haringey strategic partnership

NOTICE OF MEETING

Well-Being Strategic Partnership Board

TUESDAY, 8TH DECEMBER, 2009 at 19:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see the Membership List set out below.

AGENDA

1. APOLOGIES

To receive any apologies for absence.

2. URGENT BUSINESS

That Chair will consider the admission of any items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items of Urgent Business will be dealt with under Item 16 below).

3. DECLARATIONS OF INTEREST

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

4. MINUTES (PAGES 1 - 8)

To confirm the minutes of the meeting held on 24 September 2009 as a correct record.

DISCUSSION ITEMS:

5. MENTAL HEALTH NEEDS ASSESSMENT UPDATE (PAGES 9 - 14)

6. SPORTS AND PHYSICAL ACTIVITY STRATEGY

This report will be sent to follow.

BUSINESS ITEMS:

7. PERFORMANCE REPORT (PAGES 15 - 32)

8. STRATEGIC APPROACH TO COMMISSIONING -INCLUDING AREA BASED GRANT AND SUPPORTING PEOPLE

A verbal update will be provided.

9. AREA BASED GRANT END OF YEAR REVIEW (PAGES 33 - 46)

10. DEPARTMENT FOR HEATH -NATIONAL SUPPORT TEAM FOR HEALTH INEQUALITIES VISIT (PAGES 47 - 60)

11. SAFEGUARDING ADULTS -UPDATE ON IMPLEMENTATION PLAN (PAGES 61 - 64)

12. TOBACCO CONTROL STRATEGY 2009-12 (PAGES 65 - 102)

INFORMATION ITEMS:

13. COMMUNITIES FOR HEALTH FUNDING 2009/10 (PAGES 103 - 110)

14. COMMUNITY AND VOLUNTARY SECTOR REPRESENTATION NO THE HARINGEY STRATEGIC PARTNERSHIP AND THEMATIC BOARDS (PAGES 111 - 114)

15. UPDATES FOR BOARD MEMBERS

Members of the Board are invited to give a brief verbal update on the most prevalent issues affecting their organisation.

16. NEW ITEMS OF URGENT BUSINESS

To discuss any new items of Urgent Business admitted under Item 2 above.

17. ANY OTHER BUSINESS

To raise any items of AOB.

18. DATES OF FUTURE MEETINGS

The next meeting is scheduled for 7pm, on 25 February 2010, at the Civic Centre.

Please note that the Council's Calendar of meetings for the new Municipal Year, which runs from May 2010 – April 2011, is currently being complied.

As soon as the draft dates are available members of the Board will be advised.

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Deputy and of Local Democracy and Member Services
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Published 30 November 2009

SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	9	Mun Thong Phung Councillor John Bevan Councillor Dilek Dogus (Vice-Chair) Councillor Liz Santry Margaret Allen Susan Otiti* John Morris Lisa Redfern
Health	Haringey Teaching Primary Care Trust	6	Fiona Aldridge Tracey Baldwin Cathy Herman Marion Morris James Slater Richard Sumray (Chair)
	North Middlesex Hospital trust	1	Clare Pannicker
	BEH Mental Health Trust	1	Michael Fox
	Whittington Hospital Trust	1	Rob Larkin
Community Representatives	Community Link Forum	3	Abdool Alli Angela Manners Faiza Rizvi
		1	Sue Hessle
	HAVCO	2	Robert Edmonds Naeem Sheikh
Education	College of North East London	1	Paul Head
	Middlesex University	1	Gina Taylor
Other agencies	Haringey Probation Service	1	Mary Pilgrim
	Metropolitan Police	1	Dave Grant
	Total	**27**	

** Jointly appointed by the Council and Primary Care Trust*

Agenda Item 4

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
THURSDAY, 24 SEPTEMBER 2009

Present: Councillor John Bevan, Eugenia Cronin, Councillor Dilek Dogus (Vice-Chair), Keith Edmunds, Cathy Herman, Sue Hessel, Richard Milner, Howard Jeffrey, Lisa Redfern, Faiza Rizvi, Councillor Liz Santry, Richard Sumray (Chair), Gina Taylor.

In Attendance: Councillor Gina Adamou, Xanthe Barker, Sarah Barter Trevor Cripps, Melanie Ponomarenko, Councillor David Winskill.

MINUTE NO.	SUBJECT/DECISION	ACTON BY
OBHC154	**APOLOGIES** Apologies for absence were received from the following: Fiona Aldridge Tracey Baldwin Robert Edmonds Rob Larkin John Morris Marion Morris Claire Panniker Mary Pilgrim	
OBHC155	**URGENT BUSINESS** No items of Urgent Business were raised.	
OBHC156	**DECLARATIONS OF INTEREST** A personal interest was expressed by Faiza Rizvi with respect to agenda item 8 and did not taken part in discussion on this item.	
OBHC157	**MINUTES** The following updates were given with respect to the minutes of the previous meeting: <u>OBHC142 –Well-Being Strategic Framework</u> The Chair requested that Barbara Nicholls was contacted and asked to circulate the link referred to in the minutes (if this had not already been done). <u>OBHC143 –Experience Still Counts 2009-12</u> It was requested that progress in drafting the Options Paper requested by the Board was checked with Margaret Allen and that this should be programmed into the Board's Forward Plan.	Lisa Redfern Lisa Redfern

	OBHC144 –User Payments Policy There was agreement that officers should liaise with Robert Edmonds to programme the update requested at the previous meeting into the Board's Forward Plan. OBHC146 –Transforming Social Care The Chair asked for the report requested at the previous meeting, setting out how the issues raised during the pilot phase would be addressed, should be added to the Board's Forward Plan. **RESOLVED:** That the minutes of the meeting held on 14 May 2009 be confirmed as a correct record.	Xanthe Barker / Helen Constantine Xanthe Barker / Helen Constantine
OBHC158	**TOBACCO CONTROL STRATEGY 2009-12** The Board received a report and presentation on the new development of the new Tobacco Control Strategy and Action Plan. An overview was given of how the Borough was affected by smoking and it was noted that the prevalence of smoking in Haringey was 4.5% higher the London average. More detailed comparisons were also drawn between Haringey, London and National averages with respect mortality rates attributable to smoking and the cost to the NHS. It was noted that the Board would be asked to sign off the finalised version of the Strategy at its December meeting. It was suggested that the age group focussed upon should be thirty-five to fifty-four year olds, rather than sixteen to thirty-four year olds, as smoking in Haringey was most prevalent amongst this group. It was recognised that smoking was more prevalent in the older age bracket, however; in order to discourage people from taking up smoking the younger age group had been targeted as a preventative measure. In response to a question, the Board was advised that smoking and health inequalities generally, reflected the social economic picture across the Borough. In preparing the Strategy work to 'drill down' and consider in more detail the issues associated with deprivation and increased rates of smoking was being carried out. The Board was advised that existing strategies would be fed into and reflected in the Tobacco Strategy and Action Plan. The Board broke into three groups and considered the approach that should be taken to the three following issues: • Tackling Cheap and Illicit Tobacco • Helping Young People to be Tobacco Free	All to note

	• Maintaining and Promoting Smoke Free Environments The notes taken during discussion were collected and the issues raised would be considered as the Strategy was drafted. **RESOLVED:** i. That the report be noted. ii. That the Board would receive the final version of the Tobacco Strategy and Action Plan for sign off in December.	Susan Otiti
OBHC159	**FIRST QUARTER PERFORMANCE REPORT** The Board received a report setting out performance against LAA targets, within its responsibility, during the first quarter of 2009/19. The Board discussed the format of performance reports and there was agreement that the introduction of more detailed exception reporting was useful. The Chair noted that the Board needed to concentrate its focus on areas of concern and requested that exception reports were not issued if an area was improving and requested that verbal updates were provided with respect to these targets. The Chair further requested that exception reports were given where targets were showing as Amber and performance was not improving. The Board discussed performance reporting and concern was raised as to whether data was being captured and measured across the partnership as a whole. There was agreement that work was required to develop a systematic approach to demonstrate this and that this issue should be raised with the HSP Manager. There was discussion around outputs and outcomes and the need to shift to outcome based measures. The Chair noted that a development session to look at the role of the Board, with respect to performance, would be useful. The Board discussed performance against Breast Feeding targets and it was noted that these fell within the responsibility of the Children's Trust. There was agreement that there should be discussion with the Children's Trust with respect to these targets and that the action being taken to address under performance should be reported to the Board at its next meeting. There was agreement that performance against targets relating to Safeguarding should be reported within each performance report. **RESOLVED:** i. That the report be noted.	Sarah Barter Sarah Barter Lisa Redfern / Helen Constantine Lisa Redfern / Helen Constantine Lisa Redfern Sarah Barter

	ii. That future performance reports should be developed to reflect the points raised above.	Sarah Barter
	iii. That a Development Session for the Board should be organised to help develop the Board's approach to performance monitoring.	Lisa Redfern
	iv. That officers should liaise with the lead officer for the Children's Trust to ascertain what measures were being taken to address under performance with respect to Breast Feeding targets and that feedback should be reported at the next meeting.	Lisa Redfern
OBHC160	**AREA BASED GRANT PROJECTS: 2008/09 END OF YEAR REVIEW** The Board received a report that provided an overview of findings of the review carried out projects funded by the Area Based Grant (ABG) during 2008/09. The Board discussed the report there was a general consensus that the format used made it difficult to identify which projects were subject to further review. The Chair noted that the report did not include the criteria against which the review had been carried out and consequently it was difficult for the Board to hold an informed discussion. Councillor Bevan noted that the Council had procured a new performance management system and expressed concern at the way performance information was now presented with reports. He noted that this was a wider issue that he had raised with the Leader of the Council. It was agreed that a more detailed report was required with respect to the eighteen projects undergoing further review and the criteria against which these had been selected and that this should be re-submitted at the Boards next meeting. **RESOLVED:** That a more detailed report was required with respect to the eighteen projects undergoing further review and the criteria against which these had been selected and that this should be re-submitted at the Boards next meeting.	Margaret Allen / Helen Constantine Margaret Allen / Helen Constantine
OBHC161	**INFORMATION SHARING PROTOCOL** The Board considered a report presenting the revised multi agency Information Sharing Protocol (ISP) for vulnerable adults. It was noted that the Haringey Strategic Partnership (HSP) Board had considered the Information Sharing across the Partnership in June 2009 and following this a multi agency officer group had been established to ensure that existing ISP's reflected changes in legislation and the Information Commissioner's template for good practice.	

	The Chair expressed disappointment that the report was presented for noting and that it did not contain criteria against which the Board could recommend changes. He requested that future reports should be presented in a way that highlighted where the Board could shape and make an impact on emerging policies rather than presenting the final pieces of work in their final stages. (This point applied to all future reports being submitted to the Board).	Lisa Redfern / Helen Constantine
	In response to a question it was confirmed that Data Protection issues had taken into consideration in the drafting of the Protocol.	
	The Chair requested that the London Ambulance Service was contacted and that provision was made within the Protocol to covering emergency situations and how these should be handled between the respective organisations. It was noted that this would be extremely useful in aiding organisations to work together quickly in an emergency.	Lisa Redfern
	RESOLVED: i. That the report be noted. II. That the London Ambulance Service should be contacted and provision should be made within the Protocol covering emergency situations and these should be handled between the respective organisations.	Lisa Redfern
OBHC162	**HEALTH INEQUALITIES NATIONAL SUPPORT TEAM VISIT**	

	The Board received a report setting out the process for the Health Inequalities National Support Team (NST) visit taking place between 5 to 9 October. It was noted that the visit was not intended to measure performance or audit services in any way. Instead it was designed to support and improve performance. An overview was given of the timetable for the visits and the briefing sessions that would take place prior to these. The Board was advised that since report had been written a meeting had been held with HAVCO to identify further community groups to take part in the workshop sessions. To date the North Middlesex had not advised who its representative would be and Richard Milner agreed to take this issue forward. There was agreement that 'Patient Link' should be included within the briefing session as their input would be vital in ensuring that the patient perspective was provided. In addition to Patient Link the CLF would be included within the briefings and the CLF's role in representing the Community and Voluntary Sector was acknowledged. **RESOLVED:** i. That the report be noted. ii. That Patient Link should be invited to attend the briefing sessions.	Richard Milner / Susan Otiti Susan Otiti Susan Otiti
OBHC163	**STRENGTHENING OVERVIEW AND SCRUTINY LINKS WITH THE HARINGEY STRATEGIC PARTNERSHIP** The Board received a report that set out how Overview and Scrutiny (O&S) would operate with respect to the Haringey Strategic Partnership. A key area of focus would be the Local Area Agreement (LAA) and performance against LAA targets. To support the HSP in achieving LAA targets the Scrutiny arrangements had been structured to reflect the areas covered by the Theme Boards. The Board was advised that Councillor Gina Adamou had been appointed as the lead member for Well-Being. In addition Councillor David Winskill had been appointed to look specifically at Health issues and Councillor Gideon Bull, Chair of the O&S Committee, would take on overarching role looking at scrutiny across the HSP Thematic Boards. The Chair noted that there had not, as stated in a letter sent to the Theme Board Chairs by the Chair of O&S, been discussion with the Theme Boards in determining the topic areas during the first year. He requested that as the relationship between the Scrutiny function and	Lisa Redfern /

	Boards developed there should be a dialogue regarding the areas that would be focused on. It was acknowledged that Members ultimately determined the topics that would be reviewed. There was agreement that once the O&S Work Plan had been set this should be shared with the Board and that there should be ongoing discussion between lead officers from the Scrutiny Team and Adult Services. **RESOLVED:** i. That the report be noted. ii. That once the O&S Work Plan had been set this should be shared with the Board and that there should be ongoing discussion between lead officers from the Scrutiny Team and Adult Services.	Trevor Cripps Lisa Redfern / Trevor Cripps Lisa Redfern / Trevor Cripps
OBHC164	**NEW ITEMS OF URGENT BUSINESS** No new items of Urgent Business were raised.	
OBHC165	**ANY OTHER BUSINESS** No items of AOB were raised.	
OBHC166	**DATES OF FUTURE MEETINGS** The dates of future meeting, set out below, were noted: • 8 December 2009 • 25 February 2010	

RICHARD SUMRAY

Chair

The meeting closed at 9.20pm.

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Agenda Item 5

haringey strategic partnership

Meeting: **Well Being Strategic Partnership Board**

Date: **8 December 2009**

Report Title: **Mental Health Needs Assessment - Update**

Report from: **Susan Otiti, Interim Joint Director of Public Health**

Purpose

To provide Board members with an update on the progress made in producing a mental health needs assessment and to highlight an area of concern.

Background

The Mental Health Needs Assessment (JSNA) forms part of Phase 2 of the Joint Strategic Needs Assessment. A briefing was presented and accepted by the JSNA Steering Group. Dr Klynman also presented the needs assessment briefing to the Well Being Chairs Executive in the spring to seek approval on the approach and to gain support in its development (Appendix 1). The proposal was approved and all partners agreed to identify officers to assist with the needs assessment.

NHS Haringey Public Health team is aiming to complete the needs assessment by the end of January 2010. The literature review is complete and most of the data has been analysed. We are now at the engagement part of the needs assessment process. We will be undertaking approximately 30 stakeholder interviews from health and mental health services. We are involving users through the Haringey Mental Health Services User consultation day.

The aim of the needs assessment is to identify the mental health need for patients in primary care, particularly those from black and minority ethnic groups, in order to improve access to services and reduce stigma for mental health conditions.

It will be important to keep the JSNA for mental health as a living working document as many aspects will need revisiting within a given time.

Key issues for consideration

Currently there is a gap in the depth of study of social care. If this gap continues the needs assessment will be biased towards health unfortunately there isn't anymore capacity within public health. We need an identified resource in the Council to take forward two areas;

- Interviews need to take place with stakeholders e.g. social services, housing community safety and the DAAT
- Would the Council like to undertake further user involvement, if so who will take this forward

Legal/Financial Implications

None.

Recommendations

i. That the Council to identify support to enable the completion of a comprehensive needs assessment.

ii. That Health Links to consider supporting the user engagement aspect of the needs assessment.

For more information contact:

Contact: Dr Nicole Klynman
Tel: 020 8442 5444
Email: Nicole.Klynman@haringey.nhs.uk

Use of Appendices

Appendix 1 –Proposal for Mental Health Needs Assessment

Appendix 1

Proposal for Mental Health Needs Assessment

Background

Mental health problems are common amongst the general population[i] however it is estimated 1 in 5 patients come from a black and minority ethnic group (BME)[ii]. It is likely that the combination of ethnicity with factors associated with deprivation lead to a greater proportion of black and minority ethnic patients suffering from a variety of mental health problems[iii].

The majority of patients, including BME groups, suffering from mental health problems will access services via primary care. It is vital that early identification and treatment is available for all patients. There is much literature on difficulties BME communities have accessing primary care and the level of stigma attached to mental health conditions in their communities[iv] [v] [vi]. Services for BME groups are often not specific to their cultural needs. BME patients themselves site a 'lack of choice and voice' when trying to access health services[vii] [viii]. It is vital that primary care services are responsive to the needs of the ethnically diverse communities.

In Haringey, it is estimated that 55% of the 228,000 residents come from a black and minority background[ix] [x]. It is known that some patients, especially those from BME groups, do not access services until they are at crisis point. This has led to recent failures of care[xi]. Haringey needs to ensure that primary care services are available for early identification and treatment and that its services are culturally specific.

Aim

To identify the mental health need for patients in primary care, particularly those from black and minority ethnic groups, in order to improve access to services and reduce stigma for mental health conditions.

Objectives

1) To determine if there is any unmet mental health need in primary care by:-

    a. Identifying relevant national and local policy in relation to primary care mental health provision

    b. Identifying an ideal model of primary care mental health service provision, including the use of IAPT and counsellors

    c. Predicting the prevalence of mental health need and comparing this to number of mental health patients known in primary care by age, sex, ethnicity and locality.

d. Predicting future primary care mental health need.

e. Mapping the provision of mental health services according to population need

f. Making recommendations to increase the number of patients accessing treatment in primary care

2) To identify the unmet needs of the black and minority ethnic (BME) community by:-

a. Identifying which BME groups are accessing primary and secondary care mental health services

b. Comparing the number of BME groups currently accessing services to the predicted number

c. Identifying those cases who only reach services at crisis point and ascertaining reasons for lack of early intervention

d. Understanding how Community Development workers can work with particular ethnic groups to improve access to services and decrease stigma

e. Understanding the cultural barriers to accessing mental health care in relation to stigma and discrimination.

f. Identifying specific services for BME communities and discovering how users may access these services

g. Engaging with service users in the BME communities and recognising why patients access services late and developing ways to overcome stigma.

h. Benchmarking BME specific services across London areas with large BME communities to ascertain if our services are comparable.

i. Making recommendations to improve the access and update of services for BME communities and reduce stigma

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[i] Goldberg D, Huxley P. Common mental disorders: a bio-social model. Tavistock/Routledge

[ii] Minister calls for improvements to mental health services for BME patients. Department of Health. 2007

[iii] King et al. The incidence of psychotic illness in London: a comparison of ethnic groups. BMJ 309:1115-1119

[iv] Street, Cathy, et al. Minority voices : research into the access and acceptability of services for the mental health of young people from black and minority ethnic groups. London : Young Minds, 2005 http://www.youngminds.org.uk/publications/all-publications/minority-voices/file

[v] Taha, Amjad BME Health Forum and Migrant & Refugee Communities Forum Caught between stigma and inequality : black and minority ethnic communities and mental well-being in Kensington and Chelsea and Westminster : recommendations for improved service delivery and partnership with local communities. London : BME Health Forum ; MRCF, 2005

[vi] Fernando, Suman Cultural diversity, mental health and psychiatry: the struggle against racism. Hove : Brunner-Routledge, 2003

[vii] Lakhami M. No patient left behind: how can we ensure world class primary care for black and ethnic minority people?. Department of Health 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971. Accessed on 1 April 2009

[viii] Palmer D, Ward K. 'Unheard voices': listening to refugees and asylum seekers in the planning and delivery of mental health service provision in London. CPPHIH 2006 http://www.irr.org.uk/pdf/Unheard_Voices.pdf

[ix] ONS – Census 2001

[x] GLA 2007

[xi] Care blunders 'failed to stop' knifeman who went on stabbing spree. http://www.thisislondon.co.uk/standard/article-23659426-details/Care+blunders+'failed+to+stop'+knifeman+who+went+on+stabbing+spree/article.do

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haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **8 December 2009**

Report Title: **Performance Report**

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

Purpose To inform the Wellbeing Partnership Board of any issues relating to performance of National and Local Indicators within the Well-Being Scorecard.
Summary A list of Performance Indicators from the Wellbeing Scorecard missing target, those on target * and those where no data is available with timescale.
Legal/Financial Implications None identified.
Recommendations To note the report.
For more information contact: Name: Leks Omiteru Title: Performance & Quality Assurance Manager Tel: 020 8489 2402 Email address: leks.Omiteru@haringey.gov.uk

Background

1. This report summarises performance in the key LAA indicators which form part of the Wellbeing Thematic Board. Appendix 1 shows performance against all the indicators that the thematic board has agreed to overview. Appendix 2 provides an exception report focusing on those indicators which are missing target. For many of these indicators the Wellbeing board is not the lead body.

Key performance messages

2. Overall the majority of the Wellbeing indicators are on or close to target some highlights are:

- Number of older people permanently admitted into residential and nursing care (65 older people in the year to September against the target of 67)

- Number of adults permanently admitted into residential and nursing care (6 adults in the year to September against a target of 11)

- Percentage of carers receiving needs assessment or review and a specific carer's service, or advice and information (14.3% against the year to date target of 11.2%)

- The targets for reducing smoking have been met for the first quarter of the year although data for the second quarter is awaited.

- The percentage of vulnerable people achieving independent living at 81.5% is exceeding the 75% target.

3. In the following areas indicators at risk of missing targets For the majority of these indicators the Wellbeing board is not the lead body:

- Adults in contact with secondary mental health services in settled accommodation (NI 149) - Uncertainty relating to where we are in terms of performance as Mental Health has not supplied any verifiable data for this indicator.

- Percentage change in under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline. NI 112) – Although the target is not being met, the rate of decrease in Haringey is far greater that the average for London. The rolling quarterly average is now down to 61.2 per 1000, the first time we have achieved a quarterly average rate lower than our 1988 base rate of 62.7. Annual rates for 2008 will be released in Feb 2010.

- Early Access for Women to Maternity Services (NI 126) - Currently under target, but showing an improving trend with an increase from 51.9% to 73.6% since the end March. A Maternity action plan is in place, overseen by the Maternity Steering Group.

- Prevalence of breast-feeding at 6-8 wks from birth (NI 53 a & b) – For quarter 2 figures appear low but this is mainly because data is still awaited from a number of GPs who have been late to submit due to H1N1 swine flu. This additional data will be resubmitted to NHS London and the Department of Health when it becomes available. The expected impact should lift performance above target.

- Number of accidental dwelling fires – Quarter 2 performance is within the expected range for this indicator. The projected performance is short of the target. Steps put in place to improve performance include:
  - Increase in Home Fire Safety Visit target
  - Targeting households that fall within priority areas identified as most likely geographic areas for fires to occur.
  - Working with drug and alcohol practitioners and those that work with the elderly and disabled to identify individuals who are vulnerable to fire.

Indicators with no Quarter 2 data

Source	Indicator	Due Date
ACCS	NI 141 Percentage of vulnerable people achieving independent living	Data due end of November
Health	% of HIV infected patients with CD4 count less than 200 cells per mm3 diagnosed	Data due December 2009.
Health	Smoking cessation – increase in the number of smoking quitters in N17 (2007 – 2010 stretch target)	Data available mid December
Health	NI 123_N Number of 4-week smoking quitters who attend NHS Stop Smoking Services	Data available end of November.
Health	NI 39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm	Q2 data not available because North West Public Health Observatory are experience delays in publishing their figures. However, PCT provides us local quarterly estimates which will be available in December.
Health	NI 39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm.	2 quarters behind. Qtr 1 data will be available in January.

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Appendix 1

Well-being Theme Board Scorecard - Quarterly Indicators

Sort	Short Name	2008/09		Q1 2009/10			Q2 2009/10			2009/10 (YTD)			Latest Note
		Value	Status	Value	Target	Status	Value	Target	Status	Value	Target	Status	
L0114 LAA	Improved living conditions for vulnerable people ii) Number of older people permanently admitted into residential and nursing care - YTD (2007 -2010 stretch target)	135		20	29		57	57		65	67		Please note that the 2009/10 target shown is YTD, YTD performance is good and on course to improve on last year's performance.
L0115 LAA	Improved living conditions for vulnerable people iii) Number of adults permanently admitted into residential and nursing care - YTD (2007 -2010 stretch target)	10		1	5		5	10		6	11		Please note that the 2009/10 target is YTD. YTD performance is good and on course to improve on last year's pe
LAA stretch	Smoking cessation - increase in the number of smoking quitters in N17 (2007-2010 stretch target)	632		133	50			75		133	50		
NI 39	Rate of Hospital Admissions per 100,000 for Alcohol Related Harm	1626		433	414			413		433	414		The latest provisional figures from NWPHO on NI39 are available for 08-09 financial year (available from: http://www.nwph.net/alcohol/lape/download.htm). The data indicates we have missed the target by 51 admissions for that period with admissions per 100 000 population at 1630 against the target of 1579. The local estimate derived from PCT SUS data for the Q1 in 09-10 shows admissions at 433 per 100,000. This is higher than any quarter in 2008/09 and if the admissions continue to be as high the yearly target will not be met.

Sort	Short Name	2008/09		Q1 2009/10			Q2 2009/10			2009/10 (YTD)			Latest Note
		Value	Status	Value	Target	Status	Value	Target	Status	Value	Target	Status	
													It should be noted however that outcomes from the new investment and the local actions are likely be seen long term as a large number of admissions are a result of long term drinking. This target also includes partially attributed conditions like falls and hypertensive diseases that can be linked to alcohol but may have other causes.
NI 40	Number of drug users recorded as being in effective treatment			1022		?	995		?	989	1017	▲	
NI 53a	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants being breastfed at 6-8 weeks	65.95 %	✓	62.36 %	60%	✓	43.1%	61.7%	●	43.1%	60%	●	All data for Q1has now been collected.Q2 2009-10 prevalence is low, as we are still awaiting data from a number of GPs, it is anticipated that like Q1 the target will eventually be met.
NI 53b	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants for whom breastfeeding status is recorded (as being totally or partially breastfed at 6-8 weeks that quarter)	86.4%	✓	86.4%	85%	✓	32.8%	86.6%	●	32.8%	86.6%	●	Q1 2009-10 prevalence is low, as we are still awaiting data from a number of GPs who have been late to submit due to H1N1swine flu. This additional data will be resubmitted to NHS London and the Department of Health when it becomes available. The expected impact should lift performance above target.
NI 112 BV197	Percentage change in under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline)	12.4%	●	-16.5%	-18.1%	●	-8.2%	-18.1%	●	-8.2%	-18.1%	●	This covers the quarterly period April-June 2008 (49 actual number of conceptions) The rate as 57.2 per 1000 (49 actual conceptions), this is a decrease of 23.8 from Q2 07 which was 81.0per 1000. London rate showed a 2.00 per cent decrease from the Q2 07 rate. This means our rolling quarterly average is now down to 61.2 per 1000 which is first time we have a achieved a quarterly average rate lower than our 1988 base rate of 62.7 and the first time that we have acheived two consecutive rates on the 50s. Our Q2 rates have consistently shown a significant increase from Q1 but the today's data shows there has been a small increase from Q1 08 which was 52.1 per 1000 (45 actual conceptions). 2008 Annual rates will be released in Feb 2010.

Sort	Short Name	2008/09		Q1 2009/10			Q2 2009/10			2009/10 (YTD)			Latest Note
		Value	Status	Value	Target	Status	Value	Target	Status	Value	Target	Status	
													ONS Q3 2008 is due for release end of November 2009. Local TP data monitoring compiled by Public Health, NHS Haringey currently shows the number of conceptions for Q3 2008 as 30 – if this is similar to ONS data then the significant decrease in rates achieved in 2008 will continue. ONS Q3 2007 was 65.2 per 1000 with 58 actual numbers of conceptions. Our trajectory target for 2008 from Teenage Pregnancy Unit is 56 per 1000. We are currently on target to achieve this.
NI 113a	Prevalence of Chlamydia in under 25 year olds - Part 1 - Chlamydia screens/tests	17.1%		3.4%	3.1%		7.0%	6.2%		7.0%	6.2%		To be verified by HPA
NI 113b	Prevalence of Chlamydia in under 25 year olds - Part 2 - new diagnoses of chlamydia	No data for this range					5.8%			5.8%			To be verified by HPA
NI 121	Mortality rate from all circulatory diseases at ages under 75 per 100,000 population	93.80		90.00	94.00		90.00	94.00			94.00		This data is due December 2009
NI 123_N	Number of 4-week smoking quitters who attended NHS Stop Smoking Services	1939		356	250			500		356	250		
NI 125	Achieving independence for older people through rehabilitation/intermediate care	79.8%					79.2%			78.3%			We are slightly below the 80% target for the month of October. The method of recording the NI 125 data will be recorded on the Framework-I system as from November, which will be a more robust system for recording the data. We expect with this increased scrutiny that this target will be acheived.
NI 126	Early Access for Women to Maternity Services	51.9%		73.6%	80.0%		79.2%	80.0%		76.4%	80.0%		Currently under target, but showing an improving trend with an increase from 51.9% to 73.6% since the end March. A Maternity action plan is in place, overseen by the Maternity Steering Group.
NI 135	% of carers receiving needs assessment or review and a specific	22.1%		7.7%	4.8%		12.8%	9.6%		14.3%	11.2%		Target has been profiled to hit 19.2% by year end in line with LAA.

Sort	Short Name	2008/09		Q1 2009/10			Q2 2009/10			2009/10 (YTD)			Latest Note
		Value	Status	Value	Target	Status	Value	Target	Status	Value	Target	Status	
	carer's service, or advice and information - YTD												
NI 141	Percentage of vulnerable people achieving independent living	81.5%		81.5%	75%			75%		81.5%	75%		
NI 153	% of working age people claiming out of work benefits in the worst performing neighbourhoods	26.4%									26.3%		The measurement time period for this indicator is the four quarters to May of each year. Data for 2008/09 (four quarters to May 2009) will not be available until November 2009. However, in the four quarters to February 2009 the out of work benefits claim rate was 26.5% down from a rate of 26.8% in the previous year. The interventions that contribute to achieving the target associated with NI 153 include the Haringey Guarantee and DWP/JCP mainstream provision such as the New Deal, Employment Zones and Pathways to Work.
NI 156	Number of households living in temporary accommodation	4548		4403	4280		4123	4032		3982	3952		The number of Homeless Households in Temporary Accommodation continued to fall during October with a significant reduction of 141 in the month, this combined with the reduction achieved in September of 144 household has meant that the actual figure in TA is just 30 households short of the original forecast for October set in April 2009 . These improved performances over the last couple of months arise from the significant progress of the EA project in reducing high cost nightly rated accommodation and the improvement in performance by the Housing Service as a whole. The year end target of 3552 households in Temporary Accommodation is now well within reach of the service and will represent a reduction of nearly 1000 households in Temporary Accommodation during this financial year.

Well-being Themeboard Scorecard - Annual Indicators

Sort	Short Name	2008/09		2009/10			Latest Note
		Value	Status	Value	Target	Status	
LAA local	% of HIV infected patients with CD4 count less than 200 cells per mm3 diagnosed				40.1%		Data is now due from NHS Haringey in December 09 due to diversion of resources into dealing with the swine flu pandemic.
NI 1	% of people who believe people from different backgrounds get on well together in their local area	75.6%			77.9%		Final published Place Survey result from Communities and Local Government. This outturn is comparable with the London average of 76.3%. The next Place Survey will be carried out in 2010.
NI 6	% of people who take part in formal volunteering at least once a month.	21%			22.7%		Final published Place Survey result from Communities and Local Government. No target was set for 2008/09. The next Place Survey will be carried out in 2010.
NI 7	Environment for a thriving third sector	18.9%			21.9%		No target was set for 2008/09, this performance will act as baseline for future years. Targets for 2009/10 and 2010/11 are now set.
NI 08	Adult participation in sport and active recreation (2007-2010 stretch target)				26.9%		2008/09 active people data will be available in November 2009 The Hariactive 'make a Change' programme designed to increase the number of residents engaging in physical activity was formally launched on 27th June. Free Swimming for Over-60s and 16's and under was successfully launched on the 1st April. At the end of June over 10,000 people were registered on the scheme.
NI 35	Building resilience to violent extremism	2			3		Self evaluation has been completed and average score submitted to DCLG Data Interchange Hub.
NI 51	Effectiveness of child and adolescent mental health	13			15		Four elements of CAMHS (learning difficulties, 24 hour cover urgent mental health, services for 16 and 17 years old, early

Sort	Short Name	2008/09		2009/10			Latest Note
		Value	Status	Value	Target	Status	
	(CAMHS) services						identification and intervention) and scored on a scale of 1-4, maximum overall score is 16.
NI 56(x)	Obesity in primary school age children in Year 6: Line 10				23.8%		2008/09 figure expected December 09
NI 116	Proportion of children in poverty				32.5%		Frozen target to be reassessed at year 2 refresh.
NI 119	Self-reported measure of people's overall health and wellbeing	80%			80%		Final published Place Survey result from Communities and Local Government
NI 127	Self reported experience of social care users (measured by survey every 3 years)			No data for this range			This indicator is measured by survey every 3 years. Annual survey due to take place in 09/10. The latest results from the service user questionnaire from Adults Services found that 89% of clients were satisfied with the services they were receiving.
NI 140	Fair treatment by local services	60.8%			62.6%		Final published Place Survey result from Communities and Local Government
NI 175	Access to services and facilities by public transport, walking and cycling						Joan Hancox is contacting neighbouring boroughs to assist with target setting.
NI 187a	Tackling fuel poverty – % of people receiving income based benefits living in homes with: (i) Low energy efficiency	13.53%			12.53%		This Indicator relates to the SAP ratings of homes occupied by vulnerable households. Performance is assessed on the basis of a postal survey form sent to 5000 households (selected at random from a list supplied by the Benefits and Local Taxation Service) that is sent out in December each year. The returned survey forms are analysed and returns submitted to DEFRA by the end of February. Although the results of the 2009/10 survey will not be known until February 2010, the results for 2008/09 showed that 13.5% of vulnerable residents were living in homes with a poor SAP rating of less than 35 (compared to this year's target of 12.5%) and 13.0% of vulnerable residents were living in homes with a good SAP rating of above 65 (compared to this year's target of 14.0%). The target is based on matching the average percentage

Sort	Short Name	2008/09		2009/10			Latest Note
		Value	Status	Value	Target	Status	
							decrease in England (0.8%). Haringey's Affordable Warmth Strategy 2009-19 will be published in Autumn 2009.
NI 187b	Tackling fuel poverty – % of people receiving income based benefits living in homes with: (ii) High energy efficiency	13.04%			14%		This Indicator relates to the SAP ratings of homes occupied by vulnerable households. Performance is assessed on the basis of a postal survey form sent to 5000 households (selected at random from a list supplied by the Benefits and Local Taxation Service) that is sent out in December each year. The returned survey forms are analysed and returns submitted to DEFRA by the end of February. Although the results of the 2009/10 survey will not be known until February 2010, the results for 2008/09 showed that 13.0% of vulnerable residents were living in homes with a good SAP rating of above 65 (compared to this year's target of 14.0%). The target is based on matching the average percentage increase in England (0.8%) Haringey's Affordable Warmth Strategy 2009-19 will be published in Autumn 2009.
QoL23 NI 4	% of people who feel they can influence decisions in their locality	40.3%			42.9%		Final published Place Survey result from Communities and Local Government. In Haringey, 40.3% agreed that they felt they could influence decisions in locality. This is above the London average of 35% and places us 4th highest in London and above the national average of 29%. The next Place Survey will be carried out in 2010.

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Wellbeing Theme board Exception Report

Appendix 2

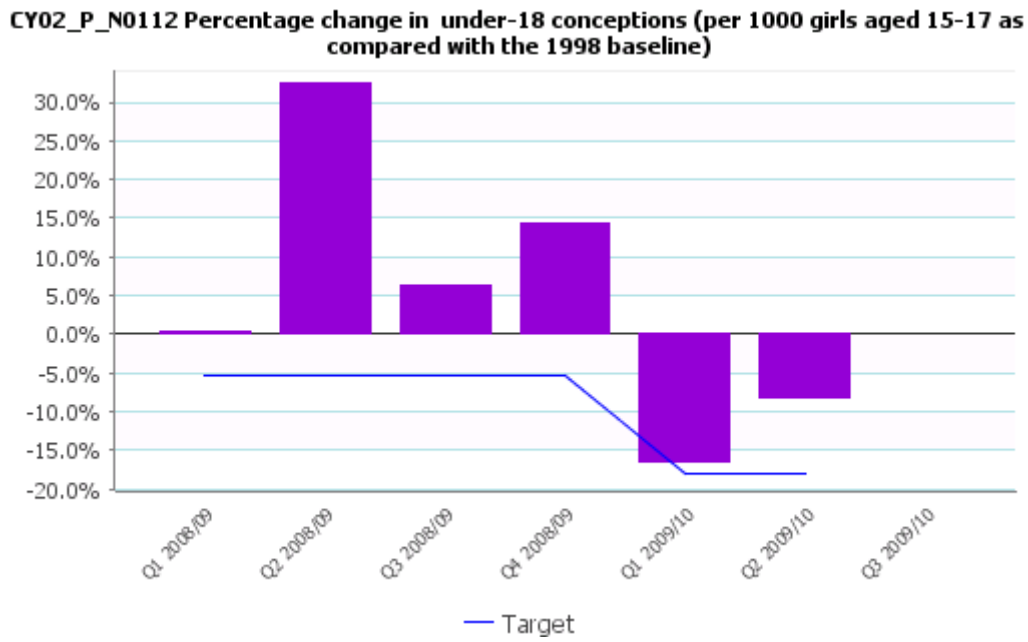
NI 112 BV197	**Percentage change in under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline)**

Sustainable Community Strategy Outcome: **Healthier People with a better quality of life**	Portfolio: **Children and Young People**

There is a national target to reduce the under 18 conception rate by 50% by 2010 (compared to the 1998 baseline rate) as part of a broader strategy to improve sexual health. (Target shared between the Department of Health and the Department for Children, Schools and Families.)

2009 - 2010		
	Value	Target
Q1 2009/10	-16.5%	-18.1%
Q2 2009/10	-8.2%	-18.1%
Q3 2009/10		
Q4 2009/10		
2009/10	-8.2%	-18.1%

Red



This covers the quarterly period April-June 2008
The Q2 rate as 57.2 per 1000 (49 actual conceptions), this is a decrease of 23.8 from Q2 07 which was 81.0 per 1000. London rate showed a 2% decrease from the Q2 2007 rate.

This means our rolling quarterly average is now down to 61.2 per 1000 which is first time we have a achieved a quarterly average rate lower than our 1988 base rate of 62.7 and the first time that we have achieved two consecutive rates in the 50s. Our Q2 rates have consistently shown a significant increase from Q1 but the current data shows there has been a small increase from Q1 08 which was 52.1 per 1000 (45 actual conceptions).

2008 Annual rates will be released in Feb 2010.

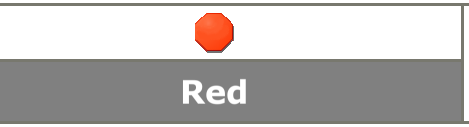
ONS Q3 2008 is due for release end of November 2009. Local TP data monitoring compiled by Public Health, NHS Haringey currently shows the number of conceptions for Q3 2008 as 30 – if this is similar to ONS data then the significant decrease in rates achieved in 2008 will continue. ONS Q3 2007 was 65.2 per 1000 with 58 actual numbers of conceptions. Our trajectory target for 2008 from Teenage Pregnancy Unit is 56 per 1000. We are currently on target to achieve this.

NI 53a	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants being breastfed at 6-8 weeks

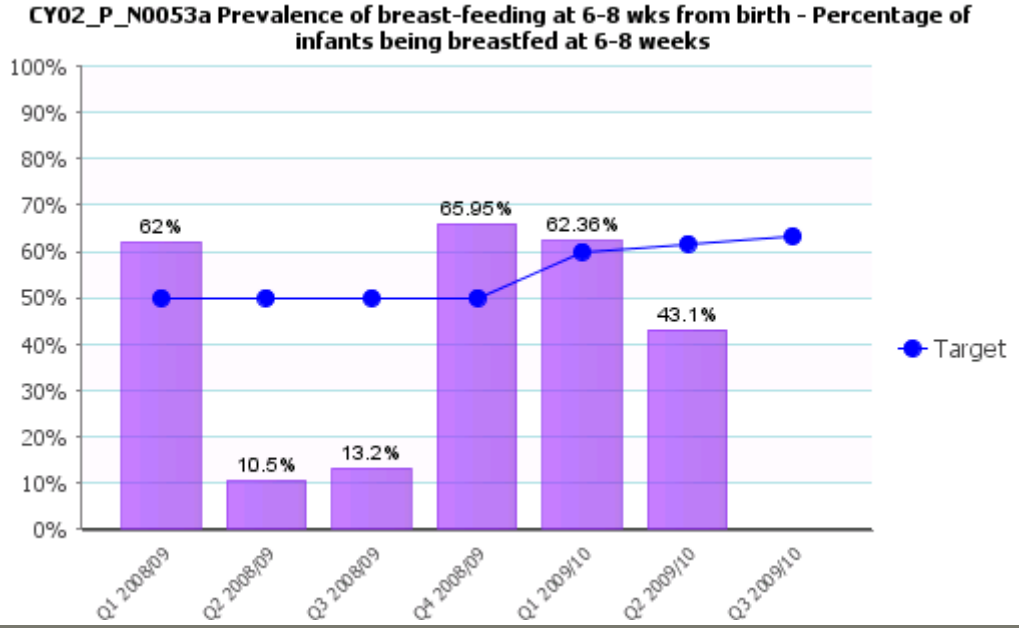
Sustainable Community Strategy Outcome: **Healthier People with a better quality of life**	Portfolio: **Children and Young People**

To provide an impetus to enhance health and children's support services to mothers to sustain breastfeeding and thus give children a good start early in life.

2009 - 2010		
	Value	Target
Q1 2009/10	62.36%	60%
Q2 2009/10	43.1%	61.7%
Q3 2009/10		63.3%
Q4 2009/10		64.8%
2009/10	43.1%	60%



Red



All data for Q1 has now been collected. Q2 2009-10 prevalence appears low, as we are still awaiting data from a number of GPs, it is anticipated that like Q1 the target will be met.

NI 53b	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants for whom breastfeeding status is recorded (as being totally or partially breastfed at 6-8 weeks that quarter)

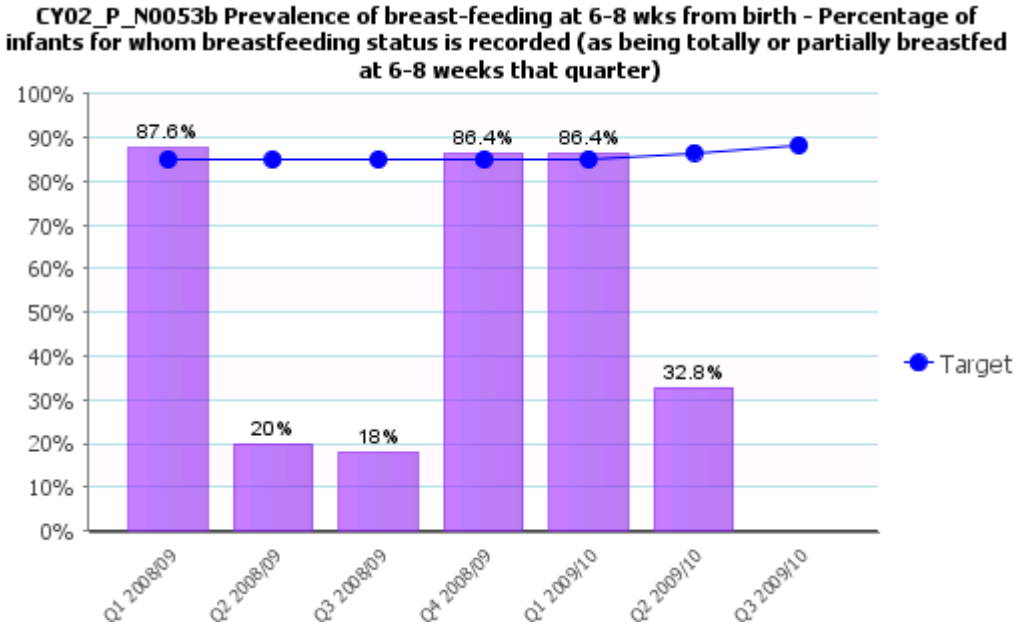
Sustainable Community Strategy Outcome:
Healthier People with a better quality of life

Portfolio:
Children and Young People

To provide an impetus to enhance health and children's support services to mothers to sustain breastfeeding and thus give children a good start early in life.

2009 - 2010		
	Value	Target
Q1 2009/10	86.4%	85%
Q2 2009/10	32.8%	86.6%
Q3 2009/10		88.3%
Q4 2009/10		90%
2009/10	32.8%	86.6%

Red



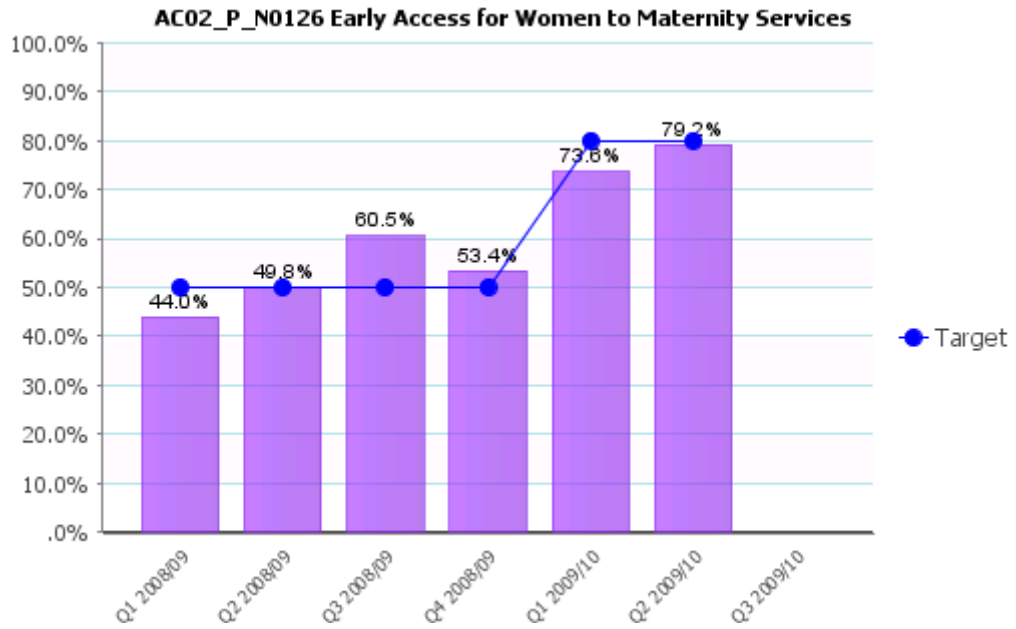
Q1 2009-10 appears prevalence is low, as we are still awaiting data from a number of GPs who have been late to submit due to H1N1 swine flu. This additional data will be resubmitted to NHS London and the Department of Health when it becomes available. The expected impact should lift performance above target.

NI 126	Early Access for Women to Maternity Services
Sustainable Community Strategy Outcome: **Healthier People with a better quality of life**	Portfolio: **Children and Young People**

All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby.

2009 - 2010		
	Value	Target
Q1 2009/10	73.6%	80.0%
Q2 2009/10	79.2%	80.0%
Q3 2009/10		
Q4 2009/10		
2009/10	76.4%	80.0%

Amber



Currently under target, but showing an improving trend with an increase from 51.9% to 73.6% since the end March. A Maternity action plan is in place, overseen by the Maternity Steering Group.

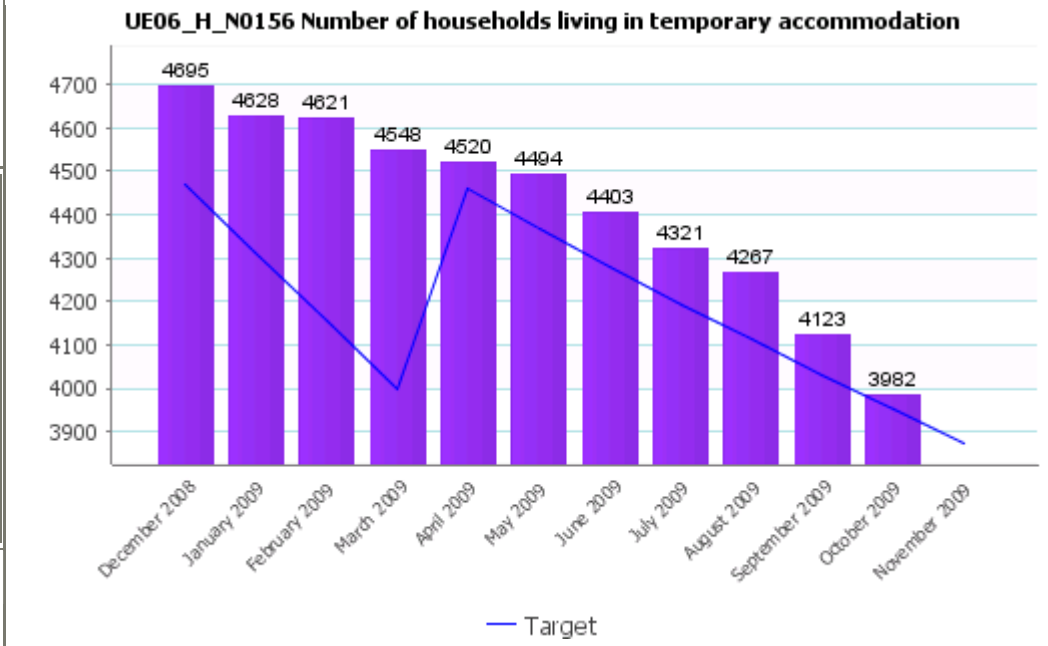
NI 156	Number of households living in temporary accommodation

Sustainable Community Strategy Outcome: **Healthier People with a better quality of life**	Portfolio: **Integrated Housing**

To monitor progress towards halving the number of households in temporary accommodation provided under the homelessness legislation from 101,000 households in Q4 2004 to 50,500 households by 2010.

2009 - 2010		
	Value	Target
Q1 2009/10	4403	4280
Q2 2009/10	4123	4032
Q3 2009/10	3982	3952
Q4 2009/10		
2009/10	3982	3952

Amber



The number of Homeless Households in Temporary Accommodation continued to fall during October with a significant reduction of 141 in the month, this combined with the reduction achieved in September of 144 households has meant that the actual figure in TA is just 30 households short of the original forecast for October set in April 2009 . These improved performances over the last couple of months arise from the significant progress of the Emergency Accommodation project in reducing high cost nightly rated accommodation and the improvement in performance by the Housing Service as a whole. The year end target of 3552 households in Temporary Accommodation is now well within reach of the service and will represent a reduction of nearly 1000 households in Temporary Accommodation during this financial year.

haringey strategic partnership

Meeting: **Well-Being Partnership Board**

Date: **8 December 2009**

Report Title: **Area Based Grant Projects End of Year Review**

Report of: **Margaret Allen Assistant Director, Safeguarding and Strategic Services**

Purpose

To provide the Well-being Partnership with additional information requested by the Board on 24 September 2009 regarding the end of year review.

Summary

(i) Key criteria of the review:

The panel, made up of officers from Corporate Finance, Strategic Commissioning and the Governance and Partnerships Team, assessed projects against the following criteria:

- Delivery against agreed project targets.
- Delivery against the well-being priority outcomes, Local Area Agreement, National Indicators and Sustainable Community Strategy outcomes.
- Evidence of value for money.

The 'Self-Assessment Form' (Appendix 2), which all project leads completed, provides more detail of the criteria against which projects were assessed. The 'Panel Assessment Form' (Appendix 3) was used by panel members to assess the completed self-assessments and during the one-to-one meetings with project leads.

(ii) Projects required to undergo further review:

Following the end of year review, based on the self-assessments, one-to-one meetings and evidence submitted, the panel identified a number of projects that required further review prior to 2010/11. The attached spreadsheet (Appendix 1) provides a breakdown of these projects with details of the required action.

A significant number of the aforementioned projects/initiatives deliver statutory services, and leads have been requested to review said projects with a view to rationalise or merge where appropriate. The panel also requested that any overlap between projects was explained in detail.

All projects/initiatives are regularly monitored using the Council's budget and

performance monitoring processes. Those that have a contract with the Council are also required to undergo regular contract monitoring.

Financial Implications

Funding has been agreed for 52 projects, allocating all available funding for the current financial year. No allowance has been made for inflation and projects will be required to make efficiency savings in order to remain within their funding allocation.

For 2010/11, funding for 34 projects has been agreed and the remaining 18 will undergo further review. However the overall ABG funding for 2010/11 is still subject to confirmation from Communities and Local Government (CLG), which will come through as part of the local government settlement, early in 2010. Again, no allowance will be made for inflationary increases and further efficiencies within the projects must be found.

Recommendations

That the Board notes the information within this report.

For more information contact:

Name: Helen Constantine
Title: Head of Governance and Partnerships
Tel: 020 8489 3905
Email address: helen.constantine@haringey.gov.uk

Background:

For further background information, please see report entitled 'Area Based Grant Projects: 2008/9 End of Year Review' presented to the Well-being Partnership Board on 24 September 2009.

Use of Appendices:

Appendix 1: Breakdown of the projects required to undergo further review and the panel's recommendations.

Appendix 2: Self Assessment Form

Appendix 3: Panel Assessment Form

Appendix 1: Projects with confirmed funding until end of 2010

Ref:	Project Title	Statutory Service	Project Description	08/09 ABG Allocation	Review Recommendations
WB-01	Support for Carers	✓	Provision of short breaks, training, counselling, advocacy and access to assessments to mental health carers living in Haringey	29,500	Project did not meet carers assessments target. Funding confirmed until March 2010. Contracts to undertake a review and quality assurance of the service prior to confirming 2010/11 funding. SMART targets to be set on award of contract.
WB-01	Asian Carers Support Centre	✓	Provision of linguistically and culturally appropriate support, information and advocacy to Asian carers in Haringey through a community-based, inclusive approach (carer and cared for)	26,900	Funding confirmed until March 2010. Contracts to undertake a review and quality assurance of the service and to ensure evidence of carers assessments is gathered throughout 2009/10, prior to confirming 2010/11 funding.
WB-01	Respite	✓	Provision of culturally appropriate support and respite to carers in Haringey	707,800	Funding confirmed until March 2010. Contracts to undertake a review and quality assurance of the service prior to confirming 2010/11 funding. SMART targets to be identified with clear milestones.
WB-11	Health in Mind - Mental Health	X	Therapeutic network and graduate mental health workers	133,000	Funding confirmed until March 2010, The panel have requested an update on the new commissioning arrangements with NHS Haringey prior to confirming funding for 2010/11.
WB-12	Alexandra Road	✓	Provides emergency 24 hour care to prevent hospital admission and respite care to mental health service users and their carers	128,200	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring.
WB-13	Clarendon Centre	X	Service for adults recovering from severe and enduring mental illness receiving a service from secondary mental health services	56,601	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring. Project manager needs to ensure targets are linked to the performance management framework and data is captured by way of evidence.
WB-14 / WB-28	CSW Assertive Outreach	X	Provides intensive daily support to mental health service users living in their own homes and work to maintain clients living independently and seek to prevent readmission to hospital	94,000	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring. Project manager needs to ensure targets are linked to the performance management framework and data is captured by way of evidence.
WB-15	Employment & Training (Clarendon Centre)	X	Provision of access to employment, the development of individual employment projects and training for service users	89,822	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring. This should include particular focus on linkage between WB-15 and WBH-17. The target for voluntary work experience should increase to 40 & target for income maximisation increase to 40.
WB-17	Studio 306	X	Emerging social firm providing volunteering and potential employment for adults recovering from mental illness.	26,478	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring. This should include particular focus on linkage between WB-15 and WBH-17.
WB-27	Approved Social Work Services (Canning Crescent)	✓	Approved Social Worker (ASW) posts within the community mental health service	80,800	Funding confirmed until March 2010. Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring.
WB-29	Social Workers (North Tottenham)	✓	Funds a Social Worker post within the community mental health service and contribution to team running cost	50,000	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring.

Ref:	Project Title	Statutory Service	Project Description	08/09 ABG Allocation	Review Recommendations
WB-30	Social Workers Running Costs	✓	Funds running costs to enable social Worker posts within the community mental health service to carry out duties effectively	34,200	Funding confirmed until March 2010. Panel requested project manager to provide further report (prior to confirming 2010/11 funding) outlining how the MHG projects link with each other, with the possibility of merging projects for ease of performance and budget monitoring.
WB-32	Happy Opportunities	X	Empower at least 30 adults, 50 years and older primarily from BME communities, to build their capacity so that real positive changes are made	17,000	Funding confirmed until March 2010. Governance and Partnerships to meet with project manager for progress of catering firm to generate income prior to confirming 2010/11 funding.
WB-34	Salsa Club 50+	X	Dance and salsa classes for elderly in Haringey. Classes are combination of exercise, music, self expression and socialising	9,000	Funding confirmed until March 2010. Governance & Partnerships to meet with project manager to review plans for attracting more male participants (life expectancy for males) prior to confirming 2010/11 funding.
WB-39	Commissioning Support	✓	Supports the placements of individuals in the community, who have particularly high needs.	76,818	Funding confirmed until March 2010. Head of Governance and Partnerships to meet with Head of Commissioning to ensure targets set are SMART and that evidence is captured, prior to confirming 2010/11 funding.
WB-40	Mental Health Commissioning	✓	Supports the placements of individuals in the community, who have particularly high needs	51,142	Funding confirmed until March 2010. Head of Governance and Partnerships to meet with Head of Commissioning to ensure targets set are SMART and that evidence is captured, prior to confirming 2010/11 funding.
WB-46	Open Door	X	Provides a range of specialist projects to provide emotional and therapeutic support to young people (12 – 24), parents and carers	25,000	Funding confirmed until March 2010. Commissioning service to undertake a review prior to confirming 2010/11 funding. Commissioning should agree targets with provider and ensure that performance is being tracked and benefits/outcomes are evidenced. The panel also thought there may be a possibility to increase support to parents and carers. In addition, contract manager to receive update on potential funding from the National Lottery to provide Parenting Teenagers Project on an outreach basis, as well as a grant from City Bridge Trust for a schools based project and CBT across the age range.
WB-48	Rainer	✓	Offers an Appropriate Adult Service in Haringey custody suites for people with mental health, learning disabilities and children who have been arrested for an offence	20,081	Funding confirmed until March 2010. Outstanding evidence to be supplied . Contracts to undertake a review prior to confirming 2010/11 funding.

Well Being Strategic Partnership

INSERT PROJECT TITLE

Project Reference WB-XX

START DATE: []
END DATE: []

Quarterly Highlight Report

LEAD PARTNER:	
PROJECT MANAGER:	
CONTACT DETAILS	
FUNDING	
REPORTING PERIOD	**End of Year Report**

Overall RAG Status		Time-scale	Human Re-sources	Issues	Risks	Budget
This quarter	*Last quarter*					

[See RAG Guidance Appendix A for definition of each RAG status]

1	LAA Outcomes & Well-being Targets

2	Project Objectives/Targets

3	**What were the overall outcomes and key achievements over the lifetime of the project? Include any Capacity building.** *Did the project meet all the objectives and targets? If not, why not?*

4	**How has the project made a real impact on service users?** *(Please provide at least 1 case study – ensure that you maintain confidentiality i.e. no names, address etc)*

5	What challenges did you face delivering this project and what would you have done better?

6	How has the project achieved value for money?

7	Sustaining the project/future developments?

8 PROJECT TIMESCALES / MILESTONES

[Definition of a milestone: high-level events that must take place in order for the project to succeed]

[Milestones should be taken from the project initiation document (PID) where one exists. Where there is no PID Milestones should be as reported in the previous quarterly highlight report]

[Milestones should include key outputs, activities and outcomes]

Project Milestones							
No	**Milestone(s)**	**Original Target Date**	**Current Target date**	**Actual Completion date**	**Status (RAG)**	**Explanation for Red/Amber status and any target date variances**	**Projected Financial Impact* £'000**
1							
2							
3							
4							
5							
6							
7	*[Add rows as required]*						
Total Financial Impact							

**The amount (i.e. financial impact) that relates to the milestone not meeting its target*

9 PROJECT BUDGET

Budget for the current financial year								
Project cost	**Original budget**	**Revised budget**	**Profiled budget to date**	**Actual expenditure to date**	**Year to date variance ***	**Projected expenditure for year**	**Projected variance for year**	**RAG status**
[Add rows as required]								
TOTAL								

(Note RAG status – RED if projected in excess of 5% or £500k over or under, whichever is the lower amount; AMBER if between 2.5% and 5% or £250k and £500k over or under, whichever is the lower amount; GREEN up to 2.5% or £250k over or under, whichever is the lower amount.)

**This is the difference between Actual expenditure to date and Profiled budget to date.*

9.1 EXPLANATION FOR VARIANCES AND REMEDIAL ACTION BEING TAKEN

In budgetary terms, there is no 'variance' visible. The actual expenditure and profiled budget are the same. This is because the contract value is paid in full, with issues of under-performance addressed retrospectively. Committed costs for the 3 quarters of 2008-9 are cumulatively 25% under budget, hence ongoing concern with value for money. This is to be addressed with an action plan agreed with the provider.

The project manager has notified the implications of the present situation to Association members.

10 ISSUES

*[**Issues** are events or actions that **are already a reality** and could or are impacting the project in some way. Once a risk becomes an issue, that is, it is happening, it should no longer be reported as a risk]*

No.	Issue	Issue Owner	Resolution plan	Status (RAG)	Deadline
1					

11 KEY RISKS

*[**Risks** are events or actions that **have not yet happened.** They could be an opportunity or may adversely affect a project team's ability to deliver the project on time, within budget and to the agreed objectives. State clearly both what may happen and what the impact will be if it were to occur e.g. **there is a risk that… which would lead to…)***

Risk	Risk Owner	Impact (H/M/L)	Probability (H/M/L)	Proximity MM/YY	Mitigation Plan Summary
					•

***Impact status** -*
H in excess of 5% project budget or £500k, whichever is the lower amount OR adverse national publicity;
M between 2.5% and 5% project budget or £250k and £500k, whichever is the lower amount OR adverse local publicity;
L up to 2.5% project budget or £250k, whichever is the lower amount AND no adverse publicity

Probability status *– H more that 60% likelihood, M up to 60% likelihood, L up to 20% likelihood*

Proximity *– when is the risk likely to occur OR until when is risk relevant to the project*

Appendix A

Corporate RAG Status Guidance

	Green	Amber	Red
Overall	Project on schedule to deliver the agreed benefits in line with Project Plan. Budget status is GREEN and funding for over spends has been identified.	The project has encountered some issues which could affect the delivery of overall benefits within agreed time, cost and resources. Recovery action is underway, but has either not yet been approved or tested.	Delivery of overall benefits within agreed time, cost and resources is not presently possible; OR The project may have stalled and requires URGENT project board attention.
Timescales	Project progressing to plan and scheduled to deliver on, or ahead of, time.	At least one key milestone has been or will be missed which will impact the overall delivery date. A revised project plan which evidences that recovery is possible has been produced but not approved.	At least one key milestone has been or will be missed which will impact the overall delivery date. A revised project plan which evidences that recovery is possible has yet to be produced.
Human Resources	The project is fully resourced.	A lack of human resource exists which will impact successful delivery if not addressed.	Lack of human resource is impacting successful delivery and needs to be addressed immediately.
Issues	All risks & issues under control and none outstanding requiring immediate attention.	Outstanding issues which could impact overall delivery require immediate attention. These may need to be referred to Thematic Lead for resolution.	Outstanding issues which will impact the overall delivery require URGENT attention. This may need to be referred to Thematic Lead for resolution.
Risks		Risks have been logged that have a medium probability of occurring and will have a medium impact on the project if they occur.	Risks have been logged that have a high probability and impact or a combination of high and medium probability and impact if they occur.
Budget	Committed costs are up to 2.5% over or under budget; OR The project is up to £250k over or under budget, which ever is the lower	Committed costs are up to 5% over or under budget; OR The project is up to £500k over or under budget, which ever is the lower amount.	Committed costs in excess of 5% over or under budget, OR The project is in excess of £500k over or under budget, which ever is the lower amount, OR

	amount.		The project is spending without any sanctioned funding.

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WELL BEING STRATEGIC PARTNERSHIP

AREA BASED GRANT REVIEW

Project End of Year Review 2008/09

PROJECT TITLE:	
WELL-BEING PROJECT REF:	
PROJECT MANAGER:	
FUNDING:	

		R	A	G
RAG STATUS	Spend on target			
	Objectives/outputs			
	Overall Status			

1. Achievement of expected benefits

This section notes whether or not the anticipated benefits have been realised.
Comments/Evidence on overall objectives/targets/LAA indicators

2. Unexpected benefits

This section notes if additional benefits have been realised that were not in the original objectives/targets.

3. Unexpected problems

This section details any issues or problems that arose during the project and the methods used to deal with them.

4. User reaction/Value for money

This should detail the response of the users to the deliverables from the project.

5. Areas of concern

Any areas of concern/issues

6. Other information

Any other points the review team may wish to discuss

7. Review recommendations/Decision

Recommendations to continue/cease project/programme in September 08. If ceasing funding, why?

Meeting: **Well Being Strategic Partnership Board**

Date: **8 December 2009**

Report Title: **Department of Health - National Support Team for Health Inequalities (NSTHI) Visit**

Report from: **Susan Otiti, Acting Joint Director of Public Health**

Purpose

To update Board members on the outcome of the visit in October 2009 and to present the draft Health Inequalities Action Plan (Appendix 1) for review and comments.

Background

The National Support Team for Health Inequalities (NSTHI) visited Haringey in October to review what we are doing in relation to reducing adult health inequalities in the borough. They were particularly interested in keeping up the momentum around the national 2010 life expectancy targets against which Haringey is currently on track for both men and women. The team provided detailed feedback at the end of the visit and Cathy Herman, Non Executive Director, NHS Haringey and Cllr. Dilek Dogus, Cabinet Member for Adult Social Care and Well Being thanked them on behalf of the partnership.

The NST held interviews, six workshops and a community engagement focus group to understand the local context and assess barriers to and opportunities for continued progress at a population level. The visit benefited from the input of many individuals within NHS Haringey, the Council, North Middlesex Hospital and the voluntary and community sector. The team congratulated the partners on their commitment and passion for this area; on NHS Haringey's 'visionary' primary care strategy; on the adults' wellbeing arrangements; and on a variety of other aspects of our collective work to make progress on inequalities. Thank you to Board members who either participated in the visit or identified individuals from their organisations.

For those of you who were part of the visit you should have received a copy of the presentation directly from the NSTHI for others it is available from Susan Otiti. A draft action plan is attached for members to review and provide comments.

A follow up meeting with senior managers will take place in December and the NSTHI have been invited to the next Haringey Strategic Partnership in January 2010.

There is an agreement in principle from the Well Being Chairs Executive to establish a Healthier Communities Group and this group would have a role in

supporting delivery of the action plan.

Policy implications

The NSTHI identified the following high level recommendations, the detail can be found in the draft plan in the appendix;

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

Legal Implications

None identified.

Financial Implications

All resource needs have not been identified as yet.

Recommendation

Board members to give their comments to help shape the action plan.

For more information contact

Susan Otiti
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NHS Haringey/Haringey Council
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National Support Team Visit – DRAFT Health Inequalities Delivery Plan November 2009- March 2011

High level recommendations
1. Undertake further analysis quantifying the number of lives that need to be saved and assessment of the necessary scale and reach of interventions required to reduce mortality rates to sustain progress towards the 2010 mortality targets and address inequalities within Haringey. 2. Develop detailed delivery plans informed by the above analysis, equity audit and social marketing. 3. Develop a culture of data and analysis underpinning all strategic and commissioning decisions, as part of a whole systems approach to addressing health inequalities. 4. Establish clear local clinical and practitioner leadership in Cardiovascular Disease (CVD), Stroke, and Cancer. 5. Continue to focus intensively on improving the quality of primary care across the 3 levels of support, and build a partnership approach to case-finding. 6. Take a partnership approach to the development of commissioning groups relating to the contributing factors to health inequalities and the development of improved patient pathways. 7. NHS Haringey should fully integrate its strategic and operational community engagement work internally and with other partners. 8. Continue the development of the Well-Being Partnership Board and the Haringey Strategic Partnership structures in relation to locality working, engagement of the Voluntary Community Services (VCS) and the broader healthy communities' agenda. 9. Ensure specific initiatives are developed and implemented to embed the 'Health is Everyone's Business' approach including introducing Health Gain Schedules. 10. Speedily recruit a new Joint Director of Public Health.

Priority **Improve the vision and strategy**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Modelling of the numbers and an alignment to commissioning and operational delivery plans	The Life Expectancy Action Plan (LEAP) to incorporate a greater understanding of the population's health	Dec 2009	Public Health	Public Health Analyst	Limited time to complete
Develop or refresh delivery plans for each of the contributors to health inequalities	All interventions should be systematically applied and appropriately scaled up to target populations. This can be reinforced through the development of a health gain schedule by commissioners to accompany service level agreements for all provider services	March 2010	Public Health	Public Health Strategist	Actions identified may require a re-prioritisation against spend in light of current financial constraints
Consider adding the following to contribute to life expectancy:	All interventions should be systematically applied and	March 2010	Public Health	Public Health Strategist	Actions identified may require a re-prioritisation against

Infectious diseases Seasonal excess deaths COPD	appropriately scaled up to target populations. This can be reinforced through the development of a health gain schedule by commissioners to accompany service level agreements for all provider services				expenditure in light of current financial constraints
Develop a joint communications strategy	Information is produced in a user friendly 'marketing' format for a range of audiences including seldom heard groups, staff and independent contractor clinicians		Communications Team	NHS Haringey and LBH	Limited time to complete

Priority **Leadership**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Establish clear local clinical and practitioner leadership in CVD, Stroke, and Cancer	An effective link into the HSP, the two locality commissioning teams, the PBC Collaboratives and the Clinical Executive Committee	Jan 2010	PBC Collaboratives	Clinical Directors	Clinical Directors unable to identify clinicians
Re establish the Equality and Diversity group as a sub group of the Commissioning Committee	A high level of leadership of the Equality and Diversity agenda	Dec 2009	NHS Haringey	Director of Professional Standards	
Continued commitment and senior leadership to the health inequalities agenda	Speedy recruitment to the vacant JDPH post to avoid any loss of leadership momentum	Dec 2009	NHS Haringey and LBH	Chief Executives	Unable to recruit to the vacant post

Priority **Partnerships: structures and processes**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Increase the focus on how the Borough wide HSP thematic Boards and area assemblies link with the locality and PBC Collaboratives structures	Work plans demonstrate the links. Encourage shadowing, mentoring, joint training.	Ongoing		Chairs of Thematic Boards and Clinical Directors	Clinical Directors and Thematic Boards may not have the capacity
Consider where healthy communities sits so it is influential and better aligned with the wider	A new Healthy Communities Group	Jan 2010	NHS Haringey, LBH and VCS	Assistant Director of Recreation	

social determinants of health agenda				Services and Associate Director of Public Health	
NHS Haringey commissioners to capitalise on the more developed contracting experience in Haringey Council	Improved commissioning for health outcomes	Ongoing	NHS Haringey	NHS Haringey commissioners	
Carry out a joint building review	Identify suitable premises for joint services	March 2010	NHS Haringey and LBH	Director of Urban Environment and Associate Director of Strategic Finance	
Pooled resource allocation to be geared to targeted outcomes in relation to health inequalities	Mainstream activity rather than fund short term projects	Ongoing	NHS Haringey and LBH	NHS Haringey and LBH commissioners	Financial position constraint progress
Review existing commissioning groups to maximise addressing the contributing factors of health inequalities e.g. CVD, Cancer	These groups would ensure the development of improved patient pathways, in the context of the outcomes of the work of 'Healthcare for London'	March 2010	NHS Haringey and LBH	NHS Haringey and LBH commissioners	
Develop a 'Health is Everyone's Business' approach to build public health capacity	Develop training on 'effective 'brief interventions'. Develop a programme targeted at commissioners and policy makers	March 2010	Public health	JDPH	Targeted personnel not able to attend the training

Priority **Data**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
The recruitment of additional public health analytical capacity with an emphasis on health economics	Public Health Analyst recruited	Dec 2009	Public Health	Consultant in Public Health	Unable to recruit due to the calibre of applicants
More detailed analysis undertaken to understand current mortality trends and population health needs	Identification of key factors driving this improvement and to understand if improving trends are occurring throughout the	Jan 2010	Public Health	Public Health Analyst	Delays due to other work priorities

	borough, or are concentrated within particular areas or population groups.				
Obtain a more detailed understanding of the variable health needs across different population groups using geo demographic data (e.g. MOSAIC data) to inform the targeting of interventions	Geo demographic data produced	Feb 2010	NHS Haringey and LBH	Analysts	Delays due to other work priorities
Establish a whole systems approach to sharing public health intelligence	Public health intelligence regularly presented to a wide range of audiences including commissioners, Non Executive Directors and Councillors	Ongoing	Public Health	Public Health Analyst	Delays due to other work priorities
The LEAP to quantify the number of lives that need to be saved to sustain progress towards 2010 mortality targets and address inequalities within Haringey	Translation of mortality targets into absolute numbers and a cost benefit analysis of interventions	March 2010	Public Health	Public Health Analyst	Delays due to other work priorities
Formalise links between NHS Haringey's and Haringey Council's information teams to facilitate improved data sharing	Closer working with agreed outcomes	Feb 2010	NHS Haringey and LBH	Analysts	Delays due to other work priorities
Partners need to work together to develop targeted awareness	Increased communication programmes to benefit those most at risk of premature illness	Ongoing	Communications Team	NHS Haringey and LBH	Delays due to other work priorities

Priority **Frontline services**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
The achievement of the 2010 health inequalities targets is dependent on effective Primary Care	Key deliverables in the Primary Care Strategy identified, implemented and realised in the short term	March 2011	East and West Commissioning teams	Deputy Director of Primary Care	Delays due to other work priorities
NHS Haringey to continue to improve **GP performance** and quality of care through a co-ordinated approach using clinical governance, medicines management, primary care	target indicator dashboards produced and shared with GPs. Undertake a review of the resource base from which practices are working. Use of QOF clinical outcomes	Ongoing	NHS Haringey	Associate Director of Performance and Director of Professional Standards	

commissioning, prescribing support and lay/patient input.	data and information during practice visits.				
'Raise the bar' for all practices	Regular monitoring and reporting of Local Enhanced Services. Regular production of good quality, well presented information at practice level on important delivery areas e.g. CVD, diabetes. Medicines management to continue to work with practices to ensure efficient prescribing	Ongoing	NHS Haringey	Deputy Director of Primary Care and Head of Medicines Management	
Implement the NHS Health Checks programme	Identified significant numbers of high risk patients who have been missing from registers Modelling checked to ensure sufficient numbers identified to impact on the PSA target Pathways for established disease reviewed to ensure a comprehensive approach Multi disciplinary workforce identified and supported	Ongoing	NHS Haringey	Associate Director of Public Health	Financial resources not sufficient
Assess the feasibility of a move towards Fair Share allocation of primary care funding so that practices in areas of greatest need have funding calibrated to need	Feasibility completed and considered by Commissioning Teams.	April 2010	NHS Haringey	Deputy Director of Primary Care	
The review of services being undertaken by NHS Haringey's Provider service to consider good joint working through multi disciplinary teams aligned to the locality hubs and designed according to need.	Review completed and recommendations considered	March 2010	NHS Haringey's Provider service	Director of Operations	
Consider extending the model of utilising Community Matron Assistants to all 4 PBC Collaboratives.	Community Matron Assistants in all 4 PBC Collaboratives	April 2010	NHS Haringey	Commissioners	Financial resources not sufficient
Assess the feasibility of adopting a Health Gain Schedule for all	Health Gain Schedule introduced and performance managed	April 2010	NHS Haringey	Associate Director of	

provider services, making tobacco, alcohol and weight management everybody's business. Haringey Council commissioners to consider the Health Gain Schedule with respect to their providers				Public Health	
Focus on vulnerable older people, using a systematic and scaled up approach to reduce excess winter deaths	Evaluate the Neighbourhood Well Being Network in Central Collaborative	December 2010	Community Provider Service and Adult Social Services	Associate Director of Operations	

Priority **Community engagement**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
The HSP Community Engagement Framework to be discussed and adapted by NHS Haringey to include the User Payment Policy	Formally adopted by NHS Haringey Board;	March 2010	NHS Haringey	Associate Director of Communications and Stakeholder Engagement	
Develop a Communications Plan that includes a 'You Said - We Did' approach to feeding back to communities.	Communications Plan implemented and monitored	March 2011	NHS Haringey	Associate Director of Communications and Stakeholder Engagement	
Develop a strategic plan using a social capital approach with the 3rd sector	Plan implemented and monitored	March 2011	LBH	Director of Urban Environment	

Priority **Secondary prevention of cardiovascular disease (CVD)**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
A more in-depth analysis of practice performance on individual QOF indicator to tailor action to improve practice performance.	Data shared with PBC Collaboratives	Ongoing	Public Health	Associate Director of Public Health	

Share expected and actual prevalence numbers with collaboratives	Improved patient management	Feb 2009	Public Health	Associate Director of Public Health	
Identify a CVD Champion	Greater sharing of good practice between organisations. CVD issues highlighted and given a consistent message across the health economy	Jan 2010	Public Health	Associate Director of Public Health	
Establish a Local Implementation Team (LIT) for CVD	LIT monitoring NSF implementation and linking with the NCL Cardiac and Stroke Network Board	Feb 2010	Public Health	Associate Director of Public Health	
Undertake Equality Impact Assessments on CVD plans and policies	Equality Impact Assessment completed and shared with the LIT to inform future planning	June 2010	Public Health	Associate Director of Public Health	
The Well-Being Partnership Board to monitor the CVD LIT	Six monthly reports received by the Well-Being Partnership Board	Ongoing	Public Health	Associate Director of Public Health	
NHS Health Checks implementation (see page 7)					
Targeted CVD risk awareness campaigns planned	Plans jointly developed and implemented targeting those most at risk	Ongoing	NHS Haringey and Haringey Council	Associate Director of Public Health	

Priority **CVD acute management**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Establish a Local Implementation Team (LIT) for CVD ensure strong links with the North Central London Cardiac and Stroke Network (see secondary prevention of CVD)	LIT monitoring NSF implementation and linking with the NCL Cardiac and Stroke Network Board	Feb 2010	Public Health	Associate Director of Public Health	
Increase the profile of stroke services	Reduction in stroke mortality and morbidity	Ongoing	NHS Haringey	Stroke Care Coordinator	

Undertake audits to enable a greater understanding of hotspots in the community and access to services	An understanding of; late presentation to services both MI and stroke GP practice referral patterns to Trans Ischaemic Attacks (TIA) clinics	Ongoing	Public Health	Associate Director of Public Health	
Review the delivery of cardiac rehabilitation across the borough	Identify inequity of provision and gaps in service	June 2010	Public Health	Associate Director of Public Health	
Monitor the development of stroke services at North Middlesex Hospital as it develops its specialist acute stroke unit (part of the Healthcare for London development).	North Middlesex Hospital meets the standards in the stroke Strategy		NHS Haringey	Director of Commissioning/West team	

Priority **Tobacco control**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
See Tobacco Control Strategy and Action Plan	Implementation of the strategy	March 2012	NHS Haringey and LBH	Tobacco Control Alliance	
Smoking cessation care pathway reviewed and updated	Good access to the most appropriate service for all	Jan 2010	NHS Haringey	Tobacco Control Commissioner	Unable to recruit to the vacant post

Priority **Cancer**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Establish a LIT for Cancer	LIT monitoring the Cancer Plan implementation and linking with the NCL Cancer Network Board	Feb 2010	Public Health	Associate Director of Public Health	
Identify a Cancer Champion	Greater sharing of good practice between organisations. Cancer issues highlighted and given a consistent message across the health economy	Feb 2010	Public Health	Associate Director of Public Health	
Strengthen the links between NHS Haringey and the cancer registry	Sharing of data and information to improve services	Feb 2010			

Closer working with primary care to improve early detection/referral	Increase screening uptake	Ongoing	Public Health	Consultant in Public Health	
Increase engagement in the national audit of primary care of newly diagnosed cancer	Increase engagement from 4 GPs	Ongoing	Public Health	Associate Director of Public Health	
Integrate recommendations from Social Marketing into commissioning	Increase screening uptake	Ongoing	Public Health	Consultant in Public Health	
Strengthen public awareness around early symptoms, screening (see Communications Plan in Community Engagement section)					
The health promotion capacity with community services needs to be expanded	Community nurses proactively promoting screening programmes	Ongoing	Public Health	Consultant in Public Health	
Assess the feasibility of a network wide approach to non-NICE drugs assessments	Cancer Network Board to consider	March 2010	Public Health	Associate Director of Public Health	
The learning from the Healthy Communities Collaborative is extended to other wards		March 2010	Public Health	Associate Director of Public Health	
Identify the gaps in community liaison nursing capacity, psychological support and in advice on welfare issues for cancer patients	Gaps identified and addressed	July 2010	NHS Haringey	Commissioners	
Sustainable measures identified to capture and use cancer data at a more local level	Data includes: staging data 1- and 5-year survival data with benchmarking Benchmarking of rates of surgery Data to identify late presentation by locality/ethnicity/tumour type Improved data on bowel screening uptake and follow up of positives	July 2010	Public Health	Public Health Analyst	Delays due to other work priorities

Priority **Seasonal excess deaths (SEDs)**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Audit data in relation to seasonal excess deaths	Audit completed and delivery plan developed to be implemented by a multi agency group	March 2010	Public Health	Public Health Analyst	Delays due to other work priorities
Focus on vulnerable older people, using a systematic and scaled up approach to reduce excess winter deaths	Evaluate the Neighbourhood Well Being Network in Central Collaborative	December 2010	Community Provider Service and Adult Social Services	Associate Director of Operations	
Incorporate 'seasonal excess deaths' into the terms of reference of the Older People's Partnership Board		Ongoing	HSP	Older People's Partnership Board	
Propose investment in a specialist officer post to prepare bids for potential grants available from range of sources that could help housing and health	The quality and number of bid applications increases	Jan 2010	NHS Haringey and LBH	Older People's Partnership Board	Financial resources not sufficient
Consider extending the model of utilising Community Matron Assistants to all 4 PBC Collaboratives.	Community Matron Assistants in all 4 PBC Collaboratives.	April 2010	NHS Haringey	Commissioners	Financial resources not sufficient
Community Pharmacists to be brought more pro-actively into multi-disciplinary partnership initiatives to target SEDs.	Community Pharmacists actively engaged in the Older People's Partnership Board	Ongoing	NHS Haringey	Head of Medicines Management	
Consideration be given to including temperature sensors as part of Telehealth and Telecare packages	temperature sensors part of Telehealth and Telecare packages	March 2010	NHS Haringey and LBH	Commissioners	Financial resources not sufficient
Consideration is given to the expansion of the Carers Card with active promotion.		March 2010	Carers Partnership Board	Commissioners	
Older people visiting relatives/friends in residential and nursing homes could be an important (and accessible) group to target regarding 'Affordable	The 'Affordable Warmth' implementation group plan a promotional campaign	March 2010	LBH	'Affordable Warmth' implementation group	

Warmth' and other key prevention measures					
Consider including the main local energy providers in the 'Affordable Warmth' implementation group	Local energy providers members of the 'Affordable Warmth' implementation group	March 2010	LBH	'Affordable Warmth' implementation group	

Priority **Alcohol harm reduction**					
Key Actions	**How do we measure progress**	**By when**	**Resources**	**By whom**	**Risks**
Review membership of the Alcohol Harm Reduction Strategy Group	Clear senior leadership with alcohol champion identified. Appropriate people contributing to the strategy group	Dec 2009	DAAT	Marion Morris	
Review GP registers to enable targeted screening to those who drink harmfully and hazardously	Pilot sites for NHS Health Checks evaluated	March 2010	NHS Haringey DAAT	Vanessa Bogle and Linda Somerville	
Alcohol Liaison Nurses at NMUH to work to Identified and agreed defined outcomes	Defined outcomes monitored	Jan 2010	DAAT	Sarah Hart	
Alcohol identification and brief advise (IBA) centrally co-ordinated	E learning tool used to support NHS Health Checks	Jan 2010	DAAT	Sarah Hart	
A scaling up of supported self management materials for identified' at risk' populations	Information integrated into the NHS Health Checks resource pack for primary care	March 2010	NHS Haringey DAAT	Vanessa Bogle and Linda Somerville	
Review the Alcohol Service treatment pathway Use the RUSH model to identify numbers Monitor the Alcohol Treatment Requirements (ATRs) following Magistrates training	'Bottlenecks' eliminated Increase the number of ATRs	March 2010	DAAT/HAGA	Marion Morris and Linda Somerville	No additional money
Ensure the appropriate actions related to Licensing Act 2003 within the strategy are implemented and monitored	Regularly evaluate the training programme	Ongoing for the life of the strategy	DAAT	Alcohol Strategy Group	
Ensure a coordinated approach to updating data on a regular basis to inform needs assessment,	Data updated regularly and stored in a central depository	Ongoing	DAAT and Public Health	DAAT Data Officer and Public Health	

commissioning and performance Management				Analyst	

haringey strategic partnership

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

Date: **8 December 2009**

Report Title: **Safeguarding Adults -Update on Implementation Plan**

Report of: **Margaret Allen - Assistant Director, Safeguarding and Strategic Issues**

Summary

The safeguarding and DoLS teams under the auspices of the Adult Protection Team, moved to the Safeguarding & Strategic Services division on 1 July.

Since then a number of developments have been taken forward.

Adult Protection Team (Safeguarding & DoLS)

- The team has been brought together as a combined service and re-named, to increase the profile of these two areas of work.
- The recruitment campaign recently undertaken, has resulted in 92 applications for the Business Support Officer post, with a further 5 applicants for the Independent Chair position, but only 1 for the Head of Service post.
- Short listing for the Independent Chair is almost complete and interviews are planned for early November, from a strong set of candidates.
- The interview panel for the Independent Chair, will comprise the AD for Safeguarding & Strategic Services (S&SS), the interim Head of Service, Cllr Dogus (Cabinet Member, adults and Wellbeing), and Susan Tokley (NHS Haringey) as the SAB representative.
- The "to be" structure for the combined team had been agreed by the Director and includes an OT, CPN and Police Officer along with existing management and social work posts.
- The APT had a very successful away day on 1 September to address a number of issues for development/improvement. The outcomes from the away day are now being incorporated into the team development plan and the CQC service inspection action plan.
- The update plan will be discussed with Cllr Dogus in November.

Strategic issues (including partnership working)

- The Designated Complaints Officer for Adult Services has begun working with the APT to design an Allegations protocol to capture information from the Public and others pertaining to potential exploitation and abuse. This will be linked to the overarching policy and

procedures.

- Work has been completed linking the safeguarding and DoLS pathway to the pathway for personalisation and self directed support. The APT away day also worked on developments to enhance the workflow process.
- A new DoLS workflow is being implemented to the system currently, FW-I team is in the process of concluding this piece of work.
- A cross borough meeting was held on 7th October with Sutton, Hackney, Camden and Haringey addressing a number of aspects and issues regarding safeguarding.
- AD S&SS is to lead on a "4 borough" combined review of the case file audit toolkit to create a 'shared' toolkit and protocol for future use. This piece of work will be undertaken over the next 3 months and will report back to the combined cross borough board in January 2010.

Operational

- Overall, activities are going well, with improved information sharing and utilisation of data to support developments and feedback to operational teams. There has been an increase in requests for APT to support strategy meetings in complex cases.
- The Assistant Safeguarding Manager has met with the new Mental Health Trust AD for Safeguarding to begin looking at operational aspects of joint working across the two organisations.
- 1 case involving mental health services was reported to the Police by the Assistant Safeguarding Manager and the Sapphire Unit is now involved.
- A small number of LD cases are ongoing at present with reported good input and joint work across the APT and LD partnership.
- The number of 'old' cases in LD has been significantly reduced during September, from 29 to 7 and these cases are currently in process of being closed.
- A similar response has been seen from colleagues in mental health.
- There are 2 cases within Physical Disability Services, and the APT reports very effective input and communication with the relevant team managers.
- Over quarter 2, there were 5 best interest assessments carried out under DoLS.

Further developments/issues

- The national safeguarding performance indicators were implemented on 1 October 2009.
- Work to improve and clarify the access pathway to Children's services especially for service users who are transferring to adult services but have allocated social workers in children's services, is in train.
- The Assistant Safeguarding Manager has been involved in joint "bite size" training with Children's Services, with more sessions planned.
- Appointments have been set up for the APT to carry out briefing sessions with colleagues in housing and HAGA.
- The meeting for Cllr Dogus to review case file audits was scheduled for 22 October, due to attending the National Social Services Conference,

this will be re-scheduled.

As reported in June, there are a number of other reports still in development which will be included in future briefings as they are developed.

Legal/Financial Implications

N/A.

Recommendations

That the information report noted.

For more information contact:

Name: Margaret Allen
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haringey strategic partnership

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

Date: **8 December 2009**

Report Title: **Tobacco Control Strategy 2009 - 2012**

Report from: **Susan Otiti, Acting Joint Director of Public Health**

Purpose

The Public Health team has developed a draft Tobacco Control Strategy and Action Plan. The Strategy and Action Plan sets out a clear direction for the Haringey Strategic Partnership and its member organisations to reduce the impact of tobacco in Haringey. A Tobacco Control Alliance, with defined terms of reference, has been established as a fixed-term group to oversee the implementation of the Strategy and Action Plan to the end of March 2012.

Background

The strategy and action plan was developed from national guidance and local consultation with key stakeholders. Members of the Well Being Partnership Board provided suggestions for the action plan during a workshop held during the last board meeting in September 2009. The workshops focussed on (1) the need to tackle sales of cheap and illicit tobacco; (2) the need to provide more support to young people and those aged 35-54 years; and (3) the need to take action to maintain and promote smoke free environments. The action plan also includes recommendations from the recent Department of Health (DH) Health Inequalities National Support Team visit.

The aim of the strategy and action plan is to reduce the impact of smoking on health and health inequalities in Haringey by setting out the key actions to be taken by the end of March 2012.

The outcomes of the strategy and action plan are as follows:

- To reduce smoking prevalence and increase smoking quitters in the following groups:

  - People with a mental health diagnosis
  - Teenage pre and post-partum mothers
  - Young parents
  - Those living in areas of high deprivation
  - Specific BME groups, particularly Irish and Turkish men
  - Routine and manual workers

- To reduce the impact of smoking on health inequalities in Haringey
- To denormalise smoking in Haringey

- To develop measures to assess achievement against the above outcomes

In order to achieve these outcomes, the following objectives have been set derived from the Department of Health 10 High Impact Changes.

- Work in partnership
- Gather and use a full range of data to information tobacco control
- Use tobacco control to tackle health inequalities
- Deliver consistent, coherent and co-ordinated communication
- Integrated stop smoking approach
- Build and sustain capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Help young people to be tobacco free
- Maintain and promote smoke free environments

A Tobacco Control Alliance (TCA) has been established and held its first meeting. The TCA will oversee delivery of the strategy and action plan. The intention is that the TCA will be a fixed-term group, which will have overseen implementation of this strategy by the end of March 2012.

Policy implications

For the past 7 years, tobacco control has been seen as the domain largely of the Stop Smoking Service (commissioned by NHS Haringey) and the Borough's Enforcement Services. The national documents mentioned previously make it clear that if Haringey is going to succeed in denormalising tobacco and reducing health inequalities, this has to be the business of a range of organisations that comprise the Haringey Strategic Partnership.

For this policy change to be successful, the intention is that the strategy and action plan be implemented in a structured, measurable, and targeted way. The Comprehensive Approach to Tobacco Control, as developed and prescribed by the Health Inequalities National Support Team will be applied. This approach represents a holistic model of tobacco control with seven broad themes, including:

- Planning and commissioning
- Communication
- Normalising smoke-free lifestyles
- Tackling illegal and underage availability
- Making it easier to stop smoking
- Multi-agency partnership working
- Monitoring, evaluation and response

Legal Implications

None identified.

Financial Implications

The aim is to implement the strategy and action plan within existing resources.

Recommendations

i. That Board members are requested to approve the strategy and action plan (Appendix 1), and:

ii. That accept six monthly monitoring reports from the Tobacco Control Alliance.

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Use of Appendices

Appendix 1 –Tobacco Control Strategy and Action Plan

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APPENDIX 1

HARINGEY TOBACCO CONTROL STRATEGY

2009-2012

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Executive Summary

Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between rich and poor. It has long since been acknowledged by national bodies that smoking is harmful to the nation's health and that targeted methods are needed to help people stop smoking. These have included the workplace ban on smoking on 1st July 2007, which was extended to include mental health services on 1st July 2008.

There is now a wide body of evidence on effective practice to reduce smoking uptake and increase smoking cessation, most recently set out in NICE Guidance on Smoking Cessation Services, the Department of Health's (DH) '10 High Impact Changes to Achieve Tobacco Control' and most recently NHS Stop Smoking Services: service and monitoring guidance 2009/10. The documents have significantly informed the content of this strategy.

This document will form a coherent strategy and action plan for a range of stakeholders, who will form a 'Tobacco Control Alliance'. Together they will both implement and monitor progress of the strategy. The intention is that the Tobacco Control Alliance will be a fixed-term group, which will have overseen implementation of this strategy by the end of March 2012.

The aim of this strategy is to reduce the impact of smoking on health and health inequalities in Haringey by setting out the key actions to be taken by the end of March 2012.

The outcomes are as follows:

- To reduce smoking prevalence and increase smoking quitters in the following groups:
    - People with a mental health diagnosis
    - Teenage pre and post-partum mothers
    - Young parents
    - Those living in areas of high deprivation
    - Specific BME groups, particularly Irish and Turkish men
    - Routine and manual workers
- To reduce the impact of smoking on health inequalities in Haringey
- To denormalise smoking in Haringey
- To develop measures to assess achievement against the above outcomes

In order to achieve those outcomes, the following objectives have been set and are derived from the DH 10 High Impact Changes.

- Work in partnership
- Gather and use a full range of data to information tobacco control
- Use tobacco control to tackle health inequalities
- Deliver consistent, coherent and co-ordinated communication
- Integrated stop smoking approach
- Build and sustain capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Help young people to be tobacco free
- Maintain and promote smokefree environments

1 Introduction

1.1 Background information

Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between rich and poor. It increases infant mortality by about 40% and more than a quarter of the risk of sudden infant death is attributable to smoking.

It is an addiction rarely acquired in mature adulthood and between the ages of 14 and 15, there is a 92% increase in smoking behaviours amongst young people. It is most common amongst the socio-economic groups exhibiting the worst health profiles in the community: low-income groups, pregnant and post partum teenage mothers and lone parents. Almost half of all teenage mothers smoke during pregnancy and 55% of single mothers. 31% of routine and manual workers are smokers, compared to 22% of the total population. Amongst people with mental health problems, the prevalence of smoking is estimated to be approximately 70% and for hard-drug users the figure is 'practically 100%'.

The highest prevalence for men is between the ages of 20-34 and for women between the ages of 25-34. Cigarette smoking is highest amongst Turkish, Bangladeshi and Irish men.

As well as cancer, respiratory and circulatory diseases, smoking is responsible for stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts and age-related macular degeneration (ARMD). It also contributes to a lower survival rate following surgery, delayed wound healing and post-operative respiratory complications. It contributes to higher rates of infant mortality and child illness, including asthma. Smoking costs the NHS an estimated £1.5 billion a year, excluding payment of sickness or invalidity benefits. [1]

'Smokeless tobacco' is a very broad term that refers to over 30 different types of products. Smokeless tobacco products include chewed tobacco ('dry chewing tobacco') and sucked tobacco ('moist oral tobacco'), rather than smoked tobacco in the form of cigarettes. There are some inhaled tobacco products ('nasal snuff'), but these are less common in the UK. Some people believe that smokeless tobacco is a harmless alternative to smoking cigarettes. But scientists have shown that many forms of smokeless tobacco increase your risk of mouth cancer. They could also increase your risk of pancreatic cancer, oesophageal cancer, and other conditions including gum disease and heart disease. Almost all types of smokeless tobacco can cause mouth cancer. But some types or brands can be more dangerous than others. This is because different products can have very different levels of cancer-causing chemicals.

Most smokeless tobacco products in the UK are used by South Asian communities. In these communities, dry chewing tobacco is often used as part of a 'betel quid' or 'paan'. These consist of a mixture of betel nut (or areca nut), slaked lime and various herbs and spices, wrapped in a betel leaf. Betel nut itself can cause cancer, so chewing betel quids can cause mouth cancer even if no tobacco is added.
Smokeless tobacco contains as much, if not more, nicotine than smoked tobacco products do. So like cigarettes, it is highly addictive. People who use smokeless tobacco absorb 3-4 times as much nicotine as smokers do. The nicotine is also absorbed more slowly and stays in the blood for a longer time.

[1] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished

1.2 The national context

It has long since been acknowledged by national bodies that smoking is harmful to human health and that targeted methods are needed to help people stop smoking. In the three years prior to April 2006, NHS services were expanded to support smoking quitters and a target for primary care trusts was introduced. In that period, 800,000 people were reported to have remained quit at four weeks. At the end of 2006, the NHS and all Government Departments became 'Smokefree'. This preceded the workplace and public places ban on smoking on 1st July 2007, which was extended to include mental health services on 1st July 2008.

The greatest single reduction in smoking prevalence appears to have followed the announcement of this ban. Recent research has demonstrated a 1.6% reduction in smoking in the 9 months leading up to the ban with a further reduction of 5.5% in the first 9 months of the ban. It has estimated that this will prevent as many as 40,000 deaths over the next 10 years. [2]

Tobacco advertising is prohibited nationally and picture warnings appeared on tobacco products from late 2007. Tobacco marketing of any sort is likely to become increasingly curtailed as measures are formulated to reduce the visibility of tobacco goods for sale in retail outlets.[3]

The Tackling Tobacco Smuggling Strategy (launched in March 2000) has succeeded in cutting the illicit cigarette market by a quarter to 16%. A new strategy was announced in the Budget 2006 to reduce the illicit cigarette market to 13%.

There is now a wide body of evidence on effective practice to reduce smoking uptake and increase smoking cessation, most recently set out in NICE Guidance on Smoking Cessation Services[4] and the Department of Health's '10 High Impact Changes to Achieve Tobacco Control'.[5] Both these documents have significantly informed the content of this Strategy.

1.2.1 Nice guidance

NICE sets out the following recommendations for smoking cessation services:

Specific groups

1. Target ethnic minorities and socio-economically disadvantaged groups and tailor services to those groups, providing services in the language chose by clients, wherever possible (more use of link workers and language line)

2. Aim to treat BME and disadvantaged groups at least in proportion to their representation in the local population of tobacco users

3. Needs of target groups must be put first and relationships must be developed with target groups and stakeholders

[2] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished
[3] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished
[4] NICE public health guidance 10: Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, February 2008
[5] Department of Health (2008) Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control, Tobacco Control National Support Team May 2008

4. Mothers eligible for Healthy Start – use registration as an opportunity to offer information, advice and support on stopping smoking

Stop Smoking Service

5. Provide a good Stop Smoking Service by maintaining adequate staffing levels, including a full-time co-ordinator

6. Set realistic performance targets for both the number of people using the service and the proportion who successfully quite smoking

7. Aim to treat at least 5% of the estimated local population of people who smoke each year

8. Audit performance of services regularly, especially those with under 35% or over 70% success rate

Links with other services

9. Establish links with contraceptive services, fertility clinics and ante/postnatal services

10. At first contact with pregnant woman, discuss smoking status, provide information about risks and offer personalised information and cessation advice

11. Monitor smoking status and offer smoking cessation advice through pregnancy and beyond

12. All hospital patients should be advised to quit and offered appointment

13. Fast-track referral system after discharge for patients trying to quit in hospital, particularly cardiac rehabilitation teams

Social marketing and interventions

14. Learning from social marketing theory suggests that efforts to combat smoking should be multifaceted: media campaigns coordinated with smoking cessation services, policy change and school interventions. Initiatives should aim to bring about sustained individual and social change, which takes time.

15. Workplace – most effective strategies are those successful elsewhere i.e. group therapy, individual counselling, pharmacological treatment

16. NICE recommends that there is a range of interventions which have proven to be effective:

- Brief interventions, usually opportunistic and referral to more intensive treatment
- Individual behavioural counselling
- Group behaviour therapy
- Pharmacotherapies
- Self-help materials
- Telephone counselling and quitlines
- Mass media

NHS Haringey commissioned Porter Novelli to conduct a local social marketing scoping exercise the findings were published April 2009 and have been integrated into the action plan.

In addition to the NICE Guidance, NHS Haringey has identified two additional categories for further specific attention, as part of its developing Tobacco Control Strategy. These are: Smoke Free Homes and Enforcement activity.

Smoke Free Homes – Tackling Second Hand Smoke
Second hand smoke (also known as 'Environmental Tobacco Smoke' (ETS) or 'passive smoking') is a mixture of side stream smoke from the burning tip of a cigarette, and mainstream smoke exhaled by a smoker. Second hand smoke kills, and scientific evidence shows that there is no safe level of exposure.

The Government's independent Scientific Committee on Tobacco And Health (SCOTH) reported in 2004 (reaffirming the conclusions of its report in 1998) that exposure to second hand smoke can cause a number of serious medical conditions:

- Lung cancer
- Heart disease
- Asthma attacks
- Childhood respiratory disease
- Sudden infant death syndrome, and
- Reduced lung function

The World Health Organisation has classified second hand smoke as a known human carcinogen. In 2006, the US Surgeon General concluded that:

- second hand smoke causes premature death and disease in children and adults who do not smoke.
- children exposed to second hand smoke are at an increased risk of sudden infant death syndrome (SIDS), acute respiratory infections, ear problems and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in children.
- exposure of adults to second hand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
- the scientific evidence indicates that there is no risk-free level of exposure to second hand smoke.

The Royal College of Physicians has also published a comprehensive report on second hand smoke, July 2005. Pages 43-49 look at deaths from second hand smoke. The report is available www.smokefreeengland.co.uk/files/going-smokefree.pdf

In view of this evidence, a key objective therefore of Haringey's Tobacco Control Strategy, is to increase the number of smoke-free homes, particularly in identified targeted settings and areas – such as Social Housing and Residential Care. The aim of the scheme is to encourage people to pledge to either make their home smoke-free or to limit where and when they smoke.

Enforcement – Ensuring Compliance & Tackling Illegal & Illicit Tobacco Sales
Local Authorities are responsible for enforcing the no smoking legislation and supporting people and organisations to comply with the law across the community. This is usually the department responsible for Environmental Health and/or Trading Standards.

The no smoking legislation referred to above, is contained in the Health Act 2006, which was implemented on 1st July 2007. However, further information of what is and is not allowed is set out in detail in secondary legislation. These are as follows: *the Smoke-free (Premises and Enforcement) Regulations 2006* - these regulations set out definitions of 'enclosed' and 'substantially enclosed' premises, and the bodies responsible for enforcing smoke-free legislation. *The Smoke-free (Exemptions and*

Vehicles) Regulations 2007 - these regulations set out the exemptions to smoke-free legislation and vehicles required to be smoke-free. *The Smoke-free (Penalties and Discounted Amounts) Regulations 2007* - these regulations set out the levels of penalties for offences under smoke-free legislation. *The Smoke-free (Vehicle Operators and Penalty Notices) Regulations 2007* - These regulations set out the responsibility on vehicle operators to prevent smoking in smoke-free vehicles and the form for fixed penalty notices. *The Smoke-free (Signs) Regulations 2007* requires a sign to be displayed at each entrance to smoke-free premises containing the words "No smoking. It is against the law to smoke in these premises".

In addition to the legal requirements covering the monitoring of tobacco control in workplaces and public places, enforcement activity also extends to ensuring compliance regarding under age sales, advertising, and illegal supply of tobacco (and related products).

Implementing the tobacco control legislation (2006), in practice also means that it is an offence for retailers and their staff to sell cigarettes or any tobacco products to a person under the age of 18 years. It is up to the retailer and their staff, to decide whether or not that person looks 18 years of age. If in doubt, they should not sell cigarettes or tobacco products to them. Cigarettes can only be sold in packets of 10 or more and in their original packaging. Retailers must display a clear sign where they sell cigarettes stating "It is illegal to sell tobacco products to anyone under the age of 18". Retailers selling cigarettes to any person under the age of 18 years, could face a fine of up to £2,500.

Retailers must not sell or supply cigarette lighter fuel or any cigarette lighter re-fill canister containing butane, or any other substance containing butane, to any person under the age of 18 years. The penalty for selling the above to an under age person is up to 6 months imprisonment, or a fine of £5,000, or both.

Environmental Health and Trading Standards Officers continue to enforce the law relating to the sale of tobacco products to under–age consumers. Both the sales person and the business owner could be prosecuted for any illegal sales, even if it was believed that the purchase was being made on behalf of an adult or if the person looked like they were over 18. The recently passed Health Act 2008-9, will further strengthen the powers of Local Authorities to tackle the advertising and illegal sales oftobacco.

Smuggling & Illicit Sales

Since the UK's first Tackling Tobacco Smuggling Strategy was published in 2000, HM Revenue & Customs and the UK Border Agency have reduced the proportion of illicit cigarettes from 21% in 2000 to 13% in 2009. HM Revenue & Customs and the UK Border Agency have also seized more than 14 billion cigarettes and more than 1000 tonnes of hand rolling tobacco in the UK and abroad. They have broken up 370 criminal gangs involved in large-scale smuggling; prosecuted more than 2,000 people; and issued more than £35m worth of confiscation orders.

From 1 April 2009, HMRC established nine regional inland enforcement teams to focus on tackling the sale of inland illicit tobacco sales. These teams will concentrate on retailers who sell illicit products. However they will also look at low level illicit trade, such as car boot sellers and sales from vans, since these are unregulated and could be supplying tobacco to children. Evidence from a survey undertaken by Action on Smoking Health (ASH), 2008, found that 1 in 5 'poorer' smokers and 1 in 3 younger smokers (16-24) buy smuggled tobacco. www.ash.org.uk/ash_1spmepp7.htm

Against this background, a further key objective of Haringey's Tobacco Control Strategy is to reduce access to tobacco products - with the specific intention of

reducing illegal tobacco sales to minors; and sales of counterfeit and smuggled tobacco products. LB of Haringey, together with members of the Tobacco Control Alliance will work with the Metropolitan Police, local retailers, the Licensing Trade, and local employers to raise awareness to illegal and illicit sales and enforce law.

1.2.2 10 high impact changes

This document sets out that the driving principle of tobacco control is that of fairness for children and young people to grow up in an environment where smoking is not seen as the norm, for smokers to get help to quit and for people to live and work without being exposed to second-hand smoke.

There are a number of central themes running through this policy:

- Working in partnership
- Social marketing
- Denormalising smoking
- Tobacco control is everybody's business, not just the domain of the health sector
- Each approach is founded upon an evidence base

The objectives in 2.3 use the central themes from the High Impact Changes as their starting point. These themes seem to get to the heart of what is required to address Tobacco Control in Haringey.

The 10 High Impact Changes are as follows:

1. Work in partnership
2. Gather and use full range of data to information tobacco control
3. Use tobacco control to tackle health inequalities
4. Deliver consistent, coherent and co-ordinated communication
5. Integrated stop smoking approach
6. Build and sustain capacity in tobacco control
7. Tackle cheap and illicit tobacco
8. Influence change through advocacy
9. Help young people to be tobacco free
10. Maintain and promote smoke free environments

1.3 The local context

Haringey is the 5th most ethnically diverse borough in London[6] and the 18th most deprived borough in England. 26% of Super Output Areas are amongst the 10% most deprived in the country (2007 data). Over half the population is under the age of 35 and a quarter of the population are under 18 years of age. The current population is 225,700[7] and the GLA estimates the population will reach over 270,000 by 2031. 8.9% (8,311) of households were identified as living in overcrowded[8] conditions in the 2005 Haringey Housing Needs Survey. As at June 2007, there were

[6] The ethnic diversity of an area can be measured using Simpson's Index. It takes into account the number of individuals in categories present, as well as the number of categories. The Simpson's Diversity Index was applied to the 2001 Census in this example (source GLA).
[7] Haringey Strategic Partnership Wellbeing Strategic Framework for Improving Adults' Well-being 2007-2010 http://www.haringey.gov.uk/well-being_strategic_framework.pdf
[8] The standards used to check for overcrowding/under-occupation in the Haringey Housing Needs Survey 2005 were as follows: Overcrowding: each household was assessed as to the number of bedrooms required. Any household without enough bedrooms was deemed to be over-crowded

around 5,700 households living in temporary accommodation in Haringey and just over 30% of households live in social housing[9].

In 2006/07, 8,000 people were estimated to be unemployed in Haringey[10], 71% of the working age population. The employment rate is 69.0% (2006/07), compared with 69.3% in London and 74.3% in England.

Whilst all age all cause mortality in people aged under 75 years has been steadily reducing in Haringey between 1993 and 2006, consistent with the trend observed in London and in England as a whole, premature mortality in Haringey males is still considerably higher than London and England/Wales and male life expectancy in Haringey is also lower than in England/Wales. Male life expectancy is lower than the borough average in the wards of Tottenham Green, Northumberland Park, Bruce Grove, White Hart Lane, Tottenham Hale and Hornsey. However, female premature mortality is lower than in England/Wales and London respectively.

Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities. Reducing prevalence is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher. Every year in Tottenham there are 130 deaths related to smoking and 600 hospital admissions, at a cost of nearly £1.4m (as at 2004)[11].

Modelled smoking prevalence data derived from the Health Survey for England (2003-2005)[12], predicts that Haringey has a prevalence of current smoking of 23.5% (95% confidence interval), compared with 23.3% in London and 24.1% in England. However, smoking prevalences of between 29 and 33% were predicted for Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale & White Hart Lane.

The prevalence of current smoking is reported for major ethnic groups. Respondents from the Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups were less likely to be current smokers than England as a whole, whereas Irish respondents were more likely to be current smokers. However, it should be noted that these estimates do not reflect the ethnic diversity within Haringey and the complex relationship between ethnicity and smoking prevalence. More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant.

1.4 Purpose of this strategy

Tobacco control in Haringey is intended to be a wide ranging schedule of work, not focusing on any one specific subject, which ultimately reduces the prevalence of smoking in the borough, improves public health and reduces health inequalities. Tobacco control and reducing smoking prevalence requires partnership working on a wide scale and should not be seen as being the responsibility of any one service or organisation within Haringey.

The purpose of the strategy and action plan is to set a clear direction for the Haringey Strategic Partnership and its member bodies to reduce the impact of tobacco in Haringey. The intention is that a Tobacco Control Alliance will be created as a fixed-term group to oversee implementation of this strategy by the end of March 2012.

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[9] 2001 Census
[10] Using International Labour Organisation (ILO) definition
[11] Tobacco in London: The preventable burden.
http://www.lho.org.uk/viewResource.aspx?id=8716
[12] Available at: www.neighbourhood.statistics.gov.uk

1.5 Reason for the change in policy

For the past 7 years, tobacco control has been seen as the domain largely of the Stop Smoking Service (commissioned by NHS Haringey) and the Council's Enforcement Services. The national documents set out above make it clear that if Haringey is going to succeed in denormalising tobacco and reducing health inequalities, this has to be the business of a range of organisations that comprise the Haringey Strategic Partnership. For this policy change to be successful the strategy will be implemented in a structured, measurable, justifiable and targeted way. The Comprehensive Approach to Tobacco Control, as developed and prescribed by the Health Inequalities National Support Team will be used. This approach represents a holistic model of tobacco control with seven broad themes:

The aim of the model is to focus specifically on local delivery, so there is naturally a greater emphasis on multi-agency formulation of local strategy, rather than waiting for policy development at a national level. At the centre of the model is multi-agency partnership working. This is vital for tobacco control work to be planned strategically and to deliver evidence based interventions. A multi-agency Tobacco Control Alliance will be formed to implement this strategy. Closely aligned to multi-agency partnership working is the need for the effective planning and commissioning of tobacco control/stop smoking work, based on needs assessment and identification of those populations and areas with the highest burden from tobacco. These, together with monitoring evaluation and response, form the most important areas of the model.

The four remaining elements form the basis of the interventions needed for effective local tobacco control. Normalising smoke free lifestyles is central to reducing the perceived attractiveness of smoking. Making it easier to stop smoking looks to the provision and accessibility of evidence based ways to help smokers stop. Tackling illegal and underage availability remains crucial since price sensitivity and young people is crucial in preventing the uptake of smoking. Communication is vital to publicise the benefits of stopping smoking, the means of doing so, to advocate for further progress in denormalising smoking and to fully capitalise on social marketing. Communication between different organisations who work around tobacco control in the borough also needs to be excellent.

2 Policy statement

2.1 Aim

The aim of this strategy is to reduce the impact of smoking on health and health inequalities in Haringey by setting out the key actions to be taken by the end of March 2012.

2.2 Outcomes 2009-2012

- To reduce the impact of smoking on health inequalities in Haringey
- To denormalise smoking in Haringey
- To reduce smoking prevalence and increase smoking quitters in the following groups:
    - People with a mental health diagnosis
    - Teenage pre and post-partum mothers
    - Young parents
    - Those living in areas of high deprivation
    - Specific BME groups, particularly Irish and Turkish men
    - Routine and manual workers
- To develop measures to assess achievement against the above outcomes

2.3 Objectives 2009-2012

In order to achieve those outcomes, the following objectives have been set and are derived from the 10 High Impact Changes[13] set out above.

- Work in partnership
- Gather and use full range of data to information tobacco control
- Use tobacco control to tackle health inequalities
- Deliver consistent, coherent and co-ordinated communication
- Integrated stop smoking approach
- Build and sustain capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Help young people to be tobacco free
- Maintain and promote smokefree environments

In addition, we will develop measures to assess our achievement against the above outcomes

2.4 Current position

A diagram of the current tobacco control services is set out in Appendix D.

NHS Haringey has consistently met its 4 week quitter smoking target although in recent years it has become more and more challenging.

Due to the challenging target and a number of key staff leaving the Stop Smoking Team, it became clear in February 2008 that a significant restructure of the team was necessary. The restructure resulted in the separation of commissioning and provision of tobacco control services, with the creation of a fixed-term Joint Tobacco Control Commissioner post, accountable to both NHS Haringey and the local authority. The Stop Smoking Service became part of the Provider side of NHS Haringey.

[13] Department of Health (2008) Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control, Tobacco Control National Support Team May 2008

As part of the separation of the commissioning function, NHS Haringey has commissioned Innovision to project manage all the primary care stop smoking services i.e. those being delivered from GP practices, pharmacies and dental surgeries. Innovision is an existing partner of NHS Haringey, which provides support to a number of GP practices locally and achieved a large number of quitters for Haringey in 07/08 and 08/09. As part of the PMA findings, Innovision were found to have achieved a significant correlation in their quitters with those from high prevalence groups, particularly in the east of the borough.

In addition to commissioning Innovision to deliver primary care services, NHS Haringey has commissioned other providers to work with voluntary and community groups within Haringey, where those groups represent one of the priority areas. These providers are delivering services in settings such as CONEL and a school with whom they have existing relationships, and also developing relationships with faith groups, and areas such as the Broadwater Farm and Tiverton estates.

The Stop Smoking Service went through a formal HR consultation to create a number of new roles in particular the new Service Manager. As set out above, the recommendations from NICE and the tobacco control review suggest that new pathways into the service are required e.g. from other health service providers (sexual health, mental health, children's services), from BME and deprived communities, from other services for vulnerable adults (e.g. supported housing, DAAT, social care, worklessness), and from employers. Therefore, the restructure also created new 'Advisors with a Special Interest', which are focused around the following priority areas:

- teenage pregnancy, young parents and young people generally
- supporting quitters in hospital, particularly surgical, respiratory, cardiac and maternity patients
- mental health patients and 1st July 2008 smokefree implementation for mental health inpatient wards
- those from deprived communities particularly in N17, N15 and N22, and those from BME (black and minority ethnic) groups known to have a high smoking prevalence, such as Turkish and Irish men
- Workplaces, particularly with manual workers.

The restructure coincided with the launch of the new NHS Haringey Smokefree Policy. Amongst other things, it sets out that staff can access stop smoking clinics during working hours, with agreement of their line manager and dependent on the needs of their particular service. The Stop Smoking Service has set up a stop smoking clinic during lunchtime. The policy also makes it clear that it is everyone's responsibility to maintain a smokefree environment at St Ann's Hospital and staff have been asked to lead by example in not smoking on site.

2.5 Scope of strategy

This strategy applies to anyone who smokes or who is affected by second-hand smoke in the borough of Haringey.

3 Equalities statement

As part of the development of the strategy, an Equalities Impact Assessment (EIA) has been carried out.

The purpose of EIAs is for any specific piece of work, to:

- identify the needs of each equality target group

- identify gaps in knowledge
- identify the positive impacts
- identify the negative impacts
- identify what needs to be done to reduce negative impacts and add to positive ones
- amend what is being done accordingly.

The Greater London Authority (GLA) and the other organisations in the GLA group, (and adopted by Haringey) have specified the equality target groups (ETG) as

- women
- Black, Asian and minority ethnic people
- disabled people
- children and young people
- older people
- faith groups
- lesbians, gay men, bisexual and trans people

The EIA looked at the following:

i. whether the strategy leads to any of the ETG groups being discriminated against and if so, whether the discrimination is lawful.

The EIA concluded that the aim of the strategy is to reduce the impact of smoking on health inequalities. Therefore, it is targeted towards groups of people with high smoking prevalence, for whom smoking has the greatest impact on their health. However, there is nothing in the strategy that discriminates against any of the ETG groups either explicitly or by omission. The ETG groups form part of the high prevalence communities and will be targeted in the same way as anyone who is not part of an ETG group.

ii. what the positive outcomes for each of the ETGs should be

The positive outcomes are that those people within ETGs who form part of high prevalence communities will be targeted to support their smoking cessation. There is a focus on pregnant women, particularly teenagers and also on young people more generally. In addition, those minority ethnic groups for which there is known to be high prevalence of smoking will have a specific focus.

iii. what the negative outcomes for each of the ETGs could be

The negative outcomes could be that if anyone in these ETGs does not form part of a high prevalence community, they will not be targeted for smoking cessation support. However, there are also generic actions for all areas of Haringey, in terms of delivering smoking cessation and wider tobacco control measures and all residents will have access to these, without discrimination on any of these grounds.

iv. what amendments can be made to remove any unlawful discrimination and/or negative outcomes or to improve the neutral and/or positive outcomes

The EIA concluded that more work needs to be done to identify the minority ethnic groups which have high prevalence to ensure that the focus is evidence-based and not anecdotal and thus to ensure that no unlawful discrimination occurs against Black, Asian and minority ethnic people.

This recommendation will be referred to the Joint Strategic Needs Assessment steering group for consideration in developing the data set on health needs in Haringey.

4 Links with the other strategies

4.1 Links with the Sustainable Community Strategy

The key outcome of the Sustainable Community Strategy to which this strategy relates is' Healthier people with a better quality of life'. On page 24, it states that 'people need access to information and support to help them make healthy lifestyle choices [and]. it is crucial that people are also given ready support to give up smoking.' This strategy sets out how people can be supported to give up smoking and how they can have access to information tailored to their needs and that ensures all sections of the community can access information and support, particularly those groups within the community with high smoking prevalence.

The Sustainable Community Strategy also has as one of its outcomes 'economic vitality and property shared by all'. It sets out to 'target poverty: putting efforts into income maximisation'. As has already been stated, the aim of this strategy is to address the health inequalities related to smoking. In the introduction, it is clear that these inequalities also impact economically upon certain groups and by addressing health inequalities amongst disadvantaged groups in Haringey, this will have a positive economic impact also.

4.2 Links with Haringey's well-being strategic framework

The strategy aids in the achievement of improved health and emotional well-being, which is Outcome 1 of the Well-being Strategic Framework. The objective of this is to promote healthy living and reduce health inequalities in Haringey. This strategy has as its aim the reduction of the impact of smoking on health inequalities and the 'denormalising' of smoking in Haringey.

4.3 Links with other relevant strategies

'Changing Lives: the Children and Young People's Plan'[14] sets out some key actions related to smoking in order to meet the vision of enabling children and young people to be healthy. They are as follows:

- Reduce the number of women smoking in pregnancy
- Ensure that all midwives, health visitors and children's centre staff are trained to encourage smoking cessation and to access smoking cessation services
- Reduce the number of children and young people who take up smoking

All of these actions are addressed specifically in the recommendations and action plan in Appendix 1. Pregnant women and young people are priority groups for this strategy.

5 Monitoring the strategy

The responsibility for day-to-day implementation of the strategy will be through the Tobacco Control Commissioner supported by the Tobacco Control Alliance.
A tobacco control alliance can be defined as collaboration between two or more multi-agency parties that pursue a set of agreed goals for tobacco control. Local tobacco alliances have been crucial in the delivery of tobacco control work throughout the country. A Tobacco Control Alliance for Haringey will implement the targets in the strategy. Members will contribute to the reaching of objectives and will work to reduce the prevalence of smoking within Haringey. The major function of the alliance in Haringey will be to develop, implement and monitor the Tobacco Control Action Plan (Appendix E).

[14] http://www.haringey.gov.uk/changing_lives_-_the_children_and_young_peoples_plan.pdf

Key members of the Tobacco Control Alliance will be NHS Haringey, London Borough of Haringey, North Middlesex Hospital, Barnet, Enfield & Haringey Mental Health Trust, Police/Fire, Voluntary/Charitable Organisations, Housing Associations, Chamber of Commerce, Connexions, CONEL and Schools. The alliance needs to consist of participants who can beneficially contribute to developing and implementing the Tobacco Control Action plan. The alliance will ensure a structured and well informed approach to tobacco control and ensure partnership working across Haringey. It will be a major step to creating a Smoke free Haringey. The alliance will meet bi monthly for its duration. This alliance will report formally to the Wellbeing Strategic Partnership Board.

5.1 Links with Haringey's Local Area Agreement

There is an LAA target for stop smoking which is to support 1008 per 100,000 population aged 16 and over each year until 2010/11. In addition, there is a stretch target from April 2007 to March 2010, to achieve 300 quitters each year from the N17 area. The target to achieve a reduction of 1008 per 100,000 is also the NHS Operating Plan target, meaning that targets for the Alliance are now aligned. Reporting of these targets are now to both the Council's Performance Team and to the Department of Health.

This strategy will also contribute to achievement of the following LAA targets:

- NI121- mortality rate from all circulatory diseases at age under 75 years
- Number of accidental dwelling fires

Appendix A: Needs assessment

The development of this strategy builds on an understanding of the needs of Haringey residents that has been developed over time. Key sources include:

- Haringey Health Report (2006)
- Health equity audit of utilisation of smoking cessation services in Haringey (2007)
- Joint Strategic Needs Assessment: minimum data set (2008)

In addition, PMA associates were commissioned to undertake a review to inform the development of this strategy. The objectives were:

1. Identify health inequalities due to tobacco in Haringey, and the population groups on which interventions should focus.
2. Review the effectiveness and cost-effectiveness of interventions currently in place in reducing health inequalities including quit smoking, enforcement, licensing, maternity and health promotion services.
3. Review the literature to identify relevant guidance or good practice that could be applied in Haringey.
4. Consider how tobacco-related performance management arrangements could be used to support work to reduce health inequalities.

Table A below sets out by Super Output Area the areas in Haringey where smoking prevalence is likely to be highest. The indicators used to derive this result included the following:

- % lone parent households with dependent children
- IMD 2007 Barriers to Hosing and Services score
- IMD 2007 Education Skills and Training score
- Job Seeker's Allowance claimants
- % working age persons unemployed
- IMD 2007 Income Score
- IMD 2007 Living Environment Score

Table A. Smoking prevalence likely to be highest

SOA code	Score	Ward	Postcodes (4 digits)
E01002037	19	Northumberland Park	N17-0
E01002035	17	Northumberland Park	N17-8
E01002038	16	Northumberland Park	N17-0, N17-8
E01002039	16	Northumberland Park	N17-0, N17-8
E01002066	16	Tottenham Green	N15-4, N17-9
E01002012	15	Hornsey	N8-7
E01002093	15	White Hart Lane	N17-7
E01001979	14	Bruce Grove	N17-6
E01002034	14	Northumberland Park	N17-0, N17-8
E01002054	14	Seven Sisters	N15-6
E01002074	14	Tottenham Hale	N17-0, N17-9
E01002094	14	White Hart Lane	N17-7
E01002099	14	Woodside	N22-5
E01001978	13	Bruce Grove	N17-6
E01002026	13	Noel Park	N22-6
E01002081	13	Tottenham Hale	N17-9
E01002089	13	West Green	N17-6
E01002033	12	Noel Park	N22-5, N22-6
E01002072	12	Tottenham Green	N15-4, N15-5
E01002091	12	White Hart Lane	N17-7, N17-8
E01002003	11	Haringey	N15-3, N8-0
E01002029	11	Noel Park	N22-6
E01002082	11	West Green	N17-6
E01002096	11	White Hart Lane	N17-7
E01001971	10	Bounds Green	N22-4, N22-8
E01002032	10	Noel Park	N22-5, N22-6
E01002045	10	St. Ann's	N15-5
E01002077	10	Tottenham Hale	N17-9
E01002095	10	White Hart Lane	N17-7
E01002097	10	White Hart Lane	N17-7

It can be seen that, in addition to targeting N17, parts of N8, N15 and N22 are also areas where there is likely to be a significant concentrated population of smokers.

Appendix B: Development of the strategy

Development of a coordinated, strategic approach to tobacco control in Haringey is a key priority in the Well-Being Strategic Framework, and an evidence review was commissioned through a tender process from Public Management Associates (PMA) in January 2008. The development of the strategy was led by the Improving Health and Emotional Well-being sub group of the Well-Being Partnership Board, in consultation with a range of stakeholders from across the Haringey Strategic Partnership.

Appendix C: Consultation about the strategy

The Consultation has gone through a number of stages already:

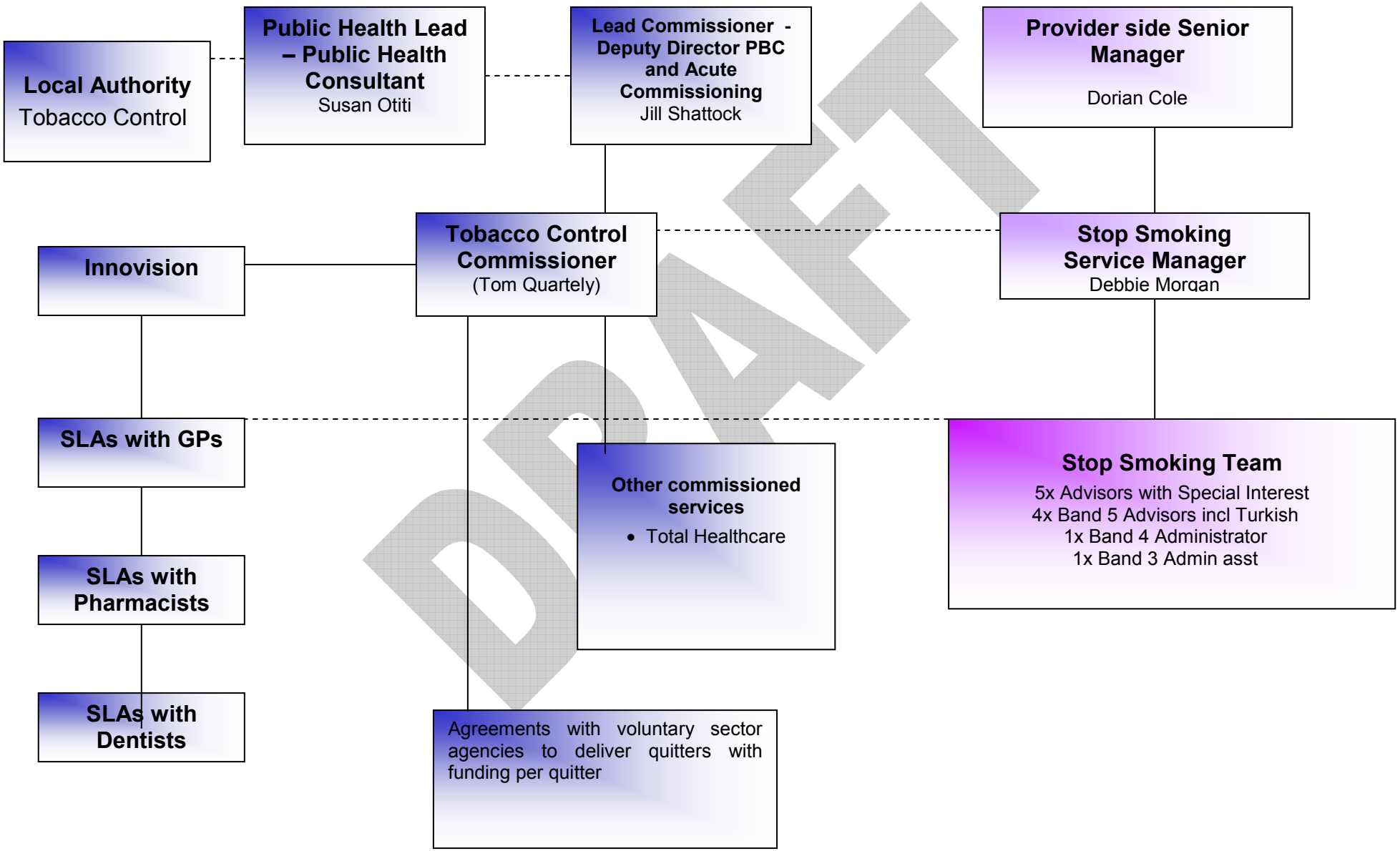
- PMA Associates consulted with over 20 stakeholder individuals and groups during February and March 2008, covering the Council, NHS Haringey CONEL, HAVCO and Tottenham Traders Association.

- To develop this strategy, further discussions were undertaken with a number of the stakeholders referred to above and additional Council staff and voluntary sector organisations.

- The draft strategy was presented to the Improving Health and Wellbeing Sub-group in April 2009

- A workshop held with Well Being Strategic Partnership Board members in September 2009 to provide members with an opportunity to shape the action plan.

Appendix D: Tobacco control diagram



APPENDIX E ACTION PLAN

Haringey Tobacco Control Strategy 2009-12

The overall aims of Haringey's Tobacco Control Strategy are to:

- Reduce the total consumption of cigarettes and other tobacco products across the community; and
- Reduce the number of people exposed to environmental or second-hand smoke.

To meet these aims there are five objectives:

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

Underpinning the aims and objectives of this strategy are a number of important guiding principles:

- Smoke-free is best for health; there is no safe level of exposure to smoke or second-hand smoke.
- People should have the right to be protected from the harmful effects of second-hand smoke.
- Tobacco control should be anti-smoking not anti-smoker.
- Tobacco control should seek to shift public opinion and promote non-smoking as the social norm.
- Children should have the right to be free from exposure to tobacco advertising and promotion.
- All smokers should have the opportunity to receive smoking cessation advice and support.
- Tobacco control should target neighbourhoods and communities and those with the highest prevalence of smoking and smoking related disease.

Haringey Tobacco Control Strategy 2009-12 – ACTION PLAN

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Leading and Monitoring Strategy	Set up a Tobacco Control Alliance that is committed and active in reducing the impact of smoking on health inequalities - with a clear but detailed purpose.	Set up a committed and active Tobacco Control Alliance formed from all relevant partners in the HSP, in order to monitor implementation and evaluate the strategy.	Associate Director of Public Health & Tobacco Control Commissioner (TCC).	First meeting November 2009	Robust multi-agency Tobacco Control Alliance Established. Monitoring and Evaluation of Haringey's Tobacco Control Strategy 2009-12.
		Dedicated managerial capacity to develop effective working relationships and shared sense of mission.	Appoint a fixed-term commissioner to implement strategy.	NHS Haringey Commissioning Team.	November 2009	NHS Management Trainee.
	Commissioning Services	Commission cost effective stop smoking services - with the aim of increasing support for smokers who want to stop smoking.	1. Continue to commission Innovision to project manage primary care stop smoking services 2. Commission other providers to deliver stop smoking within priority groups 3. Review current Commissioning arrangements.	TCC	By February 2009	Revised Commissioning of services based on DH Commissioning Guidance and DH 10 High Impact changes.
		Services will target the N17 area.	Continue this activity until 2010.	TCC	Ongoing	Local Area Agreement stretch target will be achieved.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Commissioning Services	Practice Nurses and Community Pharmacy staff to be offered Level 2 training and regular updates, including a quarterly visit. GPs will be incentivised to mail out to smokers with offers of support and to refer them to Stop Smoking Service.	1. Innovision to set up service level agreements with GP practices, pharmacies and dental surgeries which will include ensuring training and updates and quarterly monitoring. 2. The Stop Smoking Service will continue to deliver Level 2 training, updates and advice for primary care advisors. 3. GPs, pharmacists and dentists will receive £15 per quitter they refer to Stop Smoking Service under their SLA with Innovision.	TCC	Ongoing	NHS Haringey achieves the 4 week quitter target for 2009-10.
		Ensure that all contracts with Acute Providers specify that training of ALL Midwives provides level 2 interventions.	Negotiate new SLAs with acute providers which clarify obligation to refer patients and provide stop smoking clinics at Acute Trusts.	TCC	By March 2010	Acute Providers actively engaged with Tobacco Control agenda and referring patients to SSS.
		All cases of myocardial infarction will be offered cessation support and NRT on discharge.	Pilot automatic referral process to hospital-based stop smoking clinic at North Middlesex or cardiac and respiratory outpatients and vascular surgery.	SSS	Ongoing	Pilot underway – monitor progress by April 2010.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Priority Groups	Align Tobacco Control services with priority areas by postcode set out in Appendix A - to contribute to reducing health inequalities.	1. Stop Smoking Service to work in defined localities 2. Advisors to use the recommendations from Social Marketing to understand how to effectively engage different population groups.	SSSM TCC	Ongoing	Targeted activity to reduce Health Inequalities.
		Practice Nurses and Health Visitors will be asked to prioritise lone parents for smoking cessation advice.	SSS to work with Practice Nurses and Health Visitors.	SSS NHS Haringey – Provider Services.	By March 2010	Increase referrals to SSS.
	Pregnancy	All women will be offered CO monitoring and nicotine testing at first booking with referral to stop smoking clinic.	Pilot automatic referrals for pregnant women with positive smoking status at North Middlesex.	SSS	Ongoing	Evaluate impact, outcome and effectiveness of current Pilot.
		Utilise early booking programme in Children's Centres as an opportunity to refer for smoking cessation support.	Tobacco Control Commissioner to explore with LB Haringey Children's Services and Commissioned Services.	TCC SSS	Ongoing	Increase in number of people referred to SSS.
	Young Smokers	Sexual health services will offer referral to smoking cessation clinics.	Work with sexual health services and teenage pregnancy services to identify referral pathway and train staff to provide stop smoking advice.	SSS	By January 2010	Increase in the number of people referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Young Smokers	Promote Tobacco Control in the School Setting.	1. Work with Healthy Schools Co-ordinator to integrate Tobacco Control messages in PSCHE curriculum and 2. School Nursing Service.	SSS and Healthy Schools Co-ordinator	By March 2010	Tobacco Control messages integrated into PSCHE curriculum and School Nursing.
	BME Groups	Target specific ethnic groups such as Turkish and Irish men, known to have high prevalence.	1. Engage with Turkish voluntary sector groups, and Irish Groups, to explore commissioning of stop smoking services &/or delivering clinics in partnership.	TCC SSSM	November 2009 – March 2011	Targeted Stop Smoking Services available to people from identified BME Groups.
		Materials developed in community languages to target communities known to have highest prevalence - Turkish and Bangladeshi.	Work with Local Authority language services to ensure correct languages selected and obtain translations of smoking cessation materials.	SSS	By February 2010	Tobacco Control information and learning materials available to people from identified BME Groups.
	Workplaces	Target public sector employees on low incomes and set up referral routes through Occupational Health in Local Authority/NHS.	Work with the Local Authority's occupational health department to identify and target relevant employees and set up clinic.	SSS	November 2009 – March 2011	Tobacco Control Programmes, plus Stop Smoking Services targeted at and made available to Workplaces and employees across Haringey.
		Target large employers with 250 employees or more, to promote Tobacco Control with referral routes to SSS.	Identify 4 large employers - with a special focus on routine and manual workers - who would support Tobacco Control and/or referral routes to Stop Smoking Services.	SSS	November 2009 – March 2011	Tobacco Control Programmes, plus Stop Smoking Services targeted at Corporate employers and their employees across Haringey.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Workplaces	Target small and medium size businesses, particularly those with routine and manual workers.	1. Contact the local Chamber of Commerce, place an article in their newsletter about cost of smoking to employers. Mailout to members to seek their views on running workplace clinics 2. Contact North London Business (inward investment agency) and to place an article in their magazine about cost of smoking to employers 3. Develop links with Haringey businesses to run 6 workplace stop smoking clinics 4. Contact Green Lanes Traders Association to engage in providing clinics for members & aid Tobacco Ctrl compliance; 5. Identify best practice examples, where changing the "built-working" environment can help support no-smoking policy implementation; 6. Seek Local Authority assistance to target no-smoking support in workplaces with high levels of tobacco rubbish.	SSS	April 2010	Tobacco Control Programmes, plus Stop Smoking Services targeted at SMEs and their employees across Haringey.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Workplaces		7. LB Haringey Enforcement and SSS to work together to develop incentives for employers to send staff on stop smoking programmes.	SSS	April 2010	Tobacco Control Programmes, plus Stop Smoking Services targeted at SMEs and their employees across Haringey.
	Mental Health	Target people with mental health diagnoses.	1. Stop Smoking Service to offer a co-ordinated staff training programme 2. Identify opportunities to deliver clinics in mental health settings 3. Promote the Tobacco Control ban.	SSS	November 2009 to March 2011	Training Programme delivered.
		Stress Management.	Target smokers with identified stress related ill-health symptoms. Focus prevention and support activities on workplace based programmes in first phase.	SSS	November 2009 to March 2011	Targeted Stop Smoking Services available to people affected by stress at work.
	Community	Train to Level 1 and Health Trainers to provide appropriate advice to members of the community.	Continue to develop the Health Trainer in order to provide community based Level 1 advice – and increase referrals to Stop Smoking Services.	Michele Daniels	Ongoing	Health Trainer Programme developed. Health Trainers equipped to deliver this targeted programme. Increased referrals to SSS.
		Major professional sports facilities will be offered Stop Smoking Services support & publicity.	Integrate Smoking Cessation into Men's Health programme.	SSS together with Tottenham Hotspur FC	Ongoing	Increased referrals to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Community	Work with Citizens Advice Bureau (CAB) to offer referral to smoking cessation clinics and provide information.	Offer Level 1 advice and promotion materials at CABs especially in N17.	SSS	By March 2010	CAB facilities actively engaged in Tobacco Control. Users referred to SSS.
		Promote, and where possible, deliver smoking cessation services aimed at the hard to reach communities through the following: supermarkets, job centres, pharmacies, local health centres, schools, pubs, libraries, bookmakers, community centres, sports centres, places of worship.	Already delivering services in pharmacies, health centres, schools, libraries, community centres and places of worship. Seek opportunities to commission other services.	TCC	Ongoing	Hard to reach communities actively engaged. Users referred to SSS.
		Passive Smoking - working together with key stakeholders, continue to raise awareness to the dangers to health associated with environmental passive smoking across the community.	NHS Haringey to support the Local Authority Environmental Health teams to continue to promote the dangers to health caused by "environmental" passive smoking.	SSS	By March 2010	Programme to deal with environmental tobacco/passive smoking produced. Promotional publicity campaign established.
		Unemployed and Vulnerable Groups.	1. NHS Haringey to identify ways in which it can work closely with LB Haringey, Connexions and Jobcentreplus (JCP) employment programmes	SSS	By March 2010	LB Haringey, Connexions & JCP facilities actively engaged in the Tobacco Control agenda. Users referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Community		in order to promote tobacco control and Stop Smoking support to the unemployed. 2. NHS Haringey to identify ways in which it can work closely with Local Authority and 3rd Sector organisations in order to promote tobacco control and Stop Smoking support to vulnerable grps.			
		Tobacco Control programmes will be explored with the Health Visiting service to target households with <5 year olds.	Engage Health Visitors and Children's Centres in providing stop smoking support and identifying clients for referral and whether they could provide stop smoking clinic(s).	SSS NHS Haringey – Provider Services	By March 2010	Community Nursing Services & Children's Centres actively engaged with SSS and referring patients.
	Enforcement	The Tobacco Control Alliance in association with Trading Standards and Environmental Health will monitor the No Smoking ban.	1. Enforcement to provide information on Stop Smoking Services in food hygiene and health and safety courses 2. SSS to prepare leaflets on the smoking ban, in appropriate community languages, for Enforcement Teams to distribute to shops, restaurants and the hospitality settings, as part of routine visits.	SSS and LB Haringey Enforcement Teams	By March 2010	Tobacco Control integrated into LB Haringey Enforcement programmes. illegal Sales reduced. More smokers referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Enforcement	Tackle the availability of cheap and illicit Tobacco; Reduce illegal tobacco sales to minors; and Reduce sales of counterfeit & smuggled products.	LB Haringey and Metropolitan Police to reduce (and prevent) the availability of cheap and illicit tobacco. Key examples of proposed activity include: 1. Police – to target areas/outlets where illicit tobacco is being sold; 2. Licensing Trade – to target identified pubs/clubs where "illegal" imports & selling is prevalent; seek support of the Licensed Victuallers Society in undertaking this activity; 3. Employers – to support local employers (HR Teams) to implement & maintain "robust" no-smoking restrictions at work; 4. HMRC - Customs & Excise to prevent the importation/sales of illicit tobacco; explore linkages with Border Control Agencies too; 5. Prevention & Marketing – LB Haringey to set up & co-ordinate a PR/media campaign (plus local helpline) to raise awareness on illicit/illegal tobacco imports/sales	Police, SSS, Enforcement	By March 2010	Programme of activity on Enforcement to deal with cheap and illicit tobacco produced. Action plan agreed and implemented. Tobacco control measures enforced. Illegal Sales reduced - more smokers referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Enforcement		and what the community (as a whole) can and should do to tackle it - link this activity to other London Boroughs where possible. (see Publicity below).	Police, SSS, Enforcement	By March 2010	Programme of activity on Enforcement to deal with cheap and illicit tobacco produced. Action plan agreed and implemented. Tobacco control measures enforced. Illegal Sales reduced - more smokers referred to SSS.
		Explore developing a proof of 18 year age card to distribute through secondary schools and colleges.	Work towards introducing an existing Proof of Age scheme and distribute through schools and colleges.	SSS, Healthy Schools and Enforcement	By March 2010	Proof of Age Scheme established - with take up from local schools and colleges.
		All licensed premises will receive 'Responsible Retailers' information packs, giving advice on sale of tobacco particularly underage sales.	1. Use Responsible Retailers Scheme template from Barnsley as a model 2. Utilise materials from Portman Group to support proof of age and Responsible Retailers Sch	Enforcement Team	By March 2010	Packs produced and distributed link to enforcement and illicit sales above.
	Smoke Free Homes - focus on Social Housing & Care Sectors	1. All social housing tenants will be targeted with cessation support materials and access to Stop Smoking Service. 2. Explore opportunities for No-Smoking Policy development in residential care homes; plus increased referrals to Stop Smoking Services.	1. Work with Local Authority Housing Team to identify potential quitters from social housing tenants 2. Provide stop smoking materials to social housing tenants through Local Authority Housing Team 3. Work with parents to make homes smoke free - via Community Nursing.	SSS, Housing Services, Community Health Services, Voluntary Sector	By March 2010	Reduce the impact of second-hand smoke. Increase the number of users referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Smoke Free Homes - focus on Social Housing & Care Sectors		Services and voluntary organisations 4. Scope potential for provision of no-smoking support in residential & wider Homecare Care Sector.	SSS, Housing Services, Community Health Services, Voluntary Sector	By March 2010	Reduce the impact of second-hand smoke. Increase the number of users referred to SSS.
	Data and Audit	Develop economic data to demonstrate smoking costs locally - and to inform future developments and progress.	Provide economic data for partners to highlight the cost of smoking to the local economy.	Public Health	By March 2010	Robust data monitoring systems agreed and implemented. Evidence directly impacting on future commissioning arrangements.
		Reflect priority areas better in quit numbers.	Develop an audit cycle to ensure priority groups are being reached.	Public Health	By March 2010	Robust data monitoring systems agreed and implemented. Evidence directly impacting on future commissioning arrangements.
	Publicity	Establish a co-ordinated multi-agency media campaign.	Tobacco Control Alliance members to implement and ensure integration of Social Marketing recommendations.	Tobacco Control Alliance members	By February 2010	Multi-agency publicity and marketing campaign agreed and implemented across the community - more smokers referred to SSS.
	Consultation and Engagement	Engage locally elected members, Citizens' Panels, and New Deal for Communities.	SSS to work with HAVCO and the Local Authority to provide information at area assemblies and other forums on a regular basis.	SSS and Voluntary Sector	By March 2010	Promote the Tobacco Control Alliance's programme of activities. Increase the number of referrals to Stop Smoking Services.

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haringey strategic partnership

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

Date: **8 December 2009**

Report Title: **Communities for Heath Funding 2009/10**

Report of: **Margaret Allen - Assistant Director, Safeguarding and Strategic Commissioning**

Purpose

To provide an overview of the Communities for Health grant funding for 2009/10.

Summary

Haringey has been allocated **£220,000** for 2009-10 to meet the Choosing Health Agenda[1] under the Communities for Health (CfH) Programme run by the Department of Health (DH), to deliver community based programmes with clear links to Haringey's Local Area Agreement (LAA).

The strategic aims of the CfH are to:

- Engage communities in their own health and develop their capacity to support individual behavioural change for healthier lifestyles;
- Build partnerships between organisations and communities; and
- Develop innovative practices for community based health improvement.

The criteria set by DH, was that the resource be used to develop local capacity, and to strengthen the role that community groups and the voluntary sector have, in changing behaviours that have an adverse effect on health. The grant is to focus local activity on the key health priorities of tackling health inequalities, reducing smoking, tackling obesity, improving sexual health and mental health, and encouraging sensible drinking. Where possible, CfH funding should be aligned with Local Area Agreements, to support the delivery of health outcomes.

The aims of the CfH programme link to Haringey's Well-being Partnership Board (WBPB) outcome of Be Healthy[2] and used to:

- identify local projects that engage communities in improving their own health and help to reduce health inequalities;

[1] Choosing Health: Making healthy choices easier (Published by Department of Health 16th Nov 2004)
[2] As agreed by WBCE on 20th March 2007 and 22nd April 2009

- foster and enable the implementation of innovative, sustainable practice across a number of different properties;
- encourage partnership working between different sectors, agencies and communities;
- strengthen the role of regional partners;
- promote and disseminate good practice; and
- reinforce the community leadership role of local authorities and the NHS.

The Well-being Chairs Executive agreed that activities commissioned should achieve at least one of the following outcomes:

- Tackling Obesity (TO) – overcoming barriers to physical activity and healthy eating;
- Improving Sexual Health (SH) – raising awareness of how to access sexual health services and supporting people to adopt safer sexual practices; and
- Improving Mental Health (MH) – address stigma experienced by people with mental health problems and their carers **and** community based mental health promotion.

2009/10 FUNDING

Invitations were sent out welcoming new bids for 2009/10 (see appendix A for template) and an overwhelming 44 applications were received.

An Evaluation Panel (see table below) was set up to review the submissions and make recommendations against the programme priorities and key criteria (those that did not meet these key criteria were excluded from further consideration). Representatives from HAVCO and NHS Haringey were excluded from the panel due to conflict of interests.

Evaluation panel assessing the bids
Healthy Communities Development Officer, Corporate Voluntary Sector Team
Head of Governance and Partnerships, Adult, Culture and Community Services
Senior Governance and Partnerships Officer, Adult, Culture and Community Services
Head of Finance, Corporate Finance
Head of Strategic Commissioning, Adult, Culture and Community Services

A rating system of low, medium and high was used and marked according to whether the project met some or all of the necessary criteria. The projects (see Appendix B) were agreed by the panel and endorsed by the Director of Adult, Culture & Community Services for in 2009/10 (projects commenced on 01/10/09).

Legal/Financial Implications

All projects have a Service Level Agreement (SLA) in place and it is

expected that all the funded organisations will abide by the contract and deliver its services/targets during the contract period 1 October 2009 to 30th April 2010.

Performance of services including expenditure is monitored monthly by the Governance & Partnerships Team. A timetable is in place for mid year reporting in January 2010 and an end of year report within 4 weeks of project expiry (April 2010), that will highlight the key achievements and overall outcomes of the service, impact on service users, and value for money.

Recommendations

That the Board notes the information within this report.

For more information contact:

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Use of Appendices:

Appendix A:	Project Information Form
Appendix B:	Projects receiving *Communities for Health* funding 2009/10

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APPENDIX A

Communities For Health

Project Information Form 2009/10

Project title:

Lead organisation:	
Contact address: .	**Project Manager**:
	Job title:
	Tel:
	Email:

Main project theme:

Part I: Project summary

1. Target(s) to be achieved:

2. Describe the project(s):

Part II: Organisation arrangements

3. Describe Applicant Organisation and how it will deliver project: (please include description of skills/facilities etc to deliver)

4. Evidence of ability to deliver project : (e.g. previous experience, trained staff, organisational achievements)

Part III: Priorities

5. Please indicate which outcome the project contributes to:	
OUTCOMES:	
Tackling obesity	
Improving sexual health	
Improving mental health	

6. How will the project achieve the outputs?

APPENDIX A

7. How will you evaluate the effectiveness of this project?
8. How will achievement of project become sustainable?
9. Describe your exit strategy:
10. How will the project promote community cohesion and reduce social isolation?

Part V: Project expenditure

11 Project expenditure:
Please indicate the total budget you are bidding for

Please indicate a breakdown by target

Please indicate forecast total spend in the table below.

	2009/10				
	Q1	**Q2**	**Q3**	**Q4**	**Total Year Spend**
Capital					
Revenue					
Total					
Other					
Total					

12. Please attach budget plan of cost of programme including staffing, training, facilities, general running costs, publicity, Monitoring and evaluation, other expenses such as travel and any other funding?

13. Please demonstrate efficiencies of project(s)
(e.g. complementarily with more than one project, previous efficiency savings, value for money etc)

APPENDIX B

ORGANISATION / PROJECT	PROJECT DESCRIPTION	FOCUS & APPROACH TO DELIVER	OUTCOMES			FUNDING 01/10/09-30/04/10
			SH	MH	TO	
Equals Training CIC Alleviating mental health stigma and promoting increased social inclusion and well-being	Equals Training delivers training intervention programme using proven Disability Equality Strategies to alleviate mental health stigma. This delivers improvements in social inclusion outcomes and secondary improvements in clinical outcomes for Haringey mental health service users.	• Managed by disabled people in Haringey • Employment outcomes linked to increased engagement in employment activities and increased volunteering • Increased personal well-being • Improvement in clinical outcomes due to bio/psycho/social reality of mental health illness • **5 x 4** day courses to a total of **75** service users.		✔		35,000
Mental Health Carers Support Association (MHCSA) Haringey Befriend Service	Sponsored by a local consortium, to offer one to one befriending service; offering clients choice and service innovation linked to Personalisation and the shift away from institutional provision to inclusive and individualised community services.	• Endorsed by Mental Health Partnership Board. • Devise social enterprise feasibility study and business plan for Haringey Befriending Service linked to 3 year mental health commissioning strategy and Personalisation • Exchange information/liaise with potential referrers through joint planning and strategic groups. • Recruit & induct **15** volunteer befrienders		✔		35,500
Nafsiyat Inter-cultural Therapy Centre Haringey Include	Tackling widespread stigma around mental health within Asian, Minority Ethnic and Refugee (BAMER) communities by dispelling stereotypes and challenging discrimination	• One day workshops focused on issues around stigma BAMER communities to **40** mental healthcare professionals • Self help therapeutic support groups to **75** Turkish speaking people and host **10** community events		✔		46,500
Kurdish Community Centre Healthy Body Healthy Mind Community Café	A 'Healthy Body, Healthy Mind' Community Café at the Kurdish Community Centre to use as a base for projects tackling ignorance and negative attitudes and habits in relation to health issues including healthy eating, sexual health and smoking.	• Increased numbers quitting smoking and positive changes in dietary habits within the Community • **150** individuals to take part in physical activities • Delivery of **20** targeted sexual health / family planning sessions to specific groups • Interactive support sessions for people with mental health problems	✔	✔	✔	40,000
Embrace UK Mental Health Improvement Project	Provides a range of workshops, projects and initiatives (including befriending, advice, support, referral to counselling, developing healthier lifestyles through healthier eating programmes), to promote improved health and well being of migrant communities.	• Increase awareness about mental health issues through the provision of reliable and updating facts about mental illness. • Decrease stigma associated with mental health. • Healthier lifestyles through making informed decisions about substance misuse, eating balanced diets and exercising		✔	✔	34,474
Embrace UK Chlamydia Screening Programme [Funding to 30 Sept 09]	Increased the level of awareness of Chlamydia among young people, in particular Black and Minority Ethnic (BME) males aged between 15 - 24 year olds	• Young men aged 15-24 from BME communities • Information and skills development training • one-to-one, peer and small group discussions to initiate behavioural change	✔			5,000
Groundwork Haringey Timebank [Continuation from 08/09]	Improved well-being and self-esteem of people with mental health issues, especially those from deprived communities	• Time banking infrastructure developed • **80** new people engaged in volunteering activity through time bank, who will benefit from help/support		✔		28,500

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haringey strategic partnership

Meeting: Well-being Partnership Board

Date: 8th December 2009

Report Title: Community and Voluntary Sector representation on the Haringey Strategic Partnership (HSP) and Theme Boards

Report of: Mary Connolly, Partnership Manager

Purpose

To remind the board of the model agreed by the HSP for community and voluntary sector engagement with the partnership including representation on the HSP and its sub-structures.

Summary

The report sets out the arrangements for community and voluntary sector representatives across the partnership.

Financial Implications

There are no specific financial implications. HAVCO currently receive Area Based Grant to support the running costs of Haringey Community Link Forum (HCLF).

Recommendations

To note the report.

That the Well-being Partnership Board observes the conditions set out within the HSP and HCLF agreement regarding community and voluntary sector engagement across the HSP structures.

To note that the HCLF election process for community and voluntary sector representatives (from 2010-12) is currently underway, and this provides the opportunity to regularise the representation.

For more information contact:

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Introduction

This report reminds the Well-being partnership of the agreement adopted by the HSP for community and voluntary sector engagement across the partnership. It was specifically prompted by a recent meeting called by the Haringey Community Link Forum (HCLF) with the chair and vice chair of the Well-being board. At the meeting the HCLF expressed their concerns that the agreement regarding community and voluntary sector representation was not being adhered to.

It should be noted that the current HCLF representatives took up their seats across the HSP structure including the Well-being partnership board from April 2008 following a formal election and induction process. Representatives hold their seats for a period of two years. A new election will commence at the beginning of the New Year, and the board should take this opportunity to regularise voluntary and community sector engagement in accordance with the HSP and HCLF agreement. Newly elected representatives will take up their seats from June 2010.

Background

In July 2007, the Haringey Strategic Partnership agreed a new model for voluntary and community sector engagement with the partnership. The model introduced a new system whereby voluntary and community sector representatives on the main HSP Board and its sub structures are elected through a new forum called Haringey Community Link Forum (HCLF).

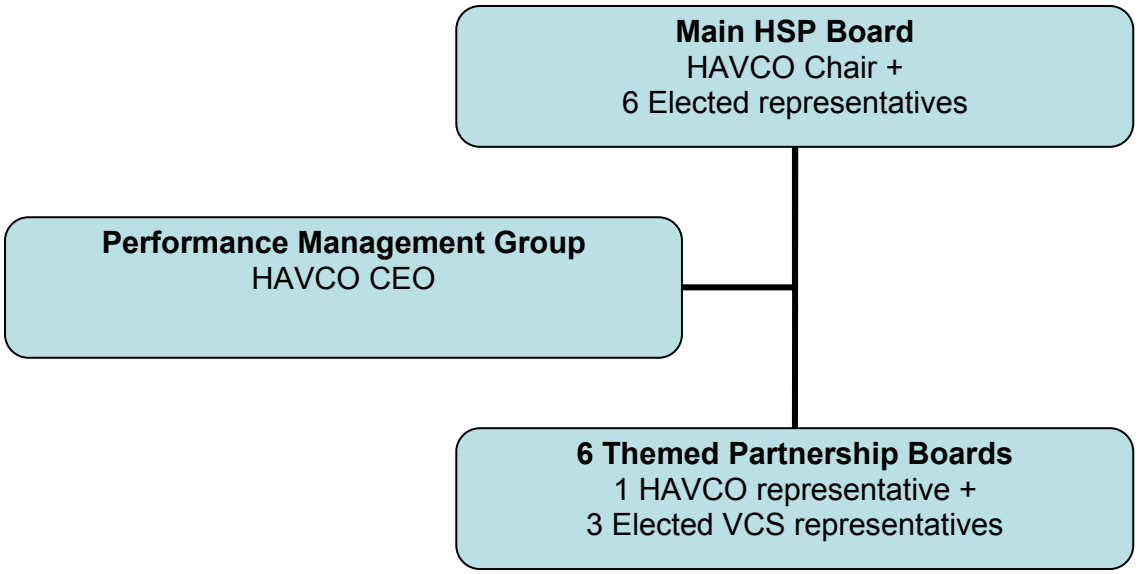
The model standardised the number of places available for community and voluntary sector representation on the HSP and its sub-structures with 24 elected places and 8 standing places for HAVCO representatives. The non elected standing places are in recognition of HAVCO's role as the organisation representing the interests of the voluntary and community sector, in the same way that the Chamber of Commerce or Small Business Federation represents the business sector.

The introduction of the new system for securing voluntary and community sector representatives provided for replacing *all* existing mechanisms (some of which varied by theme board) and thereby ensuring greater consistency and accountability both to the partnership and the voluntary and community sector as a whole. With the creation of the HCLF, it was envisaged that, through time, it would become the 'forum of forums' for the voluntary and community sector.

Community and Voluntary Sector representation on the HSP and sub-structures

Haringey Community Link Forum Agreement provides for 32 places to represent the community and voluntary sector across the partnership. These

are distributed as illustrated below.



The establishment of the HCLF together with the election of the VCS representatives created for the first time legitimacy to community engagement in the partnership. All voluntary and community representatives represent the HCLF and *not* individual or specialist interest areas such as disability, faith etc. The reason for this is to avoid competing demands from the sector for a 'voice' at the table.

The HCLF Agreement also provides for the co-option of strategic, voluntary and community organisations with specialist skills or knowledge to the partnership boards, in addition to the elected representatives. For example, where a board considers there is a specific specialist need and/or a deficit in representation is identified the board may wish to co-opt additional members. Such co-option must however, be agreed with the HCLF and the HSP or Theme Board. Such co-optees must also become members of the Forum. This is also reflected in the HSP terms of reference.

In addition to providing a mechanism for the community and voluntary sector representation, the role of the HCLF is to provide a formal gateway to communicate with a wide range of organisations on policy and service issues, through regular structured meetings, seminars and events. The HCLF is supported by HAVCO.

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