MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 13 JANUARY 2015

Board Members Present: Councillor Claire Kober (Chair), Dr Jeanelle de Gruchy (Director of Public Health, LBOH), Zina Etheridge (Deputy Chief Executive LBOH), Sir Paul Ennals (Chair of Haringey LSCB), Sharon Grant (Chair, Healthwatch Haringey) , Cathy Herman (Lay Member, Haringey CCG), Dr Helen Pelendrides (Vice-Chair Haringey CCG), Sarah Price (Chief Operating Officer, Haringey CCG), Jon Abbey (Interim Director of Children's Services), Dr Sherry Tang (Chair, Haringey CCG), Beverley Tarka (Interim Director Adult Social Care) and Cllr Ann Waters (Cabinet Member for Children, LBOH).

Officers Present: Philip Slawther (Principal Committee Coordinator LBOH), Clifford Hart (Democratic Services Manager), Stephen Lawrence-Orumwense (Assistant Head of Legal Services), Cassie Williams (Assistant Director of Primary Care Quality and Development – Haringey CCG), Sarah Barron (Interim Manager, Primary Care – NHS England).

MINUTE NO.	SUBJECT/ DECISION	ACTION BY
CNCL115.	**WELCOME AND INTRODUCTIONS** In the absence of the Chair the Vice–Chair (Dr Sherry Tang) took the Chair. The Chair welcomed those present to the meeting.	
CNCL116.	**APOLOGIES** The following apologies were noted: • Gill Hawken (HAVCO) • Councillor Peter Morton (Cabinet Member for Health and Wellbeing) In addition, Cllr Kober sent apologies for late arrival.	
CNCL117.	**URGENT BUSINESS** None.	
CNCL118.	**DECLARATIONS OF INTEREST** Sharon Grant noted the following two amendments to the register of interests: • Was recently confirmed as Chair of Healthwatch Haringey, as opposed to Interim Chair.	

	• Confirmed as Director of Public Voice CIC, and that it was envisaged that this community interest company would manage Healthwatch Haringey from April 2015.	
CNCL119.	**QUESTIONS, DEPUTATIONS, PETITIONS** There were no Questions, Deputations or Petitions.	
CNCL120.	**MINUTES** It was noted that there were two main actions contained in the previous minutes: • Set up a Task and Finish Group around Primary Care. This will be discussed later as part of item 8. • Report back to the Health and Wellbeing Board on how the Board will be included in the Health and Care Integration Programme. This will be discussed later as part of Item 10. **RESOLVED:** That the minutes of the meeting held on 30 September 2014 be confirmed as a correct record.	
CNCL121.	**STRATEGIC COMMISSIONING FRAMEWORK FOR PRIMARY CARE TRANSFORMATION IN LONDON** Cllr Kober arrived at the meeting and assumed the role of Chair. The Board received a presentation, from Ms Cassie Williams, Assistant Director of Primary Care Quality and Development for Haringey CCG giving an overview of primary care. Following the presentation the Board discussed the findings. It was noted that NHS England had put out an offer for Co-Commissioning of Primary Care with local Clinical Commissioning Groups (CCG's). The aim of which was to create a joined-up clinically led commissioning system delivering integrated routine and unplanned primary care services based on the needs of local people. There were three types of co-commissioning offered: Greater involvement; joint commissioning or delegated responsibility. North Central London opted for a joint commissioning approach. Ms Williams noted that this process was still ongoing and that Haringey CCG was submitting a further bid to provide joint commissioning at the end of January. The three main elements of the strategic commissioning framework were:	

- Proactive Care: Promoting self-care, health literacy and helping people to stay healthy.
- Accessible Care: Providing a personalised, responsive, timely and accessible service.
- Co-ordinated Care: Patient centred, co-ordinated care with GP-patient continuity.

Ms Williams outlined NHS England's 5 year forward view. The three main areas were noted as:

- Prevention
- Restructure how care is provided
- Invest into Primary Care

In response to this the Government had agreed to give an additional £1.95 billion to the NHS for 2015/16.

Haringey CCG's Primary Care Strategy was currently being redrafted. The key objectives of which were noted as:

- Make primary care more accessible
- Coordinate care around the needs of our patients
- Make care more proactive
- Support practices to work at scale
- Develop our workforce, recruit & retain the best staff
- Ensure our premises are of the highest possible quality
- Improve our technology and information systems

Ms Williams advised that one of the most significant technological improvements was the development of interoperable IT databases so that GP's etc would be able to see each other's records. The acute care and community providers would shortly have the capacity to do this as well.

Dr Helen Pelendrides commented that as a GP, the ability to access a patient's records across different surgeries and IT systems was "revolutionary". Every GP in Haringey had agreed to the data sharing protocols, not just among themselves but with other partners externally. This would have a significant impact on health and care integration. The next stage was to complete the join up with synthesis in A&E and Out of Hours services.

The Chair asked Dr Pelendrides what the impact of this change would be on her as a GP in 5 years time. Dr Pelendrides responded that this would positively impact on both the quality of patient care as well as deliver financial savings as the number of duplicate referrals and wasted appointments should dramatically decrease, with patients being able to access services with fewer delays. It was noted that, by way of an information safeguard, patient consent to share these records was required every time a clinician accessed their personal records. Dr Pelendrides also commented that this process would be likely to

encourage greater prioritisation of work flow and in the longer term it should be possible to hold “virtual” clinics.

Ms Price commented that the provision should have a particular impact on being able to see people that a GP may not have been able to see previously as it would open up access to more specialised clinics, especially where patients were assigned to smaller practices. Dr Pelendrides commented that although the Prime Minister had stated that access to services would be opened up and patients would not necessarily have to wait to see their own GP, there may be a significant amount of education involved in this as many people may prefer to wait to see their own GP.

Ms Herman asked whether the new service would really enable the NHS to offer more flexibility in its primary care services as, she noted, the current service offer was very much one size fits all. Dr Sherry Tang commented that bringing secondary care up to the same standard of digitalisation and information sharing would be a key challenge, though overall the process of bringing about greater interoperability should further increase flexibility and give people greater choice. For example, choice in terms of what types of consultations they would like to receive i.e. virtual or non-virtual.

The Deputy Chief Executive, Zina Etheridge commented that the co-commissioning proposal presented some significant opportunities, but also some significant challenges. For instance, co-commissioning brings about some issues around conflicts of interest particularly in terms of public perception. Ms Etheridge also asked colleagues from Haringey CCG what support they would require from those around the table to assist in the implementation process and that sharing access to the system with partners around the table might help tackle some of those concerns early on. Ms Etheridge also sought clarification with regard to governance arrangements for the project and whether progress would continue to be monitored by the HWB.

Ms Etheridge further enquired what the project would mean for the system as a whole, particularly around the points raised on specialisation. In particular how were colleagues from Haringey CCG going to ensure that those benefits were realised across the system and used to drive further reforms, as well as implications for the integration of primary care and the acute care sector and whether these services would remain separate.

Ms Williams responded to a number of points of clarification by advising that part of the governance arrangements for co-commissioning would involve the creation of a joint commissioning board at the North Central London level, including representations from; all of the CCGs, GPs, lay member representation, NHS England and Healthwatch organisations. Final arrangements about the specific make up and voting rights were still to be determined as were whether there would be representation

from all 5 Health and Wellbeing Boards at the joint commissioning board.

In terms of specialisation, Ms Williams agreed that the CCG could be more intentional about how we share the specialisms and the different services available. Ms Price added that in terms of federations developing in the borough and groups of GPs working together, the CCG as commissioners could commission services to work better at a local level across primary, acute and community services. This would encourage and foster the creation of specialist services as groups of GPs look to take advantage of those development opportunities.

Sharon Grant, from Healthwatch Haringey, commented that increasing access to primary care on its own would not engender the required outcomes; the challenge was to do it strategically, looking at prevention and looking at different models of care. Otherwise the danger was that the Strategic Commissioning Framework would just create a lot of new appointments across different formats and media but no real change to the delivery services would be realised. The key was to focus on the enablers for this change. Dr Tang responded that the ability to review other records and the wider drive towards interoperability would hopefully mitigate any potential capacity for duplication and limit any negative consequences of expansion of access.

In terms of any potential support required from the wider HWB, it was noted that there would be a number of discussions with partners required about what kind of models would be required. For example, as Tottenham developed discussion was needed about the services offered to residents and the local demand needing to be met. Dr Tang commented that one of the key challenges faced was around workforce, as it was difficult to find and retain local staff and to keep the skill set of the workforce up. It was noted that if there was anything partners can do to help retain a specialised workforce, then that would have a significant impact on the efficacy of these proposals.

The Chair commented that the physical regeneration of the borough and the desire of the CCG to play its part in this would create something that could be quite exciting. Particularly in terms of creating a compelling offer to Haringey's workforce and ensuring that residents had access to the highest quality well motivated staff. The Board should keep this in mind as a key challenge going forward.

Ms Grant noted three main issues for patients:

- Communication – a lot of work would be needed to be invested in this to explain the changes and explain what they meant to people.
- Impact on the continuity of care – would someone still retain responsibility for a particular person's care and would patients still be able to make appointments to see the same GP regularly?
- Confidentiality – Clearly this was going to open up people's health

records to a far wider array of staff working across an array of health and social wellbeing groups. There was a risk that just a few cases where confidentiality was breached could seriously undermine the proposals.

The Chair asked Ms Grant whether she had any sense of what residents had to say about continuity of care versus a demand for greater flexibility. Ms Grant responded that this may be something that Healthwatch could undertake as a piece of work.

Ms Williams responded, noting that she shared concerns around the need for communications and engaging far and wide with residents. Similarly, it was agreed that confidentiality was a risk and a challenge but that the GP's would not have signed up to this agreement if they did not feel that the protections etc were not in place. It was also noted that people could choose to opt of the new system in the first instance and nobody would be able to share their confidential records. In addition, as mentioned earlier, the clinician would be required to ask the patient for permission to access their records each time. There were therefore a number of checks in place to guard confidentiality issues but no system was 100% foolproof.

Dr Pelendrides responded that in terms of continuity of care, her perception was that younger people and those who worked full time or worked unsociable hours would prefer additional flexibility to speak to or see a clinician when they wanted. However people with complicated conditions would be far more inclined to utilise the same services and the information sharing process should help reduce patients needing to explain the details of their case to numerous health care workers. Dr Pelendrides also added that there were no proposals to prevent people seeing the same GP if that was their wish. The example of the over 75's project was noted and the use of care coordinators to supervise the care of the top 2% most vulnerable patients.

The Director of Public Health – Dr Jeanelle de Gruchy asked for further clarification on the model of primary care development and integration with secondary care that Haringey was exploring. Dr Jeanelle de Gruchy also asked for more detail on plans to improve the physical infrastructure, developing new premises, built to a high standard. Ms Williams responded that in terms of primary and secondary care specific details of the Haringey model were to be developed.

Ms Price noted that NHS England were going to begin work on the range of models acceptable for integration. The challenge for the CCG is to be ambitious and to be ready to act when integration options were released.

Ms Price also noted that in the Claire Gerrarda work that was undertaken, the conclusions were that it would be very difficult to bring the standard of primary care up to the level of acute care as the cost of investing in facilities would be prohibitive. Money (c. £1billion) was made

available by the Government in the Autumn Statement for improving the standards of facilities. NHS England would be communicating with GPs on how to potentially access some of these additional funds.

The Interim Director of Children's Services – Mr Abbey noted that the rationale and link to Early Help was really reassuring. Despite concerns around confidentiality, information sharing protocols did already exist with child protection agencies etc. In addition, the flexibility of offering a universal standard whilst also being able to tailor access to services to suit different needs would be a real positive.

Ms Grant noted that in terms of confidentiality, what people would be concerned about was how much their personal details would be accessed by Local Authority services and this would require a significant programme of communications and one that might raise a number of questions.

The Chair then summarised and it was:

RESOLVED:

That the information outlined in the presentation relating to the future of primary care be noted.

CNCL122. LSCB ANNUAL REPORT 2013-14

The Chair advised that Sir Paul Ennals had to leave the meeting at around 14:50 and so proposed that Item 11 was brought forward, after which the Board would return to the agenda. The Board agreed to the variation.
The Board received a copy of the annual report, previously circulated within the agenda pack, from Sir Paul Ennals, Chair of Haringey's LSCB.

Sir Paul Ennals summarised some of the key aspects of the report. It was commented that the LSCB had two roles; one to promote partnership and the other was to bring together all of the relevant agencies within Haringey, in order to facilitate each agency being able to hold one another to account. There was a legal requirement that an annual report was published. It was noted that in summary, for last year, there were no serious concerns highlighted in the report. Sir Paul Ennals commented that hopefully this year's report would show an improvement.

Cathy Herman from the Haringey Clinical Commissioning Group commented that when the board last looked at attendance there were a couple of organisations that stood out as having low attendance. Ms Herman asked what happened when organisations do not attend these meetings regularly. Sir Paul Ennals responded that if this became a serious issue then contact would be made with the head of the relevant

agency and regular attendance would be requested. Sir Paul Ennals advised that attendance at the meeting was not the most accurate way of measuring engagement with the LCSB process. It was also commented that one of the issues raised by Ofsted and referred to in the tabled report was difficulties with getting schools engaged in this process (now that schools are fully independent). Significant progress had been made in the last period and engagement was much improved.

Ms Herman asked Sir Paul Ennals what happened if, despite contacting the head of the partner agency and reiterating expectations around levels of engagement, this did not improve. In response, Sir Paul highlighted that there was a process of biennial formal reviews of safeguarding practices in all partner agencies which every LSCB undertakes. This involved each agency doing a self evaluation of safeguarding practice and then this would be challenged and scrutinised by each of the constituent agencies.

Ms Herman further commented that a key challenge going forward for the Board was how to make consultations more joined up with partners, particularly around young people. Sir Paul Ennals responded that this was indeed one of the priorities identified in the report.

The Chair commented that she was pleased to see the link between gangs and Child Sexual Exploitation highlighted as a priority for this year in the annual report and asked Sir Paul to comment on how he thought this work was progressing. In response, he commented that one of the actions arising from previous LSCB discussion was the need to update and expand our CSE strategy. Ms Etheridge was leading a task and finish group bringing together all of the agencies on behalf of the LSCB which was due to be reported back to the LSCB Board on the 27th January. Ms Etheridge noted that the third Task & Finish group was taking place on the 14th January and that engagement from partners to this group so far has been very good. Ms Etheridge also commented that she believed that we are getting to a much better place on CSE than we had been previously and that the task would be to ensure that this work was fully embedded in practice.

The Chair then summarised and it was:

RESOLVED:

i. That the Annual Report of the Haringey LCSB (2013-2014) be noted; and
ii. That the Priorities for 2014-16 also be noted.

CNCL123. PRIMARY CARE TASK AND FINISH REPORT

The Board received a presentation, previously circulated within the

agenda pack, from Sarah Barron, Interim Manager, Primary Care at NHS England on behalf of the Task & Finish Group Following the presentation the Board discussed the group's findings.

Ms Barron noted that she had asked Ms Williams to help present this item in order to show that NHS England and the CCGs had been working closely on this to allay the perception that the two organisations tend to work in isolation. It was also noted that Nicky Hopkins of North London Estate Partnerships had also been asked to help present part of this item. Ms Hopkins would be presenting what North London Estate Partnerships would be doing as part of the strategic plan that was being developed.

Ms Barron commented that although she was on a short term interim posting, she was fully aware of the level of concern around primary care access around east Haringey and Tottenham Hale in particularly. At the last meeting in September 2014 a mapping of need was called for and proposals were requested from NHS England on how that need for primary care would be met. As part of this process a Task and Finish group was established and it was noted that it had now had three meetings. In addition an officer sub-group and an access taskforce was also set up as a sub group to look at the immediate issues that were arising. The idea was that the Task &Finish group would look at the strategic concerns that have been raised.

Ms Barron noted that since that last meeting of the HWB a PID document was submitted to the NHS Finance Investment Committee to get funding to undertake a full strategic plan. This included what needs to happen around primary care as part of the regeneration of east Haringey, but also what quick wins could be achieved to tackle immediate concerns around primary care. It was commented that the process of commissioning primary care was a statutory process and that it required clear evidence of strategic need; this was what the strategic plan was intended to give. Ms Barron noted that the plan would hopefully provide evidence of the strategic case for investment. The plan was envisaged to be completed by April but a draft would be brought to the next meeting of this Board.

Ms Barron advised there seemed to be some disconnection between known capacity and what patients were experiencing. The presentation tabled in the agenda pack contained a graph showing the GP Full Time Equivalent rate (FTE) across London of which Haringey sat in the middle. When the figures were broken down to show individual practices that were experiencing problems with access, these practices did not necessarily have the fewest doctors. In addition, it was noted that one particular practice that concerns were raised with in the past regarding access was actually towards the upper end of GP FTE rate scores.MS Barron commented that this showed that GP access was a multi faceted problem that was not just about capacity. However, it was commented

that, the strategic plan would examine the capacity problems and attempt to fill those gaps.

In addition, Ms Barron commented that one of the key things she wanted to highlight was what they could do in the short term to address some of the issues identified. Some of the key access issues in this respect were; the management of appointment systems, utilisation of nurse capacity, using alternative methods of consultation and a poor level of patient experience of access in areas of east Haringey.

The GPs Survey had recently been released and it was noted that a number of improvements had come about in supporting some of the practices that were at the bottom end of the curve on the aforementioned GP FTE rate graph. Including one example where patient satisfaction levels with being able to see or speak to a GP went from 41% to 76 %. Showing that a commitment from those practices where improvements were needed was taking place. NHS England was working with those practices to bring about these improvements to accessibility and the ability to see or speak to a GP.

Ms Barron noted that in cases where GP practices were not engaging with current processes to improve performance levels around accessibility NHS England were able to take contractual compliance measures where necessary, including serving breach and/or remedial notices. It was commented that some of the practices were in the process of being taken through the contractual compliance route.

Ms Barron noted that work has been undertaken with the CCG to understand if there were any short term fixes in the Tottenham / east Haringey area that can be undertaken to tackle these accessibility problems. There were no solutions that NHS England could get funding for through their Finances & Investment Committee without demonstrating clear evidence as part of the strategic plan. Initial conversations had taken place with the developer at Tottenham Hale around finding an on-site solution but again this funding would have to be fully evidenced and again would have to go through the Finances & Investment Committee. Ms Hopkins would continue to explore this as part of the process of bringing together the strategic plan.

Ms Hopkins spoke to the Board and outlined that her organisation was a public-private partnership that was established to address premises needs in Health and Social Care in the Barnet, Haringey and Enfield area. They have developed two health centres in the area at Hornsey and Lordship Lane. They were tasked by NHS England to develop a Primary Care Premises Plan or a Strategic Premises Development Plan for east Haringey and to support the decision making processes. In order to do this the short, medium and long term primary care needs were to be determined and a clear picture of existing capacity to deliver services developed. As part of this process Ms Hopkins commented that they hoped to identify some quick wins such as a potential temporary solution

at Tottenham Hale. The timescales for completion of this project were noted as usually taking 3-4 months; however it was hoped that it would be done sooner in this instance. An update on the project will be brought back to this Board at its next meeting.

Beverly Tarka, Interim Director for Adult Social Care, asked for a little further clarification about the short term routes that were available to tackle poor performance from individual practices. Ms Barron noted that the routes available ranged from the more severe contractual processes that were outlined above, to the CCG providing support to ensure that a practice was able to provide everything that they should provide. Examples of this included liaising with them to determine whether their operating system is operating as smoothly as it can or working to see if a practice provided access through other forms of consultations.

Ms Tarka noted that these routes would take some time before a resolution was found and questioned whether the integrated collaborative GP system provided any opportunities for residents to access appointments quicker. Ms Williams responded that this was currently being looked at by the CCG. In addition to actively going in and supporting a particular practice, the working at scale project was highlighted as having enabled some practices to open up their appointment processes. However it was commented that in the north east the pilot project focused on enabling telephone appointments with doctors, as opposed to making more appointments available. Any future roll-out of the working at scale pilot would also need to be funded.

Ms Barron noted that the current pilots could not provide an immediate solution as the federation of practices was at a very embryonic stage and asking them to undertake any additional tasks could destabilise them. It was further commented that, any additional funding for primary care capacity had to be agreed through the NHS Finances and Investment Committee and this required evidence of strategic need.

The Chair noted that she still did not have a clear sense of where the problem was in Haringey following the last session when a number of residents and Councillors recounted their difficulties of getting an appointment. Ms Barron responded that the charts were provided to illustrate that there was not necessarily a correlation between a lack of capacity and an inability of residents to access services. Ms Price commented that this was not necessarily an issue of just GP numbers. Instead the issue was less straightforward and was more about; how these services were run, the quality of individual GPs or how practices organised themselves. Ms Herman commented that instead of this being a capacity issue it seemed that this was more about the capability of particular primary care providers.

Cllr Waters, the Cabinet Member for Children and Families asked Ms Hopkins to give the board an estimation of how long this process would take. Ms Hopkins responded that for some of the issues around

organisational practices and the re-development alterations, the next step would be to go back to the NHS England governing bodies to see how the projects could be taken forward. It was commented that a key consideration in taking any projects forward would be how they fitted into the strategic plan. It was commented that it would take at least 12 months to build a new building and 6 months to secure planning permission. A range of options would likely be required and that was why a short, medium and long term plan was being developed.

The Chair asked for clarification on what the timescales were for resolution if there were contractual issues. Ms Barron responded that a remedial route involved serving a notice and giving a timescale for improvement; a timescale of two months was suggested. In the case of a breach notice the practice would be informed that they were in breach of contract and NHS England would continue to monitor the practice to ensure that this did not happen again. Both of these courses of action would ordinarily happen at the same time.

Ms Grant expressed concern that the representatives from NHS England and the CCG were unable to give any assurances of remedying the situation in the short term. Ms Grant commented that Healthwatch had previously demonstrated that a severe lack of access to primary care existed around Tottenham Hale. It was also commented that the graph showing the GP FTE was based on averages and did not necessarily do much to help those people who were struggling to access GP services. Ms Barron commented that a key practice in the area was within the top quartile of GP FTE and the correlation wasn't necessarily about lack of capacity and an inability of residents to access services. Health inequalities existed in a number of areas of the borough not just around Tottenham Hale. In the short term NHS England's role was around contract management.

Ms Herman commented that consideration should be given to providing solutions to the primary care shortage that do not necessarily involve providing new facilities i.e. ones that looked into other models of primary care provision.

Ms Etheridge thanked colleagues from NHS England, the CCG and North London Estate Partnerships for their levels of engagement in this process.

It was:

RESOLVED:

i. That progress of the Primary Care Task And Finish Group, be noted;

ii. That the next steps given as part of the presentation be noted; and

iii. That an update on the progress of the Primary Care Task And Finish Group be brought back to the Health and Wellbeing Board on 24th March 2015.

CNCL124. HEALTH AND WELLBEING STRATEGY 2015-2018 - LAUNCH OF CONSULTATION

The Board received a report, previously circulated within the agenda pack, from Dr de Gruchy. A draft copy of the Health and Wellbeing strategy and an accompanying presentation was also tabled. Ms De Gruchy talked through the presentation and both reports and then summarised the key points.

Dr de Gruchy outlined the wider context of the strategy and the HWB Strategy refresh programme. It was noted that the refresh programme was agreed by the HWB in May 2014 and included reviewing the Joint Strategic Needs assessment (JSNA). The program also included setting up a range of key stakeholder group meetings and setting up workshop survey focus groups of voluntary sector stakeholders set up by HAVCO and Healthwatch and some of this work was included in the wider Council budget consultation for the Council's Corporate Plan. These measures were then integrated to facilitate an understanding of areas where we need to take a strong strategic lead.

Dr de Gruchy then gave a brief overview of the outcomes identified in the strategy and a summary of the highs and lows. It was noted that:

- Outcome 1 was to give every child the best start in life and that the key points were: A reduction in teenage pregnancy (but was still high compared to London and nationally); a reduction in infant mortality (but was still high compared to London and nationally); one in three children lived in poverty; childhood obesity was high and tooth decay in children has worsened.

- Outcome 2 was to increase healthy life expectancy. The key points were: Life expectancy was improving generally, especially for men. But men died younger than women primarily due to early death from heart disease and stroke); the inequality gap for men (8 years) and women (about three years) has remained constant over the last 10 years; on average, women lived the last 20 years of their lives in poor health which was worse than London and national average and the number of people with dementia and long term conditions was increasing.

  Dr de Gruchy outlined that analysis of demographics around life expectancy was increasingly focused on 'healthy life expectancy'.

A graph included in the presentation slides showed the average life expectancy and average healthy life expectancy against an index of deprivation levels. It was commented that in the most deprived areas long term poor health started to develop around age 53 and this was increased to around age 70 for the most affluent areas.

- Outcome 3 was improving mental health and emotional wellbeing and the key points were: Recorded crime was down 40%, partially due to a downward trend in drug use; there was an increased national focus on mental health; there were high numbers of children with behavioural problems; a high level of people suffering from anxiety and depression who were not receiving help and a high level of people with severe mental illness across the borough.

Dr de Gruchy commented that this showed that there are still a number of ongoing challenges in these major areas as these were long term major issues and that these issues had by no means been resolved in the three year lifespan of the previous strategy. The same issues remained key for the borough going forward. Dr de Gruchy also commented that the context for the strategy going forward is that the Health and Wellbeing Board has grown in strength and now benefits from some much stronger partnership working. In terms of the future role of the Health and Wellbeing Board, Dr de Gruchy noted that the potential for Haringey is huge and that the Board should be considering how to capitalise on regeneration and other opportunities in the borough to deliver the biggest health improvements for residents. Dr de Gruchy advocated that the new strategy needed to be ambitious and to find synergies with some of the other key corporate priorities.

It was noted that the three month consultation on the draft strategy was being launched that day and an easy read version was to be developed. The consultation process would involve a consultation on the overall priorities as well as consultation activity on each of the three individual priorities. Delivery plans would also be developed throughout the consultation period. Dr Jeanelle de Gruchy noted that the Health and Wellbeing Strategy and high level delivery plans would be brought back for approval to the Health and Wellbeing Board in June.

Dr de Gruchy asked the Board to give their opinions on the strategy and in particular sought their input on the purpose of the strategy and the role of the Health and Wellbeing Board. Opinions were also sought on what the role of partners was and finally, how ambitious did the HWB want to be – should there have been some headline ambitions stated at the end of the strategy?

The Chair asked that a discussion on the above points and on the strategy as a whole was delayed until the next meeting of the Board in order to do it justice given that the meeting was due to finish very shortly.

It was:

RESOLVED:

i. That the start of a three month public consultation on the draft Health and Wellbeing Strategy be noted.

ii. The Health and Wellbeing Strategy and high level delivery plans be presented to the Health and Wellbeing Board in June 2015 for approval; and.

iii. That a discussion topic on the Health and Wellbeing Strategy be a scheduled for consideration at the Health and Wellbeing Board on 24 March 2015.

CNCL125. HEALTH AND CARE INTEGRATION UPDATE

Ms Etheridge asked the Board to note that progress was being made with Health and Care integration. It was commented that there was a renewed strategic governance structure in Appendix A, on page 35 of the agenda pack, and Ms Etheridge asked the Board to note and approve the revised governance structure.

It was:

RESOLVED:

i. That the progress made to date around Health and Care integration be noted; and

ii. That the proposed governance structure in Appendix A of the report be noted and approved.

CNCL126. MENTAL HEALTH CRISIS CARE CONCORDAT

Ms Price, from the Haringey CCG, outlined that the Mental Health Crisis Concordat is something that ties-in very closely with the work of the Board. The Mental Health Crisis Concordat was published in February 2014 by the Department of Health and the Home Office and it set out how organisations would work together to ensure that people receive the required help when suffering mental health crisis. As part of the concordat, there was a requirement to achieve local sign-up and to

develop an action plan to deliver the aims of the concordat. Following a London workshop in October local organisations signed the concordat before the 31st December deadline. The task was now to develop a multi-agency action plan by March 2015; some resources had been secured to assist with the development of the action plan.

It was:

RESOLVED:

i. that the Mental Health Crisis Concordat be noted and endorsed; and

ii. That an action plan be brought for consideration and approval to the Health and Wellbeing Board on 24 March 2015.

CNCL127. **HWB GOVERNANCE: BOARD MEMBERSHIP APPOINTMENT AND CHANGE TO VOTING RIGHTS**

The Board considered a report, previously circulated, which recommended a change to the HWB membership to change the Lay Member to a full voting member and also confirmed the appointment of the Chair of the LSCB as a non-voting member of the Board. It was suggested that the reason for this change was that that following the appointment of an additional elected member to the Board, there had been an imbalance in the voting rights between Council and non-Council members of the Board.

Ms Grant noted that she had no objection to the proposal but asked whether the composition of the Board could be altered further to strengthen patient/user representation levels.

It was:

RESOLVED:

i. That the Chair of the Haringey LSCB be appointed to the Health and Wellbeing Board as a non-voting member of the Board.

ii. That it be recommended to Full Council that voting composition on the Health and Well Being Board be amended to allow voting rights to the Lay Board Member of the Clinical Commissioning Group; and

iii. That the detail of the report be accepted and agreed as a consultation by Full Council, for the purpose of altering the voting rights of the Board member.

iv. That the voting rights issue be progressed without further delay

	due to the immediate need to resolve the imbalance in voting rights. v. That the makeup of the Board be kept under review That future business be brought back for consideration at the Health and Wellbeing Board on the 24th March.	
CNCL128.	**NEW ITEMS OF URGENT BUSINESS** No new items of urgent business were tabled.	
CNCL129.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 24th March at 18:30.	

The meeting closed at 15.30pm.

COUNCILLOR CLAIRE KOBER

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Chair