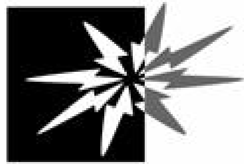

Health and Wellbeing Board

TUESDAY, 8TH OCTOBER, 2013 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE.

MEMBERS: Please see attached membership list.

AGENDA

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 16).

4. DECLARATIONS OF INTEREST

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

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

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

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

5. QUESTIONS, DEPUTATIONS, PETITIONS

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

6. MINUTES (PAGES 1 - 10)

To consider and agree the minutes of the meeting of the Board held on 9 July 2013.

7. HARINGEY CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS 2014/15 (PAGES 11 - 18)

Report of the Chief Officer, Haringey CCG, to outline the proposed commissioning intentions to date for 2014/15 for Haringey CCG.

8. INTEGRATED HEALTH AND SOCIAL CARE - ADULTS (PAGES 19 - 36)

Report of the Director, Adult and Housing Services, and the Chief Operating Officer, Haringey Clinical Commissioning Group to update the Board on progress made taking forward the integration of health and social care services for adults in Haringey.

9. SECTION 256 AGREEMENT - HEALTH AND SOCIAL CARE - ADULTS (PAGES 37 - 46)

Report of the Director of Adult and Housing Services and the Chief Operating Officer, Haringey Clinical Commissioning Group, to seek Health & Wellbeing Board (HWB) formal ratification of a raft of schemes agreed between Haringey Clinical Commissioning Group and Haringey Adult & Community Services, enabling the Council to enter into a formal section 256 agreement with NHS England in respect of the 2013/14 transfer of funds from the NHS to social care.

10. HEALTHWATCH HARINGEY PROGRESS REPORT (PAGES 47 - 52)

Report of Healthwatch Haringey.

11. DOMESTIC AND GENDER-BASED VIOLENCE - HARINGEY STAT REPORT (PAGES 53 - 56)

To update the Health and Wellbeing Board on the work progressing in Haringey to address domestic and gender based violence.

12. PHARMACEUTICAL NEEDS ASSESSMENT (PAGES 57 - 62)

Report of the Director of Public Health setting out details of the Haringey Pharmaceutical Needs Assessment.

13. PERFORMANCE HIGHLIGHT REPORT (PAGES 63 - 66)

To provide an update to the summary indicators in the Health and Wellbeing Outcomes Framework and provide an exception report for the physical activity measure.

14. DELIVERY BOARD HIGHLIGHT REPORT (PAGES 67 - 72)

Report of the Director of Public Health to provide a highlight report to the board regarding delivery of the outcomes in the Health and Wellbeing Board Strategy 2012-1015.

15. CHANGES IN CCG BOARD REPRESENTATION ON HWB (PAGES 73 - 76)

Report of the Director of Public Health to inform the Health and Wellbeing Board of the Haringey Clinical Commissioning Group GP election process outcome.

16. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at item 3 above.

17. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are as follows:

7 January 2014, 1.30pm
20 March 2014 (TBC), 6.30pm

David McNulty
Head of Local Democracy
and Member Services
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Helen Chapman
Principal Committee Coordinator
Level 5
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Monday, 30 September 2013

Membership of the Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	2	Cabinet Member for Health and Adult Services	Cllr Bernice Vanier (Chair)
			Cabinet Member for Children and Young People	Cllr Ann Waters
	Officers' Representatives	3	Director of Adult social Services	Mun Thong Phung
			Director of Children and Young People's Services	Libby Blake
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	Chair	Dr Sherry Tang (from 1 October 2013)
			GP Board Member	Dr Helen Pelendrides (from 1 October 2013)
			Chief Officer	Sarah Price
			Lay Member	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	Chief Executive	Fitzroy Andrew

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 9 JULY 2013

Members: Fitzroy Andrew (Chief Executive, HAVCO), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Sharon Grant (Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Dr Helen Pelendrides (Chair, Haringey CCG), Lisa Redfern (Deputy Director Children's Commissioning, LBOH), Jill Shattock (Director of Clinical Commissioning, Haringey CCG) Beverley Tarka (Acting Deputy Director – Adult and Community Services, LBOH) and Cllr Bernice Vanier (Chair - Cabinet Member for Health and Adult Services, LBOH)

Apologies: Libby Blake, Director of Children's Services
Mun Thong Phung, Director of Adult and Housing Services
Sarah Price, Chief Officer, Haringey CCG
Dr Sherry Tang, GP Board Member, Haringey CCG
Councillor Waters, Cabinet Member for Children

MINUTE NO.	SUBJECT/DECISION	ACTION BY
HWB24.	**APOLOGIES** Apologies for absence were received from: Cllr Waters Mun Thong Phung (for whom Beverley Tarka was substituting) Libby Blake (for whom Lisa Redfern was substituting) Sarah Price (for whom Jill Shattock was substituting) Dr Sherry Tang	
HWB25.	**URGENT BUSINESS** There were no items of urgent business.	
HWB26.	**DECLARATIONS OF INTEREST** There were no declarations of interest.	
HWB27.	**QUESTIONS, DEPUTATIONS, PETITIONS** There were no deputations, questions or petitions submitted.	
HWB28.	**MINUTES** Matters arising Director of Public Health Annual Public Health Report Further to the discussion on how to engage specific groups in a more targeted way, as set out in the seventh bullet point on page 2 of the minutes of the meeting held on 21 May 2013, it was agreed that there would be discussion outside the meeting around how Healthwatch could assist with this.	

With regard to the action indicated on page 3, the Director of Public Health reported that there was sufficient capacity within alcohol treatment services, for which there was currently no waiting list. It was reported that there had been investment in HAGA to maximise the accessibility of services.

Further to the discussion around how primary care services could do more on alcohol-related harm, it was reported that analysis had been undertaken of alcohol-related hospital admissions by GP practice and that meetings would be held with each of the GP collaboratives to look at the data and identify further action. In addition, practice profiles would be issued very shortly and these would include information around alcohol. The Board asked to be kept informed of developments in this area.

Mental Health in Haringey
Further to the discussion around the definition of a 'low' number of beds, it was clarified that benchmarking was based on 43 Mental Health Trusts in the country, 75% of all the trusts. Variation was from 15 beds per 100,000 population to 53 beds per 100,000 population, with the median position for the country 23 beds per 100,000 population. BEHMHT have 22.4 beds, which was the lowest number in their peer group. It was noted that the exact make-up of the peer group was not known, but was from trusts in London.

Data requested by the Board on ethnicity in relation to the Mental Health statistics had been received from the Trust, and was contained within the agenda pack under the HaringeyStat item.

RESOLVED

That the minutes of the meeting held on 21 May 2013 be approved and signed by the Chair.

HWB29. CHILDREN AND YOUNG PEOPLE'S PLAN

The Chair agreed to vary the order of the agenda to take the Children and Young People's Plan next, presented by Lisa Redfern and Helena Pugh, Strategic Partnership Manager.

- The intention was for this to be a full partnership plan. Partners were encouraged to contribute, and those who had already done so were thanked. The Board was also asked to think about its role in developing and refining the plan.
- It was noted that the plan represented a shift in core focus towards early intervention and prevention, and was underpinned by the vision 'Haringey is known to be a place where children and young people are known to thrive and achieve'.
- Outcome 1 of the Health and Wellbeing Strategy 'Every child has the best start in life' had been taken as the starting point for developing the Children and Young People's Plan.
- The report outlined the partner discussions that had taken place to date around the development of the plan, which sought to build

	a picture of the needs of children and young people in the borough within the national context. • Five initial outcomes had been proposed: Every child has a healthy start in life, thriving families, raised educational attainment, children and young people are safer from risk of harm and quality services. Details of these outcomes and the associated priorities and principles were set out in the report. • It was noted that a number of the issues covered in the Children and Young People's Plan were cross-cutting, for example housing and domestic violence. • In respect of the outcome 'Children and young people are safer from risk of harm', Claire Kowalska, Community Safety Strategic Manager, suggested that there was scope to strengthen this with regards to the work of the Youth Offending Service and agreed to discuss this with Helena Pugh outside the meeting. • Sharon Grant suggested that Healthwatch may be able to assist with regards to engaging with some of the communities within the Borough that it had traditionally been harder to engage with, particularly the Muslim community. It was agreed that she would speak with Helena Pugh outside the meeting regarding how to progress this. • Fitzroy Andrew suggested that HAVCO might be able to facilitate a meeting with the Council and relevant people within the voluntary sector for an in-depth discussion on the strategic approach to voluntary sector involvement in the Children and Young People's Plan, and it was agreed that this would be valuable. • An event organised *by* young people *for* young people had been proposed at a previous meeting of the Board, and it was suggested that linking consultation on the Children and Young People's Plan in with such an event could be explored. • Board Members were invited to provide any thoughts or comments on the Plan after the meeting directly to Helena Pugh, for incorporation into the draft plan.	
HWB30.	**HEALTH AND WELLBEING STRATEGY AND JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)** The Board received a report seeking formal approval of the Health and Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA). Both documents had been approved by the Board when it was in shadow form, but as statutory requirements, both needed to be approved by the Board now that it was formally constituted. **RESOLVED** That Haringey's JSNA 2012 and Health and Wellbeing Strategy and Delivery Plans be approved by the Board for adoption.	
HWB31.	**ESTABLISHING THE HWB DELIVERY GROUPS** The Board received a report proposing Chairs for the three delivery groups that had been proposed at the previous meeting of the Board.	

Each delivery group corresponded with one of the outcomes of the Health and Wellbeing Strategy, and the intention was to provide a mechanism for the delivery, monitoring and reporting of the Strategy. It was noted that further work was needed around wider mapping of the current partnership structure and how the delivery groups would link in with this.

- It was suggested that, as the Children and Young People's strategy shared the same outcome as Outcome 1 of the HWB Strategy, the same delivery group should work on this issue in order to avoid duplication.
- It was felt that the work of the existing Mental Health Partnership Board needed to be looked at alongside the proposed remit of the Outcome 3 delivery group, in order to deliver an integrated approach and avoid duplication.
- It was agreed that Claire Kowalska and Jeanelle de Gruchy would discuss the way in which Community Safety could link in effectively with this structure outside the meeting. It was noted that the delivery groups would need to be flexible in order to deal with cross-cutting issues. **Dir PH**
- The Board requested to see the terms of reference of the delivery groups as these emerged. In order not to delay the development of the groups, it was agreed that these would be circulated by email so that Board Members could comment before the next scheduled Board meeting in October.
- It was noted that Adults Services had been undertaking work recently around aligning with the partnership boards, and would submit some comments and proposals on how this might work in respect of the HWB delivery groups.
- The Board discussed the accountability of the delivery groups to the Board, and how the work of the groups would be reported up to the Board. It was proposed that the delivery groups would report into the senior officers group, who would then report into the Board. The format of the reporting was under discussion, but it was anticipated that this would be on an exception basis so that the Board could consider any concerns or barriers to delivery that had been identified, and look at how these could be addressed.
- It was agreed that the role of Healthwatch in relation to the delivery groups would be explored further, as this would be a useful link.

RESOLVED

That the changes to the governance structure as recommended in May 2013 be agreed, and that the Chairs of the delivery groups be agreed as follows:

Outcome 1 Delivery Group (Giving every child the best start in life) – Jan Doust (Deputy Director Prevention and Early Intervention, CYPS)
Outcome 2 Delivery Group (Reducing the life expectancy gap) – Fiona Wright (Assistant Director of Public Health)
Outcome 3 Delivery Group (Improving Mental Health and Wellbeing) –

	Jill Shattock (Director of Commissioning, Haringey Clinical Commissioning Group)	
HWB32.	**JOINT STRATEGIC PLAN (WINTERBOURNE VIEW CONCORDAT DELIVERY PLAN) AND ACHIEVEMENT OF CARE REVIEWS** The Board received the report on the implementation and progress of the Haringey Winterbourne Review Joint Action Plan, against targets set by the Department of Health's Winterbourne View Review Concordat Programme of Action. The report was presented by Beverley Tarka and Tristram Brice, Adult Commissioning Manager. The Board was asked to note progress against the key targets and the following were highlighted: • The compilation of a register of people with learning disabilities in NHS funded care had been completed on time, and the cohort of clients with learning disabilities in Assessment and Treatment Units had been identified. • It was important to ensure systems were in place to enable the CCG and Local Authority to have oversight of clients within forensic services. • Appendix 3 set out the plans for facilitating the discharge of service users into the community. Of the service users listed, it was anticipated that 50% would have moved on by the end of 2013, which was a positive development. • The Winterbourne Joint Improvement Programme was keen to share practice and challenges, and to discuss and share information nationally. • It was noted that Haringey had developed areas of good practice, for example the joint establishment concerns process which was now being rolled out as part of the pan-London procedures. • In terms of engagement with families, questionnaires had been developed, interviews had taken place and focus groups were planned as part of a process of reflective learning. It had been identified that some families were not aware of how to recognise early signs of neglect, and also what to do about it if signs had been recognised, and officers were looking at how these issues could be addressed. • The importance of there now being a pathway for people in Assessment and Treatment Units was emphasised, as this had not been the case previously. Progress was also recognised in terms of clinical oversight for people placed in Assessment and Treatment Units out of borough, and the facilitation of discharge back into the community. • A key piece of work was gathering information on the needs of this particular cohort in order to identify gaps; this work would help to inform commissioning and the JSNA. • Funding was identified as a challenge, as there was the risk of a potentially significant cost-shunt to the local authority. Funding arrangements in this area were complex, and there was concern that this had not been fully taken into account at a national level. • The Board congratulated the team for the progress they had	

	made within the timescales set out by the Government, and noted the financial concerns, which would need to be addressed nationally. • With regard to addressing the financial challenges, it was reported that the Council was looking at more innovative ways of delivering services and greater use of partnership working, but it was acknowledged that this was an ongoing challenge. One of the approaches that had been successful in delivering greater value for money was integrated working and commissioning around health and housing, which had led to several projects for helping people into supported housing with tailored care. The Local Authority was doing what it could to minimise the impact on services, but it was recognised that there may come a time when greater impact on services would become unavoidable. • The Board asked to be kept up to date with this work. **RESOLVED** That the content of the report be noted.	
HWB33.	**COMMUNITY SAFETY STRATEGY** The Board received a report on the new Community Safety Strategy, which had been produced in response to changes promoted by the Mayor of London as well as financial pressures on local authorities and partners. Claire Kowalska presented the report, and the following points arose during discussion of the item: • Six principal outcomes were proposed within the strategy; rebuild and improve public confidence in policing and maintaining community safety, prevent and minimise gang-related activity and victimisation, break the cycle of domestic and gender-based abuse by working in partnership to promote healthy and safe relationships, reduce re-offending with a focus on 16 – 24 year olds, prevent and reduce acquisitive crime and anti-social behaviour (to include residential burglary, personal robbery, vehicle crime, fraud and theft) and deliver the PREVENT strategy in Haringey. • It was agreed that the delivery plan, which was almost finalised, would be circulated to the Board after the meeting for information and feedback. A performance monitoring group had been established to oversee the implementation of the delivery plan. It was agreed that the wording of the relevant sections of the Children and Young People's Plan would be amended in order to align with the Community Safety Strategy delivery plan more closely. • The prevention plan, alcohol, violence and drug intervention work were highlighted as key areas of overlap between the work of the Health and Wellbeing Board and Community Safety Partnership. • It was noted that there had been a change in the structure of the Community Safety service to align with the new strategy. • The strategy was going to Full Council on 15 July for approval.	Clerk / CS Mgr Str. P/ship Mgr

	RESOLVED That the content of the strategy be noted.	
HWB34.	**HARINGEYSTATS - MENTAL HEALTH: FEEDBACK AND NEXT STEPS** The Board received the report on the information covered at the first HaringeyStat event on mental health, and the key outcomes of this event, which were listed in paragraph 5.2 of the report. • It was suggested that the Board should receive an update on this work in around 6 months time in order to monitor the emerging actions. • With regard to the HWB Strategy delivery groups, the Board queried where the Children and Adolescent Mental Health Services (CAMHS) should sit; it was felt that it would probably be most appropriate for this to fall within the remit of the Outcome 1 delivery group, but that this would be discussed further outside the meeting. • The Board looked at the data on hospital admissions 2012/13 by ethnicity. While it was felt that this information was useful, it was acknowledged that there were limitations in that it related only to hospital admissions and would therefore not necessarily pick up on communities where people may tend to deal with mental health issues within the community rather than seek medical assistance. It was suggested that there may be scope for more detailed research around this area, but also that information from other national and local data sources could be applied to the information contained in the presentation to give a more detailed picture. **RESOLVED** That the areas identified at the HaringeyStat session for focused actions on mental health be noted.	
HWB35.	**PERFORMANCE REVIEW** The Board received the performance report, which set out the performance summary and an exception report on suicide and undetermined injury. It was felt that a discussion was needed outside the meeting to determine where suicide prevention work needed to sit within the delivery group structure. It was felt that this issue could be linked with the men's health agenda and work around male access to health services. **RESOLVED** That the content of the performance report be noted.	

HWB36.	**HARINGEY CCG PROSPECTUS** The Board received the report on the CCG Prospectus. The intention of the prospectus was to make the work of the CCG more widely understandable, and comments and feedback were sought on the document. • The Board felt that the prospectus was useful, and Fitzroy Andrew reported that HAVCO had already started using the information in the document as part of their work. • Ways of providing feedback or comments were set out in the prospectus. • The Board asked about the complaints process for the CCG – this was not in the prospectus but was on the CCG website and was set out as Frequently Asked Questions. **RESOLVED** That the Board note the report.	
HWB37.	**HEALTH AND WELLBEING BOARD FORWARD PLAN** The Board received the forward plan, and it was suggested that complaints and feedback processes should be added to the forward plan for discussion at a future meeting of the Board as an item with contributions from Healthwatch. **NOTED**	
HWB38.	**NEW ITEMS OF URGENT BUSINESS** There were no new items of urgent business.	
HWB39.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the next meeting of the Board on 8 October 2013 was scheduled for a 7pm start. It was intended to alternate the meetings between daytime and evening start times in order to ensure that the maximum number of people were able to attend these meetings. The meeting closed at 3.10pm.	

Councillor Bernice Vanier

Chair

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Report for:	**The Health and Wellbeing Board**	**Item Number:**	

Title:	Haringey Clinical Commissioning Group commissioning intentions 2014/15

Report Authorised by:	Sarah Price, Chief Officer, Haringey CCG

Lead Officer:	Denise Tyrrell, Commissioning Support Director, Haringey

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

1. **Describe the issue under consideration**
   This paper outlines the proposed commissioning intentions to date for 2014/15 for Haringey CCG. The CCG Board approved the commissioning intentions at their meeting on 25 September 2013.

   The proposed 2014/15 commissioning intentions build on the direction of travel set out in the Plan on a Page, Strategic Priorities, Haringey's Health and Wellbeing Strategy and the available evidence about the impact of current QIPP (Quality, Innovation, Productivity and Prevention) schemes.

   There have been a number of discussions with the CCG Governing Body, the public at open meetings and at the CCG Engagement Network and various stakeholder groups since they were last discussed with the Health and Wellbeing Board. There will be a large stakeholder event on 17 October 2013 which will further inform the commissioning intentions.

   A number of proposed new service areas or changes have been identified and are outlined within this paper.

2. **Recommendations**
   The Health and Wellbeing Board is asked to **NOTE** the proposed Commissioning Intentions for 2014/15

3. **Patient & Public Involvement (PPI)**
   This paper builds on feedback from recent public engagement events including two public meetings in June and meetings of the CCG's engagement network.

4. **Equality Impact Assessment**
   The commissioning intentions for 2014/15 aim to reduce health inequalities among the people of Haringey. The development of the commissioning intentions will build on and encourage on-going community engagement as raised in recent public events. A full equality impact assessment will be undertaken when the details of the commissioning intentions are developed.

5. **Risks**
   Development of the 2014/15 commissioning intentions through a transparent and open approach will enhance commissioning in 2014/15 and support the achievement of the CCGs vision, values and priorities.

6. **Resource Implications:**
   Resource implications will become clear as the commissioning intentions are developed through the next phase.

1. INTRODUCTION

This paper outlines the proposed commissioning intentions for 2014/15 for Haringey CCG to date.

As part of the annual planning cycle the CCG is developing commissioning intentions to signal the areas we want to develop and commission/decommission over the forthcoming year. The proposed commissioning intentions for 2014-15 will be shared with providers at the end of September. The intentions have been developed from Haringey-specific plans and those worked up across the North Central London CCGs as part of their collaborative working.

The proposed 2014/15 commissioning intentions build on the direction of travel set out in earlier discussions at the CCG Governing Body, the 'Plan on a Page', the CCG's strategic priorities, Haringey's Health and Wellbeing Strategy and the available evidence about the impact of current Quality, Innovation, Productivity and Prevention (QIPP) programme. QIPP is one of the mechanisms used to benchmark service provision and secure improvements in productivity, efficiency and best practice.

The Governing Body last discussed the commissioning intentions for 2014/15 at their meeting on 25 July 2013. At that meeting the population needs and drivers for change were reiterated as outlined in the Plan on a Page. The feedback from that meeting, the CCG Clinical Cabinet, several QIPP Delivery Group meetings, public engagement and network events, joint working with the London Borough of Haringey Public Health department and recent national clinical guidance have informed the next stage development of the commissioning intentions. Subsequent work has been undertaken to identify the areas where the CCG had a commissioning responsibility and focus on the implications for commissioning intentions for 2014/15.

There will be a stakeholder event on 17 October 2013 which will further inform the commissioning intentions and will involve GPs, providers, council colleagues, members of the CCG's engagement network and representatives from the voluntary sector.

The Governing Body is asked to note the proposed commissioning intentions for 2014/15 and identify any gaps.

2. PROPOSED COMMISSIONING INTENTIONS

STRATEGIC PRIORITY: PREVENTION

1. Continue with the prevention CQUIN for stop smoking support and use of 'brief intervention input' for drug and alcohol misuse. Potentially expand to include diet and physical activity for adults and children.
2. Encourage local trusts to move towards becoming a 'Health Promoting Hospital'.

3. Increase the capacity of the alcohol liaison nurse (link worker) to target repeat admissions.
4. Proactive early diagnosis of long term conditions (LTCs) by the hospital trusts - particularly heart disease, diabetes, COPD and cancer.
5. Review the Hepatitis B and Hepatitis C referral pathways
6. Pan-London programme: Transforming Cancer Services in London (TCSL). Listed below are those intentions that relate to CCG areas of responsibility. There are additional intentions related to cancer screening and specialist cancer services. The commissioning intentions for the CCGs include:
   - Continued support for early detection and population awareness
   - Reducing variation (along the pathway) between providers and within providers, including implementation of Co-ordinate my Care on a consistent basis across London
   - Implementation of the living with and beyond cancer elements of the Best Practice Commissioning Pathways.

STRATEGIC PRIORITY: INTEGRATED CARE

1. Values Based Outcomes

Implementation of values based outcomes commissioning across North Central London covering frail elderly, mental health and diabetes.

Outcome-based commissioning means putting in place a set of arrangements whereby a service is defined and paid for on the basis of a set of agreed outcomes. It means shifting the basis on which services are purchased and resources allocated from units of service provision (hours, days or weeks of a given activity) for pre-defined needs to what is needed to ensure that the outcomes desired by service users are met. This is defined by patients, providers and commissioners working together.

2. Integrated Care

In 2014/15 the CCG will work with the local health and social care economy using specific pathways as a ‘litmus test’ for the benefits of integration. These services will be diabetes, heart failure and end of life care.

Continue the developments in the Integrated Care Programme, particularly targeted at admission avoidance for the frail elderly. This includes early identification of at-risk patients, multidisciplinary team meetings, developing strong community services, coordinating care around the patient, and integrating and improving pathways of care.

Initiatives that support the development of community services include a review of the lymphoedema service and transferring the ordering, supply, review and management of wound dressings to one supplier to manage and streamline the process.

STRATEGIC PRIORITY: URGENT CARE

1. Continue to improve the pathway for unscheduled care with the secondary care providers, working closely with Primary Care.

Better use of A&E including:

- Rollout of the mental health RAID (Rapid Assessment Intervention and Discharge) model for 2014/15 to help manage patient flows
- Helping the public to better understand the local urgent care system and how to access it so they get treated in the most appropriate place the first time. To do this we will build on the 'choose well' campaign that will run in Haringey this autumn/winter to make sure messages are clear, consistent, targeted to different communities and communicated through a variety of formats and mediums. The need for this campaign has come through very strongly from the public meetings and the engagement network events.
- This includes involvement of the acute trusts in giving patients messages in the use of A&E/urgent care.
- Investigate the opportunity to increase access for patients to register with GP practices from A&E, urgent care and on the wards.
- Explore the use of having navigators within A&E. Feedback from the engagement network indicated that this type of role would be very useful, providing the navigators were well-trained, worked across sectors e.g. health and social care, and had easy access to local service information and translation services.

STRATEGIC PRIORITY: PLANNED CARE AND CARE CLOSER TO HOME

1. Progress the existing planned care/care closer to home schemes. These include:
   - Cardiology – redesign the Heart Failure pathway to ensure that it delivers a seamless pathway across all providers by setting up a 'One Stop Service' model. Work with the providers of cardiac rehabilitation services to review the services in 2014/15 and, if necessary, redesign these services. Increase the number of patients that have an annual primary care review of their oral anticoagulation medicine.
   - Urology – the full year effect of commissioning a single point of referral and triaging service model managed by the new Community Urology Service
   - Dermatology – review the specification for the GPSI services and a wider specification to commission a single service for community dermatology and minor skin surgery
   - Gynaecology – develop a single community gynaecology service to provide routine gynaecology activity in the community
   - Ophthalmology – investigate the provision of a community based cataracts service(s)
   - Ear, nose and throat (ENT) - the full year effect rollout of the new ENT pathway to one community provider

- Gastroenterology – the full year impact of the implementation of the pathways for dyspepsia, irritable bowel syndrome, iron deficiency anaemia and constipation.

2. Diagnostics
   The current contract with In Health ends on 31 March 2014. Recommissioning of these diagnostic services across all of the North Central London CCGs is being carried out.

3. Routine Vasectomy Services
   Investigate recommissioning of routine vasectomy services to streamline the pathway and governance.

4. Colorectal Community Service
   Investigate a community service to treat patients suffering from a range of minor colorectal conditions and requiring specific colorectal procedures that would otherwise have been provided in an acute hospital setting.

5. Musculoskeletal Pathway
   Review the musculoskeletal pathway.

STRATEGIC PRIORITY: ADULT MENTAL HEALTH

1. There is further development of the commissioning intentions being undertaken. To date the proposed commissioning intentions include:

   - Implementation of a personalised recovery model facilitating re-integration into meaningful life roles. This includes commissioning value based outcomes for mental health services
   - Improving access to psychological therapies (IAPT) including the use of telehealth options (for example, online platforms that would give people a different access route to IAPT services)
   - Explore extending the role of the voluntary sector to improve self-management
   - Developing a dementia pathway to increase early detection and better management of people with dementia and ensure the provision of appropriate placements for people with complex needs
   - Developing an adult learning disabilities model and increasing personalisation amongst learning disability population
   - Support Haringey Council's Public Health team to roll out their 'Time to Change' campaign locally, including signing the 'Time to Change' organisational pledge
   - Explore how we can help to tackle stigma and discrimination around mental health, for example, looking at the wording we use around mental health issues in our dealings with the media, and supporting Public Health to roll out mental health first aid training for frontline staff. The use and effectiveness of mental health first aid training was supported by the engagement network.

STRATEGIC PRIORITY: CHILDREN & YOUNG PEOPLE

1. Children's commissioning

Haringey CCG will commission services to improve the health and wellbeing of children, in partnership with NHS England and the London Borough of Haringey. This includes a number of community and hospital based services including:

- Focusing on minimising acute, secondary and tertiary hospital admission
- Reducing dependence on out of area, long-term residential care
- Improve access to Child and Adolescent Mental Health Services (CAMHS), ensuring that children are cared for at the most appropriate intervention level. This also includes exploring ways of helping parents manage crises with their children in other ways, preventing the need for a referral to CAMHS.
- Improve the life chances of disadvantaged babies and young children by delivering a step-change in the use of preventative approaches in pregnancy and the first three years of life. This will be through social and emotional development, communication and language development, diet and nutrition. This will be in partnership with voluntary organisations, health agencies, and the local authority. The work is being led by Barnardos.

2. Maternity services

The introduction of a new pathway tariff in 2014-15 replacing payments for individual episodes of care during pregnancy and early life provides a number of opportunities for both providers and commissioners. The new pathway tariff also takes account of social as well as medical need which is very important in a borough like Haringey. Providers will be able to more effectively target resources, for example post natal care, which has been poorly evaluated in the past.

Accurate activity modelling, ensuring women are not booked with more than one provider and that assessment of clinical need is accurate, will be required to ensure high quality services and mitigate financial risk for commissioners and providers. The North Central London CCGs will work with individual Trusts as part of the maternity network on a data and information project to achieve these aims. The maternity network recognises that caesarean section rates continue to be above the national average in most Trusts within the sector. An audit will be undertaken to identify whether Trusts are following agreed network guidelines for planned caesarean sections and to recommend appropriate actions.

3. IVF
Review the Fertility policies in the light of NICE guidance published in February 2013 and maximising outcomes.

3. CONCLUSION

This paper is an update on progress of the on-going process to develop the CCG's commissioning intentions. There are events with stakeholders planned to further develop these intentions.

4. NEXT STEPS

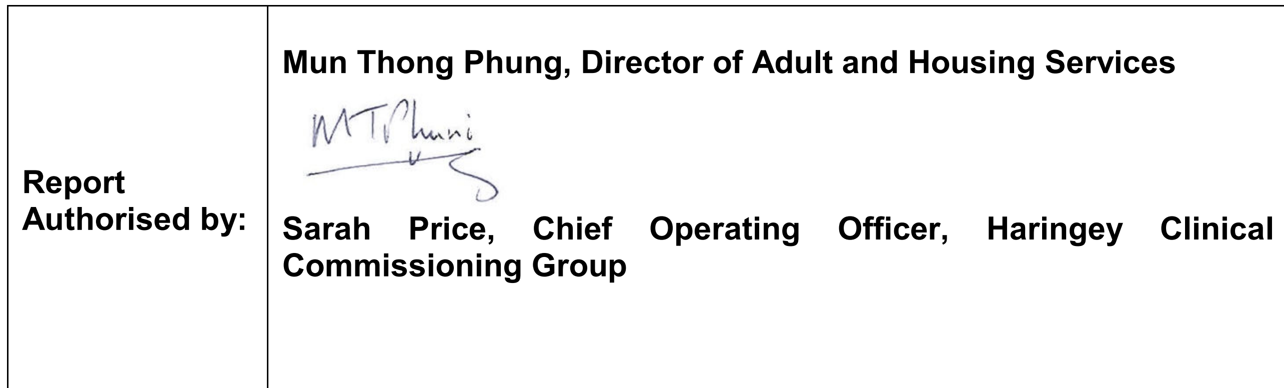
The next steps in the development of the commissioning intentions are:

- Early notice to the provider of the CCGs commissioning intentions by 30 September 2013
- Stakeholder event 17 October 2013
- Further develop commissioning intentions with stakeholders and providers to 31 March 2014
- Develop technical contracting elements including service specifications, key performance indicators and information schedule, QIPP programme and values, CQINs plan
- Collaborative development of shared commissioning intentions across North Central London CCGs up to 31 March 2014.

Haringey Council

Report for:	**Health and Wellbeing Board (HWB) on 8th October 2013**	**Item Number:**	

Title:	**Integrated Health and Social Care – Adults**



Report Authorised by:	**Mun Thong Phung, Director of Adult and Housing Services** **Sarah Price, Chief Operating Officer, Haringey Clinical Commissioning Group**

Lead Officer:	Beverley Tarka, Acting Deputy Director, Adult and Community Services, Adult and Housing Services Jill Shattock, Director of Commissioning, Haringey Clinical Commissioning Group

Ward(s) affected: All	**Report for: Non-Key Decision**

1. Describe the issue under consideration

This report updates the Health & Wellbeing Board (HWB) on progress made taking forward the integration of health and social care services for adults in Haringey. This report summarises current joint working arrangements in the borough, and sets out our joint approach for the future of integrated working. This report covers three key areas:

- Current joint services in operation within the borough. This set of joint proposals covers initiatives that have already been launched, developed for 2013/14 and endorsed by Haringey Clinical Commissioning Group and Haringey Adult & Community Services. The Health & Wellbeing Board is asked to ratify these as part of a separate Board paper;
- Other key areas across health and social care where there are mature joint working arrangements; and

- The future of integrated working across health and social care for adults, introducing to the HWB the 'Integration Transformation Fund', which provides the framework around how local authorities and clinical commissioning groups must work together in future to deliver integrated care for adults 18 years of age and over.

2. Chair of the HWB Introduction

I am delighted to present to the Health and Wellbeing Board this report about integrated working in Haringey, both present and future plans. Haringey is dedicated to pursuing integration on the basis of a strong partnership between health and social care. This report demonstrates the excellent progress already made in this regard and in terms of health and social care support to adults, and also seeks support for proposals with respect to the development of the new Integration Transformation Fund. The interests of our residents remain at the heart of working jointly across health and social care and we are committed to ensuring that there is a relentless focus on the creation of real and robust integrated services leading to real benefits for people over which they will be able to exercise control. The programme of work outlined below is specifically designed to deliver this important objective and to sustaining a well integrated and vibrant care economy within a tough public spending environment.

3. Recommendations

It is recommended that Members of the HWB:

a) Read and note the contents of this report;
b) Note the new Integration Transformation Fund (ITF) and the timetable for implementation, including HWB input and sign-off;
c) Agree to receive for consideration the ITF plan at the HWB in January 2014, to sign off our plans; and
d) Provide a steer concerning the types of projects it wishes to be explored to promote the further integration of health and social care.

4. Alternative options considered

No alternative options are presented as schemes promoting integration are already in place while an options appraisal will be presented with respect to those proposed in the ITF plan when it is presented to the HWB at a later date.

5. Background information

This section of the paper covers integrated working between health and social care for adults. Whilst this report does not include services delivered through Public Health, the HWB is asked to note that Public Health commissioning includes drug and alcohol services across the borough, sexual health services across the borough (prevention, assessment and treatment services), and the commissioning of services that deliver the Health & Well-being Strategy outcomes.

The key policy documents and guidance contained in appendix 1 to this report make clear that the integration of health and social care services is a high national priority aimed at maximising the synergies between health and social care and the value for money (i.e. economy, efficiency and effectiveness) accruing from the investment made in these services while improving outcomes for people.

5.1. Defining Integrated Care

Haringey's health and social care economy has proactively responded to the challenge of delivering this important national agenda and it is suggested that the following definition of integrated care be adopted which from the individual's perspective means:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*
> http://www.nationalvoices.org.uk/defining-integrated-care-agreeing-narrative

This definition is recommended as it is person centred, has a good fit with personalisation and takes forward choice and control for individuals over their services. In addition, the definition emphasises that integration is not just about organisational arrangements; it is also about the experiences of people who receive services.

Furthermore, the proposed definition reflects the approach to the integration of health and social care that the London Borough of Haringey and Haringey Clinical Commissioning Group (CCG) have taken to this task in the form of those schemes we have put in place or propose to develop for adults in Haringey. These are outlined in the rest of this section.

5.2 Current areas of integrated and joint working

Below is a summary of the key areas of joint working across health and social care in the borough. These schemes have been agreed by Haringey CCG and the council's Adult and Community Services, as they deliver health and social care outcomes for residents through supporting prevention, avoidance of hospital admission, discharge from hospital at the right time and right place, as well as supporting residents to maximise a return to independence. The last two initiatives (g & h) are designed to support health and social care commissioners in ensuring we have the right skills and capacity around future service design, with the Winterbourne scheme specifically linked to meeting government requirements for both health and social care, in reviewing and arranging alternative places of care for people with learning disabilities who are currently in long stay hospitals.

a) ***Multi-Disciplinary Reablement Service:*** Jointly staffed local authority and health employees, the reablement service helps people learn or re-learn skills of daily living they have lost through deterioration in their health and/or increased support needs. The service is delivered on an *'in-reach'* basis to A&E and other hospital departments to support avoidable admissions and facilitate timely discharges. This has contributed to the downward management of delayed discharges of Haringey residents at the North Middlesex and the Whittington hospitals.

b) ***Step Down, Step Up Care:*** Step down residential and nursing care placements support discharges from acute hospital settings. These placements provide a non-acute setting for people to convalesce prior to returning to their own homes or somewhere to make choices about, perhaps, moving into a long-term care setting. Step up care provides significant additional support to residents who might otherwise present and be admitted to hospital. Step up and step down care play critical roles in managing delayed transfers of care.

c) ***Community Development:*** This scheme has put in place stakeholder networks based around the four General Practitioner Collaboratives consisting of local residents, GP's, Adult Social Care, neighbourhood forums and NHS Community Services. The purpose of the networks is the delivery the prevention and early intervention ambitions of the Health and Wellbeing Board through better case management of individuals' health and social care needs. The service also focuses on tackling the isolation of older adults, reducing their levels of depression and associated admissions to hospital. In addition, it seeks to prevent falls by older adults which are strongly associated with hospital admissions and increased dependence.

d) ***Rapid Response:*** A small but steady stream of patients are admitted to hospital in circumstances where the provision of Health and Social Care Assistants, overseen by Community Matrons, to provide support in the home could avoid or shorten their hospital stays. The business case for a Rapid Response Service has been agreed, and it will be piloted for 1 year commencing September 2013.

e) ***Older People and Dementia Pathway*:** Haringey Council runs some of the most successful dementia services in London. The dementia day services are a key factor in the support of informal carers which enables them to continue to care, thereby, allowing people with dementia to remain at home for as long as possible. A weekend drop-in service is available and transport is service based enhancing the accessibility and flexibility of provision. Dementia Day Services run at 95% occupancy, as they work to 110% capacity, through over-booking.

f) ***The Mental Health Recovery Pathway:*** This scheme targets people with mental health needs, including those who are or have been inpatients and has put in place a Recovery College at the Clarendon Day Centre. Recovery Colleges are well established nationally and internally and have track records of success in helping people build lives beyond mental illness. The Haringey College operates according to an educational paradigm and teaches students the skills they need to live and cope with mental illness well as providing courses that help them manage the practicalities of daily life.

g) ***Winterbourne View (WV):*** To put in place high quality care for people with learning disabilities that will enable them to move back to their local communities the multi disciplinary WV Project Team is working closely with commissioners to identify how

their needs can best be met. The allocation of S256 has allowed commissioning capacity to be expanded to support this work.

h) ***Data Analysis:*** The proposal is to fund data analyst post(s) specifically to support monitoring and reporting of the schemes funded via the Section 256. A data analyst will work closely with both health and social care commissioners, reporting to both and will provide information to inform future Section 256 allocations.

Schemes (a) to (h) have been agreed by Haringey CCG and Haringey Adult & Community Services, and will be subject to a 'section 256 agreement' that must be ratified by the Health and Wellbeing Board. This matter is subject to a separate report to the HWB, agenda item 15.

In addition to the schemes described above several others have been established which contribute to the ongoing integration of health and social care in Haringey:

a) ***Multi-Disciplinary Teams (MDTs):*** Weekly teleconferences are held within each of the GP Collaboratives in Haringey. The teleconferences include GPs, community matrons, district nurses, social workers, community mental health and hospital geriatricians. Each GP dials into the teleconference for a given 10-15 minute slot in which they present their patients for input and views from the wider team. The objective is to make sure that the right support is in place at the right time. The focus is on patients who have been frequently attending A&E or recently discharged and/or have particularly complex health or social care needs. An academic evaluation of the early pilot of the teleconferences indicated a statistically significant drop in A&E attendances for the cohort of patients whose care had been discussed at the MDT. A wider evaluation is now being undertaken by UCLP, Whittington Health and Haringey Public Health Department.

b) ***Learning Disabilities:*** The Learning Disabilities Partnership offers an integrated service for adults with learning disabilities operated as a pooled fund under Section 75 of the National Health Service Act 2006 which allows the pooling of resources and delegating certain NHS and local authority health related functions to the other partner(s) if this leads to an improvement in the way those functions are exercised. The Partnership empowers people who use services and their carers to influence and shape the social care, housing, employment, education, training and health agenda for people with learning disabilities. Its work reflects best practice in this important area of provision and responds to its service users as whole people.

c) ***In-reach Social Work*** : This is provided at the Whittington and North Middlesex Hospitals on an in-reach basis to promote the timely discharge of patients and reduce *'bed blocking'.*

d) ***Integrated Community Equipment Service***: Haringey Council has hosted a joint equipment store with NHS Haringey via a Section 75 Partnership agreement for many years. Last year this Agreement was extended to a more cost effective

alternative for both Council and the NHS through a framework arrangement with other boroughs.

e) ***Joint mental health services for adults and older people:*** Haringey Clinical Commissioning Group commission a range of services from Barnet Enfield and Haringey Mental Health Trust, whilst the Council has seconded social workers to the Trust and runs its AMHP Service from the Trust.

In addition to the schemes already listed considerable effort has been invested to better integrate services within the local health economy. These are described in Appendix 2.

5.3 Integrated Services For Adults – The Next Steps.

In June 2013 the Government announced the Integration Transformation Fund' (ITF) initiative, the creation of a single pooled budget of £3.8 billion (by 2015/16), for health and social care services to work more closely together in local areas when delivering services to adults. It is the clear intention that the ITF will be the main driver for the increasing integration of health and social care services for adults in coming years and will be formed from funds already committed via health commissioned services.

Moreover, in the context of an extremely tough public spending round, reducing budgets and growing demand the pooled budget for integration has been welcomed by the LGA and NHS England as a positive, practical move that can contribute to delivering the goal of using the money in the health and social care system to best effect. The fund is an important catalyst for change, by taking forward the move towards preventative, community-based care intended to keep people out of hospital and in community settings for longer. This is in the interest of the individual and the public purse. Integration across health and social care is regarded as a *'game changer'* but the creation of pooled ITF monies will be contingent on the production of local Integration plans, covering the period 2014/16, which ministers will sign-off in March 2014.

It is already clear that Health and Wellbeing Boards will be crucial to the success of the ITF. They are key to local decision making on health and care and in signing off the plans for how the money is spent locally, and will play a key role in the assurance process. At all times the way health and social care works together in local areas will be absolutely central to the process of transformation.

It is too early to be certain about what Haringey's ITF expectation will be, but the borough currently receives £4m from the current national pot of £860m. If there is an additional £1.9billion, as indicated, then assuming the same proportionate share Haringey will be expected to find up to £12m by 2015/16. Although it is difficult to be precise at this time, the HWB are asked to note that the funding as set out in the ITF guidance, will be reallocated from existing funding streams across health and social care. A potentially confounding factor is that the allocation of the ITF will happen at the same time as the next Spending Review.

For further details of the ITF and the production of Haringey's Transformation Plan see Appendix 3.

6. Comments of the LBH Chief Finance Officer and financial implications

There are no direct financial implications arising from the approach to Integrated care outlined above. As local plans are developed the costs and benefits of proposals will need to be estimated and resources found from within NHS and Council budgets. This will require prioritisation and could necessitate reallocation of funding. This will form part of the work to be undertaken in the coming months.

It is too early to provide more than very indicative estimates of the level of funding for the Haringey area that will be involved in the Integration Transformation Fund – however the indications are that it will be significant (a potential fund of £12m to 16m). It is important to understand that this funding is not new money but a reallocation of funds currently within the health and social care budget. This will require very careful planning by both the Council and the NHS to ensure cost neutrality across the local health and social care economy. This will require working in partnership to ensure that any reallocation of funds in line with the new ways of working does not create financial pressures on any one part of the sector.

7. LBH Head of Legal Services and legal implications

The Head of Legal Services (Haringey Council) has been consulted on this Report. Under Section 195 of the Health and Social Care Act 2012, the Health and Wellbeing Board is under a duty to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. The Board must provide advice, assistance or other support in order to encourage partnership arrangements under section 75 of the National Health Service (NHS) Act 2006.

Section 75 of the NHS Act 2006 allows NHS bodies and local authorities to pool their resources, delegate functions, integrate service provision and transfer resources from one party to another. The section permits:

a) Pooled fund arrangements: A pooled fund arrangement provides an opportunity for the partners to bring money together, in a discrete fund, to pay for the services that are an agreed part of the pooled fund arrangement for the client group who are to benefit from one or all of the services. This allows staff from either partner agency to develop packages of care suited to particular individuals irrespective of whether health or local authority money is used;

b) Delegation of functions – lead commissioning: where health and local authorities delegate functions to one another and there is a lead commissioner locally. Lead Commissioning provides an opportunity to commission, at a strategic level, a range of services for a client group from a single point and therefore provide a level of co-ordination which improves services for users, and provides an effective and efficient

means of commissioning. In effect, one partner takes on the function of commissioning of services which are delegated to them; and

c) Delegation of functions – integrated provisions: this consist of the provision of health and social care services from a single managed provider. The arrangement can be used in conjunction with lead commissioning and pooled fund arrangements.

Section 256 NHS Act 2006 (as amended) permits relevant NHS bodies (NHS England or the Clinical Commissioning Group) to make payments to local authorities towards expenditure incurred or to be incurred by it in connection with any social services functions. Also, payments can be made in connection with the performance of any of the authority's function, which have an effect on the health of any individual or on any NHS functions or are connected with any NHS functions. The payments may be made in respect of expenditure of a capital or of a revenue nature or in respect of both kinds of expenditure. The payments may be subject to conditions or directions that may be issued by the Secretary of State.

The reference in this Report to section 75 and section 256 agreements means agreements entered into under the above statutory provisions.

8. Equalities and Community Cohesion Comments

Commissioners and providers of services for adults, whether delivered through integrated working arrangements or by health and social care singly, must have due regard to the equalities implications of service delivery as well as any planned changes to how services are delivered in the future. The future approach to integrated care as set out in this report will require robust equalities monitoring to ensure there are no adverse impacts to vulnerable adults and children, in regard to the relevant protected characteristics covered by the Single Equality Duty that came into force on 6th April 2011, as set out in the Equality Act 2010.

In respect of the Integration Transformation Fund (ITF), as noted above, the Fund will mostly be made up of a reallocation of funds within the NHS to a pooled budget across health and adult social services. Whilst the use of the ITF provides a valuable opportunity to develop and promote services that will better meet the needs of Haringey's diverse communities, regard will need to be paid to any equalities impact of disinvestment in current service provision in the NHS. Therefore individual schemes started as a result of the ITF will be equality impact assessed prior to their commencement.

9. LBH Head of Procurement Comments

Not applicable.

10. Policy Implication

In preparing this report to the HWB, due regard has been played to key policy drivers for health and social care. These are set out below and in Appendix 1.

Health and Social Care Act 2012

This Act introduced significant changes to the NHS and local authorities, with the implementation of much of the Act taking effect from 1st April 2013, including:

- Introduction of statutory local Health and Wellbeing Boards to ensure coordination and integration of public health, NHS and social care services.
- Transfer of responsibility for much of public health commissioning to local authorities (at a local level) and Public Health England (a new national body)
- A new independent NHS Board to allocate resources and provide commissioning guidance
- Increase in GPs' powers to commission services
- A strengthened role for the Care Quality Commission
- Monitor, the body that currently regulates NHS foundation trusts, to be developed into an economic regulator to oversee aspects of access and competition in the NHS
- A cut in the number of health bodies, including abolishing Primary Care Trusts and Strategic Health Authorities.

The Care & Support Bill (introduced May 2013)

This Bill provides enabling legislation for reforms set out in the White Paper, and will be introduced in into Parliament in late 2013, with proposed legislative changes to be implement from April 2015 onwards.

- The Bill takes forward recommendations from the Law Commission on adult social care (replacing the current myriad of law covering adult social services);
- There are proposed changes to how much an individual requiring care services will have to contribute towards their care.
- The Bill sets out a clear duty to promote the integration of care support with local authorities (including social services and housing), health and other provider services to ensure the best outcomes are achieved for the individual.
- The Bill sets out responsibilities for prevention and market shaping;
- Adult safeguarding on a statutory footing. For the first time.
- It incorporates recommendations from Francis Enquiry into Mid Staffordshire NHS Foundation Trust and the government response.

Welfare Reform Act

The Welfare Reform Act 2012 reforms welfare to improve work incentives, simplify the benefits system and tackle administrative complexity. In summary it:

- Introduces a single Universal Credit, which will replace six income-related work-based benefits
- Limits the payment of contributory Employment and Support Allowance to a 12-month period
- Caps the total amount of benefit that can be claimed, including specific caps on housing allowance
- Reforms the Social Fund and replaces it with locally based provision delivered by local authorities

11. Reasons for Decision

Not applicable.

12. Use of Appendices

Appendix 1. References
Appendix 2. Service Integration Within the Local Health Economy
Appendix 3. Statement on the Health and Social Care Integration Fund.

13. Local Government (Access to Information) Act 1985

Refer Section 10 above and Appendix 1.

APPENDIX 1. REFERENCES

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APPENDIX 2. SERVICE INTEGRATION WITHIN THE LOCAL HEALTH ECONOMY

Risk Stratification

Risk stratification concerns the identification of the differing levels of risk individuals are at of requiring hospital admission. Haringey CCG and Enfield CCG are working together to progress this task and have agreed to:

- Write to all residents over 65 years to obtain consent their consent to share their information to allow their risks of admission to be estimated: They can opt out of sharing.
- The pseudonymisation (i.e. anonymisation) of data at source i.e. the Commissioning Support Unit.

NHS England has been made aware that risk stratification is a fundamental part of integrated care and, therefore, about the delivery of care. It has agreed to that further guidance on risk stratification will make reference to integrated care.

Overnight District Nurses and increased Palliative Care Support

Whittington Health's preparations to commence an overnight district nursing service are progressing well, following Haringey CCG's decision to invest £102,000 in a 1 year pilot service. The service to commence in November 2013.

Daytime Catheter Care for Ambulatory Patients

A 1 year pilot of catheter care for ambulatory patients in the community in Haringey commenced on 1st July 2013. The service is provided by Whittington and will be promoted through hospital departments and GP practices.

Telehealth

Training for Community Matrons and the Specialist Nursing Teams has been completed. The service is now operational

Falls

The community led falls prevention and exercise service run by the Integrated Care Therapy Team, Whittington Health is now fully operational since the end of August 2013. A communications strategy is in place to publicise the service.

Community Matron In-Reach

A review of the secondment of a community matron into the revised Admissions Avoidance team at the North Middlesex Hospital is underway to evaluate its impact. The role is planned to be incorporated within the new Rapid Response service (see above).

Diabetes

The diabetes specification for 2013/14 has been revised to clearly identify the scope of the community service. The intermediate diabetes service has scaled up to triage all new referrals for diabetes patients. Repatriation of patients is underway.

Chronic Obstructive Pulmonary Disease (COPD

Training programmes have been run through the Primary Care Strategy Team to improve quality and consistency of diagnosis and work is underway to evaluate the impact of the

Acute Exacerbation of COPD pilot (enabling access to rapid assessment and treatment from pulmonary rehabilitation team). 10 Practices have come forward to undertake detailed review of their COPD management and the Whittington Health was successful in winning a Local Authority run tender to provide Long Term Exercise therapy for patients who have completed pulmonary rehabilitation. This service is due to commence in September 2013.

Step Up and Step Down Beds
Haringey and Enfield CCG are reviewing their acute beds and working together where there are overlaps to identify efficiencies.

APPENDIX 3. THE HEALTH AND SOCIAL CARE INTEGRATION TRANSFORMATION FUND (ITF)

> *"The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. ....Unless we seize this opportunity to do something radically different, then services will get worse, costs to taxpayers will rise, and those who suffer the most will be people who could otherwise lead more independent lives".*

Local Government Association and NHS England (8th August 2013), *"Statement on the Health and Social Care Integration Transformation Fund".*

The TIF is dedicated to the further integration of health and social care for adults. Detailed guidance is awaited but the Government has made it clear that it will create a £3.8bn pooled budget in 2015/16 to move more care out of hospitals and into the community by intervening earlier to prevent people from reaching crisis points. This ambition is coupled to the demand that much better integration is needed between health and social care, so that care is centred around the person rather than the service, and to reduce the amount of money that is wasted when services do not work together effectively. The ITF provides the means of powerfully driving and incentivising the integration of health and social care across England. At this time it is not known what Haringey's ITF allocation will be, but it estimated to be about £8 m. It is difficult to be precise at this time, but not all this money will be new and the allocation of the ITF may be impacted upon by a national Spending Review.

The Composition of ITF

The Integration Transformation Fund will consist of a combination of new and existing funding streams. Some of the existing funding is for particular provision, such as that for carers breaks and reablement. It is expected that these responsibilities and services to continue, with local authorities and CCGs working together more closely to improve their delivery.

The £1.9bn of existing funding that will already be allocated across the health and social care system to support integration in 2014/15 is broken down as follows:

a) **£1.53bn revenue funding**
   - **£1.1bn – continuation of the 2014/15 NHS transfer**. Over the course of the 2010 Spending Review period, the NHS has transferred money to support care and support with a health benefit. Previously, it was intended that this would amount to £900m in 2014/15 – this Spending Round has announced a further £200m to help local authorities prepare for the implementation of the Integration

Transformation Fund and make early progress on priorities. In 2015/16, this £1.1bn will be put into the pooled budgets.

- **£300m – reablement funding.** Reablement funding is currently identified within CCG allocations. In 2015/16, this money will be placed within the pooled budgets.
- **£130m – Carers break funding**. Funding for carers breaks is provided by the NHS. This money will form a part of the pooled budget.

b) **£354m capital funding**

- **£134m – Community Capacity Grant.** The Department of Health's capital grant for care and support will form a part of the pooled budget in 2015/16. Of this, £50m is to fund the changes in IT systems necessary for integration and funding reform.
- **c.£220m – Disabled Facilities Grant.** This will be put into the pooled budget. More work needs to be done on how this will work in practice, given that this is currently also allocated to lower tier councils.

c) **£1.9bn additional NHS funding**

- In addition to the existing funding streams outlined above, the NHS will contribute a further £1.9bn to the Integration Transformation Fund.

The Conditions of the ITF

To access this funding, Haringey will need to produce a local plan for how the money will be used across health and social care, signed off by the Council and CCG, with the HWB having a strong oversight role. The plan must demonstrate that care and support services will be protected and include:

a) 7-day working in health and social care, to stop people from being stuck in hospital over the weekend;
b) better data sharing, including universal use of the NHS number as a unique identifier;
c) a joint approach to assessment and care planning;
d) implications for acute service redesign;
e) support for accountable lead professionals in respect of joint care packages, and;
f) arrangements for redeploying funding that is held back in the event that outcomes are not fully delivered.

£1bn of the funding in the pooled budgets will be linked to outcomes achieved, based on a combination of locally and nationally set outcome measures. Half of the funding will be paid at the beginning of 2015-16 (based on performance in the previous year) and the remainder paid in the second half of the year against performance in year. To access all funding, local areas will need to meet their planned outcomes.

Timescale

The outline timetable for developing the local ITF plan is very challenging. Available guidance states:

August - October 2013	Initial local planning discussions and further work nationally to define conditions etc.

November/December 2013	NHS Planning Framework issued.
December - January 2013/14	Completion of Plans
March 2014	Plans assured

To deliver a robust integration plan that is owned as widely as possible by the Council, CCG and other key stakeholders it is proposed to take a programme management approach, employing the PRINCE 2 methodology, to its production which will bring together officers from all parties to undertake a highly structure planned piece of work to deliver Haringey's Integration Plan. This will be an innately partnership undertaking that will be as open and transparent as possible. The indicative critical path for this work is shown immediately below.

August – September 2013

- Stakeholder Engagement.
- Audit of Integrated Services.
- Examination of best practice.
- Initial Service Modelling.

October – November 2013

- Redrafts of Service Model.
- Ensure compliance with ITF funding requirements – prepare funding proposal.
- Draft reports for the London Borough of Haringey, Haringey's Clinical Commissioning Group and Health and Wellbeing Board.

December 2013

- Finalise service model
- Finalise reports for the London Borough of Haringey, Haringey's Clinical Commissioning Group and Health and Wellbeing Board.

January 2014

- Submit Service model, reports and ITF plan to London Borough of Haringey, Haringey's Clinical Commissioning Group and Health and Wellbeing Board.

February 2014

- Make such changes to the ITF Plan as may be required by the London Borough of Haringey, Haringey's Clinical Commissioning Group and Health and Wellbeing Board.

- Funding proposal signed-off locally.

March 2014	• Submit funding proposal to DH for ministerial sign-off.

A risk log will be developed to monitor and proactively manage risks while extra capacity has been put in place to enable the successful completion of the programme of work. This is designed to lead to the award, in full, of ITF funding to Haringey.

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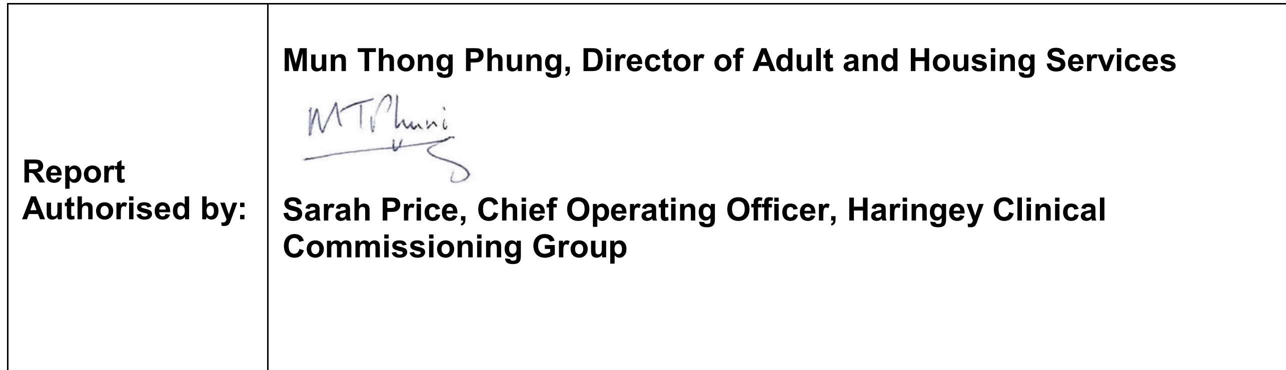
Haringey Council

Report for:	Health and Wellbeing Board (HWB) on 8th October 2013	Item Number:	

Title:	Section 256 Agreement – Health and Social Care - Adults



Report Authorised by:	Mun Thong Phung, Director of Adult and Housing Services Sarah Price, Chief Operating Officer, Haringey Clinical Commissioning Group

Lead Officer:	Beverley Tarka, Acting Deputy Director, Adult and Community Services, Adult and Housing Services Jill Shattock, Director of Commissioning, Haringey Clinical Commissioning Group

Ward(s) affected: All	Report for: Non-Key Decision

1. Describe the issue under consideration

This report seeks Health and Wellbeing Board (HWB) formal ratification of a raft of schemes agreed between Haringey Clinical Commissioning Group and Haringey Adult and Community Services, enabling the Council to enter into a formal Section 256 Agreement with NHS England in respect of the 2013/14 transfer of funds from the NHS to social care. The Health and Wellbeing Board is asked to ratify these, in order to ensure the Borough obtains its 2013/14 full funding allocation from NHS England. This report should be read alongside the report: ‘Integrated Health and Social Care – Adults’ at item 8 of the agenda

2. Chair of the HWB introduction

I am pleased to support this report to the Health and Wellbeing Board, setting out the proposals agreed between Haringey Clinical Commissioning Group and Council in respect of integrated services in Haringey. I have noted the schemes set out within this report,

and am confident these will have a positive impact in delivering outcomes for Haringey residents. The schemes reflect our shared agenda in improving health and social care outcomes in Haringey, particularly around reducing the need for people to both go to hospital unnecessarily, and to be able to return home as soon as possible, where they are admitted.

The interests of our residents, both adults and children remain at the heart of working jointly across health and social care and we are committed to ensuring that there is a relentless focus on the creation of real and robustly integrated services leading to real benefits for people over which they will be able to exercise more control.

3. Recommendations

It is recommended that Members of the HWB:

a) Read and note the contents of this report; and
b) Ratify the proposed Section 256 transfer of £4.1m to fund the schemes listed in section 5.

4. Alternative options considered

No alternative options are presented as schemes promoting integration are already in place.

5. Background information

5.1 Section 256 Funded Schemes.

Section 256 of the National Health Act 2006 allows NHS bodies to enter into arrangements, including the transfer of funds, with local authorities, Such arrangements are known as section 256 agreements. For the past three financial years, including 2013/14, Haringey Primary Care Trust (now Clinical Commissioning Group) and the local authority have agreed a section 256 agreement specifically for the 'Funding Transfer from the NHS to social care', and have agreed a set of projects and services to be delivered through social care but to also carry out activities with health benefits. The key difference between this financial year and previous years is that the Section 256 agreement for this year is between the Council and NHS England rather than the Council and Haringey CCG.

The Department of Health has made available £859m of funding specifically to pay for Social Care services that also have health benefits. This funding is held by NHS England and can be accessed by local authorities by entering into a Section 256 with NHS England, with endorsement from the relevant Clinical Commissioning Group. It is a condition of the funding that the Health and Wellbeing Board agree the use of the funding. The sum available for Haringey in 2013/14 is £4,109k.

5.2 Haringey's proposed schemes

Discussions have been held between officers of the Council and CCG to agree a raft of schemes that support the wellbeing of residents and support them close to their homes. The schemes have been endorsed within Adult and Housing Services, and also by the Haringey CCG Finance Committee. These schemes make, or will make, a significant contribution to delivering integrated care across the local health and social care economy and these are set out in the table below:

Table 1 – Section 256 Schemes

Item	Scheme	Rational/Plan	Proposed Allocation 2013/14	Outcomes Achieved (Supported Health Objectives)	NHS England Subjective Descriptor
1	Reablement Assessment Team	Assessment, care management and support for clients - providing hospital based social care resource, working to avoid unnecessary admissions and facilitate early discharge, including accessing reablement and stepd-down care.	500,000	Reduces delayed transfer of care and admission avoidance Reduce delayed discharges; Prevent unnecessary readmission into hospital Reduced long-term care costs/dependency.	Re-ablement services
2	NHS reablement staff costs	specialist reablement team to facilitate discharge into community. Based at Whittingon health	250,000	Enables earlier discharge and reduced length of stay - therapeutic input to patients otherwise not available Admission avoidance and improved outcomes for clients supported to manage independently in the community	Re-ablement services
3	Occupational Therapy	Contribution to the Occupational Team team to fund additional OT capacity to respond to the high rate of referrals for reablement and admission avoidance.	90,000	More complex clients can be supported in their own homes without requiring residential or nursing care. Admission avoidance and improved outcomes for clients supported to manage independently in the community	Re-ablement services

Item	Scheme	Rational/Plan	Proposed Allocation 2013/14	Outcomes Achieved (Supported Health Objectives)	NHS England Subjective Descriptor
4	Reablement Focused Home Care Service	A reablement focused home care service using highly experienced and skilled home carers to work intensively with clients newly discharged from hospital and support them to regain their independence.	1,040,000	65% of clients are supported to regain skills to the point they no longer need on going care. Reduce delayed discharges; Prevent unnecessary readmission into hospital Reduced long-term care costs/dependency.	Re-ablement services
5	Personal care and support at home	Additional care and support packages for increased numbers of Older People and Adults with Disabilities being supported in the community	350,000	Numbers of Older People and Adults with Disabilities requiring Social Care support have increased by 9% over last year. Externally commissioned Personal Care support to assist the discharge process and to reduce long term social/health cost of care maximising function and long term care dependency.	Re-ablement services
6	Step Down Care	step down beds to facilitate hospital discharge of most vulnerable patients	375,000	Reduces delayed transfer of care Reduce delayed discharges; Prevent unnecessary readmission into hospital Reduced long-term care costs/dependency.	Re-ablement services
7	Rapid Response Service Part year effect (September 2013 to March 2014)	Part of the Rapid Response Plan A small but steady stream of patients are admitted to hospital in circumstances where the provision of health and social carers at home, overseen by community matrons, could avoid or shorten their hospital	55,000	The provision of Health and Social Care Assistant staff for the service, available on stand-by, to fulfil the role of a competent carer for patients. Most of the patients would be identified for the service by LAS or	Integrated crisis and rapid response services

Item	Scheme	Rational/Plan	Proposed Allocation 2013/14	Outcomes Achieved (Supported Health Objectives)	NHS England Subjective Descriptor
		admission. The carers would be available faster than normal, stay for longer and be able to stay overnight if necessary.		within A&E. The scheme would run as a 1 year pilot with evaluation informing future roll-out.	
8	Community Development Workers + expansion of Good Neighbours scheme	Work to build community engagement and volunteering for and with elderly and disabled people; reducing social isolation, signposting and preventative work Pilot of new more preventative and personalised approach to assessment and care management with a view to transition to a new style of working with clients.	120,000	Designed to reduce social isolation, lowering incidence of depression (including depression related admissions), reducing length of stay for those admitted.To prevent or delay the first fall	Other preventative services
9	Older People and Dementia Pathway	A range of social care support available for Older People with dementia including specialist day care services for Older People with High Needs and Dementia.	475,000	Prevention of social isolation and daytime respite for carers Admission avoidance and improved outcomes for clients supported to manage independently in the community	Mental health services
10	Mental Health Recovery Pathway	Social Care services for people with Severe Mental Health problems including new Supported Living Schemes, specialist day care and residential step down	580,000	Prevention of social isolation, skills development and intensive support of Adults with severe mental health needs. Early intervention and crisis prevention, admission avoidance and recovery promotion	Mental health services
11	Joint Commissioning Posts Based in Haringey CCG	Joint commissioning manager and specialist LD/MH commissioning lead to develop an strategic commissioning service and ensure improved and integrated provision	85,000	To support more integrated commissioning of services Integrated working Improved client pathways Improved value for money	Other social care (please specify)

Item	Scheme	Rational/Plan	Proposed Allocation 2013/14	Outcomes Achieved (Supported Health Objectives)	NHS England Subjective Descriptor
12	Data Analysis	Funding of data analysis post, to support CCG/ASC commissioning. To be based in ASC Comissioning. Work to understand health and social care data, better understanding of local needs and identification of key risk factors. Special emphasis on OP Commissioning	50,000	Better health and social care commissioning intelligence, to plan services to respond to changing patterns of need.Integrated working Improved client pathwaysImproved value for money	Other social care (please specify)
13	Winterbourne Response	Bringing vulnerable clients with high needs back into community based settings - preferably Supported Living - closer to LB Haringey.	140,000	Additional commissioning capacity to support the development of new services in Haringey, to support people with learning disabilities who have complex health and social care needs. Prevent deterioration of health needs, in transfer arrangements Integrated working Improved client pathways Improved value for money	Other social care (please specify)
		Agreed expenditure	**4,110,000**		

The HWB are asked to note that the CCG and Adult and Community Services are currently developing a suite of key performance indicators for the above programmes so that we can be sure the schemes and projects are ultimately delivering the right outcomes for Haringey residents. The draft indicators in broad terms enable us to measure the effectiveness of the joint schemes, by promoting people to live as independently as possible, manage their conditions as far as they can, reduce unnecessary admissions to hospital, reduce delayed transfer of care, and reduce the need for long term support from health and social care for as long as possible.

It is recommended that the HWB supports the proposed Section 256 transfer to ensure the continuity of provision and to help ensure that Haringey advances the national integration agenda for health and social care.

6. Comments of the LBH Chief Finance Officer and financial implications

The £4,109k funding for social care services that are also of benefit to health has already been reflected in the Adults and Community Services budget for 2013-14. The proposed allocation funds a range of services that meet the stated objectives of the funding. It is also a condition of the grant that the approval of the Health and Wellbeing Board is obtained.

7. LBH Head of Legal Services and legal implications

The Head of Legal Services (Haringey Council) has been consulted on this Report.

Section 256 NHS Act 2006 (as amended) permits NHS England to make payments to local authorities towards expenditure incurred or to be incurred by it in connection with any social services functions. Also, payments can be made in connection with the performance of any of the authority's function, which have an effect on the health of any individual or on any NHS functions or are connected with any NHS functions. The payments may be made in respect of expenditure of a capital or of a revenue nature or in respect of both kinds of expenditure. The payments may be subject to such Directions as may be issued by the Secretary of State. The rational for the payment and transfer of funds is to promote partnership working and to support investment in social care that also benefits health.

The Secretary of State for Health has also issued Directions that set conditions for all section 256 payments, entitled "The National Health Service (Conditions Relating to Payments by NHS Bodies to Local Authorities) Directions 2013" and "The National Health Service Commissioning Board (Payments to Local Authorities) Directions 2013. The Directions include a requirement that: a) the funding must be used to support adult social care services in each local authority, which also has a health benefit; b) that the local authority agrees with its local clinical commissioning groups how the funding is best used within social care, and the outcomes expected from this investment; c) that local authorities and clinical commissioning groups must have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used; and d) local authorities must be able to demonstrate how the funding transfer will improve social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

The funding transfer is to be the subject of a written Agreement between the Council and the NHS England which is referred to as a Section 256 Agreement.

8. Equalities and Community Cohesion Comments

Commissioners and providers of services for adults and children, whether delivered through integrated working arrangements or by health and social care singly, must have due regard to the equalities implications of service delivery as well as any planned changes to how services are delivered in the future. The integrated care schemes as set out in this report will be subject to robust monitoring of key performance indicators and this will include equalities monitoring to ensure that any adverse impacts to vulnerable adults

as a result of the services we are providing are identified and rectified. Any proposed changes to the service models, will also be subject to a equalities impact assessment.

9. Head of Procurement Comments

Not applicable.

10. Policy Implication

In preparing this report to the HWB, due regard has been played to key policy drivers for health and social care. These are set out below and in Appendix 1.

Health and Social Care Act 2012
This Act introduced significant changes to the NHS and local authorities, with the implementation of much of the Act taking effect from 1st April 2013, including:

- Introduction of statutory local Health and Wellbeing Boards to ensure coordination and integration of public health, NHS and social care services;
- Transfer of responsibility for much of public health commissioning to local authorities (at a local level) and Public Health England (a new national body);
- A new independent NHS Board to allocate resources and provide commissioning guidance;
- Increase in GPs' powers to commission services;
- A strengthened role for the Care Quality Commission;
- Monitor, the body that currently regulates NHS foundation trusts, to be developed into an economic regulator to oversee aspects of access and competition in the NHS; and
- A cut in the number of health bodies, including abolishing Primary Care Trusts and Strategic Health Authorities.

The Care and Support Bill (introduced May 2013)
This Bill provides enabling legislation for reforms set out in the White Paper, and will be introduced in into Parliament in late 2013, with proposed legislative changes to be implement from April 2015 onwards.

- The Bill takes forward recommendations from the Law Commission on adult social care (replacing the current myriad of law covering adult social services);
- There are proposed changes to how much an individual requiring care services will have to contribute towards their care;
- The Bill sets out a clear duty to promote the integration of care support with local authorities (including social services and housing), health and other provider services to ensure the best outcomes are achieved for the individual;
- The Bill sets out responsibilities for prevention and market shaping;
- Adult safeguarding on a statutory footing for the first time; and
- It incorporates recommendations from Francis Enquiry into Mid Staffordshire NHS Foundation Trust and the government response.

11. Reasons for Decision

Not applicable.

12. Use of Appendices

None.

13. Local Government (Access to Information) Act 1985

Refer Section 10 above.

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Agenda Item 10

Report to: Haringey Health and Wellbeing Board

From: Mike Wilson - Healthwatch Director

Date: 16th September 2013

Haringey Healthwatch Progress Report

Background

The Government has said that its vision for health and social care reform is based on the principle that patients, service users and the public must be at the heart of health and social care services. The Health and Social Care Act 2012 set out that local Healthwatch (LHW) would replace Local Involvement Networks (LINks) as of April 2013.

Local Healthwatch will be the new consumer champion for both health and social care including children's social care. The aim of local Healthwatch will be to give residents and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Local authorities are required to commission a local Healthwatch organisation from 1 April 2013. Haringey Council has commissioned Haringey Citizens Advice Bureau (HCAB) to establish our local Healthwatch, and Sharon Grant; currently Chair of HCAB is its interim Chair. The community engagement function is sub-contracted to Haringey Race and Equality Council, which shares the same building with Healthwatch Haringey in Turnpike Lane. There is a total budget of about £200k per year.

Local Healthwatch will carry forward the functions of the LINk but will have additional functions and powers. It will incorporate the good practice of LINks, establishing relationships with local authorities, Clinical Commissioning Groups (CCGs), patient representative groups, the local voluntary and community sector and service providers to ensure it is inclusive and truly representative of the community it serves.

It is expected that after 2 years Healthwatch Haringey will become a social enterprise in its own right. In the meantime, the Healthwatch Board will be in effect a sub-committee of Haringey CAB, which has ultimate responsibility for delivering the contractual deliverables specified by the Council.

Vision for Healthwatch in Haringey

Healthwatch Haringey will be at the heart of the local community, embracing its diversity, and playing a key part in enabling people to become real partners in health and social care provision. As the independent local consumer champion for health and social care in the borough, it will effectively engage and involve individuals, organisations, professionals and the wider public to facilitate genuine improvements in health and social care services in Haringey.

Healthwatch Haringey will help to ensure people are aware of the health and social care services available to them and how they can get the best out of these services. It will also have a seat on the Haringey Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and others are taken into account when preparing local needs assessments and commissioning strategies, including the Joint Strategic Needs Assessment (JSNA). It will also have a seat as an observer on Haringey's Clinical Commissioning Group.

Healthwatch Functions

Function One: Gathering views and understanding the experiences of people who use services, carers and the wider community

Local Healthwatch will achieve this function in a number of ways:

- by gathering the information that is already available and working with other local voluntary and community groups to understand local views and experiences of health and care services
- by actively seeking the views of those who don't generally come forward
- by publicising information using good information governance, including confidentially, through a range of channels
- by working in collaboration with the Care Quality Commission (CQC)
- by working in collaboration with other local Healthwatch organisations
- by developing the skills to understand and interpret different kinds of data and information
- by collating information as evidence to support recommendations to Healthwatch England and /or the CQC

Function Two: Making people's views known

In order to do this effectively, Local Healthwatch will:

- identify and use existing arrangements to avoid duplication
- develop systematic methods of gathering views from local and national sources, where there are currently gaps
- be responsive to what it finds out and report back on developments
- publish findings and make them fully accessible

- identify causes for concern and celebration amongst the local community and feedback on these findings to the CQC and to local commissioners as part of an ongoing, regular dialogue
- use people's views to influence the relevant decision-making bodies including local commissioning groups, health and wellbeing boards and, through Healthwatch England and the CQC, the national regulators (including Ofsted) and the Secretary of State

Function Three: Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised

If it is to promote the involvement of local people in decisions about health and care provision, Local Healthwatch will need to be completely independent and able to demonstrate its credibility, knowledge and successes. To this end, it will be a highly visible organisation that ensures it:

- is easy to reach – for example, by having a local contact number
- is inclusive of all groups within its local community
- respects, involves and collaborates with existing networks
- provides adequate reimbursement and suitable indemnity for its members
- offers support and training to its staff and volunteers on, for example, equality and diversity legislation, safeguarding and interviewing
- practices and promotes "enter and view" through support and training
- prioritises the need for continuous dialogue with its members and local community
- develops a strong relationship with the local health and wellbeing board, making full use of its representative on the health and wellbeing board to act as a constructive "critical friend"
- is an essential contributor to the local Joint Strategic Needs Assessment

Function Four: Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)

Local Healthwatch and Healthwatch England will work together to create a single system to champion the voice of people who use health and care services, locally and nationally. To ensure the relationship works, they need to:

- agree, establish and ensure timely two-way information flows between Healthwatch England and Local Healthwatch organisations
- use protocols for good information governance
- ensure that urgent concerns are escalated
- enshrine the NHS Constitution as the benchmark of NHS service-users' rights
- understand CQC's essential standards of quality and safety
- be aware of the good practice outlined in Think Local Act Personal

Function Five: Providing advice and information about access to services and support for making informed choices

Local Healthwatch will have to meet specific criteria that will be set out in their contracts. To carry out this function effectively, Local Healthwatch will:

- identify what information already exists and how to access it
- identify unmet needs so gaps in information can be plugged
- have its finger on the pulse of the latest information and news and know where to direct people
- fully understand and champion the NHS Constitution and the concept of personalisation
- build people's knowledge of Local Healthwatch as an information and advice resource, ensuring visibility and ease of access
- develop relationships with commissioners and providers
- make sure people can get information in different formats e.g. electronic, hard copy, Braille, preferred language translations·
- make full use of social networking tools to reach communities that are otherwise under-represented
- have the capacity and systems to direct people to services they require
- ensure that it provides feedback to individual members of the public and other partners

Function Six: Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion

A timely two-way information flow will be established between Healthwatch England (HWE) and Local Healthwatch organisations. The role of local Healthwatch will be to:

- have robust protocols for keeping HWE up to date with issues and concerns
- ensure that contacts are more than 'a conversation'.
- exercise its influence in steering and directing the emphasis of HWE's work
- ensure that accountability is a central principle in all exchange with and from HWE
- inform HWE of local matters relevant to wider public health agendas, OSCs, NCB, Monitor, FTs, ADASS, Ministers and the Secretary of State.
- ensure that HWE audits the evidence of Local Healthwatch's contributions to improving health and care outcomes nationally
- foster its own independence by enshrining clear rules of engagement, self-assessment tools etc.

Evidence based decision making

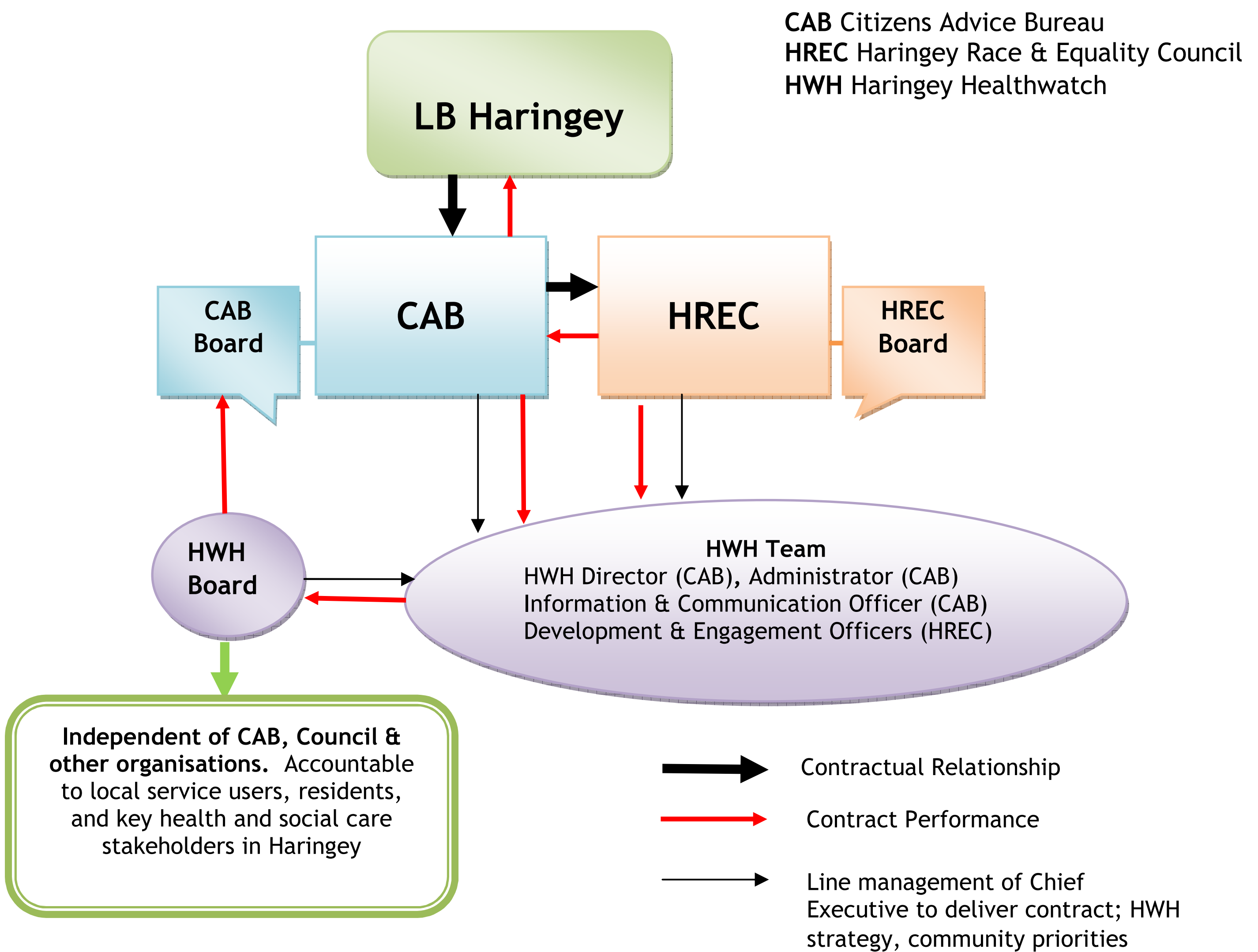
A theme running through all Healthwatch activities is the use of information to inform strategy and policy making and highlight areas of service failure. In order to be credible Healthwatch must evidence their contributions with information collected from a range of sources and not base their recommendations on anecdotal evidence from individuals, some of whom may have vested interests. Effective community engagement techniques and qualitative and quantitive research methods are tools which will be used to gather evidence from members of the public and other stakeholders to inform the decision

making process.

Priorities

In order for Healthwatch to make an impact with such limited resources there will be a need to focus on specific priorities which may change each year. The decision on priorities will be informed by the Health and Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA) and in future years Healthwatch will be in a position to influence these priorities. One area that has already been identified as a potential focus is "complaints procedures" and the use of complaints by health and social care agencies to inform service improvement.

Organisational arrangements



The team comprises a full time Director, a part time administrator, part-time communications officer and two part time community engagement officers. The staff team is now in place and beginning to put procedures in place to deliver the Healthwatch service. The relationship between the Citizens Advice Bureau and the Council is a contractual one with targets and milestones outlined in the service specification and exemplified in detailed method statements; the HCAB has a sub-contract with HREC to deliver the engagement activities. Contract performance is reviewed quarterly against the performance targets and milestones.

It is clear from the above that the financial and human resources available to Healthwatch are very limited given the scope of the responsibilities and in order to make a difference to commissioning health and social care services the team must work with existing partnerships and networks and train a number of volunteers to be "Healthwatch champions" in the community. Volunteers can perform a number of roles including: mystery shopping, enter and view visits to care establishments, signposting to services, representing Healthwatch on specific forums and disseminating information. Developing extensive networks and channels of communication is fundamental to the success of Healthwatch.

It is intended that there will be a Healthwatch Board comprising eight members including the Chair. The recruitment process for Board members is currently underway and it is hoped to have appointed at least some board members by mid-October.

Progress to date

In order to capture the latest progress an update will be provided at the meeting.

END

Report for:	Health & Wellbeing Board	Item Number:	

Title:	Domestic and Gender Based Violence: HaringeyStat Data and Update

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

Lead Officer:	Althea Cribb, Strategic Domestic and Gender Based Violence Lead

Ward(s) affected: All	Report for Key/Non Key Decisions: No

1. Describe the issue under consideration
The purpose of this report is to update the Health and Wellbeing Board on the partnership work progressing in Haringey to address domestic and gender based violence.

2. Chair of the HWB introduction
I welcome this focus on domestic and gender based violence. This violence has such a large negative impact on the health and wellbeing of our children, families and communities. We need to work in partnership, as a Health and Wellbeing Board with the Community Safety Partnership. We also need to work specifically with our health partners, to ensure that we have clear pathways in place to support those who come forward for help.

3. Recommendations
N/A

4. Alternative options considered
N/A

5. Background information
Haringey has a long history of working in partnership to address domestic and gender based violence, which is a pernicious problem that requires ongoing and constant focus from all partner agencies, as well as significant culture change to reduce/remove the acceptability within society.

The partnership response to domestic and gender based violence is led by the Community Safety Partnership. The Community Safety Strategy contains the following outcome: Break

the cycle of domestic and gender based abuse by working in partnership to promote healthy and safe relationships.

This work is delivered through the Domestic and Gender Based Violence Strategic Group, with the support of the Operational Group. The Strategic Group is chaired by the Director of Public Health, which supports the need for the partnership to link across from Community Safety to Health and Wellbeing.

The domestic and gender based violence actions within the Community Safety Strategy also support the aims of the Health and Wellbeing Strategy, specifically:

Outcome 1 – Every child has the best start in life: through ensuring that all areas of work and responses to domestic and gender based violence recognise and address the needs of children and young people. This includes: children and young people living in a home with a perpetrator; children and young people perpetrating abuse/violence against parents and/or family; young people perpetrating / experiencing domestic and sexual violence who are involved in gangs.

Outcome 3 – Improved mental health and wellbeing: the experience of domestic and gender based violence from a partner/ex-partner/family member has been shown to have significant impacts on the mental health, safety and wellbeing of victims, and the partnership is working to ensure they are identified and offered help as early as possible.

This is the first report to the Health and Wellbeing Board, and the focus of this report is to:

- Inform the Board about the HaringeyStat meeting held 22nd July 2013, and the actions that resulted from it
- Inform the Board of the work of the new Strategic Domestic and Gender Based Violence Lead

HaringeyStat

A 'HaringeyStat' meeting was held in July to look at the available data on domestic and gender based violence, and to identify actions to ensure that as a partnership we are addressing the issues effectively. This is provided in the PowerPoint presentation.

Actions covered the following areas:

- Map and understand existing pathways into specialist services:
  - universal health and local authority services' role in early identification and response
  - address the need for accurate recording and data collection and sharing
- Map and review pathways for specialist services
  - services inclusive and open to all
  - who is being supported and how
  - whether a risk based pathway is required/appropriate
- Consider role of schools in prevention and response
- Consider role of family unit and wider community – encouraging an "open conversation"

- Police: Develop more sophisticated ways to identify top perpetrators based on risk posed to victims

In response to the focus at the meeting and in some of the actions above, a meeting is being held on 8th October to focus on health and domestic violence. This will look at the data available, where the gaps are, and to identify best practice responses and how these are developing / can be developed for Haringey.

Strategic Domestic and Gender Based Violence Lead
The Strategic Lead started in post at the end of June 2013, with a remit to support the Strategic Group and its Chair in ensuring the delivery of the domestic and gender based violence part of the Community Safety Strategy, and to take a lead on the mapping of services, responses and data, and the commissioning of services.

Many of the actions outlined above from the HaringeyStat link in with the existing work plan of the Strategic Domestic and Gender Based Violence Lead.

Work areas and achievements:

- Mapping:
  - Identify the specialist services that are in place, who accesses them, whether there are any gaps / duplication
  - Identify how statutory services (including health, LA, police) identify, respond and refer, and how they record for data purposes
  - Develop a more complete 'picture' of domestic and gender based violence in Haringey, through an increase in data sources – to support commissioning and future partnership and service delivery plans
- Commissioning:
  - Independent Domestic Violence Advocacy (IDVA) service has expanded, and gone from one IDVA to three, able to work with up to 240 clients per year via the MARAC, as well as servicing of Specialist Domestic Violence Court (SDVC)
  - Multi-Agency Risk Assessment Conference (MARAC) Coordinator is in post, looking into expanding that service if required
  - Public Health domestic and gender based violence primary prevention commissioning is going forward
  - Partnership response to perpetrators through a specialist programme being available – researching options, costs, to result in appropriate commissioning for borough's needs

6. Comments of the Chief Finance Officer and financial implications
There are no financial implications arising directly from this report. Most of the actions identified link in with existing work plans and can be met from existing resources. If new activity is identified then a business case will need to be made as funding will have to come from reductions elsewhere in the service budget.

7. Head of Legal Services and legal implications

N/A

8. Equalities and Community Cohesion Comments

Domestic and gender based violence fall within the UN definition of violence against women and girls; that is:
Any act of gender-based violence that is directed at a woman because she is a woman or acts of violence which are suffered disproportionately by women.

The greatest risk factor for experiencing domestic and gender based violence is being female. However, men and boys also experience it and responses must address this. Responses must also be sensitive to the additional needs victims/survivors have due to their particular circumstances that can impact on help-seeking, e.g. sexual orientation, ethnicity, disability, religion/faith.

Research shows that there are no causal links between socio-economic position, employment status or poverty and the experience of domestic and gender based violence. There are no additional risk factors relating to ethnicity or religion.

9. Head of Procurement Comments

N/A

10. Policy Implication

N/A

11. Reasons for Decision

N/A

12. Use of Appendices

N/A

13. Local Government (Access to Information) Act 1985

N/A

Agenda Item 12

Report for:	Health and Wellbeing Board	Item Number:	

Title:	Pharmaceutical Needs Assessment

Report Authorised by:	Jeanelle De Gruchy, Director of Public Health

Lead Officer:	Tamara Djuretic, Assistant Director of Public Health

Ward(s) affected: All	Report for Information

1. Describe the issue under consideration

1.1 From 1st April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The PNA is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

1.2 The NHS Commissioning Board – now NHS England – has the responsibility to commission pharmaceutical services taking into account the local need for services. If someone wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list and must prove they are able to meet a pharmaceutical need. This is commonly known as the NHS “market entry” system.

1.1 Haringey has a PNA in place which was published in March 2011 with a three year review date (i.e. March 2014), while the current regulations i.e. the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require every HWB to publish its first PNA by 1st April 2015.

1.2 The detailed process for revising a PNA as laid down by these regulations makes the process challenging and it is estimated to take between 6 and 12 months depending on the delivery mechanism chosen.

1.3 If there are significant changes to the availability of pharmaceutical services since the publication of its PNA within this time, the HWB is required to publish a revised assessment as soon as is reasonably practical unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. The HWB can, if necessary, publish supplementary statements to the PNA.

2. Cabinet Member introduction

2.1 It is reassuring to note that the HWB inherited a PNA produced by NHS Haringey in 2011. In March 2013 the North Central London Primary Care Trust (PCT) Cluster commissioned an independent review of the PNA which concluded that the Haringey PNA document is comprehensive and addresses all of the regulatory requirements, most are addressed adequately. For future PNAs, the report of the consultation would benefit from a more explicit report of what took place.

3. Recommendations

3.1 Note that from 1 April 2013 the Board assumed responsibility for the Pharmaceutical Needs Assessments (PNA) published by NHS Haringey and that it has to publish its first PNA by April 2015.

3.2 Note that the inherited PNA was assessed externally as fit for purpose.

4. Alternative options considered

None

5. Background information

5.1 The Health and Social Care Act (2012) changed the responsibilities for commissioning of pharmaceutical services to meet the new provider landscape.

From April 2013:

- The Department of Health will continue to have the power to make regulations.
- The NHS Commissioning Board – now NHS England – has the responsibility to commission pharmaceutical services taking into account the local need for services.
- Local HWB have the responsibility to undertake PNAs.

5.2 A PNA is a report that includes a count of local pharmacies and the services they already provide including dispensing, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. A PNA often includes other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area. A PNA also describes the demographics of its local population, across

the area and in different localities, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should contain relevant maps relating to the area and its pharmacies.

5.3 The preparation and consultation on the PNA should take account of the Joint Strategic Needs Assessment (JSNA) and other relevant strategies. However, the PNA cannot be subsumed as part of these other documents (but can be annexed to them).

5.4 Upon receiving a pharmacy application the Local Area Team of NHS England notifies interested parties of the application and since April 2013 HWBs are included as an interested party. The Local Area Team invites interested parties to make written representation on the applications within 45 days, should they wish. It then considers all representations and arranges an oral hearing to determine the application if it identifies a matter on which it wishes to hear further evidence.

5.5 The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 came into force on the 1st April 2013. These Regulations are made under s.128A of the National Health Service Act 2006 (see Appendix 1). Health and Wellbeing Boards (HWBs) will be required to produce the first Pharmaceutical Needs Assessment by the 1st April 2015 with revised assessments within three years thereafter. If there are significant changes to the availability of pharmaceutical services since the publication of its PNA within this time, the HWBs are required to publish a revised assessment as soon as is reasonably practical unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. The HWBs can, if necessary, publish supplementary statements to the Pharmaceutical Needs Assessment as necessary.

5.6 The current Pharmaceutical Needs Assessment was undertaken and published by NHS Haringey in March 2011. It can be found at www.haringey.gov.uk/haringey_pharmaceutical_needs_assessment_jan_2011_1-_.pdf

5.7 North Central London PCT Cluster commissioned independent consultants to review the quality of Haringey's PNA to ensure that it complied with the legal guidance. The review concluded that the local PNA is comprehensive and it addresses a number of the regulatory requirements fully and partially meets all other requirements in the regulations. It is suggested that future PNAs could be improved by ensuring that the report of the consultation conducted is a narrative account of what happened. Future PNAs will therefore place specific emphasis on the detail of who was consulted, how they were consulted, when and for how long.

6. Next steps

6.1 The planning cycle for production of the PNA is very long and is likely to take 6-12 months; there is a statutory requirement for a minimum 60 day period of public consultation and the PNA requires board-level sign-off.

6.2 Failure to comply with the regulatory duties and to produce a robust PNA as detailed in the 2013 Regulations could lead to legal challenges because of the PNAs relevance to decisions about commissioning services and new pharmacy openings, for example where a party believes that that they have been disadvantaged following the refusal by NHS England of their application to open new premises.

6.3 It is therefore recommended to establish Haringey's PNA Steering Group by December 2013 to oversee production of a comprehensive project plan on behalf of the HWB. Project plan including timescales, membership of the group, governance structure and engagement plan will be presented to the Board by April 2014.

7. Policy Implication

7.1 The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

7.2 The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.

7.3 As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[1]. In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

8. Legal

8.1 Health and Well-Being Boards are statutorily required to produce a Pharmaceutical Needs Assessment. These requirements are set out in Section 128A of the NHS Act 2006, as amended by Section 206 of the 2012 Health and Social Care Act. The Department of Health has laid regulations for undertaking Pharmaceutical Needs Assessments in Regulations 3 - 9 and Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. These include specific requirements as to those organisations and groups that must be consulted in developing the Pharmaceutical Needs Assessment, including:

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[1] "*Healthy lives, healthy people*", the public health strategy for England (2010)

a. any Local Pharmaceutical Committee for its area;
b. any Local Medical Committee for its area;
c. any persons on the pharmaceutical lists and any dispensing doctors list for its area;
d. any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;
e. any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and
f. any NHS trust or NHS foundation trust in its area;
g. the NHSCB; and
h. any neighbouring HWB.

8.2 Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require the content of the Pharmaceutical Needs Assessment to include:

i. Necessary services – current provision and gaps in provision
ii. Other relevant services – current provision and gaps in provision
iii. Other NHS services
iv. How the assessment was carried out
v. Map of provision

9. Use of Appendices

Appendix 1: Section 128A of NHS Act (2006), as amended by Health Act (2009) and Health and Social Care Act (2012)

10. Local Government (Access to Information) Act 1985

Appendix 1: Section 128A of NHS Act (2006), as amended by Health Act (2009) and Health and Social Care Act (2012)

128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations--
- (a) assess needs for pharmaceutical services in its area, and
- (b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision--
- (a) as to information which must be contained in a statement;
- (b) as to the extent to which an assessment must take account of likely future needs;
- (c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;
- (d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision--
- (a) as to the pharmaceutical services to which an assessment must relate;
- (b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment;
- (c) as to the manner in which an assessment is to be made;
- (d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

Agenda Item 13

Meeting: Health and Wellbeing Board

Date: 8th October 2013

Report Title: Performance Summary

Report of:

Purpose To provide an update to the summary indicators in the Health and Wellbeing Outcomes Framework and provide an exception report for the physical activity measure.
Summary **Outcome summary:** • An increase in male life expectancy from 78.0 years to 78.9 years. Provisional data suggest the following: • A reduction in the under 75 CVD mortality rate from 78.7 per 100,000 to 65.7 per 100,000 • A reduction in the suicide rate from 9.9 per 100,000 to 8.7 per 100,000 • A slight increase in the rate of alcohol related hospital admissions from 2,253 per 100,000 to 2,350 per 100,000 **Exception Report:** • A description of local initiatives to increase physical activity in the borough.
Legal/Financial Implications None
Recommendations • None
For more information contact: Name: Jeanelle DeGruchy Title: Director of Public Health Tel: 020 8489 2828 Email address:

Use of Appendices:

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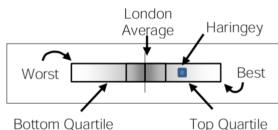
Health and Wellbeing Partnership Board - Performance Summary (October 2013)

Produced by Public Health and Strategy and Business Intelligence Team

Health and Wellbeing's Key Service Measures

The table below shows the most recent benchmarking data available for Health and Wellbeing's key service measures. The 'Range' column shows where Haringey sits in comparison to the other London Boroughs. Anything left of the centre line is worse than the London average, anything right of the line is better than the London average.



	Outcome Indicator	2009/10	2010/11	2011/12	2012/13	Local Data			London Benchmarking
						Haringey (most recent)*	Target (2012/13)	Trend	
Outcome 1: Every child has the best start in life	**Infant mortality rate**	4.8	4.3			**4.3**	4.5	↓	
	Early access for women to maternity services(%)	73.9	67.2	69.2	76.9	**76.90**	80.0	↑	
	Under 18 conception (PHOF)	41.2	49.2	36.2		**36.20**	52.8	↓	
	Prevalence of overweight and obesity in 10 and 11 years old (PHOF)	38.6	35.4	39.3		**39.30**	39.30	↑	
Outcome 2: A reduced gap in life expectancy	**Male Life expectancy**	78.0	78.9			**78.90**		↑	
	Alcohol related hospital admissions (PHOF)	1,949	2,257	2,253	2,350 Provisional	**2,350**	2,391	↑	
	Take up of health checks (PHOF)			6,047	6,464	**6,464**	5000	↑	
	Cardiovascular mortality (under 75)	78.7	65.7 Provisional			**65.7**	65.7	↓	
Outcome 3: Improved mental health and wellbeing	**Mortality rate for suicide and undertermined injury (PHOF)**	9.9	8.7 Provisional			**8.7**	8.0	↓	
	% successfully completing drug treatment (as a proportion of all adults in treatment	16.7	22.3	18.4		**18.4**	22.3	↓	

Health and Wellbeing Partnership Board Exception Report - Physical Activity (October 2013)

Adult participation in sport and active recreation.

Good performance is...	High

Percentage of the adult population (aged 16 years and over) in a local area who paricipate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week)

Long term trend	2008/09	2009/10	2010/11	2011/12	2012/13	Performance
Haringey rate		23.1	21.3	21.5		Better
London rate		21.5	21.0	20.2		

Proposed Targets	
2012/13	2015
23.1	25.0
Local	Local

Statistical neighbours rank (1st is best)
NA

The percentage of adults participating in sport and recreation has declined in the past 3 years from 23.1% to 21.5% but has remained above the London percentage.

The target is to increase the rate to 25.0% by 2015.

Rationale

Lack of sufficient physical activity costs the NHS over £1bn per year - £6.5bn per year to the wider economy - and is one of the top few rislk factors for premature mortality.

What are we doing?

We are running a number of programmes targetting adults who are physically inactive as they will benefit most from increasing their levels of physical activity. Projects include 'Tottenham Active' and 'Active with Ease'.
In addition, the Health Trainer Service provides one-to-one personalised support and advice to people who want to increase their levels of physical activiity to improve their health.
Health Champions raise awareness about the benefits of increasing physical activity and signpost local people to a range of physical activity programs in the borough.
We are also in the process of commissioning a provider to train a range of frontline staff in brief interventions to support them in their efforts to encourage clients to increase their levels of physical activity.
We will also be rolling out physical activity promotion training to ensure that those promoting it are giving out correct and consistent messages.
We are also increasing the use of open spaces, ie. green gyms and walking and cycling projects

What needs to be done?

A communications campaign (eg. social marketing) to encourage people to increase their levels of physical activity. Workplace health initiatives to increase physical activity. Public Health will work closely with the new lesiure providers, namely Fusion Lifestyle to improve access to local people with a specific focus on those who are the least active.

Report for:	Health and Wellbeing Board	Item Number:	

Title:	DELIVERY GROUPS UPDATE REPORT

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

Lead Officer:	Andrew James, Public Health

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

1. Describe the issue under consideration

To provide a highlight report to the board regarding delivery of the outcomes in the Health and Wellbeing Board Strategy 2012-1015

2. Cabinet Member introduction

Three Health and Wellbeing Board Delivery Groups have been set up that are accountable for a specific outcome from the Health and Wellbeing Board's Strategy 2012-2015. There are

- Outcome 1: Giving every child the best start in life;
- Outcome 2:Reducing the life expectancy gap
- Outcome 3: Improving mental health and wellbeing

Each group will report to the Health and Wellbeing Board's Senior Officers Group.

3. Highlight Report.

This is the first highlight report to the board since the inception of the delivery groups. The purpose of a highlight report is to provide the board with a summary of the status of the delivery groups. This report covers the period up to end of September 2013.

On 27th September 2013 the HWB Autumn seminar has taken place. This seminar covered the bid for funding from the Big Lottery Fund (BLF). Haringey has been successful in attaining £395,142 of Big Lottery funding for a new joint project to help vulnerable families give their children the best start in life. Representatives from the Health and Wellbeing Board and the Children's Trust were brought together to facilitate the next stage in the bid in a very successful event.

A workshop to address a stocktake of the delivery plan and membership of the group has been arranged for October due to staff availability and the demands of running three delivery workshops in a short period.

The draft terms of reference are in appendix 1.

Winter Seminar on 12th November has been organised with the Health and Wellbeing Board and Community Safety partnership. The programme will address impact of alcohol in the community. An invite will be sent out shortly but invitees have already been asked to protect the date and time.

A workshop has been arranged for 11th October 2013 which will be addressed the delivery plan for outcome two. Dr Chris Bentley from Health Inequalities National Support Team (HINST) Associates will be speaking and participating in the event The aim of the workshop is to: Obtain common understanding of reducing life expectancy gap and agree next steps – including defining membership and TORs.

A workshop on 19th September 2013 for outcome three had good representation from all participating organisations/directorates. Outcomes were to include new or changes to national policies to all plans, which will be led by Public Health; linking back to JSNA, again to led be Public Health; the group defined separate leads for each priority and they will become the delivery group membership; Under priority 10 to formally explore healthy schools, families with mental health issues, children who are carers, gangs, links between physical health and mental health and to review an assets approach looking at children who play. Under priorities 12 and 13 the group wanted to include the Mental Health Recovery model.

A thorough review of all delivery plans has been undertaken, including update of who is responsible for the milestones as many named individuals on the plans have left their respective organisations. Outcome 2 plan is mainly delivered through groups and boards where as outcome three is mainly delivered by individuals. Outcome three delivery workshop has now indentified priority leads. The review has also included adding version control processes .It was also found that there was discrepancy in how to allocate a red, amber or green aspect to a milestone. A new milestone guide has been added to the plans. The updated plans are to be tabled at the meeting.

One issue that became apparent was that governance for mental health issues was fragmented across the partnership. The fragmentation of the governance makes it

difficult for partnership solutions to be addressed. Examination of the updated plans by the delivery group is need before a recommendation can be made to the board.

4. Recommendations

None

5. Alternative options considered

None

6. Comments of the Chief Finance Officer and financial implications

There are no new financial implications directly arising from this report.

7. Head of Legal Services and legal implications

N/A

8. Equalities and Community Cohesion Comments

N/A

9. Head of Procurement Comments

N/A

10. Policy Implication

This strategy sets out to improve the health and wellbeing of children and adults in our borough and reduce health inequalities between the east and west of the borough.

The strategy:

- incorporates the health and wellbeing priorities of the Children and Young People's Plan 2011 review;
- Replaces the Wellbeing Strategic Framework which aimed to improve wellbeing and tackle health inequalities among adults in Haringey (expired in 2010); and
- Incorporates Experience Still Counts, our strategy for improving the quality of life for older people (2009-2012).

11. Reasons for Decision

For Information only

12. Use of Appendices

1. Draft Terms of Reference

13. Local Government (Access to Information) Act 1985

None

14. Appendix 1

HARINGEY HEALTH AND WELLBEING STRATEGY DELIVERY GROUP: OUTCOME THREE

Draft Terms of Reference – September 2013

Membership:
Jill Shattock (Chair); Tamara Djuretic; Mary Dos Santos Justo; Susan Otiti; Lisa Redfern; Barbara Nicholls; Clare Drummond; Tristan Brice; Janet Aldridge; Marion Morris

Associates members: As and when identified. *Those identified as leads for actions (circa 13 people) and relevant information analysts.*

Frequency of meetings: prior to Chief Officer Group Meetings.

Governance – The Outcome Three Delivery Group will report to the Health and Wellbeing Senior Officers Meeting

Objectives

1. To monitor and report on the performance of the Health and Wellbeing Strategy Delivery Plan April 2012 – March 2015, Outcome 3: Improving Mental Health and Wellbeing, to ensure it achieves its outcome to the Health and Wellbeing Chief Officers Group;
2. To monitor and highlight performance in meeting the four priorities, key measures and their respective actions as defined in the Health and Wellbeing Strategy Delivery Plan April 2012 – March 2015, Outcome 3: Improving Mental Health and Wellbeing to the Health and Wellbeing Senior Officers Meeting;
3. To identify, task and monitor relevant stakeholder partnership boards, partnership directorates/departments and/or individuals accordingly to ensure that the priorities and actions identified in the plan are achieved;
4. To maintain risk management processes to negate threats to the completion of the outcome;
5. To work at a systems level to ensure good data management practice, exchanging best practice, supporting auditing, bench marking service and/or intervention evaluation monitoring accuracy and quality of reporting and produce an Action Plan where required to enhance performance;
6. To develop and maintain integrated solutions, ensuring and improving access, effectiveness, and outcomes are delivered to services users irrespective of which partner/stakeholder is coordinating the action;
7. To identify and address a programme or intervention that is not achieving its outcomes to either resolve issues with the partner or remove the intervention/initiative from the delivery plan; and
8. To identifying opportunities for integration of commissioning and/or services between the Haringey Council's departments, Haringey CCG and the voluntary sector to promote value for money?

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Report for:	**Health and Wellbeing Board**	**Item Number:**	

Title:	**CHANGES TO CCG HEALTH AND WELLBEING BOARD REPRESENTATION**

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

Lead Officer:	**Andrew James, Public Health**

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

1. Describe the issue under consideration

To inform the Health and Wellbeing Board of the Haringey Clinical Commissioning Group GP election process outcome.

2. Cabinet Member introduction

A statutory requirement of Haringey Clinical Commissioning Group is for GP's, from its constituent collaborations, to be elected to its board. Those successful will, be election by peers, be voted to posts on Haringey Clinical Commissioning Group Board. An election process was undertaken in September.

3. Outcome

Following the completion of the nomination process there were insufficient GPS nominated to fill all GP positions on the board. Therefore all nominated GPs were automatically elected to the Haringey Clinical Commissioning Group Board.

Following election by peers the following GPs were elected to posts that relate to the Health and Wellbeing Board:

Dr Sherry Tang was voted Chair of the Clinical Commissioning Group.

Dr Helen Pelendrides has taken on the role of GP Board Member to the Health and Wellbeing Board.

These changes occurred on 1st October 2013.

Chair of the Clinical Commissioning Group holds one of the four voting statutory positions on the Health and Wellbeing Board. As such the legal team at the London Borough of Haringey commenced the process for Dr Tang to sign a register of interests which will be published. As outgoing Chair of the Clinical Commissioning Group, Dr Pelendrides' details have been removed on the 1st October from the published register of interests.

The Chair of the Clinical Commissioning Group is also vice chair of the Health and Wellbeing Board.

At time of writing this report a nominated voting substitute for the Chair of the Clinical Commissioning Group has yet to be agreed.

4. Recommendations

To welcome and congratulate Dr Tang and Dr Pelendrides to their respective positions and to thank Dr Pelendrides for her stewardship as vice chair over the inception and transition period of the Health and Wellbeing Board.

5. Alternative options considered

None

6. Background information

None

7. Comments of the Chief Finance Officer and financial implications

There are no financial implications arising from this report.

8. Head of Legal Services and legal implications

N/A

9. Equalities and Community Cohesion Comments

N/A

10. Head of Procurement Comments

N/A

11. Policy Implication

None

12. Reasons for Decision

For information

13. Use of Appendices

None

14. Local Government (Access to Information) Act 1985

None

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