NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Tuesday, 19th May, 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.

18:00 – 18:05

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 19).

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.

l8:00 – 18:05

7. MINUTES

To consider and agree the minutes of the meeting of the Board held on 23 February 2016.

18:05-19:15

8. STRATEGIC DISCUSSION ITEMS:

9. Intermediate Care and Integration **18:05-18:45**

10. Haringey and Islington Work **18:45-19:00**

11. NCL Sustainability and Transformation Plan (STP)**. 19:00-19:15**

19:15-19:55

12. BUSINESS ITEMS:

13. North Middlesex University Hospital NHS Trust's Future Organisational Model. **19:15-19:25**

14. Mental Health Survey – Update **19:25-19:35.**

15. Devolution – Update **19:35-19:45.**

16. Transforming Care **19:45-19:55.**

19:55-20:00

17. URGENT ACTIONS TAKEN IN BETWEEN MEETINGS

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

- Better Care Fund

19:55-20:00

18. NEW ITEMS OF URGENT BUSINESS

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

19:55-20:00

19. 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:

- 12th September 2016 - 18:00-20:00
- 8th December 2016- 18:00-20:00
- 2nd March 2017 -18:00-20:00

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Wednesday, 11 May 2016

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 Peter Christian
			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	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Chair	Sir Paul Ennals

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Agenda Item 7

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY 23 FEBRUARY 2016

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

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

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: • Sir Paul Ennals. • Cllr Waters and Zina Etheridge gave apologies as they had to leave the meeting at 18:30.	
CNCL103.	**URGENT BUSINESS** There were no items of Urgent Business.	
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 November 2015 be confirmed as a correct record.	
CNCL107.	**DISCUSSION ITEM** **DEVOLUTION PREVENTION PILOT IN HARINGEY** A report setting out the progress on establishing a Devolution Prevention Pilot in Haringey for 2016-17, for both the Healthy Environment and the Sustainable Employment strands was included as part of the agenda pack (pages 19-25). The Appendix to the report, which set out the proposals for the prevention pilot, was tabled at the meeting as it had been omitted from the agenda pack in error. A copy of the presentation was also included in the agenda pack (pages 27-35). Dr Jeanelle de Gruchy, Director of Public Health introduced the report. Hard copies of the Annual Public Health report were distributed to the Board as background information for the item. Following the presentation the Board discussed its findings. The Director of Public Health outlined that the London Health and Care Collaboration Agreement was signed on the 15th December by the Mayor of London, London CCGs, London Councils, NHSE and Public Health England; and set up five pilots: • Barking and Dagenham, Havering and Redbridge – Developing an Accountable Care Organisation (primary & secondary care integration) • Lewisham – Integrating physical and mental health services alongside social care • Hackney – The aim was full integration of Health and Social Care budgets and joint provision of services, with a focus on prevention • North Central London – estates pilot to: Develop a regional capital programme; devolve powers to approve NHS capital business cases; retain more of the proceeds of sales. Haringey was a part of this pilot as part of NCL. • Haringey Prevention Pilot The Prevention Pilot would have two strands. The Healthy Environment strand would be a series of projects in which qualitative research would be undertaken along with focused licensing enforcement activity	

to expose the limits of existing licensing regimes (alcohol), or demonstrate the consequences where no positive licensing powers were available (Fixed Odds Betting Terminals and Tobacco). Evidence gathering would also be used to make the case for new powers to be devolved to London (such as Minimum Unit Pricing).

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

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

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

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

made easier with a subsequent larger round of devolution in 12 months time.

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

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

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

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

The Chief Officer, Haringey CCG agreed that a number of planning aspects were looked at during the scoping work for the bid but the focus was on options that had a defined devolution ask. The Committee were advised that the Mayor already had devolved powers around housing density and the percentage of social housing formula, through approval of the London Plan. The Chair commented that she

	was unsure whether housing density was the best proxy for determining poor health outcomes, instead the Chair advocated that aspects such as licensing, particularly of private landlords would be more significant. Cathy Herman, Lay Member Haringey CCG, commented that many of the outputs involved in the pilot would be long term goals and suggested that the impact on public health being a Licensing objective would be a very beneficial outcome. Ms Herman also advised that the positioning and influence for Haringey in being involved at the forefront of the devolution process was very important, particularly given the likely political agenda around aspects such as Minimum Unit Pricing for alcohol. The Chair commented not all of the devolution strands would be successful but that it was important to try a range of approaches to develop a robust process and to find which strands could have a significant impact and improve outcomes. ** Clerks note – The Cabinet Member for Children and Families and the Deputy Chief Executive left the meeting at this point ** Gill Gibson, Assistant Director, Early Help & Prevention, highlighted that the Troubled Families programme was already in place and that sustainable employment outcomes were a significant factor in that. The Committee considered that there were three years of learning gathered through the programme and that substance misuse was a key underlying factor for a large number of the adults involved. The AD Early Help & Prevention advised of the need to bring that learning into the pilot and the need to strengthen links between the two areas of work. The Chief Executive of the Bridge Renewal Trust suggested that part of the solution around sustainable employment should involve the voluntary sector and advised that the voluntary sector could do more in that area. The Assistant Director of Public Health acknowledged the need for heavy engagement with both the voluntary sector and communities to see how they could be supported to deliver sustainable employment outcomes. The Board noted that the voluntary sector would also be invited to form part of the sustainable employment delivery group. The Assistant Director Public Health agreed to discuss this further with the Bridge Renewal Trust outside of the meeting. The chair thanked those present for their contributions. RESOLVED: I). That the HWB notes the content of the report and the proposals for the development of a ‘Prevention Pilot’ (and the aims contained within the Healthy Environment strand and Sustainable Employment strand), as set out in appendix 1 of the report.	Tamara Djuretic

	II). That the HWB notes the next steps in terms of submitting final proposals for the delivery of the 'Prevention Pilot' to the London Devolution Programme Board, by the end of February, and the suggested timetable for detailed project planning from April 2016. III). That the Devolution Steering Group provides regular updates on progress to the HWB	
CNCL110.	DISCUSSION ITEM SOCIAL PRESCRIBING A report was included in the agenda pack at page 37. Dr Tamara Djuretic, Assistant Director of Public Health, gave a presentation to the Board on social prescribing and the local and national policy drivers involved. Following the presentation the Board discussed the findings. The Assistant Director of Public Health introduced: Charlotte Woodhead, a researcher from UCH who had been working on the evidence background to social prescribing and Andrea Somasundram, a HAGA community engagement worker from JS Medical Practice, who was part of a pilot scheme established in the borough around social prescribing. Approximately 70% of health outcomes were determined by socio-economic factors and 30% by clinical factors, according to the Marmot Review in 2010. Social prescribing sought to address this by offering referral to non-clinical services coupled with support to engage with these services, which ranged from arts and culture to physical exercise, benefits and debt advice etcetera. Social prescribing models focused on factors that positively support health and wellbeing rather than on factors that cause disease, promoting a more holistic community centred model of primary and community care. The Committee noted that the social prescribing model contained synergies with; Haringey Communities strategy, Haringey Corporate Plan and Priority 2 of Haringey's Health and Wellbeing Strategy. Ms Woodhead gave part of the presentation to the group, outlining the different models available as well as the pros and cons. There were a number of broad strands of models around social prescribing, the main ones included: • Signposting which involved directing patients to non-clinical community services during GP consultations • A more formalised route where the GP spoke to the patient about their needs and then agreed a particular programme of	

community based activities with the patient. Issues could arise with the GP not necessarily having a full and complete understand of the range of services available in the community.

- Involving a link worker/co-ordinator/facilitator, where the patient was referred by the GP to an individual who had a good knowledge of the range of local services within the voluntary and community sector and was engaged with both the health sector and the voluntary sector. The models varied around how long the link worker spent with the patient from a one-off home visit to a series of one-hour sessions. The Board noted that this increased the likelihood of successful outcomes and also facilitated much better feedback to the health sector, improving the quality of evaluation. The downsides were that it was considerably more expensive.
- The Bromley-by-Bow model was outlined to the Board. This involved 6 satellite GP practices that reported into the Bromley-by-Bow centre, which had a dedicated social prescribing team who sat with the patient to review their needs and then the centre could refer the patent to one of the 1000 different organisations that the centre had links to.
- The Rotherham model involved referrals being made within a multidisciplinary team as part of an integrated case management pilot scheme.
- Other social prescribing models have involved linking up as part of Improving Access to Psychological Therapies (IAPT) provision

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

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

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

- HAGA had been working in the borough for 35 years working with people and their families who had been affected with alcohol. HAGA has undertaken a nine month pilot, launched in

November, aimed at improving wellbeing outcomes among its service users through social prescribing.

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

Social prescribing empowered people to make a difference to their own lives.

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

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

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

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

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

The Director of Adult Social Services commented on the presentation slide that showed the range of similar activities carried out within

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

Cllr Morton, the Cabinet Member for Health and Wellbeing echoed some of the points put forward by the Director of Adult Social and emphasised the need to draw together existing resources, for example through an asset mapping exercise. The Cabinet Member for Health and Wellbeing raised a question regarding what the key aspects of a social prescribing model that were needed in order for it to work. Officers suggested that the involvement of local people was crucial. It was also noted that a key consideration with a social prescribing model was that it facilitated more time to spend with the individual to tailor activities to their specific needs. The Leader commented that the Bromley-by-Bow model was an exemplar; any model used in Haringey had to be tailored to local needs and also rooted in the community. The Leader also suggested that in addition to considering what the key components of the model were, there was a related consideration around what were the outcomes that the Board wanted to deliver. It was agreed that the task and finish group would be the most appropriate forum to agree what the key components and outcomes required would be. The task and finish group should also give consideration into how to achieve the step change from a small scale pilot scheme to delivering across the system.

To note - Tamara Djuretic

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

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

To note - Tamara Djuretic

Ms Herman echoed other comments around the importance of local

	knowledge and raised concerns with creating a number of new structures on to services that already exist, the issue was that these services needed to be co-ordinated. Ms Herman commented that keeping up to date information was a key challenge in terms of coordinating services and also very expensive. The Board requested an update from the task and finish group at the next meeting of the Board. RESOLVED: I). To agree that social prescribing is the right approach for Haringey. II). To establish a 'task and finish' group – including representatives from the CCG, primary care Haringey Council, Healthwatch and a range of providers already delivering some aspects of social prescribing in the borough – to scope the local model to best suit the landscape and existing services across the borough.	Tamara Djuretic
CNCL111.	BUSINESS ITEM INTEGRATRATION OF HEALTH & SOCIAL CARE SERVICES The Board received a report which provided an update on several strands of joint working between Haringey Council and Haringey CCG and the other councils, CCGs and healthcare providers in North Central London. The report was introduced by the Chief Officer CCG and was included in the agenda pack at page 55. The Board noted that the government set out its further intention to focus on delivering joined up care during the Autumn Spending Review and also announced that the BCF would continue as a key programme in 2016/17. The Spending Review also set out an ambition that by 2020 health and social care would be integrated everywhere. The Board also noted that NHS leaders were required to produce two separate but connected plans. A one-year operational plan for 2016/17, focused on individual organisations and a five-year sustainability and transformation plan (STP). The STP would be an umbrella plan, holding underneath it a number of different specific delivery plans and would involve local authorities, CCGs and providers agreeing the geographical footprint covered by the plan. From 2017/18 onwards, STPs will become the single planning process for being accepted onto programmes with transformational funding. Full STPs were due for submission at the end of June 2016. Chief Officer Haringey CCG advised that the bid to develop a vanguard proposal in conjunction with Islington was unsuccessful but that the two councils and two CCGs had continued to explore joint working	

	opportunities around transforming health and social care services. A clinical workshop was held on 29th January to consider place-based systems of care and a population segmentation approach to identifying health and care needs. Chief Officer Haringey CCG also advised that the Better Care Fund Planning for 2016/17 was progressing well with positive discussions on budget planning and a review of appropriate services to be included within the BCF. The technical guidance had only just been released; it was anticipated that the current outcome measures would be maintained. A draft plan was submitted in early February to NHS England and feedback should be provided before the end of March. The final submission was due on 20th April and would require the Board to sign it off. The final plan was to be reviewed by the HACI Board prior to sign off. The Board noted that the BCF would be signed off by the Chair as an Urgent Action as the deadline for submission was prior to the next meeting. Chief Officer Haringey CCG agreed to send round copies of the BCF submission to the Board. Ms Grant raised concerns around the ongoing inclusion of patient groups in future given the increased joint working across boroughs. The Chief Officer Haringey CCG responded that so far engagement with voluntary and community organisations had been done through the individual projects within the BCF. The Chief Officer Haringey CCG acknowledged concerns around maintaining the voice of the patent and agreed that this would be considered going forward. The Director of Public Health advised that this was the first time in NHS planning that local authorities were formally included in the process and that the Public Health teams across NCL were coordinating into the process from a local authority perspective. The Director of Public Health commented that this could provide further opportunities to embed other devolution workstreams including the Prevention Pilot. **RESOLVED:** I). To note the overall progress in partnership working in several areas II). To support the approach taken to closer working with partners in North Central London, as set out in Section 6.1 of the report. III). To support the approach taken to closer working with partners in Islington, as set out in Section 6.2 of the report IV). To agree to Chair's actions to approve the BCF submission for 2016/17, as set out in Section 6.3 of the report **HEALTH & WELLBEING BOARD MEMBERSHIP**	Sarah Price

	The Board considered a report setting out the proposed changes to the membership of the Board. The report proposed the appointment of the Bridge Renewal Trust Moracle Foundation to the Health and Wellbeing Board as the Council's voluntary sector partner following Cabinet's decision in December 2015 to appoint the Bridge Renewal Trust as the Council's voluntary sector partner. RESOLVED: I). To appoint the Bridge Renewal Trust Moracle Foundation to the HWB, to replace HAVCO as the non-voting member previously designated as fulfilling a developmental role on the Board in building partnerships across the public and voluntary sectors. This is in line with section 194 (8) of the Health and Social Care Act 2012. II). To recommend the change in membership to the Full Council meeting on the 17th March following which the Terms of reference of the HWBB can be amended to reflect the change in membership. III). To put forward an amendment to the Council Constitution, Part three, section B paragraph 8.4, bullet point 10, replacing HAVCO with the Bridge Renewal Trust Moracle Foundation. IV). To undertake a wider review of Board membership to ensure the right representation to provide system leadership for Haringey and its residents. V). That a paper setting out any proposed changes arising from the review be brought to the June meeting of the Board for approval. Following this, the revised membership will go forward to Full Council in July for approval.	
CNCL112.	NEW ITEMS OF URGENT BUSINESS No new items of Urgent Business were tabled.	
CNCL113.	FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS It was noted that the future meeting dates were provisional: • 19th May 2016 at 18:00 • 12th September 2016 at 18:00 • 8th December 2016 at 18:00 • 2nd March 2017 at 18:00	

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: 19 May 2016

Title: Intermediate Care: A Case Study of Integrated Care in Haringey

Report authorised by : Dr Jeanelle De Gruchy, Director of Public Health

Lead Officers: Dr Will Maimaris, Consultant in Public Health, Haringey Council Tim Deeprose, Joint Integration Programme Manager, Haringey Council and and Haringey CCG
Rachel Lissauer, Assistant Director of Commissioning Haringey CCG

Ward(s) affected: All

Report for Key/
Non Key Decision: Not applicable- report for discussion

1. Describe the issue under consideration

1.1 This report outlines the importance of intermediate care in achieving Haringey's vision for integrated person-centred services set out in Haringey's Better Care Fund plans. The report describes the findings of a local review of intermediate care provision in Haringey, looking at progress in this area as a case study of local efforts to provide person-centred integrated care and improve value for money of service provision.

2. Cabinet Member Introduction

2.1 Improving access to integrated health and social care services that support independence and prevent admissions to hospital in people with long-term conditions is an important aim of Haringey's Health and Wellbeing Strategy.

2.2 Developing an integrated intermediate care pathway, which builds on existing good quality service provision, provides us with an opportunity to keep people healthy in the community for longer and prevent hospital and care home admissions.

3. Recommendations

3.1 The Board is asked to support the approach being taken by Haringey Council and Haringey CCG to develop and scale up an integrated intermediate care pathway in Haringey.

3.2 Board members are asked to consider how their organisations can contribute to the development of an integrated intermediate care pathway in Haringey.

4. Reasons for decision

Not applicable.

5. Alternative options considered

Not applicable.

6. Background information

6.1 Like many other localities, Haringey is faced with an ageing population, most of whom have one or more long-term conditions. This is placing an increased demand on emergency hospital care and on care home placements.

6.2 Integrated, person-centred care is seen as one way of improving the quality of care and reducing demand on acute services in older people with long-term conditions. The Better Care Fund in Haringey has been the vehicle for providing such integrated care in Haringey. Haringey's Better Care Fund plans outline how person-centred care will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care).

6.3 Intermediate care provision is an important area of focus for Haringey's Better Care Fund plans. Intermediate care services are provided to people (usually older people), after leaving hospital or when they are at risk of being sent to hospital or having an escalation of care need. Intermediate care is always focused on rehabilitation and re-ablement and getting people as independent as possible. Intermediate care includes rapid response services, step-down and step up rehabilitation beds and re-ablement.

6.3 There is good evidence that intermediate care services can improve service user experience and independence as well as saving money by preventing emergency hospital admissions and care home admissions and reducing delayed discharges from hospital.

6.4 A review of local intermediate care services found that Haringey has some good local intermediate care services in place, including Rapid Response, Home from Hospital and Re-ablement. However, these services are all currently delivered at small scale, are often not provided as part of an integrated pathway and are usually only accessed once someone has already attended hospital.

6.5. Looking at best practice in other parts of London and beyond, there are significant opportunities to expand and improve our intermediate care services in Haringey.

6.6 As a result of the review of local intermediate care provision a number of recommendations are being taken forward to improve the local intermediate care offer. These include:

- Increasing the capacity and scope of our Rapid Response service
- Commissioning dedicated rehabilitation and re-ablement beds for step-down from hospital and step-up from the community
- Increasing re-ablement capacity
- Bringing together existing services into an integrated intermediate care pathway with clear links to the hospital discharge process

6.7 This remains an incremental rather than transformational approach to service improvement, particularly when compared to other examples across the country.

7. Contribution to strategic outcomes

Priority 2 of the Corporate Plan and Ambition 5 and 6 of the Health and Wellbeing Strategy. Better Care Fund outcomes (reducing non-elective hospital admissions, reducing permanent residential home admissions, reducing delayed transfers of care)

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

Finance and Procurement

8.1 As set out above the development of an integrated intermediate care service is expected to produce improved outcomes and reductions in expenditure for both the NHS and the social care system; this will support the delivery of the Council's MTFS savings.

Much of the funding for an improved service can be found by using existing budgets such as the residential and nursing care budgets more effectively. A small amount of additional investment may be required in the short term and some provision has been made for this in the Adult's budget.

The outcomes of the service improvements and the new pathway will need to be carefully monitored as it is very important to ensure that the expected savings are delivered.

Legal

8.2 Section 2 of the Care Act 2014 *('preventing needs for care and support')* requires the local authority to *"provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will"* contribute towards preventing, delaying or reducing individuals' needs for care and support, or the needs for support for carers. In performing this duty, the authority must have regard to, amongst others, the importance of identifying services, facilities and resources already available in its area and the extent to which the authority could involve or make use of them in performing that duty. The Care and Support Statutory Guidance at paragraph 2.1 provides that *"It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.*" The Guidance emphasise the importance of preventative services such as re-ablement and intermediate care across health and social care - "*To prevent needs emerging across health and care, integrated services should draw on a mixture of qualified health, care and support staff, working collaboratively to deliver prevention. This could involve, for instance, reaching beyond traditional health or care interventions to help people develop or regain the skills of independent living and active involvement in their local community*" (paragraphs 2.12-2.15).

Equality

8.3 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.
- In the design of new service pathways we will involve service users and explore and take into account any equalities issues that are raised
- Whenever significant service changes are made, specific equalities impact analyses (EQIA) will be carried out.
- We intend that plans to improve intermediate care will benefit all our communities, especially older people who are most likely to use intermediate care services.

9. Use of Appendices

Appendix I: Intermediate Care a case study of integrated care in Haringey

10. Local Government (Access to Information) Act 1985

Not applicable

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Intermediate Care: A case study of integrated care in Haringey

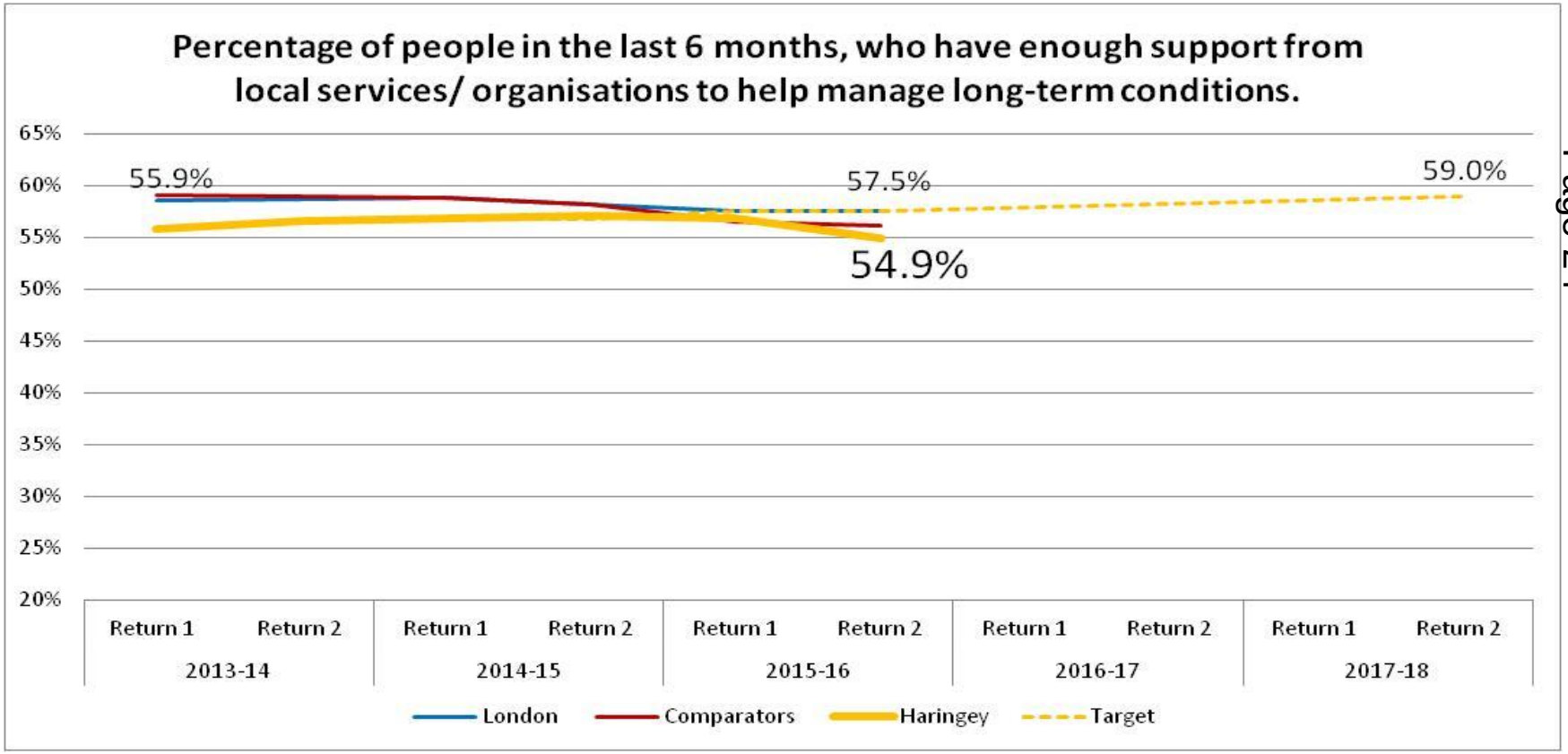
Dr Will Maimaris. Public Health Consultant, Haringey Council

NHS Haringey Clinical Commissioning Group

Haringey

Health and Wellbeing Strategy ambition & target

This presentation topic is linked to ambition 6: “More people will do more to look after themselves”



Source: GP patient survey

NHS Haringey Clinical Commissioning Group

Haringey

Overview

1. Background and context
2. What is intermediate care
3. The evidence base for intermediate care
4. Reviewing intermediate care in Haringey
5. Next steps
6. Discussion points

Context: Population health need

Ageing population

- 11,000 Haringey residents over 75
- Projected to rise to 15,000 in 10 years and 19,000 in 20 years

High prevalence of long-term conditions

- 3 in 4 people over 70 have at least one LTC
- Over 1400 over 65s with dementia

Context: Pressure on health and care services

- Over 7000 emergency hospital admissions in people over 65 each year in Haringey
  - Account for more than 1 in 4 of all admissions
  - Admissions cost over £15 million
  - Majority of health spend is in acute hospitals
  - Slight decline in admissions in over 65s in last 12 months
- Around 150 permanent residential home admissions in over 65s per year
- Current system of health and care for older people is unsustainable

Context: Integrated care in Haringey

- Integrated, person-centred care seen as a way of improving quality of care and reducing demand on acute services in older people with long-term conditions
- The Better Care Fund as a vehicle for delivering integrated services
  - Overseen by Haringey Health and Care Integration Board
- Haringey's Better Care Fund Vision
  - The Haringey Better Care Fund is developing a health & social care system in which all adults are supported to live healthy, long and fulfilling lives. Haringey Clinical Commissioning Group and the London Borough of Haringey want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible.
  - This will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care).

Better Care Fund: Areas of focus

Admission Avoidance

Named Care Co-ordinator

Health and Social Care Plan

Referral for bereavement counselling

Effective Hospital Discharge

Less time in hospital

Support to return home

Regain confidence to prevent falls

Promoting Independence

Identification

Link to an 'expert patient' group

Link to a local gardening group

Integration Enablers

All relevant professionals know important information

Services in the evening

Support for Harry's daughter

NHS Haringey Clinical Commissioning Group

Haringey

What is intermediate care?

- Provided to people (usually older people), after leaving hospital or when they are at risk of being sent to hospital or having an escalation of care need
- Always focused on rehabilitation and re-learning of skills to get people as independent as possible
- Can be provided in people's own homes, in settings like cottage hospitals and care homes or in purpose-built accommodation.
- Usually delivered by a multi-disciplinary team, normally for a maximum of 6 weeks at a time

Types of intermediate care services

1. Rapid response services
   - Provide extra nursing and therapy support in people's own homes to prevent hospital admission or allow people to be discharged early from hospital
2. Home-based re-ablement services
   - An approach to social care that focuses on people re-learning how to do things for themselves (e.g. cooking, washing) rather than doing these things for them.
3. Step-down and step-up beds
   - Provide multi-disciplinary support in community-based beds for people to re-gain independence after a worsening of ill health or following a hospital admission

How does intermediate care complement Haringey's integrated locality teams?

- Haringey is piloting and scaling up **integrated locality teams**
  - Involves identification, care planning and care co-ordination of people with high levels of health and care needs.
  - Support is offered over a long period by a multi-disciplinary team
- Intermediate care services differ in that:
  - They are focused around crisis or admission to hospital
  - They have to respond quickly
  - They are focused on providing support and rehabilitation for up o 6 weeks rather than on long-term needs.
- Both intermediate care and locality teams are key components of Haringey's Better Care Fund Plans
- Potential for clients to receive ongoing support from locality teams after a period of intermediate care.

Why is intermediate care important?

- Supports independence in people with health and care needs
- Provides a **return on investment**
  - Prevention of hospital admissions
  - Reduced length of hospital stay and prevention of re-admission to hospital
  - Prevention of escalation of social care need and residential care admissions
- Gives a positive experience for service users

The evidence base for intermediate care

- Good evidence that **re-ablement:**
  - improves independence and quality of life
  - reduces long-term social care costs.
- **Rapid response** type services can improve outcomes for patients and save overall healthcare costs.
- Enhanced hospital discharge processes, which include early identification of complex discharges and links to support in the community can:
  - prevent hospital re-admissions, reduce length of stay and improve outcomes for patients.

Case study: Richmond Rehabilitation and Response team

- Managed by Hounslow and Richmond Community Healthcare Trust (HRCH) with council staff seconded to the trust. It provides three core functions:
  - support to allow early discharge from hospital
  - crisis and rapid response
  - community rehabilitation support
- The service has 6 intermediate care beds in the local hospital, and 50 beds in the community.
- It also has a re-ablement service which has a 50% success rate in helping people get to the point that they no longer need a service.
- They report their admissions to hospital rate has fallen from 100 per 10,000 to 80 per 10,000 and contributed £2.1million pounds in savings over a 3 year period.

Case Study: Roseberry Mansions re-ablement flats: Camden

- 10 bedded re-ablement unit
- Self-contained flats
- Multi-disciplinary team delivers intensive re-ablement and rehabilitsation
- Access to 24/7 support
- 72% of customers either returned home following the service or were re-housed in either sheltered or extra care housing.
- 28% of customers had a reduced care package after the service
- Significant health and care savings reported

Reviewing current intermediate care provision in Haringey: Examples of good practice

- Rapid response service
  - A nurse-led service that provides time-limited support in people's homes to prevent hospital admission
  - Provided by Whittington Health
- Re-ablement
  - An approach to social care that focuses on people re-learning how to do things for themselves (e.g. cooking, washing) rather than doing these things for them.
  - Provided by Haringey Council
- Home from hospital
  - Volunteers provide support to get people settled back at home after a hospital admission
  - Provided by Bridge Renewal Trust

Reviewing current intermediate care provision: evaluating our local rapid response service

- Funding for rapid response service is through the Better Care Fund
- The service is provided by Whittington Health and provides rapid access to intensive nurse-led support at home for people who may otherwise need hospital admission.
- Service users also have access to night-time carers
- Service can by accessed via A and E or by direct GP referral

- **Hospital admission is avoided in more than 8 out of 10 clients**
- **For every £100k invested in the service it is estimated that over £260k is saved through reduced hospital activity**

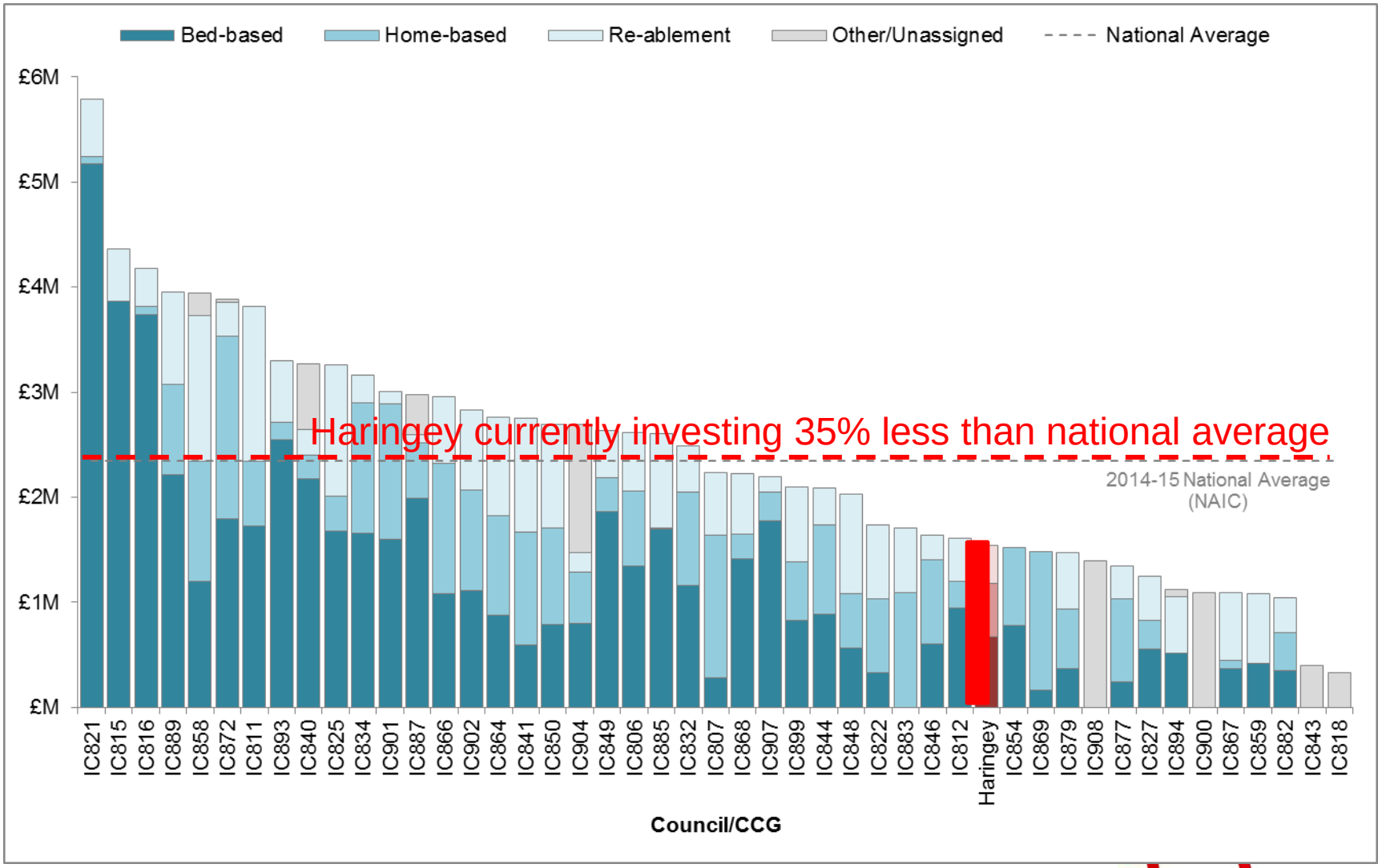
Reviewing current intermediate care provision in Haringey: Service activity

	Clients (new per year)	Source		Average time in service (days)	Total Bed Days (if applicable)
Service	**2014-15**	**Hospital**	**Community**	**2014-15**	
Rapid Response service	445	78%	22%	3	n/a
Homecare reablement	508	93%	7%	27	n/a
Home from Hospital	143	94%	6%	16	n/a
Social Care Step Down (Spot-purchased)	55	100%	0%	104	5,750
Winter Step Down	7	100%	0%	46	320
Cavell Ward	117	100%	0%	29	3070

NHS Haringey Clinical Commissioning Group

Haringey

Reviewing current intermediate care services in Haringey: Lower than average investment in intermediate care



Spend per 100,000 weighted population

NHS Haringey Clinical Commissioning Group

Source: National audit of intermediate care

Haringey

Review of intermediate care in Haringey: What residents are telling us

- People are not always given access to support from community services when they need it after leaving hospital
- Patients and their carers are often unsure about who is responsible for their care when they are discharged from hospital
- Patients referred to community therapists can experience long waits for the service to start
- Voluntary sector organisations could play a much greater part in supporting older people with health and care needs

Summary of gaps in intermediate care services in Haringey

- Current services are small scale
- No integrated intermediate care pathway
- Multiple organisations involved in intermediate care
  - Often not joined up
  - Different access points to different services
  - Communication to patients and GPs about what is available is patchy
- Limited bed-based intermediate care provision at present
- Hospital teams not fully linked to community teams in the hospital discharge process.

Recommendations of intermediate care review

1. Develop an integrated intermediate care pathway, including bed based and home based elements with the following features:
   - Multi-disciplinary teams including links to voluntary sector
   - A common point of access to the service
   - Access to rehabilitation and re-ablement
   - Crisis response at home as well as bedded units.
   - Duration of service up to 6 weeks.
2. Develop business cases for expansion of intermediate care services
   - Rapid response
   - Re-ablement
   - Bed based intermediate care
3. Develop an enhanced discharge pathway for complex patients in North Middlesex Hospital and Whittington Hospital, that includes the following:
   - early identification and planning of complex discharges
   - a clear link to the intermediate care pathway

Next steps

- Recommendations of review of intermediate care in Haringey being taken forward by Health and Care Integration Board
- Initial focus is on:
  1. Increasing capacity and scope of our Rapid Response service
  2. Commissioning dedicated rehabilitation and re-ablement beds for step-down from hospital and step-up from the community
  3. Increasing re-ablement capacity
  4. Bringing together existing services into an integrated intermediate care pathway with clear links to the hospital discharge process
     - Linking to Safer, Faster, Better improvement programme at North Middlesex Hospital.

Summary

- Development of an integrated intermediate care model could help support sustainability of the local health and care system.
- Other areas of London have achieved this and have seen a return on investment.
- We have some good local services to build on, but these are small scale.
- To achieve a significant impact on demand for hospital services and long-term care we will need to scale up and integrate our current intermediate care services
- At present we are taking an incremental rather than a transformational approach, with activity still centred on the hospital rather than the community setting.

For discussion:

1. The Board is asked to support the approach being taken by Haringey Council and Haringey CCG to develop and scale up an integrated intermediate care pathway in Haringey.

2. Board members are asked to consider how their organisations can contribute to the development of an integrated intermediate care pathway in Haringey.

Report for:	**Health and Wellbeing Board – 19 May 2016**
Title:	**Haringey and Islington Wellbeing Partnership**
Organisation:	**Haringey Clinical Commissioning Group**
Lead Officer:	**Sarah Price, Chief Officer, Haringey CCG** **Report draft by: Rachel Lissauer, Haringey CCG**

1. Describe the issue under consideration

1.1 This report provides information to the Health and Wellbeing Board about a partnership that is being formed between NHS organisations and local authorities in Haringey and Islington.

1.2 This partnership is driven by a shared recognition that major changes are needed to ensure that health and care services are of the right quality and capable of meeting the future needs of our local communities. It outlines the rationale for working together across Haringey and Islington; key work areas; how the Partnership fits within the North Central London Sustainability and Transformation Plan (STP) and the next stages of the programme.

1.3 HWB members are asked to discuss the direction of travel for the work, noting the intention for Haringey and Islington to work as a strong partnership, where this will add value and improve outcomes for our residents, within North Central London.

2. Recommendations

2.1 The Board is asked to note the immediate areas of work:

- Developing care that supports independence in older people with health and social care needs
- A re-designed pathway for people needing musculoskeletal care (ranging from physiotherapy to treatment for chronic pain and rheumatology)
- An integrated model of care for people with learning disabilities
- A model of care that improves the prevention, identification and management of diabetes and cardiovascular disease.

The cross-cutting themes across all these four areas will include: sustaining good mental health, prevention, action on the wider determinants of health (including housing and the environment), early identification of illness and maintaining independence.

2.2 The Board is asked to support the approach being taken by the Haringey and Islington Health and Wellbeing Partnership, noting the principles underpinning our joint work and recognising the value in working across organisations in Islington where this offers scope for increased impact and pace of change for people in Haringey.

3. Background information

3.1 Organisations in Haringey and Islington individually and collectively face significant challenges with meeting health and care needs in the face of serious budget constraints.

3.2 We do not want a system that we cannot sustain and neither do we want to cut care down to the core We are therefore all looking for fundamental changes in the orientation of our health and care system, away from a focus on providing reactive care and towards helping our populations to live healthier lives and to retain their independence for longer. This will involve using technology to ensure that people have the information that they need, in the way that they want it, so that they are more in control. It means taking a shared responsibility across health, housing, education, welfare and social care rather than passing people between agencies. It means recognising the links between mental and physical health. It means never passing up an opportunity to grow and learn from great practice and ideas within and outside our Boroughs.

4. Rationale for working together across Haringey and Islington

4.1 Haringey and Islington have similar populations:

- Combined populations c 500,000 with expected growth of 14% in the next 15 years
- Ageing populations – highest growth in those aged 65+ although this age group remains the smallest in absolute numbers
- Deprived and affluent neighbourhoods side by side
- High population churn

4.2 Our populations have similar health and care needs:

- Overall life expectancy is increasing in both boroughs, however people live (on average) the last 20 years of their life in poor health
- Similar prevalence of lifestyle risk factors

- Similar prevalence of long term conditions (20% of the overall population living with long term conditions). This means more long term, complex illness and disability – increasing demand for health and social care. There is also inequality, with deprived communities experiencing more illness and shorter lives than those in more affluent areas.
- High prevalence of severe mental ill health and high rates of co-morbidities in people with mental ill health

4.3 We have shared ambitions

- We are committed to change: to fitting our organisations and care around people's needs. We need to focus now on people whose needs are complex. Too often we make people fit in and around our own organisations.
- We want to provide world class care. To do this we need to enable those who are well to stay healthy and to support those whose lifestyle puts them at risk to make healthier choices. Our local plans for housing, schools, employment, business as well as health services need to support this. But we recognise that agencies alone do not drive change. People, technology and communities drive innovation to which we will respond.
- Within and across different public sector organisations we are willing to work together, to listen carefully to our diverse populations; to challenge ourselves; to innovate and to learn from our staff and residents who hold the answers to how health and care could be improved.

4.4 We have shared values

Our focus is on preventing poor health and working towards demonstrable improvements in outcomes when people need care and treatment. Given the financial pressures on all organisations, we need to make sure that services are of value, affordable and fit for the future.

5. How will the Wellbeing Partnership work together?

5.1 The current Wellbeing partner organisations are:

Haringey Council, Islington Council, Whittington Health, Camden & Islington Foundation Trust, Islington Clinical Commissioning Group, Haringey Clinical Commissioning Group. Together these organisations provide and commission a significant proportion of the social and clinical care for the residents of Haringey and Islington.

Other health providers have been involved during the preparatory work and will further join in with the partnership work as plans develop. We are building an extensive stakeholder group to be engaged in the work plan, including the

voluntary and third sector, our workforce, Healthwatch and other community, public, patient and service user representative groups.

5.2 We have established some agreed principles which are summarized here:

- Partner organisations will work together for the benefit of local people
- We will involve local people in our design, planning and decision-making
- Partner organisations will find innovative ways to cede current powers and controls to explore new ways for working together
- We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates
- Partner organisations have agreed to find ways to 'risk share' during transformational change
- We will find ways to share joint incentives and rewards
- Partner organisations will make improvements by striving to be the best, together
- We will be rigorous in ensuring value for money and financial sustainability

6. How does the Wellbeing Partnership fit with the North Central London (NCL) Sustainability and Transformation Plan (STP)?

6.1 NHS England has mandated all areas of the country to be part of a pre-determined local footprint that will prepare health and social care sustainability and transformation plans for 2016-2021. Haringey and Islington are part of the North Central London footprint.

6.2 The Chief Officers/Executives of the Wellbeing Programme are all actively engaged in and, in some instances, leading key areas of work in the NCL STP.

6.3 There will be some areas of transformation and change where there are clear benefits from working collaboratively across the wider NCL footprint. In time it will provide access to central funding for transformation activity.

The critical question posed by the Wellbeing Partnership will always be: how will the proposed NCL plans benefit the residents of Haringey and Islington. We will work on the footprint that we consider will enable the needs of our populations to be met most directly and most sustainably.

7. Preparation work

7.1 We started working together to establish the Wellbeing Partnership late in 2015. We held a senior stakeholder event in the autumn and clinical and care practitioners' early in 2016. We took all the information and learning found in each organisation from what our workforce and local people told us in the past about their experience of health and care.

7.2 Using all available information to inform future plans, we grew our understanding of the health needs of the local population and the evidence of what is working well locally. We have identified some priority area in population segments and clinical & care pathways.

7.3 We have looked at local 'good practice and innovation': to see where we might scale up across the partnership as a 'quick win' for positive change.

7.4 We have undertaken an outline financial analysis, identifying the precise scale of the financial challenge and are working out what the potential is for efficiencies and what requires bigger changes across the whole system.

7.5 We have set up a programme structure to take forward an agreed work plan which recognises current governance and decision making within the health and care systems.

8. The Wellbeing Partnership: what next – recommended priority work programme

8.1 Using all the information and data described above, the Wellbeing Partnership has identified the following key priorities areas for the next phase of work. It is proposed to engage in co-production with key stakeholders, develop detailed scoping work and business cases for each of the pathways to identify the opportunities for working together in a different way.

Population based and health and care pathways:

- A model of care that supports independence in older people with health and social care needs.
- A re-designed musculoskeletal care pathway
- An integrated model of care for people with learning disabilities
- A model of care that improves the prevention, identification and management of diabetes and cardiovascular disease.

The cross cutting themes across all these four areas will include: sustaining good mental health, prevention, action on the wider determinants of health including housing and environment, early identification and diagnosis of illness, maintaining independence.

8.2 Forms of Health and Care

In addition, an important area of work will focus on future care models; identifying the range of options which might be most appropriate for providing health & care and commissioning health & care.

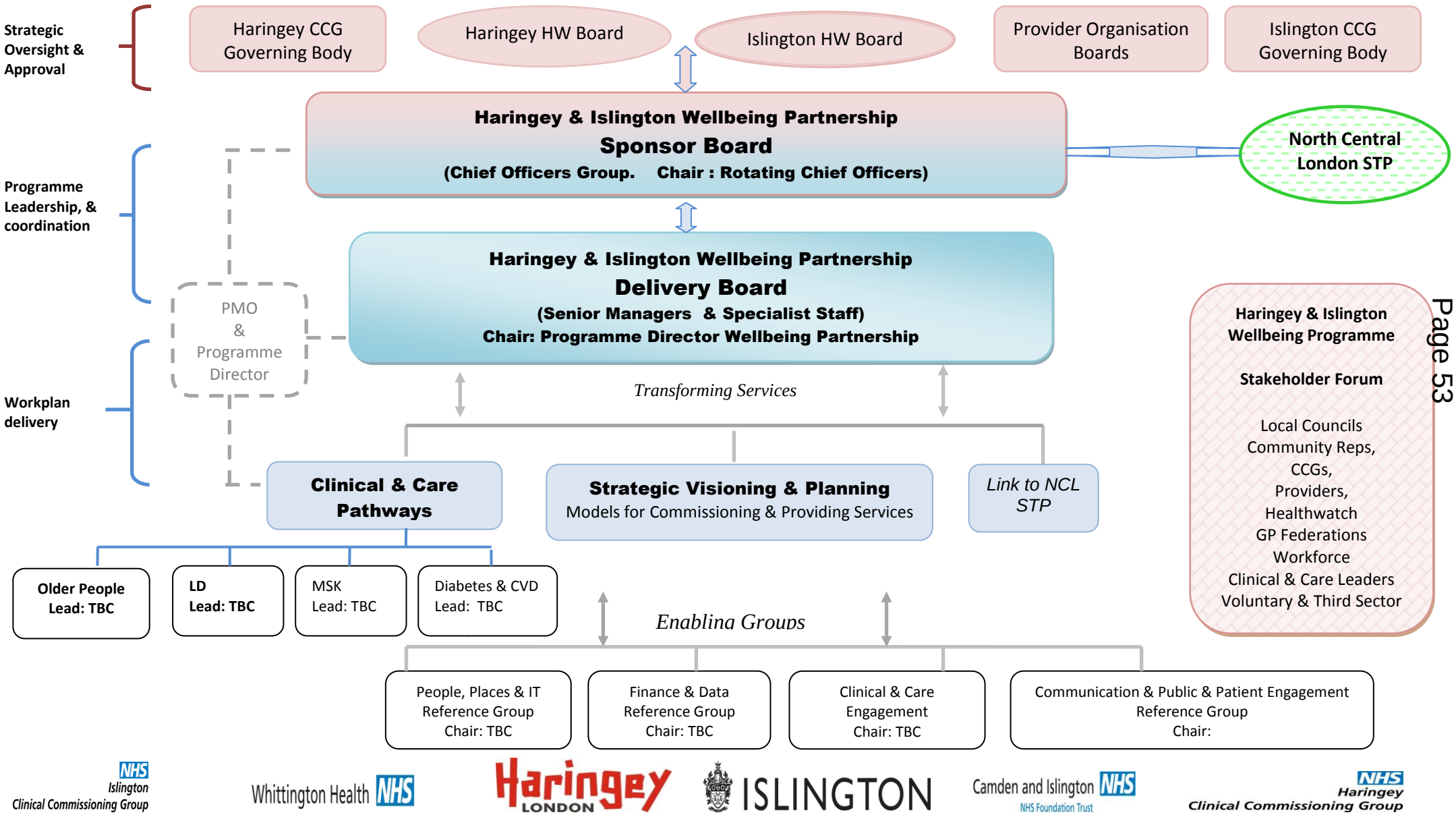
We propose to undertake detailed financial modeling of savings and investments required across the whole system and look at additional key enablers: workforce, IT, estates.

9. Use of Appendices

Appendix I: Proposed Governance structure for the Haringey and Islington Wellbeing Programme

Appendix 2: Population and Health and Care Profiles

The Wellbeing Partnership
Working side by side in Haringey and Islington



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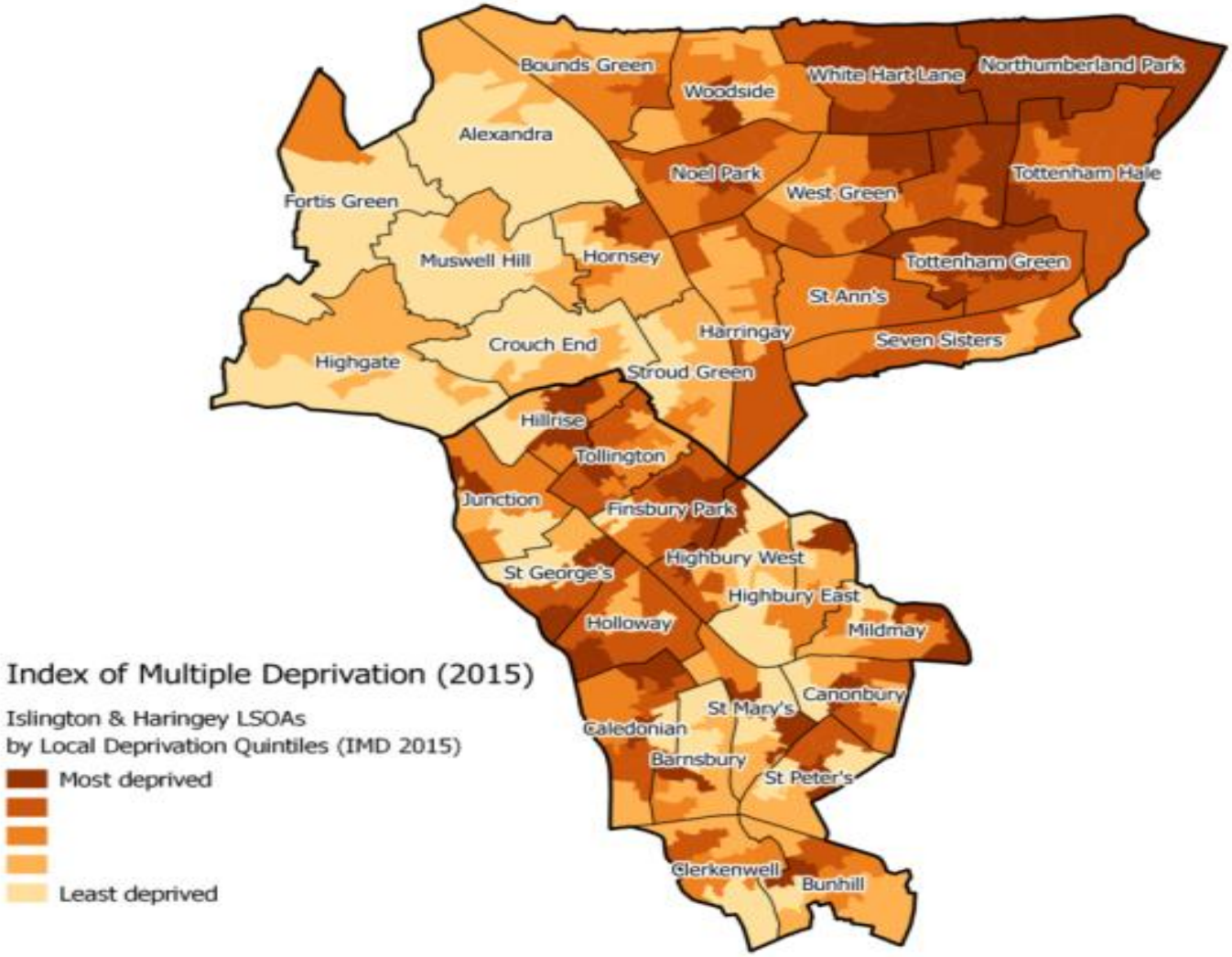
Haringey & Islington

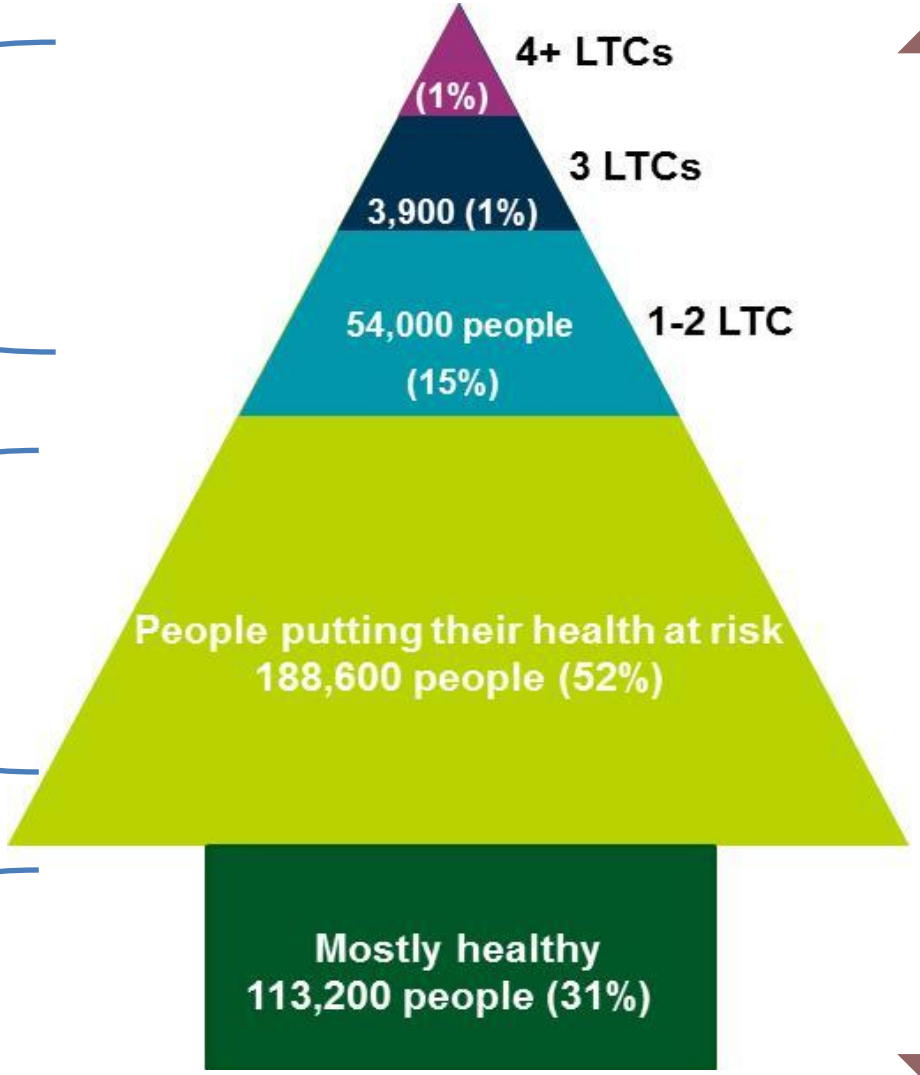


Haringey & Islington Population Health & Care Profile

Focusing on:
- Scaling up the coverage of integrated services
- Delivering measurable outcomes
- Releasing costs
- Secondary prevention

Focusing on:
- Prevention
- Providing information and access
- Reaching out into local communities
- Early intervention and diagnosis

Focusing on:
- Maintaining health and wellbeing
- Children and young people
- Single episodes of ill health



Diabetes and Cardiovascular Disease

Musculoskeletal care

An integrated model of care for Learning Disability

Supporting independence for Older People

* LTC: Long Term Conditions

Report for: **Health and Wellbeing Board – 19 May 2016**

Title: **North Central London – Sustainable Transformation Plan**

Lead Officers: **Zina Etheridge, Deputy Chief Executive, Haringey Council and Sarah Price, Chief Officer, Haringey CCG**

Ward(s) affected: **All**

Report for Key/
Non Key Decision: **For information**

1. Describe the issue under consideration

NHS England, along with other agencies including NHS Improvement, Health Education England, Public Health England, in response to the *Five Year Forward View* published in October 2014, has adopted a new strategic planning approach to ensure a whole system focus across health and social care. The new Sustainability and Transformation Plans (STPs) will be produced in partnership by providers of health and care services, Councils and CCGs across an agreed geographical footprint of at least 1 million people.

Along with Barnet, Camden, Enfield and Islington, Haringey is working as part of the North Central London (NCL) STP footprint area. NCL has established a Transformation Board and Programme Management Office to oversee the production of the NCL STP. The Health and Wellbeing Boards for each respective borough are being asked to note progress in relation to the NCL STP to date.

The STP will be submitted at the end of June, so work continues to finialise areas for development.

2. Recommendations

1) To note progress made to date with regard to the NCL STP.

2) To note that the finalised NCL case for change will be brought to the Health and Wellbeing Board for endorsement.

3. Reasons for decision

Not applicable – information report.

4. Alternative options considered

Not applicable – information report.

5. Background information

Appendix 1 – NCL STP Briefing Pack.

6. Contribution to strategic outcomes

Priority 2 of the Corporate Plan and the Health and Wellbeing Strategy.

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

Finance and Procurement

This is a information report and, as such, there are no recommendations for action that have direct financial implications.

Legal

There are no legal implications arising from this report.

Equality

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.

The intention of the NCL STP is that services will be planned around place rather than institutions. This approach places greater emphasis on the needs of populations. Any specific proposal or service change that comes out of the STP will involve a specific EQIA being carried out.

8. Use of Appendices

Appendix 1 – NCL STP Briefing Pack.

9. Local Government (Access to Information) Act 1985

None.

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North Central London Sustainability and Transformation Plan

North Central London
Sustainability and Transformation plan

May 2016

The background to the STP

North Central London Sustainability and Transformation Plan

1. The development of the STP involves five key aspects:
   - **Local leaders** coming together as a **team**
   - Developing **shared vison** with the local community **which also involves local government**
   - **Programming a coherent set of activities** to make it happen
   - **Execution** against plan
   - Learning and adapting

2. Access to future transformation funding
   - The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards
   - This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

3. The most **compelling and credible** STPs will secure **funding from April 2017 onwards**. The process will be iterative. NHS England will consider:
   - the **quality of plans**, particularly the **scale of ambition** and **track record of progress already made**. The best plans will have a **clear and powerful vision**. They will create **coherence across different elements**, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically **borrow good practice from other geographies**, and adopt **national frameworks**;
   - the **reach and quality of the local process**, including community, voluntary sector and local authority engagement;
   - the **strength and unity of local system leadership and partnerships**, with **clear governance structures** to deliver them; and
   - how **confident are NHS England that a clear sequence of implementation actions will follow as intended**, through defined governance and demonstrable capabilities.

There are a number of objectives for the NCL STP

North Central London Sustainability and Transformation Plan

Goals

The **goals** of our STP are:

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities

Outputs

The STP needs to deliver several **key outputs:**

- A compelling clinical case for change that provides the foundation for the programme and is embedded across the work, and supports the identification of priorities to be addressed through the STP
- A single version of the truth financial 'do nothing' base case with quantified opportunity impacts based on the priorities identified
- A robust and credible plan for implementation and delivery over five years
- A governance framework that supports partnership working across the STP and collective decision making
- The resource in place to deliver transformation at scale and pace in the key areas identified

Process

The **process** to developing our STP needs to:

- Be collaborative, and owned by all programme partners in NCL
- Be structured and rigorous
- Move at pace, ensuring quick wins are implemented and transformation is prioritised
- Involve all areas of CCG, local authority and NHS England commissioned activity, including specialised services, primary care and reflecting local HWB strategies

Where we are now: current status

North Central London Sustainability and Transformation Plan

Building relationships across NCL

- We are continuing to **build relationships** across the programme partners to ensure that health and care commissioners and providers are aligned in our ambition to transform care
- Our governance framework supports **effective partnership working**
- The SROs are working to bring CCGs, providers and local authorities together across the 5 boroughs together **recognising the history and context** that underlies working together in a new way

Developing the case for change

- We have undertaken analysis to **identify the gaps in health and wellbeing, and care and quality in NCL** in order to prioritise areas we need to address
- We now need to focus on **ensuring there is local buy-in and ownership** of the case for change which we will achieve through a programme of widespread engagement from now until June
- The **clinical cabinet** which will meet for the first time on 5th May will lead this work

Understanding our financial position

- Finance directors from all organisations have been **working well together** to identify the NCL position in 20/21 should we keep going as we are
- This includes some **assumptions around QIPP and CIP**, which we need to develop in further detail to remove the **risk of double counting** when we come to quantify opportunities, particularly around productivity

Mobilising the programme

- We have developed a **high level roadmap** to the end of June, based around the mobilisation of opportunity workstreams in each of our key themes: population health, productivity, consolidation and specialisation and enablers
- We are in the process of **recruiting a programme director and clinical lead** based on a shared understanding of what we need to drive this work forwards
- A key risk is how we **manage the impact of specialised services** in our patch which we will look to address through working closely with NHS England to identify what might be best considered at a pan-London level

Current overarching governance framework

North Central London Sustainability and Transformation Plan

- CCG COs
- NCL CCGs
- LA CEOs
- DsPH
- DASSs
- HWBs
- NHS PROVIDERS
- HENCEL
- NHS ENGLAND LONDON
- HEALTHY LONDON PARTNERSHIP
- HARINGEY AND ISLINGTON WELLBEING ALLIANCE BOARD

NCL Transformation Board

Chair: David Sloman
SROs: David Sloman (Convenor), Dorothy Blundell, Mike Cooke
Members

- SROs
- NHS CCG reps
- NHS Acute Providers reps
- NHS Community Providers reps
- NHS Mental Health Providers reps
- Local authority reps
- LAS
- HENCEL
- UCLP
- NHS specialised commissioning
- NHS England
- NHS Improvement
- Healthwatch
- Clinical lead
- Finance lead
- Programme Director

NCL STP PMO

Programme Director: Alice Hopkinson
PMO Lead: Abi Holland
Programme support: Julie Chan Jones
Comms and engagement lead: TBC

Clinical Cabinet
Lead: TBC

Clinical Reference Group
Lead: TBC

Finance and Activity Modelling Group
Lead: Tim Jaggard

Transformation Group
Lead: David Sloman

Sustainability and transformation plan priorities

Clinical work-streams	**Urgent and emergency care** **SRO:** Deborah McBeal	**Mental Health** **SRO:** Dorothy Blundell	**Primary Care** **SRO:** Alison Blair	**Cancer** **SRO:** Cathy Gritzner	Further opportunity areas to be confirmed
System enablers	**Estates** **SRO:** Cathy Gritzner Dawn Wakeling	**Workforce** **SRO:** Maria Kane Cathy Gritzner	Further opportunity areas to be confirmed		

Developing the NCL case for change

North Central London Sustainability and Transformation Plan

Development and engagement process	• The case for change is undergoing an iterative development process with feedback being provided from all health and social care organisations that are in scope of the NCL STP programme. • The fourth in a series of workshops was held on 20th April with clinicians and social care practitioners from across NCL, particularly those in the outer boroughs. The workshop focused on analysing the data, agreeing the emerging hypotheses and identifying gaps to address in the case for change so far. • Key themes discussed included a focus on primary, secondary and tertiary prevention, self management of minor illnesses, early diagnosis, LTCs, investment in primary care, and workforce. • Between now and June, energy will be focused on addressing the gaps and broadening the engagement such that widespread collective ownership of the case for change is achieved.
Clinical cabinet	• The NCL STP Clinical Cabinet, responsible for the case for change, will lead the further development of this work through to the STP submission in June. • The clinical cabinet will sign off the case for change with ultimate responsibility falling to the NCL STP clinical lead.
Final submission	• The STP submission in June will include the final version of the NCL case for change.

5 key priority workstreams have been identified and mobilised

North Central London Sustainability and Transformation Plan

	Description
Primary care (SRO – Alison Blair)	Currently has a medium term focus on delivering a plan which sets out the vision of the CCGs to transform Primary Care in NCL. The focus is on driving up the quality of primary care, recognising there are differences and opportunities to tackle variation in the quality and outcomes delivered to our patients
Urgent and emergency care (SRO – Deborah McBeal)	Programme to support people to access urgent and emergency care appropriately, in the right place at the right time. The aim is to provide consistently high quality care to patients, significantly reducing variation across NCL providers as well as across the days and times of the week
Mental Health (SRO – Dorothy Blundell)	Develop a MoC and support to enable our population to live well in the least restrictive setting; by breaking down barriers between mental and physical health, delivering consistent and better outcomes that matter to service users and carers, and reducing inappropriate use of acute inpatient beds. This 5 year, all age approach programme has a focus on early intervention
Estates (SRO – Cathy Gritzner, Dawn Wakeling)	The estates workstream is an enabler. It aims, at the NCL level, to support the development of remodelled estate for transformed health and care services, secure efficiencies and release capital, release land for housing. The workstream is also a devolution pilot project as part of the London programme .
Workforce (SRO – Cathy Gritzner, Maria Kane)	Define the workforce requirements required to deliver the STP across NCL and determine how we will train, recruit, retain, develop and support the health and care workforce of the future in NCL

Next steps

For all 5 workstreams to:

- Clarify the scope
- Determine SMART objectives
- Identify timeline and key milestones
- Define the immediate priorities for delivery
- Articulate the quantifiable impact anticipated at the end of year 1 and at the end of year 5
- Specify the support and/or resource requirements
- Identify any asks to put forward to the national leaders

Our identified priority workstreams maximise leverage of existing work but we know we need to do more

North Central London Sustainability and Transformation Plan

Further opportunities need to be identified and analysed to close the key gaps identified in the clinical case and the finance base case. Together, we have agreed a number of principles for selecting additional priorities in order to fully address the gaps:

- We should be **radical in our approach** and **not constrict ourselves** to opportunities available within the constraints of the current system
- We should be considering **more effective vehicles for taking change forwards** including taking advantage of opportunities to **share resources**
- We should be able to **articulate the opportunities to all audiences**, including patients, health commissioners and providers, local authorities and NHS England
- We should be looking to **reduce demand** through new opportunities
- New opportunities should be focused around **eliminating variation** and **adding value**

We have established four key themes that will enable us to deliver the changes needed to create viable and sustainable system, including:

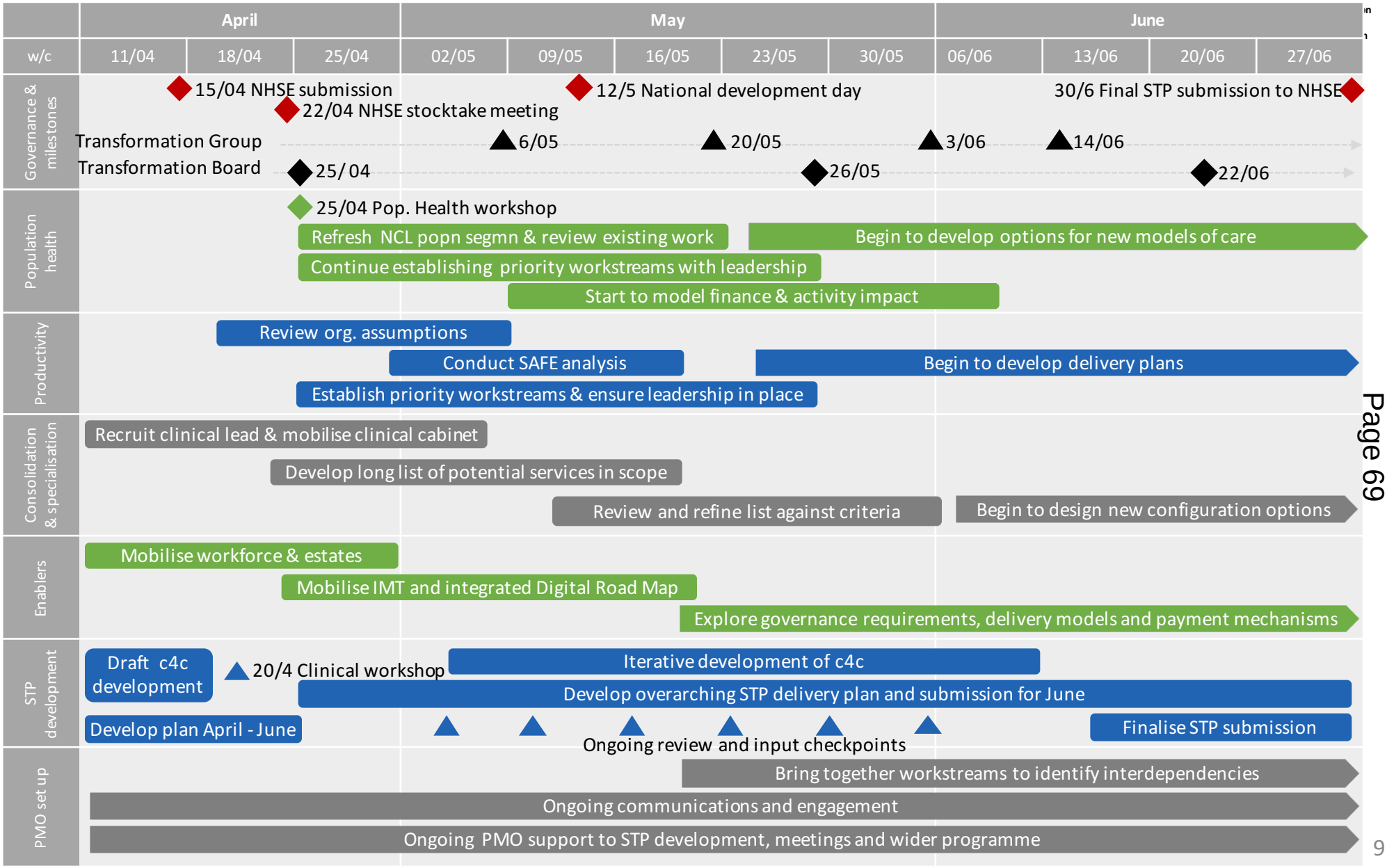
- **Population health**: understanding our population, segmenting into different groups, understanding what different interventions are required for each, and shifting the balance of care from reactive to proactive, starting with prevention and self care. This lens is important because it will enable us to do something radical and ensure we are non-institutional in our approach.
- **Productivity:** leveraging productivity opportunities both within organisations, but also through exploring opportunities for efficiency and savings through collaboration across organisations
- **Consolidation and specialisation:** in order to deliver improved safety, better outcomes and value for money
- **Stopping things**: stopping services or initiatives that aren't working

We recognise that a set of **key enablers** will be vital for transformation, including:

- information
- estates
- workforce
- new payment models
- governance and organisational models

Our Transformation Group will review the additional opportunities and recommend and prioritise where further effort can be made

High level roadmap to STP submission in June in development



Next steps: priority actions prior to STP submission in June

North Central London Sustainability and Transformation Plan

- ❑ Mobilise clinical cabinet
- ❑ Develop structure of the 30th June submission and refine the roadmap
- ❑ Agree the shape of the full programme architecture
- ❑ Clarify scope, plans and quantify the potential impact for each workstream
- ❑ Progress population based approach to health
- ❑ Identify pan-NCL productivity opportunities
- ❑ Map out existing local and collaborative work and ensure alignment with STP plans
- ❑ Agree programme budget and funding beyond June
- ❑ Develop communications and engagement strategy and roll out across NCL

Report for:	**Health and Wellbeing Board – 19 May 2016**
Title:	**North Middlesex University Hospital NHS Trust's Future Organisational Model**
Organisation:	**North Middlesex University Trust**
Lead Officer:	**Richard Gourlay, Director of Strategic Development**

1. Describe the issue under consideration

1.1 North Middlesex University Trust (NMUH) agreed at their March Board meeting a "Memorandum of Understanding" with the Royal Free London NHS Foundation Trust to explore becoming a founding member of the Royal Free London group. This is part of the vanguard development work that is happening nationally to look at hospitals working together to develop more sustainable models for the delivery of care to their local populations.

1.2 The Trusts are now progressing how the relationship between the two trusts might work into the future.

1.3 The presentation will give the Health and Wellbeing Board a broader understanding of the national context of vanguards and how the North Middlesex University Hospital has reached the view to progress their partnership with Royal Free London and a more detailed view on the potential impact for Haringey of this new way of working.

2. Recommendations

a. The Health and Wellbeing Board is asked **to note** the work that is underway between NMUH and RFL.

b. The Health and Wellbeing Board are asked **to discuss** how they would like to be involved in the development of the project going forward.

3. Timings

Discussions will be ongoing during 2016-17.

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Report for: Health and Wellbeing Board: 19 May 2016

Title: Mental Health and Wellbeing Survey Update

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

Lead Officer: Tamara Djuretic, Assistant Director Public Health

Ward(s) affected: ALL

Report for Key/ Non Key Decision: N/A – Discussion item

1. Describe the issue under consideration

1.1 Haringey's Health and Wellbeing Strategy's Priority 3 focuses on 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.

1.2 This paper highlights the main findings of the mental health survey undertaken in Haringey (enclosed as a full report in Appendix 1).

2. Cabinet Member Introduction

2.1 Mental health and wellbeing is a key priority for Haringey and one that we have recognised as a focus in the Haringey Health and Wellbeing Strategy.

2.2 The survey shows that mental health and wellbeing in Haringey is at moderate levels and it is encouraging to note that there are no significant differences between the overall borough score compared to the scores in the most deprived areas of the borough.

3 Recommendations

3.1 The Board is asked to note the overall findings of the borough-wide mental health and wellbeing survey and consider its implication for the overall Health and Wellbeing Strategy and Corporate Plan.

4. Reasons for decision

4.1 To note the relationship between mental health and wellbeing and the wider Health and Wellbeing Strategy, Corporate Plan and health and social care integration.

5. Alternative options considered

N/A

6. Background information

6.1 The first Haringey Mental Wellbeing Survey was undertaken in summer 2015 to gain a greater understanding of positive mental health and wellbeing across the local authority. Conducted by the Knowledge and Intelligence Liverpool Team at Public Health England, the survey provides a baseline measure of mental wellbeing across Haringey and within the most deprived population of the borough. Results will be used to support the ambitions and priorities set out in Haringey's Corporate Plan and Health and Wellbeing Strategy 2015-18.[i]

6.2 The Haringey Mental Wellbeing Survey 2015 results provide a baseline, to support the target of increasing the average short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score by 2018. The methodology of the survey is described in detail in the full report (see Appendix 1).

6.3 The average WEMWBS score for adults in Haringey in the borough was 26.10 and in the most deprived areas was 26.21. Any score of 21 or less is regarded as low, scores between 22 and 29, or 30 for the most deprived area is a moderate score and anything over 30 is regarded as a high score.

6.4 Respondents between 16 and 24 years old were most likely to have low mental wellbeing in the borough, while those aged 65 years and over were most likely to have low mental wellbeing in the most deprived sample. More men than women were categorised as having high mental wellbeing across both samples.

6.5 Childhood experiences of unhappiness and violence were associated with worse mental wellbeing; however the only significant relationship was for childhood happiness and mental wellbeing level in the borough sample.

6.6 Good health and fewer medical conditions were associated with better mental wellbeing as well as having more time to do things people really enjoy and regularly spending leisure time outdoors. More days of exercise and spending less time being sedentary had a significant association with better mental wellbeing in the borough sample.

6.7 Satisfaction with personal relationships showed a strong association with mental wellbeing, as did levels of trust, being well supported, and feeling safe in a local area. Feelings of neighbourhood belonging, being satisfied with local area and social capital were significantly associated with better mental wellbeing.

6.8 Employment was associated with better mental wellbeing, while those unable to work due to sickness or disability were most likely to report low mental

wellbeing. Poor educational attainment was associated with worse mental wellbeing, as were financial difficulties.

6.9 The survey explored health behaviours and the overall health of residents in relation to mental health and wellbeing and these are some key findings:

- Prevalence of smoking was 20% across the borough and increased to 24.2% in the most deprived sample. Smoking was strongly associated with lower mental health and wellbeing scores;
- Prevalence of cannabis use was approximately 6% across the borough and further 16% of residents were ex-users;
- The most common medical conditions reported by residents were high blood pressure (12-15%), anxiety, depression and stress (9-10%), asthma (6-8%) and diabetes (5.3 – 6.5%);
- Those with three or more conditions had significantly lower mental wellbeing scores;

6.10 It is proposed to repeat this survey annually, potentially using social media or other digital solutions.

7. Contribution to strategic outcomes

7.1 Priority 1-3 of the Corporate Plan and Health and Wellbeing Strategy Ambition 8.

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

8.1 Finance and Procurement

8.1.1 This is an update report for noting and as such there are no recommendations for action that have a direct financial implication.

8.2 Legal

8.2.1. This is an update report for noting and, as such, there are no recommendations for action that have direct legal implication.

8.3 Equality

8.3.1 The survey measures a number of protected characteristics such as age, ethnicity, illness and disability and compares mental health and wellbeing scores between the whole borough and those people in the most deprived areas.

8.3.2 The evidence established by the survey will inform planning of services and interventions that target those with the worst mental health and wellbeing outcomes (e.g. younger people and those over 65 years of age in most deprived areas.

9. Use of Appendices

Appendix one – Mental Wellbeing in Haringey: Findings from the Mental Wellbeing Survey 2015.

10. Local Government (Access to Information) Act 1985

Mental Health and Wellbeing Framework
http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=771&MId=6848&Ver=4

Health and Wellbeing Strategy 2015-2018

Haringey's Corporate Plan 2015-2018
http://www.haringey.gov.uk/local-democracy/policies-and-strategies/corporate-plan-2015-18

[i] Haringey Council (2015) Haringey's Health and Wellbeing Strategy 2015-18 [Online]. Available at: www.haringey.gov.uk/

Public Health England

Protecting and improving the nation's health

Mental wellbeing in Haringey

Findings from the Mental Wellbeing Survey 2015

A study commissioned by Haringey Council

Haringey LONDON

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Contents

Key findings

The key findings from the Haringey Mental Wellbeing Survey 2015 were as follows:

- there was no significant difference in the average WEMWBS score between the two survey samples at 26.10 in the across area sample and 26.21 in the most deprived sample
- age and gender were significantly associated with mental wellbeing in both samples
- respondents aged between 16 and 24 were most likely to have low mental wellbeing in the across area sample, while those aged 65 and over were most likely to have low mental wellbeing in the most deprived sample
- more men than women were categorised as having high mental wellbeing across both samples
- good health and fewer medical conditions were associated with better mental wellbeing
- having more time to do things you really enjoy and regularly spending leisure time outdoors were associated with better mental wellbeing, as was drinking alcohol at a lower risk[a] level
- more days of exercise had a significant association with better mental wellbeing in the across area sample and spending less time being sedentary was significant for both samples
- satisfaction with personal relationships showed a strong association with mental wellbeing, as did levels of trust
- being well supported and feeling safe in your local area were strongly associated with better mental wellbeing
- childhood experiences of unhappiness and violence were associated with worse mental wellbeing; however, the only significant relationship was for childhood happiness and mental wellbeing level in the across area sample
- employment was associated with better mental wellbeing, while those unable to work due to sickness or disability were most likely to report low mental wellbeing
- poor educational attainment was associated with worse mental wellbeing, as were financial difficulties
- feelings of neighbourhood belonging and being satisfied with your local area were associated with better mental wellbeing
- social capital had a significant relationship with mental wellbeing

[a] Lower risk drinking: consumption of less than 22 units of alcohol per week for males and less than 15 units of alcohol per week for females.

1. Introduction

1.1 The Haringey Mental Wellbeing Survey

The first Haringey Mental Wellbeing Survey was undertaken in 2015 to gain a greater understanding of positive mental health and wellbeing across the local authority. Conducted by the Knowledge and Intelligence Team (North West) at Public Health England (PHE), the survey provides a baseline measure of mental wellbeing across Haringey and within the most deprived population of the local authority. This study was commissioned from PHE's Knowledge and Intelligence team due to their previous experience of conducting large scale mental wellbeing surveys in the North West.[b]

The resident population of Haringey is an estimated 267,541 people (2014 mid-year population estimates).[1] Deprivation is higher than average, however life expectancy for both men and women is better than the England average.[c] Over a quarter of children living in Haringey live in poverty (26.8%).There is wide variation in life expectancy for males across the borough, with those in the most deprived areas having a life expectancy 6.6 years lower than males in the least deprived areas.[2]

1.2 Mental wellbeing

Mental wellbeing has been defined as "a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society".[3] Thus, rather than focusing on the negative aspects of mental illness, mental wellbeing refers to positive attitudes and situations that promote happiness, health and prosperity, [4] and can be thought of simply as feeling good and functioning well.[5, 6] An individual with good mental wellbeing is better able to cope with daily life, engage fully in society and be productive.[7] Critically, mental wellbeing is also strongly related to health; good mental wellbeing is associated with better mental and physical health, fewer risky health behaviours and greater life expectancy.[8] Thus, improving mental wellbeing should

[b] The Knowledge and Intelligence Team (North West) was formerly the North West Public Health Observatory (NWPHO). The NWPHO conducted two North West Mental Wellbeing Surveys in 2009 and 2012/13 (see www.nwph.net/nwpho). The NWPHO transitioned to PHE on 1 April 2013.
[c] The difference is not statistically significant.

have major impacts on health across a population, and consequently improve economic and social returns.[3]
There are two dimensions of wellbeing:[9]

1. *Subjective wellbeing (or personal wellbeing)* focusses on what people think and feel about their own wellbeing and quality of life, including life satisfaction (evaluation), positive emotions (hedonic), and whether their life is meaningful (eudemonic).

   The Office for National Statistics (ONS) has a programme of work to measure subjective wellbeing as part of the Measuring National Wellbeing Programme. It includes four measures of personal wellbeing as well as subjective measures of some of the influences on wellbeing: relationships, health, where we live, what we do, personal finance, and trust in government. The four subjective measure indicators are in PHOF[d] under the Health Improvement domain and figures for Haringey are shown in Table 1.

2. *Objective wellbeing* centres around assumptions about basic human needs and rights, such as adequate food, physical health, education and safety. It can be measured either through self-reporting (asking the individual about a specific health issue), or by using more objective measures such as life expectancy or mortality rates. Life expectancy figures for Haringey from PHOF (under the Overarching Indicators domain) are detailed in Table 2.

Understanding what factors impact on mental wellbeing therefore allows policymakers to target interventions to improve mental wellbeing. There is a great deal of research which explores the factors that are linked to mental wellbeing, including demographics, income, education, employment, health, recreational activities, attitudes and beliefs, relationships and environment.[e 10] Understanding how such factors interact with mental wellbeing at a local level is important in understanding which interventions might be most beneficial in Haringey.

Table 1. Self-reported wellbeing in Haringey compared to England, 2013/14

Indicator	Haringey value	England value	Significance
People with a low life satisfaction score	5.8	5.6	Not significantly different

[d] www.phoutcomes.info/public-health-outcomes-framework
[e] For further information, see the 2009 and 2013 North West Mental Wellbeing reports. Available at: www.nwph.net

People with a low worthwhile score	*	4.2	-
People with a low happiness score	12.5	9.7	Not significantly different
People with a high anxiety score	22.9	20.0	Not significantly different

*Data supressed due to disclosure rules. Source: Public Health Outcomes Framework (PHOF), Public Health England. Data correct as at October 2015.

Table 2. Life expectancy in Haringey compared to England, 2011-13

Indicator	Haringey value	England value	Significance
Healthy life expectancy at birth (Male)	63.6	63.3	Not significantly different
Healthy life expectancy at birth (Female)	59.6	63.9	Significantly worse
Life expectancy at birth (Male)	80.1	79.4	Significantly better
Life expectancy at birth (Female)	84.7	83.1	Significantly better

Source: Public Health Outcomes Framework (PHOF), Public Health England. Data correct as at October 2015.

1.3 Policy context

The White Paper *Healthy Lives, Healthy People* acknowledges the importance of mental wellbeing to physical health and lifestyles.[11] As a result, policy focus is now aimed at improving mental health and wellbeing and preventing mental disorders. The Department of Health policy report, *No health without mental health,* advocates a shift from centralised control to local control and prioritises work with all sectors.[8] The Government Office for Science report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century,* highlights the importance of a long-term focus on age specific needs, with the 'five ways to mental wellbeing' underscoring work.[3] These policies are set against a backdrop of reforms that could increase the inequalities in mental wellbeing and health.[12]

Local policy and strategy

One of the key recommendations in Haringey Council's Annual Public Health Report 2014 was to "undertake a survey of issues affecting our residents' wellbeing to understand the key issues we need to focus on".[13] In response, the Public Health Department at Haringey Council commissioned this study. Results will be used to support the ambitions and priorities (see Box 1) set out by Haringey Council's Health and Wellbeing Board in the Health and Wellbeing Strategy 2015-18.[14] The Haringey Mental Wellbeing Survey 2015 results will provide the baseline; with the specific aim of increasing the average short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score by 2018 (see Section 2.2 for further information about WEMWBS).

Box 1. Ambitions and priorities in Haringey's Health and Wellbeing Strategy 2015-18[14]

Three ambitions:

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

Supported by nine priorities:

1. Fewer children and young people will be overweight or obese
2. More people will do more to look after themselves
3. More adults will be physically active
4. More adults will have good mental health and well-being
5. Haringey is a healthy place to live
6. More children and young people will have good mental health and well-being
7. Every resident enjoys long lasting good health
8. People with severe mental health needs live well in the community
9. People can access the right care at the right time

Haringey Council's Annual Public Health Report (2014) details numerous projects in place in Haringey that aim to improve wellbeing, some examples of which are detailed in Box 2. Details of all of the mental wellbeing resources on offer in Haringey can be found on the mental wellbeing section of their website (see www.haringey.gov.uk/social-care-and-health/health/public-health/mental-wellbeing).

Box 2. Examples of wellbeing activities taking place across Haringey

Supporting people and communities

Tottenham Thinking Space: aimed at bringing people living in Tottenham together, to talk and think about their experiences, develop understanding and take steps to improve themselves and the community.[f]

Neighbourhoods Connect: supports people to make new friends, connect to social activities, hobbies, fitness and wellbeing services, community groups, volunteering and befriending opportunities.[g]

Challenging stigma and discrimination

State of Play: uses sport to help young people build resilience and learn to look after their own mental health and wellbeing, with the opportunity to gain accreditation both as a 'Wellbeing Champion' and a Level 1 FA football coach. This is a partnership between Barnet, Enfield and Haringey Mental Health Trust, the Tottenham Hotspur Foundation and charity New Choices for Youth.

Integrate Haringey: in partnership with MAC-UK the integrate project offers young people (aged 16 to 25 years) the opportunity to take control of their own mental health and wellbeing. Targeted at those involved in gangs and antisocial behaviour that do not access traditional services.

2. Survey Methodology

This section summarises the methodology used in the 2015 Haringey Mental Wellbeing Survey.

2.1 The questionnaire

The questionnaire gathered data on participants' demographics, lifestyle choices (including substance use, exercise and diet), health status, mental wellbeing, life satisfaction, and social capital (a representation of person's community participation and sense of social cohesion). There were also questions on childhood experiences, health conditions, housing situation and satisfaction, financial situation compared to past and future situations, reasons for continuing smoking and more in depth analysis of alcohol use. The questionnaire was based

[f] For further information see: www.haringey.gov.uk/events/tottenham-thinking-space-mens-group
[g] For further information see: www.haringey.gov.uk/social-care-and-health/help-home/neighbourhoods-connect

upon the North West Mental Wellbeing Survey 2012/13. The full questionnaire is available in Appendix A.

Ethical approval for this study was gained from the NHS Health Research Authority in January 2015.

2.2 Measuring mental wellbeing

The survey used the short Warwick-Edinburgh Mental Wellbeing Scale (hereafter referred to as sWEMWBS) to measure mental wellbeing. The full WEMWBS contains 14 items covering aspects of positive mental health that broadly involve perspectives on pleasure and happiness. The shorter, seven-item version was developed as a more practical alternative to the full version of WEMWBS.[15] The seven items included in the sWEMWBS refer to participants' feelings over the past two weeks. They are:

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling close to other people
- I've been able to make up my own mind about things

Responses are scored on a five-point Likert system, ranging from 1 meaning 'none of the time' through to 5 meaning 'all of the time'. Scores for each item are summed, meaning a respondent can score between 7 (lowest possible mental wellbeing) and 35 (highest possible mental wellbeing).

2.3 Sampling

Sample size calculations were conducted to ensure a representative sample at local authority level, and these suggested that 500 participants would be sufficient for the size of the population in Haringey. In addition to the primary (across the whole local authority population) sample of 500, Haringey Council opted to conduct an additional 500 'boost' sample of people living in the most deprived quintile of the population. This would allow comparison of survey responses from those in the most deprived areas with the primary sample.

Households were selected for inclusion in the survey using a stratified random sample approach. The Post Office Address File (PAF) was the sampling frame as this provided an up-to-date list of all the households in Haringey. Lower super output areas (LSOAs) were the primary sampling unit. An LSOA is the smallest

geographic unit into which an area is divided, containing between 1,000 and 3,000 individuals and 400 and 1,200 households. The LSOAs were listed by quintile of deprivation from the Index of Multiple Deprivation 2010, and a random selection of LSOAs was made for each quintile in line with their proportion in the local authority. Households were then selected at random within the selected LSOAs.

Interviewers were given set ‘quotas’ to interview a certain number of people according to set demographics (gender, age, and ethnicity). This has ensured that the achieved sample is highly representative of Haringey thereby controlling for any bias that may otherwise be inherent amongst certain sub-groups.

2.4 Fieldwork

Prior to any interviews taking place, a survey notification letter was distributed to 10,000 households in Haringey (ten times the number of surveys required; 5,000 addresses covering the primary sample and 5,000 addresses covering the boosted sample). A copy of the survey letter is available in Appendix B.

Fieldwork was conducted between 18 June and 27 July 2015. The interviews took place between the hours of 9am and 8pm on weekdays and 10am and 8pm at the weekends (unless an alternative appointment was agreed with a respondent). The average interview length was 15 minutes.

All interviewers carried photo ID, a letter of authorisation from Haringey Council containing a named Council contact and their contact details. These details included a freephone number for the Market Research Society (MRS) and one for M.E.L. Research Ltd (the independent company that conducted the survey) so that members of the public could check the bone fide nature of the study. Interviewers were also provided with a laminated copy of the pre-survey letter that was sent to households along with the M.E.L letter of authorisation which provided details of the survey objectives.

Interviewers were provided with a paper copy of the list of eligible addresses that had been randomly generated. Where no one was home at the time of the initial call, the next eligible address was visited. For households that were present, a ‘next birthday’ approach was taken to randomly select eligible adults (16+). This approach asked for the birth dates of adult household members. The interviewer then requested an interview with the person whose birthday falls next in the calendar year. Where this individual was not at home at the time the interviewer called, then contact details were requested and an appointment was made to call back at a different time/date.

Up to three attempts to secure an interview with the selected household member were made to either successfully complete an interview, accept a refusal to participate or deem the interview unsuccessful. Where refusals or unsuccessful attempts (three attempts to secure an interview) resulted, a subsequent address was visited. Interviewers were given set 'quotas' (based on 2011 Census data) for gender and age.

A total of 1,003 face-to-face interviews were undertaken with a household member using computer assisted personal interviewing (CAPI). The computers allow people to answer questions confidentially and anonymously. The survey was conducted by the independent market research company, M.E.L. Research Ltd,[h] within the MRS Code of Conduct.

2.5 Achieved sample

In total, 1,003 interviews were completed; 503 within the primary (across area) sample and 500 in the boost (most deprived) sample. The unweighted demographic profile of respondents is shown in Table 3.

Table 3: Unweighted demographic profile of respondents by sample, Haringey 2015

		Primary	Boost	Total
Gender	Male	243	219	462
	Female	260	281	541
Age	16 to 24	57	74	131
	25 to 39	157	167	324
	40 to 54	124	111	235
	55 to 64	66	61	127
	65+	87	71	158
	Not known	12	16	28
Ethnicity	White	313	260	573
	Non-White	144	178	322
	Not known	46	62	108
IMD	1 (Most Deprived)	126	500	626
	2	87	0	87
	3	106	0	106
	4	95	0	95
	5 (Least deprived)	89	0	89

[h] The Knowledge and Intelligence (Liverpool) team commissioned Measurement Evaluation Learning (M.E.L) Research Limited to conduct the survey.

Qualification level	None	78	106	184
	Entry/level 1	37	47	84
	Level 2	55	44	99
	Level 3	63	64	127
	Level 4+	188	141	329
	Other/foreign†	76	91	167
	Not known	6	7	13
Employment status	Employed	297	280	577
	Unemployed	27	28	55
	Not working: domestic	34	35	69
	Sick/disabled	10	13	23
	Other≠	112	107	219
	Not known	23	37	60
Total		**503**	**500**	**1003**

Foreign qualifications, vocational qualifications or other. ≠Retired, in full time education or other.

2.6 Weighting and confidence limits

A weighting variable was added to the survey dataset to equalise the sample characteristics with population characteristics, so that the resulting analysis more accurately reflects the population under study. Every respondent that has a valid gender, age group and national Index of Multiple Deprivation (IMD) 2010 quintile entered in the dataset was assigned a weighting value.

When performing analysis on the weighted dataset only the respondents that were assigned a weighting variable were included in the analysis. Weighting increased the across area sample by 19.5% and decreased the most deprived sample by 3.3%.

Separate weighting values were calculated for each of the two samples (referred to as ‘across area’ and ‘most deprived’). The weighting calculations were conducted as follows:

- a three-way crosstab (gender, age group, IMD 2010 quintile) was produced for the population of Haringey local authority. This was obtained from lower super output area (LSOA) single year of age population estimates for 2013, which IMD 2010 quintiles had been matched with. The proportion of the total population that each cell represented was then calculated (for example, the proportion of the total population that were male, aged 16-24 years, living in the least deprived quintile)

- a three-way crosstab (gender, age group, IMD 2010 quintile) was also performed on the dataset. The proportion of the overall sample that each cell represented was then calculated
- for each subgroup (gender, age group, IMD 2010 quintile), the proportion of the population was divided by the proportion of the sample to produce weighting value

During analysis, when subgroups of the population were compared, 95% confidence intervals were applied to the results to indicate where there were 'significant' differences. When examining data by mental wellbeing category (low, moderate, high), Pearson's Chi-squared tests were performed in SPSS which generated 'p' values to give an indication of the significance of the association between mental wellbeing and each variable. A p value of less than 0.05 represents a significant association.

2.7 Analysis

Measuring wellbeing allows us to form some understanding of how the people of Haringey feel about their lives, and examining changes in the other areas (domains) of wellbeing, such as health, education and the economy gives an indication of where to focus attention to make improvements.

Wellbeing was examined and reported in two ways for this study, firstly by assessing mean WEMWBS score and secondly by comparing wellbeing levels within both samples to assess the proportions of the population that had low, moderate or high mental wellbeing (see results section for details). The questions within the survey were examined and grouped in to domains; so for example, questions relating to employment, finance and education were grouped together and reported on.

3. Results

This section provides key findings from the Haringey Mental Wellbeing Survey 2015. It examines associations between mental wellbeing and a range of health, lifestyle, housing and income variables. Weighted results are presented for the two samples, the primary sample (referred to as 'across area') and the boost sample (referred to as 'most deprived' - see Section 2.3 for more details).

3.1 Distribution of WEMWBS scores

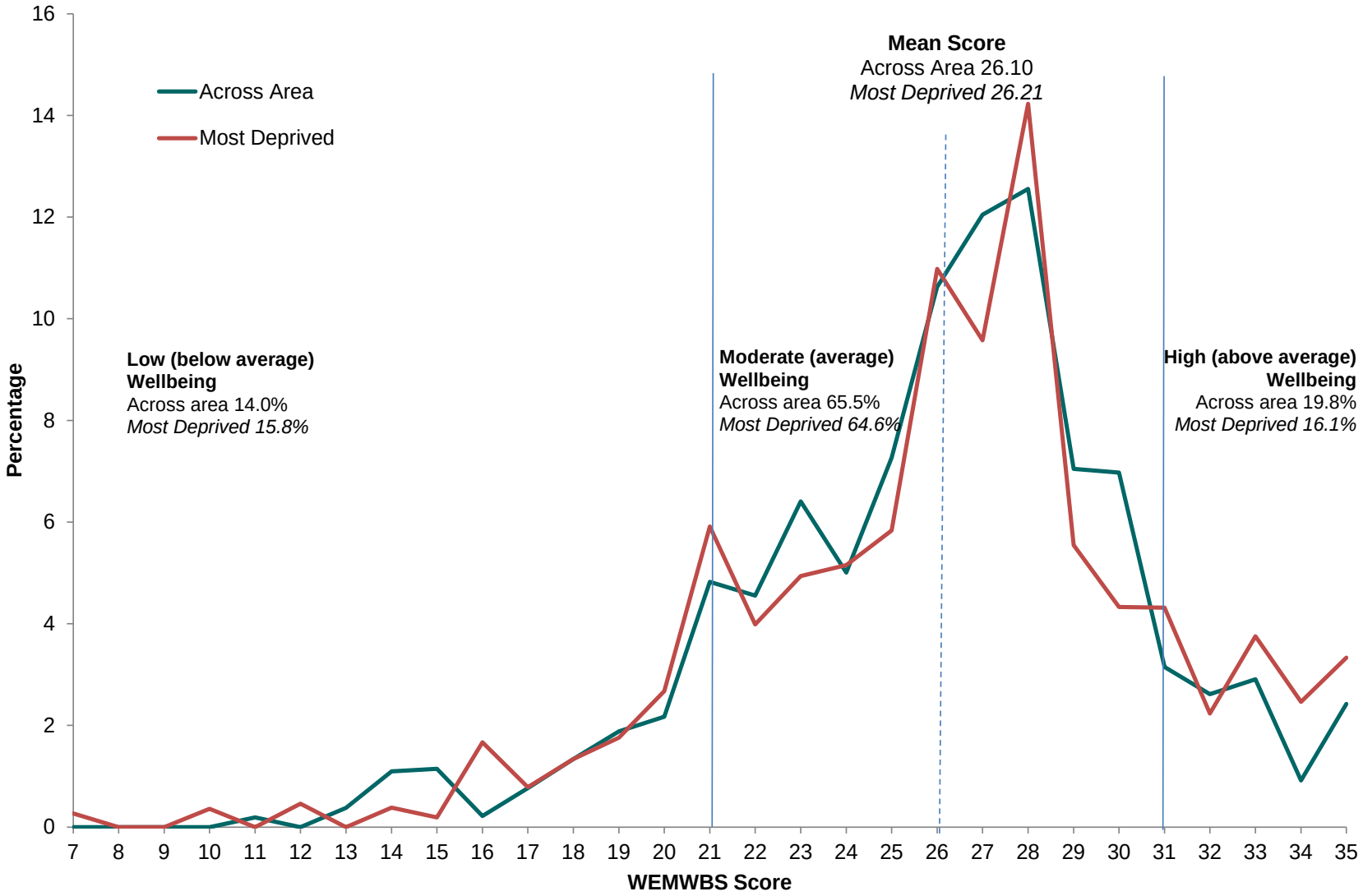
The total WEMWBS score for each respondent was calculated by summing their responses to the seven WEMWBS questions (see Section 2.2). The highest possible score is 35 and the lowest is 7. Scores were split into three categories of low (below average; one standard deviation (SD) below the mean), moderate (average) and high (above average; one SD above the mean) mental wellbeing based on their distribution across Haringey (Table 4).

Table 4. Mental wellbeing categories based on WEMWBS score distribution, Haringey 2015

	Across area WEMWBS score	Most deprived WEMWBS score
Low	21 or less	21 or less
Moderate	22 to 29	22 to 30
High	30 or more	31 or more

The mean WEMWBS score for Haringey in 2015 was 26.10 across area and 26.21 in the most deprived sample. This difference in means was not significant. Figure 1 shows the overall distribution of WEMWBS scores for Haringey. The distribution was fairly similar across both samples, with both peaking at 28.

Figure 1. Distribution of WEMWBS scores, Haringey 2015



3.2 Demographics

Table 5 shows mental wellbeing in Haringey by participants' basic demographics. High mental wellbeing was most prevalent among 40 to 54 year olds and least prevalent in the 55 to 64 age group in the across area sample, whilst in the most deprived sample it was most common among those in slightly lower age group of 25 to 39 year olds and least prevalent in the 65 plus group. Across both samples, age was significantly associated with mental wellbeing ($p<0.05$). Gender was also significantly associated with mental wellbeing, with more men than women categorised as having high mental wellbeing (across area, 23.2%; most deprived, 20.9%). When examining the data by deprivation quintile in the across area sample, high mental wellbeing is most prevalent among those living in the fourth most deprived quintile (28.8%).

Table 5. Wellbeing in Haringey by age, gender and deprivation, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Age	16-24	90	16.7%	64.4%	18.9%		78	20.5%	66.7%	12.8%	
	25-39	227	13.7%	70.9%	15.4%		182	16.5%	60.4%	23.1%	
	40-54	163	14.7%	56.4%	28.8%		116	12.1%	73.3%	14.7%	
	55-64	53	13.2%	75.5%	11.3%		43	11.6%	74.4%	14.0%	
	65+	60	11.7%	71.7%	16.7%	p<0.05	48	25.0%	68.8%	6.3%	p<0.05
Gender	Male	285	12.3%	64.6%	23.2%		234	12.8%	66.2%	20.9%	
	Female	308	16.2%	68.2%	15.6%	p<0.05	234	20.1%	67.5%	12.4%	p<0.05
IMD*	Least deprived	65	10.8%	70.8%	18.5%						
	4th most deprived	146	17.8%	53.4%	28.8%						
	3rd most deprived	102	4.9%	73.5%	21.6%						
	2nd most deprived	92	18.5%	69.6%	12.0%						
	Most deprived	184	15.2%	70.7%	14.1%	p<0.01	467	16.3%	67.0%	16.7%	

*IMD = Index of Multiple Deprivation. P values represent chi-squared tests (see Section 2.6 for details).

3.3 General Health

When asked to rate their general health, the majority of respondents rated it as 'good' (57.4%, across area; 46.8%, most deprived) or 'very good' (23.6%, across area; 26.7%, most deprived) (Table 6). The proportion of respondents who reported 'good' health in the most deprived sample was significantly lower than the across area sample.

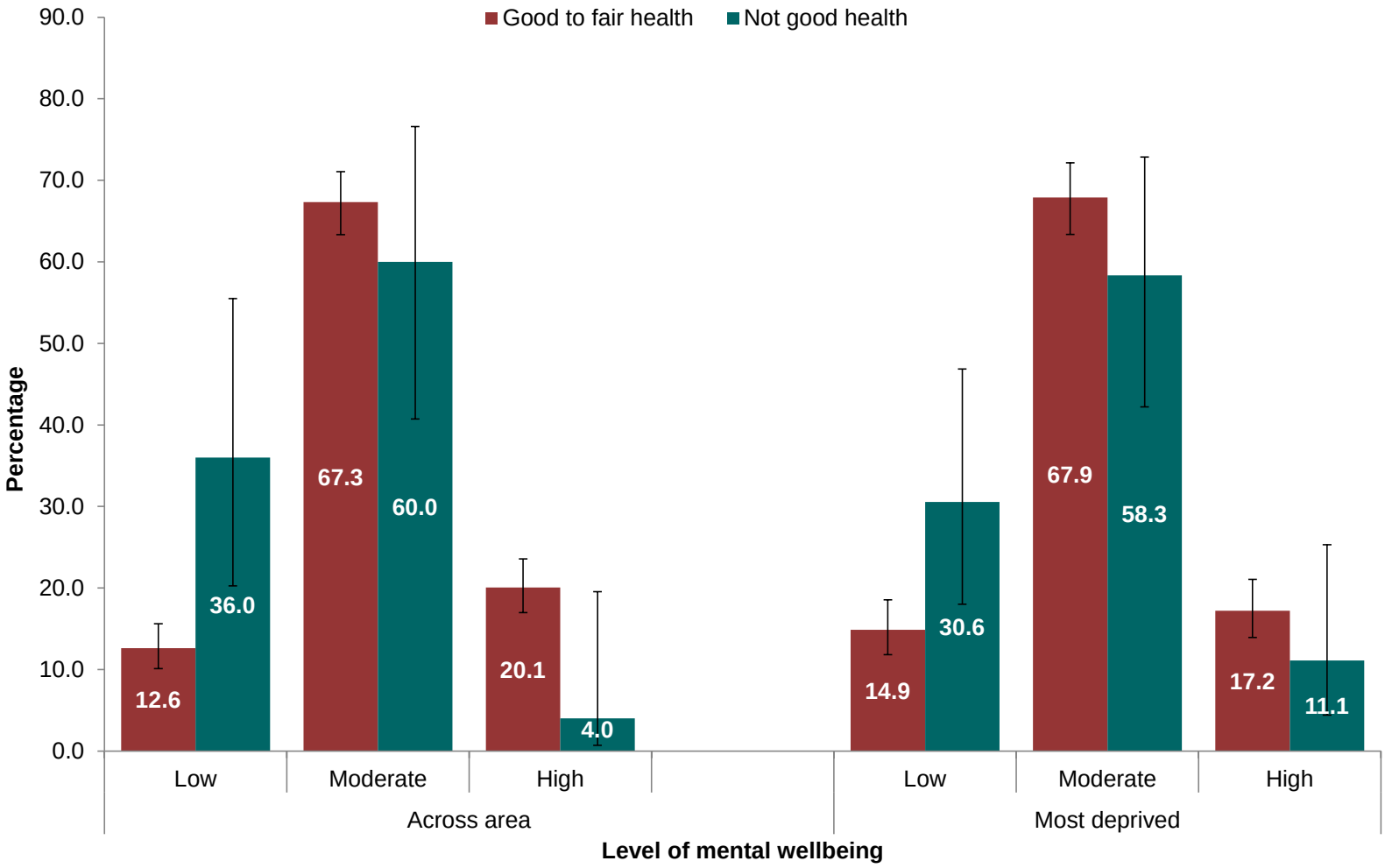
Table 6. Self-rated general health in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very good	23.6%	26.8%	NS
Good	57.4%	46.8%	Sig diff
Fair	14.1%	18.6%	NS
Bad	3.6%	7.9%	NS
Very bad	0.6%	0.5%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

To identify associations between self-rated health and mental wellbeing, responses to self-rated health were grouped into two categories: 'good to fair', including those who rated their health as very good, good or fair; and not good, including those rating their health as bad or very bad. Figure 2 shows a clear relationship between self-rated health and mental wellbeing. Low mental wellbeing was less prevalent in respondents who rated their health as good to fair compared to those who rated their health as not good (across area: 12.6% vs. 36.0%; most deprived: 14.9% vs. 30.6%).

Figure 2. Mental wellbeing in Haringey by self-rated health status, 2015



3.4 Medical conditions

Respondents were asked whether a doctor or nurse had ever told them they had one of a range of medical conditions. The most common conditions reported by Haringey participants were high blood pressure (12.1% across area; 15.7% most deprived), depression, anxiety or stress (10.6% across area; 9.1% most deprived), asthma (8.3% across area; 5.7% most deprived) and diabetes (5.3% across area; 6.5% most deprived, Table 7). There were no significant differences in reported conditions across the two samples.

Table 7. Medical conditions reported by respondents, Haringey 2015

	Across area	Most deprived	Significant difference*
High blood pressure (hypertension)	12.1%	15.7%	NS
Angina	0.5%	1.0%	NS
Coronary Heart Disease or Heart Attack	2.5%	1.5%	NS
Stroke	0.3%	0.2%	NS
Asthma	8.3%	5.7%	NS
Respiratory Disease (Chronic bronchitis/ Emphysema/ Chronic Obstructive Pulmonary Disease)	1.0%	0.4%	NS
Diabetes	5.3%	6.5%	NS
Digestive disease (gastritis, ulcer, Crohn's disease, colitis)	3.1%	2.9%	NS
Liver disease	0.9%	0.0%	NS
Cancer	1.4%	1.5%	NS
Depression, anxiety or stress	10.6%	9.1%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

To measure associations between the presence of medical conditions and mental wellbeing, respondents were grouped into those with none, one, two, three, or four or more medical conditions. In the across area sample, respondents with no medical conditions

were most likely to have high wellbeing (22.5%; p<0.001), and those with three or four or more three conditions were most likely to have low wellbeing (66.7%; p<0.001). In the most deprived sample, respondents with four or more medical conditions were most likely to have high mental wellbeing (20.0%) and low wellbeing (60.0%) however the relationship between mental wellbeing and medical conditions was not significant for this sample (Table 8).

Table 8. Presence of medical conditions, Haringey 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Medical conditions	None	405	9.4%	68.1%	22.5%		340	14.7%	66.5%	18.8%	
	One	123	27.6%	56.9%	15.4%		73	17.8%	72.6%	9.6%	
	Two	46	15.2%	76.1%	8.7%		32	15.6%	65.6%	18.8%	
	Three	14	28.6%	71.4%	0.0%		17	29.4%	64.7%	5.9%	
	Four or more	3	66.7%	33.3%	0.0%	p<0.001	5	60.0%	20.0%	20.0%	NS

P values represent chi-squared tests (see Section 2.6 for details).

3.5 Health State (EQ-5D)

Participants' health states were measured using the EQ-5D (see Box 3). This allocates each respondent with a health score index ranging from -0.59 (worst imaginable health) to 1 (full health).[16]

Mean EQ-5D score for Haringey in 2015 was 0.90 across area and 0.88 in the most deprived sample; this difference was not significant (Table 9).

Box 3. The EQ-5D measure

The EQ-5D is a standardised instrument for measuring health outcomes that allows for comparison across a range of conditions. It asks five questions on:

- physical mobility
- self-care
- performance of usual activities
- pain and discomfort
- anxiety and depression

For each area, participants identify whether they are not affected, moderately affected or severely affected.

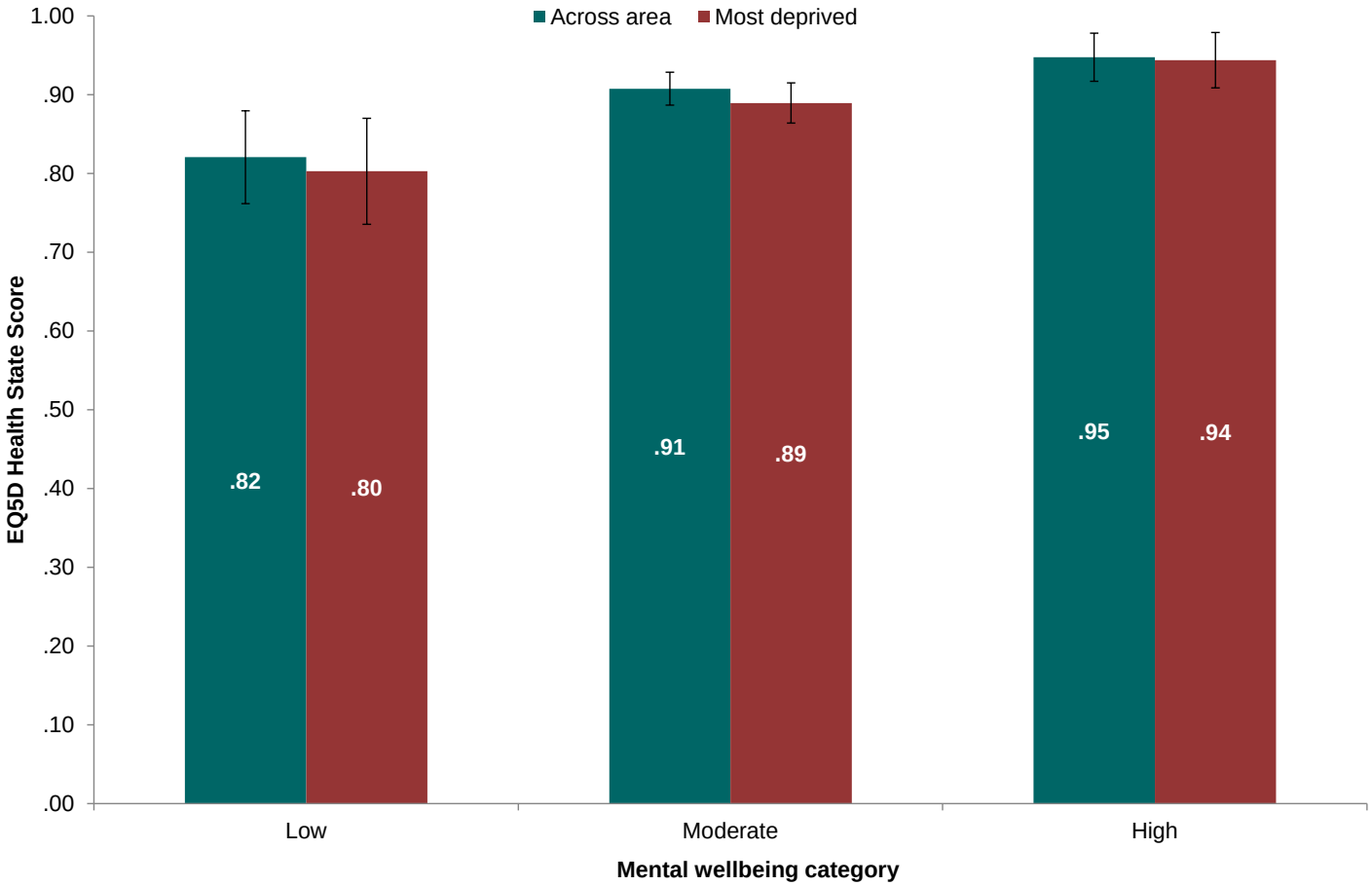
Table 9. Mean EQ-5D scores for Haringey

	Across area	Most deprived	Significant difference*
Mean EQ-5D score	0.90	0.88	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

A clear relationship was found between health state and mental wellbeing in Haringey (Figure 3). People with low wellbeing had the lowest mean EQ-5D score (0.82 across area; 0.80 most deprived), whilst those with high wellbeing had the highest (0.95 across area; 0.94 most deprived).

Figure 3. Mean EQ-5D (health state) index score by wellbeing category in Haringey, 2015



3.6 Life satisfaction

To measure life satisfaction, respondents were asked: “All things considered, how satisfied are you with your life as a whole nowadays?” Responses were measured on an 11-point scale with 0 being extremely dissatisfied and 10 extremely satisfied. The mean life satisfaction score for Haringey participants in 2015 was 8.37 across area and 8.33 in the most deprived sample, this difference was not significant.

Participants were grouped into four life satisfaction categories: low life satisfaction - score 0 to 4; moderate life satisfaction - score 5 to 6; high life satisfaction - score 7 to 8, very high life satisfaction - score 9 to 10. These categories match those used by the Office for National Statistics when measuring national and personal wellbeing.[17] Comparing life satisfaction results from this survey with the most recent ONS data for Haringey (2013/14)[18] reveals that there was no significant difference between Haringey and England in the proportion of the population falling into each life satisfaction category (see Appendix C for data tables).

The majority of respondents across both samples reported high (56.3% across area; 56.2% most deprived) or very high (21.5% across area; 22.5% most deprived) levels of life satisfaction (Figure 4). There were no significant differences by life satisfaction group between the two samples.

Examining responses by level of mental wellbeing (Table 10) shows the clear relationship between life satisfaction and mental wellbeing in Haringey. Over half of those that had low life satisfaction had low mental wellbeing (54.1% across area; 54.5% most deprived).

Figure 4. Mental wellbeing in Haringey by life satisfaction, 2015

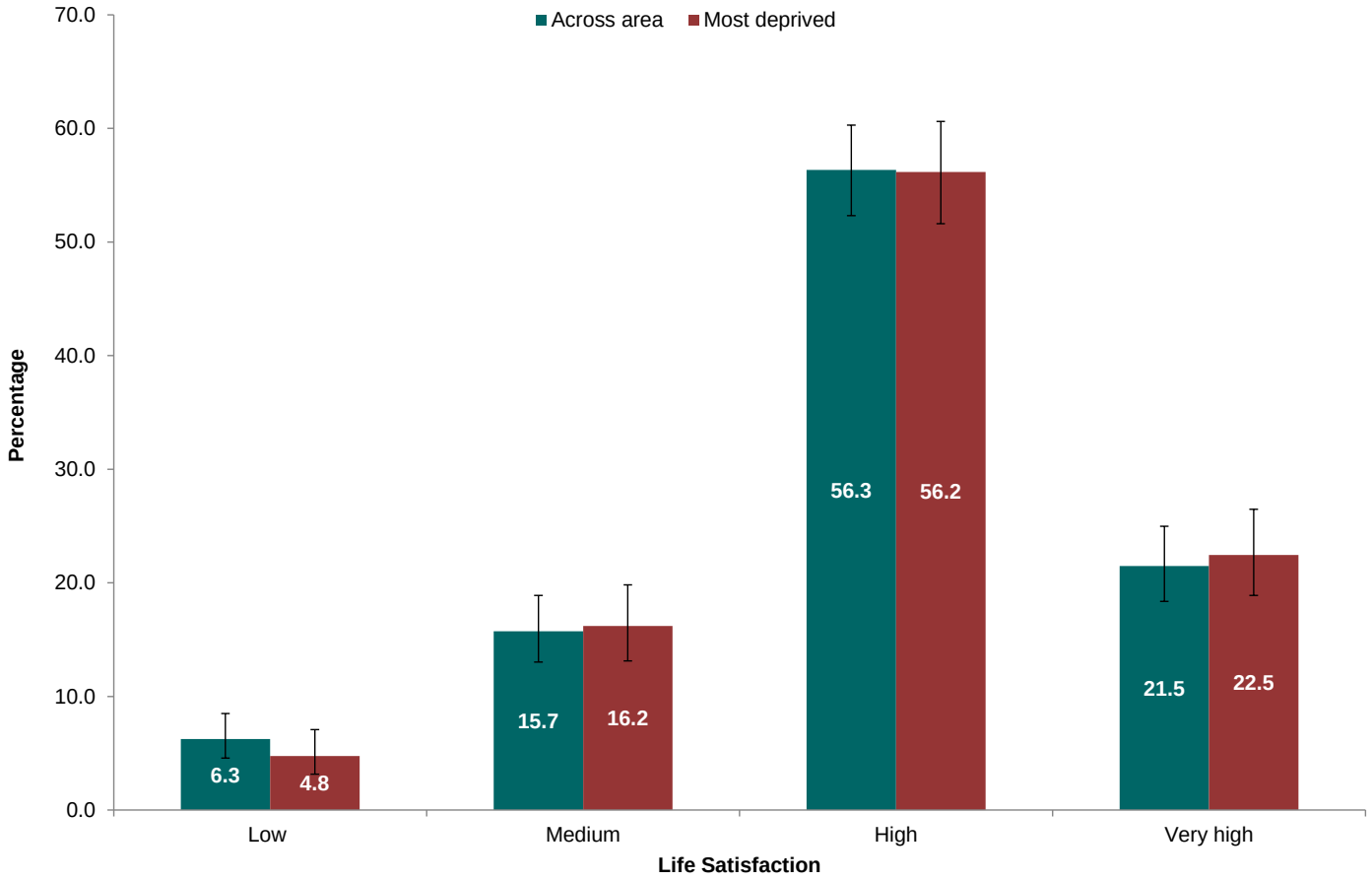


Table 10. Life satisfaction in Haringey, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Life Satisfaction*	Low	37	54.1%	40.5%	5.4%		22	54.5%	36.4%	9.1%	
	Medium	93	34.4%	62.4%	3.2%		75	30.7%	65.3%	4.0%	
	High	333	7.2%	73.0%	19.8%		260	6.7%	58.7%	34.6%	
	Very high	127	5.5%	60.6%	33.9%	p<0.001	104	11.5%	74.2%	14.2%	p<0.001

*Don't know: across area, n=1; most deprived, n=2. P values represent chi-squared tests (see Section 2.6 for details).

3.7 Sense of worth

To measure sense of worth, respondents were asked: "Overall, to what extent do you feel the things you do in your life are worthwhile?" Responses were measured on an 11-point scale with 0 being not at all worthwhile and 10 completely worthwhile. Participants were grouped into four life worthwhile categories: low life worthwhile - score 0 to 4; moderate life worthwhile - score 5 to 6; high life worthwhile - score 7 to 8, very high life worthwhile - score 9 to 10. These categories match those used by the Office for National Statistics when measuring national and personal wellbeing.[17] Comparing life worthwhile results from this survey with the ONS data for Haringey (2011-14),[i,19] reveals that for both Haringey mental wellbeing survey samples, the proportion with high life worthwhile were significantly higher than the ONS results. In addition, the proportion of respondents with very high life worthwhile in the across area sample was significantly lower than the ONS results (see Appendix C for data tables).

The mean score for Haringey respondents was 8.36 across area and 8.30 for the most deprived sample. Participants were grouped into three categories based on their ratings: low, moderate (medium), high/very high sense of worth. Almost three-

[i] Due to data suppression, life worthwhile results for Haringey were not presented in the ONS Personal Wellbeing 2014/15 or 2013/14 tables; therefore aggregated results for 2011-14 from the Measuring National Well-being, Life in the UK, 2015 report have been used as a comparison.

quarters of Haringey participants had a high/very high sense of worth (76.8% across area; 71.9% most deprived; Figure 5). There were no significant differences by sense of worth category between the two samples.

When examining sense of worth by level of mental wellbeing (Table 11), results show that the majority of those with low sense of worth had low mental wellbeing (62.5% across area; 45.0% most deprived), whilst high mental wellbeing was most likely in those with a high/very high sense of worth (22.7% across area; 21.1% most deprived). Across both samples there was a significant relationship between sense of worth and mental wellbeing ($p<0.001$).

Figure 5. Wellbeing in Haringey by sense of worth, 2015

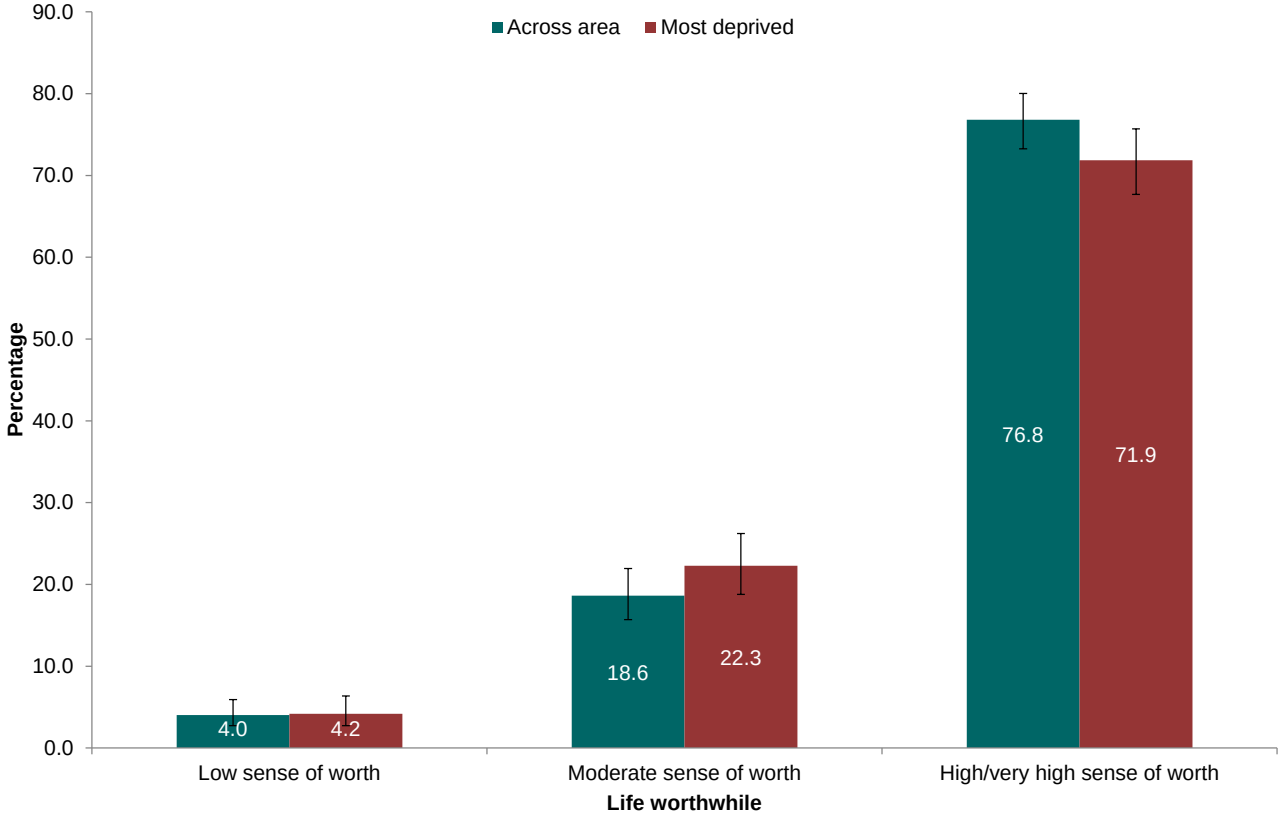


Table 11. Sense of worth by level of mental wellbeing in Haringey, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Sense of worth*	Low	24	62.5%	37.5%	0.0%		20	45.0%	45.0%	10.0%	
	Medium	109	32.1%	56.9%	11.0%		105	30.5%	64.8%	4.8%	
	High/Very High	449	6.2%	71.0%	22.7%	p<0.001	332	9.6%	69.3%	21.1%	p<0.001

*Don't know: across area, n=4; most deprived, n=3. P values represent chi-squared tests (see Section 2.6 for details).

3.8 Involvement in leisure and other activities

Participants were asked a range of questions about their involvement in leisure and other activities.

Having time to do enjoyable things: Results showed a strong relationship between respondents having time to do things they enjoy and mental wellbeing (Table 13). A third of those that definitely agreed they had time to do enjoyable things had high mental wellbeing (37.9% across area; 28.6% most deprived), whilst only 6.5% (across area) and 13.3% (most deprived) of those who definitely disagreed had high mental wellbeing. Conversely, none of the most deprived sample and just a quarter of the across area sample (26.1%) who definitely disagreed they had time to do enjoyable things had low wellbeing, compared with 4.3% (across area) and 9.5% (most deprived) of those that definitely agreed (Table 13).

Participation in voluntary work: One fifth of respondents in the across area sample (19.8%) had participated in voluntary work in the past year, slightly higher than the most deprived sample (14.3%, Table 13). Across both samples, high mental wellbeing was most prevalent in individuals who had volunteered in the past 12 months, whilst low mental wellbeing was most prevalent in those who had not volunteered. This difference was not significant for the most deprived sample.

Participation in other organisations: Almost all of the Haringey residents reported participating in other organisations[j] on a regular basis, such as political parties, religious groups and leisure groups (98.5% across area; 98.1% most deprived, Table 13). There was no significant association between organisation participation and mental wellbeing.

Spending leisure time outdoors: Respondents in the most deprived sample were significantly less likely to spend leisure time outdoors daily compared to those in the across area sample (9.5% and 16.2% respectively) (Table 12). Conversely, those in the most deprived sample were more likely to spend leisure time outdoors monthly than those in the across area sample (21.1% and 14.3% respectively). Across both samples, over half of respondents reported spending their leisure time outdoors on a weekly basis (58.3% across area; 57.6% most deprived), however this difference was not significant.

Table 12. Leisure time spent outdoors

	Across area	Most deprived	Significant difference*
Never	2.7%	3.3%	NS
Daily	16.2%	9.5%	Sig diff
Weekly	58.3%	57.6%	NS
Monthly	14.3%	21.1%	Sig diff
Yearly or less	8.6%	8.3%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

Frequency of spending leisure time outdoors was strongly associated with mental wellbeing (Table 13). Over a third of respondents that participated in outdoor leisure time yearly or less had low mental wellbeing (36.0% across are; 37.8% most deprived) while the prevalence of high wellbeing was greatest among those who spent leisure time outdoors on a daily basis (25.8%, p<0.001 across area; 21.4%, p<001 most deprived).

[j] For a full list of the organisations see question 4 of the survey (Appendix A).

Table 13. Mental wellbeing in Haringey by leisure and activities, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Time to do things you really enjoy*	Definitely agree	116	4.3%	57.8%	37.9%		84	9.5%	61.9%	28.6%	
	Tend to agree	298	13.8%	71.1%	15.1%		250	19.2%	66.0%	14.8%	
	Tend to disagree	115	14.8%	67.8%	17.4%		103	15.5%	71.8%	12.6%	
	Definitely disagree	46	26.1%	67.4%	6.5%	p<0.001	15	0.0%	86.7%	13.3%	p<0.01
Volunteered in past 12 months?	No	474	15.4%	67.5%	17.1%		394	16.8%	67.5%	15.7%	
	Yes	117	10.3%	61.5%	28.2%	p<0.05	66	12.1%	63.6%	24.2%	NS
Organisation participation	None	9	0.0%	88.9%	11.1%		9	22.2%	66.7%	11.1%	
	1 or more	582	14.4%	66.2%	19.4%	NS	459	16.3%	66.9%	16.8%	NS
Leisure time outdoors	Never	16	56.3%	37.5%	6.3%		15	33.3%	53.3%	13.3%	
	Daily	97	13.4%	60.8%	25.8%		42	9.5%	69.0%	21.4%	
	Weekly	346	9.0%	70.8%	20.2%		270	14.8%	64.4%	20.7%	
	Monthly	81	16.0%	69.1%	14.8%		100	14.0%	76.0%	10.0%	
	Yearly or less	50	36.0%	54.0%	10.0%	p<0.001	37	37.8%	59.5%	2.7%	p<0.01

* Don't know: across area n=4; most deprived n=4. P values represent chi-squared tests (see Section 2.6 for details).

3.9 Substance use

Smoking: The proportion of current smokers in Haringey was slightly higher in the most deprived sample (24.2%) compared to the across area sample (20.1%), however this difference was not significant (Table 14). Smoking had a significant relationship with mental wellbeing in the across area sample, with non-smokers most likely to have high mental wellbeing (21.4%) and current smokers most likely to have low mental wellbeing (21.6%). In the most deprived sample, current

smokers were most likely to have both low mental wellbeing (15.6%) and high mental wellbeing (20.2%), however these differences were not significant (Table 17).

Table 14. Smoking status in Haringey, 2015

	Across area	Most deprived	Significant difference*
Non-smoker	56.9%	56.0%	NS
Current smoker	20.1%	24.2%	NS
Ex- smoker	22.9%	19.8%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Alcohol consumption: Across both samples, the majority of respondents were classed as lower risk drinkers (58.5% across area; 50.1% most deprived) followed by abstainers (36.8% across area; 46.2% most deprived, Table 15)[k]. Significantly more respondents were classed as abstainers in the most deprived sample as compared to the across area sample.
As Table 17 shows, low mental wellbeing was most prevalent in abstainers (15.1% across area; 18.6% most deprived), while high mental wellbeing was most prevalent in lower risk drinkers (20.0% for both samples).

Table 15. Alcohol consumption in Haringey, 2015

	Across area	Most deprived	Significant difference*
Abstainer	36.8%	46.2%	Sig diff
Lower risk	58.5%	50.1%	NS
Increasing risk	4.5%	3.4%	NS
Higher risk	0.2%	0.3%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

[k] Lower risk drinking: consumption of less than 22 units of alcohol per week for males and less than 15 units of alcohol per week for females. Increasing risk drinking: consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. Higher risk drinking: more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

Cannabis use: Respondents were categorised into three groups: never used, ex user (used but not in the last 12 months) and user (used in the past 12 months). The majority of respondents had never used cannabis (72.8% across area; 77.8% most deprived, Table 16). There were no significant differences in cannabis use across the two samples. The relationship between cannabis use and level of mental wellbeing was not significant (Table 17).

Table 16. Cannabis use in Haringey, 2015

	Across area	Most deprived	Significant difference*
Never used	72.8%	77.8%	NS
Ex user	15.9%	10.7%	NS
User	5.7%	3.5%	NS

Prefer not to say: 5.6% across area; 7.2% most deprived. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Table 17. Mental wellbeing in Haringey participants by substance use, 2015

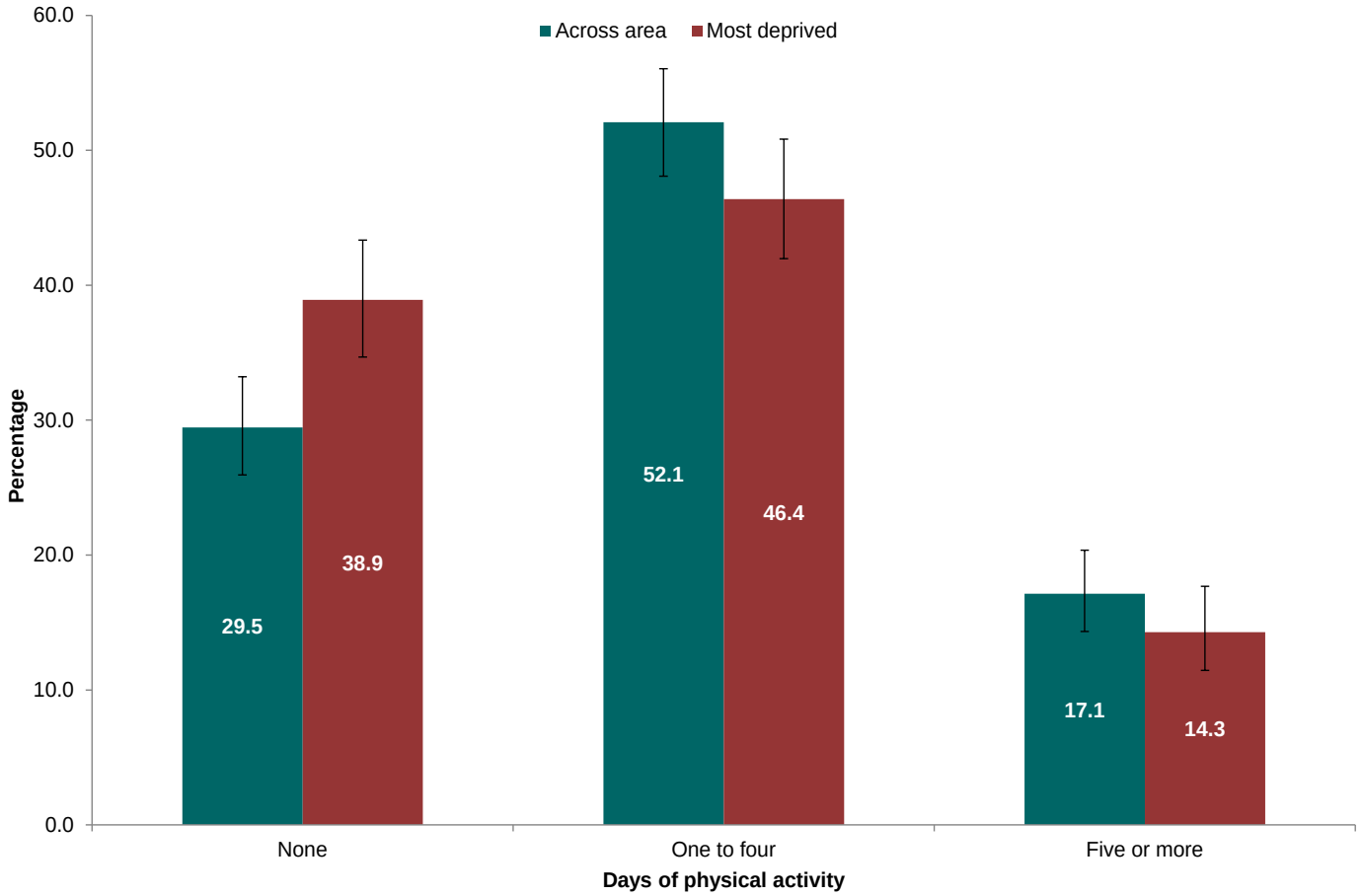
		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Alcohol use	Abstainer	219	15.1%	66.2%	18.7%		215	18.6%	67.9%	13.5%	
	Lower risk	345	14.2%	65.8%	20.0%		235	14.9%	65.1%	20.0%	
	Increasing/higher risk	30	10.0%	73.3%	16.7%	NS	15	6.7%	80.0%	13.3%	NS
Smoking	Non-smoker	327	14.4%	64.2%	21.4%		254	16.5%	66.1%	17.3%	
	Current smoker	116	21.6%	62.1%	16.4%		109	15.6%	64.2%	20.2%	
	Ex-smoker	132	6.1%	75.8%	18.2%	p<0.01	89	15.7%	73.0%	11.2%	NS
Cannabis use	Never used	432	12.3%	67.4%	20.4%		362	17.4%	65.5%	17.1%	
	Ex user	94	19.1%	62.8%	18.1%		52	11.5%	78.8%	9.6%	
	User	32	15.6%	65.6%	18.8%	NS	20	5.0%	70.0%	25.0%	NS

3.10 Physical activity and sedentary time

Physical activity: Participants were asked how many days in the past week they had accumulated at least 30 minutes of moderate intensity physical activity (for example, brisk walking, cycling, sport, exercise and active recreation). They were then grouped into categories of no days of activity, one to four days and five or more days. In 2015, 17.1% of Haringey respondents across area and 14.3% in the most deprived sample met the physical activity target of five or more days (this difference was not significant, see Figure 6). In the most deprived sample, 38.9% of respondents reported that they had done no days of physical activity in the week prior to survey, significantly higher than the across area sample (29.5%).

Those who exercised on five or more days were most likely to have high wellbeing (36.6% across area; 26.5% most deprived, Table 18), while those who did no exercise were most likely to have low wellbeing (24.0% across area; 20.0% most deprived).

Figure 6. Days of physical activity in Haringey, 2015



Sedentary time: Low mental wellbeing was most prevalent in respondents who spent more than four hours per day time sitting or reclining (14.7% across area; 18.7% most deprived), while high mental wellbeing was most prevalent in those that spent less than two hours sitting or reclining (21.7% across area; 24.0% most deprived, Table 18). There was a significant relationship between sedentary time and mental wellbeing for both samples ($p<0.05$).

Table 18. Mental wellbeing in Haringey participants by exercise and sedentary time, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		n	Low	Moderate	High	p value	n	Low	Moderate	High	p value
Days of physical activity*	None	175	24.0%	65.1%	10.9%		180	20.0%	69.4%	10.6%	
	One to four	308	9.7%	71.4%	18.8%		216	13.9%	67.1%	19.0%	
	Five or more	101	9.9%	53.5%	36.6%	p<0.001	68	11.8%	61.8%	26.5%	NS
Time spent sitting or reclining	Less than 2 hours	115	12.2%	66.1%	21.7%		100	16.0%	60.0%	24.0%	
	2 to 4 hours	170	12.9%	66.5%	20.6%		142	11.3%	72.5%	16.2%	
	More than 4 hours	300	14.7%	67.3%	18.0%	p<0.05	219	18.7%	67.1%	14.2%	p<0.05

* Don't know/prefer not to say: across area n= 5; most deprived n=2. P values represent chi-squared tests (see Section 2.6 for details).

3.11 Social connections

Personal relationships: Most Haringey respondents were either very satisfied with their personal relationships (45.5% across area, 41.6% most deprived) or fairly satisfied (34.9% across area; 31.1% most deprived, Table 19).
Satisfaction with personal relationships showed a strong association with mental wellbeing (Table 24); those who were very satisfied were most likely to have high wellbeing and least likely to have low wellbeing.

Table 19. Satisfaction with personal relationships in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very satisfied	45.5%	41.6%	NS
Fairly satisfied	34.9%	31.1%	NS
Neither satisfied nor dissatisfied	15.5%	12.8%	NS
Fairly dissatisfied	2.5%	1.5%	NS
Very dissatisfied	0.9%	0.4%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Social interaction - talking with friends and family: Significantly fewer people in the most deprived sample reported talking to friends or family (that they did not live with) on most days, compared to the across area sample (24.7% and 34.9% respectively, Table 20). The relationship between this variable and mental wellbeing varied across the samples with a significant relationship found in the across area sample ($p<0.01$, Table 24), but no significant association seen in the most deprived sample; those who spoke to neighbours on most days were most likely to have high mental wellbeing (29.5% across area; 21.2% most deprived), whilst those doing so monthly or less were most likely to have low mental wellbeing (21.4% across area; 17.3% most deprived, Table 24).

Table 20. Social interaction: frequency of talking with friends or family in Haringey, 2015

	Across area	Most deprived	Significant difference*
On most days	34.9%	24.7%	Sig diff
Once or twice a week	38.1%	43.0%	NS
Once or twice a month	16.3%	18.7%	NS
Less often than once a month	7.6%	7.6%	NS
Never	3.1%	6.0%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

Social interaction - meeting with friends and family: A quarter of Haringey respondents reported meeting with family and friends on most days (24.5% across area; 24.6% most deprived, Table 21). There was no significant difference between the samples. Examining this variable by level of mental wellbeing reveals no significant association in the across area sample, but a significant relationship in the most deprived sample (Table 24). Respondents who reported meeting with family and friends on most days were most likely to report high mental wellbeing in the across area sample (23.9%), however in the most deprived sample it was those who met with once or twice a week who were most likely to have high mental wellbeing (18.6%).

Table 21. Social interaction: frequency of meeting with friends or family in Haringey, 2015

	Across area	Most deprived	Significant difference*
On most days	24.5%	24.6%	NS
Once or twice a week	50.5%	50.3%	NS
Once or twice a month	21.1%	19.3%	NS
Less often than once a month	3.0%	4.9%	NS
Never	0.9%	0.9%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Social support: Social support score was based on responses to the questions regarding available help if the respondent; was in financial difficulty and needed to borrow £100; needed a lift urgently; was ill in bed and need help at home; or had a personal crisis and needed support. The majority of respondents felt well supported (38.1% across area; 35.4% most deprived, Table 22), with low mental wellbeing being most prevalent in those who felt least supported (scored 0 or 1) (33.1% across area; 22.6% most deprived, Table 24).

Table 22. Level of social support in Haringey, 2015

		Across area	Most deprived	Significant difference*
Little support	0-1	23.0%	26.0%	NS
	2	12.7%	12.2%	NS
	3	26.2%	26.3%	NS
Well supported	4	38.1%	35.4%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Trust: Levels of trust were measured through the question: “Generally speaking, would you say that most people can be trusted, or that you can’t be too careful in dealing with people?” Responses were on a scale of 1 (can’t be too careful) to 10 (most people can be trusted). The mean rating for Haringey was 6.86 across area and 6.26 in the most deprived sample. Participants were categorised into three groups based on low (score 1 to 3), moderate (score 4 to 7) and high (score 8 to 10) levels of trust. Across both samples, the majority of respondents demonstrated moderate levels of trust (58.2% across area; 53.8% most deprived, Table

23). The proportion of respondents who were had low levels of trust were significantly higher in the most deprived sample (25.7%) compared to the across area sample (16.2%).

Having low levels of trust was significantly associated with low mental wellbeing across both samples (Table 24).

Table 23. Level of trust in Haringey, 2015

	Across area	Most deprived	Significant difference*
Low trust	16.2%	25.7%	Sig diff
Moderate trust	58.2%	53.8%	NS
High trust	25.5%	20.6%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

Table 24. Mental wellbeing in Haringey participants by social connections, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Satisfaction with personal relationships	Very satisfied	269	5.6%	69.5%	24.9%		184	9.8%	65.2%	25.0%	
	Fairly satisfied	205	13.2%	67.8%	19.0%		175	19.4%	65.7%	14.9%	
	Neither or dissatisfied	93	32.3%	61.3%	6.5%		86	20.9%	73.3%	5.8%	
	Fairly dissatisfied	15	53.3%	33.3%	13.3%		10	20.0%	80.0%	0.0%	
	Very dissatisfied	5	60.0%	40.0%	0.0%	p<0.001	4	50.0%	25.0%	25.0%	p<0.01
Social interaction- talk to friends or family	On most days	207	8.7%	61.8%	29.5%		113	16.8%	61.9%	21.2%	
	Once or twice a week	226	14.2%	74.3%	11.5%		200	16.0%	71.0%	13.0%	
	Monthly or less	159	21.4%	61.0%	17.6%	p<0.001	150	17.3%	64.0%	18.7%	NS
Social interaction- meet with friends or family	On most days	142	9.9%	66.2%	23.9%		113	19.5%	64.6%	15.9%	
	Once or twice a week	300	13.7%	67.3%	19.0%		231	10.0%	71.4%	18.6%	
	Monthly or less	146	19.9%	65.1%	15.1%	NS	118	26.3%	59.3%	14.4%	p<0.01
Social support	Little support 0-1	133	33.1%	60.2%	6.8%		122	26.2%	61.5%	12.3%	

available	2	76	6.6%	75.0%	18.4%		58	12.1%	69.0%	19.0%	
	3	157	10.2%	62.4%	27.4%		122	16.4%	60.7%	23.0%	
Well supported	4	225	8.9%	70.2%	20.9%	p<0.001	165	10.3%	75.2%	14.5%	p<0.01
Low		94	27.7%	59.6%	12.8%		117	19.7%	73.5%	6.8%	
Trust in others Moderate		343	13.7%	69.1%	17.2%		248	18.1%	64.9%	16.9%	
High		149	6.7%	64.4%	28.9%	p<0.001	96	5.2%	65.6%	29.2%	p<0.001

P values represent chi-squared tests (see Section 2.6 for details).

3.12 Childhood experiences

Respondents were asked two questions regarding their happiness and their exposure to violence during childhood.

Childhood happiness was measured through the question: "Overall how happy would you say your childhood was?" Responses were measured on a scale of 1 (extremely unhappy) to 10 (extremely happy) and grouped into three categories: happy (scores of 8 to 10); moderate (scores of 4 to 7); and unhappy (scores of 1 to 3) childhoods. The majority of Haringey participants had happy childhoods (66.2% across area; 70.4% most deprived, Table 25). There was a strong association between childhood happiness and mental wellbeing in the across area sample (p<0.001) but no significant association in the most deprived sample (Table 27). In the across are sample, 16.7% of respondents with unhappy childhoods had low mental wellbeing compared with 5.6% of those who reported very happy childhoods.

Table 25. Level of childhood happiness in Haringey, 2015*

	Across area	Most deprived	Significant difference*
Unhappy (1-3)	4.0%	3.4%	NS
Moderate (4-7)	29.4%	25.3%	NS
Happy (8-10)	66.2%	70.4%	NS

Don't know: across area, n= 3; most deprived, n=5. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Childhood violence was measured through the question: "Overall how violent would you say your home life as a child was?" Responses were measured on a scale of 1 (free from all violence) to 10 (very violent) and grouped into three categories: free from all violence (score of 1); some violence (scores of 2 to 4); and violent (scores of 5 to 10). While the majority of Haringey respondents were in the free from all violence group across both samples (Figure 7, Table 26), a quarter (25.5%) of the across area sample and almost a third (31.8%) of the most deprived sample experienced some violence in childhood. Almost one in ten (9.9% across area; 8.5% most deprived) reported a violent childhood.

There was no significant association between mental wellbeing and childhood violence, however, those with violent childhoods were most likely to report low levels of mental wellbeing (25.9% across area; 35.0% most deprived, Table 27).

Table 26. Experience of childhood violence in Haringey, 2015

	Across area	Most deprived	Significant difference*
Free from violence (1)	64.6%	59.7%	NS
Some violence (2-4)	25.5%	31.8%	NS
Violent (5-10)	9.9%	8.5%	NS

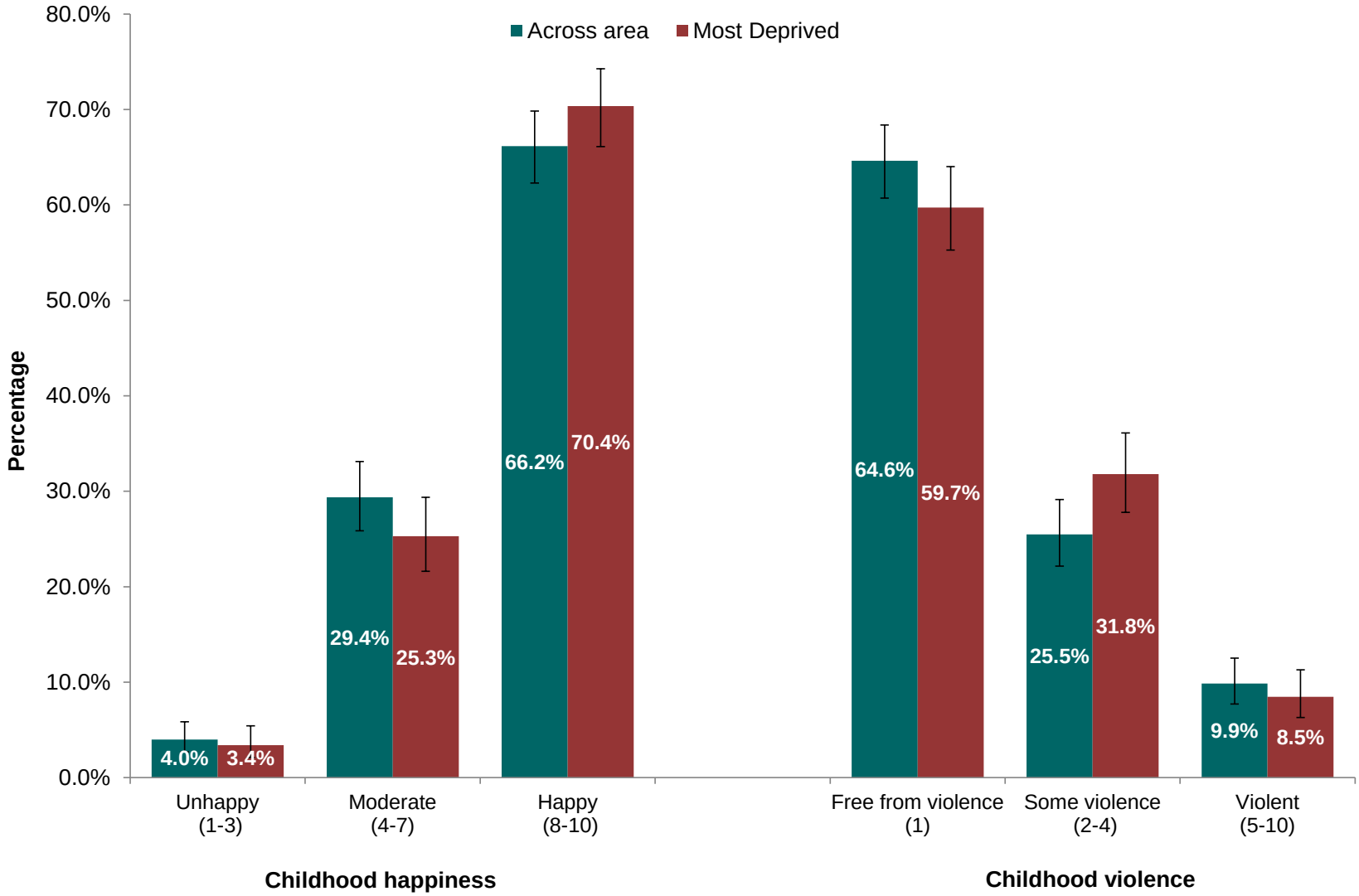
*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Table 27. Childhood experiences in Haringey, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
How happy was your childhood?*	Unhappy (1-3)	24	16.7%	75.0%	8.3%		16	25.0%	68.8%	6.3%	
	Moderate (4-7)	174	33.3%	56.9%	9.8%		116	24.1%	63.8%	12.1%	
	Happy (8-10)	391	5.6%	70.1%	24.3%	p<0.001	328	12.8%	67.7%	19.5%	NS
How violent was your home life as a child?	Free from violence (1)	379	13.5%	66.2%	20.3%		276	14.9%	65.2%	19.9%	
	Some violence (2-4)	150	11.3%	70.0%	18.7%		148	14.2%	73.6%	12.2%	
	Violent (5-10)	58	25.9%	58.6%	15.5%	NS	40	35.0%	52.5%	12.5%	NS

* Don't know: across area, n= 3; most deprived, n=5. P values represent chi-squared tests (see Section 2.6 for details).

Figure 7. Wellbeing in Haringey by childhood experiences, 2015



3.13 Employment, finances and education

Employment: The majority of Haringey respondents were employed (63.1% across area; 61.0% most deprived, Table 28). As Table 29 shows, there was a significant relationship between employment and wellbeing (across area $p<0.001$; most deprived $p<0.05$); employed respondents were most likely to have high wellbeing, and sick or disabled respondents were most likely to have low wellbeing.

Table 28. Employment status in Haringey, 2015

	Across area	Most deprived	Significant difference*
Employed	63.1%	61.0%	NS
Unemployed	5.9%	5.0%	NS
Not working: domestic	8.9%	6.8%	NS
Sick/disabled	1.7%	2.4%	NS
Other[≠]	20.3%	24.8%	NS

[≠]Retired, in full time education or other. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Finances: When asked "Which of these phrases comes closest to describing your feeling about your household income these days?" almost half of respondents across both samples said they were 'coping' (44.3% across area; 47.6% most deprived, Table 29).

Respondents who were living comfortably on their present income were most likely to have high wellbeing (28.6% across area; 22.5% most deprived, Table 31) whilst those finding it difficult/very difficult were most likely to have low wellbeing (34.7% across area; 19.4% most deprived). The relationship between mental wellbeing category and feelings about current household income were significant only in the across area sample ($p<0.001$, Table 31).

Table 29. Feelings about current household income in Haringey, 2015

	Across area	Most deprived	Significant difference*
Living comfortably	39.2%	32.6%	NS
Coping	44.3%	47.6%	NS
Finding it difficult/very difficult	16.5%	19.8%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Education: Across both samples, Level 4+[I] was the most common qualification level (Table 30). A significantly higher proportion of the most deprived sample had no qualifications (18.9%) compared to the across area sample (11.8%), whilst a significantly lower proportion of the most deprived sample had Level 4+ qualifications (29.8%) than the across area sample (38.6%). Association between mental wellbeing and educational attainment varied between the samples (Table 31) with the across area sample having a significant relationship ($p<0.001$). Across both samples, those with Level 4+ qualifications were most likely to have high mental wellbeing (26.0% across area; 21.0% most deprived).

Table 30. Educational attainment in Haringey, 2015

	Across area	Most deprived	Significant difference*
None	11.8%	18.9%	Sig diff
Entry/level 1	7.9%	8.8%	NS
Level 2	12.7%	9.0%	NS
Level 3	13.2%	14.7%	NS
Level 4+	38.6%	29.8%	Sig diff
Other/foreign[†]	15.7%	18.8%	NS

[†]Foreign qualifications, vocational qualifications or other. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

[I] Level 1 = 1+ O levels/CSEs/GCSEs (any grade), Basic Skills and/or NVQ Level 1, Foundation GNVQ; Level 2 = 5+ O levels (any grade), CSEs (grade 1), GCSEs (grades A*-C), School Certificate, 1+ A levels / AS levels / VCEs and/or NVQ Level 2, Intermediate GNVQ City and Guilds Craft, BTEC First/General Diploma, RSA Diploma and/or Apprenticeship; Level 3 = 2+ A levels, 4+ AS levels, Higher School Certificate and/or NVQ Level 3, Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND, BTEC National, RSA Advanced Diploma; Level 4+ = First Degree (e.g. BA, BSc), Higher degree (e.g. MA, PhD, PGCE) and/or NVQ Level 4-5, HNC, HND, RSA, Higher Diploma, BTEC Higher level and/or Professional Qualifications (eg nursing, teaching, accountancy)

Table 31. Wellbeing in Haringey by employment, finance and educational status, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Employment status*	Employed	373	12.6%	67.0%	20.4%		286	11.9%	67.8%	20.3%	
	Unemployed	36	36.1%	44.4%	19.4%		24	33.3%	58.3%	8.3%	
	Not working: domestic	52	3.8%	78.8%	17.3%		31	19.4%	64.5%	16.1%	
	Sick/disabled	11	36.4%	63.6%	0.0%		12	41.7%	58.3%	0.0%	
	Other[≠]	87	18.4%	63.2%	18.4%	p<0.001	84	21.4%	66.7%	11.9%	p<0.05
Current household income	Living comfortably	231	8.7%	62.8%	28.6%		151	12.6%	64.9%	22.5%	
	Coping	261	11.1%	72.8%	16.1%		221	17.6%	67.4%	14.9%	
	Finding it difficult/very difficult	98	34.7%	59.2%	6.1%	p<0.001	98	19.4%	68.8%	11.8%	NS
Educational attainment	None	68	19.1%	69.1%	11.8%		89	23.6%	64.0%	12.4%	
	Entry/ Level 1	48	25.0%	68.8%	6.3%		39	25.6%	59.0%	15.4%	
	Level 2	74	18.9%	67.6%	13.5%		41	26.8%	56.1%	17.1%	
	Level 3	78	17.9%	56.4%	25.6%		67	11.9%	76.1%	11.9%	
	Level 4+	231	10.8%	63.2%	26.0%		138	10.1%	68.8%	21.0%	
	Other/foreign[†]	93	6.5%	78.5%	15.1%	p<0.001	89	14.6%	66.3%	19.1%	NS

* Prefer not to say: across area, n= 32; most deprived, n=33. [≠]Retired, in full time education or other. [†]Foreign qualifications, vocational qualifications or other. P values represent chi-squared tests (see Section 2.6 for details).

3.14 Housing and household occupancy

Home ownership: The proportion of respondents who owned their own home (either outright, through a mortgage or shared ownership) was significantly lower in the most deprived sample of Haringey (25.1%) than the across area sample (35.3%, Table 32). Compared with the across area sample, a significantly greater proportion of Haringey respondents in the most deprived sample rented their home (70.4% vs 61.8%).

Low mental wellbeing was most common among those who owned their own home (10.1% across area, 11.2% most deprived, Table 35). The relationship between home ownership and mental wellbeing was significant in the across area sample ($p<0.05$) but not for the most deprived sample.

Table 32. Home ownership in Haringey, 2015

	Across area	Most deprived	Significant difference*
Owns	35.3%	25.1%	Sig diff
Rents	61.8%	70.4%	Sig diff
Other[≠]	2.9%	4.5%	NS

[≠]Residential home, student halls or other. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

Housing satisfaction: The majority of Haringey respondents were either very satisfied with their housing (31.8 % across area, 27.3% most deprived) or fairly satisfied (46.0% across area, 49.7% most deprived, Table 33).
High mental wellbeing was most prevalent in respondents who were very satisfied with their housing (29.6% across area; 27.3% most deprived, Table 35), whilst low mental wellbeing was most prevalent in respondents who were very dissatisfied with their housing (38.1% across area; 50.0% most deprived). Across both samples, the relationship between mental wellbeing category and housing satisfaction was significant (across area, $p<0.001$; most deprived, $p<0.01$).

Table 33. Housing satisfaction in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very satisfied	31.8%	27.3%	NS
Fairly satisfied	46.0%	49.7%	NS
Neither satisfied nor dissatisfied	12.6%	15.0%	NS
Fairly dissatisfied	5.9%	6.6%	NS
Very dissatisfied	3.6%	1.3%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Household occupancy: In Haringey, respondents were mostly living as a family (30.7% across area; 24.6% most deprived, Table 34). Almost a quarter of respondents in the most deprived sample were living alone (24.1%), slightly higher than the across area sample (18.7%), however this difference was not significant.
Respondents who were lone parents were most likely to have low mental wellbeing (32.1% across area; 31.0% most deprived, Table 35). In the across area sample, those that lived in a family were most likely to have high mental wellbeing (27.3%), whilst in the most deprived sample it was those living in multiple adult households that were most likely to report high mental wellbeing (21.5%).

Table 34. Household occupancy in Haringey, 2015

	Across area	Most deprived	Significant difference*
Lives alone	18.7%	24.1%	NS
One other adult	20.5%	22.2%	NS
Multiple adults	24.8%	21.9%	NS
Family	30.7%	24.6%	NS
Lone parent	5.2%	7.1%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Table 35. Wellbeing in Haringey by housing status, housing satisfaction and household occupancy, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Housing status	Owns	208	10.1%	63.9%	26.0%		116	11.2%	72.4%	16.4%	
	Rents	365	16.4%	68.8%	14.8%		328	18.3%	65.2%	16.5%	
	Other*	17	17.6%	47.1%	35.3%	p<0.05	22	18.2%	59.1%	22.7%	NS
Housing satisfaction	Very satisfied	186	5.9%	64.5%	29.6%		128	11.7%	60.9%	27.3%	
	Fairly satisfied	273	14.3%	68.9%	16.8%		231	17.3%	69.3%	13.4%	
	Neither or dissatisfied	131	26.0%	64.1%	9.9%		109	20.2%	68.8%	11.0%	
	Fairly dissatisfied	36	27.8%	61.1%	11.1%		32	28.1%	62.5%	9.4%	
	Very dissatisfied	21	38.1%	61.9%	0.0%	p<0.001	6	50.0%	33.3%	16.7%	p<0.01
Household occupiers	Lives alone	102	15.7%	65.7%	18.6%		101	16.8%	70.3%	12.9%	
	One other adult	111	16.2%	62.2%	21.6%		92	15.2%	65.2%	19.6%	
	Multiple adults	135	14.1%	71.1%	14.8%		93	12.9%	65.6%	21.5%	
	Family	165	9.7%	63.0%	27.3%		105	17.1%	63.8%	19.0%	
	Lone parent	28	32.1%	67.9%	0.0%	p<0.01	29	31.0%	58.6%	10.3%	NS

*Residential home, student halls or other. P values represent chi-squared tests (see Section 2.6 for details).

3.15 Neighbourhood and community

Satisfaction with local area: The majority of Haringey respondents were either very (24.2% across area; 24.4% most deprived) or fairly satisfied with their local area (57.7% across area; 53.1% most deprived, Table 36).
There was a significant relationship between mental wellbeing and satisfaction with local area as a place to live. High mental wellbeing was most prevalent in respondents who were very satisfied with their local area (38.5% across area; 33.9% most deprived, Table 40) whilst low mental wellbeing was most prevalent in those who were dissatisfied (33.3% in both samples).

Table 36. Satisfaction with local area in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very satisfied	24.2%	24.4%	NS
Fairly satisfied	57.7%	53.1%	NS
Neither satisfied nor dissatisfied	11.4%	15.8%	NS
Fairly dissatisfied	4.2%	4.4%	NS
Very dissatisfied	2.5%	2.3%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Local influence: Respondents were asked: "Do you agree or disagree that you can influence decisions affecting your local area?" A small proportion of Haringey respondents definitely agreed they could influence local decisions (3.5% across area; 3.2% most deprived), while the majority either tended to disagree (32.2% across area; 29.1% most deprived) or definitely disagreed (21.7% across area; 19.7% most deprived, Table 37). Table 37 shows that perceptions of one's own levels of influence had a significant relationship with wellbeing ($p<0.001$ across area; $p<0.05$ most deprived). Respondents who definitely agreed that they could influence decisions were most likely to have high wellbeing (57.1% across area; 40.0% most deprived), however, in the across area sample they were also most likely to have low mental wellbeing (19.0%), while in the most deprived sample it was those who definitely disagreed that had the highest proportion of low mental wellbeing (24.7%).

Table 37. Influence on decisions affecting local area in Haringey, 2015

	Across area	Most deprived	Significant difference*
Definitely agree	3.5%	3.2%	NS
Tend to agree	28.8%	29.1%	NS
Tend to disagree	32.2%	35.2%	NS
Definitely disagree	21.7%	19.7%	NS

Don't know: across area, n=82; most deprived n=62. *95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Neighbourhood belonging: Respondents were asked how strongly they felt they belonged to their immediate neighbourhood. The majority of respondents felt 'very strongly' (20.9% across area; 16.3% most deprived) or 'fairly strongly' (47.2% across area; 45.7% most deprived, Table 38). There were no significant differences in responses between samples. There was a significant relationship between neighbourhood belonging and wellbeing (across area $p<0.001$; most deprived $p<0.01$, Table 40), with high wellbeing most likely in those who felt very strongly that they belonged to their immediate neighbourhood (40.5% across area; 31.1% most deprived).

Table 38. Neighbourhood belonging in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very strongly	20.9%	16.3%	NS
Fairly strongly	47.2%	45.7%	NS
Not very strongly	23.0%	29.0%	NS
Not at all strongly	6.5%	5.6%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference.

Feelings of safety: Participants were asked three questions on how safe they felt outside during the day; outside after dark; and home alone at night. Five responses were available and were scored from one to five: very unsafe (1), fairly unsafe (2), not safe or unsafe (3), fairly safe (4) and very safe (5). Scores for all three question responses were summed; a score of 12 or above was grouped as very safe, scores between 8 and 11 were moderately safe, and scores of 7 or less were very unsafe. The majority of respondents across both samples felt very safe (64.9% across area; 63.9% most deprived, Table 39), while a small proportion felt very unsafe (6.3% across area; 8.1% most deprived).

There was a significant relationship between feelings of safety and reported wellbeing across both samples ($p<0.001$, Table 40); low mental wellbeing was most prevalent in respondents who felt very unsafe (27.8% across area; 41.7% most deprived) whilst high mental wellbeing was most prevalent in those who felt very safe (21.9% across area; 21.8% most deprived).

Table 39. Feelings of safety in Haringey, 2015

	Across area	Most deprived	Significant difference*
Very safe	64.9%	63.9%	NS
Moderately safe	28.8%	27.8%	NS
Very unsafe	6.3%	8.1%	NS

*95% Confidence Intervals were examined to determine if differences between the two samples were significant. NS = no significant difference; Sig diff = a significant difference between results.

Table 40. Wellbeing in Haringey by local area satisfaction, influence, neighbourhood belonging and feelings of safety, 2015

		Across area Mental wellbeing category					Most deprived Mental wellbeing category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Local area satisfaction	Very satisfied	143	3.5%	58.0%	38.5%		112	8.0%	58.0%	33.9%	
	Fairly satisfied	337	15.7%	71.8%	12.5%		246	15.0%	71.5%	13.4%	
	Neither/dissatisfied	108	23.1%	61.1%	15.7%		104	28.8%	64.4%	6.7%	
	Fairly dissatisfied	26	15.4%	57.7%	26.9%		72	25.0%	68.1%	6.9%	
	Very dissatisfied	15	33.3%	60.0%	6.7%	p<0.001	21	33.3%	57.1%	9.5%	p<0.001
Can influence decisions in local area*	Definitely agree	21	19.0%	23.8%	57.1%		15	13.3%	46.7%	40.0%	
	Tend to agree	171	13.5%	62.6%	24.0%		133	12.0%	70.7%	17.3%	
	Tend to disagree	189	14.3%	74.1%	11.6%		164	15.9%	71.3%	12.8%	
	Definitely disagree	128	10.9%	70.3%	18.8%	p<0.001	93	24.7%	62.4%	12.9%	p<0.05
Neighbourhood belonging≠	Very strongly	121	5.0%	54.5%	40.5%		74	13.5%	55.4%	31.1%	
	Fairly strongly	283	13.1%	72.1%	14.8%		211	13.3%	71.6%	15.2%	
	Not very strongly	136	17.6%	69.1%	13.2%		134	20.1%	70.1%	9.7%	
	Not at all strongly	39	28.2%	61.5%	10.3%	p<0.001	27	33.3%	48.1%	18.5%	p<0.01
Feelings of safety	Very Safe	374	11.2%	66.8%	21.9%		289	8.7%	69.6%	21.8%	
	Moderately Safe	167	18.6%	68.3%	13.2%		128	25.0%	66.4%	8.6%	
	Very Unsafe	36	27.8%	63.9%	8.3%	p<0.001	36	41.7%	55.6%	2.8%	p<0.001

*Don't know: across area, n=80; most deprived n=57. ≠ Don't know: across area, n=13; most deprived n=16. P values represent chi-squared tests (see Section 2.6 for details).

3.16 Social capital

Method for generating social capital scores

Scores for five key aspects of social capital were created using the Office for National Statistics information on measuring social capital as a template.[20] The five areas were:

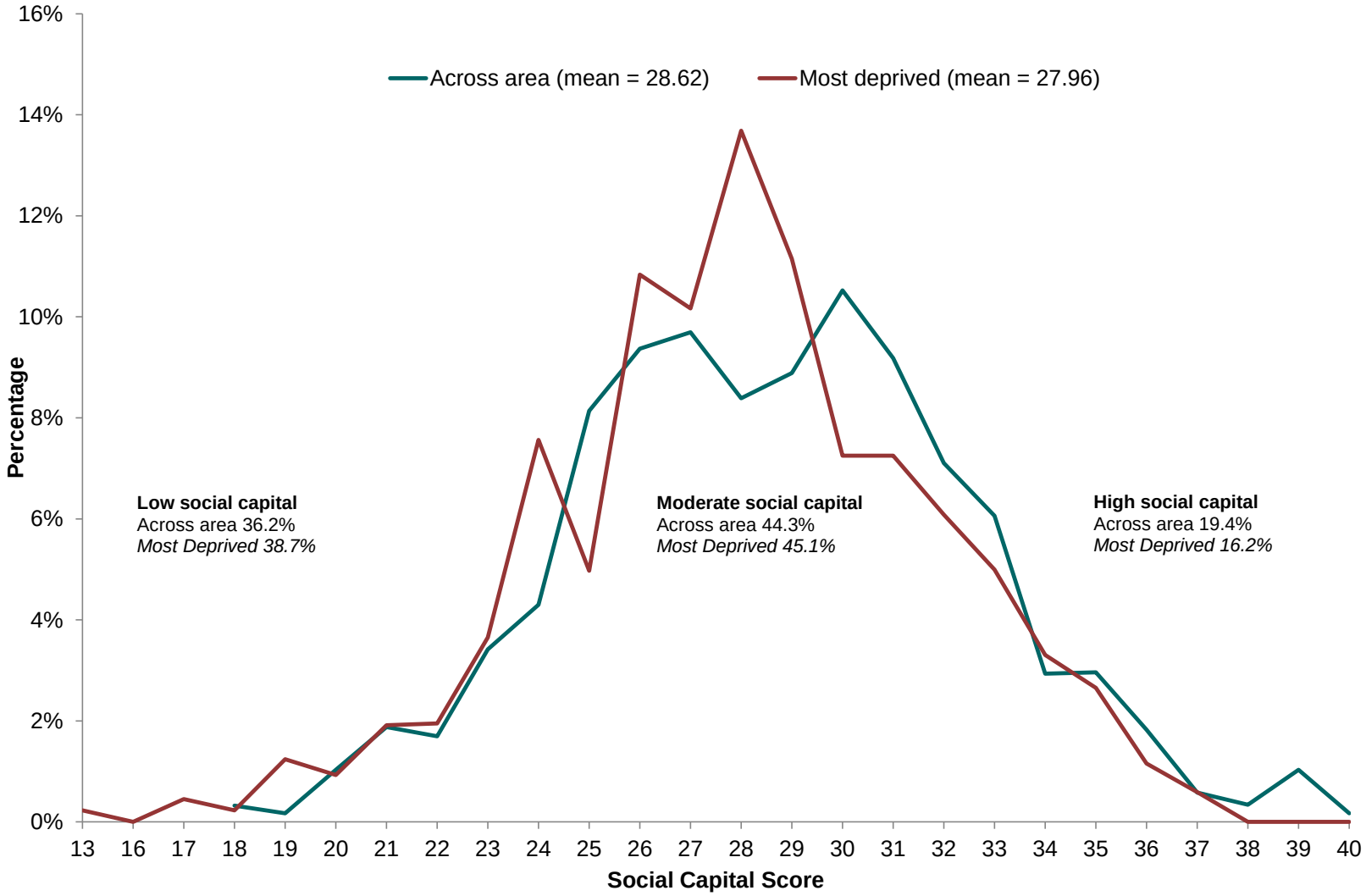
- social participation: variety and breadth of participation in community organisations
- social networks: frequency of contact with friends, relatives or neighbours, social support and social satisfaction
- social cohesion: length of residence in local area, sense of belonging to neighbourhood and trust
- civic participation: perception of local influence and life satisfaction
- local area views: satisfaction with local area and perception of safety in local area

Details of the questions used for each area can be found in Appendix D.

Once a score for each aspect of social capital was determined, weighting was applied to provide scores out of 10. All five were then summed to provide a proxy measure of social capital. The social capital variable was then categorised into low (less than 27), moderate (greater than or equal to 27 and less than 32) and high (greater than or equal to 32).

Figure 8 displays the distribution of social capital scores across Haringey. Over one third of respondents were categorised as low social capital (36.2% across area; 38.7% most deprived), 44.3% across area and 45.1% in the most deprived sample had moderate social capital scores, whilst 19.4% across area and 16.2% in the most deprived sample were categorised as having high social capital. The mean social capital score was 28.62 across area and 27.96 for the most deprived sample. There was no significant difference between the two mean social capital scores.

Figure 8. Proportion of respondents with low, moderate or high social capital, Haringey 2015



Age, gender and deprivation all had a significant relationship with social capital category in the across area sample (Table 41). For the most deprived sample, age showed a significant relationship with social capital. High social capital was most

common among those aged 65 years and over (39.3% across area; 29.8% most deprived). In the across area sample, females were significantly more likely to have low social capital than males (41.8% vs 30.4%; p<0.01). The reverse was true in the most deprived sample, however, this difference was not significant. The across area sample also reveals a significant relationship between social capital and deprivation, with low social capital increasing with increasing deprivation.

Table 41. Social capital by age, gender and deprivation in Haringey, 2015

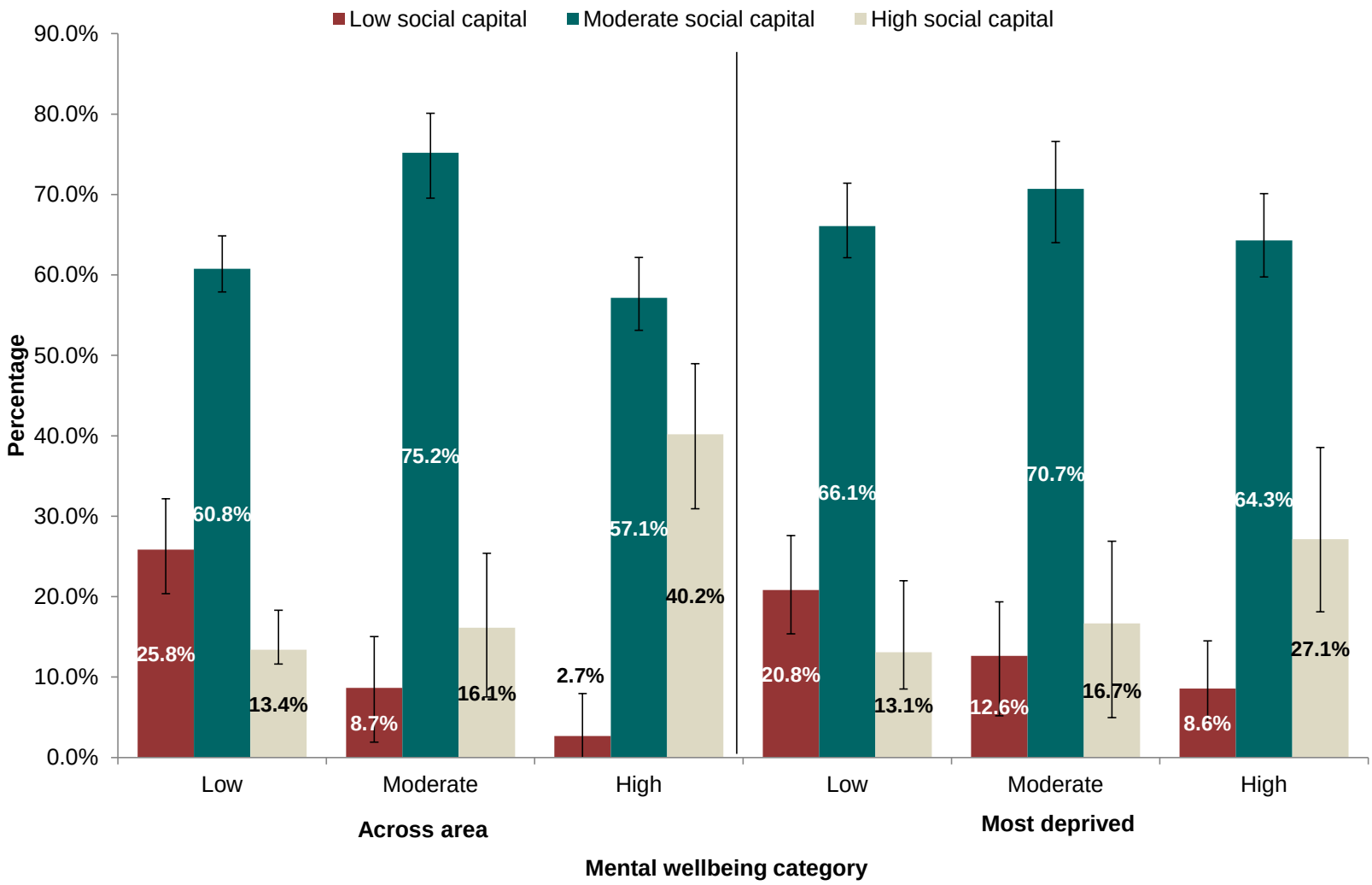
		Across area Social Capital Category					Most deprived Social Capital Category				
		N	Low	Moderate	High	p value	N	Low	Moderate	High	p value
Age	16-24	84	54.8%	35.7%	9.5%		69	39.1%	55.1%	5.8%	
	25-39	224	44.2%	47.3%	8.5%		178	43.8%	44.4%	11.8%	
	40-54	162	25.9%	40.7%	33.3%		115	40.0%	38.3%	21.7%	
	55-64	52	36.5%	48.1%	15.4%		43	32.6%	44.2%	23.3%	
	65+	61	9.8%	50.8%	39.3%	p<0.001	47	21.3%	48.9%	29.8%	p<0.01
Gender	Male	283	30.4%	46.6%	23.0%		223	42.2%	44.4%	13.5%	
	Female	299	41.8%	42.1%	16.1%	p<0.01	227	35.2%	45.8%	18.9%	NS
IMD*	Least deprived	64	23.4%	45.3%	31.3%						
	4th most deprived	146	21.9%	48.6%	29.5%						
	3rd most deprived	100	38.0%	42.0%	20.0%						
	2nd most deprived	91	46.2%	38.5%	15.4%						
	Most deprived	182	46.2%	44.5%	9.3%	p<0.001	450	38.7%	45.1%	16.2%	

* IMD= Index of Multiple Deprivation. P values represent chi-squared tests (see Section 2.6 for details).

Social capital and mental wellbeing

There was a significant relationship between social capital and mental wellbeing in Haringey, both across area (p<0.001) and for the most deprived sample (p<0.05; Figure 9). Across both samples, low mental wellbeing was most common among those with low social capital (25.8% across area; 20.8% most deprived).

Figure 9. Level of social capital by WEMWBS category, Haringey 2015



4. Summary

4.1 Mental wellbeing and its associations in Haringey

Results from the 2015 Haringey Mental Wellbeing Survey show that there was no significant difference in the average WEMWBS score across the two samples that were surveyed.[m] However, there were a number of variables for which there were significant differences in responses; for example respondents in the most deprived sample were significantly more likely to have low levels of trust, have no qualifications, and to rent, rather than own their home than those in the across area sample. In addition, they were less likely to report being in 'good' health, spending leisure time outdoors on a daily basis or meeting with family and friends daily.

A number of different variables displayed a significant relationship with mental wellbeing in Haringey. Of the demographic factors, both age and gender had a significant impact, with levels of low mental wellbeing highest among those aged 16 to 24 in the across area sample, and among the 65 and over group in the most deprived sample.

As self-perceived general health and health state score improved so did mental wellbeing, and a higher number of medical conditions resulted in worse mental wellbeing. Feeling satisfied with life was also an important indicator of mental wellbeing, with those reporting low life satisfaction being most likely to report low mental wellbeing. This was also true of sense of worth, with the lowest levels of mental wellbeing seen among those who reported that they had a low sense of worth.

Lifestyle and leisure were both significantly associated with mental wellbeing. Respondents who felt they had time to do things they enjoyed, and those who spent more leisure time outdoors were both more likely to have high and less likely to have low mental wellbeing. Lower risk drinkers had better wellbeing than abstainers and increasing/higher risk drinkers, whilst increasing physical activity (across area sample only) and less time spent sitting or reclining were associated with significantly higher levels of mental wellbeing.

Social connections and networks displayed an important association. For example, in the across area sample, respondents who were very satisfied with their personal relationships were nearly 11 times less likely to have low mental wellbeing than those who were very dissatisfied. Having more frequent social interaction with friends and family was associated with better mental wellbeing. Respondents who were well socially supported were almost four times less likely to have low wellbeing than those who had little support in the across

[m] Primary 'across area' sample and boost 'most deprived' sample.

area sample and over two times less likely in the most deprived sample. In addition, those with high levels of trust were two times more likely to have high wellbeing in the across area sample, increasing to four times more likely in the most deprived sample.

Childhood experiences were also important; respondents who had happier childhoods and those that experienced a childhood free from violence had higher mental wellbeing.

Being employed had a positive impact on mental wellbeing, whilst those who could not work due to sickness or disability, those struggling on their current income and those with no educational qualifications were all more likely to report low wellbeing.

Respondents' satisfaction with their local area and housing were both significantly associated with mental wellbeing. Respondents who owned their home were less likely to have low mental wellbeing compared to those who rented, while those who were very satisfied with their home had the highest levels of mental wellbeing. Those who felt strongly that they belonged to their neighbourhood and those who were very satisfied with their local area were least likely to have low mental wellbeing and most likely to have high. Respondents who felt very safe[n] were almost three times more likely to have high mental wellbeing in the across area sample, and eight times more likely in the most deprived sample.

The proxy measure of social capital developed and used in this survey is useful to show the proportion of the population with low, moderate and high social capital. Social capital was shown to have a significant relationship with mental wellbeing; as level of social capital increased, the prevalence of low mental wellbeing fell significantly and the prevalence of high mental wellbeing increased. Respondents who were young (aged 16 to 24 in the across area sample; aged 25 to 39 in the most deprived sample) and those from the most deprived quintiles had the lowest levels of social capital.

4.3 Limitations

A number of limitations exist when examining the results. It is important to recognise that these data do not confirm causality. For example, healthy lifestyle behaviours are positively associated with mental wellbeing, however, it is not possible to determine whether people with high mental wellbeing are more likely to have healthy behaviours or whether healthy behaviours lead individuals to have higher mental wellbeing.

Additionally, care must be taken when the effects of factors on mental wellbeing conflict with health messages. For example, respondents who drank alcohol at lower risk had better mental wellbeing than those who were abstainers. In this instance, it is important

[n] A 'feelings of safety' score generated from questions about how safe respondents felt; outside during the day, outside after dark and home alone at night.

to consider whether the effect is real or caused by confounders; are respondents who abstain from alcohol more likely to have low mental wellbeing due to other factors (for example, poor health)?

4.4 Next steps

These data provide a unique opportunity to determine the local factors important to mental wellbeing. For example, employment status is an important contributor to mental wellbeing; employed individuals display the greatest levels of mental wellbeing, while for individuals who cannot work due to permanent sickness or disability there is a significant deterioration in mental wellbeing.

In discussion with Haringey Public Health Team, the following actions have been proposed for consideration by Haringey Council:

- to continue to measure improvements in population mental wellbeing in Haringey through routine monitoring of the average WEMWBS score
- to ensure that all public policy in Haringey enhances mental wellbeing and mitigates against any adverse impacts, through using Health In All Policies Approaches (HiAP), Health Impact Assessment or Mental Wellbeing Impact Assessment and mental wellbeing outcome measurement
- for Haringey's health and wellbeing board to lead strategic direction on improving mental wellbeing across the local authority via the implementation of evidence-based interventions and integrated approaches across sectors and the life course
- to focus attention on the significant impact that relationships and social support have on health and wellbeing, through furthering understanding of its contribution to healthy life expectancy and implementing evidence based approaches with families and communities
- to integrate mental wellbeing into all physical health pathways, considering interventions during prevention, treatment, recovery and condition management, including the measurement of mental wellbeing outcomes using WEMWBS
- to value social capital as an asset within the communities and invest in community development to build social capital, especially within the most deprived communities and using intergenerational approaches
- to continue to develop our understanding of the determinants of mental wellbeing and how mental wellbeing is linked to other social outcomes

5. Appendices

5.1 Appendix A: Survey questionnaire

15075 Haringey Mental Wellbeing Survey 2015

Good morning/afternoon/evening. My name is xxxxxxx and I am calling from M·E·L Research on behalf of Haringey local authority who are responsible for the health services across your area. We are conducting a survey on their behalf to help your local health service better understand how they can help people improve their overall wellbeing and live happier, healthier lives.

It will not be possible for Haringey to identify you from the answers that you give. You can fill in your answers privately using the tablet if you wish and all information that you provide will be treated confidentially. If you do not wish to answer a question you do not have to and you can stop the survey at any time. Anything you tell us will not be shared with any organisations other than Public Health England and Haringey local authority in an anonymous format.

Would you be happy to take part?

Please enter your MEL ID

SECTION A: YOUR LOCAL AREA

Q1 How many years have you lived in this local area? **NOTE**: local area is defined as area within 15-20 minutes walking distance from home

- ○ Less than 1 year
- ○ 1 year but less than 2 years
- ○ 2 years but less than 5 years
- ○ 5 years but less than 10 years
- ○ 10 years or more

Q2 Overall how satisfied or dissatisfied are you with your local area as a place to live? **NOTE**: local area is defined as area within 15-20 minutes walking distance from home

- ○ Very satisfied
- ○ Fairly satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Fairly dissatisfied
- ○ Very dissatisfied

Q3 How strongly do you feel you belong to your immediate neighbourhood? **NOTE**: nearer to home than previous question

- ◯ Very strongly
- ◯ Fairly strongly
- ◯ Not very strongly
- ◯ Not at all strongly
- ◯ Don't know

Q4 Do you join in the activities of any of the following organisations, on a regular basis? **[Select all that apply]**

- ☐ Political parties
- ☐ Trade Unions (including student unions)
- ☐ Environmental group
- ☐ Credit Union
- ☐ Parents'/School Association
- ☐ Parenting support group/mums and toddlers group
- ☐ Tenants'/Residents' group or Neighbourhood Watch
- ☐ Education, arts or music group/evening class
- ☐ Choir, reading groups/book club
- ☐ Religious group or church organisation
- ☐ Support/Self-help group
- ☐ Group for elderly people (eg lunch clubs)
- ☐ Youth group (eg Scouts, Guides, Youth Clubs, etc)
- ☐ Women's Group
- ☐ Social club/working men's club
- ☐ Sports club/sports group (e.g. swimming, Zumba)
- ☐ Slimming Group (eg Weight Watchers, Slimming World)
- ☐ None of the above
- ☐ Other

Other, please specify

Q5 In the past twelve months, have you done any volunteer work for any groups, clubs or organisations? By volunteering, we mean any unpaid work done to help people besides your family or friends or people you work with.

- ◯ Yes
- ◯ No

Q6 Do you agree or disagree that you can influence decisions affecting your local area?

- ◯ Definitely agree
- ◯ Tend to agree
- ◯ Tend to disagree
- ◯ Definitely disagree
- ◯ Don't know

Q7 How safe or unsafe do you feel when...?

	Very safe	Fairly safe	Neither safe nor unsafe	Fairly unsafe	Very unsafe	Don't know
Outside after dark	◯	◯	◯	◯	◯	◯
Outside during the day	◯	◯	◯	◯	◯	◯

Home alone at night	○	○	○	○	○	○

SECTION B: YOUR FEELINGS AND RELATIONSHIPS

Q8 Below are some statements about feelings and thoughts. Please tick the box that best describes your experience for each statement over the past two weeks

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	○	○	○	○	○
I've been feeling useful	○	○	○	○	○
I've been feeling relaxed	○	○	○	○	○
I've been dealing with problems well	○	○	○	○	○
I've been thinking clearly	○	○	○	○	○
I've been feeling close to other people	○	○	○	○	○
I've been able to make up my own mind about things	○	○	○	○	○

Q9 Overall, how satisfied are you with your life nowadays?

○ 0- Not at all satisfied ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10- Completely satisfied ○ Don't know

Q10 **Overall, to what extent do you feel the things you do in your life are worthwhile?**

○ 0- Not at all worth while ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10- Completely worthwhile ○ Don't know

Q11 Overall, how happy did you feel yesterday?

○ 0- Not at all happy ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10- Completely happy ○ Don't know

Q12 On a scale where nought is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday?

○ 0- Not at all anxious ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10- Completely anxious ○ Don't know

Q13 Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

- ○ 0- Can't be too careful
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10- Most people can be trusted

Q14 How often do you talk to any of your neighbours? **NOTE**: This does not include anyone who lives in your home such as flatmates
Is it . . .

- ○ On most days
- ○ Once or twice a week
- ○ Once or twice a month
- ○ Less often than once a month
- ○ Never

Q15 We would like to ask how often you meet people, whether at your home or elsewhere. How often do you meet friends or relatives who are not living with you?
Is it . . .

- ○ On most days
- ○ Once or twice a week
- ○ Once or twice a month
- ○ Less often than once a month
- ○ Never

Q16 I am going to read a list of situations where people might need help. For each one, could you tell me if you would ask anyone for help?

	Yes	No	Don't know / It depends
You need a lift to be somewhere urgently	○	○	○
You are ill in bed and need help at home	○	○	○
You are in financial difficulty and need to borrow £100	○	○	○
If you had a serious personal crisis, do you have people you feel you could turn to for comfort and support?	○	○	○

Q17 All things considered, how satisfied are you with your personal relationships?

- ○ Very satisfied
- ○ Fairly satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Fairly dissatisfied
- ○ Very dissatisfied
- ○ Don't know

Q18 To what extent do you agree that you have time to do the things that you really enjoy?

- ○ Definitely agree
- ○ Tend to agree
- ○ Tend to disagree
- ○ Definitely disagree
- ○ Don't know

Q19 Thinking about the last 12 months, how often, on average, have you spent your leisure time out of doors?

By out of doors we mean open spaces in and around towns and cities, the coast and the countryside. This could be anything from a few minutes to all day. It may include time spent in your own garden, time spent close to your home, further afield or while on holiday. However this does not include routine shopping trips.

- ○ More than once per day
- ○ Every day
- ○ Several times a week
- ○ Once a week
- ○ Once or twice a month
- ○ Once every 2-3 months
- ○ Once or twice a year
- ○ Never

Q20 Overall how happy would you say your childhood was on a scale of 1 to 10 where 1 is extremely unhappy and 10 is extremely happy?

- ○ 1 - Extremely unhappy
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10- Extremely happy
- ○ Don't know

Q21 Overall how violent would you say your home life as a child was on a scale of 1 to 10 where 1 is free from all violence and 10 is very violent? This includes violence you may have witnessed at home, not just been directly involved with.

- ○ 1 - Free from all violence
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10- Very violent
- ○ Don't know

SECTION C: ABOUT YOUR HEALTH

Q22 How is your health in general? Would you say it is….

- ○ Very good
- ○ Good
- ○ Fair
- ○ Bad
- ○ Very bad
- ○ Don't know

Q23 For each following category please indicate which statement best describes your own health today.

CODE ONE OPTION FOR EACH CATEGORY

Mobility

- ○ I have no problems in walking about
- ○ I have some problems in walking about
- ○ I am confined to bed

Self-care

- ○ I have no problems with self-care
- ○ I have some problems washing or dressing myself
- ○ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ○ I have no problems with performing my usual activities
- ○ I have some problems with performing my usual activities
- ○ I am unable to perform my usual activities

Pain / Discomfort

- ○ I have no pain or discomfort
- ○ I have moderate pain or discomfort
- ○ I have extreme pain or discomfort

Anxiety / Depression

○ I am not anxious or depressed	○ I am moderately anxious or depressed	○ I am extremely anxious or depressed

Q24 Has a doctor or nurse ever **told you that you have** any of the following

	Yes	No
High blood pressure (hypertension)	○	○
Angina	○	○
Coronary Heart Disease or heart attack	○	○
Stroke	○	○
Asthma	○	○
Respiratory Disease such as Chronic bronchitis/ Emphysema/ Chronic Obstructive Pulmonary Disease	○	○
Diabetes	○	○
Digestive disease such as gastritis, ulcer, Crohn's disease, colitis	○	○
Liver disease	○	○
Cancer	○	○
Depression, anxiety or stress	○	○

Q24 How many years ago were you first told? **(please write in number of years rather than date when told)**

High blood pressure (hypertension)	
Angina	
Coronary Heart Disease or heart attack	
Stroke	
Asthma	
Respiratory Disease such as Chronic bronchitis/ Emphysema/ Chronic Obstructive Pulmonary Disease	
Diabetes	
Digestive disease such as gastritis, ulcer, Crohn's disease, colitis	
Liver disease	
Cancer	
Depression, anxiety or stress	

Q24 Are you taking medication for this?

	Yes	No
High blood pressure (hypertension)	○	○
Angina	○	○
Coronary Heart Disease or heart attack	○	○
Stroke	○	○
Asthma	○	○
Respiratory Disease such as Chronic bronchitis/ Emphysema/ Chronic Obstructive Pulmonary Disease	○	○
Diabetes	○	○
Digestive disease such as gastritis, ulcer, Crohn's disease, colitis	○	○
Liver disease	○	○
Cancer	○	○
Depression, anxiety or stress	○	○

Q25 Do you care for someone with long term ill health OR problems related to old age, other than as part of your job? And if so, for how many hours?

○ No ○ Yes, 1-19 hours a week ○ Yes, 20-49 hours a week ○ Yes, 50+ hours a week

Q25a Does this person live in your home?

○ No ○ Yes

SECTION D: LIFESTYLES AND LIFE EVENTS

Q26 In the past week, on how many days have you accumulated at least 30 minutes of moderate intensity physical activity such as brisk walking, cycling, sport, exercise, and active recreation? (Do not include walking at a slow or normal pace).

○ 0 days ○ 1 days ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days ○ Don't know / prefer not to say

Now we would like to ask you about the times when you are not being physically active; when you are sitting or reclining at work and at home. This may be when you are sat in front of a computer or television, or listening to music. Do not include the time you spend sleeping.

Q27 Not including the time you spend sleeping, how much time do you usually spend sitting or reclining on a typical day?

Hours (**WRITE IN NUMBER**)

Minutes (**WRITE IN NUMBER**)

Q28 Smoking - which best describes you?

- ○ I have never smoked
- ○ I used to smoke occasionally but do not smoke at all now
- ○ I used to smoke daily but do not smoke at all now
- ○ I smoke occasionally but not daily
- ○ I smoke daily
- ○ Prefer not to say

Q29 Which of these factors is stopping you from quitting smoking? **(select all that apply)**

- ☐ I do not want to quit
- ☐ My spouse/partner smokes
- ☐ My friends smoke
- ☐ Life is too stressful / just not a good time
- ☐ Couldn't cope with the cravings
- ☐ Would miss the habit / something to do with my hands
- ☐ Worried about putting on weight
- ☐ Lack of commitment to quitting
- ☐ Other (specify)
- ☐ Don't know

Other, please specify

Q30 How often do you drink alcohol?

- ○ I have never drunk alcohol
- ○ Never - I used to drink alcohol but have now given up
- ○ Less than once a month
- ○ 1 or 2 times a month
- ○ Weekly
- ○ 2-4 times a week
- ○ Daily (or almost)
- ○ Prefer not to say

Q31 Which of these are the reasons you drink? **(select all that apply)**

- ☐ It helps me to relax and unwind
- ☐ It makes socialising more fun
- ☐ It gives me confidence
- ☐ It goes well with food
- ☐ It relieves boredom
- ☐ It helps me to forget my problems
- ☐ Other reason
- ☐ Don't know / prefer not to say

Other, please specify

Q31b Of these, which is the one main reason you drink?

- ◯ It helps me to relax and unwind
- ◯ It makes socialising more fun
- ◯ It gives me confidence
- ◯ It goes well with food
- ◯ It relieves boredom
- ◯ It helps me to forget my problems
- ◯ Other reason
- ◯ Don't know

Q32 Did you drink alcohol in the last week?

◯ Yes ◯ No

INTERVIEWER NOTE: DOUBLE CHECK WITH THE RESPONDENT IF HE/SHE DOES DRINK ALCOHOL ON A DAILY OR ALMOST DAILY BASIS

Q32 Did you drink alcohol on…?

	Yes	No
Monday	◯	◯
Tuesday	◯	◯
Wednesday	◯	◯
Thursday	◯	◯
Friday	◯	◯
Saturday	◯	◯
Sunday	◯	◯

Q32 **MONDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **TUESDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	

Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **WEDNESDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **THURSDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **FRIDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **SATURDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic beer/lager/cider	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q32 **SUNDAY** If so, what did you drink? Please complete the table below, entering the number of drinks in the spaces provided

Pints of low alcoholic	
Pints of normal strength beer/lager/stout/cider	
Pints of strong beer/lager/cider	
Bottles of alcopops (330ml)	
Single glasses of spirits (25ml)	
Standard glasses of wine (175ml)	
Single glasses of fortified wine e.g. sherry/port/martini	

Q33 How often do you have six or more drinks in one session?

NOTE: A single drink is a half pint of regular beer, lager or cider, a small glass of wine, a single measure of spirits, or a small glass of sherry (click here for a visual definition).
A session refers to that period of time of drinking alcohol.

- ○ Never
- ○ Less than monthly
- ○ 1 or 2 times a month
- ○ Weekly
- ○ 2-4 times a week
- ○ Daily (or almost)

Q34 How often, if ever, have you taken cannabis?

- ○ Never
- ○ Used, but not in last 12 months
- ○ Used in the past 12 months
- ○ Used in the past month
- ○ Prefer not to say

Q35 Which of these phrases comes closest to describing your feeling about your household income these days?

- ○ Living comfortably on present income
- ○ Coping on present income
- ○ Finding it difficult on present income
- ○ Finding it very difficult on present income

Q36 How often would you say you have been worried about money during the last few weeks?

- ○ Almost all the time
- ○ Quite often
- ○ Only sometimes
- ○ Never

Q37 Compared to a year ago, would you say that financially you are currently...?

○ Better off ○ Worse off ○ About the same ○ Prefer not to say

Q38 Looking ahead, how do you think you yourself will be financially a year from now, will you be...?

○ Better off than now ○ Worse off than now ○ About the same ○ Prefer not to say

SECTION E: ABOUT YOURSELF

Q39 What term do you usually use to describe your sexual identity?

○ Lesbian/Gay ○ Bisexual ○ Heterosexual ○ Other ○ Prefer not to say

Q40 Are you currently in a long term sexual relationship?

○ Yes ○ No ○ Prefer not to say

Q41 Have you been pregnant, or got someone pregnant in the last 12 months?

○ Yes ○ No ○ Prefer not to say

We would like to find out a little bit about the people who live with you in your household. If you live alone, then we only need information about yourself. If you have other people living with you, please complete the following questions for ALL household members.

Q42 Including yourself, how many people live in your household?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ Prefer not to say

Q43 How old are you? Please write in a number, e.g. 45

[ ]

Q44 Are you male or female?

○ Male ○ Female

Q45 Are you aged over 18?

○ Yes ○ No

Q46 Which of the following best describes your working status?

NOTE: Full time is typically described as 35 hours or more, and part time would be less than this.

- ◯ Paid Work: Full Time
- ◯ Paid Work: Part Time
- ◯ Self Employed
- ◯ Full Time Education
- ◯ Out Of Work, registered unemployed and actively seeking work
- ◯ Out Of Work , registered unemployed but not actively seeking work
- ◯ Permanently Sick Or Disabled
- ◯ Not Working For Domestic Reasons
- ◯ Retired
- ◯ Other
- ◯ Prefer not to say

Q47 **PERSON 2**: Do you have a spouse (husband/wife) or partner that lives with you?

- ◯ Yes
- ◯ No

Q48 **PERSON 2**: What is the relationship between you and this household member?

- ◯ Spouse (husband/wife)
- ◯ Partner
- ◯ Natural parent
- ◯ Step parent
- ◯ Foster carer
- ◯ Child
- ◯ Grandparent
- ◯ Sibling
- ◯ Niece/nephew
- ◯ Friend
- ◯ Other
- ◯ Not applicable
- ◯ Prefer not to say

Q49 **PERSON 2**: How old is s/he?

[ ]

Q50 **PERSON 2**: Is s/he male or female?

- ◯ Male
- ◯ Female

Q51 **PERSON 2** : Is s/he aged over 18?

- ◯ Yes
- ◯ No

Q52 **PERSON 2**: Which of the following best describes this persons working status? **NOTE**: Full time is typically described as 35 hours or more, and part time would be less than this.

- ◯ Paid Work: Full Time
- ◯ Paid Work: Part Time
- ◯ Self Employed
- ◯ Full Time Education
- ◯ Out Of Work, registered unemployed and actively seeking work
- ◯ Out Of Work , registered unemployed but not actively seeking work
- ◯ Permanently Sick Or Disabled
- ◯ Not Working For Domestic Reasons
- ◯ Retired
- ◯ Other

Note: questions 48 to 52 repeated for up to 12 persons

Q103 Do you, or anyone living in your home, own or rent the accommodation in which you live?

- ○ Owns outright
- ○ Owns with a mortgage or loan
- ○ Pays part rent and part mortgage (shared ownership)
- ○ Accommodation is a residential home or student halls
- ○ Rents from the Council
- ○ Rents from a housing association
- ○ Rents from a private landlord
- ○ Other

Q104 Overall, how satisfied or dissatisfied are you with your home?

- ○ Very satisfied
- ○ Fairly satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Fairly dissatisfied
- ○ Very dissatisfied

Q105 Which of these qualifications do you have? (If your qualification is not listed choose the nearest equivalent)

- ☐ 1+ O levels/CSEs/GCSEs (any grades), Basic Skills
- ☐ NVQ Level 1, Foundation GNVQ
- ☐ 5+ O levels (any grade), CSEs (grade 1), GCSEs (grades A*-C), School Certificate, 1+ A levels/ AS levels / VCEs
- ☐ NVQ Level 2, Intermediate GNVQ City and Guilds Craft, BTEC First/General Diploma, RSA Diploma
- ☐ Apprenticeship
- ☐ 2+ A levels, 4+ AS levels, Higher school Certificate
- ☐ NVQ Level 3, Advanced GNVQ, City and Guilds Advanced Craft, ONC,OND, BTEC National, RSA Advanced Diploma
- ☐ First Degree (eg BA, BSc), Higher degree (eg MA, PhD, PGCE)
- ☐ NVQ Level 4-5, HNC, HND, RSA, Higher Diploma, BTEC Higher level
- ☐ Professional Qualifications (eg nursing, teaching, accountancy)
- ☐ Other vocational/work related qualifications
- ☐ Foreign qualifications
- ☐ No qualifications

Q106 Which of the following best describes your ethnicity?

- ○ White - British
- ○ White - Irish
- ○ White - Eastern European
- ○ White - Other White Background
- ○ Mixed - White and Black Caribbean
- ○ Mixed - White and Black African
- ○ Mixed - White and Asian
- ○ Mixed - Any Other Mixed Background
- ○ Asian or Asian British - Indian
- ○ Asian or Asian British - Pakistani
- ○ Asian or Asian British - Bangladeshi
- ○ Asian or Asian British - Other Asian Background
- ○ Black or Black British - Caribbean
- ○ Black or Black British - African
- ○ Black or Black British - Other Black Background
- ○ Chinese
- ○ Prefer not to say
- ○ Don't know
- ○ Other

Other (please specify)

Q107 May we have your postcode? The information will only be used by M·E·L Research and Public Health England for the purpose of geographical analysis.

- ○ Yes
- ○ No

WRITE IN

5.2 Appendix B: Pre-survey letter (mailed out in advance of survey)

Front page

MEL_ID

June 2015

Dear Resident,

Re: Haringey Mental Wellbeing Survey 2015

I am writing to you on behalf of the Haringey Public Health team. We will soon be carrying out an important survey in your local area about the health and wellbeing of residents and you *may* be contacted to take part.

The survey has been designed by Public Health England based on similar surveys conducted in other parts of the country over the past few years. The aim of the survey is to help your local services better understand how they can help people to improve their overall wellbeing and live happier, healthier lives.

The survey is being carried out by M·E·L Research Ltd, an independent market research company. A member of their team may call at your home in the next few weeks to ask you to take part in our survey. This person will be a fully trained interviewer who carries an identification card which shows their name, their photograph and M·E·L Research's name and address.

The survey contains a number of questions about you, your lifestyle and your general health and wellbeing. Your participation and honest responses are important to us. You do not have to take part. If you do take part you do not have to reveal your name to the interviewer. You can fill in your answers privately if you wish and all information that you provide will be treated confidentially. If you do not wish to answer a question you do not have to and you can stop the survey at any time. It will not be possible for us to identify you from the answers that you give. Anything you tell us will not be shared with any organisations other than Public Health England and the Haringey Public Health Team in an anonymous format.

M·E·L Research is a Market Research Society (MRS) Company Partner. You can contact the Market Research Society to confirm this via the MRS helpline on Freephone 0500 39 69 99. If you do not wish to be included in the survey, please contact M·E·L Research on Freephone 0800 073 0348.

Yours sincerely,
Dr Tamara Djuretic
Assistant Director of Public Health
tamara.djuretic@haringey.gov.uk

Back page

To whom it may concern

Haringey Mental Wellbeing Survey
June – July 2015

This is to certify that the interviewer seeking your views is working for M·E·L Research, an independent research company acting on behalf of Haringey Public Health team to carry out an important survey in your local area about the health and wellbeing of residents.

The survey has been designed by Public Health England based on similar surveys conducted in other parts of the country over the past few years. The aim of the survey is to help your local services better understand how they can help people to improve their overall wellbeing and live happier, healthier lives.

In order to talk to a cross-section of Haringey residents, the interviewer may ask to speak to a respondent of a particular profile (such as a respondent of a certain age or gender). This is purely so we can make sure we talk to a variety of different people in Haringey, and gain a diversity of opinions.

Please ask to see your interviewer's identification card. This will contain:

- Their name
- Their photograph
- M·E·L Research's name and address.

M·E·L Research is a **Market Research Society** (MRS) Company Partner. You can contact the Market Research Society to confirm this via the MRS helpline on **free phone 0500 39 69 99**. If you require any further information about our research please contact **Azim Khan, Field and Client Services Manager** at M·E·L Research on **0121 604 4664**.

Many thanks for participating in the survey.

Kind regards

Azim Khan
Field and Client Services Manager

MRS Evidence Matters™ Company Partner

Appendix C: ONS Subjective wellbeing questions – comparison of Haringey 2015 and ONS Measuring National Wellbeing results

The following tables compare Haringey Mental Wellbeing Survey 2015 results with ONS Personal Wellbeing Survey results. The most recent ONS Personal Wellbeing Survey results were published in September 2015 for 2014/15,[21] however due to data suppression rules, they did not publish results for Haringey for life satisfaction or life worthwhile. Therefore the life satisfaction results presented here in Table 42 are from 2013/14[18], whilst the life worthwhile results presented in Table 43 are from 2011-2014 aggregated tables (as they were not presented in 2013/14).[19]

Table 42. Level of life satisfaction, Haringey 2015 survey and ONS Personal Wellbeing Survey 2013/14[18]

	Across area			Most deprived			ONS Haringey		
Life satisfaction	%	LCL	UCL	%	LCL	UCL	%	LCL	UCL
Low	6.22	4.55	8.45	4.69	3.13	6.98	5.79	3.51	8.07
Medium	15.66	12.97	18.80	16.32	13.28	19.90	19.81	14.95	24.67
High	56.55	52.55	60.47	55.42	50.94	59.82	50.36	45.05	55.68
Very high	21.70	18.58	25.18	23.45	19.88	27.45	24.04	18.86	29.21

Note: methodology for generating confidence intervals may differ slightly therefore results should be interpreted with caution

Table 43. Level of life worthwhile, Haringey 2015 survey and ONS Personal Wellbeing Survey 2011 to 2014[19]

	Across area			Most deprived			ONS Haringey		
Life worthwhile	%	LCL	UCL	%	LCL	UCL	%	LCL	UCL
Low	4.05	2.73	5.96	4.25	2.77	6.47	5.36	3.61	7.12
Medium	18.75	15.80	22.10	22.66	19.12	26.65	20.03	16.98	23.09
High	56.25	52.22	60.20	51.28	46.78	55.76	45.87	41.91	49.83
Very high	21.08	17.98	24.55	21.79	18.30	25.73	28.73	25.01	32.46

Note: methodology for generating confidence intervals may differ slightly therefore results should be interpreted with caution

Table 44. Level of happiness, Haringey 2015 survey and ONS Personal Wellbeing Survey 2014/15[21]

	Across area			Most deprived			ONS Haringey		
Happiness	%	LCL	UCL	%	LCL	UCL	%	LCL	UCL
Low	5.0	3.5	7.0	6.8	4.9	9.4	8.3	5.6	11.0
Medium	20.7	17.7	24.1	14.6	11.7	18.0	19.4	14.9	24.0
High	45.4	41.5	49.4	48.7	44.3	53.2	42.7	36.8	48.6
Very high	27.2	23.8	30.9	29.4	25.5	33.6	29.6	24.4	34.8

Note: methodology for generating confidence intervals may differ slightly therefore results should be interpreted with caution

Table 45. Level of anxiety, Haringey 2015 survey and ONS Personal Wellbeing Survey 2014/15[21]

	Across area			Most deprived			ONS Haringey		
Anxiety	%	LCL	UCL	%	LCL	UCL	%	LCL	UCL
Low	43.5	39.5	47.5	46.4	41.9	50.8	36.1	30.8	41.5
Medium	29.9	26.4	33.7	28.4	24.6	32.6	26.3	20.7	31.8
High	12.8	10.3	15.7	9.7	7.4	12.7	19.9	15.3	24.4
Very high	13.8	11.3	16.8	14.5	11.6	17.9	17.8	13.5	22.0

5.3 Appendix D: Questions used to generate Social Capital score

Social Participation: Variety and breadth of participation in community organisations.

Q. Do you join in the activities of any of the following organisations, on a regular basis?

Q. In the past twelve months, have you done any volunteer work for any groups, clubs or organisations? By volunteering, we mean any unpaid work done to help people besides your family or friends or people you work with.

Social Networks: Frequency of contact with friends, relatives or neighbours, social support and social satisfaction.

Q. How often do you talk to any of your neighbours? (This does not include anyone who lives in your home such as flatmates.)

Q. We would like to ask how often you meet people, whether at your home or elsewhere. How often do you meet friends or relatives who are not living with you?

Q. All things considered, how satisfied are you with your personal relationships?

Q. I am going to read a list of situations where people might need help. For each one, could you tell me if you would ask anyone for help?

- You need a lift to be somewhere urgently;
- You are ill in bed and need help at home;
- You are in financial difficulty and need to borrow £100;
- If you had a serious personal crisis, do you have people you feel you could turn to for comfort and support?

Social Cohesion: Length of residence in local area, sense of belonging to neighbourhood and trust.

Q. How many years have you lived in this local area?

Q. How strongly do you feel you belong to your immediate neighbourhood?

Q. Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

Civil Participation: Perception of local influence and life satisfaction.

Q. Do you agree or disagree that you can influence decisions affecting your local area?

Q. All things considered, how satisfied are you with your life as a whole nowadays on a scale of 1 to 10 where 1 is extremely dissatisfied and 10 is extremely satisfied?

Local Area: Satisfaction with local area and perception of safety in local area.

Q. Overall how satisfied or dissatisfied are you with your local area as a place to live? (local area is defined as area within 15-20 minutes walking distance from home).

Q. How safe or unsafe do you feel when...?

- Outside after dark
- Outside during the day
- Home alone at night

6. References

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Report for: Health and Wellbeing Board: 19 May 2016

Title: Progress on Establishing a Devolution Prevention Pilot Sustainable Employment Strand

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

Lead Officer: Tamara Djuretic, Assistant Director Public Health
Vicky Clark, Head of Economic Growth and Development

Ward(s) affected: ALL

Report for Key/
Non Key Decision: Not applicable

1. Describe the issue under consideration

1.1 The Haringey Devolution Pilot has two strands - Healthy Environments (which is exploring the licensing and planning powers needed to create environments that support health) and Sustainable Employment (SE). Appendix 1 shows the Haringey devolution programme timeline and governance. This report provides an update on the Sustainable Employment (SE) strand and proposes a local model of support for people with mental ill health to find and maintain sustainable employment.

1.2 Scoping and evidence gathering work has been underway, supported by the guidance of a multi-partner Working Group, including representatives from the CCG, a GP, Job Centre Plus (JCP), BEH Mental Health Trust and local voluntary sector.

1.3 The Working Group has proposed interventions for improving local systems, and while this is an iterative process, early conversations with the Joint Work and Health Unit (DH and DWP) suggest that our logic model described in Appendix I and the wider rationale behind the model are in line with the national priorities of the Unit.

1.4 The Work and Health Unit was set up in the Autumn Spending Review to pilot ways to join up the health and employment systems and is made up largely of members from the Department for Work and Pensions (DWP) and Department of Health (DH) with secondees from local government and NHS England and the Department for Business Innovation and Skills. The Unit was set up in a recognition of the need to bring work and health agendas together to break down the silos of the welfare agenda and employment on one side and health, social care and carers on the other.

1.5 Our proposed local model is a mixture of whole system improvements that can be achieved by strengthening local partnerships as well as new interventions potentially involving additional resource investment and devolution of service redesign at the local level.

2. Cabinet Member Introduction

2.1 Haringey is a borough that faces major challenges and inequalities around health and wellbeing. Employment is seen as one of the main factors impacting on wellbeing yet locally, there are over 21 000 people out of work and in receipt of benefits. Of those, approximately 6 000 are unemployed due to their mental ill health.

2.2 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 outcomes 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 breaking the 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 Our Prevention Pilot will enable us to accelerate our progress towards a 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.

3. Recommendations

3.1 The Health and Wellbeing Board are asked to:

a) Take note of the current proposed early intervention model and rationale, its potential scale and inherent risks.

b) Take note of the potential to collaborate with the Joint Work and Health Unit and Maximus.

c) Provide strategic support across the partnership to implement the pilot as part of the Health and Wellbeing Strategy.

d) Champion the pilot as part of the Health and Wellbeing Strategy and ensure that all partners are actively engaged in planning and delivery.

4. Reasons for decision

4.1 The Council recognise that a whole system approach to the prevention of ill-health is required in order to improve the health and wellbeing of local residents. The proposed pilot will test the limit of existing powers and emerging models of intervention. It will help make the case for powers and resources to be devolved to the local level to re-design a health and employment offer around residents' needs.

The pilot will support delivery of the Health and Wellbeing Strategy's Priority 3: Improvement of mental health and wellbeing.

4. Alternative options considered

N/A

5. Background information

6.1 The proposal is to focus the sustainable employment pilot on the cohort of people with mental ill health as there is a clear need among our local population, and a good evidence base that their health and employment outcomes can be improved.

6.2 The main objective of the pilot is to support people who are living with/recovering from a mental health problem to have sustainable employment – an outcome evidenced by reduced numbers of people with a mental health condition claiming Employment Support Allowance (ESA) and reduced demand for health services, specifically primary care. There is a clear financial case for change - successful interventions should produce savings for the DWP and the local NHS. The devolution aspect of the pilot is about developing a mechanism for distributing some of these savings locally to enable investment in effective interventions (invest-to-save).

6.3 Early intervention is at the heart of our proposed model - preventing people from becoming unemployed in the first place. This is supported by evidence from other countries and from DWP pilots carried out in 2010-13. This distinguishes Haringey's work from other LAs/CCGs who are seeking to innovate in this area but are focusing on improving support (typically via Individual Placement Support) for the unemployed (often long term).

6.4 Proposed interventions will be supporting people at the critical moment when they contact their GP seeking a Fit Note to enter into a period of sickness absence. The intervention will be targeted at 4 weeks after a person who is employed has been on a Fit Note. The aim is to quickly and effectively provide people with the holistic support they need to return to work on a sustainable basis (addressing medical *and* non-medical needs and the role of the employer), rather than to potentially lose their employment at the end of their sickness absence and go on to claim ESA.

6.4 The key features of our early intervention model are:

- Supporting GPs to make the most of the Fit Note asset-based conversation with training and clear referral pathways and ongoing assurance for the new interventions.
- Segmenting and triaging the cohort. Employment retention support will not be suitable for all and some people will be sufficiently supported by their employer's Occupational Health service or by the national Occupational Health service (Fit for Work).
- Additional support for the targeted cohort for whom the evidence suggests would respond positively, but lack access to appropriate interventions in the current system. Additional support would be face-to-face and holistic. It would involve liaison with employers to plan workplace adjustments. It would involve case management and referral to different medical and non-medical support services as well as VCS resources/social prescribing.

- Re-design of the Work Capability Assessment (WCA). We are keen to work with DWP and the local NHS to design and commission an alternative assessment for determining health and employment support pathways for ESA claimants (separate but complementary to their benefit entitlement). This strand of the pilot requires further scoping and evidence building in close collaboration with current providers of this service e.g. Maximus.

6.5 Piloting the model:

- Evidence suggests that length of absence from work, and employer status (Public/Private sector, large company vs. small and medium businesses) are the way to segment the cohort and this is reflected in our proposed model.
- The current intention is to conduct a small pilot of this model to test whether this is the best way to segment the cohort, and whether we can identify any additional criteria that may be more relevant (e.g. factors based on social functioning, behaviour and attitudes).
- Initial conversations with Maximus – the provider of the national Fit for Work service (remote occupational health advice) – suggest that they may be interested in working with Haringey to test the impact of a more locally tailored service, which introduces face-to-face support. Maximus would potentially be the source of the additional capacity required to run a small pilot.
- We anticipate that the evidence gathered through a small pilot would enable us to create a business case for a scaled-up invest-to-save model that we would put forward to the Government as devolution 'ask'. The Sustainability and Transformation Plan (STP) process or the Innovation Fund of the (joint DWP/DH) Work and Health Unit, are two possible vehicles for the business case.
- This would be a large 'at scale' transformation, starting with the introduction of genuinely new ways of working on the ground through a pilot. There are risks involved with innovation, including the inability to deliver change quickly, failure to secure adequate resources, and the risk of adverse publicity that comes from engaging in the potentially controversial area of benefits and employment support.

7. Contribution to strategic outcomes

7.1 The Prevention Pilot would be one way of achieving the Corporate Plan's vision for enabling all residents to live healthy, long and fulfilling lives and improving mental health and wellbeing. 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 tackling alcohol, smoking, gambling 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 involve 'whole system' rewiring with

local partners, and a new relationship with national partners involving data sharing, new forms of support and ultimately 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

8.1.1 In general the spirit behind the proposals set out in this document is about making best use of public resources through changes to powers and responsibilities, processes and systems rather than through seeking significant amounts of new investment. As such the financial implications from the local health and care economy are limited. Instead, we are working closely with the Joint Work and Health Unit, which is currently scoping out priorities for their £40 million Innovation Fund. It is envisaged that the Innovation Fund will invite bids from devolution areas across the country, with a specific focus on prevention and early help.

In addition, there will be external resources identified for this project (e.g. health economist) and most likely secondees and temporary posts.

The Head of Procurement notes the content of the report.

8.2 Legal

8.2.1. The Board's operating principles include ensuring the delivery of its Health and Wellbeing Strategy. The Devolution Pilot would facilitate the delivery of the strategy to improve mental health and wellbeing in Haringey.

8.3 Equality

8.3.1 Health-related unemployment and prevalence of mental ill health is 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. The sustainable 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 – Haringey devolution programme timeline and governance
Appendix two – Haringey Devolution Pilot Proposal on Sustainable Employment

10. Local Government (Access to Information) Act 1985

The London Health and Care Collaboration Agreement, December 2015

Appendix 1

Devolution Programme Timeline and Governance

Timeline for all Devolution Pilots – there is an expectation that these will be flexed depending on scope.

	2016							2017			
	Jun	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Programme Deliverables	**Pilot Business Case / Proposals with Resource Require-ment**	**Additional resource and partners onboard**	**Research / Piloting detailed design complete**	**Research / Piloting commenced**	Data collection and analysis →		**Preliminary results evaluated to feed into Devo Announce-ment**	Final report written and London-wide preparations made			**Potential launch of London-wide Devolution Pilots**

Dates coming up

Healthy Environments Programme Sustainable Employment

16th May
Maximus meeting

19th May
Haringey Health and Wellbeing Board

19th May
Working Group

6th June
Devolution Steering Group

10th June
Prevention Deep Dive at Devolution Programme Board

Mid-June
Gambling Workshop

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Appendix 2

Haringey Devolution Pilot Proposal on Sustainable Employment

Prevention and Early Help focus

May 2016

The case for change

- There is robust evidence showing the positive impact of employment on physical health and mental wellbeing, including reports by Waddell and Burton (2006) and Dame Carol Black (2008).

- Employment helps with self-management of long term conditions and other chronic conditions, and reduces poverty (root causes of complex disadvantage).

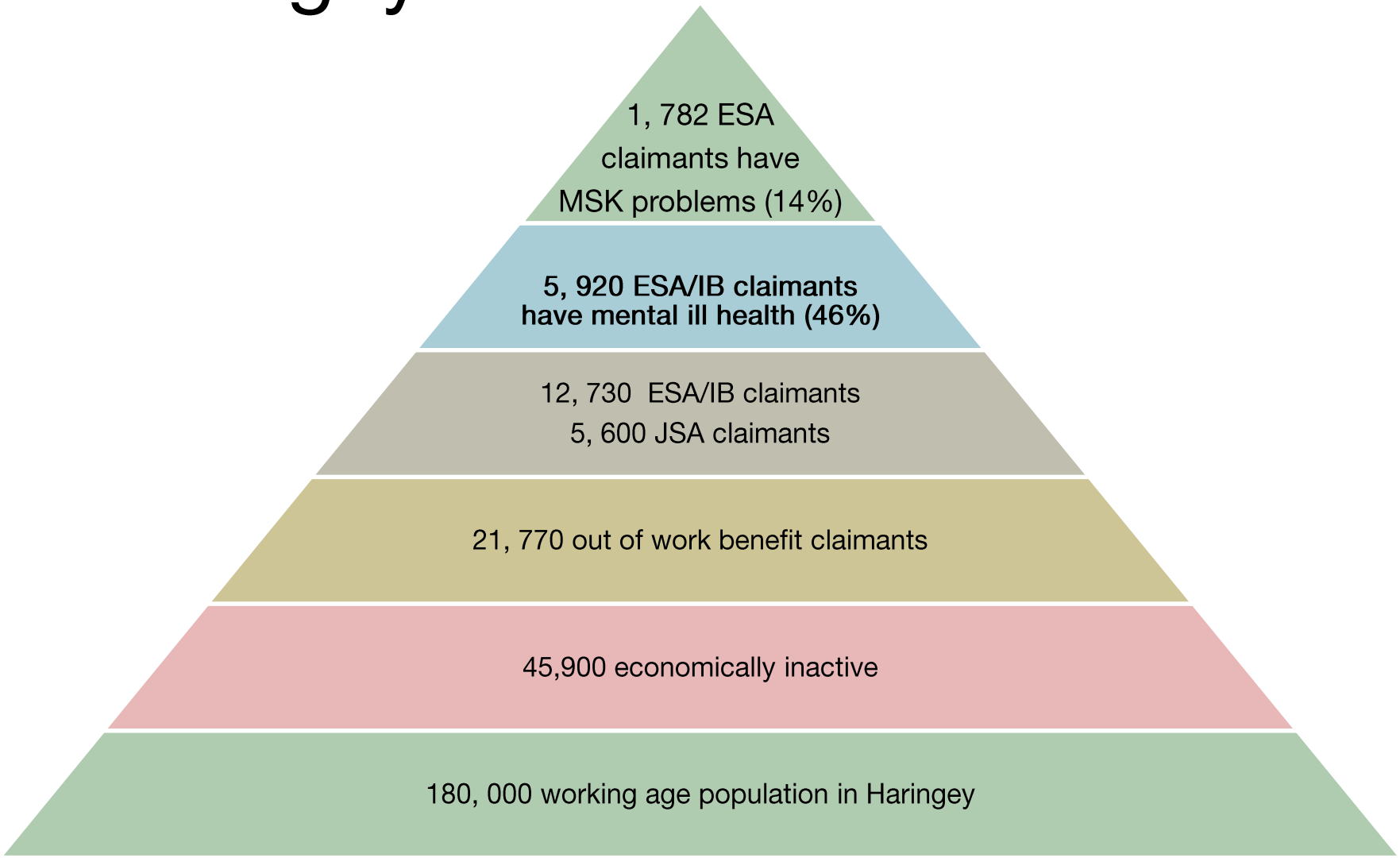
- The Five Year Forward View for Mental Health identifies stable employment as a major factor in successful recovery, but highlights the fact that just 43% of people with mental health problems are in employment.

- There is a clear financial case for change. Those who have mental ill health and are in employment place less demand on GP appointments, medication and hospitalisation, so that successful employment initiatives should result in financial gains to the health system, while the savings to the Treasury in reduced benefit payments can be forecast quite reliably.

- Mental health is strategic priority for Haringey Council and the CCG and is major factor behind unemployment in Haringey. Almost half of ESA claimants have mental ill health (c.6,000 people) and current Work Programme does not achieve good outcomes for this cohort of people.

- Anecdotal evidence from Haringey GPs, secondary mental health services, voluntary sector providers of employment support, and local JCP officials indicates a lack of join-up of local health and employment systems and a lack of early intervention.

Health related unemployment in Haringey



Devolution as part of a whole system approach

- There are **a range of employment support services** in Haringey commissioned by the LA, CCG & JCP. We will enhance the whole system by:
  - Ensuring all professionals have a common understanding of the how the system works (through guidance and training);
  - Joining up the system through clearer referral pathways and linking this with Haringey's new model for **Social Prescribing**;
  - Promoting a common assessment/monitoring tool and information;
  - Bring additional capacity into the system by expanding our Individual Placement Support model already part funded by Social Investment Fund (using European Social Fund).

- In addition, we are seeking devolved powers and funding to introduce:
  - A new **preventative/early help** intervention aimed at people who develop mental health problems while still in employment, to help them stay in, or return quickly, to work. This is likely to involve:
    - Preventative work with employers to promote mental health friendly polices and procedures
    - Developing criteria to segment the in-work cohort and identify those most likely to benefit from retention support
    - Equipping GPs to identify this cohort, have asset based Fit Note conversations, and refer them to a 'wellbeing hub' for retention support
    - Establishing virtual wellbeing hubs that can provide individual retention support (featuring local case worker, occupational therapy, employer liaison and social prescribing capacity)
- An innovative, locally commissioned **Work Capability Assessment**
  - That effectively identifies people with potential to work, and quickly refers them to employment support that best suites their medical needs, skills and preferences.

Rationale behind our devolution proposals

- There is a greater emphasis on **prevention and early help** in countries with the lowest unemployment rates for people with mental ill health (i.e. Scandinavia).

- Prevention/early help interventions **would complement** (not complicate) the redesign of support for people already on benefits, (such as the introduction of the Work and Health Programme, and any changes to the Work Capability Assessment). Preliminary conversations with Maximus suggested that they'll be keen to work with Haringey.

- Other parts of the UK that are looking to integrate their local health and employment systems, have focused on people already on benefits and IPS (individual Placement and Support) with less focus on prevention and early help.

- There is value in building an **evidence base** for prevention and early help that would cover:
  - The economic case and Return on Investment to both NHS and DWP
  - Proven criteria for identifying people who most benefit from retention support (distinguishing those from those who would return to work anyway) – enabling the approach to be rolled out elsewhere
  - The original Fit for Work pilots (2010-13) provide evidence of the cohort that would benefit from retention support. These criteria are based on length of absence and employer status/size. We would want to build on this evidence base – by testing additional criteria based on social functioning, attitudes and behavioural factors

- Feedback from local partners has focused on the impact of the **Work Capability Assessment** in generating excessive demands on GP time, creating negative incentives and (most importantly) failing to result in effective employment support for people with mental ill health and there is a national momentum on improving WCA current system anyway.

- Assessment is a fundamental part of the employment system and greater local control will better enable a whole systems approach to integrating health and employment support.

Draft logic model for early intervention: local improvements and devolution ask

Haringey LONDON

Mental ill health is driving unemployment in Haringey and GP/NHS demand

People with mental health conditions can be helped back to work

Our model is for people with mental health conditions

GPs are the best gatekeepers, but training is needed to increase referrals

- Training
- Communications
- Simple assessment/triage tool
- Feedback/assurance

Some people faced such health barriers that rapid return to work is not possible

We are NOT focusing on the hardest to help cases

People who have been off work for longer than eight weeks

People with severe mental health conditions

- Normal process of GP support, SSP & ESA claim
- Social prescribing

Some people will return to work without additional support, as they have access to other resources

We are NOT focusing on the easiest to help cases

People who have been off work for less than four weeks

Employees with access to Occupational Health services

- Referred to national FFW - telephone assessment
- Social prescribing

Haringey public sector employees

- Join up FFW with PS HR departments
- HR responsibility for embedding FFW return-to-work plans
- Monitoring of outcomes

Some people are less likely to support themselves, but can be supported back to work

We are focusing on those we are likely to help (where the impact wouldn't happen anyway)

This group are defined by length of absence and the status of their employer

Support must be holistic, quick and address the employee's relationship with their employer

People who have been off work between four and eight weeks

Small and Medium Employees (SME)

- Face to face assessment
- Liaison with employers
- Holistic/biopsychosocial
- Case management
- Fast access to services

Local improve-ments

Devolution ask (invest to save)

Report for: Health and Wellbeing Board: 19 May 2016

Title: Transforming Care (previously Winterbourne View)

Report authorised by : Jill Shattock (Director of Commissioning, CCG)
Beverley Tarka (Director of Adult Social Services)

Lead Officer: Laura Gordon (Head of the Learning Disability Partnership)
Temmy Fasegha (Vulnerable Adults Commissioning Manager-CCG)

Ward(s) affected: All

Report for Key/
Non Key Decision: N/A

1. Describe the issue under consideration

1.1 This report provides an update on the joint response of the Haringey Clinical Commissioning Group (CCG) and London Borough of Haringey (the Council) to the national three-year Transforming Care programme expectations, set out in the new guidance *Building the Right Support,* developed by NHS England, the LGA and ADASS and published in October 2015. The primary aim of this guidance is to reduce the use of long stay hospitals for the on-going care of people with learning disabilities and autism by ensuring the development of alternative community based models of care. 'Building the Right Support' delegates the local lead for the Transforming Care Programme to CCG commissioners with the expectation that health agencies work in close partnership with the local authority to deliver change. This report sets out:

6.1 How Haringey's performance is assessed
6.2 Principles underpinning the Transformation programme
6.3 Haringey's health and social care economy
6.4 Transformation programme governance
6.5 Stakeholder engagement
6.6 Alignment with Haringey plan
6.7 Haringey's population
6.8 Haringey's Transforming Care performance
6.9 Performance improvement

2. Cabinet Member Introduction

2.1 The Transforming Care programme in Haringey is a whole systems approach that is required to transform care for people of all ages with a learning disability and/or autism who display behaviour that challenges, including people with a mental health condition. The process of planning and implementing the changes proposed, including the involvement of service users and carers, will require strong joint working between the Local Authority and the Clinical Commissioning Group (CCG).

2.2 I welcome the opportunity for the Health and Wellbeing Board to note the contents of this update report that demonstrates the joint work and progress being made.

3. Recommendations

The Health, and Wellbeing Board is asked to note and comment on the report and the joint work to develop a three year plan for the delivery of the Transforming Care Programme.

4. Reasons for decision

4.1 This paper is brought to the Health and Wellbeing Board as a whole systems approach is required to transforming care for people of all ages with a learning disability and/or autism who display behaviour that challenges, including people with a mental health condition. The process of planning and implementing the changes proposed, including the involvement of service users and carers, will require strong joint working with a focus on co-production.

5. Alternative options considered

N/A

6. Background information

6.1 How Haringey's performance is assessed

6.1.1 *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015) identifies CCG commissioners as the local lead for the Transforming Care Programme and requires the CCG to submit performance data every two weeks on the progress towards achieving local plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including people with a mental health condition. The expectation is that the CCG and the Council will work closely together in collaboration with other CCGs and councils to develop and implement a three-year Transforming Care Plan to deliver Transforming Care outcomes.

6.1.2 Haringey's Joint Transformation Plan will be developed with stakeholders and will demonstrate how the CCG and the Council will implement the national service model expectations by March 2019 and reduce use of inpatient beds, starting with the national planning assumptions set out in *Building the Right Support.* These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater for[1]:

i. 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population

ii. 20-25 inpatients in NHS England-commissioned beds (such as those in low-medium- or high-secure units) per million population

6.1.3 A new financial framework will underpin delivery of the new care model:

i. Local Transforming Care Partnerships will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way that achieves better results.
ii. To enable that to happen, NHS England's specialised commissioning budget for learning disability and autism services will be aligned with the new Transforming Care Partnerships.
iii. CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.
iv. For people who have been in hospital the longest, i.e. five years or more, the NHS will provide a 'dowry' – money to help with moving people home.
v. During a phase of transition, commissioners will need to invest in new community support before closing inpatient provision. To support them to do this NHS England will make available up to £30 million of transformation funding nationally, to be matched by CCGs locally and a further £10 million in capital funding over the three years of the programme.

6.1.4 In October 2015, local areas were required to complete a self-assessment of the Transforming Care programme against the seven standards which NHSE have identified as being critical to the success of the programme:

i. **Standard 1:** All Transforming Care inpatients have a realistic discharge date, agreed at a CPA or CTR meeting;
ii. **Standard 2:** All Transforming Care inpatients have a Care and Treatment Review (CTR) in line with the national CTR guidance;
iii. **Standard 3:** Arrangements are in place between the CCG and Local Authority which allow timely identification of individuals at risk of admission to inpatient services;
iv. **Standard 4:** All patients have a care manager delivering active case management and discharge planning;
v. **Standard 5:** The CCG works with LA and community providers to assess patients' progress for at least six months after discharge;

[1] The rates per population will be based on GP registered population aged 18 and over as at 2014/15

vi. **Standard 6:** The CCG Board has oversight of the Transforming Care programme, enabled via regular discussion at named governance forums and reporting mechanisms;

vii. **Standard 7:** The CCG's contracts with providers allow the CCG to hold the provider to account for delivery of the recommendations made in patients' CTRs or CPA reviews.

6.1.5 NHS England has initially rated Haringey as meeting 2 of the 7 standards. An action plan has been developed to respond to the areas of improvement identified and will inform the three year Transforming Care Plan required for Haringey.

6.2 Principles underpinning the Transformation Programme

6.2.1 Transforming Care Partnerships should tailor their plans to the local system's health and care needs and as such individual plans may vary given provider landscape, demographics and the system-wide health and social care context. However local plans should be consistent with the following principles and actively seek to evidence and reinforce these:

i. Plans should be consistent with Building the Right Support and the national service model developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

ii. People with a learning disability and/or autism are citizens with rights and should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling the closure of all but essential inpatient provision.

iii. To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

iv. Strong stakeholder engagement is required. Providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, housing) including people with direct experience of using inpatient services.

6.3 Haringey's health and social care economy

6.3.1 Children and young people Services

There are well established multiagency approaches to supporting pre-school children with Autism including:

i. a comprehensive speech and language service provided to children both at home and in pre-school settings.
ii. there is a portage service being developed which is an early education intervention for pre-school children in their own homes
iii. families can be offered both retained services such as family link carers to support children with complex needs at home providing short breaks – these are registered foster carers who can take children for one or two nights to provide respite and support
iv. personal budgets either maintained by the Council or as a direct payment
v. the Council commissions a range of specialist interventions for mainstream schools to improve access for children and young people with disabilities.

6.3.2 Adult services

The CCG and the Council commission a range of statutory and independent sector organisations to offer support, care and/or treatment for adults with learning disabilities and or autism.

i. Haringey Learning Disabilities Partnership is an integrated health and social care service providing assessment, care management and health interventions people with learning disabilities aged 18 and over and their carers. The Partnership aims to support people with learning disabilities to achieve independence and life-time well-being. The service currently supports 721 people.
ii. HLDP incorporates the 'Assessment & Interventions Team'- AIT and the Transition service. The AIT works with adults being discharged from hospitals and supports individuals at risk of placement breakdown in the community. The Transition service aims to support young people from the age of 18 moving to adult services, ensuring that planning for adulthood starts early. However, due to capacity limitations the transition team picks up cases much later.
iii. There is a S75 Agreement in place for a pooled budget, lead commissioning by the London Borough of Haringey and an integrated service framework. The service is currently subject to a review as the 3-year section 75 Agreement comes to an end in March 2016.

6.3.3 Collaborative Commissioning Arrangements

In Haringey, the Council, through the Learning Disability Partnership, leads the procurement and setting up of packages of care for service users who are joint-funded or in receipt of S117 aftercare in receipt of jointly funded.

The Council is also working with the CCG on the implementation of a supported living framework, which is due to be implemented by June 2016. The aim of the framework is to increase the supply of high quality local alternatives to residential care and to ensure that people are able to live more independent lives.

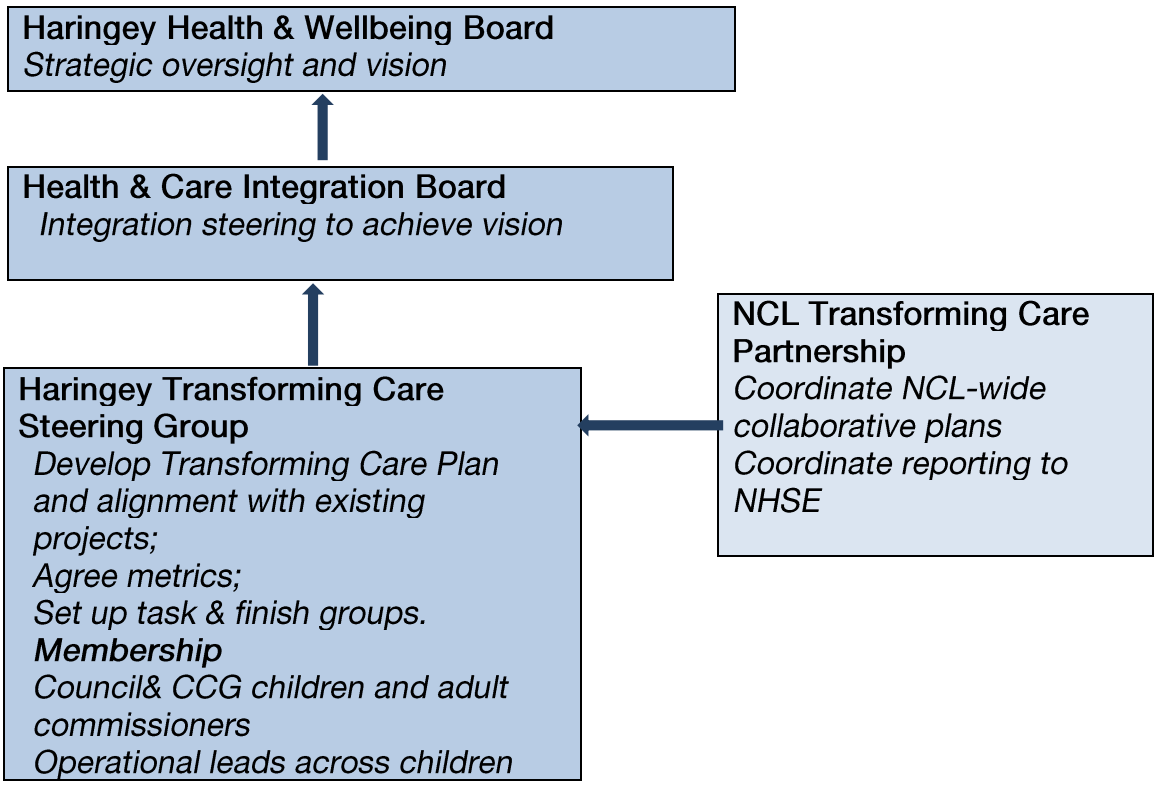
6.4 Transformation programme governance

NHS England, in its letter, '*Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015) requires CCGs to collaborate across borough boundaries to form Transforming Care Partnerships. In response, CCGs and Councils across Barnet, Camden, Enfield, Haringey and Islington have joined up to form the North Central London TCP (NCL TCP). The collaborative governance arrangements will include:

i. An overarching NCL Transforming Care Board to provide oversight and governance for the plan;
ii. Local Partnership arrangements where decision-making by commissioners, clinicians and relevant professionals and experts takes place including local service user/carer involvement and participation;
iii. An Implementation Steering Group to drive and manage progress in developing and implementing this plan with all local leads in attendance.

The NCL TCP Board will convene quarterly to oversee progress against the plan, to agree and sign-off all reporting to NHSE and to ensure the collaborative arrangements are adding value to the transformation work. The Partnership will be led by the Enfield Accountable Officer who is Senior Responsible Officer (SRO) for the programme. The Senior Commissioning lead from each NCL CGG and/or Councils and NHSE Specialist Commissioning Team are members.

The CCG and the Council are in the process of developing Haringey's local transforming care governance structure and it is being set up as outlined below:



and adults services
Finance
SUG & parent/carer representatives

Engagement & Reference Groups

Haringey Learning Disabilities Partnership Board
Haringey Autism Partnership Board
My Voice
Haringey Autism
Haringey Involve (children and young people parent/carers)
SEND Reform Group
Co-produce new service model and plans

6.5 Stakeholder engagement

A presentation on the Transforming Care Programme was made to the Haringey Autism Partnership Board on Tuesday, 12 January 2016. A similar presentation is to be made to the Haringey Learning Disabilities Partnership Board. As per the outline Governance plan above, both partnership boards have been identified as reference groups for the project. Both groups include people with lived experiences and their family carers.

The Haringey Transforming Care Steering Group is committed to developing an engagement and communication plan which will map key stakeholders, including carers and user groups as well as clarifying how they will be involved in the development of our plans.

6.6 Alignment with Haringey plans

The Transforming Care project is aligned to a number of existing projects/initiative being implemented across the CCG and Council:

i. review and re-commissioning of day centre service;
ii. review of the S75 Agreement for the Haringey Learning Disability Partnership;
iii. development of the supported living and domiciliary care frameworks
iv. CAMHs review.

6.7 Haringey's Population

6.7.1 Prevalence & Needs

Appendix A, Table 1 sets out the number of people with learning disabilities (per age range) and/or autism in Haringey and Table 2 projects demand over the next three years of the Transforming Care plan. In summary, 2% of Haringey's population (5,350) are expected to have a learning disability and 1.1% (3000 people) are expected to have an autistic spectrum condition.

6.7.2 Haringey's population compares with similar boroughs as follows[2]:

i. There are slightly more children with autism in Haringey compared to the local sub-group average; a rate of 5.57 compared to 5.17 (rate is per 1,000 from 0-25 years);
ii. Haringey has more statemented pupils with moderate learning disabilities (rate of 3.22 compared with 1.81);
iii. Haringey has less statemented pupils with profound and multiple learning disabilities (rate of 0.37 compared with 0.41). The trend continues for behaviour, emotional and social difficulty (rate of 1.79 compared with 1.92);
iv. Of the 500 children and young people with learning disabilities assessments that are to be converted to Education, Health and Care- (ECH) plans by April 2018, 110 have been issued;
v. By December 2015, there were 67 new ECH and 151 draft ECH to be authorised.

6.7.3 The draft Children and Young People Joint Commissioning Strategy also points to an increase in demand for support and transition planning for leavers due to increased level of uncertainty about the SEND process and lack of familiarity of the local offer. There has also been an increased demand for support for those not in employment, education or training (NEET) who are 19-25 years and who are wishing to return to education.

6.7.4 Haringey has a register tracking everyone with a Statement of Educational Need (SEND) and/or Learning Disability assessment. The list managed and overseen by Council's 14+ Panel includes a total of 1914 children and young people. An initial analysis of the children and young people on the tracker shows that there are 361 children and young people of school age with Autistic Spectrum Conditions and 268 children of school age with a learning disability. .

6.8 Haringey's Transforming Care performance

6.8.1 Hospital placements for people with learning disabilities and/or autism

Appendix B Table 3 provides details of Transforming Care programme activity since April 2014. There are currently nine people with learning disability and/or autism cared for in a hospital setting of which eight are the original Winterbourne View cohort. While the first year of the programme saw a swift reduction in the number of discharges of long term patients, the rate of

[2] CIPFA SEND Benchmarking Club report- 2014; Hackney, Lewisham, Waltham Forrest and Southwark

discharges has slowed from eight in 2013/14 to five in 2014/15. Notably three of the six people discharged since 2014/15 have been readmitted.

The lower rate of discharges and level of readmissions are due to a number of factors including the:

i. combination of the complex needs of the patients and level of institutionalisation,

ii. lack of robust discharge planning in hospital settings, and

iii. limited provision of appropriate and high quality community alternatives.

6.8.2 Most of the people discharged to date have been resettled in supported living settings or in their own accommodation with live in support staff. Due to the shortage of housing and the limited supply of providers Haringey makes use of out of area placements in particular in Enfield; pointing to the need for more collaborative commissioning including reciprocal arrangement to ensure timely access to crisis services across neighbouring boroughs. Appendix C, Table 4, sets out the length of stay of Haringey's current Transforming Care service user group.

6.8.3 Other CCGs and local authorities also make placements in residential and supported living service services in the borough, these placements often do not come to the attention of the HLDP until there is a crisis and/or safeguarding concern raised. This also puts pressure on HLDP resources. There is a need therefore to put in place a robust protocol to notify relevant teams when a placement is made.

6.8.4 Service users in receipt of forensic care

Information provided by NHS England Specialised Commissioners, shows that:

i. With 14 patients in adults secure and CAMH services, Haringey has the highest number of forensic patients in the North Central London Transforming Care Programme. Of this number, seven are in medium secure units, six in low secure units and one in Children and Mental Health Service inpatient provision;
ii. There is no record of any patient being discharged in 2014/15. two patients, (one adult and one young person) have been discharged in the current financial year;
iii. Of the two discharges in 2015/16, one person has been discharged to a supported living service and one person to a residential college.

6.8.5 Haringey At Risk Register

There are currently a total of 51 people on the Haringey At Risk of Hospital Admissions Register- HAHAR. The individuals include people managed by HLDP within the Care Programme Approach. A number of the people on the register have been placed by other authorities (CCGs and Councils) and picked up by HLDP as a result of safeguarding concerns.

6.9 Performance improvement

6.9.1 The case for change

i. The review of residential and nursing care undertaken by the Council shows that that the Service User Group (SUG) with the largest net expenditure per year is Learning Disability. This group also has the largest average net unit cost per person per year;
ii. Haringey has one of the highest hospital patients across adults in the London region;
iii. There is a high level of readmissions following discharges;
iv. There is a need to realign spend from high-cost interventions to preventative, early intervention and crisis prevention services;
v. The 2014 Learning Disabilities and Autism Self-assessment Framework identified gaps in the data about the needs this cohort;
vi. A review of primary care QOF registers undertaken by Haringey Public Health has identified health risks in our learning disabilities population in particular to do with diabetes;
vii. There is a need to improve and enhance transition pathway and experience.

6.9.2 Improvements identified

The Council and the CCG have together identified a number of improvements to be made, in light of the Transforming Care Programme:

i. Developing clear care pathways with agreed outcomes and interventions;
ii. Roll out and implementation of an integrated care coordination/case management approach;
iii. Build on good practice examples by reviewing and enhancing the Assessment & Intervention Team to improve crisis prevention and response;
iv. Development of systems for collating and reporting on a range of health metrics;
v. Clarifying and documenting as necessary the interface between HLDP and the CCG Continuing Health Care team and the roles and responsibilities of all stakeholders, especially as regards the monitoring and management of quality and safeguarding in provider services;
vi. Information sharing across the wider system to improve user experience and reduce duplication through multiple assessments;
vii. Remodelling of the Transition pathway service to start planning for young people from the age of 14 years;

viii. Development of the provider market place to respond to the needs of adults with challenging behaviour and complex needs reducing the needs for out-of-area placements;
ix. Demand forecast analysis of the diverse needs of people with learning disabilities taking into account the needs, age and frailty of their family carers;
x. Workforce capacity & development required in the areas of active/positive behaviour support, mental health, forensic care pathway;
xi. Scale up the use of personal budgets to promote the development of a competitive market able to provide personalised services and choice;
xii. Shift from a reliance on residential care model of support to supported living models promoting independence by increasing the range of high quality providers in the Market- Supported living and domiciliary care framework;
xiii. Expansion of extra care sheltered provision for all care groups;
xiv. Growth in the Shared Lives scheme to enable more people to live in family settings;
xv. Improving access to mainstream services including crisis prevention and planning;
xvi. Development of a local autism diagnostic service with Barnet and Enfield borough;
xvii. At risk register to ensure preventative approaches linked to the remodelling of the HLDP;
xviii. Shift from traditional building based day centres to services that promote community inclusion and use of mainstream opportunities available to other Haringey citizens.

7. Contribution to strategic outcomes

The Transforming Care Programme will contribute to both Priority 1 Give All Children the Best Start in Life and Priority 2 Empower all adults to live healthy, long and fulfilling lives of Haringey's Corporate Plan. There is a strong link to the Health and Wellbeing Strategy given the focus on improving the quality of life of people of all ages with a learning disability and/or autism who display behaviour that challenges, including people with a mental health condition.

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

8.1 Finance

The Chief Finance Officer has been consulted. The Transforming Care Programme is likely to result in a significant shift in financial flows between the NHS and Local Authorities. Although the number of individuals involved in the programme is relatively small the costs of providing care to meet their needs can be high. As set out in 6.1.3 a new financial framework has been drawn up at the national level to ensure that neither Health nor Local Authorities are disadvantaged by the programme; the Council will need to work closely with our local CCGs and NHS England to make appropriate local arrangements within this framework.

A small amount of transformation funding has been announced. Details of how this will be allocated are not yet clear. Any funding received locally will be ringfenced for this programme and details will be included in future updates.

8.2 Legal

The Assistant Director of Corporate Governance has been consulted and has no comments to make at this stage.

8.3 Equalities

This report outlines how improvements to services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including people with a mental health condition, will be planned and implemented in Haringey. These people will include those with protected characteristics other than disability and it will be important to ensure that the planning process takes account of the multiple factors affecting health and wellbeing for this cohort.

9. Use of Appendices and Attachments

Appendix A	Haringey's learning disabled and/or autistic population prevalence
Appendix B	Transforming Care programme activity since April 2014
Appendix C	Length of stay of Haringey's current service users
Appendix D	Transforming Care Programme for People with a Learning Disability and/or Autism

10. Local Government (Access to Information) Act 1985

N/A

Haringey's learning disabled and/or autistic population

Table 1 estimates the number of people with learning disabilities and/or autism in Haringey per age category.

Table 1

Age Range	Actual Population- ONS MYE 2014	2% learning disabilities Estimate	Autism Estimate 1.1%
0-4	18,823	376	207
5-9	16,750	335	184
10-14	15,078	302	166
15-19	14,624	292	161
20-24	17,589	352	193
25-29	27,533	551	303
30-34	30,020	600	330
35-39	25,126	503	276
40-44	20,935	419	230
45-49	19,192	384	211
50-54	15,746	315	173
55-59	11,903	238	131
60-64	9,573	191	105
65-69	8,016	160	88
70-74	5,734	115	63
75-79	4,936	99	54
80-84	3,341	67	37
85-89	1,665	33	18
90+	957	19	11
Total	267,541	5,351	2,943

Table 2 forecasts the prevalence of learning disabilities and autism in the community over the next three years.

Table 2

3-year trend	Year	GLA POPULATION projections	learning disabilities (Est. 2%)	Autism (Est. 1%)
Current	2016	274,300	5486	2743
Year 1	2017	277,600	5552	2776
Year 2	2018	280,700	5614	2807
Year 3	2019	283,900	5678	2839

Appendix B

Table 3 provides details of Transforming Care programme activity since April 2014.

Table 3

Transforming Care Programme (April 2014- Jan 2016)		
Ref	**Item**	**Nos.**
1a	Nos. of patient In Hospital Settings in April 2014	11
1b	Nos. of patients in Hospital Settings in April 2015	8
2	**Admission**	
2.1	Nos. of New Admissions*	3
2.2	Nos. of Re-admissions	3
3	**Discharges**	
3.1	Nos. Discharged	*6*
3.2	Nos. of planned discharges by March 2016	*3*
4	**Discharge Planning**	
4.1	Nos. of current pts. with an agreed discharge date	*7*
*4.2***	Nos. current pts. with an identified step down option	*3*
5	***Discharge Destination***	
5.1	Residential Care	*1*
5.2	Supported Living	*2*
5.3	Own Home with Live in Support	*3*
6	**Location of Community Placements/Place of Discharge**	
6.1	In borough	*2*
6.2	Out of borough***	*4*
7	**Nos in Hospital Setting (Breakdown Below)**	*9*
7.2	Independent Hospital (learning disabilities Specific)	*6*
7.3	Mental Health Ward –NHS Trust	*2*
7.4	NHS Trust- (learning disabilities Specific)	*1*

** Transfer to CCG funded placement from a forensic setting commissioned by NHSE as part of MH Tribunal recommendation*
***Housing still to be identified for 1 patient*
****2 in boroughs within the NCL area*

Appendix C

Table 4 sets out the Length of stay of Haringey's current service users

Table 4

Admission date	LOS up to Dec 2015	LOS up to March 2016
09/05/2012	4 years 7 months	5 years
27/06/2005	10 years 6 months	10 years 9 months
03/06/2005	10 years 6 months	10 years 9 months
24/09/2008	8 years 3 months	8 years 6 months
01/11/2012	3 years 2 months	3 years 5 months
28/09/2012	3 years 3 months	3 years 6 months
23/10/2013	2 years 2 months	2 years 5 months
29/04/2015	8 months	11 months

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Transforming Care Programme for People with a Learning Disability and/or Autism

Haringey Health and Well Being Board

19th May 2016

Overview of TCP

- We've already got the Winterbourne View programme … so what's new?
  - Guidance on new models of care – out of hours and crisis prevention
  - Expectation of regional collaboration – NCL footprint
  - New guidance about number of CCG and NHSE commissioned beds per million population
  - New financial framework – dowries, NHSE budgets, pooling
  - Care and Treatment Reviews and At Risk Register – inpatient and blue light
  - Increased scrutiny- fortnightly returns, monthly meetings and teleconferences

Commissioning challenges

- Preventative approaches require joined up commissioning:
  - From childhood to adulthood – EHCs and transitions
  - Across departments (housing, social care, education) and commissioning organisations (council, CCG, NHSE) and provider organisations (NHS Trusts, council, independent sector)
  - Across commissioning teams – dual/unclear diagnosis
- Cross borough working – low demand services, commissioning responsibility
- Provider availability and quality – inpatient and community, personalisation

Operational and clinical challenges

- Lack of availability of suitable placements and quality of providers
  - Barrier to discharging patients who no longer require inpatient care
  - Increases risk of readmission
  - Person centred models of care – affordability and range of available support locally
  - Local resettlement – working with families
- Engaging with inpatient provider services in devising robust and sustainable discharge pathways
  - Differing clinical perspectives – hospital/community clinicians
  - Perceived limitations – hospital vs. community – management of complex physical health needs and challenging behaviours
- At risk individuals - At Risk Register, AIT, MH pathway, CPA

Where do we go from here……..

- NCL wide planning
- Section 75 under review
- SEND, transitions, HLDP improvement planning
- Engagement with service users and carers
- Procurement Frameworks
- Utilising NHSE support - IOOH

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Report for:	Health and Wellbeing Board
Title:	Approval of Haringey Better Care Fund (BCF) 2016-17 Submission to NHS England
Report authorised by :	Beverley Tarka, Director of Adult Social Services
Lead Officer:	Marco Inzani, Commissioning Lead Better Care Fund 020 3688 2780 Marco.Inzani@haringeyccg.nhs.uk
Ward(s) affected:	All
Report for Key/ Non Key Decision:	Reports to the Cabinet should be classified according to the definition of a key decision set out in the Council's Constitution (Part 4, Section D, Rule 12 Access to Information Rules).

1. Describe the issue under consideration

1.1. This report is seeking approval of the submission of the Haringey Better Care Fund 2016-17 Plan to NHS England on Tuesday 3rd May 2016.

2. Cabinet Member Introduction

2.1. Not Applicable

3. Recommendations

3.1. The Health and Wellbeing Board are asked to approve the Haringey Better Care Fund (BCF) 2016-17 Plan which states:

- Haringey is meeting the BCF Funding Allocations
- Targets for the six BCF outcome measures and how they have been set
- The list of BCF Schemes and Services that have been agreed across Haringey CCG and the London Borough of Haringey (LBH)
- How the BCF Plan meets the eight national conditions of the BCF
- The Haringey governance and accountability for the Haringey BCF

4. Reasons for decision

4.1. The Better Care Fund (BCF) is a national programme to support the integration of health and social care to protect the independence and improve outcomes for local people.

4.2. 2015-16 was the first full year of implementation of the BCF in Haringey. The BCF has made steady progress in integrating health and social care services

to be focused around local people and their needs. There have been a number of positive impacts of this work. With the development of the BCF Plan for 2016-17 there has been an opportunity to review the BCF and to determine the priorities. This is within a broader context of a range of other programmes supporting further integration of health and social care to enable the people of Haringey to have healthy, long and fulfilling lives.

4.3. The London Borough of Haringey (LBH) have been working with Haringey CCG and a broader set of partners to develop and agree plans for 2016-17. This has involved engagement through the Health and Care Integration governance structure (which includes health and social care providers, clinicians, voluntary and community sector and public representatives) as well as specific community events for public, service users and carers in collaboration with the Haringey Forum for Older People. The culmination of all this engagement has been the Haringey BCF 2016-17 Plan.

4.4. The information presented in the Haringey BCF 2016-17 Plan should give the Haringey Health and Wellbeing Board the assurance that Haringey is maintaining its commitment to progress further health and social care integration to deliver the vision of the Haringey BCF to reorient health and social care provision from reactive and fragmented care towards more proactive and integrated care that builds on peoples' strengths.

5. Alternative options considered

5.1. Not Applicable

6. Background information

6.1. Haringey must submit a Better Care Fund (BCF) Plan for 2016-17 on Tuesday 3rd May 2016 to NHS England. This is the final checkpoint for submission and this must be approved by the Health and Wellbeing Board. The plan sets out how Haringey has interpreted the national requirements to progress plans for the integration of health and social care to improve outcomes for local people.

6.2. Both Haringey CCG and London Borough of Haringey (LBH) are expected to make a minimum contribution to the Haringey BCF. This is not new money but has had to be found from existing budgets. Both organisations have agreed to meet the minimum contributions. In addition, Haringey CCG has decided to contribute over £600,000 more than the minimum contribution as follows:

Contribution	Value
Haringey CCG Minimum Contribution: 2016/17	£17,064,128
Haringey CCG Additional Contribution: 2016/17	£638,173
London Borough of Haringey Minimum Contribution: 2016/17	£1,818,183

Total agreed value of pooled budget: 2016/17	£19,520,484

6.3. The Haringey BCF 2016-17 Plan outlines the targets that Haringey has set for the six national outcomes that the BCF is expected to deliver. These are summarised as follows:

Outcome	Target	Actual	Savings
Non-Elective Admissions (NELS)	2.6% reduction	740 NELs	£1,332,740
Delayed Transfers of Care (DTOC)	8% reduction	599 delayed days	£159,933
Residential/ Nursing Care Home Admissions	7% reduction	10 permanent admissions	£304,480
Falls Related Injuries (NELs)	3.9% reduction	100 NELs	Part of saving above
Reablement effectiveness – 91 days still home	1.8% increase	N/A	
Patient Survey – received support for Long Term Conditions	2.2% increase	N/A	

6.4. Working within the allocated budget and to deliver the six BCF outcomes, Haringey has agreed to fund 24 services from the BCF. The majority of these were within the BCF 2014-16 Plan, with the addition of the Cavell Ward which are non-stroke rehabilitation beds within Whittington Hsopital. The list of Haringey BCF services is:

Scheme	Service Area	Description
1	Social Care Team (LBH)	General social care team supporting integration.
1	Whittington ICTT/ Nursing	General community matrons, district nursing, physiotherapy and occupational health team.
1	Locality Team	Focused around GP practices, patients at risk of an emergency hospital admission will be supported by a multi-disciplinary team through care co-ordination to identify health and social care goals that promote self-care and self-management to improve health and well-being.

Scheme	Service Area	Description
1	Multi-Disciplinary Team (MDT)	A weekly Multi-Disciplinary Team (MDT) teleconference meeting involving representatives from primary, secondary, community, mental health and social care to discuss Haringey's most vulnerable patients (aged over 65) who are at risk of an emergency hospital admission.
1	Overnight District Nursing Service	Provides district nursing from 10pm to 8am.
1	Dementia Day Opportunities	Provides social, intellectual and physical stimulation to aid the well-being of people with dementia.
1	Whittington falls service	Provides a strength and balance exercise programme to prevent falls in older people.
1	Palliative Care	Increased access and advanced care planning for people at the end of life.
2	Rapid Response	Determines a community health and social care response in people's homes, within 2 hours, to prevent a hospital attendance.
2	Reablement	Provides health and social care expertise to help people learn, or re-learn, the skills necessary to self-manage in their own homes.
2	Step down	Provides temporary, non-acute step-down placements made for patients who have received hospital treatment but cannot be discharged home due to a delayed transfer of care.
2	Home from Hospital	Provides a home accompaniment and visiting service to patients discharged from hospital.
2	MH Navigator	Supports the transfer of care for mental health patients by identifying potential delays and avoiding DTOCs
2	7 Day Social Worker	Additional hospital social workers to cover 7 day working
2	Cavell Ward	In-patient rehabilitation at Whittington Hospital for non-stroke patients
3	Neighbourhoods Connect	Identifies residents who are socially isolated and through community development and motivational interviewing links them into the community.

Scheme	Service Area	Description
3	Information, Advice and Guidance (IAG)	A universal, comprehensive and quality assured information, advice and guidance offer to improve the capacity of all residents in Haringey to live independently and to access the right support at the right time, within an early help and prevention framework.
3	Self-Management Support	Increased knowledge, skills and confidence to manage long term conditions using expert patient programmes.
4	Interoperable IT	Supporting the development of interoperable IT.
4	BCF Programme	Programme support via: BCF Commissioning Lead; BCF Data Analyst; and BCF Project Officer
4	Principal Social Worker	Principal social worker supporting workforce development
4	VBC IPU Support	Supporting the development of integrated services via Value Based Commissioning
4	Disabled facilities grant	Provides financial help for the cost of essential adaptation work to make a house suitable for a disabled person to live in.
4	Carers	Increases the assessment of carers and provides additional support and resources to improve health and well-being for carers.
	Contingency	To cover the costs of non-elective admissions if the target is not met.

6.5. Areas must meet eight national conditions in order for their BCF plans to be approved. Haringey meets all the national conditions which are summarised as follows:

Condition	Definition
1. Jointly agreed plans	The Haringey BCF 2016-17 Plan has been developed with the engagement of all stakeholders including LBH, Haringey CCG, health and social care providers, community and voluntary sector, and public, service users and carers.
2. Maintain social care provision	Haringey CCG has protected the budget that is transferred from NHS to social care.
3. 7-day services	The Haringey BCF has a range of services that are available 7 days a week to facilitate the transfer of care of patients.

Condition	Definition
4. Data Sharing	Haringey is engaged in plans to deliver an Integrated Digital Care Record for Haringey residents taking into account confidentiality and data protection protocols.
5. Health and Social Care Assessments	The Haringey Locality Teams have been piloting person centred health and social care assessments and planning. The learning from this will be spread across health and social care providers.
6. Impact on providers	Haringey have engaged providers through the Health and Care Integration governance structure as well as through contract meetings. Haringey has also undertaken a number of public and service user engagement events regarding the BCF.
7. Out-of-hospital service	As Haringey did not meet the outcome target for the reduction in non-elective admissions in 2015-16 it has decided to maintain a contingency fund that will be used to pay for any increase in activity if the target is not met or will be released for use on out-of –hospital services if the target is met.
8. Delayed Transfer of Care (DTOC) action plan	The Haringey BCF 2016-17 Plan articulates a range of actions to reduce DTOCs from Barnet, Enfield and Haringey Mental Health Trust, North Middlesex Hospital and Whittington Hospital.

6.6. The Haringey BCF is governed through the Health and Care Integration (HACI) governance structure. This includes monthly highlight reports to the HACI Board and quarterly finance and performance reports to the Finance and Performance Partnership Board. All risks are also identified and escalated through this structure.

7. Contribution to strategic outcomes

7.1. The BCF is one of the key plans for the London Borough of Haringey (LBH) and Haringey CCG. In particular it supports:

- 2014/19 North Central London 5-Year Plan
- 2014/19 Haringey CCG 5-Year Plan
- 2016/17 Haringey CCG Operating Plan
- LBH (2012) Joint Health and Well-being Strategy

7.2. The BCF is helping to deliver Priority 2 (Healthy Lives) of LBH's Priorities 2016/17 and Priority 2 (Integration) of Haringey CCG's Priorities 2016/17.

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

8.1.Finance and Procurement

8.1.1. The Better Care Fund (BCF) is a pooled budget between the London Borough of Haringey (LBH) and Haringey Clinical Commissioning Group (CCG). Funding is provided by the Department of Health to the sum of £18,882k. Haringey CCG has pooled an additional £638k to allow the full contract value for the non stroke rehabilitation service to be included.

8.1.2. The funding included in the Haringey BCF is not new money; it draws together a number of sources. However the purpose of the fund is to enable the two parties to work together to ensure the money is spent more effectively.

8.1.3. The funding has been allocated jointly by LBH and Haringey CCG in accordance with the aims and objectives of the plan.

8.2.Legal

8.2.1. The NHS England Better Care Fund Planning Requirements for 2016-17 requires the Health and Wellbeing Board to approve the BCF Plan and also the constituent Council and Clinical Commissioning Group.

8.3.Equality

8.3.1. An Equalities Impact Assessment (EIA) was completed for the whole BCF Programme in December 2014. The overall outcome was to continue with the programme as there were a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on older people (over 65), disability (including mental health), gender, religion/belief, marriage, human rights, socio-economic group, social inclusion and community cohesion. These positive impacts were mainly due to: the cohort of patients and services users that will be the main beneficiaries; the delivery of services in people's homes; working in a service user centred way to define health and social care goals; and the intention to improve health and well-being. No negative impacts were highlighted.

9. Use of Appendices

9.1. Haringey HWBB BCF 2016-17 Narrative Plan Submission 3
9.2. Haringey HWBB BCF 2016-17 Planning Template Submission 3

10.Local Government (Access to Information) Act 1985

10.1. The original BCF 2014-16 plans and papers, including the equality impact assessment, can be found on the following web-link:

http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm

RECORD OF COMMITTEE CHAIR'S URGENT ACTION

Title of Report: Better Care Fund (BCF) Quarterly Return – Quarter 4 2016-17

Reason for urgency or
Relevant paragraph for authority under scheme of delegation
Part 3 Section E, - Scheme of delegation section 5, indicates that where action need to be taken on an urgent matter between meetings of the Cabinet, or any Committee or Sub Committee of the Cabinet or Council this can be taken forward by the Leader for Executive functions and in the case of non Executive functions, the director can take the decision in consultation with the Chair of the Committee.

The Better Care Support Team (which sits across the Department of Health, Department for Communities and Local Government, the Local Government Association and NHS England) has requested a Better Care Fund (BCF) plan for 2016-17 to be submitted to NHS England by Tuesday 3rd May 2016.

The BCF 2016-17 Plan is part of the national administration of the BCF as set out in the Technical Guidance for Better care Fund Planning Requirements for2016-17 (Local Government Association and NHS England). The guidance recommends that the BCF 2016-17 Plan is signed off by Health and Well-being Boards (HWBBs).

Due to the time needed to get agreement across all stakeholders and the dates that various requirements were published by NHS England the completion of the BCF 2016-17 Plan was not able to be discussed at a Health and Wellbeing Board and it was agreed that Chair's action would be sought to approve the plan before submission.

Decision of the Director for Adults Social Services

I approve the recommendation as set out in the attached report having consulted with the Deputy Chief Executive.

Signature **Date**

Concurrence of the Chair of Health and Wellbeing Board

I confirm that I have been consulted in the making of this decision.

Once signed by the Chief Officer this cover sheet together with the substantive report must be forwarded to the Committees Team - Level 5, River Park House - for processing.

Template for BCF submission 3: due on 03 May 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Haringey

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Haringey	% Haringey resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Barnet CCG	1.1%	1.6%	7,625	86	7,312	82	7,867	88	7,693	86	30,497	343
NHS Camden CCG	0.5%	0.5%	4,317	23	4,214	22	4,422	23	4,564	24	17,517	92
NHS City and Hackney CCG	3.0%	3.1%	5,455	162	5,455	162	5,455	162	5,542	164	21,907	649
NHS Enfield CCG	1.3%	1.4%	7,482	94	7,313	92	7,467	94	7,346	93	29,608	373
NHS Haringey CCG	87.7%	91.6%	6,051	5,306	6,120	5,366	6,033	5,290	5,967	5,232	24,171	21,195
NHS Islington CCG	2.3%	1.9%	4,750	110	4,802	111	4,802	111	4,694	109	19,048	442
Totals		**100%**	**35,680**	**5,780**	**35,216**	**5,836**	**36,046**	**5,769**	**35,806**	**5,708**	**142,748**	**23,094**

Are you planning on any additional quarterly reductions?	No							
If yes, please complete HWB Quarterly Additional Reduction Figures								
HWB Quarterly Additional Reduction Figure								
HWB NEA Plan (after reduction)								
HWB Quarterly Plan Reduction %								
Are you putting in place a local risk sharing agreement on NEA?	Yes							
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£4,849,141							
Cost of NEA as used during 15/16 ****	£1,770	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.						
Cost of NEA for 16/17 ****	£1,801	This has been recalculated as part of the CCG Operating Plan submission						
Additional NEA reduction delivered through the BCF	£0							£0
HWB Plan Reduction %	0.00%							

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 12th April 2016.
** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)
*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx
**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	588.3	421.5	570.0	519.9	Haringey has set itself a trajectory to achieve the same rate of care home admissions as the London average within three years.
	Numerator	145	105	142	132	
	Denominator	24,650	24,910	24,910	25,389	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data. Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
	Annual %	76.0%	91.0%	77.5%	79.0%	Data is not available for reablement measure 15/16 therefore a linear projection has been applied for 15/16 forecast. Haringey has set itself a trajectory to achieve the same level of achievement in reablement as the England average within three years.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Numerator	55	91	55	79	
	Denominator	75	100	71	100	

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	842.5	634.2	911.1	877.2	824.9	715.1	998.2	1030.8	823.7	823.2	823.2	815.2	Haringey has set itself a trajectory to achieve the same rate of DTOCs as the London average within three years.
	Numerator	1,780	1,340	1,925	1,885	1,743	1,511	2,109	2,215	1,770	1,769	1,769	1,778	
	Denominator	211,288	211,288	211,288	214,889	211,288	211,288	211,288	214,889	214,889	214,889	214,889	218,114	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Injuries due to falls in people aged 65 and over, per 100,000 people	Metric Value	2,544.7	2,445.1	Haringey has set itself a trajectory to achieve the same rate of falls as the London average within three years.
	Numerator	620.0	634.4	
	Denominator	24,364.0	25,945.1	

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
GP Patient Survey: In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)? (Measure biannually)	Metric Value	0.6	0.6	As this is a survey response numerator and denominators are not given. Haringey has set itself a trajectory to achieve the same response as the London average within three years.
	Numerator	0.0	0.0	
	Denominator	0.0	0.0	

Haringey Better Care Fund (BCF) Narrative Plan 2016-17

Local Authority	London Borough of Haringey (LBH)
Clinical Commissioning Group	Haringey CCG
Date agreed by Health and Well-Being Board:	
Version	0.3
Date submitted:	
Haringey CCG Minimum Contribution: 2016/17	£17,064,128
Haringey CCG Additional Contribution: 2016/17	£638,173
London Borough of Haringey Minimum Contribution: 2016/17	£1,818,183
Total agreed value of pooled budget: 2016/17	£19,520,484

Authorisation and signoff

Signed on behalf of Haringey Clinical Commissioning Group	
Name	Jill Shattock
Position	Director of Commissioning
Date	

Signed on behalf of London Borough of Haringey	
Name	Beverley Tarka
Position	Director of Adult Social Services
Date	

Signed on behalf of Haringey Health and Wellbeing Board	TBC
Name	
Position	
Date	

Contents

Please note that documents referenced as evidence in this BCF Narrative Plan are not sequentially numbered due to being submitted over two checkpoints. 15 documents were submitted at Checkpoint 2 and will not be submitted again. An additional X documents will be submitted at the final Checkpoint 3 following feedback on further evidence needed by NHS England.

Introduction

The Haringey Better Care Fund (BCF) is developing a health & social care system in which all adults are supported to live healthy, long and fulfilling lives. Haringey Clinical Commissioning Group (CCG) and the London Borough of Haringey (LBH) want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible.

This will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care). The Haringey BCF will not define people by their disabilities, but by their abilities, their potential and what they can do for themselves, with and without support.

This vision for the Haringey BCF has remained unchanged since the publication of the Haringey BCF 2014-16 in January 2015 (http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm) and continues to support the overall aim of the Better Care Fund; the Care Act and the NHS 5-Year Forward View.

This vision is also supported by broader work in Haringey to develop a 'Healthy, Long and Fulfilling Lives Transformation Programme' (Appendix 3). This programme is a broader health and social care programme to develop 'key lines of defence' in order to protect the independence of Haringey residents. This programme will build on, and incorporate, the work of the Haringey BCF.

The following table summarises the nine must dos for health and social care services in 2016/17 from the NHS Five Year Forward View and the implications for the Haringey BCF:

'Five Year Forward View' Must Do	**Implications for Haringey BCF**
1. Develop a Sustainability and Transformation Plan (STP)	Better integration between Haringey CCG and LBH, building on progress with the BCF
2. Return the system to an aggregate financial balance	Delivering savings through delivery of the four main BCF outcomes
3. Address the sustainability and quality of general practice	Developing health and social care MDT support for GP registered patients
4. Get back on track with access standards for urgent care	Reducing demand for urgent care through delivery of proactive and preventative care
5. Improve referral to treatment targets	Developing care co-ordination to facilitate access to service for high risk patients
6. Deliver cancer wait targets	Red flag processes with BCF services
7. Achieve mental health access targets	Including mental health within BCF service pathways
8. Transform care for people with learning disabilities	Linkage with appropriate services
9. Plan to improve quality across all	Undertake Quality Impact Assessment

'Five Year Forward View' Must Do	Implications for Haringey BCF
organisations	across all BCF health and social care providers

These implications will be built into the implementation of the BCF over 2016/17. The Haringey BCF now forms part of a range of integration programmes between LBH and Haringey CCG grouped into three themes: Adults; Children; and Mental Health. These form part of the Health and care Integration (HACI) Programme.
The BCF is focused on adults and older people but does have interdependencies with the other programmes. There is further joint work underway for adults with mental health conditions. This was identified through the production of a Mental Health Framework which has resulted in an enablement approach to supporting people preferably in the community. The principle echoes that taken by the BCF. A great deal of work is also underway between the CCG and LBH to improve children's services. Building on the learning from the BCF approach to integrated working those involved in children's services are exploring opportunities for greater integration of children's services. Combined these programmes demonstrate a journey towards full health and social care integration by 2020.

Case for Change

The original case for change is articulated in the initial Haringey BCF 2014-16 (link as before). It built up the case for a focus on older adults (65+) as being at highest risk of a non-elective hospital admission and care home admission, and the need for improvements in health and social care provision. The case for change was based on a combination of segmented risk stratification, local data and evidence of best practice.

A January 2016 review of work across Haringey and Islington "Working towards a place-based system of care in Islington and Haringey" (Doc 16, attached) used population segmentation and risk stratification to support further planning and reinforced the need to focus on older people to make an impact on non-elective admissions.

In February 2016 a Haringey stakeholder event was held on the theme of 'Preventing Hospital and Residential Care Admissions When They Are Not Necessary' (Doc 1, attached). This was an opportunity to review the original case for change and a number of the drivers within the BCF and to determine if there were any more actions that could be undertaken to tackle these issues. Some particular highlights from this data include:

- Higher current numbers and proportions of older people in the west of Haringey, but a higher rate of growth in older people in the east of Haringey in the next 10 years
- Higher prevalence of Long Term Conditions in older people in the east of Haringey
- Shorter healthy life expectancy in the east of Haringey
- Poor health starts at an early age in the east of Haringey which is linked with higher levels of deprivation

The event reinforced the themes driving the BCF and the need to increase the scale and pace of delivery in order to make a significant impact on the issues presented.

The Haringey BCF 2014-16 (link as before) also specifies public and service user outcomes. These outcomes have been articulated in a number of community engagement events to check back with the public on progress to meeting these outcomes. The outcomes have remained the same and so has the corresponding proposals for how health and social care services will transform in order to meet these outcomes which is articulated in the BCF 2014-16 section on 'Health and Social Care Service Changes'. This is reinforced through the vision articulated in the introduction and the move from reactive and fragmented care to proactive and integrated care. More detail is provided below on the specific services and schemes for 2016/17.

To support the implementation of the Haringey BCF in 2015/16 a more detailed review was also undertaken of a number of patients who were at high risk of non-elective admissions. One such case, named Harry Gray (the name was changed to protect his identity), became the figure head for the Better Care Fund as he embodied the change needed. Harry is a 75 year old widower living with his daughter. Harry has several health conditions including COPD, dementia, and depression; and has had a number of falls. In the last year he visited A&E 32 times and was admitted on 10 occasions. Most of Harry's admissions were in the evening and it was evident that he had been waiting for a number of months for referrals to some services. There was evidence that there was a breakdown in communication between services, there was information missing in his notes and services were often trying to pass him onto other services.

The Haringey BCF is organised into four schemes (described in more detail below) and these were charged with making the changes that would ensure that Harry was supported by a range of health and social care organisations, including the community and voluntary sector, to regain his independence and live a long healthy and fulfilling life. This is summarised in Figure 1:

Figure 1: How the Haringey BCF will impact on Harry Gray

This is now articulated as 'The Harry Gray Test' to determine if we are making an impact on the important issues for our local population. Through implementation of the

2016/17 BCF, Haringey will continue to: provide health and social care that is co-ordinated around Harry's and his daughter's needs; will build on his strengths and connect him to his community so that he regains his independence; will be proactive and preventative in approach; if Harry is admitted to hospital his care will be transferred more effectively and efficiently; which will all be supported by interoperable IT systems, accessible services, and staff who role model the behaviours needed to ensure that care is improved.

Following publication of BCF Policy Framework by the Department of Health and BCF Planning Guidance by NHS England in January 2016 the focus of the BCF has been clearly articulated as focusing on reducing non-elective admissions (NELs), reducing delayed transfers of care (DTOCs) and supporting further health and social care integration.

Following the first year of implementation, the Haringey BCF was reviewed to ensure that the current service areas will best meet the main aims articulated within national policy and guidance. It is hoped that by reducing non-elective admissions and delayed transfers of care, as well as care home admissions, the BCF will deliver improvements in outcomes for patients and will also produce financial savings.

Outcomes

The BCF is measured against six outcome measures:

- Reduction in Non-Elective Admissions (NELs)
- Reduction in the number of delayed transfers of care (DTOC, delayed days)
- Reduction in the number of non-elective admissions for falls related injuries
- Reduction in rate of permanent admissions (65+) into residential and nursing care
- Increase in proportion of patients discharged into reablement/ rehabilitation services still at home 91 days following discharge
- Increase in the proportion of patients who felt that they have received enough support to manage their long term health conditions

The document 'Better Care Fund Performance Measures – Benchmarking, Feb 2016' (Doc 2, attached) details performance on each of the outcome measures over 2015-16 compared to previous years. It proposes a number of options for setting the targets for 2016-17. The following summarises and outlines each recommended target for each outcome measure.

The trajectory for most of the outcome measures described have been set by making comparisons to averages for the following groups:

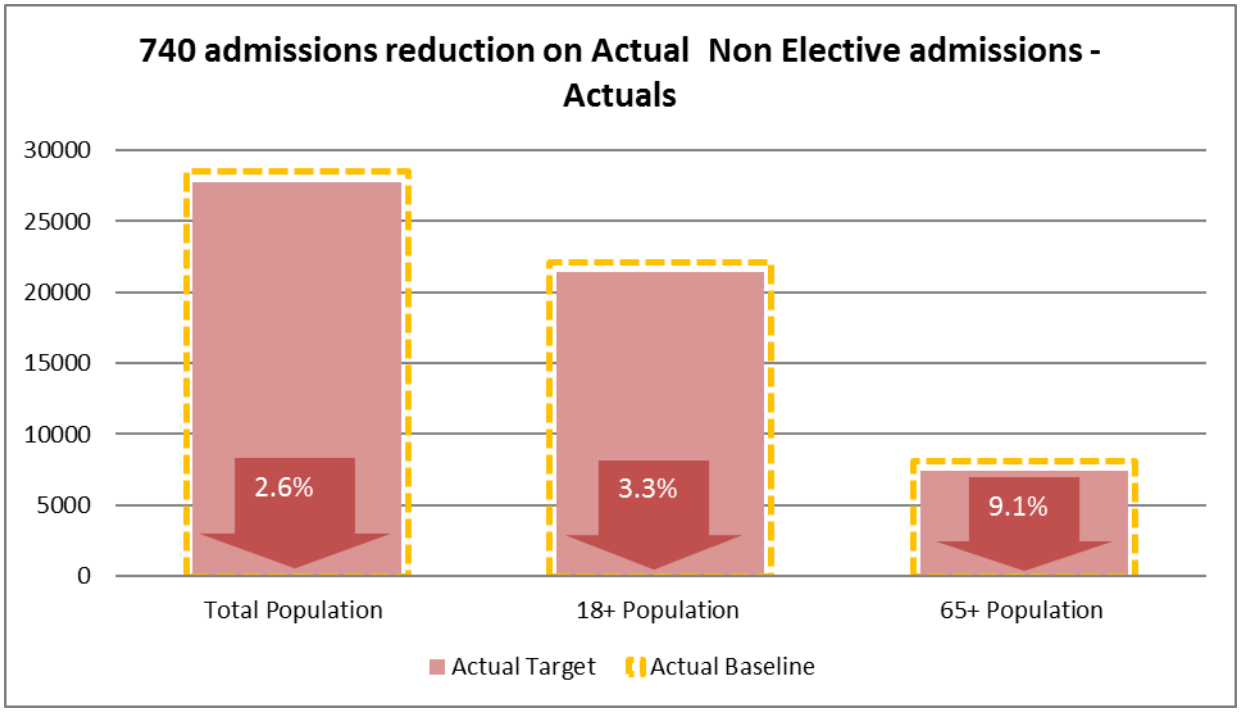
- Comparator Group (Hackney & City; Lambeth; Lewisham; Southwark; Waltham Forest)
- London
- England

Non-Elective Admissions (NELs)

To set the 2016/17 target for NELs a financial target was set to maintain the savings expected from the Haringey ambition for the reduction in NELs for 2015/16. This equated to gross savings of £1.3m. This translates into the need to reduce NEL's by 740 fewer NELs as follows:

£1.3m Savings / £1,801 Average cost of a NEL in Haringey = 740 fewer NELs

Currently the BCF is using a specific definition of NELs. This definition excludes 20 Speciality codes (e.g. well babies, oral surgery) from the CCG Operating Plan definition of NELs. From April 2016 the BCF will be using the same definition of NELs as defined within the CCG Operating Plan submission.



The BCF will be contributing a 2.6% reduction in total NELs. As the BCF is targeting adults (over 18), we would expect there to be a 3.3% reduction in NELs in this group. The majority of schemes are targeting older people (over 65) and if reductions were only in this group we would expect a 9.1% reduction in NELs for over 65s.

This reduction in NELs has been reflected in the CCG operating plan and has been apportioned to the main acute providers in Haringey as follows:

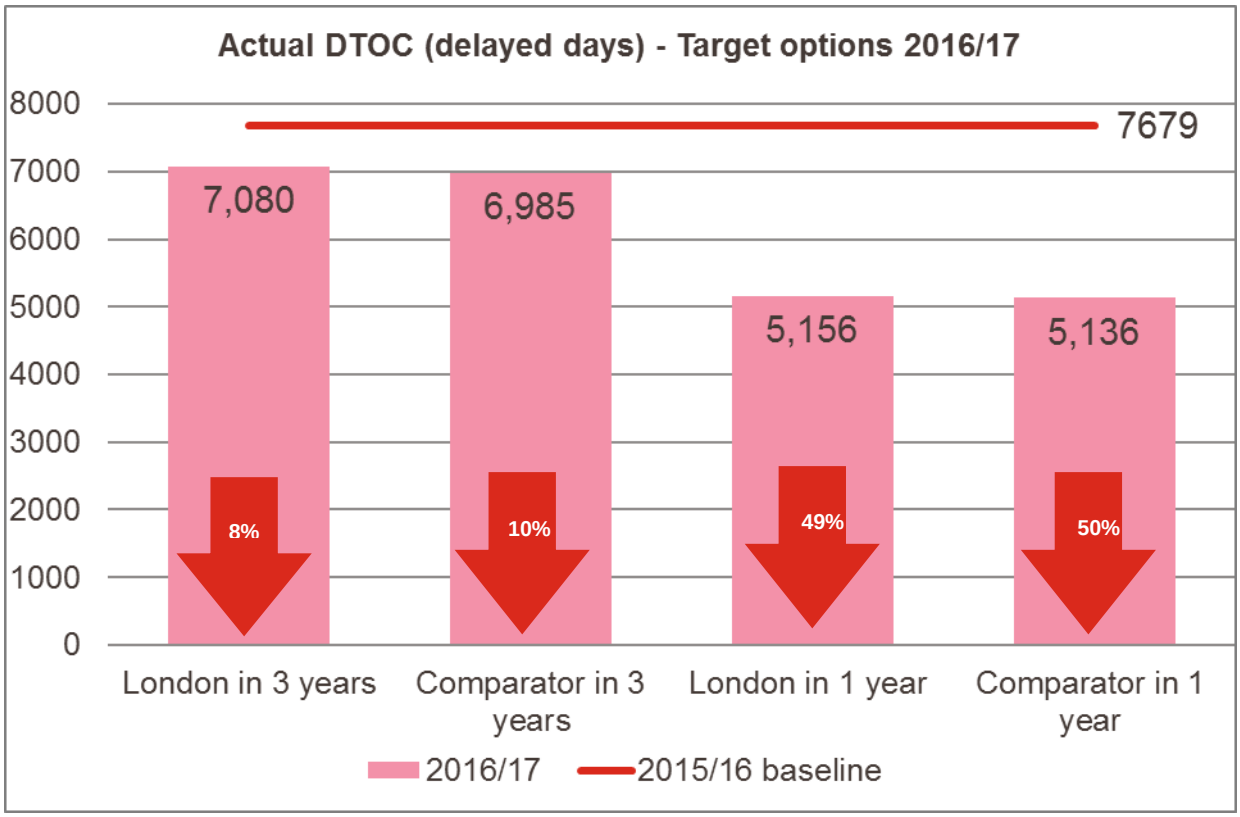
Acute Trust	NEL Reduction
North Middlesex Hospital	351
Whittington Hospital	232
Barnet and Chase Farm	28
Royal Free	28
University College London Hospital	27
Moorfields	2
Royal National Orthopaedic Hospital	3
Other	69
TOTAL	740

Delayed Transfers of Care (DTOCs)

Haringey is currently already delivering fewer DTOCs than the England average. Therefore to set a level of ambition for Haringey a trajectory has been set against the Comparator Group and London for bringing targets in line over one or three years.

The 2016/17 target will be to deliver an 8% reduction in DTOCs, which is 599 fewer delayed days. Reducing DTOCs at this rate would bring Haringey in line with the London trajectory within three years (by 31 March 2019). This would equate to a saving of £159,933:

599 Delayed days saved x £267 average cost per excess hospital bed day = £159,933



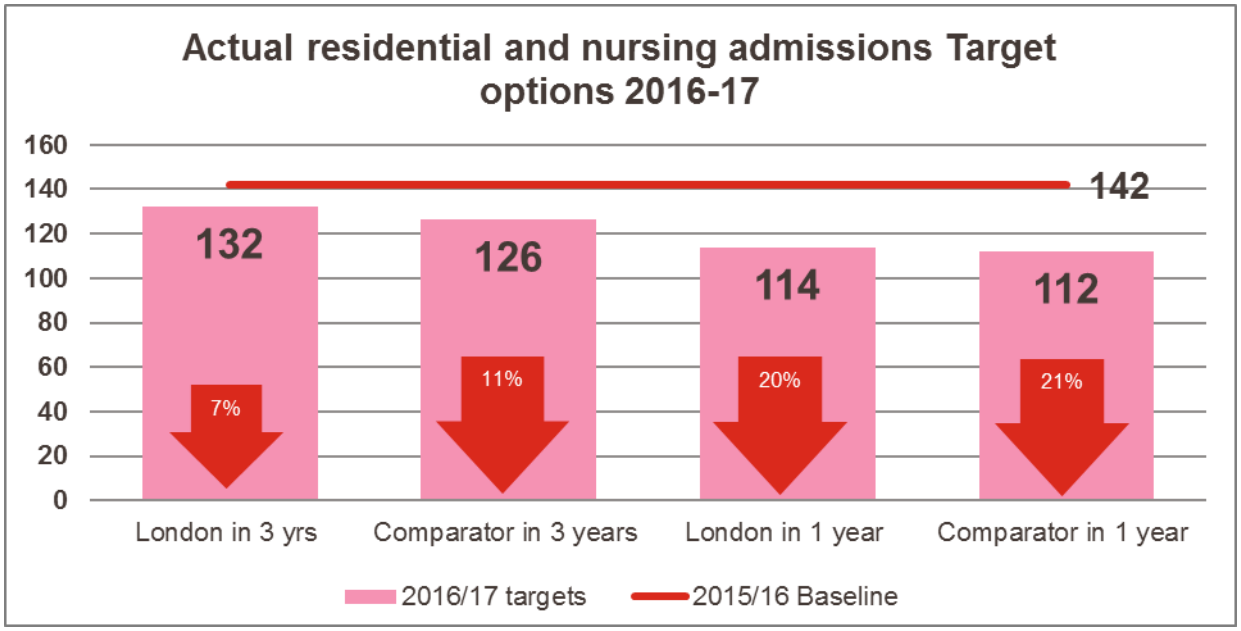
This reduction in DTOCs has not yet been reflected in the CCG operating plan and has not been apportioned to the main acute providers in Haringey as further work is needed to engage stakeholders in agreeing these figures.

Care Homes Admissions

Haringey is currently already delivering fewer care home admissions than the England average. Therefore to set a level of ambition for Haringey a trajectory has been set against the Comparator Group and London for bringing targets in line over one or three years.

The 2016/17 target will be to deliver a 7% reduction in care home admissions, which is 10 fewer permanent admissions. Reducing care home admissions at this rate would bring Haringey in line with the London trajectory within three years (by 31 March 2019). This would equate to a saving of £337,480:

10 permanent admissions saved x £33,748 average cost per care home admission = £337,480

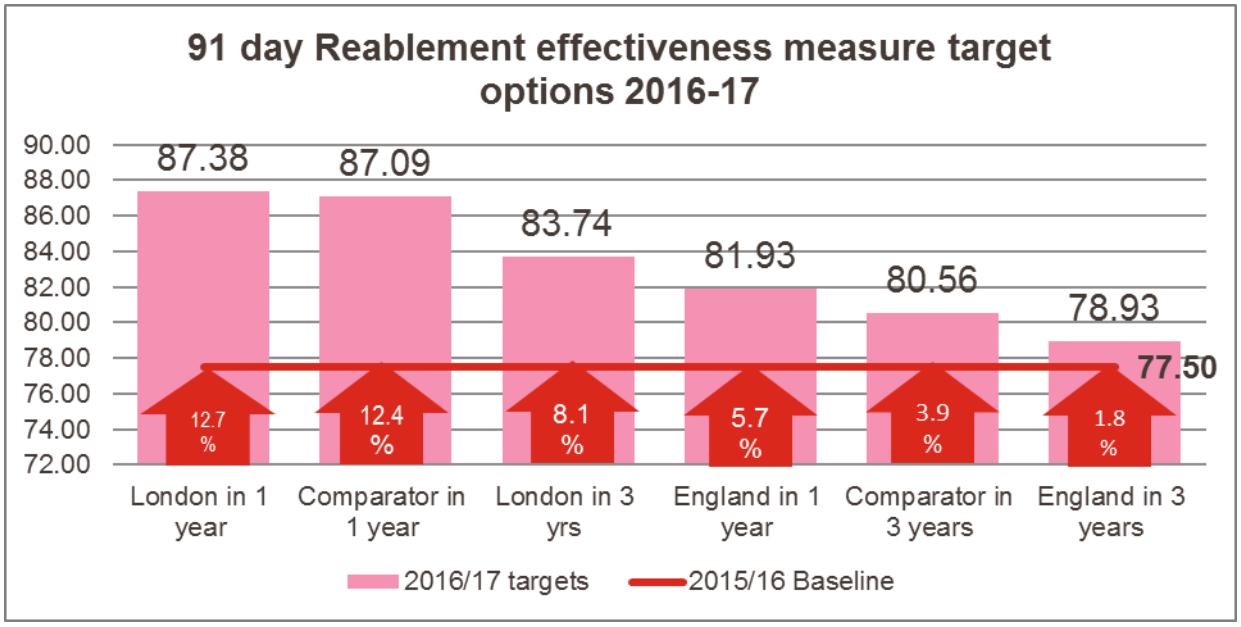


As permanent care home placements are spot purchased these have not been factored into contract negotiations with care home providers.

Reablement

The 2016/17 target will be to deliver a 1.8% increase in the proportion of patients discharged into reablement/rehabilitation services still at home 91 days following discharge. Increasing reablement outcomes at this rate would bring Haringey in line with the England trajectory within three years (by 31 March 2019).

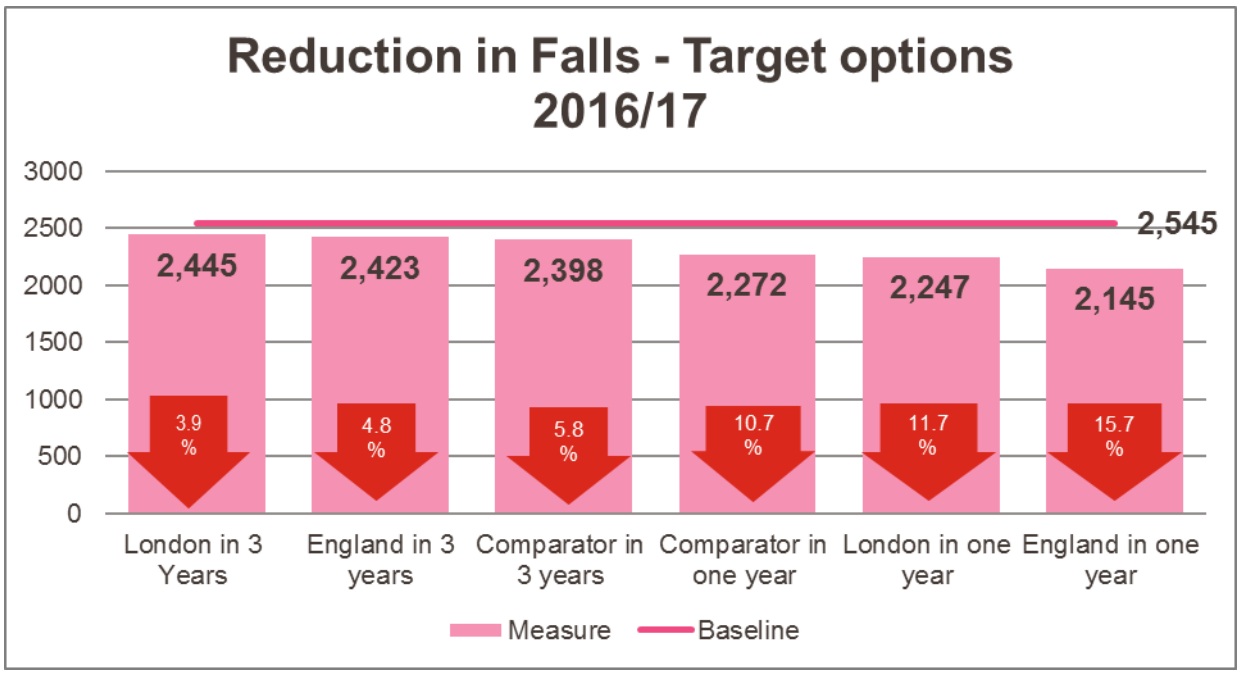
We would expect that the reduction in non-elective admissions following reablement would be a subset within the overall reduction in non-elective admissions already stated earlier.



Falls

The 2016/17 target will be to deliver a 3.9% reduction in the number of non-elective admissions for falls related injuries in older people (65+), which equates to 100 fewer admissions. Reducing the falls outcome at this rate would bring Haringey in line with the London average trajectory within three years (by 31 March 2019).

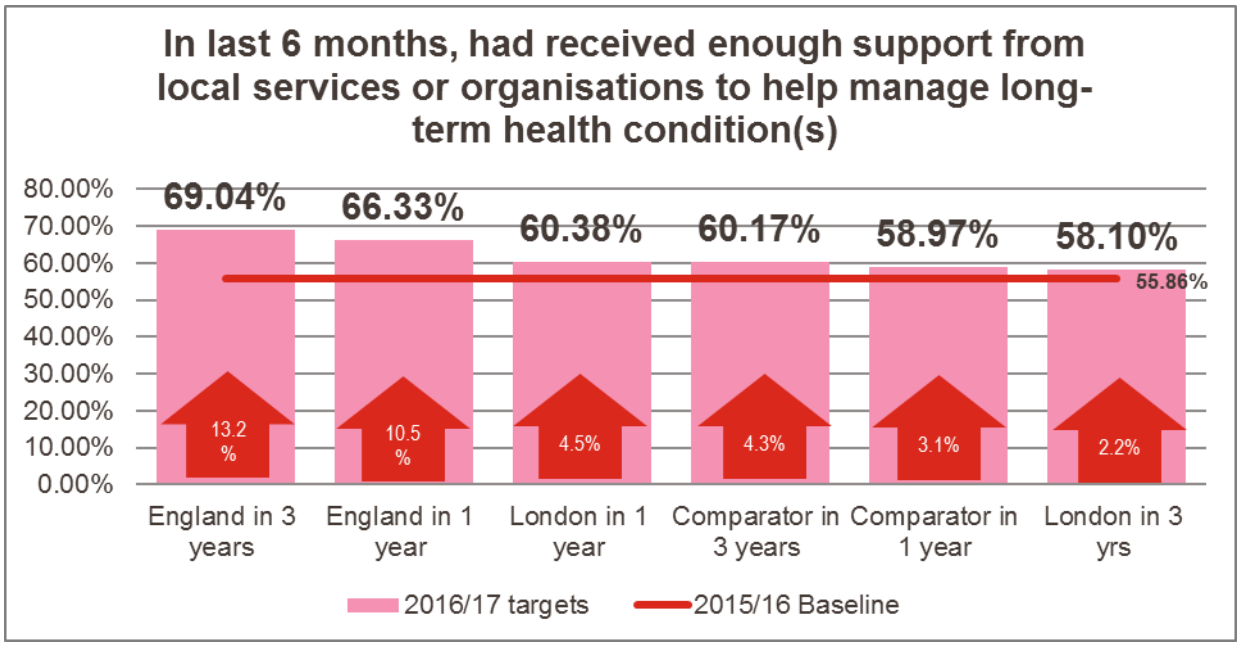
We would expect that non-elective admissions for fall related injuries would be a subset within the overall reduction in non-elective admissions already stated earlier.



GP Patient Survey

The 2016/17 target will be to deliver a 2.2% increase in the percentage of patients who answered that they had received enough support from local services or organisations

to help manage their long term health conditions. Increasing the survey response at this rate would bring Haringey in line with the London average trajectory within three years (by 31 March 2019).



Total Savings

The following savings would be expected through achievements of the outcome targets:

Target	Saving
NEL	£1.3m
DTOC	£0.16m
Care Home	£0.38m
TOTAL	**£1.84m**

As articulated under each measure the NEL savings have been factored into the contract negotiations with Haringey acute providers and the DTOC savings will be once confirmed. Savings from care home admissions will not factor into contract negotiations due to spot purchasing arrangements.

The narrative plan outlines below how the services and schemes for the BCF have been agreed. Following this an analysis will be made of the impact of the schemes on the BCF outcomes.

BCF Funding Allocations

The BCF budget allocations have been announced by NHS England for 2016/17 as follows (with a comparison to allocations in 2015/16):

Source	Funding	2015/16 /£'000	2016/17 /£'000	Variance /£'000
CCG	Relative Need Formula (prev. s256)	£5,261	£5,353	£92
	Additional	£11,137	£11,711	£574
	Sub-Total	£16,398	£17,064	£666
LBH	Disabled Facilities Grant	£949	£1,818	£869
	Grand Total	£17,347	£18,882	£1,535

Risk Share	£1,237	£4,849	£3,612

NHS England have recommended the 2016/17 risk share figure but the size of this is to be locally determined. Haringey has agreed to reserve £1.3m as a contingency fund due to not meeting the target reduction in non-elective admissions for 2015-16. This is described further under the National Conditions section 'Out of Hospital Services' below which describes how Haringey has determined the contingency fund and how it will be governed.

In order to meet these minimum contributions Haringey CCG and LBH scoped the following funding streams into the BCF:

Source	2015/16 Budget	2016/17 Budget
LBH Disabled Facilities Grant (a grant to provide adaptations and facilities to enable disabled people to live at home)	£0.9m	£1.8m
LBH Base Budget (budgets that LBH voluntarily contributed to the BCF)	£4.7m	£0m
CCG Case Management Budget (a CCG budget focused on older people aged over 75 with frailty)	£1.3m	£1.3m
CCG Re-admissions (a CCG budget withheld from acute hospital funding regarding reductions in patients being readmitted 30 days following discharge)	£1.0m	£1.0m
CCG s256 (NHS funding for social care with a health benefit)	£5.2m	£5.3m
CCG Transformation (funds to facilitate the transformation and modernisation of primary health care)	£1.5m	£1.5m
CCG Whittington (funding within the Whittington Health block contract)	£7.4m	£8.6m
TOTAL	£22m	£19.5m

In 2015/16 LBH contributed a voluntary amount into the BCF, which included funding for the: Disabled Facilities Grant; Community Capacity Grant; and social care team. The 2016/17 allocations do not have a separate Community Capacity Grant as it is now included in the Disabled Facilities Grant funding stream. LBH have agreed to

only include the Local Authority minimum contribution in the 2016/17 BCF of the Disabled Facilities Grant (£1.8m).

The additional funding to increase the CCG minimum contribution by £666k will be found from the CCG investment in the Cavell Ward, an in-patient rehabilitation at Whittington Hospital for non-stroke patients. The decision to include this in the scope of the BCF was to explore potential opportunities to improve the intermediate care pathway through closer linkage with the other intermediate care services funded from the BCF. Haringey CCG has agreed to put the whole budget for this service, included in the CCG Whittington line above. This results in the Haringey CCG contribution being £0.6m more than the expected minimum contribution.

National Guidance indicates that the BCF includes funding to cover the following requirements:

- Care Act 2014 Monies
- Former Carers' Break Funding
- Reablement Funding

The 2016-17 Haringey allocations have been estimated using the same ratios as used for the Haringey proportion of the national budget for the Disabled Facilities Grant. The following table assesses the amounts apportioned to these requirements within the Haringey BCF:

Funding Contributions	2016-17 Allocation (estimated)	Haringey BCF 2016-17	Variance
Reablement Funding	£1,425,052	£2,450,000	£1,024,948
Former Carers Break Funding	£617,522	£407,000	-£210,522
Care Act 2014 Monies	£660,000	£660,000	£0
Total	£2,702,574	£3,517,000	£814,426

As shown the Haringey BCF is funding Reablement by £1m more than expected, however Carers Break Funding is £0.2m lower than expected. In total Haringey is funding these requirements by £0.8m more than expected.

Planning for 2016/17 BCF has been discussed in the December 2015 Health and Care Integration (HACI) and Finance and Performance Partnership Boards (these structures are discussed in the Governance section below). These meetings agreed to a series of special budget planning workshops/sub-groups to discuss and agree plans for the BCF 2016/17. These workshops/sub-groups included senior members of the HACI Board as well as the Senior Responsible Officers for the BCF services and projects across Haringey CCG and LBH. It was agreed at these workshops/sub-groups that recommendations would be taken back to the HACI Board for approval at the following Finance and Performance Partnership Board. The following information summarises these decisions.

2015/16 BCF Scheme and Service Assessment

The following process was agreed at the BCF budget planning workshops:

1. Agree the three aims of the BCF 2016/17: Reduce NELs; Reduce DTOCs; Support Integration
2. Assess current (2015/16) BCF service areas (the category of investment rather than the provider) against the three aims
3. Make the following recommendations on BCF service areas: BCF (continue to include within the BCF); Stop (decommission the service area); Mainstream (mainstream the service area within existing BCF service provision); Switch (fund service area from another non-BCF budget but bring in another area currently not funded in the BCF to replace it)
4. Where service areas are recommended to switch - recommend alternative existing service areas currently not funded through BCF to bring into BCF
5. Recommend commissioning decisions for services (providers) based on outcomes of assessment
6. Determine timescales for services based on recommendations

The Haringey BCF is focused on four schemes to achieve the main aims of reducing NELS, reducing DTOCs and supporting integration:

- Scheme 1: Admissions Avoidance - this will deliver proactive care coordination that will prevent health conditions from escalating to a crisis where emergency services are needed
- Scheme 2: Effective Hospital Discharge - this will deliver services that will facilitate discharge from hospital as quickly, safely and effectively as possible
- Scheme 3: Promoting Independence - this will deliver services that build on peoples strengths and community capacity to reduce isolation and improve health and wellbeing
- Scheme 4: Integration Enablers - this will deliver services, mainly interoperable IT and workforce planning and development, that support the implementation of the first three schemes

There are 29 service areas in the Haringey BCF spread across the different schemes. Each area was assessed against the three main aims. The following recommendation was given against each service area:

			BCF Aims				
Scheme	Service Area	SRO	NELs	DTOC	Integ-ration	Recommen-dation	Budget
1	Social Care Team (LBH)	Jeni	✓	✓	✓	BCF	£ 4,325,200
1	Whittington ICTT/Nursing	Rachel	✓	✓	✓	BCF	£ 7,364,000
1	Locality Team	Priyal	✓		✓	BCF	£ 1,041,253
1	MDT	Priyal	✓	✓	✓	BCF	£ 89,000
1	Lymphedema	Leo	?			Switch	£ 48,000
1	Rapid Response	Leo	✓	✓	✓	BCF	£ 250,000
1	Overnight District Nursing Service	Leo	✓	✓	✓	Main	£ 150,000

			BCF Aims				
Scheme	Service Area	SRO	NELs	DTOC	Integ-ration	Recommen-dation	Budget
1	Dementia Day Opportunities	Sanjay	✓		✓	BCF	£ 475,000
1	MH Navigator	Jeni	✓	✓	✓	BCF	£ 40,000
1	MH Employment Project	Sanjay	?		?	Switch	£ 55,000
1	Clarendon	Jeni	?		?	Switch	£ 580,000
1	Whittington falls service	Will	✓			BCF	£ 58,000
2	Reablement	Claire	✓	✓	✓	BCF	£ 2,450,000
2	Integrated discharge catheter care	None				Stop	£ 100,000
2	Step down	Claire	✓	✓	✓	BCF	£ 625,000
2	Home from Hospital	Claire	✓	✓	✓	BCF	£ 139,749
3	Neighbourhoods Connect	Sebastian	✓		✓	BCF	£ 160,000
3	Information, Advice and Guidance (IAG)	Sanjay	✓		✓	BCF	£ 55,000
3	Palliative Care	Rachel	✓	✓	✓	BCF	£ 300,000
3	Self-management Support	Andrea	✓		✓	BCF	£ 116,600
4	Interoperable IT	Marco	✓	✓	✓	BCF	£ 22,333
4	Winterbourne	Claire	?	?	?	Switch	£ 100,000
4	BCF Programme	Marco	✓	✓	✓	BCF	£ 175,000
4	VBC IPU Support	Rachel	✓	✓	✓	BCF	£ 69,496
4	7 Day Social Worker	Claire	✓	✓	✓	Main	£ 146,067
4	Disabled facilities grant	Pauline	✓	✓	✓	BCF	£ 949,000
4	Community Capacity Grant	Beverley	✓	✓	✓	Stop	£ 639,000
4	Care Act (Carers)	Sanjay	✓	✓	✓	BCF	£ 240,000
	Contingency	Marco	✓	✓	✓	BCF	£ 1,236,502
						Total	£ 21,999,200

The majority (21 out of 29) of service areas were recommended to continue to be included within the BCF. For those areas assessed differently the following was recommended:

Stop:

- To correct the budget for the Integrated Discharge Catheter care service as this was a mistake in the budget and a duplication of existing services within district nursing.
- To remove the Community Capacity Grant as this is now included in the Disabled Facilities Grant.

Main

- To mainstream the provision of the overnight district nursing service and 7 day social work into the existing BCF budgets for those services.

Switch

- To remove the following services from the BCF and replace them with other services currently not funded within the BCF:
  - Lymphedema
  - Mental Health Employment Project
  - Clarendon Recovery College
  - Winterbourne

The financial implications for these decisions are as follows:

Service Area	Budget	Source
Main		
Overnight District Nursing Service	£ 150,000	Trans
7 Day Social Worker	£ 106,067	s256
7 Day Social Worker	£ 40,000	Trans
Main Sub-Total	*£ 296,067*	
Switch		
Lymphedema	£ 48,000	Case Man
MH Employment Project	£ 55,000	s256
Clarendon	£ 580,000	s256
Winterbourne	£ 100,000	s256
Switch Sub-Total	*£ 783,000*	
Stop		
Integrated discharge catheter care	£ 100,000	Trans
Community Capacity Grant	£ 639,000	LBH Base
Stop Sub-Total	*£ 739,000*	
Grand Total	**£ 1,818,067**	

Budget	Source
£ 48,000	Case Man
£ 841,067	s256
£ 290,000	Trans
£ 639,000	LBH Base
£ 1,818,067	**Grand Total**

At the BCF budget planning workshop it was agreed that the two services recommended for mainstreaming (Overnight District Nursing Service and 7 Day Social Workers) would need further work to develop options to enable this to happen. The

LBH Base budgets would be removed from the BCF and so would not be available for reinvestment.

Removing these budgets would leave the following budgets available for reinvestment:

Budget	Source
£ 48,000	Case Man
£ 735,000	s256
£ 100,000	Trans
£ 883,000	Grand Total

These budgets would be supplemented by the additional £666k within the increased CCG minimum contribution:

CCG Increase	Source
£ 92,000	s256 Increase
£ 574,000	Additional Increase

The final budget for additional investment into the Haringey BCF (known as the BCF Budget Transfer) is:

Budget	Source
£ 48,000	Case Man
£ 827,000	s256
£ 100,000	Trans
£ 574,000	Additional Increase
£ 1,549,000	**Grand Total**

The BCF has been used as a lever to drive the transformation of health and social care for adults in Haringey. Not all budgets which contribute to the BCF objectives have been included in the pooled fund and some transformation projects are managed elsewhere. Haringey continues on a number of transformation programmes in mental health and children under the umbrella of Health and Care Integration (HACI). This will support the direction of travel towards more integration within the health and social care system across a broader range of areas.

2016/17 BCF Schemes and Services

The HACI Board and Finance and Performance Partnership Board agreed that there was no new money to meet the expected additional increase in the CCG minimum contribution and that the s256 budget continues to fund social care services to mitigate any cost pressures and to meet the national condition of protecting social care services. Therefore the decision was made to identify existing health and social care services that met the aims of the BCF of a value equal to the additional £1.5m BCF Budget Transfer described above.

The existing 2015/16 BCF services that were remaining in the 2016/17 BCF were evaluated against five criteria to determine if there were any additional issues or areas of investment that needed to be considered for 2016/17 (Doc 3, attached). This information in combination with discussions regarding existing health and social care services led to the following lists of services being agreed for the £1.5m BCF Budget

Transfer. These would be in addition to the existing BCF services that had been agreed to continue:

			BCF Aims					
Scheme	Service Area	SRO	NELs	DTOC	Integ-ration	Budget /£,000	Source	Comments
2	Home from Hospital	Claire	✓	✓	✓	£10	Trans + Case Man	A balancing budget for the service
2	Cavell Ward	Leo	✓	✓	✓	£1,254	Whit + Case Man	Linked to work to improve the intermediate care pathway
4	Carers	Sebastian	✓	✓	✓	£827	S256	Meeting the expected requirements for support to carers
	Contingency	David	✓	✓	✓	£96	Trans	Increase to cover full cost of not meeting NELs target
					TOTAL	**£2,187**		

The total of these services is over £0.6m more than the BCF Budget Transfer total. The HACI Board sub-group agreed that the whole budget for the Cavell Ward will be brought into the BCF management, therefore increasing the CCG contribution to the BCF.

In addition to the investments the LBH base budget voluntary contribution would reduce by £3.8m as explained earlier.

The following table summarises the agreed list of 24 services for the BCF 2016/17 and a brief description; the portion of the 2015/6 BCF budget that will be rolled forward into 2016/17; the portion of the BCF Budget Transfer, seen as new investment into the 2016/17 BCF; and the total BCF budget for that service. All service budgets that have been amended or are new to the BCF for 2016/17 have been shaded green.

Scheme	Service Area	Description	Budget from 2015/16	BCF Budget Transfer (New) 2016/17	TOTAL 2016/17 Budget
1	Social Care Team (LBH)	General social care team supporting integration.	£252,000	£-	£252,000
1	Whittington ICTT/ Nursing	General community matrons, district nursing, physiotherapy and occupational health team.	£6,771,095	£-	£6,771,095

Scheme	Service Area	Description	Budget from 2015/16	BCF Budget Transfer (New) 2016/17	TOTAL 2016/17 Budget
1	Locality Team	Focused around GP practices, patients at risk of an emergency hospital admission will be supported by a multi-disciplinary team through care co-ordination to identify health and social care goals that promote self-care and self-management to improve health and well-being.	£1,041,253	£-	£1,041,253
1	MDT	A weekly Multi-Disciplinary Team (MDT) teleconference meeting involving representatives from primary, secondary, community, mental health and social care to discuss Haringey's most vulnerable patients (aged over 65) who are at risk of an emergency hospital admission.	£89,000	£-	£89,000
1	Overnight District Nursing Service	Provides district nursing from 10pm to 8am.	£150,000	£-	£150,000
1	Dementia Day Opportunities	Provides social, intellectual and physical stimulation to aid the well-being of people with dementia.	£475,000	£-	£475,000
1	Whittington falls service	Provides a strength and balance exercise programme to prevent falls in older people.	£58,000	£-	£58,000
1	Palliative Care	Increased access and advanced care planning for people at the end of life.	£300,000	£-	£300,000
2	Rapid Response	Determines a community health and social care response in people's homes, within 2 hours, to prevent a hospital attendance.	£250,000	£-	£250,000
2	Reablement	Provides health and social care expertise to help people learn, or re-learn, the skills necessary to self-manage in their own homes.	£3,042,905	£-	£3,042,905
2	Step down	Provides temporary, non-acute step-down placements made for patients who have received hospital treatment but cannot be discharged home due to a delayed transfer of care.	£625,000	£-	£625,000
2	Home from Hospital	Provides a home accompaniment and visiting service to patients discharged from hospital.	£139,749	£10,251	£150,000
2	MH Navigator	Supports the transfer of care for mental health patients by identifying potential delays and avoiding DTOCs	£40,000	£-	£40,000
2	7 Day Social	Additional hospital social workers to cover 7 day working	£146,067	£-	£146,067

Scheme	Service Area	Description	Budget from 2015/16	BCF Budget Transfer (New) 2016/17	TOTAL 2016/17 Budget
	Worker				
2	Cavell Ward	In-patient rehabilitation at Whittington Hospital for non-stroke patients	£-	£1,254,233	£1,254,233
3	Neighbourhoods Connect	Identifies residents who are socially isolated and through community development and motivational interviewing links them into the community.	£160,000	£-	£160,000
3	Information, Advice and Guidance (IAG)	A universal, comprehensive and quality assured information, advice and guidance offer to improve the capacity of all residents in Haringey to live independently and to access the right support at the right time, within an early help and prevention framework.	£55,000	£-	£55,000
3	Self-Management Support	Increased knowledge, skills and confidence to manage long term conditions using expert patient programmes.	£116,600	£-	£116,600
4	Interoperable IT	Supporting the development of interoperable IT.	£22,095	£-	£22,095
4	BCF Programme	Programme support via: BCF Commissioning Lead; BCF Data Analyst; and BCF Project Officer	£175,000	£-	£175,000
4	Principal Social Worker	Principal social worker supporting workforce development	£60,000	£-	£60,000
4	VBC IPU Support	Supporting the development of integrated services via Value Based Commissioning	£69,496	£-	£69,496
4	Disabled facilities grant	Provides financial help for the cost of essential adaptation work to make a house suitable for a disabled person to live in.	£1,818,000	£-	£1,818,000
4	Carers	Increases the assessment of carers and provides additional support and resources to improve health and well-being for carers.	£240,000	£827,000	£1,067,000
	Contingency	To cover the costs of non-elective admissions if the target is not met.	£1,236,740	£96,000	£1,332,740
		TOTAL	£17,333,000	£2,187,484	£19,520,484

The contingency fund has been identified to cover the expected savings in non-elective admissions (as described earlier). The use of this contingency fund will be governed by the Finance and Performance Partnership Board under the rules established in the BCF Section 75 agreement.

National Conditions

Haringey can demonstrate that it is meeting the following national conditions of the BCF:

Joint Plans

Condition 1: Plans to be jointly agreed

All plans have been developed through the Haringey Health and Care Integration (HACI) governance structure (as described below) with the involvement of all key stakeholders across health and social care (as described throughout the plan, including below).

Adult Social Care has strong links with Housing and a number of surveyors for the Disabled Facilities Grant are managed through Adult Social Care rather than the Housing Department. Local Housing Authority representatives are involved in the transformation of adult social care and are linked through the HACI governance structure.

Social Care Provision

Condition 2: Maintain provision of social care services

The BCF will continue to invest in social care services to meet the aims of the Haringey Better Care Fund in line with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14, known as Section 256 funding. Haringey maintains its Section 256 budget for adult social care according to the amount specified by NHS England and described in the table under the BCF funding allocations section above. An analysis of the CCG minimum contribution spend in the BCF shows that the investment into social care has increased as follows:

	2015/16	2016/17
Social Care Investment from CCG minimum contribution	£4,656,000	£7,422,911

The investment into social care is within the context of a broader integrated health and social care system supporting out of hospital care.

7 Day Services

Condition 3: Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Haringey's health and social care providers have made a commitment in the Haringey Better Care Fund Plan to ensure that services that support hospital discharges are available 7-days a week and over extended hours. Current plans build on those articulated in the Haringey BCF 2014-16 (link as before).

There are currently a number of health and social care services in the Haringey BCF that operate on a 7-day basis which support both admission avoidance and hospital discharge:

- Rapid Response
- Reablement in social care
- District Nursing and Community Matrons
- Palliative Care
- The Home from Hospital service

These are also supported by existing acute, primary care, social care services and community equipment that are available 7-days a week, which includes emergency or urgent provision.

During the winter months additional funding for systems resilience has enabled social care and community rehabilitation support services in Haringey to provide support for weekend discharges primarily to the North Middlesex Hospital.

A business case for BCF funding was developed for 7-day social work beyond the winter months (Doc 17, attached). This was approved in April 2015 and increased the complement of services offering 7-day access.

Reviews have been undertaken of both Overnight District Nursing and 7-day Social Workers in particular. Both of these services support the timely discharge of patients form acute, community health and mental health settings seven days a week. There have been a few issues with the data from District Nursing but the data from the social workers showed that on average two patients require social work input on discharge over the weekend and five patients are discussed in the RAG ward rounds. The additional capacity has also supported other areas of social work including follow ups to ease the pressure on social care services. For this reason Haringey has made the decision to maintain seven day social work and overnight district nursing with a view that these services should be mainstreamed into existing services.

Under the Governance section below the Community Education Providers Network (CEPN) is described which is overseeing progress with integrated workforce planning and development. Part of this planning involves a number of areas that will impact on 7-day working including the transformation of roles to enable more flexibility in the health and social care system. This will include actions on the development of standardised terms and conditions and supervision for staff working across more than one organisation.

Key milestones supporting 7-day working have been included in the milestone plan below.

Data Sharing

Condition 4: Better data sharing between health and social care, based on the NHS number

Haringey is committed to the development of interoperable IT in order to facilitate the integration of health and social care services. Harry Gray demonstrated that there are cases of people who have information missing in their records and this can lead to a number of the issues that the BCF is trying to improve. Through the use of interoperable IT and the development of an integrated digital care record Haringey will seek to improve the care of people and to reduce (and potentially eliminate) the factors that can block the delivery of appropriate care.

All health and social care services continue to use the NHS number as the primary identifier. As of 31 January 2016 of all Adult Service Users (receiving a service) 88% have an NHS number entered on the system. This is a 47% increase from the initial BCF submission (60% of social care service users with an NHS number). Social care will continue to build on this success and make the recording of NHS numbers an integral part of recording social care referrals. As part of the transformational work in Haringey's Adult Social Care Department over the next 2 years will:

- Ensure social care staff are aware of the requirement to capture NHS numbers on social care records.
- Use guidance from the Health and Social Care Information Centre to ensure staff are trained from the front door onwards in the use and location of NHS numbers
- Reviewing that all forms and templates used by adult social care have the ability to record the NHS number on it

For 2016/17 the Adult Social Care Department has set a target of recording the NHS number on 95% of new referrals into the service.

Through the development of the Locality Team (see below) work has progressed to clarify the position on multi-agency data sharing that supports patient care. Each primary care, community healthcare, social care and acute organisation involved in the care of patients via the Locality Team are expected to follow their own information governance policies and protocols. Overall, the Locality Teams have been following the rules for sharing information as stipulated in, 'A guide to confidentiality in health and social care' HSCIC, version 1.1, September 2013, available online: http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf .

The guidance was used to develop a patient consent process and form (Doc 4 & 5, attached) that requests consent for the Locality Team to: access health and social care records; and sharing the NHS number to evaluate the Locality Team project. The Locality Team is being fully evaluated in April 2016 which will determine the impact of the consent process which will influence the process across all health and social care services more broadly in Haringey.

In addition options have been developed to facilitate the access of patient records across multiple systems whilst plans are being developed for full IT interoperability. This includes shared access to existing health and social care IT systems and the use of a Medical Interoperability Gateway (MIG) for the sharing of information between Primary Care IT systems.

Commitments to open APIs and data protection have not changed since the 2014-16 BCF submission (link as before).

Haringey is also a partner of the North Central London NHS Digital Roadmap. A commitment has been made to work towards a paper free NHS by 2020 and the use of an Integrated Digital Care Record. Haringey is currently developing options to meet these requirements.

Key milestones supporting interoperable IT have been included in the milestone plan below.

Health and Social Care Assessments

Condition 5: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The Locality Team is a multi-disciplinary team that assigns a care co-ordinator to patients who are most at risk of a non-elective admission. The care co-ordinator is the accountable professional who will undertake a combined health and social care assessment and develop a person centred care plan with the patient based on identified needs. The Locality Team was piloted with two GP practices from April 2015 and has expanded to cover all of Haringey from November 2015. 32 out of 50 GP practices are engaged with the Locality Team as of March 2016.

A decision was made to target the top 2% of GP registered patients at risk of a non-elective admission. In Haringey this equates to 4402 patients. Patients are identified for the Locality Team through the use of a risk stratification tool and GP clinical judgement. The Locality Team is given an annual target of working with 1099 patients. The multi-disciplinary care co-ordinators will be working with 770 patients and GP will be care co-ordinating 329 patients. As the Locality Team has only been operating across all practices from November 2015, and is still developing its capacity and capabilities, a proportion of this target was agreed. The 2015/16 target was 273 patients equivalent to approximately one quarter. A full evaluation of this phase of the Locality team will be completed in April to determine the impact of care co-ordination on a range of outcomes and to give a clear steer on the development of the next phase of implementation and the scaling up of impact.

A Locality Team Tool-kit has been developed (Doc 6, attached) which includes guidance on joint health and social care assessments and the embedded care plan template.

The Locality Tem have developed their links to a range of different services that support a range of Long Term Conditions including Dementia. If any patient is assessed as having impaired or worsening cognitive function they will be referred to services including the memory clinic. In addition the BCF fund Dementia Day Opportunities for people with dementia and their carers. The next stage of the BCF will be looking at how we can improve the health and social care pathways between all the different services so that people with dementia can be fully supported at home and in the community.

Key milestones supporting integrated health and social care assessments have been included in the milestone plan below.

Impact on Providers

Condition 6: Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The main providers for the BCF are engaged throughout the governance structure of the BCF, as described below. Key service leads are members of the working groups that steer services that are within the three BCF schemes: Admissions Avoidance; Effective Hospital Discharge; and Promoting Independence. These groups all feed into the Operational Group Adults, which has senior staff (Chief Officers/Directors) from the main providers as members. These groups have all contributed to the development of the BCF in Haringey and all providers are involved in plans.

In addition to this, as described in the Non-elective admission part of the Outcomes section above, BCF targets are built into the contracting process with all providers. Acute providers have been notified of the expected savings that will be generated by the BCF programme and these are being agreed as part of the contract negotiations. These are outlined in the table of providers in this section.

Haringey have run four large public engagement events in collaboration with the Haringey Forum for Older People. These have been on the following themes:

- June 2015: BCF Launch Event – To feedback to the public, patients and carers how the Haringey BCF is meeting the priorities they have defined through previous consultations
- September 2015: Let's Talk About…Loneliness and the Community – To discuss the BCF Promoting Independence services and what more we could do to tackle loneliness and isolation (Doc 7, attached)
- December 2015: Let's Talk About…Leaving Hospital – To discuss the BCF Effective Hospital Discharge services and what could be done to improve hospital discharge and reduce delayed transfers of care.
- April 2016: Let's Talk About…Staying Well at Home – To discuss the BCF Admissions Avoidance services and in particular to get public feedback on the next phase of implementation for the Locality Team

Haringey continues its commitment to regularly engaging and involving the public in the development and monitoring of the BCF.

One of the Haringey public priorities for the BCF is that 'Integrated services will promote wellbeing and reduce loneliness'. This supports the requirements that mental and physical health are treated equally. The mental health provider for Haringey, Barnet, Enfield and Haringey Mental Health Trust (BEHMHT), is an equal partner through the BCF Governance Structure. Mental health services are integrated into the four BCF schemes:

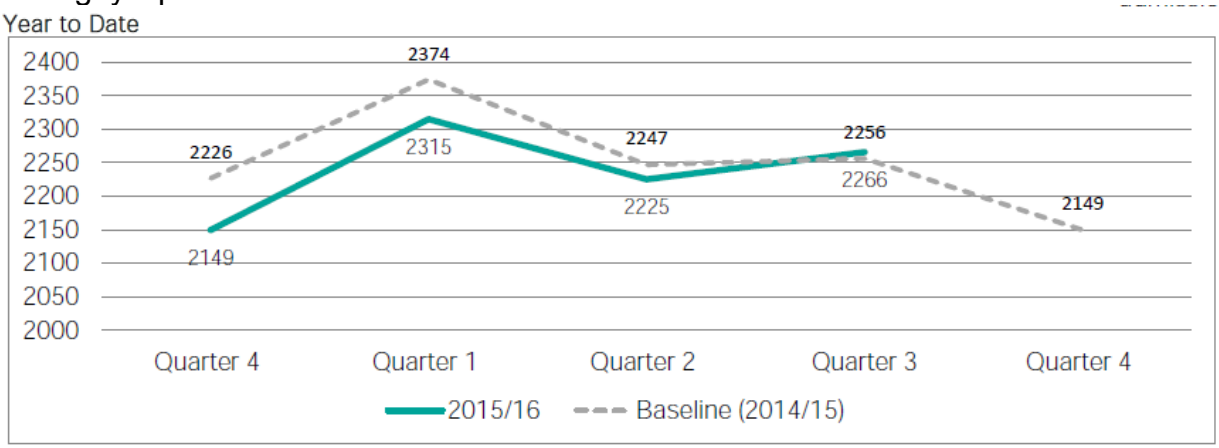
- Admission Avoidance – two mental health nurses are part of the Locality Team MDT, dementia day opportunities are within the BCF budget
- Effective Hospital Discharge – mental health is mapped onto the hospital discharge pathway, Home from Hospital is a voluntary sector service targeting people being discharged form hospital who are isolated, Mental Health Navigators support the transfer of care for mental health patients
- Promoting Independence – supports improvements in health and wellbeing through participation in the community

- Integration Enablers – BEHMHT IT systems will be linked to IT interoperability solutions and a priority has been identified with all health and social care providers through the Community Providers Education Network to support staff development with tackling the interrelationship between physical and mental health

Out-of-Hospital Services

Condition 7: Agreement to invest in NHS commissioned out-of-hospital services

Haringey has agreed to reserve £1.3m as a contingency fund due to not meeting the target reduction in non-elective admissions for 2015-16. The following graph shows Haringey's performance over 2015.



There have been 114 additional non-elective admission in Haringey from January 2015 to February 2016 compared to the same period in the previous year. This equates to a 0.41% increase in non-elective admissions. However it should be noted that from April 2015 to February 2016 there has been a 7% decrease in non-elective admissions amongst the over 65s, which equates to 524 fewer non-elective admissions. Over 65s are the main focus on the BCF in Haringey. As Haringey did not meet its target reduction in non-elective admissions the contingency was not used to fund any out of hospital services and instead was released to cover the increased costs generated by the increase in non-elective admissions.

As described earlier Haringey is aiming to deliver 740 fewer non-elective admissions which equates to:

740 fewer NELs x £1,801 Average cost of a NEL in Haringey = £1.3m Savings

Haringey will maintain £1.3m in the contingency fund which will be released quarterly to cover the cost of non-elective admissions if the non-elective target is not met. If the target is met this budget will be available to spend on out of hospital services which will support the aims of the Haringey BCF.

Once the BCF plan is agreed and submitted a redrafted s75 agreement will be developed which will set out the risk sharing agreement for use of the contingency.

In order to develop an appropriate risk sharing agreement between all BCF stakeholders the following processes and actions have been agreed:

Governance – The Governance of the BCF has been established for a few years and is represented by a number of senior stakeholders from a range of partner organisations including Haringey CCG, London Borough of Haringey; Health and Social Care Providers; Voluntary and Community Sector; and Public and Patient representation. The governance structure gets frequent reports on progress with actions, risks and the monitoring of outcomes and supporting indicators. These reports enable partners to monitor progress with the BCF programme. Within the last year the Haringey BCF has been audited three times, twice by Haringey CCG and once by LBH. All three audits (Doc 8-10, attached) have stated that the BCF is operating with full compliance of the appropriate finance and performance mechanisms. The Finance and Performance Partnership Board (described below in the Governance Section) will jointly make decisions on releasing the contingency fund at its quarterly meetings, to either cover the costs in additional non-elective activity or to fund additional out-of-hospital services if the target is met.

Risk Influence – The BCF has assigned Senior Responsible Officers (SROs) for each of the projects and services. These officers give frequent highlight reports to the BCF Commissioning Lead to track the progress with implementation of the BCF. The SROs range from commissioners to operational leads within Haringey CCG and LBH. The SROs are expected to engage the appropriate stakeholders in the development and delivery of their key projects and services. This includes monitoring services through regular contract meetings with providers, as well as broader stakeholders in project meetings. Risks are identified for each project and clear risk owners are identified. All risk, both financial and non-financial, are escalated to through the BCF governance structure. The current risk register is attached (Doc 13).

Baseline and Tracking Mechanism – The BCF data analyst has a clear link to each SRO and collates information on the service or project they oversee. This can be from the SRO themselves or from any commissioned BCF services. The data analyst then translates this data into a BCF dashboard that is reviewed monthly at the Health and Care Integration (HACI) Board. The monitoring of this information enables senior partners to make decisions regarding the progress of the BCF and to determine if any remedying actions need to be implemented and by whom. This information was used in the assessment of BCF services under the BCF 2015-16 Scheme and Service Assessment section above.

In addition Haringey has engaged in delivering a programme of Value Based Commissioning for Older People with Frailty linked to a number of services delivered through the BCF. This programme aims to develop an accountable care organisation for delivering on a range of outcomes, a number of which correlate to the BCF outcomes. As the programme develops it will seek to get more provider ownership for the risks in delivery through the development of incentives linked to the delivery of these key outcomes.

Modelling of the 2016/17 BCF services demonstrates the following potential impact on reducing non-elective admissions:

Scheme	Service Area	Target Number of Service Users 2016-17	% Reduction	NELs
1	Locality Team	600	0.1	60
1	MDT	1080	0.15	162

Scheme	Service Area	Target Number of Service Users 2016-17	% Reduction	NELs
1	Dementia Day Opportunities	62	0.05	3
1	Whittington falls service	280	0.1	28
1	Palliative Care	355	0.1	36
2	Rapid Response	470	0.8	376
2	Reablement	490	0.07	34
2	Step down	80	0.05	4
2	Home from Hospital	370	0.05	19
2	MH Navigator	50	0.05	3
3	Neighbourhoods Connect	890	0.05	45
3	Self-Management Support	140	0.05	7
4	Disabled facilities grant	140	0.07	10
4	Carers	970	0.05	49
	Total	**5977**		**834**

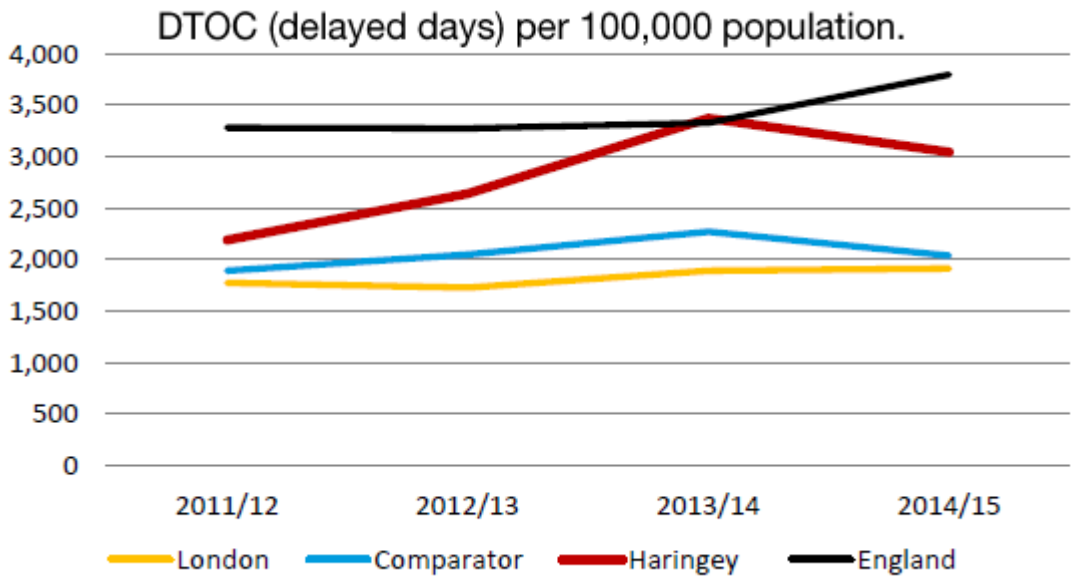
The percentage reductions have been based on a combination of local service evaluations and national best practice evidence, or conservative estimates where evidence was not available. From this modelling the BCF 2016/17 services are predicted to deliver a greater reduction in non-elective admissions than the Haringey target of a reduction of 740 non-elective admissions. The target of 740 fewer non-elective admissions is being maintained due to the number of assumptions used to model the reduction.

Delayed Transfers of Care

Condition 8: Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

A Delayed Transfer of Care (DTOC) occurs when a patient is ready to leave acute, community health or mental health care and is still occupying a bed. Delays can be caused by a number of different factors which can be mainly attributed to delays from health and social care services.

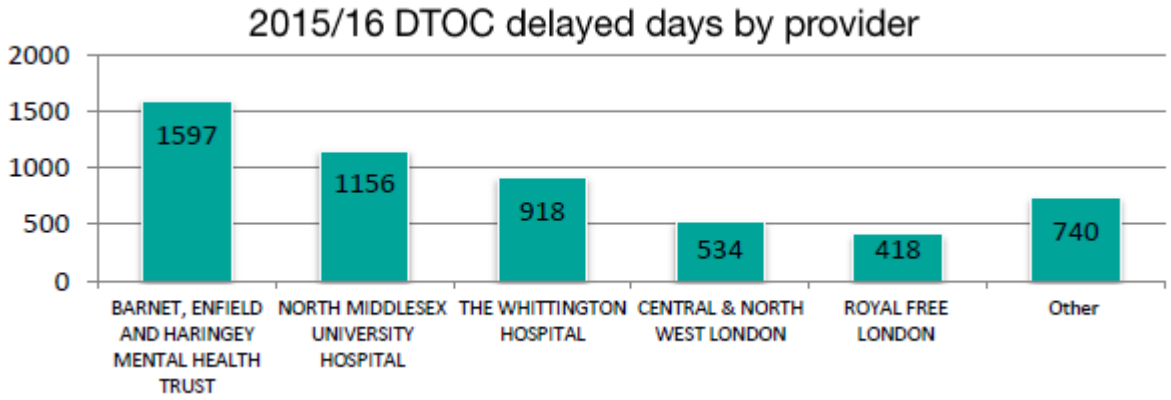
Over the last five years, Haringey's rate of delayed days have been lower than the England average apart from in 2013/14.



In the same time period Haringey's rate of delayed days continues to be above that of London and the Comparator Group. From April to December 2015 there has been 5363 delayed days, an 18% increase compared to the same period in 2014.

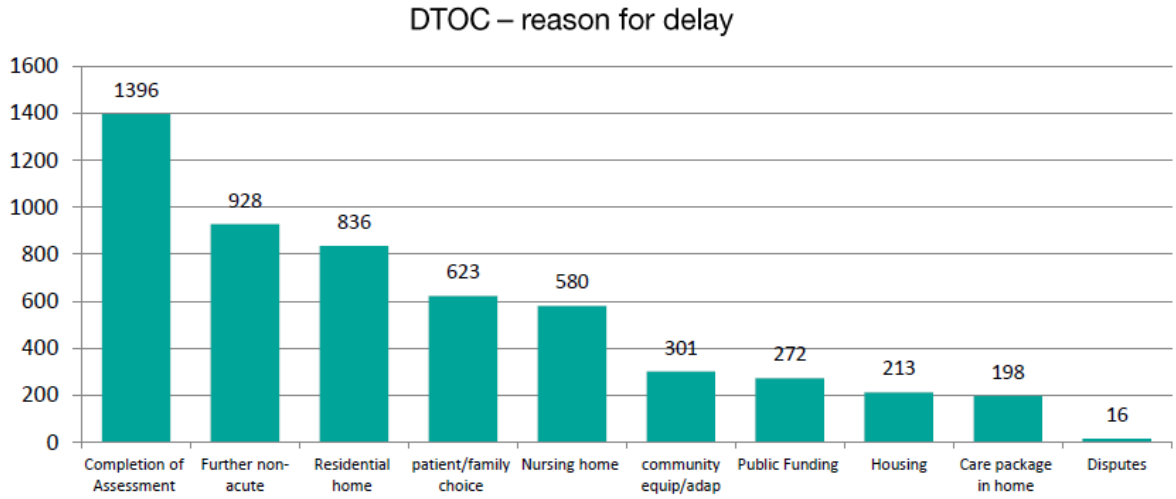
As described earlier, the 2016/17 target will be to deliver an 8% reduction in DTOCs, which is 599 fewer delayed days. Reducing DTOCs at this rate would bring Haringey in line with the London trajectory within three years (by 31 March 2019).

A breakdown of these DTOCs by provider highlights the top three providers that Haringey will focus on to reduce DTOCs.



The reduction in DTOCs has not yet been included in the CCG Operational Plan due to current negotiations with acute trusts. It is within CCG Plans to include the DTOC reductions as part of the processes described below under each provider. As these plans have not been fully confirmed Haringey has not yet developed a risk sharing agreement to cover DTOCs. This will be considered as plans are confirmed.

The causes of DTOCs in Haringey (across all providers) are:



The top four causes of DTOCs are:

- Delays in completion of assessments of future care needs and an identification of appropriate care setting undertaken by either a health and/or social care professionals
- Awaiting further community health or mental health care e.g. rehabilitation following completion of assessment
- Awaiting availability of a nursing or residential care home placement to meet assessed needs
- Patient or family exercising choice on where they are transferred to based on meeting their needs

It is important to note that NHS organisations currently define patients as Medically Optimised (MO) when they have been clinically assessed as ready for transfer. When patients are ready for transfer they are placed on the MO list. This is a clinical decision only and has not involved other health and social care professionals regarding future care needs and appropriate care settings. An MO list can be used to improve patient flow which supports effective discharges.

Focusing on the top three providers with the most delayed days the following actions have been developed in collaboration with the relevant acute, community, social care, voluntary and community sector providers:

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

DTOCs and improvements in care pathways are being overseen and supported by:

- A programme of Trust-wide quarterly DTOC improvement workshops, which started in January 2016, led by Andy Graham, BEH MHT Executive Director of Patient Services.
- The 'Haringey Enablement Programme', driving service transformation across primary and secondary healthcare, social care and the voluntary sector
- A cross-organisational working group on improvements to the accommodation pathway.
- Contract round negotiations and re-specification of services, in particular the Crisis Response and Home Treatment Team

Key achievements to date have included:

- BEH MHT have introduced new ways of working, including daily Jonah meetings (discharge planning on inpatient wards) which were identified as good practice in the recent Care Quality Commission (CQC) inspection

- Haringey Council have recommissioned supported housing/living services along new pathways with streamlined processes to drive faster throughput from April 2016
- Haringey CCG have led development of guidance resources for staff in health and housing sectors covering the housing pathway and key issues, targeted at DTOC prevention and management; released in March 2016 and will be reviewed quarterly

Key activity planned for 2016/17 which will impact on DTOCs includes:

- Shared protocols between mental health sector and social landlords, by August 2016
- Develop No Recourse to Public Funds guidance and refresh the Trust Discharge Policy, by October 2016
- Review and improvement of processes for DTOC planning and management, and assessment and decision making for funded care and support services, also by October 2016
- A new primary care mental health model including better transfers on discharge and crisis prevention, to be rolled out by April 2017
- Developing Estates plans to provide in-patient rehabilitation services and Female Psychiatric Intensive Care (PICU) on the patch, dates subject to the Sustainability and Transformation Plan (STP) development

North Middlesex University Hospital (NMUH)

DTOCs and improvements in care pathways are being overseen and supported by:

- The NMUH Systems Resilience Group (SRG) supporting system wide planning to meet needs and improve outcomes during high activity periods over winter.
- The Safer, Faster, Better Delivery Group established to oversee the development and implementation of an urgent care improvement plan covering the health and social care economy connected to NMUH
- The Intermediate Care Group overseeing the development of an improved intermediate care pathway as part of the BCF Governance Structure

Key achievements to date have included:

- The development of the 'Salford Report' (Doc 18, attached) to illuminate contributions to reduced performance at NMUH, to support a focused action plan to improve & sustain acceptable levels of ED performance
- Development of the Safer, Faster, Better Programme (Doc 11) improvement plan focusing on four key areas: the emergency department; assessment and short stay admission; wards; and out of hospital services
- Self-assessment by health and social care colleagues in two workshops on all eight of the 'Eight High Impact Standards for Improvement in Discharge & Delays Management'. This resulted in priorities for the out of hospital services plan.
- Improvements to the process for patients on the MO list including clear lines of accountability for the DTOC and MO escalation process (see Appendix 1). This process ensured only appropriate patients would be placed on the MO list, enabling effective discharges and working towards a reduced DTOC and MO list.
- Development of plans for an Integrated Discharge Team with multiple stakeholder input, including voluntary and community sector, for a whole system approach to reduce DTOCs

Key activity planned for 2016/17 which will impact on DTOCs includes:

- Review the MO/DTOC escalation process and plans by May 2016

- Establish an agreed senior decision makers' model by July 2016
- Identify the role of the Single Health Resilience Early Warning Database (SHREWD) on capacity planning and escalation by July 2016
- Refresh current discharge and choice policy by October 2016
- Implement the Integrated Discharge Team model agreed by the health and social care economy, including voluntary and community sector, by November 2016
- Improve inter-operability and shared records by December 2016

The Whittington Hospital

DTOCs and improvements in care pathways are being overseen and supported by:

- The Whittington Health Systems Resilience Group (SRG) supporting system wide planning to meet needs and improve outcomes during high activity periods over winter.
- The Intermediate Care & Delayed Transfers of Care Operational Group (Islington based) facilitates effective and efficient transfers of patients between Whittington Hospital services and the community
- The Intermediate Care Group overseeing the development of an improved intermediate care pathway as part of the BCF Governance Structure

Key achievements to date have included:

- Linking with Islington as the lead commissioner for Whittington Hospital and discussing an aligned approach
- A review of the eight steps for system maturity for DTOCs

Key activity planned for 2016/17 which will impact on DTOCs includes:

- Develop a clear plan for reducing Haringey DTOCs at Whittington Hospital by September 2016
- Improve inter-operability and shared records by December 2016

The main forum for bringing all these separate plans together for Haringey will be the Intermediate Care Group, as part of the BCF governance structure (described below), which has a special interest in supporting effective hospital discharge.

The Intermediate Care Group has already undertaken work across the whole system to map an Intermediate Care Pathway, which will support the reduction in DTOCs (Appendix 2). This pathway includes work to improve the use of Intermediate Care beds which include step up, step down, reablement and rehabilitation (as part of the Cavell Ward). It is for this reason that the Cavell Ward has now been brought into the BCF management to ensure it is linked into the pathway.

Haringey views the entire Intermediate Care pathway as supporting a model of 'Discharge to Assess' as there will be a range of options through all parts of the pathway to ensure that people are supported, transferred and discharged appropriately, safely, effectively and efficiently.

All providers in Haringey will also be part of the North Central London Sustainability and Transformation Plan (STP) development which will also be exploring health and social care economy proposals to reduce DTOCs.

Governance and Accountability

The BCF Section 75 agreement outlines the overarching governance and accountability structure. Figure 5 details the Haringey BCF governance structure, which is a slight amendment to the one in the Haringey BCF Plan 2014-16:

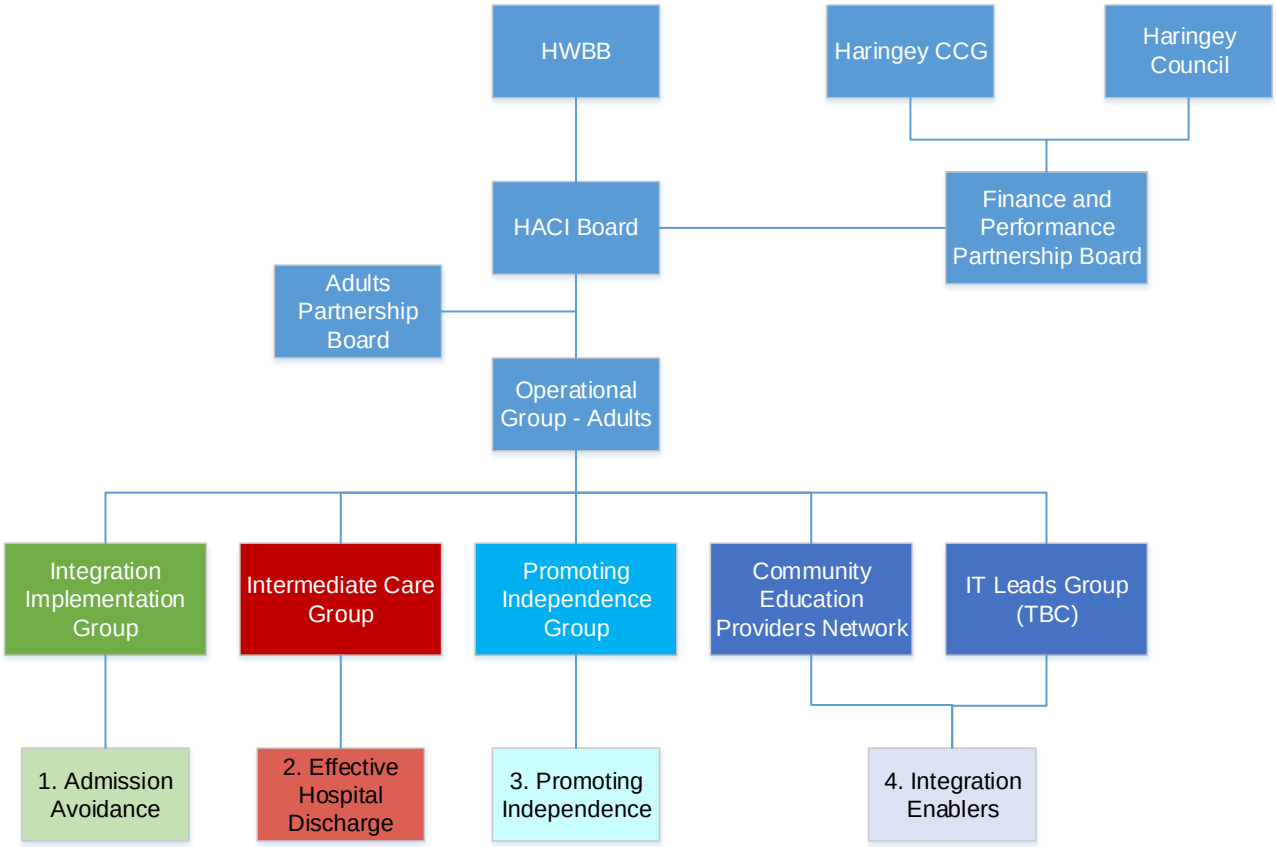


Figure 5: Haringey BCF Governance Structure

The Haringey Health and Well Being Board (HWBB) has responsibility for setting the vision and ambition for Integration in Haringey. The HWBB provides guidance and strategic direction and will make strategic decisions (impacting vision and direction of travel) as long as they are within the agreed scope and principles.

The Health and Care Integration Board (HACI) Board reports into the Health and Well Being Board and has oversight of the Integration Programme delivery including the Better Care Fund. The HACI Board steers the integration programme and associated projects and will assure progress is on track to achieve the delivery of the BCF plan. The HACI Board will take management decisions enabling the programmes and projects to deliver.

The four BCF Schemes feed into separate working groups. These working groups are overseen by the Operational Group – Adults, which is accountable to the HACI Board.

BCF finance and performance information is reported once a quarter to the HACI Board who will note the Finance and Performance (F&P) Report and make recommendations which will then go to the Finance and Performance Partnership Board who will make decisions and approvals. The Finance and Performance

Partnership Board also links to both the Haringey CCG and Haringey Council governance structures.

The Finance and Performance Partnership Board will have delegated approval from the CCG Governing Body to make financial allocation decisions relating to the Better Care Fund of up to £150,000 per issue. For financial issues greater than the £150,000, the Finance and Performance Partnership Board will make recommendations to the CCG Governing Body.

Similarly the Finance and Performance Partnership Board has delegated authority from the Council to take decisions on financial allocations for the Better Care Fund up to £250,000, for issues greater than £250,000 recommendations will be made to the Council's Cabinet.

No decisions may be taken by the Finance and Performance Partnership Board without the agreement of both the Council's nominated officers and the Finance and Performance Committee.

Three BCF specific joint commissioning posts are funded out of the BCF to support the BCF programme and reporting for the BCF governance structure:

- Commissioning Lead – Better Care Fund, who is the overall programme lead
- BCF Project Officer
- BCF Data Analyst

These three posts are responsible for developing all the programme documentation including Milestone plan (Doc 12, attached), Risk register (Doc 13, attached), BCF dashboard (Doc 14, attached) and Highlight reports (Doc 15, attached).

As well as at a commissioning level joint working is also supported by a large programme of integrated staff workforce planning and development through the Community Education Providers Network (CEPN). The CEPN is currently developing joint priorities for integrated workforce planning and development which include:

- Communication – ensuring all staff are aware of health and social care services in Haringey and the potential for integrated working, training and development
- Recruitment and Retention - supporting each other to improve recruitment and retention
- Proactive Care – links to a range of service and support to enable more preventative and proactive care
- Transformation of Roles – enabling staff to work flexibly across health and social care
- Mental and Physical Health – ensuring that parity of esteem is given to mental and physical health

Through the CEPN a number of staff listening events have been held to help shape an integrated workforce training and support programme. This has included workshops, action learning, the development of a Locality Team toolkit and the development of 85 Integration Change Champions to role model the staff behaviours expected to support the NHS 5 year forward view and the Care Act 2014 (e.g. being person centred and proactive). A report on this is attached (Doc 19, attached).

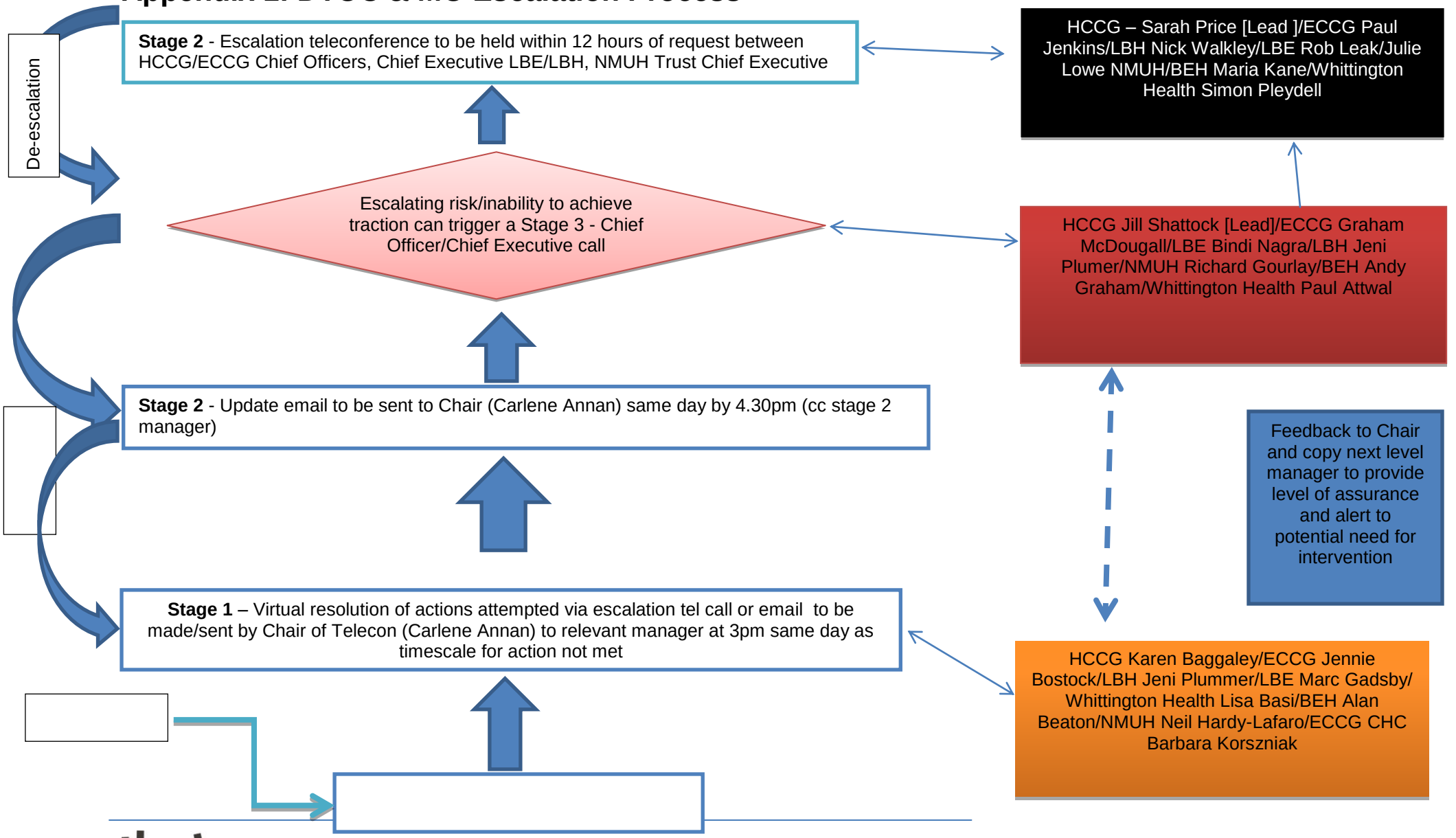
BCF 2016/17 Milestones

As plans are firmed up for delivery of the BCF 2016/17 the milestone plan (Doc 12) will be updated. The following broad milestones have been confirmed:

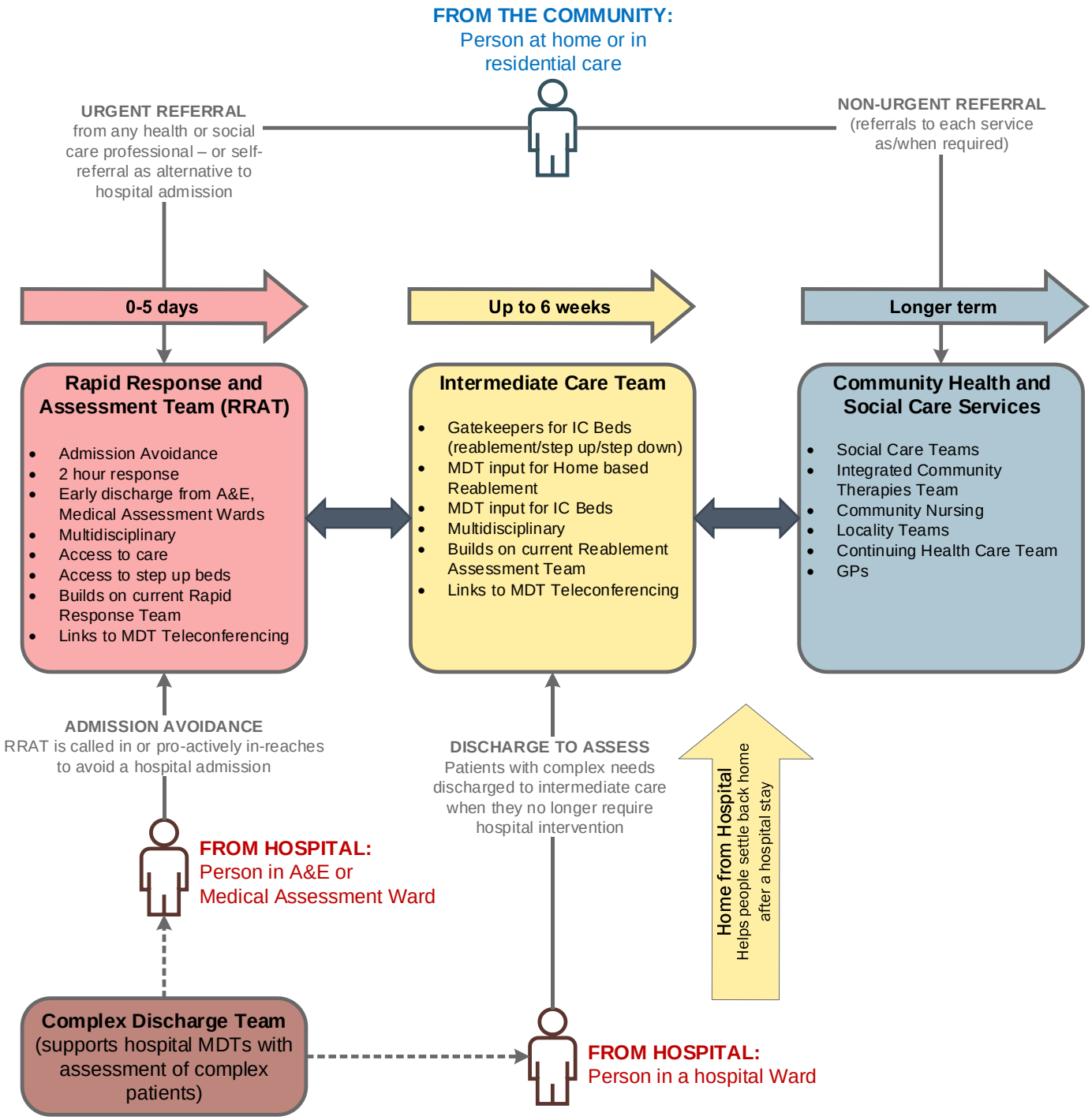
No.	Milestone	Date Completed
0.0	**Programme Management**	
0.1	Present overarching BCF Highlight reports and BCF Outcomes Dashboard to HACI Board.	Monthly
0.2	Engage all senior stakeholders (across LBH, CCG, providers, voluntary/community sector, and public/service user/carers) in development and review of BCF via the Operational Group -Adults.	Bi-monthly
0.3	Approve BCF finance and performance information, including decisions on the use of the contingency Fund at the Finance and Performance Partnership Board.	Quarterly
0.4	Undertake two large community events to engage the public, service users and carers in the pans and developments in the BCF.	Bi-annually
1.0	**Scheme 1: Admission Avoidance**	
1.1	Engage stakeholders across LBH, CCG, providers, voluntary/community sector, and public/service user/carers on development and review of BCF Admission Avoidance services and plans to reduce non-elective admissions via the Integration Implementation Group.	Bi-monthly
1.2	Complete evaluation of Locality Team and agree plans for next phase of implementation.	June 2016
1.3	Plans to build on and develop the joint health and social care assessment and planning tools used by the Locality Team for use by all health and social care services in Haringey.	Sept 2016
1.4	Finalise plans for supporting day opportunities for people with dementia to protect independence, developed through co-production with service users/carers	Sept 2016
1.5	Develop plans for closer synergy between Overnight District Nursing and Rapid Response to create a more efficient response	Oct 2016
1.6	Pilot work to prevent non-elective admissions from care homes building on existing BCF services	Oct 2016
1.7	Plans agreed for the development of broader community health and social care services (e.g. reshaping of community nursing and ICTT) to work in a more integrated way based on lessons from the Locality Team.	Nov 2016
2.0	**Scheme 2: Effective Hospital Discharge**	
2.1	Engage stakeholders across LBH, CCG, providers, voluntary/community sector, and public/service user/carers on development and review of BCF Effective Hospital Discharge services and plans to reduce DTOCs via the Intermediate Care Group.	Monthly
2.2	Complete business cases for next stage of development and expansion of three Intermediate Care Services: Rapid Response; Step Up/Down (bed based Reablement); Reablement (community based) and approve at Finance and Performance Partnership Board.	May 2016
2.3	Develop Intermediate Care Pathway to improve patient flow and outcomes through integrated intermediate care services	June 2016
2.4	Re procurement of Home from Hospital service completed	Sept 2016
2.5	Review Cavell Ward to support more integrated intermediate care	Sept 2016
2.6	Review impact of Mental Health Navigator on DTOCs	Oct 2016
3.0	**Scheme 3: Promoting Independence**	
3.1	Engage stakeholders across LBH, CCG, providers, voluntary/community sector, and public/service user/carers on development and review of BCF Promoting Independence services via the Promoting Independence Group.	Quarterly
3.2	Complete service evaluation of Neighbourhoods Connect and agree plans for next phase, supporting plans for social prescribing and care navigation	June 2016
3.3	Develop broader plans for a social prescribing model across Haringey	Sept 2016

No.	Milestone	Date Completed
3.4	Complete service evaluation of Supported Self-Management and agree plans for next phase	Jan 2017
4.0	**Scheme 4: Integration Enablers**	
4.1	Engage stakeholders across LBH, CCG, providers, voluntary/community sector, and public/service user/carers on development and review of an integrated workforce plan supporting workforce planning, education and development via the CEPN.	Monthly
4.2	Participate in the development of plans for a paper free NHS and Integrated Digital Care Record via the North Central London Digital Roadmap Steering Group.	Monthly
4.3	Complete outline business case for a Haringey Integrated Digital Care Record and approve at HACI Board	May 2016
4.4	Submit funding bid for Transformation Funding across North Central London to support the implementation of an Integrated Digital Care Record across Haringey	June 2016
4.5	Develop plans with Principal Social Worker to support system wide workforce transformation in line with Care Act 2014.	July 2016
4.6	Review 7-day working across all health and social care providers to determine progress with implementation, gaps in provision and corresponding actions	Sept 2016
4.7	Develop plans to link Disabled Facilities Grant into supporting BCF pathways	Oct 2016

Appendix 1: DTOC & MO Escalation Process



Appendix 2: Haringey Draft Intermediate Care Pathway



Appendix 3: Haringey's Draft Target Operating Model – Healthy, Long & Fulfilling Lives

Enabling Healthy, Long & Fulfilling Lives in Haringey **– A draft framework for developing an Integrated Target Operating Framework**

Objectives	1. *A healthier Choice is an Easier Choice*	2. *Strong Communities where Residents are Healthier and Live Independent Lives*		3. *Support at an Earlier Stage for those who are struggling*			4. *Those who need care will have responsive & high quality services*	
	5. Adults Safeguarded from Abuse							
Hypothesis: Adult Social Care	Evidence suggests done correctly 75% of all contacts to Adult Care could be dealt with in the community without the need for formal assessment or care			Additionally if Intermediate care is effective 90% of contacts could be supported without the need for long term formal care			10% who need support enabled to maximise their independence	
'Haringey's Key Lines of Defence' to Protect Independence Building blocks for the TOM	One **Early Help & Prevention**	Two **'Help To Help Yourself'**	Three **Community Offer**	Four **ACS Front Door**	Five **Reablement & Rehabilitation**	Six **Intermediate Care**	Seven **Assessment & Menu of Services (Market)**	Eight **Enabling Reviews & Re-provision**
	Carers Support (Information & Advise, Break from Caring Responsibilities, Carers Assessments, Carers PBs, Emergency Support)							
TOM & Associated Projects: Finalise & Launch *All to consider: 'One Council', Full H&C Integration, and NCL Options*	**Key Considerations:** Falls Prevention Targeted Health Promotion Regeneration Housing & Built Environment	**Key Considerations:** Digital Offer Website Offer Self Service for assessments IAG Community Assets Self Care	**Key Considerations:** Customer Service Remodelling 'Community Clinics' in libraries Assistive Tech Equipment Housing Support Community Navigators	**Key Considerations:** Predictive Risk Profiling Locality Teams Local Area/Care Coordination Self Management Social Prescribing	**Key Considerations:** Enablement (MH), Rehabilitation (Health) & Promoting Independence Reablement (OP/PD), Employment	**Key Considerations:** Rapid Response Bed Based Step up /Step Down Discharge to Assess	**Key Considerations:** Having the right 'Menu of Services' Personal Health Budgets	**Key Considerations:** Workforce, Practice, Training & Culture
Enablers	**Internal** Communications Workforce, Practice, Training & Culture Information Technology, Systems & Processes Data, Performance & Outcomes Monitoring				**External** Communications Coproduction, Engagement, Consultation Market Development			

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