AGENDA FOR THE HARINGEY AND ISLINGTON
HEALTH AND WELLBEING BOARDS JOINT SUB-COMMITTEE

Members of the Haringey and Islington Health and Wellbeing Boards Joint-Sub-Committee are summoned to attend a meeting which will be held at Haringey Civic Centre, High Road Wood Green, N22 8LE on **29 January 2018 2.00pm**

Bernie Ryan
Assistant Director – Corporate Governance
London Borough of Haringey

Peter Fehler
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Despatched : 19 January 2018

Islington Membership

Councillors:
Councillor Richard Watts
Councillor Janet Burgess MBE
Councillor Joe Caluori

Islington CCG:
Tony Hoolaghan, Chief Operating Officer
Dr. Josephine Sauvage, Chair
Dr Katie Coleman, Vice-Chair (Clinical)
Jennie Williams, Director of Nursing and Quality
Sorrel Brookes, Lay Vice-Chair

Islington Healthwatch:
Emma Whitby, Chief Executive

Islington Council Officers:
Julie Billett, Director of Public Health
Sean McLaughlin, Corporate Director Housing and Adult Social Services
Carmel Littleton, Corporate Director Children's Services

Local NHS Representatives:
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Siobhan Harrington, Chief Executive, The Whittington Hospital NHS Trust

Haringey Membership

Councillors:
Councillor Claire Kober
Councillor Jason Arthur
Councillor Elin Weston

Haringey CCG:
Tony Hoolaghan Chief Operating Officer
Dr Peter Christian, Chair
Dr Dina Dhorajiwala, Vice-Chair
Cathy Herman, Lay Member

Haringey Healthwatch:
Sharon Grant, Chair

Haringey Council Officers:
Tracie Evans, Interim Deputy Chief Executive
Dr Jeanelle de Gruchy, Director of Public Health
Beverley Tarka, Director of Adult Social Care
Margaret Dennison, Interim Director of Children's Services
Geraldine Gavin Haringey Local Safeguarding Boar

Voluntary Sector:
Geoffrey Ocen, Chief Executive, The Bridge Renewal Trust

Quorum is 3 voting members of each constituent borough, including one local authority elected representative of each borough and one of their Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes)

A. Formal Matters

1. Filming at meetings

Please note this meeting may be filmed or recorded for live or subsequent broadcast 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 for Absence

4. Notification of Urgent Business

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.

6. Minutes of the Previous Meeting

7. Questions and Deputations

Notice of questions must be given in writing to the Committee Clerk of either or both boroughs by 10 a.m. on such day as shall leave five clear days before the meeting (e.g. Friday for a meeting on the Monday 10 days later). The notice must give the name and address of the sender.
A deputation may only be received by the Sub-Committee if a requisition signed

by not less than ten residents of either or both boroughs, stating the object of the deputation, is received by the Committee Clerk of either borough not later than 10am five clear days prior to the meeting.

B.	**Discussion Items**	**PAGE**
8.	Prevention at Scale Project in Haringey and Islington: Cardiovascular Disease Prevention	7-28
9.	Good Thinking – London's Digital Wellbeing Service	29-50
10.	Haringey and Islington Wellbeing Programme Partnership Agreement	51-68
11.	Proposal for Resident, Community and Staff Engagement in the Development of Integrated Health and Wellbeing Networks	69-90
12.	Items for Future Meetings	

C. **Urgent Items** (if any)

13. New Items of Urgent Business

To consider any new items of urgent business admitted above.

14. Exclusion of the Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

15. New Items of Exempt Urgent Business

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

16. The next meeting of the Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee will be on 13th June 2018 2.00pm – TBC.

Agenda Item 6

Minutes of the Meeting of the Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee Held on Monday 9 October 2017 at 2.00 pm.

PRESENT:

Cllr Richard Watts, Leader of the Council, LB Islington [Chair]
Cllr Claire Kober, Leader of the Council, LB Haringey [Vice-Chair]
Cllr Janet Burgess, Executive Member for Health and Social Care, LB Islington
Cllr Joe Caluori, Executive Member for Children, Schools and Families, LB Islington
Tony Hoolaghan, Chief Operating Officer, Haringey and Islington Clinical Commissioning Groups
Dr Jo Sauvage, Chair, Islington Clinical Commissioning Group
Dr Peter Christian, Chair, Haringey Clinical Commissioning Group
Sorrel Brookes, Lay Vice-Chair, Islington Clinical Commissioning Group
Emma Whitby, Chief Executive, Healthwatch Islington
Sharon Grant, Chair, Healthwatch Haringey
Julie Billett, Director of Public Health, LB Islington
Sean McLaughlin, Corporate Director of Housing and Adult Social Services, LB Islington
Tracie Evans, Interim Deputy Chief Executive, LB Haringey
Jeanelle De Gruchy, Director of Public Health, LB Haringey
Beverley Tarka, Director of Adult Social Care, LB Haringey
Margaret Dennison, Interim Director of Children's Services, LB Haringey

ALSO PRESENT:

Helen Taylor, Clinical Director and Deputy Director of Strategy, Whittington Hospital
Rachel Lissauer, Director of the Haringey and Islington Wellbeing Partnership
Zina Etheridge, Interim Chief Executive, LB Haringey

15 FILMING AT MEETINGS (Item 1)

Councillor Watts referred to information on the agenda and members noted the guidance in respect of filming at meetings.

16 WELCOME AND INTRODUCTIONS (Item 2)

Councillors Watts and Kober welcomed everyone to the meeting and the members of the Sub-Committee introduced themselves.

17 APOLOGIES FOR ABSENCE (Item 3)

Apologies for absence were received from Councillor Weston, Councillor Arthur, Dr Katie Coleman, Carmel Littleton, Angela McNab, Cathy Herman, Geraldine Gavin, Geoffrey Ocen and Siobhan Harrington (representative: Helen Taylor, Clinical Director and Deputy Director of Strategy, Whittington Hospital).

18 NOTIFICATION OF URGENT BUSINESS (Item 4)

There were no items of urgent business to consider.

19 DECLARATIONS OF INTEREST (Item 5)

Dr Jo Sauvage declared a personal interest as a GP provider in Islington.

20 MINUTES OF THE PREVIOUS MEETING (Item 6)

RESOLVED:

That the minutes of the previous meeting held on 19 June 2017 be agreed and the Chair be authorised to sign them.

21 QUESTIONS AND DEPUTATIONS (Item 7)

No questions or deputations were received.

22 JOINT WORK ON OBESITY (Item 8)

Julie Billett and Jeanelle De Gruchy introduced the report and presented on a cross-borough approach to tackling obesity. It was proposed that the Joint Sub-Committee agree to six pledges to improve healthy food choices in Islington and Haringey, and that Islington and Haringey Councils sign up to the Local Government Declaration on Sugar Reduction and Healthier Food.

The following main points were noted in the discussion:

- It was queried if the removal of sugar sweetened soft drinks could have unintended consequences, for example an increase in the sale of sugar-rich fruit juices and unhealthy 'zero calorie' beverages. In response, it was advised that consideration was needed to ensure that messages around the health benefits of fruit were consistent with messages around reducing sugar consumption.
- Dentists were particularly concerned about dental decay in children and this was attributed to the consumption of sugar-rich food and drink, including fruit.
- It was suggested that further work was needed on communicating the benefits of avoiding sugar.
- A discussion was had on how sugary food and drink is advertised to children, particularly through the use of brand characters. Children felt an attachment to certain products and brands because they were advertised in a "fun" way.
- Work was needed to address the idea of home cooked food always being a healthier option, as home cooked food could contain high amounts of sugar and fat.
- It was suggested that communications on sugar reduction should be customised for different ethnic and cultural groups, otherwise key messages may only reach a narrow section of the population and health inequalities may be enhanced, particularly among non-English speakers.
- The Sub-Committee considered the difficulties of encouraging local business to reduce the supply of sugar-rich food and drink. It was noted that there was a high profit margin on these items and several small businesses were struggling in the difficult economic climate. In response, there was an appreciation of these challenges, and it was also noted that the greatest impact would potentially be realised through a focus on major retailers.

- It was suggested that communications on reducing sugar consumption and healthier eating should be also related to communications on physical activity, including sustainable transport options such as walking and cycling.

RESOLVED:

(i) That the Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee agree to the pledges set out in the report submitted;
(ii) That Islington and Haringey councils sign up to the Local Government Declaration on Sugar Reduction and Healthier Food.

23 STP UPDATE (Item 9)

Tony Hoolaghan introduced the report and presented on the progress of the North Central London Sustainability and Transformation Plan (NCL STP).

The following main points were noted in the discussion:

- The NCL STP was transitioning to the implementation phase. It was intended for some joint acute commissioning to be carried out across North Central London in the near future.
- A new CCG leadership team had been appointed across Haringey and Islington.
- NCL STP arrangements had been subject to scrutiny at a local level and at the NCL Joint Health Overview and Scrutiny Committee.
- The STP was a complex and ambitious plan and capacity was needed to deliver the work identified in the plan. It was intended for the STP to enhance prevention, primary care, and community resilience, however, capacity to deliver the ambitious plans set out in the STP will be drawn largely from within existing resources and capacity.
- In response to a question on voluntary sector engagement, it was advised that engagement with the sector had increased as the STP process had developed.
- A member queried how hospital discharge could be improved through the STP. In response, it was advised that national guidance would be followed and patients would be categorised into streams. Work was in progress for patients to be dealt with in a consistent way across Islington and Haringey. Once a patient had been admitted to hospital, it was intended for the patient to be safely discharged as soon as possible.
- It was commented that those with complex care needs were best assessed in their normal place of residence, as those in need of care may have different capabilities in different environments.
- A discussion was had on hospital discharge arrangements. It was emphasised that hospital discharge should only occur when the patient is able to care for themselves independently or with appropriate support. It was commented, for example, that the discharge of patients with mental health conditions should not take place while patients are still vulnerable.
- The Sub-Committee noted the work of the National Housing Federation, which was working with housing providers to support hospital discharge. It was suggested that housing officers should be contacted at the point of admission so bespoke arrangements can be made, if required.
- The Sub-Committee considered examples of patients who did not require acute care, however were returning home to a hazardous environment. It was considered

that engagement with housing providers was essential to ensure that vulnerable patients were appropriately supported.

- In Haringey, multi-disciplinary team conferences were held weekly, which considered the needs of vulnerable patients planned for discharge.
- The Sub-Committee noted concerns about the STP process, and on the financial pressures of public bodies. Whilst it was welcomed that progress had been made, it was commented that honest conversations were needed between partner bodies about how services can improve and work closer together within existing resources. It was suggested that the STP needed a stronger focus on social care services and would benefit from a more system-wide approach.
- The importance of public consultation was emphasised. It was commented that engagement with the public must be pitched appropriately.
- The Sub-Committee noted concerns that the need for financial savings was driving short-term approaches rather than long-term solutions in the health and care sector. It was important to ensure that the needs of all STP partners were appreciated and system-wide solutions were found, otherwise positive work to improve services and make savings could be undermined.
- It was suggested that STP processes had previously delayed meaningful conversations taking place, however it was thought that there would be opportunities for all partners to contribute to the STP in the near future.

RESOLVED:

That the report be noted.

24 WELLBEING PARTNERSHIP PROGRAMME UPDATE (Item 10)

Rachel Lissauer, Director of the Haringey and Islington Wellbeing Partnership, introduced the report.

The following main points were noted in the discussion:

- The Wellbeing Partnership was recognised within the NCL STP as a positive example of cross-borough partnership work.
- Work was underway to develop working arrangements across organisations and foster a more collaborative approach.
- Governance structures had been re-shaped to streamline decision-making. Following this preliminary work, there was a need for the Partnership to deliver real change.
- The Partnership was focusing on improving hospital flows, simplifying discharge processes, and reducing the length of admission for patients. It was previously the case that hospitals serving both boroughs had to work with separate discharge and intermediate care arrangements, however there was now a single process in place.
- Future work would focus on recruitment, workforce development, and estates strategies.
- It was queried what differences patients were experiencing in health and care services. In response, it was advised that a number of improvements were in progress, for example the availability of physiotherapy in GP surgeries. In other cases, efficiency savings would improve sustainability and protect existing services.
- It was commented that trust had developed between partner organisations and as a result positive conversations were taking place. It was thought that a more collaborative approach would improve clinical pathways and lead to a more positive patient experience.

- Whilst the positive work of the Wellbeing Partnership was recognised, it was suggested that further work was needed to demonstrate and communicate that the Partnership was making a tangible difference.

RESOLVED:

That the report be noted.

25 JOINT JSNA UPDATE (Item 11)

Julie Billett and Jeanelle De Gruchy introduced the report and presented on progress with developing a cross-borough Joint Strategic Needs Assessment.

The following main points were noted in the discussion:

- There would be practical benefits to having a joined up health analytics and intelligence function. It was suggested that this would help to determine how cross-borough services were commissioned and delivered.
- It was noted that the full JSNA would include a detailed population analysis, and would reflect the number of residents suffering from multiple disadvantages.
- The Sub-Committee emphasised the importance of a joint narrative to accompany the raw data.
- The Sub-Committee noted the importance of equalities data, and noted the importance of ensuring the needs of different communities are understood and described, in order to help shape services to better meet those needs and reduce inequalities.

RESOLVED:

That the report be noted.

26 MAYOR'S HEALTH INEQUALITIES STRATEGY (Item 12)

Julie Billett introduced the Mayor's Health Inequalities Strategy. The Mayor of London was seeking partner organisations to endorse and contribute to the strategy's five aims. It was proposed that a joint Islington and Haringey response be submitted to the strategy consultation.

The Sub-Committee endorsed the strategy and agreed to submit a joint response, however emphasised that the GLA also had responsibilities and powers which influenced the health of local people. For example, the GLA had influence over air quality through public transport emissions and the regulation of taxis and other vehicles.

It was suggested that the strategy's objectives could be more specific, and strengthening the objectives was more likely to result in meaningful change.

RESOLVED:

That the development of a joint Islington-Haringey response to the consultation be endorsed.

27 **NEW ITEMS OF URGENT BUSINESS (Item 13)**

None.

The meeting ended at 3.15 pm

CHAIR

Report for: Haringey and Islington Joint Health and Wellbeing Board Sub-Committee: 29 January 2018

Title: Prevention at Scale Project in Haringey and Islington: Cardiovascular disease prevention with a focus on identifying and managing high blood pressure and atrial fibrillation

Authorised by: Dr Jeanelle de Gruchy, Director of Public Health, Haringey Council and Julie Billett, Director of Public Health, Camden and Islington Councils

Lead Officers: Dr Will Maimaris, Consultant in Public Health, Haringey Council, Charlotte Ashton, Consultant in Public Health, Camden and Islington Councils

1. Purpose

1.1 **The purpose of this report is to:**

- Provide the Joint Health and Wellbeing Board with an introduction to the Local Government Association supported Haringey and Islington Prevention at Scale project, which is focusing on cardiovascular disease prevention and;
- Seek support from partners on the Joint Health and Wellbeing Board for our Prevention at Scale Project on cardiovascular disease prevention.

2. Describe the issue under consideration

2.1. Cardiovascular diseases are diseases that affect the blood vessels and heart, including heart attacks and strokes. Cardiovascular disease (CVD) is the second biggest cause of premature death after cancer in Islington and Haringey, and a major contributor to health inequalities in both boroughs. Cardiovascular disease, and in particular stroke are a major contributor to health and social care costs, and Haringey and Islington Clinical Commissioning Groups (CCGs) have higher health spend on cardiovascular disease than comparator CCGs.

2.2. Physical inactivity, smoking, poor diet, excess alcohol use and high blood pressure are all important risk factors for cardiovascular disease. Most strokes and heart attacks can be prevented by taking action on these risk factors. Atrial fibrillation, which is a kind of irregular heart-beat, is an important risk factor for stroke.

2.3. Prevention at Scale is a Local Government Association (LGA) funded programme that provides local areas with 20 days of funded expert support over the next 12 months to tackle an important prevention challenge. Haringey and Islington successfully bid to be one of a small number of sites across the country receiving support from the Local Government Association.

2.4. The LGA support provides tailored assistance to areas to deliver prevention at a bigger scale for a risk factor or condition that is causing demand on services locally. The term ‘at scale’, means taking a population health approach to the risk

factor or condition so that the widest possible number of people are reached by local interventions. This is not just about scaling up a service that is commissioned or delivered by a council or CCG, it is about utilizing policy levers, influencing partners and using a range of initiatives that can impact on the risk factor or condition.

2.5. Haringey and Islington's Prevention at Scale project is on cardiovascular disease prevention. While current work on cardiovascular disease prevention in Haringey and Islington encompasses a broad range of interventions, from tobacco control policies to local community based walking schemes, we have focused our efforts for this project on two key risk factors for stroke, high blood pressure and atrial fibrillation. This focus is because this is an area where there is clear evidence that we can make gains in this area in the next 12 months through scaling up simple interventions and it builds on positive existing local good practice and partnership work.

2.6. Nearly one in five adults in Haringey and Islington have high blood pressure, and nearly half of these are not diagnosed, as high blood pressure usually has no symptoms. Atrial fibrillation is a kind of irregular pulse rhythm, which is less common than high blood pressure, but significantly increases a person's risk of stroke. Like high blood pressure, people with atrial fibrillation are often unaware they have the condition.

2.7. If a person with high blood pressure or atrial fibrillation is aware of their condition and takes action to manage their condition with medical treatment or by lifestyle change they can significantly reduce their risk of stroke and other cardiovascular diseases.

2.8. We are already doing some good work across Haringey and Islington to improve the identification and management of high blood pressure and atrial fibrillation, which is starting to see some excellent outcomes. These projects include NHS Health Checks in both boroughs, a targeted programme of identification of atrial fibrillation and high blood pressure in Haringey GP practices, and a new British Heart Foundation funded project in both boroughs to carry out blood pressure checks in community settings, delivered through 5 local voluntary and community sector organisations.

2.9. However, in spite of these projects, Haringey and Islington still lag behind the best performing areas in London, such as Tower Hamlets and Hackney, in terms of population level outcomes for the identification and management of people with high blood pressure and atrial fibrillation.

2.10. The prevention at scale programme therefore provides us with an excellent opportunity to further develop our local strategy for improving the identification and management of high blood pressure and atrial fibrillation so, over time, we can match our best performing comparator boroughs.

Plans are at an early stage, but we will use the Local Government Association and their partners to help us:

1. Co-design and deliver **consistent messages** for residents and staff about prevention of CVD (in particular about blood pressure) using social marketing techniques.

2. Mobilise our communities and local health and care organisations to take action on these messages with an aim to create a bottom up social movement.

3. Developing an agreed **vision and action plan** for improving detection and management of high blood pressure in primary care, secondary care and community settings

    – This will link to work on care closer to home networks (CHINS) and quality improvement work in primary care (QISTs)

We are provisionally calling this project **Haringey and Islington Healthy Hearts.**

2.11. This programme of work will form part of the Haringey and Islington Wellbeing Partnership cardiovascular disease and diabetes work stream. The project leads will report into the Wellbeing Partnership Delivery Board.

Opportunities to rapidly disseminate learning and share outputs from this local programme of work across the broader North Central London health and care system will also be pursued, as part of an emerging whole-system focus on CVD prevention within the STP

3. Recommendations

3.1. The Joint Health and Wellbeing Board is asked to support the Prevention at Scale project on cardiovascular disease described above and in the attached slide pack.

3.2. Members of the Joint Health and Wellbeing Board are asked to consider and discuss how their organisations can support this programme of work – ideas might for example be:

- CCGs and GP federations – continued commitment to programmes that support detection and management of high blood pressure and atrial fibrillation in primary care
- Voluntary sector – build on community blood pressure checks project to be champions for CVD prevention.
- Acute trusts – improve opportunistic detection of high blood pressure and atrial fibrillation and improve communication of findings back to general practices
- Mental health trusts – ensure service users have access to blood pressure checks and support to maintain healthy lifestyles
- Adult social care leads – train enablers to carry out BP checks and talk about CVD prevention
- Councillors – be champions for local community on knowing your blood pressure and taking action.

4. Contribution to strategic outcomes

This work contributes to the following strategic priorities and outcomes.

Haringey Health and Wellbeing Strategy: Increasing healthy life expectancy priority

Haringey Corporate Plan Priority 2 (adults) indicators:

- Reducing premature mortality from cardiovascular disease
- Improving the proportion of people with diagnosed and controlled blood pressure

Islington Health and Wellbeing Strategy: Priority 2. Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

Islington's Corporate Plan commitment - Making Islington a place where our residents have a good quality of life, including helping residents to live healthy independent lives.

5. Statutory Officer Comments (Legal and Finance)

Legal

The Sub-Committee is required to encourage joint consideration and co-ordination of health and care issues that are of common interest or concern to the population of the two boroughs

Finance

The cost of the programme in 2018/19 is fully funded by the Local Government Association.

The work will be one of the enablers in the Priority 2 strategy of managing demand and will contribute towards achievement of MTFS savings in 2018/19 and beyond.

Any future action that the council decides to take in order to further the objectives set out in this report will need to be managed from within relevant existing budgets.

Any details relating to such actions will be assessed for financial implications as and when they arise.

6. Environmental Implications

Environmental implications for the planned work identified in this report includes that associated with office usage (energy and water use, waste generation) and publicity (use of resources for leaflets, if used). The indirect impacts in reducing CVD are likely to be positive, including the subsequent reduction in need for treatment (which in turn may reduce the environmental impact of the health services), reduced levels of smoking (which could reduce cigarette-related

littering – cigarette butts are the single biggest item of litter in the UK) as well as the encouragement of more physical activity (which may reduce transport-related emissions if people are more likely to walk or cycle).

7. Resident and Equalities Implications

The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

Cardiovascular disease is a major contributor to health inequalities in Haringey and Islington:

- People from Black Caribbean and Black African ethnic backgrounds are more likely to have high blood pressure and strokes;
- The risk of getting cardiovascular disease, high blood pressure and atrial fibrillation increases with age;
- People with serious mental illness are more likely to die young from cardiovascular disease;
- People living in most deprived parts of Haringey and Islington wards – who are more likely to be from a BAME background - are more than 3 times more likely to die young (under the age of 75) from cardiovascular disease than people living in the most affluent areas;
- Men are more likely to die young from cardiovascular disease than women.

This programme of work will aim to narrow health inequalities in Haringey and Islington. By giving people with protected characteristics a greater chance to live longer, healthier lives, this programme will help to advance equality of opportunity between people who have protected characteristics and those who do not.

Through the programme we will obtain more insight on local population groups who are most at risk of having unidentified or uncontrolled high blood pressure or atrial fibrillation, and use targeted or tailored approaches to increase identification and management of these conditions in these groups.

8. Appendices

Slide pack: Haringey and Islington Prevention at Scale project: Cardiovascular disease prevention with a focus on improving the identification and management of high blood pressure and atrial fibrillation.

9. Local Government (Access to Information) Act 1985

Background Papers: None

Haringey and Islington Prevention at Scale: Cardiovascular disease prevention with a focus on blood pressure and atrial fibrillation

Dr Will Maimaris, Consultant in Public Health – Haringey Council

Charlotte Ashton, Consultant in Public Health – Islington Council

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Overview

This slide set covers:

- Why cardiovascular disease (CVD) remains a major local health issue
- Joint CVD Prevention at Scale project
- Focus on high blood pressure and atrial fibrillation (AF)
- Existing examples of local good practice in CVD prevention
- Call for support from the Joint Health and Wellbeing Board

Background: Cardiovascular disease

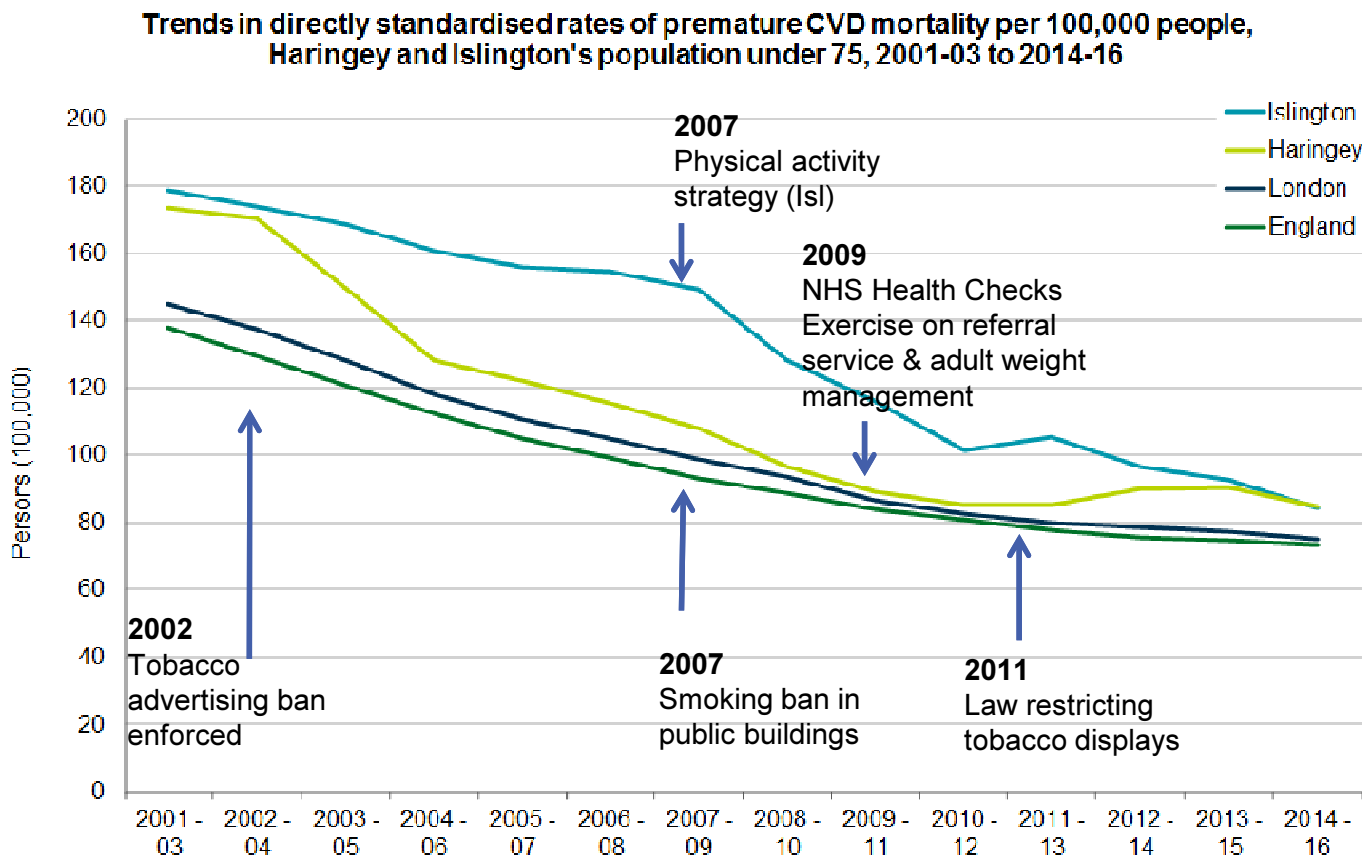
What is CVD?

- Cardiovascular diseases are diseases that **affect the blood vessels and heart**, including heart attacks and strokes.
- They are the **second biggest cause of early death** after cancer.
- Important driver of gap in life expectancy between affluent and deprived parts of Haringey and Islington
- Stroke is the **leading cause of complex disability** in adults.

Can we prevent it?

- Most strokes and heart attacks can be prevented by taking action on the main risk factors, e.g:
  - Behavioural: Physical inactivity, smoking, poor diet, excess alcohol use.
  - Clinical: High blood pressure and atrial fibrillation (a kind of irregular pulse rhythm).

Local need for action: Health needs



Source: PHOF, 2017

Rates of early death from CVD are falling nationally and locally.

Local rates have fallen faster, closing the inequality gap to national CVD rates.

However, the rates in Islington and Haringey remain significantly higher than that for London and England.

Islington and Haringey have the 6th and 9th highest rates respectively amongst London boroughs.

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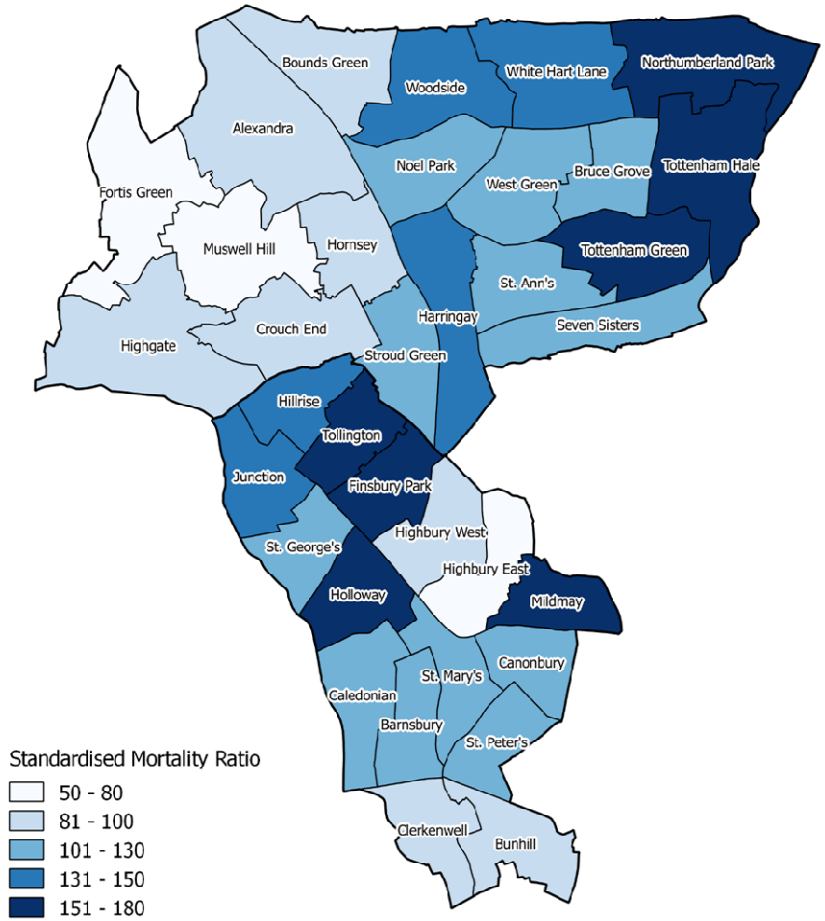
Local need for action: Health inequalities

Deaths from circulatory disease, under 75 years. 2011-15.



Some groups are more likely to die young (under the age of 75) from CVD:

- People living in **most deprived parts** (3 times more likely)
- **Men**
- People with **serious mental illness**
- People from **Black Caribbean and Black African** ethnic backgrounds are more likely to have high blood pressure and stroke.

Source: PHE local health – A standard mortality ratio of 100 is equivalent to the national average. Wards with a ratio above this value have higher death rates from stroke than the national average.

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Local need for action: Health and care cost

Hospital care:

- Total spending on emergency hospital care for diabetes and cardiovascular disease in Haringey and Islington is estimated as **£16 million per annum**.
- This is **£1.2 million and £1 million more per year**, respectively, than the top quartile of comparable CCGs.

Prescribing:

- Total combined spending on prescribing for diabetes and cardiovascular disease in Haringey and Islington estimated as **£11 million per annum**.

Social care:

- Over **£25,000 per stroke** on average for health and social care services.
- Long-term care costs of stroke estimated at **£7,000 per year per stroke**.

Prevention Pyramid: Current activities to prevent stroke and other cardiovascular diseases in Haringey and Islington

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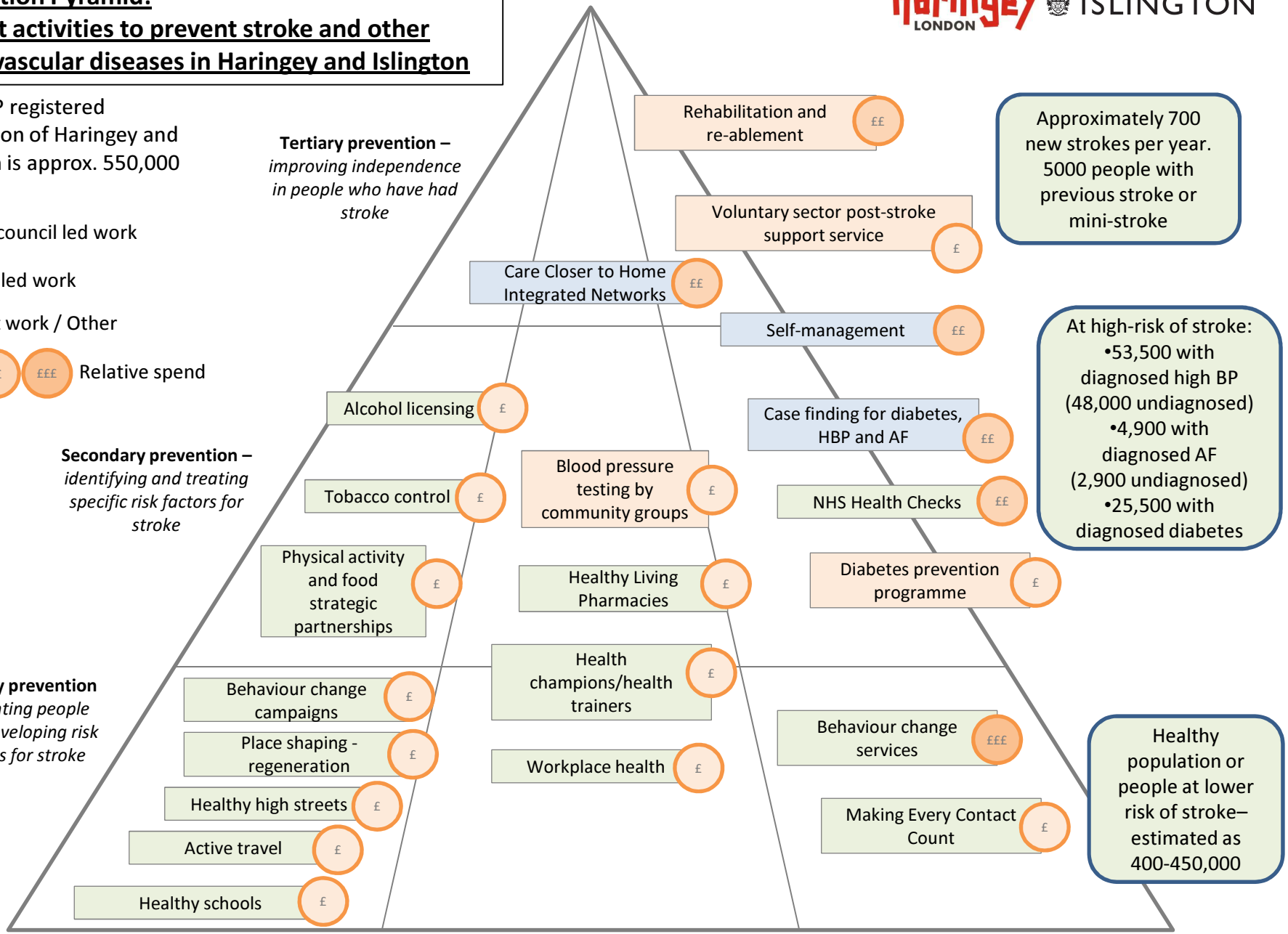
Adult GP registered population of Haringey and Islington is approx. 550,000

PH/ council led work

CCG led work

Joint work / Other

£ ££ £££ Relative spend



Approximately 700 new strokes per year. 5000 people with previous stroke or mini-stroke

At high-risk of stroke:
•53,500 with diagnosed high BP (48,000 undiagnosed)
•4,900 with diagnosed AF (2,900 undiagnosed)
•25,500 with diagnosed diabetes

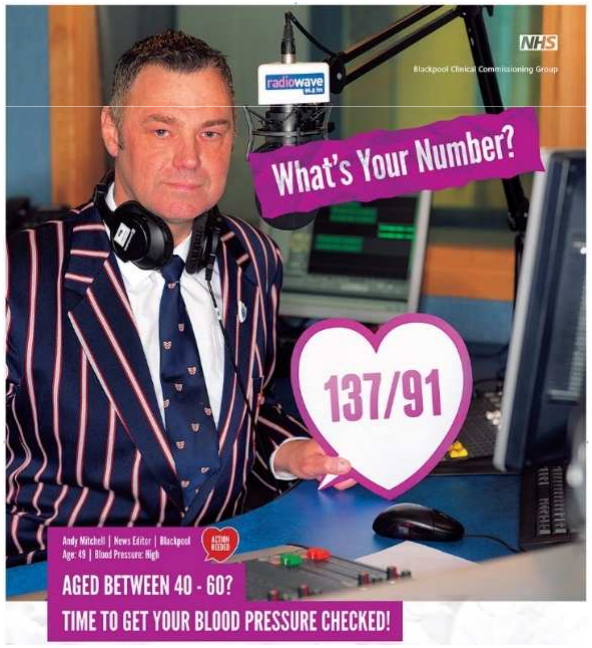
Healthy population or people at lower risk of stroke– estimated as 400-450,000

Prevention at Scale programme: Intro and focus

What is the *Prevention at Scale* programme?

- Led by the **Local Government Association** (LGA) and **Public Health England**
- Offers **20 days** of expert support over **12 months**.

Why did we decide to focus on high blood pressure and atrial fibrillation?

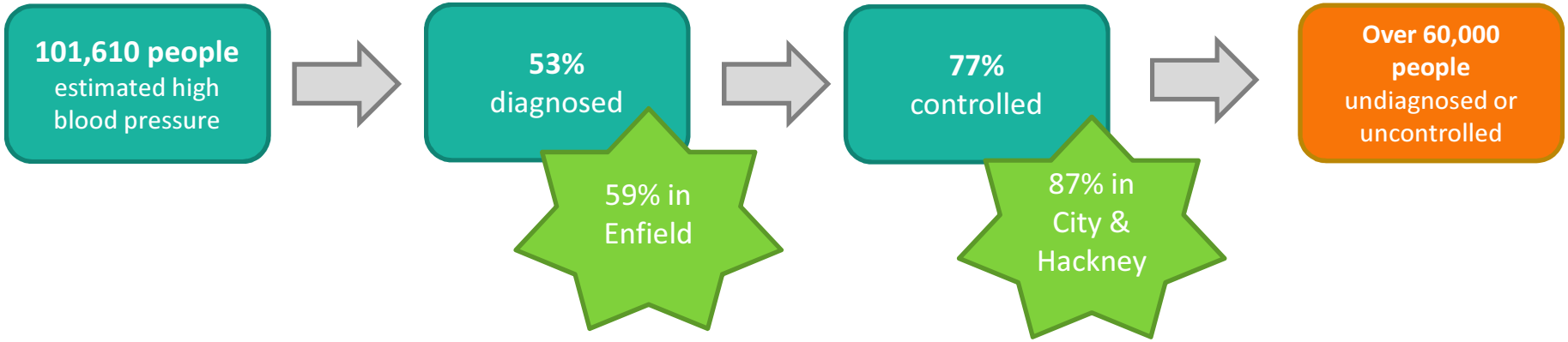


- Need to **focus down** to make gains in 12 months.
- Clear **evidence of gains** through scaling up simple interventions.
- Builds on **local good practice** and partnership.
- Chance to follow **national examples** (see left)

Haringey LONDON ISLINGTON

“Size of the prize”: Better identification and treatment of hypertension

In Haringey and Islington in 2016/2017…



The same diagnosis and control rates as best performing nearby boroughs over the next 5 years would mean:

- 11,300 more people with diagnosed and controlled blood pressure
- 120 strokes could be prevented
- 53 heart attacks could be prevented

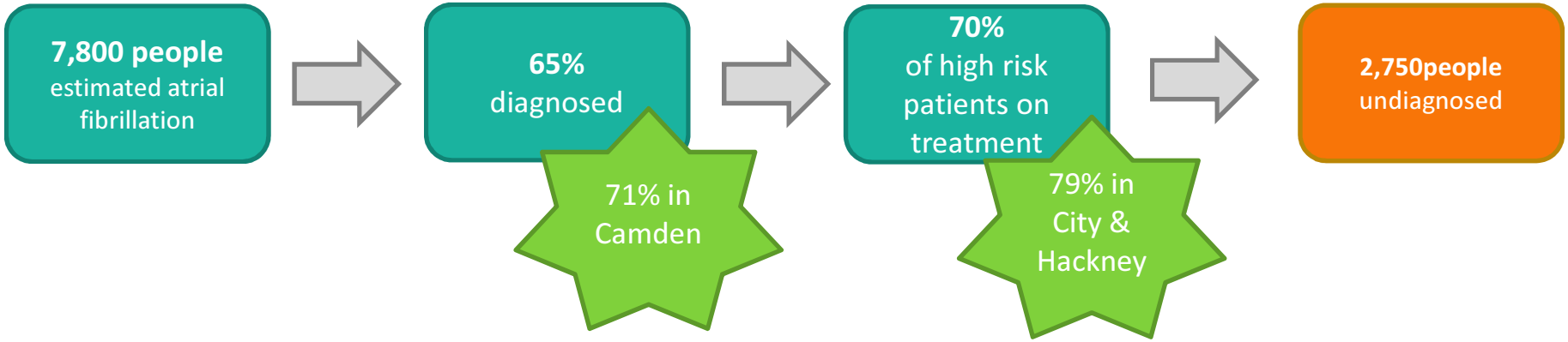
- A potential saving to health and social care of **£3,184,200***

* Based on cost of stroke = £24,855 (National audit office report),
Cost of primary heart attack treatment = £3,804 (NICE costing tool)

Haringey LONDON ISLINGTON

“Size of the prize”: Better identification and treatment of atrial fibrillation

In Haringey and Islington in 2016/2017…



The same diagnosis and treatment rates as best performing neighbouring boroughs over the next 5 years would mean:

- 674 additional cases of atrial fibrillation diagnosed
- 958 more people on the right treatment
- 96 strokes could be prevented

- A potential health and care saving of **£2,306,000***

* Based on cost of stroke = £24,855 (National audit office report),
Cost of primary heart attack treatment = £3,804 (NICE costing tool)

Haringey LONDON ISLINGTON

Local good practice: Community blood pressure checks

Overview

- **2-year** British Heart Foundation grant worth **£100k** secured by Haringey and Islington
- **5 VCS organisations** trained to deliver blood pressure checks in community settings
- Focus on **BME communities**
- People also given **lifestyle advice**
- Those requiring follow-up **linked to primary care**

Outcomes so far

- Over **75 staff and volunteers trained** to deliver blood pressure checks
- Roll out of programme from **Nov 2017**
- Residents detected with high blood pressure and engaging in behaviour change conversations

Haringey LONDON ISLINGTON

Local good practice: NHS Health Checks Islington

Overview

- Comprehensive programme for **checking and managing CVD risk** in 40-74 year-olds in **GP practices, community and pharmacies.**
- **Targeting high-risk groups**:
  - High estimated CVD risk and people with mental illness/ learning disabilities (GPs).
  - People from deprived areas, ethnic minorities and men (community).

Outcomes so far (2010-2015)

- **42,113** NHS Health Checks delivered in Islington
- **42%** of eligible people received a check (27% national).
- **1:20** NHS Health Checks resulted in a CVD diagnosis.
- **1:10** NHS Health Checks resulted in statin prescription, further 10% were prescribed antihypertensive.

Haringey LONDON ISLINGTON

Local good practice: Stroke prevention scheme Haringey

Overview

- £80k per year invested by Haringey CCG between 2015 and 2017 on detection of high blood pressure and atrial fibrillation.
- Opportunistic pulse and blood pressure checks (e.g. during annual flu vaccination)

Outcomes thus far (2015-2017)

- Over **10,000 blood pressure and pulse checks** carried out each year
- Over **500 new AF diagnoses** and **1,500 new high blood pressure diagnoses**
- Over **30 strokes will be prevented** as a result of this work
- Stroke mortality and hospital admissions now beginning to fall

Haringey LONDON ISLINGTON

Our Prevention at Scale Project: -What we plan to do

We plan to scale up and build on existing local work on high blood pressure and atrial fibrillation

Plans are at an early stage, but we will use the Local Government Association and their partners to help us:

1. Co-design and deliver **consistent messages** for residents and staff about prevention of CVD (in particular about blood pressure) using social marketing techniques.

2. Mobilise our communities and local health and care organisations to take action on these messages with an aim to create a bottom up social movement.

3. Developing an agreed **vision and action plan** for improving detection and management of high blood pressure in primary care, secondary care and community settings
   - This will link to work on care closer to home networks (CHINS) and quality improvement work in primary care (QISTs)

We are provisionally calling this project **Haringey and Islington Healthy Hearts**

The ask of the Health and Wellbeing board partners

1. To support the Prevention at Scale project on cardiovascular disease prevention described here
2. To think about how your organisation can take practical steps to support this work – examples include:

   - **CCGs and GP federations** – continued commitment to investing and improving programmes that support detection and management of high blood pressure and atrial fibrillation in primary care
   - **Voluntary sector** – build on community blood pressure checks project to be champions for CVD prevention
   - **Acute trusts** – improve opportunistic detection of high blood pressure and atrial fibrillation and improve communication of findings back to General Practices
   - **Mental health trusts** – ensure service users have access to BP checks and support to maintain health lifestyles
   - **Adult social care leads** – train enablers to carry out BP checks and talk about CVD prevention
   - **Councillors** – be champions for the local community on knowing your blood pressure and taking action, linking to existing local assets that support healthier lifestyles

Appendix: High blood pressure and atrial fibrillation: Quick introduction

High Blood Pressure

- Also referred to as “hypertension”
- Causes extra strain on heart and blood vessels
- When left untreated – can cause heart attacks and strokes
- Occasionally can cause headache, usually ***no symptoms***

120
_____
80

“Systolic”: the pressure in blood vessels during a heart beat
120 - normal, above 140 - high

“Diastolic”: the pressure in blood vessels in between heart beats
80 - normal, 90 - high

Atrial Fibrillation

- Irregular heart rhythm
- Can affect ability of heart muscle to pump
- Major cause of stroke
- Can cause dizziness, breathlessness or palpitations, often ***no symptoms***

AF is diagnosed with an **ECG** –which shows the electrical activity of the heart

Haringey LONDON ISLINGTON

Report for: **Joint Haringey and Islington Health and Wellbeing Board**

Title: ***Good Thinking* – London's Digital Wellbeing Service**

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

Lead Officer: **Jeanelle de Gruchy, Director of Public Health, Haringey Council**

1. Purpose

1.1 To present *Good Thinking*, the innovative new digital service to support Londoners to improve their mental wellbeing; to ask for feedback on the service and views on its future development.

2. Issue under consideration

2.1 *Good Thinking* is an innovative new digital service for mental wellbeing for all Londoners. Funded by all London CCGS and half of London Councils – including Islington and Haringey – *Good Thinking* has recently 'gone live' (in 'beta' phase). The report presents the service, demonstrating how digital services can support our residents in improving their mental wellbeing and preventing issues of concerns becoming worse – it is an excellent example of 'prevention at scale'.

3. Recommendation

3.1 The HWB is asked to comment on *Good Thinking*, including on future development and sustainability.

4. Background

4.1 Two million Londoners will experience mental ill health this year. About 75% of Londoners with depression and anxiety do not receive any treatment at all. In response to the scale of the need, all 32 London NHS Clinical Commissioning Groups and a majority of London local authorities – including Haringey and Islington – commissioned a digital mental wellbeing service.

4.2 The ambition is to develop a world first - the first global city to provide a 24/7 digitally enabled support system focussed on mental health and wellbeing. The

vision is that: *'London should be a place where everyone enjoys good mental health and wellbeing and no-one is left to suffer alone"*[1]

4.3 The development and delivery of this digital mental wellbeing service – since named *Good Thinking* – has been overseen by local government, CCGs, Healthy London Partnership, NHS England and Public Health England and supported by the Mayor of London. Tower Hamlets CCG would be the host organisation and lead commissioner for this service. LA and CCG sponsorship for the Programme is provided by Mike Cooke, (Chief Executive LB Camden) and Jane Milligan (Accountable Officer, NEL STP); Dr Jeanelle de Gruchy, Director of Public Health, Haringey Council, chairs the Steering Group.

4.4 *Good Thinking* is a quality-assured prevention and early intervention digital service that uses targeted marketing to direct people who self-identify as having issues around sleep, anxiety, low mood and stress towards personalised digital interventions.

4.5 Service development partners have included Mindwave Ventures, the design, development and live service provider; and Fresh Egg, responsible for content strategy and digital marketing. Both these providers have put in place data protection and site security protocols.

4.6 The Good Thinking service:

- Went live (in beta phase) in late 2017
- Uses digital interventions to provide preventative and personalised journeys to self-help and self-care.
- Is available to all people in London 24/7
- Is 'prevention at scale' (see early performance data, Appendix 1)
- Actively finds and guides those in need to clinically- and behaviourally-endorsed digital apps and other beneficial resources[2]
- Offers a wellbeing self-assessment to support the personalisation of self-care offerings
- Can provide hyper-local resources to users, as well as provide each borough will local service usage data.
- Has e-safety, safeguarding and clinical risk management at the core of the service, but in a non-intrusive way – with a focus on behavioural change and self-management[3]

[1] London Digital Mental Wellbeing Business Case 2015

[2] The health and wellbeing apps are being endorsed against the NHS digital assessment criteria with the support of our expert partner, Our Mobile Health led by Julie Bretland, our Clinical Lead, Dr Richard Graham and Dr Amanda Bunten and the Public Health England Behavioural Insights Team.

[3] **Clinical governance oversight** given from Clinical Lead, Good Thinking, Clinical Lead Digital IAPT, Haringey, Assistant Director, Public Health England and NHSE (London Region) Mental Health Clinical Network

- Has the potential to improve the mental wellbeing of all Londoners, it could also reduce pressure on local services, saving London and health and care services money.

4.7 Through Google Analytics the service is able to follow journeys to and through *Good Thinking*. Through partners, it is able to see people's progress through the intervention they choose.

4.8 *Good Thinking* is currently 'live' in an extended beta phase with positive early testing demonstrating the potential to make an impact at population level. Initial results showed uptake from over 1000 users per week searching for help with sleep related wellbeing issues. In the first two weeks of going live in Nov, over 5000 users visited the *Good Thinking* platform, which has capabilities to reach up 50,000 users by 31st March 2018.

4.9 A two-year academic evaluation is being undertaken by King's College London, covering the clinical, economic, behavioural and digital outcomes of the service.

4.10 **Plans for 2018/19**: With robust arrangements now in place to develop further in London, the focus during 2018/19 will be the continuation of innovative ways to connect with people at scale through digital channels they are already using and guide those looking for help to the right resources to improve health and wellbeing. The emerging evidence available through 24/7 collection of data will be evaluated by the KCL team and disseminated in the coming months.

4.11 The results so far (Appendix 1) suggest potential for the roll out a personalised, but scalable online population based prevention strategy with further developments planned to increase the number of quality assured apps and services, undertake additional discovery work to establish the potential for the approach to be expanded into other areas including social prescribing linked to primary care and local community networks; self-management of long term conditions.

4.12 The combined collaborative force of the local partnership in London – local authorities and CCGs – working with leaders within PHE and NHSE has already helped to make evidence based self-managed online therapy and support available to the whole population in London.

5. Contribution to strategic outcomes

5.1 In 2014/15, *Better Health for London: Next Steps* set out a number of ambitious plans to support one overarching goal: *To make London the healthiest major*

Leadership Group in July, which was chaired by Dr Phil Moore, GP. **Information Governance** for the service is through NHS Tower Hamlets CCG, with Henry Black, SIRO and Osman Batti, Caldicott Guardian

global city. This includes the aspiration to put London at the centre of the global revolution in digital health which includes supporting Londoners through digital wellbeing services.

5.2 The Programme is championed by the London Health Board and is delivering on recommendation 28 in the London Health commission report *Better Health for London* and is acknowledged as a positive innovation by the Chief Medical Officer and cited within the *Mental Health Five Year Forward View*. It fits with the *Five Year Forward View* and closely aligns with the self-care and prevention focus of all London Sustainability and Transformation Plans. The Steering Group ensures that the service pathway alignment with digital IAPT developments.

6. Statutory Officer Comments (Legal and Finance)

Legal

The Sub-Committee is required to encourage joint consideration and co-ordination of health and care issues that are of common interest or concern to the population of the two boroughs.

Chief Finance Officer

For information: Investment from London CCGs and Local Authorities: £66k paid over two years would be the financial contribution from each commissioner for the service to be piloted. This included contributions from all 32 London CCGs and 17 Local Authorities with significant support from DPHs.

Contributions from Public Health England: £75k and NHS England: £160k

The total investment available from all contributions across the various organisations, over three financial years beginning in 2015/16 has been c £2.668 million.

7. Environmental implications

The main environmental impact of the Good Thinking service is the electricity use of the servers that the website is hosted on, as well as the usual office-related environmental impacts of the staff running it (i.e. energy, water and resource use and waste generation). The service being online means that it potentially has fewer impacts than an in-person service, as it eliminates the need for users to travel.

8. Resident and equalities implications

*Good Thinking i*s an excellent example of user-centred co-design: digital listening and in-depth interviews with Londoners in over 23 boroughs were carried out during its development; users can publicly feedback on the service: that’s

Londoners telling Londoners what works for them and providing us with a constant feedback loop for service improvements.

The current beta version of the service does not require the visitor to enter any personal information into the system. This is to maintain the user's anonymity and is based on previous consultation suggesting remaining anonymous would be important.

Further work is planned during 2018/19 to seek feedback from users to establish different approaches to collecting data to enable equality impact to be monitored in terms of access and outcomes. This will involve further consultation with users and potential service users to determine the extent to which equalities data could be collected and monitored without adverse effects on
service engagement, usability and perceived quality of user experience.

9. Local Government (Access to Information) Act 1985

Background papers: None

Appendix 1: *Good Thinking performance data*

Data since going live: 1st November to 9th Jan 2018 (NB. 2 week pause for review during this period)

- 18,934 website users
- 1232 Completed Self-Assessment actions (includes partner services)
    - 500 mental/physical symptom check (Self-Assessment)
    - 621 Sleep Test (Sleepio)
    - 111 Stress (PSS), Depression (PHQ9), Anxiety (GAD7) combined assessment (BeMindful)
- 1436 clicking out of the site to self-help resources
- 32% are returning visitors during this period
- Most popular page is the initial Self-Assessment page
- Gender - 64% female and 36% male
- Age: Majority of users fall within the 25 to 34 (25%) and 35 to 44 (22%) age group
    - 18 to 24 = 8%
    - 25 to 34 = 25%
    - 35 to 44 = 22%
    - 45 to 54 = 19%
    - 55 to 64 = 15%
    - 65+ = 11%
- Device most commonly used is mobile (74%)
    - Mobile = 74%
    - Desktop = 12%
    - Tablet = 14%

The initial version of the service offers two evidence based self-management services

a) Sleepio – Sleep advice and CBT

b) Be Mindful – mindfulness based cognitive therapy (MBCT) for anxiety, stress and depression.

<u>Nov to Jan 9th 2018</u>

Sleepio up to 9th Jan		
Numbers completed Sleep test	Signed up for Sleep help/registered account	Started full CBT programme
621	264	78*
*>130 new user accounts in during Dec/Jan. Expecting this will result in users starting CBT imminently		

Be Mindful up to 9th Jan		
Numbers enrolled	Registered account and started Mindfulness based CBT course	Numbers who have completed all questionnaires on Stress (PSS), Anxiety (GAD7) Depression (PHQ9) and fully engaged with course
311	237	111

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Good Thinking

London's Digital Mental Wellbeing Service

Joint Haringey and Islington HWB
January 2018

Public Health England

NHS

Healthy London Partnership

SUPPORTED BY
MAYOR OF LONDON

LONDON COUNCILS

London mental wellbeing statistics

95% of Londoners are online

1-2 million Londoners will experience mental ill health this year

75% of Londoners in need are not receiving any support for mental ill health

What we decided to do about it

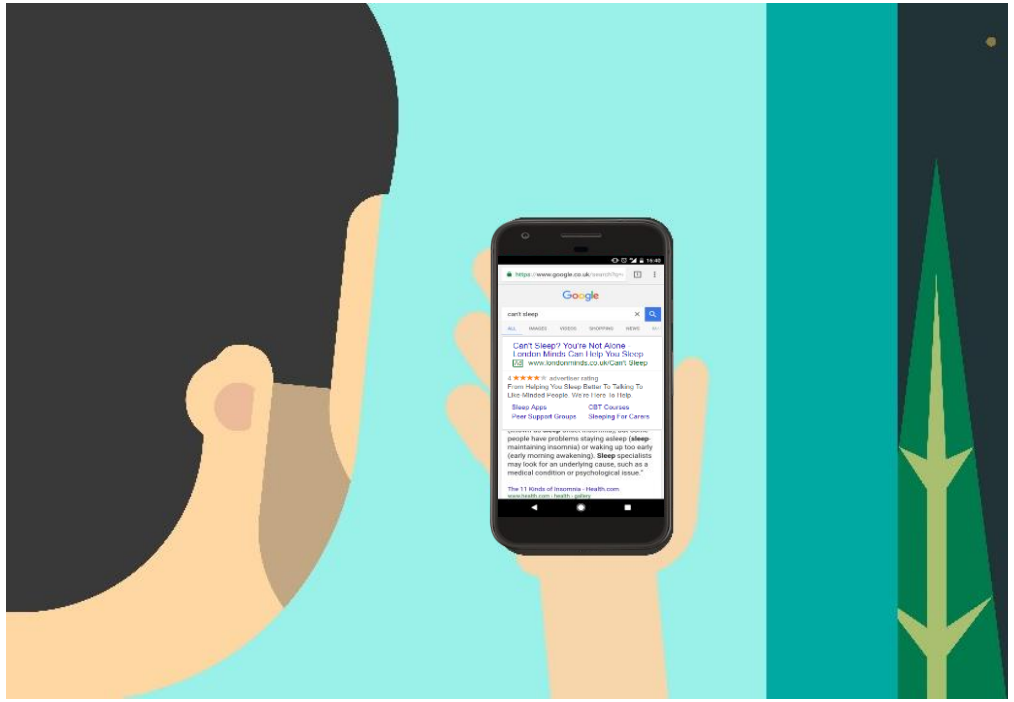
Our Vision

'London should be a place where everyone enjoys good mental health and wellbeing and no-one is left to suffer alone.'

- In 2015 a business case for a pan-London digital mental wellbeing service was shaped by more than 200 people
- **London CCGs** and the majority of **London Boroughs and Councils** came together to commission the programme, providing funding up until the end of March 2018 to develop the service
- We have **built a service designed around Londoners**, that finds and guides those is need and provides them with personalised journeys to digital self-help and self-care, 24/7
- The service went **live in Beta at the end of October 2017**
- We **continue to develop and improve** the service based on user feedback
- Development of the service has been facilitated Local government, Healthy London Partnership, NHS England and Public Health England and the Mayor of London

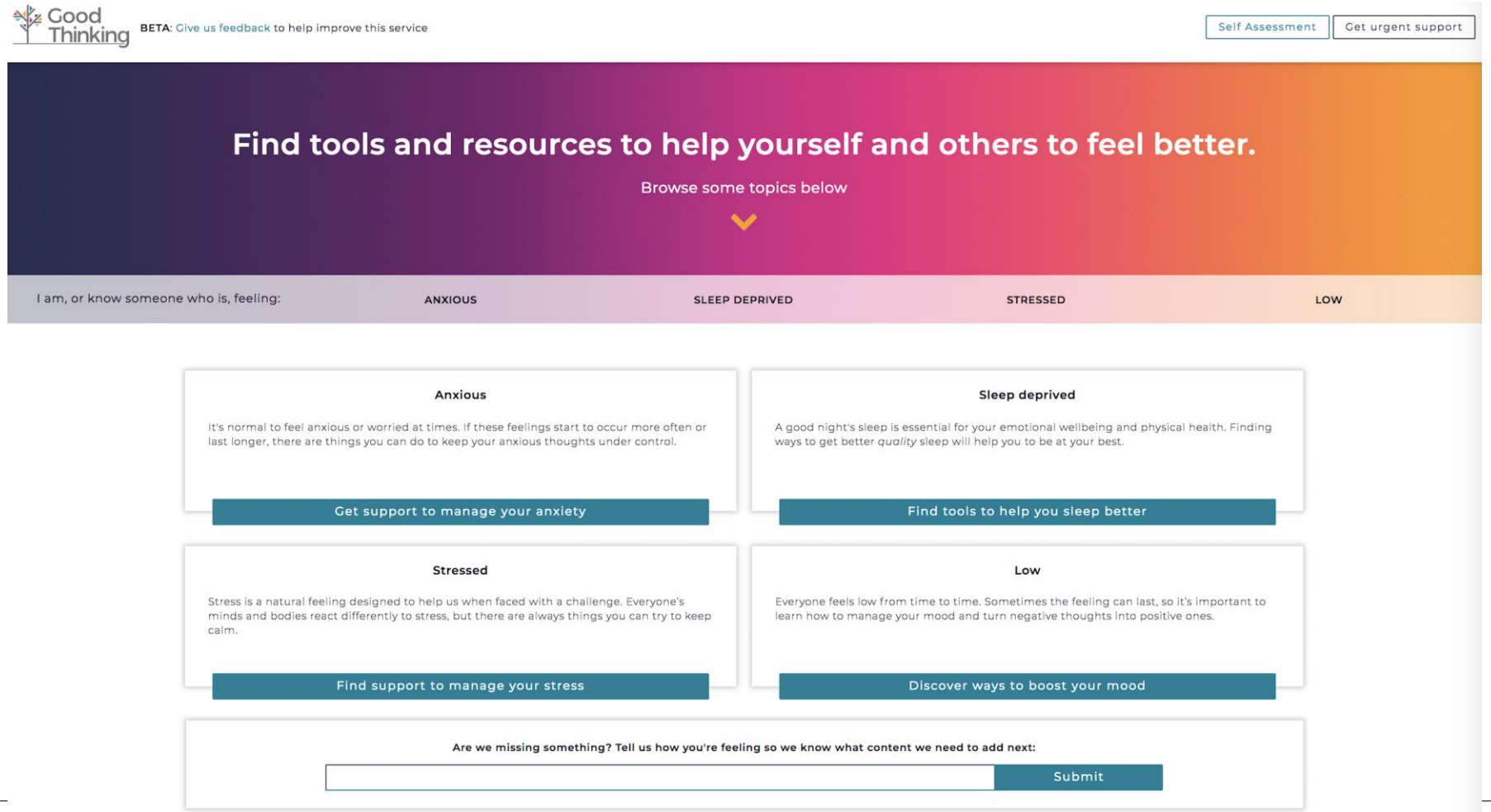
Martin, 42

- Martin works as a builder
- He is stressed, can’t sleep, has extreme tension headaches and outbursts of anger
- He is a carer for his ill wife. He prefers anonymity and self-help tips

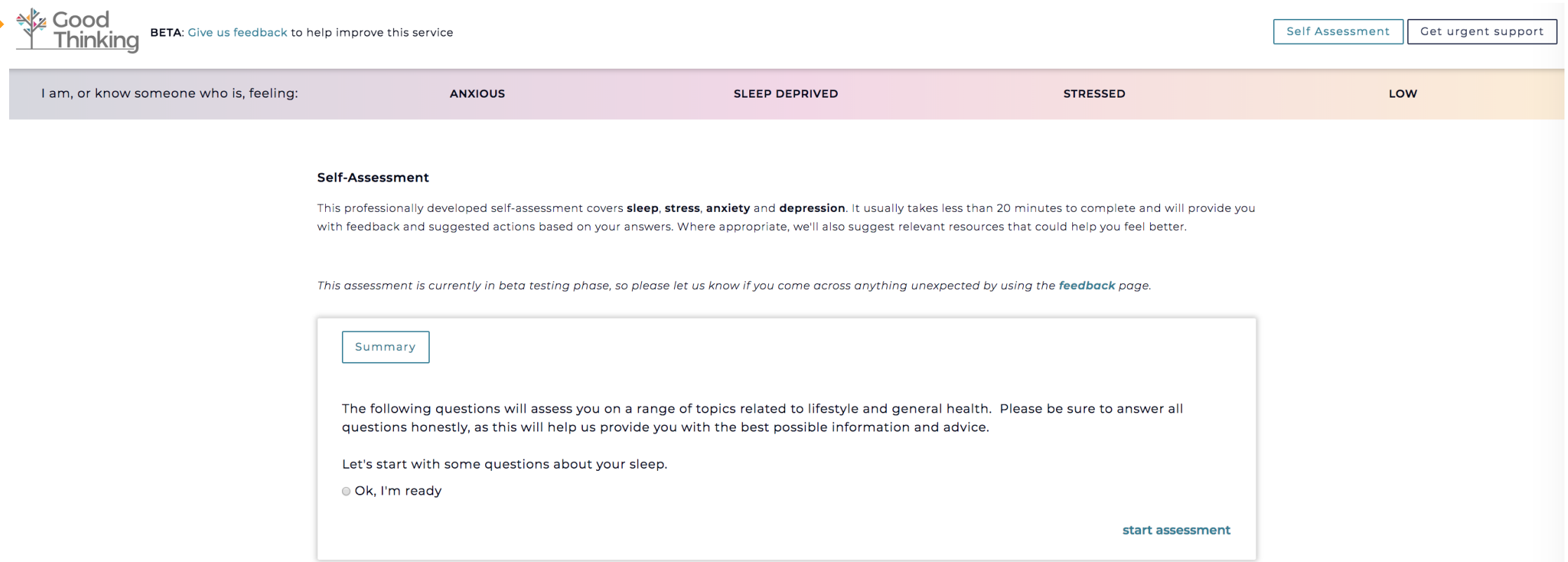


- Martin Googles “can’t sleep”
- He see an advert for Good thinking

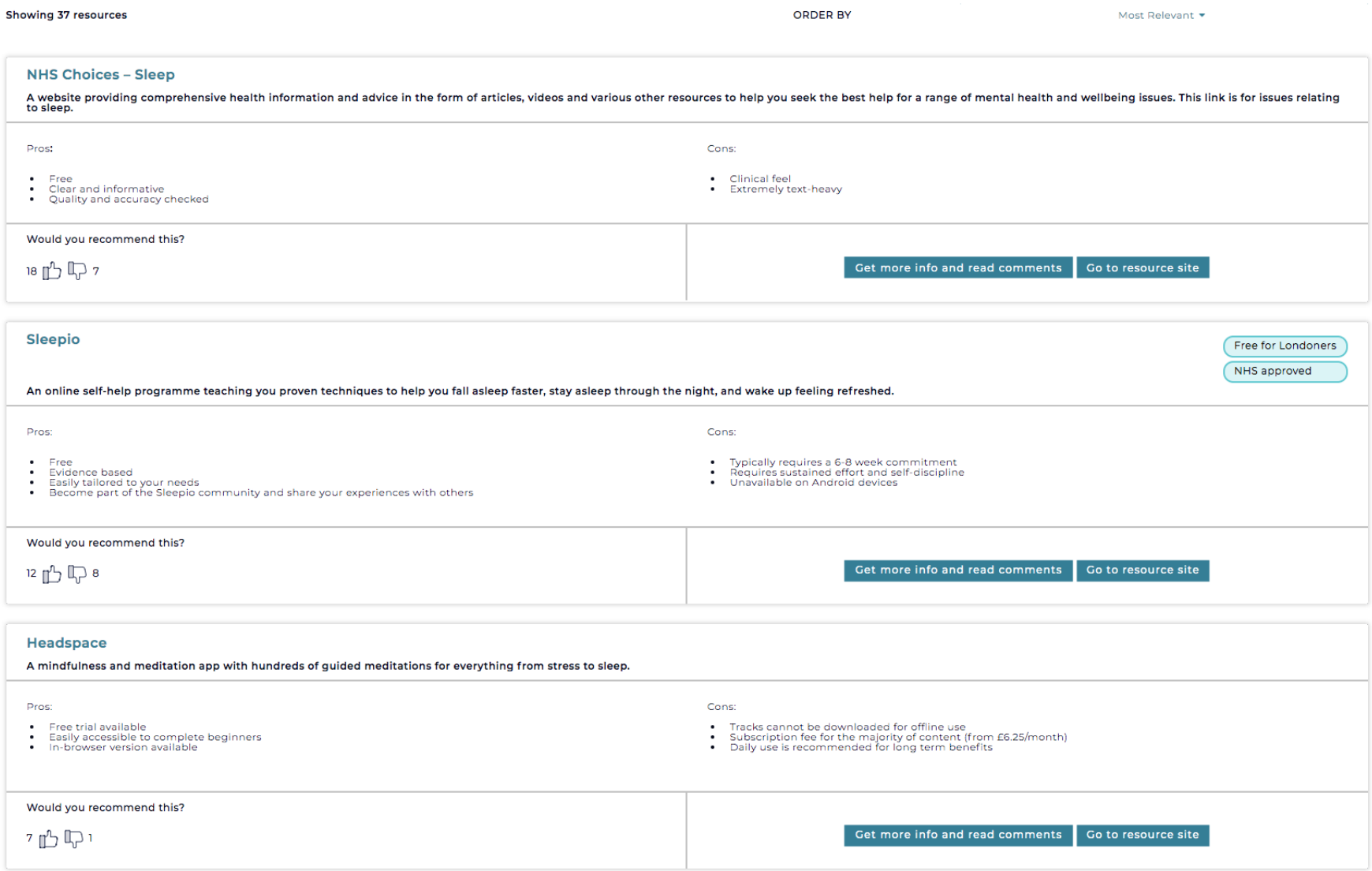
- He is taken to the Good Thinking landing page

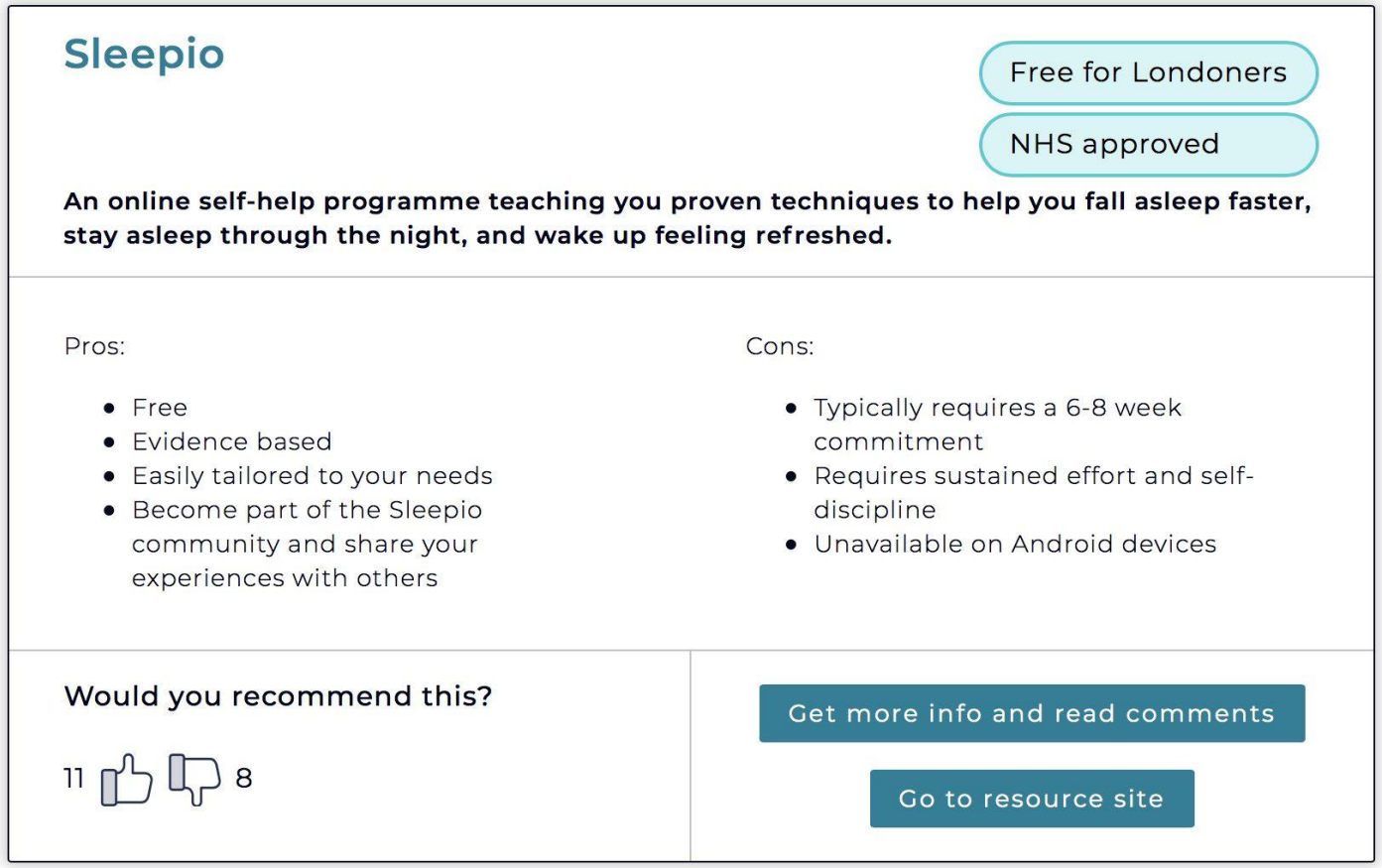


- He decides to completes the clinical self-assessment that highlights moderate depression



- He is offered a range of sleep and mindfulness apps



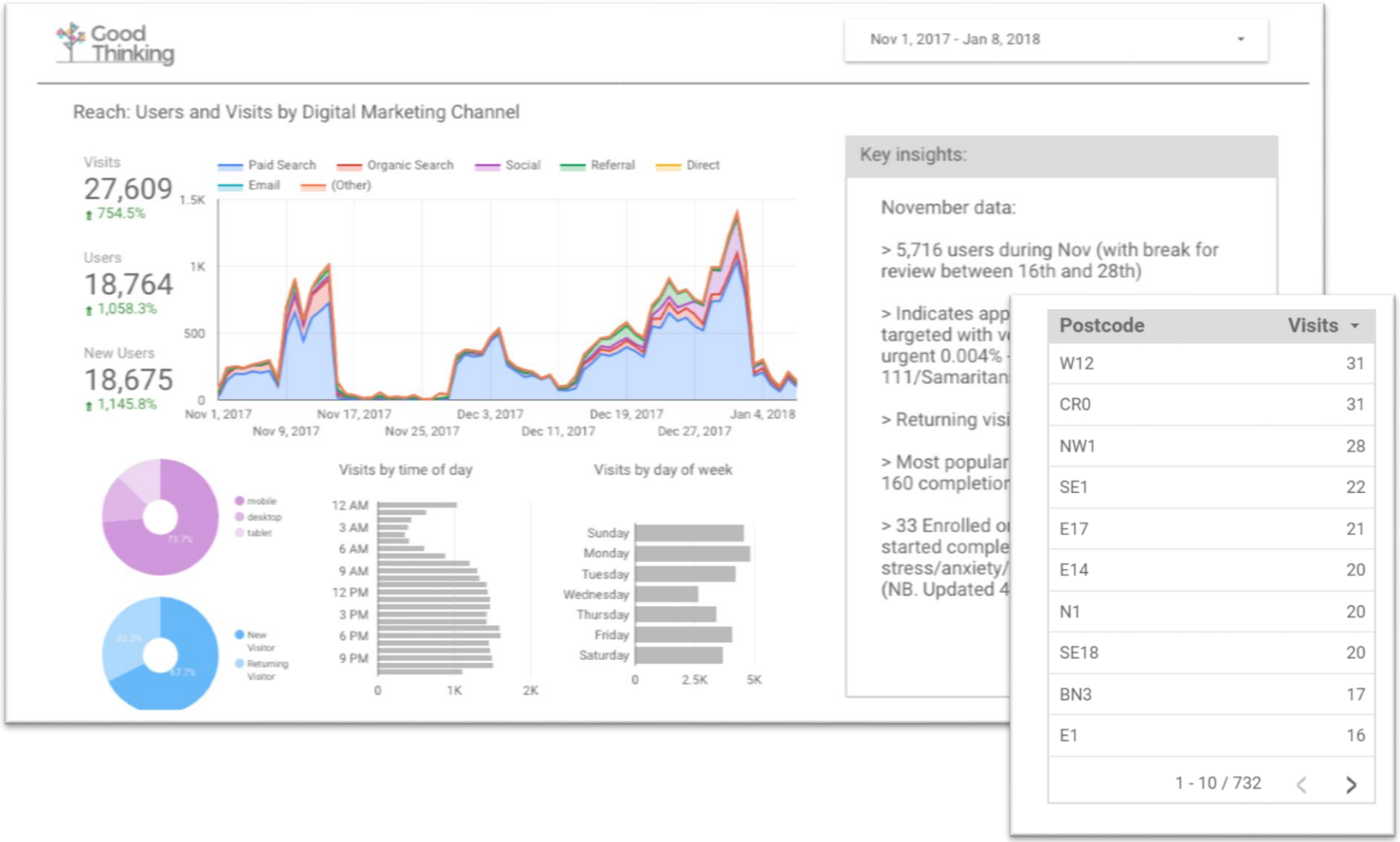


- Martin chooses to begin the Sleepio programme based on user recommendations and the opportunity for peer support

- This option allows him to stay in work, continue to care for his wife and prevents any further deterioration in his mood.

Good Thinking data dashboard

- A data dashboard has been developed to enable service monitoring and improvements
- It provides real-time data on site visits and referral information
- It represents visits by post codes
- Further capabilities are being developed



Public Beta: Live from 1st Nov 2018
Targeting stress, anxiety, depression, sleep problems

Targeted Campaigns Running for 9 Weeks in Since Live Public Beta
Data from 1st Nov to 8th Jan (with 2 week pause during Nov.)

Channels	Google Facebook	
Reach Total number of times messages shown - Google/Facebook (impressions)	1,287,460	
Engagement/Visits Clicks on targeted messages	20,470	Total Cost £9,489 48 pence average cost per visitor
Number continuing journey through to self-help resources	1,424	
Number visitors completing validated self-assessments	• 601 Sleep Test • 500 mental/physical symptom check • 111 Stress (PSS), Depression (PHQ9), Anxiety (GAD7) combined assessment	
Numbers signed up for self-managed evidenced based CBT (Two interventions for a) Insomnia and b) Mindfulness Based Cognitive Therapy (MBCT) for stress, anxiety and depression	311	

The future of Good Thinking

2018/19 and beyond

- Offering support to any Londoner seeking help online for their mental wellbeing
- Potential to scale regionally and nationally
- Looking into branching out to other health issues, such as smoking, sexual health and obesity
- Integration with traditional health systems e.g. as a way to facilitate social prescribing in outpatient clinics
- Linking to resources based on user location
- Real time local population wellbeing data to support planning of other services
- Service development is dependent on available funding.

info@good-thinking.uk

https://www.healthylondon.org/good-thinking/

@GoodThinkingUK

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Report for:	Haringey and Islington Health and Wellbeing Board Joint Sub Committee
Title:	Haringey and Islington Wellbeing Programme Partnership Agreement
Report authorised by:	Dr Jeanelle de Gruchy, Director of Public Health, Haringey Julie Billett, Director of Public Health, Camden and Islington
Lead Officer:	Rachel Lissauer, Director, Wellbeing Partnership

1. Describe the issue under consideration

The Joint Health and Wellbeing Sub-Committee provides the strategic leadership for the Haringey and Islington Wellbeing Partnership.

This paper describes progress with the Wellbeing Partnership in relation to the ambitions set in the Partnership Agreement and the aims of individual workstreams. The Partnership Agreement will be refreshed in April 2018. The paper recommends a process for discussing and agreeing next steps for the Partnership.

2. Recommendation

The Joint Health and Wellbeing Sub-Committee is asked to:

- Note good progress in many areas against the ambitions set out in the Partnership Agreement and some areas where progress has been slower than intended.
- Note the evolving model of care in which we have 'horizontal integration' at a local level from integrated community and primary care networks, together with 'vertical integration' for managing long term conditions like diabetes.
- Note the requirements for integrated working emerging from CQC area inspections and NHSE criteria for accountable care systems.
- Approve or amend the suggested process for reviewing the Partnership Agreement, particularly the recommendation that the Partnership Agreement is carried forward which will allow options to be discussed in June.

3. Issue under consideration

3.1 **Progress Report Haringey and Islington Wellbeing Partnership 2017/18**

The Wellbeing Partnership is both a strategic alliance and a commitment to joint working ‘on the ground’ to accelerate improvements for particular cohorts of the population.

Priority population groups for shared focus were selected following a process, led by public health of reviewing health needs, health and care spend and potential for improvement.

We need to see our progress both in relation to the strategic aims set out in the Wellbeing Partnership and the aims of programmes of work for particular population cohorts.

3.2. The changing landscape

Over the past year, organisations across Haringey and Islington have made some significant progress towards becoming a system that takes shared responsibility for improving the health of our populations.

Certain structural changes have supported this direction of travel. Between July and September 2017 Haringey and Islington CCGs came together under a combined management team. This has consolidated the joint approach between the two CCGs. The CCGs’ finances and statutory responsibilities remain clearly distinct. However, drawing together the management teams has brought transparency about finances and opportunities to align commissioning approaches. The two CCGs are connecting decision-making through joint Governing Body committees and meetings. Differences and similarities in embedded commissioning approaches are coming into much clearer focus. In practice, there is greater communication and movement of staff and practical joint working between the different CCGs than has been seen before. This is happening alongside continuation of existing joint commissioning arrangements between CCGs and the Local Authorities.

The leadership and governance landscape has changed considerably within the year, with appointments of new chief executives for Whittington Health, North Middlesex, Haringey Council and a single Chief Operating Officer for the CCGs. Whittington Health and UCLH have continued to make progress on a clinical partnership.

A key area of change has been the development in the ability of primary care to work ‘at scale’. GP Federations in both boroughs have significantly strengthened their infrastructure. Federations have continued to consolidate out-of-hours access to GPs through hubs. Quality Improvement teams are

being developed to support primary care to focus on reducing unwarranted variation. On the ground we have seen the development of integrated networks, in which practices have linked together around their particular geographies to drive improvements based on local need. These have focused on management of long term conditions and frailty and are explored in more detail later in this paper.

However, the past year has also seen considerable challenges for individual organisations, financially and operationally. Overall, capacity within the workforce at every level has been a significant constraint both in running day-to-day services and in delivering system transformation. Changes in the levels at which decisions are being made, both across North London Partners and across Haringey and Islington has created considerable complexity. The Wellbeing Partnership has therefore been working within a stretched and complex health and care environment.

3.3 Progress in relation to the Partnership Agreement

Appendix 1 sets out progress against the commitments set out in the Partnership Agreement.

Aims of the Partnership Agreement

- Shifting resources over the longer term to prevention and ill health avoidance impacting directly on the health and wellbeing of the population of Haringey and Islington
- Bringing together all our resources (including budgets), sharing budget information and taking collective decisions about their most effective use.
- Working together to redesign services in a different way using all the skills available to us across our collective workforce recognising that the necessary skills are not vested in one organisation or professional approach.
- Ensuring every organisation is seen to succeed by collective success.
- Developing using our collective information to create insight into how we can improve systems as a whole, where investment needs to go and to drive innovative ways of doing things.
- Bringing teams together, acting on behalf of each other, to more efficiently use our staff.
- Working together with our communities and workforce we will accelerate the transformation of our health and care system in Haringey and Islington.

- Collectively taking budget decisions, agreement will be reached on levels of activity and cost creating joint commitment to a collective financial and activity target. This should also reduce transaction costs between organisations.

The review in Appendix 1 highlights good progress at a strategic and practical level, including bringing together public health needs assessments and working collaboratively on preventative programmes.

Public health teams have produced a joint Strategic Needs Assessment. This represents a strong, shared point of reference and a mechanism for identifying priorities. Public health teams have successfully bid for additional resources to focus on improving the management of diabetes and cardio-vascular disease.

Progress has been made in developing a shared outcome dashboard which is an articulation of our collective aims and how they will be measured.

The Sponsor Board has acted as a forum for reviewing investment decisions and progress, most notably reviewing use of the Better Care Fund and investment into primary care both for integrated working and for quality improvement. It is notable that joint areas of focus between councils, such as market-management, continuing care and workforce development, have been taken forward primarily at STP level.

Progress has been more limited in several key areas. One is the plan for a system-wide financial control total. There has been limited capacity or appetite for exploring a Haringey and Islington system control total given the work happening at the level of North London Partners, North Central London's STP. The overwhelming direction has been towards sharing financial risk and planning at this wider level. It has not been clear that the benefits of disaggregating a bi-borough financial position within the wider North London Partnership, would be proportionate to the work required, given the complexity and challenge of this disaggregation, nor whether a two-borough control total would be acceptable within the wider North London partnership.

However, within the Wellbeing Partnership we do share a strong ambition to use our partnership and its aims as a way of directing more resource within our system towards prevention and the determinants of ill health. A proposal is being taken to the Sponsor Board in January to commission a piece of work to articulate our shared model of care across Haringey and Islington health and social care and to assess the financial implication for the Boroughs of delivering this model of care. This would provide a high level assessment of the financial position across our system, looking across our constituent organisations. This will be the basis of a system level

financial plan that will inform decisions about how resources are used and managed, without necessarily seeking to delineate a system-level control total.

Our experience is that some very good progress has been made in developing joint leadership. We have examples of programme leads from one organisation working across boroughs and leading on service developments across agencies. This has progressed well for MSK, intermediate care, frailty, diabetes/CVD and children and young people. Where it has worked well it has enabled rapid scale-up of schemes across both Boroughs. Implementation of a simplified and more personalised process for discharging people from hospital is a very good example. However, it is challenging to lead across organisations, whilst individual organisations already have their own programmes of work, leadership structures and governance in place. We can consider whether there needs to be greater permissions and enablers to facilitate leadership across organisations in the next phase of work.

A small team with project management and service improvement expertise has now been recruited to support the Wellbeing Partnership and will be taking up posts from February 2018, based at Whittington Health. Members of the team have been seconded from councils, CCG and Whittington Health. This will make a significant impact on the ability of the Partnership to progress at pace and to measure and evaluate its impact.

Recommendations

The joint Health and Wellbeing sub-committee is asked to note the key areas of progress in relation to the Partnership Agreement commitments, as well as areas where progress has been slower or more challenging.

The sub-committee is asked to consider what the key issues are for consideration when thinking about the next iteration of the Partnership Agreement. Some suggested areas are:

Is the geography of the partnership right?
Are our aims and principles fit for purpose?
Do we have a clear shared vision and focus?
Do we want to go further in articulating a shared model of care?
Do we want to maintain or revise our governance?

3.4 Achievements from work-streams

The Sponsor Board, after securing agreement to the Partnership Agreement through Governing Bodies in May and June 2017, has been keen to focus on delivery over the past 6 months. At its meeting in August, the Sponsor Board also provided a steer for the Wellbeing Partnership to have a greater focus on the development of integrated primary and community services at a local level.

Some of the key deliverables from the workstreams over the past 6 months include:

- Discharge to Assess has saved an estimated 1466 bed days between April and October 2017 in Haringey.
- The waiting time for MSK services has reduced progressively for patients in both Boroughs. In.
- A clinical model for MSK services has been agreed and a pilot is now being launched across Haringey and Islington.
- In Haringey there has been a 1.03% reduction in non-elective admissions compared to the same period in 2016/17, which is in line with the progress of vanguard sites
- In Islington there has been a significant reduction in acute activity for patients who were discussed by a multi-professional team, with some networks showing a reduction of greater than 50%.
- An asthma pathway has been developed to support improved management of asthma in children across both Haringey and Islington. This has now been expanded to include other boroughs.
- A Haringey and Islington air-pollution group has been established involving children's commissioners, Whittington Health and air pollution leads.
- Over 70 staff and volunteers received training to implement blood pressure checks as part of the British Heart Foundation programme grant;
- Haringey and Islington are now both commissioning GPs to improve the management of diabetes and CVD.
- Joint borough plans are in place to improve achievement of 3 diabetes treatment targets (blood pressure, cholesterol and blood glucose) through Quality Improvement Support Teams (QISTs).

3.5 General practice at scale and multi-professional working

Significant work from GPs and from primary care teams within CCGs has gone into the development of Care and Health Integrated Networks (CHINs) and setting up Quality Improvement Support Teams, which are being run by each borough's GP Federation.

CHINs and QISTs - overview

CHINs are networks of integrated services, where non-primary care services are integrated with primary care and other service providers (e.g. social care, mental health, community and voluntary sector), to manage the health needs and improve outcomes for the populations of a group of practices. CHINs bring staff together from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector to provide care closer to patients' homes.

CHINs give patients faster and easier access to health professionals and other services that can help to resolve their issues at an early stage before they become more serious. They help people to take control of their own wellbeing, manage their long term health conditions and be active members of their community.

Quality Improvement Support Team (QIST) is a team of professionals, supporting a CHIN and whose role is to drive continuous quality improvement and innovation across the patient journey, by reducing variation and sharing good practice. It supports the CHIN to deliver the outcomes for which it is jointly accountable.

There has been good progress with getting projects up and running at a local level in both Haringey and Islington. The common areas of focus are early identification / diagnosis and pro-active case management of patients with long term conditions and frailty.

An example of how a CHIN is working – North Islington

What is it?

The Islington North Frailty initiative is building a multi-disciplinary team in the community to support people who are frail or becoming frail. It is using technology, phone triage and physical assessment to:

- Identify "people of interest" from across the population (in this case around 70,000 patients in North Islington, from nine GP practices) who are mildly or moderately frail and who are likely to benefit from proactive support.
- Identify from that list a "patient register" of people who could benefit from a co-ordinated, proactive response from health, care and voluntary sector services to reduce any duplication, and reduce or delay the need for long-term formal care.
- Provide new and appropriate pathways to support these patients in the community — clinical, social prescribing or other welfare support.

How is it working?

GP practices have allowed the GP Federation, through a very carefully managed process, to create a register of patients who fall into mild, frail or 'unsure' frailty status. The initial focus is on supporting people who might be struggling with taking medication and who are at risk of falls.

A multi-disciplinary team has been formed from the participating GP practices, Whittington's Community Health ICAT team, Age UK and Islington GP Federation. Through a mix of agreements and individual honorary contracts, with Islington GP Federation being the primary responsible/accountable body.

The team includes:

- An AGE UK navigator who will provide 'universal' support for clinical and social prescribing activities
- Pharmacist with expertise in care of the elderly and a physiotherapist
- Clinical supervision from the Care of the Elderly Team at Whittington Health
- GP Federation provides a range of data searches, analysis, quality improvement support, project management and clinical leadership.

Does this type of multi-professional input work?

We have strong emerging evidence of the positive impact that multi-professional working has in providing support for people with complex needs.

A multi-professional team has been running in Haringey since 2015, supporting people at high risk of a hospital admission. The team is made up of nurses, physiotherapists, a pharmacist, social workers, a mental health nurse and a dementia navigator.

They were put in contact with Mr R, 35 years' old who had anxiety and depression with post-traumatic stress disorder, alcohol dependency and housing problems. Members of the team spent time with Mr R and became aware of underlying mental health problems. They worked with him to identify goals and assigned a care coordinator. They supported Mr R to link with multiple services and to engage with the GP and physical health services and worked with the mental health dual diagnosis team. Mr R is now in appropriate housing. His alcohol consumption has reduced and he is using techniques to manage his anxiety.

The graph below indicates the difference in A&E admissions for patients at practices that use the locality team by comparison to practices that do not. Through the development of CHINs the aim is to make sure that this approach is embedded across both boroughs.

Recommendation

The joint Health and Wellbeing sub-committee is asked to:-

Note progress within workstreams and, in particular, note the emerging model of care, in which CHINs are supporting 'horizontal' integration across agencies at a local level to offer pro-active management of 'at risk' populations. Workstreams are also driving and supporting 'vertical' or pathway integration and are putting specialist health and care services into closer contact with local primary and community teams.

Note that in 18/19 this approach will be consolidated further, with a clearer articulation of how individual project objectives link into and contribute towards delivery of an overarching outcome dashboard.

3.6 Regulatory drivers for integration

Haringey and Islington have been careful to resist classification or any formal contractual process for our partnership. It is important for us to use our own vocabulary and to forge a way of working that is driven by bringing real benefits for residents.

However, it is useful for us to work with an awareness of the expectations for joint working that are being set both by the Care Quality Commission (CQC) and by health regulators. Within North London Partners the Haringey and Islington Wellbeing Partnership is one of the more developed examples of joint working and we are therefore going to be asked to evaluate our progress in these terms.

3.6.1 CQC

CQC local area reviews include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources. These reviews are looking at how people move between health and social care, including looking at delayed transfers of care, with a particular focus on people over 65 years old. These reviews will not include mental health services or specialist commissioning but, through case tracking, will look at the experiences of people living with dementia as they move through the system.
It is important for us to work with an awareness of this upcoming requirement so that, at Borough level and at the level of the Wellbeing Partnership, we are in a strong position to respond to changing system level regulation.

3.6.2 NHSE

Within the NHS, Accountable Care Systems (ACSs) are increasingly being viewed as the next, evolved iteration of successful Sustainability and Transformation Plans.

NHSE proposes that ACSs are able to agree a performance contract in which the system commits to make quicker improvements in relation to the NHS 5 Year Forward View. In return, the system gains some of the benefits associated with devolution. These include, for example, freedom to access and allocate transformation funding and a single regulatory arrangement.

It is unlikely that any of the next wave of Accountable Care Systems will be from London, given the requirement of ACSs to meet and exceed performance targets and be in a position to achieve financial balance.

For the Wellbeing Partnership, there is interest in understanding the degree to which we meet or aspire to meet the criteria for ACSs. In preparation for an assurance meeting with NHSE in October 2017 we considered that we met the majority of criteria, with the significant exception of achieving NHS constitutional targets and meeting a system control total. The Wellbeing Partnership will want to consider how far we want to monitor performance and finances across ourselves as a partnership rather than either as individual organisations, individual boroughs or as an STP. There appears to be relatively little appetite for this given our inter-dependencies with other boroughs and with Trusts outside Haringey and Islington, particularly given the approach towards managing finances across the STP as a whole.

However, the Sponsor Board and the Health and Wellbeing Joint sub-committee, in considering the next steps for the Wellbeing Partnership, may want to review this in more detail and provide a steer.

NHSE Criteria for Accountable Care Systems

Effective leadership and relationships

- Strong leadership and mature relationships across NHS and Local Authorities
- Effective collective decision-making
- Clinicians, including primary care, involved in decision-making
- Leaders share a vision

Track record of delivery

- Tangible progress towards delivery of Five Year Forward View (reducing avoidable A&E attendances; improving access to general practice; delivering cancer waiting time targets and priorities for mental health and management of frailty).
- Delivering constitutional standards
- Capability to exercise decisions on priorities

Strong financial management

- Delivering financial balance
- System wide plan to delivery control totals
- Shared system responsibility and risk arrangement

Coherent and defined population

- Meaningful geographical footprint (>0.5m)
- 'Core' providers cover 70% of care for the population
- Contiguous with local authority boundaries
- Effective operating arrangements within STP

Care Re-design

- Provider integration plans (vertical and horizontal) are in place
- Primary care and GP involvement
- Population health approach
- Draws on new models of care

3.7 Decision-making in the next phase

The Wellbeing Partnership Agreement commits partners to periodically reviewing the agreement.

It is proposed that, over next 4-5 months, the Partnership Agreement is discussed within the Sponsor Board and informally with Council Leaders and Executive/Cabinet members, with an options paper coming to the June meeting of the Joint Health and Wellbeing sub-committee. The aim will then be for the next iteration of the Partnership Agreement to be ready for review in September / October.

In March, it is proposed that an extended Sponsor Board meeting be held, and this will provide an opportunity to engage with and be challenged by external experts, including Sam Jones, who led the development of the New Care Models programme of work at NHSE. The Sponsor Board will then consider and develop options for 2018 / 2019, for further testing and development with Leaders and other Joint Sub Committee members.

This report invites members of the Joint sub-committee to discuss and comment on what they would like to see from the next iteration of the Partnership Agreement, in order to provide an initial steer to this next phase of development.

4. Contribution to strategic outcomes

The Wellbeing Partnership contributes towards the strategic outcomes set both by Haringey and Islington's Health and Wellbeing Boards: Ensuring every child has the best start in life; reducing obesity; improving healthy life expectancy; improving mental health and wellbeing and reducing health inequalities. It is expected to contribute towards delivering high quality, efficient services within the resources available.

5. Statutory Officers comments (Chief Finance Officer

Legal

There are no legal implications of this report.

Finance

Paragraph 1.1 of this report highlights that 'borough finances and statutory responsibilities remain clearly distinct' under the current arrangements.

If the Sponsor Board approves the commissioning of the piece of work to articulate the shared model of care, it is imperative that sufficient detail is provided on where responsibility for specific areas of activity will sit and the vision on the alignment of financial responsibility and associated resources that will be required.

Details will be required on the status quo and the new arrangements, so that the financial implications can be clearly identified and assessed at each decision stage. Particular considerations will include the need to ensure VFM, and how any savings/pressures will be managed within the confines of each entity's medium term financial strategy whilst securing the delivery of joint targets and outcomes.

Any future action that the council decides to take in order to further the objectives set out in this report will need to be managed from within relevant existing budgets.

6. Environmental Implications

Not applicable at this stage

7. Resident and Equalities Implications

Public bodies have a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

b) Advance equality of opportunity between people who share relevant protected characteristics and people who do not

c) Foster good relations between people who share relevant characteristics and people who do not.

This duty covers the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

An equality impact assessment is not needed for this decision but consideration will be needed in the governance process of how members of partnership will pay due regard to the Public Sector Equality Duty in an effective and proportional way when making decisions through the partnership.

8. **Use of Appendices**
Programme Update is attached as Appendix A.

9. Local Government (Access to Information) Act 1985
Background papers: None

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Wellbeing Partnership Progress on Partnership Agreement

Theme	#	Action	Responsibility - lead	Qtr	Target Date	Status	Action/progress
A. Joint Health and Wellbeing Strategy	1	**Public Health Leadership Group**: Form a Haringey-Islington Public Health Leadership group by June 2017 to determine a process for developing a future operating model for collaborative working.	Jeanelle de Gruchy/ Julie Billet	**Q1**	Jun-17	Ongoing and on track	The H&I Directors of Public Health are working together on thematic areas in common and have been successful in winning bids in relation to diabetes and a BHF bid for stroke. The next step is to develop the evolving process into a future operating model for collaborative working. It is suggested a stocktake paper co-incide with the commissioning update in 4 below.
	2	**Joint Strategic Needs Assessment**: Bring together the iterative processes underpinning the JSNA as a precursor to establishing a single Health and Wellbeing Strategy for the two boroughs.	Jeanelle de Gruchy/ Julie Billet	**Q2**	Sep-17	Complete	A JSNA summary has been produced and shared with the Joint health and wellbeing strategy (2 below).
	3	**Joint Health and Wellbeing Strategy**: Develop a single Strategy for the boroughs of Haringey and Islington by December 2017.	Jeanelle de Gruchy/ Julie Billet	**Q3**	Dec-17	Complete	The process of aligning the two strategies has been completed.
	4	**Public Health Commissioning**: Review commissioned services and budgets between both boroughs by September 2017: providing a deeper understanding of the services commissioned and supported by both Public Health teams. In the future, this work will serve as a guide for (1) which services might be jointly recommissioned to potentially improve outcomes for the populations for both boroughs and (2) which services would be better managed locally.	Jeanelle de Gruchy/ Julie Billet	**Q2**	Sep-17	Ongoing and on track	The review of PH commissioning will follow the development of an operating model (1 above) and joint strategy (3 above), so that form follows functions identified through these processes. The review would include alignment of JSNA processes (2 above) in future years. In the meantime, joint areas of work are underway, including work on obesity and Sugar Smart.
B. Joint Transformation Programes and Management Teams	5	**Transformation Programmes**: To share each organisation's programmes with Partners by 30 June 2017	Sanjay Mackintosh	**Q1**	30-Jun-17	Complete	A joint staff workshop was held on 4 May at which programmes were shared. Areas for collaborative working between councils including CHC, workforce training and market management are being taken forward through STP.
	6, 11	**Transformation Programmes**: To establish joint work on council transformation programmes and peer review priorities by September 2017 and align local authority social care transformation programmes by 30 July 2017	Sanjay Mackintosh	**Q2**	30-Jul-17	Limited Progress	From discussions in 5 above, it was agreed that Assistive Technology is a key area for collaboration, in addition to existing joint work already taking place on intermediate care and reablement. There is little appetite to formally merge transformation programmes. The intention is to bring a paper to the Sponsor Board relaying feedback and how we might refine the actions, as discussions have since progressed further.
	7	**Service Improvement Projects**: To bring together existing projects undertaken by separate organisations where they are addressing similar cohorts of the population, conditions or diseases so as to optimise improvement work under the leadership of the Wellbeing Partnership by September 2017	Sean McL/ Beverley T/ Rachel L/ Paul S/ Carol G	**Q2**	Sep-17	Limited Progress	This is happening for CHIN / QIST, MSK, intermediate care and to a degree for diabetes. It is only happening to a limited degree for Children and Young People and mental health. There is mixed appetite for integrating existing work and projects.
	8	**Service Savings and Transformation Plan**: To develop a joint plan for 2018/19 between Councils, CCGs and Trusts by October 2017 so that this can be built into each organisation's financial plan for 2018/19	Stephen B / Ahmet K/ Paul D / Shakeen Y	**Q3**	Oct-17	Limited Progress	Requires capacity - plan for 18/19 both to develop a strategic financial plan and to employ a member of staff to develop a shared savings plan.
	9	**Single Management Leads**: To establish by 30th June 2017, a single management lead across all organisations for specified services e.g. diabetes, with the autonomy to make system wide decisions to improve services. The role would have accountability to all organisations through the Partnership Board.	Project Director	**Q1**	30-Jun-17	Limited Progress	This is happpening to a limited degree. Leadership for much of the work within the Wellbeing Partnership sits within commissioning and operational teams. There would need to be a clear case for change and significant level of buy-in to having single management leads which is not in place at the moment.

Wellbeing Partnership Progress on Partnership Agreement

Theme	#	Action	Responsibility - lead	Qtr	Target Date	Status	Action/progress
	10	**Management Team Alignment**: Managing alignment of CCG management teams to support a partnership approach by September 2017	Tony Hoolaghan	**Q2**	Sep-17	Complete	Single executive team is in place across the two CCGs
C. Joint Performance Measures	13	**Performance Indicators**: To establish by 30th September 2017, a set of performance indicators (ideally from existing data sources) which will help demonstrate increased collaborative working across the Partnership.	Jill S / jenny W / Jess McGreggor/Charlotte P	**Q2**	30-Sep-17	Complete	Outcome dashboard has been completed
	14	**Better Care Fund - Joint Measures**: To investigate joint measurement of service initiatives such as the Better Care Fund and shadow from July 2017.	Jess McGreggor/ Marco Inzani	**Q2**	Jul-17	Complete	BCF leads have shared their approaches and BCF reporting will now come to a joint Wellbeing Delivery Board. This will align reporting and evaluation of schemes.
	15	**Data Sharing Agreements**: To confirm existing data sharing agreements and ensure consistency, establishing new ones where needed by December 2017, so data can be used between organisations to improve and deliver services to users.	Sarah Dougan	**Q3**	Dec-17	Limited Progress	Considerable progress has been made towards sharing data to enable joint working within primary care and within integrated networks. This has been led by Federations and primary care leads. Data sharing across primary and secondary care and across agencies has made little progress.

Wellbeing Partnership Progress on Partnership Agreement

Theme	#	Action	Responsibility - lead	Qtr	Target Date	Status	Action/progress
D. Joint Budget Management	19	**System Control Total**: To shadow a single system control total (from September 2017)	Stephen Bloomer	**Q2**	Sep-17	Limited Progress	The benefit and requirement of a system control total at Haringey and Islington level needs further investigation. A statement of shared strategic aims and a shared financial plan to achieve this is a priority and the Sponsor Board will make a decision in January about whether to commission this work.
	16	**Budget Sharing**: To establish a regular monthly sharing of budget (and activity data) at a level of detail that enables each organisation to understand how resources are being used to deliver health and care services (from April 2017).	Ahmet K	**Q1**	From April 17, monthly	Limited Progress	As above
	17	**Dis/Investment Decision-making**: To bring significant investment / disinvestment decisions (eg over £250k) to the Partnership Board to enable partners to understand the impact such changes might have. This does not fetter an organisation's independent decision making autonomy but ensures one organisation does not make unexpected changes which negatively impact upon another (from April 2017).	Simon Pleydell	**Q1**	From April 17, monthly	Ongoing and on track	This has occurred with BCF plans and CHIN / QIST investment being brought to the Sponsor Board for multi-agency discussion.
	18	**System-wide Budgets**: To establish system wide budgets for specific services eg for diabetes, MSK, to support the transformation work of the individual work streams (by April 2017).	Finance Directors	**Q1**	Apr-17	Limited Progress	In progress for MSK. This will be explored for intermediate care in Haringey. There needs to be a strong case for change for this to be progressed.
E. Governance	20	**Governance**: To establish the overall governance arrangements as described below by 30th June 2017.	Programme Director	**Q1**	30-Jun-17	Ongoing and on track	Governance structure has changed in light of the governance for CHINs. Need to consider how Trust Chairs are involved in decision-making. Governance and membership of Operational Board has now been reviewed.
	21	**Community Reference Group**: To support local people to coproduce the community reference group by 30th June 2017.	Lizzie Stimson	**Q1**	30-Jun-17	Ongoing and on track	Agreement reached in July not to progress with a separate community reference group. Healthwatch and residents are represented on the Delivery Board.
	22	**New Governance Forms**: To consider alternative, stronger governance arrangements and organisational forms such as Multispecialty Community Providers (MCP) or Primary and Acute Care Systems (PACS) between September 2017 and March 2018.	Programme Director	**Q2**	1 Sept 17 to 1 April 18	Limited Progress	Not pursuing currently
	23	**Partnership Agreement**: To refresh this Partnership Agreement for April 2018.	Programme Director	**Q4**	Apr-18	Ongoing and on track	This will be progressed through February and March.
	12	**Delivery Plan** - to include: To establish four Care Closer to Home Networks (CHINs) as a local delivery teams by September 2017.	Clare Henderson Cassie Williams	**Q2**	Sep-17	Ongoing and on track	On track

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Report for:	Haringey and Islington Health and Wellbeing Board Joint Sub Committee
Title:	Proposal for resident and community and staff engagement in the development of integrated health and wellbeing networks
Report authorised by:	Dr Jeanelle de Gruchy, Director of Public Health, Haringey Julie Billett, Director of Public Health, Camden and Islington
Lead Officer:	Rachel Lissauer, Director, Wellbeing Partnership

1. Describe the issue under consideration

Haringey and Islington are undertaking informal engagement around the development of local integrated care networks. This engagement aims to ensure that networks are being developed in a way that is visible and responsive to local residents and patients. It is also a way of raising awareness of the Wellbeing Partnership.

The joint sub-committee is asked to note that this engagement represents a statement of commitment from health and care organisations in.

2. Recommendation

The Joint Health and Wellbeing Sub-Committee is asked to:

- Discuss and comment on the proposal to engage with communities about the Wellbeing Partnership.
- Note that we will be moving away from using the term Care and Health Integrated Networks (CHINs) to describe our local integrated networks.
- Approve plans for further engagement about the Wellbeing Partnership.

3. Next step with CHIN development and engagement

This paper proposes a process of engagement with both health and social care staff and members of the public around the Wellbeing Partnership. It suggests that this engagement process is used to discuss the vision and the aims of the Wellbeing Partnership. The development of integrated networks offers a clear way of communicating what we are trying to achieve through the Wellbeing Partnership. It is also vital that integrated networks respond to the priorities of local people. Communicating about the Wellbeing Partnership and about the development of local networks is part of how we, as organisations, can create a

meaningful dialogue with residents and patients, and work together with people living in our boroughs to promote better health and wellbeing.

3.1 **Strengthening integrated local networks**

Progress with the development of Care and Health Integrated Networks in Haringey and Islington is described in the report on this agenda entitled "Haringey and Islington Wellbeing Programme Partnership Agreement". These developments have been supported by all Partnership member organisations and were and continue to be a strong feature of the STP:

> "At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services. This will be underpinned by a systematic focus on prevention and supported self-care with the aim of reducing demand on the system over time. We will deliver the right care at the right time for the whole population"

Working in this way involves early identification of vulnerable patients or patients at risk of developing poor health. For this, access to registered patient lists is critical. So it is appropriate that GPs have been the starting point for this work. However, the vision for CHIN development is for integrated care and leadership. Much of the enthusiasm amongst GPs and primary care teams more widely is the potential opportunity through CHINs to address the wider determinants of ill health and to connect more readily and efficiently with professionals in other sectors, particularly those working in mental health, the voluntary sector and social care.

There has already been very good engagement in CHINs from professionals within Trusts and councils. However, for integrated local networks to progress, staff need permission to dedicate more time to becoming part of these teams and to work in new ways. Managers of front-line staff need assurance that this is in line with organisational priorities and financial plans. If local networks of care are going to have longevity, then they will need to be strongly driven and supported by councils and all Trusts.

It is therefore very important to establish, as leaders of health and care organisations within our local system, a shared commitment towards the development of integrated local networks. In order to engage with residents on network / CHIN development, leaders would need to have clarity about what they see as the function and purpose of local networks, both now and in future.

Across London and nationally a range of different approaches are being taken, with networks having different levels of formality and responsibility. On the one hand, networks are being developed as small multi-professional teams working on care coordination and case management. In other places local networks are preparing to take on a more formal role as multi-agency leadership teams, able to plan health and care services and preparing to hold budgets to support managing the health needs of their population. Thus far, no one approach has been demonstrated to be more effective than another; however, any model requires commitment from system leaders.

Under any model, networks offer an opportunity to draw different professionals together around the needs and strengths of the people and communities within a geography. Building a multi-professional team provides opportunities for people to share skills, communicate more easily and make smarter use of non-clinical staff. Having a local unit of organisation around a group of practices makes it possible to consider new solutions to entrenched issues. It can act as a prompt to engage the staff who provide care and for particular populations in a dialogue about how they consider care could be provided most efficiently and effectively. The development of integrated networks provides the opportunity for residents and patients to help shape in a tangible way how care and support is defined, delivered and experienced at a local level.

3.2 **A 'road map' for network development**

A piece of work is now being undertaken to set out, in conjunction with stakeholders, the next steps in developing local networks.

CHINs need to develop more consistently and their coverage needs to be extended so that no Haringey or Islington patients or groups of residents are excluded.

Some of the headline expectations for how CHINs will develop over the next year are set out below.

Current position	**2019 position**
Population coverage • Not all practices within a network	Population coverage • All registered patients are located within and part of a defined network • CHIN has considered local geography and assets

Leadership • Largely GP led • CCG driven	Leadership • All networks have multi-agency leadership • CHINs able to define health and wellbeing priorities for their area
Level of public awareness and engagement • Only in relation to particular projects	Level of public awareness and engagement • Neighbourhood engagement events held and local priorities informing plans
Demonstrating improvement • Planned improvements identified	Demonstrating improvement • Explicit, measurable objectives and evaluation underway
Governance • Structure being established to support decision-making and clear accountability	Governance • Process is in place for CHIN to influence decision-making • Accountability for delivery/performance and for finances is clearly established

Recommendation:
The Joint Sub-committee is asked to note and approve that Haringey and Islington will develop a new term, which replaces CHINs, to describe our local integrated networks. We will use our existing engagement meetings to test some options with residents and service users.

3.3 Building on a strengths-based approach

For Haringey and Islington Councils, this is an opportunity to connect the work that is happening in the Wellbeing Partnership with the asset and strengths-based approach that is being developed as part of the Spark Programme in Islington and through the Target Operating Model in Haringey.

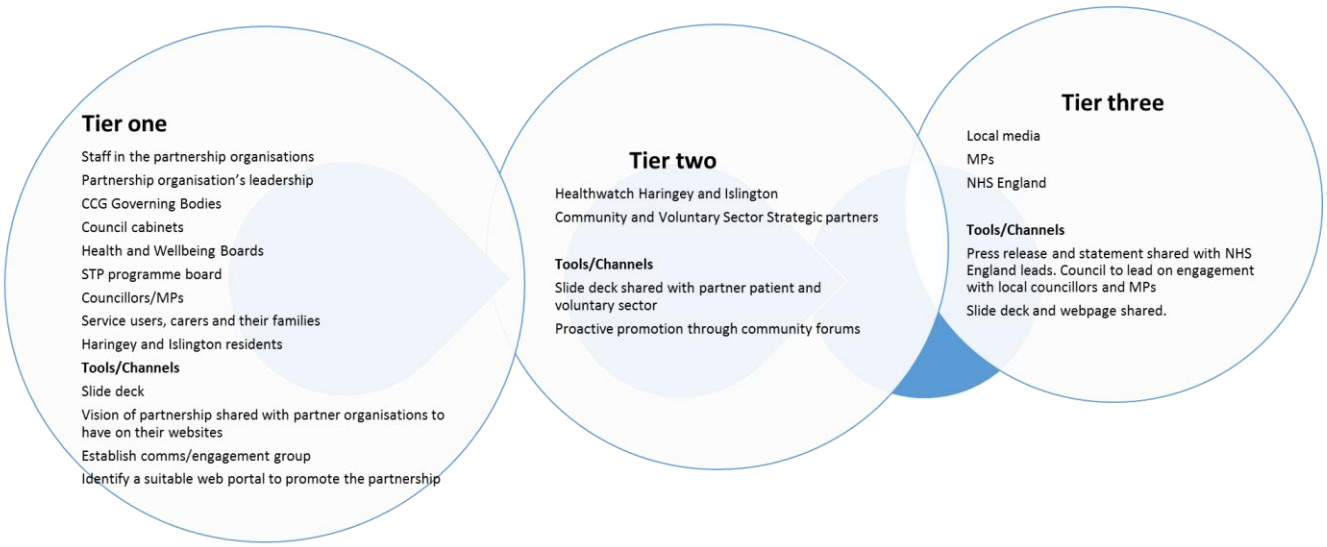
A strengths-based approach reverses the traditional and paternalistic care model. Rather than starting with ‘what's wrong’ and deciding which services can ‘fix’ things for people, a strengths-based approach concentrates on the assets of individuals, families, groups and community organisations, which can allow people to live independently and do more for themselves.

For social care this is seen as part of moving towards more personalised services which focus on prevention and building resilience in individuals and communities. Clearly there is also strong alignment with the move towards supporting personalisation and self-management in health.

A focus on building resilience, and on individual, family and community assets and strengths, provides the Wellbeing Partnership with an opportunity to set out a positive vision for health and care transformation. This does not negate or disregard our system challenges, particularly around health inequalities and the financial sustainability of the system. However, it does allow us to have a dialogue with patients and residents about how we can work together to improve health and wellbeing.

3.4 Engaging and communicating – next steps

A process below is proposed for developing communications and starting informal engagement on the Wellbeing Partnership.



Setting out our approach

Initial steps Jan- April 2018

- Communication and engagement leads group in place
- Assigning overall leadership for communications and engagement

- Collecting case studies to help bring the partnership to life, which would be an opportunity for partners to come forward to feature as part of the partnership. Considering how we promote the partnership with community groups and residents through forums and events – and ensuring this is meaningful.

Mid-term April – July

- Communications and engagement group up and running with case studies being shared regularly on proposed portal site and across partner organisations.
- Ongoing discussions of progress shared with local patient and resident partners. Plans to host a series of engagement events, using existing forums in both boroughs for Wellbeing Partnership partners to share with residents what we want to achieve and how local people can get involved.

Long term – July 2018 – March 2019

- Proposed events aligned to local existing fora and events to share vision and engage on the Wellbeing Partnership; engagement tailored / aligned to Council priorities
- Determine whether we host an official re-launch of the Partnership with Council and NHS leaders post local elections.
- During this period continue work to promote the work of the partnership with frontline services in both boroughs which reflect the ambitions of working together.

Audience	Channel/tools	Lead	Time scales
Tier one	Slide deck vision of partnership shared with partner organisations to have on their websites Establish comms/engagement group Identify a suitable web portal to promote the partnership	Head of Comms Haringey and Islington CCG Islington and Haringey Council comms leads Haringey and Islington CCG comms lead	Jan- March 2018
Tier two	Slide deck shared with partner patient and voluntary sector	Engagement lead for Haringey and Islington CCG	March – July 2018

	Proactive promotion through community forums		
Tier three	Press release and statement shared with NHS England leads. Council to lead on engagement with local councillors and MPs Slide deck and webpage shared.	Head of Comms Haringey and Islington CCG Islington and Haringey Council comms leads Haringey and Islington CCG comms lead	July 2018 - 2019

Recommendation
The joint sub-committee is asked to comment on and approve this engagement process.

4. Contribution to strategic outcomes

4.1.1 The Wellbeing Partnership contributes towards the strategic outcomes set both by Haringey and Islington's Health and Wellbeing Boards: Ensuring every child has the best start in life; reducing obesity; improving healthy life expectancy; improving mental health and wellbeing and reducing health inequalities. It is expected to contribute towards delivering high quality, efficient services within the resources available.

5. Statutory Officers comments (Chief Finance Officer

5.1 Legal

There are no legal implications arising from the recommendations in the report.

5.2 Finance

Paragraph 1.1 of the previous report highlights that 'borough finances and statutory responsibilities remain clearly distinct' under the current arrangements.

If the Sponsor Board approves the commissioning of the piece of work to articulate the shared model of care, it is imperative that sufficient detail is provided on where responsibility for specific areas of activity will sit and the

vision on the alignment of financial responsibility and associated resources that will be required.

Details will be required on the status quo and the new arrangements, so that the financial implications can be clearly identified and assessed at each decision stage. Particular considerations will include the need to ensure VFM, and how any savings / pressures will be managed within the confines of each entity's medium term financial strategy whilst securing the delivery of joint targets and outcomes.

Any future action that the council decides to take in order to further the objectives set out in this report will need to be managed from within relevant existing budgets.

Any details relating to such actions will be assessed for financial implications as and when they arise.

6. Environmental Implications

Not applicable at this stage

7. Resident and Equalities Implications

Public bodies has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

b) Advance equality of opportunity between people who share relevant protected characteristics and people who do not

c) Foster good relations between people who share relevant characteristics and people who do not.

This duty covers the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

An equality impact assessment is not needed for this decision but consideration will be needed in the governance process of how members of partnership will pay due regard to the Public Sector Equality Duty in an

effective and proportional way when making decisions through the partnership.

8. **Use of Appendices**
   Presentation
9. **Local Government (Access to Information) Act 1985**
   Background papers: None

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Together – we care

We want to simplify how you can access health and social care in Haringey and Islington

Haringey and Islington Partnership – An Opportunity

- Our partnership is unique so we should seek to build a distinctive local identity.
- All partners are committed to finding sustainable solutions to address economic and social inequalities, maximise our collective expertise and skills and value our workforce.
- It's easy to describe the deficits. Now, we need to emphasise our many shared assets – clinical expertise, innovation in social care, creative approaches to economic growth, and more.
- Developing a strategic communication plan provides a vehicle to engage our stakeholders and to articulate how the partnership will add value.
- Partnership allows us to have conversations about health and social care, that are relevant to this part of London – focusing on a locally devolved system.

Together – we care

For a long time, people have been asking for better local care. Care that's joined up. Care that's closer to home. Care that actually helps people get back to living their lives.

Why hasn't it happened yet?

Well, it's a massive challenge and an opportunity to get everyone, from GPs to nurses, social workers to volunteers, and even patients and residents themselves, changing the way people and professionals think, work and act. It means rethinking the way care funding is spent. It requires nothing less than a whole social movement.

We have started to operate in new and better ways – but now we need to get everyone involved in making change happen

High quality and accessible care for those who need it
Improving efficiency and coordination of care across GPs, hospitals and social care for families, people with long term conditions, frailty and mental health problems.

Supporting independence and avoiding crisis
Offering integrated support for people when they leave hospital and when they are at risk of going into residential care or needing hospital care.

Coordinating care
Linking with communities on how we improve health and wellbeing. Building teams of GPs, 'care navigators', community groups, nurses, pharmacists and others to support people who are vulnerable.

Why Now?

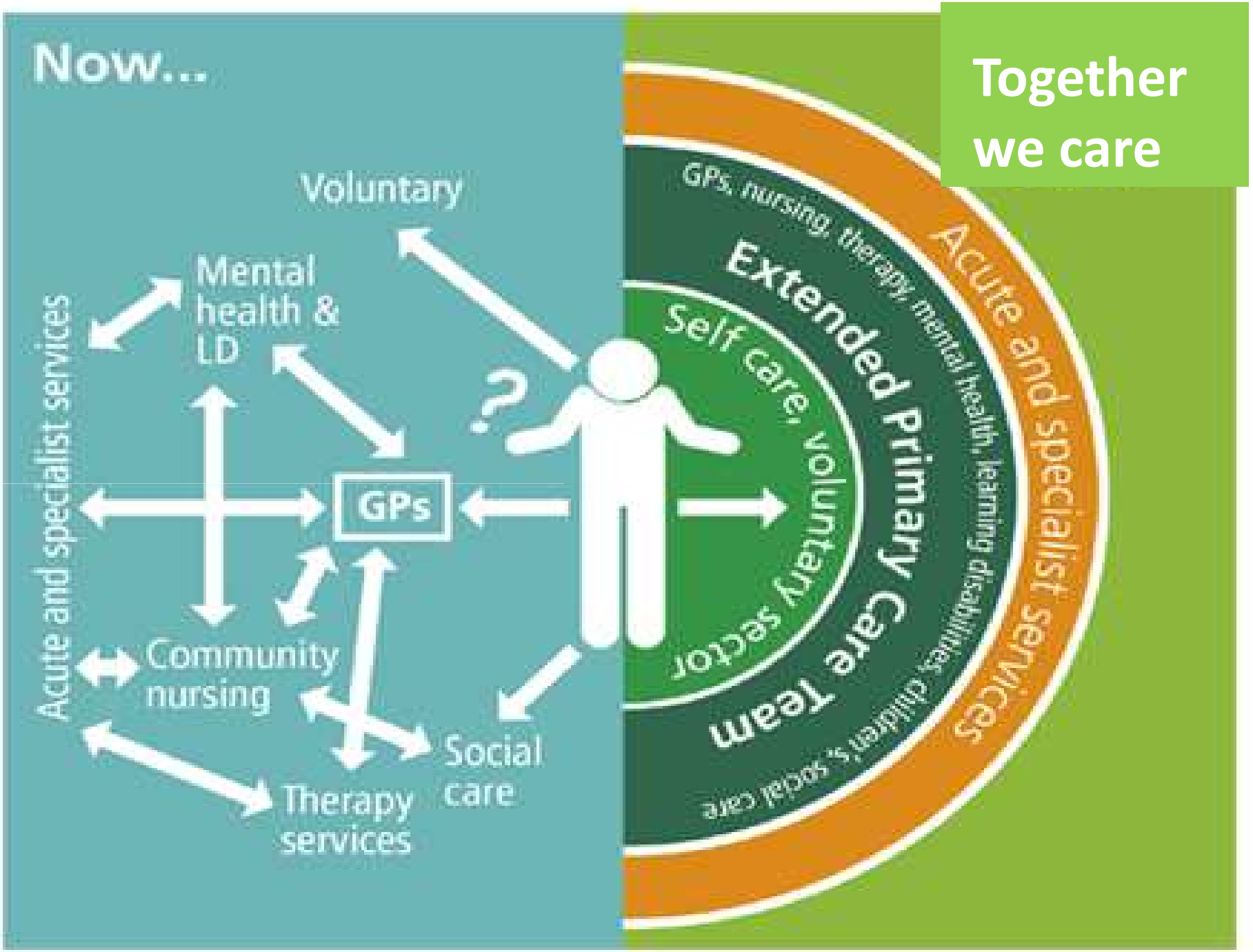
- Haringey and Islington Wellbeing Partnership has potential to secure a whole system change - economic and social wellbeing for local people.
- However, there is a risk that 'top down' pressure on the local NHS - to rapidly adopt new models of care – could divert us from creating a bespoke local model.
- National language (ACS/ACO, New models of care)– is almost meaningless to local people and some staff. Evidence (Nottinghamshire, Wakefield, GM healthier Together) that local ownership from staff, clinicians, political leaders and local people is key to improving outcomes.
- This is the right time to work together to identify and create a health and social care system designed and owned by local partners.
- Communication and engagement is a tool to help all stakeholders own and understand new approaches.

Communication Plan

- Developing the plan will be part of the overall engagement with the partnership. The plan will aim to:
- Take the opportunity to build on the local engagement and communication that partners have already undertaken - not start from scratch.
- Be implemented by stakeholders. It's essential that clinicians, care providers, staff and local people – have opportunities to shape and test the messages.
- Be specific to Haringey and Islington, and about our local system
- Allow each partner to bring experience and knowledge to the development of the plan. Leadership can be delegated amongst ourselves.

What's in it for me?

- We need to be able to clearly articulate what the potential benefits are for different stakeholders.
- If we do not articulate the benefits for our audiences, it will be difficult to engage and energise people.
- Benefits need to be articulated in clear plain English; avoiding jargon.
- Messages need to be realistic and real - about local people being listened to by clinicians and able to make decisions about their care.


Now...
Voluntary
Mental health & LD
Acute and specialist services
GPs
Community nursing
Therapy services
Social care
?
Self care, voluntary sector
Extended Primary Care team
GPs, nursing, therapy, mental health, learning disabilities, children's, social care
Acute and specialist services
Together we care