NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Monday, 12th September, 2016, 6.00 pm - Haringey Civic Centre

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.

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

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

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

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

5. DECLARATIONS OF INTEREST

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

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

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

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

6. QUESTIONS, DEPUTATIONS, PETITIONS

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

7. MINUTES (PAGES 3 - 20)

To consider and agree the minutes of the meeting of the Board held on 19th May.

18:05-19:30
STRATEGIC DISCUSSION ITEMS

8. FUTURE HEALTH AND WELLBEING OF THE POPULATION (PAGES 21-24) 18:05-18:35 (30 minutes).

9. DEVOLUTION AND PREVENTION (PAGES 25-44) 18:35-18:55 (20 minutes).

10. VIOLENCE AGAINST WOMEN & GIRLS (PAGES 45-76) 18:55-19:30 (35 minutes).

19:30-20:00
BUSINESS ITEMS

11. REVIEW OF MEMBERSHIP AND TERMS OF REFERENCE (PAGES 77 - 90) 19:30-19:38.

12. COMMISSIONING PRIMARY CARE (PAGES 91 - 102) 19.38-19:46.

13. COMMISSIONING INTENTIONS (PAGES 103 - 108) 19:46-19:54.

14. SECTION 75 (PAGES 109 - 220) 19:54-20:00.

20:00-20:05

15. ACTION LOG (PAGES 221 - 224)

To consider the updated action log from the Board meeting on 19th May 2016.

16. NEW ITEMS OF URGENT BUSINESS

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

17. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are as follows:

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

Philip Slawther
Principal Committee Coordinator
Tel – 020 8489 2957
Fax – 020 8881 5218
Email: philip.slawther2@haringey.gov.uk

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

Friday, 02 September 2016

This page is intentionally left blank

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 Elin Weston
			*Cabinet Member for Finance and Health	Cllr Jason Arthur
	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

This page is intentionally left blank

MINUTES OF THE HEALTH AND WELLBEING BOARD
THURSDAY 19 MAY 2016

Board Members Present: Cllr Claire Kober (Chair), Councillor Jason Arthur (Cabinet Member for Finance and Health), Cllr Elin Weston (Cabinet Member for Children & Families), Dr Jeanelle de Gruchy (Director of Public Health), Sharon Grant (Chair, Healthwatch Haringey), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Cathy Herman (Lay Member, Haringey CCG) Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services) Geoffrey Ocen (Bridge Renewal Trust – Chief Executive).

Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Stephen Lawrence Orumwense (Assistant Head Social Care – Legal Services), 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. The Chair formally thanked Cllr Moron and Cllr Waters for their contributions to the Board.	
CNCL102.	APOLOGIES The following apologies were noted: • Sir Paul Ennals. • Dr Peter Christian	
CNCL103.	URGENT BUSINESS There were no items of Urgent Business.	
CNCL104.	DECLARATIONS OF INTEREST No Declarations of Interest.	
CNCL105.	QUESTIONS, DEPUTATIONS, PETITIONS No Questions, Deputations or Petitions were tabled.	

CNCL106.	MINUTES RESOLVED: That the minutes of the meeting held on 23rd February 2016 be confirmed as a correct record.	
CNCL107.	DISCUSSION ITEM IMMEDIATE CARE AND INTEGRATION A report outlining the importance of intermediate care in achieving Haringey's vision for integrated person-centred services, as well as the findings from a local review of intermediate care provision in Haringey was included as part of the agenda pack (pages 17-21). A copy of the presentation was also included in the agenda pack (pages 23-46). Dr Will Maimaris, Public Health Consultant introduced the report. Other contributors to the presentation were: Lynn Carrington Designated Nurse Children in Care Nurse – Whittington Health; A slightly updated version of the presentation slides was distributed as hard copies to the Board. Following the presentation the Board discussed its findings. Dr Maimaris advised the board that an aging population, where the majority of older patients had at least one long term condition, placed huge demand on hospital services and residential care placements. Furthermore, a significant proportion of older patients were being admitted to hospital when they did not necessarily need to be admitted, intervention at an earlier stage could have prevented those admissions or services could have been provided which meant that the person was supported in their own home. Integrated or person-centred care could improve quality of care for residents and also save money. In the vision for the Better Care Fund (BCF) submission 2016/17, the Council set out it's ambition to improve health and care through a reorientation of the way health and social care was provided in the borough, moving away from the model of reactive hospital-based care to a more proactive and integrated care in the community model. The Board noted clear synergies with Priority 2 in the Haringey Health and Wellbeing Strategy (increasing healthy life expectancy) and objective 1 of Haringey Council's Corporate Plan 2015-18; 'enable all adults to live healthy, long and fulfilling lives'. Dr Maimaris advised the Board that intermediate care was an extra layer of support in between low level GP-based community care services and long term care provided by hospitals. This extra support	

was ideally community based and was needed in response to when a patient had an escalation of need, such having had as a fall. The aim of which was to either keep that person out of hospital all together or to reduce the amount of time spent in hospital, whilst still receiving the required care. Other parts of the country had succeeded in boosting Intermediate care and had seen success in terms of reducing hospital admissions. The Board were advised that LB Waltham Forest had a very large rapid response service with over 20 nurses and it also had the lowest rate of hospital admissions across London. Evidence was starting to emerge from a number of authorities around the effectiveness and cost-effectiveness of intermediate care.

Dr Maimaris introduced Sue Gibbs, who managed the Rapid Response and the Ambulatory Care services at Whittington Hospital. Ms Gibbs outlined a number of examples of good practice in relation to intermediate care currently being undertaken in Haringey. The Board were advised that these were two stand alone teams, however they did work collectively. The Rapid Response service was a seven day service which provided health and social care to patients in their own homes, with the aim of reducing unnecessary hospital admission. The Service was staffed with community matrons who oversaw the recovery process and also provided short-term case management. The service normally provided care for a maximum of 5 days and could respond almost immediately with a visit by a matron who could initiate the nursing care management. As part of the service, Haringey Council could provide experienced care assistants; including over night carers for up to two nights and a carer visiting during the day for up to 4 visits. Ms Gibbs advised that the admission criteria were that the person had to live in the borough of Haringey and they had to be cleared as medically stable and by a GP or an A&E department. The referral to the Rapid Response service was via a phone call made from the GP, the A&E department or the Acute Admissions Unit.

Dr Maimaris introduced Marcelle Van-Tull, from BRT Home from Hospitals which also provided intermediate care services in Haringey. The Board were advised that the service looked after patients who were 50 and over and had been discharged from hospital and were also a resident in Haringey. The service provided practical support including; shopping, assisting with GP/outpatient appointments, a 'Check and chat service' providing friendly telephone calls to check everything is alright and signposting patients so that they did not have to return to hospital. There was a 91% non-readmission rate to hospital within 4 weeks for medical reasons.

Haringey currently invested 35% less than the national average in intermediate care services. Dr Maimaris gave the Board a summary position on the gaps within intermediate care within Haringey:

- Current services were 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.

Dr Maimaris identified a number of next steps identified from the review of intermediate care in Haringey being taken forward by the Health and Care Integration Board:

- Increasing 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. Linking to Safer, Faster, Better improvement programme at North Middlesex Hospital.

The Cabinet Member for Finance and Health enquired what would be needed to adopt a transformational approach as opposed to the proposed transitional approach and how long a transformational approach would take to implement. The Cabinet Member for Finance and Health also enquired how much funding from the Council would likely be required, in addition to the funding applied for from the BCF submission. In response, Dr Maimaris advised that in order to work at a faster pace, changes would be required of the whole system such as looking at how resources were spent across the whole system including hospitals to determine the best pathway. Dr Maimaris suggested that the next agenda items of the NCL Sustainability Transformation Programme and the Haringey and Islington Wellbeing Partnership could contribute to a transformation shift.

Sharon Grant, Chair Healthwatch Haringey, applauded the idea of developing an integrated intermediate care pathway in Haringey but enquired whether the plans were sufficiently ambitious and gave her support to investing in sufficient scale to produce the transformational shift required, particularly given the potential savings involved. Ms Grant also commented that there seemed to be a policy around intermediate care without a strategy behind it.

Zina Etheridge, Deputy Chief Executive commented that in terms of funding; in order to invest in the development of an intermediate care pathway, partners would need to disinvest in other aspects of service provision as there was only a limited amount of funding available. The Board were advised that because this resulted in a slow process, there

was an unavoidable impact on the ability to effect a transformational change. Any transformational change would require the whole system to shift how it operated and this would create inevitable barriers to achieving that shift and the pace at which it was implemented. Sarah Price, Chief Officer Haringey CCG echoed the comments of the Deputy Chief Executive, acknowledging that the Board would have to look very carefully of what was already being funded. Furthermore, any scaling up of services would need to be properly evaluated to ascertain what services were perhaps not delivering in the same way as for example the Rapid Response service and where the funding for that upscaling of services would come from. It would also be important to bring the patient and wider public along with us on any transformational shift to ensure that any shift was viable. It was proposed that the next step should include dialogue with patients to ascertain what services they would value most, as well as being part of a wider goal to measure outcomes instead of inputs.

Geoffrey Ocen, Chief Executive BRT, suggested that the Board should look at how other organisations had achieved the change required whilst still operating under comparable financial restrictions. Mr Ocen also enquired how well the different pockets of intermediate care were integrated and questioned whether signposting of patients involved links to community and wellbeing services. Dr Maimaris commented that attempting to integrate those services was an ongoing process and that there were clear links between this and say the social prescribing model discussed at the previous meeting of the Board.

Jon Abbey, Director of Children's Services commented that the non-readmission rate given in the presentation in relation to the Home from Hospital service was compelling. The Director of Children's Services also asked what LB Waltham Forest had done in order to create that shift in intermediate care. Dr Maimaris responded that they had been working on an integrated footprint in that part of London for the last four or five years and in order to achieve that transformative shift, there would have to have been some engagement with other services such as hospitals.

Cathy Herman, Lay Member Haringey CCG, commented that there seemed to be big pluses to be achieved from an integrated approach and from looking at the pathway as a whole. Ms Herman advised that in terms of looking at the transformation, the Board would need to consider this in the context of the whole North Central London area and the application for transformational funding due to the clear synergies involved. The Board were also cautioned that the challenge would be finding the upfront investment required to implement these changes and the clear savings involved.

Beverley Tarka, Director of Adult Social Services advised that she

	attended a recent finance and performance meeting around the Better Care Fund and that there had been an agreement in principle to increase investment based on an evidence based assessment of the intermediate care pathways. Enabling people to remain at home after discharge from hospital was a key outcome for Adult Social Services and the Board was advised that performance around this had risen from 76% to 91% in the last year, which was considered to be directly attributable to the intermediate work that had been undertaken. The Board were advised that a lot of detailed business case work and evidence base had been undertaken by Dr Maimaris and his team and this had enabled the Council to invest in additional funding for pathways for intermediate care. The Director of Adult Social Services advocated that further development of intermediate care services should be a key outcome for the Council and partners but acknowledged the critical element of being able to release money from the system in order to invest money more effectively.	
	Carol Gillen, Chief Operating Officer Whittington Health NHS Trust advised that often hurried decisions were made in acute care about people going into long term care because beds were at a premium. Ms Gillen advocated that intermediate care allowed patients to get home quickly and to maintain their independence. Ms Gillan also advised that she worked at Waltham Forest throughout the development of their intermediate care programme and that the present arrangements were a result of a lot of joint working that was initiated around 2003. The Board were informed that it took a long time to build those relationships in order to for the system to work. Richard Gourlay, Director of Strategic Development North Middlesex University Hospital NHS Trust, echoed the comments of Ms Gillen and emphasised the need to make decisions about long term patient care and ensuring that this was done in a joined up fashion, involving the families and in the most appropriate setting.	
	Dr Maimaris was asked to consider how the development of an integrated intermediate care pathway could be best monitored by the Board going forwards, particularly in terms of the Board playing a key role in ensuring a step change in intermediate care provision. Dr Maimaris stated that there was an existing project sitting within the CCGs governance structure and agreed to bring back an update on intermediate care to either September or December Board.	Will Maimaris
	In regards to the development of a strategy, officers advised that there was an intermediate care strategy developed as part of the Better Care Fund and that this along with the recommendations from the review, formulated a strategic approach to developing and scaling-up an integrated intermediate care pathway in Haringey.	
	The Chair thanked those present for their contributions.	

	RESOLVED: I). That the HWB supports the approach being taken by Haringey Council and Haringey CCG to develop and scale up an integrated intermediate care pathway in Haringey. II). That the Board members were asked to consider how their organisations could contribute to the development of an integrated intermediate care pathway in Haringey.	
CNCL110.	DISCUSSION ITEM HARINGEY AND ISLINGTON WORK A report was included in the agenda pack at page 47. Zina Etheridge introduced the report to the Board which provided information about a partnership that was being formed between NHS organisations and local authorities in Haringey and Islington. Ms Etheridge introduced Anni Hartley-Walder, Programme Director for the Wellbeing Partnership to the Board. Following the presentation the Board discussed the findings. The Board were advised that the partnership was made up of representatives of Haringey & Islington Councils, Haringey & Islington CCGs, Whittington Hospital and Camden and Islington Mental Health Trust and built upon some work that had been undertaken around bidding for NHS innovation funding. The Wellbeing Partnership looked at whether there were ways for the organisations to work together more effectively; to make sure that they were reshaping the health and social care economy across Haringey and Islington to support better quality outcomes for service users and to do so in a more financially stable way. The Deputy Chief Executive advised that the report was brought to the Board to outline the proposed governance arrangements, reflect on next steps and to highlight that there were significant benefits for residents in both boroughs to continue to work in a more joined up way. It was proposed that the Haringey & Islington Health and Wellbeing Boards would provide the overall governance for the programme and that on occasion the two Health and Wellbeing Boards would come together and meet as a joint body to provide high level governance. The Board noted that the constitutional arrangements for any joint meetings would need to be determined. The Deputy Chief Executive advised that the Wellbeing Partnership was a really important part of the overall NCL Sustainability & Transformation Plan and formed a key platform for governing and taking forward the reshaping of the health and social care economy locally. The Chief Officer Haringey CCG suggested that the Wellbeing Partnership would be an obvious home for some of the work being	

undertaken around outcomes based commissioning. The Board were advised that the themes of frailty in older people and diabetes care would benefit from being aligned together and then pulling them in to the value based commissioning work to ensure an alignment of incentives for all the organisations involved, to provide the desired outcomes such as keeping patients at home.

The Chair advised the Board that she had met with Richard Watts, the Chair of the Islington Health and Wellbeing Board along with the Wellbeing Partnership Sponsor Board on two occasions recently. The Chair fed back that the progress made in those two meetings was fairly heartening and that there was a significant improvement in coherence from the first meeting to the second. The Chair advised that at the last meeting it was agreed that the next step was to arrange a joint meeting of the two Health and Wellbeing Boards, ideally before the summer holidays to give the impetus and oversight that the project required. Clerk to look into holding a joint Health and Wellbeing Boards and possible dates prior to summer recess.

Clerk

The Lay Member Haringey CCG commented on the increasing focus on shared working between the Council and various partners and welcomed the impact of this on improving services for patients and residents. The Lay Member Haringey CCG also advised that the Board needed to be cognisant of what these proposals meant for the east of the borough and that the Board needed to acknowledge that would be a key question. The Lay Member Haringey CCG also commented on the significant number of governance structures involved in the process and advocated that this would need to be simplified in the future. The Deputy Chief Executive acknowledged the complex governance arrangements and suggested that these would only become sustainable when they became the way that the Board worked in its day-to-day functions. It was noted that the workstreams chosen were because they were absolute priorities for the authority and the Board would have to look at merging some of the governance strands to facilitate progress.

Sharon Grant, Chair Healthwatch Haringey, acknowledged the administrative benefits and financial drivers behind the Wellbeing Partnership but raised concerns about how the Board would ensure that patients and residents continued to have an input into the decision making process if decisions were increasingly taken by centralised bodies. Ms Grant also raised concerns about what would happen in the event of differing priorities and questioned how different needs across parts of the two authorities would be managed. The Board acknowledged the need for transparency and suggested that it was part of the reason behind the desire to bring the two Health and Wellbeing Boards together. The Chair advised that this would not require the merging of Haringey and Islington Healthwatch due to an acknowledgement that the two bodies would have different interests.

The Chair also commented that through being very clear about the four initial priorities for the partnership, 2 of which were more population based and 2 of which were of a clinical nature, the Board should be able to target the groups and individuals it wanted to regardless of location.

The Cabinet Member for Finance and Health enquired about the wider prevention piece and the extent to which determining factors such as housing, environment and education were fed into the governance structure. The Chief Officer Haringey CCG commented that the name Wellbeing Partnership was selected because of a desire to start with a much more preventative approach. The Chief Officer Haringey CCG advised that there was currently no incentive in the health system to tackle determining factors at a preventative level and that by aligning the two boards together it was hoped that levels of need could be driven down and risk factors tackled before they developed into more severe issues. The Deputy Chief Executive commented that a significant amount of work had been done as part of the cross-cutting mental health strand, looking at accommodation and employment pathways for people with severe and enduring mental illnesses which resulted in commissioning a support package to get those people into employment in a targeted way. The Board was advised that the partnership enabled them to understand some of the issues around determinants and the tensions contained therein, precipitating a wider conversation about what the earliest stage was that prevention measures could be in place collectively as a system. The Deputy Chief Executive acknowledged that the current work strands did not necessarily reflect these proposed developments due to it being at a an early stage but reflected that work was being undertaken to determine the pathways or population groups that required focus.

The Cabinet Member for Finance and Health further enquired whether, in feeding those issues into discussions, it would be primarily the Council that would be responsible for achieving this or whether the Board would look to bring specialists in, such as community sector representatives. In response, the Deputy Chief executive suggested that other Health and Wellbeing Boards regularly involved outside organisations and that hopefully this process would afford the Board more scope in determining whether it needed to involve specific groups for specific programmes.

The Chief Executive BRT commented that the BEHMHT did not seem to be included in the partnership and suggested that it seemed as though mental health did not appear as prominent in the work streams as physical health. The Chief Executive BRT also sought clarification on the stakeholder forum and how that might work. Clarification was sought how the process would link into the community and voluntary sectors.

The Chief Officer Haringey CCG responded that the officers were in discussions with mental health providers including BEHMHT about how they would tie into the process. The Board was given assurances that mental health would be at the heart of each of the areas looked at and that initial discussions had suggested that because it was so fundamental and overlapping to each area it was felt that having it as a specific work stream would have been unsuitable. The Chief Officer Haringey CCG agreed to ask Dr Maimaris' team to look at better reflecting the crucial role that mental health would play in the partnership's priority setting process. In relation to the stakeholder forum, the Chief Officer Haringey CCG advised the Board that a lot of groups had already been involved in the forum, particularly the disease based groups. The Chief Officer Haringey CCG acknowledged the ongoing need to develop a robust forum in which ideas could be tested out and a broad array of opinions included.

Sarah Price

The Chair of Healthwatch Haringey sought clarification around the integrated model of care for people with learning disabilities proposed as an immediate area of work, and how that would interact with the existing work being done in the borough and the role of the current steering group. Dr Maimaris advised that over the coming weeks and months partners would be looking to more detailed scoping of each of these proposals to try and build on what was happening in the borough. Dr Maimaris argued that in terms of mental health, they would consider which areas of work could really benefit from the added value of working on a shared Haringey and Islington footprint. Dr Maimaris also reassured the Board that mental health and wellbeing would be a key work stream undertaken. The Deputy Chief Executive commented that the physical health outcomes for people with learning disabilities were really poor and the partnership would be looking at the pathway as a whole, such as the transition from children to adulthood and the connection to physical health.

The Vice-Chair, Haringey CCG enquired about the extent to which links to schools had been considered, given the importance of promoting health and wellbeing from a young age. The Director of Children's Services responded that prevention was a key priority within the early help arena and acknowledged the need to work with partners to reach out to school children at a fairly early age. The DCS also commented on the need to capitalise on some of the existing work that was already being done in local schools and within the wider community.

The Programme Director for the Wellbeing Partnership commented that the wellbeing partnership gave partners the opportunity to upscale projects to make them transformational, utilising the combined focus of the local authority and health organisations. The Programme Director for the Wellbeing Partnership highlighted that the timing of this piece of work also seemed to be right given the clear links with the NCL STP and the need to have a repertoire of well developed schemes, on a

	transformational footprint, in place in order to access funding once it becomes available in April 2017. RESOLVED: I). That the Board 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. II). That the Board support the approach being taken by the Haringey and Islington Health and Wellbeing Partnership, noting the principles underpinning the 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.	
CNCL111.	DISCUSSION ITEM NORTH CENTRAL LONDON SUSTAINABILITY & TRANSFORMATION PLAN (STP) The Board received a report which provided an update on a new strategic planning approach being taken by NHS England and partners to ensure a whole system focus across health and social care. The new STPs will be produced in partnership with providers of health and care services, Councils and CCGs. The report was introduced by the Chief Officer CCG and was included in the agenda pack at pages 57-59. A presentation on the North central London STP was also included in the agenda pack at pages 61-70. Along with Barnet, Camden, Enfield and Islington, Haringey was working as part of the North Central London (NCL) STP footprint area. NCL has established a Transformational Board and Programme Management Office to oversee the production of the NCL STP, which was scheduled to be submitted at the end of June. The Board noted that the plan would look at how NCL could be financially sustainable over a five year period, how they could improve the health and wellbeing of residents and how they could improve the quality of	

services delivered over that five year period.

The Board was advised that the Chief Executive of Camden was pulling together the views of Councils across the five boroughs, whilst the Chief Officer of Camden CCG was the CCGs representative and the David Sloman who was the Chief Executive of the Royal Free Hospital was leading on the provider side. Meetings were taking place on a monthly basis with all representatives of health and social care from the five boroughs, with smaller groups meeting more frequently including the Director of Children's Services who was LBH's representative. The Chief Officer advised that current estimates suggested that a do nothing option would result in a funding shortfall of around £600m by 2020. The Chief Officer further advised that prior to submission of the STP the next steps were, an engagement exercise and the development of a communications plan. The Chief Officer commented that she would be speaking to individuals outside of the meeting for their inputs.

Sarah Price

The Lay Member CCG commented that there was a limit to the amount of consultation that can be undertaken on this project due to need to access transformation funding given the budgetary pressures involved and suggested that the only way to achieve the savings required was to work together collectively. The Lay Member CCG also drew the Board's attention to the Health Service Journal which contained Simon Stevens categorically backing David Sloman and highlighting that individual organisations would not be allowed to veto the STP. The article also stated that some form of consolidation across CCGs would be required. The Leader agreed with the points raised and commented that the Haringey and Islington Wellbeing Partnership was a very useful exercise in terms of laying the ground work for the STP and provided a base from which projects could be scaled up.

The Chair Healthwatch Haringey advocated that a broad consultation should be undertaken with the public around what their priorities were in the face of declining resources and increased need and raised concerns with a submission deadline of the end of June in light of the need to engage. The Lay Member CCG clarified that any consultation had to be undertaken carefully and within clearly defined parameters because there wasn't really a choice involved; as people may resent being consulted on something that was already a given and being driven by a top-down approach.

The Chief Officer Haringey CCG advised that the version of the plan at the end of June wouldn't necessarily be absolutely final and that there were rumours that a further submission would be required in October. In this scenario it was likely that the engagement process would primarily be undertaken in the Autumn.

	RESOLVED: I). To note progress made to date with regard to the NCL STP. II). To note the finalised NCL case for change will be brought to the Health and Wellbeing Board for endorsement.	
CNCL112.	BUSINESS ITEMS NORTH MIDDLESEX UNIVERSITY HOSPITAL TRUST'S FUTURE ORGANISATIONAL MODEL The Board received a report which outlined the proposed Memorandum of Understanding that had been put in place for North Middlesex University Trust (NMUH) with the Royal Free NHS Foundation Trust to explore becoming a founding member of the Royal Free London Group. This was part of a wider stream of vanguard development work happening nationally to look at hospitals working together to develop more sustainable models of care delivery. The report was introduced by Richard Gourlay, Director of Strategic Development NMUH and was included in the agenda pack at page 71. The Director of Strategic Development also gave a presentation to the Board. The Clerk agreed to circulate the presentation slides to the Board after the meeting. Mr Gourlay advised that the work around the drafting of the Memorandum of Understanding took place in April and the next steps would involve developing more detailed project plans and the establishment of a Partnership Board from early June. The Partnership Board would have a number of work streams sitting underneath it which would start to develop and design the model for the Royal Free London Group. The Chief Executive BRT asked for clarification on what benefits could be expected from this arrangement. Mr Gourlay advised that there were a number of benefits from the care provider's perspective, particularly around resilience such as staffing and capacity in specialist areas such as A&E. Mr Gourlay also advised that this would assist in the development of additional clinical pathways that would improve the quality of care across a range of services. The Deputy Chief Executive welcomed the proposals, advocating that any steps taken to improve resilience and patient care were clear benefits. The Deputy Chief Executive cautioned that the Board continued to monitor what the implications of that change model were going forward suggesting that for instance, it was important that the hospital did not become more divorced from the wider population	Clerk.

based measures that were being proposed.

RESOLVED:

I). That the Health and Wellbeing Board note the work that is underway between NMUH and RFL.

MENTAL HEALTH SURVEY-UPDATE

The Board received a report which outlined the main findings of the Mental Health and Wellbeing Survey undertaken in Haringey. A copy of the findings from the survey were attached as an appendix to the report. The report was introduced by Tamara Djuretic, AD Public Health and was included in the agenda pack at page 73 and the survey results were included at pages 77-155.

The AD Public Health outlined some of the key headlines from the findings:

- The survey was conducted in July last year and encompassed 1000 people being canvassed, 500 from across the borough and an additional 500 responses sought from the most deprived areas.
- The Haringey Mental Wellbeing Survey 2015 results would provide the baseline, with the specific aim of increasing the average short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score by 2018.
- Average WEMWBS score for adults in Haringey measured by a survey across the borough was 26.10 and in the most deprived areas was 26.21. Any score of 21 or less was regarded as low in Haringey, scores between 22 and 29, or 30 for most deprived was a moderate score and anything over 30 was regarded as a high score.
- Respondents between 16 and 24 years old were most likely to have low mental wellbeing in the “across area” sample, whilst 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.
- Good health and fewer medical conditions were associated with better mental wellbeing
- Employment was associated with better mental wellbeing, whilst 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.

The survey also explored the overall health of the residents in

relation to mental health and wellbeing. Some of the key findings identified were:

- The 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.
- The prevalence of cannabis use was approximately 6% across the borough and a 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%) and diabetes (5.3 – 6.5%).
- Those with three or more conditions had significantly lower mental wellbeing scores.

It was proposed that the survey was repeated on annual basis.

In terms of the next steps, the AD Public Health advised that as well as taking the Mental Health Survey to the Priority 3 Board, it would also be taken to the Priority 1 and Priority 2 Boards.

The Director Healthwatch Haringey commented that there seemed to be a lack of data broken down by ethnicity, advising that this seemed to be an important dimension of the mental health picture in Haringey. The AD Public Health advised that around 200-300 of the 1000 respondents provided their ethnicity details, as a result it was felt that the analysis would have been unreliable.

The Cabinet Member for Finance and Health enquired whether there was any information broken down by ward level. The AD Public Health responded that again, this was not done due to the relatively small sample size that would be created by breaking down the data on a ward level basis.

RESOLVED:

I). That the Board 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.

DEVOLUTION-UPDATE

The Board received a report which gave an update to the Board on the Sustainable Employment strand of the Devolution Prevention Pilot. The report was introduced by Tamara Djuretic, AD Public Health and was included in the agenda pack at page 155-161 and a copy of the

presentation slides were attached to the report, at pages 163-167 of the agenda pack. The AD Public Health introduced Vicky Clark, Head of Economic Growth and Development to the Board, who assisted in presenting this item to the Board.

The Board were advised that the pilot scheme would focus on the cohort of people with mental ill health as there was a clear need and a good evidence base that their health and employment outcomes could be improved. The main objective of the pilot was to support people who were 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. Early intervention was at the heart of the proposed model - preventing people from becoming unemployed in the first place.

The following comments were noted in relation to piloting the proposed early intervention model:

- Evidence suggested that length of absence from work, and employer status (Public/Private sector, large company vs. small and medium businesses) were the way to segment the cohort and this was reflected in our proposed model.
- The current intention was 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 introduced face-to-face support. Maximus would potentially be the source of the additional capacity required to run a small pilot.
- It was anticipated that the evidence gathered through a small pilot would enable the development of 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, were 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.

The Chair Healthwatch Haringey commented that she had concerns about the application of the Fit for Work programme and particularly in light of some of the mistakes made by ASOS. The Chair Healthwatch Haringey requested that the Board be kept up to date with the

progress of this work and an evaluation of its implementation. The AD Public Health commented that there would be a robust evaluation process and agreed to bring this item back to a future meeting of the Board. Ms Clark advised that the Fit for Work programme was unrelated to the previous Work Capability Assessment.

Tamara Djuretic / Clerk

The Director of Public Health advised that she recently spoke at a GLA meeting on the devolution piece, commenting that the prevention pilot demonstrated that Haringey was a borough committed to prevention and early help and that devolution was a mechanism to deliver these outcomes at a local level.

The Lay Member Haringey CCG welcomed the devolution pilot. The Lay Member Haringey CCG commented that she was not surprised to see that people in deprived areas were less well, as poverty was a real factor in determining health outcomes. The Lay Member Haringey CCG suggested that there could be scope to bring together cohorts of older people in more deprived areas with younger people, particular in regards to those with lower employment outcomes in a wider intergenerational piece of work that would have the potential to be transformational.

The Cabinet Member commented that he was struck by the extent to which environmental factors played a key role in physical health outcomes, such as physical health and feeling safe in your community. Cllr Arthur sought clarification on how the data might be used to prioritise these aspects and to do something differently in those areas.

RESOLVED:

I). To take note of the current proposed early intervention model and rationale, its potential scale and inherent risks.

II). To take note of the potential to collaborate with the Joint Work and Health Unit and Maximus.

III). To provide strategic support across the partnership to implement the pilot as part of the Health and Wellbeing Strategy.

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

TRANSFORMING CARE

A report was included in the agenda pack at pages 169-183, which provided an update on the joint response of the Haringey CCG and Haringey Council to the three-year Transforming Care expectations,

	developed by NHS England, the LGA and ADASS and publicised in October 2015. RESOLVED: I. To note report and the joint work to develop a three year plan for the delivery of the transforming Care programme.	
CNCL113.	URGENT ACTIONS TAKEN IN BETWEEN MEETINGS The Board noted the record of Urgent Action taken following the previous meeting regarding the Better Care Fund submission 2016/17. NEW ITEMS OF URGENT BUSINESS No new items of Urgent Business were tabled. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS It was noted that the future meeting dates were provisional: • 12th September 2016 at 18:00 • 8th December 2016 at 18:00 • 2nd March 2017 at 18:00	
CNCL114.		
CNCL115.		

The meeting closed at 19.50pm.

Cllr Claire Kober

....

Chair of the Health and Wellbeing Board

Report for: **Health and Wellbeing Board: 12 September 2016**

Title: **Future Health and Wellbeing of the Population**

Organisation: **Haringey CCG and Haringey Council**

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

1. Describe the issue under consideration

1.1 This report provides an update to the Health and Wellbeing Board on the work being undertaken at a local level around health and social care within Haringey; jointly between Haringey and Islington through the Wellbeing Partnership and; across North Central London through the Sustainable Transformation Plan (STP).

1.2 Haringey

1.3 In June 2016 the Joint Executive Team (JET) meeting replaced the Health and Social Care Integration (HACI) Board, which had been established to oversee a programme of service integration projects and the Better Care Fund (BCF). This was considered to be appropriate as service integration is now managed as business as usual, rather than a separate stream of work. To facilitate ongoing health and social care integration, a joint meeting of the CCG and Social Care executive teams has been established.

1.4 The following objectives for the Joint Executive team (JET) are:

- To set the strategic direction to achieve the joint objectives of the two organisations
- To review performance against joint key performance indicators
- To review and manage activity, escalating response to excess demand
- To jointly review the financial position of the two organisations, taking joint remedial action where necessary
- To set the strategic direction for further integration of the organisations

1.5 Haringey and Islington Wellbeing Partnership

1.6 A facilitated workshop was held on 1 September to support the partnership design needed to deliver a financially sustainable model for health and care, across the two boroughs, which will deliver high quality outcomes for our residents.

1.7 The workshop considered:

- The potential options for the design of a new Accountable Care Partnership structure
- The actions needed to successfully apply to the new round of national systems' 'Vanguards' just opened up for new bids this autumn
- Haringey and Islington Health and Care system and the North Central London Sustainability and Transformation plan (STP).

1.8 The workshop was attended by Haringey and Islington Councils, health, social care, clinical and care professionals, specialists, key local partners and community stakeholders.

1.9 North Central London (NCL) Sustainability and Transformation Plan (STP)

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.

1.9.1 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.

1.9.2 The current draft STP document was submitted in June and feedback from NHSE was that the Case for Change needed to provide further detail on the proposed framework. As a result it was agreed that there should be a meeting of senior leaders from the five Local Authorities in early September to discuss this.

1.9.3 During September and October there will be:

- Further development of the STP
- 21 October: Submission of the STP

2. Recommendations

That the HWB notes developments on health and social care locally, with Islington and across North Central London.

3. Appendices

None.

This page is intentionally left blank

Agenda Item 9

Report for: Health and Wellbeing Board – 12 September 2016

Title: Progress on the Healthy Environment Strand of Haringey Prevention Devolution Pilot

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

Lead Officer: Marion Morris, Head of Health Improvement
Eubert Malcolm – Head of Community Safety and Regulatory Services

Ward(s) affected: All

Report for Key/ Non Key Decision: Non Key Decision

1. Describe the issue under consideration

1.1 The Haringey Devolution Pilot has two workstreams - Healthy Environments (which is exploring the licensing powers needed to create environments that support health) and Sustainable Employment (increased support for people when they first seek help when their mental health is affecting their work). This report provides an update on the healthy environments workstream.

1.2 The aim of this workstream is to explore how devolution can provide local authorities with the powers needed to create healthier environments. We have prioritised our 'asks' in three ways:

- Tackling behaviours which have the biggest impact on Haringey's health and wellbeing priorities (tobacco and alcohol)
- Tackling issues where we are not yet clear on the extent of the health impact and where the local authority has limited power and there is limited regulation (betting shops/gambling, specifically Fixed Odds Betting Terminals (FOBTs)
- Considering areas where further devolved powers will enable 'good health' by supporting behaviour change through population level interventions.

1.3 A Business Case outlining our proposals was presented to the London Health and Care Devolution Programme Board at the end of July. Haringey will continue to work with London partners and national government over the coming months in refining the proposals. A final Business case needs to be submitted to the London Prevention Board by December 2016.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1 The Health and Wellbeing Board are asked to comment on the development of the Haringey devolution prevention pilot 'asks'.

4. Reasons for decision

4.1 Not applicable.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1 Haringey's Health and Wellbeing Strategy commits to using a range of policy levers to create an environment which prevents people from developing long term conditions – such as diabetes, hypertension and chronic respiratory disease – in the first place through measures such as strengthening tobacco control and a consistent approach to alcohol licensing. Our devolution 'asks', as part of the Healthy Environment's workstream seeks to build on this approach by increasing the powers available to the local authority.

6.2 We know from the academic literature and experience at a local borough level that there are three primary drivers that affect behaviour around alcohol, tobacco and gambling: affordability, accessibility and advertising. Our local focus has primarily been on influencing accessibility through licensing, an area for which local authorities have some responsibility. Our devolution pilot seeks to strengthen our ability to tackle issues of alcohol, tobacco and gambling through increased licensing powers.

6.4 Appendix 1 provides a detailed outline of the Healthy Environments asks.

6.5 Appendix 2 outlines how the Healthy Environments 'asks' contribute to Haringey's Health and Wellbeing Boards priorities.

7. Contribution to strategic outcomes

7.1 The Haringey devolution prevention pilot contributes to 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.

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

8.1 **Finance and Procurement**

8.2 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. Furthermore this report does not recommend specific actions that would have a direct additional financial implication at this time.

The Head of Procurement notes the content of the report.

8.3 **Legal**

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

8.5 All of the 'Asks' detailed in Appendix one to the report fall within the overarching purpose behind the London Health Devolution Agreement which the Council is committed to, and which is designed to transform health and wellbeing outcomes in London. The proposals also align with terms of the pilot topic which the Council has been asked to lead on, namely "exploring the use of existing flexibilities in planning and licensing to develop new preventative approaches to public health issues".

8.6 As the report acknowledges, the 'Asks' are going to require legislative changes in order to facilitate implementation of the proposals. In addition, where relevant, amendment to the Council's internal polices such as its Gambling policy will also be required. That said, there is currently a Bill making its way through Parliament which would enable the Council, as Licensing Authority, to restrict the number and type of category B2 gaming machines having regard to a new cumulative impact test – i.e. a power for Councils to limit the number of new betting shops and fixed odds betting terminals in areas already saturated with them. The Bill has the support of the Local Government Association.

8.7 In light of the above, the Assistant Director of Corporate Governance confirms that there are no legal or Constitutional reasons which would stop the Board from considering the recommendations contained in this report.

9 **Equality**

9.1 The Council has a public sector equality duty under the Equality Act 2010 to have due regard to:

- Tackle discrimination and victimisation of persons that share the characteristics protected under Section 4 of the Act. In the context of this report, these include the characteristics of age, disability, gender reassignment, 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.

9.2 The prevention pilot seeks to have a positive impact on reducing health inequalities. The pilot aims to prevent vulnerable people within Haringey's communities from developing long term health conditions caused by problem gambling, tobacco and alcohol misuse. The pilot will produce in-depth analysis for the prevalence of problem gambling and its health impact, as well as building an evidence base for introducing health as a 5th licensing objective. The studies will seek to gain a full understanding of the susceptibility of developing gambling problems and the associated health impacts for people who share different protected characteristics. They will also look at the impact of socio-economic and geographical factors. This will inform the ask for greater control and local approaches to prevention.

9.3 The pilot focuses on some of the key causes of early death and ill health – tobacco and alcohol which are more concentrated in deprived communities and in addition to the research outlined above seeks to address some of this inequality by using population level approaches to create healthier environments.

8. Use of Appendices

Appendix one – Healthy Environments Devolution Proposals
Appendix two – Presentation on the Devolution Prevention Pilot: Healthy Environments workstream.

7. Local Government (Access to Information) Act 1985

The London Health and Care Collaboration Agreement, December 2015.

Appendix 1: Healthy Environments: using licensing powers to shape healthy environments

1. Alcohol

Health as a 5th licensing objective (HALO)
Context • Health impacts are linked to levels of consumption – which is linked to availability; there is therefore a role for public health bodies to be actively engaged in the licensing process • The Licensing Act 2003 does not adequately allow health-related harms to be taken into account in alcohol licensing decisions or reviews • Haringey's alcohol landscape consists of an over concentration of off licenses, mainly in the east of the borough, where problem drinking is fuelled by the availability of cheap super strength alcohol.
'Ask': Health as a 5th licensing objective (HALO) • Health as a 5th licensing objective to enable local authorities to take health impact into account. This will allow Haringey and other local authorities to restrict the number of new premises selling alcohol if there is evidence of local alcohol related health problems.

2. Gambling

Greater local control of Fixed Odd Betting terminals
Context • The Gambling Act (2005) removed the controls limiting access and availability to many forms of gambling and required Local Authorities and the Gambling Commission to 'aim to permit gambling' • Current licensing and planning restrictions do not allow Haringey and other local authorities to influence the a) location, b) the hours, c) the number of fixed odd betting terminals and stakes • Betting shops and associated FOBTs have a disproportionate impact on more deprived communities and vulnerable individuals. In Haringey there is an over-representation of betting shops in the poorer parts of the borough
'Asks':

Greater local control of Fixed Odd Betting terminals

Design and deliver local solutions to tackle problem gambling

- Local Authorities and local betting shops need to work together to design and deliver responses to problem gambling that are appropriate for specific communities. This includes shifting power and resources to the local level which will help shift the focus of the gambling industry towards local cooperation
- Additional resources will allow local authorities to commission holistic and joined up services for problem gamblers.

3. Tobacco

3.1 Smokefree outdoor restaurants, cafes and pubs

Context

- Smokefree environments support smokers to quit (Hackshaw et al, 2010) and reduce the number of children taking up smoking by reducing exposure to smoking (Leonardi-Bee J et al, 2011).
- Opinion polls show strong public support for the Smokefree Legislation. 82% of respondents supported the smokefree legislation in the latest Smokefree Britain YouGov survey in 2014.
- Smokefree laws have been effective in improving health for example, a study of nine Scottish hospitals found a 17 per cent fall in admissions for heart attacks in the first year after the smokefree legislation came into force (Pell, et al 2008)

'Ask': powers for smokefree outdoor restaurants, cafes and pubs

- Current powers for mandatory smokefree places is covered by the Health Act 2006 and Section 4 of Part One of the Health Act 2006 and it is enforced by local Environmental Health departments
- Additional powers will need to be devolved by the national authority (Department of Health) under Section 2 of Part One of the Health Act 2006.

3.2 Licensing of tobacco products

Context

- There is currently no legislative framework covering the sale of tobacco products and retailers selling tobacco in England do not need a license despite the fact that it is a uniquely dangerous product, killing half of all long term smokers.
- Retailers can have their right to sell tobacco withdrawn through a restricted sales order if they are convicted of selling tobacco to a person under the age of 18 and if two other offences occurred in the preceding two years relating to the same premises. This is an over burdensome process and puts an excessive amount of pressure on already stretched enforcement teams.

'Ask': Introduction of a positive tobacco licensing system

- The introduction of a positive licensing system for the sale of tobacco products overseen by HM Revenue & Customs and the Department of Health

Appendix 2

Haringey LONDON

Health and Wellbeing Strategy

Priority 2: Increasing Healthy Life Expectancy

Devolution prevention pilot: Healthy Environment workstream

Health and Wellbeing Board – 12th September 2016

Haringey LONDON

Devolution to shape healthy local environments

- The aim of the Healthy Environments pilot is to explore how devolution can provide local authorities with the powers needed to create healthier environments so the healthier choice is the easy choice.
- The Healthy Environment pilot will increase Haringey's Health and Wellbeing Board ability to shape the environment and delivering **ambitions 3 and 4** at pace and scale

Healthy Environments

- The Healthy Environment work stream has prioritised the ‘asks’ for further powers in two ways:
  - tackling issues that have the biggest health impact in Haringey (tobacco and alcohol)
  - tackling issues where we are not yet clear on the extent of the health impact and where the local authority has limited power and there is limited regulation (betting shops/gambling)
  - Considering areas where further devolved powers will enable ‘good health’ by supporting behaviour change through population level interventions.

Summary of devolution 'asks'

Haringey LONDON

Powers to address problem gambling

- Greater local control of Fixed Odd Betting Terminals (FOBTs)
- Devolved funding for local solutions to tackle problem gambling

Health as a 5th licensing objective

- Establish health as a 5th licensing objective (HALO) to enable local authorities to take all health impact into account when considering licensing applications

Tobacco control powers

- Extend smokefree areas to smokefree outdoor restaurants, cafes and pubs
- Introduce positive licensing of tobacco products

Healthy Environments
HWB Priorities and ambitions

Haringey LONDON

Priority 2: Increasing healthy life expectancy

Ambition 3: Haringey is a healthy place to live

Ambition 4: Every resident enjoys long lasting good health

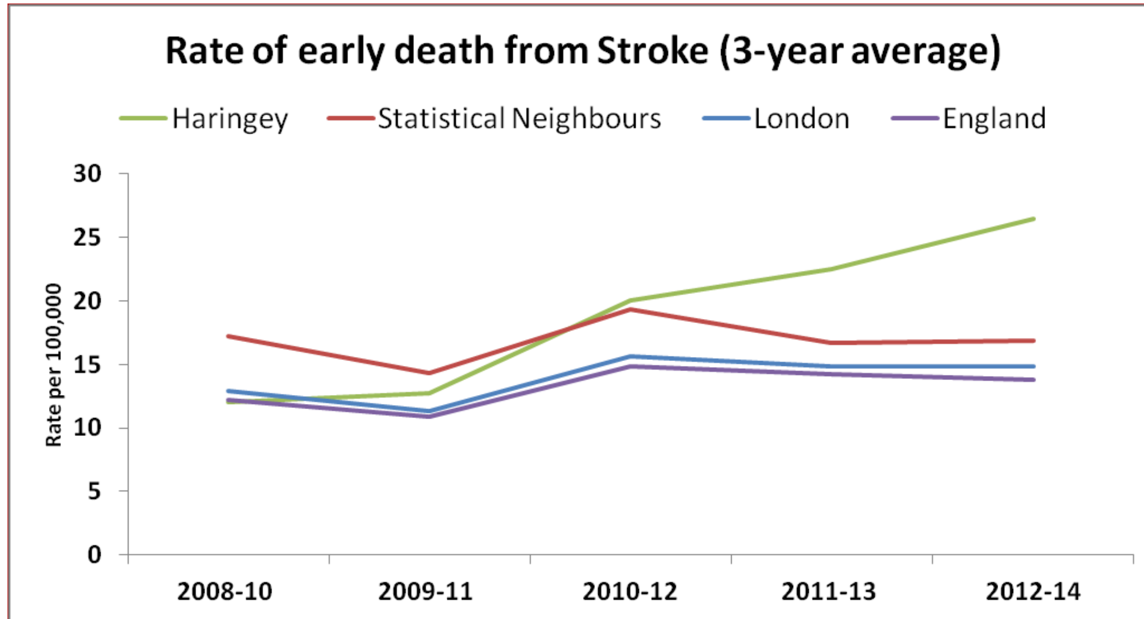
What are we going to do about it?

Create an environment that prevents people from getting long term conditions in the first place through measures such as strengthening tobacco control and a consistent approach to alcohol licensing Source: Health and Wellbeing Strategy (pg .9)

Haringey LONDON

Ambition 4: Every resident enjoys long lasting good health

Our target: a 25% reduction in early death from stroke by 2016-2018



Currently:
- Worst in London
- 2nd worst in England
- An increase by 120% from 2008-10 baseline, with an increasing trend.

Our target would mean a reduction in early deaths from 92 to 68 each year

Source: PHE (2014)

HWB discussion: a focus on tobacco and the smokefree outdoor restaurants, cafes and bars ‘ask’

Haringey LONDON

Smoking is one of the top **five** risk factors for early death & unhealthy life expectancy

Smoking is a major cause of stroke and heart disease

£ 70.7 million
The estimated cost of smoking to society in Haringey

Impact of Secondhand smoke

Ambition 4: Every resident enjoys long lasting good health

Ambition 3: Haringey is a healthy place to live

SHS exposure increases the risk of stroke
Source: CDC 2006 US Surgeon General Report

Secondhand smoke increases blood pressure which is a risk factor for stroke

0% There is no safe level of SHS. It can cause heart disease, stroke & lung cancer

£3.2m Cost of smoking to social care in Haringey
Source: ASH local Toolkit Study

Going smokefree saves lives

17% reduction in hospital admissions for heart attacks since the smokefree legislation was implemented in Scotland

More people in **disadvantaged** communities smoke

Making smoking less acceptable & more difficult encourages quitting & stops children from starting

Cigarettes are now smoked less in all areas except those which are outside
Source: Better Health for London Report,2014

Tobacco

Haringey LONDON

Smokefree outdoor restaurants, cafes and pubs

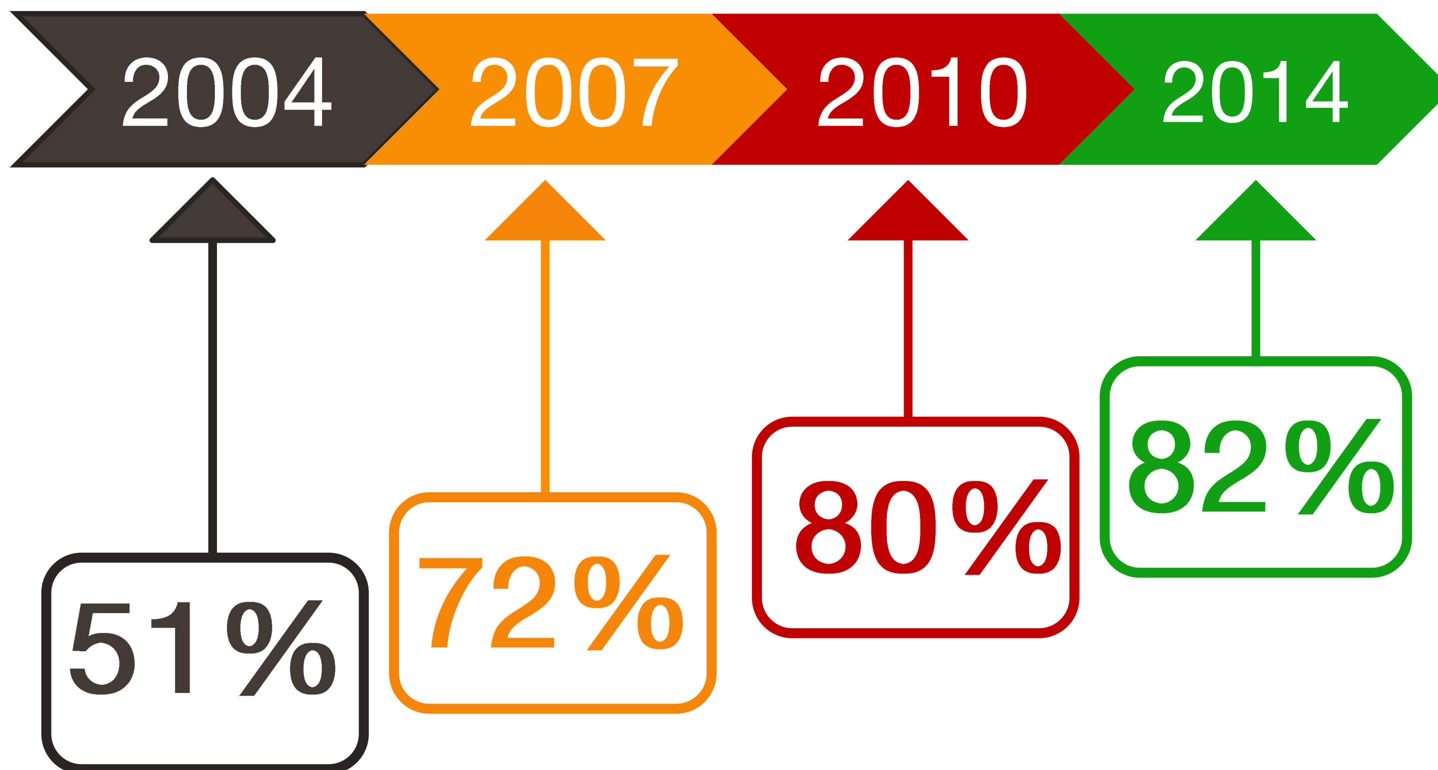
•Smokefree environments support smokers to quit (Hackshaw et al, 2010) and reduce the number of children taking up smoking by reducing exposure to smoking (Leonardi-Bee J et al, 2011).
•Opinion polls show strong public support for the Smokefree Legislation. 82% of respondents supported the smokefree legislation in the latest Smokefree Britain YouGov survey in 2014.
•Smokefree laws have been effective in improving health for example, a study of nine Scottish hospitals found a 17 per cent fall in admissions for heart attacks in the first year after the smokefree legislation came into force (Pell, et al 2008)

Devolution 'ask':

• Current powers for mandatory smokefree places is covered by the Health Act 2006 and Section 4 of Part One of the Health Act 2006 and it is enforced by local Environmental Health departments
•Additional powers will need to be devolved by the national authority (Department of Health) under Section 2 of Part One of the Health Act 2006.

Strong public support for smokefree places

Opinion polls show strong and growing public support for smokefree legislation



Source:
2004 - Mori
2007,2010, 2014 - YouGov

93% of people support smoking restrictions in restaurants

Source: Smoking-Related Behaviour and Attitudes Survey for 2008/09

Haringey LONDON

Health and Wellbeing Board discussion

- ➡ Discuss the development of the Haringey devolution prevention pilot ‘asks’ for the healthier environments workstream, in particular
- ➡ Consider the ‘ask’ for smokefree outdoor restaurants, cafes and bars

This page is intentionally left blank

Report for: **Health and Wellbeing Board – 12 September 2016**

Title: **Violence Against Women and Girls Strategy Consultation**

Report authorised by : **Dr. Jeanelle de Gruchy, Director of Public Health**

Lead Officer: **Fiona Dwyer, Viloence Against Women and Gilrs Strategic Lead**

Ward(s) affected: **All**

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

1. Describe the issue under consideration

1.1 To present the draft Violence Against Women and Girls (VAWG) Strategy which is currently out for consultation for discussion and input by the Health and wellbeing board. The particular focus for the HWB discussion will be on the impact of VAWG on children and young people.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1 The Health and Wellbeing Board members comment on the violence against women and girls strategy, and in particular how the Board can contribute to the delivery of the strategy.

4. Reasons for decision

4.1 Not applicable.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1 Introduction

Haringey's Violence Against Women and Girls Draft Strategy sets out our 10 year ambitions (2016-2026) for addressing and preventing violence against women and girls in Haringey.

6.2 The consultation on the strategy runs from 1st August 2016 to 30th September 2016. Our strategy covers 4 key priorities:

- Priority 1: Developing a Coordinated Community Response
- Priority 2: Prevention
- Priority 3: Support for victim/survivors[1]
- Priority 4: Holding perpetrators accountable

The Strategy will enable:

- All partners to be clear about our agreed priorities for the next 10 years and embed these within their own organisations and strategic plans, including joint plans
- All residents to understand and feel able to contribute towards making Haringey a safer and healthier place for all
- Victim/survivors to feel supported to seek help and empowered to lead safe lives, free from abuse
- Perpetrators to know that their behaviour will not be tolerated and where they can seek support for abusive behaviour.

The strategy has been developed in partnership with a wide range of statutory, voluntary and community organisations from across Haringey. We have utilised existing evidence around 'what works' in addressing and preventing violence against women and girls. We will ensure that we co-produce all of our action plans with communities and survivors to ensure that we deliver meaningful change.

6.3 What is Violence Against Women and Girls?

Violence against Women and Girls (VAWG) is both a form of discrimination and a violation of human rights. Locally we have adopted the United Nations Declaration on Elimination of Violence against Women, which defines violence against women as:

'Any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women [or girls], including threats of such acts, coercion or arbitrary deprivation of liberty' (1993, Article 1)

The definition incorporates a wide range of abusive behaviours including physical, sexual, financial, emotional and psychological abuse.

[1] We use the term victim/survivor rather than 'victim' or 'survivor' to recognise the different stages that people who have experienced VAWG are at in their journey to recovery and independence.

It is important that Violence against Women and Girls (VAWG) is not seen as a series of incidents or assaults which an individual experiences. Violence against women and girls describes violent and oppressive patterns of behaviour and practises, which achieve power and control over women and girls. It impacts on the physical safety, health and emotional well-being of individuals and impacts on families, carers, children and the community as a whole.

Violence against Women and Girls includes violence that is targeted at women or girls because of their gender or affects women and girls disproportionately. Examples of this type of violence are:

- Sexual violence, abuse and exploitation
- Sexual harassment and bullying
- Stalking
- Trafficking and forced prostitution
- Domestic violence and abuse
- Coercive and controlling behaviour
- Female genital mutilation
- Forced marriage
- Crime committed in the name of ‘honour’

6.4 The impact of violence against women and girls on children and young people’s health and wellbeing

The focus for the HWB discussion will be primarily on our response to the impact of VAWG on children and young people.

Abuse can affect every aspect of a child's life:

- Physical needs
- Emotional well-being
- Relationships with peers
- Relationships with others
- Leisure activities

Generally, preschool children are more likely to have physical symptoms of their anxiety, primary school children present their fears behaviourally and emotionally, and adolescents may try to gain relief through drugs, early marriage or pregnancy, running away or involvement in criminal activity.

Children and young people can be extremely affected by their experiences of living with domestic abuse. The impacts can be physical, behavioural, psychological or educational and they can also be long-term or short-term. The way that children can be affected depends on a wide range of factors including: age and developmental stage, gender, ethnicity, position within the family, sexuality, disability, their relationship with their mother, whether the abuse was direct or indirect, their access to safety and existence of support networks.

There is a growing recognition that experiencing violence in their home lives or their own relationships can have a significant impact on young people's ability to participate fully in school life and achieve academically as well as the huge impact on their physical and mental health from witnessing or experiencing abuse at home. Furthermore, children and young people are the next generation of potential victims and perpetrators of domestic abuse and wider forms of VAWG. We need therefore to have a strategic approach to prevention, with a clear focus on children and young people.

Working with schools and other youth settings is just one element of prevention. There is a need to embed longer term messages across the whole community through an integrated approach. The goal is to challenge attitudes that condone and underpin VAWG across the whole borough through a coordinated approach with all agencies. This is why a co-ordinated community response is also a priority in the new strategy. We need to make VAWG everyone's business.

6.5 What are we currently doing around prevention?

Haringey has funded the development of an innovative prevention programme aimed at young people under 24 – the Protect Our Women (POW) project. The programme is a 12 week programme with a peer training element for young people to become accredited peer learners. About 100 young people have been trained by the project.

Solace Women's Aid, who are the organisation commissioned to run POW, have also obtained Big Lottery funding to run a much larger-scale prevention programme across Haringey and Islington for 5 years from September 2016, which will dovetail with the existing commissioned service.

Our Healthy Schools programme has a focus on Female Genital Mutilation and Child Sexual Exploitation (CSE). Safer London provides two council-funded programmes aimed at schools and addressing child sexual exploitation (CSE).

Our newly commissioned perpetrator programme, which starts in September 2016, will also take referrals for young people who are exhibiting concerning behaviour towards partners or family members and will support the aim within the prevention priority of stopping violence against women and girls in the future.

7. Contribution to strategic outcomes

The Violence Against Women and Girls Strategy links to Haringey Council's Priority 3: Clean and Safe under which there is a specific objective around preventing violence against women and girls. The work around the Violence Against Women and Girls Strategy also links to Priority 3 in the Health and Wellbeing Strategy: Improving Mental Health and Wellbeing.

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

8.1 Finance

This report is consulting on a strategy, which would operate within whatever resources were available to support this area of work. The report is not seeking any additional funding.

8.2 Legal

There are no legal implications arising from the recommendations.

8.3 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.

VAWG affects women regardless of age, ethinicity, sexuality or disability and has a detrimental impact on their health and emotional well-being. An Equalities Impact Assessment (EqIA) will be completed and will inform the final strategy.

9. Use of Appendices

9.1 Violence Against Women and Girls Consultation
9.2 The impact of abuse on children and young people

10. Local Government (Access to Information) Act 1985

Not applicable.

This page is intentionally left blank

Violence Against Women and Girls Draft Strategy 2016-2026

Consultation

1 August – 26 September

Introduction

This strategy sets out our 10 year ambitions (2016-2026) for addressing and preventing violence against women and girls in Haringey.

The consultation on the strategy runs from 1st August 2016 to 26th September 2016.

Our strategy covers 4 key priorities:

Priority 1:
Developing a Coordinated Community Response

Priority 2:
Prevention

Priority 3:
Support for victim/survivors *

Priority 4:
Holding perpetrators accountable

The Strategy will enable:
- all partners to be clear about our agreed priorities for the next 10 years and embed these within their own organisations and strategic plans, including joint plans
- all residents to understand and feel able to contribute towards making Haringey a safer and healthier place for all
- victim/survivors to feel supported to seek help and empowered to lead safe lives, free from abuse
- perpetrators to know that their behaviour will not be tolerated and where they can seek support for abusive behaviour.

This strategy has been developed in partnership with a wide range of statutory, voluntary and community organisations from across Haringey. We have utilised existing evidence around 'what works' in addressing and preventing violence against women and girls. We will ensure that we co-produce all of our action plans with communities and survivors to ensure that we deliver meaningful change.

Why are we consulting on the violence against women and girls Strategy?

- We value your views on our proposals as we want you to help us develop these priorities so that they make a real and sustainable difference to the safety and wellbeing of Haringey's residents. Feedback from the consultation will help us develop a plan to implement the strategy.

* We use the term victim/survivor rather than 'victim' or 'survivor' to recognise the different stages that people who have experienced VAWG are at in their journey to recovery and independence.

- We want to encourage you to take part by reading this document and responding to the questions set out in the consultation chapter at the end.
- The full draft strategy is available at www.haringey.gov.uk/vawgconsultation

What is Violence Against Women and Girls?

Violence against Women and Girls (VAWG) is both a form of discrimination and a violation of human rights. Locally we have adopted the United Nations Declaration on Elimination of Violence against Women, which defines violence against women as:

'Any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women [or girls], including threats of such acts, coercion or arbitrary deprivation of liberty' (1993, Article 1)

The definition incorporates a wide range of abusive behaviours including physical, sexual, financial, emotional and psychological abuse.

It is important that Violence against Women and Girls (VAWG) is not seen as a series of incidents or assaults which an individual experiences. Violence against women and girls describes violent and oppressive patterns of behaviour and practises, which achieve power and control over women and girls. It impacts on the physical safety, health and emotional well-being of individuals and impacts on families, carers, children and the community as a whole.

Violence against Women and Girls includes violence that is targeted at women or girls because of their gender or affects women and girls disproportionately. Examples of this type of violence are:

- Sexual violence, abuse and exploitation
- Sexual harassment and bullying
- Stalking
- Trafficking and forced prostitution
- Domestic violence and abuse
- Coercive and controlling behaviour
- Female genital mutilation
- Forced marriage
- Crime committed in the name of 'honour'

What do we mean by community?

We see community as an umbrella term that covers groups of people who share common interests, faith, ethnicity, sets of experiences or who share a common characteristic such as living in the same neighbourhood, being in a particular population group or sharing a common culture.

What do we know about violence against women and girls in Haringey?

While we know that violence against women and girls is a major problem in the borough, it is difficult to get detailed information on how many women and girls this affects each year in Haringey as there is underreporting and many victim/survivors do not come to the attention of services.

However... we do know that:

- In the rolling year from April 2015 to March 2016: Haringey had the 5th highest rate of recorded domestic abuse in London (22 recorded incidents per 1000 population). There were 2787 domestic abuse incidents, a 21% increase on the previous 12 months. 592 sexual offences were recorded which represents nearly 10% increase in sexual offences from the previous 12 month period
- Of all contacts to Children and Young People Services in Haringey 70-80% involve domestic abuse.
- More than 1 in 5 women have been subject to stalking or harassment at some point in their lives. This means that 5000 women in Haringey will have been stalked.
- An estimated 3,500 women and girls are affected by female genital mutilation in Haringey, with 115 victim/survivors reported between April 2015 and March 2016 and we also know that there are high, but hidden levels of forced marriage and crimes committed in the name of 'honour'.
- The Everyday Sexism campaign which was set up to catalogue the experiences of women being sexually harassed on a regular basis has received over 100,000 submissions since its inception in April 2012.

What are we proposing to do, in partnership with the whole community, for the next 10 years?

Our vision over the next 10 years is for Haringey to become one of the safest boroughs in London for women and girls in which no form of abuse is tolerated.

Our ambitions are to develop a coordinated community response to Violence against Women and Girls where:

1. Community groups play a key role in building the resources of victims to help deliver lasting improvement in their lives.
2. Community groups and champions provide safe spaces for disclosure and know how to respond appropriately.
3. Views that condone or support violence against women and girls are challenged and changed.
4. Education and community initiatives promote positive attitudes.
5. All services are trained and supported to take active steps to identify signs of abuse.
6. All services are equipped to support victim/survivors in a way that delivers lasting improvement in their lives.
7. Perpetrators of abuse are held accountable for their actions and supported to change their behaviour.
8. Perpetrator programmes support the safety and recovery of victims.

What is our starting point?

Locally we have adopted some key statements to inform our response to violence against women and girls:

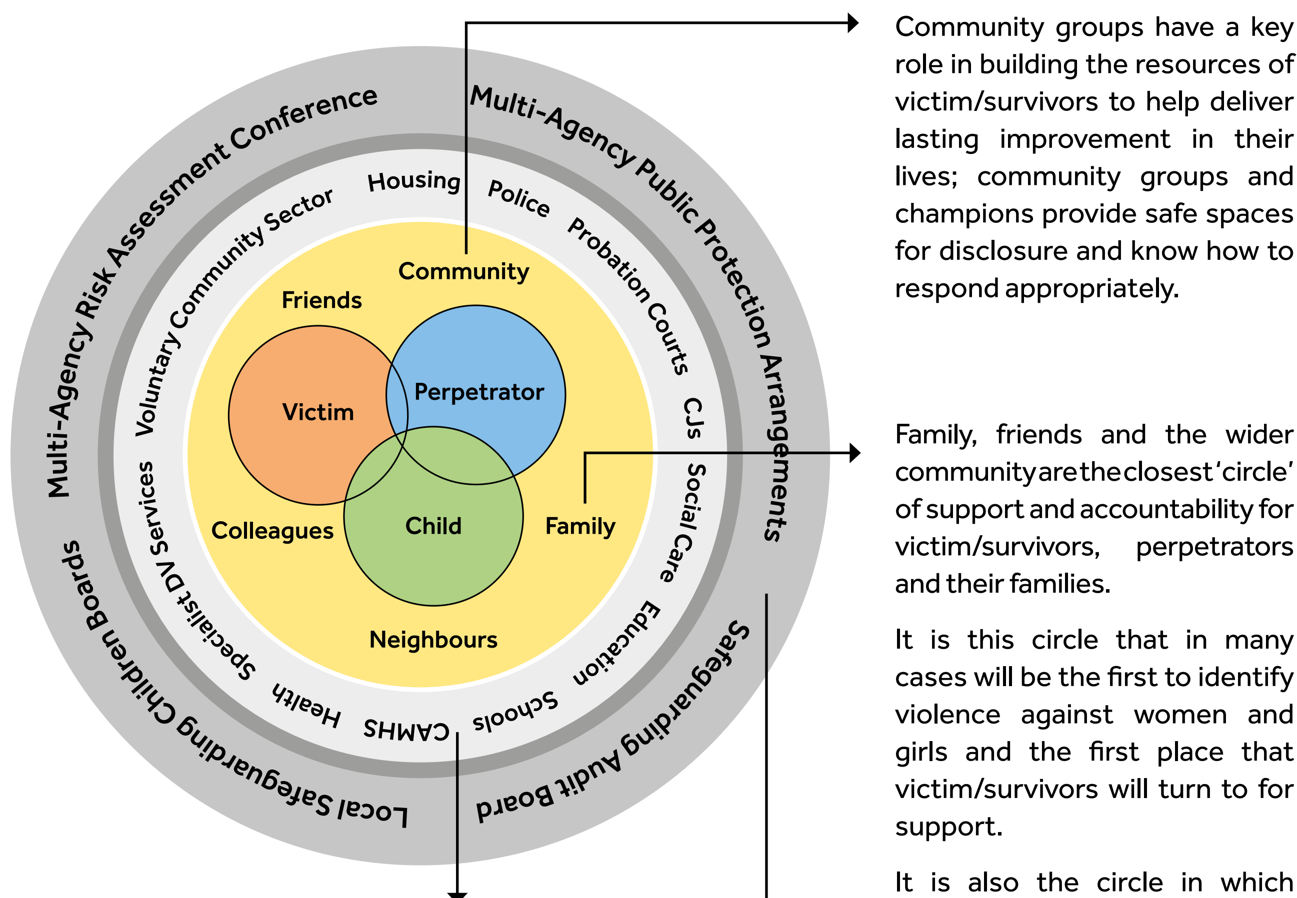
1. Violence against women and girls is an abuse of human rights.
2. Women and girls are disproportionately victims of the forms of abuse and crimes that are listed in the definition of violence against women and girls.
3. Too often women and girls are blamed for this form of abuse; the onus needs to be on our communities to create safe spaces where women and girls can disclose if they're experiencing abuse and seek support.
4. Perpetrators are responsible for their behaviour.
5. Perpetrators and abusers of violence against women and girls are overwhelmingly men, but men and boys can also be victims of some of these forms of violence.
6. Violence against women and girls is about power and control of women's behaviour and sexual agency by partners or family members, which reinforces gender inequality.
7. A coordinated community response, where agencies and the community work together, is the only effective way to prevent and respond to violence against women and girls.
8. Abuse can take place regardless of gender, class, income levels, ethnicity, faith, ability, sexuality or age although some people are at greater risk of some of the forms of violence including disabled women, young women, LGBT women and men and older women.
9. The forms of violence against women and girls are not discrete strands – they are often connected in a continuum of abuse. Victims often experience more than one form of this violence at any one time, or during their experience of abuse.
10. Haringey is an extremely diverse borough and a 'one size fits all' approach to supporting victim/survivors will not be effective. We need a person-centred approach to effect real change in the borough.

Priority 1: Coordinated community response

Why a coordinated community response?

- Our starting point: a coordinated community response, where agencies and the community work together, is the only way to prevent and respond to violence against women and girls.
- Our ambition: To have a coordinated community response to violence against women and girls in Haringey.

The Coordinated Community Response Model



Community groups have a key role in building the resources of victim/survivors to help deliver lasting improvement in their lives; community groups and champions provide safe spaces for disclosure and know how to respond appropriately.

Family, friends and the wider community are the closest 'circle' of support and accountability for victim/survivors, perpetrators and their families.

It is this circle that in many cases will be the first to identify violence against women and girls and the first place that victim/survivors will turn to for support.

It is also the circle in which the attitudes that facilitate violence against women and girls are 'located'. It is within the community that these attitudes are most effectively challenged.

The agencies in this circle are involved in a variety of capacities when help is sought by victim/survivors of violence against women and girls. They are the first professional points of contact where abuse can be identified and support given.

Information and Advice services must effectively signpost victim/survivors to the right support.

It is essential that training equips front-line staff to respond effectively.

There needs to be information sharing between partners so that support for victim/survivors is joined up.

The outer circle is where the safety and risk management procedures sit that take a multi-agency approach to supporting victim/survivors and holding perpetrators accountable.

What do we know?

- The elements of a coordinated community response (see diagram above) are in place – Haringey has a strong community that can be supported to address violence against women and girls.
- No single agency can be responsible for ending violence against women and girls.

Where do we want to be in 10 years?

- All victim/survivors have the confidence to disclose violence against women and girls; this triggers immediate efforts to connect victims to specialist support organisations to deliver long term, person-centred change.
- The wide range of community organisations, community centres, libraries, faith communities and informal support networks of mutual support work together in a coordinated way meaning the best outcomes for victim/survivors.

What are we, in partnership, going to do?

- Ensure that our model means that any disclosure of violence against women and girls will trigger immediate efforts to support the victim/survivor, including connecting them to community initiatives that can reduce their isolation, increase their confidence and provide them with a supportive network.
- Work with community groups to co-design the guidance and support they need to create safe spaces, deal with disclosures and connect victims to support.
- Develop a community response where everyone feels that they have a role to play – everyone feels 'this relates to me' when they see or hear communication messages about supporting friends and family or about safely holding perpetrators to account.

Priority 2: Prevention

Why is prevention a priority?

- Our starting point: violence against women and girls is an abuse of someone's human rights and must be prevented.
- Our ambitions: Views and behaviours that condone or support violence against women and girls are challenged and changed; Education and community initiatives promote non-abusive, healthy ways of relating.

What do we know?

- Violence against women and girls is a continuum of abuse (from sexual harassment through to homicide) defined by power and control, which reinforces gender inequality.
- Prevention is fundamentally about challenging and changing views and behaviours that perpetuate violence against women and girls and encouraging healthy ways of relating.
- Witnessing or experiencing abuse in their home lives or own relationships can have a significant impact on young people's ability to participate fully in school life and achieve academically.

Where do we want to be in 10 years?

- Everyone knows about all forms of violence against women and girls and everyone across all our services and communities is involved in preventing abuse.
- Haringey is a borough that has a zero tolerance to violence against women and girls and rates of reporting of all forms of violence against women and girls have increased but a shift in attitudes means that less violence is happening; robust data enables us to target interventions and assess their effectiveness.

What are we, in partnership, going to do?

- Work with all communities across the borough to ensure that everyone has the language to describe, and has an understanding about, what healthy relationships are and ensure that everyone is on message about not tolerating or condoning violence against women and girls.
- Ensure high quality relationship education in schools and other youth settings as well as providing resources for parents, carers and guardians; support the facilitation of youth champions/peer supporters, recognising that young people will often disclose abuse to other young people, and equip them with the skills, knowledge and experience to support other victims.

Priority 3: Support for Victims

Why is this a priority?

- Our starting point: Haringey is a diverse borough and a 'one size fits all' approach to supporting victim/survivors will not be effective. We need a person-centred approach to effect real change in the borough.
- Our ambitions: All services are trained and supported to take active steps to identify and respond to signs of abuse; services are equipped to support victim/survivors in a way that delivers lasting improvement in their lives.

What do we know?

- We know that victim/survivors often have to tell their stories up to 16 times before they are listened to and provided with support. We know that providing targeted interventions and a personalised approach at an earlier stage means better outcomes for victims as well as saving money for services.
- Victims of abuse face a range of barriers (financial, fear, multiple disadvantage, 'cultural' and so on), to reporting abuse and we need to support them to overcome these barriers to facilitate disclosure.

Where do we want to be in 10 years?

- Where violence against women and girls is identified in a family, risk and need assessment for all members of a family takes place at the same time and leads to wrap-around support for families.
- All interventions are trauma-focused and treat victim/survivors as individuals based on an understanding of their existing resources and vulnerabilities, and the resources they need to achieve independence.

What are we, in partnership, going to do?

- Ensure that safeguarding procedures include all violence against women and girls referral pathways and procedures, ensuring professionals and victim/survivors know how to access support to signposting.
- Ensure that women have a choice of specialist support services, designed with real survivor input, based on what they feel is the most appropriate and making sure that small, specialist organisations who provide support to particular groups (BME, disability, LGBT, older women etc.) are involved in the partnership.
- Facilitate all organisations supporting victims of violence against women and girls to develop skills practice around asking the right questions to elicit disclosures and to discuss risk and safety planning as well as exploring the victim's own wishes and feelings around support.

Priority 4: Perpetrator Accountability

Why is this a priority?

- Our starting point: perpetrators are responsible for their behaviour – it is a chosen intentional behaviour.
- Our ambitions: perpetrators of abuse are held accountable for their actions; the levels of violence they perpetrate decrease.

What do we know?

- Perpetrators of violence against women and girls are overwhelmingly men, but men and boys can also be victims of some forms of violence against women and girls.
- A multi-pronged approach with criminal justice interventions and support to change behaviour as well as support for the non-abusing partner has been proven to be most effective with perpetrators and reduce rates of violence against women and girls.
- In the wider context of violence against women and girls, perpetrators can be intimate partners but also wider family members, sometimes in collusion with the community.

Where do we want to be in 10 years?

- Haringey has zero tolerance to abuse; women and girls feel safe at home, in public places and on public transport.
- Haringey holds perpetrators to account through a range of interventions that decrease risks to victims and their wider family members, provide appropriate penalties, as well as provide specialist support to identify and change behaviour
- All services are equipped to recognise and address *patterns* of abuse, and identify perpetrators of coercive and controlling behaviour as well as recognising the 'charm bias' of perpetrators.
- Perpetrator programmes lead to sustainable behaviour change in perpetrators, and are connected to specialist services so that the safety of the victim/survivor is always maintained.

What are we, in partnership, going to do?

- Commission perpetrator programmes and fully integrate them into the wider response to violence against women and girls, so as to inform risk assessments, training for frontline staff, support for community groups, and delivery of communications campaigns.
- Ensure effective multi-agency working between perpetrator and children and young people services as well as wider family services are strengthened to increase perpetrator accountability.
- Work with the CPS and other criminal justice partners to increase the percentage of successful criminal justice outcomes for victim/survivors and increased accountability for perpetrators across all strands of violence against women and girls.

Haringey's Violence Against Women and Girls Strategy Consultation 2016

How can you respond to this consultation?

We are consulting on Haringey's Violence Against Women and Girls (VAWG) Strategy, a plan in which we set out our approach to addressing and preventing violence against women and girls.

We are proposing to focus on 4 priorities for the Violence against Women and Girls Strategy. These priorities are:

Priority 1:
Coordinated Community Response

Priority 2:
Prevention

Priority 3:
Support for Victim/Survivors

Priority 4:
Perpetrator Accountability

We would value your views on our suggested strategic priorities to ensure they make a real and sustainable difference to the lives of Haringey's residents.

Feedback from this consultation will be used to help develop a plan to implement the strategy.

Please complete the questions by the 26th September 2016 and e-mail your response to: **vawgconsultation@haringey.gov.uk** or post to Violence Against Women and Girls Strategy Consultation, Public Health Directorate, Level 4, River Park House, 225 High Road, London N22 8HQ. You can also complete the consultation online at **www.haringey.gov.uk/vawgconsultation**

Q1. Are you responding as a:

☐ Local resident

☐ Public sector organisation

☐ Local business

☐ Local community or voluntary sector organisation

☐ Other (please specify) ____________________

Q2. If responding on behalf of an organisation/business, please give the organisation's name

Priority 1: Coordinated Community Response

Q3. Looking at the CCR diagram (on page 6), how can we best support victims as a whole community?

Q4. What can we all do better to support victims?

Q5. Do you have any additional comments?

Priority 2: Prevention

Q6. Can you suggest other actions we can take to prevent violence against women and girls?

☐ No ☐ Yes (please specify below)

Q7. What is the best approach to take with young people to prevent violence against women and girls in the future?

Priority 3: Support

Q8. Are there any other ways we could better support victim/survivors?

☐ No ☐ Yes (please specify below)

Q9. What more could you do to support your friends/families and neighbours? What support would you need to do this?

Priority 4: Perpetrators

Q10. What do you think we should have as our approach to perpetrators?

Q11. How do you think we could best engage people within the community to safely tackle perpetrators?

Q12. Do you think we are missing anything important from our priorities?

☐ No ☐ Not sure ☐ Yes (please specify below)

About you

These questions help us understand who has answered this survey – the answers will be confidential. Please only answer if you are completing the questionnaire as an individual and as a Haringey resident.

Q13. What is your age?

☐ Under 18
☐ 18-25
☐ 26-35
☐ 36-45
☐ 46-55
☐ 56-65
☐ 66-75
☐ 75+

Q14. Do you consider yourself to have a disability?

☐ Yes
☐ No
☐ Prefer not to say

Q15. What is your sex/gender?

[ ]

Q16. What is your ethnic group?

☐ White - British
☐ White - Irish
☐ White Other - Greek / Greek Cypriot
☐ White Other - Turkish
☐ White Other - Turkish / Cypriot
☐ White Other - Kurdish
☐ White Other - Gypsy / Roma
☐ White Other - Irish Traveller
☐ Black or Black British - African
☐ Black or Black British - Caribbean
☐ Asian or Asian British - Indian
☐ Asian or Asian British - Pakistani
☐ Asian or Asian British - Bangladeshi
☐ Asian or Asian British - East African Asian
☐ Mixed - White and Black African
☐ Mixed - White and Black Caribbean
☐ Mixed - White and Asian
☐ Chinese
☐ Any other ethnic background (please specify)
☐ Prefer not to say

Q17. What is your religion?

☐ No religion
☐ Christian (including Church of England, Catholic, Protestant, & all other Christian denominations)
☐ Buddhist
☐ Hindu
☐ Jewish
☐ Muslim
☐ Sikh
☐ Any other religion (please specify)
☐ Prefer not to say

Q18. Which of the following options best describes how you think of yourself?

☐ Heterosexual or Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Other (please specify)
☐ Prefer not to say

Thank you for taking the time to complete this questionnaire.

Please complete the questions by the 26th September 2016 and e-mail your response to: **vawgconsultation@haringey.gov.uk** or post to Violence Against Women and Girls Strategy Consultation, Public Health Directorate, Level 4, River Park House, 225 High Road, London N22 8HQ. You can also complete the consultation online at **www.haringey.gov.uk/vawgconsultation**

We recognise that Violence Against Women and Girls may have affected you personally. If you need support after reading or completing this consultation, please contact:

National Support Services	Contact Details
National Domestic Violence Helpline	0808 2000 247 or www.nationaldomesticviolencehelpline.org.uk/
Men's Advice Line	0808 801 0327 or www.mensadviceline.org.uk/
Respect phone line (for perpetrators)	0808 802 4040 or www.respect.uk.net
Forced Marriage Unit	0207 0080151 or fmu@fco.gov.uk
IKWRO	0207 920 6460 or www.ikwro.org.uk
FGM Helpline	0800 028 3550 or www.childline.org.uk/fgm
Karma Nirvana	0800 5999247 or www.karmanirvana.org.uk
FORWARD (for FGM)	www.forwarduk.org.uk
Paladin (for stalking)	020 3866 4107 or www.paladinservice.co.uk

Haringey Support Services	**Contact Details**
IDVA Service	0300 012 0213 or www.niaendingviolence.org.uk
Solace Women's Aid	0808 802 5565 or www.solacewomensaid.org
Hearthstone	020 8888 5362
IMECE	020 7354 1359 or www.imece.org.uk
North London Rape Crisis	0808 801 0305 or http://solacewomensaid.org/get-help/north-london-rape-crisis/

If you provide services for victims of any form of violence against women and girls and want to get involved in our partnership, please let us know.

Haringey LONDON

Appendix 2

Impact of Abuse on Children and Young People[1]

Abuse can affect every aspect of a child's life[2]

- Physical needs
- Emotional well-being
- Relationships with peers
- Relationships with others
- Leisure activities

The most common impact is fear.

*Generally, preschool children are more likely to have **physical symptoms** of their anxiety, primary school children present their fears **behaviourally and emotionally**, and adolescents may try to gain relief through **drugs, early marriage or pregnancy, running away or involvement in criminal** activity.*[3]

Children and young people can be extremely affected by their experiences of living with domestic violence. The impacts can be physical, behavioural, psychological or educational and they can also be long-term or short-term impacts. The way that children can be affected depends on a wide range of factors including: age and developmental stage, gender, ethnicity, position within the family, sexuality, disability, their relationship with their mother, whether the abuse was direct or indirect, their access to safety and existence of support networks.

"*Children exposed to sudden, unexpected man-made violence appear to be more vulnerable – making the millions of children growing up with domestic violence… at great risk for profound emotional, behavioral, physiological, cognitive, and social problems*."[4]

Physical

Children and young people can be hurt, either by trying to intervene and stop the violence or by being injured themselves by the abuser. They may develop self-harming behaviour, or eating disorders. Their health could also be affected as they may not be being cared for appropriately (perhaps due to the mother not being allowed to parent well by the abuser).

---

[1] This section has been adapted from Dwyer, F. (undated) *Safe and Sound: A Manual for Professionals Working with Children affected by Domestic Violence*, Bristol: WAFE

[2] For a detailed discussion of the impact of domestic violence on children see Hester et al (2007) op cit., Wolfe, D., Crooks, C., Lee, V., McIntyre-Smith, A., and Jaffe, P., (2003), 'The effects of children's exposure to domestic violence: a meta-analysis and critique', *Clinical Child and Family Psychology Review*, 6(3), Kitzmann, K., Gaylord, N., Holt, A. and Kenny, E., (2003), 'Child Witnesses to Domestic Violence: A Meta-Analytic Review', *Journal of Consulting and Clinical Psychology*, 71(2) and Evans, S., Davies, C. and DiLillo, D. (2008), 'Exposure to Domestic Violence: A meta-analysis of child and adolescent outcomes', *Aggression and Violence Behavior*, 13(2).

[3] Hester et al, (2007), p. 89.

[4] Perry, B., Pollard, R., Blakley, T., Baker, W. and Vigilante, D. (1995) 'Childhood Trauma, the Neurobiology of Adaptation, and "Use-Dependent" Development of the Brain: How "States" Become "Traits", *Infant Medical Journal*, 16:4, p. 273

They may have suicidal thoughts or try to escape the violence through misuse of alcohol or drugs, truanting or by running away.

Sexual

There is a high-risk that children and young people will be abused themselves where there is domestic abuse. In homes where living in fear is the norm, an atmosphere of secrecy can develop and this creates a climate in which sexual abuse could occur. In addition to this, children may sometimes be forced to watch the sexual abuse of their mother. This can have a long-lasting impact on the sexual and emotional development of the child.

Economic

The mother of the child may have limited control over the family finances. Therefore, there might be little or no money available for extra-curricular activities, clothing or even food, which can have a detrimental impact on their health and development. It may also mean that children who go into refuge provision have to leave behind personal possessions, including toys, books, computers and so on which cannot easily be replaced due to lack of money. Separation can also lead to poverty for many mothers and children, especially if mothers deem that fighting their ex-partner for their house or possessions may adversely affect their safety.[5]

Emotional

Children will often be very confused about their feelings. They may, for example, love both parents but want the abuse to stop. They may be given negative messages about their own worth, which may lead to low self-esteem or depression. Many children feel guilty and believe the abuse is their fault. Some children may internalise feelings and appear passive and withdrawn whilst others externalise their feeling in disruptive behaviour. Any of these reactions could result in problems at school, for example becoming a victim of bullying, or engaging in bullying behaviours themselves as well as the negative impact that living with abuse can have on educational attainment.

Isolation

Children may become withdrawn and isolated. They may not be allowed out to play by the perpetrator and if there is abuse in the home, they are less likely to invite their friends around. Schooling may be disrupted by a variety of factors including: being too scared to leave their mother alone or they may have had to move schools when they are moved into refuge provision or other safe or temporary accommodation; disruption which can also make children vulnerable to bullying.

Threats

Children are likely to have heard threats to harm their mother. They may also have been directly threatened with harm or heard threats to harm their pet. They also live under the

[5] Abraham, (1994), *op. cit.*

constant and unpredictable threat of violence, resulting in feelings of intimidation, fear and vulnerability, which can lead to high anxiety, tension, confusion and stress.

Age-Specific Impacts on Children

"*Violence affects children's view of the world and of themselves, their ideas about the meaning and purpose of life, their expectations for future happiness and their moral development. This disrupts children's progression through age-appropriate developmental tasks*."[6]

Children will exhibit different impacts as a result of domestic violence depending on their age. A brief overview of some of the impacts on each age group is given below.

Unborn Children

Pregnancy is often a time when domestic violence either starts or escalates. Domestic abuse during pregnancy has been referred to by one commentator as, 'double-intentioned violence', as physical attacks directly affect both the mother and the unborn child.[7] The Confidential Maternal and Child Health Enquiry in England and Wales indicated that 39 percent of women experienced domestic abuse during pregnancy (n=70) and that 19 of the women died as a direct result of the abuse.[8] The Enquiry also found that 81 percent of women found it difficult to access ante-natal services; 77 percent were in contact with their local social services ; 64 percent of mothers and children were in contact with child protection services and that 62 percent of pregnant women under the age of 18 had experienced domestic violence in the home. An Australian population survey showed that 41 percent of women who experienced domestic abuse reported violence during pregnancy, and that 20 percent of these women who experienced domestic abuse reported that their first experience of violence was during pregnancy.[9]

There is also a very strong link between miscarriage and domestic violence with one study showing that women who were subjected to domestic violence in pregnancy were four times more likely to miscarry than women who had not been abused during pregnancy.[10]

Studies have also found that pregnancy is a time of increased risk with a significant association between pregnancy, miscarriage, low-birth rate and poor mother-child attachment and physical or sexual violence; abused women have said that they are more likely to be kicked in the abdomen or breasts during pregnancy.

---

[6] Margolin, G. and Gordis E. (2000), 'The effects of family and community violence on children', *Annual Review of Psychology*, 51, pp445-479

[7] Kelly, L (1994) 'The Interconnectedness of Domestic Violence and Child Abuse: Challenges for Research, Policy and Practice', in Mullender, A and Morley, R (eds.) Children Living With Domestic Violence, London: Whiting and Birch

[8] Lewis, G (ed.) (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH): Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer 2003-2005, London: CEMACH.

[9] ABS (2006) Personal Safety Survey, Australia, Australian Bureau of Statistics, Catalogue No 4906.055.003, Canberra

[10] Schornstein, S (1997) *Domestic Violence and Health Care: What every professional needs to know* , Thousand Oaks, California, USA: Sage and Campbell, J (2002) 'Health Consequences of Intimate Partner Violence', *Lancet*, Vol. 359

The health risks to unborn children resulting from domestic violence are extremely high. As discussed above, domestic violence often begins or escalates in pregnancy. Direct effects on the unborn child include: risk of miscarriage; placental abruption and premature birth. Studies have also shown that there is a link between the mother's fear, emotional trauma and stress and 'neuro-developmental' trauma.[11] Women may also be prohibited from attending ante-natal appointments and many are ambivalent about their pregnancy which has implications for their own self-care and also for attachment with their child. Indirect effects include other risk factors which may have implications for both mother and child including: sexually transmitted infections, urinary tract infections, HIV, substance and alcohol misuse, depression, smoking and low-weight gain.[12]

Infants

Infancy is a time when babies are completely dependent on others to look after them. As with unborn children there are direct and indirect impacts of domestic violence. Direct impacts include mothers holding the baby whilst being abused – having things thrown at her or being hit, resulting in injury to the child in arms; or mothers not being allowed to look after the baby, resulting in neglect. Indirect impacts on infants include hypersensitivity to noises around them – loud noises can be extremely distressing to infants. There may also be a disruption of attachment between mother and child due to the abuse. Research, by Perry especially, has shown that exposure to violence, stress and trauma associated with domestic violence can change the brain's development in infancy resulting in difficulties dealing with stresses later on in life. Changes in infants' behaviour include: sleep disturbances, irritability, minor illnesses, excessive crying and extreme startle responses.[13]

Pre-school

This can be the age at which children start to blame themselves for domestic violence in the home and is also the time at which children do not know how to express themselves fully. Children of pre-school age may learn unhealthy ways to express their anger and emotions from learned behaviour from their parents. They may also be confused about the paradox between what they are told and what they witness happening in their homes. They may display higher level of behavioural problems including self-destructive or aggressive behaviour.

Conversely, children at this age may also be extremely well behaved to compensate for what is happening at home. Physical symptoms at this age can be very wide ranging and include: regressive development including toilet training and bed wetting; sleep problems; failure to thrive and low weights and cognitive abilities; fear of touch or of a particular gender or person

---

[11] See for example the work of Bruce Perry, http://www.traumacentral.net/TC_brucedperry.htm (last accessed 11.02.11)

[12] Cunningham, A. and Baker, L. (2004) *What about me! Seeking to Understand the child's view of violence in the family*, Centre for Children and Families in the Justice System, London, Ontario, p. 56

[13] Perry, B., (2009) 'Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics', J*ournal of Loss and Trauma*, 14: 240-55

and language delay. Emotional impacts include: anxiety (especially about separation); withdrawal and clinginess.[14]

"*Important at this age is the learning of appropriate ways to express emotions to others, especially peers, and emotional self-regulation. They will also develop an understanding of gender roles from messages relayed by family and other sources such as the media*." (Cunningham and Baker, 2004:75)

School-age

"There may be serious effects on children who witness domestic violence, which can result in behavioural issues, absenteeism, ill health, anti-social behaviour, drug and alcohol mis-use, self-harm and psycho-social impacts" (HM Government, 2006:202)

School age children may also display extreme behavioural problems – both internal and external behaviours. Children at this age may start to rationalise what has happened much more and have a heightened sense of worry about their mother's safety and health. Some children may also try to escape the violence through fantasy and make-believe or by withdrawing. At this age education may suffer as a result of a range of factors including: learning difficulties (perhaps as a result of staying home to protect their mother or siblings), tiredness and inability to concentrate, lack of completion of homework. Relationships with other children may also suffer at this age as they will often not socialise or be able to invite friends home.[15]

Adolescents

"Adolescents exposed to domestic violence may live in constant fear of violence, arguments, being threatened, or actual physical violence being directed at a parent (usually the mother) or themselves."[16]

Adolescence can be a time of dual impact of domestic violence – both witnessing domestic violence at home and also experiencing it in their own intimate relationships. Adolescents may experience a wide range of impacts including:

- Prematurely adopt care-taking roles (for mother and siblings)
- Premature independence/emancipation from family
- Intervening in physical fights
- Diversions and interruption of normal trajectory to young adulthood
- Peer relationship problems: isolation, avoidance, risk taking

---

[14] Jaffe, P. *et al* (1990) op. cit. and Community Services, (2002), 'Domestic violence and its impact on children's development', New South Wales Government, Australia

[15] Baker, L., Jaffe P. and Asbourne, L., (2002), *Children Exposed to Domestic Violence: An Early Childhood Educator's handbook to increase understanding and improve community responses,* available at : http://www.lfcc.on.ca/ece-us.PDF (last accessed 22.08.14) and Child Welfare Information Gateway, (2003), *Children and Domestic Violence: Bulletin for Professionals*, US Department of Health and Human Sciences, http://www.childwelfare.gov/pubs/factsheets/domesticviolence.cfm, (last accessed 22.08.14)

[16] HM Government (2010) *Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children*, London: Department for Children, Schools and Families (DCSF) p.265

- Use of costly coping strategies such as drugs and alcohol abuse or self-harm
- Difficulty establishing healthy relationships (including potentially engaging in
- abusive peer relationships)
- Cognitive distortions
- All-or-nothing interpretations
- Pro-violence attitudes
- Negative gender-role stereotypes

Teenage relationship abuse consists of the same range of abuse and patterns of coercive and controlling behaviour as domestic abuse in older relationships. However, there is sometimes a lack of recognition as to the seriousness of teenage relationships because they are more likely to be short-lived. This does not mean that they cannot be as abusive as adult relationships – in fact research has shown that teenagers experience as much abuse in their intimate relationships as adults, with several studies showing that up to 40 percent experience abuse.[17]

A 2009 study by the NSPCC and Bristol University which questioned 1,353 young people (aged between 13 and 17 years old) on violence in their intimate relationships found that 33 percent of girls and 16 percent of boys reported some form of sexual abuse; 25 percent of girls (the same proportion as adult women) and 18 percent of boys reported some form of physical abuse and around 75 percent of girls and 50 percent of boys reported some form of emotional abuse in their intimate relationships.[18] (Barter *et al*, 2009)

Some lessons children might learn from living with domestic abuse[19]:

- The victim of violence is the one to blame
- Violence and threats get you what you want
- You can solve problems with violence
- Boys/men should be in control and girls/women should obey
- When people hurt others they do not get in trouble
- Hurting others (or yourself) is OK
- Women are weak, helpless, incompetent, stupid or violent
- Anger is the same as violence
- Drink, drugs make people violent
- A person can love you and hurt you at the same time. Love is dangerous
- Violence is not to be talked about
- Feelings are not talked about
- They (the children) are not important or lovable
- People don't have boundaries (boundaries don't matter)
- Life is unpredictable
- Anxiety / fear are part of everyday life
- People are either victims or aggressors

[17] Schutt, N. (2006), *Domestic violence in adolescent relationships: Young people in Southwark and their experiences with unhealthy relationships*, London: Safer Southwark Partnership; Sugar Magazine Poll (2005); End Violence Against Women (EVAW) (2006) UK Poll of 16-20 Year Olds. November 2006. ICM

[18] Barter, C., McCarry, M., Berridge, D. and Evans, K. (2009) *Partner exploitation and violence in teenage intimate relationships*, London: NSPCC

[19] Adapted from Baker and Cunningham, *op. cit.*

How can we understand the experiences of children in homes where they are witnessing abuse?

Lundy Bancroft argues that as professionals we need to consider the whole family context and the behaviours of the abusive parent, the non-abusive parent and the child. [20]

By understanding the abusive strategies that are directed at mothers by perpetrators

- Retaliating against her for her efforts to protect the children
- Sowing divisions with the family
- the favored child is particularly likely to be a boy
- Using the children as weapons
- Disabling the mother physically through violence so she is unavailable to her children
- Undermining the mother's authority
- Disabling the mother mentally through trauma and depression so she is emotionally unavailable
- Criticising and insulting the mother in front of the children which undermines their respect for her.

By understanding perpetrators of domestic violence as partners[21]

- Coercive, controlling, intimidating
- Self-centered
- Manipulative / Good public image
- Disrespectful, Superior, De-personalising
- Punishes, retaliates
- Sense of entitlement
- Justifies the use of violence and abuse, denies, blames

By understanding perpetrators as fathers[22]

- Usually authoritarian
- Under-involved (esp. with babies and toddlers)
- Neglectful, reckless
- Good under observation
- Psychologically and physically abusive
- Uses children to meet his own needs
- Sees children as personal possessions

By understanding the consequences of the abuse on the mother child relationship

- Lack of communication due to the ‘veil of secrecy’
- Children ‘out of control’ – poor discipline patterns in the family – too much or too little or inconsistent

[20] Bancroft, L. (2002) ‘The Batterer as Parent,’ *Court Review*, 36, pp. 44-49.

- Lack of appropriate boundaries with some children taking on ‘parenting’ or ‘carer’ roles
- A mismatch between children’s needs and their mother’s needs

By understanding the effects of abusive strategies on mothers as parents:

- woman believes she is an inadequate parent
- woman loses the respect of some or all children
- woman believes twisted excuses abuser provides for his behaviour
- woman changes her parenting style in response to abuser's parenting style
- woman's capacity to manage is thwarted or overwhelmed
- woman may use survival strategies with negative effects
- woman's bond to children is compromised
- woman gets trapped in competition for children's loyalties

Bancroft argues we can only direct effective support to families if we understand the impacts of abuse and direct support at the non-abusive parent and child.

Impacts / Indicators

VAWG has a range of impacts on young people including physical, psychological, social, emotional and behavioural effects.

Behaviour

- Aggression
- Criminal activities
- Secretive
- Change in physical appearance
- Spending less time with friends
- Constantly checking a mobile, and getting upset when asked to turn it off
- Withdrawn or quieter than usual
- Irritable when asked how things are
- Making excuses for a partner
- Relationships with peers/family
- Increase possibility for risky behaviour
- Substance use
- Recruiting others into exploitative situations
- Running away / missing
- Transference

World View

- Desensitisation to violence
- Labelling others

Health and wellbeing

- Sexual activity / Displays of sexual awareness beyond actual age
- Recurring urinary/vaginal infections
- Repeat sexually-transmitted infections
- Itching/soreness.
- Self-harm
- Bruises/scratches/bite mark
- Suicide attempts/depression
- Anorexia/Eating disorders
- Difficulty in walking/sitting
- Pregnancy / repeat pregnancy, termination
- Loss self esteem

Education

- A fall in standard of work or inability to concentrate
- Truancy
- Changes to attainment

Indicators

- Estranged from family
- Receipt of gifts from unknown sources
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking

This page is intentionally left blank

Report for: Health and Wellbeing Board – 12 September 2016

Title: Review of Membership of Health and Wellbeing Board

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

Lead Officer: Stephen Lawrence-Orumwense, Assistant Head of Legal Services

Ward(s) affected: All

Report for Key/ Non Key Decision: Not applicable

1. Describe the issue under consideration

1.1 At the Health and Wellbeing Board (HWB) meeting on 26th February it was agreed that a review of the membership of the Health and Wellbeing Board should be undertaken to ensure the right representation to provide system leadership for Haringey and its residents and to take account of wider developments across the local health and care system. Wider developments to be considered as part of the review included the introduction of five year Sustainability and Transformation Plans, the increasing collaboration between Haringey and Islington health and care economies, and the statutory footing of the Safeguarding Adults Board under the Care Act 2014. It was agreed that a paper setting out any proposed changes arising from the review be brought to a future meeting of the Board for approval and that following this, any revisions to membership should go forward to Full Council for approval. The review has also offered an opportunity to consider the Board's terms of reference to ensure they reflect the Board's current operations and support its future ambitions.

2 Cabinet Member Introduction

2.1 Not applicable.

3 Recommendations

3.1 It is recommended that:

a) The existing framework in the Board's terms of reference should be used to engage other partners or stakeholders to contribute to the workings of the Board as systems leaders;
b) The HWB reviews reporting links between the Board and other relevant partnerships or forums and considers ways in which these links could be strengthened to contribute to the workings of the Board;

c) The current Local Authority membership of the HWB should be amended to include the Deputy Chief Executive who has the strategic oversight of children and adult social care and public health;

d) The current membership of the HWB should be amended to include the Independent Chair of the Safeguarding Adult Board (with attendance at meetings when appropriate) and the membership of the Independent Chair of the Local Safeguarding Children Board should be on the same footing; and

e) The HWB terms of reference should be amended to reflect the Board's ambition to collaborate across borough boundaries and pan London and to enter into joint working arrangements in its area of responsibility with other HWBs and for the benefit of residents of the borough.

4 Alternative options considered

4.1 Consideration was given to whether further organisations should be represented on the Board. However, it was felt that Board was currently operating effectively with its existing member organisations and instead wider engagement of other stakeholders should be enabled through current engagement mechanisms within the Board's terms of reference.

5 Background information

5.1 Current membership of Haringey's Health and Wellbeing Board

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

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

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

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

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

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

c) Chair, Healthwatch.

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

Under the terms of reference, the Board is also able to set up workshop meetings or informal decision making seminars to facilitate its work. Workshops and seminars are intended to provide an opportunity to cement links with partners, to air complex and sensitive issues, or to manage potential blockages to delivery of the Health and Wellbeing strategy.

The Board's terms of reference as set out in the Constitution is attached to this report as Appendix 1. It covers the Board's functions, operating principles, roles and responsibilities, membership, meetings of the Board and the arrangements to facilitate the work of the Board (as mentioned above).

5.2 Wider developments impacting on Health and Wellbeing Boards

At its meeting in February 2016, the Health and Wellbeing Board requested a review of existing membership to ensure effective system leadership in light of wider developments across the local health and care system. Key developments which are potential drivers for the board when reviewing its membership include:

- Sustainability and Transformation Plans – 44 geographic footprint areas have been established across the health and care economy and are expected to develop sustainability and transformation plans setting out how health and care will be transformed over the next 5 years. Haringey is part of the North Central London footprint area. STP plans must be clear on how they will link to local Health and Wellbeing Boards and devolution plans and how existing plans such as Health and Wellbeing Strategies will be built on.

- Health and wellbeing devolution – Haringey is one of the signatories to the London Health and Care Collaboration Agreement and is leading on one of the

five devolution pilots within this agreement, focussed on local prevention. Within the agreement a commitment has been made to explore expanding the membership of the HWB to reflect the pilot's objectives.

- Islington and Haringey Wellbeing Partnership – To reflect greater collaboration across the Islington and Haringey health and care economy, the authorities are looking at scheduling joint meetings of their Health and Wellbeing Boards.

- The statutory footing of adult safeguarding – The Care Act 2014 put adult safeguarding on a statutory footing. From April 2015 each local authority has been required to set up a Safeguarding Adults Board with an Independent Chair and with core membership from the local authority, police and NHS and power to include other relevant bodies.

Within this wider context, Health and Wellbeing Boards will increasingly have to operate on multiple levels:

- Providing direct oversight for the health and wellbeing of the Haringey population, including through commissioning mechanisms

- Representing the health and wellbeing needs of the Haringey population at STP and London-wide level.

5.3 Comparisons with other Health and Wellbeing Boards in London

To inform the membership review, other local Health and Wellbeing Boards within London were contacted to explore their approach to membership. HWBs contacted included those in neighbouring boroughs as well as a selection of local areas which are leaders in terms of sub-regional collaboration, such as the tri-borough and Outer North east London (Barking & Dagenham, Redbridge and Havering). Boards were asked whether they had expanded their membership and what the drivers for doing so had been.

Membership varied across the authorities spoken to. Whilst some authorities had not departed from the statutory membership set out in Health and Social Care Act 2012, others had broadened their membership beyond this, for example to include NHS providers, voluntary sector representation, LSCBs, other officers (e.g. housing), or other public sector bodies (e.g. housing providers, the police).

In areas where they had expanded membership, authorities pointed to the positives of doing so, such as providing different perspectives on the board, strengthening discussions around specific themes, and holding key organisations to account. However, authorities also stressed that the reasons for expanding membership needed to be compelling and clearly underpin the purpose of the board; otherwise there was a risk that expanding board membership would dilute or distract from the priorities of the board, make the board's business unwieldy, or duplicate other engagement mechanisms.

Expanding Board membership was not always felt to be the best means of engaging with a wider group of organisations and a number of authorities referred to other mechanisms by which other organisations, such as providers, were linked to their board's work, including:

- Representation on subgroups looking in more detail at a particular theme, care pathway or client group
- As part of specific programmes for delivering change
- Through invitation to Board meetings for relevant items.

Other authorities were also asked about their response to new collaborative arrangements and how this was impacting on their Health and Wellbeing Boards if at all. The response from other authorities indicated there had been little impact on the governance of HWBs, with no evidence of a move to alter the sovereignty or geographical scope of HWBs. Authorities pointed to the continued importance of local democratic accountability and the principle of subsidiarity in terms of planning. However, it was recognised that HWBs needed to influence the development of STPs and some were contributing directly to the development of governance arrangements within their footprint area and had sought to align their Health and Wellbeing strategy and JSNA with the development of STPs.

6 Conclusions

Strengthening relationships with a range of organisations is crucial to the Health and Wellbeing Board's ambition to develop a systems leadership approach to health and wellbeing. Changes in the health and care economy also mean that the HWB must become more outward looking, extending their influence at the sub-regional and regional level. Although Health and Wellbeing Boards increasingly need the ability to influence and improve accountability across the health and care economy, expansion of Board membership is not necessarily the best way of achieving this aim. The most effective Boards are likely to employ a range of mechanisms to engage with key organisations and promote collective leadership around local health priorities. Haringey's HWB existing terms of reference already provide clear mechanisms for engagement with a wider range of organisations, such as through informal seminars, workshops or through invitation to attend Board meetings.

Haringey has not to date expanded its membership much beyond the core statutory membership set out in the Health and Social Care Act. However, there is a general consensus that the HWB has moved to a point where it is operating effectively and this is due in part to its tight membership and focus. Given the changing landscape around health at the moment, it is also important to retain a strong focus on Haringey in the short to medium term. Whilst it will be important for the Board to engage with a wider range of organisations, it should be noted that the existing terms of reference for the Board already provide mechanisms that support wider engagement.

It is therefore recommended that the Board should explore how it can strengthen its use of existing mechanisms for engaging with a wider range of partner organisations and other stakeholders. The Board should consider as part of its agenda setting process which organisations should be engaged from a systems leadership perspective and how existing mechanisms can be used to engage with them to contribute to the workings of the Board. Also, the Board should consider how links with other relevant partnerships and forums could be strengthened.

The review of the Board membership noted the Deputy Chief Executive by invitation was a regular attendee and contributor at Board meeting and was not listed as a member of the Board. The review acknowledged that the Deputy Chief Executive has strategic responsibility for the Local Authority children and adult social care and public health functions and should be a member of the Board.

The Independent Chair of the Local Safeguarding Children Board is listed as a member of the Board so as to ensure that the children wellbeing and safeguarding agenda is taking into account in the strategic role of the HWB. With the Care Act 2014 and the creation of the Safeguarding Adult Board chaired by an independent person, the review acknowledged that the Independent Chair of the Safeguarding Adult Board should also be a member of the HWB to ensure due consideration is given to the adult safeguarding agenda. But for both Independent Chairs, attendance at Board meetings should be for agenda items that they consider relevant to their function.

As mentioned in Paragraphs 5.5 and 5.6 above, the wider developments across the health and social care economy means that the Board has to operate on multiple levels - locally, across borough boundaries and pan London. This position should be reflected in the Board's responsibilities. Therefore, the review recommended that the Board's terms of reference should be amended to reflect the Board's ambition to collaborate across borough boundaries and pan London and enter into joint arrangements in its area of responsibility and for the benefit of residents of the borough.

7 Statutory Officers comments

Finance and Procurement

Not applicable.

Legal

Section 194 of the Health and Social Care Act 2012 provides for the establishment and membership of the Health and Wellbeing Board. The Board's membership must include the director of children's services, the director of adult social services and the director of public health. There must be at least one elected representative, which may be the leader of the local authority and/or councillors nominated by the Leader.. The local Healthwatch organisation and each relevant CCG must also appoint representatives. The section enables the Board to appoint additional

persons as members. The local authority is also able to invite other persons (other than councillors) or representatives of other persons to become members. The local authority must consult the Health and Wellbeing Board before appointing additional persons after the Board has been established. *The Board's current membership meets the statutory requirements.*

The additional members recommended to be appointed to the Board will be non-voting members.

Section 198 of the Health and Social Care Act 2012 allows two or more Health and Wellbeing Boards may make arrangements for any of their functions to be exercised jointly. The recommended changes to the Board's terms of reference to permit collaboration across borough boundaries and enter into joint working arrangements with other HWBs will require the approval of Full Council.

Equalities

Not applicable

8 Use of Appendices

Appendix 1: Current Terms of Reference of the Haringey Health and Wellbeing Board.

9 Local Government (Access to Information) Act 1985

Not applicable.

This page is intentionally left blank

Appendix 1

Health and Wellbeing Board functions

The Health and Wellbeing Board will have the following functions:

(a) To carry out the Board's statutory duties as set out in the Health and Social Care Act 2012, in particular:

(i) for the purpose of advancing the health and wellbeing of the people in its area, to encourage persons who arrange for the provision of any health or social care services in its area to work in an integrated manner;

(ii) to provide advice, assistance or other support as it thinks appropriate for the purpose of encouraging arrangements under section 75 of the NHS Act. These are arrangements under which, for example, NHS Bodies and local authorities agree to exercise specified functions of each other or pool funds;

(iii) to encourage persons who arrange for the provision of any health-related services in its area to work to closely with the Health and Wellbeing Board;

(iv) to encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together;

(v) to discharge the functions of CCGs and local authorities in preparing joint strategic needs assessments (JSNA) and joint Health Wellbeing Strategy (HWB strategy);

(vi) to inform the local authority of its views on whether the authority is discharging its duty to have regard to the JSNA and joint HWS in discharging its functions;

(vii) to discharge any other function as the Council may from time to time choose to delegate to the Board.

Health and Wellbeing Board operating principles

The Health and Wellbeing Board will have the following operating principles:

(a) To provide collective leadership and enable shared decision- making, ownership and accountability;

(b) To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making in an open and transparent way;

(c) To ensure the delivery of the Health and Wellbeing Strategy;

(d) To reduce health inequalities;

(e) To promote prevention and early help.

Health and Wellbeing Board roles and responsibilities

The Health and Wellbeing Board will have the following roles and responsibilities:

(a) The Board will set a strategic framework for the authority's statutory duties and have a key role in promoting and coordinating joint commissioning and integrated provision between the NHS, social care and related children's and public health services in Haringey;

(b) The Board has a duty to develop, update and publish the JSNA and related needs assessments, and the HWB Strategy;

(c) The Board has a duty to develop, update and publish the local pharmaceutical needs assessment as set out in section 128A of the NHS Act 2006;

(d) The Board will advise on effective evidence based strategic commissioning and decommissioning intentions for children and adults based on the JSNA's robust analysis of their needs. It will ensure that commissioning plans are in place to address local need and priorities, in line with the HWB Strategy, and will deliver an integrated approach to the planning and delivery of services;

(e) The Board expects, and seeks assurance from, partners that the views of children, adults and their carers about the services they receive are taken into account in the commissioning, decommissioning and delivery of those services;

(f) The Board expects, and seeks assurance from, partners that the views of patients and the public have a voice through Healthwatch in the commissioning, decommissioning and delivery of those services;

(g) The Board will collaborate with and involve local stakeholders to secure better health outcomes, quality of services, a more focussed use of resources and value for money for the local population;

(h) The Board will promote the strengthening of working relationships between professionals and organisations which support people in Haringey, ensuring effective sharing and use of information and best practice; including collaborating with the CCG in the development of its plan;

(i) The Board will lead commissioning for particular services with pooled budgets and joint commissioning arrangements where commissioning plans are delegated to them;

(j) The Board will oversee the delivery of the authority's strategic outcomes for

local health and wellbeing targets, holding those responsible to account;

(k) The Board will work with the local health scrutiny process and the local Healthwatch to improve outcomes for communities and people who use services.

Membership of the Board

Meetings of the Board will be chaired by a member of the local authority:

- Local authority councillor(s), who will be (or be nominated by) the Leader of the Council
  - (i) The Leader of the Council
  - (ii) The Cabinet Member for Children and Families
  - (iii) The Cabinet Member for Health & Wellbeing

- Chair, Clinical Commissioning Group (Vice Chair of HWB)
- Chair of Healthwatch
- Director of Adult and Housing Services
- Director of Children and Young People's Services
- Director of Public Health
- Chief Officer, Clinical Commissioning Group
- Lay Board Member, Clinical Commissioning Group
- GP Board Member, Clinical Commissioning Group
- HAVCO representative
- Representative for the NHSCB (when required)
- Chair - Haringey Local Safeguarding Children Board

The local authority may appoint others to the Board as it deems appropriate, following consultation with the Board. The Board may itself also appoint such additional members to the Board as it deems appropriate.

The Board may invite additional officers to attend on an ex-officio basis, who will not be voting members of the Board, to advise and guide on specific issues when appropriate. Attendance by non- members is at the invitation of the Chair.

Public Meetings

(a) A minimum of four formal public decision-making business meetings a year will be held. The Board will have the ability to call special meetings as and when required.

(b) A meeting of the Board will be considered quorate when at least three voting members are in attendance, including one local authority elected representative and one of either the Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes).

(c) The Chair of the meeting will have a casting vote.

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

(e) Board members will agree protocols for the conduct of members and meetings.

(f) The Board will determine its sub groups/committees.

(g) Only the following members of the Board will have voting rights:

- Local authority councillor(s), who will be (or be nominated by) the Leader of the Council
  - (i) The Leader of the Council
  - (ii) The Cabinet Member for Children and Families
  - (iii) The Cabinet Member for Health & Wellbeing

- Chair, Clinical Commissioning Group (Vice Chair of HWB)
- Chair, Healthwatch
- Lay Member Haringey Clinical Commissioning Group

(h) Any additional persons appointed to the Board either by the local authority or the Board will be appointed on a non-voting basis.

(i) The Full Council may at any time make a direction to alter the voting right of Board members, following consultation with the Board.

Committee procedures

(a) The Board will be accountable to Full Council in its capacity as a committee of the local authority. The Board will be subject to health scrutiny as set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

(b) The Access to Information Procedure Rules in Part 4 of this Constitution apply to the Board. The Committee Procedure Rules in Part 4 apply to the Board except where this would be inconsistent with either these Terms of Reference or the legislation governing this board.

Facilitating the work of the Health and Wellbeing Board

(a) Workshop meetings will be held to cement links with partners including the Community Safety Partnership, the Children's Trust, and regeneration partners, to facilitate co-ordination and focus on priority issues relevant to all parties.

(b) In addition to formal board meetings, the Board will hold informal, non-decision making seminars as and when required with attendees specifically invited by

the Board. These seminars will be held in private in order to ensure the ongoing organisational development of the Board and to provide a forum in which complex and sensitive issues can be fully aired and discussed to manage potential blockages to effective delivery of the strategy.

Representatives and substitutes

(a) Representatives will provide a link with their own organisation, reporting back and instigating partner action, being responsible for disseminating decisions and actions within their own organisation, ensuring compliance with any actions required and reporting back progress.

(b) Partner bodies are responsible for ensuring that they are represented at an appropriate level (either equivalent to the core member they are representing and no more than one tier below).

(c) If a representative is absent for three consecutive meetings the organisation/sector will be asked to re-appoint/confirm its commitment to the Board.

(d) Substitutes for voting members will not be permitted with the exception the Chair of the CCG and the Chair of Healthwatch. In their absence, the Deputy Chair of the CCG and the Deputy Chair of Healthwatch may attend in their place. All substitutes must be declared in name at the beginning of each municipal year.

This page is intentionally left blank

Agenda Item 12

Report for: **Health and Wellbeing Board – 12th September 2016**

Title: **Primary Care Update**

Organisation: **Haringey Clinical Commissioning Group**

Lead Officer: **Cassie Williams, Assistant Director of Primary Care Quality and Development**

1. Introduction

1.1 This report sets out the ongoing work in Haringey in relation to Primary Care, specifically General Practice. This is articulated through the framework of the Haringey CCG General Practice Development Plan 2016-17.

1.2 The report includes an update on Primary Care premises development, particularly in relation to the new zero list practice in Tottenham Hale and additional work being progressed to secure adequate and appropriate premises for general practice in Haringey. This work has developed out of the Haringey Strategic Premises Development Plan which was presented to the Health and Wellbeing Board on 23rd June 2015.

1.3 The report further details the current and future options for Haringey in relation to primary care commissioning. Haringey CCG, in collaboration with the other 4 CCGs of North Central London, currently jointly commission General Practice together with NHS England but are now being invited to consider whether to submit an expression of interest to take on Level 3, delegated commissioning from April 2017.

2 Haringey General Practice Development Programme

2.1 Haringey CCG is committed to ensuring that Haringey has high quality, resilient and sustainable general practice which is able to deliver accessible, coordinated and proactive care for all its residents. In order to provide this it will be necessary to do some things differently; considering new ways of working and new models of care. Some elements will be best provided at scale. It also requires proactive planning to secure the necessary infrastructure (estates and IT) as well as a motivated, equipped and sustainable workforce.

2.2 In order to achieve this, Haringey CCG has developed a plan for 2016-17 containing six priority pillars, which are shown in the diagram in appendix 1. These priorities are aligned to the NCL Primary Care Strategy and the NCL Sustainability and Transformation Plan (STP).

2.3 The programme articulates the desired outcomes and this year's programmes of work underway and planned to deliver it.

4. Haringey General Practice Priority Areas

4.1 Quality and Reducing Variation

4.2 The goal is to improve quality across all of General Practice in Haringey particularly focusing on reducing variability between practices. This will be measured through reviewing patient experience feedback on the GP survey and General Practice Outcome Standards. The focus this year is on the provision of, and peer discussion about, data provided in dashboards that includes A&E attendance and referral rates, immunisations and vaccination data and disease prevalence. Dashboards already provide information around community referral rates and A&E attendances (see Appendix 2 – practice names removed), other dashboards are in the process of being created. A Quality Dashboard will be created as part of work being progressed with University College London Partners.

4.3 It will also involve a programme of practice visits to engage practices around these matters and to support them in improving quality.

4.4 Accessible Care

The goal is to improve the experience of patients in relation to access, as measured in the GP patient survey. This will include extending hub working. The current commitment is to provide 4 hubs on a Saturday mornings available to every patient in Haringey. The 4 hubs will be open by October 2016. In addition, and subject to confirmation of funding through the national GP access fund, there is a plan to deliver an 8-8, 7 days a week service by the end of the financial year through hub working.

There is also a focus on supporting those practices who particularly struggle to provide good primary care access to their patients. Practices will receive advice and support around how to make best use of technology, patient education about self-help and self-referral, and workforce utilisation to improve access.

4.5 Proactive and Coordinated Care

The goal is to improve secondary prevention through better identification of disease, as evidenced by a reduction in the expected and observed prevalence gap. The focus in this year is around stroke prevention but Haringey CCG hopes to expand this to other disease areas including diabetes, chronic obstructive pulmonary disease and chronic kidney disease in the new financial year, subject to completion of the PMS review (one type of GP contract which is due for review by NHS England in this financial year).

Locality teams, which provide a multidisciplinary approach to care, are continuing and the goal is to increase utilisation of this service to support those most at risk of hospital admission.

In addition, there will be an increase in the availability of social prescribing, which provides support for a wider range of needs beyond specific health issues, but which have an impact on health and wellbeing.

4.6 Resilience, Sustainability and Transformation

The goal is to improve individual practice resilience and support ongoing development of the Haringey GP Federation to provide population level provision of services. This will be achieved through the Haringey Practice Resilience Programme. Data will be triangulated to understand the most challenged practices who will then be helped to access support, including national programmes articulated in the GP Forward View, such as Time to Care, and local initiatives including a programme across Enfield and Haringey being developed with UCL Partners which will work with surgeries to optimise time within a practice in order to improve clinical capacity and to improve quality.

Another aspect of UCLP support will be to support the development of an additional primary care offer in relation to children, particularly identifying a reliable alternative to taking a child to A&E when they are unwell. This approach will consider current research and evidence to identify a primary care response which may include GPs with a special interest (GPwSI) and additional training.

4.7 Provider Development

The goal is to ensure there is a motivated and equipped workforce within Primary Care who are actively engaged to come and work in Haringey and who want to stay here. A current programme enabled 2 nurses to shift from acute to practice nursing last year and the goal is to have 4 further nurses join the workforce this year. A survey is also underway with GP trainees to understand the factors that cause people to stay or leave. Other work has been focused on thinking about broadening the workforce, including extending the skills of healthcare assistants and using pharmacists in primary care.

There will also be additional leadership development made available to equip system leaders in improving quality and delivering transformation.

4.8 Infrastructure

In this priority area, the goal is to ensure that Haringey has the necessary estate and technology to support better access and multidisciplinary working. 18 bids were submitted to the Estates and Technology Transformation Fund (EFFT) to support this including a bid for an Integrated Digital Care Record which would enable access to records across health and social care and provide a patient held

record. This is key in delivering more coordinated care and supporting patients to take more responsibility for their health. The outcome of ETTF bids will be made known in November 2016. Further information in relation to Estates Development is provided below.

4.9 Estates Development

4.10 The following sets out some of the key developments in relation to primary care premises during the past 12 months:

4.11 Tottenham Hale Medical Practice

The new temporary site is due to be open on 31st August 2016. Whilst waiting for the site itself to be ready, the practice has been able to start registering patients and approximately 400 patients have registered to date. Where immediate treatment is needed, patients are being seen at Lawrence House. At the time of writing this report final 'snagging' of the new building is being worked through. The practice have confirmed that they intend to move into the building on the planned date and a formal launch of the new practice will be arranged in September.

4.12 ETTF bids for Primary Care Premises

Nine estates bids were submitted for Haringey. These include key developments n areas where there is an identified shortage of primary care and housing growth, namely Tottenham Hale, Wood Green, Green Lanes and Northumberland Park. Whilst awaiting the outcome of these bids, the CCG is continuing to work with the Council and NHS Property colleagues, to be ready to progress bids where they are successful and to consider other opportunities where developments are required but capital funding is not available through ETTF.

4.13 Clarification of the Primary Care Estates Strategy

Significant work has already been undertaken to articulate a single estates strategy across Haringey and Islington. As part of that work, Haringey CCG is working to develop a specific description of the type of estate which general practice would ideally be delivered from. This is particularly important as the CCG is asked to comment on practice moves and estates developments. The CCG is currently working with local GPs to articulate this and will seek the view of the Health and Wellbeing Board at the meeting. Engagement with the public will occur subsequent to this

4.14 Delegated Commissioning (Level 3)

The CCGs in Barnet, Enfield, Haringey, Islington and Camden (NCL) currently jointly commission primary care with NHS England. At this stage CCGs are part of decision making, but NHS England has the casting vote on decisions. NCL CCGs have now been invited to submit an expression of interest by October 2016 if they

wish to move to level 3, delegated commissioning. Following discussion in local Collaboratives, Haringey GPs are now voting as to whether they would support this move. A final decision will be agreed at the September Governing Body following the outcome of the vote.

Level 3 includes making decisions about GP contracts in the local area, including whether a practice can move to a new location or merge with another practice. It would also mean being responsible for the budget. Greater financial responsibility would enable CCGs to commission primary care in a way that most effectively addresses the local need. However, it is also important to ensure that the finances are adequate for the task. Should an expression of interest be submitted, further analysis will be conducted around the money prior to formally agreeing to adopt level 3.

5 Conclusion

The CCG is clear in its intent to develop, on a continuing basis, a coherent work plan which addresses the key priorities for primary care in the Haringey borough. This report provides a summary of the work which is being progressed in 2016-17.

6 Recommendation

That the Health and Wellbeing Board considers and comments on the report.

7 Timings

It is proposed that a further update is brought to the Board in early 2017.

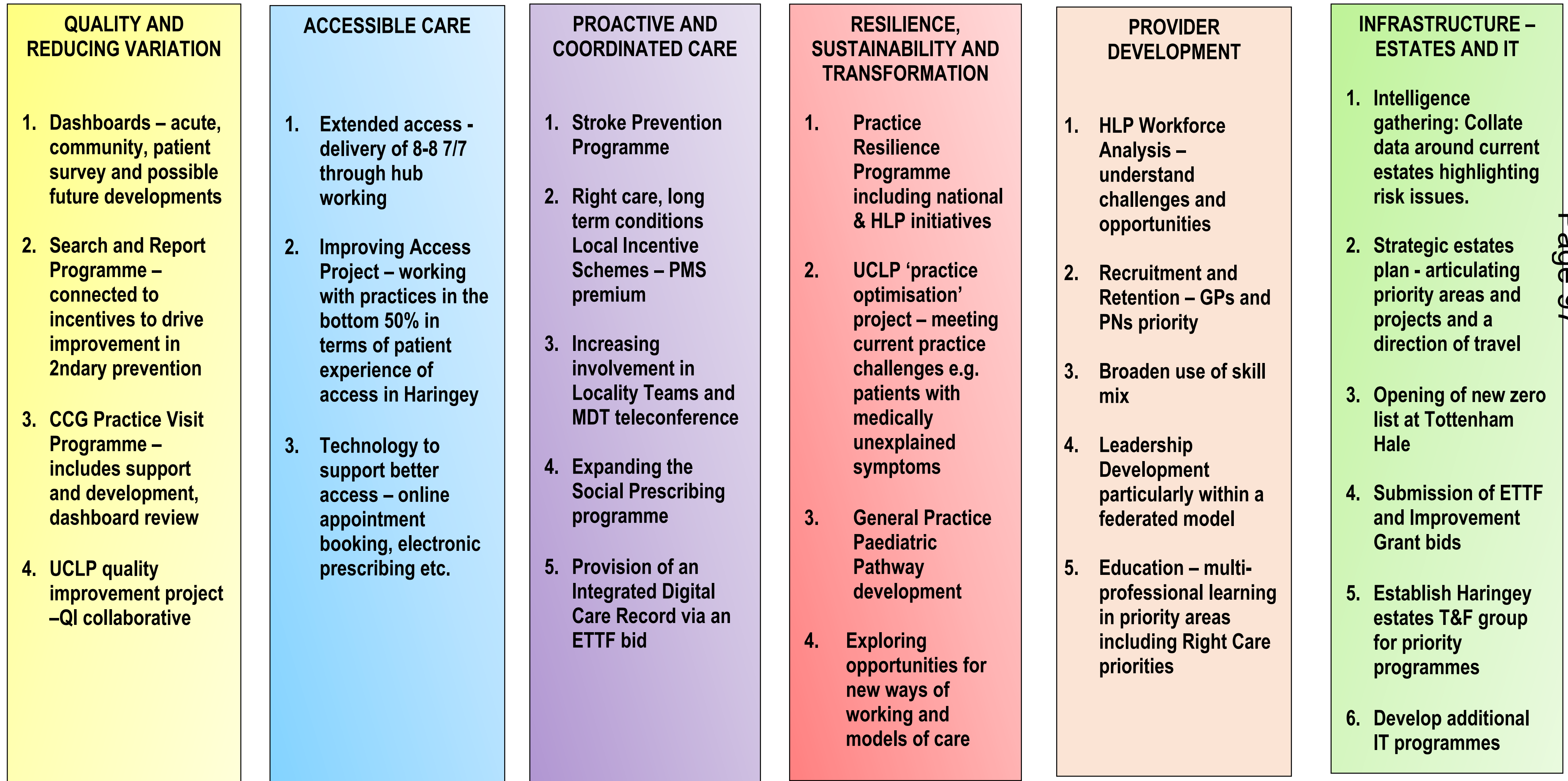
This page is intentionally left blank

Appendix a

NHS
Haringey
Clinical Commissioning Group

HARINGEY GENERAL PRACTICE DEVELOPMENT PROGRAMME 2016-17

Haringey CCG is committed to ensuring that Haringey has a high quality, resilient and sustainable general practice which is able to deliver accessible, coordinated and proactive care for all its residents. This will include consideration of how to do things differently; including new models of care and providing some elements at scale across Haringey. It will also require proactive consideration of the necessary infrastructure and the workforce requirements. The diagram below describes the various pillars of the Haringey CCG 2016-17 workplan. This plan is aligned to the NCL Primary Care Strategy and the NCL Sustainability and Transformation Plan.



This page is intentionally left blank

GP Commissioning Dashboard

Issue 13 **Mar - Apr 2016 - Data is cumulative**

Key

Practices showing a higher referral rate /spend than last month	↑
Practices showing a lower referral rate / spend than last month	↓

The highest 10% of spending / referring practices are highlighted in RED

The highest 10% - 20% of spending / referring practices are highlighted in ORANGE

2	Secondary Care					GP Referral				Urgent Care			
Weighted Practice Size	Secondary Care - Cost per patient per Year (2014/15)	A&E Attendance - Cost per patient per Year (2014/15)	Outpatient Attendances - Cost per patient per Year (2014/15)	Elective Inpatients -Cost per patient per Year (2014/15)	Non-Elective Inpatients - PBR cost per patient per Year (2014/15)	GP Referred First Appts, rate per 1000 (2015/16 Forecast)	Non GP Referred First Appts, rate per 1000 (2015/16 Forecast)	% Patients Discharged from First GP Referred OP Appointment	All Follow-Up Appts, rate per 1000 (2015/16 Forecast)	A&E Attendances, rate per 1000 (2015/16 Forecast)	A&E Attendances, Actual	A&E Minor (Band 5) admissions during core hours per 1000 (2015/16 Forecast)	A&E Minor (Band 5) admissions outside core hours per 1000 (2015/16 Forecast)
SOUTH EAST	**£256**	**£57**	**£105**	**£17**	**£78**	**167**	**131**	**29%**	**405**	**481**	**464**	**69**	**35**
2,753	£252	£48	£99	£18	£88	183	137	33%	427	401	184	33	31
5,400	£293	£54	£115	£37	£88	228	134	35%	407	450	405	76	21
3,163	£352	£65	£117	£46	£123	154	156	24%	455	561	296	93	46
11,904	£249	£49	£93	£25	£82	150	112	31%	346	438	869	68	38
7,041	£188	£66	£122	£0	£0	157	130	22%	500	558	655	84	40
9,824	£134	£48	£86	£0	£0	137	131	33%	365	385	630	40	22
1,100	£314	£49	£124	£0	£141	224	120	28%	464	387	71	76	22
1,749	£419	£72	£127	£35	£184	158	144	16%	494	611	178	75	51
12,193	£206	£45	£81	£10	£70	177	118	38%	278	405	823	53	38
5,199	£155	£71	£84	£0	£0	103	132	26%	314	614	532	95	38
WEST	**£273**	**£42**	**£111**	**£32**	**£88**	**222**	**162**	**38%**	**461**	**357**	**449**	**31**	**15**
15,480	£280	£38	£110	£40	£92	198	160	33%	438	318	820	27	10
12,886	£278	£35	£105	£37	£101	213	150	37%	433	304	652	21	12
4,667	£314	£53	£123	£20	£117	224	156	35%	582	441	343	66	19
7,088	£272	£37	£109	£58	£67	217	155	37%	426	299	353	23	14
6,060	£323	£48	£106	£33	£136	238	139	39%	428	437	441	35	30
6,059	£273	£40	£124	£29	£80	259	149	39%	444	377	381	23	14
2,478	£415	£48	£146	£78	£142	266	228	38%	685	361	149	22	12
4,754	£305	£37	£115	£48	£105	221	139	36%	475	362	287	23	10
3,708	£249	£45	£95	£1	£108	173	170	38%	405	367	227	31	11
2,492	£287	£46	£92	£36	£113	212	176	47%	388	373	155	34	24
9,355	£124	£36	£87	£0	£0	204	133	37%	332	312	487	35	12
19,499	£160	£42	£117	£0	£0	240	195	39%	492	336	1,092	30	16
CENTRAL	**£287**	**£50**	**£102**	**£28**	**£107**	**146**	**122**	**25%**	**411**	**442**	**440**	**61**	**36**
9,908	£302	£51	£118	£33	£99	177	139	28%	431	447	738	59	34
3,935	£306	£45	£116	£52	£93	188	119	25%	442	396	260	50	35
15,265	£278	£37	£110	£29	£102	197	117	29%	465	365	928	34	28
6,128	£309	£50	£119	£23	£118	255	130	32%	454	439	448	63	28
2,758	£309	£50	£96	£19	£145	85	96	17%	402	450	207	83	48
14,639	£332	£55	£108	£37	£131	131	143	30%	427	489	1,192	65	41
3,507	£261	£45	£112	£33	£70	109	135	23%	457	393	230	51	22
4,079	£259	£59	£75	£2	£124	118	112	34%	307	502	341	82	34
3,112	£287	£50	£103	£41	£92	139	121	24%	442	424	220	50	37
2,260	£442	£67	£137	£37	£201	194	162	27%	520	573	216	69	32
987	£75	£41	£33	£0	£0	12	73	11%	170	389	64	61	55
NORTH EAST	**£311**	**£54**	**£96**	**£35**	**£126**	**152**	**120**	**29%**	**374**	**466**	**734**	**73**	**44**
15,834	£293	£46	£95	£48	£104	208	123	37%	387	397	1,049	50	41
10,338	£287	£55	£93	£31	£107	113	132	25%	393	488	840	78	44
13,140	£406	£67	£112	£34	£192	126	127	19%	417	583	1,276	89	62
7,966	£286	£45	£79	£42	£120	122	108	28%	316	370	491	59	24
4,987	£265	£51	£76	£33	£105	108	112	26%	315	449	373	65	48
7,073	£309	£58	£94	£32	£125	175	132	41%	364	497	586	90	38
12,542	£337	£60	£123	£31	£123	180	145	31%	443	507	1,059	80	48
8,232	£359	£57	£89	£54	£160	82	103	16%	335	495	679	94	44
3,727	£253	£47	£101	£7	£97	254	93	38%	391	409	254	53	48
	£281	**£50**	**£104**	**£28**	**£99**	**174**	**135**	**30%**	**416**	**432**		**57**	**31**

This page is intentionally left blank

Community Outpatient Dashboard

Note

April - May 2016 - Data is cumulative

Key:

- White - Top 30% of referring practices within collaborative
- Light blue - Middle 40% of referring practices within collaborative
- Dark blue - Lowest 30% of referring practices within collaborative
- ↑ Increased since last publication (2 months)
- ↔ Stayed same since last publication
- ↓ Decreased since last publication

		Ophthalmology (inc children)			ENT (inc children)			MSK (AQP only)			Dermatology / Minor Surgery GPSI (inc children)			Direct Access Diagnostics (over 16 only)			Urology (Over 18 only)			Gynaecology (over 16 only)			POLCE		Gastroenterology (Calprotectin)			Gastroenterology Medefer		
		M2	M2		M2	M2		M2	N/A		M2	M2		M2	M2		M2	M2		M2	M2		M2	M2	M2	M2		M2	M2	
	Weighted List Size	Secondary OP	Community OP	% Community	Secondary OP	Community OP	% Community	Secondary OP	Community OP	% Community	Secondary OP	Community OP	% Community	Secondary Activity	InHealth Activity	%	Secondary OP	Community OP	% Community	Secondary OP	Community OP	% Community	Secondary POLCEs	Triage Referrals	Secondary (Lower Endoscopies)	Calprotectin Tests	% Community	Secondary OP	Community OP	% Community
		7.1	6.6	54%	3.9	7.1	46%	3.3	#DIV/0!	0%	10.0	11.7	43%	25.8	96.3	74%	10.3	1.8	9%	13.0	1.7	9%	4.7	7.6	2.8	5.7	45%	7.9	0.4	3%
South East	2797	0.0	4.0	100%	1.0	8.4	89%	2.0		0%	3.0	10.0	77%	0.0	107.0	100%	6.0	2	25%	10.0	0.0	0%	2.0	5.00	1.0	8.0	89%	1.0	0.0	0%
	5213	8.0	6.0	43%	7.0	4.8	41%	4.0		0%	9.0	10.0	53%	37.0	135.0	78%	16.0	2.0	11%	15.0	2.0	12%	2.0	2.00	2.0	18.0	90%	6.0	0.0	0%
	3159	2.0	5.0	71%	3.0	13.2	81%	0.0			3.0	3.0	50%	0.0	60.0	100%	5.0	0.0	0%	4.0	3.0	43%	3.0	7.00	5.0	1.0	17%	11.0	0.0	0%
	13757	20.0	11.0	35%	16.0	3.6	18%	5.0		0%	9.0	16.0	64%	16.0	165.0	91%	24.0	3.0	11%	26.0	5.0	16%	8.0	9.00	5.0	5.0	50%	20.0	3.0	13%
	6977	14.0	6.0	30%	2.0	2.4	55%	7.0		0%	22.0	9.0	29%	29.0	68.0	70%	12.0	0.0	0%	19.0	0.0	0%	6.0	3.00	4.0	1.0	20%	5.0	1.0	17%
	8721	9.0	17.0	65%	3.0	3.6	55%	0.0			16.0	12.0	43%	82.0	68.0	45%	10.0	0.0	0%	9.0	0.0	0%	7.0	16.00	4.0	6.0	60%	6.0	0.0	0%
	1298	1.0	1.0	50%	0.0	0.0	0%	1.0		0%	1.0	0.0	0%	15.0	24.0	62%	7.0	0.0	0%	2.0	0.0	0%	1.0	2.00	0.0	0.0	0%	0.0	0.0	
	1953	4.0	4.0	50%	2.0	0.0	0%	1.0		0%	2.0	2.0	50%	11.0	4.0	27%	4.0	0.0	0%	2.0	0.0	0%	3.0	3.00	0.0	0.0	0%	4.0	0.0	0%
	10424	7.0	8.0	53%	2.0	33.6	94%	13.0		0%	29.0	55.0	65%	58.0	272.0	82%	15.0	11.0	42%	29.0	6.0	17%	8.0	28.00	4.0	15.0	79%	21.0	0.0	0%
	4809	6.0	4.0	40%	3.0	1.2	29%	0.0			6.0	0.0	0%	10.0	60.0	86%	4.0	0.0	0%	14.0	1.0	7%	7.0	1.00	3.0	3.0	50%	5.0	0.0	0%
		8.2	9.1	49%	6.9	8.8	59%	5.6	#DIV/0!	0%	31.3	4.2	16%	155.0	63.9	25%	10.1	1.5	12%	19.2	3.8	17%	5.7	10.1	3.3	5.6	41%	7.5	0.0	0%
West	13673	18.0	23.0	56%	19.0	6.0	24%	13.0		0%	76.0	0.0	0%	313.0	153.0	33%	13.0	2.0	13%	46.0	3.0	6%	10.0	11.0	2.0	9.0	82%	6.0	0.0	0%
	11455	7.0	21.0	75%	4.0	25.2	86%	12.0		0%	78.0	6.0	7%	336.0	12.0	3%	19.0	6.0	24%	25.0	5.0	17%	8.0	24.0	6.0	12.0	67%	12.0	0.0	0%
	4994	5.0	2.0	29%	7.0	2.4	26%	5.0		0%	21.0	0.0	0%	116.0	48.0	29%	10.0	0.0	0%	16.0	2.0	11%	7.0	0.0	2.0	0.0	0%	8.0	0.0	0%
	6237	7.0	5.0	42%	11.0	4.8	30%	3.0		0%	13.0	0.0	0%	167.0	40.0	19%	10.0	0.0	0%	20.0	1.0	5%	5.0	15.0	4.0	3.0	43%	11.0	0.0	0%
	5577	13.0	3.0	19%	14.0	2.4	15%	4.0		0%	18.0	12.0	40%	198.0	2.0	1%	8.0	0.0	0%	21.0	0.0	0%	5.0	3.0	3.0	1.0	25%	6.0	0.0	0%
	5217	6.0	11.0	65%	3.0	14.4	83%	7.0		0%	15.0	16.0	52%	132.0	132.0	50%	11.0	0.0	0%	9.0	9.0	50%	0.0	8.0	1.0	0.0	0%	7.0	0.0	0%
	2627	4.0	1.0	20%	3.0	6.0	67%	1.0		0%	13.0	4.0	24%	88.0	40.0	31%	6.0	1.0	14%	8.0	0.0	0%	4.0	2.0	0.0	0.0	0%	1.0	0.0	0%
	4270	4.0	8.0	67%	2.0	7.2	78%	6.0		0%	10.0	4.0	29%	133.0	21.0	14%	7.0	3.0	30%	11.0	6.0	35%	1.0	5.0	3.0	1.0	25%	5.0	0.0	0%
	3483	5.0	7.0	58%	1.0	8.4	89%	0.0			9.0	3.0	25%	98.0	5.0	5%	1.0	1.0	50%	9.0	5.0	36%	1.0	4.0	1.0	4.0	80%	2.0	0.0	0%
	2158	3.0	5.0	63%	0.0	1.2	100%	0.0			11.0	1.0	8%	67.0	6.0	8%	1.0	0.0	0%	3.0	0.0	0%	2.0	3.0	2.0	1.0	33%	2.0	0.0	0%
	7618	5.0	5.0	50%	8.0	4.8	38%	2.0		0%	31.0	3.0	9%	212.0	8.0	4%	6.0	0.0	0%	19.0	6.0	24%	7.0	17.0	6.0	21.0	78%	14.0	0.0	0%
	16883	21.0	18.0	46%	11.0	22.8	67%	14.0		0%	80.0	1.0	1%	0.0	300.0	100%	29.0	5.0	15%	43.0	9.0	17%	18.0	29.0	9.0	15.0	63%	16.0	0.0	0%
		6.6	7.8	52%	5.2	11.6	70%	4.8	#DIV/0!	0%	9.3	5.5	42%	42.5	102.9	64%	9.5	1.5	11%	14.9	1.1	6%	6.6	5.5	3.0	12.5	51%	8.0	0.4	7%
Central	9797	8.0	15.0	65%	6.0	10.8	64%	8.0		0%	23.0	0.0	0%	37.0	204.0	85%	16.0	2.0	11%	24.0	3.0	11%	11.0	0.0	6.0	30.0	83%	17.0	0.0	0%
	4002	6.0	2.0	25%	3.0	14.4	83%	6.0		0%	6.0	0.0	0%	25.0	87.0	78%	13.0	2.0	13%	11.0	0.0	0%	6.0	5.0	3.0	5.0	63%	7.0	0.0	0%
	14080	18.0	23.0	56%	20.0	31.2	61%	7.0		0%	25.0	1.0	4%	113.0	432.0	79%	20.0	2.0	9%	30.0	2.0	6%	18.0	26.0	8.0	63.0	89%	23.0	0.0	0%
	6034	9.0	5.0	36%	7.0	9.6	58%	6.0		0%	8.0	6.0	43%	112.0	225.0	67%	14.0	0.0	0%	23.0	1.0	4%	7.0	10.0	3.0	8.0	73%	11.0	2.0	15%
	2541	4.0	1.0	20%	0.0	2.4	100%	1.0		0%	4.0	4.0	50%	0.0	3.0	100%	3.0	0.0	0%	7.0	0.0	0%	3.0	1.0	2.0	0.0	0%	2.0	1.0	33%
	13897	16.0	22.0	58%	10.0	33.6	77%	11.0		0%	15.0	14.0	48%	100.0	72.0	42%	20.0	7.0	26%	38.0	2.0	5%	13.0	14.0	6.0	18.0	75%	15.0	0.0	0%
	3583	5.0	10.0	67%	4.0	8.4	68%	1.0		0%	2.0	3.0	60%	16.0	42.0	72%	2.0	1.0	33%	5.0	0.0	0%	6.0	4.0	0.0	3.0	100%	3.0	1.0	25%
	3729	2.0	3.0	60%	4.0	2.4	38%	4.0		0%	9.0	1.0	10%	41.0	38.0	48%	4.0	1.0	20%	10.0	0.0	0%	1.0	0.0	1.0	0.0	0%	2.0	0.0	0%
	3193	2.0	2.0	50%	2.0	3.6	64%	1.0		0%	7.0	12.0	63%	13.0	29.0	69%	3.0	0.0	0%	9.0	1.0	10%	4.0	0.0	2.0	10.0	83%	2.0	0.0	0%
	2098	3.0	2.0	40%	1.0	10.8	92%	8.0		0%	3.0	11.0	79%	11.0	0.0	0%	9.0	1.0	10%	6.0	3.0	33%	3.0	1.0	1.0	0.0	0%	6.0	0.0	0%
	902	0.0	1.0	100%	0.0	0.0		0.0			0.0	8.0	100%	0.0	0.0		1.0	0.0	0%	1.0	0.0	0%	1.0	0.0	1.0	0.0	0%	0.0	0.0	0%
		8.8	14.8	64%	7.2	13.6	59%	4.0	#DIV/0!	0%	10.6	9.4	49%	28.2	232.8	75%	11.7	1.4	15%	15.1	1.7	9%	7.8	10.1	4.9	11.7	59%	15.3	0.7	5%
North East	15525	18.0	20.0	53%	8.0	18.0	69%	6.0		0%	22.0	8.0	27%	24.0	834.0	97%	18.0	1.0	5%	27.0	2.0	7%	13.0	30.0	8.0	29.0	78%	23.0	1.0	4%
	10757	4.0	20.0	83%	7.0	9.6	58%	3.0		0%	12.0	15.0	56%	31.0	104.0	77%	19.0	1.0	5%	20.0	1.0	5%	13.0	13.0	3.0	9.0	75%	14.0	1.0	7%
	13900	16.0	26.0	62%	14.0	26.4	65%	5.0		0%	16.0	16.0	50%	51.0	9.0	15%	25.0	0.0	0%	23.0	0.0	0%	6.0	10.0	11.0	25.0	69%	36.0	0.0	0%
	7624	7.0	11.0	61%	7.0	6.0	46%	3.0		0%	10.0	3.0	23%	21.0	93.0	82%	5.0	2.0	29%	9.0	1.0	10%	6.0	8.0	5.0	17.0	77%	14.0	0.0	0%
	5015	7.0	3.0	30%	3.0	8.4	74%	5.0		0%	0.0	8.0	100%	14.0	80.0	85%	1.0	1.0	50%	9.0	1.0	10%	1.0	1.0	3.0	0.0	0%	3.0	0.0	0%
	7414	1.0	10.0	91%	5.0	9.6	66%	4.0		0%	3.0	21.0	88%	27.0	346.0	93%	8.0	1.0	11%	9.0	2.0	18%	10.0	8.0	3.0	6.0	67%	6.0	0.0	0%
	12805	15.0	27.0	64%	12.0	36.0	75%	4.0		0%	23.0	2.0	8%	47.0	367.0	89%	12.0	7.0	37%	24.0	7.0	23%	13.0	21.0	7.0	11.0	61%	30.0	2.0	6%
	8301	9.0	10.0	53%	7.0	0.0	0%	4.0		0%	4.0	11.0	73%	26.0	19.0	42%	12.0	0.0	0%	10.0	1.0	9%	4.0	0.0	4.0	0.0	0%	6.0	0.0	0%
	4044	2.0	6.0	75%	2.0	8.4	81%	2.0		0%	5.0	1.0	17%	13.0	243.0	95%	5.0	0.0	0%	5.0	0.0	0%	4.0	0.0	0.0	8.0	100%	6.0	2.0	25%
		7.7	9.6	55%	5.8	10.3	59%	4.4	#DIV/0!	0%	15.3	7.7	37%	62.9	124.0	59%	10.4	1.5	12%	15.5	2.1	10%	6.2	8.3	3.5	8.9	49%	9.7	0.4	4%

This page is intentionally left blank

Agenda Item 13

Report for: **Health and Wellbeing Board – 12 September, 2016**

Title: **Haringey CCG and Local Authority draft Commissioning Intentions for 2017/18**

Organisation: **Haringey CCG**

Lead Officer: **Sarah Price, Chief Officer, Haringey CCG**
Rachel Lissauer, Acting Director of Commissioning, Haringey CCG

1. Describe the issue under consideration

Health and Wellbeing Board members will be aware that organisations Commissioning Intentions are developed each year in order to signal changes to contractual process, any services to undergo procurement or any changes to strategy. For the purposes of NHS Organisations formal notice of contractual changes needs to be issued to providers by 30 September.

Members will be aware that Haringey (LBH and CCG) have been developing joint Commissioning Intentions for 2017-2020, which is included below. Of note also is the work that Haringey and Islington have been jointly leading.

A presentation will be made at the meeting to outline the areas that will be reviewed and potential changes. Members should also note that all NCL 5 Borough organisation Commissioning Intentions will fall under the STP going forward.

2. Recommendations

The HWBB is asked to note progress on the Commissioning Intentions.

3. Joint commissioning intentions with London Borough of Haringey

The CCG and Local Authority recognise that people's health and care needs are inextricably connected. We have a strong and shared commitment to promoting and maintaining the health and wellbeing of Haringey residents, as articulated in our Health and Wellbeing Strategy.

Our shared vision for Haringey is:

1. A Borough where the healthier choice is the easier choice – this objective supports a focus on primary prevention

2. Strong communities where residents are healthier and live independent, fulfilling lives – this objective supports a focus on secondary prevention
3. Support at an earlier stage for residents who have difficulty in maintaining their health and wellbeing – this objective incorporates the strengthening of an intermediate care pathway and the further integration of these services
4. Those who need care and/or health support will receive responsive and high quality services – this objective supports the improvement of out of hospital services and A&E improvement

These objectives will be delivered by initiatives that maximize service users and carer's independence; achieve financial sustainability, are preventative; work with communities, create a fair and equal borough; and safeguard vulnerable adults from abuse.

We are rapidly taking forward arrangements for jointly commissioning services. From 2017/18 we will be operating pooled budgets for mental health; child and adolescent mental health; learning disabilities services and for integrated services for older adults. The Local Authority will be the Lead Commissioner for learning disabilities and Haringey CCG will be the Lead Commissioner for mental health.

The CCG and the Local Authority will work together to develop more integrated commissioning and provision for children and young people particularly focusing on the health of looked after children; children with complex needs; asthma. We will also work together across agencies on reducing A&E attendances for children and young people.

The following intentions are jointly developed between Haringey CCG and London Borough of Haringey:

Integrated Care for Adults

Our aim is to enable integrated services for adults which improve outcomes, enhance patient experience, drive costs out of the system and are sustainable in the medium to long term. These services will include a raft of provision across provision, early intervention, acute and specialist care and will work to a shared set of outcomes and principles, as set out in the s. 75 Partnership Agreement.

Intermediate Care

In light of our intention to integrate intermediate care services we will review step down provision, Cavell Ward, 7-day/wk social care, re-ablement, MDT teleconferences, mental health navigators and home from hospital. We will be reviewing and evaluating current services. Any commissioning / de-commissioning decisions will be given with appropriate notice.

Locality teams will continue the valuable work that they are doing with complex patients at risk of hospital admission. For 2017/18 we anticipate that the teams will

be reaching up to 650 patients and we will continue to monitor impact in reducing avoidable admissions. The learning from Locality Teams will potentially be used to shape the future provision of community ICTT and nursing services as well as social care provision.

The overnight District Nursing service will continue to have a role to play in supporting housebound patients 24/7. Its operating model will be reviewed within a broader review of intermediate care services.

Rapid Response: Expansion of the service will take place in M05-M06 2016-17. We will continue to develop the service in 2017-18, on a test and learn basis, and it will play a key role in Haringey's vision for Intermediate Care.

There are a number of services traditionally viewed as social care services which are being transformed and will deliver through alternative models and in a joined up way across health and social care over the next year. These include: Shared Lives; Home Care; Residential and Nursing Care; Assistive Technology; Supported Housing where joint planning and commissioning processes are being developed.

Strong communities

Following a strategic consideration of the model for community wellbeing services, a new Community Wellbeing Framework across the CCG and the Council for the delivery of preventative community health provision is being agreed – this will encompass a range of services designed to strengthen communities, develop volunteer and peer support, enhance partnerships and collaboration and improve access to community resources and will require some re-commissioning of services in this field.

Supporting self-management

Exploring the impact of the self-management support through the service evaluation and planning the next phase of development.

Dementia
The ongoing review of dementia day care, led by LBH, will continue.

Carers
We have consulted on a new model for carers' support services and will re-commission these services in a joined up way across the CCG and the Council following further stakeholder engagement in the late summer.

Palliative Care: The service will be reviewed in line with its service specification to ensure that it is delivering the appropriate outcomes.

Services for vulnerable adults

Stroke Pathway & Services

The findings of the NCL-wide review will inform the re-commissioning of inpatient rehabilitation. As part of our joint commitment to promote independence, choice and control, the CCG and Council will be commissioning a new community support service for stroke survivors and their carers

Transforming care for people with a learning disability and/or autism:

CCGs and councils across NCL have come together under the national transforming care programme to develop and implement a 3-year plan to transform care and improve services for children and adults with a learning disability and/or autism who display behaviour that challenges, or those with a mental health condition. These improvements will focus on early intervention, preventing crisis and hospital admission, increasing choice and control by using personal health budgets, personal budgets and direct payments, making sure that services for children, adults and young people are joined up so that people get the right support as they get older and ensuring that education services support young people to develop their independence and skills in preparation for adulthood.

Community support for people with mental health needs (non-medical interventions such as advocacy, day opportunities, citizens' advice bureau) will be reviewed.

Our Wellbeing Partnership Commissioning Intentions

The Haringey and Islington Wellbeing Partnership is a partnership across organisations involved in delivering and commissioning health and social care in Haringey and Islington.

We are coming together formally as a partnership in order to increase the scale and pace with which can support our populations to live healthier, happier and longer lives.

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. The current Wellbeing partner organisations are:

Haringey Council, Islington Council, Whittington Health, Camden and Islington Foundation Trust, Islington Clinical Commissioning Group and 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.

We have, together, been through a process of evaluating where we have greatest scope to improve quality and gain efficiency by working together. As a result we are focusing on the needs of a range of population groups:

- 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)
- Mental health services that are focused on enablement and recovery
- 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

This page is intentionally left blank

Report for: **Health and Wellbeing Board – 12 September 2016**

Title: **S.75 Partnership Agreement between Haringey Council and Haringey Clinical Commissioning Group**

Report authorised by : **Jeanelle de Gruchy, Director of Public Health, Haringey Council**

Lead Officer: **Charlotte Pomery, Assistant Director, Haringey Council**

Ward(s) affected: **All**

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

1. Describe the issue under consideration

1.1 Haringey Council (the Council) and Haringey Clinical Commissioning Group (the CCG) are proposing to implement a model of commissioning and pooled budgets supported by a partnership agreement under S.75 of the National Health Services Act 2006. The partnership agreement sets out shared outcomes and objectives, and contains detailed schedules enabling:

i. Lead commissioning for specified care groups
ii. Pooled budgets for specified care groups

1.2 Whilst the initial focus is predominantly adult services, the partnership agreement will act as a framework and is designed to enable schedules to be added for other care groups, including children's services, as required.

1.3 The partnership agreement will be presented to Cabinet for approval on 13th September 2016 and to the CCG's Governing Body for approval on 23rd September 2016. It is brought to the Health and Wellbeing Board for strategic oversight and consideration of the proposed approach in line with wider approaches to integration across the health and care landscape of Haringey and beyond.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to consider and endorse the proposed S.75 Partnership Agreement between the Council and the CCG which provides for:

a) Lead commissioning and the establishment and maintenance of pooled fund for the commissioning of learning disability services for eligible adults resident in Haringey;
b) Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of mental health services for eligible adults resident in Haringey;
c) Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of older people's services, including those services identified in the Better Care Fund 2016/17, for eligible adults resident;
d) Joint commissioning and the establishment and maintenance of a pooled fund for the commissioning of children and adolescent mental health services for the residents of the London Borough of Haringey;
e) Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for eligible adults resident in Haringey: and
f) which is attached as Appendix 1 and is due to be considered by the Cabinet and the CCG's Governing Body in September.

4. Reasons for decision

4.1 There has been previous work on developing joint commissioning across the CCG and the Council and recently there has been an appetite for working up proposals for greater integration at pace and scale. To this end, the Council and the CCG are now proposing to implement strategic plans for more integrated commissioning through the establishment of a partnership agreement, under s. 75 of the National Health Services Act 2006.

4.2 The proposals support a shared vision for integration of the commissioning activities of the CCG and the Council through a transformational approach which enables the shared strategic objectives of a shift towards community based provision; greater involvement of residents in their care and treatment; a focus on enablement and person centred provision; and the active promotion of independence to be achieved within an efficient, value for money framework.

4.3 Local residents have frequently called for greater integration of health and care arrangements locally to support a better experience and to improve outcomes. The proposals set out in this report and draft partnership agreement are designed to improve services to local residents but focus on arrangements for pooling funding and integrating commissioning. Whilst these arrangements will create greater efficiencies and a more joined up approach, they will not directly affect or change models of service delivery and consultation has not been undertaken on the detail of the s. 75 partnership agreement at this time.

4.4 Alongside the work to develop more fully integrated partnership arrangements in Haringey, the wider health and care landscape has been undergoing

significant reshaping in light of the development of the NHS led Sustainability and Transformation Plan for North Central London (a footprint covering Barnet, Enfield, Haringey, Camden and Islington). The Plan requires planning and transformation of the health and care landscape across the five borough area but also requires articulation of integrated models locally to ensure that arrrangements for commissioning and budgets meet local need, based on local requirements and existing local plans. The draft s. 75 Partnership Agreement supports this approach.

4.5 By implementing the partnership agreement in a phased way, focusing on different care groups, the CCG and the Council together will have the flexibility to respond to changing need and to focus on areas of greatest need, demand and pressure.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1 The s. 75 Partnership Agreement offers the opportunity for the CCG and the Council to work together in a more joined up way – commissioning on behalf of each other as appropriate from fully pooled budgets which can be deployed to meet local resident need. By implementing the partnership agreement, the CCG and the Council will be using their resources in a truly joined up way to address local need, to shape local provision and to manage local demand. This is a significant development, setting out an ambitious approach, across considerable areas of commissioning activity and spend with high levels of impact for local residents and provision.

6.2 There is a high degree of synergy between the outcomes and objectives sought by the Council and the CCG for local residents, as demonstrated in the Corporate Plan and the CCG Operational Plan. In addition, both organisations are facing significant financial and demand pressures, both now and for the foreseeable future, which it is agreed cannot be addressed by continuing current activities or delivering a slight reduction in current activity. Both organisations have already committed to working together in a genuinely integrated way to achieve better outcomes for residents and to achieve cost efficiencies in our approach.

Proposed partnership arrangements – vision and outcomes

6.3 This partnership agreement in the first instance sets out the nature of the partnership between the Council and the CCG and the shared vision and key outcomes for integration which the partners, on a number of occasions, have attempted to articulate. These outcomes include the following key strategic areas:

6.3.1 Improved health and care outcomes for local residents: the aims are to increase healthy life expectancy for all residents; help to maintain independence for longer; improve wellbeing and quality of life; establish prevention and early intervention; deliver re-ablement; implement an enablement approach

6.3.2 Improved health and care experience for local residents: the aims are to enable everyone to have more control over the health and social care they receive, for it to be centred on their needs, more joined up and delivered closer to home wherever possible, with high quality continuity of care

6.3.3 Optimal impact of joined up resources: the aims are to align spending to ensure funding is sustainable and focused on the things which have greatest impact; plan effectively; commission for outcomes; achieve economies of scale; reduce duplication and increase efficiency; share intelligence; focus on delivery

6.3.4 Market shaped to deliver for Haringey residents: the aims are to stimulate and shape the local health and care economy to deliver the best outcomes for local residents; increase leverage; maximise influence; embed quality assurance; benefit from economies of scale

6.3.5 Increased local accountability: the aims are to ensure that services are accountable to local residents and that desired outcomes are met through local interventions

6.3.6 Strengthened local health and care economy: the aims are to build stability; focus on excellence; develop a commissioning culture

6.3.7 Effective and efficient use of joint corporate resources to improve outcomes: the aims are to enable a healthier society with healthier choices, where all aspects of civic life contribute to health and wellbeing outcomes, through prevention and early intervention and strong partnerships with primary care

Proposed partnership arrangements – commissioning

6.4 Within this context and in response to the support from stakeholders the Council and the CCG have worked together to develop the overall model. This is based on integrated commissioners working to the shared objectives of the CCG and the Council, each supported by a pooled budget. Whilst the plans initially cover learning disabilities, adult mental health, CAMHS, elements of domestic violence and the work contained within the scope of the Better Care Fund, it is envisaged that other areas of commissioning activity across the Council and the CCG will be covered by the partnership agreement in future, such as elements of children's services.

6.5 Whilst integrated commissioners could either be lead or joint commissioners, lead commissioning has been identified as the preferred model. Lead commissioners will be employed and managed by either the Council or the CCG but act on behalf of both the CCG and the Council and be accountable to both at Board level. The s. 75 agreement as drafted allows for the CCG to lead

commission on behalf of the Council or for the Council to lead commission on behalf of the CCG with appropriate governance. In effect, one organisation delegates the exercise of its responsibilities (not those responsibilities themselves) to the other organisation. Each organisation will take a lead role on behalf of the other in specific areas. This is to ensure shared strategic commissioning and specifications, best use of stretched commissioning resources and ownership of integrated working across the whole system.

6.6.1 The proposed plan for the first tranche of integration is as follows:

6.6.2 Learning Disabilities: the lead commissioning role will lie with the Council in line with Valuing People.

6.6.3 Mental Health: the lead commissioning role will lie with the CCG given the significantly higher spend of the CCG as compared with the Council in this area.

6.6.4 Older People (within the scope of the existing Better Care Fund): the lead commissioning role has yet to be agreed, subject to further discussion about the impact of recent changes for the configuration of the CCGs locally.

6.6.5 Violence Against Women and Girls: the lead commissioning role for domestic violence will lie with the Council in line with the strategic lead for this area.

6.6.6 CAMHS: the proposal is to leave this as a joint commissioning role as currently set up as it is integrated with the local approach to children with special educational needs and disabilities.

6.7 At a high level, the roles of the integrated commissioners will be to:

6.7.1 Understand and respond to the need and demand in the local health and care economy

6.7.2 Lead on the development of the strategic commissioning intentions of the Council and the CCG, reflecting these in all service specifications.

6.7.3 Ensure the sufficiency and quality of market provisions to meet need.

6.7.4 Contribute to the transformation and re-design of services in line with the agreed strategic commissioning intentions.

6.7.5 As pooled fund manager, manage the pooled budget to support and enable the strategic commissioning intentions.

6.7.6 Deliver savings as set out in the Council's MTFS and the CCG's QIPP Plans

Proposed partnership arrangements - pooled budgets

6.8 To enable lead commissioners to act in a fully integrated way, it is proposed that pooled budgets are established for specified care groups as set out in the

partnership agreement. These budgets are to be pooled to allow flexibility of spend across health and care in response to assessed need and will not act solely as a ring fence for aligned budgets. The specific budgets to be pooled (at the values currently held) are set out in schedules to the partnership agreement – these can be added to as required should different care group budgets be identified as areas for pooling.

6.9 The pooled budgets will be significant as they will include all areas of spend whether currently in blocks with secondary care providers, in care purchasing budgets or in the voluntary sector and whether currently held by the CCG or by the Council. The scope of the pooled budget will be all spend in the area whether preventative and community based or secondary and acute based, whether for public health, social care or continuing health care. It is acknowledged that this is the aspiration and a phased approach is being deployed to achieve the assurances which will be required by the Council and the CCG. However, rather than gradually pooling different elements of budget, it has been agreed that all spend on a particular care group is included in a pooled budget and that ring fences and aligned budgets continue to exist within the overall pool until it is possible to lift the ring fences and to create genuinely pooled budgets with fluid spend on health, public health and social care interventions as required by need and demand.

6.10 Pooled budgets will go beyond aligning budgets within a ring fence and will be genuine pools with flexibility of spend across public health, health and social care in response to need, but with clear lines of accounting and accountability back to the funding authority – that is, either the Council or the CCG. The Lead Commissioner would in this regard act as the Pooled Fund Manager and under the terms of the partnership agreement would be required to act in the best interests of both organisations flagging any conflicts of interest – whether financial or otherwise – to senior managers through the Joint Executive Team in the event that these arise.

6.11 From the pooled budget, the lead commissioners would commission all providers using a single specification which would share the same set of high level outcomes and objectives, with specification of particular outputs and outcomes for particular services added in to this framework to ensure that all providers are working to a shared set of outcomes and objectives, within the wider strategic frameworks of the Council and the CCG's partnership agreement.

6.12 The aim is for the relevant elements of the pooled budget (that is, not the totality of the pooled budget) to transfer also to the provider as a pool. The elements transferred would be linked directly to the lead commissioner's specification. This allows the provider to operate as a lead provider taking decisions about how to direct resources in a joined up way to meet the outcomes set out in the specification from the pool. This would enable providers to create integrated teams with new roles, with mixed management of teams and with an emphasis on professional specialism rather than organisational role.

6.13 To ensure that understanding of the implications of the approach to pooling budgets is articulated robustly, a risk share agreement has been worked through between the CCG and the Council, reflecting the levels of pressure and risk in the wider financial landscape. The risk shared agreement forms part of the body of the s. 75 Partnership Agreement and covers how the CCG and the Council will deal with both over and under spends and specify how any savings or cost efficiencies will be achieved. The pooled budgets will be transparently managed with clear accounting and accountability lines back to each funding organisation enabling each to follow the money and their contribution.

Proposed partnership arrangements – financial implications

6.14 The proposed partnership agreement provides for pooling of Council and CCG budgets for specified care groups. The Schedules in Part 2 of the agreement set out the budgets which have been identified to be aligned and then pooled in the first stage but the partnership agreement also acts as a framework and allows for other budgets to be aligned and pooled as agreed, within the principles and approach of the overall agreement.

6.15 In the first stage, as set out in the Schedules currently included within the Partnership Agreement, the aligning and then pooling of budgets will cover all elements of spend across the CCG and the Council for adults with learning disabilities, adults with mental health needs, children and adolescents with mental health needs and adults with long term conditions and older people including the Better Care Fund. This will include block contracts with fixed contract values and demand led budgets which demonstrate considerable volatility and respond to changing individual needs, across both the CCG and the Council.

6.16 Whilst pooling budgets between the CCG and the Council enables greater flexibility in meeting health and care needs in a joined up way, it also reduces the scope for the CCG and the Council to manage their own budgets autonomously as risks are mitigated and action is taken to reduce spend within the partnership and any savings generated are applied first to the pooled budget arrangements.

6.17 As the partnership agreement represents a fundamentally different approach from that currently followed, and to manage the level of uncertainty generated by moving immediately to fully pooled budgets, it is proposed that the implementation of the pooled budget element of the partnership agreement is phased.

6.17.1 In the first phase, from September 2016 to April 2017, all budgets which have been identified for pooling will be aligned bringing them into a ringfence for the specified care group they support. This will give greater transparency over spend and demand pressures and enable both the CCG and the Council to contribute in a meaningful way to each other's budget setting processes. The baseline for the pooled budgets will be agreed, in line with the partnership agreement, by December for the following financial year, based on a clear and

accurate understanding of activity, performance, costs and demand over the previous period.

6.17.2 In the second phase, from April 2017, aligned budgets will be fully pooled allowing the CCG and the Council to deliver the ambition of the partnership agreement to deliver joined up care to local residents to meet need and achieve outcomes; to be more efficient in service delivery; to manage demand and the market in a streamlined and effective way.

Proposed partnership arrangements - governance

6.18 The proposed partnership agreement will fundamentally strengthen and reshape the partnership between the CCG and the Council with regard to health and care. It has been recognised that existing arrangements for oversight of joint working between the CCG and the Council are not adequate to ensure the proposed new arrangements are robust and offer the levesl of assurance required by both the CCG and the Council.The proposed partnership agreement does not affect the decision making powers of the Cabinet or of the CCG's Governing Body.

6.19 In order to provide adequate governance at an officer level to the lead commissioning and pooled budget arrangements, the Health and Care Iintegration Board has been reviewed and replaced by a Joint Executive Team. This comprises senior managers from the Council and CCG who will have the operational responsibility for holding lead commissioners and pooled fund managers, and therefore each organisation, to account for their decisions and actions and to ensure strategic and operational coherence to the arrangements. It meets monthly and is jointly chaired by the Chief Officer of the CCG and the Deputy Chief Executive of the Council. The Joint Executive Team has the following overarching aims:

6.19.1 To set the strategic direction to achieve the joint objectives of the two organisations

6.19.2 To oversee the implementation of the s. 75 Partnership Agreement and to hold to account the lead commissioners and pooled fund managers

6.19.3 To review performance against key joint performance indicators

6.19.4 To review and manage activity, escalating response to excess demand

6.19.5 To jointly review the financial position of the two organisations, taking joint remedial action where necessary

6.19.6 To set the strategic direction for further integration of the organisations, including further areas where integrated commissioning and pooled budgets will be implemented within the terms of the s. 75 partnership agreement

6.20 The Joint Executive Team will be supported by a monthly Joint Finance and Commissioning Group which will operate at lead commissioner and pooled fund manager level to operationalise the partnership arrangements.

6.21 At a member and non-executive level, governance of the lead commissioning and pooled budget arrangements set out in the s. 75 partnership agreement will be through the Haringey Finance and Performance Partnership Board, to be attended both by Governing Body Executive and Non Executive Members and by Council Members and Officers. Similiarly to the Joint Executive Team, the role of the Haringey Finance and Performance Partnership Board will be to exercise oversight of the lead commissioning and pooled budget arrangements set out in the s. 75 Partnership Agreement, holding officers to account and ensuring that the focus of the Joint Executive Team is adequately robust.

6.22 The Health and Wellbeing Board will maintain its statutory role and have strategic oversight of the integration and partnership arrangements delivered through the s. 75 Partnership Agreement.

6.23 The scope of decision making of the Council's Cabinet and the CCG's Governing Body is not affected by these proposals as decisions made in the joint executive team meeting are made within the delegated powers of the roles of the individuals attending the meeting.

7. Contribution to strategic outcomes

7.1 These proposals support Priorities 1 and 2 in Haringey Council's Corporate Plan 2015-18.

7.2 They also enable and support the four core priorities in Haringey CCG's Strategy 2014/15 – 2018/19:

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

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

8.1 Chief Finance Officer

8.1.1 This is a financial agreement where the Authority is contributing funding it would normally have managed itself to a pooled budget, together with contributions from the CCG, administered by a Lead Commissioner and managed according the governance arrangements set out in the proposed Section 75 Agreement.

8.1.2 The financial management arrangements for the pooled budgets are set out in sections 10 and 11 of the proposed agreement in the Appendix. They would require the Authority to agree their contribution to the pooled budget(s) before the start of the financial year jointly with the CCG on the basis of the prevailing and expected level of activity and the planned levels of efficiencies and synergies that are possible, all in the context of what was affordable.

8.1.3 Illustrative financial details of the services that would comprise the proposed agreement are set out in the schedules to Part 2 of the Appendix. A particular issue for the Authority is that the Adults Social Care budget is currently forecast to overspend by £12m in 2016/17, including within budgets affected by these pooled arrangements. Full pooled budgets would require sufficient funding to be included broadly to cover existing and expected commitments, less any planned efficiencies. This may require some virements if pooled budgets are to be introduced during 2016/17 and/ or it will require some rebalancing of budgets from 2017/18. Without that, budgets would continue to be aligned.

8.1.4 The recommendations of this report recognise that there are some final details to the Section 75 Agreement that will need to be agreed by officers before implementation. This will include finalising financial contributions (ie resolving the adequacy issue of existing funding levels from both partners), confirming which Authority would act as lead commissioner (ie which body would administer the funding) for each element of the pooled budget and determining the appropriate financial reporting and accounting arrangements for pooled monies.

8.1.5 The desired impact of the pooling of budgets is to secure efficiencies and synergies in the management of resources that could not be achieved if budgets were managed separately. It is important, however, to bear in mind the acute financial circumstances which each of the partner organisations is currently experiencing. A possible constraint that pooled budgets could have may be to limit the scope of either partner to directly manage their own resources if circumstances require it. The financial management arrangements have been written with this in mind and they acknowledge the need to work jointly and to recognise the importance of affordability in the management of the pool.

8.1.6 The section 75 Partnership agreement with lead commissioning responsibilires is a model for improved servoice delivery and increased market development.

8.1.7 Each lead partner for any procurement projects must ensure that the other partner is named in any opportunites that are advertised to ensure compliance and mitigate any Risk.

8.2 Assistant Director for Corporate Governance

8.2.1 Under Section 195 of the Health and Social Care Act 2012 (duty to encourage integrated working) the Board must for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner. The Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of services.

8.2.2 Section 75 of the NHS Act 2006 (arrangements between NHS bodies and local authorities) and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) permits the Council and the CCG to pool their resources, delegate functions, integrate service provision and transfer resources from one party to another. The provisions provides for: a) Pooled fund arrangements: A pooled fund arrangement provides an opportunity for the partners to bring money together, in a discrete fund, to pay for the services that are an agreed part of the pooled fund arrangement for the client group who are to benefit from one or all of the services; b) Delegation of functions – lead commissioning: where health and local authorities delegate functions to one another and there is a lead commissioner locally. Lead Commissioning provides an opportunity to commission, at a strategic level, a range of services for a client group from a single point and therefore provide a level of co-ordination which improves services for users, and provides an effective and efficient means of commissioning. In effect, one partner takes on the function of commissioning of services which are delegated to them; c) Delegation of functions – integrated provisions: this consist of the provision of health and social care services from a single managed provider. The arrangement can be used in conjunction with lead commissioning and pooled fund arrangements.

8.2.3 The partnership arrangement must lead to an improvement in the exercise of the CCG functions and the Council health related functions. The arrangements do not affect the liability of CCG for the exercise of any of their functions, the liability of the Council for the exercise of any of their functions, or any power or duty to recover charges in respect of services provided in the exercise of any Council functions.

8.2.4 Where the partners have decided to enter into pooled fund arrangements the agreement must be in writing and must specify— a) the agreed aims and outcomes of the pooled fund arrangements; b) the contributions to be made to the pooled fund by each of the partners and how those contributions may be varied; c) both the NHS functions and the health-related functions the exercise of which are the subject of the arrangements; d) the persons in respect of whom and the kinds of services in respect of which the functions referred to may be exercised; e) the staff, goods, services or accommodation to be provided by the partners in connection with the arrangements; f) the duration of the

arrangements and provision for the review or variation or termination of the arrangements; and g) how the pooled fund is to be managed and monitored including which body or authority is to be the host partner. The partners shall agree that one of them ("the host partner") will be responsible for the accounts and audit of the pooled fund arrangements and the host partner shall appoint an officer of theirs ("the pool manager") to be responsible for managing the pooled fund on their behalf; and submitting to the partners quarterly reports, and an annual return, about the income of, and expenditure from, the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements. There are similar prescribed requirements for delegation of functions and lead commissioning arrangements.

8.3 Equalities

8.3.1 As part of its decision making process, the Board as a Committee of the Council must have "due regard" to the public sector equalities duties. Under Section 149 Equality Act 2010, the Council in exercise of its functions, must have "due regard" to the need to eliminate unlawful discrimination, advance equality of opportunity between persons who share a protected characteristic and those who do not, foster good relations between persons who share a relevant protected characteristic and persons who do not share it in order to tackle prejudice and promote understanding. The protected characteristics are age, gender reassignment, disability, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Council is required to give serious, substantive and advance consideration of what (if any) the proposals would have on the protected groups and what mitigating factors can be put in place.

8.3.2 The report makes recommendations on a proposed model for joint commissioning and pooled budgets across the CCG and Council, affecting the commissioning of services for specialised care groups. The services within scope are delivered to meet the needs of some of the most vulnerable residents within our communities, including victims of domestic violence and those with learning disabilities, many of whom share characteristics protected under the Equality Act.

8.3.3 The proposed partnership agreement and the implementation of pooled budgets is intended to deliver more flexible use of resources which should better meet identified need and demand and is therefore expected to have a positive impact in relation to the Public Sector Equality Duty. Future commissioning decisions which fall under the partnership agreement will continue to be subject to assessment for their equalities impact and reported to the relevant decision-making body.

9. Use of Appendices

Appendix 1 is the proposed partnership agreement.

10. Local Government (Access to Information) Act 1985

Not applicable.

This page is intentionally left blank

Appendix 1

DATED 2016

BETWEEN

THE LONDON BOROUGH OF HARINGEY

AND

HARINGEY CLINICAL COMMISSIONING GROUP

FOR THE COMMISSIONING OF LEARNING DISABILITY SERVICES, ADULT MENTAL HEALTH SERVICES, CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES, INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES AND BETTER CARE FUND SERVICES AND OTHER AGREED SERVICES

DRAFT

This page is left blank

INDEX

Page

Part 1 **The Agreement**

Preamble

Signatures

1. Definition and Interpretation
2. Duration of Agreement
3. Extension of Partnership Agreement
4. Summary of the Partnership Arrangements
5. Pooled Fund Arrangements
6. Aligned Fund Arrangements 24
7. Lead Commissioner Arrangements 27
8. Staffing Arrangements
9. Charging
10. Financial Contributions
11. Overspends and underspends
12. Capital Purchases
13. Governance Arrangements
14. Standards of Service and Monitoring

15. Governing Law and Dispute Resolution

16. Complaints

17. Regulation and Inspection

18. Information Sharing

19. Serious and Untoward Incidents

20. Termination

21. Indemnity and Limitation of Liability

22. Other Provisions

Appendix 1 Joint Information Sharing Protocol

Appendix 2 NHS Haringey Member Practices 62

Appendix 3 Form of Notification to the Department of Health 63

Part 2 **Schedule of Agreed Services** 66

Schedule 1 Community Learning Disability Services

Schedule 2 Mental Health Services

Schedule 3 Long Term Conditions and Older People

Schedule 4 Child and Adolescent Mental Health Services

Schedule 5 Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service

This page is left blank

SECTION 75 OF THE NATIONAL HEALTH SERVICE ACT 2006
PARTNERSHIP AGREEMENT

between

LONDON BOROUGH OF HARINGEY

and

HARINGEY CLINICAL COMMISSIONING GROUP

Commencing 1 2016

PART 1

Preamble

THIS IS AN AGREEMENT BETWEEN

(1) **THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF HARINGEY** of River Park House, 225 High Road, Wood Green, London N22 8HQ (referred to herein as “the Council”)

and

(2) **THE HARINGEY CLINICAL COMMISSIONING GROUP** (known as Haringey CCG) of River Park House, 225 High Road, Wood Green, London N22 8HQ (referred to herein as “the CCG”)

BACKGROUND

(A) *The Council* is a Local Authority and by virtue of section 2 of the Local Authority Social Services Act 1970 the Council is responsible for the provision of social care services for adults and children who are ordinarily resident in its area.

(B) *The CCG* is established under the Health and Social Care act 2012 and is responsible for commissioning services to meet the health needs of persons who are patients of the providers of primary medical services in the area of the CCG.

(C) Section 82 of the National Health Service Act 2006 requires Local Authorities including *the Council* and NHS bodies including the CCG, when exercising their respective functions, to co-operate to secure and advance the health and welfare of people of England and Wales.

(D) The Council and the CCG (“Partners”) have agreed, pursuant to Section 75 of the National Health Service Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 to enter into this overarching Partnership Agreement which currently provides for:

i) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of learning disability services for adults who are resident in the London Borough of Haringey (described in Part 2 Schedule 1 of this Partnership Agreement);

ii) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of adult mental health services for resident in the London Borough of Haringey (described in Part 2 Schedule 2 of this Partnership Agreement);

iii) The Partners to establish and maintain a pooled fund and lead commissioning arrangements for the commissioning of long term conditions and older people's services, including those identified in the Better Care Fund Plan dated June 2016, for adults who are resident in the London Borough of Haringey (described in Part 2 Schedule 3 of this Partnership Agreement);

iv) The Partners to establish and maintain a pooled fund and joint commissioning for the commissioning of child and adolescent mental health services for the residents of the London Borough of Haringey (described in Part 2 Schedule 4 of this Partnership Agreement); and

v) The Partners to establish and maintain lead commissioning arrangements for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for the residents of the London Borough of Haringey (described in Part 2 Schedule 5 of this Partnership Agreement).

(E) The Services that the Partners have agreed to be delivered under this Section 75 Partnership Agreement are set out in the Schedules in Part 2 of this Agreement. As the Partners develop further partnership arrangements, the Schedules may be varied or supplemented to include other services which the Partners consider would be better provided through the partnership arrangements under this Agreement.

(F) *The Partners* are satisfied that the Partnership Arrangements are likely to lead to an improvement in the way in which their functions are exercised in relation to the provision for and meeting care and support needs and health services and the management of associated funds.

(G) *The Partners* are satisfied that the Partnership Arrangements are likely to further the shared objectives of reducing health inequalities and improving health and wellbeing and that these arrangements contribute to fulfilment of objectives set out in the Health and Wellbeing Strategy and Out of Hospital Strategies.

(H) The Partners have consulted such persons and/or bodies as appear to them to be affected by the Partnership Arrangements and in accordance with Regulation 4(2) of the Regulations.

(I) The Partnership Arrangements do not affect the liability of *the Council* or *the CCG* for the exercise of their respective functions, or any power or duty to recover charges for the provision of any services in the exercise of any Local Authority function.

(J) The Council is responsible for the resident population of Haringey and the CCG is responsible for the population who are registered with a General Medical Practitioner approved to operate within the boundaries of Haringey, and who are constituted members of the CCG. Appendix 2 lists the approved General Medical Practitioners who are constituted members of the CCG for the purposes of this Agreement.

(K) The provision of the Individual Services secured by the Pooled Fund, within the powers of the Council and the CCG, shall be limited to Eligible Service Users.

(L) The Council and the CCG have approved the terms and conditions of this Agreement.

SIGNATURES

THE SIGNATURES BELOW indicate complete and unconditional acceptance of all the above terms and conditions in Parts 2 and 3 of this Agreement by both *the Council* and the *CCG*.

Signed on behalf of

The Lord Mayor and Burgesses of the London borough of Haringey of, River Park House, 225 High Road, Wood Green, London N22 8HQ

by:

Name: ……………………………………………………………..

Authorised Officer Signature.. London Borough of Haringey

on ………………………..

Signed on behalf of

NHS Haringey Clinical Commissioning Group (Haringey CCG) of River Park House, 225 High Road, Wood Green, London N22 8HQ

by:

Sarah Price ………………………………………………………

Chief Officer, Haringey Clinical Commissioning Group

on …………………..

IT IS AGREED AS FOLLOWS:

1 Definition and Interpretation

Definition

_1.1._ In this Agreement the following expressions will have the following meanings:

"the 2006 Act"	means the National Health Service Act 2006
"Agreement"	means this Agreement between the Council and the CCG comprising these terms and conditions, together with all Schedules and Appendices attached hereto
"Aims and Objectives"	has the meaning ascribed to it in Clause 4.3
"Aligned Fund"	means those monies available for the pooled budget in respect of an Individual Service, as specified in the relevant Schedule of Part 2, which are made up of separate Contributions by the Partners and out of which payments may be made by the Lead Commissioner towards expenditure incurred in the exercise of *the Lead Commissioner Functions in respect of that Individual Service*
"Aligned Fund Arrangements"	means the establishment and maintenance of Aligned Funds as described in Clause 6 (Aligned Fund Arrangements), Clause 10 (Financial Contributions), Clause 11 (Overspends and underspends) and Part 2
"Best Value Duty"	means the duty imposed on the Council by Section 3 of the Local Government Act 1999 in relation to, inter alia, any one (1) or more of the Services
"Budget"	means the statement of total approved funds required to operate the Partnership Arrangements in any one Financial Year
"Clinical Commissioning Group"	means a clinical commissioning group established as a corporate body pursuant to Chapter A2 of Part 2 of the 2006 Act
"Commencement	means 2016

Date”	
“Social Care Functions”	means the Council's health related functions specified in Regulation 6 of the Regulations in relation to the provision of, or making arrangements for the provision of, the Services, but excluding the Excluded Functions
“Contributions”	means the respective financial contributions of the Partners in accordance with Clause 5 (Pooled Fund Arrangements), Clause 10 (Financial Contributions) and Part 2, for use by the Lead Commissioner in connection with the Lead Commissioning of the Services in fulfilment of the Lead Commissioner Functions and in accordance with the terms of this Agreement
“Eligibility Criteria”	means the joint eligibility and assessment procedure criteria for an Individual Service as set out in Part 2
“Eligible Service Users”	means those residents of Haringey for whom the Council or CCG are responsible and who require the needs of an Individual Service(s) and who otherwise meet the Eligibility Criteria
“Excluded Functions”	means any exclusions set out in the Regulations
“Finance and Performance Partnership Board”	means the accountable body established by the Partners pursuant to Clause 12, being the group responsible for the Partnership Arrangements
“Financial Year“	means 1 April to 31 March
“Guidance”	means the guidance on partnership arrangements under section 75 of the 2006 Act published by the Department of Health
“Individual Service”	means one of the constituent services set out in Part 2 which is allocated an Aligned Fund or Pooled Fund by the Partners and which together comprise the Services
“Individual Service Budget”	means the budget allocated by *the Partners* to an Individual Service
“Initial Term”	means the period of five (5) years commencing on the Commencement Date

"Joint Executive Team""	means the senior officers group established by the Partners pursuant to Clause 12, being the group responsible for overseeing the Partnership Arrangements
"Joint Finance and Commissioning Management Group"	means the lead commissioner and pooled fund manager group established by the Partners pursuant to Clause 12, being the group responsible for implementing the Partnership Arrangements
"Lead Commissioner"	means the Partner carrying out Lead Commissioning in respect of an Individual Service, as set out in Part 2, and, where a Pooled Fund is to be entered into in respect of such Individual Service (as identified in Part 2), the Partner who is responsible for the accounts and audit of such Pooled Fund (as described in Regulation 7(4) of the Regulations)
"Lead Commissioning"	means the mechanism by which the Lead Commissioner commissions the Services for both the Council and the CCG as further detailed in Part 2
"Lead Commissioner Functions"	means the Community Care Functions and the NHS Functions in relation to the provision of, or making arrangements for the provision of, the Services to meet the needs of the Eligible Service Users, but excluding the Excluded Functions
"Lead Commissioning Arrangements"	means the Lead Commissioning arrangements set out in this Agreement and more particularly described at Clause 7 (Lead Commissioner Arrangements) and Part 2
"Legislation"	means a statute, statutory provision or subordinate legislation
"NHS Functions"	means those functions of the CCG specified in Regulation 5 of *the Regulations as are exercised in the provision of, or making arrangements for the provision of, the Services, excluding the Excluded Functions*
"Nominated	means the individual responsible for

Commissioning Manager"	overseeing specific service programmes as set out in Part 2 in relation to the Partnership Arrangements, having been delegated this function by the Nominated Director
"Nominated Director"	means the individual referred to in Clause 12.1.3 being an officer of *the Lead Commissioner* responsible for managing *the Pooled Fund(s)* and Non Pooled Fund(s) on behalf of *the Partners* and submitting to *the Partners* quarterly reports and annual returns and other information, who may in turn delegate this function to the relevant Commissioning Manager for the Individual Service(s)
"Part 2"	means the Schedules of Part 2 of this Agreement which detail the Individual Services
"Partners"	means *the Council* and the *CCG* and "Partner" means either *the Council* or *the CCG;* the term includes the organisation(s), their employees, agents and sub-contractors
"Partnership Arrangements"	has the meaning ascribed to it in Clause 4.2
"Performance Measures"	means those performance measures in respect of the Partnership Arrangements, as set out in Part 2 or as otherwise agreed in writing by the Partners
"Pooled Fund"	means the pooled fund in respect of an Individual Service as set out in the relevant Schedule of Part 2, which is made up of Contributions by *the Partners* and out of which payments may be made by the Lead Commissioner towards expenditure incurred in the exercise of *the Lead Commissioner Functions in respect of that Individual Service*
"Pooled Fund Arrangements**"**	means the establishment and maintenance of Pooled Funds as described in Clause 5 (Pooled Fund Arrangements), Clause 10 (Financial Contributions), Clause 11 (Overspends and underspends) and Part 2
"Pooled Fund	shall have the meaning ascribed to it in Clause

Manager”	5.14
“Regulations”	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (Statutory Instrument 2000 No. 617) and any amendments thereto and subsequent re-enactments thereof
“Services”	means the Individual Services together

Interpretation

1.2 In this Agreement (except where the context otherwise requires):

1.2.1 Any reference to this Agreement includes Parts 2 and 3 of this Agreement and the Schedules of, or to, this Agreement which form part of this Agreement and will have effect as if set out in full in the body of this Agreement but not including the table of contents which is provided for convenience of reference only and will not be construed as part of this Agreement. For the avoidance of doubt, Part 1 (Joint Policy Statement) is included solely for information purposes and is not intended to be legally binding and does not form part of this Agreement;

1.2.2 Any reference to a Schedule or an Appendix is to a Schedule or an Appendix of or to this Agreement;

1.2.3 Any reference to a clause is to a provision of this Agreement that is uniquely identifiable by a preceding number and clauses may be nested so that a clause may contain subordinate clauses each uniquely identifiable by a subordinate preceding number and any reference to a clause includes all other clauses nested within that clause;

1.2.4 Any reference to a paragraph is to a paragraph of a Schedule or an Appendix to this Agreement (as appropriate)*;*

1.2.5 Any reference to Legislation will be construed as referring to such L*egislation* as amended and in force from time to time and to any L*egislation* which re-enacts or consolidates (with or without modification) any such L*egislation* provided that, unless *the Partners* agree otherwise, as between *the Partners*, no such amendment or modification will apply for the purposes of this Agreement to the extent that it would impose any new or extended obligation, liability or restriction on, or otherwise adversely affect the rights of, any *Partner;*

1.2.6 Any reference to a person or body will not be restricted to natural persons and will include natural persons, firms, partnerships, companies, corporations, associations, organisations, governments, states, foundations and trusts (in each case whether or not having separate legal personality);

1.2.7 Clause headings of all kinds including those that stand above, run into or appear to the side of clauses are provided for convenience of reference only and will not be construed as part of this Agreement or deemed to indicate the meaning of the clauses to which they relate or in any other way affect the interpretation of this Agreement or include the unique identifying numbers that precede every clause;

1.2.8 Where any conflict may arise between the provisions contained in this Agreement and any Schedules or other documents referred to herein, the provisions of this Agreement will prevail, except for any Legislation or other law or regulation which will prevail over the provisions of this Agreement;

1.2.9 Use of the singular will include the plural and use of the plural will include the singular;

1.2.10 Use of any gender will include the other genders;

1.2.11 Any phrase introduced by the terms “including”, “include”, “in particular” or any similar expression will be construed as illustrative and will not limit the sense of the words preceding those terms; and

1.2.12 References to a Partner, or any other person, includes a reference to that Partner's or person's successor and permitted assigns.

2. Duration of Agreement

2.1 This Agreement shall come into force on the Commencement Date and shall continue for the Initial Term (and such further period(s) as may be agreed by the Partners pursuant to Clause 3 (Extension of Partnership Agreement), unless terminated earlier in accordance with the terms of this Agreement.

3. Extension of Partnership Agreement

3.1 Subject to this being permissible under the then regime relating to public procurement in force in England and Wales, with effect from the end of the Initial Term of the Agreement, the Partners may extend the period of this Agreement in accordance with this Clause 3 for further period(s) of two (2) years provided that the aggregate of all such extensions does not exceed four (4) years.

Notice of Extension

3.2 Where a Partner wishes to extend the period of this Agreement pursuant to Clause 3.1, it shall serve not less than twelve (12) months’ notice in writing (prior to the date this Agreement is due to expire) to this effect on the other Partner and that other Partner shall respond in writing within thirty (30) days of the date such notice is served as to whether it wishes to agree to such extension.

3.3 Where the Partner on whom the notice was served pursuant to Clause 3.2 agrees to the proposed extension, this Agreement shall continue on the same terms as existed on the day before the Agreement would otherwise have expired but for such extension.

3.4 Where the Partner on whom the notice was served pursuant to Clause 3.2 declines the proposed extension or fails to give a written response within thirty (30) days of the date the notice is served, this Agreement shall not be extended and shall expire at the end of the Agreement period then current, unless terminated earlier in accordance with the terms of this Agreement.

3.5 Extension notices pursuant to Clause 3.2 shall be served on:

3.5.1 The CCG: Chief Officer of NHS Haringey Clinical Commissioning Group.

3.5.2 The Council: Deputy Chief Executive

4. The Partnership Arrangements

4.1 The Partners wish to ensure that services for people with health, wellbeing and social care needs are planned, commissioned and provided in an integrated manner. The primary aim of this Agreement is to ensure the most cost-effective use of the combined resources of the Partners to address the health and care needs of people who are their responsibility.

4.2 The Partners have agreed that, with effect from the Commencement Date, the partnership arrangements are to comprise:

4.2.1 Lead commissioning and the establishment and maintenance of pooled fund for the commissioning of learning disability services for eligible adults resident in Haringey as set out in Part 2 Schedule 3 and in accordance with the terms of this Agreement;

4.2.2 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of

mental health services for eligible adults resident in Haringey as set out in Part 2 Schedule 4 and in accordance with the terms of this Agreement;

4.2.3 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of long term conditions and older people's services, including those services identified in the Better Care Fund 2016/17, for eligible adults resident in Haringey as set out in Part 2 Schedule 5 and in accordance with the terms of this Agreement

4.2.4 Joint commissioning and the establishment and maintenance of a pooled fund for the commissioning of child and adolescent mental health services for the residents of the London Borough of Haringey (described in Part 2 Schedule 6 of this Partnership Agreement);

4.2.5 Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of the Independent Domestic Violence Advocacy Service and the Identification and Referral to Increase Safety Service for eligible adults resident in Haringey as set out in Part 2 Schedule 7 and in accordance with the terms of this Agreement.

AIMS AND OBJECTIVES

4.3 The Partners' agreed aims and objectives of the commissioning arrangements (including for the purposes of Regulation 7(3) (a) of the Regulations*)* are to ensure that:

4.3.1 the commissioning of the Services is based on an agreed picture of needs rather than historical service configurations;

4.3.2 the commissioned Services present good value for money and best value;

4.3.3 the Services seek to promote emotional and physical good health and work to overcome social exclusion;

4.3.4 the Services are culturally competent in meeting the needs of people from black and minority ethnic communities;

4.3.5 a whole systems approach is taken to the commissioning and provision of the Services by preventing duplication of such services and to make more effective use of the current resources (e.g. integrated care pathways);

4.3.6 robust arrangements to collect performance management information are established and maintained and that the information is used to evaluate performance against targets, monitoring both the effectiveness of the commissioning process and the commissioned Services, as more particularly described in Part 2 (the "**Aims and Objectives**").

4.4 Nothing in this Agreement shall affect the liabilities of the Partners to any third parties for the exercise of their respective functions and performance of their respective obligations.

4.5 On entering into this Agreement, the Partners shall jointly give notification of this Agreement to the Health and Social Care Joint Unit of the Department of Health. The notification shall be in the form annexed hereto as Appendix 3 (Form of Notification to the Department of Health), subject to such amendments as may be agreed in writing between the Partners. The Partners shall arrange for such notification to be updated on an annual basis, so as to reflect any variations to this Agreement.

4.6 The Partners may agree to enter into arrangements for the joint commissioning of system-wide initiatives. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners.

5 **Pooled Fund Arrangements**

5.1 The Partners agree that this Clause 5 shall apply where Pooled Funds are to be used in respect of an Individual Service as allowed for in Part 2.

5.2 The Partners acknowledge that they are entering into the Pooled Fund Arrangements pursuant to section 75(2)(a) of the 2006 Act and Regulation 7 of the Regulations. The Partners hereby agree that with effect from the Commencement Date they shall establish and thereafter during the period of this Agreement maintain a Pooled Fund for revenue expenditure in respect of the relevant Individual Service (the "**Pooled Fund Functions**") in accordance with the terms of this Agreement, the Partners being satisfied that the Pooled Fund Functions are a combination of NHS Functions and Social Care Functions.

5.3 The Partners agree to develop an annual Joint Strategy and Savings Plan. to ensure that there is transparency over the budgets, investments and savings in respect of the relevant pooled and aligned funds.

Partner Contributions

5.4 The Partners shall make Contributions annually to each Pooled Fund. The Contribution to each Pooled Fund of each Partner shall, for the first Financial Year of the Partnership Arrangements be as set out in the relevant Schedule of Part 2, and thereafter shall be determined in accordance with Clause 10 (Financial Contributions) of this Agreement and the relevant Schedule of Part 2. The Partners may agree in writing that further services become included in the Pooled Fund Functions for meeting the needs of Eligible Service Users where the additional services meet the Aims and Objectives.

5.1The persons in respect of which the Pooled Fund Functions may be exercised shall be the Eligible Service Users.

5.2The agreed aims and outcomes of the Pooled Fund Arrangements shall be the Aims and the Objectives respectively.

Host Partner Responsibilities

5.3The "host partner" for the purposes of the Regulations for each Pooled Fund shall be the Lead Commissioner. The Lead Commissioner will comply in all respects with the Regulations, the Guidance and any other relevant laws, regulations or guidance in the exercise of its functions as "host partner".

5.4The obligations of the Lead Commissioner as "host partner" pursuant to the Regulations shall be deemed to have been fulfilled if such reports, returns and information as are referred to therein are submitted to the Joint Executive Team (or successor body) by the Nominated Director or Nominated Commissioning Manager in accordance with the timings set out in the Regulations.

5.5The standing orders and standing financial instructions of the Lead Commissioner as notified to the other Partner from time to time shall apply to the management of the Pooled Fund.

5.6The Lead Commissioner shall be responsible for establishing the necessary financial and administrative support to enable the effective efficient management and effective monitoring and audit of the Pooled Fund.

5.7The Lead Commissioner shall also be responsible for establishing appropriate accounting arrangements for any Contributions transferred by the other Partner to enable effective monitoring and audit, and to comply with all relevant NHS or local authority guidance, including without limitation those relating to controls assurance. These arrangements shall comply with the relevant partner's standing orders and rule so as to be within vires of that partner's Constitution.

5.8The Lead Commissioner shall provide such information as deemed necessary by the Partners and the Joint Executive Team to enable such effective monitoring and reporting.

5.9The Lead Commissioner shall provide the other Partner with the necessary information it requires to meet the other Partner's controls assurance requirements.

Pooled Fund Manager's Responsibilities

5.10 The Lead Commissioner shall appoint the Nominated Commissioning Manager as the "pooled fund manager" for the purposes of the 7(4) of the Regulations for each of the Pooled Funds in respect of each Individual Service (the "**Pooled Fund Manager**") and the Pooled Fund Manager will be responsible for:

5.10.1 effectively and efficiently managing the Pooled Fund on behalf of the Partners*;*

5.10.2 authorising payments from the Pooled Fund in accordance with the Pooled Fund Functions and description of the Individual Services, as set out in the Schedules at Part 2;

5.10.3 submitting quarterly reports and annual returns on the relevant Pooled Fund in accordance with the Guidance and the Regulations and setting out in detail the income and expenditure from the Pooled Fund and other information by which the Joint Executive Team can monitor the use and effectiveness of the Pooled Fund;

5.10.4 ensuring that actions taken in respect of the relevant Pooled Fund are in line with the annual Joint Strategy and Savings Plan

5.10.5 ensuring that management arrangements and reporting for the Pooled Fund comply with audit requirements.

5.11 The Pooled Fund Manager shall be responsible for managing the Budget of the Pooled Fund and forecasting and reporting to the Joint Executive Team upon the targets and information in accordance with the relevant Schedule of Part 2 and any Performance Measures or further targets which the Partners may agree from time to time. Reporting will include progress against the agreed Services objectives plus information on actual or likely overspends and underspends, this to include monthly reporting in the case of any variances of or in excess of plus or minus 1% of an agreed Budget.

5.12 Where the Partners agree in writing, and in accordance with the terms of this Agreement, the Partners shall be jointly responsible (in the proportions of their respective Contributions to the Pooled Fund for the current Financial Year) for any costs, claims, expenses or liabilities in excess of the Pooled Fund at any time incurred.

5.13 The Partners will provide whatever information is deemed necessary to enable effective auditing of the Pooled Fund. The Lead Commissioner will arrange for the audit of the accounts of the Pooled Fund Arrangements each year and will require the Audit Commission (or successor body) to make arrangements to certify an annual return of those accounts under section 28(1) (d) of the Audit Commission Act 1998.

Use of Pooled Funds

5.14 The monies in the Pooled Funds:

5.14.1 may be expended on the Functions in such proportions as the Partners shall agree is necessary to undertake the Lead Commissioner Functions and to procure or otherwise provide the Services;

5.14.2 shall be spent in accordance with any restrictions agreed in writing between the Partners from time to time; and

5.14.3 are specific to the Partnership Arrangements and shall not be used for any other purpose.

6. Aligned Fund Arrangements

6.1 The Partners agree that this Clause 6 shall apply where Aligned Funds are to be used in respect of an Individual Service as identified in Part 2.

6.2 The Partners hereby agree that with effect from the Commencement Date they shall establish and thereafter during the period of this Agreement maintain an Aligned Fund for revenue expenditure incurred in the exercise of the Lead Commissioner Functions in respect of the relevant Individual Service (the "**Aligned Fund Functions**") in accordance with the terms of this Agreement, the Partners being satisfied that the Aligned Fund Functions are a combination of NHS Functions and Social Care Functions.

Partner Contributions

6.3 The Partners shall make Contributions annually to each Aligned Fund. The Contribution to each Aligned Fund of each Partner shall, for the first Financial Year of the Partnership Arrangements be as set out in the relevant Schedule of Part 2, and thereafter shall be determined in accordance with Clause 10 (Financial Contributions) of this Agreement and the relevant Schedule of Part 2. The Partners may agree in writing that further services become included in the Aligned Fund Functions for meeting the needs of Eligible Service Users where the additional services meet the Aims and Objectives.

6.4 The persons in respect of which the Aligned Fund Functions may be exercised shall be the Eligible Service Users.

6.5 The agreed aims and outcomes of the Aligned Fund Arrangements shall be the Aims and the Objectives respectively.

6.6 The standing orders and standing financial instructions of the Lead Commissioner as notified to the other Partner from time to time shall apply to the management of the Aligned Fund.

Lead Commissioner Responsibilities

6.7 The Lead Commissioner shall be responsible for establishing the necessary financial and administrative support to enable the effective efficient management and effective monitoring and audit of the Aligned Fund.

6.8 The Lead Commissioner shall also be responsible for establishing appropriate accounting arrangements for any Contributions transferred by the other Partner to enable effective monitoring and audit, and to comply with all relevant NHS or local authority guidance, including without limitation those relating to controls assurance. These arrangements shall comply with the relevant partner’s standing orders and rule so as to be within vires of that partners Constitution.

6.9 The Lead Commissioner shall provide such information as deemed necessary by the Partners and the Joint Executive Team (or successor body) to enable such effective monitoring and reporting.

6.10 The Lead Commissioner shall provide the other Partner with the necessary information it requires to meet the other Partner's controls assurance requirements.

Nominated Commissioning Manager Responsibilities

6.11 The Lead Commissioner shall appoint the Nominated Commissioning Manager as the manager for each of the Aligned Funds in respect of each Individual Service Manager will be responsible for:

6.11.1 effectively and efficiently managing the Aligned Fund on behalf of the Partners;

6.11.2 ensuring that actions taken in respect of the relevant Aligned Fund are in line with the annual Joint Strategy and Savings Plan

6.11.3 authorising payments from the Aligned Fund in accordance with the Aligned Fund Functions and description of the Individual Services, as set out in the Schedules at Part 2;

6.11.4 setting out in detail the income and expenditure from the Aligned Fund and other information by which the Joint Executive Team can monitor the use and effectiveness of the Aligned Fund;

6.11.5 ensuring that management arrangements and reporting for the Aligned Fund comply with audit requirements.

6.12 The Nominated Commissioning Manager shall be responsible for managing the Budget of the Aligned Fund and forecasting and reporting to the Joint Executive Team upon the targets and information in accordance with the relevant Schedule of Part 2 and any Performance Measures or further targets which the Partners may agree from time to time. Reporting will include progress against the agreed Services objectives plus information on actual or likely overspends and underspends, this to include monthly reporting in the case of any variances of or in excess of plus or minus 1% of an agreed Budget.

6.13 Where the Partners agree in writing, and in accordance with the terms of this Agreement, the Partners shall be jointly responsible (in the proportions of their respective Contributions to the Aligned Fund for the current Financial Year) for any costs, claims, expenses or liabilities in excess of the Aligned Fund at any time incurred.

7. Lead Commissioner Arrangements

7.1 The Partners agree that with effect from the Commencement Date the Partners shall enter into Lead Commissioning Arrangements, as set out in Part 2, in accordance with this Agreement, the Regulations and the Guidance. For each Individual Service, the Partner which shall be the Lead Commissioner and shall exercise the NHS Functions in conjunction with the Social Care Functions will be identifed in the relevant Schedule of Part 2.

7.2 The persons in respect of whom the Lead Commissioner may carry out Lead Commissioning shall be the Eligible Service Users.

7.3 The agreed aims and outcomes of the Lead Commissioner Arrangements shall be the Aims and the Objectives.

7.4 The Lead Commissioner shall in performing the Lead Commissioner Functions comply with the requirements of this Agreement, the Regulations, the Guidance and any other relevant laws, regulations or other governmental guidance.

7.5 Excluding any of the Services which are commissioned from a Pooled Fund, the Lead Commissioner may only commission Services under the NHS Function from the CCG's Contributions for the relevant Individual Service and under the Community Care Function from the Council's Contributions for the relevant Individual Service.

7.6 The Lead Commissioner shall, subject to the provisions relating to overspends and underspends in Clause 11 below, only commission Individual Services using funds from the corresponding Individual Service Budget.

7.7 The Nominated Commissioning Manager for each Individual Service or her delegated representative shall be the person responsible for tendering contracts for that Individual Service with any appropriate providers on behalf of the Partners. All contracts or service level agreements for jointly commissioned services will be entered into in the name of and executed by the Lead Commissioner.

7.8 Where the Council is the Lead Commissioner, it shall ensure that all contracts that include provision to commission the Services under the NHS Functions shall include a provision that those parts of contracts which relate to the commissioning of the Services under the NHS Function shall upon expiry or termination of this Agreement either expire or terminate or, at the sole option of the CCG, be assigned from the Council to the CCG upon the same terms mutatis mutandis as the original contract.

7.9 Where the CCG is the Lead Commissioner, it shall ensure that all contracts that include provision to commission the Services under the Community Care Function shall include a provision that those parts of contracts which relate to the commissioning of the Services under the Local Authority Function shall upon expiry or termination of this Agreement either expire or terminate or, at the sole option of the Council, be assigned from the CCG to the Council upon the same terms mutatis mutandis as the original contract.

8. Staffing Arrangements

8.1 The Lead Commissioning Functions will be carried out by a variety of staff within the partner's organisations. The partnership arrangements were already in place between the Council and the CCG and therefore no staff will transfer from one party to another on commencement of the new Agreement.

8.2 In the event that upon termination or expiry of this Agreement, the Transfer of Undertakings (Protection of Employment) Regulations 2006 (the "**Regulations**") is deemed to apply, then the Partners will be entitled to rely upon the following indemnities:

Indemnities in favour of the Transferee

8.2.1 The Partner from whom employees will transfer pursuant to the Regulations (the "**Transferor**") shall indemnify and hold harmless the Partner to whom employees will transfer pursuant to the Regulations (the "**Transferee**") against any claims that the Transferee incurs or suffers from relating to:

8.2.1.1 a determination or allegation that the employment of any of the Transferor's employees transfers to the Transferee pursuant to the Regulations in connection with the operation of this Agreement; and

8.2.1.2 any act, fault or omission (or any alleged act, fault or omission) of the Transferor in relation to any employee or former employee of the

Transferor whether arising prior to or after the transfer date (including, without limitation, any unfair dismissal liabilities);

Indemnities in favour of the Transferor

8.2.2 The Transferee shall indemnify and hold harmless the Transferor against any claims that the Transferor incurs or suffers from or relating to, but without limitation, any proposed changes to the terms and conditions of employment of the Transferor's employees, imposed by the Transferee.

8.3 For the avoidance of doubt, there is intended to be no double recovery under the indemnities set out in Clause 8.2

8.4 The Partners may agree to the secondment of staff to carry out the Lead Commissioner Functions. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners.

8.5 The Partners may agree to jointly appoint staff to carry out the Lead Commissioner Functions. The terms of any such agreement will be set out in writing by way of a variation to this Agreement, or in a separate written agreement between the Partners

9. Charging

9.1 The Council retains the power to charge Eligible Service Users for certain of its functions and it is agreed that in accordance with the Guidance the income therefrom shall be paid to the Council, and the Council shall not account for such income in calculating its contribution to the Pooled Funds, which shall be paid by the Council gross. The Partners shall establish and maintain a charging policy and protocol to ensure that the delivery of health care through the performance of any NHS Functions pursuant to this Agreement shall remain free at the point of delivery whilst ensuring that effective procedures exist to facilitate the exercise by the Council of its charging function.

9.2 The Partners acknowledge that there may be occasions where an adjustment to the Pooled Funds is required to reflect the relationship between income (held outside of the Pooled Funds) and expenditure (within the Pooled Funds) where, for example, there are significant reductions or increases in activity leading to variations in income and expenditure.

9.3 Where a package of NHS Functions commissioned services and Social Care Functions commissioned services are being provided to an Eligible Service User and the Social Care Functions commissioned services are being charged, the care management team responsible for the care of the said Eligible Service User will ensure that it is explained to the Eligible Service User as early as practically possible that the NHS Functions commissioned services continue to be provided free to avoid any misunderstanding that the NHS Function commissioned services are being charged for.

10. Financial Contributions

10.1 The Partners shall no later than 1st April of each Financial Year during the period of this Agreement confirm their respective Contributions to each Pooled Fund for that Financial Year.

10.2 The Partners shall use their reasonable endeavours in each Financial Year during the period of this Agreement to agree draft Budgets by each 1st February for the following Financial Year.

10.3 The Contributions by the Council and by the CCG to the Pooled Funds and the Aligned Funds for the period from the Commencement Date to the end of the first Financial Year are set out in Part 2.

10.4 When determining the Partners' Contributions to the Pooled Funds and the Aligned Funds in Financial Years subsequent to the first Financial Year, it is the intention of the Partners, in normal circumstances, to apply the following principles of joint business planning to provide assurance about the adequacy of resources:

10.4.1 Identifying prevailing levels of activity and cost drivers for the services to be provided;

10.4.2 Identifying trends and other financial and non-financial factors likely to influence costs of the services;

10.4.3 Identifying the scope for securing efficiencies and synergies in the delivery of services; and

10.4.4 Considering the affordability of Partner Contributions in the context of the Joint Strategy and Savings Plan, overall available resources and their prioritisation.

10.5 In determining the required budget for the year and the relevant Partner Contributions, the Partners shall negotiate and jointly agree appropriate changes in the Individual Services, including the identification of efficiencies and management actions so that expenditure will be covered by the Partners' Contributions for the new Financial Year. These changes will be reported as part of the formal reporting process.

11. Overspends and underspends

11.1 Where in the course of a Financial Year it appears that an overspend of any Individual Service Budget is likely at the end of the said Financial Year and the Partners have recognised that overspend, the Joint Executive Team will manage the Individual Service Budget by, in sequential order:

11.1.1 taking action to reduce expenditure;

11.1.2 identifying underspends that can be vired; and

11.1.3 asking for greater Contributions from *the Partners*;

11.2 Anticipated overspends of Individual Service Budgets that are part of a Pooled Fund will be apportioned in accordance with the percentage Contribution of each Partner to the Individual Service

Budget unless the Partners agree in writing to an alternative approach.

11.3 Anticipated overspends of Individual Service Budgets that are part of an Aligned Fund will be apportioned on a case by case basis following joint agreement between the Partners.

11.4 Where in the course of a Financial Year it appears that an underspend of any Individual Service Budget is likely at the end of the said Financial Year, the Joint Executive Team will manage the Individual Service Budget by, in sequential order:

11.3.1 viring to rectify overspends

11.3.2 returning their respective Contributions to the Partners proportionate to their respective Contributions, in order to meet individual cost pressures;

11.3.3 agreeing improvements to the Services; and

11.3.4 carrying forward for use against any previously agreed objectives for future Financial Years

11.5 The Partners shall not make any reductions to their respective funding levels until it has been agreed through the Clinical Commissioning Group's Governing Body for the Clinical Commissioning Group's investment level and the Council's Cabinet or relevant Cabinet Member for the Council's funding level. Neither Partner will reduce their Contribution without giving the other Partner not less than six (6) months' written notice of their intention to do so, and each party should have regard to any representations or observations made by the other party.

11.6 Should exceptional circumstances require significant unilateral change to funding levels during a financial year, outwith the agreed Joint Strategy and Savings Plan, the financial implications of any contractual commitments or other unavoidable financial impact to a partner will be met by the organisation making the unilateral funding reduction.

11.7 Where one Partner provides to the other Partner a taxable supply, the Partner providing that taxable supply will provide the other Partner with a Value Added Tax invoice for that taxable supply. The Partners confirm that the Partnership Arrangements have not been designed to avoid tax in any way. These arrangements may with the agreement of the Partners be amended from time to time in accordance with any advice and options for local protocols offered from HM Customs and Excise under guidance affecting partnership arrangements.

12. Capital Purchases

12.1 This Agreement does not provide any mechanism for making capital purchases. If the Partners decide at any time throughout the duration of this Agreement that it is necessary to make capital purchases then the Partners will agree this separately in writing.

13. Governance arrangements

13.1 Oversight of the Partnership Arrangements will be carried out by the Finance and Performance Partnership Board which will meet at least quarterly, in February, May, August and December. The Board will be co-chaired by a GP Governing Body Member and by a Member of the Council. The membership will comprise the following:

From the CCG:

- GP Governing Body Member (the "Co-Chair")
- Lay Member of the Governing Body who shall be qualified for membership due to holding qualifications, expertise or experience such as to enable him or her to express informed views about financial management and audit matters and who shall lead on audit, remuneration and conflict of interests matters (the "Deputy Chair")
- Accountable Officer
- Chief Finance Officer
- Director of Commissioning

From the Council:

- the Lead Member for Adults and Health
- Deputy Chief Executive
- Assistant Director of Commissioning
- Director of Adult Services
- Assistant Director of Finance

13.1.1 The quorum for the Partnership Board is at least three members from the CCG including a GP or Lay GB member and one CCG officer) and three members from Haringey Council (including the lead Member for Adults and Health and one Council officer).

13.1.2 The Finance and Performance Partnership Board will have delegated approval from the CCG Governing Body to make financial allocation decisions relating to the Section 75 Pooled Budgets to an agreed level.

13.1.3 The Finance and Performance Partnership Board will have delegated approval from the Council by the delegated budgetary authority vested in the council members of the committee to make financial allocation decisions relating to the Section 75 Pooled Budgets.

For financial issues outwith the delegated authority of the Board, the Board will make recommendations to the CCG Governing Body and the Council's Cabinet.

13.2 Reporting to the Finance and Performance Partnership Board will be the Joint Executive Team, which is the officer group with oversight of the Partnership Arrangements. The Team will be co-chaired by the Deputy Chief Executive of the Council and the Chief Officer of the CCG. In addition to the co-chairs, the membership of the Joint Executive Team will include senior officers of the CCG and the Council.

13.2.1 The Lead Commissioners will report to the Joint Executive Team for both their pooled fund manager and lead commissioner functions and report on their areas of responsibility as required.

13.2.3 A Joint Finance and Commissioning Group will meet at least every two months to monitor expenditure and performance of the Partnership Arrangements and prepare reports to the Joint Executive Team.

13.2.4 Monthly monitoring of activity and expenditure will be undertaken by the Lead Commissioner so that early warning can be given and action taken to address any concerns arising.

13.2.5 An annual report on the implementation of this Agreement shall be provided to the Health and Wellbeing Board.

13.2.6 Individual Services may also wish to report annually to the service specific partnership boards on the delivery of the Aims and Objectives through the mechanism of this Agreement.

13.2.7 The role of the Deputy Chief Executive of the Council and of the Chief Officer of the CCG shall be to:

13.2.7.1 resolve jointly any actual or potential conflicts of interest relating to this Agreement;

13.2.7.2 address sub-standard performance as described in Clause 13 (Standards of Service and Monitoring);

13.2.7.3 agree strategies for media contact;

13.2.7.4 receive notices served on *their respective Partner Organisation*; and

13.2.7.5 take part in the first stage of the dispute resolution procedure set out in Clause 14 (Governing Law and Dispute Resolution);

14. Standards of Service and Monitoring

14.1 In the event that either Partner shall have any concerns about the operation of the Partnership Arrangements or the standards achieved in connection with the carrying out of the Partnership Arrangements it may convene a review with the other Partner with a view to agreeing a course of action to resolve such concerns.

Performance measures

14.2 *The Partners* will be accountable for the efficiency and effectiveness of the commissioning process and for Services commissioned under this Agreement by reference to Performance Measures. The Partners will monitor the effectiveness of the Partnership Arrangements and use measures of performance to develop their work. The Performance Measures will demonstrate:

14.2.1 how far the aims of the Partnership Arrangements are being achieved;

14.2.2 the extent to which the outputs including timescales and milestones are being met;

14.2.3 the extent to which agreed Aims and Objectives are being fulfilled, and targets met;

14.2.4 the financial inputs and outputs;

14.2.5 the extent to which the exercise of the flexibilities in Section 75 of the 2006 Act is the reason for improved performance, or a reduction in the performance of the Services;

14.2.6 how the Partnership Arrangements compare with the previous arrangements, and other approaches to providing the Services.

14.3 The Partners shall each exercise the required degree of care, skill and diligence in accordance with best practice in relation to performance of their duties under this Agreement, and will meet their obligations under this Agreement in accordance with the relevant laws, regulations and guidance.

14.4 The Partners shall review the operation of the Partnership Arrangements and all or any procedures or requirements of this Agreement on the coming into force of any relevant statutory or other Legislation or guidance affecting the Partnership Arrangements so as to ensure that the Partnership Arrangements comply with such Legislation.

Best value duty

14.5 The Council is subject to the Best Value Duty. The Social Care Functions will be subject at all times to compliance with the Best Value Duty.

14.6 The CCG shall ensure that any requirements which the Council reasonably requires to meet its Best Value Duty are incorporated and reflected in its delivery and performance of the Social Care Functions. This is only insofar as this is subject to the Council's Contributions being sufficient to cover any increased costs. For the avoidance of doubt, this may include efficiency savings or reconfiguration of the Services and the Partners shall undertake any appropriate consultation prior to implementation.

Clinical governance duty

14.7 The Council shall ensure that any of the Services commissioned through this Agreement comply with expected requirements for clinical governance and controls assurance to which the CCG is subject. The CCG is subject to a duty of clinical governance, which (for the purposes of this Agreement) shall be defined as a framework through which it is accountable for assuring the quality of services commissioned and to promote a continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The Council acknowledges that clinical governance (as described above) applies to the treatment of NHS patients. Such patients are entitled to expect to receive services which are part of a clinical governance system irrespective of where they are treated. The Partnership Arrangements will therefore be subject to ensuring that there are clinical governance obligations included in contracts commissioned by the Lead Commissioner where relevant to the particular services commissioned. The Council shall use reasonable endeavours to co-operate with all reasonable requests from the CCG, which the CCG considers necessary in order to fulfil its clinical governance obligations.

14.8 Where the Council, acting as Lead Commissioner, is undertaking procurement and contracting on behalf of the CCG, the form of contract and performance requirements therein will be developed with regard to the requirements of NHS contracts and of the CCG.

14.9 For the avoidance of doubt, this Agreement in no way releases either Partner from any requirement to comply with the general law or any internal standing order, by-law, policy, financial procedure or decision of the Council or the CCG which is inconsistent with this Agreement.

14.10 Each Partner shall be entitled to make representations and recommendations to the other Partner relating to the other Partner's performance of its obligations under this Agreement. Each Partner will in good faith give due regard to the other Partner's representations and recommendations, and shall promptly respond, in writing, giving reasons why such representations and/or recommendations were or were not followed.

14.11 Sub-standard performance will in the first instance be addressed through the Joint Executive Team and thereafter referred as indicated in Clause 15 below.

15. Governing Law and Dispute Resolution

15.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter, shall be governed and construed in accordance with English Law and subject to the exhaustion by the Partners of the dispute resolution procedure set out in this Clause 15, the Partners hereby submit to the exclusive jurisdiction of the English courts.

15.2 Any dispute concerning this Agreement shall be first referred in writing to the Deputy Chief Executive for the Council and the Chief Officer for the CCG who shall enter into good faith negotiations to resolve the matter.

15.3 In the event that the dispute remains unresolved on the expiry of twenty eight (28) days from the date of the referral under Clause 14.2, or such longer period as the Partners may agree, the dispute shall be referred to the Cabinet Member for Adult Social Care and Health, or for Children's Services (as appropriate), and the Chair of the CCG who shall enter into good faith negotiations to resolve the matter.

15.4 In the event that the dispute remains unresolved on the expiry of twenty eight (28) days from the date of the referral under Clause 14.2, or such longer period as the Partners may agree, the Partners shall jointly refer the dispute to a mediator appointed by the Centre for Effective Dispute Resolution ("CEDR").

15.5 The mediator shall determine the rules and procedures by which the mediation shall be conducted save that:

15.5.1 each Partner shall be entitled to make a written statement of its case to the mediator prior to the commencement of the mediation, provided that such statement shall be provided to the mediator not less than fourteen (14) days or such other period as may be agreed by the mediator before the mediation is to commence; and

15.5.2 within fourteen (14) days of the conclusion of the mediation the mediator shall provide a written report to the Partners which report shall set out the nature of the dispute and the nature of its resolution if any.

15.6 The mediator shall be entitled to be paid their reasonable fee, which the Partners shall pay in equal shares.

15.7 Neither Partner may commence court proceedings in relation to any dispute concerning this Agreement until fourteen (14 days) after mediation in accordance with Clause 14.5 has failed to resolve the dispute, provided that either Partner's right to issue proceedings is not prejudiced by a delay and nothing in this Clause 14 shall prevent either Partner applying to the court for injunctive or other interim or equitable relief.

16. Complaints

16.1 As soon as reasonably practicable following the Commencement Date, the Partners will agree and operate a joint complaints system relating to the Lead Commissioner Functions. The application of such a joint complaints system will be without prejudice to a complainant’s right to use either of the Partners’ statutory complaints procedures where applicable.

16.2 Prior to the Partners agreeing a joint complaints system or if the Partners agree to cease operating any such joint complaints system (without agreeing a replacement system), the following will apply:

16.2.1 where a complaint wholly relates to one or more of the Council's Social Care Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

16.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG;

16.2.3 where a complaint relates partly to one or more of the Council's Social Care Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the CCG, in line with local joint protocol;

16.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the Partnership Arrangements by the Joint Executive Team or the content of this Agreement, then the Joint Executive Team will set up a complaints subgroup to examine the complaint and recommend remedies.

16.3 All complaints relating to the Lead Commissioner Functions shall be reported by the Partners to the Joint Executive Team and on to the Finance and Performance Partnership Board as appropriate. .

17. Regulation and Inspection

17.1 The Partners shall cooperate with any investigation undertaken by the Care Quality Commission, the Health Service Commissioner and/or the Local Government Commissioner for England or any regulatory authority/body.

17.2 The Partners shall cooperate with any audit undertaken by the Audit Commission (or any successor body), the Department of Health, the NHS Commissioning Board and/or any local government audits.

18. Information Sharing

18.1 Both Partners shall follow and ensure that the Partnership Arrangements comply with all Legislation, regulations and guidance on information sharing produced by the Government.

18.2 The Partners shall establish and keep operational and ensure that there are kept operational:

18.2.1 procedures (including forms) for handling Eligible Service User access and consent;

18.2.2 documentation for Eligible Service Users which explains their rights of access, the relevance of their consent, rules and limits on confidentiality, and how information about them is treated; and

18.2.3 such additional policies procedures and documentation as shall be necessary in order to meet the purposes, guidance and requirements of Government and of all relevant data protection Legislation as they apply to the Partners and the Partnership Arrangements.

18.3 The Partners shall in the performance of their obligations under this Agreement comply with the Information Sharing Agreements in place between the council and CCG.

19. Serious and Untoward Incidents

Adults

19.1 Both Partners acknowledge that the Safeguarding Vulnerable Groups Act 2006 and Multi-Agency Policy and Procedures to Protect Vulnerable Adults from Abuse shall apply to the Services.

The Partners agree that any clinical governance incidents shall be investigated by the CCG.

19.2 The Partners acknowledge that serious and untoward incidents may occur in relation to the Services. In the case that the allegation relates to:

19.2.1 the Services, then the allegation shall be handled in accordance with the relevant Partner's serious and untoward incident policy;

19.2.2 if the allegation refers to a Partner itself then the allegation shall be handled in accordance with the Council's serious and untoward incident policy.

19.3 Any incidents being investigated by a Partner shall be notified as soon as reasonably practical by that Partner to the Joint Executive Team, who shall be kept informed of all stages of the investigations.

19.4 The Partner leading the investigation shall make the Council's and CCG's Press Office (or equivalent) aware of any situations that may have an impact on the Council or CCG.

Children

19.5 Both Partners acknowledge that the Children Acts 1989 and 2004 apply to the Services. All Services shall adhere to the current statutory framework (Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, March 2015) and London Child Protection Procedures.

19.6 Any serious incidents regarding children that involve Individual Services shall be investigated in accordance with Legislation, London Child Protection Procedures and the relevant Partner's serious and untoward incident policy.

19.7 Where an allegation relates to a member of staff from one of the Partners itself, then the case shall be referred to the Local

Authority Designated Officer for Allegations against staff working with children.

19.8 Any serious incidents involving children or the death of a child known to Individual Services shall be reported to the Designated Nurse for Safeguarding Children for the CCG and the Head of Children Safeguarding for the Council.

19.9 In the event of a death or serious injury of a child, the Local Safeguarding Children Board shall consider whether a serious case review is required in accordance with Legislation. Both Partners shall ensure that full cooperation is given to the review. The CCG shall lead the review on behalf of health organisations within the terms of reference set by the Local Safeguarding Children Board.

Assistance

19.10 Each Partner shall provide to the other, all reasonable assistance required in relation to the investigation of any serious and untoward incident in relation to the Services.

20. Termination

20.1 Either Partner may:

20.1.1 terminate this Agreement; or

20.1.2 terminate this Agreement solely in so far as it relates to an Individual Service or Individual Services (in which case the provisions of this Agreement as to termination shall mutatis mutandis apply),

by giving not less than twelve (12) months' written notice to the other Partner.

20.2 Either Partner (the "First Partner") may terminate this Agreement by giving not less than three (3) months' notice in writing to the other Partner if:

20.2.1 the Partners cannot agree the Budget for any

subsequent Financial Years;

20.2.2 the other Partner commits a material breach of a provision of this Agreement and (where such breach is capable of remedy) fails to remedy such breach within two calendar months of a written notice being given which requires such breach to be remedied and which states that it is the intention of the notifying Partner to terminate this Agreement forthwith if the breach is not so remedied;

20.2.3 the other Partner commits a material breach of a provision of this Agreement which is not capable of remedy;

20.2.4 the Services persistently fail to meet the Performance Measures or any standards required by law or guidance or which have been agreed by the Partners;

20.2.5 the other Partner suffers an Event of Force Majeure (as defined in Clause 21.16.1) and such Event of Force Majeure persists for more than thirty (30) days following the service of the notice referred to at Clause 21.16.4.2;

20.2.6 the First Partner's fulfilment of its obligations under this Agreement would be in contravention of any guidance from any Secretary of State issued after the date hereof;

20.2.7 the fulfilment of the Partnership Arrangements would be ultra vires; or

20.2.8 the Partners are unable to agree a variation to this Agreement in accordance with Clause 21.3 (Entire Agreement, Variations and Change Control) so as to enable either/both Partners to fulfil its/their obligations in accordance with law and guidance.

20.3 Where this Agreement is terminated by a Partner under either Clause 20.1 or 20.2 (Termination) on the other Partner, each Partner shall (unless the Partners agree in writing otherwise) continue to perform its obligations under this Agreement throughout the relevant termination notice period.

20.4 Upon termination or expiry of this Agreement howsoever occurring, the Partners will be entitled to a proportion of any monies held by the Lead Commissioner with regard to any of the Individual Services included in Part 2. The entitlement with regard to each Pooled Fund will be in proportion to each Partner's contribution to that Pooled Fund and the Lead Commissioner(s) will pay such amount to the other Partner within thirty (30) days of the date that this Agreement terminates or expires, subject always to the terms in relation to the continuing liabilities set out at Clause 19.5 below.

20.5 Upon expiry or termination of this Agreement for any reason whatsoever the following shall apply:

20.5.1 The Council and the CCG shall continue to be liable to purchase the various Individual Services set out in Part 2 in accordance with the terms of this Agreement to fulfil all existing obligations to third parties;

20.5.2 The Partners shall remain liable to operate the Pooled Fund and joint commissioning arrangements in accordance with the terms of this Agreement so far as is necessary to ensure fulfilment of their obligations;

20.5.3 Each Partner shall remain liable to contribute that proportion of the cost of each Individual Service which either is its proportionate Contribution in the current or most recent Financial Year. If such Contribution has not at the date of notice of termination yet been confirmed, the Partners' liability will be based on their respective contributions in the immediately preceding Financial Year;

20.5.4 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Eligible Service Users, employees, the Partners and third parties;

20.5.5 Any assets purchased from any of the Pooled Fund will be disposed of by the relevant Lead Commissioner for the purposes of meeting any of the costs of winding up the Services or where this is not practicable such assets will be shared proportionately between the Council and the CCG according to the level of past contributions to the Pooled Fund;

20.5.6 upon expiry or termination of this Agreement, monies in the Pooled Fund shall continue, notwithstanding termination, to be used by the Pooled Fund Manager to pay for any of the Services delivered by third parties under contracts approved by the Joint Executive Team. Thereafter any underspend (including any interest) shall be returned to the Partners pro rata to their Contribution. Any overspend shall be borne by the Partners pro rata to their Contributions provided that where and to the extent any overspend is caused or contributed to by either Partner acting in breach of the terms of this Agreement, such Partner shall be fully responsible for such element of the overspend;

20.5.7 the Joint Executive Team shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

20.5.8 expiry or termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such expiry or termination takes effect.

20.6 Where a Partner is entitled to terminate this Agreement pursuant to Clause 19.2 and the circumstances giving rise to such right relate to a particular Individual Service or Individual Services, the Partner may at its sole option choose to terminate this Agreement solely in so far as it relates to such Individual Service or Individual Services and the provisions of this Agreement as to termination shall mutatis mutandis apply.

21. Indemnity and Limitation of Liability

21.1 Each Partner *(*the "Indemnifying Partner"*)* will fully indemnify the other and its staff, officers and agents (the "Indemnified Partner") against all losses, costs, expenses, damages, liabilities, actions, claims or proceedings at common law or under Legislation which arise as a result of or in connection with any act, default, negligence, breach of contract or breach of statutory duty on the part of the Indemnifier, its staff, officers or agents, except and to the extent that such losses, costs, expenses, damages, liabilities, actions, claims or proceedings arise out of the act, default, negligence, breach of contract or breach of statutory duty on the part of the Indemnified Partner*.*

21.2 Neither Partner excludes or limits its liability for death or personal injury caused by negligence, or fraudulent misrepresentation.

21.3 Subject to Clause 21.2, neither Partner will be liable for any indirect losses suffered by the other Partner whether such losses or the potential for such losses were made known to the Partner or not and the limit of each Partner's aggregate liability to the other under this Agreement in any twelve month period shall not exceed one million pounds (£1,000,000). For the purposes of this Clause 21.3, twelve month periods shall be measured from the Commencement Date and anniversaries thereof.

21.4 If any third party makes a claim or intimates an intention to make a claim against either Partner*,* which may reasonably be considered as likely to give rise to an indemnity under Clause 20.1, the Indemnified Partner that may claim against the Indemnifying Partner will:

21.4.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Partner specifying in reasonable detail the nature of the relevant claim;

21.4.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Indemnifying Partner (such consent not to be unreasonably conditioned, withheld or delayed);

21.4.3 give the Indemnifying Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

21.5 For the avoidance of doubt, the Indemnified Partner shall be under a duty to mitigate any loss in accordance with the principles of common law and the indemnity given at Clause 21.1 above shall not extend to losses, costs, expenses, damages, liabilities, actions, claims or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement committed by the Indemnified Partner.

21.5 Each Partner shall ensure that they maintain appropriate insurance arrangements in respect of employers' liability, liability to third parties and other insurance or risk pooling arrangements to cover their liability under this Agreement.

22. Other provisions

22.1 Confidentiality

22.1.1 Except as required by law and specifically pursuant to Clause 22.9 (Freedom of Information Act 2000), each Partner agrees at all times during the continuance of this Agreement and after its termination to keep confidential any and all information, data and material of any nature which either Partner may receive or otherwise obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of the other Partner, its employees, agents and/or any other person with whom it has dealings including any client, patient or Eligible Service User of either Partner. For the avoidance of doubt this clause shall not affect the rights of any workers under Section 43 A-L of the Employment Rights Act 1996.

22.1.2 The Partners agree to provide or make available to each other sufficient information concerning their own operations and actions and concerning client, patient and Eligible Service User information (including material affected by the Data Protection Act in force at the relevant time) to enable efficient operation of the Partnership Arrangements (which include the Services).

22.1.3 The Partners will ensure that the provision of the Services complies with all relevant data protection legislation regulations and guidance and that the rights of access by Eligible Service Users to their data are observed.

22.2 Public Relations

The Partners will co-operate and consult with each other in respect of matters involving public relations in so far as reasonably practicable having regard to the nature and urgency of the issue involved. The parties may agree Protocols of the handling of public relations from time to time.

22.3 Entire Agreement, Variations and Change Control

22.3.1 The terms herein contained together with the contents of the Schedules under Part 2 constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on either Partner.

22.3.2 No agreement or understanding varying or extending any of the terms or provisions of this Agreement shall be binding upon either Partner unless in writing and signed by a duly authorised officer or representative of the Partners.

22.3.3 If at any time during the Term of this Agreement:

(a) the Council or CCG requests in writing any change to the Services described or the manner in which the Services are commissioned; or

(b) if a change to the manner in which an Individual Service is or the Services are commissioned is required by operation of NHS or local government law through statutes, orders, regulations, instruments and directions made by a Secretary of State in relation to the NHS Functions or the Social Care Functions respectively or others duly authorised pursuant

to statute or other changes in the law which relate to powers, duties and responsibilities of the Partners and which have to be complied with, implemented or otherwise observed by the Partners in connection with their functions then, the Partners will investigate the likely impact of any such change on an Individual Service, the Services or any other aspects of this Agreement and shall prepare a report in writing within a reasonable period of time of receipt of a change request;

22.3.4 Any report prepared by the Partners pursuant to Clause 22.3.3(b) shall include:

(a) a statement of whether the change will result in an increase or decrease in Contributions to the relevant Pooled Fund or Aligned Fund by reference to the relevant component elements of the Individual Service(s) the subject of the change;

(b) a statement of the individual responsibilities of the Partners for any implementation of the change;

(c) a timetable for the implementation of the change;

(d) a statement of any impact on and any changes required to the Individual Service or Services;

(e) details of any proposed staff and employment implications; and

(f) the date for the validation or expiry of the report.

22.3.5 Where the Partners are unable to agree on the terms of the report then the dispute resolution provisions

set out at Clause 14 (Governing Law and Dispute Resolution) in this Agreement shall apply.

22.3.6 If agreement in principle to the change(s) is reached, the Partners shall confirm in writing their decision to proceed with the change(s) referred to in the said report and shall agree a formal variation of this Agreement in accordance with Clause 21.3.2 (Entire Agreement, Variations and Change Control) of this Agreement.

22.3.7 The Partners shall comply with their respective duties to consult on any change in, or addition to, the Services in accordance with the Regulations.

22.4 No Partnership

22.4.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

22.4.2 Except as expressly provided otherwise in this Agreement, neither Partner will have authority to, or hold itself out as having authority to:

22.4.2.1 act as an agent of the other;

22.4.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

22.4.2.3 bind the other in any way.

22.5 Contracts (Rights of Third Parties) Act 1999

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

22. 6 Notices

22.6.1 Any notice of communication hereunder shall be in writing.

22.6.2 Any notice or communication to the Council hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the Council at the address set out above and marked for the Chief Executive of the Council or to such other addressee and address notified from time to time to the CCG for service on the Council.

22.6.3 Any notice or communication to the CCG hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the address set out above and marked for the attention of the Managing Director of the CCG or to such other addressee and address notified from time to time to the Council for service on the CCG.

22.6.4 Any notice served by hand delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice forty eight (48) hours after the time it was posted.

22.7 Data Protection

22.7.1 The Partners acknowledge their respective duties under the Data Protection Act 1998 (the “DPA”) and

shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

22.7.2 To the extent that the Lead Commissioner is acting as a Data Processor (as such term is defined in the DPA) on behalf of the other Partner, the Lead Commissioner shall, in particular, but without limitation:

22.7.2.1 only process such Personal Data (as such term is defined in the DPA) as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the other Partner under this Agreement;

22.7.2.2 put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

22.7.2.3 take reasonable steps to ensure the reliability of employees who will have access to such Personal Data; and

22.7.2.4 not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the other Partner.

22.8 Freedom of Information Act 2000

22.8.1 Each Partner acknowledges that the other Partner is subject to the requirements of the Freedom of Information Act 2000 (the “FOIA”) and the Environmental Information Regulations (the “EIR”) and each Partner shall assist and cooperate with the other (at their own expense) to enable the other Partner to comply with these information disclosure obligations.

22.8.2 Where a Partner receives a "request for information" under either the FOIA or EIR (as defined under those Acts) in relation to information which it is holding on behalf of the other Partner, it shall (and shall procure that its sub-contractors shall):

(a) transfer the request for information to the other Partner as soon as practicable after receipt and in any event within two (2) Working Days of receiving a request for information;

(b) provide the other Partner with a copy of all information in its possession or power in the form that the other Partner requires within five (5) Working Days (or such other period as may be agreed) of the other Partner requesting that information; an

(c) provide all necessary assistance as reasonably requested to enable the other Partner to respond to a request for information within the time for compliance set out in the EIR or section 10 of the FOIA, as relevant.

22.8.3 Where a Partner receives a request for information which relates to the Agreement, it shall inform the other Partner of the request for information as soon as practicable after receipt and in any event within

two (2) Working Days of receiving a request for information.

22.8.4 If either Partner determines that information must be disclosed pursuant to Clause 21.8.6 it shall notify the other Partner of that decision at least two (2) Working Days before disclosure.

22.8.5 Each Partner shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

22.8.6 Each Partner acknowledges that the other Partner may be obliged under the FOIA to disclose Information:

(a) without consulting with the other Partner, or

(b) following consultation with the other Partner and having taken its views into account.

22.9 Severability

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

22.10 Changes in Legislation

Partners may review the operation of the Agreement and all or any procedures or requirements of this Agreement on the coming into force of any Legislation or guidance affecting the provision of the Services so that the commissioning of the Services under this Agreement complies with such Legislation or guidance.

22.11 Assignment or Transfer

This Agreement and any rights and conditions contained in it may not be assigned or transferred by either Partner without the prior written consent of the other Partner except to any statutory successor to the relevant function.

22.12 Waivers

22.12.1 The failure of any Partner to enforce at any time to or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

22.12.2 No waiver in any one or more instance of a breach of any provision hereof shall be deemed to be a further or continuing waiver if such provision in other instances.

22.13 Costs

Each Partner shall be liable for their own respective costs in relation to this Agreement.

22.14 Further acts

The Partners agree to do or procure to be done all such further acts and things and execute or procure the execution of all such other documents as either Partner may from time to time reasonably require for the purpose of giving full effect to the provisions of this Agreement and the intentions of the Partners as expressed in this Agreement, and the Partners will at all times act and deal in good faith towards each other in respect of all matters the subject of this Agreement.

22.15 Force majeure

22.15.1 Where a Partner is affected by an event or circumstance which is beyond the reasonable control of the Partner, including without limitation war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or

earthquake, and which directly causes that Partner to be unable to comply with all or a material part of its obligations under this Agreement (an “Event of Force Majeure”), it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

22.15.2 Subject to Clause 22.15.1, the Partner claiming relief shall be relieved from liability under this Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Agreement.

22.15.3 The Partner claiming relief shall serve initial written notice on the other Partner immediately it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

22.15.4 The Partner claiming relief shall then either:

22.15.4.1 serve a detailed written notice within a further seven (7) days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

22.15.4.2 in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Partnership Arrangements to continue, serve notice of this to the other Partner and either Partner may then terminate this Agreement in accordance with Clause 21.2.5 of this Agreement.

APPENDIX 1

JOINT INFORMATION SHARING PROTOCOL

TO BE INSERTED

APPENDIX 2

NHS HARINGEY CCG MEMBER PRACTICES

The following General Medical Practitioners are members of the Haringey CCG and are approved to operate within the boundaries of Haringey.

Practice Name	Address

APPENDIX 3

FORM OF NOTIFICATION TO THE DEPARTMENT OF HEALTH

ROCR/OR/0226 **Licence Expiry Date:**

The use of this collection has been approved by the Review of Central Returns Steering Committee – ROCR.

This is a Mandatory collection from clinical commissioning groups and NHS Trusts. Monitor, Independent Regulator of Foundation Trusts, has provided approval for a voluntary collection.

NOTIFICATION FORM
SECTION 75 PARTNERSHIP ARRANGEMENTS

To be completed for each partnership arrangement and updated annually for amendment of a partnership arrangement.

This form below should be sent to the Health and Social Care Joint Unit, c/o CSIP ICN, Department of Health, Room 304 Wellington House, Waterloo Road, London SE1 8UJ.

Email: MB-HSD-SCJU@dh.gsi.gov.uk

1. NAMES OF THE STATUTORY PARTNERS (Officers & Organisations)	
2. DATE OF AGREEMENT	
3. DATE WHEN PARTNERSHIP IS INTENDED TO START OR DATE OF ANNUAL UPDATE FOR DH IF THIS HAS BEEN PREVIOUSLY NOTIFIED	
4. TITLE OF OFFICER RESPONSIBLE FOR THE PARTNERSHIP	

5. CONTACT NAME	
6. CONTACT TEL. NO.	
7. WHICH FLEXIBILITIES ARE BEING USED? • LEAD COMMISSIONING (LC) • POOLED FUNDS (PF) • INTEGRATED PROVISION (IP)	

8. WHICH CARE GROUP OR CATEGORY DOES THE PARTNERSHIP SERVE?	
9. SUMMARY OF KEY OBJECTIVES **(DO NOT COMPLETE AGAIN IF PREVIOUSLY NOTIFIED AND THESE REMAIN UNCHANGED AT THE TIME OF ANY ANNUAL UPDATE)**	
10. CONTRIBUTIONS **IDENTIFY THE FINANCIAL CONTRIBUTION OF EACH PARTNER SEPARATELY** **(To be updated by notification annually)**	

OVERARCHING SECTION 75 NATIONAL HEALTH SERVICE ACT 2006 HEALTH AND SOCIAL CARE PARTNERSHIP AGREEMENT

between

LONDON BOROUGH OF HARINGEY

and

NHS HARINGEY CLINICAL COMMISSIONING GROUP

Commencement Date: 2016

FOR THE COMMISSIONING OF LEARNING DISABILITY SERVICES, ADULT MENTAL HEALTH SERVICES, CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES, INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCRAESE SAFETY SERVICES AND BETTER CARE FUND SERVICES

PART 2

SCHEDULE OF INDIVIDUAL AGREED SERVICES

The Schedule of Agreed Services is agreed on an annual basis and should be read in conjunction with PART 1 of this Agreement

PART 2
SCHEDULE 1

LEARNING DISABILITIES SERVICES

SCHEDULE OF AGREED SERVICES 2016-17	
Name of Service	**Community Learning Disabilities Service**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Council Lead Commissioning with Pooled Budget (containing pooled and aligned funds)
Delegated Function	**Health Function** – The commissioning of Learning Disabilities Services on behalf of Haringey Clinical Commissioning Group
The Services	Haringey Council will commission on behalf of itself and Haringey CCG a Community Learning Disabilities Team. Haringey Council will manage a pooled budget to fund the commissioning of the staffing in this service and additional placements and packages required to meet the needs of users of the service. The specification for the service is set out as an addendum.
Aim of Service(s)	The aim of the service is to support people with learning disabilities by commissioning services that seek to build resilience, promote independence, support balanced risk taking in the context of being safe, are innovative in approach and reduce the need for statutory services over time.
Outcome of Service(s)	Outcomes are set out in full in the specification and include: • Reduced inpatient activity by 50% • Reduced average length of stay for all admissions • No use of residential care except where no other option is available • Support planning that helps users of the service to achieve their outcomes and goals, promotes independence and control and involves them at all stages • Access to positive behaviour support for all patients of all ages with challenging behaviour • Reduction in the use of out of area placements and increased support for care closer to home • Increased use of Personal Integrated Care Budgets and Direct

	Payments • Elimination of/reduction in existing health inequalities • Transformation of care and culture working towards a life course approach with local services built around the individual and integrated approaches as the norm • Increased employment, education and vocational activity for people with learning disabilities • Effective engagement with users and carers to inform service delivery and improvement • Increases in numbers of people with a learning disability with a Health Action Plan
Strategy/Framework Documents (if applicable)	• Building the Right Support • The Care Act, 2014 • The Mental Health Act, 1983 • The Mental Capacity Act, 2005
Eligibility and Assessment Procedures	As set out in the addendum.
Key Performance Indicators	For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	No staff or other resources are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments. Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.
Pooled Budgets	• LD (Haringey Learning Disability Partnership Staff): **£3,161,227** • LD (Packages of Care): **£22,800,000** • Haringey CCG (Packages of Care): **£9,000,000**

ADDENDUM

OUTLINE SPECIFICATION

HARINGEY COMMUNITY LEARNING DISABILITY TEAM (CLDT) SERVICE

1. Strategic vision

1.1 Haringey Clinical Commissioning Group (the CCG) and London Borough of Haringey (the Council) wish to commission a Community Learning Disability Team (CLDT) service which supports our strategic vision for adults and transitioning children with learning disabilities for whom they have they a responsibility.

1.2 Our aim is support people with learning disabilities by commissioning services that seek to build resilience, promote independence, support balanced risk taking in the context of being safe, are innovative in approach and reduce the need for statutory services over time. We will do this in partnership and as part of a whole-system transformation to improve care for all people with learning disabilities.

1.3 We expect the CLDT to work closely and in full partnership with service users and carers to identify the goals and outcomes which are important to them and which promote their independence, enable them to live in the community and support them to lead ordinary lives. As a partnership, we expect the provider of the service to adopt an integrated approach which ensures seamless delivery of health and social care to people accessing the service and minimises barriers to delivering joined up care and support. To enable this, the specification is supported by a pooled budget which will enable the service to work in creative and innovative ways to deliver outcomes for users that matter to them, engage them in wider civic life and keep within the budget allocated.

1.4 As Transforming Care is implemented locally and across North Central London we expect the CLDT to be engaged in and responsive to the programme of change in partnership with commissioners.

1.5 This specification will be supported by a Delivery Plan which details how the provider will offer an integrated approach will delivers against the requirements of this specification, drives changes in workforce culture and operates within the budget available.

2. Principles

2.1 We wish to commission services based on the principles set out in the national guidance, Building the Right Support. These principles are as follows:

2.2 People should be supported to be independent and to have a **good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2.3 Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

2.4 People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

2.5 People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

2.6 People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

2.7 People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

2.8 People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

2.9 When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or ‘offending’ behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and

care function to support people who may pose a risk to others in the community.

2.10 When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

2.11 In addition, people should receive care closer to home which promotes their independence.

3. Outcomes for users

3.1 Outcome 1: Promoting independence

- I want to live at home and as independently as possible
- I want to do as much for myself as I can including managing my own health and wellbeing needs
- I want be as active and as healthy as I can
- I want to set my goals and outcomes and work to achieve them with support where necessary
- I want my friends and family to be involved in my care and to make new friends and relationships
- I want to be able to go outside my home to lead an ordinary life including employment, education, leisure and social relationships

3.2 Outcome 2: Help in a crisis

- I want short term help when I am in a crisis to enable me to do the things I could do before the crisis
- I want to be independent and return home as quickly as possible

3.3 Outcome 3: Safeguarding

- I want to be free from abuse
- I want to feel safe

3.4 Outcome 4: Quality when services are necessary

- I want a responsive service, with consistency of care
- I want a service delivered by people who care
- I want a service delivered by people trained to support my condition
- I want to be involved in decisions about my care package

4. Service Outcomes supported

4.1 The expected outcomes that the service will support are as follows:

- Reduced inpatient activity by 50%
- Reduced average length of stay for all admissions
- No use of residential care except where no other option is available
- Support planning helps users of the service to achieve their outcomes and goals, promotes independence and control and involves them at all stages
- Access to positive behaviour support for all patients of all ages with challenging behaviour
- Reduction in the use of out of area placements and increased support for care closer to home
- Increased use of Personal Integrated Care Budgets and Direct Payments
- Elimination of/reduction in existing health inequalities
- Transformation of care and culture working towards a life course approach with local services built around the individual and integrated approaches as the norm
- Increased employment, education and vocational activity for people with learning disabilities
- Annual reviews as a minimum – target 100%
- Multi-disciplinary assessments and reviews
- Effective engagement with users and carers to inform service delivery and improvement
- Increases in numbers of people with a learning disability with a Health Action Plan

5. Eligibility

i)Eligibility by residence, registration and statutory duty:
Individuals resident in Haringey and/or registered with a Haringey GP (or otherwise usually resident as defined in the Responsible Commissioning guidance) are eligible for this service. For avoidance of doubt, individuals for whom the council or CCG has responsibility under the Care Act, Section 117 of the Mental Health Act or who are Continuing Health Care are also eligible for this service. This may include individuals placed in or out of the borough and those being discharged from forensic units.

ii) Eligibility by need:
The specific cohorts of individuals whom can access the service are:

a) **People aged 18 and over who have a global learning disability (GLD) in community, acute, acute mental health and learning disability hospital settings.**

b) **Individuals with a GLD in any of those settings who have another formal diagnosis** – for example autism, mental health or substance misuse – the CLDT will be expected to provide services to that individual in collaboration with other relevant agencies. On a case by case basis, dependent on clinical need, the CLDT may also act as the lead agency with care co-ordination responsibility for that individual.

c) **Individuals in any of those settings who have an unclear or disputed GLD diagnosis**, the CLDT is expected to offer support and advice to other relevant agencies and to provide services to the individual if professionals agree this to be of clinical benefit. This will need to be agreed on a case by case basis between professionals involved in the patient's care.

d) **Under-eighteens in the community and residential schools transitioning to the CLDT service from children's teams** - the CLDT should offer advice support and take an active part in transition planning for these individuals including leading the Transition Team

6. Services offered

6.1 The following services will be offered in a way consistent with the principles set out in Building the Right Support. In a person centred, multi-disciplinary, and integrated way and in accordance with all guidance and clinical guidelines associated with the council and CCG's statutory duties and the relevant professional bodies, the service will provide the following:

a) Assessment of health and social care needs.

b) Integrated pathways for service users with multiple and complex needs and challenging behaviour, including those with physical health needs.

c) The development of care and support plans to meet those needs which specify expected outcomes and timescales for progress towards achieving these.

d) Referral to Haringey's Brokerage Team which will design and broker packages of care which meet the identified health, care and support needs.

e) Regular multi-disciplinary review and revision as necessary of those care plans at least annually.

f) Care co-ordination which is proactive and part of an multi-disciplinary approach.

g) Provision of learning disability specialist treatment and care which meets the needs of those using the service, including nursing, social

work, psychology, positive behaviour support, occupational therapy, speech and language therapy and psychiatry.

h) Support to individuals to ensure that they access employment or meaningful activity, have secure income and accommodation and positive social networks.

i) Preventing and responding to crises, including maintaining a register of people at risk of hospital admission.

j) Support to service users to access mainstream health and care services, including for their physical health.

k) Liaison and support to families and carers as part of a person centred care planning process.

7. Recommendations to the Council and CCG in relation to specific statutory duties

7.1 The CLDT will deliver services to ensure that the council and CCG are compliant with their statutory duties under all relevant legislation. These are:

a) Acceptance or discharge of a S117 duty

b) Application for a Deprivation of Liberty order

In both these cases, it is expected that the CLDT will make full clinical recommendations to the CCG and council to enable these bodies to make the necessary approvals and decisions in relation to these duties. The CLDT is expected to take full responsibility for organising assessments and reports and preparing documentation in relation to these duties as necessary.

Continuing Healthcare (CHC)

7.2 The CLDT will undertake CHC assessments and reviews in full accordance with national guidance and make recommendations to the CCG as regards eligibility or otherwise for individuals who have met the threshold. The CLDT will present the outcome of assessments and reviews to Haringey's Eligibility Panel in accordance with the agreed terms of reference.

8. Budget

8.1 The CLDT will manage a pooled budget, allocated by the Lead Commissioner. The aim of the pooled budget is to enable the CLDT to offer an integrated approach which ensures joined up delivery of health and social care and better outcomes for service users. It is expected that each of the salary and care purchasing elements of the budget will be considered as a pool to enable an integrated workforce to be developed and care and support

planning which meets needs rather than follows separate health or social care requirements.

8.2 The CLDT will ensure that the pooled budget is managed effectively and will report monthly to the Lead Commissioner for Learning Disabilities on the budget, including identifying any risk of over or under spends arising.

8.3 The CLDT will report to the Lead Commissioner in the format required which meets the requirements of both the Council and the CCG.

9. Monitoring and delivery

9.1 The Lead Commissioner for Learning Disabilities will meet at least monthly with the CLDT to monitor delivery against the requirements of this specification and to ensure the targets and outcomes are on track for achievement.

9.2 The CLDT will develop a Delivery Plan to share with the Lead Commissioner which shows how it will meet the service requirements set out here, including how the workforce will be shaped to reflect the requirements for an integrated approach set out in this specification.

9.3 During this meeting, the Lead Commissioner will review progress on managing within the budget, savings targets, projected activity and performance levels and person centred outcomes. Any variance will be reported in a timely manner at these monthly monitoring meetings to enable mitigating action to be taken.

10. Quality assurance

10.1 The CLDT will be accepted to deliver high quality services in accordance with all relevant standards of care. The CLDT will have an internal quality assurance framework which complies with relevant guidance and includes as a minimum clinical governance structures, clinical audit, policies for serious untoward incidents, safeguarding and complaints, monitoring of service user and workforce experience and satisfaction, risk management and workforce development.

11. Liaison and interface with other services

11.1 The CLDT is expected to act as a source of expertise in relation to people with learning disabilities. It will act as a point of advice and support to other agencies in making reasonable adjustments to their services including primary care services, acute and mental health inpatient provision, mental health and general community services and council services.

12. Supporting CCG and council returns

12.1 The council and CCG are expected to make returns to NHS England, the Department of Health and Department of Communities and Local

Government. These include the monthly submission to NHSE about progress in relation to the discharge of inpatients and the annual Learning Disabilities and Autism Self Assessments. The CLDT is expected to provide accurate and full information that is held by the service in a timely way in accordance with the requirements of the returns and to offer support and advice to commissioners as necessary. The CLDT may be requested to join meetings with these government departments as required.

13. Purchase of packages of care

13.1 The CLDT will be responsible for-approving spend on packages of care within the allocated budget to meet health and social care needs identified through the assessment and care planning process. To give assurance of quality and cost effectiveness of these packages, the CLDT will work directly with Haringey's Brokerage Team, with appropriate senior management oversight. The Brokerage Team will:

a) Identify potential providers/cost benchmarking

b) Set up packages of care as appropriate to meet user need and in line with the principles and outcomes set out in this specification.

c) Quality check providers' proposed care plans – to include, compliance with person centred principles and positive behaviour support approaches, least restrictive options, appropriate risk management, goals which maximise independence, clear interventions to address needs, clear outcomes for the service user in relation to these needs and clear timescales for progress and review.

d) Have in place clear processes for raising quality concerns found as a result of the review or in between reviews and issues associated with safeguarding, incidents and CQC inspections.

13.2 In addition, the CLDT will carry out:

a) Robust review processes including a forward plan of annual reviews, an internal assurance process for ensuring the quality of the review and that the review has robustly considered how independence can be maximised and least restrictive options for the service user.

b) Robust financial monitoring and reporting on year to date and forecast spend.

c) Systems for identifying risks of overspend and developing clear recovery plans to bring the budget in line with allocation.

14. National legislation, Guidance and Good Practice

14.1 It will remain the responsibility of the service provider to be aware of current and changing legislation governing and informing the delivery of services, and will remain the responsibility of the service provider to ensure that it complies with all and any changes to national legislation and published guidance on good practice

PART 2
SCHEDULE 2

ADULT MENTAL HEALTH SERVICES

Name of Service	**Adult Mental Health Services**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	CCG Lead Commissioning with a pooled budget (containing pooled and aligned funds)
Delegated Function	**Local Authority Function** –The commissioning of adult mental health services on behalf of the London Borough of Haringey
The Services and Functions	Haringey CCG will commission on behalf of itself and Haringey CCG a range of services and pathways which enable the implementation of priorities 1, 3 and 4 of the Haringey Mental Health and Well Being Framework (the framework).* Haringey CCG will manage a pooled budget to support this. An addendum to this schedule summarises what the CCG will commission on behalf of itself and the council. *These are the priorities relating to adults, there is a separate schedule under this section 75 agreement for CAMHS which sits under Priority 2 of the framework.
Aim of Service(s)	The overall aim is that all residents in Haringey are able to fulfil their mental health and wellbeing potential which includes ensuring the following: • **A prevention and early help offer** based on working with communities to build emotional resilience, to tackle root causes of mental illness such as unemployment, low levels of education and reduce social isolation, stigma and discrimination; • **Effective, evidence based primary care mental health** services - models focusing on multidisciplinary teams based in communities and arranged as 'hubs'. • **Secondary and specialist services** that are commissioned based on the outcomes, with co-ordinated single point of entry with information about services, waiting times and support to access services readily available to service users, carers and professionals. • A **whole system approach** to integration and enablement

Outcome of Service(s)	• **Improved resilience and self-confidence**
	  ○ Access to appropriate settled accommodation
	  ○ Engaged in paid and sustained employment and/or other meaningful activity
	  ○ More people with mental health problems will have good physical health
	• **More people will have good mental health**
	  ○ Strong social networks and reduced isolation
	  ○ Fewer people will suffer avoidable harm and die by suicide
	  ○ Fewer people will experience stigma and discrimination
	• **Increased activity in low intensity, lower cost resources**
	  ○ There is a choice of readily accessible resources available that meets a range of needs and preferences
	  ○ Pathways to (including access standards) and availability of resources understood by all stakeholders
	  ○ Reduced activity in intensive, high cost resources

Statutory Guidance / Strategy / Framework Documents (if applicable)	The Care Act, 2014 The Mental Health Act, 1983 The Mental Capacity Act, 2005 Haringey Joint Mental Health and Wellbeing Framework
Eligibility and Assessment Procedures	Various dependent on specific service.
Key Performance Indicators	For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	Mental Health Enablement Lead – Jointly funded post Council contribution: £39k CCG contribution: £39k Other than this, no staff are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments. Any alterations to those establishments which may impair the

operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.

Pooled Budgets

Mental Health Adults and Dementia Budgets - Haringey Council and CCG
based on 2015/16 - to be updated / confirmed

Budget	Council	CCG	Sub total	Comments
	£'000s	**£'000s**	**£'000s**	
Mental Health				
Care Purchasing 18-64 with MH	6,378	700	7,078	
Care Purchasing 65+ with MH	1,030		1,030	
Joint funded with MH		877	877	incl all joint funded
CMHT seconded to BEH	1,285	40	1,325	CCG £ paid via S255
Clarendon Centre	-24	580	556	CCG £ paid via S256
			10,866	
Voluntary Sector				
Catch 22 (svc also for LD)	28		28	
North London Samaritans	4		4	
Twining Enterprise	-5	55	50	CCG £ paid via S256
The Brandon Centre	114		114	
MIND		65	65	
NAFSIYAT		47	47	
MH Carers		86	86	
ACL Pyramid		20	20	
Embrace		10	10	
Mental Health Education Project		10	10	
CAB		101	101	
			535	
BEH MH Trust				
BEH Adults community		13,898	13,898	
BEH Adults inpatient		9,046	9,046	
BEH OP community		2,832	2,832	
BEH OP inpatients		2188	2,188	
BEH other		154	154	BEH total contr is

Item				
BEH total excl CAMHS (£2.436), RAID (£646)				**28,118**
Other NHS Trusts				
Camden and Islington FT		715	715	
East London FT		446	446	
S London and Maudsley FT		52	52	check CAMHS %
Tavistock and Portman (excl CAMHS)		113	113	CAMHS excluded
NCA activity		297	297	
RAID at North Middlesex (paid to BEH)		646	646	paid to BEH
RAID at Whittington (paid to WH)		200	200	
IAPT (incl in WH contract)		2100	2,100	assumption
Big White Wall - via PH c£30k				remains of 14/15
			4,569	
Dementia				
Care Purchasing 18-64 with dementia	10		10	
Care Purchasing 65+ with dementia	4209	1137	5,346	
Care Mgmt & Assess SW Team	274		274	
Day services - The Grange	64.5	237.5	302	CCG £ paid via S256
Day services - The Haynes	94.5	237.5	332	CCG £ paid via S256
			6,264	
Public Health MH Promotion	205		205	
	13,667	**36,890**	**50,557**	

Budget Manager (NHS) Cost Centre	
Budget Manager (LA) Cost Centre	

ADDENDUM

OUTLINE SPECIFICATION ADULT MENTAL HEALTH SERVICE

ARRANGEMENTS FOR LEAD COMMISSIONING TO IMPLEMENT THE HARINGEY MENTAL HEALTH AND WELL BEING FRAMEWORK

1. Context

1.1 The Haringey Mental Health and Wellbeing Framework (the Framework)[1] and the completion of the CAMHS Review and Transformation Plan have set out the strategic vision, priorities and outcomes for mental health in the borough for children and adults. To implement the framework, the CCG and the Council will build wider partnerships and relationships with relevant stakeholders including service users and carers, voluntary sector partners, Mental Health NHS Trusts, GPs, acute NHS Trusts, emergency services and criminal justice agencies.

1.2 The development of the framework has highlighted the synergy of approach between the CCG and the Council towards improving mental health and wellbeing for all, with a strong emphasis on approaches and services which deliver prevention and early intervention, enablement and high quality.

1.3 To implement the framework, the Council and CCG have agreed to establish CCG lead commissioning and pooled budget arrangements. This addendum specifies what the CCG will commission on behalf of itself and the council to deliver the framework with the available pooled budget which is set out in the attached schedule.

2. Principles on which services and pathways will be commissioned

2.1 The principles on which the CCG as lead will commission services and associated pathways are as follows:

- Working together in partnership to co-design services with residents and patients.
- Offering person-centred services based on outcomes for the individual within an enablement approach.

1

http://www.haringey.gov.uk/sites/haringeygovuk/files/mental_health_and_wellbeing_framework_document_pdf_2803kb_0.pdf

- Promote an asset based approach that builds individual, family and community strengths and avoids the need for more intensive and high cost services.
- Strive for quality and ensure timely access to appropriate services.
- Commission and deliver efficient and effective services based on robust evidence.
- Develop integrated services to ensure that those with mental ill health, their families and carers feel enabled and supported.

3. Priorities

3.1 To support implementation of the Framework, the CCG is expected to lead on a number of work streams within the identified priorities. These are:

Priority 1: Promoting mental health and wellbeing and preventing mental ill health across all ages

Priority 2: Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood

Priority 3: Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa

Priority 4: Commissioning and delivering an integrated enablement model which uses individuals, families and communities' assets as an approach to support those living with mental illness to lead fulfilling lives

3.2 The CCG is expected to refine, develop and lead these work streams throughout the lifetime of the agreement and report against agreed milestones within the overall governance structure of the S75.

4. Supporting CCG and Council returns

4.1 The CCG will ensure that statutory data collection requirements as set out in national Outcomes Frameworks are collected in an accurate and timely way by all relevant suppliers.

4.2 The lead commissioner will prepare, provide information for, or assist with the co-ordination of, returns to NHS England, the Department of Health and the Department of Local Government and Communities, or others as required.

5. Pooled fund development

Through these arrangements the council intends to delegate its care purchasing responsibilities through a pooled fund. Whilst care purchasing budgets will be aligned from the start of this agreement it is acknowledged that full pooling will take further work and the CCG as lead commissioner will propose a delivery plan to be agreed through the governance arrangements of the S75.

PART 2

SCHEDULE 3

LONG TERM CONDITIONS AND OLDER PEOPLE'S SERVICES, INCLUDING BETTER CARE FUND

Name of Service	
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	CCG Lead Commissioning with a pooled budget (containing pooled and aligned funds)
Delegated Function	Haringey Council delegates commissioning responsibility for the Better Care Fund to Haringey CCG.
The Service	The Better Care Fund
Aim of Service(s)	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.
Outcome of Service(s)	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
Strategy/Framework Documents (if applicable)	• Haringey Better Care Fund (BCF) Narrative Plan 2016-17 • Haringey BCF 2014-16 (http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm)
Eligibility and Assessment Procedures	• Governed by the Care Act 2014.
Key Performance Indicators	• 2.6% reduction in Non-Elective Admissions (NELs) • 8% reduction in the number of delayed transfers of care (DTOC, delayed days) • 3.9% reduction in the number of non-elective admissions for falls related injuries • 7% reduction in rate of permanent admissions (65+) into residential and nursing care • 1.8% increase in proportion of patients discharged into reablement/ rehabilitation services still at home 91 days following discharge • 2.2% increase in the proportion of patients who felt that they have received enough support to manage their long term health conditions
Resources (Staffing)	
	A joint commissioning post (Commissioning Lead – Better Care Fund) will oversee the programme management of the Better Care Fund and be the lead commissioner. This post is line managed and employed by Haringey CCG and reporting to Haringey CCG and Haringey Council. A Commissioning Project Officer – Better Care Fund will report to the Commissioning Lead – Better Care Fund. A joint commissioning Data Analyst Post shall be managed and employed by Haringey Council. The Better Care Fund shall meet the agreed salary costs of all three Joint Posts; the budget for which is as indicated in Scheme 4 (BCF Programme).
Resources (Financial)	

Service	LBH	NHS HCCG	TOTAL
Social Care Team (LBH)		£252,000	£252,000

Whittington ICTT/ Nursing		£6,771,095	£6,771,095
Locality Team		£1,041,253	£1,041,253
MDT		£89,000	£89,000
Overnight District Nursing Service		£150,000	£150,000
Dementia Day Opportunities		£475,000	£475,000
Whittington falls service		£58,000	£58,000
Palliative Care		£300,000	£300,000
Rapid Response		£250,000	£250,000
Reablement		£3,042,905	£3,042,905
Step down		£625,000	£625,000
Home from Hospital		£150,000	£150,000
MH Navigator		£40,000	£40,000
7 Day Social Worker		£146,067	£146,067
Cavell Ward		£1,254,233	£1,254,233
Neighbourhoods Connect		£160,000	£160,000
Information, Advice and Guidance (IAG)		£55,000	£55,000
Self-Management Support		£116,600	£116,600
Interoperable IT		£22,095	£22,095
BCF Programme		£175,000	£175,000
Principal Social Worker		£60,000	£60,000
VBC IPU Support		£69,496	£69,496
Disabled facilities grant	£1,818,000		£1,818,000
Carers		£1,067,000	£1,067,000
Contingency		£1,332,740	£1,332,740
TOTAL	**£1,818,000**	**£17,702,484**	**£19,520,484**

Budget Manager (NHS) Cost Centre	Marco Inzani, Commissioning Lead – Better Care Fund Scheme 1 – Admission Avoidance: 162726 Scheme 2 – Effective Hospital Discharge: 162731 Scheme 3 – Promoting Independence: 162736 Scheme 4 – Integration Enablers: 162741
Budget Manager (LA) Cost Centre	

PART 2

SCHEDULE 4

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Name of Service	**Child and Adolescent Mental Health Services**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Joint Commissioning with Pooled Budget (containing pooled and aligned funds)
Delegated Function	**Local Authority Function** – The commissioning of Child and Adolescent Mental Health Services on behalf of the London Borough of Haringey
The Services	Haringey CCG will commission on behalf of itself and Haringey CCG a range of services and pathways which enable the implementation of priority 2* of the Haringey Mental Health and Well Being Framework (the framework). Haringey CCG will manage a pooled budget to support this. An addendum to this schedule summarises what the CCG will commission on behalf of itself and the council. *This is the priority relating to CAMHS, there is a separate schedule under this section 75 agreement for adult mental health which sits under Priorities 1, 3 and 4 of the framework.
Aim of Service(s)	• To provide appropriate mental health support for children and young people, delivering the right service at the right time • To meet and deliver the outcomes outlined in Haringey's CAMHS Transformation Plan
Outcome of Service(s)	The CAMHS Transformation Plan identifies the following outcomes: 1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value 2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support which avoids over-medicalising children and young people and that builds a system of support in natural contexts such as school and home. 3. A coordinated preventative approach for children and young people, parents/carers and families through systems around the child working

	well together to support emotional wellbeing across the children's workforce. 4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support 5. Flexible services that meet the preferences and developmental needs of children and young people 6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery 7. Better inter-agency working and improved communication with referrers and better discharge planning 8. More focused work that reduces dependency and promotes resilience and enablement 9. Improved crisis planning and pathways that provide timely support and robust follow up 10. Clear protocols for cross-boundary issues and working between child and adult services 11. Better engagement with under-represented communities/groups
Strategy/Framework Documents (if applicable)	• Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (DH) • Haringey CAMHS Transformation Plan
Eligibility and Assessment Procedures	Various dependent on specific service
Key Performance Indicators	• For each of the services commissioned we will develop an agreed set of local KPIs in addition to any existing national indicators.
Resources for managing the partnership	
	Children and Young People's Vulnerable Children's Joint Commissioning Manager, funded jointly by the Council and the CCG. Other than this, no staff are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments. Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in

	sufficient time to allow mitigations to be agreed.

Pooled budgets

Service	LBH	NHS HCCG	TOTAL
Barnet, Enfield and Haringey Mental Health Trust (Specialist CAMHS- Generic, AOT)	£0	£2,436,203*	
Tavistock and Portman Specialist Child & Adolescent Services	£0	£412,930*	
Extra-Contractual Referrals/Non-Contracted Activity	£0	£31,166	
Primary Care CAMHS/CAMHS in GP Surgeries	£0	T	
Royal Free (Eating Disorders & Generic)	£0	£256,280 ED £25,000 Gen***	
SLAM (CIPP)	£0	£25,000***	
Whittington Paediatric Mental Health Liaison Team	£0	**	
North Mid University Hospital Child and Adolescent Paediatric Liaison Team	£0	**	
CAMHS Transformation Projects- Various Providers	£0	£515,302	
Commissioning Budgets			
Tavistock and Portman First Step (LAC)	£362,921	T	
Barnet, Enfield & Haringey Mental Health Trust (CAMHS LD, Youth Offending)	£172,000	T	
Multi-Systemic Therapy	£114,000	£0	
Open Door	£46,500	£123,991 + T	
CYPS Budgets			
Barnet, Enfield and Haringey Mental Health Trust (Edge of Care)	£38,800	£0	
Public Health Budgets			
Young Minds	£21,200	£0	
Whittington PIPs	£69,000	£235,000*	

*: Reference costs/estimations only as part of block contracts.

**: Within Acute Tariff

***: Cost/Volume (Estimated)

T: CAMHS Transformation Funding 16/17 allocation - included in line' **CAMHS Transformation Projects- Various Providers'**	
Budget Manager (NHS) Cost Centre	
Budget Manager (LA) Cost Centre	

PART 2

SCHEDULE 5

INDEPENDENT DOMESTIC VIOLENCE ADVOCACY AND THE IDENTIFICATION AND REFERRAL TO INCREASE SAFETY SERVICES

SCHEDULE OF AGREED SERVICES 2016-17	
Name of Service	**Independent Domestic Violence Advocacy (IDVA) and the Identification and Referral to Increase Services (IRIS)**
Type of agreements *(e.g. section 75, 76 or 256)*	Section 75
Type of Service *(e.g. Lead Commissioning, Pooled Budget)*	Council Lead Commissioning
Delegated Function	**Health Function** – The commissioning of the IRIS on behalf of Haringey Clinical Commissioning Group
The Services	Haringey Council will commission on behalf of itself and Haringey CCG a joint IDVA and IRIS function. Haringey Council will manage a pooled budget to fund the commissioning of the staffing and interventions in this service and additional placements and packages required to meet the needs of users of the service. The specification for the service is set out as an addendum.
Aim of Service(s)	The aim of the service is to support people affected by domestic violence by commissioning services that seek to build resilience, promote independence and support a balanced risk approach.
Outcome of Service(s)	Outcomes are set out in full in the specification and include: A. Improved access to justice and experience of the criminal justice system for all victims/survivors/clients of DV/A who report to the police – including reducing case attrition and providing support at the Specialist DV Court B. Victims/survivors/clients are satisfied with the service C. Victims/survivors/clients experience a reduction in risk and have increased feelings of safety D. Reduced harm to victim/survivor/client (and their children) E. Incidents of repeat victimisation identified and responded to

	F. Male victims appropriately screened/identified and able to access as required specialist national and Pan London services G. Victims/survivors/clients/service user supported to increase their (and their children's) safety and control over their lives, by working with them to develop appropriate safety plans and providing practical safety measures H. Improved emotional, mental and physical health of victims/survivors/clients and support to access resources to maintain their health and wellbeing I. Victims/survivors/clients/service user supported to regain autonomy and control of their lives
Strategy/Framework Documents (if applicable)	• VAWG Strategy (in development) • Communities Strategy • National Strategy
Eligibility and Assessment Procedures	As set out in the specification, contained within the contract.
Key Performance Indicators	For the IDVA/IRIS service there is an established set of local KPIs and national indicators set out in the contract.
Resources for managing the partnership	
	No staff or other resources are transferred or seconded between the partners as a result of this agreement. The partners will make available staffing resources and capacity to enable the operation of the agreement from their existing establishments. Any alterations to those establishments which may impair the operation of the partnership will be notified to the other partner in sufficient time to allow mitigations to be agreed.
Pooled Budgets	N/A

Addendum
Aims and Objectives
As set out in the contract and specification

A key element of delivering the revised Domestic Violence Pathway for Haringey, as endorsed by the Haringey Violence Against Women and Girls Strategy Group, is to ensure sufficient and focused capacity for independent domestic violence advocacy across the borough. The key aim of this Partnership Agreement is to support delivery of enhanced and joined up capacity across the borough to respond to the needs of women affected by domestic violence through the joint commissioning of Identification and Referral to Improve Safety (IRIS) and IDVA provision in Haringey. This Agreement enables the Council to act as lead commissioner of a joined up IRIS and IDVA service to strengthen the response to women affected by domestic violence and support a joint approach across the borough. A single commission which ensures that future provision across the IDVA and IRIS service is delivered jointly will ensure a more joined up experience for women using the service. This will in turn increase effectiveness and efficiency, reduce duplication and decrease the amount of fragmentation in the system.
An Independent Domestic Violence Advisor (IDVA) is a specialist domestic violence professional who supports victims at the highest risk of murder or serious injury. Their job is to make the victim and their family as safe as possible. They stand alongside victims and make sure they get whatever help they need.

Experts in high risk domestic violence, IDVAs provide vital emotional and practical support to victims. They deal with everything from getting an injunction to sorting out money to having the locks changed. Their job is to make sure the victim is safe – and they do whatever it takes.

The main purpose of Independent Domestic Violence Advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short- to medium-term to put them on the path to long-term safety. They receive specialist accredited training and hold a nationally recognised qualification.

Since they work with the highest risk cases, IDVAs are most effective as part of an IDVAs service and within a multi-agency framework. The IDVA’s role in all multi-agency settings is to keep the client’s perspective and safety at the centre of proceedings. Studies have shown that when high risk clients engage with an IDVA, there are clear and measurable improvements in safety, including a reduction in the escalation and severity of abuse and a reduction or even cessation in repeat incidents of abuse.

The IRIS project provides resources in general practice so that staff at all levels can be trained in identifying those who are at risk of or may be experiencing domestic violence. The project is successful as an Advocate Educator (AE) will be recruited to provide training to practice staff and will be integrated into the wider IDVA services.

The AE will raise awareness of VAWG issues, provide training so the practice staff can effectively use the HARKS software, and will support victims of domestic violence by referring them into the IDVA service as appropriate. The AE will be integrated into the provider organisation, ensuring continuity of service, while at the same time having a distinct role within the pathway.

The specification for this single, unified service is contained in the contract for the service which reflects the aims and objectives set out above.

The NHS and the Council's Functions and Responsibilities

Introduction

1. This schedule sets out the Functions of both the CCG and the Council relevant to the provision of the Services. It also sets out the scope of delegation of functions to the Designated Body required to enable it to ensure the provision of the Services.

The Council's Functions:

2. The Council's Functions relevant to the provision of the Services are:

To agree to the arrangements so that the provision of a joint IRIS and IDVA service for women affected by domestic violence is embedded as an essential component of the revised domestic violence pathway approved by the Haringey Violence Against Women and Girls Strategy Group.

To act as the Designated Body and commissioning Lead.

To discuss and agree the service requirements annually with the nominated CCG Officer/s.

To embed the service requirements into the main contracts with the designated and appropriate providers.

To ensure delivery of the service requirements and standards as part of the regular contract performance meetings; raising any issues or concerns about the Service from the CCG with the provider/s and feeding back issues from the providers to the nominated CCG Officer/s. The Council should invite the CCG officers to contract performance meetings if appropriate or necessary.

To forward agreed monitoring data in the agreed format from the provider to the nominated CCG Officer/s.

To make payments for the Service to the provider at the level agreed with the CCG as part of the regular contract payments.

To invoice the CCG at the agreed rates and for the appropriate volume of activity undertaken by the provider on a quarterly basis.

The CCG's Functions:

4. The CCG's Functions relevant to the provision of the Services are:

To set out the service requirements and service and staff standards and requirements annually for discussion and agreement with the Council.

To ensure identified GPs work effectively with the commissioned IRIS IDVA service, providing the Advisors with the requests and relevant information for the activity.

To liaise directly with the advisors and advocate educators on operational and quality matters for specific cases and panels, raising any general concerns with the Council to be addressed via contract performance meetings.

To scrutinise monitoring return from the providers and confirm to the Council that they reflect and meet the requests made directly to the providers by the CCG.

To provide and/or authorise appropriate training for the providers.

To pay the invoices received from the Council.

Scope of Delegation to the Designated Body

5. The following functions are delegated to the Designated Body by the CCG**:**

To commission the providers best placed to deliver the service
To embed the service requirements into the main contracts
To performance manage the providers
To pay the providers
To provide appropriate service and financial reporting to the Council
To invoice quarterly at the agreed rates for the Council's contribution

This page is intentionally left blank

Action List from Health and Wellbeing Board

Action	Owner	Response
23rd February 2016		
AD Public Health agreed to discuss the role of the voluntary & community sectors in delivery of sustainable employment outcomes with BRT	Tamara Djuretic	Assistant Director Public Health met with Bridge Renewal Trust to discuss the role of the voluntary & community sectors. Chief Executive of BRT is now a member of the Sustainable Employment working group.
The Board requested an update from the Social Prescribing Task and Finish Group.	Tamara Djuretic	The draft model for Social Prescribing, outcomes and the way of integrating the model into the wider system was discussed at the Social Prescribing Task and Finish group on 10th May. A phased approach to developing and scaling up the model in the borough will be taken, starting by extending the pilot linked to the one GP practice to at least one or two another practices in both, east and west of the borough. The approach will also focus further work on developing the referral pathway and referral criteria for the model. The group agreed to start developing the business case and look into various funding opportunities across the borough, both regionally and nationally. A proposal will be made to the HWB Board in autumn for discussion and approval.
Chief Officer, Haringey CCG agreed to circulate copies of the BCF submission to the Board.	Sarah Price	The Leader has signed off the BCF plan and it has been submitted. The BCF plan is included in the agenda pack at Item 18.
19th May		
Written update on Immediate Care and Integration	Will Maimaris	Progress against the next steps as laid out in the health and wellbeing board presentation on intermediate care on 19th May 2016 is outlined below. <u>Increasing capacity and scope of our Rapid Response service</u> Investment has been secured from NHS winter resilience funds to pump prime expansion of Haringey's rapid response service. Expansion of the service will enable the service to increase support to the Emergency Departments and Short-stay Assessment Wards at North Middlesex Hospital and Whittington Hospital and will also make it simpler for GPs to refer into the service. The additional investment will also mean that the team can pilot a new scheme to support residential care/nursing homes avoid unnecessary hospital admissions (starting with Pricilla Wakefield (nursing home) and The Meadow (care home). Staff are expected to be in place by 30th August 2016 to start

		delivering these improvements. <u>Commissioning dedicated rehabilitation and re-ablement beds for step-down from hospital and step-up from the community</u> Haringey Council and Haringey CCG are commissioning 10 intermediate care beds in Protheroe House, a new extra-care facility in Tottenham. These beds will be ready to accept patients in late September/October. Service users in these intermediate care beds will receive re-ablement and rehabilitation from a new multi-disciplinary team, which will include therapy, social work and medical personnel. This multi-disciplinary team will also provide support for a further 4 intermediate care beds for people who need higher levels of nursing care. These 4 beds will be commissioned from November 2016, initially over the winter period. <u>Increasing reablement capacity</u> Haringey's re-ablement service is on track to increase its capacity, so that is has 750 clients going through reablement each year. <u>Bringing together existing services into an integrated intermediate care pathway with clear links to the hospital discharge process</u> We are working in an integrated way with both North Middlesex and Whittington hospitals to improve the hospital discharge process so people can access re-ablement or other support they need in the community in a quicker and more joined up way. For example: • Haringey Council's reablement staff are now based in North Middlesex Hospital, as a 'Social Care Intervention' team performing triage and linking with hospital therapists to facilitate prompt discharge. • The social care intervention team aims to identify therapy input or other relevant intervention at point of assessment and reduce the need for long-term care. • A "Home first" approach is being tried where patients are promptly discharged home with reablement and have a detailed assessment at home within 24 hrs of discharge.
An initial joint meeting of the Haringey and Islington HWBs to be arranged, prior to summer recess if possible.	Clerk	An initial informal meeting of the two HWBs took place on 26th July 2016.

Further scope to include Mental Health providers into the Joint Haringey and Islington work should be explored.	Sarah Price / Zina Etheridge	Barnet, Enfield and Haringey Mental Health Trust have now joined the Haringey and Islington Wellbeing Partnership, and are represented at Board level. We are looking to develop a mental health recovery work-stream as part of the work of the Wellbeing Partnership.
Finalised NCL STP case for change to be brought back to the Board for endorsement.	Sarah Price	NCL STP to be included as a business Item at the September meeting of the Board.
North Middlesex Hospital presentation slides to be circulated to Board	Clerk	Complete.
Written Update on the Sustainable Employment Devolution Pilot	Tamara Djuretic	The Sustainable Employment devolution pilot proposal was presented to all GP collaborative, three signed up to the pilot. Haringey was shortlisted for Innovation Fund bidding process and an interview was held at the beginning of August. Initial feedback was positive and announcements on successful trial sites are expected by mid-September. In addition, we are also working closely with the Fit for Work service to develop detailed protocols. The pilot is expected to begin by mid-October and will be used as a 'proof of concept'.
Written Update on Social Prescribing.	Tamara Djuretic	The Social Prescribing task and finish group has met and developed a set of outcomes and agreed an emerging model that would be most suitable for Haringey. It was agreed that the components of social prescribing were incorporated into Haringey's wider approach to prevention and community wellbeing. A community wellbeing framework is being developed; this will incorporate social prescribing as well as other elements of community engagement to improve the wellbeing of our residents. Funding from Neighbourhood Connect will be used to fund the emerging community wellbeing framework. It is expected that a business case on the community wellbeing framework will be presented to the P2 Operational Board in October and a further update will be brought to the HWB Board shortly after that.

This page is intentionally left blank