Local Democracy and Member Services
5th Floor, River Park House, 225 High Road, Wood Green, London N22 8HQ
Tel: 020 8489 0000 **Fax:** 020 8881 5218
www.haringey.gov.uk

Haringey Council

Matter being dealt with by Natalie Cole
Telephone Number 020 8489 2919
Fax 020 8489 5218
Email address Natalie.Cole@haringey.gov.uk

4th May 2011

To: All Members of the Overview & Scrutiny Committee

Dear Member,

Re: Overview & Scrutiny Committee – 9th May 2011

Please find attached a copy of the following reports for the Overview & Scrutiny Committee meeting on 9th May 2011 at 6pm, which were not available at the time of collation of the agenda:

Item
No

11. CORPORATE PARENTING SCRUTINY REVIEW (PAGES 1 - 38)

To receive the scrutiny review report on corporate parenting. **TO FOLLOW**

12. HEALTH INEQUALITIES SCRUTINY REVIEW (PAGES 39 - 98)

To receive the scrutiny review report on health inequalities. **TO FOLLOW**

15. MINUTES (PAGES 99 - 112)

To approve the minutes of the meetings held on 14th March (attached), 16th March (attached), 28th March 2011 (**to follow**) and 30th March 2011 (**to follow**).

Yours sincerely

Natalie Cole
Principal Committee Coordinator

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Agenda Item 11

Haringey Council

Overview and Scrutiny Committee **On 9 May 2011**

Report Title. Scrutiny Review – Corporate Parenting	
Report of Councillor Ejiofor, Chair of Review Panel	
Contact Officer : Robert Mack, Principal Scrutiny Support Officer Tel: 0208 489 2921	
Wards(s) affected: All	Report for: Non Key Decision

1. Purpose of the report (That is, the decision required)

That Members approve the report and recommendations of the review, as outlined in the report.

2. State link(s) with Council Plan Priorities and actions and /or other Strategies:

- Council Plan: A thriving Haringey and a caring Haringey
- Sustainable Community Strategy outcome: Economic vitality and prosperity shared by all

3. Recommendation

3.1 That the report and its recommendations be approved and referred to Cabinet for a response.

4. Reasons for recommendations

Please refer to the scrutiny review report (attached)

5. Other options considered

Please refer to the scrutiny review report (attached)

6. Chief Financial Officer Comments

6.1 To follow

7. Head of Legal Services Comments

7.1 To follow

8. Head of Procurement Comments

N/A

9. Equalities & Community Cohesion Comments

As outlined within the report, looked after children and young people (LACYP) 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. The report considers how the Council and its partners seek address these issues and makes recommendations for improvement.

10. Consultation

10.1 The review sought and received evidence from a wide range of stakeholders. In particular, it listened to the views of a groups of foster carers and care leavers and undertook a survey of Councillors.

11. Service Financial Comments: The retaining of specific sexual health provision for looked after children will require additional budget savings to be made elsewhere in order to compensate. The provision of free leisure passes for all LACYP will have budgetary implications for the Leisure Service but these may be difficult to quantify as they will be dependent on the level of potential lost income from LACYP using leisure facilities who would otherwise have been required to pay. There are currently 609 children in care but around 70% of these are in out of borough placements so might not be in a position to take advantage of the offer of free passes. Other recommendations may also have some financial implications but further work will be required to quantify the size and nature of these.

12. Local Government (Access to Information) Act 1985

The background papers relating to this report are:

- The Role of Councillors as Corporate Parents – Rotherham MBC Lifelong Learning Opportunities Scrutiny Panel
- Aspects Of The Council's Corporate Parenting Responsibilities – Middlesbrough Children and Learning Scrutiny Committee
- Children Looked After by Camden – Camden Corporate Parenting Scrutiny Committee
- Children and Young People's Strategic Plan – Haringey Council
- The Role of Councillors as Corporate Parents – Wakefield MDC Children's Services Scrutiny Working Group
- If This Were My Child – A Councillors Guide to Being a Good Corporate Parent – Department for Education and Skills/LGiU
- Show Me How I Matter; A Guide to the education of Looked After Children – LGA/IdEA
- London Borough of Greenwich Corporate Parenting Review Jan 2010 - PricewaterhouseCoopers LLP Children's Services Consulting Team

These can be obtained from Robert Mack, Principal Scrutiny Support Officer on 0208 489 2921, 7th Floor, River Park House,
E- Mail rob.mack@haringey.gov.uk

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Haringey Council

Scrutiny Review – Corporate Parenting

A REVIEW BY THE OVERVIEW AND SCRUTINY COMMITTEE

MAY 2011

www.haringey.gov.uk

Contents: **page**

Chair's Foreword:

The Council has an important duty in making sure that looked after children and young people (LACYP) have the same opportunities as other children. We know that many LACYP face tough challenges and do not generally enjoy outcomes that match those of other children. The Panel was nevertheless very pleased to find out just how well many LACYP in Haringey do, particularly in terms of their educational attainment. We were also very impressed by the children and young people that we met, who were very articulate and highly motivated. They had often successfully overcome considerable adversity.

There is nevertheless still room for improvement as outcomes for LACYP still lag behind those for other children. This review looks at what the Council and its partners currently do to support these young people and improve their health, well being and life chances and makes recommendations for how this could be further enhanced. The key message that has come out of our work is that the responsibility for corporate parenting needs to be shared more widely. It is not just down to Children and Young People's Services - we should all make at least some contribution, including local Councillors.

Councillor Joseph Ejiofor
Chair of the Review Panel

Executive Summary

Corporate parenting requires the sharing of responsibility for meeting the needs of looked after children and young people (LACYP) and ensuring good outcomes for them. Those parts of the Council that have direct responsibility for providing services for LACYP will inevitably assume the vast majority of the responsibility. This applies particularly to the Children and Young People's Service (C&YPS). If CYPS act as the parents of our corporate children, then the Council's other departments - Leisure, Housing, Adults, Environment - are the Uncles and Aunts of these corporate children. Whilst the involvement of services without a direct role in providing services may always be subject to inherent limitations, there is nevertheless scope for them to do more. The Panel would therefore like to see the responsibility shared more widely and embedded into the business planning process of the Council. Even small areas of assistance can potentially be of great benefit to LACYP and the Panel is of the view that all areas of the Council should ensure that they contribute something.

The Council does not only exist to provide services. It also has both a community leadership and place shaping role. It also works with a large number of third party organisations. The Panel is of the view that the Council should use its position of influence to promote the needs of LACYP amongst partners and other external bodies and encourage them to provide opportunities as well.

Children often benefit greatly from having assertive parents who actively promote their interests and ensure that they get the best. LACYP could particularly benefit from having someone to do this for them. The Panel is of the view that this is one area where Members and officers who are not currently directly involved can contribute significantly by asking the same questions as parents would and demanding the best outcomes.

The educational attainment of LACYP in Haringey is a success story and the achievements of the young people deserve to be celebrated more widely. However, there is still room for further improvement, particularly in the light of the continuing gap with the attainment of other children. More challenging but achievable targets may help to secure even greater success.

Teenage pregnancy can be detrimental to the life chances of LACYP. The Panel is therefore greatly encouraged at the current low levels of teenage pregnancies amongst LACYP. It is nevertheless aware that they are at particular risk and concerned to ensure that current take up levels for support are maintained in the light of budget reductions.

Like other children, LACYP should be encouraged to enjoy leisure pursuits. The Panel feels that this could be assisted further by providing all of them with free access to Council run leisure facilities.

LACYP can be very young when they leave home and become independent. Not all of them find this easy and the Panel is of the view that housing support for LACYP, whilst good, could be enhanced by assistance being available at an earlier stage and by greater assistance being provided for them in bidding for properties.

Finally, the Panel noted that many care leavers suffer from social isolation and have emotional support needs. It therefore strongly supports the development of measures to improve support and, in particular, develop a mentoring scheme.

Recommendations:

1. That the corporate parenting function be embedded in the performance management framework of the Council through each Council service being required to identify a specific action within their business plan that contributes to the corporate parenting agenda. (paragraph 2.17)

2. That, subject to minimum criteria being met, all Council care leavers be guaranteed an interview for advertised posts within the Council for the first 5 years after leaving care. (5.13)

3. That each Council service and key partner agencies be requested to identify a staff member of appropriate seniority to champion the interests of looked after children and care leavers and, in particular, provide a role in service development and as a key contact for staff working directly with children. (2.21)

4. That the Council use its key strategic role to influence partners and other third party organisations to provide opportunities and support for looked after children and care leavers. (2.22)

5. That, in order to enhance accountability and transparency, the specific role of providing the scrutiny and challenge function for performance in corporate parenting be allocated to the Overview and Scrutiny Committee. (2.23)

6. That Member engagement be enhanced through:
   - Measures being taken to ensure that that all Members attend both initial and refresher training on their corporate parenting role;
   - All Members of the Council receiving more regular updates on looked after children and, in particular, their achievements;
   - An Annual Report to all members highlighting the Council's Corporate Parenting performance towards delivering the 47 promises that the Council signed up to in "*The London Pledge for Children and Young People in Care*" and performance monitoring statistics that Councillors are considered to have a "need to know"; and
   - All Members being given the opportunity to participate in celebrating the achievements of looked after children. (2.26)

7. That an appropriate scheme be developed for Members to champion the educational attainment of particular looked after children. (2.28)

8. That in the light of concerns raised in evidence received by the panel concerning children missing from our care, especially children missing from our care homes, a scrutiny review be undertaken on the Council's policy, procedures, practices and performance in this area, and the "Missing From Care and Home" Action Plan in particular. (2.30)

9. That enhanced local education targets be developed that provide additional challenge to further improve educational achievement for looked after children. (3.18)

10. That a proactive approach be adopted to delivering and increasing the uptake of tutoring opportunities and to improve and expand the Study Centre. (3.23)

11. That funding be retained to provide specific sexual health provision for looked after children and care leavers, including advice on preventing conceptions. (4.22)

12. That all of Haringey's looked after children be provided with free leisure passes for Haringey leisure centres, irrespective of where they live. (4.29)

13. That the element of the carers allowance intended to provide for savings for young people be "top sliced" and used to establish individual savings plans or trust funds for children in care. (4.33)

14. That all schools be encouraged to repatriate funds provided from central government for careers guidance for LACYP to either Connexions or C&YPS and that, if successful, this be used to provide a dedicated worker providing careers advice for all LACYP. (5.11)

15. That enhanced support be developed to assist care leavers with finding and maintaining accommodation and that this include support being provided from an earlier stage and a specific resource to assist them in bidding for properties. (5.17)

16. That a policy be developed on semi-independent living for looked after children between 16 and 19. (5.19)

17. That initiaitives to improve emotional support for care leavers and the development of a specific mentoring scheme for care leavers be strongly supported that a report on progress be submitted to the Overview and Scrutiny Committee in due course. (5.22)

18. That enhanced systems for monitoring of long term outcomes be developed and in particular the progress of NEETs, and that a practical way for remaining in contact with vulnerable care-leavers into their 20s be developed. (5.23)

1. Background

1.1 The review was set up to look at how well the needs of Haringey's children and young people in care were being addressed. In doing this, it looked in depth at the contribution of a range of wide range of services provided by the Council and its partners to the parenting of LACYP including:

- Housing
- Leisure
- Adults
- Health

1.2 In addition, the review looked at the role played by Councillors and school governors.

1.3 The terms of reference for the review were as follows:

"To consider how well the full range of parental needs of looked after children and young people are addressed corporately by the Council and to make recommendations on how this role could be strengthened"

1.4 In undertaking this, the review specifically considered:

- How the educational needs of LACYP are supported
- The promotion of health and well-being
- Preparation for leaving care, including support for housing and training needs
- The role of local Councillors and how this can be enhanced
- How the views of LACYP are taken into account

1.5 The Panel considered a wide range of evidence, including:

- Research documentation, national guidance and targets
- Statistical evidence including relevant performance data and information on outcomes
- Comparison with other areas such as statistical neighbours
- Interviews with a range of stakeholders
- The views and concerns of LACYP, care leavers and foster carers.
- The results of a questionnaire of all Councillors

1.6 The Overview and Scrutiny Committee appointed the following membership of the Panel:

Councillors: Ejiofor (Chair) Alexander, Gibson and Solomon
Co-opted Members (statutory): Yvonne Denny, Marcelle Jemide, Sarah Marsh and Sandra Young

2. Corporate Parenting - Roles and Responsibilities

Introduction

2.1 Looked after children and young people (LACYP) are children who are in the care of the Council through a care order made by a court or voluntary agreement with their parent(s). They can be looked after in a children's home or by foster carers or by other family members. Care leavers are children who have been looked after by the Council and are still provided with assistance, advice and guidance. Children and young people do not like the term but it is a term that is generally understood by people.

2.2 The term does not have a formal legal definition but it recognises that Councils should have the same interest in the progress and achievements of children and young people in its care as a reasonable parent would have for their own children. The responsibility applies to the local authority *as a whole* and not just services directly responsible for children's and young people's services. It requires ownership and leadership at a senior level and includes a key role for elected Members.

2.3 Being a good corporate parent means that the Council should:

- Accept responsibility for children in it's care and make their needs a priority; and
- Seek for them the same outcomes any good parent would want for their own children.

2.4 Whilst LACYP have a right to expect the same life opportunities and outcomes as other children, they may nevertheless experience disadvantage. Research indicates that they experience significantly poorer outcomes across a range of measures, including health and education:

- Nearly 50% have a diagnosable mental health disorder compared to 10% in the general population. Figures for those in residential care are even higher
- Between a quarter and a third of rough sleepers have been looked after by local authorities as children
- Children who have been in care are two-and-a-half times more likely to become teenage parents.
- Young people who have been in care are disproportionately likely to become unemployed
- Twenty-six per cent of prisoners have been in care as children, compared with just two per cent of the total population

LACYP in Haringey

2.5 Haringey is currently responsible for 601 looked after children and 462 care leavers. The largest age group is children between the ages of 10 and 15. The numbers have gone up significantly in recent years and are well above the national average

yet they still track those of statistical neighbours. Encouragement and support is given to families to provide care where possible. Children cared for by such "kinship" arrangements are not categorised as looked after. 65% of Haringey care leavers are in employment, education and training (EET) and 94% are in appropriate accommodation. Around 70% are currently in placements outside of Haringey.

2.6 The Children Act 2004 specifies that the Cabinet Member for Children's Services has the lead political role in respect of LACYP but also states that *all* Members of the local authority have a shared responsibility for corporate parenting. In addition, all officers in the Council and the Children's Trust are corporate parents.

2.7 There is a particularly important role for C&YPS. In particular, the Director of Children's services has a statutory role and officers in C&YPS have key responsibilities as they directly manage the case work and support for LACYP and care leavers. The Deputy Director for Children and Families has direct management responsibility for corporate parenting and making sure that it is carried out effectively. Officers within the service have regular contact with relevant children and young people. Part of this role includes seeking their views on the care and services they receive. Officers in C&YPS also have a role in liaising with schools to ensure that they know which children and young people are looked after and are aware of their responsibilities to LACYP.

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2.8 Council Officers working in housing services also have additional responsibilities relating to LACYP and care leavers. This includes helping to re-house care leavers and ensuring that they are supported effectively so that they are able to live independently and sustain their accommodation. LACYP should be given the same opportunities to take up hobbies and interests as other children and relevant services have a responsibility to ensure that they have access to these.

2.9 Communicating with LACYP and obtaining their views is undertaken in a range of ways. There was an expectation arising from the "Care Matters" White Paper that each local area would develop a pledge for looked after children based on its corporate responsibilities. London Councils agreed on a London wide pledge, which Haringey has signed up to. Every child and young person's care or pathway plan must reflect how the commitments made in the pledge will be delivered for that individual child. There is also a requirement to set up a Children in Care Council to enable regular dialogue and involvement from LACYP in developing and delivering services and to monitor the implementation of the pledge. This has now been set up in Haringey and has met twice. There should also be mechanisms in place for involving young people in care in the recruitment of key staff members.

2.10 All looked after children are required to have a named Independent Reviewing Officer (IRO). This person plays a very important role as a mentor for the young person. Such individuals are not connected with the decision making process. Their primary focus is to quality assure the care planning process for each child and to ensure that his/her current wishes and feelings are given full consideration.

2.11 Haringey has a Corporate Parenting Advisory Committee (CPAC), which brings together Members from across the political spectrum. The CPAC is responsible for the Council's corporate parenting role and for those children and young people who are in care. The Corporate Parenting Advisory Committee has the key role within the decision making structure in respect of LACYP. It was established in April 2009 and

reports to Cabinet and full Council. It is chaired by the Cabinet Member for Children and Young People and has three other Members of the Majority Group and three Members of the Minority Group.

2.12 Its terms of reference are as follows:

- To be responsible for the Council's role as Corporate parent for those children and young people who are in care;
- To ensure the views of children in care are heard;
- To seek to ensure that the life chances of children in care are maximised in terms of health, educational attainment and access to training and employment to aid the transition to a secure and fulfilling adulthood;
- To ensure that the voice and needs of disabled children are identified and provided for;
- To provide an advocacy function within the Children's Trust and the Council on behalf of children in care;
- To monitor the quality of care provided by the council to Children in Care; and
- To ensure that children leaving care have sustainable arrangements for their future wellbeing

2.13 The Committee receives a range of statistical information including the numbers of children in care, their age groups, feedback from visits and educational performance. It has a specific role in listening to the views of children in care and the Committee meets with the Children in Care Council twice per year. Some LACYP have also attended meetings of the Committee and engagement events have been held, sometimes hosted by Tottenham Hotspur. The Committee also considers issues relating to the Councils two children's residential homes – Muswell House and Haringey Park.

2.14 The Panel received evidence from the Cabinet Member for Children and Young People. She felt that the Committee provided a good element of challenge to C&YPS but was less able to address the wider corporate parenting agenda and the role of other Council services and partners. Services such as parks and leisure had a particular role as both providers of services and potential sources of work placements. There was a specific officer in the leaving care team with responsibility for finding work placements and opportunities at a wide range of organisations had been found but, due to the junior status of the post, its influence could be limited. In addition, economic circumstances were currently very challenging and it was now difficult to arrange things like apprenticeships. She felt that other parts of the Council had the potential to contribute more through, for instance, providing work placement opportunities. One possibility would be to involve care leavers in the Haringey Guarantee scheme.

2.15 The Panel notes the conclusion of the recent OFSTED report on services for looked after children that;

"Corporate parenting arrangements for looked after children are adequate but lack flair and imagination in engaging all partners and listening to users. Corporate parents could offer more challenge to services on behalf of looked after children, including in relation to setting joint service targets for continued improvement."

2.16 It concurs with the view that the corporate parenting responsibility could be shared

more equally across the Council and partners. Whilst C&YPS has the lead responsibility and will always have the greatest level of involvement, this does not mean that other services and partners cannot also make a significant contribution. There are a wide range of ways in which they could benefit LACYP and care leavers such as providing work experience, job opportunities, access to recreation and leisure facilities, support and mentoring. Any assistance that can be offered can potentially be of benefit to LACYP. Work experience is particularly important to young people and even a few weeks of work experience could make a lifetime of difference.

2.17 The Panel feels that there is a need to further embed the corporate parenting function into the performance framework to ensure that all services play their part. The Panel heard the fact that all services at Oldham Metropolitan Borough Council are required to identify an action within their business plan that would assist care leavers. It was noted that this initiative has already been identified as an example of good practice in training courses for relevant staff. The introduction of such a scheme in Haringey could help to ensure that each part of the organisation plays at least some part in corporate parenting and increasing opportunities for young people. Despite spending cuts, the Council is still a large organisation and should be able to provide some assistance and opportunities for LACYP. A range of offers could be made but mentoring, work placements or apprenticeships would be particularly welcome. Council staff could also help by acting as mentors and assisting with things such as mock interviews. This could help LACYP to develop aspirations and build better self belief.

Recommendation:
That the corporate parenting function be embedded in the performance management framework of the Council through each Council service being required to identify a specific action within their business plan that contributes to the corporate parenting agenda.

2.18 The Panel is of the view that the Council could play a particular role in assisting care leavers in finding employment. In addition to its corporate parenting responsibilities, it is also one of the largest employers in the area. It therefore feels that it should guarantee an interview for care leavers for all advertised posts provided they meet the minimum criteria. Such a move would also assist in encouraging other organisations to offer work opportunities as the Council will be able to provide an example from its own practices.

Recommendation:
That, subject to minimum criteria being met, all Council care leavers be guaranteed an interview for advertised posts within the Council for the first 5 years after leaving care.

2.19 The Panel noted that the recent OFSTED report on looked after children had stated that the work of the Council's Corporate Parenting Advisory Committee was not disseminated across the partnership. Improvements to address this and other issues that have been highlighted by C&YPS and have already begun to be put into place. For example, a multi agency group from across the Council and partners had

been set up to champion the interests of LACYP in different parts of the organisation and outside. The Panel noted an initiative being developed in the London Borough of Greenwich to appoint LACYP champions within the Council and key partner organisations. These are identified staff members who provide key services to LACYP and can "unblock" problems where the useful joint working arrangements are not working for individual children and young people.

2.20 They can also provide:

- A service development role by identifying key activities or initiatives which could make a positive contribution to the welfare of LACYP
- A monitoring and reporting role by identifying what activities the department or partner in question is undertaking
- A role as a key contact for staff working directly with LACYP so they can be contacted for support or guidance.

2.21 The Panel is of the view that a similar initiative should be launched in Haringey as this could assist in ensuring that all Council services and key partner agencies share corporate parenting responsibilities as well as increasing opportunities for LACYP.

Recommendation:
That each Council service and key partner agencies be requested to identify a staff member of appropriate seniority to champion the interests of looked after children and care leavers and, in particular, provide a role in service development and as a key contact for staff working directly with children.

2.22 Local authorities do not only have a role in providing services. They also have a community leadership role. As part of this, the Council work closely with local strategic partners as a "place shaper" and promotes community cohesion. It has a relationship with a wide variety of external organisations and has an important commissioning role. The Council could therefore also potentially use its position and influence to promote the interests of LACYP through a wider range of channels.

Recommendation:
That the Council use its key strategic role to influence partners and other third party organisations to provide opportunities and support for looked after children and care leavers.

2.23 The Panel notes the role of the Corporate Parenting Advisory Committee and recognises the useful and important role that it undertakes. However, its formal function within the decision making structure is as a Cabinet advisory body and, accordingly, it is chaired by the Cabinet Member for Children and Young People. As previously stated, the recent OFSTED report identified a need for "more challenge to services on behalf of looked after children". The Panel is of the view that this would be best addressed by specifically allocating the role of providing challenge and scrutiny in corporate parenting to the Overview and Scrutiny Committee. As a non Cabinet and semi independent body, it is best placed to undertake these important roles and therefore enhance accountability and transparency.

Recommendation
That, in order to enhance accountability and transparency, the specific role of providing the scrutiny and challenge function for performance in corporate parenting be allocated to the Overview and Scrutiny Committee.

The Role of Councillors

2.24 When they are elected, all Councillors take on the role of 'corporate parents'. They have a duty to take an interest in the well-being and development of LACYP as if they were their own children. Although the Cabinet Member for Children's Services has particular responsibilities, the responsibility to act as corporate parents is held by *all* Councillors, regardless of their particular role. There is an expectation that systems, processes and support should be in place to enable them to fulfil that role. This was emphasised in the launching of the *Quality Protects* programme in 1998, when the then Secretary of State wrote to all councillors about their role and said:

"Elected councillors have a crucial role. Only you can carry it out. You can make sure that the interests of the children come first. You bring a fresh look and common sense. As councillors you set the strategic direction of your council's services and determine policy and priorities for your local community within the overall objectives set by Government."

2.25 The role of Councillors as corporate parents is defined in 'Think Child' (1999) as the following:

- "**find out** – get the facts and follow them up
- **make decisions** – play your part in the business of the council
- **listen to children and young people** – find out from them how your council's services work for them and remember that children are citizens too
- **be a champion for children** – take a lead in your community in putting children first"

2.26 The Panel undertook a survey of all Councillors in order to determine their views on their corporate parenting role. The Panel was disappointed that only 16 Members responded to the questionnaire. From the results, it appears that whilst Members are satisfied with the training and information that they receive, there may be a need for more regular and ongoing information. A wide variety of information is available including key performance indicators and can be shared with Members on a regular basis. Consideration needs to be given to what information might be of particular interest to Members and has the potential to improve engagement. The achievements of LACYP are celebrated through an annual event that takes places at Tottenham Hotspur and another event that specifically recognises the educational achievement of LACYP. However, space is limited so invitations can only be extended to a small number of Members. It would, however, be possible to circulate information after the event had taken place.

Recommendations:
That Member engagement be enhanced through:

- **Measures being taken to ensure that that all Members attend both initial and refresher training on their corporate parenting role;**
- **All Members of the Council receiving more regular updates on looked after children and, in particular, their achievements;**
- **An Annual Report to all members highlighting the Council's Corporate Parenting performance towards delivering the 47 promises that the Council signed up to in "*The London Pledge for Children and Young People in Care*" and performance monitoring statistics that Councillors are considered to have a "need to know"; and**
- **All Members being given the opportunity to participate in celebrating the achievements of looked after children.**

2.27 One area of good practice from other local authorities involves providing a role for Members in championing the educational attainment of specific looked after children. This is a behind the scenes role where Members act as "pushy parents" on their behalf in order to help enhance educational outcomes. There is no direct contact with the children or young people, who are not normally aware of the involvement of a Member. It involves social workers keeping specific Members updated on the progress of particular children through periodic e-mails and/or telephone conversations. The intention is that the Member will use their influence to help overcome any barriers that the child might face in their education. Members are updated on the progress on the children and young people by the social worker.

2.28 A scheme of this nature has been undertaken in Westminster and is also being considered in Greenwich. Members involved have developed a greater understanding of the challenges that face LACYP whilst social workers have reported that the scheme has helped to enhance the quality of their work and not been a distraction. The Panel is of the view that it would be beneficial for such a scheme to be developed within Haringey. However, it is noted that the educational attainment of LACYP in Haringey is comparatively good and the scheme may therefore need to be adapted to better reflect local conditions.

Recommendation:
That an appropriate scheme be developed for Members to champion the educational attainment of particular looked after children.

2.29 The Overview and Scrutiny Committee has considered statistics on children missing from care on an ongoing basis. The Opposition Spokesperson, when giving evidence to the Panel, referred to this issue. The view of the Cabinet Member for Children and Young People was that the statistics do not always tell the full story. For example, the figures do not state how long the absence had been or how often. She stated that the issue is taken very seriously and if there was any suggestion that the whereabouts of LACYP were unknown, the Police were informed. It was a complex area and statistics required a degree of interpretation and explanation.

2.30 The Panel noted that foster carers were aware of their role and responsibilities if children went missing. It is included within the foster carers handbook and covered as part of foster carer support meetings. There is also an out-of-hours helpline. There are agreed London wide procedures for addressing such issues. Foster

carers are involved, with the social worker, in the follow up to any instances where a child has gone missing. A risk assessment is undertaken together with an action plan. Where issues have previously arisen, plans are put in place before placements commenced.

Recommendation
That, in the light of concerns raised in evidence received by the panel concerning children missing from our care and especially children missing from our care homes, a scrutiny review be undertaken on the Council's policy, procedures, practices and performance in this area, and the "Missing From Care and Home" Action Plan in particular.

3. Education

Introduction

3.1 Education plays a crucial role in improving the life chances of LACYP. Foster carers that gave evidence to the Panel stated that education was the biggest challenge that faced LACYP. In 2008, only 14% of LACYP nationally achieved 5 A* - C GCSE grades compared to 65.3% of all children. Disruption caused by constant placement moves can have a particularly adverse affect on educational performance. It may not so much be the fact of being in care that causes LACYP to miss out on education but the circumstances which lead to them entering care. Ensuring LACYP have the right support to be able to participate fully in school life is therefore vitally important. For example, they may need specific help to catch up. A high proportion of LACYP see entering care as having been good for their education.

3.2 The previous government brought in the following initiatives to raise the educational attainment of looked after children:

- Each local authority now has a "virtual school head" to champion the educational needs of all LACYP;
- Each school has a designated teacher for LACYP;
- Children at risk of falling behind at school have a personal educational allowance; and
- One-to-one tuition is available if necessary for some looked after children.

Performance Indicators

3.3 The National Indicator Set includes several performance indicators about LACYP and three specific educational targets were included within Haringey's Local Area Agreement:

- NI 99; Looked after children reaching level 4 in English at Key Stage 2 – current performance 58.0% (target 47.0%).

- NI 100; Looked after children reaching level 4 in mathematics at Key Stage 2 – current performance 63% (target 48.0%)

- NI 101; Looked after children achieving 5 A*- C GCSEs (or equivalent) at Key Stage 4 (including English and mathematics) – current performance 17.5% (target 11%)

Admissions

3.4 The Panel noted that specific measures had been taken by the Council to ensure that LACYP have access to a good education. All care plans for children under five describe arrangements for the child to access high quality early years education. The Council also tries to ensure that children in its care go to the best possible schools available. The current admission criteria for both Haringey primary and secondary schools puts children in care as the highest priority.

3.5 The Panel noted that the Council's Virtual Head works with the Admissions Service to ensure that all LACYP are placed appropriately. Efforts are made to ensure that

all LACYP attend a school that is either as rated good or outstanding by OFSTED. Schools rated as satisfactory are considered if they are known to be particularly good at working with LACYP. It was noted that it is not always the best performing schools that are most successful at working with LACYP. School admission appeals are made if applications for preferred options are unsuccessful. Efforts are also made to put gifted children in schools that will enable them to realise their full potential.

3.6 However, unnecessary moves are avoided and children only moved normally if changing schools. Moving children during the year of their GCSEs can be particularly detrimental and is avoided wherever possible. Measures are also taken to ensure that children placed out of borough have the same access to high quality education as those in borough. In addition, there is also provision of £500 a year for looked after children who are at risk of not achieving expected standards.

3.7 There is now also guidance for local authorities on how to support carers in the SEN process. Additional funding is provided for looked after children to have the opportunity for 2 hours free extended activities per week. Home school agreements are also being reviewed in order to ensure that full consideration is given to foster carers and residential staff. Training for foster parents now addresses educational achievement and how to support children's literacy. School governors also have a role and specific training is now provided.

Attainment Levels

3.8 The Panel heard that good grades at GCSE are of particular importance for LACYP and help to keep them out of the NEETs (not in education, employment and training) category. The Panel noted that the ages between 16 and 19 can prove challenging if young people have not secured 5 passes at A – C. 69% of current care leavers are in employment and training, although this does not necessarily mean that they will go on to do well. Action to address the educational performance of LACYP focuses on the whole period of their education, up to 19 years of age. One of the reasons why the virtual school had been set up was to enable an overview to be taken. The service had not previously realised just how important the years between 16 and 19 were.

3.9 A number of tools are used in Haringey to monitor progress. Data is used and the progress of children tracked. The service can face particular challenges. For example, 40% of LACYP were the subject of fixed term exclusions in the last academic year and schools can find them hard to handle. However, there was only one permanent exclusion.

3.10 There is a requirement for all looked after children to be allocated a designated teacher to promote their educational achievement and this role has been strengthened in Haringey. There are also designated school governors for LACYP. All governing bodies have been:

- Sent information on statutory guidance for children in care; and
- Offered bespoke training on strategic management of school systems in the context of this guidance to ensure LACYP make rapid and accelerated progress

3.11 18 school governing bodies have taken up the offer of bespoke training. Governing bodies have responsibility for the oversight of the role of the Designated Teacher of

Children in Care. On most governing bodies, this role is generally taken on by the either the Chair of Governors or by the Governor with responsibility for Safeguarding and Child Protection.

Exam results

3.12 The exam performance of LACYP in Haringey is a success story. Children in Haringey perform notably better than those in statistical neighbours and a significant number of care leavers – 44 at the moment - now go on to university. . GCSE results for 2010 were as follows:

- 17% 5A* - C including Maths and English
- 31% A5* - C
- 71% 1A – G

3.13 Only a few local authorities have achieved figures above 30% for A-C passes in 5 GCSEs for LACYP. Only 2 young people out of the 31% of LACYP that got 5 passes between A and C had been predicted to gain such passes two years ago at KS3.

3.14 Young people are not always successful though and things can happen to them which inhibit their performance. For some young people, getting one A-G pass might be a significant achievement and it is therefore important that the achievements of *all* young people children are celebrated.

3.15 It is normally the case that the performance of LACYP attending schools in borough do not vary significantly from those attending schools out of borough. However, the Panel noted that there was likely to be a big fluctuation in the GCSE performance figures for the forthcoming year as a large percentage of LACYP in this particular cohort were in specialist provision.

3.16 Consideration is now being given by C&YPS to what can be done to support 'A' level performance. There is currently a mismatch between birth dates relating to placements and the dates for 'A' Level exams which can lead to difficulties. Whilst care ends at 18, exams take place the following June for most young people.

3.17 Although the borough is doing very well, the aspiration is to do even better. This will allow young people to be more successful and independent and to close the gap with other children. C&YPS has high expectations for young people and had submitted more challenging targets than the ones that were set within the LAA but they were turned down. The targets had been nationally set as part of the set of performance indicators.

3.18 The Panel noted that it was possible to set local educational performance targets for LACYP. The Panel is of the view that current targets are relatively unambitious and that more challenging ones are achievable, particularly in view of the high quality support provided by C&YPS and the recent levels of success.

Recommendation:
That enhanced local education targets be developed that provide additional challenge to further improve educational achievement for looked after children

3.19 The Panel noted that all those who achieved 5 A-C grades were assisted by a range of opportunities including:

- Taking advantage of the 20 hours after school tuition that was offered in KS4
- Attending the Study Club. This had had existed since 2005 and involved young people between key stages 2 and 4 meeting every week with staff from the Tuition Service.
- Visiting Highgate Independent School as part of the Study Club for science lessons
- Undertaking work experience at Tottenham Hotspur

3.20 All of the young people remained in the same school and care placements during Key Stage 4. In addition, the Haringey Virtual School maintained regular contact with school designated teachers throughout. Interventions can be a range of simple and small things like getting to know the young people, showing an interest and having high expectations.

3.21 Foster carers that gave evidence to the Panel were of the view that the children that performed best were generally those that had received after school tuition at home and that provision of this had provided a real benefit for children. All LACYP are offered after school tuition and there is no need for children to be referred as this is a standing offer. The amount of tuition is fixed at 10 hours per academic year. In 2009, although 66 offers of tuition were made, only 29 were accepted. A lot of work is undertaken to ensure that the offer is accepted and there is currently a drive to encourage more young people to take up the offer.

3.22 The Panel is of the view that tuition offers clear benefits to LACYP. Take up levels could nevertheless be higher and it welcomes the fact that LACYP are encouraged by the service to take up such opportunities.

3.23 Panel Members visited the Study Centre for LACYP and were impressed with the dedication shown by the young people in attending the centre as many had come a long way. The centre was also not very accessible. The young people felt that the centre had helped them to improve their performance and all of them were keen to attend. The Panel is of the view that all efforts should be made to both increase the level of tuition that is provided and to improve and expand the Study Centre.

Recommendation:
That a proactive approach be adopted to delivering and increasing the uptake of tutoring opportunities and to improve and expand the Study Centre.

3.24 The Panel noted that the service had been short listed for four Children and Young People Now awards. This included:

- One for corporate parenting for the work to develop a book club. This involved working with the Library Service and the Big Green bookshop to deliver books to children's homes.

- The Learning Award for their Study Club.
- There had also been a nomination for Third Sector Engagement for their South Africa project. This had entailed children and young people who were considered at risk from going into residential care getting the chance to go to South Africa.

3.25 In addition, BBC's Newsround has used the borough as an example of how children in care could do well academically. Of particular note was the partnership with Tottenham Hotspur who were involved in providing a range of opportunities and events for LAC, including work experience.

4. Health, Well Being and Leisure

Introduction

4.1 Although education is very important, LACYP have a range of other needs. For example, many can also experience poor health outcomes. LACYP share many of the same health risks and problems as their peers but they frequently enter care with a worse level of health due to the impact of poverty, abuse and neglect. For example, evidence suggests that looked after children are nearly five times more likely to have a mental health disorder than other children.

4.2 Local authorities, primary care trusts and strategic health authorities must currently have regard to statutory guidance issued in November 2009 on promoting the health and well-being of looked after children, which requires children in care to have a personal health plan. They must:

- Be registered with a GP
- Have their immunisations up to date
- Receive a regular health assessment and dental checks.

Health Assessments

4.3 The Panel received specific evidence on how the health and well being needs of LACYP were addressed. There are two nurses who work specifically with LACYP. A health assessment of children is undertaken after four weeks in care. This is reviewed every six months until the child is 18. Nursing staff liaise closely with social workers, who pick up on comments from assessments.

4.4 The service is offered first and foremost from Bounds Green Health Centre but the nurses can visit if need be. If any needs are identified, these are followed up to ensure that children receive the appropriate service. Comparisons can now be made with the health of other children and a tool has been developed that allowed a wider picture of health issues to be taken.

4.5 The previous system had been a source of frustration to C&YPS. Health assessments had been undertaken previously by GPs and the quality of them was considered to be variable. Foster carers could also find it difficult to get appointments with GPs for children. There was now an electronic system for recording assessments and consideration was currently being given to uploading this directly onto case records.

4.6 Nurses who are specially trained in sexual health issues are available and it is discussed in detail with young people. They can also provide chlamydia screening and contraception. In addition, a lot of targeted work is undertaken and schemes like Teens and Toddlers used. A similar approach is adopted in respect of substance abuse.

Emotional Needs

4.7 The Panel noted that it is not unusual for LACYP to have a need for emotional support as they all come from difficult family situations. A small number have a specific psychiatric condition whilst others are upset, unhappy, traumatised or

neglected.

4.8 The Panel received evidence on the emotional support that is provided for LACYP in Haringey by the Tavistock NHS Trust. There are two different services that are provided by them:

- The Tavistock – Haringey service that was provided locally for children who were being fostered or in residential care or in transition between placements: and

- The Fostering, Adoption & Kinship Care service provided centrally at the Tavistock Clinic in Swiss Cottage that was open to children in care once they had been permanently placed

4.9 The Tavistock-Haringey service is commissioned by C&YPS and based at Bounds Green Health Centre. It undertakes a lot of the work that would otherwise be done by CAMHS. The team is multi disciplinary and includes a psychiatrist, two psychotherapists, a family therapist and psychologist. Referrals came from social workers and other professionals. Specific packages of care are developed for individuals. The service takes children and young people who were based in or around Haringey and are currently providing services for 135 children in care, which was 22% of the total.

4.10 The service liaises closely with Barnet, Enfield and Haringey Mental Health Trust. They offer flexible services in a range of settings and endeavour to make them as accessible as possible. For example, home visits can be undertaken or clinics used for consultations. The Bounds Green location has the benefit of being co-located with nurses so physical and emotional issues could be better linked.

4.11 The Panel noted evidence from the Tavistock-Haringey service that it was a misconception to suggest that children could not access the service until permanently placed but it was acknowledged that the current arrangements could cause confusion. There is no waiting list for the local service. The central clinic is a pan London service that requires a referral from a GP. If issues need to be addressed urgently, the local service is available.

4.12 Foster carers felt that support services could respond more quickly and were of the view that this was particularly true of the Tavistock Clinic . Such support was not always wanted by children or carers or suitable for children. Many children went once and did not go back. Although some children needed counselling, others would be more suited to mentoring. Their perception was that that both the Tavistock and CAMHS had long waiting lists and there was little support that was available below this level.

4.13 It was noted that although some of the young people who are referred might feel that they do not need or want the service, they are referred because others, for instance their carers, teachers or social workers, are worried about them.

4.14 There is currently no formal system for following up on people who have been supported by them. There are close links with social workers so there is an awareness of how many young people progress through the system but long term outcomes are not known. There are differences between children's and adults services but if emotional issues are identified at a later stage, professionals would

want to look at the earlier history of patients. It was noted that the Leaving Care team might be in the best position to co-ordinate the monitoring of long term outcomes.

Challenging Behaviour

4.15 The Panel received evidence from some foster carers that there was a need for support to address challenging behaviour by young people as it was important that they understood boundaries. Working to impose discipline on them would be better than constantly moving them. It was noted that the service did not wish to have to move children in such circumstances but had to if carers were unable to cope. Challenging behaviour could sometimes be due to the experience of trauma.

4.16 Challenging behaviour is addressed through training for foster carers. In addition, Tavistock-Haringey can also provide assistance when required. Foster carers have social workers who are able to assist them whilst LACYP have their own social workers who can also have a role in providing support. There is also guidance on the issue included in the foster carer's handbook. It is also covered as part of annual reviews.

Sexual Health

4.17 The Leaving Care team has a particular role in addressing the sexual health needs of care leavers. It currently has a sexual health clinic on site. This service had been requested by the young people and can also be accessed by their partners. Chlamidya testing and condom distribution is carried out. It is currently not clear whether it will survive the current budget cuts. Whilst budget savings are taking place, the member of staff providing this service for LACYP will still remain as part of the service.

4.18 LACYP are a priority group for work to avoid teenage pregnancies. A number of young girls who are in care aspire to be mothers from an early age and some care leavers are young mothers. The motivation for this includes a wish to create a family and to provide a child with a better start then they had been given. A proportion of them have been subject to emotional distress and some have suffered sexual abuse. Some have little interest in protecting themselves and can see parenthood as an opportunity to have something of their own. Whilst some care leavers lose their children to adoption, the Panel noted that others are very good parents.

4.19 The number of young women getting pregnant has reduced. Figures for the last financial year are as follows:

Under 16s: 4
17 next birthday: 4
18: 11
19: 3
20+: 10

4.20 The Panel noted that the service tries to influence young women to make different choices and a range of resources are available on site, including virtual babies which can be used to give young people the opportunity of experiencing the reality of childcare. Young people in care have also access to the borough teenage

pregnancy worker and the designated nurses.

4.21 The Leaving Care service also supports a number of young fathers and assists them in developing parenting skills. This can sometimes be difficult, especially where there are access issues. Efforts are made to keep young families together where at all possible. There are monthly targeted mother and toddler sessions and the partnership between nurses and families generally works well.

4.22 The Panel is concerned that the potential loss of the specific on site sexual health facility could have a detrimental effect on this vulnerable group of young people who may be less inclined to seek support and guidance if is not so readily available.

Recommendation:
That funding be retained to provide a specific sexual health provision for looked after children and care leavers, including advice on preventing conceptions.

4.23 Whilst there is currently a dedicated post to address substance abuse, it is unlikely that this post will survive the current round of budget savings. This does not mean that no service will be provided for LACYP, however, since mainstream services can be accessed instead.

Leisure

4.24 It was noted that foster carers receive a weekly allowance that is intended to cover the full range of needs. Checks are made on how the allowance is used. Although this could be more specific about levels of activity and sporting opportunities, it is not possible to ring fence any money for certain activities as allowances are subject to national parameters. In addition, around two thirds of foster carers also live outside of the borough.

4.25 The Panel noted that the Leisure Service is responsible for a wide range of facilities including parks and leisure centres. It is a universal service and does not target specific groups of individuals. However, there are specific arrangements for some groups at Tottenham Green Leisure Centre and children from residential care homes can obtain free access to the pool.

4.26 The service is aware of the fact that leisure opportunities are important to many disadvantaged groups. However, they do not want to stigmatise them by specific targeting. They instead prefer to, where appropriate, provide vouchers to partners that offer concessionary prices to specific groups of people. They can then use facilities when they wish to.

4.27 Entitlement to concessionary rates for children in care who are fostered is currently dependent on the status of their foster carer(s). No leisure services are currently provided free – they are already heavily subsidised. For example, the economic cost of a swim is £7. The service costs the Council around £2 million per year. Subsidies are set to be reduced and the service externalised. The service was concerned that if a particular group of people gained free entry, there was the danger that it would set a precedent.

4.28 There are reduced rates for the Haringey Active card offered to specific groups

within the community and discounts vary from 30% to 70%. Members of the Council had indicated that they were committed to continuing with this. The service promotes the use of its leisure centres but it accepts that they could link up better with particularly disadvantaged groups within the community, such as children in care.

4.29 The Panel notes that if leisure passes are bought for children in care the cost of these comes out of the budget for C&YPS. It is of the view that it is inappropriate for one Council service to be charging another for services to its *own children*. Allowing free access for LACYP to Council leisure centres will have little or no actual cost to the Leisure Service. It notes that it will not be easy to quantify any potential loss of income that might occur as a result of this as this is dependent on the number of LACYP who might otherwise have leisure passes funded by C&YPS.

Recommendation:
That all of Haringey's looked after children be provided with free leisure passes for Haringey leisure centres, irrespective of where they live.

4.30 The Leisure Service has no specific schemes to assist with the career development of young people who wish to work in the leisure industry. However, they work closely with the College of Haringey, Enfield and North East London who run specific placement projects. They also provide work experience for local schools. There is a substantial need for lifeguards and a rookie lifeguard scheme for under 16s is currently provided. There were further opportunities that could possibly be investigated including increasing awareness amongst staff of the needs of children in care.

4.31 The Leisure Service does not have a volunteer programme. Qualified staff are required by the service and it is essential for their qualifications to be maintained. There is a casual pool of staff who filled in on an "as and when" basis. There is generally a low turnover of staff. Volunteers are, however, used in parks. There were also opportunities outside of leisure centres. For example, sports clubs require volunteers on a regular basis and can sponsor individuals who wished to gain coaching qualifications. The service could nevertheless look at what could be done to assist in terms of work placements.

Savings

4.32 Foster carers who spoke to the Panel suggested that all children in care should be given a trust fund that the Council controlled and that they received at the age of 18. The allowance given to carers currently includes an element for savings for young people but not all carers are good at using this effectively. A trust fund could replace this. The longer that children were in care, the more money that they would get. It could also be extended to those cared for by agency carers. It was noted that the Council had looked at this option previously but it had proven to be difficult to set up.

4.33 The Panel noted that savings arrangements for LACYP were currently being reviewed and various options were being considered. Trust funds could be complex to administer but simple savings plans would not. This was due in part to the number of children and young people that passed through the Council's care. Many already had savings accounts but the service was looking to ensure there was

appropriate provision for all LACYP. There was a particular need to consult with young people on this.

4.34 The Panel is of the view the provision of a trust fund would enable there to be some consistency in the savings provision that is made for LACYP. It could also assist in ensuring that good returns on savings were achieved for all LACYP.

Recommendation:
That the element of the carers allowance intended to provide for savings for young people be "top sliced" and used to establish individual savings plans or trust funds for children in care.

5. Leaving Care

Introduction

5.1 LACYP face particular challenges when they leave care. The Children (Leaving Care) Act 2000 sets out local authorities' responsibilities to help care leavers develop a 'pathway plan' to independence with the help of a personal adviser. Assistance must currently be provided for care leavers up to the age of 21 and beyond if they are in full time education. This is shortly due to increase to 25. The expectation is that Councils should provide the support a good parent would give on housing, education, training and employment. This can make the difference between achieving independence and requiring long-term help. Whilst Councils will now have a statutory duty to keep in touch with care leavers until they are 25, parents normally remain in touch and offer help and advice to their children throughout their lifetime.

The views of care leavers

5.2 The Panel met with a group of care leavers from a range of backgrounds to obtain their views on the issues that faced them on leaving care. All had been fostered and none adopted. Several of them were still in touch with foster carers and some still regularly visited them. The length of placements varied and there were often a number of social workers that they had contact with. The majority of them were currently in higher education. The following points were raised:

- The experience of being in care could affect their outlook on life. There was not much opportunity to talk about this. Support from social workers was good but sometimes they were over stretched. Young people got less attention as they got older but they still felt that they needed someone to provide support and guidance. Social workers were only available to provide support for them during the day and not out-of-hours.

- People could be wary of them and they were often reluctant to disclose that they had been in care because of this. Sometimes people were not aware that how they responded could be upsetting. Their reluctance to disclose could be a limiting factor on friendships as it meant that they put up barriers and were wary of becoming too close to people. They felt more able to be open with other people who had been in care. They were able to look after themselves and had adapted to being in care. They had learnt to be independent from an early age.

- Care leavers were frequently affected by loneliness and lack of social contact. There was nowhere for them to meet other people from a similar background and socialise. They met in cafés occasionally but this cost money. Although there were youth clubs, these cost money to attend which put them off going. In addition, youth clubs could be dangerous places due to the post code rivalries that existed. Just wearing the wrong clothes could result in trouble.

- Some of the accommodation that they were given was not regarded as being very good. Although they were given £500 to help them settle in, this was not felt to be sufficient. They were given some information and advice about housing but felt that more assistance could be provided. It could be hard to make ends meet and it was easy to get into debt.

- They thought that they could be better prepared for leaving care through being given more explanation of life outside of care and what they would need to do. The sudden change could be traumatic and could happen when people were still very young.

- It could be tough being in higher education. Bills and travel costs had to be met and the student loan was not enough to cover these. It was particularly difficult for them to go to university outside of London as they would lose their home. It was noted that local authorities were now required to assist with this. A bursary was now available which amounted to around £2,000 over the period of the course. The young people had not been aware of this. The current situation meant that most young people in their situation would not go to university outside of London.

- They would all be interested in acting as mentors for other young people coming out of care. A mentoring scheme would be beneficial as young people might be more inclined to listen to advice from their peers.

Preparations for Leaving Care

5.3 The Panel received evidence on how young people were prepared for leaving care and supported once they became independent. The Leaving Care and Asylum Service works with young people between 16 and 21 and provides personal advisers and an after care service. Their work includes preparing pathway plans, which help to prepare young people for the transition to adulthood. These are holistic and include reference to their families as well as education and employment and housing issues. In addition, they also deal with both practical and emotional issues. Residential social workers assist young people who are placed in Children's Homes to develop their life skills.

5.4 The Panel noted that foster carers have a specific role in helping young people to prepare for leaving care. Care leavers are currently given £52 to live on and, to assist with this, they are taught budgeting skills. However, foster carers that gave evidence to the Panel felt that young people could sometimes not be prepared for the range of costs associated with independence, such as heating and lighting.

5.5 There is a range of accommodation options for young people who leave residential care at 16. If they are felt to be in substantial need, foster care was found. However, some young people are in residential care as they cannot cope with foster care. Permanent accommodation is normally found when a young person is 18, although exceptions can be made if further support is needed. Accommodation is normally social housing.

5.6 The Leaving Care team undertake work with particularly challenged young people. Whilst some young people cope very well with the transition, others struggle. In particular, some have mental health issues and, in such circumstances, links need to be developed with adult social care as well as mental health services. Care leavers can have problems with relationships and struggle to make friends.

5.7 The transition of support from C&YPS to Adults tends to be smoother if the referral takes place before the age of 18. The lack of a diagnosis can be a barrier to this but they did not wish to unnecessarily stigmatise young people. Efforts are currently

being made to improve the transition process. Once young people were known to Adults, there could be difficulties in engaging with them as there was a tendency for some to not turn up for appointments. C&YPS staff had to persuade them to attend in such circumstances.

5.8 The Cabinet Member for Children and Young People felt that the practical needs of care leavers were addressed well. Housing support was particularly effective with care leavers placed in the highest priority band for housing. Young people could be accommodated in a wide range of accommodation including some that was semi independent. All young people received specific guidance on finance and budgeting and there was also input from health partners.

5.9 The Panel noted that many care leavers take advantage of the services provided by Connexions and the Youth Service. The services have access to a young persons counselling service and can make referrals for mental health issues, substance abuse, trauma and other issues. Targeted support is available for young people at risk of offending.

Employment and Training Opportunities

5.10 The main purpose of Connexions is to help young people into employment and training. Although it is a universal service, much of its work is targeted. The service also receives referrals. The support that can be provided is generally of a light touch but more intensive assistance can be provided if need be. Individuals can be passed onto specialist advisers or referred to other services if necessary. The service is proactive in making contact with young people before the age of 16 and has good sources of information. All young people are tracked until the age of 19. The relationship with young people is nevertheless purely voluntary. Particular attention is given to young people not in education or employment (NEETs). The service works intensely with them and helps with things like the preparation of CVs. They liaise closely with Job Centre plus and Housing.

5.11 Connexions was funded by the Department of Education through Area Based Grant. However, this ended in March 2011. The Youth Service receives core funding but Connexions would have to revert back to being the Careers Service. Funding for the additional services that had been provided has been moved back to schools. Funding for career guidance for young people in care is to be given to schools but the Panel noted that they can pass it back to Connexions if they wished. The Panel is of the view that, where possible, all schools should be strongly encouraged to do this.

5.12 Careers education can also be undertaken as part of the school curriculum. The Panel noted that the Connexions worker in the Leaving Care team is to be lost and there is concern about the implications of this as it would make such assistance less accessible for care leavers.

Recommendation:
That all schools be encouraged to repatriate funds provided from central government for careers guidance for LACYP to either Connexions or C&YPS and that, if successful, this be used to provide a dedicated worker providing careers advice for LACYP.

5.13 The Panel also heard evidence on the Haringey Guarantee scheme, which is aimed at people above the age of 16 to help them get into sustained employment. The aim is to remove any barriers to finding work. An action plan is developed that aimed to not only get people into work but to enable them to stay in work. The scheme provides employment advisers and wrap around services. Training opportunities can be provided in a wide range of areas such as social work, security, construction and fashion. Support is also given to people who want to establish their own businesses. There are very good relations with Tottenham and Wood Green Job Centre plus as well as Connexions, who can refer to the scheme. The Panel noted that the future of the scheme in its current form was uncertain. However, it is likely that the opportunities that it provides will still be available in some form.

5.14 Job Centre Plus deals with young people with a wide range of needs. It is a universal service and they will not normally be aware that someone is a care leaver. There are close links with both the Haringey Guarantee scheme and Connexions. Some care leavers can be particularly attracted to a career in the armed services as it could appear to be an extension of the care background.

Housing

5.15 Care leavers above the age of 18 are considered for permanent housing when their placements end. Care leavers are given 'reasonable preference' under the Council's allocations policy. Approximately 1,000 households are re-housed into social housing each year, including roughly 200 who are re-housed in one bedroom flats. There are currently around 20,000 people on the Council's housing register. A new policy is shortly to be introduced which will see the end of the points system. It will instead place people into bands according to their level of need. A quota of care leavers (currently set at 50) will be placed in band A, which is the highest level of need. This normally means that they are re-housed in a matter of weeks/months rather than a longer period. The quota of 50 lets for care leavers will be reviewed each year to ensure that it is consistent with actual demand. The Panel noted that the Leaving Care team advise young people on what was the best option for them.

5.16 In situations where young people are placed out of borough, the responsibility to re-house them rests with the home borough. If they wish to re-locate to where they have been placed, they need to approach the Council in that area for assistance and, if necessary, make a homeless application. Alternatively, help can be given to them in finding private rented accommodation in that area. It is possible for young people to defer their right to be re-housed until after university if that is agreed in advance between the Housing Service, Leaving Care and the young person.

5.17 A social housing map is available that shows the location of properties, the nature of the area and what is available. If particular issues have been identified with a property, a decision can be made not to offer it to a young person and to deal with it as a "sensitive let". The service has someone who can assist people in bidding for properties and is able to look out for suitable properties for them. The Housing Support service stated that consideration could be given to providing a specific resource for care leavers. In addition, they felt that support could be improved by starting to work with the young person at an earlier stage in order to increase the opportunity for planned moves and a smooth transition.

Recommendation:
That enhanced support be developed to assist care leavers with finding and maintaining accommodation and that this include support being provided from an earlier stage and a specific resource to assist them in bidding for properties.

5.18 The Panel noted that some LACYP apply for universities outside of London. In such circumstances, social housing allocation will nevertheless be in Haringey. If LACYP return home to their foster carer during holidays, then an allowance is payable. If they opt to stay in halls of residence, their rent will be paid. It is currently beyond the power of any local authority to swap entitlement to social housing via a reciprocal arrangement with another local council. It is acknowledged though that this can be an issue of some LACYP, particularly where they have not received a permanent offer of housing before going to university. Concerns relating to this were raised by both the foster carers and the care leavers that the Panel received evidence from. It is apparent that this issue may be deterring some care leavers for applying for universities outside of London.

5.19 The Panel notes that a semi independent care scheme is being developed. A specification has been designed and the intention was to go out to tender shortly. Discussions were taking place housing regarding the provision of floating support. The Panel supports the setting up of a specific scheme and is of the view that it has the potential to be of benefit to young people between 16 and 19 who might not be completely ready for full independence.

Recommendation:
That a policy be developed on semi-independent living for looked after children between 16 and 19.

Emotional Support

5.20 The Cabinet Member for Children and Young People had particular concerns about emotional support. Care leavers could become very vulnerable and loneliness was a big problem. Most young people were still living at home at the age that young people left care. They therefore did not have the same support networks. Two young care leavers had died in the previous year. It was unclear whether these cases were suicide or neglect but care leavers were a high risk group. There were particular challenges in meeting the needs of young people who came into care as teenagers, such as those affected by the implications of the Southwark judgement. These young people could be very damaged.

5.21 She felt that one option that could be explored was mentoring, which some other local authorities had set up. She had asked the Leaving Care Service to consider how emotional support could be improved and a report is being prepared for the Corporate Parenting Advisory Committee. Although peer support could be developed, some young people did nevertheless not wish to be defined as being in care.

5.22 The Panel notes the views of both care leavers and the Cabinet Member in respect of emotional support. It welcomes the development of a mentoring scheme as a means of supporting care leavers. In particular, it feels that a mentor who is able to

follow a young person for a sustained period of time would be especially beneficial.

Recommendation:
That initiaitives to improve emotional support for care leavers and the development of a specific mentoring scheme for care leavers be strongly supported that a report on progress be submitted to the Overview and Scrutiny Committee in due course.

5.23 The Panel has noted that there is a lack of means of monitoring long term outcomes for LACYP. It is, however, mindful of the practical difficulties that exist in tracking people over a longer period of time as it can only be done on a voluntary basis. In addition, there is a greater likelihood of young people who have been successful remaining in voluntary contact as opposed to those who may have encountered challenges or difficulties.

5.24 It is nevertheless of the view of the Panel that more information on outcomes would help to better inform future service planning. There remains a concern that a small amount of additional contact, or input into the lives of care leavers into their 20s, could return long-term lifestyle benefits for them. The law now instructs Council's to do this and Haringey is complying. In addition, it could also provide a potential pool of sources of support and guidance for future care leavers, many of whom may be without immediate family to assist.

Recommendation:
That enhanced systems for monitoring of long term outcomes be developed and in particular the progress of NEETs, and that a practical way for remaining in contact with vulnerable care-leavers into their 20s be developed.

Appendix A

Participants in the review:

Debbie Haith - Deputy Director for Children and Families, Children and Young People's Service (C&YPS)
Attracta Craig - Virtual School Head, C&YPS
Chris Chalmers - Head of Service, Children in Care, C&YPS
Emma Cummergen - Senior Team Manager, Leaving Care and Asylum Team, C&YPS
Louise Jones - Head of Integrated Youth Support, C&YPS
Andy Briggs - Head of Sport and Leisure, Adults, Culture and Community Services
Wendy Lobatto - Manager, Tavistock - Haringey Service
Judy Mace - Haringey Designated Nurse for Children in Care, Bounds Green Health Centre
Paul Clarke – Programme Manager Employment and Skills, Urban Environment
Denise Gandy - Head of Housing Support and Options, Urban Environment
Helen Smith - Job Centre Plus
Councillor Lorna Reith - Cabinet Member for Children and Young People and Councillor Rachel Allison - Opposition Spokesperson for Children and Young People
A group of foster carers
A group of care leavers

Appendix B

Documents referred to in the preparation of this review report:

The Role of Councillors as Corporate Parents – Rotherham MBC Lifelong Learning Opportunities Scrutiny Panel
Aspects Of The Council's Corporate Parenting Responsibilities – Middlesbrough Children and Learning Scrutiny Committee

Children Looked After by Camden – Camden Corporate Parenting Scrutiny Committee
Children and Young People's Strategic Plan – Haringey Council
The Role of Councillors as Corporate Parents – Wakefield MDC Children's Services Scrutiny Working Group
If This Were My Child – A Councillors Guide to Being a Good Corporate Parent – Department for Education and Skills/LGiU
Show Me How I Matter; A Guide to the education of Looked After Children – LGA/IdEA
London Borough of Greenwich Phase Three Corporate Parenting Review

Agenda Item 12

Haringey Council

Overview and Scrutiny Committee **On Monday 9th May 2011**

Report Title: **Health: Everyone's Business**	
Report of: **Councillor Gideon Bull, Chair of the Overview and Committee**	
Contact Officers : Melanie Ponomarenko/Jodie Szwedzinski Email: Melanie.Ponomarenko@haringey.gov.uk / Jodie.Szwezinski@haringey.gov.uk Tel: 0208 489 2933/2405	
Wards(s) affected: **All**	Report for: **[Key / Non-Key Decision]**

1. Purpose of the report (That is, the decision required)

1.1. That the Overview and Scrutiny Committee approve the recommendations laid out in the attached report.

2. Introduction by Cabinet Member (if necessary)

2.1. N/A

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. This review links with the Sustainable Community Strategy Outcomes of:

- Healthier people with a better quality of life, specifically:
  - Tackle health inequalities

4. Recommendations

4.1. Recommendations are laid out in the attached report.

5. Reason for recommendation(s)

5.1. Reasons for the recommendations laid out in the main report are covered within the main body of the attached report.

6. Other options considered

6.1. N/A

7. Summary

7.1. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. Following an external audit by Grant Thornton the Overview and Scrutiny Committee held its first 'Health: Everyone's Business' event in 2008. This event highlighted the wider determinants of health and their links to health inequalities as well as emphasising the role that each Thematic Board under the Haringey Strategic Partnership has in tackling health inequalities in Haringey.

7.2. Since this event the Overview and Scrutiny Committee have continued to be actively involved in work around health inequalities, and were commended on this work by the Health Inequalities National Support Team in their feedback in 2009.

7.3. In late 2010 the Overview and Scrutiny Committee, in conjunction with the Well-Being Partnership Board, held a follow up event focusing on three specific areas where it is felt there are significant health inequalities in the borough and where the Committee felt value could be added by it's involvement along with a range of other stakeholders. Dr Lynne Friedli attended as the key speaker.

7.4. This event focused on three areas:

- Mental Health
- Tobacco Control
- Physical Activity

7.5. These areas formed the focus of group discussions with the following questions.

- What should we as a partnership be doing that we aren't doing?
- What could we as a partnership be doing differently?

7.6. In response to the above questions key messages were collated from each group. These include:

Mental Health:

- Increased community education of mental health and further support for children with mental health issues

- Prevention
- Increased community education and support of mental health

Tobacco Control:
- Advantages of brief interventions
- Ethnic and cultural targeting according to prevalence
- Support/Social networks

Physical Activity:
- Walking-based initiatives
- Interventions targeting children
- Closer partnership working with providers of sport/physical activity initiatives

7.7. This report provides best practice examples and cost effective interventions linked to the key messages of the event.

8. Chief Financial Officer Comments

8.1. To Follow

9. Head of Legal Services Comments

9.1. To Follow

10. Head of Procurement Comments – [Required for Procurement Committee]

10.1. N/A

11. Equalities & Community Cohesion Comments

11.1. Haringey has a high burden of mental illness and the needs of east and west Haringey are reflected by their demographic differences. There are more patients with dementia in West Haringey which has a greater proportion of older people. In the East of Haringey there are more people with common mental illnesses. It is likely that both dementia and common mental illnesses (particularly depression) are under-diagnosed.

11.2. The mental health problems are related to a variety of socio-economic conditions and within east Haringey there are greater levels of deprivation, poorer housing and a wider variety of socioeconomic groups which lead to greater health inequalities.

11.3. Modelled smoking prevalence data derived from the Health Survey for England (2006/08), predicts that Haringey has a current smoking prevalence of 24.1%, compared with 20.8% in London and 22.2% in England. The figures for 2003/05 were released to Middle Super Output Area (MSOA) level. Highest smoking prevalence of between 29% and 33% was predicted for MSOAs in Noel Park,

Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

11.4. 17.7% of residents registered with a GP in Haringey were recorded as smokers as at March 2009. Smoking rates were lowest in the West Neighbourhood (15.4%) and highest in the North East Neighbourhood (19.9%).

11.5. In the UK there are significant inequalities in levels of physical activity in relation to age, gender, ethnicity and disability, and corresponding inequalities in health. For example, in Haringey white adult populations are more active than non-white adults, men tend to be more active than women, younger people are more active than their older counterparts and activity levels are lower in those who have a limiting illness or disability.

12. Consultation

12.1. A wide range of stakeholders were consulted at the 'Health: Everyone's Business' event. These included Age Concern Haringey, Crucial Steps, BEH Mental Health Trust, NHS Haringey, Haringey Council departments, Polar Bear, Middlesex University, Whittington NHS Trust, Cabinet Members and Non-Executive Members.

12.2. The Public Health Department has been consulted in the writing of this report.

13. Use of appendices /Tables and photographs

11.2 Please see Contents page in main report for appendices

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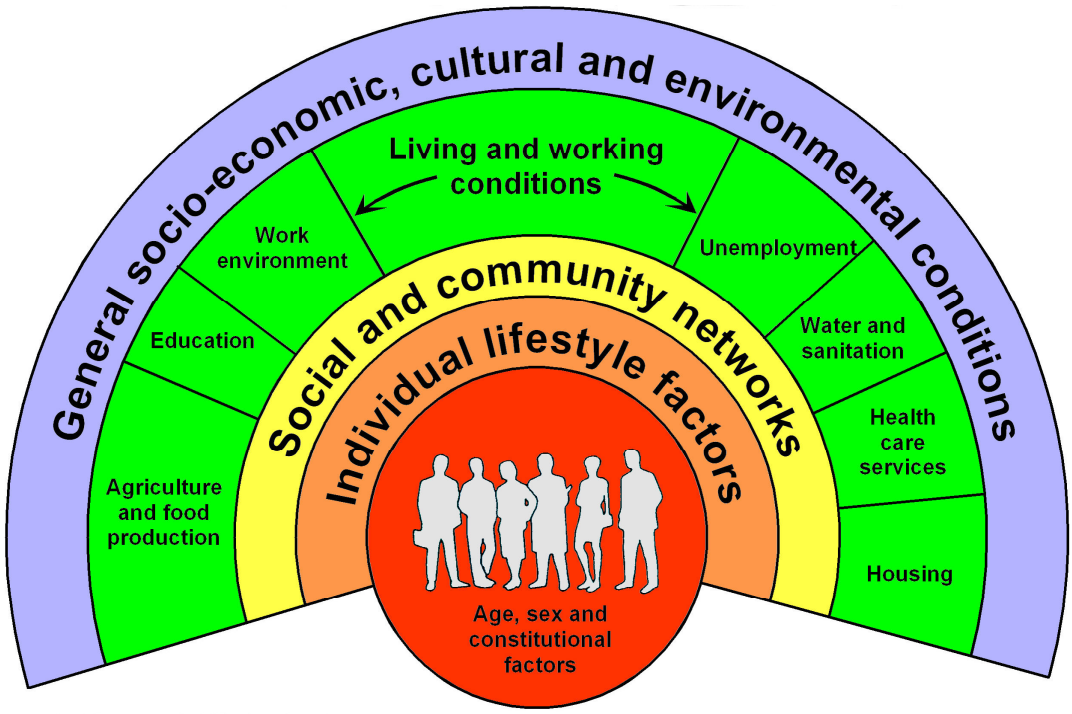
Haringey Council

Health: Everyone's Business (2010)



Source: Dahlgren and Whitehead, 1991

A REPORT OF THE OVERVIEW AND SCRUTINY COMMITTEE

March 2011

www.haringey.gov.uk

Chair's Foreword

I am pleased to present the report of the second 'Health: Everyone's Business' event on tackling health inequalities in Haringey. The Scrutiny Committee became involved in health inequalities back in 2008 when we hosted the first of these events in order to raise awareness of the importance of working together across the partnership to tackle health inequalities in the borough.

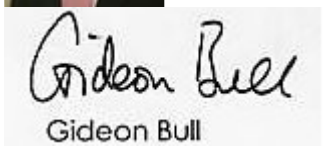
Although commonly considered factors such as access to and use of health care services have an impact on health and well-being, they are also determined by individual circumstances and the local environment. Factors such as where people live, income, education, life experiences, behaviours and choices and relationships with friends and family all have an impact.

All of these health determinants can be influenced by the work of the local authority and its partners. This is why I believe that it is crucial to work openly and collaboratively with all our partner agencies and the third sector, particularly as Haringey, in common with other local authorities, assumes responsibility for Public Health in the borough.

I would like to thank all of those stakeholders who attended this very interesting event, as well as Officers both in the Council and in Public Health and also the Well-Being Partnership Board who worked jointly with the Overview and Scrutiny Committee to make the event a success.

I would particularly like to thank Dr Lynne Friedli who attended as our key note speaker and presented the attendees with some very thought provoking information.

I look forward to working further on this challenging yet very important topic.



For further information:

Melanie Ponomarenko/Jodie Szwedzinski
Policy, Intelligence and Partnerships
7th Floor River Park House
High Road
Wood Green N22 4HQ
Tel: 020 8489 2933/2405
Email: Melanie.Ponomarenko@haringey.gov.uk
Jodie.Szwedzinski@haringey.gov.uk

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Appendices

1. Executive Summary

1.1. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. Following an external audit by Grant Thornton the Overview and Scrutiny Committee held its first 'Health: Everyone's Business' event in 2008. This event highlighted the wider determinants of health and their links to health inequalities as well as emphasising the role that each Thematic Board under the Haringey Strategic Partnership has in tackling health inequalities in Haringey.

1.2. Since this event the Overview and Scrutiny Committee have continued to be actively involved in work around health inequalities, and were commended on this work by the Health Inequalities National Support Team in their feedback in 2009.

1.3. In late 2010 the Overview and Scrutiny Committee, in conjunction with the Well-Being Partnership Board, held a follow up event focusing on three specific areas where it is felt there are significant health inequalities in the borough and where the Committee felt value could be added by it's involvement along with a range of other stakeholders. Dr Lynne Friedli attended as the key speaker.

1.4. This event focused on three areas:

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- Tobacco Control
- Physical Activity

1.5. These areas formed the focus of group discussions with the following questions.

- What should we as a partnership be doing that we aren't doing?
- What could we as a partnership be doing differently?

1.6. In response to the above questions key messages were collated from each group. These include:

Mental Health:

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- Advantages of brief interventions
- Ethnic and cultural targeting according to prevalence
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Physical Activity:

- Walking-based initiatives
- Interventions targeting children
- Closer partnership working with providers of sport/physical activity initiatives

1.7. This report provides best practice examples and cost effective interventions linked to the key messages of the event.

2. Recommendations

1. That the OSC hold a further 'Health: Everyone's Business' event in 2011/2012.

2. That the Health Inequalities Cross Party Working Group note this report and utilise it as part of their evidence base.

3. So that awareness of the Health Inequalities agenda is embedded in all of Haringey's policies and services, the report should be distributed to all heads of business units, appropriate partner agencies and third sector organisations.

4. That the appropriate partnership group identify what is already being done locally to tackle health inequalities and consider where best practice identified in this paper may apply.

3. Health: Everyone's Business

3.1. Overview and scrutiny has a specific role in relation health inequalities as part of its health scrutiny powers. These powers have been used regularly in looking at inequality in terms of access to healthcare. Following an external audit by Grant Thornton the Overview and Scrutiny Committee held its first 'Health: Everyone's Business' event in 2008. This event highlighted the wider determinants of health and their links to health inequalities as well as emphasising the role that each Thematic Board under the Haringey Strategic Partnership has in tackling health inequalities in Haringey.

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- What should we as a partnership be doing that we aren't doing?
- What could we as a partnership be doing differently?

3.6. In response to the above questions key messages were collated from each group and these have been further explored in the main body of this report by way of best practice examples. The report provides further information on cost

effective interventions. The report also provides an overview of the demographics and health inequalities associated with each of the above areas. It should be noted that the best practice examples are only a sample of best practice available and a starting point for further investigation.

4. National and Local Policy Context

4.1. Healthy Lives, Healthy People - Public Health White Paper

4.1.1. The White Paper 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.

4.1.2. 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.

4.1.3. 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.

4.1.4. 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.

4.1.5. 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.

4.2. Marmot review- 'Fair Society, Healthy Lives'

4.2.1. 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 the 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 from the review were:

1. The reduction of health inequalities is reliant on fairness and social justice being achieved. Evidence suggests that in England, many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
2. Further evidence points to the fact 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.
3. 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.
4. The reduction in the steepness of the social gradient in health should include actions which are universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism. Therefore

showing that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
5. 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.
6. Statements were made to stress the point that economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Reducing health inequalities will require action on six policy objectives (See below)
8. 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.
9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

4.2.2. 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

4.3. **Marmot indicators for Local Authorities in England**

4.3.1. To mark the one year anniversary since the publication of 'Fair Society, Healthy Lives' the London Health Observatory and Marmot Review Team have 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*:*

- Male life expectancy
- Female life expectancy
- Slope index of inequality (SII) for male life expectancy
- Slope index of inequality (SII) for female life expectancy
- Slope index of inequality (SII) for male disability-free life expectancy
- Slope index of inequality (SII) for female disability-free life expectancy
- Children achieving a good level of development at age 5
- Young people who are not in education, employment or training (NEET)
- People in households in receipt of means-tested benefits

- Slope index of inequality for people in households in receipt of means-tested benefits

The Haringey Indictor set can be found at Appendix E

4.4. **London Health Inequalities Strategy**

4.4.1. 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.

4.4.2. 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.

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

4.5.1. 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.

4.5.2. 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 mentions include 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.
- Generate a planned communication programme to increase positive attention on health issues, starting with HIV and mental health (in order to reduce stigma).
- Work with NHS to scale up approaches to building capacity in Voluntary and Community Sector to deliver physical activity services.

4.6. **Health Inequalities National Support Team (HINST)**

4.6.1. The Department of Health Inequalities National Support Team (HINST) visit took place in Haringey from the 5th to the 9th October 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

4.7. **Infant Mortality National Support Team (IMNST)**

4.7.1. The Department of Health Infant Mortality National Support Team (IMNST) visited Haringey in January 2010. The Team identified examples of good practice and strengths in Haringey, and also made a series of recommendations to be taken forward in the revised partnership Haringey Infant Mortality Strategy.

The IMNST identified the top 5 take home messages for Haringey:

1. Vision and Strategy
In order to keep the vision relevant and maintain momentum:

- NHS Haringey and partners to consider how they can communicate to all staff who contribute to the Infant Mortality Strategy regarding their role and responsibility, and progress on reducing infant mortality.
- Build on the commitment to increase the focus on early intervention and prevention and its critical role in implementation of the Infant Mortality Strategy

2. Commissioning

- The Children's Trust Joint Commissioning Group to explore and develop opportunities to strengthen commissioning arrangements with respect to universal and targeted interventions.

3. Communications
Further strengthen:

- Communication across and between organisations in Haringey
- Communication with the many and diverse population groups and individuals.

4. Community Engagement

- Adopt a strategic approach that integrates the efforts and resources of Haringey Council and NHS Haringey. The risk factors for infant mortality should be embedded in this approach.

5. Workforce, Capacity and Training
A small task and finish group to be established led by Haringey Children's Trust, to:

- Identify where skills need updating and develop training plans
- Spread the existing good practice in Haringey in relation to skill mix and stratification of resources i.e. matching the right skill to the particular needs of the population and service.
- Ensure that the workforce resource is allocated according to local need and priorities.

4.8. **Haringey**

4.8.1. 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[1], 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.

4.9. **Health Inequalities Cross Party Working Group**

4.9.1. A Health Inequalities Cross Party Working Group has been 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.

4.9.2. The proposed objectives of this group are:

- "Evidence base – consider current priorities for tackling health inequalities and identify gaps in knowledge.
- Resources - Identify areas where resources are available and those where programmes have ended as funding has been withdrawn.
- Priorities – determine the priorities on which to focus, ensuring they are integrated with Council policies.
- Recommendations – Make proposals to CAB
- Action – Participate in ensuring that Group's work informs the development of the Health and Well Being Strategy."[2]

5. Social Prescribing

5.1. The advantages of social prescribing emerged as a cross-cutting issue in each of the group sessions. Participants felt that social prescribing could be applied for a wide range of lifestyle choices.

5.2. There is also good evidence of effectiveness in relation to alcohol, where a review of six published studies suggests that between 5 and 10 minutes of advice from GPs to patients with harmful alcohol consumption leads to reductions in consumption of around 25-35% at follow-up six months or a year later[3].

5.3. While the evidence in relation to diet and exercise is less strong, in all these areas only a very low level of effectiveness is needed to make the intervention cost-effective, given the scale of potential benefits and the very modest cost of GP advice.

6. Mental Health

6.1. Key themes which emerged from the Mental Health groups were

- Increased community education of mental health and further support for children with mental health issues
- Prevention
- Increased community education and support of mental health

6.2. **Demographics**

6.2.1. Haringey has a high burden of mental illness and the needs of east and west Haringey are reflected by their demographic differences. There are more patients with dementia in West Haringey which has a greater proportion of older people. In the East of Haringey there are more people with common mental illnesses. It is likely that both dementia and common mental illnesses (particularly depression) are under-diagnosed.

6.2.2. The mental health problems are related to a variety of socio-economic conditions and within east Haringey there are greater levels of deprivation,

poorer housing and a wider variety of socioeconomic groups which lead to greater health inequalities.

6.2.3. In 2010 Haringey was the 13th most deprived borough in England and the 4th most deprived borough in London[4]. Deprivation is not evenly distributed across the borough with areas in the east of the borough experiencing much higher levels of deprivation than the west. Psychiatric morbidity (including anxiety, depression, schizophrenia and psychotic disorders) is known to be associated with social deprivation. Social deprivation is also known to result in longer duration of illness episode, higher risk of relapse, poorer treatment response and clinical outcome.

6.2.4. In Feb 2011, 6.9% (10,159) of the working age population were claiming Job Seekers Allowance (JSA). This includes 7.9% of all working age males and 4.7% of working age females. All three rates are the third highest in London. Unemployment affects mental health especially anxiety and depression, and increases the risk of suicide and self-harm. Unemployment is not evenly distributed across the borough. In Feb 2011, 11.6% (1026) of the working age population in Northumberland Park were claiming JSA. This is the highest ward in London. Duration of unemployment is also an important predictor of psychiatric morbidity. In August 2010, 79.6% of Haringey residents claiming Income Support had been claiming for over 2 years.

6.2.5. Housing and homelessness is an important determinant of mental health. Higher prevalence of mental illness has been found in homeless people or in people in insecure accommodation. Haringey is tackling a serious homelessness challenge. As at 31st December 2009 there were 3,800 households in temporary accommodation. This had reduced to 3,547 by 31st March 2010, a reduction of 22% on 2008/09.

6.3. **Key Health Inequalities**

6.3.1. **Mental health in black and minority ethnic groups**

6.3.1.1. Some black and minority ethnic groups have a higher risk of suicide, psychotic illness and hospital admissions. It is likely that there is significant under-diagnosis in this group of patients due to a variety of cultural and social factors. There is evidence that Black Caribbean ethnic groups are at higher risk of being admitted to psychiatric hospital than White ethnic groups. In Haringey 9.5% of residents are of Black Caribbean origin. This proportion is higher than that predicted for London and nationally.

6.3.2. **Dementia and depression in older patients**

6.3.2.1. Older people make up a significant percentage of Haringey's population. According to the 2009 ONS Mid-Year Estimates, it was estimated there were 21,200 people aged 65+ in Haringey, making up approximately 9.4% of the total population.

6.3.2.2. Depression in elderly people is most often related to social isolation, lower levels of deprivation and chronic medical problems. In Haringey, 2,363 people aged 65+ are predicted to have depression and 741 predicted to have severe depression by 2030.

6.3.2.3. According The Audit Commission's 'Forget me Not' report, one quarter of people aged 85 and over will develop dementia. By 2030, it is estimated that 1,796 people aged 65+ in Haringey will have dementia.

6.3.3. **Refugees and Asylum Seekers**

6.3.3.1. There is evidence that refugees and asylum seekers are especially vulnerable to psychiatric disorders including depression, suicide and post-traumatic stress disorder. It is estimated that between 25 and 30,000 refugees and asylum seekers live in Haringey. This group also has more complex needs and often have more difficulty accessing health services than the general population.

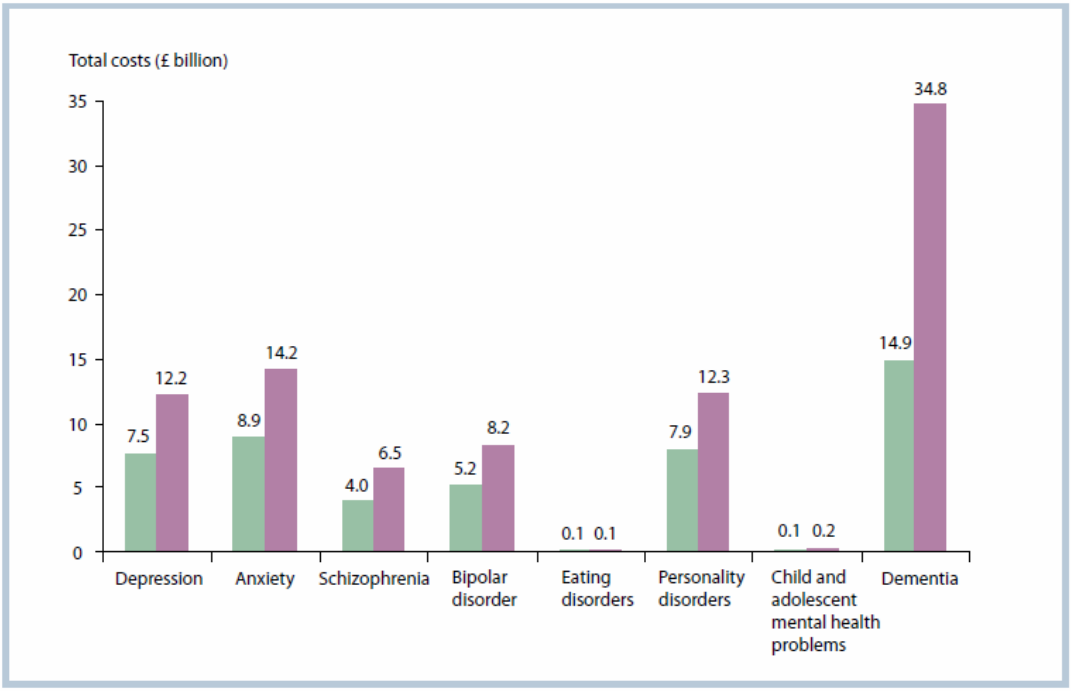
6.3.4. **Mental health care for people with substance misuse problems**

6.3.4.1. There is an established link between mental illness and substance misuse. There are a number of crack and opiate users in Haringey; the latest estimated prevalence is 2,666. A significant majority use crack (80%; 2,141) but, partly due to our specialist stimulant service Eban, commissioned in 2007, Haringey had the sixth highest proportion of crack users in treatment between 2006/07-2008/09 in London (NTA:2010). The estimate for opiate users in 2008/09 was 1,936. This data, suggests that a poly use of crack and opiates is common, a trend by no means unique in comparison to the rest of London. Problem drug use mirrors geographical deprivation with most residing in the more deprived and densely populated north east of the borough, higher levels of mental ill health and poor housing conditions, and a higher likelihood of involvement in acquisitive crime. At least 60 different nationalities were represented in treatment last year and a vast majority were non white British (65%). Women made up a quarter of the drug treatment population in 2008-9, a proportion on par with national and regional averages.

6.3.5. **Projected costs of poor mental health**

6.3.5.1. Figure 1 below is adapted from a report published three years ago that looked at how the costs of mental health problems might change over a 20-year period. For each of eight mental health disorders (depression, anxiety, schizophrenia, bipolar disorder, eating disorders, personality disorders, child and adolescent mental health problems, and dementia), Figure 1 shows the costs of mental health problems in 2007 and the expected costs in 2026 if treatment and support arrangements remain unchanged, and if impacts on, for example, employment patterns also remain unchanged. The projections also assume that the proportion of mental health needs that are recognized and treated remains the same. The projections clearly show a substantial increase in the impact of mental health problems on the economy under current treatment and care arrangements. It is debatable whether such an increase would be widely seen as affordable.

Figure 1: Current and projected future costs by mental health disorder, England 2007, 2026



Source: McCrone, Dhanasiri, Patel, Knapp, Lawton-Smith. *Paying The Price*. London: King's Fund, 2008.

6.4. Examples of Best Practice based on the workshop key messages

Increased community education of mental health and further support for children with mental health issues

6.4.1. Parenting interventions for the prevention of persistent conduct disorders (For further details see Appendix C)

Conduct disorders are the most common childhood psychiatric disorders, with a UK prevalence of 4.9% for children aged 5–10 years.[5] The condition leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.[6]

The intervention

Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour. [7]

Key points

- Parenting programmes are cost-saving to the public sector, and to the NHS alone, over the long term, with the main benefits accruing to the NHS and criminal justice system.
- When the wider costs of crime are included, total gross savings over 25 years exceed the average cost of the intervention by a factor of around 8 to 1.

Prevention

6.4.2. **Workplace screening for depression and anxiety disorders (For further details see Appendix C)**

Substantial economic costs arise for employers from productivity losses due to depression and anxiety in the workforce.

The intervention

Workplace-based enhanced depression care consists of completion of a screening questionnaire by employees, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks.

Key points

- The intervention is cost-saving from the perspectives of both business and the health system, on the assumption that all costs are borne by business.
- The costs of the intervention are more than outweighed by gains to business due to a reduction in both presenteeism and levels of absenteeism.
- Public sector employers also have the potential to benefit from investing in universal workplace depression and anxiety screening interventions.

6.4.3. **Debt and mental health (For further details see Appendix C)**

Research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.[8]

The intervention

For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable,[9] while telephone services achieve 47%[10]. In comparison, around one-third of problem debt may be resolved without any intervention.

Key points

- In nearly all modelled scenarios, at least one type of debt management intervention has better outcomes and lower costs over a two-year period compared to no action.
- For greatest cost-effectiveness, careful consideration needs to be given to models of financing and to the mix between face-to-face, telephone and web-based provision.

6.4.4. **Collaborative care for depression in individuals with Type II diabetes (For further details see Appendix C)**

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression,[11] while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression.[12]

The intervention

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type II diabetes who screen positive for depression, compared with care as usual.

Key points

- The intervention is cost-effective after two years, but has high net additional costs in the short term due to implementation costs.

- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

6.4.5. Increased community education and support of mental health

Good support networks and social support are well recognised as important for preventing mental health problems. NICE, in a review of public health interventions to promote positive mental health and prevent mental health disorders among adults, emphasizes the importance of social support.[13] In particular, they noted that trust in the community has been found to predict psychological distress[14]. As such, interventions aimed at promoting mental health could focus on building trust in the community

Community mental health services can improve the social support of isolated and excluded people in the community through 'befriending' or 'one-to-one support' services. Local authorities can assist these organisations in making the community aware of their services. Local authorities can also assist by supporting local community events such as street parties where people can get to know their neighbours. Supported access to information involves primary care staff providing details about voluntary agencies, self-help groups, leisure, sporting, cultural and educational activities within the community (Blastock et al, 2005).

6.4.6. Befriending of older adults (For further details see Appendix C)

Befriending initiatives, often delivered by volunteers, provide an ‘upstream’ intervention that is potentially of value both to the person being befriended and the ‘befriender’. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness;[15] for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

The intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural relationship develops between the participants, who will usually have been matched for interests and preferences.

Key points

• Befriending interventions are unlikely to achieve cost savings to the public purse, but they do improve an individual’s quality of life at a low cost.

• The targeting of at-risk groups (e.g. older people discharged from hospital or mothers at risk of post-natal depression) would potentially offer better returns on an investment in befriending, and this could be explored through further research.

7. Tobacco Control

7.1. Key themes which emerged from the Tobacco control group were:

- Brief interventions
- Ethnic and cultural targeting according to prevalence
- Support/Social networks

7.2. Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between socio-economic groups. It has long since been acknowledged by national bodies that smoking is harmful to the nation's health and that targeted methods are needed to help people stop smoking. These have included the Tobacco control legislation that prevented smoking in public places in 2007 (extended to include mental health services in 2008).

7.3. Reducing prevalence is a key priority in improving the health of the population in Haringey, particularly in the more deprived areas where smoking rates tend to be higher.

7.4. **Cost and deaths related to smoking**

7.4.1. It has been estimated that smoking costs the health service over £5 billion per year.

7.4.2. The report Tobacco in London: the preventable burden indicated that in Haringey in 2001 there were 260 deaths related to smoking and 1,120 hospital admissions, at a cost of nearly £2.6m[16].

7.4.3. From 2006-08 there were 195 deaths related to smoking. This was 203 deaths per 100,000 persons aged 35 years and over, a similar rate to the England rate at 207 per 100,000.

7.4.4. Women who smoke during pregnancy have an elevated risk of miscarriage, complications, preterm birth and low birth-weight[17], and exposure to smoke after birth is a cause of health problems including sudden infant death syndrome[18].

7.4.5. The evidence base on smoking cessation is substantial. Cost-effectiveness studies indicate that the cost per quality-adjusted life year (QALY) gained of smoking cessation interventions is in the range of £174 to £873.246 Given that NICE's threshold for cost-effectiveness is between £20,000 and £30,000 per QALY, it is clear that smoking cessation is highly cost-effective. Interventions in healthcare settings, including brief interventions by GPs, pharmacological therapies and nicotine replacement, are known to be effective, but are not covered here because of their limited relevance to local authorities.

7.5. **Key Health Inequalities:**

7.5.1. Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities. Reducing prevalence of smoking is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher.

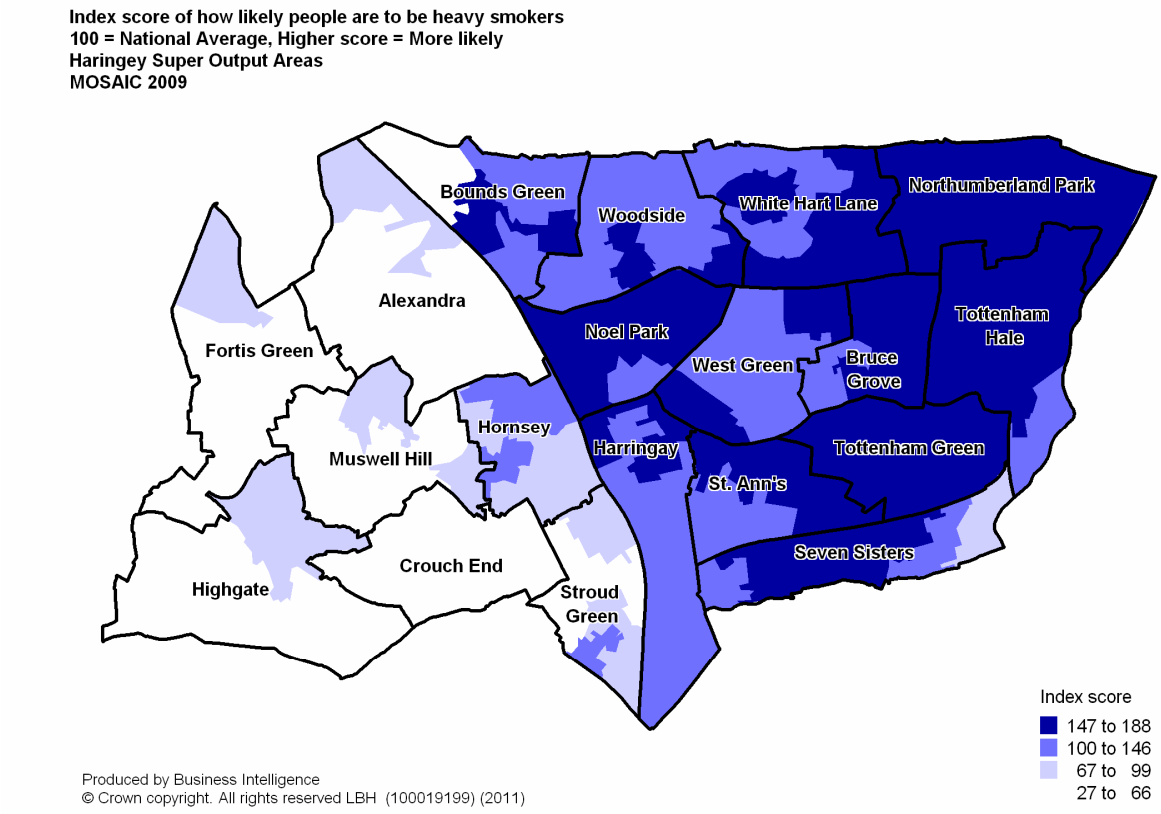
7.5.2. There were 260 deaths related to smoking between 2006 and 2008, with 1,120 hospital admissions, at a cost of nearly £2.6million.

7.5.3. Modelled smoking prevalence data derived from the Health Survey for England (2006/08), predicts that Haringey has a current smoking prevalence of 24.1%, compared with 20.8% in London and 22.2% in England. The figures for 2003/05 were released to Middle Super Output Area (MSOA) level. Highest smoking prevalence of between 29% and 33% was predicted for MSOAs in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

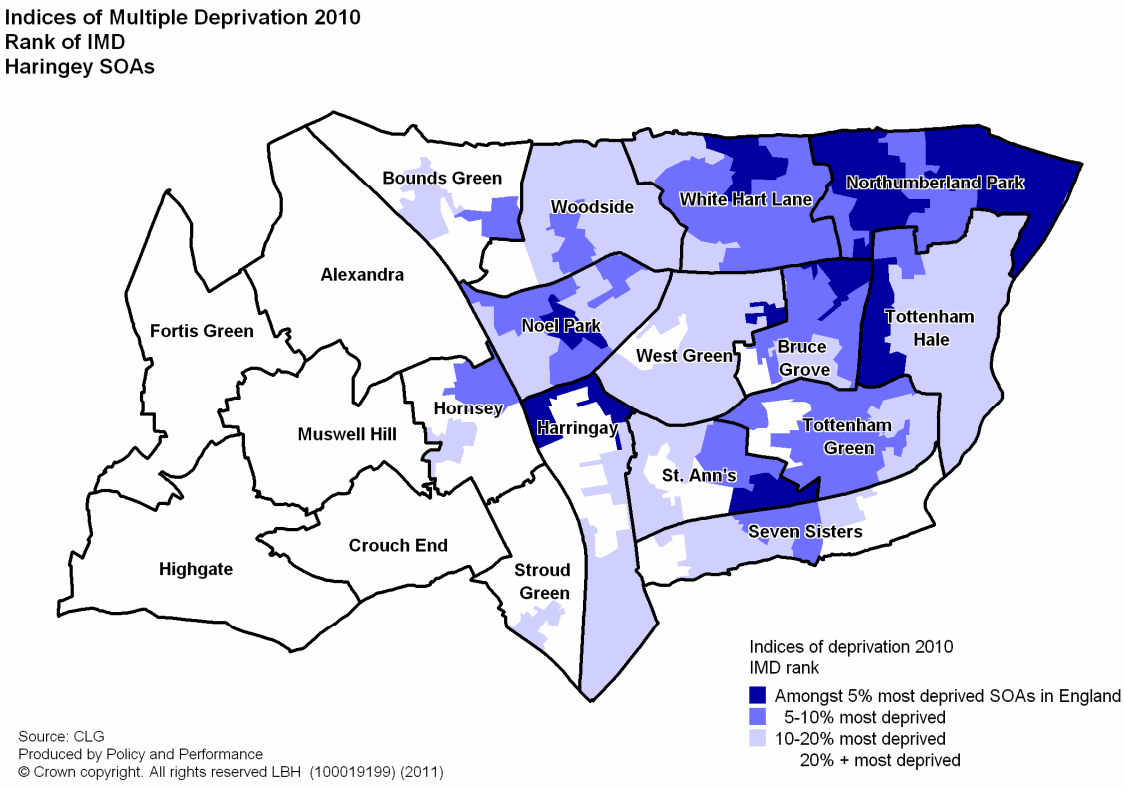
7.5.4. 17.7% of residents registered with a GP in Haringey were recorded as smokers as at March 2009. Smoking rates were lowest in the West Neighbourhood (15.4%) and highest in the North East Neighbourhood (19.9%).

7.5.5. Smoking rates vary considerably between ethnic groups and between men and women within those groups. The Health Survey for England suggests people from the Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups are less likely to be current smokers than England as a whole, whereas Irish respondents are more likely to be current smokers[19]. However, it should be noted that these estimates do not reflect the ethnic diversity within Haringey and the complex relationship between ethnicity and smoking prevalence. More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant. The Association of Public Health Observatories (APHO) has released a technical briefing on this issue[20].

Map A – showing likelihood of residents to be heavy smokers as mapped by Super Output areas.



Map B – Indices of Deprivation by Super Output area



7.5.6. As can be seen from the above two maps, those living in the more deprived areas of the borough are more likely to be heavy smokers than those living in the less deprived areas of the borough.

7.6. **Smoking quit rates**

7.6.1. In 2008/09 3,282 persons in Haringey set a smoking quit date, with a success rate of 59% (1,939 persons) at the four-week follow-up. These success rates are higher than London (47%) and England (50%) averages.

7.6.2. Haringey have an active Tobacco Control Alliance that is committed and active in reducing the impact of smoking on health inequalities. The alliance is formed from partners in the Haringey Strategic Partnership and monitors and evaluates the local Tobacco Control Strategy running from 2009-2012. There are five objectives for the Tobacco Control Strategy:

- Increase support for smokers who want to stop smoking;
- Increase the number of smoke-free environments;
- Increase awareness and understanding of tobacco use and health;
- Reduce access to tobacco products; and
- Make sure developments are informed, co-ordinated and supported by a trained workforce.

N.B the Delivery Plan is due to be revisited in light of reduced resources.

7.7. **Examples of best practice**

7.7.1. **Brief interventions**

7.7.1.1. Brief interventions are acknowledged to be effective for smoking cessation involve opportunistic advice, discussion, negotiation or encouragement and referral to more intensive treatment, where appropriate. They are delivered by a range of primary and community care professionals, typically in less than 10 minutes. The package provided depends on a number of factors including the individual's willingness to quit, how acceptable they find the intervention and previous methods they have used. It may include one or more of the following:

- simple opportunistic advice
- an assessment of the individual's commitment to quit
- pharmacotherapy and/or behavioural support
- self-help material
- referral to more intensive support such as the NHS Stop Smoking Service[21].

7.7.1.2. There is robust evidence to suggest that advice from GPs can have a beneficial effect on lifestyle behaviours. Much of this relates to smoking, where there is evidence to show that simple, brief, unsolicited advice from GPs is effective in increasing rates of smoking cessation[22] and is extremely cost-effective, mainly because it is so cheap: a typical 10-minute GP consultation cost £21 in 2005/06[23].

7.7.2. **Social Networks**

7.7.2.1. Individually focused approaches such as advice and counselling are effective in promoting smoking cessation, although they are less suited to prevention. Family-based interventions may be effective in preventing the uptake of smoking by children and young people, although the evidence is mixed.

7.7.2.2. Community-based interventions offer social support to people wishing to quit smoking, disseminate messages about prevention, and may also promote access to other services. Such interventions are usually multi-component and may include media campaigns, campaigns to restrict tobacco availability, interventions in schools and workplaces, and increasing access to therapies such as nicotine replacement. The evidence on such programmes indicates that some are effective in reducing smoking, although many such programmes have not been successful, and the most extensive and most rigorously evaluated programmes have found little or no evidence of effectiveness. Actively engaging and mobilising communities may increase the chances of success. Targeted community-based interventions are promising for decreasing smoking in low-income and disadvantaged areas.

7.7.2.3. Interventions in workplaces may be of particular interest to local authorities as a means to improve the health and wellbeing of their own employees, which may result in substantial efficiency savings; in addition, such programmes may form part of broader community strategies. However, although individually oriented interventions such as counselling are effective in workplace settings, comprehensive workplace strategies, such as those involving environmental changes or incentives, are less successful.

7.7.3. **Environmental and policy change**

7.7.3.1. Environmental and policy changes for smoking may take a variety of forms. Restricting the sale of tobacco products to minors may reduce smoking among young people, although enforcing such restrictions consistently is challenging.

7.7.4. **Media campaigns**

7.7.4.1. Media campaigns can combine a variety of multiple types of media, such as TV, radio and national newspaper advertising. They can be used alone to encourage and support quit attempts or combined with other activities at a local or regional levels[24].

7.7.5. **Cultural and Ethnic targeting based on local prevalence data**

7.7.5.1. NICE guidance[25] recommends that services should aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year.

7.7.5.2. There is no evidence to suggest that mainstream interventions proven to be effective with white smokers should not be successful with BME groups. The key is to *improve accessibility*. It seems likely that the simplest way is to make mainstream services more accessible. However, considering local circumstances and community views, it may be appropriate and cost effective to produce specific targeted services[26].

8. Physical Activity

8.1. Key themes from group discussion were:

- Walking-based initiatives
- Interventions targeting children
- Closer partnership working with providers of sport/physical activity initiatives.

8.2. Physical activity levels are low nationally, with only 21.9% of adults participating in moderate intensity sport and active recreation on at least 3 days per week for at least 30 minutes. Participation levels in London and Haringey are 20.9% and 21.3% respectively (Active People Survey 3). The Health Survey for England (2002) found that only two-thirds of boys and girls aged 2-11 years achieve the recommended levels of physical activity. However, in girls this activity declines steadily from 10 years of age to about half by the age of 15. Based on locally held data, this year's results for the Borough wide survey of Primary schools indicate that whilst 93% of pupils were evaluated as achieving the required 2 hours of quality PE time, 24% of pupils in year 6 were obese.

8.3. The current physical activity recommendation for adults to achieve health benefits is to undertake 30 minutes of at least moderate intensity physical activity on at least 5 or more days of the week. Children and young people should achieve a total of 60 minutes of at least moderate intensity physical activity each day.

8.4. Participation in regular physical activity can help to prevent and manage a range of long term conditions or disorders including obesity, stroke, coronary heart disease (CHD), type II diabetes, some cancers and mental health. Physical inactivity is a major risk factor for the development of a number of long term conditions and is one of the leading causes of death in developed countries. It has been estimated that it is responsible for an estimated 22-23% of CHD, 16-17% of colon cancer, 15% of diabetes, 12-13% of strokes and 11% of breast cancer.

8.5. **Key Health Inequalities**

8.5.1. In the UK there are significant inequalities in levels of physical activity in relation to age, gender, ethnicity and disability, and corresponding inequalities in health. For example, in Haringey white adult populations are more active than non-white adults, men tend to be more active than women, younger people are more active than their older counterparts and activity levels are lower in those who have a limiting illness or disability.

8.5.2. The data also indicates that there is a very 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 14.4% and 24.6% respectively. Such evidence exists for some long term conditions, e.g. CHD and cancer which, indicate that increases in physical activity levels in lower socioeconomic groups could help offset such gradients. For example, circulatory disease (includes heart disease and stroke) is a leading cause of premature mortality in Haringey. These deaths are not evenly distributed across Haringey, with higher rates observed in the East of the borough compared to the West. This suggests that there are differences in prevalence of disease and disease risk factors (including physical inactivity), in addition to the management of circulatory disease in different areas of the borough.

8.6. Best Practice - Adults

8.6.1. The evidence on effective strategies for increasing physical activity across all age groups is limited. The National Institute for Health and Clinical Excellence[27] produced guidance on methods used to increase the physical activity levels of the adult population. Four commonly used methods were selected, namely brief interventions in primary care, exercise referral schemes (ERSs), pedometers and community based exercise programmes for walking and cycling.

8.6.2. Brief interventions in primary care refer to a broad range of approaches including opportunistic advice, discussion, negotiation or encouragement. The delivery of these interventions may vary greatly in that they may involve giving basic advice to more lengthy person centred approaches. ERSs are programmes that direct individuals to a service that offers an assessment, a tailored physical activity programme, monitoring of progress and follow up. These programmes may require attendance at a facility such as a leisure centre. Pedometers were assessed regarding their effectiveness in increasing activity levels. Walking and cycling programmes were defined as organised walks or cycle rides.

8.6.3. NICE concluded that there was insufficient evidence to support the use of pedometers, walking and cycling schemes and ERSs to increase physical activity. However, In March 2007, in response to NICE guidance on ERSs, the Department of Health[28] issued a statement (best practice guidance) on this topic to clarify the opinion regarding the commissioning of ERSs in England, designed to be read in conjunction with NICE (2006) guidance. DH guidance stated that commissioners, practitioners and policy makers should continue to provide high quality ERSs for their local population where they address the medical management of conditions, such as type 2 diabetes, obesity and osteoporosis or aim to prevent or improve individual health conditions (e.g. falls prevention). The DH ended their statement urging that these schemes continue to be provided in accordance with the National Quality Assurance Framework for exercise referral in England[29].

8.6.4. However, there was evidence that brief interventions were effective in increasing activity levels. NICE recommend that practitioners should identify inactive patients, assessed using the DH general practitioner physical activity questionnaire (GPPAQ)[30], and advise them of the current recommendations for physical activity. They further recommend that advice should be delivered using a person□centred approach and should be complemented with written information about the benefits of physical activity. In addition, NICE recommend that patients should be followed up over a period of three to six months.

8.7. Children

8.7.1. In 2009, NICE[31] produced guidance on promoting physical activity for children and young people up to the age of 18.

8.7.2. **National Campaign**

- At a national policy level NICE recommends the delivery of a long-term (minimum 5 years) national campaign to promote physical activity among children and young people, which should be integrated with and support

other national health campaigns and strategies to increase participation in play, physical activity and reduce obesity.

8.7.3. **High level policy and strategy to raise awareness of the importance of physical activity**

- NICE recommend that the needs of children and young people to be physically active be addressed through JSNA, local development and planning frameworks, sustainable community plans and strategies and through children and young people's plans. These should be coordinated through a local strategy to increase physical activity.

8.7.4. **Local strategic planning**

- NICE recommend the development of physical activity plans which include identifying local children and young people who are amongst the least active and involving them in the planning and delivery of physical activity opportunities. It is also recommended that different groups of children, young people and their families be consulted on a regular basis to gain insight into what helps or prevents them from being physically active. This information should be used to increase opportunities for children and young people to be physically active and to plan programmes which tackle inequalities in provision.

- It is also recommended that consideration is given to the planning and provision of spaces and facilities, with a particular focus on ensuring physical activity facilities are suitable for those from lower socioeconomic groups, those from minority ethnic groups and those who have a disability. School facilities should be made available to children and young people before, during and after the school day, at weekends and during school holidays. Public parks and facilities should be actively promoted as well as more non-traditional spaces as places where children and young people can be physically active. Town planners should make provisions for children, young people and their families to be physically active in urban settings. Facilities and spaces should meet safety standards. Lastly, all proposals for signs restricting physical activity in public spaces should be assessed to judge their potential effect on physical activity levels.

- Local transport plans should aim to increase the number of children and young people who regularly cycle, walk and use other modes of physically active travel, making provision for those with a disability or impaired mobility. Assistance should be given to develop, implement and promote school travel plans. In addition, local transport and school travel plans should be aligned with other local authority plans which may impact on physical activity.

8.7.5. **Local Organisations: planning, delivery and training**

- Factors which affect physical activity participation should be identified through regularly consulting with children, young people and their families. Physical activity sessions should be delivered by those who have achieved the relevant sector standards/skills or qualifications for working with children. Continuing professional development should be provided for these staff. Education institutions should be identified to deliver multi-component physical activity programmes and multi-component physical activity programmes should be developed. Opportunities, facilities and

equipment should be available to encourage children (up to 11 years) to develop movement skill. Girls and young women (11-18 years) should be supported to become more physically active through, for example, consulting with them on their preferences for physical activities, barriers to participation should be addressed and school-based activities should be made available, and multi-component physical activity programmes developed. Active and sustainable school travel plans should be developed.

8.7.6. **Local practitioners: delivery**

- Children up to the age of 11 years should be helped to be active through the provision of a range of indoor and outdoor physical activities, including in pre-school establishments; during playtimes, lunch breaks at school and as part of extra-curricular and extended school provision and during leisure time within the community and private sector. In addition, girls and young women (11-18 years) should be helped to be more active through, for example, the use of appropriate role models, encouraging a dress code that minimises concerns regarding body image, help those who are amongst the least active towards gradual full participation and support those of all abilities to participate in an inclusive and non-judgemental way, with the focus on enjoyment and personal development rather an on the evaluation of performance.

Appendices

Appendix A – Attendees

Cllr Bull	Chair of Overview and Scrutiny
Cllr Winskill	Scrutiny (Well-being Lead)
Cllr Dogus	Cabinet Member for Adult and Community Services
Cllr Gorrie	Leader of the Liberal Democrats
Cllr Basu	Councillor
Cllr Erskine	Councillor
Cllr Scott	Councillor
Cllr Waters	Councillor
Cllr Goldberg	Cabinet Member for Finance and Sustainability
Cllr Mallett	Cabinet Member for Planning and Regeneration
Cllr Watson	Councillor
Cllr Wilson	Councillor
Cllr Weber	Councillor
Cllr Newton	Councillor
Kevin Crompton	Chief Executive of Haringey Council
Marion Morris	Drug & Alcohol Action Strategic Manager
Dr Therese Shaw	Clinical Director, BEH Mental Health Trust
Gina Taylor	Middlesex University, School of Health and Social Sciences
Stephen Wish	Polar Bear Mental Health Charity
Cathy Herman	Non Executive Director, NHS Haringey
John Morris	Assistant Director, Recreation
Paul Ely	Policy and Development Manager, Recreation Services
Naeem Sheikh	Chief Executive, Haringey Association of Voluntary and Community Organisation
Helena Pugh	Corporate Head of Policy
Mun Thong Phung	Director of Adult, Culture and Community Services
Susan Otiti	Interim Joint Director of Public Health
Diana Edmonds	Assistant Director, Culture, Libraries and Learning
Eve Pelekanos	Head of Policy & Performance
Helena Kania	Haringey LINk Chair
Rob Mack	Scrutiny Officer
Fiona Wright	Associate Director of Public Health
Mobola Alex-Oni	Public Health
Barbara Nicholls	Head of Commissioning (Adults)

Leo Atkins	Head of Healthy Communities Programme
Robert Edmonds	Director, Age Concern Haringey
John Ota	Community Services, NHS Haringey
Anastasia Georgiou	Mental Health Charity Polar Bear Community
Jodie Szwedzinski	Policy Officer
Melanie Ponomarenko	Scrutiny Officer
Mike Davis	Participation Manager
Tamara Djuretic	Associate Director of Public Health
Vanessa Bogle	Senior Public Health Commissioning Strategist
Michael Fox	Chairman, Barnet, Enfield & Haringey MH NHS Trust
Laura Copolovici	Polar Bear Community
Dimitrie Copolovici	Polar Bear Community
Gloria Salmon	NHS Haringey
Patrick Morreau	Age Concern Haringey
Anna Jozefwicz	Health Worker, Children and Young People, Haringey Council
Stephen Deitch	NHS Haringey
Marlon James	Project Worker - Community Health Workers
Yvonne Denny	Parent Governor
Pam Moffat	LINk
Ify Adenuga	Crucial Steps
Mary Connolly	Partnership Manager
Chris Giles	Whittington NHS Trust
Janet Alldred	Barnet, Enfield and Haringey Mental Health Trust
Olivia Darby	HAVCO

Appendix B – Case Studies

Appendix One: Best Practice taken from Mental health promotion and mental illness prevention: The economic case, January 2011

Parenting interventions for the prevention of persistent conduct disorders

Context

Conduct disorders are the most common childhood psychiatric disorders, with a UK prevalence of 4.9% for children aged 5–10 years.[32] The condition leads on to adulthood antisocial personality disorder in about 50% of cases, and is associated with a wide range of adverse long-term outcomes, particularly delinquency and criminality.[33] The costs to society are high, with average potential savings from early intervention previously estimated at £150,000 per case.[34] Costs falling on the public sector are distributed across many agencies and are around ten times higher than for children with no conduct problems.[35] The cost of conduct disorder-related crime in England may be as high as £22.5bn a year, and £1.1–1.9m over the lifetime of a single prolific offender.[36]

Intervention

Parenting programmes can be targeted at parents of children with, or at risk of, developing conduct disorder, and are designed to improve parenting styles and parent-child relationships. Reviews have found parent training to have positive effects on children's behaviour, and that benefits remain one year later. [37] Longer term studies show sustained effects but lack control groups; cost-effectiveness data are limited, but health and social services costs were found to reduce over time in one trial.[38] Without intervention, conduct disorder will persist in about 50% of children.[39]

The median cost of an 8–12 week group-based parenting programme is estimated at £952 per family, while that of individual interventions is £2,078.vii Assuming 80% of people receive group-based interventions and 20% individual interventions, in line with NICE guidance, the average cost of the intervention works out at £1,177 per family. An important ingredient of success in the design and implementation of these programmes is maximising the engagement of 'at-risk' families, as there is evidence that some services suffer from low rates of take-up and high rates of drop-out.

Impact

The model looks at the costs/savings for 5-year-old children with conduct disorder whose parents attend a parenting programme, and estimates the impact to age 30 compared to no intervention. It is assumed that the intervention decreases the chance that early onset conduct disorder will persist into adulthood, thus avoiding high costs to society. Among those whose parents complete the programme, 33% of children improve to 'no problems', and 5% improve to moderate conduct problems; however, behaviour changes are not sustained beyond one year for 50% of children who initially improve.

Table 1: Gross pay-offs from parenting interventions at age 5, per child with conduct disorder (2008/09 prices)

	Age 6 (£)	Age 7–16 (£)	Age 17+ (£)	Total (£)
NHS	-168	-912	-197	-1,278
Social services	-24	-29	-14	-67
Education	-132	-304	0	-437
Criminal justice system	0	-1,247	-340	-1,588
Public sector total	**-324**	**-2,493**	**-551**	**-3,368**
Voluntary sector	-3	-6	-5	-15
Victim costs (crime)	0	-3,361	-810	-4,171
Lost output (crime)	0	-995	-232	-1,227
Other crime costs	0	-377	-129	-506
Other sectors/individuals total	**-3**	**-4,740**	**-1,176**	**-5,919**
Total	-328	-7,233	-1,727	-9,288

Table 1 shows that total gross savings over 25 years amount to £9,288 per child and thus exceed the average cost of the intervention by a factor of around 8 to 1. Savings to the public sector come to £3,368 per child, including £1,278 accruing to the NHS. Under the assumptions made, the intervention will provide a positive return to the public sector in year 8, and to the NHS in year 14, after the intervention. No benefits are assumed from a range of other potential wider impacts such as improved employment prospects, reduced adult mental health issues, and improved outcomes for the child's family and peers; these are likely to be substantial, making the intervention an even better investment.

Further details: Eva-Maria Bonin (e.bonin@lse.ac.uk)

Workplace screening for depression and anxiety disorders

Context
Substantial potential economic costs arise for employers from productivity losses due to depression and anxiety in the workforce. The main costs occur due to staff absenteeism and presenteeism (lost productivity while at work). From the perspective of the public purse, failure to intervene also risks higher future health and social care costs.

It is estimated that the average annual cost of lost employment in England attributable to an employee with depression is £7,230, and £6,850 for anxiety (2005/06 prices).

The proposed intervention
Workplace-based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention.[40]

Initial Costs
It is estimated that £30.90 (at 2009 prices) covers the cost of facilitating the completion of the screening questionnaire, follow-up assessment to confirm depression, and care management costs.[41] For those identified as being at risk, the cost of six sessions of face-to-face CBT is £240. Computerised CBT courses are cheaper, but may be less effective, with less known about their longer-term effectiveness.

Impact
The model assesses the cost-effectiveness of a workplace-based intervention for depression and anxiety disorders, and whether it reduces sickness, absenteeism and presenteeism, compared with no intervention.

The target population is a hypothetical cohort of working age individuals in a white collar enterprise with 500 full time equivalent employees, all of whom are screened. The cost/savings impact is addressed from the perspective of the health system (including personal social services) and business, with the enterprise bearing the total costs of the intervention. It assumes that only two-thirds of employees offered CBT as a result of screening will make use of this treatment. It is estimated that the reduction in presenteeism as a result of successful intervention is equivalent to an extra 2.6 hours of work per week.iv In year 1 it is assumed that this benefit is seen only in the 36 weeks after the completion of the CBT course. If depression and anxiety orders are averted, then 27.3 days of absenteeism per annum associated with these disorders will be avoided.

Conservatively, the model assumes that health and personal social services costs relating to depression and anxiety only occur in year 2.
The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees (Table 6). Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and personal social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

Table 6: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

Further details: David McDaid (d.mcdaid@lse.ac.uk)

Debt and mental health

Context

Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress.[42] These problems have wide-ranging implications.

In particular, research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems.[43]

The vast majority of these mental health problems take the form of depression and anxiety-related disorders.

These conditions are associated with significant costs arising from health service use, legal fees, debt recovery and lost productivity. On average, the lost employment costs of each case of poor mental health are £11,432 per annum, while the annual costs of health and social service use are £1,508.[44]

Only about half of all people with debt problems seek advice,[45] and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later.

Intervention

The current evidence suggests that there is potential for debt advice interventions to alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable,[46] while telephone services achieve 47%[47]. In comparison, around one-third of problem debt may be resolved without any intervention.

The costs of this type of intervention vary significantly, depending on whether it is through face-to-face, telephone or internet-based services. The Department for Business, Innovation and Skills suggests expenditure of £250 per client for face-to-face debt advice; telephone and internet-based services are cheaper. Funding for debt advice comes from a range of sources including government, NHS, charities and creditors.

Impact

The model explores the cost-effectiveness of different types of debt advice services targeted at working age adults without mental health problems. It follows a hypothetical cohort of people at risk of unmanageable debt over a 24-month period, and looks at the impact of subsequent debt-related mental health problems (depression and anxiety) on costs to the health, social care and legal systems, and from lost productivity due to reduced employment. Legal and debt advice costs are assumed to fall in year 1, while other costs fall mostly in year 2.

A range of scenarios was explored in models. Even under conservative assumptions, investment in debt advice services can both lower expected costs and reduce the risk of developing mental health problems. The intervention appears to be cost-effective from most societal and public expenditure perspectives. However, face-to-face services will only be the most cost-effective option if a high proportion of the costs of providing the service is recovered from creditors. This is feasible: one major not-for-profit debt advice service covers more than 90% of its costs in this way. In other scenarios, where cost

recovery is lower, either telephone or web-delivered services will be most cost-effective. Table 8 shows the impact on costs/savings of face-to-face intervention for a hypothetical population of 100,000, compared with no intervention, assuming that one third of the cost of the debt advice is borne by the NHS, with the rest paid for by creditors.

Table 8: Impact on costs/pay-offs of face-to-face debt intervention (with NHS paying one-third of the costs of the debt advice services) (2009 prices)

	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)
Health and social care	151,512	-13,209	-13,017	-12,829	-12,643
Legal	-87,908	-	-	-	-
Productivity losses	-7,827	-100,128	-98,677	-97,426	-95,837
Net costs/pay-offs	55,777	-113,336	-111,694	-110,075	-108,480

In practice, this type of intervention could be targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

Further details: Martin Knapp (m.knapp@lse.ac.uk)

Collaborative care for depression in individuals with Type II diabetes

Context

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression,[48] while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression.[49]

These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes, in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences. In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work.[50] In the US, health care costs for those with severe depression and diabetes are almost double those with diabetes alone.[51]

Intervention

'Collaborative care' can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Like 'usual care', collaborative care includes GP advice and care, the use of antidepressants and cognitive behavioural therapy (CBT) for some patients. The difference is that for collaborative care a GP practice nurse acts as a case manager for patients receiving care; GPs also incur additional time costs liaising with practice nurses.

Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the US found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year 1, but there were cost savings in year 2.[52]

Impact

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type II diabetes who screen positive for depression, compared with care as usual.

The costs associated with screening are not included in the baseline model; we were given expert advice that in GP care all individuals with diabetes would already be screened for depression. The analysis assumed that 20% of patients under collaborative care would receive CBT, compared with 15% of the usual care group. Existing data on the cost-effectiveness of CBT were used to estimate the impact on health care and productivity losses.

Table 11 shows the estimated costs/savings for 119,150 new cases of Type II diabetes in England in 2009, assuming 20% screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in year 1 and 111,860 depression-free days in year 2. According to the model, the intervention results in substantial additional net costs in year 1 due to the costs of the treatment. In year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13% rate of co-morbid diabetes and depression, total net costs in year 1 would be more than £4.5m, while net savings in year 2 would be more than £450,000. The study also estimated the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

These estimates of the potential benefits are, however, very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure. Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-relates cases the average initial health care costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000.[53] If, on average, costs of just £150 per year could be avoided for the intervention group then investment in collaborative care would overall be cost-saving from a health and social care perspective after just two years.
Further details: David McDaid (d.mcdaid@lse.ac.uk)

Table 11: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

Table 11: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay-off	6,967,690	-699,570

Befriending of older adults

Context

Befriending initiatives, often delivered by volunteers, provide an 'upstream' intervention that is potentially of value both to the person being befriended and the 'befriender'. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness;[54] for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

Intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural relationship develops between the participants, who will usually have been matched for interests and preferences. This relationship facilitates improved mental health, reduced loneliness and greater social inclusion. A recent research review confirmed that, compared with usual care and support (which may mean no intervention at all), befriending has a modest but significant effect on depressive symptoms, at least in the short term.[55] Another evaluation showed decreased depression and anxiety in 5% of people receiving socio-emotional interventions, including befriending.[56]
The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is estimated at £85, based on the lower end of the cost range for befriending interventions.[57]

Impact

The model looked at the cost-effectiveness of befriending interventions in terms of the reduction in depressive symptoms and the consequent decline in the use of health services by the recipient of the intervention. The intervention is assumed to be targeted at lonely and isolated individuals aged over 50. The analysis included costs/savings associated with the use of mental health services, primary care, hospital services and medication; home helps, but no other social care services, were included. The model did not
factor in any benefits to the befriender.

Using existing estimates of savings associated with reduced treatment of depression,[58] the model found total gross cost savings to the NHS were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the
intervention. Thus, befriending schemes do not appear to be cost-saving from a public expenditure perspective.

If the analysis includes the quality of life benefits associated with reduced depressive symptoms, then befriending schemes have the potential to create further improvements worth £270 per person and are likely to be cost-effective with an incremental cost effectiveness ratio (ICER) of around £2,900.
Further details: Annette Bauer (a.bauer@lse.ac.uk)

Case study: Tower Hamlets

A successful Stop Smoking Service targeted specifically at the Bangladeshi community

The Bangladeshi Stop Tobacco Project

This was set up following publication of *Smoking Kills* and the completion of primary research indicating the need for a local BME tobacco programme. National surveys have reported that smoking prevalence in Bangladeshi men is around 40% and research in Tower Hamlets has shown that 49% of local Bangladeshi women chew tobacco in paan (a leaf wrapping which can contain spices as well as tobacco). One third of the population of Tower Hamlets is of Bangladeshi origin. Few Bangladeshi men set quit dates with the NHS Stop Smoking Services or successfully stop smoking.

The project aims to tackle barriers to accessing tobacco use by addressing language and cultural sensitivities. It has developed a community-oriented approach to address the needs of the Bangladeshi residents. It actively seeks feedback from the community and uses this to enrich the service delivery model.

The expectation is that clients will be contacted and supported in locations and ways that help them to feel most at ease. This includes:

- being supported by a gender specific project worker
- providing home visits to women and the elderly
- holding regular drop-in sessions
- using language of preference
- offering support, understanding, and Nicotine Replacement Therapy.

The project accepts referrals from GPs, practice nurses and other health professionals. There is a 24 hour client recruitment telephone line, which is advertised through leaflets and a website. It also gains clients and publicity by participating in local community events.

There have been positive results, with the project achieving higher quit rates than the national average (63–66% through 2004–06) in what tends to be regarded as a 'hard to reach' group.

Case study: Islington

Engaging the Turkish community, and using alternative settings for treatment

Turkish stop smoking project

This project was established in March 2000 to provide community based smoking education and Stop Smoking support to the Turkish speaking communities of Camden and Islington. Its key objectives were:

- to develop culturally appropriate stop smoking resources
- to develop Stop Smoking services to both individuals and groups
- to identify innovative ways of encouraging smokers to quit
- to advertise services to the community

It was launched in the 3 main Turkish Community Organisations within the London borough of Islington: IMECE (Turkish Speaking Women's Group), TEG (Turkish Education Group) and Turkish Cypriot Community Centre. Research into the Turkish communities in Camden & Islington indicated that 57% of the adult population smokes

an average of 17 cigarettes a day (Camden and Islington Health 1996). This is higher than the national average of 28% (DOH 1998).

Each organisation employed a part-time Stop Smoking advisor who worked 6 hours per week, making a total of 18 hours per week. The advisors accessed clients in community settings other than primary care and adopted a pro-active approach taking services directly to the clients rather than waiting for clients to approach the service. Due to the Advisors' knowledge of local communities, the publicity was targeted at key areas within the community, where many Turkish-speaking people congregate (e.g. Turkish cafes, events etc).

Brief opportunistic advice was offered to smokers who the advisers saw on a casual basis. This may have been through a planned health or community event or discussions with individuals at community centres. The advisers also provided one-to-one behavioural support and made recommendations about Stop Smoking aids.

In 2001, the first Stop Smoking clinic for Turkish speakers was launched to provide intensive group support to smokers who wished to stop smoking. A health centre location for the clinic was chosen for the convenience of the community and was in easy travelling distance to where Turkish communities live.

Leaflets, posters, cards and other stop smoking resources were translated into Turkish. Many resources included cartoon designs, which were found to be popular amongst the Turkish community. A Turkish freephone telephone line was also provided, which allowed clients increased access to the service.

Results

The success rates of clients attending one-to-one sessions and group clinics were similar to those of mainstream Stop Smoking Services. One stop smoking group was run every 3 months from February 2001. The overall success rate of 4-week quitters who attended the clinic was 63%.

This outcome is viewed by the organisers as a great achievement when taking into account the perception that Turkish speaking communities will achieve lower success rates.

Appendix C – End notes

[1] Sustainable Community Strategy
[2] Health Inequalities Cross Party Working Group, Haringey Council, 2011
[3] Anderson, 1993
[4] Based on average scores of Super Output Areas.
[5] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005) *Mental Health of Children and Young People in Great Britain*, 2004. Basingstoke: Palgrave Macmillan.
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The role of mental health and wellbeing in tackling health inequalities

Dr Lynne Friedli

Haringey 'Health: Everyone's Business'

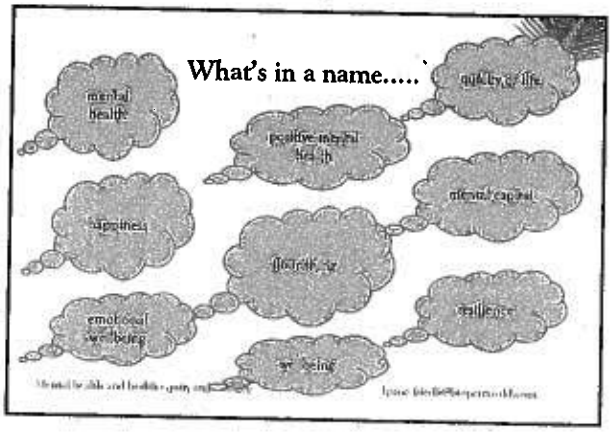
25th October 2010

'Everyone in every part of the borough has the best chance of an enjoyable, long and healthy life'

Summary

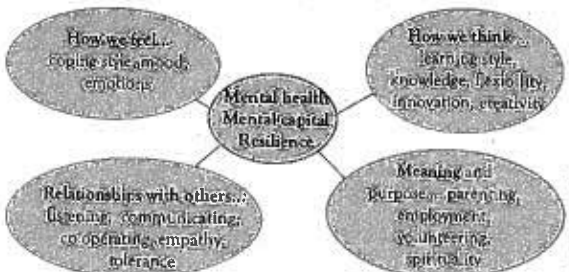
Institutions have reached their problem solving limits
John McKnight

- Theory: what mental health can contribute to *understanding inequalities*
- Practice: what promoting mental health and wellbeing can contribute to *reducing inequalities*
- Resources: promoting mental wellbeing in a recession

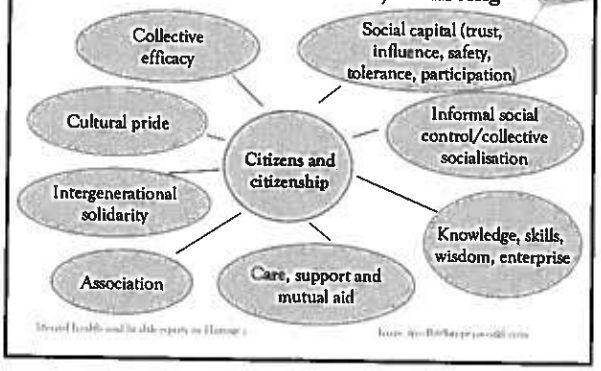


Dimensions of mental health

If I am not for myself, who will be for me?
And if I am only for myself, what am I? If not now, when?



Dimensions of Community wellbeing



Why mental health matters

'It's better to be roughly right than precisely wrong'

- Mental wellbeing influences wide range of outcomes
- Improving mental wellbeing saves (a lot of) money
- Improving mwb delivers social (as well as economic) returns
- Improving mental health reduces health inequalities

Mental health as a determinant?

Can mental health help to explain outcomes that cannot be wholly accounted for by other factors?

- Contribution mental health and mental illness make to wide range of outcomes
- The 'unexplained excess' – classical risk factors do not account for level of variation in outcomes
- Presence as well as absence...
- Key element of resilience

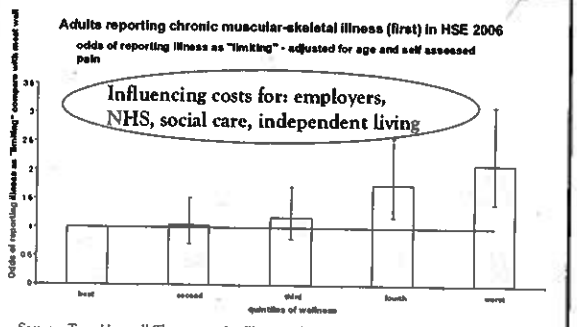
(Friedli 2009)

Outcomes associated with positive mental health

A worthwhile goal in itself and leads to better outcomes:

- reduces prevalence of mental illness
- physical health: mortality/morbidity
- health behaviour
- employability, productivity, earnings
- educational performance
- crime / violence reduction
- pro-social behaviour/social integration/relationships
- quality of life

Recover from, and manage, illness sooner



Source: Tom Hennell *The nature of wellbeing and its relationship to inequalities* 2010

Contribution of mental health to inequalities

Key domains: education/employment/behaviour /health/ consequences of illness /services

(Whitehead & Dahlgren 2006)

Mental health is a significant determinant in each case, influencing:

- readiness for school/learning
- employability
- capacity, motivation and rationale for healthy behaviours
- risk for physical health (e.g. coronary heart disease),
- chronic disease outcomes (e.g. diabetes)
- relationship to health services, including uptake/treatment

Mental wellbeing is a core asset...

"It gets so lonely around here that I phone myself seven or eight times a day, just to see how I am"

Phantom Tollbooth)

- Resilient places
- Resilient communities
- Resilient individuals

"extent to which communities are able to exercise informal social controls or come together to tackle common problems"

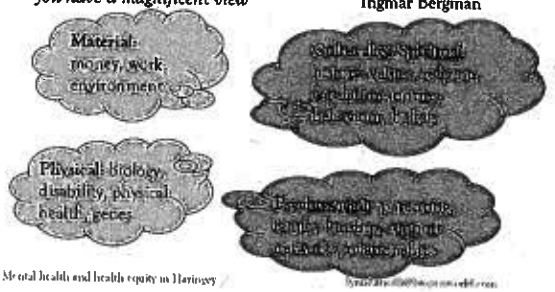
"mostly about the quality of human relationships"

Mental health and health equity in Haringey

What influences mental health?

Ageing is like climbing a mountain: you get out of breath but you have a magnificent view

Ingmar Bergman



Mental health and health equity in Haringey

(the ecology of)Relationships matter

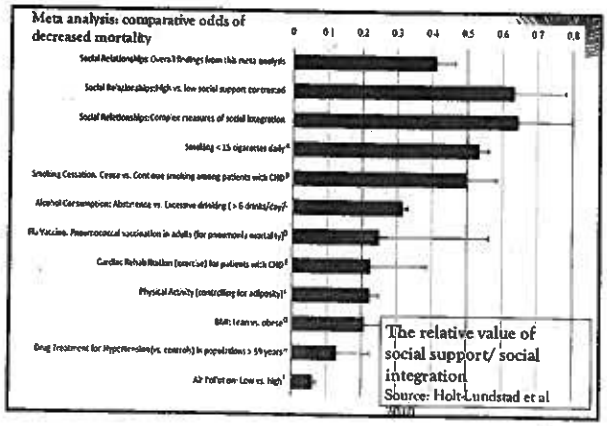
We do not have to be a Gandhi, or a Martin Luther King, or a Nelson Mandela or a Desmond Tutu or an Aung San Suu Kyi, to recognise that we can have aims or priorities that differ from the single minded pursuit of our own well being only.

Amartya Sen

- Mental health is produced socially
- Quality of social relationships is key factor in resilience
- Social integration buffers other risk factors
- Social support is unevenly distributed

Mental health and health equity in Haringey

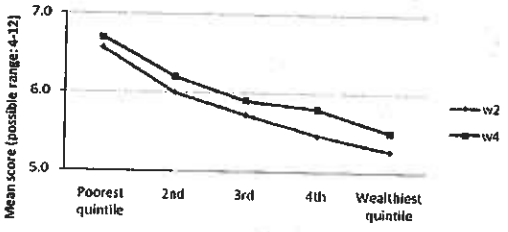
Meta analysis: comparative odds of decreased mortality



The relative value of social support/ social integration

Source: Holt-Lundstad et al

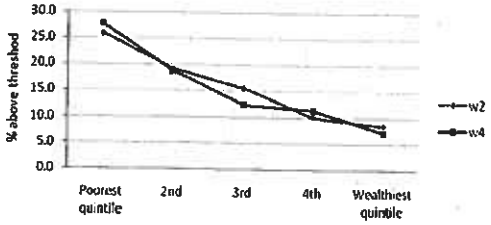
Loneliness score by wealth in wave 2 and wave 4



Source: 2008 English Longitudinal Study of Ageing (IFS 2010)

Mental health and health equity in Haringey

Elevated depressive symptoms by wealth (quintiles) in wave 2 and wave 4



Source: 2008 English Longitudinal Study of Ageing (IFS 2010)

Mental health and health equity in Haringey

Evidence based action: 'what and how'

While there are multiple barriers to economic growth, the growth of human potential is unlimited

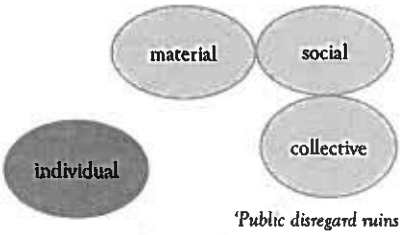
Coote and Franklin 2010

Scope of public mental health

Resources, relationships, meaning, respect

Focus of interventions

Policy responses that enhance connections and collectivity



'Public disregard ruins the spine'

Brecht

'best buys'

- Supporting parents and early years: **parenting skills/ pre-school education/home learning environment/reading**
- Supporting lifelong learning: **health promoting schools and continuing education**
- Improving work: **employment/ workplace**
- Mental health assets **(diet, exercise, sensible drinking)** and social support/integration
- Supporting communities: **environmental improvements /environmental justice**

Befriending, volunteering, timebanks, community development

Cost benefits: scale of return

- **Parenting programmes:** £8 return per £1 invested
- **Health promoting schools** (life skills, social skills):
  - $25 - $45 return per dollar invested

The Place2Be individual and group school counselling services:

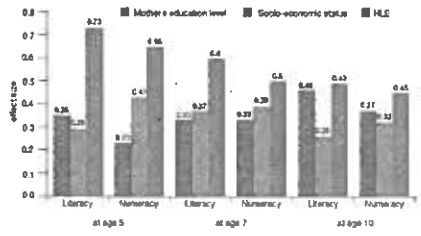
- £6 return per £1 invested

Adult learning: increase education of women to basic qualifications: £230m per year saving in cost of depression

- Access to **green open spaces** = 50% reduction in health gap (all cause and circulatory disease mortality)
- **Education Maintenance Allowance:** 1 less burglary conviction per 1,000 pupils in EMA areas relative to other LEAs
- **Reading Recovery:** £17 per £1 invested (KPMG 2006)

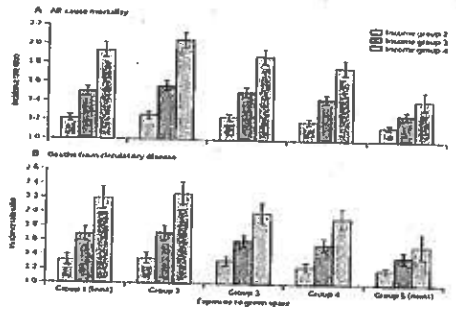
US DHHS 2007, Chevalier & Feinstein 2006, Mitchell & Popham 2008; Feinstein & Sabates 2005)

Figure 3.2: Impact of the Home Learning Environment, relative to the impact of socio-economic status and mother's education, on children's achievement at different ages[1]



Equalities Review 2007 Crown Copyright

Exposure to green space: reducing the health gap



(Marmot 2010)

London Health Inequalities Strategy

- Early years, parenting
- Lifelong learning → Promote access to life long learning → Volunteering/greenspace volunteering
- Health & Wellbeing → Increase support for community based arts & health → Physical activity
- Community development/VCS → Active in open space
- Maximise incomes → Cooking skills Funding for adult learning → Promote free/low cost Wellbeing opportunities
- Affordability of health and wellbeing → investment to build social capital/engage communities → Challenge to boroughs
- Increased commitment toTimebanks → Good jobs campaign
- Healthy places: housing, greenspace, transport → Welfare advice in health & LA settings → Commitment to London Living Wage (public procurement leverage)

Promoting mental health supports wider goals

- Empowering Haringey's People and Communities
- Enabling Best Start in Life
- Primary and Social Care Equity
- Health, Work and Wellbeing
- Maintaining Healthy and Sustainable Places
- Preventing Ill-Health and Supporting Lifestyle Changes

Re-imagining the social....

To value the contribution of those whom the market excludes or devalues and whose genuine work is not acknowledged or rewarded

Edgar Cahn

To be open to the unbidden - to abide the unexpected, to live with dissonance, to reign in the impulse to control...

Michael Sandel Reith Lectures 2009

I am, because we are...

Towards an index of multiple assets/JSAA

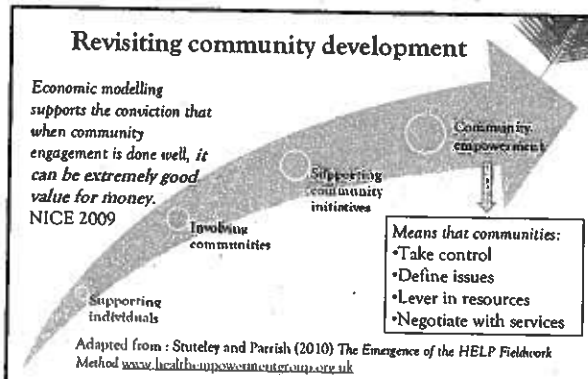
"too often the price of receiving support is exclusion from the life of citizenship

Simon Duffy

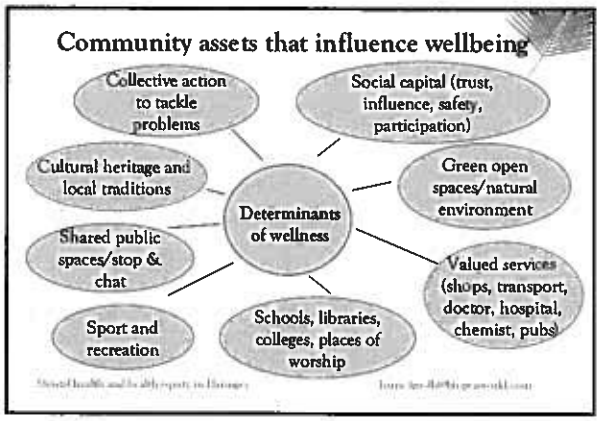
- Map assets/build on assets: appreciative inquiry
- Commission for social value/ SROI: *How can each £1 spent on delivery also produce wider community benefit?*
- Co-production: redefining '*need*' and '*provider*'
- Start from existing passions/enthusiasms
- Focus on addressing barriers to community action

Revisiting community development

Economic modelling supports the conviction that when community engagement is done well, it can be extremely good value for money.
NICE 2009



Adapted from : Stuteley and Parrish (2010) *The Emergence of the HELP Fieldwork Method* www.health-unpowerment-empowerment.org.uk


Community assets that influence wellbeing
Collective action to tackle problems
Social capital (trust, influence, safety, participation)
Cultural heritage and local traditions
Green open spaces/natural environment
Determinants of wellness
Shared public spaces/stop & chat
Valued services (shops, transport, doctor, hospital, chemist, pubs)
Sport and recreation
Schools, libraries, colleges, places of worship


madpride.org.uk
The Mad Hatters of Bath
bathmadhatters@hotmail.co.uk
tel. 01225337787/07816133285
BACK TO WORK? NO CHANCE! HANDS OFF OUR BENEFITS!
Source: The Survivors' History Group Pageant of Survivor History

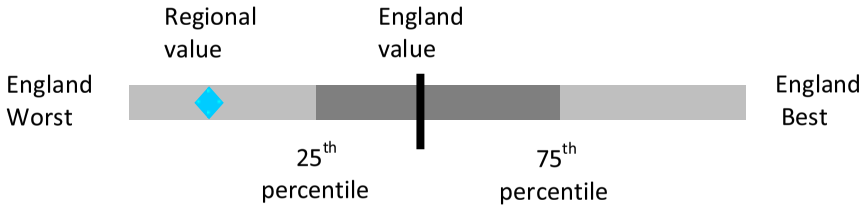
Fair Society, Healthy Lives

London Health Observatory

Marmot Indicators for Local Authorities in England

The chart below shows 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. Results for each indicator for this local authority are shown below. On the chart, the value for this local authority is shown as a circle, against the range of results for England, shown as a bar.

- Significantly better than England value
- Not significantly different from England value
- Significantly worse than England value



Haringey

	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	76.6	78.6	78.3	73.7		84.4
2	Inequality in male life expectancy (years)	6.8	7.1	8.8	16.6		2.7
3	Inequality in male disability-free life expectancy (years)	11.5	9.1	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	83.7	83.1	82.3	79.1		89.0
5	Inequality in female life expectancy (years)	3.8	4.7	5.9	11.5		1.8
6	Inequality in female disability-free life expectancy (years)	9.5	7.9	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	41.9	54.7	55.7	41.9		69.3
8	Young people not in employment, education or training (NEET) (%)	7.3	5.8	7.0	13.8		2.6
9	People in households in receipt of means-tested benefits (%)	30.5	20.6	15.5	41.1		5.1
10	Inequality in people in receipt of means-tested benefits (% points)	47.8	30.1	30.6	61.3		2.9

Indicator Notes

A copy of this report and a more detailed Indicator Guide is available from the London Health Observatory website:
http://www.lho.org.uk//LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Life expectancy at birth (Indicators **1** and **3**)
Estimate of the average number of years of life expectancy at birth, based on current mortality rates.
Figures for England and the English regions represent the actual life expectancies for these areas.
Time period: 2007-09 Source: Office for National Statistics (ONS)

Inequality in life expectancy (Indicators **2** and **4**)
This indicator is the Slope Index of Inequality in life expectancy. It summarises the social inequality in life expectancy within each local authority. It was calculated by, firstly, grouping lower layer super output areas (LSOAs) within each local authority into deciles based on the Index of Multiple Deprivation score (IMD 2007) for each LSOA. Deciles each contain approximately a tenth of the LSOAs in the local authority. The life expectancy for each decile is calculated, based on mortality data for the five-year period 2005-09. The Slope Index of Inequality represents the gap in years of life expectancy between the least and most deprived areas within the local authority, based on a statistical analysis of the relationship between life expectancy and deprivation scores across the whole authority. The higher the value, the greater the inequality within the local authority.
The figure for England is the median value of the figures for all upper-tier local authorities. The figure for each English region is the median value of all upper-tier LAs within that region.
Time period: 2005-09 Source: Association of Public Health Observatories, based on analysis of ONS mortality data and population estimates

Inequality in disability-free life expectancy (Indicators **3** and **6**)
Disability-free life expectancy (DFLE) is the average number of years a person could expect to live without an illness or health problem that limits their daily activities. This indicator is the Slope Index of Inequality in DFLE. It summarises the social inequality in DFLE within each local authority. It was calculated by, firstly, ranking the middle layer super output areas (MSOAs) in each local authority by their level of deprivation using IMD 2007 scores. The Slope Index of Inequality represents the gap in years of disability free life expectancy between the least and most deprived areas within the local authority, based on a statistical analysis of the relationship between DFLE and deprivation scores across the whole authority. As with life expectancy, the higher the value, the greater the inequality within the local authority.
The figure for England is the median value of the figures for all upper-tier local authorities. The figure for each English region is the median value of all upper-tier LAs within that region.
Time period 1999-2003 Source: Slope Index of Inequality - London Health Observatory based on analysis of DFLE figures from ONS

Children achieving a good level of development at age 5 (Indicator **7**)
Percentage of children assessed by a teacher as having achieved a 'good level of development' in the year they turn five.
Figures for England and the English regions are the actual percentages for these areas.
Time period: 2010 Source: Department for Education

Young people not in employment, education or training (NEET) (Indicator **8**)
Percentage of young people aged 16-19 who are not in education, employment or training (NEET).
Figures for England and the English regions are the actual percentages for these areas.
Time period: 2009/10 Source: Department for Education

People in households in receipt of means-tested benefits (Indicator **9**)
Percentage of people living in households in receipt of selected means-tested benefits.
Figures for England and the English regions are the actual percentages for these areas. *Time period: 2005 Source: Income Domain of the Index of Multiple Deprivation 2007 - Communities and Local Government; percentages for LAs - London Health Observatory*

Inequality in percentage in receipt of means-tested benefits (Indicator **10**)
This indicator is the Slope Index of Inequality in the percentage of people in households in receipt of selected means tested benefits. It summarises the social inequality within each local authority. It is calculated by, firstly, grouping lower layer super output areas (LSOAs) within each local authority into deciles based on their IMD 2007 scores for each LSOA. Deciles each contain approximately a tenth of the LSOAs in the local authority. The percentage of people in households in receipt of means-tested benefits is calculated for each decile. The Slope Index of Inequality represents the difference in percentages between the least and most deprived areas within the local authority, based on a statistical analysis of the relationship between the percentage in receipt of means-tested benefits and deprivation scores across the whole authority. The higher the percentage, the greater the inequality within the local authority.
The figure for England is the median value of the figures for all upper-tier local authorities. The figure for each English region is the median value of all upper-tier LAs within that region.
Time period: 2005 Source: Slope Index of Inequality - London Health Observatory based on analysis of the Income Domain of the Index of Multiple Deprivation 2007 from Communities and Local Government

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MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
MONDAY, 28 MARCH 2011

Councillors: Councillors Bull (Chair), Browne (Vice-Chair), Alexander, Basu, Ejiofor, Newton and Winskill

Apologies: Yvonne Denny (Church Representative), Helena Kania (Local Involvement Network (LINk))

Also Present:
Co-optees: Pam Moffatt (LINk)
Councillors: Cllr Nilgun Canver, Cllr Lyn Weber
Officers: Anne Lippit (Interim Director of Urban Environment), Robin Payne (Head of Enforcement), Nick Powell (Head Of Housing Strategy, Development & Partnerships), Steve McDonnell (Head of Environmental Resources), Graham Jones (Client Performance Manager – Waste Services), Martin Tucker (Regeneration Manager), Rob Mack (Scrutiny Officer), Melanie Ponomarenko (Scrutiny Manager), Natalie Cole (Clerk)

MINUTE NO.	SUBJECT/DECISION
OSCO211.	**WEBCASTING** The meeting was recorded for future or live broadcasting on the Council's website.
OSCO212.	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Helena Kania (LINk) and Yvonne Denny (Church Representative).
OSCO213.	**URGENT BUSINESS** There were no such items.
OSCO214.	**DECLARATIONS OF INTEREST** Councillors Bull and Winskill declared personal interests in item 9 – Performance of Registered Housing Providers as they were Council leaseholders.
OSCO215.	**DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS** There were no such items.
OSCO216.	**CABINET MEMBER QUESTIONS - CABINET MEMBER FOR NEIGHBOURHOODS** RECEIVED the briefing from the Cabinet Member for Neighbourhoods, Councillor Nilgun Canver, and the questions and answers submitted in advance of the meeting. The Cabinet Member highlighted that the Government had allocated £214,000.71 to Haringey for pothole repairs and expressed concerns that the Localism Bill introduced a power to recover from local and public authorities European Union infraction fines for non compliance with EU law. The

Cabinet Member would circulate a briefing about and a letter responding to the Localism Bill (Action No. 216.1).

The Committee noted the new waste contract and that, in the first year of the contract there would be a comprehensive education and engagement programme and whilst recyclables would continue to be collected on a weekly basis, starting from January 2012 residual waste for street properties would move to fortnightly collections; starting in the Muswell Hill area and rolling out across the Borough. The Cabinet Member would email the colour brochure from Veolia, the new waste service provider (Action No. 216.2).

NOTED the following in response to supplementary questions:

Q3 – Area Committees – The Cabinet Member reported that the details of how the Area Committees will serve will be agreed as part of the Council's governance review. A key role for engagement and enablement officers will be to identify priorities in each area which will then be agreed by each Neighbourhood Committee to enable local communities to action.

Q5 – Fortnightly Refuse Collections – In response to a concern about the lack of a pilot scheme and consultation with residents the Cabinet Member explained that the waste contractor, Veolia, will carry out extensive consultation with the community in the first year of the programme including education about recycling. The Committee questioned the proposals put forward in the new waste contract and noted that the aims were to increase recycling rates and reduce carbon emissions as well as provide a high quality service. A new trade waste contract partnership would provide an attractive incentive to encourage pubs and clubs to recycle more.

Q12 & Q13 – Engagement & Enablement Teams and Neighbourhood Management Service - A Committee Member expressed concerns about gaps in service and how the new teams would deal with existing workloads. It was reported that the Council's Governance review would clarify how the teams would work although many neighbourhood management services functions had ceased. Officers will work with residents to encourage communities to be more involved in neighbourhoods.

Q18 – Parking Charges – A Committee Member sought assurance that help would be provided to businesses if they were affected by the increased parking charges. The Cabinet Member assured the Committee that concerns about the impact of the parking charges had been taken seriously and surveys on the potential impact had been conducted. 99% of people surveyed had raised issues mainly about parking signs rather than pricing. The Cabinet Member stated that she would discuss with officers the possibility of a review of the arrangements, which would not be implemented until May 2011, before the scheduled 1 year review if businesses are shown to be suffering as a result.

Q22 – Cranford Way Recycling Site – The Committee asked for a briefing note (to be copied to Hornsey Ward Councillors) providing history and plans for the site including clarity about the Council paying business rates for the site (Action No. 216.3).

	Q28 - Street Cleansing – It was noted that the issue of enforcing responsible dog ownership and fixed penalty notices will be issued for dog fouling. During recent patrols dog-walkers who were challenged had mostly been prepared with bags to clear-up their dog mess and the few that were not had been given warnings. It was highlighted that there had been a Keep Britain Tidy campaign relating to dog fouling. The Cabinet Member would circulate to all Council Members proposals by Transport for London (TfL) to reduce the number of bus stops in the Borough so that their feedback can be reported at the next quarterly meeting with TfL (Action No. 216.4). The Cabinet Member would circulate the date of the quarterly transport Liaison meetings to enable all Council Members to raise issues involving all transport providers and bus stops. **RESOLVED** to note the report.
OSCO217.	**RECYCLING AND COLLECTION METHODOLOGIES** RECEIVED an update on the progress made against recommendations in the scrutiny review of Recycling Collection Methodologies in Haringey, introduced by Graham Jones (Client Performance Manager – Waste Management) and Stephen McDonnell (Head of Environmental Resources). A discussion followed. NOTED • A re-tendering process including recycling, food and green waste, took place further to the review and Veolia won the contract from April 2011. A Committee member expressed that they would have liked to have seen some detail of the food and green waste options. • Recyclables were collected and taken to the North London Waste Authority where it was sorted and sent to processors accordingly. • A briefing note on the proposals for a new waste depot in Pinkham Way would be circulated to the Committee (Action No. 217.1). Committee members expressed concern about the large volume of lorries going in and out of Pinkham Way and whether the plant would emit fumes and bad smells. It was noted that there would not be an incinerator on the site. • A briefing note on the reasons for co-mingled recycling collections would be provided to the Committee (Action No. 217.2). **RESOLVED** to note the report
OSCO218.	**IMPLICATIONS FOR THE OVERVIEW AND SCRUTINY COMMITTEE OF THE HEALTH AND SOCIAL CARE BILL AND THE LOCALISM BILL** RECEIVED the briefing on the implications for the Overview and Scrutiny Committee of the Health and Social Care bill and the Localism Bill, presented by Melanie Ponomarenko (Scrutiny Officer). NOTED

	• Overview and Scrutiny would continue to have the power to refer matters of significant services to the Secretary of State. However, under the Bill this would need to be triggered by a meeting of Full Council. • Overview and Scrutiny powers under the Bill will be expanded to cover all NHS funded services. • The Committee would, at such a time that the Health and Social Bill is finalised, seek confirmation from the Leader of the Council that statutory health scrutiny powers will be retained by the Overview & Scrutiny Committee. • A Committee member expressed concern about how GP Consortia and NHS budgets would be scrutinised and noted that the committee could request the information from the GP consortia, who will be accountable to the NHS Commissioning Board. • The Committee asked for a briefing note on "designated services" mentioned in the Health and Social Care Bill (Action No 218.2). • The Local Involvement Network (LINk) would become "Healthwatch" and would sit on the Health and Wellbeing Board. **RESOLVED** to note the report.
OSCO219.	**PERFORMANCE OF REGISTERED HOUSING PROVIDERS** RECEIVED briefing note on the annual performance report of registered housing providers, introduced by Nick Powell (Head of Housing strategy, Development and Partnerships). A discussion followed in response to Members' questions. NOTED • The Council did not regulate registered housing providers but worked closely with those which were signed up to the Council's partnership agreement and took part in sub-regional forums with other boroughs that compared performance. • In response to questions it was reported that registered housing providers were required to meet the decent homes standard and fund any repairs and their tenancy agreements varied slightly from Council tenancies (assured as opposed to secure tenancies). • Housing associations were required to have their own complaints procedures in place but the Council would by exception get involved in any member enquiries that had not been resolved. • There were approximately 16000 council housing units and 12000 housing association units in the borough. Less new social rent housing would be provided in the future due to reductions in grant funding and the government encouraging the supply of affordable rent housing 80% of market rent levels. The slow down in the market also affects the level of Section 106 funding which can be obtained fro developments to put towards new affordable housing. • The Committee asked for figures for the number of Extra Care housing units that will be available in the Borough (Action No. 219.1). • The displacement of rough sleepers from central London into Haringey was a concern to the Council. The Council's Rough Sleepers Strategy was in place and in addition an annual count of rough sleeper was conducted to provide the Council with intelligence on the number of rough sleepers in the borough

	RESOLVED to note the report.
OSCO220.	**ANIMAL WELFARE UPDATE** The Committee received the report updating on the progress made against the recommendations of the scrutiny review of Animal Welfare in Haringey. Robin Payne (Head of Enforcement) reported that the Council's Animal Welfare partnership, including local partners (page 47 of the agenda pack), had devised a programme of action covering the scrutiny recommendations, which would be circulated to Committee Members once signed off by the Animal Welfare Partnership (Action No. 220.1). The Animal Welfare Policy was likely to be permanently amended to allow performing domestic animals on Council land further to the trial period and positive feedback. The Committee noted that the Council's Animal Welfare Policy was relevant to events on Council owned land; all other events must conform to the Animal Welfare Act. In response to the Committee's questions on dangerous dogs it was reported that a licence was required for breeding dangerous dogs except for "Hobby Breeding" – where dogs were not bred as a form of income. The Council was working with partners in the Bruce Grove area on challenging young people in control of dogs and a pilot scheme in collaboration with the Parks Department was being considered. The Cabinet Member would email all Council Members details on how they could report details of breeders of dangerous dogs (Action No. 220.2). **RESOLVED** to note the report.
OSCO221.	**20 MPH SPEED LIMIT - SCRUTINY REVIEW** RECEIVED the scrutiny review on the introduction of a 20 mile per hour (mph) speed limit and a discussion took place. NOTED • A local organisation representing driving instructors has expressed support for the 20mph limit. The organisation encouraged instructors to teach learner drives to limit their speed to 20mph. • A Committee Member suggested introduction a borough-wide pilot scheme of 20 mph rather than only in a town centre. • All waste contract vehicles included a GPS monitoring system and would be monitored to ensure they did not exceed 20pmh. **RESOLVED** to approve the report and refer it to Cabinet for a response.
OSCO222.	**HARINGEY GUARANTEE - SCRUTINY REVIEW** RECEIVED the scrutiny review of the Haringey Guarantee introduced by Martin Tucker (Regeneration Manager) and Melanie Ponomarenko (Scrutiny Officer). A discussion followed. NOTED

	• In response to a question raised by a Committee Member it was reported that discussions had been held with Tottenham Hotspur Football Club about the employment of local people during the new stadium development and afterwards. Jointly funded training programmes (particularly for hospitality and catering) had been planned but discussions had halted as the planning application was not being taken forward. • In relation to recommendation 4 the Committee noted that the work done with local big employers included assisting them in setting up workshops for the recruitment of local people. • The Families into Work projects meant that where there were 2 people in a family out of work they would be seen as one project. **RESOLVED** to approve the report and refer it to Cabinet for a response.
OSCO223.	**PRE-SCRUTINY UPDATES** NONE.
OSCO224.	**NEW ITEMS OF URGENT BUSINESS** There were no new items.
OSCO225.	**MINUTES** The minutes of the meetings held on 1st November 2011 (Call-in) and 21st February 2011 were agreed as correct records.
OSCO226.	**FUTURE MEETINGS** The Committee noted the dates for future meetings: Wednesday 30th March 2011 Monday 9th may 2011
OSCO227.	**SCRUTINY COMMITTEE ACTIONS REQUESTED** NOTED the actions completed since the last meeting. The meeting ended at 20:45 hrs.

COUNCILLOR GIDEON BULL
Chair

SIGNED AT MEETING…….DAY

OF……

CHAIR……

MINUTES OF THE OVERVIEW AND SCRUTINY COMMITTEE
WEDNESDAY, 30 MARCH 2011

Councillors: Councillors Bull (Chair), Browne (Vice-Chair), Basu, Ejiofor, Newton, Winskill and Allison

Apologies: Councillor Alexander

Also Present: **Councillors:** Cllr Lorna Reith (Cabinet Member for Children's Services), Cllr Reg Rice (Chair of the Children's Safeguarding Policy and Practice Advisory Committee)
Officers: Peter Lewis (Director – Children & Young People's Service), Marion Wheeler (Assistant Director for Safeguarding), Sarah Hunt (Drug and Alcohol Team (DAAT)), Duncan Mulvany (Involve), Doda John-Baptist (Nightingale Primary School), Jane Flynn (Alexandra Primary School), Wendy Tomlinson (Head of Service Commissioning and Placements), Bob Garnett (Interim Deputy Director, School Standards and Inclusion), Rob Mack (Scrutiny Officer), Natalie Cole (Clerk)

MINUTE NO.	SUBJECT/DECISION
OSCO228.	**WEBCASTING** NOTED that the meeting was webcast for live or future broadcasting on the Council's website.
OSCO229.	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Councillor Alexander (Councillor Allison attended as substitute), Helena Kania (Haringey LINk), Yvonne Denny (Church Representative), Hilary Corrick (Independent Social Work Consultant and Member of the Children's Safeguarding Policy & Practice Advisory Committee), Debbie Haith (Deputy Director – Children and Families) and Marion Morris (Drug and Alcohol Action Strategic Manager).
OSCO230.	**URGENT BUSINESS** There was no urgent business.
OSCO231.	**DECLARATIONS OF INTEREST** There were no declarations of interest in relation to items on the agenda.
OSCO232.	**DEPUTATIONS/PETITIONS/PRESENTATIONS/QUESTIONS** There were no such items.
OSCO233.	**SUPPORT TO CHILDREN AT RISK OF SUBSTANCE MISUSE** RECEIVED the report updating on the review of support to young people at risk of substance misuse (pages 1-18 of the agenda pack) further to the 2009 scrutiny review, presented by Sarah Hunt (Drug and Alcohol Action Team),

	Wendy Tomlinson (Head of Service - Commissioning and Placements) and Duncan Mulvany (In-Volve). A discussion took place. NOTED • The Common Assessment Framework (CAF) now included a section on substance misuse and a team worked together to provide screening and drug and alcohol treatment. The commissioning of services would soon be transferred to the Drug and Alcohol Action Team (DAAT). • There was a link between parental substance misuse and the impact on children but the other side of substance misuse was young people misusing as they became adults. • Adults Services worked with Children's Services where parents were known to be misusing drugs or alcohol and the police were also informed in cases where substances were obtained by children from their parents. • In-Volve, a voluntary sector organisation, conducted group and targeted work with a pilot school, which was very effective and would be rolled out across other schools. In-Volve also provided advice to parents and referred them on to other services such as COSMIC who often worked with parents and children from individual families at the same time. **RESOLVED** to note the report.
OSCO234.	**CABINET MEMBER QUESTIONS - CABINET MEMBER FOR CHILDREN'S SERVICES** RECEIVED the briefing (pages19 -22 of the agenda pack) from the Cabinet Member for Children's Services, Cllr Lorna Reith and the responses to advance questions submitted. Supplementary questions were asked and discussions noted below. NOTED • Re: Q2 & 22 – School meals - Take-up might be low for a number of reasons including where a school was near an estate of houses pupils might go home for lunch. The answer to Q22 focussed on free school meals; the Committee would be provided with an updated answer in relation to general school meals take up, particularly in primary schools (Action No. 234.2). • Re. Q5 – Children in Care Placements - The Committee requested a more expansive briefing note on why more children being placed in care needed re-placements and more specific detail about legal costs with reference to Action 98.1 from the meeting held on 1st November 2010, Page 114 of agenda pack, (and Action 159 from Budget Scrutiny 17th January 2011). It was noted that some of the re-placements were due to bringing together children as a family group when they had been separated as emergency interim measures. Such re-placements did not require additional court action as court orders had already been obtained for the children (Action No. 234.1). • Re. Q5 – In response to the Committee's concerns about the number of times a case can go to court the Director of CYPS explained that this was often due to judges and guardians asking for additional assessments to

	be conducted. • Re. Q22 – A Committee Member expressed concern that 17.6% of referrals had been previously referred in the last 12 months and asked why. It was noted that the referrals could be for different issues and could come from different professionals. After the initial information gathering it could be concluded that there was no underlying issue and the referral not followed through. • Re. Q29 – The Committee commented that the role of Corporate Parent should be defined. It was noted that the Assistant Head of Legal – Social Care was preparing a briefing, which would be circulated to all members, in response to new regulations coming into force. • Re. Q34 & 35 – The work of children centres will be more targeted towards early intervention and all centres will have a set of outcomes to meet which might include health visiting targets or looking at families in temporary accommodation or those on child protection lists. The Cabinet Member agreed that early intervention would impact children's behaviours. **RESOLVED** to note the briefing. *Clerk's note: 19:55 hrs - Cllr Bull left the meeting and Cllr Browne, Vice-Chair, took over as Chair.*
OSCO235.	**CHILDREN'S SAFEGUARDING POLICY AND PRACTICE ADVISORY COMMITTEE** RECEIVED the report for the Children's Safeguarding Policy and Performance Advisory Committee (pages 23 – 24 of the agenda pack), presented by Cllr Reg Rice (Chair of the Advisory Committee). A discussion followed. NOTED • The last paragraph in the report stated that the Advisory Committee would no longer report to the Overview & Scrutiny Committee under the new governance arrangement. Committee members asked which other bodies scrutinised the quality of advice given to the Cabinet. The Chair of the Advisory Committee stated that he understood scrutiny of the Cabinet's role to be the responsibility of the Overview & Scrutiny Committee. • The Advisory Committee differed from the Local Safeguarding Children Board (LSCB – a statutory committee) and the Children's Trust (which focused on partnership planning and working) as it formally considered specific matters and recommended action and provided independent social worker advice. • The Committee, the Cabinet Member for Children's Services and the Chair of the Safeguarding Policy & Practice Advisory Committee all recognised that there was duplication of work among committees. The Committee asked that the Children & Young People's Service provide a short report on the roles, remits and composition of the different committees which considered the safeguarding of children including the Children's Safeguarding Policy and Practice Advisory Committee, Local Safeguarding Children's Board and the Children's Trust, for future

	consideration by the Committee. (Action No. 235.1). • The Chair of the Advisory Committee would discuss the issue of children's needs assessments (which the Committee expressed some concern about) being undertaken by assistant social workers with Hilary Corrick (Independent Social Work Consultant and Independent Member of the Advisory Committee) (Action 235.2). *Clerk's note: 20:05 hrs Cllr Bull returned to the meeting and resumed in the Chair.* **RESOLVED** to note the report.
OSCO236.	**SAFEGUARDING ACTION PLAN - UPDATE ON PROGRESS** RECEIVED the report on the Safeguarding Plan for Haringey (pages 25 – 86 of the agenda pack) introduced by the Director of Children & Young People's Service (CYPS). NOTED • The Committee congratulated the Director of CYPS on achieving Grade 2 "Good" rating by Ofsted in "capacity for achievement" (paragraph 18, appendix 3). • In response to a suggestion by a Committee Member it was reported that until recently a magistrate had sat on the Haringey Children's Trust and discussions about recruiting a permanent magistrate to the Trust will be taken forward. • In response to concerns raised about assistant social workers conducting assessments (supervised by qualified social workers and signed off by managers) the Director of CYPS reported that, whilst the Ofsted report highlighted that this was not consistent with national guidance, assistant social workers conducted assessments in many other local authorities and this was a comment found in many Ofsted reports. • The Committee requested information on how children in care homes (including the 5 private homes) were monitored in terms of where children spent their time if they were not at the home and who they mixed with and whether the Police were involved when there were concerns (Action No. 236.1). • Committee Members expressed concern about the additional investment for 2011-12 (paragraph 19, appendix 3) and noted that this was further investment by the Council and NHS rather than overspending. The Director of CYPS explained that the service had been asked to make savings and was doing so. • The Committee recommended that the Safeguarding Action Plan be considered by the Committee twice per year (Action No. 236.2). **RESOLVED** to note the report and that the Safeguarding Action Plan be considered by the Overview & Scrutiny Committee at least twice a year in future.
OSCO237.	**CHILD PROTECTION PERFORMANCE AND KEY ISSUES REPORT** RECEIVED the update report on key performance information on child

	protection (pages 87-100 of the agenda pack), introduced by Marion Wheeler (Assistant Director for Safeguarding). A discussion followed. NOTED • The Committee questioned the discrepancy between the figures provided on Page 90 (Children with a Child Protection Plan (CPP) moving into the Borough) and Page 115 (minutes of the previous Child Protection Overview & Scrutiny Committee meeting) of the agenda pack. Page 90 stated that 43 Children on CPPs had moved-into the Borough and 36 had moved out since January 2011 and Page 115 provided the figure of 40 children on CPPs moving into the Borough. The Director of Children and Young People's Service would investigate and provide Committee members with an explanation (Action No. 237.1). • In response to questioning it was reported that where assessments were not completed within timescales managers would establish the reasons, however, some assessments were immensely complex and meeting high standards of work was a priority. • The Director of Children and Young People's Service and Councillor Joseph Ejiofor would be meeting to discuss how information should be reported to the Committee and would include how to clarify the performance indicators NI 59 and NI60 (Action No. 237.2). • The Committee asked for a presentation at a future meeting on the causes for delays in assessments (Action No. 237.3). • A piece of work had recently been conducted within the Children's Services department on how child protection had been audited over the past two years and meeting quality standards and timings. It was agreed that a presentation on the results of this piece of work would be presented to the Committee at a future meeting. • First Response process was explained to the Committee and in response to questioning it was reported that the First Response team did not always write to people, by way of a follow-up, who had contacted the First Response team as this could compromise cases or confidentiality. **RESOLVED** to note the report.
OSCO238.	**SCHOOL EXCLUSIONS** RECEIVED the report (pages 101-106 of the agenda pack) on fixed term and permanent exclusions in schools for the autumn term 2010/11 introduced by Peter Lewis (Director – Children and Young People's Service (CYPS)) and Cllr Lorna Reith (Cabinet Member for Children's Services). A discussion and questions followed. NOTED • The Director of Children & Young People's Service had identified some inaccuracies in the report. An amended School Exclusions report would be considered by the Committee at its meeting on 9th May 2011 and the Headteachers from St. Thomas More and Gladesmore Secondary Schools would be invited (Action No 238.3). • The report of a previous Scrutiny Review on Exclusions would be

circulated to the Committee (Action no 238.1).

- The Committee asked for details about whether children who were being excluded had accessed Children's Centres. (Action No. 238.2).

The Committee welcomed and questioned the Headteachers from Nightingale Primary School, Doda John Baptist, which had comparatively high levels of exclusions and Alexandra Primary School, Jane Flynn, where there had been no exclusions during the autumn term, on their practices regarding exclusions in their schools.

NOTED

- Nightingale Primary School had recently seen a change in the area's demographics and this was reflected in the intake of children at the school. The last 5 years had seen more children enter the school with complex needs which had not previously been identified. Where a child displayed behavioural problems resulting in exclusion the school conducted an informal assessment and worked with other agencies where necessary. The best results were when the school was able to work with the parents of a child and they engaged with the additional services offered.
- In response to questioning Ms John-Bapstist explained that at Nightingale School every single incident was officially recorded, for example, if a parent was asked to collect a child from school early as a result of behaviour – some schools did not record this as an exclusion.
- Committee members expressed concern that children's needs were not picked up before they started at the school and Ms John Baptist explained that in previous years children had been identified by health visitor checks and concerns followed up.
- Alexandra Primary School was a small school and had a strong ethos focussed on children understanding their behaviour and there were structures followed when bad behaviour was identified, for example a child would be sent out of class and if such behaviour persisted the next stage of the structure would be implemented. Some staff at the school had commented that the school was too lenient as there were some younger children who displayed violent behaviour. Ms Flynn worked closely with these children rather than excluding them, which she felt was sending them back to where the problem was created.
- The Director of CYPS highlighted that there were different perceptions of levels of behaviour and different ways to deal them but all schools had access to support services to find the right programme for children to help them manage their own behaviour and return to school as quickly as possible. Schools Special Education Needs (SEN) teachers met on a termly basis and exclusions and behaviour were regular topics for discussion.
- National Research showed that between 1990-2000 black boys were eight times more likely to be excluded from school.
- In response to concerns that pupils were being excluded from the Support Centre (who had already been excluded from school) the Director of CYPS explained that it was important to maintain that there would be sanctions for inappropriate behaviour.

	RESOLVED that the amended Exclusions Report be considered at the next meeting of the Committee and that representatives from St. Thomas More and Gladesmore Secondary Schools be invited.
OSCO239.	**EXAM RESULTS** RECEIVED the preliminary analyses of results at the end of the Foundation Stage, Key Stages 1,2,4 and Post 16 for 2010 (pages 107 – 112), introduced by Bob Garnett (Interim Deputy Director, School Standards and Inclusion) who highlighted that whilst Haringey's improvement rates were twice the national average there were still gaps in performance and looked after children were still underperforming. A discussion followed. NOTED • Higher performing schools had fewer exclusions and schools that fostered a good ethos had better academic results. • A Committee Member highlighted that in relation to the figures for Key Stage 2 results on page 112 the data was not a comparison of like for like as only 20 schools had taken the SAT tests in 2010 therefore it could not be concluded that these results were improving. The Director of CYPS explained that the schools that had not taken SATs had undertaken rigorous teacher assessments and the Secretary of State had agreed that Haringey's overview of Key Stage 2 was valid and action plans robust. • Concerns were raised about categorising all schools together as some schools performed better than others. It was explained that the borough was judged as a whole and therefore had to be recorded as such but more in-depth information was available. **RESOLVED** that the report be noted.
OSCO240.	**NEW ITEMS OF URGENT BUSINESS** There were no new items.
OSCO241.	**MINUTES** **RESOLVED** that the minutes of the Child Protection Overview & Scrutiny Committee held on 1st November 2010 were agreed as a correct record. NOTED the following matters arising. • Re: Action 100.2 – NI 148 – Number of Care Leavers not in Education, Employment or Training (NEET) – a Committee Member requested more information on why the numbers had increased from 7 to 9 since the last meeting (Action 241.1). • Re: Gap Widening – In relation to P112 of the agenda pack, Summary of Provisional Results, the Committee expressed concern that officers were stating that results had improved when, whilst the national average was increasing, Haringey's figures were decreasing. (Action 241.2).
OSCO242.	**FUTURE MEETINGS**

	The next meeting will be on 9th May 2011. The meeting ended at 21.15 hrs.

COUNCILLOR GIDEON BULL

Chair

SIGNED AT MEETING…….DAY

OF……

CHAIR……