Public Document Pack

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 11 November 2015	Committee Room 2 - Town Hall

Members: 12, Quorum:

BOARD MEMBERS:

Elected Members:	Cllr Steven Kelly, Chairman Cllr Wendy Brice-Thompson Cllr Meg Davis
Officers of the Council:	Cheryl Coppell Isobel Cattermole Philipa Brent-Isherwood Susan Milner
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, NHS Clinical Commissioning Group Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer, Havering CCG Alan Steward, Chief Operating Officer, Havering CCG
Healthwatch:	Anne-Marie Dean, Havering Healthwatch John Atherton

For information about the meeting please contact:
Jade Fortune 01708 432834
jade.fortune@havering.gov.uk

What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform

- Tackling health inequalities

- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities

- Developing a Joint Health and Wellbeing Strategy (JHWS)

- Ensuring patients, service users and the public are engaged in improving health and wellbeing

- Monitoring the impact of its work on the local community by considering annual reports and performance information.

A G E N D A

1. CHAIRMAN'S ANNOUNCEMENTS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building’s evacuation.

2. APOLOGIES FOR ABSENCE

   (If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

   Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES OF PREVIOUS MEETING (Pages 1 - 4)

   The minutes of the meeting held on 19 August 2015 were agreed as a correct record and signed by the Chairman.

5. MATTERS ARISING

   To consider any matters arising.

6. ACTION LOG (Pages 5 - 6)

   Action Log attached.

7. CCG COMMISSIONING INTENTIONS FOR CYP

   Presentation to follow / to be tabled.

8. HEALTH OF HAVERING'S LOOKED AFTER CHILDREN (Pages 7 - 12)

Report attached.

9. UPDATE ON TRANSFER OF THE HEALTH VISITOR SERVICE (Pages 13 - 22)

Report attached.

10. CQC/OFSTED INSPECTION UNDER THE CHILDREN AND FAMILIES ACT

11. ACO UPDATE (Pages 23 - 30)

Report attached.

12. SAFEGUARDING ADULTS AND CHILDREN'S BOARDS (Pages 31 - 92)

Reports attached.

13. HEALTHWATCH ANNUAL REPORT (Pages 93 - 128)

Report attached.

14. FORWARD PLAN

To be tabled.

15. ANY OTHER BUSINESS

16. DATE OF NEXT MEETING

Dates of future Health and Wellbeing Board meetings:
27 January 2016
23 March 2016

This page is intentionally left blank

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
19th August 2015 (1.30 - 3.00pm)

Board Members Present:

Councillor Steven Kelly (Chairman)
Councillor Meg Davis – Cabinet Member – Children & Learning **(MD)**
Atul Aggarwal, Chair, Havering CCG **(AA)**
Alan Steward, Chief Operating Officer, Havering CCG **(AS)**
Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs **(CB)**
Gurdev Saini, Clinical Director, Havering CCG **(GS)**
Susan Milner, Interim Director of Public Health, London Borough of Havering **(SM)**
Isobel Cattermole, Deputy Chief Executive of Children's, Adults and Housing incorrect name of directorate, London Borough of Havering **(IC)**

Officers Present:

Phillipa Brent-Isherwood, Head of Business and Performance **(PB)**
Deborah Redknapp – Head of Childrens and Health Commissioning incorrect title**(DR)**
Mary Pattinson, Head of Learning and Achievement **(MP)**
Jade Fortune, Public Health Strategist
Deborah Taylor, Interim PA to Interim Director of Public Health (minutes)

Members of Public Present:

Three members of the public were also present.

1. CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised of arrangements in case of fire or other event that would require the evacuation of the meeting room.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cheryl Coppell, Chief Executive, London Borough of Havering
Councillor Wendy Brice-Thompson, Cabinet Member – Adult Services and Health
Anne-Marie Dean, Chair, Healthwatch Havering
John Atherton, Head of Assurance North Central and East London, NHS England

3. DISCLOSURE OF PECUNIARY INTERESTS

No pecuniary interests were disclosed

4. MINUTES

The minutes of the meeting held on 15 April 2015 were agreed as a correct record and signed by the Chairman.

5. MATTERS ARISING

There were no matters arising.

6. MEMBERSHIP

It was agreed by the membership that Councillor Steven Kelly will remain as Chair of the Health and Wellbeing Board.

Isobel Cattermole introduced herself to the group as the interim Deputy Chief Executive of Children's, Adults and Housing for London Borough of Havering.

7. ACTION LOG

The action log was discussed and updated.

8. MENTAL HEALTH - OVERVIEW

SM made a presentation to the Board on "Mental Health of Children and Young People".

The Chairman asked a question on the impact social media has on children and young people's mental health and wellbeing. A discussion took place and it was agreed that there were two main areas for concern; one being the potential for cyber bullying and the other focussed on the way individuals compare themselves to one another.

9. MENTAL HEALTH - PREVENTION

DR made a presentation to the Board on the "Promotion of Mental Health and Prevention of Mental ill-health in Children and Young People".

The transfer of the Health Visiting Service from NHSE to Local Authorities in October was discussed. Havering was the only borough to be awarded an uplift to the budget to account for population changes.

There was a discussion about delivery of the 6-8 week and 1 year check for babies, and how to improve uptake. It was agreed that more information was needed to understand why babies were not receiving their checks. The Children's Commissioner will raise this issue with the health visiting service.

10. MENTAL HEALTH - TREATMENT

AS made a presentation to the Board on 'Treatment for Children and Young People with mental health issues'.

The Chairman commented information to be made available for parents about mental health in children and recognising problems. Cllr Davis commented that parents may feel isolated if they are unaware about who to turn to for advice.

MP said that there had been an increase in Education Health Care Plans among under five year olds, and that GPs could be provided with more information about this. The Chairman commented that it would be preferable that there be a more coordinated approach. MP described the discussions taking place between the Council and CCG to address to co-locate a multi-agency team and pool budgets, which would help to strengthen local arrangements.

AS presented the Local Transformation plan to the board for children's mental health. It proposed to use a multi-agency approach and that the Health and Wellbeing Board approve the proposal.

11. WORKING BETTER TOGETHER TO COMMISSION AND DELIVER MH SERVICES FOR CYP

MP presented an options paper for a new governance structure. The Board agreed to Option 4, which was to establish a Children's MH Partnership Board in the first instance to undertake key tasks related to children's mental health.

The board agreed Option 4, with the caveat that the proposal is amended to include a task and finish group to undertake this work rather than setting up a Partnership Board.

12. STROKE SERVICES

AS gave a verbal update on Stroke Services. A 'Stroke Services: Case for Change' paper is currently being finalised and will be presented to the CCG Governing Body in September, and to the Health and Wellbeing Board following this.

Action: AS to bring to a future Health and Wellbeing Board the "Stroke Services: Case for Change" paper.

13. FORWARD PLAN

The forward plan was tabled and shared with Board.

Action: SM to take off the topic of Health Visiting from the forward plan.

14. ANY OTHER BUSINESS

No other business.

15. DATE OF NEXT MEETING

Wednesday 14th October 2015.

HWB Formal Board - ACTION LOG

Date Raised	Owner	Brief Description	Action to be taken	Date for completion	Chased date	Completed	Comments
Chairman's Briefing 01/04/2015	Sue Milner	Scoping Paper	Need to reframe and review Board priorities as delivery and performance needs to be measured. More focus on prevention required. HWB Strategy needs to be overarching. ½ day workshop to be arranged to flesh out.	13 May and 2 June mtgs		Yes	Review of HWB on hold pending outcome of local devolution discussions.
01 April 2015	Sue Milner	Primary Prevention	To be centrally focused – SM will produe presentation			Yes	
01 April 2015	Sue Milner	JSNA	How can we make this into a more user friendly / "live" - possibly Dashboard?			Yes	
01 April 2015		Affordable Housing and Mental Health	Agenda items to be added to Forward Plan.	April		Yes	
01 April 2015		Bi-monthly Board and Development Sessions	Board mtgs to take place bi-monthly, with a Development Session on alternative months. First Development Session mtg scheduled for May - agenda items will be Mental Health and Re-visiting priorities. Chairman's Briefing mtgs will continue to be held 2wks before Board mtgs.			Yes	
Development Session 13/05/2015	Cllr Kelly	Next Meeting	Cllr Kelly requested that the next meeting of the HWB, scheduled for 16 June, be used as a private meeting to continue our review of the role and function of the HWB			Yes	
13 May 2015	Sue Milner	Forward Plan	The Forward Plan has been amended to cover all HWB-related meetings. This will provide a complete overview of what is being scheduled where. Any additions/deletions/errors to Sue Milner and c.c. in Agatha Williams (Clerk).			Yes	
13 May 2015	Cllr Kelly	Distribution List	Distribution list to be reviewed to ensure that only HWB members, their PAs and appropriate LBH support officers are included.	18-May		Yes	
13 May 2015		Agenda Items / Themes	12 August should have a Mental Health theme. 8 July HWB development session will be used as an opportunity to look at mental health issues in more depth in preparation for the board meeting and any formal decisions that the board has to make. We need to start pulling the programme together for the development session and identify any items that need to go to the formal board. All ideas and suggestions for what should be covered under this theme to Sue Milner by CoP 29 May			Yes	
19-Aug-15	Alan Steward	Paper	AS to bring to a future Health and Wellbeing Board the "Stroke Services: Case for Change" paper.	TBC			
19-Aug-15	Sue Milner	Forward Plan	SM to take off the topic of Health Visiting from the forward plan.	Immediately		Yes	
19-Aug-15	Alan Steward, Mary Phillips, Debbie Redknapp	Governance of CYP MH issues	A single governance structure to be established to deal with all aspects of CYP MH service commissioning and provision. A TFG initially set up and then combine with Adults MH Partnership Board.	Dec-15			TFG to be set up ASAP

This page is intentionally left blank

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Health of Looked after Children
Board Lead:	Tim Aldridge
Report Author and contact details:	Deborah Redknapp@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the ‘frail elderly’ population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report describes how initial health assessment and health assessment reviews of looked after children are carried out in the borough and highlights current issues and risks.

It is the responsibility of the local authority to ensure that health assessments are carried out for every looked after child. The Clinical Commissioning Group (CCG) has a duty to comply with requests by local authorities for help in the exercise of their functions to make sure that this happens in accordance with statutory duty on local authorities[i].

Whist the guidance sets out clear roles and responsibilities of local authorities and the clinical Commissioning Group, many of these responsibilities can only be

carried out by the different agencies by co-operating with each other and this has been further strengthened in more recent regulations[ii]

The responsible authority is required to make arrangements for a registered medical practitioner to carry out an assessment of the child's state of health and provide a written report of the assessment. The aim of the assessment is to provide a comprehensive health profile of the child, to identify any acute or chronic health needs that may have been overlooked in the past or require treatment to improve his/her physical and mental health and wellbeing, and to provide a basis for monitoring his/her development while she is being looked after.

Key Deliverables

Health assessments and health assessment reviews need to be carried out in a timely manner so that they can be an effective resource in the holistic care planning process as children and young people are received into care and while they remain in care. The timeliness of the process is clearly set out in the statutory guidance for us to follow.

Initial Health Assessment (by a registered medical practitioner) and the subsequent written report have to be carried out, either before the child is placed, or if not reasonably practicable, before the first review of the child's case. Locally we require the assessment to be carried out within fifteen days of a young person coming into care.

The Health Assessment review requirement (by a registered nurse/midwife) is defined by the age of the child, and are required twice a year for children under five and annually for children over five.

Performance in this area does not currently meet either local or national targets or expectations – as such this represents a significant risk to both the Local Authority, the CCG and NELFT and as such requires urgent remedial action.

A number of issues have been identified that are impacting on our performance and these are: access to health data, capacity of clinical staff, consistency of the quality of initial health assessment reports, local authority internal monitoring processes and some GP's declining the request to carry out an initial health assessment .

The following is our current position:

224 LAC as at 28/10/15

Initial health assessments: 26 are due within 4 weeks from today
Of the 26, 21 are overdue (9%)

- 3 are overdue by less than 15 days
- 10 are overdue by 20-70 days

- 8 are overdue by 84 to 565 days

Review Health Assessments
35 are due within 4 weeks from today.

Of the 35, 30 are overdue (13%)
- only 1 is still with SW; 29 have been forwarded to NELFT
- 6 are less than 20 days overdue
- 18 are overdue by 22 to 84 days
- 6 are overdue by 100 to 431 days
-

These pose a serious risk to the local authority and the CCG in terms of failing to meet the needs of looked after children.

RECOMMENDATIONS

A recovery plan over the next 3 months to be agreed between all parties and this will include:

- Clarity of what the additional health review capacity agreed by the Clinical Commissioning Group consists of. Fornal notification of when can this be implemented and the revised projection for completing the back-dated review health assessments.

- Formal governance processes to monitor and oversee progress need to be urgently put into place. Involving LA, CCG and NELFT.

- NELFT to prioritise the overdue review health assessments – and formulate an action plan to complete all outstanding review assessments in the next twelve weeks.

- The Local Authority is given access to RIO urgently so that the health status of looked after children can be monitored in an open and transparent manner. This will include health assessments and reviews, immunisations, dental checks, vision screening, dental etc.

- Clinical Commissioning Group/NELFT to prioritise the overdue initial health assessments and concentrating on the under-fives, those with complex needs and unaccompanied asylum seekers in the first instance We understand that proposals have been put forward for locum community paediatric cover so that this can be undertaken. A clear plan as to when this additional capacity can be put in place and a projection as to when the back-

log of initial health assessments can be completed needs to be drawn up by the CCG and NELFT and overseen by the governance group.

- The Clinical Commissioning Group to put into place a quality assurance framework to review the quality of the health assessments and ensure that appropriate capacity is put in place for this to happen

- Permanent funded arrangements are put in place in the event that a GP declines the request to carry out initial health assessments (additional on-going clinical capacity for Initial Health assessments?)

REPORT DETAIL

1.0 Roles and Responsibilities

“Evidence indicates that accurate and up to date personal health information has significant implications for the immediate and future wellbeing of children and young people during their time in care and afterwards. Understanding their own health history is an essential part of growing up securely. Inconsistent record keeping can lead to wrong decisions by professional and adversely affect the child or young person” [iii]

It is the responsibility of the local authority to make sure that health assessments are carried out for every looked after child and the Clinical Commissioning Group have a duty to comply with requests by local authorities for help in the exercise to make sure that this happens in accordance with statutory requirement on local authorities. The following principles should be taken into account when planning or conducting health assessments:

- Each child or young person should have a holistic assessment on entering care

- This first assessment should be carried out by a registered medical practitioner in accordance with the Children Act (miscellaneous Amendments) (England) regulations 2002. Review assessments may be carried out by an appropriately qualified registered nurse/midwife

- The first health assessment should result in a health plan by the time of the first review of the child care plan, four weeks after becoming looked after

- The health assessment is not an isolated event, but part of a continuous process, with emphasis being put on ensuring actions in the health plan are being taken forward.

2.0 Historical arrangements

During the time of the Primary Care Trust (PCT) supporting the local authority to carry out its duty for health assessments and health assessments review was relatively straightforward. The PCT instructed general practitioners to carry out the initial health assessments and school nurses and health visitors to carry out the health assessment reviews. Where a general practitioner declined the instruction the patients of that particular GP were signposted to the community paediatrician.

This arrangement was in place for a number of years and some of the issues that have arisen in recent times have been as a consequence of the changes to health care commissioning.

3.0 Current Arrangements

The CCG are responsible for commissioning the initial health assessment and reports and in the main these is carried out by the GP. Thereafter the reports are being quality assured.

Commissioning of review health assessments are split across the local authority and the CCG and this has arisen due to the changes in commissioning responsibility and some commissioning areas not being clearly defined.

The under five year olds review health assessments are included within the national health visitor specification that transferred to the local authority on 1st October and has therefore become a local authority responsibility. The same degree of clarity did not apply to school nursing and this became clear during the joint local authority/Clinical Commissioning Group tender for school nursing and special school nursing.

During the tender process the gap in review health assessment capacity was identified and acknowledged as a CCG commissioning responsibility and as a consequence the CCG agreed to temporarily fund two band 6 school nurses. This was put in place as a temporary arrangement and significant improvements have been made. This arrangement now needs to be formalised.

The local authority notifies the statutory agencies once a child becomes looked after and this prompts a number of actions including the letter to the GP, the social worker to compile their information and an assessment appointment to be made. Children’s social care has looked at their internal processes so that any delay about making the notification and sharing information between the social worker and the health professional is minimised. This is regularly monitored and action is taken where necessary.

However there remains difficulties in gaining access to RIO so that the local authority can be assured of the health status of our looked after children. An example of this is not being able to confidently say what the immunisation status is for each child. Our last annual submission reported that 86% of looked after children had an up to date immunisation status. An appropriate post has been put

in place, agreed with NELFT but the formality of gaining access to RIO needs to be overcome.

IMPLICATIONS AND RISKS

The lateness of initial assessments and review health assessments carries significant risk both to the local authority and the Clinic Commissioning Group and to the health and wellbeing of looked after children. Holistic care plans cannot be put in place until the health status of our looked after children are known and appropriate actions are identified and monitored. Until we get this right we will be failing in our statutory duty.

BACKGROUND PAPERS

None

[i] Statutory Guidance on Promoting the Health and Well-being of Looked after Childrens DCSF, DOH 2009
[ii] The Children's Act 1989 guidance and regulations Volume 2:care planning. Placement and case review
[iii] NICE Looked after children and young people Oct. 2010

HEALTH & WELLBEING BOARD

Subject Heading:	Transfer of commissioning responsibility for health visiting services
Board Lead:	Sue Milner, Director of Public Health
Report Author and contact details:	Mark Ansell mark.ansell@havering.gov.uk 01708 431818

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the ‘frail elderly’ population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The report describes the process whereby responsibility for the commissioning of health visiting services provided by NELFT transferred to the Council on 01/10/15.

At transfer, the service was under-resourced with a relatively small establishment of qualified health visitors and hence high case loads. As a result, the service is unable to deliver the national ‘4,5,6’ model of health visiting in full. However, delivery of the mandated health reviews element of the service specification is similar to if not better than that in adjacent boroughs and the service has agreed to pilot new ways of working.

The cost of the service is charged to the Council’s Public Health Allocation. It is unlikely that the Public Health Allocation will grow in the foreseeable future. Therefore further investment in health visiting would require disinvestment elsewhere and/or investment from other sources.

Health visitors have a central role in identifying and supporting families with additional needs; often in collaboration with colleagues from Children’s Services and Learning and Achievement.

There is good evidence, supported by the views of local professionals, that improvements in prevention, early identification and intervention during the early years is both effective and cost effective – improving health, education and social outcomes and in so doing reducing the overall cost to the public purse.

On this basis, and despite the obvious financial obstacles, further improvement of the health visiting service as part of a coordinated early years offer spanning health, public health, children’s services and learning and achievement should be a priority.

RECOMMENDATIONS

Members of the health and wellbeing board are asked to note the contents of the report.

REPORT DETAIL

1.0 Background

Health visitors are crucial to the delivery of the 0-5 element of the Healthy Child Programme (HCP) – the universal preventative service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The goals of the HCP are to identify and treat problems early, help parents to care well for their children, change health behaviours and protect against preventable diseases. The programme is based on a systematic review of evidence and is expected to prevent problems in child health and development and contribute to a reduction in health inequalities.

The final part of the transfer of public health responsibilities from the NHS to local government was delayed until 2015 whilst central Government made good on a 2010 commitment to increase the national health visitor workforce by 4,200 full time whole time equivalents (wtes).

This commitment was underpinned by evidence about the importance of the early years for developing emotional resilience and laying the foundations for good health and the role of health visitors in supporting families to achieve this.

Responsibility for the commissioning of health visiting eventually transferred on 1st October 2015.

In many areas, but not Havering, responsibility for commissioning Family Nurse Partnership (FNP) services also transferred. FNP is a targeted support service for teenage mothers. However FNP was never commissioned in Havering as the programme was focused on areas with higher numbers of first time teen mothers.

All health visitors remain employed by the relevant provider organisations i.e. for Havering, the North East London Foundation Trust (NELFT).

Commissioning responsibility for some resources relevant to the 0-5 HCP was retained by NHS England:-

- Child Health Information Systems (CHIS) in order to improve systems nationally. This will be reassessed in 2020.
- the six to eight week GP check (also known as the Child Health Surveillance) because of its complex commissioning arrangements.

2.0 Resources

2.1 Financial

Funding for health visiting for the period October 2015 to March 2016 is provided in the form of a one-off increase to the Council's public health allocation. As the transfer is intended to be a 'lift and shift', the additional funding was based on existing spending on health visiting services (and any spending on FNP) as captured in a baseline assessment exercise (BAE) undertaken by NHS England. Subsequently, the Dept. of Health established a minimum funding floor such that no local authority would receive less than £160 per child aged 0-4. Locally, spend per head on health visiting was only £118. Therefore, as a result of the minimum funding floor, the addition to the PH allocation to cover the cost of health visiting for the remaining half of 2015/16 is £350K more than the value of the existing contract between NHS England and NELFT. Thus, at the time of its announcement, it appeared that there would be the opportunity for significant additional investment.

Table 1: Existing spend, spend per head and final allocation for health visiting, London Borough of Havering and other boroughs in ONEL[1].

Local Authority	Existing spend identified in BAE (£000s) - Full year	Adjustments* post BAE (£000s) – Full year	Effective existing spend (£000s) - full year	Estimated population 0-4, 2015	Adjusted** spend per head (£)	New allocations (£000s) - Full year Increased to minimum of £160 per head of 0-4	New allocations (£000s) - Half year	New allocations, including commissioning costs (£000s) - Half year	Difference between existing spend and new allocation (£000s) - Half year
Barking & Dagenham	4,790	204	4,994	19,900	229	4,994	2,497	2,512	0
Redbridge	2,903	200	3,103	23,600	118	4,195	2,097	2,112	546
Waltham Forest	5,557	229	5,786	22,400	231	5,786	2,893	2,908	0
Havering	**1,856**	**150**	**2,006**	**15,500**	**118**	**2,714**	**1,357**	**1,372**	**354**

*In ONEL, existing spend was increased to raise contract overhead from 9 to 15%
** includes impact of market forces factor

However, following the election, the Treasury announced that the public health allocation to local authorities in England would be reduced by £200m or 7% in-year. The exact impact of this reduction at individual local authority level has still to be announced but assuming a 7% reduction is applied uniformly to all local authorities, the 15/16 allocation to Havering will be reduced by £690K thereby removing any opportunity for additional investment in health visiting this financial year.

In 2016/17 and beyond, monies for health visiting will be included within the overall public health allocation. The PH allocation for 16/17 will be announced in

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465521/Minimum_Floor_Calculations.xlsx

December. As public health spending is not included within the NHS ring-fence and therefore liable to cuts in the forthcoming spending review, it is likely that the in-year cut applied in 2015/16 will be made recurrent and possibly further extended. Therefore, as the Council's public health allocation is already entirely committed, any additional investment in health visiting would probably require disinvestment from other services or securing investment from elsewhere.

2.2 Staffing at transfer

As noted above, the Health Visitor call to action (C2A) committed central government to increase the national health visitor complement by 4200 wtes by 2015. Unlike some neighbouring boroughs Havering did not benefit to any great extent from this growth so that the health visiting establishment at transfer remains small and the ratio of children to staff high.

Table 2: Growth in qualified Health Visitors posts resulting from the Call to Action (C2A) and ratio of children aged 0-4 to qualified health visitors posts; Havering and other boroughs in ONEL

	Establishment pre C2A (wte)	C2A growth (wte)	HV establishment at transfer (wte)	0-4 pop 2015	ratio 0-4 pop : HV posts
Barking and Dagenham	40.84	41.5	82.34	19900	242
Redbridge	32.07	11	43.07	23600	548
Waltham Forest	31.1	63.8	94.9	22400	236
Havering	**22.93**	**4.6**	**27.53**	**15500**	**563**

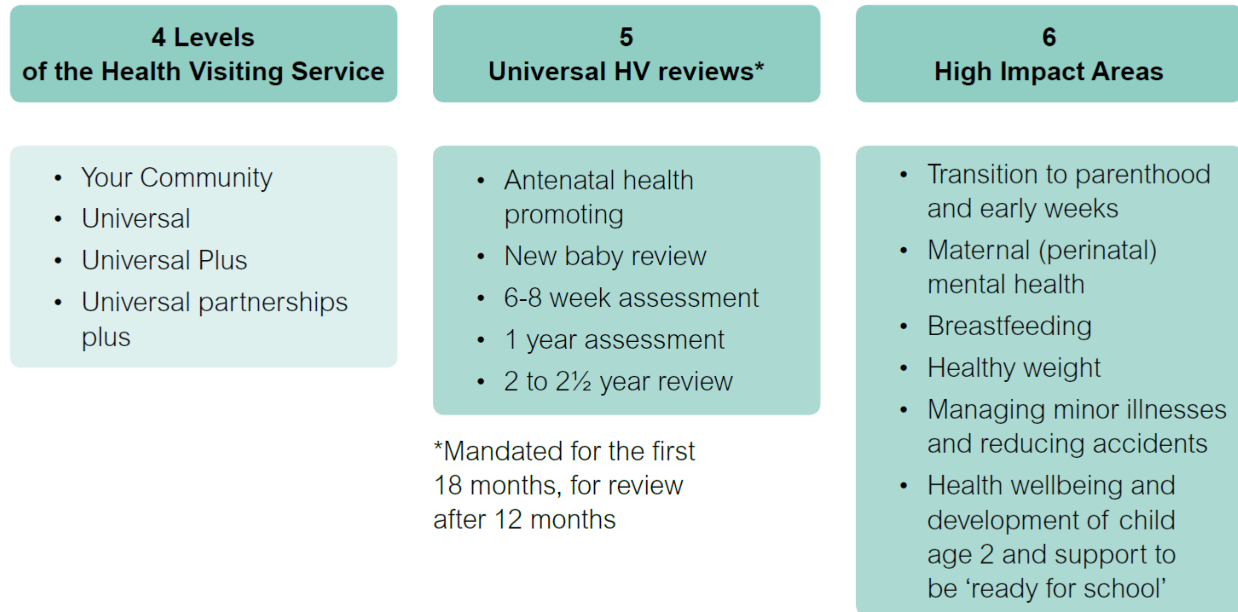
Source: NHSE

Prior to transfer, and whilst there appeared to be a realistic prospect of further investment, NELFT estimated that an additional 20+ wtes was necessary to bring caseloads down to levels (<300) needed to deliver the new national service specification in full.

3.0 Contract and new service specification

On the basis of legal advice, the Council has issued a contract variation to add the health visiting service specification to the existing school nursing contract with NELFT to elapse in April 2018. The service specification sets out the '4,5,6 model' of transformed health visiting.

Figure1: the '4,5,6 model' of transformed health visiting.



Describing a services that works at 4 levels: -

1. Community: health visitors have a broad knowledge of community needs and resources available e.g. Children with Disabilities (0-5) Service, Children's Centres and self-help groups and work to develop these and make sure families know about them.
2. Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive 5 developmental checks (mandated for at least 18 months after transfer) and receive good information about healthy start issues such as parenting and immunisation[2].
3. Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
4. Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or special learning or physical additional needs.

Making a significant contribution to the health and wellbeing of children particularly in the 6 high impact areas.

4.0 Current performance

In the run up to transfer, NELFT has been clear that the service is inadequately resourced to deliver the '4,5,6' model in full. Limited resources are pulled towards children and families with greater needs, particularly where there are safeguarding

[2] The Childhood Immunisation Programme is delivered by general practice. Uptake is recorded on the CHIS.

concerns[3], at the expense of the universal and particularly community elements of the service.

Of the 5 mandated checks, the new birth, 1 year and 2- 2½ year checks are offered universally but uptake is lower for older children. The 6-8 week check is targeted on a broadly defined cohort of children percieved to be at increased risk following the new birth check or based on the advice of other health and social care professionals. Antenatal checks are only undertaken in exceptional circumstances guided by concerns of midwifery services. The interaction of universal versus targeted offer, together with the decline in uptake with age is such that the great majority of babies get a new birth check; a half or more of all children receive the 6-8 week, 1 year and 2 ½ year checks and very few mothers are seen by a health visitor antenatally. This performance is similar to, if not better than that achieved in adjacent boroughs served by NELFT and the average for England and London.

Table 3: Delivery of mandated health checks, Q1 2015/16, boroughs in ONEL

LA Name	% of children who received new birth check within 14 days of birth	% eligible children who received a 6-8 week check by 8 weeks	% of children who received 1 year check by age 15 months	% eligible children getting 2 - 2.5 year check by age 2.5 years
BARKING AND DAGENHAM	86%	27%	58%	24%
HAVERING	87%	45%	78%	61%
REDBRIDGE	89%	72%	68%	2%
WALTHAM FOREST	85%	23%	44%	27%

Data source: NELFT

Children who Did Not Attend for an earlier check and / or have an incomplete immunisation history are proactively followed up if they fail to attend the following scheduled check to minimise the chance that individual children go without a review for long periods.

The contract variation agreed between LBH and NELFT regarding the health visiting service includes clear outcome measures and KPIs. These require NELFT to maintain performance at pre-transfer levels with modest service developments regarding the 2- 2 ½ year check (see below).

5.0 Future development of the health visiting services

The regulations regarding the health visitor transfer require local authorities to take a reasonably practicable approach to improve delivery of the mandated[4] elements

[3] Health visitors attend all initial case conferences and review meetings where the child concerned is aged 0-5 or has a sibling in this age group.

[4] The Regulations regarding the transfer provide for a ‘sunset clause’ after 18 months that will have the effect of ending mandation, unless further legislation is made that continues the provisions in

of the Healthy Child Programme 0-5 years over time but no specific targets regarding improving performance above that achieved at the point of transfer are set.

Although there isn't an external requirement to improve the health visitor offer, an excellent case can be made for doing so to improve outcomes for children in the borough and reduce overall costs to the public purse.

The most obvious opportunities relate to the '6 high impact areas'identified by the Dept. of Health. The 6 high impact areas draw on the extensive evidence base regarding the benefits of early help and prevention emphasising the potential contribution of health visiting to health outcomes.

Reports by Graham Allen[5] and Frank Field[6] concluded that early intervention can reduce a much wider basket of negative, and financially costly outcomes such as absence from school, antisocial behaviour, crime, welfare dependency and the need for statutory social care services.

Allen identified 25 of the best, evidence-based, cost effective early intervention programmes which he encouraged local areas to consider for implementation spanning 3 distinct opportunities for intervention and improvement:-

- 0–5: Readiness for primary school
- 5–11: Readiness for secondary school
- 11–18: Readiness for life stage

The opportunity afforded by the transfer of health visiting to the local authority and future priorities for the service were discussed at the recent series of 'visioning' workshops facilitated by the LBH Public Health Team.

The opportunity to support all children and parents through the universal offer and identify those at risk of problems and signpost them to appropriate community resources and / or refer to more specialist services was widely acknowledged. Equally it was accepted that capacity in the community was limited and many children and their families identifed as being in need nonetheless fall below the threshold to access existing specialist services. Consequently it was recommended that any improvements in the delivery of the mandated checks to identify families with needs should progress in parallel with an expansion in resources to support those families. This support could be fostered by health visitors themselves, and or by linking with a number of Council teams including the Early Years Service, the 0-5 children with disabilities team, the early years quality assurance team and the 0-5 placements team. Thus as a minimum, plans to develop health visiting need to complement work in Early Years and the possible benefits of much closer working should be explored.

Specific opportunities for closer coordination and cooperation exist with Learning and Achievement. Most obviously, the 2–2 ½ year check undertaken by health

---

force. A review, involving Public Health England, is intended to inform whether the sunsetting needs to be amended.

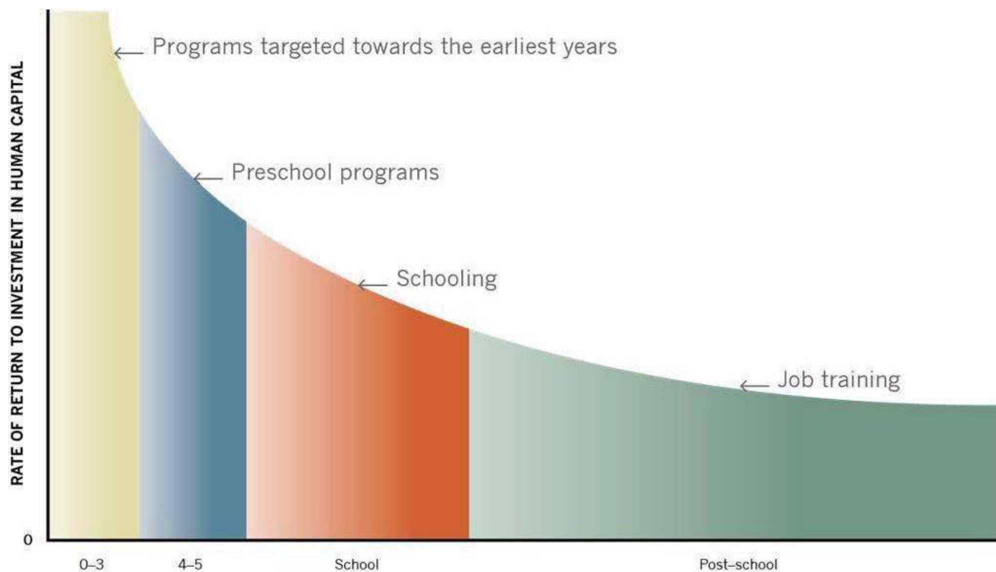
[5] Graham Allen MP – Early Intervention the next steps (Jan 2011)

[6] Frank Field - Review of Poverty and Life Chances, (Feb 2010)

visitors coincides with the progress assessment undertaken by providers of free,state-funded early education. Currently 2-2 ½ year checks in Havering are undertaken by health visitors in clinics for small groups of parents and children, relying on the experience of the health visitor to identify children who may require additional support. As part of the recently agreed contract, NELFT has agreed to pilot the provision of this check in child care settings and the use of the ages and stages questionnaire (ASQ). The ASQ comprises a series of questions to be completed by the parent about their child which serve to compare the child's progress against well established norms to improve the early identification of problems and inform plans as to how they might best be addressed by parents, educational practitioners and health professionals.

The benefits of intervention in early years to improve school readiness was a recurrent theme throughout the visioning workshops e.g. maternal mental health issues predispose to poor parental attachment which increases the risk of poor communication skills which impedes educational progress which may/may not be made good following input from speech and language therapy at a later date. This view is consistent with the available evidence regarding improving skills and educational outcomes which also supports the view that intervention during the early years offers the greatest rate of return from programmes across different stages of childhood.

Figure 2: Rates of return to human capital investment



From [Heckman, J.J. and Masterov, D. (2004) Skills policies for Scotland. Institute for Study of Labour. Discussion Paper 1444]

Accepting that there little chance that the Public Health allocation will be increased allowing for more investment, alternative sources of funding for health visiting and early intervention services to support at risk children and families should be explored.

Given that the potential benefits would be felt very widely, cooperation and coordination across a number of different stakeholders (Public Health, Children's

Services, Learning and Achievement and schools, the CCG) should be encouraged to attract additional investment to support early intervention initiatives and thereby improve outcomes for local children and the cost effectiveness of statutory services.

IMPLICATIONS AND RISKS

None. Decisions will be made within the agreed governance arrangements taking into account financial, legal, HR and equalities implications and risks.

Financial implications and risks:

Legal implications and risks:

Human Resources implications and risks:

Equalities implications and risks:

BACKGROUND PAPERS

None

Integrated Care Coalition

Better care, better lives, together

Barking and Dagenham, Havering and Redbridge

An Accountable Care Partnership Building on Integration and successful collaborative working

Barking and Dagenham CCG | Havering CCG | Redbridge CCG | Barking, Havering and Redbridge University Hospitals NHS Trust | NELFT | London Borough of Barking and Dagenham | London Borough of Havering | London Borough of Redbridge | Together First | Havering Health | Healthbridge Direct

Vision

"To accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and contribute towards sustainable provision of health and social care services"

Challenges

Area		Challenges
Health and wellbeing challenges	Population	▪ Life expectancy is variable across the patch and very low in some places ▪ Fast growing population projected to increase in by over 110,000 in the next 10 years (a 15% increase by 2025) and within this there are significant forecasts in both 0-19 and over 75 year olds – above the London average ▪ Behavioural risk factors: Smoking (23.1% vs 17.3% London), alcohol abuse (B&D 7% harmful, 17% high risk, 14% binge drinkers) and inactivity ▪ Proportion of overweight and obese children is significantly higher that the London average and not declining ▪ Emerging needs linked to population change, e.g. housing challenges/pressure on primary, acute and social care, changing disease profiles and expectations of health services
Care and quality challenges	Disease prevalence	▪ Health outcomes are mixed and reflect wide socioeconomic gradients across the patch ▪ Significant variation in take up and delivery of screening, health checks and immunisations across the system ▪ High prevalence of hypertension and diabetes, with a significant proportion undiagnosed ▪ Wide variation in care outcomes for people with long term conditions, particularly for Diabetes and COPD ▪ High rates of late diagnosis of cancer and the second worst one-year survival rate in London (63.9% in B&D vs 69% national average) and variability across the system ▪ Delayed diagnosis of cardiac problems and variability across the system ▪ 50% of dementia cases are undiagnosed, with limited support for people and their families post diagnosis ▪ Prevalence of multiple conditions is significant in the over 75s ▪ High admission rates: higher than average unplanned hospitalisation for chronic ambulatory care sensitive conditions (898 per 100,000 pop vs national average 784 per 100,000)
	System issues	▪ Fragmented health and care commissioning system that needs to work to address and support a 'distressed economy' ▪ BHRUT (and Barts Health) currently in special measures ▪ Large number of GPs approaching retirement age ▪ Local/national shortage of key clinical and professional staff ▪ Inability to retain and recruit staff across the system and address workforce development requirements ▪ Inability to generate robust data and intelligence on interventions and outcomes across whole pathways of care ▪ Embed prevention immunisations (childhood vaccines 93.2% vs 95% England; PPV 62.5% vs 70% England) ▪ Embed early intervention, e.g. health checks (3-4.5% offered vs 7% London) ▪ Unhelpful structures and governance arrangements in general practice, which inhibit whole-system working ▪ Access to and quality of Primary care (active programme of work including Prime Minister's Challenge fund for out of hours access) ▪ Quality of residential and domiciliary care in a market under financial pressure; not helped by fragmented commissioning ▪ Market diversification, in response to personalisation, leading to a multitude of unregulated care providers and fewer contractual levers
Funding and efficiency challenges	Funding Gap	▪ BHR system total estimated funding gap of £429.9m and our current plans will not fully address this. (LA figures are for adult social care and public health but scope could expand to children's services) ▪ Marked distance from capitation at organisation level ▪ Public Health Grant reductions proposed; further pressure on public health and social care expected in CSR15 ▪ Pressures emerging in parts of the social care market (residential and domiciliary care), exacerbated by National Living Wage and compromising ability to meet Care Act duty to promote sustainability
	Efficiency	▪ BHRUT has: High non-elective admissions rate (41% emergency admissions as a percent of total admissions vs 35% England, 33% London) High occupancy levels (94.7% vs England average 86.9%) Planned care performance and efficiency challenges ▪ All three BHR CCGs have higher than average inpatient spend for over 75s (e.g. B&D gastro 6.5 per 100,000 pop higher than comparable CCGs; respiratory 5.5 per 100,000 higher; gastro intestinal 5.5 per 100,000 higher) ▪ Commissioning for Value: Integrated care pathways, February 2015, Redbridge CCG, Havering CCG, Barking and Dagenham CCG, Public Health England, NHS England and Right Care

Delivery & impact timeline - ACO

	Year 1 – 2016/17	Year 2 – 2017/18	Year 3 – 2018/19
	Consistency	**Evolution**	**Transformation**
Objective	▪ complete business case for ACO – determine scope, structure and accountability ▪ develop implementation plan ▪ establish co-design principles and commence work ▪ understand and address ACO risks	▪ phase one of implementation (driving out first phase of resource shift) ▪ re-engineering budget structure ▪ evaluate progress and impact	▪ develop full ACO Governing Body with full budget accountability ▪ consolidated governance structure: ACO established with combined commissioning and provision ▪ aligned incentives for tariff and combined budgets ▪ evaluate progress and impact
Co-design	▪ engagement with front line staff ▪ engagement with local population ▪ engagement with Healthwatch and VCOs ▪ Identify front line staff to lead re-design	▪ address outcomes of the engagement ▪ develop detailed design with staff and the BHR population	▪ robust systems of co-design embedded
Workforce	▪ staff and professional engagement ▪ workforce plan linked to the CEPN ▪ identification of staffing and skills gaps to be addressed and engagement of Royal Colleges	▪ consultation on change ▪ fundamental review of skills and roles across health and social care ▪ commencement of training and development	▪ transition to new organisation form ▪ recruit and train staff in new roles ▪ infrastructure to support new roles
Leadership and governance	▪ shadow ACO Governing Body reporting to respective organisations decision making bodies	▪ shadow ACO Governing Body reporting to respective organisations decision making bodies	▪ ACO Governing Body; a decision maker in its own right
Academia	▪ establish academic partners, brokered by Care City and UCL Partners ▪ develop approach to ongoing evaluation	▪ embed '4P' approach (Pre-emptive, Predictive, Personalised and Partipatory) in ACO	▪ ensure ACO transformation underpinned by latest evidence and ongoing commitment to population health
Public system reform and regulation	▪ review current regulatory body reporting and statutory accountabilities to propose changes and plan future governance	▪ shadow changes to regulatory body reporting ▪ need to take account of Personalisation – public commissioning services for themselves and how will this fit	▪ amend and reduce regulatory body reporting

6

Business case development timeline

	Completed by
SET UP ▪ ICC leadership agreed and joint SROs confirmed as Cheryl Coppell and Conor Burke ▪ Confirm resources for business case and set out project structure ▪ Full engagement and involvement of all partner organisations at front line level, including the LMC and regulators, to shape the ACO through early enabling workshops ▪ Determine ACO membership and leadership model ▪ Define the challenges and risks for the ACO and how these will be addressed ▪ Development of communications strategy with all partners	31/12/15
ENGAGEMENT ▪ Public engagement ▪ Staff engagement	Ongoing
GOVERNANCE: ▪ Establish Project ACO Board arrangements ▪ Develop model to include clarification of ACO governance and accountability arrangements ▪ Sign off of model by all partners to ensure system ownership at ICC	31/03/16
BUSINESS CASE DEVELOPMENT, SUBMISSION AND DECISION MAKING: ▪ Develop options for ACO model including scope/coverage, operational model and impact evaluation on existing commissioning plans and strategies ▪ Quantify outcomes – linked to scope ▪ Confirm budgets for inclusion (linked to scope) – including centrally held budgets, e.g. specialised commissioning ▪ Identify the other gaps alongside the health and social care system funding gap, e.g. worklessness, welfare, etc. and how an ACO would benefit these ▪ Complete business case options appraisal to determine preferred option and if not ACO what changes can be made ▪ Finalise and sign off business case ▪ Submit business case for review by NHSE	30/06/16
LEADERSHIP AND OVERVIEW ▪ ICC to receive statement of progress at the end of each quarter ▪ Updates submitted to NHSE at the end of each quarter	Quarterly

Support Required: System asks

BHR partners will require the following support to implement this ACO bid

Provide investment and access to expertise

- financial support to enable the co-creation of a detailed business case for the creation of the ACO over the next three months, in partnership with primary care practitioners and staff across BHR
- **phase one: first six months £750,000 required for engagement and surveys to establish a PMO and develop business case. These funds will be match funded through local resource (staff and resource equivalent to £100k per organisation from 3 LAs, 3 CCGs, BHRUT, NELFT, and UCLP)**
- expert advice including: Legal/HR advice, expert financial support (Treasury), Communications support, Engagement support, population health analytics support (PHE)
- peer review and challenge
- access to the Transformation Fund and financial support for double running to establish new system (determined by business case)

Revolutionise regulation

- create a separate and single regulation system for the ACO to reinforce required behaviours across the system and focusing on population outcomes
- ensure individual regulation reflects additional ACO obligations proportionately in the performance assessment
- permissions to operate differently/ outside of guidance in development stages
- ACO enabled to take control of the setting of priorities and planning timelines

Develop new workforce models

- professional and contractual issues
- training and development link to national agenda

Reform to financial flows

- relevant centrally held commissioning budgets, including Specialised Commissioning, that have large population impact, being returned to the ACO, e.g. primary care, public health etc.
- budgets brought to capitation level within an agreed timeframe
- flexibility around tariffs and payment mechanisms – beyond current flexibilities
- ACO to take accountability for all relevant property enabling a system wide view of estates to support the development of the ACO and release relevant resources for transformation

Decision Timescale

- Part of the overall devolution package for London
- Current shape of bids:
  - Sub regional care integration (BHR)
  - Sub regional estates pilot
  - Local care integration
  - Local prevention pilot
- November/December final decision

This page is intentionally left blank

Havering Safeguarding Adults Board

Annual Report 2014-2015

Are we keeping people safe?

How do we know?

Foreword by Brian Boxall

Chair of Havering Safeguarding Adults Board

One of the outcomes of the recently introduced Care Act 2014, has been to create a legal framework so key organisations with responsibility for adult safeguarding can agree on how they must work together to keep adults at risk safe.

In order to coordinate this multi-agency working, the Act has placed a responsibility on local authorities to set up safeguarding boards, and for the first time has given Adult Safeguarding Boards a statutory footing.

In order to facilitate this requirement, the Havering Safeguarding Adult Board during 2014/15 has focussed on ensuring that the Board and its member agencies were prepared for the introduction of the Act. This preparation has been achieved although the full impact of the new Act will only start to fully emerge during 2015/16.

Similar to previous years there has continued to be organisational changes and changes in personnel, including at the Board. The Board will continue to monitor changes to gauge the impact on adult safeguarding.

This year's annual report demonstrates that the Board continues to respond to key safeguarding issues that have arisen over the past year. The Board also recognises that the its member organisations will face significant challenges over the coming year, due to issues including the Care Act and the continuing financial savings all agencies must face.

As Chair, I would like to acknowledge the support that all agencies and individual Board members have given to the Board over the past year. It is this level of commitment that will ensure that over the coming year, the Board will continue to provide support to the adults at risk in the Havering area and fulfil its statutory responsibilities.

Table of Contents

1. INTRODUCTION 3

What is Havering Safeguarding Adults Board? 3

Our main responsibilities 3

2. THE CARE ACT 2014 5

3. HOW SAFEGUARDING WORKS IN HAVERING 6

The Safeguarding Adults Board 6

SAB Sub-groups 6

Safeguarding Adults Team 7

Board Challenge 7

4. SAFEGUARDING ACTIVITY 2014/15 7

Safeguarding Contacts 7

5. SAFEGUARDING ADULTS BOARD PARTNERSHIP REPORTS 10

Community Safety Service 10

Violence against Women and Girls (VAWG) 10

Domestic Abuse multi agency risk assessment conference (MARAC) 11

Long and short term risks and priorities 11

Reducing Re-offending 11

Anti-Social Behaviour 11

Counter Terrorism and Prevent 12

Havering Clinical Commissioning Group (CCG) 12

Barking, Havering and Redbridge NHS Hospitals NHS Trust 13

6. REVIEW OF SAFEGUARDING ACTIVITY 2014-2015 14

How has the organisation contributed to the Havering ASB strategic priorities? 15

Long and short term risks and priorities 15

Actions to be taken to address the risks and the expected impact on outcomes 15

Review of Safeguarding Activity 2014-2015 16
7. TRAINING 16
Long and short term risks and priorities 17
North East London Foundation Trust 17
Metropolitan Police Havering Borough 20
8. SAFEGUARDING ADULTS BOARD PRIORITIES 2015-2018 21
The results we expect from our work are 22
Risks and Challenges .... **Error! Bookmark not defined.**
9. CONCLUSION 23

1. INTRODUCTION

What is Havering Safeguarding Adults Board?

Safeguarding Adults who may be at risk from significant harm is **everyone's responsibility**. Everyone who lives in, works in, visits or runs a business in Havering has a responsibility to support, protect, prevent harm and report concerns about potential abuse and neglect. Most people can look after themselves. Some people with care and support needs may be more at risk of abuse or neglect and therefore need some extra help to stay safe. No one agency or organisation can do this alone, we have to work together. To work together well requires strong leadership and direction, sound policies and protocols, consistency, timeliness and true multi-agency working – this is why Havering's Safeguarding Adults Board is there. We come from many different organisations including adult social services, NHS, Community and Hospital Trusts, police, housing, community safety, community and voluntary groups. All our work supports our shared vision.

Our Vision

To make sure that Adults at risk from harm in Havering are safe and able to live free from neglect and abuse.

Our main responsibilities

- Involve adults at risk and carers, making sure they are the centre of all we do – help people to identify and manage risks
- Prevent abuse and neglect from happening – raise awareness everywhere, not just in statutory agencies
- Respond appropriately and consistently when abuse or neglect take place or when concerns are raised – investigate and protect when abuse happens
- Involve the community and work in partnership with them – make sure people know what neglect and abuse is and how to report concerns

The Board is not completely independent. It reports to the Havering Health and Wellbeing Board and all its members report Board plans, activity and progress to their own agencies. It also reports to Havering Residents in its Annual Report and its Business Plans.

The **Six Adult Safeguarding Principles** are at the centre of all we do, and our business plans and performance monitoring reflect these:-

> **EMPOWERMENT** – people feeling safe and in control, encouraged to make their own decision and giving informed consent. People feeling able to share concerns and manage risk of harm either to themselves or others
>
> **PREVENTION** –it is better to take action before harm happens, so good information and advice are really important
>
> **PROPORTIONALITY** – not intruding into peoples' lives more than is needed by responding in line with the level of risk that is present
>
> **PROTECTION** – support and representation for those adults who are in greatest need because they are most at risk of harm
>
> **PARTNERSHIP** – working together with the community to find local solutions in response to local needs and issues
>
> **ACCOUNTABILITY** – being open about what we are doing and responsible for our actions - focusing on outcomes for people and communities

2. THE CARE ACT 2014

The Care Act 2014 came into force in April 2015. Over the past year the Board has been focused on ensuring that agencies were prepared for the introduction of the act.

What is the Care Act?

The Act refers to an adult at risk as someone who:

a) Has needs for care and support (whether of not the Local Authority is meeting any of those needs),

b) Is experiencing, or is at risk of abuse or neglect, and

c) As result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The Act sets out the first ever statutory framework for adult safeguarding which stipulates local authorities' responsibilities and those with whom they work, to protect adults at risk of abuse or neglect.

These provisions require the local authority to:

- Carry out enquiries into suspected cases of abuse or neglect.
- Establish Safeguarding Adults Boards in their area.
- Arrange where appropriate for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or review.

The provisions require a Safeguarding Adults Board to:

Publish an annual report detailing what the Board has done to achieve its objectives and what it and its members have done to implement its strategy.

Arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if certain laid out conditions are met.

Request where necessary a person to supply information to it or to some other person specified in the request; the person to whom the request is made must comply if certain laid out conditions are met.

Local Authorities have always been expected to lead adult safeguarding and this legislation will formalise that as a duty. However safeguarding has to be everybody's business, therefore the Local Authority plays a pivotal role in building strong relationships with other organisations such as the NHS, the police, third sector and providers. They form the trust and bedrock on which a multi-agency approach thrives and they lead the formation of sound local policies, procedures and lines of accountability.

.

3. HOW SAFEGUARDING WORKS IN HAVERING

The Safeguarding Adults Board

The Safeguarding Adults Board works within current Pan-London Policy and Procedures for protecting adults at risk of harm. It also oversees the application of the Mental Capacity Act and Deprivation of Liberty Safeguards activity.

Effective safeguarding activity is led by Adult Social Care, but the Board has a multi-agency responsibility to oversee the partnership working to keep people vulnerable to abuse or neglect safe.

In terms of governance, the SAB reports to Havering's Health and Wellbeing Board and the Overview and Scrutiny Committee and it works closely with the Community Safety Partnership.

SAB Sub-groups

The Board has sub-groups, which meet quarterly, or more frequently on a task and finish basis. These are:-

- Quality & Performance
- Transitions

Board Challenge

During 2015/16 the structure of the board and the sub groups will be reviewed so that board business processes are better stream lines. This will lead to better communication across the SAB and Safeguarding Children Board (SCB) when priorities are identified to be cross cutting.

Safeguarding Adults Team

The Local Authority Safeguarding Adults Team responds to reports, queries and requests for expert advice. These requests can be received from the Safeguarding Adults Partnership, adults at risk and/or their carers and members of the general public. Local Authority Safeguarding Adults Team staff act as safeguarding lead professionals in institutional abuse investigations and very complex cases.

Board Challenge

During 2015/16 a new Safeguarding Adult Team structure will be introduced.
The board will need to monitor changes including any impact on other agencies.

4. SAFEGUARDING ACTIVITY 2014/15

Safeguarding Contacts: Multi Agency Sharing Hub (MASH)

In June 2014, Havering became the first borough in London and one of the first authorities in the country to implement a joint children's and adults MASH. A MASH is a co-located, multi-agency team working in a single, secure, assessment and referral unit. The MASH receives notifications about potential risk and is now the front door for safeguarding contacts.

Contacts are assessed and graded and then signposted to the appropriate structure to progress as required.

MASH June 2014 to March 2015		
Contacts	305	
MASHed	484	15%
Not MASHed	1949	63%
Number of Repeat contacts	1233	40.3%
Outcomes: All Contacts		
Non safeguarding–Welfare	2234	73%
Progress to Safeguarding Adult Team	249	8.1%
Outcomes: MASHed Contacts		
Non safeguarding–Welfare	199	41%
Progress to Safeguarding Adult Team	95	19.6%
Went onto full investigation	132	27.3%

The majority of referrals were assessed to be non-safeguarding cases.

Feedback from the initial stages of the joint MASH has been positive with evidence of improving communication and information sharing across the partnership agencies involved within MASH. This has improved working relationships between agencies.

A number of services have been developed to support the MASH including a Community MARAC (Multi-Agency Risk Assessment Conference); a family approach to risk-improved adult safeguarding service for Care Leavers; supporting vulnerable adults.

The MASH will during 2015/16 be subject to independent review

Board Challenge

For the Board to progress learning identified in the MASH review.

Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS)

MCA DOLS Authorisations	
2013/14	33
2014/15	383

A Supreme Court Judgment in March 2014 significantly impacted on the number of applications made in the last 5 months of 2014/15 as is likely to continue during 2015/16.

It is the role of the Best Interest Assessors (BIA's) to assess whether someone is deprived of their liberty and whether this is in their best interest. The significant increase in applications, noted within the table above, has placed a big strain on the local authority's ability to process the applications in a timely way due to the time pressures placed on the limited number of BIA's.

Board Challenge

The board will continue to monitor the use of MCA DOLs and challenge were necessary.

Safeguarding Referrals Outcomes

The table below provides information regarding the reason for referral and source of referral to the safeguarding team.

Type of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical	50	45	14
Sexual	6	2	1
Psychological and Emotional	22	38	2
Financial and Material	25	41	17
Neglect and Omission	113	20	29
Discriminatory	2	0	0
Institutional	3	1	1

Location of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Care Home	112	18	9
Hospital	2	5	16
Own Home	73	80	31
Community Service	4	1	0
Other	13	8	5

The majority of referrals are related to incidences of neglect and omission especially within Care Home settings. Referrals relating to financial and physical abuse were more prevalent within own home settings.

Action and Result	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	23	25	8
Action taken and risk remains	5	14	5
Action taken and risk reduced	107	50	33
Action taken and risk removed	69	23	15

The outcome in the majority of cases has led to either the reduction or removal of the risk.

Board Challenge

- With the emphasis on providing support to vulnerable adults in order to enable them to remain within their own home environment, the board need to continually ensure that this environment remains safe. This will be undertaken through audits and increase information available to the public.

- The challenge is to ensure that action taken is a long-term solutions so the monitoring of repeat referrals will help identify failure to find long term solutions.

5. SAFEGUARDING ADULTS BOARD PARTNERSHIP REPORTS

The Adult Safeguarding Boards Statutory Partners and Partnerships have prepared activity reports for inclusion in this annual report.

Community Safety Service

The Local Authority Community Safety Service is responsible for the development and implementation of work to reduce crime and disorder, as well as the fear of crime, within the borough. It achieves this through both direct work and by co-ordinating strategic partnership working with the wide range of public, private and voluntary sector partners represented on the Havering Community Safety Partnership (HCSP) and the Safer Neighbourhoods Board.

Violence against Women and Girls (VAWG)

The VAWG strategic partnership is well established within the borough and continues to meet on a quarterly basis. Representatives from the council, police, probation and the voluntary sector attend this meeting ensuring that, on a strategic level, the partnership is supporting children and adults in the most effective way.

A partnership VAWG strategy has recently been signed off by the HCSP, a comprehensive action plan focusses on the prevention, protection, safeguarding and provision of services to support victims of domestic violence, FGM, Forced Marriage and Honour based Crimes, CSE and Girls and Gangs.

Domestic Abuse multi agency risk assessment conference (MARAC)

The MARAC is the forum where high risk domestic violence cases are presented and is chaired by Havering Police. In 2014-15 The number of referrals to MARAC continued to increase, with 241 for the 12-months to February 2015 (compared to 180 for the corresponding period of February 2014). The proportion of repeat cases during the same period increased from 15.6% to 21.6%.

MARAC data evidenced a rise in BME victims being referred (21 up to 31), an increase in male victims (6 up to 13), and an increase in victims with a disability (3 up to 9).

Long and short term risks and priorities

The total number of reported and recorded Violence against Women & Girls incidents and offences has increased by 1,008 offences in the current financial year to date (to February 2015), representing a rise of 19.6%. This has been driven by a notable rise in the volume of both Domestic Offences and Domestic Incidents.

The increase in DV Offences is above the regional average, showing a 25.0% increase compared to a 20.7% increase across London. Havering has the 3rd highest percentage increase of DV with injury across London.

Reducing Re-offending

The London Borough of Havering's Public Health Service (PHS) is responsible for promoting health and well-being and commissioning drug and alcohol treatment services. Earlier this year, the Public Health Service & Community Safety recruited a specialist substance misuse officer to oversee the criminal justice work with substance misusing offenders.

At present North East London Foundation Trust (NEFLT) and Crime reduction Initiatives (CRI) deliver drug and alcohol treatment within the borough and the substance misuse officer ensures that safeguarding procedures are embedded in the delivery of the boroughs' drug and alcohol services.

There are a number of changes occurring in the borough the first of which is the retendering of the drug and alcohol service. The new provider will be operational by 1st October 2015. The substance misuse officer is supporting the PHS with the mobilisation of the new integrated service provider and is currently reviewing drug and alcohol safeguarding processes in order to develop pathways between statutory services with responsibility for areas such as mental health, children and families and domestic abuse.

Anti-Social Behaviour

The new ASB Crime and Policing Act 2014 brought in a range of new enforcement powers for dealing with anti-social behaviour. The new act has led to a complete overhaul of the ASB policy for Havering which focuses on how victims will be treated and the measures that can be used to tackle complaints that are received.

The ASB Panel is attended by professionals from Education, Early Help and YOS who play an integral role in deciding action plans for those engaged in ASB. The ASB Panel is monitored by the HCSP.

Counter Terrorism and Prevent

The Counter-Terrorism and Security Bill 2015, places a duty on specified authorities which includes Local Authorities, Schools and colleges and Health providers to 'have due regard, in the exercise of its functions, to the need to prevent people from being drawn into terrorism'. Preventing people becoming terrorists or supporting terrorism also requires challenge to extremist ideas where they are used to legitimise terrorism and are shared by terrorist groups. In carrying out this duty, the specified authorities must have regard to guidance issued by the Secretary of State.

A multi-agency Prevent strategic group will be established in 2015 to oversee the delivery of the Prevent Plan,

Havering Clinical Commissioning Group (CCG)

CCGs are statutory NHS organisations and are responsible for the quality of healthcare they commission for the local population regardless of the care setting. Therefore it is important that we are assured of the services that our patients, their families and carers receive, and that we are working collaboratively with our partners to keep them safe from harm.

Work undertaken by the CCG

The CCG implemented a quality assurance framework across all of our contracts that use a risk based approach. As part of this framework the CCG completed unannounced quality assurance visits across our commissioned services, e.g. hospital wards and care homes with nursing.

Where the CCG identified safeguarding risks it immediately raised these with the provider, notified the Local Authority and undertook a review site visit. The CCG also completed care assessments with residents in care homes when safeguarding alerts have been made. The CCG completed these assessments in partnership with the Local Authority.

The CCG made approximately 49 visits to the 18 care homes in Havering between 1 April 2014 – 31 March 2015.

The CCG undertook monthly quality assurance visits to Barking, Havering & Redbridge University Hospital NHS Trust (BHRUT), and North East London Foundation NHS Trust (NELFT).

The service hold formal contractual meetings monthly with BHRUT and NELFT called Clinical Quality Review Meetings (CQRM). These meetings are assurance meetings and have a strong focus on safeguarding, especially serious incident management and safeguarding training.

The CCG has developed an early warning system that uses both soft and hard intelligence and feedback that is used as an indication of care being provided.

The CCG has also continued to implement the recommendations from the Francis Report, especially the development of a GP service alert system.

Developments in Safeguarding Adults

The CCG has identified a prevent lead, who has been working with the prevent coordinator to meet the borough's strategic objectives.

The CCG participated in reviewing service users' welfare where safeguarding alerts have been raised.

The CCG has supported all CCG staff to complete mandatory training and we have a clinical supervision process in place for all staff with a clinical role in the continuing health care team.

Care Act 2014

The CCG has worked collaboratively with our colleagues across Havering to ensure that all are fully prepared for the implementation of the Care Act. Part of this preparation includes the completion of a gap analysis to identify areas for development in 2015/16, which is one of the safeguarding priorities.

Making Safeguarding Personal

The CCG has supported and challenged its commissioned services to evidence personalisation. For example, we review all serious incidents and monitor if there are any safeguarding concerns and the outcome for individuals.

The CCG oversee the continuing healthcare service and the outcome service users want for themselves.

Work planned April 2015 – March 2016

- To fully participate as a statutory partner of the SAB and ensure that the Board fulfils its Care Act responsibilities and accountabilities.
- To ensure the CCG meets its responsibilities with regards to the Care Act 2014.
- To appoint a designated safeguarding adults manager (DSAM).
- To strengthen the monitoring arrangements of providers to ensure we do our part in preventing harm, or where harm does occur that we respond in a way that reduces further harm to individuals.
- To raise prevent awareness among CCG staff.
- To implement our Quality Strategy and refresh our Safeguarding Adults Framework.

Barking, Havering and Redbridge NHS Hospitals NHS Trust

Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) has introduced measures at all levels to ensure that it is doing everything it can to prevent the abuse or neglect of the people who use the Trust services and their carers. The organisation has established processes, by way of the Trust's Protecting

Adults at Risk - Safeguarding Adults Policy, Safeguarding Adults Training, Incident Reporting and Safeguarding investigations, to ensure there is a timely and proportionate response when allegations of abuse or neglect are raised.

Review of Safeguarding Activity 2014-15

The Safeguarding Adults Annual Work Plan 2014/15 was developed in April 2014 to identify the key priorities/actions for the Safeguarding Adults Team. The majority of the actions were achieved; two ongoing actions relating to Mental Capacity and Deprivation of Liberty Safeguards and Independent Mental Capacity Advocacy were transferred to the 2015/16 Work Plan.

The Trust has developed a Safeguarding webpage and Learning Disability webpage for the BHRUT external website which is accessible to the general public. Available on the webpage is the Trust's Safeguarding leaflet which has been produced for the general public.

A Safeguarding Adults Supervision Policy was produced in July 2014. The purpose of this policy is to provide a framework for practice which outlines the principles and functions underpinning supervision within the context of Safeguarding Adults.

Following the findings of the CQC's Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards, published each year for the last five years, and the results of the Trust's Safeguarding MCA/DoLS Assessment of Knowledge audit a key priority for the Safeguarding Adults team has been to address the educational requirements of the clinical staff.

Delivery of Safeguarding Adults Training as per the Trust's Safeguarding Training Needs Analysis and Training Strategy has been maintained throughout 2014/15.

The Trust produced a Safeguarding Adult audit framework for 2014/15. Audits undertaken included:

- Mental Capacity and Deprivation of Liberty Safeguards – assessment of staff knowledge
- Knowledge of Safeguarding amongst Foundation Trainee Doctors
- Reasonable Adjustment Audit – knowledge of staff in out patients
- Deprivation of Liberty Safeguards (DoLS) Audit – are staff recognising a deprivation of liberty

The Learning Disability Working Group, chaired by the Learning Disability Liaison Nurse (LDLN) meets every other month to explore issues pertaining to the safe delivery of hospital services for people with a Learning Disability. All work streams in relation to the Learning Disability agenda are discussed at this group. This group is attended by people with Learning Disabilities, family and carers, Local Advocacy Services, members of community Learning Disability Teams, BHRUT staff including LD Champions, representatives from Healthwatch and Clinical Commissioning Groups.

The Dementia Team introduced monthly coffee mornings in May 2014 across both hospital sites. These are for newly diagnosed patients and their families to provide a forum to share their experiences.

How has the organisation contributed to the Havering ASB strategic priorities?

BHRUT is a member of three Local Safeguarding Adult Boards, including the London Borough of Havering. The Deputy Chief Nurse represents the Trust at this meeting.

The Trust also attends all partnership committees and sub-committees hosted by all three Boroughs. These meetings include Domestic Violence, Performance and Serious Case Reviews, Training and Development and Policy and Practice.

The LDLN attends the Learning Disability Partnership Boards for Barking & Dagenham, Havering and Redbridge. The LDLN maintains a link between the local Community Learning Disability Teams and the Trust and with advocacy and carer groups within the three Boroughs the Trust serves.

Long and short term risks and priorities

A quarterly Safeguarding Adults Progress report and Learning Disability Progress report are discussed at the BHRUT Safeguarding Strategic & Assurance Group and any identified exceptions or risks are discussed at the Trust's Quality & Safety Committee, which is a sub-group of the Trust Board.

The current risk identified is the completion of Mental Capacity Assessments and Deprivation of Liberty Safeguards.

Actions to be taken to address the risks and the expected impact on outcomes

The Trust has devised a clear action plan to ensure Trust compliance with meeting the statutory legislative requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

The appointment of a Mental Capacity Act and Deprivation of Liberty Safeguards Advisor will assist in the delivery of the Trust's action plan and sustain the changes that have already been achieved.

National Probation Service

It has been a year of significant change for probation services nationally and in London. From 1st June 2014, the National Probation Service (NPS) and Community Rehabilitation Companies (CRC) were created. In London, this meant the establishment of the NPS - London Division and London CRC.

The NPS assesses and allocates all offenders, whether to the NPS or CRC. The NPS works with high or above risk of serious harm offenders sentenced to community or custodial sentences, and or those subject to Multi-Agency Public Protection Arrangements. The service prepares reports for courts and offers advice to sentencers', is responsible for Approved Premises, preparing parole reports and oversees the Victim Liaison Unit. The CRC supervises low and medium risk of serious harm offenders, runs Community Payback and delivers the majority of

offender interventions. Probation services work with offenders who may present a risk of harm to an adult(s) at risk, but who may also be an adult at risk.

Review of Safeguarding Activity 2014-2015

The governance arrangements and structure for Safeguarding Adults within NPS London has been established.

The Senior Manager with lead responsibilities is James Jolly. He attends and reports on Safeguarding Adults matters to the NPS London, Public Protection Sub-group. This reports to the NPS London Senior Leadership Team.

All Clusters should have a Senior Probation Officer, Single Point of Contact lead for Safeguarding Adults. Some also have practitioner leads.

Quarterly practitioner SPOC forums are held at which developments are discussed. During the year these were held for both CRC and NPS staff. However, it was decided at the February meeting to hold separate meetings going forwards due to the increasing separation of the work of both organisations.

Training

Two Safeguarding Adults – Train the Trainer events have been run, one in February and one in April. This event is to train those who attend in delivering the Safeguarding Adults – Awareness Briefings, for all probation staff. Eighteen staff have attended. Staff representatives from all the twelve clusters have now attended this.

The Awareness Briefings have continued to be run this year. Since it was developed at the end of 2013, approximately 300 staff across London have attended the Awareness Briefings across 14 boroughs.

The training has been revised to reflect the responsibilities of Probation within the Care Act.

The MAPPA Strategic Management Board held a MAPPA Chairs training event this year on Safeguarding Adults. It was attended by managers from the Met Police, London Probation. The aim was to promote understanding of safeguarding adults and the role of MAPPA.

The Care Act

Key issues for probation have been; ensuring staff understand the eligibility criteria for safeguarding duties to apply, understand the prison and local authority responsibilities for offenders in prison and Approved Premises. Practice guidance has been developed for staff including a series of presentations and papers on the sections which relate to probation services, for staff and managers.

NPS London held an event in March for Approved Premises managers and representatives from the Local Authority. This was to build understanding regarding the work of Approved Premises in advance of the Care Act and the responsibilities the Local Authorities would have for adults with care and support needs accommodated within them.

A national Probation Instruction was issued in April related to Adult Social Care, which includes probation responsibilities regarding the Care Act.

Long and short term risks and priorities

There are a number of initiatives which need to be pursued. Amongst these are:

- National practice guidance, and a policy are being developed.
- Contacts and registers in the offender database to support performance.
- Agreeing whether the NPS London will make a financial contribution to Safeguarding Adult Boards.
- Ensuring the NPS are compliant with the Care Act and other agencies whose work impacts on the NPS.
- Continuing to train NPS staff in Safeguarding Adults, including the Care Act.

North East London Foundation Trust (NELFT)

NELFT provides an extensive range of mental health and community health services for people living in the London Borough of Havering. Our community services include district and school nursing, health visiting, therapies, care and support for people living with long term conditions, intermediate care beds and community based mental health services, CAMHS and Inpatient services.

As an NHS organisation, we come into contact with adults with care and support needs both directly through providing a service to them and indirectly, through providing a service to a member of their family.

All health professionals working throughout NELFT have a critical role to play in safeguarding and promoting the welfare of adults with care and support needs. The Think Family approach is firmly embedded in practice and the safeguarding adults and team work collaboratively to identify risk and to protect adults with care and support needs.

The Chief Nurse & Executive Director of Integrated Care Essex is the executive lead and board member for safeguarding. The Chief Nurse has Board level responsibility for safeguarding adults and children, LAC and Prevent, which is the health service component of Contest which is the British government's counter terrorism strategy.

The Safeguarding Team acts on the Chief Nurse's behalf to ensure that the Board is assured that all necessary measures are taken to safeguard adults at risk. The Director of Nursing, Patient Safety is the Strategic Lead for Safeguarding and supports the management oversight of safeguarding issues in relation to adults with care and support needs. All Senior Leads and Managers including the executive team have received safeguarding training at the required statutory level. The Integrated Care Director works closely on all safeguarding matters with the Director of Nursing and Associate Director and is a member of the LSAB.

Review of Safeguarding Activity 2014-2015

The Safeguarding Adults Team has further increased its visibility across the Trust by directly working alongside front line staff to facilitate the embedding of safeguarding, Mental Capacity Act 2005 and Deprivation of liberty Safeguards. In addition the Clinical Advisers are regularly engaging with staff through attendance at

Multidisciplinary Team meetings, and monthly staff meetings. The Safeguarding Adults duty desk has been established for 18months, which provides direct support to staff via telephone, email and face to face contact and through the screening of all safeguarding related incident reports.

In August 2014 the Associate Director for Safeguarding Adults was successfully appointed to the post of Interim Director of Nursing - Clinical Effectiveness. The Director of Nursing, Patient Safety, is the Strategic Lead for Safeguarding. The Named Nurses for Adult Safeguarding have been allocated additional responsibilities to meet the organisational requirements regarding Safeguarding Adults and to ensure on going service continuity.

During 2014 three additional Clinical Advisors joined the team further enriching the skill mix of the team with backgrounds in occupational therapy and End of Life. One seconded Clinical Advisor returned to a role in Practice Improvement to assist with embedding safeguarding across the Trust, and the substantive vacancy has now been successfully recruited to. The Named Nurse for Adults post has also been successfully appointed to.

The internal joint Adults and Children's Safeguarding Strategy and Action Plan are now in place and the senior leadership team have assigned ownership to each operational action which identifies and monitors the organisations safeguarding priorities. The Safeguarding Adults and Children's Teams continue to progress the actions outlined in the accompanying action plan along with the operational leads. The progress of the strategy action plan is monitored quarterly through the internal safeguarding locality meetings and actions within the strategy are reflected in the individual work plans of the Safeguarding Adults and Children's teams.

There are a variety of ways in which patient experience is captured by NELFT and service users and carer's views are vital when a change is being considered. Most recently there has been service user input into the proposed changes in service delivery within the inpatient mental health area Sunflowers court at Goodmayes hospital. Service user forums are in place across the Trust and changes in practice have resulted from direct feedback from these. There is also work ongoing in relation to the implementation of the Barking Havering and Redbridge Clinical Commissioning groups Intermediate Care Consultation which NELFT is implementing on their behalf regarding relocating community inpatient service to the King George's hospital site in late 2015.

One of the areas of identified as a priority in the Havering Self-Assessment carried out in January 2014, was around patient/service user involvement in the Safeguarding Adults process. A method for capturing recorded consent in relation to Safeguarding Adults Alerts has been initiated by the Safeguarding Adults Team and an Audit of consent is scheduled to be conducted by the end of October 2015. This audit is also in line with the principles of the 'Making Safeguarding Personal' initiative being implemented nationally.

How has the organisation contributed to the Havering ASB strategic priorities?

The Trust continues to be an active member of the Havering Local Safeguarding Adults Board. Evidence of strong partnership work is demonstrated through attendance at board and contribution to the board's annual development day participation in working groups, audit programmes and policy development. The NELFT training strategy has been shared as part of the ongoing priority centered on Safeguarding Adults Mandatory training requirements driven by the Training and Development subgroup. The Interim Director of Nursing for clinical effectiveness continues to chair the transition subgroup and progress work aligned with this priority area. In addition the Mental Health Social Care Lead chairs the audit subgroup which monitors and aligns the various audits in relation to Safeguarding Adults agenda which are being undertaken by the partner agencies to ensure emerging themes and risks identified in the results and recommendations are appropriately escalated to the board.

Long and short term risks and priorities

- To further embed integrated working across the adult and children safeguarding teams via a joint consultation to integrate the two teams.

- To review the training strategy for delivery of Prevent awareness training in line with the government proposal of a more towards statutory awareness raising. The proposal is that Prevent training will become a mandatory training required three yearly for all staff by face to face and e-learning depending on staff role. This work will be taken forward by the Prevent lead for the organisation who is overseeing the development of a Home office compliant Elearn package. Additional members of staff will be trained in the delivery of WRAP3 to ensure effective delivery to all priority staff groups.

- A Review of the Duty Desk standard Operating procedures is planned for completion in July 2015 in line with the impact of the Care Act 2014, and local and national guidance relating to Domestic violence and harmful practices.

- A Review of all Mandatory training packages has been undertaken to ensure compliance with the Care Act 2014 and are being rolled out as part of the organisations' on line training strategy. NELFT overall Compliance as of 30 December 2014 is 88.75% for Safeguarding Adults Training which demonstrates a significant improvement from 77.17% compliance reported as of 30 December 2013. In Havering the overall compliance figure is currently 88.40% for Enhanced Safeguarding Adults Training and 87.09%for recognition and referral delivered via an e-learning package. The long term priority is to ensure training stays constantly above 85% a collaborative action is in place between the Integrated Care Director for Havering, Education and Development and the Safeguarding Adults team.

- Mental Capacity Act 2005 and Deprivation of Liberty Safeguards continues to be a priority area for the organisation. A pilot audit undertaken has identified that whilst knowledge is good, application in terms of Mental Capacity Assessments is an ongoing piece of work. The Safeguarding Adults Advisors have been delivery bespoke training to inpatient staff and working alongside community staff and this work will continue in the coming year. The DoLS

administrator post which was implemented in June 2014 as part of the action plan responding to the risk identified by the changes in the interpretation of the legislation around DoLS brought about by the Supreme Court Judgement in 2014 and the impact this would have on the organisation. This post has been extended to October 2015 to facilitate further embedding of the process within both Mental Health and Community inpatient areas.

Metropolitan Police Havering Borough

The MPS responds to calls for assistance from a variety of forums, spanning the emergency requiring an immediate response to the slower less time critical requests for assistance. Our officers provide a 24/7, 365 days a year service to the people of London. We have Emergency Response Teams augmented by Safer Neighbourhood Team and the more specialist services provided by the Community Safety Unit. The CSU's remit is the more protracted, complex and serious crime allegations.

We have London's first fully integrated MASH, staffed by 1 Detective Sergeant, 3 PCs and 5 support staff. Here Havering Police provide the initial RAG rating and disseminate cases partners for action, addressing fast time actions and mitigating risk. The MASH deal with about 160 Merlin enquiries and about 50 Adults Coming to Notice referrals each week.

Risks and Challenges

The risks presented over the next 12 months are the increasing demand identified as a result of the implementation of the Care Act. This will require greater accountability for a verity of services and will have an impact on many partners. We are closely monitoring any increased in identified victims and where necessary increasing the police response. This may require an increase in MASH staffing levels. We are awaiting the findings of the MASH review to be published to identify any learning or operations requirements.

The financial challenge over the next 5 years are not clear at this stage, the implications of the second round of the Strategic Spending Review will not be realised until late October 2015. Once this has been published the MPS will need to assess the impact and devise plans according to risk.

There will inevitably be closer working with other local boroughs from a policing perspective as a result of the reorganisation. The Child Investigation Abuse Teams will feature here with a potential to share skill sets to be considered.

ASG Training is a key aspect of police probation training with refreshers delivered to more experienced officers to ensure that all officers are up to date with legislation and any policy changes.

Commander Christine Jones is the MPS lead for Mental Health, her work informs training and development, her work here helps shape our response to mentally vulnerable people.

We are a statutory body required and represented at Serious Case Reviews we provide a professional assessment of response and are a conduit for local, MPS

wide and national learning from a policing prospective. All learning is sanitised and disseminated in a support and constructive manner.

6. SAFEGUARDING ADULTS BOARD PRIORITIES 2015-2018

The board has produced a three year plan based on the **Six Adult Safeguarding Principles**. It has the following aims:-

Empowerment

- We will ensure that all our procedures put the adult at risk at the centre of prevention and protection planning
- We will listen to what the adult at risk wants to happen and will help them to achieve that
- We will make use of a number of different methods to make sure that the response is proportionate and meets the adult at risk's preferences as far as possible
- We will make sure that advocacy is available for those people who are incapable of representing themselves, or who find it very difficult to do so without help.

Prevention

- We will make sure we have good public information available, in a way that people can understand
- We will develop a good website which tells local people and partners what we are doing and how we do it. We will seek the views of local communities about what information should be there and how the information should look on the website.
- We will make sure that our Advice and Information outlets include information and advice about preventing harm to adults at risk and what to do if you have concerns

Proportionality

- Risk assessment is the key to ensuring that we can prevent and protect adults at risk from harm. When we do this, it will only be as intrusive as it needs to be. Therefore we will review our risk threshold and risk assessment tools to make sure that we can assess the level of risk and respond appropriately.

- We will ask people who have been at risk from harm what there experience was of how we worked with them

Protection

- We will have clear policies and procedures to make sure that we keep people safe from harm and act swiftly where there are concerns
- We will work with our providers to make sure that people are safe within their services. Where providers fail to ensure people are safe we will act in a swift, open and transparent way to keep people safe and to improve performance.
- We will learn from our own work and from that of other places and will change how we do things if necessary.

Partnership

- We will review what we need in terms of time and money to make sure the Board works properly, as required by the Care Act 2014
- We will improve business support to the Board
- We will work with providers of services, including Community and Voluntary Services, to make sure that they prevent harm, act appropriately when adult(s) a risk have been caused harm and report concerns appropriately
- We will work with local banks and businesses to prevent and keep people safe from financial abuse
- We will share information on a need to know basis to ensure that adults at risk are kept safe from harm.
- We will work more closely with the Local Safeguarding Children's Board

Accountability

- We will review and update what we do and how we do it, including the Safeguarding Adults Board and all its Sub-Groups.

  - We will be clear about the authority/expectation and decision-making powers of Board Members
  - We will make sure that all our actions are recorded and accounted for.
  - We will publish our Annual Report.
  - We will publish a Business Plan each year set out the detail of what we will be doing. We will consult with local people and providers on our Business Plans.
  - We will monitor safeguarding adults performance
  - We will ensure that we have a Training Strategy.

The results we expect from our work are

1. People living, working or supporting those that live in Havering know abuse or neglect of adults at risk from harm happens and how raise concerns if it does

2 Abuse of adults at risk from harm is prevented whenever possible

3 Adults are protected from harm in a way which works for them, when they need to be

4 Staff and volunteers can spot abuse and take timely, consistent and proportionate action to prevent and protect those at most risk

5 Partners work together, share information and resources and join up with others

6 Safeguarding Adults policies and procedures work and we can prove they do

7 People know what the Safeguarding Adults Board is doing

The Board Performance Sub-Group will monitor what we are doing through our Action Plan each year.

Managing risks and challenges across the partnership

Resourcing/Finance

To be able to effectively implement the requirements of the Care Act 2014, the Board needs an infrastructure to support it. All agencies that form part of the Safeguarding Adults partnership are struggling with reducing budgets and the Board needs their investment to enable it to function efficiently and effectively. Consideration will need to be given to how this can be achieved by pooling resources and getting best value for money through economies of scale, but it does need to be a priority for partners members of the Board.

7. CONCLUSION

Adult abuse happens. Havering is making progress to ensure that adult abuse is reported, investigations are carried out and, most importantly, the abused adults' voices are heard and they receive appropriate support.

Safeguarding adults is everybody's business. It is vital to be aware that we all have a part to play in promoting good practice when dealing with adult abuse within Havering or as it affects Havering's most vulnerable residents. People have a right to be safe and we all share the responsibility for helping that to happen for those adults who are at risk from harm, neglect or abuse of any nature.

WORRIED? REPORT IT!

01708 433999

This page is intentionally left blank

Havering Local Safeguarding Children Board Annual Report 2014-2015

Havering Safeguarding Children Board Chair Forward

This is my second annual report as Chair of Havering's Local Safeguarding Children Board (HSCB).

The HSCB continues to be well supported by both statutory and non-statutory partners and I would like to thank all members for their support and commitment.

The multi-agency partnership in Havering must ensure that partnership working is effective in order to ensure that quality services are delivered in the most cost effective manner.

The introduction of the integrated adult and children Multi Agency Sharing Hub (MASH) has increased agency engagement and improved decision making when determining the level of service required to respond to identified needs.

The Havering MASH is now a leading example of an adult and child integrated service for other London Boroughs.

The introduction of the Early Help and Troubled Families Service, which has integrated all the early help support including the previously names youth offending service now provides a holistic response to early help.

Over the year there has been significant activity in respect of the multi-agency service response to child sexual exploitation (CSE) and missing. This has resulted in a co-ordinated multi-agency response to CSE and missing, which will lead to a consistent understanding of CSE and missing when safeguarding concerns are identified. .

The HSCB has improved the multi-agency understanding of prevalence and identification gang activity and violence against women and girls, which includes female genital mutilation (FGM). This is leading to greater insight into the activity in Havering and better approaches to dealing with victims.

The board continues to work closely with partners. The agency section 11 statutory requirement reviews reflect the work being undertaken and the willingness of agencies to continue to identify and address risks and challenges.

There are many new and varied challenges facing the board. The priorities for the next financial year will be CSE, FGM, gangs and the prevent agenda. This will require the Board to actively seek the voice of Havering's children and listen to their views so that services respond to their needs during this of significant change.

The impact of austerity and budgetary restraints is a challenge that must be a focus of the board during this next financial year.

I am pleased to be in a position to support the development of a strong and effective multi agency safeguarding offer to children and young people during the upcoming year.

Brian Boxall

HSCB Independent Chair

Introduction

The purpose of this report is to fulfil the statutory requirement set out in Working Together to Safeguard Children 2015, which states that all Local Safeguarding Children Boards must publish an annual report on the effectiveness of safeguarding in their local area.

Working Together 2015 asserts that LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

Our Vision

The safety of children is Havering Safeguarding Children Board's (HSCB's) overarching priority. All agencies are committed to raising safeguarding standards and improving outcomes for all the children of Havering.

In discharging our duty we will:

- Act to protect children from harm.
- Make Havering a safer place to live.
- Identify and act upon priority areas for improvement so that every child is given the opportunity to achieve potential.
- Involve children and young people in decisions made about them.

This report will provide an overview of a number of areas. These are

1. 2014/15 Board Priorities
2. Learning and Improving Framework
3. Board Sub Groups

Agencies statutory responsibilities

Boards Governance and structure and finance

Board Priorities 2014-2015

In May 2014 the HSCB identified the five key priorities for the Board:

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding.

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents.

In addition to the above priorities HSCB was to ensure:

- That all statutory requirements set out within Working Together 2013 are fully implemented.
- The HSCB would work with the Adult Safeguarding Board (ASB) to streamline services and processes that were relevant o both boards.

Section 1

2014/15 Board Priorities

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards

The Front Door

The front door to child protection services in Havering is the Havering Multi Agency Safeguarding Hub (MASH). This is an essential multi agency team function that ensures that the information, contacts and referrals received are reviewed and analysed to so that they receive the most appropriate and timely intervention.

Since its inception in September 2012 the Havering MASH has continued to develop and improve. In 2014 the MASH integrated with adult safeguarding. This is the first joint adult and children MASH in London and one of only a few fully integrated MASH's in the country. This change was closely monitored by the HSCB to ensure that the integration was not to the detriment of children's safeguarding.

The integration has strengthened multi agency engagement and also resulted in Mental Health practitioners and housing officer's joining the MASH. This has enabled improved information sharing and has increased the focus on the whole family approach: problems encountered by adults in a family can now been considered within the MASH to include the impact of adult issues on caring capacity, which in turn leads to better outcomes for the child.

Impact

Is the MASH making a difference?

MASH audits undertaken in 2014 to 2015 identified some good practice and found that MASH processes were having an impact on improved outcomes for children.

The audit identified areas for further development and these are being implemented and monitored through the MASH steering group. Audits of MASH will continue throughout 2014 to 2015 and findings will be presented to the HSCB Operational group

MASH processes include a RAG rating system, which is linked to a timescale in which agencies are required to submit information to support decision making. There has been a 75 per cent increase in the proportion of children's cases referred where the RAG rating was increased following completion of the MASH information sharing. This indicates that a higher level of need than initial thought is being identified earlier, leading to the correct level of intervention being provided to the children and their families.

MASH Referrals and Assessments		
Years	2013-14	2014-15
Contacts received.	7410	6984
Contacts progressed to referral	1106 (15%)	1774(25%)
Referral progressed to Assessment.	1066 (91%)	1783 (95%)
Contacts progressed to Early Help.	889 (12%)	964 (13%)
Contacts progressed to Early Help Assessment	126 (2%)	391 (5%)

The improved quality of decision making is also reflected in the proportion of referrals from MASH progressing to a full assessment.

2012/13: 41 per cent

2013/14: 91 per cent

2014/15: 95 per cent

The past year has seen a slight decrease in the number of contacts within the MASH, but the percentage of contacts being progressed to referral has significantly increased. This suggests that the quality of contacts in to MASH is improving. The number of contacts progressed to Early Help has remained steady but the number then progresses to Early Help Assessment has increased significantly.

Contact Sources.

The source of the contacts/referrals has remained consistent to previous years with the Police being the main referral source at 65 per cent. Schools have dropped slightly from 9 per cent to 7 per cent but it is of note that there was a significant increase in school contacts for the last quarter of the year.

Health partners, comprising of acute and community settings, midwives, GPs and the London Ambulance Service, account for 3%. This is a significant drop from the 9% 2013/14. This is an area of concern that needs to be further examined to better understand why this is taking place. A question to consider is whether children are being missed by health professionals or whether the children are being referred by other agencies.

Board Challenge

To be provided with data from multi-agency partners that will assure the Board that those children requiring support are identified at the earliest opportunity to reduce the risk of unnecessary escalation of concerns.

MASH decision making processes are required to be continually tested to ensure that they remain robust and consistent especially during this time of austerity. MASH audits to be undertaken throughout the year and reported to the HSCB quality and effectiveness group for consideration and challenge.

Child Protection

Whilst the MASH acts as the front door and provides the initial direction, it is the effectiveness of the multi-agency response to referrals that impacts on the life of the child.

Does the intervention improve the child's life?

In respect of child protection the increased referrals from the MASH during 2014/15 has directly impacted upon the number of section 47 investigations and the number of children who have subsequently become subject to a Child Protection Plans (CPP)

Category	2013-14	2014-15
Emotional abuse	40%	24%
Neglect	45%	55%
Physical abuse	12%	16%
Sexual abuse	3%	6%

The average number of children being made subject to a new CPPs per month has increased from fourteen last year to twenty-one this year.

In addition Havering has seen an increase in the number of children living within Havering being subject to a CPP from another borough.

One of the HSCB board challenges last year was to improve the identification and response to children that may be suffering from neglect

The breakdown of categories of new child protection plans has changed during 2014/15 with a higher proportion of children being made subject to a plan due to neglect.

This increase may indicate an increased awareness and better identification of neglect.

Fourteen children were made subject to a plan under the category of sexual abuse during 2014 – 2015: this is double that of 2013/14 but is still low. This evidences a low detection rate of sexual abuse, which is reflective of the national picture.

Timeliness.

Category	2013-14	2014-15
Number of children on CP plan at the end of March.	124	214
Number of Children in CIN plan	182	148
Number of other LA children on CP plan	17	41
Number of new section 47 investigations	469	841

The number of Initial Case Conferences increased by 71 per cent in 2014/15. This increased number has impacted on the number of case conferences being held within the required fifteen day timeline set out within Working Together 2015. The number held within timescale dropped from 72 per cent in 2013-14 to 52 per cent during 2014/15.

It is important that the CP plans impact on improving the lives of the children in a reasonable time.

93 per cent of active CPPs during 2014 – 2015 had been in place for twelve months or less. This is an increase from last year of 83 per cent. Only 4 per cent [seven children] had remained on a plan for more than 2 years.

For the year 2013/14 19 per cent [twenty-seven] of CP cases ended within 3 months. The question from the Board was for agencies to consider whether children were being made subject to a plan unnecessarily. An audit was undertaken in March 2015 to review all CPPs that ceased within three months. The audit identified a number of issues, which will be a focus for the Children Services Improvement Board during the next financial year.

One measure of the effectiveness of a CP processes is the number of children who are removed from a CP plan and then placed back on a CP plan within two years. For 2013/14 the number of children placed back on a plan within two years was 5.8 per cent. In the year 2014/15 this percentage reduced to just 1.6 per cent.

The continued use and development of the Family Group Conferences in the more complex and high need cases has proven to be an effective mechanism to facilitate better family engagement. This includes the identification of risks and the actions required to reduce them. This is helping to achieve positive outcomes for children and young people with improved family engagement.

Audit and Review.

Havering Children Services set up a Children Services Improvement Board (CSIP) in April 2014. The CSIP is comprised of representatives from Havering Council and includes Children Services, Learning and Achievement, Business and Performance and Public health. The CSIP was implemented to better understand the effectiveness of the services being provided to children and young people in Havering across the continuum of need. The CSIP process has significantly improved the services approach to auditing, reviewing and monitoring its service offer.

CSIP processes have led to improved data quality and regular auditing of the Children Service functions. The HSCB has worked closely with CSIP and is aware of outcomes in order to be able to act when multi agency responses are identified as a possible area of concern.

The CSIP board has identified some risks and challenges that will be monitored over the next year. One is in relation to timely completion of assessments:

- Delays in completion of assessments – During 2014-15 45 per cent were completed within 45 days
- Improve quality of planning processes.

Staffing

One of the biggest impacts on effective responses to child protection is agency staffing levels and workloads. This was identified as an area of concern in 2013/14 especially in light of significant funding restraints and major organisational changes.

The HSCB has during 2014/15 monitored the work force across the agencies. Agency staffing levels now forms part of the HSCB data collection.

Social work staffing continues to be the most challenging. The introduction of a new workforce strategy and recruitment and retention policy for 2014 to 2015 has started to impact on the situation. The vacancy rate for the end of year 2013/14 was 29 per cent this has now dropped to 23 per cent. The Social worker turnover rate was also dropped from 19 per cent 2013/14 to 12 per cent 2014/15 this has positively impacted on the use of agency staff, which has reduced form 28 per cent 2013/14 to 23 per cent for this year.

Within health, Midwife posts have increased by 8 per cent to 275; however, there is still a vacancy rate of 10 per cent. The number of paediatric nurse posts has also remained steady with a vacancy rate of 10 per cent.

During 2013 to 2014 the board chair challenged the Metropolitan Police Commissioner regarding the staffing levels of the local Child Abuse Investigation Team (CAIT). In their 2015 section 11 response they highlighted the following

'The main issue facing CAIT in the past year has been a lack of trained police staff to cope with the rise in reported incidents. This has impacted on performance and particularly child protection case conference attendance'.

In the short term Havering CAIT has catered for this by utilising police officers who were working on attachment to the team. The long term goal is to increase trained staff and CAIT is in the process of recruiting more police officers to fill vacancies. This will continue to be monitored as crime & staff workloads increase.

The HSCB is working with the CAIT in order to support them during transition and find new way of working e.g. video conferencing.

Board Challenge

- For the board to continue to seek information regarding workforce stability and assurance that staffing levels does not have an impact on the provision of services and to challenge when necessary.

Looked-after-Children (LAC)

Looked after Children are vulnerable and the HSCB needs to be continually satisfied that they are in receipt of timely support in a stable environment. This continues to be a challenge for Havering.

The end of year statistics March 2015 showed that there were 240 LAC, which was an increase of 26 per cent from the previous year. There has also been some changes in the ethnicity of LAC in Havering with an increase of 4 per cent of Black African LAC and a decrease of 7 per cent of White British LAC. There has also been a slight increase in White Eastern European LAC.

The high levels of children starting to be looked after on Police Protection has continued with an end of year figure of 84 compared to 63 the previous year. This is an area that is being reviewed regularly within the Havering Quality and Effectiveness (Q&E) working group.

Placement Stability

Placement Stability meetings, which commenced in February 2014, brings professionals from relevant agencies together to agree the most appropriate support package and placement for each LAC. The meeting predominantly focusses attention on children and people that are in long-term care

All children require stability and continuity if they are to be given every opportunity to reach their potential. LAC have not experienced stability or continuity of care and it is crucial to provide this to them to help them to heal and to provide them with the best opportunity to achieve their potential Significant effort has been put into placement stability and the improvement identified in 2013 -14 has been maintained and slightly improved. Year-end data evidenced that 10 per cent of LAC experienced three or more placement moves within the year. Although this is an improving picture, this remains an area of concern for the HSCB.

LAC generally achieve more poorly within education than their peers. In response to this Havering council has established a LAC Education Panel to oversee the drive to improve educational amongst this group: HSCB will

monitor the stability of education placements for LAC matched to their educational achievements during 2015 -2016. This will support the HSCB to identify whether an increase in educational placements impacts negatively on attainment.

LAC placement lasting two years or more has also increased from 79 per cent in 2013/14 to 83 per cent for 2014/15. This is a good achievement and it will be important to understand why this has improved to allow good practice to be built upon.

The number of LAC who are placed outside the local authority area and more than 20 miles away from where they used to live has increased slightly to 11.6 per cent (25). The local authorities target was 10 per cent. 59 per cent of LAC placed out of borough are placed in neighbouring boroughs.

It is important that LAC, in most cases, remain close to family and support.

Havering children services has worked hard to reduce the use of residential placements for LAC within the last year so that children are placed near to their usual area of residence.

The Board will continue to monitor the LAC Improvement plan, which focuses on placement stability, improving outcomes and increasing the numbers of LAC placed in family placements within the borough.

Health

All LAC should be offered a LAC health assessment. These must occur shortly after placement and then annually. The Havering CCG identified this as an area of risk, which was responded to through the introduction of a LAC administrator in place to work across Children Social Care Services and NELFT to assist with administrative functions.

Board Challenge

- To review the use of Police Protection to ensure that its use is consistently applied and appropriate
- To ensure LAC out of borough placements are appropriate and that the children are receiving good quality support
- To monitor and challenge the difficulties completing LAC health assessments as identified by the CCG.

Private fostering

If a child under the age of sixteen or eighteen if the child has a disability, is being cared for by an adult who is not the parent or 'close relative' for a period of twenty-eight days or more the arrangement is known to be a private fostering arrangement. The child is not looked-after by the local authority. The arrangement is solely between the parent or guardian and the adult caring for the child (known as the private foster carer). Any person caring for a child under these circumstances has a statutory duty to report the arrangement to Children Social Care.

Private Fostering is still a major challenge. The number of registered privately fostered children remains low despite extensive publicity and training. Action is being taken to address this situation and is led by Children Social Care. This remains a priority for the HCSB.

Private Fostering Board Challenge

The board partners will continue to promote and raise awareness of Private Fostering in order to ensure that such arrangements are identified and registered.

Board Challenge

For the board to ensure that partners continue to promote and raise awareness of Private Fostering in order to ensure that such arrangements are identified and registered.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Early Help

Early help is the bedrock to improving outcomes for children and young people. Effective early

help will improve outcomes and help reduce the need for more serious child protection processes.

Early help is crucial in the 'step down' from child protection to child in need and child in need to early assessment processes. Thresholds for services must be fully understood and embedded if step down or step up transitions are to be smooth and supportive to families.

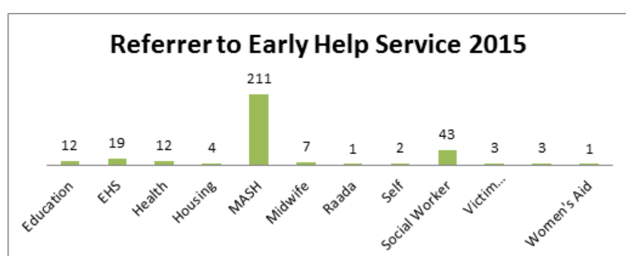
'Early help is better for children: it minimises the period of adverse experience and improves outcomes for children'

Eileen Munro March 2011

It was highlighted in last year's annual report that Havering council had commenced a significant restructuring of the local early help provision. The new structure was fully implemented during 2014 / 15 and included joining Havering Youth Offending services to the early help structure.

The Early Help Service now offers some of Havering's most vulnerable families support in the following areas:

- Family intervention and support – under 12s and over 12s
- Children's centres
- Targeted Youth Support
- Employment Advice
- Adult mental health assessments
- Opportunities to volunteer with the LA
- Housing support and advice
- Support for victims of Domestic Abuse
- Family Group Conferencing
- Parenting Support – surgeries and programmes
- The Youth Engagement Service



There is evidence that MASH and schools are referring cases to early help. This good practice needs to be better embedded across all HSCB partners to ensure children and families are being given the opportunity to access support and help services at the earliest point of need.

The HSCB will require all partnership agencies to provide data evidencing the uptake of early help processes by staff working within their organisation.

The consistent use of early help assessment processes by all partners is crucial to the success of this priority area.

Early Help Board Challenge

The expectation for 2015 – 2016 will be an increased uptake of early assessment processes that will offer consistent response to early need:

The board will to continue to monitor and challenge the speed of implementation and engagement of all agencies.

MASH feedback to provide clear information to partners regarding decisions and identified next steps.

The development of an early help dataset to assist the Board partners to understand the impact of the early help processes on improved outcomes for children and their families.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Havering MASH is in place to ensure children and young people are provided with the correct service response at point of need. MASH considers children across the continuum of need and determines the level off response required. The integration of MASH with safeguarding adults has improved the ability of MASH to think holistically when determining the type of service that is required to address the identified needs.

The newly agreed threshold document will assist agencies to determine the type of service that is being requested when making referrals to MASH. This will assist the MASH to understand the level of concerns when considering the information being referred. As previously stated, MASH is being audited regularly to ensure that processes do provide the correct response consistently to all children.

The HSCB and SAB have a joint independent chair. This structure has enabled better information sharing across both boards. This has increased awareness of priority areas that are important to both boards and includes the impact of parental issues such as mental health, domestic violence and drug and alcohol abuse on parenting / carer capacity.

A critical area for children is when they are experiencing transitions. HSCB and SAB implemented a transition group in 2014 to review transition processes. This has included the transition of children with special needs and autism into adult services.

It is important to continue to develop responses to domestic violence. The majority of this is addressed within the Community Safety Service annual report submission. The HCSB works closely with the service to continually examine all aspects of

- Domestic violence
- Mental Health & Substance abuse
- Violence against Women and Children

Community Safety Service

This team is responsible for the development and implementation of work to reduce crime and disorder, as well as the fear of crime, within the borough. It achieves this through both direct work and by co-ordinating strategic partnership working with the wide range of public, private and voluntary sector partners represented on the Havering Community Safety Partnership (HCSP) and the Safer Neighbourhoods Board.

Domestic Abuse Service Responses

Domestic Abuse multi agency risk assessment conference (MARAC)

The MARAC continues to meet monthly and is chaired by Havering Police. High Risk Cases are presented to the Domestic Violence MARAC with them.

The MARAC's partner agencies include, representatives from the council, police, probation and the voluntary sector. Children's Services, Early Help, Schools and School Nurses are all involved in the MARAC, and this ensures that child protection is a high priority in the cases discussed at MARAC. The support and guidance given by the MARACs partner agencies utilises the knowledge and close working relationship of the service users to ensure the best possible outcome.

During 2014-15 the number of referrals to MARAC has continued to increase, with 241 for the 12-months to February 2015 (compared to 180 for the corresponding period of February 2014). The proportion of repeat cases during the same period increased from 15.6 per cent to 21.6 per cent.

The majority of referrals continue to be made via IDVA's (90 referrals), followed by the Police (includes outside forces, 74 referrals). Referrals made by police (up from 34 to 74) and Children Social Care (up from 20 to 41) have seen the largest numerical increases in the past 12-months. Other MARAC data showed a rise in BME victims being referred (21 up to 31), an increase in male victims (6 up to 13), and an increase in victims with a disability (3 up to 9). There has been 1 referral each for LGBT victim aged 16-17 cases.

Long and short term risks and priorities

The total number of reported and recorded Violence against Women & Girls incidents and offences has increased by 1,008 offences in the current financial year to date (to February 2015), representing a rise of 19.6 per cent. This has been driven by a notable rise in the volume of both Domestic Offences and Domestic Incidents.

The increase in DV Offences is at present currently above the regional average, showing a 25 per cent increase compared to a 20.7 per cent increase across London. Where DV Violence

with Injury is concerned, Havering has the 3rd highest percentage increase.

Havering will receive an additional 3.5 Independent Domestic Violence Advocates (IDVA) provided by the MOPAC Pan London IDVA service. An IDVA will be based in the MASH and Maternity Services/ A&E

Violence Against Women And Girls

The partnership VAWG strategy has recently been signed off by the HCSP a comprehensive action plan focusses on the prevention, protection, safeguarding and provision of services to support victims of domestic violence, FGM , Forced Marriage and Honour based Crimes , CSE and Girls and Gangs.

The VAWG strategic partnership is well established within the borough and continues to meet on a quarterly basis. Representatives from the council, police, probation, Health and the voluntary sector attend this meeting ensuring that on a strategic level the partnership is supporting children and adults in the most effective way.

VAWG Board Challenge

To fully understand the extent in Havering of VAWG especially in respect of children and young people of:

- Female genital Mutilation
- Forced Marriage
- Honour based violence.
- Child Sexual Exploitation and Trafficking.

Parental Substance Misuse.

One of the most common factors that increases risk to children is parental substance misuse. Community Safety has recently recruited a specialist substance misuse worker who works closely with the London Borough of Havering Public Health Team, who are responsible for promoting health and well-being and commissioning drug and alcohol treatment services. At present North East London Foundation Trust (NEFLT) and Crime reduction Initiatives (CRI) deliver drug and alcohol treatment within the borough and our substance misuse officer offers us a unique opportunity to ensure that the procedures around safeguarding are embedded in the delivery of the boroughs drug and alcohol services.

Any safeguarding concerns identified by NEFLT and CRI that are linked to parental substance misuse trigger an enhanced risk assessment. If this reveals a medium to high risk to child/ren, a referral is made to MASH and/or police. This supersedes local service provider interventions and these referrals are tracked and managed using a partnership approach.

There are many changes occurring in the borough of Havering and the first is the re-tendering of drug and alcohol services. This process will aim to have one integrated provider. This new provider will be operational by October 2015.

Serious Group Violence (SGV)

Serious Group Violence is an emerging issue in Havering. The Home Office conducted a five day peer review in November 2014 in the Borough. The Home Office identified a number of areas of good practise which included

- Strong vision and leadership in Havering with a clear focus on preventing problems escalating
- Good understanding of interrelated issues of child sexual exploitation, serious youth violence and missing children through analysis of partnership information via the Multi-Agency Safeguarding Hub (MASH) Missing Person's Protocol and accompanying form.
- Partnership working in Havering is a real strength
- Relationships with local schools and colleges are good: there is a firm foundation for further work to spot risk factors early on and work to build resilience
- The Troubled Families programme in the borough is very strong
- Assessment and referral through the MASH works very well, including sharing individual A&E data
- A number of promising interventions to address youth violence are in place

- The Serious Youth Violence Panel provides opportunities for knowledge transfer and practice development
- Commitment to community/family-based values

Young People, schools and community youth groups were consulted as part of the review.

A Serious Group Violence (SGV) panel meets monthly to discuss work with key gang nominals. Safeguarding is embedded in these meeting and consideration is given to the risks caused by an individual and the risk that is posed to the individual.

The HCSP developed a Serious Group Violence Strategy for the Borough with a comprehensive action plan which is refreshed annually.

Gangs' awareness training has been provided to front line practitioners. Early intervention is key to preventing the escalation of youth violence and the other gang associated issues such as child sexual exploitation.

Havering has commissioned a specialist service (Spark2Life) to provide:

A) One-two-one prevention work with identified gang nominals.

B) Preventative work within schools. Targeting young people at risk through Assemblies, Classwork and one-two-one sessions.

Community Safety is raising parent awareness of SGV through working with schools through a programme of targeted parent awareness evenings.

The SGV panel works closely with the gangs researcher within the MASH.

Increasing numbers of complex and vulnerable families moving into the Borough from Inner London Boroughs has increased the risk of gangs associated violence in Havering.

Board Challenge

To fully understand the extent in Havering of VAWG especially in respect of children and young people of:

- Female genital Mutilation
- Forced Marriage
- Honour based violence.
- Child Sexual Exploitation and Trafficking.

To continue to increase awareness and understanding of the level of make-up of the gang structure in Havering.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents.

HSCB has developed a communication strategy, which was presented and ratified by HSCB partnership agencies during 2013 -2014.

Communication Board Challenge

To ensure that each partner agency fully embeds the communication strategy and reports back information making the HSCB leads conduits for information in and out of the HSCB.

HSCB has produced termly newsletters, which have been distributed to in excess of one thousand HSCB contacts.

Views of Children &Young People

There are number of process across agencies that captures the views of the children, young people and families.

LAC are accessed via view point the views of children subject to CP plan are also captured via view point.

The Viewpoint findings 2014/15 were reported to the HSCB. The challenge is to ensure that each agency utilises the feedback so that services are improved to better meet the needs and requirements of children and young people.

The annual Children and Young peoples survey is carried out with aged 10 to 17 years olds in the Borough of Havering.

There were 1440 respondents

- 14% eligible for free school meals
- 25% carer for relative
- 80% feel happy
- Large number stated they felt unsafe on public transport
- 28% stated they had been bullied over past 12 months

- 61% two stated they had been bullied admitted to bullying others
-

The feedback from the children has helped to inform the Children Service section 11 action plan.

These responses are fed back to the HSCB: the HSCB needs to be more proactive in involving children and young people.

The proposed action to progress this during 2015/16 includes the following:

In March 2015 the London Assembly Police and Crime Committee published a report entitled "Confronting Child Sexual Exploitation in London". The report contained a number of recommendations including recommendation 5 which states *"Every LSCB in London should have a forum in place to engage with children and young people affected by CSE, including those that have in the past gone missing and looked after children, to increase understanding, provide appropriate care and support to young victims and those at risk of CSE, and encourage confidence in reporting"*

The HSCB has worked with the Children's Society, which has agreed to pilot the establishment of such a forum in Havering.

The re-launch of the Children in Care Council provides an opportunity during 2015/16 to engage LAC young people in the work of the board. The HSCB chair will meet with this group to explore how they can help the board.

The Havering Youth Parliament will also be consulted and asked to present finding from their activity to the board.

The Children Society CSE forum pilot, commissioned by the HSCB, will help provided good feedback from CSE victims.

Board Challenge

To improve the use of feedback to better inform board future board strategy.

Section 2

Learning and Improving Framework

Case Reviews

Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations that work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result

Summary of Work Group Purpose

The purpose of the HSCB Case Review Working Group is to ensure that the statutory requirements contained in Chapters 3 and 4 of Working Together to Safeguard Children 2015 are embraced and delivered. The main statutory requirement is for the group to implement a learning and improvement framework where partner agencies are clear about:

- Their responsibility for contributing to the learning and improvement processes.
- Effective dissemination of learning.
- Making sustainable changes to services.

The local framework should cover the full range of reviews and audits including:

- Serious Case Reviews.
- Child Death Reviews.
- Management review of a child protection incident which falls below the threshold of a SCR to provide useful insights about the way organisations work together to safeguard and promote the welfare of children.
- Review or audit of practice in one or more agencies.
- Identify and drive improvements to safeguard and promote the welfare of children.
- Translate the findings from reviews into programmes of action to bring about sustainable improvement and prevention of future deaths/harm.

Activity 2014/2015

Serious Case Reviews.

One serious case review has been undertaken during 2014/15 it involved a review of a child

protection case where a decision was made to prematurely cease as a child protection case. This over a period of a number of years led to children failing to thrive and suffering long-term effects. Whilst Havering commissioned and led the serious case review the history of the case involved 2 other London Boroughs. All agreed to support the serious case review and learn from the case findings. The case is near to it conclusion and will be publish in early 2015/16.

A second serious case review has recently been commissioned and will commence in 2015/2016. It concerns the response to allegations of physical abuse and the subsequent information sharing process.

Learning Reviews

2014/15 saw the completion of three learning reviews. All three cases are subject to a multi-agency action plan which has pulled the learning together from the three reviews. It will be monitored during 2015/16 to ensure learning has been embedded in practice.

The following is a summary of the recommendations for the HSCB to ensure learning.

Case one

A young person involved with CAMHS services and being at risk of committing serious sexual offences.

Case Two

Case concerns where a young person committed a serious crime and caused serious harm to a member of the community.

Case Three

The use of Section 20 (CA1989) to place a child with an extended family when mother went missing. This raised the issue of who had parental responsibility for a vulnerable child.

The three learning reviews were considered by the case review working group and an amalgamated action plan developed. The action will be reviewed and implementation monitored through the case review working group. The action plan forms **appendix 1**

Conclusion

The working group continues to monitor cases and make recommendation is respect of learning /serious case reviews. The board will monitor the agreed action plan to ensure that learning from these case are embed in the organisation culture.

The risk is the on-going costs of reviews and the ability of agencies to be able to allow staff time to support the review process. This will lead to delay. The board will continue to consider the best alternatives in order to obtain the best learning process in a cost effective way and reasonable time scales.

Board Challenge.

- To incorporate national and local learning into briefings and to ensure that this is disseminated widely and understood by practitioners.
- To continue to ensure multi agency learning impacts on service delivery through focused audit and feedback

Child Deaths: The Child Death Overview Panel (CDOP) and Serious Case Reviews

Working Together 2015 states:

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the HSCB's area is undertaken by a CDOP The CDOP will have a fixed core membership drawn from organisations represented on the LSCB with flexibility

The Havering CDOP is responsible for reviewing the circumstances of all child deaths within the borough.

Gender & Expectation			
	Female	Male	Total
Expected	4	2	6
Unexpected	1	2	3
Total	5	4	9

During 2014-15, CDOP were notified of nine deaths in total. Six were categorised as

'expected'. The three remaining cases were classified as having modifiable factors relating to co-sleeping, poor lifestyle choices from mum and poor obstetric care resulting in an internal investigation at the hospital.

Havering has seen a decline in the rate of child deaths since 2012-13 across all ages and categories. Neonatal deaths remains the most common cause of expected death for infants within Havering, this is reflective of the national picture. There have been no identified trends this year which indicates that previous common causes such as co-sleeping and blind cord safety deaths are currently reducing within Havering.

There continues to be two Designated Doctors sharing the role, both of which have been very responsive to supporting the service. In addition to this all statutory and voluntary agencies have continued to be supportive in attending the Rapid Response meetings. There is also a good working relationship with the London Ambulance Service and Police who continue to attend or provide information to the Rapid Response meetings when necessary. This means that Havering's CDOP has been compliant with the requirements set out in Working Together as well as working jointly on the key issues arising from childhood deaths to learn lessons and minimise deaths arising from specific areas.

Safeguarding in Employment

Working Together 2015 Chapter 2

Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

Local Authority Designated Officer (LADO) Role

The role of LADO was under the management of the Havering Council Children Services

Year	Number of cases	Percentage increase/decrease year on year
2005/06	12	
2006/07 -	6	(50%)
2007/08	23	283%
2008/09	47	104%
2009/10	44	(6%)
2010/11	51	16%
2011/12	62	22%
2012/13	106	71%
2013/14	160	51%
2014/15	121	**(24%)**

Safeguarding Service Standards Unit. LADO activity until November 2014 was shared across the team with appropriate professionals undertaking the functions. This included duty team managers, the group manager and independent reviewing officers. There is no statutory training for the post.

In early 2014 it was identified that a number of issues had arisen due to an increase in the volume of LADO referrals and because there was no one person responsible for the post. These included:

- Lack of continuity and ownership
- No single point of contact for both in-house and external partners
- The volume of LADO work increased but those carrying out the role had their own 'full-time' role to address
- No specific administrative support
- Occasional oversights in record-keeping.

The role is now carried out by dedicated one member of staff supported by a business support colleague. This has improved communication between key partner agencies including Ofsted, Youth Groups and nursery settings for example.

As a result of this new dedicated position it was felt that the HSCB safeguarding in Employment Group could be disbanded. The new LADO is a member of the Operational board and will report regularly to the board on the progression of the LADO action plan.

Activity

When looking at the data recorded and taking no account of the first two quarters of 2014 -2015, the expectation is a continued rise in referrals. This is reflected in the last two quarters of last year and the first quarter of this counting period.

The reason for this is:

- Improved awareness of process;
- Single point of contact for LADO within the Local Authority;
- Internal and external training sessions.

Furthermore when attending the National LADO meeting in March 2015, it was a point of discussion that nationally there has been an increase in referrals.

Working with Partners

Since November 2014 new relationships have been developed with various groups in Havering by the LADO officer.

Board Challenge

- To monitor the LADO action plan and ensure that it receives multi agency support.
- To continue to highlight and challenge areas of concern.

Training & Development

HSCB has offered a range of training courses for the borough's multi-agency partners. This training is available to all agencies and individuals in the borough who work to protect children and young people.

Training and Events 2014-15

- 49 scheduled courses delivered
- 4 cancelled
- 5 additional training events delivered
- Havering LSCB Annual Conference

HSCB training was delivered to nine hundred and ninety-eight delegates during 2014-15

HSCB implemented an on-line training application system during 2015-15. Whilst overall the on line system worked well, complications were experienced because ICT systems were not always compatible. This is being addressed by Havering Council during 2015/16. .

Introduction of Impact Analysis Process

During this year we introduced the process to evaluate the impact of training. Delegates were asked to complete post course evaluations 4 – 6 weeks after attending training. A full analysis and review has been carried out and the report is attached as an appendix to this training report.

The impact of training is expected to lead to increased knowledge and skills thereby improving performance. We encountered difficulties when assessing the feedback as delegates attended training for a variety of reasons:

- New to position so part of their general development
- As a refresher
- Safeguarding leads need to have knowledge of a variety of areas so attend a number of courses
- Staff attend training but may never experience related issues so may never put learning into practice
- Delegates found it difficult to articulate how the training could be applied to their day to day role, often siting confidence as the key
- Delegates found it difficult to articulate how the training could be applied to their team with the most common response being 'sharing information'
- Delegates found it very difficult, almost impossible to articulate how the training impacted on children and families.

LSCB Newsletter

The LSCB newsletter is expected to be produced and distributed termly. The newsletter is developed through board partner input and during the year only one has been produced. This will be improved during 2015/16

SECTION 3

Board Sub groups Groups

Child Sexual Exploitation and Missing (CSE) Working Group

Child Sexual Exploitation continues be a priority for the board. The main objective and activity for the year 2013/14 was to raise the awareness of CSE for all professionals. This was achieved and the introduction of the assessment tool and a significant level of training helped to support understanding.

2014/15 has seen a greater focus on the identification and responding to young people who have been or may be vulnerable to CSE, which includes those children that go missing. This section will consider both CSE and missing.

CSE Prevalence

During 2014/15 there was an increase in recording of CSE incidents within Havering. There were 55 recorded crimes (Havering borough ranked 18th out of the 32 boroughs) and a further 25 CSE incidents recorded as non-crime.

There were 133 additional cases brought to the attention of the Local Authority for CSE/exploitation who were not victims recorded within the police system.

There is a question over some of the recording processes and much is at the discretion of the individual reporting understanding that they may be dealing with a victim or potential victim of CSE.

This would indicate that there is still a level of under reporting/recording of CSE incident.

Challenge

There is a need to improve consistency of recording.

What this improved level of data has enabled the first attempts to profile what CSE looks like in Havering.

- The victims are predominantly female 96 per cent of recorded CSE
- The most common age of victims was 13 to 16 90 per cent of recorded victims.
- The ethnic profile found that 72 per cent of clients were White British, 12 per cent white other, 75 mixed , 5 per cent Asian and 4 per cent black
- Just 7 per cent were children with child protection plans.
- 33 per cent were Looked after Children
- Categories most frequently recorded alongside CSE clients were 'family dysfunctional, 'missing from home', abuse of neglect', sexual abuse and 'domestic violence.
- 16 to 18 may be identified as victims of domestic violence rather than CSE

Contact points.

The CSE Exploitation and Missing group review identified a number of issues that will hamper the process.

There is need for more sophisticated training in order to ensure that all professional are fully conversant. Training has been undertaken but is patchy

The CSE risk assessment Tool Kit is in place but following the Rotherham report by Professor Alexis Jay in November 2014 there is a need to review the tool.

There is a need for a highly developed local profile. This has commenced but need to be supported by consistent data set and accurate recording.

The LA and the board have also started to work with the Children Society in respect of working with children and young persons identified as being at risk of CSE and also to undertake missing person interviews.

The Children Society was commission by LBH to provide an independent advocacy service for Havering Children and young people under the age of eighteen living in care or leaving care or a child in need.

Below is an example of the work and outcomes for the young person.

Case Study

B= Young person engaging in the Missing out Service

PW= Missing out Service Project Worker.

B is a White British young person from Havering, who is 14 and looked after by Havering Children services. B is assessed as a high risk young person who frequently goes missing and is a risk of child sexual exploitation.

PW attended strategy meeting with other professionals involved to discuss the level of risk B was facing, her needs and what services need to be put in place to best support B.

Her needs included:

-Practical support attending meetings and appointments with regards to specific issues.- Practical support to advise keyworkers on addressing sensitive issues with B.

-Emotional support to address missing episodes, physical health, mental and emotional health and drug misuse

B has had three formal sessions with three more remaining.

Missing episodes have decreased with no further missing episodes since B has been accessing support and settled into new placement

B has had sessions on the following topics

- Risks when going missing: Push & pull factors, safe choices when going out

- Physical health (attending a GUM clinic)

- Understanding emotions and feelings in friendships & relationships.

B has reported that being in a new placement has enabled her to concentrate on herself and to not worry about what people are saying about her. She has reported to be missing her friends and having access to her mobile phone however, she understands that this is something that will help to reduce taking risks.

B has engaged well with the Missing Out service and has reported that she is enjoying the sessions because PW listens and encourages better communication between B and other professionals.

B is starting to have a better understanding of what it means to go missing and why it is important for responsible adults to report her as missing if they do not know where she is. B still needs support with emotional and mental health issues as well as physical health which is on-going between B and her keyworker.

B will need further support when she is placed back with her parents to apply these life tools to real life situations if/when they occur.

The Board is now working to support the Children Society to undertake work obtaining feedback from the young people they support.

In March 2015 the London Assembly Police and Crime Committee published a report entitled "Confronting Child Sexual Exploitation in London". The report contained a number of recommendations including recommendation 5 which states *"Every LSCB in London should have a forum in place to engage with children and young people affected by CSE, including those that have in the past gone missing and looked after children, to increase understanding, provide appropriate care and support to young victims and those at risk of CSE, and encourage confidence in reporting."*

The Children's Society has agreed to pilot the establishment of such a forum in Havering

In December 2014 Havering took part in a peer review with LB Hillingdon. This identified a number weakness in front line practice and in particular processes around the MASH. These findings were supported by a further case audit undertaken by children social care.

Further audit and review of CSE referrals through the MASH continue to indicate cases at level 1 & 2 are not always receiving a timely responses.

As a result of these identified concerns a 'Virtual Assessment and Intervention Team' is being piloted. This is being managed within the 12 Plus Service.

The aims and objectives of the team will be to ensure that all CSE referrals are responded to effectively and appropriately.

The HSCB will receive regular updates and is overseeing the pilot through a CSE steering group.

Quality and Effectiveness Working Group

1. Summary of Work Group Purpose

Working Together (2015) sets out the requirement for each LSCB to have in place processes to monitor and challenge the effectiveness of the safeguarding offer to children across the spectrum of need:

In order to fulfil its statutory function under regulation 5 a LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Working Together 2015

The Quality and Effectiveness group is in place to oversee the effectiveness of the multi-agency safeguarding and child protection service offer to children, young people and their families in Havering. The group receives and reviews performance data from the partnership, challenges information and identifies actions required to improve the service offer when required.

Audits are undertaken to assure the group of the effectiveness of the partnership when working throughout the child's journey across the continuum of need.

2. *Key Areas of Progress and Achievement*

The multi-agency performance dataset has been embedded during this financial year and reported on biannually to the Quality and Effectiveness group and to the HSCB. The performance framework has been amended as required to ensure that the board receives the best possible data to assist it to understand the effectiveness of the partnership when responding to safeguarding needs.

The group undertook a number of multi-agency and single agency audits over the year in order to understand the effectiveness of multi-agency response to children identified to require services. This process provided assurances to the Board regarding the service offer and also identified areas that required further scrutiny. Areas requiring additional scrutiny have been included within the Quality and Effectiveness audit plan for the forthcoming year.

The HSCB requested partnership agencies to undertake an self-assessment audit of S11 compliance in November 2014 with a request for submissions by March 2015.

The S11 audit findings will be used to inform future s 11 audits with a focus on the effectiveness of agencies response to Child Sexual Exploitation (CSE).

There has been a significant amount of progress to understand the partnerships response to adolescents and vulnerability, which includes CSE, LAC, Missing, Gangs and youth offending. The partnership is developing processes to strengthen and support a co-ordinated response to all of these important areas so that there is collaboration and meaningful communication pathways across all areas of work to reduce duplication and streamline work streams.

3*. Current Activities*

The Group will continue to monitor the impact of the multi-agency service offer on improved outcomes for children and will further develop the performance framework to understand the effectiveness of services across the spectrum of need.

An audit programme will be developed to assist the Group to better understand the story beneath the data and to identify where services can be improved for children.

Multi-agency partnership working has been identified nationally and locally to present challenges to practitioners. The Q&E group has identified the need to better support staff in their understanding of each agencies role and function to better support them when working across organisations.

This will be addressed through the provision of multi-agency briefing offered to front line practitioners to focus on

- Threshold for services
- Agency professional's roles and responsibilities
- Lessons learned from learning reviews, case reviews, audit activity and national learning

The briefings will be facilitated by Q&E group members and will provide time for reflection and learning in a safe place. The briefings will allow for networking opportunities to develop and strengthen working relationships further.

4. *Long and short term risks and priorities*

The current dataset does not report on the effectiveness of early help services. There has been significant work undertaken to strengthen the early help response within Havering. Understanding the impact of the changes will be a priority for 2015 – 2016. The Group will develop an audit programme to assist in its understanding:

- Effectiveness of MASH and how this relates to practice across the partnership
- How systems support staff to work effectively
- Effectiveness of the Child Protection Response
- Effectiveness of Early Help
- Effectiveness of multi-agency response to adolescent vulnerability.

The LSCB priorities for 2015-16 will be child protection, early help, child sexual exploitation and neglect: The Group will embed a process to understand the effectiveness of the partnership in relation to the LSCB priorities.

Transition Sub Group

The Transitions Group is a sub group of both the Local Safeguarding Children's Board (LSCB) and the Local Safeguarding Adult Board (LSAB). It was set up in 2014 and held the first meeting on the 8th May 2014. The aims of the group are as follows:

- To review current children to adults services transitions policies and procedures in health and local authority services in Havering.
- To audit compliance with existing policies and procedures.
- To highlight and share good practice initiatives
- To disseminate learning from policy and practice reviews.
- To provide assurance to the LSAB and LSCB of policy compliance with regard to transitions.
- Liaising, coordinating and responding appropriately to actions agreed by Local Safeguarding Children's Board (LSCB) Local Safeguarding Adults Board (LSAB)

Membership includes representatives from health and social care, including children and adult services across a range of functions such as physical disability, learning disability and mental health, community safety, police, youth offending, education and commissioning. Attendance and engagement at each meeting has been good.

The work plan for the group identified a range of service pathways with a review programme in line with the aims as above.

The first identified area for the group to look at was child to adult transitions across mental health services. A sub group was formed which fed back to the main group. The findings were as follows and recommendations were agreed by the group

1. NELFT does not have an up to date Transitions policy at the moment although this is currently being developed and this group will liaise with the author to ensure learning is shared.

   Recommendation: The NELFT draft policy will be agreed by all partner agencies in Havering and will be informed by the learning from the sub group.

2. Havering Transition Protocol is currently under review and the group will link in with the author to ensure learning is shared.

   Recommendation: The Havering Transition

Protocol will reference and be referenced by the NELFT Transitions Policy and will be informed by the learning from the sub group.

3. Where children and young people have a clear diagnosis or treatment plan transitions into adult mental health services are robust.

   Recommendation: That this continues and the good practice identified in these processes are shared to inform practice in other pathways.

4. Autism services for children are identified, however, provision for adults is not consistent across the borough

   Recommendation: Transition arrangements must take account of differences in service provision and criteria between children and adults services.

5. Where children and young people do not have identified diagnosis, but on going social and emotional problems, once they leave the structure of education, and are not in receipt of adult health services, there is little in place from statutory services. The group identified that hand over back to GPs in these cases is not always robust.

   Recommendation: That discharge planning take account of loss of structured services and that information handed back to GPs is more robust. That an assessment take place at point of discharge outlining ongoing issues and vulnerabilities to GP.

6. There are concerns that young people are being discharged from CAMHS then coming back into mental health services through Improving Access to Psychological Therapies (IAPT) teams, where they don't engage despite having identified needs.

   Recommendation: scoping to identify the scale of this, whether it is clinically indicated or as a result of poor transition practice. Once identified, actions to be agreed as necessary.

7. There is recognition that transition may be a time of stress for a young person. Where they are not moving onto identified statutory services and they have a history of mental health and/or emotional problems then the stress may be greater. National guidance identifies suicide as a risk during transition.

   Recommendation: That a Suicide Prevention Strategy for Havering is developed with all statutory and third sector providers, led by Public Health.

We propose that examining the experience of people who have gone through transition will be helpful in informing future work and discussions are underway as to how this could happen.

The group has identified that there are a number of groups in Havering also looking at transition pathways: we are currently scoping these in order to link up and ensure that work is not replicated and that information is shared to enable learning to inform future practice.

Section 4

Agencies statutory responsibilities

Section 11 statutory requirements

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Working Together 2015

Havering Safeguarding Children Board (HSCB) during 2014/15 undertook an audit of section 11 compliance.

Each agency completed a section compliance report covering each statutory requirement. These were supported by comprehensive single agency action plans that will be subject to regular monitoring by the board.

The following are the overarching conclusions and actions.

Standard 1: Senior Management have commitment to the importance of safeguarding and promoting children's welfare

This standard was fully understood by all partners with each response evidencing that there was a clear line of accountability within the organisation that was held within job descriptions and understood throughout the organisations.

As within the previous S11 self-assessment audit, agencies referenced internal audit processes as evidence of compliance with S11

standards. This audit activity has not been consistently submitted to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

Action from Standard 1: all SCB partners to submit reports and actions regarding single agency activity to the HSCB quality and effectiveness group once the reports have been formally signed of by agency quality assurance business processes. Each agency to submit their safeguarding audit programme to the quality and effectiveness group annually so that there is a thorough understanding of each agency's quality assurance processes.

Standard 2: There is a clear statement of the agency's responsibility towards children and this is available to all staff

Each submission evidenced that processes were in place to ensure that all staff at all levels of each organisation were aware of their safeguarding responsibilities.

The returns provided evidence of the growing importance of working together to strengthen the multi-agency response to safeguarding. This included MASH processes, multi-agency audit processes and multi-agency meetings. The submission from Havering Council noted that better processes had allowed agencies to identify more accurately the families in need of services, which has allowed a better targeting of services. This was identified to have led to a reduced in the number of families being subjected to agency scrutiny unnecessarily.

All s11 returns noted that S11 requirements were embedded within contracts if commissioning was undertaken by the agency.

The 2013 S11 returns identified a need to continue to strengthen the work being progressed in relation to capturing and responding to the views of services. This area continues to be a focus of organisation business so that the views of services users are utilised to support the development of services.

Standard 3: There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare

All s11 returns identified that this standard was met despite an increase in the workload of all agencies in relation to safeguarding. Each agency has clear lines of accountability within their organisational structures and these are freely available to staff.

As previously stated, agencies provided assurance that staff were aware of their responsibility to act if a safeguarding concern was identified regardless of their role or core responsibility.

Supervision processes have been embedded across all organisations and additional supervision capacity is being added to meet the increasing demands of staff.

Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families

There was evidence of considerable activity across partnerships in improving the multi-agency service response to this standard. All s11 returns provided assurance that the views of service users were sought and taken in to account when developing and delivering services.

The change to probation service process has allowed more autonomy when developing a service response: this has led to a more 'think family' approach to service delivery.

The returns from both NELFT and Havering Council discussed a number of new and emerging activities that had been developed to provide processes to assist in capturing the views and opinions of children, young people and their families.

The CCG noted that both NELFT and BHRUT provided the CCG with evidence that this standards was understood and implemented.

Standard 5: There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children & families

All agencies reported that an induction programme was in place for staff joining the organisation. Each s11 response referenced a single agency training programme that was in place to ensure that staff were provided with the correct level of training to support them in their role within the organisation.

All audit returns provided assurance that each organisation understood the importance of training to equip staff to identify and respond to possible signs and symptoms of harm.

Evidence of the impact of training on improved

outcomes was the identified increase in reporting of concerns notably in relation to CSE, FGM and domestic violence.

Standard 6: Safer recruitment procedures include vetting procedures and those for managing allegations are in place.

a. Organisation has safer recruitment & selection procedures in place in line with statutory guidance.

   All agency returns provided assurance of compliance with this element of the standard.

b. Organisation can demonstrate that agencies commissioned to provide services have safer recruitment in place

   Havering Council provided assurances that commissioning processes included a requirement for service to provide evidence of compliance with all s11 standards. Compliance with contract requirements is monitoring by Havering Council within usual business processes.

   The CCG response provided a level of assurance that services commissioned directly by the CCG were required to comply with the standard and to provide evidence of this. The CCG does not have oversight of management use of recruitment agencies: there is an expectation that the recruitment agencies used by BHRUT and NELFT are part of the NHS Buying Solutions Framework with an expectation that they comply with s11 standards. Although not explicitly noted within S11 returns, both NELFT and BHRUT confirmed that they comply with CCG expectations when using recruitment agencies.

c. Safer recruitment training is in place for managers involved in recruitment

   All returns provided assurance that training was available to all relevant staff to ensure compliance with this element of the standard.

d. Organisation has managing allegations procedures in place

   All returns provided assurance that processes were in place to respond correctly when a safeguarding allegation was made against a professional.

e. A senior manager has been identified for the managing allegations process & knows who the LADO is and when to contact them

   All s11 submissions provided assurance that a designated professional was in place to manage allegations and to support staff through this process: This was not explicitly stated within the LCRC return; however written confirmation of compliance with this standard was submitted separately.

f. Support is available for staff who are subject to allegation

   All s11 submissions confirmed that there were appropriate services in place within the organisation to support staff when an allegation is made against them.

g. Audit processes are in place to monitor safer recruitment & managing allegations

   All returns provided assurance that processes are in place to monitor processes at an organisational revel.

Standard 7 the response to this standard evidenced a commitment to ensure effective multi agency working across the continuum of need. The evidence supports a commitment to multi agency safeguarding hub processes, information sharing and embedding early assessment processes.

The number of early help assessments completed in year 2014-15 was 396, which is an increase on previous years but still suggests a low take up when considering the high level of tier 4 CSC assessments completed that result in no further action.
Uptake and completion of early help assessment processes will be required to be reported quarterly to the HSCB Quality and Effectiveness working group for scrutiny and challenge. The newly implemented early help service will help to improve take up of early help assessments and will provide support to those initiating early help processes.

Standard 8 returns from all agencies and service areas evidenced a good understanding of information sharing processes and protocols. Single and multi agency training was identified as a key to embedding good practice.

Conclusion

There is evidence of a strong commitment across HSCB partners to ensure section 11 standards are complied with. The s11 has provided assurance to the HSCB that all agencies required to comply with S11 understand their duty and are committed to ensuring compliance with processes.

The returns indicated that there was a comprehensive audit programme embedded

across all services reporting with the exception of the Metropolitan Police: Metropolitan Police quality assurance processes are progressed through daily 'Grip and Pace' where senior managers review cases and determine timelines as appropriate. KPIs are scrutinised during regular performance meetings. Risks are escalated through agreed internal escalation pathways and, when necessary, escalated to the HSCB.

The quality assurance work undertaken at single agency level is not routinely reported into HSCB quality and effectiveness group. Audit reports including actions to address emerging issues should be reported quarterly to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

The impact of training on improved outcomes has not always been easy to determine. The impact of learning on improving knowledge and understanding is evidenced within post course analysis: an increase in referrals regarding CSE and FGM may also be indicative of improved understanding of this area of work.

The s11 self-assessment audit provided the HSCB with assurance that S11 requirements have been priorities across statutory partners during structural and transformational organisational changes. Partners have identified gaps within standards and identified action to ensure that each element within the standards are embedded.

The section 11 audit tool requires agencies to report on compliance biennially. The HSCB will need to determine whether an annual self-assessment audit of compliance should be completed to allow the HSCB to fully understand agency commitment to these standards during this time of austerity and shrinking resources.

Recommendations:

1. Each agency to implement their agreed action plan and report to the quality and effectiveness group quarterly and by exception.

2. Single agency audit activity to be reported to the HSCB Quality and Effectiveness group at quarterly intervals.

HSCB to consider whether to initiate a further section 11 audit in 2016

Single agency successes and areas for further improvement

In preparation of this annual report each agency represented on the board except Havering Council Children and Young People Services, which is intrinsically incorporated throughout the body of this report, were requested to submit a report setting out their individual successes and areas for future improvement.
This section will set out the agencies identified risks and challenges and their actions and priorities for the year 2014 to 2015

Havering Public Health Service

Background

The Public Health Service helps the London Borough of Havering (LBH) protect and promote the health of the population by providing expert health related advice to elected members, the Health and Wellbeing Board, council services, partner agencies and the public. The service has a range of mandated and non-mandated functions.

As well as providing system leadership, multi-disciplinary perspectives and a commitment to evidence based practice the Public Health Service is responsible for commissioning a number of services. The most pertinent to children and young people's safeguarding include:

- School Nursing
- Substance Mis-use
- Sexual Health
- Health Visiting (to be transferred in October 2015)

Safeguarding remains an important aspect of Public Health work.

Review of Safeguarding Activity 2014 – 2015

School Nursing

The Public Health team has been working with health and social care partners to understand the role of health professionals in safeguarding of children and young people. A pilot audit was undertaken with partners from children services and school nurses, to review school nurse involvement in safeguarding. The preliminary findings suggest that in some instances other health professionals may have had more to contribute to safeguarding efforts than school nurses, who are often seen as the default health representative. This work is on-going and reports will be submitted to the LSCB Quality and Effectiveness group in the upcoming weeks.

Looked After Children (LAC)

The Public Health team has worked with partners in the CCG and Community Trust (NELFT) in order to understand how initial health reviews and subsequent health reviews are undertaken for LAC. Clarity over commissioning arrangements are currently being explored to ensure this group receive a high quality and responsive health care service that's has the capacity and skills set to meet the needs of LAC in Havering.

Sexual Health & Substance Misuse Services

Through contract monitoring, on-going safeguarding issues are raised and discussed with the provider to ensure any action necessary to safeguard service users is taken. Ensuring that providers actively contribute to local efforts to tackle FGM, CSE and gangs has been a priority in 2014/15.
The last year has seen a number of major changes in the Council's Housing service:

- The new Housing Service structure designed to improve service quality and control risks to residents came into effect.
- An audit of the Housing Service by the Chartered Institute of Housing (CIH) resulted in the service developing a comprehensive action plan including elements relating to safeguarding
- Housing policies designed to support and protect service users were revised and updated.
- A review of the Council's Supported Housing was undertaken as a result of the changes to the changes to the Supporting People funding.

Priorities of the service

Housing Services manages and maintains the Council's stock of some 9,900 tenanted and 2,200 leasehold homes. It also provides services for people in housing need and co-ordinates housing strategy across the Borough.

The priorities of the service for the forthcoming year include:

- Delivering on all aspects of the CIH action plan in relation to the safeguarding agenda – in particular training and awareness building
- Continuing with our programme of home improvement and modernisation to bring all our homes up to an agreed decency standard
- Building new social housing homes in Havering and adapting existing homes to new uses where possible.
- Working with our partners to tackle anti-social behaviour across the Council's social and commercially managed housing stock.
- Responding to the changes in the welfare system to give advice to residents and to minimise the impact on them, and to reduce poverty and Financial Exclusion
- Reviewing and updating the way we deliver our services to make it easier and more convenient for residents to use them.

Working in partnership with Children's Services

The Housing Service recruited a Housing professional to a new post, Housing Link Officer, in the Multi Agency Safeguarding Hub (MASH) to act as the link between MASH and housing.

The Housing Service funded a Housing professional to a housing advisory post in the Early Help team to act as the link between the teams.

Welfare reforms

This has been a key issue for Housing Services and for residents on low incomes. Many local

families have seen Housing Benefit reduced or are subject to a cap in the total amount they can receive in benefits. Through a team of officers the Housing Service advises residents on how to mitigate the impact and to sustain their tenancies in both the social and private housing sectors.

Anti-Social Behaviour

The Anti-social Behaviour, Crime and Policing Act 2014 comes into effect on April 2015. Housing has made preparations for the new legislation by:

- Reorganising services internally so that tackling anti-social behaviour is carried out in the same team as tenancy management
- Retaining our Neighbourhood wardens and CCTV services
- Revising our anti-social behaviour policy and procedures to reflect the emphasis on supporting residents responsible for anti-social behaviour who are often themselves victims in need of support.

Housing

The last year has seen a number of major changes in the Council's Housing service:

- The new Housing Service structure designed to improve service quality and control risks to residents came into effect.
- An audit of the Housing Service by the Chartered Institute of Housing (CIH) resulted in the service developing a comprehensive action plan including elements relating to safeguarding
- Housing policies designed to support and protect service users were revised and updated.
- A review of the Council's Supported Housing was undertaken as a result of the changes to the changes to the Supporting People funding.

Priorities of the service

Housing Services manages and maintains the Council's stock of some 9,900 tenanted and 2,200 leasehold homes. It also provides services for people in housing need and co-ordinates housing strategy across the Borough.

The priorities of the service for the forthcoming year include:

- Delivering on all aspects of the CIH action plan in relation to the safeguarding agenda – in particular training and awareness building
- Continuing with our programme of home improvement and modernisation to bring all our homes up to an agreed decency standard
- Building new social housing homes in Havering and adapting existing homes to new uses where possible.
- Working with our partners to tackle anti-social behaviour across the Council's social and commercially managed housing stock.
- Responding to the changes in the welfare system to give advice to residents and to minimise the impact on them, and to reduce poverty and Financial Exclusion
- Reviewing and updating the way we deliver our services to make it easier and more convenient for residents to use them.

Working in partnership with Children's Services

The Housing Service recruited a Housing professional to a new post, Housing Link Officer, in the Multi Agency Safeguarding Hub (MASH) to act as the link between MASH and housing.

The Housing Service funded a Housing professional to a housing advisory post in the Early Help team to act as the link between the teams.

Welfare reforms

This has been a key issue for Housing Services and for residents on low incomes. Many local families have seen Housing Benefit reduced or are subject to a cap in the total amount they can receive in benefits. Through a team of officers the Housing Service advises residents on how to mitigate the impact and to sustain their tenancies in both the social and private housing sectors.

Anti-Social Behaviour

The Anti-social Behaviour, Crime and Policing Act 2014 comes into effect on April 2015. Housing has made preparations for the new legislation by:

- Reorganising services internally so that tackling anti-social behaviour is carried out in the same team as tenancy management
- Retaining our Neighbourhood wardens and CCTV services
- Revising our anti-social behaviour policy and procedures to reflect the emphasis on supporting residents responsible for anti-social behaviour who are often themselves victims in need of support.

Schools

School safeguarding and whistleblowing policies have been revised, and as of July 2015 every school in Havering – maintained, academy and independent – has implemented policies which clearly reference 'Working Together' and 'Keeping Children safe in Education'.

Required 3 year training for all school staff is also up to date, with every school having run this essential training, or have it booked to deliver between September and December 2015. Many schools run this training twice and attendees are from across the whole school workforce, including teachers, teaching assistants, support staff, midday assistants, cleaners and bus escort staff.

Schools use a section 175 audit document; this covers the statutory elements of Section 175 Education Act 2002, Section 11 Children Acts 2004 and Keeping Children Safe in Education, March 2015. 27 schools have completed a detailed, supported audit, all schools audited are compliant, many have very well developed in school processes which support high quality recording of child protection issues, enabling timely and detailed referrals and on-going support for the child. A further 36 schools have completed the S175 self-review as part of a self-evaluation of safeguarding processes.

A range of additional training has been run specifically for schools, in addition to the training run by the LSCB. This additional training has included training for designated leads and also specific topics such as FGM, Radicalisation and Extremism.

Early Years Settings

Since May 2015 five training sessions have been facilitated for Early Years staff in PVI (private, voluntary and independent) settings or schools across Havering. To date 90 practitioners have participated in either an Introduction to Child Protection course or Safeguarding for the Designated person training. A further 50 practitioners will be trained in autumn 2015.

Early Years Quality Assurance support to PVI settings has been revised and as of May 2015 all settings visited have participated in a Safeguarding Audit. The audit, written by the Quality Assurance Team, requires settings to audit their own policies and procedures and draw up an action plan. The trialling of this has been successful and it is envisaged that the audit will be made available to all settings to consider prior to their Safeguarding Audit.

Police: Local Havering Command

Havering police have responsibility for the initial response to calls from the public and then the ongoing investigation thereafter. This relates to Emergency response team as initial responders

and initial investigators. In addition CID units based at Romford Police station then support further with secondary investigations and links into partner agencies while giving ongoing support to victims and their families. CID units most likely to be involved in safeguarding matters will be Community Safety Unit led by a Detective Inspector and supported by 3 Detective sergeants and 15 Constables.

3. How has the organisation contributed to the Havering LSCB strategic priorities?

a) Havering Police attend LSCB and sub groups. Data is reviewed and fed back to the senior leadership team to ensure we are providing an effective response to child issues in collaboration with our partner agencies.

b) Havering Police are an integral part of the safe guarding partnership, through the Multi Agency Safeguarding Hub (MASH) having been one of the first Borough in London to launch the MASH unit . We have 1 Detective sergeant and 3 constables and 3 analysts embedded within the hub. We continue to evolved and develop the MASH responding to local needs.

c) Havering Community Safety Unit is very much part of the Safeguarding Portfolio which consists of management of Sexual offenders (Jigsaw), Multi Agency Public Protection Arrangements (MAPPA) , Multi Agency Risk Assessment Conference (MARAC) Youth offending services (YOS) . Child Sexual Exploitation (CSE). Through these portfolios Havering Police seek to best co-ordinate the right support for families

4. Long and short term risk and priorities

Havering Police have formed a Child Sexual Exploitation unit, this links in very much with central Sexual offences abuse command. Cases are identified and graded according to risk. Short term we are seeking to increase staffing levels by 50% over the summer 2015. Longer term aims are to increase staff knowledge of CSE issues as they change and develop.

5. Actions to be taken to address the risk and expect impact on the outcomes

Staff have been identified to increase staff numbers within the CSE unit.

As intelligence comes to light the CSE will circulate and cascaded MPS wide and Havering CSE officers will act as subject experts to offer advice and support for first responders and secondary investigators

6. Example of Effective/Emerging Practice

Child Sexual Exploitation is a relatively new and emerging way of Policing, learning on local and national best practises.
CSE is very much imbedded in local safeguarding Havering Police seek to build on this success with a view of securing an intelligence picture of exploitation within our Borough and beyond. With this intelligence in place then putting plans in place to disrupt and bring offenders before the courts

Police: Child Abuse Investigation Team (CAIT)

Long and short term risk and priorities

In support of Havering CID the Metropolitan police have a unit of specialised investigators dedicated to child abuse - CAIT, this team has responsibility for Barking & Dagenham and Havering Boroughs and are based at barking side Police station. Their remit covers;

- Intra- familial abuse.
- Professional abuse.
- Other carers such as carers, babysitters, voluntary groups.
- Allegations outlined in the Child Abduction Act 1984 Section.
- Intelligence led investigations in relation internet crimes
- To investigate sudden and unexpected death in infancy of children under 2 years with the family.

Havering CAIT has a strong working relationship with other safeguarding partnership agencies (Child Social Care, Education, Health etc). They also have a dedicated team of police staff deployed to represent the MPS at case conferences and to produce reports for them.

There has been improved input and understanding of the Child Risk Assessment Matrix (CRAM). This is the research conducted into every CAIT allegation to ensure any direct or potential risk to children can be managed and strategies implemented.

CAIT's are subjected to inspection by the Continuance Improvement Team (CIT) on an annual basis.

CAIT's are further held to account by the Metropolitan Police Authority.

- Initial Case conferences 44% attended / target 100%
- Review Case conferences 6% attended / target 50%
- Strategy discussions 654 - 545 with 24 hrs (83.3%)
- There has been a 21% annual increase in reported offences.

a. What the agency has learnt from its performance information

CAIT has struggled to attend conferences through the financial year due to staff vacancies. However as staffing levels have increased so has performance (ie:- initial case conference attendance in February was 89% compliant).

b. How this learning has informed decision making

The senior leadership team within SOECAC continue to review processes to establish if video / phone conferencing can be implemented to increase conference compliance.

2. Main achievements and areas of strength

The MPS constantly reviews its commitment and development of policies to safeguard children. Since the 'Baby P' inquiry, the MPS has implemented a detailed risk assessment matrix (CRAM) to ensure that all factors are considered when decisions are made with regards to child protection investigations.

The MPS have developed new requirements on the Crime Reporting Investigation System (CRIS) to ask questions of reporting and investigating officers relating to risk factors to consider when making safeguarding decisions. It also ensures managers can make informed and focused decisions whether to commence single or joint agency investigations.

It has been a longstanding practise that children's evidence is obtained via video recorded interviews (ABE's) and that if a child is under 5 or has special needs then consideration should be made to use intermediaries. This enables the most vulnerable children to be heard and improve their outcomes in the criminal justice system.

The partnership team actively seek the views of partner agencies regarding local CAIT teams and reviews the effectiveness of partnership working as stipulated in "Working Together to Safeguard Children 2015".

3. Main areas of concern and issues for development in relation to safeguarding

The main issue facing CAIT in the past year has been a lack of trained police staff to cope with the rise in reported incidents. This has impacted on performance and particularly child protection case conference attendance.

In the short term Havering CAIT has catered for this by utilising police officers who were working on attachment to the team. The long term goal is to increase trained staff and CAIT is in the process of recruiting more police officers to fill vacancies. This will continue to be monitored as crime & staff workloads increase.

6. Key areas for development and action plan

A key area for CAIT is to develop case conferencing by video / phone links to improve CAIT input within conferences. CAIT and partnership agencies have seen a marked increase in demand of their services. CAIT continue to try and meet the challenge of case conference attendance by finding an effective way to improve CAIT input and engagement.

7. Key messages / recommendations for LSCB Priorities

CAIT reported incidents have continued to rise over the last 3 years. CAIT senior managers

continue to address staff vacancies to meet that demand.

CAIT's recommendation to the board is to review working practices regarding case conferences to consider video / phone conferencing.

Health: Clinical Commissioning Group

Long and short term risks

Clinical Commissioning Groups (CCGs) are statutory NHS bodies with a range of statutory duties, including, safeguarding children and young people. Havering CCG is a major commissioner of local health services for residents living in Havering and need to assure itself that all the CCG commissioned services for children and young people across the health economy in Havering have effective safeguarding arrangements in place and is in accordance with their statutory duty under section 11 of the Children Act 2004.

The CCG safeguarding structure is established for Havering CCG where the Nurse Director has executive responsibility for safeguarding within the Governing Body. The safeguarding accountabilities are discharged through the delegation of responsibilities through the Nurse Director and is supported by the Deputy Nurse Director and the designated professionals. The Chief Operating Officer (COO) within the CCG is the operational lead for ensuring implementation of safeguarding functions supported by the CCG designated professionals for safeguarding.

Havering CCG has developed a Safeguarding Children & Adults Framework which detailed how the CCG will discharge and fulfil all the statutory safeguarding children and adult functions both strategically and operationally.

The CCG has appointed the following professionals in 2014/15

Named GP for Havering

Designated Doctor for Looked After Children across BHR CCGs (interim)

Designated Doctor for Safeguarding Children

Designated Nurse for Safeguarding Children

Risks and Challenges

There is an ongoing risk with the initial and review health assessments for looked after children which are not completed within the statutory requirement and there is concern raised regarding the quality of the assessments. It is a priority for the CCG to ensure there is a robust system in place to improve the timeliness and quality of health assessments for looked after children

It is also a priority for the CCG to ensure there are robust contractual service specifications for safeguarding and reviewing processes for services commissioned for children and young people

Actions to be taken to address the risks and the expected impact on outcomes

To address the risk for looked after children, the appointed Designated Doctor and Designated Nurse for looked after children have been charged with the strategic task of reviewing the health assessment service and identify gaps in service. Following this review, they will make recommendations to the CCG for an improved and sustainable service.

Example of Effective/Emerging Practice

The Designated Nurse lead for child protection information sharing project is in a unique position of being a CP-IS board member and had personally championed the implementation of the first LIVE integrated CP-IS project at Homerton Hospital. The designated nurse is the CCG CP-IS lead and will use her knowledge and experience to help support and drive implementation of CP-IS

North East London Foundation Trust (NELFT)

Long and short term risks

North East London NHS Foundation Trust (NELFT) provides mental health and community services for people living in the London Boroughs of Waltham Forest, Redbridge, Barking & Dagenham and Havering and also manages community health services in south west Essex. NELFT is committed to ensuring that all patients

receive care in a safe, secure and caring environment supported by a number of Safeguarding Children arrangements. There is senior management commitment to the importance of safeguarding within the Trust; the Chief Nurse undertakes this Executive lead role.

NELFT has Named Doctors and Named Nurses who provide advice, guidance and support to staff across the Trust on safeguarding children issues. Roles and responsibilities for these roles are clearly outlined in the job descriptions.

Integral to NELFTs Governance arrangements, the Strategic Safeguarding Group for NELFT meets on a quarterly basis .Its function is to ensure that the Trust executes its statutory safeguarding responsibilities and to ensure that national policy and guidance are interpreted and applied at a local level.

A safeguarding report is presented to both the Trust Board of Directors annually and to the Quality & Safety Committee (QSC) on a bi-annual basis; this report covers all areas of safeguarding children including changes in national and local policy, audit results, key developments and staff training.

Long and short term risks and priorities

With the changing demographics and increase in safeguarding activity in Havering, NELFT needs to ensure that staff have the appropriate skills and competencies and are appropriately supported in their safeguarding role.

Collaborative working with the Strategic Lead for Domestic Abuse and Harmful practices will continue to progress the actions identified in the Rotherham enquiry around Child Sexual Exploitation.

Integrated working across the adult and children safeguarding teams to be further embedded to support an increase in the numbers of referrals to MARAC.

Improvement in access to and quality of advice and support in relation to safeguarding adults and children for NELFT staff and multi-agency colleagues

Actions to be taken to address the risks and the expected impact on outcomes

- NELFT to continue to review and challenge its arrangements to support safe and consistent practice to ensure that children and young people are appropriately safeguarded.
- For there to be an improvement in access to and quality of advice and support in relation to safeguarding adults and children for NELFT staff via the provision of a single point of contact for advice and support.
- Completion of the development of Safeguarding Operating Procedures to support the Safeguarding Children Policy

Example of Effective/Emerging Practice

- NELFT recognises the importance of high quality safeguarding children supervision to support staff in practice to improve outcomes for children. To strengthen the delivery of safeguarding children supervision NELFT has developed a formal induction programme for safeguarding children supervisors to support practitioners in this key role.

Barking, Havering & Redbridge University Hospitals NHS Trust

Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT) continues to ensure that it is doing everything it can to ensure that as an Local Safeguarding Children's Board (LSCB) partner agency member it is fulfilling its commitment as required under Section 11 Working Together 2015.

BHRUT has established robust systems and processes to ensure there is a timely and proportional response when safeguarding concerns are raised when a child/children are considered to be at risk or likely to be at risk of "Significant Harm".

This has been achieved as follows:

Safeguarding Team

The Safeguarding Children's Team is fully established and comprises of:

- Full time Named Nurse
- Full time Named Midwife
- Full time Named Doctor for Safeguarding Children
- Full time Paediatric Liaison Nurse/Child Death Co-ordinator
- Full time Team Secretary

The Deputy Chief Nurse line manages the Named Nurse Safeguarding Children and Named Midwife on behalf of the Chief Nurse, who has Executive responsibility for safeguarding.

Long & Short Term Risks, PRIORITIES & Actions Taken

- To develop practice in responding to Domestic Violence/Sexual Violence and Abuse in line with the Publication of the NICE Guidelines March 2014

Actions:

The Trust's Named Midwife has been nominated as the Trust's Domestic Abuse Champion and is a member of the B&D Domestic Violence/Sexual Violence Group.
The Trust is reviewing its approach to managing Domestic Abuse, which includes developing a Trust wide Domestic Abuse Policy.

- At least 85% of eligible staff to attend Level 3 safeguarding children's training.

Actions:

Regular monitoring by the Deputy Chief Nurse/Head of Safeguarding and compliance reported at the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Group meetings.
Compliance monitored at the Trust's monthly Divisional Performance meetings.

- To develop staff awareness of harmful practice i.e. Child Sexual Exploitation (CSE) Trafficking and Female Genital Mutilation (FGM)

Actions:

To establish FGM/CSE leads in all relevant clinical areas.

Quarterly FGM/CSE meetings to be established and chaired by the Trust's Deputy Chief Nurse/Head of Safeguarding.

Effective /Emerging Practice

In April 2014 the Trust introduced mandatory safeguarding screening tool within the Emergency Care Department to encourage a "think family approach" and recognition to the "invisible child/ren.

Since implementation, Emergency Care staff (Adults and Paediatrics) recognition of vulnerabilities and risk to children has increased.

An audit of the effectiveness of this tool is due for completion in early Q 1 2015.

Conclusion The Safeguarding Team continue to make significant progress in ensuring that the Trust executes its duties and safeguarding responsibilities and maintains focus on the welfare of children. This is evidence based by interagency working and improved inter-hospital and external working relationships with Havering LSCB Board members and related subgroup members

Children and Families Court Advisory and Support Services (Cafcass)

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families.

Cafcass' statutory function, as set out in the Criminal Justice and Court Services Act 2000, is to "safeguard and promote the welfare of children". Safeguarding is therefore a priority in all of the work we undertake within the family courts and the training and guidance we provide to staff reflects this.

Review of Safeguarding Activity 2013-2014

A key focus during 2014/15 was continued improvement following our "good" Ofsted judgement in April 2014. Ofsted summarised that Cafcass consistently worked well with families to ensure children are safe and that the court makes decisions that are in the children's best interests. The report also highlighted areas where Cafcass should make improvements, and these areas formed a dedicated action plan which we implemented throughout the remainder of the year. An audit in November 2014 assessed that all of the following actions had been met:

- To improve the minority of safeguarding letters which are not yet fit for purpose: this has been met;
- Improve effectiveness of efforts to contact parties. Where sufficient efforts have been made these should be better recorded: this has been met;
- Ensure that in all private law work casework begins as early as possible once a Family Court Adviser (FCA) has been allocated: this has been met;
- Improve the percentage of "good" work in private law work after first hearing (WAFH) in London: this has been met;
- Improve further the analysis in the report to the court and ensure that all relevant information is pulled through in to the report based on research: this has been met.

-

A national audit of practice was undertaken in November 2014 with the objective of providing a snapshot assessment of the standard of casework. The audit measured the progress of work since the audit in September 2013 and the Ofsted inspection of April 2014. The conclusions were positive, reporting the percentage of work graded as "good" at 65%. This represents a significant improvement of 16% from the previous year's audit.

We will undertake three thematic audits in 2015/16, focusing on further improvements required. These will look at the extent of the improvement in the joint working between the Independent Reviewing Officer (IRO) and the Guardian; the Guardian's involvement and agreement to any position statement filed in proceedings; and evidence in WAFH of the improvement in analysis of assessment and increased use of research and tools.
Further scrutiny is given to our safeguarding practice and processes by the Family Justice Young People's Board (FJYPB) comprising young people with direct experience of the family court. The FJYPB contribute to our publications, review our resources for direct work with children, and are involved in the recruitment of frontline staff. Board members also review the complaints we receive from children and young people.

Long and short term risks and priorities

We continue to respond to, and facilitate, developments within the family justice system and in particular the move, in private law towards supporting parents, where possible, to make safe decisions outside court proceedings. We are currently piloting a programme announced by the MoJ, to provide advice and to encourage out of court pathways for separating parents, where it is safe to do so. The supporting separating parents in dispute (SSPID) helpline was launched in November 2014. Callers are put through to a Cafcass practitioner who can talk through the difficulties of separation, offering support, guidance, and information. We also ran a six month pilot of a safeguarding advisory support service for mediators, aimed at providing support in cases featuring child protection concerns.

Cafcass is also working on the Parents in Dispute pilot, in partnership with the Tavistock Centre for Couple Counselling. The chief aim of the project is to support separating parents involved in high conflict disputes in the family courts. FCAs in London have been able to recommend that separating parents attend the course in order to help parents to reconsider their behaviour in order to better focus on their children and create positive outcomes for them.

A significant emerging issue in recent years has been child sexual exploitation (CSE), We are implementing a CSE strategy which involves consolidating systems to capture data on CSE in cases known to us; providing mandatory training on CSE to our staff, running workshops to increase awareness; reviewing policy guidance to staff; creating dedicated management time to support the delivery of the strategy at a national level; and creating CSE ambassadors within each service area.

Section 5

Board Governance and structure and finance

LSCB Financial Contributions

HSCB is funded under arrangements arising from Section 15 of Children Act 2004. The contribution made by each member organisation is agreed locally. The member organisations' shared responsibilities for the discharge of the HSCB's functions include determining how the resources are provided to support it.

During the financial year 2014-2015 the largest proportion of the budget was spent on:

Staffing £108,519

Havering's independent chair £17,835.

Multi-agency training programme £25,000, which included classroom based learning and a conference.

The budget agreed for 2014/15 was comprised of contributions from the key partner agencies represented on the Board and in all cases except Havering Council, which increased its contribution, is the same as the previous three years.

Name of Agency	Contribution 14/15
Havering Council	£121,640.00
Police	£5,000.00
CCG	£28,706.49
BHRUT	£4,778.33
NELFT	£4,778.33
National Probation Service	£1,000.00
The London Community Rehabilitation Company LTD	£1000.00
CAFCASS	£562.15
Totals	**£167,465.30**

The projected contributions from partner agencies total £167,465.30. This budget excludes the additional contribution required to finance CDOP statutory requirements: CDOP was jointly funded by Children's Social Care and Havering Health services as previously agreed by Havering LSCB.

The Child Death Overview Panel is funded by contributions from Health and Children Social Care and covers all CDOP processes. CDOP costs for the year were £44,465

The HSCB had a carry forward from the previous year of £17,000

Governance

Due to changes in agency structures and funding the HSCB chair agreed to review the current board structure including membership, board meetings and sub group structures. During 2015/16, the board will introduce an executive group, which has a smaller membership consisting of agency, leads. This will be the strategic board., which will be supported by an operational group, that has a bigger membership reviewing operational issues including the work of the sub groups. This operational group will work closely with the SAB operational group including having a shared meeting.

During 2014/15 the board recruited a Lay member, unfortunately a second was recruited but was unable to take up the post.

Board Challenge.

- To keep the structure under review to ensure that it enables the board to operate at the level required.
- To recruit a second lay member
- To have open and honest communication to understand the impact of austerity and budget cuts on services and how this will impact on safeguarding.
- To continue to challenge all partnership agencies to ensure that safeguarding remains a core priority during times of budget cuts.

Staffing and support

Board staffing has remained stable over the year. A business manager, training and development officer and an administrator are in place to assist the board in achieving agreed priorities. The Board is chaired by an independent person.

Moving forward: Priorities

2015 – 2016

In the forthcoming year, the Board's focus will be:

- child protection,
- early help,
- child sexual exploitation and missing
- neglect:

The Board Priorities will remain the same

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents

This page is intentionally left blank

ANNUAL REPORT, 2014/15

Making a difference…

Presented in accordance with
"The Matters to be Addressed in Local Healthwatch Annual Reports Directions, 2013"

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both health and social care professionals and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

***'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill***

CONTENTS

Foreword by Anne-Marie Dean, Chairman, Healthwatch Havering	2
1 Making a difference: the governance of the organisation	4
2 Making a difference: the Enter and View opportunity	8
3 Making a difference: influencing official bodies and others	11
4 Making a difference: public consultation and participation	14
5 Making a difference: Health and Wellbeing	17
6 Making a difference: Learning disabilities	18
7 Funding, staff and organisational structure	21
8 Looking forward	24
Appendix 1: Specialist Member role	26
Appendix 2: Enter and View visits	29
Appendix 3: Summary statement of Income and Expenditure	32

We will be sending copies of this Annual Report to the statutory recipients (including the British Library) and circulating it widely to local health and social care organisations. Printed copies will be available for the public. It will also be available on our website, www.healthwatchhavering.co.uk .

Foreword

Anne-Marie Dean, Chairman, Healthwatch Havering

Welcome to Healthwatch Havering's second annual report. It has been an exciting year, with the vitality and vigour shown by our staff and volunteers we have made incredible progress, particularly with our work on Enter and View and in our continued work in Learning Disabilities.

Healthwatch was created as part of the reforms which followed from Sir Robert Francis's report into the failings at the Mid-Staffordshire Hospital Trust, which highlighted the appalling lack of high standards of care and also the failure of the Trust to listen carefully and to respond to the complaints and concerns of families, carers and friends.

The Department of Health, responsible for the care given by all NHS providers, are now even clearer about the expectations regarding the quality of care that trusts provide. The Care Quality Commission, CQC, is well established with a robust inspection regime and continues to monitor the danger for patients when any health or social care organisation loses sight of the standard of care that they provide. Healthwatch Havering's governing body is Healthwatch England and this is a member of the CQC board.

Healthwatch Havering's role is to respond to the importance of listening carefully, observing and monitoring how the health and social care services are delivered and how they respond to our local residents whether patients, families, carers or friends.

During the year our team of volunteers have undertaken over 20 Enter and Views. Our reports of those visits include recommendations for change that we feel are needed to improve life for residents and patients, and our reports are published on our website. Any patient, family member or resident can access these reports and also they can

contact us and share any concerns that they have about any health or social care services in the borough.

Access to care, not just for today and tomorrow but in the years ahead, has also been a priority for us this year. We have been instrumental in achieving the interim Primary Care Service for the residents of Orchard Village (formerly the Mardyke Estate) in South Hornchurch and the on-going discussions with NHS England on the development of a new purpose built centre. We are also a member of the St. George's Hospital Development working party: the plans for the future of the old hospital site are now coming to fruition.

As part of the role of listening carefully to residents, we have continued our series of 'Have Your Say' events. These have included working in partnership with the CCG and Havering Health in seeking residents' views about primary care services and the suggestions and recommendations of local people are included and published.

Being accountable for how we use our grant money is an important aspect of how we, at Healthwatch Havering, view our responsibilities. As our organisation has been running for two years, the directors and volunteers have reviewed our working arrangements. We have reviewed our Enter and View policy against national standards and guidance and we have developed a standardised reporting sheet which is used to record all meetings or visits undertaken by staff or volunteers, details of which are circulated to members and discussed at our monthly board meetings.

Our Annual Report this year could not be complete without mentioning our former manager Joan Smith. Joan, who was known to many people in her former role at Havering LINk, was the Healthwatch Manager until her retirement in March 2015. Joan was inspirational in establishing Healthwatch and we would like to thank her publicly for all her hard work.

Finally, a huge "thank you" to all our volunteers and staff. This has been an exciting year; thank you also to our partner organisations they have been supportive and responsive. Thank you to you for finding the time to read our report – your thoughts and comments are very welcome.

1. Making a difference: the governance of the organisation

Our sponsoring authority, Havering Council, had from the outset sought to design an organisation which was publicly accountable to residents, worked with and through a lay and volunteer membership, was able to contribute to the wider strategic health and social care debate and fully engage with all the key stakeholders.

Recognising this challenge, it was inevitable that Healthwatch Havering would need to have a flexible and responsive approach to designing and maintaining the organisation (without becoming too inwardly-focussed), expecting to revisit from time-to-time our structures and in an increasingly financially challenged health and social care environment recognise that we too would have to make a financial contribution.

A key factor was the need to meld professionalism with a voluntary work ethic. The directors each brought extensive experience of working in an NHS or local authority environment while many of the volunteer members were, or had been, senior NHS or social care staff. This meant that it was comparatively easy for Healthwatch Havering to engage with senior management of both the local NHS Trusts and bodies and the local authority and thus become a “behind the scenes” influence rather than having to adopt an arms’ length, campaigning approach.

Although the law relating to Healthwatch volunteering distinguishes between health and social care professionals (termed “volunteers”) and others (“lay persons”) we have chosen to treat both in the same way and refer to them as “members” without further distinction.

1.1 Involving members in the governance of the organisation

As reported in our last Annual Report, it had become clear fairly soon after we began operating that our initial arrangements were inadequate and would need a comprehensive review.

During the latter part of 2014/15, together with our members, we reviewed how effective we had been during the year. Most importantly, together we began work to determine:

- How we could further improve our effectiveness in our statutory role
- Redesign the roles and responsibilities of the paid staff
- Plan for no increase in the payments made by the local authority
- Create the role of the volunteer specialist advisor
- Review and update all of our Enter and View procedures, benchmarking against Healthwatch England's recommendations
- Attract new volunteer members
- Ensure an open and inclusive approach to managing our decisions through the board structure

Changing the organisation

So changes were necessary both at management level and for focusing our members' efforts. After discussion and debate to address our statutory role, we reviewed our manpower availability to ensure we could interact with other organisations and key stakeholders, and the extent of "backroom" activity required of us to comply with the legal obligations of a company and employer.

The challenge, which had not been fully anticipated, is now to attract new members. However, we are fortunate that our existing members are of a very high calibre, with a wide range of very relevant experiences within the health and social care sectors that enable them to "punch above their weight" and work with other organisations' professionals on a basis of equality. We are aware that their expertise is valued by the agencies with which we deal regularly.

Decisions which we made and agreed

- New staff structure
- Reduction of staff, revised remuneration and new roles and responsibilities
- New 'Enter and View' Policy and Procedures
- Specialist Member Role, to act as advisors to the management board

- The Management Board has been restructured – although the directors retain their statutory responsibilities and those imposed by the Company's Articles of Association, the Specialists are now also members of the Management Board and able to contribute fully to the management of the organisation
- Rationalisation of Board-level organisation
- To widen the approach to recruiting volunteers
- Budget planning for 2015/2016
- Work planning for 2015/2016

1.2 *The involvement of lay persons and volunteers in the carrying-on of the relevant section 221 activities*

Section 221 activities are the responsibilities that every Healthwatch has in respect of the statutory obligations to undertake Enter and View as set out in the Local Healthwatch Organisations Directions 2013.

During 2014/15 we undertook over 20 Enter and View visits to organisations which provide health and social care to the residents of Havering. The full list of visits, together with our reasons for visiting the particular establishment and a summary of our findings, is set out in Chapter 2 following and Appendix 2.

Our members are fully involved in determining the Enter and View visits programme. We have set up an Enter and View Programme Panel that is responsible for

- Determining the selection criteria for establishments to be visited
- Agreeing the priorities for visits
- Arranging visits
- Debriefing after visits to identify:
  - Whether follow-up action is needed
  - What recommendations to make
  - Whether there are "lessons to be learned" for future visits

Our members who carry out the visits prepare the reports of their visits and make recommendations for improvements that will benefit

residents and patients. The manager or other responsible person at the establishment visited is given the opportunity to comment on the final report of the visit before it is published.

2. *Making a Difference: the Enter and View opportunity*

2.1 The section 221 activities which have been undertaken during the year

2014 saw the beginning of our ambitious Enter and View programme.

Havering has one of the largest residential and care home sectors in Greater London and, consequently, there is a need for a large programme of E&V visits. Given the size of the sectors and our need to concentrate resources where we can be most effective, we decided early on to focus the Enter and View programme on visiting such homes as a principal area of activity.

The power to carry out "Enter and View" visits to health and social care premises is the most powerful tool available to local Healthwatch organisations. The law allows entry to almost all premises where publicly-funded health or social care is provided, including not only hospitals and residential care homes, but also GP surgeries, pharmacies, dental surgeries and opticians' practices.

Our activities during the year were determined and prioritised by our voluntary membership. To help set their priorities they draw on feedback from

- Members of the community
- Members of staff from a range of organisations
- Their own experience
- CQC weekly reports
- Information from the local authority's QAS team
- Press reports

So far as possible, we aimed to ensure a wide spectrum of care providers was included within the programme.

As reported in last year's Annual Report, recruitment, training and careful planning of the programme meant that it was not until near the end of 2013/14 that the first formal E&V visit could be undertaken (this was reported on in the 2013/14 Annual Report).

However, during 2014/15, the number of visits increased and, in all, we carried out 22 visits, including two visits to one particular home.

On the whole, our visiting teams were made welcome and managers, proprietors and staff were very co-operative in facilitating the visits. The team members were made to feel welcome by staff, residents and residents' friends and relatives alike.

Our teams also visited several wards or units at Queen's Hospital and Ogura Ward at Goodmayes Hospital (a mental health facility); there too they were made welcome and their visits were carried out with the full co-operation of management and staff.

Few problems were identified and mentioned in our teams' reports of their visits. Where we did make recommendations, we will be following up to see what effect they have had.

Except as noted in the table, all reports of our visits have been published on our website (www.healthwatchhavering.co.uk/enter-and-view-visits) and shared with the home or hospital, the Care Quality Commission, the Clinical Commissioning Group, Havering Council

During the course of the year, we reviewed our Enter & View policy in the light of experience gained (among other things).

In addition to the formal Enter & View visits, we have been working informally with a health centre/GP practice about which we had received a number of complaints to improve facilities there for patients.

We have not yet exercised Enter & View powers at a GP practice, dental practice, pharmacy or ophthalmology practice (although we are actively planning to do so during 2015/16).

Future programme

We have set up an Enter & View Programme Panel, chaired by our Executive Director, which any member may attend. Panel meetings are generally held monthly, and their proceedings are reported to the Management Board. Individual Enter & View visits must be authorised

by the Executive Director and are carried out only by trained and authorised members.

Our future programme is informed by CQC reports on establishments, by information gathered through meetings with local regulatory agencies and by complaints (and compliments, should we receive any) from service users.

We have identified a number of establishments that we are planning to visit during the course of 2015/16.

2.2 *Did any service providers or persons who had a duty to response to Local Healthwatch not do so?*

Almost without exception, the service providers with whom we have had dealings during the year have been as helpful and co-operative as we would have wished. Local NHS bodies in particular have taken our recommendations on board and responded appropriately to them.

In just one case, a provider failed to allow our Enter and View team access to particular premises. Following strong representations to the senior management of the provider, it was established that there had been a misunderstanding on the part of junior staff and assurance (and an apology) was given – and accepted – that it was a “one off” incident that would not be repeated. The report of that particular Enter and View visit (one of several to the same establishment) has not yet been published as there are other, ongoing issues that make it inappropriate for the report to be published at present.

2.3 *The reasons for all decisions to enter and view premises and what actions, if any, were taken by the relevant persons of the representatives entering and viewing each of those premises*

Please refer to Appendix 2 for the reasons for particular Enter and View visits.

3. Making a difference: influencing official bodies and others

3.1 Enabling our activities to have an impact on the commissioning, provision and management of the care services.

As an organisation, we are well equipped to ensure that the issues and concerns which arise from the Enter and View process are quickly fed back into the appropriate organisations.

We are represented at meetings of the local authority's Quality Assurance Team, represented by the Specialist volunteer lead for nursing and care homes. At those meetings, we ensure that the information which has been gleaned from our visits is shared and recorded as part of the formal meeting. In addition the QA Team share with us their key issues and concerns, which include safeguarding matters; this partnership helps to ensure effective working across the borough on behalf of our local residents.

We are, of course, a statutory member of the Havering Health & Wellbeing Board and in that capacity have continued to play a full and evolving role. We are also formally represented at meetings of Havering Council's Overview and Scrutiny Committees for Health, Individuals and Children's services and our Executive Director is a co-opted Member of the standing Joint Health Overview and Scrutiny Committee for Outer North East London (Havering, Barking & Dagenham, Redbridge and Waltham Forest).

We are members of the Urgent Care Board and the Systems Resilience group and attend the Quality Summit meetings with the TDA and CQC for BHRU Trust.

Influencing organisations that commission and manage care services is a major part of our responsibility and role. We seek to make a difference by providing evidence to other organisations which enables them to understand the issues which we are concerned about.

This is achieved in a variety ways: by the sharing of all our Enter and View reports with the QAT, the commissioners of the service and the local CQC representative; by circulating widely our 'Have Your Say'

reports; and by speaking to, or participating in events with, key local organisations, Council Members and other stakeholders.
We publish all our Enter and View reports and our 'Have Your Say' reports on our website, providing the maximum level of scrutiny and opportunity for local residents to contact us and to be informed of our work.

In June 2014, our Executive Director joined the Chief Executive of Healthwatch England in addressing a seminar at the Care in the ExCEL Centre in London's Docklands on the work that Healthwatch can do to influence others.

3.2 Recommendations that have been made to Healthwatch England

We have not found it necessary to escalate any matters to Healthwatch England nor have we made any recommendations to them.

However, during 2014, Healthwatch England initiated a Special Inquiry into arrangements for the discharge of patients from hospital, focussing especially on the arrangements for homeless people.

Havering is fortunate in that it does not have the level of homelessness that other parts of London experience (although this trend is changing as competition within the private rented sector means that an increasing number of households on low incomes or in receipt of housing benefit can lose their tenancy because their landlords can achieve a higher rent in the current market). For the most part, homelessness in Havering is the result of eviction by a friend or family member or the result of private rented tenancies being terminated through no fault of the tenant. Despite these growing pressures, the Council is able to accommodate most of those to whom it has a duty through the use of hostel or leased accommodation, avoiding the use of "bed and breakfast" accommodation.

Our contribution to the Special Inquiry was, therefore, based on work initiated by our predecessors, the Havering LINk, in 2011 and carried forward in conjunction with Havering's Health Overview & Scrutiny Committee.

In addition, Havering Council has placed residents with learning disabilities or autism in about sixty care homes across the England. The borough undertook a review of these providers and, as part of that work, asked us to make enquiries through the network of Healthwatch organisations to source any local knowledge about those care providers.

The homes in question were spread over more than ten counties and in total nineteen Healthwatch organisations were contacted about the homes within their area. We are grateful for the co-operation we received from our colleagues and for the concerns, and also positives, shared with us, all of which were then passed on to the borough.

As the recommendations from the Francis report and the Winterbourne report become more embedded within health and social care the more important the role of Healthwatch will be in gathering local knowledge from residents, carers and families and ensuring that good use is made of it.

4. Making a difference: public consultation and participation

We try to be as innovative as possible in seeking the views of our local residents. The traditional approach of holding meetings and events does not necessarily fit in with people's busy lives. In our borough older people often have transport or mobility problems.

Wherever possible we seek to go to where we will find our residents already meeting, to work in partnership with other organisations or using a particularly venue.

4.1 How we have used different methods to seek the views of our local residents

This year we have:

- Continued our 'Have Your Say' events using community-based venues around the borough
- Worked in partnership with the CCG on community events
- Developed and implemented the opportunity for residents to share their views on the new GP 'HUB' and access to the electronic patient record, using ballot boxes in GP practices
- Worked with BHRUT seeking residents' views on the hospital service
- Chaired and supported meetings with parents of vulnerable groups
- Attended meetings of organisations such as the 'Havering over Fifties Forum' (HOFF), presenting key issues and asking them to vote on the proposals
- Expanded the content of our website
- Taken our Healthwatch Havering stand to organisations and events

Regrettably, our limited staff and financial resources have prevented us from making use of social media such as Twitter and Facebook. We do hope at some point to be able to make use of them but we consider that, for the present, our resources are better deployed in dealing with more pressing issues.

4.2 Seeking views from a wide range of local people

People from the older generation

Havering has one of the largest older populations in London and (proportionately) in England. This group of individuals, over 65, are the highest users of local health and social care services. Therefore it is really important that every effort is made to understand their needs and how they can effectively gain the best health benefit from the services available.

Seeking the views of these residents and their carers is undertaken by working closely with organisations such as the Havering Over 50s Forum (HOFF). We attend the monthly meetings of HOFF and give presentations, provide the opportunity to vote on ideas and provide support in the questions and answer sessions on aspects of health and social care.

This group of people regularly use their GP practice and we are working closely with the newly formed Havering Health – GP consortium.

Members reflecting concerns within their communities

All members take time to share their views, often at meetings, by email or by calling. They recognise that they can be an excellent conduit for the anxieties and concerns of people who live in their neighbourhood, who they work with or who they mix with on a social basis.

These views or concerns are always followed up, and the information placed on our database to enable us to determine if there are any obvious trends in residents' concerns. Recent concerns regarding the availability of GP appointments times resulted in Healthwatch undertaking a series of 'Mystery Shopping' events and working with a particular GP practice to secure service improvements for its patients.

Listening to the views of individuals or families from groups perceived as vulnerable

Our Enter and View programme provides an excellent platform as it offers us direct access to patients in hospital environments both in the ward and in the outpatient settings.

Residents in care and nursing homes both for the elderly or learning disabled are able to share their worries and concerns with our volunteers who have had the wider training of the mental health act and the deprivation of liberties.

Equally important when we are seeking the view of patients and residents are their families, carers and friends, who provide additional knowledge and information about the care that is being given.

5. Making a Difference: Health and Wellbeing

The Health and Wellbeing Board is the key strategic meeting for our Healthwatch. It provides the opportunity to be a direct participant in setting the wider agenda across the health and social care environment in the borough.

We are recognised as a key member of the Board and our views are sought and respected. Healthwatch participates in the development meetings and the public meetings, and are able to express views across the care provision.

An example of this would be that during the latter part of 2014/15 concerns regarding the provision of primary care provided to the residents of Orchard Village were raised by Healthwatch. These concerns have been recognised, with prompt action from the CCG to provide interim primary care arrangements. In addition, there was leadership from our Chairman in seeking the support of NHS England in respect of the new long term development.

When the CCG are designing new services such as the GP Hub, the CCG sought our support in seeking the views of local patients.

Currently the membership of the Health and Wellbeing Board are reviewing and redefining the role of the Board and Healthwatch are seen as an important part of this discussion and process.

6. Making a Difference: Learning disabilities

In February and March 2014, we held a series of Have Your Say sessions in different parts of the borough to give service providers, users and carers an opportunity to tell us what they thought about the way in which services for people with dementia or who have learning disabilities were planned, provided and delivered.

As a result, in May 2014 we published a report containing a range of recommendations to the CCG, the Council and other health and social care providers. A number of our recommendations were subsequently acted upon and funding was identified to support work within the Better Care Fund.

One of the key issues that emerged was the distress being caused to parents of children with learning disabilities as a result of what they perceived to be the inadequacies of services provided by both Havering Council's Children's Services and the NHS, particularly the North East London Foundation Health Trust (NELFT), which has responsibility for healthcare for children with learning disabilities. The parents told us of problems with obtaining health checks from GPs; of difficulty communicating with health care providers in both the primary and secondary care sectors; of a lack of facilities for those who have a learning disability who want to live more independently; of identifying what services were available, especially for carers who have their own needs to attend to; and how to access services as children and their parents get older.

We were told that health and social care professionals needed better training to help them understand learning disability and its effects on both the individual in question and that person's friends, family and carers, including staff in residential care homes.

The report created awareness and began a process of change which involved parents and statutory agencies coming together committed to making a real step change in the services.

One consequence of this initiative was that we were asked by parents and carers to organise a meeting between Positive Parents, representatives of parents of children who have learning disabilities and of the various statutory organisations dealing with them. As a neutral participant, we were also invited to chair the group, which

has gone from strength to strength in re-establishing a good working relationship between the parents and the service providers. The meeting has addressed long standing concerns and is now confidently moving towards designing services which reflect the needs of the children, their families and carers. It became clear there was a need for a Learning Disabilities Liaison Nurse for Paediatrics.

A second consequence is that a Learning Disabilities Working group has been attended which has been tackling the issue of older people with Learning Disabilities. The Learning Disability Liaison Nurse (Adults) has only been in post for 15 months. Each Learning Disability Patient who is registered is electronically flagged up on entry to the Trust. There are now 80 Learning Disability Champions, who provide extra support for people with a learning disability during their hospital stay or visit. Through the working group we have input into designing of Easy Read booklets which explain common hospital procedures, in pictures and plain language these include Patient Experience, Hospital communication book, Checklists for in and outpatients, A & E and Ward stays. Hospital Passports are used across the Trust to help staff understand the individual needs for patients. The group help test pagers, if someone has a long time to wait for an appointment they are not confined to the waiting area, which can be distressing and be paged when the clinician is ready. Projects we are still working on are Head board magnets, Carers Policy, Easy Read Blood Test. The Learning Disability Liaison Group reports to the Learning Disability Health Pathway Group, we became involved with this group as another re occurring problem in our have your say forums was the right to have an annual health check.

When this work began the number of residents receiving health checks in Havering 2013/14 was 275. A total of 442 out of 852 (16 declined) were completed during 2014/15. In addition 298 LD service users received Health Action Plans following their health checks in 2014/15, which is a significant increase from 104 in 2013/14. During the year the CCG has provided training to GP practices, to Doctors and staff to be able to undertake the health checks. This step change in the number of health checks has been achieved by us, working in partnership with NHS England and the Community LD Team. At the last meeting it was announced the NHS England have agreed to handover the delegation of services to

Havering Health, which includes Annual Health Checks. This means service users will be able to go to one of the 'Hubs' for their Health Checks. As a direct result of this group funding has been agreed to recruit a Children's Learning Disability Liaison Nurse at the Hospital, interviews have already started.

7. Funding, Staff and Organisational structure

7.1 Funding

For 2013/14, Havering Council gave a main grant of £117,359, to which was added two supplementary grants totalling £21,184 for start-up costs and for improving the resilience of the organisation. The Directors decided to apply £8,184 of these grants to spending in 2013/14 and to spend the remaining £12,000 in 2014/15. The Council made available the same amount of main grant in 2014/15 so, with £7,443 brought forward from 2013/14, this meant that a total of £138,663 was available for spending in 2014/15.

A summary of the detailed accounts is set out in Appendix 3.

Allowing for Corporation Tax adjustments, the amount carried forward at the end of 2014/15 was £2,325.

7.2 Staff

During the course of our first year of operations, it became clear that workload expected of, and accordingly the level of staffing originally envisaged for, Healthwatch Havering had been greatly under-estimated. Based on the previous experience of the Havering LINk, the workload was envisaged as requiring one full-time employee (the Manager) and three part-time directors for a few hours a week; but it soon became obvious that far more would be required of Healthwatch than of the LINk. Initially, two of the directors took on additional hours but by the end of that year, it had become clear that more staff support was essential.

On 1 April 2014, therefore, we took on two additional, part-time members of staff: an Administrative Assistant, whose role was to support the Manager and Directors, and a Community Support Assistant, whose role was to assist the Lead Members, and the Manager in her dealings with our volunteer members.

Sadly, during March, the Manager left us for personal reasons. This required a review of the workloads of both the assistants and the two Directors who undertake executive roles, with commensurate adjustment of their respective salaries. It was considered

impracticable to seek to replace the Manager, and dispensing with that post resulted in an overall saving of some £13,000 per annum.

7.3 Organisational Structure

There have been a number of changes to the organisation's structure and management. These changes have been discussed and agreed with our voluntary membership.

The key changes are:

- The former distinction between Lead Members and Active Members was replaced by a new approach: in place of Lead Members, we now have Specialists, who no longer have responsibilities for managing teams of volunteer members but are able to concentrate on specific areas of health and social care activity or policy, and act as advisers to the Management Board on those specialist areas (Appendix 1: Specialist Member Role)

- The Management Board has been restructured – although the directors retain their statutory responsibilities and those imposed by the Company's Articles of Association, the Specialists are now also members of the Management Board and able to contribute fully to the management of the organisation.

The Strategy, Governance and Assurance Board has been abolished.

These changes were agreed during March 2015 and have been implemented from April.

The "Healthwatch" logo and trademark

Havering Healthwatch Limited has a licence agreement with Healthwatch England governing use of the Healthwatch logo and trademark.

The Healthwatch logo is used widely for Healthwatch Havering activity. It is used on:

- The Healthwatch Havering website
- This Annual Report

- Publications such as reports of public consultation events and Enter & View visits
- Reports to official bodies, such as the Health & Wellbeing Board and Overview & Scrutiny Committees
- Official stationery, including letterheads and business cards
- Members' identity cards
- Newspaper advertisements
- Flyers for events

8. Looking Forward

We develop a work plan as a tool that helps us to identify the issues and activities that we need to undertake. The work plan is led and developed in participation with our volunteers. As an organisation that is grant funded, our work plan acts as a useful document contributing also to transparency as it is available to organisations that have a need to know what we are doing during this period.
Below is the executive summary.

The key components of the plan are to include:

- The continuation of the programme of 'Enter and View' (E and V) visits across the borough for nursing in residential homes. As part of the preparation for 2015/16 we have reviewed and redesigned our 'Policy and Procedures for Enter and View visits to health and social care premises'.

- We will continue to develop the positive relationship with Queens Hospital at both a strategic and an operational level.

- To continue to work with parents, voluntary and statutory organisations to ensure that people with Learning Disabilities within our borough have an influential and effective voice.

- To monitor the services provided within Primary Care, looking at concerns raised by patients on an individual basis, statutory organisations and access of communities to basic primary care facilities.

- Monitoring the impact of changes to funding and policies on the services

- Working with the Health and Wellbeing board, the Overview and Scrutiny Committees, the CCG's, colleagues across the Healthwatch network and the CQC.

In addition to extending our role within these areas we will monitor the work and achievements which have happened in 2014/15 to ensure that, where we have been successful in 'Making a Difference', this improvement to health and social care is maintained and wherever possible developed further.

Appendix 1: Specialist Member Role

Specialist Members are members of the Management Board, principally to act as its advisers within their field of speciality.

This is the most senior voluntary role and helps to provide stewardship, leadership, governance and innovation to the Management Board and the Enter and View Panel.

Specialist Members have the lead role in providing knowledge and expertise in their area of speciality. They will, with help and assistance from the management team, develop a work plan with a clear purpose for each dedicated area. The work plan will help to support the choices and rationale for Enter and View visits and other Healthwatch activity, providing a clear purpose for activity within the specialism and enabling a generic process to be applied by volunteers.

Developing the work plan

The aim of the work plan is to improve some aspect of service delivery within the local health and social care services in Havering. The plan will intuitively identify people and organisations who can contribute to the planning of the work, encouraging and supporting a collaborative approach with providers, commissioners, regulators and other local health and social care groups.

Planning of the overarching work programme should ascertain where a requirement exists for Enter and View activity, to collect evidence; hence the Enter and View programme is an initiative with a clearly defined purpose.

The work plan helps to distinguish the Enter and View from an inspection.

By assigning a distinct purpose to Enter and View activity, and communicating this to all stakeholders, the aim is to distinguish it from other activities – such as CQC inspections and Local Authority QA checks – with which it has been too often confused in the past.

Providers, in particular, can then understand the potential benefits of Enter and View to themselves and to their service users by enabling them to see Enter and View as an opportunity for lay people to engage with vulnerable service users and their families, in order to gain a better view of how they feel about the services they receive.

The role of the Specialist Member is an essential key to building influential and effective relationships. Specialist Members, supported by the management team, will attend meetings which help to build effective relationships with commissioners to will help influence and design work plans which support the Enter and View programme and other activities.

Gathering relevant information to support the work plan and the Enter and View visit

Healthwatch England identifies the follow as relevant information searches

- Previous local Healthwatch or LINK visit reports
- CQC inspection reports, especially any outstanding issues

- Any information about the service already received by local Healthwatch, e.g. comments from service users or their relatives, user forums, local and national groups and charities
- Any outstanding safeguarding alerts
- Any outstanding issues with the Local Authority commissioners / QA teams
- Overview & Scrutiny Committee reviews and recommendations
- Patients & Public Involvement and/or Patient Advice & Liaison Services (PALS) intelligence
- Complaints information in the public domain
- Any relevant Healthwatch England national advice
- Governors reports, annual reports and quality accounts

Training

The Specialist Member will, working with the management team, help to identify any new training requirements, advise on any re-training and consider and recommend any conferences or seminars which they think will be both helpful and enjoyable for the teams to attend. The specialist will help in the development of suitable training events and programmes.

About the Role

- The time commitment is approximately equivalent to 5 days per month
- The role is subject to a formal recruitment process
- The role will receive a full induction and be supported with on-going training where appropriate
- A Specialist Member will be an authoritative representative of Healthwatch Havering at external meetings
- All travelling and when appropriate subsistence expenses will be paid
- The role reports to the Chairman of the Enter and View Panel
- The role will receive support and help from the Office and Community Support team
- The role will have direct access to the Chairman of the Board

Main Objective of the Role

- Listen non-judgementally to the concerns raised by users of health and social care provision, and determine what appropriate and proportionate action may be taken
- Proactively seek out and present/consider the views of the less vocal or seldom heard individuals and communities
- Use the views of users, and information gained through the reporting of trends via Healthwatch partners to develop an evidence based approach to drive the priorities
- Monitor and act as a voice for the views of the public in response to proposed service or policy changes

Volunteer responsibilities

- To enter into electronic communications with other panel members, the Office and Community Support team, board members.
- To attend meetings
- To establish constructive working relationships with other members, representatives of key stakeholder partners, and members of Healthwatch Havering groups
- To identify their area of personal knowledge and experience of health or social care, and draw on this to add value to the work of the Healthwatch Havering
- To undertake delegated work as agreed in an appropriate and timely manner
- To abide by the Healthwatch Havering Code of Conduct as set by the Board
- To act as an ambassador for Healthwatch Havering

Appendix 2: Enter and View visits

2014 saw the beginning of our ambitious Enter & View programme.

Havering has one of the largest residential and care home sectors in Greater London and, consequently, there is a need for a large programme of E&V visits. Recruitment, training and careful planning of the programme meant that it was not until near the end of 2013/14 that the first formal E&V visit could be undertaken (this was reported on in the 2013/14 Annual Report). However, during 2014/15, the number of visits increased and, in all, we carried out 22 visits, including two visits to a particular home. Details of the visits are given below (a couple more visits are not shown as the reports are not yet ready for publication).

On the whole, our visiting teams were made welcome and managers and proprietors were very co-operative in facilitating the visits. The team members were made to feel welcome by staff, residents and residents' friends and relatives alike.

Our teams also visited several wards or units at Queen's Hospital and Ogura Ward at Goodmayes Hospital (a mental health facility); there too they were made welcome and their visits carried out with the full co-operation of management and staff.

Few problems were identified and mentioned in our teams' reports of their visits. Where we did make recommendations, we will be following up to see what effect they have had.

Except as noted in the table, all reports of our visits have been published on our website (www.healthwatchhavering.co.uk/enter-and-view-visits) and shared with the home or hospital, the Care Quality Commission, the Clinical Commissioning Group, Havering Council and any other relevant agency.

Visits undertaken

All visits were announced in advance.

Abbreviations in table: **CQC - Care Quality Commission**
HASC - Havering Council Adult Social Care

Date of visit	Establishment visited		Reason for visit
	Name	Type	
2014			
17 February (reported in 2014 Annual Report)	*Barleycroft*	*Residential care*	*Concerns raised by CQC*
4 April	The Lodge	Residential care	Concerns raised by CQC and HASC

Date of visit	Establishment visited		Reason for visit
	Name	Type	
2014 continued…			
5 April	Maternity Unit, Queen's Hospital Romford	Hospital ward	Past evidence of poor care
26 April	Romford Grange	Residential care	To observe the normal operation of the home
29 April	Dury Falls	Residential care	Concerns about care practices within the home
9 May	Meadowbanks	Residential care	Concerns raised by CQC and HASC
20 May	Romford Care Centre	Nursing Home	To follow up previous, informal visit (October 2013)
24 June	The Fountains	Nursing Home	Concerns raised by HASC and reported safeguarding issues
30 June	Hornchurch Nursing Centre	Nursing Home	Concerns raised by CQC and HASC
3 July	Neave Crescent	Residential care (Learning Disability)	Concerns raised by HASC and reported safeguarding issues
24 July	Peel Way	Residential and nursing care (Learning Disability)	Concerns about reported safeguarding issues
31 July	The Oaks	Residential and nursing care	Concerns raised by CQC
1 September	Barleycroft (second visit)	Residential care	Following up the visit undertaken in February 2014
15 September	The Priory	Residential care	Concerns raised by CQC and reported safeguarding issues
3 November	Heatherbrook	Residential and nursing care	To observe the normal operation of the home
17 November	Clover Cottage	Residential care	Concerns raised by CQC
3 December	Ravenscourt	Nursing Home	To see an example of a home that had a "good" CQC report
11 December (Report not yet ready for publication as further work on going)	Lilliputs	Residential care (Learning Disability)	Concerns raised by HASC

Date of visit	Establishment visited		Reason for visit
	Name	Type	
2015			
12 January	Dothan House	Residential care and (proposed) domiciliary care service	To see an example of a home that had a "good" CQC report; and to understand proposals for domiciliary care provision
16 January	Elderly Receiving Unit and General Surgery Ward, Queen's Hospital	Hospital Ward	Joint visit with Members of Havering Council's Health Overview & Scrutiny Committee (treated as E&V but not conducted formally)
19 January	Ogura Ward, Goodmayes Hospital	Hospital Ward	Concerns raised by relatives of patients
9 February	Romford Care Centre (Report published June 2015)	Nursing Home	Concerns raised by CQC and HASC
23 March	Nightingale House (Report published June 2015)	Residential care	Concerns raised by CQC

In addition to these formal Enter & View visits, we have been working informally to improve facilities for patients at a health centre/GP practice about which we had received a number of complaints.

We did not exercise Enter & View powers at a GP practice, dental practice, pharmacy or ophthalmology practice during this year.

Future programme

Our future programme will be informed by CQC reports on establishments, by information gathered through meetings with local regulatory agencies and by complaints (and compliments, should we receive any) from service users.

We have already identified a number of establishments that we plan to visit during the course of 2015/16, and expect to include GP practices and pharmacies in the programme.

Appendix 3: Summary statement of Income and Expenditure

This Appendix is summarised from the Annual Accounts of Havering Healthwatch Limited. A copy of the full set of Annual Accounts is available from the Company on request, and may be viewed on the Healthwatch Havering website.

	£	£	£	£	£ 2013/14
INCOME					
Havering LBC: Main grant, 2014/15	**117,359**				
Havering LBC: Supplementary grant, 2014/15	**12,000**			**129,359**	*126,919*
EXPENDITURE					
1 COSTS OF MANAGEMENT					
Administration costs					
Office expenses, insurance and fees	7,822				
Office rent (including refundable deposit)	17,285				
Mileage, travel and subsistence -21990-84639-	1,922	27,029			*21,990*
Payroll					
Fees and salaries	92,811				
Employers' pension contribution	1,675				
Payroll administration	2,440	96,926			*78,690*
Taxation					
Employers' NICs (2014/15)		7,135	131,090		*5,949*
2 COSTS OF VOLUNTEERING					
Volunteers' out of pocket expenses reimbursed		976			
Publicity		0			
Recruitment expenses		663			
Equipment and supplies		1,732	3,371		*5,460*
3 COSTS OF TRAINING AND DEVELOPMENT			528		*1,902*
4 COSTS OF PUBLIC CONSULTATION AND EVENTS			767		*3,624*
TOTAL EXPENDITURE				135,756	*117,615*
OPERATING SURPLUS (DEFICIT) FOR YEAR BEFORE TAX				**(6,397)**	*9,304*
CORPORATION TAX				**(1,279)**	*1,861*
NET SURPLUS (DEFICIT) FOR YEAR				**(5,118)**	*7,443*
RESERVE CARRIED FORWARD TO FOLLOWING YEAR				**2,325**	***7,443***

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email

enquiries@healthwatchhavering.co.uk

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Morland House, 12-16 Eastern Road, Romford RM1 3PJ
Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk

This page is intentionally left blank