NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Thursday, 2nd March, 2017, 4.00 pm - Civic Centre, High Road, Wood Green, N22 8LE

Members: See enclosed.

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

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

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 10).

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 - 46)

To consider and agree the draft minutes of the following meetings:

- Joint Health and Wellbeing Board 3rd October 2016.
- Health and Wellbeing Board on 8th December 2016.
- Joint Health and Wellbeing Board 31 January 2017.

8. ANNUAL PUBLIC HEALTH REPORT (PAGES 47 - 48)

9. SUICIDE PREVENTION ACTION PLAN (PAGES 49 - 72)

10. NEW ITEMS OF URGENT BUSINESS

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

11. 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:

Joint Health and Wellbeing meeting 11th May 2017 TBC

Health and Wellbeing Board 27th June 6.00pm TBC

Ayshe Simsek
Tel –0208 489 2929
Fax – 020 8881 5218
Email: philip.slawther@haringey.gov.uk

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

Wednesday, 22 February 2017

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	*Leader of the Council	Cllr Claire Kober
			*Cabinet Member for Children and Young People	Cllr Elin Weston
			*Cabinet Member for Finance and Health	Cllr Jason Arthur
	Officers' Representatives	3	Director of Adult Social Services	Beverly Tarka
			Director of Children's Services	Jon Abbey
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	*Chair	Dr Peter Christian
			Vice Chair	Dr Dina Dhorajiwala
			Chief Officer	Sarah Price
			*Lay Member (confirmed as voting member by Full Council 23/02/15)	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Chair	Sir Paul Ennals

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON MONDAY, 3RD OCTOBER, 2016, 12:30

Haringey Board Members Present: Cllr Claire Kober (Chair of Haringey Health and Wellbeing Board), Councillor Jason Arthur (Cabinet Member for Finance and Health), Cllr Elin Weston (Cabinet Member for Children & Families), Susan Otiti (Assistant Director of Public Health, substitute for Dr Jeanelle de Gruchy), Sharon Grant (Chair, Healthwatch Haringey), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Peter Christian (Chair, Haringey CCG) Cathy Herman (Lay Member, Haringey CCG) Beverley Tarka (Director Adult Social Care LBOH), Sarah Alexander (Head of Safeguarding, Quality Assurance and Practice, substitute for Jon Abbey) Geoffrey Ocen (Bridge Renewal Trust – Chief Executive).

Haringey Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Charlotte Pomery (Assistant Director of Commissioning), Tim Deeprose (Interim Director - Wellbeing Partnership), Will Maimaris (Consultant in Public Health), Stephen Lawrence Orumwense (Assistant Head of Legal Services), Philip Slawther (Principal Committee Coordinator LBOH).

Islington Board Members Present: Cllr Councillor Richard Watts (Chair of Islington Health and Wellbeing Board), Councillor Janet Burgess (Executive Member for Health and Social Care), Cllr Joe Caluori (Executive Member for Children, Young People and Families), Alison Blair (Chief Executive Islington CCG), Melanie Rogers (Director of Quality and Integrated Governance, Islington CCG), Dr. Josephine Sauvage (Chair of Islington CCG), Lucy de Groot (Lay Member, Islington CCG, substitute for Sorrell Brookes), Simon Pleydell (Chief Executive, The Whittington Hospital NHS Trust), Julie Billett (Joint Director of Public Health - Camden and Islington), Sean McLaughlin (Corporate Director of Housing and Adult Social Services).

Islington Officers Present: Lesley Seary (Chief Executive, Islington Council), Andy Stopher (Deputy Chief Operating Officer - Camden and Islington NHS Foundation Trust, substitute for Angela McNab), Jonathan Moore (Senior Democratic Services Officer, Islington Council).

*** ***Clerk's Note*** *- The meeting was held as a 'meeting in common' of the Haringey and Islington Health and Wellbeing Boards. As a joint committee had not been established, this was two separate meetings of the Boards, held concurrently.*

*Each Board could make decisions related to its own functions, but functions could not be exercised jointly. The usual procedure rules governing each meeting were applicable, including quorum and voting rights. ***

1. FILMING AT MEETINGS

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

2. WELCOME AND INTRODUCTIONS

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

3. APOLOGIES FOR ABSENCE

The following apologies were noted:

- Jon Abbey, Director of Children's Services, London Borough of Haringey (substitute Sarah Alexander).
- Sir Paul Ennals, Chair of Haringey's LSCB
- Dr Jeanelle de Gruchy, Director of Public Health, London Borough of Haringey (substitute Susan Otiti)
- Dr Dina Dhorajiwala, Vice Chair Haringey CCG
- Sorrel Brookes, Lay Member, Islington CCG (substitute: Lucy de Groot)
- Emma Whitby, Chief Executive, Healthwatch Islington
- Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust (representative: Andy Stopher)
- Carmel Littleton, Corporate Director of Children's Services, London Borough of Islington

In addition, apologies for lateness were received from Cllr Joe Caluori, Executive Member for Children, Young People and Families, London Borough of Islington)

4. NOTIFICATION OF URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

No Declarations of Interest.

6. QUESTIONS, DEPUTATIONS, PETITIONS

No Questions, Deputations or Petitions were tabled.

7. POPULATION HEALTH - CHALLENGES, SIMILARITIES AND DIFFERENCES ACROSS HARINGEY AND ISLINGTON

The Board received a presentation which set out the key health challenges faced by Haringey and Islington. The presentation slides were included in the agenda pack at pages 5-20 and the presentation was given by Julie Billet, Director of Public Health Camden and Islington. Some of the key points raised in the presentation were:

- Life expectancy was a really good indicator of overall health outcomes across the two boroughs. Life expectancy at birth had increased in both Islington and Haringey over the past decade and Haringey was now comparable to London and England for both males and females. Male life expectancy in Islington remained significantly lower than London and England. In both boroughs residents spent on average the last 20 years of their life in poor health. A key challenge going forward was to address the gap in life expectancy between the less affluent and more affluent areas of the population of both boroughs.

- Resident population was close to 500k across the two boroughs with a projected growth of 8% by 2016. Population growth would be concentrated amongst older age groups, which had particular consequences for health and social care services in the future.

- Deprivation was a key influence on Health and Wellbeing and overall both boroughs had similar levels of deprivation.

- Both boroughs had ethnically diverse populations seeing an increase in that diversity between 2001-2011. Both boroughs would see a reduction in the Black Caribbean and Bangladeshi populations, according to population projections.

- Both boroughs had similar prevalence of health behavioural risk factors, although Islington had significantly more alcohol-related hospital admissions compared to Haringey. Prevalence of smoking in Islington and Haringey was significantly higher than the London average.

- Both boroughs had a similar prevalence of diagnosed and undiagnosed long term conditions.

- Islington had the second highest prevalence of serious mental health conditions in London (1.5%) and Haringey had the 10th highest. Both boroughs were significantly above the England and London average.

- Both boroughs had amongst the highest numbers residents of working age claiming out of work benefits.

- Both Haringey and Islington had significantly higher proportion of their working age population claiming sickness/disability benefits due to physical and/or mental ill health.

In summary, Director of Public Health Camden and Islington advised that the key challenges were:

- The complexity in provider landscape and patient flows and a lack of neat system boundaries.
- Different organisational cultures and ways of working across the partners
- The need to balance continued focus and work at a local level with work across the Wellbeing Partnership and at a sub-regional level.

The key opportunities were identified as:

- Similar population health and care needs
- The shared challenge of improving population health outcomes, care quality and system sustainability in the face of significant financial constraints.
- Possessing shared ambitions for the residents of the boroughs, along with shared values and a commitment to working in partnership.

8. HARINGEY AND ISLINGTON WELLBEING PARTNERSHIP

8A. Update on the Wellbeing partnership.

The Board received a verbal update on the Haringey and Islington Wellbeing Partnership by Sarah Price, Chief Officer Haringey CCG. The Chief Officer, Haringey CCG advised that over the summer, Haringey and Islington had consolidated their position in relation to the other boroughs within NCL; the work that was occurring across the two boroughs was widely recognised as being a key component of the sustainability and transformation of health and care in the five boroughs. A lot of work had been undertaken behind the scenes to clarify what the partnership was trying to achieve, and to set out its principles and objectives.

The Board was advised that the work that was being undertaken around Cardiovascular Disease and Diabetes would be significant in helping to deliver sustainable health and care services, both across the two boroughs and more broadly. The Board was also advised that the work being undertaken around mental health was also important and that work on MSK was due to start in earnest following the appointment of an MSK lead. A children's and young people project was also being developed under the partnership, in response to feedback from staff that they wanted to see its inclusion as one of the initial workstreams. It was noted that Tim Deeprose had recently been appointed as the Interim Programme Director for the Wellbeing Partnership, and that establishing a team to support the work was a key task to help drive the project forwards.

In response to a request for clarification, the Chief Officer Haringey CCG gave some further background information on the reasons why it had taken longer to get the work around MSK going. The Board was informed that part of the reason was due to capacity and the need to identify resources to lead on delivery of the project, particularly in terms of coordination across the different organisations involved. A lead had been appointed and work was underway to develop this work stream. The

Assistant Director of Public Health LBOH, outlined some of the main factors behind why the MSK piece of work was so important. The Board noted that representatives from CCGs, local authorities and the Whittington and North Middlesex hospitals had met the previous week to look at the agenda around children and young people. The Board also noted that the work plan for children and young people would be reviewed to support the wider work of the STP around the demands on acute care and A&E, as well as to look at the pathways for children with long term conditions with community support needs. As a result of these discussions, Whittington Health agreed to lead on putting together a proposed work plan and this would be presented to the next Haringey Health and Wellbeing Board. The Assistant Director of Public Health reiterated that there were clear links between the children and young people workstream and acute community services.

Simon Pleydell; Chief Executive, the Whittington Hospital NHS Trust commented that it was felt that not having a dedicated work stream around children and young people was an anomaly. The Chief Executive of the Whittington Hospital NHS Trust suggested that it was an encouraging sign that those contributing to the partnership were identifying additional areas, and that they were willing to put in the additional work to support. In response to a question on the pressures involved on A&E services at the Whittington, the Chief Executive of the Whittington Hospital NHS Trust advised that the issue was around what was the most suitable setting to receive care and whether that was in a community setting or whether this was at an emergency department. This was a key challenge faced across the health sector and it was commented that the whole of North Central London had some ambitious thoughts about how this could be achieved.

8B. Developing an Accountable Care Partnership

The Board received a report which provided an update on the work being undertaken to develop an Accountable Care Partnership. The report was included in the agenda pack at pages 21-28. The report was introduced by Zina Etheridge, Deputy Chief Executive LBOH and Charlotte Pomery, Assistant Director of Commissioning LBOH.

The report set out the work achieved to date and the Deputy Chief Executive advised that the partnership was working sufficiently well that the consideration should be given to developing more formal governance arrangements. It was reiterated that there were significant issues with organisations making the transition to a more integrated model, given the piecemeal approach undertaken so far. However, there were also significant areas of commonality across the system. The system wide basis had been clearly set out through the STP case for change and the issues highlighted during the presentation at item 7, however the Deputy Chief Executive suggested that at present there was no the system wide response available to tackle them effectively.

The fact that each organisation had its own funding streams and its own contracting and commissioning arrangements was highlighted and, as a result significant inefficiencies existed. The Board considered that both commissioners and providers were increasingly moving towards pooled budget arrangements. The way funding flowed within an accountable care partnership was often significantly different from current, organisationally based funding. The Wellbeing Partnership was currently looking into what a single control mechanism across organisations could look like. The

Deputy Chief Executive advised that there were challenges in working out pooling arrangements between two organisations, not least consideration of at what level budgets would be pooled, and that moving to new ways of thinking about population level pooling would add further complexity to the picture.

The Deputy Chief Executive outlined the Wellbeing Partnership had created a partnership at two levels; with a top strategic layer and also a number of work strands that existed from the bottom up. The proposals in the report would aim to facilitate the 'bottom-up' work of scaling up areas of good practice so that there was a constant iteration between new ways of planning, resourcing and delivering services and an organisational form that facilitated these approaches. The Deputy Chief Executive advised that it would be really important to ensure that there was sufficient leadership from clinicians, social care organisations and other professionals. It was commented that there was a significant amount of learning available about different organisational forms, but that the development of models of accountable care organisations was still at an early stage.

The Deputy Chief Executive suggested that the evidence base around aspects such population size was not strong and that a lot of the international examples were working with very different systems to those that existed locally. The Board was advised that they needed to be mindful of the huge complexity that existed within NCL; with a number of different providers serving different populations, as well as the different local authorities and different commissioning organisations that also existed. As a result, there was no existing model of an accountable care partnership that could be used. Furthermore, the Board was advised that any different sort of partnership that Haringey and Islington set up would have to be able to work with other models, partnerships and providers that existed within North Central London and across other organisational boundaries more generally.

The Deputy Chief Executive emphasised that the Board was not being asked to agree to become an accountable care partnership at this stage but instead it was being asked to make a formal commitment to undertaking the next stage of work. Any formal move to becoming an accountable care partnership would need to be taken by a series of constituent bodies of the groups present. Agreement in principle to move to an accountable care partnership type organisation was sought by the Board. Work would be undertaken in the coming months in order to get to a position by next spring whereby the constituent bodies could start reviewing the proposals and taking them through their decision making processes.

The Assistant Director of Commissioning, LBOH outlined the role of an accountable care partnership to the Board. Accountable care partnerships were a fairly new and innovative structure, and the AD Commissioning commented that a key consideration was to ensure that the particular form of partnership chosen was right for the population of Islington and Haringey. The Board was advised that some of the feedback received during the formation of this report was around the need to ensure that it linked to local communities and also linked in to the wider STP and NCL work. The AD Commissioning advised that an accountable care partnership differed from a single accountable care organisation and that the Wellbeing Partnership was seeking to build on the assets and strengths of the different organisations involved. The Board

was also advised that officers were keen to ensure stakeholder engagement was undertaken with local communities around this work.

Dr Josephine Sauvage, Chair of Islington CCG welcomed the commitment around engagement with local residents and commented that feedback from the recent Joint Overview and Scrutiny Health Committee was that there was a real appetite from the local population to be involved in the development of this process. The Chair of Islington CCG also added that the STP work undertaken could feel quite distant and removed to residents and that this offered an opportunity for engagement in a meaningful way, specifically to agree how to embed the process of co-production.

******Clerk's Note*** *– Cllr Caluori entered the meeting. ***

The Chair advised that the key benefits of exploring more formalised arrangements around joint working were around the need to for both boroughs to have a significant influence going forwards; particularly as part of the STP process, and also to ensure that incentives within the system were in the correct place. The Chair suggested that this would be would be a very powerful tool for local authorities and NHS providers in terms of facilitating a more sustainable future. It was commented that the pressures on organisations through the health and care system were so severe that some form of structural fix was necessary in the medium term. It was felt that this was the best opportunity available to develop that fix, whilst ensuring that organisations also maintained control over their own destiny.

The Chair of Healthwatch Haringey cautioned that service users were having difficulty in keeping up to date with the number of changes that were going on within the health and care landscape. The Chair of Healthwatch Haringey commented that the governance issues raised in the report were going to be very important going forward as service users needed to be able to understand how and where decisions were being made and be given an opportunity to influence those decisions. The Chair of Healthwatch Haringey also suggested that service users would likely want to see more information in relation to the comments of the Chief Finance Officer with regards to the amount of money spent on setting up this additional partnership and what the additional costs were. In response to the query around the additional costs, the Deputy Chief Executive, LBOH advised that a business case would need to be developed before any changes were implemented, and that the costs involved would vary significantly dependant on the type of partnership sought.

The Chair acknowledged that clarity around governance arrangements was something that all partners were concerned about and that a key consideration was ensuring the transparency and accountability of any organisation established to the wider community. The Chair advised that the sponsor board would be tasked to focus on accountability issues in tandem with work that was underway on governance and that this would be brought back early in the new year. The proposal would be based around a decision on whether a joint committee was established and would also set out clear expectations and parameters around accountability. The Board was advised that it was important to get the structures right in order to ensure that the accountability and decision making capacity were there.

The Chair of the Islington CCG cautioned the need to consider where the other big health providers would sit within the context of the partnership, as service users would want to see that there was an equitable service offer across both boroughs. The Deputy Chief Executive, LBOH advised that both UCLH and North Middlesex Hospital were on the sponsor board and that both providers had attended the last meeting.

The Chief Executive, the Whittington Hospital NHS Trust commented that, in partnership with social care, this was a unique opportunity to form something which was appropriate and relevant to the populations of both boroughs. Whilst acknowledging that the accountability issue was very important for services users, the Chief Executive of the Whittington Hospital NHS Trust urged the Board to seize the opportunity of developing their own model of service provision and the rules and governance arrangements around that.

RESOLVED

I. To adopt the principles and high level outcomes as developed by the Sponsor Board of the Haringey and Islington Wellbeing Partnership
II. To agree in principle to the development of a form of accountable care partnership which best supports the outcomes sought by the Haringey and Islington Wellbeing Partnership
III. To endorse further work to develop the detail of such a partnership, with the aim of gaining agreement on the final structure and form from constituent decision making bodies by April 2017
IV. To require the Sponsor Board to report back on progress in developing and implementing a project plan
V. To request the Sponsor Board to consider as a matter of priority how community and stakeholder engagement will be undertaken and involve key stakeholders including Healthwatch

8C. Workstream on Cardiovascular Disease and Diabetes in Haringey and Islington

The Board received a report and presentation which gave an overview of health and care needs relating to diabetes and cardiovascular disease (CVD) in Haringey and Islington. The report was included in the agenda pack at pages 29-36. The presentation was given by Dr Will Maimaris, Consultant in Public Health and Claire Davidson who was lead on self-management support and behaviour change at Whittington Health. Some of the key points raised in the presentation were:

- Haringey had the 2nd highest rate of early death from stroke in the country. There were 23,000 people diagnosed with diabetes in Haringey and Islington and 1 in 5 of these people was likely to have depression.

- 1 in 5 people had high blood pressure in Haringey and Islington and half of these would not have been diagnosed. People living in the most deprived parts

of Haringey and Islington were more than 3 times more likely to die young from cardiovascular disease than people living in the most affluent areas.

- The highest level of spending was currently on those who had already developed diabetes, CVD and complex health needs. Dr Maimaris suggested that the biggest impact could be made by targeting interventions at the wider population such as Healthy high streets, as all of the interventions that made Haringey and Islington a healthier place applied to everyone including those with existing conditions.

- The self-management support approach at the Whittington was seen as a golden thread through all services for integrated care. This involved patient programmes which focused on building knowledge skills and confidence so that patients could effectively self-manage their health conditions. Support for clinicians was also involved, to build knowledge skills and confidence to support self management and build coaching and communication skills. The approach also included providing support to services to embed the approach into their way of working.

- It could often take a significant amount of time for people to build up to being able to self manage their conditions. At present services were set up so that patients received short interventions and consideration needed to be given to think about how the system as a whole could operate to facilitate self-management and become more integrated.

- The diabetes self management programme could achieve a reduction in HbA1c (blood sugar control) of 0.6% which was equivalent to the reduction achieved through anti-diabetic drugs but was considerably cheaper. There were currently 200 places available per annum on the programme.

- Dr Maimaris advised that engagement with clinicians and partners to find the main opportunities for improving outcomes and value for money was already underway and that the Wellbeing Partnership was had the potential to be a vehicle to help drive improvements in CVD and diabetes.

- Two main opportunities for collaborative working were identified in the report: Working as a whole system to develop a sustainable integrated model of clinical and social care for people with diabetes and cardiovascular disease; and, developing whole population approaches to preventing cardiovascular disease and diabetes.

- Dr Maimaris advised that gaps identified locally were also highlighted within the NCL STP case for change: Challenges in primary care provision; a lack of focus on prevention across North Central London; gaps in early detection of disease and Lack of integrated care and support for people with long-term conditions. Whilst the NCL STP would provide a framework to tackle some of the challenges identified, many of the solutions would need to be implemented at a local level.

Following the presentation the Board discussed its findings and was asked to consider: How could improvements be made to outcomes and value for CVD and diabetes through working in partnership; and, in which areas could the biggest impact be made by working together. The Chair, Islington CCG commented that one of the first opportunities identified was around working collaboratively to pull strings and that diabetes and CVD was one of those opportunities for both authorities to exact greater control through working collaboratively. The Chair, Islington CCG also advised that she had recently attended a public engagement event around the STP during which the importance of building on social capital was discussed, particularly through engaging local communities in activities such as the prevention work.

The Deputy Chief Executive, LBOH emphasised the need for a whole community approach to activities such as healthy high streets and the Daily Mile, issues like this would never be solved from a hospital or GP's surgery. The Deputy Chief Executive stressed that the Board needed to consider how the whole community and all council services could be genuinely engaged to resolve these problems. The Chair commented that both she and the Cabinet Member for Finance and Health, LBOH were very supportive of the Daily Mile and welcomed the fact that 15 primary schools in Haringey had signed up to the event but, given there was around 72 primary schools in the borough, there was still a way to go. The task for the Board was how to ensure that they sold the wider wellbeing benefits of schemes such as the Daily Mile got the buy-in from schools and fostered that culture across the two boroughs. The Executive Member for Health and Social Care, LBOI also shared her enthusiasm for the initiative and advised that work was also being undertaken around the Daily Mile in Islington along with work to support this, though mapping out how far a mile was in parks.

Joint Director of Public Health - Camden and Islington commented that the preventative work required to tackle the cardiovascular disease and diabetes on a population level was also fundamentally important to improving the whole health of the population. The same risk factors were present for mental health and cancer as cardiovascular disease and diabetes, and therefore the potential impact was huge and further reiterated the need for population level leaders. The Cabinet Member for Finance and Health, LBOH commented that the Haringey Obesity Alliance had been set up a year previously and that in terms of the preventative work, that there was an opportunity to bring together voluntary sector organisations and health organisations across the two boroughs to combine to tackle issues such as CVD and obesity.

The Chief Executive, Bridge Renewal Trust suggested that a key consideration should be where were the areas that the biggest impact could be made, and that this would likely include early work with school children and work around obesity. The BRT was working with the Healthy London Partnership to involve children and parents in a scheme to raise awareness of healthy eating and to make healthy food available at an affordable rate. One of the issues raised as a result of engagement with the wider voluntary sector was the number of disparate but small initiatives and how to scale those up.

The Chair remarked on the correlation between some of these issues and poverty and deprivation across both boroughs. The Board was advised that between health organisations and local authorities there was the capacity to use levers to effect change but, in order to utilise these levers fully, it was imperative that organisations worked collaboratively. By doing so, it was felt that there was a real opportunity to tackle broad issues of inequality and social justice.

The Director Adult Social Services, LBOH highlighted the impact of the prevention work at the front end of the system on budgets and outcomes for residents. The Board was informed of an ongoing dialogue that she had with Corporate Director of Housing and Adult Social Services at Islington around a reciprocal peer review. The aim was to look at areas for collaboration following the peer review of the two respective Adults Social Services. Haringey Adult Social Services were looking at a new target operating model which embraced the prevention and population level approach rather than focusing just on the delivery of services. The Director of Adult Social Services, LBOH advised that this would likely create a number of opportunities for Islington and Haringey to develop joint working. The Corporate Director of Housing and Adult Social Services, LBOI suggested that the mutual peer review piece of work was something that should be brought back to a future meeting of the Health and Wellbeing Boards. The Chair agreed to bring this item back to the next meeting of the Board **(Action: Beverley Tarka & Sean McLaughlin)**.

RESOLVED

I. To note the issues raised and the areas of good practice highlighted.
II. To note the opportunities for improving population health outcomes and value for money for cardiovascular disease and diabetes prevention and care through the Haringey and Islington Wellbeing Partnership

9. UPDATE ON NORTH CENTRAL LONDON SUSTAINABLE TRANSFORMATION PLAN (STP)

The Board received a report which was included at pages 37-40, copies of the NCL STP progress report and the case for change were also included in the agenda pack at pages 41 and 69 respectively. The report provided an update to the Board on the development of the STP, which was a five year, strategic plan for the health and care system across the five boroughs of North Central London. The report was introduced by Julie Billet, Joint Director of Public Health Camden and Islington.

The Chair commented that they welcomed that the Board had the opportunity to put some of the information involved with the STP into the public domain and expressed frustration with the level of transparency around the process to date. The Chair also commented that it was clearly in the interests of both populations that the two Health and Wellbeing Boards were engaged and sat round a table discussing the STP, as the impact would be very significant. The Chair furthered that whilst the Board was happy to engage, they would reserve judgement until more concrete proposals were in place and the outcomes were known.

The Joint Director of Public Health Camden and Islington identified that as part of the STP process, officers were developing a plan on how to improve outcomes and financial sustainability across the health and care system. An initial high level STP plan was submitted in June 2016. Over the summer, further work was undertaken to further develop the STP and a final plan would be submitted to NHS England on 21st October. Following submission on the initial plan in June, partners across the health and care system continued to develop the 'case for change' and to develop plans across the following key workstreams:

- Population health and prevention
- transforming primary care
- mental health
- urgent and emergency care
- optimising planned care pathways
- consolidation of specialties
- organisational-level and system-level efficiencies

Discussions around transitioning to an accountable care partnership model were also being discussed through the NCL STP process. The Joint Director of Public Health Camden and Islington advised that there had been an initial engagement process around the STP, with a series of public events taking place in September. Although the final plan was due to be submitted in October, this version would not have been formally endorsed by any of the statutory constituent bodies of the STPs and would need to be approved by the individual Health and Wellbeing Boards.

Lesley Seary, Chief Executive, Islington Council commented that it was important to get the relationship right between the work involved in the Wellbeing Partnership, and the work involved in the STP process and the change of commissioning arrangements across NCL. The Chief Executive emphasised the need for subsidiary in the process to be able to deliver at a local level where it was most appropriate. It was considered that one of the important messages that needed to be conveyed as part of the STP process was about the need for space to develop the Wellbeing Partnership to contribute to overall NCL and the STP goals, and for it to not be undermined by a restrictive governance structure.

In response to a request for clarification on the process following submission of the final STP on 21st October, the Joint Director of Public Health Camden and Islington advised that concrete timescales after this point were largely unclear. It was advised that the plan would be presented to NHS England and would then go through a process of assurance through NHSE's internal governance arrangements, and also to ensure buy-in and sign-off within NCL. The challenge and complexity involved and lack of democratic accountability in the process would mean that the final plan submitted on the 21st October would not have had widespread system support behind it and as a result there would need to be some subsequent engagement with each of the governing bodies, provider boards and individual HWB Boards involved. The Board was advised that delivery plans would be developed from November onwards and there would be an opportunity, both as individual organisations and collectively to review those.

The Chair of Islington CCG advised that she saw the STP not as a definitive set of objectives, but more as the beginnings of a series of conversations about how things

would need to be done differently. A key element of this would involve how services were paid for within the NHS and how some of the contractual levers that currently existed didn't necessarily result in delivering the best quality service in the best and most appropriate way. The Chief Executive of the Whittington Hospital NHS Trust reiterated that as accountable statutory organisations, all partners would get the opportunity to consider and approve the submission made on the 21st October and that they would not be doing so lightly and without proper scrutiny. In terms of how the system worked from a health perspective, it was commented that once the numbers were hardwired through the Treasury there was no going back. As a result partners needed to be quite focused on what they were committing to.

The Chair echoed some of the comments made by the Chair of Islington CCG, and stated that having re-read the case for change it was apparent that whilst the process had been pushed through at speed there were still significant gaps in the information around what it was that was going to be delivered. Furthermore, the current iteration of the plan and the information surrounding it was at a very high level. The Chair stated that the conversations that were taking place around the Wellbeing Partnership felt very important as a result, as they were at much more accessible level and based on a recognisable geographic area. The Chair of Islington CCG summarised that the case for transformative change across the health, social care and wellbeing agenda was clear. However, further consideration needed to given to how this was to be implemented and what was needed was some space to be able to develop something that worked at a local level, in contrast to some of the big changes proposed that felt unaccountable to the local area and local communities. The Chair of Islington CCG emphasised the need for the organisations around the table to be able to influence the process and be able to remain in charge of their own destiny.

RESOLVED

I. That the progress to date on the development of a Sustainability and Transformation Plan for North Central London be noted.

II. That the overall objectives, vision and emerging plans for the transformation of the health and care system across NCL, and its implications for and synergies with the Islington and Haringey Wellbeing Partnership be noted.

10. FUTURE JOINT HWB MEETINGS

The Board received a report which set out a number of considerations relating to future joint meetings of the Haringey and Islington Health and Wellbeing Boards, including the frequency of joint meetings and the possibility of formalising joint arrangements. The report was included in the agenda pack at pages 119-122, and was introduced by Stephen Lawrence-Orumwense. The Chair advised that, having discussed this with their counterpart, the sense was that the two Health & Wellbeing Boards should meet around three or four times a year. The Chair also advised that if the Board agreed to formalise joint arrangements then further consideration should be given to the frequency of individual Health and Wellbeing Board meetings. The Board agreed that further work would be undertaken around formalising arrangements and that a follow up report would be brought to the next meeting in common of the

Haringey and Islington Health and Wellbeing Boards **(Action: Stephen Lawrence-Orumwense).**

RESOLVED

I. That the frequency of joint meetings be agreed at three or four meetings per year
II. That further work be undertaken with a view to potentially establishing a Joint Committee.

11. DATES FOR FUTURE JOINT MEETINGS

The Boards agreed that the Clerks would email round future meeting dates to the two Boards. **(Action: joint-Clerks).**

12. NEW ITEMS OF URGENT BUSINESS

None

13. EXCLUSION OF THE PRESS AND PUBLIC

N/A

14. NEW ITEMS OF EXEMPT URGENT BUSINESS

N/A

CHAIR: Councillor Claire Kober

Signed by Chair ……..

Date ……

MINUTES OF THE HEALTH AND WELLBEING BOARD
MONDAY 8 DECEMBER 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), Dr Peter Christian (Chair Haringey CCG), Cathy Herman (Lay Member, Haringey CCG) John Everson (Assistant Director Adult Social Care LBOH – Substitute for Beverley Tarka), 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** ** Clerks note – Dr Christian began the meeting as Chair as Cllr Kober was running late** The Chair welcomed those present to the meeting and the Board introduced themselves.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Sir Paul Ennals. • Dr Dina Dhorajiwala • Sarah Price In addition, apologies for lateness were noted from Cllr Kober and Cllr Weston	
CNCL103.	**URGENT BUSINESS** There were no items of Urgent Business.	
CNCL104.	**DECLARATIONS OF INTEREST** No Declarations of Interest were noted.	

MINUTES OF THE HEALTH AND WELLBEING BOARD
MONDAY 8 DECEMBER 2016

CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** No Questions, Deputations or Petitions were tabled.	
CNCL106.	**MINUTES** **RESOLVED:** That the minutes of the meeting held on 19th May 2016 be confirmed as a correct record.	
CNCL107.	**BUSINESS ITEM** In a change to the scheduled agenda, the Chair agreed to take Item 12, on the HSCB and HSAB Annual Reports, and Item 14 on the North Middlesex University Hospital update first. **HARINGEY SAFEGUARDING CHILDREN'S BOARD (HSCB) & HARINGEY SAFEGUARDING ADULTS BOARD (HSAB): ANNUAL REPORTS** A cover report was included in the agenda pack (pages 69-70), and the HSCB & HSAB annual reports were included in the agenda pack at pages 71 & 139 respectively. Patricia Durr, HSCB & HSAB Business Manager introduced the reports and the Board discussed their findings. The Board were advised that there was a statutory requirement to produce an annual report for both bodies. The LSCB and SAB Business Manager drew the Board's attention to the Adult's strategic plan and the five year strategy in Children's. Cathy Herman, Lay Member Haringey CCG commented that there was significant work being undertaken between the HSCB and the Enfield Safeguarding Children's Board and enquired whether there were any plans to develop similar relationships with Islington. The LSCB and SAB Business Manager advised that facilitating greater joint working across London was one of the key enabling priorities identified, particularly in dealing with major issues that existed across London such as CSE. The Board was advised Haringey was part of the wider north London cluster and that she also sat on the task and finish group for the London Safeguarding Board, both organisations also included Islington. **Clerks Note – Cllr Kober entered the meeting** Dr Jeanelle De Gruchy, Director of Public Health commented that the VAWG Strategy was presented at the previous meeting of the HWB and during the meeting the Board discussed the impact of VAWG on children and young people. The LSCB and SAB Business Manager	

reassured the Board that work was being undertaken to understand connection between the VAWG Strategy and supporting vulnerable young people, a key element in the process was around ensuring that links were made across different services and agencies.

Sharon Grant, Chair Healthwatch Haringey commented that there was a long way to go in terms of gathering enough data to be able understand the problems that existed in adult social care. The Chair Healthwatch Haringey also commented that there were significant issues around incompatibility of systems used between the Council and other partners and questioned whether there needed to be a dedicated performance measure to track referrals into adult social services. The LSCB and SAB Business Manager agreed that there was still some way to go to fully understand where referrals came from and how to track them cross the system.

The Assistant Director of Adult Social Services acknowledged that there was a conversation to be had around ensuring the correct metrics were in place to be able to asses overall performance levels and whether improvements were being made. The Chair Healthwatch Haringey, advocated that the annual report should refer to performance around referrals to Adult Social Services and highlight where the 'pinch points' were in the system and how to address them. The LSCB and SAB Business Manager acknowledged these concerns and agreed to check and ascertain whether the information was contained in the accompanying performance report. The LSCB and SAB Business Manager also advised that the system around referrals changed following the implementation of the Care Act and that there were difficulties in comparing statistics across the two reporting systems.

Zina Etheridge, Deputy Chief Executive advised that there was a proposal to hold a joint meeting of the HWB and the Community Safety Partnership sometime in spring 2017 in light of their being clear areas of overlap between the two Boards such as VAWG, alcohol and mental health.

The Director Children's Services advised that, from a Children's perspective, the VAWG Strategy was a key piece of work but strategically sat within Community Safety. In addition, domestic abuse was a key component at monthly vulnerable children's group meetings involving key partners. The Director Children's Services suggested that the police were showing an appetite to improve partnership working and commented that significant progress had been made in the last 12 months, particularly around domestic abuse. The Board was also advised that the CSP recognised the need to work together as a system in order to improve outcomes around VAWG.

Cllr Kober commented that she had been reading the HMFIC report on child safeguarding and a key theme that emerged across London was the extent to which the Metropolitan Police missed cases of CSE and a

tendency to mislabel instances of CSE as something else. The Leader suggested that the Board needed to prioritise looking into this issue at a local level, in order to get underneath the issues highlighted in the report.

RESOLVED:

I). That the HWB notes the HSCB and HSAB Annual Reports

NORTH MIDDLESEX UNIVERSITY HOSPITAL (NMUH) AND ROYAL FREE LONDON (RFL) JOINT PARTNERSHIP DEVELOPMENT

Clerks Note – Cllr Kober took over as Chair for the remainder of the meeting

A cover report was included in the agenda pack (pages 317-318), which updated the board on proposals being developed around the NMUH joining the Royal free London NHS Foundation Trust "Group". A presentation was also given jointly to the Board by the Richard Gourlay, Director of Strategic Development, North Middlesex University Hospital and Ron Agble, Director of Partnership & Transactions, Royal Free London Hospital.

The Board were advised that Royal Free London proposed developing as a Group in order to develop the capability and infrastructure to reduce unwarranted variation – which was intended to result in improved clinical outcomes, patient safety and patient satisfaction. The Group intended to consolidate a range of clinical support services and non-clinical activity, which should also deliver financial benefits. NMUH had experienced significant operational challenges, in terms of both quality and delivery of access standards that may have been mitigated with access to a wider workforce resource.

North Middlesex University Hospital took a decision in March 2016 to explore how joining the group would help secure the future sustainability of services – both financially and clinically. A Partnership Board was established in June 2016 to maintain an overview of the progress towards the decision and the integration of NMUH into the new group structure. This Partnership Board incorporated senior leaders from the Trusts as well as representatives from Haringey CCG, Enfield CCG, NHS England and NHS Improvement. Both trusts boards would make ultimate decisions regarding progress of the Partnership Programme, with the Partnership Board acting as the collective forum to oversee the work on behalf of both organisations. The Director of Partnership & Transactions, Royal Free London Hospital assured the Board that any decision to join the Royal Free London Group would not result in NMUH being centrally managed from RFL and that local management

arrangements would be maintained.

In response to a request for clarification on the risks involved in the proposal, the Board was advised that during a leadership away day for senior managers at NMUH' one of the key areas of concern was around the need to protect the identity of NMUH. The Director of Partnership & Transactions, Royal Free London Hospital advised that the biggest risk in his opinion was around staff retention and staff recruitment.

The Director of Strategic Development, NMUH emphasised the need for any investment to deliver a return given the financial pressures facing the NHS and that getting this wrong would carry significant risks around public perception and wasting public money. The Board were also advised that there were risks to wasting the time and commitment of clinical staff and the wider impact this could have on staff morale. The Director of Strategic Development advised that whilst the group was aware of the risks involved, there was a much greater risk around not doing anything at all.

In reference to a possible Accountable Care Organisation model, the Deputy Chief Executive stressed the need to have community based services closely connected to acute services in order to build resilience and keep people out of hospitals. The Deputy Chief Executive asked whether community care providers & GP's were being considered as part of the process, alongside acute care providers. In response, the Board was advised that primary care, social care, mental health provision and community health services were all being considered as part of the process but cautioned that the extent of that consideration varied across the different sectors. The Director of Partnership & Transactions, Royal Free advised that they would be working closely with partners in each of those sectors.

The Board was also cautioned that no decisions had been taken on the model of population health care and that an Accountable Care Organisation was just one of the potential options being considered.

The Deputy Chief Executive sought clarification from the CCG as to whether it was felt that GP's were being engaged with in that conversation. The Deputy Chief Executive also urged the Director of Partnership & Transactions, Royal Free to engage with the partners around a social care perspective sooner rather than later.

The Leader enquired how the Royal Free London Group would ensure that recent improvements to the standard of care delivered at NMUH

	were sustained. In response the Board was advised that discussions were taking place through the NMUH Executive Board, around improvement plans and what investments needed to be made in the next 12 months. The Director of Strategic Partnership acknowledged that there was a risk around capacity within the system but advocated that by doing this at scale, there were greater opportunities available, such as being able to share consultant resources across the network. In response to a question around the structure of clinical leadership, the Board was advised that there was a clear understanding from the group of the need to operate as a homogenous group across all of the sites. The Board noted that clinical practice groups would meet periodically, consisting of clinicians from across each of the sites, to review data on outcomes and the practices that are leading those outcomes. There would be structural resources available across the sites that would be supported at group level, in addition to the conventional structures of clinical management usually seen at hospitals. In response to concerns raised around the complications involved in setting up an Accountable Care Organisation across such a large footprint, the Board was advised that the ACO was just one example of an approach to population health based system and it was reiterated that the group was a long way off establishing such a system. The paper set out an ambition for population health in broad terms but the details of this required significant further consideration. The Lay Member Haringey CCG urged the group to initiate conversations with the CCG at a very early stage in the process. In response to a question as to whether, in terms of commissioning, the proposals would be cost neutral; the Director of Partnership & Transactions, Royal Free commented that he would hope to see a positive return on investment to any population based system that was introduced. In response to a request for clarification around the level of financial modelling that had been undertaken, the Board was advised that this was still very much at an embryonic stage and that further work would be undertaken with clinical and leadership teams in the coming weeks and months to try and identify what could be possible in terms of the financial modelling.	
CNCL110.	**DISCUSSION ITEM** **HEALTH AND WELLBEING STRATEGY UPDATE** A report was included in the agenda pack at page 21. Jeanelle de Gruchy, the Director of Public Health introduced the report to the Board. There was also a presentation which was included in the agenda pack at page 27. The report and presentation provided an update to the Board on progress in delivering Haringey's Health and Wellbeing Strategy 2015-18 and also set out the challenges in delivering the	

ambitions, as well as areas for focus for the next 18 months. Following the presentation the Board discussed the findings.

The Board was reminded that nine ambitions were identified for the Health and Wellbeing Strategy with three priority areas for sustainable improvements: Reducing obesity, increasing health life expectancy and improving mental health and wellbeing. In the first 18 months of delivering the Health and Wellbeing Strategy significant progress was reported in the following areas: Establishing strategic frameworks for delivery, establishing partnerships and governance to deliver improvements at population level and initiating key interventions. The Board noted successful improvements made through stroke prevention initiatives in Primary Care; with a 7 % increase in the number of people diagnosed with hypertension from 2014/15 – 2015/16, and a 13% increase in the number of people diagnosed with atrial fibrillation from 2014/15 – 2015/16.

The Director of Public Health updated the Board on current performance levels against the 9 nine ambitions set out in the Health & Wellbeing Strategy. The Board's attention was drawn to significant underperformance on Ambition 4, around achieving a reduction in the rate of early death by stroke by 25%. Haringey's stroke rate stood at 22.3 per 100k compared to 16.3 for similar boroughs and placed Haringey as the worst performing London Borough for early deaths from stroke. The Director of Public Health also drew the Board's attention to the key areas of focus over the next 18 months. The Board previously agreed to the prevention pyramid approach which focused on getting health into all policies at a population level. The Director of Public Health outlined examples of clear priorities that Haringey wanted to take forward at population, community and personal health levels, as well as the opportunities that existed through the Haringey and Islington Wellbeing Partnership.

The Director of Children's Services advised that in relation to Ambition 7, he undertook a piece of work with a group of 60 young people during the summer and it was clear from the discussion that those young people had a very good awareness of mental health in and amongst each other. The Director of Children's Services also advised that the Bridge Renewal Trust were coordinating a piece of work on young people's mental health in Tottenham called Young Minds, and that this would provide a key opportunity for awareness raising around young people and mental health.

The Deputy Chief Executive commented that the organisations represented at the Board, as well as the services that were commissioned through them, employed a significant number of people in the borough and advocated that if the Board was able to successfully encourage health improvements through work based health policies then this could make a significant impact on overall heath levels in the borough. The Deputy Chief Executive suggested that this might be

something that the Board wanted to consider in greater detail going forward.

The Cabinet Member for Health and Finance commended the ambitious targets that had been set through the Health & Wellbeing Strategy but questioned whether, given that the first 18 months had been spent developing the frameworks and partnerships necessary for implementation, whether there was enough time to deliver activities and meet those targets. The Cabinet Member questioned whether the Board might want to review the targets going forward. The Director of Public Health advised that significant activities had been undertaken in the first 18 months as demonstrated by the pyramid diagram that was included in the slides in the agenda pack. The Director of Public Health suggested that the targets were seen in terms of aspirations and were therefore quite set at an optimistic level, but acknowledged that there would only be a certain amount of progress that was achievable in a 3 year period.

The Deputy Chief Executive commented that the Board did spend a significant period of time previously setting out exactly where to set that level of ambition and that it was decided at the time to preference setting a high level of ambition and fail to reach that level in certain areas, given how challenging some of the ambitions were. The Leader suggested that during earlier discussions it was felt that these targets could roll into the following three year period, and in doing so would give a greater sense of strategic continuity from one planning period to the next. It was suggested that it would take a significant period of time to turn around some of the issues involved in a meaningful and lasting way.

In response to concerns about the strategic level of the outcomes and targets agreed, the Director of Public Health acknowledged that there was a suite of 4 or 5 sub-indicators and agreed to compile these for the board, to give a more comprehensive overview of performance and show where improvements were being made. The Director of Public Health cautioned that the data would need to show the link between the activity and its impact on a potentially complex range of outcomes.

Jeanelle De Gruchy

The Director of Children's Services highlighted that there was a disconnect between having an investment period of 5 or 10 years through the STP and a three year health and wellbeing strategy. The Director of Children's Services further highlighted the work that had been done through the Board and the HWB Partnership with Islington to promote the health and wellbeing of children and young people such as the healthy schools programme, given some of the significant health issues involved; such as smoking, diabetes and childhood obesity.

RESOLVED:

	I). That the Board note the progress implementing the health and wellbeing strategy over the last 18 months and agree the key areas of focus for the next 18 months.	
CNCL111.	**DISCUSSION ITEM** **PRIMARY CARE ESTATES UPDATE** The Board received a report which was included in the agenda pack at page 21. The paper provided an update to the Board on primary care and described the progress which had been made during the year in meeting capacity demands. The report was introduced by Cassie Williams, Assistant Director of Primary Care Quality and Development – Haringey CCG. Following the introduction of the report, the Board discussed its findings. The Board noted the opening of the new zero list practice at Hale Village in August 2016. In addition, the Board was advised that Haringey CCG had been provisionally awarded £11.6m for three estate developments in areas previously identified as having particular capacity needs; Tottenham Hale, Wood Green and Green Lanes. There was still a significant process involved in accessing these funds but the award was highlighted as being very significant, given that the total amount of funding available to London was £67m. The Assistant Director of Primary Care Quality and Development advised the Board that 7 bids for improvement grants had been submitted to support some of the smaller scale work that was required in some of the smaller sized practices. Examples of the bids included; improved infection control, hearing loops and improved disability access. The Board was advised that notification on the outcome of the bids was expected in a month's time. The Assistant Director of Primary Care Quality and Development also drew the Board's attention to appendix 2 of the report which contained a draft of the guiding principles for future commissioning of premises; setting out a vision for larger premises, with a high number of clinicians and providing a high level of care. The Board's views were sought on the governing principles and it was noted that there would also be also be a consultation process with the public. The Leader advised that she attended a meeting the night before in Seven Sisters and that there was still significant concerns from residents around the quality of buildings and accessibility of the service, with residents still reporting difficulties in getting appointments. The Leader suggested that there was still a perception issue around primary care in the borough and that the Board needed to continue monitoring the issue. The Chief Executive of the Bridge Renewal Trust sought clarification on	

how support was being offered to GP's in commissioning excellent clinical facilities. The Assistant Director of Primary Care Quality and Development advised that following the failed Estates and Technology Transformation Fund (ETTF) bids for three premises, partners were looking at options and the financial availability to see how those schemes could be progressed without the initial capital investment from the ETTF fund. It was noted that there may be another round of bids available after 2019.

The Deputy Chief Executive commented that it was really useful having all of the information presented in the report to the Board and stated that it was important to recognise that there had been significant progress in some areas.

In response to a query about how the estates work linked in with the potential for co-location of community and health and social care services, the Assistant Director of Primary Care Quality and Development acknowledged that potential site for co-location was being considered. The Assistant Director of Primary Care Quality and Development advised that a lot of the work done to establish the bids considered flexible use of space and that this was part of the reason why large scale premises in key locations had been prioritised. The Welbourne centre was noted as an example of a facility where there were plans to have a range of co-located services but the Board was advised that there was still work to be done to understand how community services might work alongside health and social care services.

The Chair of Haringey CCG welcomed the opportunities afforded through having bigger hubs offering wider array of services and hopefully attracting health care professionals with a variety of skills to live and work in the area. The Chair of Haringey CCG also commented that there was an increasing blurring of the lines between primary and secondary care that was being driven by the STP process.

The Cabinet Member for Children & Finance commented that the report highlighted that most of the current practices were assessed to have high or significant rate of statutory non-compliance. The Cabinet Member also queried how quickly the purpose built hubs needed to be put in place and also where the key locations would be. In response The Assistant Director of Primary Care Quality and Development advised that proposals for integrated networks was based on a population level of 50k-80k and that this would likely involve a number of smaller practices and a key aspect would be to have enough purpose built buildings in place.

The Board noted that there had been a number of smaller purpose built practices leaving the system recently due to retirements and that practices had expanded to cope with the additional patients. The Assistant Director of Primary Care Quality and Development advised

	that in addition to the purpose built practices in Noel Park, Tottenham Hale and Green Lanes, it was likely that additional premises would be required in Northumberland Park and Muswell Hill due to population growth. The Board considered that the joint working undertaken between the Council, CCG and Healthwatch; to see where the areas of need were and where the suitable sites were, was a significant positive in terms of planning for developing future sites. The Cabinet Member for Children and Families cautioned that some consideration would need to be given to the ease with which residents could access their closet hub and the proximity of residents to their nearest primary care provider. Assistant Director of Primary Care Quality and Development acknowledged these concerns and agreed that there was consideration of how to meet the needs of a local population within a particular area. The availability of GP's practices was noted as an ever evolving picture with a number of smaller practices closing down. The Chair of Haringey CCG commented that there was a discussion to be had around the provision of specialised services and whether residents were prepared to travel further for a better standard of care. The Board considered that with technology moving so rapidly, there would opportunities for people to have contact with primary care services without necessarily needing to access a building. **RESOLVED:** That the Health and Wellbeing Board: I). Notes and comments on the progress of primary care capacity and developments. II). Provide feedback in relation to the draft guiding principles document.	
CNCL112.	**BUSINESS ITEMS** **DEVELOPING AN ACCOUNTABLE CARE PARTNERSHIP ACROSS HARINGEY & ISLINGTON.** The Board received a report which outlined how an Accountable Care Partnership (ACP) could support delivery of the aims of the Haringey and Islington Wellbeing Partnership and to provide a vehicle for delivery of the STP. The report was introduced by Rachel Lissauer, Acting Director of Commissioning Haringey CCG and was included in the agenda pack at page 57. The Board also received a presentation to accompany the report. Following the presentation, the Board discussed its findings. The Board considered how the Haringey and Islington Wellbeing Partnership could use its organisational structure to bring about the	

biggest improvements in health and social care outcomes. The Acting Director of Commissioning Haringey CCG set out what an ACP looked like in practice and examples of different models being used by other authorities. The Board noted that there was a range of terminology used around Accountable Care Organisations and that a number of models that could be adopted. The Haringey and Islington Wellbeing Partnership was currently set up as an informal collaboration but was moving to a more formal collaboration model. The Board noted that an essential feature of an Accountable Care Organisation was that it involved a population based budget for either a single or a group of providers who had responsibility for achieving health and wellbeing outcomes for that particular population.

The Board noted a number of examples of different models that were being developed in other areas:

1. Northumbria was noted as an example of how shared commissioning across the council and CCG was enabling shared provision; as both organisations had came together as joint commissioners and held the budget for population services. In this example the health foundation trust held a single contract for acute services, mental health services, community services and adult social care.

2. Stockport was in the process of establishing a care trust involving the health foundation trust, GP federation, council and another provider.

3. South Somerset had developed a much more GP led Accountable Care System, which originated from groups of practices wanting to develop ownership of community services. In practice this involved a joint venture to bring GP's in to the community health care system, but ensuring that membership for individual practices was done on a voluntary basis.

The Acting Director of Commissioning, Haringey CCG sought to gauge the Board's view on the degree of ambition and the pace of change that might be required. The Board was also asked to comment on the role it would like to take in the process and how it might interact with some of the other bodies involved.

The Deputy Chief Executive commented that this discussion was partly influenced by the earlier discussions around an ACO with the Royal Free and NMUH and how to build a new partnership. The Board considered that primary care in both Haringey & Islington would play a central role along with Healthwatch, the voluntary sector, the acute trust, community health provider and adult social care services. There were a number of activities already underway and it was commented that the Haringey and Islington Wellbeing partnership were effectively trying to build this from both the bottom up as well as the top down. In

terms of the pace of change, the Deputy Chief Executive suggested that it was important that the partnership did not get left behind by taking too cautious an approach and should consider that the Royal Free and NMUH were seeking to move to a decision by Autumn next year.

The Leader cautioned that adopting a model which involved acute care providers absorbing greater amounts of funding seemed to undermine the idea of reorientating funding towards primary & community care, and adopting a more preventative approach. The Leader advocated adopting population based health interventions involving providers from across health and social care. The Leader also suggested targeting the small group of individuals who spent a significant amount of time using health and social care services, due to the nature of their condition/s, and targeting their support in a community setting.

In response to a question, the Acting Director of Commissioning, Haringey CCG advised that appointing either a lead partner or adopting a joint venture seemed to be the direction that most authorities had gone with but there were other models that could be adopted. The Chair Healthwatch Haringey commented that there had not yet been an effort to explain the development of ACP/ACOs to service users and the rationale behind setting up a separate organisation.

The Chair Healthwatch Haringey also suggested that service users may have some concerns with potential conflicts of interest developing as a result of abolishing the commissioner/provider split and a wider issue of understanding who the new organisation would be accountable to. The Cabinet Member for Children & Families echoed concerns around accountability structures and suggested that the existing health and social care landscape was confusing and this process offered partners the opportunity to engage with residents and outline the direction in which the Council and partners wanted to go. The Cabinet Member advocated adopting an ambitious approach instead of smaller incremental adoption.

The Chair, Haringey CCG echoed concerns around the power of large acute trusts to pull resources towards them and that adopting an ACP/ACO model was an opportunity to adopt a more population based patient-centred focus. The Lay Member Haringey CCG advised that the Board needed to engage with patients to explain the large amount of structural change underway but cautioned that any explanation needed to be based around patient experience. The Lay Member Haringey CCG also reiterated concerns about acute providers seeming to become even more powerful, and that this was in contrast to the strategic direction of the NHS and vision set out in the Five Year Forward Plan. The Lay Member, Haringey CCG commented that the partnership needed to adopt an ambitious approach to try and move services away from the acute sector towards community services and a preventative approach.

The Cabinet Member for Finance & Health commented that adopting a more formalised structure was the best way to drive accountability, and advocated a more formalised ACO-type organisational structure. The Deputy Chief Executive commented that it was crucial that the top level governance structure was worked out in order to ensure that resources were not centralised through acute care providers and that the Council, CCG, GP surgeries and patient representation were enabled to be as powerful as possible. The Assistant Director of Adult Social Services advised that the partnership needed to articulate an outcome based framework, as opposed to one based on organisational structure in order to ensure that large acute care providers or social care providers did not dominate. The Chief Executive of BRT advocated adopting an organisational structure that facilitated greater influence for voluntary sector organisations.

RESOLVED:

I. To note progress with the Wellbeing Programme and the continued work to explore how an Accountable Care Partnership can support the Wellbeing Partnership's aims of taking a preventative approach to maintaining population health and wellbeing.

II. To discuss options on organisational form, governance and pace of change and to consider what arrangements are most likely to enable the partnership to drive efficiency and improve outcomes in the long term

III. To discuss the role of the Health and Wellbeing Board in shaping the Wellbeing Partnership.

SECTION 75 AGREEMENT – LEAD COMMISSIONING ARRANGMENTS

The Board received a report which set out progress on implementation of a model of commissioning and pooled budgets supported by a partnership agreement under S.75 of the National Health Services Act 2006. Lead commissioning and pooled budgets for specified care groups were due to be in place by April 2017. The report was introduced by Rachel Lissauer Director of Commissioning, Haringey CCG and was included in the agenda pack at page 69.

RESOLVED

The Health and Wellbeing Board was asked to note the work underway to ensure the following arrangements could be in place from April 2017:

I. Lead commissioning and the establishment and maintenance of pooled fund for the commissioning of learning disability services

for eligible adults resident in Haringey;

II. Lead commissioning and the establishment and maintenance of a pooled fund for the commissioning of mental health services for eligible adults resident in Haringey;

III. 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;

IV. 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;

V. 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.

CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN

The Board received a report which provided an updated version of the CAMHS plan, taking into account the work that had been completed in the last year and to also set out further details on what implementation would look like over the next four year period. The report was introduced by Catherine Swaile, Vulnerable Children's Joint Commissioning Manager and was included in the agenda pack at page 217. The updated CAMHS Transformation Plan was also included in the agenda pack at page 221, as an appendix to the report.

The Lay Member, Haringey CCG commended the report and commented that it was a really helpful piece of work that clearly set out what the issues were and what was being done to tackle them.

The Director of Children's Services raised concerns about the transition of young people into adult mental health services and commented that although the report set out that this shouldn't be arbitrarily based on age, there was a concern that this was still the case and that there were significant issues involved. The Director of Children's Services queried how that transition could be improved.

In response the Vulnerable Children's Joint Commissioning Manager advised that a number of pieces of work had been undertaken following

	an Overview and Scrutiny Committee report on CAMHS transition in 2014. A three year action plan around transition had been developed with the aim of understanding the current cohort, who was making the transition and how many wanted additional support but were ineligible. In addition, there was a pilot scheme being introduced involving BEH Mental Health Services, the voluntary sector and a group of young people at transition age. The pilot scheme involved the co-production of a manualised training package for young people about life skills and the development of peer support arrangements. The Vulnerable Children's Joint Commissioning Manager advised that this would hopefully be successful in helping those young people between tier 2 and tier 3 who would not be eligible for additional support at transition. The Board were also advised that work was being undertaken to look at how to relax the boundary between CAMHS and adult mental health services to ensure that the young person was referred to the most appropriate treatment. There would be a joint panel with adult mental health services and CAMHS to decide the best referral pathway. In response the Director of Children's Services urged that the transitional approach should involve a wider array of partners including Children's services and Adult Social Services. **RESOLVED:** I. To note the contents of the CAMHS Transformation Plan Refresh and formally sign-off the plan for publication.	
CNCL113.	**ACTION LOG** The Board noted the action log.	
CNCL114.	**NEW ITEMS OF URGENT BUSINESS** No new items of Urgent Business were tabled.	
CNCL115.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** The Board agreed in principle to holding a joint meeting of the HWB and Community Safety Partnership at the next Board meeting in March. It was agreed that there would be short Board meeting for business items and that the main strategic item would be a joint discussion of both Boards focusing on one of the key areas of overlap such as VAWG, alcohol or mental health. It was noted that the future meeting dates were:	Board to note.

	• 2nd March 2017 at 18:00	

The meeting closed at 20.00pm.

Cllr Claire Kober

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Chair of the Health and Wellbeing Board

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 31ST JANUARY, 2017, 09:30

Haringey Board Members Present: Cllr Claire Kober (Chair of Haringey Health and Wellbeing Board), 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 Peter Christian (Chair, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair, Haringey CCG), Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services) Geoffrey Ocen (Bridge Renewal Trust – Chief Executive).

Haringey Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Charlotte Pomery (Assistant Director of Commissioning), Tim Deeprose (Interim Director - Wellbeing Partnership), Dr Helen Taylor (Clinical Director and Deputy Director of Strategy – Whittington Health), Stephen Lawrence Orumwense (Assistant Head of Legal Services), Philip Slawther (Principal Committee Coordinator LBOH).

Islington Board Members Present Cllr Councillor Richard Watts (Chair of Islington Health and Wellbeing Board), Councillor Janet Burgess (Executive Member for Health and Social Care), Cllr Joe Caluori (Executive Member for Children, Young People and Families), Alison Blair (Chief Executive Islington CCG), Melanie Rogers (Director of Quality and Integrated Governance, Islington CCG), Dr. Josephine Sauvage (Chair of Islington CCG), Sorrell Brookes (Lay Vice-Chair, Islington CCG), Simon Pleydell (Chief Executive, The Whittington Hospital NHS Trust), Angela McNab (Chief Executive, Camden & Islington Foundation Trust), Public Health - Camden and Islington), Jason Strelitz (Assistant Director Public Health. Substitute for Julie Billet), Carmel Littleton (Corporate Director of Children's Services), Emma Whitby (Chief Executive, Islington Healthwatch), Sean McLaughlin (Corporate Director of Housing and Adult Social Services).

Islington Officers Present: Lesley Seary (Chief Executive, Islington Council), Brenda Scanlan (Interim Service Director of Adult Social Care), Jonathan Moore (Senior Democratic Services Officer, Islington Council).

*** ***Clerk's Note*** *- The meeting was held as a 'meeting in common' of the Haringey and Islington Health and Wellbeing Boards. As a joint committee had not been established, this was two separate meetings of the Boards, held concurrently.*

*Each Board could make decisions related to its own functions, but functions could not be exercised jointly. The usual procedure rules governing each meeting were applicable, including quorum and voting rights. ***

1. FILMING AT MEETINGS

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

2. WELCOME AND INTRODUCTIONS

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

3. APOLOGIES FOR ABSENCE

The following apologies were noted:

- Cathy Herman, Lay Member, Haringey CCG
- Sir Paul Ennals, Chair of Haringey's LSCB
- Julie Billett, Joint Director of Public Health - Camden and Islington (substitute: Jason Stellar)
- Sean McLaughlin, Corporate Director of Housing and Adult Social Services (substitute: Brenda Scanlan)
- Dr Helen Brown

4. NOTIFICATION OF URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

No Declarations of Interest.

6. QUESTIONS, DEPUTATIONS, PETITIONS

No Questions, Deputations or Petitions were tabled.

7. UPDATE ON THE NORTH CENTRAL LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

The Board received a report which updated the Health and Wellbeing Board on the development of the North Central London Sustainability and Transformation Plan

(STP). The report was introduced by Zina Etheridge, Deputy Chief Executive Haringey and was included in the agenda pack at pages 5-17.

The Chair advised that the draft Sustainability and Transformation Plan and the joint statement were published in October on all 5 NCL council websites following submission to NHS England. The Chair raised concerns with the overall lack of public engagement that had been undertaken around the STP and welcomed the opportunity to hold a discussion in public with both Health and Wellbeing Boards. The Board were advised that they were not being asked to endorse the STP, instead this was an opportunity to raise any concerns or seek clarification, and that a note of the discussion would be sent to those leading and managing the STP process for NCL.

The Board were advised that the STP estimated a financial gap in NCL NHS Services of £876m by 2020/21. For social care, the combined social care budget gap across NCL's boroughs would be in excess of £300m by 2020/21. A number of opportunities for public engagement had been carried out since publication of the NCL STP, including via each respective council and CCG website, a public event convened by Keep Our NHS Public on 15th December, meetings with the voluntary sector and respective CCG meetings held in public. In addition the NCL Joint Health Overview & Scrutiny Committee undertook a review of the draft NCL STP, they received written and verbal evidence from a range of stakeholders and published a report which set out a number of recommendations to challenge and inform development and delivery of the plan going forward.

The aim of the STP was to set out how to transform the whole system in order to improve both system sustainability and to make financial savings, whilst also improving outcomes. The Deputy Chief Executive advised that a key concern with the STP was a failure to consider the implications for wider care services within the overall health care system.

The Chief Executive, Bridge Renewal Trust reiterated concerns raised around a lack of public consultation and a lack of clarity about what exactly the STP would look like.

The Haringey Cabinet Member for Finance and Health welcomed the fact that the STP gave equal consideration to mental health and wellbeing and physical health but commented that further consideration needed to be given on how to support the voluntary sector in providing more community level care, given the significant financial constraints on the voluntary sector. The Cabinet Member for Finance and Health further commented that the STP needed to set out how to capacity build within the voluntary sector to support the development of community level mental health and wellbeing services. The Cabinet Member for Finance and Health sought clarification on what the next steps were in terms of the formal sign off process and the process of public consultation, given the lack of visibility and public scrutiny.

In response, the Chief Officer Haringey CCG acknowledged that the CCG shared the concerns raised around public consultation and suggested that the Wellbeing

Partnership may want to consider the lessons learnt from this. The Board considered that the document published in October set out the key concepts and was orientated at a fairly high level. Over the next few months, more detailed delivery plans were being developed and that this process offered an opportunity for broader public engagement. The Chief Officer Haringey CCG, advised that the CCG were developing stakeholder plans to set out a clear engagement process going forward. The Board was advised that the plans would not be completed by the end of March and that the wider STP sign-off process was ongoing. It was anticipated that there would be further opportunity to involve the voluntary sector.

The Chief Executive LB Islington, emphasised some of the concerns raised in the report and commented that the looming spectre of an £800m funding gap resulted in the STP having a disproportionate focus on the sustainability element at the expense of transformation and system change. The concern was that funding for adopting a preventative approach and provision of care services would be swallowed by a short-term approach to bridging the funding gap. The Chief Executive LB Islington advised that transformation was a key focus for local authorities and that there were a significant concerns with getting social care and issues around Children's Services recognised as part of the process.

The Chair welcomed that the report and highlighted the social care funding gap of around £300m against the back drop of the STP's overall focus on sustainability. The Chair advised that the both increased sustainability and the transformation of the social care system was going to necessitate much greater integration.

Cllr Watts reiterated that there were well documented frustrations with the STP process, such as the very top down approach and what felt like unnecessary levels of secrecy which was damaging to public consultation. It was noted, that there were also some significant positives to highlight, such as the parity of esteem between physical and mental health services, the care close to home proposals and the facilitation of conversations on the long term sustainability of the health and care system. Cllr Watts raised concerns that at present the STP was not a long term strategic transformation plan but more a short term deficit funding plan for the NHS. Cllr Watts suggested that social care and a focus on what integration of health and care meant in practice was key to the STP being a long term strategic transformational plan. The Committee considered there were significant issues across the two boroughs around the demand for urgent and emergency care and Cllr Watts commented that the STP did not present a case for a reduction in urgent and emergency care services across NCL, instead it was advocated that NCL needed an increase in urgent and emergency care services due to a long term failure to manage demand in this area.

The Chair, Healthwatch Haringey commented that there was a lack of public engagement around the STP process and also questioned what kind of model of public engagement might be used. The Chair, Healthwatch Haringey queried whether the Board could agree a sense of what kind of level of public engagement might be

undertaken and how that might be structured. Cllr Kober responded that it was not possible to undertake a satisfactory discussion at this juncture but acknowledged that the Board was keenly aware that the process had not been handled well enough, and from the outset the need for greater transparency and accountability had been pressed on the NHS. The Chair commented that the Board would ensure that a process of public engagement was put in place locally if it was not done through NCL.

Simon Pleydell, Chief Executive of Whittington Health acknowledged that NCL was under significant strain in terms of the numbers of patients presenting at an emergency department and that the system was near the limit of how far it could be stretched, as a result it was not envisaged that there would be a reduction to urgent and emergency care services. The Board considered that the overall objective in urgent & emergency care was to keep more people out of hospital and to treat more patients locally in the community. The Chief Executive of Whittington Health advised that the STP was currently at such a high level that it was difficult to undertake any meaningful consultation with either users or the public as it was not possible to say what the impact would be in terms of local service provision. It was anticipated that NHS partners would be reviewing the high level numbers over the coming two to three months following which a process of meaningful public and user engagement would be developed.

The Chief Officer Haringey CCG advised that a communications and engagement lead had been appointed to improve the engagement process around the STP and the Chief Officer, Haringey CCG agreed to speak to the communications and engagement lead and arrange a meeting. **Action: Sarah Price.**

The Director of Children's Services advised that the governance arrangements around the STP had been altered recently and that Healthwatch were going to be part of the oversight group and the delivery group. The Director of Children's Services also raised concerns that the parts of the STP process had felt transactional rather than transformational.

Cllr Watts summarised that there was a balance to be struck between the need for meaningful public engagement and having firm proposals to be able to consult upon. Cllr Watts urged that as more practical considerations began to emerge that there would need to be a high level of engagement with both the public and with local politicians and welcomed the Chief Officer, Haringey CCG's offer to lead on engagement with NHS bodies. The Chief Executive, Islington Healthwatch agreed to draft some principles of engagement. **Action: Emma Whitby.**

8. DEVELOPING THE WELLBEING PARTNERSHIP AGREEMENT

The Board received a presentation from Dr Helen Taylor on the frailty workstream of the Wellbeing Partnership. Following the presentation the Board discussed its findings.

The Board considered that in addition to age, there were a number of factors that determined health needs such as; social housing, possessing long term conditions,

reduced mobility and mental health issues. In determining how to care for these people it was evident that there was a cohort of patients who received a high level of care and were know to the system. Dr Taylor advised that in developing the frailty workstream it was hoped that the partnership could intervene in cases where people may be developing long term conditions or have reduced mobility but only became known to the system once they had suffered a crisis and were admitted to an A&E department. The Board was advised that the proposal was to mirror schemes undertaken by south west academic health science networks and in places like Humberside in which frailty was considered as a long term condition. Frailty was described as a loss of reserve, due to factors such as a loss of mobility and the presence of other long term conditions etcetera, which would result in a period of hospitalisation following a crisis.

Using this definition, a cohort of service users had been identified through workshops and pathways were sought to reduce their level of potential vulnerability and to intervene before they reached a crisis point. In determining what was already in place, the Board was advised that there were already a significant amount of interventions available but the challenge was to connect these together and think strategically at a population level. Dr Taylor also advised that the task was to deliver the correct outcomes, that the patient wanted, and to do so before they suffered a health crisis. An e-frailty index had been developed to that effect which provided a way of indentifying frailty across a range of factors and categorising them in terms of mild, moderate and severe frailty which would then be linked to GP records. The Board was advised that the proposal was due to be taken to the sponsor board and Dr Taylor invited the Board to provide comments and consider what the next steps were. In response to a request for clarification, Dr Taylor advised that a key consideration was how to take the work been done by the Wellbeing Partnership and get it to the point where this could work at a population level. The Chair commented that there were some interesting pilot schemes involved, and the question was at what point was there enough of an evidence base to incorporate into them into mainstream service provision.

The Board also received a report from Tim Deeprose, Programme Director for the Wellbeing Partnership which sought views on the extent of the collaboration involved in the establishment of the Wellbeing Partnership Agreement, which was to be presented to Council Cabinets, Trust Boards and CCG Governing Bodies in April and May 2017. Support was given to establish a Haringey & Islington Wellbeing Partnership at the 3rd October meeting in common and the Board was asked to consider areas for greater joint working.

The Deputy Chief Executive, LB Haringey commented that some of the questions raised in the report were easier to answer than others and that having a joint health & wellbeing strategy should be easy to agree as without a strategy it would be difficult to join up any of the other aspects that would sit underneath it. The Deputy Chief Executive suggested that the Board might want to consider whether to include all health and care services or whether there were some services that would be best placed to be delivered outside of the Wellbeing partnership, at a very local level. The Board considered the need to develop the management & leadership capability in order to facilitate greater joint working across the proposed workstreams and that in reference to the point raised by Dr Taylor about next steps; it was likely that the

Wellbeing Partnership would need to move towards joint management structures. The Deputy Chief Executive suggested that joint performance management would likely follow on from the development of a joint health and wellbeing strategy.

The Chair echoed the comments of the Deputy Chief Executive, LB Haringey and suggested that this seemed like a sensible approach. The Chair proposed that the assumption was for joint working whilst protecting the principle of subsidiarity and that partners should be able to their own due diligence and consider their own legal responsibilities.

The Chief Executive, LB Islington echoed the comments of the Deputy Chief Executive, LB Haringey around the need for a joint health and wellbeing strategy and that areas of greater joint working would flow from there, along with the principles already agreed by the Wellbeing Partnership such as the need for subsidiarity. The Chief Executive advocated being selective in the areas of joint working and focusing on getting those right before broadening the approach. The Board considered that agreement had already been secured through the CCG for a joint local CCG type arrangement across the two boroughs with shared commissioning post and that this would help develop a joint management structure. The Chief Executive, LB Islington advised that adopting a 'big bang approach' would likely scare people and generate concerns about budgets and where they would sit in future, instead the Wellbeing partnership should build confidence by focusing on a joint strategy and clear areas of focus around particular workstreams.

The Programme Director for the Wellbeing Partnership presented a draft governance structure to the Board which was included at page 27 of the agenda pack. The Board considered that the Wellbeing Partnership Board would have oversight of the system as a whole, deal with strategic issues and have sight of all of the funding being used in the area. Whereas the delivery group would be operationally focused and clinically driven, involving professionals from each of the services involved. The Board was advised that it was felt necessary to include a community reference group in the proposed governance structure in order to ensure there was enough community/service user influence across the system. The Programme Director for the Wellbeing Partnership advised that the work groups across the bottom of the structure clustered activities being undertaken by the programme and reflected the same groupings as set out in the STP. The Board where asked to provide comments on governance arrangements and the draft governance structure.

The Haringey Cabinet Member for Finance & Health commented that he felt that the proposed governance structure looked sensible but that an interim governance structure was selected for the wellbeing programme when it was adopted last year and challenged whether there was enough evidence from that period of informal collaboration to justify formalising the structures as proposed. The Programme Director for the Wellbeing Partnership acknowledged these concerns and advised that the sponsor board were meeting later that week to discuss the barriers that were being faced by each of the working groups as they have tried to establish how new services could be put in place. The Programme Director for the Wellbeing Partnership suggested that the governance structure needed to be nudged along in order to stay ahead of where the working groups had got to so that they were in a position to remove barriers as and when they arose.

The Cabinet Member sought clarification on what some of those barriers had been to date. In response, the Board was advised that a key barrier was around the need to get information governance in place in order to be able to share information across a large population base. The Programme Director for the Wellbeing Partnership also advised that workstreams to help people self manage their conditions needed to be established at a local level to support the STP, and that having a formalised governance structure facilitated this through encouraging greater interaction between constituent parts of the system.

Cllr Kober enquired where democratic accountability would sit within the proposed governance structure. The Board was advised that this would depend upon the type of partnership arrangement that was sought and what it was that the Wellbeing Partnership Board needed to do. It was envisaged that if there was a significant element of budgetary responsibility transferred over then this would likely necessitate greater political oversight. The Programme Director for the Wellbeing Partnership suggested that ultimately a very different accountability might be required but that over the next 12 to 18 months democratic accountability would remain with the individual statutory organisations that made up the Wellbeing Partnership Board.

The Chief Executive, LB Islington commented that she had assumed that the Wellbeing Partnership Board was an evolution of the two Haringey and Islington Health & Wellbeing Boards meeting jointly, reflecting a formalisation of existing arrangements. In doing so, it was assumed that there would continue to be a mix of democratically elected members and professional officers.

The Chief Executive of the Bridge Renewal Trust queried whether the community reference group referred to in the draft governance structure would be one group, combining voluntary and community sector groups across Haringey and Islington or whether there would be two groups. The Board also considered the need to ensure that local organisations were included in any future commissioning arrangements.

The Chair advised of the need to set some fairly short timescales to resolve some of the queries raised. The Board agreed for a proposal setting out the governance arrangements and a resolution to some answers to some of the questions raised, to come back to the next meeting of the Board.

Action: Tim Deeprose/Clerk

9. HARINGEY AND ISLINGTON: TACKLING OBESITY TOGETHER

The Board received a report and presentation which set out a joint approach to tackling obesity across Islington and Haringey. The report and presentation were included at pages 37 and 53 respectively and were introduced by Dr Jeanelle De Gruchy, Director of Public Health LB Haringey.

The Director of Public Health advised that both Haringey and Islington Public Health teams had come together to workshop what was being done locally to tackle obesity. Haringey and Islington faced similar challenges with over 1 in 3 children aged 10-11 classed as overweight or obese. Tackling obesity through the partnership emerged as a priority area following the scoping of the CVD/diabetes, children's and prevention

work streams. The Board was advised that the potential impact between a healthy and non-healthy life style was hugely significant in terms of overall health outcomes and their knock on effect. The Director of Public Health, LB Haringey outlined the areas for collaboration set out in the report and the types of approach being taken. It was emphasised that the aim was to create healthy environments to facilitate a wider culture shift within the population. The Director of Public Health, LB Haringey highlighted the removal of 'no ball-game signs' and the play weekend in April as activities designed to encourage children to be physically active.

The Director of Public Health, LB Haringey also drew the Boards' attention to the Sugar Smart campaign in conjunction with the Jamie Oliver Foundation and Sustain. The aim was to increase awareness of and reduce sugar consumption across all age groups and communities, and in doing so becoming the first Sugar Smart joint borough. As part of the campaign it was proposed to undertake an audit of all Council and commissioned properties to assess what their food offer was and to then develop a food standards policy and toolkit to help providers look at alternatives. The Healthy Workplace Charter was also highlighted to the Board, which was a structured framework to recognise and support business investment in employee health and wellbeing. Initiatives included: Promotion of 5 a day and the 'one you' website, reduced price gym membership, running clubs, walks at lunchtime, cycle to work schemes and the provision of showers and lockers for people to promote cycling and running to work.

Cllr Watts advised that he welcomed proposals to remove 'no ball-game' signs and that he and Cllr Kober were keen to include the Play Streets scheme into the proposals. Cllr Watts also proposed that a high profile campaign should be launched to generate public interest and garner momentum, and suggested that the Board might want to focus on campaigning against a particular product. The Chair requested that the Director of Public Health, LB Haringey and the Assistant Director Public Health LB Islington develop proposals around launching a profile campaign.

Action: Jeanelle De Gruchy & Jason Strelitz

RESOLVED

That Haringey and Islington work together to:

I. Create healthier food environments and reduce sugar consumption

- To sign up to London's Sugar Smart Campaign and to agree a joint pledge to make healthier food more affordable and accessible for our residents.
- To encourage sign up to the Sugar Smart Campaign from our partners (including schools and community organisations).
- To undertake a snapshot audit of the current food offer in public sector facilities across both boroughs in order to understand the quality and nutritional value of food on sale to our residents.
- To develop a food standards policy and toolkit to work with providers to improve the food offer for all our residents.

- That all organisations on the joint board work towards Healthy Workplace Charter 'Excellence'.

II. Building capacity and knowledge within the wider public health workforce

- To promote Making Every Contact Count (MECC) within all organisations represented in the Haringey and Islington Health and Wellbeing Board.

III. Work together to identify joint funding to increase levels of physical activity

- To support a joint Haringey and Islington bid for the Local Area Fund pilot.

10. HARINGEY AND ISLINGTON JOINT HEALTH AND WELLBEING BOARD - TERMS OF REFERENCE

The Board received a report which set out the terms of reference for more formal joint arrangements between the Haringey and Islington Wellbeing Boards, to strengthen governance arrangements and provide a platform for further joint working.
The report was included at pages 59 and was introduced by Stephen Lawrence-Orumwense, Assistant Head of Legal Services, and LB Haringey.

The Board agreed two minor amendments to the proposals as set out in the report: The committee would be a joint sub-Committee of each borough's respective Health and Wellbeing Board and that voluntary sector representation would be added to the membership of the Board. The Board agreed that discussions would be held with the Bridge Renewal Trust to ascertain how to work with Islington voluntary sector organisations to ensure that there was representation across both Haringey and Islington voluntary sectors.

Action: Geoffrey Ocen & Emma Whitby

11. DATES OF FUTURE MEETINGS

The dates of future meetings were to be agreed.

12. NEW ITEMS OF URGENT BUSINESS

None

13. EXCLUSION OF THE PRESS AND PUBLIC

N/A

14. NEW ITEMS OF EXEMPT URGENT BUSINESS

N/A

CHAIR: Councillor Claire Kober

Signed by Chair ……..

Date ……

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Report for: Health and Wellbeing Board – 2 March 2017

Title: Annual Public Health Report 2016/17

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

Lead Officer: Susan Otiti, Assitant Director of Public Health

1. Describe the issue under consideration

1.1 The Annual Public Health Report (APHR) is the Director of Public Health's (DPH) professional statement about the health of local communities, based on sound epidemiological evidence and interpreted objectively.

1.2 The APHR is an important vehicle by which DsPH can identify key issues, flag up problems, report progress and, thereby, serve their local populations. It is also a key resource to inform local inter-agency action.

1.3 This year's report focuses on sexual and reproductive health, particularly young people's sexual health.

1.4 The APHR should be publicly accessible to view and will be available at the board meeting on the 2nd March. Thereafter it will be published on line and hard copies will be available for distribution.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to consider the APHR 2016/17.

3. Background information

3.1 The title of the APHR is 'sexual health matters'. In Haringey we have made significant progress in reducing teenage conceptions and have developed a variety of sexual health projects and services for young people, however there is much more to do particularly in relation to the high rates of sexually transmitted infections (STIs). The report highlights that young people in Haringey have an overall rate of STIs which is considerably higher than England's.

3.2 Prevention is important - young people tell us they want a holistic approach to discussing their welfare and to be able to get that from an adult they trust. We will continue to improve young people's access to tailored information and support parents to have open conversations with their children as they grow up. We will continue to support frontline staff working with children and young people in schools, colleges, the voluntary sector and primary care to develop essential skills and attributes for talking about health issues with young people.

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

4.1 Finance and Procurement

4.2 There are no financial or procurement implications arising directly out of this report.

4.3 Legal

4.4 Under Section 73B (5) and (6) of the NHS Act 2006, the Director of Public Health has a statutory duty to publish an annual report on the health of the local population. The content and structure of the report is to be decided locally. The Council is required to publish the report.

4.5 Under Section 2B of the NHS Act 2006, the Council must take such steps as it considers appropriate for improving the health of the people in its area. The steps to be taken may include providing information and advice, providing services or facilities designed to promote healthy living and providing services or facilities for the prevention, diagnosis or treatment of illness."

4.6 Equalities

4.7 The report highlights that young people in Haringey have an overall rate of STIs which is considerably higher than England's. The measures set out in this report will contribute to tackling this aspect of health inequality experienced within this group, most of whom share the characteristics protected by the Equality Act 2010. Consideration will be needed for those groups who have disproportionately high levels of STI and sexual health needs. This includes sex, ethnicity and sexual orientation protected characteristics.

6 Use of Appendices

6.1 None.

7 Local Government (Access to Information) Act 1985

7.1 Not applicable.

Report for: Health & Wellbeing Board, 2nd March 2017

Item Number: 9

Title: Suicide Prevention Action Plan

Report Authorised by: Zina Etheridge, Interim Chief Executive Officer

Lead Officer: Tamara Djuretic Tamara.djuretic@haringey.gov.uk, 0208 489 3265

Ward(s) affected: ALL

Report for Key/ Non Key Decision: Non Key Decision

1. Describe the issue under consideration

1.1 Haringey's Health and Wellbeing Strategy's Priority 3 focuses on improving mental health and wellbeing across the borough. One of the focuses of Priority 3 and joint Mental Health and Wellbeing Framework is suicide prevention.

1.2 This paper presents the suicide prevention action plan to be discussed and endorsed by the Board.

2 Recommendations

2.1 The Board is asked to consider and approve the Haringey Suicide Prevention Action Plan.

3. Reasons for decision

3.1 Five Year Forward View on Mental Health published in February 2016 and Public Health England guidelines on suicide prevention action planning, published in October 2016, recommend having multiagency, local suicide prevention plan endorsed by a partnership body such as Health and Wellbeing Boards.

4. Alternative options considered

N/A

5. Background information

5.1 In Haringey, local suicide prevention planning includes following components:

- Considering suicide prevention more generally within our priority in the health and wellbeing strategy or improving mental health and wellbeing;
- Understanding data on suicide including a **local suicide audit** to reveal the pattern of suicides, groups at risk and factors relevant to suicide prevention planning and using Public Health England Suicide Prevention Profile;

- A **multi-agency suicide prevention group** chaired and led by MIND in Haringey. The group includes statutory and voluntary organisations and NHS Trusts to support the development and implementation of suicide prevention interventions;
- A **suicide prevention action plan** based on the national strategy and local intelligence on suicide risk overseen by Haringey's Suicide Prevention Group (HSPG).

5.2 The Haringey Suicide Prevention Group (HSPG) was formed in June 2015 to strengthen community response to suicide prevention planning and implementation. The Group, which is chaired by MIND in Haringey (Professor David Mosse), meets on a quarterly basis and has broad membership from statutory and non-statutory organisations including: Haringey Public Health, Children's Services, the CCG, Met Police, BEH-MHT, British Transport Police, local charities (including North London Samaritans). Haringey MPs David Lammy (Tottenham) and Catherine West (Wood Green and Hornsey) attended the group and workshops on few occasions, invited by MIND chair.

5.3 HSPG has coordinated and overseen a development of Haringey's Suicide Prevention Plan using the PHE prevention guidelines published in October 2016. The Plan is geared towards the high-risk and vulnerable groups identified in the audit and other risk groups emerging from the national evidence. It has set actions for the whole system to address the mental health and risk of suicide in specific groups by: reducing access to the means of suicide (e.g. Archway Bridge); addressing the vulnerability and mental health issues in particular community settings (e.g. Eastern European migrants); supporting those bereaved or affected by suicide; working with the media to prevent harmful exposure; and expanding and improving the systematic collection of and access to data on suicides.

5.4 Wider actions on mental health and wellbeing prevention recommended by Public Health England manual, such as training programmes for schools that include self-harm prevention component, community mental health and wellbeing interventions in more deprived areas of Haringey etc. are picked up by implementation of Haringey's Health and Wellbeing Strategy.

5.5 HSPG is meeting between times of the publication of HWB Board papers and meeting on 2nd March to sign off enclosed action plan. It is therefore suggested that any further amendments to action plan in Appendix I will be tabled at the meeting.

6 Contribution to strategic outcomes

6.1 Priority 1-3 of the Corporate Plan and Health and Wellbeing Strategy Priority 3.

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

7.1 Finance and Procurement

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

7.1.2 Legal

7.2.1. The recommendation in the report falls within the Board's responsibility to oversee the delivery of the Council's strategic outcomes for local health and wellbeing targets.

7.2.2 Equality

7.2.3 Suicide audit was undertaken locally to identify particular groups of people at higher risk of suicide in Haringey, in addition to national evidence on risk groups and vulnerability. These information were basis for development of an action plan that focuses on specific interventions targeting groups at risk including men 25-40 years of age, care leavers, mental health issues, Eastern European population, lesbian, gay, bisexual and transgender people, as well as children and young people.

8. Use of Appendices

Appendix I – Haringey's Suicide Prevention Action Plan

9. Local Government (Access to Information) Act 1985

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

Health and Wellbeing Strategy 2015-2018

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

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Haringey Suicide Prevention Plan 2017 – 2020*

*Subject to approval by Haringey's Suicide Prevention Group on 23rd February 2017

Acknowledgement

James Barber, Public Health Intelligence Analyst, Haringey Council

Dr Tamara Djuretic, Assistant Director of Public Health, Haringey Council

Professor David Mosse FBA, Chair, Haringey Suicide Prevention Group

Haringey's Suicide Prevention Group

Contents

Introduction

Suicide is one of the top twenty leading causes of death for all ages worldwide with more than one million deaths per year globally (ONS, 2016). In England, there has been an overall decline in the numbers of suicides with 4,820 registered suicides in 2015, 82 fewer than in 2014. However, the rate of suicides continues to increase with a rate of 10.1 deaths per 100,000 in 2015. This increase was driven by a rise in female suicides which increased from 4.9 per 100,000 in 2014 to 5.0 per 100,000 in 2015. Despite a recent increase in female suicide rates, approximately 75% of all deaths by suicide are committed by men. Suicide is now the leading cause of death for men aged 15–49. The highest suicide rate in England in 2015 was 45-49 year olds, at 22.4 deaths per 100,000. This age group also had the highest rate among women, at 6.9 deaths per 100,000.

London's suicide rate has increased from 7.8 per 100,000 in 2014, to 10.4 per 100,000 in 2015. Haringey has the 5th highest 3-year average suicide rate in London at 10.8 per 100,000 between 2013-2015 (ONS, 2015). The 2016 Haringey Suicide Audit also revealed an average of 21 registered suicides between 2013-2015. This Haringey Suicide Prevention Plan (HSPP) aims to consolidate the interventions of key local stakeholders to form a coherent overall plan, using resources and good practice examples in order to reduce the number of local suicides.

Suicide prevention work is cost effective when conducted in accordance with evidence and by working in partnership. The financial cost of a death by suicide estimated at £1.67 million (2009 prices) in terms of care and lost productivity. This means that the 73 suicides registered in Haringey between 2013 and 2015 cost £116.85 million, and a 10% reduction in suicides saves £5 million. Alternatively put, for every year of life that an individual suicide is prevented, costs of £66,797 may be averted (Bolton SPSF, 2013).

Interventions aim to prevent individual tragedies with life-altering consequences for those bereaved or affected by suicide. Each death from suicide seriously affects at least 10 people. Local government, statutory services, the third sector, local communities and families each have a role to play.

National Context

In 2012, the coalition Government published a new national strategy 'Preventing Suicide in England'[1]. The strategy focuses on two leading objectives:

- A reduction in the suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

There are also six key areas for action to achieve the objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

In 2016, PHE published local authority suicide prevention planning guidelines. This guidance aims to support the commitment and capability that exists in public health, local government, health services, primary care and the voluntary sector to:

- develop a multi-agency suicide prevention partnership
- make sense of local and national data
- develop a suicide prevention strategy and action plan

PHE identified some risk groups emerging as a national trend and areas of focus for population approach (e.g. men, children and young people and those with undiagnosed depression) however it has been recognised that there is a great variation between localities.

PHE therefore recommended undertaking local suicide audits to inform action planning.

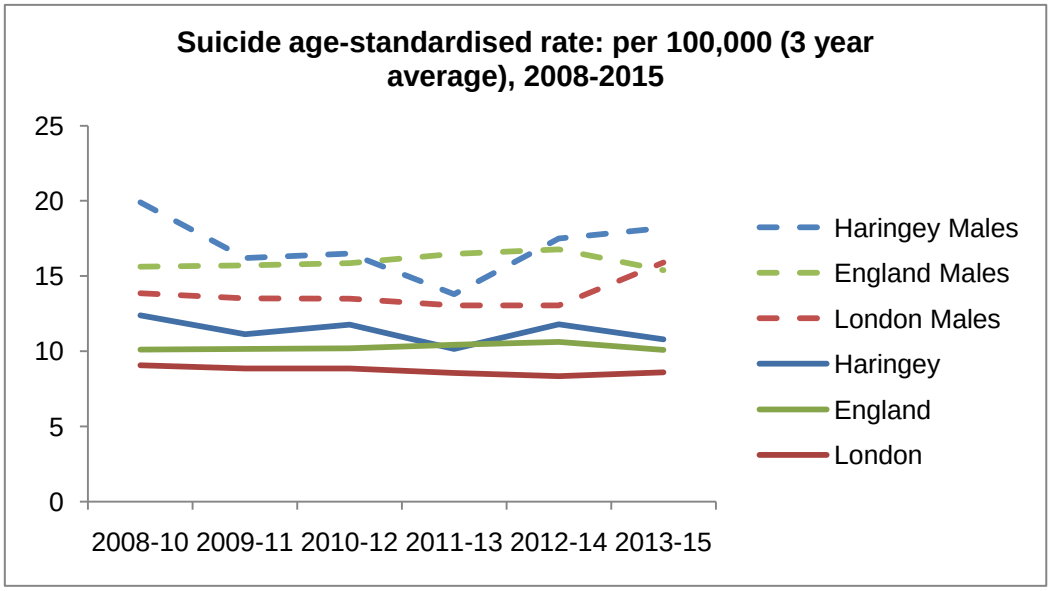
Suicide in Haringey

In 2012-2014, Haringey had the highest 3-year average suicide rate in London at 11.8 per 100,000 (ONS, 2015). However, recently published data suggest decreasing trend with a rate of 10.8 per 100, 000 for 2013-2015 (sixth highest in London after Camden, Islington, Hammersmith and Fulham and Southwark). There are, on average, 24 people a year who complete suicide in Haringey.

Since 2008-2010 (12.4 per 100,000) there have been year to year fluctuations in suicide rates in Haringey, with the current age-standardised suicide rate standing at 10.8 per 100,000 for 2013-2015. This is currently the 5th highest suicide rate in London. In relation to Haringey's comparator boroughs in 2013-15, Hackney's 3-year suicide rate is 9.2, Lambeth's is 10.0, Lewisham's is 7.0 and Southwark's is 11.0. Figure below highlights an increase in suicide rates from 2011-2013 which triggered repeat of suicide audit in 2016. Haringey's overall suicide rate decreased slightly in 2013-15 but remains higher than both London and England, whilst the male suicide rate continues to increase.

[1]

Figure 1 - Age-standardised suicide rate 2008-2015 (ONS, 2016):



Haringey Public Health intelligence team has recently carried out a 2016 Suicide Audit, using coroner's reports and data to identify recent patterns and explain trends in suicide in the local area and inform local prevention planning. This audit included in-depth information review of each suicide case over the last ten years or so. The audit found several salient features of deaths by suicide including:

- 75% of deaths were men, the highest rate being among men aged 25-44;
- Only half of those who died by suicide had a record of employment. Of those, 35% were amongst those in "higher managerial, admin and professional occupations". e.g. financial advisor or head-teacher, followed by 24% in routine and manual;
- Following 18% of people completing suicide were retired and further 12% were students;
- 66% of suicides took place in the east of the borough;
- The main method of suicide was hanging and main places were homes followed by train stations.

Those particularly at risk in Haringey include young and middle aged men in employment, those experiencing various forms of crisis (e.g. financial, relationship, housing or health problems), those with mental health conditions and those with limited or late access to health services. Haringey Public Health has met with both Enfield and Barnet, who have replicated Haringey's audit as best practice, with the aim of compiling findings for a more accurate picture of suicide across North London. However, there have been several limitations to the collection of coroner's data, including the incompleteness of coroner's reports on suicide verdicts. There is an underlying need for detailed and regular reviews of coroner case files, which is currently being undertaken in Haringey.

Additional information on the broader public health context of suicide risk in the borough can be gained from national data on suicide-related factors. In particular, the Public Health England Suicide Prevention Profile provides Haringey-specific data related to general risk

factors including mental health conditions and service contacts.[2] As well as high levels of poverty, [3] Haringey has high rates of long-term unemployment (7.6 per 1,000) and homelessness (657 people, or 6/1000, are statutory homeless, and 2,997 households, or 27.5 per 1000, are in temporary accommodation).[4] Homelessness, which is an outcome of poverty, relationship breakdown and cause and consequence of mental health problems, represents extreme vulnerability. Rates of severe mental illness (at 1.27%) in Haringey are well above the England benchmark (0.88%). The lower levels of diagnosis of depression (5.1% of GP lists vs 6.6% for England) might indicate poor help-seeking given that the estimated level of common mental disorders in the population (16-74 yrs) at 17.57% is above the England benchmark (15.62%), although a *comparatively* high proportion (17.8%) of those estimated with anxiety and depression do enter IAPT services (15.1% in all-England). In a 3-month period, Haringey (along with Islington and Camden) has a significantly higher than benchmark proportion of mental health service users with crisis plans in place (35.5%) (England 13.3%, London 19.4%), and there are very low rates of attendances at A&E for a psychiatric disorder (44/100,000, England 243.5/100,000, London 215.8). Haringey is higher than the benchmark for alcohol-related hospital admissions (1,353 per 100,000, England 1,258, especially men [1,890 vs England 1,717]), but has relatively low rates of hospital admission for intentional self harm (94.1 per 100,000 compared to England benchmark of 191.4).

Developing the Haringey Suicide Prevention Plan (HSPP)

The national strategy is implemented locally by three key means:

- a **local suicide audit** to reveal the pattern of suicides, groups at risk and factors relevant to suicide prevention planning;

- a **multi-agency suicide prevention group** bringing together statutory and voluntary organisation necessary to support the development and implementation of suicide prevention interventions;

- a **suicide prevention strategy and/or action plan** based on the national strategy and local intelligence on suicide risk (the present document).

The HSPP is framed with reference to national policy frameworks and guidelines, especially the National Suicide Prevention Strategy (2012)[5] and recently published Public Health

[2] . http://fingertips.phe.org.uk/search/suicide#pat/6/ati/101/par/E12000007

[3] 24.8% children living in households with incomes less than 60% of the median income; 11.9% in 'fuel poverty'. England long-term unemployment rate is 4.6%.

[4] These data from PHE derive from a snapshot (31 March) give levels of homelessness only exceeded by Newham in London (England benchmark for the temporarily accommodated homeless is 2.8/1000).

[5] The suicide prevention plan will help report on the quality and success of initiatives against indicators on suicide, self-harm and excess mortality in the Public Health Outcomes Framework (2013-2016). Other relevant **national policy frameworks** and guidelines are: the NHS Outcomes Framework (2015-16); No Health Without Mental Health (2011); the Five Year Forward View for Mental Health (2016); Children and Young People's Mental Health Taskforce report (2015); the Mental Health Crisis Care Concordat; Sustainability and Transformation Plans; Local Transformation Plans for Children and Young People's Mental Health and Wellbeing; the All Party Parliamentary Group on Suicide and Self-Harm Prevention. Important guidelines: Public Health England's Local

England's guidelines. It identifies recommendations and actions for key stakeholders, includes ongoing implementation of stakeholders own local plans and it also identifies further areas of action across the partnership (Appendix I).

Development and implementation of HSPP is overseen by Haringey Suicide Prevention Group (HSPG). The Group is facilitated by Mind in Haringey and led by a suicide prevention champion from the community, aims to raise awareness of the issue of suicide, steer the suicide prevention strategy for Haringey and coordinate local action planning to reduce the death rate from suicide in all age groups in Haringey. It has agreed Terms of Reference and a Declaration.

The group has broad membership from statutory and non-statutory organisations involved in suicide prevention including: Haringey Public Health, the CCG, BEH-MHT, GPs, Haringey Council, Young Adults Service YAS- CYPS (Children & Young People's Service), Homes for Haringey- Supported Housing, Public Health England, the Metropolitan Police Central Mental Health Team, Haringey Police, British Transport Police, the Coroner's office, local charities (including North London Samaritans, Maytree, Mind, HAIL, Open Door, Grassroots, North London YMCA, First Step, Citizen's Advice Bureau, Tottenham Job Centre Plus, as well as Haringey MPs David Lammy (Tottenham) and Catherine West (Wood Green and Hornsey). Appendix II

The suicide prevention strategy and plan aims to map into the broader health and wellbeing agenda in Haringey. The Health and Wellbeing Board, as well as the wider Council Corporate Plan which aims to 'enable all adults to live healthy, long and fulfilling lives', will offer broader strategic oversight and guidance. More detailed operational guidance will come from a range of existing wider partnerships including the Crisis Care Concordat, the Enablement programme and the Safeguarding Adult board.

How will we gauge success?

HSPG partners are encouraged to develop outcome measures for SP interventions, to ensure monitoring and impact evaluation. The plan will be monitored via the following indicators:

Indicators for success
Outcomes indicators
- 10% annual reduction in the overall suicide rate - At least 10% reduction in male suicide rate - Reduction in recorded attempted suicides - Reduction in self-harm (A&E attendances and hospital admissions)
Process indicators:
- Resources identified for delivery and oversight of Haringey's Suicide Prevention Plan by March 2017 - Project manager recruited by MIND to monitor and support implementation of an action plan by June 2017 - Action plan agreed and signed off by HSPG and Haringey's HWB Board by March

Suicide Prevention Planning (due 2016), and the NICE Guidelines on Preventing Suicide in the Community (due 2018).

2017

It is envisaged to develop a local Suicide prevention database in line with the national guidelines described in Appendix III.

Appendix I – Haringey's Suicide Prevention Action Plan

Action plan contains actions already in place (marked in green) and actions to be implemented over the next three years.

Action 1: Reduce the risk of suicide in key high-risk groups:

Specific services and training for those working with the following vulnerable groups/individuals that have been identified as high-risk groups within Haringey:

- People who have attempted suicide
- Those bereaved by suicide
- Care leavers
- Those in police custody

Area for Action	Key issue/target group	Intervention description	Lead	Delivery timeframe
1.1	**Suicide attempt survivors**	Review and strengthen pathway for people attending A&E departments following suicide attempt	CCG and Psych Liaison services	By Dec 17
		Identify gaps in NHS primary care relating to self harm	Public Health/Acute Trusts Audit	By Dec17
		Provide suicide prevention respite retreat	Maytree	In place
		Open Door piloting a home-based intervention with a digital component to engage depressed young people 'stuck at home'	Open Door	In place
		Ensure GPs are contacted with details of suicidal/vulnerable person so that appropriate help and support can be offered e.g. Public Protection Unit/Liaison Team	British Transport Police	By Apr 17

		Continue to promote: • Talking therapies • Big White Wall • Ensure NICE guidelines on self-harm and depression are followed Improve support to patients after a suicide attempt	All BEH	In place and ongoing By Sep 17
1.3	**Those bereaved by suicide**	Provide information to those bereaved through 'help is at hand' leaflet as well signposting to Samaritans/other charities Survivors of Bereavement by Suicide (SOBS) peer support group	British Transport Police, Met Police and Coroners Court Mind in Haringey	In place In place
1.4	**Care leavers**	Strengthen pathways and support for care leavers mental health and wellbeing placed in and out of borough Stand alone awareness and communication package relating to suicide prevention/intervention to be developed for care leavers	Haringey Youth Adults Service (16-25 years old) BTP/Met Police	By Sep 17 By Sep 17
1.5	**Those in police custody**	Provide information/signposting for those in police custody or charged with crimes that are likely to cause significant distress. Continue to share intelligence relating to suicidal individuals to build a 'trace'	British Transport Police/ Met Police	In place By Sep 17

Action 2: Tailor approaches to improve mental health in specific population groups:

The Haringey Health and Wellbeing Strategy (HWBS) and Joint Mental Health and Wellbeing Framework place a direct emphasis on building individual and community resilience and promoting mental health and wellbeing in the borough and across the whole population. Taking a broader population approach in improving mental health and wellbeing of Haringey's residents will contribute to suicide prevention, especially if interventions are tailored for specific groups more at risk of developing mental ill health and not seeking help. The 2016 Suicide Audit identified the following population groups where tailored interventions are needed:

- Children and Young people
- People who are socially isolated
- Survivors of abuse or violence, including sexual abuse
- People living with a mental health condition and long-term physical health conditions
- Eastern European migrants
- Those with sexuality issues
- Middle-aged men facing life crisis due to failure of relationships, health, housing, finance

HWB Strategy and the Framework focus on a range of interventions aimed at defined population groups identified above, Table below specifies some further actions that may strengthen the overall approach to mental health and wellbeing improvement with a specific reference to suicide prevention:

Area for Action	Intervention description	Lead	Status
2.1	**Children and Young People**		
a	Identify children at high risk of emotional problems and signpost to services e.g. First Steps organisation for 9-18 year olds	Healthy Schools	By Dec 17
b	Ensure Child Overview Death Panel reviews findings and lessons learnt for cases due to suicide are regularly feedback to the Haringey Suicide Prevention Group	Open Door	By Apr 17
2.2	**Socially isolated**		

a	A number of interventions are being delivered through HWB Strategy and the Council's corporate plan	Partnership	In place
2.3	**Survivors of abuse**		
a	Develop the TRiM (trauma risk management) model for MPS staff through pilot project on Westminster Borough	Metropolitan Police	By Dec 17
2.4	**Those with a mental health condition**		
a	See Mental Health and Wellbeing Framework and HWB Strategy	Partnership (BEH MHT, CCG, Haringey Council)	Ongoing
2.5	**Those with a physical health condition**		
c	Ensure the routine assessment for depression as part of personalised care planning Increase uptake of IAPT services for people with physical disabilities and long term health conditions	CCG, BEH MHT and Primary Care Whittington	By Dec 17 By Dec 17
2.6	**Eastern European migrants**		
a	Mental health awareness raising in non-clinical setting including churches, shops, hairdressing salons and retail shops	Open Door, Voluntary and Community Sector	By Dec 17
b	Suicide prevention training of staff and recognition of signs and symptoms of depression within specific ethnic minority groups	Public Health and Samaritians	By Dec 17
2.7	**Those with sexuality issues**		
a	Ensure existing/planned training of frontline staff is LGBT aware	Public Health and CCG	By Sep 17
2.8	**General population (including middle age men facing crisis)**		
	Improve capacity of key people to recognise and respond to signs of distress and crisis (information, skills) Deliver suicide/self harm training for GPs; develop materials in line with NICE guidelines on self-harm Further dissemination of 'It's Safe to Talk About Suicide';	Samaritans/BEH MHT Public Health/Primary Care Tbc	By Sep 17 By Sep 17 By Dec 17

	Programme of training for those in contact with high-risk individuals including 'SafeTalk'	All	By Dec 17

Action 3: Reduce access to the means of suicide:

According to 2016 Suicide Audit, the most common suicide method was hanging in the home. As a means of suicide, this is best targeted through other means of prevention. However, there was a high number of suicides taking place in the following locations:

- Suicides as a result of hanging in the home
- Hanging in public parks and spaces
- Train stations and bridges
- High-rise buildings

The leading NSPS recommendation for reducing the number of suicides as a result of self-poisoning is for further consideration of the prescribing and sale of particularly toxic drugs.

Area for Action	Area for Action	Lead	Status
3.1	**Reducing the number of suicides as a result of hanging**		
a	Ensure safer environment for at risk patients	BEHMHT	In place
b	All contracts for commissioned services, including mental health trusts, to include a standard of compliance with best practice on suicide prevention, including safe clinical areas	CCG	By Mar 19
3.2	**Reduce hanging in public parks and public spaces**		
a **b**	Train staff in public parks on Mental health first aid Review need for more lighting in parks	Mind Haringey Council	By Apr 17 By Apr 17
3.3	**Reduce the number of suicides at train stations and bridges**		
a	Signage detailing support services on bridges, flyovers, train and bus	Samaritans and Haringey	By Mar 17

	stations and train local businesses on suicide prevention	Council	
b	Install physical barrier at Archway Bridge	TfL	By Jun 17
c	Train rail staff on identifying and engaging people who may be considering suicide	British Transport Police	Ongoing
3.4	**Reduce number of suicides from high-rise buildings**		
a	Continue to put in measures to secure roofs and reduce access to windows through restrictors in all medium and high rise blocks Work with shopping malls to monitor danger spots	Homes for Haringey	Ongoing By Apr 17
b	Promote suicide risk prevention via Haringey's Development Vehicle (e.g. when designing high structures such as multi-storey car parks, bridges and high-rise buildings, structures close to facilities for particularly vulnerable people)	Public Health and HDV	By Mar 18

Action 4: Provide better information and support to those bereaved or affected by suicide:

Post-suicide interventions at family and community level are essential to deal with the effects of suicide, the risk of contagion and cluster suicides and the ongoing impact on the mental health of the bereaved.

Haringey currently does not have a coherent approach to suicide bereavement, family liaison, and community response to suicide (i.e. a comprehensive postvention element in the SP strategy and plan. This is an important area for development.

There is a key role here for the police and the Coroner's office in offering immediate help to bereaved families in access to information and to find support from local and national organisations. There are also possibilities for developing real-time local intelligence gathering systems, involving the Coroner, to identify and respond to local suicide trends (as in Durham).

Area for Action	Intervention Description	Lead	Status

4.1	**Provide effective and timely support for families bereaved or affected by suicide**		
a	Tri borough project around leaflet to be handed out by police attending suspected suicides to relatives. Would contain information on what happens next and support groups *'Help is at Hand'* booklet Immediate outreach after suspected suicide through a liaison role (with a named individual who is responsible for suicide bereavement support) Training for police/other first responders in response to suicide; also funeral directors; coroner staff; faith group leaders	Metropolitan Police/Coroner's Office	In place By Dec 17 By Dec 17
b	Work with coroner to obtain 'real-time' data on possible suicides. Learn from Durham 'real-time' Suspected Suicide Early Alert System to ensure proactive contact with families in cases of suspected suicide by GPs and referral to services (SOBS, Inquest etc.) Coroner to use contacts with GPs to signpost for support services for bereaved/affected people	HSPG Coroner's Office	Ongoing By Mar 18
c	Establish local branch of Survivors of Bereavement by Suicide (SOBS) – volunteer-run self-help group hosted by Mind in Haringey	MIND in Haringey	Ongoing
d	GPs to provide bereaved families with explanation of policies on investigation of patient suicides Respond effectively to suicide in schools and colleges e.g. Step by Step	CCG Samaritans	Not yet in place Ongoing
4.2	**Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide**		
a	Ensure clear contact details are provided by mental health, primary care and social services by: • Distributing leaflets aimed at family/friends to primary care and support services in Haringey • Provide training on suicide awareness, recognising and responding to warning signs	All Open Door Local Authority	 Not yet in place By Dec 17

	for suicide in self or others delivered in a variety of settings and targeted to where people are more likely to encounter those who are at risk (e.g. staff in job centres, the police and emergency departments)		
b	Develop protocol for meeting with families and other relatives	BEHMHT	In place

Action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour:

The NSPS suggests two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour:

1. Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media

2. Continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

Area for Action	Intervention description	Lead	Status
5.1	**Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media**		
a	Encourage responsible reporting by ensuring that local/regional newspapers by: • Provide information about sources of support and helplines when reporting suicide and suicidal behaviour • Avoid insensitive and inappropriate graphic illustrations accompanying media reports of suicide • Avoid use of photographs taken from social networking sites without relatives' consent • Avoid the re-publication of photographs of people who have died by suicide when reporting other suicide deaths • Implement Samaritans guidance for the media on the reporting of suicide: www.samaritans.org/media_centre/media_guidelines.aspx • Evidence that media reporting can influence copycat suicides espeically in	All	In place

	young and those already at risk. Develop an “agreement” with local media		
c	Set up a working group to liaise with the media and indentify ‘responsible reporting’	Haringey Council Communications department	By Sep 17
5.2	**Continue to support the removal of content that encourages suicide and provide ready access to suicide prevention services**		
a	Raise awareness of e-safety education on good practice in creating a safer online environment for children and young people (as compiled by UK Council for Child Internet Safety (UKCCIS)	Healthy Schools	Not yet in place

Action 6: Support research, data collection and monitoring

Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and are of tremendous Public Health importance. Analysis of the circumstances surrounding suicides in an area can inform strategies and interventions, highlight trends and changes in patterns, identify key factors in suicide risk and enhance our understanding of high risk groups, evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention.

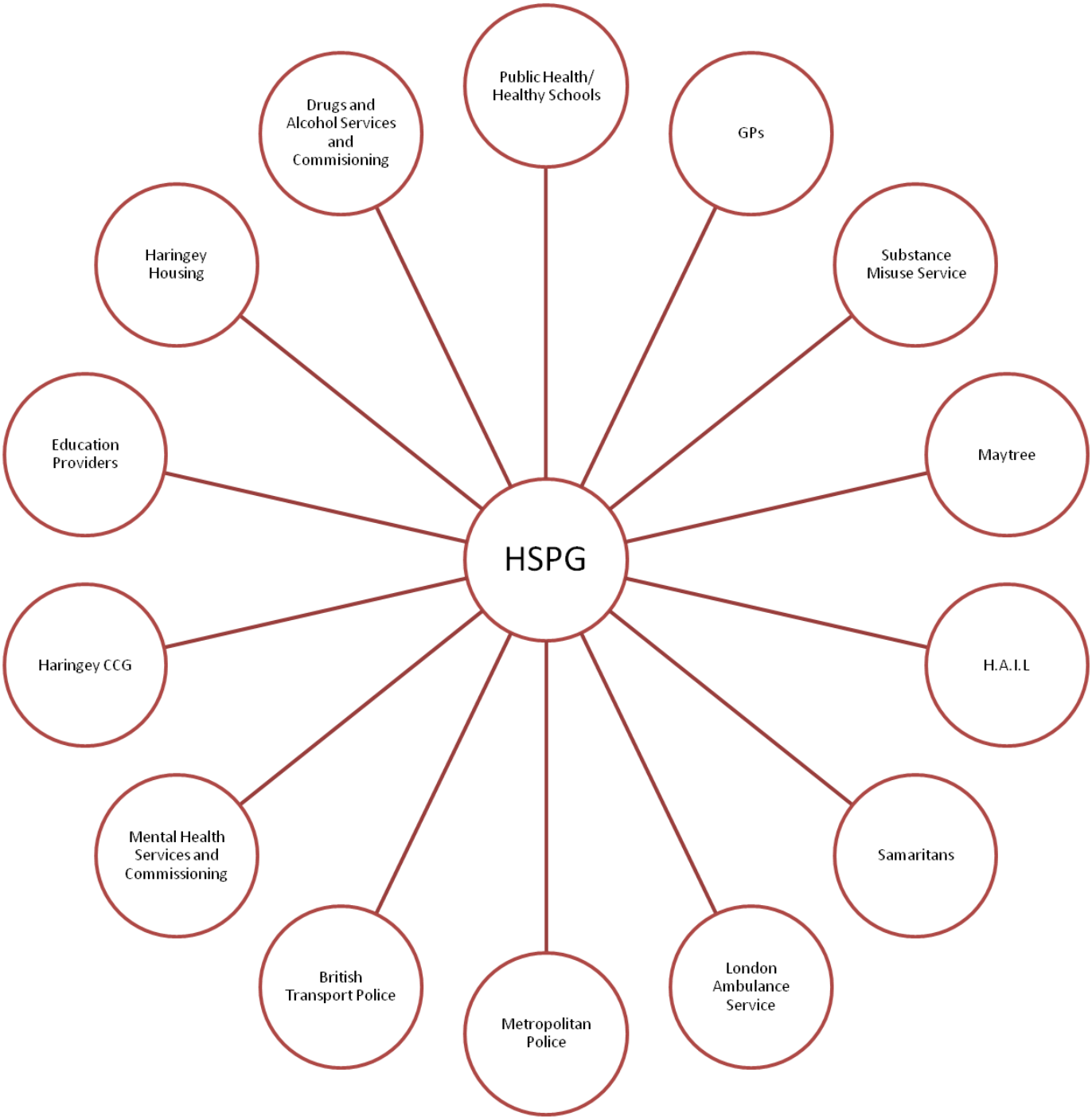
The NSPS has two recommendations to support research, data collection and monitoring:

- Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention
- Expand and improve the systematic collection of and access to data on suicides

Area of Action	Intervention description	Lead	Status
6.1	**Build on the existing research evidence and other relevant sources of data on suicide prevention**		
a	Complete annual Haringey Suicide Audits and review schedules of data	Public Health/HSPG	Ongoing

	collection relating to suicides with the coroner's office Routine review of coroner files to gather data relevant for suicide prevention planing		
b	Create a 'suicide prevention database' and dashboard with ongoing data collection from stakeholder, national and local data sources (Appendix II)	All	By Dec 17
c	Alert local services to inquest evidence that suggests areas for service development to prevent future suicides	Coroner's office	Ongoing
6.2	**Expand and improve the systematic collection and access to data on suicides**		
b	Establish protocol regarding sharing information and data on suicide with next of kin Monitoring interventions; impact evaluation; HSPG as key source of information on suicide prevention needs as well as feedback for monitoring.	HSPG HSPG	By Mar 18 By Mar 18

Appendix II – Haringey's Suicide Prevention Group



Appendix III - Building a suicide prevention database

Building a suicide prevention database is essential to the processes of suicide prevention. By continually processing and building data from national, local and coroner's records, the HSPG can create a long-term view of patterns in Haringey, rather than a one-off data collection activity.