Health and Wellbeing Board

THURSDAY, 24TH SEPTEMBER, 2015 at 7.00 pm- COMMITTEE ROOMS 1&2, CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE

MEMBERS: SEE ATTACHED

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

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

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 10).

5. DECLARATIONS OF INTEREST

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

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

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

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

6. QUESTIONS, DEPUTATIONS, PETITIONS

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

7. MINUTES (PAGES 3 - 14)

To consider and agree the minutes of the meeting of the Board held on 23 June 2015.

8. DISCUSSION ITEMS: (PAGES 15 - 44)

1. Health and Wellbeing Strategy - Ambition 9: People with Severe Mental Health Needs Living Well in the Community

2. Health and Wellbeing Strategy - Ambition 7: More Children and Young People will have Good Mental Health and Wellbeing

3. Update on GP Provision in Tottenham Hale - Health and Wellbeing Strategy - Ambition 5: People Can Access the Right Care at the Right Time

9. BUSINESS ITEMS: (PAGES 45 - 60)

1. Priority 2 Governance Arrangements

2. NHS 111 and GP Out-of-Hours Procurement Update

10. NEW ITEMS OF URGENT BUSINESS

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

11. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

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

The dates of future meetings are as follows:

- 24th November, 18:00 – 20:00
- 23rd February, 18:00 – 20:00

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Wednesday, 16 September 2015

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	*Leader of the Council	Cllr Claire Kober
			*Cabinet Member for Children and Young People	Cllr Ann Waters
			*Cabinet Member for Health and Wellbeing	Cllr Peter Morton
	Officers' Representatives	3	Acting Director of Adult Social Services	Beverly Tarka
			Interim Director of Children's Services	Jon Abbey
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	*Chair	Dr Sherry Tang
			Vice Chair	Dr Dina Dhorajiwala
			Chief Officer	Sarah Price
			*Lay Member (confirmed as voting member by Full Council 23/02/15)	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	CEO	Paul Leslie
Haringey Local Safeguarding Board		1	Chair	Sir Paul Ennals

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Agenda Item 7

MINUTES OF THE HEALTH AND WELLBEING BOARD
WEDNESDAY 23 JUNE 2015

Board Members Present: Councillor Peter Morton (Cabinet Member for Health and Wellbeing) Councillor Claire Kober (Leader of the Council - Chair), Dr Jeanelle de Gruchy (Director of Public Health), Sharon Grant (Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Sarah Price (Chief Operating Officer, Haringey CCG), Dr Dina Dhorajiwala (Vice Chair Haringey CCG), Gill Gibson (substitute for Jon Abbey - Interim Director of Children's Services) Gill Hawken (HAVCO Interim Joint CEO / Management Consultant) , and Cllr Ann Waters (Cabinet Member for Children, LBOH).

Officers Present: Zina Etheridge (Deputy Chief Executive LBOH), Philip Slawther (Principal Committee Coordinator LBOH), Stephen Lawrence-Orumwense (Assistant Head of Legal Services), Cassie Williams (Assistant Director of Primary Care Quality and Development – Haringey CCG), Jonathan Weaver (NHS England).

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: • Sir Paul Ennals - Chair of Haringey LSCB • Beverley Tarka - Interim Director Adult Social Care • Jon Abbey - Interim Director of Children's Services (Gill Gibson attended as substitute). • Dr Sherry Tang and Cllr Waters noted that they needed to leave the meeting early.	
CNCL103.	**URGENT BUSINESS** None.	
CNCL104.	**DECLARATIONS OF INTEREST** Cathy Herman, Lay member; Haringey CCG, advised the Board that she was chairing the Primary Care Co-commissioning Committee across North Central London. Haringey was identified as part of that group. Dr. Dina Dhorajiwala, Vice Chair Haringey CCG, notified the Board that	

	she was a GP provider at the Vale practice in Crouch End.	
CNCL105.	**QUESTIONS, DEPUTATIONS, PETITIONS** No Questions, Deputations or Petitions were tabled.	
CNCL106.	**MINUTES** **RESOLVED:** That the minutes of the meeting held on 24th March 2015 be confirmed as a correct record.	
CNCL107.	**PRIMARY CARE UPDATE** The Board received a presentation, from Jonathan Weaver, NHS England, and Cassie Williams, Assistant Director of Primary Care Quality & Development which gave an overview of key developments relating to the development of additional Primary Care capacity, particularly in Tottenham. Following the presentation the Board discussed the findings. A copy of the draft Strategic Premises Development Plan was included in the agenda pack; the Board noted some of the key issues raised by that report. The current progress to date was summarised as: • The baseline for Haringey primary care locations and their conditions were identified. • Growth areas were identified. • Capacity plan had been undertaken in key areas of focus across predominately the east of Haringey. • The Board was requested to give comments on the draft report prior to its submission to July FIPA (NHSE financial planning committee) for NHS England endorsement. The main conclusions of the report were noted as: • Haringey was identified as having a poor primary care estate – 79% of the premises were identified as being red or amber rated for non-statutory compliance. • Haringey population predicted to increase by 37k by 2026 • All of Haringey wards fall in top half of deprived wards nationally, and 8 were in the top 500. • GP practice capacity pressures identified in east of borough. (particularly around Tottenham Hale) • Many residents c.28,500 (10.5%) in Haringey were registered with a practice outside of the borough. • No evidence of a significant number of unregistered residents	

- The need to plan for retiring GPs was identified as a key consideration, particularly in terms of the potential for existing capacity issues to be exacerbated.

The key recommendations of the draft Strategic Premises Development Plan were outlined as:

- Pursuing with Primary Care Infrastructure Fund (PCIF) applications.
- Appetite to absorb current capacity issues to be determined through dialogue with GPs.
- New Primary Healthcare facilities needed to be established. The Board noted that this would be a medium to long term solution to capacity issues. Mr. Weaver commented that new primary healthcare facilities would need to be built with a view to co-location with other services and linked into planning cycles with housing developments.

Mr. Weaver advised the Board that the draft Strategic Premises Development Plan identified that, with expected population growth levels over the next 10-15 years including the current deficit, an additional primary care capacity for 70k people could be required as a worst case scenario. This translated into 39 additional doctors (Whole Time Equivalents) and 7,842 square metres of additional consulting capacity.

The following short term responses from NHS England to the recommendations from the Draft Strategic Premises Development Plan, were noted:

- A temporary new surgery in Tottenham Hale established by autumn.
- Existing surgery premises improved, based on PCIF Bids incl. increasing consulting room capacity.
- Practices encouraged to bid for next round of PCIF & for 2015/16 Improvement Grants for existing surgery premises based on PCIF Bids.

In addition, by 31st March 2016:

- GP succession plans developed.
- Focus on existing GP contract performance.
- Schemes explored to facilitate more efficient operational use of existing GP premises.

Proposals for the medium / long term primary healthcare needs of Haringey were identified as:

- Permanent new health facility in Tottenham Hale established (3-5 years).
- Permanent new health facilities established in other strategic locations in Haringey (3–10 years), this was yet to be determined. Suggested locations for additional sites were noted

as:

- A second site in Tottenham Hale
- A site in Noel Park area
- A site in Northumberland Park Area

- Each individual premises development would be required to develop a business case and further detailed analysis prior to agreement from NHS England. Mr Weaver noted that the approval of the draft Strategic Premises Development Plan by FIPA in July would expedite the process for approval of the business case for the above sites by an estimated 3-6 months.

The Chair invited the Board to focus questions around the specific issue of primary care capacity around Tottenham Hale first. The following questions and responses were noted.

Sharon Grant, Chair of Healthwatch Haringey, commented that she had concerns that delays could occur to securing the practice that would operate the temporary additional premise and requested reassurances that additional primary care capacity would be implemented quickly and would not be held up by a lengthy procurement process. Mr Weaver responded that NHS England was fairly confident that they could secure the additional practice. Mr Weaver also stated that NHS England were working as hard as they could to adopt an innovative approach to try and find a route that would put a facility onsite as soon as possible, and that the facility would include additional GP capacity.

The Board noted that the autumn timescale was based on a realistic assessment of the process and the steps required in establishing the practice. The Chair, Cllr Kober, welcomed the commitment from NHS England to find an innovative solution to the problem in the Tottenham Hale area, but reiterated the scale of the issue that existed in Tottenham Hale and reaffirmed the need to deliver the additional capacity as quickly as possible.

Cllr Kober commented that the process had highlighted the difficulties that existed in terms of being able to augment significant changes and requested reassurances that the borough would not be subject to similar circumstances in the future, whereby it was only at the point where residents have had to suffer significant shortfalls in service that remedial action was undertaken. Mr. Weaver responded that he had met with local residents and understood the sense of urgency involved, Mr. Weaver committed to get the additional facility up and running as soon as possible. The Board noted that, going forward, the challenge was to ensure that the Strategic Premises Development Plan was kept up to date and was maintained as a live document, so that the Board could use it to access funding and opportunities when they became available.

Cllr Morton, the Cabinet Member for Health & Wellbeing, thanked the contributors for the work that had been undertaken in the past months. Cllr Morton reiterated the concerns raised by the Chair and Ms. Grant that the situation as it existed in Tottenham Hale was wholly unacceptable and welcomed the evidence compiled and the progress made to rectify the primary care deficit.

Cllr Reith welcomed the body of evidence that had been compiled, but commented that the issues were raised by residents a year ago, supported by Healthwatch Haringey, and questioned why work couldn't have begun a year ago in parallel to the evidence gathering process. Cllr Reith requested a commitment from NHS England to work in parallel going forward to prevent further delays. Mr Weaver acknowledged Cllr Reith's concerns and commented that the proposals included a back stop date for those parallel pieces of work, noting that that this was however reliant upon working with partners. Mr. Weaver advised that the next meeting of the primary care task and finish group would involve going through and agreeing the timetable for delivery of all of the specific pieces of work contained in the draft Strategic Premises Development Plan.

Ms. Herman enquired as to how NHS England would prevent similar issues happening again in the future, particularly around a perceived lack of adequate forward planning. Ms. Herman sought assurance that the Strategic Premises Development Plan would be kept as a live document and asked how the Board could ensure that it was updated and was something that people would take notice of. Mr. Weaver commented that the process of NHS commissioning was constantly changing and that more changes to primary care commissioning were in progress. The Board noted that a key challenge was to manage the transition in responsibility for commissioning primary care from NHS England to the CCG and to ensure that the different organisations maintained a forward facing view. Mr. Weaver commented that the draft Strategic Premises Development Plan provided the basis to move forward on the issue and that the Board would hopefully provide additional impetus to ensure that the document did not fall out of date.

Ms. Williams advised that from a CCG perspective, premises were one of the key priorities within NCL and that discussions were already underway about how to ensure that the document was kept live and how the CCG could use the information to ensure that sufficient forward planning was undertaken.

Zina Etheridge, the Deputy Chief Executive, advised that parallels existed with the process of school place planning, where the Council looked at changes in demand and a series of other key considerations on an annual basis. A set of principles were used and the Council's attitude was that despite legislative changes having affected the powers available to the Council, that the Council still maintained a leadership

	role of understanding what the overall needs of its residents were. Ms. Etheridge suggested that the Board may want to consider an annual process of bringing the Strategic Premises Development Plan back to the Health and Wellbeing Board for review. Dr. Dhorajiwala echoed previous comments welcoming the development of the Strategic Premises Development Plan. Dr. Dhorajiwala asked how it might tie in with the theme of the emerging community education provider networks. Dr. Dhorajiwala also asked how training practices such as the Vale, could feed into this work. Mr. Weaver noted that in addition to the task and finish group, a collaborative approach was required from all partners. Mr. Weaver welcomed other groups, such as local GP practices, being brought in who could provide solutions to issues such as training, utilisation of buildings and recruitment and retention of practices. Ms. Grant supported Ms. Etheridge's suggestion of holding an annual review of planning for general practices in the area. Ms. Grant suggested the Board would want a report back every quarter to monitor progress and ensure the document was live, at least until some of the shorter term issues had been resolved. Cllr Kober responded that a further primary care update would be on the next agenda, including the status of a new temporary practice in the Tottenham Hale area. Cllr Kober commented that the Board should have a discussion on the monitoring arrangements for primary care at the next meeting, once the new temporary provision was in place. Ms. Grant commented that there was a discrepancy between the report coversheet and the body of the report in the agenda pack, around the working time equivalent projected levels of GP's required in the Tottenham Hale area with 10.4 and 16 quoted respectively. Mr Weaver agreed to look into the discrepancy and feed back to the Board. Cllr Morton noted that the report described the NHS England's four stage approval process for construction, refurbishment and capital project activity and requested clarification on this process. Mr. Weaver responded that the process normally started with a PID, which was then expanded into an outline business case and then a full business case. The final stage was a sign off process by NHS England. Each stage then went through a 'pipeline' governance body before going to FIPA (financial planning committee). The Board noted that the Strategic Premises Development Plan document should help shorten the process in this instance. Ms. Herman queried how the Board ensured a strategic view in the longer term was built into this commissioning work. Mr Weaver acknowledged the need for a strategic view and reiterated the need for NHS England to work with its CCG partners. Mr. Weaver noted the example of co-location of non-primary care premises with the CCG as well as the long term strategic possibilities of co-locating with Council	Jeanelle De Gruchy /Zina Etheridge. Clerk Jonathan Weaver - NHSE

	services. The Chair thanked colleagues from NHS England for their contributions. **RESOLVED:** I). That the content of the plan be noted, and the recommendations for the plan for substantial improvement and development of the primary health care estate in Haringey over the next 10 years, be agreed in principle.	
CNCL108.	**HEALTH & WELLBEING STRATEGY** A report was circulated as part of the agenda pack. Dr Jeanelle de Gruchy, Director of Public Health, gave a presentation to the Board on the draft Health and Wellbeing Strategy, which incorporated revisions made following the public consultation that concluded in March. Following the presentation, the Board discussed the presentation and agreed a number of performance measures for the strategy. The Board noted that the purpose of the strategy was to enable: • All partners to be clear about our agreed priorities for the next three years. • Priorities to be embedded by all members of HWB within their own organisations and ensure that these were reflected in their commissioning and delivery plans. • Joined-up commissioning and delivery plans to be developed by key agencies to address these priorities. • Member organisations held to account by the HWB for their actions towards achieving the priorities within the strategy. • Members of the HWB to work with and influence partner organisations outside the HWB to contribute to the priorities and the approaches for working agreed within this strategy; this included residents engaged in co-producing solutions. The Board noted that strategy focused on three key priority areas: • Reducing obesity. • Increasing healthy life expectancy. • Improving mental health and wellbeing. Dr. de Gruchy proposed that the Strategy had nine ambitions to be delivered within the three key areas. The nine ambitions were: • Fewer children and young people will be overweight or obese	

- More adults will be physically active
- Every resident enjoys long lasting good health
- Haringey is a healthy place to live
- People can access the right care at the right time
- More people will do more to look after themselves
- More adults will have good mental health and wellbeing
- More children and young people will have good mental health and wellbeing
- People with severe mental health needs live well in the community

The Board was asked to agree the performance measures and the level of the ambitions for the Health and Wellbeing Strategy.

The Board agreed to work towards a 35% target for childhood obesity at Year 6 by 2018, in line with the England average. A 35% target equated to a 2% year on year decrease. Gill Hawken, HAVCO Interim Joint CEO / Management Consultant commented that targeting parents, possibly through a programme of evidence based parenting activities, was required. Dr. de Gruchy responded that a number of intervention programmes were in place, starting with breastfeeding, but the challenge was how to affect change at scale.

Ms. Etheridge commented that the Board may wish to set an ambition that reflected the aim of reducing childhood obesity without specifically saying by how much to prevent setting a level of specifity and targeting that may not be achieved. Ms. Herman advocated a less specific measure such as, agreeing to match the England average, as this was more likely to be relevant to local residents. Sarah Price, Chief Operating Officer of Haringey CCG, commented that obesity figures would be very different across different parts of the borough and suggested that the Board should ensure that the ambition didn't incentivise a greater disparity between those with higher levels and obesity and those with lower levels. The Board agreed that the target would include an equalities check, to monitor discrepancies around deprivation levels (by ward) and ethnicity factors. Jeanelle de Gruchy

The Board agreed to set a target of 25% for the proportion of adults participating in less than 30 minutes of physical activity per week. Dr. de Gruchy advised that reducing inactivity levels would produce the largest health improvement gain (as opposed to increasing activity levels in those who were already active).

The Board agreed to set a target of being in the London top quartile by 2018, for proportion of people who travel by walking and bicycle in London where trip origin is in Haringey. Dr. de Gruchy commented that

	the current percentage of people to travel to work via cycling was 3% and walking was 37%. The Board agreed a 25% reduction in the current (2011-13) mortality rate (22.5 per 100,000) to 16.9 deaths per 100,000 (2016-2018), for the rate of early death from stroke. The Board noted that this target was in line with what was in the Corporate Plan. Dr. de Gruchy advised that this was an ambitious but doable target that required all of the determining health factors, such as smoking and high levels of alcohol consumption, being tackled as part of a wider approach. The management of underlying conditions such as hypertension and diabetes will also play a significant role in improving performance around this indicator. Regarding, the proportion of patients able to get a GP appointment to see or speak to someone, Cllr Morton advocated setting an ambitious target as a statement of intent. Ms. Grant requested the inclusion of equalities targets to offset the likely unequal distribution across different equalities groups. Ms. Price agreed that a collaborative level target should feasible, with the aim of reducing the gap between different collaboratives. The Board agreed to set an 83% target, in line with the projected England average, for the proportion of patients able to get a GP appointment to see or speak to someone. The Board also agreed in principle to also have a collaborative level target. Chief Operating Officer, Haringey CCG & Director of Public Health agreed to look into the possibility of having an individual target in each ward area not just as an overall target, to safeguard against the persistence of an underlying level of equality. The Board agreed to set a target of 59%, in line with Better Care Fund target, for the percentage of people with a long-term condition who reported that in the last 6 months, they have had enough support from local services/organisations to help manage their long-term conditions. The Board noted that a residents' survey using the Warwick-Edinburgh wellbeing scale would be used to measure the number of adults who have good mental health and wellbeing. Whilst a school's survey using questions drawn from a set of well developed and tested questions created by the Schools Health Education Unit (SHEU), would be used to measure the number children and young people who have good mental health and wellbeing. The Board agreed to defer the setting of a target for these two ambitions until the results of a local survey commissioned to establish a baseline was available. The Director of	Jeanelle de Gruchy/ Sarah Price

	Public Health agreed to bring the baseline information back to a subsequent meeting of the Board to agree targets for 2018.	Jeanelle de Gruchy
	Ms. Price advised that mental health issues in children can emerge at quite a young age and proposed using some of the existing work that was potentially being done in schools around wellbeing as a proxy to the SHEU survey. Dr. de Gruchy commented that Sir Paul Ennals had made a similar point and he had suggested using early years foundation status (EYFS). The Board noted that the issue with this proposal was that EYFS was being discontinued as a statutory measure and that going forward, the measure would be optional for schools.	
	The Board agreed that the ninth ambition would be people with severe mental health needs live well in the community. The Board agreed the measure of: The number of people receiving co-ordinated care for their mental health condition who were in employment or settled accommodation. The board opted for this indicator instead of the number of people sectioned under Mental Health Act section 136 as the numbers of people sectioned would be very low. Ms. Price commented that an indicator that monitored serious mental health conditions, such as the number of psychotic episodes, may also be required going forward.	
	Ms. Grant reiterated Sir Paul Ennals' comments from the previous meeting of the Board around the need to have a single central strategy that bound all of the other Health and Wellbeing strategies together and drove improvement. Ms. Grant agreed that the Health and Wellbeing Strategy was that central strategy. Ms. Grant proposed that there should be a Health and Wellbeing comment on every report that the Council and CCG produced as standard, to ensure the proposals and any implications were aligned to the Health and Wellbeing Board. The Board agreed to review the possibility further and bring an item back to a subsequent agenda for further discussion.	Jeanelle de Gruchy/ Sarah Price / Clerk
	Stephen Lawrence-Orumwense, Assistant Head of Legal Services, proposed a minor agreement to the Health and Wellbeing Strategy. The Board agreed to remove the sentence "It has a general duty to promote the individual wellbeing of all local residents (Care Act 2014)" from draft strategy, at page 180 of the agenda pack, as this was a duty of the Council as a whole.	Jeanelle de Gruchy
	The Board agreed the Health and Wellbeing Strategy and also formally agreed the establishment of the Haringey Obesity Alliance. The Director of Public Health agreed to circulate an updated report, along with a summary version and big print version to the Board in due course.	Jeanelle de Gruchy

	It was: **RESOLVED:** I). That the responses to the consultation on the draft Joint Health and Wellbeing Strategy were considered; II). That the final version of the Health and Wellbeing Strategy was agreed, as per Appendix 1 of the agenda pack; III). The Board formally established the Haringey Obesity Alliance; IV). The Board agreed targets for the nine Health and Wellbeing Strategy ambitions (where possible).	
CNCL110.	**HEALTH & CARE INTEGRATION** The Board received a verbal update from Ms. Etheridge on Health and Care Integration programme. The Board noted that the programme was divided into three overall themes; adults, children and mental health & wellbeing. Under the adults theme there were 19 projects running which were divided into four sub-themes. Ms. Etheridge commented that a very successful launch event for the Better Care Fund took place recently. The Board noted that there was also a significant amount of work underway on the children's theme, including support for childrens special educational needs and disabilities and a series of pieces of work looking at childrens paediatrics. In relation to the mental health and wellbeing framework, a number of projects were being progressed. In particular, a mental health and wellbeing framework strategy was being developed along with a number of action plans that sat below it. A number of pieces of work around enablement were also being progressed.	
CNCL111.	**URGENT ACTIONS TAKEN IN BETWEEN MEETINGS.** The Board noted the record of Urgent Action taken following the previous meeting regarding the Better Care Fund.	
CNCL112.	**NEW ITEMS OF URGENT BUSINESS** No new items of urgent business were tabled.	
CNCL113.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS**	

MINUTES OF THE HEALTH AND WELLBEING BOARD
WEDNESDAY 23 JUNE 2015

	It was noted that the date of the next meeting was 24th September at 19:00 The following agenda items were agreed for the next meeting: • Primary Care Update – Including a discussion on the monitoring arrangements going forward. Remaining performance measures for Health & Wellbeing Strategy to be discussed at November meeting of HWB	Clerk

The meeting closed at 20.00pm.

COUNCILLOR CLAIRE KOBER

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Chair

Haringey Council

NHS
Haringey
Clinical Commissioning Group

Mental Health and Wellbeing: Progress update

Health and Wellbeing Board

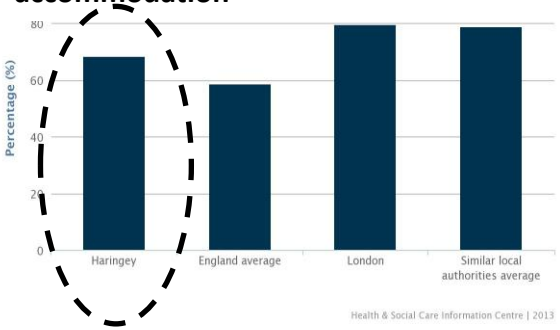
24th September 2015

Agenda Item 8

Ambition 9: People with severe mental health needs live well in the community - 2015 baseline

Stable accommodation for lower than London and similar local authorities (76.8%)

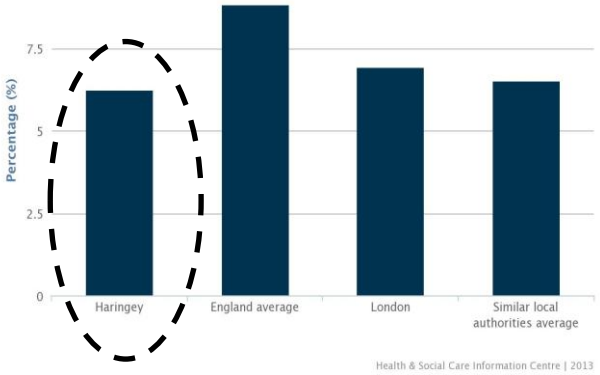
% of adults in contact with secondary mental health services in stable accommodation



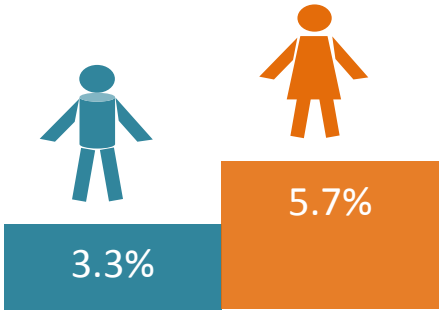
Paid employment lower than all London, England and similar local authorities (5.1%)

Source: ASCOF, 2014/15

Adults secondary mental health services in paid employment

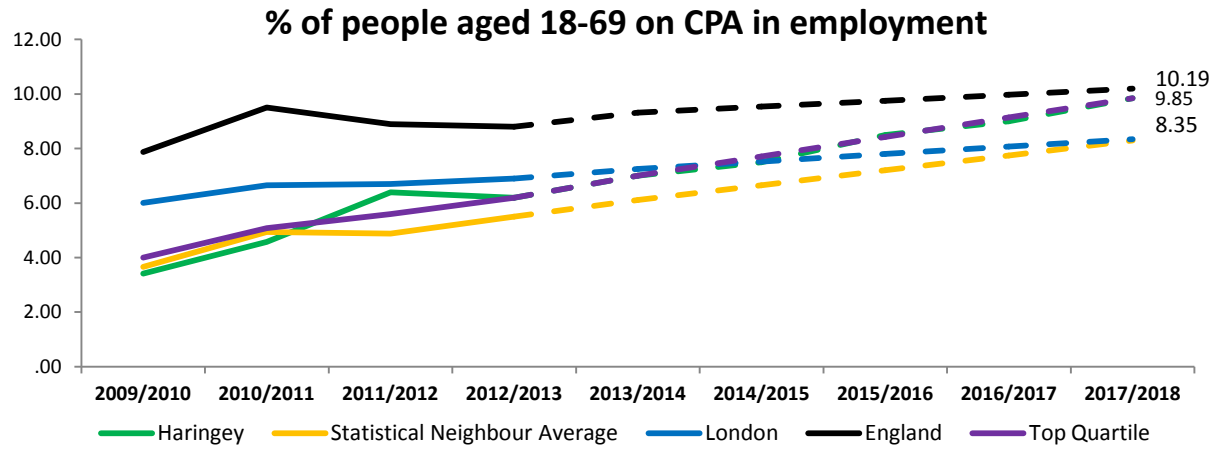


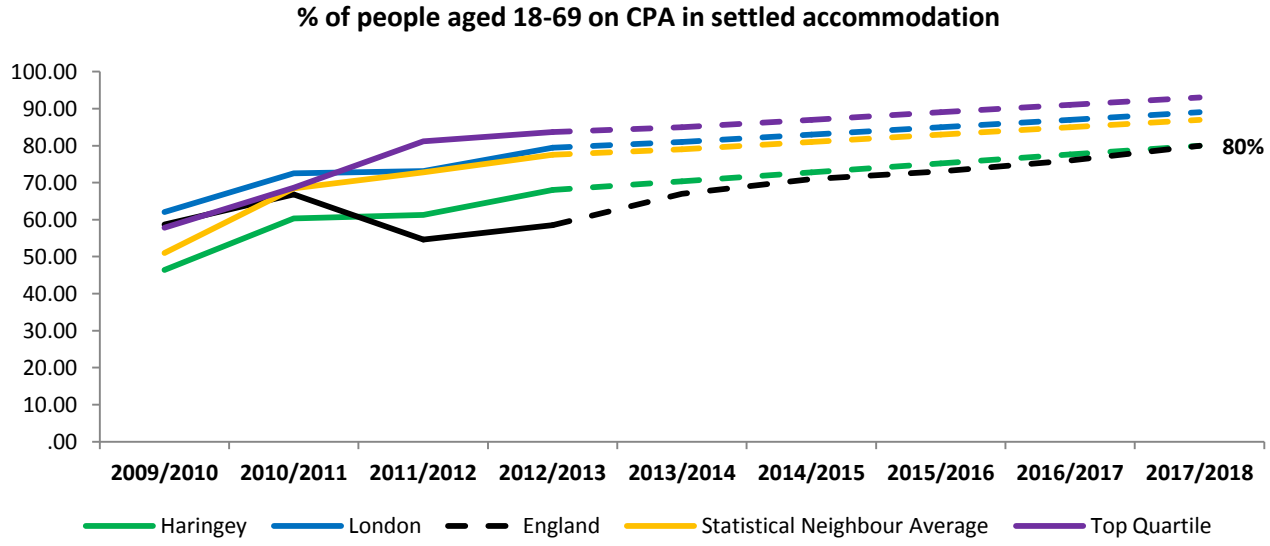
Low employment rates for both for men and women



Source: ASCOF, 2013

Ambition 9: People with severe mental health needs live well in the community – 2018 target





Increase in the % of adults receiving co-ordinated care (CPA) who are in employment (to 9.85%) and settled accommodation (to 80%)

Haringey Mental Health Framework- Overview

- Joint CCG and LBH MH and Wellbeing Framework published March 2015 following extensive engagement and consultation;
- Contained four priorities, each with a high level delivery plan and fed into HWB Strategy refresh – Priority 3 (Ambition 7, 8 and 9);
- This presentation focuses on Ambition 9 - Enablement
- Update on Children and Young People Mental Health and Wellbeing will follow in the next agenda item.

Definition of enablement

Our definition of enablement was set out 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."

Evidence on what works?

Commissioning approach

- VBC,[1] Co-production,[2] Focus on early prevention/intervention and building voluntary sector capacity

Effective service models

- IMROC
- Psychiatric liaison services[4]
- Hub models in primary care[5]

Effective interventions

- Individual Placement Support[6]
- Supported accommodation [7]
- Peer support workers
- Smoking cessation and Smoke Free MHT

1. Joint Commissioning Panel for mental Health, 2014: Guidance foor implementing VBC in mental health
2. Slay, J. & Stephens, L. (2013). *Co-production in mental health: A literature review.*
3. London: new economics foundation3. JCPMH Guidance for commissioners of rehabilitation services for people with complex mental health needs
4. LSE: RAID Model, 2010
5. London Strategic Clinical Network: A commissioner's guide to primary care mental health. July 2014
6. Sainsbury Centre for Mental Health (2009c) commissioning what works: The economic and financial case for supported employment.
7. Crisis UK and University of York: Staircases, elevators and cycles of change, 2010

Principles of enablement

- Working with individuals to be as independent as possible
- Supporting people to make their own choices
- Helping people to develop their own skills in daily living
- Being flexible with people to meet their needs
- Offering a solution focused approach in order to achieve identified goals
- Developing strategies to overcome obstacles in people's lives
- Increasing self-esteem and confidence

Proposed enablement outcomes

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 is a choice of readily accessible resources available that meets a range of needs and preferences

What do we need to deliver these outcomes?

- Use integrated, personalised and goal orientated care approaches throughout – ‘a life beyond diagnosis.’
- Deliver more preventative and earlier interventions in the community and primary care, including shared care models which address physical and mental health.
- Strengthen community based mental health services to prevent admissions to inpatient services and respond to crises effectively.
- Deliver high quality interventions in inpatient care to ensure earlier discharge.
- To do this we need shift the balance of resources to lower tiers of care.

Individual Placement Support

- Twining Enterprise started delivery in Haringey July 2015
- 2 Employment Specialists integrated into EIS & RET teams (secondary care)
- 35 engaged, 5 jobs to date
- IPS Evidence based model
- Based on 8 Principles including client-centred, paid work focus, ongoing in work support, employer engagement.
- IPS case study- client journey

Accommodation pathway

- Accommodation issues were being identified as a key reason for delayed discharges
- Discussion across 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 has subsequently been established across health, social care, housing and BEH.
- It has clarified the accommodation pathway for people with mental health needs.
- This includes the roles and responsibilities of key agencies involved in a person's care, and a guide for care co-ordinators which is being trialled in September before roll out.
- The aim is to ensure effective and timely assessment, access to least restrictive housing options and move on which maximises independence for people with mental health needs.
- The group is also developing an accommodation pathway dashboard to monitor improved outcomes for service users.

Key implications of adopting enablement approach

- Harnessing the role of communities in offering support – expanding and making comprehensive the prevention and promotion strand of the framework (priority 1) and linking this to the primary care offer to maximise well-being.
- Potential need to pump prime to allow time for preventative, primary care and strengthened secondary care community offer to be piloted and be shown to work with an intent to release resource from secondary care to fund longer term.
- Need to consider investment, capacity and skills in voluntary sector organisations.
- Consensus about management of clinical risk will be vital as we seek to empower people to manage their own care and offer support in less restrictive settings.
- Discussions about roles and responsibilities will also be vital – including those of people with mental health needs.
- Using resources across the system – mental health enablement can't be delivered by mental health services alone – children's (see separate presentation) housing, environmental and regeneration developments are key.

What we need HWB to do

- Promote and support the whole system approach to developing and implementing integrated enablement service model;
- Strategically advocate integrated commissioning approach based on the outcomes and co-production;
- Act as a body to which multiple stakeholders are held publicly accountable to ensure a system wide response;
- Have oversight of risks to the programme and support risk mitigation;
- Actively performance monitor progress of the implementation.

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Haringey Council

NHS
Haringey
Clinical Commissioning Group

Review of Haringey CAMHS
Haringey Health and Wellbeing Board
Thursday 24th September 2015

Catherine Swaile
Vulnerable Children's Joint Commissioning Manager

Ambition 7: More children and young people will have good mental health and wellbeing

What is being measured?

Average Warwick-Edinburgh wellbeing score for children and young people

Future In Mind Overview

Earlier this year the Department of Health published Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

Five **key themes** provide the structure of the report :

- Promoting resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Participation and collaboration identified as a core principle - services designed in collaboration with children, young people and families to meet their needs

49 proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs

The £280 million Transformation funding for CAMHS announced in the Autumn budget has been top sliced to support a number of pilots and national developments. Additionally each area has been given a proportion to implement local transformation plans. Haringey's allocation is £515,302 recurrent for 5 years (not including perinatal allocation to follow)

Review Process Update

- CAMHS Review Project Board leading the Review comprising representatives from the CCG, the Council, NHSE, CSU and Healthwatch
- Engagement event for over 50 people in March with follow up event booked for 18th September to feedback Review outcomes and develop transformation plan
- Themed workshops on Looked After Children, Children with Learning Disabilities/ASD and Crisis
- Online surveys with feedback from 152 stakeholders including children and young people and parents
- Meeting held with Children and Young People and Parents/Carers
- Participation from all providers in the Review through a series of meetings and service level activity data provided by nearly all providers
- Benchmarking where available with national services
- Review of good practice and alternative models nationally

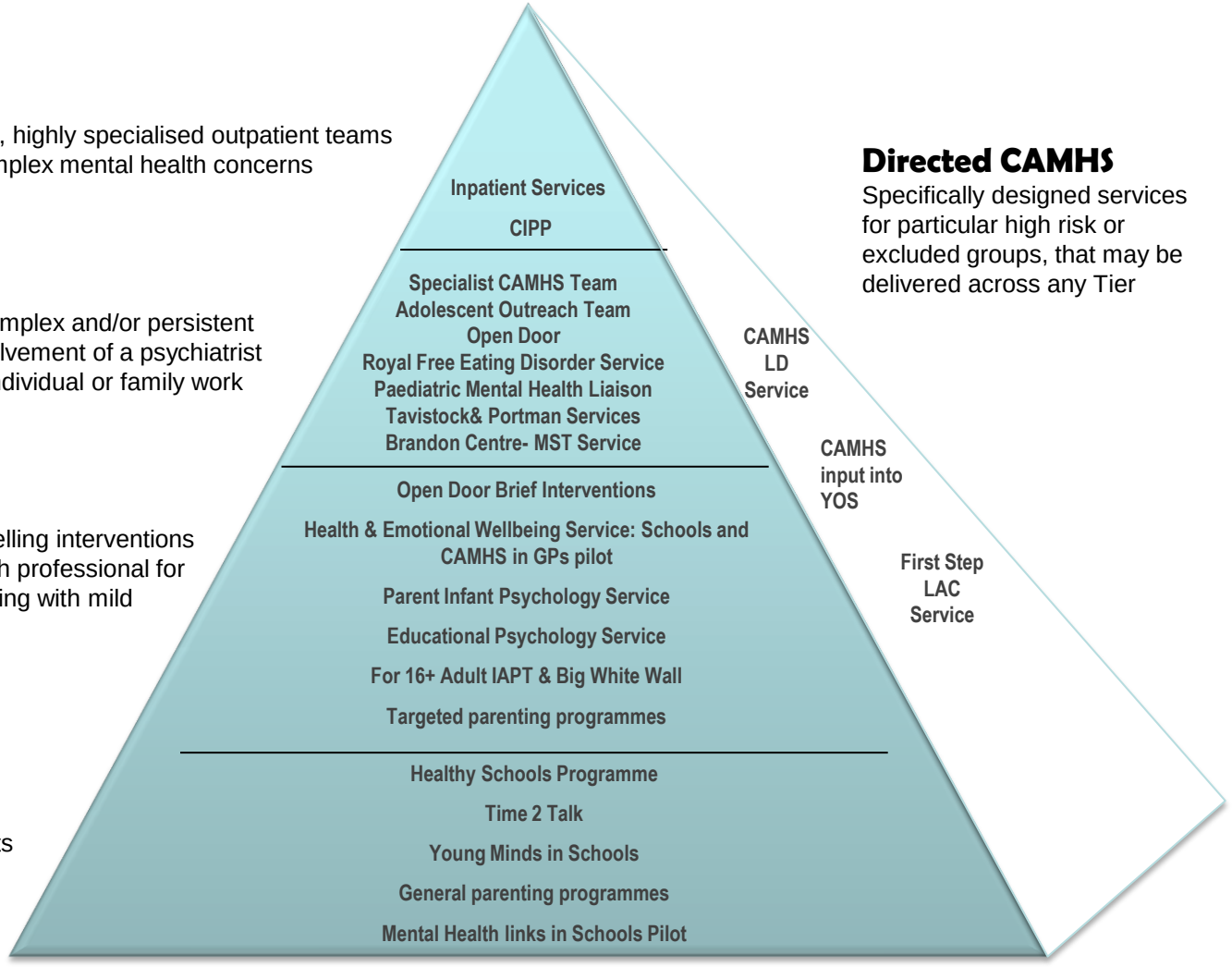
Child and Adolescent Mental Health Services (CAMHS) in Haringey

Tier 4 CAMHS
Tertiary services such as day units, highly specialised outpatient teams and inpatient units for high risk/complex mental health concerns

Tier 3 CAMHS
Services for clients with severe, complex and/or persistent disorders that may require the involvement of a psychiatrist and/or multi disciplinary team for individual or family work

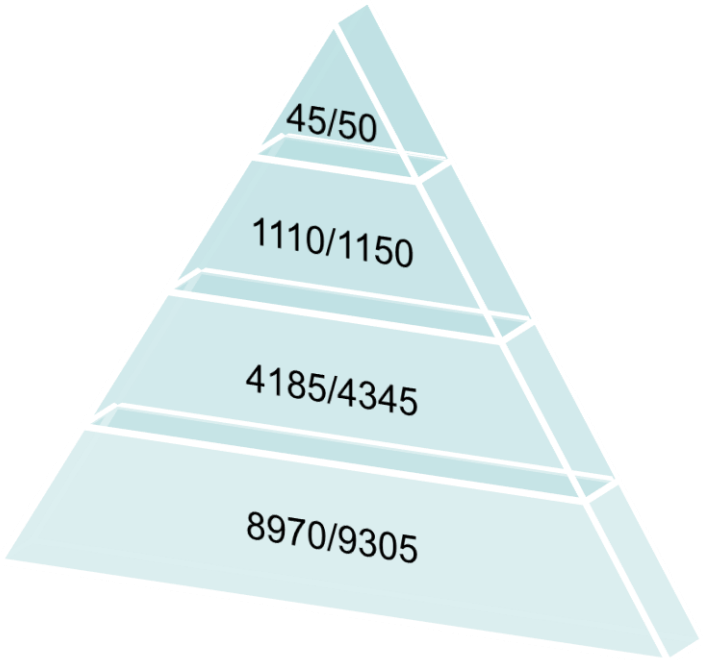
Tier 2 CAMHS
Short term psychological or counselling interventions delivered by a trained mental health professional for children and young people presenting with mild emotional or mental health issues

Tier 1 CAMHS
Universal Services such as GPs, Schools and Health visitors who provide emotional support to Clients facing difficulties with normal life problems

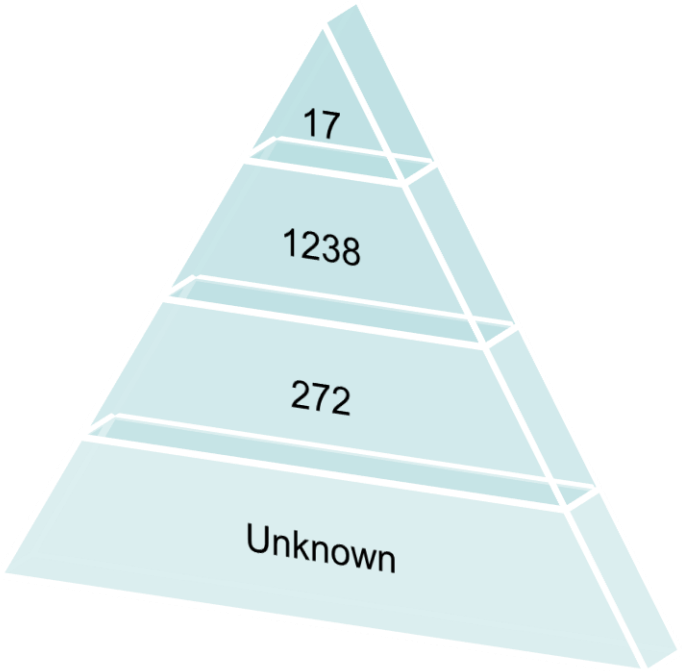


Directed CAMHS
Specifically designed services for particular high risk or excluded groups, that may be delivered across any Tier

Prevalence vs Activity



Haringey's estimated Prevalence of CYP requiring a response at each of the tiers



Haringey's commissioned activity 2014/15

Key Feedback Themes

- **Quality:** Young People and Parents find services helpful, on the whole providing positive feedback & parents feel well supported, families are greeted in a friendly and supportive manner and report convenience of first appointment
- **Communication:** Families do not have sufficient information on services prior to attending CAMHS and referrers want more ongoing communication & better discharge information
- **Crisis:** Families do not know what to do in the event of a crisis
- **Workforce:** Safeguarding training is inadequate across services, with an unacceptable proportion of staff not meeting their mandatory training requirements. There is a good range of skills and a broad range of modalities available
- **Choice:** Families are not offered choice of setting or location and would like more appointments outside of 9am-5pm.
- **Access:** Waiting times are unacceptable
- **Enablement:** Young people and parents would like the opportunity to talk to other young people and parents
- **Inter-Agency Working:** Services need better promotion to wider children's workforce, pathways need to be clear, joint working between CDC and CAMHS needs developing (gaps around post diagnostic support for autism)
- **Looked After Children:** Insufficient treatment services available
- **Infrastructure:** Better IT required to support a modern, efficient CAMHS

Key Findings: Commissioning

Current commissioning arrangements mean there is no 'whole system approach' and a lack of coherence to provision. Current funding arrangements do not allow us to accurately determine levels of investment and spend and associated outcomes.

Future in Mind Requires a '**lead accountable commissioning body**' and a '**single separately identifiable budget for children's mental health services**'. Joint commissioning arrangements should be developed that facilitate

- Single CAMHS contract across statutory commissioning agencies per provider
- Clearer, more transparent investment & monitoring of spend
- Joint planning & integrated services designed to meet the needs of the whole population

Key Findings: Provision

- There is a relative lack of **early intervention** (Tier 2) support. This should be expanded building on the CAMHS in GP practices pilot including developing services which support attachment and a coherent programme of **parenting support** using evidence based models. **Peer support** and **digital solutions** should be developed as part of this model.
- There is a lack of **out of hours** support around **crisis** presentations, pathways should be developed in partnership with Enfield & Barnet
- Targeted services should be enhanced for **vulnerable children and young people** e.g. Looked After Children/LD/ASD/Youth Offenders/Young Carers
- Services need to be more focussed on **outcomes**, using evidence based approaches, CYP-IAPT should be embedded across services
- Current capacity issues within Tier 3 are leading to long **waiting times**, Expanding early intervention services should reduce demand and improve access, additionally use of group interventions and digital solutions should increase service efficiency.
- Interagency working and **communication** between CAMHS and wider work-force should be improved, linking CAMHS into other services and upskilling of wider children's workforce
- **Enablement** should be promoted through peer support models for children and young people and their parents
- There is a need for improved **transition** between CAMHS and adult mental health services with appropriate step-down for those who will not require ongoing support
- Closer working between physical and mental health services is required. **Joint clinics with paediatrics** (social communication & neurodevelopmental clinics) and post assessment psychological support for families should be developed

Next Steps

Transition Plan Submission Date- 16th October

Merging of CAMHS Review Project Board and CYP-IAPT Steering Group into multi-agency CAMHS Transformation Board to develop and oversee Transformation Plan implementation

Report for:	**Health and Wellbeing Board – 24th September 2015**

Title:	**Update on GP Provision in Tottenham**

Organisation:	**NHS England**

Lead Officer:	**Jill Webb, Head of Primary Care, NHS England (London)**

1. Describe the issue under consideration

At the last Haringey Health and Wellbeing Board on 11 September 2015, NHS England presented the Haringey Strategic Premises Development Plan. This document established, as one of a number of specific recommendations, the need for additional GP primary medical services in the Tottenham Hale Ward.

This Paper provides an update of progress since that meeting.

- NHS England Finance, Investment, Procurement & Audit Group (FIPA) have ratified the findings and recommendations of the Strategic Premises Development Plan
- NHS England Decision Making Group (DMG) have 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, have completed the competitive process of pilot provider selection
- A provider has been selected, and the decision ratified by NHS England (DMG). The decision will be announced at the Haringey Health and Wellbeing Board following formal notification of the successful and unsuccessful providers
- An application for planning permission has been submitted by Lea Valley Estates to establish a temporary health facility on the site

- Lea Valley Estates have confirmed that they will have builders on site until June 2016, who will be able to rapidly establish services to the facility

- NHS England and Haringey CCG are working on an IT solution that will rapidly allow connectivity to the new temporary facility.

Next Steps

- Completion of dialogue with proposed pilot provider to establish final costs and service specification.

- Final Agreement of pilot costs and service specification by NHS England (DMG)

- Preparation of contract for services

- Preparation of business case for pilot premises

- Establishment of premise funding responsibilities

- Sourcing of temporary facility

- Approval of business case for pilot premises by NHS England (FIPA)

- Site mobilisation with new Partner Practice

2. Recommendations

1. The Haringey Health and Wellbeing Board are asked to note the progress on this project to date.

2. A further update on the process will be tabled at the Health and Wellbeing Board meeting on 24 September.

Report for:	**Health and Wellbeing Board – 24 September 2015**

Title:	**Priority 2 Governance**

Organisation:	**Haringey Council**

Lead Officer:	**Charlotte Pomery - Assistant Director for Commissioning**

1. Describe the issue under consideration

1.1 To support the implementation of the Corporate Plan "***Building a Stronger Haringey Together***", the Council has established governance arrangements to oversee delivery of each of the five priorities in the Plan. The current arrangements consist 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 has been set up to focus on delivery of the second priority in the Plan, to "***Empower all adults to live healthy, long and fulfilling lives with control over what is important to them."***

1.2 In order to foster and enable the whole systems and collaborative working needed to deliver the Corporate Plan, it is proposed that a partnership Outcome Board for each priority is also established. This paper sets out the background to this requirement and recommends 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.

2. Background

2.2 Haringey Council's Corporate Plan sets out the Council's five priorities and the key outcomes that it wants to deliver over the next three years. In order to assure delivery of the Plan, the Council has set up internal Priority Boards for each of the five priorities and it is intended to mirror each of these with a borough-wide external Outcome Board, reflecting the commitment made at the November partnership event to ensure our corporate priorities evolve as borough priorities alongside partners. The overall aim of the external Outcome Boards is to embed shared objectives for the Borough, share intelligence, funding and operational information and develop more effective strategic and operational partnerships.

2.3 Given that the Health and Wellbeing Board brings together key partners in the Borough to consider health issues and that there is significant synergy between the agendas it is therefore considered that it is well placed to become the external Outcome Board for Priority 2.

2.4 Priority 2 is a vision to:

Empower all adults to live healthy, long and fulfilling lives with control over what is important to them.

2.5 In meeting this aspiration it is anticipated that all communities, providers and residents in Haringey embrace a prevention and early intervention approach, which builds resilience and capacity and enables community support. This represents a significant change in the way in which health and social care systems currently work and will require closer working and the building of partnerships to meet shared goals. The following table sets out the objectives that the council is looking to achieve and makes clear that these objectives can only be delivered through closer working with partners and communities.

Objective	Role of the Council
A borough where the healthier choice is the easier choice	We will: • Work with partners and communities to create physical, social and cultural environments that encourage healthy lifestyle for all. • People will have high quality information to make informed choices that will lead to improved health outcomes.
Strong communities, where all residents are healthier and live independent, fulfilling lives	We will: • Work with communities, developing ways to build capacity and bring investment into the voluntary sector to provide support for one another
Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing	We will: • Work with partners to identify those who may need help with their health and wellbeing, providing advice on support • Optimise the use of technology to keep people as independent as possible • Help residents make choices and decisions, before they enter formal care and support

	systems
Residents assessed as needing formal care and / or health support will receive responsive and high quality services	We will: • Work together with health partners to provide high quality person-centred services, while informing residents to help them to understand the level of service they should expect • Intervene (with the Care Quality Commission) when services fall below standard
All vulnerable adults will be safeguarded from abuse	We will work with our partners to protect adults in vulnerable situations and ensure that residents will have increased awareness of the early signs of potential abuse.

2.6 There are clear synergies and overlap between the approach the Council is looking to adopt to deliver these objectives in partnership across Haringey and the statutory duties of the Health and Wellbeing Board as set out in the Health and Social Care Act 2012 notably:

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

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

2.7 In taking on the role of external board it is expected that much of the role sits within the Health and Wellbeing Board's current functions, and to create another Board or group to take on this function would represent unnecessary duplication and confusion.

Recommendations

That the Health and Wellbeing Board be ratified as the external Outcomes Board to oversee the delivery of Priority 2 of the Council's Corporate Plan.

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Report for:	**Health and Wellbeing Board – 24 September 2015**

Title:	NHS 111 and GP Out-of-Hours Procurement Update

Organisation:	Haringey CCG

Lead Officer:	Leo Minnion – Commissioning Manager, Haringey CCG (report written by Felicity Bull, NEL CSU Communications Team)

1. Describe the issue under consideration

Haringey CCG is working with the other four CCGs in north central London (Barnet, Camden, Enfield, and Islington) to improve the local NHS 111 and GP out-of-hours services (OOH). This includes bringing together the NHS 111 service and the GP out-of-hours service to enable them to work better together. The contract for the current NHS 111 service needs to be renewed in 2016, which means we now have a real opportunity to learn from experience and make NHS 111 work better for patients. We are doing it because we want to improve patients' experience of using and accessing urgent care services, making sure they receive the best care, from the best person, in the right place, at the right time.

NHS 111 has been piloted in different forms across England since early 2013. From these pilots, we have learned:

- Combining NHS 111 and GP out-of-hours services under a single contract helps patients get to the right service quicker, with less time spent being passed from one call handler to another.
- Nurse, GP or pharmacist input early on may help patients get the right advice or treatment more quickly.
- When an NHS 111 call handler directly books appointments for patients with the right service, such as a GP appointment, this works very well and improves patients' experience.
- NHS 111 services could make much better use of local community services.
- NHS 111 services need to develop better online access.

Over the past eight months we have held a large number of events and have heard from a wide range of members of the local community on the 111/OOH procurement proposals. The evidence we have gathered so far from the people we have spoken to, along with clinical evidence, shows that bringing the two services together across the five boroughs will both meet local need for the service and provide a sustainable service.

2. Recommendations

That the report be noted.

NHS
Haringey
Clinical Commissioning Group

NHS 111 and GP Out-of-Hours Procurement Update

Summary

Haringey CCG is working with the other four CCGs in north central London (Barnet, Camden, Enfield, and Islington) to improve the local NHS 111 and GP out-of-hours services (OOH). This includes bringing together the NHS 111 service and the GP out-of-hours service to enable them to work better together. The contract for the current NHS 111 service needs to be renewed in 2016, which means we now have a real opportunity to learn from experience and make NHS 111 work better for patients. We are doing it because we want to improve patients' experience of using and accessing urgent care services, making sure they receive the best care, from the best person, in the right place, at the right time.

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1. WHY THIS REPORT IS NEEDED

1.1 This report provides the Board with an update on the planned procurement of an integrated NHS 111/OOH service across Barnet, Camden, Enfield, Haringey and Islington.

1.2 NHS 111 and the out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111. It is vital to make sure they work in a co-ordinated way to support the patient's journey and deliver high quality, safe patient care.

1.3 Currently the CCGs in north central London commission three different organisations to deliver separate NHS 111 and out-of-hours services to patients in north central London.

- The NHS 111 service is provided by one provider for all five CCGs in North Central London – *London Central and West Unscheduled Care Collaborative (LCW),* a GP-led not for profit organisation.
- The GP out-of-hours service for Barnet, Enfield and Haringey is provided by *Barndoc Healthcare* Ltd. and the service for Camden and Islington is provided by *Care UK*.

1.4 The contracts all three services were set to expire in March 2015, but these have now been extended to allow the Clinical Commissioning groups (CCGs) to refresh and improve the service and consider commissioning a combined NHS 111 and out-of-hours (OOH) service across the five boroughs.

1.5 Haringey CCG, along with the other CCGs in north central London think it therefore makes sense to commission NHS 111 and OOH as a single contract, with a single specification, so that patients would receive a more joined-up service with fewer transfers between medical staff and better information-sharing.

1.6 A single contract, does not, however, mean that a single provider would be commissioned to provide the service. Our proposal is to develop a single contract, where a lead provider(s) would coordinate the work with all the local providers (which could include NHS trusts, GP collaboratives or private and voluntary sector providers), making sure they are working together to deliver the best possible outcomes and care for patients – they would be held accountable by CCGs for delivering those outcomes and care, with a detailed and clear specification for the service. We believe this would be the right model because it matches how patients actually access these services.

1.7 The current services have all demonstrated excellent performance over the years of their current contracts – north central London residents have access to NHS 111 and out-of-hours services that are as good as, or better than, any in London.

1.8 We know this from the evidence we see at the monthly clinical quality review meetings. Also, evidence published on the NHS England website[1] shows that 86% of our patients said they were fairly or very satisfied with their NHS 111 experience.

1.9 However, we also know from complaints, incidents and feedback that some patients have had a poor experience, and this needs to be improved.

[1] [1] http://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

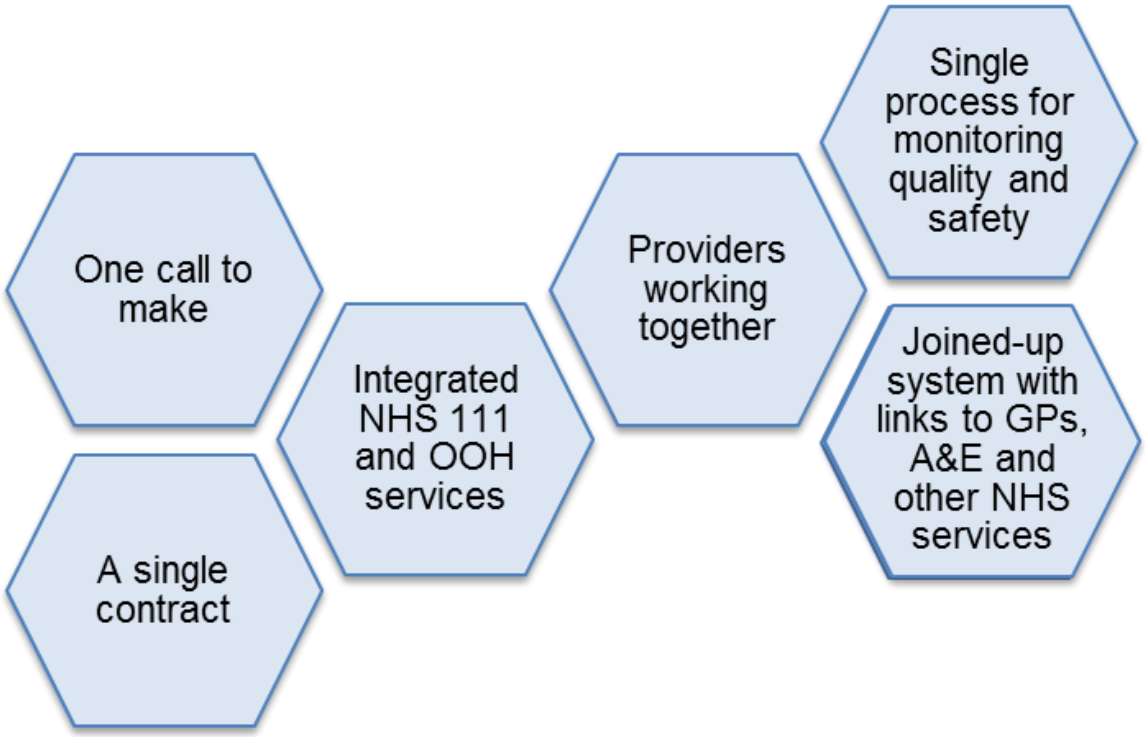
1.10 Because the current contracts for these services are all drawing to an end, the CCGs are legally required to undertake a formal procurement process.

1.11 By commissioning a service across NCL, doctors believe it would mean the NHS could develop better systems and infrastructure which would be more flexible and reactive to patients' needs; for example, we want the service to employ a skills-mix of health professionals – including pharmacists and paramedics as well as GPs and nurses – so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111 – and this would be the same for our patients, wherever they live.

1.12 This is also an opportunity to redevelop the NHS 111 and OOH service as an integral part of the health system across north central London, and ensure that it works intuitively with other aspects of primary care and emergency care.

1.13 In developing our proposals we have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. The CCG's preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers.

1.14 The proposed model would look like this:



1.15 Callers to NHS 111 are often not near their registered GP practice when they call, but are usually somewhere within the NCL area, so it makes sense for NHS 111 to be able to refer them to healthcare services near to where they actually are at the time of their call. Combining the two services would make this easier.

1.16 By commissioning a service across NCL, doctors believe it would mean the NHS could develop better systems and infrastructure which would be more flexible and reactive to patients' needs; for example, we want the service to employ a skills-mix of health professionals – including pharmacists and paramedics as well as GPs and nurses – so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111 – and this would be the same for our patients, wherever they live.

1.17 Deaf service users and those with learning difficulties also sometimes experience a poor service, and we want to develop systems to improve this. This is achievable if we commission at a five borough scale, and would be much less viable if we commissioned separate services.

1.18 Current model vs proposed model:

	Current model	Proposed model
Contract	One organisation providing NHS 111 for all of north central London (Barnet, Camden, Enfield, Haringey and Islington). Two organisations providing OOH services for north central London (one in Barnet, Enfield and Haringey; one in Camden and Islington)	A single contract with responsibility for all NHS 111 and OOH services in north central London. This may be delivered by a single organisation or (more likely) by a group of organisations working together. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.
Clinical support	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need.

Assessment	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
Appointments	Some direct bookings – but patients usually need to hang up and call a different number to make an appointment with the appropriate service	Direct bookings for OOH appointments, including home visits. Direct bookings available for most other services.
Medical history	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS 111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
Equity of access	Access to OOH services is different depending on where people live in north central London	Access to OOH services would be the same, regardless of where people live in north central London – and patients would have more choice

1.19 The CCGs believe that investing in an integrated NHS 111/out-of-hours service would provide numerous benefits for patients and residents of north central London:

- Patients would be more likely to be seen by the right clinician, earlier in the process
- There would be fewer transfers as the patient progresses through the system – you should only have to give your information once
- Patients would no longer be bound by administrative barriers (eg residents in West Haringey could be directed to the OOH base at the urgent care centre at the Whittington hospital, rather than travel across the borough to the North Middlesex hospital) – you would be able to choose the services most convenient to you
- The skills mix model, combined with more timely access to a GP, would help support the urgent care system – you would be directed to the most appropriate service that meets your medical needs and this should mean you are less likely to have to wait around at a busy A&E

- The integrated service would have flexibility to redeploy staff to where they are most needed to meet changes in patient use throughout the day and year
- Clinicians would be able to prescribe without the need for duplication or unnecessary referral
- All contracts would be rigorously monitored, as is the case today; providing assurance thatthe service is safe and of a high quality. Providers would be accountable for delivering the outcomes and care that patients need
- NHS 111 call advisers would be able to book patients directly to appointments with OOH and other services
- Commissioning at this scale would allow the development of systems and infrastructure that are more flexible and reactive to patients' needs – for example online tools to enable you to assess your own health needs, and systems for deaf service users.

2. REASONS FOR RECOMMENDATIONS

2.1 Not Applicable as the report is an update on the planned procurement of an integrated NHS 111/OOH service across Barnet, Camden, Enfield, Haringey and Islington.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 In further developing our proposals we have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. Our preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers. The following table outlines the advantages of each option:

✓ = the option partially offers this advantage
✓✓ = the option fully offers this advantage

	Patients get clinical advice quickly from the right person, without calling a different number	Reduces pressure on A&E by making sure patients get treatment early on	Equal access to services wherever you live in north central London	Fewer transfers from one adviser to another	Can adapt to deal with pressure at peak times	Service provided by local clinicians	Contracts can be rigorously monitored	Could develop new systems – e.g. for deaf service users – that are better at meeting patients' needs

Option 1 – Commission one NHS 111 and two GP OOH providers – No change	✓	✓			✓	✓[2]	✓✓	✓
Option 2 – Each CCG to commission its own NHS 111 and GP OOH providers	✓	✓				✓[2]	✓✓	
Option 3 – Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – our preferred option	✓✓	✓✓	✓✓	✓✓	✓✓	✓[2]	✓✓	✓✓

3.2 The initial idea to commission NHS 111 and OOH services as a single service across NCL was developed based on extensive feedback from service users and clinicians. In particular, the Review of Urgent Care carried out in Camden and Islington in 2013/4, in which the CCGs spoke to hundreds of patients, which recommended a more joined-up approach to commissioning urgent care and specifically NHS 111 and OOH services.

3.3 There was also an independent review by the Primary Care Foundation which showed how reducing transfers between NHS 111 and OOH would speed up the clinical care patients received and improve their experience.

4. IMPLICATIONS OF DECISION

4.1 Corporate Priorities and Performance

The key projects described in this report are closely aligned to the remit of the HWBB as it relates to key leaders from the health and care system working together to improve the health and well-being of local communities through local commissioning of health care, social care and public health; informed by the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy. There is also close alignment with the strategic aims of the other four CCGs for the delivery of high-quality health and health care services for the residents of north central London.

4.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

None in the context of this report.

[2] * The current national shortage of GPs means it can be difficult for OOH services to recruit local doctors. We couldn't guarantee, regardless of how we commission these services; that they would employ local doctors – but we do want to make sure that the local service is an attractive career option that good local clinicians would want to take part in.

4.3 **Risk Management**

4.3.1 None in the context of this report.

4.4 **Equalities and Diversity**

4.4.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies **to have due regard** to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

4.4.2 The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services.

4.4.3 Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports. Proposals are therefore assessed for their impact on equality and diversity in line with the Haringey CCG Equality Delivery System

4.4.4 The current service configuration results in an access inequality between boroughs. The proposed service will reduce this inequality by offering consistent access and availability of services across NCL. The NHS 111 and OOH Patient and Public Reference Group has been involved in the service development which informed the equality analysis. A number of engagement events have been held with patient groups such as those with hearing difficulties or learning difficulties with useful feedback on current services.

4.5 **Consultation and Engagement**

4.5.1 The CCGs have undertaken a substantial engagement programme across NCL over the past six months, which has included:

- Individual CCGs discussing NHS 111 and OOH proposals at local events, including discussions with hundreds of individual service users and meetings with community and voluntary groups
- Presentations at the regular meetings with GPs across NCL to ensure local doctors understand what is proposed and how they could be involved
- Two phases of focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which were attended by hundreds of interested service users and encouraged in-depth discussion of the proposals. In Haringey, these took place in March, April and May.
- An online survey to find out the views of stakeholders and service users on our commissioning proposals.

- The setting-up of a Patient and Public Reference Group, involving service users from all five boroughs and Healthwatch representation – this is looking in detail at the proposed service specification and has had a fact-finding visit to the current NHS 111 provider. Members who have expressed an interest are being invited to participate in the Procurement Panel when it goes ahead.
- Market events with local and national providers, letting them know what we are proposing so they can decide whether to bid for the new contract.
- Presentations to the joint health overview and scrutiny committees.

4.5.2 We have had very useful feedback from many service users and local campaign groups, with considerable support for joining up NHS 111 with the GP out-of-hours service to improve patients' experience. That a future service would mean fewer handoffs between services has been particularly welcomed, as have the improvements proposed in the clinical model such as the opportunity to talk to other NHS services (dentists, pharmacists, mental health workers) and earlier access to clinicians including pharmacy, repeat prescriptions and direct access into GP appointments.

4.5.3 There were concerns and anxieties too, so in July, a focused piece of engagement took place, sharing further with residents and service users, exactly why the CCGs are proposing to commission an integrated NHS 111/OOH service. Despite wide communications highlighting the engagement document and its survey, there was a very small response to the engagement, of those that did respond Option 3 was the most favoured option.

4.5.4 The draft service specification for the proposed integrated service has been under development since Spring 2015, with input from the programme's clinical sub-group, whose members are clinical leads from Barnet, Camden, Enfield, Haringey and Islington CCGs. The Patient and Public Reference Group and Healthwatch organisations have had the opportunity to discuss the specification and make line-by-line comments. Additionally, the draft specification was published on the websites of all five CCGs from 21 July to 19 August, and circulated to same stakeholder list as the engagement document, inviting comments which will be fed back to the drafting team before the final specification is produced for discussion by CCGs in September.

4.5.5 In July, CCG Chief Officers, with other NHS leads, received a letter from Dame Barbara Hakin, National Director of Commissioning Operations for NHS England, informing of proposals for 'commissioning a functionally integrated urgent care access, treatment and clinical advice service.' This letter notes that NHS England is developing new commissioning standards for an integrated NHS 111 and OOH service, and asks commissioners to suspend procurements of these services until the end of September 2015. This is already in line with the timetable to which

CCGs in north central London (NCL) are working – our procurement is planned to start in October, allowing time for a further period of engagement and communication with our local communities.