MINUTES OF THE HEALTH AND WELLBEING BOARD
THURSDAY 24 SEPTEMBER 2015

Board Members Present: Dr Sherry Tang (Chair), Councillor Peter Morton (Cabinet Member for Health and Wellbeing), Dr Jeanelle de Gruchy (Director of Public Health), Sir Paul Ennals (Chair of Haringey LSCB), Mike Wilson (Director, Healthwatch Haringey – Substitute for Sharon Grant), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Beverley Tarka (Director Adult Social Care LBOH), Jon Abbey (Director of Children's Services LBOH), Paul Leslie (HAVCO - Interim CEO).

Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Philip Slawther (Principal Committee Coordinator LBOH), Stephen Lawrence-Orumwense (Assistant Head of Legal Services).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL101.	**WELCOME AND INTRODUCTIONS** The Chair welcomed those present to the meeting.	
CNCL102.	**APOLOGIES** The following apologies were noted: • Cllr Claire Kober - Leader of the Council • Cllr Ann Waters - Cabinet Member for Children • Sharon Grant – Chair, Healthwatch Haringey (Mike Wilson attended as substitute). • Cathy Herman (Lay Member, Haringey CCG)	
CNCL103.	**URGENT BUSINESS** None.	
CNCL104.	**DECLARATIONS OF INTEREST** None	
CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** No Questions, Deputations or Petitions were tabled.	
CNCL106.	**MINUTES**	

	RESOLVED: That the minutes of the meeting held on 23rd June 2015 be confirmed as a correct record.	
CNCL107.	**DISCUSSION ITEM** **UPDATE ON GP PROVISION IN TOTTENHAM HALE - HEALTH AND WELLBEING STRATEGY – AMBITION 5: PEOPLE CAN ACCESS THE RIGHT CARE AT THE RIGHT TIME** The Board received a presentation from Mike de Coverley, NHS England, and Jill Webb, Head of Primary Care - NHS England which gave an overview of key developments related to the provision of additional Primary Care capacity in Tottenham Hale. Following the presentation the Board discussed the findings. A copy of the presentation slides was included in the agenda pack and the Board noted some of the key points raised. The current progress to date was summarised as: • NHS England Finance, Investment, Procurement & Audit Group (FIPA) ratified the findings and recommendations of the Strategic Premises Development Plan. • NHS England, Haringey CCG and Haringey Council planners were developing a Delivery Plan which set out, in detail, proposed solutions to meet the challenges outlined in the Strategy Plan. • NHS England Decision Making Group (DMG) approved a process for the selection of a provider to enter into competitive dialogue to establish the proposed pilot practice in Tottenham Hale. • NHS England, in conjunction with colleagues from the London Borough of Haringey and Haringey CCG, undertook and completed the competitive process of pilot provider selection. • A local practice partner was selected as the provider. The decision was then ratified by PCC DMG and the provider was notified. • Lea Valley Estates confirmed that they would have builders on site until June 2016, who would be able to rapidly establish services to the facility. • NHS England and Haringey CCG were working on an IT solution that would rapidly allow connectivity to the new temporary facility. The next steps and upcoming milestones for the project were noted as: • Completion of dialogue had been commenced with pilot provider	

to establish final costs and service specification

- Final Agreement of pilot costs and service specification required by DMG Primary Care Commissioning.
- NHSE had begun the process of drawing up the contract for services
- Preparation of business case for pilot premises
- Dialogue and agreement of co-commissioners on premise funding responsibilities (in progress). Ms. Webb advised that NHSE were undertaking a process to bring primary care medical services commissioning arrangements back within the CCG umbrella.
- Sourcing of temporary facility (commenced)
- Approval of business case for pilot premises by FIPA
- Site mobilisation with new Partner Practice
- Planned service commencement by early January 2016

Cllr Morton, the Cabinet Member for Health & Wellbeing, welcomed the commitment from NHSE and acknowledged that this was a significant step forward on something that partners had been working on for a long time to get it to the position that it was currently in. Cllr Morton advised that the process had taken 12 months and a resolution was at least another 6 months away. Cllr Morton emphasised that a resolution could not happen fast enough both for existing residents but also to meet the additional demand as a result of the area being a major regeneration zone for London. Cllr Morton observed that primary care was part of the wider investment in the area and offered an unprecedented opportunity to improve the borough and the lives of the people in it. Cllr Morton commented that it was refreshing to see a large public body being accountable to the public in such a clear way.

Sarah Price, Chief Operating Officer Haringey CCG, reiterated that going forward the arrangements for commissioning would change and that this would involve closer working with CCG colleagues in other areas to plan for primary care investment in the future. Ms. Price agreed that being very clear about what Haringey's commissioning priorities were would put us in a strong position to ensure that we get the sort of input required from partners. Ms. Price advised that the Board was absolutely committed to ensuring that a resolution was found to the primary care shortfall but also noted that some difficult decisions would need to be made about how things were taken forward. Ms. Price expressed a desire to work together with NHSE to prioritise some of the more difficult decisions and thanked NHSE for supporting the initial investment.

Zina Etheridge, the Deputy Chief Executive, recognised that there were a special and specific set of circumstances around this issue and expressed gratitude to colleagues in the CCG and NHSE for developing a solution. Ms. Etheridge emphasised the importance of local and partnership working across this piece of work, and stated that the Board made a commitment to bring back local needs assessment for primary

care at the last meeting. The Board noted that this evidence base would be crucial for accessing future public funding and would support collective evidence based decision making, at a local level, in a way that was transparent and accountable to local people.

Mike Wilson, Director of Healthwatch Haringey, acknowledged the challenges involved in the process and thanked NHSE colleagues for the work that had been undertaken. Mr. Wilson stated that he would like some assurances that the service provided was going to meet resident needs and that it would be a sustainable service that was adequately staffed. In response, Mr de Coverley recognised the concerns raised and advised that NHSE had identified a reliable local provider who would be able to provide experienced GP's from day one. The committee noted that adopting a local provider added a level of flexibility, and would allow NHSE to increase provision if required.

Ms. Webb advised the Board that it was unusual for primary care infrastructure to be funded by capital, but negotiations were ongoing nationally in order for NHSE to use capital funding within General Practice, as part of the Primary Care Infrastructure Fund. Ms. Webb advised that a move to a more commissioner led strategy by NHSE, around funding and infrastructure would potentially be an advantage as the commissioning structures were already in place in Haringey. This would potentially mitigate the impact and the pressure on revenue by virtue of the type of schemes that could be adopted.

Cllr Reith, thanked fellow members of the task and finish group for primary care for their efforts. Cllr Reith raised concerns with a lack of urgency and advised that many residents in Tottenham Hale Ward currently had no primary care services at all and were unable to register with a GP. Cllr Reith commented that one of the key learning points from this process should be for co-commissioning and NHSE to listen to what patients were saying. Cllr Reith urged that a solution to the funding issue needed to be found and emphasised the need to assure residents that the funding would be long term, in order to ensure that residents felt secure in registering at the new practice. Cllr Reith also urged NHSE to consider pressures resulting from regeneration schemes, such as in Tottenham and the migration of families to outer-London areas, when planning the future allocation of funding and primary care services.

The Chair thanked colleagues from NHSE coming and presenting to the Board and also thanked those present for their contributions.

RESOLVED:

That the progress to date around additional primary care capacity in Tottenham Hale be noted.

CNCL108.	**DISCUSSION ITEM** **HEATH AND WELLBEING STRATEGY – AMBITION 9: PEOPLE WITH SEVERE MENTAL HEALTH NEEDS LIVING WELL IN THE COMMUNITY.** A Presentation was circulated as part of the agenda pack. Dr Tamara Djuretic, Assistant Director of Public Health and Shelley Shenker, Assistant Director MH Commissioning – Haringey CCG, gave the first part of the presentation on Mental Health and Wellbeing. The second part of the presentation was delivered by colleagues from Barnet, Enfield and Haringey Mental Health Trust: Dr Jonathan Bindman - Medical Director; Maria Kane - Chief Executive and Katherine Edelman - Clinical Director of services for Haringey. Following the presentation the Board discussed the findings. Some of the key points raised in the presentation were: • The performance indicators for Ambition 9 were: Percentage of people aged 18-69 on Care Programme Approach in employment and percentage of people aged 18-69 on Care Programme Approach in settled employment. • Current performance was noted as 76.8% of adults in contact with secondary mental health services were in stable accommodation which was similar to our statistical neighbours but was lower than the London average and higher than the England average. 5.1% of adults in secondary mental health services were in paid employment. 5.1% was lower than Haringey's statistical neighbours and both the London and national average. • 5.7% of women in secondary mental health services were in paid employment, compared to only 3.3% of men. • The aim for Ambition 9 was to increase the percentage of adults receiving coordinated care who were in employment to 9.85%, which would be top quartile nationally and to increase the percentage of adults receiving coordinated care who were in settled accommodation to 80%, which would be in line with Haringey's statistical neighbours. • The joint CCG and LBH Mental Health and Wellbeing Framework was published in March 2015 following extensive engagement and consultation. A whole system approach was adopted in the definition of enablement adopted in the framework: *"...supporting people to meet their potential to live independently, to have meaningful social relationships, maintain good quality housing, find and/or maintain employment and live a*	

satisfying life."

- The proposed enablement outcomes were divided between outcomes for the individual and outcomes for the system:

For the individual:

  - Strong social networks and reduced isolation
  - Sustained employment, meaningful activity
  - Stable accommodation
  - Improved resilience and self-confidence
  - Resources are effective in achieving personal goals
  - Improved physical health
  - Positive service user experience

For the system:

  - Reduced activity in intensive, high cost resources/increased activity in low intensity, lower cost resources
  - Pathways to and availability of resources understood by all stakeholders
  - Improved mental health awareness and reduced stigma
  - There was a choice of readily accessible resources available that met a range of needs and preferences

- In order to deliver these outcomes, an integrated, personalised and goal orientated care approach would need to be adopted in order to facilitate a life beyond diagnosis.
- The delivery of more interventions at the earliest possible stage in order to keep people well and supporting people with community based services when they do become un-well was also a key aspect of delivering the above outcomes.
- The need to respond quickly and to deliver high quality interventions and in-patient care was also highlighted to the Board, in order to provide effective support and ensure early discharge.
- A shift in the balance of resources to lower tiers of care was required so that people were supported in a variety of settings.

Julie Proudly, Manger for the Twining Enterprise service gave an overview of the individual placement support model to the board, as an example of a successful highly evidenced model of supporting people with severe mental illness into employment. The key points were:

- Delivery in Haringey started in July 2015
- The model involved the integration of employment specialists within health teams so that employment became part of the health package and part of the recovery package
- One employment specialist was integrated into the Early Intervention Services and one employment specialist was integrated into Recovery Enablement Track which was in the process of being set up.
- To date, 35 clients had been engaged in the process and 6 had been offered jobs.

- The process was based on 8 evidence-based principles including; a client-centred approach to get patients the jobs that they want, a paid work focus, ongoing in work support and employer engagement.
- A similar project was established in Barnet in January which had been successful and Twining Enterprise hoped to be a centre of excellence by March 2017.
- The process involved an integrated approach involving a partnership between statutory partners and the voluntary sector.

Ms. Shenker gave a further example of successful enablement model, the accommodation pathway, to the Board. The key points were:

- The model was driven by a significant number of delayed discharges from Mental Health in-patient beds.
- The partnership identified multiple challenges including:
  - Lack of joined up approaches to early assessment ensuring that housing needs were being addressed early on.
  - Confusion about the range of available accommodation options and approvals routes for health and social care funding.
  - No clear escalation routes for when blockages occurred.
  - No regular multi-agency forum for resolving these issues proactively.
- A multi-agency steering group was established across health, social care, housing and BEH to clarify the accommodation pathway for people with mental health needs.
- This included the roles and responsibilities of key agencies involved in a person's care, and a guide for care co-ordinators which was being trialled.
- The aim was to ensure effective and timely assessment, access to least restrictive housing options which maximised independence for people with mental health needs.
- The group was also developing an accommodation pathway dashboard to outcomes.

The Board was advised that key implications of adopting an enablement approach were:

- Harnessing the role of communities in offering support and linking this to the primary care offer to maximise well-being.
- A need to pump prime to allow time for preventative, primary care and strengthened community based mental health services to be piloted and be shown to work with intent to release resources from secondary care to fund longer term developments.
- Need to consider investment, capacity and skills in voluntary sector organisations.
- Consensus about management of clinical risk would be vital as patients were empowered to manage their own care.

	• Roles and responsibilities would need to be clarified • Patients lived in the community and interacted with others in a host of settings prior to presenting at mental health services and resources should be utilised across the system in order to keep people well. In support of the enablement approach, the Board were asked to: • Promote and support the whole system approach to developing and implementing integrated enablement service model • Advocate integrated commissioning approach based on the outcomes and co-production models • Hold the multiple stakeholders to account publicly to ensure a system wide response • Have oversight of risks to the programme and support risk mitigation • To monitor performance. Dr Jonathon Bindman, Medical Director of BEH Mental Health Trust (BEH MHT), provided an update to the Board on the enablement approach from a clinical perspective. • Dr. Bindman agreed with the enablement definition given in the presentation. • Dr. Bindman reiterated that where people received their care and how that clinical risk was managed was a crucial factor. • Significant improvements had been made in community mental care services but there were a number of cultural assumptions made around mental health that remained and were problematic: That mental health problems were lifelong; they were disabling and that those problems made it impossible for people to work or engage fully within the community. • The existing community mental health system managed some aspects of clinical care but didn't do enough across the whole spectrum of people's lives, hence the notion that enablement was about a life beyond diagnosis. • BEH MHT's official Enablement Programme launch was launched in 2015 and created a new vision for the organisation: *Live, Love, Do.* • Enablement was an important transformation programme for BEH MHT and required a transformation across the whole health economy. Dr Bindman advocated that it was key that the programme was led by commissioning and had buy-in from both service users and the third sector. • Dr. Bindman commented that a significantly higher percentage of people with severe mental illness who are on the Care Programme Approach could undertake meaningful activities and paid work, than the current levels of between 3-5%. The issue was that there were too many barriers that got in their way.	Board to note

- Dr Bindman advised that enablement within secondary care was not just limited to recovery for people with the most severe mental illness, instead for BEH MHT this meant changing their approach right from the point they presented to their services and across a range of diagnoses and problems.
- Dr Bindman outlined a number of enablement projects that were being taken by BEH MHT. The aim of the projects was to challenge people's expectations and assumptions right from the point they came into contact with services and then providing them with a different model for their recovery and their support into independence.
- The name of the front end of the enablement intervention pathway was being changed from triage to assessment service. It was at this initial stage that the enablement principles needed to be rolled out in order to counter some of the negative assumptions about mental disorders that people may be exposed to at this early stage.
- Dr Bindman advocated that the existing pathway could sometimes encourage dependence and created unhelpful patient expectations and that the enablement approach sought to change this.

Ms Etheridge commented that she was pleased to see how much progress had been made on enablement model and stated that it was interesting to hear some of the different projects that were being developed to facilitate some of the service users to live the enablement model. Ms Etheridge commented that behind this was funding from number of sources, which demonstrated the importance of bringing budgets together.

Ms Etheridge asked what types of barriers needed to be overcome as a system in order to make a whole systems approach a reality for of the service users. In response, Ms Shenker stated that the enablement approach was in the process of being implemented and that the CCG would be working with partners to look at a wider array of projects that would deliver the outcomes that they were looking for. As the implementation of these projects progressed and as the shift in resources continued, it would be at this stage that barriers would start to emerge. Ms Shenker elaborated that barriers would likely emerge: At the point where people had anxieties or concerns about clinical risk; if there was a failure to develop a co-production model with service users and at the point at which movement of resources was discussed.

Dr. Djuretic elaborated that all of the relevant bodies were required to work together in order to provide holistic support, and that whilst currently the different bodies talked to each other they still delivered services individually instead of as one package of care. This would require a big cultural shift and for increased community involvement.

Dr Bindman advised that there were a lot of barriers involved and that

	services users were heavily disadvantaged by changes to the welfare and benefits system. Dr Bindman further advised that any changes in the model and attempting to challenging dependence would be difficult and would take a lot of time and hard work to convince people of the advantages of this approach. The Board noted that there were also barriers in changes to the NHS work force and that this type of system transformation required a lot of changes to working practices, and in some cases would be contrary to some of the training that people had received. Maria Kane, Chief Executive BEH MHT, advised that a further challenge would be how the primary care system was supported to become part of the enablement approach, particular when taking in to account the existing pressures facing GP's. Ms Kane also commented that some discussion would be required as to how the funding regime would be developed, to potentially create longer contracts and how funding would need to shift from secondary care to lower tiers. Paul Leslie, Interim CEO HAVCO, commended the proposals. Mr Leslie also enquired as to what the training and communication processes were for voluntary sector organisations, and asked how some of those gaps would be filled. Dr Djuretic responded that the enablement approach would be taken to the voluntary sector forum on the 5th October to begin a dialogue on the role of the voluntary sector, and to establish what capacity there was within the community and where the gaps were. The Board agreed to further consider its role in how it would contribute to the delivery of a whole system approach. The chair thanked those present for their contributions. **RESOLVED:** I). That the progress to date of the enablement approach be noted.	Board
CNCL110.	**DISCUSSION ITEM** **HEATH AND WELLBEING STRATEGY – AMBITION 7: MORE CHILDREN AND YOUNG PEOPLE WILL HAVE GOOD MENTAL HEALTH AND WELLBEING** A Presentation was circulated as part of the agenda pack. Catherine Swaile, Vulnerable Children's Joint Commissioning Manager, gave the presentation to the Board on the review of Haringey Children's and Adolescent Mental Health Services (CAMHS). Following the presentation the Board discussed the findings. Some of the key points raised in the presentation were:	

- The review was linked to Ambition 7 of the Health and Wellbeing Strategy, more children and young people will have good mental health and wellbeing. The performance measure for this ambition was based on a survey that was being developed for school children, based on the Warwick-Edinburgh wellbeing score for children and young people. As the process was not finalised, a target had not yet been set for this ambition
- The Department of Health published a report earlier this year called Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. The report identified participation and collaboration as a core principle, promoting services designed in collaboration with children, young people and families to meet their needs. The report also contained 49 proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs
- Haringey's allocation of the £280m Transformation fund for CAMHS announced in the Autumn Budget was £515,302, recurrent for 5 years.
- CAMHS Review Project Board were leading the review of Haringey CAMHS, comprising representatives from the CCG, the Council, NHSE, CSU and Healthwatch. The process involved an engagement event for over 50 people in March and a follow up event was booked for 18th September to feedback on the review outcomes and to develop a transformation plan. Themed workshops were held on Looked after Children, Children with Learning Disabilities/ASD and Crisis.
- In addition, online surveys were conducted with feedback from 152 stakeholders including both children and young people and parents.
- Participation in the review was received from all providers to ascertain what the issues were in mental health and to see what improvements could be made.
- The latest estimated prevalence data showed that low level universal support was required by around 9000 children or young people in Haringey. No data was available for the numbers or Haringey's commissioned activity.
- Ms Swaile identified a significant gap at the next tier of support up, where a mental health professional was working with a family (but not as part of a multi disciplinary team) where Haringey commissioned around 300 services across health and social care but would expect about 4000 people requiring a response.
- Haringey's commissioned activity was around 1200 cases for multi- disciplinary specialist care services, against an estimated 1150 cases. Ms Swaile commented that this suggested an escalation of cases because need was not being met at the tier below.
- The number of cases at tier 4, which was classified as highly specialist inpatient services, was below what the estimated

prevalence data would suggest with 17 cases against an estimate of around 50.

- Feedback was positive in terms of the quality of service. Feedback also indicated that improvements needed to be made in; crisis management, availability of choice, waiting times, inter-agency working, Looked After Children services IT infrastructure and concerns were raised about inadequate safeguarding training.

The Board noted that transformation plans needed to be submitted on 16th October and that these would require Chair sign-off. The transformation plans would be based on the outcomes of CAMHS review.

Catherine Swaile / Chair

Jon Abbey, the Director of Children's Services raised a query regarding the future model and transformation, requesting some further detail on the future operating model and where the prevalence scores suggested in the presentation might fit in with Early Help and schools. The Director of Children's Services also commented that the presentation highlighted the difficult transition for 16-18 year olds and raised concerns with the fragility of the workforce in regards to safeguarding training.

Ms Swaile responded that one of the key conclusions of the review were that there was a lack of support at tier 2, a lot of which could be developed in conjunction with schools, and that this required much more coherence in terms of planning. A further key conclusion identified by the review was that the lengths of interventions in CAHMS were longer than the national average. The concern therefore, was that dependencies were being built and the challenge was to ensure that people were getting useful interventions at the right time and that people were not being held in services. The Board noted that transition became difficult when children were held in services inappropriately, because they didn't meet the threshold for adult mental health services but discharge was equally unsuitable.

Sir Paul Ennals, Chair of Haringey LCSB, commended the presentation and commented that there were close links to the enablement model. Sir Paul agreed that the key concern seemed to be strengthening the links at tier 2 and identifying what the evidence showed were the key interventions that could reduce the flow of children and young people up into tier 3. Sir Paul added that in terms of the enablement model, there was evidence to suggest that intervening at the time of initial attachment was the most cost effective time of intervening and the most effective way of reducing the later flow of needs.

Ms Swaile agreed that developing a proper attachment pathway was key and was one of the main areas that had been identified to be taken forward. A lot of work already took place on working on attachment with families but it wasn't coordinated. The Board was advised that there

	was a high level of provision in Haringey, CAHMS spending was appropriate and a number of successful outcomes were achieved. The main issues revolved around coherence of planning and alignment. Sir Paul added that there were other conclusions to be drawn around the enablement link; namely more powerful use of the voluntary sector from within the community and shifting the focus of front line delivery away from highly trained mental health professionals to other providers who were much closer to home. There were a number of models within the voluntary sector that should be reviewed and considered. Mr Wilson advised that the wider report that the CAHMS presentation was drawn from contained some equalities issues that were not reflected in the presentation. The equalities issue related to the number of referrals in the central and south east being lower than the west. Mr Wilson recommended that these issues needed to be flagged up as part of this work. Ms Swaile acknowledged the discrepancies outlined and suggested a possible correlation with lower referral rates for Black African and Black British African demographics and suggested that targeting certain areas with high proportions of certain communities may improve the referral rates. Ms Swaile advised that further work would need to be undertaken to look into this issue. Sir Paul queried what the Board was being asked to do in relation to this paper. Ms Swaile responded that the paper was for information purposes and to update the Board on current progress. Ms Swaile stated that she would like to bring the more detailed transformation plan Back to the Board for approval prior to its publication on the Council and CCG website in November. Dr de Gruchy advised that the next meeting of the Board would fall too late to bring a subsequent paper back to board and reiterated that the purpose of this item was so that the Board could have a conversation about the review of CAMHS, particularly prior to it going to public consultation. The Board agreed that any comments would have to be fed back outside of the Board on an individual basis to Catherine Swaile. It was noted that the timescales for the review were nationally driven with the planning guidance issued in August and a final submission deadline of October. The Chair thanked those present for their contributions.	Catherine Swaile Board
CNCL111.	**BUSINESS ITEM** **PRIORITY 2 GOVERNANCE ARRANGEMENTS** A report on the governance arrangements for Priority 2 of the Corporate Plan was included in the agenda pack. Charlotte Pomery, Assistant Director of Commissioning, presented the report to the Board. The Council established governance arrangements to oversee delivery	

of each of the five priorities in the Council's Corporate Plan. The current arrangements consisted of internal boards focusing on delivery of both the outcomes in the Corporate Plan and the budget reductions required in the Medium Term Financial Strategy. The Healthy Lives Board was set up to focus on delivery of the second priority of the Corporate Plan: Empower all adults to live healthy, long and fulfilling lives with control over what was important to them.

In order to foster and enable the whole systems and collaborative working needed to deliver the Corporate Plan, the establishment of a partnership Outcome Board for each priority had been proposed. The paper set out the background to this requirement and requested that the Health and Wellbeing Board be ratified to take on this function for Priority 2, working across Haringey's health and social care system.

Dr Jeanelle de Gruchy, Director of Public Health requested more information around the Board's role in Priority 1 of the Corporate Plan: Enable every child and young person to have the best start in life, with high quality education. In response, Ms Pomery agreed that there was a significant synergy across health and wellbeing for both adults and children as shown by the CAMHS review. Ms Pomery advised that there was a proposal to establish a separate partnership Outcomes Board for Priority 1. The Board noted that there would need to be discussions on how the two partnership Outcomes Boards linked together in order to ensure that there were no gaps between the two priorities.

RESOLVED:

I). That the Health and Wellbeing Board, within the context of its functions, be ratified as the external Outcomes Board to oversee the delivery of Priority 2 of the Corporate Plan.

NNS 111 AND GP OUT-OF-HOURS PROCUREMENT UPDATE

A report on the NHS 111 service and the GP Out-of-Hours Procurement update was included in the agenda pack. Jill Shattock, Director of Commissioning – Haringey CCG, presented the report to the Board.

The Board noted that Haringey CCG was working with the other four CCGs in north central London (Barnet, Camden, Enfield, and Islington) to bring together the NHS 111 service and the GP out-of-hours service to enable them to work better together.

The CCG held a number of events over the preceding 8 months and received feedback from a wide range of members of the local community on the 111/OOH procurement proposals. The evidence gathered, including clinical evidence, showed that bringing the two services together across the five boroughs would meet local need for

	the service and provide a sustainable service. The procurement process was due to begin from 2nd October **RESOLVED:** I). That the report be noted.	
CNCL112.	**NEW ITEMS OF URGENT BUSINESS** No new items of Urgent Business were tabled.	
CNCL113.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** It was noted that the date of the next meeting was 24th November at 18:00. The following agenda items were agreed for the next meeting: • LSCB Annual Report. • Remaining performance measures for Health & Wellbeing Strategy (From June HWB) The Board agreed that future reports should more clearly define what was being asked of the Board in the recommendations and to ensure that a covering report was included in the agenda pack. Cllr Morton observed that keeping future agendas tight and to as few agenda items as possible in order to review those items in detail seemed to work well and also agreed that focusing items on the ambitions in the Health and Wellbeing Strategy was useful. Cllr Morton suggested that the issue was maintaining the correct balance between accountability and policy making. The Deputy Chief Executive commented that there were a number of areas were the Board had to make a decision due to the powers vested in it, such as approving the Pharmaceutical Needs Assessment. The Deputy Chief Executive suggested that the discussion items on future agendas should focus on what the barriers were to the system delivering the changes required. Sir Paul Ennals endorsed this approach. The Board agreed to keep the main format of future meetings to one or two strategic discussions, based on the ambitions of the HWB Strategy. The Board also agreed with tightening agendas and keeping the amount of time dedicated to	Clerk Clerk Jeanelle de Gruchy / Sarah Price Jeanelle de Gruchy / Sarah Price

	presentations shorter in order to facilitate more discussion time. Stephen Lawrence-Orumwense to be invited to future Health and Wellbeing agenda setting meetings. The Board agreed to a start time of 18:00 for future meetings of the Board.	Jeanelle de Gruchy / Clerk

The meeting closed at 20.55pm.

Cllr Claire Kober

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Chair of the Health and Wellbeing Board