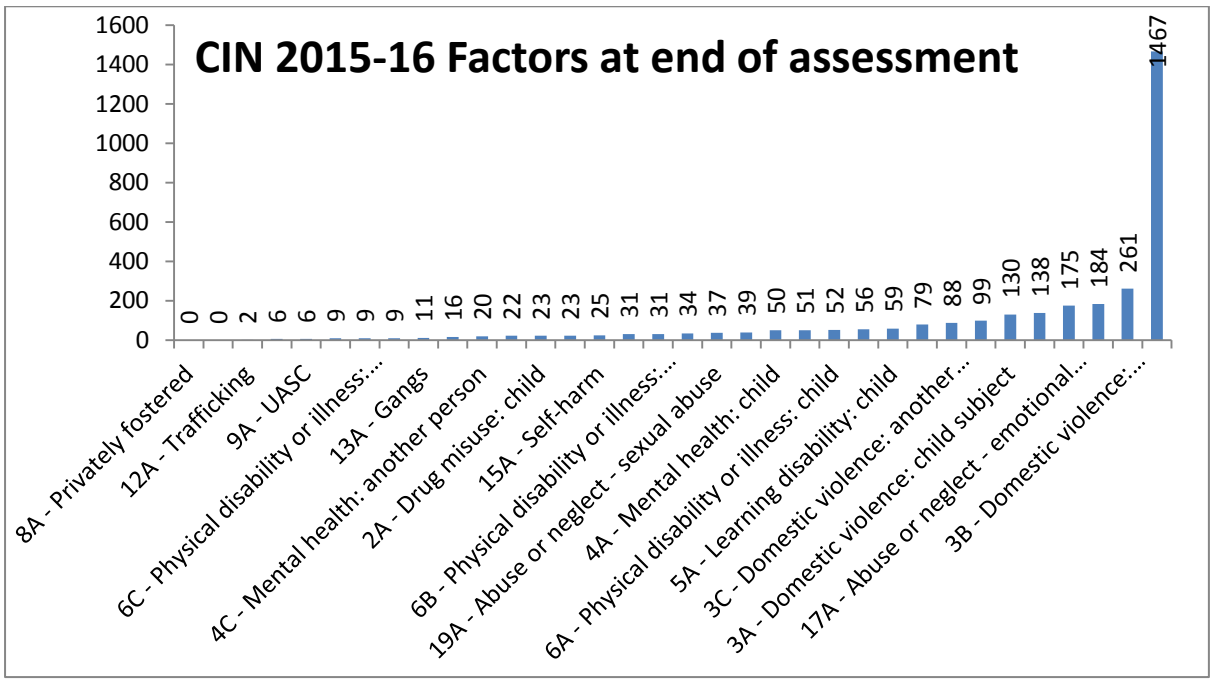
Concern was raised through the latter part of the year that the increase in contacts appears to be due to the number received that do not meet thresholds but there is also identified real need within the increase. The picture is being looked at within the partnership taking note of referral routes to the multi-agency front door. As the chart below shows most referrals come from the police, schools and health services as expected.



		2014/15			2015/16										
		Haringey	England 2013/14	SNs 2013/14	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16			YTD	Target	Traffic Light
OP388	Children subject to a child protection plan	257	48300	257	207	224	220	231	228	214	V	↓	214	-	Data Only
	Month on month net change (No. CP)	-	-	-	-	+17	-4	+11	-3	-14	V	↓	-43 (-17%)	-	Data Only
OP388a	The rate of Children Subject to a child protection plan per 10,000 pop	44		40	35	38	37	39	39	36	L	↓	36	42	Amber
OP 411	Children Becoming Subject to a child protection plan in the period	391	-	272	33	52	27	22	27	16	V	↓	335	-	Data Only
OP 413	Children Ceasing Subject to a child protection plan in the period	335	-	248	27	37	15	27	31	28	V	↓	373	-	Data Only
HY64	Child Protection Plans ceasing after two years or more	1%	5%	6%	0%	0%	0%	0%	0%	0%	L	→	1.5%	7%	Green
Op64a	CP Plans lasting over 2 years at period end (snap shot)	2.7%	3%	0%	1%	1%	1%	3%	3%	3%	L	↑	3%	2.6%	Amber
Op 365	Subject of Child Protection Plan for a second or subsequent time	22%	16%	14%	6%	14%	7%	5%	22%	38%	L	↑	14%	13%	Green
Op613	The number of ICPCs initiated	372	-	-	42	59	32	26	32	17	V	↓	403	-	Data Only
Op615a	ICPCs in 15 working days	65%	-	-	76%	95%	78%	46%	75%	82%	H	↑	82%	78%	Green
OP380	Child Protection Visits	84%		0%	94%	93%	97%	94%	97%	93%	H	↓	93%	90%	Green
OP381	Children in Need Visits	73%		0%	90%	93%	89%	91%	90%	89.5%	H	↓	89.5%	90%	Amber

The percentage of assessments completed within 45 working days declined to 75% in comparison to 93% in January and February; the Board received assurance regarding actions taken to improve performance, which are reflected in later data. The 2015-16 position (80%) remains below the expected target (90%). The proportion of children seen in 10 days as part of an assessment has continued to increase over the last 3 months.

In terms of factors at assessment, domestic violence and abuse remain the biggest single safeguarding risk to children and young people in Haringey.



7.4 **Looked After Children (LAC)**

The number of children looked after has continued to decrease. The percentage of LAC with up to date care plans, pathway plans and personal education plans has increased significantly; 92% of care plans were up to date (above target), 85% of pathway plans and 87% of PEPs were up to date.

The percentage of LAC reviewed within timescale has remained in line/above the expected target in the last 4 months. 93% were in timescale in February.

7.5 **Private Fostering**

During 2015-16 there were 12[3] new referrals to social care for potential private fostering arrangements, consistent with the national average and comparable to 2014-15.

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

[3] This figure needs to be checked

7.6 Missing Children and Young People

During the year we have improved our approach to children and young people missing or who run away from home, care or education. We developed our integrated partnership protocol and a new High Risk Missing Panel now meets regularly to look at high risk cases and plan for safety. There is some way to go with ensuring that police and social care data is integrated and to demonstrate performance around welfare checks and return home interviews. During the year the Metropolitan Police produced a dataset as below that broke down the information about missing under 18s. Albeit that the data does not cover the time period accurately for this report, it does give us a good indication of volume across the borough and the intention is that this will continue in the new Safeguarding Children Dataset that the Met is developing.

Under 18s missing persons volumes by month

Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
50	73	70	79	78	89	79	61	92	80	90	96	937

Under 18s missing persons volumes by age

	0-5	5-7	8-10	11	12	13	14	15	16	17	Total
	11	16	21	30	31	42	209	171	232	174	937

Under 18s missing persons by length of time missing

Cancelled before creation	Same day	1 day	2-4 days	5-7 days	8-14 days	15-21 days	22-28 day	29-39 days	40-49 days	50-90 days	90+ days	Open investigation	Tota
23	535	167	109	33	19	10	3	2	2	3	1	30	937

Under 18s missing persons by gender

	Male	Female	Trans	Unknown		Total
	395	542				937

Number of children missing from care at any one point in the month

2014/15	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb		Total to date
31	2	3	5	7	5	10	4	6	9	12			63

Through the year we became more aware of the growing numbers of children educated otherwise or home educated, which at the end of the year stood at 143. There were 43 children open to the children missing education team, who assist parents whose children are not in education to apply for school places. 9 permanent exclusions and 172 fixed term exclusions from Haringey schools.

	Missing and Stability	2014/15			2015/16										
		Haringey	England 2013/14	SNs 2013/14	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16			YTD	*Target*	Traffic Light
00	Number of children missing from care at any point in the month	31	-	-	4	6	9	16	13	11	L		60	-	Data only
01	Number of children away from Placement without Authorisation	19	-	-	4	9	7	6	3	6	L		23	-	Data only
62	Stability of placements of looked after children: number of moves	7.5%	11%	13%	8%	9%	8%	7%	9%	8.6%	L	↓	8.6%	*8%*	Amber
63	Stability of placements of looked after children: length of placement	74%	67%	70%	75%	75%	75%	77%	75%	79%	H	↑	79%	-	Data only
1b	Percentage of children placed outside of the Borough	73%	38%	65%	77%	75%	77%	75%	77%	78%	L	↓	78%	-	Data only
53	Percentage of children placed 20 miles or more	18.0%	13%	18%	19%	19%	21%	19%	21%	23%	L	↓	23%	*16%*	Red

7.7 Child Sexual Exploitation (CSE)

7.7.1 Between March 2015 and November 2015, 76 young people were identified as being at risk of or victims of CSE. The system of recording changed after this time so we don't have full year data but the MASE reviews the CSE list regularly and has identified some key actions moving forward to address the problem. The most common ages at referrals are 14, 15 and 16 with very similar numbers identified across that cohort. There is a small number of single young adult men (between 18 and 21 years) identified as potential perpetrators.

7.7.2 The majority of victims are female, consistent with the London CSE Profile. The ethnic breakdown of the young people included in the most recent CSE Profile is broadly representative of the borough population and ethnic breakdown of the looked after child population.

7.7.3 There is an emerging trend of peer on peer abuse being linked to episodes of being missing and/ or association with gangs. The Haringey and Enfield CSE profile is reflective of the London profile in that, to date, there have been no organised adult exploitative networks identified (but this does not mean that they do not exist, rather that we have yet to identify them) with most concerns centred around peer-on-peer exploitation. Scoping through the Bi-borough CSE and Vulnerable Children Project identified the following:

- Young people do not recognise borough boundaries. Our young people are very mobile and their peer group networks extend across and outside of their home authorities.
- Cross border peer networks are common.
- Cross borough allegiances are being formed by gangs.
- Many young men, including those affected by gangs, are reluctant to use condoms during sexual activity.

- Young people do not always understand issues of consent in relation to sexual activity.
- 35% of young people discussed at the Enfield MASE in November 2015 had a connection to the borough of Haringey. Likewise, 25% of young people discussed in Haringey MASE in the same month had a connection to Enfield.
- Haringey and Enfield share significant numbers of children on a daily basis. Scrutiny of School's Census data for 2015 identifies that 4224 children cross the Enfield/Haringey borough boundary to attend school in their neighbouring borough.
- These numbers are roughly evenly split, with 2063 children travelling from Haringey into Enfield to attend school daily and 2161 children from Enfield travelling into Haringey.
- North Middlesex University is a further significant area of bi-borough activity through the Accident and Emergency (A&E) Department of the Hospital. The hospital is located in Enfield, but sits on the borough boundaries between Edmonton and Tottenham; both areas of high gang activity. This cohort includes some of the most vulnerable and hard to reach young people and includes young people attending with gang related injuries; presentations resulting from substance misuse; those exhibiting poor mental health and self-harm; injuries resulting from domestic abuse; young people who are missing; presentations with injuries, sexually transmitted infections, pregnancy and poor mental health that are indicative of CSE.

7.8 Female Genital Mutilation (FGM)

FGM is also known as female genital cutting and female circumcision: is the ritual removal of some or all of the external female genitalia. An estimated 3,500 women and girls are affected by FGM in Haringey, with 115 victim/survivors reported between April 2015 and March 2016. We also know that there are high, but hidden, levels of forced marriage and crimes committed in the name of 'honour'.

A new mandatory reporting duty for FGM came into force in October 2015 via the Serious Crime Act 2015, following a public consultation. The duty requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police. As FGM has been recognised as a safeguarding issue by partners for some time, we do not anticipate that this will affect numbers reported.

8 How safe are children & young people here?

8.1 As I stated last year, it is never possible to say categorically that all children are safe. Whilst use of data and external inspections suggest that our services across Haringey are at least as good as in most areas, I have never been more conscious of the impact of austerity on core services, and there is no doubt that vulnerabilities exist across several parts of the public and voluntary sector. Haringey is a complex urban authority, facing reductions in budgets in all its public services, and enduring much higher than average effects of the cuts in welfare benefits. The population within Haringey is under severe pressure.

8.2 We can be reassured that the quality of schools and education in Haringey remains largely very high, with very high proportions being rated as good or outstanding, and this provides a significant source of protection to children and young people. Good schools are normally safe schools. However the data suggests we may be seeing an increase in the number of children being educated at home, which in some cases can place them at risk.

8.3 Some public health indicators are also showing positive trends – the rates of obesity are better than might be expected, as are the low levels of hospital admissions due to injury, and teenage pregnancy rates have fallen faster than in any other areas. However other data, such as levels of tooth decay, are worrying, and there has been some evidence of the reappearance of some conditions associated with severe poverty, such as rickets.

8.4 For most of last year the rates of referrals were steady, with gradual reductions in the numbers of Children in need, children on Child Protection Plans, and numbers of Looked after Children. However the final months of the year produced a significant rise in referrals, the causes and consequences of which are not yet entirely clear and are being closely monitored. This coincided with a relaunch of the MASH and front door arrangements, and follows on from the gradual establishment of the improved Early Help arrangements. Performance in relation to timescales for assessments and visits has been largely positive; occasional drops in performance are rapidly identified in data and responded to. Outcomes for children in care continue to be largely satisfactory,

8.5 Our focus on highly vulnerable young people who are at risk of Child Sexual Exploitation, are missing or at risk of trafficking, has been strong.

8.6 2015-16 brought many changes in safeguarding in Haringey; changes to the Early Help offer, establishing new Thresholds, relaunching the front door and MASH, introducing, ‘Signs of Safety’. 2016-17 brings the possibility of fundamental review of the organisation of multi-agency safeguarding arrangements, and the creation of new partnerships with neighbouring boroughs within the health service, council and police.

8.7 Our partnership is strong, but the weather around us is stormy.

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Appendix A: Role, scope and function of the LSCB

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

The objectives of the Board are:

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

Scope

The scope of the LSCB role falls into three categories:

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

Function

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

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

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

Appendix B: Section 11 The Children Act 2004

Section 11 places a duty on:

- local authorities and district councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services;
- NHS organisations, including the NHS England and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts;
- the police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London;
- the British Transport Police;
- the National Probation Service and Community Rehabilitation Companies;22
- Governors/Directors of Prisons and Young Offender Institutions;
- Directors of Secure Training Centres;
- The section 11 duty is conferred on the Community Rehabilitation Companies by virtue of contractual arrangements entered into with the Secretary of State.
- Principals of Secure Colleges; and
- Youth Offending Teams/Services.

These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed;23
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;

- appropriate supervision and support for staff, including undertaking safeguarding training:
- employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
- all professionals should have regular reviews of their own practice to ensure they improve over time.
- clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

Appendix C: *Haringey Local Safeguarding Children Board Priorities and Business Plan 2014– 2016 (needs updating)*

Haringey Local Safeguarding Children Board

Priorities and Business Plan 2014– 2016

This business plan outlines the agreed priorities and actions to be undertaken by the Board and its partners to deliver this year's safeguarding priorities. The actions also take into account areas of improvement as identified in the May 2014 Ofsted review of the LSCB.

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

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

P1	Action	Lead group/person	By When	Evidence required	Progress/last updated	priority	RAG
1	Review the current range of multi-agency groups working with highly vulnerable groups of young people (gangs, CSE, missing children, violence against women & girls, etc) & recommend (if appropriate) more functional & proportionate systems	CSE sub group	March 2015	Work plans of existing groups Statistical information from multi-agency partners Risk assessments	The CSE Sub-group is now overseeing this work and has a clear governance and accountability structure and agreed strategy, which includes connections and routes into the VAWG, Gang Action Group Strategy and	H	Green

	OFSTED 2 - Review Haringey's CSE multi-agency guidance and consider whether the involvement or association with gangs by young women should be included as a risk factor to strengthen arrangements to provide a coordinated response to this vulnerable group of young people.		Sep 14		oversight of our work on Missing Children & Young People. The workflow into MASE and MASH is developing. There is a clear action plan and agreed accountabilities and reporting into the Board. Completed.		
2	Complete Missing Children strategy, emphasising the links to gangs	Vulnerable Children's	October 2015 Board	All agency local strategies to inform the multi-agency	Protocol integrated across children and young people missing	H	Green

		Group	meeting	oversight by the LSCB	from care, home and education has been agreed in principle at October Board and further development via the DfE Innovation Fund Project and CSE Sub-group. High risk senior management group now established led by DCS considering missing cases monthly.		
	OFSTED 4 - Ensure that the Board receives an annual report on children missing from home, missing from care and missing from education to assure itself that appropriate processes and practice are in place to safeguard this vulnerable group of children and young people. Strengthen the existing Board's annual report arrangements to include an evaluation of service responses for		Nov 2014		Narrative included in LSCB Annual Report 2014 and 2015 agreed October 2015. Reporting and data collection is being developed through a number of routes incl MASE, PPO Sub-group, MASH, high risk meetings and DfE Project.		

	missing children, to support multi-agency actions and reduce risks posed to children						
3	Complete and implement CSE strategy **OFSTED 3** - Accelerate plans to formally agree the draft CSE strategy and ensure it is clearly linked to the gang action plan. Make clear how the strategy will link to front-line practice, and what success criteria will be used to measure and evaluate progress.	CSE Sub Group	December 2014	Clear evidence of multi-agency systems	Strategy approved and being implemented via the CSE Sub-group	H	Green
4	Review engagement of disabled children with gangs	Disabled children policy and review group	March 2015	The LSCB will have the findings of the review presented to the LSCB board and the Chair or representative will discuss findings with appropriate strategic leads to assure that the needs of disabled children affected by gangs is appropriately responded	The Disabled Children's Sub-group undertook the review with the Gang Action Group and reported to the Board in May - the findings to be fed into the Gang Action Group Strategy in June. Five key areas were requested to be	M	Green

				to.	looked at in more detail for a further report to the Board in autumn/winter 2015		
5	Review relevant performance data and information-sharing systems	PPO Sub group	November 2015	The LSCB performance management report. This will incorporate the findings of this review.	Performance framework and model dataset has been approved and quarterly performance reports presented to the Board. Still with work to be done with partners to integrate and make consistent.	M	Green
6	Review the impact of the Early Help offer on future gangs engagement	CSE & Vulnerable Children Group	Taken forward into 2016-17 due to embedding of the Early Help service	The findings will be presented to the LSCB and the review to be included within the new strategy Priority Two	This action is being looked at within the process of monitoring the Early Help Strategy and the Board manager is discussing with GaG lead about the best way to take forward.	M	Amber
7	Make this a feature of our Section 11 review	Quality Assurance group	December 2014	The S11 audit will have gangs as a themed area to assess agency's safeguarding arrangements.	S11 Audit was completed and presented to the Board in March 2015 with questions regarding this priority summarised in the		Green

					report. This will be ongoing moving forward. Next audit due end of year 2016		

- ❖ **PRIORITY TWO - Early Help**
- ❖ Scrutinise the move towards strengthening early help offer across Haringey, seeking assurance on the common understanding of definitions, on the impact on child protection services, and on appropriate multi-agency engagement.
- ❖ The role of the LSCB in relation to the Early Help offer is to seek assurance that the introduction of the Early Help Offer does not inadvertently introduce new safeguarding risks.

P2	Action	Lead group/person	By When	Evidence required	Progress/last updated		RAG
1	Consider the draft Early Help Strategy with particular focus on the safeguarding aspects of the strategy	LSCB Chair	November Board meeting	The draft report	Happened at Board in November 2014 and came back to the Board for further consideration in July 2015. Outcome measurements will be agreed with Board Manager and agreed to look at in Q4 audit and report back to Board in march 2016	M	GREEN
2	Request reports to the full Board initially every 6 months from the Early Help Partnership Board, specifically seeking to	LSCB Chair	First report to our May 2015 Board.	report	On track. Report came to July 2015 meeting with above agreements. Specific issue relating to step	L	Green

	answer the question as to whether the processes of step up and down are being undertaken safely and appropriately				down processes included within audit programme.		
3	Review the training the LSCB currently undertakes, in order to consider whether any adjustments are required in the light of the changes.	LSCB Training Officer – post vacant currently and Chair is vacant			New Head of Early Help, Gareth Morgan is now a member of Training, Learning & Development Sub-group and work needs to be progressed to ensure our courses reflect the EH offer. One event held for health colleagues in September but need to build on this now EH offer has been launched.	L	Amber
4	Make this a feature of our Section 11 review	Quality Assurance Group	December 2014	The S11 audit will have early help as a themed area to assess agencies safeguarding arrangements.	S11 Audit was completed and presented to the Board in March 2015 with questions regarding this priority summarised in the report. This will be ongoing.	M	Amber

❖	❖ PRIORITY THREE – Neglect ❖ Improving effectiveness of all agencies in recognising and responding to neglect						
P3	**Action**	**Lead group/person**	**By When**	**Evidence**			
1	Sign off Neglect Strategy	Performance & Practice Outcomes Sub-group	Moved to Priority One in the new Five Year Strategy	The development and monitoring of the neglect strategy will be included in the work plan of the Performance and Practice Outcomes Sub-group.	This action was amended; the key element of the strategy was agreed to be the revised process of compiling chronologies which has now moved through to the MASH Board. However the Executive agreed November 2015 to review following Neglect audit and mapping of current position to be taken forward by a Task & Finish Group via the PPO Sub-group and it is now included as Priority One moving forward with the new strategy		Amber
2	Finalise delivery of the strategy	Performance & Best Practice Sub-group	Under review as above		As above – now Priority One	M	Amber

3	Oversee delivery of Neglect Strategy	Performance & Best Practice Sub-group	March 2016		As above – to be taken forward	L	Amber
4	Make this a feature of our Section 11 review	Quality Assurance Group	December 2014	The S11 audit will have neglect as a themed area to assess agencies safeguarding arrangements.	S11 Audit was completed and presented to the Board in March 2015 with questions regarding this priority summarised in the report. This will be ongoing.	M	Green
❖	❖ **PRIORITY FOUR - Promoting good practice** ❖ Shift the overall balance of our activities more towards identifying and promoting elements of good practice.						
P4	**Action**	**Lead group/person**	**By When**	**Evidence**			
1	Create an annual Good practice in Safeguarding Award – perhaps as part of a wider Haringey Awards scheme; invite nominations for examples of effective multi-agency practice, create positive publicity around the awards	Chair/Board Manager	On hold due to capacity	The LSCB will include the details of the award winners in their annual report.	Issues reviewed at the September 2014 best practice sub group and some criteria discussed. BM needs to pursue resourcing options	L	Amber
2	Develop a programme for disseminating examples of good practice in safeguarding	Chair/Training Officer	November 2014	Local and national safeguarding news will be	Three examples of good practice went into the Jan/Feb 2015 newsletter and next	L	Amber

	through existing agency newsletters. Have regular slots in agency e-bulletins (for example, HAVCO's e-bulletin, CCG newsletter etc).			available to all partners via the LSCB and their internal communications.	steps are to interview teams/individuals and include in the next newsletter. Limited response and Communications strategy needs to be reviewed		
3	Design and deliver at least one specific campaign, in partnership with local agencies. These will include SCR learning, FGM in schools and the community, promoting positive parenting and involving children and young people.	Chair/Board Manager/Training Officer	Some deliver but on hold due to capacity	The LSCB will have agreed a one year campaign programme – first to run Jan/April 15 on learning from SCRs.	SCR poster campaign was welcomed across the partnership. CSE Safeguarding Campaign throughout March and beyond including learning lunches. Full programme not yet agreed but should include the views and ideas of children and young people.	L	Amber
4	Review and update branding of LSCB.	Chair/Board Manager	On hold due to capacity	The LSCB will re-launch its vision for safeguarding children in	Work started on this with website refresh but needs development.	L	Amber

				Haringey.			
5	Develop a new vision for LSCB and 3-5 year strategy	Chair/Board	September 2015 - initial work being developed through 2016-17 in light of Government Review of LSCBs	Partners and the public will be clear of the LSCB's ambitions for ensuring safeguarding arrangements in the borough	Will be reviewed at the Board Development Day 2016	L	Green
6	Explore potential for "Community Champions" – a proposal from the voluntary sector to actively engage local people in specific safeguarding activities.	Chair/Board Manager	On hold due to capacity	The children and adults safeguarding boards with the third sector will discuss the viability of this proposal.	Increased synergy between the Boards needs to be progressed	L	Amber
7	**OFSTED 1**- Ensure that schools are fully involved at Board level so that their representations are known, understood and considered and their contribution fully harnessed to influence the shape of services.	Chair/Board Manager	March 2016	The Board will be able to evidence clear dialogue and influence from schools on the safeguarding agenda which will be outlined in the annual report.	Primary and Secondary HTs now members of the Board and attending. PE has addressed Primary and Secondary HT meetings. Board Manager works with the School Improvement Lead to develop the	M	Green

					Designated Safeguarding Lead Forum.		
❖	❖ **PRIORITY FIVE - Engaging the voices of children and young people** ❖ Identify an effective and proportionate way of tapping into the already available views of children and young people, to inform the work of the LSCB						
P5	**Action**	**Lead group/person**	**By When**	**Evidence**			
1	Explore potential for focus groups of young people to discuss particular issues based around our priorities	Chair/Board Manager	Being reviewed into 2016-17 and Enabling Priority One in the new Board Strategy	Engagement of young people and participation team	Work needs to be done to develop this priority and increased focus will be given to this by the Business Manager to make the existing activity more meaningful. There was some progress in relation to the Special School Council communication through the Disabled Children's Sub-group which provides a good model. Now moving forward into the new strategy as an Enabling Priority	H	Amber
2	Explore possible ways of engaging with "Takeover Day" in	Chair/Board Manager	November 2015	The LSCB will have engaged young people in	Delayed due to ongoing staffing issues. Was picked up	M	Amber

	November.			new creative ways.	by the Training sub group with a delivery date scheduled for November 2015 but not delivered due to capacity issues.		

Appendix D: Haringey LSCB Strategy 2016-21

HARINGEY SAFEGUARDING CHILDREN'S BOARD STRATEGY 2016-2021

1. About the Safeguarding Children's Board

1.1 The role and responsibilities of the Local Safeguarding Children Board are those stated in chapter three of Working Together to Safeguard Children (2015). This Strategy, along with the Board's Annual Business Plan, seeks to implement those duties and assure the local community that the Board facilitates local stakeholders to work together to ensure that all children and young people are safe and feel safe within their homes, schools and communities. The LSCB is the statutory body for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in the London Borough of Haringey. The objectives of the Board are:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area[4];
- to ensure the effectiveness of what is done by each such person or body for that purpose.

1.2 The scope of the LSCB role falls into three categories:

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

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

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

[4] This includes children looked after by the local authority placed out of borough

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

1.4 Working Together 2015 defines safeguarding and promoting the welfare of children as:
- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

2 Haringey LSCB Strategy: Vision & Mission

2.1 **Vision:**
We believe that every child should grow up in a loving and secure environment which is free from abuse, neglect and crime, enabling them to be safe and healthy, to enjoy life and to fulfil their social and educational potential.

2.3 Mission:
- Ensure we fulfil our shared responsibilities to safeguard the wellbeing of children and young people
- Demonstrate our commitment to participation of children and young people
- Promote and facilitate effective joint working between front-line staff across all agencies
- Establish a culture of “high support, high challenge” between partner agencies

- Ensure there are systems for effective shared learning across our partnership
- Celebrate the strengths and positive achievements of partners in keeping children and young people safe.

3 Consultation

3.1 This is the five year strategic plan of the Local Safeguarding Children Board (LSCB). It is written in collaboration with all of the partner agencies that are the key stakeholders of the Board and has been considered in line with other related borough plans and strategies including that of the Health and Well-Being Board, the Safeguarding Adults Board and the Community Safety and Cohesion Partnership, the Violence Against Women and Girls Partnership, Haringey Council Corporate Plan and Haringey CCG 5 year plan.

3.2 We are keen to know what the local community views are and have an online consultation response form here (insert link) or you can send responses to the questions below to the LSCB Business Manager, Patricia Durr patricia.durr@haringey.gov.uk We are also asking community and voluntary sector groups working directly with children and families through our Board partner representatives.

3.2 **Consultation Questions:**

1. Does the Strategy set out the right strategic priorities, bearing in mind the statutory duties and functions of the Board?
2. Are there any other strategic priorities that you think the Board should address?
3. How can you help the Board to achieve its objectives?
4. How can we improve communication about the role of the Board?
5. Do you have any further comments?

4. Background

4.1 Contrary to what is too often reported, England and Wales have one of the safest child protection systems in the world. The number of children who die as a result of maltreatment has not increased over the last thirty years. Social workers, teachers, health visitors and police officers often successfully intervene to make children's lives better. Safeguarding boards are here to coordinate the multi-agency partnership to keep children safe and ensure its effectiveness: they have a clear mandate to scrutinise and hold local organisations to account for the quality of services. Boards can only ever be the sum of their parts: the strength comes in the joint endeavour to work more effectively and closely together

4.3 At the time of writing the Government is undertaking a national review of LSCBs offering an opportunity to take stock of the local child protection partnership within the current climate of constrained funding and the possibilities afforded through new local bodies such as Health & Wellbeing Boards and consideration of different regional structures to hold local arrangements to account. A key consideration will be the focus of multi agency collaboration – the balance between protecting children and the wider safeguarding issues.

4.4 Haringey is an exceptionally diverse and fast-changing borough. We have a population of 267,451 according to the 2014 Office for National Statistics Mid Year Estimates. Almost two-thirds of our population, and over 70% of our young people, are from ethnic minority backgrounds, and over 100 languages are spoken in the borough. Our population is the fifth most ethnically diverse in the country. The borough ranks as one of the most deprived in the country with pockets of extreme deprivation in the east. Haringey is the 13th most deprived borough in England and the 4th most deprived in London with the 4th highest level of child poverty in London. Haringey is the most unequal borough in London, with over half of its wards being either very rich or very poor. Northumberland Park, a ward in the East, is the most widely deprived ward in London.

4.5 There are approximately 63,400 children and young people under 20 living in Haringey (approximately one third of the total population). The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane and Tottenham Hale. 1 in 3 children live in poverty, 1 in 4 children live in household with no working adult (23% compared to 18% in London). Over 10, 000 households are with lone parents (34% compared to 28% in London). It is estimated that over 11, 000 children in Haringey live with some form of long-standing disability. Over 9,000 children and young people have Special Educational Needs (SEN) in primary and secondary schools. Approximately 1,200 children have a Statement of SEN; of those, 35% had autism followed by moderate learning difficulties (21%) and emotional, behavioural and social difficulties (12%).

4.6 In recent years there have been a number of significant changes in the context in which agencies must work together to safeguarding children at national, regional and local levels. There has been legislative change including the Children and Families Act 2014 and the Care Act 2014 and new guidance, policy and programmes. Across all, there is a strong emphasis on increasing partnership working, integration, prevention, participation and strengthening communities. There is a strong desire locally to strengthen and integrate both strategic and operational partnership.

5 Principles

5.1 This Strategy is underpinned by the two key principles set out in Working Together 2015:

- **safeguarding is everyone's responsibility**: for services to be effective each professional and organisation should play their full part; and
- **a child-centred approach:** for services to be effective they should be based on a clear understanding of the needs and views of children.

6 Our priorities

6.1 Priority One: Overhaul the ways in which agencies tackle chronic neglect

Why is this a priority?

- Neglect is the ongoing failure to meet a child's basic needs.
- It is estimated that one in ten children have suffered from neglect.
- Nationally, neglect remains the most common form of child abuse across the UK as well as the most common cause for being subject to a child protection plan (CPP) or on a child protection register (CPR).
- Numbers of recorded cruelty and neglect offences in England and Northern Ireland are now the highest they have been for a decade.
- In Haringey, neglect is the second most common factor identified following assessment – the most common being physical abuse
- Neglect was an identified priority for our 2014-16 Business Plan and whilst some progress was made, it is acknowledged that there is a need for increased multi-agency focus: all agencies recognise the pervasiveness of neglect, its long-term impact on children's health and wellbeing and its connectedness to other forms of abuse.
- The most common problems identified as serious causes for concern are chaotic family lifestyles with absence of routines and poor home conditions. Poor hygiene and domestic violence are also common factors.
- Consequences can include an array of health and mental health problems, difficulties in forming attachment and relationships, lower educational achievements, an increased risk of substance misuse, higher risk of experiencing abuse as well as difficulties in assuming parenting responsibilities later on in life.

Where do we want to be by 2021?

- Prevention is key. The strategic aim is to ensure there is early recognition of neglect. From early support to statutory intervention there should be appropriate, consistent and timely responses across all agencies working together.

- Work with children and families should be positive and empowering and keep a clear focus on the impact of neglect on the child.
- All those who have contact with children and families have their role to play in the recognition of potential neglect.
- There should be improved awareness and understanding of neglect across all agencies ,using Signs of Safety and Wellbeing methodology so that early identification is achieved and there is effective working between services working with children and adults;
- We should improve the recognition, assessment and support of children and young people and their families where neglect has been identified but before statutory intervention is required; and improve the assessment and intervention with children and young people once statutory intervention has become necessary.
- The safeguarding system should be clearly understood and communicated and the role of communities acknowledged. Haringey should be known for its development of protective communities.
- Multi-agency auditing should consistently demonstrate the impact, supported by data on those children on CPP plans where chronic neglect is a factor.

What are we going to do to get there?

- Develop a LSCB neglect strategy ensuring that prevention and Early Help is at the centre of response
- Develop understanding across the partnership of attachment theory
- Develop and roll out a training programme to ensure thresholds are correctly applied
- Get messages out into communities through information and other campaigns
- Support early intervention and parenting programmes such as Family Nurse Partnership and Parent-Infant Programme.

7.2 Priority Two: Improve outcomes for children with particular vulnerabilities and those subject to particular risks

Why is this a priority?

- It is recognised that there are particular vulnerabilities and risks that require particular attention, some of which are supported by supplementary statutory and regional and local guidance, and for which the Board has particular responsibility and accountability
- Supplementary guidance to Working Together includes:
    - Safeguarding children who may have been trafficked
    - Safeguarding children and young people who may have been affected by gang activity

- Safeguarding children from female genital mutilation
- Forced marriage
- Safeguarding children from abuse linked to faith or belief
- Radicalisation - Prevent strategy
- Radicalisation - Channel guidance
- Use of reasonable force in schools
- Safeguarding children and young people from sexual exploitation
- Safeguarding Children in whom illness is fabricated or induced

- CSE was a priority for our 2014-16 Business Plan with the development of our Child Sexual Exploitation (CSE) Strategy and accompanying action plan ratified by the LSCB in January 2015.
- There has been much progress embedding strategic leadership, pathways and practice and a developed understanding of the interconnectedness of vulnerabilities
- The multi-agency CSE diagnostic identified the need to improve outcomes for victims of CSE

Where do we want to be by 2021?

- A safeguarding system informed by increased understanding of the needs and experiences of children and young people at risk and ways to support them and to tackle perpetrators
- Improved outcomes for vulnerable children and young people
- Increased action against perpetrators of CSE
- A responsive, swift and confident pathway for all children and young people at particular risk
- Efficient multi-agency performance monitoring systems in place to enable us to identify emerging trends in vulnerabilities and risks and to be responsive in developing priorities

What are we going to do to get there?

- Capture the opinions and the experiences of those who are at risk of or who have experienced CSE and parents/carers of young people who have been victims of CSE to inform more effective response to reduce risk and harm.
- Consider the CSE + Champions model within a broad range of agencies and providers.
- Develop a system to enable Schools & CYPS to cross reference schools absence information with risk assessments for individual children and young people to vulnerable to or at risk of CSE.

- Data regarding CSE and related activity and response to be regularly included in the LSCB performance framework.
- Map local street gang profiles to identify gang-associated women and girls, and ensure their risk of CSE is considered and responded to appropriately.
- Scope Haringey's response to young people identified as perpetrators of CSE or harmful sexual behaviour and consider appropriate responses to any gaps identified.
- Utilise a problem profile for intelligence led planning and commissioning so that resources are allocated in response to known risks, themes and trends.
- Develop a high level, targeted disruption and prosecution strategy.
- Screen and risk assess all children and young people for CSE over the age of Ten who are referred for CYPS.
- Ensure that Commissioners include working with vulnerable children and working in partnership to support and protect them in service specifications, monitor through contracts and report to the Board
- Monitor the delivery of the gangs strategy
- Strengthen Haringey's safeguarding response to tackling extremist radicalisation
- *Add in suitable targets relating to FGM & violence against women and girls, missing children, Home Educated Children, disabled children*

7.3 Priority Three: Strengthen cross-borough partnership

Why is this a priority?

- The lives and experiences of the communities we serve are not determined by borough boundaries in the same way that services are currently configured
- Children and young people cross borough boundaries everyday, particularly through their schools
- We have a number of agencies that currently serve more than one borough including NMUH and BEH-MHT
- We know through profiling and mapping work around gangs, serious youth violence, children missing or running away and CSE that we need to strengthen cross-borough working to better safeguard children
- We know that themed cross-borough working is useful – CSE, gangs
- We know that many statutory agencies are looking at future restructuring and reorganisation that will involve cross borough merger
- At a time of decreasing resources, cross-borough partnership makes economic sense
- Our experience of Serious Case Reviews is that they are rarely restricted to one local authority area

Where do we want to be by 2021?

- Improved outcomes for children and young people as a result of effective and consistent cross-borough partnerships particularly for children with particular vulnerabilities including CSE, gang involvement, serious violence, missing and runaway and trafficking
- Haringey is ready for forthcoming reorganisation of local public services because of confident collaborative senior leadership focused on children's needs
- More effective and efficient use of resources in respect of safeguarding children due to collaboration

What are we going to do to get there?

- Develop consistent approaches to make working together easier (such as what we are doing through DfE Project)
- Provide more joint learning opportunities for sharing good practice and promoting professional relationships
- Develop greater integration and links with London Safeguarding Board, its role and the value it can add to local cross borough and other opportunities
- Scope possibilities for greater synergy and resource pooling between Boards
- Take forward recommendations from our bi-borough 2015/16 DfE Innovation Fund project on CSE and Vulnerable Children
- Scope out opportunities for more themed cross-borough projects with other boroughs
- Resolve and improve Looked After Children notifications as a priority

7.4 **Priority Four: Develop high quality partnership working at all levels between our agencies**

Why is this a priority?

- The safeguarding system is dependent on professionals working effectively together to put children first and at the centre of the system, and by every individual and agency playing their full part, working
- Working Together 2015 seeks to emphasise that effective safeguarding systems are those where:
    - the child's needs are paramount
    - all professionals who come into contact with children and families are alert to their needs and any risks of harm
    - all professionals share appropriate information in a timely way and discuss any concerns
    - high quality professionals are able to use their expert judgement
    - all professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes;

.

Where do we want to be by 2021?

- Front line practitioners feel confident sharing information in a timely, appropriate way and in line with best practice and the legal framework.
- There is improved sharing, recording and reporting information in the best interests of children across the partnership
- Concerns about the safety and welfare of children are responded to within time and with joint accountability and risk management across the partnership.
- Decisions are made with the whole safeguarding system and how it can better safeguard children.
- Children are better protected by frontline practitioners who feel respected, listened to and confident and their views, knowledge and experience inform decision making in a tangible and/or measurable way.

What are we going to do to get there?

- Significantly improve the quality of information-sharing between front-line workers
- Improve the IT systems which underpin information-sharing
- Improve the effectiveness of the MASH and other multi-agency teams
- Review our systems for sharing learning at the front line
- Actively explore the potential for greater joint planning, joint commissioning and collocation between agencies

7.5 **Enabling Priority One: Meaningfully engage children and young people in our work**

Why is this priority?

- The United Nations Convention on the Rights of the Child (UNCRC, 1989) enshrines the right of children to be involved in all decisions that affect their lives. In England there is also national legislation and guidance stressing the importance of involving children in decision-making, specifically in child protection cases and for children in need of support. (Children Act 2004; DCSF, 2010).
- However, the evidence, including our own auditing, clearly shows that the child's voice is often not heard and effectively represented and that agencies are less able to safeguard and protect children and young people when their views, wishes and feelings are not ascertained or taken into account.
- The failure to listen to children and to make sure their views are taken into account in child protection cases was highlighted in an Ofsted report of 67 serious case reviews (Ofsted 2010).

- Safeguarding legislation and guidance makes clear that all agencies have a responsibility to safeguard children and to take a child centred approach that does not lose sight of the needs and views of children themselves.
- The Board's role and responsibility to undertake audit exercises as part of its quality assurance function. An overriding consideration is to evaluate how well current practices elicit the child's voice and to identify areas of strength as well as areas for improvement.
- Additionally the Board is committed to improving engagement of children and young people in its work to improve its understanding of children's and young people's experiences of safeguarding and their priorities and how we can better communicate about safeguarding across the borough.

Where do we want to be by 2021?

- Board priorities and decisions are informed by children's views in a tangible and/or measurable way and there is a clear feedback mechanism to communicate this to them.
- The annual Board business plan clearly sets out where the Board will hear directly from CYP. Issues raised are driven by CYP themselves.
- Safeguarding practice and outcomes for children are improved because of consistent application of a child centred approach

What are we going to do to get there?

- Establish a robust, proportionate system for securing the views of children and young people on key issues concerning the Board, including CYP who are themselves at risk.
- Build on the extensive existing mechanisms for capturing CYP's views, to allow for key issues to surface for consideration by the Board.
- Establish a system for CYP to present periodically to the Board on key issues.
- Ensure annual audit cycle and performance framework consistently includes attention to children's lived experiences and journeys

7.6 **Enabling Priority Two: Promote and develop the children's workforce to better safeguard children and promote their welfare**

Why is this priority?

-

Where do we want to be by 2021?

- Haringey is an attractive proposition for the multi-agency children's workforce, with a clear vision for children and practice and a strong and stable workforce.

- The children's safeguarding workforce in Haringey is:
  - child centred
  - excellent
  - committed to partnership and integrated working
  - respected and valued as professionals
- All working with children and families understand safeguarding and promoting children's welfare

What are we going to do to get there?

- Support and develop strong and innovative safeguarding leadership across the partnership
- Support significant reductions in use of agency and interim staff across all partners
- Identify joint opportunities to recruit and retain key staff
- Develop a programme for delivering and expanded range of multi-agency training opportunities, as a means of improving the quality and range of multi-agency working

Appendix E: Haringey LSCB Members attendance 2015-16

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

Attendance LSCB Board - 2015 – 2016

* Denotes representative attended on behalf of the member

✕ Denotes membership ceased

- Post name changed

Organisation	Job Title	Meeting Dates						No of Meetings attended
		May 2015	July 2015	September 2015	October 2015	November 2015	January 2016	
Independent	Chair	✓	✓	✓	✓	✓	✓	6/6
Independent	Lay Member	-	-	-	-	-	-	0/6
CAFCASS	Service Manager	✓	✓	-	-	✓	-	3/6
Local Authority	Deputy CEO	-	✓	-	-	-	-	1/6
	Director of Children's Services	✓	-	✓	✓	✓	✓	5/6
	Assistant Director, Safeguarding & Social Care	✓	✓	✓	✓	✓	✓	6/6
	Deputy Head of Service, Additional Needs & Disabilities	✓	✓	-	✓	×	×	3/4
	Strategic Lead - Joint Governance and	✓				✓	✓	3/6

	Improvement Service for Adult Services							
Health	• AD of Quality & Nursing (Haringey CCG)	*	✓	✓	✓	✓	✓	6/6
	• Assistant Designated Nurse for Safeguarding (Haringey CCG)	✓	*	*	*	✓	✓	6/6
	Consultant Paediatrician, Designated Doctor (Haringey CCG)	✓	✓	-	✓	✓	✓	5/6
	Named GP (Haringey CCG)	-	-	-	✓	✓	✓	3/6
	Director of Nursing (NMUH)	✓	✓	-	✓	-	*	4/6
	Director of Nursing Whittington	*	-	✓	-	*	*	4/6
	Head of Safeguarding (Whittington)	✓	✓	✓	✓	✓	✓	6/6
	NHS England	-	-	-	-	-	-	0/6
	Consultant Psychiatrist (CAMHS/BEH-MHS)	*	*	-	-	-	*	3/6
	Executive Director of Nursing Quality & Governance (CAMHS/BEH-MHS)	✓	✓	-	-	-	*	3/6
	Assistant Director (Public Health	✓	-	-	✓	✓	✓	4/6
Legal	Assistant Head of Legal	✓	-	✓	✓	✓	-	4/6
Police	Borough Commander	✓	-	✓	✓	✓	*	5/6
	DI, CAIT	✓	*	-	✓	✓	✓	5/6
	DCI, CAIT	-	-	✓	-	✓	✓	3/6
Probation	ACO (Haringey Probation Service)	✓	✓	✓	-	-	-	3/6

	ACO (Probation Community Rehabilitation Company	✓	✓	✓	-	*	-	4/6
Voluntary	HAVCO	-	✓	✓	-	✓	-	3/6
Lead Member	Councillor	✓	✓	✓	✓	✓	-	5/6
Primary School	Head Teacher	✓	✓	✓	✓	✓	✓	6/6
Secondary School	Head Teacher	✓	✓	✓	✓	✓	✓	6/6
London Ambulance Service	Ambulance Operations Manager	-	-	-	✓	*	-	2/6
Housing	Deputy Director	✓	-	-	-	✓	-	2/6
YJS	• Head of Targeted Response & Youth Justice	-	-	✓	-	-	-	1/6
LSCB	Business Manager	✓	✓	✓	✓	✓	✓	6/6

Appendix D: Haringey Safeguarding Children Board Budget 2015-16

HARINGEY LSCB BUDGET 2015 - 16			
Income		**Expenditure**	
Contribution	**Amount**	**Item**	**Amount**
Metropolitan Police	£5,000	Salaries	146,800
Haringey Council, CYPS	£190,400	Consultant Fees	39,900
Cafcass	£550	Project Management	20,800
Probation	£2,046	Training Programme	20,800
Tottenham Hotspur FC	£2,046	Hire of premises	8,600
North Middlesex Hospital	£5,115	Stationary	9,200
Whittington Health	£5,115	Catering	2,200
Barnet, Enfield & Haringey MHT	£5,115	Travel	1,400
Haringey CCG	£5,115	Subsistence	800
Sub Total	**£220,502**		**250,500**
DfE Innovation Fund	£56,800	DfE Project costs	56,800
Grand Total	**£277,302**		**£307,300**

Haringey Safeguarding Adults Board

Annual Report 2015 – 2016

Haringey Safeguarding Adults Board
Annual Report 2015-16

CONTENTS

Haringey Safeguarding Adults Board
Annual Report 2015-16

1 Foreword by the Chair

I am very pleased to introduce the Annual Report of the Haringey Safeguarding Adults Board (HSAB) 2015/16, covering the first year of operation under the Care Act 2014, and my first full year as Independent Chair. I am grateful for the ongoing support for the partnership, which has developed as reflected in this report.

The Annual Report shows how the HSAB has delivered on the areas of work previously identified as priorities for 2015/16. This is important because it shows what the HSAB aimed to achieve and what was actually done both as a partnership, and through the work of participating partners. The report provides a picture of who is safeguarded in Haringey, in what circumstances and why. This helps us to know what we should be focusing on in the future, so the Report includes our priorities for 2016/17.

I am pleased that we have been able to engage with residents in Haringey through consulting on the Safeguarding Adults Board Strategic Plan and with groups concerned about the changes to social care.

The HSAB has initiated a Safeguarding Adults Review (SAR) during this year, which will report in 2016/17, and provide significant learning for all partners to take forward. This is important also for us all to learn how to undertake these reviews in accordance with Care Act 2014 statutory requirements.

I am very mindful of pressures on partners in terms of resources and time and grateful to all those who have engaged in the work of the HSAB. In particular I would like to thank the HSAB Board Manager, Patricia Durr for her work, which helps the Board to function. There continues to be a great deal that we need and want to do to reduce the risks of abuse and neglect in our communities and support people who are most vulnerable to those risks. This is a journey that we are all making together and I look forward to continuing to chair the partnership in the following year.

Dr Adi Cooper OBE
Independent Chair of Haringey Safeguarding Adults Board

2 Introduction

2.1 This annual report is for the period 1st April 2015 to 31st March 2016 and is produced as part of the Board's statutory duty under *The Care Act 2014* and Chapter 14 of the Care & Support Guidance. It is one of the three core statutory duties of the Chair of the Board to publish an annual report in relation to the preceding financial year, on the effectiveness of safeguarding in the local area.

2.2 This Annual Report gives details of progress on our priorities and Strategic Plan 2015-18; sets out how effective the HSAB has been over the 2015/16 year; provides detail on the SARs that it has commissioned, and describes how its partners have contributed to the work of the Board to promote effective adult safeguarding.

2.3 The report will be submitted to the Local Authority Chief Executive, Leader of the Council, the local London Mayor's Office for Policing and Crime, the Chair of Haringey Health and Wellbeing Board and Haringey Healthwatch. The report provides an overview of SAB activities and achievements during 2015 – 2016; it summarises the effectiveness of safeguarding activity in Haringey including the work of individual member agencies

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

3 About Haringey Safeguarding Adults Board

3.1 The Haringey Safeguarding Adults Board is a statutory body that works to make sure that all agencies are working together to help keep adults in Haringey safe from harm and to protect the rights of citizens to be safeguarded under the Care Act 2014, Mental Capacity Act 2005 and the Human Rights Act 1998.

3.2 **Vision**

The work of the Board is driven by its vision is that 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.

3.3 Statutory Duties

The Board has three core duties defined by the Care Act 2014:

- developing and publishing an annual strategic plan setting out how we will meet our objectives ;
- publishing an annual report which sets out what we have achieved; and
- commissioning safeguarding adults reviews where serious abuse or death has occurred and learning can take place.

3.3 **The Safeguarding Principles**

The work of the Haringey SAB is underpinned by the safeguarding principles which were set out by the government in the statutory guidance accompanying the Care Act 2014. The following six principles apply to all sectors and settings including care and support services. The principles inform the ways in which we work with adults.

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

3.4 Strategic Plan

The Board has agreed four statutory SAB purposes under the Care Act 2014 for achieving its vision and meeting its statutory duties to ensure that local safeguarding arrangements are in place. These form the basis of our Strategic Plan in which we set ourselves, the partnership and community specific actions to prevent and respond to abuse:

- We are assured that **safeguarding practice** is person-centred and outcomes focused
- We **prevent** abuse and neglect
- **We respond to abuse and neglect in a timely and proportionate way**
- **We are committed to learning and improving**

During the 2015/16 transition year, Haringey SAB has been working to a set of objectives to establish its operation and effectiveness under the Care Act 2014. A number of key actions and objectives were achieved, set out at Section 4.

During October to December 2015 all HSAB partners were asked to complete a self-audit that enabled them to evaluate their ongoing adult safeguarding activity. This, along with the publication consultation we conducted in March-April 2016, helped us to review our effectiveness as a Board and set priorities for 2016-17 within our Strategic Plan.

During 2015-16 the Board focused on strengthening governance and its transition under the Care Act 2014. Governance continues to be strengthened with regular reporting from sub-groups through to the Board, along with a realignment of sub-groups to ensure the full range of statutory duties and functions is met.

3.5 Governance

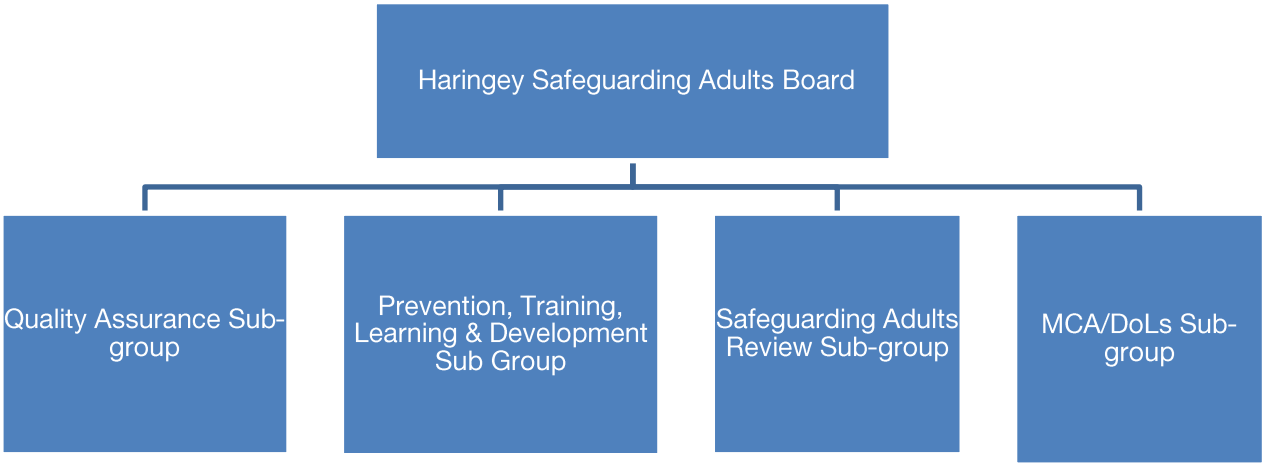
Haringey Safeguarding Adults Board is chaired by its Independent Chair, Dr Adi Cooper, and meets four times a year bringing partners together from: Haringey Council, Metropolitan Police Haringey Borough Command, London Fire Services, London Ambulance Service, Haringey Clinical Commissioning Group, health trusts, probation services, the voluntary sector and lay members, representing health, care and support providers and the people who use those services across Haringey.

The Chair is accountable to the Chief Executive of the local authority in chairing the SAB and overseeing its work programme. However, she is accountable only to the Board for the decisions she takes in that role. The role of Vice-Chair is undertaken by the Director of Adult Services.

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

The SAB has a number of subgroups chaired by senior members from across the partner agencies. During the year the structure of the Board changed to reflect priorities and efficiencies. We report on the business of each of the sub-groups operating during 2015-16 in this report and the structure below reflects the shape of the Board from April 2016.

3.6 Board Structure 2016/17



3.7 Relationship between the SAB and other strategic boards

The Chair of the SAB attends the Health and Well-Being Board. She meets regularly with the Chief Executive and Deputy Chief Executive, the Director of Adult Services, the Lead Member for adult safeguarding, the Leader of the Council, and the Chair of the Safeguarding Children Board. She meets annually with the Council's Scrutiny Committee. Links are maintained through representation on key strategic partnerships:

- Community Safety Partnership
- The Health & Wellbeing Board
- The Safeguarding Children Board
- The Violence Against Women & Girls Strategy Group
- The Preventing Radicalisation & Violent Extremism (Prevent) Delivery Group

This year, the Board has developed a Prevent Action Plan and the Board Manager sits on the borough Prevent Delivery Group.

3.8 The Partnership

Each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria (paragraph 14.2 of the guidance). The core statutory members of the SAB are the local authority, the CCGs in the area and the local chief officer of police. A range of other local agencies, are also encouraged on the membership of the Board. In Haringey there is good representation of all agencies involved in safeguarding adults.

3.9 Financial arrangements

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

4 Local Context

4.1 Haringey is an exceptionally diverse and fast-changing borough. We have a population of 267,540 according to 2014 Office for National Statistics Mid Year Estimates. Almost half of our population is from ethnic minority backgrounds, and around 200 languages are spoken. Our population is the fifth most ethnically diverse in the country.

4.2 The borough still ranks among the most deprived in the country but has seen improvement in its ranking over the past six years - with the exception of *Education and Living Environment*, Haringey has seen an improvement in rankings for all domains in the English Indices of Deprivation 2015. Haringey is the 30th most deprived borough in England and the 6th most deprived in London with the 10th highest level of child poverty in London. 7 of Haringey's 19 wards are within the most deprived 10% nationally. All of these wards are in the east of the borough where Northumberland Park remains the most deprived.

In terms of crime, Haringey is ranked 8th most deprived in England out of 326 local authorities and 8th in London out of 33 local authorities.

4.5 Haringey's Joint Strategic Needs Assessment (JSNA) 2014/2015 describes the health, care and wellbeing needs of the local population. This helps the Clinical Commissioning Group and Haringey Council commission the best services to meet those needs.

5 What we have done 2015-16

5.1 This is the first year that Safeguarding Adults Boards have operated on a statutory footing under the Care Act 2014 from 1 April 2015. Building on its previous preparations for the incoming legislation, this year the HSAB undertook significant work to ensure that it fulfilled its statutory responsibilities and established a firm platform for continuing to do so. Our Strategic Plan has clear delegated responsibilities to roles and sub-groups to ensure clear lines of governance and accountability.

5.2 ACHEIVEMENTS in 2015/16

- We reviewed the multi-agency membership of the Board, sub-group structures and systems, and processes are now in place to drive the work of the Board
- We developed a Quality Assurance Performance Framework and indicators that include user and carer experience
- We reviewed multi-agency policies and procedures and can track review and refresh, (this is delegated to the Quality Assurance Sub-group for oversight)
- We established a Prevention Strategy and delivery plan, which the Prevention, Training, Learning and Development Sub-group is taking forward
- We developed a Prevent Action Plan to take a partnership approach to our respective duties and responsibilities under the section 26 of the Counter Terrorism and Security Act 2015
- We developed a Safeguarding Adults Review (SAR) Procedure and established a SAR Sub-group which considered three SAR referrals and commissioned one SAR
- We developed our strategic planning cycle and consulted on our Strategic Plan

5.3 Sub-groups

This year the roles and composition of the HSAB sub-groups were consolidated to ensure that they will continue to support the work of the Board and deliver on its strategic and annual plans. Each sub-group now has Terms of Reference, which will be reviewed regularly to ensure that they support the HSAB's strategic priorities. The sub-groups benefit from multi-agency representation with staff from statutory and non-statutory agencies attending and contributing to the work. We are moving to better involve people who use services or their representatives in the work of the subgroups.

5.3.1 Safeguarding Adults Review (SAR) Sub-group

Chair: Dr Adi Cooper

Remit: to consider referrals of any case which may meet the statutory criteria and to make decisions on this basis; to make arrangements for and to oversee all SARs; to ensure recommendations are made, messages are disseminated and that lessons are learned.

The SAR Sub-group was established this year and held its first meeting in November 2015. Terms of reference and membership were developed. The SAR sub-group received three referrals for consideration as SARs during the course of 2015/16. Following evaluation of these against the statutory requirements and in line

with the HSAB's SAR Protocol, the HSAB commissioned one SAR this year, which will be reported on in 2016/17. Although the other two referrals did not meet the criteria for a SAR, the sub-group retained oversight of the single agency investigations and learning processes and agreed to disseminate learning from them across the partnership – one involved a Section 42 investigation and the other a NHS Serious Incident investigation. Neither of the investigations were completed before the end of March 2016. The SAR sub-group will be monitoring the improvement actions undertaken in response to these investigations.

The SAR commissioned into the death by suicide of '*Robert* 'adopted a traditional approach set out by other SARs and Serious Case Reviews, of establishing a SAR Panel, with an independent Panel Chair and an independent lead reviewer, with commissioned Individual Management Reports (IMRs) and further evidence from the agencies involved.

5.3.2 Quality Assurance Sub-group

Chair: Charlotte Pomeroy, AD Commissioning
Remit: to support the HSAB to assure itself of the effectiveness of safeguarding arrangements in delivering the outcomes that people want.

This year has the seen the development of a fully multi-agency Quality Assurance sub-group which has worked to develop a Quality Assurance Framework based on:

- Understanding adult at risks experiences – their journey;
- Knowing what impact safeguarding has had; and
- Working together.

This group reviews the multi-agency adult safeguarding dataset, which is also reported regularly to the SAB. This will enable the partnership to be informed of local adult safeguarding activity and better placed to identify trends and patterns that the intelligence may highlight.

The group also developed a cycle of policy development and review and has worked this year to update and develop a range of multi-agency policies and procedures including:

- Safeguarding Adults Multi Agency Policy and Procedure
- Safeguarding Adults Multi Agency Hoarding Protocol
- Market oversight/Provider Concerns
- Escalation Policy
- Safeguarding Adult Review Protocol
- Haringey's Joint Establishment Concerns Procedure
- Mental Capacity Act and Deprivation of Liberty Safeguards Procedure
- Joint Safeguarding Adults S42 Enquiry Framework
- Information Sharing Protocol and Practitioners Guide
- Multi Agency Pressure Ulcer Protocol and Decision Pathway

5.3.3 Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS) Sub-group

Chair: Jeni Plummer, Head of Operations
Remit: To oversee the ongoing implementation and operation of the Mental Capacity Act (MCA) 2005, including the Deprivation of Liberty Safeguards (DoLS)[1].

The sub-group was formed this year and works strengthen the partnership's inter agency relationships to support implementation of the MCA including the Safeguards in addition to providing assurances around governance and quality, sharing practice and improving DoLS compliance. The sub-group supports the aim of Government to embed rights and responsibilities of the MCA in mainstream work. The key message is that the MCA applies to everyone who works with and/or cares for an adult who may lack capacity to make specific decisions. Each member organisation of the Board promotes awareness and good practice under the MCA within their services, training and through commissioned services

[1] The Supreme Court judgment of 2014 in the case of Cheshire West clarified an "acid test" for what constitutes a "deprivation of liberty": an individual is deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights if they:

- Lack the capacity to consent to their care/ treatment arrangements
- Are under continuous supervision and control
- Are not free to leave.

The Deprivation of Liberty Safeguard (DoLS) is a statutory administrative arrangement managed by the local authority in its capacity as the supervisory body and through which a person can lawfully be deprived of his liberty. The arrangements comprise

1. the procedure where under a supervisory body may authorise a deprivation of liberty, ("standard authorisation");
2. the procedure where under the managing authority of a care home of hospital may authorise a deprivation of liberty for the period pending the grant of a standard authorisation ("urgent authorisation");
3. the qualifying requirements for making authorisations;
4. procedures for carrying out of assessments to establish whether the requirements are satisfied, including an assessment by a best interests assessor ("BIA");
5. a process for instigating and carrying out a review of a standard authorisation;
6. provisions concerning "relevant person's representatives" ("RPRs"); and
7. provisions concerning independent mental capacity advocates ("IMCAs").

In being able to authorise a deprivation of liberty under DoLS, the local authority must make sure that a number of assessments are undertaken by a Best Interest Assessor (BIA) and a Doctor approved under the Mental Health Act 1983. . These assessments are Age, Mental Capacity, Mental Health, Eligibility, No Refusals and Best Interest Assessments. Given the complex nature of this work assessments must be very detailed and comprehensive and require the input of family members and professionals.

The potential risk to the council for unlawful detention will depend on each case. However recent rulings by the court have seen payouts of £3500 and £4600 per month for unlawful deprivation of liberty (Essex County Council v RF 2015). There is also the impact that the negative publicity would have on the local authority. Given the very large backlog, most cases have not been managed within the required timescales. In some cases these timescales have been exceeded by 6+ months.

The subgroup meets quarterly and reports regularly to the Board

Achievements in 2015-16 have included:

- Developed a Multi-Agency policy and procedure for MCA and DoLS.
- Reviewed Acute Trusts MCA and DoLS internal MCA and DoLS policies and procedures.
- Participated in the Law Commission consultation of DoLS. The MCA and DoLS SAB Subgroup reviewed the proposal to reformed Deprivation of Liberty Safeguards and provided a response on behalf of the SAB.
- Reviewed and supported the implementation of the revised DoLS forms in 2015.
- Agreed the data set for DoLS.
- Monitoring of the DoLS back log and associated actions.
- The Local Authority's Safeguarding Service and Commissioning Team and the CCG work closely together when there are allegations about health care provision and with providers where there are concerns around delivery of care. Joint learning plans have been developed and shared with provider forums via commissioning colleagues in the Authority.

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Key challenges in 2015-16 have included

- The Supreme Court ruling about the Deprivation of Liberty Safeguards and the 'acid test' (lacks capacity, under constant supervision and not free to leave) in March 2014 led to an unprecedented demand for DoLS.

  2013/2014 80
  2014/2015 346
  2015/2016 508

- All Local Authorities have experienced the same uplift and there has been a general failure by Authorities to meet the statutory timeframes.
- DoLS can be granted up to 12 months and a renewal is required if there has been no change in circumstances. Subsequent Case Law has recognised that there are times where a renewal is required earlier. (eg covert medication)
- A new DoLs is required for each hospital admission and LBH remain responsible for the DOLs of any ordinary resident who is placed outside of the borough.

Priorities moving forward include:

- The identification of resource to fulfil this statutory duty.
- Ongoing work with the external provider to complete the backlog of BIA assessments and on track to complete backlog in December 2016.
- An increase in external s12 Psychiatrists to complete the assessments has taken place,
- Internal BIA's who have recently qualified complete assessment
- Managers continue to identify eligible staff during supervision that can be trained as BIAs
- Mandatory annual refresher training for internal BIAs

- Invested in ongoing training, peer group support and a forum for internal staff to manage the 'business as usual' applications.
- The Strategic and Operation Plan has been made compliant with the Care Act 2014 and with Pan London Safeguarding Adults Policy and Procedure
- Work to ensure that performance analysis that serves to inform safeguarding work going forward, identify trends and areas of concern that will serve to generate multiagency discussions at Board level
- Safeguarding training is on-going across the Local Authority and the CCG. This is delivered using different models - face to face, e learning, supervision and in practice forums

5.3.4 Prevention, Training, Learning & Development Sub-group

Chair: DCI Paul Trevers, Haringey Borough & Marianne Ecker, Workforce Development Change Manager

Remit: Oversee the delivery of the Haringey Safeguarding Adults Prevention Strategy 2014-2017, and development and coordination of multi-agency safeguarding adults training provision

The subgroup has responsibility for the Prevention Strategy's Delivery Plan to increase awareness of safeguarding and co-ordinate single and multi agency safeguarding adults training. Work has concentrated on better understanding the data collected and what this means for prioritising preventative work and planning for a community awareness raising campaign.

Achievements in 2015-16 have included:

- Prevent Duty strategy developed and training for trainers rolled out across partners
- Work to better understand safeguarding data collected resulted in first language introduced as compulsory monitoring field
- External grant application made (via Havco) to fund an external awareness campaign
- Task & finish group formed to co-ordinate awareness campaign
- 96 partners attended council organised courses to understand responsibilities of undertaking S42 enquires of Care Act 2014, which has been main focus of 2015 /6 provision
- Partners regularly share ideas and good practice of Level 1 & 2 training content
- Basic safeguarding e-learning updated for 2016 and available to all partners via both Fuse learning portal and council external web pages (2015 version gained nearly 700 views)
- offer of a range of short courses on offer targeted to different groups including: S42 training; Leading & Chairing Safeguarding meeting; Financial & Material Abuse; Self neglect & Hoarding
- Safeguarding adult conference organised by North Middlesex Hospital

Priorities moving forward include:

- how to fund training provision and move from single agency to fully multi agency offer that is jointly managed

- increasing engagement of the online learning portal by all partners so it becomes a source for shared learning
- launch awareness campaign from 6 different community locations over a 12 month period focused on financial & material abuse, domestic and psychological abuse, and self-neglect and hoarding

5.4 Partner Self-audits

In October to December 2015 all HSAB partners were asked to review adult safeguarding activity and share this with the Board. Partners identified areas where they considered that they were performing well and areas where they felt they needed to improve. Compiling the audits led the HSAB to establish that there were shared thematic issues across the partnership and the HSAB has used these to develop and inform its priorities for the coming year. HSAB came together with other boards within North London at a learning and challenge event in January 2016 which HSAB led on.

Key strengths across the partnership were identified as:

- Commitment to safeguarding
- Safeguarding policies in place
- Safeguarding training compliance
- Information sharing across the partnership
- Engagement with the Board and partners
- Quality Assurance processes

The main areas for improvement were identified as:

- Prevent Duty awareness
- Training on Prevent Duty and Mental Capacity
- Learning from staff feedback
- Learning from service user feedback and embedding it in the work
- Improving multi-agency safeguarding data

5.5 Consultation

We ran a public consultation in March 2016 to involve the community and statutory and non statutory providers, as well as Haringey Healthwatch in the development of the Board's three year strategy. This strategy will lead the development of the HSAB's annual strategic plans over the coming years. The consultation set out the four strategic aims that the HSAB should use to frame its planning.

Specific suggestions to improve the plan included:

- involvement of an independent body such as Healthwatch to measure user and carer involvement in the performance framework
- consider developing an Adult Multi-Agency Safeguarding Hub (MASH)
- use creative methods to engage and support user voice – e.g. Enfield Quality Checkers

- develop a Safeguarding Information Panel (Enfield model)
- review membership to improve user and carer representation
- establish a newsletter to improve communication and ensure reaching out the community to raise awareness
- promote a Dignity Code across the borough
- develop the plan to address the six safeguarding principles more clearly

6 Adult Safeguarding Activity 2015-16

What the statistics are telling us

Source: Haringey Statutory Return Analysis and April 15- March 16 Analysis

6.1 The council collects information about safeguarding adults work in Haringey, so we know how well people are being safeguarded. This information helps the Haringey SAB decide what their next steps should be.

6.2 Data in relation to all safeguarding issues is monitored both locally and nationally. All safeguarding concerns and enquiries are recorded and co-ordinated by Haringey Council. Progress from initial concern through to conclusion is monitored for timeliness and quality across a wide variety of measures including the nature and location of harm, service user groups, outcomes, age, gender, ethnicity, etc. This information is scrutinised by the Quality Assurance Sub-group who report key issues and trends.

6.3 Haringey Council submits returns annually to the Department of Health (DH) for collation and comparison of the key data across all authorities in England. The following commentary includes extracts from the data, trends and areas for improvement and development in Haringey.

6.4 Concerns and Enquiries

There are two different types of safeguarding enquiries

The type of safeguarding enquiry depends on the characteristics of the adult at risk. If the adult fits the criteria outlined in Section 42 of the Care Act, then local authorities are required by law to conduct enquiries. These will be referred to as **'Statutory Safeguarding Enquiries'.**

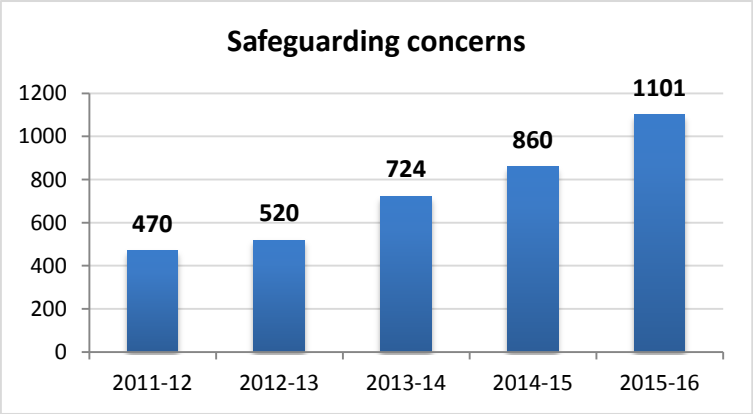
Local authorities will sometimes decide to make safeguarding enquiries for adults who do not fit the Section 42 criteria. These enquiries are not required by law and therefore will be referred to as **'Non Statutory Enquiries'.**

The Adult Social Care Integrated Access team (IAT) provides a single point of access for reporting adults safeguarding concerns

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a 'safeguarding concern'.

After a concern has been received, IAT then gather more information about the person and the concern. Once this has been done, we decide whether the case needs to be referred for investigation. A case that went on to be investigated is known as an 'enquiry'.

In the period 2014-15– 2015/16 there was a **28% increase** in the numbers of individuals for whom a safeguarding concern has been identified, from 860 in 2014-15 to 1101 in 2015-16.



The enquiry statistics over the past three years (from 2013/14) seems to be fairly consistent:

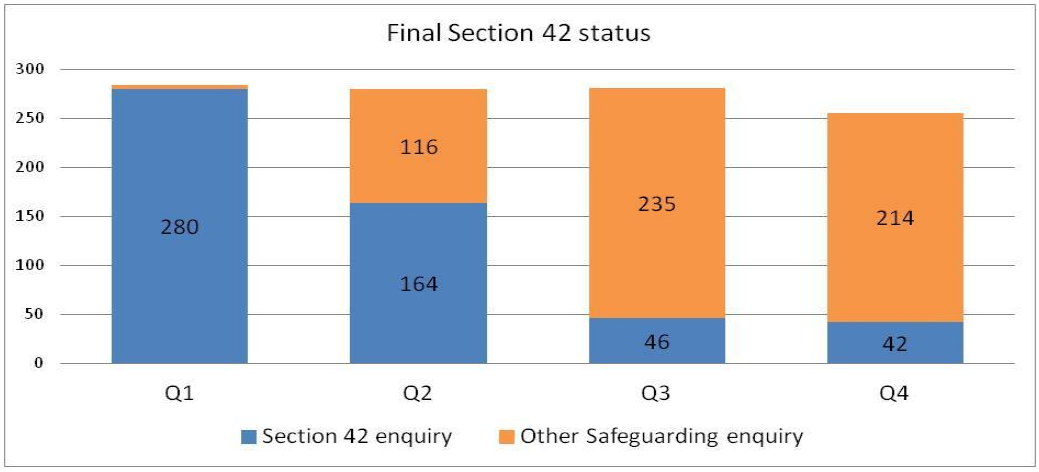
- mainly occurring in users own home, however 17% occurred in residential or supported housing;
- mainly older people (about half are aged 65+ years);
- with an over representation of black ethnic groups;
- involving mainly those with social care support reasons of physical support followed by mental health.
- the most common abuse types are Psychological/Emotional, Neglect, Physical Abuse and Financial Abuse.

6.5 Section 42 Enquiries status

In the period April 2015 – March 2016 there were a total of 1101 safeguarding concerns (excluding no further action). 48% were classed as Section 42 Enquiries and 52% as other safeguarding enquiries. See the table below.

Quarter by quarter the number of Safeguarding Enquiries has remained consistent. The number of Section 42 Enquiries appears to have fallen due to a change in recording from August 2015 that separates those enquiries that are Section 42 and those that are other enquiries.

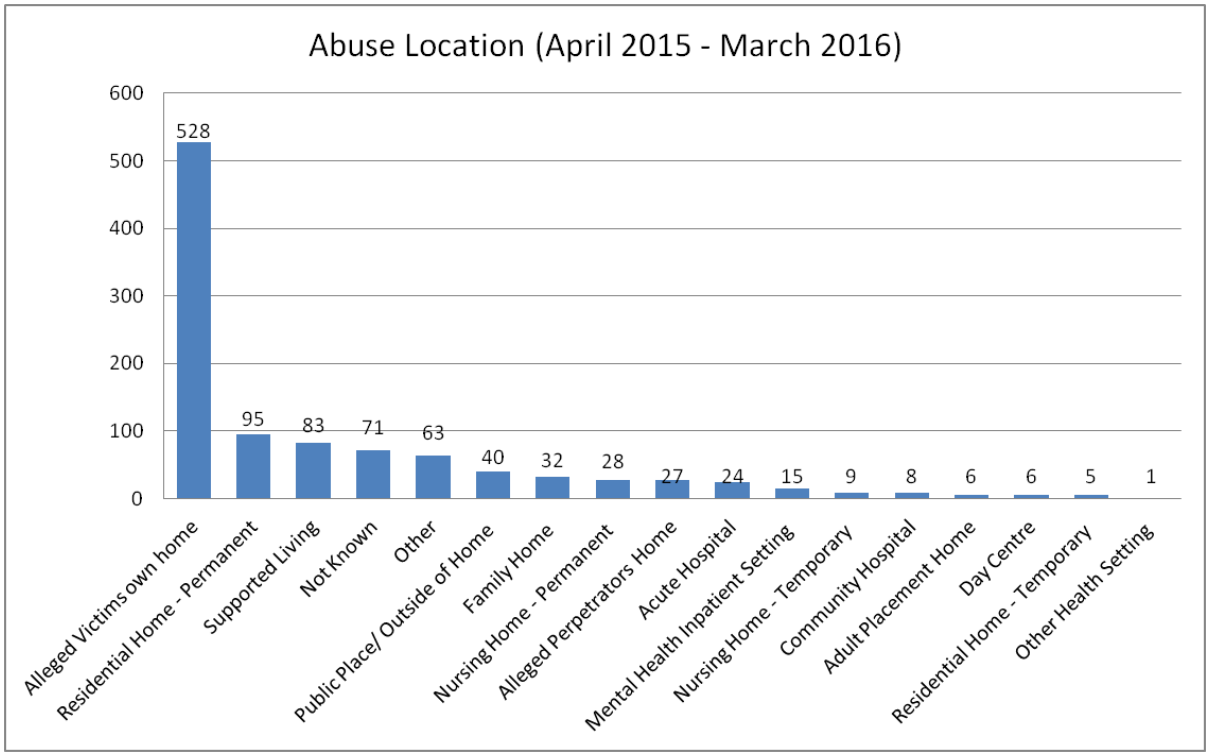
Haringey Safeguarding Adults Board
Annual Report 2015-16



6.6 Abuse Location

Abuse can happen anywhere; in someone's own home, in a public place, in hospital, in a care home for example. It can happen when someone lives alone or with others. It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

Abuse and neglect in care homes and hospitals often make media headlines. The abuse at Winterbourne View Care Home and the neglect at Mid-Staffordshire NHS Trust rightly got a lot of media coverage but overall figures indicate that the majority of cases do not occur on scale in large institutions. The chart below shows the real story, with 48% of Section 42 abuse occurred in the individuals own home (in line with 2014/15 data) and 17% in both residential and supported living settings.

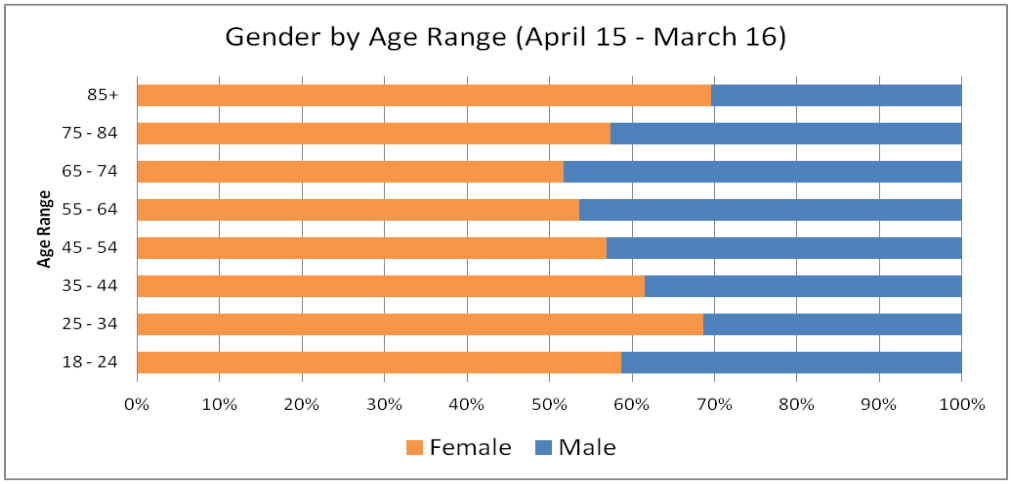


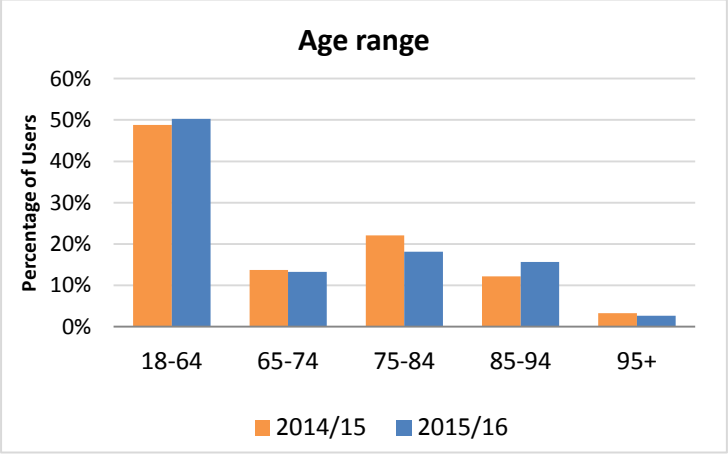
6.7 Age

49% of people going experiencing a Section 42 enquiry in 2015/16 were aged 65 and over. This is an overrepresentation compared with that age group in the general population (9.2%). Within the over 65 age group the largest percentage of Section 42s enquiries involve people aged 75-84 years (18%) and 85+ (18%).

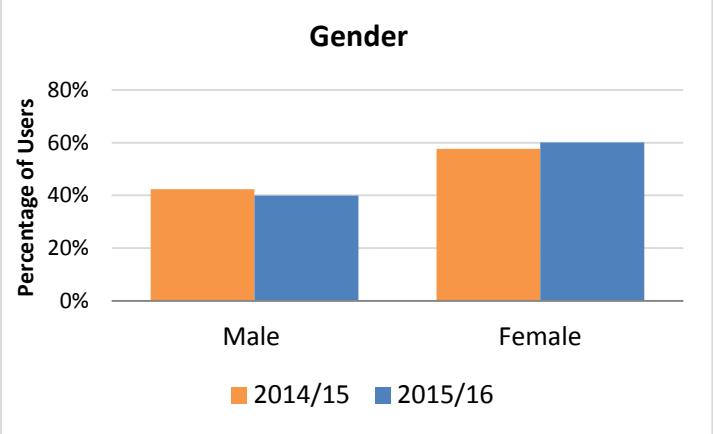
6.8 Gender and Age range

While 49.9% of the Haringey population is female, 60% of those involved in a safeguarding enquiry are female. This is consistent with 2014/15 data. For women aged 25-34 years and 85+ years, this increases to 70%.





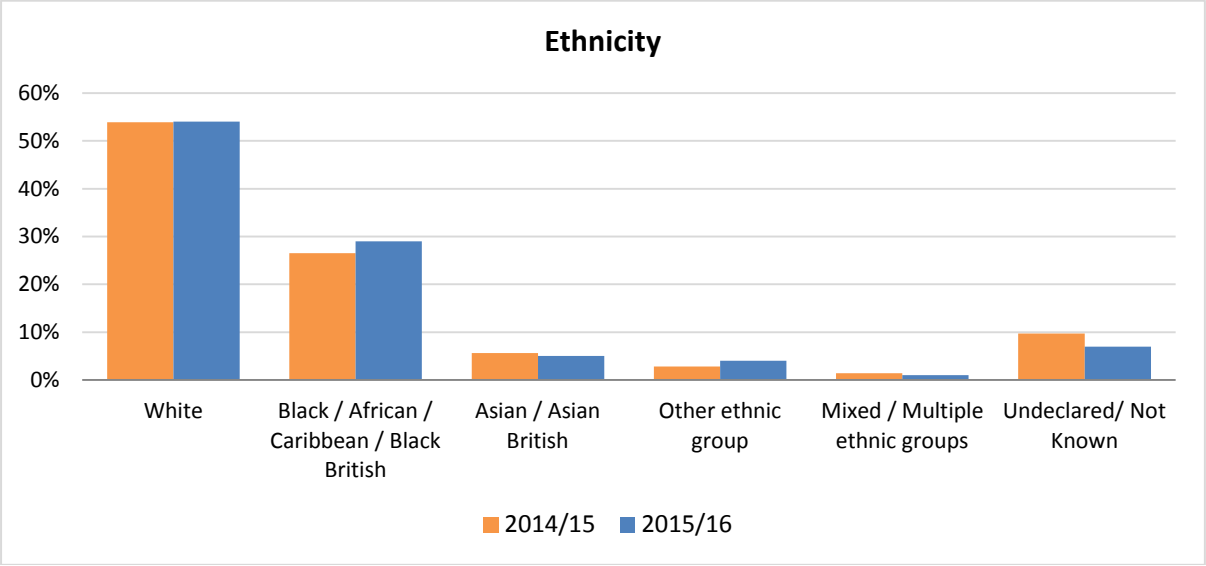
The proportion of age bands across the two year period remains relatively consistent. The largest percentage change is seen in individuals aged 85-94 an increase of 57%.



The gender profile across the two year period also remains relatively consistent 42% of individuals in 2015/16 were male, compared to 40% in 2014/15. 60% were female, compared to 58% in 2014/15.

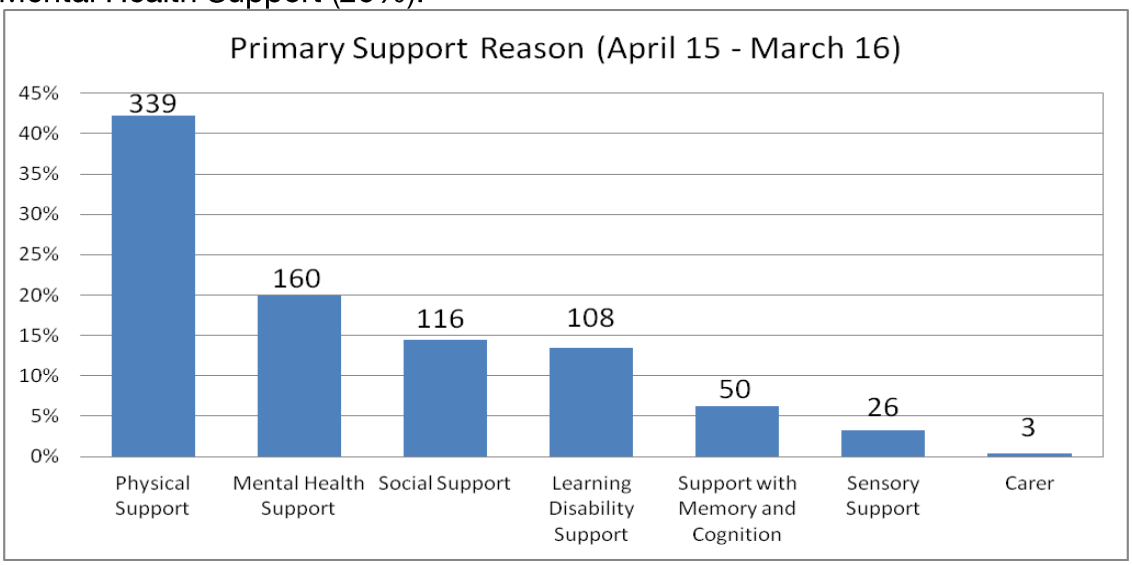
6.9 Ethnicity

Year on year the ethnic breakdown of individuals for whom a safeguarding concern has been raised is similar, with the two main ethnic groups White (54%) and Black/African/ Caribbean/Black British (29%).



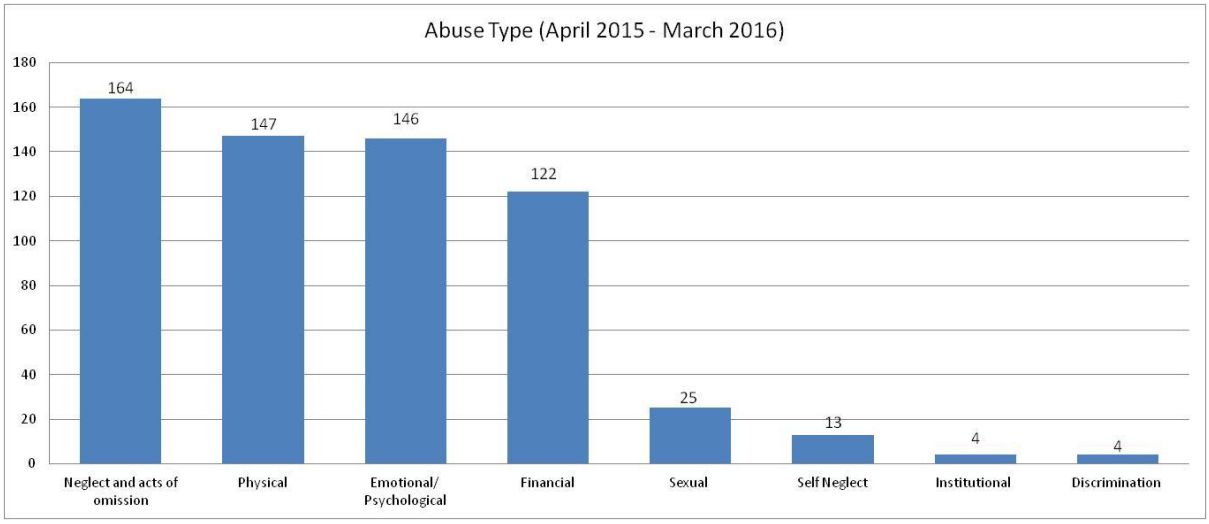
6.10 Primary Support Reason

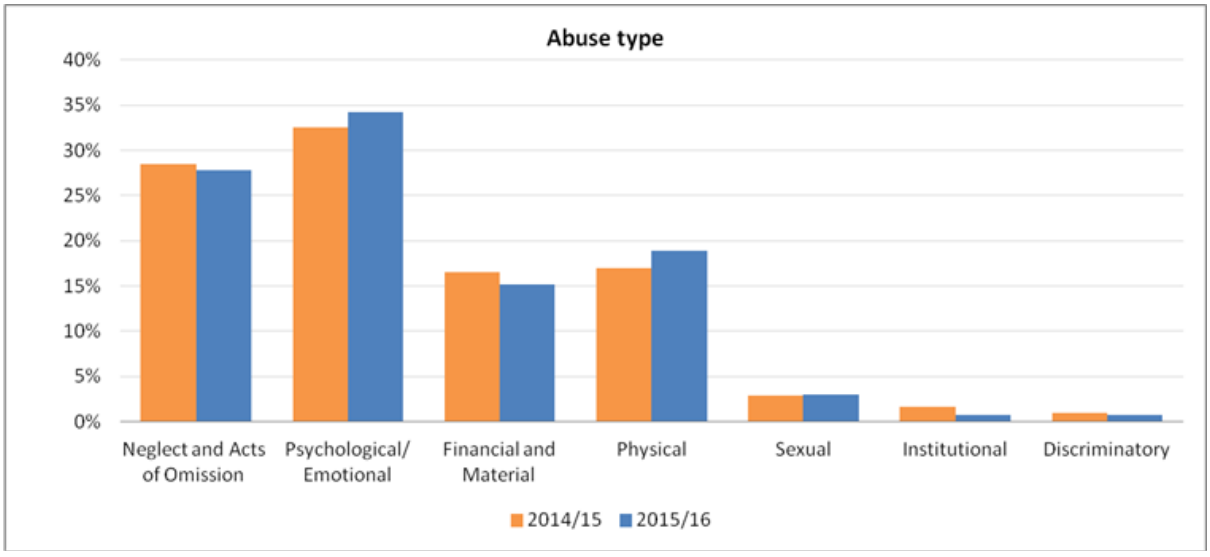
The 'Primary Support Reason' is the main 'reason' why an adult requires support or care. The chart below shows that the most common Primary Support Reason for people experiencing a Section 42 enquiry is Physical Support (42%), followed by Mental Health Support (20%).



6.11 Abuse Type

The charts below shows that the most common abuse types recorded by people experiencing a Section 42 enquiry are neglect, physical abuse, psychological /emotional abuse and financial abuse. This is consistent with data from both 2013/14 and 2014/15. The second chart shows the comparison with 2014-15 with the abuse type profile for both years very similar. The largest percentage change year on year is physical abuse, an increase of 21%, followed by Psychological/Emotional (14%). The largest reduction was institutional abuse (36%).





6.12 Referral Source

The people who are most likely to report concerns about abuse and neglect are health staff[2]. This is not surprising because health staff get a lot of training and advice on spotting abuse and neglect.

36% came from NHS services, with the majority from Acute Hospital 13% of Section 42 referrals came from Housing Agencies[3], 12% from a Social Care[4] setting and 9% of referrals were from the Police.

6.12 Safeguarding Outcomes

In 2015/16 there were more cases closed than the previous year and a reduction in the number of new cases compared with the previous year. 44% of those involved in an enquiry said that their 'Making Safeguarding Personal[5]' outcomes were met or partially met, an improvement of 4% compared with last quarter.

In all safeguarding enquiries the person at risk of abuse or neglect will be helped to stay safe from harm. If necessary, monitoring of their risk will be increased, and the frequency, type or location of their care may change. Action will be taken against the person who caused the harm. This might include removal from a service, further training or disciplinary action if they were a paid carer.

[2] Health Services includes referrals from acute hospitals, ambulance service, community mental health team, GP, CCG etc.

[3] Housing agencies include Council Tenant, Housing Association, Residential/Nursing, Sheltered Housing and Supported Housing.

[4] Social care staff includes day care, domiciliary, residential workers and Care Managers.

[5] Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end.

7 What we will do 2016-17

The following pages set out the annual strategic objectives that we have developed for 2016/17. These objectives have been reviewed against the six statutory principles of adult safeguarding with an emphasis on Making Safeguarding Personal. You can find a more detailed version of the annual plan on the HSAB website.

1	We are assured that safeguarding practice is person-centred and outcomes focused				
	Objective	**Key principle**	**Timescale**	**Lead**	**Success criteria**
1.1	Implement the Quality Assurance Framework to include both performance data and analysis and auditing that explicitly considers how person-centred safeguarding interventions are, and how reflective of users' views and needs	Prevention	First full quarterly report from Q1 2016/17	Chair QA Sub-group	The Board is assured: • that people are asked about the outcomes they want; • that the outcomes are defined by them; and that the extent to which they are realised is measured and aggregated
1.2	Improve user and carer involvement in safeguarding (Making Safeguarding Personal) across the partnership with clarity about how to measure and demonstrate outcomes with both baselines and targets.	Empowerment	Piloting by December 2016 and assessing improvements through performance monitoring by end Q4 2016/17	Chair QA Sub-group	The Board is assured: • that safeguarding is person-led and outcome-focused; • that it engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

1.3	Feasibility into the development of an Adult/Family MASH Board to include in particular a focus on transition into adulthood.	Partnership Protection	Q4 2016/17	Director Adult Social Services	The Board is assured of: • More effective use of resources development of a whole family approach to safeguarding; improved approach to safeguarding during transition periods.
1.4	Establish standards and agreed competencies in MSP and adult safeguarding prevention for all staff across the partnership	Prevention Empowerment	Q4 2016/17	Chair QA Sub-group & Chair Prevention and Training & Development Sub-group	The Board is assured that: • the safeguarding workforce is person-centred and understands MSP; the system is focused on prevention
1.5	Develop a multi-agency person-centred strategic risk management policy and register with clear accountability lines.	Partnership Proportionality	October 2016 Board meeting	Chair QA Sub-group	Improved understanding of and approach to multi-agency risk management across the partnership
2	**We prevent abuse and neglect**				
	Objective	**Key principle**	**Timescale**	**Lead**	**Success criteria**
2.1	Improve targeting and prevention by monitoring and identification of poor quality Safeguarding practice, increased risks and vulnerabilities to abuse,	Prevention	Q4 2016/17	Chair QA Sub-group	The Board is assured that partnership safeguarding priorities, responses and prevention planning and are informed by local intelligence about risk.

	safeguarding themes, trends and locations and ensure engagement of service users, carers and community and voluntary sector to current concerns and trends are captured				
2.2	Use intelligence to identify key themes and raise awareness of abuse and neglect with staff, partners and the public through improved communications and campaigns	Prevention Empowerment	Campaign schedule agreed from April 2016 and devised on annual basis through the Prevention Sub-group	Chair Prevention and Training & Development Sub-group	The Board is assured that there is a cycle of well-informed public campaign and communications in place with evaluation criteria that includes measuring access and impact.
2.3	To monitor the implementation of the SAB Prevent Action Plan and agency statutory duties under the Counter-Terrorism Security Act 2015 in respect of preventing and dealing with radicalisation and extremist activities	Prevention Protection	Quarterly reporting	Chair Prevention and Training & Development Sub-group	The Board is assured that assured of partnership practice and performance to: • understand the risk of radicalisation& understand the risk and build the capabilities to deal with it; • implement the duty effectively; communicate and promote the importance of the duty
2.4	Disseminate Haringey's Safeguarding	Partnership	Q2 and Q3	SAB Chair and Chair	The Board is assured that the partnership

	Adults Multi Agency Policy & Procedure, in Line with Pan London developments through launch		2016/17	Chair Prevention and Training & Development Sub-group	is implementing the procedure, is compliant and that working together in safeguarding practice is improved
2.5	Review of the approach to information sharing across Haringey multi-agency safeguarding and SAB's Multi-agency Information Sharing Protocol and Practitioners Guide against MSP that also engages the voluntary and community sector and is well communicated to users and carers.	Partnership Protection Prevention Accountability	Q3 2016/17	Chair QA Sub-group	The Board is assured that safeguarding information: • is shared efficiently and purposefully; • is shared in a timely manner to ensure vulnerable adults are safeguarded; is evidenced in performance monitoring and audits.
3	**We respond to abuse and neglect in a timely and proportionate way**				
		Key principle	**Timescale**	**Lead**	**Success criteria**
3.1	Develop a consistent approach to conducting and learning from SARs, Domestic Homicide Reviews and Fire Death Reviews	Prevention Accountability	Q4 2016/17	Chair SAR Sub-group	The Board is assured that all deaths and other incidents involving serious abuse or neglect are assessed within the protocol and the process managed well with the focus on learning to inform improvements.
3.2	Monitoring implementation of the MCA/Deprivation of Liberty Safeguards (DOLs) policy and in particular assuring of demand management	Protection	Quarterly reporting	Chair MCA/DoLS sub-group	The Board is assured that assessments and decisions are: • person-centred • timely • proportionate; and that demand and risk management is

					sound.
4	**We are committed to learning and improving**				
		Objective	**Timescale**	**Lead**	**Success criteria**
4.1	Improve multi-agency knowledge and awareness of mental health including Mental Capacity Act and the use of Advocates in safeguarding work	Empowerment Protection	To be reviewed and embedded in annual training cycle	Chair Prevention and Training & Development Sub-group and Chair MCA/DoLS subgroup	The Board is assured that practice has improved through auditing of the quality of assessments and increased use of advocates
4.2	Ensure learning from safeguarding cases is embedded in multi-agency practice.	Accountability	Quarterly reporting on multi-agency auditing	Chair QA Sub-group	The Board is assured that learning is embedded and leads to improved safeguarding practice
4.3	Implement local agreed guidance on Safeguarding Adults Reviews (SAR) and ensure learning is embedded across the partnership	Partnership Accountability	Quarterly reporting	Chair SAR Sub-group	The Board is assured that all deaths and other incidents involving serious abuse or neglect are assessed within the protocol and the process managed well with the focus on learning to inform improvements and monitoring of action plans arising.
4.4	Develop the facilitation and commissioning of multi-agency training resources and the regular review and evaluation of the training provision	Partnership	Q4 2016/17	Chair Prevention and Training & Development Sub-group	The Board is assured of that the opportunity for learning together across the partnership leads to improved working together and better outcomes for vulnerable adults

4.5	Explore feasibility of better links with LSCB, Health and Wellbeing Board and Community Safety Partnership strengthened to make better use of resources and strengthen safeguarding awareness and practice	Partnership	Q4 2016/17	Board Manager	The Board is assured that there is more effective use of resources and shared learning within a whole family approach
4.6	SAB Annual Reports, development days and peer challenge and audit drive improvement and strategic planning are a driver for strategic planning	Accountability	Annual cycle of review and development days annually in January	SAB Chair	Strategic plan is reviewed and revised as a result and all partners can see the role of their agency and its priorities reflected in ongoing planning.

8 Partner Contributions

8.1 In this section HSAB partners set out how they have contributed to the work of the HSAB and to the ongoing improvement of local safeguarding adults' arrangements. Each key partner was asked to frame their contribution in response to the following key areas:

- Safeguarding adults work undertaken and key achievements in 2015-2016
- Key challenges
- Safeguarding adults work planned for 2016-2017
- Details of internal arrangements for providing staff (and others) with safeguarding adults training
- Case studies
- Examples of good partnership working

8.2 Haringey Clinical Commissioning Group

Haringey Clinical Commissioning Group (CCG) is the major commissioner of local health services across the borough and is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. All health providers in Haringey are required to have effective arrangements in place to safeguard vulnerable adults and to assure the CCG, as commissioners that these are working. Designated Professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the Local Authority and the Haringey Local Safeguarding Adults Board (HSAB). They also provide advice and support to multi-agency health professionals.

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015) defines the safeguarding responsibility and duty of CCGs. CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding.

NHS England conducted a series of deep-dive exercises across CCGs' arrangements and in 2015, one of the areas of focus was safeguarding. The results of this process were reported in February 2015 and they acknowledged the extent of focus and commitment to safeguarding within Haringey CCG.

Name of organisation:	**Haringey Clinical Commissioning Group**
Completed by:	**Karen Baggaley**
Title/Designation:	**Assistant Director for Quality and Nursing**

Overview 2015-16	NHS Haringey Clinical Commissioning Group (HCCG) is committed to working with partner agencies to ensure the safety, health and well-being of the local people in Haringey. Protecting the vulnerable is a key part of HCCG's approach to commissioning and, together with a focus on quality and patient experience, is integral to our working arrangements. Our approach to Adult Safeguarding is underpinned by quality and contracting systems and processes that aim to reduce the risk of harm and respond quickly to any concerns.
Internal safeguarding	Within Haringey CCG's organisational structure

adults' governance arrangements.	safeguarding is positioned within the Quality and Integrated Governance Directorate under the leadership of the Executive Nurse and Director of Quality and Integrated Governance. This clearly embeds safeguarding as a patient safety service with robust clinical governance reporting arrangements via the Quality Committee. HCCG's Chief Officer is the executive lead for HCCG's Safeguarding Adults' agenda and has the responsibility for ensuring the effective contribution by health services to safeguarding and promoting the safety of adults at risk and vulnerable people. The Chief Officer is a member of HCCG's Governing Body. HCCG's Executive Nurse & Director of Quality & Integrated Governance is responsible for ensuring that the monitoring of Safeguarding Adults work across Haringey takes place through the Quality Committee of Haringey CCG's Governing Body and the Haringey Safeguarding Adults Board (SAB). The Assistant Director for Quality and Nursing oversees the Safeguarding Adults at Risk Agenda in the CCG. This role also ensures that all health organisations with whom HCCG has commissioning arrangements with have links with their SAB and is responsible for ensuring Safeguarding Adults systems are in place and monitored. The Designated Professional for Safeguarding Adults provides expertise, a point of contact for advice, and intelligence regarding Adult Safeguarding across the health economy. This role ensures that HCCG fulfils its statutory functions for Safeguarding as detailed in statutory and national guidance, providing assurance to executive leads for Safeguarding, that there is a systematic approach to Safeguarding Adults across HCCG. The Designated Professional for Safeguarding Adults is a member of Whittington Health, North

	Middlesex Hospital and Barnet, Enfield and Haringey Mental Health Trusts Safeguarding Committees. The Designated Professional for Safeguarding Adults utilises attendance at the committees as one way of gaining assurance that Provider Trusts are ensuring high quality Safeguarding Adults practice is embedded within their organisations. The Designated Professional for Safeguarding Adults monitors compliance with the Trusts respective Safeguarding Adult training strategies through representation on the committees and takes action as required. Information obtained from these meetings is included in the Quality Committee Safeguarding Briefings. Safeguarding is a standing agenda item at HCCG's Quality Committee. A bi - monthly briefing is discussed with a more detailed report being submitted 6 monthly. The Quality Committee minutes go to the Bi-monthly Governing Body meetings. HCCG Designated Professional for Safeguarding Adults is a member of Safeguarding Adult Board (SAB) and its respective sub groups. The Designated Professional for Safeguarding Adults is a member of the NHS England (London) CCG Safeguarding Adult forum, The NHS England (London) Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Steering Group and the MCA and DoLS London Network. An Annual Report is submitted to HCCG Governing Body.
Safeguarding adults work undertaken and key achievements in 2015-2016. To include specific examples of work undertaken.	HCCG's responsibilities as commissioners is to promote the safety and welfare of adults in all of the services it commissions and provide assurance of HCCG's commitment to prevent and reduce the risk of abuse and neglect of adults and of continuing to improve safeguarding practice in the NHS.

	• Rated as 'Good' by NHS England (London) following a deep dive audit.
	• MCA project funds were secured to deliver a programme of training and awareness raising including:
	  • Patient engagement and awareness raising events on Lasting Power of Attorney and Advance Decisions for patients and carers.
	  • Patient information leaflets developed on Advance Decisions, Preferred Priorities for Care and Lasting Power of Attorney for GP practices and Acute Trusts.
	  • Twelve three hour bespoke training sessions delivered for GPs across Barnet, Enfield and Haringey. Ninety-one delegates received training of which 63% were general practitioners, 26% were district or practice nurses and 11% were practice managers.
	  • An MCA template and guidance developed with GPs.
	• The CCGs showcased through their first Seminar (to over 40 delegates), the dedicated work relating to MCA/DoLS from a multi-agency partner perspective and keynote speakers from Department of Health, NHS England and provider trusts all provided their dedicated time.
	• All MCA tools through the joint Barnet, Enfield & Haringey CCG MCA/DoLS project are published on Social Care Institute for Excellence (SCIE) web site as examples of best practice.
	• Supported the development of a commissioner MCA and DoLS checklist as part of the NHS England (London) MCA and DoLS steering group.
	• Developed a HCCG Prevent strategy including; HCCG Prevent policy, training matrix, and rolled out Prevent awareness training to HCCG staff.
	• Localised the Safeguarding Adult Pressure

	ulcer protocol. • Care Act (Safeguarding) updates delivered to Continuing Health Care Team. **<u>Specific examples</u>** **Awareness Raising on Lasting Power of Attorney and Advance Decisions for Patients and Carers** Six patient and carer events were held across Barnet, Enfield and Haringey around advance care planning. Specialist speakers from the Office of the Public Guardian[6] and Compassion in Dying gave a short talk to attendees, followed by a question and answer session at each event. Questions asked included: *"What happens if I lose capacity suddenly and I don't have a LPA?"* *"Who decides if you have lost 'capacity'?"* *"What is a 'certificate provider'?"* *"What does 'lack capacity' mean?"* *"What happens if your advance decision doesn't take account of recent medical treatments?"* A patient *frequently asked questions (*FAQ) leaflet has been developed on lasting power of attorney and advance decisions to refuse treatment based on these questions: the FAQs are designed to supplement a suite of patient information leaflets on advance care planning which were developed in conjunction with patients and carers at these events.
Key challenges	HCCG will review whether the recruitment of a Named GP for Adult Safeguarding will strengthen Safeguarding adult arrangements within Primary Care.

[6] The Office of the Public Guardian (OPG) protects people in England and Wales who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.

Safeguarding adults work planned for 2016-2017	**Key Objectives for April 2016 –March 2019** • The challenges for Safeguarding over the coming year are to continue to develop, expand and embed Safeguarding practice within the core work of the CCG; and to build up partnership working with the local authority, local health providers and NHS England (London). • Implement the NHSE Mental Capacity Commissioner framework. • Develop processes with adult commissioners to ensure that adult care placements (such as in care homes, nursing homes or independent hospitals) are based on knowledge of standards of care and Safeguarding concerns: Agree rollout of Independent Placement Agreements (IPA) and standard contract with commissioning: Agree program of audit roll out to existing providers with CHC commissioning team. Annual quality audit tool to be devised and based on CQC quality standards. • Review and update Safeguarding Adults Policy, Procedure and training competency framework to reflect changes in legislation, national and intercollegiate guidance: Review the NHSE Intercollegiate Guidance and updated Bournemouth Competency Framework. Apply changes to HCCG Training and Competency Framework roll out in 2016. • Strengthen internal assurance process by identifying a GP Governing Body member with lead responsibility for safeguarding adults to ensure safeguarding will be appropriately represented at the Governing Body meetings.

	• To ensure HCCG has a system for identifying, analysing and referring complaints which raise safeguarding concerns, including potential neglect. This will facilitate early identification of quality issues/safeguarding concerns with providers enabling actions to put in place to mitigate risk. • To ensure where a patient under the responsibility of HCCG is in a private sector hospital or care home there are effective systems for recording and monitoring of Deprivation of liberty application. • To ensure actions from Safeguarding Adult Reviews (SARs) and Domestic Homicide reviews (DHRs) are implemented, monitored and lessons shared across all the relevant organisations including provider services.
Details of internal arrangements for providing staff (and others) with safeguarding adults training.	HCCG have implemented the Bournemouth University (National Competence Framework for Safeguarding Adults 2010) which is a national framework that provides consistency and standardisation across practice settings in measuring competence leading to greater accountability. HCCG's mandatory training programmes encompasses the five core standards of the Bournemouth Framework and expects that staff should be trained to: • Understand what adult safeguarding is and their role in safeguarding adults; • Recognise an adult potentially in need of safeguarding and take action; • Understand procedures for making a "safeguarding alert";

	• Understand dignity and respect when working with individuals; and • Have knowledge of policy, procedures, and legislation that supports safeguarding adults' activity. All HCCG staff have been allocated a training level according to their contact with Adults at Risk and any subsequent role in the Safeguarding Adults process. The NHSE intercollegiate document for Safeguarding Adults will be published in 2016 which will provide a more detailed competency framework. Training compliance is monitored monthly by the Senior Management Team and reported Bi-monthly at the Quality Committee.
Case studies	
Examples of good partnership working	• HCCG contributes to the Haringey LA Information Panel meetings and the Establishment Concerns process; agreeing actions and sharing and disseminating information as appropriate. As part of this HCCG have supported the review of Establishment Concerns Policy with Haringey Local Authority. • HCCG Designated Professional for Safeguarding Adults attends all provider Safeguarding Adults committees, SAB and respective subgroups. • HCCG Designated Professional for Safeguarding Adults is a member of DHR panels and contributes to the learning from these reviews. • HCCG Designated Professional for Safeguarding Adults has worked with LBH to develop a localised Safeguarding Adult Pressure Ulcer Protocol.

	• The Quality Matters in Care Home Team work in conjunction with LBH to support care homes to drive up quality in care homes. This has included effective management episodes of ill health, and the provision of training to care home staff on basic health care provision which are often indicators of neglect during safeguarding investigations. The service also provides telephone support and visits after hospital discharges.
Safeguarding Reports *(please embed or provide links to any reports)*	

8.3 Barnet, Enfield and Haringey Mental Health Trust

Barnet, Enfield and Haringey NHS Mental Health NHS Trust
A University Teaching Trust

Completed by Ruth Vines, Head of Safeguarding on behalf of Mary Sexton Executive Director of Nursing, Quality and Governance.

Overview 2015 -2016

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. We recognise that effective safeguarding is a shared responsibility which relies on strong partnership and multi-agency working. Over the last 12 months The Trust has strengthened its safeguarding arrangements in many ways including the recruitment of a full-time Head of Safeguarding. We are continually improving systems and processes; and developing a clear strategic approach to safeguarding across all our services.

Internal governance arrangements

Our aim is to ensure there is a whole organisational approach to safeguarding patients and service users, their families and carers. In order to do this we have developed an Integrated Safeguarding Committee (ISC). The ISC is chaired by the Executive Director of Nursing, Quality and Governance and provides strategic leadership and oversight. The work of the ISC is informed by our newly developed Safeguarding Strategy and overarching work plan. The ISC meets each quarter and is accountable to the Trust Quality and Safety Committee. The Executive Director of Nursing, Quality and Governance is the Executive lead for safeguarding and provides bi-monthly safeguarding updates to the Trust Quality and Safety Committee. In addition an annual safeguarding report is provided to the Trust Board. Safeguarding is a standing item for each of the Borough Clinical Governance meetings.

Safeguarding adults work undertaken and key achievements in 2015 – 2016

- A Domestic Violence and Abuse Policy has been completed.
- Domestic Violence and Abuse training have been included in Corporate Induction for all staff.
- The Trust Safeguarding Adults at Risk Policy has been updated to ensure it is Care Act compliant.
- A safeguarding inbox has been set up to allow improved monitoring of safeguarding alerts.
- A safeguarding screen saver has been established to prompt staff to use the Trust safeguarding inbox.
- A safeguarding dashboard has been designed.
- A prompt to consider safeguarding has been included in the Trust incident reporting system (Datix).
- Mental Capacity Act and Deprivation of Liberty Safeguards training has been included in the mandatory training matrix.
- Prevent Training has been included in Corporate Induction for all staff.

- An Integrated Safeguarding Committee has been established with clear terms of reference.
- A safeguarding strategy has been completed with key aims and objectives
- A safeguarding training strategy has been completed
- The safeguarding surgeries have been recognised as good practice and these continue.
- The terms of reference for the Trust safeguarding champions have been refreshed and revised

Key Challenges

- Safeguarding practice is complex and varied. The challenge of collecting accurate meaningful data is recognised. Work continues to ensure data is captured and analysed effectively.
- To continue to develop and improve systems to promote effective lessons learnt from safeguarding incidents.
- To review the training needs analysis for level 3 safeguarding adults training in line with recently published Intercollegiate Document Safeguarding Adults (April 2016)
- To ensure the challenge of working across three borough Safeguarding Adult Boards and their associated sub-groups is managed effectively.
- To ensure that the principles of the MCA are embedded into everyday practice.

Safeguarding adults work planned for 2016- 2017

The work of the Integrated Safeguarding Committee is informed by an overarching work plan which underpins the Safeguarding Strategy. The Strategy has five broad aims which form the overall framework of work going forward:

- To ensure safeguarding is everyone's business across the Trust
- Develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes.
- Develop a culture of learning with robust internal systems to support this.
- Promote early help to prevent abuse from happening in the first place.
- Develop seamless pathways that promote joined up working at every level.

Safeguarding Training

Safeguarding Adults at Risk training levels 1 and 2 are delivered at mandatory Corporate Induction for all staff. The training is delivered as a safeguarding day and includes safeguarding children training, domestic violence training, and training in MCA and DoLS. Prevent Healthwrap3 is also delivered at Corporate Induction and has been mandatory since September 2015.

Staff are required to refresh safeguarding training at least every 3 years.

The Trust target for mandatory training compliance is 85%. Safeguarding adult training compliance for April 2016 is 86.5%

Case Examples

A safeguarding concern was raised regarding the welfare of a service user who has physical health problems and frailty. There were concerns that the carer was preventing the

service user from receiving healthcare support. Mental capacity established. A professionals meeting was held and a plan put in place to support both the service user and the carer.

A safeguarding concern was raised following a revelation by an adult at risk that she is receiving weekly threatening phone calls from her family members. The police were informed. There were also other allegations of historic sexual, physical and emotional abuse. A strategy meeting was held and the police are investigating the allegations. The adult at risk was offered assessment of her care and support needs, referral for counselling and MARAC referral completed. She is regularly reviewed by the clinical team.

8.4 North Middlesex University Hospital

North Middlesex University Hospital NHS Trust

Eve McGrath, Safeguarding Adults Lead

COMMITMENT TO SAFEGUARDING ADULTS AT RISK

North Middlesex University Hospital NHS Trust's Board takes the issue of safeguarding extremely seriously and receives annual reports on both safeguarding children and safeguarding adults. The Trust acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all our patients remains a priority for the Trust as we see it as a fundamental component of all care provided. Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust is essential.

The Trust has an established Safeguarding Adults Group which has representation from our inter professional and inter agency groups. It meets bi-monthly and provides the strategic direction to safeguarding adult activities across the Trust and ensures that all safeguarding commitments and responsibilities are met.

During 2015/16 the Trust has worked with partner organisations to safeguard some of the people who are most at risk of abuse, harm and neglect. This enables the Trust to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of an adult at risk occurs.

The Director of Nursing is the Executive Lead for Safeguarding Adults and represents the Trust at Haringey local multi agency safeguarding adult board meetings.

KEY ACHEIVEMENTS FOR 2015-2016

The Trust is committed to learning so that we can make improvements. Some examples include:

- the Trust Board and Non-Executive Directors attended a training session on the 'Implications of the Care Act and Making Safeguarding Person' in December 2015
- the Trust completed the Safeguarding Adult Provider Audit in December 2015 which was jointly developed by London Chairs of Safeguarding Adults Boards (SABs) network and NHS England London and provides all organisations in the Borough with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements
- the Trust updated its Safeguarding Adults at Risk Policies in January 2016 to ensure compliance with the implications of the Care Act 2014 and **the London Multi-Agency Safeguarding Adult Policy and Procedures**
- a significant amount of work has been done to ensure that staff are trained to the correct level for level 1 and level 2 Safeguarding Adult training and at end March 2015/16, 86% of all staff had attended level 1 training and 74% of relevant senior staff had attended level 2 training
- 8 ward managers and matrons have attended section 42 investigation training

- continued improvements in reduction of risks of hospital acquired pressure ulcers
- development of the Trust Dementia care strategy led by the Dementia clinical leads and roll out of training to ward staff
- the Trust has increased its focus on the 'making safeguarding personal' agenda and involves patient's relatives and carers in safeguarding adults enquiry meetings and at Case Conferences
- the Trust has introduced monthly 'Lessons Learned Events' for Ward Managers and Matrons and other members of the multi-disciplinary team to enable reflection of recommendations from safeguarding adult enquiries
- quarterly safeguarding adult reports outlining numbers of safeguarding concerns raised and themes arising from Safeguarding Adult enquiries are presented to the Trust Risk and Quality Committee.

PRIORITIES AND WORK PLANNED FOR THE COMING YEAR

Key priorities for the Trust in 2016/17 are to:

- ensure learning from safeguarding cases is embedded into practice, via supervision and Trust training programmes
- develop a training plan for Mental Capacity Act, Best Interest Decisions, Deprivation of Liberty Safeguards and Domestic Violence
- further work to progress PreventWrap training for all staff
- improve Domestic Violence support available to patients and our staff
- ensure adequate handover of information about the patient's condition on discharge and audit discharge checklists for discharge procedures in order to ensure that patients are discharged with relevant and up to date information
- ensure that capacity assessments (Mental Capacity Act 2005) and rationale for best interest decisions are fully completed and discussed with family members
- ensure that medical staff consult the families of patients without mental capacity, or their significant others, before putting 'Do Not Attempt Resuscitate' orders in patient medical records
- ensure that End of Life Care Plans are developed in consultation with patients and their families / carers
- continue to implement recommendations from lessons learned from Safeguarding Adult investigations
- ensure that Mental Capacity Assessments and Deprivation of Liberty Safeguard applications are audited by CBU Matrons.
- progress further work on improving care for those with Learning Disabilities to ensure that reasonable adjustments are made as necessary

8.5 Whittington Hospital

Name of organisation:	**Whittington Health**
Completed by:	**Theresa Renwick**
Title/Designation:	**Safeguarding Adults Lead**

Overview 2015-16	
Internal safeguarding adults' governance arrangements.	Whittington health has the following governance structure in place to ensure safeguarding adults is embedded within the organisation: **Executive lead for safeguarding**: Philippa Davies, Director of Nursing **Named doctor for Safeguarding Adults**: Dr Rhodri Edwards, consultant geriatrician **Deputy executive lead for safeguarding**: Dr Doug Charlton, deputy director of nursing **Safeguarding Adults Lead**: Theresa Renwick A more detailed explanation of roles is given in the Trust annual report for 2015-2016, attached below.
Safeguarding adults work undertaken and key achievements in 2015-2016. To include specific examples of work undertaken.	• Training compliance has increased from 65% for Level 1 in April 2015 to 88% in March 2016. A similar increase has been seen with level 2, a figure of 60% in April 2015 and 85% in March 2016. • There has been a significant increase in numbers of capacity assessments recorded on the internal database Anglia Ice, with a high of 52 in December 2015. • Implementing a robust central system for Deprivation of Liberty Safeguards, in conjunction with specific training on the area, has seen a sustained increase in numbers of patients recorded to be subject to DoLS, with 12 recorded for April-June 2015, and 91 for Jan-March 2016. • The weekly emergency department meeting to discuss patients identified as vulnerable adults is now an embedded part of safeguarding adults. This was recognised by the CQC report published in July 2016 following an inspection in December 2015, in which CQC found "*within the ED there*

	was outstanding work to protect people from abuse." The meeting looks at all safeguarding adult concerns identified by ED staff to ensure correct processes have been followed. Triangulation of source of concerns have enabled us to liaise directly with the local authority, and via the GP teleconference held weekly by geriatrics, to discuss with GPs such concerns, and offer support and advice. • In line with an increase in training compliance, there has been an increase in numbers of concerns identified amongst patients at Whittington Health, passed to the local authorities. • Four staff members are now WRAP 3 trainers • The three new categories of abuse introduced by the Care Act 2014 form a key part of safeguarding adult Level 2 training. • An increased knowledge amongst staff of their duties around use of the Mental Capacity Act and implementation has been recognised by the CQC inspection (see report below) • Conference around use of DoLS which had Mr E, carer of HL as the keynote speaker • Conference for White Ribbon day focusing on 'The survivors' journey' • Safeguarding adult lead presented at the Pan London launch • Identification of situation which required referral to the SAR panel, and subsequently drawing up an action plan to address findings of our internal investigation
Key challenges	Ensuring all safeguarding adult responsibilities are discharged with the resources available.
Safeguarding adults work planned for 2016-2017	• Roll out of sustained PREVENT WRAP 3 training across the organisation to comply with statutory obligations under the Counter Terrorism and Security Act 2015 • Introduction of new course of four half day

	sessions, which looks at increasing awareness of working with people with dementia, carers, use of the MCA, safeguarding responsibilities for carers, self-neglect • Continue to embed use of the MCA amongst the organisation • Continue to embed identification of patients deprived of their liberty, and legal responsibilities • Commence safeguarding adult forums for community staff
Details of internal arrangements for providing staff (and others) with safeguarding adults training.	• Safeguarding adults training is part of the Trusts' induction programme. Every member of staff receives Level 1, and those interacting with patients receive level 2 • There are monthly refresher training sessions for level 1 and 2 in addition to the induction training • Bespoke training sessions for teams around safeguarding adults, use of MCA and /or DoLS are also available.
Case studies	Four patients were admitted in a very short space of time to ED from the same high support community resource. The named doctor for safeguarding adults spoke with the GPs covering this provision, the safeguarding adults lead liaised with the local authority and ED staff were aware there were concerns about possible neglect at the resource. This resulted in closer monitoring of care provision.
Examples of good partnership working	As above

8.6 Haringey Adult Social Services

Name of organisation:	**Adult Social Services**
Completed by:	**Helen Constantine**
Title/Designation:	**Strategic Lead Governance and Improvement Service**

Overview 2015-16	The Adult Social Services Quality Assurance Board (QAB) meets quarterly and ensures that quality assurance arrangements are in place across Adult Social Services. Haringey's Adult Social Services continues to make great strides in terms of further enhancing its safeguarding practice. We are transforming care to assure ourselves that we have good care quality standards. Perhaps the most fundamental change facing the Council arose from the implementation of the Care Act which received Royal Assent in May 2014 - to bring all care and support legislation into a single statute and address many of the recommendations made by the Dilnot Commission into the funding of adult social care. From April 2015 local authorities must: – Lead a **multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens. – **Make enquiries**, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect. – Set up a **Safeguarding Adults Board** (SAB) with core membership from the local authority, Police, NHS and others. – Carry out **Safeguarding Adults Reviews** when someone with care and support needs dies as a result of neglect or abuse and there is a

	concern that the local authority or its partners could have done more to protect them. – Arrange for an **independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required. Adult Social Services is the responsible lead agency for providing care services for people in need, including those at risk of abuse. Haringey Adult Services MUST: – Investigate allegations of abuse – Liaise with advocacy services – Complete needs assessments for vulnerable people and their carers. – Contribute to Strategy Meetings and Case Conferences, where appropriate. As lead agency, Making Safeguarding Personal is a key component of the improvement work that is being led by ADASS and LGA. – Introduced an adult safeguarding user survey in January 2016 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.) Safeguarding referral data is reported to the QAB on a quarterly basis. This information has fed into work with the Council's 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' 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.

Internal safeguarding adults' governance arrangements.	Safeguarding adults at risk of abuse remains a priority for the Council. The *Corporate Plan 2015-18* – Priority 2 Healthy Lives, sets out that all vulnerable adults will be safeguarded from abuse Adult Social Services has an important role to play in delivering this priority through its work around adult safeguarding. We will work with our partners to protect adults in vulnerable situations and ensure that residents will have increased awareness of the early signs of potential abuse. The Adult Social Services Quality Assurance Board involves a wide cross-section of Haringey's Adult Services staff to ensure a high level of ownership and to embed good practice right across Adult Social Services. The purpose of the QAB is to ensure that quality assurance arrangements are in place across Adult Social Services to gather information on the quality of services provided, service user feedback and data on the outcomes achieved for people using Adult Social Services. The Board ensures that this information is analysed and used to inform service delivery as well as strategic planning and commissioning. Adult Services have taken a strategic and operational approach to identify general risks to safeguarding that may arise as a result of the implementation of the transformation agenda. Mitigation and actions have been considered and are taken forward to reduce and manage the risk. A quarterly report is presented to HSAB that also highlights risks that are beneficial coming from increased independence and market growth; this is changing the focus to the positive impact of the transformation.
Safeguarding adults work undertaken and key achievements in 2015-2016. To include specific examples of work undertaken.	The Board's Improvement and Quality Action Plan is currently being developed to include key improvement projects identified in the 2014-15 Local Account, 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. To ensure that adult safeguarding is given a high priority, we have a dedicated **Adult Safeguarding Team** which carries out safeguarding investigations upon referral. The team investigates the circumstances to establish whether abuse has taken place and will develop an action plan to minimise the risk of any further abuse occurring. This may involve working in partnership with other agencies, such as health, care providers and the Police. Every year, the number of safeguarding referrals is increasing as the Council raises awareness of adult safeguarding and how to report it. The adult social care Integrated Access Team provides a single point of access for reporting adult safeguarding concerns. In 2015-16, the Council received 524 section 42 enquiries, 1,101 safeguarding referrals - an increase of 28% (860) on the previous year. Complaints learning reports are presented to the QAB. There were 2 upheld complaints concerning adult safeguarding in 2015-16. New case file audit templates have been introduced to reflect new Department of Health and Care Act requirements. These include adult safeguarding case file audits. Adult Commissioning is continuing to work with external providers to improve their safeguarding practice and whistleblowing policies. Safeguarding Adults Joint Establishment Concerns procedure and guidance in place for managing large scale investigations of Care providers; as well as Managing Provider Failure procedure

	There is an established safeguarding and quality assurance process in place with regard to providers, based on the approach set out clearly and published in the Market Position Statement 2015 The SAB receives regular reports on the level of safeguarding alerts, whistle blowing and quality issues raised with regard to the provider market, keeping all partners appraised of any areas of concern. Contracts clearly indicate adherence to safeguarding standards. Safeguarding adults' performance data for is presented and analysed at the Quality Assurance Board, prior to presentation to the Safeguarding Adults Board. We extended the local network of Dementia Friends to help support people with dementia in the community. We have a tri-borough contract for an advocacy service. The new service links to assessment and care planning and will ensure the Council meets its new statutory duties arising from the Care Act 2014. Adult Social Services informed the draft Safeguarding Adults Multi-agency pan-London policy and procedure which was formally launched in February 2016. All local procedures, protocols and guidance have been updated to ensure we are Care Act compliant Adult Social Services commissioned an Audit of Care Act implementation, which included a review of: • Compliance with statutory and local requirements – ensuring that comprehensive and documented policies and procedures exist; • Assessments that are person centred, holistic and take a strengths based approach that

	recognises the resources an individual has at their disposal with which to manage their needs; • Financial Control - full cost of any care package is identified and documented within any Care Plan; • Payments for care services are only in accordance with the agreed Care Plan, and for services actually received by the individual; and • Cross Council Working. The result of the audit provided substantial assurance to the Council and Members. Over the last year, the Adults and Health Scrutiny Panel considered various issues in relation to safeguarding and Haringey's ambition to develop a community wide partnership approach to quality assurance, including: • An update on the Council's approach to quality assurance and its relationship with the Care Quality Commission (CQC); the Inspection Manager for the Adult Social Care Directorate, CQC, London Region, presented 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 • Progress made in delivering an improvement plan in relation to the CQC inspection of Haringey's Community Reablement Service • Outlined work underway to develop a multi-agency approach to safeguarding and quality assurance, with particular reference to the provider market. The Adults and Health Scrutiny Panel Chair attended, and spoke at, a London Scrutiny Network workshop that was established to consider the role of scrutiny in adult safeguarding Adult Social Services delivered various member learning and development activities, including site visits, briefings and conferences. These activities helped Panel members to consider the role of scrutiny in this complex area and to learn from

	safeguarding/scrutiny best practice. These activities helped Panel members to consider the role of scrutiny in this complex area and to learn from safeguarding/scrutiny best practice. The transformation of adult social care is needed in order to deliver a more sustainable model of adult social care as the demand for services increases. Demand for services has increased by more than 5 times population growth since 2011, and is expected to increase further as the older population continues to grow. At the same time, the Council's funding for adult social services over the next 3 years will see a significant reduction of around £24.5 million. In 2015-16, the Council developed a future **operating model** setting out how we will deliver adult social care within these changing circumstances. There is a greater focus on encouraging healthy lifestyles, early intervention and prevention through enablement and reablement to promote independence, the integration of health and social care, achieving outcomes that build on people's strengths, and reduced reliance on long-term care. This model will also continue to shift to more commissioning of services and support less in-house provision to enable the development of more diverse markets and choice for people. The Council is committed to designing services in co-production with service users and staff and have carried out a full consultation process with those affected by the proposed changes. The new model will deliver the following changes: – Greater emphasis on reablement, enablement and recovery to increase independence. – Growth in Shared Lives schemes. – Expansion of extra care schemes for all care groups. – Increase in supported living placements. – Less use of residential care.

	– Expanded telecare and assistive technologies. – New model of day opportunities, moving away from building based provision to accessing opportunities in the community. – Changes to the ways services are purchased by the Council, establishing a framework agreement for domiciliary and reablement services. – Greater integration of health and social care services for all care groups. We have moved to a multi-agency Quality Assurance subgroup and widened the remit to include partnership working. The focus is on partnership issues, predominantly good practice, performance and quality assurance.
Key challenges	The SAB's Quality Assurance subgroup is currently developing a multi-agency Quality Assurance Framework and performance dashboard of indicators and outcomes for SAB A constant approach of implementing MCA/DoLS policy, training and act as a reporting mechanism to the SAB on DOLs referrals Staff to understand the Making Safeguarding Personal agenda ensuring that service users' voices are heard and listened to
Safeguarding adults work planned for 2016-2017	Continue to promote awareness of adult safeguarding, including a targeted safeguarding awareness campaign to raise knowledge and reporting of adult safeguarding concerns. Fully embed adult safeguarding user survey to identify whether people's needs are met through the safeguarding investigation process, by piloting the new Making Safeguarding Personal resource developed by London SAB Chairs network. Embed Deprivation of Liberty Safeguards (DoLS) procedure and guidance for staff. Continue to review and consolidate methods for

	monitoring safeguarding referral data. HSAB multi-agency safeguarding adults procedure to be refreshed in line with the updated multi agency pan London procedures Continue prevention work as part of the North Central London (NCL) Transforming Care Partnership (previously known as Winterbourne View Programme) to: • embed Crisis Intervention into existing Community Learning Disabilities Services; • establish a NCL 'PBS School of Excellence' to support best practice within LD Services, the provider workforce and family carers; • Develop a joint NCL accommodation strategy; and • Develop an NCL Crash Pad commissioning strategy, including agreement for cross-borough emergency placements. NCL will develop a five year, strategic plan for the Health and Care system across the five boroughs (Islington, Haringey, Camden, Barnet and Enfield). This will see a transformation in the way that healthcare is commissioned and provided in NCL through this Sustainable and Transformation Plan (STP), ensuring the system is both high performing, and clinically and financially sustainable in the future. Key decisions going forward will include how we design care for the specific needs of population groups, the delivery vehicles for care and the way we can optimally commission services. Priority groups for focus are **people with mental illness and people at risk of poor mental or physical health**. It is also important to make sure **high quality services are available when required** for the majority of local people who are **not high users of services**. Consideration needs to be given to **reducing health inequalities**, the

	requirements of different ethnic groups and **the significant movement of people** into and out of NCL.
Details of internal arrangements for providing staff (and others) with safeguarding adults training.	The Council has developed a Safeguarding Development and Learning Opportunities work programme for all staff and partners. Haringey's large voluntary and community sector continue to access training such as safeguarding and Prevent All the courses are designed in accordance with the National Minimum Standards implemented by the Care Standards Act 2000. Haringey is committed to providing high quality multi agency safeguarding adults training and the main focus has been to support staff across the various partners in carrying out their duties and to ensure compliance against a number of Care Quality Commission requirements.
Case studies	A safeguarding alert was raised by the London Ambulance Service and the hospital after an elderly resident had a fall. The resident lives independently in the community and has a package provided by a domiciliary care provider. A neighbour (and key-holder) was concerned that the newspaper was still in the letterbox and accessed the flat. The resident was unable to get up after the fall or call for help. The medical evidence indicated that the resident must have been on the floor between 18 to 24 hours. This was based on skin damage and resulting pressure sores. After 3 weeks the resident was discharged with a referral for the District Nurse to dress the sustained pressure sores twice weekly. The views of the resident and next of kin were obtained, that the Domiciliary Care provider was held accountable for the neglect. On discharge

	from hospital a new provider was identified. The Section 42 enquiry focussed on neglect and was substantiated and closed.
Examples of good partnership working	An established safeguarding and quality assurance process in place with regard to providers, based on the approach set out clearly and published in the Market Position Statement We have continued to work in partnership with our external care providers, Haringey CCG and the Care Quality Commission around the monitoring of adult social care services for residents in Haringey. We have developed a close working relationship with the Care Quality Commission, the independent regulator of health and adult social care in England, enabling us to share information and intelligence about the quality of care provision in the local area. This approach enables concerns to be identified at an early stage and appropriate action to be taken to keep people safe. Where there have been major safeguarding concerns regarding a provider, we have used the Joint Establishment Concerns Procedure to work in partnership to investigate concerns and to take action where necessary, such as increased provider monitoring. Haringey's High Risk Panel took forward and progressed in the setting up of a Haringey Multi-Agency Hoarding Protocol (the Head of Operations and head of Safeguarding (. The panel consists of representatives from the LFB, Homes for Haringey, Mental Health, and LBH. The Multi-Agency Hoarding Protocol presented protocol at a multi-agency capita workshop) was approved and published by the SAB. Adult Social Services and Quality Assurance Board have developed/reviewed the following multi-agency policies/procedures: – Market oversight/Provider Concerns 2015-16 – Safeguarding Adults Prevention Strategy and Delivery Plan 2014-17

	– MCA/DoLS procedure 2016 – Joint Safeguarding Adults Enquiry Framework and Incident/Alert Form 2016 – Safeguarding Adults Multi Agency Procedure 2016-19 (in conjunction with Pan London P&P) – Information Sharing Protocol/Practitioners Guide 2016-19 – Multi Agency Quality Assurance Framework 2016-19 – Multi Agency Performance Dashboard 2016 – Safeguarding Adult Review Protocol 2016-18 – Haringey's Joint Establishment Concerns Procedure 2015-18 The newly formed multi-agency Quality Assurance (QA) subgroup will be taking forward work on policies and procedures on behalf of the SAB, contributing to the review and monitor impact of the multi-agency Safeguarding Adults procedures.

6.7 Voluntary Sector: Bridge Renewal Trust

Name of organisation:	The Bridge Renewal Trust
Completed by:	Geoffrey Ocen
Title/Designation:	Chief Executive

Overview 2015-16	
Internal safeguarding adults' governance arrangements.	Overall accountability for safeguarding within Bridge Renewal Trust lies with the Board of Trustees. The Board's responsibility is delegated to the Chief Executive, who has executive responsibility for safeguarding children and adults, and ensuring that the Board's responsibilities are fulfilled including investigations into any allegations and annual review of safeguarding policy.
Safeguarding adults work undertaken and key achievements in 2015-2016. To include specific examples of work undertaken.	Safeguarding work undertaken: • Provided staff and volunteers with training to gain an overview of safeguarding and how to support vulnerable adults. • Provided a clear procedure to be implemented where abuse of vulnerable adults arose including procedures for referrals, how we manage safeguarding allegations and what support is given to staff, service user and complainant during and after safeguarding investigation. Key achievements have included: • No allegations of safeguarding reported to-date. • All affected staff and volunteers trained in safeguarding.
Key challenges	Include: • Accessing affordable face to face training for staff and volunteers.

Safeguarding adults work planned for 2016-2017	Includes: • Review of our safeguarding policy and procedures. • Ongoing training for staff and volunteers to take account of changes in legislations and/or best practices.
Details of internal arrangements for providing staff (and others) with safeguarding adults training.	We keep service users safe by ensuring staff, volunteers and vulnerable adults receive training on our safeguarding and H&S policies, risk assessment toolkit and best practices to ensure they are safe at work or during home visits. Staff and volunteers are trained to recognise different kinds of abuse including Physical Abuse, Sexual Abuse, Psychological Abuse, Financial or Material Abuse, Neglect or Acts of Omission and Institutional abuse.
Case studies	Successfully delivered the Home from Hospital service which provided home accompaniment and practical support to vulnerable older people aged over 50 years by putting in place systems and processes to ensure safeguarding of vulnerable adults.
Examples of good partnership working	Online training in safeguarding received via Haringey Council's FUSION portal.
Safeguarding Reports *(please embed or provide links to any reports)*	N/A

Haringey Safeguarding Adults Board
Partner Statements 2015/16

This partner statement will inform the end of year safeguarding business plan and annual report 15/16

Name of organisation:	**Haringey Police**
Completed by:	**Paul Trevers**
Title/Designation:	**Haringey Police response to Adult Safeguarding**

Overview 2015-16	Haringey Borough Police is committed to making Haringey a safer place to live, work and visit. To do this we seek to maximise our visibility and approachability, whilst working closely with our communities as well as our statutory and voluntary sector partners. In conjunction, we continue to fulfil our role as a statutory partner on the Safeguarding Adults Board, as set out by the Care Act 2014. The Public Protection Detective Chef Inspector co-Chairs the Prevention and Training Safeguarding Sub Group alongside Social Care colleagues, leading the delivery and sharing of effective training and prevention expertise for public and voluntary sector colleagues. This presents continuing and real opportunities to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of a vulnerable adult occurs or is reported across the partnership.
Internal safeguarding adults' governance arrangements.	The Haringey Police Borough Commander is a member of the Board, supported by the Detective Superintendent or Detective Chief Inspector. Sub-groups are supported with attendance and co-chairing responsibilities. Day to day business, whilst central to all Haringey police leadership team's ethos, is overseen by the Public Protection Detective Chief Inspector

	ensuring a consistent and compliant approach to safeguarding. Daily checks and quality assurances processes are implemented by a Detective Inspector and all safeguarding issues are brought to the Senior Leadership team at a daily management meeting known as “Pacesetter”. This ensures a high level of scrutiny and oversight, whilst ensuring safeguarding risks are effectively managed and local processes develop. Haringey Police supports all internal and external audits with the ambition of ever-enhancing all we do, whilst recognising best practice to ensure our service is the best it can be in the safeguarding arena.
Safeguarding adults work undertaken and key achievements in 2015-2016. To include specific examples of work undertaken.	There have been some key developments across the current year, each based and developed against a backdrop of excellent partnership working. Our local Multi Agency Safeguarding Hub continues to develop, whilst we develop our processes to gain greater focus and research into the less well known adult safeguarding matters reported to us including financial abuse, carer abuse and neglect. Ethical and proportionate information sharing ensures a partnership led approach to problem-solving, maximising adult safety and the prevention of crime and abuse. Greater ties between police safeguarding units and other crime units such as the Gang Unit has been developed under the lead Detective Chief Inspector with responsibility for all matters. Focus continues for our front line staff to identify and record safeguarding matters on the MPS Merlin system, this being the primary notification channel to strategic partners of risks identified.

	Safeguarding training continues to be mandatory for all officers and a toolkit has been made available to assist with identification of safeguarding matters and recording procedures. The Police Borough Commander attends and participates in Safeguarding Board meetings. A Detective Chief Inspector has been identified to manage and lead all safeguarding issues, ensuring consistency and compliance in our approach and extending professional trust and relationships. This role includes a clear communication strategy promoting safeguarding principles at the core of all we do. Haringey Police will continue to provide a collaborative approach to safeguarding principles. Finally, where cases have been referred for consideration as Safeguarding Adults Reviews, Haringey Police have supported and contributed openly and transparently with all such enquiries in the objective of ensuring best practice is shared and areas of development recognised and improved.
Key challenges	The continued turnover of staff from Constable to Management level presents both negative and positive challenges. With new staff coming to Haringey, good practice from other regions can be developed and shared - whilst with new inexperienced staff, learning has to be effective very quickly. Further, the forever changing financial landscape also impacts on our ability to involve ourselves not just only with financial contributions but also the commitment of managers to the increasing number of strategic programmes.

Safeguarding adults work planned for 2015-2016	Haringey Police place great importance on victim care and crime prevention, linking into public confidence and satisfaction. We therefore are dedicated to fulfil our responsibilities under the MPS Total Victim Care Strategy. We recognise the prevention and management of safeguarding matters is a key contributor to this and we are committed to the provision of outstanding service to adults at risk of, or who have experienced abuse. Haringey Police will ensure expertise and processes continue to develop in the early identification of Vulnerable Adult victims of abuse and/or crime and that these cases are appropriately resourced by specialist officers to improve victim care and case outcomes. We will continue to develop and contribute to the Multi Agency Safeguarding Hub, with the aim being to capture as many safeguarding adult concerns and referring to appropriate services as possible. We will strive to engage with all communities across the Borough, our aim being to build trust and confidence in the services provided.
Details of internal arrangements for providing staff (and others) with safeguarding adults training.	Safeguarding Adults training is mandatory across the MPS - Haringey Police ensures all staff comply with such training requirements. All officers across the Borough have dedicated training days set within their working shift pattern and these days are utilised for such topics. This training is IT and focus group based, ensuring positive examples of early identification, effective risk management and positive interventions are shared locally and across London as well as with external partners. Further, Haringey Police SLT hold regular “staff briefing” days in which safeguarding is placed at the heart of the days learning and development. This promotes the importance the Police Leadership team places on Safeguarding.

Case studies	
Examples of good partnership working	
Safeguarding Reports *(please embed or provide links to any reports)*	

Appendix A: Role of the SAB – Summary from the Social Care Institute for Excellence

The **overarching purpose** of an SAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

Core duties

SABs have three core duties. They must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

In order to meet their core duties and overarching objective, SABs will require information including general and personal data. Personal data is needed to undertake, for example, safeguarding adults reviews and general data is needed to identify trends and patterns in safeguarding activity, abuse and neglect. The

grounds on which SABs can require information to be supplied to them are specified in Section 45 of the Care Act.

The six statutory safeguarding principles underpin all the work undertaken by SABs:

- Empowerment: people being supported and encouraged to make their own decisions and give informed consent
- Prevention: it is better to take action before harm occurs
- Proportionality: the least intrusive response appropriate to the risk presented
- Protection: support and representation for those in greatest need
- Partnership: local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability and transparency in safeguarding practice

Appendix B: Haringey SAB Members attendance 2015-16

* Denotes representative attended on behalf of the member

× Denotes membership ceased

Organisation	Role	Meetings				Total attendance
		April 2015	July 2015	Oct 2015	Jan 2016	
Safeguarding Adults Board	Independent Chair	√	√	√	√	4/4
	Business Manager	√	√	√	√	4/4
Lay Member	Volunteer	√	√	√	√	
Local Authority						
Chief Executive Service	Zina Etheridge, Deputy CEO	-	-	-	-	0/4
Adult Services	Director of Adult Services	√	-	√	√	3/4
	Service Manager, Integration & Personalisation	√	√	√	x	3/3
	Operational Lead Manager	x	x	x	√	1/1
	Performance Manager		-		√	1/4
	Performance Officer	√	-	√	√	3/4
	Strategic Lead - Joint Governance & Improvement Service	√	√	√	√	4/4
	Lead OD Consultant	√	√	√	√	4/4
Commissioning	AD Commissioning	-	represented	represented	√	1/4
Children's & Young People's	AD Safeguarding & Social Care	-	-	-	-	0/4

Services						
Community Safety	Community Safety Strategic Manager	-	-	√	√	2/4
Legal Services	Assistant Head of Legal	-	√	-	-	1/4
Housing	Homes for Haringey Deputy Director of Housing Operations	√	-	√	-	2/4
Elected member - observer	Lead Member for Health & Wellbeing	-	-	--	-	0/4
Health Services						
Haringey Clinical Commissioning Group	Assistant Director of Quality and Nursing	√	√	√	√	4/4
	Safeguarding Adults Lead	x	x	x	√	1/1
Whittington Health	Safeguarding Adults Lead	√	√	√	-	3/4
	Deputy Director of Nursing			√	√	2/4
NMUH	Safeguarding Adults Lead	√	√	-	-	2/4
	Director of Nursing				-	0/4
	Deputy Director of Nursing	x	x	√	√	2/2
BEH-MHT	Executive Director of Nursing Quality & Governance	-		-	-	0/4
	Safeguarding Adults Lead	-	√	√	-	2/4
Police						
	Borough Commander	represented	-	√	represented	1/4
	Public Protection Desk DCI	√	-	-	√	2/4

Probation						
National Probation Service	Assistant Chief Officer	-	-	√	√	2/4
Community Rehabilitation Company	Assistant Chief Officer	-	-	√	√	2/4
Care Quality Commission	Inspection Manager	-	-	-	-	0/4
London Fire Brigade`	Haringey Borough Commander	√	-	-	-	0/4
	Station Manager	-	-	-	-	0/4
London Ambulance Service	Operations Manager	-	-	-	-	0/4
HAVCO	Chief Executive	√	-	√	√	3/4
Haringey Healthwatch	Chair	Not a member at this time	Not a member at this time	Not a member at this time	√	1/1

Appendix C: Haringey Safeguarding Adult Board Budget 2015-16

2015-16 was a transition year for the SAB following implementation of the Care Act 2014. There was no opportunity to agree a formal budget to move the existing Board onto the statutory footing including contributions from partners. Despite this, a number of partners made financial contributions for the year including core partners from health, police and the local authority.

The below budget is indicative of expectation and has been agreed for 2016-17:

Income		
Local Authority Adult Social Services		40,000.00
NHS Haringey Clinical Commissioning Group		5,115.00
Whittington Health NHS Trust		5,115.00
North Middlesex University Hospital		5,115.00
Metropolitan Police Service		5,000.00
Barnet, Enfield & Haringey Mental Health Trust		5,000.00
London Fire Brigade		1,000
Total Projected Income 2016/17		**66,345.00**
Expenditure		
SAB staffing (agreed for Q4)		42,000
SAB Independent Chair		15,000.00
SAR Reviews		11,500.00
Development Days		TBC
Communications and Campaigns		TBC
Total Projected Expenditure 2015/16		**68,500.00**

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Report for: Health and Wellbeing Board – 8 December 2016

Title: Haringey CAMHS Transformation Plan Update

Organisation: Haringey Clinical Commissioning Group and Haringey Council

Lead Officers: Catherine Swaile, Vulnerable Children's Joint Commissioning Manager

1. Describe the issue under consideration

1.1 A joint review of Child and Adolescent Mental Health Services (CAMHS) was launched in February 2015 by Haringey Council and Haringey Clinical Commissioning Group. The publication of 'Future in Mind' in March 2015 framed this review in light of national drivers and provided a context by which to review Haringey provision. The Review had significant input from a wide range of stakeholders and was a collaborative process with local organisations delivering support to children and young people. The Review then formed the basis for our CAMHS Transformation Plan which was signed off by Health and Wellbeing Board in 2015. This plan is a five year action plan for the improvement of child and adolescent mental health services and covers a range of areas for improvement, and is supported by dedicated funding made available to CCGs by NHS England.

1.2 Since publication of our CAMHS Transformation Plan in September 2015 Haringey CCG and Haringey Council have been working with our local providers to implement our CAMHS Transformation Plan. The Haringey CAMHS Transformation Board has been meeting regularly in order to drive this work and engagement from a broad range of commissioners, providers and patient groups has been sustained. Some elements of our Transformation Plan are being implemented locally, and others across a broader North Central London footprint.

1.3 The purpose of the attached document is to provide an updated version of the plan to take into account the work that has been completed in the last year and to provide further detail on what implementation will look like over the next four years. This document is formed of two parts: Part One is our original Transformation Plan and reflects the context and work going on in Haringey and provides an update on 2016 progress within each section. Part Two (starting on page 75) is a new summary of the priorities that we are working on jointly across North Central London. Part of the assurance process for Transformation Plans and ongoing funding is that the Health and Wellbeing Board supports and endorses the refreshed plan.

2. Recommendation

2.1 That the Health and Wellbeing Board note the contents of the CAMHS Transformation Plan Refresh and formally sign-off the plan for publication.

3. Background

3.1 CAMHS Transformation Funding

3.2 The below table outlines the estimated allocations made to Haringey CCG under Future in Mind, which are being invested in our Local Priority Schemes, outlined later in the document. Additionally it has been announced that a further £25 million will be available nationally to support CAMHS Transformation in 2016/17 and we are currently awaiting information on allocations, but will be using this money to reduce waiting times and support the implementation of improved crisis care with NCL partners.

Investment	2015/16	2016/17	2017/18	2018/19	2019/20
Transformation Funding	£368,203	£635,000	£747,000	£907,000	1,013,000
Eating Disorder Funding	£147,099	£160,000	£160,000	£160,000	£160,000
MH Links Funding	£150,000	£0	£0	£0	£0
CYP-IAPT Funding	£13,000	£39,000	TBA	TBA	TBA

Key Developments in Year One:

- Future in Mind emphasises the need for a single point of access. CAMHS Access fulfils that role but is limited to paper/phone call triage, and involves no face to face interaction. As of October 2016 a new service has been in place to provide a face to face one-off appointment for children, young people and their families. This new access point, named 'Choices', takes self-referral and CAMHS Access will be incorporated into it over the coming year. The triage appointment will take a community asset based approach to ensure that those requiring CAMHS are quickly identified and those who can be supported by community or digital resources are diverted, with self-management information in line with the Thrive approach.
- We are piloting several new approaches to CAMHS including peer support, group therapy, parental peer support and a co-designed life skills course for those approaching transition
- We have supported providers with the development of their IT infrastructure to support better reporting and monitoring of outcomes.
- A significant programme of training has been delivered to the universal workforce to improve their understanding of mental health, and how to support better access to services.
- We are working more closely with schools through the Anchor Project which helps schools to support attachment and through the CAMHS in Schools Pilot which helped improve mechanisms for communication between CAMHS and Schools.
- A number of projects to support vulnerable groups have been developed, including:

- Hosting a CAMHS worker into paediatric services to improve the post-diagnostic support for those accessing the neuro-developmental and social and communication assessment clinics
- Intensive support for looked after children who have had a number of placement disruptions that has prevented them from accessing CAMHS
- Support for the emotional health of young carers

4. Timings

4.1 There is considerable work underway to implement the plan across partners, with significant progress having been made in the last year. It is likely that the process of refreshing the Plan and presenting it to the Health and Wellbeing Board for endorsement will be an annual requirement as part of the NHS England assurance process.

5. Appendices

Appendix A: Haringey Child and Adolescent Mental Health Services Transformation Plan.

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Haringey Child and Adolescent Mental Health Services Transformation Plan

On behalf of Haringey Council and Haringey Clinical Commissioning Group

October 2016 Update

FOREWORD

Since publication of our CAMHS Transformation Plan in September 2015 Haringey CCG and Haringey Council have been working with our local providers to implement our CAMHS Transformation Plan. The Haringey CAMHS Transformation Board has been meeting regularly in order to drive this work and engagement from a broad range of commissioners, providers and patient groups has been sustained. Some elements of our Transformation Plan are being implemented locally, and others across a broader North Central London footprint. Regular meetings are held between commissioners from the five boroughs of Haringey, Barnet, Enfield, Islington and Camden to share ideas and developments and look for opportunities for close working. The NHS CAMHS Providers across NCL; Barnet, Enfield and Haringey Mental Health NHS Trust, Tavistock and Portman NHS Foundation Trust, Royal Free London NHS Foundation Trust and Whittington Health NHS Trust, have been working closely together on a number of developments. The purpose of this document is to provide an updated version of the plan to take into account the work that has been completed in the last year and to provide further detail on what implementation will look like over the next four years. It should be read in conjunction with the delivery plan, which is updated annually. This document is formed of two parts: Part One reflects the context and work going on in Haringey and Part Two is a summary of the priorities that we are working on jointly across North Central London.

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1. Executive Summary

A joint review of Child and Adolescent Mental Health Services (CAMHS) was launched in February 2015 by Haringey Council and Haringey Clinical Commissioning Group. The publication of 'Future in Mind' in March 2015 has framed this review in light of national drivers and provided a context by which to review Haringey provision. The Review has had significant input from a wide range of stakeholders and has been a collaborative process with local organisations delivering support to children and young people. Haringey has a rich array of provision, and a number of innovative partnership projects meeting the needs of vulnerable groups. On the whole CAMHS provision across the Borough is valued, and high quality; however there are also a number of areas that require development. Whilst there is a lot of support for families, it requires more coordination, better awareness and promotion amongst universal provision and a greater focus on early intervention.

1.1 Key Findings of the Review in 2015

1.1.1 Key Findings for Commissioning

Commissioning arrangements mean there is no 'whole system approach' and a lack of coherence to provision. Funding arrangements do not allow us to accurately determine levels of investment, spend and associated outcomes. Future in Mind requires a '**lead accountable commissioning body**' and a '**single separately identifiable budget for children's mental health services**'. Whilst there is a joint commissioner in place for this area, joint commissioning arrangements should be developed further to facilitate:

- Single CAMHS contracts across statutory commissioning agencies per provider
- Clearer, more transparent investment and monitoring of spend
- Joint planning and integrated services designed to meet the needs of the whole population

1.1.2 Key Findings for Provision

- The Review has identified a relative lack **of early intervention** (Tier 2) support. This should be expanded building on the CAMHS in GP practices pilot and the mental health links in Schools pilot in light of the borough's Early Help Strategy. Work with universal provision should be prioritised, developing understanding and support for attachment and promoting access to a coherent programme of **parenting support** using evidence based models. **Peer support** and **digital solutions** should be developed as part of this model.
- There is a lack of **out of hours** support around **crisis** presentations, pathways should be developed in partnership with neighbouring boroughs and the role of the Adolescent Outreach Team should be reviewed as part of this work
- Targeted services should be enhanced for **vulnerable children and young people** e.g. Looked After Children/Care Leavers/Children with learning disabilities/Autistic Spectrum Disorder/Youth Offenders/Young Carers/Children who are abused
- Services need to be more focussed on **outcomes**, using evidence based approaches and CYP-IAPT should be embedded across services
- Current capacity issues within Tier 3 are leading to long **waiting times**. Expanding early intervention services should reduce demand and improve access over time and use of **group interventions** and **digital solutions** should increase service efficiency.

- Interagency working and **communication** between CAMHS and the wider children and families work-force should be improved, linking CAMHS into other services and through the upskilling of the wider children and families workforce
- **Enablement** should be promoted through peer support models for children and young people and their families.
- Services should be more **accessible,** better **information** should be available to families early on and appropriate use should be made of **community assets** at the earliest stage to prevent escalation of mental health concerns.
- There is a need for improved **transition** between CAMHS and adult mental health services and increased flexibility in age eligibility criteria with appropriate and timely step-down for those who will not require ongoing support.
- Closer working between physical and mental health services is required. **Joint clinics with paediatrics** (social communication & neurodevelopmental clinics) and post assessment psychological support for families should be developed
- There are proportionally fewer children and young people accessing services from the most deprived areas in the Borough and work needs to be done to **target referrers and families** in these areas, especially in Black/Black British African communities who are **under-represented** in provision.

1.2 Recommendations

The key strategic recommendations of the Review:

1. Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing
2. Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care
3. Develop an early intervention approach that is embedded across the whole system.
4. Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement.
5. Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs.
6. Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation.

1.3 Implementation

The outcomes of the Review and strategic recommendations are being implemented through the Transformation Plan in Section 5. This is monitored through the CAMHS Transformation Board, a partnership board for the borough, which leads the implementation of Haringey's CAMHS Transformation Plan.

1.4 Outcomes

Implementation of the Transformation Plan will deliver the following outcomes for child and adolescent mental health services, families using these services and professionals working within the broader children and young people's workforce:

1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value
2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support which avoids over-medicalising children and young people and that builds a system of support in natural contexts such as school and home.
3. A co-ordinated preventative approach for children and young people, parents/carers and families through systems around the child working well together to support emotional wellbeing across the children's workforce.
4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support
5. Flexible services that meet the preferences and developmental needs of children and young people
6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery
7. Better inter-agency working and improved communication with referrers and better discharge planning
8. More focused work that reduces dependency and promotes resilience and enablement
9. Improved crisis planning and pathways that provide timely support and robust follow up
10. Clear protocols for cross-boundary issues and working between child and adult services
11. Better engagement with under-represented communities/groups

2. Background

2.1 Introduction

The development of the Mental Health and Wellbeing Framework in Haringey has highlighted a need to gain a better understanding of local Child and Adolescent Mental Health Services (CAMHS). Haringey's commitment to developing early help services is especially poignant in relation to CAMHS. Peak onset of mental ill health is between 8 to 15 years; 10% of children have a mental health issue and half of lifetime mental ill health starts by age 14. If the appropriate support is in place at this critical time, we have a real opportunity to improve the lives of our residents and generate future financial savings for the system, through reduced adult mental health prevalence and through better life chances for our children and young people. For example it is estimated that children with early conduct disorder are ten times more costly to the public sector by the age of 28 than other children[i] and that overall lifetime societal costs associated with a moderate behavioural problem are £85,000 and a severe behavioural problems £260,000[ii].

Given recent key national developments and the changes to the landscape for CAMHS it was important that Haringey took stock of the current provision and the models of care currently being used. The Review sought to comprehensively review CAMHS spanning provision commissioned across health, education and social care, to get a holistic understanding of the current system. This however is an ongoing iterative process in many senses, as we seek to adapt and transform CAMHS provision.

The Review enabled us to gain an understanding of what is working well, and what barriers are facing children and young people. More fundamentally, it has supported us to be able to ensure that we are commissioning high quality, evidence based, efficient services that are accessible to our population.

2.2 Methodology

Haringey CCG and Haringey Council initiated the Review of CAMHS in February 2015. A project Board was convened to lead the Review consisting of:

- Haringey CCG
- Haringey Council: commissioning, public health and children and young people's services.
- Healthwatch
- NHS England
- NCL Commissioning Support Unit
- Parent representative

Needs analysis and mapping have been completed to understand the local needs and this has been triangulated with national data. The vast majority of local providers provided service level data to ensure the most accurate basis for any assumptions. Visits to other areas to look at examples of good practice include Bromley-By-Bow, Tower Hamlets and Hackney.

2.2.1 Feedback

In March 2015 a stakeholder event was held to launch the Review, comprising over 50 professionals from a broad range of statutory and non-statutory agencies. Further engagement has been undertaken with

stakeholders including children and young people, parents, statutory and non-statutory providers, Schools, GPs, social care and community and acute health services through meetings and online surveys. Feedback from CAMHS providers has been gathered through a series of provider meetings coordinated by Open Door, individual meetings with services and an online survey. Additionally themed workshops have been held on the following areas:

- The mental health of Looked After Children (25 attendees)
- Child and Adolescent Mental Health Learning Disability Services (23 attendees)
- Crisis care for children and young people (15 attendees)

Table 1: Online Survey Response Rates:

Stakeholder Group	Number of returned questionnaires
Children and Young People	33* (2.2% approx.) children/young people engaged with CAMHS
Parents/Carers	50* (3.3% approx.) current families engaged with CAMHS
Professionals/ Stakeholders	69 (Includes 11 GPs responding to follow up survey)
CAMHS Provider Staff	42 Total: 33 responses from staff and volunteers specific to Haringey (37% approx.) 9 responses from staff and volunteers from cross-borough services working with Haringey children and young people
Schools Audit	17 Schools (23% of Haringey Schools)

*As Child and Adolescent Mental Health Services are currently seeing approximately 1500 of Haringey's children and young people and their families the sample of service users and parent/carers was very low. Information was supplemented with outcome and satisfaction data from CORC (CAMHS Outcome Research Consortium), and other mechanisms within services used to gather feedback. Of the online responses the vast majority of young people were from Open Door and all were from young people over 15 years of age. Two workshops were held at Burgoyne Road, one for young people (5 attendees) and one for parent/carers (9 attendees); information gathered at these has also been considered as part of this feedback. The themes are summarised below, with a more detailed report at appendix 1.

Feedback Themes

- **Quality:** Young People and Parents find services helpful, on the whole providing positive feedback. Parents feel well supported, families are greeted in a friendly and supportive manner and report convenience of first appointment
- **Communication:** Families do not have sufficient information on services prior to attending CAMHS and referrers want more ongoing communication & better discharge information
- **Crisis:** Families do not know what to do in the event of a crisis, however they are able to contact services between appointments
- **Workforce:** There is a good range of skills and a broad range of modalities available however safeguarding training was found to be inadequate across services, with some staff not meeting their mandatory training requirements. Training for the wider children's workforce is required.
- **Choice:** Families are not offered choice of setting or location and would like more appointments outside of 9am-5pm
- **Access:** Families and referrers do not feel waiting times are acceptable

- **Enablement:** Young people and parents would like the opportunity to talk to other young people and parents affected by similar issues
- **Inter-Agency Working:** CAMHS services need better promotion to the wider children's workforce and pathways need to be clearer. Joint working is required between the Child Development Centre (paediatrics) and CAMHS to meet identified gaps around post diagnostic support for CYP with autism
- **Looked After Children:** Insufficient treatment services are available for vulnerable young people
- **Infrastructure:** Better systems including for IT are required to support a modern, efficient CAMHS

2.3 Policy and Context

There is a significant amount of policy and guidance in relation to CAMHS which has been consulted as part of this review (appendix 2). This policy and guidance should be consulted individually but some of the key developments are summarised here:

2.3.1 No Health without Mental Health

In February 2011 the Government published 'No Health without Mental Health'[iii] following the Royal College of Psychiatrists' publication 'No Health without Public Mental Health'[iv] in October 2010 outlining the importance of mental health on physical health. Since then we have seen a drive to increase the esteem within which mental health is held to equal that of physical health services, this policy is called 'parity of esteem'.

2.3.2 Health Select Committee Report

In February 2014 the Health Select Committee launched an Inquiry into Child and Adolescent Mental Health Services (CAMHS) in response to media concerns about the availability of Tier 4 beds and the Chief Medical Officer's Annual Report 2013. In November 2014 the Health Select Committee published their report outlining "serious and deeply ingrained problems with the commissioning and provision of Children's and adolescents' Mental Health Services. These reports cover the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people."[v]

A joint NHS England/Department of Health Children and Young People's Mental Health and Wellbeing Taskforce was announced and they published their report 'Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing' in March 2015[vi].

2.3.3 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report[vii]

This report released by NHS England in July 2014 sets out a range of national issues with inpatient services for CAMHS the most significant of which is a shortage of available inpatient beds.

2.3.4 Mental Health Crisis Care Concordat[viii]

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

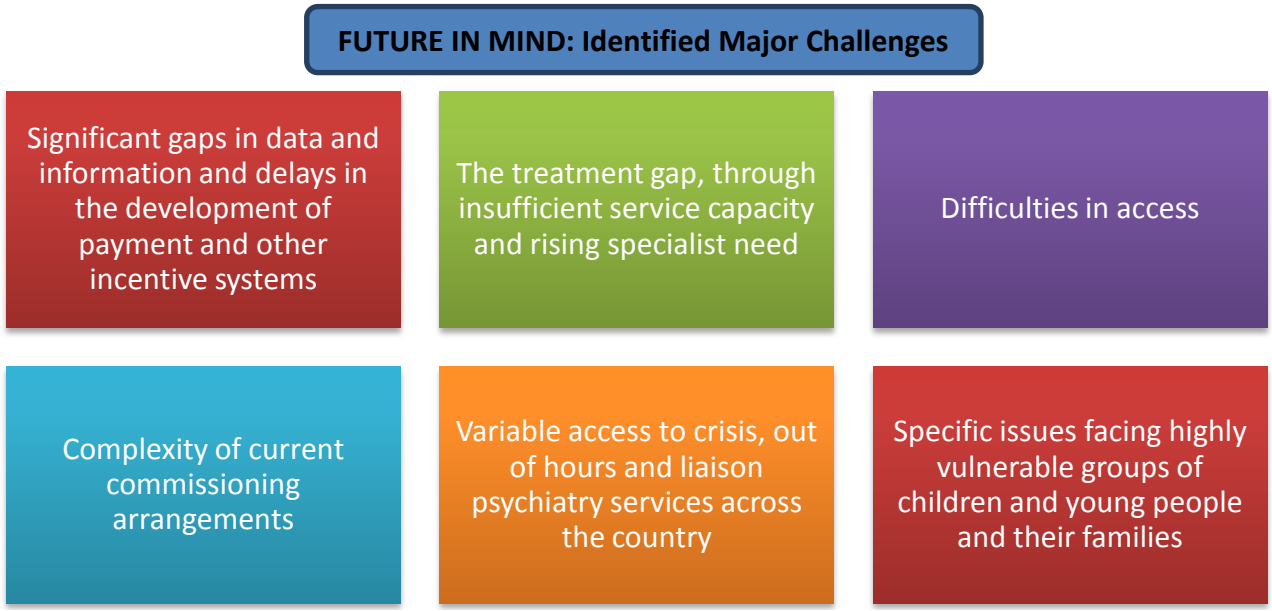
The Concordat focuses on four main areas:

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

2.3.5 Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

The report sets out 49 proposals for Schools, Services and Commissioners, covering early years mental health, proposals for the most vulnerable, proposals for improving access and proposals around data and standards. The five key themes are:

- Accountability & Transparency
- Promoting resilience, prevention and early intervention
- Improving access to effective support- a system without tiers
- Care for the most vulnerable
- Developing the workforce



As part of the government response to Future in Mind the Department of Health has allocated £30m for investment in eating disorders and self-harm services and a further £250m recurrent annual increase from 1st April 2015 for:

- Improved access to perinatal mental health
- Improved access to mental health care for children and young people with mental health problems:
    - New access targets (110,000 additional children and young people over next five years)

- New waiting time standards
- Expanding Children and Young People's Improving Access to Psychological Therapies transformational programme to the whole country and to include children with learning disabilities and under fives

The £280 million Transformation funding for CAMHS has been top sliced to support a number of pilots and national developments. Additionally each area has been given a proportion to implement local transformation plans. Haringey's allocation for both the CAMHS Transformation and Eating Disorder/Self ham element is £515,302 (2015/16) recurrent funding for 5 years. This does not include the perinatal mental health allocation which will be made separately.

2.3.6 Children and Young People's Improving Access to Psychological Therapies

Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) is a whole service transformation model that seeks to improve the quality of children and young people's mental health services. The principles behind CYP-IAPT will underpin the development and delivery of the 'Transformation Plans' outlined in Future in Mind.

It is different from the adult IAPT model (adult IAPT focused on setting up new services) CYP-IAPT is about improving the quality of existing Child and adolescent mental health services. The key principles are:

- Collaborative Working & Participation
- Routine Outcome Monitoring
- Evidence Based Practice

2.3.7 Transforming Care Programme

Transforming Care is a nationally driven programme, to improve services for people with learning disabilities and/or autism, who display behaviour that challenges. This includes those with a mental health condition who are likely to receive hospital treatment, the aim is to reduce inappropriate admissions and support timely discharge to the community. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

The Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

2.3.8 Regional & Local Context

Mental health continues to be a local priority in Haringey. Several key documents have emphasised the need for improved child and adolescent mental health support see appendix 2. On a local/regional level these include:

- Better Health for London

- Improving care for children and young people with mental health crisis in London: Recommendations for transformation in delivering high quality accessible care. (Healthy London Partnership – Children and Young People Programme)
- Haringey Health and Wellbeing Strategy
- Haringey Council Corporate Plan
- Haringey CCG Plan on a Page
- Haringey's Mental Health and Wellbeing Framework
- Haringey Early Help Strategy for Children, Young People and Families
- Haringey's Crisis Care Concordat
- Haringey's Youth Strategy

Additionally in late 2014 the Adults and Health Scrutiny Panel completed a panel report on 'Transition from Child Mental Health Services to Adult Mental Health Services'. This identified a number of areas for development which are being taken forward through the local transformation plan.

2.3.9 Child and Adolescent Mental Health Services (CAMHS) Models

The tiered model of CAMHS provision has been subject to increased debate in recent years. The model was first described in the National Service Framework for Children, Young People and Maternity Services, 2004.
Tier 1: refers to universal services. The level of support described here is informal and provided by professionals within the broader children's workforce such as teachers, GPs and health visitors, their main role is not specifically mental health, but they should be trained and supported to recognise mental health distress, and be able to support or signpost children for help.
Tier 2: offers more structured approaches provided by specialist trained mental health professionals. It is generally provided by professionals working on their own to support young people who require more support than is available at Tier 1.
Tier 3: is aimed at people with more complex or persistent mental health problems and is often delivered within a multi-disciplinary team in the community.
Tier 4: services are aimed at children and adolescents with severe and/or complex problems and may be offered in residential, day patient or out-patient settings. They provide a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. These services include adolescent in-patient units, secure forensic adolescent units, eating disorder units, specialist teams for sexual abuse and specialist teams for neuro-psychiatric problems.

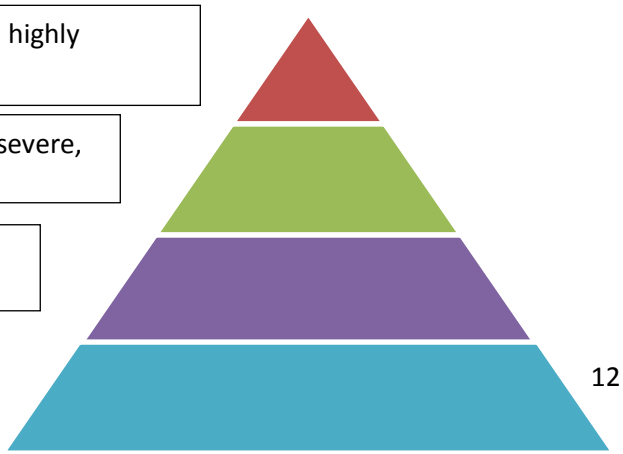
The Four Tier CAMHS Framework
National Service Framework for Children, Young People and Maternity Services 2004[ix]

Tier 4: Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.

Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders.

Tier 2: A service provided by specialist individual professionals relating to workers in primary care

Tier 1: A primary level of care



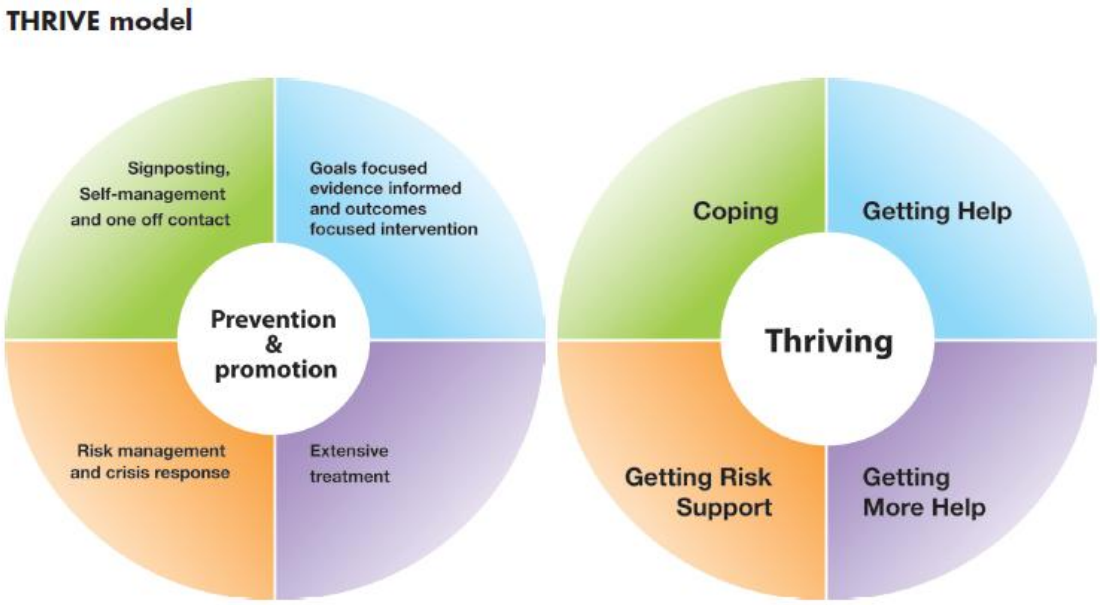
Whilst this has been a useful way to understand provision- giving the opportunity for standardisation and comparison of services across the country, concerns have been expressed that it has led to barriers between services, with children and young people not fitting neatly into a 'tier'. This was not the intention of the NSF which was to identify various types of provision, suitable for a variety of needs and that could/should be delivered across the whole system of healthcare, and not just by mental health provider Trusts. In reality due to a decrease in the level of support/intervention provided at Tier 2 (in most areas of the country) in recent years, mental health Trusts providing Tier 3 increasingly receive referrals which would previously have been sent to Tier 2 and are increasingly commissioned to provide this level of service. This, in turn, has meant longer waits for assessment and treatment.

However although CAMHS is articulated for the purposes of planning, by a series of separate commissioners and providers, from the point of view of the family there should be a seamless, integrated and coordinated offer. Until the Department of Health complete the updated prevalence survey outlined in 'Future in Mind' the best data available is framed in the tiered structure, and therefore tiers are referenced a number of times in the report for the sake of clarity and consistency.

Thrive: The AFC-Tavistock Model for CAMHS[x]

In November 2014 The Tavistock and Portman NHS Foundation Trust in partnership with the Anna Freud Centre published a new approach to CAMHS modelling that seeks to group children and young people into clusters according to the type of support and treatment they require.

The benefits of this model is that these clusters fit with final report of the CAMHS payment system project published in June 2015 and that it is articulated on need rather than diagnosis. The limitations are that there is no mapped prevalence data or modelling which indicates what levels of resource are required for each cluster. Work is being done to develop and pilot this model, and hopefully as this matures it can be used to inform commissioning intentions.



2.4 Current Service Provision

2.4.1 Commissioning Arrangements

The commissioning of CAMHS is a shared responsibility across health, education and social care. Historically the CAMHS grant was delegated to the local authority to invest in targeted services (Tier 2 and directed provision) whilst the bulk of provision delivered through specialist multi-disciplinary teams (Tier 3) was the responsibility of the local NHS. Commissioning for Tier 4 (inpatient and highly specialised outpatient resources) passed over from local NHS organisations to the NHS England's Specialised Commissioning Team in April 2013.

Public Health, which has recently moved into the Council, has responsibility for promoting emotional wellbeing at a population level and schools have the responsibility for supporting mental health in their schools through a healthy schools approach, this has recently been added to the OFSTED framework. As part of this responsibility schools commission their own counselling or psychological support to see pupils in school and for assessing and supporting access to education through educational psychology (provided by the Council). These overlapping responsibilities have generated disparity between what children and young people in one part of Haringey can access compared to another. An audit of Haringey Schools completed as part of this review shows even within the small sample (17 schools) there are variations in spend from £0 to over £10,000 per school.

2016 Update:

Work has now started to establish collaborative commissioning arrangements with NHSE to look at how pathways can be improved by integrating commissioning of inpatient services with intensive community support.

Work is being done at the moment to better understand what Schools are buying and to support schools in delivering a whole school approach as part of the Transformation Plan.

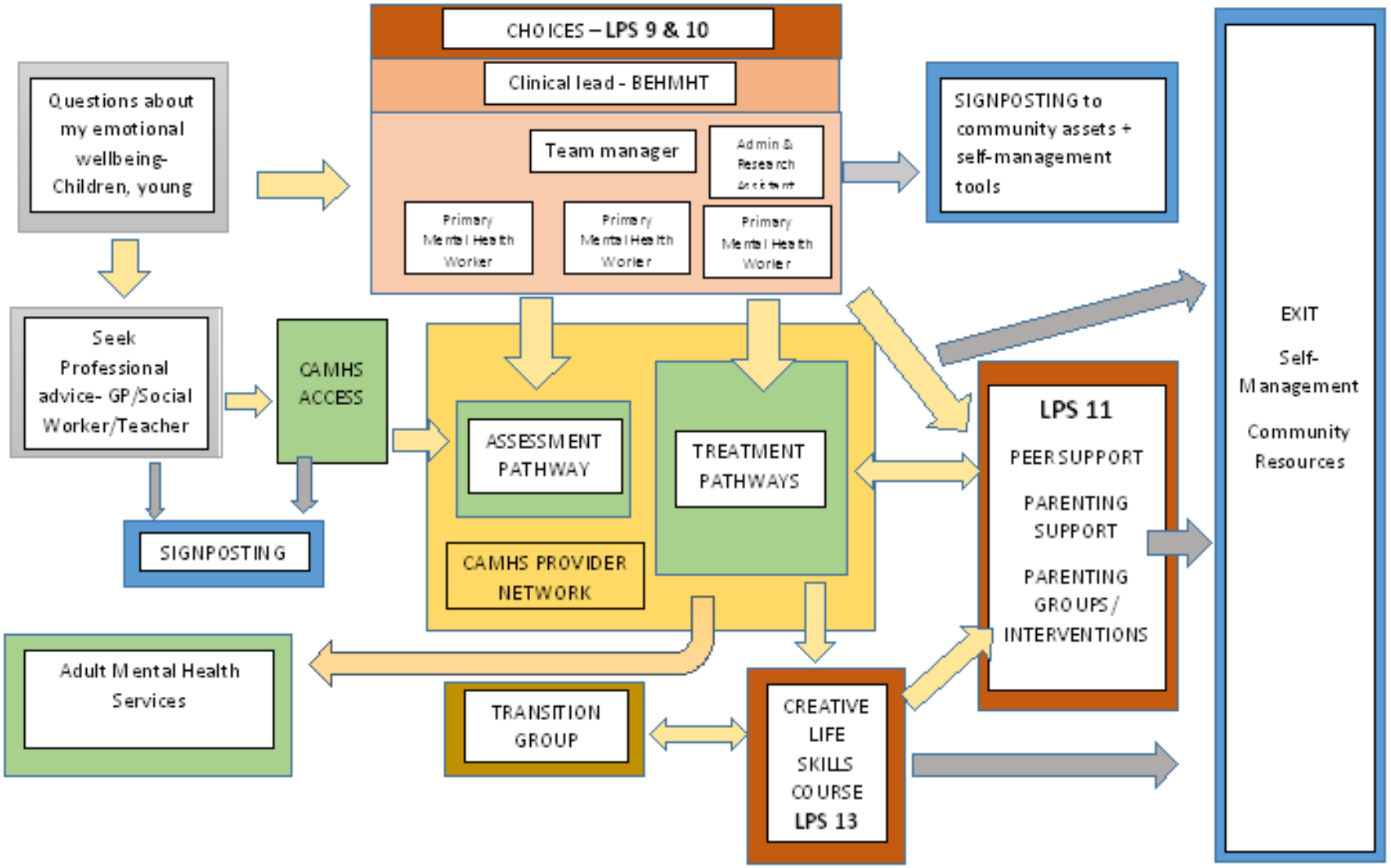
2.4.2 Service Mapping

Barnet Enfield and Haringey Mental Health Trust is the main CAMHS provider in Haringey, delivering a number of services including a single point of entry known as 'CAMHS Access', which was established in 2009. CAMHS Access functions as a front door for referrals to all commissioned Haringey CAMHS services, though some also accept direct referrals. CAMHS Access also links with non-CAMHS agencies such as Insight Platform who provide drug and alcohol services. Referrals to CAMHS Access can be made by a GP, School, Social Worker, Health Visitor or other professional but it does not currently accept self-referrals.

All tertiary services and bespoke packages where there is not a commissioned pathway are managed through Tier 3, for example second opinions from Great Ormond Street Hospital or South London and Maudsley NHS Foundation Trust. These are sometimes immediately identified by CAMHS Access but most often would be identified by a local CAMHS service having undertaken an assessment. CAMHS Access is currently only officially linked in to a small number of voluntary sector agencies. There are alternative pathways for some provision such as First Step, which is a notification service for all Haringey's Looked After Children and services commissioned directly by schools.

As of October 2016 a new service has been developed to provide a face to face one-off appointment for children and young people and their families. This new access point, named ‘Choices’ takes self-referral and CAMHS Access will be incorporated into this service over the coming year. This triage appointment will take a community asset based approach to ensure that those requiring CAMHS are quickly identified and those who can be supported by digital or community resources are diverted appropriately, with self-management information in line with the Thrive approach. Below is a diagram of the current pathways, incorporating the new local priority schemes (LPS).

Haringey CAMHS Transformation – LPS 9, 10, 11 & 13



Self- referral, peer support and tackling transition – enabling and empowering children, young people and families in Haringey

Dr. Nick Barnes

Standard Offer- Direct Intervention Services

Table 2: The following services are available across the Borough and are commissioned to provide services up to 18th birthday meeting the provider eligibility criteria

Service	Provider	Description	Age Eligibility
Choices	Barnet, Enfield and Haringey Mental Health Trust	Single appointment consultation service for CYP and families who have concerns around emotional wellbeing/behaviour , offering an assets based approach	0-18 years
Parent Infant Psychology Service	Whittington Health NHS Trust	Perinatal community service supporting parental mental ill-health and attachment	0-2 years
Generic CAMHS (Burgoyne Road)	Barnet, Enfield and Haringey Mental Health Trust	A multi-disciplinary service delivering a range of interventions to children and young people with severe/complex or persistent mental health concerns	0-18 years
CAMHS in GP Surgeries Pilot	Health and Emotional Wellbeing Service (HEWS) Barnet, Enfield and Haringey Mental Health Trust	Brief psychological interventions delivered in primary care for those not meeting the threshold for Tier 3 CAMHS currently running as a pilot	2-18 years
Haringey Adolescent Outreach Team (St Ann's Hospital)	Barnet, Enfield and Haringey Mental Health Trust	An assertive team who provide support on discharge from inpatient services, crisis and risk support in the community and outreach for those unable to attend clinic services/hard to engage with significant risk, also fulfilling the role of an Early Intervention in Psychosis service for under 18s. Currently 5 days and little evening cover	12-18 years
Open Door Young People's Service	Open Door (Voluntary Sector)	Psychological therapies for young people experiencing emotional difficulties ranging across tiers 2 and 3 with a focus on psychotherapy- both brief and longer term interventions are available	12-25 years
Parenting Teenagers Project	Open Door (Voluntary Sector)	Therapeutic support for parents of adolescents and young adults aged 12-21	Parents of young people 12-21 years
Paediatric Mental Health Team	Whittington Hospital	Support to children and young people admitted to hospital in mental health crisis or for self-harm and supports acute paediatric services with mental health presentations	0-16 years
Child and Adolescent Psychiatry Paediatric Liaison Team	North Middlesex University Hospital	A multi-disciplinary mental health team providing support to patients accessing North Middlesex University Hospital with medically related conditions. Does not provide an emergency response for deliberate self-harm.	0-16 years
CAMHS Inpatient Services	Various Local unit- The Beacons (BEHMHT)	Intensive psychological and psychiatric support and treatment for young people with significant mental health problems who cannot be successfully managed in the community.	0-18 years 13-18 years

Service	Provider	Description	Age Eligibility
Adult IAPT & Big White Wall	Whittington Health Big White Wall	Adult 'Improving Access to Psychological Therapies' Service provides access to brief psychological interventions primarily for anxiety and depression. Big White Wall is a monitored and supported online resource primarily for peer support. Both are available for young people 16+ subject to the appropriateness of the service for the individual young person.	16+ years
RAID at North Middlesex University Hospital & Barnet General	Barnet, Enfield and Haringey Mental Health Trust	Psychiatric liaison within hospital settings. For over 16s, this team will provide support 24/7 linking young people into CAMHS on discharge.	16+ years

*Services deliver up to but not including the upper limit age specified.

Tailored Offer- Direct Intervention Services

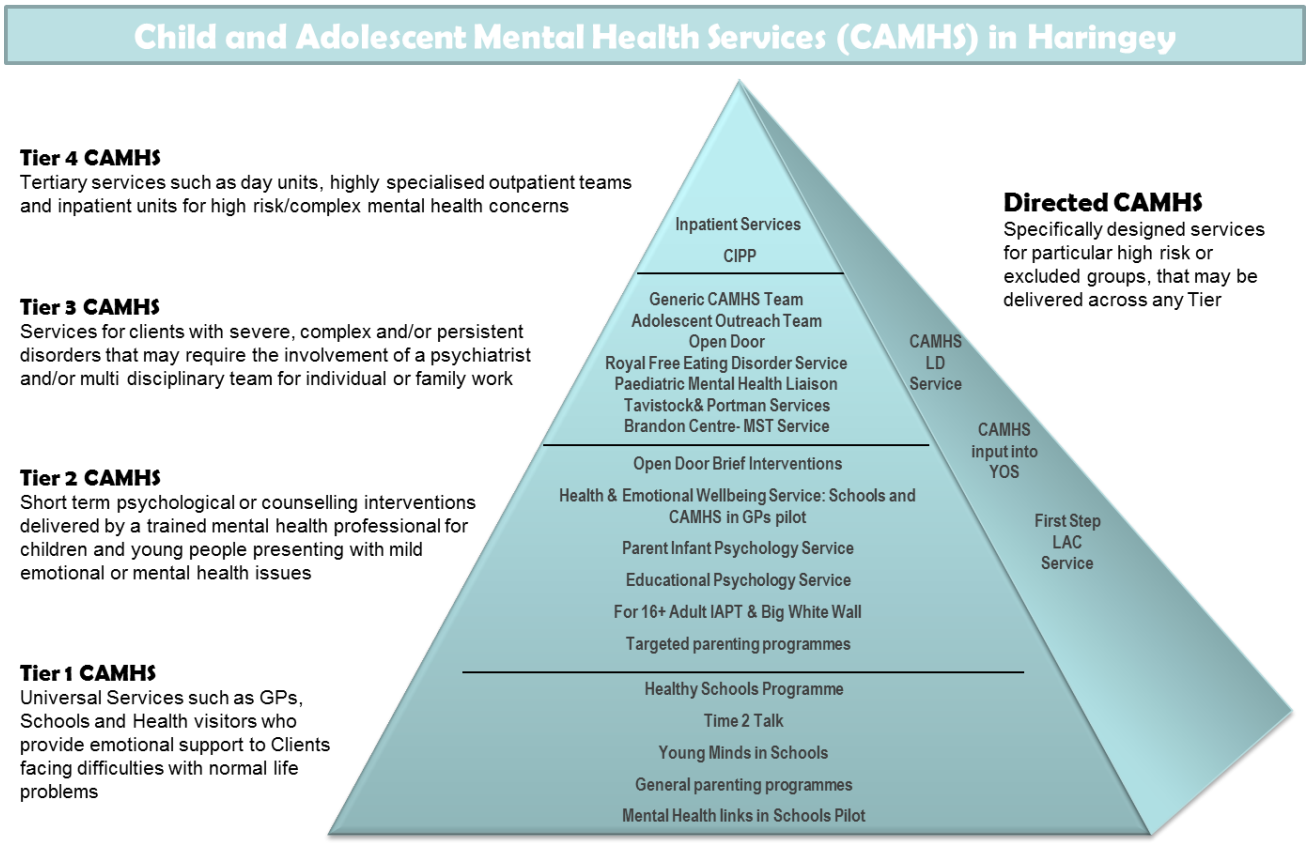
Table 3: The following services are designed to meet the needs of specific groups of children and young people and are not part of the standard offer. They may be commissioned for a particular group or for a specific locality

Service	Provider	Targeted Group
Health and Emotional Wellbeing Service (Schools)	Barnet, Enfield and Haringey Mental Health Trust	Commissioned by Schools for individual school populations
Counselling in Schools	Various agencies/providers including Open Door and Hope in Tottenham	Commissioned by Schools for individual school populations
Bounds Green Outreach Service	Tavistock and Portman NHS Foundation Trust	Commissioned by the CCG to provide generic CAMHS for the locality and an outreach base for Tavistock and Portman specialist services
CAMHS LD Service	Barnet, Enfield and Haringey Mental Health Trust	Service for children aged 3-18 with a learning disability (IQ below 50, P levels or low level national curriculum) severe challenging behaviours, or suspected co-morbid mental health issues
CAMHS input into Youth Offending Service	Barnet, Enfield and Haringey Mental Health Trust	CAMHS support hosted into the Youth Offending Service to support children and young people in the criminal justice system
First Step Looked After Children Service	Tavistock and Portman NHS Foundation Trust	A screening and assessment service for looked after children and up to six sessions where required
Tavistock and Portman Child and Family Services	Tavistock and Portman NHS Foundation Trust	Specialist Services meeting the needs of groups who need tailored treatment and support: • Fostering Adoption & Kinship Care • Adolescent and young adult transition service • Lifespan autism/ neurodevelopmental • Trauma and Refugees

Educational Psychology Service	Haringey Council	This service has a statutory duty around contributing to the Education Health and Care Plan process to facilitate an understanding of how learning can be accessed. Additional services can be commissioned by schools such as applying psychological principles, methods and techniques to help parents/carers, and schools increase the effectiveness of teaching and learning, for children where concern has been identified.
Centre for Interventional Paediatric Psychopharmacology (CIPP)	South London and Maudsley NHS Foundation Trust	Tier 4 Service for highly complex presentations of neuropsychiatric disorders
Gloucester House Day Unit	Tavistock and Portman NHS Foundation Trust	A highly specialist joined-up health and education service within a single setting, that can involve psychotherapeutic, psychiatric, psychological and social work input.

In addition to the above direct intervention services there are a number of projects within universal services to build resilience in more general populations, and time limited programmes targeted at specific groups. These include: State of Play, a project funded by Haringey Public Health, delivered in partnership with Tottenham Hotspur Foundation, New Choices for Youth and Haringey Adolescent Outreach Team and are usually time limited projects rather than services.

The below diagram represents Haringey CAMH specific services according to the Tiered Model.



2.5 Understanding Need

2.5.1 Prevalence Data

- *9.6% of children and young people aged between 5 and 16 years have a mental health disorder*
- *7.7% children aged 5-10 years have a mental health disorder*
- *11.5% of young people aged between 11 and 16 years have a mental health disorder*
- *In an average class of 30 school children 3 children will suffer from a diagnosable mental health disorder*

Future in Mind, 2015

Existing prevalence data is based on estimates from the latest epidemiology study by Green et al in 2004 (Future In Mind pg 5). The rates we have used are based on current population and according to the Green methodology. The limitations to this are that they do not include the 0-5 or the 16-18 groups to which CAMHS also deliver.

Future in Mind highlights the need for more up to date prevalence data, and this is likely to result in a national survey being completed every 5 years. When this becomes available we will use this data to update our needs assessment and assumptions. Additionally the Health and Social Care Information Centre (HSCIC) has developed a new data set for CAMHS. From 2016 providers are required to submit data including outcome data, which should improve national data and understanding of children and young people's mental health services.

Figures are also different depending on whether you look at the numbers which the council are responsible for (those living in Haringey) or those for whom the Clinical Commissioning Group is responsible (those registered with a Haringey GP). Various services are commissioned on the basis of these different parameters so therefore where possible both figures are included, though broadly the populations are similar.

Table 4: Estimated number of Haringey children with mental health disorders by age group and sex

		Estimated Number of Children 5-10	Estimated Number of Children 11-16	Estimated Number of Children TOTAL
Based on ONS (local authority)	BOYS	1100	1200	2300
	GIRLS	525	925	1450
	TOTAL	1625	2125	**3750**
Based on GP registration (CCG)	BOYS	1165	1230	2395
	GIRLS	565	955	1515
	TOTAL	1730	2185	**3910**

Table 5: Estimated number of Haringey children with mental health disorders by disorder 5-16 years

	Based on ONS (local authority)	Based on GP registration (CCG)
Conduct Disorders	2310	2410
Emotional Disorders	1490	1550
Hyperkinetic Disorders	630	660
Less Common Disorders	540	565

NB. Table 4 and 5 figures are both sourced from Chimat [xi].Totals differ as one in five of the children were diagnosed with more than one of the main categories of mental health disorder. The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder

Definitions (Green et al, 2004 and ICD10 2015)

Emotional Disorders: Emotional problems involving anxiety, depression and obsessions.

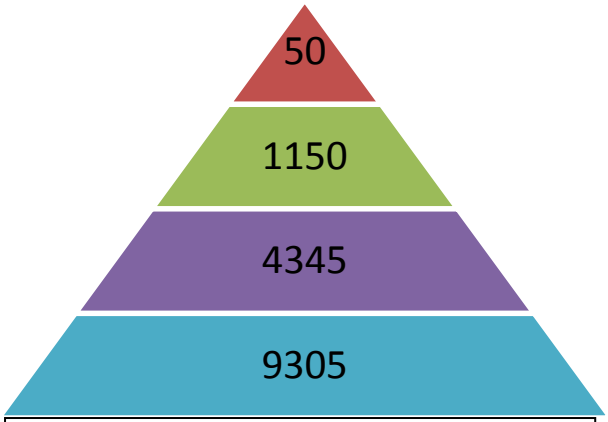
Conduct Disorder: Disorders characterised by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations (ICD 10 version 2015) e.g. Oppositional Defiant Disorder

Hyperkinetic Disorders: Lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. (ICD 10 version 2015) e.g. Attention Deficit Hyperactivity Disorder

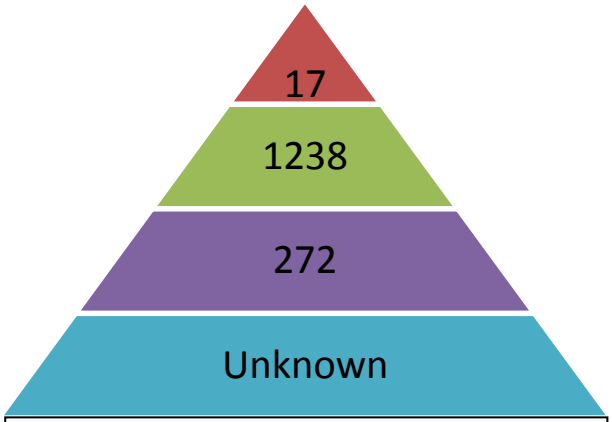
Less Common Disorders: Other disorders outside above such as autism spectrum disorders (developmental) tic disorders (motor and vocal tics) and eating disorders (anorexia nervosa and bulimia)

2.5.2 Mapped Activity Data

The majority of commissioned Haringey providers have contributed information and data in the course of this review. This data has been used to map prevalence data against activity data. It does not include activity within non-commissioned provision such as private therapists.



Children and Young People requiring a response by Tier: Estimates based on CCG population (under 18 year olds)



Approximate number of Children and Young People receiving a commissioned response by Tier in 2014/15

The figures in the left pyramid denote the number of children and young people who may experience mental health problems appropriate to a response at each of the tiered levels according to CCG population figures.

The figures in the right pyramid show the number of children and young people accessing a commissioned service at each Tier.

Tier 1

This relates to children and young people who are receiving emotional support through universal services such as schools, nurseries, children's centres and GPs who provide support to children and young people facing difficulties with normal live events such as bullying and bereavement. As this support is informal it is not recorded in any way and therefore it is impossible to know how many children and young people are accessing support at this level. Further intelligence will be gathered through a population survey currently being developed by public health. Delivered at this level are initiatives such as whole school approaches to mental health, and resilience programmes to promote a healthy environment.

Tier 2

In Tier 2 the figure used relates to the number of accepted referrals within 2014/15 as the caseload is likely to be unrepresentative due to the short term nature of the interventions. This however demonstrates the gap between commissioned provision and expected need. Tier 2 interventions are usually delivered by a mental health worker or counsellor in a uni-disciplinary way. Predominantly these are brief interventions aimed at young people who need additional support but who do not meet the 'severe and/or persistent' criteria for Tier 3. The figure in the table includes only commissioned services across the Council and CCG, and does not include any individually commissioned work by Schools outside of the Health and Wellbeing Service (HEWS) or private provision as we were not able to get exact figures for these, though they are unlikely to bring to total to more than a thousand.

Tier 3

Currently Tier 3 makes up the bulk of commissioned services. The data shows that the caseload of Tier 3 is roughly approximate to predicted need, however in addition to the caseload at period end there will have been some young people seen and discharged within the year. Where caseload data was not available accepted referral data has been used. This data excludes those seen by paediatric A&E liaison as these were not available. All figures relate to those seen by Haringey teams or under Haringey contracts, and could vary depending on whether reporting was organised by GP registration, residence or school attendance.

Tier 4

The majority of Tier 4 services are commissioned through NHS England. The figures included are the number of children who were admitted in 2014/15 and those accessing the CCG commissioned CIPP (Centre for Interventional Paediatric Psychopharmacology) Service or the Tavistock and Portman's Day Unit Gloucester House. Additionally some children may be accessing specialist services such as the Gender Identity Disorder Service at the Tavistock and Portman or the Portman Clinic which offers specialised long-term psychoanalytic psychotherapeutic help to people who suffer from problems arising from delinquent, criminal or violent behaviour or from disturbing and damaging sexual behaviours or experiences. These and other Tier 4 services which may have very small numbers are not included in these figures but are unlikely to increase the numbers accessing to anywhere near expected prevalence rates.

Since 2004 when prevalence rates were calculated a lot of work has been undertaken by local community CAMHS to reduce the numbers of children and young people needing to access support at this level. The small numbers in Tier 4 may reflect a robust community approach.

2016 Update:

Nationally there is a commitment to extend access for those with a diagnosable mental health condition to Child and Adolescent Mental Health Services. Calculations based on Transformation Plans estimate that approximately 25% of the population requiring CAMHS currently have access, with a target to improve this to 35%. The limitation of this is that there is not an agreed methodology nationally for calculating this prevalence rate, some areas are using the numbers they anticipate to need a Tier 2, 3 or 4 service, and others are applying the Future in Mind estimated 9.6% rate across their child population. Other areas are using the Public Health Fingertips Tool for estimated prevalence of MH disorder using 2014 ONS data, however this only includes 5-16 year olds. For Haringey these various figures are:

Table 6: Prevalence Modelling

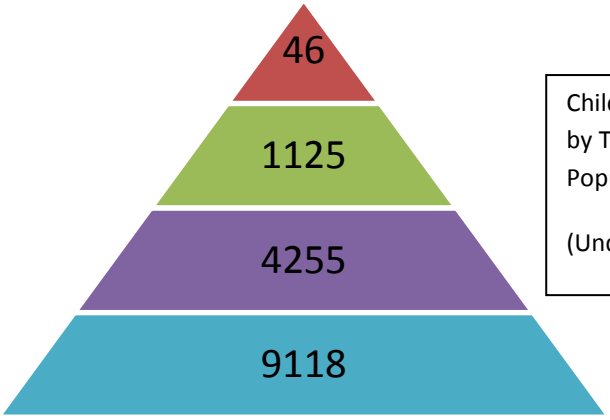
Source	Population numbers	Estimated prevalence of MH Condition
PHE Fingertips using 2014 ONS data calculating estimated MH Disorders for 5-16 year olds	37,905	3,745 (9.9% of 5-16 year olds)
Future in mind estimated prevalence (9.6%) using 2015 ONS data for 0-18 year olds	60,785	5835 (9.6% applied to 0-18 year olds)
Extrapolated Kurtz 1996 by Tier (including Tier 2, 3 and 4) using 2015 ONS data for 0-18 year olds	60,785	5426 (0-18 year olds)

Using our 2014/15 review data across services 1527 CYP were accessing commissioned CAMHS at Tiers 2,3 and 4, with a further 500 estimated to be receiving through school counselling. Using only commissioned figures the below table demonstrates the 2014/15 position against the 25% national estimate and 35% target.

Table 7: Activity Projections

Source	25% Estimate	35% Target	2014/15 Actuals %
PHE Fingertips using 2014 ONS data calculating estimated MH Disorders for 5-16 year olds	936	1,311	41%
Future in mind estimated prevalence (9.6%) using 2015 ONS data for 0-18 year olds	1459	2,042	26%
Extrapolated Kurtz 1996 by Tier (including Tier 2, 3 and 4) using 2015 ONS data	1356	1899	28%

Given that we will be calculating prevalence against service access we intend to use Kurtz as the figures are applicable to the 0-18 population that we commission and deliver services for. Additionally using this figure provides us with a stretch target, supporting our ambition to expand and invest in early intervention.



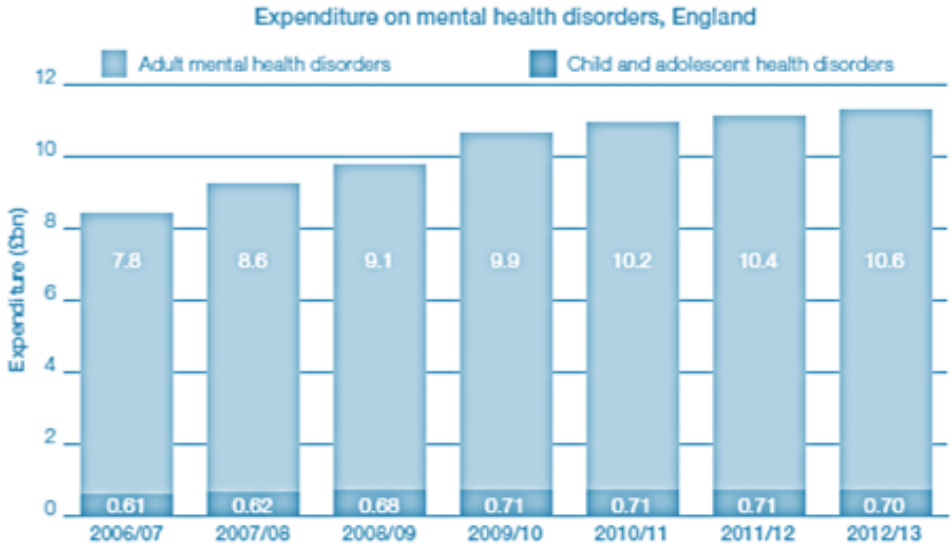
Children and Young People requiring a response by Tier: Estimates based on Local Authority Population using 2015 ONS figures

(Under 18 year olds)

2.5.3 Investment and Financial Data

Nationally it's been reported that in 2012/13 NHS expenditure on child and adolescent mental health was estimated to be £700 million or 6% of the total spend on mental health, however we do not currently have reliable local rates, and no nationally collected more recent data.

NHS expenditure on mental health



Gaining a clear understanding of investment in CAMHS has proved challenging. Neither Haringey CCG nor Haringey Council has specifically disinvested in CAMHS over the last few years; however some services have lost other funding avenues such as national grants, and in April 2016 the Brandon Centre gave notice on our MST service, which has not yet been re-commissioned. Part of the challenge is agreeing which services sit within the remit of CAMHS and being able to get reliable financial information on a service line level. The vast majority of CAMHS spend sits within block contracts and disaggregating this has proven challenging, for some services the funding is within the acute tariff and therefore not possible to report on a service line level.

Due to the nature of block contract arrangements, financial reporting for BEHMHT is based on activity (contacts) with costs then extrapolated. Financial data provided by BEH on the service costs show that the 2015/16 amount is an approximately accurate picture of funds allocated to the Haringey Service. As

reporting improves and we disaggregate the block we are getting a clearer understanding of spend. However we need to do more work to understand resourcing and outcomes and we cannot be confident that the level of investment made is translated into service capacity to provide the outcomes required for the population. In order to get this level of clarity we have provided notice to providers that we are looking to disaggregate the CAMHS Spend from within the block contract.

It is also important to note the vital contribution of the voluntary sector including Mind in Haringey and Open Door. Open Door receives only 42% of its total funding from statutory agencies, attracting a significant amount of investment into Haringey through national grants and charitable trusts. It is important to maintain voluntary sector capacity to draw in other funding, and the ability to pilot and test new approaches and respond to developing needs outside of statutory contracts.

Table 8: Financial Investment in CAMHS

CAMHS SPEND	CONTRACT	2015/16	2016/17 Budget
Haringey Clinical Commissioning Group			
Barnet, Enfield and Haringey Mental Health Trust	BLOCK	£2,436,203	£2,496,377
Tavistock and Portman Child & Adolescent Services (approx. 80% of block)	BLOCK	£449,162	£412,930*
Open Door	BLOCK	£121,000	£123,984
Extra-Contractual Referrals/Non-Contracted Activity	Cost Per Case	£13,500	£30,000
Primary Care CAMHS/CAMHS in GP Surgeries	BLOCK	£45,456	£- **
Royal Free (Eating Disorders & Generic)	Cost Volume (Estimated)	£256,280 ED £25,000 Gen	£264,660 ED £25,823 Gen
SLAM (CIPP)	Cost Volume (Estimated)	£25,000	£22,424
Whittington PIP	BLOCK	£235,000	£242,689
Paediatric Mental Health Liaison Team (Whittington)	BLOCK	Within Acute Tariff	Within Acute Tariff
Child and Adolescent Paediatric Liaison Team (NMUH)	BLOCK	Within Acute Tariff	Within Acute Tariff
TOTAL	TOTAL	£3,645,198	£3,618,988
Haringey Council			
Children and Young People's Services			
Tavistock & Portman (First Step)	BLOCK	£352,796	£362,921
BEH	BLOCK	£172,000	£172,000
BEH- Edge of Care	BLOCK	£38,000	£38,800
Brandon Centre (Multi-Systemic Therapy)	BLOCK	£114,000	£114,000***
Open Door (Development of Open Door Tottenham)	BLOCK	£37,000	£37,000
Open Door (18-25 years)	BLOCK	£9,500	£9,500
SUBTOTAL		£723,296	£734,221

Public Health			
Young Minds	BLOCK	£24,200	£21,200
Whittington PIP	BLOCK	£40,000	£69,000
SUBTOTAL		£64,200	£90,200
TOTAL		£787,496	£824,421
NHS England Specialised Commissioning London			
Acute Units in London	Cost per case	£500,394	N/A
Acute Units out of London		£94,219	N/A
TOTAL		£594,613****	N/A
HARINGEY TOTAL		**£5,027,307**	**N/A**

*Value is set based on activity figures from month 6 of previous year and fluctuates annually based on usage.
** Ongoing service past pilot phase funded through CAMHS Transformation Funding
*** This figure reflects the budget, however provider has given notice on service and we are yet to re-commission so anticipate underspend on this budget line.
**** This figure has been updated based on NHSE provided figures for 2015/16

CAMHS Transformation Funding

The below table outlines the estimated allocations made to Haringey CCG under Future in Mind, which are being invested in our Local Priority Schemes, outlined later in the document. Additionally it has been announced that a further £25 million will be available nationally to support CAMHS Transformation in 2016/17 and we are currently awaiting information on allocations, but will be using this money to reduce waiting times and support the implementation of improved crisis care with NCL partners.

Table 9: CAMHS Transformation Funding

Investment	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Transformation Funding	£368,203	£635,000	£747,000	£907,000	1,013,000
Eating Disorder Funding	£147,099	£160,000	£160,000	£160,000	£160,000
MH Links Funding	£150,000	£0	£0	£0	£0
CYP-IAPT Funding	£13,000	£39,000	TBA	TBA	TBA

2.5.4 Benchmarking Data

The latest CAMHS benchmarking data is from the 2013 CAMHS benchmarking report, some of the data from this is useable and has been utilised in this report, other data such as the exact staffing profiles and averages is not clear and the detailed information is only available to participating Trusts and CCGs, of which Haringey was not. What is clear is that Haringey has a very psychotherapy heavy staffing model. This is to an extent due to the nature of how the local voluntary sector has developed, looking at the workforce across providers is therefore important to ensure the right skills mix.

Haringey was part of the London and South East Collaborative for CYP-IAPT in the first wave. Emerging outcome data shows the partnership which currently comprises Barnet, Enfield and Haringey Mental Health Trust and the Educational Psychology Service are within the normal range for achieving clinical outcomes.

This data is gathered from a number of clinical outcome measures including Strengths and Difficulty Questionnaires and RCADs, however the data is currently only available in a small sample of cases (data completeness at 51.4% in quarter 3 2014/15 against a target of 90%) and significant work to improve recording and reporting on these measures is currently being undertaken.

Open Door has been collating outcome data for a number of years across their service and has recently joined the partnership. As CYP-IAPT becomes more embedded and data becomes more complete we will get a better picture of the clinical efficacy across commissioned services and how these compare to other areas.

Another source of benchmarking is CORC (CAMHS Outcome Research Consortium). Currently only BEHMHT is able to report on their CORC data, though Open Door has recently joined CORC and should be able to provide benchmarked data in future. Other services should also look to benchmark themselves against their peers.

As with the CYP-IAPT data BEH do not have enough data to make it a meaningful benchmark of provision in a number of areas. The latest report covering 2013-2014 only had CHI-ESQ (Child Experience of Service Questionnaire) returns for 14 children and 27 parents across the Trust, this rate is significantly lower than the CORC average and BEH should immediately look at improving collection mechanisms. One area where there was good comparative data was CGAS (Children's Global Assessment Scale) which is a numeric scale used to rate the functioning of children and young people. This showed no significant variances with other CORC services in the average scores and improvement over time.

What CORC does demonstrate is that across BEH services there are significantly more 0-12 year olds receiving treatment from CAMHS than comparator Trusts and less in the 13-18 age range. This is likely to be because of the availability of Open Door for teenagers. Another area of variance from other CORC services is the types of presenting problem, BEH see significantly more children with Emotional Disorder, Conduct Disorder and Autism Spectrum Disorder. Additionally BEHMHT routinely sees children and young people over a longer period of time than comparators; this is addressed later in the document. Open Door have been collecting data for a number of years and demonstrate good return levels and clinical outcomes using HONOSCA (Health of the Nation Outcome Scales for Children and Adolescents), CGAS and CHI-ESQ.

3. How Future in Mind Relates to Haringey

3.1 Accountability and Transparency

Future in Mind places a requirement on local areas to have lead commissioning arrangements for children and young people's mental health and wellbeing services with aligned or pooled budgets and a single integrated plan for child mental health services supported by a strong Joint Strategic Needs Assessment. At the same time national change to Special Educational Needs and Disability through the Children and Families Act 2014 places a duty on health, education and social care to jointly commission and provide services in collaboration with families and young people. In Haringey joint commissioning has recently been established for CAMHS between the Council and the CCG with aligned budgets, but without pooled resources. In practice this means that whilst planning is now being done jointly, areas such as the commissioning and contract management of providers are being duplicated. Additionally schools are not currently part of joint arrangements and continue to commission independently. A further requirement of Future in Mind is that investment be fully transparent, however the full picture of CAMHS spend is not available due to block funding arrangements, without a clear understanding of current investment levels it is difficult to assess the impact of CAMHS provision and ensure value for money.

2016 Update:

A section 75 agreement to pool budgets has been drafted between Haringey CCG and Haringey Council. A pooled budget for CAMHS will be established from April 2017 and work is currently being done to update and amalgamate specs to support the development of single contracts for providers.

3.1.1 Choice

In December 2014 the right to choice was extended to mental health[xii] as part of the work around parity of esteem between physical and mental health services. This legal right covers routinely commissioned mental health services and was extended in the final guidance to not solely cover the first appointment but also the entire episode of care for which the patient was referred. Currently the CCG who now have a duty to commission with regard to this guidance do not have any flexibility within budgets to allow the funding to follow the patient. In practice there have been very few referrals outside of Haringey contracts. However, any increase in choice will result in a cost pressure to the CCG. If choice is to be promoted resources will need to be flexible enough to 'follow the child'. This right to choice and personalisation of services for an individual child is also an ethos reflected in the SEND reforms as part of the new Children and Families Act 2014.

2016 Update:

The new Choices Service will provide us with invaluable data about the sort of services required to meet the needs of the population. An assistant psychologist is incorporated into the model to monitor the outcomes of the consultations and to provide us with more information around the services families want and need.

3.1.2 Payment By Results

In June 2015 the final report on the payment by results pilot was published. Payment by results for CAMHS is loosely based on the Thrive model, grouping people into three need based categories and within these diagnostic based subsections:

- Getting Advice
- Getting Help
- Getting More Help

Currently neither commissioners nor providers are in a position to move to PBR, however in order to prepare, services should begin clustering service users and make this data available to commissioners. The document does not outline any timescales for the implementation of CAMH PBR as further work refining and piloting the model is necessary.

3.1.3 Cross-Borough Working

Barnet, Enfield and Haringey Mental Health Trust (BEHMT) are currently commissioned to provide a service for any child living in, attending school in or registered with a GP in Haringey. This attempt at ensuring seamless services means that the team rarely rejects a referral on the basis of commissioning responsibility. Currently only 88.3% of referrals into the Haringey CAMHS team at Burgoyne Road relate to children and young people with a registered Haringey GP, however Haringey patients also make up 6.9% of the Enfield team's caseload and 3.39% of the Barnet caseload. Across the five NCL boroughs there is currently an agreement to accept if the GP cross-refers on the basis of patient choice. However Whittington Health who provide CAMHS for Islington and Tavistock and Portman who provide CAMHS for Camden both have contracts with the CCG, so this activity is cross-charged.

Islington and Camden do not have contracts with BEHMT and therefore this activity is not funded. Recently scoping work has been completed to look at the size of the issue which demonstrates Camden referrals are negligible and Islington make up only 1.75% of the referrals. However there are approximately 83 referrals from outside of Barnet, Enfield and Haringey coming into the team annually, at approximately £3000 per child for treatment, this revenue should be generated and transparently reinvested in the local teams or reserved by CAMHS access to facilitate choice where an interest in out of borough services has been expressed.

3.1.4 Better Commissioning

In order to ensure high quality service provision commissioning in Haringey needs to be improved. There are currently contracts without specifications, providers with multiple contracts across the statutory agencies and a lack of coherence to both commissioning and contract monitoring arrangements. In order to meet the challenges of providing choice and establishing a position of readiness for PBR it is important to undertake changes in the way commissioning is currently done. The landscape for commissioning continues to change across the country.

Block contracts that were issued for many years are now being disaggregated across the country in order to provide greater transparency on how resources are allocated. There is an increased focus on outcomes, accountability and value, and many areas have re-commissioned CAMHS in an attempt to transform services.

However this can have negative impacts on staff morale, can cause significant disruption to service delivery and can create a situation where staff are not invested or engaged in transformation. In order to create sustainable transformation it is imperative that the process is supported by families and staff.

As a matter of urgency outcome focussed specifications should be developed for all services, working with providers and staff to meet the challenges outlined in this report. These specifications should be developed with providers and families and be in-line with CYP-IAPT principles and best practice.

In order to get a better financial understanding of CAMHS investment and in order to facilitate the implementation of a single integrated plan a section 75 should be established to pool CAMHS funding across health and social care. Where practical Haringey should look to jointly plan with neighbouring CCGs, Councils and NHS England and to this end explore the possibilities of joint arrangements.

2016 Update:

All services will have clear contracts with specifications for 2017/18 under joint commissioning arrangements. We have also developed a single dataset to use across providers in order for us to aggregate data to provide a clear picture for the Borough and to manage performance through more accurate and meaningful data. We are also working across NCL to develop co-commissioning arrangements with NHSE for Tier 4 services, to improve pathways between community and inpatient CAMHS.

3.1.5 Quality Standards

3.1.5.1 Children and Young People's-Improving Access to Psychological Therapies (CYP-IAPT)

CYP-IAPT is a transformational model developed nationally for CAMHS. The key principles of CYP-IAPT are:

- Better evidence based practice - Increasing the availability and knowledge of best evidence based interventions
- Better collaborative practice - Goal focused and client centred interventions, using feedback tools to facilitate better working between mental health professionals and families and young people using feedback tools leading to more personalised care
- Better service user participation – Children, young people and their families having a voice and influence at all levels of the organisation
- Better Cross Agency Working - Encouraging and supporting cross agency collaboration between Health, Social Care and Voluntary and Independent sectors
- More accountable services – through the rigorous monitoring of clinical outcomes to be able to share outcomes with young people and families and demonstrate effectiveness to commissioners
- Increased awareness – working in partnership with organisations delivering mental health services, and those in other sectors working with young people and families to increase understanding of the importance of emotional well-being and decrease stigma.

Although Haringey has been part of CYP-IAPT for a number of years further work is required to embed CYP-IAPT across all the services. The Review found that participation is not sufficient and outcome monitoring was not consistent across the workforce. Additionally work needed to be done across providers to develop consistent outcome measures.

In 2014 CYP-IAPT published 'Principles in Child & Adolescent Mental Health services values and standards "Delivering With and Delivering Well"'. This document outlines the quality standards by which all Haringey CAMHS services should be measuring themselves. These are compatible with the Youth Wellbeing Directory with ACE-V Quality Standards which is also a valuable tool for ensuring quality provision.

2016 Update:

CYP IAPT Funding has facilitated the training of 2 members of staff in IPT-A over the last year. Additionally Tavistock and Portman NHS Foundation Trust have joined IAPT and are rolling it out across services. Open Door and BEHMHT have arranged training for a broader cohort of staff in CYP-IAPT principles.

3.1.5.2 National Institute of Clinical Excellence (NICE) Guidance

There is a broad range of NICE guidance available on child and adolescent mental health, however it is currently unclear the extent to which this guidance is being used to inform practice and pathways. It is the expectation of commissioners that providers complete an audit of their services against these standards to identify any areas which are not currently NICE compliant for development.

3.1.6 Data and IT

Currently data systems are not equipped to supply accurate data on either the children who are being seen by CAMHS or the outcomes from the treatment. Additionally staff raised IT as a barrier to efficiency and flexibility. It is imperative that an innovative approach is taken to data and IT, harnessing new technology and using the best systems to meet the needs of a modern efficient CAMHS. All patient records should be electronic and digital communications should be put in place, where not available, to reduce DNA rates. All CAMHS providers will need to ensure that EPR systems are ready to submit CAMHS minimum data set to HCSIS in January and that this data is locally available for reporting and informing clinical practice (session by session outcome monitoring).

2016 Update:

Significant investment has gone into supporting local providers to develop their IT systems. The majority of providers are now using text reminders for appointments and the new system will provide an improved interface with service users for the collection and collation of outcome data which will support improved use in both sessions with children and young people and their families and in staff supervision. Under of Transformation Plan we are also supporting all providers across the statutory and voluntary sectors to ensure they are able to contribute to the HCSIS data collection system, in order to inform better planning and performance management.

3.2 Promoting resilience, prevention and early intervention

Future in Mind and No Health without Mental Health both stress the importance of early intervention in mental health. Building resilience, promoting good mental health and early identification and support are all vital to ensuring the best possible outcomes for young people facing mental health concerns. There needs to be adequate support at an early stage to promote children and young people's ability to self-manage, reducing dependence on more extensive and ongoing support. This is in line with Council priorities around early help, and the shifting emphasis to prevention.

Half of lifetime mental health conditions are symptomatic by the age of 14

3.2.1 Perinatal Services

> Beginning with a healthy pregnancy, a safe birth and a strong bond between a baby and its parents is vital and health promotion programmes' delivered during pregnancy and the first years of life, when the foundations of future health and wellbeing are laid down, is vital. While it has been acknowledged for some time that this phase strongly influences outcomes in later life, recent evidence reinforces the importance of early intervention to reduce the impact of stress in pregnancy and to promote attachment and this is particularly true for children born into disadvantaged circumstances. Many problems which occur later in life, and lead to enormous expenditure on service provision, arise because children did not receive appropriate support in their early years
>
> Haringey Joint Strategic Needs Assessment

According to a recent study maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of about £8.1 billion for each one-year cohort of births in the UK. 72% of this cost relates to the adverse impacts on the child rather than the mother, £1.2 billion of which is borne by the NHS[xiii]. In Haringey there is a perinatal mental health service that works with parents of children under 2 years old, addressing attachment and perinatal mental health issues. This service, the Parent Infant Psychology Service (PIPs) is delivered by Whittington Health and is co-located with health visitors and the family nurse partnership workers.

The service is funded in the majority by the CCG with one additional post funded by Public Health.

2016 Update:

From 2016/17 additional resource has been identified by Public Health to expand the PIPs team further and a recruitment process is currently underway.

Locally work has been completed across the five North Central London boroughs to develop a shared strategy to reduce inequalities across the boroughs generated by the number of Trusts delivering acute and mental health support. Further information on this is available in Part Two: NCL CAMHS Transformation Plan Priorities.

3.2.2 Mental Health Promotion and Promoting Resilience in Schools

Haringey currently has a good range of support at Tier 1 commissioned by public health, however further work is required in order to improve support to schools who identified through the online audit that they do not feel equipped to meet the presenting emotional and mental health issues in schools. It is planned to request all schools to nominate a lead for mental health and emotional wellbeing. Using these direct links into school we will be able to disseminate information, promote services, and provide support and training. This approach has worked well elsewhere and is due to be piloted by the DfE and DoH, Haringey has been successful for its bid for this pilot. All schools participating in the audit expressed an interest in nominating a lead and this can be promoted through the healthy schools programme.

The 2012 Children and Young People's Mental Health Coalition document 'Resilience and Results'[xiv] makes the case for school involvement in supporting emotional wellbeing.

Table 10: Summary of Evidence Base for Schools Supporting Mental Health Needs of CYP and Improved Attainment

RESILIENCE & RESULTS

Supporting everyone's emotional and mental wellbeing and giving emotional support to pupils with behavioural and emotional problems is important because:

- 1 in 10 or at least 3 young people in every average class will have a behavioural or emotional difficulty (Green, et al, 2005)
- Almost half of young people with fewer than five GCSEs graded A*to C said they 'always' or 'often' feel down or depressed compared with 30%of young people who are more qualified (Price's Trust, 2012)
- In an average classroom: 10 young people will have witnessed their parents separate, 1 will have experienced the death of a parent and 7 will have been bullied (Faulkner,2011)
- 1 in 4 young people of secondary school age will have been severely neglected, physically attacked or even sexually abused at some point in their lives (NSPCC,2011)

Having a behavioural or emotional difficulty can have a significant impact on young people's academic achievement, and other outcomes. Research has found that:

- Children with persistent conduct or emotional disorders are:
  - more likely to be excluded from school,
  - less likely to engage with out-of-school programmes to help them manage their behaviour and improve literacy,
  - more likely to be assessed with special educational needs, and
  - more likely to leave school without educational qualifications (Parry-Langdon, 2008)
- Children with conduct disorders and severe Attention Deficit Hyperactivity Disorder (ADHD) may be four to five times more likely to struggle to attain literacy and numeracy skills (Green, et al., 2005).

There are strong links between emotional wellbeing and children and young people's readiness to learn. Research shows that emotions can hinder or promote learning. If a pupil is feeling anxious, angry or stressed, the primitive functions of the brain will take over. This means that the part of the brain responsible for higher order thought and processing will not function effectively. Developing a whole school approach is key to supporting emotional wellbeing including:

- Promoting the confidence and self-esteem of all pupils in the School
- Ensuring child protection procedures are in place and being effectively implemented
- Providing planned opportunities for pupils to reflect on and discuss their feelings and personal experiences as part of the curriculum
- Providing opportunities for pupils to be consulted and take responsibility within the School
- Teaching pupils the importance of caring for each other and working together
- Making pupils feel welcome in new schools
- Developing pupils' skills to cope with pressures and problems

- Providing opportunities for pupils to seek and get help on a range of personal, health and emotional issues
- Ensuring teachers are trained to understand children's emotional development and how this affects learning
- Involving pupils in setting academic and personal targets for themselves.

It is therefore vital that schools take an active part in ensuring staff are appropriately trained to support emotional wellbeing, recognise symptoms of mental health problems, and know where and how to signpost the young person to appropriate support. Public Health have recently commissioned Young Minds in partnership with Barnet, Enfield and Haringey Mental Health Trust to develop a whole school approach to mental health and support schools to develop resilience in children and young people.

There is also a role for the wider CAMHS system in supporting Schools and work needs to be done to raise awareness of the range of resources and services available. Additionally our participation in the national pilot of Mental Health Links in Schools will support the development of training for mental health leads within schools and a school lead within CAMHS, improving links between the two.

There have been a number of innovative projects commissioned by public health which were targeted at vulnerable young people and developed and delivered by the Adolescent Outreach Team:

- A Game of 2 Halves which is a 12 week programme working with young people at risk of exclusion from secondary school was delivered in partnership with Tottenham Hotspur and has seen positive outcomes and reduction in behavioural difficulties in school.
- Time2Talk is a whole school approach to raising awareness about emotional wellbeing and has taken stories from young people who have had contact with mental health services, adapting these narratives to create a piece of forum theatre for each year assembly within the school, also adapting into a film that is now in use within PHSE.
- More broadly the Healthy Schools programme is available to all Haringey Schools to support them in promoting positive health and wellbeing within their school populations. Currently Haringey has 31 bronze, 10 Silver and 1 Gold rated school.

The Virtual School, which works with looked after children, has developed a range of attachment based tools - **How to BE-** to help professionals to support children and young people who have experienced trauma, including the emotionally friendly classroom, home and club. Training has been delivered with a number of schools and has recently been extended to supervising social workers. This work is an area which could be developed and expanded with applications beyond looked after children.

Some schools commission therapeutic services directly, buying services from Barnet, Enfield and Haringey Mental Health Trust's Health and Emotional Wellbeing Service (HEWS). Other providers include Hope in Tottenham (previously Fowler Newsam) who see approximately 400 students a year, delivering in over 30 schools.

Whilst this availability of in-school support is excellent for those able to receive it, it is not an equitable offer across the Borough as some schools do not commission any direct work. Work with schools forum is outstanding to explore further development of provision and appetite for jointly commissioning a standard offer. The independent, faith schools and alternative provision sector should also be invited to discuss

provision to ensure that students in these schools have the same ability to access support within their school.

2016 Update:

Haringey participated in a national Mental Health Links in Schools pilot which enabled 11 Haringey schools to work closely with CAMHS to provide more collaborative links. As part of this work we have developed a new pro forma for CAMHS to complete with key information for schools to improve communication between CAMHS and Schools. This pro forma includes information that schools identified as key, such as how they can support the child/young person within the school and information on any medication and side effects that may have been prescribed. Additionally we identified some areas that Schools would appreciate additional training on and held a multi-agency professionals training conference in July 2016 for over 100 professionals across the Borough with workshops on issues such as self-harm, attachment and online risk and resilience. We have also now adapted the Mental Health Link in School role to an Emotional Wellbeing Coordinator role and have extended this to all Haringey Schools. By Schools nominating an Emotional Wellbeing Coordinator they have access to training opportunities, information and support. We are also completing an audit with schools to better understand needs within the school population and the level of support provided.

3.2.3 Building resilience through families

Improving support to families and parents can also have a huge impact on the emotional wellbeing of children and families. Children can experience significant difficulties as a result of inconsistent or dysfunctional attachments with family members and other adult carers. Attachment difficulties and disorders can lead to interpersonal difficulties, academic under-achievement and failure to thrive. Currently there is a wide range of parenting support in Haringey but it is uncoordinated.

CAMHS, children centres and the voluntary sector all provide different parenting programmes including Webster Stratton, Triple P- Positive Parenting Programme and Open Door's locally developed programme, the Open Door Approach to Parenting Teenagers. At the moment access to this support depends on who the family are already engaged with and work needs to be done to develop a more coherent approach to these resources. Any professional in universal services should be able to signpost to resources and families should have the tools to seek support directly, and we should be better utilising family support workers and early help services.

Parenting interventions are also an area of development for CYP-IAPT which is now offering training in PT (Parenting for 3-10 year olds with conduct disorders). As part of developing an early intervention offer it is imperative that parenting support is developed. The majority of presentations at CAMHS Access relate to behaviour or family issues, therefore by having the right range of early intervention approaches extended, more intensive work may not be required. Additionally services to support attachment from early childhood through to the teenager years should be coordinated and scoped to ensure this key area is properly supported. NICE guidance on attachment is due to be released in November and should be the basis for an in-depth look at the pathway across health, education and social care.

2016 Update:

Haringey has recently developed a multi-agency Parenting Plan for the borough. This document maps the current provision and outlines the required actions in order to ensure a more robust approach to parenting

support. Implementation of the plan will be commenced immediately. In line with Haringey's Early Help Strategy the plan has the following five objectives:

1. Delivering prevention and early intervention to reduce escalation of need
2. Enhancing access to and co-ordination of integrated services
3. Sustaining resilience for children, young people and families
4. Developing the workforce to be more confident and empowered practitioners of early help
5. Increasing equity of access to quality provision for all children, young people and families

3.3 Improving access to effective support –a system without tiers

'Right time, right place, right offer' Future in Mind

Future in Mind outlines the challenges that face CAMHS nationally. These include access issues that we see mirrored in local services, a requirement to build a more enabling model of support through peer support and digital technologies and an expectation that children and young people will have appropriate support in crisis and through transition to adult services. On the whole feedback about services was positive in terms of the support and quality of treatment delivered. However locally there are issues concerning long waiting times, higher than benchmarked DNA rates in some services and lengthier interventions than comparators, creating capacity issues.

3.3.1 Waiting Times

One of the key issues facing Haringey CAMHS is access; waiting times are of concern across all services as demonstrated in the waiting time data provided by services:

Table 11: Waiting times to first appointment 2013/14 and 2014/15

Average Wait in Weeks	2013/14	2014/15
BEH- Generic CAMHS	14.43	10.14
BEH- AOT	1.43	1.71
BEH- CAMHS LD	8.86	7.86
BEH- HEWS	4.14	3.14
Open Door	22	16
Tavistock & Portman- General	6.2	6
Royal Free (Eating Disorders & Generic)	4.28	2.67
Brandon Centre- MST	6	4
Whittington- PIPS	Not Avail	5.7

As part of the stakeholder survey children, young people and parents were asked how long they waited for their initial appointment. The last national waiting time standards required families to be seen within 13 weeks, however 26% of both children and young people and parents completing the Haringey online survey reported waiting more than six months; double this timescale.

Waiting times are currently too long, and some children and young people are waiting for over a school term to be seen. In order to assure timely access for children and young people consistent waiting time standards need to be implemented across providers that meet the criteria of what is a reasonable period to expect a family in need to wait, in line with national standards. In order to meet these requirements services will need

to adjust the way in which they currently deliver in order to build capacity. Open Door have recently introduced a screening/triage system which has reduced their average wait to 6-8 weeks, learning from this approach should be shared across providers and used to inform the development of CAMHS access.

2016 Update:

We have been working with providers to establish a standardised method for recording waiting times. Across our main providers; Barnet Enfield and Haringey Mental Health Trust, Tavistock and Portman NHS Foundation Trust and Open Door, we have amalgamated data to show waiting time data for 2015/16 from referral to initial appointment (RTI), as outlined below.

Table 12: Waiting Times for Referral to Initial Appointment 2015/16

Waiting Times (RTI) 2015/16	
0 - 4 weeks	**46%**
4 – 8 weeks	**39%**
8 – 13 weeks	**9%**
13 – 18 weeks	**3%**
18 – 26 weeks	**1%**
26+ weeks	**2%**

Significant work has been undertaken to ensure that the referral to initial appointment (RTI) wait is significantly reduced. Choices has a standard of 4 weeks from referral to appointment and those who are deemed at too high risk for this service would be seen even more quickly. Therefore we expect to see the RTI waiting times significantly reduce over the next year to and for 90% of children and young people to be meeting this standard, with the rest being exceptions due to service user preference or unavailability. We would also expect this service to reduce the number of children and young people entering Tier 3 CAMHS as this will only be for further assessment or treatment. This will have a knock on impact that the average number of contacts is likely to increase as those who previously would have had a single appointment will now be given the self-management tools or reassurance to no longer require an appointment in Tier 3. Therefore we would expect to see waiting times within Tier 3 reduce due to the anticipated diversionary impact of the Choices service.

Locally we have been working with providers to find a way to measure waiting times from the perspective of the family to first appointment and to treatment, using a system-wide date of referral based on first contact with the system, regardless of provider organisation and with treatment defined as ‘commencement of treatment in line with the care plan’ as defined by clinician. However nationally there is also work going on to develop access and waiting time standards and in the interim NHSE are defining treatment as two or more contacts, and includes data on those waiting for treatment. We will be using this data to determine the success of a waiting list initiative funded through the additional non-recurrent money allocated by NHSE. We will use the funding to support pathways which we have identified as having the highest waiting times, these include ADHD and CAMHS Learning Disability and ASD Services and those provided by voluntary sector.

3.3.2 DNA (Did Not Attend) Rates

Currently DNA rates for services are as outlined in the table below. National examples of good practice where appointments are delivered on an outreach basis have DNA rates as low as 0%, this is locally the case for the MST service where the model is completely outreached. The latest national benchmarking data is 2013, for which the range was 2%-25% and the average 11%, in 2012 it was 12%. As demonstrated below local figures vary considerably. AOT's DNA rate is higher than would be anticipated for an outreach service and Open Door need to do some work to increase their understanding of why children and young people are not attending follow up appointments, though the improvement over the three years is recognised.

The profile of the service user will be an influencing factor, open door which provides services to teenagers who will often be attending on their own would be expected to have a higher DNA rate than CAMHS LD where parents will be a taking them. Learning from services with low DNA rates should be shared across providers and all services exceeding 12% should complete an audit of people referred to gain a better understanding of what deters people from attending, this will be completed in 2016/17.

Table 13: Did Not Attend rates and follow up rates of by CAMHS of those DNAs 2013/14 and 2014/15

	DNA RATE 1st Appointment		DNA RATE FOLLOW UP	
	2013/14	2014/15	2013/14	2014/15
BEH- Generic CAMHS	15%	17%	14%	13%
BEH- AOT	16%	14%	13%	14%
BEH- CAMHS LD	10%	17%	6%	6%
Open Door	2%	2%	13%	10%
Tavistock & Portman- General	5%	5%	6%	6%
Royal Free (Generic & Eating Disorders)	12.90%	4.30%	6.10%	6.80%
Brandon Centre- MST	0%	0%	0%	0%
BEH- HEWS	Not Avail	8%	Not Avail	13%
Whittington- PIPS	Not Avail	11.6%	Not Avail	11.6%

3.3.3 Length of Interventions

Haringey services have significantly longer lengths of intervention than CORC comparator services. Across CORC in 2013/14 94.4% of cases were closed within 6 months, within Haringey the averages over 2013/14 and 2014/15 were:

Table 14: Length of time on intervention caseload 2013/14 and 2014/15

Service	Average Length of Intervention in Weeks (13/14)	Average Length of Intervention in Weeks (14/15)
BEH- Generic CAMHS	62.9	99.7
BEH- AOT	54.4	56.3
BEH- CAMHS LD	141.4	127.1

BEH- HEWS	37.4	37.7
Open Door	39.0	38.0
Tavistock & Portman- General	43.0	27.0
Royal Free (Generic & Eating Disorders)	64.3	80.4
Brandon Centre- MST	24.0	24.0

Figures for 2014/15 show similar or increased averages across all services except for Tavistock and Portman who dramatically reduced their average length of intervention to 27 weeks. Data on the length of intervention was looked at across three years, using the average, median and longest length of treatment. From this it is clear that local treatment times far exceed the benchmarked standard. The median for tier 3 should not exceed six months, but this is the case across a number of services.

At Tier 2 the average and median should be far lower, and whilst Tier 2 lengths are lower they are still not within the expected range. Delivery of interventions across services should be more focussed, outcomes should be used routinely as part of case supervision, and approaches should be regularly reviewed to ensure they are meeting the desired outcomes. In addition expectations should be managed by services so that children and young people and their families are clear that their engagement with CAMHS is a focussed time-limited piece of work in line with recovery and enablement principles. It would not be appropriate to set a time limit on these interventions as the prescribed length depends on the modality and complexities of the presentation, however changes to practice as described below should help reduce the average and median lengths of intervention.

3.3.4 Single Point of Access

Future in Mind emphasises the need for a single point of access. CAMHS Access currently fulfils that role but is limited to paper/phone call triage, and involves no face to face interaction. CAMHS Access could be developed to offer 'choice' appointments, to place expertise at the front end of delivery systems to establish with children, young people and their families the intervention most appropriate to them, fulfilling a brokerage function. This would need to be developed with young people as one concern often raised by families is that of having to 'retell their story', it would need to be made very clear to families that the individual they met with would not be their ongoing therapist.

A benefit of this would be that it could incorporate a community asset based approach, so that social prescribing and alternatives to mental health treatment services could also be explored with the child, young person and their family. The community has a key role in supporting emotional wellbeing and non-CAMHS resources should be harnessed such as peer mentoring, volunteering opportunities and faith groups. A developed Access Service could also have a function as a 'hub' with information on local resources and provide a central point for signposting. Additionally it would mean that children and young people could be seen sooner, and could be prioritised more easily, diverting inappropriate referrals and ensuring timely follow up for those requiring more urgent support.

2016 Update

The new Choices Service has been designed to facilitate delivery of a THRIVE model approach for Haringey and focuses on the signposting, self-management and one off contacts to support children and young people cope. It provides a face-to-face triage function for those who require ongoing support, promoting engagement by providing better information for the Child/Young Person (CYP)/family on what to expect

from CAMHS. It also provides more detailed information on the CYP/family and their preferences, which is provided, to the services before they commence any treatment with the Child/Young Person, meaning that treatment services are more able to allocate appropriately disciplined clinicians from first engagement.

The service incorporates a community asset based approach, so that social prescribing and alternatives to mental health treatment services are also be explored with the child, young person and their family. The community has a key role in supporting emotional wellbeing and non-CAMHS resources should be harnessed such as peer mentoring, volunteering opportunities, faith groups and parenting support. Choices functions as a 'hub' with information on local resources providing a central point for signposting. Additionally, children and young people will be seen sooner, and may be prioritised more easily, diverting inappropriate referrals and ensuring timely follow up for those requiring more urgent support.

The Service will be a fully evaluated pilot which will include the evaluation of the service itself, including whether it is meeting the outcomes for families, and also the learning from the wider system, such as whether the referral pathways are clear or whether there are gaps or bottlenecks in provision. We will use this data to inform our commissioning intentions over the next few years and support our transformation.

3.3.5 Improved Choice and better resource management

Feedback from young people and parents shows that very few had any choice in the location or setting in which support was delivered. The resource implications of offering choice are often cited as a reason to maintain a clinic approach where there is reduced travel and time between appointments. However the feedback also demonstrates that the majority of children and young people are happy to be seen in a clinic or in a private room in a non-stigmatised community venue. Only 8% expressed a preference for home and only 13% for school; with such small numbers choice could be more available across services.

Additionally when staff were asked where they currently deliver 41% of respondents said they offer appointments solely within a clinic/organisational building setting, when asked where they thought their service should be delivered only 10% thought it should be solely within a clinic/organisational setting, with 73% saying it should be delivered in a mix of clinic and community settings. This is particularly pertinent for hard-to-engage groups. Services should be flexible enough to respond to the needs of the individuals, if engagement in school or at home is required then this must be a possibility for services to deliver. A more flexible, choice-driven model could reduce DNA rates and therefore improve efficiency within services.

2016 Update:

The CAMHS in GP surgeries allows the delivery of tier 2 CAMHS within primary care. Additionally the new Choices service is working closely with Early Help, Schools and Primary Care to deliver its consultations in a range of non-stigmatised community settings.

3.3.6 Use of group interventions

Group CBT is not currently part of the standard offer, however this is an evidence based intervention for both anxiety and depression. The Centre for Mental Health[xv] puts group CBT therapy for children at a cost benefit ratio of 31:1 and group CBT via the parents at a cost/benefit ratio of 10:1 for anxiety and a cost/benefit ratio of 32:1 for group CBT for depression in contrast to individual CBT which has a cost/benefit ratio of 2:1 and is nearly ten times the cost to deliver. Group CBT will not be appropriate for everyone, and this should not replace individual CBT, but should be a complementary part of the offer.

2016 Update:

As part of our Transformation Plan Open Door has been piloting group approaches to eating disorders and self-harm. We will be using the information from this pilot to inform future development and roll-out of group interventions in the Borough.

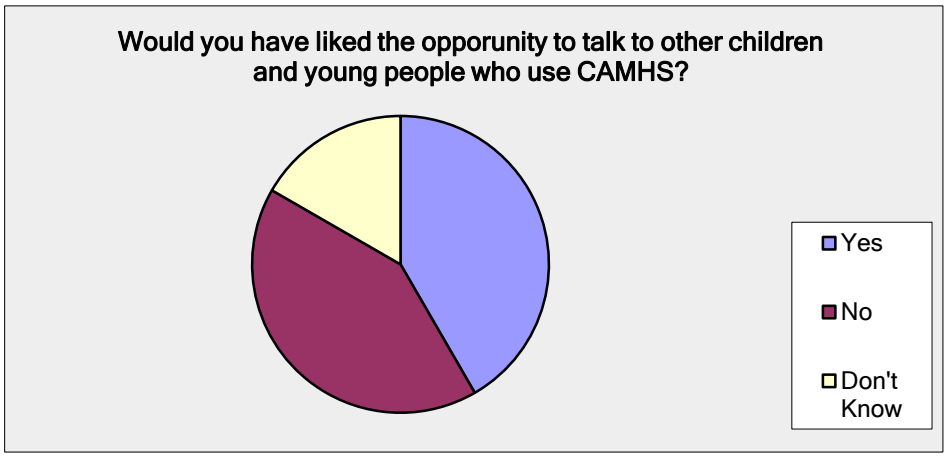
3.3.7 Investment in Early Intervention Services

Investment in early intervention services will ensure that Tier 3 CAMHS is appropriately meeting the needs of children and young people with severe and persistent mental health issues. As noted in the activity mapping there is a disparity between those we would expect to require an early intervention service and commissioned levels. Additionally current tier 3 activity exceeds that expected; if appropriate support were offered earlier, then it should reduce the number of people presenting requiring Tier 3 CAMHS.

This in turn should build capacity within Tier 3 and allow for people to be seen more quickly. An early intervention model will need to be scoped and commissioned building on the learning from the CAMHS in GP practices pilot, which is a brief intervention psychological service currently being piloted by the CCG, based in host GP practices within each GP collaborative. The early intervention offer needs to include developing services which support attachment and a coherent programme of parenting support using evidence based models. A key part of early intervention includes the up-skilling of the wider workforce and ensuring that universal services are equipped to support the emotional needs of the children and young people with whom they are working.

3.3.8 Peer Support for Children & Young People and Parents

Future in Mind highlights the need for development of peer support models for both children and young people and parents. Generally the parents we engaged with felt well supported by CAMHS. One area that emerged during the focus group was the opportunity for parents to talk to other parents of children and young people accessing CAMHS. This was followed up in the online questionnaire and half of parents responded that they would have liked/would you like the opportunity to meet with and talk to other parents/carers. Additionally half of young people said they would like the opportunity to talk to other young people who use CAMHS.



Some models of peer support have already been developed locally. **State of Play** is a partnership model between Tottenham Hotspur Foundation, New Choices for Youth and the Haringey AOT which uses sport as a way of engaging young people in tackling issues around mental health and wellbeing and challenging

stigma. This involves training young people as wellbeing champions and involving these young people in community projects where they can facilitate conversations about mental health and wellbeing. Learning from existing projects should be used to develop a sustainable model for peer support for young people. Work should be undertaken with parents to develop a peer support model that helps parents to understand mental health better and improves their ability to support their child through feeling better supported themselves.

2016 Update:

Barnet, Enfield and Haringey have established a peer support pilot for children and young people and Mind in Haringey have established a group for parents of children and young people with mental health problems. We will be evaluating these pilots by the end of 2016/17 in order to inform ongoing commissioning intentions.

3.3.9 Information and Communication

The stakeholder survey identified that further work is required to provide suitable and accessible information to families prior to attending. 26% of children and young people and 28% of parents said they did not have enough information at the time of the initial referral. This is something that can easily be resolved through appropriate use of resources such as 'my camhs choices', a website built for young people about what visiting CAMHS is like. There is also the need for regular information from all agencies such as leaflets to be updated and provided to CAMHS access so that this information can be provided at triage stage.

The stakeholder and GP surveys indicated that there is a need for better communication with referrers. Throughout treatment and post-discharge better information should be available to referrers, including information if a young person disengages with services, and how the referrer might be able to offer them alternative support.

2016 Update:

Significant work has been undertaken to improve communication with referrers, through the Mental Health Links in Schools Pilot we have developed a pro forma to provide feedback to schools on referrals made to CAMHS and Barnet, Enfield and Haringey Mental Health Trust have delivered GP training to improve understanding of the role of CAMHS and child and adolescent mental health within primary care. We are also developing a handbook for social care staff to help them to support children and young people to access services.

3.3.10 Digital Access

Future in Mind highlights the need to develop digital solutions. These can be used to both support access into services, and as a therapeutic resource. In Haringey services are currently not making the best use of technology. There are a range of resources such as 'mycamhschoices' for young people and 'MindEd' aimed at professionals which are being underutilised and under-promoted. Additionally there is currently no access to online therapy for children and young people and this is an area that should be developed. Some CAMHS services are offering online consultations and treatment appointments to provide flexibility for children and young people where they are not either willing or able to attend a clinic setting, this should be developed to promote choice and engagement. Use of apps should be supported by CAMHS clinicians, and professionals

working in universal services. Many are being developed in collaboration with children and young people and including:

- Silent Secret
- Madly in Love
- Moodbug
- Well Informed
- In Hand
- Headmeds
- Doc Ready
- Find Get Give

Awareness of these apps is also low amongst professionals and work should be undertaken to showcase and promote their use.

2016 Update:

Barnet, Enfield and Haringey Mental Health Trust are developing their website, additionally choices will be signposting to digital resources and we have integrated use of silent secret into our transition pilot.

3.3.11 Crisis Support

There is no agreed definition of what is meant by a 'mental health crisis' but Mind defines it as when a person is in a mental or emotional state where they need urgent help. Currently there is no out of hours community support and the pathway in crisis is via Accident and Emergency Departments. Hospitals have access to telephone psychiatric support which is available on a rota basis 24/7 for emergency presentations, but there is no facility for the physical presence of a child mental health professional. In many cases this use of Accident and Emergency is completely appropriate, where there is self-harm and the physical needs of the young person require attention. However there is no alternative pathway for out of hours support where self-harm is not presenting, and where the only health requirement is a mental health assessment. This should be considered in partnership with other local boroughs or through joining up with social care out of hours support.

Within office hours the Adolescent Outreach Team provides the role of crisis and home treatment, however it also fulfils a number of other functions such as early intervention in psychosis, assertive outreach and supporting children and young people with emerging personality disorder. The role and remit of this team should be further considered as part of the work to look at crisis models.

Only 50% of parents and 75% of young people said they knew what to do in a crisis, this was also an area highlighted in the parent focus group. Better crisis planning needs to be in place including information given to parents of who to contact and what to do should a crisis arise, especially out of hours.

Haringey has consistently had lower than the England average rate of self-harm over the last 5 years, the 2013/14 figures as stated in the June 2015 Child Health Profile[xvi] for Haringey are as follows:

Table 15: Recorded hospital admissions of Haringey young people for deliberate self-harm 2013/14

	Local Number	Local Value	England Average	England Worse
Hospital admissions as a result of self-harm (10-24 years)	81	173.7	412.1	1246.6
		Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14		

Despite numbers being significantly lower than the national average this measure only relates to hospital admissions for deliberate self-harm, and national intelligence indicates that hospital admissions are only a very small percentage of self-harm. Certainly colleagues locally, across agencies, express concerns around self-harm, evident across both social work and school staff. When asked 'Do you think Schools have adequate support and resources to meet these needs?' eight of the twelve schools responding to this question identified training in mental health for staff as a gap.

If young people displaying self-harm are not presenting at hospitals then focusing our entire self-harm pathway around A&E is outmoded. Open Door report that 43% of under-18s that they see present with self-harm; and 29% of the parents accessing the Parenting Teenagers Project report knowing that their child has self-harmed. There is currently little information available on self-harm for parents locally and limited availability of literature on self-management, these are areas where investment could be targeted.

Crisis cover at the A&E at the Whittington Hospital is provided by the Whittington's paediatric mental health liaison team, this is currently commissioned through the acute contract. Assessment at North Middlesex University Hospital Trust is provided by Barnet, Enfield and Haringey Mental Health Trust's Adolescent Outreach Team (AOT) for under 16s and RAID for 16 and 17 year olds under the mental health contract.

Table 16: Recorded assessments at North Middlesex Hospital by AOT 2012-2015 (part year)

Calendar Year	AOT Assessments at North Middlesex
2012	16
2013	18
2014	20
2015 (Jan-May)	18

Presentations requiring attendance from the AOT equate to less than three a month over the last few years. Data from 2015 shows an increased level of assessments in the first five months and this will need to be monitored. Data should be combined with that of the Whittington, which was not available for inclusion in this review. A&E attendance data for 2014/15 from Hospital Episode Statistics indicates one presentation a week of Haringey patients across all hospitals. Consideration needs to be given to the different paediatric mental health liaison models across the two acute hospitals. Both the North Middlesex University Hospital and Whittington Hospital have liaison paediatric mental health teams, however only the Whittington team deals with crisis presentations and has out of hours cover.

The volume of out of hours crisis presentations is unlikely to warrant a 24/7 staffing model, however work should be done to scope what can be implemented. Currently young people presenting at North Middlesex University Hospital on a Friday evening will have to wait until Monday to be seen by the AOT. An on-call rota that covered Saturday and Sunday mornings could be a more economical way of providing expedited assessment. Scoping should be done in partnership with other CCGs to develop out of hours support across the three boroughs, to benefit from the increased scale and this work should include out of hours support where self-harm is not evident.

Stakeholders identified training needs across the workforce to enable them to respond appropriately at crisis point, this is also something that could be developed jointly. Stakeholders reported that Section 136 arrangements under which police detain an individual for the purposes of a mental health assessment are unclear. However as the suite at St Ann's only offers adult service mental health professionals, A&E is likely to be the most used place of safety for children and young people. Currently though, these assessments are

not being recorded routinely by hospitals, and therefore levels of use are unclear. In addition to Section 136, mental health assessments in custody are completed by the Diversion and Liaison Service, the vast majority of which are for boys. Stakeholders reported that young people may be kept in cells awaiting assessment out of hours and this will need to be looked at in more detail.

The recently published 'Improving the care of children and young people with mental health crisis in London: Emerging findings with recommendations for transformation of Services' states that approximately 50% of children and young people who attempt suicide fail to receive follow up mental health treatment and 77% of those who do are non-compliant with their outpatient treatment. This is not anticipated to be the case in Haringey given the current arrangements but work will need to done to look at this in more depth to provide assurance given these stark statistics. Communication with primary care and schools is key to ensuring ongoing engagement of these at risk children and young people who do not engage with CAMHS.

2016 Update

Earlier in the year we completed a review of crisis services in Haringey, this has confirmed gaps in out of hours provision and unclear pathways for section 136. As part of this review service users and parents were interviewed to get some qualitative data around patient experience of the crisis pathway. We are now working across NCL to look at addressing the identified issues as part of co-commissioning arrangements with NHSE for inpatient services. Further details are included in Part Two.

3.3.12 Inpatient CAMHS

Haringey CCG were provided information by NHSE relating to 22 of Haringey's children and young people admitted to Tier 4 inpatient resources: 12 in 2013/14 and 10 in 2014/15. These 22 children and young people represented 25 admissions as two young people moved unit during the course of their admission. Readmissions were at 0% compared to the London provider survey rate of 14%[xvii].

Of the 25 admissions to different units 44% (11) of the admissions over this two year period were to Barnet, Enfield and Haringey's 12 bedded acute adolescent unit, the Beacons, based in Edgware.

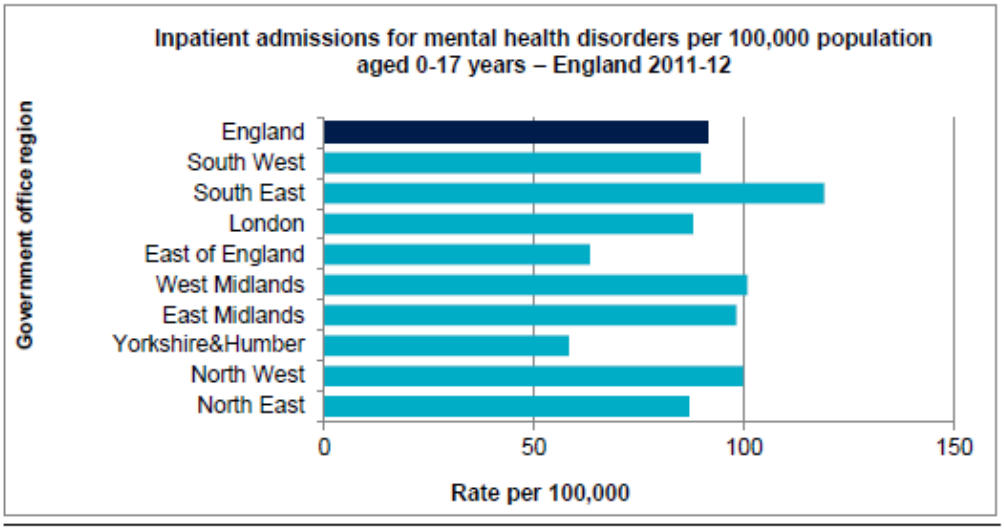
72% (18) of all admissions were within London, with a further 16% (4) within the neighbouring counties. Of the 12% (3) that were further afield, one of those was a specialist unit, one was the admission of a looked after child placed out of Borough, and one was a short term admission (10 days) when the young person was repatriated to a London unit. No issues were identified by NHSE in relation to the local CAMHS team response, however close working with NHSE is required to monitor out of London placements and ensure appropriate liaison from the local CAMHS service to support discharge planning.

Where issues have emerged around the inpatient pathway over the last two years it is in relation to looked after children, whose social care placement often ends when admitted to an inpatient unit. In order to be discharged they need a local CAMHS team identified and engaged in discharge planning however they cannot be referred to a local team without knowing where the placement will be. They cannot register with a GP prior to placement, and therefore they are currently falling between CAMHS teams and responsibilities. This is an area that should be picked up through the redevelopment of the First Step LAC screening and assessment service specification for 2017/18.

Staff within CAMHS were asked how they would rate the effectiveness of the pathway into inpatient services, and their perception was that access to a Tier 4 bed is difficult. Although many responding staff

noted that they did not have personal experience of the process. The current system means that the admitting team must find a bed, from a circulated list of vacancies that very quickly becomes out of date, finding an appropriate bed can sometimes take days. NHS England's Specialised Commissioning Team do not take responsibility for commissioning at the point at which the need for a bed is established but at the point at which the child/young person is admitted, therefore if all their commissioned beds are filled then the young person requiring the bed is the responsibility of the community team or the paediatric ward on which they are staying to manage until one becomes available. This is something which is being managed at present, and which is part of the national model to manage an expensive and limited resource.

Within Tier 4 based on the 22 cases examined the inpatient length of stay for Haringey children and young people ranged from 14 days to 555 days with an average of 142.76 occupied bed days per admission. There is little published data on the rate of inpatient admissions across CAMHS, the approximate rate for Haringey is 38 per 100,000 children and young people (0-17yrs). The NHSE Tier 4 report shows rates across England are much higher than in Haringey.



Future in Mind requires closer working between NHSE and local CCGs to co-commission to prevent inappropriate admission and facilitate safe and timely discharge. From the figures and feedback gathered through this review these are not issues that are currently evident in Haringey, though we will engage with discussions across Barnet, Enfield and Haringey and look at developing co-commissioning models as they emerge.

2016 Update:

NHSE has now compiled additional data for all CCGs and for Haringey this is as outlined below:

Table 17: NHSE Supplied Admission Data

Data Source	NHS E	NHS E	NHS E	NHS E	NHS E
Year	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 total
Haringey estimated population 2016 aged 0-18 **31,504** (GLA, 2015)					
Admission	22	16	10	4	14
LOS London	1,331	1,532	435	151	586

Cost	£679,371	£821,833	£500,394	£94,219	£594,613
Av Cost	£510	£536	£1,150	£624	£1,015

BEH-MHT have now centralised the bed management function so that individual clinicians across the Trust are not simultaneously attempting to find a bed.

We are working across NCL to develop co-commissioning arrangements with NHSE and further information on this is provided in Part 2: North Central London CAMHS Transformation Plan Priorities.

3.3.13 Eating Disorders

The current pathway for eating disorder is via CAMHS access into the Royal Free eating disorder service which is commissioned across North Central London (NCL). This is an intensive service that has the flexibility to offer community support and reduces the need for admissions. This service has good outcomes and Haringey admission rates to Eating Disorder beds are low. Part of the transformation funding has been specifically ring-fenced for eating disorders in response to national inadequacies in commissioned provision, NICE compliant services and alternatives to admission. However Haringey is currently investing £256,280 a year in this service, which in 2013/14 accepted 13 referrals out of 15 and in 2014/15 accepted 14 out of 17. This is in contrast to Barnet figures of 62 and 49 for the respective years.

We have benchmarked our spend both with our peers and against the estimated costs in the eating disorder commissioning guide[xviii] (section 4.3.4) and have found that we are over-investing in this service based on our activity. The Royal Free have self-audited as not meeting the waiting time requirements of the new guidelines, however given the currently high level of funding from Haringey we will need to work with NCL commissioners to ensure any investment into the service is done on the basis of value for money and with consideration of current investment and usage levels. It is therefore not envisaged that we use our Eating Disorder allocation for further investment in this service.

Nationally it is believed that eating disorder prevalence is increasing, a study by UCL Institute of Child Health demonstrated a 15% increase in those diagnosed with an eating disorder between 2000 and 2009, with the biggest increase in eating disorders not otherwise specified (not anorexia or bulimia nervosa). This increase puts the estimated prevalence rate at 37.2 per 100,000 for ages 10-49. Incidences of eating disorders were seen to vary by sex and age with adolescent girls aged 15-19 years having the highest incidence of eating disorders (2 per 1,000)[xix]. Using 2014 ONS figures this means Haringey would expect to see 29 new cases a year just in the 15-19 year old age bracket, double current referral rates to the Royal Free service. For eating disorders falling under the classification ‘eating disorders not otherwise specified’ the peak age for diagnosis is 10-14 years, making it another key area to explore, working closely with primary care.

Open Door are reporting 24% of their activity as presenting with eating problems, suggesting that eating problems are an issue for our children and young people locally. It is proposed that it is at this early intervention level where funding is targeted. This may require upskilling within existing provision to ensure NICE compliance across the pathway or specifically commissioning an early intervention approach for this cohort. Investment from the eating disorders allocation can also be used for addressing self-harm in localities where eating disorders are not regarded an under-invested area. This could be done by using the eating disorders allocation to integrate support for self-harm and eating disorders into the early intervention model.

2016 Update:

As part of our early intervention approach to eating disorders, Open Door are delivering group interventions for Haringey young people displaying early symptoms of Eating Disorders and/or self-harm in an attempt to reduce the likelihood of escalation into requiring specialist ED and/or crisis services.

Further information on the work we are doing across NCL with the Royal Free Hospital NHS Foundation Trust is included in Part 2: North Central London CAMHS Transformation Plan Priorities.

3.3.14 Transition to adult mental health services

A model that's recently been developed and has already been implemented in Birmingham and Norfolk is the 0-25 approach to CAMHS. This is in line with the SEND reforms for planning for children with special educational needs and disabilities. Currently there is a good breadth of provision across this age range in Haringey with access to adolescent services via Tavistock and Portman and with Open Door providing support for young people up to the age of 25. However, pathways are not currently clear on how to access from primary care and this will need to be addressed. As 0-25 models expand and develop it will be necessary to review this in line with the overall model.
Future in Mind makes clear that access to services should not be based on arbitrary ages, but should be based on the developmental stage of the young person. The focus should not be on artificial boundaries but about seamless care, we will therefore need to develop a local response to this if we are not to move to a 0-25 model. This could involve relaxing age restrictions on both CAMHS and adult services to enable the most appropriate provision to the young person to be accessed. For children with learning disabilities closer working between CAMHS LD and the Learning Disabilities Adult Partnership should be developed to ensure effective handover of care.

In late 2014 the Adults and Health Scrutiny Panel completed a panel report on 'Transition from Child Mental Health Services to Adult Mental Health Services'. This identified a number of areas for development which will be taken forward through the local transformation plan. The new approach requires a change to the current model of care, through reducing lengths of intervention, delivering interventions which are more focused and which promote resilience, self-management and enablement.

All CAMHS providers will need to work in partnership with other children and young people's services to ensure that young people can be safely discharged with the support they need. Where young people are likely to require adult mental health services, planning should start early and more work needs to happen to develop information sharing and early transfer planning. Follow up of the Scrutiny Panel actions will be taken forward under our local transformation plan, in the context of improved inter-agency working, better planning and smooth transition.

2016 Update:
In the last year we have held a multi-agency workshop to look at how we can take forward the recommendations from the Scrutiny Panel and improve transition. This has resulted in an action plan being developed in collaboration between CAMHS and adult mental health commissioners and providers. Additionally we have used Transformation Funding to invest in a pilot of a co-designed creative lifeskills course for children and young people who require additional support but will not meet the threshold for adult mental health services.

3.4 Care for the most vulnerable

Just like adults any child can experience mental health problems, but some children are more vulnerable to this than others. These include those children who have one or a number of the following risk factors:

- From low-income households; families where parents are unemployed or families where parents have low educational attainment
- From black and other ethnic minority groups
- Who are looked after by the local authority
- With disabilities (including learning disabilities)
- Who are lesbian, gay, bisexual or transgender (LGBT)
- Who are in the criminal justice system
- Who have a parent with a mental health problem
- Who are misusing substances
- Who are refugees or asylum seekers
- In gypsy and traveller communities
- Who are being abused.

HM Government. 2010. Healthy Lives, Healthy People: Our strategy for public health in England

Data is more easily available in relation to some of these groups than others but where there is not currently data universal provision should be aware of these risk factors in order for them to support the young people they work with for whom these risk factors may apply.

3.4.1 Inequality within the Borough

Haringey is an exceptionally diverse and fast-changing borough. It has a population of approximately 254,900 residents, a quarter of which are under 20 years. The Borough stretches from the prosperous neighbourhood of Highgate in the west to Tottenham in the east, one of the most deprived areas in the Country. Nearly half of the residents and nearly 81% of our school children come from Black and Minority Ethnic (BME) communities and 190 different languages are spoken in our Schools.

High levels of deprivation, low educational attainment and unhealthy lifestyles (smoking, alcohol misuse and low levels of physical activity) primarily in the east of the borough, are all interrelated determinants of poor health outcomes and the considerable health inequalities in the borough. The level of child poverty in Haringey is worse than the England average at 26.8%, with significantly higher levels in the east of the Borough. The rate of family homelessness is also worse than the England average. When examined the CAMHS caseloads for Barnet, Enfield and Haringey Mental Health Trust and Open Door do not reflect the high need in the South East.

The below data show CAMHS caseloads for the two services mapped against the four GP collaboratives, the highest presentations are displayed across the West and North East collaboratives. This may mean that services are not accessible to those in the most deprived areas, and further investigation will need to be done, mapping caseloads against postcodes to ensure the most deprived wards have access. Updated deprivation data is due to be published immanently and should be used to ensure appropriate access across wards. This data reflects a similar picture of the uptake of the 'CAMHS in GP surgeries' project. Work with

primary care in the South East should be done to understand why referral numbers are so low, and what sort of services their patients may wish to engage with.

Table 18: Caseload data per GP collaborative: combined for Open Door and BEH

GP Collaborative	BEH & Open Door Caseload Rate per 10,000 weighted GP population
Central	35.83
North East	41.89
South East	37.27
West	41.02

3.4.2 Diversity and Ethnicity

Haringey has a very diverse population, so it is important to examine the demographic profile of service users against that of the population to ensure that no group are either over or under-represented in services. Across the aggregated service figures for 2014/15 ethnicity was recorded in 69% of cases, not stated in 7% and not known in 24% of cases. In order to get a full understanding of the relative representation of different ethnicities within services, recording figures need to be higher.

The introduction of the new national CAMHS minimum data set should support providers in resolving this issue. From the data recorded the service profile matches very closely with the latest available demographic data (Census 2011) across the majority of ethnicity groupings and it is incredibly positive that providers are meeting the needs of the diverse community within Haringey.

The largest variance demonstrates an under-representation in services of Black/Black British African children and young people. This will need to be monitored once we have more complete data, additionally work will need to be undertaken with the communities within this group to promote CAMHS targeting wards with larger African communities such as Northumberland Park and Tottenham.

Table 19: Haringey demographics population ethnicity and all CAMH services usage. Census 2011

0-17 inclusive	Haringey	Population Percentage	Service Percentage	Variance
All categories: Ethnic group	57,670	100%	100%	0%
White: English/Welsh/Scottish/Northern Irish/British	16,673	29%	30%	1%
White: Irish	451	1%	2%	1%
White: Gypsy or Irish Traveller	174	0%	0%	0%
White: Other White	10,193	18%	18%	1%
Mixed/multiple ethnic group: White and Black Caribbean	2,604	5%	6%	2%
Mixed/multiple ethnic group:	1,316	2%	1%	-1%

White and Black African				
Mixed/multiple ethnic group: White and Asian	1,722	3%	1%	-2%
Mixed/multiple ethnic group: Other Mixed	2,351	4%	8%	4%
Asian/Asian British: Indian	698	1%	0%	-1%
Asian/Asian British: Pakistani	505	1%	0%	0%
Asian/Asian British: Bangladeshi	1,463	3%	1%	-2%
Asian/Asian British: Chinese	576	1%	0%	-1%
Asian/Asian British: Other Asian	1,504	3%	2%	-1%
Black/African/Caribbean/Black British: African	7,734	13%	7%	-7%
Black/African/Caribbean/Black British: Caribbean	3,927	7%	11%	4%
Black/African/Caribbean/Black British: Other Black	2,894	5%	5%	0%
Other ethnic group: Arab	593	1%	0%	-1%
Other ethnic group: Any other ethnic group	2,292	4%	8%	4%

2016 Update:

Barnet, Enfield and Haringey Mental Health Trust in collaboration with Mind in Haringey have started work to better engage with faith and community groups to promote emotional wellbeing within some of the above communities in Haringey and to examine some of reasons behind the figures included above.

3.4.3 Looked After Children

Haringey Council is responsible for 451 looked after children (as at 31st March 2015), of those 121 live in the Borough of Haringey and 330 are placed out of borough. In addition to those looked after children who are the responsibility of Haringey Council there are a number of children placed into Haringey from other areas who require access to local CAMHS services, the data has not yet been published for 2014/15 but in 2013/14 there were 115 children and young people placed into Haringey by other local authorities.

NHS Responsible Commissioner Guidance places the responsibility for health commissioning on the CCG to which the child or young person was registered at the time of coming into care, so that Haringey CCG and Council have the same population to plan for. In order to better understand the mental health of Haringey's looked after children the Council commissioned the Tavistock and Portman to provide the First Step service. This service provides screening of all children and young people coming into care and annually thereafter through the Strength and Difficulties Questionnaire (SDQ). It then provides consultation to social workers and foster carers and up to six sessions with the children and young people where the SDQ results are outside of the normal range.

In some areas targeted services for Looked After Children (LAC) are commissioned by social care in order to provide either a lower threshold for LAC (Tier 2) or an expedited service. In Haringey the decision was taken to focus resources on broader screening and thorough assessment. This approach means that there is a far better understanding of the mental health of the whole looked after population, and issues should be picked

up swiftly. However national data indicates the average SDQ score for Haringey LAC has increased in 2013 and 2014 demonstrating a higher level of need. Between 2009 and 2012 Haringey average SDQs were lower than the national and London average, however in 2013 and 2014 averages exceed the London average, but remained lower than the national average. In terms of the rate falling within the normal range, this have gone from 59% in 2012, to 48% in 2013 and were at 54% in 2014. This means that there may be as many as 200 looked after children requiring some form of emotional or mental health support.

The limitations of the current First Step model are that it does not pick up those on the edge of care, nor provide longer term work. This means that those requiring a CAMHS intervention have to be referred to their local CAMHS which can then mean long waiting times due to the variability of CAMHS around the Country. Additionally stakeholders identified that for 0-5s it would be useful to have a fuller psychological assessment and liaison at the point of entering care. For this cohort there is a low return rate for SDQs and because the SDQ is age 3+ and does not fully reflect the psychological difficulties which may not yet be presenting symptomatically.

For those on the edge of care wrap-around provision for families should be available to include psychological support. To this end Children and Young People's Services are looking at having CAMHS and adult mental health practitioners hosted into targeted social care service for families with complex needs. Currently 0.5 WTE of a BEHMT CAMHS practitioner is working with edge of care services. Further work with Children and Young People's Services is required to understand how CAMHS can be integrated into social care to provide a multi-agency, multi-disciplinary approach that meets the needs of families with complex issues.

There is currently a lack of awareness across social care teams on how to refer to CAMHS and the remit of CAMHS provision. This is a fundamental pathway for children who are known to social services and all social workers should have clear understanding of how to refer and liaise with local CAMHS Services. In order to support social workers and team managers a tool and training should be developed to outline the processes by which children and young people can access mental health support and how they can ensure funding is in place from the responsible commissioner. It will also need to support social workers' understanding of what type of issues can usefully be referred to CAMHS and what sort of interventions can be implemented by the network around the child/young person.

Some looked after children may experience multiple placements in the course of a year. Whilst this is a small minority of cases, for these children there is a real lack of available CAMHS support as with every move a new referral to a new CAMHS service means they start at the bottom of the waiting list. Recent First Step data over the last 9 months shows 13 children and young people have had 10 or more placements and 81 have had over five. In order to meet the needs of this cohort, it is recommended that First Step have the flexibility within their contract to provide therapeutic support throughout the transition period. For some longer term interventions a stable placement is needed in order to successfully provide the intervention. However bridging support should be provided as the chances of a placement stabilising is likely to be increased if emotional support is continuously available to the child/young person and their carers.

Longer term work can then be initialised and planned as part of a coherent care planning approach, with an adequate understanding of the child/young person's needs. Additionally as noted earlier when a young person is being discharged from an inpatient provision there is a role for a holding clinician to support in order to facilitate the finding of an appropriate placement and a transfer to local CAMHS. As the number of looked after children has reduced over the last few years so has the funding for First Step, investment will

have to be considered in the context of the amendments made to the specification, and treatment provision could be piloted prior to any significant changes to the current model.

Another area identified by stakeholders is the lack of support to foster carers. The Virtual School, which supports the education of looked after children is currently training supervising social workers in how to create an emotionally friendly home, using the How to BE Tool. Support on this and other training on trauma and attachment should be developed directly for foster carers. Further to this CAMHS services should work in partnership with foster /kinship carers to deliver support for children and young people where they are not willing to engage. Services should also be accessible for adoptive partners, kinship carers and carers of children under Special Guardianship Orders, promoting attachment and supporting the stability of the family placement.

All CAMHS services should have the skills to adequately address the mental health of looked after children. LACS living in Haringey have access to the Fostering, Kinship and Adoption team at the Tavistock and Portman, while those placed out of Borough receive their local CAMHS service. Barnet Enfield and Haringey Mental Health Trust are currently not seeing Haringey's looked after children; this is an area that needs to be addressed as services should be based on need and the presenting issue rather than social care status. The Tavistock fostering, kinship and adoption treatment services should be targeted for those with specific issues arising from their trauma and familial separation. In order to ensure that services are sufficiently equipped to meet the needs of all looked after children living in Haringey BEHMHT will need to review training for their staff to meet the needs of this cohort. Interagency working and liaison is a necessary and intrinsic part of this work and BEH should feed into planning and support processes as required.

Care leavers are a group of particularly vulnerable young people, often having had traumatic experiences and without the familial support networks that many young people rely on when moving to independence. Mind in Haringey have been working with young care leavers to support transition, however the contract for this ends in December 2015. The outcomes of this work should be considered and mechanisms should be put in place for better identification of care leavers within mental health services, as this is not currently a recorded group. Further work is required to understand the levels of need and consider how this is met for the future in collaboration with adult mental health commissioners.

2016 Update:

As part of our Transformation Plan we have developed a 'First Step Plus' service, building on the First Step screening and assessment service delivered by the Tavistock and Portman NHS Foundation Trust. This new service is working with approximately ten complex young people who have had multiple placement breakdowns and who therefore have not been able to successfully engage with a local CAMHS. The team work with a child or young person no matter where they're placed in the Country, delivering direct interventions and/or support to the placement and network as appropriate to the needs of the child/young person.

3.4.4 Children with Disabilities and Special Educational Needs

Learning Disabilities

According to national statistics 40% of families with children with learning disabilities feel they do not receive sufficient help from medical professionals, social workers or mental health services.[xx]

The 2007 Report by Lancaster University 'The Mental Health of Children and Adolescents with Learning Disabilities in Britain' identified an increased risk of mental health problems for children with learning disabilities across all types of psychiatric disorders, with over 1 in 3 children and adolescents with a learning disability in Britain having a diagnosable psychiatric disorder, whereas the rate for the general population is estimated at 1 in 10. Their data suggests that children with learning disabilities are:

- 33 times more likely to have an autistic spectrum disorder
- 8 times more likely to have ADHD
- 6 times more likely to have a conduct disorder
- 4 times more likely to have an emotional disorder
- 1.7 times more likely to have a depressive disorder

In Haringey there is a specialist team dedicated to supporting these young people which was jointly commissioned in 2007 between the local NHS and the Council. The CAMHS Learning Disability Service (CAMHS LD) provided by Barnet, Enfield and Haringey Mental Health Trust is a small team comprising psychology and psychiatry. It provides support to children and young people who present with behavioural and/or mental health difficulties associated with learning disabilities. This service is currently aligned to BEHMHT CAMHS and this model seems to be working well with skills embedded across BEHMHT CAMHS.

The model of delivery is linked well into the local special schools and the Disabled Children's Team and provides a good example of inter-agency working. Additionally Open Door provides a specific service for teenagers with special educational needs and disabilities funded through BBC Children in Need. Feedback from the staff survey demonstrated that staff across services feel confident in addressing the mental health needs of children and young people with learning disabilities. In Haringey the estimated figure for children with a learning disability and mental health problem (2014) is 380 children and young people between 5 and 19 years[xxi]. The CAMHS LD service has a caseload of approximately 85-95 and accepts approximately 30 new referrals a year, therefore we may need to consider service capacity.

Autism Spectrum Disorder (ASD)

The National Autistic Society cites data estimating that 1 in 100 children have autism, and that more than seven in ten children with autism have a co-morbid mental health problem. They argue that many of these problems are preventable with the right support and that changes to the way that CAMHS are delivered can stop them from occurring. In Haringey local data shows prevalence to be much higher than one in a hundred, with referrals for autism assessment increasing significantly in the last few years (from 97 in 2011 to 229 in 2014). Local paediatric services report that between 2/3rds and 3/4s of referrals result in a diagnosis. With figures at this level autism within the Borough far exceeds the approximate number of cases a year we would expect to be diagnosed on the basis of prevalence data.

The current diagnostic pathway for children and young people is via the paediatric social communication and neurodevelopmental clinics for under 12s and via Great Ormond Street Hospital for over 12s. Specialist CAMHS currently do all ADHD assessment and treatment, and this split means that despite the high likelihood of co-morbidities there is no current mechanism for joint clinics between paediatrics and CAMHS. Psychological input into autism assessments will provide increased capacity, improved assessments and better integrated care for families; this is an area that should be developed whilst scoping the feasibility of providing a local diagnostic service for all children and young people within Haringey.

The CAMHS LD service will see young people with autism with a mental health or challenging behaviour issue but they are not currently commissioned to provide early intervention post diagnostic support, where these needs are not yet presenting. Neither does the Child Development Centre provide any psychological support. A key area to be considered for investment is the development of post-assessment follow up psychological and group support. This could be developed for families to support attachment, and help the families to accept and understand the diagnosis.

Sensory difficulties are commonly associated with attachment disorders, autism and ADHD. Occupational Therapy input as part of the autism diagnostic process and post diagnostic care is currently another gap. Increased access to Occupational Therapy as part of this pathway could reduce challenging behaviour related to unidentified or unmanaged sensory needs. This could prevent behaviour escalating to a level where medication is required and/or the family are unable to cope and expensive residential settings are necessitated. The CCG and Council are currently reviewing the whole life pathway for autism and this will need to be considered within that context.

Special Educational Needs

The SEND (Special Educational Needs and Disabilities) Reforms placed extended duties on health, social care and education services to work more closely in planning for children with special educational needs and disabilities. To date CAMHS involvement in the Education, Health and Care plan process has been limited. Training for staff is required to ensure they are aware of the duties and role of health professionals in this process.

Chronic physical health problems

Children with a long-lasting physical illness are twice as likely to suffer from emotional problems or disturbed behaviour. This is especially true of physical illnesses that involve the brain, such as epilepsy and cerebral palsy. Locally paediatric mental health liaison supports the integration of physical and mental health support, though joint clinics between community paediatrics and CAMHS would also provide additional skills within paediatrics to support this cohort.

2016 Update:

Issues have arisen relating to diagnosis for over 12s who were previously being seen at GOSH, who have adjusted their criteria and now only provide second opinions on complex presentations. In the short term we have agreed cover with the Tavistock and Portman NHS Foundation Trust's Lifespan service, however we need to find a longer term solution and this is an opportunity to develop a more local service. Additionally a joint working group between community paediatrics and CAMHS has been established and we have developed joint case discussion meetings with a view to developing closer working and looking at the possibility of joint clinics. We are also using this meeting to look at neurodevelopmental pathways and assessment processes. As part of the Transformation Funding we have established a CAMHS worker, hosted into the community paediatric service to provide post-diagnostic support to families.

3.4.5 Lesbian, gay, bisexual and transgendered (LGBT) Young People

Mental health and emotional wellbeing services often do not ask about or know the sexual orientation or gender identity of the young people who access their services. However a high percentage of LGBT young people have mental health problems, aspects of which are often related to coming to terms with their sexual

orientation and stigma. As such it is important to be aware that a proportion of young people being referred to CAMHS or to emergency departments in the case of self-harm, are likely to be in this vulnerable group. In order to do this we need to provide a culture of service delivery which promotes equality and safe disclosure. Additionally according to The School Report by Stonewall many of the emotional and mental health issues experienced are rooted in bullying and stigma. Schools have a role to play in promoting inclusive communities with a zero tolerance for bullying.

3.4.6 Young Offenders

A study completed by the Centre for Mental Health identified that poor mental health and childhood behavioural problems were a key risk factor for female gang affiliation, with nearly 40% of girls with gang associations having shown signs of behavioural problems before the age of twelve. Other risk factors included poor maternal mental health, exposure to violence in the home and experience of trauma. More broadly young women involved in violence or crime (and particularly those in custody) often have significantly higher levels of mental health problems that their peers and are more likely to self-harm or attempt suicide.

Point of arrest screening identified 10% of girls in gangs with suspected development difficulties (such as ADHD or autism) which is roughly comparable to rates found in males in the same sample and five times that of other females[xxii]. International studies also demonstrate higher levels of girls with ADHD in custody[xxiii]. Locally MAC-UK have been working in Haringey since November 2014 with 16-25 year olds to improve links between at risk young people and mental health support including through streetherapy, taking mental health provision out of clinic settings into the community and integrating it into wider engagement work.

In 2014/15 Haringey had 272 young people within the youth criminal justice system and the Youth Offending Service is currently working with 194 young people. The Haringey YOS has access to 0.3WTE CAMHS worker via Barnet, Enfield and Haringey Mental Health Trust. Additionally NHS England commission 1WTE post to screen first time entrants to the system (at arrest point) and those at Police stations. National research indicates a high prevalence of mental health conditions in youth offending and studies have indicated rates can be as high as 70%[xxiv]. Services therefore need to be integrated and accessible. This is an area for development and current resourcing should be increased in order to provide meaningful input into the youth justice pathway. 0.3WTE is insufficient to carry out assessment, consultation (for staff) and treatment for young people engaged with the YOS on Court orders and subject to formal interventions.

One of the evidence based interventions for these vulnerable young people is Multi-Systemic Therapy. It is an intensive in-home programme aimed at families of children aged 12-17 who are at risk of, or who have a history of arrest. It seeks to empower parents with the skills and resources to address the difficulties that arise in raising teenagers and to empower young people to cope with family, peer, school and neighbourhood problems. This was previously commissioned for ten of Haringey's young people, however in April 2016 the existing provider gave notice and we are yet to re-commission this service. We are currently examining the best approach to meet the needs of this high risk group.

2016 Update:

We are currently working with the Ministry of Justice to co-commission liaison and diversion services and mental health support to those on the youth justice pathway. We have identified that additional resource is

needed locally and are looking at how we use this to form an integrated approach with the MoJ commissioned provision. We are holding a multi-agency workshop in November 2016 in order to map current provision and look specifically at groups such as Looked after Children/care leavers and children and young people with Special Educational Needs and Disabilities to ensure that pathways are in place that meet their needs.

3.4.7 Young Carers and Parental Mental Health

According to the report produced by the Princess Royal Trust for Carers 'At What Cost To Young Carers' the implications of being one of the UK's 177,918 (2011 census) known young carers, include the risk of truancy, under-achievement, isolation, mental and physical ill health, poverty and stress. These risks are particularly acute for young people affected by parental substance misuse (250,000 young people in the UK), parental alcohol misuse (1.3 million young people) and parental mental health problems (4.2 million parents).

An increase in the number of unpaid carers aged 5 to 17 was observed in all regions between 2001 and 2011 (ONS). In England and Wales combined, the number of young unpaid carers increased by almost 19% during this period. The South East had the largest increase of 41.2%.

Haringey has the third highest rate of severe mental illness in London and a regular concern reported by Schools is supporting children and young people where parents have mental health needs. Interactions with families affected by parental mental ill-health often become very difficult for schools and they are often left feeling very isolated in dealing with complex situations and dynamics within the family whilst seeing the child struggle to access education. Adult mental health services should be trained in thinking about the holistic needs of the family including support to children where a parent is receiving support for their mental health.

In addition to parents affected by severe mental illnesses, many Haringey parents experience less severe but still debilitating anxiety and depression, often linked to financial or housing difficulties, or domestic violence. Haringey has high levels of lone parent households designated as statutorily homeless. Domestic violence is the most common reason for contact with children's social services in every ward across the borough, and 58% of parents contacting Hearthstone, the local voluntary sector agency supporting families affected by domestic violence, have mental health problems. Children whose parents are struggling with these issues may be both directly and indirectly affected in terms of their emotional wellbeing.

In Haringey parents with mental health problems have access to Kidstime. This provides workshops for children, young people and their parents who are affected by mental illnesses. It's a safe place where children and families can have fun, learn and get help and support from people who understand what's going on in their lives. The Kidstime workers create an environment which fosters a mixture of informal and intimate relations combined with their professional responsibility to protect both adults and young people.

In July 2015 the Department of Health and Department for Education launched a joint bidding process to pilot approaches for vulnerable groups in schools as part of their response to 'Future in Mind'. Haringey was successful in its bid to look at how this group can be supported, and was allocated £100,000. The pilot includes training for school staff in parental mental health and emotional wellbeing and resilience building support to young carers, however funding is only for 2015/16 and we must therefore consider sustainability. Additionally we currently have no data on the numbers of young carers accessing mental health services, or the mental health of our young carers and this should be developed to better inform planning.

2016 Update:

Using the pilot funding we have been working with schools in the borough to improve awareness of, and support to young carers. The pilot has been delivered by a partnership between Haringey SHED, Haringey Council, Barnet, Enfield and Haringey Mental Health NHS Trust and Family Action, with support from Haringey CCG. Haringey SHED worked with young people to produce a video, which is available on youtube as a training resource to professionals on what it means to be a young carer:

https://youtu.be/4sETL7nZSvA

This resource has been integrated into a training package that has been delivered to adult mental health teams, and will soon be rolled-out to Children's Services staff in the Council. The training seeks to explore the emotional impact of being a young carer, and how they can be supported. Additionally parent information sessions and drop-ins have been established in pilot schools. We are now reviewing our Young Carer offer and using the outcomes of the pilot to inform this.

3.4.8 Refugees and Asylum Seekers

Refugees and asylum seekers currently have access to specialist trauma services via the Tavistock and Portman contract. Benchmarking data for 14-15 has not been published yet but as at 31st March 34 unaccompanied asylum seekers were looked after by the local authority in Haringey. Further scoping work needs to be completed about the mental health needs of this cohort and their ability to access support.

3.4.9 Abuse and Sexual Assault

> A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by others (eg via the internet). They may be abused by an adult or adults, or another child or children.

How Safe Are Our Children, NSPCC. 2015

Children and young people who have been abused or are being abused are more likely to suffer from poor mental health than their peers. In Haringey 248 children were subject to child protection plans at 31st March 2015. Appropriate support should be offered for these young people and services should not be deterred by ongoing legal action. There are guidelines for how children and young people can be supported during the period awaiting legal resolution; however one parent reported that her child was refused any support on this basis, leading to an escalation of their mental health issues. New guidelines are due to be published by the Crown Prosecution Service which should provide more clarity and support to mental health services to enable appropriate support through-out a hugely traumatic time for children and young people.

In March 2015 NHS England in partnership with King's College Hospital undertook a Review of the pathway following sexual assault for children and young people in London. This report identified a lack of CAMHS provision within the pathway. Work is being developed on an NCL wide basis to look at the recommendations of this report and how this might be translated into improved CAMHS support.

2016 Update:

We are working on implementation of the CSA Review across North Central London. Further information on this can be found in Part Two.

3.5 Developing the workforce

At the time of the Review there were 90 staff working across Haringey services totalling 52.92 WTE (39.22 clinical, 13.7 non clinical and 6 volunteers). These figures are specific to Haringey and do not include staff working with Haringey children and young people based in services working across CCGs such as the Royal Free and Tavistock and Portman, nor does it include the Whittington PIP service. Using the 2004 National Service Framework recommendations the CAMHS workforce should equate to at least 15 WTE for every 100,000 population.

Given Haringey's population of approximately £267,541 (2014 ONS estimate) this would equate to 40 WTE. The Royal College of Psychiatrists[xxv] recommend 20 FTE and 5FTE primary mental health workers (Tier 2), this would make the recommended staffing complement of 53.5WTE in Tier 3 and an additional 13WTE primary mental health workers. Given the current clinical staffing of 39.22 plus the Tavistock and Portman and Royal Free staff input we are currently between the two recommended levels. As we increase our early intervention services, this will bring us more in line with Royal College of Psychiatrists' recommendations.

3.5.1 Skill Mix & Competencies

One of the benefits of the broad range of providers delivering CAMHS in Haringey is that there are a wide range of competencies and interventions available within the services including:

Table 20: Interventions available to Haringey Children and Young People

• Adult Psychoanalytic Psychotherapy	• Parent and Child Game
• Brief systemic intervention	• Psychoanalytic Psychotherapy
• Child and Adolescent Psychotherapy	• Psychodynamic Psychotherapy
• Child Psychodynamic Counselling	• Short-Term Psychoanalytic Psychotherapy (STPP)
• Cognitive Analytic Therapy (CAT)	• Solution-Focused Therapy
• Cognitive Behavioural Therapy (CBT)	• Specialist speech and language therapy (CAMHS LD)
• Dynamic Interpersonal Therapy	• Systemic Family Therapy
• Eye movement desensitization and reprocessing (EMDR)	• Systemic Psychotherapy
• Intercultural Psychoanalytic Psychotherapy	• Triple P Parenting
• Interpersonal Psychotherapy for Adolescents (IPT-A)	• Triple Track Therapy (locally developed)
• Medication	• Video Interactive Guidance (VIG)
• Mindfulness Based Therapy	• Watch Wait and Wonder
• Mindfulness counselling	• Webster-Stratton Parenting
• Multi-Systemic Therapy (MST)	

Due to the psychotherapy focussed nature of local voluntary sector provision provided by Open Door there is a very strong psychotherapy bias with Haringey CAMHS. However Open Door are also expanding to provide psychological interventions and have recently joined the CYP-IAPT partnership which will give staff access to additional training in psychological therapies. In order to get a clear understanding of the workforce Future

in Mind proposes a national audit. In order to support this but also to ensure that staff have the competencies to deliver evidence based models of care all providers should complete a skills audit identifying any gaps or training needs.

3.5.2 Training analysis of CAMHS provider staff

Across three of the main providers the review has identified training needs around safeguarding children. Whilst all responding staff either felt confident in addressing child protection issues themselves or knew where in the team to seek support, mandatory training is not being complied with. Some administrative staff had never undertaken safeguarding training and some clinicians working with families had not undertaken it within the last year, with a small proportion not having taken it in over two years. Action to rectify should be taken by providers and this will be followed up through contract management.

Other themes from the training needs identified by staff responding to the online questionnaire which should be considered by providers are:

- Mentalization based techniques and Dynamic Interpersonal Therapy (DIT)
- Cognitive Behavioural Therapy
- Family Interventions
- Dialectical Behavioural Therapy (DBT)

Despite Haringey being part of the CYP-IAPT programme for a number of years it has not been embedded across the Service. Close working with the London and South East collaborative to develop this has been started in recent months and they have agreed to develop brief training opportunities on the CYP-IAPT principles for staff, including session by session outcome monitoring and child and young person participation. As noted earlier training is also required for the workforce on the recent SEND reforms and how they can contribute to the Education, Health and Care Plan process.

3.5.3 Upskilling the Universal Workforce

Future in Mind states that anyone working with children and young people in universal settings should have training in children and young people's development and behaviours as appropriate to their professional role. Further than that it is vital that we have a skilled workforce who can both recognise mental health issues and which knows how support the child or young person to access appropriate help. This will be supported by developing links between CAMHS and other services, though it anticipated there will be additional workforce training needs.

Areas identified in this report specifically include training for Schools which will be addressed through the Mental Health Links pilot, through the Virtual School's How to BE programme and through the Young MInds work. Training for social workers and foster /kinship carers should be specifically developed appropriate to their roles with a focus on trauma. Training around self-harm, supporting children in crisis, how to recognise mental health issues and how to access services should also be available to all professionals working with families.

2016 Update:

In 2016 providers completed a return to Health Education England outlining their current staffing levels. Providers have submitted these returns to commissioners in order to ensure that we are able to plan across

providers for the Borough. The audit identified that as noted above Haringey Children and Young People have access to a broad range of interventions and support.

Open Door currently has two staff attending the IPT-A training and one member of staff attended the management training in addition. The Tavistock and Portman NHS Foundation Trust are now part of CYP-IAPT and are also accessing training, due to the multi-borough nature of the Tavistock and Portman's teams these staff are not directly allocated to Haringey, but some Haringey children will benefit from the broader access to psychological therapies.

Over the last year significant work has been done to develop the universal workforce including a CAMHS Training conference available to multi-agency professionals including school staff working with Haringey families, which was attended by over 100 professionals. In addition the Tavistock and Portman NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust have developed training currently being rolled out to all teams across Haringey Council's Children and Young People's Services, tailored for each team. The aim of this training is to increase understanding of mental health, how to support it, and raise awareness of resources and services and how to access them. The Young Carers project includes training on identifying young carers and the impact of caring on the emotional wellbeing of young carers. This training has been rolled out to adult mental health services as well as children's teams across early help.

A key part of CAMHS Transformation is increasing the workforce in order to support children and young people requiring Child and Adolescent Mental Health Services. This has seen the workforce increase from 39.22 WTE clinical staff in 2015 at the time of the Review, to 44.44 WTE clinical staff at 31st October 2016, with a further 2 WTE clinical staff to be recruited into permanent positions by the end of the year. Additionally we intend to use additional workforce to provide temporary staffing in order to clear the current waiting lists, with the new Choices model expected to support the ongoing sustainability of reduced waiting times. Over the coming years the workforce will further increase in line with investment. The exact numbers are difficult to project as it depends on the final models agreed for both Tier 2 provision and crisis support. We will be evaluating the success of all pilots over 2017-2018 and will then commission based on what has worked well and delivered the required outcomes for children and young people.

4. Conclusion

As outlined in this report we have a good range of provision and skills within Haringey, the diverse tapestry of providers and provision means there are no significant gaps in service delivery at Tier 3. As we move to implementation of the recommendations of this report our intention is to work collaboratively with existing stakeholders and service providers to develop new models of care and embed an early intervention approach. In order to develop improved pathways we will need increased participation of children and young people and their families, and robust multi-agency partnership working. Some of the recommendations within this report will require additional funding, however some will require changes to practice within existing resources. Under each recommendation are a number of actions, and these are outlined in the Transformation Action Plan (section 5) with the proposed transformation resource.

4.1 Key Findings for Commissioning

Current commissioning arrangements mean there is no 'whole system approach' and a lack of coherence to provision. Current funding arrangements do not allow us to accurately determine levels of investment, spend and associated outcomes. Future in Mind requires a '**lead accountable commissioning body**' and a '**single separately identifiable budget for children's mental health services**'. Whilst there is a joint commissioner in place for this area, joint commissioning arrangements should be developed further to facilitate:

- Single CAMHS contracts across statutory commissioning agencies per provider
- Clearer, more transparent investment and monitoring of spend
- Joint planning and integrated services designed to meet the needs of the whole population

4.2 Key Findings for Provision

- The Review has identified a relative lack **of early intervention** (Tier 2) support. This should be expanded building on the CAMHS in GP practices pilot and the mental health links in Schools pilot in light of the borough's Early Help Strategy. Work with universal provision should be prioritised, developing services which support attachment and promoting access to a coherent programme of **parenting support** using evidence based models. **Peer support** and **digital solutions** should be developed as part of this model.
- There is a lack of **out of hours** support around **crisis** presentations, pathways should be developed in partnership with neighbouring boroughs and the role of the Adolescent Outreach Team should be reviewed as part of this work
- Targeted services should be enhanced for **vulnerable children and young people** e.g. Looked After Children/Care Leavers/Children with learning disabilities/Autistism Spectrum Disorder/Young Offenders/Young Carers/Children who are abused
- Services need to be more focussed on **outcomes**, using evidence based approaches and CYP-IAPT should be embedded across services
- Current capacity issues within Tier 3 are leading to long **waiting times**. Expanding early intervention services should reduce demand and improve access over time and use of **group interventions** and **digital solutions** should increase service efficiency.
- Interagency working and **communication** between CAMHS and the wider children and families work-force should be improved, linking CAMHS into other services and through the upskilling of the wider children and families workforce

- **Enablement** should be promoted through peer support models for children and young people and their families.
- Services should be more **accessible,** better **information** should be available to families early on and appropriate use should be made of **community assets** at the earliest stage to prevent escalation of mental health concerns.
- There is a need for improved **transition** between CAMHS and adult mental health services and increased flexibility in age eligibility criteria with appropriate and timely step-down for those who will not require ongoing support.
- Closer working between physical and mental health services is required. **Joint clinics with paediatrics** (social communication & neurodevelopmental clinics) and post assessment psychological support for families should be developed
- There are proportionally fewer children and young people accessing services from the most deprived areas in the Borough and work needs to be done to **target referrers and families** in these areas, especially in Black/Black British African communities who are **under-represented** in provision.

4.3 Recommendations

1. Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing
2. Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care
3. Develop an early intervention approach that is embedded across the whole system.
4. Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement.
5. Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs.
6. Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation.

4.4 Outcomes

Implementation of the Transformation Plan will mean the following outcomes for child and adolescent mental health services, families using these services and professionals working within the broader children and young people's workforce and Key Performance Indicators will need to be developed to measure the achievement of these outcomes, additionally each recommendation will produce a number of out:

1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value.
2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support without over-medicalising children and young people and that builds a system of support in natural contexts such as school and home.
3. A co-ordinated preventative approach for children and young people, parents/carers and families through systems around the child working well together to support emotional wellbeing across the children's workforce.
4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support.
5. Flexible services that meet the preferences and developmental needs of children and young people.
6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery.
7. Better inter-agency working and improved communication with referrers and better discharge planning.
8. More focused work that reduces dependency and promotes resilience and enablement.
9. Improved crisis planning and pathways that provide timely support and robust follow up.
10. Clear protocols for cross-boundary issues and working between child and adult services.
11. Better engagement with under-represented communities/groups.

5. Five Year Transformation Action Plan

The below action plan outlines the recommendations of the Review for implementation over the next five years. Some of the actions are what we can currently identify as requiring action, and therefore this will be subject to change over this period as actions are completed and we are able to gather further information and inform our planning. We will publish an annual delivery plan which will take this into account and build on our progress.

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Accountability and Transparency						
1	A) Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing. This will involve exploring the potential for: • Developing pooled budgets between the CCG and the Council • Disaggregating block funding arrangements • Joint commissioning with other boroughs to be considered • Developing choice through flexible commissioning • Looking at how we can jointly commission with schools for better outcomes • Working with providers to start clustering young people according to CAMHS PBR • Gaining a better understanding of what is important to children and young people and parents through better participation work using existing forums such as youth councils and supporting the development of new ones.	Haringey Clinical Commissioning Group, Haringey Council, Providers, Schools Forum, neighbouring CCGs and LAs, Children and Young People, Parents	September 2015-March 2017	• Improved commissioning • More integrated and coherent services • Better transparency of spend and outcomes • Increased participation of Children and Young People and Parent/Carers in commissioning and service delivery	Transformation funding may be required for: • Stakeholder engagement and participation work • Completion of any required audits • Developing and improving provider IT infrastructures • Commissioning resource to look at areas of joint planning across NCL • Commissioning resource to support transformation • Monitoring and evaluation of pilots/new ways of working across providers	• Joint Commissioning arrangements in place • Clear understanding and articulation of spend • Cross-borough protocols in place • Specifications in place for all services • Improvement in CYP-IAPT data completeness (90% target) • Providers ready to submit to HCSIS • Increased participation of

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
B) Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care: • Working with providers to develop outcome based service specifications • Developing cross-borough protocols • Ensuring services are meeting quality standards e.g. NICE, CYP-IAPT • Supporting providers to develop an appropriate IT infrastructure to meet the needs of a modern and efficient CAMHS. All patient records should be electronic and digital communications should be put in place, where not available, to reduce DNA rates. All CAMHS providers to ensure that EPR systems are ready to submit CAMHS minimum data set to HCSIS in January and that this data is locally available to inform planning and clinical practice (session by session outcome monitoring) • Ensure all pilots are robustly evaluated so that learning from them can be shared and successful approaches sustained • Support providers to include children and their families in the planning and delivery of services		September 2015- March 2017			Children and Young People and Parent/Carers

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Promoting resilience, prevention and Early Intervention						
2	Develop an early intervention approach that is embedded across the whole system. This will include: • Developing a coordinated and coherent approach to the offer of parenting interventions across agencies including children's centres and CAMHS, linking in professionals to CYP-IAPT training where appropriate • Building on the learning from the CAMHS in GP surgeries pilot • Improving links between CAMHS services and universal provision through developing CAMHS leads within Schools and other key agencies and providing them with links into services, training and information. • Developing a robust local offer of brief evidence-based interventions to meet the current un-met need • Scoping the development of an attachment pathway to ensure this is supported across all ages and stages. • Developing early intervention approaches to eating disorders and self-harm • Scoping the use of digital solutions including online therapy services as part of the early intervention offer • Development of resource directory to support workforce in signposting and linked in to the local offer	Haringey Clinical Commissioning Group, Haringey Council, Universal provision, Schools forum, Children's Centres, CAMHS providers, Children and Young People, Parents	Planning in 2015/16 for implementation in 2016/17	• To reduce the level of un-met identified through local prevalence and activity data • Universal providers to have access to appropriate information and a good understanding of what's available locally and how to support families to access • Families to have appropriate support in parenting their children and developing secure attachments • Reduced reliance on Tier 3 CAMHS • Improved access to support for children and young people	Transformation funding may be required for: • Scoping and development of different early intervention models • Mapping and coordination of available support • Stakeholder engagement and participation work to support the development of the offer • Piloting different approaches in 2015/16 Funding levels to be increased from 2016/2017 for full implementation and commissioning of additional early intervention support	• Better understanding of available services across child and young person workforce • Increased proportion of Children and Young People accessing early intervention support against expected prevalence • Improvement in clinical outcomes for Children and Young People accessing commissioned early help services • Increase in number of foster carers using How To BE Tool

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Improving access to effective support- a system without tiers						
3	Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement. This will include: • Broadening the range of available evidence based interventions to include group interventions e.g. CBT • Providers developing a broader range of community locations and their ability to offer home and school visits where appropriate • Building capacity for extended hours out so that children and young people can have appointments out of school time, especially where regular and ongoing work is required • Scoping the extension of CAMHS Access to improve front facing services and look at a non-stigmatised, integrated, community-asset based approach to triage and assessment • Improve information on locally available resources and ensure a more coordinated approach, which will improve accessibility through developing a local offer • Waiting time standards to be developed for routine urgent and crisis referrals in line with national standards • Providers to audit DNAs and gain a better understanding of the reasons for DNAs and disengagement • Developing peer support models for children	Haringey Clinical Commissioning Group, Haringey Council and CAMHS Providers, Schools, Acute providers, Referrers, Children and Young People and Parents	September 15-March 17	• More choice for children and young people • Better engagement with CAMHS • Improved access to CAMHS • Better crisis support for families • Improved transition to adult services • Enablement of children and young people • Improved support for parents/carers	Majority of changes to be made using existing resources, however transformation funding may need to be available for: • Piloting changes to CAMHS access • Project managing and supporting the development of peer support models that are self-sustaining and co-produced • Developing crisis and out of hours support • Implementing waiting time standards • Investing in digital solutions • Piloting new approach to transition	• Reduced waiting times • Reduction in DNA rates • Reduction in length of intervention • Increase in the number of children, young people and parent/carers accessing peer support • Development of an agreed pathway for crisis and out of hours support • Transition KPI to be developed

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
and young people including opportunity for developing self-management skills and participation in the planning and development of services • Developing peer support models for parents and carers including training opportunities and developing their understanding of mental health conditions and management • Crisis and out-of-hours support to be scoped and developed in partnership with neighbouring boroughs including a more in-depth review of the role and remit of AOT and section 136 pathways • Work across NCL to ensure eating disorder pathways are in line with published standards. • Transition work to look at improving protocols between CAMHS and adult mental health services, using the principle of most appropriate service. Scoping work to look at step-down options for those accessing CAMHS who will not be eligible for adult mental health provision • Better promotion of digital solutions and apps available to children and young people. Providers to look at how these can usefully be used in clinical practice • Improving support for schools and parents in addressing self-harm • Better communication and inter-agency working. CAMHS to keep referrers better informed through regular updates, working					

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
	with GPs and other referrers to understand what is helpful and developing information sharing protocols where necessary.					
Care for the Most Vulnerable						
4	Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs. This will include: • Work with the wider children's workforce to understand and recognise vulnerabilities to poor mental health and know how to support children and young people if they require it • Engaging with under-represented communities to understand why they are not accessing CAMHS • Reviewing current commissioning for LAC to ensure that there is flexibility to respond to need and offer interventions when no appropriate local CAMHS team can be identified/during placement moves • Gaining a better understanding of the training needs of the children's workforce including foster carers on mental health and how to support access to services. • Barnet, Enfield and Haringey Mental Health Trust to ensure they have the skills within the team to address the complexities of working with LAC where theirs is the most	Haringey Clinical Commissioning Group, Haringey Council, CAMHS Providers, Community health services, Schools, Children and Young People and Parents	Scoping Planning and establishing pilots Sep 15-March 16	• Improved access to services for a number of vulnerable groups • Improved quality of services available to vulnerable groups • Better supported and trained workforce • Better understanding of how we're meeting the needs of different communities and groups	Transformation funding may be required for: • Engaging with children and young people not accessing CAMHS • Piloting extension of LAC service to include treatment elements as outlined • Developing integrated role in YOS • Developing post-diagnostic assessment support Increased investment from 2016/17 to support full implementation	• Improved recording rates for ethnicity and vulnerable factors • Reduction in variation of engagement rates across the Borough • Improved interagency working (via stakeholder survey) • Improved mental health and emotional wellbeing for LAC • Improved clinical outcomes for young people engaged with the Youth Offending

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
appropriate service • Developing joint pathways between CAMHS and paediatrics for children who require their physical and mental health needs to be looked at holistically • Improving data on hard to reach and vulnerable groups to be used in planning • Working with Children and Young People's Services to develop integrated roles including into early help, targeted services and the Youth Offending Service • Further work to look at how we support children and young people with learning disabilities and autism including improving access to psychological and group support for families post diagnostic assessment to support attachment, and how we might develop the CAMHS LD resource • Develop pilot for working with Young Carers and children and young people affected by parental mental ill-health in Schools • Closer working between SEND services and CAMHS to ensure that staff are meeting their duties under the SEND reforms to contribute to EHC planning. • Work with NCL partners to develop the sexual assault pathway and ensure appropriate CAMHS input.					Service • Increased proportion of parents of children with ASD reporting satisfaction with post diagnostic support • Improved pathway for child sexual assault

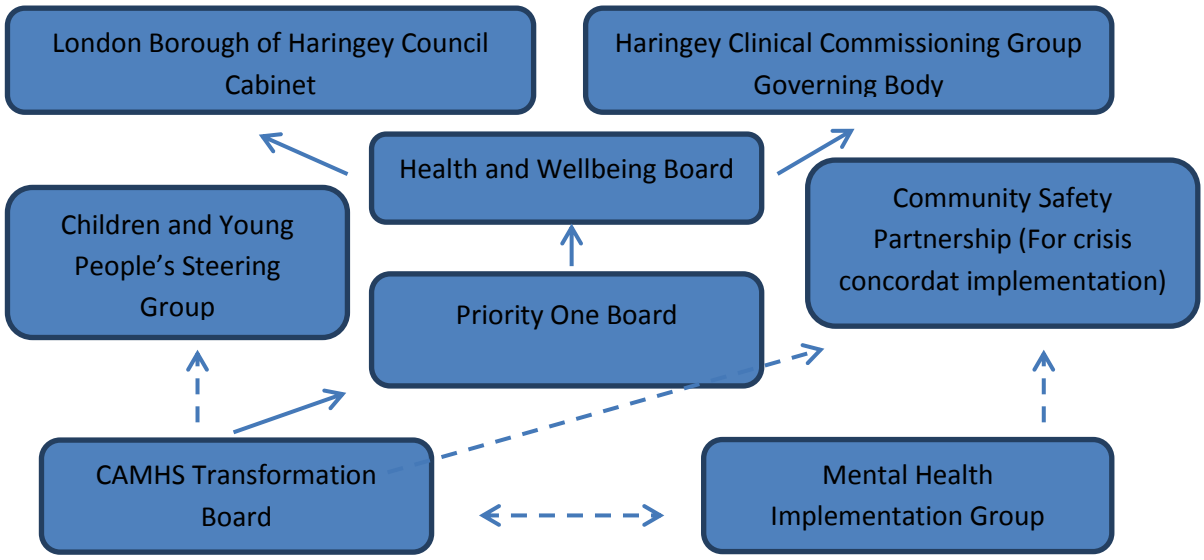
Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Developing the Workforce						
5	Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation. This will involve: • Events on CAMHS for wider children's workforce to promote CAMHS services and to provide an opportunity for non-CAMHS professionals to develop their understanding of mental health and the impact on social inclusion, development and the ability to learn including training needs as outlined in previous sections • Developing named contacts to be available across CAMHS to provide advice and guidance for worker supporting families where child/adolescent mental health is a concern including schools • Working with the CYP-IAPT Collaborative to develop brief training opportunities on CYP-IAPT principles to be available to all CAMHS practitioners across Haringey • Providers to immediately ensure that all staff have an appropriate level of up to date child safeguarding training. CCG to follow up through contract monitoring • All providers to complete a skills audit to ensure staff are qualified to deliver evidence based models of care appropriate to presenting need.	CAMHS Providers, Agencies working with children and young people, Haringey Council, Haringey CCG, Children and Young People and Parents	September 15- April 2016	• Improved skills and resilience within the workforce • Improved practice through the embedding of CYP-IAPT	Transformation funding may be required for: • Developing and delivering training events for wider children's workforce • Completing an audit of skills within CAMHS • Developing resources to support staff to promote emotional health Funding required in this area will be significantly less in future years.	• Improvement in Mandatory Training Compliance Rates • Children's workforce reporting they feel equipped to support the mental health needs of children and young people • Increase in those trained in CYP-IAPT evidence based therapies

6. Governance

6.1 Organisational Governance Structure

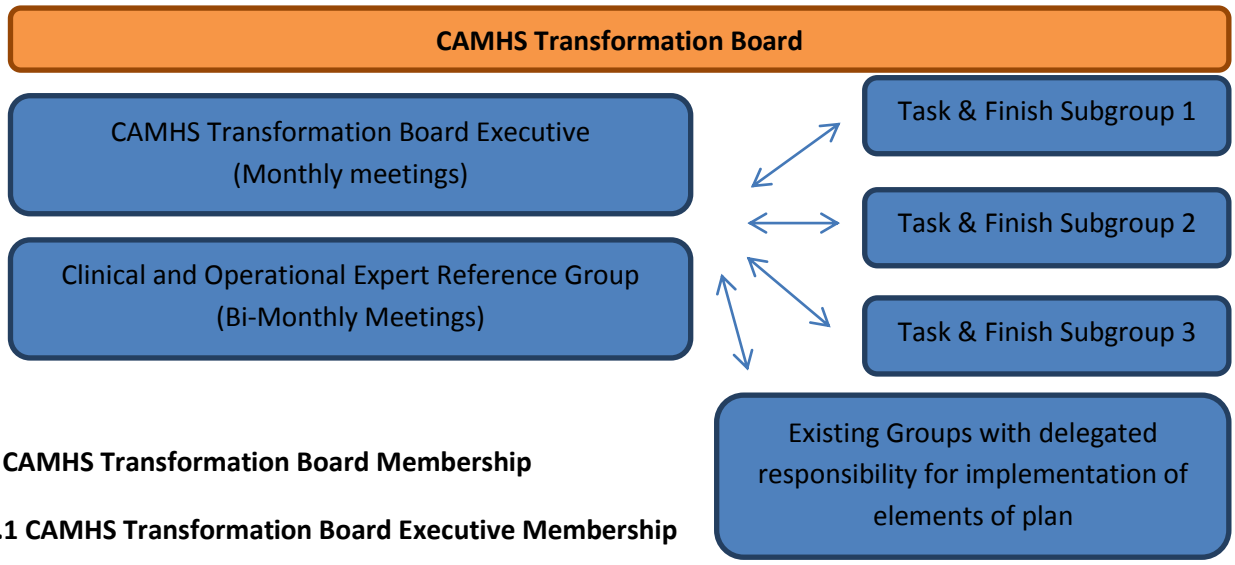
The implementation of the CAMHS Transformation Plan is overseen by a CAMHS Transformation Board. The CAMHS Review Board includes a CAMHS Transformation Board Executive and the previous provider forum and CYP-IAPT Steering Group have formed a Clinical and Operational Expert Reference Group. Currently we do not have any children and young people on this Board but do have parent and Health Watch representation. The CAMHS Transformation Board has now been integrated into the reporting structure for the Council's Corporate Plan under Priority 1: Outstanding for all: Enable every child and young person to have the best start in life, with high quality education. There is joint representation on this Board from health and the local authority.

The filled arrows below demonstrate the formal reporting structures for risk and accountability; the dashed lines demonstrate co-dependencies and informal reporting to ensure a consistent and joined up approach, linking the CAMHS Transformation in with both adult mental health services through the mental health implementation group, and with the broader health agenda for children through the CCG led Children and Young People's Steering Group.



6.2 CAMHS Transformation Board Structure

The CAMHS Transformation Board itself is a multi-agency partnership structure that supports a broad representation of partners but which also enables accountability in the Executive part of the Board which will bring together decision makers. The Executive meets monthly, and the Clinical and Operational Expert Reference Group meets bi-monthly separately. Every quarter the Executive and Clinical and Operational Expert Reference Group join together for a Full Board to ensure appropriate clinical input and partnership working. In addition there are a number of time-limited task and finish subgroups which are driving individual projects and programs sitting under the Plan.



6.3 CAMHS Transformation Board Membership

6.3.1 CAMHS Transformation Board Executive Membership

- Assistant Director Mental Health, Haringey CCG (Joint Chair)
- Director of Commissioning, Haringey Council (Joint Chair)
- Governing Body GP Lead for Children, Haringey CCG (Vice Chair)
- Assistant Director of Public Health
- CAMHS Case Manager, Specialised Commissioning, NHS England
- Vulnerable Children's Joint Commissioning Manager, Haringey CCG and Haringey Council
- Head of Integrated Service SEN & Disabilities
- Healthwatch Haringey Representative
- Parent Representative

6.3.2 Clinical and Operational Expert Reference Group

This Group comprises both clinical and operational representation from providers to ensure a good mix of clinical input into the delivery of plans and organisational buy-in from providers through senior representation.

6.3.3 Task and finish Subgroups

The focus of these groups changes over time and they pull together the right people from the Executive and Expert Reference Group as well as relevant partners to drive improvement in an area. They report into the Executive and Expert Reference Group and each have to identify how children, young people and their families will be involved in the workstream. Any decisions that are required can then be made through the Executive, depending on the level of the decision required this would then be signed off by Priority 1 Board, the Health and Wellbeing Board and/or the Council's Cabinet/ CCG Governing Body. Where there are existing groups that can take forward elements of the plan, these will have delegated responsibility for implementation; for example using the existing workforce development group which also sits under Priority 1 of the Council's Corporate Plan. Additionally for areas where there is a benefit to working closely with other CCGs/Councils we have developed joint task and finish groups. These groups also feed into the CAMHS Transformation Board.

PART 2

North Central London
CAMHS Transformation Plan Priorities

Barnet, Enfield and Haringey NHS Mental Health NHS Trust | Camden and Islington NHS NHS Foundation Trust | The Tavistock and Portman NHS NHS Foundation Trust | Whittington Health NHS

BARNET LONDON BOROUGH NHS Barnet Clinical Commissioning Group | Camden NHS Camden Clinical Commissioning Group | ENFIELD Council NHS Enfield Clinical Commissioning Group | Haringey LONDON NHS Haringey Clinical Commissioning Group | ISLINGTON NHS Islington Clinical Commissioning Group

1.1 Mental Health is identified as a priority area in the North Central London (NCL) STP Case for Change. This has resulted in the development of the NCL Mental Health Programme as part of the NCL STP, which covers mental health support for all age groups. The programme currently has seven identified initiatives: community resilience, primary care mental health, acute pathway, female psychiatric intensive care unit, CAMHS and perinatal, liaison psychiatry, and dementia.

1.2 The CAMHS Transformation Plan Priorities are focussed on producing improved outcomes for children and young people, and on ensuring the best use of resources to generate those good outcomes. The transformation of children and young people's mental health and wellbeing services, and of perinatal mental health services, will not necessarily bring savings during the time period of the STP, but have been prioritised because of their future positive impact on the need for services. 50% of all mental illness in adults is associated with mental health needs that begin before 14 years of age, and 75% are associated with needs that are expressed by age 18[1]. Similarly, the negative impact on a child's mental wellbeing[2] associated with perinatal mental ill health confirms that these are two key service areas for ensuring improved long term mental health outcomes for our population.

Borough	Population aged 5-16	Est. prevalence of any MH disorder, aged 5-16 (2014)	
		Count	Percentage
Barnet	56,063	4,691	8.4%
Camden	27,904	2,546	9.1%
Enfield	52,460	5,195	9.9%
Haringey	37,905	3,745	9.9%
Islington	23,981	2,417	10.1%

Source: Fingertips, 2014

1.3 Across the 5 boroughs of NCL (Barnet, Camden, Enfield, Haringey and Islington) there are varying rates of mental ill health prevalence, and varying services and outcomes across the 5 boroughs; such as:

- Three of our boroughs have the highest rates of child mental health admissions in London (Fingertips, 2014/15)

[1] Cavendish Square Group
[2] Centre for Mental Health and London School of Economics

- There is limited perinatal community service in NCL, with no specialist team in the North and in the southern boroughs the service does not meet national standards (Maternal Mental Health Everyone's Business)
- Most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight (Mental health crisis care ED audit, NHS England (London), 2015).

1.4 In order to address variation and improve care for our population, as well as to meet the requirements set out in the Five Year Forward View and Future in Mind, the 5 NCL Boroughs will be working together on 8 areas as part of the NCL STP CAMHS and Perinatal initiative.

1.5 These are:

1. **Shared Reporting Framework** - to enable comparison and shared learning across the 5 boroughs
2. **Workforce Development and Training** - planning for the workforce in order to meet the mental health and psychological well-being needs of children and young people in NCL; including CYP IAPT workforce capability programme
3. **Specialist Community Eating Disorder Services** - dedicated eating disorder teams in line with the waiting time standard, service model and guidance
4. **Perinatal Mental Health Services** - to develop a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
5. **Crisis and Urgent Care Pathways** - 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis; this includes local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136 facilities for children and young people.
6. **Transforming Care** - supporting children and young people with challenging behaviour in the community, preventing the need for residential admission
7. **Child House Model/Child Sexual Assault (CSA) Services** - following best practice to support abused children in NCL
8. **Young People in the Youth Justice System** - working with NHS E to develop co-commissioning model for youth justice

1.6 In the development of the NCL CAMHS work, the principles of THRIVE will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

Priority 1: Shared Reporting Framework

Rationale for Joint priority across NCL:

2.1 In order to better plan across a broader NCL footprint we are working with providers to develop a minimum data set for local reporting on key indicators including quality indicators such as DNA rates and clinical outcomes. Importantly, we also wish to embed approaches such as the Thrive model with evaluation embedded in the process.

Our Ambition

- To better understand activity, performance and quality through the use of a set of metrics that support us to benchmark and combine consistently measured data
- To drive significant improvements in performance, requiring providers to demonstrate the production of better outcomes for children and young people, and holding them to account where they are failing to meet agreed outcome, output and quality targets.

Current picture

2.2 Across NCL there are currently a range of providers including:

- Barnet and Enfield Mental Health NHS Trust
- Tavistock and Portman Foundation Trust
- Whittington Health NHS Trust
- Royal Free NHS Foundation Trust
- Voluntary Sector Organisations unique to each Borough

2.3 Each provider uses a different Electronic Patient Record (EPR) system and has different reporting and monitoring arrangements with commissioners.

What we are aiming to achieve across NCL:

2.4 Currently we have a range of providers both within the NCL Boroughs and across them. We are working with all providers to agree a data set using definitions from the mental health minimum data set where available to ensure consistency. This will provide a mechanism for local reporting that will pick up a set of basic indicators to better monitor activity and performance across multiple providers, both for each
borough and across the broader STP footprint.

- Agree a dataset with providers for more consistent and comparable monitoring
- Agree a methodology for recording RTI and RTT waiting times from the perspective of the Child/Young Person based on NICE Guidelines

2.5 Improving access is a key driver for us. In order to better ensure that access is improving we are working on waiting time standards and an agreed methodology for measuring waiting times which takes into account the wait from the perspective of the family. Waiting times will be measured from the first point of contact with the system, rather than from the first point of contact with a particular service. This will ensure that people being redirected or passed to an alternative provider are not disadvantaged.

Key Milestones

- Development of Dataset (Completed)

- Agreement of Dataset with Providers (Partially Completed)
- Implementation of Dataset (2016/17)
- Reporting on Dataset (2017/18)

Funding

2.6 The changes to reporting do not require any additional funding and will be managed through the contracts.

Linked to key policies and initiatives

Future in Mind	• Mental Health Minimum Dataset (CAMHS) • Children and Young People's IAPT Programme

Priority 2: Workforce Development and Training

Rationale for Joint priority across NCL:

3.1 Across NCL, there are three mental health trusts that provide CAMHS services for the 5 boroughs. In addition, the specialist Eating Disorder Service for the 5 boroughs is provided by Royal Free London NHSE Trust. Due to the shared provider landscape, along with the migration of our population within the NCL patch, it has been agreed to conduct workforce mapping across the entire patch as this is seen as the most beneficial and efficient method of doing so, while also allowing for local variations in workforce need. The result will be a multiagency strategy to develop the workforce for the NCL STP footprint.

Our Ambition:

3.2 To review the current workforce provision which will enable the planning for the workforce requirements in order to meet the mental health and psychological well-being needs of children and young people in NCL; including the CYP IAPT workforce capability programme. It is anticipated this will result in more children and young people being able to access support, with more professionals able to support children and young people with mental ill health.

What we are aiming to achieve across NCL:

3.3 From undertaking the mapping of the current workforce, we will be able to identify what changes to the NCL CAMHS workforce will be required in order to deliver the new model of care and support contained in the 8 sections of the NCL CAMHS and Perinatal STP initiative, and achieve the ambitions of the Five Year Forward Plan, the Mental Health Taskforce and Future in Mind. Questions to be addressed are: what additional staff are required, and how will we recruit these; what new roles are required; what alternative ways of delivering support are required; and what training is required to ensure the workforce is adequately skilled to deliver the support required by children and young people with mental health needs. The mapping will also inform plans and commissioning intentions.

3.4 This multiagency workforce plan will be developed across partners and wider stakeholders, looking at how care can be delivered to maximise support. This may result in care and support being delivered in alternative ways to how it is delivered currently, such as increasingly through the voluntary sector, school and colleges. We do not envisage moving to a single workforce model for each area but will share ideas, expertise and learning across the area in order to produce a more efficient CAMHS system.

Key Milestones

- Secure funding – September 2016
- Appoint resource to conduct mapping – October 2016
- Completed mapping to be reviewed and next steps agreed – November 2016
- Wider stakeholder engagement – January 2017
- Completed workforce plan – March 2017

Funding

3.5 Commissioners are seeking funding for initial mapping work from NCL MH STP Programme funding.

Linked to key policies and initiatives

Linked to key policies and initiatives:	Aims
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Roll out CYP IAPT – incl. training via CYP IAPT for staff under 5, autism, and LD • Make MH support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH

Priority 3: Specialist Community Eating Disorders Services

Our Ambitions

4.1 All NCL CCG's submitted plans for improving provision for eating disorders across the area in our Local Transformation plans 2015 / 16. NCL jointly commissions the specialist Eating Disorders Service at the Royal Free Hospital, Barnet CCG is the lead commissioner. The services comprise of the Intensive Eating Disorder Service (IEDS) and the Community Eating Disorder Service. Priorities we identified in Transformation Plans 2015.16 included

- Increase capacity and reduce waiting times to meet key requirements of NICE Guidance
- Outreach education training for eating disorders to primary care health and education staff
- Offer telephone support for General Practitioners
- Improved performance monitoring and management

4.2 Baseline performance for referrals under 4 weeks was 54% 2014.15. NCL and RFL agreed milestone for improvement at 60% Q4 2015.17, 80% 206.17

Progress against Ambitions

4.3 Overall the number of referral in 2015.16 (181) increased by 50% since to 2012-13 (119) and increased 26% compared to the two previous years. 94.5% of referrals received were accepted in 2015.16.

Referrals for all five boroughs for 2015.16		
CCG	**Number of referrals received**	**Number of referrals accepted**
Barnet	63	60
Camden	35	33
Enfield	22	21
Haringey	32	31
Islington	29	26
TOTAL	181	171

4.4 Waiting times for first appointment for ED patients seen in 2015/2016: In 2015/2016, 69.2% of patients were seen within 3 weeks and 6 days of referral and 97.5% within 6 weeks. This was a significant improvement from previous year (54%).

CCG	Waiting Times to first face to face contact (weeks)	Number of patients (Percentage of patients)
All NCL CCGs	**0 - 3**	69.2%
	4 - 6	28.3%
	7 - 9	2.5%
	10 - 12	0%
	13 – 18	0%
	18+	2.2%

4.5 The table below shows the waiting times for first appointment for patients referred in Q4 of 2015/2016 which evidences progress in the first period after the additional investment was made. At this time referrals were not categorised in the RFL reporting system as 'urgent' or 'non-urgent'.

	Waiting Times Q4	Performance
All NCL CCGs	**0 - 3**	36 (75.6%)
	4 - 6	9 (22.2%)
	7 - 9	1 (2.2%)
	10 - 12	0 (0%)
	13 – 18	0(0%)
	18+	0 (0%)

4.6 NCL led by Barnet CCG initiated performance monitoring meetings in Q1 2016.17 with a new set of targets and data reporting. RFL began reporting urgent and non-urgent referrals separately and further progress was made in reducing waits with 100% of urgent referrals seen with 1 week and 85% of non-urgent with 4 weeks so a total of all referrals seen with 5 weeks of 97%

		Waiting Times Q1 2016.17	***Waiting Times Q1 2016.17***
All NCL CCGs		**Urgent**	**Non-Urgent**
	0 – 1	4 (100%)	2 (7.4%)
	1 – 2	0 (0%)	8 (29.7%)
	2 – 3	0 (0%)	7 (25.9%)
	3 – 4	0 (0%)	6 (22.2%)
	4 – 5	0 (0%)	3 (11.1%)
	5 – 6	0 (0%)	0 (0%)
	6 – 12	0 (0%)	1 (3.7%)
	12+	0 (0%)	0 (0%)

Workforce Capacity NCL/RFL Eating Disorders Services: Roles	***Grade***	***Existing funding WTE CAMHS and Eating Disorders***	***+Transformation Funding additional WTE Eating Disorders***
Clinical Psychologist	***7***	***1.4***	***1***
Clinical Psychologist	***8a***	***1.2***	
Clinical Psychologist	***8c***	***1***	
Psychotherapist	***8d***	***.6***	
Psychotherapist	***8a***	***1.9***	***.4***
Family therapist	***8a***	***.8***	
Family therapist	***8b***	***.6***	
Family therapist	***8c***	***.4***	
Psychotherapist	***7***		***.8***
Family therapist	***7***		***.8***
Assistant Psychologist	***4***	***4.6***	
Health Care Support Worker	***3***	***1***	
Reception/Med sec	***3-5***	***3.1***	***.4***
Dietician	***7***	***.4***	***.6***
Consultant		***4.4***	
Junior Medical Staff		***1***	***.6***
Nursing outpatient	***6***	***1***	***.87***
Nursing outpatient	***7***	***1***	
Nursing	***8a***	***2***	

Nursing	***7***	***1***	
Nursing	***6***	***2***	
Nursing	***5***	***7***	

Next Steps	**Targets**	**Performance milestones**
Service Improvement	RTT Non-Urgent < 4 weeks Urgent < 1 week	90% 2017.18 95% by 2018.19
Performance Management	Quarterly reports and Meetings Change from Reporting RTA to RTT (Referrals to Treatment)	Ongoing By Q4 2016.17
Workforce Capacity	Recruit to vacancies	Ongoing
Transformation and Development	RFL Service Review More community based work and prevention Community facing training events in place for school and primary care practitioners starting 18th November 2016.	Q4 2016.17 Q4 2016.17 Q3 2016.17

Linked to key policies and initiatives

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Make support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH
NCL Sustainability and Transformation Programme	

Priority 4: Perinatal Mental Health Services

Rationale for Joint Priority across NCL

5.1 The population of NCL is approximately 1.4 million people. There are 4 acute Trusts, three mental health Trusts and a range of community providers. In 2014-15 there were approximately 20,000 births to NCL residents and 24,000 births delivered by the local Trusts. Within this provider geography are specialist maternity services centred around a single tertiary level neonatal unit, as well as a number of midwifery led units and home births.

5.2 This is a population with high levels of risk and vulnerability to mental health problems. The population is diverse and growing and experiences significant churn as people using health and care services move in and out of the city. The network covers areas of deprivation and includes women who are older, more likely to be overweight and obese and to experience gestational diabetes during pregnancy when compared with national averages. There are high numbers of households in temporary accommodation across the patch and around a quarter of the population in NCL do not have English as their main language.

5.3 Suicide is one of the leading indirect causes of death (CMACE 2011). In a recent audit by BEH Mental Health Trust there were two maternal suicides in 2014/2015.

Our Ambition

5.4 Our ambition for 2020 is to improve the care pathways so that there is better continuity of care. This may involve redesign and investment. As part of the redesign services should be co-located with maternity services e.g. IAPT, drug and alcohol services. All CCGs will have parent infant services.

5.5 There is an NCL working group led by the Tavistock and Portman Clinic. The work of this group is informed by stakeholder involvement e.g. Cocoon, the NCL maternity services participation groups, the Family Nurse Partnership in the Maternity Services Liaison Committee.

Current picture

5.6 There is no specialist community mental health service in NCL despite having some good parent-infant and psychology services. The majority of the local maternity services have perinatal mental health specialists. The continuity of care and the care pathways is very complex across several mental health providers and local community services. In Barnet, Enfield and Haringey Mental Health Trust there is no specialist perinatal mental health service and BEHMHT is one of two mental health trusts in London without a dedicated service.

5.7 The availability of services for families affected by perinatal mental illness in North Central London is dependent on where a woman lives and where she chooses to have her baby. Only women who choose to give birth at the Whittington can expect to have access to a comprehensive, specialist perinatal mental health service. Services are in effect provider delivered, rather than effectively commissioned.

5.8 NCL partner organisations have calculated that 1,200 women a year will be supported by a proposed perinatal mental health service model. This is equivalent to 5% of all women giving birth in NCL and includes women that have a previous history of serious illness, those experiencing psychosis, serious depression or other complex difficulties. The service will focus

resources and develop approaches to engage people who find help harder to access including teenagers and mothers from some BME groups including those for whom English is not their first language.

5.9 Outlined below are the rates of perinatal psychiatric disorder per thousand births and the numbers that would be expected by borough.

2014 births ONS			Barnet 5244	Enfield 4824	Haringey 4006	Camden 2700	Islington 2879
Disorder	Established rate per 1000 births	% women affected	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases
Postpartum psychosis	2/1000	0.2%	10	10	8	5	6
Chronic serious mental illness	2/1000	0.2%	10	10	8	5	6
Severe depressive illness	30/1000	3%	157	145	120	81	86
Mild-moderate depressive illness	100-150/1000	10-15%	524-786	482-724	400-601	270-405	287-431
Post-traumatic stress disorder	30/1000	3%	157	145	120	81	86

Birth Data: ONS, July 2015

What we are aiming to achieve across NCL

5.10 This ambition is dependent on additional funding. An NCL application has been submitted to NHS England by Islington CCG and clinically led by the Tavistock and Portman Trust.

5.11 We are proposing a hub and spoke model for North Central London. The hub will be primarily administrative with a central meeting place for training and to oversee and maintain quality and equity across the patch and co-ordinate activity and outcome data. Accommodation has already been provisionally identified on both the St Ann's and Whittington sites. There will be five spokes each relating to one of the five maternity units in NCL so that each maternity unit has clinicians with whom to make effective relationships but facilitating cross cover and a capacity to respond to urgent referrals. Although the maternity units are best placed to identify early vulnerability throughout pregnancy and the early post-natal period, we anticipate that many women will be identified by other professionals including GPs, adult MH workers including IAPT, HVs, CAMHS, Children's Centre staff, etc. The work strand will overlap with, and be included in, work being undertaken on pathways.

Key Milestones

5.12 In addition to the proposed implementation plan submitted as part of the NCL application, the key milestones have been identified:

1. Continue to develop NCL Perinatal Mental Health partnership and workstream
2. Secure additional NHSE funding for community based perinatal mental health service
3. Continue mapping of care pathways

4. Continue improving communication between providers
5. Continue improving care pathways from pre-conception to one year after birth
6. Continue NCL/Pan London perinatal training programme
7. Continue NCL/Pan London perinatal mental health champions programme
8. Ensure each service provider has perinatal mental health champions

Funding

5.13 Below are the proposed costs for implementing the community perinatal health services within NCL.

	2016/17	**2017/18**	**2018/19**
Costs Staffing, building, equipment and training	£163k	£1,233k	£1,218k
Existing and proposed North Central London annual resource	Barnet - Camden - Enfield - Haringey - Islington -	Barnet £ 50,000 Camden £ 40,000 Enfield Resource to be identified through redesign of existing services. Haringey £ 80,000 Islington £ 150,000	Barnet £ 100,000 Camden £ 40,000 Enfield Resource to be identified through redesign of existing services. Haringey £ 80,000 Islington £ 150,000

Note: There are other costs associated with the care pathways and part of the NCL Perinatal Mental Health Group will be to identify existing services, current expenditure and gaps.

Linked to key policies and initiatives

- NCL Perinatal Mental Health Strategy
- Healthy Child Programme
- NICE Guidance on Perinatal Mental Health

Priority 5: Crisis and Urgent Care Pathway and Collaborative Commissioning proposal of Tier 4 beds.

Rationale for an NCL wide approach

6.1 Local management of CAMHS beds and the development of 24/7 community based rapid response service for children and young people experiencing mental health crisis are national and regional priorities. The North Central London Sustainable Transformation Plan, mental health work stream, includes out of hours crisis response for children and young people across all boroughs. Our ambition to deliver this will work best across NCL wide population to deliver economies of scale and an effective, efficient service.

Aim

6.2 We will develop a local integrated pathway for CYP requiring beds that includes rapid community based response to crisis. This will result in admission prevention, reduced length of stay and support appropriate and safe discharge and a reduction of admission to acute paediatric beds across the footprint. We will work closely with Specialised Commissioning and jointly with Health and Justice Commissioners to develop local integrated pathways including transitioning in or out of secure settings, SARCs plus liaison and diversion provision.

I. Local management Tier 4 beds (Collaborative Commissioning)

6.3 The Tavistock and Portman NHS FT is co-ordinating a provider led bid to NHSE to manage inpatient stays of children and young people across NCL. The stakeholder partnership includes Barnet, Enfield and Haringey Mental Health NHS Trust, Whittington Health, Royal Free NHS Foundation Trust, CAMHS commissioners from all boroughs. The data we have on admissions and length of stay in CAMHS beds across NCL is shown on the next page.

NCL Tier 4 CAMHS Admissions

Data Source	NHS E	NHS E	NHS E	NHS E	NHS E	HLP	HLP	HLP
Year	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 total	15-16 HLP London	15-16 HLP Out of London	15-16 HLP total
Barnet est popn 2016 aged 0-18 **48,471** (GLA, 2015)								
Admission	33	39	34	7	41	35	6	41
LOS London	1,923	2,220	2,740	749	3,489	2,852	735	3,587
Cost	£958,686	£1,007,955	£1,595,878	£467,354	£2,063,232	£1,597,062	£459,307	£2,056,369
Av Cost	£499	£454	£582	£624	£591	£560	£625	£573
Camden est popn 2016 aged 0-18 **22,597** (GLA, 2015)								
Admission	5	19	9	14	23	11	10	21
LOS London	650	1,218	701	1,064	1,765	1,049	1,021	2,070
Cost	£143,739	£601,102	£630,340	£663,904	£1,294,244	£631,263	£645,020	£1,276,283
Av Cost	£221	£494	£899	£624	£733	£602	£632	£617
Enfield est popn 2016 aged 0-18 **44,312** (GLA, 2015)								
Admission	20	23	5	6	11	4	5	9
LOS London	1,187	1,165	185	213	398	473	207	680
Cost	£663,675	£625,566	£291,389	£132,906	£424,295	£291,389	£174,103	£465,492
Av Cost	£559	£537	£1,575	£624	£1,066	£616	£841	£685
Haringey est popn 2016 aged 0-18 **31,504** (GLA, 2015)								
Admission	22	16	10	4	14	9	2	11
LOS London	1,331	1,532	435	151	586	833	148	981
Cost	£679,371	£821,833	£500,394	£94,219	£594,613	£500,394	£90,018	£590,411

Av Cost	£510	£536	£1,150	£624	£1,015	£601	£608	£602
Islington est popn 2016 aged 0-18 **21,344** (GLA, 2015)								
Admission	13	17	7	2	9	7	3	10
LOS London	697	1,591	857	81	938	1,234	81	1,315
Cost	£142,332	£810,165	£786,502	£50,542	£837,043	£786,502	£53,600	£840,102
Av Cost	£204	£509	£918	£624	£892	£637	£662	£639
NCL est popn 2016 aged 0-18 **168,226** (GLA, 2015)								
Admission	93	114	65	33	98	66	26	92
LOS London	5,788	7,726	4,918	2,258	7,176	6,441	2,192	8,633
Cost	£2,587,803	£3,866,621	£3,804,503	£1,408,924	£5,213,427	£3,806,609	£1,422,048	£5,228,657
Av Cost	£447	£500	£774	£624	£727	£591	£649	£606

Note

- 15-16 out of London cost base assumed at £623.97 per unit
- Data excludes ED, CLD, PICU, Low Secure, Medium Secure, Daycare, SCAAND (GOSH, Ellern Mead excluded)
- For HLP OOA where NHS E had provider cost as £0, updated to £623.97
- Before managing tertiary budget locally, would need support from NHS E to validate data as variances between data sets
- Due to LOS and cost coming from different sources for in London placements, cannot be 100% sure that the LOS and costs align. Admissions and costs do align.

II. Community based rapid response to young people experiencing crisis

6.4 A mental health crisis is defined as when someone is in an emotional or mental state where they need urgent help. A mental health crisis can be unpredictable. A person in crisis may need support at any time of day or night. They may seek help from a GP, or medical attention from a local hospital, or the crisis may result in an intervention by the police.

6.5 We are in the process of gathering data about the numbers of children and young people presenting to emergency departments and those being admitted in all boroughs.

6.6 The picture at the moment is that at least **350** children and young people were admitted to acute paediatric wards in 15-16. However at this stage the data is incomplete. We are also consulting with children and young people to inform both proposals for the local management of inpatient beds and development of crisis care provision.

III. Crisis Concordat and young person appropriate Place of Safety

6.7 Crisis Care Concordat planning is taking place across North London Central (NCL) with local forums developing action plans for Camden & Islington and for Barnet, Enfield & Haringey. This has led to work on revising local S136 pathway protocols and exploration of options to further young person appropriate develop local place of safety provision.

6.8 Simultaneously work is being undertaken by the NCL stakeholder partnership group to review places of safety currently provided across NCL, focussing on the appropriateness of provision for children & young people.

Key Milestones

1. Project plan locally to pilot extended hours for community based out of hours crisis response across NCL. November 2016
2. Recruitment plan with identified provider Trust December 2016
3. Proposed go live date of April 2017
4. NHSE approval to develop local management of provider led CAMHS inpatient beds
5. Project plan to implement local management of inpatient beds. January 2017

Summary

1. NCL boroughs will develop jointly a whole system pathway to respond to children and young people experiencing mental health crisis as required. This will include primary care.
2. The system wide pathway includes local management of inpatient beds for children and young people as required
3. Outcomes will include reduced attendance and admissions to acute hospital beds; reduced admissions and length of stay to T4 beds; improved patient experience and patient outcome measures
4. The timescale for delivery of 24/7 response is by 2020.

Priority 6: Transforming Care Programme

Rationale for Joint priority across NCL

7.1 Transforming Care is a nationally driven programme to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

7.2 The Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

7.3 We are working together across North Central London, and in collaboration with Local Authority Children and Young People's Services, in order to deliver this programme and have identified a number of areas in common for joint work.

Our Ambition

- To keep Children and Young People with their families through commissioning an appropriate range of community and respite provision that reduces the need for residential and inpatient admissions.

What we are aiming to achieve across NCL

I. Care and Treatment Reviews (CTRs) and Admission Avoidance Register

7.4 When someone is identified as being at risk of admission they are placed on an 'admission avoidance register'. This enables professionals to arrange a Care and Treatment Review meeting with the child/young person and/or their parent/carer to think about what can be done to support them in the community and to retain oversight and regular review of the case. In NCL we are working towards a single process for this. Guidance is being completed for professionals to support the identification of those at risk and how to seek consent from the family to join the register. We are also looking at how we can also support those at risk of requiring a residential placement, through additional support to enable families to stay together.

II. Early support for behaviour

7.5 There are different models for delivering behaviour support across NCL. We intend to undertake a sufficiency audit to look at those different models, and numbers of children and young people accessing this support against identified need.

III. Intensive Family Support

7.6 Enfield are currently developing an intensive family support model based on the Ealing model, using positive behaviour support. The proposal is for an Intensive Behaviour Therapeutic & Assessment Service (IBTAS) to develop a viable local alternative to for a cohort of young people with challenging behaviours so that they are intensively supported preventing such behaviours deteriorating to the point where external placement become the only solution. The new service aims to avoid permanent

residential accommodation for approximately four children / young people per year through a combination of timely and intensive therapeutic support and the provision of regular, planned short breaks. With small numbers such as these across each of the Boroughs consideration is being given to the possibility of a jointly commissioned service, or roll-out of a single model across the five CCGs.

IV. Shared Learning to inform Commissioning

7.7 The Care and Treatment Review process enables colleagues across NCL to share learning about what is helpful in both preventing the need for Tier 4 services, including hospital admissions, and for expediting step down. We aim to monitor the approaches tried across NCL to inform future commissioning intentions. For example we are looking at the possibility of mentors who visit the young person in hospital and then support them when they return to area. As admissions are very small numbers, this is an area which would be better considered across the larger NCL footprint.

V. Improving Pathways and Models of Care

7.8 We are currently working across adult's and children's services to look at the pathways for ASD, from pre-diagnosis to post-diagnosis support, looking at any opportunities for joint working. Additionally we will be considering the different models of CAMHS delivered to those with learning disabilities and/or ASD. There are a number of teams across NCL using different models, we will be working closely to review these models in order to take a view as to which functions are better delivered locally (for example support into special schools) and which could create improved quality and efficiency through jointly planning for (for example specialist assessments).

VI. Workforce

7.9 Integral to the pathway review outlined above is the workforce. This will be reviewed in the context of the pieces of work to look at current services and pathways and in the context of the HEE and CYP-IAPT opportunities for staff development. Some of the presenting issues which our teams support are quite rare, providing an ability to call on a wider workforce mean that specialist expertise are available to a larger range of families, reducing the need for high cost specialist assessment and treatment services which may currently be contracted on a cost per case basis, and enabling that resource to be used to invest in local services.

VII. Market Development

7.10 In order to deliver a flexible model of community provision to avoid admission to hospital or residential units, we need to develop the market across the sector. This will involves stimulating the market and working jointly to attract providers who can provide innovative solutions. Commissioning intentions will be led by the outcomes of the sufficiency audit around early help, and the learning from CTR processes.

VIII. Capital and Housing

7.11 NCL will have a representative on the pan- London Capital and Housing sub-group to support the development of capacity on a regional basis.

Key Milestones

- Establish consistent process for admission avoidance register

- Improve data through work with providers to record LD/ASD and through better use of and profile of admission avoidance register
- Develop a clear engagement plan to ensure patient/family rep are engaged as partners at all stages and levels of decision making
- Complete sufficiency audit of current behaviour support and complete any required business cases for funding
- Market Testing
- Develop a new service model (avoidance of admission)
- Develop a new service model (moving individuals back to the community)
- Reduce the use of hospital beds in line with the TC assumptions from 43 in April 2016 to no more than 21 in March 2019

Funding

7.12 We will be seeking to bid for Transforming Care funding in order to support this area of transformation. We will also be looking locally at developing business cases to support this work through the reduction of costly residential placements.

Linked to key policies and initiatives:

- Transforming Care: A National Response to Winterbourne View - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
- Care and Treatment Review: Policy and Guidance - https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf

Priority 7: Development of local Child Sexual Assault (CSA) Services / Child House Model

Our ambitions

8.1 This priority area sets out the work to date at a pan-London level and locally in North Central London to progress towards the Child House model for victims of child sexual abuse (CSA), including sexual exploitation. The 2015 "Review of the pathway following Children's Sexual Abuse in London" recommended the Child House model based on the Icelandic Barnahus[1]. This model has been subsequently been supported by Children's Commissioner for England, Home Secretary and the London Mayor.

8.2 It was estimated by the NSPCC study[2] that 9.4% of 11 to 17 year olds had experienced sexual abuse (including non-contact) in the past year. The same incidence as childhood asthma (9%) and more common than diabetes (2.5%), and yet these children are hidden from sight. When they do come forward, the minimum that all children and young people that experience sexual abuse should expect includes:

- A safe place to live
- Being listened to and believed
- Ability to develop a narrative
- Early emotional support is available before therapeutic interventions start e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on returning to normal daily life – such as night terrors, flashbacks, self-harm
- Reducing risk of further abuse

8.3 Following the publication of the Review of services in London, a North Central London sector steering group was established, one of 5 across London, to look at the outcomes of the review and take forward recommendations across a sector wide partnership. CAMHS services are central to this piece of work and NCL CAMHS Commissioners have come together to support this initiative and ensure the sector wide work is reflected in CAMHS transformation plans as well as being linked into our NCL Sustainability and Transformation Plan.

I A single pathway for C&YP across NCL who have experienced child sexual assault

8.4 The partnership is working to bring clinicians together from existing services, identifying resources to ensure CAMHS and Advocacy support is available as part of the pathways, and agreeing access for young people is based on what makes sense for them rather than geographical boundaries. This is viewed as the first step in improving available support and initial funding has been made available from DH to support a 1 year pilot of providing CAMHS and Advocacy into these pathways.

II Development of the Child House Model

8.5 Ultimately the ambition is to develop the Child House Model in NCL. Following the development of this initiative, we would envisage a reduction in service demand on tier III CAMHS, and reduced wait times, through early intervention to minimize the risk of severe and enduring mental health

[1] Link to Children's Commissioner report on Barnahus
https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[2] Radford L, Corral S, Bradley C et al. Child abuse and neglect in the UK today, 2010

conditions. Safeguarding teams and children's social care teams will be supported by a streamlined process to access all health and police investigations immediately after disclosure, as well as through a case management and advocacy service in the Child House.

Current picture

8.6 NCL Commissioners previously invested CAMHS Transformation funding in a demand and capacity mapping project of CSA/CSE services. This work was commissioned to map current commissioning arrangements and service provision, estimate future demand, and provide an options appraisal and business case for the CSA hub and Child House model.

8.7 Early intervention emotional support services are being designed as part of the CSA Hubs in North Central and South West London, funded by the Department of Health and local CCGs respectively. This evidence-based support gives immediate access to CAMHS or advocacy services and is predicted to reduce progression to PTSD and the need for long-term CAMHS intervention.

8.8 In the North Central Sector:

- CSA medical examinations are being provided by two CSA Hubs at University College Hospital and St Ann's Hospital.
- The Department of Health has funded an early intervention emotional support service for all children and young people accessing the CSA Hubs. The service will be provided by the Tavistock and Portman and Solace Women's Aid, and will consist of 1 WTE CAMHS clinician and 0.8 WTE Child Advocate. The service is currently being designed and is due to launch in September 2016.
- 3 of the 5 North Central CCGS have funded demand and capacity mapping to be completed in August 2016
- A multiagency co-design workshop ran in March 2016 with more than 50 professionals attending. A smaller multiagency group is now working to develop the detail of the Child House model for the sector
- Engagement with children and young people is ongoing with consultations already conducted with Barnet Youth Board, Enfield Youth Parliament, and Islington In Care Council

8.9 Funding has been secured from MOPAC to support the development of two Child House Pilots in London. We are currently awaiting a decision as to where these pilots will be sited.

8.10 If successful in the first instance this will be done by looking to redesign existing resources and services to enable CAMH services to be delivered from a Child House to support C&YP across NCL accessing services here.

8.11 We will also be utilising the findings of the NCL mapping to consider the data and the projected numbers of C&YP expected to access services (it is thought this project will uncover current unmet need) and jointly consider commissioning arrangements to further support the model with CAMHS input

Benefits

- Clear pathway for children and families to use existing commissioned services in paediatrics, CAMHS and early help as well as third sector provision
- Reduced pressure on CAMHS specialist inpatient and outpatient services, through early emotional support and stabilisation of child and family, reducing the risk of progression to long-term mental health conditions and emergency presentations in mental health crises

- High quality medical examinations – sufficient throughput to meet the RCPCH guidelines in all boroughs
- Children and families less traumatized
- Doubling of conviction rates at trial [3] [4]
- Significant long-term savings for the health and social care economy through reduction in chronic mental health, drug and alcohol use, further abuse and sexual violence, school refusal and unemployment, dependency. NSPCC estimates London Alone spends £0.4billion on the outcomes of unsupported victims of CSA.

Next Steps

- October 2016 – Notification of decision re location of MOPAC funded pilot sites for Child House Model
- December 2016 – Discussion with existing providers re service reconfiguration to support implementation by April 2017 (if successful pilot area)
- April 2017 – Review and consider how the current CSA CAMHS and Advocacy services (1 year funding from DFE) are mainstreamed into our local pathways.
- December 2017 – review Child House reconfigured pilot and numbers of C&YP access data to consider additional funding to be made available across the sector for April 2018.

Funding

8.12 Commissioning intentions reflect a commitment to service redesign to reconfigure existing pathways in the first instance to support the Child House Model

8.13 We are awaiting the outcome of the funding decision by The Mayor's office regarding the location of the 2 proposed pilot sites in London.

8.14 Further funding decisions will then be made across NCL re identification of additional funding if and where required.

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promote early Intervention • Improving access and reducing waiting times • Make support more visible and easily accessible
NCL Sustainability and Transformation Programme	• MH Workstream

[3] Link to Children's Commissioner report on Barnahus
https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[4] http://www.bvs.is/media/barnahus/Dublin,-sept.-2013.pdf

Priority 8: Pathways for Young People in the Youth Justice System

Our Ambitions

9.1 Future in Mind 2015 outlined the need to transform 'care for the most vulnerable' which includes mental health of children who come to the attention of criminal justice system. The 'Health and Justice Specialised Commissioning of Children and Young People's Mental Health Services' transformation work stream aims to address this gap.

9.2 We wish to ensure timely assessment and support for vulnerable young people with mental health problems before they become ingrained with offending culture. Since 2007, there have been 82% fewer young people coming into the formal Youth Justice System as a result of diversionary activity. Furthermore, the number of young people aged 10-17 years in custody has fallen by 70% over the last decade. Therefore we will develop an NCL offer that reaches young people in the early stages of contact and provide assessment and treatment where needed including those already in YOS caseloads.

Mental Health Needs of Young Offenders

Youth Justice Board research (2005) found that 31% of a 300 sample of CYP had mental health needs, which included:

- 18% having problems with depression
- 10% suffering from anxiety
- 9% reporting a history of self-harm within the last month
- 9% suffering from post-traumatic stress disorder
- 25% identified as having learning difficulties
- Individuals involved in gangs have higher chances of diagnosable difficulties and poorer general mental health than other young people (Coid, et al., 2013).

North Central London STP

9.3 NCL CCG's and YOS Managers are working with Health and Justice partners in the London region across their STP footprint to enhance the local health offer for CYP that come into contact with the justice system. We have agreed and signed a Memorandum of Understanding with the NHSE Health and Justice Team in relation to roles, responsibilities, funding and governance that jointly ensure a comprehensive local response is in place for CYP in the justice system. Detailed proposals for local service provision will be submitted by December 2016 for assurance in order to release resources for commissioning of new capacity

Priorities and Outcomes for the Health & Justice work stream

9.4 Due in part to the success of liaison and diversion schemes in keeping young people out of formal court proceedings we believe that additional capacity for mental health within youth justice must also extend to exploring options for pre-court interventions Our objective is to close the treatment gap and promote integrated commissioning in line with the national health and justice work stream priority areas:

- Development of Specialist Child and Adolescent Mental Health Services for High Risk Young People with Complex Needs

- Development of Collaborative Commissioning Networks between Health & Justice regional teams and CCGs

9.5 Across NCL STP we wish to achieve a reduction in variation in care for CYP in London in contact with the justice system. CYP Mental health pathways will seek to support diversion of individuals, where appropriate, out of the youth justice systems into health, social care, education and training, or other supportive services. We will offer a mental health assessment to every young person at second appointment to support a reduction in re-offending and/or escalation of offending behaviours.

9.6 Each CCG will develop KPI's with their local providers and YOS managers. Some of these will be congruent across the STP footprint while others will have a local focus to reflect the different starting positions of each area. NCL will aim to establish a greater level of consistency across the STP footprint by ensuring all areas have:

Principals of NCL CCG Model for Health and Justice CAMHS
• Single local point of access for all YOS/CAMHS referrals • Service design based on in-reach to YOS and strengthening pathways into community and specialist CAMHS • Measure outcomes using YJS performance monitoring and CAMHS minimum data set • Benchmarking reported outcomes across NCL by 2017.18 • Each YOS/CCG area to develop bespoke aspects of provision based on local needs

NCL also exploring options for STP wide work including:
• Early intervention for Sexually Harmful Behaviours • Self-Harm and Crisis Care • Transition from secure settings into community CAMHS

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Professionals who work with children and young people trained in child development and Mental Health
NCL Sustainability and Transformation Programme	• Efficient use of resources and provision with a view to future proofing local health services.

Part Three

1. References

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[iii] No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages

[iv] http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf

[v] Report: Children's and adolescents' mental health services and CAMHS (PDF 1.49MB)

[vi] Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

[vii] http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

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2. Appendices

2.1 Policy and Guidance

Appendix One- Policy and Guidance

2.2 Stakeholder Feedback Summary

Online Survey Summary

Report for: Health and Wellbeing Board – 8 December 2016

Title: NMUH & RFL joint partnership development

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

Lead Officer: Richard Gourlay, Director of Strategic Development, North Middlesex University Hospital

1. Describe the issue under consideration

North Middlesex University Hospital is considering joining the Royal Free London NHS Foundation Trust "Group".

Royal Free London became one of four foundation trusts in England to be 'accredited' by NHS Improvement to lead groups or chains of NHS providers. The Trust is part of the Acute Care Collaboration (ACC) vanguards, part of the new care models programme coordinated by NHS England.

RFL has successfully proposed developing as a Group in order to develop the capability and infrastructure to reduce unwarranted variation in all its various forms – which are intended to result in improved clinical outcomes, patient safety and patient satisfaction. The Group also intends to consolidate a range of clinical support services and non-clinical activity, which (in addition to the clinical standardisation) should deliver financial benefits.

The proposal for NMUH to join the RFL Group is aligned with national, local and organisational strategies and has the potential to deliver benefits to patients, staff and the wider health system.

North Middlesex University Hospital is currently exploring how joining the group will help secure the future sustainability of services – both financially and clinically. It has recently experienced significant operational challenges, in terms of both quality and delivery of access standards that may have been mitigated with access to a wider workforce resource that may only be achievable through greater scale.

A Parntership Board has been established since June 2016 to maintain an overview of the progress towards the decision and if the decision is to proceed to the integration of NMUH into the new group structure. This Partnership Board incorporates senior leaders from the Trusts as well as representatives from Haringey CCG, Enfield CCG, NHS England and NHS Improvement.

Both trusts boards will make ultimate decisions regarding progress of the Partnership Programme, with the Partnership Board acting as the collective forum to oversee the work on behalf of both organisations.

Regulatory approval from NHSI, & CQC as well as approval from other central stakeholders such as HMT, DH and NHSE will be required. Support from system stakeholders, such as CCGs, patient groups and politicians will also be important.

The partnership programme has recently met with both Healthwatch organisations covering Enfield and Haringey. It is developing a suite of communication materials and engagement events that will be utilised to talk and listen to the views and thoughts expressed by key local stakeholders on both the perceived strategic benefits as well as the operational architecture of the new “Group” structure.

2 Recommendations

The Board is asked to note the content of the report.