haringey strategic partnership

NOTICE OF MEETING

Well-Being Partnership Board

TUESDAY, 10TH JUNE, 2008 at 19:00HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22.

MEMBERS: See membership list attached below.

AGENDA

1. WELCOME, APOLOGIES AND SUBSTITUTIONS

To welcome those present to the meeting and receive any apologies for absence.

2. MINUTES (PAGES 1 - 10)

To confirm the minutes of the meeting held on 4 March as a correct record of the meeting.

3. ELECTION OF CHAIR

To elect a Chair for the new Municipal Year.

4. APPOINTMENT OF VICE-CHAIR

To appoint a Vice-Chair for the new Municipal Year.

5. DECLARATIONS OF INTEREST

Members of the Board must declare any personal and/or prejudicial interests with respect to agenda items and must not take part in any decision with respect to these items.

6. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under Item 21 below).

7. COMMUNITY LINK FORUM PRESENTATION (PAGES 11 - 46)

A presentation will be made by the Community Link Forum.

8. MEMBERSHIP AND TERMS OF REFERENCE: 2008/09 (PAGES 47 - 58)

9. APPOINTMENT OF REPRESENTATIVE TO THE HARINGEY STRATEGIC PARTNERSHIP

To appoint a representative from the Board to the Haringey Strategic Partnership (HSP) for 2008/09.

10. PRIMARY CARE STRATEGY (PAGES 59 - 106)

11. HEALTH INEQUALITIES AUDIT FEEDBACK (PAGES 107 - 110)

12. JOINT MENTAL HEALTH STRATEGY (ADULT'S WORKING AGE)

A verbal update will be provided.

13. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST: FOUNDATION TRUST STATUS UPDATE

A verbal update will be provided.

14. AREA BASED GRANT

A verbal update will be provided.

15. CORE STRATEGY: DRAFT ISSUES AND OPTIONS (PAGES 111 - 116)

16. LOCAL AREA AGREEMENT UPDATE (PAGES 117 - 126)

17. WELFARE TO WORK FOR THE DISABLED -PROGRESS REPORT (PAGES 127 - 132)

18. REVIEW OF LIFE EXPECTANCY ACTION PLAN (PAGES 133 - 134)

A presentation will also be provided.

19. PREPARATION OF TOBACCO STRATEGY FOR HARINGEY (PAGES 135 - 136)

20. HEALTH CARE FOR LONDON

A verbal update will be provided.

21. NEW ITEMS OF URGENT BUSINESS

To consider any new items of Urgent Business admitted under Item 6.

22. WORKING NEIGHBOURHOOD FUND/COMMUNITIES FOR HEALTH (PAGES 137 - 144)

This item is for information.

23. WELL-BEING BALANCED SCORECARD (PAGES 145 - 166)

This item is for information.

24. ANY OTHER BUSINESS

To consider any items of AOB.

25. DATES OF FUTURE MEETINGS

Please note that the following dates have been set for 2008/09:

2 October 2008
8 December 2008
2 March 2009

YUNIEA SEMAMBO
Head of Member Services
5th Floor
River Park House
225 High Road
Wood Green
London N22 8HQ

Xanthe Barker
Principal Committee Coordinator
Tel: 020-8489 **2957**
Fax: 020-8881 5218
Email:
xanthe.barker@haringey.gov.uk

SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	9	Cllr Bob Harris (Vice-Chair) Mun Thong Phung Councillor John Bevan Councillor Dilek Dogus Councillor Gideon Bull Margaret Allen John Morris Marion Morris Lisa Redfern
Health	Haringey Teaching Primary Care Trust	6	Judy Allfrey Tracey Baldwin Eugenia Cronin Vicky Hobart Cathy Herman Richard Sumray (Chair)
	North Middlesex Hospital trust	1	Claire Panniker
	BEH Mental Health Trust	1	Michael Fox
	Whittington Hospital Trust	1	Joe Liddane
Community Representatives	Community Link Forum	3	Abdool Alli Angela Manners Rizvi Faiza
	HAVCO	2	Robert Edmonds Naeem Sheikh
Education	College of North East London	1	Cathy Walsh
Other agencies	Haringey Probation Service	1	Mary Pilgrim
	Metropolitan Police	1	Richard Wood
	Total	**26**	

Agenda Item 2

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 4 MARCH 2008

Present: Richard Sumray (Chair), Judy Allfrey, Margaret Allen, Councillor John Bevan, John Brown, Eugenia Cronin, Councillor Isidoros Diakides, Jan Dunster, Councillor Dilek Dogus, Robert Edmonds, Susan Hessle, Cathy Herman, Cecelia Hitchen, Vicky Hobart, Ian Kibblewhite, John Morris, Marion Morris, Mun Thong Phung, Lisa Redfern, Naeem Sheikh.

In Attendance: Xanthe Barker, Helen Constantine, Phil Harris, Martin Tucker.

MINUTE NO.	SUBJECT/DECISION	ACTON BY
OBHC38.	**WELCOME, APOLOGIES AND SUBSTITUTIONS** The Chair welcomed those present to the meeting and noted that apologies had been received from Councillor Gideon Bull. It was noted that the membership of the Board had altered and the agenda papers need to be amended to reflect this prior to the next meeting.	XB
OBHC39.	**MINUTES** Councillor Harris noted that minute number OBHC19, paragraph, referred to the Haringey Federation being given an 'observer' place on the Board. He contended that this was not an observer place and it had been agreed that a full place should be given to the Haringey Federation. **RESOLVED:** That, subject to the amendment referred to above, the minutes of the meeting held on 13 December 2007 were confirmed as a correct record of the meeting.	XB
OBHC40.	**URGENT BUSINESS** Under this item Councillor Bevan requested that an item on The Laurels be tabled as a new item of Urgent Business and considered by the Board. Councillor Bevan noted that since the last meeting he had visited The Laurels and as a result he had concerns regarding its organisation and the way it was managed. Given the reoccurring nature of concerns over The Laurels, Councillor Bevan and some other Councillors contended that this item should be considered by the Board. The Chair noted the concerns raised in relation to The Laurels. However, given that the Board was a forum for strategic issues, he considered that	

	it would be more appropriate if the Board requested that a meeting was organised, outside the Board meeting, in order to address this. After further discussion the Chair did not accept this as an item of Urgent Business and requested that officers from the PCT and Council liaise to arrange a meeting, prior to the Board's next meeting, in order to discuss The Laurels and the concerns raised in relation to its management. The outcome of this meeting would then be reported to the Board. **RESOLVED:** That a meeting should be arranged, prior to the Boards next meeting, between the Council and the PCT, to discuss the issues of concern raised regarding The Laurels.	Dir ACCS/ PCT Dir ACCS/ PCT
OBHC41.	**DECLARATIONS OF INTEREST** Councillor Dilek Dogus advised the Board that she worked for the Mental Health Trust. However, she did not make a formal personal or prejudicial interest in respect to any specific item.	
OBHC42.	**PRIMARY CARE STRATEGY NEXT STEPS** The Board considered a report that set out the next steps for the development of the Primary Care Strategy for Haringey. It was noted that this now took into account the recent consultation and Equalities Impact Assessment (EIA). The Board was advised that following this meeting, the final Strategy would be produced, which would take into account the outcome of Healthcare for London and would then be brought back to the Board for consideration in May. The next phase would engage stakeholders, particularly members of the public and GP's. During this phase detailed plans in relation to each Super Health Centre would be drawn up prior to the consultation process. It was noted that many members of the public attached significant value to the personal relationship that they had built up with their GP and it was likely that there would be a lot of concern in relation to the proposals. This would particularly affect vulnerable groups and other groups who had a particularly close relationship it their GP. It was recognised that vulnerable individuals used to receiving regular support from their local GP may require specific support to address the vacuum this may create. In response to the concerns raised, the Board was advised that the loss of GPs was recognised as an issue that would require attention within the Consultation document. In addition to this, the Health Equalities Impact Assessment addressed this issue and made a series of recommendations. The Board was reminded that there was a balanced argument in relation to the introduction of the Super Health Centres and	

	that work at a local level was required to address specific issues of concern. It was noted that at present, the lack of detail in relation to the proposals made it difficult for the Board to sign up to the document and there was agreement that, once available, the Issues and Options paper should be submitted to the Board for consideration. The Board was advised that the revised version of the Strategy would set out how the PCT planned to retain the positive aspects of the old system and would explore how these aspects would be balanced in more detail. The Board was advised that in terms of improving access the PCT were working closely with Transport for London, Dial-a-Ride and local taxi firms. **RESOLVED:** i. That the report be noted. ii. That the Issues and Options Paper and an update be brought to the next meeting of the Board.	PCT
OBHC43.	**WELFARE TO WORK FOR DISABLED STRATEGY 2005/15** The Board considered a report on the Welfare to Work for Disabled People Strategy. The Strategy was launched in October 2005 with the aim of providing a clear focus point to all those working in the field of employment and disabilities. Partnership working was key to the Strategy, which encouraged collaboration across a range of agencies. The Strategy was strongly linked to one of the Boards key priorities around improving access to employment and mainstream provision for people with physical and mental health disabilities. It was noted that as part of the Strategy a community interest company had been established that was staffed by disabled people who provided training on disability awareness to mainstream employers. The Governments agenda for tackling Worklessness provided an emphasis on reducing the number of long term Incapacity Benefit claimants. It was noted that although there was a degree of cross over between this and the Strategy, there were different issues affecting these groups and therefore different approaches were required. It was noted that the progress against the Strategy had not been reported to the Well Being Board during 2006/07 and there was agreement that a report should be submitted for 2007/08. Concern was expressed that the Strategy did not set out in enough detail how BME groups would be assisted. It was noted that there were specific issues in certain parts of the Borough affecting BME groups and	BS

	it was suggested that stringent targets were required to ensure that these groups were reached. It was also suggested that specific measures to improve skills levels amongst BME groups were required. It was suggested that it may be useful for Services to meet in order to discuss how Social Enterprises could be supported by the Partnership and HAVCO stated that it would be happy to support this. The Chair noted that the recommendations set out in the report were wide ranging and considered that, given the level of information available at present, the Board was not able to respond to all of these at this meeting. There was agreement that officers should be tasked with looking at the recommendations set out in the report in more detail and that a report should be brought back to the Board in July setting out detailed options. **RESOLVED:** i. That the report be noted. ii. That officers consider the recommendations set out in the report and that a report should be brought back to the Board in July setting out detailed options.	Dir ACCS/ PCT Dir ACCS/ PCT
OBHC44.	**SAFEGUARDING VULNERABLE ADULTS POLICY AND PROCEDURES** The Board received a report setting out revisions to the Safeguarding Vulnerable Adults Policy and Procedures. It was noted that a multi-agency approach to the safeguarding of vulnerable adults in the Borough had first been implemented across the Council and Partner organisations in 2002. Since 2002 there had been significant improvements in awareness and the number of instances of suspected abuse being reported had risen. In order to increase capacity and support stakeholders, the post of Adult Protection Manager had been created. Resources for this post had been identified within budget proposals for 2008/09. The Board discussed the new policy and procedures and in response to a query, the Board was advised that although a multi-agency approach was being taken, each individual organisation would still be accountable, via its own internal procedures, if a serious incident were to occur. It was noted that family members were informed, where appropriate, if there was a suspicion of abuse. However, if there was any suspicion of abuse by a family member, they would not be informed of an investigation. The Board discussed training arrangements and it was recognised that organisations across the partnership would require further training in order to meet the requirements placed on them under the policy. It was	

	recognised that the Council had made a significant investment in relation to training around the new Safeguarding arrangements and that further training would be arranged as required. The Chair emphasised the need for there to be clarity around the reporting process and for all organisations to report instances of suspected abuse to the Local Authority as the central contact point. It was noted that the Terms of Reference currently stated that the quorum for the Haringey Safeguarding Adults Board should consist of a minimum of five members. However, the wording around the mix of the five members was unclear and it was agreed that this should be amended to reflect that the quorum should include at least three members from both the Council and PCT with a minimum of one from each. There was agreement that Board should receive regular report on this issue in order to monitor how the Strategy was being implemented across the partnership. **RESOLVED:** i. That the revised policy and procedures be endorsed by the Board and commended to all stakeholders across the partnership for implementation. ii. That stakeholder within the Partnership review internal procedures to ensure that they are aligned to the revised policy and procedures.	TB All
OBHC45.	**DEVELOPMENT OF TOBACCO CONTROL STRATEGY FOR HARINGEY** The Board considered a report that provided an update on the on development of an over arching Tobacco Control Strategy for the Borough. It was noted that the Strategy formed part of the Tobacco Control Project funded by Neighbourhood Renewal Funding (NRF). Tobacco consumption was recognised as being a significant contributor towards ill health and premature mortality. Therefore, specific strategies were being devised to target BME residents and residents' living in deprived areas as there was often a greater level of tobacco consumption amongst these groups. Smoking cessation classes were also being held specifically for BME groups and vulnerable adults. In response to a question the Board was advised that the Performance Management system in place to monitor the performance of the PCT would ensure that the figures that the information was based on were accurate. This information was also subject to audit.	

	It was requested that a meeting be held between the PCT's Substance Abuse Team and the Council's Drug and Alcohol Team to discuss this issue further. There was agreement that this would be useful. The Chair noted that using schools as a forum to ensure that young people were given information regarding smoking was important and also provided a good method for engaging young people from BME backgrounds. In terms of engaging employers, the Chair noted that as part of other projects, exemplars were needed. This approach could be used to highlight employers who assisted supported employees to stop smoking. **RESOLVED:** That the specification and timescales attached to the project be noted.	
OBHC46.	**UPDATE ON THE DEVELOPMENT OF THE NEW STYLE LOCAL AREA AGREEMENT** The Board received a report setting out the progress that had been made towards agreeing the thirty-five National Indicators to be included within the new Local Area Agreement (LAA). The Board was advised that a second meeting had taken place between the HSP Performance Management Group (PMG) and GOL on 25 January where GOL had confirmed that the HSP was on track to meet the June deadline for selection of the targets. However, GOL had proposed a number of amendments at that meeting and these were now being considered by each of the Thematic Boards. The Board discussed the suggestions made by GOL in relation to the Indicators within its responsibility. It was noted that existing Stretch Targets were included as Local Indicators. Although there was not a statutory obligation to report on Local Indicators they would be monitored and form an important role in the LAA. Concern was expressed at GOL's suggestion that NI 198 should become a Local Indicator and there was agreement amongst the Board that this should remain included within the list of thirty-five indicators. **RESOLVED:** i. That the suggestions made by GOL, as set out in the report, be accepted, with the exception of the suggestion that NI 198 should be replaced by NI 56. ii. That the HSP PMG should be advised of the Board's view in relation to NI 198.	VH/HP VH/HP

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 4 MARCH 2008

OBHC47.	**AREA BASED GRANT** The Board received a report, which provided a broad overview of its allocation under the new ABG and it was noted that approximately £5.3M had been allocated to the Board. The Board was advised that a more detailed report would be submitted in June. **RESOLVED:** To noted the report.	
OBHC48.	**MOVE ON STRATEGY** The Board received a presentation from the Councils Assistant Director of Strategic & Community Housing on the Move on Strategy. It was noted that the Well-Being Strategic Partnership Board and the Integrated Housing Board, would be working closely together on housing related issues and that the Move on Strategy formed a key part of this. The Chair noted that one of the aims of the Strategy was to include a variety of partner organisations and ensure that these had a sense of ownership and a responsibility for delivering the Strategy. The Director of Public Health noted that the Joint Strategic Needs Assessment (JSNA) would provide a useful tool to enable partners to take a more joined up approach to achieving the goals of the Strategy. In response to a query regarding the re-housing of people being released from prison, the Board was advised that at present there was not a consistent partnership approach to addressing this. However, it was envisaged the Strategy would help establish a more joined up approach to this and other issues. **RESOLVED:** That the presentation be noted.	
OBHC49.	**NORTHUMBERLAND PARK UPDATE** The Board was advised that the Families into Work (FiW) project aimed to improve the life chances of people living in Northumberland Park by working with families to identify and provide the services they required to assist them back into work. A key part of the project was the multi agency approach that would be employed. It was proposed that a team of four people was established that would work closely with one hundred families in Northumberland Park over a two year period. Existing resources would be used rather than using new funding and one of the aims of the project was to better	

	utilise existing resources and improve the coordination Services. The Board was advised that as part of the project, forty children, at risk of becoming NEET had been identified and thirty of these were being worked with to help prevent this happening. As part of this action the parents of children at risk of becoming NEET were also being targeted and measures to help raise their skill levels would be included. If successful the project would act as a model that could be replicated and rolled out in other areas. In response to questions regarding how the families would continue to be supported after the internal three year period, the Board was advised that it was recognised that ongoing support would be required and that provision was being made for this. A mapping exercise had been carried out and the Steering Group was looking at developing measures to address this. The Board noted that substance abuse was a common factor affecting people in deprived areas and it was suggested that organisations that specialised in working with people to address this should be included within the Programme. The Chair concluded discussion and noted that the Board supported the Programme in principal and requested that a more detailed report be submitted to the Board for endorsement once completed. **RESOLVED:** i. That the specification and timescales for the project be noted. ii. That a more detailed report be brought back to the Board for endorsement once the project was further advanced.	MM/MT MT
OBHC50.	**NEW ITEMS OF URGENT BUSINESS** No new items of Urgent Business were considered.	
OBHC51.	**WELL BEING SCORECARD** The Board considered a report setting out progress against the key strategic objectives within its responsibility. Councillor Bevan noted that the totals in columns nine and ten did not tally and queries were also raised as to whether estimates in relation to column thirteen, which referred to Community Alarms were correct. It was agreed that Councillor Bevan should be provided with a response to his queries outside the meeting. **RESOLVED:**	JM

	That the report be noted.	
OBHC52.	**NEIGHBOURHOOD RENEWAL FUNDING UPDATE** The Board received a report on the progress of projects funded by NRF funding. **RESOLVED:** That the report be noted.	All to note
OBHC53.	**COMMUNITIES FUNDING UPDATE** The Board received a report that provided an update on Communities Funding. **RESOLVED:** That the report be noted.	All to note
OBHC54.	**BARNET, ENFIELD, AND HARINGEY CLINICAL STRATEGY UPDATE** The Board received a brief update from the PCT regarding the Strategy. It was noted that structures for implementation of the Strategy had now been established and that more detailed work particularly around elective surgery had begun. **RESOLVED:** That the verbal update provided be noted.	All to note
OBHC55.	**ANY OTHER BUSINESS** The Board was advised by Robert Edmonds of HAVCO that there had been a good response to the Community Link Forum elections from members of the public. By July the representatives from the Community Link Forum should be appointed to each of the HSP Thematic Boards.	All to note
OBHC56.	**DATES OF FUTURE MEETINGS** **RESOLVED:** i. That the tentative dates for future meetings be noted. ii. That consideration should be given to moving the two Autumn meetings further apart.	XB

RICHARD SUMRAY

Chair

Havco
Haringey Association of Voluntary and Community Organisations

Community Engagement Systems for Haringey Strategic Partnership

Haringey Community Link Agreement

Background

The current provider of community engagement systems in the Haringey Strategic Partnership (HSP) has been derecognised as of 22nd March 2007, following a performance review. This situation leaves the HSP with a vacuum in ensuring effective community engagement in the partnership and its themed boards. Therefore the London Borough of Haringey have commissioned a community development advisor to work with the Council, HSP and HAVCO to develop new proposals and model for engagement that can be introduced within the financial year 2007/8.

The first draft of the proposal for new community engagement systems in the HSP was published in May 2007. Following its publication and presentation to the HSP it has been subjected to a period of consultation and scrutiny by the voluntary and community sector in the borough.

The wider engagement, consultation and scrutiny process has taken three forms. Firstly, a Reference Group of existing voluntary and community sector representatives was established to feed into the revision of the proposal and take it to the wider sector for engagement.

Secondly, a questionnaire was developed and released with the proposal to Haringey's voluntary and community sector. In total over 800 organisations received the proposal and questionnaire and 36 were completed and returned in response to the invitation to comment, along with 35 evaluation forms with further comments made by those attending the stakeholder meetings on 12th July 2007.

Two stakeholder meetings were held on 12th July to engage those organisations who preferred to discuss and explore the proposal in person. Attendance at these meetings was good and engaged a wide range of organisations both voluntary and community from many different backgrounds.

Overall the results of the consultation and engagement process highlighted widespread support for new systems of engagement in the HSP as long as they lead to real influence and change. There were however some real issues outlined in the original proposal which some parts of the voluntary and community sector found

difficult to agree with. Despite the consultation process some of these issues have not been resolved and therefore this revised proposal has been amended to address areas of concern where this was possible without undermining the integrity of the model outlined in the first proposal. The key areas are: -

- Definition of constituted body allowed to be in membership of Haringey Community Link Forum (Page 9)
- Co-option to HSP and its sub-structures (Page 3)
- Revision of compulsory training and induction programme (Page 6)

The funding that was available through Government Office for London to establish and manage Community Empowerment Networks no longer exists. Therefore the priority for Haringey is to ensure we secure effective systems that offer the partnership effective engagement, accountability and real influence. Sustainability and appropriate resourcing were also critical factors important to the voluntary and community sector that came through very clearly from the consultation process.

This document outlines new engagement systems proposed by HAVCO following engagement led by the Reference Group with the wider voluntary and community sector and supported by the Council and the wider Partnership.

Interim Arrangements

The HSP still has approximately 11 representatives from the community sector and 14 from the voluntary sector remaining on its Main Board and Themed Partnership Boards. In some cases Themed Partnership Board Chairs have taken action to fill voids during this interim period.

Main HSP Board	Community Sector	- Youth Council (2)
	Voluntary Sector	- HAVCO (3), Peace Alliance (1), Race Equality Joint Consultative Committee – REJCC (1)
Well Being Board	Community Sector	- Federation of Residents Association (1)
	Voluntary Sector	- HAVCO (2)
Safer Communities Board	Community Sector	– Haringey Community and Police Consultative Group - HCPCG (1)
	Voluntary Sector	- Peace Alliance (1), HAVCO (1)
Children & Young Peoples Board	Community Sector	- Youth Council (2)
	Voluntary Sector	- HAVCO (2)
Better Places Board	Community Sector	- Federation of Residents Association (2) Friends of Parks (2) Mobility Forum (1)

Voluntary Sector - No representation

Enterprise Board Community Sector - No representation
Voluntary Sector - Selby Trust (1) HAVCO (1)
Collage Arts (1)

Integrated Housing Community Sector - Haringey Leaseholders' Association (1) Voluntary Sector - SHADE (1) Hornsey YMCA (1)
Afrikcare (1)

It is proposed that these places remain as an interim arrangement until new systems are adopted and fully operational. This would ensure consistency, stability and remove the requirement to develop systems of securing further representatives for a 6-9 month period which would be resource intensive. The new proposals will ensure consistency across the whole partnership structure and a higher level of accountability and support for *all* representatives.

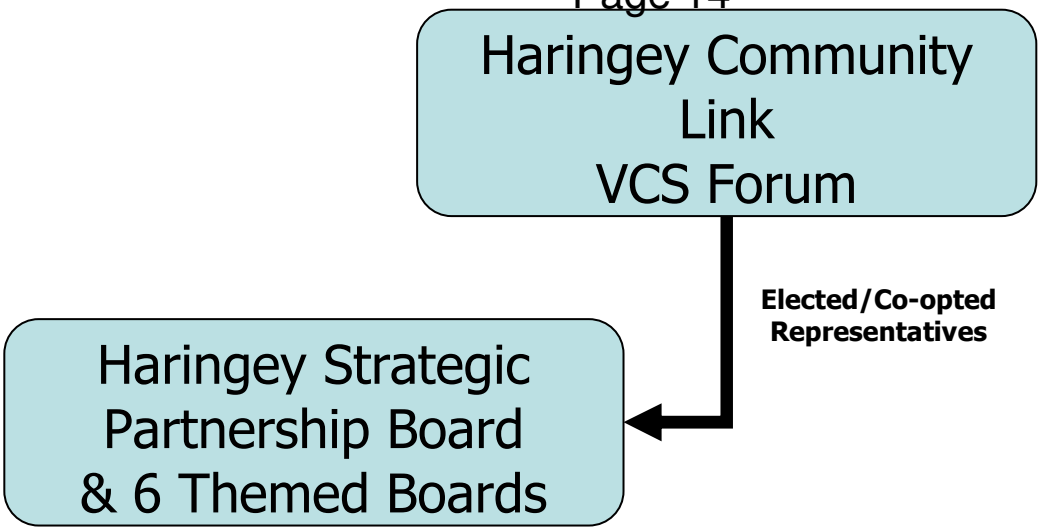
Proposed New Model for Community Engagement

It is proposed that all voluntary and community sector representatives on the Main HSP Board and its Themed Partnership Board structures are elected through a new forum called Haringey Community Link Forum. This would become the 'forum of forums' for the voluntary and community sector.

The introduction of the new system for securing voluntary and community sector representatives would replace *all* existing mechanisms (some of which vary by themed boards), ensuring consistency and accountability. This will mean that existing voluntary and community sector representatives will lose their current places at the end of the interim arrangement period. If they wish to retain their places they will have to stand for election.

The new systems will add value to the partnership and all sectors involved. It is a real opportunity to improve effective representation, as the voluntary and community sector want to build upon the Beacon Status achieved by the London Borough of Haringey for Area Assemblies. It could also offer real value for money if utilised for securing voluntary and community sector representation on other structures outside of the HSP, such as PCT partnership boards, LSC project/partnership boards etc. This is an approach being adopted in several other London boroughs.

Haringey Community Link Forum should have the power to co-opt strategic, voluntary and community organisations with specialist skills or knowledge to the partnership boards, in addition to the elected voluntary and community representatives. The Community Link Forum will monitor the performance of such organisations, who will be expected to work with the Community Link Forum representatives and help build up the Forum.



The development of Haringey Community Link, a voluntary and community sector forum will see benefits for the partnership, the voluntary and community sector and other agencies operating in Haringey. It will ensure a formal gateway is developed to communicate with a wide range of organisations on policy and service issues, through regular structured meetings.

The development of the forum will see community engagement in the partnership moving towards a generic model of representatives being elected or co-opted onto the HSP and Themed Boards. This will mean they are representatives of Haringey Community Link and not specialist areas of interest or geography (such as disability, faith etc). There is a firm belief that this will reinvigorate voluntary and community sector representation, especially on delivery partnerships. With the resources allocated by the HSP to support new engagement systems, this model is achievable.

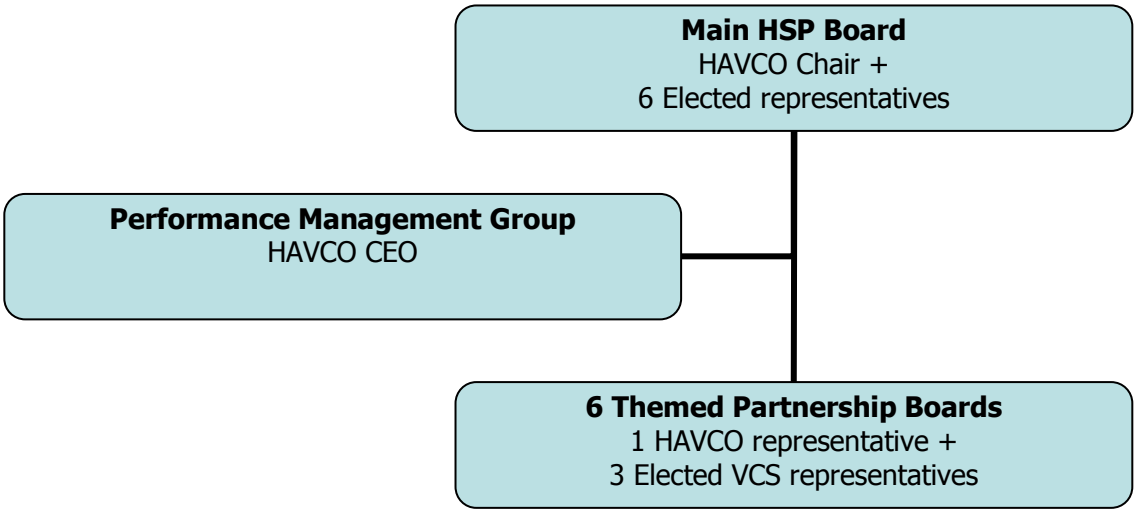
Building on experiences in other boroughs, despite not having specialist forums, people are only nominated to stand in areas of interest/specialism and therefore not having specialist structures does not affect the quality of representatives achieved or the knowledge they bring to the table. Importantly, it does, however, increase their accountability to the whole forum and wider community.

Where there are key policy areas the HSP is focusing on (such as Local Area Agreement, Children's Trusts etc) ad hoc themed forums may be convened to ensure representatives and the wider forum are briefed and informed. A successful example of this was where HAVCO organised a themed forum linked to the Well-Being Partnership in August 2006. This was to address the Local Area Agreement development. Through this forum the VCS were able to directly influence thinking in developing LAA targets and priorities. This approach should also lead to a greater level of understanding for representatives of Haringey Community Link and increase quality of contribution within the partnership as a whole.

Number of Places for Community and Voluntary Sector Representatives

It is proposed to standardise the number of places available for election across the Main Partnership Board and its Themed Partnership Boards, as at present the quality of representatives varies leading to inequality in possible routes to influence.

HAVCO are also proposing to have non elected positions on the Main HSP Board for the Chair, and new place for the CEO of HAVCO on the Performance Management Group and one position on each of the Themed Partnership Boards. These places would be in recognition of the organisation representing the interests of the voluntary and community sector, in the same way the Chamber of Commerce or Small Business Federation secure places onto the partnership. This would mirror arrangements operating across London and nationally.



This new model would see 24 elected places for voluntary and community sector representatives on the Main HSP Board and Themed Partnership Boards and 8 standing places for the HAVCO representatives looking after the interests of the voluntary and community sector.

Support for Elected Representatives

To ensure a full range of quality representatives are achieved through the new systems; support, training and development are going to be integral in the Community Link Model.

There will be three stages of support and training for representatives in Community Link.

(i) Briefing

Once the nominations for positions on the HSP and its Themed Boards have been opened, briefing sessions will be held around the Borough to ensure that

everyone considering standing is fully aware of what will be involved and expectations upon them.

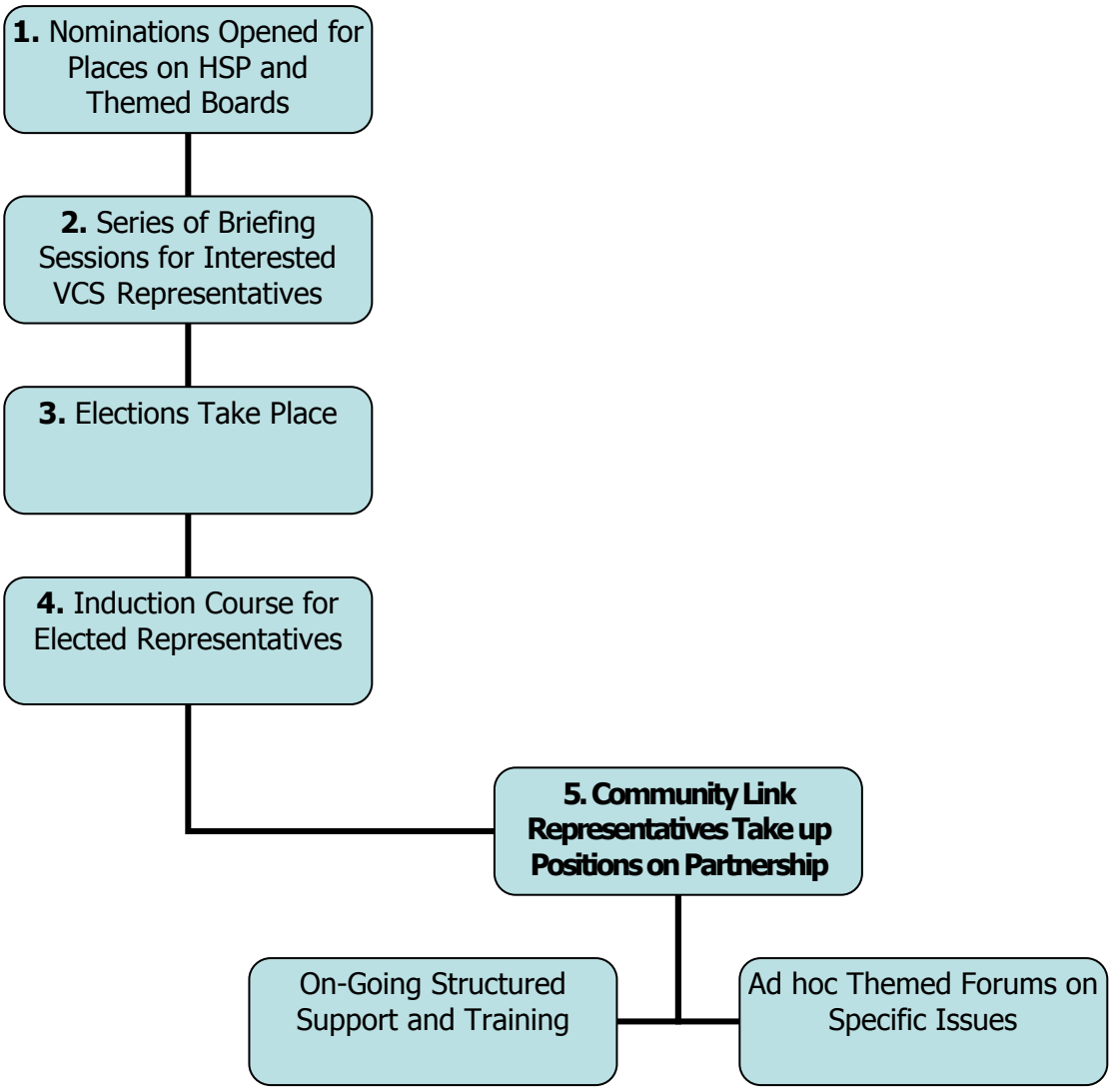
(ii) Induction

Once elected, all representatives will be required to attend a compulsory induction training course before taking up their positions. The aim is to ensure that representatives fully understand the role of the partnership, its legal structures etc and the policy environment in which it is operating. Following the consultation and engagement process it is proposed the induction training programme be 3 days but delivered on a modular basis to allow flexibility and also acknowledge prior learning and experience. The full course outline and modules will be developed as part of the next development phase of the Haringey Community Link Forum.

(iii) On-Going Training and Support

The post holder coordinating Haringey Community Link Forum will provide on-going briefings and policy support to the elected representatives. This will vary in its delivery, depending on the needs of the elected representatives on each partnership structure. It could include pre-meetings, written briefings, email forums, notice boards to exchange views and opinions etc. The role of officer employed to support the representatives will be to ensure they are given customised support to ensure the most effective contribution to the partnership.

Support Process Flow Chart



Web Portal and ICT Support

HAVCO through support of ChangeUp (lead partnership for the delivery of the Haringey Local Infrastructure Development Plan) have developed a web-portal for the voluntary and community sector in Haringey. This also has linkage to sub-regional activities across North London. The web-portal has been branded Community Link.

The aim is to further develop the website to link closely to the work of the community engagement function and bring added value to the forum. The website will offer the elected representatives and the wider VCS the following benefits: -

- Policy briefings
- All minutes and agendas for the HSP and Themed Boards
- A notice board where elected representatives can exchange views and experiences and ask for advice (not open to public)
- Consultation opportunities with the wider sector
- Email bulletins of information arising from the partnership and key priorities for influence

- Notice of meetings and themed forums

As funding has been secured for this through the Home Office, this would offer real added value to the development of new systems within the HSP and support the e-government agenda.

It is recognised that some representatives may, for reasons e.g. of disability, require added support / training to fully access ICT opportunities. The need to effectively resource the web portal to ensure it can meet expectations of functionality is also essential.

Implementation Timetable

There is a commitment to ensure the new proposed systems are explained to existing HSP community and voluntary sector representatives, the wider voluntary and community sector and those of other statutory partners before a final decision on a new model of community engagement is agreed in July 2007.

The timetable for information dissemination through formal structured events and written feedback is as follows: -

Existing community representatives	April/May 2007
Wider voluntary and community sector	May/June/July 2007
Statutory Partners	July 2007
HSP Approval of Proposal	July 19th 2007
Development Phase Begins	July 20th 2007
Community Links Membership Launch	January 2008
Elections	February - March 2008
Representatives Take Positions	April 2008

Proposed Community Link Forum Terms of Reference

Community Link Mission

To increase the level, accessibility and quality of services meeting local need and community cohesion through greater engagement and influence.

Community Link Objectives:

(i) To support community representatives on strategic partnerships
(ii) To work with stakeholders to identify how the voluntary and community sector can contribute towards delivery of targets within the LAA and Community Strategy
(iii) To collate views of the voluntary and community sector on strategic issues, ensuring they are fed into the debate through the HSP and other fora
(iv) To engage frontline organisations so they have enough information and the systems to influence policy
(v) To support community needs assessment by members of Community Link in order to influence policy
(vi) To propose solutions where things could be better
(vii) To support better partnership and collaborative working
(viii) To support statutory agencies and the partnership in clarifying the role and expectations of the voluntary and community sector in Haringey
(ix) To support the voluntary and community sector to understand the balance between campaigning role and service delivery
(x) To build trust, understanding and clarity between elected Councillors and representatives to see how they can co-exist to build a better society

Role of HAVCO in Relation to Haringey Community Link Forum

a) HAVCO's role is to represent the interests of the voluntary and community sector and to empower and support Community Link to speak for communities
b) HAVCO would be the lead and accountable body for the service, and therein have ultimate power to revoke the membership of Community Link Members who breach the terms of reference and / or the agreed code of conduct

Community Link Membership

- Membership of Community Link is separate to HAVCO's membership
- Membership is free
- Only constituted voluntary and community organisations in Haringey or organisations based outside of the borough that have a substantial percentage of Haringey residents using their services can be members. In relation to this forum constituted encompasses the following organisations: -
    - Voluntary and community organisations governed by a committee of volunteers with terms of reference
      and/or
    - Those with governing documents falling into one of the following headings; Constitution, Memorandum and Articles of Association, Trust Deed, Set of Rules (Industrial and Provident Societies), terms of reference (for community forums etc).

- Members are expected to adhere to the Community Link Forum's code of conduct.

Summary

The environment for all agencies is changing dramatically and there are increasing pressures to meet the needs of local communities through closer partnership and collaborative working. The Community Link proposal aims to ensure that Haringey has the best systems for effective representation of the voluntary and community sector. Therefore, it will be responsive and listen to its members and be subject to regular review.

haringey
COMMUNITYLINK
forum

CLF Policy Documents

WHAT IS T UNITY SECTOR

In April 2002 the Council joined with local public agencies such as the metropolitan police, primary care trust etc and community groups and businesses to create the Haringey Strategic Partnership (HSP). The aim of the HSP is to improve public services and address the key issues in the Borough through partnership working.

Haringey's voluntary and community sector are close to local people and we understand the needs of local people well. Therefore it is important that the views of voluntary and commur organisations are shared with partners who have duty in the area of public services.

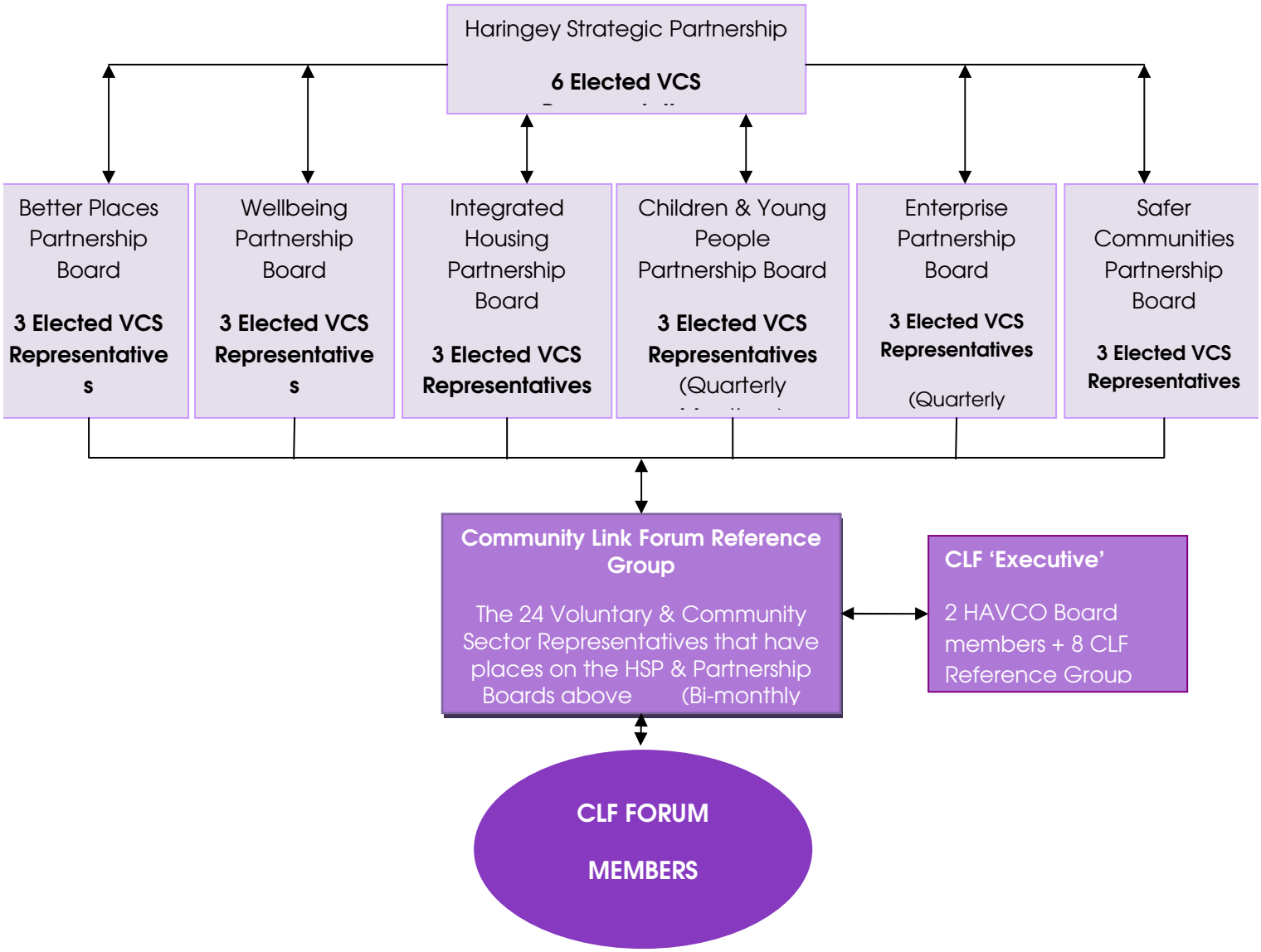
Havco
Haringey Association of Voluntary and Community Organisations

Haringey Council

The Community Link Forum will hold briefings with representatives from the voluntary and community sector that have places on the HSP and/or its Thematic Partnerships Boards. It will fully support the representatives through training/specialist guidance etc. The CLF will bring representatives together with the wider voluntary and community sector so that they are able to share their views collectively.

The priorities of the new sustainable Community are: ***"People at the Heart of Change"***

HOW THE CLF RELATES TO THE HSP



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CLF representatives Roles and Responsibilities
For CLF representative and the CLF Reference Group

What is an elected Community Link Forum (CLF) representative?
An elected CLF representative is an individual who is: a) nominated by a CLF member organisation and agrees to stand as a CLF representative; and b) is successfully elected via an open election process in their bid to become a CLF representative. For information on who is eligible to stand from election.

What is a co-opted Community Link Forum (CLF) representative?
A co-opted Community Link Forum representative has been recommended by the CLF (i.e. by the CLF Executive) and approved by the HSP to sit on the HSP Board or by one of the Thematic Partnerships to sit on that Partnership Board because:

a) a voluntary and community sector place on the HSP or the Thematic Partnership Board is vacant because it was not filled via the CLF election; or
b) a voluntary and community sector place on the HSP or the Thematic Partnership Board becomes vacant for some reason; or
c) the CLF, in accordance with its agreed principles on co-option, has identified a particular useful skill or knowledge or an important gap in the membership of the HSP Board, or one of the Thematic Partnerships and believes that the HSP or relevant Thematic Partnership Board would benefit from additional specialist input.

What is the CLF Reference Group and who are its members? The CLF Reference Group is the collective name for all elected, co-opted and HAVCO CLF representatives - all such CLF members are automatically members of the Reference Group. The CLF Reference Group will be brought together collectively a number of times each year. In addition, members of the Reference Group may be asked to meet on the thematic basis.

Overarching Roles & Responsibilities

1. **Promoting the CLF's objectives:** CLF representatives are expected to work together to promote the CLF's objectives.

2. **Acting in accordance with the CLF's agreed policies:** CLF representatives are expected to act in accordance with CLF policies, where these have been agreed by the CLF, and /or the views or the body that they are representing as opposed to representing their personal position.

   If CLF policies conflict with the views of the body that they are representing, then the representative and the CLF should seek a resolution and to come to a common agreed position. If a common position cannot be achieved, then the representative should reflect the position of their organisation but also identify that this is not the CLF position.

3. **Working collectively to promote the needs of Haringey's communities:** CLF HSP representatives are expected to work collectively and co-operatively with the CLF, other CLF representatives and the HSP to ensure that the needs and interests of Haringey's voluntary and community sectors, service users and communities are considered by the HSP. This will involve:
   a) drawing on the collated views of the voluntary and community sector on strategic issues;

b) ensuring that these views are fed into HSP Board, thematic forums and associated debates.

4. **Promoting the CLF's policies**: CLF representatives should familiarise themselves with the policies of the CLF if binding decisions have been taken.

> ***Information will be provided on the CLF website and CLF meetings to assist representatives.***

5. **Complying with the CLF code of conduct***:* CLF representatives should abide by the code of conduct set out in this annex.

6. **Complying with requirements placed on the HSP members***:* CLF representatives will be expected to comply with the requirements placed on HSP representatives that are listed below and any other roles and responsibilities agreed between the HSP and the CLF.

7. **Acting in the interest of the voluntary and community sector:** HSP members must make the interests of the community their main focus and should act in the public interest. Voluntary and community sector representatives are expected ensure that the interests of the voluntary and community sectors are raised.

8. **Issues and concern**: In bringing issues and concerns from their particular sector, HSP members should aim to contribute developing joint solutions with partners.

9. **Decision making when at meetings:** HSP representatives should be authorised to take decisions on behalf of their organisation, including decisions which may change the way in which agencies work together where this is consistent with accountability principles.

   Where CLF HSP representatives are unable to make immediate decisions, their recommendations should be made via their organisations appropriate structures. Decisions made following recommendations must be supported by the organisation. (Representatives will be informed of any time frame for decisions to be made following recommendation.)

10. **Serving the community:** HSP representatives have a responsibility to work on behalf the whole community and are not to do anything which they could not justify to the public. HSP representatives must bear in mind the duty to serve the whole community and not just part of it.

11. **Promoting equality**: HSP representatives should promote equality by not discriminating against any person and by treating people with respect, regardless of their race, age, religion, gender, sexual orientation, disability or economic or social status. In addition, HSP representatives should respect and promote human rights and where lawful give due consideration to public sector duties to promote equality of opportunity.

Role requirements

Why have role requirements been identified? The requirements listed below identify key commitments, skill, knowledge and experience required to be an effective CLF representative.

Why is there a strong emphasis on commitment as opposed to experience? A strong emphasis is being placed on commitment, in order not to exclude people unnecessarily. Obviously, people with experience of playing a representative role are welcomed and needed; but it is also important to encourage as wide, and diverse, a range of potential CLF representatives as possible.

Why is some training compulsory? The commitment to attend compulsory CLF training is key to ensuring that all the CLF representatives fully understand their role and are able to fulfil their roles and responsibilities as a CLF representative.

How will these role requirements inform the election process? In producing their election statement, potential CLF representatives are encouraged to make direct reference to their ability to how they meet these role requirements and their commitment to being an effective CLF representative.

1. Knowledge and understanding of Haringey's community and voluntary sectors.

2. A commitment to attend compulsory CLF training and to take up other relevant development and training opportunities associated with being an effective CLF representative.

3. Experience of contributing to community and/or community development strategies.

4. A commitment to developing an understanding of the strategic and policy framework and issues for HSP and the CLF.

5. A commitment to playing an active role within the CLF and the HSP.

6. The ability to represent the CLF in negotiations and /or a willingness to develop relevant negotiation skills.

7. A commitment and willingness to act in accordance with principles in relation to participation in public life and representation (see Annex G).

8. A commitment to attending agreed meetings as relevant (e.g. HSP Board meetings, Thematic Partnership meetings, CLF Executive meetings, CLF Reference Group meetings etc.).

9. A commitment to attending, participating in, and contributing to relevant meetings with voluntary and community groups in the borough.

10. An understanding of equality of opportunity and commitment to complying with, and contributing to the implementation of, the CLF's Equality, Diversity and Human Rights Policy.

Code of conduct for CLF member organisations & CLF representatives

1. Abiding by this Code of Conduct

CLF HSP representatives and members are expected to abide by the requirements set out below in this code of conduct when engaged in activities relating to the CLF. Any complaints will be dealt with in accordance with the complaints procedure identified in the CLF's operational guidelines. If a breach of this code is alleged a CLF member or representative may be suspended pending an investigation. If a serious allegation is upheld action may be taken against the member organisation or representative up to, and including, termination of membership or role as a representative.

2. Understanding & seeking to fulfil the CLF representative's role

As a CLF representative you should to seek to make sure you:

a) understand your role as a CLF member and/or CLF representative;
b) seek to fulfil your responsibilities as CLF member and/or CLF representative.

Please note: Prospective and elected CLF HSP representatives will receive development opportunities, support and training from the CLF team to assist you to fulfil your role and will be expected to make reasonable attempts take up these opportunities.

3. The Nolan principles and principles of representation

CLF HSP representatives are expected to act in accordance with the **Nolan principles** which set out standards for those holding public office and overlapping principles in relation to effective representation. CLF representatives, and where appropriate, CLF members are expected to act in accordance with the following:

▪ **Selflessness:**	The CLF representatives should act solely in terms of the public interest; not to gain financial or other benefit of themselves, their family or their friends.
▪ **Integrity:**	The CLF representatives should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them In the performance of their official duties.
▪ **Objectivity:**	In carrying out public business, including making public appointments, awarding contracts, or recommending individual's rewards and benefits, CLF representatives

	should make choices on merit.
▪ **Accountability:**	The CLF will clearly define its arrangements & responsibilities in respect of its actions and decision-making.
▪ **Openness:**	CLF representatives should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands. They should also be as open as possible in their dealings and relationships. However, due consideration should also be given to any confidentiality requirements.
▪ **Honesty:**	CLF representatives have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
▪ **Leadership:**	CLF representatives will aim to think and act strategically.
▪ **Equality:**	Equality, diversity and inclusiveness should be placed at the core of what CLF representatives do.
▪ **Clarity of purpose:**	There should be clarity about the CLF's objectives which are based on a strong evidence base.
▪ **Sustainability:**	CLF representatives should seek to work collectively, and where possible, with a collective voice.
▪ **Clarity of values:**	The CLF, and its representatives, will seek to identify and build on the values of the local voluntary and community sector.

CLF HSP representatives should note that the Haringey COMPACT also takes on board these most of these principles within the agreement.

Please note: To assist representatives, mandatory training will be provided and there will be opportunities to explore and discuss the practical implementation of these principles:

4. Resolving problems

If CLF members and/or CLF representatives experience difficulty in fulfilling their roles or responsibilities or have concerns, these difficulties should be explored with the CLF Team and/or the CLF Reference Group to seek resolution.

5. Attending meetings

CLF HSP representatives should plan to attend at least two thirds of the meetings each year at which they act as a representative and/or make suitable alternative arrangements if this is not possible.

6. Conflict of interest

Representatives should not intentionally place themselves in a position of conflict of interest. If a conflict of interest arises, they should make this known to the CLF (e.g. Reference Group) and the CLF Team and seek a resolution. In acting as an HSP representative, a CLF representative must also abide by the HSP's requirements on conflict of interest.

7. Equality and respect

Representatives and member organisations should expect to be treated with respect and in accordance with equality principles. Representatives and CLF members should treat others (e.g. CLF colleagues, council officers, HSP colleagues) with respect and accordance with equality principles at CLF and HSP meetings, in correspondence and communications. CLF members and representatives are expected to comply with the CLF's, "Equality, Diversity and Human Rights Policy".

8. Dealing with conflict

If disagreements or conflicts arise that are not resolved through normal day-to-day interactions; a CLF HSP representative should raise the matter with the CLF Team, the HSP (or relevant Thematic Board) and/or the CLF Reference Group as appropriate.

A CLF member should raise the matter with the CLF Team or the CLF Reference Group as appropriate.

If necessary, mediation should be sought to resolve profound disputes or conflicts. CLF HSP representatives and member organisations should refrain from public attacks on the CLF and each other.

9. Reporting back

CLF HSP representatives will be expected to report back verbally on their representative activities and to answer questions from other CLF members. Where applicable, the CLF Team may require the CLF HSP representative to complete a HSP/Thematic Board feedback form or similar pro-forma.

10. Financial matters

No CLF representative or CLF member organisation may commit HAVCO or the CLF to expenditure. Any expenditure related decisions must be considered in accordance with HAVCO's financial policies and procedures including procedures governing the CLF and CLF representatives.

11. Decision-making

CLF HSP representatives and CLF member organisations may promote or disagree with existing CLF policy decisions. No CLF representative, or CLF member organisation, may unilaterally commit the CLF or HAVCO to a new policy position or decision.

12. Bringing the CLF or HAVCO into disrepute

CLF HSP representatives and CLF member organisations, when engaged in any activity related to the CLF, should refrain from any action that brings, or is likely to bring, the CLF or HAVCO into disrepute. If alleged, behaviour, and/or allegations, that could bring a CLF representative, a CLF member organisation, the CLF or HAVCO into disrepute, could in the first instance lead to a suspension from CLF activities. Such conduct would have to have been relevant or related to the CLF, and it would then need to be investigated and established, based on the principles and processes of natural justice and subject to appeal. Such actions could include, but are not limited to:

a) breaches of this Code of Conduct;

b) violent or abusive behaviour;

c) allegations of serious criminal offences or breaches;

d) formal investigations into alleged serious civil or administrative breaches;

e) allegations of serious or gross misconduct.

Equality, Diversity and Human Rights policy

Introduction

Haringey Community Link Forum (CLF) is a network of voluntary and community organisations that conduct the majority of their activities or provide the majority of their services to people who live and work in the London Borough of Haringey. The CLF facilitates and promotes voluntary and community sector involvement in the Haringey Strategic Partnership Board and its subcommittees (its thematic partnerships). The CLF recognises the importance of community cohesion, diversity, equality, human rights and social inclusion.

Statement of intent

The CLF values diversity and believes that all people have an equal right to participate in, and benefit fully, from all opportunities; this includes employment rights, rights to access services and resources, and rights to participate in social and public life. We will actively work towards reducing unfair discrimination in society, the elimination of discriminatory practices within organisations and achievement of diversity, equality and human rights' objectives and agendas.

We will not discriminate and we will work with member organisations, CLF representatives, the HSP and others, to eliminate discrimination, on the grounds of age, caste, colour, disability, ethnic origin, gender, gender identity, health or HIV status, immigration status, language (including the language of deaf people), marital status, nationality or national origins, non-relevant or unrelated criminal conviction, race, religion or belief, responsibility for dependants, sexual orientation or social or economic status, trade union activity, transgender status or other conditions or requirements and cannot be shown to be justifiable.

Working together to promote equality and human rights

Discriminatory practices, inequality and a lack of the practical application of human rights principles may seriously undermine the life opportunities of Haringey residents and service users; and may also be entrenched in community, voluntary, private, public or statutory organisations. The CLF recognises that public sector duties to promote equality - currently covering disability, gender and racial equality - and duties to promote human rights are designed to tackle institutional discrimination and human rights failures.

The CLF welcomes the fact that the public sector equality and human rights duties apply directly to public sector partners, and in particular to, all statutory members of the Haringey Strategic Partnership. We also welcome the fact that the key public sector equality duties also apply to directly or indirectly to voluntary organisations that exercise public functions. We will work actively to encourage CLF and other community and voluntary organisations to understand, and address, diversity, equality and human rights principles and associated legal requirements. We will work actively with the HSP to develop positive, practical, proactive and supportive approaches to deal with challenges, and realise benefits, associated with diversity, equality and human rights.

CLF working in partnership

CLF will work in partnership with others organisations, including the HSP to:

- ***Promote a shared vision***: about how to combat all forms of discrimination, harassment and victimisation and promote good community relations, equality and human rights.
- ***Promote understanding***: of relevant equality and human rights enactments and practical strategies for benefiting Haringey's communities.
- ***Encourage diversity in the membership of the CLF***.

- ***Ensure involvement and listen***: We aim to ensure that all parts of the community feel that they have a voice and can be involved in CLF decision-making.
- ***Support community engagement and empowerment:*** We aim to encourage Haringey's diverse and rapidly changing local communities, including traditionally excluded groups, to participate in the CLF and HSP.
- ***Encourage and facilitate involvement in the CLF***: We aim to enable all members groups, sectors and communities to participate in consultation and decision-making within the CLF.
- ***Identify and remove unfair barriers to participation in the CLF.***
- ***Conduct meetings on the basis of respect and commitment to listening***: We will respect the contribution of all parties and make space to encourage genuine involvement, participation and empowerment.
- ***Promote understanding and co-operation between different communities and groups within communities:*** We will seek to develop opportunities to learn about each other's cultures and experiences.
- ***Promote policy and strategic developments***: We will aim to ensure that CLF members have equal opportunities policies in place, and assist and encourage members to develop strategies to tackle discrimination and promote community cohesion and human rights.

Key equality, civil and human rights related legal provisions

- ***Civil rights*** - including the rights of carers, civil partners, gender recognition rights and rights in relation to data protection.
- ***Equality related employment rights*** - including adoption, maternity, paternity and parental leave; pregnancy rights; rights for part time and fixed term workers; and rights in relation to holidays, minimum wage and the number of hours of work.
- ***Equality strands*** - including age, disability (including HIV and health status), gender (including marital status & transgender people), racial grounds, religion or belief and sexual orientation.
- ***Areas*** - education, employment, housing, public office, the provision of facilities, goods and services, training and a wide range of other areas.
- ***Public sector equality duties*** - including duties to eliminate unlawful discrimination in exercising public functions in relation to most equality strands and duties to promote disability, gender and racial equality.
- ***Human rights*** – including the right to life; prohibition of torture; prohibition of slavery & forced labour; right to liberty & security; right to a fair trial; right to no punishment without law; right to respect for private & family life; freedom of thought, conscience and religion; freedom of expression; freedom of assembly and association; the right to marry; prohibition of discrimination; prohibition of abuse of rights; right to protection of property; right to education; and the right to free elections.

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Community Link Forum

LAA Workshop Feedback Report

January - February 2008

Report Prepared By: CLF Team (HAVCO)

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1.0 Introduction

During Round Three of Local Area Agreement development in the borough, local voluntary and community organisations that have an interest in health, social care and wellbeing issues were able to engage with statutory partners regarding the development and selection of priority indicators and targets in this area via a half-day workshop which was jointly facilitated by Haringey's Association of Voluntary and Community Organisations (HAVCO) and the Council.

Through the half-day workshop Haringey's voluntary and community organisations were able to influence the LAA process by ensuring that mental health, which had 'fallen off' the LAA priority list, was put back onto Haringey's LAA agenda. It was also recognised that the LAA process needed to be widened for the voluntary and community sector to engage effectively regarding the other policy areas.

It was anticipated that this gap would be addressed during the current LAA refresh, however, there has been little involvement from the *wider* voluntary and community organisations. This concern has been raised by voluntary and community sector representatives at Haringey's Strategic Partnership in November 2007.

In July 2007 the HSP endorsed the development of a new community engagement mechanism for the borough called the Community Link Forum (CLF). The accountable body for the Forum is HAVCO, the Council for Voluntary Service in Haringey. The Launch for the CLF took place in January 2008, and in recognition of widening the LAA process for voluntary and community sector input and engagement, workshops were held as part of Launch. The workshops enabled voluntary and community organisations to discuss the current LAA indicators. Due to demand by participants the workshops were facilitated a second time during February with the London Voluntary Service Council (LVSC). The feedback following the workshops is contained in this report.

It was agreed with the HSP's executive - the Performance Management Group (PMG) - that this report would be available at the Thematic Partnership Workshops facilitated during March 2008. To enable members of the Thematic Partnership Boards to have an understanding of the issues that voluntary and community organisations considered key, to address critical concerns for the area and local people.

2.0 Methodology

Haringey's voluntary and community sector is a 'broad church,' with a range of expertise and competencies; some groups having detailed knowledge about LAA with others having little or no detailed knowledge of the agreement. Therefore the LAA was introduced in relation to the six priorities outlined in Haringey's Sustainable Community Strategy 2007-2016, which sets down the vision and aspirations for the borough. Discussions were encouraged around what participants felt were important to them and residents under each of the priority headings.

Workshop 1

1. Healthier People with a better quality of life
2. Be safer for all

Workshop 2

3. People at the Heart of Change
4. An environmentally Sustainable Future

Workshop 3

5. Economic Vitality & Prosperity Shared by all
6. People and customer focused

The workshop facilitators introduced the key issues under each priority, outlining the priorities objectives and aims. Participants were invited to consider the following:

1. main/overarching priority for each heading
2. detail a list of key priorities for each heading
3. consider the type of services that could be introduced or that already exist to address the priorities
4. general conclusions

Some of workshops had more than one main priority and some of them did not reach final conclusions. However in general there were key themes and concerns related to the Local Area Agreement that came out of the workshops. These are outlined below.

3.0 Outcomes and Recommendations of VCS LAA Workshops:

a. LAA development and planning

- Participants raised concerns that they rarely have access to results of consultations; therefore they are unable to evaluate the effectiveness of VCS' engagement in consultation processes/consider what difference and influence their views had on statutory-led initiatives
- Voluntary and Community organisations want to be an effective voice and ***know*** that their voices have been listened to and heard
- Empowering VCS is critical in relation to policy/service initiatives that are cross-cutting and overarching e.g. very few participants knew the purpose of the LAA
- Early engagement of the VCS is necessary regarding service development. The first step is a clear action plan to engage the VCS in commissioning processes.
- Concerns rose regarding lack of information regarding transitional arrangements for existing services delivered via LAA by voluntary and community organisations under Neighbourhood Renewal Funding. Participants were keen to learn whether this had been considered during current LAA refresh.
- Participants proposed that Council officers undertake risk assessment, as proposed Council cuts contradict the outcomes of some of the LAA targets.
- Failure of working in a joined up way, e.g. LAA development should be implemented utilising Compact working to:

- Scrutinise and challenge processes – where necessary
- Compact assess processes
- Avoid marginalisation of third sector (i.e. around consultations, contract relationships)
- Recognise Compact as the overarching document for doing business (between and across sectors)

b. VCS LAA Priorities:

- NI 7 - Environment for a thriving third sector
- NI 6 - Participation in Regular Volunteering
- NI 140- Fair Treatment by local services
- NI 4- % of People who feel that they can influence decisions in their locality.

c. General Concerns:

- Many comments were made regarding widening the process at an early stage to gauge the views of others including VCS (these are outlined in 'a.' above)
- Concerns raised that mental health, as a key issue within the borough may not be adequately addressed with the current priorities selected.
- Lack of clear service to address support needed for young people with learning difficulties. NI 54 – *Services for disabled children*, is a survey for users in respect of evaluating service quality etc. Service Providers in this field are concerned that a survey will not address some of the key concerns for these users and their families.
- Lack of understanding of the sector – research required to provide quantitative information of true value that the sector brings to the borough – e.g. faith sector work in respect of community cohesion, employment, providing skills via volunteering, specialist knowledge in environmental issues, etc

4.0 Workshop Outcomes

"Healthier People with a Better Quality of Life"

Main Priority:

This is a cross-cutting priority therefore importance of exerting influence over LAA indicators is critical, however, wider VCS participation is about playing 'catch up' in respect of the LAA process

Key Issues:

- Reducing social isolation – more opportunities should be available to achieve this
- Performance indicators should be defined by people at a local level
- Making sure local people are consulted about impact of changes
- Haringey's residents should be free from disease
- Good support available for people to manage long-term illness
- Better housing
- Reducing stress
- Accessible support services – local
- Valuing individuals/community
- Community cohesion
- Tackling discrimination – equal + fair services
- Health impact assessing for policies and activities
- Non means-tested provision
- Proactive instead of reactive services
- Removing barriers to access of health and well-being provision
- Responsive services – need based [User involvement]
- Prevention + self care support
- Mapping community need + anti-poverty strategy and implementation - plan funding independent advice services.

Self Help/ Self Worth;

- Recognition of positive contribution (e.g. careers)
- Empowerment/advocacy/ knowledge + skills
- Invest in education/awareness raising

Mental Health

- Happiness – good mental health
- Increase social networks/promote opportunity
- Awareness + preventative support;
  - Collaborative services
  - Links between support provision
  - Continuity of good services
- Maintaining local/effective service provision

"Be Safer for all"

Main Priority:

• Reduce the incidence and fear of crime • Address anti-social behaviour • Create safe and secure homes, tackling domestic violence • Safer roads • A positive future for our children and young people

Key Priorities:

- Apart from agreement that our streets need traffic calming, the discussion focused almost exclusively on concerns about serious anti-social behaviour, and particularly discouraging young people's involvement in it
- Fear of crime is a serious concern and could be reduced (i.e. be proportional) if people had accurate statistics... the media scaremongers too much
- Raise awareness of positive initiatives, alternatives and opportunities for people, especially youth, to pursue rather than crime - e.g. employment, youth facilities, creative things, education
- Need positive images of youth, rather than demonising them. Value and recognition of their achievements, e.g. via youth volunteering programme and training: positive contributions / positive opportunities for youth
- Need to engage with young people, and to listen to their views and their 'voice' - need effective practical action targeting those involved in gun and knife crime... and to prevent negative re-enforcement of such activity (e.g. glorification)
- Parents and carers of those involved in serious crimes (whether perpetrators or victims) need systematic support
- The best way to 'crowd out crime' is to ensure strong local communities with a good, positive atmosphere and people talking to each other and supporting each other
- visible crime prevention;
    - more police
    - more street wardens
- community structures;
    - neighbourhood support/responsibility - pride in our communities
- cross boundaries/multi/agency involvement
- inter-generational support/education, e.g. Inter-agency training on safeguarding adults across all VCs organisations and highlighting reporting mechanisms and available information/advice/advocacy agencies
- reducing knife/gun crime
- zero tolerance for discrimination and hate crime
- alcohol/drug dependency support

"People at the Heart of Change"

Main Priority

• Opportunity to influence • Empowering VCS • Meaningful engagement • Adhering to consultation policies • Making sure local people are consulted about impact of changes • Adequate resource to fulfil community needs

Key Priorities

- Involve users and members (access wider community)
- Use VCS as a greater means of collecting data/knowledge
- Cost to enable this to happen – pay for engaging in consultation
- Social capital:
  - ✓ involve wider sector
  - ✓ incentives VCS to link
- Impact on homelessness:
  - ✓ strategy
  - ✓ process
- Impact assessment:
  - ✓ to be conducted wider then meeting targets/money
  - ✓ what does it mean for communities/dynamics/meeting needs/ negative effects?
- Strong processes/involvement
- Increasing accessibility, accountability
- Feedback – honest in processes
- Joining up agendas
- Treatment of VCS is inconsistent
- Honouring commitment to borough
- Contradictory targets (e.g. council proposed cuts will affect LAA priorities)
- Valuing borough – consistent plus continuous improvement
- Valuing VCS – independence/campaigning
- How do we prove how good we are? – more than a paper exercise overly bureaucratic
- Consider needs of BME communities
- Genuine community cohesion
- Community perception (understanding between partners)
- Relationship with health practitioners
- Services access
- What are the priorities within the communities?
- Too many changing agendas
- Health and safety
- Quality of provision

"An Environmentally Sustainable Future"

Main Priorities

● Tackle climate change ● Manage our environmental resources more effectively ● Create sustainable and energy efficient homes and buildings ● Increase recycling and reduce waste ● Promote sustainable transport ● Encourage our future citizens to be our first 'green generation' ● Protect the natural environment Haringey

K ey Priorities:

- Need for a comprehensive and well-financed insulation programme for all homes, not just new ones
- Housing v. maintaining green space - will be a issue for Haringey
- Need to develop alternative energy sources, e.g. solar panels on all buildings
- A 'green' lifestyle is part of a positive approach e.g. to diet (healthy eating) and fitness (cycling and walking rather than car use)
- Recycling should be made easy to understand and do, be as comprehensive as possible, and be the same throughout all neighbourhoods in Haringey
- Waste reduction and recycling should apply equally to businesses as they have a huge impact
- Necessary lifestyle changes need to be viewed positively and backed by effective incentives. Such incentives should be accessible, rather than means tested or hard to apply for.
- All reports by Council and HSP boards should include a brief 'environmental impact assessment' in the same way that they include an 'equalities assessment'.
- Community access – all aspects i.e. young people
- Influence over facilities and maintaining community space
- Economics over environment
- There's a need to continually raise public awareness on these issues

"Economic Vitality & Prosperity Shared by All"

Main Priority

Involvement of VCS and people at all levels strategically plus right through the process at all stages of the [development/ decision-making] systems.

Key Issues:

- Tackling 'worklessness' effectively means working from the bottom - up
- Local Business to get involved in this debate and workless to be involved
- Promotion of volunteering
- Training payments for unemployed
- Safety net (cost effect) transition from unemployment to jobs
- training – information workshop for unemployed
- Need to be qualified from the early stages.
- More young leaders and involvement of all ages groups (as opposed to middle-aged/ near middle-aged leaders)
- Ward level involvement from communities
- Homelessness impacts upon communities being prosperous – e.g. inadequate consultation with VCS regarding LBH Housing Strategy
- Community cohesion
- Need organised debate with all stakeholders leading to consensus on economic sustainability
- Audit of local people's views on this issue to be conducted across the borough
- Education and opportunity ;

    - Day release for training workshop
    - Hands on training
    - Open up apprenticeship and target what people really need
    - Improve employment opportunities

"People and Customer Focused"

Main Priority

• High quality, needs based and customer focused services that offer value for money • Increased resident satisfaction with services and the area they live in • Greater opportunity for civic engagement and participation • Transparent and accountable local leadership • Drawing on the strength of the voluntary and community sector • Make our children and young people active citizens

Key Priorities:

- Need more funding for a wide range of local services
  local services and amenities need to be accessible for everyone to use without barriers, e.g. affordable, no 'means testing' or bureaucracy, well advertised, and a system of community transport for those needing mobility support
- Need constant and sustainable youth provision e.g... facilities in local communities, mentoring programs etc
- Improve services for the elderly and those with disabilities
- Support for parents and carers (e.g. those caring for housebound relatives etc)
  Recognise and support the huge numbers of volunteers and volunteering, formal and informal, that goes on throughout Haringey
- Communication – active + two way of communication e.g. Delivery plan – local people on scrutiny panels
- Accountabilities of service provides/transparency two-way feedback evidence and monitoring
- Client specific complaint officer to process complaints (Compact mediation for VCS service providers)
- Language support necessary for services

Some overall conclusions from the workshop:

- The CLF mission to 'increase the level, accessibility and quality of services, with greater community engagement and influence' was felt to be a good summary of the issues at hand
- Key overarching themes from the contributions were: we must have adequate resources to fulfil community needs, work towards strong communities, support engagement of young people
- There's a great deal of connection and overlap between all the issues discussed

5.0 Acknowledgements

HAVCO and the Community Link Forum team would like to thank the following:

Workshop Facilitators:

Robert Edmonds	-	VCS Wellbeing Theme Group Chair
Dave Morris	-	Haringey Federation of Residents Association
Faiza Rivzi	-	BME Carers
Stephen Wish	-	Polar Bear Community Ltd

Co-Facilitators:

Vincent Okieimen	-	HAVCO
Naeem Sheikh	-	HAVCO

Scribes:

Rachel Nussey	-	HAVCO
Pisey Pech	-	HAVCO
Stephanie Rowland	-	Haringey Council, Corporate Voluntary Sector Team

We would also like to thank Gethyn Williams, Policy and Networks Manager, London Voluntary Service Council (LVSC) who delivered the key note speech at the second LAA workshop event, Dhara Vyas, Policy Officer at the National Council of Voluntary Organisations and Paul Head, Principal of the College of North East London/HSP Vice Chair who delivered presentations at the CLF Launch. Leander Neckles, of Necko Consultancy, who has provided invaluable support regarding policy and project development to the CLF Reference Group (the main steering group of existing voluntary and community sector representatives that have places at the strategic table) and the CLF team.

Last, but not least, we would like to thank all of Haringey's voluntary and community organisations that participated in these events, your efforts, energy, dedication and input are appreciated and respected.

haringey strategic partnership

Meeting: **Well-Being Strategic Partnership Board**

Date: **10 June 2008**

Report Title: **Membership and Terms of Reference: 2008/09**

Report of: **Mary Connolly, HSP Manager, Haringey Council.**

Summary

The first meeting of the new Municipal Year provides a timely opportunity for the Board to confirm its membership and update its Terms of Reference for the forthcoming year.

Following the Community Link Forum (CLF) elections in April three new representatives have been appointed to each of the Thematic Boards. To recognise this each Thematic Board now needs to formerly amend their Terms of Reference.

The full Terms of Reference are attached at Appendix 1.

Attached at Appendix 2 is the membership including details of the individuals appointed to sit on the Board. Each partner organisation should formerly confirm the names of the individuals appointed to the Board.

The Council's Cabinet will appoint Councillors to the HSP and each of the Thematic Boards on 17 June. Therefore, until then, the Councillors appointed to the Board by the Cabinet in 2007/08 remain in place.

Recommendations

i. That the Board confirm its membership for the new Municipal Year.

ii. That the Board Terms of Reference be amended to include the new Community Link Forum representatives.

For more information contact:

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APPENDIX 1

WELL-BEING PARTNERSHIP BOARD (WBPB)

Terms of Reference

Revised version agreed by the WBPB on 22 October 2007
Further revisions made 11 March and 2 June 2008

1. Purpose

Local residents, statutory, voluntary, community and commercial organisations all have a role to play in improving well-being. This includes access to health and care services; access to appropriate leisure and educational services; access to employment; and opportunities for a healthier lifestyle.

Haringey's **Well-being Partnership Board** (WBPB) will lead in promoting and delivering a Healthier Haringey for **all people aged 18 years and over in Haringey** by:

- improving the health and quality of life of people who live and work in Haringey and reducing health inequalities
- setting a strategic framework, including outcomes and objectives, through which joint priorities can be delivered and through which statutory responsibilities can be carried out
- agreeing joint, overarching priorities for the wider well-being agenda through an annual statement which will guide the work of the Board in the light of the most recent information and developments

2. Rationale

The WBPB is a strategic body forming part of the Haringey Strategic Partnership (HSP). The HSP has established six priority outcomes which are set out in the Sustainable Community Strategy. The WBPB contributes to all six outcomes and has adopted them as its priorities:

Sustainable Community Strategy Priorities	Well-being Partnership Board Outcomes
People at the heart of change	Improved quality of life Making a positive contribution Freedom from discrimination or harassment Maintaining personal dignity and respect
An environmentally sustainable future	Improved quality of life Economic well-being
Economic vitality and prosperity shared by all	Improved quality of life Economic well-being
Safer for all	Improved quality of life Freedom from discrimination or harassment
Healthier people with a better quality of life	Improved health and emotional well-being Improved quality of life Increased choice and control Freedom from discrimination or harassment Maintaining personal dignity and respect

Sustainable Community Strategy Priorities	Well-being Partnership Board Outcomes
Be people and customer focused	Making a positive contribution

The WBPB will address the need to:

- shift from the narrow focus of treating illness to promotion of the broader concept of well-being, in line with the requirements of the Department of Health's 2006 White Paper *Our Health, Our Care, Our Say*

- create a sustainable framework for local action on health and well-being, so that partnership working is strengthened and there is greater clarity over who is responsible for agreeing and delivering local health and well-being targets, in line with the requirements of the Department for Communities and Local Government's 2006 White Paper, *Strong and Prosperous Communities* and the associated Local Government Involvement in Public Health Bill.

The WBPB also meets the requirements of the Health Act 1999 which specifies a formal duty of partnership between health organisations and local authorities. It is subject to government policy guidance and directives.

The Board is the umbrella body to statutory and non-statutory partnerships and sub groups that fall within its remit.

3. Outcomes, objectives and targets

Our Health, Our Care, Our Say **(OHOCOS) Outcome**	**WBPB Objective**	**Key Performance Indicators**
Improved health and emotional well-being	To promote healthy living and reduce health inequalities in Haringey	• Reduce health inequalities between the local authority area (Haringey) and the England population by narrowing the gap in age, all-cause mortality (LAA Target) • Increase physical activity in the borough (LAA Target) • Increase the number of smoking quitters in N17 (LAA Target) • Clients receiving a review (PAF D40) • Support the reduction of housing related delayed discharges from hospital as part of the Joint Mental Health Strategy 2005-08 (LAA)
Improved quality of life	To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes	• Increasing the number of older people attending day opportunities programmes (LAA Target) • The number of physical visits per 1000 population to public libraries (CPA C2c PLSS 6) • Increase adult education take-up • The percentage of items of equipment and adaptations delivered within 7 working days (BVPI 56) • The number of those aged 18 and over helped to live at home (PAF C29; C30; C31; C32) • Increase the number of breaks received by carers (LAA Target) • Reduce the proportion of adults saying they are in fear of being a victim of crime (LAA Target) • Households receiving intensive homecare per 1,000 population (PAF C28 BVPI 53)
Making a positive contribution	To encourage opportunities for active living including getting involved, influencing decisions and volunteering	• Increase the number of people recorded as or reporting that they have engaged in formal volunteering on an average of at least two hours per week over the past year (LAA Target) • Increase the number of volunteers recruited as part of day opportunities for older people (LAA Target)
Increased choice and control	To enable people to live independently, exercising choice and control over their lives	• The number of adults and older people receiving direct payments at 31 March per 100,000 population aged 18 or over (PAF C51) • Acceptable waiting times for assessments (PAF D55 BVPI 56) • Acceptable waiting times for care packages (PAF D56 BVPI 196) • Increasing the proportion of vulnerable single people supported to live independently, who as a result do not need to be accepted as homeless and enter temporary accommodation (LAA Target)

3. Outcomes, objectives and targets

Our Health, Our Care, Our Say **(OHOCOS) Outcome**	**WBPB Objective**	**Key Performance Indicators**
Freedom from discrimination or harassment	To ensure equitable access to services and freedom from discrimination or harassment	• Percentage of adults assessed in the year whose ethnicity was 'not stated' in RAP return A6 (key threshold) • Percentage of adults with one or more services in the year whose ethnicity was 'not stated' in RAP return P4 (key threshold)
Economic well-being	To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs	• Increase the number of residents on Incapacity Benefit for 6 months or more helped into work of 16 hours per week or more for at least 13 weeks (LAA Target) • Increase the number of people from priority neighbourhoods helped into sustained work (LAA Target) • Improve living conditions for vulnerable people ensuring that housing is made decent, energy efficient and safe (LAA Target)
Maintaining personal dignity and respect	To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur	• Availability of single rooms (PAF D37) • Numbers of relevant staff in post who have had training in addressing work with vulnerable adults. • Written guidance on personal and/or sexual relationships between people who use in-house or purchased care services

4. Core business

The WBPB will:

- Carry out all statutory duties required by government including formally approving Section 31 partnership agreements and confirming the statutory transfer of funds between agencies
- Respond, as a partnership, to new government initiatives, directives and legislation
- Contribute to the implementation and review of the Community and Neighbourhood Renewal Strategies and to monitor progress on agreed actions
- Monitor and review our overarching Well-being Strategic Framework (WBSF) based on the seven *Our Health, Our Care, Our Say* (OHOCOS) outcomes to help us shift from the narrow focus of treating illness and providing care to vulnerable people and towards the promotion of well-being for all
- Work with the other local thematic partnerships to champion the priorities of the WBSF, and to ensure there is joint ownership and delivery of the framework
- Agree the structure and terms of reference of sub groups and Partnership Board falling within the well-being structure
- Monitor the implementation of projects delegated to the well-being sub groups
- Consider, comment on and endorse, as appropriate, strategic documents from other Partnership Boards or sub groups in the well-being or wider HSP structure that require a joint multi-agency well-being response
- Monitor the effectiveness of the Partnership Boards and sub groups and other joint planning arrangements within its structure through receipt of an annual report or other agreed mechanisms
- Monitor progress on Local Area Agreement (LAA) targets
- Refresh and agree future LAA targets and priorities in line with the Sustainable Community Strategy and the WBSF
- Actively engage service users and carers, with specific emphasis on traditionally hard to reach groups, and give support to enable participation from all relevant stakeholders
- Actively encourage the contribution of all stakeholders to the wider well-being agenda, e.g. leisure, environment, housing, community safety, regeneration, education and children's services, ensuring that well-being activities are appropriately considered in their planning, including other HSP theme partnerships
- Share information, best practice and experience
- Share performance management frameworks where appropriate and possible
- Integrate, wherever appropriate, the plans and services of partner organisations including the use of Health Act 1999 flexibilities
- Account for actions and performance through regular reports to the HSP via the joint commissioning group which manages finance and performance of the WBPB

5. Operational Protocols

Membership
The membership of the Well-being Partnership Board will:

- Be related to the agreed role of the Partnership with the flexibility to co-opt members for a specified time to meet specific requirements
- Be reviewed annually
- Have the authority and resources to meet the aims and objectives of the Terms of Reference
- Possess the relevant expertise to deliver the Terms of Reference
- Be responsible for disseminating decisions and actions back to their own organisation and ensuring compliance
- Will nominate a member to represent it on the HSP Board

Chair
The WBPB will select a chair from either Haringey Council or Haringey Teaching Primary Care Trust – on rotation – at the beginning of each municipal year.

Vice Chair
The WBPB will elect a vice chair from either Haringey Council or Haringey Teaching Primary Care Trust – whichever is not currently providing the chair – at the beginning of each municipal year.

Deputies and representation
Partner bodies are responsible for ensuring that they are represented at an appropriate level. Where the nominated representative is unable to attend, a deputy may attend in their place.

Co-opting
The Partnership may co-opt additional members by agreement who will be the full voting members of the Board.

WBPB Membership

Agency	Number of representatives
Local Authority to include representatives from: Urban Environment, Safer Communities, Children and Young People and Adult, Culture and Community Services	9
Haringey Teaching Primary Care Trust (HTPCT)	6
North Middlesex University Hospital NHS Trust	1
Whittington Hospital NHS Trust	1
Barnet, Enfield and Haringey Mental Health Trust	1
Haringey Association of Voluntary and Community Organisations (HAVCO)	2
Community Link Forum representatives	3
Haringey Police	1
Haringey Probation	1
College of North East London	1
TOTAL	**26**

Well-being Chairs Executive (WBCE)
The WBPB is supported by an executive group consisting of the Chief Executive of the HTPCT, the Director of Adult, Culture and Community Services of Haringey Council, chairs of sub groups, as outlined below, and policy support. The WBCE meets monthly and its responsibilities include:

- agenda setting for the quarterly WBPB which will then be agreed by the chair and vice chair of the WBPB
- finance and performance management of the WBPB sub groups.

Sub Groups of the Haringey Well-being Partnership Board
The WBPB and the WBCE will be supported by subsidiary bodies known as outcome-focused sub groups and a joint commissioning group with responsibility for finance and performance.

Other sub bodies may be established by the Board as it evolves.

Meetings

- Meetings will be held four times a year with additional, special meetings if required
- A meeting of the Well-being Partnership Board will be considered quorate when at least six members are present, providing that two representatives each of the Council and the Teaching Primary Care Trust, including the following, are in attendance:
  - one Councillor, Haringey Council
  - one Non Executive Director, Haringey Teaching Primary Care Trust
- Attendance by non-members is at the invitation of the chair
- The agendas, papers and notes will be made available to members of the public when requested, but meetings will not be considered as public meetings
- Members will elect a chair and vice chair from Haringey Council and Haringey Teaching Primary Care Trust – on rotation – at the beginning of each municipal year
- Members will develop and agree protocols for the conduct of members and meetings

These representatives are responsible for disseminating decisions and actions required back to their own organisation, ensuring compliance with any actions required and reporting back progress to the HSP.

Agendas
Agendas and reports will circulated at least five working days before the meeting, after the agenda has been agreed by the chair and vice chair. Additional late items will be at the discretion of the chair.

Partner action
Representatives will provide a link with their own organisation regarding reporting back and instigating partner action.

Interest
Members must declare and personal and/or pecuniary interests with respect to agenda items and must not take part in any decision required with respect to these items.

Absence
If a representative is absent for three consecutive meetings the organisation/sector will be asked to re-appoint/confirm its commitment to the partnership.

Well-Being Partnership Board Membership List **APPENDIX 2**

SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	9	Cllr Bob Harris (Vice-Chair) Mun Thong Phung Councillor John Bevan Councillor Dilek Dogus Councillor Gideon Bull Margaret Allen John Morris Marion Morris Lisa Redfern
Health	Haringey Teaching Primary Care Trust	6	Judy Allfrey Tracey Baldwin Eugenia Cronin Vicky Hobart Cathy Herman Richard Sumray (Chair)
	North Middlesex Hospital trust	1	Claire Panniker
	BEH Mental Health Trust	1	Michael Fox
	Whittington Hospital Trust	1	Joe Liddane
Community Representatives	Community Link Forum	3	Abdool Alli Angela Manners Rizvi Faiza
	HAVCO	2	Robert Edmonds Naeem Sheikh
Education	College of North East London	1	Cathy Walsh
Other agencies	Haringey Probation Service	1	Mary Pilgrim
	Metropolitan Police	1	Richard Wood
	Total	**26**	

Lead director: Mun Thong Phung, Director, Adult, Culture & Community Services, Haringey Council Tel: 020 8489 5919
Email: phung.munthong@haringey.gov.uk

Lead officer: Helen Constantine, Head of Service Improvement, Adult, Culture & Community Services, Haringey Council Tel: 020 8489 3329
Email: helen.constantine@haringey.gov.uk

Lead Committee Secretariat Co-ordinator: Xanthe Barker, Principal Support Officer (Council), Chief Executive's Member Services, Haringey Council Tel: 020 8489 2957
Email: xanthe.barker@haringey.gov.uk

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Haringey NHS
Teaching Primary Care Trust

Developing World Class Primary Care in Haringey

Haringey Teaching PCT's Primary Care Strategy

May 2008

May 2008
V2.4
GH/SDS

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Foreword

In June 2007 we set out our high level plans for transforming primary and community health services in Haringey. We set out what we believed needed to change and why and how we wanted services to develop over the next 10 years.

We consulted throughout Haringey on our strategy between June and October last year, including a specific assessment of the impact of our strategy on equalities and on groups of people that we know are, or may be, disadvantaged in using health services. Our consultation drew strong views from the public and other stakeholders both for and against different elements of our vision. It gave us a clear understanding not only of what is important to our local stakeholders, such as seeing the same GP when you have an ongoing health problem, but also a very real appreciation of the difficulties faced by many people right now in getting the services they need. For example we heard how certain groups of people can find it particularly hard to negotiate appointment systems, and how some groups, such as carers, find it hard to get what they need from services, and how some services such as foot health could be made more widely available. We were, on the other hand, pleased to hear that many people currently enjoy a good relationship with their family doctor and value the services available to them. We learnt a great deal from everyone who let us know what they thought and we thank everyone who shared their views, enthusiasms and concerns. We will be doing more to listen to the views of the people of Haringey in future.

This is an **evolving strategy**. Contained in this document is the next iteration of our primary care strategy, built on what our stakeholders and the public have said, what we have learnt from other organisations who have successfully transformed out of hospital services and the national and London-wide policy context in which we operate in particular the development of *Healthcare for London: A Framework for Action,* led by Professor Sir Ara Darzi and changes in local hospital services as a result of the Barnet, Enfield and Haringey clinical strategy.

Approval of this iteration of the strategy will enable us take our planning to the next stage of development, which will involve the **testing out of our approach with stakeholders** and the working up of detailed neighbourhood plans. We will continue to consult on this strategy at each stage of its development taking a bottom up approach led by local GPs, whose services are at the heart of these proposals.

Our plans for **ongoing consultation** across each phase of the development of this strategy, planning and implementation are set out in more detail in Chapter 6 below. In summary these are:

Consultation and key next steps		
Next step	**What for?**	**By when?**
Patient experience survey	Baseline current levels of satisfaction with primary care and gauging views on the changes proposed within the strategy.	**November 2008**
Transport modelling and analysis	Baseline survey of current transport and travel times, expert advice on maximising accessibility within proposed new model.	**November 2008**
Board review	Review Primary Care Strategy in light of transport and patient experience work	**November 2008**
Development of local plans including community engagement in development	Detailed modelling of "hub and spoke" model and drawing up of specific plans for each neighbourhood led by GP collaboratives.	**Autumn / Winter 2008/09**
Formal consultation	GP led consultation on detailed neighbourhood plans.	**Spring 09**
Board review and final sign off	Board consideration of detailed strategy and plans in light of consultation responses	**Summer 2009**

We have set out in **Appendix 1** exactly how the feedback has informed, reshaped and clarified our strategy. In particular we have clarified and refined our plan for a "hub and spoke" approach, networking GP practices into five Neighbourhood Health Centres, picking up concerns and confusions identified in the consultation about the precise nature of the model we planned to adopt. We also noted that the term "super health centre" was not helpful. We have changed that to Neighbourhood Health Centre to better reflect the locality and community focus of each of our "hubs".

During the consultation we encountered some resistance to our proposed approach, especially from people who are currently very satisfied with the care they receive from their GP. We were pleased to hear about the high levels of satisfaction people had with primary care services in some areas and want to build on this so that all people in Haringey get this high level of service. What we cannot do is to simply carry on with the current model as we know that for many people the level and quality of service received falls far short of this. One of our core responsibilities as a PCT is to ensure we commission high quality, effective and accessible services for **everyone** in Haringey. As we set out below in our case for change:

- We know there is great variation in the range of care people receive at their GP practice in terms of the quality of care that is delivered there, the state of the building and how easy it is for people to get to see their GP
- We know that care has developed around the health and social care services that exist rather than around the people who use them.
- We know that the number of years you are likely to live varies significantly depending on where you live in the borough (up to 8 years

difference between East and West) and that this is down to a complexity of factors including housing, education, income, employment and importantly the accessibility and quality of primary health care services.

"Doing nothing" is not an option as this would mean accepting the status quo where we know that a significant proportion of people are not getting the primary care services they should be and in the way that will keep them well and healthy. By doing nothing we would be failing to address some of the fundamental health issues in Haringey with health inequalities continuing if not increasing. We must address these issues and we believe strongly that the service model we set out in this strategy will provide the infrastructure to enable us to make significant improvements in the health and wellbeing of all local people.

In real terms we want to see a change from the current situation. At present many people with long term conditions like diabetes need to see a whole range of health professionals in different locations, at different times, involving various referrals and diagnostic tests available only 9am-5pm on weekdays. In the future they will be seen at a "one stop shop" either at a local GP practice – from premises that are fit for purpose and set up to deliver this care – or at their local Neighbourhood Health Centre. Opening hours will be extended to offer appointments when people need them. Clinical care will not be provided in isolation but instead be linked properly through to a range of healthy living services and relevant community groups. This would mean that effective advice and support, expert patient and computer based self-care programmes, diet and exercise groups and risk and prevention work with other family members will be available either at local GP practices or from the Neighbourhood Health Centres. Developing primary care infrastructure in this way will also provide us with a significant opportunity to work with partner organisations to build a range of services to support emotional and mental wellbeing related to ongoing health issues such as help with depression, claiming welfare benefits, employment and housing advice.

The outcome will be better, more holistic care for people in Haringey keeping them well and able to live their lives to the full. We appreciate that for some people in Haringey this is already true – we want this to be the case for **everyone** living in Haringey.

At the heart of the new service delivery model is the integration of services (health and social care in the broadest sense working together to help people be and stay healthy) around the needs of the people that use those services. However we cannot make this transformation using our current primary and community services estate. Around half of our GP practice premises are not fit for purpose and cannot physically be improved. The location of practices does not provide appropriate cover in some of our most deprived areas. Many of our practices simply do not currently have the infrastructure, systems, clinical cover and clinical environment to provide the sort of services people in

Haringey deserve. As such we have necessarily needed to consider not only what we want to see provided but also how we will be able to provide it. We need to rationalise the number of premises, invest in our remaining premises to make them fit for purpose and able to provide the wider range of services we want to commission. Where practice premises are not fit for purpose we need to work with local GPs to help them find the best solution to meet the needs of their patients – this will depend on individual practice circumstances but may include relocation into the local Neighbourhood Health Centre or other suitable practice premises. We need to link remaining practices closely to the Neighbourhood Health Centres, able to provide local access to a whole range of additional services people would usually need to go to hospital for with significant extension of opening hours and ways to access care when needed. This model is explained in greater detail in Chapter 3.

We want to be very clear that this strategy is **not about reducing the number of GPs we have or cutting costs**. It is about investing in primary care and supporting our GPs to offer the best services they can. To do this we will need to ensure that there are suitable premises and the right environment to continue to recruit young GPs and other health professionals into Haringey. **Over the next 3 years we will be investing an additional £8 million in out of hospital services to do this.** Our ambition is to develop world class primary care services for all our residents as a fundamental part of improving health and wellbeing and reducing health inequalities.

Tracey Baldwin
Chief Executive, Haringey TPCT

Richard Sumray
Chair, Haringey TPCT

Executive Summary

1. The primary care strategy sets out a framework within which primary and community health services will be developed over the next 10 years and has been produced following extensive consultation with stakeholders. The vision of the strategy is of world class, high quality, and responsive primary and community services for all Haringey residents.

   Haringey Teaching Primary Care Trust (HTPCT) will work in partnership with patients, the public, the local authority, the voluntary sector and others, to ensure that primary and community services play their full part in improving the health of local people, reducing the health inequalities that exist in Haringey and maximising independence.

   The TPCT will develop new ways of providing and commissioning services that will place primary care and community services at the heart of local communities, so that Haringey's health care contributes to and benefits from community engagement and participation.

2. This is an evolving strategy for which there will be an ongoing dialogue with stakeholders. The final strategy will be signed off by the Board in July 2009 once detailed neighbourhood plans have been developed and consulted on.

3. A clear case for change is set out in the strategy in order to meet the current and future predicted needs of Haringey's growing, mobile and diverse population and to develop sustainable and modern primary care services.

4. The future of primary care in Haringey is a new delivery model of a planned and integrated network of primary and community services. Each of the four practice-based commissioning collaborative areas in Haringey will develop a large Neighbourhood Health Centre "hub" and a number of GP practice "spokes". **The number of GPs in Haringey will not be reduced.** The number of locations from which services are delivered will reduce. The details of how individual GP practices will be affected will be developed through the implementation process described in the strategy, and will be subject to formal consultation at the local level.

5. The main benefits that this strategy will bring for Haringey are:
   - Improved access to primary care;
   - Improved quality in primary care;
   - Primary care services being better able to tackle health inequalities;
   - Improved premises for services to operate from;
   - Greater range of more integrated services available

- Opportunity for Neighbourhood Health Centres to become community resources.

6. Implementing the strategy includes some key next steps, namely developing a full programme blueprint, developing neighbourhood plans and undertaking formal consultation on these plans. A patient experience survey will be carried out in 2008 to inform this process.

   Enabling strategies are in development including transport, workforce and organisational development, commissioning, information technology and finances.

Chapter 1 Introduction, Vision and Definitions

This chapter of our strategy deals with our vision and introduces some key concepts and definitions.

1.1 Introduction

This document sets out Haringey TPCT's Primary Care Strategy. It provides the framework within which primary and community services will be developed over the next ten years. The strategy will be supplemented with detailed implementation plans. Further information about how these plans will be developed is provided in Chapter 5.

This strategy has been developed following extensive consultation by the TPCT with a range of local stakeholders. There have been a number of changes made to the strategy that was produced by the TPCT in June 2007 in order to take into account the outcome of the consultation process and the equalities impact assessment (EIA) that was carried out during the consultation period. Further information about the consultation and the EIA can be found in **Appendix 2**, the full reports from these processes can be found at www.haringey.nhs.uk.

1.2 Vision

Our vision is of world class, high quality, and responsive primary and community services for all Haringey residents.

We will work in partnership with patients, the public, the local authority, the voluntary sector and others, to ensure that our primary and community services play their full part in improving the health of local people, reducing the health inequalities that exist in Haringey and maximising independence.

We will develop new ways of providing and commissioning services that will place primary care and community services at the heart of local communities, so that Haringey's health care contributes to and benefits from community engagement and participation.

1.3 Definitions

1.3.1 What is primary care and who is it for?

Primary health care can currently be defined as services that:

- Are accessible to everyone – i.e. universal not targeted
- Are 'first level' – i.e. generalist rather than specialist
- Promote health and prevent ill health
- Diagnose and treat health conditions
- Assess for onward referral to more specialist care where needed.

This strategy focuses mainly on services provided by general practice teams, community pharmacy services and how they link with community health services such as district nursing and therapy services. It incorporates the contribution made by the local authority, community and voluntary sector to primary care and how health services can work closely with these organisations particularly around a broad-based approach to prevention of ill health. Importantly it also includes developing specialist skills in primary care to enable more services to be provided closer to home in a community setting / facility rather rather than in hospital.

It does not specifically cover General Dental services or Optometry services. Whilst we acknowledge that these services are key elements in developing world-class primary care further work needs to be done to define our strategy for these services. This will include refining our understanding of the current context for these services and our local health needs, involving local dentists and optometrists in developing the strategy and understanding the opportunities available for developing services in the context of our contractual arrangements with them.

Primary care services need to respond in a safe, effective and equitable way to:

- Well people (health surveillance, health promotion, community health)
- People with urgent care needs – including minor ailments or injuries as well as more serious illnesses
- People with acute / time limited conditions
- People with long-term health conditions (e.g. diabetes, heart failure, respiratory disease, mental health problems)
- People throughout their lives - children, young people, adults and older people.

Primary care practitioners need to know when to refer patients on for more specialist care and play an important co-ordinating role for people with more complex health needs who are in contact with lots of different parts of the health and social care system. See **Appendix 3** for more information on who uses primary care.

1.3.2 What is "world class" primary care?

The way health care is organised varies significantly around the world – with different systems having very different strengths and weaknesses. Whilst we have looked at some of the evidence about 'what works' elsewhere as part of developing this strategy it is clear that there is no one blueprint as to how services should be delivered. In setting ourselves the goal of delivering 'world class' primary care for all Haringey residents what we are aiming to achieve is clinical outcomes and patient experience comparable to that delivered by the very best services both nationally and internationally. The British primary care system at its best is widely admired across the world – when it is working at its best this admiration is well founded, but as is explored in more detail in

this document, we believe that services in Haringey are currently some way from consistently delivering world class care.

Chapter 2: Case for Change

This section of our strategy explains why we need to make changes to our current primary care and community services. It reiterates and expands on the case for change set out in the original strategy – a case which was accepted by the Haringey Overview and Scrutiny Committee.

2.1 Defining the issues

One of our core responsibilities as a PCT is to ensure we commission high quality, effective and accessible services for everyone in Haringey.

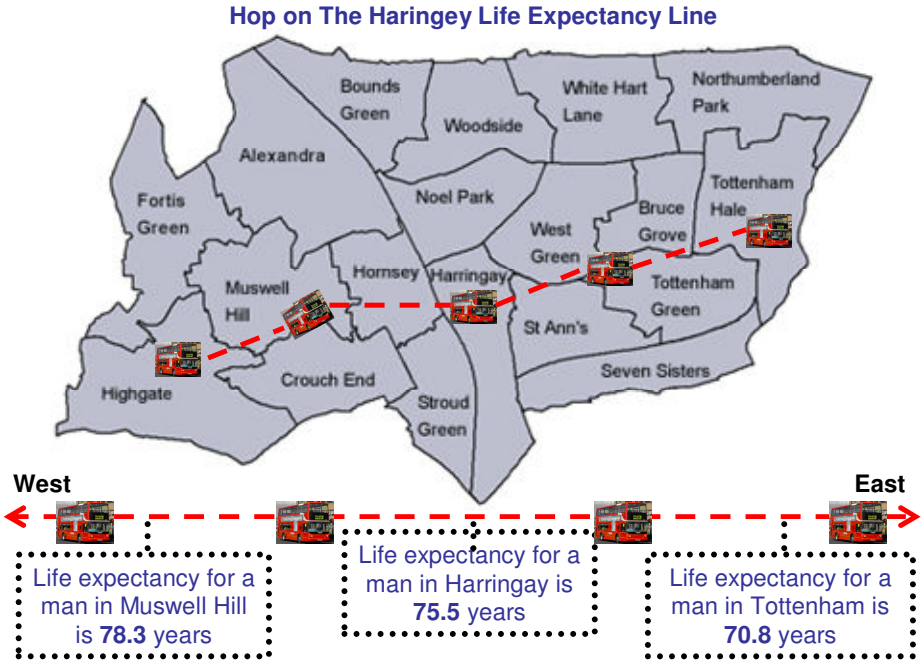
We know that:

- Our **population** will grow over the next 10 years and the profile of health needs will change
- Significant health **inequalities** exist in Haringey, demonstrated by the gap in male life expectancy, which is nearly 8 years lower in Bruce Grove (70.5 years) than in Muswell Hill (78.2 years). This is illustrated in figure 1 below.
- **Patients want** better access and continuity of care designed around their individual needs and that of their families.
- People from certain **vulnerable and disadvantaged groups** find it difficult to access the services we currently provide (see Equalities Impact Assessment www.haringey.nhs.uk)
- GP **services vary significantly** depending on which practice you are registered with – in terms of access, quality, condition of premises and range of services available.
- We need to **improve and integrate** the way our community health services work with the services provided in primary care and in hospital. In particular we need to ensure that out of hospital services complement and integrate with services delivered in hospital, taking into account the changing face of hospital-based services as a result of the implementation of the Barnet Enfield and Haringey Clinical Strategy and against the backdrop of change advocated in *Healthcare for London: A Framework for Action.*
- Our current **infrastructure and estate** is unable to support the sort of access and integration people want and need and which will give the best health outcomes to everyone in Haringey.
- We need to develop a **sustainable** approach to providing services and in particular ensure that we can **recruit** the new generation of GPs and other health and social care professionals to meet the increase need our growing population will place on services.
- We need to **invest** in our primary and community services. We also need to ensure that we make the **best use of those services and resources**. For example we know that in Haringey we are out of step with the rest of the country in terms of the number of referrals that are

made to out patient appointments and in terms of the way in which A&E services are used.

We must find a lasting solution to these issues by drawing on what we know works in primary care, taking into account the broader national strategic context. We must also ensure we develop our plans in partnership with Haringey Council in particular and in the context of the significant work that has already been done to transform services for children and families through Children's networks.

Fig. 1: The gap in life expectancy in Haringey illustrated across the No. 41 bus route.



2.2 Developing a solution – evidence and context

We have outlined above and explored in greater detail in **Appendices 4-9** the critical issues that we face locally in developing the future of primary and community services in Haringey.

In developing our solution to these issues we have taken into account of the national and London specific policy context for developing services in particular, *Our Health, Our Care, Our Say*, *Choosing Health* and *Healthcare for London: A Framework for Action*

We have also reviewed evidence of what works in primary care. The evidence is explored in more detail in **Appendix 10**.

The key messages from reviewing the context and the evidence are that we need to commission primary care services which:

- Have the flexibility and organisational structure to provide access, continuity and availability of services for all Ensure equity so that high quality primary care is available to all wherever they are registered in HaringeyHave systems for those patients who find it difficult to access the kind of care they want and need including those who may experience difficulties e.g. people with disabilities or from minority ethnic communities
- Have systems in place to make it easy for patients to express a choice of health professional.

Having set out the case for change, the next section provides the model we expect to put in place to realise our vision of world-class primary care services in Haringey.

Chapter 3: The Future of Primary Care in Haringey

Having considered why we need to change this chapter sets out our 10-year strategy to create sustainable primary and community care services for Haringey.

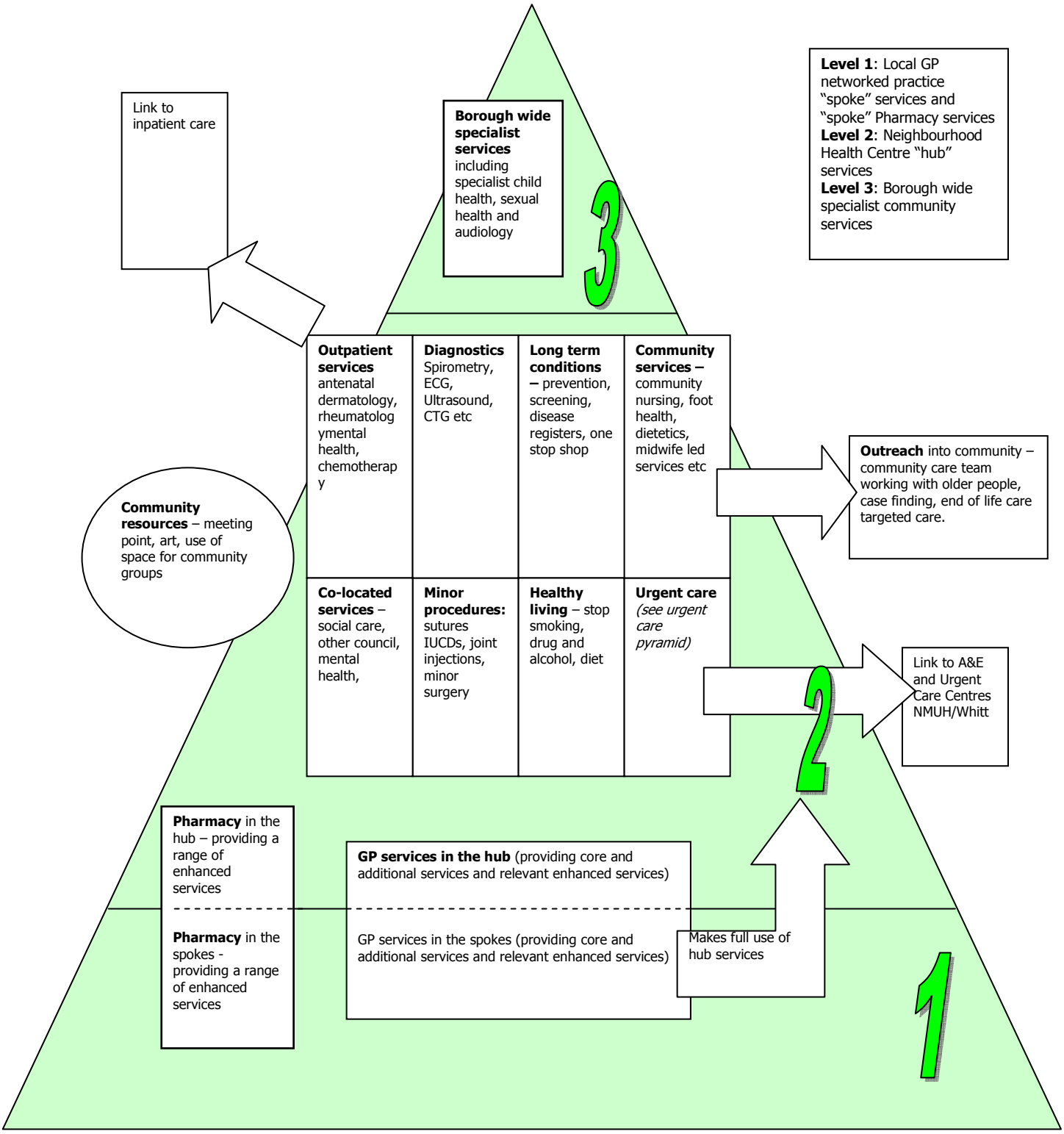
3.1 The "hub and spoke" service model

We aim to commission a planned and integrated network of primary and community services delivered from a mix of fit-for-purpose general practice "spokes" and larger Neighbourhood Health Centre "hubs". We believe this will enable us to make the most of the existing assets available to the TPCT and allow us to deliver services to the highest standard, whilst responding to the views expressed during the consultation process which preferred a hub and spoke style model to the pure model.

This is about re-organising the GPs and other services we commission in a better way NOT about reducing the number of GPs.

We believe that we need to create a service model able to serve a registered population of up to 250,000 by 2020. That service model must also be able to respond to the projected demographics, related need and potential inequalities. This model is illustrated in the diagram below (fig. 2).

Figure 2: Diagram of hub and spoke primary care model



3.2 Neighbourhood Health Centres/ hubs

The Neighbourhood Health Centre hubs will be located as follows:

- Hornsey Central – serving **West Haringey**
- Lordship Lane – serving **North East Tottenham**
- Laurels and Tynemouth Road – serving **South East Tottenham**
- Wood Green or Turnpike Lane (location to be determined) – serving **Central Haringey.**

We intend that these hubs develop over time to act not just as a focus for health services for that area, but that they can be developed by and for the local community into a valuable community resource. We have looked at the Bromley by Bow healthy living centre as an exemplar of community engagement in health services, and whilst recognising the many differences between Bromley by Bow and the different areas of Haringey, hope to learn from their experience and emulate some of their key principles which have informed their successes.

Each hub will develop in response to the identified needs of its specific local population, however it is expected that each hub will have the following main functions:

- They will provide general practice services to about half of the registered population of Haringey (a total of around 125,000 people, each hub serving about 25-35,000 registered patients).
- They will provide a base from which a wider range of services can be offered to those registered with a GP at the hub **and** to the local GP spoke practices operating around the hub. This would include blood testing and other diagnostic testing, out patient appointments usually conducted in hospital and services to support long term condition management in a "one stop shop" approach.
- They will provide a base from which other social care and voluntary services will be able to add value to health based interventions, e.g. Citizens Advice, social services linked to help at home, housing advice.
- They will provide health promotion and prevention activities and programmes.
- They will provide a base from which other specialised borough wide services such as specialist child health services, specialist sexual health services and audiology services can be accessed. Borough-wide services will be strategically located in accordance with the specific needs of the local population, transport links and other factors (for example Wood Green/Turnpike Lane would be a sensible location for sexual health services and promotion/prevention given the transport links in the borough and its attraction to young people in particular as a retail and commercial centre).
- Extended unplanned care services for the locality – e.g. walk in services, minor injuries and out of hours services over and above what

will be provided in the GP practice spokes (please see section on urgent care below for more information)
- Extended access in terms of opening hours across a range of services – for example general practice available 10-12 hours per day and Saturday opening.
- A health and community resource which will engage the local community in its health and health services.

The Neighbourhood Health Centre/ hubs will be developed around existing or planned new developments in Hornsey Central, Lordship Lane, the Laurels and Tynemouth Road. A new development will be required for Central Haringey, likely to be near Wood Green or Turnpike Lane, depending on availability of appropriate sites and to make best use of the good transport links in those locations.

3.3 GP practice "spokes"

GP and other primary care services will also be provided outside of the hubs, and will be commissioned to ensure a proper level of local access and choice. In addition to the hubs, we believe that we will need between 12-15 distinct delivery points for primary care services spread across the borough serving the remaining 125,000 population (usually between 8-15,000 registered population each). Work is underway to assess where best to locate these points in relation to transport and travel issues, and to determine the optimum number of locations. However from what we know about population density, natural and other barriers, transport routes/flows across the borough and patient flows/primary care planning across shared borders with Islington, Hackney, Barnet and Enfield, we currently believe the best location for these service delivery points is:

	GP practice spokes	Related Neighbourhood Health Centre hubs
	West	**Hornsey Central**
1	Muswell Hill	
2	Highgate	
3	Stroud Green	
	Central	**Wood Green or Turnpike Lane**
4	Bounds Green	
5	Either Green Lanes/Wood Green or Green Lanes/The Ladder	
	North East Tottenham	**Lordship Lane**
6	Northumberland Park	
7	White Hart Lane – (eastern end)	
8	Broadwater Farm	
	South East Tottenham	**Laurels and Tynemouth Road**
9	A10 towards border with Hackney	
10	West Green	
11	South of Harringay Green Lanes overland station	
12	Noel Park (South East)	

This is our preliminary view which needs to be further tested out through in particular our patient experience survey and transport modelling and analysis. Please see the map in section 3.12 (figure 4) below. This will also be the subject of formal consultation as part of detailed locality plans in Spring 2009.

We do not set out specifically in this strategy document the future of each practice in Haringey. There will be further consultation and engagement with patients and other stakeholders before these detailed decisions are made. This process will include individual discussion with each practice according to their individual circumstances and future plans, and with the Practice Based Commissioning Collaboratives. Clearly where there is a practice or practices in the right location with good accommodation, good standards of care and an ability to operate within the network to ensure that the benefits to patients of the new model are fully realised it will make sense to retain that practice as one of the service delivery points for primary care services in the model we want to implement. Where there is a practice in a poor standard of premises that cannot be improved it will make sense to work with that practice to identify suitable premises that will enable them to meet their clear legal, contractual and professional responsibilities to their patients regarding the environment of care.

Our overarching principle will be to commission high quality accessible services that are able to play their full part in improving the wellbeing of everyone living in the borough.

We will be working with Haringey's GPs to further develop the specification for primary care provision in the GP spokes; however we want to see the primary care services that are currently provided in the best of our GP practices made routinely available across Haringey. This will include all essential and additional services and all practice-based enhanced services being made available from every spoke throughout the day – with premises open for example from 8.30am to 6.30pm. This will include services such as type 2 diabetes clinics, sexual health and family planning (level 1), and primary care mental health being available in each spoke, rather than at present only in some practices.

To reiterate this is not about reducing the number of GPs but about organising the services of GPs in the most effective way in premises that are appropriate for delivering the highest standard of care

3.4 Pharmacy

The traditional role of community pharmacy as predominantly a source of supply and advice about medicines is in the process of radical change. The new pharmacy contract and the subsequent White Paper encourages the commissioning of a wider variety of services, enhancement of the pharmacy IT structure, new clinical opportunities for pharmacists, for instance as prescribers – all contributing to a potentially very different service.

The challenge is not only to harness these changes, but to create the right environment for the services to flourish and make significant contributions to the health of the people of Haringey. With expertise and skills that are increasingly being used to provide a wider range of services to patients, it is vitally important that we fit the contribution of our community pharmacists into the wider primary care arena. We want to encourage pharmacists to work alongside doctors, nurses and other healthcare professionals to improve the health of patients in Haringey. Whether promoting healthy lifestyles and preventing disease, treating and monitoring long-term conditions, providing services to those who do not generally access primary care, community pharmacists need to be part of multi-disciplinary teams. As GPs become more involved in commissioning care for their patients, we expect them to choose pharmacists as service providers, with appropriate roles and responsibilities in well-designed pathways of care. Pharmacies will be "healthy living" centres promoting health and supporting people to care for themselves, as well as offering specific services to patient groups that have particular needs.

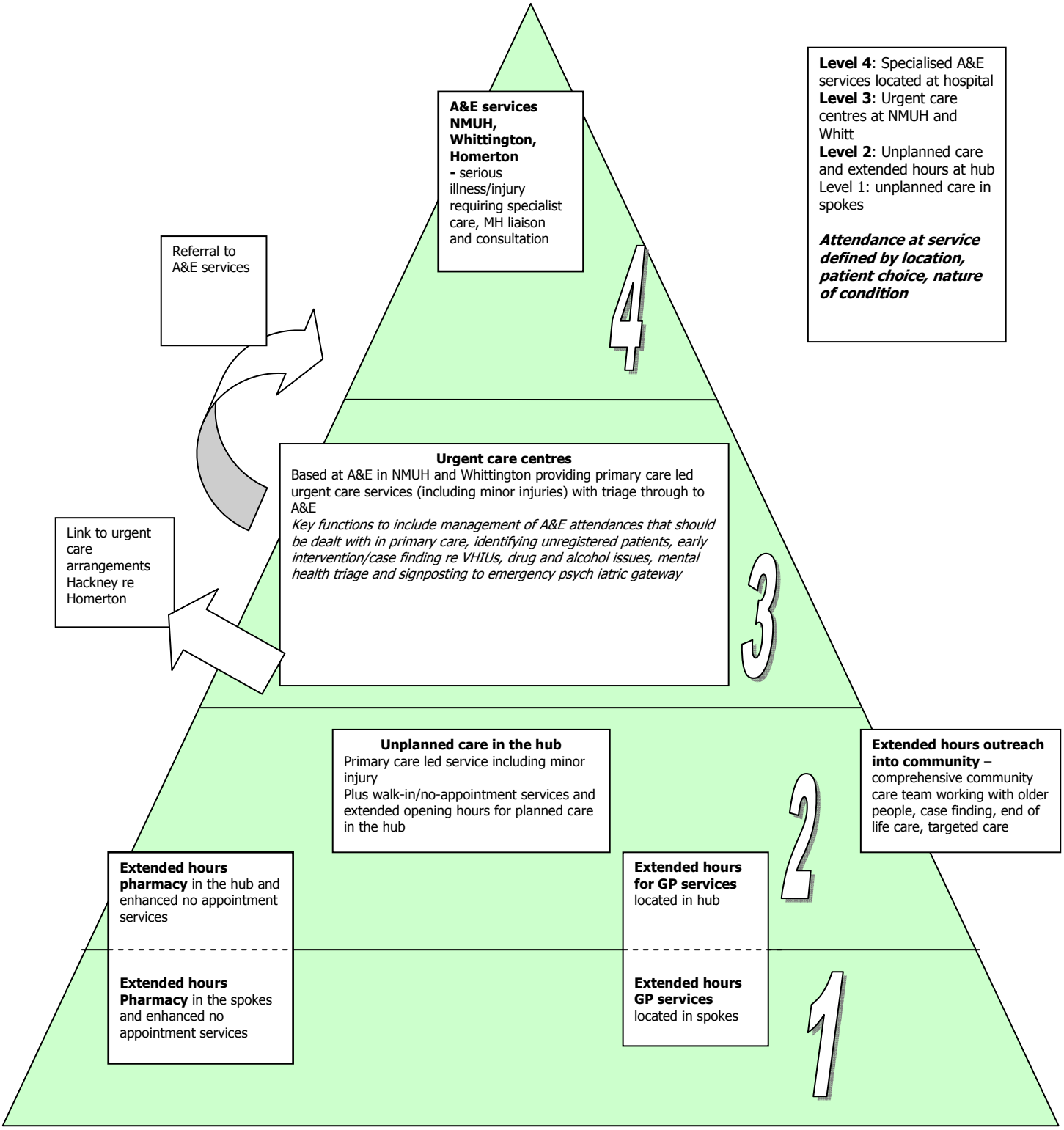
We anticipate hub pharmacies will be specially commissioned to support a range of services within the hub and elsewhere. Practice Based Commissioning groups will need to commission the same and other services from pharmacies in the spokes, ensuring equity of access to the new wider range of services that pharmacy will offer. In the future for instance, pharmacists may be charged with dealing with weight management issues for particular cohorts of patients as commissioned by the collaboratives. Diabetic patients may go to the hub pharmacy for management of their weight as it may be co-located with their diabetes clinic. Others may choose a pharmacy nearer where they live. The dispensing function of pharmacies will need to change but managing safe access to the best medicines will still remain a central function of local pharmacists.

3.5 Urgent Care

In our consultation document we referred to the development of Neighbourhood Health Centres based at North Middlesex University and Whittington Hospitals. Concerns were expressed during the consultation as to the location of these as fully functioning hubs (as described above) and the nature and scope of the services that might appropriately be based there. We are still planning to develop services at NMUH and Whittington but the focus of these services will be the provision of urgent care services(i.e. services directed to patients with urgent health care needs rather than those who have experienced an accident or trauma). These plans will be developed further as part of our urgent care strategy which will review urgent care in Haringey as a whole.

The diagram below (figure 3) illustrates how we expect to see urgent care organised, with different levels of urgent care available in the different settings.

Figure 3: Diagram showing urgent care



3.6 Children and Young People

We have made much progress in working together with Haringey Council to improve how we meet the needs of children, young people and their families in Haringey. This work is ongoing and will focus on developing an integrated model of service for health and social care as set out in the Children and Young People's Commissioning Framework.

The focus is on health promotion and early identification of problems to give children the best possible start in life, with care being providing at home or as close to home as possible, from a range of settings including children's centres, schools, special schools, and primary care settings including Neighbourhood Health Centres. Much of the work with Haringey Council has focussed on the development of multi-agency teams for children and young people who are essentially well, with provision delivered mainly from educational settings such as children's centres, as the main provider of universal services. Further work needs to be done to ensure that primary care is not only linked into this model but is an integral part of provision, and to further develop the service model for children and young people when they are unwell.

A new health-led Children and Young People's Board with multi-agency representation has been established, meeting for the first time in June 2007. This group will oversee the implementation of the Children and Young People's commissioning framework and the interface with the primary care strategy and Every Child Matters. It will be addressing as a priority long term conditions, complex care and urgent care and will be able to advise on and support the implementation of the primary care strategy to best meet the needs of children and young people.

3.7 Mental Health

Historically the main focus on many mental health services has been on crisis management and hospital-based care. We are developing services in Haringey to move towards a model based on health promotion and early intervention and that can provide a single point of access to services and a single assessment process which leads to evidence based treatment. Haringey has a local Improving Access to Psychological Therapies (IAPT) programme[1] which aims to have a simple and easy to access primary care psychological therapy service that provides the least intrusive intervention possible for Haringey residents who are suffering with common mental health difficulties (typically depression and anxiety).

The mental health strategy for Haringey is currently being reviewed, and additional work will need to be undertaken to map how the development of the hub and spoke model in primary care can best work to improve outcomes in terms of mental health and wellbeing. We are committed to delivering

[1] In discussion with the National IAPT programme re potential for Haringey service to support training of IAPT cognitive behaviour therapists.

increased access to high quality primary care mental health services and psychological therapies. This commitment has been demonstrated by implementation of the Primary Care Mental Health Local Enhanced Service, engagement of local GPs and the PBCs, and the re-shaping of services designed to increase access to areas of the borough that have previously not accessed psychological therapies. Of course there is much more to do done.

Our continued plans include:

- The further development of a Primary Care Mental Health IAPT Service to enhance partnerships, cross sector working and effective referral pathways between primary and secondary mental health services
- To ensure effective mental health interventions in primary care through clear pathways, education and training
- To Increase primary care capacity and capability to provide increased treatment and support for people with common mental health problems (such as depression and anxiety) through our Increasing Access to Psychological Therapies (IAPT) Programme and for people who have or are experiencing Severe Mental Illness (such as schizophrenia).
- Effective links and use of services that can help people get back into education and employment.
- Deliver benefits for service users through provision of appropriately trained staff, decreased waiting times, increased information and choice, reduced stigma and access to more holistic services.

3.8 Adults and older people

Long term conditions (LTCs) like diabetes, heart failure and mental health play a significant part in the ongoing health of people in Haringey. This burden is felt more acutely by people from BME communities and by deprived communities. We are currently looking at transforming the way we work with people with long term conditions to focus much more on prevention, and early and accessible community-based care that enables people to manage their conditions better and with fewer complications in the long term. This will be a key component of the new primary care model. Work to date includes developing a new service model for diabetes, with the aim of replicating the generic aspects of this model across other conditions. We are also proposing to develop the community matron, district nursing and integrated therapy teams which will help to manage long term conditions and provide rehabilitation and intermediate care services. Services for older people need to be planned appropriately, ensuring that issues around access and continuity (which were of particular importance to older people involved in the consultation on the primary care strategy) are addressed in planning primary care services.

3.9 Learning disabilities

Primary care services need to be accessible to people with learning disabilities, a series of recommendations for health services including primary care are available in the Overview and Scrutiny Committee Review of March 2007 (Healthy and Equal: Improving the health of people with profound and multiple learning disabilities). The primary care strategy will improve physical access to services by improving the physical environment, and will make healthy living activities widely and routinely available. Improved appointment systems, incorporating both booked appointments and drop-in sessions can also assist in improving accessibility for all groups. Additional work will need to be undertaken to take forward other recommendations in relation to workforce training and to assess the effectiveness of the strategy in improving access to primary care for people with learning disabilities.

3.10 Vulnerable groups

Other groups who can be vulnerable to poor health and who find it difficult to access health services include people with substance misuse problems, highly mobile people including refugees and asylum-seekers and travellers and people living in areas of high deprivation. More work needs to be done to specify the best way to take forward some of the recommendations made in our Equalities Impact Assessment to work with these groups.

3.11 Well-being

The primary care strategy will seek to improve the health and well-being of Haringey's residents, in support of the Haringey Well-being Strategic Framework.

3.12 Location of services

The map below (figure 4) show how we think services will look in 10 years time. It includes the Neighbourhood Health Centre/ hubs, both those sites already identified and the possible site in the Wood Green or Turnpike Lane area, where we think the GP practice spokes are likely to be, the location of the two local acute hospitals and the pharmacy spokes. It also shows the main roads in Haringey. As noted above, the exact location of the GP spokes remains to be determined through further negotiation and consultation including consideration of the outcome of the work proposed to analyse travel routes and times (as outlined below). Although we will have at least the same number if not more GPs and a range of additional services available in primary care we will have a reduced number of locations from which services will be provided – around 20 locations.

We have included a map of current GP practice locations at figure 5 which illustrates how the proposed GP spokes in the model relate to current GP practice "clusters" and extended provision in areas of most need where no current services.

Figure 4: Map showing proposed location of primary care services

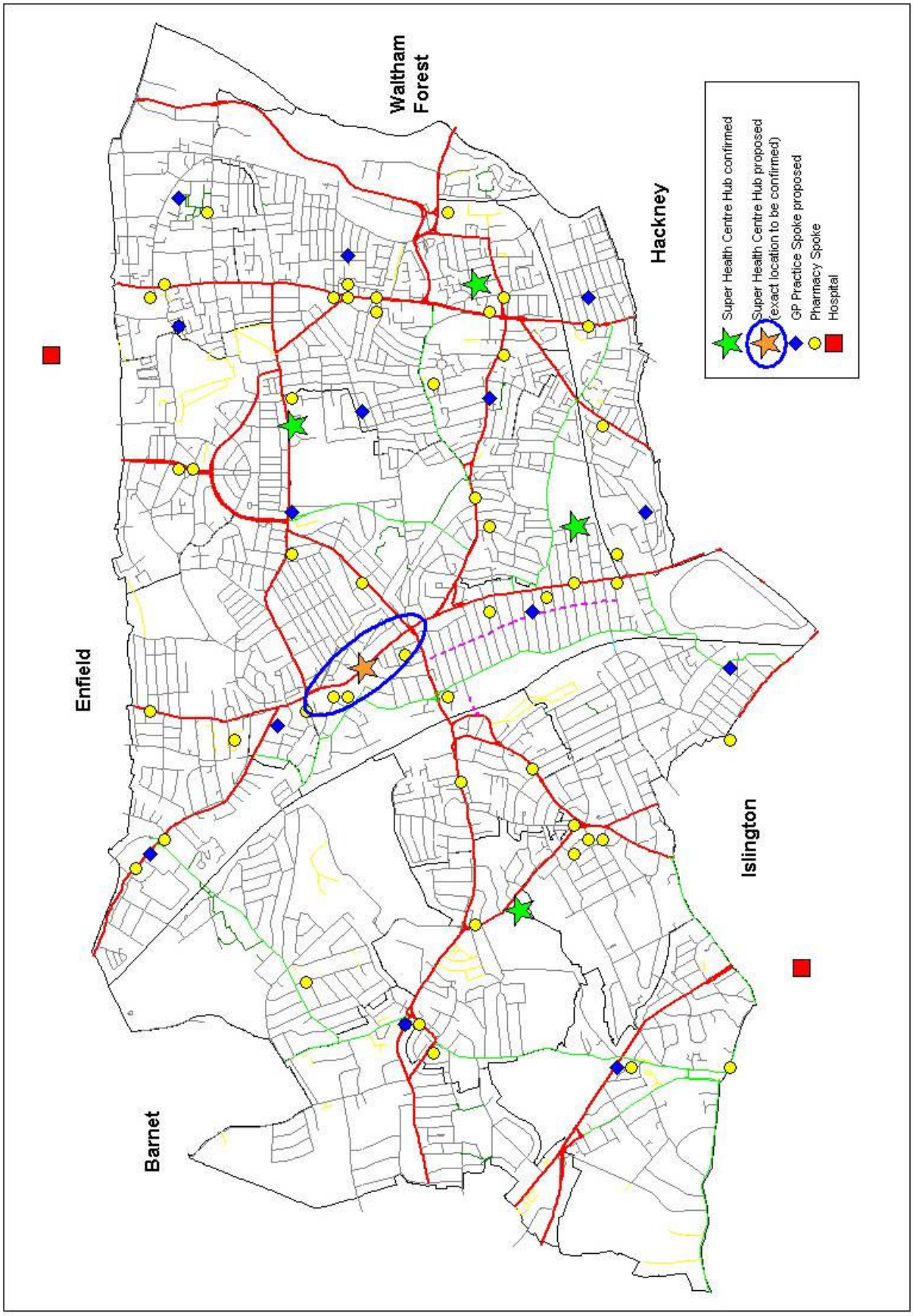
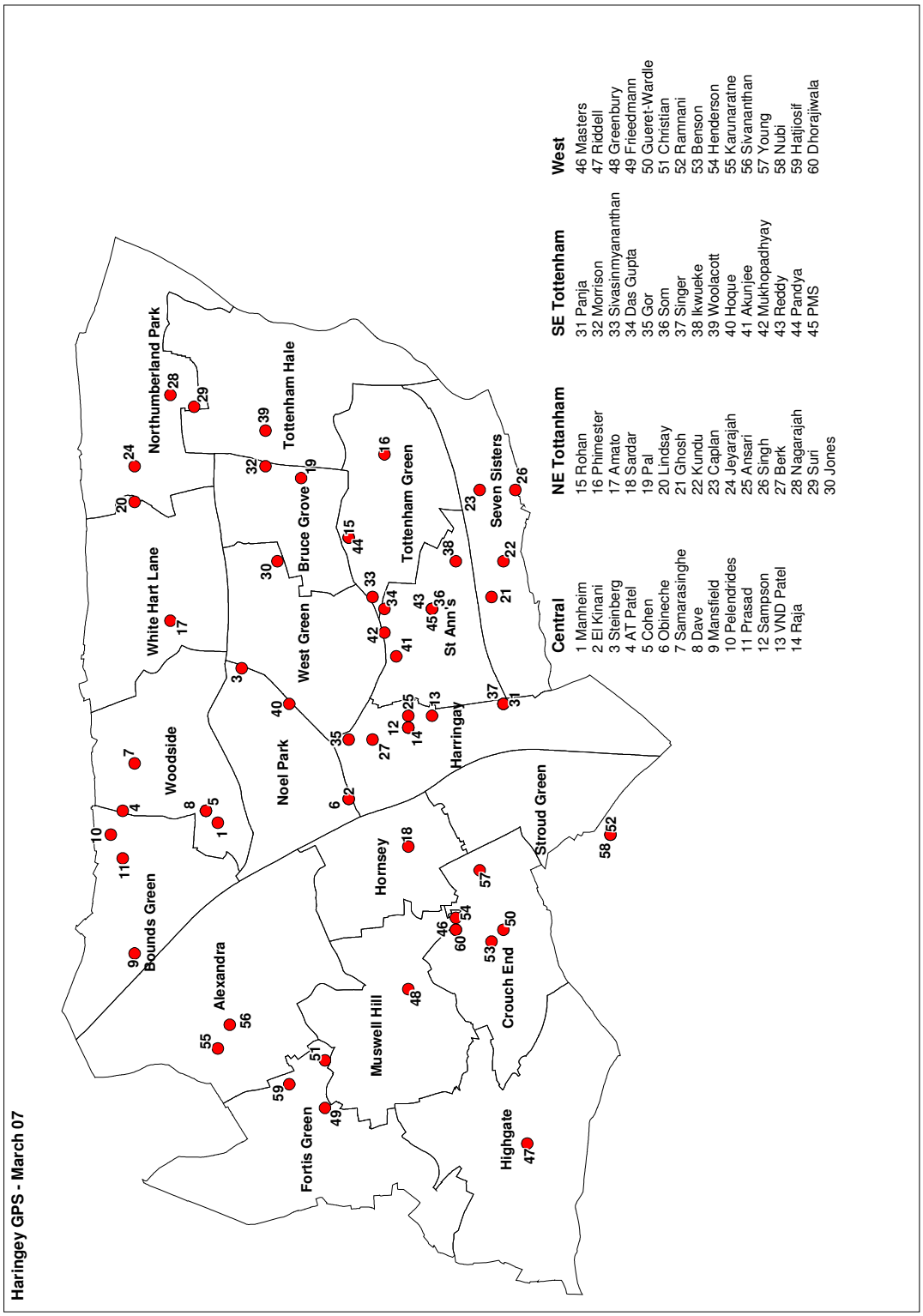


Figure 5: Current distribution of GP practices



3.13 Other existing community health premises

In the context of our Strategic Services Development Plan we are also considering the future use of all our current community premises and in particular how these might support the development of our primary and community care infrastructure. This will be worked through in more detail as neighbourhood plans are developed.

St Ann's Hospital site

The St Ann's site is owned by Barnet Enfield and Haringey Mental Health Trust (BEHMHT). We currently lease space from BEHMHT providing a number of borough wide community services from this site and also using it for our main administrative headquarters. We are actively looking to re-provide the services currently based here in more suitable locations and in more suitable quality and design of buildings. Equally we are planning in the longer term to relocate our main administrative centre in a convenient central location and one which will support closer partnership working with the Council.

As set out above we will develop a Neighbourhood Health Centre hub at the Laurels (opposite the St Ann's Site). A number of services have recently been transferred into the Laurels from the St Ann's site (including phlebotomy) as part of the move to develop more integrated person centre primary care services from that site. We are still in the process of identifying other sites, including GP practices that would work with the Laurels to provide the full range of services needed to create a local Neighbourhood Health Centre. This will include looking at how Tynemouth Road and Lordship Lane would interact with the Laurels site. It will also take into account the suitability now and in the future of commissioning services to be delivered from the St Ann's site.

Although we do not own the St Ann's site we clearly have a role in commissioning the sort of mental health services people in Haringey need. We are doing ongoing work with the Council and the mental health trust to develop the service model that will inform our commissioning decisions. In turn this will influence and shape the BEHMHT Strategic Outline Case (SOC) in terms of the premises that will be needed in the future to deliver the service we want to commission. The SOC is undergoing an extensive revision process with a view to finalising plans early 2009. Contact at Barnet Enfield and Haringey Mental Health Trust for further information about plans for the St Ann's site communications@beh-mht.nhs.uk

We like the BEHMHT are also involved with the consultation work being undertaken by the New Development for Communities around the Seven Sisters spatial development plan and linking in with the development of the St Ann's site.

Chapter 4: Benefits, trade-offs and limitations

In this chapter we talk about the benefits, trade offs and limitations of the primary care strategy. Whilst this strategy is vitally important to improving primary care services in Haringey, clearly it is not the only piece of strategic work underway to improve health in Haringey and it alone will not tackle some of the long-standing issues of health inequalities. It will however have a range of benefits for Haringey, which are described below.

4.1 Benefits

This section provides an overview of the main benefits that the primary care strategy will deliver for Haringey's residents. In addition, we will be developing a range of indicators that will enable us to measure progress against achieving these benefits.

4.1.1 Improved access to primary care

One of our key objectives in developing this primary care strategy is to improve access – and in particular to redress any inequity of access that fundamentally continues to fuel the stark health gap in the borough.

As noted in Chapter 2 above, access goes beyond travel and transport issues and includes the following dimensions:

- The resources people have to seek help from health services
- How differences between health service providers and users affect their seeking help from these services
- Availability and quality of health services
- Organisation of health services.

Merely ensuring people with equal needs are treated equally (horizontal equity) may seem fair, but will be insufficient to address the issue fully. The fact remains that those people who find it easy to find and use services will do so more often than those who do not. The equity of access we seek is to ensure that those with greater need should receive more help (vertical equity). Thus barriers to access become key and ways to reduce them for specific groups of people an important part of this strategy. Inequality of access to health services may be described as:

"*significant variations in the amount of work people with health needs have to do to reach and optimally use a service.*"

The primary care strategy will seek to ensure that all residents are able to access the right care they need, at the time they need it, in the most appropriate and convenient setting possible. Particular attention will be paid to improving access for people who currently find it difficult to access primary

care services including for example vulnerable adults and highly mobile populations.

Improved access will be achieved in the following ways:

- Providing extended opening hours: We are investing in the infrastructure in 08/09 to enable Lordship Lane and Laurels to open 12 hours a day 7 days a week and developing a Local Enhanced Service, to deliver extended hours in general practice; in direct response to the results of the national patient experience survey.
- Developing workforce skills in working with a diversity of patients so that culturally appropriate health services are made available
- Developing receptionist/health trainer role
- Providing a range of types of appointment systems to include both booked appointments and flexible opening
- Provide services in a range of settings across the borough
- Focus on improving access especially for groups experiencing discrimination and disadvantage, and developing indicators for measuring how successful the strategy is at doing this.

Also see section 4.1.3 on tackling health inequalities below.

4.1.2 Improved quality in primary care

We have set out in our case for change the variability of the quality of primary care and also the nature of the evidence about the sort of service delivery model more likely to deliver good quality care that larger practices appear to be better for clinical quality and poor quality is associated with deprived areas. We have very deprived areas in Haringey, where the health gap is most acute and which are often served by small practices which struggle for a whole range of reasons to provide the extra level of care needed to achieve improve health outcomes for people in those areas.

We want to see improved quality in primary care services across Haringey so that all services are providing the optimum levels of care for the community they serve. This means a quicker pace of improvement for some areas which are currently performing less well than others, who are already achieving high levels of clinical quality and outcomes.

This will be achieved by creating the Neighbourhood Health Centre hubs, which will develop as centres of excellence within Haringey that will enable the development and sharing of specialist skills within our primary and community services. This will happen in a number of ways including through:

- Greater opportunities, environment and infrastructure for peer and multidisciplinary team learning – including shared learning with social care and voluntary sector colleagues collocated at the hub. The opportunities provided by having the space to host learning events and the flexibility of clinical cover afforded in a larger centre to enable attendance by frontline workforce will transform the quality of professional development from current arrangements. Equally, drawing

expertise from hospitals, nurse consultants and practitioners with special interests into the larger centres to provide outpatient care will provide much greater opportunities for skills development in primary and community care.

- Greater standardisation and consistency of quality. In part this will arise from peers working with and learning from each other but the reduced number and complexity of the primary care service delivery model will also enable more focussed quality and performance management processes to be developed. It should also make the take up of improved ways of working and most clinically effective approaches faster and more consistently implemented and reviewed. For example it will be significantly easier to agree and implement care pathways in larger centres and the integrated GP practice spokes.
- Encouraging the next generation of doctors and other health professionals into Haringey, bringing the up to date skills and new ways of working into an environment that promotes peer and multidisciplinary learning.

4.1.3 Tackling health inequalities and improving health

The primary care strategy will not on its own improve health and deliver greater health equality but it will provide the core infrastructure through which we and our partners will be able to make a step change in how tackle these issues. We need to ensure that primary care services fulfil their potential to contribute fully to improving health and tackling health inequalities.

Primary care services will be better placed to **tackle health inequalities** working within the model we have set out above for a number of reasons:

- Wherever a Haringey patient is registered they will have available to them the same core range of services and standards of accessibility whether they are registered with a GP in a hub Neighbourhood Health Centre or at a GP spoke practice. In particular we will be able to address many of the issues identified in the Equalities Impact Assessment about the importance of the quality of the "front of house" services.
- Each Neighbourhood Health Centre hub and related GP practice and pharmacy spokes will form a network providing services tailored to meet the needs of the population in that area and geared up to target health inequalities. For example, language or culture specific services for long term conditions and health living advice might be focused in areas where this met population need most effectively.
- Instead of an historical, patchwork of primary and community services we will be developing a detailed blueprint of services in each locality, that have been drawn from and tested through consultation with local stakeholders and the public and informed by the new Joint Strategic Needs Assessment (in collaboration with Haringey Council). This will provide us with not only the desire to tackle health inequalities but also

an evidence based and carefully planned way forward to transform the way in which we address the health gap over the next 10 years.

- At present many of the "health improvement" services we commission and provide are not part of mainstream primary care service provision. Indeed, this was raised a number of times in our consultation, in particular in the context of health inequalities. The coherent and focused service delivery model set out in this strategy will provide the platform from which these and other interventions can be more effectively made available to everyone in Haringey.
- The opportunity for co-locating council, voluntary and community services will enable us to build truly integrated and effective healthy living services.

For further information about our strategic and joint plans around tackling health inequalities see Haringey Strategic Partnership Life Expectancy Action Plan, Infant Mortality Plan, and HTPCT Commissioning Investment Strategy 2008-11 (www.haringey.nhs.uk)

We will ensure that equalities and the learning from the Equalities Impact Assessment is at the very heart of our planning, implementation and monitoring of the new service model in particular by identifying a senior manager equalities lead as part of the core planning team and programme board (see section 5.1.1 below) and ensuring that we develop key equalities markers/indicators as the programme is rolled out. We will also use the information gathered in our patient experience survey (see 5.1.3 below) to further inform our planning and development in specific localities.

There is a growing body of evidence on how health promotion methods can significantly **improve health** status of populations over the medium to long term (Wanless Report 2004). Using this evidence we plan to invest over the next three years in a strategic programme of focused work to engage people proactively in the management and promotion of their own health and empowering communities in their efforts to do so. This programme will include social marketing targeting health messages at vulnerable and excluded groups, working to ensure services are delivered effectively for example through training local people as community wellbeing workers and tackling the worklessness agenda as well as ensuring equitable spread of health promotion services.

The development of Neighbourhood Health Centres as hubs for health and wellbeing provide a significant opportunity to place health promotion at the heart of the service delivered at the hub. We are currently looking at how we might transform the function of front of house services so that reception staff, for instance, can ensure people are signposted to appropriate information resources and other health promotion facilities (eg leisure, libraries). We are also looking at developing and expanding the centre manager role to include specific responsibilities around health promotion.

4.1.3 Improved premises

The quality, accessibility and design of all of our primary and community services premises will improve significantly as a result of implementing our primary care strategy. This does not just mean that we will develop "flag ship" Neighbourhood Health Centres but also that we will ensure that the spoke GP practices are all fit for purpose and fully accessible. This will involve making the best use of the fit for purpose estate we own as well as working with GP practices to relocate to new or improve current premises. The focus of the strategy is to ensure everyone living in Haringey is treated in clinically appropriate, accessible and health promoting environments that are fully accessible and compliant with disability discrimination legislation.

However, the primary care strategy is more than bricks and mortar. Each Neighbourhood Health Centre hub and GP spoke practice will work more effectively for people using and accessing services. This means that we will rethink/redesign reception and "front of house" services, appointment systems, how patient information is made available to health professionals, how, when and where to locate services and how service users, staff and the community more generally use the buildings to best effect.

4.1.4 Greater range of more integrated services available

The new model of provision is intended to provide a more holistic approach to people's health, recognising that as health is influenced by a wide range of determinants, so the services required to promote and improve health are wide-ranging. The new model will provide an opportunity for improved joint working across health and social care, and potential for co-location of health, social care and other related services provided by the voluntary and community sector.

4.1.5 Community resource and involvement

We are keen to see the Neighbourhood Health Centre/ hubs develop as a community resource, providing a focal point for health services in each locality and enabling the integration of a range of health-related activities to take place. It would, for example, include the use of Neighbourhood Health Centre space and potentially other resources by community and voluntary groups and bringing about a much closer relationship between health and community and voluntary groups engaged in the wider wellbeing agenda.

We have looked at the success of the Bromley-by-Bow Healthy Living Centre and hope to bring some of the innovative approaches and community engagement found in that centre to Haringey. The Neighbourhood Health Centre/ hubs are intended to be a community resource, an asset for the local community to use and to contribute to. We will need to find new ways of working with our local population to engage them fully in their health and their health services (see section 5.2.1 below on community engagement)

4.2 Measuring benefits

Given the level of funding, time, resource and public interest and engagement in this strategy it is vital that we are able to clearly and quickly demonstrate the benefits inherent in our primary care strategy.

We already have a robust performance management framework that tracks national and local targets as well and joint performance management with the Council to deliver and track delivery of local area agreement targets. Some of these targets map directly to some of our key benefits in implementing the primary care strategy (for example GP access targets and mortality rate targets).

In developing the strategy we wanted to keep at the forefront of our thinking what any changes would mean in real terms for people who use health services in Haringey. We have developed the following outcome statements[2] (see table below) that aim to capture the essence of what we are trying to achieve from a patient perspective. These statements should apply to all Haringey residents and those using Haringey primary care services.

We plan to use these outcome statements as the basis for developing a set of key performance indicators against which we will measure and monitor the implementation of the primary care strategy. We will need to develop these indicators for each locality based on the needs and priorities of local people and we will need to be accountable to local people in each locality for the performance of each locality network against the identified standards. We are particularly keen to ensure that these indicators reflect the concerns around access highlighted in the Equalities Impact Assessment.

So that we can measure improvements in services we need to identify baseline information. We are planning to undertake a detailed patient experience survey that will provide us with the baseline against which we will be able to demonstrate the improvements to services we want to make. The patient experience survey will be undertaken in summer 2008 (see section 5.1.2 below for further details)

[2] A number of these statements are drawn from the Department of Health consultation document on the future of urgent care services.

Patient outcome statements	
1	*I can register with a local GP practice of my choice – **whoever I am and wherever I live in Haringey***
2	*The care I receive meets **my needs and that of my family**.*
3	*I can rely on getting the right care **whenever** I need it and **whoever** I am.*
4	*I can easily access advice, support and screening to **keep me well***
5	***My opinions** are clearly heard and taken into account.*
6	*I know what to do when I or my family need **urgent care***
7	*In an emergency I can get care **quickly and simply.***
8	*Providing the **best care** is important to everyone who cares for me.*
9	*I can access (planned) care **at a time that suits me**.*
10	*In most **non-urgent** situations I can see a clinician who is familiar with my health history, situation and circumstances.*
11	*If I have a more complex or long-term health need, my care will be **agreed and co-ordinated** with my clinicians. Care will be provided in a way that is as convenient for me as possible.*
12	*I can book a **longer appointment** with my doctor or primary care clinician if I need it.*
13	*I have a relationship of **mutual respect** with my clinicians and care givers. I feel comfortable and receive respect for my cultural identity and my clinicians and care givers are aware of how my gender and age might affect how I access health care.*
14	*I am able to have **diagnostic and specialist treatment** (for some conditions) in primary care rather than having to visit hospital*
15	*In consultations with my clinicians and care givers I am **listened to and my concerns are respected,** whatever my age or background.*
16	*The services I use try to make it **easy for me to access** them*

4.3 Limits of strategy – links with other strategic developments

This strategy will not on its own deliver the sustained improvement in health and wellbeing that we want to see in Haringey. It needs to be seen within the context of the range of strategic activity underway in Haringey, including joint work with Haringey Council on life expectancy, wellbeing, and through Children's Networks, and other developments in services for adults and older people, mental health and other vulnerable groups focusing on early intervention and prevention as well as our investment planning over the next 3 years to support and extend these developments. What this strategy does is set out the improvements and investment in primary care that need to be made so to enable these strategic developments to play a full role in tackling health inequalities and in meeting the needs of all Haringey's residents.

4.4 Understanding the trade offs

In our original strategy document we were explicit that the Neighbourhood Health Centre model would involve a "trade off" between having further to travel to get to primary care services for some people and a wider range of better quality services in better premises and at more convenient times.

The consultation process provided no clear consensus as to the perceived benefit of this trade off. Although many concerns were expressed about the increased travel, others could see the benefits of the proposed model.

We feel strongly that the benefits of our proposed model will be worth the longer journey that some people will need to make. This is in part because we predict that fewer journeys will be needed due to the provision of more integrated services in a one-stop shop approach and that journeys currently made to hospital-based services will no longer be needed as many of these services are brought into primary care. In addition, the hub and spoke model we propose above allows for a good geographical spread of premises, closely mirroring current "clusters" of GP practices in many instances and providing additional points of access in areas currently under served (for example Northumberland Park) that should mean no one will have too far to travel to get to their nearest service. We also believe that the comprehensive community nursing services that we are looking to commission (including outreach, work with very high intensity users and case management for complex care), the delivery of a range of services in novel settings designed to maximise take-up/effectiveness (for example mental health work in local libraries, services for children and young people delivered from extended schools and children's centres) and the range of enhanced services being developed in local pharmacies will provide both the reach into communities (particularly for the most vulnerable) and an additional level of local access that will significantly enhance and complement the hub and spoke model described in this document.

We know that we have much work to do to ensure that the impact of this trade-off is managed and reduced as far as possible, particularly for older

people and other disadvantaged and excluded groups. This work will include "testing out" the location of the hubs and spokes through the patient experience survey and through the transport analysis we are commissioning (see sections 5.1 and 5.2.1 below), refining the locations as informed by this work and then working with Transport for London (TfL), Haringey Council and others to ensure that the transport options and routes to primary and community services are maximised.

Chapter 5: How will we make the strategy a reality?

In this chapter we will look at the range of activities and planning that we need to put in place to implement the primary care strategy.

5.1 Implementation planning

5.1.1 Programme management

We will be adopting a programme management approach to ensure that we maintain our focus clearly on delivering the benefits of this strategy for people in Haringey. Programme management provides a detailed framework through which to coordinate, direct and oversee the full range of interrelated work streams that will be involved in transforming primary care. It will also involve the development of a programme blueprint identifying in detail how services will look in the future covering in particular working practices, processes, organisational structure and technology and information needed to support implementation. The programme will be monitored by a high level programme board including membership from Haringey Council.

5.1.2 Development of neighbourhood plans

Building on the response we had to the consultation on the primary care strategy, we plan to undertake a detailed patient experience survey in each of the Neighbourhood Health Centre localities (e.g. West, Central, South East and North East) to report to our Board November 2008, which will include face to face interviews with a representative cross section of the local population looking at where we are now and what people want from their local primary care services. It will plan to pick up specific access and transport issues and help us to set meaningful performance indicators that we can measure against the patient experience survey baseline. Clearly this will need to link in, in the West, with ongoing community involvement in the design and development of Hornsey Central.

We also plan to undertake detailed engagement with general practice (and other independent contractors) over the summer to discuss with them the wide ranging issues relating to the implementation of the primary care strategy. This will be over and above the ongoing discussions we are already having at a collaborative and individual practice level.

The Practice Based Collaboratives in each of the four localities will take the lead in the development and design of the service model in eacjh of the respective areas. The aim is for these plans to be developed with the focus on clinical leadership and stakeholder engagement.

We will use information from both to develop, together with information from our transport modelling and analysis (see 5.2.2 below), four detailed neighbourhood plans during the autumn which will be presented to our Board in January 2009. These will form a key part of our programme blue print.

5.1.3 Formal consultation on neighbourhood plans

The aim is for there to be a period of formal consultation in Spring/Summer 2009 on the neighbourhood plans, led by general practices, which services and the changes envisaged to these services stand at the heart of the transformation of out of hospital care. Again the focus will be on a bottom up approach.

The consultation timing will to a certain extent need to be informed by Strategic Health Authority assurance processes. We will be working closely with the Council and Overview and Scrutiny Committee in ensuring that this consultation process is as inclusive as possible.

In the mean time we are still responsible for ensuring that we commission high quality, integrated and accessible services for people in Haringey. We will continue to develop the range of community and primary care based services in the light of the clear mandate from the consultation in terms of improving access to services such as phlebotomy and non-medical foot health and extending the range of services and opening hours in our emerging Neighbourhood Health Centre hubs such as the Laurels and Lordship Lane.

5.2 Enabling strategies

5.2.1 Community engagement

Our consultation has shown us that we still have much to do to engage local people in our vision for better primary and community services. We need to ensure that the views, ideas and preferences of local people are an integral guiding force in the way that we develop facilities to become health and wellbeing resources at the heart of local communities.

Building community engagement is more than putting on a series of public events and sending out newsletters (although these have their place). It is about investing in a community engagement infrastructure that is able to stimulate interest, garner involvement and develop lasting working relationships between the PCT and local people and the communities they belong to in the development of better health services and better health and wellbeing.

In our 2008/9 commissioning investment we are considering proposals to develop a strategic and evidence based community development infrastructure, learning from successful models elsewhere (in particular the Bromley by Bow Healthy Living Centre model). The infrastructure being considered includes the investing in community development workers aligned to each Neighbourhood Health Centre locality, developing the role of centre manager and front of house staff and developing the governance structures to ensure that stakeholder and community engagement has a clear voice in decision-making processes.

5.2.2 Transport

One of the key concerns raised by people during the consultation was that the journey to see a GP for some people would either take longer or be more difficult as the number of sites from which GP services are delivered reduce from to about 20 (including hubs and GP spokes).

We have given very careful consideration to this issue in identifying the location of the Neighbourhood Health Centre hubs and in particular the proposed location of general practice spokes. We have looked at main transport routes and natural/other barriers as well as population density. Additionally we have considered the issue of deprivation and population growth that are currently poorly provided for. We have also looked at cross-borough patient flows, how and why practices are currently clustered in certain areas and what that tells us about current patient flows and how access should be improved.

We have referred to the high level modelling conducted in the *Healthcare for London: Framework for Action* document. Based on average population densities at borough level this indicated that a vast majority of Londoners would be within 1 or 2 kilometres of a "polyclinic" serving a population of 50,000. In our model we are looking at 5 Neighbourhood Health Centres (3 large and two smaller centres) providing GP services to 125,000 people in total, together with additional GP practice spokes located in 12-15 other locations.

However, we recognise that we need to do much more detailed modelling and testing out of the model we want to implement. As such we have commissioned a detailed transport modelling and analysis from one of the leading transport and accessibility agencies in the country.

We have asked them to:

- Determine what transport is currently available to Haringey residents when travelling to primary care and other health services
- Determine what may be a reasonable distance for residents to travel to different primary care and other health services
- Carry out accessibility mapping to determine how far people are able to travel within the distances defined by the various modes of transport available in order to access the Neighbourhood Health Centre hubs and proposed GP practice spokes
- Determine improvements that could be made to enhance access to primary care services (whether in terms of identifying better hub or spoke locations -insofar as these are not already "givens" – or in terms of joint or other work to develop transport in the community with Transport for London and other local organisations).

This work will be supported by the travel time analysis modelling that will be made available by NHS London and Transport for London (TfL) to provide

information on travel times using different modes of transport to health services, and the impact of changing the location of services on travel times.

But we also want to go beyond this analysis and obtain a greater insight into why people decide to go to one GP rather than another and how we can accommodate and cater for those preferences in the model we are looking to implement. For example we know from a detailed analysis of practice registration lists that patients will travel further to see a GP of their choice rather than the most local GP. The reasons why are likely to be bound up in a whole range of issues around language, culture and the sense that the GP "understands" the patient. We are particularly interested in unpicking these issues because we believe they are closely related not only to how far people travel but also the sort of patient outcomes that are possible where the health professional and patient share a common understanding of the issues of importance to a patient. For example, compliance with medication may be significantly improved where the GP understands the family background and cultural context against which the patient will be taking the medication.

These issues will be explored further in the detailed patient experience survey planned for summer 2008 as described above.

The outcome of both of these processes will inform a community transport strategy to be developed with Haringey Council and TfL. We will particularly focus on improving transport routes/methods to our known sites, e.g. Hornsey Central, Lordship Lane, Laurels and Tynemouth Road.

5.2.3 Workforce

In order to deliver the service model set out in this strategy we need to ensure that we have the right workforce in place. There are a range of issues that need to be considered in order to develop a workforce strategy that will underpin the proposed changes in primary care.

NHS London is developing a workforce strategy to support the recommendations in *Healthcare for London,* this is expected to be available in September 2008 and will inform developments at a more local level. We know that out of our existing primary care workforce, more than one third of our GPs are aged 55 or over so clearly we need to think about succession planning. As well as ensuring we plan for the right numbers of workforce in the future we will also need to think about new roles, new ways of working and new skills that will be needed. Key issues for workforce development include:

- Changing workload and case mix for primary care practitioners
- Supporting clinical leadership development
- Multi-disciplinary education for the primary care teams
- Significant recruitment of Practice Nurses
- Enhancement to the role of Practice Manager.

It will be through the development and skill of the workforce that we will be able to deliver our outcome statements set out above. We will need to ensure that the services provided meet the needs of our diverse population and are culturally sensitive. Haringey TPCT will continue to develop its capability to ensure that it is an organisation fit for its purpose. Equally we must ensure that in developing our workforce we make fundamental changes in the way in which we respond as services and as individuals to vulnerable and disadvantaged people. This was a key concern highlighted in the Equalities Impact Assessment.

We must also ensure that we retain and build upon what is already world class in our workforce. We must not forget the unique role that GPs play in treating the whole person and their family, in caring for people in a holistic way and ensuring continuity of care across a wide range of interventions and services. Implementing the primary care strategy is intended to support and amplify this significant role placing GPs in a much better position to offer holistic, integrated care closer to home supported by a full range of wellbeing and social care services.

5.2.4 Organisational Development

We are well aware that simply re-housing our local health workforce in better accommodation will not create the sort of integrated multi-disciplinary care and wellbeing network we want to see in Haringey.

This must be underpinned by an intensive and co-ordinated organisational development plan that is able to exploit fully the opportunities for transforming how we work together around the needs of our population and to create a learning organisation.

This will need to encompass:

- Developing people into new roles and as members of new and different teams including teams with other agencies
- Working as teams across new boundaries and as joined up care networks across a locality
- Improving the range and flexibility of responses and systems to ensure that vulnerable and disadvantaged people are able to access services in the fullest sense.
- Stakeholder engagement.

5.2.5 Commissioning

The TPCT believes that to secure the best possible services for patients from available resources we need to support the development of a good range of strong, effective and responsive health provider organisations locally. In addition to working with existing providers to ensure that they are able to deliver demonstrably clinically effective, high quality, value for money services the TPCT is also keen to support a range of new service providers, particularly in areas where it is assessed that current providers do not have a particular

interest or expertise or where current service provision is assessed as poor quality or value for money.

Additionally there is much greater potential for the TPCT to work with community and voluntary organisations to support delivery of improved health for local residents and our commissioning strategy should actively consider how we can build stronger relationships and a stronger 'third sector' in partnership with the local authority and building on existing commitments made in the Haringey Compact.

The TPCT believes that 'contestability' (competitive tendering of services against an agreed specification) is an important vehicle for securing best value and expect it to play an increasing part in how we seek to maximise health benefits from our commissioning spending future. We do recognise that there are potential pitfalls in this approach and we will seek to develop mechanisms to ensure that local providers are not disadvantaged in any competitive tendering processes.

What we commission in general but particularly in the context of developing primary and community services must be directly influenced by local people and local clinicians. Practice Based Commissioning (PBC) provides the main tool to ensure local GPs have a direct say in what services are commissioned for their patients and for patients in their locality through the 4 Practice Based Commissioning Collaboratives. Haringey TPCT GP practices are aligned into four PBC Collaboratives. Each collaborative is lead by a Clinical Director (local GP) and covers a population between 55,000 to 85,000 patients and is broadly associated along geographical and main provider lines.

Practice Based Commissioning Collaboratives are currently having active discussions, for example, about developing new forms of GP practice led provider organisations based around consortiums of local practices/clinicians. GPs will increasingly expect to be given the opportunity to provide a wider range of services than are currently included within the core GP contract framework. This would build on existing 'local enhanced services' models and would need to be carefully managed but is an approach that the TPCT welcomes in principle.

5.2.6 Information Technology (IT)

Communication and managing information will be vital to the success of our vision. We will develop an Information Management and Technology Plan that will set out how this will be achieved in more detail but the headline work that we have undertaken and planned to date to enable the model we set out above is as follows:

Hornsey Central: Haringey IT are working closely with Connecting for Health (CfH) and the London Program for IT (LPfIT) in order to develop a solution that will provide integration between the GP Systems, RiO

Community System (see below), local clinical systems and Pharmacy Systems to be deployed at the site.

This is a high profile project focused primarily on the patient experience and all aspects of the patient journey. This project will provide the blueprint for local health centre IT and potentially throughout the country.

RiO: Work has begun on implementing the Care Records System, RiO in community services. This is one of the largest IT projects undertaken by the TPCT and will transform the way in which we provide healthcare services in Haringey. Workshops with individual services will begin in May 2008 and will look at how RiO can be used to best effect and support new ways of working.

Desktop Upgrade: Current operating systems are outdated. The HIS have developed a new desktop environment called Fusion, which uses much newer technologies facilitating remote working, enhanced security and greater resilience. HTPCT will be exploring the migration to this new environment with the Haringey Information Service in order to facilitate the introduction of RiO.

Map of Medicine: The Map of Medicine (MoM) is a web based tool supporting evidenced based medicine. First developed at the Royal Free Hospital in 1999, it is now managed by Informa Healthcare, and under national procurement by Connecting for Health, has been licensed for use by the NHS. This means that it is free to all organisations and users of the NHS.

The path provides 393 pathways across 27 specialities all supported by up to date clinical evidence including the Cochrane Collaboration and NICE guidance and all updated on an annual basis. All pathways can be viewed on a national as well as international basis.

Haringey TPCT has adopted the Map of Medicine as a key tool for developing clinical pathways and best practice and will have its own section on the map. The first local pathways being developed cover gynaecology.

Other IT Projects: Sexual Health, Contraception and Reproductive Services are implementing an integrated Electronic Patient Record (EPR) to be utilised across the service in Haringey including all satellite services. This will enable the service to access patient records from any site enabling seamless care for patients. It is also a key service development in its work towards developing a managed service network for sexual health across Haringey. Currently the Palliative Care Team is dependent upon manual systems and is implementing the nationally recognised PALL CARE system. Amongst the many benefits is the opportunity to link with other service providers who are also using Pall Care and provide out of hours cover (The North London Hospice and Enfield community team, for example, are already using this system).

5.2.7 Finances

Detailed financial modelling will be undertaken to facilitate the development of the service model above. Essentially the TPCT is expecting to invest significantly in primary care services and community based "out of hospital" services over the next three years as part of its overall commissioning investment strategy. This will include significant investment in the infrastructure required to support delivery of the strategy.

5.3 Next Steps

Consultation and key next steps		
Next step	**What for?**	**By when?**
Patient experience survey	Baseline current levels of satisfaction with primary care and gauging views on the changes proposed within the strategy.	**November 2008**
Transport modelling and analysis	Baseline survey of current transport and travel times, expert advice on maximising accessibility within proposed new model.	**November 2008**
Board review	Review Primary Care Strategy in light of patient experience and transport work.	**November 2008**
Development of local plans including community engagement in development	Detailed modelling of "hub and spoke" model and drawing up of specific plans for each neighbourhood led by GP collaboratives. Ongoing development of enabling strategies	**Autumn / Winter 2008/2009**
Formal consultation	Formal consultation on detailed neighbourhood plans.	**Spring 2009**
Board review and final sign off	Board consideration of detailed strategy and plans in light of consultation responses	**Summer 2009**

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Grant Thornton

Introduction

The purpose of this document is to provide a brief summary of our findings in respect of the work that has recently been undertaken on Health Inequalities (HI) in Haringey. We have recently presented our main findings to key staff at both the Council and the PCT. This update provides commentary on the Audit Commission's 6 Key lines of Enquiry (KLOES) for this project that we have evaluated, and includes detail on strengths in these areas, in addition to an outline of potential areas that could be developed further. At the Well Being Partnership Board meeting we will present our main recommendations and action plan resulting from the review, in addition we will provide a more comprehensive report on our findings.

Referred to within this document are the results of a 'SNAP' survey - this survey was sent to officers and staff of both the Borough and the PCT and additionally members of the voluntary sector. We received 18 responses to the survey and hence the results cannot be taken as being statistically significant, however we have included some reference to these results to generate discussion.

Overall we have found that, compared to other reviews we have carried out in the South East of England, that Haringey is advanced in its health inequalities agenda and it is important that this momentum is continued and further enhanced.

KLOE 1 Delivering Strategic and operational objectives

1. Review of the various agencies' strategies demonstrates that there are good structural links in place across the partnership to promote health and wellbeing. Each strategy document has its own focus but it is clear to see how the various documents relate to each other with the clearly stated aims of improving well being and reducing HI.

2. A key challenge for the partners going forward will be to look at developing further the Joint Strategic Needs Assessment (JSNA). The development of the JSNA at Haringey is potentially more challenging than other areas given the inherent high mobility of the population in this early part of the 21st century, especially since the admission of the accession states to the EU.

3. Leadership of the HI agenda appears to be sound - there are clear structures in place and a Joint Director of Public Health has recently been appointed which is a key role in leading and driving forward the HI agenda. Public health teams at the PCT and the Council have been instrumental in setting health priorities that have informed strategy development at an organisational and partnership level.

4. A well being scorecard has been developed incorporating targets that are monitored at the Well Being Partnership Board. We see this as a crucial initiative in helping to monitor outcomes and challenge performance.

5. Nearly 90% of staff respondents to our survey agreed that their organisation's financial plans identified resources for achieving the health inequalities plan - clearly very positive. However, when respondents were asked to indicate the extent to which they understood whether a cost benefit analysis of the options for action to reduce HI had been undertaken in the past 2 years, over half said "No". It would appear therefore from the survey and also from feedback in meetings with staff that there is an opportunity to promote a wider understanding of and focus on the cost -benefits of specific courses of action.

KLOE 2 Delivering in Partnership

1. There are examples of strong joint work on specific areas and issues. There is the joint appointment of the Director of Public Health, which is a funded via a 50/50 split between the Council and the PCT. There is a clear agreement that there is a shared process with partners for identifying local health inequalities, and Haringey has been recognised within the community for their partnership working.

2. The LAA has recently been updated with significant commitment to 35 challenging targets, some of which focus on health and wellbeing. Once these have been finally agreed it will be important to update the well being scorecard and monitor these targets. The is strong flavour of health and well being within the 35 targets.

3. The Well Being Partnership Board is a key Partnership body in Haringey, and has a busy and full agenda. It's terms of reference state that it is a strategic level body and therefore it is important it continues to have a strategic focus, and operational issues are brought there only if they relate to the Well Being Framework.

4. We took the view that although there has been engagement with provider trusts for the Health Inequalities agenda their presence and focus did not yet reflect their crucial role in taking HI forward. In particular their presence at the front line where HI are presented by a mobile population is a vital source of information as the provider trusts have access to more vulnerable people who habitually visit A&E rather than attend a GP practice.

5. There is a strong relationship with the voluntary sector, in particular with HAVCO, which has provided access to information to feed into the health inequalities agenda. There was agreement however that there is an opportunity to become more involved with research institutions and to potentially identify a university with an interest in HI to join the partnership board.

6. There is evidence that the public have been engaged in developing health strategies, there is also further engagement expected from the Public Health team leading up to the production of the JSNA. However, it was not clear that there were effective mechanisms for members of the community to get involved in developing action on HI - this was supported by our survey results.

KLOE 3 Using information and intelligence to drive decisions

1. The last public health report was in 2006, however the Director of Public Health, since appointment in January 2008, has been working on the JSNA which will in effect become the next public health report. The report will develop in a more interactive fashion than the current public health report, which is a more traditional public sector organisation driven model. It is clear that there will need to be the appropriate IT platform in place to support the functionality that is envisaged for the JSNA.

2. The lack of capacity has been flagged with the Public Health team in terms of analyst skills, as a high degree of effort is required for extraction and interpretation of data and then applying them to Commissioning. There are currently three vacant consultant posts, which once filled will address the current challenges.

3. There has been an Equalities Impact Assessment has been undertaken in relation to the Primary Care Strategy used to assess access to Primary Care by all groups within the Community. The Public Health team are being quite clear in their approach to the JSNA as to what they do and don't know about their community, they will then devise plans to address those gaps.

4. Consistent with the partnership theme, there is evidence that there has been engagement with the wider community with health strategies however input from provider trusts, research institutions could be engaged further to provide data. The community buy-in is essential to gain momentum with the HI agenda.

KLOE 4 Securing engagement from the workforce

1. The Community Strategy is in place and all partners are signed up to the Well Being Strategic Framework. The Director of Public Health role is already beginning to enhance further the positive

working relationships that exist between the Council and the PCT.

2. There is clearly specialist public health skill and capacity that is available to the partners, although the survey undertaken indicated that nearly 75% of recipients had not had joint training with partners on HI. There is potentially an opportunity to enhance joint training in HI at both Non Executive Director and Member level as well as further down the organisation.

KLOE 5 Performance Management

1. The Well Being Scorecard has been developed which has been viewed as a realistic measurement tool. When we attended the Well Being Partnership Board the Scorecard was included with a very full agenda and covered only briefly. We suggest that consideration is given to how the agenda might give greater opportunity to discuss challenges in the outturns relating to the Well Being Strategic Framework. It may be that this is done via a regular report from the Well Being Chair Executive that highlights challenging areas. It may also be assisted by agenda items being clearly labelled with the relevant Well Being Strategic Framework outcomes.

2. The Well Being Scorecard will need to be refreshed after final agreement to the new LAA targets.

3. Our work indicates, and survey results support, that there is not enough information available to show how HI has narrowed in the past two years. We accept that this is particularly challenging in HI as it is difficult to link the impact as a result of the action, however we take the view that more needs to be done to pursue and share trend information over a longer period which would provide empirical evidence.

4. The role of the JSNA is crucial in taking the HI agenda forward, once complete there may be more opportunities to ensure greater recognition of specific HI targets/performance within the wider commissioning strategies, community partnerships etc.

KLOE 6 Corporate Responsibility

1. There have been several examples identified of good practice in relation to wellbeing programmes run for staff at partner organisations. Examples include staff concessions at leisure centres, tips on staying stress free, and programmes at both the Council and the PCT focussing on cycling and walking to work. There is also a scheme in place at the Council known as the Haringey guarantee which is a scheme for tackling worklessness through working with employers and local communities to provide work and skills for local people.

2. Although the programmes identified above are all positive, we have not found evidence of formal corporate responsibility policies in place at partner organisations. If policies were developed, this could assist in promoting corporate responsibility principles more widely and also minimising potential risk (financial and reputational) to organisations from not having clear policies and guidelines in place.

3. [Financial implications of corporate responsibility - we have requested additional information in this area to further our understanding and are awaiting receipt of this.]

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haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Core Strategy: Draft Issues and Options**

Report of: **Sule Nisancioglu, Head of Planning Policy and Design**

Summary

A report on Core Strategy Issues and Options paper was presented to the Haringey Strategic Partnership Board in February 2008. Members of the Well-Being Partnership Board are invited to comment on health, well-being and related issues set out in the Core Strategy draft Issues and Options paper, particularly the key issues which are likely to have future spatial implications for Haringey.

Key areas to focus on are:

- Update on evidence base
- Role of partners in delivering spatial objectives
- Opportunities for joint actions

Recommendations

i. To note the progress on the Core Strategy Issues and Options paper.

ii. To review the Evidence Base presented in the Core Strategy Issue and Options paper and make recommendations for updates where relevant.

iii. To identify key areas of input from members of the Board in delivering Core Strategy spatial objectives and opportunities for joint actions.

For more information contact:
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1. Introduction

The Council adopted its Unitary Development Plan (UDP) in July 2006. The Planning and Compulsory Purchase Act 2004 requires the Council to replace its UDP with a new Local Development Framework (LDF). The Council must prepare a Core Strategy to replace the strategic policies and objectives of the Unitary Development Plan.

The Core Strategy, when adopted, will be the main development plan document for Haringey. It will set out a spatial (geographic) vision and objectives for the Borough up to 2020 and will contain key policies and implementation and investment framework to deliver the vision.

There is no single definition of spatial planning, but it can be defined by six principles:

- Vision - how an area will develop and change
- Goes beyond land use planning
- Strengthened community involvement
- Helps to deliver other strategies and programmes
- Flexible - responds to the need for change
- Focused on implementation and planned investment

The Core Strategy should identify sufficient land for new development to meet local and strategic needs as well as taking account of community and other stakeholder aspirations in terms of the location of development. It will set out the broad locations for delivering housing and other strategic development needs such as employment, retail, leisure, community, essential public services and transport infrastructure. It will also address the links between planning and climate change.

A Core Strategy cannot be developed in isolation. It must be consistent with national planning policy and in general conformity with the London Plan and include the priorities from Haringey's Sustainable Community Strategy. In turn, all development plan documents and supplementary planning documents should be in conformity with the Core Strategy.

2. Developing Haringey's Core Strategy

The first stage of developing Haringey's Core Strategy is the Issues and Options paper which was open to public consultation during February and March 2008. This contained key issues and possible solutions and options for challenges Haringey faces. Key spatial objectives are attached in Appendix1. Views were sought from the statutory bodies such as Environment Agency and English Nature, Government office for London and Greater London Authority, strategic partners, neighbouring boroughs and local community groups on the following:

- The Core Strategy spatial objectives;
- The options to tackle the issues facing the borough; and
- Any objectives, issues and options that we may have missed.

We are currently analysing the responses and will use the feedback we receive as part of this consultation to prepare our "preferred options", with a proposed strategy and how to achieve it. We will then consult you on the preferred options later in 2008 before the document is submitted to the government for independent examination. There will be another set of consultation during the submission stage.

3. Role of Partners in Producing a 'Sound' Core Strategy

Final version of the Core Strategy will be subject to an independent examination by a planning inspector. One of the key tests is the strength of the evidence base. The Strategy should have clear, up-to-date evidence base for its preferred options. A number of supporting documents are being undertaken as part of the process, including a sustainability appraisal, strategic flood risk assessment, a habitats assessment and an equalities impact assessment. Evidence base includes information from research and studies and the emerging Borough Profile. The Council is not starting from a 'blank sheet' - issues and priorities have so far been identified from the following:

- National planning policy and advice
- The London Plan and Mayor of London's strategies
- Haringey's Sustainable Community Strategy
- The Council's key plans and strategies, including the Unitary Development Plan and emerging strategies such as the draft Regeneration Strategy and Greenest Borough Strategy
- Other external plans and strategies, such as the Primary Care Strategy
- Sustainability objectives and key issues and opportunities identified in the Core Strategy Sustainability Appraisal Scoping Report

A Core Strategy should be based upon an appropriate level of community involvement. Strengthening community and stakeholder involvement in planning is a key principle underlying the new planning system. The process is focused on community engagement at an early stage when developing issues and options.

Test of soundness will also assess the level of corporate working and "joined-up" approach to developing the Strategy. Another test is the level of partnership working where relevant including Haringey Strategic Partnership and neighbouring Boroughs.

The Core Strategy will contain an infrastructure implementation and investment plan which will refer not only to private sector and Council investment and initiatives, but also to planned investment from other service providers. This investment plan should link with the implementation of the Community Strategy and LAA outcomes.

APPENDIX 1: Strategic Framework for Issues and Options Paper

The issues and options report identifies future challenges which are cross-cutting themes for the Core Strategy. The key challenges are:

- Climate change
- Demographic change
- Use of resources
- Health and well-being
- High quality design
- Equality and inclusion
- Economic change
- Technological change
- Transport
- Crime and safety
- Sub-regional issues

It then develops strategic priorities from the Haringey's Sustainable Community Strategy and the Council's key plans and strategies.

Vision and Spatial Objectives

The Core Strategy issue and options report proposes a vision and objectives for the future development of the borough. It is proposed that the Council use the vision from the Sustainable Community Strategy as the overarching vision for the Core Strategy, which is to:

"A place for diverse communities that people are proud to belong to"

The spatial objectives take forward the strategic priorities identified above and set out the basis for the Core Strategy and its key policies. These objectives also link with the sustainability appraisal objectives. The proposed spatial objectives are as follows:

An environmentally sustainable future

- To limit climate change by reducing CO2 emissions
- To adapt to climate change by improving the sustainability of buildings against flood risk, water stress and overheating.
- To manage air quality within the borough by travel planning and promotion of walking and cycling.
- To protect and enhance the quality of water features and resources.
- To reduce and manage flood risk.
- To increase energy efficiency and increase the use of renewable energy sources.
- To ensure the sustainable use of natural resources – by reducing, reusing and recycling waste and supporting the use of sustainable materials and construction methods.
- To manage air and noise pollution and land contamination
- To promote the use of more sustainable modes of transport.

Managing development and areas of change

- To manage growth in Haringey so that it meets our needs for homes, jobs and services, is supported by necessary infrastructure and maximises the benefits for the local area and community and the borough as a whole.
- To provide homes to meet housing needs, in terms of affordability, quality and diversity and to help create mixed communities.
- To promote the efficient and effective use of land whilst minimising environmental impacts.
- To strengthen the role of town centres as accessible locations for retail, office, leisure and community uses and new homes.

A safer, attractive and valued urban environment

- To promote high quality buildings and public realm to improve townscape character
- To promote safe and secure buildings and spaces.
- To promote a network of quality, accessible open spaces as areas for recreation, visual interest and biodiversity.
- To protect and enhance the Borough's buildings and areas of architectural and historic interest.

Economic vitality and prosperity shared by all

- To reduce Worklessness by increasing skills, raising educational attainment and improving childcare and nursery provision.
- To enhance the environmental quality and attractiveness of the borough's town centres in response to changing economic and retail demands.
- To link deprived areas with the employment benefits arising from the development of major sites and key locations in the borough and to improve access to new employment opportunities outside of the borough.
- To meet the needs of different sectors of the economy, including SMEs and those organisations within the voluntary sector through the provision of a range of premises of different types, sizes and costs.
- To support the development of Haringey's most successful growth sectors.

Improving health and community well-being

- To improve the health and wellbeing of Haringey's residents by reducing inequalities in access to health services and promoting healthy lifestyles.
- To improve the provision of, and access to, education and training facilities
- To improve access to local services and facilities for all groups
- To ensure that community, cultural and leisure facilities are provided to meet local needs.

A full copy of the document is available on the Council's website:

http://harinet.haringey.gov.uk/index/housing_and_planning/planning-mainpage/policy_and_projects/local_development_framework/corestrategy.htm

haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Local Area Agreement Update**

Report of: **Helena Pugh, Head of Policy and Strategy, Commissioning and Strategy Division**

Summary

To provide an update on the progress of the development of Haringey's LAA.

Recommendations

That the Board note contents of this report.

For more information contact:
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Adult, Culture and Community Services
Helena.Pugh@haringey.gov.uk

1. Background

The thirty-five Indicators to be included in Haringey's Local Area Agreement (LAA) have been negotiated with the Government Office for London (GOL) and central government departments. Work was undertaken to provide supporting evidence and data to inform LAA 'Story of Place'.

2. LAA Update

i. Twenty-four of the thirty-five LAA indicators have been signed of by GOL including the majority of the well-being indicators (Appendix A).

ii. Only one of the eight Well-Being Partnership Board Indicators is not yet agreed and is to be advised.

NI 39 ‘Rate of hospital admissions per 100,000 for alcohol related harm’ - this target is still being negotiated with the Department of Health, however trajectory data look in line with targets agreed previously for Hackney and Enfield.

iii. NI 149 ’Adults in contact with secondary mental health services in employment’ -this has been deferred by Central Departments until 2009 and will not be negotiated at this point.

iv. NI 126 ‘Early access for women to maternity services’ -this indicator is a Well-being Partnership Board cross-cutting indicator that the Children and Young People are leading on. The improvement offer on this target has been accepted and GOL are awaiting a baseline figure so a target can be agreed. GOL do not expect any problems with agreeing this indicator.

v. Good progress has been made on the LAA ‘Story of Place’. The supporting information and data is complete; further work was undertaken to draft a narrative providing local context for the data.

3. Next steps

i. Theme leads to promptly address concerns raised by GOL regarding the indicators not yet agreed - see above for comments re: those under the WBPB.

ii. The final LAA was agreed and will be submitted to GOL on 30th May.

iii. We are in the process of completing an action plan for each LAA target which will be available shortly.

Appendix A

WBPB LAA Indicator Set May 2008[1]

[1] N. B. We may also have to input into some of the cross cutting indicators – details to be decided.

APPPENDIX A WBPB LAA Indicator Set May 2008
Haringey Strategic Partnership's Local Area Agreement 2008/09 - 2010/11
National Outcome: Adult Health and Wellbeing

NI:	National Indicator	Sustainable Community Strategy Priority	Baseline	2008/09 Target	2009/10 Target	2010/11 Target	Strategic Lead Officers
8	Adult participation in sport (2007 – 2010 stretch target)	Healthier people with a better quality of life	22.9% (06/07 Active People Survey)	22.90%	26.90%	27.9% (provisional)	Council - Mun Thong Phung (Sport England reports)
39	Alcohol-harm related hospital admission rates	Safer for all Healthier people with a better quality of life.	Not available in the operating plan, work underway				TPCT - Tracey Baldwin (DAAT)
121	Mortality rate from all circulatory diseases at ages under 75	Healthier people with a better quality of life	TBC	94	93	92	TPCT - Tracey Baldwin/ Vicky Hobart
123	Stopping Smoking	Healthier people and a better quality of life	06/07 1872 4-week quitters (not per 100,00)	1008 per 100,000	1008	1008	TPCT - Tracey Baldwin/ Vicky Hobart
125	Achieving independence for older people through rehabilitation /intermediate care	Healthier people and a better quality of life	78%	79%	80%	81%	Council - Mun Thong Phung/ Lisa Redfern, Tom Brown
135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Healthier people with a better quality of life	PAF C62 - 14.22% - Dealyed until 09/10	14.22%	19.20%	25.00%	Council - Mun Thong Phung/ Lisa Redfern, (Jan Bryant, Bernard Lannigan, Gary Jefferson, Tom Brown,Paul Knight
141	Number of vulnerable people achieving independent living	Healthier people with a better quality of life	06/07 80%.	75%	77%	79%	Council - Mun Thong Phung
149	Adults in secondary mental health services in settled accommodation	Healthier people with a better quality of life	SP KPI 1 – 06/07 – 98.24%, 2007/08 – 98.30% AO/C31 – 06/07 – 2.8 (436), 2007/08 – 4.16 (639)	1% (increase)	1% (increase)	1% (increase)	Council - Mun Thong Phung/ Lisa Redfern, Matthew Pelling, Paul Knight

NI:	National Indicator	Sustainable Community Strategy Priority	Baseline	2008/09 Target	2009/10 Target	2010/11 Target	Strategic Lead Officers
Local	NI 119 Self reported measure of peoples overall health and well being	Healthier people with a better quality of life	Delayed until 09/10				TPCT - Tracey Baldwin
Local	NI 127 Self reported measure of social care users	Healthier people with a better quality of life	Delayed until 09/10				Council - Phung Mun
Local	% of HIV-infected patients with CD4 count <200 cells per mm3 at	Healthier people with a better quality of life	2004/05 aggregate 36%	42.10%	40.10%	27.95	TPCT - Tracey Baldwin/ Vicky Hobart
Local	Number of older people permanently admitted into residential and nursing care (2007 - 2010 stretch target)	Healthier people with a better quality of life	131	135	115	Stretch target to end in 09/10	Council - Mun Thong Phung
Local	Number of adults permanently admitted into residential and nursing care (2007 - 2010 stretch target)	Healthier people with a better quality of life	34	28	20	Stretch target to end in 09/10	Council - Mun Thong Phung
Local	Number of smoking quitters in the N17 area (2007 -2010 stretch target)	Healthier people with a better quality of life	240 (06/07)	300	300	Stretch target to end in 09/10	TPCT - Tracey Baldwin Vicky Hobart
					WBPB Cross-cutting Indicators		
126	Early access for women to maternity services	Healthier people with a better quality of life	local audits that the number of women booking before 12 weeks is low and that late	50%	60%	80%	TPCT - Tracey Baldwin
140	Fair treatment by local services - proxy to what extent does your local council treat all types of people fairly	Healthier people with a better quality of life	70% (a great deal or to some extent Q33 BVPI survey)	71%	72%	74%	Council - PMun Thong Phung

NI:	National Indicator	Sustainable Community Strategy Priority	Baseline	2008/09 Target	2009/10 Target	2010/11 Target	Strategic Lead Officers
35	Building resilience to violent extremism	Safer for all	a. 2, b. 2, c. 1, d. 4	a. 2, b. 2, c.1, d. 4	a. 3, b. 3, c. 2, d. 5	a. 4, b. 4, c. 3, d. 5	Council _ Sharon Kemp
40	Drug Users in effective treatment	Safer for all	2006/07 781 2007/08 estimated at 833	950	1045	1150	TPCT - Tracey Baldwin (DAAT)
51	Effectiveness of CAMHS services	Healthier people with a better quality of life	TBC	1)3, 2)4, 3)3, 4)3	1)4, 2)4, 3)4, 4)3	1)4, 2)4, 3)4, 4)4	Council - Sharon Shoesmith
56	Obesity among primary school age children in Year 6	Healthier people with a better quality of life	TBC	24%	24%	24%	Council - Sharon Shoesmith
112	Under 18 conception rate	Healthier people with a better quality of life		59	51	51	Council - Sharon Shoesmith
113	Prevalence of Chlamydia in under 20 years olds	Healthier people and a better quality of life	2006/2007 out turn was 600 (screening)	15%	16%	17%	TPCT - Tracey Baldwin
116	Proportion of children in poverty	Healthier people and a better quality of life	36.4% April 2007 - still provisional	Not yet confirmed			Council - Sharon Shoesmith (DWP reports)
156	Number of households living in temporary accommodation	Healthier People with a better quality of life	5696	3750	2600	2600	Council - Niall Bolger

NI:	National Indicator	Sustainable Community Strategy Priority	Baseline	2008/09 Target	2009/10 Target	2010/11 Target	Strategic Lead Officers
187	Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency rating	Healthier people and a better quality of life Environmentally sustainable future	April – December 2006 : 316 April – December 2007: 1683	TBC	TBC	TBC	Council - Niall Bolger
Local	175 Access to services and facilities by public transport (and	An environmentally sustainable future	Awaiting data from TfL (April 2009)				Council - Niall Bolger
Local	53 Prevalence of breastfeeding at 6-8 weeks from birth –	Healthier people with a better quality of life	TBC	1)50% 2)85%	1)50.1%b 2)90%	1)52.9% 2)95%	TPCT - Tracey Baldwin
Local	Increase the % of children immunised by the 2nd birthday	Healthier people with a better quality of life	TBC	605	75%	90%	TPCT - Tracey Baldwin
Local	Carbon emissions from vulnerable private households (2007 -2010 stretch target)	Healthier people with a better quality of life	108 tonnes	N/A	376 tonnes	Stretch target to end in 09/10	Council - Niall Bolger
Local	Number of accidental dwelling fires (2007 -2010 stretch target)	Healthier people with a better quality of life	248 (05/06)	230	230	Stretch target to end in 09/10	Fire Brigade
Local	Carbon emissions from vulnerable private households (2007 -2010 stretch target)	Healthier people with a better quality of life	108 tonnes	N/A	376 tonnes	Stretch target to end in 09/10	Council - Niall Bolger
ACCS/Better Places Indicators							
Local	Number of Green Flag parks (2007-2010 stretch target)	People at the heart of change	2 (06/07)	N/A	12	Stretch target to end in 09/10	Council - Mun Thong Phung
Local	Number of parks achieving Green pennant status (2007-2010 stretch target)	People at the heart of change	2	N/A	7	Stretch target to end in 09/10	Council - Mun Thong Phung
Local	The % of people who report they are satisfied or fairly satisfied with local parks & green spaces (2007-2010 stretch target)	People at the heart of change	72%	N/A	77%	Stretch target to end in 09/10	Council - Mun Thong Phung

Adult, Culture and Ccommunity Services (ACCS) Responsibility

Haringey Teaching Primary C

Accountable Officers	Thematic Board	Well-being Outcome focussed group	
John Morris AD Recreation Council	Well-being Partnership	Improved health and emotional well-being	
Marion Morris, DAAT Manager, Council	Well-being Partnership	Improved health and emotional well-being	
Vicky Hobart, Publlic Health Consultant HTPCT	Wellbeing Partnership	Improved health and emotional well-being	
Vicky Hobart, Publlic Health Consultant HTPCT	Wellbeing Partnership	Improved health and emotional well-being	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Increased choice and control	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Improved quality of life	
Margaret Allen, AD Commissioning and Strategy, ACCS, Council	Wellbeing Partnership	Improved quality of life	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Improved quality of life	

Accountable Officers	Thematic Board	Well-being Outcome focussed group	
Vicky Hobart, Publlic Health Consultant HTPCT	Wellbeing Partnership	Well-being Chairs' Executive	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Increased choice and control	
Vicky Hobart, Publlic Health Consultant HTPCT	Wellbeing Partnership	Improved health and emotional well-being	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Increased choice and control	
Lisa Redfern, AD Adult Services, Council	Wellbeing Partnership	Increased choice and control	
Vicky Hobart, Publlic Health Consultant HTPCT	Wellbeing Partnership	Improved health and emotional well-being	
	Children Young People's	Improved health and emotional well-being	
	PMG		

Accountable Officers	Thematic Board	Well-being Outcome focussed group	
	Safer Communities	Improved quality of life	
	Safer Communities	Improved quality of life	
	Children and Young People	Improved health and emotional well-being	
	Children and Young People	Improved health and emotional well-being	
	Children and Young People	Improved health and emotional well-being	
	Children and Young People	Improved health and emotional well-being	
	Children and Young People	Economic well-being	
	Integrated Housing Board	Improved quality of life	

Accountable Officers	Thematic Board	Well-being Outcome focussed group	
	Integrated Housing Board	Economic well-being	
	Better Places	Improved quality of life	
	Children and Young People	Improved health and emotional well-being	
	Children and Young People	Improved health and emotional well-being	
	Better Places	Economic well-being	
		Improved quality of life	
	Integrated Housing Board	Improved quality of life	
John Morris AD Recreation Council	Better Places	Improved quality of life	
John Morris AD Recreation Council	Better Places	Improved quality of life	
John Morris AD Recreation Council	Better Places	Improved quality of life	

are Trust (HTPCT) Responsibility

haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Detailed Options for Welfare to Work for Disabled People**

Report of: **Bill Slade, Regeneration Coordinator, Haringey Council.**

Summary

To update the Well-Being Partnership Board on options for Welfare to Work as requested at the Boards meeting in March.

Recommendations

To note the Options Paper attached.

For more information contact:

Name Bill Slade
Title Regeneration Co-ordinator
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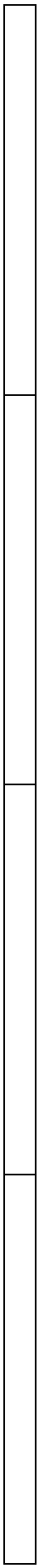
Recommendation	Facts	Factors	Options
i. Note that a major target of the Working Neighbourhoods Fund, and the LAA stretch, is worklessness, particularly that of incapacity benefit (IB) claimants, and that this presents challenges and opportunities	There are currently 12,150 I.B. claimants in the borough which is 7.7% of the working age population. LAA stretch target 2 =180 Haringey residents on Incapacity Benefit (IB) for 6 months or more helped into sustained work.	Pathways to Work is the main programme for reducing the IB claimant count and is run in this borough by Reed in Partnership. It targets people on IB for less than six months. Once a person has been on an incapacity benefits for 12 months, the average duration of their claim will be eight years. (DWP) The longer a person is out of work the harder it is to place them back in to work.	Audit within statutory and voluntary sector services to find how many service users are long term IB claimants. Develop an offer to long term IB claimants that includes appropriate support and skills training or retraining. Use existing mainstream employment pathways and ensure that they are sensitive to issues by offering expertise.
ii. Note that the largest single group of people within this overall grouping is people with mental health problems, and that they are the most disadvantaged in the labour market, and that therefore resources available under this agenda will be skewed in their direction	The biggest group of IB/SDA claimants in Haringey in terms of type of illness are people with a mental health condition; some 44.1 per cent (5,200 claimants) of IB/SDA claimants in the borough have a mental health condition. This is compared with 44.3 per cent in London and 40.9 per cent in England.	Musculoskeletal (16.1 per cent of the IB/SDA caseload) the next biggest cohort is largely made up of older people who will retire on to pensions in the main. There are a number of interventions in use, such as Computerised Cognitive Behavioural Therapy (cCBT) that have shown efficacy in respect of common mental health problems	Fund those interventions that show positive outcomes e.g. Health in Mind; Haringey Therapeutic Network. Recognise that W2W funds will be skewed towards this group as the largest and most amenable within the target population and work with voluntary sector to identify their incidence (where they turn up) so services can be targeted.

iii. Consider the resources currently deployed for the "day care" of various client groups and how these could be successfully re-aligned to support the welfare to work agenda, for example by the introduction of capacity building programmes designed to increase the motivation and confidence of participants	There is around £1.5m invested in MH and LD day opportunities, discounting the £2.8m ring fenced for services for the 200 severely disabled clients of LD services. £350K is used in LD for 60 clients in the Workwise project. The rest is used in MH services for various forms of provision from therapy groups through educational/training projects to employment advice.	There is a specialist job brokerage service for people with MH problems run by a vol. sector partner in a statutory setting, LDA funded, and in its last year. The council's mainstream programme, the Haringey Guarantee, has a 17% disability quota. All mainstream employment providers are covered by the provisions of the DDA. All the above need to engage with people who are "job ready" in terms of their "soft" or social skills in order to have positive outcomes.	Seek assurance that any commissioning or modernisation plans contain provision for programmes or services which make positive connections with and feed in to mainstream and specialist job brokerage agencies. Particularly consider the future of the specialist mental health job brokerage where there is a commitment from MH commissioning to pick up the funding on exit from the LDA stream dependent on evaluation.
iv. Ensure that various client needs assessment processes include employment aspirations as a matter of course, and that these assessments are linked to supportive programmes that can work with such aspirations (Care Programme Approach)	Many people are eligible for having their needs assessed under the care programme approach care management regime. Currently this fails to identify career and educational aspirations. This means poor information available to construct recovery and supportive pathways.	Commissioners have little aggregated data derived from CPA assessments around which to make evidenced based commissioning decisions in this sphere. Aspirations need supporting at various key stages along a pathway. Achieving aspirational goals enhances recovery.	View the process of client recovery and/or social inclusion as a whole process even when that process involves a range of agencies situated in statutory, voluntary or the private sector. Ensure the relevant staff are competent to assess for aspiration and have local knowledge of relevant provision.

v. Consider how the use of various psychological therapies may be increased to support the needs and aspirations of local people	Condition Management Programmes (CMP's) underwrote the success of 25% of people achieving employment through the Pathways to Work Programme. These were largely the hardest to help. cCBT was the most used programme. Anxiety/depression the most prevalent condition.	The TPCT has narrowly failed to win funding under the Increased Access to Psychological Therapies stream but have made a commitment to fund an increase in available therapies. The TPCT have successfully run a programme under the Haringey Guarantee offering a CMP to participants. Reed in Partnership has recruited the Priory to deliver the CMP under their Pathways contract in this locality.	Continue support of the increase in available therapies. Consider with employment professionals the basic training of front line staff (IAG, employment advisers, CAB, etc). E.g. Mental Health First Aid. Seek too ensure a high quality provision that compares favourably in terms of VFM with private provision in supporting aspiration, for the long term benefit of service users.
vi. Maintain the link with economic regeneration and mainstream programmes tackling worklessness, especially given the increased focus on welfare reform, and consider ways of increasing the dialogue	The focus of mainstream employment programmes is upon IB claimants, 12,150 in Haringey. Many of these people are also users of health and social care services.	Welfare to Work for Disabled People Partnership is the only forum where health and social care professionals meet regeneration professionals. The W2W strategy has partnership working as its top priority.	Ensure that the Partnership board has a knowledgeable membership able to consider the type of partnership working necessary to improve delivery in this area. Clarify where the partnership stands in the overall strategic framework. How does it relate to the Haringey Employment Partnership for instance?

vii. Consider the role of General Practitioners in relation to this agenda and how they might be best supported to make good choices for their patients	GP's are the gateway to Incapacity Benefit. DWP research suggests they can feel ambivalent about this role. Many acknowledge the therapeutic value of work but are wary of jeopardising patient trust. Department for Work and Pensions Research Report No 257	Placing employment advisers in GP surgeries has proved beneficial in some instances but only where the practice is fully behind the initiative and there is adequate accommodation for the adviser.	Seek to ensure that GPs are informed of the full range of CMP and capacity building programmes available. Engage GPs in a dialogue around welfare reform and assess their knowledge requirements in this area.
viii. Consider convening officer/partner groups around specific areas such as social firm development, employer engagement, and the roll out of disability equality training to front line staff	Strategic thinking tends to happen in professional silos. Social inclusion issues are cross cutting. The welfare to work strategy prioritises partnership working.	Senior reps from HAVCO, TPCT, ACCS and regeneration have agreed to meet around the development of social enterprises. Social Enterprise London are sending their chief Exec. There is a Haringey based social Firm delivering disability training to front line staff	Encourage the formation of such forums as vital elements in ensuring multi-agency co-operation. Consider our own role as employers in respect of encouraging employer engagement with this agenda. Task any group formed with specific goals.
ix. Ensure that the W2W partnership board is the co-ordinating body for all work involving employment and disabilities so that there is a rational use of existing resources	There are a number of disability specific employment initiatives in both the statutory and voluntary sectors. Funding streams are not specific beyond "disability". Some specific resources are currently underused.	Social firm development is best done across any arbitrary grouping of the marginalised. Practitioners have many common issues. A provider forum supports the board.	Recognise that the W2W partnership board occupies a unique strategic position between the well being and enterprise boards and that that is a strength. Ensure the correct membership (willing to learn a new language).



haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Review of Haringey Life Expectancy Action Plan**

Report of: **Public Health Directorate, PCT**

Summary

To update Well-being Partnership Theme Board on the planned review of the Haringey Life Expectancy Action Plan.

The Haringey Life Expectancy Action Plan 2007-2010 was published in October 2006. The purpose of the plan is to deliver priority actions to improve life expectancy and reduce health inequalities in Haringey to meet the 2010 PSA health inequalities targets.

Recommendations

That the Board note the above

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Update

Significant changes have occurred in Haringey since the publication of the previous plan including the finalisation of the *Primary Care Strategy* and work towards an obesity strategy and tobacco strategy.

In reviewing the plan we will determine what progress has been made towards the PSA targets and in improving life expectancy (and reducing mortality) in Haringey by reviewing available data. We will also conduct a desktop review to determine if interventions outlined in the plan have been commenced. We will also conduct a global review of new interventions for

improving life expectancy that may guide our actions towards the end of this strategy cycle and into the next.

We will present the findings of our early analysis of data on progress towards targets and improving life expectancy in Haringey at this meeting.

haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Preparation of Tobacco Strategy for Haringey**

Report of: **Public Health Directorate, PCT**

Summary

To update Well-Being Partnership Board on work towards development of a Tobacco Strategy for Haringey.

We commissioned an external consultant (PMA associates) to conduct a review of tobacco control activities in the partnership. This review was completed in March 2008. In the review the consultants conducted interviews/ discussions with key stakeholders across the Borough.

Recommendations

That the Board note contents of this report.

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Update

The consultants also conducted a desktop review of available data on deprivation, ethnicity, housing condition, health status, income and employment (risk factors for smoking) to identified wards with high need (in the absence of directly measured smoking prevalence in Haringey). Those wards are listed in the table below.

Ward	**Smoking prevalence score** (wards with high scores are estimated to have higher smoking prevalence)
Northumberland Park	20
White Hart Lane	19

Noel Park	19
Tottenham Green	17
Tottenham Hale	15
Bruce Grove	12
St. Ann's	12

These areas were compared with quitting performance across the borough. It was found that wards identified as high need (see Table below) had low numbers of quitters.

The review concluded that the current Stop Smoking Service, together with a number of outsourced independent providers, is providing a service, which, while achieving Haringey's current target for quitters, is not drawing these quitters proportionately from the areas experiencing the greatest health inequality and smoking prevalence.

The stop smoking service is also in the process of undergoing a service restructure in response to increasingly stringent quitting targets and the perception that quitters are increasingly difficult to recruit. A fixed term tobacco commissioning manager post has also been approved to work over the next twelve months to develop our commissioning of:

- the stop smoking service,
- level 2 advisors eg GPs, pharmacists, maternity, mental health, children's services, community,
- Referral pathways into these services from others (eg social care, housing….),
- Other tobacco control initiatives eg social marketing.

The focus of the discussion at the WBPB meeting will be how to progress the development of a joint strategy for tobacco control in Haringey.

WORKING NEIGHBOURHOOD FUND 2008/09 - APRIL 08

haringey strategic partnership

NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 08/09	Year to date
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend		
												£1,067,500	**£55,028**	**£1,012,472**		
Accessing Employment through Individual Budgets	Beverley Tarka	✔					G	G	N	G	G	£15,500	£0	£15,500	Support 10 people to gain training and skills for working life	**TBC**
															Support 10 additional people into paid work	**TBC**
															Support 5 additional people into voluntary work placements	**TBC**
															Develop an additional 10 work plans	**1**
															Train 6 people to travel independently	**1**
Appropriate Adult Training for B Tech Award (Crucial Steps)	Ify Adenuga	✔					G	G	G	G	G	£15,000	£1,621	£13,379	40 people to be recruited including people from Hornsey & Finsbury Park	**30**
															Induction for 25 people	**TBC**
															25 people complete Theoretical training, Practical training, Portfolio processing and Portfolio Assessment	**TBC**
															25 people move into employment / await B-Tech certificate	**TBC**
															25 trained AA volunteers available for PACE call-outs	**TBC**
Benefits Outreach (Age Concern)	Imelda Mullins	✔					N	N	N	N	N	£45,000	£0	£45,000	Hold 100 outreach sessions	**TBC**
															Facilitate 4 user group meetings	**TBC**
															Interview 40 people to produce detailed case studies	**TBC**
															Train 4 local older volunteers to run outreach resource desks in the super output areas	**TBC**
Black and Minority Ethnic Carers Respite Service	Faiza Rizvi		✔	✔	✔		G	G	N	G	G	£19,500	£0	£19,500	Plan, develop and deliver 12 support group meetings.	**1**
															250 carers to attend group support meetings	**35**
															One annual conference	**TBC**
															Refer 25 Carers to appropriate services	**TBC**
															50 Carers to receive therapy vouchers	**TBC**
Community Income (BME Carers Support Service)	Faiza Rizvi	✔					G	G	N	G	G	£31,500	£0	£31,500	Inform 100 local people,	**TBC**
															Inform and support at least 75 families in applying for relevant benefits	**22**
															Hold at least 40 information surgeries	**4**
															Provide language support to 40 people applying for benefits	**20**
															Advertise projects widely 3 times a year	**TBC**
Cycling Club	Beverley Tarka	✔	✔				G	G	G	G	G	£9,500	£250	£9,250	50 people with L/D accessing cycling opportunities weekly by June 08	**Avg 33 Per Week**
															100 people with L/D accessing cycling opportunities weekly December 08	**Details in July**

WORKING NEIGHBOURHOOD FUND 2008/09 - APRIL 08

haringey strategic partnership

NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 08/09	Year to date
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend		
Happy Opportunities (PHASCA)	Lena Hartley	✔	✔				G	G	G	G	G	£17,000	£650	£16,350	Increase household income by an average of £10 per week. (10 people to increase income, 10 people to save on household bills and 10 to get in to work)	TBC
															To improve the health outcome for 50 adults who are 50+	TBC
Haringey Forum for Older People Age Concern Haringey	Manuela Toporowska				✔		G	G	G	G	G	£51,000	£4,970	£46,030	10 Executive Committee meetings;	1
															Sustain membership at current (end of Mar 09) levels estimated at 800	800
															3 Older & Bolder Newsletters and distribute 4,500	1
Health in Mind (HTPCT) Physical Activity	Vanessa Bogle Physical Activity	✔	✔				G	G	G	G	G	£87,500	£8,383	£79,117	Establishing 4 further Health Walks	2
															35 participants to have attended the Health Walks programme for at least 3 months.	TBC
															Recruit and train 8 volunteers to become Walk Leaders	TBC
															25 referrals per month to the 'Active for Life' Physical Activity Referral Scheme	35 in April
															20 families to be enrolled onto the 'Watch It' Community-based childhood obesity programme	9
Health in Mind (HTPCT) Healthy Eating	Debbie Wilkins Healthy Eating	✔	✔				G	G	G	G	G	£148,000	£12,565	£135,435	Shape-Up Programme - Targets: 140 participants per year. To improve the diet for people over the age of 50 years as part of an overall lifestyle improvement	15
															To train and educate at least 4 lay people to become Community Nutrition Assistants	TBC
															Cook and Eat Programme - Target: 60-90 participants per year	8
Health in Mind (HTPCT) Mental Health	Dorian Cole Mental Health (Haringey Therapeutic Network)	✔	✔				G	G	G	G	G	£133,000	£8,645	£124,355	150 new contacts participating in physical activity – minimum half hour per week	0
															80 new contacts in employment support engaged/ refused/ signposted to paid work / voluntary work/ further education	10
															150 new contacts will report positive change in presenting problems and symptoms	TBC
															150 participants to be provided with computer packages to deliver CBT for depression/anxiety	TBC
Home Support Workers & Outreach Street	Damon Knight		✔	✔		✔	N	N	G	N	N	£78,000	£6,578	£71,422	Offer a service about alcohol misuse and service provision to 100 people with chaotic alcohol misuse problems	TBC

WORKING NEIGHBOURHOOD FUND 2008/09 - APRIL 08

haringey strategic partnership

NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 08/09	Year to date
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend		
& Outreach Street Drinkers (HAGA)	Damon Knight		✔	✔		✔	N	N	G	N	N	£78,000	£6,578	£71,422	Reduce alcohol problems and make positive lifestyle changes for 100 people in their own homes and/or on the street	**TBC**
Libraries for Life	Diana Edmonds	✔	✔				G	G	N	G	G	£194,500	£0	£194,500	Reducing obesity and improving diet and nutrition - Dietary and nutritional advisory sessions for 400 people	**52**
															Library Walker's programme = 40 people per week undertaking regular walks	**54 per week (avg)**
															Reducing the number of people who smoke, information and support sessions involving health-checks to 75 people.	**25 per class (avg)**
															Counselling advice to people with mild mental heath problems (Working with the PCT to deliver stress counselling, assisting 12 people per week)	**TBC**
															Provide advice on alcohol and drug related issues via advisory sessions targeting 8 people per week	**11 per session (avg)**
Out and About: Befriending and Community Development	Ashraf Choudry		✔	✔	✔		G	G	G	G	G	£35,500	£2,791	£32,709	5 socially isolated older people to spend time credits according to their individual preference.	**TBC**
															80 (960 for the year) older people befriended/home visits per month;	**100**
															50 (600 for the year) telephone contacts per month.	**144**
Reducing smoking prevalence	Sarah Barron		✔				N	N	G	N	N	£100,000	£2,075	£97,925	Achieve 1600 quitters in Haringey	**TBC**
Salsa Club (Scorpion Salsa Group)	Natalia Blazina		✔				N	N	N	N	N	£9,000	£0	£9,000	Increase physical activity for at least 200 participants through 2-3 classes a week	**TBC**
The six8four Centre	Diane Clark	✔	✔				N	N	G	N	N	£78,000	£6,500	£71,500	250 referrals in a year. 90% participating in Physical Activity, 75% to undertake training/capacity building in preparation for college or employment.	**TBC**
															Increase household income to address fuel poverty in 100 households	**TBC**

WORKING NEIGHBOURHOOD FUND 2008/09 - APRIL 08

haringey strategic partnership

COMMENTS/UPDATE
In the process of employing a suitable candidiate to canvass employers and support new people with L/D into employment.
2008/09 training programme commencing with a re-union event. Invited ex trainees and the 30 new people who have registered to train with us this year.
The first Support Group meeting took place on the 17th April 2008 at the Pavilion Hall, Selby Centre and was attended by 35 Carers. The subject was on Breast Cancer screening, how to be cared for and what services are available.
1 staff member employed to support cycling opporttuntities. 2 people with L/D supported as volunteers at the brakthru club 1day each per week. 1 person with L/D supported in gaining skills in cycle maintenance

WORKING NEIGHBOURHOOD FUND 2008/09 - APRIL 08

haringey strategic partnership

COMMENTS/UPDATE
Project kicked off on the 10th April 08 at the Nothumberland Park Neighbourhood Resource Centre. Number of participants registered to date is 20. The April 08 sessions included A) Yoga B) Poblems facing older people C) Back to work skills.
Attended "Campaigning Together 2008" conference, organised by Age Concern England. Members contributed to final report of Scrutiny Review of Access to Services for Older People and launch of Older People's Manifesto for London.
Two new Health Walks have recently started from two GP sugeries located within the East of the Borough. A total of 2 new walkers joined the programme in April 2008. Approximately 235 people attend the Group Health Walks per month. The 'Watch It' community-based family childhood obesity intervention programme is currently running from Tottenham Green Leisure Centre with 9 families enrolled.
5 community groups have expressed an interest in having either one or both of the programmes to take place at their centre. Groups Include: The Restoration project, I Can Care Group and The Trinidad and Tobago Association. Holding the programmes in pre- established community groups has been found to be a successful way of reaching registration and attendance targets. Many people report that they are more likely to attend programmes if they have friends also attending and if group members are of similar ethnic background, particularly if they have limited English.

haringey strategic partnership

COMMENTS/UPDATE
Haringey Libraries have initiated a long term weight care programme, this involves all nine libraries of Haringey. The programme is delivered for two hours per month from all nine libraries, this ensures that the participants have plenty of choice when selecting which library they would like to attend. The aim of the programme is to deliver group sessions where people share their own experiences, this will hopefully develop into a networking group where the participants help each other because they share the same issues. Continuing to run smoking cessation classes, open to both Haringey Council staff and the general public, held within libraries in the Borough in partnership with Haringey NHS. Partnership with DASH (Drugs Advisory Service Haringey) to improve access and advice on alcohol and drug related issues.
Number of volunteers involved during month was 25. 12 volunteers have left mainly because they have found employment or have moved from Haringey. However, numbers volunteers are waiting in the recruitment process.
As part of the implementation of the Tobacoo Control Strategy, the Stop Smoking Team is currently going through a restructure so it is aligned with the Strategy. The fixed-term Commissioner role will be funded through the ABG Grant. Recruitment for this post will take place on the week commencing 26th May.

Communities for Health Fund 07/08 - Project as end of April 2008

CfH Projects	Project Description	Project Manager	RAG Status					Finances			Project Objectives/Target 07/08	Year to date
			Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend To Date	Budget Left to Spend		
Chlamydia Screening Media Campaign Exposure	A co-ordinated media campaign to promote and raise awareness of and to encourage the target group to take advantage of the Chlamydia Screening Programme (CSP). The media campaign will utilise a range of media to take the key messages to the target group. Funding for salaries, documentary & production costs, promotion & distribution, radio adverts, fliers and posters etc.	Aysha Tegally	G	G	G	G	G	£31,194	£27,400	**£3,794**	1 x 5 minute documentary-style film about Chlamydia and the CSP	**Completed**
											4 x 60- 90 second adverts, both the film and adverts will be uploaded to YouTube, MySpace and a specially created website, the film and advert can be downloaded to mobile phones	**4**
											A dedicated website to upload films and adverts to, the site will also link to the Enfield and Haringey CSP website	**Completed**
											A flier and poster campaign	**Completed**
											4 x 30-60 second radio adverts to be played on community radio stations	**4**
											1 x 8 page Under Exposure supplement in Exposure	**Completed**
Chlamydia Screening For Haringey Residents aged 15-24 years Ethiopian Community Centre - United Kingdom	The aim of the project is to increase the level of awareness of Chlamydia among young people and in particular BME males aged between 15 - 24 years to facilitate their engagement in the screening programme by taking a test. Other aims include the prevention of Sexually Transmitted Infections (STI) in young people through one to one, peer and small group discussions to initiate behavioural change in their sexual practice. Funding for salaries, training and development, travel expenses, publicity, monitoring and evaluation etc.	Alem Gebrehiwot	A	G	G	A	A	£33,500	£16,750	**£16,750**	Targets to be achieved will be to promote annual testing with these target groups through a range of community based outreach interventions, working towards reaching **4,800** young BME men who have been tested for Chlamydia in 2007/2008 in Haringey. This will be achieved through community outreach work which will involve networking with other service providers directly to inform them about the programme and seek their agreement for the engagement of their service users in the programme. It will also target local football teams, basket ball teams, athletic teams, fitness centres and other sport activities and other Community Based Organisations (CBOs).	**292**
Timebank Haringey Haringey Timebank	To develop a time bank initiative in LB Haringey. Groundwork will employ a time broker to develop a locally focused time bank for Haringey. The time broker will set up a steering group to help develop and manage the activities. The time bank will involve socially excluded groups, especially from deprived communities and take referrals from specialist mental health agencies. Funding for salaries, publicity materials, social events, travel costs, utilities, insurance, CRB check etc	Sandra Hoisz	G	G	G	G	G	£30,332	£24,480	**£5,852**	50 new people engaged in volunteering activity through time bank who will then benefit from help/support through time bank	**50**
Total	**Total budget available**	**£100,000**						**£95,026**	**£68,630**	**£26,396**		

Communities for Health Fund 07/08 - Project as end of April 2008

Comments/Updates
The project is well on its way to completetion. All 4 radio adverts are complete and are being played on community radio stations. The posters are complete and have been distributed. The Underexposure appeared in the Feb issue of Exposure and was well recieved an additional 300 standalone copies were produced and given to the chlamydia screening co-ordinator to use as an extra tool. The 4 filmed adverts are complete and ready to be uploaded to the website. The screening took place at the muswell hill underway. Evaluation of the media campaign is on-going with forms being inserted into postal tests and returned with test, we are waiting for the CPS to pass the forms to us. One of the filmed adverts won an award for the best short film at the Wood Green International Film Festival. The radio adverts contnue to be played on various radio stations.
Several meetings have taken place with other Chlamydia screening providers including Telsa Walker, Enfield and Haringey Chlamydia Co-ordinator. Various issues have been discussed such as training of people, information resources including leaflets and posters, testing materials/kits, Identification of sites including the already existing sites for Chlamydia testing and publicity, especially with Exposure Magazine. In addition to CBOs, some of the sites include leisure centres, shopping centre (Wood Green), Libraries (regular screening), Prospects, and faith groups. Training sessions have been conducted by Enfield and Haringey Chlamydia co-ordinator and 4 staff and 5 volunteers have been trained. To date, 292 young people have taken Chlamydia test. This number is way below target compared to the proposed 07/08 objective. The most important and encouraging part of the testing is its steady increase in the number of tests in each month. ISSUES: The programme started late as screening kits were delayed and identification of areas were not easy.
The latest Northumberland Park Safer Neighbourhoods Team newsletter featured an article promoting the Time Bank. Time Banking infrastructure developed: our time bank is registered with time banks UK and we are using software specifically developed for time banks. Promotional material, joining forms and risk assessments have been produced. 50 new people engaged in volunteering activity through time bank who will then benefit from help/support through time bank: So far 50 local residents and 10 organisations have signed up to become members of the time bank. Exchanges are under-way, including IT lessons, home visits and volunteering opportunities at the Odeon cinema. Good links with mental health service users and service providers and are currently looking into developing a GP referral system.

haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **10 June 2008**

Report Title: **Well-Being Balanced Scorecard**

Report of: **Margaret Gallagher, Performance Manager, Haringey Council**

Summary

To present the Balanced Scorecard developed against the strategic objectives of the Well-Being Partnership Board.

Recommendations

That the Board note progress and key issues on performance as illustrated by the Balanced Scorecard.

For more information contact:

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1. Development of a Balanced Scorecard

1.1 The Well-Being Scorecard has been updated and aligned with the requirements of the new performance framework. It reflects the development of Haringey's well being strategic framework and key priorities as identified in our Local Area Agreement. It is based around the seven outcomes in the Government's White Paper "Our Health, Our Care, Our Say" and includes a number of cross-cutting shared measures. These reflect the Choosing Health agenda and incorporate a range of joint priorities including the Health Care Commission's core standards and indicators.

1.2 The Scorecard is designed to give an overview of performance and progress against key projects which contribute to health and well-being outcomes. It ensures that people who use social care services are at the heart of the work we do and monitors progress against the outcomes as set out in our well-being strategic framework.

1.3 The front page of the scorecard shows progress against each of the seven objectives in pie chart format. It illustrates the proportion of measures that are on target (green), close to target (amber) and not achieving target or below the expected level of performance (red). This approach relies on both the regular availability of data and targets having been set so as to enable the allocation of a traffic light.
Progress on indicators continues to be tracked on a monthly and year to date position against the 2007/08 target using a traffic light annotation where:

- green: = target achieved / performance better than planned
- amber: = just below target (normally a 5% tolerance)
- red: = target not achieved / below expectation

1.3.1 In addition, trend arrows depict progress since the last financial year, so whilst an indicator may receive a red traffic light for not achieving target, it will show an upward trend arrow if performance had improved on the previous year's outturn. Between them, the lights and arrows indicate current progress and predict the likely annual position.

1.4 The report is based on end of year data from the Council and Health, further data will be available next month.

2. Objective 1- Improved Health and Emotional Well Being

2.1 16 out of 17 (94%) of the measures are on or close to target under this objective.

2.2 The end of year performance on our LAA stretch target of smoking quitters in N17 has exceeded the 07/08 target of 240: The number of smoking quitters increased to 270 in the last quarter of year resulting in the stretch target being met. Further data will be received up until the 6th June and it is likely that the year one target will be exceeded.

2.3 Excellent progress on the number of drug users within treatment and the percentage of drug misuses sustained in treatment, both have exceeded their target.

2.4 Mortality rates from cancer have improved in 2007/08 from 117 per 100,000 in 2006/07 to 109. However cardiovascular mortality rates have increased this year from 94 per 100,000 people in 2006/07 to 98.

2.5 Good performance on the number of people participating in the Health Walks Programme, 235 attended the walks and 104 have completed a

12 week programme. 207 older people have also participated in the healthy eating programmes.

2.6 98.78% of CPA seven day follow ups were met for 2007/08 a good improvement on 90.6% in 2006/07 but falling short of their 100% target.

Infant mortality: smoking during pregnancy improved considerably in 2007/08 to 5.6% compared to 12.41% for 2006/07 but also falling short of their 4.99% target.

2.7 End of year performance on adults & older clients receiving a review (Paf D40) is 80% in 2007/08 up on the 63% achieved in 2006/07 and hitting the 80% target. This performance places us in the top performance banding but remains an area for continued focus and improvement in 2008/09.

2.8 Excellent progress has been made throughout the year on the number of delayed transfers of care per 100,000 (Paf D41). The end of year figure of 38.55 is a vast improvement on the 06/07 outturn of 65 and has moved the PI to paf banding 4.(good performance)

3. Objective 2- Improved Quality of Life

3.1 All 16 of the measures are on or close to target under this objective.

3.2 In 2007/08 there were 9136 per 1,000 visits to our libraries. This is the equivalent of 9.1 visits per head of population compared with 9.58 in 2006/07 and although a slight decrease on 2006/07, it exceeded our 2007/08 target.
The recently published CIPFA results for 2006/07 show Wood Green Central library as the 2nd busiest library in London with 783,687 physical visits

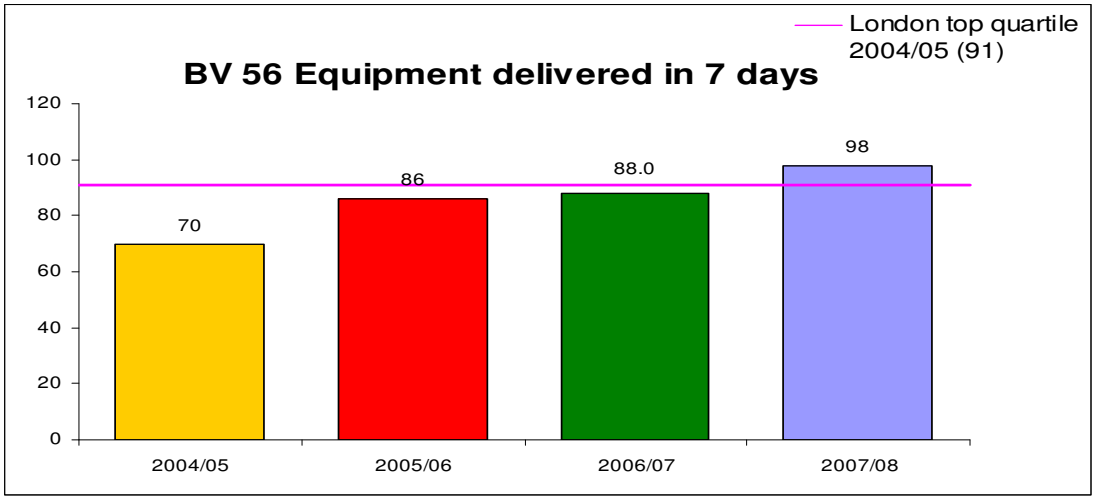
3.3 Excellent performance on the Silver Surfers (60+ educational take up) and Adult Education take up indicators with both exceeding their targets.

3.4 Good improvement on all three perception indicators in 2007/08. The 2007 Residents survey found that 65% of residents were satisfied with parks and open spaces +8% increase from 2006/07 46% of adults cited crime as an area of personal concern, a 8% reduction from the 54% in 2006 and the lowest recorded concern around crime for the past 6 years.
The sports 60 second survey found that 69% of residents were satisfied with the sports and leisure facilities a significant improvement on the 06/07 outturn of 48%.

3.5 In 2007 there were significant improvements on a number of social care indicators compared to last year – number of adults with mental

health problems helped to live at home has improved from 2.8 to 4.24 exceeding Haringey's target of 3

97.8% of equipment was delivered within 7 working days in the year, an excellent improvement on the 88% achieved in 2006/07 and exceeding our 90% target for 2007/08 on this key threshold indicator.



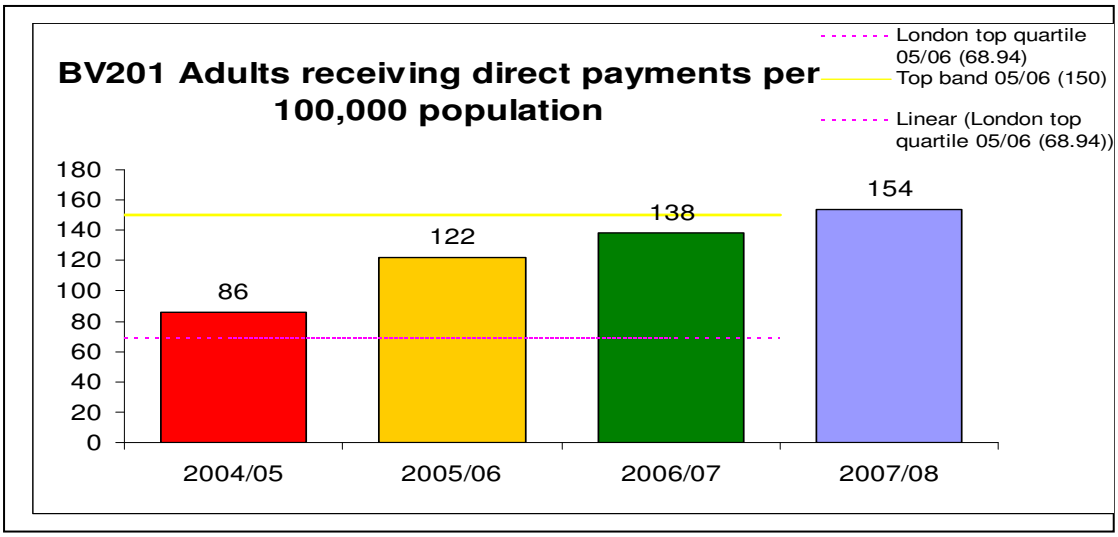
4. Objective 3- Make a Positive Contribution

4.1 Both measures have exceeded their targets. Performance on the Out and About Project which measures volunteer hours secured for work with older people. 2,851 volunteer hours were recorded compared to 2,420 hours for the 2006/07, a 17% increase.

5. Objective 4- Increased Choice and Control

5.1. All nine (100%) of the traffic lighted measures are on target under this objective.

In 2007 there were significant improvements on a number of social care indicators compared to last year – 152.9 adults and older people per 100,000 population received direct payments as at 31 March 2008. Performance improved up from 122 in 2005/06 to 138 in 2006/07 and further to 154 per 100,000 in 2007/08. This improvement has brought performance into the top PAF banding range as well as exceeding the 150 target. The graph below shows the improvement in this area.



Acceptable waiting time for Assessment and Care Packages (Paf D55/55b key threshold indicator)
Excellent performance has been maintained on this indicator which measures the average of new older clients receiving assessment where time from initial contact to first contact with the client is less than or equal to 48 hours (part a) and the percentage where time from first contact to completion of assessment is less than or equal to 4 weeks (part b). Our 2007/08 position of 95.4% exceeds our target and is an improvement on the 80.95% achieved in 2006/07. There has also been improvement in provision of care packages with 93% of services delivered in less than 4 weeks from completion of assessment. Performance on both these indicators is in the top performance band.

Adults admitted on a permanent basis to residential or nursing care improved significantly from 3.8 (05/06) to 1.1 (07/08)per 10,000 people and moved Haringey from the lowest paf banding to the highest.

6. Objective 5- Freedom from Discrimination or Harassment

6.1 Four of the five (80%) of the measures are on or close to target under this objective.

6.2 Both indicators for ethnicity of older people receiving assessments and services have exceeded their targets and remain in the top paf banding. Theses Indicators assessing whether the need for social services of people from minority ethnic groups are as great as that for the general population show no disparity with older service users receiving an assessment. The same applies to older service users receiving services following an assessment

6.3 Reduction of domestic violence repeat victimisation was positive in the first half of the year with the rolling year figure reducing to 211 in quarter two. However the number of repeat victimisations increased in

the last half of the year meaning that the end of year figure was 240, lower than the baseline year of 244 but higher than the 191 year one target.

7. Objective 6- Economic Well-being

7.1 12 out of 13 (92%) of the indicators included under this objective have been assessed as on or close to target.

7.2 Excellent progress achieved with putting in place energy efficiency homes measures, the number of homes which received energy efficiency measures (1196) exceeded the number achieved in 2006/07. This is also the case for the number of private sector non-decent homes made decent, 271 compared with 109 in 2006.

7.3 The proportion of households accepted as homeless who have been previously accepted as homeless in the last two years has remained at 0% exceeding our 2.5% target for 2007/08.
The number of households for whom advice/intervention resolved their situation is a predicted 545 or 5.6% exceeding their target of 500 and placing us in the top quartile nationally.

7.4 The number of accidental fires showed improvement in the first quarter of the year, however performance declined in the last three quarters and the end of year figure was 253 which both missed the target and was higher than the 06/07 baseline of 248.

7.5 There were 429 community alarms installed during 2007/08 an improvement on the 342 installed during 2006/07.

8. Objective 7- Maintaining personal dignity and respect

8.1 All 3 (100%) measures are on target.

8.2 Excellent performance maintained on the availability of single rooms continuing to meet its 100% target.

9. Position on all objectives

9.1 In summary the balanced scorecard shows that 95.4% of the measures are on or close to target. 55 of the 66 indicators traffic lighted achieved green status with an additional 8 achieving amber status. Only 3 of the 66 measures fell short of the target.

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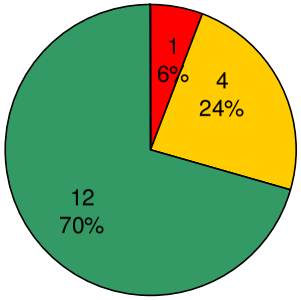
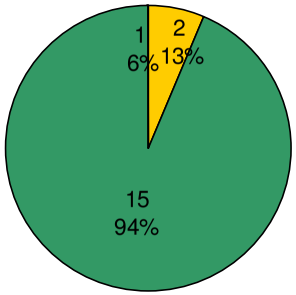
Wellbeing Scorecard March 2008

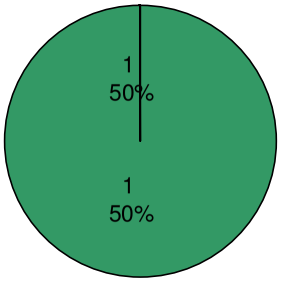
1 - Improved Health and Emotional Well-Being



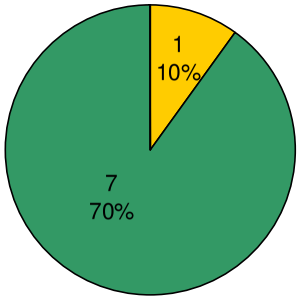
2 - Improved Quality of Life



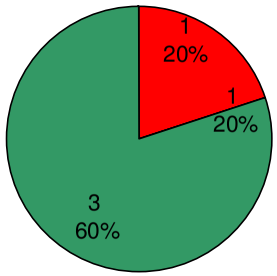
3 - Make a positive contribution



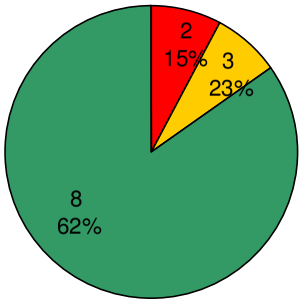
4 - Increased Choice and Control



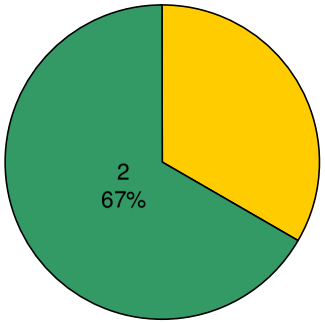
5 - Freedom from Discrimination or Harassment



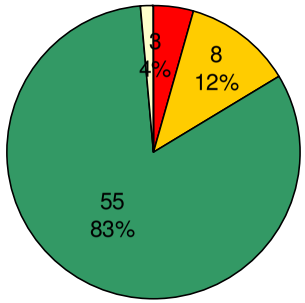
6 - Economic Well-being



7. Maintaining Personal Dignity and Respect



All objectives



Red	Well below target
Amber	Worse than, but within 5% of target
Green	On or better than target
New/Annual	
Blank	

Well-being Scorecard

Objective Name	Traffic light count					
	Red	Amber	Green	Annual or New	Blank	Total
Objective 1 - Improved Health and Emotional Well-being To promote healthy living and reduce health inequalities in Haringey	1	4	12	0	0	17
Objective 2 - Improved Quality of Life To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes	0	1	15	0	0	16
Objective 3 - Make a positive contribution To encorage opportunities for active living including getting involved, influencing decisions and volunteering	0	0	2	0	0	2
Objective 4 - Increased choice and control To enable people to live independently exercising choice and control over their lives	0	1	9	0	0	10
Objective 5 - Freedom from Discrimination or Harassment To ensure equitable access to services and freedom from discrimination or harassment	1	0	4	0	0	5
Objective 6 - Economic Well-being To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs	1	1	11	0	0	13
Objective 7 - Maintaining personal dignity and respect: To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur	0	1	2	1	0	4
Total	3	8	55	1	0	67
	4.5%	11.9%	82.1%	1.5%	0.0%	100.0%

Red	Well below target
Amber	Worse than, but within 5% of target
Green	On or better than target

Objective 1 - Improved Health and Emotional Well-being
To promote healthy living and reduce health inequalities in Haringey

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Four week quitters	Monthly	1998	14	110	286	345	469	816			1290					↑	✓	**2190 quitters.** Plan: Q3 target - 1270	PCT is expecting to achieve the target plan but waiting for cleaned data available in June	Catherine Brown (Health Report) Gerry Taylor gerry.taylor@haringey.nhs.uk
2	Smoking cessation: Increase the number of quitters living in N17	Quarterly	240			48 (Target 33)			49 (Target 34)			77 (Target 68)			96 to date but still counting until 6th June 08 (Target 135)	270	↑	✓	240 stretch 270	Profiles for Q3 and Q4 have targets of 68 and 135 quitters respectively. At present the targets are being met although there is a risk as the majority of work will need to be done in the final two quarters of the year.	Caroline Hulett (Caroline.Hulett@haringey.nhs.uk)
3	Number of drug users within treatment	Monthly	1435	805	860	910	955	996	1040	1087	1141	1170			1347	1347	↑	✓	LDP target 1146 (stretched partnership target 1342)		Catherine Brown (Health Report) Adrian Hosken PCT
4	Percentage of problem drug misusers sustained in treatment	Quarterly	68.00%			72%			77%						86%	86%	↑	✓	75% to be retained >12 weeks (local tgt. National is 82%)	2007/8 target is 75%. London performance is around 70%. Performance is calculated in rolling years, ie. Oct06 - Sept07 and is approx 5 months behind.	Adrian Hosken PCT
5	Mortality rate from Cancer in people under 75 per 100,000 people	Quarterly	117	108.03		105.9			111.5			108.1			109.2	109.2	↑	✓	117 per 100,000 in 2006 (age standardised) spearhead tgt	latest available data shows target is being achieved.	Graeme Walsh PCT
6	Cardiovascular disease mortality rates per 100,000 people	Quarterly	94			116.5			89.5			85.2			98	98	↑	✗	94 per 100,000 in 2007 (age standardised) spearhead tgt	latest available data shows target is being achieved.	Graeme Walsh PCT
7	Reduction of obesity- mean body mass index of population (recorded as having a BMI of 30 or greater)	6 monthly	14%						9.50%							9.50%	↑	✓	14% 2006/07		Vanessa Bogle/Catherine Browne PCT
8	Proportion of people 16+ taking 30 mins moderate physical activity on three or more days a week	Quarterly	72				76					93			66	235	↑	✓		Health Walks Programme Approx 235 people attend the Health Walks per month and of these 104 have completed a 12 week programme. 246 referrals have been made to the Physical Activity Referral Scheme (Active for Life).	Vanessa Bogle PCT
9	Swim usuage as% of total usage in Tottenham Green Gym usuage as% of total usage In Tottenham Green	Quarterly	30% 13%	29% 5%	25% 6%	25% 5%	34% 6%	35% 4%	26% 4%	22% 4%	20% 4%	15% 4%	30% 9%	42% 13%	32% 8%	36% 9%	↑	–	2006/07 Cumulative % 30% 13%	Swim exceeding last years performance and usage as a whole has increased. The centre's are also carrying out health initiates and marketing strategies to target other groups of people like juniors and elderly to encourage participation	Margaret Barzey LBH

Objective 1 - Improved Health and Emotional Well-being
To promote healthy living and reduce health inequalities in Haringey

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
10	Swim usuage as a % of total usuage in Park Road Gym usuage as a % of total usuage in Park Road	Quarterly	66% 11%	71% 6%	69% 6%	71% 5%	68% 7%	66% 9%	70% 12%	67% 13%	60% 9%	70% 9%	66% 13%	63% 14%	62% 14%	70% 11%	↑	✓	2006/07 Cumulative % 66% 11%	Exceeding last years performance and usage as a whole has increased.	Margaret Barzey LBH
11	CPA seven day follow up	Quarterly	90.60%			100%			100%			96.10%			99%	98.78%	↑	–	100.00%	3 breaches in October and November brought down performance. BEH say it is on the increase again in Q3.	Janice Woodruff PCT
12	Number of Older People (aged 50+) participating in a healthier eating community based programme in Noel Park, Bruce Grove and Northumberland Park	4 Monthly	22 between Jan-Mar 07						32						207	207	↑	✓		Key Achievements (Performance so far): Decrease in body weight Increased confidence in reading food labels Increased confidence in cooking from basic ingredients Increased number of people eating regular meals Increased awareness of the 5 a day fruit and vegetable message. Future Plans: Continuing to run the two programmes (Cook and Eat & Shape-Up) within the three Haringey wards. Currently running 6- (6 week) programmes, with a further 12- (6 week programmes) planned until the end of September. Follow-up for past participants - monthly one-hour Drop In session in each of the three wards. Outreach work: The two programmes are to be held within established community groups in Haringey. Currently we are holding the Shape Up Programme at a Mothers and Daughter group, with 19 people registered for the programme. Other groups who have expressed	Wilkins Debbie [Debbie.Wilkins@haringey.nhs.uk]
13	Infant Mortality: Smoking during pregnancy:% of mothers known to be smokers during pregnancy	Quarterly	12.41%			6.73%			9.10%			9.70%			5.60%	5.60%	↑	✓	4.99%	B&CF data estimated from Q1 - PAS problems means data is not available.	Vanessa Bogle/Catherine Browne PCT
14	Breast Cancer Screening for women aged 50-70 years	Annually	36.00%															–	70% of women beween 50-70	Data is not yet available for 2007/08 the service has been reinstated and backlog of Haringey patients is currently being screened. We are unlikely to be able to catch up this year, but expect that progress will be made towards meeting next year's target - Reporting Annually	Vanessa Bogle/Catherine Browne PCT
15 Paf D40	Adults & Older clients receiving a review as a percentage of those receiving a service	Monthly	63%	133%	125%	113%	103%	97%	90%	80.00%	78.60%	74.60%	64.8%	71.1%	80.0%	80.0%	↑	✓	80%	Paf Top Banding 75+ (4 blobs) Current Performance 4 Blobs	Paul Dryden LBH
16	Teenage Conception Rates (difference between 1998-2005)	Annual	62.5															–	41.3 conceptions / 1000 15-17 year old females in calendar year 2006		Vanessa Bogle/Catherine Browne PCT

Objective 1 - Improved Health and Emotional Well-being
To promote healthy living and reduce health inequalities in Haringey

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
17 Paf D41	No of Delayed Transfers of Care- Adults & Older People per 100,000 (Social Services)	Monthly	65.5	44	50	49.91	42.90	39.93	35.05	32.67	33.01	36.07	36.39	38.20	38.55	38.55	↑	✓	39.78	Paf Top Banding 0<20.12 Current Performance 4 Blobs This is a cumulative figure across all services	Manisa Patel LBH

Objective 2 - Improved Quality of Life
To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments
1	The number of physical visits per 1,000 population to public libraries	Quarterly	9,585			9057			8,733			9,171			9,535	9136	↑	✓	8600	
2	60+ Educational take up	4 Monthly	363				96					245			258	503	↑	✓	363	Performance data based on term times
3	Adult (19+)education take up collected term time	4 Monthly	3149				690					2173			1094	3267	↑	✓	3149 (787 qtr)	Performance data based on term times
4	BV119 - Increase in number of green flags award parks & public satisfaction	Annual	7 Flags 2 Pennants													8 Flags	↑	✓		
5 BV119e	% of residents satisfied with parks and open spaces	Quarterly	72% (BVPI) satisfied			72% (BVPI)			64%(Wave 2 track)			65%(residents survey)			65% Residents survey	65%	↓	–	72%	Latest residents survey show +8% rating the service as good/excellent
6 BV119a	% of residents satisfied with sports and leisure facilities	Annual	48.70%													69.8%(60 second survey)	↑	✓		
7	Residents Survey - Areas of personal concern % of sample mentioning concern with crime	Annual	54%									46%				46%	↑	✓		Latest residents survey show a 7% reduction in residents mentioning crime as an area of personal concern
8 Paf C29	Younger physically disabled helped to live at home per 1,000 population aged 18-64.	Monthly	4.6			4.7	4.8	4.8	4.7	4.6	4.6	4.49	4.41	4.79	5.19	5.19	↑	✓	5	Paf Top Banding 5+ Current Performance 5 Blobs
9 Paf C30	Number of people with learning disabilities helped to live at home per 10,000 adults in population aged 18-64.	Monthly	1.58	1.57	1.56	1.57	1.54	1.54	1.56	1.55	1.65	1.84	1.81	1.89	2.13	2.13	↑	✓	1.7	Paf Top Banding 3+ Current Performance 3 Blobs
10 Paf C31	Adults with mental health problems helped to live at home	Monthly	2.8	2.83	2.82	2.85	2.84	2.85	2.85	2.93	4.09	4.16	4.01	4.26	4.24	4.24	↑	✓	3	Paf Top Banding 2.3+ Current Performance 3 Blobs
11 Paf C32	Older people helped to live at home per 1,000 aged 18-64	Monthly	94.00	89.00	89.00	88.00	88.00	87.00	93.00	104.64	103.30	101.56	96.00	96.00	101.90	101.90	↑	✓	101	Paf Top Banding 100+ Current Performance top banding
12 PAF D54	Community equipment- social services items of equipment delivered in 7 days	Monthly	88%	94.6%	98.0%	93.0%	95.0%	96.0%	99.0%	99.00%	100.00%	99.80%	100.00%	99.80%	97.80%	97.80%	↑	✓	88%	Paf Top Banding 85<100 Current Performance 5 Blobs
13	Community equipment- health items of equipment delivered in 7 days	Monthly	96%	99%	99%	100%	100%	100%	100%	100%	100%	100%				100%	↑	✓	100%	
14 Paf C62	Services for carers	Monthly	9.00%	9.00%	8.00%	8.80%	9.40%	9.70%	10.10%	13.5%	12.10%	12.1%	9.9%	9.2%	9.9%	9.90%	↑	✓	10.0%	Paf Top Banding 12+ Current performance 4 Blobs
15	Number of black and ethnic carers of who have received a breaks service -DIS 2.1 CS064	Annual	683															✓	600	
16	Number of active card users	Quarterly	23992	6074	6626	15008	6652	6364	5609	6294	6023	4185	7232	14762	6753	91582	↑	✓	5264 (month)	

Data Source/ Contact
Erica Worth LBH
George Szervanszky LBH
George Szervanszky LBH
Paul Dryden LBH
Paul Dryden LBH
Paul Dryden LBH
Paul Dryden LBH
Paul Dryden LBH
Catherine Brown - Health Report
Paul Dryden LBH
Manisha Patel LBH
Margaret Barzey LBH

Objective 3 - Make a positive contribution
To encorage opportunities for active living including getting involved, influencing decisions and volunteering

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Out and About Project (Volunteer hours secured for work with older people) Visits and telephone	Monthly	2420	183	187	191	199	235	241	261	266	265	269	265	289	2851	↑	✓	06/07 2420		Ashraf Choudhury - Age Concern
2 Paf 30	Number of adults with learning disabilities helped to live at home per 1,000 population aged 18-64	Monthly	1.6	1.57	1.56	1.57	1.5	1.54	1.56	1.55	1.65	1.84	1.81	1.89	2.13	2.13	↑	✓	1.7	Paf Top Banding 3+ Current Performance 3 Blobs Professional support has been added which has been resulted in exceeding the 2007/08 target.	

Objective 4 - Increased choice and control
To enable people to live independently exercising choice and control over their lives

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend A	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 Paf D39	% of people receiving a statement of their needs and how they will be met	Monthly	89%	89%	90%	93%	93%	93%	95%	94%	97.3%	97%	98%	98%	98.3%	98.3%	↑	✓	98%	Paf Top Banding 100+ Current Performance 4 Blobs	Paul Dryden LBH
2 Paf C51	Adults and older people receiving direct payments per 100,000	Monthly	138	131	131	136	137	140	137	136	149	153	152	153	152.9	152.9	↑	✓	150	Paf Top Banding 150+ Current Performance 5 Blobs	Paul Dryden LBH
3 Paf D55	Assessments of older people which begin within 48 hours of first contact	Monthly	60%	97%	95%	96.50%	97%	97%	97%	97%	96.9%	97%	96%	96%	96%	96.1%	↑	✓	90%	Paf Top Banding 90<100 Current Performance 5 blobs	Paul Dryden LBH
4 Paf D55b	Assessments of older people completed within 4 weeks	Monthly	73%	95%	94%	95.10%	95.00%	95.20%	95.30%	95.90%	95.50%	95.70%	94.90%	94.70%	94.60%	94.60%	↑	✓	90%	Paf Top Banding 90<100 Current performance 5 blobs	Paul Dryden LBH
5 Paf D56	Social services for Older people provided within 4 weeks following assessment	Monthly	94%	82%	85.90%	85.30%	86%	91%	91%	91.20%	90.00%	89.90%	89.90%	93.20%	93.00%	93.0%	↑	✓	93%	Paf Top Banding 90<100 Current Performance 5 blobs	Paul Dryden LBH
6 Paf D71	% of respondents when asked " Do your care workers do the things that you want done" answered "they always do the things I want done	Annual	New																	Survey results due end of May	Paul Dryden LBH
7 Paf C72 (Formerly C26)	Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care	Monthly	85	73	76	72	63	75	69	66.6	68.9	61.9	56.4	66.3	65.0	65.0	↑	✓	Local Target <67	Paf Top Banding 0<90 Current Performance 5 Blobs	Paul Dryden LBH
8 Paf C73 (Formerly C27)	Adults aged 18-64 admitted on a permanent basis in the year to residential or nursing care	Monthly	5.2	2.3	2.3	2.6	2.1	1.2	1.0	1.0	1.4	1.2	1.31	1.4	1.1	1.1	↑	✓	1	Paf Top Banding 0<1.5 Current Performance 5 Blobs	Paul Dryden LBH
9 Paf E82	Assessments of adults and older people leading to a provision of service	Monthly	67.00	71.00	72.00	72.00	72.00	70.00	71.00	69.50	67.60	67.90	69.30	73.30	77.00	77.00	↑	✓	70	Paf Top Banding 68<77 Current Performance 5 Blobs	
10 KPI	Service users who are supported to establish and maintain independent living	Quarterly	97.90%			98.55%			98.00%			99.16%			98.35%	98.35%	↑	✓	98%		Carlos Bailey LBH

Objective 5 - Freedom from Discrimination or Harassment
To ensure equitable access to services and freedom from discrimination or harassment

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 DIS 2216 5.3LD 166	Ratio of the % of learning disabled adults receiving services that are from minority ethnic groups related to the % that are from minority ethnic groups	Annual	1.13													1.11	↑	✓	1.00	Please Note this is only an estimate	
2 Paf E47	Ethnicity of older people receiving an assessment	Quarterly	1.23			1.56			1.49	1.45	1.52	1.46	1.45	1.46	1.40	1.4	↑	✓	1	Paf Top Banding1<2 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH
3 Paf E48	Ethnicity of older people receiving services following an assessment	Quarterly	1.03			0.94			0.99	0.98	0.96	1.01	0.99	1	0.99	0.99	↑	✓	1	Paf Top Banding 0.9<1.1 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH
4	An increase in the percentage rate of sanctioned detections of domestic violence	Monthly	487			223 or 53%	69 or 48%	69 or 51.9%	238 or 54.2%	61 or 50.4%	64 or 58%	75 or 46%				51.8	↑	✓	129 or 32% stretch 34%	The year to date position is 51.8% and we are on track to exceed the year 1 target of 770 sanction detections and performance is significantly better than last year. Previous issues with this indicator have been resolved with GOL through the mid-year review and we are now on track to meet the year three target.	
5	Reduction of repeat victimisation	Monthly	244	222	218	213	200	201	211	207	209	216	230	233	240	240	↓	✗	191	Reduction of repeat domestic violence victimisation incidents Progress was good in the first half of the year, however the number of incidents increased in the second half meaning that the year one target was not met, however there has been an improvement from the baseline year	

Objective 6 - Economic Well-being
To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Reduction in worklessness/ people entering employment Employment in Haringey- data available by ward	Annual	69% (2006/07)															—	England Avg 74.3%		Ambrose Quashie LBH -Floor Targets
2	Ethnic Minority employment rate- data available by ward	Annual	59.1% (2006/07)															✓	England Avg 59.7%		Ambrose Quashie LBH - Floor Targets
3	Number of LD people aged 18-64 in paid work per 1,000 (DIS 6.4 LD168)	Annual	45													61.00	↑	✓	60	Please note this figures are still provisional	Siobhan Harper/Chloe Rawlinson LBH
4	Number of supported employment placements for employees with disabilities via Jobcentre Plus "Workstep" achieved	4 Monthly	7					7					9		9	9	↑	✓	06/07 7	7 full time. Only 2 new sign ups; both job seekers.	Bill Slade LBH
5 New for 2006/07	Number of households with reduced fuel poverty in Noel Park, Bruce Grove & Northumberland Park	Annual	235															✓	235 2006/07		Lynn Sellars LBH
6 New for 2006/07	Number of properties that have received energy efficiency measures	Quarterly	461			307			429			154				1196	↑	✓	461	The data for efficiency and decent homes is provisional until May, however there has been a significant increase in the number of households receiving energy efficiency measures and non-decent homes made decent, this is a proxy indicator but provisional carbon conversions have indicated we have met	LAA measure
7	Proportion of households accepted as homeless who have been previously accepted as homeless in the last two years (BV214)	Quarterly	2.50%			0.0%			0.0%			0%			0%	0.00%	↑	✓	2.5%		Greg Carter LBH
8	Number of households for whom advice/intervention resolved their situation per 1000 households (BV 213)	Monthly	380	15	37	70	56	69	28	77	44	33	44	19	53	545	↑	✓	500	The year to date of 545 has achieved the target of 500 households where homelessness has been prevented for more than 6 months. The year end figure for this data is calculated by dividing the final number of cases by one thousandth of the total number of households in the borough (98). Therefore 545/98 = 5.6 which is currently top quartile for national performance.	Greg Carter LBH
9	Delayed transfers of care to reduce to a minimal level by 2006 (Health)	Quarterly	2.64%			2.39%			0.75%			2.70%				1.96%(current performance)	↑	✓	Local target 2%		Alex McTeare PCT
10 Paf E47	Ethnicity of Older people receiving assessment	Monthly	1.23	1.31	1.42	1.56	1.51	1.5	1.49	1.45	1.53	1.46	1.45	1.46	1.40	1.4	↑	✓	1	Paf Top Banding1<2 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH

Objective 6 - Economic Well-being

To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs

11 Paf E48	Ethnicity of Older people receiving services following assessment	Monthly	1.03	0.8	0.84	0.94	0.95	0.95	0.97	0.99	0.96	1.01	0.99	1	1	0.99	↑	✓	1	Paf Top Banding 0.9<1.1 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH
12	Number of fire safety checks carried out by fire brigade	Annual	234			54			69	23	24	20	19	21	23	253	↓	✗	12 fewer fires over 3 years	The number of accidental dwelling fires was higher in quarter 2 than quarter 1 but fell slightly in quarter 3 to 67, scaled up for 07/08 will be 253, this is higher than last year and also higher than the year 3 target of 230.	LAA Agreement
13	Community Alarms	Monthly	342	29	22	38	44	22	35	42	34	21	41	55	46	429	↑	✓	06/07 342 (28 avg per month)		Yvette Husbands/ Maureen Smith LBH

Objective 7 - Maintaining personal dignity and respect:
To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur

	Description	Frequenc	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Progress	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 Paf D37	Availability of single rooms	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	↔	✓	100.00%	Always be 100%	Paul Dryden LBH
2	To facilitate timely hospital discharge and/or effective rehabilitation Non-residential intermediate care schemes DIS 1.2 OP005	Annual	95													484	↑	✓	115	Please note this figures are still provisional	Paul Dryden LBH
3	To facilitate timely hospital discharge and/or effective rehabilitation - DIS 1.2 OP007	Annual	629													511	↓	–	529	Please note this figures are still provisional	Paul Dryden LBH

✗	0
✓	2
–	1
New/Annual	0
Blank	0
Non blank	3

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