Health and Wellbeing Board

TUESDAY, 23RD JUNE, 2015 at 6.00 pm HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillor Kober (Chair), Cllr Ann Waters (Cabinet Member for Children, LBOH), Councillor Peter Morton (Cabinet Member for Health and Wellbeing), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Zina Etheridge (Deputy Chief Executive LBOH), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey) , Cathy Herman (Lay Member, Haringey CCG), Sarah Price (Chief Operating Officer, Haringey CCG), Dina Dhorajiwala (Vice Chair Haringey CCG), Jon Abbey (Interim Director of Children's Services), Dr Sherry Tang (Chair, Haringey CCG), Beverley Tarka (Interim Director Adult Social Care) and Gill Hawken (HAVCO Interim Joint CEO/ Management Consultant).

AGENDA

1. FILMING AT MEETINGS

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

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

2. WELCOME AND INTRODUCTIONS

The Chair will welcome those present to the meetings and introductions will then be made.

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

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

5. DECLARATIONS OF INTEREST

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

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

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

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

6. QUESTIONS, DEPUTATIONS, PETITIONS

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

7. MINUTES (PAGES 1 - 18)

To consider and agree the minutes of the meeting of the Board held on 24th March 2015.

8. PRIMARY CARE UPDATE (PAGES 19 - 164)

9. HEALTH AND WELLBEING STRATEGY (PAGES 165 - 224)

10. HEALTH AND CARE INTEGRATION

Verbal update.

11. URGENT ACTIONS TAKEN IN BETWEEN MEETINGS (PAGES 225 - 236)

Urgent action taken by the Chair of Health and Wellbeing for noting.

- Better Care Fund

12. NEW ITEMS OF URGENT BUSINESS

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

13. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are:

- 24th September, 19:00.
- 24th November, 18:00
- 23rd February, 18:00

Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Philip Slawther
Principal Committee Coordinator
Level 5
River Park House
225 High Road
Wood Green
London N22 8HQ

Tel: 02084892957
Email:
philip.slawther2@haringey.gov.uk

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Agenda Item 7

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

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

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MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY 24 MARCH 2015

Board Members Present: Councillor Peter Morton (Cabinet Member for Health and Wellbeing - Chair), Councillor Claire Kober (Leader), Tamara Djuretic (Public Health - Substitute for Dr Jeanelle de Gruchy), Zina Etheridge (Deputy Chief Executive LBOH), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey) , Dr Helen Pelendrides (Vice-Chair Haringey CCG), Sarah Price (Chief Operating Officer, Haringey CCG), Jon Abbey (Interim Director of Children's Services), Beverley Tarka (Interim Director Adult Social Care) and Cllr Ann Waters (Cabinet Member for Children, LBOH).

Officers Present: Philip Slawther (Principal Committee Coordinator LBOH), Stephen Lawrence-Orumwense (Assistant Head of Legal Services), Cassie Williams (Assistant Director of Primary Care Quality and Development – Haringey CCG), Sarah Barron (Interim Manager, Primary Care – NHS England), Sarah Hart (Senior Commissioning Manager – Haringey CCG), Tim Deeprose (Interim Assistant Director for Mental Health Commissioning – Haringey CCG).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** In the absence of the Chair Cllr Morton took the Chair. The Chair welcomed those present to the meeting.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Dr Jeanelle de Gruchy (Director of Public Health, LBOH) • Cathy Herman (Lay Member, Haringey CCG) • Dr Sherry Tang (Chair, Haringey CCG) In addition, Cllr Kober sent apologies for late arrival.	
CNCL103.	**URGENT BUSINESS** None.	
CNCL104.	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY 24 MARCH 2015

CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** There were no questions, deputations or petitions tabled.	
CNCL106.	**MINUTES** Sir Paul Ennals, the Chair of Haringey LSCB, queried that one of the actions contained in the previous minutes was to bring the Health and Wellbeing Strategy back to the March meeting of the Board. Zina Etheridge, the Deputy Chief Executive responded that the matter would be briefly covered at the meeting but, as the item was out to public consultation, legal advice was that the Board should not formally consider the Item until the following meeting in June. Sharon Grant, Chair of Healthwatch Haringey, noted that the Board agreed to keep the future makeup of the Board under review, particularly in terms of the patient/user representation. Ms Grant requested clarification on how the makeup would be kept under review. The Chair agreed to address the issue outside of the meeting and come back via correspondence; If necessary the item would be brought back to the following meeting. **RESOLVED:** That the minutes of the meeting held on 13th January 2015 be confirmed as a correct record.	Chair/ Director of Public Health
CNCL107.	**TRANSFORMING HEALTH & WELLBEING IN HARINGEY** The Board received a presentation, from Ms. Zina Etheridge and Ms. Sarah Price, the Chief Operating Officer of Haringey Clinical Commissioning Group, giving an overview of key developments related to Health & Wellbeing in Haringey. Ms. Etheridge noted that the Mental Health and Wellbeing Framework was tabled as an appendix to the report in the agenda pack. Following the presentation the Board discussed the findings. The Board noted that the Care Act 2014 involved the biggest change to adult social care since the foundation of the Welfare State in 1948. Included in the Act was a provision that the Council had a duty to promote an individual's wellbeing. It was noted that the Care Act 2014 made the principle of wellbeing a cross-Council, cross-partner and cross-third sector concern; which created a community based definition of wellbeing. Ms. Etheridge outlined the key elements of the Children and Families Act 2014. The Board noted that the Act involved changes to adoption and reforms to the way Looked after Children were cared for. It was	

also noted that the act integrated educational training provision with health care and social care provision in the context of promoting wellbeing. This duty provided a much greater emphasis of health care and social care providers to work in a more joined-up fashion and, as a result, engendered joint commissioning arrangements between the Council and the CCG in relation to children and young people with those needs.

Ms. Price noted that the Five Year Forward View for the NHS was set out in October last year and this document brought together all of the health care organisations such as NHS England, Public Health England and the Trust Development Agency to jointly set out what those organisations wanted to achieve over the next five years. The document showed how the transformation of services was to be delivered, in order to make it both affordable and also improve the quality and ensure sustainability going forward. The key consideration was noted of changing health demographics, with a rise in long term conditions and associated costs involved. The Board noted that Haringey CCG was awarded an additional £5m (including £1.7m to assist with additional demand pressures during winter) from the £1.95B announced in the Autumn Statement to support the changes set out in the Five Year Forward View. Additionally, £200m was allocated for pump priming the new models of care set out in the report and £250m a year, for a four year period, was set aside to improve primary care. Ms Price advised that the local outcome of those two bids would be known around Easter time.

Ms. Price outlined the main elements of the Haringey CCG Five Year Plan, which was coming to the end of the first year of its planning cycle. The plan had been developed locally and discussions had also been undertaken with Camden, Islington, Barnet and Enfield to ascertain what their plans were and what could be achieved through a collaborative plan. The CCG was looking to explore and commission some the alternative models of care through this plan. The overall mission of the plan was to make primary care and care closer to home really work for all Haringey's residents, and in doing so reduce the pressures on hospitals. The plan also set out how models of primary care might be set out more innovatively bringing GP's, Trusts, community and voluntary organisations into the new ways of working.

Ms. Etheridge commented that in Priority 2 of the Council's Corporate Plan 2015-2018, the Council was committed to "empowering all adults to live healthy, long and fulfilling lives". Ms. Etheridge also commented that the Council was consulting on Haringey's new Health and Wellbeing Strategy for 2015-2018, but that the three main priorities for the strategy were:

- Reducing obesity;
- Increasing healthy life expectancy; and
- Improving mental health and wellbeing

Ms. Etheridge introduced Tamara Djuretic, Assistant Director of Public Health, and Tim Deeprose, Interim Assistant Director for Mental Health Commissioning, and they presented the Mental Health and Wellbeing Framework to the Board. Dr. Djuretic commented that the Mental Health and Wellbeing Framework was jointly produced by the CCG and LBH and articulated joint vision and strategic commissioning intentions for the next three years. It was noted that dementia was excluded from the framework as it had a different set of strategies required to deliver it. The framework takes a life course approach and reflected the shifting current model of care from acute and residential care towards community care, focused on prevention and early health. The vision for the framework was: "All residents in Haringey are able to fulfil their mental health and wellbeing potential." The Board noted that this focused on the population as a whole not just high risk cases and identified wellbeing, as defined in the Care Act 2015, as a key element.

Mr. Deeprose outlined the four priorities of the framework to the board. The Board noted that each of the four priorities was to have a task and finish group established to assist in the implementation of the framework.

The priorities were noted as:

- Promoting mental health and wellbeing and preventing mental ill health across all ages.
- Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood.
- Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa.
- Commissioning and delivering an integrated enablement model which used individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives.

Ms. Etheridge noted that there was a considerable amount of change outlined in the paper. The paper and the Mental Health Wellbeing Framework in particular, contained a number of key principles and outcomes:

Principles:

- Wellbeing at the core of all we do.
- Prevention and early help – including supporting children to get the best start in life.

- Strong, collaborative partnership.
- Promoting independence, underpinned with the right support.
- Working with communities.
- A holistic approach, putting individuals, not institutions, in control.
- Reducing health inequalities.

Outcomes:

- Better wellbeing.
- Better health, for longer, for everyone.
- Independence and self managed support – enabling people to be in control of their lives.
- High quality services that are joined up around individuals, and community needs, not those of the institutions providing services.
- Resilient communities.
- Safety.

The Chair commented that a huge body of work had gone in to the paper and underlined that the report made clear that the delivery of these changes required a significant change in the way organisations worked, including greater cooperation between the public and voluntary sector. The Chair requested clarification on what some of the key challenges would be in that regard. Ms. Etheridge responded that there were some very significant challenges involved, but at the centre of this was placing early intervention and prevention at the core of everything that Council and partners undertook. Significant resources were tied up in acute provision and resources focused on people in beds as appose to enabling people to live in the community, so transitioning would be a key challenge including the work force transformation required to support this. Officers also responded that a further key challenge was ensuring that community and voluntary sector organisations were involved and operated as strong partners with the Council and CCG. Doing so would involve a level of support to those organisations to enable them take on those opportunities. Furthermore, the Care Act 2015 outlines a duty to ensure that there was a sustainable market available for delivering the goals of the Care Act.

Ms. Price noted that from the NHS' perspective, the workforce issues would require some further joint work; particularly as both the Council and NHS would be looking to recruit from the same pool of resources. In addition, reduced duplication through the better alignment of resources was also identified as a challenge. Officers also noted that people being helped to understand what the vision was across Haringey as a whole, was also a key challenge.

Jon Abbey, Interim Director of Children's Services, commented that the Care Act 2015 and the Children and Families Act 2014 should not be seen in isolation and that there were substantial crossovers, particularly in terms of the transitionary period between when a young person

becomes an adult. Possible concerns were noted in terms of the negotiation of Education Health and Care Plan and also Child Needs Assessment. The link between the two was highlighted and consideration would be required on with how best to utilise resources to ensure best outcomes. Joint commissioning was central to the overlap being tackled.

Beverley Tarka, Interim Director Adult Social Care, commented that health and social care integration was key to transformation of the health and social care economy. Ms. Tarka reiterated that significant resources were trapped in the acute sector and emphasised the need to shift activity to prevention and early intervention. Ms. Tarka also identified a number cross-cutting themes and enablers such as staff, IT and interoperability. The centrality of the communities' theme was highlighted particularly in relation to the Care Act 2015, Children and Families Act 2014 and the NHS Five Year Forward View. In order to develop the shift required the Council and partners would need to facilitate the community to self manage, which would be a huge task. The commitment to develop a diverse and sustainable market was identified as one of the key challenges in the Care Act 2015 and it was noted that this would necessitate close cooperation between the Council and its partners.

Dr. Djuretic commented that the increasing population and the effects of an ageing population were also an important consideration as this would place an increasing strain on health and social care providers.

Sir Paul Ennals, Chair of Haringey LSCB, commented that the work that had been done so far including the Mental Health & Wellbeing Framework in Haringey was a very impressive body of work, particularly in terms of its scope and the fact that all of the different stands had been brought together. Sir Paul advised that whilst the pace of change had been swift in the previous three years, the next three years would be even more difficult. Sir Paul noted that the theme of integration including integrated planning, commissioning and delivery of services would only be increased over time. Sir Paul enquired what the overall arching strategy document was, given the number of strategic documents being developed by the Board. Sir Paul also queried what the role of the draft Health and Wellbeing Strategy was in relation to these other documents. The Board needed a central strategy to bind all of the other strategies together. The Health and Wellbeing Strategy should be the central strategy, which pulled together the outcomes and principles from which all of the strategies of the Health and Wellbeing Board flowed.

Sharon Grant, Chair of Healthwatch Haringey, reiterated Sir Paul's comments about the need to have a central strategic document that outlined all of the changes that are being brought about in health and wellbeing. Ms. Grant also commented that she would like to see some indication in the document of how our strategies had been informed by

	the particular problems in Haringey, including our engagement with communities. The Leader, Cllr Kober, also agreed with Sir Paul's and Ms. Grant's comments about the need for an overarching strategy document. The Chair stated that there was a great deal of worth in the draft Health and Wellbeing Strategy and that the challenge over the next three months was to refine some of the issues and to make clear the Haringey specific elements. Mr Abbey commented that in terms of the tabled report, the draft Health & Wellbeing Strategy and the recent Overview & Scrutiny review of Mental Health and Wellbeing, there was a strong Haringey specific flavour to the work that was being undertaken. Ms. Etheridge advised that the Joint Strategic Needs Assessment was the place where the specific information that related to Haringey was brought together. Ms. Etheridge also commented that perhaps the report needed to better reflect the JSNA. Ms. Grant fed back that Healthwatch Haringey felt that the Mental Health and Wellbeing Framework in Haringey lacked sufficient emphasis on drugs and alcohol related issues. Ms Djuretic agreed to take these comments on board and agreed that this would be incorporated into the delivery plan developed through the task & finish groups. It was **RESOLVED:** I). That the impact of the Care Act 2014 and the Children and Families Act 2015 be noted; and II). That the Council, NHS England and Haringey CCG Strategic Plans and Priorities referred to in the report be noted; and III). That the progress on the consultation for the Health and Wellbeing Strategy be noted; and IV). That the Mental Health and Wellbeing Framework in Haringey be agreed.	Assistant Director of Public Health
CNCL108.	**PRIMARY CARE TASK AND FINISH REPORT** Sarah Barron, Interim Manager, Primary Care at NHS England & Cassie Williams, Assistant Director of Primary Care Quality and Development, gave a presentation to the Board on the interim findings from the Strategic Plan for Primary Care. Ms Barron emphasised that the findings were interim as the Strategic Plan was due for completion in April. The key finding was identified as reinforcement of the shortfall in	

	primary care capacity issue which had been previously identified by the Board in the area around Tottenham Hale, Tottenham Green and Bruce Grove. Ms Barron argued that although the issue had been raised previously, there was a lack of evidence of strategic need to take to the NHS Finance Committee. The findings of the report and the capacity analysis would be used to develop that strategic need. Ms Barron commented that the minutes of the Board in September, along with the Healthwatch report that was tabled was to be used as evidence to support an application for additional primary care capacity. The Board were invited to put forward any other items that may help evidence the strategic need. Ms Barron advised that the data was complex and that a significant gap existed between the GP registered population in that area and the resident population. As a result, the Board was advised that it was difficult to make a commitment on exactly how much additional capacity was to be commissioned. However, Ms Barron estimated that, based on the figures in the Healthwatch report, there was a shortfall of around 4500 patients which equated to roughly 3 GP's. The capacity analysis would be taken to the Primary Care Decision Making group next which would recommend a commissioning option; either an additional primary care practice procured, or a new premises would be commissioned and an existing practice moved in to that premises. After having been through the primary care decision making group, the decision would then be taken forward to the NHS finance committee for approval. The Board noted that the process was likely to take 2-3 months. The second option to commission a new premises and then move a new existing practice into that site was identified as problematic due to the deficit in primary care capacity identified in the area. Ms Barron noted that details of the Primary Care Infrastructure fund of around £1B over four years had been released since the last meeting. Bids from across London had been assessed under the scheme, however it was noted that the results were not available until 27th March. The Board noted that seven bids in Haringey had been approved subject to significant clarification, 5 of which were in east Haringey. It was noted that some of these bids might be in a position to support capacity in the area. These bids would be developed further in April in conjunction with the commissioning plans described earlier to ensure that a solution was found in the next three months. Ms Barron stated that a piece of work was being undertaken which involved a detailed investigation of the primary care needs over the next five to ten years. A baseline of Haringey GP capacity identified that further investigation was required in the following areas; • Noel Park • Green Lanes • Tottenham Hale • Northumberland Park	Board to note

Ms. Barron identified that NHS England had taken contractual action with underperforming practices in the areas concerned and would continue to do so given the capacity deficit that existed.

Nicky Hopkins of North London Estate Partnerships gave an update to the Board on the strategic premises development planning process. The Board noted that two stakeholder meetings had been held at which an options appraisal was undertaken for immediate/short term options for Tottenham Hale, and a set of valuation criteria was agreed. The valuation criteria was used to asses a number of temporary options including at Tamar Way, Hale Village and Board Lane. These sites were to be developed further. In addition, the Welbourne Centre scored quite highly as a more longer term solution

The Board noted the following timescales for completion of the project:

Complete:

- **Stage 1- Creating a baseline**: stakeholder engagement & analysis of data. Identify urgent needs.

In progress:

- **Stage 2- Developing a solution**: gap analysis & identification of options, develop options assessment criteria. Identify short term solutions.
- **Stage 3 – Options appraisal**; assess & prioritise the options.

To do:

- **Stage 4 – Sign off** & agree next steps. (Mid-April 2015)
  NHS England approval process (May/June 2015 for temporary solution and July 2015 for full report)

The Chair welcomed the engagement from NHS England on this issue and thanked the presenters for their contribution. The following questions and comments were noted.

Sir Paul outlined that the current shortage of GP capacity provided a real and present danger to the child protection measures that were available in the borough. The families that were having the greatest difficulty in accessing primary care services were the ones most likely to present child protection risks. Sir Paul gave an example of a recently published Serious Case Review in which one of the factors was difficulties in relation to GP provision. A lack of GP capacity impeded the ability to take corrective measures when working with a very vulnerable family.

Cllr Kober commented positively on the inclusivity, and on the overall progress that had been made and fed back similar comments from one of the Ward Councillors for Tottenham Hale. The Board noted that what was crucial was that this was now pushed on through the further stages to fruition.

	Ms Grant welcomed the evidence that had been collected and reiterated the fact that there were residents that were unable to get appointments. The example of the impact of late cancer diagnosis on recovery rates was given. The Chair welcomed the engagement from NHS England throughout the process and expressed a desire that NHS England would continue to engage with the Board going forward. It was: **RESOLVED:** I). That the progress by the Task and Finish Group against the key aims be noted.	
CNCL109.	**PHARMACEUTICAL NEEDS ASSESMENT** The Board received a presentation, from Dr. Djuretic, on the Pharmaceutical needs Assessment. Following the presentation the Board discussed the group's findings. Dr. Djuretic noted that production of a Pharmaceutical Needs Assessment (PNA) was a statutory duty of the Health and Wellbeing Board. The PNA was the document that NHS England requested when it decided if new pharmacies were needed and to make decisions on which NHS funded services need to be provided by local community pharmacies. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require every Health & Wellbeing Board to publish its first PNA by 1st April 2015. The Board noted that there were 59 pharmacies in Haringey and the PNA report concluded that Haringey was well resourced in terms of pharmaceutical services and that there were no current needs for either extension, enhanced or advanced services identified. The PNA also highlighted that there was good alignment with GP surgeries in areas of population and there was a reasonable correlation between population and number of pharmacies. The area of north east Tottenham does have a below average number of pharmacies available. In addition, given the expected population growth in Tottenham over the next ten years, there will be need for additional pharmacies going forward. It was proposed that Public Health would maintain the PNA and review the needs going forward as the Tottenham regeneration programme progressed. The Board noted that the average number of prescriptions dispensed in each pharmacy was lower than both the London and England average. Ms. Grant noted that the report was particularly relevant given the	

	increasing role that pharmacies play in health care. The fact that there was additional capacity within Haringey was welcomed. Cllr Waters, Cabinet Member for Children & Families, welcomed the report and thanked the report author for their work. **RESOLVED:** I. That Haringey's Pharmaceutical Needs Assessment 2015 be approved.	
CNCL110.	**HEALTH AND HOMELESSNESS REPORT** The Board received a report from Sarah Hart, Senior Commissioning Manager Haringey CCG, which updated the Board on the work undertaken around health and homelessness. The task and finish group that was set up to look into this issue had previous identified three key issues in terms of health barriers facing homeless people in Haringey: • The process of GP registration was not transparent which allowed some practices to ask for photo ID as part of the registration process. • It was not clear what type of primary care model should be adopted for homeless people in Haringey. • There was a homeless discharge pilot at the North Middlesex Hospital which had no links into Council or primary care services. The Board noted that the following progress had been achieved: • Guidelines had been published on registering with a GP which were homeless friendly including some discretion that GP's could use in terms of establishing place of residence. • The Homeless Health Charter was signed by Cllr Morton on behalf of the Board. • A multi-agency workshop including partners from across the spectrum was established. The Board noted that in terms of the actions that are still unresolved, a key consideration was which model the Board wanted to adopt for primary care for homeless people. Ms. Hart noted that the workshop agreed that some form specialist primary care provision would be required and so a full JSNA would need to be undertaken. In addition, surveys would be undertaken amongst Haringey's homeless population to ascertain need. The Board also noted that feedback from the pilot at North Middlesex Hospital suggested that Haringey didn't have a particular problem with homeless people without GP access. Ms. Hart advised that the workshop found this very hard to believe. The consensus from the workshop was that that the pilot was aimed towards indentifying a	

	traditional Westminster rough sleeper; however this wasn't reflective of Haringey. Haringey's homeless population was characterised by a number of people who were vulnerably housed, including those either sofa surfing or who were housed in hostels. Hostels had fed back that a key issue was inappropriate discharge of patents from hospitals. It was recommended that the Board set up a small working group to look at what the local hospital discharge strategies were for the homeless population. The Chair commented that he recently visited a St Mungo's Broadway premises and emphasised the quality of care offered and the work that was done to put people back on their feet. Ms Etheridge commended the report and noted that it was a very thorough comprehensive piece of work. Dr. Helen Pelendrides, Vice-Chair Haringey CCG, commented that there was a model adopted in Barnet that did not use a specialist service but had developed a GP who had become very interested in homeless service and had set up a separate service for homeless patients. Officers agreed to liaise with Barnet around this service, it was agreed that a key consideration was around capacity and the number of primary care practitioners required. It was: **RESOLVED:** i. An expert group consisting of the Council and CCG homeless commissioners, providers, GP's and Public Health be established to develop and complete the single homeless person needs assessment; and ii. A request that commissioners and providers adopt the cross government operational guidance; Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation – as part of the measure to ensure better integrated services for homeless people leaving hospital be agreed.	Senior Commissioning Manager Haringey CCG
CNCL111.	**HEALTH AND CARE INTEGRATION PROGRAMME** Ms. Etheridge tabled a report updating the Board on the progress of the Health and Care integration Programme. It was noted that monthly programme board meetings were underway. The Board noted that the programme had agreed three key themes, integrated care for adults, children, and mental health and wellbeing. These themes aligned with the outcomes set out in Haringey's Health and Wellbeing Strategy, the Council's Corporate Plan and the 5 year strategy for CCGs in North Central London It was recommended that a more comprehensive update was brought back to the Health and Wellbeing Board for discussion in the Summer.	

	Ms Grant commented that Healthwatch would like to be involved a number of the projects undertaken in relation to this item. Officers responded that there were a number of projects underway at a variety of different stages. Officers would take this request away and give consideration as to which projects might be suitable and when they were evaluated. **RESOLVED:** i. That the progress made to date around Health and Care integration be noted; and ii. That a further update around Health and Care integration be brought back to a future meeting of the Health and Wellbeing Board.	Deputy Chief Executive Deputy Chief Executive
CNCL112.	**CQC REPORT/COMPLAINTS** Ms. Grant presented a report to the Board that outlined the CQC's new approach to raising concerns and complaints, following the Francis Inquiry Report. The Board noted that the CQC had adopted a new key line of enquiry towards complaints which was in the process of being implemented across the board from April 2015. The Parliamentary & Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England had set out universal expectations of good complaints handling and developed a user-led vision for raising concerns and complaints which the CQC adopted. Dr. Pelendrides fed back that discussions had been undertaken with Healthwatch, as a GP provider, on what an adequate display of a complaints procedure was and how to make the complaints process more patient friendly. Dr. Pelendrides welcomed the opportunity to input into this process. Stephen Lawrence-Orumwense, Assistant Head of Legal Services, suggested a minor change to the report so that recommendation 2.2 asked commissioners to 'note' the new complaints framework, as appose to 'adopt it', as recommending an external body adopt the recommendation was outside the terms of reference of the Board. Ms. Price commented that the NHS contract stipulated that providers took on board and reported on serious complaints. This would form part of the performance management framework for health care providers and the CGG would liaise with practices about the new complaint standards. It was: **RESOLVED:**	Chair Healthwatch Haringey

	i. That the new CQC key line of enquiry relating to complaints be noted; and ii. That commissioners from the CCG and local authority be asked to note the new complaints framework as appropriate in their provider contract specifications, to achieve a consistent approach in Haringey. iii. That agreement for the CQC complaints framework to inform CCG and local authority commissioners in monitoring existing contracts be given; and providers be encouraged to improve their existing complaints system. iv. That NHS England's use of the new user led complaints framework as a performance management tool, to be built into the NHS Outcomes Framework be noted; and v. That Healthwatch Haringey's adoption of the new CQC user led framework when reviewing complaints processes in provider organisations be noted.	
CNCL113.	**NEW ITEMS OF URGENT BUSINESS** No new items of urgent business were tabled.	
CNCL114.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 9th June at 13:30 The following agenda items were agreed for the next meeting: • Health and Care Integration update • Health & Wellbeing Strategy The Chair noted that this was the last Health and Wellbeing Board that Dr Pelendrides would attend and thanked Dr Pelendrides for her contribution to the Board.	

The meeting closed at 20.00pm.

COUNCILLOR CLAIRE KOBER

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Chair

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Report for:	**Health and Wellbeing Board**

Title:	**Strategic Plan & Capacity Plan**

Organisation:	**NHS England & Haringey CCG**

Lead Officer:	**Jill Webb, Head of Primary Care NHS England London Region**

1. Describe the issue under consideration

North London Estates Partnership (NLEP) were commissioned in December 2014 by NHS England (London Region) and Haringey Clinical Commissioning Group (HCCG) to develop an integrated Primary Health Care Strategic Premises Development plan for Haringey. The goal of this work was to evidence current primary care need in Haringey, particularly in the east of the borough and to suggest short and long term solutions to meet that need. This work was commissioned following the setting up of a Primary Care Task and Finish Group for Haringey in late 2014.

As the members of the Haringey Health and Wellbeing Board are aware a number of significant regeneration schemes and housing developments are planned across the borough, with particular emphasis on the Tottenham area. A recent Healthwatch report and representations from local residents also raised concerns that there was currently a shortfall in available GP patient appointments in the Tottenham Hale area in the context of an overall shortfall in the North East of the borough.

The.Primary Health Care Strategic Premises Development Plan for Haringey sets out in broad strategic terms the anticipated Primary Health Care Premises need over the next 10 years and provides estimates of both the current shortfall in medical manpower and anticipated requirements.

It is predicted that the schemes will deliver an increase to the local population of over 26,201 people between 2011 and 2020, an increase to 37,329 between 2011 and 2026 with associated increase in demand for Primary Health Care and need for increase in GP capacity. The Plan estimates that the total population in Haringey has already increased by c12,500 since 2011 and that majority of these residents have registered with a GP, although not with a GP within their ward of residence. It should be noted that funding for Primary Care follows registration, therefore c£1.5 Million of funding will have already been

allocated to practices for these patients. Current methodology results in funding that always lags three months behind list growth which means local practices would have been under pressure during sustained periods of list increase. Furthermore there has been only limited access to premises improvement grants over the last 5 Years.

The Plan highlights the need for an estimated 10.4 WTE GPs by 2026 in the Tottenham Hale Area and a further 4.3 WTE in the Northumberland Park Area if the strategic objective is to ensure that residents have access to a GP within their own ward of residence.

The short term solution described in the Plan has two components

- The provision of premises improvement grants to existing GP practices to ensure that they have adequate space from which to provide Primary Care Services, allowing them to recruit more GPs and offer more appointments.

- The establishment of a new GP Practice in the Tottenham Hale Area

The Primary Health Care Strategic Premises Development plan is an evolving document which should support decisions to make future investments in Primary Care Infrastructure in the London Borough of Haringey. It should be noted that to make such future investments the Primary Health Care commissioner will still need to follow the prescribed approval process from Project Initiation Documentation to Full Business Case, however this Plan will provide both borough strategic context and evidence base which should speed up the process.

2. Recommendations

The Health and Wellbeing Board are asked to note the content of the Plan and support in principle the recommendations of the Plan for substantial improvement and Development of the Primary Health Care Estate in Haringey over the next 10 Years.

Strategic Premises Development Plan: Borough of Haringey

Prepared for: NHS England (London Region) and Haringey CCG

June 2015

Version 1	Initial draft template created
Version 2, 3,4 & 5	Updated content
Version 6	Client update
Version 7 & 8	Updated content following client comment
Version 9	Issued to Task & Finish Group for comment
Version 10	Updated to final draft

Contents

List of figures

1 Overview

NLEP (formerly Elevate Partnership), is a public private partnership established in July 2004 through the NHS LIFT (Local Improvement Finance Trust) framework. Along with our partner organisation **gb**partnerships, we provide a comprehensive range of property services; from strategic planning, to development and asset management. As the local partner of choice we enable our clients to focus on the provision of services, working together to improve facilities for our local communities.

NLEP were commissioned in January 2015 by NHS England (London Region) and Haringey Clinical Commissioning Group (HCCG) following an identified need for an integrated Primary Health Care Strategic Premises Development plan for Haringey. Haringey has a number of significant regeneration schemes and housing developments which have been planned across the borough, but with particular emphasis on the Tottenham area.

It is predicted that the schemes will deliver an increase to the local population of over 26,201 people by 2020, an increase to 37,329 by 2026 with associated increase in demand for Primary Health Care and need for increase in GP capacity. A recent Healthwatch report raised a concern that there was currently a shortfall in available GP patient appointments in the Tottenham Hale area in the larger context of an overall shortfall in the North East of the borough. It has been further identified by HCCG that a number of the practices premises will not be viable in the future due to poor estate conditions.

Over recent years there has been a number of different strategies produced and studies undertaken from both a regeneration and existing portfolio basis. This report looks at stages one to three (of six) for an integrated Strategic Premises Development (SPDP) bringing an overarching strategy looking at both the regeneration and the existing estate infrastructure, to identify the local health needs for both now and in the future.

There are challenges in the system to achieving this; none more challenging than bringing a number of large autonomous organisations together to develop and agree a strategic plan. The establishment of a Task and Finish Group in partnership with a wide variety of stakeholders from across Haringey including NHS England, Haringey CCG, Haringey Council and Healthwatch Haringey is seen as a starting point and one that will benefit the patients and the organisations that service. The Task and Finish Group has played an active role in determining the direction and content of this report.

2 Executive Summary

This Primary Care Strategic Premises Development Plan looks at key stakeholder strategies, the location and pace of the growth planned and the likely impact on local primary care services and infrastructure. Other factors have also been considered such as existing primary care contractors and locations of services to provide a rounded picture of Haringey.

The London Borough of Haringey has plans for a 13% population growth between 2011 – 2026, nearly two thirds of which is projected between 2015 – 2026, impacting on the existing primary care infrastructure and services. The most significant growth is planned in the Noel Park ward between 2015 to 2020, although the overall population prediction in this ward of 7,944 outweighs the next highest prediction in Tottenham Hale by nearly 30% at 5,589. This is against a backdrop of existing poor quality estate across the borough, with 79% high or significantly rated for non-statutory compliance.

With the creation of Clinical Commissioning Groups (CCGs), the trend for new models of delivery for primary care is steering towards a federated model of delivery of primary care and community-based services (integrating with services previously delivered in secondary / social care) with a hub and spoke type model, centralising administration and more specialised services to create wider and more accessible patient access to primary and community-based services within a geographical area. Haringey CCG has a number of pilots schemes in operation to support these new models of care, and currently has four GP practice collaboratives spread across the borough in the North East, South East, Central and West.

The impact of growth in each of these areas has been analysed and requirements for additional services and infrastructure has been identified. Analysis has shown that currently some capacity is available across the system that could be utilised and additional patients that could be accommodated by fully utilizing existing clinical rooms. However, dialogue will need to be undertaken with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population, otherwise an estimated 7,842m² of space would be required across the borough by 2026.

The recommendations within this strategy are to pursue with the current Primary Care Infrastructure Fund Bid applications to support the estate and access for patients in the immediate to short-term. Building on the partnerships evolved through the Task and Finish group will embed the ethos of joined up healthcare across general practice, community services and hospitals resulting in a better experience, improved results and better value for money.

3 Stage One; Information Gathering and Stakeholder Engagement

3.1 Scene setting

The Primary Health Care Strategic Premises Development Plan (SPDP) has been commissioned on the first three, of six, stages in the overall implementation of an SPDP, being;

1) Stage one - Information gathering and stakeholder engagement,
2) Stage two - Solution development, and,
3) Stage three - Stakeholder sign up and sign off.

The remaining three stages will need to progress following Stakeholder sign off, being;

4) Stage four - Public engagement
5) Stage five - Approval process
6) Stage six - Implementation

Stage One will introduce Haringey, identify those key organisations operating in the Borough and their strategies, the location of the estate in terms of Primary Care delivery, and the quality of the estate in terms modern Primary Health Care Standards.

3.2 London Borough of Haringey

3.2.1 Overview

"*The Health of the people in Haringey is varied compared with the England average. Deprivation is higher than average, and about 31.2% (16,400) children live in poverty*"[i].

The London Borough of Haringey, located in the North of London, borders six other Boroughs; Barnet, Enfield, Camden, Islington, Waltham Forest and Hackney. The Borough spans over 11 square miles, of which over 25% is green space, and is divided into 19 wards, as shown in Figure 1.

[i] Health Profile for Haringey, produced 12th August 2014. Page 1. Public Health England. http://www.apho.org.uk/. Crown copyright 2014.

Haringey is the fourth most deprived borough in London. The population of Haringey is younger than the national average but, following the national trend, the proportion of over 65s within the population is rising fast. The Haringey Joint Strategic Needs Assessment (JSNA) demonstrates that there is a nine year gap in life expectancy, for both men and women, between the West and the East of the borough. The East of the borough has the lowest life expectancy and contains Tottenham, one of the most deprived areas in the country.

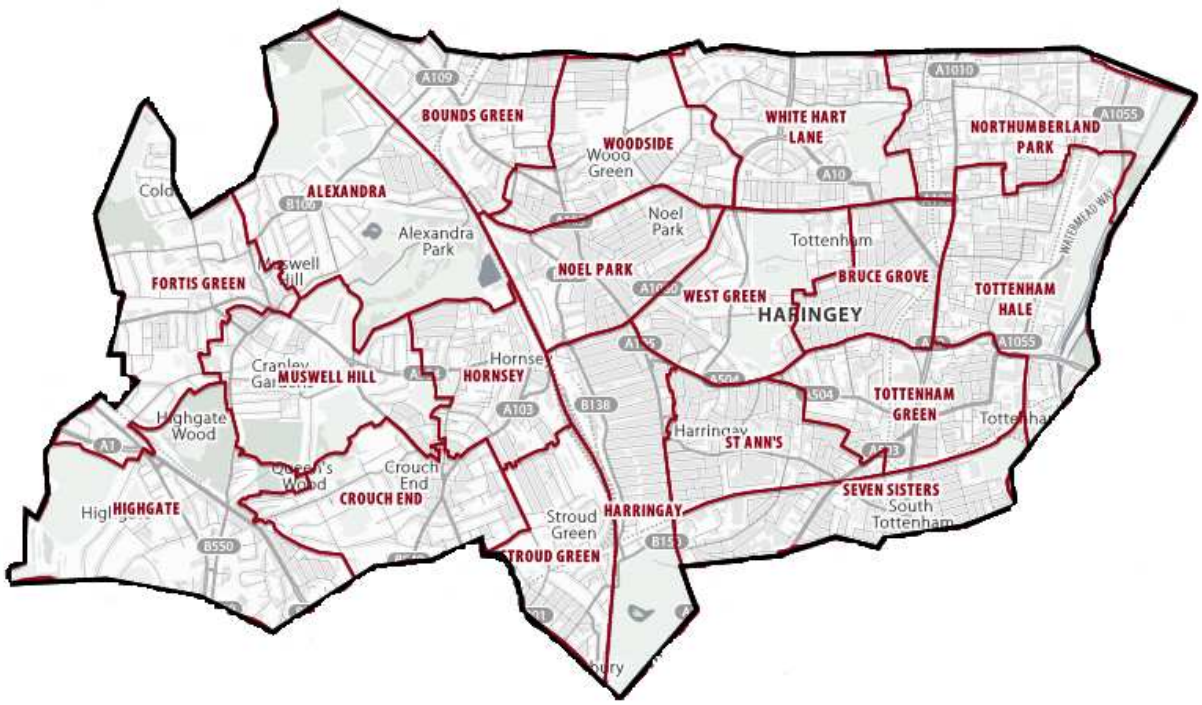


Figure 1: Haringey Ward Map (SHAPE).

3.2.2 Population

The 2013 JSNA states that the latest population in Haringey is estimated at 254,900[i]. Almost two-thirds of the population are young people, are from ethnic minority backgrounds, and over 100 languages are spoken in the borough. Haringey's population is the fifth most ethnically diverse in the country.

The population of Haringey is growing. The GLA (Greater London Authority), 2013 predicts the population to reach 293,757 by 2026, an increased population of 37,329 or 13%.

[i] Based upon 2011 National Census data

Population growth locally is mostly due to the increase in birth rates and net gain from international migration. Birth rates locally and nationally are increasing while death rates are decreasing. In 2011/12, there were 3,120 more births than deaths in Haringey.

In 2011/2012 ONS state that 19,381 people moved to Haringey from another part of the UK. Whilst inthe same period 23,002 people left Haringey for another part of the UK. At the same time, 6,797 people moved to Haringey from overseas, whilst 2,825 people left Haringey to live overseas.

Haringey has always experienced a high level of population turnover. Most population turnover occurs by people moving into and out of other parts of the UK. 26,178 migrants moved to Haringey in the 2011/12 year, with 6,797 (26%) of these coming from outside the UK. At the same time, 25,827 people moved outside the borough; of those 2, 825 (10.8%) migrated overseas. The net gain in population of the borough was therefore due to international migration.

Population growth in Haringey in recent years has been due to births outnumbering deaths coupled with the international inward migration.

3.2.3 Deprivation

Haringey is the fourth most deprived borough in London. The population of Haringey is younger than the national average but, following the national trend, the proportion of over 65s within the population is rising fast. The Haringey Joint Strategic Needs Assessment (JSNA) demonstrates that there is a nine year gap in life expectancy, for both men and women, between the west and the east of the borough. The east of the borough has the lowest life expectancy and contains Tottenham, one of the most deprived areas in the country.

It is important to note that while Figure 2 indicates the variation in deprivation across Haringey, showing the GP practice locations in context, this is only relative to the 19 wards within the borough itself. When examined in a national context all 19 Haringey wards rank in the top half of 7,679 wards nationally. In addition, 8 of Haringey's wards are in the top 500 most deprived wards nationally. Therefore it must be acknowledged that while certain wards in Haringey have low deprivation compared to their neighbours, they still exhibit deprivation above the national median. As shown in Appendix 1.

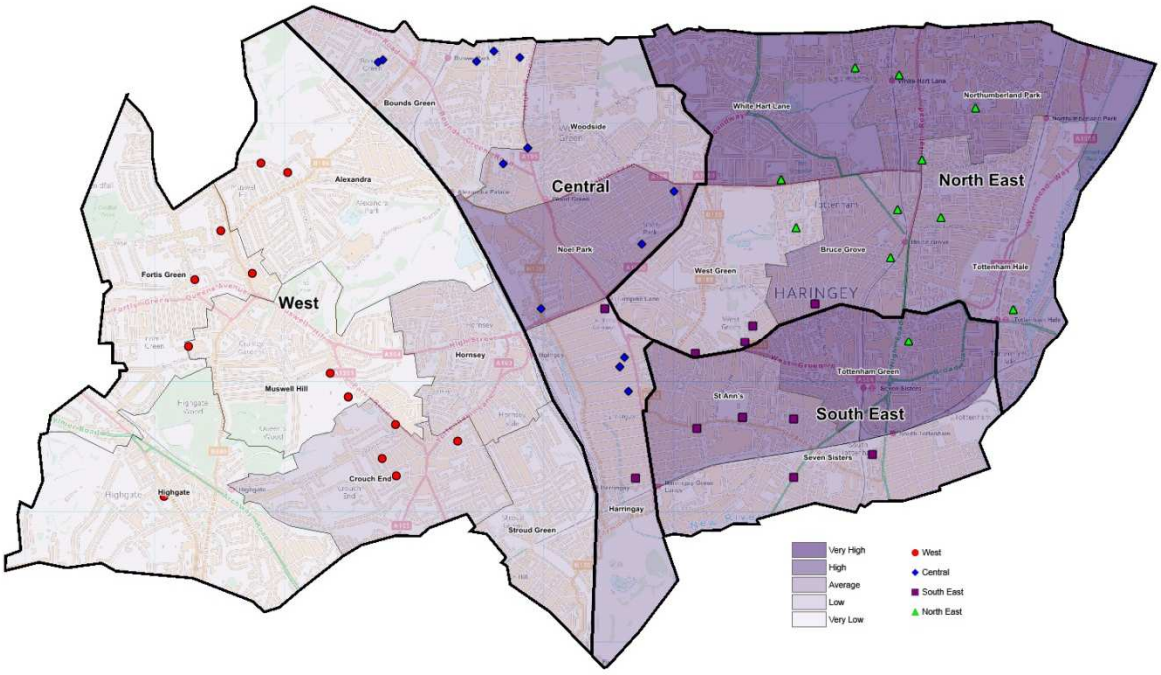


Figure 2: Index of Multiple Deprivation Heat Map with GP locations

3.2.4 Key Health Issues

Health improvement in the borough is divided along the following key areas: drug misuse, alcohol, obesity, diet and nutrition, physical activity, smoking and sexual health.

The key issues and challenges include:

- Socio-economic status plays a large role in lifestyle choices with those on lower incomes consuming more fat, processed food and less fruit and vegetables,
- A large number of fast food outlets are located in the more deprived East of the borough,
- Childhood obesity is higher in Haringey compared to England, particularly in 11-12 year old children,
- Physical inactivity is a major area of concern especially in more deprived parts of the borough where physical inactivity levels are some of the lowest in the country,
- Although sexual health in the borough in improving, focus on interventions should continue amongst those at highest risk such as young people (under 25 years),
- Smoking prevalence is unacceptable high and is a major reason for Haringey's health inequalities and life expectancy gap.

3.3 Stakeholder engagement

3.3.1 Overview

As part of the Stage One process, engagement has taken place with the following organisations:,

- NHS England
- Haringey CCG Collaborative Leads
- Haringey CCG Integrated Care Lead
- NHS Property Services
- London Borough of Haringey Council
- Community Health Partnerships
- Public Health Haringey
- Healthwatch Haringey
- Barnet, Enfield and Haringey Mental Health Trust
- Whittington Hospital NHS trust
- North Middlesex University Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- Clinical Quality Commission

An overview of the key Commissioner Stakeholder strategies is provided below including the strategies of The Haringey Health and Wellbeing Board, NHS England, Haringey CCG and Haringey Council including Public Health against the JSNA objectives.

3.3.2 Overview of stakeholder strategies

3.3.2.1 Haringey Health and Wellbeing Board

The Haringey Health and Wellbeing Strategy (2012-15) is informed by the JSNA, which sets out agreed priorities for collective action by commissioners. The vision of the strategy is "A healthier Haringey – to reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life."

The outcomes identified below will enable the vision to be fulfilled:

- To give every child the best start in life
- To reduce the gap in life expectancy

- To improve mental health and wellbeing

3.3.2.2 NHS England

In 2013, NHS England published their first business plan as a new organisation; Putting Patients First: The NHS England business plan for 2013/14 – 2015/16. This Business Plan set out NHS England's ambitions and commitment to ensuring high quality care for all.

Since 2013, a great deal of transformational change has been undertaken, which are detailed in NHS England's Annual Review for 2013/14. The revised Business Plan for 2014/15-2016/17 draws on the 'A Call for Action' strategy process which details 6 key characteristics for a sustainable NHS;

- Citizen participation and empowerment
- Wider primary care, provided at scale
- Modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective Care
- Specialised centres concentrated in centres of excellence.

3.3.2.3 NHS Five Year Forward

The NHS Five Year Forward View (October 2014) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that it can promote wellbeing and prevent ill-health. It sets out a vision of a better NHS, the steps it should now take to get there and the actions it needs from others.

1) A new relationship with patients and communities;

- Getting serious about prevention
- Empowering patients
- Engaging communities

2) New models of care;

- Multispecialty Community Providers (MCP); expanding the leadership of primary care
- Primary and Acute Care Systems (PACS); to better integrate care
- Urgent and emergency care networks; transitioning to a more sustainable model of care
- Viable smaller hospitals
- Specialised care
- Modern maternity services
- Enhanced health in care homes

Some of the change needs can be brought about by the NHS itself whilst others changes requires partnerships with local communities, local authorities and employers. The NHS has therefore set out complementary approaches required in order to achieve its Forward View:

- Backing diverse solutions and local leadership; driving change locally
- Providing aligned national NHS leadership
- Supporting a modern workforce; able to deliver innovative new care models
- Exploiting the information revolution; capitalising on the opportunities it presents
- Accelerating useful health innovation; supporting research to transform services and improve outcomes
- Driving efficiency and productive investment; to sustain a high quality NHS

The results would be a far better future for the NHS, its patients, its staff and those who support them.

3.3.2.4 Haringey CCG

Haringey CCG has summarised its plans from 2015/16 – 2018/19 in a 'Plan on a Page', which sets out what the CCG wants to achieve for the people of Haringey to improve their mental and physical health and wellbeing.

The vision for Haringey is to make primary care closer to home really work for all local residents. To achieve this vision, four main Aims and Objectives have been developed;

- Explore and commission alternative models of care.
- More partnership working and integration as well as a greater range of providers.
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their health and wellbeing.
- A re-defined model for primary care providing proactive and holistic services for local communities, supporting "healthier Haringey as a whole".

3.3.2.5 Haringey Council

Haringey's Regeneration Strategy summarises its vision *""To transform the Borough and the way in which it is perceived by creating economic vitality and prosperity for all through exploitation of Haringey's strategic location in a global city, major development site opportunities and by developing the Borough's 21st century business economy."*

Its objectives are categorised as follows:

- **People** — To unlock the potential of Haringey residents
- **Places** — Transform Haringey into a place where more people want to live
- **Prosperity** — Developing a 21st century business economy

There is a high demand for housing across all rented and privately owned tenures. The need for affordable housing outstrips supply with a shortfall in provision of 4,865 units per annum. Responding to this shortfall is a priority for the borough. A housing trajectory projects a further 19,715 housing sites will be made available by 2026, broken down by 3000 being delivered between 2011-2014 and 16000 being delivered between 2015-2026.

Haringey's Housing Strategy (2009-19) identifies areas of regeneration such as: Mid Tottenham, Seven Sisters, Northumberland Park, White Hart Lane, Bruce Grove / Tottenham Hale, Wood Green Town Centre, Noel Park and parts of Woodside. Residents in these priority areas exhibit some of the highest levels of social deprivation in the Borough.

3.3.2.6 Public Health

The Annual Public Health Report (2014) includes two priority areas of focus:

Supporting people and communities

- Including new teenage parents
- Building community connections
- Providing free 24/7 online support
- Promoting recovery
- Supporting people with disabilities
- Schools
- Turkish and Kurdish communities

Challenging stigma and discrimination

- Among young people through sport
- Through Mental Health First Aid training for front line staff
- Through the MAC –UK Integrate Project

Recommendations:

- Ensure 'healthy public policy' to create a supportive environment to enable people to lead healthy, fulfilling, independent lives.
- Ensure that plans for the regeneration of Tottenham address factors closely related to poor mental wellbeing such as employment, poor quality housing and overcrowding, noise, 'ugly' environments and lack of green space, antisocial behaviour and fear of crime.

- Undertake a survey of issues affecting our residents' wellbeing to understand the key issues we need to focus on.
- The Council and partners to sign the Time to Change pledge - with clear plans to promote wellbeing and tackle stigma and discrimination against those with mental health problems.
- Develop a Mental Health and Wellbeing Framework to ensure a quality service offer that improves outcomes for service users.
- Continue to focus on the early years of a child, on the bond between parent and baby.
- We each need to look after our own mental health, support each other and build resilience in our communities.

3.3.3 Strategic Service Development Plans (SSDPs)

NLEP were commissioned by Community Health Partnerships (CHP) in January 2014 to produce a Primary Health Care Strategic Service Development Plan (SSDP) in response to the evolving health and social care landscape and the needs of the local population. Its objective was to establish a firm strategic direction for the Haringey locality, drawing on the strategic plans of partner organisations recently established in the 'new world' of the NHS reforms. This document focussed on the strategic visions for Haringey, which has been used, reviewed and refreshed as part of compiling stages one and two of this report, and is fully presented in Appendix 2.

3.3.4 Location of Primary Care estate

To understand how the Primary Care estate fits in with the main thread of strategies providing better access to a wider range of care closer to home, the Primary Care assets within the London Borough of Haringey has been identified and mapped.

A Property Data Master (PDM) of the Primary Care estate has started to be populated which is fully presented in Appendix 3. This spreadsheet collates the information used as part of this report, and is a live and open document which contains a standard set of requirements; the majority of the requirements are not relevant at this stage.

Haringey has a wide variety of other social care and transport assets which support the population and which are also consolidated on the list below:

- 48 GPs
- 2 acute trusts[i]
- 1 mental health trust[ii]
- 6 health centres[iii]
- 12 Whittington Health sites delivering service
- 1 Kidney and diabetes centre
- 50 dentists
- 21 opticians
- 62 pharmacies
- 62 primary / infant / junior schools
- 12 secondary schools
- 4 special schools
- 2 further education colleges
- Infrastructure
  - Railway station – 11
  - Tube station – 6

Figure 3 outlines all primary care estate within Haringey.

[i] North Middlesex University Hospital and The Whittington Hospital

[ii] St Ann's Hospital

[iii] 1-3 Edwards Drive, Simmons House Adolescent Unit, Hornsey Central Health Centre, Lordship Lane Primary Care Centre, Lansdowne Clinic, Hornsey Rise Health Centre. Northern has been excluded due to its Islington location

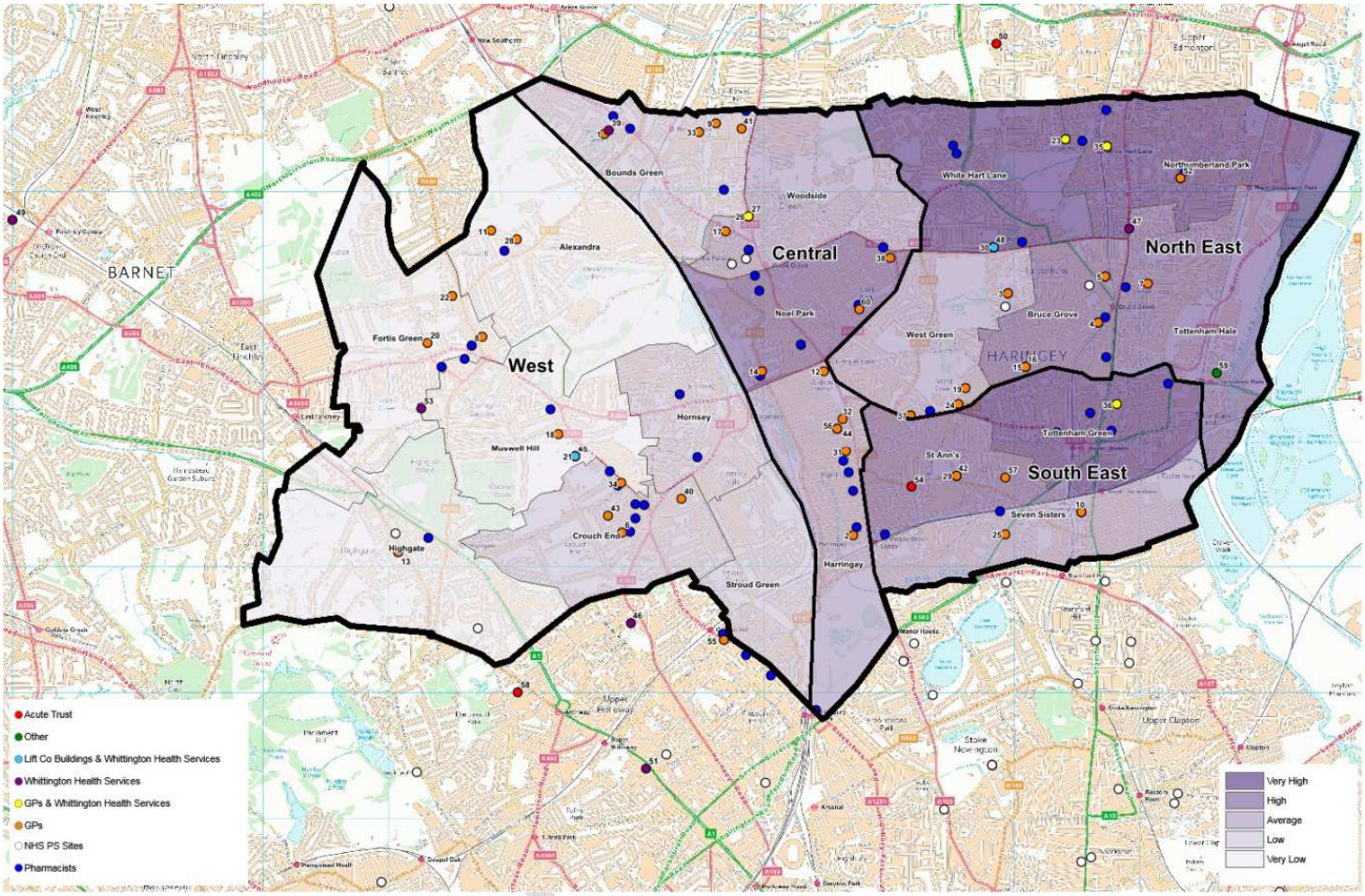


Figure 3: Haringey Primary Care Estate.

3.3.5 Quality of Primary Care estate

Haringey is supported by North London Estate Partnerships (NLEP), a Local Improvement Finance Trust (LIFTCo) which was set up by government in 2004 to improve the quality of Health and Social Care estate. To date NLEP has developed two Primary Care facilities in Haringey providing modern, fit-for-purpose accommodation. These buildings at Hornsey Central Neighbourhood Health Centre and Lordship Lane are fully lifecycled and maintained over a 25 year period to ensure they are the same in 25 years as they were on day one.

In correlation with England as a whole, the majority of the GP estate in Haringey is privately owned. Condition surveys were carried out in January 2013 by an independent surveyor, and the results of these surveys identifies that 73% do not meet statutory compliance. The reason cited why these premises failed to meet statutory compliance range from 'lights over Visual Display Unit (VDU) are non-compliant with British Standards', through to 'need for the management and surveying for Asbestos'.

The surveys which have been rated on a High, Significant and Low risk rating have been translated into a Red, Amber and Green scale respectively. Figure 4 identifies Red and Amber sites i.e Properties which should be regarded as High or Significant risks which fail to meet statutory compliance. Figure 4 further shows us that the 70% of these Red and Amber rated non-statutory compliant assets fall within the East (more deprived) area of the Borough.

Figure 4 below shows the size of the GP practices on a scale of 6,000, 6,000 – 12,000 and >12,000 , along with which GP Collaborative they are attached to (North East, South East, Central and West). The data used is shown further in to the Property Data Master (PDM) at Appendix 3.

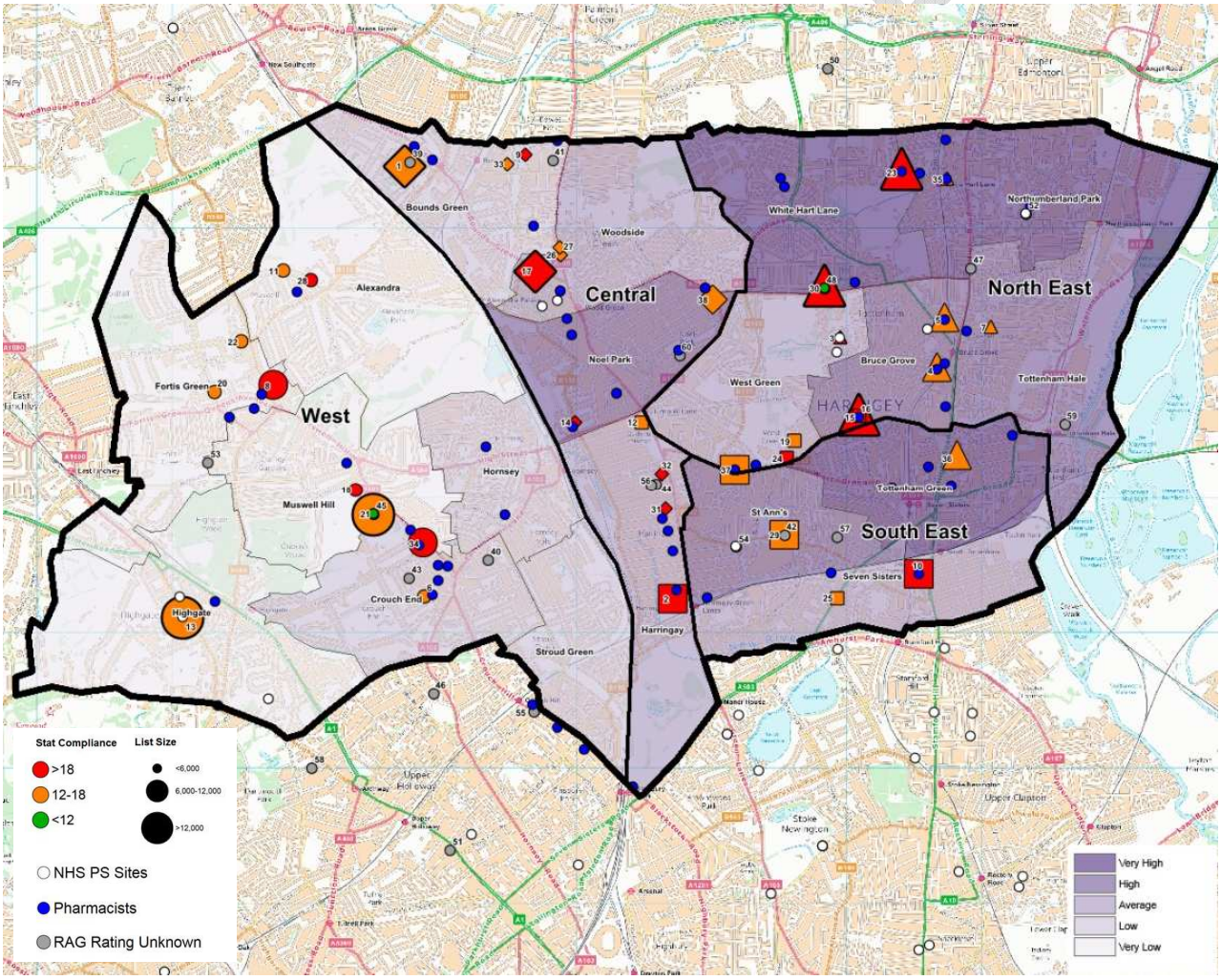


Figure 4: GP's by collaborative, list size and statutory compliance.

3.3.6 Direction of Primary Care

"*General practice in England is under significant strain, with many GPs caught on a treadmill of trying to meet current demand, while lacking time to reflect on how to provide and organise care for the future*"[i]. This lack of capacity coupled with an aging population, and increasing numbers of people with more than one long term condition is having an effect on the delivery of Primary Health Care to patients, at both a local and national level.

With the creation of Clinical Commissioning Groups (CCGs), the trend for new models of delivery for primary care is steering towards a federated /collaborative model of delivery of primary care and community-based services (integrating with services previously delivered in secondary / social care) with a hub and spoke type model, centralising administration and more specialised services to create wider and more accessible patient access to primary and community-based services within a geographical area.

The current strategic direction of travel of Primary Medical Care delivery across London is to larger, more financially viable practices, providing longer hours of opening and service delivery, with increased access to the GP and practice nurse and a wider range of services being offered in more innovative ways. In support of this the new Government has recently announced a move for the NHS to become the world's first 7-day health service, with a pledge to providing thousands more GPs.[ii]

For new practices the only contractual model available for Commissioners is the Alternative Provider Medical Services (APMS) contract prepared under Directions from the Department of Health. This contract does provide flexibility for the Commissioner to negotiate and fund a locally developed service specification that meets the needs of the local population more appropriately than the standard service specification for primary health care associated with the national GMS contract. In particular, there is flexibility in terms of practice opening hours which can be commissioned more appropriately to meet patient needs.

Haringey to a degree is reliant on such models of care working for patients, and ensuring Primary Care is delivered effectively, as there is no Acute or Community Hospital situated within the borough boundary to support, although services are provided at 12 sites across the borough through these providers, delivering Community Services

[i] http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice
[ii] https://www.gov.uk/government/speeches/pm-on-plans-for-a-seven-day-nhs

Haringey has four GP practice collaboratives, and engagement with each of the four GP Clinical Directors/Leads within the North East, South East, Central and West of Haringey has taken place. This has shown a number of pilot schemes operating across the Borough. The pilots schemes the four collaboratives are currently in operation are;

- IT Interoperability; sharing records so GPs who see patients from other practices can view patient records with consent
- Working together at scale; in the Central and West areas Saturday clinics have been provided. In the South East additional telephone appointments have been extended access and in the North East a call centre has provided better call answering and standardising front of house training and development.
- GP Matchmaking scheme; to support practices identifying salaried GPs who currently work in one Haringey practice who would be interested in also working in another
- Admission avoidance locality teams; development of care plans which support more proactive working with patients with the aim to avoid unplanned admissions

Our engagement suggests there has been strong intent to share the learnings and experiences of these pilots more widely which would further support the aims and objectives of the CCG, and direction of Primary Care.

Although each of the collaborative hubs is distinct in terms of both the patients they support, and the practices within the area, there were key messages that interlinked across the wider stakeholders as well, namely;

- Desire for more integration; addressing short and long term care pathways
- Review of Urgent Care and Ambulatory service pathways
- Care closer to home
- Sharing of patient notes across between various Care organisations.

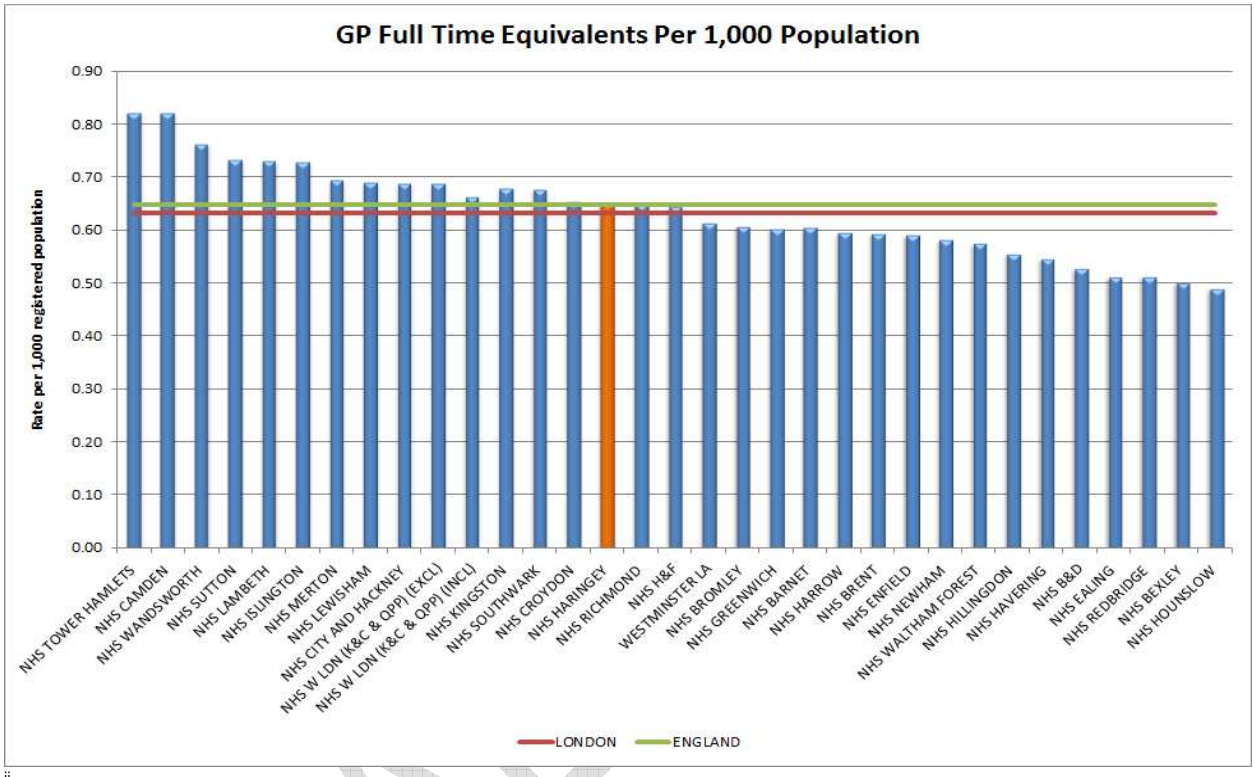
The information gathered as part of this Stage, also identified key issues that has an impact on the Primary Care landscape in the immediate and short term, namely;

- Current patient access issues to existing practice services.
- Number of GPs over 60 (that may retire from General Practice in the short / medium term)
- Population Growth planned for Haringey

This information should be considered and refreshed to support and assist future strategic direction of Primary Care as part of any Implementation of a SPDP. The four CCG collaborative areas being North East, South East, Central and West provide four distinct 'hubs' to consider as part of a Borough wide strategy basis addressing and tailoring the needs from a local level.

3.4 GP providers

Haringey has 196 GPs delivering a Primary Health Care service to a population of 254,900[i]. However, not all of the GPs are full-time. Figure 5 shows the London Boroughs, with Haringey just above the London and just below the England average for Full Time Equivalents per 1,000 population.



[ii]

Figure 5: GP Full time equivalent per 1,000 population.

Using a sensitivity analysis for this data looking at the national average of 1,800 patients per GP, by Ward for Haringey, shows us that six, or 32%, of the nineteen wards are above this average. One single hander practice in particular in Tottenham Hale has a list of 2,000 alone demonstrating the pressure on this service, and supports the Healthwatch report undertaken on access issues in this area in particular.

[i] Based on 2013 JSNA. (2011 National Census data).

[ii] Source: Analytical Services (London) 28th November 2014. Data period September 2013, HSCIC March 2014

3.5 NHS England Infrastructure Fund

In January 2015 NHS England announced funding as part of a four year £1billion investment in Primary Care to accelerate improvements in GP premises and infrastructure. The funding is to support the Five Year Forward Plan addressing immediate capacity and access issues as well as laying the foundations for more integrated care to be delivered in community settings.[i]

In February 2015 the applications were closed for 2015/16 spending, and at the time of writing the report we understand a further round of funding for 2016/17 will open later in 2015.

Eighteen GP practices within Haringey submitted to this fund for a range of projects from upgrading sinks and flooring, to extensions, portacabins and new telephone systems. The announcement on 27th March 2015 confirmed seven had received preliminary approval, which are shown in Figure 6 and the detail of their submission in Appendix 4:

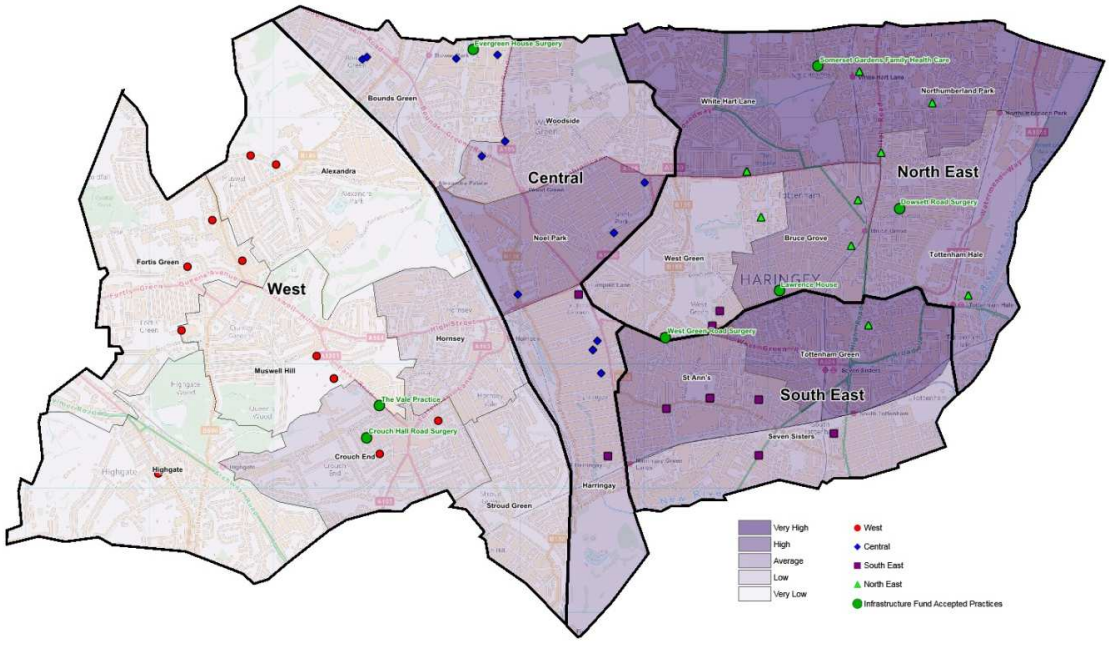


Figure 6: Preliminary granted Infrastructure Fund GP practices.

[i] NHS England website; http://www.england.nhs.uk/commissioning/primary-care-comm/infrastructure-fund/

3.6 GP providers over 60

A £10m workforce plan was launched at the end of January 2015 by NHS England to incentivise experienced GPs to stay practicing or to return after a career break[i] due to a national shortage of those GPs retiring and those GPs joining the profession. Out of the 196 GP's practicing in Haringey, approximately 28% are aged over 60. The geographical spread can be seen in Figure 7 below. It should be noted that there is no statutory retirement age for GPs so it is unclear from the data how GP retirement plans will impact on the future needs of the area. Furthermore consultation with regards to succession planning has not taken place as part of this commission, and NHS England and Haringey CCG will need to ensure appropriate planning and support is taken forward especially around those who are single handed practices

[i] http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gps-to-be-offered-incentives-to-delay-retirement-under-10m-strategy-to-solve-workforce-crisis/20009021.article#.VRLEnvmsX3Q

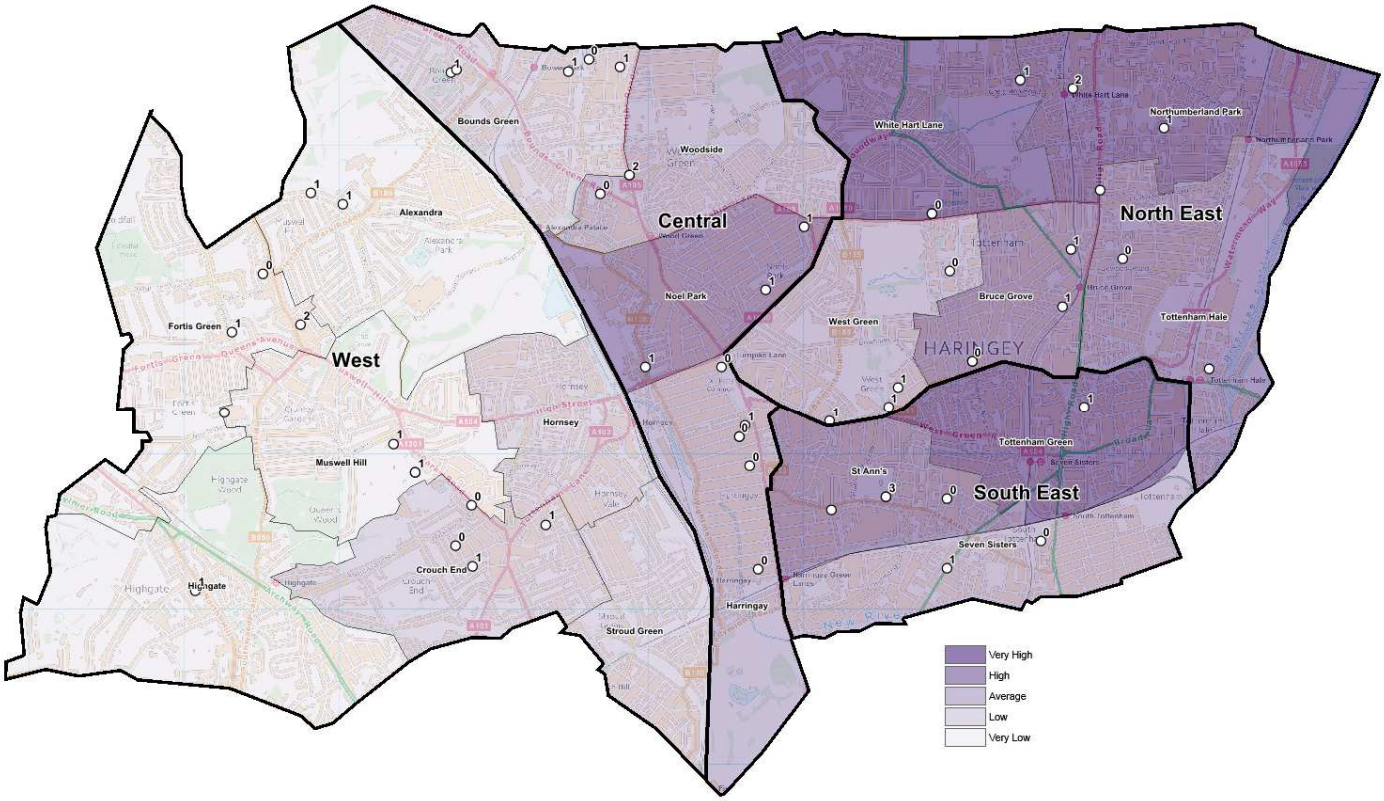


Figure 7: GP practices with partners over the age of 60.

3.7 Growth

The London Borough of Haringey, like many parts of London, is undertaking large regeneration plans increasing and improving the infrastructure, population and demand on public services. These plans have been active since 2011 and go through to 2026. The regeneration schemes are being led by Haringey Council through a number of initiatives as shown in Figure 8 below;

Growth Areas and Areas of Change

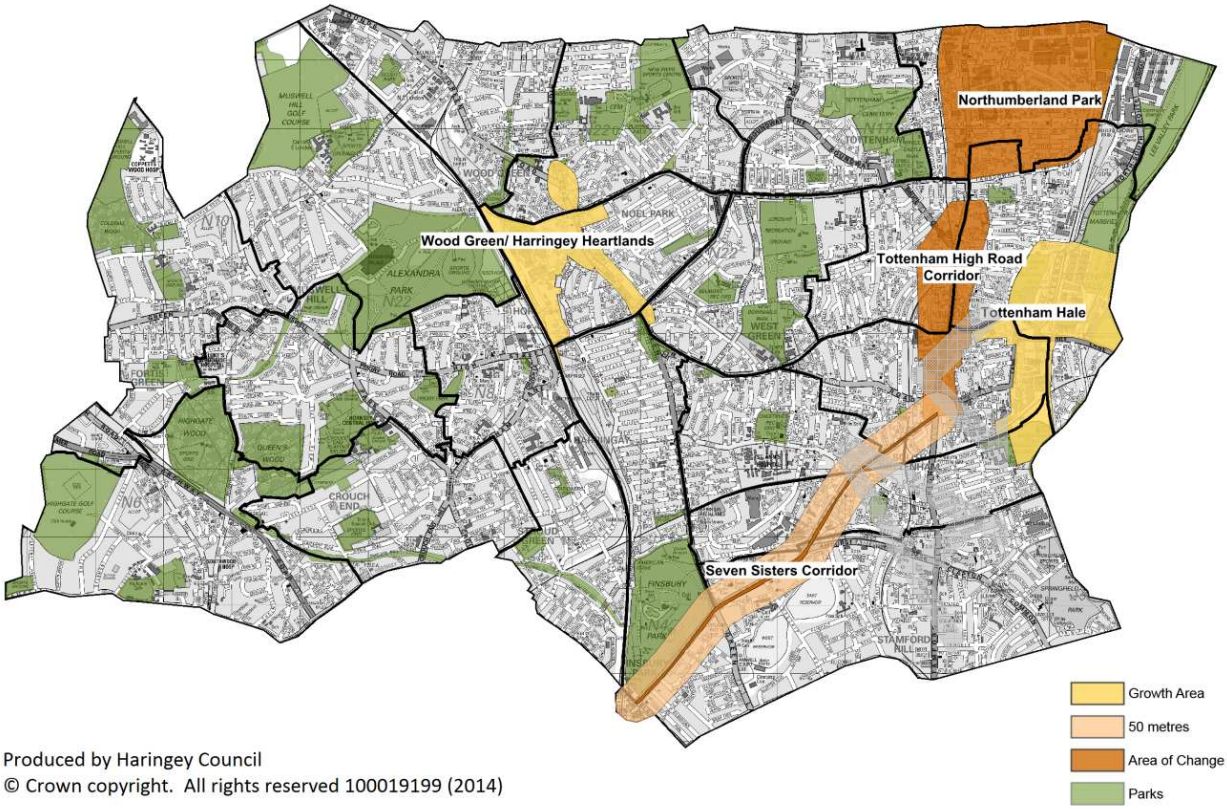


Figure 8: Haringey Growth Areas and Areas of Change

Figure 8 shows two clear Areas of Change within the East of the Borough in Tottenham High Road Corridor and Northumberland Park; both of these areas are where high deprivation is prevalent. Along with Growth Areas marked within the East also, at Tottenham Hale and centrally in the Borough at Wood Green/Haringey Heartlands.

Using the Populations Projections GLA 2013 data from Haringey Council a 13% increase (37,329 persons) in the population increase from 2011 (256,428) to 2026 (293,757) is expected across the Borough. This is shown further in Figure 9 below, and split by ward in Appendix 5.

Year	2011	2015	2020	2026	2011-2026
Totals	256,428	269,115	282,629	293,757	37,329

Figure 9: Total borough population increase from 2011 - 2026

Using the Housing Trajectory by Ward 2015 – 2026 data from Haringey Council, a total of 19,715 net housing units are expected across the Borough. This is split by ward in Appendix 6. It should be noted though that not all of the development sites are secured and therefore projections in terms of population and housing units should be reviewed as part of any implementation of a strategy as these factors will change dependent upon market requirements at the time.

The population prediction between 2011 – 2015 was 12,687. Using data from NHS England on the raw list growth between these same periods is 25,288. Although a clear increase between prediction and actual, the funding that supports these patients will have followed in line with contractual arrangements, however, this does not preclude how this additional funding is invested in additional medical staff.

In comparison to Figure 8 looking at Areas of Change and Areas of Growth, Figure 10 below shows how these pockets of housing development are not just in the Areas of Change but spread across the whole of the Borough of Haringey.

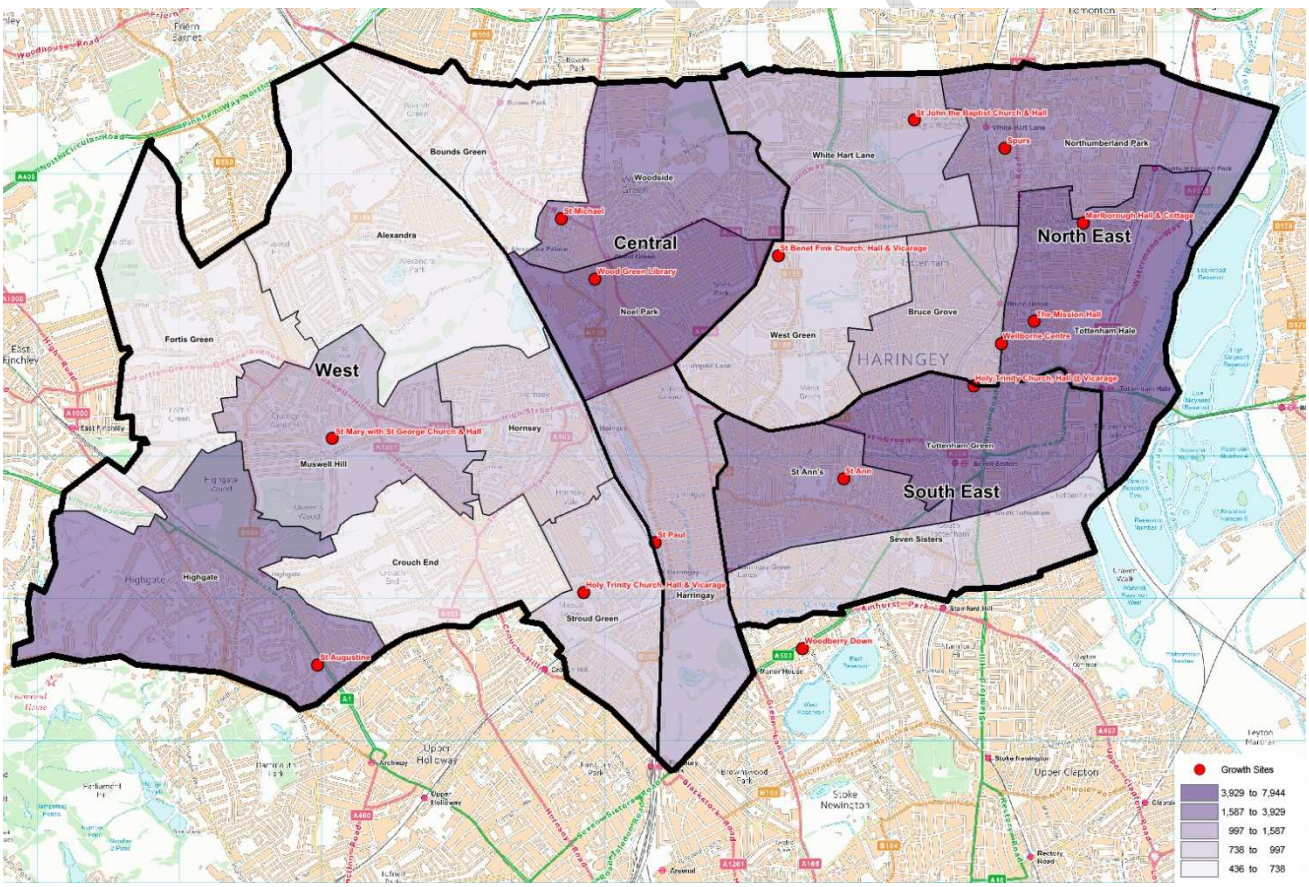


Figure 10: Growth by Ward.

3.8 Stage one summary

Stage One has shown us that Haringey has pockets of extreme of social deprivation level, not just in relative terms within the Borough but also against National benchmarks. The lists of local GPs have grown significantly in the last 5 years and nearly half of the GP Practices are operating with GP levels above the national average ratio of 1 GP per 1,800 patients, delivering services from a GP Practice Estate displaying widespread non statutory compliance.

This is baseline position that needs urgently addressing.

The strategic direction for primary care to federate/collaborate is already being undertaken in Haringey, with new ways of working being piloted currently. Commissioning strategies and a desire to do more from across the stakeholders has focussed on addressing and improving the quality of life for local residents, and the implementation and cross fertilisation of these pilots should be used as a momentum to move forward and do more.

A workshop with the Task and Finish Group stakeholders was held on 17th February 2015, presenting on the Stage One findings. The group agreed four "deep dive" areas of focus in Stage Two, of areas predominately in the Central and Eastern areas of the Borough.

4 Stage Two; Solution Development

4.1 Overview

Stage Two of the SPDP looks to develop solutions to the current and future problems.

Using the direction of new models of care for Primary Care through federations / collaboratives, a hub and spoke model would be recommended for Haringey, based around the current four GP collaborative 'hubs'; North East, South East, Central and West. This would need to be reviewed in line with affordable models of commissioning, but would not only utilise the structure that is currently in place saving time and resource, but build on the good work already in place with HCCG continuing to cross-fertilise the good practice and pilot schemes in place across the borough.

As part of understanding the Solution for each of these hubs, priority/Deep Dive areas within Haringey, agreed with the Task and Finish Group, were named. These 'Deep Dive' areas focussed on specific wards within the more deprived East of the borough;

- Northumberland Park,
- Tottenham Hale,
- Noel Park, and
- Green Lanes.

4.1.1 Deep Dive areas

The Deep Dive areas reviewed 20 practices in detail across three, of the four, GP collaborative hubs. Figure 11 below identifies those practices, wards and collaboratives which have been included as part of the Deep Dive areas.

Deep Dive Area	GP Code	Collaborative	Ward
Northumberland Park	F85030	North East	White Hart Lane
	F85615	North East	Northumberland Park
	F85660	North East	
Tottenham Hale	F85628	North East	Tottenham Hale
	F85013	North East	Tottenham Green
	F85017	North East	Bruce Grove
	F85028	North East	
Noel Park	F85031	Central	Noel Park
	F85643	Central	
	F85046	Central	
	F85008	Central	Woodside
	F85064	Central	
	F85060	South East	West Green
Green Lanes	F85669	South East	
	Y03506	South East	St Anns
	Y01655	South East	
	F85697	Central	Harringay[i]
	F85632	North East	
	Y03135	South East	
	F85708	Central	

Figure 11: Deep Dive areas by ward, practice and collaborative

4.1.2 Capacity planning

NHS England provided the current room numbers of each GP practice, and it has been assumed that these room numbers are clinical rooms only. A proforma was sent for completion to each practice to collect data to support the Capacity Planning and this information has been used, where available.

[i] One ward in Haringey, the borough, is also called Harringay, although the spelling of the two are different

The expected population growth data from 2011-2026 was provided by Haringey Council. The total expected population growth across the Borough is 37,329 by 2026 and the purpose of the Capacity Planning process was to understand the impact of growth planned in the Borough through the Deep Dive areas. The projected population growth of 30,170, or 80% of the borough, people within the Deep Dive areas is broken down by ward in Figure 12 for 2011-2026.

Deep Dive Area	Ward	Expected population projection 2011-2026
Northumberland Park	White Hart Lane	997
	Northumberland Park	2,693
Tottenham Hale	Tottenham Hale	5,589
	Tottenham Green	3,929
	Bruce Grove	1,391
Noel Park	Noel Park	7,944
	Woodside	2,365
	West Green	952
Green Lanes	St Anns	2,832
	Harringay[i]	1,478
	TOTAL	**30,170**

Figure 12: Population Increase for Haringey by ward by 2011 - 2026

Based on the national average of 1,800 registered patients per each whole time equivalent (WTE) GP, the projected population of 30,170 would require 16.76 extra WTE GPs by 2026 above the number of WTE GP's in the baseline year of 2011. It should be noted that Haringey has already experienced population growth of c12,500 and data suggests a significant growth in the lists of Haringey GP Practices since 2011. This growth in lists will have been accompanied by an increase in funding for local GP practices of circa £1,500,000. Some of the additional 16.76 WTE GPs should therefore already have been provided however the absence of baseline GP WTE data for 2011 and the complete freedom that GP Practices have to utilise contractually paid funds means that it is difficult to establish accurately how many additional WTE GPS will be required between 2015 and 2020.

[i] One ward in Haringey, the borough, is also called Harringay, although the spelling of the two are different

When this is translated into space required, high level modelling in Figure 13 shows that the following number of Primary Care clinical rooms would be required for 16.76 WTE GPs:

Consulting Hours	Number of Clinical Rooms[i]
8 hours per day	24
10 hours per day	19
12 hours per day	16

Figure 13: Number of Consulting Rooms Req. based on a population increase of 30,170

Although the direction of Primary Care is towards a seven day working week, the current five day working week has been modelled for current capacity, as the existing GMS and PMS contracts for GPs offer no control on days worked. The introduction of new APMS contracts will allow the commissioners to have a greater contractual control over such initiatives. High level modelling on the 20 practices was undertaken using current working practices of:

- 2 sessions of 4 hours per day
- 5 days per week
- 50 weeks per year
- Average appointment 12.5 minutes
- Average appointment of 20 minutes for nurse treatment
- An administration percentage of 10%
- 80% utilisation
- 6 contacts per patient per annum
- List sizes based on weighted data, unless raw data provided through proforma.

The full capacity report is attached at Appendix 7.

4.1.3 Sensitivity to capacity planning

The capacity planning has been undertaken on current working practices. Using a sensitivity analysis to the relationship of appointment times and growth is shown further in Figure 14 and 15.:

[i] based on 5 days per week, 50 weeks per year, average appointment of 12.5 minutes, 80% utilisation (an administration percentage of 10% has not been applied here as it is assumed that new ways of working will be adopted in the new building)

	TOTAL		
	10min appoints	12.5min appoints	15 min appoints
Population Increase 2015 deficit[i]	28,518[ii]		
No of GPs FTE (population increase / 1,800)	16		
No of C&E Rooms:	14	18	22
No of Treatment Rooms	18	18	18
GIA required (m2)	2870	3185	3499
Population Increase 2015	17,263		
No of GPs FTE (population increase / 1,800)	10		
No of C&E Rooms:	9	10	13
No of Treatment Rooms	11	11	11
GIA required (m2)	1737	1928	2118
Population increase 2020	13,596		
No of GPs FTE (population increase / 1,800)	8		
No of C&E Rooms:	7	9	10
No of Treatment Rooms	10	10	10
GIA required (m2)	1369	1518	1667
Population increase from 2026	10,851		
No of GPs FTE (population increase / 1,800)	6		
No of C&E Rooms:	6	7	8
No of Treatment Rooms	7	7	7
GIA required (m2)	1093	1211	1332

Figure 14; Sensitivity analysis on appointment time across Haringey

[i] The population increase 2015 deficit, accounts for the difference between 2015 population projection and registered list population figures

[ii] Accounts for 7,689 for Northumberland Park, 18,686 for Tottenham Hale and 2,143 for Green Lanes Deep Dive areas.

	TOTAL		
	10min appoints	12.5min appoints	15 min appoints
TOTAL Population increase[i]	70,228		
TOTAL No of GPs FTE (population increase / 1,800)	39		
TOTAL No of C&E Rooms:	**36**	**44**	**53**
TOTAL No of Treatment Rooms	**46**	**46**	**46**
TOTAL GIA required (m2)	**7069**	**7842**	**8616**
Sensitivity Test - Population increase for 2015 deficit only- PLUS 10%	31,370		
No of GPs FTE (population increase / 1,800)	17		
Total No. of C&E Rooms:	15	19	23
Total No. of Treatment Rooms	20	20	20
Total GIA required by m2	3,157	3,502	3,849
Sensitivity Test - population increase for 2015 Deficit ONLY - MINUS 10%	25,666		
No of GPs FTE (population increase / 1,800)	14		
Total No. of C&E Rooms:	12	16	19
Total No. of Treatment Rooms	16	16	16
Total GIA required by m2	2,582	2,866	3,150

Figure 15; Sensitivity analysis on growth across Haringey

The sensitivities on these should be reviewed at the time of implementation of strategy to determine both the Primary Care appointment assumptions, and the impact of growth projections, given the 18% variance in GIA requirements.

[i] Accounts for 2015 deficit and future population projections up to 2026. No 2015 deficit for Noel Park Deep Dive and West Collaborative.

4.1.4 Patient data analysis for Capacity Plan

From 5th January 2015, all GP practices in England are free to register new patients who live outside their practice boundary area. This means that you are able to register with practices in more convenient locations, such as a practice near your work or closer to your children's schools, providing a greater choice and aims to improve the quality of access to GP services.[i]

As a sensitivity analysis to ascertain what impact the above is having and using data analysis provided by NHS England [ii] looking at the Wards within the Deep Dive areas out of 156,357 registered patients, 3,144, or just over 2%, Haringey residents go to GP practices in Enfield. This data shows us that although patient choice is active the majority of residents are registered within the Borough.

It should be noted though that some patients who live in the area, and are registered at a GP practice, may not be picked up through the GLA population data as the transient nature of Borough allows for people to access services without having registered through the electoral system. Therefore it can be assumed that there are more people accessing services than what the GLA population prediction data shows us.

4.1.5 Options Appraisal

With the overarching principles of patient activity and the capacity requirements needed to address the growth, the Task and Finish Group met on 20th March 2015 to agree a set of criterion and scoring mechanism to address how Solution Development can be measured and ranked for priority.

The group agreed for four pre-qualification questions which had to be met prior to further scoring being undertaken, these were;

1) Able to accommodate appropriate practice size[iii].
2) Value for Money (to the best of knowledge at time of scoring).
3) Fit for Purpose (according to NHS Standards i.e disabled access, room sizes, appropriate IT).
4) Able to get suitable planning permission.

[i] http://www.nhs.uk/nhsengland/aboutnhsservices/doctors/pages/patient-choice-gp-practices.aspx
[ii] Enfield_Haringey_analysis_27 03 2015.xls
[iii] As at 20th March 2015 this is a minimum of 6,000 patients

The Option was then to be scored against four key themes of;

1) Accessibility
    i. Accessible for required population – within a 15 min walk or a 5 or more in a PTAL[i] assessment
    ii. Is it accessible 08:00 – 20:00 7 days a week
    iii. Potential for disabled parking
2) Design
    i. Flexibility of design to meet future needs
3) Deliverability
    i. Available at the right time
4) Strategic Fit
    i. Able to integrate with other community services

Each site option has been scored on the basis of the criteria above 1-3 as per rating below;

3 – High preference
2 – Medium preference
1 – Low preference

An example of this Option Appraisal Criteria is attached at Appendix 8.

4.1.5.1 Planners Brief – GP Design Requirements

To support NHS further through selecting the right Option, a full and comprehensive planning brief is included at Appendix 9 which includes reference to the following:

- Design Standards
- NHS Requirements
- Design Life
- Siting of building and landscaping/external works
- Accessibility
- Functionality
- Environment and sustainability
- Security and safety

[i] Public Transport Accessibility Level

- Privacy and dignity
- Flexibility, adaptability and futureproofing
- Control of Infection
- Lighting and ventilation

This document should be used as a guide to support decision making of Options, and will need to be tailored to individual development.

4.1.6 NHS England Approval Process

A key part to progressing a Solution Development is centred on the approval system for NHS England; the commissioning body for GP contract services. NHS England National Support Centre has recently announced a four stage process for construction / refurbishment capital investment and project activity. This is shown further in Appendix 10.

4.2 Hypothesis; North East collaborative (Northumberland Park deep dive)

4.2.1 Overview

The North East collaborative is made up of the following wards, all of which have been reviewed as part of the four Deep Dives. We also know through work undertaken at Stage One that this part of the borough has the highest deprivation levels, not only against the Borough, but are among the highest deprived wards nationally. See Figure 16 below;

Ward	Population projection for 2015	Ward rank out of 19	National deprivation rank out of 7,679 wards
Northumberland Park	15,170	1	83
White Hart Lane	13,958	2	160
Tottenham Hale	17,322	5	281
Bruce Grove	15,032	6	296
West Green	14,026	8	417
Total	**75,508**		

Figure 16; population and deprivation levels for North East Collaborative

There are 10 GP surgeries within the collaborative, with a registered patient list data of 76,352. This would appear to suggest that the majority of the local resident population (c99%) are registered with a local GP practice in the area.

4.2.2 Current capacity

The wards within the Deep Dive areas being reviewed span across three Deep Dive areas for this collaborative; Northumberland Park, Tottenham Hale and Noel Park. In order to provide some focus to this Collaborative hub, Northumberland Park has been used only, shown further in Figure 17 below.

Deep Dive Area	GP Code	Ward	List Size		Enfield Patients	Number of Rooms	No. of GPs	GPs Over 60	Condition (RAG)	Infrastructure Fund Preliminary Granted	Pro forma returned?
			Total	S/M/L							
Northumberland Park	F85030	White Hart Lane	12,900	L	544	12	8	1	Red	Y	Y
	F85615	Northumberland Park	4,500	S	985	5	4	2	Amber		Y
	F85660		2,510	S		3	4	1	Red		Y

Figure 17: Northumberland Park data overview

From the data received and using the modelling methodology, there are;

- 24 available clinical rooms in the area,
- 19 rooms required,
- Current surplus in the current estate of 5 clinical rooms,
- This suggests that this area would be able to accommodate some growth in population.

The population projection in 2015 is 29,128 people. The registered list sizes of the GP practices in this area are 19,910. This shows a deficit of 9,218 patients. Patient distribution maps also show that 1,529 of the Northumberland Park residents use GP services in Enfield; the highest amount across the Deep Dive areas. If it is assumed that the remaining population requires registration within area this deficit of 7,689 patients would require 4.3 WTE GPs (based on 1,800 patient to WTE GP ratio). However residents may be registered elsewhere, and indeed the evidence provided in 4.2.1 suggests that patients are registered with other practices within the collaborative, although residents' survey results in the Healthwatch Report implies a limited choice than patient choice of local Primary Care options.

In addition to this, one of the practices has preliminary been granted an extension through the Infrastructure Fund to part of their property with a third storey to increase clinical capacity further.

In this Deep Dive area, all three practices that were focussed on have GPs over the age of 60, although none of these practices are single handers and therefore the retirement of these individuals should be planned through normal succession planning within the individual practices. We have not therefore included this impact as part of the capacity planning.

4.2.3 Growth capacity

The Northumberland Park Deep Dive area has a planned 3,690 population increase from 2011 – 2026, as shown in Figure 18 below although some of this growth in population (c30%) has already taken place

	Population Projection				
	2011	**2015**	**2020**	**2026**	**2011-2026**
White Hart Lane	13,504	13,958	13,998	14,501	997
Northumberland Park	14,522	15,170	16,371	17,215	2,693
Total	**28,026**	**29,128**	**30,369**	**31,716**	**3,690**

Figure 18: Population increase from 2011 – 2026 for Northumberland Park Deep Dive.

Figure 19 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator) assuming that the strategic objective is to allow for the re-registration of residents with a more local GP practice as well as cater for expected population growth.

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	7,689					
Population growth		1,102	1,241	1,347		
Single handed practice retirements		0	0	0		
TOTAL GROWTH	**7,689**	**1,102**	**1,241**	**1,347**	**11,379**	
No of WTE GPs required	4.3	0.61	0.69	0.75	**6**	Assume 1,800 people per GP
No of C&E Rooms required	5	1	1	1	**8**	NHS England PID estimator
No of Treatment Rooms required	5	1	1	1	**8**	NHS England PID estimator
GIA required	859m^2	123m^2	139m^2	150m^2	**1,271m^2**	NHS England PID estimator

Figure 19: Projected population growth from 2011-2026 against WTE GPs and extra space required for Northumberland Park Deep Dive

An analysis of the information provided by the practices in the Deep Dive Area (3 returned out of 3) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these clinical rooms were fully utilised, capacity exists for approximately 2,104 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments).

It was noted that some surgeries are closed on a Wednesday or Thursday afternoon and that capacity in primary care is also dependent upon:

- List sizes remaining open for registration
- The practices identified being willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of retiring GPs

4.2.4 Solution development

Out of 10 practices in this collaborative, 9 are rated Red/High or Amber/significant properties for non-statutory compliance, coupled with four out of the five wards exceeding the average list size (1,800) per GP by ward shows an estate that is in need of investment and practices which need to be supported to recruit a larger clinical workforce.

A recommendation to further define the Solution for this area would be to engage with each GP practices to understand their willingness and ability to absorb the growth; their business plans and potential for changes in the way primary care services are provided in the future. From this, a clearer gap analysis can be developed to identify trends in practice list growth and spread, being able to fully understand the impact on local primary care services and the infrastructure requirements.

Engagement with stakeholder partners to determine estate solutions for the short, medium and long-term are taking place through the Task and Finish Group along with wider stakeholders including NHS Property Services. Although discussions on such land/building opportunities have taken place, no such opportunities present themselves for an immediate solution to the capacity issue, aside from the Infrastructure Fund application.

Although a long-term fully integrated development is aspirational, the basis to bringing these parties together should commence early, so the Planning of service and space requirements can feed-in at an early stage. An immediate solution development from a service perspective recommendation for this area, would be to focus on developing the pilot works of the collaboratives across the Borough and utilise telecare appointments and developing wider patient record sharing to reduce the need for patients to physically visit a GP practice. Further pilots for better access to Public Health in high visible locations, such as unoccupied shop units in local district centres should be developed. Given the proximity and transport links of this area to the acute hospital at North Middlesex University NHS Trust in bordering Enfield, development of ideas with these partners for Urgent Care, Ambulatory service pathways and sharing of patient notes would support the longer term management of patient care.

Recommendations would be for the Task and Finish Group to continue engagement and identify opportunities through partner organisation scoring estate/land opportunities (such as the suggestion of council owned land near the Spurs site), on the Options Appraisal criteria. Discussion should also focus on how the space allocation will be split, and whether all the growth requirements (1,271m^2) are needed. In particular establishing the probability and implications of re-registration. Having a more detailed assessment of the growth requirements discussions will need to be focussed on how the space requirements are met for example establishing a new surgery space that could be occupied by either a new practice or provide additional space for existing practices, or developing existing practice sites so that they can accommodate more registered patients.

4.3 Hypothesis; South East collaborative (Tottenham Hale deep dive)

4.3.1 Overview

The South East collaborative is made up of the following wards, two of which have been used as part of the Tottenham Hale Deep Dive. We also know through the work undertaken at Stage One that this part of the borough has two of the most deprived wards in the borough, which are also among the highest deprived wards nationally. See Figure 20 below;

Ward	Population projection for 2015	Ward rank out of 19	National deprivation rank out of 7,679 wards
Tottenham Green	15,924	3	240
St Ann's	16,123	7	387
Seven Sisters	16,627	10	638
Total	**48,674**		

Figure 20: population and deprivation ranking for South East Collaborative

There are 11 practices within this collaborative, with a registered patient list data of 56,508, equivalent to16% more people registered with the practices than the local resident population.. This shows again, that even though the collaborative includes a highly deprived collection of wards the practices within the collaborative appear to be registering and providing services to the resident population albeit not necessarily providing services to patients within the wards that they are resident. The excess of registered over resident population could be due to the highly transient population in Haringey, or patients have moved outside the immediate ward catchment and continue to travel to their previous practice. Recommendation would be to review patient surveys, discuss access with patient panel groups and further engage with practices in the locality to ascertain how current provision of services could be improved.

4.3.2 Current capacity

Tottenham Hale Deep Dive area straddles both the North East[i] and South East[ii] GP Collaborative areas. Tottenham Hale Deep Dive area encompasses the Wards of Tottenham Hale, Tottenham Green and Bruce Grove.

The wards within the Deep Dive areas being reviewed spans across two Deep Dive areas for this collaborative; Tottenham Hale and Green Lanes. In order to provide some focus to this Collaborative hub, Tottenham Hale has been used and is shown in Figure 21 below;

[i] North East Collaborative area covers the Wards of Northumberland Park, White Hart Lane, Tottenham Hale, Bruce Grove and West Green. North East Collaborative Health Profile 2012. Page 8.

[ii] South East Collaborative area covers the Wards of Tottenham Green, St Ann's and Seven Sisters. South East Collaborative Health Profile 2012. Page 8

Deep Dive Area	GP Code	Ward	List Size		Enfield Patients	Number of Rooms	No. of GPs	GPs Over 60	Condition (RAG)	Infrastructure Fund Preliminary Granted	Pro forma returned
Tottenham Hale	F85628	Tottenham Hale	3,150	S	372	3	2	0	Amber	Y	Y
	F85013	Tottenham Green	10,294	M	102	10	3	1	Amber		N
	F85017	Bruce Grove	6,800	M	245	6	6	1	Amber		N
	F85028		8,630	M		4	2	1	Amber		N

Figure 21: Tottenham Hale data overview

From the data received and using the modelling methodology, there are;

- 23 available clinical rooms in the area,
- 26 rooms required,
- Current deficit of 3 clinical rooms,
- This suggests that this area would be unlikely to be able to accommodate any growth in population.

The population projection in 2015 is 48,278 people. The registered list sizes of the GP practices in this area are 28,873, suggesting a deficit of 19,405 patients. Patient distribution maps also show that 719 of the Tottenham Hale residents use GP services in Enfield. If it is assumed based on the collaborate overview in paragraph 4.3.1 that the remaining population are already registered with practices within the Collaborative, outside of the Deep Dive Area. (This is further supported by specific additional research undertaken by NHS England). If the strategic objective is resident registration within their ward of residence then such a deficit of 19,405 patients would require 10.8 WTE GPs (based on 1,800 patient to WTE GP ratio). Access issues identified as part of the report undertaken by Healthwatch in September 2014 which focussed on Tottenham Hale ward supports action to address this deficit

In support of combating the deficit, NHS England plans to establish a new practice in the Tottenham Hale area, which will initially be based within a temporary demountable facility. This will be in advance of finding a permanent site solution within the regeneration in the area within 3 to 5 years, and will provide fully compliant additional clinical capacity for the residents**.** This facility will also allow NHS England to test their assumptions of Primary Health Care need and willingness of residents to re-register with local practices.

In this Deep Dive area, three out of the four practices have GPs over the age of 60, although none of these practices are single handers and therefore the retirement of these individuals should be planned through normal succession planning within the individual practices. We have not therefore included this impact as part of the capacity planning.

4.3.3 Growth capacity

The Tottenham Hale Deep Dive area has a planned 10,909 population increase from 2011 – 2026, as shown in Figure 22 below. This is the largest expected population increase across the four Deep Dive areas;

Ward	Population Projection				
	2011	2015	2020	2026	2011-2026
Tottenham Hale	15,140	17,322	20,270	20,729	5,589
Tottenham Green	14,661	15,924	17,074	18,590	3,929
Bruce Grove	14,573	15,032	15,278	15,964	1,391
Total	**44,374**	**48,278**	**52,622**	**55,283**	**10,909**

Figure 22. Population increase from 2011 – 2026 for Tottenham Hale Deep Dive.

Figure 23 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator).

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	18,686					
Population growth		3,904	4,344	2,661		
Single handed practice retirements		0	0	0		
TOTAL GROWTH	**18,686**	**3,904**	**4,344**	**2,661**	**29,595**	
No of WTE GPs required	10.4	2.17	2.41	1.48	**16**	Assume 1,800 people per GP
No of C&E Rooms required	12	2	3	2	**19**	NHS England PID estimator
No of Treatment Rooms required	12	2	3	2	**19**	NHS England PID estimator
GIA required	2,087m^2	436m^2	485m^2	297m^2	**3,305m^2**	NHS England PID estimator

Figure 23: Projected population growth from 2011-2026 against WTE GPs and extra space required for Tottenham Hale Deep Dive

However, dialogue will need to be undertaken with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population.

An analysis of the information returned by the practices (1 returned out of 4) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these clinical rooms were fully utilised, capacity exists for approximately 510 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments). It was noted that some surgeries that failed to return information close on a Thursday afternoon which suggests that this is an underestimate of potential clinical room capacity available. One of the action points arising from this report is will be to secure information from all 4 practices.

It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open for registration
- The practices identified being willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

4.3.4 Solution development

Out of 11 practices in this collaborative, 9 are in Red/High or Amber/significant rated properties for non-statutory compliance; the highest percentage across the four collaboratives at 82%, coupled with one out of the three wards exceeding the average list size (1,800) per GP by ward shows an estate that is in need of investment and practices which need to be supported to recruit a larger clinical workforce.

A recommendation to further define the Solution for this area would be to fully engage with each of the GP practices to understand their willingness and ability to absorb the growth; their business plans and potential changes in the way in which they expect to deliver primary care services are provided in the future. From this, a clearer gap analysis can be developed to identify trends in practice list growth and spread, being able to fully understand where growth can be absorbed and the impact on local primary care services and the infrastructure requirements.

A further recommendation is the engagement of stakeholder partners to determine estate solutions for the short, medium and long-term through the Task and Finish Group along with wider stakeholders including NHS Property Services. The short term Solution Development is to support practices with Primary Care Infrastructure Fund Grants and to ensure the temporary demountable solution in Tottenham Hale provides appropriate primary health care services in a suitable environment for patients. The Task and Finish Group recognise that this is a clear opportunity to support better access to Primary Care in an area of high deprivation, and growth change.

In addition to this Haringey Council have also presented an opportunity as part of the medium to long term solution through the development of a new Health Centre site at the former Welborne Centre. This could provide a permanent site for the practice established using the temporary demountable solution described above . This opportunity also presents wider patient and resident benefits to integrate multi-disciplinary services provided by public sector partners and create more of a Health and Wellbeing centre. The Task and Finish Group tested the Options Appraisal criteria on this long-term opportunity as part of the workshop held on 20th March 2015 which aside from scoring a 1 (Low) on the Deliverability criteria of being available at the right time, scored maximum (3 / high) throughout all other criterions.

An opportunity at the Hale Village Tower as part of the regeneration plans within Hale Village also presents a long-term solution, and greater opportunity for stakeholder partners to come together. This is being managed through a third party developer; Lee Valley Estates.

The recommendation for this Deep Dive area would be to pursue the immediate short-term solution for a new practice in a temporary, demountable facility in Tottenham Hale and for NHS England to work jointly with Haringey Council on securing the site of the former Welborne Centre for future use as the permanent solution as a Health and Wellbeing Centre.

4.4 Hypothesis; Central GP collaborative (Noel Park and Green Lanes deep dive)

4.4.1 Overview

The Central collaborative is made up of the following wards, three of which have been used as part of the Noel Park and Green Lanes Deep Dive. We can also see that two wards are amongst the most deprived wards in the borough, and are also among some of the highest deprived wards nationally. See Figure 24 below;

Ward	Population projection for 2015	Ward rank out of 19	National deprivation rank out of 7,679 wards
Noel Park	14,686	4	271
Woodside	15,387	9	570
Harringay	14,079	11	675
Bounds Green	14,417	13	969
Total	**58,569**		

Figure 24: population and deprivation ranking for Central Collaborative

There are 14 practices within this collaborative, with a registered patient list data of 68,247, or equivalent to17% more people registered with the practices than the local resident population. This shows again, that even though the area includes a highly deprived collection of wards the practices within the collaborative appear to be registering and providing services to the resident population albeit not necessarily providing services to patients within the wards that they are resident. The excess of registered over resident population could be due to the highly transient population in Haringey, or patients have moved outside the immediate ward catchment and continue to travel to their previous practice. Recommendation would be to review patient surveys, discuss access with patient panel groups and further engage with practices in the locality to ascertain how current provision of services could be improved.

4.4.2 Current capacity

Noel Park Deep Dive area encompasses the Wards of Noel Park, Woodside and part of West Green; two of which feature within this Collaborative. The Green Lanes Deep Dive area encompasses the wards of Harringay, St Ann's and part of West Green. Although the Green Lanes Deep Dive does not fit into any Collaborative completely, the ward of Haringey is seen as a significant part of the Central Collaborative, and therefore has been included in this Central Collaborative review.

These two Deep Dive areas has focussed on 13 practices with a combined list of 75,581 shown further in Figure 25 below

Deep Dive Area	GP Code	Ward	List Size		Enfield Patients	Number of Rooms	No. of GPs	GPs Over 60	Condition (RAG)	Infrastructure Fund Preliminary Granted	Pro forma returned
			Total	S/M/L							
Noel Park	F85031	Noel Park	9,008	M	178	7	6	1	Amber		Y
	F85643		4,017	S		3	2	1			Y
	F85046		3,527	S		3	5	1	Red		Y
	F85008	Woodside	15,114	L	479	23	4	0	Red		N
	F85064		3,755	S		3	1	1	Amber		N
	F85060	West Green	5,279	S	96	7	5	0	Amber		Y
Green Lanes	F85669		9,161	M		5	3	1	Amber	Y	N
	Y03506	St Ann's	7,500	M	101	5	6	3	Amber		Y
	Y01655		4,643	S		6		0	Amber		N
	F85697	Harringay	2,192	S	42	2	2	0			N
	F85632		2,000	S		1	1	1	Red		Y
	Y03135		8,699	M		6	3	0	Red		N
	F85708		686	S		1	1	0			N

Figure 25: Noel Park and Green Lanes data overview

Noel Park

From the data received and using the modelling methodology for Noel Park, there are;

- 46 available clinical rooms in the area,
- 38 rooms required,
- Current surplus of 8 clinical rooms, however one practice has a surplus of 10 rooms, otherwise the area would have a current deficit of 2 clinical room.

The current population in 2015 is 37,086 people. The registered list sizes of the GP practices in this area are 40,700. This shows that there appears to be sufficient primary care capacity within the Deep Dive Area for the resident population, furthermore an additional 3,614 out-of-area patients are registered with these practices. Patient distribution maps also show that 178 of the Noel Park residents use GP services in Enfield.

There are no current plans to improve the premises for practices in this Deep Dive Area.

In the Noel Park Deep Dive area, four out of the six practices have GPs over the age of 60, although only one is a single handed practice (i.e. practice with a single GP owner and contract holder), which will impact 3,755 patients. This has been considered as part of the Capacity review although it should be noted that this GP may make his own succession arrangements, which is not uncommon

Green Lanes

From the data received and using the modelling methodology for Green Lanes, there are;

- 28 available clinical rooms in the area,
- 32 rooms required,
- Current deficit in the current estate of 4 clinical rooms.
- This suggests that this area would be unlikely to be able to accommodate any growth in population, but would need to be confirmed with the relevant practices.

The population prediction in 2015 is 37,215 people and the registered list sizes of the GP practices in this area are 34,881, a deficit of 2,334. Patient distribution maps show that 191 of the Green Lanes residents use GP services in Enfield. If it is assumed that the remaining population requires registration within area, this deficit of 2,143 would require 1.2 WTE GPs (based on 1,800 patient to WTE GP ratio). However residents may be registered elsewhere, for example, near place of work.

28% of GPs in this area are over the age of 60 (5 out of 18), so retirement may become an added issue in the coming years. In order to model this added pressure we have assumed the potential retirement of a single handed GP practice, with an average list size of 2,000 to redistribute added to Figure 27.

4.4.3 Growth capacity

The Noel Park area includes the three ward areas of Noel Park, Woodside and West Green. Please note that the ward of West Green spans two areas of review, Green Lanes and Noel Park, so the population growth in each ward has been divided equally between both areas to avoid double counting population increase.

The Noel Park Deep Dive area has an expected 10,785 population increase from 2011 – 2026, as shown in Figure 26 below. This is the second largest population increase across the four Deep Dive areas, with a substantial proportion of the expected growth (83%) yet to materialize.

Ward	Population Projection				
	2011	2015	2020	2026	2011-2026
Noel Park	14,009	14,686	18,515	21,953	7,944
Woodside	14,594	15,387	16,870	16,959	2,365
West Green	6,725	7,013	7,194	7,201	476
Total	**35,328**	**37,086**	**42,579**	**46,113**	**10,785**

Figure 26: Population increase from 2011 – 2026 for Noel Park Deep Dive.

The Green Lanes Deep Dive area has an expected 4,786 population increase from 2011 – 2026, as shown in Figure 27 below; However a large proportion (50%) of that expected growth has already taken place.

Ward	Population Projection				
	2011	2015	2020	2026	2011-2026
Harringay	13,348	14,079	14,756	14,826	1,478
St Ann's	14,717	16,123	16,198	17,549	2,832
West Green	6,725	7,013	7,194	7,201	476
Total	**34,790**	**37,215**	**38,148**	**39,576**	**4,786**

Figure 27: Population increase from 2011 – 2026 for Green Lanes Deep Dive.

Figure 28 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator) for Noel Park Deep Dive, and following with Green Lanes.

	2015	2020	2026	Total	Notes
Population growth	1,758	5,493	3,534		
Single handed practice retirements	3,755				
TOTAL GROWTH	**5,513**	**5,493**	**3,534**	**14,540**	
No of WTE GPs required	3.06	3.05	1.96	**8**	Assume 1,800 people per GP
No of C&E Rooms required	3	3	2	**8**	NHS England PID estimator
No of Treatment Rooms required	4	4	2	**3**	NHS England PID estimator
GIA required	616m^2	613m^2	395m^2	**1,624m^2**	NHS England PID estimator

Figure 28: Projected population growth from 2011-2026 against WTE GPs and extra space required for Noel Park

This assessment assumes that the local area will lose the use of the primary health care facility when the single-handed GP retires.

An analysis of the information returned by practices (4 returned out of 6) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these clinical rooms were fully utilised, capacity exists for approximately 4,080 additional patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments). It was noted that some surgeries are closed on a Thursday afternoon.

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	2,143					
Population growth		2,425	933	1,428		
Potential single handed practice retirements		2,000	0	0		
TOTAL GROWTH	**2,143**	**4,425**	**933**	**1,428**	**8,929**	
No of WTE GPs required	1.2	2.46	0.52	0.79	**5**	Assume 1,800 people per GP
No of C&E Rooms required	1	3	1	1	**6**	NHS England PID estimator
No of Treatment Rooms required	1	3	1	1	**6**	NHS England PID estimator
GIA required	239m^2	494m^2	104m^2	159m^2	**996 m^2**	NHS England PID estimator

Figure 29: Projected population growth from 2011-2026 against WTE GPs and extra space required for Green Lanes

An analysis of the information returned by practices (2 returned out of 7) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these clinical rooms were fully utilised, capacity exists for approximately 1,275 additional patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments).

Three of the seven surgeries are closed on a Thursday afternoon. It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open for registration

- The practices identified being willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices and complete the information set (for the 7 deficient practices) so that a full picture of potential capacity within existing practices can be determined and in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of the retiring GP and any others who may be planning to retire in the near future.

4.4.4 Solution development

Out of 14 practices in this Central collaborative, 10 are in Red/High or Amber/significant rated properties for non-statutory compliance, coupled with one out of the four wards exceeding the average list size (1,800) per GP by ward shows an estate that is in need of investment and practices which need to be supported to recruit a larger clinical workforce.

Only one practice within the very north of the Collaborative has been provisionally accepted as part of the Primary Care Infrastructure Fund Bids

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

Engagement with stakeholder partners to determine estate solutions for the short, medium and long-term will need to take place through the Task and Finish Group along with wider stakeholders including NHS Property Services. A short terms solution proposed by NHS Property services at a shop unit has already been dismissed given its close proximity to a GP practice who have been provisionally awarded additional resources for premises improvements as part of the Primary Care Infrastructure Fund Bid process. This practice had been included in the adjacent Deep Dive area of Green Lanes (Central collaborative), as part of the West Green split.

Haringey Council own a library on High Road, Wood Green which is a 3minute walk from Wood Green tube station. The Council have indicated that office space is available above the library, but would offer patients additional benefits for co-location of public services. The area of this space is unknown.

Another short term solution is 250-500m² over two floors of office space which is available through a third party letting agent further down on the High Road, Wood Green, being a 5 minute walk from Wood Green tube station. This solution would require refurbishment, but is serviced by two 8 passenger lifts. This location benefits by being within the heart of the local shopping district.

The Deep Dive area of Noel Park has a LIFT development within at Lordship Lane Primary Care Centre (West Green ward), providing a range of services from Whittington Health NHS Trust such as Speech & Language Therapy, Health Visiting and District Nursing, Foot Care, Physiotherapy, Foot Biomechanics and the Dietetic service. A modern fit-for-purpose fully maintained and lifecycled property, which may have clinical room capacity that can be released for Primary Health Care use.

The recommendation for this Deep Dive area would be to undertake a utilisation review at Lordship Lane Primary Care Centre, and explore the space at the library with Haringey Council. Long term solutions should be developed in connection with the Council once the housing development sites are secured and Section 106 negotiations commence.

4.5 Hypothesis; West GP Collaborative (no deep dive area)

4.5.1 Overview

The West collaborative is made up of the following wards, none of which were reviewed as part of the Deep Dive Capacity Analysis. This collaborative covers areas with the lowest deprivation in the borough and highly positioned in national rankings of relative affluence. See Figure 30 below;

Ward	Population projection for 2015	Ward rank out of 19	National deprivation rank out of 7,679 wards
Hornsey	13,098	12	916
Stroud Green	12,227	14	1442
Crouch End	12,785	15	2535
Muswell Hill	11,074	16	2749
Alexandra	12,052	17	2925
Fortis Green	13,009	18	3006
Highgate	12,119	19	3088
Total	**86,364**		

Figure 30: population and deprivation ranking for West Collaborative

There are 13 practices within this collaborative, with a registered patient list data of 82,636, or the equivalent of 4% of residents not being able to register with a practice within the collaborative. This position is in direct contrast to the other Collaboratives which shows a higher level of registration compared to resident population..

4.5.2 Current capacity

The wards within the Deep Dives, did not include any within the West Collaborative because the West Collaborative is not perceived to have any current capacity issues

4.5.3 Growth capacity

The West Collaborative, although not the focus of Areas of Growth or Change, and the lowest across the four Collaboratives, still has pockets of growth, as shown in Figure31 below;

Across all seven wards within the west collaborative has a planned 5,785 population increase from 2011 – 2026, as shown in Figure 31 below.

Ward	Population Projection				
	2011	2015	2020	2026	2011-2026
Hornsey	12,745	13,098	13,601	13,591	846
Stroud Green	11,829	12,227	12,076	12,567	738
Crouch End	12,478	12,785	12,905	12,951	473
Muswell Hill	10,845	11,074	11,712	11,861	1,016
Alexandra	11,876	12,052	12,086	12,312	436
Fortis Green	12,569	13,009	13,078	13,258	689
Highgate	11,703	12,119	12,491	13,290	1,587
Total	**84,045**	**86,364**	**87,949**	**89,830**	**5,785**

Figure 31: Population increase from 2011 – 2026 for West Collaborative.

This growth is equated to number of additional GPs and space requirements, as shown in Figure 32 below;

	2015	2020	2026	Total	Notes
Population growth	2,319	1,585	1,881	**5,785**	
Potential single handed practice retirements	0	0	0	**0**	
TOTAL GROWTH	**2,319**	**1,585**	**1,881**	**5,785**	
No of WTE GPs required	1.29	0.88	1.05	**3.22**	Assume 1,800 people per GP
No of C&E Rooms required	1	1	1	**3**	NHS England PID estimator
No of Treatment Rooms required	1	1	1	**3**	NHS England PID estimator
GIA required	259m^2	177m^2	210m^2	**646 m^2**	NHS England PID estimator

Figure 32 Growth in relation to number of additional GPs and space requirements.

4.5.4 Solution development

10 out of the 13 practices in the West Collaborative are Red/High or Amber/Significant rated for non-statutory compliance; the second highest proportion across the four Collaboratives at 77%. The West Collaborative though, has a modern, fit-for-purpose LIFT development at Hornsey Central Neighbourhood Health Centre, located in Muswell Hill ward; the site of the second highest population increase within this Collaborative.

Engagement with stakeholder partners to determine estate solutions for the short, medium and long-term are taking place through the Task and Finish Group along with wider stakeholders including NHS Property Services. The West Collaborative has had two Primary Care Infrastructure Fund applications provisionally awarded, which will support a short-term solution.

For a medium to long term solution we understand from our stakeholder partners at Community Health Partnerships that there are six clinical exam/consult rooms, a treatment room, auxiliary space such as clean and dirty utility, waiting area and storage which are currently classified as bookable space at Hornsey Central Neighbourhood Health Centre . There is also space classified as void allocated for space for a minor treatment room and recovery unit, along with further auxiliary space of storage, clean and dirty utility and changing facilities. It would be recommended to undertake a utilisation study to determine whether further bookable/void space is available, which when the bulk of the growth in this ward is planned in 2020 will support the delivery of continuity of services.

5 Recommendations

Haringey is faced with two entwined issues of poor quality estate and high levels of deprivation. The quality of GP premises in Haringey is poor, with 79% Red or Amber rated for non-statutory compliance which coupled with a predicted increase in population of 37,329 between 2011 – 2026 across the borough will put strain on an already poor estate. When examined in a national context all 19 Haringey wards rank in the top half of 7,679 wards nationally. In addition, 8 of Haringey's wards are in the top 500 most deprived wards nationally. However, this is only part of the current issue, as a Capacity Review on key wards within the borough has identified existing capacity pressures and a need to plan for retiring GPs. The focus of patient choice rather than limited choice should be a driver for change, and improving engagement through stakeholders organisations and patient panels will better support the implementation stage.

The recommendations within this strategy are to pursue with the current Primary Care Infrastructure Fund Bid applications to support the estate and access for patients in the immediate to short-term. Analysis has shown that currently some capacity is available across the system that could be utilised and additional patients that could be accommodated by fully utilizing existing clinical rooms. However, dialogue will need to be undertaken with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population, otherwise an estimated 7,842m² of space would be required across the borough by 2026. Using a hub model this is summarised by GP practice collaborative in Figure 33 below;

Collaborative	Growth (inc. 2015 deficit and retiring single handers)	WTE	Area (m²)	Short/immediate term options under consideration	Medium/long term option
North East	11,379	6.3	1,271	PCIF bid for extension	Undefined
South East	29,595	16.4	3,305	PCIF bid for new practice demountable	Site of the former Welborne Centre
Central	14,540	8.1	1,624	Haringey Library	Undefined
	8,929	5	996	LIFT utilisation	
West	5,785	3.2	646	PCIF bid for extra clinical capacity	Utilise surplus in LIFT development
TOTAL	**70,228**	**39**	**7,842**		

Figure 33: Overview of Collaborative requirements, for growth, WTE, area and options

Coupled with this, NHS England and Haringey CCG are encouraged the merger of small GP practices and review wider options of federation, co-location and integration supporting the Collaboratives to working within a hub structure.

Joining up healthcare requires better IT infrastructure and agreements for records sharing. Encouraging more self-care management through pilots such as telehealth, coupled with better access to Public Health through vacant shop units initiatives, and building on the partnerships evolved through the Task and Finish group will embed the ethos of joined up healthcare across general practice, community services and hospitals resulting in a better experience, improved results and better value for money.

ENDS

6 Appendices

6.1 Appendix 1 – National Deprivation Rankings – Haringey Wards

1 - National Deprivation Rankings

6.2 Appendix 2 – Haringey SSDP

2 - Haringey SSDP June 2015 Final.pdf

6.3 Appendix 3 – Property Data Master

3 - Haringey PDM v0.08 190515.xlsx

6.4 Appendix 4 – Summary of preliminary granted Infrastructure Fund applications

4 - Summary of preliminary granted Ir

6.5 Appendix 5 – Haringey Growth by Ward

5 - Haringey growth by ward.pdf

6.6 Appendix 6 – Haringey Housing Trajectory by Ward 2015 – 2026

6 - Haringey housing units by ward 2015-2

6.7 Appendix 7 – Haringey Capacity Planning Report

7 - Haringey Capacity Planning Fin

6.8 Appendix 8 – Options Appraisal Criteria

8 - Option Appraisal Criteria.pdf

6.9 Appendix 9 – Planning Brief

9 - Planning Brief.pdf

6.10 Appendix 10 – NHS England Approval Process

10 - NHS England Approval Process.pdf

National Deprivation Rankings – Haringey Wards

Ward Rank	Ward 2011	IMD Score	Nat. Rank (out of 7,679)
1	Northumberland Park	254.21	83
2	White Hart Lane	231.84	160
3	Tottenham Green	215.76	240
4	Noel Park	210.69	271
5	Tottenham Hale	210.02	281
6	Bruce Grove	207.1	296
7	St Ann`s	195.5	387
8	West Green	192.7	417
9	Woodside	179.85	570
10	Seven Sisters	174.61	638
11	Harringay	172.28	675
12	Hornsey	156.07	916
13	Bounds Green	153.26	969
14	Stroud Green	129.81	1442
15	Crouch End	94.85	2535
16	Muswell Hill	89.45	2749
17	Alexandra	85.92	2925
18	Fortis Green	84.37	3006
19	Highgate	82.72	3088

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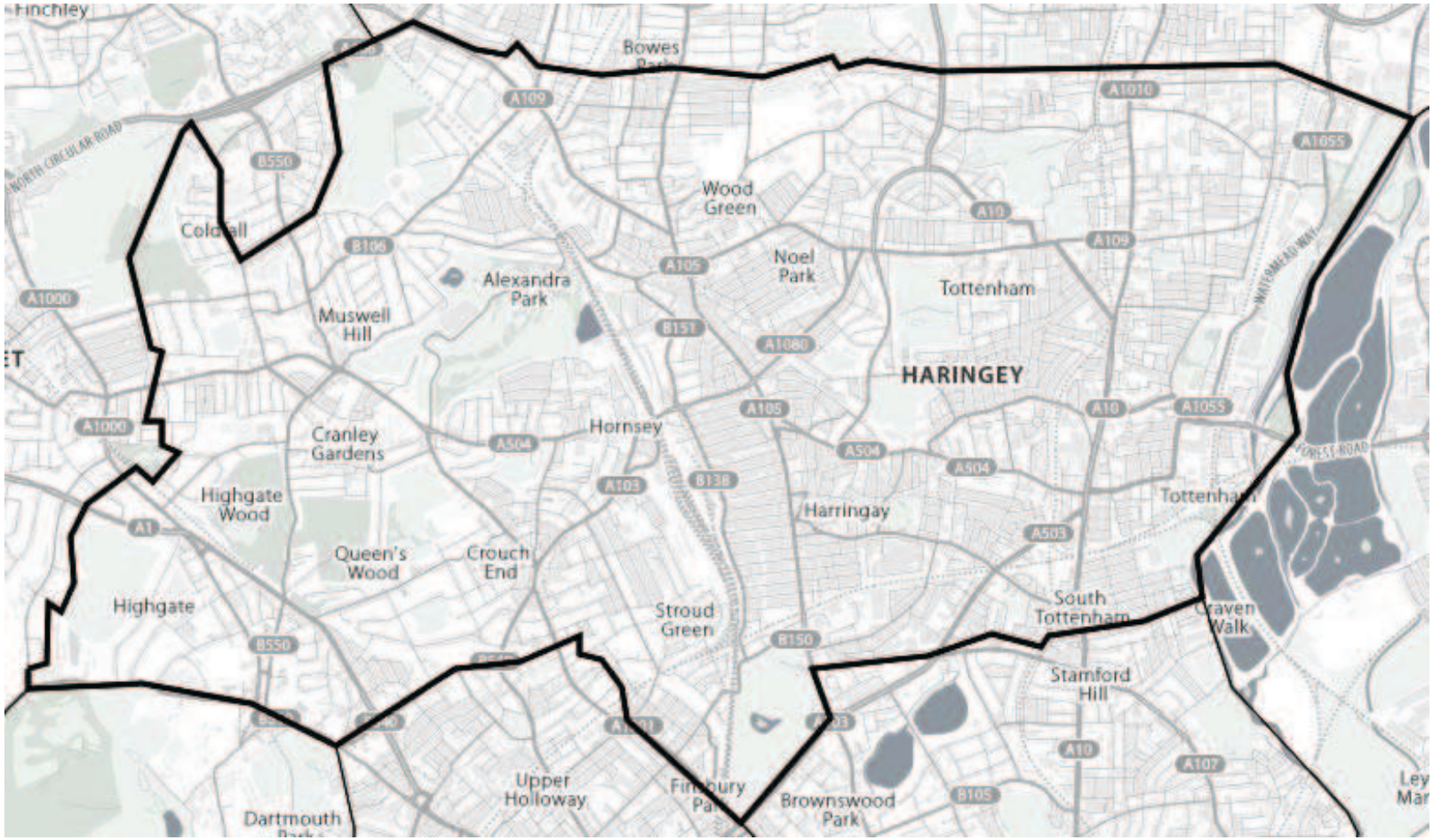
Haringey
Strategic Services Development Plan

June 2015



Prepared by:

North London Estate Partnerships LIFTCO

Prepared for:

NHS England

Executive Summary

This Strategic Service Development Plan (SSDP) has been configured in response to the evolving health and social care landscape, and the needs of the local population. Its objective is to establish a firm strategic direction for the Haringey locality, drawing on the strategic plans of partner organisations recently established in the 'new world' of the NHS reforms.

This SSDP will identify how each strategic plan meets with local health care needs, identifying any gaps in service provision and whether they align, cross over or conflict with one another. As a result of this review, we have configured key observations.

This SSDP is the first stage of strategic planning for Haringey which will go on to inform the estate solutions for Haringey, delivering a joined up, cohesive plan for the CCG area or wider North London NHS cluster.

Key Observations

Key observations identified within this SSDP;

- Haringey is the fourth most deprived borough in London and 13th borough in England.
- The population is younger than the national average but the proportion of over 65s is rising fast.
- The population is due to increase by 13% between 2011—2026.
- 65% of the population are not White British.
- There is a nine year gap in life expectancy for both men and women, between the West and the East of the borough.
- The West of the borough is affluent while the East is deprived.
- The Council are expected to provide over 19,715 new homes by 2026.

Introduction

SSDPS originally had their foundations in the Department of Health's initiatives outlined in the NHS Plan and were prepared on behalf of the Strategic Partnering Boards (SPBs) - a mix of representatives from member stakeholder organisations. The purpose of the SSDP's was to support the overall approach to improving health and wellbeing and applying this locally, breaking down the priorities identified in the NHS Plan to ascertain the specific needs for a locality, drawing on any shortfalls in primary and community care.

The SSDP's were developed in hand with the Local Improvement Finance Trust (LIFT), which was regarded as the ideal vehicle for stimulating the plan at a local level and, one of the key benefits of working with the LIFT Companies was the advantage of integrated working and local partnerships.

Over the last few years, there has been a natural decline in the number of representatives attending the SPBs, and as a result the SSDP's were no longer produced. However, with the recent changes to the NHS and the promotion for new, integrated, ways of working, Community Health Partnerships (a shareholder of North London Estate Partnership – the local LIFT Company covering the Barnet, Enfield and Haringey locality) have decided to re-invigorate the SPBs and produce the SSDP's for Outer North East London, for discussion between stakeholder organisations and as a first step towards establishing the required estate solutions for the locality.

Purpose of the SSDP

This SSDP has been configured in response to the evolving health and social care landscape and the needs of the local population. Its objective is to establish a firm strategic direction for the Haringey locality, drawing on the strategic plans of partner organisations recently established in the 'new world' of the NHS reforms. This SSDP will identify how each strategic plan meets with local health care needs, identifying any gaps in service provision and whether they align, cross over or conflict with one another. The SSDP will go on to inform the estate solutions required in order to deliver a cohesive plan for the CCG locality or wider North London NHS cluster.

Content

This report has been broken down into the following sections:

Key Organisations

A break down of the roles and responsibilities of key organisations established in the 'new world' of the NHS

Need

Need considers the core drivers that currently, and will in the future, shape the healthcare landscape

Commissioning

Commissioning draws upon the local commissioning strategies aligning values and priorities with the local health needs for each CCG area.

Providers

Providers looks at local provider Annual Reports and Quality Accounts to identify how provider plans meet with the commissioning intentions identified by the CCG.

Key Organisations

A break down of the roles and responsibilities of key organisations established in the 'new world' of the NHS.

Context

The 'New World' NHS

Over the last few years the NHS has undergone major structural changes to its core structure, with most changes having taken full effect from 1st April 2013. The changes have focussed on the organisations making the decisions, NHS services, commissioning and the way in which public money is spent. Organisations such as the Primary Care Trusts (PCT) and Strategic Health Authority (SHA) were abolished from 1st April 2013 and other new organisations such as the Clinical Commissioning Groups (CCGs) and NHS Property Services (NHS PS) were put in place. As a result of this, the NHS is still in a deeply transitional phase and it may be some time before all the changes are fully implemented.

As part of the reform, NHS services have now opened up to competitive tenders, with providers now competing on their standards, price, quality and safety.

Local Authorities

In addition to the changes to the NHS, the government has given local authorities a much bigger role. Local councils have assumed the responsibility for budgets for public health and council led, Health and Well Being Boards have now been configured. The Health and Well Being Boards have a duty to promote integrated ways of working across health, social care, public health and children's services and local authorities are now required to link more closely with health and care providers, community groups and agencies.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England, inspecting and licensing providers of health care by giving clearer focus on essential levels of safety and quality. Inspections are targeted and risk-based, assessing the suitability or 'fitness' of organisations/individuals and partners to operate a health service, checking for the following; 'Fitness of Premises', 'Fitness of People' and 'Fitness of Service.'

Monitor

Monitor is the sector regulator for health services in England. Its job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercises a range of powers which includes setting and enforcing a framework for providers and commissioners. It works closely with the CQC and the quality and safety regulator to ensure good quality care in foundation hospitals, ambulance trusts, mental health and community care organisations. Monitor also sets prices for NHS funded services and tackles anti-competitive GP practices that work against the interest of patients.

Roles and Responsibilities: National

NHS England

Formerly established as the NHS Commissioning Board in October 2012, NHS England is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England by;

- Providing national leadership for improving outcomes and driving up the quality of care
- Overseeing the operation of clinical commissioning groups
- Allocating resources to clinical commissioning groups
- Directly commissioning

NHS directly commissions:

- Primary care contracts and nationally commissioned enhance services, out of hours primary medical services (where practices have retained the responsibility)
- Pharmaceutical services provided by community pharmacy services
- Primary ophthalmic services, NHS sight tests and optical vouchers
- All dental services, including primary, community and hospital based services, including urgent and emergency dental care
- Health (excluding emergency care) and public health services for people in prisons and other custodial settings
- Health services for members of the armed forces and their families, prosthetics for veterans – primary care for the armed forces is commissioned by the Ministry of Defence.
- Specialist and highly services – these services are provided in relatively few hospitals, accessed by a small number of patients who require specialist treatment for physical or mental health. This accounts for 10% of the NHS budget, spending circa £11.8 billion per annum.

In addition to the above, NHS England also commission some Public Health Services. Although the commissioning of public health services is carried out by Public Health England (PHE) and local authorities, NHS England directly commissions, on behalf of PHE, many of the preventative public health services delivered by the NHS, at a total of 2.2 billion. These services include;

- National immunisation programmes
- National screening programmes – including antenatal and new born screening programmes
- Public health services for offenders in custody
- Sexual assault referral centres, HIV treatment
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme)
- Child health information systems

NHS Property Services

NHS Property Services (NHS PS) was created by the Health and Social Care Act 2012. On 1 April 2013, 3,200 NHS staff transferred from former Strategic Health Authorities (SHAs) and PCTs, to make NHS PS a major employer. The set up of NHS PS is to work closely with NHS England and the 211 Clinical Commissioning Groups, nationwide.

NHS PS is a private limited company, 100 per cent owned by the Secretary of State for Health, they manage, maintain and improve NHS properties and facilities, working in partnership with NHS organisations to create safe, efficient, sustainable and modern healthcare and working environments.

NHS PS is national company, with a local structure, focusing on strategic and operational property management skills to support better health outcomes and experience for patients.

NHS Property Services has two main roles:

- Strategic estates management – acting as a landlord, modernising facilities, buying new facilities and selling facilities the NHS no longer needs.
- Dedicated provider of support services such

Roles and Responsibilities: National

as cleaning and catering.

NHS PS are responsible for 4,000 buildings – worth over £3 billion – which were previously owned, leased or managed by Primary Care Trusts and Strategic Health Authorities. Most of these buildings are used to provide patient care, such as GP surgeries and community hospitals. NHS PS does not have responsibility for hospital estates run by NHS Trusts and NHS Foundation Trusts.

NHS PS has a clear mandate to provide a quality service to its tenants and minimise the cost of the NHS estate to those organisations using it. Any savings we make will be passed back to the NHS.

Haringey's Clinical Commissioning Group (CCG)

The borough of Haringey is represented by the Haringey CCG who have taken over the role of commissioning (buying) the following health services for its residents;

- Urgent and Emergency Care – including 111, A&E and ambulance services, out of hours services (except where this is retained by the GP practice)
- Elective Hospital care
- Community health services, such as rehabilitation services, speech and language therapy, continence services, wheelchair services, home oxygen services – but not public health services such as health visiting of family nursing.
- Other community based services including services provided by GP practices that go beyond the scope of the GP contract.
- Rehabilitation services
- Maternity and new born services – excluding neonatal intensive care.
- Children's healthcare services (mental and physical health)
- Services for people with learning disabilities
- Mental health services – including psychological therapies
- Infertility services for the armed forces and in some cases, veterans.

Community Health Partnerships

Community Health Partnerships (CHP) is wholly owned by the Department of Health, the organisation was established in 2001 and until 2007 was known as Partnerships for Health.

Over the past 10 years CHP has worked in partnership with a variety of organisations across England to build and maintain a wide range of estate and facilities used by GPs, primary and community healthcare providers and Local Government. During this time, CHP has established 49 LIFT companies - locally based joint ventures between public and private sectors - and together they have delivered more than 300 buildings, with over 800,000m2 of space, which are used by communities throughout England. CHP has a shareholding and a Director on the Board of all of the 49 LIFT companies, safeguarding the public interest and facilitating local partnerships.

Local Improvement Finance Trust (LIFT)

The Local Improvement Finance Trust (LIFT) Programme was conceived in 2000 and since then has resulted in the most concentrated investment in new locally run primary health and social care facilities since the advent of the National Health Service (NHS).

This has been achieved through the formation of 49 LIFT Companies, combining the expertise and knowledge of the private sector with the skills with the experience and drive of the NHS, General Practice and Local Authorities.

Roles and Responsibilities: National

In many areas LIFT supports its local partners (GPs/CCGs/Local Authorities) to develop detailed estate reviews, capital works programmes and short-term estate solutions to ensure the local estate is fit for purpose.

Strategic Partnering Board

The Strategic Partnering Board (SPB) is the key component of the LIFT infrastructure and provides the framework for the local health and social care community to propose new projects as well as monitoring existing schemes. Its role is to undertake the roles and responsibilities of the participants and LIFTco under the Strategic Partnership Agreement (SPA) and its purpose is to establish a long-term partnership between LIFTco and the participants.

The Council

Each local council is responsible for commissioning:

- The Healthy Child Programme for school-age children, including school nursing
- Contraception (over and above what GPs provide) Testing and treatment of sexually transmitted infections, sexual health advice, prevention and promotion
- Mental health promotion, mental illness prevention and suicide prevention
- Local programmes to address physical inactivity and promote physical activity
- Local programmes to prevent and address obesity, including National Child Measurement Programme and weight management services
- Drug misuse services, prevention and treatment
- Alcohol misuse services, prevention and treatment
- Local smoking related activity, including stop smoking services and prevention activity
- Locally-led initiatives on nutrition
- Population level interventions to reduce and prevent birth defects (with PHE)
- Dental – oral health promotion

Public Health England

Public Health England (PHE) is the public health advisor to NHS England, working in partnership with the Chief Medical Officer for England to protect and improve the public's health. PHE is the expert, national public health agency which fulfils the Secretary of State for Health's statutory duty to address health inequalities and the wellbeing of the nation. PHE has operational autonomy. It has an Advisory Board, with a non-executive Chairman and non-executive members. It employs scientists, researchers, public health professionals and essential staff support.

Health and Wellbeing Boards

The Health and Social care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Health and wellbeing boards will:

- Have strategic influence over commissioning decisions across health, public health and social care
- Strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion, and the involvement of local people
- Bring together CCGs and councils to develop a shared understanding of the health and wellbeing needs of the community
- Undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations

Roles and Responsibilities: National

for joint commissioning and integrating services across health and care

- Drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Healthwatch

Healthwatch England is the national consumer champion in health and care. They have significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

The Health and Social Care Act formalises the relationship between:

- Healthwatch England
- The Secretary of State
- NHS England
- Care Quality Commission
- Monitor
- English local authorities

They have a unique power to advise this wide range of organisations and their ultimate recourse is the Secretary of State. Their work covers health and care, allowing them to see how providers interact with each other and where their system fails to join up different aspects of an individual's care.

They advise on where change is most needed. Sometimes they give advice formally, using their powers to raise issues of concern or where they feel they, or any local Healthwatch, are not getting an adequate response. Often, they work together with partners to influence their thinking at an early stage and to help them get the design of services right from the start.

Acute Trusts

Hospitals in England are managed by acute trusts some of which already have gained Foundation Trust status. Acute trusts ensure hospitals provide high quality healthcare and that they spend their money efficiently. They also decide how a hospital will develop, so that services improve.

Acute trusts employ a large part of the NHS workforce. Some acute trusts are regional or national centres for more specialised care, others are attached to universities and help to train health professionals.

Acute trusts can also provide services in the community, for example through health centres, clinics or in people's homes.

Mental Health and Community Service Providers

There are 58 mental health trusts in England, 41 have reached foundation trust status. They provide health and social care services for people with mental health problems.

Mental health services can be provided through a GP, other primary care services, or through more specialist care. This might include counselling and other psychological therapies, community and family support, or general health screening.

Roles and Responsibilities: Local

NHS England Area and Regional Teams

NHS England is divided into 4 Regional Teams;

- North of England
- Midlands and East of England
- London and;
- South of England

Barking, Dagenham, Havering and Redbridge (BHR) sits within the Midlands and East of England Regional Team and within this, the Essex Area Team.

As well as carrying out local functions for NHS England, NHS England is responsible for offender and armed forces health regionally.

NHS England work with other local organisations such as Public Health England, the NHS Trust Development Agency, local authorities and Health Education East Midlands.

NHS Property Services Regional Team

NHS Property Services (NHS PS) is divided into 4 Regional Teams:

- North of England
- Midlands and East
- London and;
- South of England

Haringey is covered by NHS Property Services Regional Team London. They play a vital role in the day-to-day running of the NHS, managing and developing almost 500 NHS facilities across the Capital, from community hospitals and GP practices to administrative buildings.

The London region supports healthcare provision to more than 8million people across 32 boroughs, each with its own identity and specific healthcare needs. The specialist team work closely with the CCGs and NHS England to identify and meet the healthcare estate needs of London's many diverse communities.

Clinical Commissioning Groups (CCG)

The CCG has the responsibility of commissioning healthcare for the Haringey locality.—Haringey CCG.

Local Improvement Finance Trust (LIFT)

The Haringey locality is currently covered by North London Estate Partnerships (NLEP) LIFT Company.

The Council

Haringey Council operates in the borough.

Ambulance Services

The London Ambulance Service covers the area of Haringey.

Acute Trusts

Whittington Health

Whittington Health provides general hospital and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield and Camden.

Whittington Health has an income of £281m and more than 4,000 staff delivering care across North London in The Whittington Hospital and from 30 locations in Islington and Haringey.

As one organisation providing both hospital and community services, it is known as an "integrated care organisation".

North Middlesex University Hospital

North Middlesex University Hospital is one of London's busiest acute hospitals, serving more than 350,000 people living in Enfield and Haringey and the surrounding areas, including Barnet and Waltham Forest. Most of its patients live in Enfield and Haringey - about half in each borough.

Roles and Responsibilities: Local

Mental Health and Community Service Providers

Barnet, Enfield and Haringey Mental Health NHS Trust

BEH MHT is a provider of integrated mental health and community health services to people living in the London boroughs of Barnet, Enfield and Haringey. It serves a population of approximately 950,000.

BEH MHT employs 2,800 staff and its annual income in 2014/15 was £186 million.

The Need

Need considers the core drivers that currently, and will in the future, shape the healthcare landscape

Area Overview:

Area Overview:

Haringey Overview

The London Borough of Haringey, located in the North of London, borders six other Boroughs; Barnet, Enfield, Camden, Islington, Waltham Forest and Hackney. The Borough spans over 11 square miles, of which over 25% is green space, and is divided into 19 wards. The east of the Borough is deprived and the west is affluent.

Haringey is the fourth most deprived borough in London. The population of Haringey is younger than the national average but, following the national trend, the proportion of over 65s within the population is rising fast. The Haringey Joint Strategic Needs Assessment (JSNA) demonstrates that there is a nine year gap in life expectancy, for both men and women, between the West and the East of the borough. The East of the borough has the lowest life expectancy and contains Tottenham, one of the most deprived areas in the country.

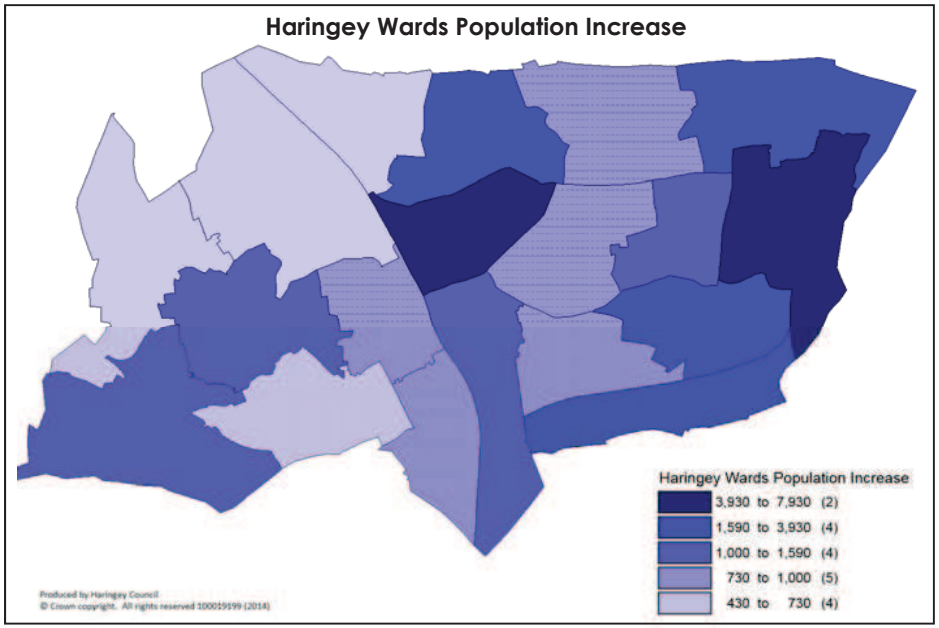
Population

The 2013 JSNA states that the latest population in Haringey is estimated at 254,900. Almost two-thirds of the population are young people, are from ethnic minority backgrounds, and over 100 languages are spoken in the borough. Haringey's population is the fifth most ethnically diverse in the country.

The population of Haringey is growing. The Greater London Authority (GLA), 2013 predicts the population to reach 293,757 by 2026, creating a surplus population of 37,329 or 13% between 2011—2026.

Population growth locally is mostly due to the increase in birth rates and net gain from international migration. Birth rates locally and nationally are increasing while death rates are decreasing. In 2011/12, there were 3, 120 more births than deaths in Haringey .

Haringey has always experienced a high level of population turnover. Most population turnover occurs by people moving into and out of other parts of the UK. 26,178 migrants moved to Haringey in the 2011/12 year, with 6,797 (26%) of these coming from outside the UK. At the same time, 25,827 people moved outside the borough; of those 2, 825 (10.8%) migrated overseas. The net gain of migration in the borough was due to international migration. Population growth in Haringey in recent years tends to be more due to births outnumbering deaths coupled with the international inward migration.



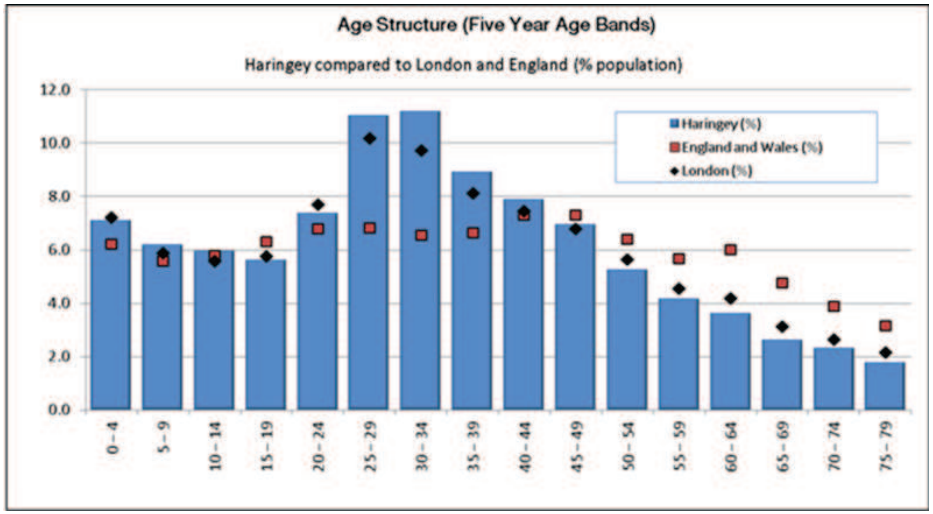
Age Structure

The proportion of the population aged 25-39 in Haringey is significantly higher than London (31.1% vs. 28.1%). Those aged 20 – 64 make up 66.3% of the total population. The population of residents aged 65 and over in Haringey is 8.8%.

Area Overview:

There are approximately 63,400 children and young people under 20 living in Haringey (approximately one third of the total population).

It is worth noting that there are more children in the East of Haringey, which has higher levels of deprivation than the West.

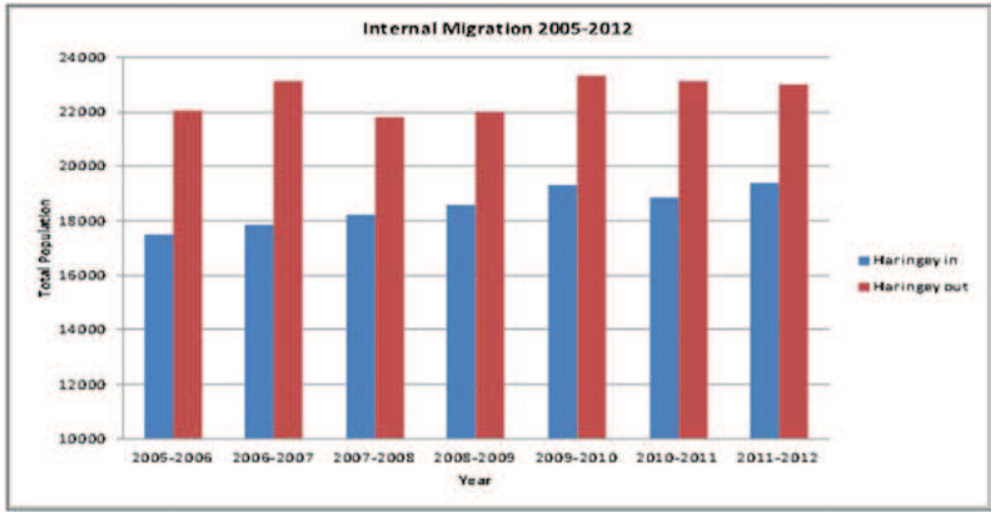


Migration

In 2011/2012 ONS state that 19,381 people moved to Haringey from another part of the UK. In the same period 23,002 people left Haringey for another part of the UK. At the same time, 6,797 people moved to Haringey from overseas, whilst 2,825 people left Haringey to live overseas.

Historically, Haringey has experienced a high level of population turnover – most of it in the form of people moving into Haringey from elsewhere in the UK or moving out of Haringey to somewhere else in the UK. The 2012 Mid Year Estimates found a total of 26,178 migrants moved to Haringey between 2011 and 2012. 34.2% of these came from outside the UK.

Haringey has a growing population that is mostly due to the number of babies being born in the borough rather than the number of people moving into the borough coupled with net gain from international migration



Ethnicity

Haringey is the 5th most ethnically diverse Borough in the country.

According to the Census 2011, 65% of the Haringey population are not White British. This is higher than the London figure of 55%. It was estimated that the largest ethnic groups in Haringey are White British (34.7%), White Other (23.0%), Black Caribbean (7.1%) and Black African (9.0%).

Area Overview:

Deprivation

The borough ranks as one of the most deprived in the country with pockets of extreme deprivation in the East. Haringey is the 13th most deprived borough in England and the 4th most deprived in London. The majority of children living in poverty do so in the East of the borough; there is a stark contrast between the West of the borough in areas such as Highgate and Muswell Hill, and the East in areas such as Tottenham.

Key Health Issues

Health improvement in the borough is divided along the following key areas: drug misuse, alcohol, obesity, diet and nutrition, physical activity, smoking and sexual health.

The key issues and challenges include:

- **Socio-economic status** plays a large role in lifestyle choices with those on lower incomes consuming more fat, processed food and less fruit and vegetables
- A large number of **fast food outlets** are located in the more deprived East of the borough
- **Childhood obesity** is higher in Haringey compared to England, particularly in 11-12 year old children
- **Physical inactivity** is a major area of concern especially in more deprived parts of the borough where physical inactivity levels are some of the lowest in the country
- Although **sexual health** in the borough in improving, focus on interventions should continue amongst those at highest risk such as young people (under 25 years)
- **Smoking prevalence** is unacceptable high and is a major reason for Haringey's health inequalities and life expectancy gap

Assets

Haringey is made up of:

- 48 GPs
- 2 acute trusts (North Middlesex University Hospital and The Whittington Hospital)
- 1 mental health trust (St Ann's Hospital)
- 6 health centres
- 12 Whittington Health service providers
- 1 Kidney and diabetes centre
- 50 dentists
- 21 opticians
- 62 pharmacies
- 62 primary / infant / junior schools
- 12 secondary schools
- 4 special schools
- 2 further education colleges
- Infrastructure
    - Railway station – 11
    - Tube station – 6

Housing and Regeneration:

Current Housing Profile

Haringey's population is projected to expand by up to 15% over the next 11 years and within this there is expected to be a general shift upwards in the average age, but also an increase in the numbers of very young people. It is the dynamics of the borough's population that lie behind the growth in housing demands in the borough.

Haringey's housing stock comprises of (2010):

- Under half of households are owner-occupiers
- 30% live in the social rented sector
- 22% live in private rented accommodation

There is a high demand for housing across all tenures. The need for affordable housing outstrips supply with a shortfall in provision of 4,865 units per annum. Responding to this shortfall is a priority for the borough. A housing trajectory projects a further 19,715 housing sites will be made available by 2026, broken down by 3000 being delivered between 2011-2014 and 16000 being delivered between 2015-2026.

Housing Regeneration

Haringey's Housing Strategy (2009-19) identifies areas of regeneration such as: Mid Tottenham, Seven Sisters, Northumberland Park, White Hart Lane, Bruce Grove / Tottenham Hale, Wood Green Town Centre, Noel Park and parts of Woodside. These priority areas contain the highest levels of deprivation.

Haringey's Regeneration Strategy:

Vision and Values

The vision of the strategy is **"To transform the Borough and the way in which it is perceived by creating economic vitality and prosperity for all through exploitation of Haringey's strategic location in a global city, major development site opportunities and by developing the Borough's 21st century business economy."**

Priorities and Schemes

A number of priorities and schemes have been identified to help achieve the vision of regeneration in Haringey:

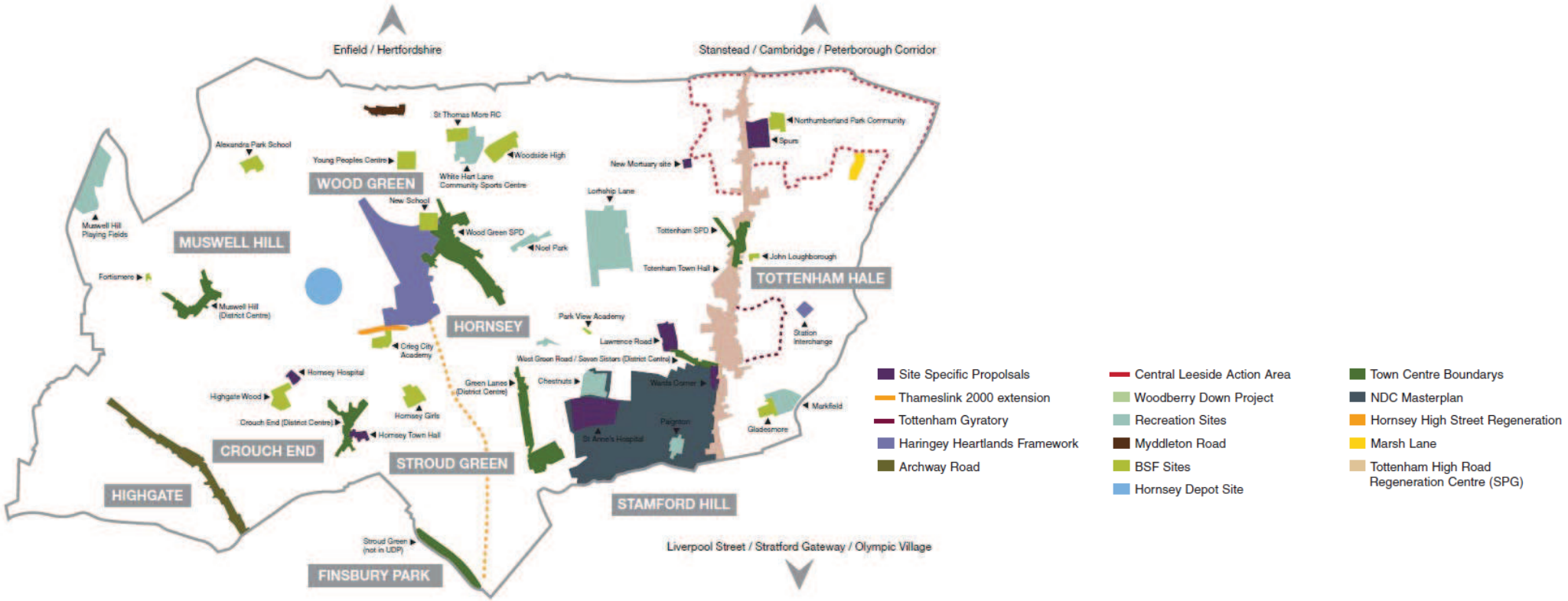
Table 1: Priorities and Schemes in Haringey

Objective 1: People — To unlock the potential of Haringey residents	• Creating strong links with Central London where significant job growth is projected (Stratford, Brent Cross, Stansted Airport) • Position key developments in the Borough to ensure they create jobs for local people • Reduce worklessness through employer led programmes such as the Haringey Guarantee • Focusing skills development on key growth sectors, ensuring employers have access to the required skills • Raising educational attainment to ensure people have the skills for work • Targeting of key groups ; young people, incapacity benefit claimants, users of council services and the low skilled • Ensure mainstream services e.g. childcare are focused on the challenge of worklessness • Ensure clear co-ordinated 'packages' of services — benefits advice / childcare are offered to help people into employment
Objective 2: Places — Transform Haringey into a place where more people want to live	• Transforming Tottenham — delivery of a new town centre, major residential development at Tottenham Hale, revitalising the area around Seven Sisters and maximising gateway opportunities centred on Tottenham Hotspurs FC to the north of the High Road. • Securing the position of Wood Green at the heart of the North London economy —by driving forward major mixed use development on the Haringey Heartlands east and west sites; creating an urban centre for the 21st century. • Transforming the Lee Valley — by taking full advantage of its status as one of the major business and housing growth locations for London and delivering the North London Strategic Alliance (NLSA) vision for the area. • Recapturing the Victorian vision for Alexandra Palace as a cultural, leisure and entertainment centre for the benefit of London. • Maximising cultural landmarks — including the redevelopment of Hornsey Town Centre and a town centre piece in Crouch End. • Ensuring neighbourhoods in Haringey that suffer long term poverty and deprivation, are integrated with new developments. • Attracting investment from central and regional government for improvements to transport and infrastructure; connecting people to key job growth locations.

Haringey's Regeneration Strategy:

Table 1: Priorities and Schemes in Haringey

Objective 3: Prosperity — Developing a 21st century business economy	• Unlocking the entrepreneurial talent in growth sectors such as: cultural and creative industries, food and drink production and distribution, professional services and hospitality, leisure and tourism retail. • Making use of new development opportunities in the Borough to create business space that better matches the needs of businesses. • Provision of good quality, simple to access, business support that businesses want and value. • Capitalising on Haringey's locational advantages and new developments order to generate new investment. • Delivering high quality Town Centres to ensure they meet the needs of demanding consumers. • Building on Haringey's diverse community to take advantage of innovation, global trade opportunities and promote entrepreneurship. • Make the relationship with the Council an asset for business by improving the quality and responsiveness of Council services. • Using the enormous procurement and purchasing power of businesses to create opportunities for local businesses.



Health and Wellbeing Strategy

The Health and Wellbeing Strategy (2012-15) in Haringey is informed by the JSNA, which sets out agreed priorities for collective action by commissioners.

Vision and Values

The vision of the strategy is: **"A healthier Haringey – to reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life."**

The outcomes identified below will enable the vision to be fulfilled:

- To give every child the best start in life
- To reduce the gap in life expectancy
- To improve mental health and wellbeing

Priorities and Schemes

A number of priorities have been identified to help achieve the outcomes desired in Haringey:

Table 2: Priorities and Schemes in Haringey

Outcome 1: **Every child has the best start in life**	• Reduce infant mortality • Reduce teenage pregnancy • Reduce childhood obesity • Ensure readiness for school at 5 years (physical, emotional, behavioural and cognitive)
Outcome 2: **A reduced gap in life expectancy**	• Reduce smoking • Increase physical activity • Reduce alcohol misuse • Reduce the risk of cardiovascular disease and cancer • Support people with long term conditions
Outcome 3: **Improved mental health and wellbeing**	• Promote the emotional wellbeing of children and young people • Support in independent living • Address common mental health problems among adults • Support people with severe and enduring mental health needs • Increase the number of problematic drug users in treatment

Commissioners

Commissioning draws upon the local commissioning strategies aligning values and priorities with the local health needs for each CCG area

Commissioning - Primary Care

The new world of the NHS has seen major reforms to the commissioning of healthcare services. NHS England now commission all Primary Care Contracts (for full commissioning responsibilities see Section 1) and the local CCGs are now responsible for commissioning elective hospital care, A&E services and Community and Mental Health Services.

This section looks at the new commissioners for Barking and Dagenham, Havering and Redbridge. identifying the key commissioning priorities presented within their individual strategies and their response to the Health and Wellbeing Strategy's top themes and the local health needs identified for the area.

'A Call to Action'

'A Call to Action' was published by NHS England in July 2013. The document sets out the national challenges ahead, such as an aging population, lifestyle risk factors in the young, the rise in the number of people with long term conditions and how these challenges, combined with rising costs and constrained financial resources all threaten the long term sustainability of the health service.

A Call to Action' identifies that while there are some impressive facilities in London, there is also a great deal of health care estate that is ageing and in need of improvement, if it is to support the improvement of services. Approximately 30% of primary care estate in London will not be fit for purpose in 10 years' time.

'A Call to Action' is an engagement process which is public and patient centred. It aims to produce data and information that the CCGs can use to develop a 3-5 year commissioning plan, setting out their commitments and how they plan to improve services. This engagement process is the broadest and deepest public discussion that the service has ever undertaken.

With the new world of the NHS looking for creative ways for integrated working, it is crucial that 'A Call for Action' and the CCG's new commissioning intentions deliver a commissioning strategy that builds upon joint working opportunities and partnership.

Five Year Forward View

The NHS Five Year Forward View (October 2014) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that it can promote wellbeing and prevent ill-health. It sets out a vision of a better NHS, the steps it should now take to get there and the actions it needs from others.

What will the future look like?

1) A new relationship with patients and communities;

- Getting serious about prevention
- Empowering patients
- Engaging communities

2) New models of care;

- Multispecialty Community Providers (MCP); expanding the leadership of primary care
- Primary and Acute Care Systems (PACS); to better integrate care
- Urgent and emergency care networks; transitioning to a more sustainable model of care
- Viable smaller hospitals
- Specialised care
- Modern maternity services
- Enhanced health in care homes

Some of the change needed can be brought about by the NHS itself whilst others equire partnerships with local communities, local authorities and employers. The NHS has therefore set out complementary approaches required in order to achieve its Forward View:

- Backing diverse solutions and local leadership; driving change locally
- Providing aligned national NHS leadership
- Supporting a modern workforce; able to deliver innovative new care models
- Exploiting the information revolution; capitalising on the opportunities it presents
- Accelerating useful health innovation; supporting research to transform services and

Commissioning - Primary Care

improve outcomes

- Driving efficiency and productive investment; to sustain a high quality NHS

The results would be a far better future for the NHS, its patients, its staff and those who support them.

Putting Patients First: The NHS England business plan for 2013/14 – 2015/16

In 2013, NHS England published their first business plan as a new organisation. This Business Plan set out NHS England's ambitions and commitment to ensuring high quality care for all.

Since 2013, a great deal of transformational changes have been undertaken, which are detailed in NHS England's Annual Review for 2013/14. The revised Business Plan for 2014/15-2016/17 draws on the 'A Call for Action' strategy process which details 6 key characteristics for a sustainable NHS;

- Citizen participation and empowerment
- Wider primary care, provided at scale
- Modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective Care
- Specialised centres concentrated in centres of excellence.

The business plan also identifies a newly developed service model, which sets out a systematic approach to the way NHS England will work.

There are 7 components for the new delivery model;

- **Leadership for change**—NHS England plan to harness clinical leadership to ensure the best available research and evidence to inform decision making.
- **Engagement to mobilise**—Increasing patient experience, engagement and participation. NHS England will work to align themselves with their partners on any shared objectives
- **Spread of Innovation**—They will work systematically with leading edge health systems and organisations to back success and advance learning for the NHS as a whole. NHS England will support and encourage healthcare systems to learn from the best and learn from their mistakes.
- **Improvement methodology:** Support the development of the NHS commissioning system, providing tools, resources and guidance to support best practice.
- **Rigorous delivery:** Adopt a clear approach of business delivery ensuring rigorous and proportionate assurance and oversight of the commissioning system.
- **Transparent measurement:** Significantly increase the information available to patients and the public on quality and variation in services. The NHS England Board will act openly and transparently.
- **System drivers:** Working collaboratively with local and national partners to develop system rules, standards and incentives that create the conditions for improving services and outcomes.

Primary Care Estate

- The quality of GP premises in Haringey is 'inconsistent' - this is in line with NHS England's 'A Call to Action' which states that 30% of all GP premises will not be fit for purpose ion 10 years' time.
- Many GP practices across Haringey are in poor, non-statutory compliance and mostly needing replacement. Users should be encouraged to maximise usage rates and "sweat the asset".

Service Models

- Locality-based Integrated Community Care GP practices will be collaborating in localities focused on populations.
- Delivering on new provisions of GMS, designed to place the GP at the heart of care planning for patients at risk of emergency admissions — **investment in 7 day GP access.**

Commissioning - Primary Care

- Encouraging self-care management — telecare, telehealth.
- Encourage the merger of GP Practices—Move away from small, single-handed practices. Review options for co-location and integration.
- Joined up healthcare services across general practice, community services and hospitals resulting in a better experience, improved results and better value for money.
- GP Patient satisfaction surveying.

London's Health Commission

The London Healthcare Commission (LHC) is an independent inquiry established in September 2013 by the Mayor of London, to examine how London's healthcare can be improved for the benefit of the local community.

Findings show there are vast inequalities which need to be addressed to improve health outcomes. These are outlined below:

- Ethnical and cultural diversity;
- Extremes of poverty and wealth;
- Cost of living creating barriers to services;
- High and fast increasing life expectancy;
- Inequalities in life expectancy;
- Certain groups experiencing poorer health outcome (mental health, learning disabilities, ethnic minorities)

Vision and Values

The LHC aims to address inequalities by improving London's healthcare for the benefit of the population, under the following four themes:

- Improving the quality and integration of care;
- Enabling high quality and integrated care delivery;
- Healthy lives and reducing health inequalities;
- Health economy, research and education.

Findings

The LHC Recommendations Report (2014) outlines LHC's draft recommendations to the Mayor, which should have an overall impact on improving the health of Londoner's and reducing some of the inequalities (stage 1). These have been formulated under the following headings:

- Better health for all;
- Better health for London's children;
- Better care;
- Maximising science, discovery and innovation to enhance economic growth; and
- Making it happen.

Next Steps

The second stage of the process which will be conducted following the publication of the LHC report will include:

- Facilitate discussions on what is fair and equitable in the implementation of the recommendations to maximise the benefits and minimise the impacts as far as possible to reduce health inequalities;
- Prepare a reflective report on the LHC process with recommendations on how the GLA could implement such an approach in the future;
- Work with the LHC team to ensure recommendations are developed in a way that maximises health gain and reduces inequalities.

North Central London CCG Strategy 2015—16

The North Central London (NCL) Primary Care Strategy launched in 2012 to improve primary care across NCL. Over a 6 year period, £46.7million was ring-fenced for spend on primary care until 2014/15 across Barnet, Camden, Enfield, Haringey and Islington.

Vision and Values

"We want to ensure the sustainability of the NCL health economy and reduce the variability of services through an increase in the quality of the offer to patients, enabling all patients to access a wide range of integrated services from premises that are fit for purpose and with the support to manage their own care."

Priorities and Schemes

A list of priorities for delivering the vision is outlined below:

Table 3: Priorities and Schemes in Haringey

Priority 1: High Quality	We will ensure that we provide high quality care for all through a continued commitment to drive improvements in patient centred, clinically safe and effective care.
Priority 2: Coordinated	Through the way we deliver services, we will ensure care is coordinated around the needs of our patients.
Priority 3: Accessible	We will ensure that care is delivered in a way that is accessible to our population, which will contribute to an improved patient experience for our patients.
Priority 4: Proactive	Our practices will work in a proactive way to empower patients to take a greater role in their care, encouraging prevention and supporting people to receive the care they need in the community with which they live.
Priority 5: Workforce Development	We will develop our workforce ensuring that North Central London is a leader in primary care workforce development, ensuring we recruit the best staff and retain them securing the future of our workforce.
Priority 6: Premises	We will work towards ensuring that our premises are of the highest possible quality within the resources we have, seeking out opportunities for improvement.
Priority 7: Technology & Information Systems	We will develop our technology and information systems ensuring that these are fit for purpose to support our primary care services.

Better Care Fund Strategy Plan

The Better Care Fund (BCF) Plan (2014-16) is an ambitious programme across the NHS and Local Government which creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The BCF is a critical part of the NHS 2 year operational plans and the 5 year strategic plans as well as local government planning.

Vision and Values

The vision for health and social care services for this community for 2019/20 is based around enabling independence through integration.

"By April 2019, we want people in Haringey to be healthier and to have a higher quality of life for longer. We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible."

Aims and Objectives

The objectives outlined below for the BCF are drawn from the Haringey Health and Wellbeing Strategy (HWBS), which identifies three key priority areas:

Table 4: Aims and Objectives in Haringey

	Children	Life Expectancy	Mental Health & Wellbeing
Aims and Objectives	Giving every child the best start in life by exploring further opportunities for integrated services for children.	Tackling health inequalities and the life expectancy gap through a focus on early interventions in Long Term Conditions.	Improving mental health and wellbeing through a focus on choice, control and empowerment.

Better Care Fund Strategy Plan

Priorities and Schemes

A list of local priorities was developed to understand and address people's experiences of health and social care:

Table 5: Priorities and Schemes in Haringey

	Understanding the Priority	Addressing the Priority
Priority 1: Access	Haringey people lack knowledge of what health and social care services are available and lack clarity about which access points should be used to obtain services.	Integrated services will be easy to access, through a single point of access. Health and social care pathways will be clearer and shorter with fewer 'hand-offs' including the use of a single assessment process and care co-ordination.
Priority 2: Safety	This theme is related to the confidence people have in both the health and social care services and staff. Comments included "Services should be monitored and take stock of where we are and where we are going" and "Social workers should really know what they are doing and be sufficiently qualified".	Integrated services will be well managed and provided by competent professionals and staff. Interoperable IT will support the work of staff to better manage patient and service user care.
Priority 3: Person Centred	"Being treated decently and with kindness". Haringey people emphasised that their care and support are intensely personal services and the ways in which they are delivered have a direct impact on both the quality of people's experiences and on their general sense of wellbeing.	Integrated services will be person centred and highly personalised to the experiences and views of the people who use them. Services will uphold peoples' sense of self-worth, focusing on peoples' assets and refusing to define people by their disabilities. Services will offer people as much choice and control as possible, which may include personal budgets.
Priority 4: Information	To exercise choice and control Haringey people need high quality up-to-date information which identifies available services and how to access them. They also stressed the need to protect personal information and for it to only be shared with their consent.	Integrated services will provide good and timely information, from a variety of sources including the voluntary and community sector. Consent will be sought before any personal information is shared with other services and professionals.
Priority 5: Self-Care	Haringey people are worried about being a 'burden' on carers and do not want services to take-over and do things for them, thereby, creating avoidable dependency. They want to maximise the amount of time they spend in good health and value services that help them to do things for themselves, supporting their independence.	Integrated services will enable individuals to do things for themselves through prevention of ill health, self-management of existing long term conditions and reablement towards independence when recovering from a period of poor health. Support will also be offered to carers, friends and families of patients and service users so that they can continue to care.
Priority 6: Team Work	Haringey people recognise that health and social care services that work together as one team, including the service user/patient, deliver a better experience and outcomes. Communication is seen as central to this: "I want people to speak to each other – pick-up the old telephone instead of unnecessary paperwork".	Integrated services will work together as one team, including the patient/service user, with clear and constant communication. Staff will come from primary, community, social and acute care services, as well as the voluntary and private sector, and include GPs, community matrons, district nurses, therapists and social workers.
Priority 7: Wellbeing	Older people in particular value services that promote wellbeing and reduce loneliness as expressed by one respondent "I want to see people, to have companionship, to have someone to talk to."	Integrated services will promote wellbeing and reduce loneliness through the building of community capacity and caring networks in partnership with the third sector. Services will better align responses to physical and mental health needs.

Haringey Outline Strategy 2014/15—2018/19

Haringey CCG has summarised its plans for the next five years in a 'Plan on a Page', which sets out what the CCG wants to achieve for the people of Haringey to improve their mental and physical health and wellbeing.

Vision and Values

The vision for Haringey is to **make primary care closer to home really work for all local residents.**

Table 6: Vision and Values in Haringey

Improved Health Outcomes	Population Centred	Self-Care	Partnership
Moving from buying healthcare to buying improved health outcomes as defined by residents.	A population centred approach to commissioning – fitting in with people's lives, improved and more flexible access.	Specifically promoting and supporting self-care where appropriate – the public empowered in their own care.	Strengthening and extending partnership working across the whole Haringey community.

Aims and Objectives

To achieve the vision, the following objectives have been outlined:

Table 7: Haringey Aims and Objectives

Objective 1: **Explore and commission alternative models of care.**	• Actively promote and support self-management in the most appropriate setting • Look at "*developing the most suitable settings for car, recognising that this will men reducing our spend in the acute sector*" • A global transformation of services and service providers
Objective 2: **More partnership working and integration as well as a greater range of providers.**	• Explore opportunities to extend integrated packages of support "*beyond our conventional partnerships with Adult Social Care and children's Services to include working with: housing, public health and the third sector.*" • Look to expand our range of providers • Develop collaborative packages with other CCGs and work differently with NHS England • Work with partners to "*better define the ideal outcomes for residents*"
Objective 3: **Engaging communities in new / innovative ways to build capacity for populations**	• Build communities and social networks through a more positive approach which enhances existing strengths and resources within communities. • Think more creatively about providers, particularly how we work with community and voluntary groups.
Objective 4: **A re-defined model for primary care providing proactive / holistic services for local communities**	• Look at developing the role of practices in prevention and community interventions so our GPs are responsible for "health in Haringey" overall • Develop better mechanisms for case management. • Improving how primary care teams respond to complex needs; referring appropriately to more specialised services • Primary care will continue to work together to achieve quality improvements for patients, better access and economies of scale.

Engagement Strategy

Haringey CCG developed an Engagement Strategy (2014-15) which focuses on aspirations for engagement; required to focus on promoting wellbeing and preventing ill health. The CCG recognises a need to work with patients, carers, local people, voluntary and community groups and other agencies and together build healthier communities which have strong networks, friendships and trust. There is a need to make changes in the health service to meet the needs of an ageing population and the increasing number of people living with long term conditions, such as diabetes and asthma. A partnership with patients and carers is required to create effective service change.

Vision and Values

The vision for Haringey is to make primary care closer to home really work for all local residents.

Table 8: Vision and Values in Haringey

	Improved Health Outcomes	Population Centred	Self-Care	Partnership
Vision and Values	Moving from buying healthcare to buying improved health outcomes as defined by residents.	A population centred approach to commissioning – fitting in with people's lives, improved and more flexible access.	Specifically promoting and supporting self-care where appropriate – the public empowered in their own care.	Strengthening and extending partnership working across the whole Haringey community.

Aims and Objectives

The aims and objectives are outlined below:

Table 9: Haringey Aims and Objectives

Objective 1: **A global transformation of services and service providers.**	Explore and commission alternative models of care which actively promote and support self-management in the most appropriate setting.
Objective 2: **A greater range - as well as more integration - of providers.**	Explore opportunities to extend integrated packages of support "*beyond conventional partnerships with Adult Social Care and Children's Services to include working with: housing, public health and the third sector*".
Objective 3: **Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing.**	Build communities and social networks through a more positive approach which enhances existing strengths and resources within communities.
Objective 4: **A re-defined model for primary care providing proactive and holistic services for local communities, supporting "healthier Haringey as a whole".**	Look at developing the role of our GPs so that they are responsible for "*health in Haringey*" overall – e.g. greater role in prevention and early intervention; navigation to other services including partner provider organisations such as the Local Authority.

Local Authority

Haringey council offers a range of services for local residents, to improve their health and wellbeing. This includes:

- Active for Life
- Alcohol Support
- Cancer Screening
- Diabetes Prevention
- Drug Addiction Support
- Immunisations and Vaccinations
- Infectious Diseases
- NHS Health Checks
- Pregnancy and Birth
- Sexual Health
- Smoking Cessation

Public Health Responsibilities

Public Health is concerned with improving the overall health and well being of communities and addressing inequalities. It encompasses three broad areas of work and diverse activities:

- Health Improvement — this includes programmes that work with individuals and communities to improve life styles. Examples are: support in stopping smoking, encouraging physical activity and NHS Health checks.
- Health Protection — this includes protection against communicable diseases and use of legal or regulatory powers to improve health. Examples are: immunisation and vaccination against childhood diseases, cancer screening programmes and traffic calming.
- Improving Health and Social Care Quality — this incorporates the production and use of best evidence and a description of the needs of a community. It is about working with others to ensure commissioning and provision of health care is of high quality, equitable, appropriate to the needs of the population and gives good value for money. Examples include Joint Strategic Needs Assessments and design of evidence based care pathways.

Public Health

The Annual Public Health Report (2014) includes two priority areas of focus:

Supporting people and communities

- Including new teenage parents
- Building community connections
- Providing free 24/7 online support
- Promoting recovery
- Supporting people with disabilities
- Schools
- Turkish and Kurdish communities

Challenging stigma and discrimination

- Among young people through sport
- Through Mental Health First Aid training for front line staff
- Through the MAC –UK Integrate Project

Recommendations:

- Ensure 'healthy public policy' to create a supportive environment to enable people to lead healthy, fulfilling, independent lives.
- Ensure that plans for the regeneration of Tottenham address factors closely related to poor mental wellbeing such as employment, poor quality housing and overcrowding, noise, 'ugly' environments and lack of green space, antisocial behaviour and fear of crime.
- Undertake a survey of issues affecting our residents' wellbeing to understand the key issues we need to focus on.
- The Council and partners to sign the Time to Change pledge - with clear plans to promote wellbeing and tackle stigma and discrimination against those with mental health problems.
- Develop a Mental Health and Wellbeing Framework to ensure a quality service offer that improves outcomes for service users.
- Continue to focus on the early years of a child, on the bond between parent and baby.
- We each need to look after our own mental health, support each other and build resilience in our communities.

Providers

Providers looks at local provider Annual Reports and Quality Accounts to identify how provider plans meet with the commissioning intentions identified by the CCG.

Providers

Ambulance Services

Ambulance services in Haringey are commissioned by the CCG and provided by the London Ambulance Service (LAS).

In 2013/14 LAS handled over 1.7 million emergency calls from across London and attended more than one million incidents. There is no specific mention of the delivery of ambulance services within Haringey. The CCG will need to ensure however that ambulance services are incorporated into their future commissioning plans for the locality.

Mental and Community Health Services

Barnet, Enfield and Haringey Mental Health NHS Trust (BEH MHT)

The Trust provides a full range of child and adult community health services in Enfield and is increasingly integrating these with mental health services to provide a range of holistic services.

The BEH MHT Clinical Strategy 2013 – 18 presents a strategy for the future developments of the Trust's clinical services.

Current Estate

The Trust's current estate and facilities is presented below:

- St Michael's Hospital, Enfield
- St Ann's Hospital, Haringey
- Edgware Community Hospital, Enfield
- Baytree House, Enfield
- Springwell Unit, Barnet

Changes in Estate

The Trust is reviewing the future of the acute mental health inpatient beds at St Ann's in Haringey as part of the planning for the redevelopment of the overall St Ann's site. The following options are being considered:

- Retaining inpatient mental health beds at St Ann's in improved facilities or
- Consolidating the mental health beds for Haringey and Enfield in much more suitable, modern, facilities based at Chase Farm in Enfield

The future vision for the St Ann's Hospital site is to create a modern health campus with a sustainable mix of mental health and other services including the existing Moorfields Eye hospital, Whittington health services, North Middlesex Hospital and breast screening services, with a mix of new family houses and flats and public open space.

Acute Trusts

Whittington Health

Whittington Health (WH) provides general hospital and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield and Camden.

The organisation delivers care across North London and from 30 different locations in Islington and Haringey.

Current Estate

The Whittington Hospital is the main acute site situated in the borough of Islington. WH also has rights of occupancy over two further buildings:

- Highgate Wing
- Off-site residential accommodation at 220 Sussex Way, London, N19 4GH

WH is also responsible for providing community services previously managed by Haringey and Islington PCTs. The principle community estate lies at St Ann's Hospital site where WH occupies a number of buildings.

The community properties WH operates services from include:

- 1 -3 Edwards Drive
- Simmons House Adolescent Unit
- Hornsey Central Health Centre
- Lordship Lane Primary Care Centre
- Lansdowne Clinic
- Hornsey Rise Health Centre
- Northern Health Centre
- Tynemouth Road Health Centre
- New Stroud Green Health Centre
- Somerset Gardens Family Health Centre
- Stuart Crescent Health Centre
- Tottenham Health Centre

Additionally, WH takes responsibility for providing services from the following properties which are occupied either from a sub-lease or under the terms of a Service Level Agreement:

- Hunter St Health Centre
- Laurels Healthy Living Centre
- Bloomsbury Day Hospital
- Finsbury Health Centre
- New Park Day Centre
- 133 St John's Way
- Lordship Lane HC
- Hornsey Central HC
- Bingfield HC
- Partnerships P Care Centre
- Belsize Priory HC
- Crowndale HC
- Kings Cross PCC
- Kentish Town HC
- Hanley Road HC
- St Ann's Hospital

Changes in Estate

WH have been working closely with BEHMHT to facilitate the relocation and removal of WH departments where required as part of the BEHMHT site rationalisation programme.

Acute Trusts

North Middlesex University Hospital

North Middlesex University Hospital is one of London's busiest acute hospitals, serving more than 350,000 people living in Enfield and Haringey and the surrounding areas, including Barnet and Waltham Forest. Most of its patients live in Enfield and Haringey - about half in each borough.

Next Steps

This SSDP is the first stage of strategic planning for Haringey, producing high level recommendations formulated from a combined service review of strategic plans, for discussion by key stakeholders. The SSDP is a service driven document which will go on to inform the estate solutions for Haringey, delivering a joined up, cohesive plan for the CCG area.

References

Annual Public Health Report 2014

Barnet, Enfield and Haringey Mental Health Trust, Trust Clinical Strategy 2013 – 18

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Haringey's Health and Wellbeing Strategy 2015 – 18

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Haringey CCG Plan on a Page2014 – 19

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Haringey Local Plan, Infrastructure Delivery Plan Update 2015

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Haringey Council webpage 2015

Health Impact Assessment on London Health Commission Recommendations Final Report 2014

Joint Strategic Needs Assessment, Health Improvement

Joint Strategic Needs Assessment, Population Profile of Haringey 2014

London Ambulance Service Annual Report 2013 – 14

NHS England's 'A Call to Action'

NHS Five Year Forward View, October 2014

North Central London CCGs Strategy Refresh 2015 – 16

North Middlesex University Hospital webpage 2015

Putting Patients First, The NHS England Business Plan for 2013/14 – 2015/16

Whittington Health Estates Strategy 2013 – 18

Whittington Health webpage 2015

Strategic Estates Planning - Core Data Template

	Section 1: Property Location and Tenure	5										
	Property Location								Tenure			
	Property Name	Property Reference Number	Location Town	Location Post Code	Property Mapping Coordinates	CCG Area	Collaborative	Ward	Lead NHS Organisation	Property Tenure	LPA Lease Expiry Date	Date of Next Lease Break
1	Arcadian Gardens NHS Medical Centre	F85034	London	N22 5AB		Haringey	Central	Woodside				
2	Bounds Green Group Practice	F85066	London	N11 2PF		Haringey	Central	Bounds Green		Leasehold		
3	Bridge House	Y03135	London	N4 1TL		Haringey	South East	Harringay				
4	Broadwater Farm Community Health Centre	F85699	London	N17 6BF		Haringey	North East	West Green		Leasehold		
5	Bruce Grove Primary Care Health Centre	F85028	London	N17 6QB		Haringey	North East	Bruce Grove				
6	Highgate Group Practice	F85014	London	N6 4QA		Haringey	West	Highgate				
7	Charlton House Medical Centre	F85017	London	N17 6SB		Haringey	North East	Bruce Grove				
8	Christchurch Hall Surgery	F85061	London	N8 8AE		Haringey	West	Crouch End				
9	Dowsett Road Surgery	F85628	London	N17 9DL		Haringey	North East	Tottenham Hale				
10	Dukes Avenue Practice	F85063	London	N10 2PS		Haringey	West	Fortis Green				
11	Evergreen House Surgery	F85640	London	N22 8JJ		Haringey	Central	Bounds Green				
12	Fernlea Surgery	F85071	London	N15 6JR		Haringey	South East	Seven Sisters				
13	Park Lane Surgery (JS Medical Branch)	F85660	London	N17 0JP		Haringey	North East	Northumberland Park				
14	Havergal Surgery	F85060	London	N15 3DY		Haringey	South East	West Green				
15	St Johns Road Surgery	F85059	London	N15 6QP		Haringey	South East	Seven Sisters				
16	Hornsey Park (Obineche)	F85046	London	N8 0PH		Haringey	Central	Noel Park				
17	JS Medical Practice - Dr J Pandya and Dr Sejal Pandya	F85705	London	N15 4JR		Haringey	South East	Tottenham Green				
18	Chestnuts Park Surgery	Y03506	London	N15 5AZ		Haringey	South East	St Ann's				
19	Lawrence House	F85007	London	N15 4JR		Haringey	North East	Tottenham Green				
20	Morum House	F85008	London	N22 8HE		Haringey	Central	Woodside				
21	Tynemouth Road Health Centre	F85013	London	N15 4RH		Haringey	North East	Tottenham Hale		Freehold		
22	Park Road Surgery	F85026	London	N8 8JJ		Haringey	West	Muswell Hill				
23	Philip Lane Surgery	F85049	London	N15 4AB		Haringey	South East	West Green				
24	Queens Avenue	F85045	London	N10 3BJ		Haringey	West	Fortis Green				
25	Queenswood Medical Practice	Y03035	London	N8 8JD		Haringey	West	Muswell Hill				
26	Rutland House Surgery	F85688	London	N10 1DX		Haringey	West	Fortis Green				
27	The Old Surgery	F85697	London	N8 0RP		Haringey	Central	Harringay				
28	Somerset Gardens Family Health Care	F85030	London	N17 8NW		Haringey	North East	White Hart Lane				
29	Spur Road Surgery	F85052	London	N15 4AA		Haringey	South East	Tottenham Green				
30	West Green Road Surgery	F85669	London	N15 3PB		Haringey	South East	West Green				
31	Stuart Crescent Health Centre (Samarasinghe)	F85064	London	N22 5NJ		Haringey	Central	Woodside		Freehold		
32	Stuart Crescent Health Centre (Dave)	F85065	London	N22 5NJ		Haringey	Central	Woodside		Freehold		
33	The Alexandra Surgery	F85675	London	N22 7UN		Haringey	West	Alexandra				
34	Allenson House Medical Centre	F85679	London	N8 9TB		Haringey	West	Crouch End				
35	The Laurels Healthy Living Centre	Y02117	London	N15 5AZ		Haringey	South East	St Ann's				
36	The Vale Practice	Y01655	London	N8 8SU		Haringey	West	Muswell Hill				
37	The Morris House Medical Practice	F85019	London	N17 6AA		Haringey	North East	West Green				
38	The Surgery (Grove Road)	F85623	London	N15 5HJ		Haringey	South East	West Green				
39	Grosvenor Road Surgery (Karunaratne)	F85658	London	N10 2DR		Haringey	West	Alexandra				
40	The Surgery (Ansari)	F85632	London	N8 0SD		Haringey	Central	Harringay				
41	The Surgery (Prasad)	F85645	London	N22 8NW		Haringey	Central	Bounds Green				
42	The Surgery (Dr Sampson)	F85646	London	N8 0RE		Haringey	Central	Harringay				
43	Tottenham Health Centre	F85615	London	N17 8AH		Haringey	North East	Northumberland Park				
44	Westbury Medical Centre (Steinberg)	F85031	London	N22 6RX		Haringey	Central	Noel Park				
45	Westbury Avenue Surgery	F85643	London	N22 6RS		Haringey	Central	Noel Park				
46	Crouch Hall Road Surgery	F85069	London	N8 8HJ		Haringey	West	Crouch End				
47	Green Lanes (Raja)	F85708	London	N8 0RE		Haringey	Central	Harringay				
48	The 157 Medical Practice, (Ramnani)	F85067	London	N4 3PZ		Haringey	West	Stroud Green				
49	1-3 Edwards Drive		London	N11 2HD		Haringey	Central	Bounds Green		Freehold		
50	Simmons House Adolescent Unit		London	N10 3HU		Haringey	West	Muswell Hill		Leasehold		
51	Hornsey Central Health Centre		London	N8 8JD		Haringey	West	Muswell Hill		LIFT		
52	Lordship Lane Primary Care Centre		London	N17 6AA		Haringey	North East	West Green		LIFT		
53	Lansdowne Clinic		London	N17 0LL		Haringey	North East	Tottenham Hale				
54	Hornsey Rise HC		London	N19 3YU		Islington						
55	Northern Health Centre		London	N7 6LB		Islington						
56	New Stroud Green HC		London	N3 3PZ		Islington						
57	St Anns Hospital		London	N15 3TH		Haringey	South East	St Ann's				
58	The Whittington Hospital		London	N19 5NF		Islington						
59	North Middlesex University Hospital		London	N18 1BX		Enfield						
60	Tottenham Hale Kidney & Diabetes Centre		London	N17 9NE		Haringey	North East	Tottenham Hale				

Section 2: Asset Information

Occupation				Utilisation							Condition		
Holding Area GIA (m²)	Main Occupation Category	Opening Hours	Is List of Services Provided from Premises Known?	Is Building Utilisation Actively Measured	Total estimated Void Space (m²)	No of Rooms	No of principals	No of Pricipal GP 60+	List Size	Estimate of Overall Building Utilitisation	Has Building been Assessed in last 2 years?	Assessment Tool Available	General Assessment Condition RAG
	GP Surgery	Mon-Fri Day Only				4	2	1	3523				Not Known
522.47	GP Surgery	7 Days not 24/7				15	12	1	13542		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				6	3	0	8699		Yes	*6 FS*	Red
23.38	GP Surgery	Mon - Fri Extended				5	2	0	2681		Yes	*6 FS*	Red
	GP Surgery	Mon-Fri Day Only				4	2	1	8630		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				12	13	1	13687		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				6	6	1	6800		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				6	2	1	3420		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				3	2	0	3150		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				8	13	2	10077		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				4	3	0	5465		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				6	5	0	7594		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				3	4	1	2510				Not Known
	GP Surgery	Mon - Fri Extended				7	5	0	5279		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				3	1	1	2100		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				3	5	1	3527		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				5	2	1	4740		Yes	*6 FS*	Red
309.91	GP Surgery	Mon - Fri Extended				6	2	0	4643				Not Known
	GP Surgery	Mon - Fri Extended				10	11	0	12133		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				23	4	0	15114		Yes	*6 FS*	Red
1316.62	Health Centre	Mon - Fri Extended				10	3	1	10294		Yes	*6 FS*	Amber
	GP Surgery	Mon-Fri Day Only				3	5	1	2748		Yes	*6 FS*	Red
	GP Surgery	Mon-Fri Day Only				4	1	1	2737		Yes	*6 FS*	Amber
	GP Surgery	Mon-Fri Day Only				4	4	1	4384		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended					11	1	16688		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended					4	0	5017		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				2	2	0	2192		Yes	*6 FS*	Red
	GP Surgery	Mon-Fri Day Only				16	8	1	12900		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				2	1	1	1093		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				5	3	1	9161		Yes	*6 FS*	Amber
376.76	GP Surgery	Mon - Fri Extended				3	1	1	3755		Yes	*6 FS*	Amber
	Health Centre	Mon - Fri Extended				4	2	2	2972		Yes	*6 FS*	Amber
	GP Surgery	7 Days not 24/7				4	2	1	3969		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				2	1	1	2243				Not Known
	GP Surgery	Mon - Fri Extended				7	6	3	7500		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				8	5	0	6992		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				13	7	0	12754		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				3	2	0	2963				Not Known
	GP Surgery	Mon - Fri Extended					2	1	2185		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				1	1	1	2000		Yes	*6 FS*	Red
	GP Surgery	Mon - Fri Extended				2	3	1	2433		Yes	*6 FS*	Amber
	GP Surgery	7 Days not 24/7				4	1	1	10				Not Known
	GP Surgery	Mon - Fri Extended				5	4	2	4500		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				7	6	1	9008		Yes	*6 FS*	Amber
	GP Surgery	Mon - Fri Extended				3	2	1	4017				Not Known
	GP Surgery	Mon - Fri Extended				10	6	0	6185				Not Known
565.09	GP Surgery	7 Days not 24/7				1	1	0	686				Not Known
	GP Surgery	Mon - Fri Extended					3	1	5041				Not Known
90.28	Health Centre	Not Known											Not Known
	Health Centre	Not Known											Not Known
4557	Health Centre	Mon - Fri Extended											Green
2525	Health Centre	Not Known											Green
	Health Centre	Not Known											Not Known
	Health Centre	Mon - Fri Extended											Not Known
	Health Centre	7 Days not 24/7											Not Known
	Health Centre												Not Known
26116	Acute												Not Known
71593	Acute												Not Known
	Acute												Not Known
	Other												Not Known

Section 3: Commercial		
Book Value	Costs	
Capital Value of Owned Asset (£)	Total Annual Property Occupation Cost (£)	Annual Occupation Cost £ per M2
2,040,000		
1,262,770		
4,959,000		
1,846,000		
2,325,000		
1,775,000		
2,354,000		
6,799,000		
145,000,000		

Section 4: Initial Estate Hypothesis	
Category	Comments
Property Category	Comments

Section 5: Deprivation Indices

Under 18 Conception Rate	Levels of obesity in 10-11yr olds	Drug Users in Treatment	Premature Death from circulatory dieseases	Sexuallt Transmitted Infection Rates (per 100,000)	CHD	Diabetes	COPD	Cancer	Mental Health	Dementia % as part of the whole register UK wide
49.3	35.6-45.6%	121-150	91-120.9	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
64.9	15.4-25.4%	80-120	151-181	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
67.6	45.7-55.8%	80-120	91-120.9	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
81.5	35.6-45.6%	151-161	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
17.1	15.4-25.4%	27-49	91-120.9	1500-1999	1.54	2.77	0.64	1.25	1.03	0.28
81.5	35.6-45.6%	151-161	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
20.2	15.4-25.4%	50-79	61-90.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
77.6	35.6-45.6%	80-120	151-181	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
31.4	15.4-25.4%	27-49	91-120.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
64.9	15.4-25.4%	80-120	151-181	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
14.8	35.6-45.6%	121-150	121-150.9	r higher)/ 1500-1999	1.54	5.04	0.77	0.96	1.34	0.26
62	45.7-55.8%	151-161	151-181	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
14.8	35.6-45.6%	121-150	121-150.9	r higher)/ 1500-1999	1.54	5.04	0.77	0.96	1.34	0.26
70.3	45.7-55.8%	121-150	121-150.9	2500 (or higher)	1.54	4.64	0.64	1.09	1.19	0.19
68.1	35.6-45.6%	80-120	91-120.9	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
72.3	15.4-25.4%	121-150	151-181	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
68.1	35.6-45.6%	80-120	91-120.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
49.3	35.6-45.6%	121-150	91-120.9	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
68.1	35.6-45.6%	80-120	91-120.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
31.4	15.4-25.4%	27-49	91-120.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
31.4	15.4-25.4%	27-49	91-120.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
21.8	15.4-25.4%	27-49	61-90.9	<500	1.54	2.77	0.64	1.25	1.03	0.28
31.4	15.4-25.4%	27-49	91-120.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
67.6	45.7-55.8%	80-120	91-120.9	2500 (or higher)	1.54	4.64	0.64	1.09	1.19	0.19
45.8	35.6-45.6%	50-79	151-181	1500-1999	1.54	5.04	0.77	0.96	1.34	0.26
68.1	35.6-45.6%	80-120	91-120.9	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
72.3	15.4-25.4%	121-150	151-181	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
49.3	35.6-45.6%	121-150	91-120.9	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
19.1	15.4-25.4%	27-49	61-90.9	1000-1499	1.54	4.64	0.64	1.09	1.19	0.19
20.2	15.4-25.4%	50-79	61-90.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
72.3	15.4-25.4%	121-150	151-181	2500 (or higher)	1.45	4.41	0.54	0.71	1.34	0.13
21.8	15.4-25.4%	27-49	61-90.9	<500	1.54	2.77	0.64	1.25	1.03	0.28
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
67.6	45.7-55.8%	80-120	91-120.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
64.9	15.4-25.4%	80-120	151-181	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
64.9	15.4-25.4%	80-120	151-181	1500-1999	1.54	4.64	0.64	1.09	1.19	0.19
62	45.7-55.8%	151-161	151-181	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
70.3	45.7-55.8%	121-150	121-150.9	2500 (or higher)	1.54	4.64	0.64	1.09	1.19	0.19
70.3	45.7-55.8%	121-150	121-150.9	2500 (or higher)	1.54	4.64	0.64	1.09	1.19	0.19
74.5	35.6-45.6%	80-120	121-150.9	2500 (or higher)	1.54	5.04	0.77	0.96	1.34	0.26
20.2	15.4-25.4%	50-79	61-90.9	1000-1499	1.54	2.77	0.64	1.25	1.03	0.28
62.5	35.6-45.6%	80-120	91-120.9	2000-2499	1.54	4.64	0.64	1.09	1.19	0.19
62.5	35.6-45.6%	80-120	91-120.9	2000-2499	1.54	2.77	0.64	1.25	1.03	0.28

Strategic Estates Planning - Core Data Template

	Section 1: Property Location and Tenure 5												Section 2: Asset Information													Section 3: Commercial			Section 4: Initial Estate Hypothesis	
	Property Location							Tenure					Occupation				Utilisation						Condition			Book Value	Costs		Category	Comments
	Property Name	Property Reference Number	Location Town	Location Post Code	Property Mapping Coordinates	CCG Area	Collaborative	Ward	Lead NHS Organisation	Property Tenure	LPA Lease Expiry Date	Date of Next Lease Break	Holding Area GIA (m²)	Main Occupation Category	Opening Hours	Is List of Services Provided from Premises Known?	Is Building Utilisation Actively Measured	Total estimated Void Space (m²)	No of Rooms	No of principals	No of Principal GP 60+	List Size	Estimate of Overall Building Utilitisation	Has Building been Assessed in last 2 years?	Assessment Tool Available	General Assessment Condition RAG	Capital Value of Owned Asset (£)	Total Annual Property Occupation Cost (£)	Annual Occupation Cost £ per M2	Property Category	Comments
1	Arcadian Gardens NHS Medical Centre	F85034	London	N22 5AB		Haringey	Central	Woodside						GP Surgery	Mon-Fri Day Only				4	2	1	3523				Not Known					
2	Bounds Green Group Practice	F85066	London	N11 2PF		Haringey	Central	Bounds Green		Leasehold			522.47	GP Surgery	7 Days not 24/7				15	12	1	13542		Yes	6 FS	Amber	2,040,000				
3	Bridge House	Y03135	London	N4 1TL		Haringey	South East	Harringay						GP Surgery	Mon - Fri Extended				6	3	0	8699		Yes	6 FS	Red					
4	Broadwater Farm Community Health Centre	F85699	London	N17 6BF		Haringey	North East	West Green		Leasehold			23.38	GP Surgery	Mon - Fri Extended				5	2	0	2681		Yes	6 FS	Red					
5	Bruce Grove Primary Care Health Centre	F85028	London	N17 6QB		Haringey	North East	Bruce Grove						GP Surgery	Mon-Fri Day Only				4	2	1	8630		Yes	6 FS	Amber					
6	Highgate Group Practice	F85014	London	N6 4QA		Haringey	West	Highgate						GP Surgery	Mon - Fri Extended				12	13	1	13687		Yes	6 FS	Amber	1,262,770				
7	Charlton House Medical Centre	F85017	London	N17 6SB		Haringey	North East	Bruce Grove						GP Surgery	Mon - Fri Extended				6	6	1	6800		Yes	6 FS	Amber					
8	Christchurch Hall Surgery	F85061	London	N8 8AE		Haringey	West	Crouch End						GP Surgery	Mon - Fri Extended				6	2	1	3420		Yes	6 FS	Amber					
9	Dowsett Road Surgery	F85628	London	N17 9DL		Haringey	North East	Tottenham Hale						GP Surgery	Mon - Fri Extended				3	2	0	3150		Yes	6 FS	Amber					
10	Dukes Avenue Practice	F85063	London	N10 2PS		Haringey	West	Fortis Green						GP Surgery	Mon - Fri Extended				8	13	2	10077		Yes	6 FS	Red					
11	Evergreen House Surgery	F85640	London	N22 8JJ		Haringey	Central	Bounds Green						GP Surgery	Mon - Fri Extended				4	3	0	5465		Yes	6 FS	Red					
12	Fernlea Surgery	F85071	London	N15 6JR		Haringey	South East	Seven Sisters						GP Surgery	Mon - Fri Extended				6	5	0	7594		Yes	6 FS	Red					
13	Park Lane Surgery (JS Medical Branch)	F85660	London	N17 0JP		Haringey	North East	Northumberland Park						GP Surgery	Mon - Fri Extended				3	4	1	2510				Not Known					
14	Havergal Surgery	F85060	London	N15 3DY		Haringey	South East	West Green						GP Surgery	Mon - Fri Extended				7	5	0	5279		Yes	6 FS	Amber					
15	St Johns Road Surgery	F85059	London	N15 6QP		Haringey	South East	Seven Sisters						GP Surgery	Mon - Fri Extended				3	1	1	2100		Yes	6 FS	Amber					
16	Hornsey Park (Obineche)	F85046	London	N8 0PH		Haringey	Central	Noel Park						GP Surgery	Mon - Fri Extended				3	5	1	3527		Yes	6 FS	Red					
17	JS Medical Practice - Dr J Pandya and Dr Sejal Pandya	F85705	London	N15 4JR		Haringey	South East	Tottenham Green						GP Surgery	Mon - Fri Extended				5	2	1	4740		Yes	6 FS	Red					
18	Chestnuts Park Surgery	Y03506	London	N15 5AZ		Haringey	South East	St Ann's					309.91	GP Surgery	Mon - Fri Extended				6	2	0	4643				Not Known					
19	Lawrence House	F85007	London	N15 4JR		Haringey	North East	Tottenham Green						GP Surgery	Mon - Fri Extended				10	11	0	12133		Yes	6 FS	Red					
20	Morum House	F85008	London	N22 8HE		Haringey	Central	Woodside						GP Surgery	Mon - Fri Extended				23	4	0	15114		Yes	6 FS	Red					
21	Tynemouth Road Health Centre	F85013	London	N15 4RH		Haringey	North East	Tottenham Hale		Freehold			1316.62	Health Centre	Mon - Fri Extended				10	3	1	10294		Yes	6 FS	Amber	4,959,000				
22	Park Road Surgery	F85026	London	N8 8JJ		Haringey	West	Muswell Hill						GP Surgery	Mon-Fri Day Only				3	5	1	2748		Yes	6 FS	Red					
23	Philip Lane Surgery	F85049	London	N15 4AB		Haringey	South East	West Green						GP Surgery	Mon-Fri Day Only				4	1	1	2737		Yes	6 FS	Amber					
24	Queens Avenue	F85045	London	N10 3BJ		Haringey	West	Fortis Green						GP Surgery	Mon-Fri Day Only				4	4	1	4384		Yes	6 FS	Amber					
25	Queenswood Medical Practice	Y03035	London	N8 8JD		Haringey	West	Muswell Hill						GP Surgery	Mon - Fri Extended					11	1	16688		Yes	6 FS	Amber					
26	Rutland House Surgery	F85688	London	N10 1DX		Haringey	West	Fortis Green						GP Surgery	Mon - Fri Extended					4	0	5017		Yes	6 FS	Amber					
27	The Old Surgery	F85697	London	N8 0RP		Haringey	Central	Harringay						GP Surgery	Mon - Fri Extended				2	2	0	2192		Yes	6 FS	Red					
28	Somerset Gardens Family Health Care	F85030	London	N17 8NW		Haringey	North East	White Hart Lane						GP Surgery	Mon-Fri Day Only				16	8	1	12900		Yes	6 FS	Red					
29	Spur Road Surgery	F85052	London	N15 4AA		Haringey	South East	Tottenham Green						GP Surgery	Mon - Fri Extended				2	1	1	1093		Yes	6 FS	Red					
30	West Green Road Surgery	F85669	London	N15 3PB		Haringey	South East	West Green						GP Surgery	Mon - Fri Extended				5	3	1	9161		Yes	6 FS	Amber					
31	Stuart Crescent Health Centre (Samarasinghe)	F85064	London	N22 5NJ		Haringey	Central	Woodside		Freehold			376.76	Health Centre	Mon - Fri Extended				3	1	1	7755		Yes	6 FS	Amber	1,846,000				
32	Stuart Crescent Health Centre (Dave)	F85065	London	N22 5NJ		Haringey	Central	Woodside		Freehold				Health Centre	Mon - Fri Extended				4	2	2	2972		Yes	6 FS	Amber					
33	The Alexandra Surgery	F85675	London	N22 7UN		Haringey	West	Alexandra						GP Surgery	7 Days not 24/7				4	2	1	3969		Yes	6 FS	Red					
34	Allenson House Medical Centre	F85679	London	N8 9TB		Haringey	West	Crouch End						GP Surgery	Mon - Fri Extended				2	1	1	2243				Not Known					
35	The Laurels Healthy Living Centre	Y02117	London	N15 5AZ		Haringey	South East	St Ann's						GP Surgery	Mon - Fri Extended				7	6	3	7500		Yes	6 FS	Amber					
36	The Vale Practice	Y01655	London	N8 8SU		Haringey	West	Muswell Hill						GP Surgery	Mon - Fri Extended				8	5	0	6992		Yes	6 FS	Red					
37	The Morris House Medical Practice	F85019	London	N17 6AA		Haringey	North East	West Green						GP Surgery	Mon - Fri Extended				13	7	0	12754		Yes	6 FS	Red					
38	The Surgery (Grove Road)	F85623	London	N15 5HJ		Haringey	South East	West Green						GP Surgery	Mon - Fri Extended				3	2	0	2963				Not Known					
39	Grosvenor Road Surgery (Karunaratne)	F85658	London	N10 2DR		Haringey	West	Alexandra						GP Surgery	Mon - Fri Extended					2	1	2185		Yes	6 FS	Amber					
40	The Surgery (Ansari)	F85632	London	N8 0SD		Haringey	Central	Harringay						GP Surgery	Mon - Fri Extended					1	1	2000		Yes	6 FS	Red					
41	The Surgery (Prasad)	F85645	London	N22 8NW		Haringey	Central	Bounds Green						GP Surgery	Mon - Fri Extended					2	1	2433		Yes	6 FS	Amber					
42	The Surgery (Dr Sampson)	F85646	London	N8 0RE		Haringey	Central	Harringay						GP Surgery	7 Days not 24/7					4	1	10				Not Known					
43	Tottenham Health Centre	F85615	London	N17 8AH		Haringey	North East	Northumberland Park						GP Surgery	Mon - Fri Extended					5	4	2	4500		Yes	6 FS	Amber					
44	Westbury Medical Centre (Steinberg)	F85031	London	N22 6RX		Haringey	Central	Noel Park						GP Surgery	Mon - Fri Extended					7	6	1	9008		Yes	6 FS	Amber					
45	Westbury Avenue Surgery	F85643	London	N22 6RS		Haringey	Central	Noel Park						GP Surgery	Mon - Fri Extended					3	2	1	4017				Not Known					
46	Crouch Hall Road Surgery	F85069	London	N8 8HJ		Haringey	West	Crouch End						GP Surgery	Mon - Fri Extended					10	6	0	6185				Not Known					
47	Green Lanes (Kaia)	F85708	London	N8 0RE		Haringey	Central	Harringay					565.09	GP Surgery	7 Days not 24/7					1	1	0	686				Not Known					
48	The 157 Medical Practice, (Ramnani)	F85067	London	N4 3PZ		Haringey	West	Stroud Green						GP Surgery	Mon - Fri Extended					3	1	1	5041				Not Known					
49	1-3 Edwards Drive		London	N11 2HD		Haringey	Central	Bounds Green		Freehold			90.28	Health Centre	Not Known											Not Known	2,325,000				
50	Simmons House Adolescent Unit		London	N10 3HU		Haringey	West	Muswell Hill		Leasehold				Health Centre	Not Known											Not Known					
51	Hornsey Central Health Centre		London	N8 8JD		Haringey	West	Muswell Hill		LIFT			4557	Health Centre	Mon - Fri Extended											Green	1,775,000				
52	Lordship Lane Primary Care Centre		London	N17 6AA		Haringey	North East	West Green		LIFT			2525	Health Centre	Not Known											Green					
53	Lansdowne Clinic		London	N17 0LL		Haringey	North East	Tottenham Hale						Health Centre	Not Known											Not Known					
54	Hornsey Rise HC		London	N19 3HU		Islington								Health Centre	Mon - Fri Extended											Not Known	2,354,000				
55	Northern Health Centre		London	N7 6LB		Islington								Health Centre	7 Days not 24/7											Not Known	6,799,000				
56	New Stroud Green HC		London	N3 3PZ		Islington								Health Centre												Not Known					
57	St Anns Hospital		London	N15 3TH		Haringey	South East	St Ann's					26116	Acute												Not Known					
58	The Whittington Hospital		London	N19 5NF		Islington							71593	Acute												Not Known	145,000,000				
59	North Middlesex University Hospital		London	N18 1BX		Enfield								Acute												Not Known					

Colour Code	Description
	Acute Trust
	Other
	Whittington Health Services
	Lift Co Buildings & Whittington Health Services
	GP's and Whittington Health Services
	GPs

Column B **GP Practice name**

Column O **List Size**

Small	<3000
Medium	3000-8000
Large	8001-12000
Very Large	>12001

Column L **Stat Compliance**

Red	>18
Amber	12-18
Green	<12

Column K **Total Cost to improve**

Red	>20,000
Amber	10,000-20,000
Green	<10000

Column M **Total No of non complainces**

Red	>10
Amber	5-10
Green	<5

Column N **Rooms**

Small	<3
Medium	3-6
Large	>6

Columns P & Q shown side by side against the GP practice indicator

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Haringey ward summary of preliminary granted Infrastructure Fund application (March 2015)

GP Practice	Bid Description	Cost
Lawrence House (Dowsett Rd)	Relocation of the practice in Tottenham Hale, in advance of regeneration in the area.	£230,000 + ground rent and service charge
Somerset Gardens	Extend part of practice with third storey to increase clinical capacity.	£853,000
West Green Road Surgery	Requesting a two storey extension to practice with the addition of a two storey portacabin with an addition of five clinical rooms, admin space and a meeting facility.	£500,000
Lawrence House Surgery	Move patient record filing system from a room to a new filing system; improving premises and increasing clinical capacity.	
Evergreen House Surgery	Extend the first floor to create two new consulting rooms and new waiting area. It would increase capacity including with nurse clinics.	£35,000
Crouch Hall Surgery	Conversion of a basement room into a clinical room, replacing flooring in clinical rooms, hall and waiting room.	£16,000
The Vale Practice	Extend premises into neighbouring blank space that NHSE pays the rent of, following the move of the neighbouring practice 5 years ago. It will provide additional clinic rooms and reception space.	£150,200

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Haringey population growth 2011 – 2026 by ward

Ward	2011	2015	2020	2026	2011-2026
Alexandra	11,876	12,052	12,086	12,312	436
Bounds Green	13,805	14,417	14,225	14,291	486
Bruce Grove	14,573	15,032	15,278	15,964	1,391
Crouch End	12,478	12,785	12,905	12,951	473
Fortis Green	12,569	13,009	13,078	13,258	689
Harringay	13,348	14,079	14,756	14,826	1,478
Highgate	11,703	12,119	12,491	13,290	1,587
Hornsey	12,745	13,098	13,601	13,591	846
Muswell Hill	10,845	11,074	11,712	11,861	1,016
Noel Park	14,009	14,686	18,515	21,953	7,944
Northumberland Park	14,522	15,170	16,371	17,215	2,693
St Ann's	14,717	16,123	16,198	17,549	2,832
Seven Sisters	16,061	16,627	16,737	16,949	888
Stroud Green	11,829	12,227	12,076	12,567	738
Tottenham Green	14,661	15,924	17,074	18,590	3,929
Tottenham Hale	15,140	17,322	20,270	20,729	5,589
West Green	13,449	14,026	14,388	14,401	952
White Hart Lane	13,504	13,958	13,998	14,501	997
Woodside	14,594	15,387	16,870	16,959	2,365
	256,428	**269,115**	**282,629**	**293,757**	**37,329**

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Haringey Housing Trajectory by ward 2015 - 2026

Ward	2015-2020	2020-2026
Alexandra	132	105
Bounds Green	185	63
Bruce Grove	238	110
Crouch End	176	114
Fortis Green	53	84
Harringay	216	204
Highgate	210	321
Hornsey	593	63
Muswell Hill	290	63
Noel Park	1,663	2,046
Northumberland Park	977	3,069
Seven Sisters	118	1,297
St. Ann's	509	63
Stroud Green	53	201
Tottenham Green	1,023	196
Tottenham Hale	2,420	1,457
West Green	140	223
White Hart Lane	53	119
Woodside	53	815
Total	**9,102**	**10,613**

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Haringey: Capacity Planning

Prepared for: NHS England (London Region) and Haringey CCG

April 2015

NORTH LONDON
ESTATE PARTNERSHIPS

Contents

1 Introduction

The Haringey CCG and NHS England (London Region) health economy has identified the need for an integrated Strategic Premises Development plan for Haringey. Haringey has a number of significant regeneration schemes and housing developments which have been planned across the borough, but with particular emphasis on the Tottenham area.

It is predicted that the schemes will deliver an increased population of circa 21,201 people by 2020 from 2011 increasing to circa 30,170 by 2026 and the potential of continuing increased demand in capacity. A recent Healthwatch report raised a concern that there was a shortfall in patient appointment in the Tottenham Hale area in the larger context of an overall shortfall in the North East of the borough. It has been further identified by the Haringey Clinical Commissioning Group (HCCG) that a number of the practices premises will not be viable in the future.

This report looks at the first phase of the integrated Strategic Premises Development for Haringey by conducting high level capacity modelling to model where the population growth will be, by ward and how much additional health capacity this will require.

1.1 Proposed Population Growth

The projected population growth of 30,170 people is broken down by ward in Table 1 for 2011-2026. We have subdivided the borough into areas for which the in depth capacity is reviewed in later sections.

Deep Dive Area	Ward	Population Increase 2011-2026
Green Lanes	St Ann's	2,832
	Haringey	1,478
	West Green	952
Noel Park	Noel Park	7,944
	Woodside	2,365
Northumberland Park	White Hart Lane	997
	Northumberland Park	2,693
Tottenham Hale	Tottenham Hale	5,589
	Tottenham Green	3,929
	Bruce Grove	1,391
	Total:	**30,170**

Table1: Population Increase for Haringey by ward by 2026

The population growth data from 2011-2026 was provided by Haringey Council.

Based on the national average of 1,800 registered patients per each whole time equivalent (WTE) GP, the projected population of 30,170 would require 16.76 extra WTE GPs by 2026.

When this is translated into space required, high level modelling shows that the following number of Primary Care clinical rooms would be required:

Consulting Hours	Number of Clinical Rooms*
8 hours per day	24
10 hours per day	19
12 hours per day	16

Table 2 Number of Consulting Rooms Req. based on a population increase of 30,170

***** based on 5 days per week, 50 weeks per year, average appointment of 12.5 minutes, 80% utilisation (an administration percentage of 10% has not been applied here as it is assumed that new ways of working will be adopted in the new building)

1.2 Assumptions and methodology

High level modelling was undertaken using current working practices of:

- 2 sessions of 4 hours per day
- 5 days per week
- 50 weeks per year
- Average appointment 12.5 minutes
- Average appointment of 20 minutes for nurse treatment
- An administration percentage of 10%
- 80% utilisation
- 6 contacts per patient per annum
- List sizes based on weighted data, unless raw data provided through proforma

Please see Appendix 1 for further information.

NHS England provided the current room numbers of each GP practice. It has been assumed that these room numbers are clinical rooms only. A proforma was sent to each practice to gather further information and this information has been used, where available.

2 Green Lanes Area

The Green Lanes area includes the three ward areas of Haringey, St Ann's and West Green. Please note that the ward of West Green spans two areas of review, Green Lanes and Noel Park, so the population growth in each ward has been divided equally between both areas to avoid double counting population increase.

Table 3 shows the total projected population growth to 2026 in the area is 4,786:

	Population Projection				
	2011	2015	2020	2026	2011-2026
Harringay	13,348	14,079	14,756	14,826	1,478
St Ann's	14,717	16,123	16,198	17,549	2,832
West Green	6,725	7,013	7,194	7,201	476
	34,790	**37,215**	**38,148**	**39,576**	**4,786**

Table 3: Projected population growth from 2011-2026 by ward

The Greens Lane area covers the following practices:

- Ansari Green Lanes (2,000)
- Bridge House Medical Practice (8,699)
- Chestnut Parks Surgery (4,643)
- The Laurels Medical Practice (7,500)
- The Old Surgery (Dr Patel) (2,192)
- The Surgery (Dr Raja) (686)
- West Green Surgery (9,161)

From the data received and using the modelling methodology (see 1.2), there are 28 available clinical rooms in the area but 32 rooms required, which gives a current deficit in the current estate of 4 clinical rooms. This suggests that this area would be unlikely to be able to accommodate any growth in population, but would need to be confirmed with the relevant practices.

The population prediction in 2015 is 37,215 people and the registered list sizes of the GP practices in this area are 34,881, a deficit of 2,334. Patient distribution maps show that 191 of the Green Lanes residents use GP services in Enfield. If it is assumed that the remaining population requires registration within area, this deficit of 2,143 would require 1.2 WTE GPs (based on 1,800 patient to WTE GP ratio). However residents may be registered elsewhere, for example, near place of work.

28% of GPs in this area are over the age of 60 (5 out of 18), so retirement may become an added issue in the coming years. In order to model this added pressure we have assumed the potential retirement of a single handed GP practice, with an average list size of 2,000 to redistribute added to Table 4.

Table 4 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator).

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	2,143					
Population growth		2,425	933	1,428		
Potential single handed practice retirements		2,000	0	0		
TOTAL GROWTH	**2,143**	**4,425**	**933**	**1,428**	**8,929**	
No of WTE GPs required	1.2	2.46	0.52	0.79	**5**	Assume 1,800 people per GP
No of C&E Rooms required	1	3	1	1	**6**	NHS England PID estimator
No of Treatment Rooms required	1	3	1	1	**6**	NHS England PID estimator
GIA required	239m^2	494m^2	104m^2	159m^2	**996 m^2**	NHS England PID estimator

Table 4: Projected population growth from 2011-2026 against WTE GPs and extra space required

An analysis of the returned proformas issued to the practices (2 returned out of 7 – Ansari Green Lanes and The Laurels Medical Practice) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these 10 additional sessions were utilised, capacity exists for approximately 1,275 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments).

It was noted that three of the seven surgeries are closed on a Thursday afternoon. It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open
- The practices identified are willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of any GPs who may be planning to retire in the near future.

3 Noel Park Area

The Noel Park area includes the three ward areas of Noel Park, Woodside and West Green. Please note that the ward of West Green spans two areas of review, Green Lanes and Noel Park, so the population growth in each ward has been divided equally between both areas to avoid double counting population increase.

Table 5 shows the total projected population growth to 2026 in the area is 10,785:

	Population Projection				
	2011	2015	2020	2026	2011-2026
Noel Park	14,009	14,686	18,515	21,953	7,944
Woodside	14,594	15,387	16,870	16,959	2,365
West Green	6,725	7,013	7,194	7,201	476
	35,328	**37,086**	**42,579**	**46,113**	**10,785**

Table 5: Projected population growth from 2011-2026 by ward

The Noel Park area covers the following practises (with associated list sizes):

- Havergal Surgery (5,279)
- High Road Surgery (3,755)
- Hornsey Park Surgery (3,527)
- Morum House Medical Centre (15,114)
- Westbury Avenue (4,017)
- Westbury Medical Centre (9,008)

From the data received and using the modelling methodology (see 1.2), there are 46 available clinical rooms in the area but 38 rooms required, which gives a current surplus in the current estate of 8 clinical rooms. Please note that the Morum House Medical Centre has a surplus of 10 rooms, otherwise, the area would have a current **deficit** of 2 clinical room, but would need to be confirmed with the relevant practices.

The current population in 2015 is 37,086 people. The registered list sizes of the GP practices in this area are 40,700. This shows an additional 3,614 out-of-area patients are registered with these practices. Patient distribution maps also show that 178 of the Noel Park residents use GP services in Enfield.

17% of GPs in this area are over the age of 60 (4 out of 23), so retirement may become an added issue in the coming years. High Road Surgey has given notice of retirement which will impact 3,755 patients, this has been added to the summaries in Table 6.

It should also be noted that a practice has 1 out of 2 GPs over the age of 60 which has a list size of 4,017. 50% of the 4,017 list size (2,000 patients) will require 1.1 WTE GPs, but is not included in the capacity planning for additional clinical space, as it is assumed that this will be accommodated within the existing practice.

Table 6 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator).

	2015	2020	2026	Total	Notes
Population growth	1,758	5,493	3,534		
Single handed practice retirements	3,755				
TOTAL GROWTH	**5,513**	**5,493**	**3,534**	**14,540**	
No of WTE GPs required	3.06	3.05	1.96	**8**	Assume 1,800 people per GP
No of C&E Rooms required	3	3	2	**8**	NHS England PID estimator
No of Treatment Rooms required	4	4	2	**10**	NHS England PID estimator
GIA required	616m^2	613m^2	395m^2	**1,624m^2**	NHS England PID estimator

Table 6: Projected population growth from 2011-2026 against WTE GPs and extra space required

An analysis of the returned proformas issued to the practices (4 returned out of 6 – Havergal Surgery, Hornsey Park Surgery, Westbury Avenue and Westbury Medical Centre) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these 40 additional sessions were utilised, capacity exists for approximately 4,080 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments).

It was noted that one surgery is closed on a Thursday afternoon. It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open
- The practices identified are willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of the retiring GP and any others who may be planning to retire in the near future.

4 Northumberland Park Area

The Northumberland Park area includes the three ward areas of White Hart Lane, and Northumberland Park.

Table 7 shows the total projected population growth to 2026 in the area is 3,690:

	Population Projection				
	2011	2015	2020	2026	2011-2026
White Hart Lane	13,504	13,958	13,998	14,501	997
Northumberland Park	14,522	15,170	16,371	17,215	2,693
	28,026	**29,128**	**30,369**	**31,716**	**3,690**

Table 7: Projected population growth from 2011-2026 by ward

The following practices reside in the Northumberland Park area (with associated list sizes):

- Park Lane Surgery (2,510)
- Somerset Gardens Family Healthcare Centre (12,900)
- Tottenham Health Centre (4,500)

From the data received and using the modelling methodology (see 1.2), there are 24 available clinical rooms in the area but 19 rooms required, which gives a current surplus in the current estate of 5 clinical rooms. This suggests that this area would be able to accommodate some growth in population, but would need to be confirmed with the relevant practices.

The current population in 2015 is 29,128 people. The registered list sizes of the GP practices in this area are 19,910. This shows a deficit of 9,218 patients. Patient distribution maps also show that 1,529 of the Northumberland Park residents use GP services in Enfield. If it is assumed that the remaining population requires registration within area, this deficit of 7,689 patients would require 4.3 WTE GPs (based on 1,800 patient to WTE GP ratio). However residents may be registered elsewhere, for example near place of work.

25% of GPs in the area are over the age of 60 (4 out of 16), so retirement may become an added issue in the coming years. We have not included any retiring practices for this area in Table 8.

It should also be noted that a practice has 2 out of 4 GPs over the age of 60 which has a list size of 4,500. 50% of the 4,500 list size (2,250 patients) will require 1.25 WTE GPs, but is not included in the capacity planning for additional clinical space, as it is assumed that this will be accommodated within the existing practice.

Table 8 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator).

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	7,689					
Population growth		1,102	1,241	1,347		
Single handed practice retirements		0	0	0		
TOTAL GROWTH	**7,689**	**1,102**	**1,241**	**1,347**	**11,379**	
No of WTE GPs required	4.3	0.61	0.69	0.75	**6**	Assume 1,800 people per GP
No of C&E Rooms required	5	1	1	1	**8**	NHS England PID estimator
No of Treatment Rooms required	5	1	1	1	**8**	NHS England PID estimator
GIA required	859m^2	123m^2	139m^2	150m^2	**1,271m^2**	NHS England PID estimator

Table 8: Projected population growth from 2011-2026 against WTE GPs and extra space required

An analysis of the returned proformas issued to the practices (3 returned out of 3 – Park Lane Surgery, Somerset Gardens Family Healthcare Centre and Tottenham Health Centre) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these 22 additional sessions were utilised, capacity exists for approximately 2,104 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments).

It was noted that two surgeries are closed on a Wednesday or Thursday afternoon. It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open
- The practices identified are willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of the retiring GP and any others who may be planning to retire in the near future.

5 Tottenham Hale Area

The Tottenham Hale area includes the three ward areas of Tottenham Hale, Tottenham Green and Bruce Grove.

Table 9 shows the total projected population growth to 2026 in the area is 10,909:

	Population Projection				
	2011	2015	2020	2026	2011-2026
Tottenham Hale	15,140	17,322	20,270	20,729	5,589
Tottenham Green	14,661	15,924	17,074	18,590	3,929
Bruce Grove	14,573	15,032	15,278	15,964	1,391
	44,374	**48,278**	**52,622**	**55,283**	**10,909**

Table 9: Projected population growth from 2011-2026 by ward

The following practices reside in the Tottenham Hale area (with associated list sizes):

- Bruce Grove Primary Health Care Centre (8,630)
- Charlton House Medical Centre (6,800)
- Lawrence House Surgery (Dowsett Road) (3,150)
- Tynemouth Medical Practice (10,294)

From the data received and using the modelling methodology (see 1.2), there are 23 available clinical rooms in the area but 26 rooms required, which gives a current deficit in the current estate of 3 clinical rooms. This suggests that this area would be unlikely to be able to accommodate any growth in population, but would need to be confirmed with the relevant practices.

The current population in 2015 is 48,278 people. The registered list sizes of the GP practices in this area are 28,877, a deficit of 19,405 patients. Patient distribution maps also show that 719 of the Tottenham Hale residents use GP services in Enfield. If it is assumed that the remaining population requires registration within area, this deficit of 18,686 patients would require 10.4 WTE GPs (based on 1,800 patient to WTE GP ratio). However residents may be registered elsewhere, for example near place of work.

23% of GPs in the area are over the age of 60 (3 out of 13), so retirement may become an added issue in the coming years. We have not included any retiring practices for this area in Table 8.

It should also be noted that a practice has 1 out of 2 GPs over the age of 60 which has a list size of 8,630. 50% of the 8,630 list size (4,315 patients) will require 2.4 WTE GPs, but is not included in the capacity planning for additional clinical space, as it is assumed that this will be accommodated within the existing practice.

Table 10 shows the potential impact of these increases and the potential extra space required (taken from the NHS England PID Space Estimator).

	2015 deficit	2015	2020	2026	Total	Notes
Difference between population and registered population	18,686					
Population growth		3,904	4,344	2,661		
Single handed practice retirements		0	0	0		
TOTAL GROWTH	**18,686**	**3,904**	**4,344**	**2,661**	**29,595**	
No of WTE GPs required	10.4	2.17	2.41	1.48	**16**	Assume 1,800 people per GP
No of C&E Rooms required	12	2	3	2	**19**	NHS England PID estimator
No of Treatment Rooms required	12	2	3	2	**19**	NHS England PID estimator
GIA required	2,087m^2	436m^2	485m^2	297m^2	**3,305m^2**	NHS England PID estimator

Table 10: Projected population growth from 2011-2026 against WTE GPs and extra space required

However, dialogue will need to be undertaken with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population.

An analysis of the returned proformas issued to the practices (1 returned out of 4 – Charlton House Medical Centre) show that some of the clinical rooms are not used by clinicians for two sessions per day, five days per week. If these 5 additional sessions were utilised, capacity exists for approximately 510 patients (based on each session being a three-hour face-to-face session; 10 minute GP appointments and 20 minute nursing appointments). It was noted that one surgery is closed on a Thursday afternoon. It should also be noted that capacity in primary care is also dependent upon:

- List sizes remaining open
- The practices identified are willing to take on new patients
- Availability of resources/workforce
- Length of consultation times
- Practice opening hours
- Retirement age of single handed practice GPs

The next step is for NHS England to have discussions with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population. Additionally, decisions will need to be made regarding the impact of the retiring GP and any others who may be planning to retire in the near future.

6 Summary

Table 11 below summarises the growth and health implications for each area:

Sub-area	Total population impact	No WTE GPs	No consult/exam rooms	No treatment rooms	GIA required m^2
Green Lanes	4,786	5	6	6	996
Noel Park	10,785	8	8	10	1,624
Northumberland Park	3,690	6	8	8	1,271
Tottenham Hale	10,909	16	19	19	3,305
Haringey totals:	**30,170**	**35**	**95**	**43**	**7,196**

Table 11: Summary of total Haringey impact

These totals are based on the modelling assumptions (section 1.2 and Appendix 1) in order to give an indication of the likely impact to the health system.

However, as previously indicated there is currently some capacity available across the system that could be utilised and additional patients that could be accommodated with more sessions made available where practices are currently closed. However, dialogue will need to be undertaken with the existing practices in order to understand how much capacity they have and their ability and willingness to absorb the increase in population.

This is summarised below:

Sub-area	Current rooms	Rooms required	Total rooms available	Additional patient capacity	2015 projected growth*	Impact
Green Lanes	28	32	- 4	1,275	2,425	-1150
Noel Park	46	38	8	4,080	1,758	2,322
Northumberland Park	24	19	5	2,104	1,102	1,002
Tottenham Hale	23	26	- 3	510	3,904	-3,394
Haringey totals:	**122**	**115**	**7**	**7,969**	**9,189**	**-1,220**

Table 12: Current Capacity within the system

****Note this does not include any current deficit or impact of retirement***

In conclusion there is currently enough capacity within the system for the projected 2015 growth in both the Noel Park and Northumberland Park areas. The Green Lanes area is projected to have a small impact of -1,150 patient growth in 2015. Tottenham Hale however has hardly any current system capacity is projected to have a deficit of -3,394 patient growth on top of already potentially having 18,686 patients in the area not registered with local practices.

We recommend that Tottenham Hale be highlighted as a priority area for investment in Primary Care.

Appendix 1: Modelling Constraints

This paper relates to general practice only. It excludes dentists, opticians and pharmacies. High level capacity modelling reflects current general practice working practices only, as capacity would increase even further if an evening session a day was added, as well as weekend services. However, apart from population growth, it is anticipated that there will also be growth in primary care service provision, such as:

- The primary care caseload is steadily increasing, with more services being offered by GP practices (such as mental health, phlebotomy and diagnostic services) and increasing multi-morbidity, clusters of risk factors and the rising needs of frail older people are adding to the primary care workload. General practice is expected to tailor treatment and act preventively, but may have an increase of consultations per list size as the needs of patients and populations continue to grow, in both complexity and volume
- The move towards more integrated working with acute, community and social care services, meaning that there will be the development of larger multidisciplinary teams based around primary care
- An understanding of the profile of people moving into Colindale regeneration area as this will inform the health needs of that population, dictate the number of consultations made to a GP and the type of services that need to be offered
- From October 2014, patients will be able to register with any GP convenient to them, so may register with GPs near their work or children's schools
- Aspirations to become training practices which, if successful, would necessitate the use of further consultation/examination rooms in the system
- Potential of longer consultation times
- It is not a foregone conclusion that each GP practice will be required to open on evenings and at weekends. The £50 million Prime Minister's Challenge Fund is piloting schemes to improve GP access. Examples of pilot schemes are:
    - North West London: GP practices are working together to create 39 networks – covering 365 surgeries – to improve access for 1.8 million residents. **Each network will offer appointments 8am to 8pm on weekdays and for six hours on weekends**, with same-day appointments for patients who need them, within four hours. For people with non-urgent needs, they will be able to book appointments within 24 hours with a local GP, or at their own practice within 48 hours. Patients with more complex needs will have access to longer appointments and a named care co-ordinator, who will liaise with health and social care services, to co-ordinate their care
    - Barking & Dagenham and Havering & Redbridge: patients across London will benefit from significantly increased access to GP services and a tailored care programme for patients with complex needs. Around 759,000 patients across 137 practices in Barking, Dagenham, Havering and Redbridge, will be able to **book appointments from 6.30pm to 10pm on weekdays and 8am to 8pm on weekends, at central sites**, starting with one in each borough. People can access services by calling a single contact number to talk to a clinician who can then guide them to the most appropriate service for their needs

OPTION APPRAISAL CRITERIA

Pre Qualification Questions: If options do not meet these questions, they do not go onto full appraisal.

Answer Y/N

1) Able to accommodate appropriate practice size.
2) Value for Money (to the best of knowledge at time of scoring).
3) Fit for Purpose (according to NHS Standards i.e disabled access, room sizes, appropriate IT).
4) Able to get suitable planning permission.

Options Appraisal

Weight each criterion 1 – 3

3 – High
2 – Medium
1 – Low

Accessibility

1) Accessible for required population – within a 15 min walk or a 5 or more in a PTAL1 assessment
2) Is it accessible 08:00 – 20:00 7 days a week
3) Potential for disabled parking

Design

4) Flexibility of design to meet future needs

Deliverability

5) Available at the right time

Strategic Fit

6) Able to integrate with other community services

	Weighting	**Score**	**Total Score (Weighting x score)**
Accessible for required population			
Within a 15 minute walk of tube and/or			

[1] Public Transport Accessibility Level

bus station			
Will provide increased opening hours or other access measure			
Fit for purpose premises (according to NHS Standards)			
Able to integrate other community services			
Flexibility of design to meet future needs			
Ability to get suitable planning permission			
Available at the right time			

Detailed planning brief

The new health centre at [ ] shall provide accommodation to support [ ].

- Opening hours of the practice will be [ ] Monday to Saturday and [ ] Sundays and Bank Holidays.
- The centre will accommodate a range of primary care services [ ]

The design should incorporate principles which are sympathetic to the environment and create a sense of peace which will make working in or visiting the building an uplifting experience.

General
This document is intended as a guide to performance specification for the various elements of the proposed building relating to the site – actual method of construction relating to this is to contractor's discretion. The specification contained here within is intended as the minimum acceptable standard of specification & any deviation from these standards or requirements of any referenced material should be highlighted & agreed in writing by the client/project manager.

All materials and components must be suitable for their intended purpose and location and must be manufactured and installed in accordance with all relevant current British Standards, code of practice, manufacturers specifications and have regard to sustainable sourcing. Any reference made to an approved document in this specification relates to the relevant approved building regulation documents.

Standards
All elements of the building, materials and workmanship shall be designed and constructed in accordance with all relevant standards current at the Date of Practical Completion, including:-

a) IEE Wiring Regulations.
b) Health & Safety at Work Act.
c) Local Water Company Requirements.
d) Water Supply (Water Fittings) Regulations 1999.
e) The Clean Air Acts.
f) Building Regulations.
g) Specific requirements of local utility supply companies.
h) Specific requirements of local Planning Authorities, Building Control, Fire Authorities and Acts.
i) British Standards and Codes of Practice.
j) CIBSE Guides.
k) Local Authority Bye-Laws.
l) The Electricity Supply Act
m) Construction (Design and Management) Regulations 2007
n) Disability Discrimination Act
o) BS 8300:2009: Design of buildings and their approaches to meet the needs of disabled people

NHS Requirements
In addition to the Building Regulations, European Standards, British Standards and Codes of Practice, guidance on the design and construction of primary care and general medical practice facilities is contained in a series of NHS publications comprising the following:

a) Health Technical Memoranda (HTMs)
b) Health Building Notes (HBNs)
c) Health Guidance Notes (HGNs)
d) Health Facilities Notes (HFNs)
e) Design Guides
f) ENCODE – making energy work in healthcare – HTM 07-02
g) Fire Code and the relevant Regulatory Reform Orders (RRO) – Fire Risk Assessments – Healthcare Premises – 2006 – HM Government
h) Model Engineering Specifications (MES)

Design Life

The buildings should provide:

a) A professional environment from which staff can deliver a wide range of high quality integrated services to patients
b) An environment that will promote a sense of wellbeing for both staff and patients
c) An improved image of the service and the organisation

The anticipated life expectancies for the following architectural and engineering systems included in the designs are as follows:

Element	Minimum Design Life to First Replacement
External Building Fabric	60 Years
Drainage	60 Years
Internal Walls	25 Years
Finishes	5-10 Years
M&E Plant	15 - 25 Years
M&E Systems	15-20 Years
Lifts	25 Years
Telephone & Data Systems	15 Years

Siting of Building

The location and design of the building should consider the following:

a) Client brief (incl. internal layout requirements)
b) Overlooking of adjacent sites (in particular residential gardens) and separation distances to existing buildings and site boundary
c) Privacy of the patients whilst in the treatment rooms
d) Right of light
e) Planning policy and Design Guidelines
f) Existing Parking arrangements and allowance to separate between patient and staff parking.
g) Allocation of disabled parking bays, drop off points and cycling provision.
h) Pedestrian level access between parking and main entrance.
i) Separate access points for patients and staff.
j) Location of main entrance (to address eligibility, design aesthetics, way finding, practicality of access, visual links with the car park, passing surveillance etc)
k) Most efficient use of the space on the site.
l) Potential retention of the existing access into the site.

m) Utilisation of existing boundary treatments.
n) Building orientation and other aspects that may affect sustainability of the development.
o) Refuse/Waste Strategy
p) Existing trees, vegetation and ecology features.
q) Construction Deliverability (eg. Contractors access, location of site compound, scaffolding, temporary works, H & S requirements, etc.)
r) Local vernacular (eg. Continuation of existing street scenes, introduction of focal features that contribute/enhance the adjacent context, promotion of contemporary and innovative design)
s) Existing building, services, easements, covenants, and any other restrictions that may affect development of the site.
t) Prioritising pedestrian flows over vehicular movement.

The appointed contractor shall commission a detailed borehole/trial pit and soils investigation report from a specialist company experience in carrying out such surveys. The recommendations/results of the investigation shall be used in the subsequent substructure and foundation design.

Accessibility
The availability of good level access both into and within the premises is critical.

- The centre will need to be accessible to a wide range of patients including frail elderly with carers and families with young children with buggies and double buggies, ideally at ground floor level or if at first floor with access to at least one elevator large enough to accommodate a wheelchair turning circle so as not having to reverse out. 2 elevators will be required where there is more than X consultation and treatment rooms within the premises.
- Provision of some clinical space will be required at ground floor level and should sit alongside the provision of commercial space for provision of a pharmacy (where appropriate for co-location).
- Access into the premises should be convenient and direct, avoiding the need for stairs and ramps wherever possible. All routes should be clearly illuminated and where practicable access from the car park route should link to the general footpath provided
- Where car parking is provided as undercroft or basement parking, the same lift shafts connecting floors within the practice should also connect to the car park.
- Escape routes from the building to the assembly point must be provided with adequate emergency lighting to illuminate a safe escape route from the building.
- Disabled and able-bodied users must share the same entrance.
- Materials selected for hard landscaping must not impede the passage of wheelchairs and pushchairs (i.e. no gravel or chippings.)
- Consideration must be given to the movement of service vehicles including refuse and delivery vehicles as well as emergency services. Delivery vehicles are generally box vans or smaller which will be required to reverse into or out of the site. A space for ambulance pickup should be made available at ground floor level for rapid onward transfer where required.
- Entry and exit positions must be well illuminated and should open onto public areas to maximise security. Where possible patients and staff and visitors should enter under supervision through the main entrance, however additional separate entrances or exit points may be required for medical emergencies, out of hours access, goods in and out, and to underpin the operational requirements of some services.
- Consideration will require to be given to the location of services in the building and the resultant impact upon the access and egress requirements for both patient and staff visitors as well as materials movement. Consideration should be given to locating the high volume services on the ground floor.

- Where services are located on upper floors then consideration should be given to the volumes of patients traffic requiring access the upper floors and the location and type of vertical circulation provided e.g. escalators, lifts and staircases.
- A separate staff entrance, which avoids the need to pass through public spaces, is required.
- All parts of the building should be able to be accessed by disabled persons including those that are confined to a wheelchair.

Functionality

Clear way finding with signage and easy circulation for all patients shall be a critical part of the design.

- The disposition of departments and clinical adjacencies shall include consideration for patient flow, journey and travel distances.
- There shall be a strong connectivity and clarity of route between main entrance reception and circulation areas which patients are required to navigate by themselves (i.e. to sub ait areas or consultation rooms).
- Circulation areas should be interesting, imaginative and well-designed spaces in their own right to provide attractive routes to all public, semi-public and restricted areas.
- Natural and view out, or to destination points should be provided.
- Wherever possible, routes shall be reduced in length and shall provide good sight lines as well as stopping/resting points along length of travel.
- The design must also incorporate a sense of arrival in each area should have a sense of place. There is an opportunity to create individual identities to main department/facilities; this shall enable patients to orient themselves. Waiting areas and in particular any sub-wait areas shall be positioned and designed so that patients do not feel isolated.
- The design of the interior environment shall be welcoming, comfortable, and enjoyable for patients and staff. It should be appropriately designed to meet the needs and interest of all ages.
- The lay out shall present an equitable and barrier free environment, where security requirements allow, with easy access for all patients and visitors and staff. The design shall incorporate features to mitigate an institutional feel. A key factor shall be the promotion of art and design features that express the locality and diverse community that it serves.
- All consult/exam rooms, treatment rooms and counselling rooms shall be designed to offer a relaxing environment to the patient; this may be achieved by views out to external areas as well as the interior design and layout of the rooms.

Environment

The health centre shall be designed to present a calm, welcoming and secure environment for patients, in order to facilitate patient recover and a positive patient experience.

- The use of natural light, sound, smell, touch, together with a careful choice of natural material shall be carefully considered to create bright, modern environments, which reflect current good practice heath care facility design. Internal landscape design shall be incorporated into the public/common areas of the facility; there is evidence of clinical benefit from encountering landscape features as patients navigate the building.
- With respect to the internal environment, special considerations shall be given to the needs of specific patient groups such as children and adolescence, the elderly and patients with disabilities.

Sustainability

The designs should, where practical, reflect sustainability issues in ensuring that the facilities provide for the needs of the present generation without compromising the ability of future generations to provide for their needs.

- Designs should promote sustainable development by demonstrating an integrated approach to the social, environmental and economic well-being of the area reserved, both now and for future generations.
- Assessments on the proposed design and project specific sustainability proposals will require to be undertaken in accordance with the latest Building Research Establishments Environmental Assessment Methodology (BREEAM) which came into effect in June 2008. Buildings may need to achieve a certain BREEAM level, which is to be confirmed by the Local Authority.
- Contractors design to make allowance for adjustment of thermal requirements for various building elements to meet SBEM requirements.

Security and Safety

Designs should aim to assure the security and safety of patients, staff and visitors and their property within the building and its immediate vicinity. Designs must also safeguard the security of equipment, patients' records, drugs, etc.

- The design and specification of new facilities should be carried out in consultation with the local Police Architectural Liaison Officer/Crime Prevention Officer and the stakeholders' safety representatives.
- Where possible the proposals should promote passive surveillance and design-out any potential crime risk elements.
- The designs should provide for general security measures including suitable locks (proximity operated) on doors to contain patient access within the building.
- A zoned security alarm system should be fitted for the protection of premises and personnel.

The design should consider or implement where possible, the requirements of "The Secured by Design Award Scheme" and "The Secured Car Park Award Scheme".

Privacy & dignity

The privacy and dignity of patients shall be considered throughout the design, particularly in respect of patient flow.

- Due care and attention shall be paid to patient and professional confidentiality, in the layout of spaces and in the sound separation performance of partitions and screens.

Staff wellbeing and staff operations

The design shall be such as to present a positive, inspiring and healthy environment for the staff, both in the public areas and in the non-public areas, i.e. office spaces, where current good practice guidance for office layout shall apply.

- Opportunities for social interaction of staff should be provided throughout the health centre.
- The layout shall demonstrate a clear understanding of the clinical and non-clinical operations to enable staff to carry out operational activity smoothly effectively and efficiently this shall include:

  Interdepartmental movement between each area for staff and good and waste, both clinical and general.

  Careful planning of room and departmental relationships to maximise daily and weekly availability throughout the working week.

  Attention to the disposition of shared use spaces by co-located facilities

A design which permits clinical rooms to be well supported by non-clinical facilities.

Flexibility, adaptability and future-proofing
Healthcare is continuously in a state of development and change. It is therefore essential that the new health centre should be as adaptable and flexible in design as possible to accommodate medium and long term future change and diversification in treatments, technologies and management practices.

- Rooms shall be standardised wherever possible; in particular, all consulting rooms should be designed to the same layout. The general practice and community health consulting facilities should be located such that space can be flexed between the two organisations.
- The site layout, drainage design and structural form of new facilities should allow for extension and internal alteration without unreasonable cost or disruption to the existing fabric and with minimum disruption to ongoing use of the rest of the premises.

If possible the design and positioning of the building on site should be capable of demonstrating the potential for further increasing space in the future and that possible expansion within the site will sit well within the whole site context.

Infection control
The design shall incorporate current good practice with regard to control of infection such as automatic taps, disposable screen and curtains and bio resistant services to door pulls and finger plates are to be used.

- Materials used within the building shall support the prevention of infection through all the design and operational aspects.

General arrangement
As far as possible, public space shall be located on the ground floor. Where public spaces are located above ground they shall be designed with consideration to clear and intuitive way-finding and direct, short routes.

- The overall building height and massing should allow for minimum ceiling heights of 2.5m, except for the reception area which should provide a minimum height of 2.7-2.8m high.
- Building footprint can be split over two storeys, however certain impacts must be considered (efficiency and viability of the accommodation, massing/visual relationship with adjacent sites, separation of patients and staff flows/facilities, provision of (vertical circulation eg. Lift)

Main entrance arrival zone
The arrival zone shall be a vibrant public area and shall present an environment that is uplifting and inspiring. The zone areas provide a focal point for all patients and visitors attending the new health centre. The entrance can also be used by staff, although they shall also have a designated staff entrance.

- It is anticipated that some areas of the health centre will be open out of hours in the future. The arrival zone includes the following;

  Entrance Hall

  Reception desk

  Main waiting area, including child waiting

  Interview room

  Patient WC and nappy change room

Baby feeding room

Lighting
Daylight is generally considered to provide the best colour rendering and the design of the building should maximise the benefits of natural light.

- Wherever possible, rooms and corridors should receive natural light and the provision of deep plan areas avoided.
- Of necessity however, a significant proportion of practice work is carried out under artificial light due to both the design of rooms and the availability of daylight. Artificial lighting must therefore ensure good colour rendering by using, for example, intermediate or warm fluorescent lights.

Ventilation
Natural ventilation should preferably be used for all spaces with windows.

- Some clinical or sanitary facilities may require mechanical ventilation to comply with HTM/HBN standards or building regulations; however, natural ventilation should still be encouraged to compliment these spaces.

Drainage
The building should be provided with separate foul and surface water systems connected to the adopted sewers or soakaways if feasible.

- The layout and design should allow for possible future extension of the buildings without the need for major redesign but allowing for potential relocation of pipes constructed within the footprint of the potential extension at the time of construction of the extension. Consideration should be given to the retention of surface water on site if feasible to avoid increasing the pressure on existing sewers.
- All drainage must be designed to provide adequate discharge from the property and have rodding access for cleaning and maintenance. Rodding points should be located to avoid backflow in the event of blockages. Internal manholes should be avoided.

Landscaping and External Works
The design of the external hard and soft landscaping should be carefully considered to provide a successful and aesthetically pleasing scheme. Any issues contained in Planning Consent conditions should be fully addressed in the landscape design. Full details should be submitted to the Local Authority Planning Department in advance of the commencement of construction.

- Site boundaries should be marked by a perimeter fence to the rear and sides and be edged by defensive planting. The boundary to the front should remain open. Grounds should be landscaped to provide a simple but pleasing effect, maintaining existing trees wherever practicable.
- A careful review of the location, boundary conditions and natural circulation routes should be undertaken prior to detailed design.
- Maintenance of soft landscaping should be kept to a minimum by the use of robust shrub planting and hard wearing grassed areas.
- Paved areas should be provided with safe, durable and level paving with adequate falls to avoid ponding. Steps should be avoided. Ramps should have appropriate gradients, handrails and balustrades. Tactile paving should be provided at highway/footpath junctions and at all changes in direction or gradient.
- The Secured Car Park Award Scheme design requirements should be complied with.

All works carried out beyond the site boundary should be to adoptable standards and to the approval of the Highways Department.

Cleaners' rooms
The design shall incorporate a strategy for how the FM shall be integrated in the facility in terms of maintenance and cleaning. Space provision for suitably sized and located cleaning cupboards etc. should be incorporated in the design. Each cleaning cupboard shall have a utility sink.

Computer Facilities/Server room
The design shall incorporate a strategy for IT. A server room shall be provided in a suitable location within the building.

Medical records facilities
It is anticipated that Patient Records shall be held electronically. However there is a requirement for paper records and provision shall be made for a medical records archive room. This room may be located remote from the rest of the Health Centre accommodation, but there should be a direct access from the staff areas.

Receipt and Delivery area
An area shall be provided for receipt and distribution (R&D) of goods and materials to all departments. This shall be located near to the staff entrance door and within reasonable proximity to the external vehicular delivery bay. The R&D point shall have suitable shelving for bulk items and smaller packages delivered to the Health Centre.

Disposal Hold/Waste Store
A disposal hold and waste store shall be provided. This room must have distinct and separate sections for holding of clinical and general waste. Ideally it shall be near to the department GP treatment suite so that dirty bins are not taken through clinical areas; separate routes should be demonstrated. The disposal hold shall be located with consideration to the vehicular refuse collection strategy. The areas should be easily accessible from the public highway/service areas

Cycle storage
Secure, well lit, covered cycle parking should be provided which benfits from good natural surveillance and CCTV coverage. This should be provided near to the main entrance; some may be provided near to the staff entrance.

Car Parking
Car park provision should clearly identify disabled person's spaces close to the main entrance with reserved parking for doctors and key staff near to the staff entrance or main entrance.

Accessible drop-off bay
It is expected that many patients and visitors shall arrive to the Health Centre by foot or public transport. One or two dedicated on-street accessible drop-off parking bays shall be provided, located within reasonable proximity to the main entrance. This shall be suitable for cars and ambulances.

Delivery bay
One dedicated delivery bay shall be provided for shared use by the Health Centre, within reasonable proximity to the staff entrance.

Maintenance
The size and shape of the building should allow access for maintenance and repair which may involve the need to employ contractors, scaffold or special equipment. The ability to replace materials in areas of high use will require careful consideration.

***NHS* England National Support Centre**

Projects Appraisal Unit

Construction / refurbishment capital investment and project activity guide: 2015-2016

Version: Spring 2015

This 'At a Glance' guide is provided to assist those organisations and staff new to NHS business case process for construction and refurbishment projects. It is recommended that the exact requirements and timings of their buisness case are confirmed with key stakeholders including the approving body before progressing individual project proposals.

Standard project business case phasing	**Strategic Outline Case** (SOC) [Project Initiation Document - **PID**- for smaller schemes]	**Pre OBC** procurement option review and recommendation	**Outline Business Case** (OBC)	**Full Business Case** (FBC)	Construction Phase	**Post Project Evaluation** (PPE)
Private Finance Initiative (PFI /PF2) business case phasing	**Strategic Outline Case** (SOC)		**Outline Business Case** (OBC)	**1.** OJEU **2.** Shortlist Bidders **3.** Issue ITPD **4.** Draft Appointment Business Case (dABC) approval **5.** Issue ITSFB **6.** Final Tenders **7.**Recommend Preferred Bidder **8.**Appointment Business Case (ABC) approval **9.**HM Treasury approval **10.** Confirmatory Business Case (CBC) approval. **11.** Financial/Contract close	Construction Phase	**Post Project Evaluation** (PPE)
NHS Local Improvement Finance Trust (LIFT) business case phasing	**Strategic Outline Case** (SOC)	OBC procurement decision	**LIFT Stage 1** business case	**LIFT Stage 2** business case Financial Close	Construction Phase	**Post Project Evaluation** (PPE)
Department of Health (DH) 'Health Gateway Reviews' ***(DH Health Gateway update July 2013)***	**Gateway 0** (Strategic Assessment)	**Gateway 1** (Business Justification)	**Gateway 2** Procurement Strategy) **Gateway 3** (Investment Decision)	**Gateway 4** (Readiness for Service)	Construction Phase	**Gateway 5** (Benefits Evaluation)
Building Information Modelling (BIM) ***(BIM Task Group update July 2013)***	**DATA DROP 1** Requirement & Constrain Model	**DATA DROP 2** Outline Solution Model		**DATA DROP 3** Construction Information Model	**DATA DROP 4** Operation and Maintenance Information Model	**DATA DROP 5** Post Occupation Validation Information Model and on-going O&M
BRE Environmental Assessment Model (BREEAM)	**Pre Assessment**	**Design Stage Assessment**		*Issue Interim Certificate*	**Construction & Post Construction Assessment**	**Evaluation** *Issue Final Certificate*
Design (Quality Indicator) assessments (DQI) ***(Construction Industry Council update July 2013)***	**Stage 1** Briefing	**Stage 2** Mid Design		**Stage 3** Detailed Design	Construction Phase **Stage 4** Ready for Occupation	**Stage 5** In use
External Design Review Panel (DRP) via CABE / Design Council	**Dependant on nature of scheme**	**Dependant on nature of scheme and Local Authority planning requirements**		**Dependant on nature of scheme and Local Authority planning requirements**	Construction Phase	**Post Project Evaluation** (PPE)
Royal Institute of British Architects (RIBA) Stages **RIBA 2007 ►**	**Stage A** Project Appraisal **Stage B** Design Brief	**Stage C** Design Concept Check drawing requirement with approving body	**Stage D** Developed Design (1:200) **Stage D/E** Design and cost estimates Minimum1:200 drawings for preferred option. Possibly greater detail for novel, contentious, derogated designs	**Stage E:** Technical Design **Stage F:** Production **Stage G:** Tender documentation **Stage H:** Tender Action	**Stage J:** Mobilisation **Stage K:** Construction to practical completion.	**Stage L** Post Practical Completion
RIBA 2013 ►	**0** Strategic Definition **1** Preparation & Brief	**2** Concept	**3** Definition	**4** Technical Design	**5** Construction	**6** Handover **7** In use
Procure 21 *plus* (P21+)Key Stages Optimum time period ⇔	**P21+ Stage 1**	**P21+ Stage 2**		**P21+ Stage 3**	**P21+ Stage 4**	
Trust registers scheme	←	→				
PSCP selection process	←	→				
PSCP selected	←	→				
Contract entered into	←	→				
Design Development				← Reach GMP		
Construction					Construction Phase	**Post Project Evaluation** (PPE)
Other key activity. Optimum time period ⇔	**SOC**	**OBC**		**FBC**	**Construction Phase**	**Post Project Evaluation**
Developing Operational Policies to support the design and budget options		←	→			
Approved clinical service strategy	←	→				
Approved Estates Strategy	←	→				
Approved Travel Plan	←	→				
Approved Sustainable Dev. Policy/Plan	←	→				
Commissioner support	**For SOC** ■	**For OBC** ■		**For FBC** ■		
Local Authority Planning Approval (Full)	**Allow 13 weeks post written approval for challenge / judicial review**			← →		

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Haringey Council Clinical Commissioning Group | NHS Haringey | healthwatch Haringey | HAVCO Haringey Association of Voluntary and Community Organisations

Report for:	**Health and Wellbeing Board – 23rd June, 2015**

Title:	**Approval of Health and Wellbeing Strategy**

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

Lead Officer:	**Jeanelle De Gruchy, Director of Public Health, LBH**

1. Describe the issue under consideration

1.1 Following the expiry of the Health and Wellbeing Strategy (2012-15) a new Health and Wellbeing Strategy has been developed for the next three years (2015-18). This strategy will enable:

- all Health and Wellbeing Board (HWB) partners to be clear about our agreed priorities for the next three years
- all members of the HWB to embed these priorities within their own organisations and ensure that these are reflected in their commissioning and delivery plans
- key agencies to develop joined-up commissioning and delivery plans to address these priorities
- the HWB to hold member organisations to account for their actions towards achieving the priorities within the strategy
- members of the HWB to work with and influence partner organisations outside the HWB to contribute to the priorities and the approaches for working agreed within this strategy; this includes engaging residents in co-producing solutions.

1.2 This paper summarises the revisions that have been made to the draft Health and Wellbeing Strategy following the public consultation that concluded at the end of March. The purpose is to enable the Health and Wellbeing Board to agree the final version of the Health and Wellbeing Strategy (attached as Appendix 1).

2. Cabinet Member introduction

2.1 Haringey faces considerable challenges with areas of high health need and rising demand for services, particularly in social care; this at a time of shrinking budgets. At the same time, regeneration in the borough provides considerable potential to improve health and wellbeing and reduce inequalities.

2.2 The Health and Wellbeing Strategy presents an opportunity to transform the way in which we seek to improve the health and wellbeing of our residents. Working with our partners and residents, we must ensure that we are ambitious and bold in our approach to delivering our vision.

3. Recommendations

3.1 Consider the responses to the consultation on the draft Joint Health and Wellbeing Strategy;
3.2 Agree the final version of the Health and Wellbeing Strategy (attached as Appendix 1);
3.3 Formally establish the Haringey Obesity Alliance;
3.4 Agree targets for the nine Health and Wellbeing Strategy ambitions (where possible).

4. Alternative options considered

4.1 Haringey Health and Wellbeing Board has a duty to develop a Health and Wellbeing Strategy to prioritise effort to address needs identified by the JSNA. The previous Health and Wellbeing Strategy covered 2012-15 and has now expired. Therefore no alternative options were considered.

5. Background information

5.1 The legislation and local policies that have informed the development of the Health and Wellbeing Strategy were summarised in a report to the 24th March 2015 Health and Wellbeing Board. They include the Care Act, Children and Families Act, LBH Corporate Plan, NHS Five Year Forward View, Haringey CCG Five Year Plan, and Better Health for London report (London Health Commission).

5.2 At the meeting of 24th March, the Board discussed the common outcomes and principles behind these policies and agreed that they should inform the Health and Wellbeing Strategy. They were as follows:

Outcomes:

- Better health, for longer, for everyone
- Improved wellbeing
- Reducing health inequalities
- Enabling people to be in control of their lives
- Resilient communities
- Safety (protection from abuse and neglect)

Principles:

- An approach that considers the health of all residents

- Tackling stigma and discrimination
- Prevention and early help – including supporting children to get the best start in life
- Strong, collaborative partnerships
- Working with communities
- High quality services that are joined up around individuals, and community needs, not those of the institutions providing services
- Promoting self-care and independence, underpinned by the right support
- Considering the impact on health and wellbeing of the environment, housing, and education

5.3 The Board agreed that the Health and Wellbeing Strategy should seek to improve overall health and wellbeing by focussing on those areas which will have the greatest impact and for which the Health and Wellbeing Board is the place to drive them forwards. There are other partnerships that have a role to play in improving health and wellbeing – such as the Local Safeguarding Children Board, Community Safety Partnership, Learning Disabilities Partnership Board, Employment and Skills Board, and Adult Partnership Board. The Strategy reflects this by focusing on three key priority areas.

5.4 The draft Health and Wellbeing Strategy (2015-2018) was developed following a review of the current Health and wellbeing strategy (2012-2015) and significant pre-consultation work with partners and residents/service users. The draft strategy was put out for consultation in February and March 2015.

5.5 The responses from the consultation have been summarised in a report (see Appendix 2). The main themes from the consultation were:

- Many residents recognise that Health and Wellbeing can be improved through better education and awareness and therefore see an important role for parents and schools.
- Residents are most likely to see their role in supporting Health and Wellbeing as being to educate themselves and spread messages to those around them.
- Many respondents believe that cost is an issue, and that a healthy lifestyle needs to be more affordable. Consequently respondents tend to believe the quality and safety of the public environment is important because of the opportunities it provides for free exercise.
- There is quite a sophisticated understanding of the links between mental and physical health and the importance of healthy relationships and sociability in improving Health and Wellbeing. Loneliness amongst older people was a commonly raised issue.
- There was widespread recognition that different communities have different health needs, and that Health and Wellbeing professionals should work closely with communities to develop targeted solutions.

5.6 The Health and Wellbeing Strategy has been updated to reflect the consultation responses. Common resident responses and example quotations have been added.

Particular policies have been illustrated with examples raised by respondents i.e. the example of peer support schemes was added to illustrate the proposal for community-based services for people with mental ill-health issues. Throughout the document it has been made clearer that the specific health needs of different communities will be addressed by working closely with those communities.

5.7 Following the consultation, a number of key objectives were drawn out of the Health and Wellbeing Strategy, to offer a simple structure that would facilitate the Board's oversight of the delivery of the Strategy and enable a clear focus on the most important outcomes. The approach of the London Health Commission should be taken as the model – whose Better Health for London report features 10 'ambitions' for the Health and Wellbeing of the city.

5.8 Following the London Health Commission model, 9 'ambitions' for the Health and Wellbeing of Haringey were identified. For each, a single headline indicator has been chosen.

5.9 Measurable targets will be set for each ambition. Provisional targets are included in the Health and Wellbeing Strategy. A presentation will be tabled at the Health and Wellbeing Board which will show the data and trends behind the provisional targets. The Board will have the opportunity to review the data and revise the targets if necessary.

5.10 Supporting the ambitions, the Health and Wellbeing Strategy proposes a focus on three areas where we need to make the most significant and sustainable improvements:

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

5.11 The Strategy has been updated to feature a series of charts that show the structure of the delivery plan through which the priorities will be implemented. The structure charts are mapped against the 9 ambitions and indicate the dependencies with other programmes and partnerships. Fundamentally, the structure shows that priority 1 will be delivered under the auspices of the Obesity Alliance, priority 2 through the (Corporate Plan) Priority 2 Portfolio, and priority 3 through the Mental Health Framework.

5.12 The primary mechanism for achieving the ambitions, and delivering the planned interventions, around obesity will be the creation of a Haringey Obesity Alliance.
The Obesity Alliance will be a partnership with health and social care services, schools, local businesses and voluntary and community groups. Over the next three years the Obesity Alliance will work together to contribute to the reduction of obesity in the borough through co-ordinated, effective and sustained action. It will provide a

platform for partners to advocate, exchange information, and develop and coordinate projects that contribute to tackling obesity.

5.13 The Obesity Alliance will be chaired by Haringey Council's Cabinet Member for Health and Wellbeing and will report to the Health and Wellbeing Board. It will develop, implement and monitor a delivery plan for fulfilling the Health and Wellbeing Strategy's ambitions around obesity. A provisional delivery plan for the Obesity Alliance is featured in the Health and Wellbeing Strategy.

5.14 There will be four versions of the Health and Wellbeing Strategy:

Full Strategy
Summary version
Easy read version (to be commissioned once Full Strategy is agreed)
Large print version (to be commissioned once Full Strategy is agreed)

All versions of the strategy and the report summarising the results of the consultation will be uploaded to the Council's dedicated web page for the Health and Wellbeing Strategy 2015-18:

http://www.haringey.gov.uk/social-care-and-health/health/health-and-wellbeing-strategy

6. Comments of the Chief Finance Officer and financial implications

6.1 This report for Cabinet summarises the revisions that have been made to the draft Health and Wellbeing Strategy (2015-18) to enable the Health and Wellbeing Board to agree the final version of the Strategy. As such there are no financial implications arising directly from this report. However it is important to note the financial context in which the Health and Wellbeing Strategy will operate.

6.2 The Council's Medium Term Financial Strategy (MTFS) sets out actions to achieve savings of at least £70 million by the end of the period to 2018. This is in addition to a £117 million reduction that has already been made since 2010. The Medium Term Financial Strategy and the Corporate Plan have been developed together to meet this challenge and in order to ensure that the Council remains clearly focused on its objectives. The MTFS has been drawn up in terms of investment in each of five key priorities. Priorities one and two are most closely linked to the Health and Wellbeing Strategy although, given the general duty of promoting wellbeing, all priorities must be seen as contributing to it.

6.3 The 2015-16 net revenue budget for the Council is £276 million which includes budgets allocated to Adults Social Care and Children and Young People's Services; and Public Health. These budgets support the delivery of two priorities in the Corporate Plan:

- £53 million for Corporate Plan Priority One - Enable every child and young person to have the best start in life, with high quality education
- £96 million for Corporate Plan Priority Two - Empower all adults to live healthy, long and fulfilling lives

6.4 In this challenging financial context the successful implementation of the Health and Wellbeing Strategy is a key component to supporting the financial position of the Borough and Haringey CCG in addition to the undoubted benefits that will accrue from achieving health improvements for our residents.

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

7.1 Section 196 of the Health and Social Care Act 2012 requires the function of the CCG (Clinical Commissioning Group) and the local authority of preparing joint strategic needs assessments (JSNA) and joint health and wellbeing strategies (JHWS) to be discharged by the Health and Wellbeing Board.

7.2 Section 193 of the Act imposes a duty on the local authority and the CCG to produce JHWS for meeting the needs identified in the JSNA. The local authority, CCG and the NHS Commissioning Board (in relation to its local commissioning responsibilities) must have regard to the JSNA and JHWS when carrying out their functions. The Act does not specify the form the JHWS should take. It requires the local authority and the CCG to have regard to the Secretary of State's mandate to the NHS Commissioning Board which sets out the Government priorities for the NHS and any guidance issued by the Secretary of State when preparing the strategy. The Act also requires the local authority and CCG to involve the Local Healthwatch organisation and the people who live or work in the local authority's area when preparing the JHWS.

7.3 The local authority and the CCG must consider how the needs in the JSNA could more effectively be met through the use of flexibilities available under section 75 of the NHS Act, such as pooled budgets, when preparing the JHWS. The Act enables the local authority and CCG to include in the strategy their views on how arrangements for the provision of health-related services could be more closely integrated with arrangements for the provision of health services and social care services in the area.

7.4 The Statutory Guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy 2013 provides that “Local authorities and clinical commissioning groups have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process. Success will not be achieved if a few members of the board assume ownership, or conversely do not bring their area of expertise and knowledge to the process. As the duties apply across the health and wellbeing board as a whole, boards will need to discuss and agree their own arrangements for

signing off the process and outputs. What is important is that the duties are discharged by the board as a whole" (Paragraph 3.1).

7.5 The Statutory Guidance also requires the Health and Wellbeing Board to give consideration to the Public Sector Equality Duty under the Equality Act 2010 throughout the JHWS process. "This is not just about how the community is involved, but includes consideration of the experiences and needs of people with relevant protected equality characteristics, (as well as considering other groups identified as vulnerable in JSNAs); and the effects decisions have or are likely to have on their health and wellbeing" (Paragraph 7).

7.6 Once approved, Health and Wellbeing Board must publish the JHWS.

8. Equalities and Community Cohesion Comments

8.1 The development of the Health and Wellbeing Strategy has been subject to an Equalities Impact Assessment.

8.2 The EQiA provides substantial detail on the evidence base around Health Inequalities that informed the Strategy. It also details the consultation work that has been carried out and how the demographic profile of respondents was monitored.

8.3 The EQiA concludes that proposals to increase healthy life expectancy and prevent people from developing long term health conditions will have a positive effect on older people, and (because children from BME groups are more likely to be obese) proposals to tackle obesity in the HWB Strategy should have a positive impact on BME groups.

9. Head of Procurement Comments

9.1 The Health and Wellbeing Strategy does not have any identified Procurement activities within it. Any Procurement that needs to be undertaken to meet the objectives set out within the Strategy will be dealt with on an individual basis under normal procurement practise.

10. Policy Implication

10.1 The Health and Wellbeing Board (HWB) has a duty to develop, upgrade and publish the Health and Wellbeing Strategy. The Health and wellbeing strategy aims to improve the health and wellbeing of children and adults in our borough and reduce health inequalities by pursuing the three priorities of reducing obesity, increasing healthy life expectancy and improving mental health and wellbeing.

10.2 The Health and Wellbeing Strategy has clear synergy with Priorities 1 and 2 of the Corporate Plan. It is clear that the intention is to integrate the delivery plan for the Strategy into existing/emerging Corporate Plan delivery plans – primarily the Priority 2 Portfolio.

10.3 The Community Strategy currently being developed will be relevant to the delivery of the Health and Wellbeing Strategy – given that working with communities is identified as one of the key methods for implementing the Health and Wellbeing Strategy. The Policy team are involved in both Strategies are so are well placed to ensure that they complement one another.

11. Reasons for Decision

It is recommended that the Health and Wellbeing Strategy 2015-18 is approved as the Health and Wellbeing Board has a duty to develop a Health and Wellbeing Strategy and the previous Strategy has now expired.

This strategy will enable all partners to be clear about our agreed priorities for the next three years; all members of the HWB to embed these priorities within their own organisations; key agencies to develop joined-up commissioning and delivery plans to address these priorities; and the HWB to hold member organisations to account for their actions towards achieving the priorities within the strategy.

12. Use of Appendices

Appendix 1: Health and Wellbeing Strategy (final v1.9)
Appendix 2: Summary of Consultation responses

A presentation on the data trends behind the targets proposed for the Health and Wellbeing Strategy will be tabled at the Health and Wellbeing Board meeting.

13. Local Government (Access to Information) Act 1985

See the paper 'Transforming health and wellbeing in Haringey' - Health and Wellbeing Board (24th March 2015)

Haringey Council

healthwatch Haringey

HAVCO
HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

NHS
Haringey
Clinical Commissioning Group

Haringey Health and Wellbeing Board

Haringey's Health and wellbeing strategy 2015-2018

All children, young people and adults live healthy, fulfilling and long lives

Contents

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Authors	*Susan Otiti, Tamara Djuretic, Marion Morris, Will Maimaris, Debbie Arrigon: Public Health Team, Haringey Council* *Rachel Lissauer, Assistant Director of Commissioning, NHS Haringey* *Liz Marnham, William Shanks, Policy and Equalities, Chief Executive's Service, Haringey Council*
Lead Officer	*Jeanelle de Gruchy, Director of Public Health, Haringey Council 020 8489 5119*
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Version history

Version	Change/Reasons for Change	Date
V0.1	*Consultation draft: Haringey's Health and Wellbeing Strategy 2015-2018*	*13 January 2015*
V1.6	*Updated to reflect consultation comments*	*24 April 2015*
V1.7	*Updated after comments from senior LBH officers, ready for informal meeting of HWB partners 5th May*	*1 May 2015*
V1.8	*Updated after comments from HWB partners. 9 ambitions and delivery plan structure added*	*11 May 2015*
V1.9	*Updated following SLT 26th May*	*4 June 2015*

Approval history

Version	Approving body	Date
V0.1	*Health and Wellbeing Board*	*13 January 2015*
V1.9	*Health and Wellbeing Board*	

Introduction

Haringey is a borough of great assets and enormous opportunity. We have fantastic parks and open spaces, some of the best schools in the country and our transport links provide good access to employment opportunities within London. Many of our residents are thriving and happy with their lives and health.

However, a big issue for us is that many people experience a range of challenges that mean their health and wellbeing are not as good as they could be. This affects how healthy they are as they age and how early they die - on average, men in the poorer wards of our borough die 8 years younger than men in the wealthier wards; this difference is 3 years for women. There would be a similar difference in how healthy people are as they age. Inequalities in health due to people's different social circumstances are, quite simply, unfair.

Mental ill health is also a big issue for Haringey, and again shows inequalities. We need to make sure that the mental health of our residents gets as much attention as their physical health.

The rise in obesity, in children in particular, is very worrying. Becoming overweight as a child means they may already experience problems of poor health or self-esteem. But it also means that they are storing up real problems for the future.

No organisation can tackle these issues on their own. We all need to work together – residents and community groups working with the Health and Wellbeing Board and its partners. This strategy is about how we focus our efforts to do that.

Councillor Claire Kober

Leader of Haringey Council

Chair of the Health and Wellbeing Board

Dr Sherry Tang

Chair of Haringey Clinical Commissioning Group

Deputy Chair of the Health and Wellbeing Board

Summary: Haringey Health and Wellbeing Strategy 2015-2018

Our vision:	**All children, young people and adults live healthy, fulfilling and long lives**		
Our ambitions:	Fewer children and young people will be overweight or obese More adults will be physically active Every resident enjoys long lasting good health Haringey is a healthy place to live	People can access the right care at the right time More people will do more to look after themselves	More adults will have good mental health and well-being More children and young people will have good mental health and well-being People experiencing Mental Health crisis will receive the care they need when they need it
Our principles:	Tackling inequalities Prevention and early help and support Working with communities		
Our priorities:	**Reducing obesity**	**Increasing healthy life expectancy**	**Improving mental health and wellbeing**
Why have we chosen these?	• Obesity in the UK is rapidly rising; related long-term conditions reduce life expectancy by an average of nine years • Overweight children are more likely: to be ill and absent from school; to be bullied; to become overweight adults • Haringey has significant numbers of overweight children – an estimated 13,675, with 1 in 4 Reception children and 1 in 3 Year 6 children overweight or obese • Obesity is closely linked to deprivation - Year 6 children living in deprived areas are 2.5 times more likely to be overweight or obese than those in more affluent areas. • Many people with learning disabilities have a problem with obesity	• On average, women in Haringey live the last 23 years of life in poor health ('unhealthy life expectancy') and men live the last 20 years of life in poor health. • There are also large inequalities in life expectancy between the east and west of the borough (on average 8 years for men; 3 years for women) • Long-term conditions – health problems such as heart disease and diabetes that cannot be cured but can be controlled – are the major causes of early death and poor health • The number of people with long-term conditions is increasing; this is related to increases in physical inactivity, poor diet, alcohol misuse	• Mental health and wellbeing have a great impact on our ability to live happy and fulfilling lives • Poor mental health increases the risk of long-term conditions. • In Haringey an estimated 3000 children and young people have some form of mental health problems at any time; over 34,500 adults will have a common mental disorder (anxiety or depression) • About 4000 adults with severe mental illness live in Haringey; a low percentage of these adults are in employment or settled accommodation • Suicide rates are 33% higher than the London average • Despite high levels of mental illness in Haringey, a large proportion of our residents

			do not seek help
What would a healthier Haringey look like?	• Healthy lifestyle change is a part of all strategies and policies • More mothers breastfeed • More children, families and adults eating healthier options and are more active • More schools achieve their Healthy School awards • We stop the rise in childhood obesity.	• A borough that enables people to make the healthy choice the easy choice • More people aging well and fewer people with long-term conditions • More people able to self-manage their long-term conditions with support from quality primary care services. • Fewer caring relationships will break down • Fewer people feel alone • Fewer emergency admissions to hospital for people with long-term conditions. • An improvement in healthy life expectancy for men and women in all parts of the borough.	• More people with mental health problems will recover and be able to participate in their communities; • More people with mental health problems will have good physical health • More people will mental health problems will have employment and live in settled accommodation • More people will have a positive experience of care and support, including carers • More people who use services will feel more in control of their life • Fewer people will experience stigma and discrimination
Related strategies	This strategy complements the council's corporate plan, local NHS (CCG) 5-year strategy, NHS North Central London 5-year plan and Community safety plan		

What influences our health and wellbeing?

It's not just a case of genetics – where we are born, study, work and retire affects our health and wellbeing. Poor quality housing, low educational attainment, unemployment, lack of leisure facilities, air pollution and a range of behavioural factors – such as smoking, physical inactivity, excessive alcohol, overweight and poor diet and social isolation – influence our ability to stay mentally and physically healthy and flourish.

Some of these behaviours are established at a young age – we know that obese toddlers are more likely to grow into obese children and obese children are more likely to grow into obese adults. So to give children their best chance of a healthy future, we need to start encouraging healthy eating and physical activity early.

A good start in life is also a key part of ensuring good mental health and wellbeing through life. For babies and young children, care and development are strongly linked, and the bond between baby and parent or carer is crucial.

Unhealthy behaviours have led to the rise in 'long-term conditions' (health problems such as diabetes that cannot be cured but can be controlled by medication or other therapies) and the increase in years spent in poor health. People with long-term conditions are more likely to experience mental health issues like depression and anxiety.

Obesity, long-term conditions and poor mental health are more common in people who live in more deprived areas – contributing to the significant health inequalities in our borough.

While some change can be brought about by the NHS, other actions need to be taken by the local authority and other statutory partners, businesses and employers, and local residents and communities. Indeed the NHS has acknowledged[1] that while the health service has improved dramatically over the past 15 years, the quality of care can be variable, preventable illness is widespread and health inequalities deep-rooted. It argues that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain depend on a radical upgrade in prevention and public health – this is a core principle of this strategy.

Role of the Health and Wellbeing Board

By law, every local authority is required to have a Health and Wellbeing Board (HWB), which is a committee of the local authority.

In Haringey the HWB is a small, decision-making partnership board. Members include councillors, the local authority's public health team, adult and children's services, the NHS (including local GPs), Healthwatch and the Community and Voluntary (VCS) sector. However, improving health and wellbeing in the borough is not the sole responsibility of one or two organisations; the responsibility is shared among us all.

The Health and Wellbeing Board (HWB) takes the lead in promoting a healthier Haringey. It has a general duty to promote the individual wellbeing of all local residents (Care Act 2014).

It has a duty to develop a joint strategic needs assessment (JSNA) and a Health and Wellbeing Strategy to prioritise effort to address needs identified by the JSNA.

Purpose of this strategy

This strategy will enable:

- all partners to be clear about our agreed priorities for the next three years
- all members of the HWB to embed these priorities within their own organisations and ensure that these are reflected in their commissioning and delivery plans
- key agencies to develop joined-up commissioning and delivery plans to address these priorities
- the HWB to hold member organisations to account for their actions towards achieving the priorities within the strategy
- members of the HWB to work with and influence partner organisations outside the HWB to contribute to the priorities and the approaches for working agreed within this strategy; this includes engaging residents in co-producing solutions.

The strategy will focus on a small number of priority areas to ensure these receive the required level of attention from the Board. The delivery plans that support each of these will set out the detail of how we will measure progress and achievement.

How we will measure success

- The inclusion of the priorities and approaches in the commissioning and delivery plans of board members and wider partners
- Monitoring the impact of our commissioned work
- Monitoring of the key Outcomes Frameworks
- Engagement with and learning from stakeholders and the community

Background

In recent years, there has been significant change across the health and wellbeing policy landscape. There are a number of policies and programmes, (national, regional and local) that the Health and Wellbeing Strategy must take account of, complement and implement. They include:

- Implementation of the Care Act
- Implementation of the Children and Families Act
- London Borough of Haringey Corporate Plan
- Haringey CCG Five Year Plan
- The London Health Commission's *Better Health for London* strategy

All of these policies and programmes share common outcomes;

- Better health, for longer, for everyone
- Improved wellbeing
- Reducing health inequalities
- Enabling people to be in control of their lives
- Resilient communities
- Safety (protection from abuse and neglect)

and lay out common principles:

- An approach that considers the health of all residents
- Tackling stigma and discrimination
- Prevention and early help – including supporting children to get the best start in life
- Strong, collaborative partnerships
- Working with communities
- High quality services that are joined up around individuals, and community needs, not those of the institutions providing services
- Promoting self-care and independence, underpinned by the right support
- Considering the impact on health and wellbeing of the environment, housing, and education

These outcomes and principles are strongly reflected in the Health and Wellbeing Strategy 2015-18 – having shaped the underlying vision, key priorities and approach to delivery. This ensures that the implementation of the Strategy can be pursued in an integrated way with all partners responsible for health and wellbeing in Haringey.

Process

In May 2014, the Health and Wellbeing Board began a programme to refresh the 2012-2015 Health and Wellbeing Strategy. The programme (see www.haringey.gov.uk/refreshing-hwb-strategy.htm) included:

- A review of the current strategy through a series of meetings with key stakeholder groups, and a workshop, survey and focus groups with the voluntary sector and residents organised by Healthwatch and HAVCO (see:

http://www.haringey.gov.uk/index/council/haveyoursay/ourtomorrow.htm).

- Reviewing the joint strategic needs assessment (JSNA) www.haringey.gov.uk/JSNA
- Identifying areas where the HWB needs to take a strong strategic lead.

The review showed that there have been improvements in health and wellbeing in the borough, including a reduction in infant mortality and teenage pregnancy and an increase in life expectancy.

However, some things are not going well at the moment – many people are becoming overweight and obese from an early age, developing long-term conditions at a relatively young age, and there are significant numbers of people with mental health issues. Unfortunately this is more likely in poorer areas of the borough where people face multiple challenges – this leads to inequalities in health, particularly in life expectancy.

There was a strong acknowledgement of the importance of factors such as the environment, housing, environment and education and their impact on health and wellbeing.

The review also stressed the importance of individuals and communities looking after their own health and wellbeing – and being actively involved in policy or service changes - needed to support this.

However the complexity of these issues, and the need for a longer-term consistent approach to address them was also recognised. Finally, there was support to continue the work that was started by the previous strategy (2012-2015) – and this strategy can be seen as a continuation of that, but with more focused effort and clearer principles for action.

Our vision, ambitions and priorities

Our vision is to work with communities and residents to reduce health inequalities and improve the opportunities for **all children, young people and adults to live healthy, fulfilling and long lives**

To achieve this vision, we have identified 9 ambitions for the future health and wellbeing of Haringey residents:

1. Fewer children and young people will be overweight or obese
2. More adults will be physically active
3. Every resident enjoys long lasting good health
4. Haringey is a healthy place to live
5. People can access the right care at the right time
6. More people will do more to look after themselves
7. More adults will have good mental health and well-being
8. More children and young people will have good mental health and well-being
9. People experiencing mental health crisis will receive the care they need when they need it

Progress towards these ambitions will be measured using the Key Performance Indicators listed in appendix 1.

Principles underpinning the strategy

In addition to the ambitions, the strategy is underpinned by three principles.

1. Tackling inequalities

Inequalities due to residents' different characteristics and social circumstances are, quite simply, unfair. Living in a fairer society with reduced health inequalities has both social and economic benefits. Our actions to tackle underlying factors of poverty and discrimination must be universal, but with a scale and intensity that is proportionate to the level of need in a certain area or community.

2. Prevention and early intervention

Prevention means shifting our focus from treating symptoms to reducing underlying causes. We have to prevent problems starting in the first place by creating environments where the healthy choice is the easier choice. Where problems arise, we need to act in partnership and intervene earlier to work with residents and communities to build on their own skills and capacity and improve outcomes for all.

3. Working with communities

Existing approaches to the delivery of public services traditionally focus on the deficits and vulnerabilities in a population. However, increasingly there is a desire to shift the focus of these services so that they build on residents' and communities' strengths, especially in areas and communities facing many challenges including higher levels of health need. This requires a radical transformation in how the public sector works, and how its relationship with communities is considered. Services will need to be designed with residents to ensure that every contact promotes independence, self-sufficiency, and a greater sense of self-worth and self-efficacy.

Approach to delivery

To achieve the 9 ambitions, the strategy will focus on three areas where we need to make the most significant and sustainable improvements:

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

This is a three year strategy and progress will be monitored every year against delivery plans for each of the priorities. See appendix 2 for the high level delivery plan structure.

For each priority, the key interventions for delivering the strategy are detailed below. There are three types of intervention: borough level interventions, working with communities and support through services.

Priority 1: Reducing obesity

Why this is a priority

Obesity in the UK is rapidly rising. By 2050 it is predicted that 60% of men and 50% of women will be obese.

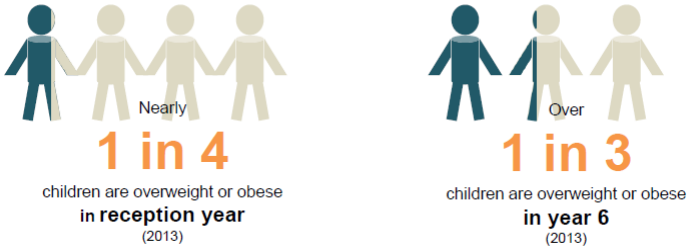
Obesity-related disorders and complications such as diabetes (a long-term condition), increase the time people live in poor health (unhealthy life expectancy) and reduce their life expectancy by an average of nine years. They also place a huge economic burden on health services and the wider economy. For instance, diabetes accounts for 10 percent of the total NHS spend.

Child obesity is particularly worrying because of its short and long-term effects. Obese children:

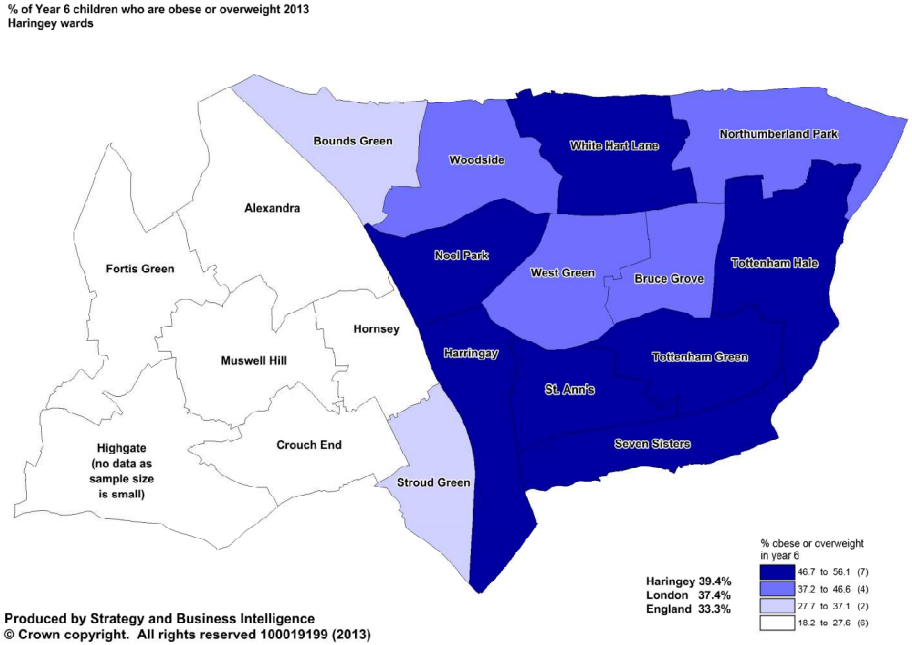
- are more likely to be ill and therefore absent from school and require more medical care than normal weight children
- are more likely to have tooth decay - the top cause for child non-emergency hospital admissions in most London boroughs
- are more likely to experience bullying and mental health issues including low self-esteem
- are at a higher risk of becoming an obese adult.

We know that in Haringey:[2]

1. A higher proportion of children are obese in both Reception (ages 4 to 5) and Year 6 (ages 10 to 11) than London and England as a whole (2012/13).



2. Obesity levels are closely linked to deprivation - Year 6 children living in deprived areas are 2.5 times more likely to be overweight or obese than those in more affluent areas.



3. Children from black and minority ethnic (BME) groups are more likely to be obese than white British children.
4. Many people with a learning disability have a problem with obesity.

5. Our local research with students shows that intake of fast food and sugary soft drinks tends to go up when it is easily available and cheap.

Where do we want to be by 2018?

- Prevention is key - we want the whole community and all of our partners to be committed to and involved in preventing obesity in the first place. We want a culture and environment that supports eating well and being physically active, where the healthier choice is the easier choice.
- We want the rise in childhood obesity to be halted.

What people have told us

Residents have told us that tackling obesity should be the responsibility of individuals, and that communities and the public and private sectors have a significant role to play in creating a healthier environment. More specifically, they told us:

- Inviting, welcoming facilities can help people be more active (e.g. the popular outdoor gyms). There needs to be effective promotion and marketing of these opportunities.
- Increasing the availability of safe places for people to walk, exercise and children of all ages to play
- Responses to the Council's *Investing in our Tomorrow* consultation included:
  - 1 in 3 think individuals could exercise more. One respondent said: *'We should promote the benefits of walking and cycling, for instance by ensuring cycling lanes are part of plans for improving roads.*
  - 42% of respondents think individuals could change their eating habits to eat healthier. '*Eat healthier and take exercise. Limit fast and processed food. Learn to cook and have support in learning how to cook from scratch...'*
  - Less unhealthy food. 26.32% of respondents think there are too many fast food shops in Haringey. *'Restrictions on fast food establishments would help.'*
  - Affordable and easily available exercise and healthy food options.
- Responses to the Council's public consultation on the Health and Wellbeing Strategy included:
  - 11% of respondents raised the importance of education about healthy living in schools
  - 11% of respondents think cooking classes would help people to eat healthier: *'Developing more family cooking projects will help children and families eat more healthily.'*
  - A number of respondents recognised the link between mental health and obesity: *'Help and support on a psychological level can also have an important role to play in initiatives to reduce obesity'.*
- In a focus group for the consultation, the Learning Disabilities Partnership noted that many people with learning disabilities have a problem with obesity. They felt this priority should include children and adults, especially if they are vulnerable and rely on others to meet their needs.

What are we going to do about it?

Education and personal responsibility are critical elements of any approach to reduce obesity; but they are not enough on their own. Additional interventions are needed that rely less on conscious choices by individuals and more on changes to the environment and societal norms. Such interventions help make healthy behaviours easier. They include reducing default portion sizes, changing the way food is marketed, and changing the urban and school environment to encourage physical activity.

Evidence strongly suggests that any single type of intervention is unlikely to be effective on its own, but many will contribute to a change. A recent report noted 74 cost-effective interventions in 18 areas.[3]

Similarly, no one part of society – the NHS, council, community groups, traders, restaurants, employers or individuals – can address obesity on their own. All need to be involved.

That is why we are forming a **Haringey Obesity Alliance –** a partnership between the Council, health and care services, schools, local businesses and voluntary and community groups committed to tackling obesity. The Obesity Alliance will provide a platform for partners to advocate, exchange information, and develop joint projects that help create a healthier Haringey. By working in partnership we can ensure that activities to tackle obesity are co-ordinated, effective and sustained.

The Obesity Alliance will be chaired by Haringey Council's Cabinet Member for Health and Wellbeing and will report to the Health and Wellbeing Board. It will develop, implement and monitor a delivery plan for fulfilling the Health and Wellbeing Strategy's ambitions around obesity:

1. Fewer children and young people will be overweight or obese
2. More adults will be physically active

See appendix 2 for a provisional Obesity Alliance delivery plan.

The majority of the interventions outlined below will be overseen or directly delivered by the Obesity Alliance, (some are distinct projects to be delivered by the Council).

1) Create a healthy environment – borough-level interventions:

Our aim is to create an environment where the healthy choice is the easier choice. One way to do this is for the Council to work with residents, developers and businesses to create healthy-weight environments through strong healthy public policy.

- The way we use the planning system to design our built environment influences the health outcomes of residents. We will work in partnership with planning, regeneration, environmental health, residents and businesses to co-ordinate a long term approach which will create a supportive health-enhancing environment where the healthy choice is the easy choice; for example, where it's easy, safe and enjoyable to play, walk or cycle.
- We will design a policy for the Local Development Management Plan to restrict the over-concentration of fast food outlets within 400 metres of schools. At the same time, we will work with and support schools and academies on their school food polices including their policies on 'open gates' at lunchtimes and possible alternatives.
- Develop a Food Charter with local stakeholders (including businesses and enterprise) to improve our food system.
- Shape the built environment through regeneration in Tottenham, in partnership with residents, businesses and communities as part of the Healthier Catering Commitment Scheme to improve the availability of healthy food.

2) Work with communities

Our aim is to work with residents and communities to build their ability to help themselves and others alongside offering 'early help' to those who need it.

- Develop an ambitious programme for resident-led community food growing
- Breastfeeding decreases the risk of obesity so we will continue to support women to breastfeed. Haringey has achieved Level 1 Baby Friendly Accreditation that has created supportive environments for women to breastfeed. Alongside this, the Council is piloting a healthy start vitamin offer, providing vitamins to all pregnant and breastfeeding women and children under four.
- Work with parents of young children to share their experience and learning from the HENRY programme with other parents (parents supporting other parents).
- Continue to work closely with schools to support them in promoting healthy eating, physical activity and emotional wellbeing throughout the whole school community. This includes the Healthy Schools Programme linked with the Smarter Travel and Sport, Leisure and Park initiatives.
- We will train community leaders and interested residents to promote healthy lifestyle messages and information to residents. The public consultation confirmed that many residents are willing to spread healthy lifestyle messages to their peers and associations.
- We will promote opportunities for residents to take part in healthy cooking classes.
- Work with local residents and community leaders to expand the number of Haringey 'Playstreets' – a scheme that allows local children and families to reclaim their neighbourhoods by closing selected streets to through traffic, and turning them into temporary play streets.

- Supporting local businesses to develop healthy workplace policies and programmes to encourage healthy eating choices and increase physical activity levels. The Council and local NHS organisations can take a leadership role in this as they employ a significant number of Haringey residents; as commissioners, they could encourage such practice in providers through contracts.
- Build on links with sports activities (schools, leisure and key partners – e.g. Tottenham Hotspur Football Club) to improve access to and engagement for young people and for adults.

3) Support through services

Ensure that tackling obesity is an integral consideration within the Council's transformation programmes such as the Best Start in Life work stream (Priority1), Early Help and the Tottenham regeneration programme, and within NHS plans.

- Transform the health visiting service to enable universal delivery of the Healthy Child Programme (pregnancy to age five) to support prevention and early intervention.
- Ensure that all schools and all professionals who work with children and young people continue to have access to funded child obesity training to enable them to work sensitively and effectively with families.
- Develop and promote obesity pathways to help professionals support children, young people, families and vulnerable groups (such as adults with learning disabilities) who have concerns regarding their weight.
- Ensure all services 'make every contact count'. We will train health and social care professionals and other front-line staff to promote healthy lifestyle messages and information to residents. This will include mental health promotion given the role that mental wellbeing plays in tackling obesity.
- The recently developed Haringey Sports and Physical Activity Framework with its vision of an 'Active Haringey' will help more people to become active through raising awareness of how to integrate physical activity into the daily lives of residents. The framework, developed with partners, includes a particular focus on children and young people.

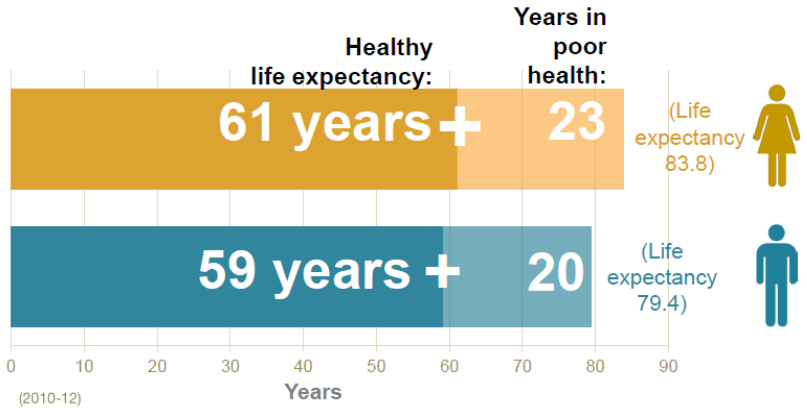
We will know it's working when

- Healthy lifestyle change is embedded as an objective in council, CCG and partners' strategies and policies
- More mothers breastfeed
- More people are eating healthier options. This includes vulnerable groups such as children and young people, and adults - especially those with impairments.
- More children, families and adults, especially those with impairments, are more active and are visiting local sports centres and use the outdoor gyms
- More schools achieve their Healthy School awards. We will strive for 50% of schools to achieve their Healthy School Bronze and 25% to achieve their Silver awards.
- We halt the rise in childhood obesity.

Priority 2: Increasing healthy life expectancy

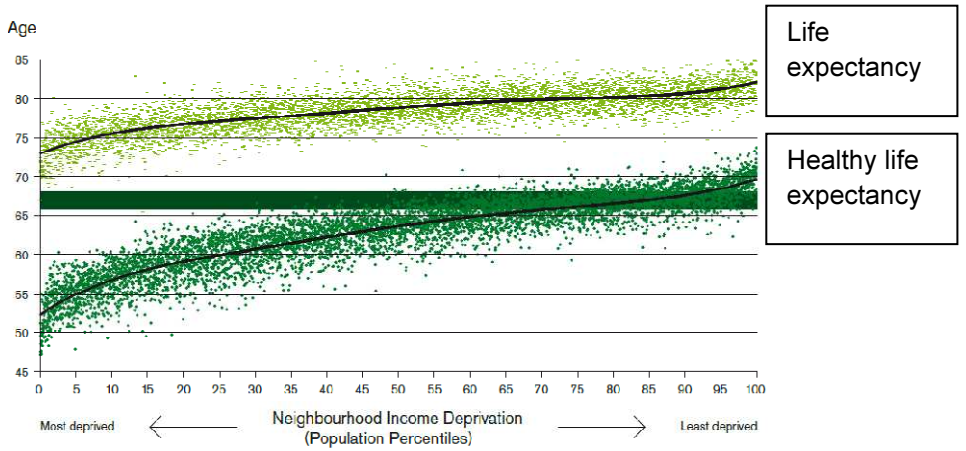
Why this is a priority

On average, women in Haringey live the last 23 years of life in poor health, compared to 19 years for women in England as a whole. Men in Haringey live the last 20 years of life in poor health, compared with 16 years for men in England.



The major cause of reduced life expectancy and early deaths are 'long-term conditions' – health problems such as cardiovascular disease, diabetes, cancer and respiratory disease that cannot be cured but can be controlled by medication or other therapies. They can have a strong impact on the quality of life of individuals and their families. They increase the risk of mental health problems and affect wellbeing.

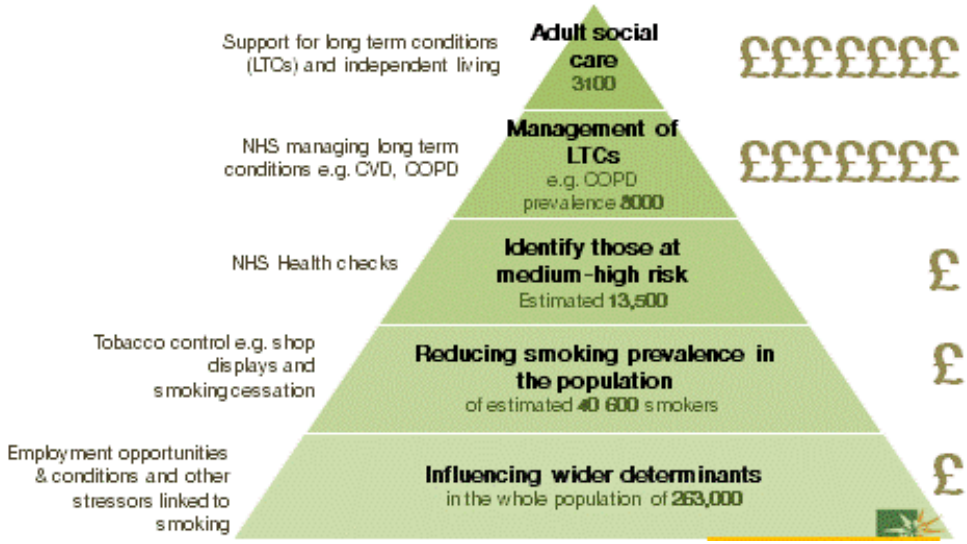
Long-term conditions are more common among people from lower socio-economic groups and certain black and minority ethnic (BME) groups (related to a combination of deprivation, discrimination and genetics). They are a major contributor to the difference in poor health or unhealthy life expectancy within the borough - on average, 8 years poorer health for men and 3 years for women in the east compared to the west. They are also the main reason for the gap in life expectancy between the east and west of the borough. Both are markers of inequality. The figure below shows this strong link across the country.



The number of people with long-term conditions is increasing. This is partly due to the fact that our population is aging, but is also related to increases in physical inactivity, poor diet, smoking and alcohol misuse. The causes of long-term conditions are largely preventable.

Haringey has an estimated 23,895 residents aged 65 or over. An estimated 3 in 4 people over the age of 65 who are registered with Haringey GPs, have at least one long-term condition.

The figure below shows our approach to managing the impact of one behavioural factor – smoking – on health.



What people have told us

At engagement events led by Haringey CCG, local residents said the following would improve care in the borough:

- Better access to GPs and primary care services, particularly in the east of the borough.
- Integration of services across health and social care
- Ensuring that integrated services are accessible to all
- Promoting a holistic approach to health and wellbeing
- Ongoing community engagement to help build strong local networks and promote peer support schemes.
- Better working with the community and voluntary sector. More co-production with community groups to tackle the specific health needs of different communities.

20% of respondents to the Council's *Investing in our Tomorrow* consultation gave specific suggestions about supporting people to age better; one respondent said: *'Support individuals and organisations that care for older people, with funding and with appreciation. Ensure the streets are clean. Introduce better and more police. Better street lights. Better medical services.'*

In focus groups for this consultation residents told us that one of the main barriers to being healthy was a lack of information about having a healthier lifestyle, as well as the cost and accessibility of exercise and healthy food options.

11% of respondents to the public consultation on the Health and Wellbeing Strategy raised the need to tackle social isolation as a contributing factor to long term health conditions, particularly amongst the elderly: *'Reducing the feeling of loneliness can take a lot of pressure off people who live alone, reducing blood pressure, risk of stroke etc'*

Where do we want to be by 2018?

- We want to prevent people from developing long-term conditions, wherever possible. This means we want a borough that enables people to make the healthy choice the easy choice – being more active, eating well, not smoking and not drinking to excess. We want people to be more informed about healthy lifestyles. We want residents to take a more proactive role in their own health and wellbeing (physical and mental).
- We want people who have long-term conditions to feel confident to manage their condition and continue to live a normal life.

- We want residents and communities to play a greater role in supporting people with long-term conditions to live longer and healthier lives.
- We want all people with long-term conditions and their carers to have access to high-quality primary care.
- When people need more complex support, we want them to experience joined up health and social care services.

What are we going to do about it?

1) Create a healthy environment - borough-level interventions:

- We aim to create an environment that prevents people from getting long-term conditions in the first place; if they do develop an illness, this will also support them to manage their conditions better. We will do this by working in partnership with planning, regeneration, environmental health, residents and businesses to create an environment where the healthy choice is the easy choice, so people are more likely to walk and cycle, eat well, stop smoking and not drink to excess
- This will include strengthening tobacco control, and having a consistent approach to local alcohol licensing applications.

2) Work with communities

- We will work with residents, communities and the Community and Voluntary sector (VCS), to equip residents with the skills and knowledge to live healthy lifestyles, for example:
    - Through the Well London Programme with an initial focus on Northumberland Park.
    - Through Health Champions to promote healthy lifestyles within their own communities.
- We will support voluntary organisations to improve opportunities for people to actively participate in volunteering.
- We will support people to have improved access to learning and to employment.
- We will promote expert patient/peer support schemes programmes that assist people with LTCs (and their families) to understand their conditions and how to manage them.
- We will work with specific community groups to tackle long term conditions and their risk factors i.e. BME, LGBT groups.

3) Support through services

- We aim to improve services so that people are supported to live healthy lifestyles to prevent them from getting long-term conditions in the first place.
- We will improve services so that people who already have long-term conditions receive early help to have a better quality of life and improved health. This includes reviewing and strengthening self-management programmes to support them and their carers in managing their condition.
- We recognise that unpaid carers play an invaluable role in supporting those they care for in the community, and we will support them to carry on caring and to have a life of their own beyond this responsibility. We will do this through the provision of bespoke carer's assessments and such support as may be required.

Service support to promote healthy lifestyles

- We will implement the Making Every Contact Count programme across primary care, front-line council services and the voluntary sector. This will equip front-line staff to offer advice to people on a range of lifestyle issues including smoking, alcohol, diet, physical activity and mental health.
- We will support social prescribing; enabling GPs to refer people to community initiatives that provide support.
- We will integrate our existing behaviour change programmes including Stop Smoking, NHS Health Checks, Health Trainers and Health Champions and the GP Exercise Referral Scheme, making it easier for residents to get help earlier and in an integrated, holistic way.

Service support for people with long-term conditions

- We will further develop and implement care pathways for diabetes, chronic obstructive pulmonary disease (COPD), cancer and heart failure. We will do this in partnership with people with these conditions and their carers.
- We will develop integrated health and social care locality teams that will use holistic health and social care plans developed with patients and their carers to prevent their long-term condition getting worse.
- When people need support, there will be a single point of access to integrated health and social care services.
- We will further develop the Reablement Service to provide access for a greater number of people. The service will focus on learning or relearning daily living skills to sustain independence and to prevent readmission to hospital.
- We will strengthen primary care so that it can provide high quality, proactive and holistic services with improved access by:
  - Continuing to support education and training for clinicians and other staff to improve treatment and care.
  - Supporting GP practices to work together so that they can offer improved access to borough residents.
  - Ensuring that there are sufficient GPs for our residents, especially in areas of population growth.

We will know it's working when

- There are more visible, sustainable community-led health initiatives, such as Well London.
- Fewer residents smoke, are overweight, physically inactive or drink to excess
- People report improved access to quality primary care
- More people say they received the support they needed to manage their long-term health condition
- Fewer people with long-term conditions feel lonely
- Fewer caring relationships break down
- Fewer people with long-term conditions have an emergency admission to hospital
- There is an improvement in healthy life expectancy for men and women in all parts of the borough.

Priority 3: Improving mental health and wellbeing

Why this is a priority

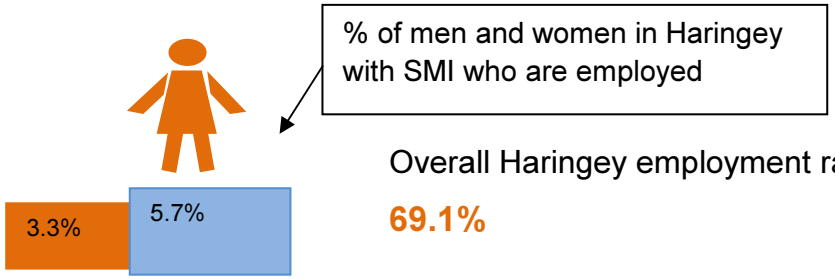
Our mental health and wellbeing have a great impact on our ability to live happy and fulfilling lives, achieve our goals, have good social relationships and contribute positively to society. However, 1 in 4 people will experience some form of mental health problem during their lives, ranging from mild anxiety and depression to severe mental illness. Those who experience poverty, unemployment, social isolation, poor quality housing and lower levels of education, or are exposed to violence or substance misuse, are more at risk of developing mental illness.

In Haringey:

- it is estimated that over 3,000 children and young people will have some form of mental health problem at any point in time and over 34,500 adults will have a common mental disorder (anxiety or depression)
- there are approximately 4,000 adults locally living with Severe Mental Illness (SMI) - three times more than expected, given the borough's levels of deprivation, unemployment and other factors which impact on mental wellbeing
- Suicide rates are 33% higher than the London average, especially for young men and some black and minority ethnic (BME) groups.

Despite high levels of mental illness in Haringey, a large proportion of our residents do not seek professional help. This is possibly due to the stigma and discrimination surrounding mental illness, along with a lack of trust and understanding of how statutory health services work.

People with mental ill-health in Haringey are less likely to find employment or live in settled accommodation.



Source: ASCOF 2013 *Source: Census 2011*

People with Serious Mental Illness (SMI) are more likely to be affected by lifestyle risk factors than the general population. They are more likely to have poor physical health and long-term conditions and are at risk of dying significantly younger.

Source: GP registers, Haringey 2011/12

What people have told us

Local people have told us that they would like:

- A focus on prevention of mental illness and improvement of mental health and wellbeing
- More emphasis on the impact of drugs and alcohol on mental health
- More interventions at an earlier stage of ill health to tackle social isolation
- More focus on information, advocacy and support for children's and adults' mental health services
- Better outreach for people living with mental illness
- Seamless services supporting people to live independent, fulfilling lives in the community, with opportunities to volunteer.
- Communities to be used more to provide access to advocacy and employment opportunities e.g. peer mentoring and support
- Support for self-help
- Better training of professionals, and better awareness and understanding of mental health throughout society.
- More focus on transitions (into adulthood, parenthood) through improved cross-organisational communication.
- Services that use a person-centred response to respond to individual needs and preferences.

Where do we want to be by 2018?

- We want to promote opportunities that would positively impact on mental health and wellbeing e.g. employment, affordable housing, use of green spaces, a safer community
- We want our children and young people to be emotionally and mentally resilient and have a positive outlook on life
- We want our residents and communities to build on existing strengths and capacity to be solution-oriented
- We want mental health services to be integrated, flexible and person-centred (wrapped around an individual, their family and their carers' needs);
- We want to mobilise a whole system approach in enabling people with mental ill-health to be supported in the community to live independently and have satisfying, hopeful and meaningful lives.
- We want to end the stigma around mental ill health in Haringey, and improve understanding.

What are we going to do about it?

Haringey CCG and the Council published a joint Mental Health and Wellbeing Framework that sets out our ambition for transforming mental health services locally and improving the mental health and wellbeing of our residents. There needs to be a greater focus on moving care from inpatient settings to the provision of integrated services in the community and a focus on support for independent living. We recognise that successful examples of mental health service modernisation did not happen overnight and we will reflect this in a phased approach over the

next three years in the Mental Health and Wellbeing Framework Delivery Plan.

The Framework has four local priorities:

1. Promoting mental health and wellbeing and preventing mental ill-health across all ages
2. Improving the mental health outcomes of children and young people through commissioning and delivering effective and integrated interventions and treatment and focusing on transition into adulthood
3. Improving the mental health outcomes of adults and older people by focusing on three main areas:
    - meeting the needs of those most at risk
    - improving care for people in mental health crisis
    - improving the physical health of those with mental-ill health and vice versa
4. Commissioning and delivering an integrated enablement model which uses individuals' and communities' assets (or strengths) as an approach to support those living with mental illness to lead fulfilling lives.

This Health and Wellbeing Strategy will have high level oversight of the delivery of the whole Framework and focus further specifically on mobilising system leadership and cross-partnership working to ensure that the design, commissioning and delivery of an innovative enablement model is based on community assets. This approach will improve outcomes for people with mental ill health summarised in three simple terms: LIVE - for example, having good housing or access to welfare benefits advice), LOVE - having fulfilling social relationships and DO – having either employment or volunteering opportunities

We will deliver this by focusing on the following areas:

1) Create a healthy environment- borough level interventions:

- We will strive to create a safer environment in Haringey that will positively impact on maintaining wellbeing
- We will create more opportunities for people to get appropriate employment, volunteering opportunities, affordable housing and create social networks
- We will work across Haringey to reduce stigma and discrimination associated with mental ill health. This includes a change of attitude within workplaces/ employment with an improvement in how people with learning disabilities or mental ill health have access to and are treated at work.

2) Work with communities

- We will support the Community and Voluntary sector (VCS) and other interested providers (e.g. housing associations) to create an innovative and integrated enablement model that is seamless and effective and builds on the existing assets in the community
- We will work together with residents and the VCS to develop an asset-based community approach that promotes independence, self-reliance and resilience and reduces social isolation

- We will develop effective pathways into employment and housing for people with mental ill-health and develop support for people in employment to better manage episodes of mental ill-health and to sustain employment through the experience
- We will create community-based services and interventions for people with mental ill-health, their families and carers so they feel supported and know where to turn for help (e.g. by promoting befriending and peer support schemes)
- Safeguarding partners, with the local authority as lead agency, will take a community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that safeguarding arrangements are there to protect individuals (children and adults).

3) *Support through services*

We will create a whole system approach to integration and enablement by:

- Integrated commissioning which supports joined up delivery of services, including through commissioning services based on the outcomes people value
- Integrating our services, including through multi-disciplinary hubs, to ensure a person experiences a more seamless service
- Designing and implementing effective primary care mental health services.

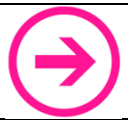
We will know it's working when

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will mental health problems will have employment and live in settled accommodation
- More people will have a positive experience of care and support, including carers
- More people who use services will feel more in control of their life
- Fewer people will experience stigma and discrimination
- Fewer people will leave employment as a result of episodes of mental illness

Appendix 1 – Key Performance Indicators

For each ambition, a specific target will be set to enable progress to be monitored. The 2018 targets in the table below are **provisional, indicative targets** and may differ from the final targets set by the Health and Wellbeing Board. For the Mental Health ambitions there is a need to carry out further work to establish the 2015 baselines before 2018 targets are set.

Ambition		Key Performance Indicator	2015 baseline	2018 target
Fewer children and young people will be overweight or obese		Halt the rise in overweight or obese children at year 6 (ages 10-11)	Overweight: **15.2%** Obese: **22.8%** (Total: **38.0%**)	**Halt** the rise in overweight or obese children (HWB target)
More adults will be physically active		Reduction in proportion of adults participating in less than 30 minutes of physical activity per week	Percentage of adults who do less than 30 minutes of physical activity per week: **26.8%**[4]	Reduction in percentage of adults who do less than 30 minutes of physical activity per week to **25%** (HWB target)
Every resident enjoys long lasting good health		Reduction in age-standardised rate of mortality considered preventable from stroke in those aged <75 per 100,000 population	Stroke mortality rate 2011-2013: **22.5 per 100,000**	**Reduction of 25%** in the current stroke mortality rate for the three year average 2016-18 (Corporate Plan Priority 2 target)
Haringey is a healthy place to live		Proportion of people who travel by bicycle in London where trip origin is in Haringey[5] Proportion of people who travel by walking in London where trip origin is in Haringey[6]	2012/2013 = **2%** 2013/2014 = **38%**	Increase in the number of people who cycle by 2018* Increase in the number of people who walk by 2018*
People can access the right care at the right time		Increase in patients able to get an appointment to see or speak to someone	**80%** patients in Haringey CCG were able to get an appointment to see or speak to someone[7]	**83%** patients report they are able to get a GP appointment to see or speak to someone (HWB target)
More people will do more to look after themselves		Percentage of people in last 6 months, who have enough support from local services/	**57%** (including those supported 'to some extent')	**59%** adults feel supported to manage their long term conditions (BCF target)

		organisations to help manage long-term conditions[8]		
More adults will have good mental health and well-being		Warwick-Edinburgh wellbeing score from local survey	2015 baseline survey	Increase the average score of adults on the short Warwick-Edinburgh mental wellbeing scale by 2018**
More children and young people will have good mental health and well-being		Mental health and wellbeing score per new survey to be commissioned as part of corporate plan priority 1	2015 baseline survey	Improvements in measures by 2018**
People experiencing Mental Health crisis will receive the care they need when they need it		Number of people sectioned under the mental health act (section 136)	2015 baseline to be established	Reduction in number of sections by 2018**

* Specific 2018 target will be set as part of Corporate Plan Priority 3 performance monitoring

** HWB targets for the mental health ambitions will be set once baseline surveys and research have been carried out

Appendix 2 – Delivery Plan

We have developed a delivery plan to implement the Health and Wellbeing Strategy. The Delivery Plan details the programmes and projects that will deliver the interventions identified in the Health and Wellbeing Strategy.

Delivery plan format

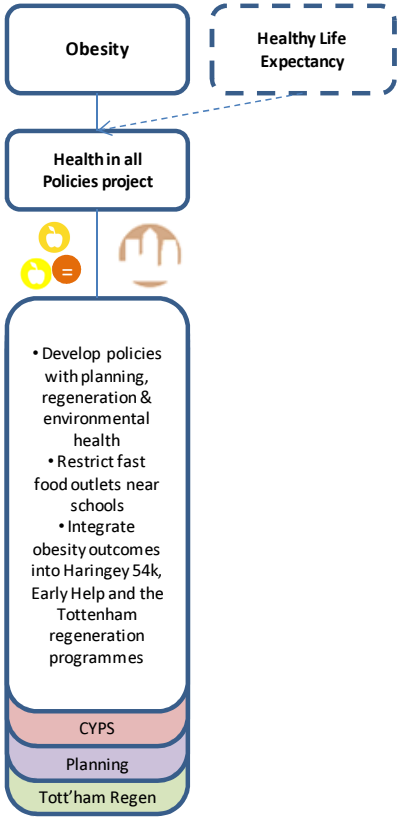
Full box – portfolio name
Dashed box – indicates where a programme is within two portfolios

Programme/project name

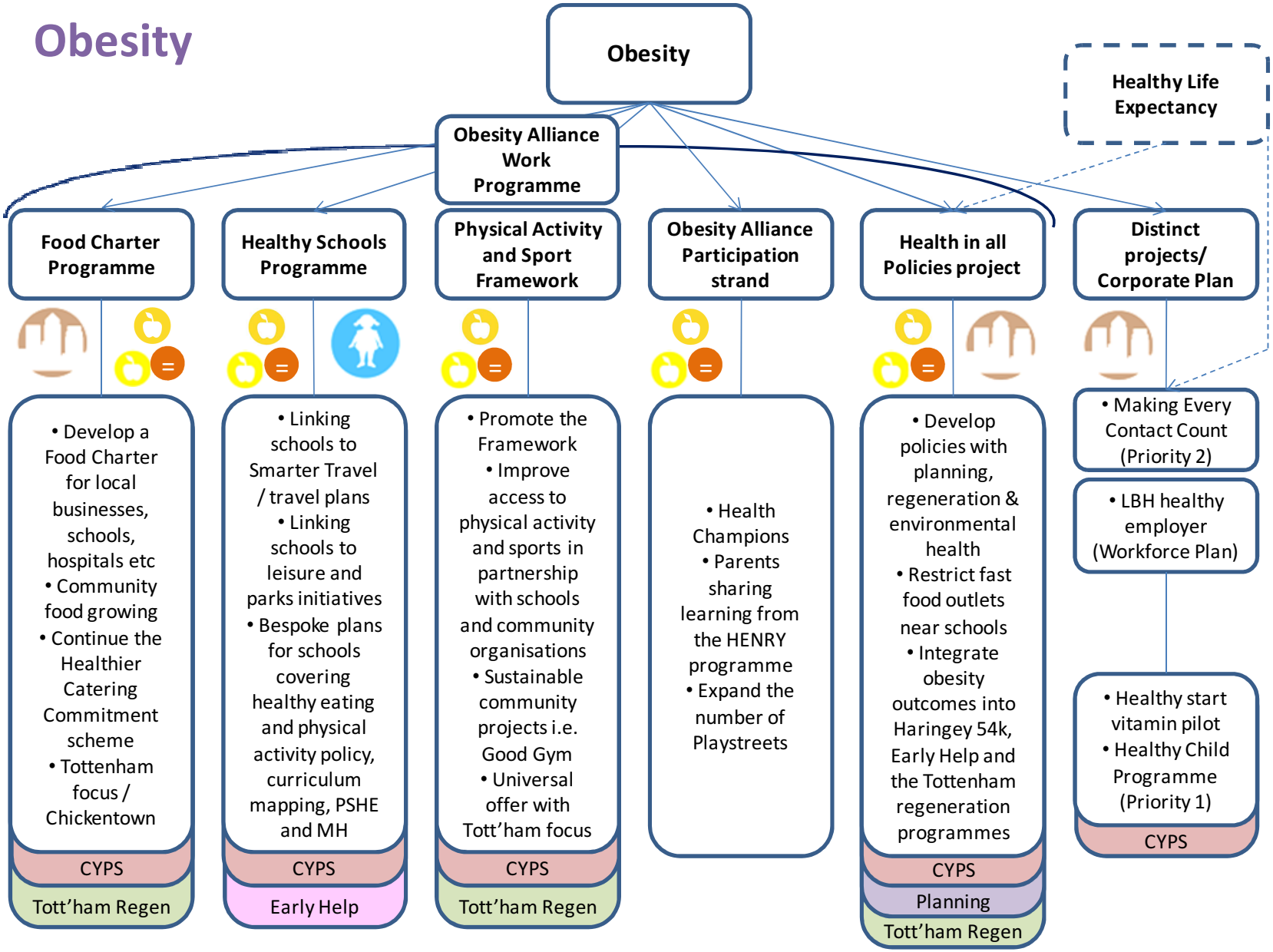
Ambitions that the programme/project delivers

Projects and interventions *identified in the Health and Wellbeing Strategy* that will be delivered by the programme/project.
(This is not an exhaustive list of everything delivered by existing programmes)

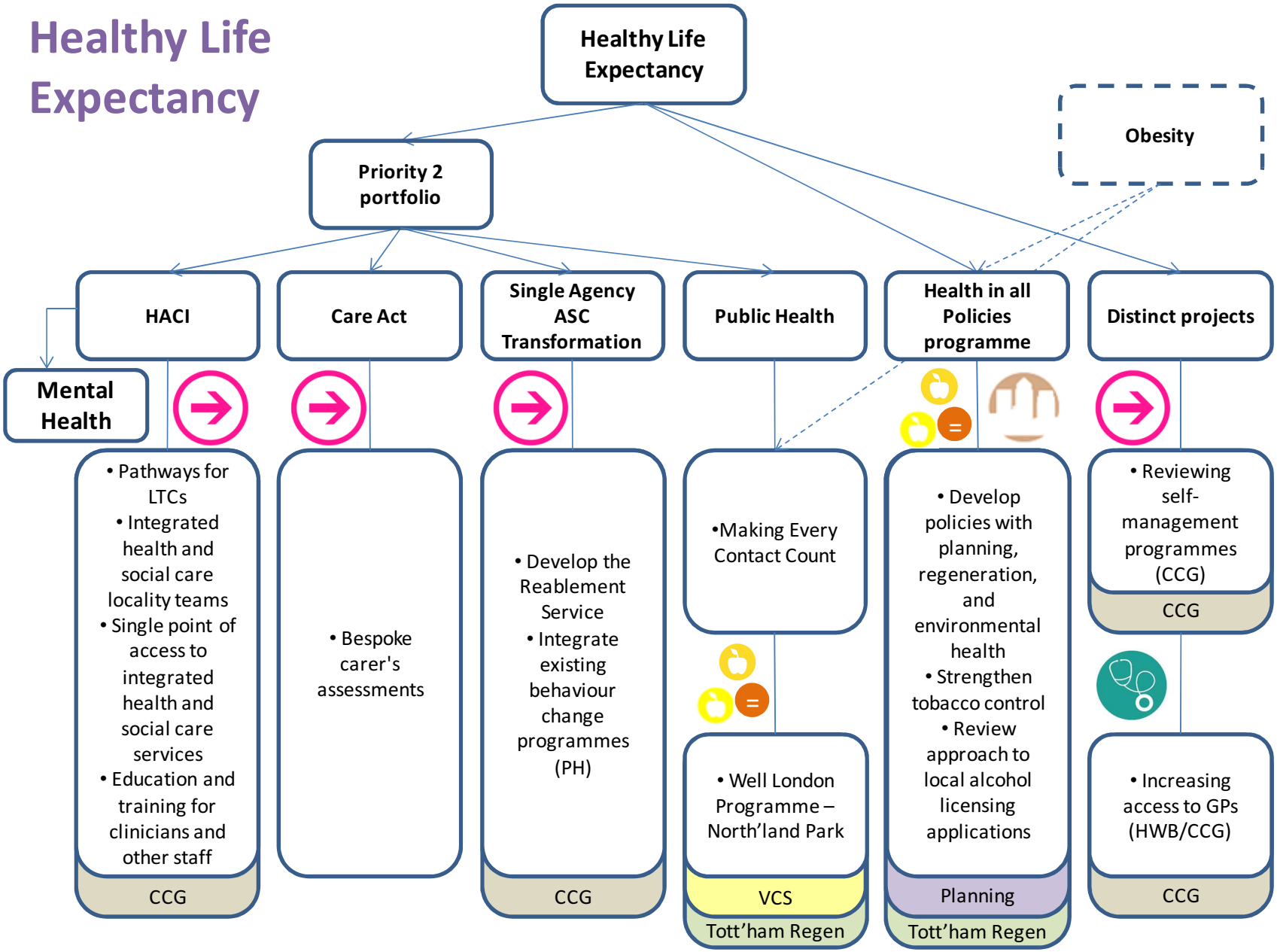
Dependencies with other departments, programmes and partners



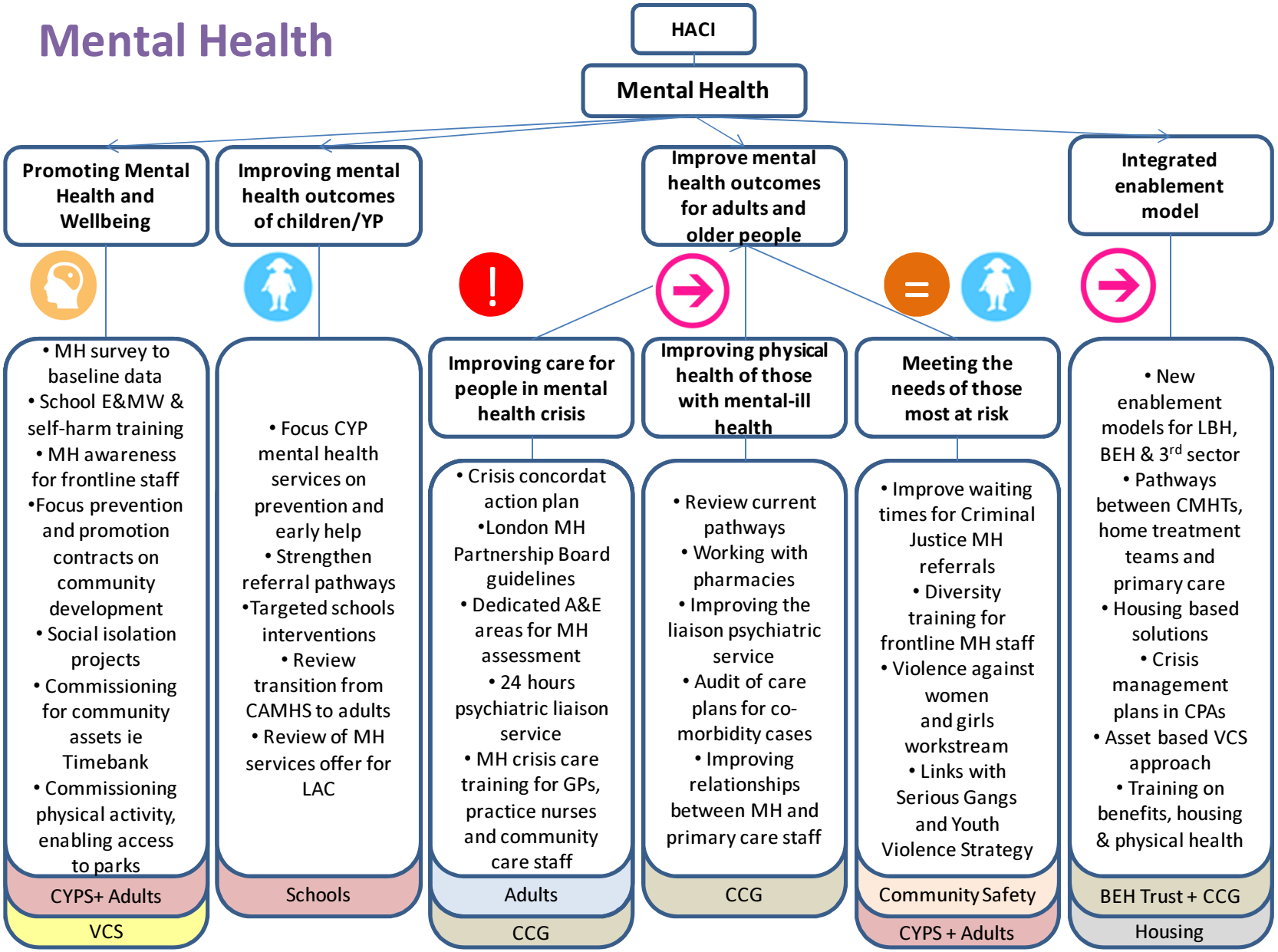
Obesity


Obesity
Healthy Life Expectancy
Obesity Alliance Work Programme
Food Charter Programme
Healthy Schools Programme
Physical Activity and Sport Framework
Obesity Alliance Participation strand
Health in all Policies project
Distinct projects/ Corporate Plan
• Develop a Food Charter for local businesses, schools, hospitals etc
• Community food growing
• Continue the Healthier Catering Commitment scheme
• Tottenham focus / Chickentown
CYPS
Tott'ham Regen
• Linking schools to Smarter Travel / travel plans
• Linking schools to leisure and parks initiatives
• Bespoke plans for schools covering healthy eating and physical activity policy, curriculum mapping, PSHE and MH
CYPS
Early Help
• Promote the Framework
• Improve access to physical activity and sports in partnership with schools and community organisations
• Sustainable community projects i.e. Good Gym
• Universal offer with Tott'ham focus
CYPS
Tott'ham Regen
• Health Champions
• Parents sharing learning from the HENRY programme
• Expand the number of Playstreets
• Develop policies with planning, regeneration & environmental health
• Restrict fast food outlets near schools
• Integrate obesity outcomes into Haringey 54k, Early Help and the Tottenham regeneration programmes
CYPS
Planning
Tott'ham Regen
• Making Every Contact Count (Priority 2)
• LBH healthy employer (Workforce Plan)
• Healthy start vitamin pilot
• Healthy Child Programme (Priority 1)
CYPS

Healthy Life Expectancy



Mental Health



Appendix 3 – Related strategies and plans

Haringey Council Corporate Plan 2015-2018

The new council plan has a clear connection with improving general health and wellbeing with its priorities of:

- Supporting children and families to thrive
- Enabling adults to live longer and healthier lives
- Cleaner, greener safer streets and public places
- Better housing and stronger communities
- Promoting economic growth.

Haringey Clinical Commissioning Group Five-Year Plan

The four core objectives of the plan are to:

- Explore and commission alternative models of care
- More partnership working and integration as well as a greater range of providers
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing
- Redefine the model for primary care providing proactive and holistic services for local communities, supporting "healthier Haringey as a whole".

NHS North Central London Five-Year Plan

The NHS North Central London (NCL) is completing its five-year strategic plan which aligns the plans across Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups. Success is dependent on the development of stronger partnerships and collaboration across NCL CCGs and with local authorities.

The vision is to develop an integrated care network between organisations (supported by current technology to share clinical records) focused on outcomes for and shaped by patients. There is a need to support patients in having a more independent role in looking after their own health needs which will be achieved through greater patient participation in shaping local healthcare.

This vision will be achieved when the NCL health system demonstrates characteristics in line with health and wellbeing board strategies:

- A systematic approach to prevention including earlier diagnosis of disease
- Reducing inequalities in health outcomes by targeting vulnerable groups
- Individuals encouraged and supported to take greater responsibility for their health
- Integrated, compassionate, high quality, effective and efficient care pathways that are shaped by patients
- Easy access to services delivered in ways and places convenient to patients
- Financial sustainability though a clinically driven focus on quality of services.

Community Safety Partnership

The vision of the Community Safety Partnership (CSP) Strategy 2013-17 is to make Haringey one of the safest boroughs in London. The CSP works closely with health and safeguarding partners to address alcohol, drugs and mental disabilities as critical drivers of offending, disorder and ill health across all crime types. An effective community safety programme makes a significant contribution to good health and wellbeing, evident in the activities supporting the six outcomes.

Outcome 1: Rebuild and improve public confidence in policing and maintaining community safety

Outcome 2: Prevent and minimise gang-related activity and victimisation

Outcome 3: End violence against women and girls by working in partnership and promote healthy and safe relationships

Outcome 4: Reduce re-offending with a focus on 16-24 year olds

Outcome 5: Prevent and reduce acquisitive crime and anti-social behaviour

Outcome 6: Deliver the PREVENT strategy (which aims to stop people becoming terrorists or supporting terrorism)

Haringey Council Priority 1 Board – Best Start in Life

The Priority Board provides strategic oversight of Priority 1 – Best Start in Life. It is responsible for setting strategic direction for the delivery of outcomes for children and families and the savings outlined in the Medium term Financial Strategy. The Board provides operational assurance of change projects and business as usual in pursuit of the outcomes and savings.

The Board takes an intelligence led approach, building on customer insight and other relevant data, and ensures that the design, commissioning and development of services will secure ambitious outcomes in a context of reducing resources.

There are eleven work streams including:

- *Early help:* ensuring there is evidence-based provision to meet the needs of families
- *Looked after children:* ensuring sufficient quality placements and developing the fostering service
- *Children with additional needs:* preparing for special educational needs and disability (SEND) reforms and implementing a joint commissioning approach with partners.

Tottenham transformation programme

Tottenham is the most deprived area in the borough – and this where, on average, our health outcomes are poorest. We want Tottenham to be a thriving place where people choose to live, work and stay throughout their lives, and this is the focus of many excellent projects, some of them conducted with partner agencies and organisations.

Our Strategic Regeneration Framework – a landmark 20-year vision for the future of Tottenham – sets out how local people's priorities could be achieved through long-term regeneration. It includes not just new buildings and a changing landscape but also a strong social element. The 2014 Tottenham Delivery Plan places 'people' priorities alongside 'place' priorities:

- *World-class education and training* – including new schools, better access to apprenticeships and more young people at university

- *Improved access to jobs and business opportunities*
- *A different kind of housing market* – improving existing homes and building new, high-quality homes to meet demand
- *A fully connected community with even better transport links* – improving rail, Tube and bus links and more walking and cycling routes
- *A strong and healthy community* – improved healthcare facilities, reduced crime and strong social networks for young people
- *Great places* – putting Tottenham's character and heritage centre-stage, creating better public spaces to meet, shop and have fun
- *The right investment and quality development.*

Appendix 4 – Funding

Both Haringey Council and the local NHS continue to manage a highly challenging financial position in the short and medium term. Budgetary pressures are significant with services operating in an environment of rising customer expectations and demand for higher quality services. Demand for health and social care services is expected to continue to rise due to demographic change and the increase in illness linked to lifestyle risk factors. These factors are placing additional pressures on finite resources.

Other partners contributing to health and social care, including the Voluntary and Community Sector are similarly experiencing constraints on funding. We need to work with partners to ensure efficient use of our funding; and to attract further investment into the borough.

The programmes and initiatives outlined in this strategy will reshape and integrate services, producing some savings and efficiencies. With less funding for services, those services that are provided must work effectively and produce the results that are needed.

There have also been changes to welfare which have impacted on the benefits some individuals and families receive. Ongoing welfare reform poses a challenge for Haringey in:

- minimising the impact on household incomes and children
- increasing the number of residents in sustained employment while ensuring those entitled to claim welfare benefits can do so.

Haringey Council budget

The overall level of funding for local authorities has been significantly reduced from 2011 to 2015 (in the region of 29%) and further reductions are scheduled or expected for the period of this strategy (2015-18).

As a result, Haringey Council is expecting to have to make savings of at least £70 million by the end of this period (in addition to the £117 million reduction that has already been made since 2010.) This will be managed through the Medium Term Financial Planning Process (which is part of the Corporate Planning process). For the current proposals see: http://www.minutes.haringey.gov.uk/mgAi.aspx?ID=40179#mgDocuments

The 2014-15 net revenue budget is £281 million which includes budgets allocated to adults social care and children and young people's services; and the Public Health Grant of £18 million. These budgets support the delivery of two priorities in the new Corporate Plan:

- £55 million for Corporate Plan Priority One - Enable every child and young person to have the best start in life, with high quality education
- £88 million for Corporate Plan Priority Two - Empower all adults to live healthy, long and fulfilling lives

Haringey NHS Clinical Commissioning Group (CCG) budget

- The overall budget available to the CCG for 2014/15 is £326 million. The CCG is currently forecasting expenditure of £326 million in 2014/15 and a break-even position at the end of the year. This is consistent with the financial plan agreed at the start of the year with NHS England. A breakdown of forecasted 2014/15 expenditure is shown in the table below.

	£m
Acute and Integrated Care	194.6
Mental Health	36.8
Community Health Services	32.2
Continuing Care	19.5
Primary Care	33.6
CCG Operating Costs	9.1
Total CCG Expenditure	**325.8**

- The financial outlook for 2015/16 is challenging. The CCG has recently been informed of its budget for 2015/16 and is planning to deliver a balanced financial position at the end of the financial year. In order to achieve this, it is believed that the CCG will need to deliver financial efficiencies of in excess of £9 million.

Glossary

BCF	Better Care Fund
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
HAVCO	Haringey Association of Voluntary and Community Organisations
HENRY	Health Exercise Nutrition for the Really Young
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
LGBT	Lesbian Gay Bisexual and Transgender
NCL	NHS North Central London
SEND	Special Educational Needs and Disability
SMI	Severe Mental Illness
VCS	Voluntary and Community Sector

Notes

[1] NHS Five Year Forward View, NHS England. October 2014
[2] Information on Childhood obesity has been drawn from the Haringey JSNA. See http://www.haringey.gov.uk/jsna-childhood-obesity.htm
[3] McKinsey Global Institute. *Overcoming obesity: an initial economic analysis.* Nov, 2014
[4] The number of respondents aged 16 and over, with valid responses to questions on physical activity, doing less than 30 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16 and over.
[5] TFL data for 2012/13 relates to an average for period 2010/11 to 2012/13. LIP target is for cycling mode share of 3% by 2013/14 and 5% by 2025/26.
[6] TFL data for 2012/13 relates to an average for period 2009/10 to 2011/12. No data is available for 2012/13 year alone. LIP target is for walking mode share of 32% by 2013/14 and 35% by 2030/31.
[7] Including answers ‘Yes, but I had to call back closer to or on the day I wanted’.
[8] Applies to all people who have a medical condition.

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Haringey Council Clinical Commissioning Group NHS Haringey healthwatch Haringey HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

Consultation summary for the Health and Wellbeing Strategy 2015-18

This document outlines the consultation work that has been carried out to inform Haringey Health and Wellbeing Board's *Health and Wellbeing Strategy 2015-18*. It provides a detailed summary of the responses to the public consultation carried out in February-March 2015.

Evidence gathering and early consultation work to inform the draft Health and Wellbeing Strategy

Haringey Health and Wellbeing Board launched a refresh of the Health and Wellbeing Strategy in July 2014. This began with an update of the data measures that had informed the current 2012-2015 strategy, and a review of the Joint Strategic Needs Assessment (JSNA). This provided the evidence that informed the new strategy. The evidence was reviewed by a series of workshops held within the Council and Clinical Commissioning Group.

Haringey Association of Voluntary and Community Organisations (HAVCO) and Haringey Healthwatch were commissioned to deliver a series of pre-consultation workshops with residents and service users. In addition, during September and October 2014, HAVCO conducted a survey on Health and Wellbeing issues under the theme of 'enabling adults to live longer and healthier lives'. This survey was conducted as part of HAVCO's wider public survey called 'Investing in our tomorrow'. The responses to the survey can be found at http://www.haringey.gov.uk/council-and-democracy/have-your-say-haringey/investing-our-tomorrow. Responses from the workshop and survey informed the draft Health and Wellbeing Strategy.

The draft Health and Wellbeing Strategy was also informed by two other consultation exercises conducted to inform two parallel pieces of work – the Joint Mental Health and Wellbeing Framework, and the Better Care Fund.

Joint Mental Health and Wellbeing Framework Consultation:

The Haringey Health and Wellbeing Board conducted a consultation on the draft Joint Mental Health and Wellbeing Framework. The consultation had the following features:

- An online consultation ran for 6 weeks to 25th February 2015. There were 20 responses from service users, professionals and the Voluntary and Community Sector.
- Workshops were held with the 4 GP collaboratives of Haringey Clinical Commissioning Group (CCG), and a special session of the CCG cabinet discussed the Framework.
- 9 Focus Groups were held, involving service users and carers. The sessions were facilitated by independent facilitators from the Mental Health Foundation.
- A Joint Children and Young People and Adults Health Scrutiny Panel reviewed the Framework on 18th March 2015.

The consultation process concluded at the end of March 2015. Comments received during the consultation were incorporated into the final Framework and delivery plan.

Engagement to inform the Better Care Fund Plan:

Haringey Council Clinical Commissioning Group NHS Haringey healthwatch Haringey HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

A programme of public engagement was carried out in order to develop the vision and plan for the Haringey Better Care Fund, the aim of which is to provide joined up, co-ordinated health and social care services which reduce the need for people to go to hospital. The engagement programme had the following features:

- A public workshop attended by 117 residents, patients/service users and carers. The workshop was held at a local theatre in collaboration with local voluntary and community groups (including Haringey Age UK and Haringey HealthWatch).
- 2 CCG Network events attended by 50 patients and members of the public
- One-to-one semi-structured interviews with 4 service users
- A discussion at the Older People's Partnership Board
- A discussion forum at the Adult Partnership Board

In total almost 200 residents, patients/service users, and carers were consulted.

2015 public consultation

Once the draft Health and Wellbeing Strategy was prepared, it was put to public consultation during February and March 2015. Respondents could contribute their views online, via email or through written submissions. In total there were 45 responses. The demographic make-up of respondents is summarised in the table below.

Age		**Sex**		**Ethnicity**		**Religion**	
Under 18	1	Male	4	Black - African	1	Christian	2
26-35	4	Female	11	White/Asian	1	Jewish	1
36-45	1	No information	30	Filipino British	1	Buddhist	1
46-55	3			White British	9	No religion	7
56-65	2			Other White	4	No information	34
66-75	2			No information	29		
75+	1						
No info	31						
Disability		**Sexuality**					
Yes	1	Heterosexual	13				
No	13	Gay or Lesbian	2				
No info	31	No information	30				

Responses were split quite evenly between local residents, local VCS and professional/public sector organisations.

Type of respondent	
Local resident	16
Local voluntary/community sector	11
Organisation (local business)	12 (1)
Other (Cllr)	6 (2)

Summary of common themes from the public consultation

The consultation questions were organised according to the three priorities within the draft Health and Wellbeing Strategy and most respondents addressed their responses in the same way. The summary of common themes has therefore been organised according to the three priorities.

Questions 9 to 12 asked respondents how they or their organisations could *support* the achievement of the priorities. In the summary below, the contribution offered by residents is summarised in a separate boxed section for each priority.

Priority 1: Reducing obesity

43 of 45 respondents agreed with this priority except for 2 who were 'not sure'.

The suggested actions to reduce obesity can be categorised as follows:

- Affordable food and fitness

Respondents expressed a desire for more affordable leisure and fitness options, and affordable sources of healthy food. One respondent linked this to the importance of Children's Centres providing healthy meals for children, and Meals on Wheels serving elderly people. Green gyms in parks were a popular suggestion. A local social enterprise dance studio highlighted the value of dance as an alternative form of exercise that appeals to different groups.

- Healthy, safe environment

Another common theme was the view that everyday exercise could be encouraged through improving the quality of the environment. Respondents called for more green space, more attractive and safer neighbourhoods (especially in the east of the borough) that would make people more inclined to walk, safer parks, and the expansion of the Play Streets schemes.

- Education

Many respondents highlighted the importance of educating young people about exercise and diet. A common suggestion was to work with parents and schools to develop education schemes, while others called for youth-designed campaigns. Cooking classes for adults/parents was another common suggestion.

- Fewer takeaways

A common theme was a call to reverse the increase in fast food restaurants in the borough, with one respondent suggesting a ban on takeaways near schools.

- Joined up working

Professional and VCS respondents highlighted the need to integrate anti-obesity measures across a range of agencies, or to tackle obesity as part of a holistic, multiple-needs approach. For example one respondent called for criminal/rehabilitation services to do more to promote healthy lifestyles amongst their users, while

another argued that obesity is rooted in mental health and relationship issues and should be tackled through investment in mental health and whole-family services.

Local residents – the suggestions from the public were limited to the affordability, environment and education categories. In terms of contribution, residents said that they were willing to stay informed, speak to other parents, and take part in campaigns.

Priority 2: Increasing healthy life expectancy

41 of 45 respondent agreed with this priority, 2 were 'not sure' and 2 disagreed. No reasons were giving for not agreeing with this priority.

Responses were often very similar to those for priority 1 – reducing obesity. The importance of parents and schools, education, reducing takeaways and creating a healthy, safe environment were common themes. Additional actions to increase healthy life expectancy can be categorised as follows:

- Social isolation

Respondents frequently called for more to be done to tackle social isolation, particularly amongst the elderly, in order to address a root cause of ill-health (particularly in the form of alcoholism). There were specific suggestions around 'Good Neighbour', befriending and Neighbourhood Watch-style schemes. The value of intergenerational projects in tackling loneliness was raised. The risk of isolation faced by people with mental health conditions and the LGBT community was also raised.

- Air quality

A number of respondents called for more to be done to improve air quality – in terms of measuring, drawing attention to, and campaigning to the Mayor of London.

- Alcohol

Two voluntary sector respondents made very detailed cases for tackling alcohol abuse – calling for specialist advice and support, more early screening for risk, diligent licensing and the promotion of alcohol-free entertainment. Other respondents recognised that drug and alcohol abuse was a key factor in reducing life expectancy. Smoking was only mentioned in terms of banning it in parks and hospitals.

- The role of the Council

There were suggestions for promoting the Health and Wellbeing of Haringey staff through 'walk to work' schemes, discounts for gyms and healthy food, and other incentives. One respondent stressed the need to make 'every contact count', with all frontline staff promoting healthy lifestyles to their clients/the public.

- Housing

Housing was a common theme with respondents calling for more social housing, improved quality of social and private rented accommodation and greater efforts to tackle overcrowding.

- Working with specific communities

A number of respondents from the VCS and partner agencies called for bespoke interventions targeted at specific communities. They made the case for commissioning "providers with expertise of working with specific target groups".

Local residents – as well as suggestions around school sports and green space, residents also talked about housing quality and social isolation. One resident made a specific call for improved access to GPs in Tottenham Hale. In terms of contribution, residents said that they were willing raise Health and Wellbeing issues at their community groups/clubs for discussion and awareness raising.

Priority 3: Improving mental health and emotional wellbeing

All 45 respondents agreed with this priority.

There was some overlap with the suggested actions for priorities 1 and 2 – with respondents raising the role of parents and schools, the importance of affordable support (i.e. affordable Mindfulness, Pilates and Yoga sessions), and the need for better access to GPs/Primary Care. Housing was also identified as an important factor, with a couple of respondents calling for more supported accommodation for people with mental health conditions, especially in the east of the borough. Additional actions to improve mental health and wellbeing can be categorised as follows:

- Community participation and empowerment

Many respondents identified the value of community participation, volunteering and sociability for people with mental health conditions. Befriending and peer support schemes were suggested.

Connected to this, a number of respondents spoke about the need to empower mental health service users, involve them in service-design and to build services around individual aspirations. VCS respondents highlighted their organisations' capacity to engage and co-design services with their particular client groups (over 65s, LGBT groups).

- Mental Health training and awareness

A common theme was the need for greater understanding about mental health throughout society and for organisations and businesses to be better equipped to identify mental health issues and support their employees. Awareness campaigns and training programme were called for. One respondent called for Haringey Council to lead by example and ensure that its Occupational Health service is equipped to address mental health issues. Other respondents identified GPs and offender rehabilitation services as requiring greater knowledge around mental health.

- Joined up working

Professional and VCS respondents tended to emphasise that mental health is connected to a range of other factors and therefore requires a holistic approach and joined up working between support organisations. Respondents from an alcohol charity made the case for tackling mental health and substance abuse issues in a joined up way.

Local residents – amongst residents there was a recognition of the importance of community involvement and sociability opportunities, particularly for the over 65s. GP knowledge and access to Primary Care were also raised, as was relationship advice for young people. Residents suggested that their contribution to achieving the mental health objective would (again) be in terms of staying informed and raising mental health issues at their community groups/clubs.

Other priorities and additional comments

9 respondents proposed additional issues for the Health and Wellbeing Strategy to cover.

- Alcohol

One VCS respondent proposed that alcohol be featured as a priority in its own right, arguing that it cuts across the three original priorities.

- The Health and Wellbeing of over 65s

A number of respondents suggested that the health and wellbeing of over 65s be featured as a priority. With so many other respondents included suggestions about social isolation, positive ageing and intergenerational participation in their responses, it might suggest that the wellbeing of older residents is a priority amongst residents. One resident respondent proposed annual checkups for over-70s in their 'additional comments'.

- Green space and air quality

One resident proposed making these environmental issues priorities in their own right.

- Equalities

One resident made a detailed case for making anti-discrimination an additional priority of the Health and Wellbeing Strategy. They called for greater access to free and independent legal advice and targeted projects to improve opportunities for disadvantaged groups. A number of respondents raised issues around equalities – mainly calling for the Health and Wellbeing Strategy to explicitly target the specific health needs of particular communities and guarantee input from the targeted communities into the design of these interventions.

- Children and Families

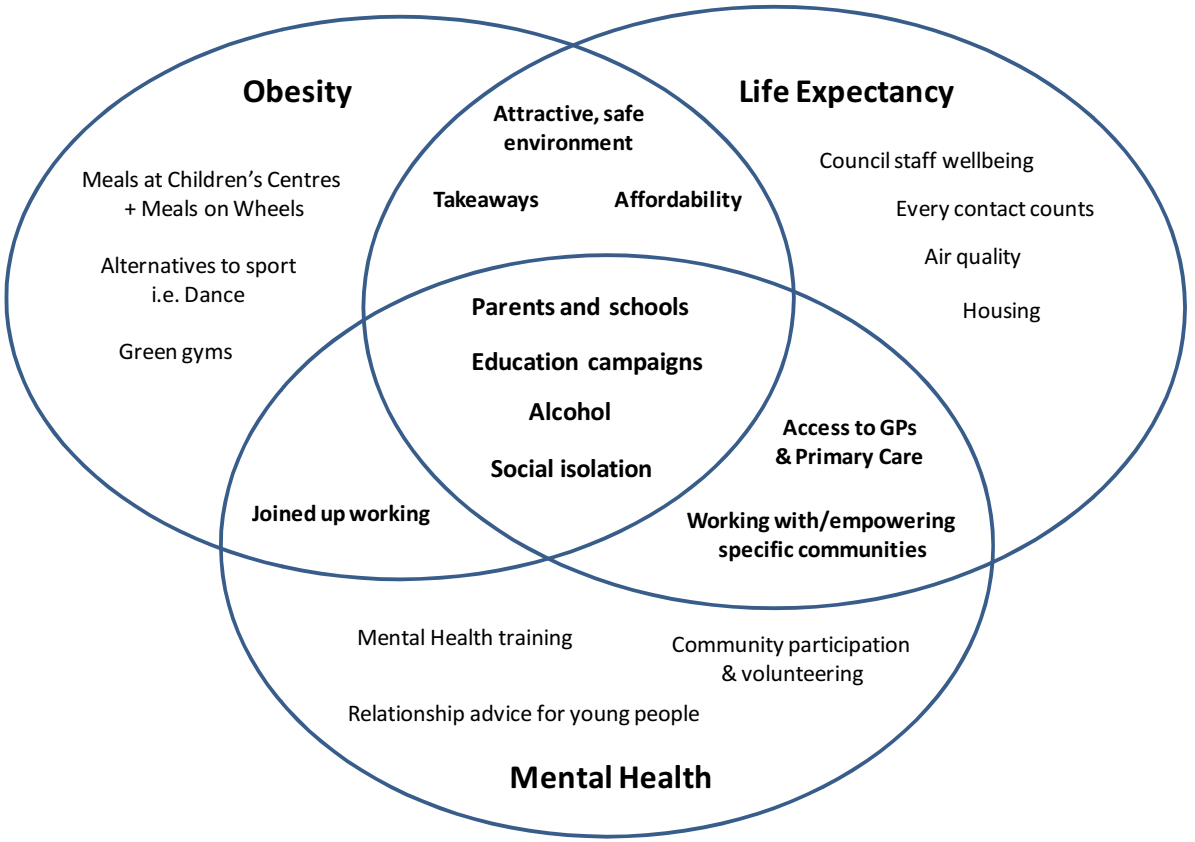
Haringey Council Clinical Commissioning Group

NHS Haringey healthwatch Haringey HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

One VCS respondent called for preventative work with young children and their families to be made an explicit priority of the Health and Wellbeing Strategy. One resident respondent called for teenage pregnancy to be prioritised, while other respondents raised other family issues such as domestic violence and child neglect.

Venn diagram

As a summary of the findings above, the Venn diagram shows the common themes from the consultation responses and where the same issues were raised for more than one priority.



Conclusions

The following conclusions can be drawn from the public consultation exercise:

- The responses to the 2015 public consultation provide further insights into the views, priorities and proposals of residents, local VCS and partners. They supplement the information gained from the pre-consultation workshops and surveys which continue to inform the development of the Health and Wellbeing Strategy.
- Many respondents believe Health and Wellbeing can be improved through better education and awareness and therefore see an important role for parents and schools. Residents are most likely to see their role in supporting Health and Wellbeing as being to educate themselves and spread messages to those around them.
- Many respondents believe that cost is an issue, and that a healthy lifestyle needs to be more affordable. Consequently respondents tend to believe the quality and safety of the public environment is important because of the opportunities it provides for free exercise.
- There is quite a sophisticated understanding of the links between mental and physical health and the importance of healthy relationships and sociability in improving Health and Wellbeing. Loneliness amongst older people was a commonly raised issue.
- There was widespread recognition that different communities have different health needs, and that Health and Wellbeing professionals should work closely with communities to develop targeted solutions.

Glossary

CCG	Clinical Commissioning Group
HAVCO	Haringey Association of Voluntary and Community Organisations
JSNA	Joint Strategic Needs Assessment
LGBT	Lesbian Gay Bisexual Transgender
VC S	Voluntary and Community Sector

Haringey Council

healthwatch Haringey

HAVCO HARINGEY ASSOCIATION OF VOLUNTARY AND COMMUNITY ORGANISATIONS

NHS Haringey Clinical Commissioning Group

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

Title:	**Better Care Fund (BCF) Quarterly Return – Quarter 4 2014-15**

Report Authorised by:	**Beverley Tarka, Acting Director of Adult Social Care**

Lead Officer:	**Marco Inzani, Commissioning Lead – Better Care Fund**

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

1. **Describe the issue under consideration**

   To consider the submission of the Better Care Fund (BCF) Quarterly Return – Quarter 4 2014-15 to NHS England.

2. **Cabinet Member introduction**

   N/A

3. **Recommendations**

   To approve the Better Care Fund (BCF) Quarterly Return – Quarter 4 2014-15.

4. **Alternative options considered**

   N/A

5. Background information

5.1 The Better Care Support Team (which sits across the Department of Health, Department for Communities and Local Government, the Local Government Association and NHS England) issued a Better Care Fund (BCF) reporting template on 11th May 2015. The first reporting template covers the Quarter 4 2014-15 period (Jan to Mar 2015) and must be submitted by 29 May 2015.

5.2 The report is part of the national administration of the BCF as set out in the Guidance for the Operationalisation of the BCF in 2015-16 (NHS England). Five reports are expected, to cover the year of delivery for the BCF, on the following dates:

- 29 May 2015 – for the period January to March 2015
- 28 August 2015 – for the period April to June 2015
- 27 November 2015 – for the period July to September 2015
- 26 February 2016 – for the period October – December 2015
- 27 May 2016 – for the period January – March 2016

5.3 The BCF guidance recommends that the template is signed off by Health and Well-being Boards (HWBBs) and a space is left on the template for the name of the HWBB signatory. The Better Care Support Team have simplified the template and the first one will briefly capture assurance that areas are meeting national conditions.

5.4 For future BCF returns sufficient time will be given, where possible, that the reporting template can be discussed at the HWBB. Where this is not possible due to the time lag in data being available, delegated authority will again be sought.

6. Reasons for Decision

6.1 The BCF quarterly return template was issued on the 11 May 2015 and must be submitted by 29 May 2015. A completed version was tabled for discussion at the Health and Care Integration (HACI) Board on 13 May 2015. The HACI Board agreed that to meet the submission deadline that delegated authority will be needed from the HWBB.

6.2 The first quarterly return for Haringey is assessed as low risk as four of the six national conditions have been met and two are in progress. An explanation has been given for the response to all these questions, however it is noted that any comments to questions answered 'yes' will be cleared before submission in accordance with guidance.

6.3 In the case of non-executive functions, under Part 3 Section E Scheme of Delegation Paragraph 5.01 (b), following the preparation of a report (which is

attached), the Director having operational responsibility can take the urgent decision in consultation with the Chair of the Committee.

6.4 An urgent decision to approve the Better Care Fund (BCF) Quarterly Return – Quarter 4 2014-15 is therefore required.

7. Comments of the Chief Finance Officer and financial implications

The report seeks the Health and Wellbeing Board's approval of the Better Care Fund Quarterly Return – Quarter 4 2014-15. The Chief Financial Officer confirms that there are no financial implications arising directly from the contents of this report.

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

There are no legal implications arising from the recommendations

9. Equalities and Community Cohesion Comments

An equalities impact assessment was completed for the whole BCF Programme in December 2014. The overall outcome was to continue with the programme as it was as there were a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on older people (over 65), disability (including mental health), gender, religion/belief, marriage, human rights, socio-economic group, social inclusion and community cohesion. These positive impacts were mainly due to the cohort of patients and services users that will be the main beneficiaries, the delivery of services in people's homes, working in a service user centred way to define health and social care goals and the intention to improve health and well-being. No negative impacts were highlighted.

10. Head of Procurement Comments

N/A

11. Policy Implication

N/A

12. Use of Appendices

1. Haringey BCF Quarterly Data Collection Template Q4 14-15 v0.2

13. Local Government (Access to Information) Act 1985

N/A

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RECORD OF COMMITTEE CHAIR'S URGENT ACTION

Title of Report: Better Care Fund (BCF) Quarterly Return – Quarter 4 2014-15

Reason for urgency or
Relevant paragraph for authority under scheme of delegation

Section E, - Scheme of delegation section 5, indicates that where action need to be taken on an urgent matter between meetings of the Cabinet, or any Committee or Sub Committee of the Cabinet or Council this can be taken forward by the Leader for Executive functions and in the case of non Executive functions, the director can take the decision in consultation with the Chair of the Committee.

The Better Care Support Team (which sits across the Department of Health, Department for Communities and Local Government, the Local Government Association and NHS England) issued a Better Care Fund (BCF) reporting template on 11th May 2015. The first reporting template covers the Quarter 4 2014-15 period (Jan to Mar 2015) and must be submitted by 29 May 2015.

The report is part of the national administration of the BCF as set out in the Guidance for the Operationalisation of the BCF in 2015-16 (NHS England). The guidance recommends that the template is signed off by Health and Well-being Boards (HWBBs) and a space is left on the template for the name of the HWBB signatory. The Better Care Support Team have simplified the template and the first one will briefly capture assurance that areas are meeting national conditions.

As the template has only recently been issued, a completed version was tabled for discussion at the Health and Care Integration (HACI) Board on 13 May 2015. The HACI Board agreed that to meet the submission deadline that delegated authority will be needed from the HWBB.

The first quarterly return for Haringey is assessed as low risk as four of the six national conditions have been met and two are in progress. An explanation has been given for the response to all these questions, however it is noted that any comments to questions answered 'yes' will be cleared before submission in accordance with guidance.

Decision of the Acting Director for Adult Social Care

I approve the recommendation as set out in the attached report having consulted with members of the Health and Social Care integration Board, which included the Chief Operating Officer of the CCG and the Deputy Chief Executive, Haringey council on the 13th May 2015.

Signature B. J. Tarka **Date: 27th May 2015**

Concurrence of the Chair of the Health and Wellbeing Board

Once signed by the Chief Officer this cover sheet together with the substantive report must be forwarded to the Cabinet Committees Team - Level 5, River Park House - for processing.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details
Q4 2014/15

Health and Well Being Board	Haringey

completed by:	Marco Inzani
e-mail:	Marco.Inzani@haringeyccg.nhs.uk
contact number:	020 3688 2780
Who has signed off the report on behalf of the Health and Well Being Board:	?

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Haringey

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	No
If the answer to the above is 'No' please indicate when this will happen	01/07/2015

Selected Health and Well Being Board:

Haringey

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	Clear HACI governance structure and involvmeent of stakeholders at all levels, looking to increase capacity of providers in 2015-16 to reduce risks
2) Are Social Care Services (not spending) being protected?	Yes	HACI governance over the BCF budget includes protection of the budgets available for social care
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	Health services are available 7 days a week, however there has not been a corresponding level of service in social care services. Following a trial over the winter period a business case has been approved for 7 day social care to support hospital discharge. This will be implemented from June 2015.
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	All health and social care services now using NHS number
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	All new IT systems will have open APIs
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Data sharing agreements signed by all providers, clarity given from the national guidance via Integration Implementation Group, all providers using their own information governance controls in line with national guidance
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	A business case for care co-ordination has been approved and will be rolled out across Haringey following some successful pilots. This will increase the capacity of primary care and community health and social care services (including mental health) to undertake integrated assessments and care plans by an accountable professional. Roll out will be happening from May to July 2015.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	All sectors have been engaged in th impact of the BCF on their services including the savings in acute and the investments in community health and social care services (including mental health services). There will be an increase in capacity in 2015-16 to reduce risks to providers.

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Haringey

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	30,777

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.
Haringey has changed the level of ambition for the Pay for Performance Target compared to the original submission. Following guidance from NHS England, Haringey will now be looking to deliver a 2% reduction in Non-Elective Admissions from the actual baseline. The BCF Governance Structure has become more established with good participation across a range of stakeholders including Haringey CCG, London Borough of Haringey, Health and Social Care Providers and public/service user representatives. There have been a number of key developments since April 2015. We now produce a local dashboard to monitor a range of supporting indicators to the six BCF outcome measures. This allows us to idenitfy areas for futher detailed investigation. We have developed a business case for Locality Teams. These are four multi-professional teams that will provide a navigation, assessment and case management function. Several new services are being commissioned. These include additional services and on-line programmes to support self management; commissioning neighbourhood connects to build capacity within local communities and a Home from Hospital service to support people following discharge from hospital. Underpinnng the BCF has been work on integrating IT systems via a Medical Interoperability Gateway (MIG) that allows a shared view of patient level information between GPs and between acute and community services. We have been working on developing the local workforce through a number of listening events and educationa and training workshops. The BCF is now becoming more embedded into strategies and operating plans so that providers align towards a more integrated delivery model. 20 services have now been identified within the BCF, which includes exsiting health and social care services and some newly developed services. Exisiting services are being aligned to BCF Plans, monitored and reviewed mid-year. New services have been through a business case planning cycle.

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