haringey strategic partnership

NOTICE OF MEETING

Well-Being Partnership Board

THURSDAY, 2ND OCTOBER, 2008 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22.

MEMBERS: See membership list set out below.

AGENDA

1. WELCOME, APOLOGIES AND INTRODUCTIONS

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

2. MINUTES (PAGES 1 - 14)

To confirm the minutes of the meeting held on 10 June 2008 as a correct record of the meeting.

3. 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.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under agenda Item 15 below).

5. HARINGEY'S ALCOHOL HARM REDUCTION STRATEGY 2008-11 (PAGES 15 - 18)

A presentation will also be provided.

6. HARINGEY OBESITY STRATEGY (PAGES 19 - 52)

7. SPORTS AND PHYSICAL ACTIVITY PARTICIPATION IMPROVEMENT PLAN – HARIACTIVE (PAGES 53 - 70)

8. UPDATE ON HARINGEY SEXUAL HEALTH STRATEGY (PAGES 71 - 72)

A presentation will also be provided.

9. TACKLING HEALTH INEQUALITIES AUDIT REPORT AND ACTION PLAN (PAGES 73 - 114)

10. RISK MANAGEMENT

A verbal update will be provided.

11. SAFEGUARDING ANNUAL REPORT 2007/08 AND ACTION PLAN 2008/09

Please note that this report will be sent to follow.

12. HARINGEY TEACHING PRIMARY CARE TRUST INVESTMENT PLAN (PAGES 115 - 124)

A presentation will also be provided.

13. AREA BASED GRANT REVIEW UPDATE

A verbal update will be provided.

14. INFORMATION ITEM -SCORECARD: EXCEPTION REPORTING (PAGES 125 - 134)

A verbal update will also be provided.

15. NEW ITEMS OF URGENT BUSINESS

To consider any new items of Urgent Business admitted under Item 4.

16. DATES OF FUTURE MEETINGS

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

- 8 December 2008
- 2 March 2009

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Head of Member Services
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225 High Road

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Wood Green
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SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	9	Cllr Bob Harris *(Chair)* Councillor John Bevan Councillor Gideon Bull Councillor Dilek Dogus Eugenia Cronin *(Director of Public Health –joint appointment PCT/Council)* Mun Thong Phung Margaret Allen John Morris Lisa Redfern
Health	Haringey Teaching Primary Care Trust	6	Judy Allfrey Tracey Baldwin Vicky Hobart Cathy Herman Marion Morris Richard Sumray *(Vice-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	Paul Head
Other agencies	Haringey Probation Service	1	Mary Pilgrim
	Metropolitan Police	1	David Grant
	Total	**26**	

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Agenda Item 2

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 10 JUNE 2008

Present: Councillor Bob Harris (Chair), Margaret Allen, Councillor John Bevan, Lee Bojtor, Helen Brown, Eugenia Cronin, Robert Edmonds, Siobhan Harrington, Cathy Herman, Sue Hessel, Vicky Hobart, Ian Kibblewhite, Angela Manners, Marion Morris, Mun Thong Phung, Lisa Redfern, Faiza Rizvi, Richard Sumray.

In Attendance: Councillor Isidoros Diakides, Xanthe Barker, John Morris, Pamela Pemberton, Helena Pugh, Andrew Wright.

MINUTE NO.	SUBJECT/DECISION	ACTON BY
OBHC57.	**WELCOME, APOLOGIES AND SUBSTITUTIONS** The Chair welcomed those present to the meeting and noted that apologies had been received from the following: Judy Allfrey Abdool Alli Tracey Baldwin -Helen Brown substituted Councillor Dilek Dogus Michael Fox Joe Liddane -Siobhan Harrington substituted Cathy Walsh Richard Wood -Ian Kibblewhite substituted	
OBHC58.	**MINUTES** The minutes of the meeting held on 11 March were confirmed as a correct record in terms of accuracy. Councillor Bevan advised the Board that since the previous meeting a visit to The Laurels had been arranged and requested that any issues arising from this visit should be discussed at the Board's next meeting if it was not resolved prior to this. Under minute number OHBC51, Councillor Bevan noted that he had not received a response to his query until the day of the meeting. He requested that the figures referred to be circulated along with the figures contained within the original report following the meeting. **RESOLVED:** That the minutes of the meeting held on 11 March be confirmed as a correct record of the meeting.	XB
OBHC59.	**ELECTION OF CHAIR**	

	Councillor Bob Harris was nominated and duly seconded as Chair for the Well-Being Strategic Partnership Board for the ensuing Municipal Year. No further nominations were received. Following his election as Chair Councillor Harris thanked Richard Sumray for his work as Chair over the previous year. **RESOLVED:** That Councillor Bob Harris be elected Chair of the Well-Being Strategic Partnership Board for the ensuing Municipal Year.	
OBHC60.	**APPOINTMENT OF VICE-CHAIR** Richard Sumray, Chair of the PCT, was nominated and duly seconded as Vice-Chair for the ensuing Municipal Year. No further nominations were received. **RESOLVED:** That Richard Sumray be appointed as Vice-Chair for the ensuing Municipal Year.	
OBHC61.	**DECLARATIONS OF INTEREST** No declarations of interest were received.	
OBHC62.	**URGENT BUSINESS** No items of Urgent Business were received.	
OBHC63.	**COMMUNITY LINK FORUM PRESENTATION** The Board received a presentation from the Community Link Forum (CLF) setting out its objectives and work to date. It was noted that the CLF had been established as a means of improving the link between the Voluntary and Community Sector and the Partnership. Following ratification of the CLF Agreement by the Haringey Strategic Partnership (HSP) in July 2007, work had been carried out by the organisation that culminated in the CLF Elections in April 2008. The CLF was allocated four places on the HSP and three places on each of the Thematic Boards. Three of these were given to the elected CLF representatives and one to a representative from HAVCO. The representatives elected to the Well-Being Board were as follows: • Angela Manners • Abdool Alli	

	• Faiza Rizvi • Robert Edmonds (HAVCO) The Board was advised that the aims of the CLF were clearly aligned to that of the Well-Being Strategic Partnership Board and that building upon and empowering existing networks to remove barriers to Well-Being was a shared goal. That Chair thanked Pamela Pemberton of the CLF for the presentation. **RESOLVED:** That the presentation be noted.	
OBHC64.	**MEMBERSHIP AND TERMS OF REFERENCE: 2008/09** The Board received a report requesting that it confirm its membership and Terms of Reference for 2008/09. It was noted that the Boards Membership and Terms of Reference needed to be amended to reflect the inclusion of the new CLF members recently appointed. The Chair proposed that Sue Hessel of the Haringey Federation of Residents' Associations (HFRA) be co-opted to the Board and this was agreed. HAVCO contended that the CLF was the formal conduit for Community and Voluntary groups to be appointed to the Board and such appointments should be made via the CLF. There was agreement that the Chair and Robert Edmonds of HAVCO would discuss this issue further outside the meeting. The Vice-Chair raised concern that the Probation Service had not been able to attend several meetings during the course of the year and requested that they be contacted prior to the next meeting to determine whether they wished to retain their place on the Board. It was also clarified that HAVCO only one place on the Board, rather than two, as set out in the Terms of Reference at present and that this would need to be amended to reflect this. It was confirmed that Robert Edmonds had been nominated by HAVCO to fill this place. The Board was advised that Marion Morris was employed by the PCT and that the membership should be amended to reflect this. In order to ensure that the balance of places between the PCT and Council was maintained, it was agreed that Eugenia Cronin should be listed as a Council representative. **RESOLVED:**	Chair Dir ACCS Dir ACCS XB

	i. That the Membership and Terms of Reference be confirmed, subject to the reference to HAVCO's number of places on the Board being listed as one, rather than two. ii. That Sue Hessel of HFRA be co-opted to the Board.	Dir ACCS
OBHC65.	**APPOINTMENT OF REPRESENTATIVE TO THE HARINGEY STRATEGIC PARTNERSHIP** **RESOLVED:** That Mun Thong Phung, Director of ACCS, be appointed as the Well-Being Strategic Partnership Board's representative on the Haringey Strategic Partnership for 2008/09.	
OBHC66.	**PRIMARY CARE STRATEGY** The Board received a verbal update on the development of the PCT's Primary Care Strategy. The Board was advised that the Strategy was an evolving document and that the version included within the agenda papers had been agreed by the PCT's Board in May. A programme of work had also been agreed by the PCT's Board, which included further stakeholder engagement and as part of this a Household Survey would be carried out. The Survey would use the same methodology as the Council's Survey and was intended to obtain a broader base of perceptions. The Board was advised that local plans would be consulted upon in early 2009 and signed off in summer 2009. An implementation plan for the next ten years would be compiled following this. It was highlighted that at this stage there were no definite proposals in place in terms of the location of Health Centres. It was intended that proposals would be 'worked up' over the next year, taking into consideration the results of the Household Survey and further consultation. At the end of this process five 'hubs' would be identified and 'spokes', which would be comprised of smaller services, would feed into these. The aim of the Strategy was to provide a set of consistent 'core' services to everyone living in the Borough. In response to concerns over the timing of the proposed Household Survey the Board was advised that the Survey did not form part of the main consultation programme in 2009. It would be based on a sample that was representative of the Borough as a whole and conducted by an external company.	

	The Board discussed the document and it was suggested that it could be strengthened if a greater emphasis was placed on prevention and the relationship of the PCT with the Community and Voluntary Sector. In response to a query as to whether the Council and PCT had begun discussion over the location of Health Centres via the planning process, the Board was advised that no planning application had been made at present. However, there had been discussion at a recent Overview and Scrutiny meeting, where the PCT had answered questions in relation to the consultation process attached the positioning of Health Centres. As a result of this meeting it had been agreed that the Overview and Scrutiny Committee would work with the PCT to ensure that a wide range of people were consulted during the next phase of the process. It was requested that the Community and Voluntary Sector was also included within this process and there was agreement from the PCT that this would be built in. **RESOLVED:** That the verbal update provided be noted.	PCT
OBHC67.	**HEALTH INEQUALITIES AUDIT FEEDBACK** The Board considered a report that set out the external auditors' findings in relation to work carried out on Health Inequalities in Haringey. The Board was given an overview of the auditors' findings and the key recommendations and Action Plan arising from the review and advised that in comparison with other reviews carried out in the South East of England Haringey was well positioned. An overview was given of the findings in respect to each of the Key Lines of Enquiry (KLOE) included within the report: <u>KLOE 1 -Delivering Strategic and Operational Objectives</u> It was recognised that there were generally good structural links in place across the partnership to promote health and well-being. The Scorecard had been highlighted as being vital to the development of monitoring mechanisms and in terms of challenging performance. <u>KLOE 2 –Delivering in Partnership</u> It was recognised that there was a good relationship with HAVCO. However, it was considered that there was an opportunity to become more involved with research institutions. It was suggested that an individual from this field be identified to become a member of the Board. In addition discussion took place in relation to increasing opportunities to improve the effectiveness of provider Trusts within the health inequalities agenda.	

KLOE 3 –Using Information and Intelligence to Drive Decisions

The key issues picked up around this area related to the Joint Strategic Needs Assessment (JSNA) and it was noted that appropriate IT support would need to be put in place if this was to be successful.

KLOE 4 –Securing Engagement from the Workforce

The report noted that the Community Strategy was now in place and that a Director of Public Health had recently been jointly appointment by the PCT and Council. The report suggested that there was a potential opportunity to enhance joint training in HI at both Non Executive Director and Member level as well as further down the organisation. It was concluded that this approach could be extended via joint training sessions for non Executive Directors and Members.

KLOE 5 -Performance Management

The Scorecard was highlighted as being a key tool in terms of performance management and it was recommended that greater time should be set aside during Board meetings to discuss this.

It was recognised that that the Scorecard would be updated following the introduction of the new LAA targets. It was noted that this had already been done.

KLOE 6 –Corporate Responsibility

The report recognised that the Council provided several programmes that promoted staff well-being. However, there was no evidence of Partners having polices in relation to corporate responsibility. It was suggested that these should be introduced.

Following their presentation representatives from Grant Thornton thanked the key officers who had assisted them with their report.

In response to concerns that the number of people who had been consulted as part of the survey was not sufficient to provide a representative sample, the Board was advised that a caveat was included within the report, which stated that the sample was not wide enough to be relied upon in isolation.

The suggestion that the Board should include within its membership an individual with an educational/research background had been left open ended to allow the Board scope to discuss who the most relevant individual would be.

In response to a query as to what extent the findings of this report would be reflected in the Primary Care Strategy, the Board was advised that the PCT had carried out a Health Equity Audit, which had looked at access to resources. The JSNA was seen as the vehicle to address

	issues over access and this would also look at capacity building measures and provide an opportunity to draw on the expertise of an educational/research representative on the Board, as suggested in the report. The Chair noted that Councillor Bevan had requested that a response be sought as to how policies on corporate responsibility could be developed and whether this applied to the Partnership as a whole or to individual organisations. The Board was advised that the recommendation applied to both; at present there was a lack of evidence of such policies in relation to the provision amongst individual partner organisations and these needed to be introduced and reflected by the Partnership. The Board was advised that the recommendations included within the report would be reviewed. A report would then be submitted to the Council and PCT's Senior Management Teams and the Board itself, setting out how these would be addressed. **RESOLVED:** i. That the report be noted. ii. That a report setting out how each of the recommendations included within the report would be addressed should be received by the Board at a future meeting.	Dir ACCS Dir ACCS
OBHC68.	**JOINT MENTAL HEALTH STRATEGY (ADULT'S WORKING AGE)** The Board received a verbal update on the Joint Mental Health Strategy. It was noted that the previous Strategy had now expired and a new three year Strategy was being compiled. A workshop had been held earlier in the year that had brought together a range of stakeholders to discuss and identify priorities for the new Strategy. The general consensus arising from the workshop had been that there was a need to address the following areas: • Stigma around mental health • Inequalities • The need to focus on the broader well-being agenda In addition to this there had also been agreement that there should be a strong focus on recovery and participation. The Board was advised that a programme of work was being devised that would set how the Strategy would be delivered. Options in relation to the modernisation of services delivered from the St Ann's site were being reviewed and the Mental Health Executive was considering this on 13 June. A two stage process was being proposed with a Service Model being drafted that would incorporate work on St Ann's and set out a timescale for delivery. This would also link into the	

	JSNA and the boarder issues identified at the workshop. It was noted that this would need to reflect work being done around prevention and employment, older people and children with mental health needs. **RESOLVED:** That the verbal update provided be noted.	PCT
OBHC69.	**BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST: FOUNDATION TRUST STATUS UPDATE** The Board was provided with a verbal update in relation to the Mental Health Trust's (MHT) application for Foundation Trust status. It was noted that the MHT's Board had formally agreed to apply for Foundation Trust status in March. The formal application would be submitted in December 2008 and it was envisage that, if successful, the application would be granted in Autumn 2009. A key issue for the Trust was the future of the St Ann's site and in the autumn a consultation process would begin in relation to this. The Trust was keen to engage with the public and partners before options were formalised and these would be fed into the Foundation Trust application. In response to a query from the Chair as to whether the Council and Partnership had been consulted on the future of the St Ann's site, the Board was advised that at present there were still issues that needed to be discussed further with the Council and the PCT. However, the Trust was confident that these could be resolved and that the Council and PCT would be able to support the application. It was noted that there had been discussion over this issue at a meeting of the Council's Overview and Scrutiny Committee during the previous week. It was contended that the provision of Services in the Borough, rather than the buildings they were delivered from, should be the primary issue. At present the St Ann's site was no longer fit for purpose. A model that would deliver the Services was required for the Borough as a whole and the location of sites should follow this. **RESOLVED:** That the verbal update provided be noted.	
OBHC70.	**AREA BASED GRANT** The Board received a verbal update on the new Area Based Grant. It was noted that the preliminary meetings had been held and that a group had been established that was comprised of representatives from the Board, the CLF and HAVCO, in order to discuss the transition phase	

	in the autumn. The Haringey Strategic Partnership (HSP) Performance Management Group was due to meet on 23 June and any further developments would be reported to the Boards next meeting. It was noted that Vicky Hobart was the PCT representative for the group. **RESOLVED:** That the verbal update provided be noted.	
OBHC71.	**CORE STRATEGY: DRAFT ISSUES AND OPTIONS** The Board received a report on the Core Strategy Issues and Options paper that was presented to the HSP in February 2008. It was noted that the Council was required to replace the Unitary Development Plan (UDP) with a new Local Development Framework (LDF). As part of this a Core Strategy to replace the strategic policies and objectives of the UPD was required. Once adopted this would form the key development planning document for the Borough. Consultation on the Issues and Options paper had taken place during February 2008. The consultation exercise had been open to the public and had views had been sought from various statutory bodies on the following issues: • Spatial planning objectives • Options for tackling key issues facing the Borough • Objectives, issues and options that should be included In terms of the next steps to be taken a sustainability appraisal would be carried out and this would be subject to consultation in early 2009 and progress would be reported to the Board. It was requested that consideration should be given to the Community Buildings Strategy for the Borough. **RESOLVED:** That progress in relation to the Core Strategy Issues and Options paper be noted.	SN
OBHC72.	**LOCAL AREA AGREEMENT UPDATE** The Board considered a report that provided an update on the development of the Haringey Local Area Agreement (LAA). It was noted that the LAA document had been submitted to GOL on 30 May and at present was going through the final stages of the sign off process.	

	The Board was reminded that, in addition to the indicators specifically within its responsibility, it would also contribute towards the achievement of several other targets within the LAA. A revised Scorecard had been compiled in order to reflect the new targets and this would be received by the Board at its next meeting. In response to a query, the Board was advised that the final draft document had been submitted to GOL and was now being considered by the relevant Government departments. It was anticipated that this process would be complete by the end of June. The Board was advised that since the publication of the agenda the outstanding issues in relation to each of the Performance Indicators had been resolved with the exception of minor amendments to the figures referred to. **RESOLVED:** That the report be noted.	
OBHC73.	**WELFARE TO WORK FOR THE DISABLED -PROGRESS REPORT** The Board considered a report that provided an update on options for Welfare to Work for Disabled People. The Board was reminded that it had requested that a more detailed report be provide at its next meeting and an overview was given of the recommendations set out in the report. In response to a query as to whether a source of funding could be identified to allow the Faith Garden Centre to continue, the Board was advised that the scheme's manager had been contacted to discuss the options available. At present there was no funding available to allocate to this scheme. However, alternative options were being looked at in terms of funding and to mitigate the impact of the loss of this scheme. The Chair echoed the concerns raised in relation to the loss of the Faith Garden Centre and noted that options were being considered to allow this scheme to continue. **RESOLVED:** That the report be noted.	
OBHC74.	**REVIEW OF LIFE EXPECTANCY ACTION PLAN** The Board received an update on the forthcoming review of the Haringey Life Expectancy Action Plan. It was noted that the plan had been published in October 2006 and ran from 2007-10. The purpose of the plan was to deliver actions to improve	

	life expectancy and reduce health inequalities in Haringey. A presentation was provided, which gave an overview of the early analysis of data and progress towards meeting targets included within the plan. In response to a query in relation to child mortality, the Board was advised that this had dropped slightly since last year and that a plan was in place to address this, which was monitored by the Children and Young People's Strategic Partnership Board. **RESOLVED:** That the report be noted.	
OBHC75.	**PREPARATION OF TOBACCO STRATEGY FOR HARINGEY** The Board received an update on work towards the development of a Tobacco Strategy for Haringey. It was noted that consultants had been commissioned to conduct a review of tobacco control activities within the Partnership. As part of this a desktop review of available data had also been carried out and this was set out in the report. The Board was advised that the Well-Being Executive would monitor the development of the Strategy and that provision for this would also be picked up in the JSNA. There was a National Indicator in relation to this included within the new LAA and therefore money would be allocated to meeting this under the new ABG. **RESOLVED:** That the report be noted.	
OBHC76.	**HEALTH CARE FOR LONDON** The Board received a verbal update on Health Care for London from the Vice-Chair. It was noted that Health Care for London had been formed to consider how the findings of the Lord Darzi report could be implemented to provide a consistent level of world class healthcare across London. At present it was recognised that there was an over provision of acute healthcare across the capital and that this may need to be rationalised in order to provide better healthcare in other areas. The Board was advised that the Chairs of PCTs across London, Surrey and Essex, came together as a group to look at proposals and these were being consulted on at present. At this stage there were no specific proposals in place; these would be formed following the consultation	

	process. Running alongside this was a cross Borough Scrutiny Review that had made a number of recommendations to the group to including looking at: • Provision of Social Care • Examining the role of carers • Transport and Access Provision The joint group of PCT Chairs would meet on 12 June to make it's recommendations based on Lord Darzi's report. It was intended that the next stages would be carried out at PCT and Borough level. **RESOLVED:** That the verbal report provided be noted.	
OBHC77.	**NEW ITEMS OF URGENT BUSINESS** There were no new items of Urgent Business.	
OBHC78.	**WORKING NEIGHBOURHOOD FUND/COMMUNITIES FOR HEALTH** The Board received a report, for information, setting out details of spend against the Working Neighbourhoods Fund. **RESOLVED:** That the report be noted.	
OBHC79.	**WELL-BEING BALANCED SCORECARD** The Board received a report that set out progress against its strategic objectives. It was noted that performance at the end of 2007/08 had been good with only three of the sixty-six targets set out not being achieved. Measures to address targets that had not been achieved had been put together. The Board was advised that the Well-Being Scorecard had been updated so that it was aligned with the requirements of the new performance management framework and so that it reflected the Well-Being Strategic Framework and new LAA targets. **RESOLVED:** That the report be noted.	
OBHC80.	**ANY OTHER BUSINESS** The Board noted that an Alcohol Strategy Stakeholders event was being held on 30 June and that a report would be brought to the next meeting setting out the outcomes from this.	

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
TUESDAY, 10 JUNE 2008

OBHC81.	**DATES OF FUTURE MEETINGS** The following dates of future meetings were noted: • 2 October 2008 • 8 December 2008 • 2 March 2009	

Councillor Bob Harris

Chair

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haringey strategic partnership

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

Date: **2 October 2008**

Report Title: **Haringey's Alcohol Harm Reduction Strategy 2008-11**

Report of: **Marion Morris – Drug & Alcohol Strategy Manager**
Policy, Partnerships, Performance & Communications

1. Summary

1.1 **Why a Strategy?**

The policy context for the development of Haringey's alcohol strategy is:

- It is a statutory duty under the Crime and Disorder Act (1998) for Crime and Disorder Reduction Partnerships to have strategies in place that as a minimum tackle alcohol related crime and ASB.
- The governments updated national alcohol strategy Safe.Sensible.Social calls for strategies that go beyond this narrow focus to address health related harms and the impact of alcohol on children and families (the approach that Haringey has taken)
- For the first time ever we have a PSA to reduce alcohol (and drug) related harm PSA 25
- Haringey has chosen one of the indicators that sit underneath this PSA NI39 – reducing alcohol related hospital admissions as one of its 35 improvement targets in our Local Area Agreement.

In addition alcohol is a cross cutting issue, it impacts on many of the issues the borough is trying to tackle. It is core business for most - but low on the agenda – having a strategy will put more of a focus on this issue and bring in the necessary resources to tackle the high level of harm caused by alcohol.

2. How was the strategy developed?

2.1 The strategy was developed over a five months period from April 08 – August 08, through interviews with stakeholders, via area assemblies, and a conference in July 08.

2.2 It incorporates the findings of a review of local alcohol related problems and takes into account available alcohol related data.

2.3 It builds upon our original strategy that ended in March 2008, and takes into account new statutory duties and guidance.

2.4 Its aims are to: tackle the health and social harms alcohol causes, as well as alcohol-related crime and anti-social behaviour.

3. Significant Issues

- Haringey has the highest rate of male alcohol-related mortality in London
- Alcohol-related hospital admissions rates have more than doubled over a five year period from 2002/03-2006/07. Whilst this is part of a regional and national trend - it is still of great concern.
- Alcohol is also linked to violent crime in the borough (10% of all violent crime in the borough is recorded as alcohol related). However, in London as elsewhere alcohol related violence if often under reported.
- Alcohol is also associated with anti-social behaviour such as street drinking.
- Parental drinking is a factor in a number of cases focused on the protection of a child.

4. Key Actions to address above:

- Analyse alcohol-related hospital admissions data for: profile of patients (age, gender, ethnicity, ward of residence) patterns of repeat admissions (i.e. which conditions associated with repeats): profile of conditions contributing to the overall rate of admissions (i.e. which conditions are most important)
- Develop an action plan to reduce hospital admissions based on results of data analysis. (To include consideration of ward-based alcohol interventions for patients with key conditions; further expansion of alcohol screening and brief interventions across primary care, A & E, and out-patients clinics; development of liaison and referral pathways between hospitals and community based services, data sharing between A&E and community safety re violence related presentations)
- To develop and implement an alcohol prevention 'strategy' to include social marketing, health promotion, awareness training for generic health and social care professionals and targeted work for key identified communities
- Ensure alcohol is included in all mainstream health promotion strategies (e.g. obesity) and activities (e.g. health trainers)
- Agree a commissioning framework for alcohol treatment and prevention, to include service user involvement.

5. Strategic Framework/Monitoring and Evaluation

5.1 To be effective in reducing alcohol-related harm, there needs to be a coordinated response from a wide variety of organisations – this is not just an issue for enforcement agencies, or for the health service. The strategy proposes a strategic framework that places different strands of activity within the relevant HSP thematic board to manage delivery. The strategy objectives fall within the remit of three of Haringey Strategic Partnerships thematic boards: Safer Communities, Well-being and Children and Young People's Strategic Partnership Board. The implementation plan is therefore split across all of them, with each

board responsible for the delivery of the appropriate actions.

5.2 . An alcohol strategy group sitting under the DAAT will have oversight of the implementation plan as a whole, and will be responsible for evaluating the overall effectiveness of the strategy and for reviewing the implementation plan on an annual basis. **(see Appendix 1 Haringey's strategic framework**).

6. Recommendations:

6.1 To approve the strategy and action plan and support the proposed monitoring and evaluation framework for delivery.

6.2. To agree the proposed title for the strategy Dying For a Drink? (as proposed by Wellbeing Chairs Executive Meeting and endorsed by the Cabinet Member for Enforcement & Community Safety.

6.3. To note the strategy being presented at Overview & Scrutiny on the 6th October and for final sign off at Cabinet on 18th November 2008.

7. Financial/Legal Comments

7.1. Section 6 of the *Crime and Disorder Act 1998* places a duty on the Council, together with the local police authority, chief officer of police, fire and rescue authority and primary care trust, to formulate and implement strategies designed to reduce crime and disorder and to combat the misuse of alcohol (and other substance abuse) in the local authority area. This strategy has been drafted in accordance with that duty.

7.2. Indicative health costs for delivering the strategy are in the region of 200k. The TPCT have earmarked 250k in its Investment Strategy for 2009/10 to deliver the strategy. Detailed costings for delivery will not be known until the action plan to reduce alcohol related hospital admissions has been more fully developed. The focus will be on expanding alcohol related screening and brief interventions in primary care, A & E and ward based settings.

7.3. Discussions are underway as to how best commission services to people with alcohol misuse problems in a primary care setting. The 'Primary Care Service Framework: Alcohol Services in Primary Care' will inform these discussions.

7.4. Additional Social Care monies to commission more residential placements for people with complex needs have been applied for as part of the Councils Pre Business Planning Review Process (100k). The outcome will be known by December 08.

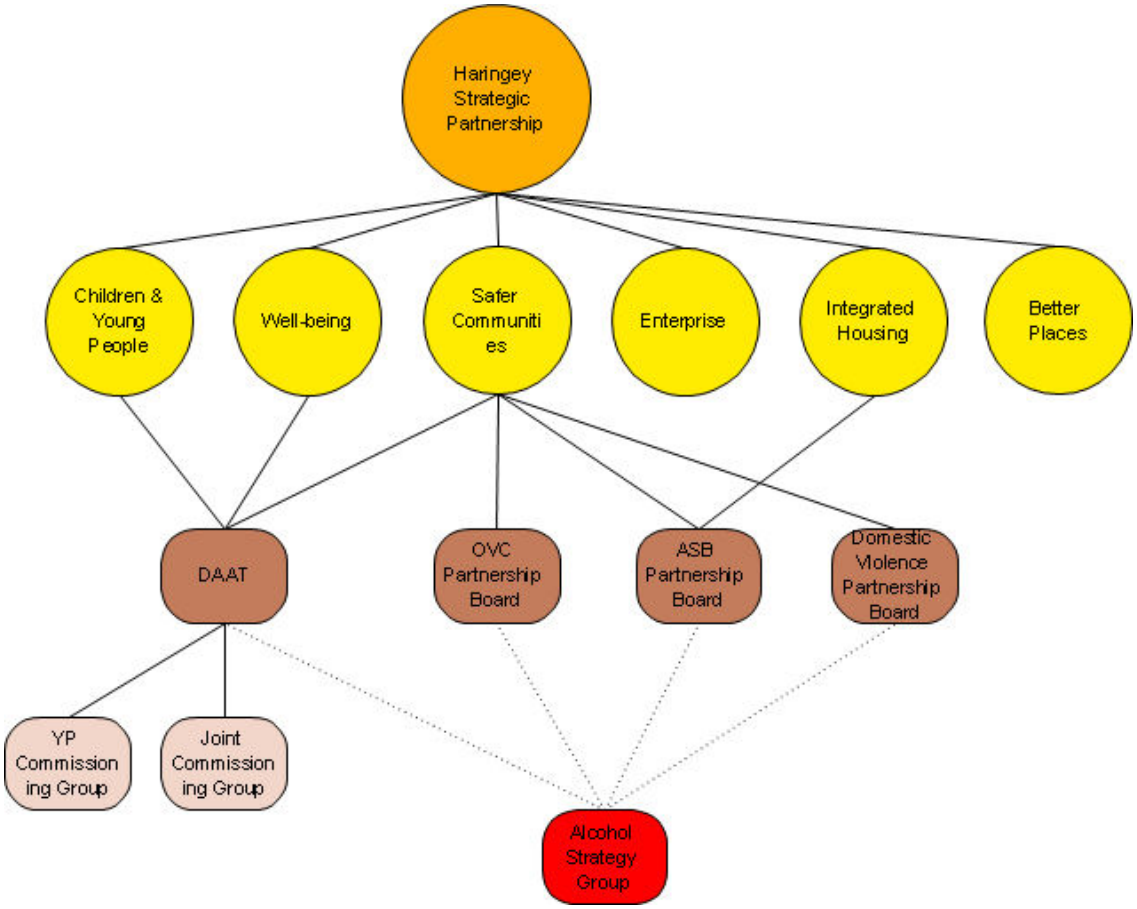
For more information contact:

Name: Marion Morris
Title: Drug & Alcohol Strategy Manager
Tel: 020 8 489 6962

Email address: marion.morris@haringey.gov.uk

Appendix 1

Strategic Framework for implementing Haringey's Alcohol Strategy 2008-11.



haringey strategic partnership

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

Date: **2 October 2008**

Report Title: **Haringey Obesity Strategy**

Report of: **Eugenia Cronin, Director of Public Health**

Summary:

The Haringey Obesity Strategy was developed to offer practical guidance for the prevention, management and treatment of obesity in children and adults within Haringey. It is supported by an adult obesity care pathway and resource pack which provides guidance for health professionals when addressing these issues (see attached). The document is linked to both national and local strategies and targets, including the Sport and Physical Activity Strategy and Infant Mortality Strategy.

The Strategy was approved by the Haringey TPCT Professional Executive Committee (PEC) in January 2008 and is being implemented. The Obesity Strategy is being presented for information.

Recommendations:

1. To note the content of the Strategy and its links to a number of outcomes in the well being strategic framework

2. To note that work on the commissioning of weight management services for children will be raised with the Children and Young People's Strategic Partnership Board.

Financial/Legal Comments:

None.

For more information contact:

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Title: Public Health Strategist
Tel: 020 8442-6878
Email address: Vanessa.bogle@haringey.nhs.uk

IDENTIFICATION

1. **Opportunistic**
2. **Existing Disease**
3. **Health Screening**
4. **Seeking Advice**

Health Professional

GP, Practice Nurse, Dietitian, Health Visitor, Pharmacist, Health Care Assistant

Consider using electronic obesity template

ASSESSMENT

1. **Height & Weight - BMI**
   BMI= weight (kg) / height (m^2)
   For Asian adults, risk factors may be of concern at lower BMI.
2. **Waist Circumference**
3. **Patient History**
4. **Raise the issue of weight (DH)**
5. **Assess readiness and motivation to change**

Classification	BMI (kg/m^2)	Waist Circumference		Co-morbidities present
		Low Men < 94cm Women < 80cm	High Men > 94cm Women > 80cm	Type 2 diabetes Hypertension Cardiovascular Disease Dyslipidaemia Osteoarthritis Sleep Apnoea
Healthy weight	18.5-24.9			
Overweight	25.0-29.9			
Obesity I	30.0-34.9			
Obesity II	35.0-39.9			
Obesity III	> 40.0			

General Advice on losing weight, healthy eating and physical activity (DH - *Why Weight Matters* card). Offer follow-up appointment.
Diet and physical activity
Diet and physical activity; consider drugs
Diet and physical activity; consider drugs; consider surgery

1ST LINE ADVICE

Lifestyle Assessment by health professional to increase physical activity and healthy eating using behavioural change techniques.

ASSESS

Discuss current lifestyle, diet and levels of physical activity.

ADVISE

Advise on dietary, physical activity and lifestyle modifications
Your Weight, Your Health booklet (DH)

AGREE

Establish individual goals and a realistic weight management plan (5-10% weight loss)

Negotiate the most effective method of managing weight loss/ maintenance.

ASSIST/ARRANGE

Signpost to local physical activity and healthy eating initiatives. Refer to other health professionals and any relevant programmes.

PATHWAY
Adult Obesity Care

Haringey NHS
Teaching Primary Care Trust

FOLLOW UP

Monitor weight loss: suggested minimum is 3 and 6 months, or more often if is patient wanting active support.

Unsuccessful weight loss
< 5% at 3 months

↓

Repeat 1st Line Advice and reassess at 6 months

Successful weight loss
> 5% at 3 months
> 10% at 6 months

↓

Maintenance phase with 3/12 monthly reassessments

Haringey NHS
Teaching Primary Care Trust

PATHWAY
Adult Obesity Care

2ND LINE ADVICE

Unsuccessful weight loss after 6 months but motivated to change.

Dietitian Assessment

- Provide a comprehensive assessment.
- Monitor weight loss
- Use referral forms if unsuccessful weight loss and recommending pharmacotherapy.

3RD LINE ADVICE

GP Assessment

Pharmacotherapy

Orlistat

- >30kg/m^2
  >28kg/m^2
  plus co-morbidity
- Continue treatment if 5% weight loss at 3 months.
- Advise patient to register with the Motivation Advice, Proactive Support (MAP) programme.

Sibutramine

- >30kg/m^2
  >27kg/m^2
  plus co-morbidity
- Continue treatment if 5% weight loss at 3 months.
- All patients should have controlled blood pressure (145/95 or below) and have no history of coronary artery disease, arrhythmias, congestive heart failure or stroke.
- Advise patient to register with the online support programme 'Change for Life'.

Rimonabant
(not assessed by NICE)

- A newer drug and much less is known about its effectiveness.
- Problems with adherence due to side effects.

4TH LINE ADVICE

Bariatric Surgery
(main provider - Whittington Hospital)

- For patients:
  > 40kg/m^2
  35-40 kg/m^2
  plus co-morbidity
- Further assessment in hospital including a psychology assessment.

MAINTENANCE

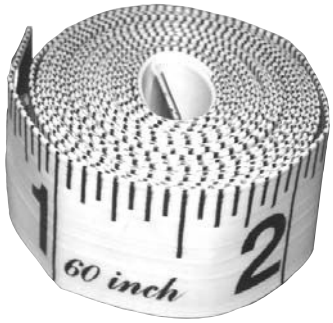
Ongoing monitoring of weight should take place to ensure that patients are supported and referred back into the pathway should they have a relapse in weight management.

North Central London Adult Obesity Care Pathway and Resource Pack for the Management of Overweight and Obesity

Haringey NHS
Teaching Primary Care Trust

Contents 3

Prevalence of overweight and obesity has trebled since the 1980s, and over half of all adults are either overweight or obese



4 Introduction

The Adult Obesity Care Pathway has been developed in partnership with the five boroughs (Barnet, Camden, Enfield, Haringey and Islington) in the North Central London sector.

The obesity care pathway is the recommended care pathway for the management of overweight or obese adult patients. It has been developed to act as an appropriate tool to help guide health professionals who come into contact with patients of varying levels of overweight and obesity. It is related to the referral criteria specific to each Primary Care Trust and is in line with the latest evidence based practice published by The National Institute for Health and Clinical Excellence (NICE) in December 2006.

The pathway is supported by an electronic obesity template, which will be sent to each general practice for uploading onto their database.

The Obesity Care Pathway is the recommended care pathway for the management of overweight or obese adults

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ASSIST/ARRANGE

Signpost to local physical activity and healthy eating initiatives. Refer to other health professionals and any relevant programmes.

PATHWAY
Adult Obesity Care

Haringey NHS
Teaching Primary Care Trust

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Ongoing monitoring of weight should take place to ensure that patients are supported and referred back into the pathway should they have a relapse in weight management.

Identification 7

Obesity is a complex disease and there are increasing demands being placed on primary care to identify and treat patients

This stage can be undertaken by a number of different health professionals: GP, practice nurse, health care assistant, health visitor, dietitian or pharmacist.

Prevalence of overweight and obesity has trebled since the 1980s, and over half of all adults are either overweight or obese (Health Survey for England, 1995-2003). This equates to approximately 24 million adults, a high proportion of these will not have been identified and classified as overweight or obese.

Obesity is a complex disease and there are increasing demands being placed on primary care to identify and treat patients. General practice is however, where most obese and overweight individuals will come into contact with health services and it is therefore, the ideal opportunity to identify and manage obesity. In addition, general practices are encouraged to maintain an obesity database of all patients recorded as obese. Collecting data on the heights and weights (BMI) of patients within a practice allows the magnitude of the problem of obesity to be assessed within individual practices.

Identification may occur under one of four categories:

- **Opportunistic**
- **Existing Disease** (e.g. type 2 diabetes, coronary heart disease, hypertension)
- **Health Screening**
- **Patient Seeking Advice**

8 Assessment

This stage needs to be handled carefully because many patients who are overweight or obese are sensitive about their weight.

Classification

The best way to assess obesity and overweight and associated health risks in a patient is to use a combination of Body Mass Index, waist circumference, and patient history (co-morbidities). Table 1 assists with the accurate classification of patients and can be completed once BMI and waist circumference have been measured and patient history/co-morbidities have been assessed.

1. **Body Mass Index (BMI) i**s used to measure the degree of overweight and obesity. The BMI is calculated by dividing a patient's weight in kilograms by the square of their height in metres.

$$\textbf{BMI} = \frac{\textbf{weight (kg)}}{\textbf{height (m2)}}$$

- Classification of Body Mass Index is outlined in Table 1.
- All patients should have their BMI recorded and changes monitored over time.
- Increasing weight in **Asian adults** is associated with a higher risk. Risk factors, therefore, may be of concern at lower BMIs.
- Clinical judgment is required when classifying **muscular patients** because BMI may overestimate the degree of fatness in these patients.

2. **Waist Circumference**
The World Health Organisation guidance recommends that waist circumference be measured using the midpoint between the lowest rib and top of the right iliac crest. The tape measure should sit snugly but not compress the skin. This is categorised as either high or low and different cut-off values are used for men and women.

LOW
Men <94cm
Women <80cm

HIGH
Men >94cm
Women >80cm

Assessment 9

There are a number of other methods for identifying patients who are overweight and obese, for example, bioimpedance, densitometry and waist to hip ratio. Bioimpedance estimates total body water crudely, as a component of lean body mass. Therefore, estimation of fat mass using this technique is relatively weak. Densitometry measures total body fat using principles of water displacement. This technique requires underwater weighing facilities, takes time, is expensive, cannot be used routinely and is unable to indicate body fat distribution. Waist to hip ratio was initially introduced because it was believed to predict fat distribution more accurately than waist circumference. This, however, has been disproved and waist circumference is the preferred anthropometric measurement. Therefore, the three methods discussed above are not recommended for assessing overweight and obesity; health professionals are advised to use BMI and waist circumference which are well validated and relatively easy for health professionals to complete.

3. **Patient History and Co-morbidities**
   A patient history (including family history) is required to assess whether any co-morbidities are currently present or whether further tests may be required for diagnosis in certain patients. NICE

Table 1: Classification of Adults

Classification	BMI (kg/m^2)	Waist Circumference		Co-morbidities present
		Low Men < 94cm Women < 80cm	High Men > 94cm Women > 80cm	Type 2 diabetes Hypertension Cardiovascular Disease Dyslipidaemia Osteoarthritis Sleep Apnoea
Healthy weight	18.5-24.9			
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Diet and physical activity
Diet and physical activity; consider drugs
Diet and physical activity; consider drugs; consider surgery

10 Assessment

states that the following co-morbidities should be recorded:

- type 2 diabetes
- hypertension
- cardiovascular disease
- dyslipidaemia
- osteoarthritis
- sleep apnoea

The electronic obesity template is a helpful tool when completing the assessment stage with a patient.

Raising the Issue of Weight

Consider using the 'Raising the Issue of Weight in Adults' card from the *Your Weight, Your Health series, DH 2006* (Appendix 1) which provides helpful samples of dialogue for initiating a conversation about the patient's weight.

Assess Readiness and Motivation to Change

The Transtheoretical (Stages of Change) Model (Prochaska and DiClemente, 1982) attempts to describe readiness to change and suggests that people move through a series of stages when attempting to change their behaviour.
The stages are outlined below:

PRECONTEMPLATION
Not intending to make any changes (patient not interested in losing weight)
CONTEMPLATION
Considering a change (patient is thinking about trying to lose weight)
PREPARATION
Making small changes (patient is making small changes/ developed a plan of action)
ACTION
Actively engaging in change (patient is making changes to their lifestyle to try and lose weight)
MAINTENANCE
Sustaining change over time (patient has lost weight and is maintaining this)

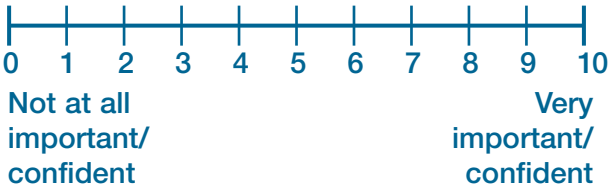
The model has gained widespread popularity and has intuitive appeal to many practitioners. However, although it provides a useful framework for thinking about behaviour change, it has been criticised for being deficient in providing insight into how to negotiate/influence behaviour change.

Readiness can be understood and roughly assessed by enquiring about the importance of change to the patient and the degree of confidence the patient has in his/her ability to do so.

Assessment 11

A useful strategy to do this is to use the *'Ruler'* to:-

- Clarify and enhance importance
- Increase confidence



On a scale of 0-10, how important is it to you to become more physically active?

On a scale of 0-10, how confident are you that you could make a change if you wanted to?

Clarify and Enhance Importance

- What makes it that important?
- What would have to happen for it to become much more important for you to change?
- Why are you at a X (e.g. 4) and not at a Y (e.g. 3) (lower number)?
- What would it take to raise your score to a Z (e.g. 5)?
- What concerns do you have about ... (current behaviour)?
- What are the good things and not so good things about ... (current behaviour)?

Increase Confidence

- What makes you that confident?
- If you decided to change your current behaviour (e.g. increase your levels of physical activity), what options might you consider?
- Is there anything you found helpful in any previous attempts to change your current behaviour?
- Why are you at a X (e.g. 4) and not at a Y (e.g. 3) (lower number)?
- What would it take to raise your score to a Z (e.g. 5)?
- How can I help you get there?

4 Combinations
(Miller and Rollnick, 2002)

1. ***Low importance, low confidence:*** Least ready to change, see change as unimportant, and have little confidence they could successfully make the change if they tried.
2. ***Low importance, high confidence:*** Not ready to change and see change as relatively unimportant. Believe they could make the change if they tried.
3. ***High importance, low confidence:*** High degree of importance, making them more ready and willing to change than people in groups 1 & 2 but low confidence gets in the way of them making the change.
4. ***High importance, high confidence:*** Most ready to change, view change as very important, high degree of confidence that they can successfully make the change if they tried.

The above can help you to assess where you need to focus your work, i.e. increasing confidence, importance or both.

12 First Line Advice

The aim of first-line advice is to help a patient to:

- **reduce calorie intake**
- **increase physical activity while reducing sedentary behaviours; and**
- **increase self-awareness about day-to-day behaviours that affect intake and activity levels.**

(DH, Your Weight, Your Health, 2006)

Assess

1. Assess dietary consumption using a record of the patient's food and fluid intake. This can be done in any form which is easy for the patient to report back and discuss with you their food and fluid intake (see Appendix 2).
2. Assess physical activity levels using the General Practice Physical Activity Questionnaire (GP PAQ) (see Appendix 3).

The GP Physical Activity Questionnaire (GP PAQ)

- The GP PAQ is used to measure a patients (aged 16+) physical activity levels.
- It takes 30 seconds for a patient to complete
- It takes between 1-2 minutes for the health practitioner to input data into an excel sheet and analyse result

It should be recorded and updated:

- Every year for patients at risk of CVD
- Every five years for all other patients

The questionnaire looks at how active the patient's daily life is (see appendix 3 for the questionnaire). An algorithm is then used to create a score from their answers.

Essentially it classifies patients as:

Sedentary	0 hours per week
Moderately Inactive	Less than 1 hour per week
Moderately Active	More than 1 hour per week, less than 3
Active	3 or more hours per week

Please note, walking, housework, childcare, gardening and DIY are in the questionnaire. However, it is very important to note that these are **not** included in the result.

If your patient does not score an "active" rating but has answered the walking, housework, childcare, gardening and DIY category, please talk to them about whether this activity is **moderate** (in minimum of 10 minute blocks). Use your training to judge whether this level of activity is sufficient.

If you are convinced that their activity does classify as moderate, add this to the notes in your EMIS template so that you can refer back to it on your next appointment. If someone does not score an active rating (after you have talked to them about walking), you should discuss their activity levels using behavioural change techniques.

The GP PAQ and excel spreadsheet can be downloaded at the Department of Health website www.dh.gov.uk

First Line Advice 13

Advise

1. Discuss general healthy eating recommendations taking into consideration what they are eating and drinking at present. Consider using The Eat Well Plate model (below).

2. Discuss physical activity – promote 5 X 30mins (to gradually build up to accumulate 30mins of moderate physical activity on 5 or more days a week).
3. Providing *Your Weight, Your Health* booklet (DH) which combines information on healthy eating and physical activity. Consider providing relevant leaflets from the British Heart Foundation range e.g. physical activity for weight loss.

Agree

Agree **SMART** goals in ***partnership*** with your patient:

Specific	"I will partake in 30 minutes of brisk walking 3 times a week".
Measurable	"I will eat 3 portions of fruit/vegetables every day".
Achievable	Negotiate goals that can be accomplished, e.g. losing 0.5kg per week.
Relevant	Goals should meet the patient's expectations, e.g. if the patient enjoys walking, a goal based around walking would be relevant.
Timely	Negotiate a time-frame for achieving the goal that is specific and realistic. This could be an interim goal working towards a achieving a main goal.

The goals may be specific to healthy eating and/or physical activity.

Agree a target weight loss. Very small levels of weight loss produce health benefits but significant changes result after a 5-10% weight loss. This can be achieved over 3 to 6 months, representing a loss of 0.5-1.0kg per week.

14 First Line Advice

Assist/Arrange

1. Signpost to local physical activity and healthy eating initiatives.
2. Provide information on electronic and paper resources.
3. Arrange referrals to other health professionals (e.g. dietician) and other programmes (e.g. 'Active for Life' physical activity referral scheme).

'Active for Life' Physical Activity Referral Scheme

See Appendix 4.This scheme is currently running in some wards but will be extended gradually across the Borough from April 2008.

Suitable for patients who:

- Lead sedentary lifestyles and are not physically active but indicate a desire to increase activity levels
- Do **NOT** require continuous one-to-one attention
- Have **NOT** been on the scheme before
- Live in Haringey or registered with a Haringey GP

Must be classified as inactive/moderately inactively using the GP PAQ and have one of the following conditions:

- Type II diabetes
- Hypertension
- Obesity (BMI >30)
- Cerebrovascular accident
- Peripheral Vascular Disease
- Established CHD
- Severe mental illness eg. bi-polar, schizophrenia

Group Health Walks Programme - 'Walk Your Way to Health'

Short walks in local parks and neighbourhoods lead by trained volunteer Walk Leaders. All walks are free and all abilities are catered for.

For more information about the 'Active for Life' and 'Walk Your Way to Health' programmes contact the Team Administrator on 020 8442 6786.

Follow Up 15

Weight loss needs to be monitored and recorded over time: the suggested minimum is 3-6 months but more often if the patient wants or requires active support.

3-month Review

>5% = successful weight loss -
Continue with the ongoing treatment and support.

<5% = unsuccessful weight loss -
Reassess motivation and readiness to change, and identify any problems which may have impacted on the lack of success so far. Repeat first line support if the patient is still ready to change.

1. Repeat first line advice - explore information and support the patient to increase their own knowledge around diet and physical activity.
2. Identify any problem areas - explore and work through them in partnership with the patient, moving towards a balanced healthier lifestyle.
3. Revise SMART goals.

Weight loss needs to be monitored and recorded over time

6-month Review

Repeat as at 3 months.

>5% = successful weight loss –
Action as at 3 months or consider moving patient to maintenance phase.

<5% = unsuccessful weight loss –
Reassess patient's motivation to change and consider referral to a dietitian for a more comprehensive assessment.

(See Appendix 6 Dietetic Referral Form)

16 Second Line Advice

Dietitian Assessment

- The dietitian will provide a more comprehensive lifestyle assessment.
- All patients must have seen a dietitian prior to being prescribed pharmacotherapy or being referred for bariatric surgery.
- Dietitians should follow the care package of dietetic care.

For more information regarding accessing the Nutrition and Dietetic Service contact the Administration Manager on 020 8442 6476.

Third Line Advice 17

GP Assessment

The GP acts as the gatekeeper for further treatment for patients if they have been unsuccessful in their attempts to lose weight and need additional assistance with weight loss as directed by the dietitian. For example, certain patients may be referred by the dietician to the GP for consideration for pharmacotherapy/ bariatric surgery.

Pharmacotherapy

- Patients should be encouraged to attempt diet, physical activity and behaviour change before prescribing drugs.
- Drug therapy should always be considered as an addition, rather than an alternative, to lifestyle intervention.

Orlistat, Sibutramine and Rimonabant are all licensed for use in England.

Patients should be encouraged to attempt diet, physical activity and behaviour change before prescribing drugs

Orlistat

Orlistat inhibits the action of pancreatic lipase enzyme in the gastrointestinal system and must therefore be taken in conjunction with a low-fat eating plan.

Confirm patient meets the specified criteria prior to prescribing the pharmacotherapy:

- Aged between 18-75 years.
- Have a BMI of >30kg/m2 or >28kg/m2 plus comorbidity.
- Monitor weight loss and continue treatment if 5% weight loss at 3-months.

Advise a patient to register with Motivation, Advice, Proactive Support (MAP) programme:
0800 731 7138
www.xenicalmap.co.uk

Sibutramine

Sibutramine is a satiety enhancer and should be taken in conjunction with healthy eating.

Confirm patient meets the specified criteria prior to prescribing the pharmacotherapy:

- Aged between 18-65 years.
- Have a BMI of >30kg/m2 or >27kg/m2 plus comorbidity.
- All patients should have controlled blood pressure (145/95 or below) and have no history or coronary artery disease, arrhythmias, congestive heart failure or stroke.
- Monitor weight loss and continue treatment if 5% weight loss at 3-months.

18 Third Line Advice

Advise a patient to register with the online support 'Change for Life' programme: www.changeforlifeonline.com

Patients are eligible for the 'Change for Life' programme pack. Health professionals can obtain copies of the pack from Abbott Laboratories (01628 644 9392).

Monitoring requirements for Sibutramine:

- Check the patient's blood pressure every 2 weeks for the first 3 months.
- After 12 weeks on Sibutramine, patients should only continue taking the drug if they have lost at least 5% of their body weight since the start of the treatment.
- Patients should show a 2kg weight loss after 4 weeks on Sibutramine. If they do not, you can increase the dosage from 10mg a day to 15mg a day.
- The Sibutramine licence recommends that treatment should not continue beyond 12 months.

Rimonabant

Unlike Orlistat and Sibutramine, NICE have not yet reported on Rimonabant.

- A newer drug and much less is known about its effectiveness.
- Problems with adherence due to side effects have been reported.

Fourth Line Advice 19

Bariatric Surgery

Bariatric surgery is generally only considered for patients who have tried all other interventions, for example, healthy eating and physical activity, and pharmacotherapy.

Bariatric surgery reduces gastric size and thus may result in malabsorption of ingested food. Patients will need to make lifestyle changes after surgery and will therefore continue to require dietetic support.

Surgery can be considered for patients who meet the following criteria:

- Have a BMI >40kg/m2 or a BMI of 35-40kg/m2 plus comorbidity
- Have been assessed by a multidisciplinary team
- Are well-informed and motivated
- Have an acceptable level of surgical risk.

The Whittington Hospital is our main provider for bariatric surgery. Applications for bariatric surgery will be assessed on an individual basis.

20 Maintenance

Ongoing monitoring of weight should take place and this will ensure that patients are referred back into the pathway should they have a relapse in weight maintenance. Consider setting goals to help them adhere to changes made in the weight loss phase.

Resources 21

Resources

- **Your Weight, Your Health - Raising the Issue of Weight in Adults (DH)**
  A card to assist health professionals with raising the issue of weight with patients.
- **Your Weight, Your Health – How to Take Control of Your Weight (DH)**
  A booklet for patients who are ready to think about losing weight.
- **Your Weight, Your Health – Why Weight Matters card (DH)**
  For patients who are not yet committed to losing weight. This card discusses the risks associated with overweight, the benefits of modest weight loss, and practical tips for people to consider.

The Your Weight, Your Health series can be ordered from DH publications.
The DH 'Your Weight, Your Health' publications are available free of charge: you can place an order by post, telephone, fax or email (quote the title and reference number).

Write to:
DH Publications Order
PO Box 777
London SE1 6XH
Telephone: 0870 155 54 55
Fax: 0162 372 45 24
Email: dh@prolog.uk.com

Publications:

- Raising the Issue of Weight in Adults – ordering code 274543
- Why Weight Matters card – ordering code 274538
- Your Weight Your Health: how to take control of your weight – ordering code 274537

www.bdaweightwise.com
A website by registered dietitians giving advice on healthy eating.

British Heart Foundation (BHF) Physical Activity Leaflets
The BHF have produced a series of patient physical activity leaflets for specific conditions.

- Physical activity and weight loss (G99)
- Physical activity and high blood pressure (G101)
- Physical activity and angina (G98)
- Physical activity after a heart attack (G100)
- Physical activity and diabetes (G102)

They can be ordered from the BHF:-
BHF order line: 0870 600 6566 or online at www.bhf.org.uk

www.bdaweightwise.com
A website by registered dietitians giving advice on healthy eating.

22 References

Useful PCT Contacts

Haringey Nutrition and Dietetics Department
General Number: 020 8442 6476

Haringey Public Health Directorate
General Number: 020 8442 6786

References

1. National Institute for Health and Clinical Excellence (2006). Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children.

2. National Institute for Health and Clinical Excellence (2006). Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.

Appendix

1. Raise issue of weight (DH)
2 Food Diary
3. General Practice Physical Activity Questionnaire (GP PAQ)
4. Physical Activity Scheme Referral Form
5. CHD GP Exercise Referral Form
6. Dietetic Referral Form

Appendix 1

Part of the YOUR WEIGHT, YOUR HEALTH Series

NHS

Raising the Issue of Weight in Adults

1 RAISE THE ISSUE OF WEIGHT

If BMI is ≥25 and there are no contraindications to raising the issue of weight, initiate a dialogue:

'We have your weight and height measurements here. We can look at whether you are overweight. Can we have a chat about this?'

2 IS THE PATIENT OVERWEIGHT/OBESE?

BMI (kg/m^2)	Weight classification
<18.5	Underweight
18.5–24.9	Healthy weight
≥25–29.9	Overweight
≥30	Obese

Using the patient's current weight and height measurements, plot their BMI with them and use this to tell them what category of weight status they are.

'We use a measure called BMI to assess whether people are the right weight for their height. Using your measurements, we can see that your BMI is in the [overweight or obese] category [show the patient where they lie on a BMI chart]. When weight goes into the [overweight or obese] category, this can seriously affect your health.'

WAIST CIRCUMFERENCE	
Increased disease risk	
Men	*Women*
≥40 inches (≥102cm)	≥35 inches (≥88cm)
Asian men	*Asian women*
≥90 cm	≥80 cm

Waist circumference can be used in cases where BMI, in isolation, may be inappropriate (eg in some ethnic groups) and to give feedback on central adiposity. In Asians, it is estimated that there is increased disease risk at ≥90cm for males and ≥80cm for females.

Measure midway between the lowest rib and the top of the right iliac crest. The tape measure should sit snugly around the waist but not compress the skin.

3 EXPLAIN WHY EXCESS WEIGHT COULD BE A PROBLEM

If patient has a BMI ≥25 and obesity-related condition(s):

'Your weight is likely to be affecting your [co-morbidity/condition]. The extra weight is also putting you at greater risk of diabetes, heart disease and cancer.'

If patient has BMI ≥30 and no co-morbidities:

'Your weight is likely to affect your health in the future. You will be at greater risk of developing diabetes, heart disease and cancer.'

If patient has BMI ≥25 and no co-morbidities:

'Any increase in weight is likely to affect your health in the future.'

4 EXPLAIN THAT FURTHER WEIGHT GAIN IS UNDESIRABLE

'It will be good for your health if you do not put on any more weight. Gaining more weight will put your health at greater risk.'

5 MAKE PATIENT AWARE OF THE BENEFITS OF MODEST WEIGHT/WAIST LOSS

'Losing 5–10% of weight [calculate this for the patient in kilos or pounds] at a rate of around 1–2lb (0.5–1kg) per week should improve your health. This could be your initial goal.'

If patient has co-morbidities:

'Losing weight will also improve your [co-morbidity].'

Note that reductions in waist circumference can lower disease risk. This may be a more sensitive measure of lifestyle change than BMI.

6 AGREE NEXT STEPS

Provide patient literature and:

- **If overweight without co-morbidities:** agree to monitor weight.
- **If obese or overweight with co-morbidities:** arrange follow-up consultation.
- **If severely obese with co-morbidities:** consider referral to secondary care.
- **If patient is not ready to lose weight:** agree to raise the issue again (eg in six months).

Appendix 1

BACKGROUND INFORMATION

Raising the issue of weight

Many people are unaware of the extent of their weight problem. Around 30% of men and 10% of women who are overweight believe themselves to be a healthy weight.[1] There is evidence that people become more motivated to lose weight if advised to do so by a health professional.[2]

Health consequences of excess weight

The table below summarises the health risks of being overweight or obese.[3] In addition, obesity is estimated to reduce life expectancy by between 3 and 14 years. Many patients will be unaware of the impact of weight on health.

Greatly increased risk

- type 2 diabetes
- gall bladder disease
- dyslipidaemia
- insulin resistance
- breathlessness
- sleep apnoea

Moderately increased risk

- cardiovascular disease
- hypertension
- osteoarthritis (knees)
- hyperuricaemia and gout

Slightly increased risk

- some cancers (colon, prostate, post-menopausal breast and endometrial)
- reproductive hormone abnormalities
- polycystic ovary syndrome
- impaired fertility
- low back pain
- anaesthetic complications

Benefits of modest weight loss[4]

Patients may be unaware that a small amount of weight loss can improve their health.

Condition	Health benefits of modest (10%) weight loss
Mortality	• 20–25% fall in overall mortality • 30–40% fall in diabetes-related deaths • 40–50% fall in obesity-related cancer deaths
Diabetes	• up to a 50% fall in fasting blood glucose • over 50% reduction in risk of developing diabetes
Lipids	• 10% fall in total cholesterol, 15% in LDL, and 30% in TG, 8% increase in HDL
Blood pressure	• 10 mmHg fall in diastolic and systolic pressures

Realistic goals for modest weight/waist loss (adapted from Australian guidelines)[5]

Duration	Weight change	Waist circumference change
Short term	2–4kg a month	1–2cm a month
Medium term	5–10% of initial weight	5% after six weeks
Long term	10–20% of initial weight	aim to be <88cm (females) aim to be <102cm (males)

Patients may have unrealistic weight loss goals.

The need to offer support for behaviour change

The success of smoking cessation interventions shows that, in addition to raising a health issue, health professionals need to offer practical advice and support. Rollnick et al suggest some ways to do this within the primary care setting. Providing a list of available options in the local area may also be helpful.[6]

Importance of continued monitoring of weight

Weight monitoring can be a helpful way of maintaining motivation to lose weight. Patients should be encouraged to monitor their weight regularly.[7] Interventions for smoking cessation have found that behaviour change is more successful when follow-ups are included in the programme.[8]

[1] Wardle J and Johnson F (2002) Weight and dieting: examining levels of weight concern in British adults. Int J Obes 26: 1144–9.

[2] Galuska DA et al (1999) Are health care professionals advising obese patients to lose weight? JAMA 282: 1576–8.

[3] Jebb S and Steer T (2003) Tackling the Weight of the Nation. Medical Research Council.

[4] Department of Health (2002) Prodigy Guidance on Obesity. Crown Copyright.

[5] NHMRC (2003) Clinical practice guidelines for the management of overweight and obesity in adults. Commonwealth of Australia.

[6] Rollnick S et al (2005) Consultations about changing behaviour. BMJ 331: 961–3.

[7] O'Neil PM and Brown JD (2005) Weighing the evidence: Benefits of regular weight monitoring for weight control. J Nutr Educ Behav 37: 319–22.

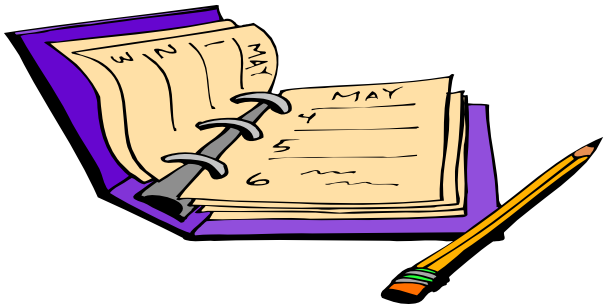
[8] Lancaster T and Stead LF (2004) Physician advice for smoking cessation. Cochrane Database of Systematic Reviews, 4.

Produced by COI for the Department of Health. First published April 2006

Haringey NHS
Teaching Primary Care Trust

SEVEN – DAY

FOOD RECORD DIARY



Name: ..... D.O.B: .....

Surgery: ..... Dietitian: .....

Please aim to complete the diary for 7 seven days before your appointment with the dietitian.

- Please give an idea of how much you eat and drink. Use household measures such as teaspoons, tablespoons, mugs, cups
- Remember to include all food and drink consumed inside and outside of your home, including snacks.
- Include details of how food was cooked and the name of any 'brand foods' used, e.g. yoghurt, chicken with skin on, Flora proactive, Muller Light.
- **Remember to bring this diary with you when you come and see the dietitian**.

Produced by Dietitians in Haringey
January 2005

Date:		
TIME	**FOOD / DRINK**	**AMOUNT**
MORNING		
MID AM		
LUNCH		
MID PM		
EVENING MEAL		
SNACKS		

Appendix 2

Appendix 3

General Practice Physical Activity Questionnaire

Date ..... Name. .....

1. Please tell us the type and amount of physical activity involved in your work.

		Please mark one box only
a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

Please mark one box only on each row

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

Appendix 4

ACTIVE FOR LIFE

Haringey NHS
Teaching Primary Care Trust

PHYSICAL ACTIVITY REFERRAL SCHEME
REFERRAL FORM

Please do not refer patients with the following contraindications: B/P ≥ 180/100 * Resting tachycardia ≥ 100 bpm
Uncontrolled atrial/ventricular arrhythmias * Unstable or acute heart failure * Febrile illness * Unstable angina
Unstable/untreated congestive cardiac failure * Chest pains/shortness of breath at low levels of activity* uncontrolled pathologies
Active pericarditis or myocarditis * Uncontrolled acute systemic illness * acute mental illness/in crisis

FOR PATIENTS WITH ESTABLISHED CHD - USE CHD FORM TO REFER

Patient's details:	**Referrers' details:**
	(or practice stamp) GP ☐ Practice Nurse ☐
FULL NAME:	FULL NAME:
ADDRESS:	ADDRESS:
POSTCODE:	POSTCODE:
TEL NO:	TEL NO:
	FAX:
DATE OF BIRTH: *male / female* (delete as applicable)	EMAIL:

GPPAQ INACTIVE ☐ MODERATELY INACTIVE ☐

Please tick which area your patient lives in
Noel Park ☐ Bruce Grove ☐ Northumberland Park ☐

REFERRAL REASON:

DIABETES TYPE II ☐ HYPERTENSION ☐ HYPERLIPIDEMIA ☐
OBESE BMI > 30 ☐ SEVERE MENTAL ILLNESS ☐ CVA ☐
(eg. Schizophrenia, please refer to manual for classification)

Other medical conditions/additional information: *Please mention any mobility issues or exercise limitations*

Current medication: *Please list all medications continue on separate sheet if necessary*

Baseline measurements:

B/P	Height:	BMI:	Any planned procedures/tests:
Pulse rate:	Weight:	Blood Sugar: HbA1c *If diabetic*	

Patient consent:
Patient understands they are taking part in a physical activity scheme ☐
Patient has agreed to have their information passed on to the Active for Life Team ☐
Patient has been informed that they will be invited to participate in a research project ☐
Patient's Signature:

Language spoken:
English ☐
Other:

Please give name and number of relative or friend who can translate
Name: **Tel:**

Please return form to:

Project Administrator
Physical Activity Referral Scheme
Public Health Directorate, Block A1
St Ann's Hospital, St Ann's Road
London, N15 3TH

Tel: 0208 442 6786

Referrer's signature: **Date:**

Appendix 5

CHD GP EXERCISE REFERRAL FORM

To be completed by the Referring Doctor or designated health professional Please print clearly

Patient Details

Name:_____
Address:
_____
_____
Postcode: _____D.O.B._____ Age:___
Telephone Home:_____
Telephone Work: _____

Referrer's Details

Name & Profession:_____
Surgery / Department: _____
Address: _____
_____
Postcode: _____
Telephone:_____

Cardiac History

✓ if applicable

MI: ❑ Date: _____
Angioplasty / Stent: ❑ Date:_____
CABG: ❑ Date:_____
Heart Failure: ❑ ICD: ❑ Pacemaker: ❑
Other Event/s:_____
_____ Date:_____

Current Angina: ❑ At Rest: ❑ On Exertion: ❑ GTN:❑ Current Dyspnoea: ❑ Arrhythmias:❑

Current Medication

✓ **if prescribed** (attach prescription list if available)

Aspirin	❑	Beta blocker	❑	Ace Inhibitor	❑	Statin	❑
Clopidogrel	❑	Warfarin	❑	Diuretic	❑	Nitrate	❑
Anti-arrhythmic	❑	Calcium channel blocker	❑	GTN	❑	Other:_____	

Investigations (if available)

ETT: Yes ❑ No ❑ Date: _____ LV Function:
Result:_____ Good ❑ Moderate ❑ Poor ❑

Current Status - CHD Risk Factors

Resting BP _____ Resting Heart Rate_____ BMI _____ Stable Type 1/Type 2 Diabetes ❑
Raised Cholesterol ❑ Physically Inactive ❑ Smoker ❑ Excess Alcohol ❑ Stress ❑

Past Medical History

✓ if applicable, please supply dates & details as far as possible

COAD / Asthma ❑ Epilepsy ❑ Hypertension ❑ Claudication ❑
CVA / Neuro. Problems ❑ Ortho/musc. skeletal problems ❑ Details:_____
Other considerations:_____

IMPORTANT NOTICE

- ❑ The patient exhibits no contraindication to exercise (as indicated on the protocol)
- ❑ The patient is clinically stable
- ❑ The patient is compliant with medication
- ❑ The patient is awaiting / not awaiting further medical or surgical treatment (see protocol)

REFERRER'S SIGNATURE:_____
Print Name:_____ Date:_____
GP's signature (if different from above):_____
Print Name: _____ Date:_____

PATIENT INFORMED CONSENT

I agree for the above information to be passed onto the Exercise Instructor. I understand that I am responsible for monitoring my own responses during exercise and will inform the instructor of any new or unusual symptoms. I will also inform the instructor of any changes in my medication, the results of any investigations or treatment.

PATIENT SIGNATURE:_____
Print Name:_____Date:_____

Appendix 6

Haringey NHS Teaching Primary Care Trust

REFERRAL FORM TO THE SPECIALIST PRIMARY CARE DIETITIANS

Please note that if this form is not completed in full it will be sent back to the referrer, as this will be deemed as a clinical risk

DATE OF REFERRAL	
PATIENTS NAME	
NHS NUMBER-This must be completed	
ADDRESS AND POSTCODE	
PATIENTS TELEPHONE NUMBER	
DATE OF BIRTH	
DOES THIS PATIENT REQUIRE A HOME VISIT	Yes 1 No 1 If yes, why is it **clinically** essential?
MEDICAL CONDITION(S) REQUIRING REFERRAL	
OTHER RELEVANT AND PAST MEDICAL HISTORY	
RELEVANT BIOCHEMISTRY (Written or attached to referral)	
CURRENT MEDICATION (Written or attached to referral)	
IS AN INTERPRETOR NEEDED?	Yes 1 No 1 PLEASE STATE LANGUAGE
DO YOU THINK THIS PATIENT WOULD BE SUITABLE FOR A GROUP SESSION?	Yes 1 No 1
NAME OF REFERRER-In bold -please state healthcare profession employed by Haringey TPCT	
G.P NAME AND ADDRESS (Practice stamp may be used)	
G.P SIGNATURE	
COLLABORATIVE: SE 1 SW 1 NE 1 NW1	

If you only have one clinic a month or do not currently have direct access to a Dietitian in Primary Care please send this referral to: Nutrition and Dietetic Service, H Block, St. Anns Hospital, St Anns Road, Tottenham N15 3TH
Tel: 020 8442 6476 / Fax: 020 8442 6476
Please leave all other referrals at the surgery to be triaged by the Dietitian.

Appendix 6

Haringey NHS
Teaching Primary Care Trust

SPECIALIST PRIMARY CARE DIETETIC SERVICE REFERRAL PROTOCOL

How to access our service:

WE DO NOT ACCEPT SELF REFERRALS FROM PATIENTS

CLINICAL REFERRALS IN WRITING TO

- The Dietitian at your own surgery (Dietitian to triage referrals)
- For practices who only have 1 clinic per month or for those who do not currently have direct access to Primary Care Dietetic service to send referrals to Nutrition and Dietetic Service, St. Anns, H Block, St Anns Road, Tottenham N15 3TH Tel: 020 8 442 6476 / Fax: 020 8 442 6476
- Computer referrals will be accepted at present but cannot be appropriately triaged.

OTHER REQUEST, QUERIES AND ASSISTANCE

By phone, in writing or in person initially at address given above

Please note that if this form is not completed in full it will be sent back to the referrer, as this will be deemed as a clinical risk, a good referral will ensure that patients are triaged appropriately.

LIPID LOWERING

a. Patients with persistent raised fasting cholesterol of >5mmol/l or LDL >3.0 mmol/l who have **not** responded to advice from other members of the Primary Healthcare Team
b. Patients with a raised fasting triglyceride level > 2.0mmol/l

DIABETES

a. Patients with persistent raised fasting glucose > 6.0 mmol/l or HbAIc% >6.5% who have not responded to initial first line advice
b. Patients who have poorly controlled diabetes who also have complications such as renal impairment, leg ulcers, CVD and/or hypoglycaemia.

WEIGHT REDUCTION

a. Patients with a BMI greater than 30 who has a comorbidity such as CHD, hypertension, endocrine disorders including PCOS. The patient will be offered one appointment for the specialist assessment and triaged by the Dietitian into the appropriate care pathway, e.g., behaviour change programme, weight management/physical activity groups or 1:1 intensive dietary counselling focussing on motivation, drug intervention, suitability for bariatric surgery. The patient may not automatically be seen for treatment following assessment. In this situation they will be referred back to the G.P with an explanation if they were not appropriate.

CHILDREN/ADOLESCENTS

a. We can only provide specialist assessment and triaging for children who have complex health needs which include faltering growth, obesity, allergies and intolerance. Where appropriate treatment will be offered or patient will the referred on as necessary.

NUTRTIONAL SUPPORT

Any patients with the following should be given a priority referral

a. Recent unplanned weight loss
b. Post surgery, e.g., post gastrectomy, bowel resection
c. Cancer cachexia, weight loss, poor appetite
d. Swallowing difficulties, e.g., post CVA, dysphagia
e. Home Enteral Feeding
f. Disease related malnutrition, e.g., degenerative neurological disorders
g. Please note patients requiring nutritional support for cosmetic reasons will **not** be accepted.

DIGESTIVE DISORDERS

a. Bowel disorders/bowel disease. Priority will be given to those patients who are rapidly losing weight and/or require symptom relief from pain, diarrhoea or severe constipation.

OTHER

a. Patients who have mental health (CPA or risk assessment must be attached as appropriate) or learning difficulties (please ensure that the key worker or carer attends with the patient) can still access Primary Care services if they fit any of the above criteria.
b. **Domiciliary visits** can be arranged with your Dietitian for house-bound patients who have complex health needs and are at risk of hospital readmission

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haringey strategic partnership

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

Date: **2 October 2008**

Report Title: **Sport and Physical Activity Participation Improvement Plan – HARIACTIVE**

Report of: **Director of Adult, Culture and Community Services**

1. Summary:

1.1 "Healthier people with a better quality of life" is one of the 6 outcomes sought through the Haringey Community Strategy 2007-2016.

Participation in sport and physical activity can make an important contribution towards this outcome by improving both physical and emotional health, reducing public expenditure on health services and promoting a sense of pride and achievement through the efforts and accomplishments of local people.

1.2 This is underpinned in the Local Area Agreement outcomes where there are 4 national indicators that sport and physical activity participation can contribute to. These are:

- NI 6 – Participation in regular volunteering
- NI 8 - (Stretch target) Adult (16 plus) participation in sport and physical activity.
- NI 56 – Obesity levels amongst primary school age children in Year 6.
- NI 121 – Mortality rate from all circulatory diseases at ages under 75.

1.3 The principal focus of the Council's current work is towards achieving an increase in adult participation. This is based on the result of the Active People survey that was first undertaken in 2005/6. This established a range of key performance indicators for participation in sport and physical activity with the key indicator being KPI 1 :- the proportion of adults participating three times a week for thirty minutes at moderate intensity. The result from 2006 was 22.9% and the HSP and the Council are seeking to achieve 26.9% by 2010.

1.4 Reducing obesity levels amongst young people with a particular focus on year 6 arises out of the Government white paper – "Every Child Matters" and is a target within the Children and Young People's Plan.

1.5 There are strong links between the adult increasing physical activity participation target and the Transforming Adult Social Care change programme for Adult Services. These links are via the principal of promoting access through the provision of information and appropriate

support with clear links to our Access Pathways Project in the Achieving Excellence programme.

1.6 There are established links between the onset of circulatory disease and a lack of physical activity. Other factors affecting circulatory disease are diet, smoking and stress.

1.7 There is currently widespread public interest in sport and physical activity because of the success achieved by the Great Britain team at the Beijing Olympics and the staging of the 2012 Olympics in London. This offers a unique window of opportunity for sport and physical activity to increase participation, particularly amongst young people and younger adults aged 16-24 who are reported as being the most enthusiastic supporters of the London 2012 Olympics (Guardian 26.8.08).

1.8 In June 2008, interim (half yearly results) from the latest Active People survey were published which though not statistically valid because of the small sample size, reported a drop in the headline participation indicator of 3.9% from 2006. This appears to be part of a London wide trend with participation across London reducing by an average 2.7%.

1.9 Within Haringey, the Council and partners have already taken action designed to increase participation. This includes:

- Substantial additional investment in Council leisure facilities;
- Financial support through the HSP for a number of initiatives;
- Securing external funding through Sport England for new activity programmes;
- The opening of a new private sector facility "Fitness First" in Green Lanes.

HARIACTIVE is proposed to act as an umbrella for all existing sport and physical activity initiatives.

1.10 Additionally, HARIACTIVE will have a number of component parts. These are:

- <u>Development of the HARIACTIVE brand</u>.
  This would be part of a high profile campaign designed to promote awareness of the benefits of participating in sport and physical activity with targeted campaigns aimed at particular groups.
- <u>Provision of information</u>
  Lack of information about the availability of facilities and opportunities is a barrier/ impairment to sustaining and developing participation. Information would be made available via a number of mediums in order to be accessible to different target groups.
- <u>New activity</u>
  A range of new activity sessions is being planned to target particular sections of the community. These include walking, netball, keep fit, basketball and football with target groups being parents of school age/ nursery children, younger women, younger and middle aged men and people aged 45+. Geographical areas being targeted are predominantly in the East of Haringey.

1.11 The HARIACTIVE initiative is an innovative approach towards

achieving a challenging target which will require the Council and partners to be focused and sophisticated in using high quality marketing information to influence and change local people's behaviour in respect of physical activity participation. It is strongly linked to current work being undertaken in the Regional Public Health group designed to more effectively target resources through improved use of marketing information.

1.12 In order to achieve the 26.9% target, the Council, with our partners, are proposing to launch the HARIACTIVE campaign from April 2009. Whilst this will explicitly be seeking to persuade people to participate three times a week, it is anticipated that the campaign will generally help to persuade local people to become more active and hence reduce the number of local residents, currently measured at 49%, who do not participate at all.

2. Recommendations:

2.1 That the Board notes the work undertaken to date, planned initiatives to be implemented and proposals currently under development.

2.2 That the Board endorses the HARIACTIVE approach and prioritises any potential future investment for this approach in support of achieving the LAA outcomes.

2.3 That the Board notes the role of the Haringey Community Sports and Physical Activity Network (CSPAN) as the principal group leading on this target.

3. Financial Comments

3.1 Any proposed development requiring funding will need to be considered as part of the Pre Business Planning process for 2009/10. As there are limited resources for new revenue investment proposals, any items must meet a key priority in the Council Plan.

3.2 The major proposal arising from the report is to initiate a high profile campaign from April 2009 to persuade more people to become more active (HARIACTIVE). Core funding for the campaign is to be provided through a new grant of £100,000 from Sports England, and a total of £70,000 from Local Area Agreement top-up funding in 2008/09 and 2009/10.

4. Legal Comments

4.1 The Council has powers under section 2 of the Local Government Act 2000 to do anything that is likely to promote the economic, social or environmental well-being of their area. In determining whether or how to exercise the power to promote well-being, the Council must have regard to their Community Strategy and this is done in the current report by reference to the proposed improvement plan's contribution to achieving one of the six outcomes of the Community Strategy – "Healthier people

with a better quality of life".

For more information contact:

Name: Paul Ely
Title: Policy & Development Manager, Recreation Services, Haringey Council
Tel: 020 8489 5690
Email address: paul.ely@haringey.gov.uk

5. Background

5.1 The 2005/6 Active People was a national survey of 363,724 adults in England with 1,012 respondents from Haringey. From the national results, there was a high correlation between the proportion participating three times a week and KPIs 3, 4, & 5 for sports club membership, receiving tuition or coaching and taking part in organised competitive sport. The key results are set out below.

KPI no.	***Indicator***	***Proportion of population***
KPI 1	Participating three times a week	23%
KPI 7	Participating twice a week	7%
KPI 8	Participating once a week	12%
KPI 9	Not participating at all	49%
KPI 2	Volunteering in active recreation for at least one hour a week	2.7%
KPI 3	Membership of sports clubs	23%
KPI 4	Receiving tuition or coaching	20%
KPI 5	Taking part in organised competitive sport	11%
KPI 6	Very or fairly satisfied with sports provision in the local area	62%

5.2 246 different sports activities including walking and cycling (but not to or from work) were included as recognised activities in the Active People survey.

5.3 Sport and physical activity takes place in a range of settings and through a number of providers. These include:

- Council leisure facilities and parks
- Through other Council service providers (Youth, Adult Services, Community Education)
- Private sector health, fitness and sports clubs
- Voluntary and community sector facilities
- On housing estates
- Schools and Colleges (FE and HE)
- Through local sports clubs
- On the street (walking and cycling)
- Within the home (private fitness equipment)

5.4 There is no data available either for Haringey or nationally indicating the percentage split between these settings. However, in order to meet the participation target, an adult participating three times a week for 52 weeks would participate 156 times in a year. The total attendances from adults at the

Council's leisure facilities in 2007/8 was 847,951. This would equate to attendance by 5,436 adults three times a week for 52 weeks. This represents an estimated 13% of all adult participation which suggests that a far greater proportion of participation takes place in locations other than Council leisure centres.

5.5 There is a direct relationship between participation and people's ages, gender, ethnicity, income and whether or not they have a disability. Participation is highest amongst younger males of white ethnic origin on higher incomes who are able bodied and lowest amongst older people, females, people from a non white ethnic origin, on low incomes and disabled.

5.6 Arising out of the Active People survey and other research, there are a number of key trends or facets which will underpin the HariActive approach. These are:

5.6.1 From a survey of Haringey young people in years 6 and 9 conducted in 2006, young people are far more likely to be physically active where another family member (parent or sibling) participate in activity.

5.6.2 As previously recorded above in 12.1, there is a high correlation at a national level between participation and club membership, receiving coaching or tuition and taking part in competitive sport. In Haringey, the 2006 survey with young people recorded very low levels (38%) participating through sports clubs compared with a north London average of (46%).

5.6.3 Whilst 64% of 11-15 year olds take part in sport and physical activity at the recommended three times a week level, only 25% of 16-24 year olds participate.

5.6.4 Related to the above, a recent study for Sport England conducted by the Henley Centre suggests that the 2 major factors contributing to stopping people from participating are:

- Changes in personal circumstances (leaving school, new job, move house, have children);
- Changes in the sport experience (facility closed, nobody to organise, became too expensive)

5.6.5 Reported in the same study, 4 major facets were identified as describing the benefits from participating. These were:

- Diversion/release/ escape
- Performance – performing to the maximum of one's ability
- Social life /belonging – the feeling of being part of a team or from the social contact achieved through activity
- Exertion/fitness – feeling healthy, sleeping well, losing/ controlling weight.
- These facets were universal but depending on the individual, certain facets would be more important than others.

5.7 From the Active People survey data, Sport England, in conjunction with the marketing analysis company Experian, has developed 19 market segments which cover the whole of the adult England population. A table illustrating the proportion of each segment resident in Haringey compared with London and England together with a map showing the dominant groups in different parts of

the Borough are attached at appendices B and C. Detailed lifestyle profiles for each of these groups have been developed.

5.8 The key conclusions that can be drawn from the various studies are:

- Supporting people to sustain their participation in circumstances such as leaving school, would have the most significant impact on increasing participation overall.
- Where people have stopped participating, in order to encourage them to start again, the information recently developed by Sport England will be invaluable in targeting groups effectively through publicity initiatives and appropriate activities.

5.9 This will build on existing provision either currently being delivered or in development. The Council and partners have taken a number of actions following agreement on the LAA target designed to increase participation. These include:

- Significant investment in refurbishing and improving the Council's directly provided facilities, both indoor and outdoor.
- A review of fees and charges for leisure centres usage partly designed to increase usage and frequency of use by those on low incomes.
- The implementation of healthy walking and GP referral schemes.
- The opening for community use of the sports facilities at the Sixth Form Centre.
- A range of programmes targeting younger people.
- The ABG funded Libraries for Life project that includes a healthy walking element as part of a wider lifestyle programme.
- The Health for Haringey programme supporting community based physical activity sessions.
- Elements of the Central Government funded Community Grants scheme accessed via HAVCO.
- Other resources managed directly through the Wellbeing Partnership structure such as physical activity provision through day centres.

In respect of leisure centre usage, this has resulted in significantly increased attendances up 35% between 2006/7 and 2007/8.

5.10 A number of new initiatives are also currently being developed to be implemented in the next 9 months. These are:

- Employment of an officer to develop the sports hubs at White Hart Lane and Finsbury Park in order to increase participation and increase club membership, volunteering and coaching.
- Employment of an officer through Haringey Sports Development Trust to increase participation in walking, jogging and cycling. (Both of these posts are part funded by Sport England with match funding from Area Based Grant).
- Refurbishment of the sports pavilion in Markfield Park.
- Implementation of an extended activities programme for young people as part of the five hour offer.

5.11 The new initiatives have been developed to address the key trends and facets identified above.

<u>Governance /Coordination</u>

5.12 A structure chart setting out the proposed Governance arrangements for sport and physical activity through the Haringey CSPAN is attached at Appendix D. The CSPAN membership is from organisations a direct interest in sport and physical activity provision and is ideally placed to provide ongoing management. This will link directly to the Haringey Strategic Partnership structures, particularly for Wellbeing.

6. Use of Appendices / Tables / Photographs

Appendix A – Haringey Participation Estimates by MSOA (.pdf)
Appendix B – Market Segmentation Table (.pdf)
Appendix C – Market Segmentation Map (.pdf)
Appendix D – Proposed CSPAN structure

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HARIACTIVE (Sport & Physical Activity Participation) Action Plan

Action	**Lead Agency (s) Responsible**	**Relevant KPIs**	**Outcomes Sought**	**How are outcomes measured**	**Progress against outcomes**
Establish Community Sport and Physical Activity Network	LBH (Recreation)	All	Effective governance arrangements in place for coordinating sport and physical activity	Project plans with targets are produced for individual work streams	First CSPAN meeting to be held in October 2008
Increase participation in walking/ cycling /jogging	LBH (Recreation)	1, 7, 8, 9, 2	Improved performance against relevant KPIs through Active People survey	Active People survey report due in December 2008. Steering group to be established to coordinate progress.	

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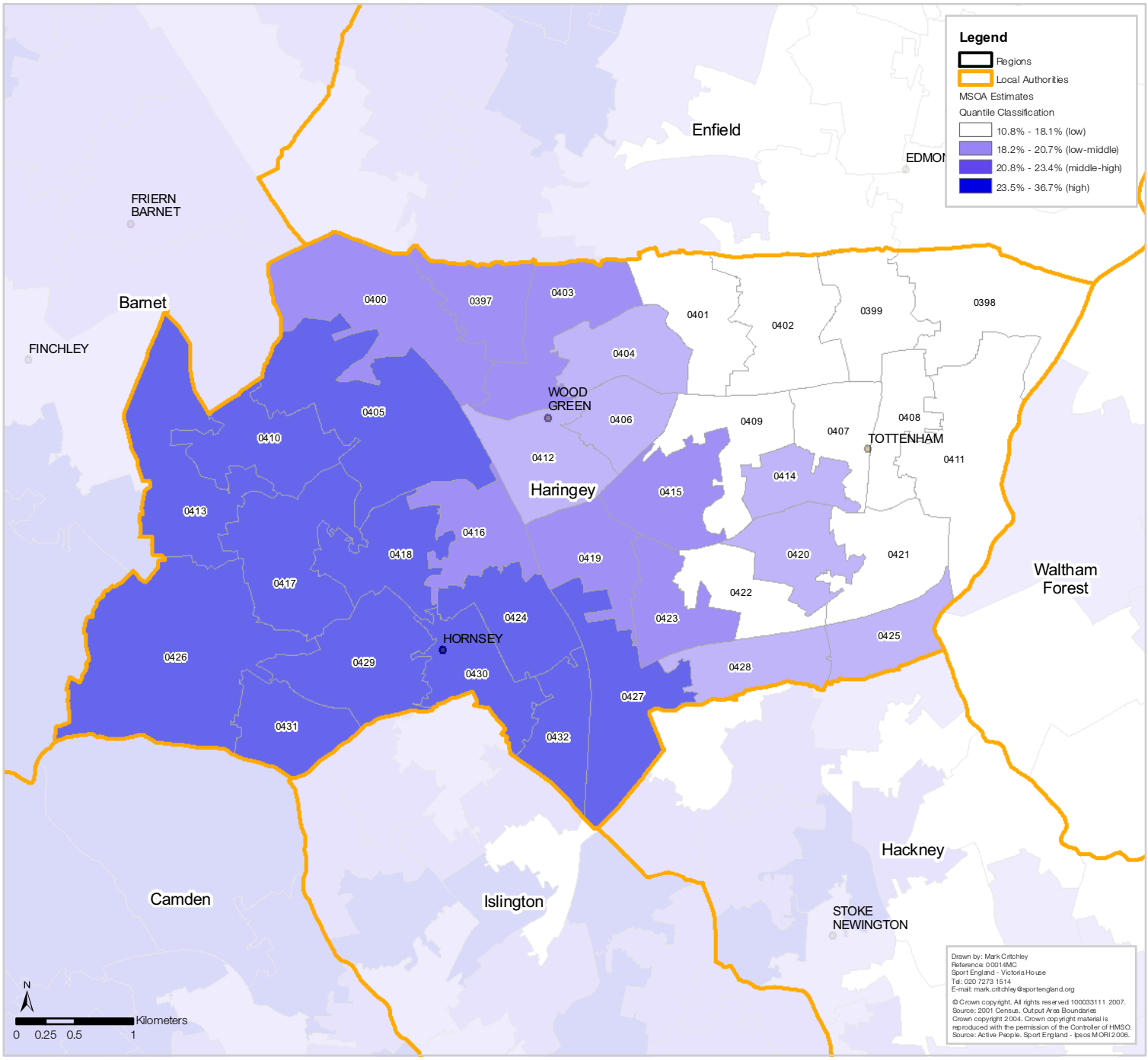
London Borough of Haringey Participation (3 x 30) Estimates by Middle Super Output Area (MSOA)



*MSOA Code	Estimate	Lower **CL	Upper **CL
E02000397	21.88%	16.81%	27.77%
E02000398	15.76%	11.76%	20.67%
E02000399	16.49%	12.51%	21.30%
E02000400	21.61%	16.56%	27.49%
E02000401	15.90%	11.84%	20.89%
E02000402	16.59%	12.58%	21.42%
E02000403	22.31%	17.15%	28.28%
E02000404	18.84%	14.02%	24.67%
E02000405	26.65%	20.51%	33.60%
E02000406	18.70%	14.16%	24.12%
E02000407	16.98%	12.84%	21.96%
E02000408	16.23%	12.32%	20.96%
E02000409	17.24%	13.05%	22.30%
E02000410	28.84%	22.30%	36.13%
E02000411	17.37%	13.19%	22.38%
E02000412	20.02%	15.01%	26.01%
E02000413	26.75%	20.72%	33.54%
E02000414	18.97%	14.37%	24.45%
E02000415	21.43%	15.94%	27.97%
E02000416	21.64%	16.59%	27.53%
E02000417	29.15%	22.59%	36.44%
E02000418	26.74%	20.47%	33.85%
E02000419	23.05%	17.49%	29.55%
E02000420	18.25%	13.88%	23.47%
E02000421	17.46%	13.18%	22.62%

*MSOA Code	Estimate	Lower **CL	Upper **CL
E02000422	17.81%	13.40%	23.12%
E02000423	21.95%	16.35%	28.62%
E02000424	25.98%	20.24%	32.44%
E02000425	19.64%	14.76%	25.49%
E02000426	26.68%	20.43%	33.79%
E02000427	24.47%	18.69%	31.14%
E02000428	18.38%	14.00%	23.58%
E02000429	29.46%	23.17%	36.38%
E02000430	28.45%	22.15%	35.46%
E02000431	31.78%	25.08%	39.06%
E02000432	26.15%	20.03%	33.11%

*Add E0200 to MSOA map label to reference correct code in table.
** Confidence Level

Participation is defined as the percent of the adult population participating in at least 30 minutes of sport and active recreation (including recreational walking and cycling) of at least moderate intensity on at least 3 days a week.

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Sport England Market Segmentation

Sport England is tasked with increasing adult participation in sport and active recreation. To achieve this it is crucial we better understand our market. To this end, Sport England has developed a segmentation model, made up of nineteen 'sporting' segments which will help us to understand the attitudes, motivations and perceived barriers to sports participation. The segmentation model enables us to develop tailored interventions, communicate more effectively with our target market and to better understand participation in the context of lifestage and lifecycles. Created by Experian Business Strategies, the segments are based on survey data (Active People and Taking Part Surveys) and external data sources (e.g. neighbourhood statistics, census data and health

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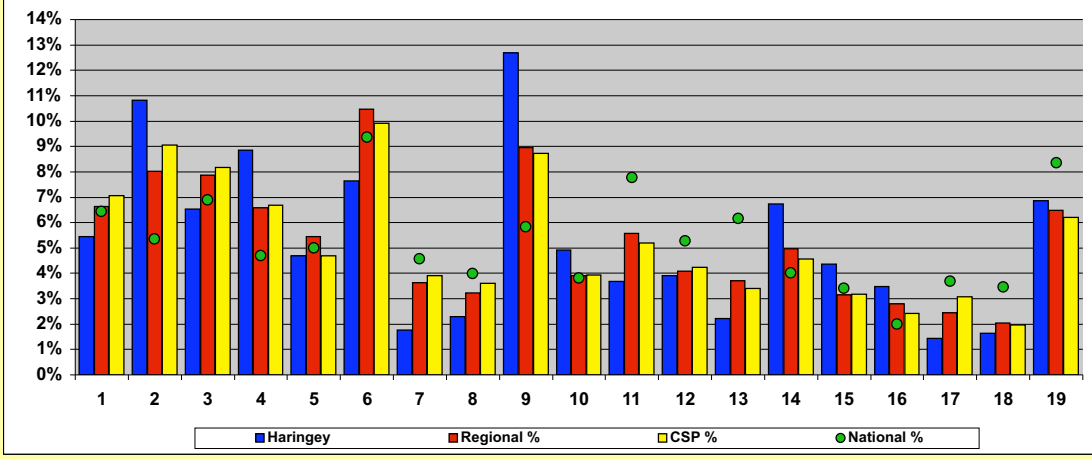
Market Segmentation for Haringey



Segment	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
LA	5.4%	10.8%	6.5%	8.9%	4.7%	7.6%	1.8%	2.3%	12.7%	4.9%	3.7%	3.9%	2.2%	6.7%	4.4%	3.5%	1.4%	1.6%	6.9%
Regional	6.6%	8.0%	7.9%	6.6%	5.4%	10.5%	3.6%	3.2%	9.0%	3.9%	5.6%	4.1%	3.7%	5.0%	3.1%	2.8%	2.4%	2.0%	6.5%
CSP	7.1%	9.1%	8.2%	6.7%	4.7%	9.9%	3.9%	3.6%	8.7%	3.9%	5.2%	4.2%	3.4%	4.6%	3.2%	2.4%	3.1%	2.0%	6.2%
National	6.4%	5.4%	6.9%	4.7%	5.0%	9.4%	4.6%	4.0%	5.8%	3.8%	7.8%	5.3%	6.2%	4.0%	3.4%	2.0%	3.7%	3.5%	8.3%

Highest % :	9	12.68%	**Segment most above National % :**	Segment 9 6.85%
Lowest % :	17	1.44%	**Segment most below National % :**	Segment 11 -4.09%
Total Population :	174,795			

The chart above shows the proportion of each of the nineteen segments in the selected local authority, set against the regional, County Sport Partnership and national distribution.

Detailed information on the nineteen segments, (which are summarised in the table opposite), is contained in 'pen portraits' (see image below).

The pen portraits outline the key characteristics of each segment, including: family status; age; social group; media consumption; participation behaviours - what sports or activities people do, factors that would encourage participation, reasons for participating and not participating; engagement in

For more information on the background to the segmentation model, how the segments were developed and to view the pen portraits and 'Frequently Asked Questions', visit the Sport England website:

www.sportengland.org/research

Segment	Segment Name	Forename (s)
1	Competitive Male Urbanites	Ben
2	Sports Team Drinkers	Jamie
3	Fitness Class Friends	Chloe
4	Supportive Singles	Leanne
5	Career Focussed Females	Helena
6	Settling Down Males	Tim
7	Stay at Home Mums	Alison
8	Middle England Mums	Jackie
9	Pub League Team Mates	Kev
10	Stretched Single Mums	Paula
11	Comfortable Mid-Life Males	Philip
12	Empty Nest Career Ladies	Elaine
13	Early Retirement Couples	Roger & Joy
14	Older Working Women	Brenda
15	Local 'Old Boys'	Terry
16	Later Life Ladies	Norma
17	Comfortable Retired Couples	Ralph & Phyllis
18	Twilight Year Gents	Frank
19	Retirement Home Singles	Elsie & Arnold

Contact your Sport England regional office for further information on how you can use the segmentation information in your

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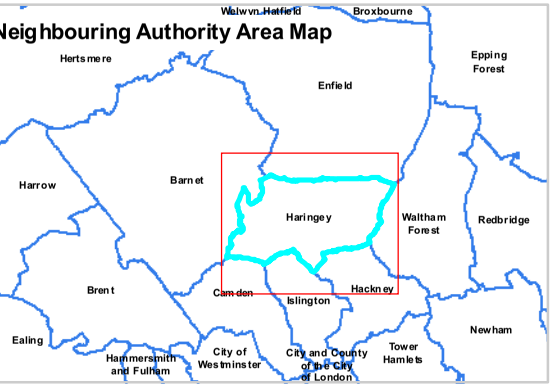
Dominant Market Segmentation Map for the Local Authority of Haringey

Dominant Market Segmentation data is shown at the Lower Super Output Area (LSOA) level. Where more than one of the 19 market segments is dominant the segment is classified as "Multiple Segments". Note that some market segments are never dominant and therefore not shown in the Lege

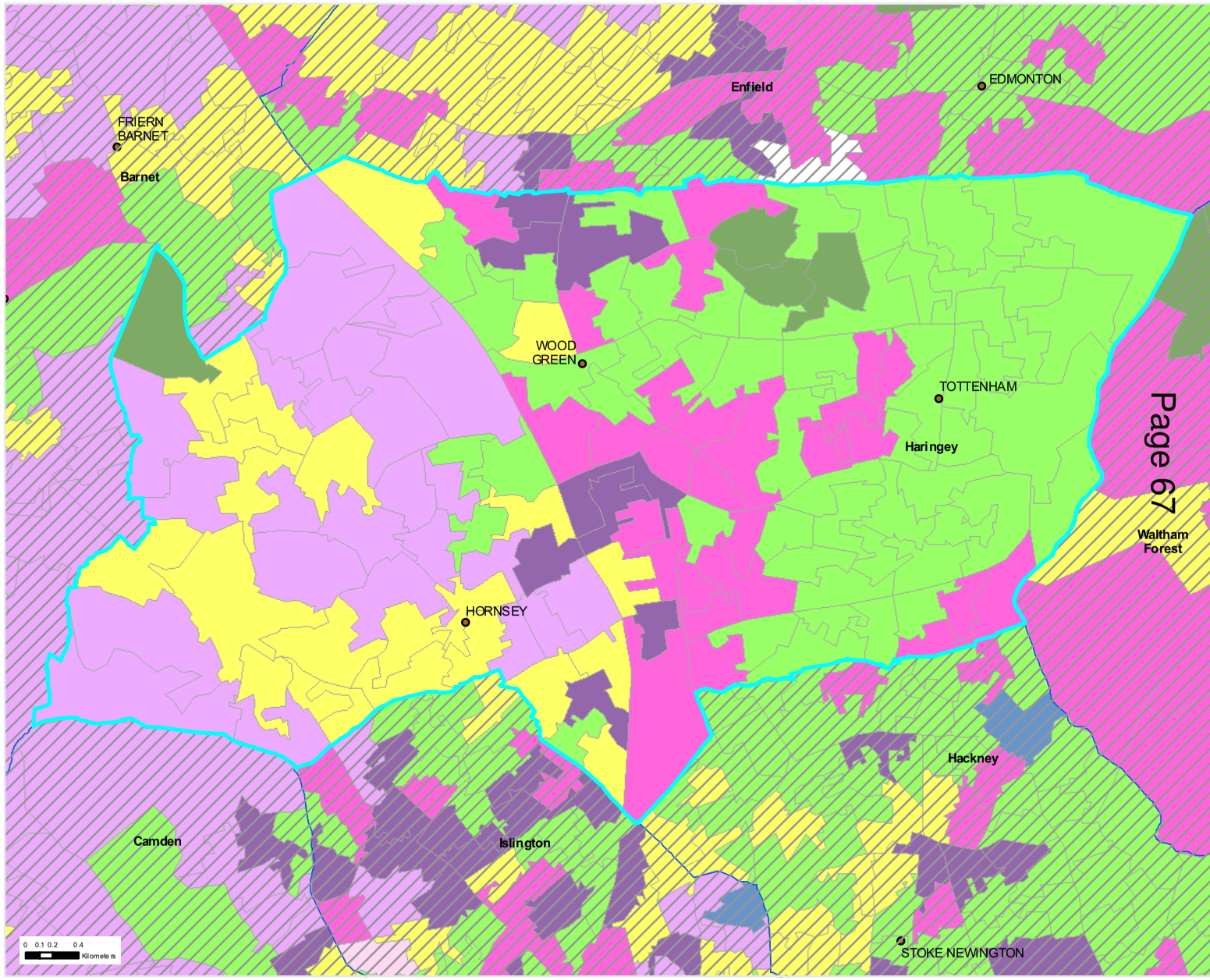


Legend

- Local Authorities
- Selected Local Authority

Dominant Segment by LSOA

- Multiple Segments
- Ben - Competitive Male Urbanites (A01)
- Jamie - Sports Team Drinkers (A02)
- Chloe - Fitness Class Friends (A03)
- Leanne - Supportive Singles (A04)
- Helena - Career Focused Females (B05)
- Tim - Settling Down Males (B06)
- Alison - Stay at Home Mums (B07)
- Jackie - Middle England Mums (B08)
- Kev - Pub League Team Mates (B09)
- Paula - Stretched Single Mums (B10)
- Philip - Comfortable Mid-Life Males (C11)
- Elaine - Empty Nest Career Ladies (C12)
- Roger & Joy - Early Retirement Couples (C13)
- Brenda - Older Working Women (C14)
- Terry - Local 'Old Boys' (C15)
- Ralph & Phyllis - Comfortable Retired Couples (D17)
- Elsie - Retirement Home Singles (D19)



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PROPOSED CSPAN STRUCTURE

People at the heart of change

An environmentally sustainable future

Economic vitality and prosperity

Safer for all

Healthier people with a better quality of life

People and customer focused

Haringey Strategic Partnership outcomes

Haringey Strategic Partnership

Wellbeing Partnership Board

Children & Young People's Partnership (reducing obesity in year 6 pupils/ volunteering

Improved Health and Emotional Wellbeing (increasing participation)

Making a positive contribution (volunteering)

Haringey Community Sport and Physical Activity Network (CSPAN)

Building schools for the future Stakeholder Group

CIF Walk /Jog/ Cycle steering group

CIF Hub /Club steering group

5 hour offer steering group (merged PESSCL and extending activity)

Clubs Forum (incorporates volunteering)

Coach Education sub group

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haringey strategic partnership

Meeting:	**Well-Being Strategic Partnership Board**
Date:	**2 October 2008**
Report Title:	**Update on Haringey Sexual Health Strategy**
Report of:	**Vicky Hobart, Head of Inequalities and Partnerships, Haringey TPCT**

Summary:

The Haringey Sexual Health Strategy 2005-2007 needs to be updated to reflect emerging national policy and a refreshed assessment of sexual health needs in the Borough, which is currently being planned.

Improving sexual health remains a national priority and sexual health outcomes relating to Chlamydia screening and reducing the late diagnosis of HIV are included in the Haringey Local Area Agreement (LAA).

Joint commissioning arrangements have supported the development of focused local sexual health promotion programmes and work to reduce teenage pregnancy. However, joint commissioning arrangements to deliver shared priorities could be strengthened, particularly for young people in transition from child to adult focused services.

An overview of the issues that will shape the new Strategy will be provided in a presentation to the Board.

Recommendations:

That the content of the presentation be noted.

Financial/Legal Comments:

None.

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haringey strategic partnership

Meeting:	**Well-Being Strategic Partnership Board**
Date:	**2 October 2008**
Report Title:	**Tackling Health Inequalities Audit Report and Action Plan**
Report of:	**Eugenia Cronin, Joint Director of Public Health, Haringey**

Summary:

Grant Thornton, the appointed external auditor for both Haringey Council and Haringey Teaching Primary Care Trust, undertook an audit of work to reduce health inequalities in the borough which was discussed at the last Board meeting.

While the audit report June 2008 (Appendix 1) was very positive, a number of areas for improvement and challenges were identified. Many of these challenges have since been addressed and the remainder will be delivered as set out in the Health Inequalities Audit Action Plan. (Appendix 2)

Recommendations:

That the Board note the Health Inequalities Audit recommendations and the Action Plan to address these recommendations.

Financial/Legal Comments:

None.

For more information contact:

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Tackling Health Inequalities in Haringey

Draft report

June 2008

Contents

Appendices Page

1 Executive summary

1.1 Context

Health inequalities are differences in health experience and health outcomes between different population groups for example, by socio-economic status, geographical area, age, disability, gender, or ethnic group.

This review assesses the extent to which public sector organisations in Haringey understand their local health inequalities; direct resources appropriately to address the gap; have arrangements in place to challenge and review their actions, and know how well they are doing.

1.2 Main conclusions

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. Although some areas for improvement have been identified, it should be noted that outcomes for local people are generally moving in the right direction.

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. We have included the replies from this survey in Appendix B for reference.

Our main conclusions are summarised below and our recommendations are detailed in Appendix A;

- 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.

  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.

- 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 its partnership work.

- We took the view that although there has been engagement with provider trusts for the Health Inequalities agenda their focus did not yet reflect their crucial role in taking HI forward. They have crucial information on people who regularly present to A&E who suffer from health inequalities and such data could be used to enhance understanding of HI issues within the Borough.

- 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 is

an opportunity for the partnership to become more involved with research institutions and to potentially identify a university with an interest in HI to join the partnership board.

- 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. There is a strong flavour of improving health and well being within the 35 targets.

- 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 an appropriate IT platform in place to support the functionality that is envisaged for the JSNA.

- There is currently a shortage of analyst skills within the public health team there is scope to work more closely with the Council in terms of providing more capacity in this area.

- Joint training in public health needs to be enhanced at all levels, we see particular benefit for joint member/NED training in this area to embed partnership working further.

- The WBPB agenda needs to be more clearly focused on Well Being Strategic Framework outcomes. Each agenda item should be clearly linked to either a HI target or future strategic development.

- The Well Being Scorecard has been developed which represents a realistic measurement tool, however at this stage it does not have the level of attention/focus at the Well Being Partnership Board that we believe it merits. We a regular report from the Well Being Chair Executive that highlights challenging areas.

- 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.

- Although the programmes identified above are all positive, we have not found evidence of corporate responsibility policies in place at partner organisations, these would enhance the development of well being programmes across the Borough and provide an example to other organisations which Haringey works in conjunction with.

Our detailed findings are highlighted in Section 3 of the report.

2 Background and context

2.1 Background

At present, there are significant levels of health inequality in some parts of the country. The basis of the issue is that some groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than the average and other groups of the population. Understanding which groups of the population these are and doing something about it is the underlying principle of this review.

The existence of health inequalities in their own right presents risks to public sector organisations. Deprived communities and their populations suffering from ill-health and increased morbidity will reduce access to work opportunities and contribute to levels of poverty and economic decline. People suffering from increased ill-health required increased support in terms of incapacity benefit and income support.

Premature death causes economic impacts in a wide variety of ways. The direct costs to health services alone of dealing with death through accidents, coronary heart disease, cancer, stroke and mental illness, as well as other issues, are well documented.

2.2 National context

Health and wellbeing is a key national focus for improvement. Narrowing the health gap between the most disadvantaged groups and the rest of the country is a top government priority. This is reflected in a single nationwide Public Services Agreement (PSA) target to reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth. Reducing health inequalities is also one of the four top-level priorities in the 2007/08 NHS operating framework.

Tackling health inequalities is a new formal requirement on both local authorities and Primary Care Trusts (PCTs). The principal role is set out for PCTs in the Department of Health's 'Roles and Functions' statement in May 2006 as follows;

'Improving the health status of its population and reducing health inequalities, in partnership with local authorities'.

The 2004 White Paper 'Choosing health: making healthy choices easier' resulted in health inequalities targets being included in PSAs for all government departments. 'Health Challenge England - next steps for Choosing Health 2007' sets out a new approach that aims to enable everybody to make a contribution to the nation's health. Further investment is expected to help achieve sustained improvement in health with a specific focus on inequalities, smoking, obesity, alcohol and substance misuse, sexual health including teenage pregnancy and mental wellbeing.

The 2007 White Paper 'Strong and prosperous communities - Health and Wellbeing' builds on this, placing the challenge of addressing health inequalities at the heart of changes. In particular, there is a focus on strengthening partnership working on the health agenda and the quality of scrutiny and overview arrangements.

The Department of Health's 'commissioning framework for health and wellbeing' sets out a reform agenda for the health service. It emphasises the need for joint strategic needs assessment by Councils, PCTs and other relevant partners; and the effective sharing and use of information.

2.3 Local context

Haringey is a Borough of major contrasts with significant differences in affluence and deprivation between the east and the west of the Borough. This is reflected in the indicators of health where the worst indicators are seen for those living in the east of the Borough.

There are two indicators of health within Haringey that are of particular concern. Firstly, Haringey has more deaths in babies under 1 year old than most other parts of London and the UK. Secondly, although life expectancy in men is improving, there are significant differences for men born in the east of the Borough compared with men born in the west of the Borough.

Deprivation is a key issue for Haringey. Haringey is the 13th most deprived borough in England and the 5th most deprived in London. Socio economic deprivation has a key impact upon people's health and this is reflected in the fact that overall, people have a higher life expectancy in the affluent west compared to the east of the borough.

2.4 Health inequalities in Haringey

Overall, people in Haringey live longer than they did a decade ago, but on average die younger when compared to the population of England and Wales. There has been a slight rise in life expectancy for women since the last Public Health report in 2006 and females born between 2002-2004 are expected to live 5.5 years longer than males born in the same period. Male life expectancy in Haringey at birth during this period was lower than the national average of 76.5 years by 1.8 years, and this gap has widened since the last equivalent period in 1996-1998.

However, progress is being made in improving the health of local people and reducing health inequalities. The Standardised Mortality Ratio for all causes and all age groups is improving compared with the national average, and the life expectancy plan outlines priorities to reduce premature mortality within the Borough.

2.5 Audit approach

This review assesses the extent to which public sector organisations in Haringey understand their local health inequalities; direct resources appropriately to address the gap; have arrangements in place to challenge and review their actions; and know how well they are doing. This review has focused on six key areas as follows;

The work involved:

- surveying partner organisations;
- document review;
- interviews; and
- focus groups.

The review was designed to examine six main issues:

- how partners set and deliver strategic and operational objectives in relation to health inequalities;
- how partners work together to tackle health inequalities;
- how partners use information and intelligence to drive decisions;
- how partners have engaged their workforce in the health inequalities agenda;
- how partners manage performance; and

- how partners are approaching the issue of corporate social responsibility.

The outcome of the review is a joint performance report across local government and the health economy in Haringey. It identifies risk areas, makes high-level recommendations, and shares notable practice to help improvement planning. An action plan is included in Appendix 1 to help partners move forward on reducing the health inequalities gap and address recommendations for improvement.

We would like to take this opportunity to record our appreciation for the efforts and assistance of Eugenia Cronin, joint director of public health, Helena Pugh from Haringey Council, Vicky Hobart from Haringey PCT, and all other staff who have taken part in this review.

2.6 Status of this report

This report is in **draft** for comments and feedback.

This report has been prepared for the members of London Borough of Haringey and the directors of Haringey Primary Care Trust, and should not be relied upon by any third parties.

3 Delivering strategic and operational objectives

3.1 Context

The health inequalities agenda is complex. In order to tackle this effectively, it is essential that organisations have a strategy to tackle inequalities that is based on health need.

It is difficult for a range of separate organisations to make a difference unless they work collaboratively. Organisations across the economy should therefore have a shared vision, identify common priorities and develop a strategy to improve health, which is jointly owned by all parties. This requires strong leadership, and management arrangements that are "fit for purpose". It also requires individual organisations to develop a clear link between the shared, economy-wide priorities and their own commissioning / procurement plans.

3.2 Is there a strategy for tackling the health inequalities agenda that is based on health need?

There are a number of strategies for tackling health inequalities within Haringey. Overall responsibility for addressing health inequalities rests with the Haringey Strategic Partnership (HSP). The HSP has developed a Community Strategy, and there are 6 agreed outcomes from this strategy with one being 'Healthier people with a better quality of life'. This sets out ambitions to reduce Health Inequalities and looks at why reduction is important, what the objectives and targets are and also how success will be measured.

The Community Strategy is supported by the Council Plan and links into the Plan's key priority of 'encouraging lifetime wellbeing at home, work, play and learning'. There are also strong links into the key strategic priorities of the Haringey PCT Commissioning Strategy Plan, such as 'promoting a healthier Haringey by improving health and well-being and tackling Health Inequalities'.

The revised LAA has targets that are cross cutting and a number of these are related to reducing health inequalities and these are clearly assigned to a lead partnership board. A key indicator in terms of reducing the gap in life expectancy is reducing the rate of premature death from CVD.

The Wellbeing Strategic Framework (WBSF) is the key strategic framework for reducing health inequalities and improving wellbeing in adults. This has been approved by the Wellbeing Partnership Board (WBPB) and represents an action plan to improve life expectancy and reduce health inequalities.

Review of the strategies that are in operation demonstrates that there are good structural links in place to promote health and wellbeing. Each strategy document is different but it is clear to see how they relate to each other with the ultimate aim of reducing health inequalities.

A key challenge for the partners going forward will be to look at developing further the structure of the Joint Strategic Needs Assessment (JSNA). This will describe the means by which partners will describe the current and future healthcare needs of the Borough and what the strategic direction of service delivery will be to ensure these needs are met. The development of the JSNA at Haringey is potentially more challenging than other areas given the high mobility of the population. Haringey is ambitious in going beyond the minimum data set required for the JSNA and seeking to enhance the quality of the data set further to ensure that a robust JSNA will result in more effective commissioning to improve well-being and to reduce Health Inequalities.

Recommendation 1 - to continue the development of the JSNA

Haringey has decided to go beyond the minimum data set in developing the JSNA and it is likely there will be considerable planning required to obtain detail for secondary analysis. There are also potential difficulties in developing a JSNA given the high mobility of the population, therefore partners will need to ensure that proper arrangements are in place to ensure development of the JSNA is successful. If this is the case, it is highly likely that benefits will arise in the form of more effective commissioning aimed at improving health and well-being and reducing health inequalities.

3.3 Is the leadership of this strategy clearly defined and operating effectively?

Leadership of the health inequalities appears to be sound. There are clear structures in place that sit underneath the Haringey Strategic Partnership, in the form of Well-Being Partnership Board and the Wellbeing Chairs Executive - both of which have the aim of promoting and delivering a healthier Borough. Each supporting programme and initiative is assigned a lead agency which is responsible for its delivery.

3.4 Is wider public health expertise influential in developing strategies?

The public health teams at the PCT and key officers within the Council have been instrumental in setting health priorities that, in turn, have informed strategy development at an organisational and partnership level. The Haringey Strategic Partnership (HSP) has also consulted with other stakeholders through a consultation event attended by over 130 people in February 2006 which focussed on 7 key issues identified to help Haringey people live healthier and longer lives. As detailed in Section 3.3 the recent appointment of the Joint Director of Public Health also brings a fresh perspective, as experiences and best practice identified from other areas can be used to assist Haringey in further development of its strategies.

3.5 Are strategic priorities being implemented with clear accountability and delivery mechanisms?

High level progress against the relevant LAA targets is monitored by the HSP. The Well Being Strategic Framework Implementation Plan is the key delivery vehicle for accountability and achievement of strategic outcomes.

A well-being scorecard has been developed and this incorporates all targets and these are monitored at the Well-being partnership board. The scorecard is updated on a quarterly basis. The WBPB has 5 sub groups, organised around the 7 outcomes of the WBSF. The chairs of these sub-groups have been identified as lead contacts for each of the outcomes.

We see the well being scorecard as a crucial initiative in helping to monitor outcomes and challenge performance.

3.6 Are Health inequalities strategies and commissioning plans reflected in financial plans and budgets?

Our survey identified that when respondents were asked the question as to what extent to they would agree with the statement 'that my organisation's financial plans identify resources for achieving the health inequalities plan' nearly 90% agreed. This has also been evident from examples identified such as Recreation services and Libraries at the Council whereby funding for promotions in respect of healthy eating, recreation and smoking cessation has occurred and therefore incorporated into budgets and financial plans.

However, when respondents were asked the question 'indicate the extent to which a cost benefit analysis of options for action *to reduce HI* has been undertaken in the last 2 years, 57% either disagreed or disagreed strongly. It would appear therefore from this survey and also feedback from meetings with staff that there could be some additional investment put into this area to ensure there is a clear understanding of what the costs and benefits are when options are being assessed.

Recommendation 2 - to improve cost/benefit analysis of options to reduce HI.
We recommend that partners further promote a wider understanding of and focus upon the costs and benefits of options of specific courses of action to reduce Health Inequalities.

4 Delivering in partnership

4.1 Context

The causes of health inequalities are complex. Individual organisations can help to address health inequalities by introducing local solutions. However, they are more likely to have a significant impact if they work in partnership with other bodies to identify the root causes of health inequalities and provide joint solutions. In order to deliver systematic and sustainable change, it is essential for health and local government organisations to work together to tackle health inequalities. This requires the engagement of service providers as well as commissioners. Working with universities and the voluntary sector can also be hugely beneficial in identifying issues and delivering solutions to specific groups - especially hard to reach communities.

4.2 Have appropriate partnerships been identified and are they engaged? Are Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs) being used effectively to deliver change?

A wide range of partners contribute to the health inequalities agenda. The Haringey Strategic Partnership (HSP) has developed a Community Strategy which sets out broad and general ambitions for the Borough to achieve by 2016. Haringey has evidenced its commitment to reducing health inequalities through its recent update in the Local Area Agreement (LAA) where 35 improvement targets have been set. The HSP has set up 5 theme boards for each of the 5 themes in the LAA, one of which is the Well Being Partnership Board, which has overall responsibility for implementation of the Well Being Strategic Framework (WBSF). The Wellbeing Partnership Board (WBPB) is comprised of representatives from the PCT and Borough Council, voluntary sector and provider Trusts. The Well Being Chairs Executive oversees this partnership board and considers its agenda.

Partnership arrangements have historically been very good within the Borough and this has been extended towards the commitment to tackling health inequalities across all organisations. Additionally, good working relationships are in place at top management level. Our survey results indicated a good level of commitment to the health inequalities agenda, with strong agreement that top management are committed to tackling health inequalities and general agreement that joint decision-making in this area is effective.

The Local Area Agreement (LAA) has a strong focus on the health inequalities agenda; there has been recent update which has identified 35 improvement targets. The Well Being Partnership have devised a Scorecard that monitors the achievement of these targets and it is important that this scorecard is updated once the LAA has final ministerial sign off in June 2008.

Good sideways communications between organisations and close working relationships between operational staff have also had a positive impact on the health of local people. 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, which is unusual as health inequalities has been mostly seen as a PCT issue in other areas.

4.3 Do overview and scrutiny committees challenge progress on tackling health inequalities?

Overview and scrutiny committees should be an effective resource for challenging the progress being made in tackling the health inequalities agenda. In reality, however, these committees may lack the knowledge of the health inequalities agenda to provide that challenge. Within Haringey the Overview and Scrutiny Committee has shown interest in getting involved in the health inequalities agenda. We consider that the challenge role of scrutiny will best be exercised when:

- The WBPB have fully embedded their strategies for delivering improved health and well being
- Robust data on outcomes is available for challenge and review

We attended the Well Being Partnership Board and assessed how well it addressed strategy and performance issues within the Well Being Strategic Framework Implementation Plan. The WBPB had an extremely full agenda and at this particular meeting the discussion mainly centred around strategy documents, a process which is seen as completely necessary, however this focus on strategy meant that review of performance (through the Wellbeing Scorecard) was neglected. We recommend that consideration be paid to the structure of the agenda of these meetings and that it is better linked to the Well Being Strategic Framework. Operational issues should only form part of this agenda if they are linked to the outcomes of this framework.

Recommendation 3 - improve structure of WBPB
Consider the agenda of Haringey's Well Being Partnership Board to have a balance between strategy and performance issues with specific linkages to the Well Being Strategic Framework. Following embedding of the Implementation Plans consideration should be given to involving Overview and Scrutiny to challenge the progress made against the Health Inequalities agenda.

4.4 Are provider trusts engaged in the health inequalities agenda?

The terms of reference for the HSP include membership of the provider trusts, there is also representation on the WBPB. The PCT and Borough have engaged provider trusts however their presence and focus did not yet reflect their crucial role in taking the HI agenda forward. We noted that there had been non-attendance at the last two meetings of the WBPB by provider Trusts. Health inequalities are having a significant impact on emergency admissions and activity in A&E and secondary care provision, which can lead to pressure on achieving national targets. As such we consider that, given that the population of Haringey are highly mobile and there is a tendency of that population to attend A&E rather than a GP, that provider Trusts have access to significant amounts of information to aid in the health inequalities agenda and greater input is required.

Recommendation 4 - effective involvement of provider trusts
There are opportunities to improve the effectiveness of provider trusts within the health inequalities agenda. In particular, they could provide further information on A&E attendance levels.

4.5 Are the public and communities of interest effectively engaged as partners?

Haringey has a strong relationship with the voluntary sector, notably with its involvement with Haringey Association of Voluntary and Community Organisations (HAVCO). This is further evidenced by the Community and Voluntary Sector having 6 members on the 33 member HSP. There are also community and voluntary sector representatives on each of the thematic boards reporting to the HSP.

Whilst engagement with the voluntary sector has been positive it is recognised that there exists opportunities to engage further with research institutions and to potentially identify a university with an interest in HI to join the partnership board. It is understood that universities undertake a lot of research into health inequalities and their causes. However, their relationships with the organisations that are responsible for tackling the health inequalities agenda are not always well developed.

There has been evidence in the past of engagement with members of the public in developing health strategies and the Public Health team expect to hold similar community meetings prior to the completion of the Joint Strategic Needs Assessment (JSNA). Our survey results found however that there was a lack of clarity on what the mechanisms were for members of the community to get involved in developing action on HI.

Recommendation 5 - improve engagement with the public and communities of interest
Opportunity exists to engage with research institutions to understand what their role could be in the health inequalities agenda. Once engaged that resource could be used to commission further studies on areas where gaps currently exist.

5 Using information and intelligence to drive decisions

5.1 Context

The basis of all good policy decision-making often comes down to effective use of data and / or intelligence. Turning data into decisions is crucial to targeting resources and no more so than when tackling health inequalities.

5.2 Does a comprehensive health needs analysis exist which is shared with appropriate bodies and addresses health inequalities?

The last public health report for Haringey was completed in 2006, this report was well received and there was clear appetite for this information within the community. The Director of Public Health (joint appointment) has been in post since January 2008 and has been working on the production of the joint strategic needs assessment (JSNA). It is envisaged that this JSNA is going to be far more interactive with an IT platform that allows interrogation of the data. This will enable users to gain insight into the areas for which they are responsible and/or interested in.

The key challenge in this area is to maintain momentum with the exercise to ensure that the output has an appropriate feed into other key developments such as the Commissioning strategy. The JSNA is making innovative use of geographical information systems to map health information, which will increase the accessibility and impact of data

Recommendation 6 - move forward the JSNA
The Public Health Team should continue with the development of the JSNA, specifically the IT platform that is envisaged should be further explored to ensure that users can interrogate the data set for their needs.

5.3 Is there effective and efficient use of data analyst skills and capacity in identifying health inequalities issues?

The new model JSNA that the public health team are developing will require increased analyst skills as a high degree of effort is required for extraction and interpretation of data and then applying this to Commissioning. Currently there is a capacity issue within the Public Health team as there are three vacant consultant posts, but when these posts are filled the challenges in place should be addressed. However, in areas that we have reviewed within the South East of England we have found that there is a national shortage of skilled data analysts, and that there has been difficulty in recruiting to the vacant posts. Going forward, there may be need to consider using some analyst capacity at the Borough Council if these posts remain unfilled.

Recommendation 7 - address capacity issues
To ensure that the data set can be developed on a timely basis it is imperative that the public health team is at full capacity. Consideration should be paid to use any capacity within the Borough Council for analyst skills.

5.4 Does public health data and intelligence inform commissioning strategies?

As recognised previously, the Public Health report of 2006 is the most up to date data set that Haringey has. In the period from 2006 to present there has been an Equalities Impact Assessment undertaken in relation to the Primary Care Strategy which has been used to assess access to

Primary Care by all groups within the Community. Our survey results showed strong agreement that Public health information is used to help understand local health inequality priorities and that public health information is used to help understand the impact of any service development on the health of the local population. It is recognised the JSNA will play a critical role in understanding the community needs further and will directly feed into commissioning plans.

5.5 Have organisations identified knowledge gaps and are they working towards filling them?

The public health team are quite open in their approach to the data set they are collating, they have been clear in what they do and do not know. Once the gaps are known they will devise plans to address the gaps and involve community where necessary. Sufficient resources need to be devoted to this area to ensure that data doesn't become out of date and inaccessible.

5.6 Do partners have a robust understanding of the issues facing diverse communities?

The Council and its partners have a good understanding of their local communities. Our survey results showed overall agreement that there is a shared process with partners for identifying key local hard to reach groups. An up to date data set will provide further information on hard to reach groups that will affect the strategy in this area. Feedback in the area of disagreement of this area outlined that they would like to see more work done to raise awareness in this area such as ensuring that newsletters and promotions actually reach hard to reach groups.

There have been some examples of partners being effective at implementing action to provide access to hard to reach groups, such as:

- there is a choose and book scheme in place at Wood Green library where outpatient appointments can be booked through the internet. Libraries are now opened on weekends and evenings to increase access.
- there is also a lot of information on health matters available in many different languages with the aim of targeting hard to reach groups.
- there is the vision to re-orientate health groups on a geographical basis, the Primary Care Strategy has been revised on this basis. Additionally the Prinmary Care Strategy with its hub and spoke model is hoping to address some of the access issues within the community, however it is noted that there has been some concerns over the transport situation in Haringey that may hinder access to these sites.

5.7 Does a wide range of stakeholder intelligence inform decision making?

There is evidence that stakeholders have been engaged in developing health strategies, for example one of the four fundamental building blocks in the LAA is "Healthier Communities and Older People", which was developed through consultation, including an event attended by over 70 people. An event was also held in February 2006 to provide a forum for staff to discuss health and well-being issues in Haringey and to identify local priorities for improving health and reducing inequalities over the next 5 years. The event was organised jointly by Haringey Council, Haringey Teaching Primary Care Trust, and Haringey Association of Voluntary and Community Organisations.

Going forward these community stakeholder meetings have been seen as an instrumental process in developing the JSNA. It is important that Haringey continues to use this forum to ensure community buy-in to the health inequality agenda.

6 Securing engagement from the workforce

6.1 Context

The public sector has a substantial workforce. This workforce needs to be used effectively to tackle health inequalities. The whole workforce, and especially those who engage directly with the public, should have an understanding of the key health inequalities that need to be tackled in their local area and how they can help to address them. Specialist public health teams need to be used effectively to enable action to tackle health inequalities to be properly targeted at the areas of need. Non-Executive Directors (NEDs) in health, and local government council members, need to understand the health inequalities agenda and how it affects their decisions on all areas.

6.2 Is the existing workforce being used effectively to tackle the health inequalities agenda?

The Community Strategy is in place and all partners are signed up to the Wellbeing 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.

There is evidence that efforts have been made to ensure that front-line staff are equipped with the skills and understanding to help address health inequalities. For example there has been investment in education and training to ensure that staff are equipped to handle potential health issues, such as a training session that was attended by over 500 people in respect of detecting abuse. Also, smoking cessation programmes are in place and classes are well attended with reasonable rates of success. A health impact assessment has also been developed whereby staff have been trained to use the impact assessment to evaluate policies, programmes or projects to maximise the health benefits from these.

6.3 Is specialist public health skill and capacity available to organisations to tackle the health inequalities agenda?

Haringey's public health team is structured in a way that aims to maximise the impact on all public services within the area. The director of public health post is a joint appointment with accountability to both the PCT and the Council. There is also specialised input from the Adults, Culture and Community Services directorate at the Council and also specialised assistance from the public health team within the PCT.

6.4 Do NEDs and members have the skills required to provide challenge in relation to plans to tackle health inequalities?

There is evidence that Members and NED's are supportive of the issues of Health Inequalities and how these can be reduced in the Borough, such as discussions on health issues at the Overview and Scrutiny Committee.

However, we understand that there has been little specific joint training for Members or NED's on this issue, and this clearly represents an opportunity particularly as the joint DPH is now in post and able to participate in training events. This could also be extended further down the organisation, as our survey indicated that 75% of recipients had not had joint training with partners on health inequalities.

Recommendation 8 - more training on HI issues
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.

7 Performance Management

7.1 Context

The health inequalities agenda requires strong performance management to ensure that strategic plans are delivering the required impact. Performance management systems need to cover performance at both an organisational and partnership level. An effective performance management system will enable organisations to identify the actions taken against plans and the extent to which these are delivering the required results.

7.2 Is there a commitment at the highest level to effective performance management of health inequalities?

The update of the LAA in September 2007 (to be finalised in June 2008) identified 35 improvement targets which represent the priorities for improvement agreed between central government and all members of the Haringey Strategic Partnership from 2008. The Haringey Well-being Strategic Framework (WBSF) outlines the priority actions to improve life expectancy and reduce health inequalities. In terms of monitoring progress, the WBPB is responsible for the implementation plan of the WBSF, it is not solely responsible for its delivery. There is joint ownership for the delivery of the framework. Each supporting programme and initiative in the WBSF is assigned a lead agency that is responsible for its delivery, and a lead thematic partnership, which is responsible for monitoring performance.

Partnership performance management arrangements have been well developed, in particular the Well Being Scorecard which is seen as a realistic measurement tool. This scorecard is based on the LAA targets. However, 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.

Recommendation 9- Well Being Scorecard
We recommend that the Well Being Scorecard is reviewed on an exception basis and that appropriate consideration is given to the performance agenda, this may require review by the Well Being Chair Executive prior to the WBPB meeting.

7.3 Is past and current performance used to plan future action to tackle health inequalities?

Partners in Haringey are taking an increasingly robust approach to target setting. HSP members negotiated targets for the next round of Local Area Agreements, which showed high commitment to 35 targets that have a heavy emphasis on health and social care indicators. There is awareness and commitment to the HI agenda and the acknowledgement that the gap is not reducing at a quick enough rate. However, the problems within the borough are quite significant as high mobility rates mean that the population changes at a rapid rate and effectiveness of action cannot easily be determined or measured.

The most recent London Health Report (January 2008) indicates that Haringey has one of the worst health and deprivation indicators, with the borough mentioned as:

- unlikely to meet life expectancy targets for both males and females,
- highest rates of infant mortality, and

- unlikely to meet 2010 target for cancers or heart disease and stroke

This indicates that the Borough faces significant challenges in meeting future targets and this in turn creates the requirement to have a robust performance management system that is reviewed and acted upon.

7.4 Is there an appropriate performance management framework in place which is regularly reviewed?

The Well Being Scorecard will need to be revised once the final set of LAA targets have been agreed. Our survey results indicate that there may be some scope to improve the information that has been provided to partners or better understand their requirements, when asked 'we can show that HI have narrowed in the last two years in the area my organisation covers' 45% disagreed with this statement. It is recognised however that there are difficulties linking what the impact has been as a result of an action – for e.g. giving up smoking and how many more years you will live as a result.

Recommendation 10 - Revise Scorecard for the LAA targets
Once agreed the Well Being Scorecard should be updated for the new LAA targets.

8 Corporate responsibility

8.1 Context

Public services generally employ a significant proportion of their resident populations, and therefore have an opportunity to directly tackle health inequalities through their day-to-day activities. This means using corporate powers and resources in ways that benefit rather than damage the social, economic and environmental conditions in which we live. How public services behave as employers, purchasers of goods and services, managers of transport, energy waste and water, as landholders and commissioners of building work and as an influential neighbour in many communities can make a big difference to people's health and to the wellbeing of society, the economy and the environment.

There are considerable benefits to public sector bodies of taking a corporate responsibility perspective to business and private industry recognises its impact on the bottom line.

8.2 Has a corporate responsibility policy / approach been developed?

There are several programmes in place amongst partners identified in section 8.3 below. However, although these 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 minimise potential risk (financial and reputational) to organisations from not having clear policies and guidelines in place.

8.3 Is there progress on taking action with corporate responsibility principles?

Although corporate approaches to social responsibility are not yet in place, in practice there has been a significant amount of ad-hoc activity aimed at improving the health and wellbeing of staff. For example;

- 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;
- staff concessions at leisure centres to encourage use and improve overall wellbeing;
- focus at both the Council and the PCT in developing the cycling scheme whereby bicycles have been purchased to encourage use. There are also walk to work programmes;
- programmes and tips on how to stay stress free such as the introduction of flexitime to improve work/life balance and improve general wellbeing.

8.4 Have organisations begun to consider the financial implications of corporate responsibility?

This is an area where we have requested additional information to further our understanding, but as yet we are awaiting information in this area.

Recommendation 11 - develop an approach to corporate social responsibility
Partner organisations should develop formal corporate social responsibility plans or policies, which recognise their significant influence as local employers, commissioners, property owners and developers, and neighbours to the local community. These plans should identify how partners can use their full range of services to stimulate health improvement and address health inequalities, and consider the financial implications of doing so.

A Action Plan

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments	Date
8	**Recommendation 1 - to continue the development of the JSNA** Haringey has decided to go beyond the minimum data set in developing the JSNA and it is likely there will be considerable planning required to obtain detail for secondary analysis. There are also potential difficulties in developing a JSNA given the high mobility of the population, therefore partners will need to ensure that proper arrangements are in place to ensure development of the JSNA is successful. If this is the case, it is highly likely that benefits will arise in the form of more effective commissioning aimed at improving health and well-being and reducing health inequalities.	1				
9	**Recommendation 2 - to improve cost/benefit analysis of options to reduce HI.** We recommend that partners further promote a wider understanding of and focus upon the costs and benefits of options of specific courses of action to reduce Health	2				

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments	Date
	Inequalities.					
11	**Recommendation 3 - improve structure of WBPB** Consider the agenda of Haringey's Well Being Partnership Board to have a balance between strategy and performance issues with specific linkages to the Well Being Strategic Framework. Following embedding of the Implementation Plans consideration should be given to involving Overview and Scrutiny to challenge the progress made against the Health Inequalities agenda.	1				
11	**Recommendation 4 - effective involvement of provider trusts** There are opportunities to improve the effectiveness of provider trusts within the health inequalities agenda. In particular, they could provide further information on A&E attendance levels.	2				
12	**Recommendation 5 - improve engagement with the public and communities of**	2				

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments	Date
	interest Opportunity exists to engage with research institutions to understand what their role could be in the health inequalities agenda. Once engaged that resource could be used to commission further studies on areas where gaps currently exist.					
13	**Recommendation 6 - move forward the JSNA** The Public Health Team should continue with the development of the JSNA, specifically the IT platform that is envisaged should be further explored to ensure that users can interrogate the data set for their needs.	2				
13	**Recommendation 7 - address capacity issues** To ensure that the data set can be developed on a timely basis it is imperative that the public health team is at full capacity. Consideration should be given to use any capacity within the Borough Council for analyst skills.	2				

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments	Date
15	**Recommendation 8 - more training on HI issues** 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.	2				
16	**Recommendation 9- Well Being Scorecard** We recommend that the Well Being Scorecard is reviewed on an exception basis and that appropriate consideration is given to the performance agenda, this may require review by the Well Being Chair Executive prior to the WBPB meeting.	2				
17	**Recommendation 10 - Revise Scorecard for the LAA targets** Once agreed the Well Being Scorecard should be updated for the new LAA targets.	2				
19	**Recommendation 11 - develop formal plans and procedures for corporate social responsibility**	2				

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments	Date
	Partner organisations should develop formal corporate social responsibility plans or policies, which recognise their significant influence as local employers, commissioners, property owners and developers, and neighbours to the local community. These plans should identify how partners can use their full range of services to stimulate health improvement and address health inequalities, and consider the financial implications of doing so.					

B Response to electronic survey questions

Q1 **Please tell us the name of the organisation you represent? (optional)**

17

Q2 **Please tick which type of body you represent**

(responses of different partner bodies will be separately identified, individuals will not

County Council	0
District or Borough Council	6
Unitary Authority	2
PCT	10
Trusts: Foundation, Acute, Mental Health/Learning Disabilities, Ambulance	0
Police Authority	0
Fire Service	0
Other (Please state below)	1

Please specify 'other' 1

Q3 **Position**

Council member / Board member	2
Chief Executive / Director level	6
Other officer	10
Other	1

Please specify 'other' 3

The local pattern of health inequalities

Q4 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
There is an effective joint health inequalities strategy based on the health needs of the partner bodies' populations	5	12	1	0
The health inequalities plan is adequately reflected in the LAA and LSP plans, including sections such as housing, crime, environment etc.	6	10	1	1
There is enough information about health inequalities for us to identify the population's needs in the area my organisation covers	3	9	5	1
There is a shared process with partners for identifying key local health inequality issues	5	12	1	1
There is a shared process with partners for identifying key local hard-to-reach groups	2	12	4	1

Local actions

Q5 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that health inequalities have narrowed in the last two years in the area my organisation covers.	1	9	8	0

Please specify 5

Q6 **Please indicate the extent to which you agree / disagree with the following statement**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation regularly uses techniques to assess impact and inform service changes	2	12	3	1
Partners use shared information well	1	13	5	0
Acute and mental health / learning disability trusts have identified roles in tackling health inequalities	1	6	8	0
My organisation has developed joint services with partners	6	12	1	0

Please specify what these are and what makes them joint, e.g. pooled budgets, joint posts 7

Increased access

Q7 **Please indicate the extent to which you agree / disagree with the following statement**

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Changes have been made to my organisation's services because inequities in access were identified	4	12	3	0

Please specify 4

Q8 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that access to services has been increased for disadvantaged groups in the area my organisation cover	1	15	3	0

Please specify 5

Q9 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that action taken in the last 2 years has had an impact on previous under-performance	6	10	3	0

Please specify 4

Local levels of understanding about roles

Q10 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Health inequalities are everybody's business and not just an NHS issue	17	1	1	0
Councils have a community leadership role which includes promoting a healthier community and narrowing health inequalities	15	3	1	0

Q11 Public health information is used to help us to understand..

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
local health inequality priorities	12	4	3	0
evidence-based research about effective interventions	12	4	2	1
the impact of any service development on the health of the local population	11	2	6	0

Governance arrangements

Q12 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Joint planning arrangements for health inequalities exist and are effective	3	12	4	0
It is clear who is accountable for work on health inequalities within relevant partnerships	3	14	1	1
It is clear who is accountable for work on health inequalities within my organisation	8	6	3	1
My organisation's health inequalities strategy / plan is consistent with the joint health inequalities plan	5	8	3	0
My organisation's health inequalities strategy / plan is consistent with my organisation's commissioning plan	6	9	1	0

The health overview and scrutiny committee addresses wider health issues beyond NHS reconfiguration	5	13	0	0

Current capacity and capability

Q13 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
The joint health inequalities strategy addresses whole system changes needed	1	9	6	0
My organisation has sufficient skills to deliver work on health inequalities	3	8	5	1
I fully understand the difference we partners intend to make in the most disadvantaged communities	6	11	2	0
I have had joint training with partners on health inequalities	1	4	10	3
There are effective mechanisms for enabling communities to participate in developing action on health inequalities	2	7	9	0

Performance management and value for money

Q14 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
Effective joint monitoring arrangements are in place	2	14	3	0
My organisation can produce the information required to monitor performance against the joint health inequalities strategy and supporting plans	3	12	2	1

Cost benefit analysis of options for action has been undertaken in the last 2 years (singly or jointly)	0	6	7	1

Please specify 1

Q15 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
We can show that we have targeted our financial resources on actions which evidence shows have the biggest impact on reducing health inequalities	2	12	3	0
Progress is benchmarked against comparable areas	2	10	6	0
I know which actions have had a measurable impact on reducing local health inequalities in the last 2 years	3	5	7	2

Decision-making and resource allocation

Q16 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation's chief officers / members / board members are committed to tackling local health inequalities	9	9	1	0
Targets are agreed by partners and locally relevant	6	12	0	1
Joint decision-making for health inequalities is effective	5	9	3	0

Please describe how it is effective or could be improved 3

Q17 Please indicate the extent to which you agree / disagree with the following statement

	Strongly Agree	*Agree broadly*	*Disagree broadly*	*Strongly Disagree*
My organisation's financial plans identify resources for achieving the health inequalities plan	5	10	2	0

Q18 Please use the space below to make any further comments

2

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Appendix 2: Health Inequalities Audit Action Plan July 2008

Action Plan

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments milestones	RAG status	Date
8	**Recommendation 1 - to continue the development of the JSNA** Haringey has decided to go beyond the minimum data set in developing the JSNA and it is likely there will be considerable planning required to obtain detail for secondary analysis. There are also potential difficulties in developing a JSNA given the high mobility of the population, therefore partners will need to ensure that proper arrangements are in place to ensure development of the JSNA is successful. If this is the case, it is highly likely that benefits will arise in the form of more effective commissioning aimed at improving health and well-being and reducing health inequalities.	1	JSNA Steering Group Eugenia Cronin		Phase 1: Core data set to be discussed at: • Council CEMB • PCT Board Core data set available on the website Phase 2: • Project Brief to be finalised • Consultation Plan to be agreed and undertaken • Area(s) focus to be decided by (Links to recommendation 6 and 7)	G	29 July 6 July August August from Sept. March 2009
9	**Recommendation 2 - to improve cost/benefit analysis of options to reduce HI.** We recommend that partners further promote a wider understanding of and focus upon the costs and benefits of options of specific courses of action to reduce Health Inequalities.	2	Joint Commissio ning Group Helen Brown/ Margaret Allen		Cost-benefit analysis is not currently undertaken, however, under World Class Commissioning, the PCT is planning a major piece of work to understand how expenditure is related to health outcomes, which will necessarily include impact on health inequalities. This will be started during Autumn 2008.	A	From October 2008

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments milestones	RAG status	Date
11	**Recommendation 3 - improve structure of WBPB** Consider the agenda of Haringey's Well Being Partnership Board to have a balance between strategy and performance issues with specific linkages to the Well Being Strategic Framework. Following embedding of the Implementation Plans consideration should be given to involving Overview and Scrutiny to challenge the progress made against the Health Inequalities agenda.	1	WBCE Eugenia Cronin ?		Restructured WBPB and WBCE agendas to link items to 7 WBSF outcomes beginning • WBCE • WBPB Discuss performance using well-being scorecard exception reporting beginning • WBPB • WBCE (Links to recommendation 9 and 10) Timetable an Overview and Scrutiny review of health inequalities for 2009-10 , following visit by National Support Team for health inequalities (July 2009).	G G G	 July October June July Need to schedule this.
11	**Recommendation 4 - effective involvement of provider trusts** There are opportunities to improve the effectiveness of provider trusts within the health inequalities agenda. In particular, they could provide further information on A&E attendance levels.	2	Joint Commissio ning Group Helen Brown		• Major acute provider Trusts already members. • Clarify how to engage more effectively with provider trusts, including in sub-groups. • Joint Commissioning Group to review which other providers should be represented and how.	A	Autumn
12	**Recommendation 5 - improve engagement with the public and communities of interest** Opportunity exists to engage with research institutions to understand	2	WBCE Eugenia Cronin		• Making a Positive Contribution group set up • Building on relationship with Institute of Child Health re: obesity	G G	May 2008 Ongoing

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments milestones	RAG status	Date
	what their role could be in the health inequalities agenda. Once engaged that resource could be used to commission further studies on areas where gaps currently exist.				• Director of Public Health to explore possibilities with Middlesex University, School of Health and Social Care	A	Autumn 2008
13	**Recommendation 6 - move forward the JSNA** The Public Health Team should continue with the development of the JSNA, specifically the IT platform that is envisaged should be further explored to ensure that users can interrogate the data set for their needs.	2	JSNA Steering and Technical Groups Eugenia Cronin / Eve Pelekanos		• Considering IT platform options such as: o the Newham model developed by Geowise using a product called Instant Atlas o Expanding the GIS internet solution developed by spatial to encompass the partnership	A	March 2009
13	**Recommendation 7 - address capacity issues** To ensure that the data set can be developed on a timely basis it is imperative that the public health team is at full capacity. Consideration should be given to use any capacity within the Borough Council for analyst skills.	2	Director of Public Health Eugenia Cronin		• JSNA Technical Group established and shares data • HTPCT has increased its capacity by successfully recruiting to 4 consultant posts • The PCT and LA have identified further resources to support the JSNA (PCT via Investment Strategy and LA via dedicated time within Information Officers' posts).	G G G	May July August
15	**Recommendation 8 - more training on HI issues** There is potentially an opportunity to enhance joint training in HI at both Non Executive Director and Member	2	Director of Public Health Eugenia		• DPH has established LBH corporate public health group, with aim of cascading training through LBH. • DPH has scheduled HI training for members.	G G	May 2008 October/ Novemb

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments milestones	RAG status	Date
	level as well as further down the organisation.		Cronin		• DPH in discussion with NEDs on training needs.	A	Autumn 2008
16	**Recommendation 9- Well Being Scorecard** We recommend that the Well Being Scorecard is reviewed on an exception basis and that appropriate consideration is given to the performance agenda, this may require review by the Well Being Chair Executive prior to the WBPB meeting.	2	WBCE Sarah Barter		• At WBCE on 20 June agreed to discuss performance using well-being scorecard exception reporting as standing item on WBCE and WBPB	G	WBPB June WBCE July
17	**Recommendation 10 - Revise Scorecard for the LAA targets** Once agreed the Well Being Scorecard should be updated for the new LAA targets	2	WBCE Sarah Barter		• Completed	G	June 2008
19	**Recommendation 11 - develop formal plans and procedures for corporate social responsibility** Partner organisations should develop formal corporate social responsibility plans or policies, which recognise their significant influence as local employers, commissioners, property owners and developers, and neighbours to the local community. These plans should identify how partners can use their full range of services to stimulate health improvement and address health inequalities, and consider the financial	2	PMG Mun Thong Phung/ Eugenia Cronin		• Both the Council and PCT are seeking to develop plans for integrating corporate social responsibility. • The Council is developing a People Strategy to cover all aspects of employment including corporate social responsibility. The Strategy will be considered at Management Board and committee stage in September 2008; it contains a series of actions that will co-ordinate corporate social responsibility activities • An overarching policy of Corporate Social	A	March 2009 September 2008

Page no.	Recommendation	Priority 1 = high 2 = medium 3 = low	Respon-sibility	Agreed	Comments milestones	RAG status	Date
	implications of doing so.				Responsibility can be developed between Haringey TPCT, Haringey Council and local voluntary and community groups, this needs discussion and agreement, initially through the PMG, Performance Management Group LBH. Agreement to develop a joint policy would need to be raised through the Haringey Strategic Partnership and agreed at that forum. • It should be noted that there are key workstreams, initiatives, projects and strategies that correlate with CSR not least the Greenest Borough Strategy, the Haringey Guarantee, well being and SCEB workstreams amongst many others. There is a need to pull this work together with overarching principles for working as ethical and socially responsible public services and employers, with a commitment and tangible evidence of creating and investing in a culture of CSR.		

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haringey strategic partnership

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

Date: **2 October 2008**

Report Title: **Haringey Teaching Primary Care Trust Investment Plan**

Report of: **Keith Edmunds, Director of Commissioning, Haringey TPCT**

Summary:

This paper provides an overview of the Haringey Teaching Primary Care Trust's (HTPCT) Investment Plan for 2008/09 the following two years.

Recommendations:

The Board is asked to note the contents of the report.

Financial/Legal Comments:

The financial resources for implementation of the Investment Plan are included within the HTPCT's budget for 2008/09 and medium term financial plans for the two subsequent years.

For more information contact:

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Contents

Summary

- This paper provides an overview of the tPCT's investment plan for 2008/09 and the following two years.
- The investment plan was developed during the first half of 2008/09. This process was overseen by a Priorities Panel, chaired by a non-executive director, with strong clinical input and informed by partner consultation and two stakeholder events.
- The investment plan deals with incremental investment, above that already agreed as part of SLA negotiations with the tPCT's main providers. The investment strategy is consistent with the tPCT's current Commissioning Strategy Plan
- Planned investment has been mapped against expected performance on key national and local targets and requirements identified to improve performance in the current year. Despite planned investment, certain targets remain challenging
- During the development of the plan, some additional cost pressures were identified, as well as the need for certain additional 'enablers' - capacity, skills and preparatory projects. These are included in this plan
- In addition to £12m SLA investment already agreed for growth in 08/09, the investment plan amounts to £6m cash spend in 08/09, £14m spend in 09/10, and £14m recurrently thereafter. This enables the tPCT to meet the key priorities identified and retains flexibility for future cost pressures and emerging priorities.
- Significant financial flexibility has been built in. A number of projects have been deferred to 09/10 (for both practical and financial reasons). In addition, whilst indicative allocations of resources have been made to certain key strategic priorities, flexibility in how these resources are committed remains

Investment strategy

The investment strategy is consistent with the TPCT's current Commissioning Strategy Plan. This is incremental investment, above that already agreed as part of SLA negotiations with the main providers

Strategic Goals	Investment strategy
To improve quality and access to services; ensuring better access to the right care in the right place, at the right time; providing more integrated care in the local community	• Continuing investment in additional capacity, to meet growth in demand and waiting time targets • Implementation of the infrastructure to support the primary care strategy (extended opening hours, walk in services, IT) • Development of community services for those with long term conditions • Development and implementation of a strategy for intermediate care, rehabilitation and end-of-life care • Meeting new standards and new targets
To promote a healthier Haringey by improving health and well-being and tackling health inequalities	• Raising the profile of the health improvement agenda, with more innovative, community development approaches • Improving the scope, reach and take-up of screening and immunisation services • A particular focus on sexual and reproductive health amongst young people
To improve the mental health and well-being of our population	• Developing primary care mental health services • Small scale, incremental investment to get the best out of existing investment
To improve our performance and the way in which we commission services to enable us to commission world class care, whilst ensuring that we maintain long-term financial stability	• Focus on delivering on key national and local priority targets • Small scale, incremental investment to improve performance and maximise the benefit from existing services or assets • Developing commissioning capacity and capability

National and local priorities

- Expected future performance against key targets has been reviewed
  - 'Vital Signs'
  - challenging areas of Annual Health Check
  - Local Area Agreement and Community Strategy

- Planned investment has been mapped against key targets, and some additional requirements identified to improve performance in the current year

- Some of the population health targets are requiring a more innovative approach, for which there is a less established evidence base
  - Eg Social marketing to address early booking for antenatal care, chlamydia screening

- Despite planned investment, certain targets remain challenging, including:

  - Smoking cessation
  - Teenage pregnancy
  - Chlamydia screening
  - Maternity – early access to antenatal care
  - Immunisation – given the scale of the catch up required
  - Breast screening
  - Breastfeeding prevalence – due to data collection
  - Choose & Book

Prioritisation

- Overseen by Priorities Panel

- Focus on what is needed to deliver on local and national priority targets in 08/09
    - E.g. stroke, screening, Choose & Book
    - Now includes a programme of non-recurrent spend
    - Additional commissioning capacity

- Identifies indicative level of resources for a number of priority areas
    - Recognition of the need to develop Adults & Older People strategy, but with package of measures to improve short term provision and performance while this strategy is developed

- In addition to £12m SLA investment agreed for growth in 08/09, agreed investment plan is now:
    - £6m cash spend in 08/09, £14m spend in 09/10, £14m recurrently thereafter
    - Retains flexibility for future cost pressures and emerging priorities

- It is acknowledged that this investment plan deals with prioritisation of incremental investment. It is not a strategic review of resource allocation across the range of services already commissioned by the PCT

Key programmes

The key programmes included in the plan are:

Adults & Older People
- Additional capacity for diabetic retinopathy and renal dialysis
- Diabetes resources and intermediate care service
- End of life care and intermediate care / rehab strategy

Public Health & Well being
- Expansion of smoking cessation programmes
- Implementation of alcohol strategy
- Immunisation and screening programmes
- Social marketing of health promotion / lifestyle issues
- Development of 'health network' and health trainers
- Development of obesity programme

Children & Young People
- Additional health visitors
- More special schools nursing, physio, and OT
- School nursing expansion for immunisation programmes and health promotion
- CAMHS single point of access and expansion
- Expansion of palliative care and long term conditions support

Sexual & Reproductive Health
- Reduction of IVF waiting times
- Chlamydia screening
- Sexual health clinics and development of primary care
- HIV testing and treatment

Primary Care
- Extended opening hours and walk-in services
- Upgrades to IT infrastructure
- Extended scope of services in neighbourhood health centres

Vulnerable adults
- Primary care psychological therapies e.g. Cognitive Behavioural therapy (CBT)
- Development of low secure forensic mental health service

Financial profile of investment plan

Summary

	08/09	09/10	10/11
	£000s	£000s	£000s
Adults & Older People	1,707	4,118	3,728
Children & Young People	574	2,486	2,736
Primary Care	509	3,165	3,487
Public Health & Well being	572	1,048	1,551
Sexual & Reproductive Health	860	1,173	943
Vulnerable Adults	714	816	729
Commissioning Capacity	1,074	1,005	800
Total investment plan	6,009	13,810	13,974
08/09 recurring SLA investment, excluding inflation	12,281	12,281	12,281
Total investments	18,290	26,091	26,255

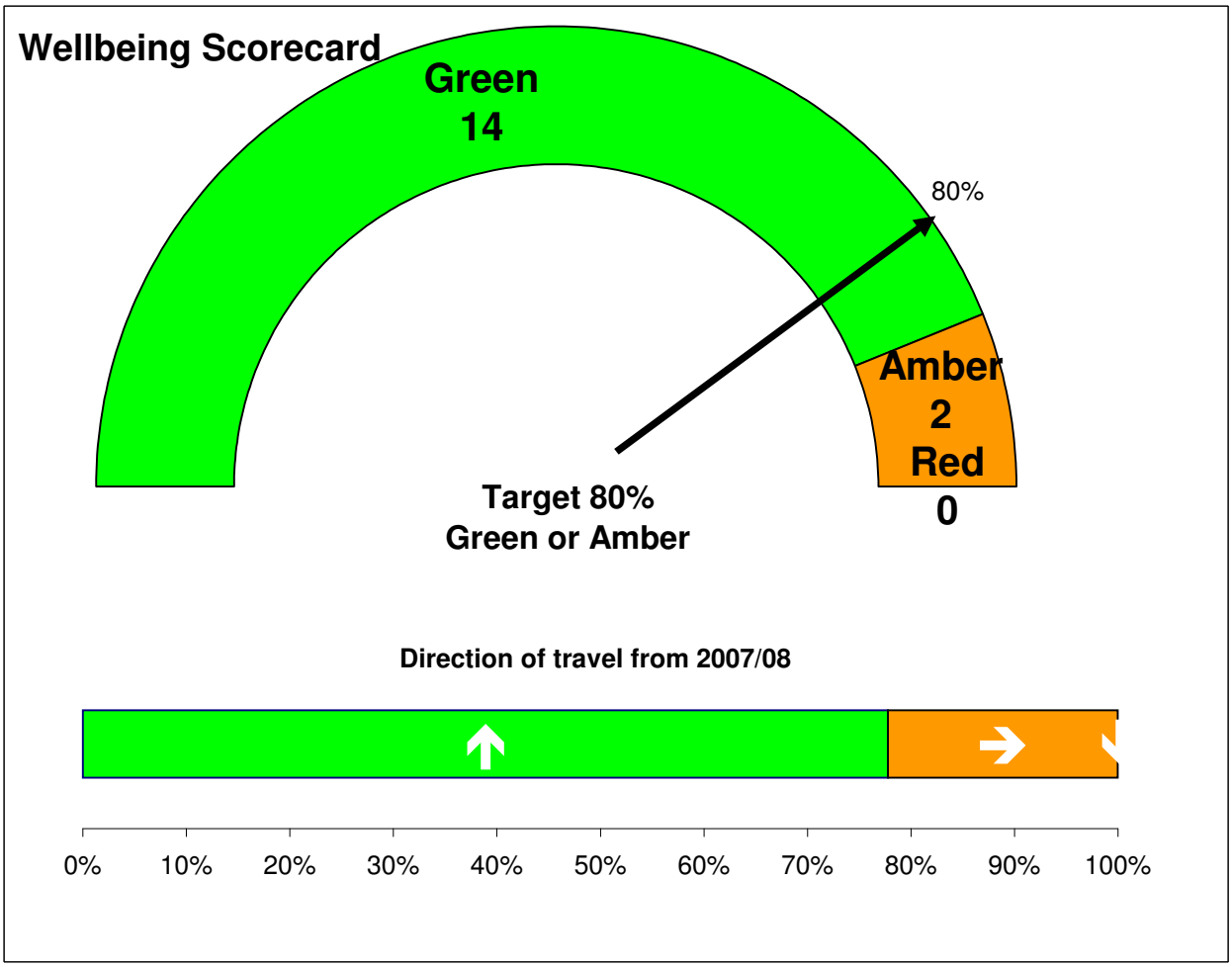
The majority of the proposed new investment plan is in out-of-hospital services, health screening and health promotion. Less than £2m is allocated to hospital and hospice services.

Haringey tPCT

Investment Plan

Report to Well-Being Strategic Partnership Board

Keith Edmunds
Director of Commissioning
Haringey TPCT
19th September 2008



Performance is reviewed against a basket of 46 National Indicators and Local Indicators from the LAA (Improvement targets and Local) were the board is either the lead or has a cross cutting interest

Quarterly and year to date position progress are tracked against the target using traffic lights and where appropriate arrows showing change in performance from last year where:

→	Same as last year	↑	Better than last year	↓	Worse than last year
Red	Performance missing target	Amber	Performance close to target	Green	Performance on target

Quarterly Performance Review - 2008/09 Q1

Outcome 1 – Improved Health and Emotional Well-being
Outcome 2 – Improved Quality of Life
Outcome 3 – Making a Positive Contribution
Outcome 4 – Increased Choice and Control
Outcome 5 – Freedom from Discrimination or Harassment
Outcome 6 – Economic Well-being
Outcome 7 – Maintaining Personal Dignity and Respect

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
Wellbeing Thematic Board							
1	*Top Quartile*	**NI 8**	Adult participation in sport				**LAA ACCS**
		Target	24.9% (LAA Target 22.9%)				
2		Comment	Annual survey - Data due November 2009, last survey took place in 2006.				
1	*London Top Quartile*	**NI 123**	16+ current smoking rate prevalence				**LAA Health**
	0	*Target*	1008				
		Comment	No data available				
	0.0%						
2	*Top Quartile*	**NI 39**	Alcohol-harm related hospital admission rates				**LAA Health**
		Target					
		Comment	Data available Jan/Feb 09				
1	*Top Quartile*	**NI 121**	Mortality rate from all circulatory diseases at ages under 75				**LAA Health**
		Target					
		Comment	No data available				
2	*Top Quartile*	**NI 135**	Carers receiving needs assessment or review and a specific carer's service, or advice and information				**LAA ACCS**
	New 2008/09	*Target*	14.2%				
		Comment					
			Green				Green
			21.0%				**21.0%**
7	*Top Quartile*	**NI 141**	Number of vulnerable people achieving independent living				**LAA ACCS**
	New 2008/09	*Target*	75%				
		Comment	Supporting People Data available August 2008				↑
			Green				Green
			85.2%				**85.2%**

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
7	*Top Quartile*	**NI 125**	Achieving independence for older people through rehabilitation/intermediate care				
	New 2008/09	*Target*	79%				**LAA ACCS**
4		Comment	Starts October 2008				
			N/A				
1	*Top Quartile*	**NI 119**	Self-reported measure of people's overall health and wellbeing				LAA local
	New 2009/10	*Target*					Lead
		Comment	Annual Place Survey, delayed until 09/10				
			N/A				
1	*Top Quartile*	**NI 122**	Mortality from all cancers at ages under 75				LAA local
		Target					Health
		Comment	No data available				
1	*Top Quartile*	**NI 127**	Self reported experience of social care users				LAA local
	New 2009/10	*Target*					ACCS
		Comment	Annual survey, delayed until 09/10				
			N/A				
	Top Quartile		Improve Living conditions for vulnerable people ensuring that housing is made energy efficient decent and safe				
		Target					LAA local
2		Comment	Made up from 5 indicators in order; number of private sector none-decent homes made decent, number of properties that have received energy efficient measures, number of accidental dwelling fires, adults admitted permanently to residential, older people admitted permanently to residential				
		Target	n/a	180	100	100	
			Available end Sept 08				
		Target	n/a	800	500	500	
			Available end Sept 08				
		230	55				**Green**
		28	12 (projected)				**Green**
		135	116 (projected)				**Green**
2	*Top Quartile*	**NI 175**	Access to services and facilities by public transport, walking and cycling				
		Target					Cross cutting
		Comment	This is currently in negotiation with Transport for London and is yet to be confirmed. Comment updated Sept 08.				
5	*Top Quartile 2008/09*	**NI 35**	Building resilience to violent extremism				Cross cutting
		Target					
		Comment	Programme of women's classes has started quarter 1, 14 people are studying English as a second language, 13 learning IT and 30 Islamic history. These classes are at full or near full capacity. Comment updated Sept 08				
			Green				**Green**
			57.0				**57.0**
6	*Top Quartile*	**NI 156**	Number of households living in Temporary Accommodation				Cross cutting
		Comment	Progress has been made this month through the on-going range of TA reduction activities.				↑
		Target	5207	4940	4469	3999	
			Green				**Green**
	5389		5182				**5182**

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
6	*Top Quartile*	**NI 187** Tackling fuel poverty – people receiving income based benefits living in					Cross cutting
		Target					
		Comment	The Area Based Grant is fully supporting the Fuel Poverty Project for 2008 – 2009, but does not extend to financing the survey requirements of NI 187. The project scope for the new grant funding is undefined, therefore, the Fuel Poverty Officer is working towards the objectives of the project that expired at the end of March 2008. Clarification as to the Project Sponsor is required. A task in the Fuel Officers JD is to undertake surveys and as this description is non specific, provides potential for this post to organise the survey and compile the results. The survey for the NI is planned for December 2008. Comment updated Sept 08				
	1683 (Apr-Dec)						
1	*Top Quartile*	**NI 51** Effectiveness of child and adolescent mental health (CAMHs) services					Cross cutting
		Target 13					
		Comment	Annual collection via CAMHS mapping exercise.				
1	*Top Quartile*	**NI 56** Obesity among primary school age children in Year 6					Cross cutting
		Target 24%					
		Comment	Data available end quarter 2				
	23.8%						
1	*Top Quartile*	**NI 112** Under 18 conception rate					Cross cutting
		Target					
		Comment	Data available September 2008				
1	*Top Quartile*	**NI 113** Prevalence of Chlamydia in under 20 year olds					Cross cutting
		Target					
		Comment	Data available Jan/Feb 09				
1	*Top Quartile*	**NI 126** Early access for women to maternity services					Cross cutting
		Target					
		Comment	Data available September 2008				
2	*Top Quartile*	**NI 116** Proportion of children in poverty					Cross cutting
		Target 34.50%					
		Comment	New indicator monitored annually.				
	36.4% (proj)						
2	*Top Quartile*	**NI 135** Carers receiving needs assessment or review and a specific carer's service, or advice and information					**LAA ACCS**
	New 2008/09	*Target* 14.2%					
		Comment					
			Green				**Green**
			21.0%				**21.0%**
1	*Top Quartile*	**NI 53** Prevalence of breastfeeding at 6-8 weeks from birth					Cross cutting
		Target					
		Comment	Data available Jan/Feb 09				

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
1	*Top Quartile*		Increase in the % of Children immunised by 2nd birthday				
		Target					Cross cutting
		Comment	Data not available				
	Top Quartile	**NI 141**	Number of vulnerable people achieving independent living				
	New 2008/09	*Target*	75%				Cross cutting
		Comment	Supporting People. Figures updated Sept 08				↑
			Green				**Green**
			85.2%				**85.2%**
6	*Top Quartile*	**NI 153**	Working age people claiming out of work benefits in the worst performing neighbourhoods				
		Target	27.60%				Cross cutting
		Comment	No data is available yet (Sept 08) and GOL has advised that the baseline is likely to change.				
2	*Top Quartile*	**NI 40**	Drug users in effective treatment				Cross cutting
		Target					
		Comment	Data available Sept 08				
2	*Top Quartile*	**NI 9**	Use of public libraries				Not LAA
	New 2008/09	*Target*					
		Comment	Annual Survey - no data available, baseline to be established.				
2	*Top Quartile*	**NI 10**	Visits to museums and galleries				Not LAA
	New 2008/09	*Target*					
		Comment	Annual Survey - no data available, baseline to be established.				
1	*Top Quartile*	**NI 120**	All-age all cause mortality rate				Not LAA
		Target					
		Comment	Data not available				
1	*Top Quartile*	**NI 122**	Mortality from all cancers at ages under 75				Not LAA
		Target					
		Comment	Data not available				
4	*Top Quartile*	**NI 124**	People with a long-term condition supported to be independent and in				Not LAA
		Target					
		Comment	Data available Sept 2008				

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
7	*Top Quartile*	**NI 128** User reported measure of respect and dignity in their treatment					Not LAA
		Target					
		Comment Annual Survey					
7	*Top Quartile* *New 2008/09*	**NI 129** End of life access to palliative care enabling people to choose to die at home					Not LAA
		Target					
		Comment Starts October 08, 1st data available qtr3					
			N/A				
2	*Top Quartile* *150*	**NI 130** Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)					Not LAA
		Target June 170, Sept 185, Dec 200, Mar 213					
	Best Quartile	Comment New 2008/09 which NI replaces PAF C51. Please note that performance is measured YTD year and includes carers. PAF C51 was measured at a snapshot and wasn't inclusive of carers.					↑
	Green		**Green**				**Green**
	152.9		194				**194**
2	*Top Quartile* *0<20.12*	**NI 131** Delayed transfers of care from hospitals					Not LAA
		Target 30					
	2nd Quartile	Comment This is very ambitious target and has vastly improved in the last 2 years. This is very closely monitored and called over weekly. Calculation and target is currently only for acute hospitals. Non-acute data will be added once data is available and the target amended accordingly.					↑
	Green		**Amber**				**Amber**
	38.6		37.6				**37.6**
2	*Top Quartile* *90<=100*	**NI 132** Timeliness of social care assessment (All Adults)					Not LAA
		Target 80%					
	Best Quartile	Comment New 2008/09 which NI replaces PAF D55(ii). Please note that PAF D55(ii) measured just 65+ and the new NI is inclusive of all over the age of 18. As a result the 2008/09 target has been reduced.					→
	Green		**Green**				**Green**
	96.0%		90.2%				**90.2%**
2	*Top Quartile* *90<=100*	**NI 133** Timeliness of social care packages (Older People)					Not LAA
		Target 93%					
	Best Quartile	Comment Submitted Qtrly					→
	Green		**Green**				**Green**
	93.0%		93.0%				**93.0%**
2	*Top Quartile*	**NI 134** The number of emergency bed days per head of weighted population					Not LAA
		Target					
		Comment Data not available					
4	*Top Quartile* *New 2008/09*	**NI 136** People supported to live independently through social services (all ages)					Not LAA
		Target 22.68					
		Comment Proxy Measure- finalised guidance not yet published on needs weighted population.					
			Green				**Green**
			23.58				**23.58**
1	*Top Quartile*	**NI 137** Healthy life expectancy at age 65					Not LAA
		Target					
		Comment Data not available					

	07/08	08/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Progress
2	*Top Quartile*	**NI 142** Number of vulnerable people who are supported to maintain independent living					Not LAA
		Target 98%					
		Comment Supporting People Data not available till August 2008					↑
	Green		Green				Green
	99.5%		99.5%				**99.5%**
2	*Top Quartile* *New 2008/09*	**NI 145** Adults with learning disabilities in settled accommodation					Not LAA
		Target 60%					
		Comment Starts October 08, 1st data available qtr3					
			N/A				
2	*Top Quartile*	**NI 148** Care leavers in employment, education or training					Not LAA
		Target 75%					
		Comment YTD is a cumulative measure.					↑
			Green				Amber
	68.0%		83.0%				**74.0%**
4	*Top Quartile*	**NI 150** Adults in contact with secondary mental health services in employment					Not LAA
	New 2009/10	*Target*					
		Comment Delayed until 09/10					
			N/A				

Name	Project Overall progress	Budget variance £'000s	Allocated Budget	Project Spend as of Q1 (as shown on SAP)	Project Actual Spend as of Q1	Project Manager's Profile of spend for Q1	Comments
Alexandra Road	Green	-32,052	128,200	0	32,052	0	Internal orders to be set up/Finance to complete spend profile
Clarendon Centre	Green	-14,151	56,601	0	14,151	0	Internal orders to be set up/Finance to complete spend profile
Employment & Training (Clarendon Centre)	Green	-22,455	89,822	0	22,455	0	Internal orders to be set up/Finance to complete spend profile
Studio 306	Green	-6,618	26,478	0	6,618	0	Internal orders to be set up/Finance to complete spend profile
Approved Social Work Services (Canning Crescent)	Amber	-24,157	80,800	443	24,600	0	Internal orders to be set up/Finance to complete spend profile
Social Workers (North Tottenham)	Amber	-15,010	50,000	-3,010	12,000	0	Internal orders to be set up/Finance to complete spend profile
Social Workers Running Costs	Amber	-8,083	34,200	917	9,000	0	Internal orders to be set up/Finance to complete spend profile
Commissioning Support	Green	-19,206	76,818	0	19,206	19,206	Internal orders to be set up/Finance to complete spend profile
HAGA	Green	-9,407	30,000	0	9,407	7,500	Internal orders to be set up/Finance to complete spend profile
MIND in Haringey	Green	-7,998	32,000	0	7,998	8,001	Internal orders to be set up/Finance to complete spend profile
Open Door	Green	-6,249	25,000	0	6,249	6,249	Internal orders to be set up/Finance to complete spend profile
African Caribbean Leadership Council	Green	-7,251	29,000	0	7,251	7,251	Internal orders to be set up/Finance to complete spend profile
Rainer	Green	-5,019	20,081	0	5,019	5,019	Internal orders to be set up/Finance to complete spend profile
PRA Haringey User Network	Amber	-4,749	19,000	0	4,749	4,749	Internal orders to be set up/Finance to complete spend profile

CAB (Citizens Advise Bureaux)	Green	-4,749	19,000	0	4,749	4,749	Internal orders to be set up/Finance to complete spend profile
CSW Assertive Outreach	Green	-11,250	45,000	0	11,250	11,250	Internal orders to be set up/Finance to complete spend profile
CSW Assertive Outreach	Green	-11,250	49,000	0	11,250	11,250	Internal orders to be set up/Finance to complete spend profile
Mental Health - Mental Capacity Act	Green	0	35,858	8,964	8,964	8,964	Spend on target
Mental Health Commissioning	Green	-12,786	51,142	0	12,786	12,786	April to June Spend not gone through yet
Mental Health Capacity Act	Amber	0	20,000	0	0	1,350	May & June Spend has not gone through yet
Learning Disability Day Services	Green	-58,800	236,000	0	58,800	0	Internal orders to be set up/Finance to complete spend profile
Physical Disabilities Residential	Green	-12,720	50,876	0	12,720	0	Internal orders to be set up/Finance to complete spend profile
Learning Disabilities Residential	Green	-130,500	522,373	0	130,500	0	Internal orders to be set up/Finance to complete spend profile
Learning Disabilities Jt Comm Residential	Green	-66,900	267,562	0	66,900	0	Internal orders to be set up/Finance to complete spend profile
Mental Health Residential	Green	-60,486	241,939	0	60,486	0	Internal orders to be set up/Finance to complete spend profile
Mental Health Jt Comm Hlth	Green	-9,564	38,250	0	9,564	9,564	April to June Spend not gone through yet
Preserved Rights Grant Income - Older People	Green	-73,251	293,000	0	73,251	73,248	April to June Spend not gone through yet
Supporting People Services	Green	-54,000	212,000	0	54,000	0	Internal orders to be set up/Finance to complete spend profile
Support to Carers	Green	-267,918	927,200	0	267,918	763,100	April to June Spend not gone through yet
Employment for People with LD	Green	-3,197	15,500	100	3,297	2,080	May & June Spend has not gone through yet
Appropriate Adult B Tech Award Training	Amber	-9	15,000	5,685	5,694	5,685	Spend on target
AC Benefits Outreach	Green	3,161	45,000	8,629	5,468	8,629	Spend on target
BME Carers Support Group	Green	0	19,500	5,411	5,411	5,411	Spend on target
Happy Opportunities	Green	-166	17,000	3,904	4,070	3,904	Spend on target
AC Haringey Forum for OP	Green	-2,194	51,000	11,820	14,014	11,820	Spend on target
AC Out & About Befriending	Green	72	35,500	8,847	8,775	8,847	Spend on target
BME Carers Community Income	Green	0	31,500	7,875	7,875	7,875	Spend on target
Salsa Club 50+	Green	1,860	9,000	5,570	3,710	5,570	Spend on target
684 Centre	Green	-15,393	78,000	4,107	19,500	21,000	April to June Spend not gone through yet

Cycling Club	Green	-1,711	9,500	813	2,524	2,100	May & June Spend has not gone through yet
HAGA - Outreach & Home Support	Green	867	78,000	20,072	19,205	20,072	Spend on target
Health in Mind - Healthy Eating	Green	-38,892	148,000	0	38,892	0	No Spend until July
Health in Mind - Mental Health	Green	-11,030	73,000	0	11,030	0	No Spend until July
Health in Mind - Therapeutic Network	Green	0	60,000	0	0	0	No Spend until July
Health in Mind - Physical Activity	Green	0	87,500	0	0	0	No Spend until July
Libraries for Life	Green	7,575	194,500	49,581	42,006	53,800	Spend on target, June spend not gone through
Reaping the Benefits	Green	-7,690	97,000	15,350	23,040	23,985	May & June Spend has not gone through yet
Smoking Cessation	Amber	13,056	100,000	13,056	0	0	Internal orders to be set up/Finance to complete
Welfare to Work	Green	579	40,000	13,119	12,540	12,540	Spend on Target