MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON MONDAY, 18TH JANUARY, 2021, 2.00 - 4.05 PM

Present:
Cllr Sarah James, Chair – Cabinet Member for Adults and Health*
Cllr Mark Blake – Cabinet Member for Communities and Equalities*
Cllr Kaushika Amin – Cabinet Member for Children, Education, and Families*
Beverley Tarka – Director of Adults and Health
Dr Will Maimaris – Interim Director of Public Health
Ann Graham, Director of Children's Services
Dr Peter Christian, NCL Clinical Commissioning Group (CCG) Board Member*
Sharon Grant – Healthwatch Haringey Chair*
Geoffrey Ocen – Bridge Renewal Trust Chief Executive
David Archibald – Interim Independent Chair Local Safeguarding Board
*Voting member

In attendance:
Christina Andrew – Strategic Lead, Communities
Nadia Burrell – Modern Slavery Co-ordinator
Melissa Cuffy, Senior Communications Officer
Chantelle Fatania – Consultant in Public Health
Jonathan Gardner – Whittington Trust Director of Strategy
Richard Gourlay – North Middlesex University Hospital Trust
Susan John – Business Manager
Rachel Lissauer – Director of Integration, Clinical Commissioning Group (CCG)
Charlotte Pomery – Assistant Director for Commissioning
Eleri Salter, Commercial Manager
Andrew Wright – Barnet, Enfield, and Haringey Mental Health NHS Trust
Emma Perry – Principal Committee Co-ordinator
Fiona Rae – Principal Committee Co-ordinator

1. FILMING AT MEETINGS

The Chair referred to the notice of filming at meetings and this information was noted.

2. WELCOME AND INTRODUCTIONS

The Chair welcomed those present to the meeting.

3. APOLOGIES

Apologies for absence were received from:

Damani Goldstein, Consultant in Public Health
Siobhan Harrington, Whittington Trust Chief Executive

Maria Kane, North Middlesex University Hospital Trust Chief Executive
Susan McDonnell-Davies, NCL CCG Executive Director of Borough Partnerships
Susan Otiti, Assistant Director of Public Health
John Rohan, NCL Clinical Commissioning Group (CCG) Board Member
Paul Sinden, NCL CCG Chief Officer

4. URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

There were no declarations of interest.

6. DEPUTATIONS, PETITIONS, QUESTIONS

No questions, deputations, or petitions were received.

7. MINUTES

RESOLVED

That the minutes of the meeting held on 4 November 2020 were confirmed and signed as a correct record.

Sharon Grant, Healthwatch Haringey, enquired whether there had been an update on the resourcing of the Reablement Service and noted that demand was impacting the support requested from Healthwatch. The Director of Adults and Health noted that the team's resources had been expanded in response to the additional demands of the Covid-19 pandemic; the team had secured at least seven or eight additional members of staff and the hours worked by the team had also been expanded.

8. MODERN SLAVERY PLAN

The Chair noted that this item presented the Modern Slavery Plan which had been held over from the last meeting.

Chantelle Fatania, Consultant in Public Health, explained that Modern Slavery was taking place in a variety of sectors, such as farming, manufacturing, and within various premises, but that it was often a complex and hidden phenomenon. It was estimated that 100,000 people in the United Kingdom (UK) and 20 million people worldwide were affected. It was explained that, in the UK, it was often British people from disadvantaged backgrounds who were victims of Modern Slavery.

It was noted that, in Haringey, the Council had identified and referred 17 and the Police had referred 150 potential victims of Modern Slavery to the national referral body. The proposed Modern Slavery Plan was a two year strategy to prevent and identify Modern Slavery and support victims. A key purpose of the Plan was to raise awareness and understanding of Modern Slavery, to develop capacity for the community and professionals to identify and support victims, and to create clear guidelines and pathways for referral. It was acknowledged that working in partnership provided the most effective way to disrupt Modern Slavery.

Nadia Burrell, Modern Slavery Co-ordinator, noted that the Modern Slavery Plan had seven key areas of focus: Data and Intelligence; Awareness and Training; Reporting Concerns; Support for Victims; Disruption, Prosecution and Procurement; Engagement with the community; and Responding to Covid-19. It was explained that the hidden nature of Modern Slavery was a key issue and that one of the strategies to overcome this would be the development of a dashboard to track data and intelligence and to identify possible victims. It was also noted that a clear pathway for referrals and support would be established and that staff would be better trained in identifying Modern Slavery. It was added that some training would be available on YouTube to maximise the availability of training and that a detailed Practitioner's Handbook would be available to all Council staff.

Geoffrey Ocen, Bridge Renewal Trust, enquired whether the increased restrictions as a result of the Covid-19 pandemic had impacted Modern Slavery. The Consultant in Public Health explained that officers were working with the London Modern Slavery Group to establish what data was available and to gather a more accurate picture of the position in London; it was known that Modern Slavery was under-reported but it was hoped that increased data recording would lead to better understanding and tracking in the long term. In relation to Covid-19, there was no direct evidence but the number of referrals for 2020 were lower than 2019. It was noted that this was concerning but was likely due to the reduced number of interactions and, therefore, the fewer number of opportunities to identify vulnerable people.

Sharon Grant, Healthwatch Chair, stated that it was important for everyone to be aware and have training but highlighted the importance of being proactive and investigating businesses and premises. The Consultant in Public Health explained that there was a strategic and operational group which included representatives from Community Safety, the Police, and the Voluntary and Community Sector. It was highlighted that the main need at present was to provide training and that, once training had been provided more widely, the ability to recognise and report issues would be more effective on an operational level.

RESOLVED

To agree the strategic focus of the Modern Slavery Plan on the following areas:

i. Data and Intelligence.
ii. Awareness and Training.
iii. Reporting Concerns.
iv. Support for Victims.
v. Disruption, Prosecution and Procurement.

vi. Engagement with the community.
vii. Responding to Covid-19.

9. COVID-19 UPDATE

Dr Will Maimaris, Interim Director of Public Health, introduced the item which provided an update on Covid-19. It was explained that the trend in Haringey was largely in line with London; there had been a rapid acceleration in the number of Covid-19 cases in December 2020. There were currently over 1,000 cases per week per 100,000 people, which was a significant increase from previous months. It was noted that there was extreme pressure on the local NHS and that the number of people in North Middlesex and Whittington Hospitals had exceeded the number from the first peak of Covid-19 in March 2020. It was commented that, up until late November 2020, there had been no excess deaths compared to the previous year. However, in late December 2020, there had been a noticeable increase in the number of deaths, with three to four deaths per day in Haringey.

In terms of demographics affected by Covid-19, it was noted that there was broad community transmission in December 2020 affecting all communities and all ages fairly equally. It was commented that a high case rate persisted in the east of the borough, particularly in working age adults, and that the lowest case rates were for children aged four years and under. In relation to people who were seriously unwell and who were at greater risk of dying in hospital, some specific data gathering was currently underway. There was some informal evidence which suggested that this was affecting minority ethnic populations, a younger demographic, and those who were overweight more significantly. The Interim Director of Public Health explained that the increased restrictions in the form of a national lockdown were having an impact but that, due to the delayed impact of the virus, hospital pressures would continue for several weeks after case rates began to reduce.

The Interim Director of Public Health highlighted that the key measure which would be effective in reducing the number of cases was the message to stay at home. It was noted that the second most effective intervention, particularly in the medium and long term, was the Covid-19 vaccination programme. It would be important to encourage all of the community to get a vaccination but it was highlighted that there was no evidence that people who had received the vaccination stopped transmitting the virus; as such, anyone who had been vaccinated would still need to comply with the restrictions for the next few months. It was added that there were asymptomatic testing sites in Haringey which provided test results within one hour; so far, these tests had identified 100 people who were carrying the virus but did not have symptoms and this was important in reducing the spread of the virus.

Dr Peter Christian, NCL CCG Board Member, highlighted the importance of informing everyone that those who had been vaccinated were still required to follow social distancing rules. In relation to the longer term preparations, it was enquired whether there were any plans to implement vaccine ‘passports’ so that people could demonstrate that they had been vaccinated. The Interim Director of Public Health explained that there was no information about this currently but that there were likely to be amended travel restrictions at some point later in the year.

Dr Richard Gourlay, Director of Strategic Development at North Middlesex Hospital, noted that pressures had been significant and intensive care and critical care had been expanded significantly to deal with the number of patients. It was added that this was very challenging for staff and staffing and hospitals had been required to work together in order to effectively care for patients.

The Health and Wellbeing Board extended thanks to all health and care staff who were working in extremely challenging situations.

RESOLVED

To note the Covid-19 update.

10. UPDATE ON THE IMPACT OF COVID-19 ON BLACK, ASIAN, AND MINORITY ETHNIC COMMUNITIES

Geoffrey Ocen, Bridge Renewal Trust, introduced the item and outlined some of the wider work and progress that was being made in relation to the key action point plan for tackling racial injustice that had been agreed with communities and stakeholders. It was explained that there was a Health Inequality Board, co-Chaired by Geoffrey Ocen, Bridge Renewal Trust, and Zina Etheridge, Haringey Council Chief Executive. This Board worked in partnership to progress the key action points: policy and strategy; community safety, social justice, and policing; health and wellbeing; education, attainment and out of school activity; faith and identity; arts, culture, heritage, and place; economy and employment; and workforce. It was noted that the Council had recently appointed a programme manager, Christina Andrew, who would be able to consolidate this work.

Geoffrey Ocen, Bridge Renewal Trust, explained that he would not go through every action point in detail but would provide key updates. In relation to data, it was reported that all boroughs in North Central London had now agreed to include ethnicity on death registrations and it was considered that this would support the monitoring of health impacts and outcomes. It was also noted that a significant number of front line staff were from Black, Asian, and Minority Ethnic (BAME) backgrounds. At North Middlesex Hospital, there had been progress in providing wellbeing and psychological support for front line staff, including the provision of health checks and wellbeing activities such as yoga. At Whittington Hospital, there was a workforce race equality team which was delivering good work, such as a programme for Black History Month. There was also a Diversity Steering Group within the CCG and a GP Lead for Mental Health who was considering BAME Inequalities in relation to mental health.

It was noted that a key element of the action plan during the Covid-19 pandemic was digital. Geoffrey Ocen, Bridge Renewal Trust, explained that there had been a pilot in relation to providing digital support and equipment to school children from an early age. The aim of the pilot was to improve children's learning as well as their families' learning. It was noted that, alongside the pilot, funding of at least £40,000 had been provided by the Council, Whittington Hospital, North Middlesex Hospital, and Barnet, Enfield, and Haringey Mental Health Trust to provide wrap around support for families

to support them more holistically. It was added that there was also a Council programme to provide internet data, mobile phones, and other digital equipment to those who needed it and an ongoing Council and Haringey Giving campaign to fund digital equipment. In addition, it was noted that Haringey Healthwatch and the CCG were working to improve digital access for patients.

In relation to funding, there had been serious discussions around how to restructure funding arrangements. It was noted that a number of organisations, including BAME organisations, struggled to become sustainable; it was considered that providing initial support for these organisations meant that they could fund their core costs and then work to generate their own funding. It was noted that the Council had provided £500,000 of funding to organisations in the first national lockdown which had directly supported community organisations, including BAME organisations. It was added that Public Health had also secured some funding for Community Protect, a 12 month partnership programme led by the Bridge Renewal Trust, together with Public Voice and Mind in Haringey, to deliver community-based health messaging via the Voluntary and Community Sector to specific target demographic groups.

Geoffrey Ocen, Bridge Renewal Trust, explained that a key action point was ensuring equitable access to services. There had been discussions relating to food strategy, free school meals, and overcrowding and how these could be addressed; this had included reviews in service areas and the possibility of introducing a template for reviewing all service areas. It was also noted that an important element in progress was communicating any ongoing work and there would be an update in the Equality and Inclusion bulletin which was due to be circulated in late January.

The Chair noted that the range of ongoing initiatives demonstrated the energy and progress on this issue and she welcomed the new programme manager on behalf of the Board.

Charlotte Pomery, Assistant Director for Commissioning, explained that a significant amount of work was underway and it would be important to embed this as ‘business as usual’ rather than initiatives. This would require a better understanding of available data in order to respond to the needs of residents and that this should be further developed over the coming months. Sharon Grant, Healthwatch Chair, noted that it would be important for some of the work to be targeted, rather than ‘business as usual’, to make sure that it was relevant and accessible for particular ethnic groups. Geoffrey Ocen, Bridge Renewal Trust, agreed and noted that this had also been discussed at Health Inequality Board meetings. He acknowledged that there would likely need to be some focus on initiatives before support was embedded in ordinary business; it was noted that this would require time and resourcing and that the new programme manager post was an important step.

RESOLVED

To note the update.

11. COVID-19 COMMUNICATIONS UPDATE

Rachel Lissauer, CCG Director of Integration, explained that Covid-19 vaccinations were now happening at a range of sites in hospitals and in the community and that all options were being used for vaccine delivery. It was noted that approximately 7,500 vaccines had been administered by GPs, mainly for those over 75 and over 80, alongside some frontline health and care staff. It was highlighted that vaccinations had been taken to all older people's care homes and all residential care settings, including mental health and learning disability settings. It was added that, where anyone had been unable to receive a vaccination, sites were being re-visited and all residents and staff were due to be fully vaccinated by the end of January where possible.

It was highlighted that the delivery of the vaccination programme was intended to be as equitable as possible. It was known, both nationally and locally, that there were some risks of differential uptake of vaccines and significant work was underway to overcome any barriers for people accessing vaccinations. For those who were struggling to physically access vaccination sites, there were transportation arrangements with community volunteers and there was a protocol for the delivery of the vaccine to care homes and to those who were housebound. For those who faced language or communication barriers, GPs were experienced in communicating in a variety of languages and communications in multiple languages had been distributed to the community. It was acknowledged that some GPs had different numbers of people on the priority list who required vaccinations and, where availability might be an issue, GPs were checking with patients who they had been unable to contact initially; practices with the lowest response rates were being targeted. In addition, it was known that some communities were more cautious of vaccinations and targeted work was taking place with a variety of local leaders to provide effective messaging. It was added that the local NHS was working with Community Protect (Bridge Renewal Trust, Healthwatch, and Mind) and the Council to ensure a joint approach and to encourage maximum uptake of the vaccination from the whole community.

Melissa Cuffy, Senior Communications Officer, noted that she was managing Covid-19 vaccination communications. Currently, the communications strategy was to promote NHS messaging as only those in the priority groups were able to access the vaccine; however, as more people would be able to access the vaccine, there would be more communications. The communications objectives were to build awareness of the vaccination programme, to encourage priority groups to take up the vaccine, to build trust in the programme, and to support NHS colleagues in delivering their messaging. It was explained that there was a vaccine toolkit which would be provided to community leaders; the toolkit provided information and FAQ (Frequently Asked Question) answers to local leaders so that they could speak knowledgeably and encourage uptake. It was noted that there would also be a vaccination animation which showed the 'life' of a vaccination from start to finish; this was aimed to share information which was accurate and more engaging. There would also be a leaflet about vaccination included in the Haringey People magazine which would reach people who did not use social media; this would be available in 10 languages and there would be an email address for people to request information in any other languages.

Eleri Salter, Commercial Manager, provided some information about the Council's digital advertising campaign. It was explained that, in the first national lockdown, the Council had used targeted advertising which used anonymised digital data to feature key messages for specific audiences. It was highlighted that this was compliant with data protection rules and would be used again. It was noted that targeted advertising was effective in getting messages to the right people and it allowed information to be provided in other languages where necessary.

The Chair thanked the CCG and Council for providing a useful and comprehensive update on communications.

RESOLVED

To note the update.

12. SEMINAR SESSION: INTEGRATED CARE SYSTEM CONSULTATION

Rachel Lissauer, CCG Director of Integration, introduced the item and noted that it was aimed to involve the Board in discussions about the next steps for Integrated Care Systems (ICS). It was explained that NHS England and NHS Improvement had produced a paper, titled 'Integrating Care', which set out a renewed ambition for greater collaboration between partners in health and care systems and this put forward options for a legislative basis for ICS. Option 1 would provide a statutory ICS Board/ Joint Committee with an Accountable Officer where NHS commissioners, providers, and local authorities would take collective decisions. Option 2 would provide a statutory ICS Body which would be established as an NHS body by 're-purposing' Clinical Commissioning Groups (CCGs), would take on commissioning functions, and would have locally defined frameworks and functions. In either case, it was anticipated that the new statutory basis would be established by April 2022.

In practice, it was expected that each ICS would lead on prevention, joining up care, access to digital services, acting as a major employer, and as an estate owner; there would also be meaningful, local, delegated budgets. It was highlighted that the proposals were not prescriptive about the framework to be used at borough level but it was anticipated that there would be partnership working, with a key role for local authorities. It was explained that the role of the ICS would be to distribute financial resources, target resources to areas with greater need, and to tackle inequalities. It was anticipated that commissioning would be strategic and there would be a single source of funding. It was noted that the proposals did not provide a detailed definition of the arrangements at ICS and borough level but noted that there needed to be a balance between the two and that the arrangements should include resident voices. It was explained that the CCG Governing Board had supported Option 2 and considered that it would be helpful to proceed at pace. It was acknowledged that the proposals would abolish the CCG but it was highlighted that the expertise and progress made in the existing arrangements would be retained. It was acknowledged that the Board had identified that further work was required in relation to public accountability and it would be helpful to receive further detail about this.

Beverley Tarka, Director of Adults and Health, noted that the Council welcomed the overall approach but that more clarity was needed to ensure that local arrangements would include health and care representatives and the community. It was considered that resident and patient involvement should have more primacy, that there should be a stronger reference to the voluntary sector, and that there could be more of an emphasis on the more expansive roles that councils needed to play. It was noted that the proposals did not include any references to the roles of Health and Wellbeing Boards or other partners and groups and it would be important to understand how these groups could provide input to improve health outcomes. It was added that Haringey had recently introduced a Community Health Advisory Board which fed into the Health and Wellbeing Board to ensure that resident voices were included and the Council wanted the ICS proposals to be clearer about the mechanisms for local engagement.

The Director of Adults and Health summarised that the Council supported the Local Government Association (LGA) response which highlighted that local authorities and partners worked alongside the NHS to effect change, reduce health inequalities, and improve health outcomes. It was noted that the consultation was at an early stage and that contributions from the Health and Wellbeing Board were welcomed in order to build on the framework of responses.

In response to a question about timescales, it was confirmed that the national consultation had been released in November 2020 and had closed on 8 January 2021. It was noted that this was an early paper and that there would be some opportunities for continued contributions. It was added that the projected endpoint was April 2022 and it was aimed to have a new statutory basis for ICS at this point.

Sharon Grant, Healthwatch Chair, noted that there were concerns from the patient and public engagement point of view, that the proposals did not have much detail about what would happen to existing duties and powers which had been long fought for. It was noted that there were some innovative initiatives that had been developed to improve health locally and it would be important that the new structure did not preclude these opportunities. It was commented that the proposals seemed to be centralising arrangements when people were generally in support of increased localisation.

Dr Peter Christian, NCL CCG Board Member, stated that he was cautiously optimistic about the proposals. In the existing arrangements, he explained that it had been unrealistic to create a competitive marketplace for health and he felt that the new arrangements might be a fairer and more equitable model for a local healthcare system. The CCG Director of Integration acknowledged the important duties and powers of Healthwatch and other organisations in holding local healthcare arrangements to account. It was noted that the CCG was working towards a transition that would be as inclusive and carefully planned as possible. It was added that effective partnership working had strongly progressed during the response to the Covid-19 pandemic and it would be a good time to maintain these ways of working. The Director of Adults and Health also noted that Haringey had always sought to include local views and this would be an important basis for any local health arrangements.

Geoffrey Ocen, Bridge Renewal Trust, enquired whether other areas across the country had generally supported Option 1 or Option 2 and noted that the balance between local and national decision making would be very important. The Director of Adults and Health explained that the consultation had closed recently; it was confirmed that there would be a national decision, rather than different options for different areas, but there was no indication as yet in relation to which option was more popular nationally. It was added that further information would be available in future but that the Covid-19 pandemic had highlighted the importance of joint working. The CCG Director of Integration also noted that, although there would be a national framework, it was envisaged that each local area would be able to develop their arrangements with local variations. Charlotte Pomery, Assistant Director of Commissioning, noted that it would be really important to ensure the continued involvement of residents in local health and care.

Sharon Grant, Healthwatch Chair, asked how other councils in NCL were responding to the consultation. The Director of Adults and Health explained that there were regular meetings between NCL Directors of Adults and Social Services and there was a general consensus which echoed the points raised by Haringey Council. It was noted that it would be important to articulate what the local area wanted to be developed and NCL Directors were working to articulate this.

The Chair noted that she had met with other lead members in NCL, discussed some key governance and resourcing questions in relation to the proposals, and submitted an initial response to the consultation in December 2020. There were some concerns about how the proposals would ensure that community voices were genuinely included and how they would focus on reducing inequality and social exclusion to improve health outcomes. It was noted that these discussions had brought forward some important points and that the Health and Wellbeing Board would welcome future updates, particularly following the outcome of the national consultation and proposed next steps.

13. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

14. FUTURE AGENDA ITEMS

Cllr Kaushika Amin asked whether it would be possible for the Health and Wellbeing Board to receive a paper on the services for children under five as there were some concerns that these services were not performing as well during the Covid-19 pandemic. The Interim Director of Public Health noted that some of the services were provided by the Council, some were commissioned by the Council, and some were commissioned by the NHS but that it should be possible to present a paper to the Board.

It was noted that the dates of future meetings would be confirmed to members by email shortly and would be published on the Council's website.

CHAIR: Councillor Sarah James

Signed by Chair ……..

Date ……