MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 23RD FEBRUARY, 2016, 18:00

Board Members Present: Cllr Claire Kober (Chair), Councillor Peter Morton (Cabinet Member for Health and Wellbeing), Cllr Ann Waters (Cabinet Member for Children & Families), Dr Jeanelle de Gruchy (Director of Public Health), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Sherry Tang (Chair, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Cathy Herman (Lay Member, Haringey CCG) Beverley Tarka (Director Adult Social Care LBOH), Gill Gibson (Assistant Director, Early Help & Prevention – substitute for Jon Abbey) Geoffrey Ocen (Bridge Renewal Trust – Chief Executive).

Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Philip Slawther (Principal Committee Coordinator LBOH).

40. FILMING AT MEETINGS

The Chair referred those present to agenda item 1 as shown on the agenda in respect of filming at this meeting and asked that those present reviewed and noted the information contained therein.

41. WELCOME AND INTRODUCTIONS

The Chair welcomed those present to the meeting and the Board introduced themselves.

42. APOLOGIES

The following apologies were noted:

- Sir Paul Ennals.
- Cllr Waters and Zina Etheridge gave apologies as they had to leave the meeting at 18:30.

43. URGENT BUSINESS

There were no items of Urgent Business.

44. DECLARATIONS OF INTEREST

None

45. QUESTIONS, DEPUTATIONS, PETITIONS

No Questions, Deputations or Petitions were tabled.

46. MINUTES

RESOLVED:

That the minutes of the meeting held on 24th November 2015 be confirmed as a correct record.

47. STRATEGIC DISCUSSION ITEMS

DEVOLUTION PREVENTION PILOT IN HARINGEY

A report setting out the progress on establishing a Devolution Prevention Pilot in Haringey for 2016-17, for both the Healthy Environment and the Sustainable Employment strands was included as part of the agenda pack (pages 19-25). The Appendix to the report, which set out the proposals for the prevention pilot, was tabled at the meeting as it had been omitted from the agenda pack in error. A copy of the presentation was also included in the agenda pack (pages 27-35). Dr Jeanelle de Gruchy, Director of Public Health introduced the report. Hard copies of the Annual Public Health report were distributed to the Board as background information for the item. Following the presentation the Board discussed its findings.

The Director of Public Health outlined that the London Health and Care Collaboration Agreement was signed on the 15th December by the Mayor of London, London CCGs, London Councils, NHSE and Public Health England; and set up five pilots:

- Barking and Dagenham, Havering and Redbridge – Developing an Accountable Care Organisation (primary & secondary care integration)
- Lewisham – Integrating physical and mental health services alongside social care
- Hackney – The aim was full integration of Health and Social Care budgets and joint provision of services, with a focus on prevention
- North Central London – estates pilot to: Develop a regional capital programme; devolve powers to approve NHS capital business cases; retain more of the proceeds of sales. Haringey was a part of this pilot as part of NCL.
- Haringey Prevention Pilot

The Prevention Pilot would have two strands. The Healthy Environment strand would be a series of projects in which qualitative research would be undertaken along with focused licensing enforcement activity to expose the limits of existing licensing regimes (alcohol), or demonstrate the consequences where no positive licensing powers were available (Fixed Odds Betting Terminals and Tobacco). Evidence gathering would also be used to make the case for new powers to be devolved to London (such as Minimum Unit Pricing).

The Sustainable Employment strand would focus on the whole system transformation required to develop a locally tailored employment support system that would be effective for those with mental health problems. The proposals would focus on early help and prevention as well as more intensive support for people with severe mental illness.

The Prevention Pilot was consistent with Priority 2 of the Council's Corporate Plan; enabling residents to live healthy, long and fulfilling lives. In addition, the Health & Wellbeing Strategy identified the key priorities as obesity, healthy life expectancy and mental health and the Prevention Pilot reflected those priorities with a focus on alcohol licensing, planning policy around takeaway food vendors and employment support for people with mental health issues. The Director of Public Health advised that the timescales were tight and that the pilot 'asks' would have to be submitted to government/external agencies in March and the commencement of building an evidence base with partners being undertaken from April. The Board noted that the Prevention Pilot conclusions would be published in April 2017, with the hope of devolved powers being granted in 2017-2018.

The Prevention Pilot would be overseen by the Board. In addition, a devolution steering group had been established, chaired by the Director of Public Health and also included: Chief Operating Officer of the CCG; senior officers across the Council and the co-chairs of the two delivery groups. The Board was advised that partners would be heavily engaged in the process, both at a local/regional level e.g. BEHMT, police, GLA and also national partners such as DWP, PHE and DCLG. A delivery group had also been established for each of the two work streams, reporting into the steering group.

The Chair commented that she attended the signing of the Agreement on 15th December and that the Secretary of State made it clear that in his view, should sufficient progress be made across the five pilot areas that further devolution of health powers would follow for London. With that in mind the Chair asked for clarification on what success would look like in 12 months time. In response the Director of Public Health responded that this was still being determined, particularly around the healthy environment strand as a number of legal issues had been identified, for instance around byelaws and the legality of varying the criteria for objections to Premises Licence applications. The Deputy Chief Executive commented that the legislative framework around some of the areas involved in the initial pilot made the process of determining success unclear. However, this should be clarified and made easier with a subsequent larger round of devolution in 12 months time.

The Deputy Chief Executive advised that the success of the second stream around sustainable employment should be easier to measure progress as some of the activities involved were around devolution of funding streams etcetera. The Deputy Chief Executive advised that going forward, the government was more likely to be looking at devolution based around the integration of health systems locally for example; through a change in the relationship between the health system and the regulators, and the granting of additional powers at a local level. The process of devolution was likely to be long term and piecemeal, involving a gradual transfer of powers away from the centre in order to create a different relationship and power balance over time.

Sarah Price, Chief Officer Haringey CCG, agreed that measuring success was a bit of an unknown and advised that through the Prevention Pilot, they would be looking to test the boundaries as much as they possibly could in the coming months. This would include exploring boundary issues and whether it was possible to implement changes at a local borough level or whether it would need to be at a London-wide level.

Geoffrey Ocen, Chief Executive of the Bridge Renewal Trust, enquired about the funding arrangements for the pilot. In response, the Director of Public Heath advised that funding for the Sustainable Employment strand could potentially receive NHS funding through the Transformation Fund and there was also potential links with funding from DWP and Job Centre Plus, and also smaller pots of money from organisations such as universities, the Department for Health and Public Health England. Whereas, funding for the Healthy Environment strand will require less in the way of resources, and would be used primarily to cover activities such as legal support.

Sharon Grant, the Chair of Healthwatch Haringey enquired whether any thought had been given to using this as an opportunity to seek greater powers for the local authority to control the density of housing development, due to the impact on residents' health and wellbeing. The Director of Public Health responded that there were a number of work streams examined for London such as employment and skills and housing but that the health and social care bid was the strongest in terms of the potential 'asks'.

The Chief Officer, Haringey CCG agreed that a number of planning aspects were looked at during the scoping work for the bid but the focus was on options that had a defined devolution ask. The Committee were advised that the Mayor already had devolved powers around housing density and the percentage of social housing formula, through approval of the London Plan. The Chair commented that she was unsure whether housing density was the best proxy for determining poor health outcomes, instead the Chair advocated that aspects such as licensing, particularly of private landlords would be more significant.

Cathy Herman, Lay Member Haringey CCG, commented that many of the outputs involved in the pilot would be long term goals and suggested that the impact on public health being a Licensing objective would be a very beneficial outcome. Ms Herman also advised that the positioning and influence for Haringey in being involved at the forefront of the devolution process was very important, particularly given the likely political agenda around aspects such as Minimum Unit Pricing for alcohol. The Chair commented not all of the devolution strands would be successful but that it was important to try a range of approaches to develop a robust process and to find which strands could have a significant impact and improve outcomes.

** Clerks note – The Cabinet Member for Children and Families and the Deputy Chief Executive left the meeting at this point **

Gill Gibson, Assistant Director, Early Help & Prevention, highlighted that the Troubled Families programme was already in place and that sustainable employment outcomes were a significant factor in that. The Committee considered that there were three

years of learning gathered through the programme and that substance misuse was a key underlying factor for a large number of the adults involved. The AD Early Help & Prevention advised of the need to bring that learning into the pilot and the need to strengthen links between the two areas of work.

The Chief Executive of the Bridge Renewal Trust suggested that part of the solution around sustainable employment should involve the voluntary sector and advised that the voluntary sector could do more in that area. The Assistant Director of Public Health acknowledged the need for heavy engagement with both the voluntary sector and communities to see how they could be supported to deliver sustainable employment outcomes. The Board noted that the voluntary sector would also be invited to form part of the sustainable employment delivery group. The Assistant Director Public Health agreed to discuss this further with the Bridge Renewal Trust outside of the meeting **(Action: Tamara Djuretic).**

The chair thanked those present for their contributions.

RESOLVED:

I). That the HWB notes the content of the report and the proposals for the development of a 'Prevention Pilot' (and the aims contained within the Healthy Environment strand and Sustainable Employment strand), as set out in appendix 1 of the report.

II). That the HWB notes the next steps in terms of submitting final proposals for the delivery of the 'Prevention Pilot' to the London Devolution Programme Board, by the end of February, and the suggested timetable for detailed project planning from April 2016.

III). That the Devolution Steering Group provides regular updates on progress to the HWB

SOCIAL PRESCRIBING

A report was included in the agenda pack at page 37. Dr Tamara Djuretic, Assistant Director of Public Health, gave a presentation to the Board on social prescribing and the local and national policy drivers involved. Following the presentation the Board discussed the findings.

The Assistant Director of Public Health introduced: Charlotte Woodhead, a researcher from UCH who had been working on the evidence background to social prescribing and Andrea Somasundram, a HAGA community engagement worker from JS Medical Practice, who was part of a pilot scheme established in the borough around social prescribing.

Approximately 70% of health outcomes were determined by socio-economic factors and 30% by clinical factors, according to the Marmot Review in 2010. Social prescribing sought to address this by offering referral to non-clinical services coupled with support to engage with these services, which ranged from arts and culture to physical exercise, benefits and debt advice etcetera. Social prescribing models

focused on factors that positively support health and wellbeing rather than on factors that cause disease, promoting a more holistic community centred model of primary and community care. The Committee noted that the social prescribing model contained synergies with; Haringey Communities strategy, Haringey Corporate Plan and Priority 2 of Haringey's Health and Wellbeing Strategy.

Ms Woodhead gave part of the presentation to the group, outlining the different models available as well as the pros and cons. There were a number of broad strands of models around social prescribing, the main ones included:

- Signposting which involved directing patients to non-clinical community services during GP consultations
- A more formalised route where the GP spoke to the patient about their needs and then agreed a particular programme of community based activities with the patient. Issues could arise with the GP not necessarily having a full and complete understand of the range of services available in the community.
- Involving a link worker/co-ordinator/facilitator, where the patient was referred by the GP to an individual who had a good knowledge of the range of local services within the voluntary and community sector and was engaged with both the health sector and the voluntary sector. The models varied around how long the link worker spent with the patient from a one-off home visit to a series of one-hour sessions. The Board noted that this increased the likelihood of successful outcomes and also facilitated much better feedback to the health sector, improving the quality of evaluation. The downsides were that it was considerably more expensive.
- The Bromley-by-Bow model was outlined to the Board. This involved 6 satellite GP practices that reported into the Bromley-by-Bow centre, which had a dedicated social prescribing team who sat with the patient to review their needs and then the centre could refer the patent to one of the 1000 different organisations that the centre had links to.
- The Rotherham model involved referrals being made within a multidisciplinary team as part of an integrated case management pilot scheme.
- Other social prescribing models have involved linking up as part of Improving Access to Psychological Therapies (IAPT) provision

Ms Woodhead advised the Board that the evidence around social prescribing was not very well established and that evaluation of the outcomes had proven difficult, partly due to the sheer number of different types of services that could be referred into, from arts programmes to physical exercise to cookery classes. Most of the evaluations undertaken so far had been simple before and after studies which were not robust.

The Assistant Director Public Health advised that that there were a range of interventions already in place in Haringey that would form part of the network of our local model such as the pilot project at JS Medical practice and welfare hubs in GP practices. There was also a range of new developments being put in place such as Cultural and Creative Industries Strategy and the IAG service, which the Council could consider integrating into a social prescribing model.

Andrea Somasundram gave a verbal update to the Board outlining the current social prescribing pilot scheme taking place at JS Medical Centre. The following key points were noted in relation to the pilot:

- HAGA had been working in the borough for 35 years working with people and their families who had been affected with alcohol. HAGA has undertaken a nine month pilot, launched in November, aimed at improving wellbeing outcomes among its service users through social prescribing.
- Ms Somasundram was the Community Engagement Worker based at JS Medical centre at Park Lane and more recently Phillip Lane, working there once a week on a Tuesday. The process involved Ms Somasundram getting a referral from a GP. As part of the referral the Community Engagement worker received a referral form, which outlined the issue/s and what could be done to help that person. The Board were advised that the reasons behind a referral included mild anxiety or depression or even someone who just wanted to engage in the community.
- The example given to the Board was of a young lady who had been socially isolated for quite some time, who wished to get back to doing voluntary work within the community. The Community Engagement Worker met with the person on four occasions, working in a person centred way to plan what could be done and agree a set of achievable goals. The outcome was that the person undertook a job interview, was successful and was due to start within the following month.
- The Community Engagement Worker outlined her reflections on social prescribing. The Board were advised that people often found it difficult to engage with services, often for a variety of related and unrelated issues; such as child care and housing issues that compounded medical issues and created additional stress. The Board considered that through adopting a flexible approach that was patient-centric it was possible to provide additional support and develop outcomes that worked for the individual in question. The patient was made to feel like they were in control and that they determined how they engaged in the process. The Community Engagement worker suggested that this had made a significant difference.
- The Community Engagement Worker stated that being from the local area also had a significant impact as she had the relevant local knowledge and was able to refer people to the range of services taking place at a local and community level. Ms Somasundram advised that being from the local area also helped in terms of being able to connect with local people and building a relationship.
- Being able to talk to the patient and understand their concerns were a key aspect of the model. Patients had on several occasions thanked the Community Engagement Worker just for listening. The Community Engagement Worker advised that a number of concerns stemmed from uncertainty about what was going to happen in the short term, concerns about housing and employment concerns.
- The Community Engagement Worker advised that, in her opinion, social prescribing could have a significant impact and had the potential to benefit a lot of people in the community. Social prescribing empowered people to make a difference to their own lives.

Ms. Grant welcomed the report and its findings and advised the Board that a workshop had been set up for the 8th March. Ms Grant commented that, in terms of evaluation, some new studies had been released in the last few months which had undertaken serious attempts to evaluate the impact of social prescribing. Contributors to those studies and representatives from Bromley-by-Bow were due to attend the workshop on 8th March.

Ms Grant advised that the key consideration was around its strategic implementation, considering the key role that the voluntary sector had to play but within a context of increasingly limited resources. Ms Grant advocated that the Board should give consideration to how to resource the organisations that would provide the services prescribed.
Ms Grant proposed that some further considerations included; the need to tailor any existing models to local Haringey needs, how to bridge the gap between the GP and the provider through an intermediary/ link worker and the need to adapt an existing model.

The Leader commented that Ms Somasundram's presentation made a strong case around the value of having a broker in the system, particularly given the limited time available to GP's during their appointments with patients.

Dina Dhorajiwala, Vice Chair Haringey CCG, welcomed the presentations given and the effort that had been put into producing them. Ms Dhorajiwala enquired how closely the pilot scheme worked with IAPT services, given the need to raise awareness of the service to patients. Ms Somasundram responded that there was no close working with IAPT at present and stated that she was beginning the engagement process so that people knew who the Community Engagement Worker was and to develop a sense of consistency. From there, the aim was to branch out and start signposting the opportunities that were available. There was a clear need to build awareness in the community that there was something else available and through that to begin to develop a series of networks to embed the model.

The Chief Officer, Haringey CCG, commented that the Board should consider using IAPT as a referral source into that link worker, not just through GPs due to their role in tackling mild levels of depression and anxiety, and the potential for a broader referral model including social support.

The Director of Adult Social Services commented on the presentation slide that showed the range of similar activities carried out within Haringey and suggested that the task and finish group would need to consider how best to coordinate that activity. The Director of Adult Social Services also commented on the GP's role in the social prescribing model and proposed that some consideration should be given to finding an alternative pathway for social prescribing other than through the GPs. It was proposed that the task and finish group should consider the need for an alternative route through the model, which coordinated the range of activities available in Haringey and also to consider how that might be promoted.

Cllr Morton, the Cabinet Member for Health and Wellbeing echoed some of the points put forward by the Director of Adult Social and emphasised the need to draw together existing resources, for example through an asset mapping exercise. The Cabinet

Member for Health and Wellbeing raised a question regarding what the key aspects of a social prescribing model that were needed in order for it to work. Officers suggested that the involvement of local people was crucial. It was also noted that a key consideration with a social prescribing model was that it facilitated more time to spend with the individual to tailor activities to their specific needs. The Leader commented that the Bromley-by-Bow model was an exemplar; any model used in Haringey had to be tailored to local needs and also rooted in the community. The Leader also suggested that in addition to considering what the key components of the model were, there was a related consideration around what were the outcomes that the Board wanted to deliver. It was agreed that the task and finish group would be the most appropriate forum to agree what the key components and outcomes required would be. The task and finish group should also give consideration into how to achieve the step change from a small scale pilot scheme to delivering across the system (to note – Tamara Djuretic).

The Chief Executive of the Bridge Renewal Trust advised that some considerations around the key components required were; having the activities to refer patients to and the impact of austerity on the voluntary sector in that regard, the need for GP involvement and having a link worker embedded in the practice was suggested as a good model, preferably one who was locally based. The Chief Executive of the Bridge Renewal Trust also suggested that whilst the GP was a key link in the model it was also important to have a broad referral pathway including wider health services such as IAPT and also referrals through the voluntary sector.

Assistant Director, Early Help & Prevention commented that consideration of community resilience was key and suggested that the task and finish group should also look into how to incorporate volunteering into the model to afford people the opportunity to invest back into their community (to note - Tamara Djuretic).

Ms Herman echoed other comments around the importance of local knowledge and raised concerns with creating a number of new structures on to services that already exist, the issue was that these services needed to be co-ordinated. Ms Herman commented that keeping up to date information was a key challenge in terms of coordinating services and also very expensive.

The Board requested an update from the task and finish group at the next meeting of the Board **(Action: Tamara Djuretic).**

RESOLVED:

I). To agree that social prescribing is the right approach for Haringey.

II). To establish a ‘task and finish’ group – including representatives from the CCG, primary care Haringey Council, Healthwatch and a range of providers already delivering some aspects of social prescribing in the borough – to scope the local model to best suit the landscape and existing services across the borough.

48. BUSINESS ITEMS

INTEGRATRATION OF HEALTH & SOCIAL CARE SERVICES

The Board received a report which provided an update on several strands of joint working between Haringey Council and Haringey CCG and the other councils, CCGs and healthcare providers in North Central London. The report was introduced by the Chief Officer CCG and was included in the agenda pack at page 55.

The Board noted that the government set out its further intention to focus on delivering joined up care during the Autumn Spending Review and also announced that the BCF would continue as a key programme in 2016/17. The Spending Review also set out an ambition that by 2020 health and social care would be integrated everywhere.

The Board also noted that NHS leaders were required to produce two separate but connected plans. A one-year operational plan for 2016/17, focused on individual organisations and a five-year sustainability and transformation plan (STP). The STP would be an umbrella plan, holding underneath it a number of different specific delivery plans and would involve local authorities, CCGs and providers agreeing the geographical footprint covered by the plan. From 2017/18 onwards, STPs will become the single planning process for being accepted onto programmes with transformational funding. Full STPs were due for submission at the end of June 2016.

Chief Officer Haringey CCG advised that the bid to develop a vanguard proposal in conjunction with Islington was unsuccessful but that the two councils and two CCGs had continued to explore joint working opportunities around transforming health and social care services. A clinical workshop was held on 29th January to consider place-based systems of care and a population segmentation approach to identifying health and care needs.

Chief Officer Haringey CCG also advised that the Better Care Fund Planning for 2016/17 was progressing well with positive discussions on budget planning and a review of appropriate services to be included within the BCF. The technical guidance had only just been released; it was anticipated that the current outcome measures would be maintained. A draft plan was submitted in early February to NHS England and feedback should be provided before the end of March. The final submission was due on 20th April and would require the Board to sign it off. The final plan was to be reviewed by the HACI Board prior to sign off. The Board noted that the BCF would be signed off by the Chair as an Urgent Action as the deadline for submission was prior to the next meeting. Chief Officer Haringey CCG agreed to send round copies of the BCF submission to the Board **(Action: Sarah Price).**

Ms Grant raised concerns around the ongoing inclusion of patient groups in future given the increased joint working across boroughs. The Chief Officer Haringey CCG responded that so far engagement with voluntary and community organisations had been done through the individual projects within the BCF. The Chief Officer Haringey CCG acknowledged concerns around maintaining the voice of the patent and agreed that this would be considered going forward.

The Director of Public Health advised that this was the first time in NHS planning that local authorities were formally included in the process and that the Public Health teams across NCL were coordinating into the process from a local authority

perspective. The Director of Public Health commented that this could provide further opportunities to embed other devolution workstreams including the Prevention Pilot.

RESOLVED:

I). To note the overall progress in partnership working in several areas.

II). To support the approach taken to closer working with partners in North Central London, as set out in Section 6.1 of the report.

III). To support the approach taken to closer working with partners in Islington, as set out in Section 6.2 of the report.

IV). To agree to Chair's actions to approve the BCF submission for 2016/17, as set out in Section 6.3 of the report.

HEALTH & WELLBEING BOARD MEMBERSHIP

The Board considered a report setting out the proposed changes to the membership of the Board. The report proposed the appointment of the Bridge Renewal Trust Moracle Foundation to the Health and Wellbeing Board as the Council's voluntary sector partner following Cabinet's decision in December 2015 to appoint the Bridge Renewal Trust as the Council's voluntary sector partner.

RESOLVED:

I). To appoint the Bridge Renewal Trust Moracle Foundation to the HWB, to replace HAVCO as the non-voting member previously designated as fulfilling a developmental role on the Board in building partnerships across the public and voluntary sectors. This is in line with section 194 (8) of the Health and Social Care Act 2012.

II). To recommend the change in membership to the Full Council meeting on the 17th March following which the Terms of reference of the HWBB can be amended to reflect the change in membership.

III). To put forward an amendment to the Council Constitution, Part three, section B paragraph 8.4, bullet point 10, replacing HAVCO with the Bridge Renewal Trust Moracle Foundation.

IV). To undertake a wider review of Board membership to ensure the right representation to provide system leadership for Haringey and its residents.

V). That a paper setting out any proposed changes arising from the review be brought to the June meeting of the Board for approval. Following this, the revised membership will go forward to Full Council in July for approval.

49. NEW ITEMS OF URGENT BUSINESS

No new items of Urgent Business were tabled.

50. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

It was noted that the future meeting dates were provisional:

- 19th May 2016 at 18:00
- 12th September 2016 at 18:00
- 8th December 2016 at 18:00
- 2nd March 2017 at 18:00

CHAIR: Councillor Claire Kober

Signed by Chair ……..

Date ……