Felicity Parker

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26 April 2012

To: All Members of the Overview and Scrutiny Committee

Dear Member,

Overview and Scrutiny Committee - Monday, 30th April, 2012

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

8. REVIEW UPDATE: SEXUAL HEALTH (PAGES 1 - 8)

To receive an update on the previous scrutiny review on Sexual Health.

10. REVIEW REPORT: MEN'S HEALTH (PAGES 9 - 102)

To consider the report on Men's Health.

11. REVIEW REPORT: MISSING CHILDREN (PAGES 103 - 144)

To consider the report on Missing Children.

Yours sincerely

Felicity Parker
Principal Committee Co-Ordinator

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Agenda Item 8

Haringey Council

Report for:	Overview and Scrutiny Committee	**Item number**	

Title:	Scrutiny Review Sexual Health and Teenagers (March 2010) - Update

Report authorised by :	Jeanelle de Gruchy Director of Public Health

Lead Officer:	Susan Otiti Assistant Director of Public Health

Ward(s) affected: All	**Report for Non Key Decision:**

1. Introduction

A review was undertaken by an Overview and Scrutiny Review Panel in 2010. Fifteen stakeholders from across the borough gave evidence to the committee including; NHS commissioner, service providers and a local GP, council service providers, further education providers and voluntary sector service providers

The terms of reference for the review were:
"To consider actions currently undertaken by NHS Haringey, the Council and other relevant partners to prevent sexually transmitted infections and re infection and conceptions amongst teenagers through the promotion of good sexual health within the Borough and make recommendations on how this might be improved"

The review panel undertook its work through:
• Interviewing key stakeholders to obtain their views
• Obtaining the views of service users, both potential and actual
• Considering relevant documentary and research evidence
• Looking at best practice elsewhere

This paper provides an update on the recommendations from the review.

2. Background

Haringey Council

Haringey Council has been through major organisational change due to reduced funding from central government. A three year efficiency savings programme was introduced in April 2011. The Children and Young People's Service has lost capacity both in terms of funding (to commission programmes) and workforce (staff who have direct contact with young people with a remit to promote wellbeing) and this has had an impact on sexual health programmes particularly the teenage pregnancy programme, the Healthy Schools programme and activities led by the Youth and Participation Service.

The local health services is going through a major programme of organisational change that started in the autumn of 2010 and resulted in the Health and Social Care Bill 2012. The organisational change has had an impact in Haringey with efficiency savings from April 2011 resulting in the loss of the full time NHS Haringey Sexual Health Commissioner post, two full time Public Health Officer posts and efficiency savings in provider services. In April 2011 responsibility for Haringey's sexual health commissioning moved to NHS North Central London and has been operating with significant reduced capacity.

The provider landscape has also changed, local community health services merged with Islington Community Services and Whittington Hospital to form Whittington Health.

3. Update following the Scrutiny Review

The significant organisational change across Haringey's statutory organisations (Haringey Council and the local NHS) has had an impact on the ability of both organisations to implement all the scrutiny review recommendations.

Strategic

1[1]. That the Children's Trust be requested to specifically raise the issue of the importance and value of the involvement of all secondary schools in programmes to promote good sexual health and the avoidance of conceptions with school governing bodies (C&YPS)

This was taken forward by the council's Healthy Schools Team and a Public Health Officer who were responsible for supporting schools in developing their Personal, Social and Health Education (PSHE) programmes within the national curriculum including promoting the national healthy schools programme. Due to efficiency savings the NHS Public Health Officer post was lost in January 2011 and the council's Healthy Schools Team was lost in May 2011. The national healthy schools programme is a well respected evidence based programme and the Director of Public Health did not want to lose the productive and effective relationship with Haringey's schools to support reducing teenage pregnancy and improving young people's sexual health. Following a capacity review the Public Health Directorate took on

[1] The numbers are not sequential but relate to the recommendation in the original scrutiny review report

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responsibility for co-ordination and supporting schools through a revised Healthy Schools programme. The DPH presented this revised programme to the secondary Head teachers in October 2011.

Reducing teenage pregnancy and improving sexual health are key priorities within the soon to be published Health and Wellbeing Strategy and a training session will be offered as part of the School Governors Support Training programme later in 2012.

Haringey's Teenage Pregnancy Co-ordinator continues to work closely with all secondary schools and the post was transferred from the council's Children & Young People's Service to the Public Health Directorate in August 2011.

Information on the importance of teenage pregnancy prevention and sexual health are sent to Head teachers regularly via 'Educomms' as well as notification of the distribution of Sex and Relationship Education resources for use with pupils, parents and school staff. Professional development meetings are held once a term with secondary school PSHE Co-ordinators.

6. That an information champion be identified from amongst C&YPS and NHS Haringey commissioners to take the lead in ensuring that young people are well informed about sexual health services. (C&YPS/NHS Haringey)

Until March 2011 the NHS Haringey information champion was the sexual health commissioner. Up to August 2011 the CYPS information champion was the Teenage Pregnancy Co-ordinator.

The Teenage Pregnancy Co-ordinator is now the information champion across both organisations and liaises regularly with all service providers.

9. That current work to establish more accurate data on spending on sexual health be welcomed and that, once more accurate data is available, a benchmarking exercise be undertaken to determine whether current levels of spending are appropriate to levels of local need, consistent with levels of statistical neighbours and providing good value for money. (NHS Haringey)

The sexual health commissioner completed the work on financial data before the post was lost in the NHS reorganisation in March 2011. Unfortunately the benchmarking exercise has not been done as the capacity (sexual health commissioner) has been lost.

Service providers

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2. That the school nurse service be flagged up as a priority area when future decisions on funding are made by NHS Haringey. (NHS Haringey)

During 2010/11 and 2011/12 and going forward into 2012/13 the priority for the Head of Children's Commissioning has been to ensure during the time of efficiency savings that the School Nursing Service did not result in dis-investment. Alongside this the focus of the School Nursing Service has been to support the safeguarding agenda and action plan.

Commissioners

3. That service commissioners consider the potential benefits of re-allocating some of the joint funding provided for teenage pregnancy initiatives to the school nursing service in order to facilitate a more proactive role for them in addressing sexual health issues. (C&YPS/NHS Haringey)

Capacity issues as well as the need for the School Nursing Service to prioritise the safeguarding agenda meant that this recommendation has not progressed however the school nurses are involved in the swift signposting to sexual health services where appropriate.

The 4YP Contraception and Sexual Outreach Nurse Team was expanded in 2009 until Haringey Council teenage pregnancy funding was reduced in 2010 and ended completely in 2011. Funding opportunities are currently being sought by Public Health to reintroduce this nurse outreach service.

4. That NHS Haringey undertake specific work to engage with young people at CoHENEL and especially recent arrivals to the UK, in order to increase awareness of local NHS services including GPs. (NHS Haringey)

Close partnership working with CoHENEL has ensured that local health services are promoted regularly at college 'Fresher's Events'. Health related training opportunities and information is provided regularly to CoHENEL's Student Welfare and Learner Support Department, its staff and student peer support teams, as well as utilising the college intranet.

To reduce the impact of the loss of the 4YP Contraception and Sexual Outreach Nurse based at CoHENEL in 2011, weekly 4YP Youth Worker led sessions were introduced to provide registration to the free condom (C-Card) scheme and advice on sexual health. Recent developments include CoHENEL commissioning weekly sessions with a 4YP Contraception and Sexual Outreach Nurse.

5. That the proactive approach and specific initiatives to address teenage

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pregnancy undertaken by many schools, such as the use of models of babies at Woodside High School, be commended and, where possible, extended. (C&YPS).

The Teenage Pregnancy Co-ordinator continues to work with and support the secondary schools. The 'Baby Think It Over' scheme used in Woodside High School was coordinated by the YMCA's Family Matters programme. YMCA ended this programme in 2010/2011. One set of dolls from a similar and improved programme was purchased as a pilot for use at the Secondary Pupil Referral Unit (The Octagon). Efficiency savings and lack of evidence base for their impact means that this scheme is operational. The Teenage Pregnancy Co-ordinator has signposted purchase information on the company providing the dolls to two schools who made an enquiry about them.

7. That full integration of sexual health services be supported and NHS Haringey be requested to provide an update on progress with its integration programme and an action plan as part of the response to the scrutiny review. (NHS Haringey)

NHS Haringey Sexual Health Commissioner worked with the Whittington Health Head of Service to strengthen the integration agenda within the 2011/12 contract. From October 2011 Whittington Health Sexual health Services has been fully integrated with all sites offering both contraception and sexual health advice and treatment.

The integration agenda will progress further with the introduction of the London wide sexual health tariff in July 2012.

8. That joint working with sexual health commissioners in neighbouring boroughs and particularly those where significant numbers of Haringey resident's access services, such as Hackney, be further developed. (NHS Haringey)

Joint working with colleagues in Hackney and Enfield have been maintained and developed further including the C-Card Scheme and Emergency Hormonal Contraception Scheme. Recent developments include the introduction of the Enfield and Haringey Sexual Health Partnership Board and joint development of young people's health and wellbeing promotion materials (mobile app) with Hackney.

10. *That the Panel supports the aspiration of service providers to develop a clinic aimed specifically at young men and requests that commissioners give consideration to the identification of funding of such provision. (NHS Haringey)*

Whittington Health received additional funding in 2011/12 for a number of

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initiatives however a clinic specifically for young men was not one of them. Once the London wide sexual health tariff is introduced this year this may be an area for development.

11. That commissioners consider the relocation of the 4YP clinic to a venue which is less stigmatising, more accessible and more attractive to teenagers as part of work on how best to reach relevant young people. (NHS Haringey/C&YPS)

It is for Whittington Health to decide where to locate their services based on the needs of the population and feedback from service users. The clinical 4YP+ for females only is held at Lordship Lane Health Centre which is accessible to those young women in the east who do not want to travel to the St Ann's Clinic.

NHS Haringey commissions community pharmacists to provide sexual health services (Chlamydia screening and Emergency Hormonal Contraception)

12. That the proposal by service commissioners to change the opening hours of the 4YP afternoon clinic at St Ann's so that it they are more convenient for young people be supported and that the Committee be provided with confirmation that this will be implemented as part of the 2010/11 commissioning process. (NHS Haringey/C&YPS)

NHS Haringey stipulated in the 2011/12 Whittington Health service specification a minimum of two specialist young people's clinics per week (out of school time starting at 4pm), these are operational.

13. That NHS Haringey routinely provide access to free condoms for all GPs providing appropriate sexual health services at their surgeries. (NHS Haringey)

NHS Haringey commissioned Whittington Health Contraception and Sexual Health Service to deliver sexual health training to GPs and practice nurses (the SHiP programme[2]) including access to free condoms.

14. That all GPs should be encouraged by NHS Haringey to provide a range of sexual health services and that, as part of the re-accreditation process for GPs, it be made a contractual obligation. (NHS Haringey)

As part of the national GMS contract all practices are expected to provide essential and those additional services they are contracted to provide to all their patients. There is a national enhanced service within the GMS contract

[2] SHiP programme – Sexual Health in Practice training programme for GPs and practice nurses to give them the skills and resources to deliver sexual health intervention

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that outlines a more specialised sexual health service to be provided. The specification of this service is designed to cover the enhanced aspects of clinical carer of the patient, all of which is beyond the scope of essential services.

Accreditation is part of the GMS contract specialised sexual health services.

15. *That NHS Haringey commissioners work with GP surgeries and primary care service providers to encourage them to obtain "You're Welcome" accreditation for their services and that a GP champion be appointed to promote the "You're Welcome" initiative within GP surgeries in Haringey. (NHS Haringey)*
The "You're Welcome" initiative is not part of the GMS contract. The "You're Welcome" initiative has been discontinued by the Department of Health.

16. *That NHS Haringey works with service providers to ensure that the importance of dealing sensitively and confidentially with patients is included as part of training for relevant reception and nursing staff in primary care and clinics. (NHS Haringey)*

This issue has been part of the SHiP training programme and is available to nursing staff in primary care.

17. *That the proposed introduction of a young persons health check to be offered through CoHENEL and sixth forms and undertaken by a nurse or health adviser be supported. (NHS Haringey/C&YPS)*

Health services for young people are promoted as described in Recommendation 4. Close partnership working with Haringey Sixth Form Centre has meant all support and activities provided to CoHENEL is replicated there as well. Haringey Sixth Form Centre are currently looking into commissioning weekly sessions with a 4YP Contraception and Sexual Outreach Nurse. All other Sixth Forms within Secondary Schools are provided with information on sexual health and related services including drugs and alcohol support and mental health and emotional wellbeing. Links to the Teen (13 - 19) Health Check is promoted on Youthspace website.

18. *That commissioners' work with service providers to ensure that all patients are made fully aware of the specific tests that had been undertaken on them for STIs by providing appropriate written information for them. (NHS Haringey)*

Whittington Health provides in-depth written information to all patients outlining the tests that will be undertaken, how the results will be shared with the patients and treatment options.

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4. Conclusion

Following the publication of the scrutiny review in March 2010 the NHS and local government have been through and continue to go through significant organisational change and efficiency savings programmes.

The majority of the recommendations have been implemented others have not due to efficiency savings and loss of workforce capacity.

Agenda Item 10

Haringey Council

Report for:	**Overview and Scrutiny Committee**	**Item Number:**	

Title:	**Men's Health: Getting to the Heart of the Matter**

Report Authorised by:	**Cllr David Winskill, Chair of the review panel**

Lead Officer:	Melanie Ponomarenko Senior Policy Officer Melanie.Ponomarenko@Haringey.gov.uk 0208 489 2933

Ward(s) affected:	**Report for Key/Non Key Decisions:**

1. Describe the issue under consideration

1.1. The focus of this scrutiny review is on men over 40 years of age who live in the most deprived areas of the borough. The review focuses on this age group for a number of reasons:

- It is in this age group that there is the biggest inequalities in death in the borough.
- By changing certain risk factors in those over 40 years of age a quick difference can be made as to whether or not the persons suffers from Cardio Vascular Disease.
- The Health Check programme focuses on those over 40 years of age.

2. Cabinet Member introduction

2.1. N/A

3. Recommendations

3.1. That the Overview and Scrutiny Committee approve the attached report and recommendation to be taken forward to Cabinet and other appropriate bodies.

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4. Other options considered

4.1. N/A

5. Background information

Key national points:

- Men under use primary health services'[1], and may take longer to present and receive a diagnosis.
- Premature death mainly affects men. 42% of men die prematurely (before the age of 75) from all causes compared to 26% of women. 21% of men aged 16-64 die from all causes compared to 12% of women[2].
- The social gradient has a greater impact on men's health than women's – the life expectancy gap between men and women widens as deprivation increases.
- Coronary heart disease kills more men than women and on average men develop it 10-15 years earlier. South Asian men living in the UK have an even higher premature death rate from heart disease and stroke than men generally.
- Men use the range of primary care services far less then women.

Key Haringey points

- 28% of the difference in life expectancy gap between Haringey and England is due to Cardio Vascular disease.
- 73% of the difference in male life expectancy gap between Haringey and England is due to men over 40 years of age.
- Male life expectancy varies greatly across the borough varying from 81.52 years in Fortis Green in the West of Haringey and 72.46 years in Tottenham Green in the East of Haringey.
- Circulatory diseases are one of the major causes of death and illness locally, accounting for 33% off all deaths in 2006/08.
- Deaths from circulatory disease are not evenly distributed across Haringey, with significantly higher rates observed in the East of the borough.
- Male life expectancy in Haringey is lower than the England and London average and within Haringey there are significant inequalities (of up to 9 years between the more affluent West and the more deprived East).
- 23.2% of the adult population took part in moderate sport and physical activity three times a week for at least 30 minutes in 2008/09; the participation rate is lower in the East of the borough.
- Obesity varies considerably across the borough with an estimated 25% of residents in the East of the borough obese.
- The gap in male life expectancy in Haringey has continued to increase with a 9 year gap across the borough. This therefore remains a key challenge.

[1] Men's Health Forum presentation, December 2011
[2] Health and Social Care Bill, Memorandum submitted by the Men's Health Forum (HS 83) http://www.publications.parliament.uk/pa/cm201011/cmpublic/health/memo/m83.htm

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This scrutiny review considered the reasons for the above points and what could be done in order to reduce the life expectancy gap focusing on the following areas:

- Barriers to men engaging in health services – reasons included men being reluctant to ask for help (often hoping the issue would go away), GP practice environment being a deterrent and men not always knowing the options which are available to them.
- Lifestyle, including smoking, physical activity, obesity and alcohol – the panel heard that whilst there are a number of services available for men to access they often do not access these services and that more could be done to market them in a men friendly way. The panel also heard some best practice examples, including Guys and Goals which is run by the Tottenham Hotspur Foundation.
- Pharmacies - The Panel felt that there was more that could be done to utilise pharmacies in the more deprived areas of the borough as they are ideal for men to drop into to ask for advice and have the potential to deliver health promotion and educational services. The pharmacy environment was also discussed with a view to trying to make it more 'male friendly'.
- Primary Care – Quality Outcome Framework (QOF) scores show some practices in more deprived areas not performing as well as others in cardiovascular disease measures. The Panel felt that the forthcoming changes under the NHS North Central London's 'Transforming the primary landscape in North Central London' could improve primary care in the area and also recommended that NHS Haringey works with relevant GP Practices to improve their QOF scores.
- Wider Determinant, Housing and Employment – The panel was conscious about the wider determinants of health that housing conditions in the more deprived areas of the borough are worse than those in other areas of the borough as well as employment having a significant impact on a person's health and particularly in the current climate of rising unemployment in the target group in Haringey.
- Regeneration – the panel felt that the regeneration of Tottenham, coupled with the Northumberland Development Project provide an excellent opportunity to reduce health inequalities in the East of the borough.

Recommendations of this review are intended to inform the Delivery Plan of the Health and Wellbeing Strategy (Outcome 2, A Reduced Gap in Life Expectancy).

6. Comments of the Chief Finance Officer and financial implications

6.1. Whilst there are a number of recommendations set out in this report, it is expected that at this stage any costs associated with these such as publicity and training will not be significant and would be met from existing resources within one or more of the partner agencies or, as noted in recommendation 7, that bids for external resources are put forward.

7. Head of Legal Services and legal implications

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7.1. Legal services have been consulted and believe that ‘there are no specific legal implications arising from this report’.

8. Equalities and Community Cohesion Comments

8.1. All public bodies have the same duty to comply with the Equality Act 2010. In doing so they are expected to promote equal opportunity and access to all services for all 'protected groups' in order to discharge their equality duty.

8.2. Within the protected groups 'sex' (previously known as gender) refers to both male and female. There are many public services that are under represented by men and all public bodies have a duty to take effective measures to ensure they promote equality of opportunity, which includes measures to increase take-up of under represented protected groups.

9. Head of Procurement Comments

9.1. N/A

10. Policy Implication

10.1. This review aims to complement the work which has been undertaken by the Cross Party Working Group on Health Inequalities.

10.2. The review will also contribute to the delivery plan of the Health and Well-being Strategy.

11. Use of Appendices

11.1. Appendices are listed in the main body of the report.

12. Local Government (Access to Information) Act 1985

12.1. A full list of documents used and referenced in the review are listed in the Appendices of the main report.

Haringey Council

Scrutiny Review
Men's Health: Getting to the Heart of the Matter

A REVIEW BY THE OVERVIEW AND SCRUTINY COMMITTEE

April 2012

www.haringey.gov.uk

Chair's Foreword

Between Fortis Green in the West of the Borough and Tottenham Green in the East of there is a 9 year difference in male life expectancy.

This shocking statistic has been known about for decades. However, with the return of Public Health to local authorities, Haringey, working with all of its partners, can now play a central role in tackling the ultimate inequality - the length of one's life.

Currently there is much renewed activity looking at how Tottenham can reach its full potential, with regeneration strategies and plans being written. This gives the borough an ideal opportunity to prioritise the improvement of men's health as a fundamental objective of this regeneration.

In Haringey's recently published Health and Wellbeing Strategy, the reduction of health inequalities has been rightly been made a central priority. In support of this objective, our panel chose to focus on the early death of men over forty years of age from Cardiovascular Disease. Deaths in this age range comprise the biggest contributing component to health inequalities so, by trying to improve the outcomes in this group, we have the opportunity of making the greatest influence in reducing the inequality figures.

Although the CVD outcomes for those in the most deprived wards in Haringey are the worst, we must not forget the pockets of deprivation in places such as the Campsbourne Estate in Hornsey and other areas.

From our first meeting with health professionals, lay people, and others active in the field, it was clear that there is a real will and determination to tackle this blight on the Borough. Already, people are meeting and planning Haringey activities that will form part of the National Men's Health Week in June this year.

It is only through long-term and determined action by residents, businesses, health providers, the voluntary sector and the council that we will be able to rid the borough of this unacceptable inequality.

This review provides a blueprint for that action and a foundation for relationships that will embed, build on and join up the fantastic work which is already taking place across the borough. The establishment of a local Men's Health Forum, as recommended in this review, provides the ideal opportunity to give impetus to the recommendations of this review.

Necessarily, this has been a very wide-ranging review. Alongside this we have a new and evolving health structure: it is therefore important that ownership is taken for the overall implementations of our recommendations and there is a central driving force, for example a local men's health forum, in order to coordinate this work.

Thanks are due to everyone who contributed their time, energy and enthusiasm to this review.

Cllr David Winskill

Panel Members:
Cllr Bob Hare
Cllr Reg Rice
Cllr Anne Waters

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Contents

Executive Summary

National context:

- Men under-use primary health services[1], and may take longer to present and receive a diagnosis.
- Premature death mainly affects men. 42% of men die prematurely (before the age of 75) from all causes compared to 26% of women. 21% of men aged 16-64 die from all causes compared to 12% of women[2].
- The social gradient has a greater impact on men's health than women's – the life expectancy gap between men and women widens as deprivation increases.
- Coronary heart disease kills more men than women and on average men develop it 10-15 years earlier. South Asian men living in the UK have an even higher premature death rate from heart disease and stroke than men generally.
- Men use the range of primary care services far less then women.

Haringey context:

- 28% of the difference in life expectancy gap between Haringey and England is due to Cardio Vascular disease.
- 73% of the difference in male life expectancy gap between Haringey and England is due to men over 40 years of age.
- Male life expectancy varies greatly across the borough varying from 81.52 years in Fortis Green in the West of Haringey and 72.46 years in Tottenham Green in the East of Haringey.
- Circulatory diseases are one of the major causes of death and illness locally, accounting for 33% off all deaths in 2006/08.
- Deaths from circulatory disease are not evenly distributed across Haringey, with significantly higher rates observed in the East of the borough.
- Male life expectancy in Haringey is lower than the England and London average and within Haringey there are significant inequalities (of up to 9 years between the more affluent West and the more deprived East).
- 23.2% of the adult population took part in moderate sport and physical activity three times a week for at least 30 minutes in 2008/09; the participation rate is lower in the East of the borough.
- Obesity varies considerably across the borough with an estimated 25% of residents in the East of the borough obese.
- Following a decrease in the male life expectancy gap between England and Haringey 2002/04, the gap has again increased over the recent few years. Therefore this remains a key challenge for the borough.

This scrutiny review considered the reasons for the above points and what could be done in order to reduce the life expectancy gap focusing on the following areas:

- Barriers to men engaging in health services – reasons included men being reluctant to ask for help (often hoping the issue would go away), GP practice environment being a deterrent and men not always knowing the options which are available to them.
- Lifestyle, including smoking, physical activity, obesity and alcohol – the panel heard that whilst there are a number of services available for men to access

[1] Men's Health Forum presentation, December 2011
[2] Health and Social Care Bill, Memorandum submitted by the Men's Health Forum (HS 83) http://www.publications.parliament.uk/pa/cm201011/cmpublic/health/memo/m83.htm

they often do not access these services and that more could be done to market them in a men friendly way. The panel also heard some best practice examples, including Guys and Goals which is run by the Tottenham Hotspur Foundation.

- Pharmacies - The Panel felt that there was more that could be done to utilise pharmacies in the more deprived areas of the borough as they are ideal for men to drop into to ask for advice and have the potential to deliver health promotion and educational services. The pharmacy environment was also discussed with a view to trying to make it more 'male friendly'.
- Primary Care – Quality Outcome Framework (QOF) scores show some practices in more deprived areas not performing as well as others in cardiovascular disease measures. The Panel felt that the forthcoming changes under the NHS North Central London's 'Transforming the primary landscape in North Central London' could improve primary care in the area and also recommended that NHS Haringey works with relevant GP Practices to improve their QOF scores.
- Regeneration – the panel felt that the regeneration of Tottenham, coupled with the Northumberland Development Project provide an excellent opportunity to reduce health inequalities in the East of the borough.
- Wider Determinant, Housing and Employment – The panel was conscious about the wider determinants of health that housing conditions in the more deprived areas of the borough are worse than those in other areas of the borough as well as employment having a significant impact on a person's health and particularly in the current climate of rising unemployment in the target group in Haringey.

Recommendations of this review are intended to inform the Delivery Plan of the Health and Wellbeing Strategy.

Recommendations

The Panel is aware of the changes to the National Health Service which may have implications on who is responsible for taking some recommendations forward. Therefore recommendations for NHS Haringey are made on the understanding that these will be taken forward by the appropriate successor body e.g. the Clinical Commissioning Group.

Recommendations below should be read in the context of the main body of this report.

1. A local targeted campaign involving all relevant partners should be run to coincide with National Men's Health Week (11-17th June 2012) to engage men in preventative and early intervention services around 'heart health'.

Participants to be encouraged to attend include:

- GPs
- Pharmacists
- Health Trainers
- Health Champions
- Whittington Health
- North Middlesex UH
- Mental Health Trust
- Employment advice and support
- Nurses/students
- Trainee GPs
- Other acute providers
- Voluntary and Community groups
- Expert patient groups/Peer support/buddy system
- Leisure centres/fitness centres
- Weight watchers/ similar groups
- Housing
- Jobcentre plus
- Retail food sector

Haringey Council's Press and Publicity should assist with ensuring that the week is advertised and messages from Men's Health Forum about Heart Health are disseminated.

2. Shadow Clinical Commissioning Group to consider ways in which men could be encouraged to attend their local GP surgery. For example:

- Holding special Men's sessions at GP surgeries.
- Consider ways in which local GPs could link up with local groups e.g. Tottenham Hotspur Foundation to take services into the community.
- Asking local practices to consider their waiting areas from a male perspective and consider any changes which they could easily implement to assist in making men feel more comfortable in the practice environment e.g. an area with male interest magazines and posters about men's health.
- Having a 'Male Champion' at GP surgeries.

3a. NHS Haringey tackles men's reluctance to engage with primary care services by:

- Initiating training programmes which would be helpful in supporting local GPs in working with men to encourage their attendance at primary health care services.
- Any training which would be helpful for practice staff, including Practice Managers and receptionists, in overcoming barriers which men feel they face in attending GP surgeries.

3b. – Pharmacies and NHS Haringey consider joint training on raising awareness of particular issues men may face in engaging with primary health care services.

4. To address the low take up of health and well-being services in the borough all key providers:

- Should examine current service delivery and look at whether they are being delivered in a way which enables and encourages men to access them.
- When commissioning new services, should consider any factors which could enable and encourage men to access them.
- Should advertise appropriate services in settings which men are most likely to attend e.g. working men's clubs, libraries, employment settings, pubs, Turkish cafes etc.
- Consider ways to engage with local schools to normalise young men's relationships with health professionals.
- For all of the above the use of appropriate language and pictures should be carefully considered in order to appeal to the target group.

5. The Haringey Community Sports and Physical Activity Network (CSPAN) develops and implements a sustained campaign to actively engage with men over 40 years of age and encourage them to take regular exercise. Part of this should include supporting:

- the Tottenham Hotspur Foundation initiative
- Men's Health Week

6. Licensing and Public Health:

- Explores options and best practice examples of work with local corner shops to reduce the sale of cheap alcohol in areas where this has an impact on the heart health of men over 40 years of age.
- That where effective examples are found that this be implemented in the target areas.

7. Public Health:

- Explores innovative options and best practice examples of where weight management have had an impact on the heart health of men over 40 years of age, for example on-line weight watchers, 'slimming without women', work place teams etc.
- That where effective examples are found that this be implemented in the target areas.
- Public health leads continue to seek to identify and apply for external funding to support locally based initiative to support the reduction of CVD in the target group.

8. Public Health works with the Haringey 'Health at work' group to ensure that there are evidence based interventions and programmes with a focus on men over 40 years of age.

9. Public Health and Environmental Health to work with "fast food" suppliers (initially in Tottenham, but to expand into the whole Borough) to develop healthier options on their menus and a "Healthier Haringey" Mark. This should include working

with smaller high street suppliers as well as parent companies. Areas to be focused on include:

- Using a healthier type of oil to fry food.
- Reducing the amount of salt used.
- Including healthy options on menus.

Consideration should be given to the involvement of local college catering courses.

10. That the Local Pharmaceutical Committee considers:

- A local awareness raising campaign in order to highlight the services available a local pharmacies as well as the professional training which pharmacy staff have undertaken.
- Working with local pharmacies in order to make them more 'man friendly' to encourage men into pharmacies.
- Encouraging local pharmacy staff to consider taking the Centre for Pharmacy Postgraduate Education module on men's health.
- Having a specific day of the month/week or time of a specific day whereby men are able to walk into consulting rooms and be given advice from pharmacists without needing to explain the issue over the counter.
- Joint projects with pharmacies taking services into male settings.

11. Haringey Community Pharmacies to run a Men's health week to tie in with the National Men's Health week as one of their 6 contractual Public Health Campaigns

12. Pharmacies to be encouraged and supported by NHS Haringey and Public Health to expand their function as a gateway to primary care and be commissioned to deliver public health and health improvement services on site and in the wider community.

13. That NHS Haringey works with local GP practices who are under-performing in the most deprived area of the borough based on the Quality Outcomes Framework scores to improve their performance. For example:

- In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment treatment tool.
- The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Focus should be placed on those QOF scores which would have the biggest impact on male life expectancy in the area.

14. The recommendation in the Primary Care Development Strategy that smaller practices join into networks enabling all patients to access higher level services should take full account of this review and ensure that particular attention is given to inequalities in men's health.

15. Partners recognise the potential of the Northumberland Development Project in improving the health inequalities in the area. We recommend that Public Health, CCG, NCL, Spurs and other appropriate partners take the redevelopment of the stadium as an opportunity to positively influence health outcomes for men over 40.

16. The plans for the regeneration of Tottenham should recognise and acknowledge the unacceptability of the continuing health inequality issues and adopt a programme of targeted health improvement as a specific strategic objective and take account of health needs in other aspects of the regeneration of Haringey.

17. It is well documented that housing is a wider determinant of health and that in the more deprived areas of the borough there is more overcrowding and often worse quality housing. The panel therefore recommends that the HMO licensing scheme currently taking place in Harringay Ward is extended to Tottenham and any other relevant areas of the borough (subject to the required criteria being met following the appropriate assessment)

18. There are clear and evidenced health risks associated with long-term unemployment and whilst the panel recognises that the Council is focusing on 18-24year olds, as a priority group, the service will not be exclusive to this age group. The panel believes that wherever possible programmes should be developed to support men over 40 years of age to gain skills and receive support into employment.

19. The significant ward differences in men over 40s' life expectancy to be recognised in the Joint Strategic Needs Assessment and tackling them to be made a priority by NHS Haringey in commissioning plans.

20. That Public Health and the Tottenham Hotspur Foundation continue in their positive working relationship to improve health outcomes of men in the target group.

21. That a local men's health forum is established to continue the momentum developed throughout the review.

1. Introduction

1.1. The focus of this review is on men over 40 years of age who live in the most deprived areas of the borough. The review focuses on this age group for a number of reasons:
- 73% of the difference in male life expectancy gap between Haringey and England is due to men over 40 years of age.
- By changing certain risk factors in those over 40 years of age a significant improvement can be made as to whether or not the persons suffers from Cardio Vascular Disease.
- The Health Check programme focuses on those over 40 years of age and so it is hoped that this review complements this work.

1.2. Using the wider determinants of health (Dahlgren and Whitehead model) the review aimed to develop recommendations to increase male life expectancy in the ethnically diverse east of the borough with a focus on engaging the population in:

- **Prevention**: smoking, physical activity, alcohol, obesity
- **Early intervention** (adults over 40):cardiovascular disease

1.3. Definition of Men's health:

'*A male health issue is one arising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level'* [3]

1.4. The European Commission published 'The State of Men's Health in Europe[4]' in 2011. This report looks at male mortality and morbidity in the 27 EU Member states, 4 states of the European Free Trade Association and the 3 candidate countries. This report is analysed in an article for the British Medical Journal (Europe's Men need their own health strategy) which states that action is needed in three areas:

- Schools – "Behaviours and values developed early in life have a critical influence on men's later health practices. There is a need for a visible, integrated focus on boys' and men's health within primary and secondary curriculum that can foster positive models of physical psychological, and social development"
- Workplace – "Employers and unions can work collaboratively to support policies and programmes to promote men's health in the workplace"
- Policies "…that target marginalised subgroups of men….[who] experience considerably higher morbidity and premature mortality[5]".

The review aims to take these areas into consideration in the main report.

1.5. **What is Cardiovascular Disease?**

[3] Men's Health: the challenges ahead, Journal of Men's health and gender, Professor Alan White, 2004
[4] European Commission, The State of Men's Health In Europe, 2011
[5] British Medical Journal, 'Europe's men need their own health strategy', Professor Alan White and colleagues, 2011

1.5.1. Cardiovascular Disease (CVD) includes all of the diseases of the heart and circulation including coronary heart disease (angina and heart attack), and stroke[6].

1.5.2. CVD – also known as heart and circulatory disease is the leading cause of death and disability worldwide[7]. Incidence of CVD in the UK is significantly higher in men as well as in those with lower social status and higher deprivation[8].

1.6. **National picture**

- Men are more likely to undertake some riskier behaviours associated with health.
- Men under use primary health services'[9], and may take longer to present and receive a diagnosis.
- Premature death mainly affects men. 42% of men die prematurely (before the age of 75) from all causes compared to 26% of women. 21% of men aged 16-64 die from all causes compared to 12% of women[10].
- The social gradient has a greater impact on men's health than women's – the life expectancy gap between men and women widens as deprivation increases.
- Coronary heart disease kills more men than women and on average men develop it 10-15 years earlier. South Asian men living in the UK have an even higher premature death rate from heart disease and stroke than men generally.
- Men use the range of primary care services far less then women.

1.7. **Haringey**

- 28% of the difference in life expectancy gap between Haringey and England is due to Cardio Vascular disease.
- 73% of the difference in life expectancy gap between Haringey and England is due to men over 40 years of age.
- Male life expectancy varies greatly across the borough varying from 81.52 years in Fortis Green in the West of Haringey and 72.46 years in Tottenham Green in the East of Haringey.
- The picture for the difference in female life expectancy does not have such a clear geographic focus.
- Circulatory diseases are one of the major causes of death and illness locally, accounting for 33% off all deaths in 2006/08.
- Deaths from circulatory disease are not evenly distributed across Haringey, with significantly higher rates observed in the East of the borough.
- Male life expectancy in Haringey is lower than the England and London average and within Haringey there are significant inequalities (of up to 9 years between the more affluent West and the more deprived East).

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[6] British Heart foundation, www.bhf.org.uk

[7] Journal of Public Health, pp 110-116, Evaluation of a cardiovascular disease opportunistic pilot ('Heart MOT' service) in community pharmacies, J.M.P. Horgan (Head of Medicines Management) A.Blenkinsopp (Professor of the Pharmacy Practice), R.J. McManus (Professor of Primary Care Cardiovascular Research.

[8] Preventing chronic disease: A Vital Investment, Geneva: World Heath Organisation, 2005

[9] Men's Health Forum presentation, December 2011

[10] Health and Social Care Bill, Memorandum submitted by the Men's Health Forum (HS 83) http://www.publications.parliament.uk/pa/cm201011/cmpublic/health/memo/m83.htm

- People in lower socio-economic groups are less active than those in the higher socio-economic groups, at levels of 14.4% and 24.6% respectively.
- 23.2% of the adult population took part in moderate sport and physical activity three times a week for at least 30 minutes in 2008/09; the participation rate is lower in the East of the borough.
- Obesity varies considerably across the borough with an estimated 25% of residents in the East of the borough obese.
- The gap in male life expectancy in Haringey has continued to increase with a 9 year gap across the borough. Therefore this remains a key challenge.

1.8. **What increases the risk of CVD?**

- Smoking
- High Blood Pressure
- High cholesterol
- Being physically inactive
- Being overweight or obese
- Family history
- Certain ethnic backgrounds
- Gender – men are more likely to have CVD.
- Age – the older you are the more likely you are of developing CVD.

Methodology

2. The review was led by a Panel of four Non-executive Councillors:
   - Cllr David Winskill (Chair)
   - Cllr Bob Hare
   - Cllr Reg Rice
   - Cllr Anne Waters

2.1. The review consisted of a number of Panel meetings, external meetings with stakeholders, a survey (See Appendix E) and two focus groups. The review was also part of a Centre for Public Scrutiny Health Inequalities Return on Investment Pilot (see Appendix F).

2.2. Evidence from a wide range of stakeholders was presented at Panel meetings (See Appendix C for a full list of review contributors). Following presentations the panel and other attendees had the opportunity to ask questions. The Panel was delighted that those who were invited to give evidence at a Panel meeting attended meetings prior to their slot and also chose to attend Panel meetings afterwards. This meant that throughout the review there was a wide range of attendees with different perspectives and professional and personal experience allowing for a thorough look at the issues relating to the target group.

2.3. The survey had three overarching aims:
   - to ascertain current behaviour that men adopt to stay healthy
   - to identify those barriers which may prevent men from keeping fit and staying healthy
   - identify those interventions which may support men to stay healthy.

2.4. The survey was designed in consultation with panel members, local officers (Policy, Public Health) and men's health organisations.

2.5. The target population of was men aged 40 years and over who lived and worked in Haringey. The survey was distributed both electronically and manually via local men's health groups, public health networks, local employers and street outreach. Of the 159 surveys returned:

- 77% were completed on-line
- 13% were completed via street outreach
- 11% were completed via local men's groups.

2.6. It is not possible to calculate a response rate given the electronic distribution of some survey. The absolute number of responses was felt to be sufficient to provide robust and meaningful data and to support the scrutiny review process.

2.7. Two focus groups were successfully run – one with men over 40 at a local Arriva Bus garage and one with older men at a local Men's health group, The Intrepid Explorers. A third focus group was set up and men over 40 invited via local networks however despite a number of local men confirming their attendance no one turned up on the day.

2.8. The successful focus groups were useful in providing a more qualitative context to the survey and some of the issues which had come to light throughout the review.

2.9. The Centre for Public Scrutiny Return on Investment Pilot used a number of tools to build on a previous pilot as part of the Health Inequalities programme. The question posed for the purpose of this pilot for the review was:

What would be the return on investment (ROI) if, in the life expectancy corridor of the Borough, we engaged men over 40 who were at risk of cardio vascular disease (referred to hereafter as Group A) with health and wellbeing services?

Policy Context

3. Over the past few years the issue of health inequalities has come to the forefront of national and local policy. Key documents include:

3.1. 'Healthy Lives, Healthy People' – a public health white paper which set out the long term vision for the future of public health in England and the creation of a 'Wellness' service.

3.2. Marmot Review – an independent review commissioned by a former Secretary of State to propose the most effective evidence-based strategies for reducing health inequalities in England.

3.3. London Health Inequalities Strategy – Recognises that there is a social gradient in health and aims to diminish the steepness of the social gradient across London.

3.4. Health and Wellbeing Strategy - A Cross-party working group on Health Inequalities was set up to recommend priority actions to reduce health inequalities in Haringey, with a particular focus on the Council's contribution. The work and recommendations of this group formed part of the consultation and have been fully integrated into the draft Health and Wellbeing strategy.

The cross-party working group made a number of recommendations, the most significant being:

- Organise a series of resident debates across the borough on factors driving inequalities and what we as a community can collectively do about it e.g. food and drink; alcohol; smoking; stigma;
- Work with schools (Head teachers and governors) and children centres, encouraging them to have immunisation as a prominent part of the school/children centre entry;
- Involve young people in devising a campaign about teenage pregnancy ;
- A smoke free Haringey – continue to 'de-normalise' smoking through ;promoting 'stop smoking' in parks, in particular in children's play areas, at bus stops, and for staff within 50m of all council buildings;
- Training frontline staff in brief interventions on alcohol and smoking;
- Explore all planning avenues to reduce the proliferation of fast food outlets in the borough and work with existing fast food outlets to make their food healthier;
- Stop the selling of all fizzy sugary drinks and junk food from all council premises; encourage schools to do the same;
- Develop a 'Safe places' scheme where local shops and businesses display a sticker so that people with a learning disability or mental ill health who are out and about who needing assistance will find refuge inside
- Encourage volunteering with Community Health Champions - offer NVQs leading to job opportunities;
- Work with council commissioned and private leisure centres to ensure that they are affordable and attract clients:
  - Who have low levels of physical activity
  - To incentivise parents to use their facilities - encouraging them to exercise with their children giving a discount when their children use the centre
  - Expand exercise on prescription.

More detailed Policy context can be found in Appendix A

Main Report

4. Survey and Focus Groups

4.1. Review Survey key points (note that this survey represents a snap shot and is not a representative sample):

- 159 responses were received from the survey.
- The majority of respondents were under 60 years of age, with just 15% over 60 years of age.
- 38% of respondents lived in Haringey.
- 92% of respondents were either in full time or part time paid employment.
- Proportionally more respondents in paid employment reported 'good' or better health than those not in paid employment (50%).
- Almost 1 in 5 respondents ages 40-49 years of age had *not* visited their GP for 3 years or more.
- The most common responses when asked about factors affecting health were stress (38%), lack of exercise (24%) and being overweight (32%).
- Smoking, eating habits, alcohol, stress and lack of exercise were found to be affecting the health those under 60 years of age more than those over 60 years of age.
- The main factor cited by those over 60 years of age affecting their health was loneliness.
- Respondents from BME groups were almost three times more likely to cite work/unemployment as affecting their health than respondents from white ethnic groups.
- Respondents living in Haringey were more likely to indicate that work/unemployment, loneliness and sexual health was affecting their health than those who lived out of Haringey.
- Proportionally more respondents living in Haringey had taken all these actions to maintain their health than those who did not live in the borough However; this pattern was not repeated when the responses of those living in the east of the borough are compared against all other respondents.
- The most popular setting for a men's health check was a GP surgery, where 84% of respondents indicated that they would be very likely or likely to attend. Equally as popular for a men's health check was the workplace where almost ¾ of respondents (71%) indicted that they would be very likely/ likely to attend. 43% were very likely/likely to attend at Chemists and 34% leisure centres.
- Haringey residents were more likely to favour more informal settings (community centres, leisure centres and chemists or a men's health check than non-Haringey residents.
- Approximately 2/5 of respondents indicated that the 'the inaccessibility of GP services' (41%) and 'hoping that the problem would go away' (40%) were likely to deter them from seeking health if they were unwell.
- Just over ¼ of respondents indicated that 'concern that the problem may be serious' (28%) and 'lack of knowledge about the NHS' (24%) were likely to deter men from seeking help if they were unwell
- A higher proportion of respondents from BME groups consistently indicated that all presented factors would likely deter them from seeking advice or support if they were unwell. For example, almost twice as many respondents from BME groups indicated that a 'lack of NHS knowledge', 'inaccessibility of GPs' and 'discomfort at talking with a female practitioner'

were likely to deter them from seeking advice if they were unwell than respondents from white ethnic groups

- Face-to-face advice from a health professional was perceived to the most helpful local intervention which could support men to stay healthy; 94% of respondents indicated that this would be helpful. A majority of respondents also indicated that a discounted gym membership (83%), a web page for local health men's health information (79%) and a men's health booklet (73%) would be helpful local developments for men to stay healthy.
- Analysis has shown that those who were already in poor health were not only less likely to have taken action to improve their health but also more likely to be deterred by a range of factors from seeking advice or support, *even when they were unwell*. Similarly, those with a disability were more likely to be affected by a range of health issues yet it was recorded that they faced similar barriers to accessing advice and support as those without a disability.

A full analysis can be found at Appendix E

4.2. Key points from the focus groups:

4.2.1. Intrepid Explorers – Over 50's Men's Group

- The group has provided some health education and awareness training on issues relating to men's health.
- A number of men noted that if they were worried about their health, they may be reluctant to seek help as they were embarrassed at talking about personal health issues. Attendees felt that this was a common position amongst men of their age.
- This embarrassment did not directly relate to the prospect of seeing a female practitioner however, as many indicated that they had regularly see a female GP. Though some men did indicate that this may deter them and others, it just depended on what was wrong (i.e. the nature of the concern).
- There was a reluctance to go for a general health check up at the GPs as men did not want to be seen as 'wasting the Doctors time'.
- The prospect of a men's health check up, perhaps to which men had been invited or was promoted as such (i.e. a dedicated space) was much more amenable to the group. There was an indication that men may find such an initiative useful and would attend.
- Possible locations for a possible men's health check up were discussed by the group. Men were open to the idea of health checks being available at traditional (GP surgery) and non-traditional health venues such as, for example community settings or chemists. (There was some indication that men already used chemists for health advice, though this appeared to be mainly medicine related).
- There was evidence that men in this group were engaging in healthy lifestyle behaviours
- Knowing what services were available locally specifically for a man was important to their uptake and usage of services. A number men in the group indicated that they had only become aware of some facilities or sessions which were useful to them opportunistically and more would benefit if these were more widely known or publicised.
- The men felt that there were groups, activities and services that were available for men in the community but they were not always aware of where and when these were.

- There was also perception that some activities were less intimidating and more enjoyable when these were undertaken as part of a group, or where they had developed contacts with other service/ facility users.

- Improved access to collated information about men's health was felt to be important. There were two clear examples provided:
  - Simpler routing for internet information, for example a dedicated page.
  - The updating and distribution of the Older Peoples Manual.
- Participants were also keen on the idea of men's health events where they could obtain information about men's health and other related activities. There was particular interest for representatives from local services and facilities to attend to inform men face to face of services which may be of help in maintaining or improving their health (i.e. recreation centre manager).

4.2.2. Arriva Bus Garage

- Participants had a good understanding of what being healthy meant and most participants said that they tried to engage in some healthy activities for example walking when possible, trying to incorporate vegetables or salad into their meal and gardening.
- The fact that being a bus driver was a sedentary job was also felt to be a challenge for staying healthy
- Participants felt that staying healthy was a challenge with shift patterns which also had an impact on family life.
- The main concern the participants had relating to their health was heart disease, with two recent examples of relatively young male drivers dying from a sudden heart attack bringing this concern to the forefront of their minds.
- Local gyms, including the Council leisure services, were felt to be too expensive and therefore they did not feel motivated to enrol here.
- Participants were often reluctant to go to the GP if they were to feel unwell due to taking time off work, and not being paid for this time. There was also a general sense that rather than seeking help or advise they would 'see what happens' and if it would 'just go away'. At the same time, if they did go it was often due to their wife or partner encouraging them to go.
- Pharmacies were not felt to be an option for health advice due to them being unable to prescribe anything for the complaint. There was a general lack of awareness about the services which pharmacies may be able to offer.
- There was a general feeling that the human body does not go on forever and so they may dismiss feeling unwell and put it down to getting older rather than seeking help.
- Participants felt that more widely available information on health campaigns and the services available at obvious places that they would notice e.g. posters on buses, would be beneficial.
- Participants all said that should health promotion, advice and health checks be available at the bus garage they would use this service.

4.3. NHS Haringey AGM (these groups consisted of a mix of voluntary and community sector representatives, health professionals and local men). Three questions were asked. Key points:

How do we get men to go to health services when they have early symptoms?
What is it that prevents them from going early enough?

- Men may avoid going to the GP until they feel it is absolutely necessary/a last resort.
- Women are use to going to the Dr/medical places and talking about their health e.g. birth control pregnancy, birth, taking children, health visitors etc.
- Men may have their own 'hierarchy of need' – this may mean that going to work and providing is more important in their minds than going to the Dr.
- A common comment was about men not feeling able to take time off work to go to a GP appointment.
- A number of psychological barriers were also discussed e.g. men may not feel that they are unwell until they are told by a medical professional that this is the case , there may be a culture of macho-ism and being ill could be perceived as a sign of weakness.
- The environment of GP practices may be seen as too feminine.
- Men may be more comfortable when more men are around.

How do we encourage men to keep themselves well?

- A number of possible ideas were discussed including:
- Men's specific clinic sessions/Breakfast meeting at surgery – drop in like session.
- Need to target adolescent boys to 'normalise' GP visits.
- More information on the options of where they can seek help and advice if they are feeling unwell.
- Mobile units/Take screening 'on the road' like they do for Breast Screening
- Raise awareness of signs and symptoms of illness

5. Barriers to men engaging in health services

5.1. Throughout the review the panel have heard about barriers men feel they face in engaging with health services:

- Appointment system as a deterrent – some men feel that arranging an appointment can act as a major deterrent in booking an appointment. 41% of respondents to the review survey said that the accessibility of GP services/appointments was likely or very likely to prevent them seeking advice or support if they felt unwell. The appointment system was also mentioned a number of times by participants of the focus groups. It has also been noted that where men have not been to their GP in a number of years, they may not be aware of the opening hours and therefore think that they are more limited than they are. There was discussion about how the appointment system could be made easier to navigate, e.g. more online bookings systems or automated telephone systems available. It is noted that the vision for Haringey by 2016 that appointments for all practices will be able to be made via the telephone, online or in person[11].
- GP practice environment – research undertaken by the men's health forum suggested that men view GP surgeries as female environments, 'like ladies hairdressers'[12] with posters and magazines targeted at women and nothing for men. Whilst the panel acknowledges that the majority of visits to GP surgeries are undertaken by women, often with their children, it was felt that more could be done to make the waiting room environment more 'male

[11] Transforming the Primary Care Landscape in North Central London, NHS NCL, 2012
[12] Men's Health Forum research

friendly, for example a corner with a few male interest magazines and posters and health information specifically aimed at men.

- Variety - There needs to be a variety of services in a variety of settings for men to access them. The panel heard of examples where health checks were carried out in work place settings e.g. in a local bus garage which was overwhelmed because men were happy and comfortable to have these at work. A lot of these men went onto other services, e.g. alcohol reduction and smoking cessation. The review survey found that 71% of respondents would be likely or very likely to attend a health check at their workplace. This view was echoed by a focus group held at a local bus garage where men were very keen on having health checks and information in the workplace.
- Media - The media men are exposed to often does not include health information which may contribute to their lack of awareness of available services.
- Men are often reluctant to ask for help. Throughout the review a number of reasons were heard and discussed about this. For example, men "you're not ill unless the Doctor says you're ill and so if you don't go you can't be ill" Focus group comment.

5.2. The role of reception staff was discussed in this context and the potential benefits of training surgery staff about issues which can act as a barrier for men to engage.

5.3. The possible advantages of having a 'male champion' at practices was also discussed. This person could lead on men's health and have a role to ensure that there were male interest magazines and posters in a particular area of the practice, try to ensure there are men on patient panels and generally raise awareness of issues which may affect and the potential barriers men may feel they face.

5.4. The Panel heard from the Men's Health Forum that men generally stop going to the GP when they are about 16 years of age and generally do not go again until they are in their 40s and visit due to a then existing health condition e.g. a heart attack.

5.5. It was noted a number of times throughout the review that men have a different relationship with health professionals to women. For many women visiting the GP is part of everyday life, with visits to discuss contraception, throughout pregnancy, with young children etc. Generally speaking men do not traditionally have this relationship with health professionals. There is a need to 'normalise' men's relationship with health services from an early age.

5.6. Often men believe that the only option they have for health advice and support is their GP whereas there are a number of other options, for example pharmacists and community health services. The Men's Health Forum also spoke to the panel about the need for better signposting of health services for men, in a way in which they would be able to engage with the information. For example the use of language which men are more likely to relate to.

5.7. Many men may also feel that it is too late to improve their lifestyle and therefore health and may therefore not be motivated to make any changes. There is a need for greater awareness raising that it is never to late to change.

5.8. The Panel heard that the Haringey Clinical Commissioning Group is discussing having a 'Haringey Health' website which would focus health and prevention rather than 'ill health'. The Panel felt that this would be a positive step.

5.9. The Panel felt that an ideal way in which to 'kick start' awareness raising to try and engage more men in health services would be to participate in the National Men's Health Week being coordinated by the Men's Health Forum and which this year is focusing on heart health.

Recommendation:

A local targeted campaign involving all relevant partners should be run to coincide with National Men's Health Week (11-17th June 2012) to engage men in preventative and early intervention services around 'heart health'.

Participants to be encouraged to attend include:

- GPs
- Pharmacists
- Health Trainers
- Health Champions
- Whittington Health
- North Middlesex UH
- Mental Health Trust
- Employment advice and support
- Nurses/students/Trainee GPs
- Other acute providers
- Voluntary and Community groups
- Expert patient groups/Peer support/buddy system
- Leisure centres/fitness centres
- Weight watchers/ similar groups
- Housing
- Jobcentre plus
- Retail food sector

Haringey Council's Press and Publicity should assist with ensuring that the week is advertised and messages from Men's Health Forum about Heart Health are disseminated.

Recommendation:

Shadow Clinical Commissioning Group considers ways in which men could be encouraged to attend their local GP surgery. For example:

a. Holding special Men's sessions at GP surgeries.
b. Consider ways in which local GPs could link up with local groups e.g. Tottenham Hotspur Foundation to take services into the community.
c. Asking local practices to consider their waiting areas from a male perspective and consider any changes which they could easily implement to assist in making men feel more comfortable in the Practice environment e.g. an area with men's interest magazines and posters about men's health.
d. Having a 'Male Champion' at GP surgeries.

Recommendation:

a - NHS Haringey tackles men's reluctance to engage with primary care services by:

- Initiating training programmes which would be helpful in supporting local GPs in working with men to encourage their attendance at primary health care services.
- Any training which would be helpful for practice staff, including Practice Managers and receptionists, in the barriers which men feel they face in attending GP surgeries.

b - That Pharmacies and NHS Haringey consider joint training on raising awareness of particular issues men may face in engaging with primary health care services.

Recommendation:

To address the low take up of health and well-being services in the borough all key providers:

- Should examine current service delivery and look at whether they are being delivered in a way which enables and encourages men to access them.
- When commissioning new services, consider any factors which could enable and encourage men to access them.
- Should advertise appropriate services in settings which men are most likely to attend e.g. working men's clubs, libraries, employment settings, pubs, Turkish cafes etc.

- Consider ways to engage local schools to normalise young men's relationships with health professionals.

- For all of the above the use of appropriate language and pictures should be carefully considered in order to appeal to the target group.

6. Lifestyle – Smoking

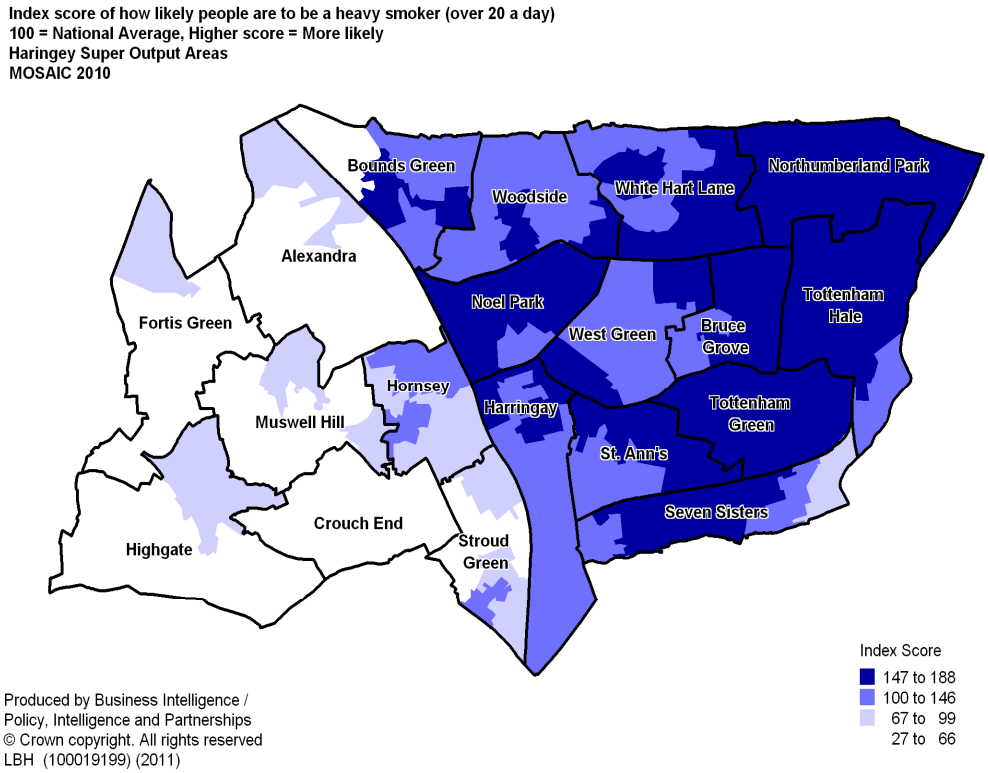
6.1. The World Health Organisation has stated that smoking cessation would have a huge impact on life expectancy.

6.2. Every year in Tottenham there are 130 deaths related to smoking and 600 hospital admissions, at a cost of nearly £1.4m[13].

6.3. In 2007, Haringey PCT commissioned a piece of work on tobacco control activities in Haringey. Data on deprivation, ethnicity, housing condition, health status, income and employment were aggregated to identify postcodes and wards that are likely to have the highest smoking prevalence. The worst third of wards were identified as Northumberland Park, White Hart Lane, Noel Park, Tottenham Green, Tottenham Hale, Bruce Grove and St Ann's.

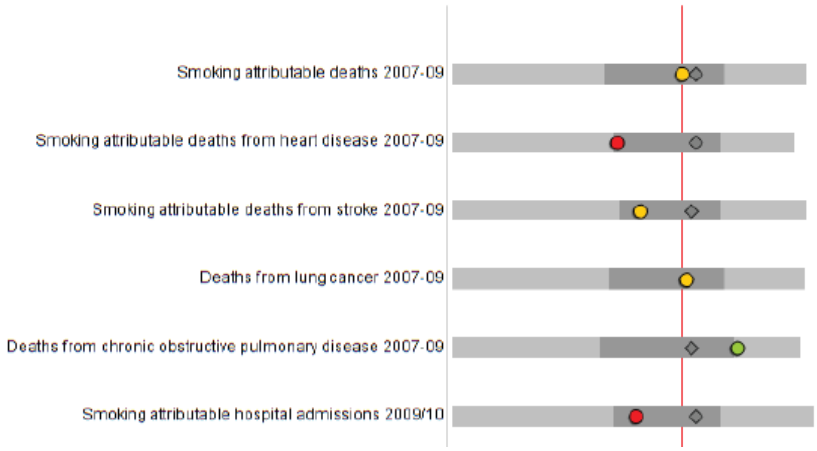
6.4. Highest smoking prevalence of between 29 and 33% was predicted for areas in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane[14].

6.5. The Panel heard that the aim in Haringey is to de-normalise smoking e.g. considering ways to make parks and bus stops smoke free. The panel also noted the educational aspect of smoking shishas as there is a perception that they are not harmful when they are.



[13] Tobacco in London: the preventable burden. Full report, London Health Observatory, 2004
[14] Health survey for England, 2003-2005

Local Tobacco Control Profiles[15] for Haringey



6.6. There are a number of recommendations which were made by the Cross Party Working Group on Health Inequalities which the Panel feels will be beneficial and therefore supports:

- Ensure council workforce is a healthy workforce through its workplace policies e.g. no smoking & a proactive occupational health service - Work/life balance for staff
- Promote 'smoke free Haringey' through new policies such as no smoking for staff within 50m of all council premises
- Run brief intervention training on smoking and alcohol for all front-line staff - links to Health Trainers
- Encourage schools to integrate anti-smoking messages into the curriculum in relevant classroom discussions e.g. when teaching biology, chemistry and citizenship.
- Promote 'stop smoking' in parks, in particular in children's areas and bus stops/shelters.

7. Lifestyle - Physical Activity

7.1. Physical inactivity is amongst the ten leading causes of death in developed countries, causing 1.9 million deaths worldwide each year[16]. The risk of premature death amongst physically active adults is reduced by 20% -30%, and the risk of developing major long□term conditions such as CHD, stroke diabetes and cancers are reduced by up to 50%[17]. The strong evidence for physical activity has led to physical inactivity being recognised as a major modifiable risk factor for CHD[18].

[15] http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles/profile.aspx?

[16] World Health Organization. (2002). World health report. Geneva: World Health Organization.

[17] Department of Health. (2004). At least five a week. Evidence on the impact of physical activity and its relationship to health. Department of Health. London.

[18] Department of Health. (2000a). National Service Framework: Coronary Heart Disease. Department of Health. London

7.2. Physical inactivity is associated with increases in obesity, cardiovascular disease (CVD), cancer, hypertension, and in the development of type II diabetes. Participation in regular physical activity can help to prevent and treat over twenty long-term conditions or disorders, including stroke, obesity, some cancers, mental health and type II diabetes.

7.3. In 2006 in Haringey 21.7% of adults participated in sport and active recreation at a moderate intensity equivalent to 30 minutes on 3 or more days a week. Activity levels have not changed in recent years[19].

7.4. Data indicates that there is a strong correlation between participation and social class. Within Haringey, people in the lower socio economic groups are less active than those in the higher socioeconomic groups, at levels of 18.3% and 26.8% respectively[20].

7.5. The Panel heard of a number of initiatives taking place in Haringey by Public Health. These include:

- Health Trainers
  - Established in 2007 and re-launched in Sept 2011 with a new provider.
  - Programme offers one to one conversation and support.
  - Focus on behaviour change around smoking, physical activity and alcohol.
  - Consists of 6 sessions each 30 minutes long.
  - Based in the Laurels, Tottenham and Wood Green.
  - Referrals are done through primary care or self referrals.
  - 28% of referrals are men.

- Health Champions
  - This is a new and voluntary role which focuses on sign posting and awareness raising
  - Health Champions are drawn from those who are knowledgeable about the local area
  - Project contributes to the worklessness agenda as volunteer Health Champions are gaining skills, work experience and confidence which can then lead them on to becoming Health Trainers (paid employment).
  - Is about having someone who can go with them the first time they go to a health/fitness centre etc/hand holding/helping people to take their first step.
  - Currently funded by Public Health but would like to engage with other partners as the project has a huge potential.

- Walk Leaders and Health in Mind
  - Currently run 12 weekly walks with 3,500 attendances per year.
  - Ten walks are run in the East of Haringey and two walks are run in the West of Haringey.
  - There are currently 14 active walk leaders.
  - Project links to physical fitness and health as well as improving mental health.

[19] Health Inequalities Cross Party Working Group, Life Expectancy Paper, 2011, Haringey Council
[20] Sport England (2010). Active People Survey 4.
http://www.sportengland.org/research/active_people_survey/active_people_survey_4.aspx)

7.6. The Panel heard about the work of the Tottenham Hotspur Foundation, a registered charity set up in 2006 and which receives significant investment from Tottenham Hotspur football club as well as other grant sources. Tottenham Hotspur Foundation is involved in Community development, education, equality and inclusion, health and wellbeing and sports development.

7.7. One of the projects which the panel was specifically impressed to hear about and which is directly linked to the aims of this review was 'Guys and Goals'. This is a Men's Health programme which aims to encourage men over 35 years of age and living in deprived areas of the borough to engage in physical activity over a ten week period. As well as being given information on health topics relevant to men. The physical activity aspect consists of 5 a side football, circuit training, basket ball and badminton. Additionally, table tennis provides a low impact activity to lower the barrier of men with sedentary lifestyle to enter the programme.

7.8. The health talks are provided by National Charities such as Diabetes UK, Bowel Cancer UK and Prostate Cancer UK as well Haringey organisations such as HAGA (support for problem drinkers), IAPT (Improving Access to Psychological Therapies), Bringing Unity Back Into the Community (support for drug and ex-drug users) and NHS Health Trainer services, who also refer their clients to the programme.

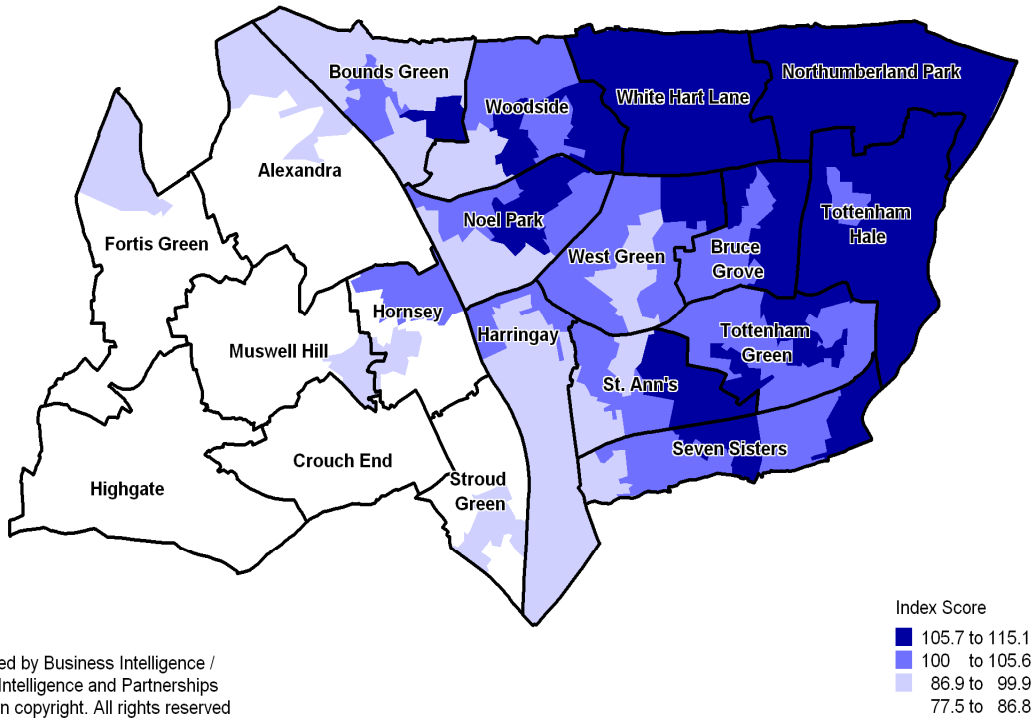
7.9. One participant who completed the programme said:

"…..I think I owe the Guys & Goals program a great deal for helping me to get active again - having suffered from depression I found it difficult at first but was amazed how quickly my fitness returned with a bit of effort….."

7.10. Guys & Goals has to date been accessed by 178 men and a new cycle has recently been launched at Broadwater Farm.

7.11. The Foundation are currently looking to secure funding from other sources to continue the programme after July 2012.

Index score of how likely people are to have done no exercise in the last week
100 = National Average, Higher score = More likely
Haringey Super Output Areas
MOSAIC 2010



Recommendation:

The Haringey Community Sports and Physical Activity Network (CSPAN) develops and implements a sustained campaign to actively engage with men over 40 years of age and encourage them to take regular exercise. Part of this should include supporting:

- The Tottenham Hotspur Foundation initiative
- Men's Health Week

8. Lifestyle - Alcohol

8.1.1. Drinking too much alcohol is one of the most common causes of hospital admission in the UK[21]. Drinking more than the recommended limits can have a harmful effect on the heart. It can cause abnormal heart rhythms, high blood pressure, damage to the heart muscle and other diseases such as stroke, liver problems and some cancers.

8.1.2. Alcohol is also high in calories and so can lead to weight gain.

8.1.3. Key points from the Alcohol Joint Strategic Needs Assessment:

- Men are more likely to drink heavily than women.
- 38% of men and 16% of women consume more alcohol than is recommended[22].

[21] http://www.bhf.org.uk/heart-health/prevention/alcohol.aspx
[22] DH 2004, ANARP Project

- Whilst those from higher income households are more likely to drink at higher levels than those from lower income households it is the most deprived fifth of the UK population who suffer two to three times greater loss of life attributable to alcohol; three to five times higher death rates due to alcohol specific causes and two to five times more admissions to hospital because of alcohol than wealthy areas[23]. This is a pattern that is recognisable in Haringey with the majority of alcohol-related and alcohol-specific hospital admissions coming from the East of the borough.
- The lowest income groups are more likely to suffer negative effects of 'risky' health behaviours than their less poor counterparts[24].
- It is estimated that liver disease could overtake stroke and coronary heart disease as a cause of death within the next 10-20 years[25].
- In particular in Haringey:
  - Males are more at risk than females; due to higher rates of liver disease, alcohol related admissions and alcohol related mortality.
  - Men from the Irish community seem particularly vulnerable in relation to alcohol related problems in Haringey.

Recommendation:

Licensing and Public Health:
a - Explores options and best practice examples of work with local corner shops to reduce the sale of cheap alcohol in areas where this has an impact on the heart health of men over 40 years of age.
b - That where effective examples are found that this be implemented in the target areas.

9. **Lifestyle - Obesity**

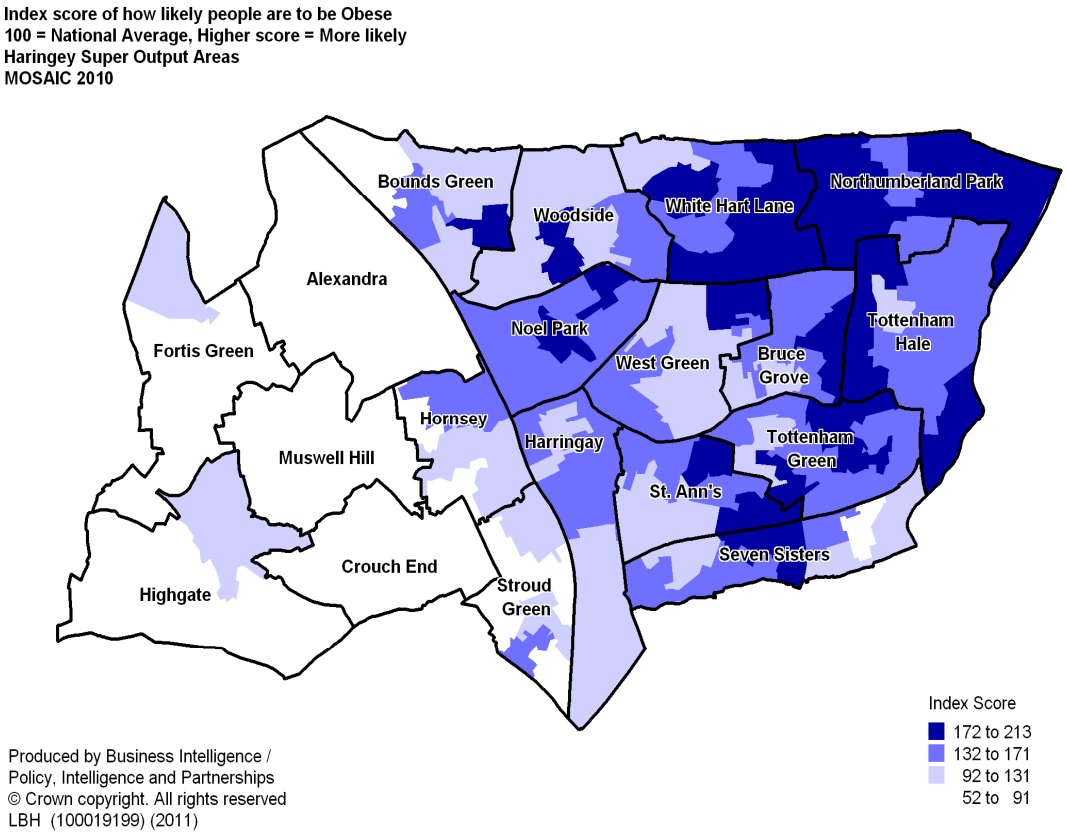
9.1.1. The following points are made in the Health Inequalities Cross Party Working Group Life Expectancy paper[26]:

- Obesity is extremely prevalent and is a major cause of ill-health and premature death. Overweight and obesity are linked to numerous health problems including cardiovascular problems (hypertension, stroke and coronary heart disease)[27].
- It is estimated that, on average, obesity reduces life expectancy between 3 and 13 years[28].
- Obesity is rising in adults and children in England. Healthy eating and increased physical activity are primary solutions to preventing and overcoming overweight[29].
- Overweight and obesity disproportionately affects the lower socioeconomic groups and socially disadvantaged groups[30].

[23] Alcohol Joint Strategic Needs Assessment, Haringey Council, 2012
[24] Department of Health, 2009
[25] Alcohol Concern, 2011
[26] Cross Party Working Group, Life Expectancy Paper, Haringey Council, 2011
[27] World Health Organisation, (2003). Obesity and overweight. Geneva: WHO.
[28] Jebb S (2004) Obesity: causes and consequences. www.medicinepublishing.co.uk/resources/sample_pages/wohm.1.1.38.pdf

[29] Department of Health, (2004). Choosing health: Making healthy choices easier. London: Department of Health.

- In Haringey there has been a slight increase in overweight and obesity between 2003 and 2006 (HSE). In 2006 37.7% of men and a further 12.7% men are obese.



9.1.2. The Panel heard that there is currently only a limited range of weight management services in the borough for those with a weight problem. The panel also heard from the Men's Health Forum that weight is still widely seen as a female issue and that nationally only 25% of weight management users are men whilst the proportion of men who are overweight and obese is much higher.

9.1.3. There are a number of online weight management services and programmes which may be more appealing to men than classes as they are able to stay anonymous should they wish too. The element of competition or 'me too-ism' may also encourage men to participate in some weight management services.

9.1.4. An example of a workplace weight reduction project is the BT Work Fit Campaign[31] which resulted in 4,400 BT staff losing a 10 tonnes of weight between them over four months. The impetus for this scheme being that BT were losing an employee a fortnight to a heart related illness.

[30] Sproston, K., Primatesta, P. (eds) (2004). Health Survey for England 2003. Volume 2: Risk factors for cardiovascular disease. London: TSO.

[31] http://www.menshealthforum.org.uk/node/19914

9.1.5. The scheme included a dedicated work fit intranet site included access to nurses signed up by the Men's Health Forum to act as lifestyle advisers, answer e-mail questions and provide dietary and fitness advice and other health information. Individuals were sent weekly activity programmes and tips for help in lifestyle improvements, such as information on food and reducing cholesterol.

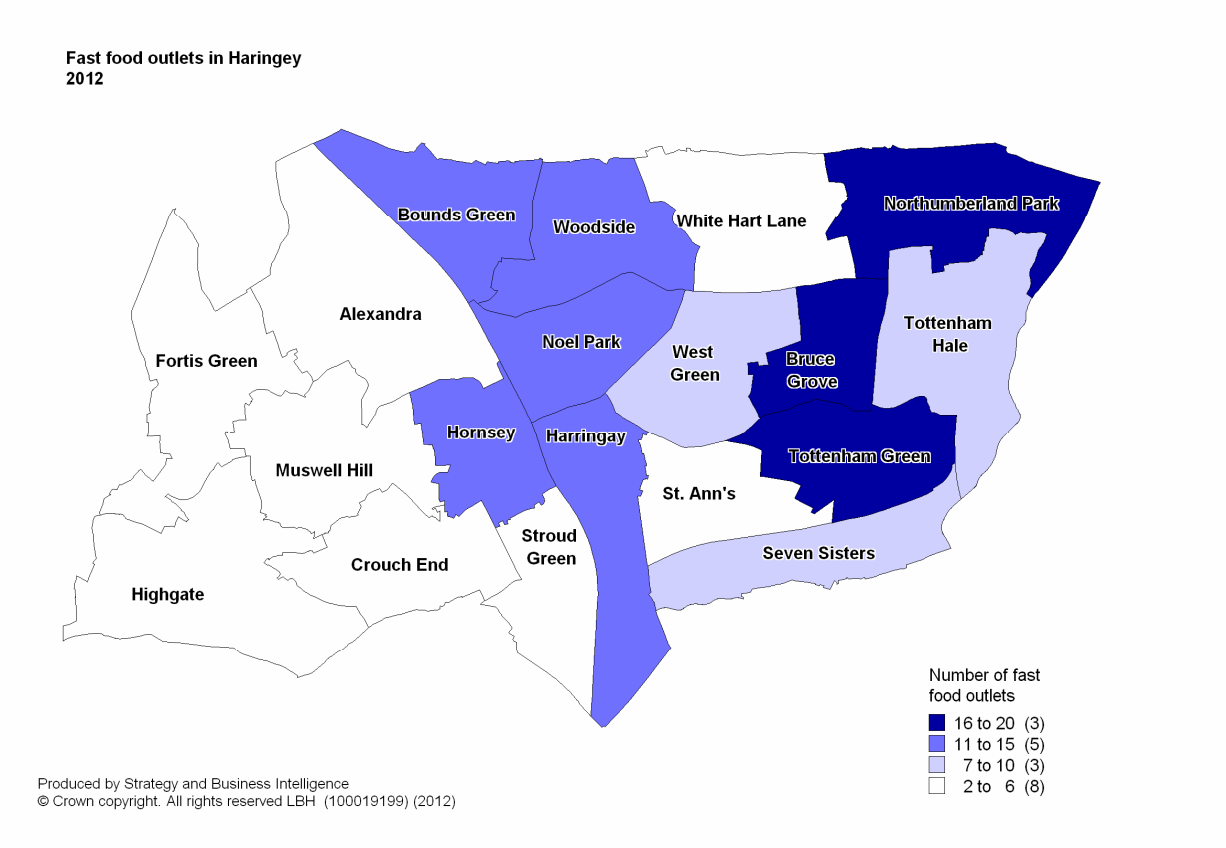
9.1.6. The panel also discussed the link between fast food outlets and obesity, particularly due to the higher density of fast food outlets in the East of the Borough and the cheap meal offers, for example just £1.99 for fried chicken, chips and a fizzy drink.

9.1.7. The panel felt that there is a real need to consider what can be done in relation to the planning and licensing of fast food outlets. For examples, Waltham Forest have a supplementary planning document (SPD) which states that planning permission will not be given to new hot food takeaways within 400 metres of a school, park or youth facility[32].

9.1.8. The panel also discussed the possibility of working with fast food outlets to develop a 'healthier menu' where there were, for example, two 'healthier' options on the menu. Alternatively, whether fast food outlets could be encouraged to change the oil they use or the amount of salt they use when frying their food. The panel heard that there are examples of this taking places in other areas and that it would be beneficial in assisting with the reduction of CVD should this be taken forward in Haringey. The Panel also discussed ways in which local fast food outlets could be incentivised to do this and considered whether a campaign linked to Haringey People which showed the first ten outlets to adopt healthier practices could be shown in an article. However, the panel also noted that this would have to be carefully considered and managed to ensure that mixed messages were not sent out which could be interpreted as encouraging people to eat from fast food outlets.

9.1.9. The panel felt that local colleges could be a useful resource in this piece of work.

[32] http://www.idea.gov.uk/idk/core/page.do?pageId=23268004



Recommendation:

Public Health:

- Explores innovative options and best practice examples of where weight management have had an impact on the heart health of men over 40 years of age, for example on-line weight watchers, 'slimming without women', work place teams etc.
- That where effective examples are found that this be implemented in the target areas.

- Public health leads an initiative to source and apply for outside funding to support locally based initiative to support the reduction of CVD in the target group.

Recommendation:

Public Health works with the Haringey 'Health at work' group to ensure that there are evidence based interventions and programmes with a focus on men over 40 years of age.

Recommendation:

Public Health and Environmental Health to work with "fast food" suppliers (initially in Tottenham, but to expand into the whole Borough) to develop healthier options on their menus and a "Healthier Haringey" Mark. This should include working with smaller high street suppliers as well as parent companies. Areas to be focused on include:

- Changing oils used to fry food to a healthier quality.
- Reducing the amount of salt used.
- Adding some healthy options to menus.

Consideration should be given to the involvement of Haringey 6th Form college catering course.

10. **Health Checks**

10.1. The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

10.2. Public Health are responsible for Commissioning the Health Checks and in Haringey the majority are being done through Locally Enhanced Services via GP surgeries.

10.3. To-date 31 of the potential 41 practices in South East/North East/Central and selected West are signed up, with 23 being active in providing NHS Health Checks.

10.4. In 2010/11 3,047 NHS Health Checks were conducted, of which 1,291 were males, equating to 45%.

10.5. The Target set by NHS London for 11/12 is 5040 Health Checks and 11827 (18% eligible population) invited. This target has been achieved.

10.6. Health Checks are also being provided by the Tottenham Hotspur Foundation following a successful bid to the Premier League and match funding by Public Health. The Tottenham Hotspur Foundation is also aiming to provide 3000 health checks in the community over the next three years. This particular project is specifically relevant to this review as it more likely to reach those men who do not attend their GP surgeries.

10.7. The aims of the Tottenham Hotspur Foundation Health Check programme are:

- To raise awareness and help to prevent cardiovascular disease (CVD)
- To bring Health Checks into the community in order to target hard to reach groups
- To reach those men who are eligible for a Health Check but who are less likely to respond to the offer by their GP
- To reduce health inequalities and life expectancy gap by identifying those individuals at ‘high risk’ of CVD
- To intervene to lower target group’s risk using evidence-based approaches

11. Pharmacies

11.1. NHS Haringey has 57 pharmacy contractors who provide pharmaceutical services to Haringey residents[33].

11.2. The NHS Community Pharmacy contract for England and Wales was introduced in 2005. Under this contract community pharmacies provide the following essential services:

- Dispensing
- Repeat prescriptions
- Disposal of unwanted medicines
- Promotion of Healthy lifestyles
- Signposting to other services
- Support for self care[34].

11.3. As well as national services provided by all pharmacies, the pharmacy contract also includes Enhanced services that are commissioned locally. There are many different services that are operating throughout the country, reflecting the varying needs in different areas.

11.4. Examples of such services include:

- Screening services (e.g. for high blood pressure);
- Minor Ailments Services to reduce waiting times in GP practices;
- Obesity management services;
- Stop smoking services;
- Anticoagulation monitoring and phlebotomy; and

11.5. The pharmacy contract has prompted the installation of private consultation areas in most pharmacies where patients can freely discuss issues.

11.6. The Panel heard that Pharmacists undertake a four year Masters in Pharmacy degree course, followed by a one year placement working in a pharmacy under the supervision of an experienced pharmacist. At the end of this year they take a professional examination and those who successfully complete the examination are able to register as a pharmacist. Pharmacists then continue to keep their knowledge up to date during their career by undertaking continuing professional development.

11.7. The Panel heard from the Local Pharmaceutical Committee who made a number of points with regards to the possible benefits of better utilising local pharmacies around men's health and health inequalities:

- 99% of the Haringey population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport
- 84% of adults visit a pharmacy at least once a year (national)
- 78% for health-related reasons
- Adults in England visit on average 14 times a year
- Around 1 in 10 who attend a pharmacy get health advice
- Around the clock and around the corner

[33] Haringey Pharmaceutical Needs Assessment, Haringey TPCT, 2011
[34] http://www.psnc.org.uk/pages/about_community_pharmacy.html

- Locations buck the inverse care law
- Contact with the 'apparently well' is a platform for lifestyle intervention
- Track record on health improvement services
- Pharmacies can and do provide a whole range of public health services.
  - The Greenlight Pharmacy[35] in Camden is a good example of a pharmacy providing a wide range of public health services.
- Pharmacies can be seen to fit in two layers of the Dahlgren and Whitehead determinants model – Social & Community Networks and Health Care Services.

11.8. Whilst it is acknowledged that men generally use pharmacies less than women the panel heard and discussed a number of possible reasons for this including:

- Low awareness of pharmacist training and expertise/lack of understanding around the role of pharmacies.
- People are not aware that many pharmacies in Haringey have private consulting rooms (Of the 57 pharmacies in Haringey, 51 (89%) had a consultation area as at 2011[36])[37].
- Men are less likely to seek advice from a pharmacy counter assistant
- Is the 'public' environment suited to the way women communicate? This was reinforced by research undertaken by the Men's Health Forum in which a participant compared pharmacists to ladies hairdressers[38].
- Pharmacies may be seen as shops and so men may fear they are going to be sold something they don't need.

11.9. At the same time the panel noted that men do visit pharmacies for a variety of reasons including to self medicate, buying other items and for general information.

11.10. The Department of Health Gender and Access to health services[39] study noted that men often make better use of NHS Walk-in centres than other health service and questioned why, given the walk in nature of pharmacies, men do not make better use of them. It concluded that "the answer is probably that pharmacies are perceived as a predominantly female environment from a consumer's point of view (since they sell cosmetics, toiletries, baby products and so on)". The study also noted that

- 50% of people using smoking cessation services delivered in pharmacies are men,
- 40% of weight-loss programmes delivered in pharmacies are men users.
- Both of which compare favourably with similar services offered in other health settings.

11.11. The panel heard from the LPC about a 'Heart MOT' project undertaken in Birmingham In Birmingham, across three PCTs and over six months, 9,500 males over the age of 40 were tested in community pharmacies and during this period, 65% of patients attending the service received onward GP referral:

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[35] www.greenlightpharmacy.com
[36] Haringey Pharmaceutical Needs Assessment, Haringey TPCT, 2011
[37] As a result of the "New Medicine Service" being introduced last October this number may have increased. The introduction of this new service may have encouraged more pharmacies to install a consultation area, LPC, 2012
[38] Racks of Mack up and No Spanners, Men's Health Forum
[39] Gender and Access to health services Study, Department of Health

- 36% were identified as having a high CVD risk
- 30% were referred due to high blood pressure levels
- 35% were referred due to high cholesterol levels
- 18% were referred due to high blood glucose results.
- The service had high user satisfaction and the programme aims, over time, to improve male life expectancy through encouraging behavioural change or early treatment of those with a raised[40].

11.12. This project was also the subject of an evaluation in the Journal of Public Health[41] which aimed to evaluate service feasibility, assess effectiveness of identifying at-risk individuals and of reaching disadvantaged groups and measure referrals from the service to local general practices. The evaluation was based on 1130 participants of the Heart MOT project and findings included:

- The delivery of a one-stop CVD risk assessment service by community pharmacies is feasible in the setting of a large city in the UK and identifies an appreciable number of individuals – around two-thirds of those screened – for whom intervention for CVD risk or an additional risk factor is indicated'
- 'The majority of clients were men for whom attendance at general practice is known to be low[42],
- Some success was had in targeting people from more deprived areas and with a minority ethnic background'.

11.13. The evaluation also asked the question 'What might community pharmacy–based vascular risk assessment add?' and concluded:

- people from deprived social communities use pharmacy more frequently than those from more affluent communities[43]
- Community pharmacy has unique characteristics to support community-based health testing.
- Pharmacies may be perceived by the public as less medical model with easier access compared with GP surgeries.
- Pharmacies are located in a wide number of settings which can support access to a wide number of communities – some are in deprived areas and some are in prime retails settings thus perfect for proactive marketing.

11.14. At the same time the evaluation noted that there was no data available on how many of those signposted to services or referred to their GP actually attended, or of those who did were retested (duplication of service).

11.15. On a Haringey basis the Panel heard that if a person is not registered with a GP the Pharmacist will give them a list of local GPs. However, this does not guarantee that they will attend. Any service commissioned through pharmacies in Haringey would need to ensure the appropriate mechanisms were in place to link up with GPs.

11.16. Study did not include an economic analysis but noted that the contract price per client was £10 – however this did not include set up costs, overhead

[40] Local Pharmaceutical Committee evidence to panel

[41] Journal of Public Health, pp 110-116, Evaluation of a cardiovascular disease opportunistic pilot ('Heart MOT' service) in community pharmacies, J.M.P. Horgan (Head of Medicines Management) A.Blenkinsopp (Professor of the Pharmacy Practice), R.J. McManus (Professor of Primary Care Cardiovascular Research.

[42] Men's Health Forum, The Gender and access to health services study, Department of Health, 2008

[43] Readers Digest and Propriety Association of Great Britain. A Picture of Health: A survey of the nation's approach to everyday health and wellbeing. London: Readers Digest Association Ltd, 2005

costs with pharmacies, equipment, marketing and NHS management costs. Repeat testing could again increase the cost therefore a mechanism would need to be put in place to prevent this from happening.

11.17. The study concluded that "Targeted cardiovascular risk assessment can be successfully provided through community pharmacies widening access and choice, particularly for men and people in deprived communities. Referral of those screened onto general practice was high, and so further research is needed to investigate the cost effectiveness and public satisfaction of the service."

11.18. Overall the panel felt that there is a big opportunity to get pharmacies more involved in delivering services and that this would be best placed alongside the following:

- Promote awareness of pharmacist (and staff) expertise, for example through Health Champions and Trainers.
- Promote awareness of pharmacy services.
- Promote awareness of consultation areas.
- Pharmacy staff training e.g. the Centre for Pharmacy Postgraduate Education (CPPE) has a module on Men's health which is not often taken up.
- Taking pharmacists' skills & knowledge into the workplace
- NHS & local authority investment through the commissioning of services.

Recommendation:
That the Local Pharmaceutical Committee considers:

- A local awareness raising campaign in order to highlight the accessibility of local pharmacies as well as the professional training which pharmacy staff have undertaken.
- Working with local pharmacies in order to make them more 'man friendly' to encourage men into pharmacies.
- Encouraging local pharmacy staff to consider the Centre for Pharmacy Postgraduate Education module on men's health.
- Having a specific day of the month/week or time of a specific day whereby men are able to walk into consulting rooms and be given advice from pharmacists without needing to explain the issue over the counter.
- Joint projects with pharmacies taking services into male settings.

Recommendation:

Haringey Community Pharmacies to run a Men's health week to tie in with the National Men's Health week as one of their 6 contractual Public Health Campaigns

12. Primary Care

12.1. The Panel heard from two local GPs (one a member of the forthcoming Clinical Commissioning Group and one a locum with experience working in the more deprived areas in the borough). A key challenge for GPs is encouraging men to attend the practice for health check ups and advise.

12.2. The Panel heard that wherever possible GP practices do encourage wives and partners to ensure that their spouses are registered and attend if necessary.

12.3. The Panel heard that all GPs should be assessing risk factors as part of their consultation with patients. This should be recorded via the Quality Outcomes Framework and includes:

- Smoking
- Weight management
- Risk factors
- Family history

12.4. It was noted that this would be done on an opportunistic basis and due to men's reluctance to attend GP surgeries this service may not be reaching men over 40 in the more deprived areas of the borough. It was also noted that there may not always be time in a busy practice for these opportunistic checks due to other patients waiting to be seen.

12.5. Under the Quality Outcomes Framework GPs are financially rewarded for meeting a range of quality targets in four main areas:

- Improving the management of chronic diseases such as asthma and diabetes (clinical),
- Improving how practices are organised,
- Enabling patients to feed back their views of the surgery,
- Offering 'additional' services such as maternity and child health.

12.6. Practices are awarded 'points' for delivering against each indicator. Many of the measures are process measures, requiring that GPs keep a record of data such as smoking status, cholesterol, blood pressure and body mass index for patients in the relevant disease areas. However, there are also a number of treatment and outcome indicators, such as treatment of coronary heart disease with beta blockers, or achieving low levels of cholesterol or blood pressure[44].

12.7. For the purpose of this review a number of indicators were looked at for practices in the East of the borough, and in relation to CVD. Looking at these indicators there is a variation of QOF scores with practices scoring a lower than the borough average as well a number of practices in the East of the borough scoring lower than the West of the borough.

12.8. For example under the indicator 'In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment treatment tool' there were variations across the borough with the lowest being just over 0% and the highest being 100%[45].

12.9. The Panel heard that as well as ad hoc health promotion (i.e. if there is time within the consultation) which is conducted by GP's wherever possible e.g. checking the patients blood pressure, the Q-Risk[46] online system is also used to calculate the risk of a heart attack or stroke within the next ten years.

[44] Impact of Quality and Outcomes Framework on Health Inequalities, The Kings Fund, 2011
[45] http://www.qof.ic.nhs.uk/
[46] http://qrisk.org/

12.10. There was discussion about men being less likely to register with GP surgeries in the first place. However, in Haringey statistics show that men over 40 years of age in the borough and men over 40 years of age registered with a GP practice are proportionally similar at 19.03% and 18.71% respectively (see table below). However, these statistics do need to be viewed with caution, for example some Wards in the East of the borough have high levels of transience which may skew the figures, the figures also do not show where men may have moved out of an area and not registered with a new Practice (therefore meaning they are still on the Practice register of the previous surgery).

	GP register Nov 2011[47]	**Mid Year Estimates 2010**[48]
40+ Men	50834	42087
Total Men	130569	114120
%	38.93	36.88
Total	267085	224996
%	**19.03**	**18.71**

12.11. GP opening hours was *not* felt to be an issue in prevention men from attending the surgery as a number of practices do have longer opening hours. It was also noted that those that this particular review are targeting may be more likely to be unemployed or working shift patterns.

12.12. In January 2012 NHS North Central London published 'Transforming the primary care landscape in North Central London". This document focuses on the future of primary care across North Central London from the patients perspective and based on networks of GP practices working together to create Integrated Care Networks. The aim of the networks being that within each network patients will be able to access all services which are offered as part of a 'guaranteed standard service'[49] thus improving access to services for patients.

12.13. The vision under the NHS NCL Transformation Strategy is also for people to be able to register with their GP at the local pharmacy as well as other settings:

"If you don't want to register online, call in at any of our NHS-signed premises – doctors, pharmacies, optometrists, dentists, community-based health services or clinics - or at any of your local council offices, Job Centre Plus, Citizens Advice Bureau, Libraries, and some local estate agents."[50]

12.14. Whilst the panel are supportive of this new model, they are keen to ensure that all practices do sign up to the Integrated Care Networks in particular those who may need extra support to do so.

[47] NHS Connecting For Health, 2011
[48] Mid Year Estimates, Office of National Statistics, 2010

[49] Transforming the primary landscape in North Central London, NHS NCL, 2012
[50] Transforming the primary landscape in North Central London, NHS NCL, 2012

Recommendation:

That NHS Haringey works with local GP practices who are under-performing in the most deprived area of the borough based on the Quality Outcomes Framework scores to improve their performance. For example:

- In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment treatment tool.
- The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Focus should be placed on those QOF scores which would have the biggest impact on male life expectancy in the area.

Recommendation:

The Panel recommends that opportunities from the Primary Care Development Strategy that smaller practices join into networks enabling all patients to access higher level services should take full account of this review and ensure that particular attention is given to inequalities in men's health.

13. Regeneration

13.1. The Tottenham Regeneration Programme is coordinating work to transform and regenerate Tottenham following the riots of August 2011. Work under this programme includes:

- Consulting and involving local residents in developing a regeneration strategy;
- Working with landowners to ensure sites are reoccupied and reopened as soon as possible;
- Developing appropriate planning policies to support sustainable businesses and uses on the High Road;
- Supporting business to access funding and financial support; and
- A total investment package of £41m from the Mayor's Regeneration fund and the Council has been identified to kick start the regeneration of North Tottenham, and also for a Employment and Skills programme to tackle worklessness, and improvements to the High Road and Tottenham Green .

13.2. Tottenham Hotspur received planning permission for the Northumberland Development Project, which includes a new football stadium, in September 2011 and further permission in March 2012 following submission of some

changes to “maximis[e].. the number of new jobs and new homes which can be created[51]”.

13.3. “The Northumberland Development Project aims to deliver:

- A huge investment in North Tottenham to create a vibrant area 365 days a year, with more people using the stadium, shops, restaurants and public spaces.
- Exceptional public space and a focus for events and activities to be used by schools, charities, community groups, local residents and the Council themselves.
- A major economic boost for the area, with more money spent in local shops and services.
- New jobs created with dedicated support in place to help local people access those jobs.
- A dramatic improvement of this part of the High Road, including the refurbishment and re-use of historic buildings within their own active setting.
- Improved shopping choice from the new supermarket.
- Improved community safety, with 'designing-out-crime' integral to the design and CCTV in place as well.
- Much needed new homes, including one bedroom apartments for first time buyers.
- New local business opportunities both during construction and in the long term.
- World class design which people will be proud to live near and visit”[52].

13.4. The Panel believes that the Tottenham Regeneration Programme together with the Northumberland Development Plans and changes to the health services, including the setting up of Clinical Commissioning Groups and the move of Public Health to the Council all provide an excellent opportunity to reduce health inequalities in the East of the borough.

Recommendation:
Partners recognise the potential of the Northumberland Development Project in improving the health inequalities in the area. We recommend that Public Health, NCL, Spurs and other appropriate development partners take the redevelopment of the stadium as an opportunity to positively influence health outcomes for men over 40 by participating in and supporting the work of the Men's Health Forum get together and explore possibilities in line with local strategies.

Recommendation:
The plans for the regeneration of Tottenham recognise and acknowledge the unacceptability of the continuing health inequality issues and adopt a programme of targeted health improvement as a specific strategic initiative.

14. Wider Determinant - Housing

[51] http://www.tottenhamhotspur.com/spurs/The+Stadium/new-stadium-plans.page
[52] http://www.tottenhamhotspur.com/spurs/The+Stadium/new-stadium-plans.page

14.1. Housing conditions also have an impact on a person's health, this includes not just the quality of the housing but also whether or not the conditions are overcrowded. 8.9% (8,311) of households were identified as living in overcrowded conditions[53] with overcrowding being more common in the more deprived areas of the borough e.g. White Hart Lane and Seven Sisters.

14.2. Whilst the panel is not aware of any statistics on the gender and age of occupants, it felt that it is likely that there may be a number of single older men living in poor quality accommodation in some areas of the borough and that this is likely to be having an impact on their health.

14.3. Concerns had been raised in a number of areas in the borough about properties which had been converted into smaller units and were subsequently both being poorly managed and in a poor state of repair[54]. This resulted in a pilot in Harringay Ward whereby Houses in Multiple Occupation (HMOs) would be subject to licensing by the Council.

14.4. By licensing HMOs the Council is able to ensure that the accommodation is well managed, safe and habitable and that it complies with the amenity standards and is in a good state of repair.

Recommendation:
It is well documented that housing is a wider determinant of health and that in the more deprived areas of the borough there is more overcrowding and often worse quality housing. The panel therefore recommends that the HMO licensing scheme currently taking place in Harringay Ward is extended to Tottenham and other relevant areas of the borough (subject to the required criteria being met following the appropriate assessment).

15. Wider Determinant – Employment

15.1. Employment is widely recognised as an extremely important determinant of health. Having a job provides a vital link between an individual and the rest of society and is important for a person's self esteem. Levels of disposable income from wages also affect the way in which people live, how they are able to spend their time and their housing.

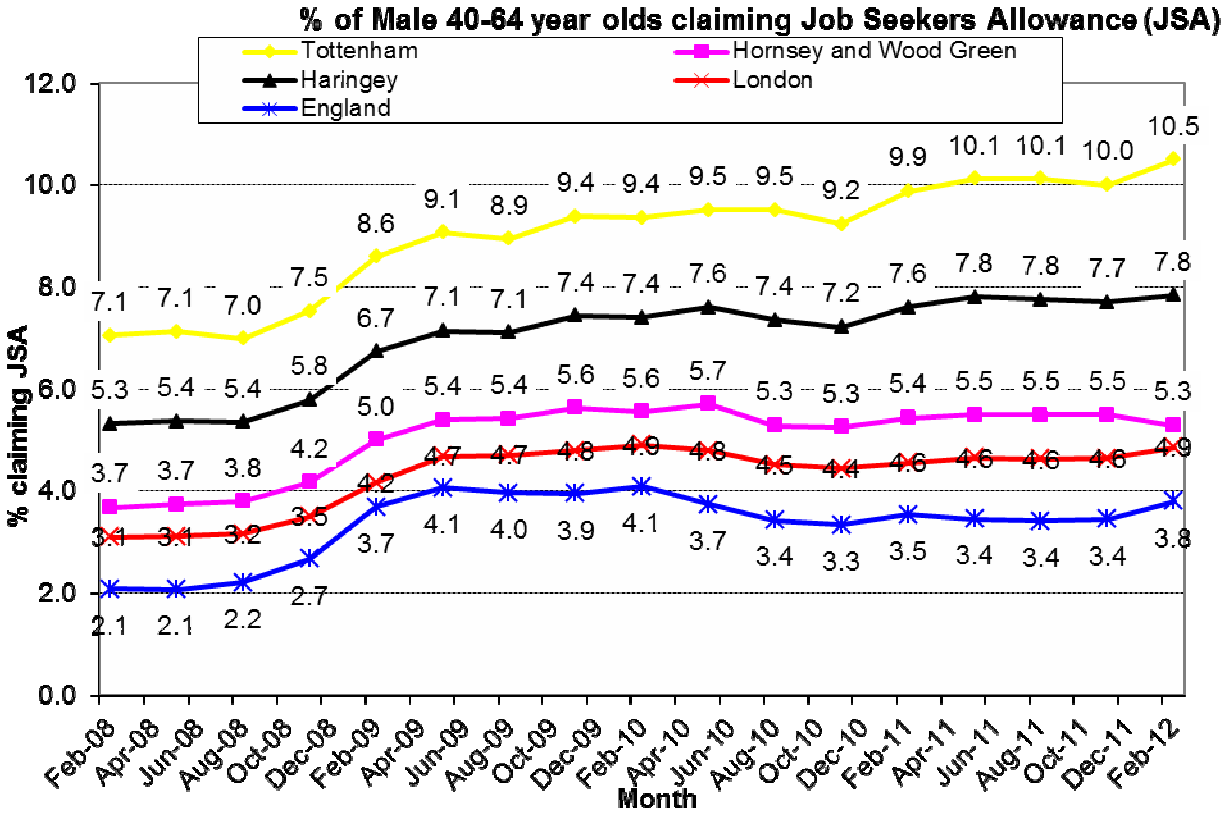
15.2. Unemployment is a significant risk factor for a number of health indicators. Unemployed people are found to have:

- Lower levels of psychological well-being.
- Higher rates of morbidity – such as limiting long term illness.
- Higher rates of premature mortality, in particular for CHD[55].

15.3. Haringey Employment projects are focusing on 18-24 year age group in order to break the cycle of intergenerational workless. There is no specific programme for those over 40 years of age; however this group will not be turned away should they approach existing services.

[53] Housing Needs Assessment, 2005, Haringey Council
[54] Proposed changes to the regulation and licensing of HMOs including the introduction of an area based Additional Licensing Scheme, Cabinet Report, Haringey Council, 2011
[55] Health: Everyone's Business, Overview and Scrutiny Committee report, Haringey Council, 2010.

15.4. As can be seen from the graph below, the number of males between 40 and 64 years of age claiming Job Seekers Allowance has increased in recent years from 1655 in February 2008 to 2580 in February 2012 (a 55.9% increase) in the age bracket. With the Tottenham constituency population accounting for 1055/1695 respectively.



Source: www.nomisweb.co.uk

Recommendation:

There are clear and evidenced health risks associated with long-term unemployment and whilst the panel recognises that the Council is focusing on 18-24year olds, as a priority group, the service will not be exclusive to this age group. The panel believes that wherever possible programmes should be developed to support men over 40 years of age to gain skills and receive support into employment.

16. **Strategy**

16.1. The Panel was updated on the work of the Cross Party Working Group on Health Inequalities and received a presentation on the Life Expectancy Paper which was submitted to the group and which this review links to.

16.2. Key priorities for action include:

- Smoking
- Physical Activity
- Obesity and nutrition (particularly in children)
- Alcohol

16.3. The Panel notes the importance of the Joint Strategic Needs Assessment and the role it plays in current commissioning cycles and the role it will play under the forthcoming Health and Wellbeing Board and Clinical Commissioning Group. Due to the importance of this document in commissioning decisions and to enable Commissioners to have a full picture of the needs of the population the panel felt that men's health should form a specific strand.

Recommendation:

The significant ward differences in men over 40s' life expectancy to be recognised in the Joint Strategic Needs Assessment and tackling them to be made a priority by NHS Haringey in commissioning plans.

17. Partnership working

17.1. Throughout the review the Panel noted the enthusiasm and willingness to improve the life expectancy of men in the more deprived areas of the borough and was particularly impressed to hear some of the ideas and discussion being taken forward.

17.2. The Panel felt that to capture and embed this enthusiasm a local men's health forum should be set up to drive the work forward on a more day to day basis.

17.3. The Panel noted a contribution of a local GP on receiving a draft copy of this report and a number of ideas put forward which could form the basis of this group (See Appendix B).

17.4. The panel is conscious about not duplicating existing structures or adding to administrative costs and therefore believes that a local men's health forum could be set up and reviewed in line with the Shadow Health and Wellbeing board becoming a formal body in April 2013.

17.5. The Panel also noted the willingness of a number of partner bodies, for example Whittington Health and Tottenham Hotspur Foundation in supporting this group.

17.6. Throughout the review the Panel also heard about the positive working relationship between Public Health and the Tottenham Hotspur Foundation, with the Health and Wellbeing Manager from the Tottenham Hotspur Foundation also working at the Council one day a week.

Recommendation:

That Public Health and the Tottenham Hotspur Foundation continue in their positive working relationship to improve health outcomes of men in the target group.

Recommendation:

That a local men's health forum is established to continue the momentum developed through this review.

APPENDICES

Appendix A – Policy Context

1. **Healthy Lives, Healthy People - Public Health White Paper (now the Health and Social Care Act, 2012)**

   1.1. The White Paper and subsequent Act sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

   1.2. The paper aims to strengthen both national and local leadership by having directors of public health, employed by local authorities and jointly appointed with Public Health England. Their role will be to lead on driving health improvement locally.

   1.3. Responding to the challenges set out in Professor Sir Michael Marmot's powerful 'Fair Society, Healthy Lives' report, the White Paper includes a proposal for a new, health premium that will reward progress on specific public health outcomes.

   1.4. The premium is intending to fight health inequalities thus formally recognising disadvantaged areas which face the greatest challenges, and will therefore receive a greater premium for progress made.

   1.5. Local authorities will deploy resources to improve health and well-being in their communities using ring-fenced health improvement budgets allocated by the Department of Health and based on a formula grant for each area.

2. **Marmot review- 'Fair Society, Healthy Lives'**

   2.1. The government has expressed its commitment to reducing health inequalities. In 2010 The Marmot review; 'Fair Society, Healthy Lives' was published in response to the request made by a former Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy includes policies and interventions that address the social determinants of health inequalities. Key messages delivered and relevant to this scrutiny review:

1. Evidence suggests that there is a social gradient in health – the lower a person's social position, the worse his or her health. Therefore our effort should also be focused on reducing the gradient in health.
2. The review also reaffirms the point that health inequalities result from social inequalities. Therefore tackling health inequalities requires action across all the social determinants of health.
3. There is also an emphasis on the fact that action taken to reduce health inequalities will benefit society in many ways. Benefits like economic benefits in reducing losses from illness associated with health inequalities, which account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
4. Reducing health inequalities will require action on six policy objectives (See below)

5. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
6. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

2.2. The review also identified 6 evidenced based policy objectives for action most likely to have the greatest impact on reducing the gap in health inequalities long-term:

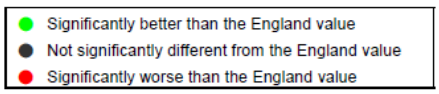
1. Give every child the best start in life
2. Enable all children young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

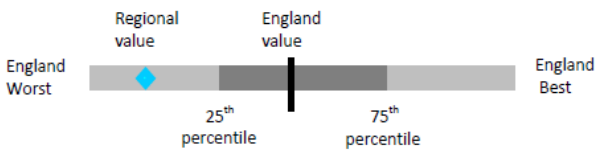
3. Marmot indicators for Local Authorities in England

3.1. ***Fair Society, Healthy Lives: The Marmot Review*** report was published in February 2010. The report included some suggested indicators to support monitoring of the overall strategic direction in reducing health inequalities. In February 2011, the London Health Observatory produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in *Fair Society, Healthy Lives*.

- The London Health Observatory and the UCL Institute of Health Equity (previously known as the Marmot Review Team) have now updated the indicators. The 2012 indicators include male life expectancy.

3.2. Extract from the Haringey Indicator set in relation to men's health showing that male life expectancy at birth is significantly worse than the England average:





	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	77.4	79.0	78.6	73.6		85.1
2	Inequality in male life expectancy at birth (years)	8.3	7.5	8.9	16.9		3.1
3	Inequality in male disability-free life expectancy at birth (years)	11.5	9.1	10.9	20.0		1.8

***Source**: London Health Observatory, Marmot Indicators for Local Authorities in England, 2012*

4. London Health Inequalities Strategy

4.1. The first London Health Inequalities Strategy was published in March 2010 and provides the framework for action. The strategy is due to be refreshed every four years. The London Health Inequalities Strategy recognises there is a social gradient in health – the lower a person's social position, the worse his or her health. The strategy aims to diminish the steepness of the social gradient so that the health gaps between all Londoners are lessened.

4.2. The Mayor's strategic objectives for reducing health inequalities in London are to:

1. Empower individual Londoners and their communities to improve health and well being
2. Improve access to London's health and social care services, particularly for Londoners who have poorer health outcomes.
3. Reduce income inequalities and minimise the negative health consequences of relative poverty.
4. Increase opportunities for people to access the potential benefits of work and other forms of activity.
5. Develop and promote London as a healthy place for all – from homes to neighbourhoods and the city as a whole.

5. The London Health Inequalities Strategy – First Steps to Delivery to 2012

5.1. Sets out agreed actions to prioritise to 2012 against the thirty high-level commitments which form the bedrock of the strategy. It summarises the first steps already identified with partners to be further built upon over the coming months.

5.2. **This includes first steps such as:**

- Encouraging regional and local organisations to review the extent of their current focus on health inequalities in strategy development, investment and programme planning and in prioritisation – key partners mentioned includes Overview and Scrutiny Committees.
- Engaging regional and local scrutiny leads in joint work to increase their focus on reducing health inequalities throughout their scrutiny plans and investigations.
- Tackle street trading of illicit tobacco, and the illegal sale of tobacco and alcohol, through use of existing effective interventions, and encourage widespread adoption.
- Work with NHS to scale up approaches to building capacity in Voluntary and Community Sector to deliver physical activity services.

6. Health Inequalities National Support Team (HINST)

6.1. The Department of Health Inequalities National Support Team (HINST) visited Haringey in late 2009. The National Support Team (NST) held several stakeholder events to understand the local context and assess barriers to and opportunities for making progress at a population level. A number of high level recommendations were made, and following the visit an action plan was developed an approved by the Cabinet member of Adult and Social Care and by the Department of Health. Key recommendations from the visit included:

1. Undertake further analysis quantifying the number of lives that need to be saved and assessment of the necessary scale and reach of interventions required to reduce mortality rates to sustain progress towards the 2010 mortality targets and address inequalities within Haringey.
2. Develop detailed delivery plans informed by the above analysis, equity audit and social marketing.
3. Develop a culture of data and analysis underpinning all strategic and commissioning decisions, as part of a whole systems approach to addressing health inequalities.
4. Establish clear local clinical and practitioner leadership in Cardiovascular Disease (CVD), Stroke, and Cancer.
5. Continue to focus intensively on improving the quality of primary care across the 3 levels of support, and build a partnership approach to case-finding.
6. Take a partnership approach to the development of commissioning groups relating to the contributing factors to health inequalities and the development of improved patient pathways.
7. NHS Haringey should fully integrate its strategic and operational community engagement work internally and with other partners.
8. Continue the development of the Well-Being Partnership Board and the Haringey Strategic Partnership structures in relation to locality working, engagement of the Voluntary Community Services (VCS) and the broader healthy communities' agenda.
9. Ensure specific initiatives are developed and implemented to embed

7. Haringey

7.1. Haringey has a significant history in tackling health inequalities and continues to address these at every level across the borough. Tackling health inequalities has been integral to the production of several key strategies and plans in Haringey over several years. The Sustainable Community Strategy is the overarching strategy of the Haringey Strategic Partnership, examples of other key strategies and plans include: Sustainable Community Strategy, Well-being Strategic Framework, Children and Young People's Plan, Community Safety Strategy, Housing Strategies, Greenest Borough Strategy and Regeneration Strategy, Safer for all, NHS Strategic Plan, Life Expectancy Action Plan, Infant Mortality Action Plan, Report of the visit of the National Support Team of the Department of Health. These existing plans will form components that will shape the future health inequalities strategy. Haringey needs assessments and local information for example Haringey Our Place and Joint Strategic Needs Assessment should inform local strategies.

8. Health Inequalities Cross Party Working Group

8.1. A Health Inequalities Cross Party Working Group was set up in order to determine the priority areas to be addressed in the health and wellbeing strategy in order to reduce health inequalities in Haringey.

8.2. The Health and Wellbeing Strategy has three outcomes:

- Giving every child the best start in life
- Reducing the gap in life expectancy in Haringey
- Improving mental health and wellbeing

Appendix B – Submitted comments from Dr Muhammad Akunjee

Comments submitted by Dr Muhammad Akunjee MBBS, MRCGP (distc.) Lead GP & Clinical Director for SE Haringey Haringey Shadow Commissioning Board Member

General Principals
Generally I feel that men like to think they are in good health (even if the facts speak otherwise). The survey revealed this fact with most men claiming to be in good health. Women seem to worry about their health and appearance a lot more - perhaps due to the huge pressures from TV / friends / marketing / women's magazines, and as a result are more likely to attend to see the GP / health clinician with complaints at a lower threshold. It may also be seen as a 'macho' for males to remain as they are and not seek help until it is too late.

In addition, as seen in the public health data, men are more likely to smoke, not exercise adequately, drink, have poor unhealthy diets and take illicit drugs. Perhaps the feeling that they are harming themselves more makes them also feel ashamed to attend for help until some aspect of their functioning is affected. Men are probably also more likely to be in employment than females (in Haringey). In addition, there is a high ethnic minority population that are more prone to developing hypertension (Afro Caribbeans), Diabetes (South East Asian) and this needs to be tackled. These all creates potential barriers that have to be overcome to try and reduce the health inequalities that are becoming more apparent in Haringey.

Marketing
We have to break the male taboo that caring for your health makes you less of a man. We need more general Public health marketing / campaigns that speak about men's health on the buses, underground, bill boards and other manners to be 'in their face' particularly in areas that they may congregate - I have seen a large number of Somali and Turkish clubs and local pubs. Job centres, newsagents and libraries would also be good venues for getting messages out. We had a very successful project backed by David Lammy post riots to reclaim Tottenham and that was very visible and had a good acceptance. A similar project may be useful, for example on all schools / public computers when someone logs in maybe get a brief 30 second video pop up explaining about health and the issues around it.

http://www.youtube.com/watch?v=If4ceLMbBiw this is a nice example of a clear video promoting the health checks.

Targeted marketing is also important. For example, communities trust their own elders and religious chaplains. They may go to them for religious advice and instruction. Having training days for different chaplains about health problems may be useful and highlight some of the key areas that focus is needed (particularly for suicide, drug abuse and depression/ anxiety). Chaplains then can sign post or send people on for more informed advice and support. We in Haringey have more than 200 languages spoken; much of these materials must be made available to all residents.

Perhaps sending out a mail shot for all males aged 40+ to visit their GP for health checks or general check up can be organised alongside the Health Check screening programme. NHS Haringey used to send out checks to see if patients live at their address - perhaps a better use of funding would be to send out promotional material inviting said males to their GP / community centres for a health check.

Access
As mentioned in the survey 81% would be happy to be assessed in their GP surgeries. I feel that perhaps it is a little bit confusing to then say that they feel GP surgeries are unwelcoming or women focused. We have to help them attend - text reminders of appointments, ease of access, men's only clinics, extended hours etc. Even though surgeries provide this, how many people who haven't been to the GP in a while actually know their GPs opening hours?

Perhaps having a freephone Male Health Hotline for the area that allows men to ring much like a generic 111 or NHS direct service but tailor it to giving advice how to access health services and general health promotion advice would be useful. This would also be useful for those men who have not registered with a GP.

We find that sometimes we get a male registering at the surgery without their families or vice versa. With women and children and husbands / partners registered elsewhere. This can sometimes make it hard to drive home key lifestyle messages about diet, cooking, exercise. We should perhaps try and register families together to ensure these issues do not occur.

As mentioned in the report the Haringey populace are highly mobile so it is essential that people have an idea of what services are available and when. The hotline may help this, but also websites which can be accessed in peoples own times, 24 hrs a day with clear, bold colours and simplistic design so that people know where they can register, where to get health advise, how to use A&E, Walk in centres etc. This information would then be at their finger tips. This would also be useful for those who are shy to speak to an operator, or those who cannot speak English. Extending this further, a brief leaflet about where to go for primary health care and health advice should be drafted and handed out to all new patients applying for benefits, at social services and the job centre.

Leaflets should be mailed out to all estate agents to include in their packs they give to new tenants moving into the area. The earlier we catch and register people the more likely we are to prevent illnesses

Improving the Primary Care patients receive
It is vitally important that we work with the NCL primary care transformation strategy to get GPs to federate. We should also focus some of this money on improving the experience at the surgeries. Remove clutter, have visual display boards, have staff training how to pick up illnesses, how to reduce aggression and anger, how to sign post people to services etc. GP surgeries should have websites with clear information about how to register - perhaps encourage online registration, online appointment booking and email access to GPs may allow men better access for their health to GPs.

Having more services located in the GP surgery and more targeted money to catch people in the waiting area. For example automated Blood Pressure machines in the waiting area, investment to perform patients information searches and target smokers and drinkers to be called in for assessment for other health issues such as Diabetes or Coronary Obstructive Pulmonary Disorder or for an ECG and blood test (near patient testing for cholesterol and sugar so no need to go to the local phlebotomy department). Less patient contact and a more one stop way of doing things would mean that if and when a patient attends they can be attended to, treated and risk assessed there and then without not having to take time off or commute elsewhere - which puts them at risk of not attending or being followed up.

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Haringey Council

Appendix E

Getting to the Heart of the Matter: a scrutiny review of men's health

Staying healthy: a survey of men aged 40 years living or working in Haringey

Overview & Scrutiny Committee
Haringey Council

April 2012

1. Introduction

1.1 The Overview & Scrutiny Committee commissions a number of in depth reviews each year. These reviews assist decision making processes within the council, and can be used to inform service improvement or policy development. Reviews are conducted by a panel of non-executive councillors and the conclusions and recommendations made within the reviews are reported to Overview & Scrutiny Committee and Cabinet (the decision making body of the council).

1.2 The following report provides an analysis of survey data collected as part of scrutiny review of men's health undertaken in 2011/2012. It is expected that the data presented in this report may guide and inform the conclusions and recommendations reached within the review.

2. About the scrutiny review

2.1 *Getting to the Heart of the Matter* is a scrutiny review of men's health. This is an in-depth study of the issues which may affect men's health and what men can do to help them stay healthy. The review will aim to develop recommendations that help to increase male life expectancy and address health inequalities that exist between those residents within the east and west of the borough.

2.2 Given local prevalence data, the review has focused on issues relating to cardiovascular disease, in particular those risk factors associated with this condition (e.g. smoking, obesity), and those underlying factors in relation to broader health inequalities (e.g. education, deprivation). Information obtained within the review will help to inform how local agencies engage the target population and develop appropriate interventions in relation to:

- prevention: smoking, physical activity, alcohol, obesity
- early intervention (adults over 40):cardiovascular disease.

2.3 The review is due to conclude and report to Overview & Scrutiny Committee in April 2012. Once approved by the committee, the recommendations will be considered by the Council executive for approval and implementation.

3. About the survey

3.1 The survey had three overarching aims:

- to ascertain current behaviour that men adopt to stay healthy
- to identify those barriers which may prevent men from keeping fit and staying healthy
- identify those interventions which may support men to stay healthy.

3.2 This survey was designed in consultation with panel members, local officers (Policy, Public Health) and men's health organisations. The survey was also piloted with a sample of officers from Haringey Council and after subsequent amendments, the final survey that was distributed is depicted in Appendix B.

3.3 The target population of this survey was men aged 40 years and over who lived and worked in Haringey. Accordingly, the survey was distributed both electronically and manually via local men's health groups, public health networks, local employers and street outreach. Of the 159 surveys returned:

- 77% were completed on-line
- 13% were completed via street outreach
- 11% were completed via local men's groups.

3.4 It is not possible to calculate a response rate given the electronic distribution of some survey. The absolute number of responses (n=159) was however felt to be sufficient to provide robust and meaningful data and to support the scrutiny review process.

4. Demographics of those who responded

4.1 Demographic characteristics of those of men who responded to the survey are given in Table 1a. This demonstrates that a majority of respondents were aged under 60 years of age, were of white British ethnic origin and heterosexual (Table 1a). Christianity was the most recorded religion among respondents, though 40% of respondents indicated that they were not religious (Figure 1a).

Table 1a – Demographics of respondents

Age Group (n=150)		**Ethnicity (n=151)**		**Religion (n=145)**	
40-49	47%	**White British**	52%	**None**	40%
50-59	39%	**White other**	15%	**Christian**	41%
60-69	11%	**Black African**	7%	**Muslim**	8%
70-79	4%	**Black Caribbean**	11%	**Hindu**	6%
Sexuality (n=135)		**Indian**	5%	**Rastafarian**	1%
Heterosexual	90%	**Asian other**	7%	**Buddhist**	1%
Bisexual	1%	**Chinese**	1%	**Other**	4%
Homosexual	10%	**Mixed orig.**	2%		

4.2 Proportionally fewer responses were received from men who lived in Haringey (38%) compared to those who lived elsewhere in London (Table 1b). Of those respondents that lived in Haringey, N17 was most commonly cited post code of residence (Figure 1). Almost one quarter of respondents (23%) indicated that they had a disability (or long term illness or infirmity). The overwhelming majority of respondents (92%) were in either full-time or part-time paid employment (Table 1b).

Table 1b - Demographics of respondents

Disability (n=151)		**Haringey resident (n=148)**		**Employment status**	
Yes	23%	**< 2 years**	2%	**Full-time**	84%
No	77%	**2-5 years**	7%	**Part-time**	8%
		6-10 years	5%	**Retired**	6%
		11 years +	24%	**Voluntary**	1%
		Non- resident	62%	**Unemployed**	1%

5.0 Health status of respondents

5.1 Respondents were asked to indicate how they would describe their current health status from a preset scale of 'excellent' through to 'poor'. In total, 79% of respondents in were in good or better health, with just 4% of respondents indicating that they were in poor health (Figure 2). Perhaps not unexpectedly, further analysis of responses found higher levels of self-reported 'fair' or 'poor' health among those with a disability and older respondents (Table 2).

Table 2 - Health status					
	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
All (n=156)	8%	31%	40%	17%	4%
Age (n=149)	**Excellent/Very Good/Good**			**Fair/ Poor**	
40-49 years	79%			21%	
50-59 years	86%			14%	
60-69 years	81%			19%	
70-79 years	33%			67%	
Ethnicity (n=151)					
White (British and Other)	85%			15%	
Black and other minority	69%			31%	
Disability (n=149)					
Yes	56%			44%	
No	87%			13%	
Resident (147)					
Haringey	71%			29%	
Out of borough	86%			14%	
Employment (n=143)					
Paid employment	84%			16%	
Not in paid employment	50%			50%	

5.2 In terms of ethnic origin, respondents from white ethnic groups (white British and white other) reported better health than those from black and other minority ethnic groups (Table 2). Thus, 85% of respondents from white ethnic groups reported good or better health compared to just 69% of BME groups (Table 2). Lower levels of good health were reported among respondents living in Haringey, though this differential is likely to be a product of survey distribution which included local men's health groups (e.g. Age UK).

5.3 Proportionally more respondents in paid employment (83%) reported 'good' or better health than those not in paid employment (50%), though this may be expected given the greater propensity of those not in paid employment to be retired, older or have a disability (Table 2).

6.0 Last visit to General Practitioner (GP)

6.1 To obtain contextual data concerning respondents use and access to health services, respondents were asked to indicate when they made their last visit to a General Practitioner. Analysis of responses found that a majority of men responding to this survey had visited their GP in the past year and almost 9 in 10 had done so in the past 2 years (Figure 3). About 1 in 20 respondents (6%) had not visited their GP for over 5 years (Figure 3).

6.2 It would appear that there is a strong positive relationship between the age of respondents and their last visit to their GP, with the proportion of respondents indicating that they have been to their GP in the past year increasing with age (Table 3). Almost 1 in 5 (19%) of respondents aged 40-49 years of age had not visited their GP for 3 years or more (Table 3).

Table 3 - Respondents last visit to GP				
	<1 year	**1-2 years**	**3-5 years**	**>5 years**
All (n=157)	66%	22%	6%	6%
Age (n=150)				
40-49 years	54%	27%	6%	13%
50-59 years	66%	24%	9%	2%
60-69 years	88%	6%	6%	0%
70-79 years	100%	0%	0%	0%
Ethnicity (n=152)				
White (British and Other)	59%	24%	9%	8%
Black and other minority	77%	18%	2%	4%
Disability (n=150)				
Disabled	83%	14%	3%	0%
No disability	59%	24%	8%	9%
Resident (n=148)				
Haringey	70%	16%	7%	7%
Out of borough	60%	27%	7%	7%
Employment (n=144)				
Paid employment	61%	25%	7%	8%
Not in paid employment	92%	0%	8%	0%

6.3 Proportionally more respondents from BME groups and those with a disability indicated that they had visited their GP more recently than their white or non-disabled counterparts (Table 3). This in part may be due to disparities in perceived health status noted earlier in the report. There is also a large differential among those in paid employment and those who are not: just 61% of respondents in paid employment indicated that they had seen their GP in the past year as compared to 92% who were not (Table 3).

7.0 Factors affecting current health

7.1 The survey sought to assess what factors were affecting the health of respondents. Here, respondents were asked to indicate which factors (from a pre-set list of 10) were currently influencing their health. Respondents were also given the opportunity to indicate whether their health was unaffected by any of these factors.

7.2 The three factors that were most commonly cited by respondents which influenced their health were stress (38%), a lack of exercise (34%) and being overweight (32%) (Figure 4). A smaller proportion of respondents indicated that their eating habits (23%), smoking (20%) or work / unemployment were factors affecting their health. Approximately 1 in 5 respondents (22%) indicated that none of the factors listed affected their health (Figure 4).

7.3 In addition to the factors listed, respondents were also able to identify any other issues that affected their health. 15 respondents indicated that other factors were affecting their health of which the most commonly cited were:

- work environment / anxiety and stress at work (pressure, redundancy)
- high blood pressure/ cholesterol
- musculoskeletal problems (back pain, Achilles, hip replacement).

7.4 Further analysis of responses to this question provided some interesting patterns and associations. Within this sample of respondents, it would appear that smoking, eating habits, alcohol, stress and lack of exercise were affecting younger age groups (under 60 years of age) more than older age groups (60 years and over) (Table 4). Conversely, the only factor which would appear to affect older men more than younger men in this survey would appear to be loneliness (Table 4).

Table 4 – Issues which respondents indicated were affecting their health (%)

	Smoking	Eating habits	Overweight	Alcohol	Sexual health	Stress	Loneliness	Family problems	Work/ unemployment	Lack of exercise	None of these
All (N=157-158)	**20**	**23**	**32**	**13**	**6**	**38**	**10**	**13**	**20**	**34**	**22**
Age (n=148-149)											
< 60 years	24	25	33	14	6	41	9	13	20	38	23
60 years and over	5	11	29	0	5	33	14	14	24	24	14
Ethnicity (n=151)											
White (British and Other)	20	23	32	15	4	36	6	11	14	31	23
Black and other minority	24	24	33	10	8	45	16	18	35	39	22
Disability (n=149)											
Disabled	11	37	40	17	17	54	23	20	31	40	14
No disability	23	18	30	10	3	35	6	11	17	35	24
Resident (n=147)											
Haringey	26	24	31	16	9	38	20	16	33	35	18
Out of borough	19	23	34	10	3	41	4	12	14	36	23
East Haringey (n=68)											
East Haringey	33	28	33	22	11	33	22	17	33	28	22
Other	18	30	38	12	8	48	8	14	16	38	20
Employment (n=143)											
Paid employment	21	24	32	12	5	42	9	14	20	36	22
No paid employment	9	18	36	9	9	27	18	9	9	18	27

7.5 Further analysis of responses to this questioning revealed a consistent pattern in relation to the disability status of respondents. Here it was noted that, with the exception of smoking, those respondents with a disability were more likely to be affected by all other listed health issues than their able bodied counterparts (Table 4). The differentials recorded between the responses of those with a disability and those without were also large, those with a disability

- were six times more likely to indicate that sexual health was a affecting their health
- were four time more likely to indicate that loneliness was affecting their health
- were twice as likely to indicate that family problems were affecting their health
- were twice as likely to indicate that eating habits were affecting their health. (Table 4).

7.6 With the exception of work/ unemployment, there was a broad consistency in the responses to those factors affecting their health by both white and BME ethnic groups. Respondents from BME groups were almost three times more likely to cite work / unemployment as affecting their health than respondents from white ethnic groups (Table 4).

7.7 Respondents living in Haringey were more likely to indicate that work / unemployment, loneliness and sexual health affected their health than those respondents who lived out of the borough (Table 4). These differentials were also confirmed among respondents specifically living in the east of Haringey, though in addition, proportionally more respondents from this area indicated that smoking and alcohol were affecting their health (Table 4).

7.8 Other key points of interest from further analysis of this data included:

- as one might expect, respondents in paid employment were more likely to indicate that stress was a factor affecting their health when compared to those not in paid employment
- there was no discernible pattern when comparing the responses of different ethnic groups to those factors which may be affecting their health.

8.0 Changes made to improve health

8.1 Respondents were asked to indicate from 5 pre-set responses which actions they had taken to improve their health over the past 12 months. Over half of respondents indicated that they had eaten more healthily (59%) and had taken more exercise (51%) (Figure 5). Approximately 1/3 of respondents indicated that they had lost weight (33%) or reduced alcohol intake (31%) (Figure 5).

8.2 Analysis of responses found that those proportionally more respondents living in Haringey had taken all these actions to maintain their health than those who did not live in the borough (Table 5). However, this pattern was not repeated when the responses of those living in the east of the borough are compared against all other respondents (Table 5).

8.3 In the actions that respondents had taken to improve their health, there was no consistent pattern when comparing the responses of different age groups. Men under the age of 60 were twice as likely to have lost weight in the past 12 months compared to those aged 60 years and over (Table 5). Conversely, men aged 60 years an over were six times more likely to have quit smoking (Table 5).

8.4 Other key points of interest from further analysis of this data included:

- there was broad consistency in the responses given by all ethnic groups in respect of the actions that they have taken to improve their health, with the exception of reduced alcohol intake: respondents from white ethnic groups were almost twice as likely to have reduced their alcohol intake than those from BME ethnic groups (Figure 5)
- the most healthy respondents (who were in excellent or good health) were more likely to have taken all those actions cited to improve their health than those who were in fair or poor health (Table 5)
- proportionally more men who were not in paid employment had taken more exercise, eaten more healthily and reduced their alcohol intake than those in paid employment; though more men in pain employment had lost weight or quit smoking than those not in paid employment (Table 5).

Table 5 - Action taken by respondents over past 12 months to improve their health

	Taken more exercise	Eaten more healthily	Lost weight	Quit smoking	Reduced alcohol intake
All (N=143-151)	**51%**	**59%**	**33%**	**11%**	**30%**
Age (n=139-147)					
< 60 years	53%	61%	36%	2%	29%
60 years and over	50%	57%	18%	12%	38%
Ethnicity (n=136-144)					
White (British and Other)	52%	59%	37%	10%	36%
Black and other minority	56%	62%	27%	14%	19%
Disability (n=137-144)					
Disabled	47%	63%	33%	15%	36%
No disability	53%	59%	34%	9%	28%
Resident (n=138-145)					
Haringey	55%	66%	40%	15%	31%
Out of borough	51%	58%	32%	9%	29%
East Haringey (n=68)					
East Haringey	47%	56%	41%	6%	28%
Other	48%	61%	32%	11%	40%
Employment (n=134-142)					
Paid employment	50%	60%	35%	12%	29%
No paid employment	63%	73%	14%	0%	63%
Health status (n=140-145)					
Excellent/good health	56%	62%	34%	12%	31%
Poor / fair	38%	53%	28%	7%	30%

8.5 Respondents were also given the opportunity to describe other actions which they may have taken to improve their health over the past 12 months. Aside from those actions already described, the actions most consistently cited were those that helped to reduce stress or promote relaxation. Thus a number of respondents indicated that they were reading more, had started yoga classes and took regular breaks from work to help them relax and reduce stress.

9.0 Men's Health Check Up

9.1 A men's health check is where various health assessments are undertaken (e.g. blood pressure, cholesterol, Body Mass Index) and health advice

provided. The survey sought to assess how likely it would be for respondents to attend for a men's heath check if these were held at different community settings.

9.2 The most popular setting for a men's health check was a GP surgery, where 84% of respondents indicated that they would be very likely or likely to attend (Figure 6). Equally as popular for a men's health check was the workplace where almost ¾ of respondents (71%) indicted that they would be very likely/ likely to attend (Figure 6). Less than half of respondents indicated they would be very likely or likely attend a health check if this was held at a chemist (43%), a community centre (37%) or leisure centre (34%) (Figure 6).

Table 6 - Possible uptake of men's health check at different community settings (%).

	GP Surgery		Work Place		Chemist		Community Centre		Leisure Centre	
	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all
All (N=116-139)	**84**	**4**	**71**	**12**	**43**	**22**	**37**	**20**	**34**	**20**
Age (n=115-138)										
< 60 years	82	4	71	11	42	21	36	19	36	19
60 years and over	100	0	72	9	55	22	50	25	20	20
Ethnicity (n=112-135)										
White (British and Other)	84	3	72	10	44	22	38	19	34	18
Black and other minority	85	4	70	14	43	21	34	23	35	24
Disability (n=114-134)										
Disabled	97	0	48	20	43	30	36	24	26	35
No disability	80	5	77	9	43	19	37	18	36	15
Resident (n=115-136)										
Haringey	84	4	61	21	48	23	50	17	42	20
Out of borough	84	4	77	6	42	20	29	21	31	19
Employment (n=111-125)										
Paid employment	83	4	75	7	43	21	36	18	35	18
No paid employment	100	0	33	67	50	25	83	17	25	25

9.3 Further analysis of the preferences for the settings for a men's health check produced some interesting results. Haringey residents were more likely to favour more informal settings (community centres, leisure centres and chemists or a men's health check than non-Haringey residents (Figure 6). Conversely, those respondents with a disability were more likely to favour established healthcare settings: in fact almost all disabled respondents indicated that they would attend a health check at a GP surgery (Table 6).

9.4 As one may expect, those respondents in paid employment were more likely to attend a health check at their work place, and conversely, more of those not in paid employment preferring a community centre setting (Table 6). On the basis of these responses, there would appear to be no differences in the likelihood of different ethnic groups attending health checks at different settings (Table 6).

9.5 Attendance at a men's health check is likely to be influenced by established patterns of usage of existing services and facilities. This may be exemplified in further analysis of the age group responses where proportionally more respondents from older age groups (aged 60 years and over) indicated that they would be likely to attend a health check at a GP surgery, chemist or community centre, settings which they may already attend and find convenient (Table 6). Similarly, proportionally more respondents from younger age groups (aged under 60 years) indicated that they would be more likely to attend a men's health check if this was held at work or at a leisure centre (Table 6).

9.6 Respondents were also given the chance to comment qualitatively to this questioning, in particular, other preferred or more convenient venues which they may be likely to attend for a mean's health check. A number of respondents indicated that they would be likely to attend their GP for a men's health check, if this was available outside of working hours. A further respondent suggested that local libraries may be a suitable community setting to hold men's health checks.

10. Barriers to seeking advice or support if UNWELL

10.1 The survey sought to identify if there were any particular barriers which may deter men from seeking advice or support if they actually felt unwell. Here, respondents were asked to indicate how likely a range issues would be in deterring them from seeking advice or support if they were unwell.

10.2 Approximately 2/5 of respondents indicated that the 'the inaccessibility of GP services' (41%) and 'hoping that the problem would go away' (40%) were likely to deter them from seeking health if they were unwell (Figure 7). Just over ¼ of respondents indicated that 'concern that the problem may be serious' (28%) and 'lack of knowledge about the NHS' (24%) were likely to deter men from seeking help if they were unwell (Figure 7). The gender of the health practitioner does not appear to be a significant deterrent, with just 15% of respondents indicating that the prospect of a female GP would deter them from seeking help if they were unwell (Figure 7).

10.3 Interestingly, proportionally more Haringey residents consistently indicated that all suggested factors were likely to deter them from seeking advice or support if they were unwell (Table 7). For example, more than twice as many respondents who live in Haringey (23%) indicated that the prospect of talking to a female practitioner would deter them from seeking advice if they were unwell than those who lived out of borough (10%) (Table 7).

Table 7 – Likelihood that certain factors would deter respondents from seeking advice or support if they were UNWELL (%)

	Lack of NHS knowledge	Inaccessibility of GP	Embarrassed talking about personal health	Hope that the problem will go away	Anxiety that problem may be serious	Discomfort of talking with a female practitioner

	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all
All (N=129-140)	**24**	**33**	**41**	**27**	**21**	**35**	**40**	**26**	**28**	**25**	**15**	**38**
Age (n=129-139)												
< 60 years	*23*	*33*	42	28	21	34	44	24	30	23	14	36
60 years and over	*29*	*29*	37	26	21	43	14	36	14	36	21	50
Ethnicity (n=127-136)												
White (British and Other)	*19*	*32*	33	27	21	32	41	22	26	23	12	36
Black and other minority	*36*	*33*	61	23	22	38	42	31	38	24	22	38
Disability (n=114-134)												
Disabled	*21*	*46*	45	28	36	36	38	31	50	25	7	44
No disability	*24*	*29*	38	27	16	35	40	24	23	24	16	36
Resident (n=129-138)												
Haringey	*30*	*32*	45	28	27	36	48	23	39	24	23	36
Out of borough	*19*	*34*	38	26	18	34	37	26	23	24	10	38
Employment (n=125-133)												
Paid employment	*23*	*33*	40	28	21	34	42	25	28	24	15	37
No paid employment	*38*	*25*	56	11	0	50	17	17	50	17	17	33
Health status (n=131-139)												
Good/ excellent health	*21*	*33*	37	30	19	39	40	28	25	26	11	42
Poor/ fair health	*35*	*31*	55	14	27	19	46	19	42	19	31	19

10.4 Analysis of this support seeking behaviour by the health status of respondents once again demonstrates a clear pattern of responses. Those respondents who were in poor or fair health were more likely to be deterred from seeking advice or support if they were unwell for all those factors listed compared to those in good or excellent health (Table 7). For example, 55% of respondents whose health was poor or fair indicated that the inaccessibility of their GP may deter them from seeking advice or support if they were unwell compared to just 37% of respondents who were in good health (Table 5). Furthermore, proportionally more of those in better health consistently indicated all these factors would 'not deter them at all' from seeking help if they were unwell (Table 5).

10.5 A similar pattern of responses is also recorded when the ethnic group of respondents is considered: here a higher proportion of respondents from BME groups consistently indicated that all presented factors would likely deter them from seeking advice or support if they were unwell. For example, almost twice as many respondents from BME groups indicated that a 'lack of NHS knowledge', 'inaccessibility of GPs' and 'discomfort at talking with a female practitioner' were likely to deter them from seeking advice if they were unwell than respondents from white ethnic groups (Table 7).

10.6 Whilst there appeared to be no discernible patterns between responses of different age groups or those with different employment status, there are a number of differentials between the responses of those with a disability and those who have not. Here, those respondents with a disability were more than twice as likely to indicate that 'embarrassment at talking of personal health issues' and 'anxiety that the problem may be serious' was a deterrent to seeking advice if they were unwell than those without a disability (Table 7).

10.7 Qualitative comments provided by respondents confirmed some of the potential barriers that they experienced when seeking help when they felt unwell. These included:

- the difficulty of getting a convenient appointment to a GP or any health practitioner
- mobility issues in accessing services
- limited time for health appointments (finding out where, making an appointment and attending).

11. Barriers to seeking advice or support if want to STAY HEALTHY

11.1 The survey sought to identify if there were any particular barriers which may deter men from seeking advice or support if they wanted to stay healthy. Here, respondents were asked to indicate how likely a range issues would be in deterring them from seeking advice or support.

11.2 There were a number of factors which appear to stand out as possible barriers that would prevent respondents from seeking advice or support to stay healthy. Almost one-half of respondents indicated that 'not feeling unwell' (54%), 'having no symptoms' (49%) or 'having limited time' (48%) were likely to prevent them from seeking advice or support to stay healthy (Figure 8). In addition, 'already knowing what to do to stay healthy' was also seen as a factor which may limit respondents from seeking advice or support to stay healthy (Figure 8).

11.3 In respect of the age group of respondents, there appears to be no consistent pattern on responses given to those issues that may deter people from seeking advice or support to stay healthy. Perhaps the most telling data however, is that those under 60 years of age were almost four times more likely to be deterred from seeking advice to stay healthy because of lack of time than those aged 60 years and over (Table 8).

11.4 Earlier analysis has suggested that those in poor or fair health were less likely to have taken action to improve their health and more likely to be deterred from seeking advice when they were unwell. However, a more complex pattern of responses is recorded for assessing barriers to *staying healthy*. Those who were in good or excellent health were more likely to indicate that 'not having enough time', 'its not a priority for me', 'I don't have any symptoms' and 'I don't feel unwell' would deter them from seeking advice or support in staying healthy than those in poorer health (Table 8). It may be that these factors are perceived as markers of respondents own good health and therefore deterrent to them seeking advice to stay healthy. This is substantiated within the analysis of responses of disabled and non-disabled people, where a similar pattern is recorded.

11.5 Qualitatively, only a small number of comments were provided by respondents within the survey. Within these comments it was apparent that there some respondents felt that there should be less reliance on services and greater use of self- help in relation to staying healthy:

"I feel you should be able to deal with things yourself…. '

Table 8 – Likelihood that certain factors would deter respondents from seeking advice or support if they wanted to stay healthy (%)

	Don't know who to talk to		Not enough time		Its not a priority for me		I don't have any symptoms		I don't feel unwell		Preaching attitude of health staff		I am too old for this to make a difference		I already know what to do to stay healthy	
	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all	Very likely/ likely	Not at all
All (N=129-140)	**18**	**32**	**48**	**20**	**36**	**23**	**48**	**17**	**54**	**18**	**16**	**37**	**9**	**45**	**49**	**16**
Age (n=124-135)																
< 60 years	*18*	*30*	*53*	*18*	*36*	*21*	50	16	54	16	16	34	10	44	48	14
60 years +	*14*	*36*	*15*	*23*	*39*	*31*	38	19	62	23	23	46	0	46	59	24
Ethnicity (n=129-137)																
White (all)	*11*	*33*	*49*	*18*	*35*	*23*	47	15	58	16	16	37	9	47	51	16
BME	*32*	*34*	*47*	*27*	*37*	*26*	48	24	45	23	14	41	11	41	48	20
Disability (n=114-134)																
Disabled	*12*	*41*	*40*	*30*	*37*	*27*	34	22	39	23	20	40	19	39	49	24
No disability	*18*	*31*	*49*	*18*	*35*	*23*	52	17	57	17	14	37	5	48	49	15
Resident (n=127-134)																
Haringey	*19*	*34*	*51*	*29*	*29*	*29*	49	22	54	24	23	32	18	40	49	20
External	*17*	*29*	*48*	*13*	*40*	*20*	48	13	55	13	12	38	4	46	49	12
Health status (n=126-137)																
Excellent/good	*17*	*35*	*48*	*22*	*38*	*26*	54	19	59	20	13	41	8	51	52	17
Fair/poor	*20*	*24*	*46*	*13*	*25*	*13*	22	12	29	8	25	21	13	13	37	15

12. Initiatives that would support men staying healthy

12.1 Final questioning within the survey sought to assess what local developments would be helpful to local men to help them stay healthy. Here respondents were given a number of preset options and asked to indicate how useful they would find these (on a scale of very helpful – not very helpful at all).

12.2 Face-to-face advice from a health professional was perceived to the most helpful local intervention which could support men to stay healthy; 94% of respondents indicated that this would be helpful (Figure 9). A majority of respondents also indicated that a discounted gym membership (83%), a web page for local health men's health information (79%) and a men's health booklet (73%) would be helpful local developments for men to stay healthy (Figure 9). There was less support for among respondents for other interventions, indeed, more respondents felt that a local men's health group (62%) and health information to mobile phones (54%) were not helpful than helpful.

12.3 Further analysis of these responses identified a number of trends and patterns. Respondents from younger age groups (aged under 60 years) were more likely to indicate that most suggested developments would help them stay healthy than older respondents (aged 60 years and over); for example,

74% of men aged under 60 indicated that a men's health booklet would be helpful compared to 57% men 60 years an over (Table 9).

Table 9 – Perceived helpfulness of local developments to support men to STAY HEALTHY (%)

	Face to face advice from health professional		Local men's groups		A booklet with local health information for men		Health advice to tips to your mobile phone		A website for local health information for men		Discounted health and fitness club membership	
	Very helpful/ helpful	Not helpful at all	Very helpful/ helpful	Not helpful at all	Very helpful/ helpful	Not helpful at all	Very helpful/ helpful	Not helpful at all	Very helpful/ helpful	Not helpful at all	Very helpful/ helpful	Not helpful at all
All (N=128-149)	**94**	**2**	**38**	**20**	**73**	**7**	**47**	**23**	**79**	**9**	**83**	**8**
Age (n=129-139)												
< 60 years	*94*	*2*	38	20	74	7	47	22	80	9	82	8
60 years and over	*94*	*0*	33	20	57	7	31	38	69	8	86	7
Ethnicity (n=129-146)												
White (British and Other)	*93*	*3*	28	25	67	10	42	27	76	10	80	10
Black and other minority	*96*	*0*	61	11	89	0	57	11	89	6	92	0
Disability (n=126-146)												
Disabled	*88*	*6*	28	31	77	10	40	33	74	16	72	20
No disability	*96*	*1*	40	17	71	6	49	20	80	7	86	4
Resident (n=123-142)												
Haringey	*96*	*2*	51	15	76	4	40	26	71	9	80	9
Out of borough	*92*	*2*	40	23	71	8	49	23	83	9	83	7
Employment (n=119-139)												
Paid employment	*94*	*2*	36	20	72	7	47	22	80	7	84	7
No paid employment	*100*	*0*	67	0	83	0	40	40	60	20	60	20
Health status (n=127-148)												
Good/ excellent health	*95*	*1*	37	19	73	6	48	22	81	6	84	6
Poor/ fair health	*89*	*7*	42	21	79	8	43	22	74	17	78	13

12.4 Black and other minority ethnic groups were consistently more enthusiastic about suggested health developments to help men stay healthy than respondents from white ethnic groups (Table 9). For example, respondents from BME groups were twice as likely to indicate that a men's health group would be helpful than respondents from white ethnic groups (Table 9).

12.5 Other key points of interest from further analysis of this data included;

- interestingly those respondents *without* a disability were more likely to be receptive to suggested health developments than those *with* a disability
- there were no discernible patterns in the responses of those respondents who lived locally and those who do not
- there were no discernible patterns in the responses of those respondents with good health and those in poor health.

12.6 Qualitatively, a small number of comments were provided by respondents in relation to interventions to support them staying healthy. These mostly concerned the need to tailor health interventions to the workplace:

'…someone to come to the work-place.'

'Wellness Clinics at the office.'

'I live in Kent - therefore it would need to be local to me.'

13. Summary

13.1 Whilst people from a range of differing background and circumstances have been included within this survey, it not suggested this sample or the issues presented within this report are wholly representative of men in Haringey. This survey has however provided a snapshot of the views of men that live or work in Haringey, and has illustrated some of the issues which may influence their health and the barriers that they face in staying healthy..

13.2 Inequalities that local men experience in relation to their health were illustrated at many points within the survey. Whilst the majority (79%) of men responding to this survey were in good health, almost 1 in 5 reported that their health was just fair or even poor: this figure was proportionally higher among those people with a disability (44%), among BME groups (31%) or those not in paid employment (50%).

13.3 There are clearly many factors which may affect people's health. The survey has provided further insight in to those factors which may affect men's health in Haringey: stress, lack of exercise and being overweight being those factors most commonly cited within this sample. The level to which these and other factors have been reported to influence men's health in this survey is however likely to be an under representation, given the self-reported nature of the survey.

13.4 The survey established that within this sample of respondents there is an element of a health improvement culture, where a significant proportion of respondents had engaged in a range of behaviours to help improve their health. For example, over one-half of those surveyed indicated that they had eaten healthier or taken more exercise in the past 12 months. However, there were wide variations in the engagement with such health promoting behaviour between different population groups.

13.5 Data presented in this report clearly illustrates how health inequalities can be perpetuated within local populations. Analysis has shown that those who were already in poor health were not only less likely to have taken action to improve their health but also more likely to be deterred by a range of factors from seeking advice or support, *even when they were unwell*. Similarly, those with a disability were more likely to be affected by a range of health issues yet it was recorded that they faced similar barriers to accessing advice and support as those without a disability.

13.6 In respect of the development of men's health checks, data analysis gave a clear indication *that in general*, there would be a preference if these were held in more formal settings such as the GP surgery or workplace over and above community settings (e.g. chemist, community centre or leisure centre). However, individual settings evidently appealed more to different groups, for

example, those under 60 were almost twice as likely to attend a health check at a leisure centre than those aged over 60 years.

13.7 Perhaps the most important analysis to be obtained from this survey is that, even when men are unwell, there are still a number of factors which may deter them from seek advice or support. Problems with getting an appointment with a GP, fear that the problem may be serious or just hoping that the problem will go away were all commonly cited amongst this group of respondents as to why they may not seek help when they need it. Such data highlights the work that needs to be done not only to improve the accessibility of services, but also in the educational and motivational spheres of men's health.

13.8 The survey has highlighted some possible developments which may guide and support local interventions to improve men's health. Analysis would seem to suggest that further improvements to the accessibility of primary care services may be welcomed by men, given that 2 in 5 men indicated that the inaccessibility of services (e.g. appointments) may deter them from seeking advice or support, *even when they were unwell*. Respondents indicated a preference for more traditional interventions for improving their health. For example, respondents preferred to have a men's health check in their GP surgery over and above most other settings. Similarly, face to face advice from a health professional was perceived to be the most helpful intervention to improve their health, over and above that of health information obtained from other new media sources.

13.9 Almost 160 men who live or work in the borough have completed this survey, and it is hoped that these responses and subsequent data analysis will contribute to an increased understanding of men's health issues in the borough. This may in turn help to improve the advice, support and services available to help reduce cardiovascular disease and reduce local health inequalities.

Appendix A – Charts

Figure 1 – Postcode of respondents

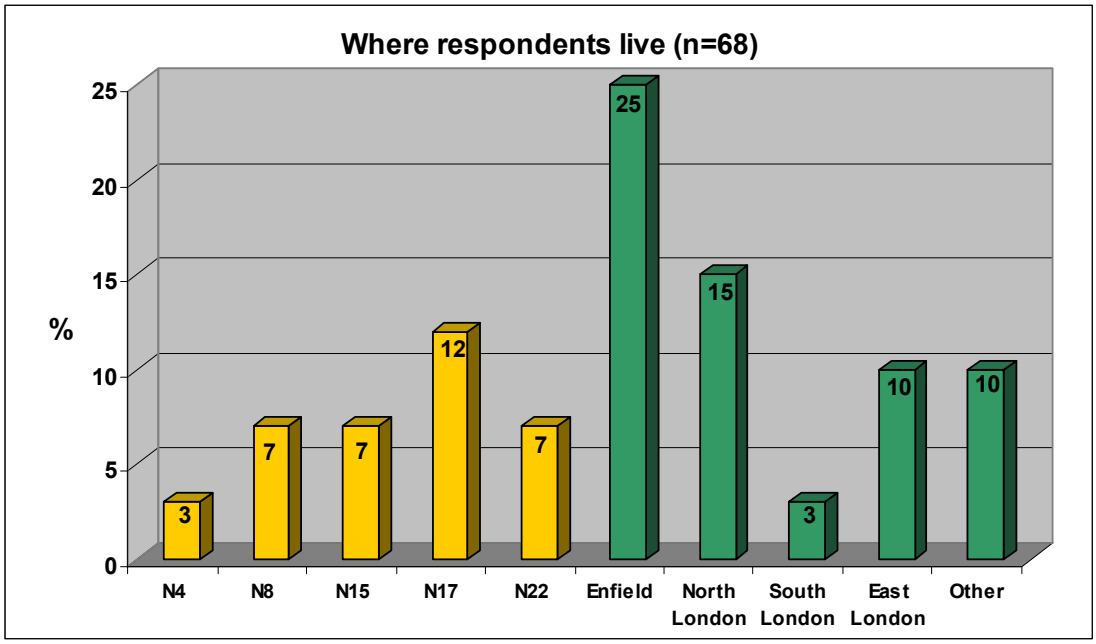


Figure 2 - Self reported health status of respondents

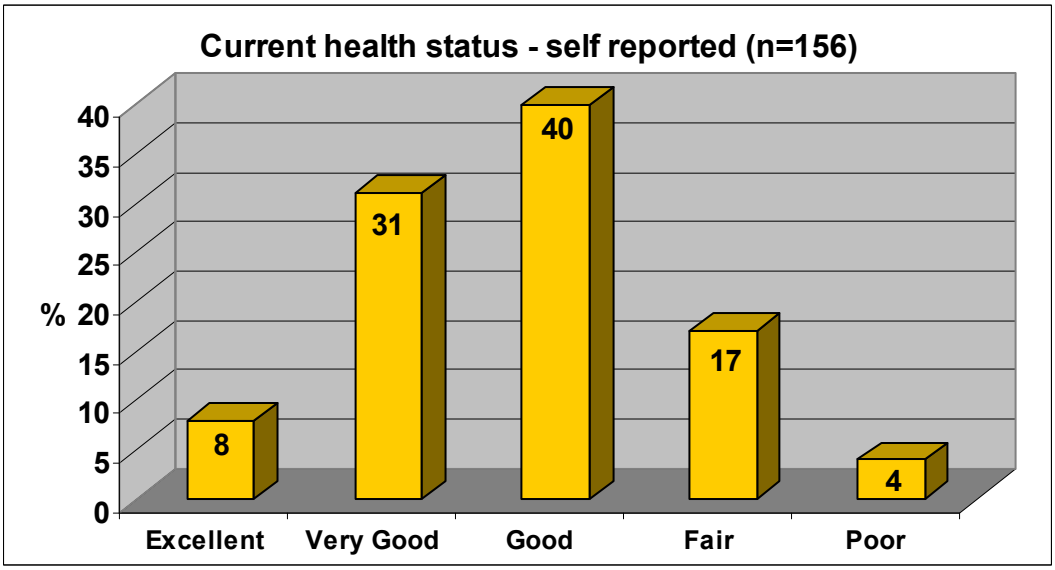


Figure 3 – Last visit to General Practitioner

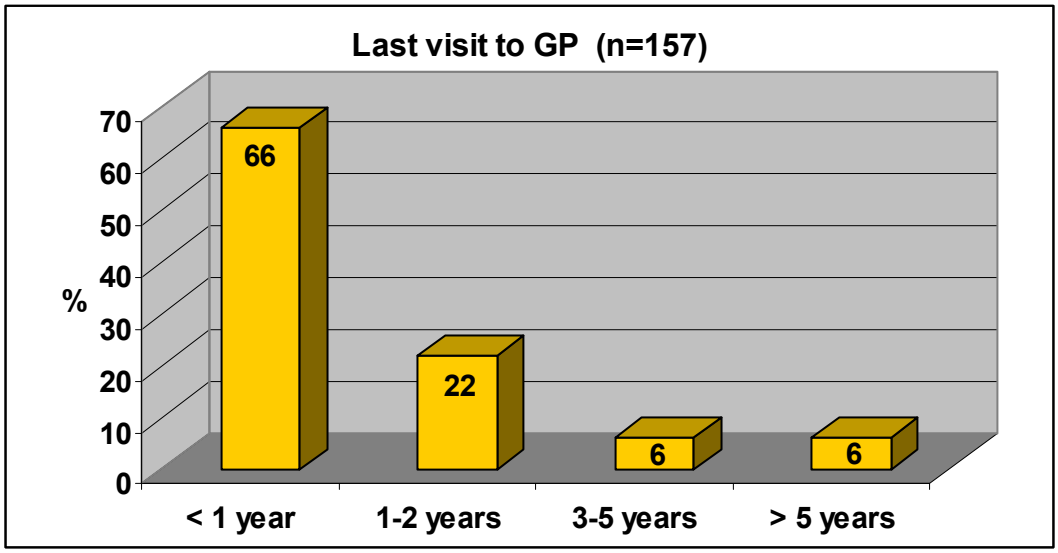


Figure 4 – Factors affecting respondent's current health.

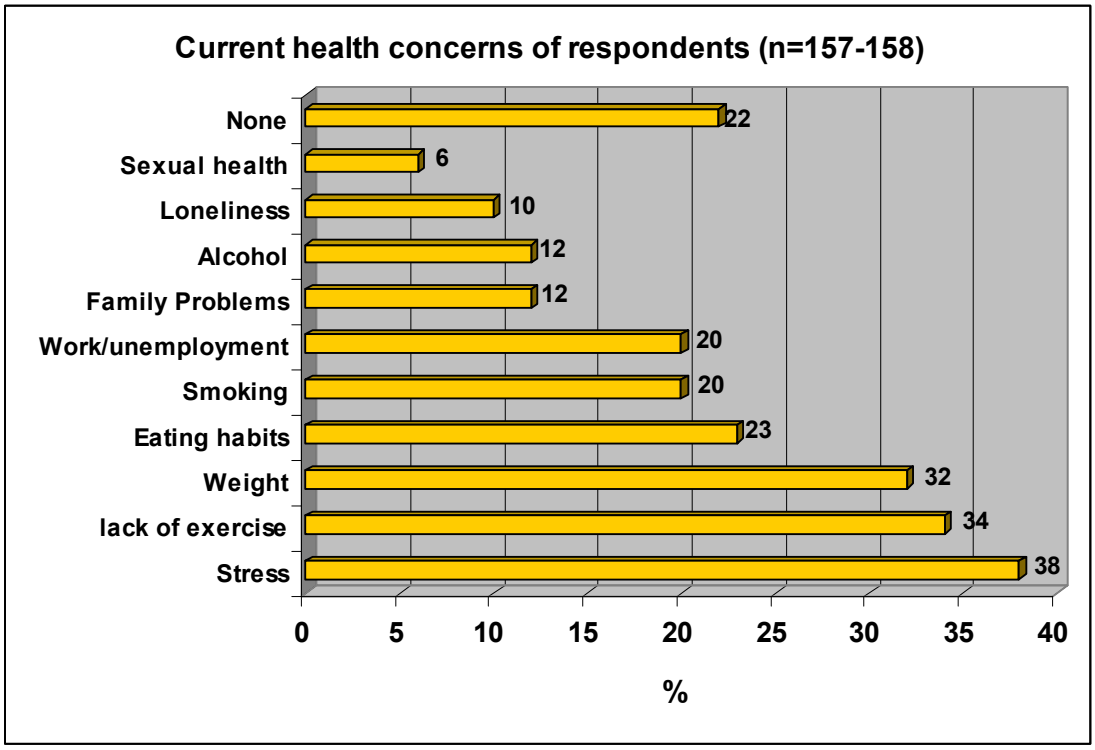


Figure 5 – Changes respondents have made to improve their health.

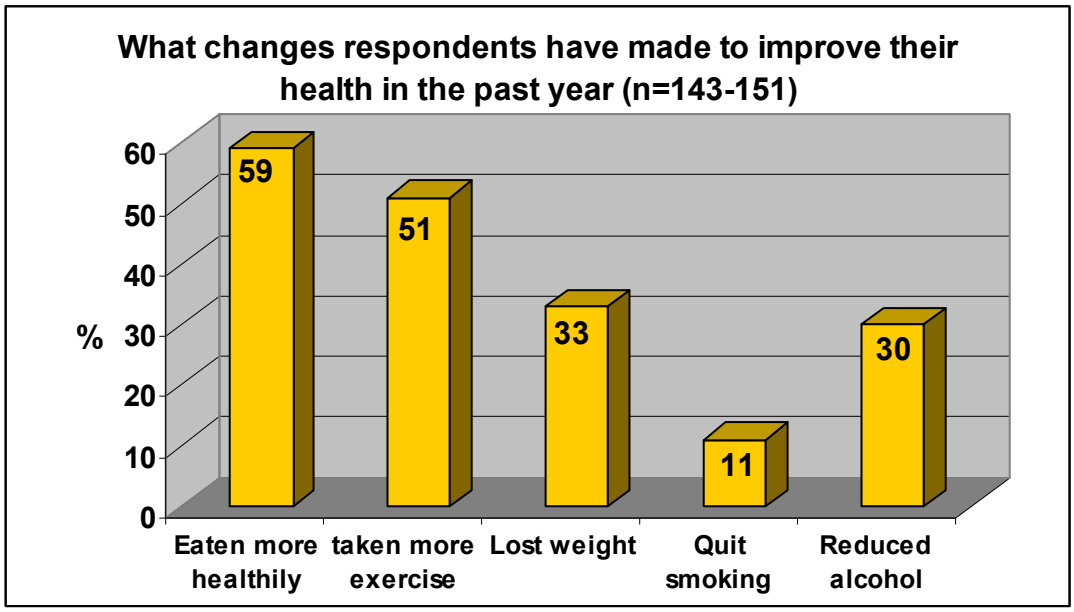


Figure 6- Possible uptake of men's health check at different community settings.

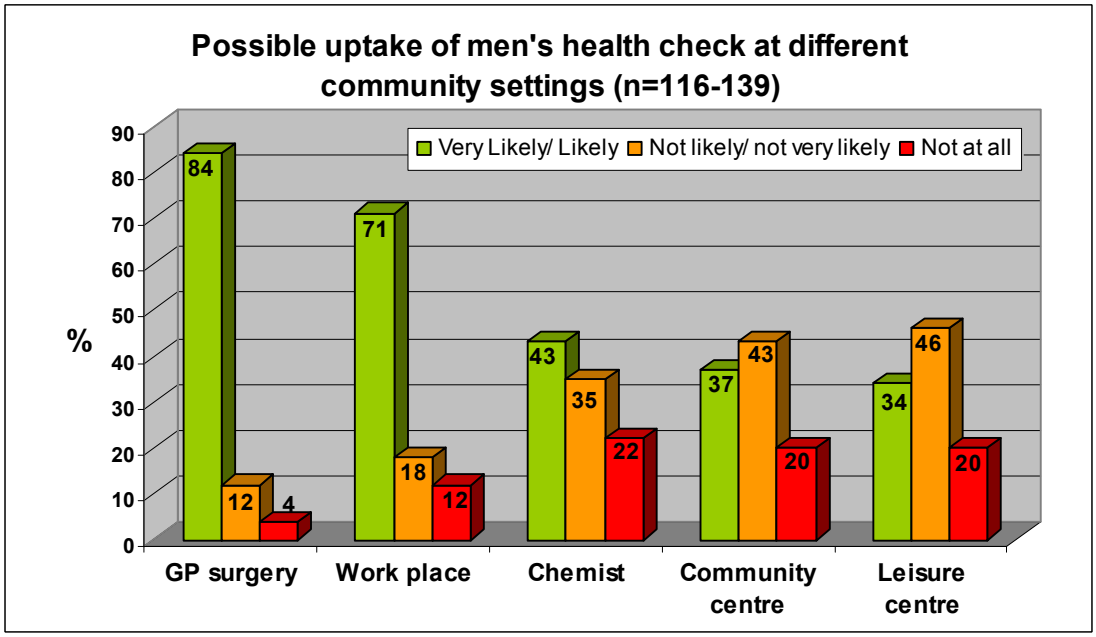


Figure 7 – Issues that may prevent respondents from seeking advice or support if they were UNWELL.

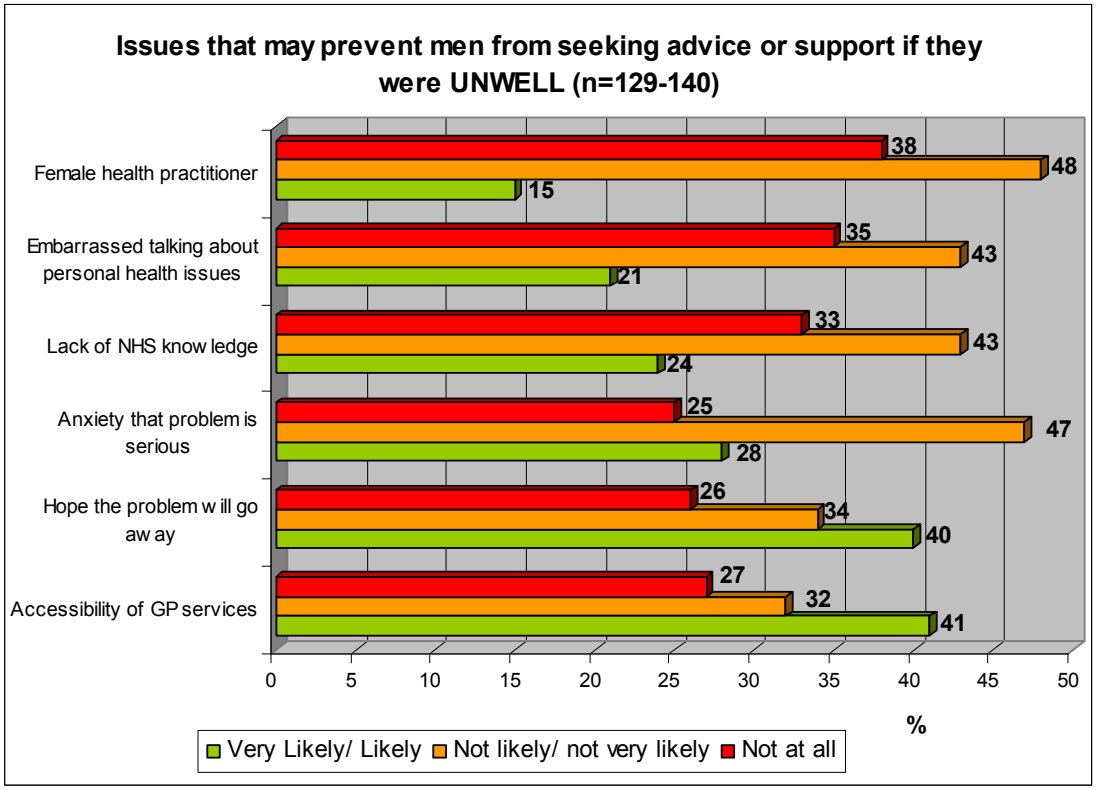


Figure 8 - Issues that may prevent respondents from seeking advice or support if they wanted to STAY HEALTHY.

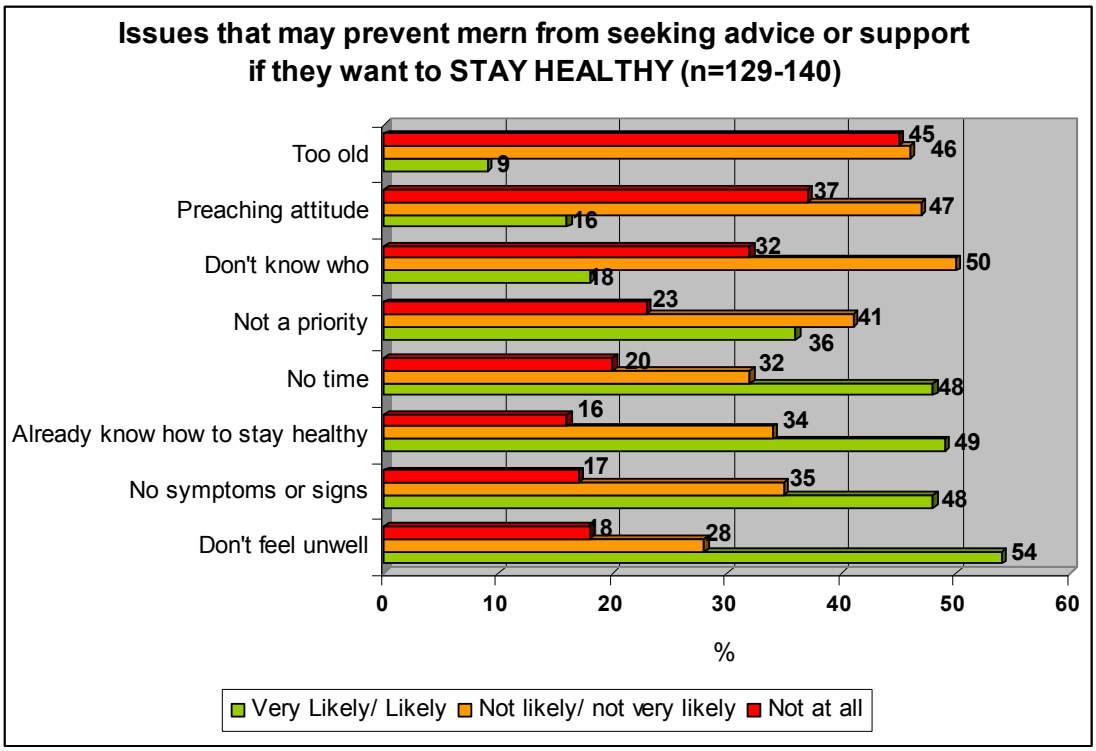
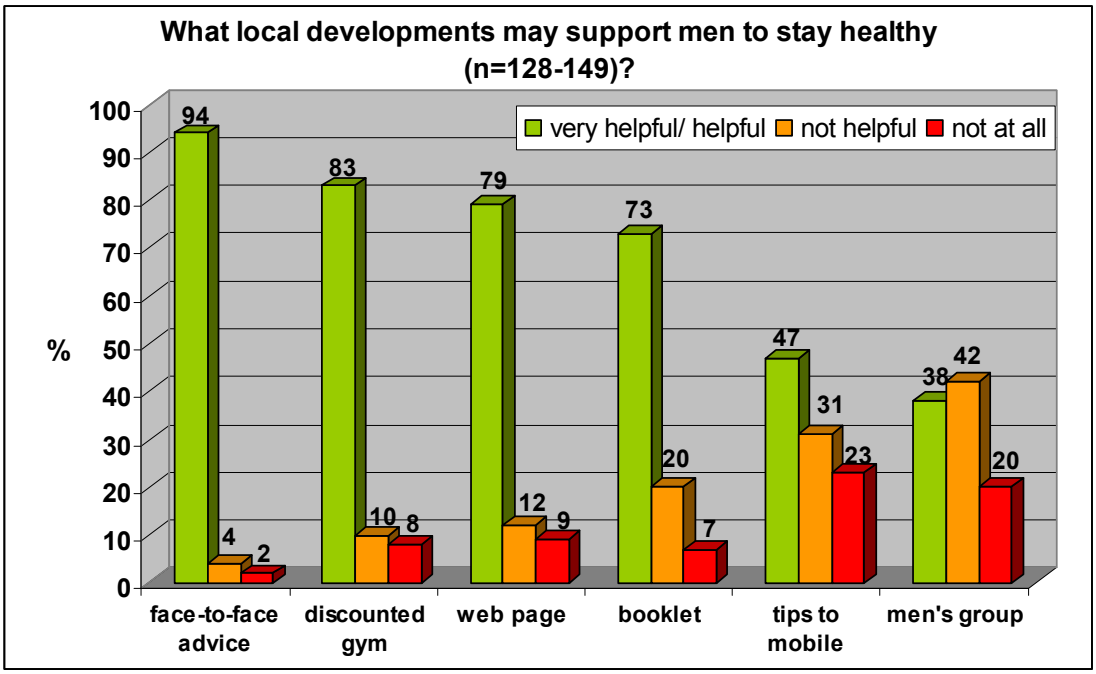


Figure 9 – Perceived helpfulness of local developments to help men stay healthy.



Appendix B – Survey

Men's Health Survey

The questionnaire aims to find out what barriers men may face in trying to stay healthy and how these may be overcome. It is for men **aged 40 and over who live or work in Haringey**. Please have your say by completing the questions below which should take no longer than 5-10 minutes. All completed surveys will be placed in a draw for one of two £20 high street vouchers. All responses must be received by **Sunday 20th February 2012** . Please start the survey on the next page.

1. How would you describe your current health? (Please tick ONE box only)

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. When was the last time you visited a General Practitioner (GP)? (Tick ONE box only)

- ☐ Less than 1 year ago
- ☐ 1-2 years ago
- ☐ 3-5 years ago
- ☐ 5+ years ago

3. Do you think that any of the following factors may be affecting your health? (Tick boxes that apply)

- ☐ Smoking
- ☐ Eating habits
- ☐ Weight
- ☐ Alcohol
- ☐ Sexual health
- ☐ Stress
- ☐ Loneliness
- ☐ Family problems
- ☐ Problems at work / unemployment
- ☐ Lack of exercise
- ☐ None of these factors affect my health
- ☐ Other

Please tell us about any other health issues that may be affecting your health.

_____

_____

4. Have you made any of the following changes to improve your health over the past 12 months?

	Yes	No
Taken more exercise	☐	☐
Eaten more healthily	☐	☐
Lost weight	☐	☐
Quit smoking	☐	☐
Reduced alcohol intake	☐	☐

Are there any other changes that you have made to improve your health (12 months)?

_____

_____

At a men's health check up you can have your health assessed such as having your blood pressure taken or your cholesterol measured. You can also get advice at a health check about how to stay fit and healthy.

5. How likely is it that you would attend an invite to a men's health check up at any of the following places?

	Very likely	Likely	Not likely	Not very likely	Not at all
At your work place	☐	☐	☐	☐	☐
At a local community centre	☐	☐	☐	☐	☐
At your GP surgery	☐	☐	☐	☐	☐
At a local leisure centre	☐	☐	☐	☐	☐
At your local chemist / pharmacist	☐	☐	☐	☐	☐

Are there any other places where you might attend a men's health check up?

6. How likely is it that any of the following issues would prevent you from seeking advice or support if you were feeling unwell?

	Very likely	Likely	Not likely	Not very Likely	Not at all
Lack of knowledge about NHS services	☐	☐	☐	☐	☐
Accessibility of GP services / appointments	☐	☐	☐	☐	☐
Feeling embarrassed talking about personal health issues	☐	☐	☐	☐	☐
Hope that the problem will go away	☐	☐	☐	☐	☐
Anxiety or fear that the health problem might be serious	☐	☐	☐	☐	☐
Feeling uncomfortable talking with female GP or other health professional	☐	☐	☐	☐	☐

Are there any other factors that may deter you from seeking advice if you were unwell?

7. How likely is it that any of the following issues would prevent you from seeking advice about staying healthy (for example how to lose weight, take more exercise or stop smoking)?

	Very likely	Likely	Not likely	Not very likely	Not at all
I don't know who to talk to about this	☐	☐	☐	☐	☐
I don't have enough time	☐	☐	☐	☐	☐
This is not a priority for me at the moment	☐	☐	☐	☐	☐
I don't have any symptoms or signs that I am unwell	☐	☐	☐	☐	☐
I don't feel unwell	☐	☐	☐	☐	☐
I don't like the preaching attitude of health workers	☐	☐	☐	☐	☐
I'm too old for anything to make a difference	☐	☐	☐	☐	☐
I already know what to do to keep healthy	☐	☐	☐	☐	☐

Are there any other reasons which may prevent you from seeking advice about how to stay healthy?

8. If you wanted support to stay healthy, would any of the following developments be helpful?

	Very helpful	Helpful	Not very helpful	Not helpful at all
Face-to-face advice from a health professional	☐	☐	☐	☐
A local men's group to discuss health issues	☐	☐	☐	☐
A booklet with information about local health services for men	☐	☐	☐	☐
Health information/ tips to your mobile	☐	☐	☐	☐
A website of local health information for men	☐	☐	☐	☐
Discounted health and fitness membership	☐	☐	☐	☐

Are there any other developments which could help you stay healthy (please describe)?

9. What is your age group? (please tick ONE box)

40-49 years	60-60 years
50-59 years	70+ years

10 Do you have any long-standing illness, disability or infirmity? (long-standing means anything that has troubled you over a period of time or that is likely to affect you over a period of time)

- Yes
- No

11. Which ethnic group best describes you?

- ❑ White category (British, Greek, Turkish, Irish, Cypriot)
- ❑ Mixed category
- ❑ Asian or Asian British category
- ❑ Black or Black British category (Caribbean, African)
- ❑ Chinese or Any other ethnic group

12. Do you have a religion or belief that you would like to mention?

- No religion
- Christian
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Rastafarian
- Other

Please write in

_____

_____

13 How would you describe your sexual orientation?

- Heterosexual
- Bisexual
- Gay

14 How long have you lived in Haringey? (please tick ONE box)

- Less than 2 years
- 2-5 years
- 6-10 years
- 11 years+
- I don't live in Haringey

15 Can you tell us the first part of your postcode? (for example N15, N8, E17)

_____

____

16. Are you? (please tick ONE box)

- Employed full-time
- Employed part-time
- Employed voluntarily
- Retired
- A student/ studying

17 If you would like to receive further information about local projects and support for improving your health please leave your email address below.

_____

_____

18 If you would like to be entered in to a draw for one of two £20 high street vouchers, please leave your name and a contact telephone number below.

_____

_____

Thank you for taking the time to complete this questionnaire.

If you would like further information about men's health and how to stay healthy you can get fast, free, independent advice from the Men's Health Forum at www.malehealth.co.uk

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Appendix F

Centre for Public Scrutiny Return on Investment - Case study

Generally: please cover planning, processes and impact; who was involved; what was interesting or different about the review.
When writing the case studies, please refer where relevant to those key attributes of a scrutiny review of health inequalities that were highlighted in 'Peeling the onion'. These were: Leadership, Vision and Drive; Local Understanding; Engagement; partnership; Being systematic; and monitoring and evaluation.

1. What was the name of the relevant Council?
London Borough of Haringey
2. What was the issue (topic) of the scrutiny review? And when did it start and finish?
The scrutiny review was entitled: Men's Health: Getting to the Heart of the Matter and aimed to build on previous work done to tackle the life expectancy gap, but with a particular focus on increasing male life expectancy in the ethnically diverse east of the borough. On average there was a nine year difference between men living in Tottenham Green ward (72.5 years) and those living in Fortis Green ward (81.5 years). Death rates from cardiovascular disease under 75 years were highest in the east of the borough whilst circulatory diseases were the greatest contributor (28%) to the gap in male life expectancy between Haringey and England. Over 50% of men were overweight or obese and less than a quarter of the adult population took part in moderate sport and physical activity. The review focused on how to engage men in early intervention and prevention services with a particular focus on cardio vascular disease. The review was started in July 2011 before active involvement of CfPS and the expert advisor and was completed at the end of January 2012.
3. What was the question you posed, that you wanted to answer on this topic?
How do we engage men over 40 years of age in Haringey's corridor of deprivation in prevention and early intervention services to close the life expectancy gap and reduce premature death from cardio vascular disease?

4. What was the "rate of return" question you decided to ask – and answer

This evolved as the review progressed and became: What would be the return on investment (ROI) if, in the life expectancy corridor of the Borough, we engaged men over 40 who were at risk of cardio vascular disease (referred to hereafter as Group A) with health and wellbeing services.

5. Stage one: Shortlist topics

What was your experience of this stage? How did you do this and how did you source the shortlist of topics?

Haringey follow the principles of Peeling the Onion and have an established process of shortlisting. When considering a review on health inequalities ordinarily the Officer would talk to the Director of Public Health and her team with reference to the Joint Strategic Needs Assessment and looking back at DoH National Support team audit recommendations. Issues would be pulled out and then mapped against what else is being done across council, speaking to stakeholders/partners and seeing where the scrutiny could add most value.

The Chair of scrutiny would have been involved in the shortlisting process and the final "choice(s)" goes to committee for discussion and approval.

What went well?

The model was not used during the selection of shortlisting topics.

What were the challenges?

What could have gone better or differently?

It is not believed that had the model been used, there would have been any other outcome. This is because the Committee had already chosen a specific topic area in order to put their bid forward. The topic area was initially suggested by the Director of Public Health.

What reflections did you hear among other participants?

6. What good practice tools or models did you use or develop in Stage 1? (Please be specific; and attach worked examples, diagrams, pictures, photographs etc).

All aspects of Peeling the Onion are covered so the health inequalities agenda is already firmly embedded into all that scrutiny does. This streamlines the process as there is an understanding by all members of what HI entails.

7. Stage 2: Prioritisation model - Impact Statements & Scoring Matrix

What was your experience of this stage? How did you do this – did you create Impact Statements using the "Marmot"- based set of 6 questions? Did you use the Scoring Matrix to decide between the topics?

As the single review topic had already been selected, the scoring matrix was not used. The impact statements were developed by officers using the Marmot based set of questions and brought to the first Panel meeting. This was passed without comment and they were then reviewed and enhanced by the CfPS expert advisor. As there was already a crowded agenda programme, the altered impact statements were emailed to members asking for any comments and none were made.

What went well?

Looking at the impact statements made the review more focused. It enabled participants to consider where scrutiny can add value whether in real measurable terms, by way of contributing and informing work already being done, or by outcomes like networking. Being part of the project did not, however, change the way review was run.

What were the challenges?

In Haringey, it is the supporting Officers role to do the background research and pull together relevant agenda items. The main discussions then take place at panel meetings once Members have read background material. To minimise any confusion for Members and add clarity to the Marmot statements, a "what it means" box was added to the template. This was to ensure that Member's had an understanding of each of the statements and so that they could not be interpreted contrary to the Marmot team's intention.

The challenge was in getting comments on the statements from Members.

Due to the way that Scrutiny is current structured in Haringey the impact statement template would not necessarily assist in getting the review Panel to think about the impact the review would have as by the time the Panel of Members comes together the review has already been chosen by the Overarching Overview and Scrutiny Committee. It could however by used as part of the report which goes to the Overview and Scrutiny Committee if there are

more than one possible review topics relating to Health Inequalities as it may then assist the Overview and Scrutiny Committee in making a decision.

What could have gone better or differently?

What reflections did you hear among other participants?

The impact statements can be revised on reflection. The impact on employment for example was considered to be low originally but should now be raised as a result of the investigation.

Health has been a 2nd tier objective in the Tottenham regeneration strategy but as a result of this investigation and the impact statement, it will help raise health to a prime position within that strategy.

Had not Haringey already embedded Peeling the Onion into its processes, the development of the impact statements would have given members and stakeholders a firm basis upon which to develop their review strategy.

8. What good practice tools or models did you use or develop in Stage 2? (Please be specific; and attach worked examples, diagrams, pictures, photographs etc).

Whilst the impact statements were utilised, specific officer knowledge regarding health inequalities and guidance to members played a significant role in this stage. This brought to the fore an area not generally considered i.e. men's health. An element of on-line reflection was introduced here with Members being asked to review the impact statement remotely.

9. Stage 3: **Stakeholder engagement model**

What was your experience of this stage? How did you do this – did you use the "determinants of health" wheel? Did you use the process to finalise and determine the review question and "KLOEs" (Key Lines of Enquiry?)

Because the review was already well advanced at the time of CfPS involvement, the wheel was used as a mechanism to highlight any gaps that might exist in the review strategy. In a crowded agenda 30 mins was allocated to developing the wheel and the number of participants grew as latecomers arrived.

What went well?

The process confirmed some of the KLOEs already being investigated and added a new one on employment. It also illustrated a subset of concern in an area of general satisfaction regarding the health trainers which led to useful debate and further investigation.

What were the challenges?
Slotting this into an existing agenda proved difficult both in respect of available time but also in ensuring the right people were there. Public Health colleagues were able to attend due to illness and travel difficulties so the group were unable to complete major segments of the wheel.

Individuals and focus groups are very hard to reach and so it is important to be very targeted and realistic about what can be achieved. At the same time it helps to be persistent! For example, it took some time to get GP involvement, but when this did happen it was with the right people who had a real interest and desire to contribute and improve the area under review.

What could have gone better or differently?
Had time be programmed in at the beginning of the review for this exercise, it would have enabled all stakeholders to be better informed as to the purpose of the wheel. In turn a richer picture of the "state of play" in the Borough might have been obtained and other "gaps" may have been identified. The review was very comprehensive and this exercise might have improved prioritisation of KLOEs.

However, the number of stakeholders evolved as the review progressed and it was only in the latter meetings that there was involvement from GP's, the Local Pharmaceutical Committee (who attended their first Panel meeting on the day the wheel was discussed) and Whittington Health for example.

What reflections did you hear among other participants?

The wheel was useful at the time to make participants think through what it was they needed to do and have impact on more than one aspect. Not sure it had a longer term impact as they already had a really good picture of health dynamics of the Borough.

This is a good early stage planning tool and if done at the beginning would have been more relevant but not sure how it influenced process of the review. You would be able to set priorities as a result of this and it can pinpoint subsets where there may be concerns.

10. What good practice tools or models did you use or develop in Stage 3?
(Please be specific; and attach worked examples, diagrams, pictures, photographs etc).

A total of five meetings were held with over 11 stakeholder organisations, most of whom attended each time once they were involved in the review. All were actively engaged in every stage of the review. Evidence was gathered from across all areas and presented to the committee in select committee style. Witnesses remained for the whole meeting and were encouraged to question their fellow witnesses and to suggest who else should be approached for

information. There was a high level of collaboration and cross-working as ideas from across and outside of the Borough were shared. Preliminary discussions and engagement were vital in creating the right atmosphere for this to happen.

11. Stage 4: Undertaking the review and a calculation of impact/ROI (return on investment)

What was your experience of this stage? How did you do this – how did you decide how to measure shorter term/process and longer term/outcome impacts? What data did you use? Did you refer back to the Impact Statements and was this useful? What was the ROI that you found?

Calculating the impact was the most difficult aspect of the review. The impact statements had illustrated that so much of the review's impact would be longer-term. Any ROI then had to deal principally with potential impact. In addition, the ROI had to be associated with an activity which would only have come about as a result of this review. In this instance, the only shorter term ROI can be networking as there are no quick wins unless pot of money available or initiatives already on-line that can be identified and slotted into.

Linking then to a recommendation that the Council should run a local targeted campaign involving all partners to act as a catalyst to engaging men in preventative and early intervention services, the ROI that was agreed (and is still being calculated) was:

Hours put in to running the review (input) the findings (activity) resulting in hours gained in increased life expectancy (output)

Cost of running the review (hours x av wage) against increased income in the target group (due to raised life expectancy) and resultant local spend

Work is also underway to identify a methodology of incorporating the quality of life equation used in public health.

What went well?

Short term returns were evident as people stayed after the meetings to exchange email addresses and engage in networking that they would not otherwise have been able to do. Professional competition was also reduced as there was a genuine partnership between all organisations working together to improve health of men.

One immediate, unexpected return was the Whittington Health Urgent Care Centre Project, a web-based health information tool for the general public which will now be redesigned to appeal more to men.

Comments are currently being collated on other non measurable outcomes of the review. Responses so far include:

- The first time I have seen in Haringey the engagement and joined up working across such a varied selection of agencies
- It is high on my agenda, so many possibilities as I start schemes and projects. I do more health checks and Q-risk (N.b. Q-Risk is a GP risk assessment tool for cardiovascular disease)
- Thanks to all of your team for making them happen, raising awareness alone will be positive and change behaviour
- I was delighted that Haringey has recognised Men's Health as one of the key issues to tackle.
- It was extremely useful to meet people who have different expertise and angle to men's health and I look forward to keeping in touch and developing these partnerships further.
- Planning and exploring ways to develop a local Men's Health Forum and how we can together develop innovative ways to celebrate and promote Men's Health Week.
- A very big thank you to you and Cllr Winskill for everything. Not only has my organisation gained for the meetings, but you made us all feel as important players in reducing gender based health inequality in Haringey.

What were the challenges?
As this is a complex process it took some time to understand how to do this. The danger is that this could be "over thought" and to go into too many layers of detail. Considerable time could be spent in thinking this through and gathering data when the outcomes are theoretical. You then have to question the cost benefit of doing it so it is important to get the balance right.

What could have gone better or differently?
Understanding the ROI at the very beginning of the project may have directed attention to gathering the necessary data at an earlier stage. However, the ROI chosen then may not have turned out to have been the one with the most impact so there has to be a level of flexibility in designing these.

What reflections did you hear among other participants?
There's a danger of using a cost benefit analysis with a long-term issue such as this. So many assumptions may have to be made that it can be all too easy to adjust the figures to get the results you want.

Calculation of specific figures are not necessary when you can have a broad answer e.g. all of costs for this work would have been paid for 20 x over if one person gave up smoking. So you can give the working behind the ROI rather than the final figure.

Focus on ROI would mean you ignored the important qualitative data as well. If

you tried to check health ambitions between Boroughs how do you measure one part of London against another and then compare commissioning for example?

Don't need to try and guess how many people have changed their lifestyle habits because of the review but if this work if successful and encourages change with other agencies etc we can say we're contributing to the huge programme of work needed to improve health.

12. What good practice tools or models did you use or develop in Stage 4? (Please be specific; and attach worked examples, diagrams, pictures, photographs etc).

13. What other reflections do you have if any?

The stakeholders were fully committed to exploring the issue and had scoped an ambitious and comprehensive study before the model was utilised. As a result, this pilot looked at how the model could be slotted in to an already constructed review. The disadvantage was that the timetable was crowded and minimal time could be allocated to the various stages of the model. The advantage was that despite this, benefits of using the model were still shown.

The way the review was carried out broke down professional silos and in particular the Local Pharmaceutical Committee has truly become involved with council.

There were problems with the project starting when it did because contact could not be made with Members during August.

Panel meetings started earlier than they would usually – in the usual review cycle more time is spent at the outset engaging with stakeholders to ensure as many are fully on board from the start as possible.

A key challenge was involving the target groups in the review. The review was launched at NHS Haringey's AGM where a Tottenham Hotspurs Legend who had heart surgery spoke of his experiences and where a number of local men attended and participated in break out sessions on the issues under review.
Some focus groups were then set up for local men, unfortunately none attended which went some way in proving how difficult it can be to engage this group!
However, a subsequent focus group at a local Arrive bus garage was very successful.

A local Health Psychology Masters student assisted with the research for the review, particularly in accessing academic journals which was extremely valuable. The student also conducted the focus group as well as preparing the

relevant paperwork e.g. consent forms, interview schedules and de-brief forms.

The review recommendations appear to have developed a life of their owns before the final report has been written up or reported through the overarching Overview and Scrutiny Committee and Cabinet with at least two of the recommendations already being taken forward! This could be due to the way in which reviews are conducted in Haringey with all stakeholders being able to share their views and input into discussions through the Panel Chair. Overview and Scrutiny in Haringey aims to be as inclusive as possible with everyone's views being given equal value which tends to create an openness in reviews with opinions being discussed and a best way forward for issues being agreed upon collectively.

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Agenda Item 11

Haringey Council

Report for:	Overview and Scrutiny Committee; 30 April 2012	**Item number**	

Title:	Scrutiny Review – Missing from Care and from Home

Report authorised by :	Councillor Alexander, Chair of Review Panel

Lead Officer:	Robert Mack, Senior Policy Officer 020 8489 2921 rob.mack@haringey.gov.uk

Ward(s) affected: ALL	**Report for Key/Non Key Decision:**

1. **Describe the issue under consideration**

   The Committee is requested to approve the final report of the Scrutiny Review of Children Missing from Care and from Home.

2. **Cabinet Member Introduction**

   N.A.

3. **Recommendations**

   That the final report of the Scrutiny Review on Children Missing from Care and from Home be approved.

4. **Other options considered**

   These are included in the Panel's report

5. **Background information**

Haringey Council

The review was set up in the light of a recommendation of the Scrutiny Review of Corporate Parenting in response to concerns that were raised in respect of missing children during the course of the review. It focused on each of the three specific categories of missing children and young people referred:

- Children missing from the Council's care
- Children missing from the care of other local authorities who have been placed in Haringey
- Children missing from home.

6. Comments of the Chief Financial Officer and Financial Implications

It appears that most of the recommendations from this scrutiny review are possible to achieve through more effective use of existing resources and consequent efficiency of the services.

The exception to this is recommendation 11 which calls for an extension to the existing Return Home Interviews (RHI) for '*all* children who have gone missing (para. 8.15). This review has identified that around 30 RHI are currently provided at no cost to the Council by Aviva/ Railway Children (para. 8.12). The review has not considered what the additional cost of an extension to this service might be.

The Children's Services management response to this scrutiny review should make it clear, the additional cost, whether it is proposing to pursue such an extension and, if so, the funding source. As part of this response the expected benefits and any 'cashable' savings, such as those in paragraph 8.18, should also be fully identified

7. Head of Legal Services and Legal Implications

The "*statutory guidance on children who run away and go missing from home or care* has been developed to help Local Authorities put better systems in place to support young runaways from both home and care.

It emphasises the importance of young runaways being offered a return interview and stresses the importance of information sharing and using common assessment. It also explains the need for a named person to be responsible at a local level.

The statutory guidance serves to safeguard **all** runaways and to redress the imbalance that currently exists between services offered to runaways from the looked after children population and those who run away from home.

This guidance was issued in July 2009 under Section 7 of the Local Authority Social Services Act 1970 which means that except in

Haringey Council

exceptional circumstances the local authority must act in accordance with it.

The Children's Society report "*Stepping Up"* found that half of local authorities surveyed had no protocol for managing cases of children missing from home however nearly 93 per cent had protocols for children missing from care.

This statutory guidance is supplementary to the statutory guidance "*Working Together to Safeguard Children" a guide to inter agency working to safeguard and promote the welfare of children"* and should be read in conjunction with that other statutory guidance because a swift and effective response for when a young person runs away is seen by the government as a key element not just in safeguarding young people but also in the link with work to raise their aspirations and improve their life chances.

8. Equalities and Community Cohesion Comments

A significant number of children and young people who go missing are looked after children, who suffer significantly poorer outcomes than other children. In particular, they have lower levels of educational attainment and higher rates of unemployment, poor mental health, imprisonment and teenage pregnancy.

9. Local Government (Access to Information) Act 1985

These are listed in Appendix 2 of the report.

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Haringey Council

Scrutiny Review – Children Missing from Care and from Home

A REVIEW BY THE OVERVIEW AND SCRUTINY COMMITTEE

April 2012

www.haringey.gov.uk

Contents: **page**

Chair's Foreword:

Missing children constitute a serious concern. They can place themselves at risk of coming to harm or getting into trouble. At the very least, they are a source of anxiety for those who care for them, whether these be parents or guardians, foster carers or residential care staff. In such circumstances, it is essential that services work together well to protect such children and young people, locate them quickly and minimise the risk of them going missing again. Our review has looked at how this is undertaken within Haringey with the aim of identifying any gaps in service and making recommendations on how improvements can be made.

Of particular significance is the fact that there is evidence nationally of under reporting, which the Children's Society has highlighted, with up to two thirds of incidents never reported. As well as having a role in making improvements, it is therefore hoped that this report will at play a part of putting the issue of the agenda locally and raising overall awareness.

Councillor Karen Alexander
Chair of the Review Panel

SCRUTINY REVIEW – CHILDREN MISSING FROM CARE AND FROM HOME

Executive Summary

The Panel were pleased to note that progress has been achieved in recent years in supporting children who go missing from care and from home following the publication by the government of the Young Runaways Action Plan in 2008 and the issuing of statutory guidance. However, the scrapping of national indicator 71, could be a retrograde step if local authorities cease to monitor progress and focus attention away from this issue.

Much useful work has been undertaken locally to focus attention on cases where risk is likely to be the greatest, particularly through work with residential care providers. This has involved ensuring that cases are correctly designated as either "missing" or "unauthorised absence". The distinction is important as a higher level of priority is generally given to instances where children and young people are classified as missing. However, it is still needs to be recognised that risk may also occur in cases of "unauthorised absence" and, as a part of this, the Panel feels that consideration should be given to putting a finite time limit on how long a child or young person can be regarded as such.

High quality statistics and data on missing children are important as they enable patterns and emerging issues to be identified. A range of these are used by the Council and its partners but some are still generated manually. There are some limitations to how much can be done locally to make improvements as the Police Missing Persons database is used across the Metropolitan Police Service as a whole. The Panel nevertheless feels that there is scope for improvement in how statistics and data are shared, collated and analysed, with better and more co-ordinated use of IT.

Foster carers do an invaluable job in looking after children in care. This can be a challenging role in some cases and dealing with children or young people who run away can be very stressful for them. In recognition of this, the Panel is of the view that better support for foster carers should be developed including provision to inform and reassurance them on follow up action by social workers and other relevant professionals after incidents have taken place. This particularly applies to out of hours periods, which is when most incidents occur.

Although the figures for Haringey reflect the fact that looked after children are more likely to go missing, there is clear evidence that there is likely to be *under* reporting of children missing from home. The Panel feels that work needs to be undertaken with schools and in the local community to raise awareness of the issue to encourage greater levels of reporting.

The Panel welcomes the setting up of the Miss U Project in Haringey as a positive move. In particular, it is now providing independent return home interviews for children and young people who have returned after going missing. However, the Panel notes that they are only able to provide these for a proportion of those who go missing. Such interviews should be undertaken independently and there is clear evidence that they are best done by a third sector organisation. The Panel is therefore of the view that sufficient capacity should be established to ensure that all children and young people who run away are provided with an opportunity to talk to an independent person by commissioning additional independent return home interviews from an appropriate third sector organisation.

Although such an arrangement may have some cost implications, it has the potential to save money in the long term by reducing the need for later interventions.

Recommendations:

1. That the Council continue to monitor and report progress in supporting and protecting young runaways through the use of National Indicator 71 (paragraph 3.11).

2. That, when available, the Council give specific consideration to signing up to the Children's Society's runaways charter (3.13).

3. That, in order to enhance monitoring of progress, action in respect of children missing from both home and from care to be included within the LCSB Annual Report (5.5).

4. That the Council consider, in consultation with partners, the setting of a finite time limit for unauthorised absences of children and young people (5.15).

5. That the Children and Young People's Service, the Police and other relevant partners work together to explore how data and statistical information on missing children and young people can be better consolidated electronically and quality improved. (5.20).

6. That risk assessments are updated automatically and as a matter of routine whenever children or young people go missing (5.29).

7. That C&YPS work with foster carers to develop improved information sharing where there is a high risk of a young person going missing through the use of a suitable pro forma to record the information necessary to assist the Police, including provision of a recent photograph (6.18).

8. That action be taken to improve support for foster carers after children or young people in their care have returned after going missing and, as part of this, all incidents be followed up by social workers to provide reassurance for carers that the situation is being monitored and, where appropriate, action being taken.(6.24).

9. The Panel recommends that work be undertaken with the out of hours service provider to ensure that:
   - All reports of missing children or young people are followed up appropriately and foster carers are kept informed of progress; and
   - Information is appropriately recorded and accessible to operatives so that callers do not need to fully repeat details of incidents that have previously been reported (6.25).

10. That the Local Authority Designated Officer (LADO) within C&YPS works with schools and, in particular, the faith community to raise the profile of the issue, including training for designated teachers (7.11).

11. That action is taken to confirm that all children and young people who go missing

from care and from home are offered an independent return home interview on the basis outlined in the pan London procedures, with any shortfall identified met through the commissioning by C&YPS of additional capacity from an appropriate third sector organisation and that this be subject to regular monitoring and evaluation to ensure its cost effectiveness.

12. That residential care providers be requested to confirm that arrangements are in place for all Haringey children who are placed out-of-borough and go missing to receive an independent interview (8.20).

13. That C&YPS should seek to gain a greater understanding of the 'push' factors behind running away from Council care and seek to develop and deliver a strategy to address them. (8,21)

1. BACKGROUND

1.1 The review was set up in the light of a recommendation of the Scrutiny Review of Corporate Parenting in response to concerns that were raised in respect of missing children during the course of the review. It focused on each of the three specific categories of missing children and young people referred:

- Children missing from the Council's care
- Children missing from the care of other local authorities who have been placed in Haringey
- Children missing from home.

1.2 The review noted the differences that exist in practices and procedures for dealing with the different categories that reflect their different circumstances.

Terms of Reference

1.3 The Terms of Reference for the review were as follows:

"To consider how the Council and its partners respond to instances where children or young people run away from home and from the Council's care and, in particular, its policies, procedures, practices and performance"

1.4 In undertaking the review, the Panel considered:

- Research documentation, national guidance and targets;
- Statistical evidence including relevant performance data and benchmarking;
- Comparison with other areas such as statistical neighbours; and
- Interviews with a range of stakeholders.

1.5 Evidence received from a range of stakeholders, including*:*

- Haringey Children and Young People's Service;
- First Response Team;
- Police Missing Persons Unit;
- Barnardos Miss U Project;
- Residential care providers and private fostering agencies; and
- Foster carers.

Consultation

1.6 Due to the nature of the young people involved, consulting directly with them proved to not be feasible. However, an indication of their views was obtained through questioning of people and organisations that work with them such as foster carers and Barnardos.

Membership

1.7 The membership of the Panel was as follows:

- Councillors: Alexander (Chair), Amin and Ejiofor
- Co-opted Members (voting): Ms. Y. Denny (church representative), Mr. A. Dauda, Ms. M. Ezeji and Ms. S. Young (parent governors.

2. INTRODUCTION

Definition

2.1 The terms 'young runaway' and 'missing' refer to children and young people up to the age of 18 "who have run away from their home or care placement, have been forced to leave or whose whereabouts is unknown".

2.2 There is an important distinction between this and 'unauthorised absence', which is where the whereabouts of looked after children (LAC) are known or thought to be known but unconfirmed. If a child's whereabouts are known, they cannot be considered as missing. In such circumstances, they may instead be classified as absent without authorisation from their placement.

Survey Data and Research Findings

2.3 The only authoritative studies to determine the numbers of children who run away have been undertaken by the Children's Society. They have now published three studies – in 1999, 2006 and 2011. Their third study on runaways was published in November 2011. It found that over 100,000 children still runaway every year, a similar figure to the previous surveys.

2.4 The Society has established the following four key facts about children who run away:

1. Many children run away repeatedly. Just under a third of children who run away do it at least three times. 10% run away up to nine times. 5% run away ten or more times.
2. A significant proportion run way for long periods. 25% run away for between two to six nights and 20% for more than a week. 10% will be away for more than four weeks.
3. Children are often forced to run away. 25% of children said that they ran away because they were told to or were physically forced to go.
4. The vast majority are not reported as missing. Two thirds of children who run away from home are never reported to the Police as missing.

Why Young People Run Away

2.5 There is normally some sort of reason why children or young people run away and some specific groups of children are more likely to run away than others:

- Children in care. They are three times more likely to run away but only make up 2% of the total number of runaways;
- Children facing difficulties at school;
- Children who use drugs and alcohol or are in trouble with the Police;
- Children who consider themselves as disabled or are having difficulties with learning;
- Children whose parents' relationship has broken down.

2.6 Girls are more likely to run away than boys and most runaways are between the ages of 13 and 15. However, a quarter of those who run away do so before the age of 13 and 10% before the age of 10.

2.7 The Panel received evidence from a number of stakeholders on the reasons why they felt that children and young people might run away. They felt that one key

driver was their wish to be with friends and socialise. There was also felt to be peer pressure to stay out late at night. Arguments with family could also be a factor and sometimes children or young people might not want to go home. Young people can also feel as if they are invincible and not be inclined to worry about potential risks. Running away can be exciting for them at first but it can be difficult to step back from such behaviour. They often did not wish to appear disloyal to their peers.

2.8 For children in care, there can be specific issues that make them more likely to run away. Some children can be put into care precisely because of their tendency to abscond. In addition, they may have previously suffered from a lack of boundaries. Some young people can feel oppressed by support from foster carers. It could also be the case that they do not want to be in care in the first place and prefer to be with their family elsewhere.

2.9 Most young people in care do not come from secure backgrounds and can seek solace with their peers. Furthermore, the fact that many of these young people in care have had to become very independent can contribute to the problem of absconding.

2.10 One residential care provider categorised children and young people who went missing from care into the following groups;

- Those who are placed in care within or close to their home areas who abscond to return to families and/or peer groups;

- Those placed in new areas that may have been involved in youth offending and had become beyond parental control. Typically these young people identified with anti-social peer groups quickly and could become involved in crime and drug use;

- Children and young people who have experienced extensive trauma. These children could abscond due the intensity of being cared for, their disorganisation and inability to regulate. When these children ran away, they often had no clarity of where they were going, nor did they have external social support networks. They therefore placed themselves at high risk;

- Children and young people who have been taken into care to remove them from abusive families or trafficking or prostitution. The conditioning of these children or young people often encouraged them to return to the perpetrators.

2.11 A lot of young people in care do not trust adults. Some have the attitude that foster carers are just doing a job. The view expressed by residential care providers and private foster care agencies was that dealing with runaways was, to some extent, just part and parcel of working with young people in care. Absconding is not normally a reflection on care or carers – it is more an indication of where the young person came from.

2.12 For a small number of young people, there is a pattern of running away. It is nevertheless not a widespread issue. If it is out of character, there are higher levels of concern. If it is a regular occurrence, this can be less alarming. Whilst there were broad and general reasons why young people ran away, they can also be individual ones.

Risks

2.13 Children who run away can place themselves at considerable risk. In particular, there is danger from physical or sexual abuse and exploitation. For example, Barnardos services that work with sexually exploited young people have reported that more than half of those that they support run away on a regular basis. Research from the Children's Society shows that 25% of those who run away each year will be at risk of serious harm. One in six interviewed said that they had slept rough, one in eight said that they had resorted to begging or stealing and one in twelve reported being actually hurt or harmed.

2.14 The Children's Society have identified four recent trends that they consider to be significant:

- An increase in younger children coming to the attention of their projects;
- An increase in the number of boys;
- An increased risk of sexual exploitation;
- The use of technology to target vulnerable children.

Cost

2.15 The Children's Society estimate that the overall cost of dealing with runaways is up to £82 million per year. Their view is that early intervention has the potential to result in net savings that range from £200 in the least severe cases to up to £300,000 in more severe cases. The costs referred to arise from:

- Missing persons reports, which are estimated to cost the Police £1,145 per incident, equating to a total cost of up to £47 million per year
- The costs of children and young people stealing to survive
- Help from professional agencies. Two hours of support from a qualified children's social worker costs £144.

2.16 Support to a young person after they have run away for the first time is calculated to cost around £800. However, the Children's Society is of the view that if this can prevent two further incidents, it will save around £1,000 to the Police and other public services.

3. STATUTORY GUIDANCE

3.1 There is a detailed framework for how agencies should work together to respond to children who run away from care or from home. In 2008, the government published the Young Runaways Action Plan. Following this, statutory guidance for local authorities was issued in 2009, together with a national target (National Indicator 71) requiring local areas to report on measures that they have in place to protect and support runaways. New guidance for the Police was also published that set out how incidents should be managed, recorded and investigated.

3.2 The Police have lead responsibility for dealing with missing children. However, is the responsibility of local government and its partners to safeguard the young and vulnerable, including young runaways. This is normally done through the Local Children's Safeguarding Board (LCSB).

3.3 The new guidance put greater emphasis on the importance of young runaways being offered an independent return home interview and stressed the importance of information sharing and using common assessment. It also explained the need for a named person to have responsibility at local level.

3.4 Three summary versions of the statutory guidance were also developed. These were for lead members of children's services, directors of children's services and care workers and foster carers. These explained their specific responsibilities to support these vulnerable young people.

3.5 The various pieces of guidance that were issued cover what should happen when a child runs away and the protocols and procedures that should be in place and followed. These include the following:

- Local Safeguarding Children's Boards (LCSBs) are required to define clearly in protocols the roles and responsibilities of different agencies in order to ensure a co-ordinated response. Procedures must be formally agreed by the Lead Member for children's services and the Council committee responsible for corporate parenting. There should be a named person in the local authority responsible for children and young people who go missing or run away and details of preventative measures;
- Procedures should be in place for the recording and sharing of information between the police, children's services and the voluntary sector. Information should be used to analyse patterns;
- The need for the Police to conduct a "safe and well" check when a child returns from running away to determine their well being and whether they have been a victim of crime or abuse;
- A return interview to be carried out, if possible, by an independent person. This is to establish why the child ran away and what additional support might be required;
- All local authorities should have access to emergency accommodation. This should not be a police cell unless the young person is under arrest;
- Where a young person persistently goes missing, a multi agency risk management meeting should be organised.

3.6 The emphasis within the guidance is on the need for effective multi agency support to children and young people. Running away should be seen as an indicator of

underlying problems rather than an isolated event.

3.7 NI 71 was based on self evaluation. Each local authority was required to provide a score in a range from 0 to 3 (low – high) based on the following five criterion:

- Local information about running away is gathered;
- Local needs analysis is in place;
- Local procedures to meet the needs of runaways agreed;
- Protocols for responding to urgent/out of hours referrals from police or other agencies are in place;
- Local procedures include effective needs assessment protocols to support effective prevention/intervention work.

3.8 Haringey scored itself as achieving a score of 2 out of 3 for each these categories – a total score of 10 - in the period from October to December 2009, which is the last period for which statistics have been published. This is around the average for London. However, the Panel expressed concern that C&YPS had shown no evidence that it was collating information enabling it to understand the underlying reasons behind children and young people running away that could justify this assessment.

Concerns

3.9 The Children's Society have expressed concern that the changes outlined in the statutory guidance may not have led to the level of improvement intended and have highlighted a number of issues:

- A lack of consistency in the implementation of the statutory guidance;
- A raising of thresholds for access to children's services;
- National Indicator 71 was introduced in 2009 and required local authorities to self assess how much progress they were making to protect and support runaways. It was scrapped last year by the government and it is now discretionary. The indicator was felt by many to assist in promoting action and improvement;
- A shortage of emergency provision. Only half of local authorities surveyed had access to emergency accommodation;
- Lack of awareness of the issue amongst some professionals working with children and parents;
- Cuts to specialist services. A number of services that provide specialised support for children who run away have suffered cuts to their budgets. Specialist services are felt to be best placed to meet the needs of some children who may be vulnerable and/or hard to reach.

3.10 Haringey's Missing from Care and from Home Action Plan was linked directly to National Indicator 71. Although the indicator has now been scrapped by the government, the Action Plan is being kept by the Council.

3.11 The Panel welcomes the fact that the Action Plan is being kept by the Council. It notes that it is now at the discretion of local authorities to decide which targets to keep in place. A small number have pledged to continue to report on National Indicator 71 and the Panel is of the view that Haringey should join this group. Although the indicator is flawed – being based on self evaluation - it may nevertheless assist the Council in retaining a focus on children who run away as

part of the performance information on child protection.

Recommendation:
That the Council continue to monitor and report progress in supporting and protecting young runaways through the use of National Indicator 71.

3.12 The Panel received evidence from the Children's Society about their current "Make Runaways Safe" campaign. The current campaign includes number of activities, including lobbying. They had recently issued a number of documents relating to this including new statistics and a report on sexual exploitation. They are currently working in many local areas as part of the local phase of the campaign.

3.13 As part of the campaign, a Freedom of Information request had been made to all local authorities about missing children in their area. The Panel expressed concern that it took Haringey Council three months to respond to this request, providing information that should have been readily available and easily accessible.

3.14 95% of local authorities had responded to this so far. The responses received from local authorities to date had shown a mixed picture with some examples of good practice. The intention was for the Society to create a runaways charter including standards of engagement. They would be asking each local authority to sign up to this.

Recommendation:
***That, when available, the Council give specific consideration to signing up to the Children's Society's runaways charter*.**

4. PAN LONDON APPROACH AND ISSUES

Introduction

4.1 There is a large concentration of children in London which makes it essential for there to be clear expectations of all agencies working within the capital. Pan London procedures on safeguarding children missing from care or from home were therefore developed, which Haringey follows.

Pan London Procedures

4.2 The procedures broadly follow the statutory guidelines and have superseded the local joint protocol and practice guidance. However, it is intended to update the Haringey procedures and ensure that they expand upon the pan London procedures and highlight responsibilities in risk assessing the distinction between "missing" and "unauthorised absence".

4.3 The London procedures note the fact that looked after children (LAC) are over represented amongst those children who go missing. They state that an assessment of the risk of the child "absenting him/herself" must be made prior to each placement by children's social care services. Where there are concerns that the child will go missing, a risk assessment should be undertaken. This should cover a number of issues, including:

- The level of supervision that it is proposed to provide for the child;
- The degree of risk to the child if they go missing; and
- The views of parents/carers on the child's needs and the action that needs to be taken if their child goes missing.

4.4 Where the risk assessment concludes that there is a high risk of a child going missing, the procedure states that as a matter of good practice the residential unit or foster carer should be provided with an information sharing form that contains information that the Police and others may need to locate the child if they go missing.

4.5 The importance of reporting children who go missing is emphasised and the procedures state that failure on the part of parents or guardians may be raised as a child protection issue. It also mentions the fact that children who repeatedly go missing are often viewed as a problem and recognises that insufficient consideration is given to the reason why they keep absenting themselves.

4.6 The procedures state that the Police should be notified as soon as possible and emphasise their role as the lead agency. The Police do not, however, have the power to use force to take children into Police protection. The procedures recommend that the child's school should always be informed as they may have valuable information that may help to establish the child's location.

4.7 In the case of LAC, where the information available suggests that it is an instance of "unauthorised absence", the residential unit or foster carer "should take all reasonable and practical steps which a good parent would take to secure the safe and speedy return of the child e.g. visiting addresses where the child may be or telephoning around known friends". They should also be the subject of continuous risk assessment whilst they remain absent.

4.8 Joint consideration should also be given to adopting a finite time limit within which a child may stay in the "unauthorised absence" category, after which they would be considered to be missing.

4.9 There is a responsibility on residential units to maintain records of each occasion when a LAC is identified as either missing are having taken unauthorised absence. These records should be made available for inspection. Foster carers should also keep similar information.

4.10 On return, the procedures state the Police will interview all children to establish whether they are "safe and well" and that no criminal activity occurred whilst they were missing or was the cause of them going missing.

4.11 Children should also be informed that they would be expected to talk about their absence to an independent person. This opportunity should be provided within 72 hours of them returning. The purpose of this is to try and understand the reasons why the child may have run away and to try and avoid it happening again. It can also assist in ensuring that they are provided with any support that may be necessary. In the case of residential children's homes, it can also help to ensure that there are no issues relating to it, which is an important issue for the local authority responsible for the placement. Children who have repeated "unauthorised absences" should also be offered an interview with an independent person.

4.12 For looked after children, it is the responsibility of the residential unit or supervising social worker and the placing authority to ensure that the interviews take place. For other children, it is the Police and children's social services that are responsible for arranging this.

4.13 There are a wide number of individuals who could be considered suitable to conduct the interview but the key issue is that they should be separate from the Police or children's social services. The procedures state that the independent person could come from amongst the following:

- A social worker other than the child's social worker, if they have one;
- A teacher, school nurse, Connexions, youth or YOT worker;
- A voluntary sector practitioner or a police officer whom the child knows or trusts.

4.14 The procedure emphasises that the child should be asked who they want to speak to.

GoL Report on Young Runaways in London

4.15 In 2010, a report was published on behalf of the Government Office for London (GOL) which provided GOL and other stakeholders with an up to date picture of the situation for young runaways in London. It made a number of findings;

- It found that the quality of data remained inadequate with little sustained and co-ordinated improvement in London since an earlier Social Exclusion Unit report from 2002. This made it difficult to determine the extent and nature of running away. It was caused, in part, by differences in definition and the various methods and timescales of collecting and collating data. The Metropolitan Police use the Merlin system which is used for recording all missing people and

includes data on age, gender and ethnicity. However, the data quality provided by Merlin was found to be variable with potential for interrogation limited.

- Concern was expressed regarding the extent to which the use of protocols were monitored and the lack of consequence for non-compliance. Protocols were found to be generally understood among senior and middle management, but there was evidence of a lack of awareness and adherence amongst front line staff.

- Where local authorities delivered services themselves, these tended to focus on either preventative or reactive provision. Where local authorities had engaged external or voluntary sector organisations, this offered a more comprehensive approach. There were found to be some examples where return home interviews were conducted independently. However, they were still often conducted just by the Police, with little responsibility of follow up.

- It was common in London for a local authority to classify the police 'Safe and Well' interview as a return home interview, despite the widespread acknowledgement that this check was ineffective in addressing the young persons needs or preventing further episodes. Young runaways frequently felt animosity towards the Police and officers did not have time to establish a relationship. A recurrent view within the consultations with the Police was that the local authorities that were effective at tackling runaways were the ones where either a third sector organisation conduct the return interviews or where Police officers had been embedded within third sector organisations as part of their return interview strategy.

- Whilst there were a number of pieces of work that suggested the cost effectiveness of early interventions, a comprehensive cost benefit analysis of provision in London was not possible due to lack of data.

5. MISSING CHILDREN IN HARINGEY

Introduction

5.1 Missing children that professionals deal with in Haringey fall into three categories:
1. Children missing from the Council's care. This covers children and young people who are fostered as well as those who are placed in residential homes within the borough;
2. Children missing from the care of other local authorities who have been placed in Haringey. There are a large number of children's residential homes in the borough that take children from other local authorities; and
3. Children missing from home.

5.2 No distinction is made in procedures between which local authority or organisation runs a residential children's home within the borough. This means that Haringey not only has to consider its own children and young people but also those that are placed within the borough by other local authorities.

5.3 The Police Missing Persons Unit has a duty to notify relevant social services departments of instances where children have gone missing. However, any involvement of children's social care services does not override the overall responsibility of the Police. Following notification of a child or young person going missing, the Police try to gain an understanding of the circumstances and make an assessment, including consideration of whether the child is at risk.

5.4 The named officer with overall responsibility for children and young people who go missing or run away in Haringey is Wendy Tomlinson, the Head of Commissioning and Placements. The day-to-day responsibility is carried out by case managers. There is an established multi agency officer steering group that monitors practice issues relating to instances of children and young people who go missing. Issues of concern are reported to the Corporate Parenting Advisory Committee and the Local Children's Safeguarding Board (LCSB). Data is kept and used to analyse any patterns.

5.5 The Panel is of the view that local monitoring by Members and senior officers and partners of support for children and young people who go missing from care and from home would be further enhanced through annual reporting of progress. It therefore recommends that action in respect of children missing from both home and from care to be included within the LCSB annual report.

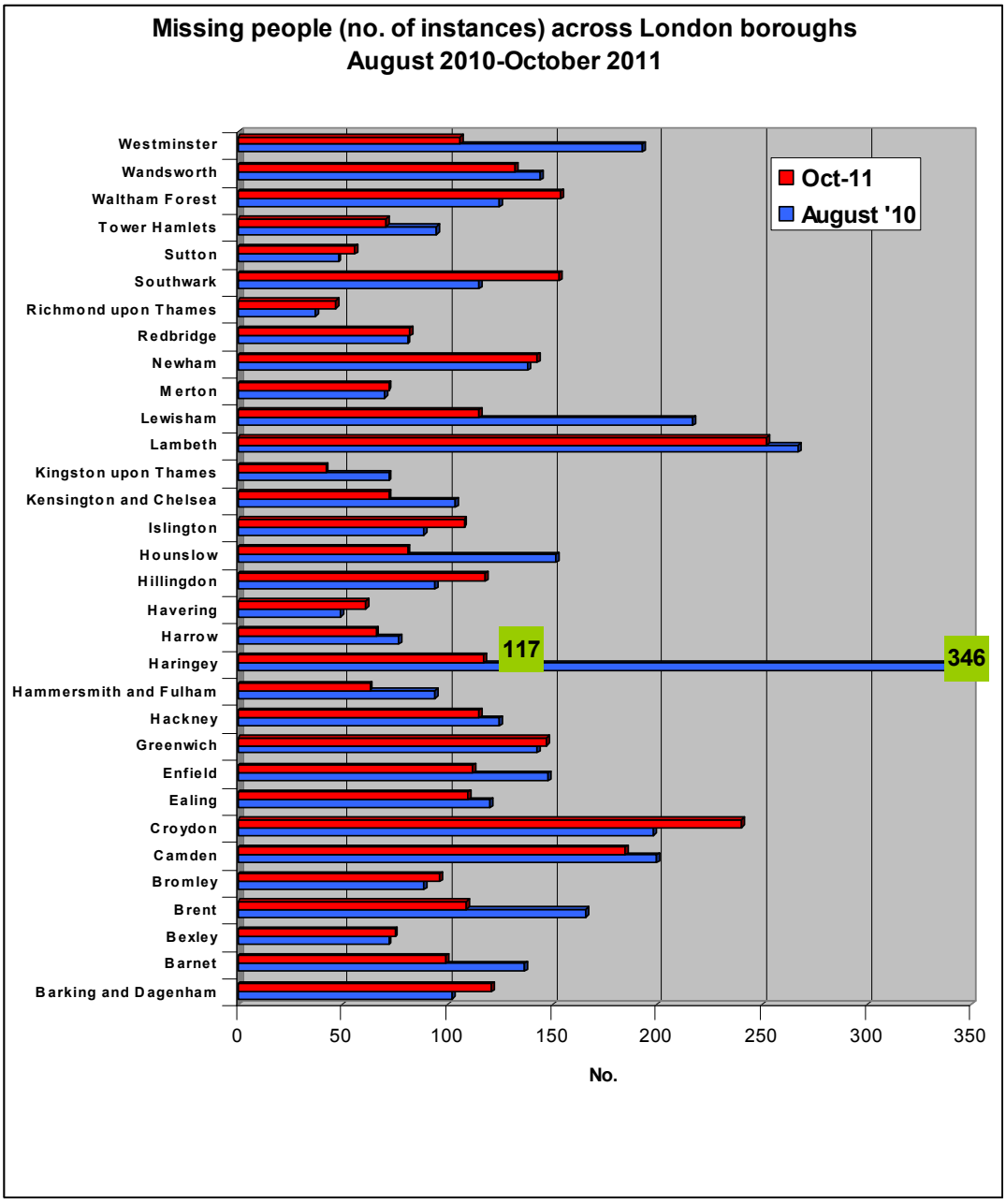
Recommendation:
That, in order to enhance monitoring of progress, action in respect of children missing from both home and from care to be included within the LCSB Annual Report.

Statistics

5.6 The Police Missing Persons Team, as the lead agency for dealing with missing people, maintain full statistics on the number of missing people, including children, as well as intelligence. The Council only keeps information on children missing from

their own care. The definition of "missing" that is used is that the whereabouts of the individual are unknown. This is determined by whoever has reported the instance.

5.7 Prior to 2010, Haringey had the highest number of missing persons of any London borough. This was mainly due to loose interpretation of the relevant guidelines and definitions and especially the distinction between missing and unauthorised absence. This was addressed by the Police in consultation with the Children and Young People's Service (C&YPS). The work undertaken has enabled Haringey to move from having the highest levels of missing people in London to 11th highest:



5.8 Detailed Police statistics for missing persons and, in particular, children and young people, in August 2010 and 2011 show in detail the change. In all cases, Police statistics refer to *instances* and not individuals.

Category	Aug. 2010	Aug. 2011	Change	% Change
All	346	120	- 226	- 65.3

Juveniles (all)	287	70	- 217	- 75.6
Juveniles (care home)	225	26	- 199	- 88.5
Juveniles (foster care)	30	15	- 15	- 50
Juveniles (not in care)	32	29	- 3	- 9.4

5.9 Statistics for September 2010 to September 2011 and October 2010 to October 2011 show the continuing trend:

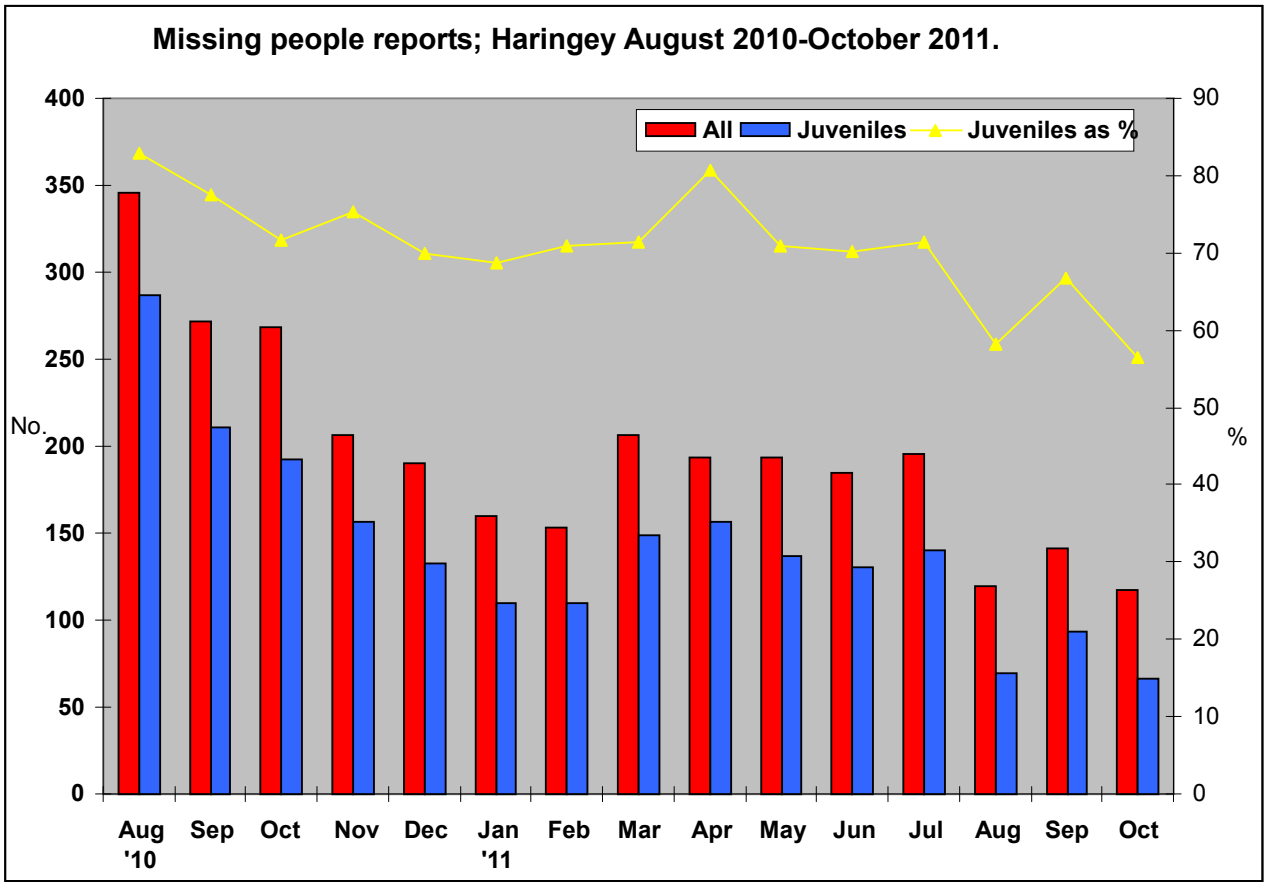
	Sept. 2010	Sept. 2011	Change	% Change
All	272	141	- 131	- 48.2
Juveniles (all)	211	94	- 117	- 55.6

	Oct. 2010	Oct. 2011	Change	% Change
All	268	117	-152	- 56.3
Juveniles (all)	192	66	- 126	- 65.6

5.10 The month by month trend is as follows:

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
All	346	272	268	207	190	160	153	207	193	193	185	196	120	141	117
Juveniles	287	211	192	156	133	110	110	149	156	137	130	140	70	94	66
Juveniles as %	82.9	77.6	71.6	75.4	70	68.8	71.0	71.5	80.8	71.0	70.3	71.4	58.3	66.7	56.4

5.11 The trend can also be shown as a graph:



5.12 The statistics show how the large number of children and young people who were being inaccurately classified as missing distorted Police statistics. The biggest

change has come from children who had previously been reported missing from residential care homes, where there has been an 88% reduction. The Panel noted that there was now a much better grasp amongst them of the guidelines and this has enabled more focussed work to be undertaken with the children and young people who are most at risk. The Police are continuing to work with care homes within Haringey to reduce the number of unauthorised absences and specific training has been undertaken.

5.13 The distinction between 'missing' and unauthorised absence' is important and is made in order to ensure a proportionate response. It enables professionals to focus attention on those at potentially the greatest level of risk. However, this does not necessarily mean that children and young people who are instead classified as absent without authorisation are *not* at risk and this was pointed out by a number of stakeholders that the Panel received evidence from. It was noted, however, that the distinction can be overridden if there are any child protection concerns as the safety of children and young people is paramount.

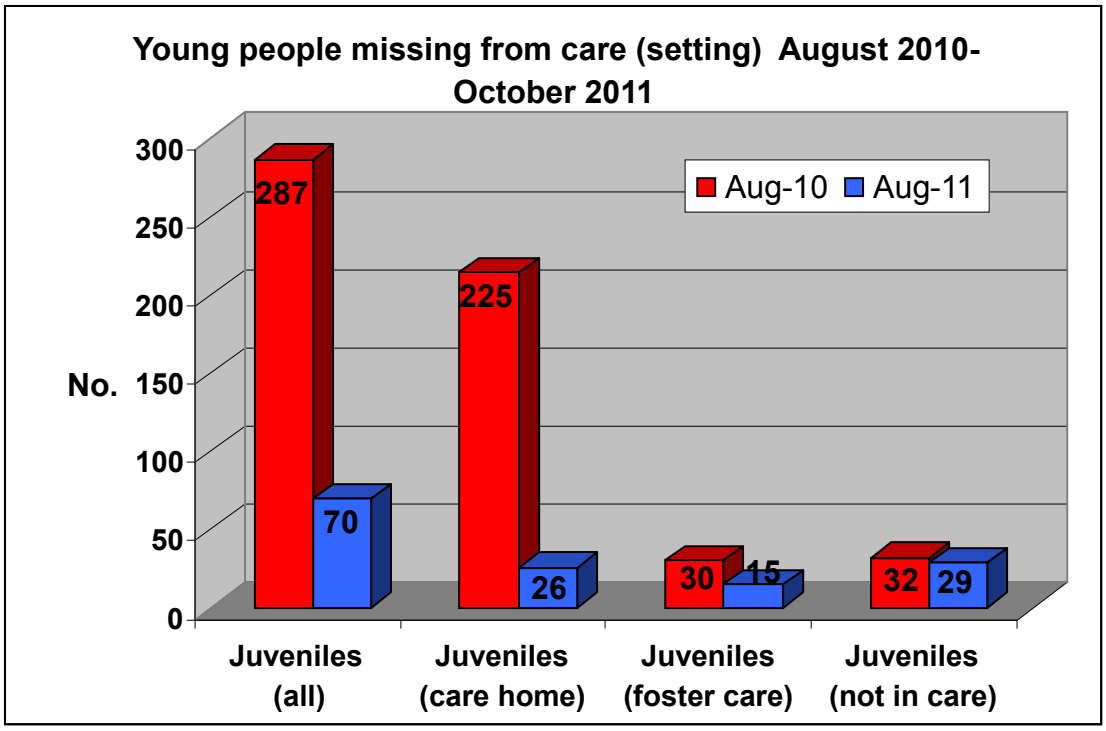
5.14 In cases of unauthorised absence, it is still necessary for liaison to take place with the Police but residential providers that gave evidence to the Panel felt that they were generally less willing to act. The Panel also heard that it can be difficult and potentially dangerous for foster carers and residential staff to go looking for young people in such circumstances. Whilst the Police may be better placed to do this, they may not always have the resources available.

5.15 The Panel is of the view that, as suggested in the London procedures, the Council and its partners should jointly consider the setting of a finite local time limit for unauthorised absences of children and young people. After this time limit has passed, they should automatically be considered to be missing. This could assist in addressing instances of unauthorised absence where there may be grounds for concern.

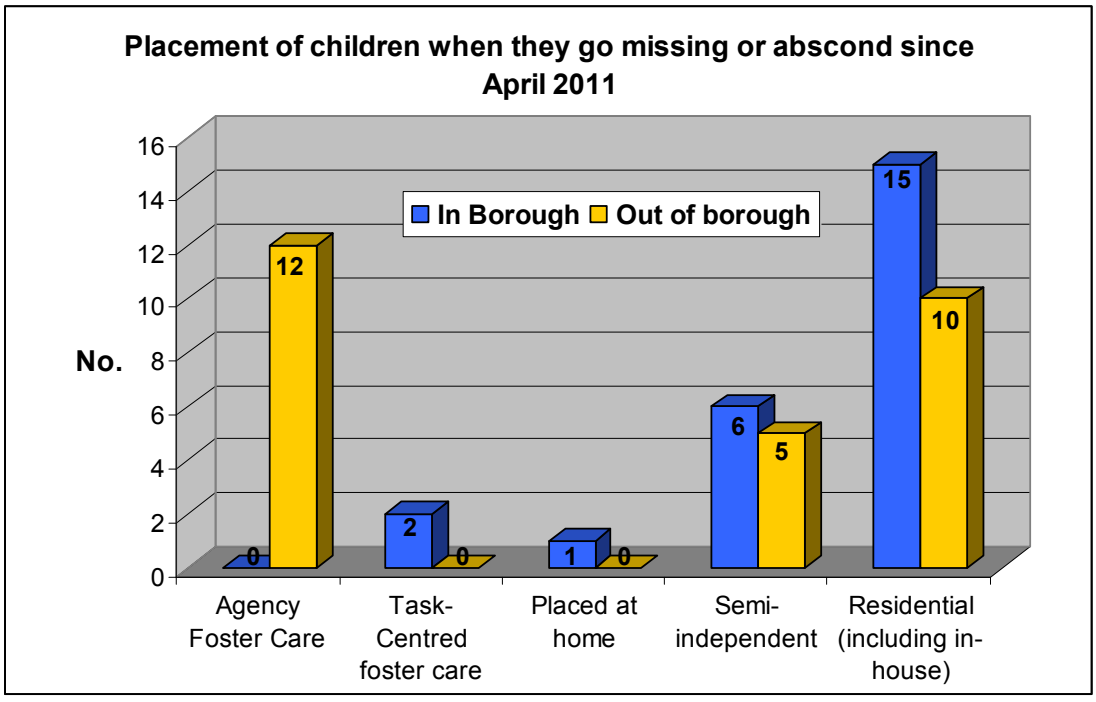
Recommendation:
That the Council consider, in consultation with partners, the setting of a finite time limit for unauthorised absences of children and young people.

Looked After Children (LAC)

5.16 The highest prevalence of children and young people who run away is amongst LAC and, in particular, those in residential care homes. It should be reiterated that the figures refer to instances and not individuals.



5.17 Figures produced by C&YPS on the placement of children who went missing between April and September 2011 break this down further:



5.18 This is in keeping with national trends and to be expected as some young people are placed in residential homes precisely because of their tendency to run away. It was the view of officers from C&YPS that Haringey's statistics for children missing from care were not much different to those of other boroughs, despite the fact that it has around twice as many looked after children as many outer London boroughs.

5.19 The statistics put together by the Police for the Panel were done using their Merlin

system. The system has some shortcomings and it can be difficult to interrogate for specific pieces of data. This was highlighted in the previously mentioned GoL report. The figures for juveniles had to be manually extracted, which can be a time consuming job. The Merlin system is used across London by the Metropolitan Police so there is limited scope for local improvements to be made by the Police locally.

5.20 The Panel noted that records have to be kept by residential homes and foster carers of missing children and that these are kept in manual format. In addition, records are also kept by C&YPS on referrals as well as children missing from care. In addition, some statistical information is now kept by the Miss U project on work that they undertake.

5.21 The Panel is of the view that there is scope for improvement in the quality and comprehensiveness of statistics. It notes that some other London boroughs have undertaken specific work in this area, such as Brent. Better data would enable potential issues and patterns to be more easily identified and therefore interventions to be better focussed and evidence based.

Recommendation:
That the Children and Young People's Service, the Police and other relevant partners work together to explore how data and statistical information on missing children and young people can be better consolidated electronically and quality improved.

Residential Care

5.22 It was the view of the Police Missing Persons Unit representative that the Panel received evidence from that there had been a tendency amongst some residential social workers to ring the Police if there was any doubt about the whereabouts of a young person. In many cases, the absence was due to a young person staying out late. The Panel noted that an appropriate time for young people to return back in the evening to their care home should be decided before they are placed and included in the risk assessment. Advice can be obtained by the care home manager from officers in C&YPS and, where appropriate, parents or guardians.

5.23 The Police Missing Persons Unit is continuing to work with residential homes to improve how they deal with incidents. Further work needs to be undertaken to ensure that all residential staff are aware of their responsibilities and the fact that missing children are not just the responsibility of the Police. They felt that there were mixed approaches amongst residential care providers regarding whether they should seek to find young people who had not returned. There is nothing that prevents them from taking action themselves to locate children or young people and their responsibilities do not end with reporting. However, they need the necessary resources to be available in order to do this. The Police have to assess the level of risk and also balance this against resources that were available to them.

5.24 As part of the risk assessment process, residential care homes are responsible for reporting any incidents to the allocated social worker. If there are concerns, the Police can be involved and the risk assessment reviewed. However, it was noted

risk assessments undertaken by the Police are different to those undertaken by care homes.

5.25 Police involvement does not just come from the Missing Persons Unit. Amongst others, the Vice Unit can also be involved. All Police officers are trained in how to deal with missing children. In many cases, there are limited powers unless court action is taken. In order for this to be successful, a risk of immediate harm needed to be clearly demonstrated.

5.26 The Panel noted that great lengths can be gone to by statutory services in order to get back children who were absent. This included court orders allowing children to be recovered from addresses and jailing individuals who are unwilling to divulge where a child or young person is. If need be, looked after children can be placed away from their home area in order to reduce the risk of them absconding and sometimes expensive out-of-borough placements are used for this purpose. These can be used for young people who are in gangs, who often prove difficult to deal with. It is occasionally necessary to place children in secure accommodation. Social services can agree for this to happen for any period up to 72 hours. Any period longer than this has to be agreed by a court. This is generally undertaken just as a temporary safety measure.

5.27 The Panel noted that sanctions can be used to discourage young people from going missing again. If they persisted in running away, their care plan could be re-visited and, where appropriate, a planned move to another residential home considered. It is possible that there might be something in the children's home that they were placed in that they did not like that was behind them running away. It might also be possible that they were absconding to a specific place for a reason. It was necessary to analyse the available information and identify any patterns.

Risk Assessments

5.28 The view of officers from C&YPS that the Panel received evidence from was that the key challenge was that of risk assessment. Whilst there are often instances where there is no concern for the safety of individuals, there were other cases where there are considerable concerns. There was now greater clarity about whether there was cause for concern through the effective use of risk assessments. It was frequently the case that professionals were reasonably sure about the whereabouts of a child although it might not be possible for them to be absolutely certain.

5.29 Risk could be present irrespective of whether children or young people were categorised as missing or "unauthorised absence". Risk assessments and specific strategies are developed to address the needs of individual children. Although risk can be minimised, it cannot be eliminated completely. It was important to keep channels of communication open and develop good and trusting relationships with children and young people.

5.30 Officers from C&YPS were of the view that risk assessments had improved and especially the actual assessment of the relevant risk and that there was no longer an over reliance on Police action. The Panel welcomes the improvement. However, it notes that risk assessments are currently not routinely updated when children or young people go missing. It therefore recommends that risk assessments are updated automatically and as a matter of routine when children or

young people go missing.

Recommendation:
That risk assessments are updated automatically and as a matter of routine when children or young people go missing.

6. LOOKED AFTER CHILDREN - STAKEHOLDER VIEWS

6.1 The Panel asked private fostering agencies, residential providers and foster carers for their views regarding children and young people who go missing from care.

Private Fostering Agencies and Residential Providers

6.2 The Panel received evidence from the representatives of private fostering agencies and residential providers, including the two Council run homes. They dealt with a range of local authorities, including Haringey.

6.3 Fostering agencies stated that it normally takes time for children and young people to develop a bond with new foster carers. In such circumstances, engagement is important. Where a bond is established, young people can be less tempted to stay out late or run away as they do not want to let their carer down. It can be hard to change patterns but it is not impossible. They emphasised the importance of engaging with the young person to establish the reasons why they were running away. This needed to involve the young person's wider network. Foster carers have a particular role to play by developing their relationship with the young person. Part of this can involve emphasising the benefits of not absconding.

6.4 Fostering agencies and residential providers ensure that all carers and relevant staff are aware of procedures through their induction programmes. Children and young people also have individualised risk management and crisis management plans. Policies are updated in connection with local police guidelines.

6.5 They sated that the role of the foster carers when young people went missing was not passive. In addition to contacting the social worker and, if appropriate, the Police, foster carers could contact friends and other contacts as well as looking for them. They should immediately phone the out-of-hours social work team and report each and every instance.

6.6 The Panel heard that the experience of residential children's homes was very similar to that of foster care agencies. Their priority was to make sure young people were safe. All young people were provided with a mobile phone so that the home could at least call and speak to them if they went missing. Homes tried to negotiate with and encourage young people. However, the draw of peer groups was difficult to break. They tried to provide a safe haven that young people knew they could come back to. Getting them to come back home earlier was progress. Boredom could also be a factor as the homes could not always provide young people with the activities that they wanted to do. This was particularly true of older children. Some young people could be used to being out late and it could take a long time to change their behaviour.

6.7 There were differences between age groups and plans needed to reflect this. Whilst it was possible to provide activities for 16 – 18 year olds, they often did not want to join in. They preferred to be with friends and such attitudes could be ingrained. They may have only been in care for a short period and mix with young people who were living semi-independently. In such circumstances, it was difficult to enforce specific times that young people should return by and this could result in them being classified as missing. 17 year olds could be particularly difficult to place and sometimes they were not given the best placement but merely the best available.

6.8 The Police were the key agency in dealing with missing young people and had their own procedures for dealing with the issue. The Police response was variable but it was recognised that their resources were finite and often over stretched. The response of the Police Missing Persons team was likely to be different to that of other Police officers. They stated that care services were proactive in assessing risk whilst the Police had a more reactive role. The process for dealing with missing children could become taxing and a greater level of joined up thinking would be welcome. It could sometimes appear that not all agencies and organisations were pulling in the same direction.

6.9 All services were focussed first and foremost on the child or young person. Residential homes would have regular one-to-one sessions with them and try to build up a relationship. It was important to make them understand that services had their welfare at heart. If a child or young person went missing who was considered to be high risk, the home would try to look for them straight away. The Police could not do this due to the need to first go through their procedures.

6.10 Fostering agencies felt that it was sometimes the case that they were more concerned about young people than local authorities appeared to be. Social workers often had very heavy caseloads. It could sometimes take time for Emergency Duty Teams (EDTs) to report incidents back to social workers and it could be necessary for agencies to follow up reports themselves to ensure that action was taken. If was rare for allocated social workers to ring up the next day after an incident had been reported.

6.11 The social worker paid an important part in the young person's life. However, there was often a lack of continuity with frequent changes in the allocated social worker. Although it was a big issue in Haringey, it was also an issue in other areas. This was mainly due to heavy turnover of social workers. Contact from social workers was important and regular contact could matter a lot to young people, even if it was just through regular phone calls. As soon as the social worker changed, the relationship was lost. After two or three changes in social workers, young people could stop bothering to engage.

6.12 There was not much difference in how individual authorities dealt with missing children though some could be slightly more proactive than others in their approach. Follow up meetings to discuss missing children did not always take place with some authorities. Although authorities had different procedures, they were all broadly similar and any differences generally arose from interpreted. Procedures were felt to be generally sound and issues were normally more concerned with their application and personnel matters. In particular, approaches were not always consistent. Good quality placement meetings could help to prevent problems arising.

6.13 Foster carers received considerable amounts of training with between three and ten sessions taking place every year. In terms of missing children, training sessions would look at the wider position and how to best engage with the young person and address their emotional well being. Children who absconded could deter carers and cause them considerable anxiety.

Foster carers

6.14 The Panel received evidence from a number of foster carers from Haringey Foster Carers Association. Whilst there was no specific section in training for foster carers on dealing with missing children, the issue could be covered as part of training on challenging behaviour. Foster carers tended to learn how to deal with situations from talking to social workers and from their own experience. They felt that nothing could adequately prepare them for having to cope with children going missing, although they felt that they were aware of what to do. There could be no prior warning.

6.15 There were limits to what they could do in response to young people running away. They felt that they there was not much that could be done to deter them from running away again as sanctions were limited and could often be ineffective. Young people could be difficult to track down. For example, they often switched their mobiles off so that they could not be contacted. Some young people who were fostered had come from homes where there were few boundaries. They might also not listen to parental figures, which could also be the reason why they were in care. Some carers stated that they would go and look for young people when they went missing but this was not always possible if they had other children to look after.

6.16 They knew to contact the out of hours service (EDT) when incidents occurred. The response from services was variable. If the child or young person had not been with the carer for long, foster carers could have difficulty describing the young person to the Police. Providing carers with photographs of the child or young person would help.

6.17 The Panel notes that that the London procedures state that where there is a high risk of a child going missing, it is good practice for residential unit or foster carers to prepare an information sharing form containing the information the police and other agencies will need to locate the child if they do go missing This form should always be provided to the Police at the time of reporting a Looked After Child missing. The Panel is of the view that work should be undertaken by C&YPS to ensure that foster carers are able to give the Police all the information necessary should the young person in their care go missing through the use of information sharing pro formas and that such information should include a recent photograph.

Recommendation:
That C&YPS work with foster carers to develop improved information sharing where there is a high risk of a young person going missing through the use of a suitable pro forma to record the information necessary to assist the Police, including provision of a recent photograph.

6.18 The foster carers stated they sometimes received a follow up phone call from the child or young person's social worker after they had returned after running away. The child's social worker was very important and one who was strong could make a big difference. There could be a lack of consistency which was exacerbated by the heavy turnover of social workers. They recognised that many social workers had a very heavy case load and could get stressed or burned out.

6.19 When young people went missing, it was often necessary to repeat the history of the

case many times. The out of hours team (EDT) very rarely called back to see if the young person had returned or to provide an update. The foster carers felt that the EDT could be improved. It appeared to not be possible for staff to access information from the previous night and carers were therefore required to repeat all the information that they had previously given. There was also the need to repeat information to different Police officers. Sometimes a number of different Police stations could be involved and it was necessary to deal with enquiries from them all.

6.20 Carers felt that better support could be provided for carers during and after an incident. In particular, following up of incidents would be much appreciated, if only to acknowledge and update foster carers. This would make it less stressful for them and make them feel that professionals empathised fully with their situation. They were not fully aware of procedures in respect of follow up interviews after children had been located and/or returned.

6.21 The Panel concurs that there is a need for improved support for foster carers after children or young people in their care have returned going missing. In particular, incidents should routinely be followed up by social workers to provide reassurance for foster carers that the situation is being monitored and, where appropriate, action being taken.

Recommendation:
That action be taken to improve support for foster carers after children or young people in their care have returned after going missing and, as part of this, all incidents be followed up by social workers to provide reassurance for carers that the situation is being monitored and, where appropriate, action being taken.

6.22 The Panel notes the foster carers, residential care providers and private fostering agencies were all of the view that the response of the out of hours service (EDT) could be improved. In particular, there was a need to reduce the need to repeat information and reassurance given that all incidents will be followed up appropriately.

Recommendation
The Panel recommends that work be undertaken with the out of hours service provider to ensure that:

- ***All reports of missing children or young people are followed up appropriately and foster carers are kept informed of progress; and***
- ***Information is appropriately recorded and accessible to operatives so that callers do not need to fully repeat details of incidents that have previously been reported.***

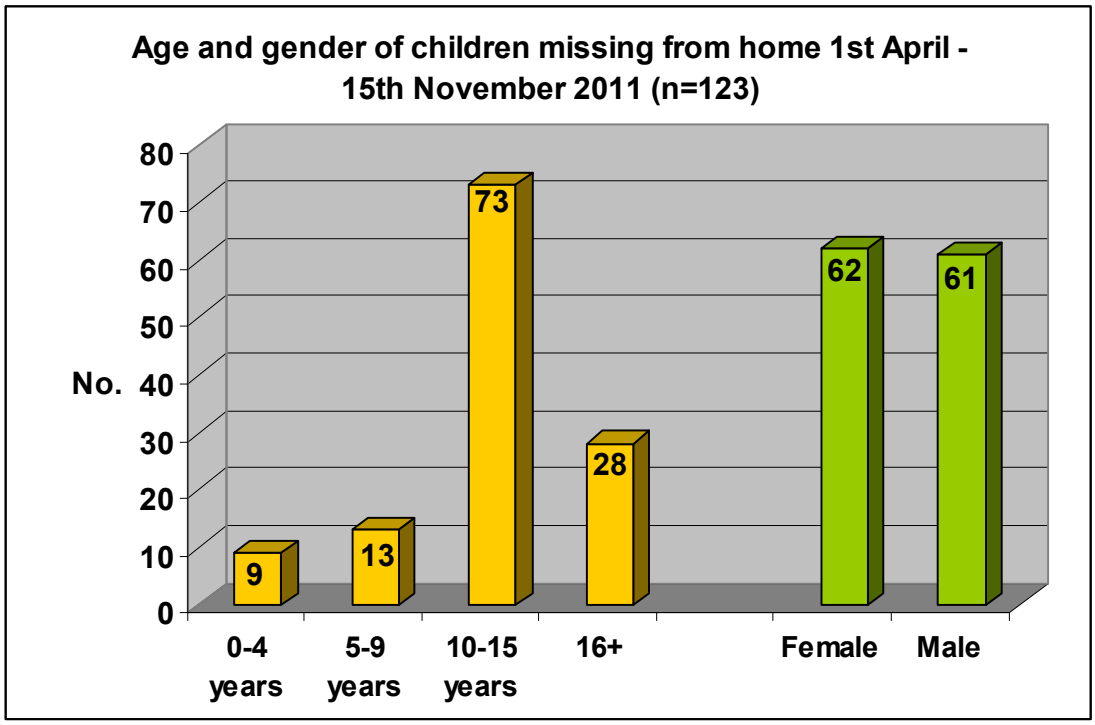
7. CHILDREN MISSING FROM HOME

7.1 The Panel received evidence from the Head of First Response on the response to children who go missing from home. These generally fall into the following three categories:

- Children who return home late from a school or for an arranged day time activity and had been reported missing by the parents. These are categorised as "unauthorised absences."
- Children who return home late from an evening activity and are reported missing. These could merely indicate that young people are pushing boundaries but could also possibly mean unhappiness or risk at home or in the community including, in some instances, gang related activity or sexual exploitation. In such instances, there could be a discussion with parents to see if the incident constituted unauthorised absence or a missing episode.
- Children who are missing for longer including overnight. The lead agency for this is the Police.

7.2 The Panel noted that between 1 April and 15 November 2011, 123 children were reported as missing from home on 139 occasions. Of these, 5 children went missing on 2 occasions, 1 child went missing on 3 occasions and 3 children went missing on 4 occasions. However, these figures also include unauthorised absence. Future reports will distinguish between missing children and unauthorised absences. This clearer distinction will assist in highlighting the specific cases that require intervention. Of the children identified as going missing on more than one occasion, all were aged between 13 -18.

7.3 The age breakdown was as follows:



7.4 Gender breakdown was as follows:

Female	62

Male	61

7.5 All cases were reviewed by the Head of Service, First Response. The majority were assessed as 'unauthorised absence'. Only one child was missing for more than 4 hours. This was a Roma child who had possibly been trafficked

Reported lost in a public place	18
Returned late from school safely	5
Reported as not in school and whereabouts unknown – both Roma families. One found and one reported to the police as suspected trafficking	2
Initial Assessment carried out. These cases all related to children who had previously been known to C&YPS and, in one case, a baby reported missing but subsequently found with parents at a new address	4

7.6 Many children who were recorded as missing had become separated from the parents in Wood Green Shopping City and found quickly. A number others had been testing boundaries. Of children under the age of 11 who had gone missing, 13 children had been lost in a public space, 2 had been reported as not in school and 4 had returned late from a school related activity.

7.7 Statistics are examined regularly by officers. Some children were only missing for a short period of time. There were approximately 3 to 4 instances per week. The figure was sometimes higher in summer. Most instances were just overnight. However, some children or young people could be absent for 3 to 4 weeks but in such cases it was often known where they were likely to be.

Reporting

7.8 The Panel noted that children are brought to the attention of First Response from several sources. The primary source is the Police. All missing children who have come to the notice of the Police are logged onto the Police Merlin system. Children may be reported missing by other agencies, including schools.

7.9 The Panel noted that procedures are clear that, where other agencies report a child or young person as missing and those with parental responsibility or care of the child have not done so, this constitutes significant harm. Children missing from school are referred to First Response if there is evidence that they are a victim of crime, if they are the subject of a child protection plan, if they are looked after, privately fostered, subject to an ongoing investigation, are constantly avoiding contact or are they are deemed at risk due to issues such as criminal activity, forced marriage or honour based violence.

7.10 The service is reliant on cases being reported, which does not always happen. Schools and the Education Welfare Service were particularly good at flagging up issues of concern. It was noted that the UK Border Agency were responsible for dealing with any cases of trafficking. Some children had been repatriated and there were good links with the Bulgarian and Romanian authorities. The service had access to a Roma specialist, who was currently working with 25 families within Haringey. There were very good relationships with partners and there was now a multi agency safeguarding hub.

7.11 The Panel is of the view that there is a need to increase the profile of the issue of missing children in order to encourage a higher level of reporting. There is strong evidence from research by the Children's Society and others that there is currently under reporting of children and young people who go missing from home. As part of this, work should be done within the community in Haringey to increase awareness and encourage wider reporting of concerns.

Recommendation:
That the Local Authority Designated Officer (LADO) within C&YPS works with schools and, in particular, the faith community to raise the profile of the issue, including training for designated teachers.

8. THE MISS U PROJECT

Introduction

8.1 The Panel received evidence from the Miss U Project that is currently operating within Haringey. The project is the result of collaboration with Railway Children, who have a long history of working with runaways and have been particularly active outside of the UK. They are now seeking to develop their services within this country and working in collaboration with Barnardos. A Barnardos project has been working within Camden for 10 years and services are now being replicated in Haringey and Islington. They have a project worker in both boroughs and, in Haringey, she has been seconded to work for three days per week within the Council. The service is relatively new, having only begun in the borough in November. Aviva funds all the direct work and the worker's salary whilst Barnardo's contribute to the management and overhead costs from their Voluntary Funds.

Outcomes

8.2 There are four specific outcomes that the project is aiming to achieve in Haringey;
- Children having a better understanding of safe options;
- Reduction in risk;
- Episodes of children going missing reduced; and
- An enhanced relationship with the primary carer.

8.3 The service aims to increase early identification of risk, whilst developing partnerships and securing a co-ordinated inter-agency response. They undertake a number of services, such as drop in sessions for runaways and awareness training for professionals. They work closely with the Police and the Children and Young People's Service, schools, the Police Missing Persons Unit and the Youth Service. They are now part of the multi agency safeguarding hub (MASH).

8.4 They are currently undertaking independent return home interviews (RHI) for children who have recently returned after going missing. Referrals are received from children's social care and the Police. They aim to make contact with children within 72 hours. The service is voluntary for the child. Interviews take place in locations that the young person would find comfortable and each session is built around them.

8.5 The project covers a number of issues within return home interviews:
- They talk about safety strategies;
- Levels of risk are assessed; and
- They assess whether the child is running to or from something.

8.6 There is also capacity to provide one-to-one work to a further 100 young people with Haringey's share being approximately 40. This can either be as follow-on work from RHIs or can be referrals from other agencies or even self-referrals where there are concerns about the risk of going missing or where young people are not being reported missing. This involves up to 6 interviews being offered within 6 weeks. It was considered that there was only a small window of opportunity to intervene successfully so they have to respond quickly. If their involvement with children was for longer than this period, they could lose their capacity to move quickly. If children

are considered to be high risk, they are referred back to the First Response team.

8.7 External referrals to the service can be made although there is unlikely to be any specific need. There are a lot of children's residential homes within the borough although many do not deal specifically with Haringey children. However, the project only deals with Haringey children as otherwise they would not be able to cope with the demand. Children in the care of other authorities are referred back to them.

Outreach Work

8.8 The drop in centre aims to provide a safe space for young people and is based in Bromley Road, N17. The project also visits local authority residential homes in order to familiarise themselves with them and the children there and undertake targeted prevention work. This includes regular group work with children and staff as well as one-to-one sessions. The Panel noted that, in the case of children or young people from residential homes or foster care, there are normally more "push" factors behind why they have gone missing.

8.9 The project will also be undertaking preventative education at two schools within the borough – Woodside High and Hornsey School for Girls. As part of this, they will be visiting school assemblies and classes to give children information about the service, advising them of the risks involved in running away and of safe strategies.

8.10 The project deals with young people between the ages of 12 and 17. Most referrals are for 14 year olds. 46% of referrals had come from the N17 area which was why the safe space had been located there. It was noted that there were a large number of foster carers that lived in that area although neither of the Council run residential homes was based there. The service was surprised that such a high percentage came from one postal code. The precise reasons for this are unclear.

Return Home Interviews

8.11 Officers from the Project felt that it was important to establish why children were running away. If the young person was running to something or someone, it would be necessary to identify this and deal with it. If the child was running from something, work needed to be undertaken with the child.

8.12 The Panel noted that the project is only able to provide RHIs to a proportion of children who have gone missing. The project is funded by Aviva/Railway Children to deliver 75 one off RHIs for children per year across Islington, Haringey and, to a lesser extent, Camden. From this figure, the Project assumes that there is capacity to provide 30 of these within Haringey.

8.13 First time runaways or children already known to social care services are prioritised. The project had not selected these categories themselves as they were part of the working agreement with Haringey. Despite being prioritised, the project nevertheless sees a relatively low number of first timers. Serial absconders can be referred to the project that Barnardos has to address sexual exploitation for longer term work. If risk levels of children have not reduced sufficiently after six weeks, a discussion takes place with the Children and Young People's Service on what further action might be necessary.

8.14 The knowledge gained by the project will be reported back to Railway Children and Aviva on a quarterly basis. Haringey Council could also have access to this but only as a matter of courtesy. The project is providing an additional service to Haringey as the Council did not fund a return home interview process.

8.15 The Panel noted that it was accepted by the Council that the service was additional. There were procedures for dealing with missing children but how these were followed depended on the nature of the child. The Council had been explicit in determining who they wanted the service to focus on. There were limits to the capacity of services to deal with missing children. Who the current priorities missed was nevertheless of interest as was who was referred onwards for further action by the project.

8.16 The Panel is of the view that it is important that independent return home interviews are offered to *all* children that have gone missing and particularly first timers. There is clear evidence that it is best done by a third sector organisation, such as Barnardos, and the Panel very much welcomes the start of their work within Haringey.

8.17 The Panel was told that, where interviews are not undertaken by the Miss U project, they are instead offered by social workers and staff within residential homes, although there is no conclusive evidence either of who has been performing this role in the past or of how this information has been collated, analysed, reported or acted upon. The London procedures suggest that, whilst a social worker would be suitable to conduct such an interview, it should be someone other than the allocated social worker. Residential staff would also not be considered to be sufficiently independent due to their relationship to the child or young persons placement. In particular, the child or young person may have concerns about their placement that are behind them going missing.

8.18 The Panel feels that it is important that there is the necessary capacity to offer independent return home interviews to all relevant children on the basis outlined in the London procedures. It is difficult to quantify precisely any potential financial implications arising from this due to the range of arrangements that are viewed as suitable and the fact that the child or young person can decide who they wish to speak to. It would also be necessary to quantify the number of children and young people that are currently not being given a suitable opportunity to speak to someone and such information does not appear to be currently readily available. In addition, due to the work that services have been doing to ensure the correct recording of cases, there has also been some volatility in the number of children classified as missing which makes it difficult to estimate the potential number of children and young people involved. Nevertheless, the Panel is of the view that it may only require comparatively modest amounts of funding from the Council.

8.19 The Panel acknowledges that, with resources currently being severely limited, it could prove challenging to identify this. However, there is evidence that such measures can be cost effective if they prevent further instances of running away, which can prove expensive to services. There is also cost involved if social workers are undertaking interviews. For example, the Children's Society estimates that two hours of a social workers time costs £144. It would nevertheless also recommend that the cost effectiveness of this provision be subject to monitoring and evaluation.

Recommendation:
That action is taken to confirm that all children and young people who go missing from care and from home are offered an independent return home interview on the basis outlined in the pan London procedures with any shortfall identified met through the commissioning by C&YPS of additional capacity from an appropriate third sector organisation and that this be subject to regular monitoring and evaluation to ensure its cost effectiveness.

8.20 In addition, the Panel is also of the view that the same opportunities should be provided for Haringey children who are placed out of borough.

Recommendation:
That residential care providers be requested to confirm that arrangements are in place for all Haringey children who are placed out-of-borough and go missing to receive an independent interview.

8.21 The Panel is of the view that the information and intelligence gained through independent return home interviews should be collated and used to better inform interventions. As part of this, action should be taken to gain a greater understanding of the underlying reasons why children and young people go missing and, in particular, those who abscond from care.

Recommendation*:*
That C&YPS should seek to gain a greater understanding of the 'push' factors behind running away from Council care and seek to develop and deliver a strategy to address them.

Appendix A

Participants in the Review:

Debbie Haith - Deputy Director; Children & Families, C&YPS

Wendy Tomlinson – Head of Service; Commissioning and Placement, C&YPS

Sylvia Chew – Head of Service; First Response, C&YPS

Sergeant Paul Davies, Metropolitan Police Missing Persons Unit

Chris Emeruwa – Coppets Road Children's Home

Vivienne Osborne – Kindercare Fostering

Ntombi Kibutu - Hillfields Children's Home

Sandra Russell - Haringey Park Children's Home

Karen Thompson – Young Generation Children's Home

Remi Johnson – Xcel 2000 Foster Care Services

Urs Bielmann – Capstone Vision Foster Care

Tim McArdle – Capstone Vision Foster Care

Haringey Foster Care Association

Gloria Stott - Barnardos

Jodie Farmer – Barnardos

Becky Hug – The Children's Society

Geraldine Boyles – The Children's Society

Appendix B

Documents referred to:

London Procedure for Safeguarding Children Missing from Care and Home – London Child Protection Committee (March 2006)

Beyond Refuge; Supporting Young Runaways – NSPCC

Missing in London: Meeting the Needs of Young People who Run Away – Barnardo's Policy and Research Unit (August 2006)

A Report on the Young Runaways Situation in London for GoL – ECOTEC Research and Consulting (February 2010)

Children and Young People Missing from Home and Care – Report to Vulnerable Children Overview and Scrutiny Committee, Birmingham City Council (July 2011)

Missing from Care in Staffordshire; A Report prepared by Barnardo's for Staffordshire Children and Lifelong Learning Directorate – Di McNeish and Sara Scott

Missing from Care, Missing from Home Joint Protocol and Practice Guidance – Haringey LSCB

Still Running: Children on the Streets in the UK – Safe on the Streets Research Team (1999)

Make Runaways Safe; Launch Report – The Children's Society (July 2011)

Supporting Young People Who Run Away or Go Missing; A briefing for Lead Members for Children's Services – DCSF

Statutory Guidance on Children who Run Away and Go Missing for Home or Care; Supporting Local Authorities to Meet the Requirements of National Indicator 71 – Missing from Care and Home – DCSF (July 2009)

Young Runaways Action Plan – DCSF (June 2008)

Children Missing from Care: Good Practice in Residential Care – NCERCC

Young Runaways – Social Exclusion Unit (2002)

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