



Haringey Council

Health and Wellbeing Board

TUESDAY, 1ST JULY, 2014 at 13:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see membership list attached.

AGENDA

1. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

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 Item 14 below).

4. DECLARATIONS OF INTEREST

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

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

A Member who discloses at a meeting a disclosable pecuniary interest which is not registered in the 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 3 - 18)

To consider and agree the minutes of the meeting of the Board held on 8 April 2014.

7. HEALTH AND WELLBEING STRATEGY OUTCOME 1 DELIVERY UPDATE (PAGES 19 - 24)

(Report of the Assistant Director Commissioning). The report provides an update on progress made by the Delivery Group for Outcome 1 of the Health and Wellbeing Strategy for 2012-2015.

8. PERFORMANCE ON CHILDHOOD OBESITY: PUBLIC HEALTH UPDATE (PAGES 25 - 48)

(Report of the Director of Public Health). The report sets out the approach being taken to tackling childhood obesity and the role that the Board would play in the whole-system approach to this. The presentation appended to this report will also be given.

9. HEALTH AND WELLBEING STRATEGY UPDATE (PAGES 49 - 58)

(Report of the Director of Public Health). The report provides an update on the current status of the Health and Wellbeing Strategy 2015-2018 refresh project.

10. LONDON BOROUGH OF HARINGEY CORPORATE PLAN

A presentation will be given.

11. HEALTH AND WELLBEING - NATIONAL AND LONDON DEVELOPMENTS UPDATE (PAGES 59 - 66)

(Report of the Director of Public Health). The report provides an update on a range of national and London developments in relation to health and wellbeing.

12. HOMELESSNESS HEALTH NEEDS ASSESSMENT TASK AND FINISH GROUP REPORT (PAGES 67 - 108)

(Report of the Director of Public Health). The report sets out proposals from the Task and Finish Group.

13. THE NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST FOUNDATION STATUS UPDATE (PAGES 109 - 118)

(Report from Deputy Chief Executive, North Middlesex University NHS Trust). The report provides an update on the progress that the Trust is making with its application to become a foundation trust.

14. NEW ITEMS OF URGENT BUSINESS

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

15. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

Members of the Board are invited to suggest future agenda items and to note the dates of future meetings are as follows:

- 30 September 2014
- 13 January 2015
- 21 April 2015

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Monday, 23 June 2014

Membership of the Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	2	Leader of the Council	Cllr Claire Kober
			Cabinet Member for Children and Young People	Cllr Ann Waters
	Officers' Representatives	3	Director of Adult Social Services	TBC
			Interim Director of Children and Young People's Services	Lisa Redfern
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	Chair	Dr Sherry Tang
			GP Board Member	Dr Helen Pelendrides
			Chief Officer	Sarah Price
			Lay Member	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	Interim Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	Interim Representative	Gill Hawken

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**MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 8 APRIL 2014**

Board Members: 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), Sarah Price (Chief Office, Haringey CCG), Jill Shattock (Director of Commissioning - CCG), Beverly Tarka (Deputy Director Adults and Community Services), Cllr Bernice Vanier (Chair - Cabinet Member for Health and Adult Services, LBOH) and Cllr Ann Waters (Cabinet Member for Children, LBOH)

Also present: Xanthe Barker (Principal Committee Officer, LBOH), Andy James (DAAT Programme Manager LBOH), Zina Etheridge (Deputy Chief Executive, LBOH), Victoria Wyatt (Senior Corporate Lawyer, LBOH).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL72.	<p>APOLOGIES</p> <p>Apologies for absence were received from the following:</p> <p>Lisa Redfern Dr Sherry Tang Mun Thong Phung</p>	
CNCL73.	<p>URGENT BUSINESS</p> <p>There were no items of urgent business.</p>	
CNCL74.	<p>DECLARATIONS OF INTEREST</p> <p>There were no declarations of interest made.</p>	
CNCL75.	<p>QUESTIONS, DEPUTATIONS, PETITIONS</p> <p>A written question was submitted by Mr Robert Lindsay-Smith (set out below) and the Chair noted that the Director of Public Health would provide a response to this in writing.</p> <p>'My question relates to Item 10 on the agenda (Immunisation and Screening Performance Report for NHS England):</p> <p>In the supplementary document pack, pages 9 and 10, section 2.2.1, the report notes that coverage is currently 65.8% for the whole of Haringey, with no figures available for different areas. The national standard is 70%.</p> <p>Section 2.2.2 discusses locations for the North London Breast Screening Service. There is only one actually in Haringey – currently a mobile unit at St Ann's Hospital – but a move to a static site model is envisaged over the next 3 to 5 years.</p>	Dir Public Health

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	<p>My question is: Could the Board note that unless a mobile or static Breast Screening site is provided in any development of St Ann's Hospital the uptake in the east of the borough is likely to deteriorate further?'</p>	
<p>CNCL76. MINUTES</p>	<p>A document was circulated that provided an update with respect to actions agreed at the previous meeting and this is attached at Appendix 1.</p> <p><u>Minutes of the Meeting Held on 7 January 2014</u> Sharon Grant noted that further discussion was required with regard to safeguarding training and that there was agreement that this was 'ongoing'. It was also noted that Healthwatch would be invited to the relevant 'Haringey Stat' sessions, as outlined Appendix 1.</p> <p><u>Minutes of the Meeting Held on 11 February 2014</u> In response to a question it was noted that Healthwatch would become a member of the Integrated Management Board Advisory Group and would also be invited to attend meetings of the Integrated Management Board when appropriate.</p> <p>With regard to a question raised with respect to the impact of ten thousand more homes in the borough and how NHS England would plan for this; it was noted that Zina Etheridge and Sarah Price has met with NHS England to discuss the issues raised and that work was now being undertaken to form a process to assesses the impact of this and the additional facilities that may be required.</p> <p>RESOLVED:</p> <p>That the minutes of the meetings held on 7 January and 11 February 2014 be confirmed as correct records of the meetings.</p>	
<p>CNCL77. OUTCOME 3 DELIVERY GROUP UPDATE</p>	<p>The Board considered a report that provided an update with respect to the work being undertaken by the Outcome 3: Improving Mental Health and Wellbeing Board (one of three delivery groups established to cover the three specific outcomes of the Health and Wellbeing Board's strategy for 2012-2015).</p> <p>It was noted that the majority of the actions contained within the delivery plan had been met and that the group had discussed commissioning arrangements across health and social care and that a detailed mapping exercise was underway. In addition discussion had begun with regard to how commissioning arrangements might need to be revised in the light of the new organisational structures that had now been implemented. In terms of the group's priorities for 2014/15 a full refresh and update of the delivery plan would be undertaken to ensure that patient 'flow' issues were dealt with. In addition a joint CCG and Council</p>	

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framework for mental health would be developed, which would form the basis for the HWB strategy refresh later in the year.

The Board was reminded that a HWB seminar had been held on 5 March in order to consider how 'sign up' might be obtained from partner organisations in order to embed value based commissioning for mental health. This had been well attended and had highlighted the need for partner organisations to improve 'joined up' working around mental health and to ensure that patient pathways were as seamless as possible.

The Chair opened discussion by noting that housing was clearly an area where fragmentation occurred and she requested that the Council's Interim Chief Operating Officer should be invited to attend future meetings of the HWB in order to input into discussion on how this might be improved and to assist in developing understanding around mental health and housing issues. It was also noted that the role of providing high quality advice to patients was not referred to in the report and it was suggested that this should be referred to along with the role that Healthwatch might be able to play in providing this.

Dir of
Public
Health

It was noted that the 'Equalities and Community Cohesion Comments' section of the report had not been completed and there was agreement that future reports should clearly state why these comments were not required if this was the case.

Dir of
Public
Health

In response to a query it was noted that work around the development of the joint CCG and Council Mental Health Framework would take into account work being undertaken as part of the refresh of the HWBB strategy and the importance of sharing resources effectively and ensuring that these pieces of work were aligned was recognised.

In conclusion it was that the development of the joint framework and the refresh of the HWB strategy would need to be reviewed by the HWB at its next meeting in July.

RESOLVED:

- i. That the key points arising from the recent HWB seminar, as outlined in the report, be noted.
- ii. That it be noted that multiple barriers to recovery were identified from the patient perspective, mainly due to the fragmentation and communications issues between partners agencies and it was important that HWB members continued to support all partners to contribute to the improvements necessary.

Alternative options considered

None listed.

Reasons for decision

For information only.

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<p>CNCL78.</p>	<p>HEALTH AND WELLBEING BOARD STRATEGY 2015-19</p> <p>The Board considered a report, previously circulated, which sought agreement to an indicative timetable for work to develop the HWB Strategy for 2015-2018. In introducing the report the Director of public Health noted that the new strategy would build on the current strategy whilst taking into account lessons learnt over the preceding three year period.</p> <p>There was agreement that a workshop session should be held in July to look at how partners would contribute towards the strategy and it was agreed that the Director of Public Health should contact partners following the meeting to discuss how they might contribute to the organisation and content of this session.</p> <p>In response to a question it was noted that reflecting the regeneration work being undertaken in Tottenham and ensuring that the strategy was aligned to this would be essential in order to address the significant disparity in the health of residents across the borough. Therefore the Public Health team would be working closely with the Council's Tottenham Regeneration team in developing the document.</p> <p>There was agreement that the Director of Public Health would also need to discuss, with representatives from Healthwatch, the areas where Healthwatch had been listed as providing support in order to ensure that the group had the capacity to meet expectations.</p> <p>Following on from earlier discussion with respect to the suggested workshop there was agreement that this would need to be held before the first meeting of the steering group that was being formed to pull together the strategy.</p> <p>RESOLVED:</p> <p>i. That the draft timetable, as set out in section 6 and Appendix 1 of the report, be approved in order that project work could commence.</p> <p>Alternative options considered No other alternatives have been considered. The production of the Health and Wellbeing Strategy is a legal requirement.</p> <p>Reasons for decision The Health and Wellbeing Board has a duty to develop, upgrade and publish the Health and Wellbeing Strategy.</p>	<p>Dir Public Health</p> <p>Dir Public Health / Chair of Healthwatch</p>
<p>CNCL79.</p>	<p>EARLY ACCESS TO MATERNITY SERVICES</p> <p>The Board received a presentation, circulated within the agenda pack, on early access to maternity services in the borough.</p>	

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The Board discussed the reasons why women notified GPs of their pregnancies at a late stage, including those women who had entered the country illegally or that had no recourse to public funds to present early on in their pregnancy. This also had an impact on women from BME groups who were living in the country legitimately as there was a perception that their immigration status may be questioned. This perception also led to women presenting at a very late stage, or actually in labour, (i.e. as emergencies) meaning that they received no ante natal care.

It was noted that another common reason for not presenting early on in pregnancy were cultural beliefs that meant that women believed that it would be bad luck to discuss their pregnancy at an early stage.

The Board was advised that the collection and analysis of data in this area was also difficult as there was a large transient population in the borough that was comprised of many different BME groups. At present Somali and Romanian groups were known to be moving into the borough; however, this often shifted and changed rapidly.

In conclusion the Chair noted that the trajectory of performance was moving the right direction; however, continued work in this area was required to address the points discussed above and those outlined in the presentation. There was agreement that the Board should continue to receive regular updates with respect to the work being undertaken to improve performance in this area.

RESOLVED:

- i. That the current performance against the target for early access to maternity services be noted.
- ii. That Board would support the promotion of early access to maternity services, particularly amongst women from groups previously identified as likely to book late.

Alternative options considered

Not applicable.

Reasons for decision

Not applicable.

CNCL80. NHS ENGLAND - PERFORMANCE OF IMMUNISATION AND SCREENING PROGRAMMES IN HARINGEY

The Board considered a report, previously circulated from NHS England, which set out the performance of NHS screening programmes within the borough and the actions being taken by NHS England and other stakeholders to address areas of underperformance.

As set out in the report there had been a slight decrease in childhood immunisation and a larger decrease in cervical screening coverage for women aged twenty-five to forty-nine years of age during Quarter 2. The

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Board was reminded that the Director of Public Health (DPH) had statutory responsibilities with regard to local health protection arrangements and that DPH had to be satisfied that there was adequate provision for immunisation and screening plans in place. As such NHS England had been asked to provide further information with regard to the arrangements that they were putting in place to improve performance in these areas.

Following a presentation from NHS England the Board discussed the report and the following points were made:

It was noted that the information presented was for quarter two and that this was now likely to be out of date and therefore was not helpful for GPs trying to measure their own performance and for CCGs making commissioning decisions.

The Board was advised that NHS England had dedicated officers in place to liaise with GP practices in terms of data collection and performance; however, in many cases, the Cover Data collected by GPs did not match the information collected by NHS England. This had been an ongoing issue and it was suggested that the information collected by GPs was often more up to date than that collected by NHS England.

NHS
England

It was requested that GPs were sent information regarding the systems and structures in place for collecting data and that this should include contact details for the officers responsible for liaising with GPs on the collection of data.

There was discussion with regard to screening undergone privately and in other countries and the impact of this upon local GP screening rates. The Board was advised that NHS England accepted screening results provided privately and from other countries with the proviso that patients should also book in for an appointment with their local GP for a further test. Concern was expressed that this approach meant that people who had been tested privately were unlikely to want to come and have another test or pass on the results of their initial test to their GPs if they were clear and that this would impact on screening rates. There were also concerns with regard to the effectiveness of screening carried out in countries outside the UK.

NHS
England

There was agreement that it would be useful if performance data was shared with the CCG and it was confirmed that NHS England were able to do this and would contact the CCG following the meeting. It was also agreed that immunisation data in relation to children should also be included in future performance reports from NHS England.

In conclusion the Director of Public Health noted that in order for the information gathered to be used effectively, and for GPs and the CCG to monitor performance in a meaningful way, it needed to be shared in a timely and consistent way and collected effectively. It was also clear that the liaison role with GPs needed to be strengthened and that more discussion was required with GP practices.

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RESOLVED:

- i. That the new governance arrangements for immunisation and screening programmes across London aimed at providing assurance to the Directors of Public Health on the overall performance of these programmes be noted;
- ii. That the progress with regard to screening and immunisation programmes in Haringey, as set out in the report from NHS England, be noted.
- iii. That the slight decrease in childhood immunisation in Haringey in Quarter Two and a larger decrease in cervical screening coverage for women aged 25 to 49 (from 69% in Quarter 1 to 63% in Quarter 2) be noted.
- iv. That it be noted that the Director of Public Health had advised NHS England to provide further information on the arrangements they were putting in place to improve performance referred to in iii) above.

NHS
England

Alternative options considered

None listed.

Reasons for decision

None listed.

CNCL81. HEALTHWATCH PROGRAMMES

The Board considered a report, previously circulated, which set out Healthwatch's proposed Strategy and Work Programme for 2014/15.

An overview was provided of how the challenges and priorities for year two had been identified and it was noted that these were aligned to the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy. A 'hub and spoke' model had been developed to illustrate priorities for year two and this approach allowed cross cutting themes and broad priorities to be articulated. Although these were stated in general terms within the document there would be prioritisation within each of these areas in order to ensure that the organisation's impact was maximised. The proposals also aimed to ensure that the resources were used as effectively as possible by deploying staff, volunteers and board members strategically to engage with the refresh of the Health and Wellbeing Strategy and other key areas of work.

In response to a question as to how Healthwatch would ensure that the appropriate weight and focus was attached to each of the 'spokes' the Board was advised that data was collected and that this would be analysed and patterns of need would be identified. The Director of Public Health noted that it would be important that focus and resources were channelled to those areas of most priority.

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RESOLVED:

- i. That the overall proposals for 2014/15 and the detailed work set out in the plan attached to the report be noted.
- ii. That it be noted that comments made by the Board would be referred to the Councils contract manager responsible for managing the Healthwatch contract for consideration.

Alternative options considered

Not applicable – submission of the report to the HWB is a statutory requirement.

Reasons for decision

For information only.

CNCL82. LSCB ANNUAL REPORT

The Board considered a report, previously circulated, which presented the Local Safeguarding Children Board's (LSCB) Annual Report 2012/13 and Business Plan 2013/14 for noting.

The Board was reminded that under the Children Act 2014 the LSCB was required to submit its annual report to the HWB in order to strengthen the links between the two bodies and to assist them in coordinating the arrangements for safeguarding and promoting the welfare of children in Haringey.

There was discussion with regard to work being undertaken in relation to addressing Female Genital Mutilation (FGM) and there was agreement that the DGBV strategic group and LSCB should coordinate a response to the issues raised.

There was agreement that formalising the process for learning from Serious Case Reviews (SCRs) was an area that needed to be developed and that this should encompass all partners in order to ensure that this was meaningful. It was also noted that recognising good practice and positive outcomes and learning from these was also important and it was suggested that this should be strengthened too.

RESOLVED:

That the content of the Haringey LSCB Annual Report 2013 and Business Plan 2013/14 be noted.

Alternative options considered

Statutory guidance provides for the Annual Report to be reported up to the Board and therefore no alternative options have been considered.

Reasons for decision

Not applicable – the report is for noting only.

Dir Public
Health /
Dir CS's

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<p>CNCL83.</p>	<p>AUTISM INCLUDING SELF-ASSESSMENT</p> <p>The Board considered a report, previously circulated, which set out progress made in Haringey's response to the Autism Strategy 2010.</p> <p>RESOLVED:</p> <ul style="list-style-type: none"> i. That the progress made in Haringey's response to the Autism Strategy be noted. ii. That it be noted that outcomes for people with autism would continue to be actively monitored and reviewed. iii. That it be noted that progress reports would be made to the Health and Wellbeing Board annually. <p>Alternative options considered Not applicable. The statutory guidance accompanying the Autism Strategy states that Health and Wellbeing Boards will play a key part in the planning, commissioning and reviewing of services for people with autism.</p> <p>Reasons for decision This is a non-key decision; however, as the Autism Strategy guidance is statutory, local Council's and local health bodies have a legal duty to implement it.</p>	
<p>CNCL84.</p>	<p>NEW ITEMS OF URGENT BUSINESS</p> <p>There were no new items of urgent business.</p>	

The meeting closed at 3.50pm.

Councillor Bernice Vanier

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Chair

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APPENDIX 1

Meeting Date	No	Action Description	Lead	Action Taken
07/01/2014	1	It was agreed that Lisa Redfern and Sharon Grant would discuss Healthwatch support for safeguarding work outside the meeting.	Lisa Redfern	Discharged - ongoing
07/01/2014	2	Can Healthwatch be invited to relevant Haringey Stat sessions? Jeanelle de Gruchy to discuss with Zina Etheridge <i>In process of doing HaringeyStat and inviting Healthwatch to appropriate sessions</i>	Jeanelle de Gruchy	
07/01/2014	3	Clarification required over drug performance on report.	Jeanelle de Gruchy	Discharged
07/01/2014	4	Homelessness: Complex issues around those without recourse to public funds and the current status of migrants from the EU. Greater clarity is required for the board to fully understand this issue issues around those without recourse to public funds, and the current status of migrants from the EU.	Jeanelle de Gruchy	Report to come to the board in July 2014
07/01/2014	5	Screening and Immunisation: It was agreed that the first formal performance report from NHSE should be requested for the 8 April 2014 meeting of the Board, with quarterly updates thereafter.	Jeanelle de Gruchy	Tamara to bring performance data to April Meeting

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11/02/2014	6	Better Care Fund: Consideration be given to having a separate identified work stream for patient / user engagement set out under ways of working for April 2014 – March 2015 (paragraph 6.20 of the report.)	Sarah Price/ Phung Mun Thong	Reference groups to be established (one already in place) and consideration to incorporating patient/service user representation in the BCF governance structure
11/02/2014	7	Better Care Fund: Consideration to be given to Healthwatch forming part of the Integrated Management Board as set out in paragraph 6.30	Sarah Price/ Phung Mun Thong	Healthwatch to be part of advisory group. Advisory Group currently being set up which already represented on the HWB which has executive and policy oversight of the BCF
11/02/2014	8	Better Care Fund: consideration to be given that engagement with Healthwatch could help to reduce some of the risks as identified in the risk log at paragraph 6.46 of the report	Sarah Price/ Phung Mun Thong	Risk log to be taken to the Advisory Group providing its members, including Healthwatch, with an opportunity to contribute to the mitigation of risks and issues.
11/02/2014	9	Better Care Fund: In response to a question regarding value-based commissioning, it was agreed that it was intended that there be a strong focus on this, and that elements of the Plan could be reworded if it was not felt that this was coming through with sufficient emphasis. Rachel Lissauer paper to be circulated.	Sarah Price/ Phung Mun Thong	
11/02/2014	10	It was noted that, at paragraph 6.31 of the report, reference was made to the Chief Executive of Healthwatch being a member of the Health and Wellbeing Board, whereas this should read the Chair of Healthwatch. To be corrected.	Sarah Price/ Phung Mun Thong	Discharged
11/02/2014	11	Tottenham Strategic Regeneration Framework: Health impact assessments should be carried out on key policies and	Jeanelle de Gruchy	On going


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		programmes to assess their health and wellbeing impact.		
11/02/2014	12	<p>Tottenham Strategic Regeneration Framework: The Health and Wellbeing Board should have a role within the governance structure for the Tottenham regeneration programme, and it was agreed that this should be the case, although further discussions would be needed outside the meeting regarding what form this should take.</p> <p>Meeting to be arranged between Cllr Vanier, Jeanelle de Gruchy, Malcolm Smith, Zina Etheridge and Jan Doust</p>	Jeanelle de Gruchy, Malcolm Smith	
11/02/2014	13	<p>Tottenham Strategic Regeneration Framework: It was agreed that the Health and Wellbeing Board needed a clear outline of the process for developing this framework, and a timetable setting out where the document was going, and the points at which the Board would have the opportunity to have input. It was felt that the Board needed to be involved in the development of the document, and was in a position to offer robust challenge around health and wellbeing aspects. The way forward on this would be discussed outside the meeting.</p> <p>Meeting to be arranged between Cllr Vanier, Jeanelle de Gruchy, Malcolm Smith, Zina Etheridge and Jan Doust</p>	Jeanelle de Gruchy, Malcolm Smith	
11/02/2014	14	<p>NHSE Performance in Primary Care: In response to question a) <i>Would you agree that the planned development of around 10,000 extra homes in Tottenham under the current</i></p>	Vanessa Lodge	

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		<p><i>regeneration plans will require between 14 and 19 GPs, or between 3 and 5 average sized GP practices, to serve the additional population?</i></p> <p>It was reported that this was not an uncommon situation, and that processes were in place regarding the way in which patients would register with GPs.</p> <p>12/03 – Vanessa Lodge has passed on the strategy documents to the primary care commissioning team so they can review the plans for increase in housing. At some appropriate point in the process do need formally for the LA to contact NHS England primary care commissioning team so that they can formally engage.</p> <p>Zina Etheridge and Sarah Price to meet NHSE outside of meeting.</p>		
11/02/2014	16	<p>NHSE Performance in Primary Care: In response to question from the public: <i>b) What steps are being taken, and by whom, to ensure that adequate premises will be available for the new GPs who will be needed?</i></p> <p>It was noted that this was a question of capital allocations, and that information on this would be provided after the meeting.</p> <p>12/03 - paper circulated by Vanessa Lodge.</p>	Vanessa Lodge	<i>ongoing</i>

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		 NHSE Commissioning NHS Premises.pdf		
11/02/2014	17	<p>NHSE Performance in Primary Care: In response to question from member of the public: <i>What assessments have been made of the other health facilities (e.g. child health clinics, dental care, urgent/out of hours care, mental health clinics and beds) which will be needed by the additional population and where will these be provided?</i></p> <p>It was reported that there was a need to make the most of existing facilities for the local population, and that additional detail on this point could be provided after the meeting.</p> <p>12/03 – Vanessa Lodge reported back: This relates to early point about formal engagement with NHS England about plans.</p> <p>Zina Etheridge and Sarah Price to meet NHSE outside of meeting.</p>	Vanessa Lodge	
11/02/2014	18	<p>NHSE Performance in Primary Care: The system for making complaints about a GP was felt to be very complex, and Ms Lodge was asked whether it would be possible to feed back to NHSE and/or the CQC that there was a need to make the system easier for the public to understand. Ms Lodge advised that training</p>	Vanessa Lodge	

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		<p>with GP practices had been arranged to improve local capacity for dealing with complaints</p> <p>12/03 - Training plan in place for GP practices. Vanessa Lodge has checked that all practices were advised about new complaints contact details prior to April 2013. We will put a reminder in the next GP newsletter.</p>		
11/02/2014	19	<p>NHSE Performance in Primary Care: With regard to complaints, it was further suggested that there be a specific NHSE work stream around getting information out to the public about how to make feedback about the services they received, and informing people about the revalidation programme.</p> <p>It was agreed that this suggestion would be fed back to NHSE.</p> <p>12/03 - Have fed this into the medical director who lead the revalidation programme. Feedback from patients is not yet a requirement.</p>	Vanessa Lodge	
11/02/2014	20	<p>NHSE Performance in Primary Care: The member of the public spoke to express concern regarding the mechanisms in place to ensure that there were sufficient premises for GP practices to meet the demand from new homes being built, and also for making GPs aware of the new opportunities being developed.</p> <p>Ms Lodge advised she would take these concerns back to NHSE, and then report back</p>	Vanessa Lodge	

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		on the mechanisms to address these issues.		
11/02/2014	21	<p>NHSE Performance in Primary Care: It was suggested that there should be an NHSE representative on the Health and Wellbeing Board, as primary care commissioning was not currently represented.</p> <p>Jeanelle de Gruchy to discuss with Cllr Vanier.</p>	Jeanelle de Gruchy	Ongoing

Key

	<i>Action Discharged</i>
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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	Update from the Outcome 1 Delivery Group		
Report Authorised by:	Charlotte Pomery, Assistant Director Commissioning		
Lead Officer:	Charlotte Pomery, Assistant Director Commissioning		
Ward(s) affected: All	Report for Key/Non Key Decisions: N/A: for noting		

1. Describe the issue under consideration

1.1 Three Health and Wellbeing Board Delivery Groups have been set up to cover each of the outcomes from the Health and Wellbeing Board's Strategy 2012- 2015. These 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.

This report provides an update to the Health and Wellbeing Board with regards to the progress from the Delivery Group for Outcome 1.

2. Cabinet Member introduction

N/A

3. Recommendations

3.1 Members of the Health and Wellbeing Board are asked to note, discuss and comment on the contents of the report and the proposed direction of travel for the Early Years Strategy.



Haringey Council

4. Alternative options considered

N/A

5. Background information

- 5.1 Early years represents the best early intervention opportunity across the public sector to improve long-term outcomes for local residents and reduce the future financial burden on the state. The evidence base for effective interventions in the early years from conception through to five is growing and underlines the importance of a strong approach by the council and its partners.
- 5.2 The Corporate Delivery Unit's (CDU) review of early years provision in Haringey has demonstrated that, whilst there are many strengths – for example, in the achievement of some outcomes – there are challenges, most notably in the area of early education: only 50 per cent of children here have a 'good' level of development and are ready for school (year one of the national curriculum) by the end of reception year. This assessment at Early Years Foundation Stage covers a range of indicators including emotional health and wellbeing and speech and language development as well as educationally based indicators such as letter and word recognition.
- 5.3 In response to the review and to ensure strategic coherence to improving early years across Haringey, the Early Years Partnership Board has been strengthened and is producing a draft Early Years Strategy with the input of partners including health (provision and commissioning), education, social care, public health, the DWP, adult learning, the private and maintained sectors for child care provision and the voluntary and community sectors. Given its broad remit and approach built on partnership, the decision was taken that the Early Years Partnership Board (the Board) will also act as the Delivery Group for Outcome 1 of the Health and Wellbeing Strategy. Members of the Board are actively involved in the process to refresh the Health and Wellbeing Strategy and aim to ensure coherence of approach going forward.
- 5.4 The main focus of the Board over the last few months has been to build the partnership and collaborative working necessary to support and drive improvements in early years outcomes and to develop an Early Years Strategy (the Strategy) for the borough. The Strategy is very much a partnership document and the vision sets out our shared ambition to improve outcomes for children in their early years – this is emerging as improved outcomes and opportunities for young children and their families which seek the success of the best in London for all our residents, as one borough.



Haringey Council

- 5.5 The draft Strategy is built across four draft priorities which reflect the outcomes set out in the corporate plan:

Priority 1: Improve access to integrated early help services

Priority 2: Improve the health and well being of our young children

Priority 3: Ensure high quality early education and childcare provision for all

Priority 4: Improve access to child care provision

- 5.6 Underlying the Strategy, and drawing together many of the key strategic elements, the Early Years Partnership Board is exploring the possibility of implementing a Universal Healthy Child Programme (the Programme) for Haringey. Whilst pressures on Health Visitor numbers may pose some challenges, the Early Years Partnership Board supports the view that the Programme is best delivered through a partnership approach which would be supported through integrated and collaborative working across a range of clinicians and practitioners. The approach to greater joined up working, therefore, will be developed in response to delivery of the Programme on a universal basis.
- 5.7 The Early Years Partnership Board is working up an operating model for early years provision which will drive improved outcomes for young children and their families at a locality level and build on community assets and strengths. This model will be aligned with the Early Help approach being developed for children and young people across the borough. This thinking is informed by rich data and analysis and notably by the work carried out to support the Big Lottery Fund application for Haringey. The focus, therefore, will be on developing family and community capacity, improving wider outcomes for families through improved access to learning and employment, peer support and joined up health provision and both supporting and holding the local network of early years provision to account for improved outcomes for local young children.
- 5.8 The Strategy will also address quality improvement across all areas of early years provision in the borough. The picture of quality is extremely varied currently, but there are real opportunities to target our capacity and to create a more sustainable approach going forward centring on equity and improved reach.
- 5.9 HAVCO is supporting the engagement of parents and carers in the development of the Strategy and operating models and the voice of parents and carers will contribute both to the thinking and to the final articulation of the Strategy and its recommendations.



Haringey Council

6. Comments of the Chief Finance Officer and financial implications

6.1 There are no financial implications arising directly from this paper.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications arising out of this report

8. Equalities and Community Cohesion Comments

8.1 This report is essentially for information of the Early Years Partnership Board (the Board) regarding progress from the Delivery Group for Outcome 1 – Giving every child the best start in life - of the Health and Wellbeing Board's Strategy 2012 – 2015. As such, Policy and Equalities Team have no specific equalities comments to make at this stage.

8.2 However, we note in paragraph 5.3 of the report that the Early Years Partnership Board is producing a draft Early Years Strategy with input from partner Services and agencies and will also act as the Delivery Groups for Outcome 1 referred to in 8.1 above. It is also noted in paragraph 5.6 that the Board is exploring the possibility of implementing a Universal Healthy Child Programme for Haringey.

8.3 The Board should be aware that both the draft Early Years strategy it is producing and the Universal Healthy Child Programme it is considering implementing would have significant implications for the Council's public sector equality duty should both be considered for a full equality impact assessment in due course. It would also require that appropriate indicators are agreed and used to monitor delivery to ensure that the corporate plan priorities restated in paragraph 5.5 of the report are delivered to all Haringey's children whatever relevant protected characteristics they may possess within the meaning of sections 4 – 12 and 17 of the Equality Act 2010.

9. Head of Procurement Comments

N/A

10. Policy Implication

10.1 The Health and Wellbeing Strategy aims 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 main objective of this Delivery Group is to improve outcomes contained in Outcome 1 of the strategy: 'to give every child the best start in life'.



Haringey Council

11. Reasons for Decision

11.1 For Information only

12. Use of Appendices

N/A

13. Local Government (Access to Information) Act 1985

N/A

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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	Performance Report on Child Obesity: Public Health Update		
Report Authorised by:	Jeanelle De Gruchy, Director of Public Health.		
Lead Officer:	Debbie Arrigon – Public Health Commissioner		
Ward(s) affected: All wards but with a priority on the 8 Tottenham wards as in the Tottenham Regeneration Strategy	Report for Key/Non Key Decisions: N/A: for noting		

1. Describe the issue under consideration

- 1.1. Childhood obesity is priority three in the Health and Wellbeing Strategy Outcome 1: Giving every child the best start in life
- 1.2. This presentation is an update on analysis of child obesity in the borough for the Health and Wellbeing Board
- 1.3. The Health and Wellbeing Board are asked to
 - 1.3.1. Note the key issues raised
 - 1.3.2. Understand and contribute to the whole-system approach to tackling child obesity and further advise on how the Health and Wellbeing Board will be involved in this whole-system approach

2. Cabinet Member introduction

N/A

3. Recommendations

- 3.1. It is recommended that the Health and Wellbeing Board:



Haringey Council

3.1.1. Note the key issues raised

3.1.2. Understand and contribute to the whole-system approach to tackling child obesity and further advise on how the Health and Wellbeing Board will be involved in this whole-system approach

4. Alternative options considered

No alternatives were considered.

5. Background information

5.1. Obesity in the UK is rapidly rising. By 2050 it is predicted that 60% of men and 50% of women will be obese. Obesity has serious implications in reducing life expectancy. On average it is estimated that it takes 9 years off life due to obesity-related disorders and complications such as diabetes, with the consequent huge economic burden on health services estimated at £27 billion for 2015.

5.2. Child obesity is a particularly worrying trend, with often long-term effects: obese children are more likely to be ill and therefore absent from school, experience health-related limitations and require more medical care than healthy weight children. They are more likely to experience bullying and mental health issues including low self-esteem and are also at a higher risk of becoming an obese adult.

5.3. Child obesity is measured annually as part of the National Child Measurement Programme (NCMP), **key findings** are:

5.3.1. In Haringey, a higher proportion of children are obese in both reception and year 6 than London and England as a whole.

5.3.1.1. In Reception (ages 4-5) - **1 in 4** children are overweight or obese

5.3.1.2. In Year 6 (ages 10-11) - over **1 in 3** children are overweight or obese

5.3.2. The Haringey trend for reception aged children has been very similar to England's; however for children in Year 6, has remained consistently above this.

5.3.3. Obesity levels in Haringey are closely linked to **deprivation**: Reception year children living in deprived areas are 2 times more likely to be overweight or obese than children in more affluent areas; this rises to 2.5 times more likely in Year 6 children.

5.3.4. Children living in the **east** of the borough generally have higher levels of overweight or obesity than children living in the west of the borough.

5.3.5. Children from **Black and minority ethnic (BME)** groups are more likely to be obese than children that are White British. Rates of overweight or obesity



Haringey Council

amongst Black African children are double those of children that are White British.

5.4. Key Actions and Challenges:

5.4.1. Child obesity is a complex issue which has several complex challenges such as:

- 5.4.1.1. Lack of awareness and perceptions of a “healthy weight” (issues around social norms.
- 5.4.1.2. Difficulty in raising the issue of weight and the patterns and/or sensitive nature of familial obesity
- 5.4.1.3. Access to affordable and healthy food and the marketing (and specifically the targeted marketing to children) and availability/affordability of fast food.
- 5.4.1.4. An important local challenge is looking at the clear disparity between overweight and obesity levels in the east compared to the west of Haringey, particularly our Tottenham wards.
- 5.4.1.5. To help tackle these issues we are working closely with early years settings and schools: strongly promoting early intervention and prevention strategies through breastfeeding initiatives and the HENRY (Health Exercise Nutrition for the Really Young) programme, which helps families with very young children, develop skills around healthy eating and leading an active lifestyle.
- 5.4.1.6. Making every contact count – and ensuring that the brief intervention training – *Raising the Issue of Weight* - is well attended from a variety of local professionals.
- 5.4.1.7. Strengthening our Healthy Schools Programme to help support schools in becoming natural hubs of health & wellbeing, including targeting evidence-based interventions in schools where they are most needed.

6. Financial Implications and comments of the Chief Finance Officer

6.1. There are no direct financial implications arising from this report. Work on reducing childhood obesity is funded from existing resources within Public Health and Children’s services.

7. Head of Legal Services and legal implications

7.1. The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications.



Haringey Council

8. Equalities and Community Cohesion Comments

- 8.1.** As highlighted in paragraph 3 of this report, there are pronounced disparities in the prevalence of child over-weight and obesity across areas and ethnicities in Haringey, with children in the east of the borough more likely to be overweight and obese than in the west and children from certain ethnic groups more likely than others to be overweight and obese than children of similar age who are from other ethnic groups.
- 8.2.** This threatens to add a new dimension to health and other inequalities that already exist in Haringey
- 8.3.** The Council has a public sector equality duty to amongst other things, advance equality of opportunity to health among all groups in Haringey.
- 8.4.** The measures outlined in this report to this duty by targeting actions at all groups, especially those at a higher risk of overweight and obesity.

9. Head of Procurement Comments

No comment required as this paper does not relate to the procurement of services.

10. Policy Implication

- 10.1.** The Health and Wellbeing Strategy aims 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 main objective of this Delivery Group is to improve outcomes contained in Outcome 1 of the strategy: 'to give every child the best start in life'.

11. Reasons for Decision

No decision required.

12. Use of Appendices

- 12.1.** Childhood Obesity in Haringey presentation

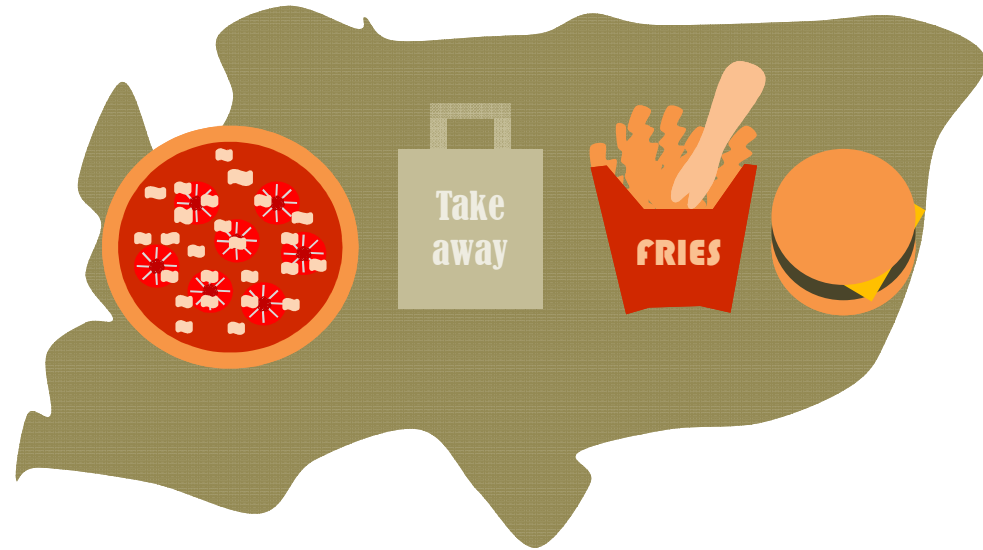
13. Local Government (Access to Information) Act 1985

N/A

14. Appendix 1: Childhood Obesity in Haringey presentation



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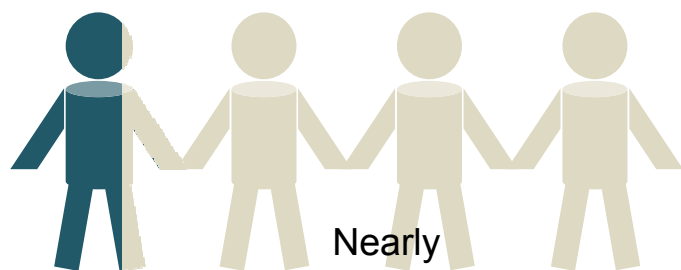
Childhood obesity in Haringey

Haringey Public Health update

Health and Wellbeing Board 1 July 2014

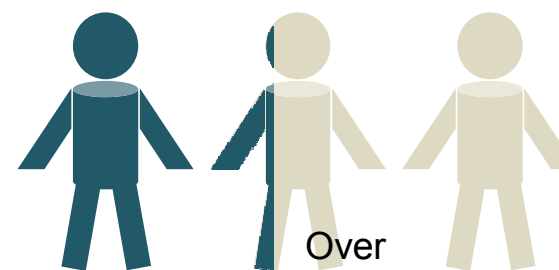
Prevalence of childhood obesity

In Haringey, a higher proportion of children are obese and overweight by year 6 than in reception year



1 in 4

children are overweight or obese in
reception year
(2013)



1 in 3

children are overweight or obese
in year 6
(2013)

2

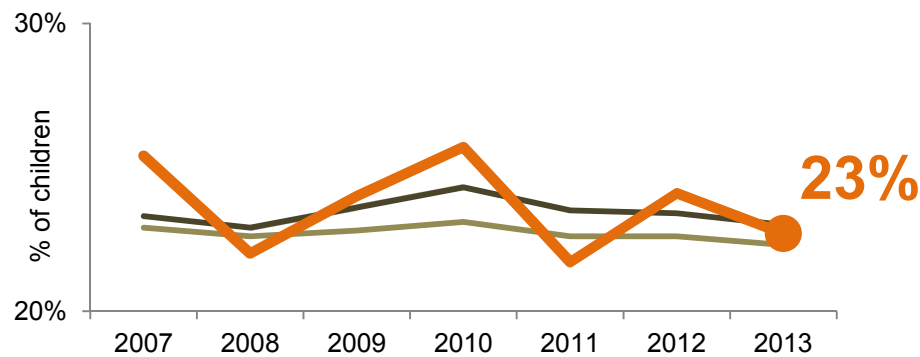
Source: Public Health England

Trends

Most recent trends show obesity and overweight in reception going down and rising in year 6

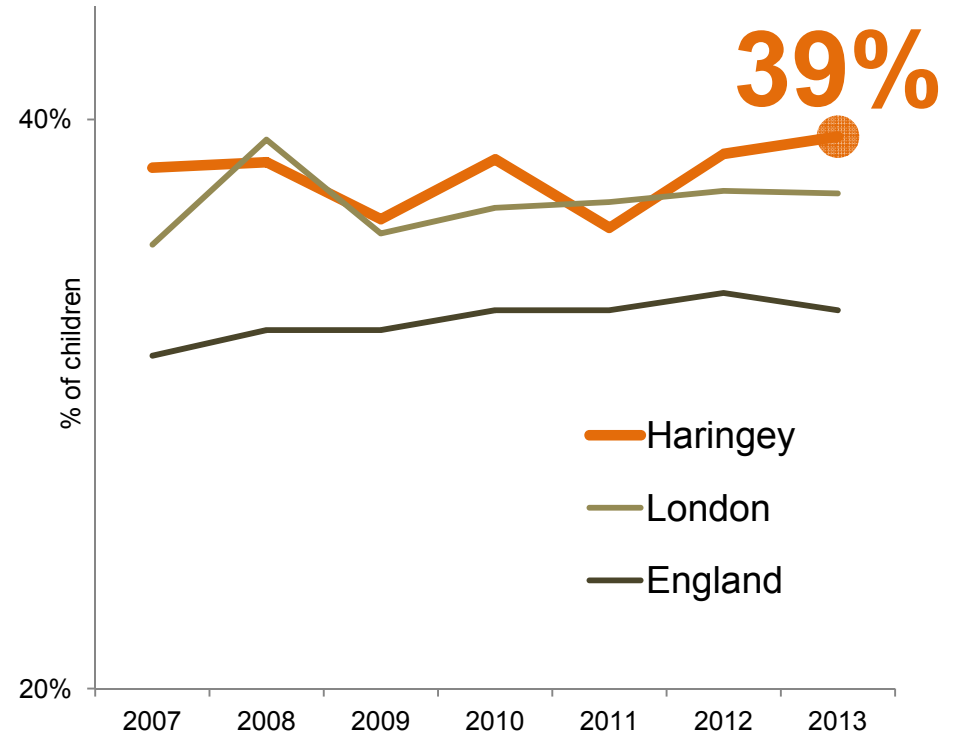
Reception children

% obese and overweight in Haringey 2013



Year 6 children

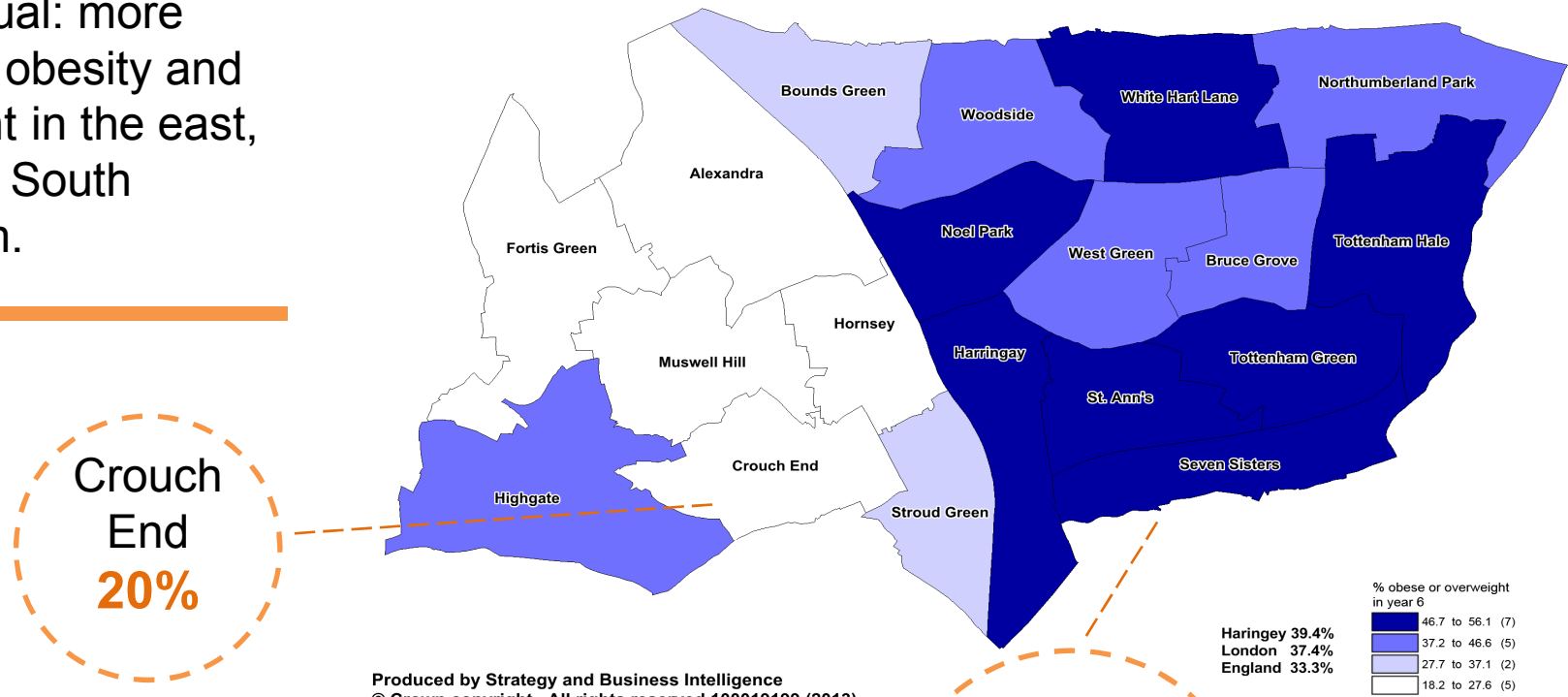
% obese and overweight in Haringey 2013



Differences by ward

Prevalence of overweight or obesity in year 6 by ward, 2013

Not all equal: more childhood obesity and overweight in the east, especially South Tottenham.



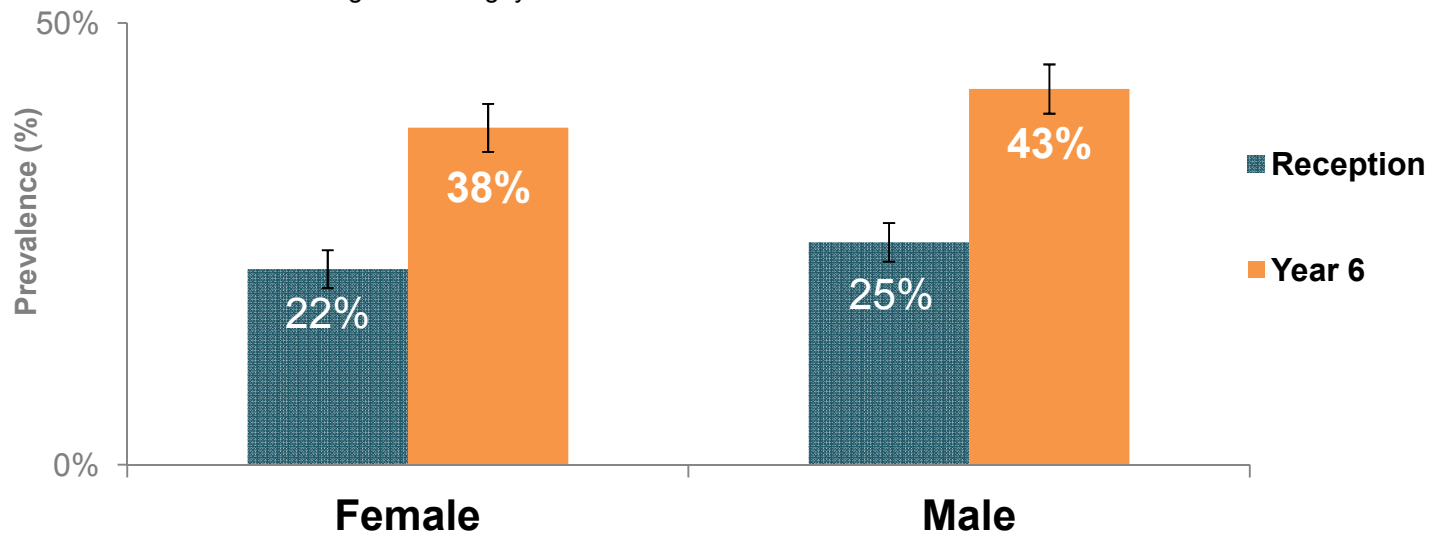
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Differences by gender

A higher proportion of boys are obese and overweight

Obesity and overweight by gender

% obese and overweight in Haringey 2013



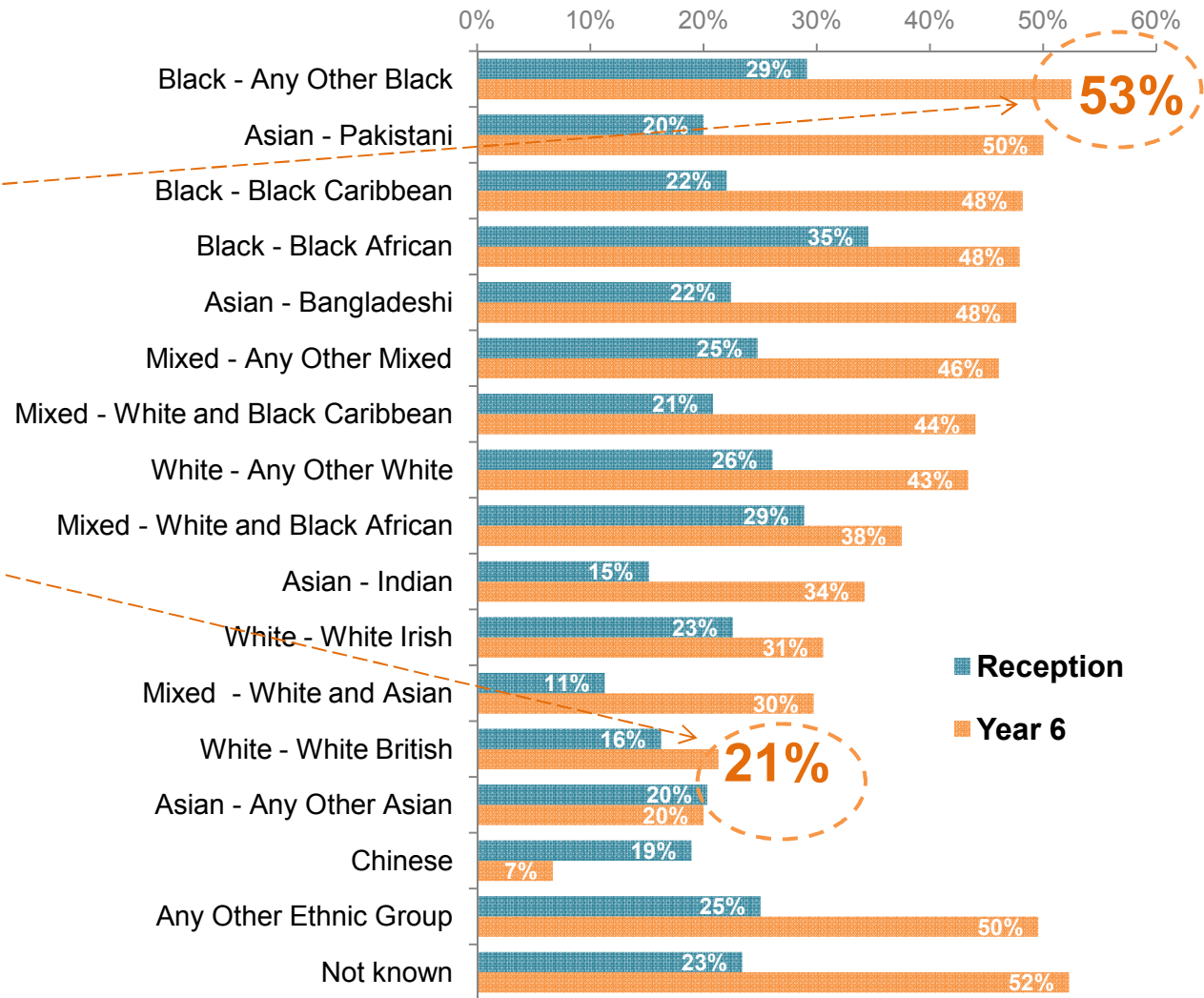
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Source: Public Health England

Differences by ethnicity

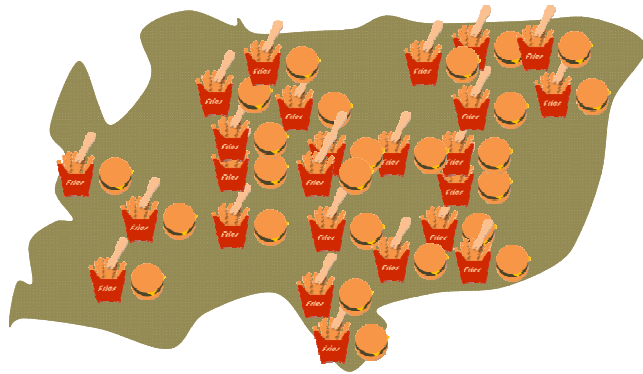
Around half of some black and minority ethnic groups are obese and overweight by year 6 compared to 1 in 5 white British children

Obesity and overweight by ethnicity
% obese and overweight in Haringey 2013



Public Health research on fast food outlets around schools: Key findings

Access & availability +



Affordability



+ Acceptability

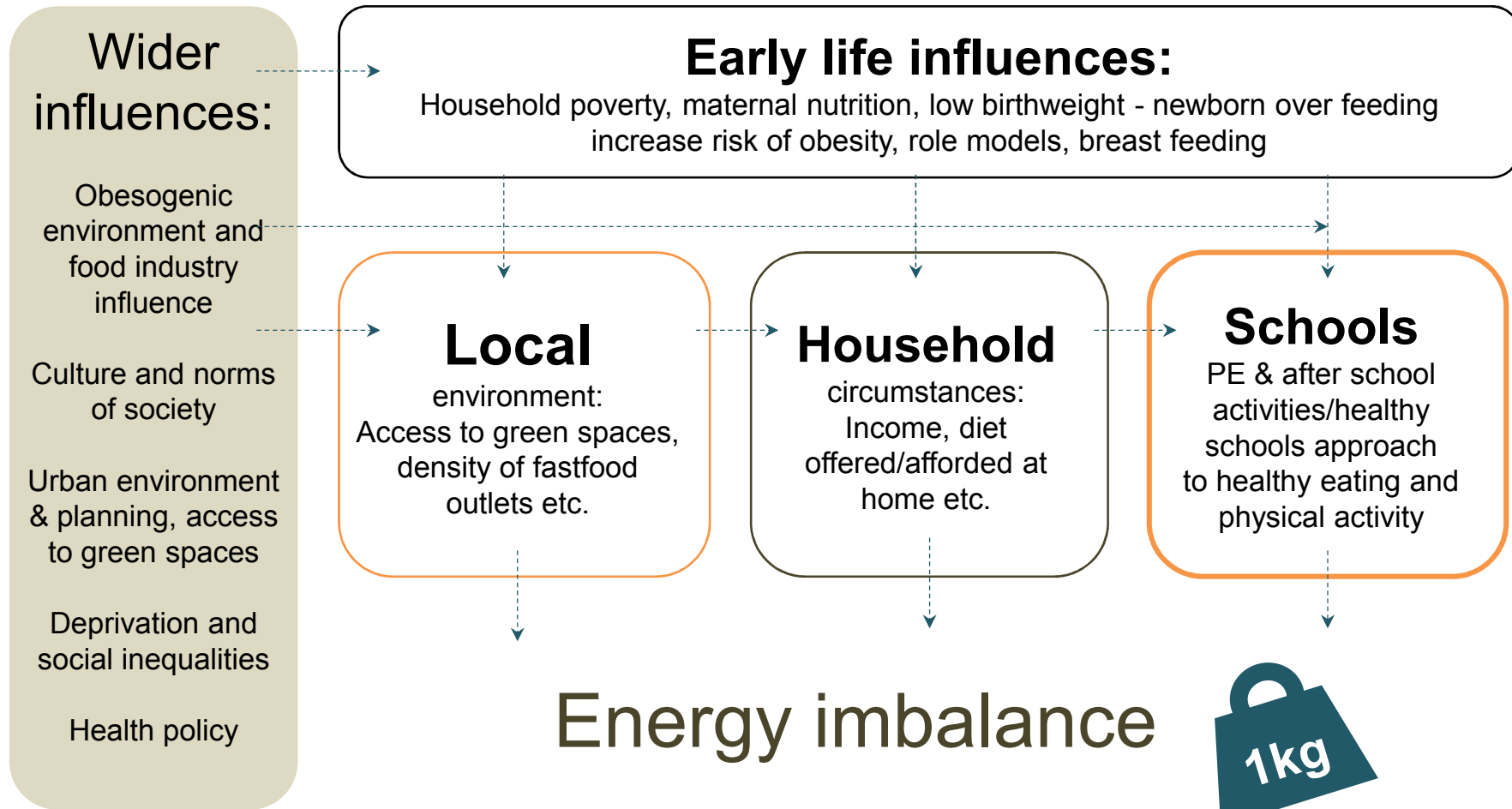


= **Obesity**

7

Source: City University (2013) Children's food choices on the streets around schools in Haringey: A wall of crisps and other food choices

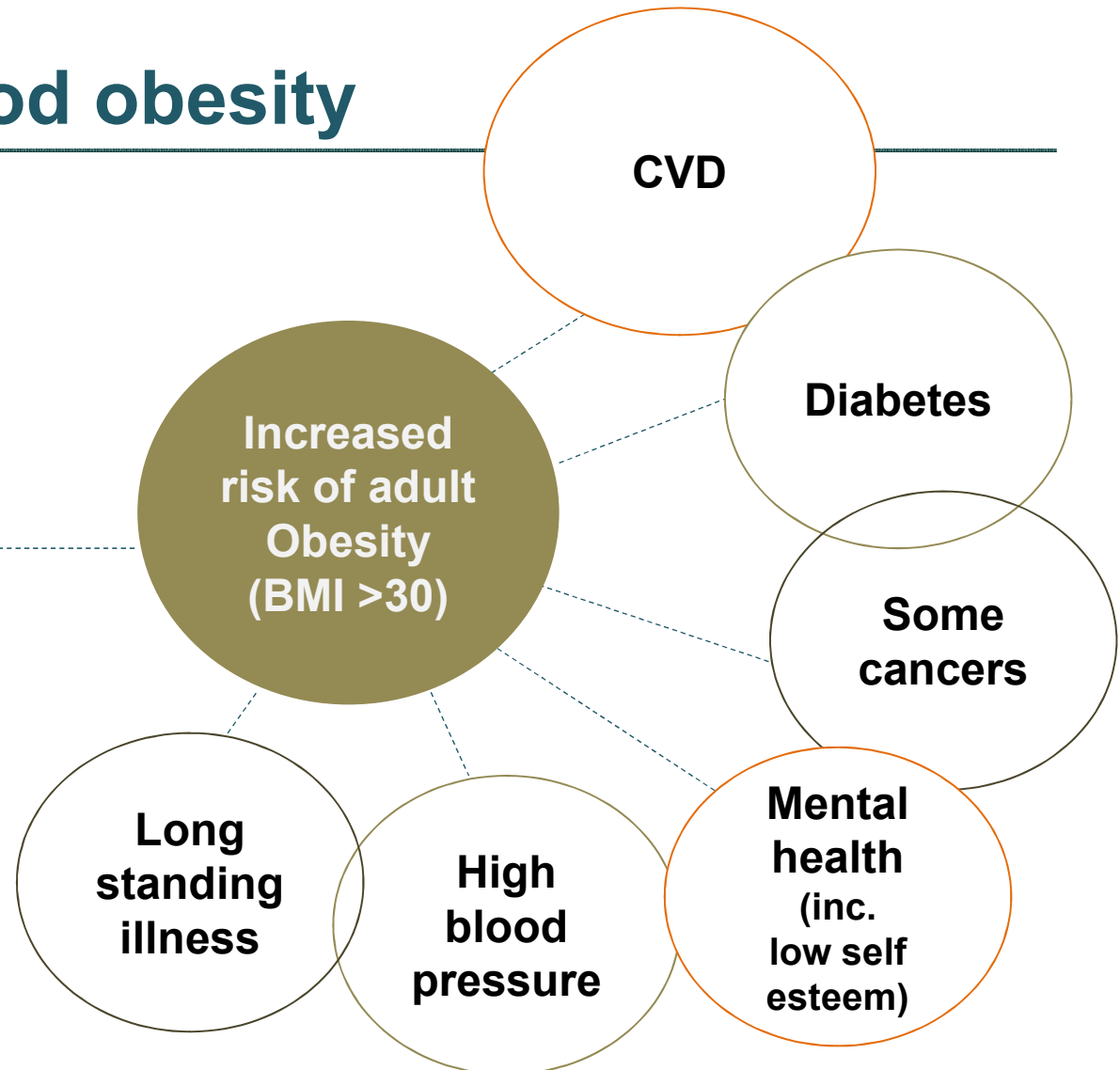
Risk factors and social determinants



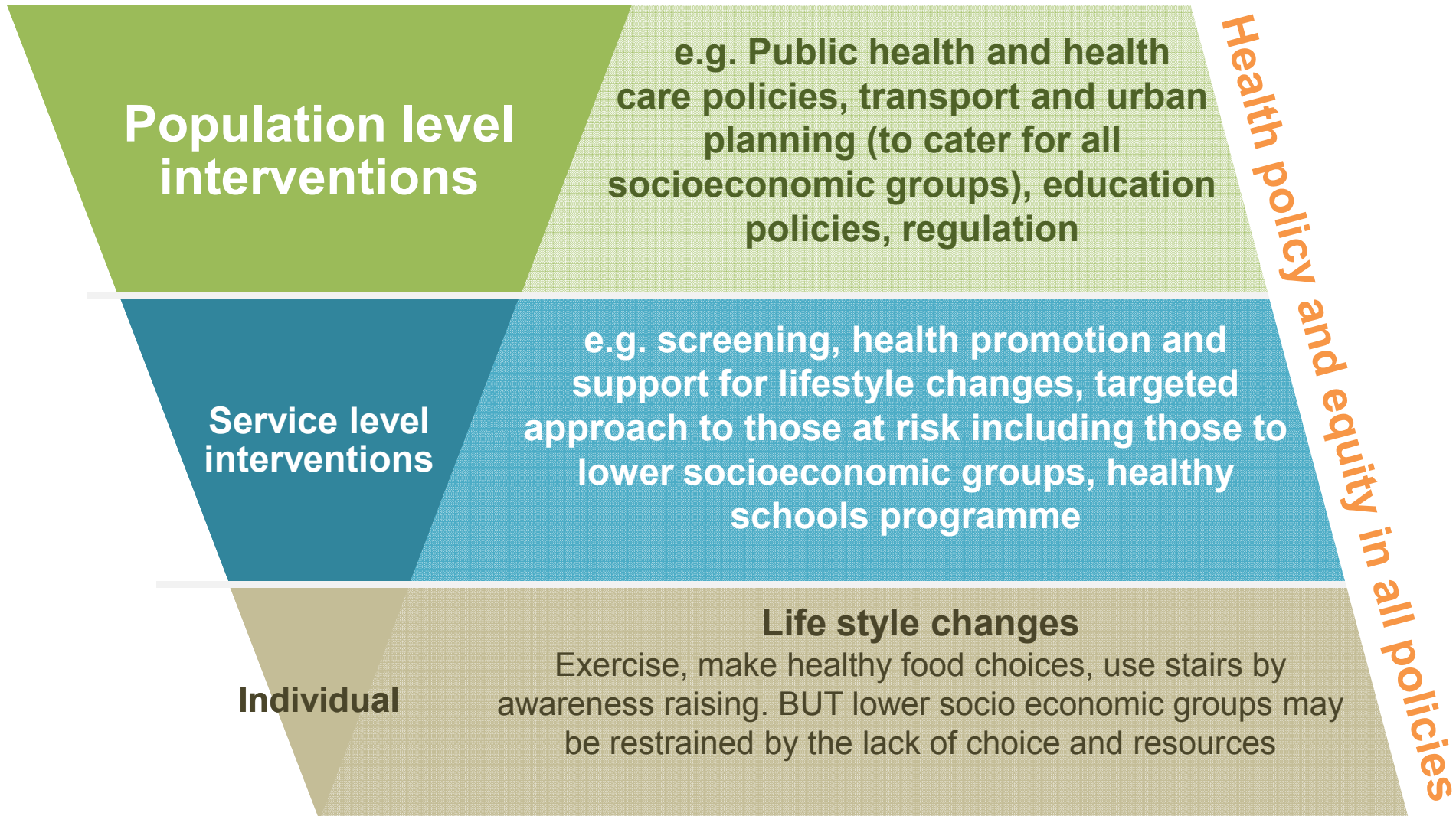
Impact of childhood obesity

- Illness and absence from school
- Asthma
- Health-related limitations
- Obstructive sleep apnoea
- Bullying
- by adolescence, at increased risk of low self-regard and impaired quality of life in obese individuals

Wijga et al, 2010; Egan et al 2013; Narang, Mathew, 2012

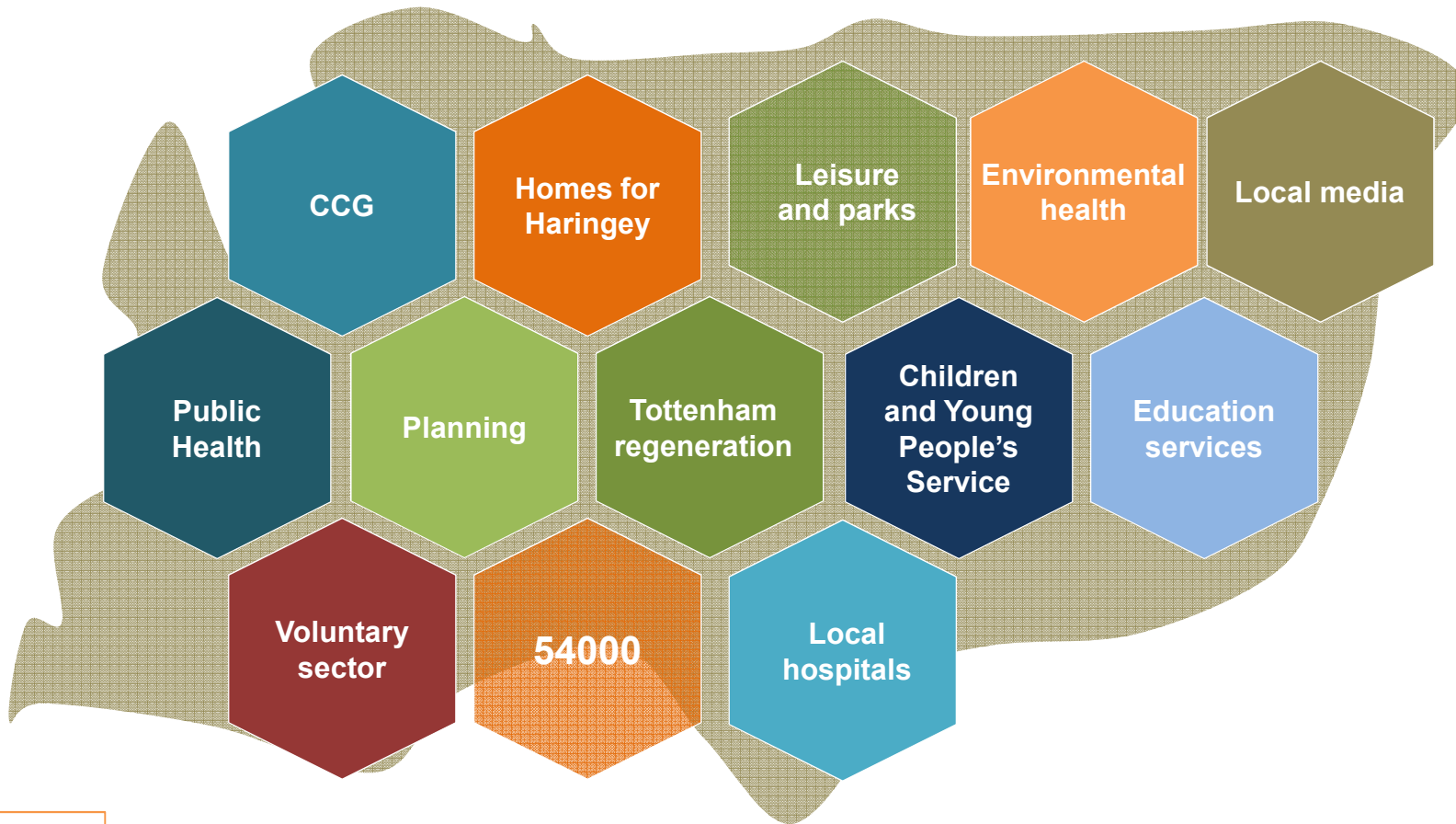


Source: Haringey JSNA, Childhood Obesity (2013)



It is all of our business

**healthy public
policy**



11

Current activities

Every contact counts

Public Health working closely with early years settings and schools

Implementing the fast food research recommendations in the new **School Food Plan**. Share good practice through the **Healthy Schools network**. Strengthening our **Healthy Schools Programme** to help support schools in becoming natural hubs of health & wellbeing, including targeting evidence-based interventions in schools where they are most needed.

Promoting **early intervention** and **prevention strategies** through **breastfeeding developments** and the **HENRY** (Health Exercise Nutrition for the Really Young) programme, which helps families with very young children develop skills around healthy eating and leading an active lifestyle.

Brief Intervention Training – *Raising the Issue of Weight* - is well attended by a variety of local professionals



Next steps

healthy public policy

Environmental health

Environmental Health: Public health additional environmental health officer post - introducing the **Healthier Catering Commitment (HCC)**. Hygiene compliant businesses in Tottenham to attend training to learn more about the HCC

Planning

Planning - A proposal for a **400m exclusion zone** for fast food outlets around schools was consulted on in March 2013. This is being further considered in light of consultation responses and the growing body of evidence

CCG

Recommendations for CCGs: **maternal obesity** within service specification for commissioning of maternity services; Actively promote the **brief intervention training** for families, to enable GPs and other health professionals to raise the issue of weight and offer brief interventions, ensuring that every contact counts.

Public Health

Public Health promoting the forthcoming childhood obesity pathway – formalising roles and responsibilities

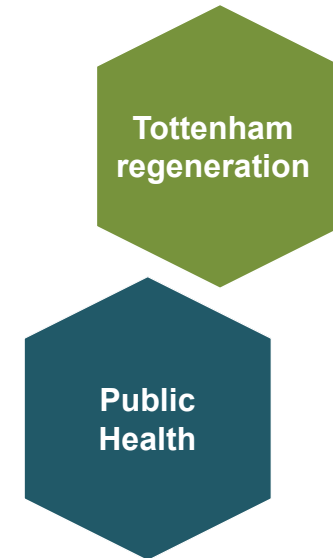
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Next steps

healthy public policy

Tottenham regeneration plan - Working together with regeneration programme we can ensure that healthy eating, physical activity and healthy weight are supported and enabled in public and community settings, health services and workplaces, by:

- **Increasing the range and accessibility of healthier meals** and snacks that are available to buy locally and across London
- **Increasing cycling and walking opportunities**, including safety, as part of transport redesign and the new Tottenham leisure offer
- **Increasing engagement and commitment** to tackle child obesity among partners in all sectors.
- **Ensuring delivery is supported by robust evaluation** and ongoing review. Childhood obesity is one of the three key health indicators proposed for the programme.



Example of community intervention best practise: EPODE approach



Food and physical environment:

- School meals programme; vending machine restrictions
- Adaptation of the playgrounds to encourage physical activity during breaks
- Organisation of sports and leisure challenges; and regular child-friendly activities led by local dieticians in school catering

Developing early awareness:

- Validated educational sessions on diet, exercise and obesity adapted to each school year, included across the curriculum
- Understanding the wider food economy: visits to supermarkets, farms, fisheries and markets; setting up school vegetable gardens
- Organisation of cooking classes involving parents and elderly people

Monitoring:

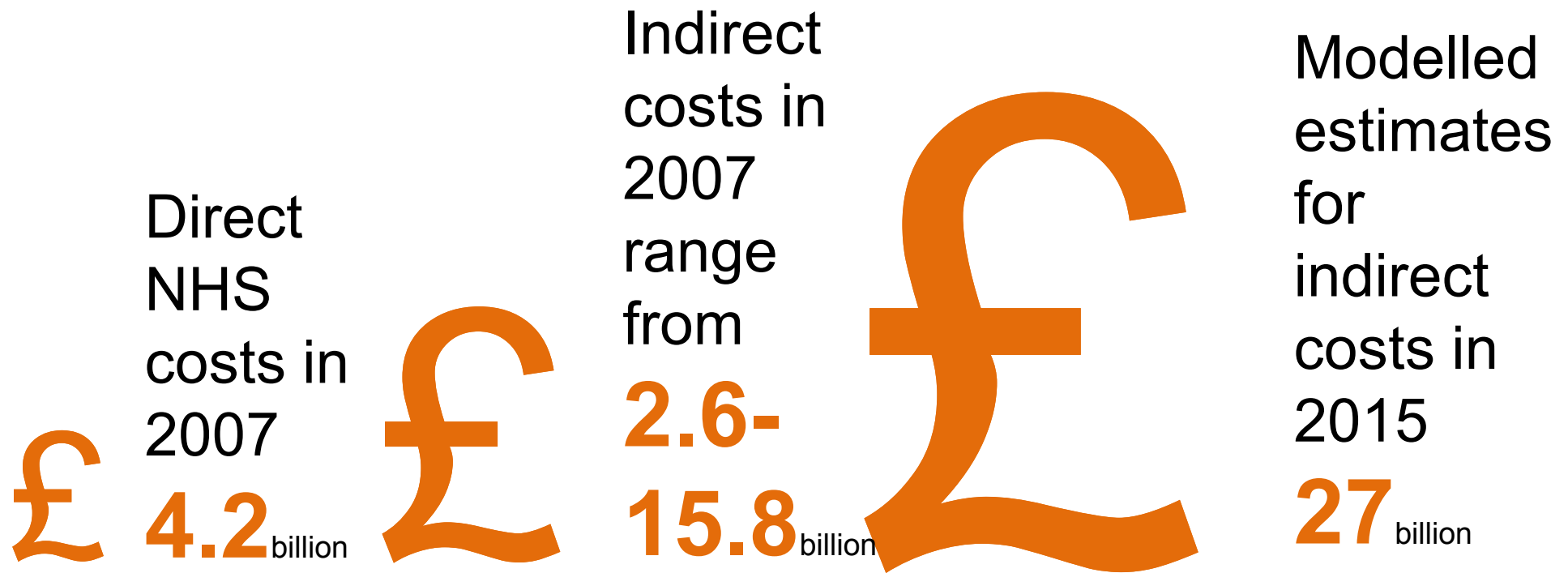
- NCMP, dental examination

Community-wide involvement through an obesity pathway

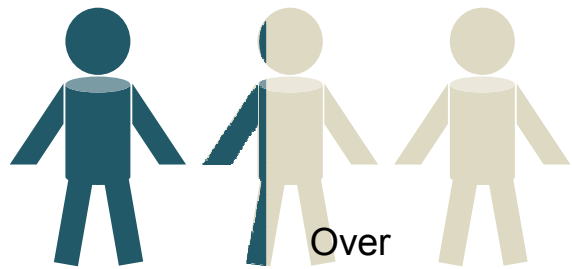
- GPs, pharmacists, nurses, school catering managers, sports associations (public and private)

Source: Borys et al. EPODE approach for childhood obesity prevention: methods, progress and international development. *Obes Rev.* Apr 2012; 13(4): 299–315

The cost of doing nothing

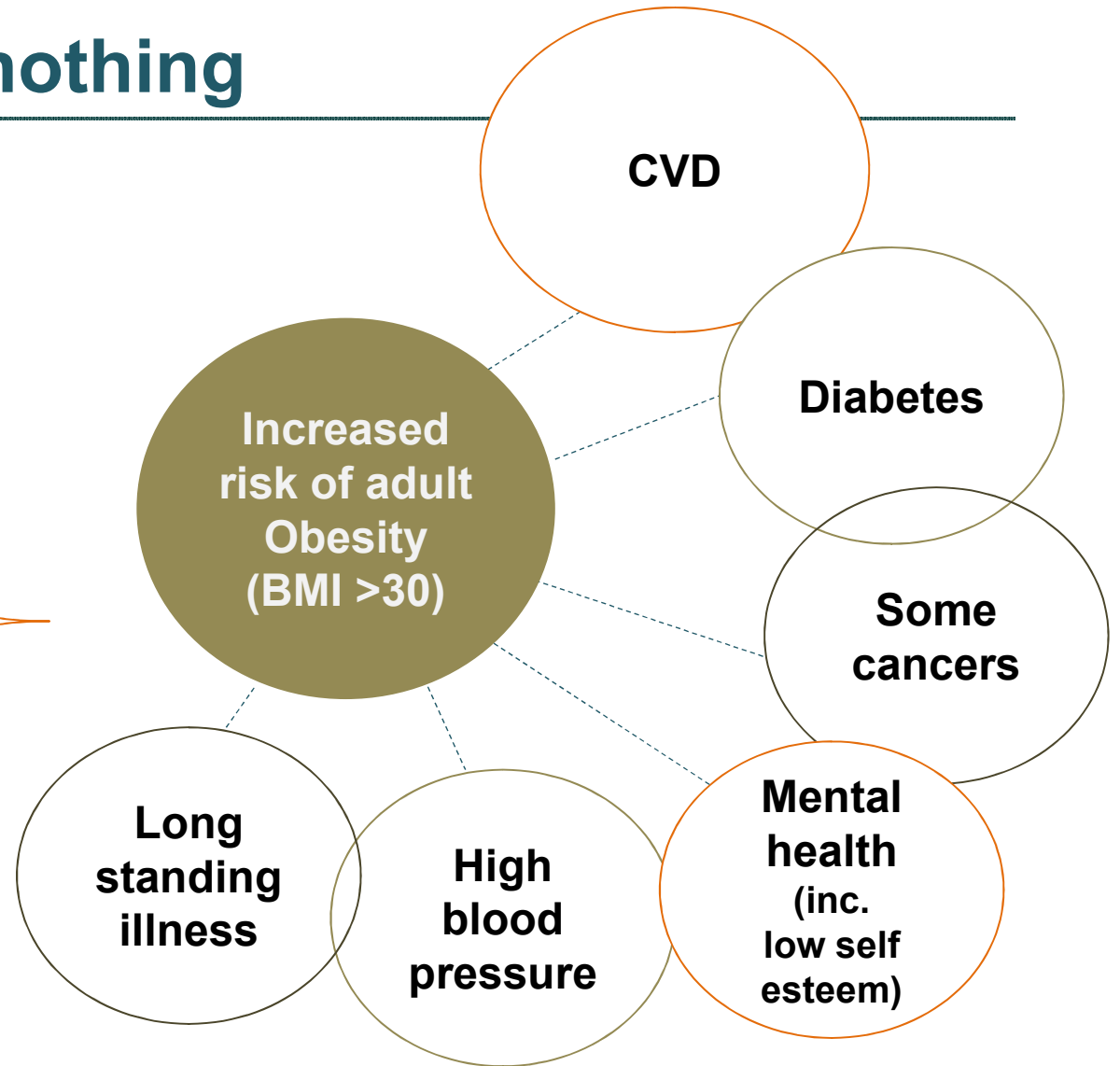


The cost of doing nothing



1 in 3
Haringey
children

Mostly in the east are at higher risk early mortality and poor health



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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	Health and Wellbeing Strategy Update		
Report Authorised by:	Dr Jeanelle de Gruchy, Director of Public Health		
Lead Officer:	Andrew James, Public Health Programme Manager		
Ward(s) affected: ALL		Report for Key/Non Key Decisions: N/A: for update	

1. Describe the issue under consideration

- 1.1. This report is to update the Health and Wellbeing Board (HWB) on the current status of the Health and Wellbeing Strategy (HWS) 2015-18 refresh project.
- 1.2. The Health and Wellbeing Board are asked to note the actions undertaken to date and to review the list of Health and Wellbeing stakeholders whose views will be captured for the strategy refresh

2. Cabinet Member introduction

N/A

3. Recommendations

- 3.1. The Health and Wellbeing Board are asked to
 - 3.1.1. Note the actions undertaken to date;
 - 3.1.2. To review the list of Health and Wellbeing stakeholders whose views will be captured for the strategy refresh



Haringey Council

4. Alternative options considered

- 4.1. No alternatives were considered as the Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health & Wellbeing Strategy.

5. Background information

- 5.1. The current Health and Wellbeing Strategy will cease in 2015. The Health and Wellbeing Board is clear in its roles and responsibilities and how its duties interrelate to improve the health and wellbeing of Haringey residents and citizens.

5.2. Progress to date:

- 5.2.1.1. Health and Wellbeing Strategy Refresh Steering Group has been set up and is meeting monthly
- 5.2.1.2. Full membership of the Steering group and its draft Terms of Reference are attached in Appendix 1. To be agreed at the meeting of the Steering Group in July 2014.
- 5.2.1.3. A separate team has been set up to write the strategy. Its membership has been drawn from the steering group, the existing strategy outcome delivery chairs and Haringey's Public Health team.
- 5.2.1.4. The Strategy Writing Team will produce its Terms of Reference in July 2014.
- 5.2.1.5. The timetable has been developed to take into account the General Election due May 2015 and is attached in Appendix 2.
- 5.2.1.6. Key Milestones to note are:
 - 5.2.1.6.1. Health and Wellbeing Board Review Workshops July 29 2014, December 2014 and May 2015 (post election)
 - 5.2.1.6.2. Public Consultation due to be undertaken between February and March 2015
 - 5.2.1.6.3. Final Approval from Cabinet , the Health and Wellbeing Board and stakeholders in April - June 2015
 - 5.2.1.6.4. Implementation of the new strategy and further public awareness sessions to take place from July 2015
- 5.2.1.7. The Joint Strategic Needs Assessment (JSNA) Steering Group has met and the chapter leads have been identified.
- 5.2.1.8. A narrative for each chapter is being written. This task has commenced and due for completion by 30th June. This is ahead of



Haringey Council

schedule. The Chair of the JSNA Steering Group sits on the Strategy Refresh Steering Group and the Strategy Writing Team to ensure that that JSNA feeds into the refresh.

- 5.2.1.9. A PowerPoint presentation is being developed that will be taken to key stakeholder meetings to commence discussion and capture views. Its aim is to:
- 5.2.1.9.1. Work together with residents, community groups, voluntary organisations, Clinical Commissioning Groups and the Council to refresh the strategy
 - 5.2.1.9.2. Take toll of the highs and the lows since 2012
 - 5.2.1.9.3. Map out the key issues and challenges for the future and how best to measure success
 - 5.2.1.9.4. Building a strategy fit for the future: one that takes into account your views, progress made and emerging issues on the local, regional and national horizon
- 5.2.1.10. The list of stakeholder meetings, dates and leads officers is attached in Appendix 3.
- 5.2.1.11. It was agreed at the first Health and Wellbeing Strategy Refresh Steering Group meeting to commence the Equalities Impact Assessment (EqIA) at the earliest opportunity in the project and that the EqIA is to be undertaken by the Strategy Writing Team to ensure that the findings of the EqIA are reflected in the strategy.
- 5.2.1.12. A draft plan for the Equalities Impact Assessment was drawn up with Council Senior Policy Officer (Equalities) and will be tabled at the next Health and Wellbeing Strategy Refresh Steering Group meeting.

6. Comments of the Chief Finance Officer and financial implications

There are no financial implications arising directly from this paper. All activities and services delivered under the Health and Wellbeing strategy will be funded from existing Public Health, Social Care and Health resources.

7. Comments of the Assistant Director of Corporate Governance and legal implications

- 7.1 The Assistant Director of Corporate Governance has been consulted in the preparation of this report.
- 7.2 In accordance with section 196 Health and Social Care Act 2012 and sections 116 and 116A Local Government and Public Involvement in Health Act 2007, the Health and Wellbeing Board is required to prepare and agree the joint strategic needs assessment (JSNA) and joint Health



Haringey Council

Wellbeing Strategy (HWB strategy) . There are no specific legal implications arising out of this report.

8. Equalities and Community Cohesion Comments

- 8.1 Policy and Equalities Team have been consulted in the preparation of this report and have commented as follows:
- 8.2 This report updates the Health and Wellbeing Board on the project to refresh the current Health and Wellbeing Strategy which expires in 2015. No specific equality comments are required at this stage. However, the Board should be aware that the refreshed strategy drafted would have significant public sector equality duty implications for the Council and would as a consequence, attract the need for a full equality impact assessment. The report recognises this and sets out in paragraphs 5.2.1.11 – 5.2.1.12, specific arrangements for a full equality impact assessment as part of the refresh project.

9. Head of Procurement Comments

No comment required as this paper does not relate to the procurement of services.

10. Policy Implication

- 10.1. The Health and Wellbeing Strategy aims 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.
- 10.2. The Health and Wellbeing Board (H&WB) has a duty to develop, upgrade and publish the Health & Wellbeing Strategy.

11. Reasons for Decision

- 11.1. No decision required

12. Use of Appendices

- 12.1. Appendix 1: Membership and draft terms of reference for Health and Wellbeing Strategy Refresh Steering Group
- 12.2. Appendix 2: Strategy Refresh Timetable
- 12.3. Appendix 3: PowerPoint Presentation Meeting Schedule



Haringey Council

13. Local Government (Access to Information) Act 1985

N/A



Haringey Council
14. Appendix 1

Health and Wellbeing Strategy Refresh Steering Group Terms of Reference

Membership:

Director of Public Health:	Jeanelle de Gruchy
Project Manager:	Andrew James
Assistant Director, Commissioning:	Charlotte Pomery
Chair of Healthwatch:	Mike Wilson
Interim CEO, HAVCO:	Gill Hawken
Policy Officer:	Liz Marnham
Communications:	Caroline Rowe
AD Public Health (JSNA):	Tamara Djuretic

Associate members:

Legal Services:	Victoria Wyatt
Existing and emerging strategies	
1. Tottenham Regeneration:	Jan Doust
2. Community Safety Strategy:	Hazel Simmons/Claire Kowalska
3. Housing	Phil Harris
4. Council Corporate Plan:	Zina Etheridge
5. Early Years Partnership Strategy	Charlotte Pomery
Adult Services:	Beverley Tarka (via Senior Officer Meeting, (SOM))
Children Services:	Lisa Redfern (SOM)
Clinical Commissioning Group:	Sarah Price (SOM)
Schools and Learning:	Zina Etheridge (SOM)
Housing/Leisure:	Tracie Evans (HWB Ex-officio)
NHS England:	(HWB Ex-officio)

Any other attendees to be invited as and when they are required.

Frequency of meetings: Monthly

Governance: The Health and Wellbeing Strategy Refresh Steering Group will report to the Health and Wellbeing Board Senior Officer Meeting (SOM).

Purpose: The purpose of the Steering Group is to:

1. To provide the vision and strategic lead for the development of Haringey's Health and Wellbeing Strategy for the period 2015-18.
2. The steering group must agree the steps and timescales for delivering an agreed strategy to commence in 2015.
3. To provide liaison and communication to members respective organisations;



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4. To identify and manage risks, actions and issues that arise for the strategy through identifying, assessing, planning, mitigation and regular review of those risks, to delivering of the strategy.;
5. Ensure the refreshed strategy meets the standards requires of their respective organisations – and that of a public document – including a review of the Joint Strategic Needs Assessment narrative, consultation report and equalities impact assessment

Responsibilities:

1. All members of the group are reminded of the requirement to declare any personal interests that they have in outside organisations that conflict, or potentially conflict with their role, at the beginning of or at any time during the project.

At the beginning of project:

2. Agree individual roles, responsibilities and objectives.
3. Approve an accurate and satisfactory project initiation document, ensuring it complies with relevant stakeholder standards and policies.
4. Commit project resources from their organisation/department required to complete each step.

As the project progresses:

5. To oversee the Strategy Writing group to ensure it delivers on time and to standard
 - a. A draft strategy for consultation;
 - b. A final version of the strategy
 - c. An Equalities Impact Assessment report
6. Provide overall guidance and direction to the project.
7. Follow procedures in changing timescales or steps in the project.
8. Provide a link between the Strategy Writing Group and their respective organisations/departments.
9. Review and approve all review and project documentation, such as JSNA narrative, consultation report, equalities impact assessment.
10. Review each completed phase and stage and oversee and maintain a log that captures all lesson learnt throughout the project for future reference.

At the end of the project:

11. Provide assurance, if requested, that the strategy has been delivered according to their organisations standards.
12. Provide assurance that all steps have been met or if not documented correctly.
13. Approve the final strategy and the end of project report which will include lessons learnt, risks and successes for future projects.



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14. Approve the lessons learnt report and the passage of this to the appropriate groups to ensure action.
15. Decide on the recommendations for follow-up actions and ensure passage of these to the appropriate authorities.



15. Appendix 2: Health and Wellbeing Strategy Refresh Timetable

Stage	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
JSNA Stage																	
JSNA Steering Group																	
JSNA leads identified																	
Complete generic chapters data																	
Chapter narratives																	
Review Stage																	
Data comparision																	
Delivery Group narrative																	
HWB Seminar/Workshop																	
HealthWatch Programme																	
HAVCO Programe																	
CCG Programme																	
LBOH Programme																	
Compilation Stage																	
Development Stage																	
Equalities Impact Assessment																	
Consultation Draft Approval Stage																	
Public consultation on draft strategy																	
Write up Public consultation																	
General Election Purdah																	
Full Approval Stage																	
Communication Stage																	
Implementation Stage																	



Health and Wellbeing Strategy Target meeting Update. 13/06/2014

Meeting	PowerPoint	Presenters	Publication	Lead	Workshop	Lead
CAB	03 July	JdG				
Members Induction	29 th July 6:30	JdG				
Health and Wellbeing Board					August 2014	AGJ
Senior Leaders Team	24 th June	JdG				
Corporate Leaders Group	? 29 th July					
Corporate Management Group	? July meeting					
Community Safety Team	18 th September	MM				
Integrated Management Board	22 nd July					
Haringey Web Site			Mid July			
Early Years Board	30 th July	SO				
Families First		MM				
CCG	30 th July					
CCG Top Management team	16 th July					
CCG Network	21 st July	JdG				
Local Medical Committee	3 rd October					
GP Central Collaborative	16 th July	SO				
GP NE Collaborative	08 July	MM				
GP West Collaborative	10 th July					
GP SE Collaborative	29 th July					
NHS Providers – Whittington						
NHS Providers – North Middlesex						
NHS Providers – BEH MHT						
HealthWatch	Awaiting date					
HAVCO	Awaiting date					
Haringey People			August 2014			
Ham and High			August 2014			

Key

JdG	Jeanelle de Gruchy	MM	Marion Morris	SO	Susan Otit	AGJ	Andy James
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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	Health and Wellbeing - National and London Developments Update		
Report Authorised by:	Dr Jeanelle de Gruchy, Director of Public Health		
Lead Officer:	Dr Jeanelle de Gruchy, Director of Public Health		
Ward(s) affected: All	Report for Key/Non Key Decisions: N/A: for update and discussion		

1. Describe the issue under consideration

1.1. This report is to update the Health and Wellbeing Board (HWB) on a number of national and London developments regarding health and wellbeing: – the Mayor’s London Health Commission, the London Health Board and Public Health England’s (PHE) Health and Wellbeing Framework.

2. Cabinet Member introduction

N/A

3. Recommendations

3.1. That the Health and Wellbeing Board discuss the National and London developments; note the implications for Haringey and any subsequent local action required.

4. Alternative options considered

No alternative options were considered.



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5. Background information

- 5.1. Mayor's London Health Commission. The London Health Commission is an independent inquiry established in September 2013 by the Mayor of London (membership of the Commission at Appendix 1). The Commission is chaired by Professor the Lord Darzi and reports directly to the Mayor. The Commission is examining how London's health and healthcare can be improved for the benefit of the population. It will advise on the unique contribution the office of the Mayor might make by doing things at the city level that work alongside local activities to magnify efforts.
- 5.2. London faces significant challenges in health and healthcare, many of them unique. There is a high burden of disease, both physical and mental; health inequalities remain stubbornly wide, between and within boroughs; despite examples of world-leading services and research, quality of care is variable and often does not meet people's needs and expectations; and the current economic climate means finances are constrained whilst healthcare costs are rising (Appendix 2 for further information on London's health and wellbeing characteristics). The London Health Commission provides an opportunity to bring together the Mayor of London with the NHS, local government and the wider public to address these challenges.
- 5.3. To date evidence has been gathered from:
- 5000 Londoners polled for their views so far
 - 250 submissions to the call for evidence
 - 50 road shows across the capital
 - 9 oral health hearing sessions
- 5.4. The commission is developing proposals covering:
- Better health for everyone
 - Better health through better care
 - Enablers for better care
 - Stronger health economy and research
- 5.5. Specific proposals will be developed and refined over the summer. The Commission is likely to make recommendations beyond health and care services to areas including air quality, walking and cycling, promoting fitness and activity including by making more use of London's green spaces, regulatory options for sugar, alcohol and tobacco, healthy schools and wider ways of improving children's health. It has been noted that there are many examples of interesting programmes and activity by boroughs in many of these areas. There are indications that they are likely to be supportive of locally-driven integration and solutions to the sustainability of health economies. The report will be submitted to the Mayor in the Autumn



Haringey Council

5.6. London Health Board. The London Health Board (LHB) was established in March 2013. Membership is made up of three parts:

- a) five Leaders of London local authorities;
- b) the Mayor of London and four Mayoral appointees; and
- c) five senior representatives from the Health Sector in the capital (from NHS England, Public Health England, the London-wide Clinical Commissioning Council – representing London Clinical Commissioning Groups (CCGs), one of the London Academic Health Sciences Network Director and the London Clinical Senate.)

The LHB is in a unique position, because of its partners and members, to be able to bring together senior leaders in health and care organisations across London. This enables the LHB to provide leadership on health and social care issues of pan-London significance, where this adds value to decisions, agreements and action at a local level.

5.7. In its first year, the LHB has met four times, settled upon five priority areas and established a number of ground-breaking programmes to improve health outcomes and services for Londoners. The London health Board is working on five priorities:

- a) Making the case for London - the Board has supported the case for changing the CCG allocation so that funding is more evenly distributed across London.
- b) Improving primary care - the Board has endorsed a proposal to leverage investment in primary care with a focus on improving the primary care estate.
- c) Enhancing patient experience through data transparency and digital access to information - the Board has asked NHSE (L) to deliver a programme on transparency to better inform the public about local services, to improve tracking performance of services and to use data to deliver self-management guidance to the public. The programmes aim to develop myhealthlondon as a platform for Londoners to access information.
- d) Promoting growth and jobs in the life sciences
- e) Improving mental health - the Board agreed to support an approach and related programme of work led by Public Health England (London) focused on:
 - ensuring that Londoners aged 16 and over can access digital support to self-manage their mental well-being, in order to achieve better overall health outcomes and to reduce the impact of mental health on the London economy; making this happen requires close collaboration across boroughs and CCGs
 - work with adolescents to improve their resilience, thereby increasing their mental health and improving education outcomes and reducing offending levels
 - the development of more effective support to ensure talent is not lost from the London workforce due to people falling out of employment or not getting a job because of their mental illness; the Board is working with public and private sector employers to develop this strand.



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5.8. Public Health England's Health and Wellbeing Framework. Public Health England (PHE) is developing a Health and Wellbeing Framework. Publication of the Framework is expected in August. This starts from the proposition that working together (national and local government, the NHS, industry, academia, the public and voluntary and community sector) can achieve a real shift to sustain improvements being led by local government to focus on health rather than the treatment of illness. The Framework offers a range of tools and analyses that will enable this to be achieved, not a prescription of what any stakeholders should do.

5.9. The Framework will set out the scale of the current health challenges the country faces and the prize to be achieved from creating a coalition for change. It will provide analyses of trends in several key areas relevant to health and set out what we know from the evidence would be effective action to be taken by national government, the NHS, business, schools etc as well as local government. This information will be presented in three themes: people, places and communities and will be supplemented over time by an interactive database so that anyone can search for what information might best support their local activities and priorities.

6. Comments of the Chief Finance Officer and financial implications

6.1. Currently we have no expectation that there will be significant new funding available for this so all new initiatives are likely to be funded from reprioritisation of existing resources in council Public Health and NHS England/London budgets.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1. The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications.

8. Equalities and Community Cohesion Comments

8.1. As this is an information report, Policy and Equalities have no specific equalities comments to make at this stage except advising that Health and Wellbeing Board should be aware that the work being done by London Heath Board (LHB) has implications for the Mayor's public sector equality duty to have due regard to the need to amongst other things and in this case, to ensure all Londoners have equal access to health and social care and to promote health equality for all Londoners across all the characteristics protected by sections 4 – 12 and 17 of the Equality Act 2010.

8.2. The characteristics protected by the Act include age and it is noted that the LHB in its work so far has a focus on Londoners aged 16 and over to improve their resilience and increase their mental health and improve education outcome for them and reduce youth offending.



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9. Head of Procurement Comments

No comment required as this paper does not relate to the procurement of services.

10. Policy Implication

- 10.1. The Health and Wellbeing Strategy refresh process should consider the recommendations of the London Health Commission and PHE's Health and Wellbeing Framework.

11. Reasons for Decision

- 10.1 No decision required.

12. Use of Appendices

- 11.1 Membership of the London Health Commission.
- 11.2 Additional information on London's health and wellbeing .

13. Local Government (Access to Information) Act 1985



Haringey Council

Appendix 1: Membership of the London Health Commission

- Professor the Lord Ara Darzi – London Health Commission Chair
- Lord Victor Adebawale – Chief Executive, Turning Point
- Colin Barrow – Executive Chairman, Alpha Strategic
- Sir Cyril Chantler – Chair, University College London Partners
- Dr Yvonne Doyle – Regional Director, Public Health England (London region)
- Dr Sam Everington – General Practitioner and Chair of Tower Hamlets Clinical Commissioning Group
- Professor David Fish – Managing Director, University College London Partners
- Professor Chris Ham – Chief Executive, The King's Fund
- Dermot Kelleher – Dean of the Faculty of Medicine, Imperial College London
- Sir Ron Kerr – Chief Executive, Guy's and St Thomas' NHS Foundation Trust
- Professor Sheila Leatherman – Research Professor, The University of North Carolina and Visiting Professor, London School of Economics
- Dr Andy Mitchell – Medical Director, NHS England (London region)
- Crystal Oldman – Chief Executive, The Queen's Nursing Institute
- Cllr Teresa O'Neil – Leader, London Borough of Bexley
- Dr Matthew Patrick – Chief Executive, South London and Maudsley NHS Foundation Trust and Clinical Director for Mental Health, NHS England (London region)
- Dr Anne Rainsberry – Regional Director, NHS England (London region)
- James Reilly – Chief Executive, Central London Community Healthcare NHS Trust
- Dr Caz Sayer – General Practitioner and Clinical Lead, NHS Camden Clinical Commissioning Group
- Dr Tim Spicer – General Practitioner and Chair of Hammersmith and Fulham Clinical Commissioning Group
- Dr Geraldine Strathdee – National Clinical Director for Mental Health, NHS England
- Dr Chris Streater, Chief Executive, South London Academic Health Sciences Network
- Jeremy Taylor, Chief Executive, National Voices
- Professor Chris Welsh – Director of Education and Quality, Health Education England



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Appendix 2

London has a number of unique population characteristics: huge inequalities, including health, within its population; a highly diverse and mobile population, which impacts on patterns of access to and uptake of services – as well as presenting information sharing challenges; an additional daytime population and a night-time economy – which creates unique pressures on the London health system, in particular A&E; high levels of vulnerability – particularly in socially excluded groups, such as older people, with many experiencing social isolation; high numbers of families in poverty; and high levels of homelessness and rough sleepers.

There are also particular population health issues and emerging challenges: high levels of sexually transmitted infections and HIV; high domestic and gender-based violence (including Female Genital Mutilation); high levels of serious mental illness and a need to improve mental health for children and young people; significant inequalities in uptake and effective prevention, including immunisation and screening; high levels of obesity, coupled with low levels of nutrition and physical activity; increasing rates of TB; high levels of smoking, increasingly concentrated in particular groups; and high levels of alcohol and drug misuse.

Poverty, social exclusion and human rights abuses are underlying factors for poor health. London also faces specific challenges around limited affordable housing; wage stagnation, and high levels of food and fuel poverty, all of which have a considerable impact on health and care needs.

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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	Homeless Health Needs Assessment Task and Finish Group report		
Report Authorised by:	Jeanelle de Gruchy, Director of Public Health		
Lead Officer:	Sarah Hart		
Ward(s) affected: ALL	Report for Key/Non Key Decisions: N/A		

1. Describe the Issue Under Consideration

- 1.1. The Homeless and Health Needs Assessment was presented to the Health and Wellbeing Board (HWB) in January 2014. The HWB asked that a Task and Finish group be set up to explore the issues raised in the Health and Homeless Needs Assessment (see part 3.1) and to report back with recommendations to the HWB.

2. Recommendations

- 2.1. To consider proposals as set out in part 4 of the report; and decide how to take these forward

3. Background Information

- 3.1. The following issues were identified from the Health and Homeless Needs Assessment for single homeless people and tasks identified for the Task and Finish group.
1. **Registration** Homeless people reported finding it difficult to register with a GP because of requests for photo identification and GPs asking for evidence of proof of residence. The Task and Finish group were asked to clarify the requirements.



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- II. **Access to health and social care for Europeans migrants and those with No Recourse to Public Funds** A need was identified for more understanding around rights to access to health and social care for European's and those with No Recourse to Public Funds. The Task and Finish group were asked to clarify this
- III. **Models of Good Practice** Haringey does not have a model for health care for homeless people in primary care. The task and finish group were asked to identify models
- IV. **Data capture** Limited local data on the health of single homeless people was found in the needs assessment. The Task and finish group were asked to explore if there was a need for better data collection
- V. **Linked up commissioning** There was found to be no joint strategy for the commissioning of health and homeless services. The Task and Finish group were asked to explore the links between commissioners of health and housing services
- VI. A homeless Pathway project with the North Middlesex hospital was identified as an exciting opportunity. The Task and Finish Group were asked to identify the stage of development.

3.2. The Task and Finish group met on four occasions

Catherine Herman - Lay Vice Chair Haringey CCG
 Marion Morris - DAAT Strategy Manager Haringey Public Health
 Claire Drummond - Commissioning Manager Housing Related Support
 Cleo Andronikou - Commissioning Officer Housing Related Support
 Sherry Tang - Chair of the CCG
 Sarah Hart – Senior Commissioner Public Health

At the fourth meeting there was also representative from Healthwatch and All People All Places (APAP)

3.3. The group's findings were as follows:

- I. **Registration:** The Department of Health Inequalities Unit confirmed that no photo identification is required for registration with a GP. The Care Quality Commission (CQC) newly responsible for the rating of primary care practices in terms of responsiveness to vulnerable groups has highlighted that registration restrictions that adversely affect the homeless are likely to result in a lower CQC practice ratings. However the NHS Choices website advises that at registration 'you may be asked for photo identification as well as proof of residence'. It would appear that there are no set Department of Health requirements regarding the identification required for registration, allowing it to be a local decision. Manchester Urban Village Primary Care Project which is recognised in the homeless field as an example of good practice in primary care, asks for a minimum of previous address and previous GP or if you are new to the country the date you entered the UK.



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- II. **Access to health and social care for Europeans migrants and those with No Recourse to Public Funds**, a presentation outlining the key rules has been completed see Appendix 1
- III. **Models of Good Practice**, at the Homeless Link Health and Homeless conference the services in table 1 were showcased as examples of good practice in improving the health of the homeless

Primary Care - York street practice in Leeds, is a practice specifically for homeless and vulnerably housed people www.leedscommunityhealthcare.nhs.uk. As is Manchester Urban Village <http://www.uvmp.co.uk/index.aspx> which runs a homeless Pathway project with their local hospital

Nurse Led Services – a number of city's i.e. Cambridge, have a primary care based nurse going into hostels and homeless/vulnerably housed provision.

Groundswell – Homeless Health Peer Advocacy is a project that aims to help improve the health of currently homeless people, primarily through Peer Advocates offering one to one support to help access health services by accompanying people to appointments. The Peer Advocates receive formal training and get insight into hospital and primary care services by working alongside nurses, GP's and reception staff. Advocates all have personal experience of homelessness and are recruited from existing volunteering schemes or are people who are interested in developing a career in the Health and Social Care field. The project started in May 2010 and was run in Westminster for a year before expanding to Hammersmith & Fulham in 2011 and Camden in April 2012. In its first year, the project worked with 70 clients and supported them to attend over 350 health appointments. The project has been funded by the NHS Regional Innovation Fund, Resolving Chaos, Inner North West London PCT, London Borough of Camden's Equalities and Cohesion Fund and the Greater London Authority.

Table 1 Models of good practice in health care for homeless people

- IV. **Data Capture**, whilst finding the public health needs assessment very informative the group identified a need for more localised data capture for the Joint Strategic Needs Assessment (JSNA).
- V. **Linking up commissioning**, Difficulties for homeless people with customer services in accessing housing services at Apex House were highlighted by the All People All Places (APAP) cold weather shelter report and Heathwatch focus groups. The Task and Finish group used the opening of the cold weather shelter in December 2013 as an opportunity to explore what could be achieved when health and housing providers work together. The shelter ran for 12 weeks during which time Haringey Public Health team organised prevention health interventions with the shelter i.e.



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tuberculosis screening ¹, Health Checks, Mental Health First Aid training and training in alcohol assessment, the alcohol service provided treatment to those guests with alcohol problems. The shelter providers assessed, collected and collated information regarding their guest's health and access to housing and health services. The shelter providers demonstrated how this data could be collected locally, their report identified high levels of exiting health need within the 35 guests, see table 2.

Issues	Percentage
Alcohol Abuse	23.4%
Drug Abuse	10.9%
Mental Health Problems	46.9%
Physical Health Problems	37.5%
Learning Disabilities	6.3%
Dual Diagnosis/Complex Needs	7.8% (a subset of the above)

Table 2 All People All Places findings

- VI. The APAP cold weather shelter report identified good usage of the Haringey Public Health commissioned services and that the service made guests feel empowered and more ready to address existing health issues.
- VII. The Council has commenced a tendering process for the supply of all of its single homeless Housing Related Support (HRS) services and the group was able to insert health promotion measures into the new contracts. The council's Homeless Strategy is also being revised and there is an opportunity to better integrate health outcomes into housing strategy.
- VIII. **North Middlesex Hospital Homeless Pathway**, the group have become aware of many occasions where homeless people are discharged from general hospital back into hostels with no clear care planning. The APAP cold weather shelter report also highlights many people being referred by hospitals. Links have now been made with Pathway² who are advising on and contributing funds into the North Middlesex Hospital Pathway project and the North Middlesex hospital has appointed a Pathway GP and Nurse. Pathway is an established hospital model for working with homeless people; there are currently 5 projects in London. There is evidence that this model

¹ The Find and Treat service is a pan London service, a van goes to places where high risk people are to test for tuberculosis

² <http://www.pathway.org.uk/publications/pathway-research-and-service-development-publications/>



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decreases numbers of readmissions and shorten lengths of stay³

4. Proposal, the Group Proposes the Following;

- 4.1. The JSNA for Homelessness and Health is further developed, exploring mechanisms to gather more local data.
- 4.2. A multi partnership work shop is facilitated to develop a homeless health pathway which would address the issues identified within this report; rules regarding GP registration, models of primary care, customer service advice from Apex House and hospital discharge.

5. Financial Implications and Comments of the Chief Finance Officer

- 5.1 There are no finance implications arising directly from this report. The Board should be aware that there is unlikely to be significant additional funding available to support any new initiatives and so funding to support new or amended services will need to be from existing resources.

6. Head of Legal Services and Legal Implications

The legal team have been consulted on this report. There are no legal implications arising from its contents.

7. Equalities and Community Cohesion Comments

- 7.1 Policy and Equalities Team have been consulted in the preparation of this report and have commented as follows:
- 7.2 The Council has a general equality duty under section 149 of the Equality Act 2010 to have due regard to amongst other things, the need to advance equality of opportunity and foster good relations between those who share the characteristics protected by sections 4 – 12 and 17 of that Act and those who do not.
- 7.3 The target group of this report – the homeless in Haringey – include people who possess most if not all of the characteristics protected by the Act and are therefore owed the general equality duty to afford them equal opportunity to health and social care.
- 7.4 Both national and local data suggests that the target groups of this report, the homeless are among the most vulnerable and hard-to-reach groups and suffer the highest rate of premature death due to the difficulties they face accessing health and social care.

³ In may 2012 Pathway hospital teams were named as an exemplar in the Depart of health report on 'improving Hospital Admissions and Discharges for People who are Homeless



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- 7.5 Like in other parts of the country, inequalities in health have been identified as a major and persistent equality issue in Haringey. Recognising this, Priority 6 of the Council's Corporate Plan, One Borough One Future is to reduce health inequality and improve wellbeing for all. This priority is reflected in the Council's Health and Wellbeing Strategy which commits to working to improve the health and wellbeing of the local population and reduce health inequalities across the life course, particularly the hard-to-reach groups.
- 7.6 The activities reported in this report and the further measures proposed in paragraphs 4.1 and 4.2 are in accord with the Council's general equality duty, the Corporate Plan priority relating to health inequalities and wellbeing and with the Wellbeing Strategy.
- 7.7 By addressing the health inequalities faced by the homeless in Haringey, the activities reported and the measures proposed will bring some of the most marginalised groups in society back into the fold and contribute to building a borough in which everyone has a stake. This would be in accord with the Council's duty to foster cohesion and good relations between groups Haringey.

8. Policy Implication

This service is linked to the Health and Wellbeing and Community Safety Partnership strategies and respective delivery plans and the following council priorities: safety and wellbeing for all, opportunities for all, and a better Council.

In terms of the Health and Wellbeing Strategy its meets responsibilities to: improve the health and wellbeing of local populations and reduce health inequalities across the life course, particularly in hard to reach groups. There is evidence that addressing barriers to health in the homeless population reduces both rates and length of hospital admissions.

9. Use of Appendices

Appendix 1: Presentation of Recourse to Public Funds
Appendix 2 Health and Homeless Needs Assessment.

10. Local Government (Access to Information) Act 1985

NA.



WORKING WITH EASTERN EUROPEAN & OR NO RECOURSE TO PUBLIC FUNDS CLIENTS

MARCH 2014
SARAH HART

Who is in the EU?

- Austria
- Belgium
- Bulgaria
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- Italy
- Latvia
- Lithuania
- Luxembourg
- Malta



- France
- Germany
- Greece
- Hungary
- Ireland
- Netherlands
- Poland
- Portugal
- Romania
- Slovakia
- Slovenia
- Spain
- Sweden
- United Kingdom

A8 Nationals '04

- Estonia
- Latvia
- Lithuania
- Poland
- Czech Rep
- Slovakia
- Hungary
- Slovenia

A2 Nationals '07

- 1. Bulgaria
- 2. Romania

Changes to A8/A2 status

- From May 2011 A8 nationals have had the same rights as other EU nationals.
- From Jan 1st 2014 onwards A2 nationals have the same rights as EU nationals.

Who is NOT in the EU?

- Serbia
- Switzerland
- Ukraine
- Kazakhstan
- Russia
- Turkey
- Georgia
- Belarus
- Albania
- Bosnia and Herzegovina
- Kosovo
- Macedonia
- Moldova
- Montenegro
- Norway

Rights of EU nationals

If you are a national of any EU/EEA country, your rights include:

- the general right to 'free movement' within the EU/EEA.
- the right to live in the UK for up to three months. This does not mean that you are automatically entitled to any benefits or help with housing.
- the right to live in the UK as a student
- the right to live in the UK if you are able to support yourself financially
- the right to seek work (which may mean that you are also entitled to claim some benefits)
- the right to work
- the right to enter self-employment or set up a business.
- It is important to remember that having the right to live and work in the UK does not necessarily give you [rights to housing or benefits](#). Your eligibility for these will depend on which EU/EEA country you are from and how long you have been in the UK.

Help with housing and benefits for EU workers

- Workers from most EU and EEA countries are entitled to apply for help with housing and benefits
- Workers and their family members have the right to:
 - [apply for social housing](#)
 - [get help from a local council if they become homeless](#)
 - claim welfare benefits, including [housing benefit](#).

When is an EU national classed as a 'worker'?

- If you are a citizen of any EEA/EU country you will have rights as a 'worker' if you:
 - ❑ are currently employed
 - ❑ are temporarily unable to work because of sickness or an accident
 - ❑ were working for at least one year and are now registered as a jobseeker
 - ❑ If you are a worker but have lost your job, and you have worked for less than one year, you will remain 'a worker' for six months after losing your job, as long as you are registered as a jobseeker.

Rights to National Health Service (NHS) treatment

- EU law on the coordination of social security systems provides that those EU citizens – and only those – who can show that they are either employed or self-employed in the UK or non-active but habitually resident in the UK are fully entitled to treatment by the NHS on the same terms as resident UK citizens.
- EU law says that before EU citizens not active in the labour market become eligible for social security benefits they have to pass a strict “habitual residence test (HRT)” proving that they have a genuine link with the UK.
- UK law is in line with this principle and does allow EU citizens who are genuinely resident in the UK to have full access to NHS treatment.

No Recourse to Public Funds (NRPF)

- NRPF - people who are subject to immigration control and have no entitlement to welfare benefits, to home office asylum support for asylum seekers or to public housing.
- Anyone with no recourse to public funds is entitled to emergency, primary care (including access to a GP) and treatment which a GP deems clinically necessary
- They do not have access to secondary care including substance misuse detoxification or rehabilitation
- They may have access to secondary care if they have the 'right to reside' in this country

Health needs assessment of homeless in Haringey

Key findings from a report by Dr Ruth Watt
Haringey 2013

“ Absolute poverty – a lack of the basic material necessities of life – continues to exist, even in the richest countries of Europe. The unemployed, many ethnic minority groups, guest workers, disabled people, refugees and homeless people are at risk. **Those living on the streets suffer the highest rates of premature death.** ”

(Wilkinson & Marmot, 2003:16)

Introduction

Aim was to explore the health needs of rough sleepers and those living in hostels in Haringey

Purpose was to make recommendations for consideration by housing and health commissioners

Objectives:

- ❑ Identify the population that are rough sleeping or in hostels in Haringey and their demographics
- ❑ Identify the priority health needs for this group
- ❑ Identify usage of emergency and acute services
- ❑ Identify any barriers to health services
- ❑ Identify the services out there already improving access to health services
- ❑ Identify areas of best practice

Why 50 homeless men are sleeping in a Tottenham church

New Economics Foundation report pinpoints how cuts are hitting England's most deprived wards, in London and Birmingham



Amelia Hill

The Guardian, Monday 19 November 2012 15.00 GMT



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Homelessness · Poverty · Benefits · Charities · Voluntary sector

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Methodology

Expert views

- Interviews with staff and managers at local hostels, dual diagnosis and alcohol treatment services

Epidemiological evidence

- Literature review
- Best practise
- Analysis of local data, e.g. GP registrations database, National Drug Treatment Monitoring System

Benchmarking

- Benchmarking data from health services i.e. prevalence and service use data

Adapted from: Stevens, A., & Rafferty, J. (1994, 1997).

Who do we mean by homeless

Conceptual Category	Operational Category
Roofless	Living rough
	In emergency accommodation
Houseless	In accommodation for the homeless
	People in women's shelters
	People in accommodation for immigrants
	People due to be released from institutions
	People receiving longer-term support (due to homelessness)
Insecure	People living in insecure accommodation
	People living under threat of eviction
	People living under threat of violence
Inadequate	People living in temporary/non-conventional structures
	People living in unfit housing
	People living in extreme overcrowding

Source: Adapted from FEANTSA. [European Typology of Homelessness and housing exclusion](#)

Homeless in Haringey – an overview

494

Statutory homeless in
2010/11

60% of households
with dependent children

41% from black ethnic
groups
(compared 19% in Haringey - Census 2011)

Half lone
parents
(From accepted
households)

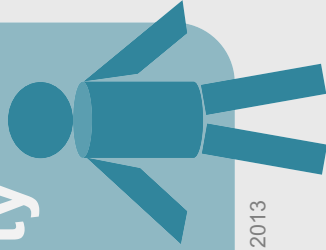


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Source: Community Housing Service, 2012.

Rough sleepers in London

Vast majority
single men



Source: Chain, 2013

Half of all rough
sleepers in
England located in
London

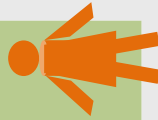
Estimated

6,437

Source: Brodie, 2013

12%

women



Source: Chain, 2013

58%

aged 26-45

Source: Chain, 2013

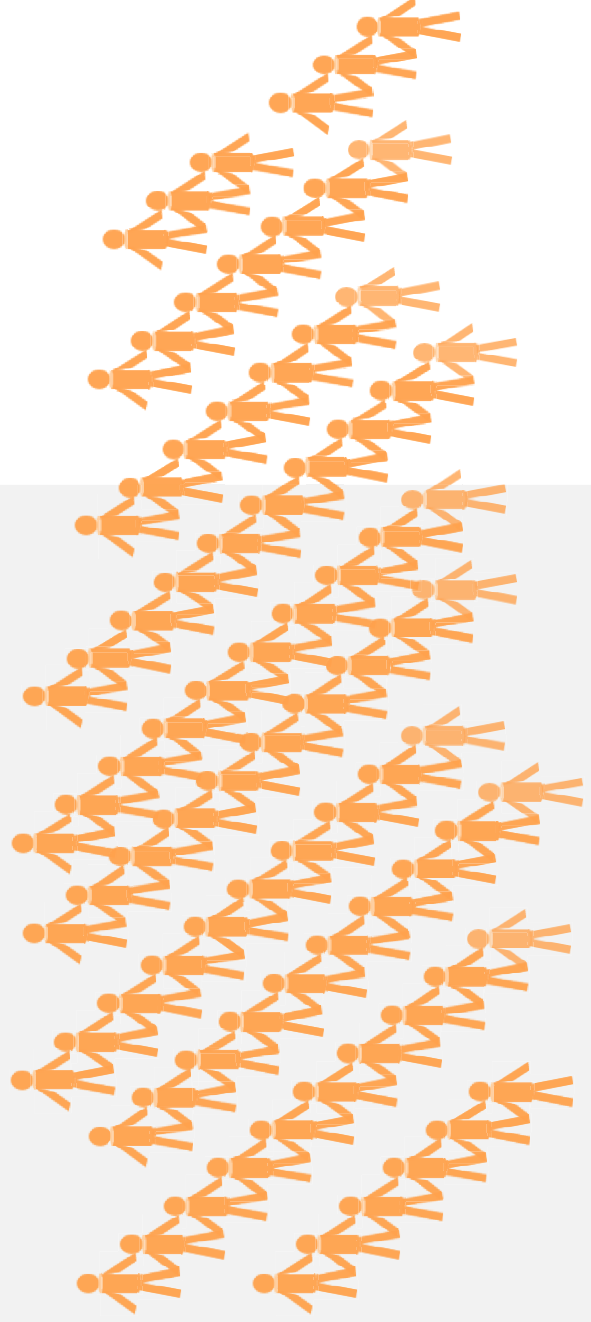
Rough sleepers in Haringey

85 people sleeping rough

at least once in Haringey in 2012/13, with 76 being new individuals.

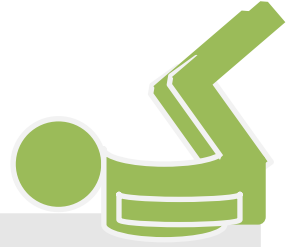
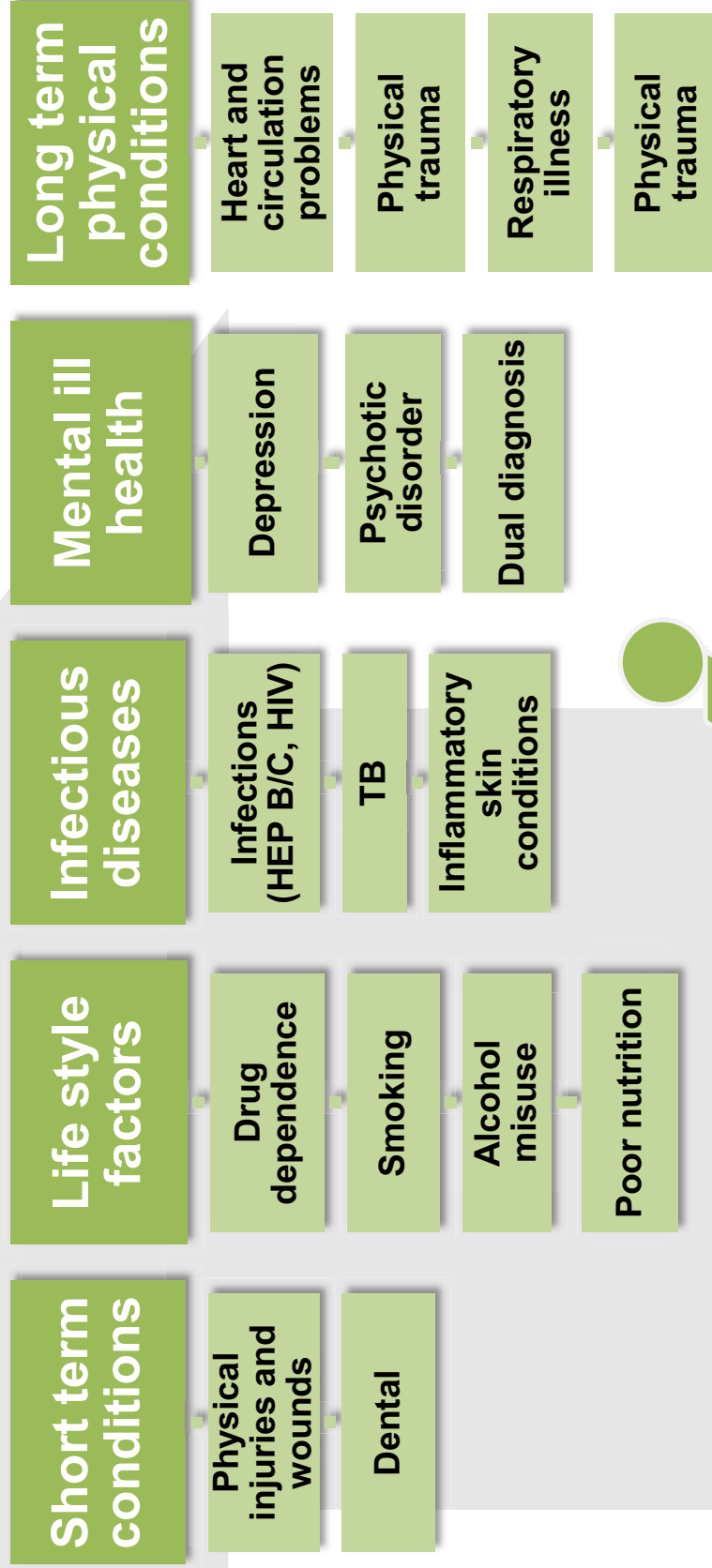
Source: CHAIN, 2012.

London Fire Brigade concerned about people sleeping in derelict buildings, garages and sheds in Haringey.



Homelessness and health

People without safe, secure affordable shelter experience more health problems than the general population



Prevalence of risk life style factors

Over

SMOKING



Source: Crosier, 2004; Ash, 2003

half

of hostel clients use drugs

Source: Homeless Link, 2010



Haringey Council

Impact on health

LIFE EXPECTANCY



Source: Brodie, 2013; ONS, 2013

Many die of treatable medical conditions

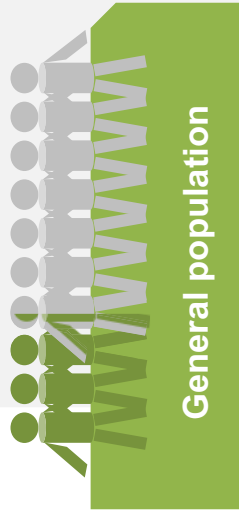
PHYSICAL HEALTH

80% with physical health needs



Source: Homeless Link, 2010

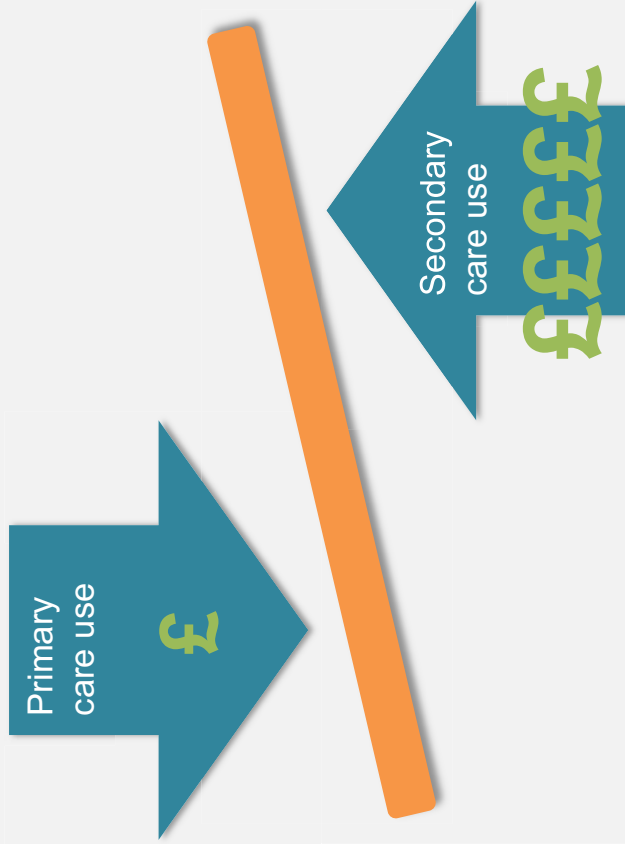
MENTAL HEALTH



Source: Homeless Link, 2010



Cost to the NHS



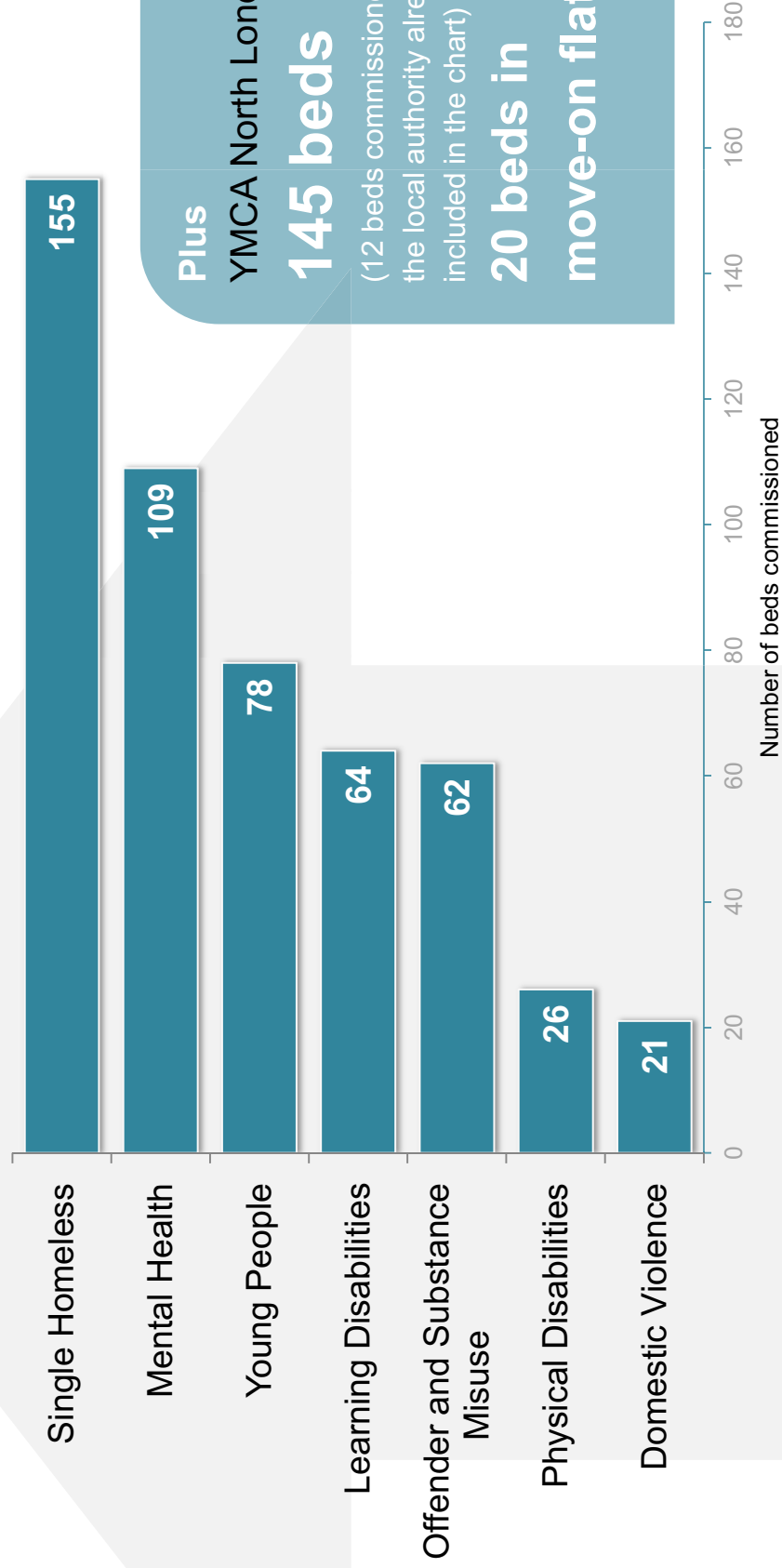
Numbers of hospital outpatient appointment “**did not attend**” are **seven times higher**” compared with the general population.

Source: Perera & Rabee, 2013

Homeless people are **admitted to hospital four times as often** as the general population and **stay in hospital three times as long** resulting in unscheduled secondary care costs that are eight times higher than for patients who are not homeless.

Source: Department of Health, 2010

Hostel dwellers and rough sleepers in Haringey: commissioned bed spaces 2012/13



Local barriers to health services

27%

of rough sleepers have a NHS number, according to study by Inner North West London (INWL)

Source: Perera & Rabee, 2013

- **Registration with a GP**- proof of residency and photo ID – limited guidance for health practitioners.
- **Getting homeless people to attend appointments**, local homeless report poor experience of medical care and unreceptive environments
- **Lack of knowledge of the UK healthcare system**, e.g. Polish
- **Mental health services** - Regional PH Group for London (2010) found specific issues with access to mental health services: waiting times and rigid eligibility criteria. Findings corroborated by local reports from hostels.

Local issues

- **Availability** - Local housing strategy reports a lack of provision of complex single homeless people, discharges from acute and mental trusts problematic when patients have nowhere to go
- **Access for homeless people** – homeless providers barriers getting clients though housing advice to the Vulnerable Adults team
- **Pathways** – poor continuity of care between specialist health and homeless services
- **Services** – Inadequate services regarding cannabis, counselling and IAPT services
- Queenswood Medical Centre has a psychotherapist at the practise but report difficulties when referring clients to external mental health services (check)
- **Role of faith organisations** - Faith groups are offering shelter in churches to homeless people independently and these have no input from health

Local services

- Single homeless projects with specialism's including substance misuse and mental health problems
- Substance misuse service in minimal residency requirements, which also providing training and in reach into hostels
- Dual diagnosis service for clients with mental health and substance misuse issues
- TB van every 6 months
- Queenswood Medical Centre – close to YMCA hostel and deals with high rate of homeless patients
- Mental health first aid training

Future projects for 2013

- St Mungo's, a major provider of supported accommodation, has won a tender to provide a substance misuse recovery service and will open the college part to all service users
- Queenswood, satellite service from DASH, with a target on Cannabis use.
- The Dual Diagnosis to provide a peer led substance misuse services based in a local hostel
- Haringey Borough Commander of the London Fire Brigade will conduct a street count of all derelict buildings in the borough.
- North Middlesex hospital setting up a homeless discharge team.

.....but no coherent unified strategy for health promotion, in primary, secondary or mental health services specifically looking at the needs of homeless people in Haringey

Four models of homelessness primary care

Models developed by Professor McCormack ranges from mainstream and outreach services to fully integrated primary care:

Mainstream practices providing services for the homeless – for example a GP from a mainstream practice holds regular sessions for homeless people either in a drop-in centre or in his or her surgery.

Outreach team of specialist homelessness nurses – for example an outreach team of specialist nurses providing advocacy, support and relevant health care treatments, and sign-posting to dedicated GP clinics

Full primary care specialist homelessness team – for example a team of specialist GPs, nurses and other services providing dedicated and specialist care, either located in a hostel or a drop-in centre

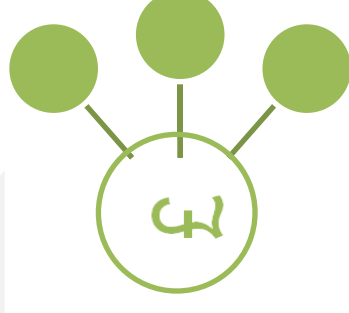
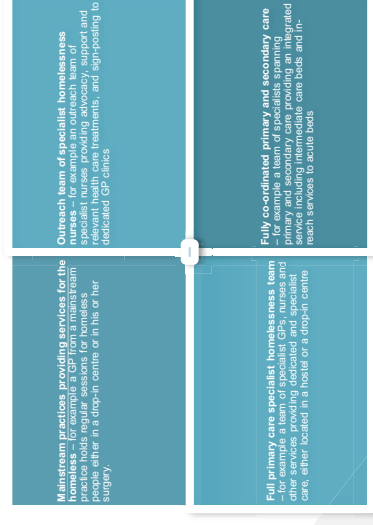
Fully co-ordinated primary and secondary care – for example a team of specialists spanning primary and secondary care providing an integrated service including intermediate care beds and in-reach services to acute beds

Source: Office of the Chief Analyst, 2010

But what is the best local model?

Recommendations

- **Develop a local model** for delivery of health and wellbeing for rough sleepers and hostel dwellers with key stakeholders, include community providers in the planning of services.
- **Joint commissioning** across the Council and CCGs to meet the health needs of homeless population – including joined up bids for external funding, explore providing similar level of support regardless of substance misuse status or history of offending.



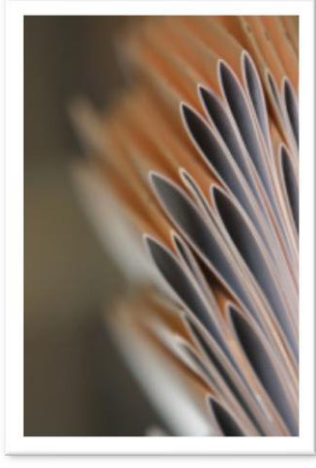
Recommendations

- **Exploit existing resources** - for example, up-skill staff at hostels for health promotion activities, arrange health satellite services at hostels and Haringey winter shelters (church based rolling shelters).
- **Explore peer led options** – as an example Groundswell have a Homeless Peer Advocacy project which aims to improve the health of homeless people through peer advocates. Peers offer clients 1:1 support and accompany clients to appointments. Other health related services include the TB Peer Education project to support homeless and vulnerable people to get screened for TB.

Recommendations

Immediate service improvements:

- Produce guidance of the proof of residents needed for GP registration
- Improve coding of homeless status in patient records to more accurately assess prevalence and health needs



Category	Value
Homeless	100
Homeless with mental health issues	50
Homeless with physical health issues	30
Homeless with substance use issues	20
Homeless with other health issues	10
Homeless with no health issues	5

...but consider the hierarchy of needs and prevention

Qualitative study (Hinton, 2000) identified a number of factors they felt were negatively affecting health of the homeless:

- sharing space and the strains of communal living in hostels
- lack of daytime occupation
- lack of health information
- limited access to food and cooking
- and little resident involvement in the management of the hostel which fosters the feeling of powerlessness

Improving living conditions in hostels and providing housing support may be the most effective intervention for better health outcomes



Next steps

- **Bring together key stakeholders** to develop a local strategy and explore the feasibility of different models locally
- **Gather further information on best practise** and different local models in London

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Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	
Title:	North Middlesex University NHS Trust's Foundation trust Application Update		
Report Authorised by:	Lance McCarthy, Deputy Chief Executive, North Middlesex University NHS Trust		
Lead Officer:	Lance McCarthy, Deputy Chief Executive, North Middlesex University NHS Trust		
Ward(s) affected: All	Report for Key/Non Key Decisions: N/A: For Update and Discussion		

1. Describe the issue under consideration

1.1. This paper updates Haringey's Health and Wellbeing Board on the progress that North Middlesex University Hospital NHS Trust (North Mid) is making with its application to become a Foundation Trust. It specifically details the next steps in the application process, the timetable and the public consultation process

2. Recommendations

2.1. It is recommended that the Health and Wellbeing Board:

- (a) Note the report attached at Appendix 1;
- (b) **NOTE** the progress being made with the North Mid's FT application
- (c) **NOTE** the process of ongoing discussions between North Mid and CCG Chief Officers and Finance Directors to ensure that plans are aligned and enable commissioner support for our application
- (d) **NOTE** the timeline for formal Governing Body support for our application in the late summer / early autumn (September Governing Body meetings)
- (e) **RESPOND** formally as a Health and Wellbeing Board to the public consultation
- (f) **ENCOURAGE** individual responses to the public consultation from colleagues and members of the public



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3. Background information

- 3.1. Foundation trusts are independent legal entities that have different governance arrangements to NHS trusts as they are accountable to local people, who can become members and governors.
- 3.2. They devolve decision making from central government to local organisations and communities, are not directed by government – giving them greater freedoms to decide their own strategy and the way services are run.
- 3.3. The North Middlesex University Hospital NHS Trust’s Foundation Trust application has not been previously discussed formally by Haringey Health and Wellbeing Board.

4. Comments of the Chief Finance Officer and financial implications

- 4.1. The resource implications will be set out by the North Middlesex Hospital in due course.
- 4.2. There are no direct financial implications for the Council.

5. Comments of the Assistant Director of Corporate Governance and legal implications

- 5.1. The Assistant Director of Corporate Governance has been consulted on this report. There are no specific legal implications.

6. Equalities and Community Cohesion Comments

- 6.1. This is an information report and as such, Policy and Equalities Team have no specific equalities comments to make at this stage.
- 6.2. It would appear from paragraph 6.2 of this report that North Mid have carried out an equality impact assessment and have found that becoming a Foundation Trust would have no negative equality impacts.
- 6.3. **Patient & Public Involvement (PPI):** Details of the 12 week consultation are provided in the following paper. (*Comment from North Middlesex*)
- 6.4. **Equality Analysis:** There are no negative equality impacts on the local population in North Mid either applying for or becoming an FT. A public consultation for 12 weeks is a requirement for a successful application. (*Comment from North Middlesex*)



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7. Policy Implication

- 7.1. The Health and Wellbeing Strategy aims 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.
- 7.2. The North Middlesex University NHS Trust is a provider of healthcare services to the residents of Haringey.



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9. Use of Appendices

9.1. Appendix 1: North Middlesex University Hospital NHS Trust's
Foundation Trust Application Update Report

10. Local Government (Access to Information) Act 1985

N/A



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Appendix 1:

NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST'S FOUNDATION TRUST APPLICATION UPDATE

1. Background to Foundation Trusts (FTs) and our application to become one

Foundation Trusts (FTs) remain part of the NHS but are authorised and regulated by Monitor. They have a different structure and governance to NHS Trusts in that they are membership organisations with members drawn from the public and staff, who can be elected to be governors on a Council of Governors to which the Board of Directors reports.

There are many benefits to patients, staff and the Trust of becoming an FT, including:

- local ownership – membership and council of governors having a greater say in shaping services and influencing investment decisions
- greater voice for staff – with increased ownership
- improved governance – the application process a catalyst to improve governance and internal systems of control
- greater financial freedoms – enabling longer term planning

North Middlesex University Hospital NHS Trust (North Mid) has recently undergone the biggest transformation in its history. Over £200 million has been spent on new buildings and new services in the past five years and we now provide high quality healthcare for more people than ever before. We are proud of the journey we have been on and with the people who work with us, with our patients and with our local community.

We will continue to grow as we seek to become the healthcare provider of choice in north London and becoming an FT is our next great opportunity and a really important step for all of us. We believe achieving FT status will yield the benefits identified above and also, ultimately, support our continuing development and improvement as an organisation and, as a membership organisation, staff, patients and our local population will have key roles to play in the development of our services.

2. Application Process

FT applications are managed by the NHS Trust Development Authority (NTDA). The process for applications is detailed in their Accountability Framework, revised most recently in April 2014. There are three stages to the NTDA approval process (diagnosis and preparation; development and assurance; approval and referral to Monitor) before a referral to Monitor is made, expected to take approximately 12 months in total. The subsequent Monitor phase is expected to take a further 6 months before authorisation is achieved.



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The format of the application process is very clear and very prescribed including, in the NTDA phase:

- Development of an Integrated Business Plan (IBP) - 10 years for North Mid as we have a PFI building
- Development of a Long Term Financial Model (LTFM) showing financial sustainability (also 10 years)
- Completion of a Board Governance Assurance Memorandum and external review of this
- Completion of a Quality Governance Memorandum and external review of this
- 2 Independent Financial Reviews (IFRs, formerly Historic Due Diligence (HDD)) of our finances
- Observations of Trust Board and key Board sub-committee meetings
- Interviews with all Trust Board members
- 'Good' or 'Outstanding' report from the Chief Inspector of Hospitals / CQC visit
- Commissioner support from key commissioners in the form of a formal letter
- Commissioner interviews
- 12 week public consultation
- Creation and development of a representative membership (c. 4,000 public members and 2,500 staff members)
- Creation of a organisational constitution
- Board to Board meetings with TDA.

The Monitor phase includes:

- Further IFR
- Additional Quality Governance review
- Observations of Trust Board and key Board sub-committee meetings
- Commissioner interviews
- The appoint of 23 (proposed) governors and development of a shadow Council of Governors
- Board to Board meetings with TDA

3. North Mid progress along the pipeline

Good progress is being made with our FT application. We are formally in the middle of the second (development and assurance) of the three NTDA stages.

The key elements to the approval of our application by the NTDA and their referral of it on to Monitor are:

- Complete and comprehensive IBP and LTFM
- 'Good' or 'outstanding' Chief Inspector of Hospitals (CIH) report
- Commissioner letters of support for the application
- Externally assessed IFR2 that doesn't raise any major concerns



Haringey Council

- Completion of a 12 week public consultation and amendments to our plans where relevant
- Successful Board to Board meeting with the NTDA

We are in discussion with the NTDA about some of the specifics of our timeline, including the exact dates of the 3 key meetings with them. These are likely to be:

- Exec to Exec meeting – 2nd July
- Readiness Review (Executive Directors and Chair) – 8 August
- NTDA Board to Board – TBC

We are continuing to progress all elements of our application with these dates whilst confirmation is attained.

3.1 Complete and comprehensive IBP and LTFM

The draft IBP and LTFM continue to be updated as time moves on, particularly as we have just moved in to a new financial year. The key ongoing pieces of work for the forthcoming months include:

- Receipt of and integration of NTDA comments on the first draft version
- Receipt and integrations of CCG comments on the first draft version (see commissioner letters of support section below)
- Continued development of specialty specific development plans supporting the Trust's Service Development Priorities and linking workforce, capital, revenue and estate implications together
- Development of a 10-year QIPP programme, by the end of June
- Updating the downside mitigations
- Refresh of the IBP documentation and all supporting strategies / documents as a result of the above

3.2 'Good' or 'outstanding' Chief Inspector of Hospitals (CIH) report

To progress along the FT timeline our CIH report needs to be rated as either 'good' or 'outstanding'. Anything else will necessitate a halt in our progress along the timeline, realistically for a minimum of 6 months whilst we are able to address any shortfalls sustainably and be re-inspected to provide evidence and assurance of the changes made. Good preparation for the visit taking place from 3rd June to 6th June, is being undertaken.

3.3 Commissioner letters of support for the application

A key requirement for progression of our application is letters of support for it from our key commissioners (those with more than approximately 25% of our activity). For us this is Enfield and Haringey CCGs only.

There are regular fortnightly meetings with the Chief Officers and Finance Directors of the CCGs, Deputy CEO and FD of the Trust and representatives of the NTDA



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and NELCSU to discuss the detail in our IBP and LTFM and the assumptions that underpin them.

There is clearly the need to ensure that our plans are broadly in line with current commissioning intentions, commissioners' 5-year plans and the Better Care Fund developments. It is expected that through these discussions and discussions at relevant Governing Body meetings, seminars and sub-committees (to be determined) that the Haringey CCG and Enfield CCG Governing Bodies will be in a place to formally discuss and support our FT application in their public meetings in the late summer / early autumn (September Governing Body meetings).

3.4 Externally assessed IFR2 that doesn't raise any major concerns

The NTDA phase of the FT application requires two IFR reviews. Part I has been completed and the actions from these are being worked through and addressed in full. The second phase is planned to commence on 16 June and run for approximately 4 weeks, with a full report received by 28 July. The Trust's finance team are working through the detailed information required in advance.

3.5 Completion of a 12 week public consultation and amendments to our plans where relevant

Consultation on our application and proposed governance structure starts on 27 May and will run for 12 weeks. This is a material piece of work engaging with our staff and public members about our plans. We are targeting 750 responses to our proposals, which will be evaluated fully and suitable amendments made to our plans as a result. A consultation document will be posted to all members and we will be running a number of public events in both Haringey and Enfield (dates below) as well as a number of additional staff events. Meetings are also being arranged with all our key stakeholders to discuss the proposals.

It is enormously important for us to hear the view of our members and the public on our proposals for how the Trust will work when it becomes an FT. A formal response from the CCG is required as part of the application process and individual responses from members of the Governing Body and colleagues would be warmly welcomed. Comments can be provided in a variety of ways, including filling out a questionnaire included in the consultation document, or by completing it online at www.NorthMidHaveYourSay.co.uk.

The public events dates are:

- 12th June 2014 - Dugdale Centre, Enfield from 18:30 – 20:30
- 16th June 2014 - Greendale Towers Community Centre, Edmonton from 14:00 – 16:00
- 3rd July 2014 - Haringey Civic Centre, High Road, Wood Green from 14:00 – 16:00
- 17th July 2014 - College of Haringey, Tottenham from 18:30 – 20:30



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3.6 Successful Board to Board meeting with the NTDA

The exact date of the Board to Board meeting with the NTDA is yet to be confirmed but is likely to be in the early autumn 2014.

3.7 Other programmes of work

There are a number of other pieces of work that are currently underway to underpin our application. These include:

- Membership recruitment – we continue to work with Membership Engagement Service to recruit public members. We are targeting 4,000 public members by the end of the autumn and currently have in excess of 3,000. Our Council of Governors will be elected in the most part from our staff and public members so good engagement with them is key to having a well-functioning Council of Governors.
- Member events – to support the engagement of all our members (staff and public) a series of monthly events is being planned from June, covering a range of topics to appeal, over time, to all members. This will be a good opportunity for public members to engage with the Trust and for staff members to understand about areas of the organisation they may not know too much about.

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