NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Tuesday, 23rd February, 2016, 6.00 pm – Civic Centre, High Road Wood Green, N22 8LE

Members: See enclosed

Quorum: 3 voting members, including one local authority elected representative and one of either the Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes).

18:00 – 18:05

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.

18:00 – 18:05

2. WELCOME AND INTRODUCTIONS

The Chair will welcome those present to the meeting and introductions will be given.

18:00 – 18:05

3. APOLOGIES

To receive any apologies for absence.

19:00 – 18:05

Haringey LONDON healthwatch Haringey NHS Haringey Clinical Commissioning Group

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 10).

18:00 – 18:05

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.

18:00 – 18:05

6. QUESTIONS, DEPUTATIONS, PETITIONS

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

18:05 – 18:10

7. MINUTES

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

18:10-19:30

8. STRATEGIC DISCUSSION ITEMS:

1. Devolution Prevention Pilot (Healthy Environment and Sustainable Employment strands) in Haringey 2016-17. **18:10-18:50**

2. Social Prescribing. **18:50 – 19:30**

19:30-19:50

9. BUSINESS ITEMS:

1. Working with Partners – Integration of Health and Social Care Services**. 19:30-19:45**

2. Health Wellbeing Board Membership. **19:45-19:50**

19:50-20:00

10. NEW ITEMS OF URGENT BUSINESS

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

19:50-20:00

11. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The provisional dates of future meetings are as follows:

- 7th June 2016 -18:00-20:00
- 22nd September 2016 - 18:00-20:00
- 8th December 2016- 18:00-20:00
- 21st March 2017 -18:00-20:00

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Monday, 15 February 2016

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Agenda Item 2

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	Dr 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	CEO	Paul Leslie
Haringey Local Safeguarding Board		1	Chair	Sir Paul Ennals

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Agenda Item 7

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY 24 NOVEMBER 2015

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 Dina Dhorajiwala (Vice Chair Haringey CCG), Cathy Herman (Lay Member, Haringey CCG) Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services LBOH), Paul Leslie (HAVCO - Interim CEO).

Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Philip Slawther (Principal Committee Coordinator LBOH), and Stephen Lawrence-Orumwense (Assistant Head of Legal Services).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** The Chair welcomed those present to the meeting and the Board introduced themselves.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Dr Sherry Tang – Vice Chair • Sarah Price gave apologies for lateness • Sir Paul Ennals advised that he had to leave the meeting at 7pm.	
CNCL103.	**URGENT BUSINESS** The Board noted that there was one item of Urgent Business, on the London Health and Care Collaboration Agreement which would be tabled at Item 11.	
CNCL104.	**DECLARATIONS OF INTEREST** None	
CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** No Questions, Deputations or Petitions were tabled.	

CNCL106.	**MINUTES** **RESOLVED:** That the minutes of the meeting held on 24th September 2015 be confirmed as a correct record.	
CNCL107.	**BUSINESS ITEM** **ANNUAL SAFEGUARDING REPORTS, CHILDREN'S ADULTS** Sir Paul Ennals, the Chair of the Haringey Safeguarding Children's Board, presented a report to the Board that was included in the agenda pack at pages 107 -155. The report was for information purposes and provided an overview of Haringey LSCB's activities and achievements during 2014-2015; it summarised the effectiveness of safeguarding activity in Haringey and provided an overview of how well children in Haringey were protected. The Chair of the Haringey Safeguarding Children's Board drew the Committee's attention to the Chair's Foreword, especially the last paragraph; Section 6 on Board effectiveness, and the summary in Section 8. The Board noted that safeguarding arrangements within Haringey were broadly robust and effective and that the partnership had demonstrated its willingness to confront and respond to issues that arose. In terms of areas for improvement, the partnership needed to; improve its data sharing, improve its engagement of children and young people in the work it undertook and to think radically about how services would be delivered in the years ahead. The Chair of the Haringey Safeguarding Children's Board highlighted considerations for the Board to note in relation to the report: • The Board considered itself to be broadly effective, providing challenge and scrutiny across partners and actively encouraging partnership working. • Services in Haringey were at least as good as in most areas. • Schools in Haringey were better than most and the Board noted that this was a significant indicator as good schools tended to keep children safe. • The last year saw a significant increase in the number of referrals to Children's Social Care, increases in the number of Children in Need, and increases in the number of children on Child Protection Plans. • Significant improvements have been made in the way the Board tackled some of the biggest risks such as CSE and missing children. • The Board were monitoring the introduction of Early Help	

services, which would be crucial in reducing the impact of a reduction in resources in years to come.

- The partnership was showing that it was ready to be open, frank and honest with each other; acknowledging when cuts were coming in and the impact this would have on children and families but try to mitigate the impact as much as it could in a multi-agency way.

Sharon Grant, the Chair of Healthwatch Haringey, asked for clarification on the reasons behind worsening performance around home visits to children subject to child protection plans within four weeks. The Chair of the Haringey Safeguarding Children's Board responded that the figures noted in the report reflected performance for the last 12 months to April and that more recent performance was more encouraging. The AD Safeguarding and Social Care added that one of the main reasons was difficulty in recruiting permanent staff, which led to a relatively high level of turnover of agency staff. The AD Safeguarding and Social Care advised that the performance reflected a shortfall in home visits being done within the four week timescale not that those visits were not happening at all.

Ms. Grant requested that future performance data be presented in a way that qualified how late visits were. The Chair advised that the Corporate Delivery Unit assessed performance in detail, beyond the headline performance figures, and that in-depth analysis of key safeguarding performance was undertaken on a periodic basis. The Chair of the Haringey Safeguarding Children's Board commented that a lot of the detailed data was monitored by the key agencies as it came through and that they would ensure that proper scrutiny and monitoring of fluctuations of key performance was undertaken. The Board's role was more around maintaining an overview.

Dr Adi Cooper, Independent Chair of the Haringey Safeguarding Adults Board (SAB) presented a report to the Board that was included in the agenda pack at pages 157-232. The Board noted that the report was significant as it reflected the preparations being done to ensure compliance with the Care Act 2014.

Dr Cooper advised that she had taken on the role of Independent Chair during the summer and that having an Independent Chair was helpful in terms of taking the Board on to the next level. The SAB was noted as being in a different place to the Children's Board in terms of the partnership and in terms of meeting the shift in emphasis required to meet the provisions of the Care Act. The Director of Adult Social Services agreed that the appointment of an independent Chair would bring an element of robustness and challenge to the multi-agency partnership.

Dr Jeanelle de Gruchy highlighted the synergies between both sets of safeguarding reports and the violence against women and girls agenda

	and that the Council and partners were in the early stages of developing a new violence against women and girls agenda and would be linking in with both safeguarding boards during this process. Zina Etheridge, the Deputy Chief Executive, asked for elaboration on the quality of provision of safeguarding processes and the quality of schools. Officers responded that quality had a direct relationship to prevention of safeguarding incidents occurring and that the Care Act placed a duty on the partnership to develop a multi-agency response to quality assurance. Officers added that up until relatively recently the Council had been fairly internally focused in terms of quality assurance but that a number of measures were being developed to broaden that relationship. Dr. Adi Cooper advised that there were a number of issues around service provision across London, about the nature of the market and the variability of the quality and availability, and the likely consequence was a commissioning model for both health and social care service provision. The SAB would need to maintain an overview of what the profile was locally. The Board also noted that whilst there was a lot of available data there was a lack of intelligence around the interface between quality prevention of safeguarding and the need for intervention. The Chair thanked both Sir Paul Ennals and Dr Adi Cooper for presenting their reports to the Board. **RESOLVED:** That the annual safeguarding reports be noted.	
CNCL108.	**DISCUSSION ITEM** **PRIORITY 2 INCREASING HEALTHY LIFE EXPECTANCY** A summary version of the presentation circulated as part of the agenda pack (pages 25-59) was tabled at the meeting. Dr Jeanelle de Gruchy, Director of Public Health gave the first part of the presentation on the Annual Public Health report. Hard copies of the Annual Public Health report were distributed to the Board. The second part of the presentation was delivered by Marion Morris, Head of Health Improvement, and focused on the delivery of Priority 2 of the Health and Wellbeing Strategy – Increasing Healthy Life Expectancy. Following the presentation the Board discussed its findings. The Director of Public Health introduced: Joan Curtis, Secretary Haringey Friends of Parks Forum; Wendy Thorogood - Smarter Travel Officer; Andrea Keeble - Commissioning Manager for Sports and Physical Activity; Dr Katrin Edelman, Clinical Service Director, Barnet	

Enfield Haringey Mental Health Trust.

The 2015 Annual Public Health report focused on encouraging Haringey residents to live longer, healthier lives. The Board noted that in spite of an overall improvement in life expectancy over recent years, not all had benefitted, and inequalities in life expectancy remained. There was a 7 year gap in average life expectancy between the most affluent and most deprived areas of the borough, and women were expected to live 4 years longer than men.

The Board also noted that, in terms of healthy life expectancy for Haringey, women were on average living the last 25 years of their lives in poor health, and men the last 16 years of their lives in poor health. The main reason people were living in poor health was because they had one or more long term health conditions. Long term health conditions were usually preventable and were often caused by a small number of lifestyle factors. These factors included; an unhealthy diet, low levels of physical activity, smoking and excessive alcohol intake. These factors were also the most important risk factors for people dying early. The impact of these factors on the provision of health and social care was significant.

In response to ensuring that residents lived long, healthy lives, the Board noted that the focus was on three key areas: Making it easier for people to make the healthy choice; working with communities and giving support to those who need it most.

The Director of Public Health drew the Board's attention to the recommendations at the back page of the Annual Public Health Report. Some of the key recommendations were noted as:

- Build on and expand the 'Health in all Policies' approach.
- Ensure that plans for the regeneration of Tottenham address factors related to healthy life expectancy such as employment, poor quality housing and ease of walking of cycling.
- Taking a multi-agency approach to prevention including tighter tobacco control.
- Ensuring prevention was everyone's business from primary care through to hospital care.

The Chair queried why West Green ward had significantly higher levels of life expectancy than some of its neighbouring wards in Tottenham. In response, officers advised that the numbers were estimates and that the numbers in individual wards could fluctuate, given the relatively small numbers of people dying in any particular ward. Officers advised that the most striking aspect of the graph contained in the Annual Public Health report was the clear disparity between east and west in terms of life expectancy.

Cathy Herman, Lay Member Haringey CCG, asked whether there was

an inequality factor involved in women leading longer parts of their lives in poor health across different parts of the borough. Officers responded that whilst there was no ward level data available, the risk factors involved in contributing to healthy life expectancy would be more prevalent in certain areas or wards and therefore there would be an inequality in healthy life expectancy, for example, from the west to the east of the borough.

Ms. Grant asked to what extent these figures were broken down by say, ethnicity. In response, the Director of Public Health commented that there was a lot more data available and a lot more analysis was undertaken on the Joint Strategic Needs Assessment.

The Board noted that there were three ambitions within the Health and Wellbeing Strategy that supported Priority 2.

- Ambition 4 - Every resident enjoys long lasting good health. The target for Ambition 4 was a 25% reduction in early deaths from stroke by 2016-2018 from 92 to 68 deaths.
- Ambition 3 – Haringey is a healthy place to live. The target for Ambition 3 was to increase the number of people who walk and cycle to the top quartile of London Authorities by 2018.
- Ambition 2 – More adults will be physically active. The target was a reduction in inactive adults to 25% by 2018.

The Head of Health Improvement clarified that being physically active amongst adults was measured by 30 minutes or more of physical activity a day and 60 minutes a day or more for children. The Head of Health Improvement also clarified that the data was self reported survey data. In response to a query around accounting for differing levels of activity amongst different age ranges of adults and how that was reflected in inactivity levels among adults, the Director of Public Health commented that the data was age standardised in terms of the sampling. The target given was an average figure for all adults; however the data was available broken down across age bands.

The Head of Health improvement identified that the second part of the presentation would focus on two of the risk factors for early death and unhealthy life expectancy; smoking and physical inactivity, in particular walking.

Some of the key points in regards to smoking raised in the presentation were:

- Smoking prevalence had declined in the general population. However, it was now more concentrated in poorer communities and those with mental health conditions. Smoking accounted for half of the difference in life expectancy between the richest and poorest.

- People were more likely to become an addicted smoker if they started to smoke as a child and it was also harder to quit.
- People with serious mental health problems died up to 17.5 years prematurely – mostly attributable to smoking
- On average, smokers needed care 9 years earlier than non smokers and were 2-4 times more likely to have a stroke
- Over 40% of UK tobacco is estimated to be consumed by people with mental health conditions
- Costs to NHS of treating smoking related diseases in people with mental health conditions estimated as £720m in 2013
- Unequal rates of smoking were a big driver of health inequalities.
- In terms of current action on tobacco, there were a number of population level interventions such as targeting underage sales and smoke free policies in the work place and in cars.
- There were also interventions through communities such as peer-to-peer support / health champions and targeting specific communities such as shisha use within the Turkish community.
- Intervention through services was also used, both on a targeted basis such as mental health or pregnant women, and from April 2016 support will be provided by an integrated wellness service linked to wider determinates of health such as debt management.

In terms of what the Board could do to help deliver a reduction in smoking as part of Priority 2, the following outcomes were highlighted:

- Ensuring smoke free work places in hospitals and Mental Health Trusts and all work places.
- Supporting work with secondary care – Acute, Maternity and Mental Health sites to ensure NICE guidance on smoking was implemented
- Signing and support of the Declaration on Tobacco Control & NHS Statement of Support.
- Championing the Making Every Contact Count (training across frontline staff working in Haringey).

Sarah Price, Chief Officer – Haringey CCG, highlighted that the CCG had the ability to allocate an element of the contract value to incentivise quality improvement and that smoking was one of the issues that the CCG had incentivised NHS trusts to undertake. The Board noted that this was an opportunity to refine how those schemes were set up in the run up to the new financial year to ensure the best value from that investment.

Paul Leslie, Interim CEO – HAVCO, asked for the clarification on whether certain communities pushed back on schemes that were targeted to them and if so, how this was addressed. Officers responded that there was some push back, for instance a misconception that shisha was not tobacco and therefore was not as harmful, and that the

solution was through education of the harm involved. The Head of Health Improvement commented that the Council had been effective around enforcement of shisha bars but a more joined-up approach across Council partners was required.

The Chair enquired about consideration of the inter-relationship between tobacco and cannabis and how much work had been done to understand the prevalence, particularly amongst young people, around cannabis use. Officers responded that there were a number of particular health concerns related to cannabis usage and that understanding the prevalence may require clearer questions around smoking tobacco as appose to cannabis. This would also likely impact the types of interventions required to tackle it.

Dr Edelman, advised the Board on the difficulty of bringing in smoke free policies and also how to work with particular groups so that they didn't feel personally targeted. The Board noted that the BEH Mental Health Trust attempted to go smoke free at the same time as acute hospitals, however significant difficulties were encountered, particularly with detained patients in wards wanting cigarette breaks and not wanting to use nicotine replacement products. Dr Edelman advised that it was felt that this contributed towards an increase in violent incidents as well as uncertainty as to whether this constituted a breach of their human rights. The ban lasted for a few months and the Board was advised that the inside of premises were now smoke free and that patient were permitted to smoke outside.

Dr Edelman commented that the numbers of BEH MET patients smoking was very high, as was evidence of poor physical health. Forensic services were due to go smoke free from 1st January, which was an NHS England initiative. This provided an opportunity to monitor its implementation as something of a pilot for other services. Dr Edelman advised that they had recently been making use of the mobile stop smoking service and that this had some limited success in engaging patients on a one-to-one basis, as well as raising the profile of stopping smoking campaigns.

Sir Paul Ennals commented that, given the strong evidence around people who smoke at a young age smoke for longer and find it harder to quit, there were strong implications around even deferring the age at which people start smoking. Sir Paul also commented that there were some very good materials produced by different agencies around the different information approaches required to bring about behaviour change in children rather than adults. The Head of Health Improvement commented that a number of targeted engagement activities had taken place with young people around smoking such as development of the 'Young and Healthy' app.

Some of the key points in regards to walking raised in the presentation were:

- Need to shift the common perception of exercise being about gyms.
- Walking decreases the risk of obesity by 4.8% for each additional KM walked per day and can be easily incorporated into everyday activities.
- GLA indicators of a healthy street have been developed which were helpful in assessing how walking friendly Haringey's streets were.
- In Haringey, 26% of people in lower socio-economic groups are inactive compared to 21% of those in higher-socio-economic groups.
- In terms of current action on walking, there were a number of population level interventions such as outdoor green space, 20 MPH speed limits and the LIP targets for reduced car use.
- There were also interventions through communities such as Smarter Travel programmes and a Sports and a Physical Activity Framework.
- Intervention through services included targeted walk programmes such as Walk for Life.

Joan Curtis updated the Board on a programme of organised walks that was being developed by the Friends of the Parks organisation, in conjunction with the Parks Service and Public Health. Refurbishment work was undertaken in Lordship Rec including works to uncover the Moselle river, this became a catalyst to utilising Haringey's extensive network of parks and historical locations to promote physical activity through organised walks. Ms. Curtis advised that a book, Walk in Haringey, was being produced which contained a number of different walks and this would be supplemented by asking each of the Friends groups to organise a walk in their local area for a Haringey Walk Weekend on 1 & 2 October 2016. The Haringey Walk Weekend would form part of a wider Year of Walking Campaign and would link to other projects such as walk to work week. The campaign would be accompanied by a communications campaign and a dedicated web page on the Council's web site.

In terms of what the Board could do to help deliver increased physical activity through walking as part of Priority 2, the following proposals were suggested:

- Support for the proposal for a Year of Walking Campaign and walk weekend in October 2016.
- Championing the GLA's 'Ten Indicators of a Health Street' programme.
- Championing walk to work week and walking generally in the work place.

Mr Leslie commended the proposed Year of Walking campaign and

	walk to work weekend and requested elaboration of how the campaign would engage with residents in the east of the borough who may be less engaged generally, as well as communities who may not ordinarily engage in community based activities. Officers advised that one example was the Moselle river walk which connected the east and the west of the borough. Officers also advised the Friends Groups were made up of a variety of people from different backgrounds. Mr Leslie requested that HAVCO's website be utilised to advertise the campaign. Ms. Curtis advised that an updated version of the Moselle walk was being reprinted to include Tottenham Marshes and that this would be available online in due course. Electronic versions of maps were also being developed. Ms Grant also commended the proposed campaign and requested that consideration be given to expanding these proposals to include encouraging walking in areas of surrounding countryside, particularly for people who tended not to leave their particular area, and advocated the benefits that this would have in tackling some of the biggest health inequalities. Cllr Morton, Cabinet Member for Health and Wellbeing paid tribute to the work that the Friends groups and others had done in the borough. Cllr Morton suggested that some of the new resources that Councillors had been given could be utilised to help scale up a walking programme. Cllr Morton reflected that the numbers involved around the gap in healthy life expectancy gap were a fairly longstanding concern and queried how much of the activities proposed here were new. The Director of Public Health responded that nationally the boundaries were constantly being pushed on smoking, such as the smoke free work place. The challenge locally was to ensure that these policies were enforced and to examine how best to enforce these policies. In terms of walking, policies on this scale were a new undertaking and the challenge for the Board was to bring together the existing pockets and to encourage a concerted effort and focus on the issue across partners. The Deputy Chief Executive asked whether GP's surgeries could do more to recommend people to local walking groups and also emphasised the number of walking resources that existed, such as TFL's map that shows the distance between Tube stations. The Deputy Chief Executive questioned if there was an opportunity to collectively find a small amount of resource to bring all of those walking related elements together. The Board also noted that the Smarter Travel team produced a map that covered all of the walking routes in Haringey, copies of which were being reprinted. Ms. Herman emphasised the need for community development and queried how the Board could encourage a culture which facilitated people to help each other. In this respect, the Board noted, GP's probably had a significant role as they were in contact with quite isolated people.	Marion Morris

	Ms Grant advocated the use of social prescribing to connect General Practice with the rest of the community, to ensure that everyone who worked in General Practice was aware of what else was available in the community. Ms Grant suggested the Board should organise holding a symposium on social prescribing, determining what it would mean in the borough and how the different ambitions and outcomes would be advanced by adopting such a model. The chair thanked those present for their contributions. **RESOLVED:** I). That the Local Government Declaration on Tobacco Control & the NHS Statement of Support for Tobacco Control, be endorsed. II). That the roll out of Making Every Contract Count Training be encouraged. III). That support be given to the proposal for a dedicated & coordinated walking programme & walk weekend. IV). That the Board champion the GLA's 'Ten Indicators of Healthy Street' programme. V). That the Board champion 'walk to work week' and walking generally in the workplace	
CNCL110.	**BUSINESS ITEM** **UPDATE ON AMBITION 8 OF THE HEALTH AND WELLBEING STRATEGY – BASELINE AND TARGET MEASURE** A report was included in the agenda pack at page 61. Dr Tamara Djuretic, Assistant Director of Public Health, gave a presentation to the Board on the baseline measure and target for Ambition 8 of the Health and Wellbeing Strategy. Following the presentation the Board discussed the findings. Some of the key points raised in the presentation were: • Haringey's Health and Wellbeing Strategy's Priority 3 focuses in improving mental health and wellbeing across the borough and Ambitions 7, 8 and 9 are set to monitor progress of the implementation of Priority 3. • Ambition 8 was more adults will have good mental health and wellbeing. • PHE were commissioned to undertake a survey. 10,000 households were contacted and over 1,000 people completed	

	the survey. 500 across the borough and an additional 500 from the most deprived areas. • The results on the Warwick Edinburgh scale were an average score of 26.10 across the borough and 26.21 in the most deprived areas. The Board noted that Haringey's baseline WE score is moderate and that there was no significant difference in the score across the borough compared to most deprived areas. • The maximum score was 35. A low score was classified as below 21, a moderate score was 22-29 and high score was 30 and over. • The national average score was 25.3. • The target for Ambition 8 was noted as increasing the average score on the short Warwick-Edinburgh mental wellbeing scale by 15% from 2015 baseline to a score of 30 by 2018. • Scores for 16-24's, over 65's in most deprived areas and women were lowest. • Factors positively impacting on mental wellbeing were; good health, time to do enjoyable activities, spending time outdoors, physical exercise, personal relationships, trust and feelings of neighbourhood belonging. • Factors negatively impacting on mental wellbeing were; childhood experience of unhappiness and violence, inability to work due to sickness and disability, poor educational attainment and financial difficulties. Ms. Grant enquired whether care had been taken in the sampling in regards to race, ethnicity, age etc. The Assistant Director of Public Health responded that care had been taken around including specific demographics including a number of factors which were linked to deprivation, such as educational attainment. **RESOLVED:** I). That the findings of the borough-wide mental health and wellbeing survey be noted; and the proposed trajectory for Ambition 8 be agreed. II). That a full report on the survey be brought back to a future meeting of the Board.	Tamara Djuretic
CNCL111.	**BUSINESS ITEM** **CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS** A cover report and presentation on the CCG Commissioning intentions for the forthcoming financial year were included in the agenda pack at page 67. The Chief Officer Haringey CCG gave the presentation to the Board. The Board noted that it was a requirement for the CCG to liaise with the Health and Wellbeing Board about its commissioning intensions.	

The Board noted that one of the main areas that had seen significant progress this year was the Better Care Fund. The BCF provided integrated care for people who were older and possibly frail, and who had complex needs and used hospitals frequently. A lot of work had been undertaken to ascertain how best to provide support to those patients in a more joined-up manner.

The Chief Officer, Haringey CCG advised that through joining a team of people around the individual had started to have a significant impact on people's experience of health care and reducing the number of times people had to go into hospital.

The Chief Officer, Haringey CCG also advised that going forward some real challenges remained around un-scheduled care. There was a high level of cases of children going to A&E at night and the Board noted that a priority for next year would be to look into providing alternative services for them. The Board noted that the CCG would also be looking at; 7 day services for end of life care, bereavement support, building capacity in services that were used to help avoid admissions to hospital and how community services might be used more effectively to stay out of hospitals. The other area that was being examined as part of this process was looking at long term conditions and how healthy life expectancy might be addressed in a more joined-up manner across different agencies.

The Board was advised that the CCG would be working with partners to develop those priorities and how they might be best achieved and that discussions would be ongoing between now and the beginning of the financial year.

Cllr Waters, the Cabinet Member for Children and Families asked whether it was know what proportion of residents were registered with GP's. The Chief Officer, Haringey CCG responded that there were significantly more people registered with GP's in Haringey than lived in the borough, due to people who lived near the borough boundary registering with a Haringey surgery. This made it quite difficult to ascertain how many people were not registered. The CCG's responsibility was to people who were registered with a GP in Haringey.

In response to a follow up question about whether people not being registered with a GP was the main reason for pressure on A&E services, the Chief Officer Haringey CCG advised that this was not the predominant reason. Factors such as communities who are not used to using general practice and the fact that A&E is open 24 hours a day and those patients knew they would be seen, were much more significant.

RESOLVED:

I). That the report be noted.

HEALTH AND CARE INTEGRATION PROGRAMME UPDATE

A report on the progress of the Health and Care Integration Programme was included in the agenda pack at page 83. The Deputy Chief Executive presented the report to the Board. The Board noted that significant progress had been made in terms of thinking about how the commissioning could be integrated services, particularly through the Better Care Fund, for example. Signals from the government suggested that integration would continue to be pushed as the preferred model. The Deputy Chief Executive advised that a Haringey Stat meeting was being planned for the new year which would be based on a discussion of the factors that drive admissions avoidance across the whole system, both in residential and acute care.

RESOLVED:

I). That the report be noted.

HARINGEY BETTER CARE FUND PLAN UPDATE

A report on the progress of the implementation of the Better Care Fund was included in the agenda pack at page 87. Beverley Tarka, Director of Adult Social Services, presented the report to the Board. The Board was asked to note the following updates on the Haringey Better Care Fund:

- The Haringey BCF, and its associated services, was making steady progress with implementation according to its assigned budget.
- The governance of the Haringey BCF was established and included a range of stakeholders in health and social care
- Quarter 1 (April – June 2015) data was available on a number of outcomes, however it was still too early to draw conclusions on the effectiveness of Haringey BCF.

RESOLVED:

I). That the report be noted.

CNCL112. NEW ITEMS OF URGENT BUSINESS

The Director of Public Health introduced an item of Urgent Business to

	the committee, which provided an update on the London Health and Care Collaboration Agreement. The London Health and Care Collaboration Agreement was agreed by all London councils and CCGs and established a London-wide framework for the acceleration of collaboration, integration and devolution, at the local, sub-regional and city-wide levels. The launch of the agreement in early December would be accompanied by the launch of a number of pilots to test different aspects of integration and devolution – Haringey CCG and Council have signalled intent to be part of two pilots. Haringey Council and the CCG had jointly submitted an expression of interest to become a 'prevention pilot'. The aim of this pilot was to build relationships and work intensively with London partners and national agencies (PHE, NHSE, DCLG and DWP) to explore the most effective ways of using planning and licensing powers to create healthy environments, and pilot new ways of supporting more people with health conditions (particularly mental health) into sustainable employment. Discussions were scheduled to continue over December around agreeing objectives and how the work would be supported by, the national agencies. In addition, The NCL Collaboration Board and its five Local Authority partners submitted an expression of interest in the application of devolved powers to facilitate the improved utilisation of the health and social care estate. A successful commissioners workshop recently identified potential devolution of powers and these were being evaluated and developed prior to submission of a Business Case in early December. The project was maintaining close working with the London Office of CCGs, the office of London Local Authorities and London Transformation Programmes. The Board noted the update on the London Health and Care Collaboration Agreement and agreed that a further update would be brought back to the Board in due course. The Director of Public Health advised that signatures for the pilot were required by the end of the week and that the Business Case would be built around April.	Jeanelle de Gruchy
CNCL113.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 23rd February at 18:00. Ms. Grant requested that a future agenda item be brought to the board around Social prescribing. Ms. Grant to liaise with the Director of Public Health to agree the details of the item.	Sharon Grant

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY 24 NOVEMBER 2015

	The Director of Public Health advised the Board that Haringey partners received a Health Services Journal Award for innovation in Mental Health. The collaborative piece of work was based around the development of peer mentoring in schools, where Year 9 and Year 10 pupils recorded videos to express their own experiences and shared them with other pupils. The aim of the videos was to de-stigmatise mental health issues.	

The meeting closed at 19.50pm.

Cllr Claire Kober

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Chair of the Health and Wellbeing Board

Report for:	Health and Wellbeing Board – 23rd February 2016

Title:	Progress on establishing a Devolution Prevention Pilot (Healthy Environment and Sustainable Employment strands) in Haringey 2016-17

Report Authorised by:	Dr Jeanelle de Gruchy – Director of Public Health

Lead Officer:	Dr Jeanelle de Gruchy – Director of Public Health

1. Describe the issue under consideration

1.1 This report provides an update on the early progress of the Haringey Devolution Prevention Pilot including the results of scoping work carried out by the Council and partners, which covers:

- potential proposals as to the priorities/ focus of the pilot
- rationale behind the proposed priorities
- what work these priorities entail
- indication of the internal resources required to pursue these priorities and
- indication of what resources we would seek from external partners in order to pursue these priorities

The Pilot will have two strands. The Healthy Environment strand will be a series of projects in which we will carry out qualitative health research and focused licensing enforcement activity to expose the limits of existing licensing regimes (alcohol), or demonstrate the consequences where we have no positive licensing powers (Fixed Odds Betting Terminals and Tobacco). We will use the evidence gathered to make the case for new powers to be devolved to London (such as Minimum Unit Pricing).

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

2. Cabinet Member Introduction

2.1 Haringey is a borough that faces major challenges and inequalities around health and wellbeing. The life expectancy gap between the most and least deprived

wards is 7 years for men and 3 years for women. The borough is facing an 'obesity crisis'. The number of people with long term conditions, such as diabetes and heart disease is increasing, and there are approximately 4,000 adults with severe mental illnesses.

2.3 The Council and its partners are determined to meet these challenges and improve the health of local residents at pace and scale. We recognise that nothing less than a whole system approach is required in which we embed health objectives in all policies and shift every partner's core business towards prevention. Our vision for prevention is fundamentally to 'normalise good health'. This involves shifting resources towards population level approaches that change norms of behaviour. It is about using the Council's place-making role to shape the physical environment in which healthier decisions are made – recognising that where we live is the biggest determinant of our health. It is about breaking the reinforcing cycle of inequality, poor health and unemployment by working with employers and joining up services to prevent people with health problems becoming locked out of employment.

2.3 The Prevention Pilot will enable us to accelerate our progress towards this whole system approach to prevention. We will work with London and national partners to leverage the expertise and support we need to embed best practice, test the limits of existing powers, and build the case for devolution as a means of delivering prevention goals in London.

2.4 The Prevention Pilot is one example of our integrated approach, working with partners within the borough and other boroughs on a wider geographical footprint. Further information and examples of the benefits of this way are set out within Agenda Item 9: 'Working with Partners – Integration of Health and Social Care Services'.

3. Recommendations

3.1 That the HWB notes the content of this 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 below.

3.2 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.

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

4. Reasons for decision

4.1 The level of health need in Haringey is set out in paragraph 2.1 above. The Council recognise that a whole system approach to the prevention of ill-health is required if the health of local residents is to be improved. In order to achieve this Haringey has become a 'Prevention Pilot', which means that it is exploring how it can use collaboration, integration and devolution (in London), to prevent health problems from developing. The pilot will test the limit of existing powers, and help make the case for powers to be devolved, with the aim of delivering a significant preventative effect. The pilot would be consistent with the Health and Wellbeing Strategy's vision for 'Place Shaping' and improvement of mental health and wellbeing.

5. Alternative options considered

There is the option not to proceed with the Pilot, but an expectation has been created by the public declaration of Prevention Pilot status at the December launch of the London Health Devolution Agreement.

There is the option to reject the proposals set out in appendix 1 and carry out further scoping to identify alternative proposals. The risk is that Haringey lags behind the other London Health Devolution Pilots, and misses out on opportunities to work with London and national partners. There is scope to continue developing proposals as the pilot progresses - i.e. to have a phase 2, such that the proposals in appendix 1 do not necessarily have to be the limit of what the pilot focuses on.

6. Background information

6.1 Haringey became a pilot for London Health Devolution when the London Health Devolution Agreement was announced on 16th December 2015. The Agreement is a framework/structure for London wide devolution regarding health and social care, signed by Government, NHS England, Public Health England, the 32 boroughs and CCGs and their London representative bodies. It sets up a governance system for closer integration and collaboration in London, and for managing the future, progressive devolution of powers and budgets. Alongside the governance structure, 5 London pilots have been established, to build the case for different aspects of devolution. The other 4 pilots are:

- Barking & Dagenham, Havering and Redbridge - developing an Accountable Care Organisation, where primary and secondary care are more closely integrated
- Lewisham - seeking to integrate physical and mental health services alongside social care
- Hackney - health and social care integration, aiming for full integration of health and social care budgets and joint provision of services. This will also have a particular focus on prevention

- North Central London (Barnet, Camden, Enfield, Haringey, and Islington) will run an estates pilot to test new approaches to collaboration on asset use. See below for details of Haringey's involvement in this pilot.

6.2 Haringey is a Prevention Pilot which means we are exploring how we can use collaboration, integration and devolution in London to prevent health problems from developing, or intervene earlier when problems emerge. It is about testing the limit of existing powers, making the case for powers to be devolved, and locally rewiring national systems so as to shift resources to prevention and early intervention.

6.3 Our declaration as a Prevention Pilot featured two overarching objectives:

- Healthy Environment - maximising licensing and planning powers to tackle alcohol, fast food, gambling and tobacco, and seeking new powers to create health enhancing environments where the healthier choice is the easy choice.
- Sustainable Employment - integrating health and employment systems to intervene earlier to prevent the mutually reinforcing issues of ill-health and unemployment.

6.4 The Pilot is a partnership initiative - the pilot declaration was signed by LBH, Haringey CCG, police and Healthwatch. It was agreed that the Health and Wellbeing Board would be the ultimate governance body for the pilot.

6.5 The declaration was a high level document, providing only a general declaration of our objectives, rather than any detail on what types of powers, policies and interventions we would be exploring through the Pilot. To move the Pilot forwards we need to agree locally on what our specific areas of focus should be, what work this will entail, and crucially what support from London and national partners we require.

6.6 The onus is very much on the pilots to clarify their priorities and specify their support asks. The London and national partners behind the Agreement (including London Councils, London Office of CCGs, GLA, NHSE, PHE) are ready to provide support, particularly in terms of brokering contact with those government departments (DH, DCLG and DWP) that are expected to be the focus of the pilots' devolution asks.

Provisional timetable

6.7 There is no fixed timetable for the London Health Devolution Pilots - the impetus is meant to come from the pilots themselves. A sub-committee of the London Health Board will be responsible for progressing the London Health Devolution Agreement and will monitor the pilots, help share their learning etc, but this will not be an onerous monitoring regime. NHSE are organising a meeting of all the pilots in early

March which will be an opportunity to compare plans and progress. Based around this milestone we have been working to the following provisional timetable:

23rd February	Health and Wellbeing Board reviews pilot priorities
24th February	Pilot Steering Group agrees priorities
End of February	Letter sent to London and national partners laying out our pilot priorities and support asks
Early March	Meeting with other pilots
March	Detailed negotiations of support with London and national partners
April	Support agreed, detailed scoping of projects/development of business cases can commence
April 2017	Pilot report published, recommendations for devolved/new powers are made; where business cases for new delivery models have been agreed, piloting of new models commences.

Early progress

6.8 Since the New Year, initial scoping workshops have taken place involving a range of Council departments (Public Health, Policy, Planning, Licensing, Community Safety, and Economic Development) and local partners (CCG, GPs, CAB, Police, JCP, local VCS). We have also consulted with London and national bodies/experts to gain additional information, explore our ideas and confirm the viability of our emerging proposals. For example we have had conversations with Manchester City Council and the Home Office to understand more about Minimum Unit Pricing, and meetings with Islington Council to find out more about their Health and Employment Programme.

6.9 This scoping work has enabled us to identify some priority areas that we propose should be the focus of the Prevention Pilot. These cover both internal/partnership improvements that are within our gift, and things that require support from Government/external bodies.

6.10 The proposals template in **appendix 1** details these priority areas and outlines

- the rationale behind the proposed priorities;
- what work these priorities entail;
- the internal resources required to pursue these priorities and;
- the resources we would seek from external partners in order to pursue these priorities

7. Contribution to strategic outcomes

7.1 The Prevention Pilot has been conceived as one way of achieving the Corporate Plan's vision for enabling all residents to live healthy, long and fulfilling lives. The Health and Wellbeing Strategy identifies our key priorities - obesity, healthy life

expectancy and mental health - and the Prevention Pilot reflects these priorities with its focus on Hot Food Takeaway planning policies, alcohol licensing and employment support for people with mental health issues.

7.2 The Corporate Plan identifies working in partnership as one of the key means through which we will pursue our objectives. The Prevention Pilot represents a deeper form of partnership working, one that will may involve 'whole system' rewiring with local partners, and a new relationship with national partners involving data sharing, new forms of support and ultimately it is hoped the devolution of powers and budgets. The Prevention Pilot represents the next step in our strategic commitment to partnership working, and to take advantage of the opportunities presented by devolution.

8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

8.1 Finance and Procurement

In general the spirit behind the proposals set out in this document seems to be about making best use of public resources through changes to powers and responsibilities, processes and systems rather than through seeking large amounts of new resource. As such the financial implications are limited. The appendices outline the local investment required from Haringey which will be met from our existing resources. In addition there are a number of asks from central government and other partners; the proposals will need to reviewed when it is clear which of these will be met.

The external resources identified for this project, external secondees or temporary posts funded by external bodies need to be appointed in line with Council procedures.

The Head of Procurement notes the content of the report.

8.2 Legal

8.2.1. The Assistant Director of Corporate Governance has been consulted in the preparation of this report, and makes the following comments.

8.2.2. In recognition of the importance of this initiative, legal input will be provided at Assistant Head level.

8.2.3. Confirmation can be given of the fact that all of the pilot initiatives set out in Appendix 1 of the report, are consistent with the two topics assigned to the Council under the London Health Devolution Agreement.

8.2.4. As the five devolution pilots have been intentionally configured to test the feasibility of delivering the reshaping of healthcare across London - with the consequential

opportunity to tackle the challenges which exist in this Borough – the Assistant Director of Corporate Governance confirms that there are no legal or Constitutional reasons which would stop the Board from adopting the recommendations contained in this report.

8.3 Equality

8.3.1 We know obesity levels are closely linked to deprivation - Year 6 children (10-11 year olds) living in deprived areas are 2.5 times more likely to be overweight or obese than those in more affluent areas. There are large inequalities in life expectancy between the east and west of the borough (on average 8 years for men and 3 years for women). Health-related unemployment is also concentrated disproportionately in the east of the borough, where there is the greatest ethnic diversity and a higher proportion of disabled residents.

8.3.2 The Prevention Pilot has the potential to have a positive impact on equalities. It will explore how to maximise the use of planning and licensing powers to create healthy environments that reduce obesity. Tottenham regeneration will mean that it will be in east of the borough that there will be the greatest opportunity to exercise new health-promoting planning and licensing powers. The Pilot's employment strand will focus on residents with mental health issues who need employment support, and again it is anticipated that it will be residents in the east of the borough that will benefit most from this. The Prevention pilot therefore has the potential to help address the health inequalities in the borough.

8.3.3 Whenever the Prevention Pilot leads to changes in policy or the delivery of services, an Equalities Impact Analysis will be carried out for each individual proposal - as part of the Council's normal decision making process. Service user data will be analysed and steps taken to consult the people who are likely to be affected by the proposal.

8.3.4 More broadly it is an aspiration of the Pilot to carry out the exploratory and policy development work in collaboration with residents and service users - through co-design, service user interviews and representation in the Pilot's working groups. This will help ensure that equalities considerations always inform the work of the Pilot.

9. Use of Appendices

Appendix one – Prevention Pilot: Healthy Environment strand proposals
Appendix two – Prevention Pilot: Sustainable Employment strand proposals

10. Local Government (Access to Information) Act 1985

Not applicable

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Devolution Prevention Pilot

Health and Wellbeing Board

23 February 2016

National context

- Council's increasingly funded by local economies
- Individual devolution deals with big cities + a single county deal (Cornwall)
- Manchester's deal is unique: includes £6 billion of NHS and social care budgets devolved

‘Devolution’ in London

Sub-regional planning/commissioning

- Discrete (though large scale) planning and commissioning exercises rather than permanent devolution of funds and powers to sub-regions
- Developed from existing collaborative (integrated) relationships on a multi borough geographical footprint

Piloting for future devolution

- Building the case for future devolution of powers/funds on behalf of London, rather than achieving devolution now
- Chance to use pilot status to spur internal improvement, build better partnerships and leverage in external support (public sector reform)

London Health and Care Collaboration (*ie Devolution*) Agreement

- Signed by Mayor (GLA), London CCGs, London Councils, NHSE, PHE (Dec 15th); set up 5 pilots:
  - **Barking & Dagenham, Havering and Redbridge** - developing an Accountable Care Organisation (primary and secondary care integration)
  - **Lewisham** - integrating physical & mental health services alongside social care
  - **Hackney** – aim: full integration of health & social care budgets & joint provision of services + focus on prevention
  - **North Central London** – estates pilot (develop a regional capital programme; devolve powers to approve NHS capital business cases; retain more of the proceeds of sales (see Agenda Item).
  - **Haringey** – prevention pilot

Prevention: a priority for Haringey

- Council's corporate plan – a 'cross-cutting' theme
- CCG (draft) operational plan: 'a radical upgrade in prevention and public health'
- Our approach: Health in all policies

Haringey prevention pilot

- To work with London and national agencies on two goals:
  - Healthy environments
  - Sustainable employment

- The ‘Healthy environments’ strand is about:
  - Finding the most effective ways of using planning and licensing powers to create healthy environments (testing the capacity of existing powers and working through the issues and risks that enhanced powers would bring).
- The ‘Sustainable employment’ strand is about:
  - Piloting new ways of supporting more people into sustainable employment – integrating the employment support and health systems, with a particular emphasis on supporting people with mental health issues, workplace retention and working with employers

Timeline

Agree Prevention Pilot priorities internally	February
Submit support ‘asks’ to Government/external agencies	March
Commence building evidence base with partner support	April
Prevention Pilot conclusions published	April 2017
Devolution of powers to Haringey/all London?	2017-18?

Governance and delivery

- Health and Wellbeing Board oversight
- Devolution steering group chaired by DPH; membership includes: CCG COO; senior officers across council; co-chairs of 2 delivery groups
- Engagement of other partners including Local – JCP, police, BEHMHT; Regional – GLA; National – DWP, PHE, DH, DCLG
- Delivery groups report into the steering group:
  - Healthy environments workstream – co-chairs: Marion Morris and Eubert Malcolm
  - Sustainable employment workstream – co-chairs: Vicki Clark and Tamara Djuretic

Discussion

- View on the focus of the two work-streams?

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Report for:	Health and Wellbeing Board – 23rd February 2016

Title:	Social Prescribing

Report Authorised by:	Dr Jeanelle de Gruchy – Director of Public Health

Lead Officer:	Tamara Djuretic, Assistant Director of Public Health

1. Describe the issue under consideration

1.1 This report introduces the concept of social prescribing, describes various models and the evidence base behind the models and summarises the rationale underpinning the approach.

1.2 The HWB is asked to discuss our strategic approach to social prescribing and the model to adopt that would best suit our local landscape and our diverse communities.

2. Cabinet Member Introduction

2.1 Improving access to primary and community care and enriching the local offer of interventions that are community based is one of the ambitions clearly articulated in Haringey's Health and Wellbeing Strategy.

2.2 Developing a local social prescribing approach for Haringey across the whole system would be an important step towards delivering that ambition. It is a real opportunity for the CCG, the council, local GPS and healthcare professionals to work together to improve community health.

3. Recommendations

3.1 The Board agrees that social prescribing is the right approach for Haringey.

3.2 The Board establishes 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 our local model to best suit our landscape and existing services across the borough.

4. Background information

4.1 Approximately 70% of health outcomes are determined by socio-economic factors and 30% by clinical factors (Marmot 2010). Social prescribing seeks to address this by offering referral into non-clinical services coupled with support to engage with these services, which range from arts and culture to physical exercise, benefits and debt advice, cookery classes, etc.

4.2 "Social prescribing is a mechanism of linking patients into non-clinical services usually linked to primary care and/or linking clients into support from within the community to promote their health and wellbeing, to encourage social inclusion, to promote self-care, where appropriate, and to build resilience within the community and for the individual" (Social Prescribing in Bristol Working Group, 2012). Social prescribing models focus on factors that positively support health and well-being rather than on factors that cause disease—and promotes a more holistic, community-centred model of primary and community care.

4.3 There are a number of different models of social prescribing across the country, as described in Appendix I. The table below describes the most common models and the pros and cons related to each model:

Social prescribing model	Pros	Cons
GPs playing a role in signposting to a range of non-clinical services;	Minimal additional workload for GP/primary care staff Patient-driven contact with VCS Inexpensive model as it does not require additional staff	Reduced likelihood of uptake by patients GPs and practice staff difficulty in maintaining awareness of diversity of services available Some GPs may not yet be accepting of social prescribing as a viable care route. No feedback from VCS Difficult to evaluate
GPs prescribe patients to a specific activity, with some models extending to allow referrals from other professionals including voluntary sector and social care;	Patient trust/familiarity of GP and other professionals Inexpensive More formalised, may increase uptake compared to signposting alone	GP not necessarily ideally placed to refer to community resources due to the additional time needed to consult with patients to identify appropriate services Reduced likelihood uptake amongst patients

		GP unlikely to have time to stay up to date with the range of available services and providers. No feedback from VCS Difficult to evaluate
Referral from GPs/other professionals to a link worker who would provide support and advice on the most appropriate set of activities based on individual needs.	Reduced burden to primary care staff to maintain contact/awareness of VCS services available 'One stop shop' for patients/health professionals and increased uptake Better patient care – time for link worker to identify most appropriate service using *local* knowledge and access to directories – can be developed into "holistic" model, in which link worker assesses whole person needs not just those raised by GP. Patient-centred. Other health and social care workers, especially domiciliary workers and healthcare assistants might be well placed to advocate schemes to older adults and/or mental health service-users at risk of social isolation. Link worker one to one sessions (e.g. up to 6 one hour sessions) has therapeutic effect Initial VCS activities may be subsidised/funded, longer term patients contribute financially to VCS Link worker may join part of	Requires clarity on which care pathways a social prescribing scheme would fit into/address. Requires investment for link worker if not integrated within already existing services Requires time to develop trusting partnerships between health/VCS sector. All "famous" SP initiatives evolved from the other "lighter" models – not an instant bolt on, a long term commitment. Difficult to evaluate

	multi-disciplinary team, providing feedback to health/social care professionals Social care, charities, other health professionals may also be able to refer	

4.4 The evidence of effectiveness of social prescribing models in terms of improving health outcomes and reducing hospital and GP activity varies in relation to specific health conditions and the way social prescribing models are delivered. In general, the evidence of effectiveness seems to be stronger in patients who have long-term conditions and mental ill health. The Rotherham Social Prescribing Pilot (2012) has identified a clear overall trend in reduced hospital usage with 21% fewer admissions, 14% fewer A&E attendances and 21% fewer outpatient appointments in those followed up twelve-months post-referral compared to twelve months pre-referral (Sheffield Hallam University, *The Social and Economic Impact of the Rotherham Social Prescribing Pilot: Summary Report*, 2014). Eighty three percent of those followed up three to four months post-discharge had experienced positive change in at least one social outcome area (e.g. money, family and friends, managing symptoms, lifestyle etc). However, only 40% of social prescribing programmes have been evaluated and available evidence is methodologically limited by the lack of a comparator group, resulting in a high risk of bias. Outcomes may vary depending on type of services offered and extent of link worker involvement. There is a need to clarify outcomes expected and to discuss with the voluntary and community sector about how best to collect monitoring data.

4.5 The social prescribing concept is not new for Haringey and there is a range of interventions already in place that would form part of the network of our local model:

- Pilot project in JS Medical Practice
- Neighbourhood Connects
- Time Credit
- Bound Green Road practice – initiatives delivered by Patient Participation Group
- Welfare hubs in GP practices
- IAG
- Integrated wellness service
- Locality co-ordinators
- Cultural and Creative Industries Strategy
- Primary Care Strategy
- NCL Estate devolution
- Healthwatch workshop

5. Contribution to strategic outcomes

Community Strategy, Priority 2 of the Corporate Plan and Ambition 5 of the Health and Wellbeing Strategy.

6. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

Finance and Procurement

6.1 This is a discussion paper and, as such, there are no recommendations for action that have direct financial implications.

Legal

6.2 This is a discussion paper and, as such, there are no recommendations for action that have a direct legal implication.

Equalities

6.3 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;
- advance equality of opportunity between people who share those protected characteristics and people who do not;
- foster good relations between people who share those characteristics and people who do not.

6.4 Social prescribing models aim to deliver better health outcomes for all of Haringey's residents, particularly those that have long-term conditions or poorer mental health.

7. Use of Appendices

Appendix I: Social Prescribing for Health and Wellbeing presentation

8. Local Government (Access to Information) Act 1985

Not applicable

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Social Prescribing for Health and Wellbeing in Haringey

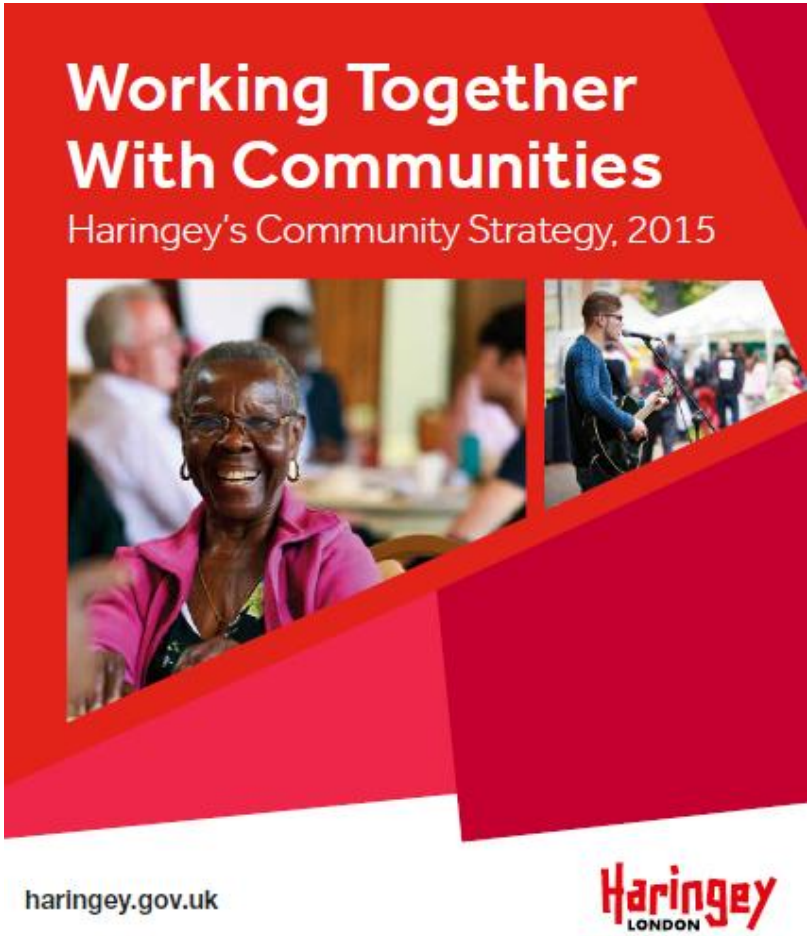
Health and Wellbeing Board

23rd February 2016

National policy drivers behind social prescribing

- Marmot Review (2010) 'Fair Society, Healthy Lives' prioritised the social determinants of health, via correlation between health inequalities and social and economic inequalities;
- Focus on prevention and health promotion as a form of 'managing' rather than treating poor health;
- Encouraging asset-based approaches to improving health and wellbeing, utilising a community's individual, organisational, cultural and physical resources;
- Co-production (service users and professionals jointly design and deliver public services) and citizen participation and volunteering in public sector.

Local policy and strategy drivers



Building a Stronger
Haringey Together

CORPORATE PLAN
2015-18

Haringey
LONDON

HAVCO

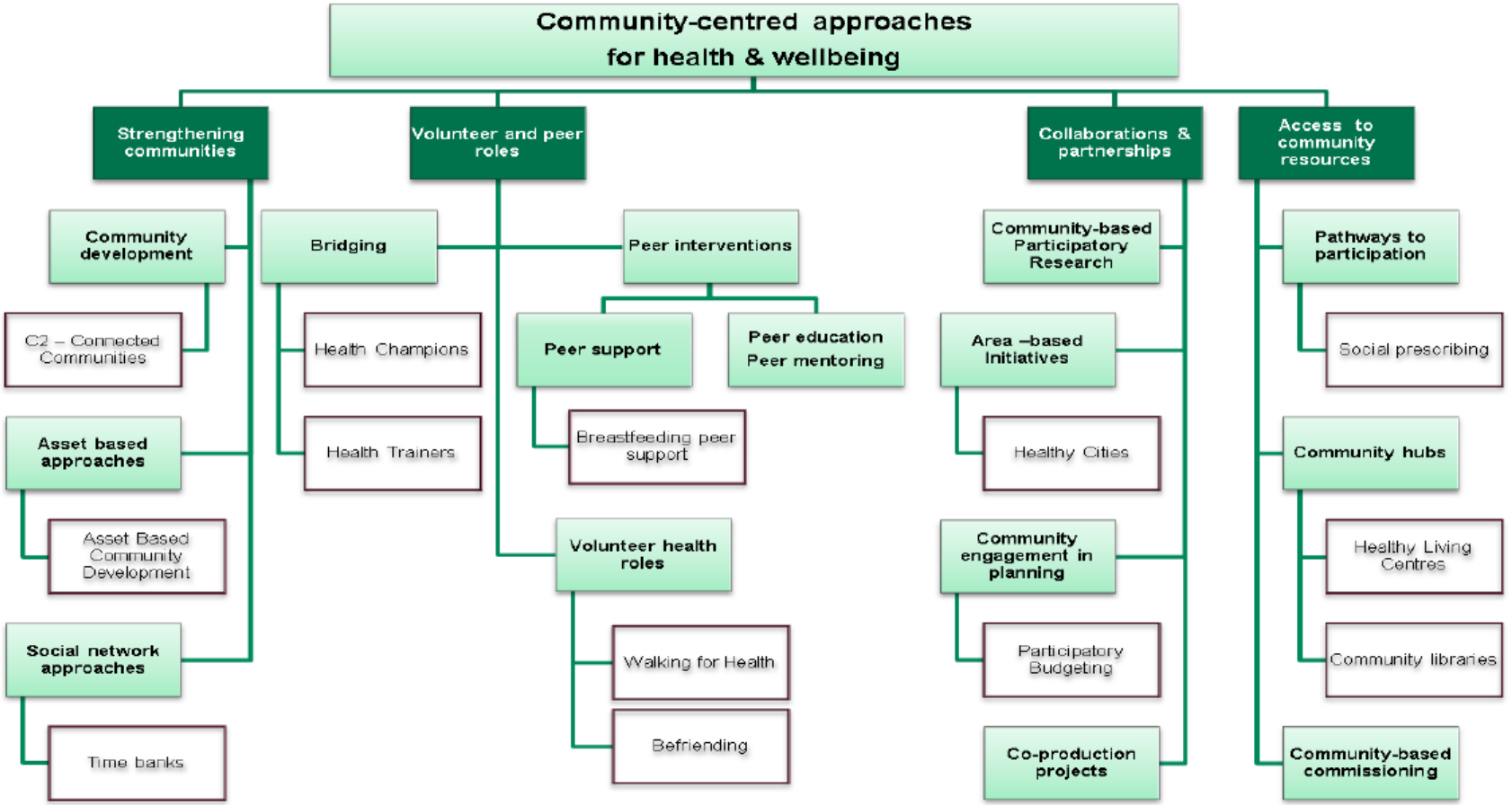
NHS
Haringey
Clinical Commissioning Group

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

The family of community-centred approaches linked to health and wellbeing



Social Prescribing (or 'community referrals')

- Linking patients with non-medical support in the community, usually via primary care but there are different models (e.g. community hubs, community navigators)
- Activities include: arts, creativity, physical activity, learning new skills, volunteering, advice on benefits, housing, debts, legal advice, parenting support, etc.

Models of social prescribing [1]

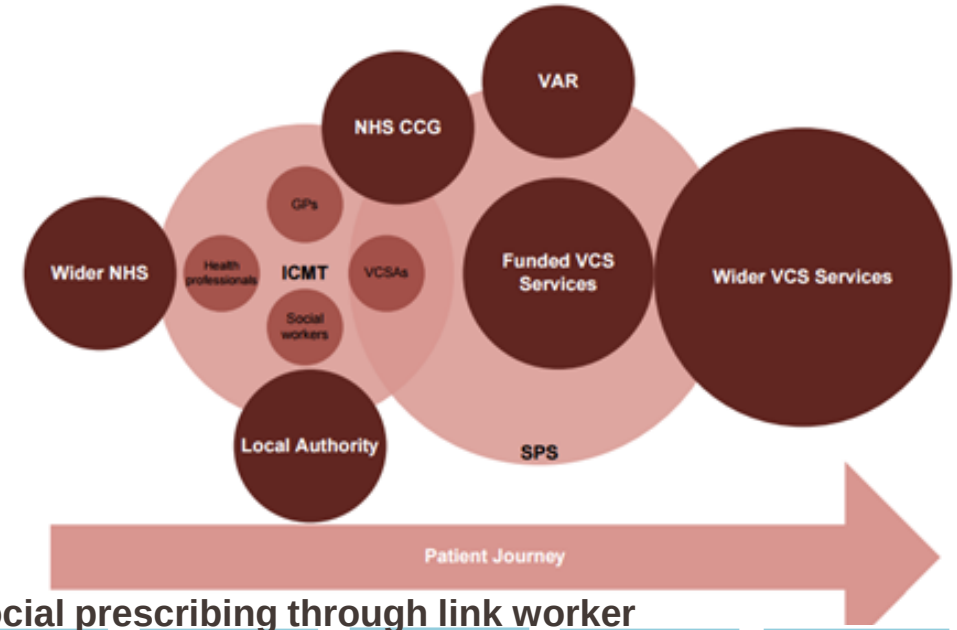
Signposting

Prescribing

Models of social prescribing [2]

Link worker/co-ordinator/facilitator

Examples



Social prescribing through link worker

Patient presents in primary care with non-medical / psycho-social symptoms	Primary care staff refer patient to link worker based in primary care practice or charity	Link worker interviews patient to determine suitable scheme available from directory	Patient attends scheme and reassessment after fixed number of sessions (free or subsidised)	Reassessment is fed back to link worker, patient is signposted to similar activities (often incurring cost)

Social prescribing as part of IAPT provision

Patient (aged 55 years or over) presents in primary care with mental health issues	GP refers patient to IAPT for Step 1 of stepped service (up to 6 sessions of psychological therapy)	Counsellor at IAPT refers patient to suitable scheme as adjunct to or while waiting for Step 1 of IAPT	Patient recovers or if condition worsens moves to Step 2 with further scheme as adjunct to IAPT	Assessment of benefits of scheme for patient is fed back to IAPT, IAPT report on patient is fed back to GP

Outcomes

- Increased levels of social interaction
- Improved overall wellbeing by improving access to opportunities
- Building confidence, resilience and coping skills
- Reduced levels of service use
- Increased patient satisfaction

Does it work?

- Some evidence of effectiveness for people with mental health problems and those with long-term conditions;
- Evaluation programmes not yet sufficiently robust (need for controlled comparisons, not just before & after)

Local initiatives and drivers

Neighbourhood connects	JS Medical Practice pilot	Time Bank	Welfare hubs
IAG	Integrated wellness	Locality coordinators	Bounds Green Medical Practice and PPG
Primary Care Strategy	NCL Estate devolution	Healthwatch workshop	Cultural & Creative Industries Strategy

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Report for:	Health and Wellbeing Board – 23rd February 2016

Title:	Working with Partners – Integration of Health and Social Care Services

Report Authorised by:	Zina Etheridge – Deputy Chief Executive, Haringey Council and Sarah Price – Chief Officer, Haringey CCG

Lead Officer:	Tim Deeprose, Interim Joint Integration Programme Manager

1 Describe the issue under consideration

1.1 This paper provides an update on several strands of joint working between Haringey Council and Haringey Clinical Commissioning Group and the other councils, CCGs and healthcare providers in North Central London. The paper is intended to inform members and to seek confirmation for the direction taken.

2 Cabinet Member introduction

2.1 Supporting everyone to be healthy and have a high quality of life for as long as possible is a core aim for the Council and its partners. Integrating health and social care so that care is person centred, joined up and meets their needs is core to that vision. Joint working with partners both within Haringey and with health and social care partners in other boroughs helps meet that objective.

2.2 Patients, service users, and residents are involved in the many project groups working to better integrate health and social care services through the redesign of clinical or service pathways eg Healthwatch Haringey are members of the Older Adults Working Group of the BCF programme. When decisions are required to enter into formal integration arrangements (eg Section 75 pooled budgets) such recommendations will be taken to the appropriate governing bodies.

3 Recommendations

3.1 The Health and Wellbeing Board is asked to:

- note the overall progress in partnership working in several areas
- support the approach taken to closer working with partners in North Central London (section 6.1)

- support the approach taken to closer working with partners in Islington (section 6.2)
- agree to Chair's actions to approve the BCF submission for 206/17 (section 6.3)

4 Background information

4.1 Successive Governments have set out a direction for greater health and social care integration[1]. The Better Care Fund Policy Framework published in December 2014 made it a requirement for Health and Social Care to create a pooled budget for joint delivery of services.

4.2 The Autumn Spending Review (25th November 2015) set out the government's intention to go further, faster to deliver joined up care. It announced that the BCF will 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 and have a plan to do so by 2017. The guidance also proposed that '*areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution'*. No single blue print is proposed for this. The examples given included Accountable Care Organisations such as in Northumberland, devolution deals joining up health and social care such as Greater Manchester and lead commissioner arrangements as in North East Lincolnshire.

4.3 It is important to clarify that the ultimate objective is to integrate services as this will provide better care for the people using them. Organisational integration or closer working is a means to achieve this greater integration of service delivery. It is expected that greater integration between commissioners and providers of service will lead to improved outcomes and more sustainable financing of service provision.

4.4 This year's NHS Planning guidance requires NHS leaders to produce two separate but connected plans:

- a one-year operational plan for 2016/17, focused on individual organisations
- a five-year sustainability and transformation plan (STP), place-based and driving delivery of the *NHS five year forward view,* for the period October 2016 to March 2021.

4.5 For the five-year sustainability and transformation plan (STP), CCGs, local authorities and providers are to agree the geographical footprint covered by the plan. The STP will be an 'umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints'. Devolution proposals are expected to use these boundaries as their footprints. As well as describing how services will be transformed to meet the Five Year Forward View vision, plans will need to address a series of 'national

[1] 2010 to 2015 Government Policy: Health and Social Care Integration (published 25 March 2013 and updated 8 May 2015)

challenges', which fall broadly into three themes: improving health and wellbeing, improving quality and developing new models of care, and improving efficiency to achieve financial balance. From 2017/18 onwards, STPs will 'become the single application and approval process for being accepted onto programmes with transformational funding', with the most credible plans – judged on a number of criteria – securing the earliest funding. Full sustainability and transformation plans are due for submission at the end of June 2016.

5 Partnership Working

5.1 North Central London Strategic Planning Group (SPG). The 5 CCGs, 5 Borough Councils and NHS Trusts in North Central London (Barnet, Enfield, Haringey, Camden and Islington) will work together to develop a five year sustainability and transformation plan (STP) as defined in the planning guidance.

5.2 Collaborative work across the SPG area had already begun following the financial analysis undertaken for NCL by Carnall Farrar in 2015:

- A first iteration of the financial base case has been agreed demonstrating the challenges faced over the next five years
- Four system-wide priorities have been established in urgent and emergency care, mental health, primary care development and estates utilisation and planning
- A programme management team is being developed to support the work going forward.
-

5.3 Governance arrangements to oversee and guide the development of our STP are being agreed and established. This will take the form of a Transformation Programme Board with supporting groups which initially will oversee and guide the development of the STP. In the medium and longer term it is anticipated that this group, which will include representation from all partners in NCL, may extend its remit to oversee delivery and implementation of the STP. This work will be developed in partnership with existing established governance arrangements including Health and Wellbeing Boards. Care will be taken to ensure that work programmes are aligned so as to avoid duplication.

5.4 One opportunity presented by the current cross boundary working is the chance to be one of five London Health and Care Collaboration Agreement pilots. The estates devolution pilot is seeking extra powers to manage the estates of health care providers, councils and CCGs across NCL. A series of workshops are being held to identify which devolved powers would enable better coordinated management and planning of all estate across NCL. The aspiration is to develop a regional capital programme, devolve powers to approve NHS capital business cases and retain more of the proceeds of sale. This approach is being supported by the Mayor's Office and London Councils and the Office of London CCGs. If benefits can be achieved during the 2017/18 pilot year in NCL, the same powers will be devolved to other boroughs across London.

5.5 It is recognised that, although the NCL footprint is already established as a group of organisations which is working together on some health and care issues (such as the Estates Devolution pilot, and the 111/OOH procurement), additional work is also undertaken at the sub-NCL level, recognising that it is at this level where many productive longstanding and natural alliances exist. NCL partners are clear in their intention to develop and build on this local work, whilst at the same time working together to ensure that full advantage is taken of the opportunities available on a bigger footprint where there is a clear benefit to the communities we serve.

5.6 A number of key principles will be important to the way NCL working will develop:

- NCL working will complement the already established local work and is not intended to slow down or delay additional sub-NCL partnerships and networks
- Working as part of the NCL geography will not preclude the partners working with other organisations in other SPG areas where this would benefit the communities we serve
- Decisions will be taken at the most local level.

5.7 Partnership work with Islington Council and CCG. Since the work last year to develop a Vanguard proposal, the two councils and both CCGs have continued to explore the opportunity to transform health and social care services together for the people of Haringey and Islington. For example, a clinical workshop on 29 January considered place-based systems of care and a population segmentation approach to identifying health and care needs.

5.8 There are many similarities in the demographics and health needs of the two boroughs. The combined population is expected to grow 14% in the next 15 years. Highest growth is in those aged 65+, both have high BME populations and a mix of deprived and affluent neighbourhoods. There is similar prevalence of long term conditions (20% of overall population) and of lifestyle risk factors. Both boroughs face similar challenges although these are not unique to Haringey and Islington

5.9 Tackling these issues requires transformation of the health and care system. This is best done by working together. As discussed earlier there is a need to work together at several different geographical footprints in order to tackle these problems. For example clinically the ideal catchment population for an A&E department is between 3-500,000 people while for a stroke unit it is up to 700,000 population. So it is helpful to explore what might be achieved within Haringey and Islington as well as supporting the North Central London wider work.

5.10 Why Haringey and Islington?

- Vanguard proposal - developed buy in and commitment from all involved
- Positive and trusting relationships between clinicians across organisations
- Good relationships between senior executives of health and care organisations
- Shared community services
- Similar demography and health needs of populations
- Increased impact working across a bigger geography

5.11 So what might a single approach across Haringey and Islington mean?

- opportunity to define the populations served where we can make the biggest impact.
- agree outcomes and a common service model to deliver to those people
- agreeing a governance model to deliver common purpose across the organisational boundaries.
- Identifying resources to support the work - system and clinical leadership
- agree a joint team across partners to resource delivery
- agree an approach to infrastructure - workforce, estates, IT - to enable delivery of new models

5.12 There is much to do to realise the benefits of such an approach. Three broad steps are to:

- Seek Health and Wellbeing Board support as sponsors to the programme
- Establish a project management team to develop the opportunities

- By end of March, aim to have a strategic proposal, committed resource and leadership and delivery milestones.

5.13 Better Care Fund Plan 2016/17. The Better Care Fund planning for 2016/17 is progressing well with positive discussions on budget planning and a review of appropriate services to be included within the BCF. Promised technical guidance is still awaited but it is anticipated that the current outcome measures will be maintained with the likely requirement for a delayed transfers of care action plan and a possible change in use of the payment for performance funding for out of hospital services.

5.14 A draft plan was submitted in early February to NHS England and feedback should be provided before the end of March. The final submission is due on the 20th April and should include Health and Wellbeing Board sign off. The final plan will be reviewed by the Health and Social Care Integration Board before recommendation to the Health and Wellbeing Board. As the required submission date is before the next Health and Wellbeing Board meeting agreement is sought that the Chair of the Health Wellbeing Board can sign off the final version on behalf of the HWB.

5.15 The Haringey Devolution Prevention Pilot. This is another of the five London Health and Care Collaboration Agreement pilots mentioned in the section above. Focussed on our approach of 'Health in all Policies', the proposal aims to work with London and national agencies on two goals: healthy environments and sustainable employment.

5.16 The ‘Healthy environments’ strand aims to find the most effective ways of using planning and licensing powers to create healthy environments (testing the capacity of existing powers and working through the issues and risks that enhanced powers would bring). The ‘Sustainable employment’ strand seeks to pilot new ways of supporting more people into sustainable employment – integrating the employment support and health systems, with a particular emphasis on supporting people with mental health issues, workplace retention and working with employers.

5.17 Health and Social Care Integration Programme. The Haringey Health and Social Care Integration Programme continues to progress well. Following a review prior to Christmas a workshop was held in early January which highlighted the opportunity to prioritise integration of services in four areas:

- Integrated Care (BCF)
- Children's Services
- Mental Health
- Continuing Health Care

5.18 It was also clear that an action plan was required to address organisational matters such as budget pooling, sharing IT systems and an organisational development

programme to help staff better understand the way in which each organisation worked and make access to colleagues easier.

5.19 Integration on differing geographical footprints. The various programmes described above work at differing geographical footprints yet all aim to maximise the opportunity of increased integrated working between organisations to deliver better outcomes and ensure sustainable financial planning.

5.20 At the most local level, the Health and Social Care Integration Programme seeks to ensure integration of services delivered in Haringey for our residents, eg continuing health care packages. Similarly, the Prevention devolution pilot brings together local organisations to use devolved powers to make improvements for residents.

5.21 There are some services which are better planned and managed across a slightly wider footprint. Working with the council, CCG and health providers in Islington enables better organisation of community health and social care services to prevent unnecessary admission to hospital or quicker discharge from Whittington Hospital.

5.22 As described in section 6.1 there are some health services which require a larger population from a wider catchment to ensure safe operating levels of activity and sustainability of services. Hence the work with other organisations in North Central London to identify and plan such services together.

6 Comments of the Chief Finance Officer and financial implications

6.1 This report is an update for noting about the progress of the Health and Care Integration Programme. The activity set out in this report is funded from various sources including Better Care Fund and the Council's Transformation reserve. There are no further financial implications as a result of this update report.

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

7.1 The Council's Assistant Director of Corporate Governance has been consulted about this report.

7.2 The Health and Care Integration programme is conducive to the Board's statutory duty to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population (Section 195 of the Health and Social Care Act 2012).

7.3 The Integration Programme is also conducive to the Council's and the CCG's statutory powers to promote integrated commissioning and provision of services in health and social care. The powers for these arrangements are set out within the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617), which include powers to pool budgets and undertake joint or lead commissioning pursuant to sections 75 -76 of the National Health Services (NHS) Act 2006 (as amended) (arrangements between NHS bodies and local authorities for

the delegation of functions), Sections 13N and 14Z1 of the NHS Act 2006 (14Z1 Duty as to promoting integration), Sections 25 and 26 of the Children and families Act 2014 (Education, health and care provision: integration and joint commissioning) and Section 3 of the Care Act 2014 (Promoting integration of care and support with health services etc).

7.3 There are no direct legal implications rising out of this report.

8 Equalities and Community Cohesion Comments

8.1 The proposed Health and Care Integration Programme is designed to provide health and social care services that produce better outcomes and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities.

8.2 Equality impact assessments will be carried out as part of the project planning and delivery process.

9 Head of Procurement Comments

9.1 There are no direct procurement implications arising out of this report however as and when the projects identify procurement requirements the appropriate processes will be followed.

10 Policy Implication

10.1 Integration of health and social care is a national policy arising from the Better Care Fund and Care Act Implementation and this programme of work will complement and add value to work under this remit.

11 Reasons for Decision

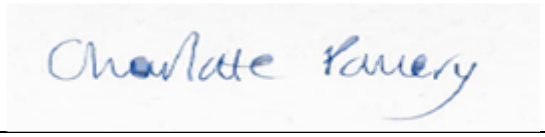
11.1 A draft Better Care Fund plan was submitted in early February to NHS England and feedback should be provided before the end of March. The final submission is due on the 20th April and should include Health and Wellbeing Board sign off. The final plan will be reviewed by the Health and Social Care Integration Board before recommendation to the Health and Wellbeing Board. As the required submission date is before the next Health and Wellbeing Board meeting agreement is sought that the Chair of the Health Wellbeing Board can sign off the final version on behalf of the HWB.

12 Use of Appendices

None.

Report for:	**Health and Wellbeing Board 23 February 2016**

Title:	**Board Member Change in Membership**

Report Authorised by:	**Assistant Director for Commissioning** 

Lead Officer:	**Ayshe Simsek, Acting Democratic Services Manager**

1. Describe the issue under consideration

To appoint the Bridge Renewal Trust Moracle Foundation to the membership of 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 Moracle Foundation as the Council's voluntary sector partner.2

To recommend to full council that the terms of reference of the Health and Well being board are amended to remove HAVCO and to insert Bridge Renewal Trust Moracle Foundation as the non voting members designated to fulfil a developmental role on the Board in building partnerships across the public and voluntary sectors,

To agree a review of the membership of the Health and Wellbeing Board to ensure effective system leadership in light of wider developments across the local health and care system. These include, but are not limited to, the introduction of five year Sustainability and Transformation Plans, the increasing collaboration between Haringey and Islington health and care economies and the statutory footing of the Safeguarding Adults Board under the Care Act 2014.

2. Cabinet Member introduction

2.1 This is not applicable (N/A)

3. Recommendation

3.1 It is recommended that:

a) The Bridge Renewal Trust Moracle Foundation are appointed 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.
b) The Board 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.
c) 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.
d) A wider review of Board membership is undertaken to ensure the right representation to provide system leadership for Haringey and its residents.
e) 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.

4. Alternative options considered

N/A

5. Background information

5.1 The Board is a Committee of the Council. The Council's Constitution (at Part 3 Section B Paragraph 8) sets out the governance arrangement for the Board. The Constitution provides for the following persons to be a member of the Board:

- The Leader of the Council
- The Cabinet Member for Children and Families
- The Cabinet Member for Health and Wellbeing
- Chair, Clinical Commissioning Group (Vice Chair of HWB)
- Chair of Healthwatch
- Director of Adult and Housing Services
- Director of Children and Young People's Services
- Director of Public Health
- Chief Officer, Clinical Commissioning Group
- Lay Board Member, Clinical Commissioning Group
- GP Board Member, Clinical Commissioning Group
- HAVCO representative[current appointed voluntary sector Partner]
- Representative for the NHSCB (when required)

The Council and the Board can appoint additional members as they deem appropriate. But the Council must consult with the Board prior to such appointment.

5.2 The Constitution restricts voting rights in the Board to the following members;

a) Local authority councillors (Leader of the Council, Cabinet Member for Children and Families and Cabinet Member for Health and Wellbeing);

b) Chair, Clinical Commissioning Group (Vice Chair of HWB); and

c) Chair, Healthwatch.

Any additional member appointed to the Board by the Council or by the Board are non-voting members. However, Full Council can make a direction to alter the voting right of Board members following consultation with the Board.

5.3 Following an open tender process for the award of a contract to be the Council's Strategic Partner for the Voluntary and Community Sector (VCS),The Bridge Renewal Trust Moracle Foundation was the preferred bidder and demonstrated it had the right values, skills and experience to be the Council's Strategic Partner.

5.4 This tender was a reflection both of the Borough's commitment to enabling and working alongside a vibrant, inclusive and self sufficient VCS and of its changing relationship with the sector in Haringey.

5.5 It is expected that the VCS will play an even more important role in helping those who live, work and visit Haringey to access the best possible services and support to help them achieve their potential. Developing a role for a Strategic Partner will help ensure we have a strong and prosperous VCS, and a solid relationship between the council and organisations in the community that deliver such important services to our residents.

5.6 The Strategic Partner will be supporting established voluntary and community-based organisations already in Haringey, and begin to encourage new and emerging organisations to develop and thrive. This will not only maximise their reach to people in Haringey, but also to increase capacity within the sector to secure external funding and to share good practice.

5.7 Given the agreed partnership role of the Bridge Renewal Trust Moracle Foundation in developing the Voluntary Sector in Haringey and increasing the capacity of the sector, it is appropriate for them to be invited to continue the work of HAVCO on the Health and Wellbeing Board which is line with section 194 (8) of the Health and Social Care Act 2012 .

6. Comments of the Chief Finance Officer and financial implications

N/A

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

7.1 Section 194 of the Health and Social Care Act 2014 provides for the establishment and membership of the Health and Wellbeing Board. This section (*subsection (2)*)

sets out that the Board's membership must include the director of children's services, the director of adult social services and the director of public health. There must be at least one elected representative, which may be the leader of the local authority and/or councillors nominated by the Leader (*subsections (3) and (4)*). The local Healthwatch organisation and each relevant CCG must also appoint representatives (*subsections (5) and (6)*). The section (s*ubsection (8)*) enables the Board to appoint additional persons as members. The local authority is also able to invite other persons (other than councillors) or representatives of other persons to become members *(subsection (2) (g)).* The local authority must consult the Health and Wellbeing Board before appointing additional persons after the Board has been established (*Subsection (9)).*

7.2 Regulation 6 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provides that a person who is a member of a Health and Wellbeing Board shall not be treated as a non-voting member of that Board unless the local authority which established the Board otherwise directs. Before making such a direction, the local authority must consult the Health and Wellbeing Board. At the Full Council meeting on 20th May 2013, following consultation with the Board, it was directed that the then local authority elected members of the Board, the Chair of the Clinical Commissioning Group and the Chair of Healthwatch will have voting rights. That any additional persons appointed to the HWB either by the Local Authority or the HWB will be appointed on a non-voting basis. This direction is reflected in the Council's Constitution.

7.3 All voting members of the Board are required to comply both with the Members' Code of Conduct and the provisions of the Localism Act 2011 relating to Standards. In particular, voting members will be required to complete a register of interests which must be kept up to date. Voting members must also declare any disclosable pecuniary interest or prejudicial interest in any matter being considered and must not take part in any discussion or decision with respect to these items.

8. Equalities and Community Cohesion Comments

N/A

9. Head of Procurement Comments

N/A

10. Policy Implication

N/A

11. Reasons for Decision

This is dealt with above.

12. Use of Appendices

N/A

13. Local Government (Access to Information) Act 1985

Full Council Report on Health and Wellbeing Board 18 March 2013

Full council Report on Health and Wellbeing board 23 February 2015

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