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Public Document Pack Agenda Item 1

AGENDA FOR THE HARINGEY AND ISLINGTON HEALTH AND WELLBEING BOARDS JOINT SUB-COMMITTEE

Members of the Haringey and Islington Health and Wellbeing Boards Joint-Sub-Committee are summoned to attend a meeting which will be held in Committee Room 5, Town Hall, Upper Street, N1 2UD on **9 October 2017 at 2.00pm.**

Bernie Ryan
Assistant Director – Corporate Governance
London Borough of Haringey

Yinka Owa
Director of Law and Governance
London Borough of Islington

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Despatched : 29 September 2017

Islington Membership

Councillors:
Councillor Richard Watts
Councillor Janet Burgess MBE
Councillor Joe Caluori

Islington CCG:
Tony Hoolaghan, Chief Operating Officer
Dr. Josephine Sauvage, Chair
Dr Katie Coleman, Vice-Chair (Clinical)
Jennie Williams, Director of Nursing and Quality
Sorrel Brookes, Lay Vice-Chair

Islington Healthwatch:
Emma Whitby, Chief Executive

Islington Council Officers:
Julie Billett, Director of Public Health
Sean McLaughlin, Corporate Director Housing and Adult Social Services
Carmel Littleton, Corporate Director Children's Services

Local NHS Representatives:
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Siobhan Harrington, Chief Executive, The Whittington Hospital NHS Trust

Haringey Membership

Councillors:
Councillor Claire Kober
Councillor Jason Arthur
Councillor Elin Weston

Haringey CCG:
Tony Hoolaghan, Chief Operating Officer
Dr Peter Christian, Chair
Dr Dina Dhorajiwala, Vice-Chair
Cathy Herman, Lay Member

Haringey Healthwatch:
Sharon Grant, Chair

Haringey Council Officers:
Tracie Evans, Interim Deputy Chief Executive
Dr Jeanelle de Gruchy, Director of Public Health
Beverley Tarka, Director of Adult Social Care
Margaret Dennison, Interim Director of Children's Services
Geraldine Gavin, Haringey Local Safeguarding Board

Voluntary Sector:
Geoffrey Ocen, Chief Executive, The Bridge Renewal Trust

Quorum is 3 voting members of each constituent borough, including one local authority elected representative of each borough and one of their the Chair, Clinical Commissioning Group or the Chair, Healthwatch (or their substitutes)

A.	**Formal Matters**	**Page**

Filming at meetings

Please note this meeting may be filmed or recorded for live or subsequent broadcast by anyone attending the meeting using any communication method. Although we ask members of the public recording, filming or reporting on the meeting not to include the public seating areas, members of the public attending the meeting should be aware that we cannot guarantee that they will not be filmed or recorded by others attending the meeting.

Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. Welcome and Introductions

3. Apologies for Absence

4. Notification of Urgent Business

Declarations of Interest

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

6. Minutes of the Previous Meeting 1 - 6

Questions and Deputations

Notice of questions must be given in writing to the Committee Clerk of either or both boroughs by 10 a.m. on such day as shall leave five clear days before the meeting (e.g. Friday for a meeting on the Monday 10 days later). The notice must give the name and address of the sender.

A deputation may only be received by the Sub-Committee if a requisition signed by not less than ten residents of either or both boroughs, stating the object of the deputation, is received by the Committee Clerk of either borough not later than 10am five clear days prior to the meeting.

New Items of Urgent Business

To consider any new items of urgent business admitted above.

Exclusion of the Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, any of them are likely to involve the disclosure of exempt or confidential information within the terms of Schedule 12A of the Local Government Act 1972 and, if so, whether to exclude the press and public during discussion thereof.

New Items of Exempt Urgent Business

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

The next meeting of the Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee will be at 2pm on 29 January 2018

MINUTES OF THE MEETING OF THE HARINGEY AND ISLINGTON HEALTH AND WELLBEING BOARDS JOINT SUB-COMMITTEE HELD ON MONDAY, 19TH JUNE, 2017, 2.35pm

PRESENT:

Cllr Jason Arthur, Cabinet Member for Finance and Health, LB Haringey [Chair]
Cllr Elin Weston, Cabinet Member for Children and Families, LB Haringey
Sharon Grant, Chair, Healthwatch Haringey
Dr Peter Christian, Chair, Haringey CCG, Beverley Tarka, Director Adult Social Care, LB Haringey
Jon Abbey, Director of Children's Services, LB Haringey, Geoffrey Ocen, Chief Executive, The Bridge Renewal Trust.
Catherine Herman Lay CCG Member.

Councillors Janet Burgess (Vice -Chair) and Joe Caluori – LB Islington

Tony 'HOOLAGHAN, Chief Operating Officer, Islington Clinical Commissioning Group
Dr. Josephine Sauvage, Chair, Islington Clinical Commissioning Group
Sorrel Brookes, Lay Vice-Chair, Islington Clinical Commissioning Group
Emma Whitby, Chief Executive, Islington Healthwatch
Angela McNab, Chief Executive, Camden and Islington NHS Foundation Trust
Julie Billett, Director of Public Health
Siobhan Harrington, Deputy Chief Executive, The Whittington Hospital NHS Trust

Tracie Evans, Interim Deputy Chief Executive, LB Haringey
Rachel Lissauer, Acting Director of Commissioning, Haringey CCG
Stephen Lawrence Orumwense, Assistant Head of Legal Services, LB Haringey
Tamara Djuretic- Assistant Director for Public Health, LB Haringey

1. FILMING AT MEETINGS

The Haringey Cabinet Member for Finance and Health referred to agenda item 1, as shown on the agenda in respect of filming at this meeting and members noted this information.

2. WELCOME AND INTRODUCTIONS

In the absence of Councillor Watts and Councillor Kober, Councillor Arthur, Haringey Cabinet Member for Finance and Health, was nominated and agreed as Chair of the meeting and Councillor Janet Burgess was nominated and agreed as co-chair.

The Chair welcomed those present to the meeting and the Board introduced themselves.

3. APOLOGIES FOR ABSENCE

Apologies for absence were received from Islington Health and Wellbeing Members: Councillor Richard Watts Leader of Islington Council and Jennie Williams.

Apologies for absence were received from Haringey Health and Wellbeing Board Members: Councillor Claire Kober, Leader of Haringey Council, Dr Dina Dhorajiwala, Dr Jeanelle de Gruchy and Zina Etheridge.

4. NOTIFICATION OF URGENT BUSINESS

There were no items of urgent business to consider.

5. DECLARATIONS OF INTEREST

There were no declarations of interest put forward.

6. QUESTIONS AND DEPUTATIONS

No questions or deputations were put forward.

7. NORTH LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

The Haringey and Islington Health and Wellbeing Boards Joint Subcommittee was asked to consider the latest version of the STP [Sustainability and Transformation Plan] which aimed to promote discussion and consideration of the implications of the STP for the Wellbeing Programme and for Haringey and Islington as boroughs.

The Acting Director of Commissioning, Haringey CCG, introduced the report, emphasising that this was not a plan for achieving financial balance as there was more work being completed on finances and partner contributions at a time of significant budget pressures. However, the report contained a lot more detail on the individual workstreams, than previously provided, Sanjay Mackintosh was completing further work on the terms of references and reporting mechanisms within the workstreams and nominated directors had been invited to reflect on the Adults element.

The Board noted that, to address the previously perceived democratic deficit around the STP, a Health and Social Cabinet had been established which was envisaged to be reflective of the Haringey and Islington partnership approach to health and work in an advisory capacity, acting as a sounding board for the implementation of STP plans.

A position was being reached where local authorities and CCG's can establish how their work fits in with the responsibilities of the STP and how the Haringey and Islington partnership work as a sub system.

Further information was provided as follows:

- Population based approach being taken forward by Haringey and Islington following approval of the partnership agreement.
- Partnership to initiate what happens at STP level, showing best practice.
- In relation to urgent care services, making sure that there was standardisation and overview ownership at the STP decision making level.
- Considering integrated model delivery and STP position with the development of the out of hospital care.
- STP required close working by agencies, in particular to support the intermediate services.

- Tier services to reduce the reliance on institutional care. The Partnership had already identified areas of working together in this respect.
- STP was an agent for quality care to ensure that this was provided to the required standard.
- Preventative approach to be routed in the communities.

In response to consideration of the report and presentation, the following comments/ issues were made:

- In relation to the STP role in urgent care, admissions to Accident and Emergency service for young people had risen and this was attributed to the rapid access initiatives in hospitals. To mitigate this rise, there would need to be same day access to GP's. Also there was work to do on improving access hubs in GP practices and discussing with paediatricians on how to provide more advice/learning to parents to prevent admissions. Noted that there was also a peak in attendance at A&E, related to respiratory conditions and low level re-current problems such as constipation and reflux in children. These were everyday examples of needing to provide the right care at the right times and this required a financially viable care system. This also involved the STP understanding the issues and developing a bespoke solution where needed. Going forward, it was essential for partner services to have a narrative about developing solutions with consistencies.

- With regard to the decision making role of the STP, there was a vital need for equalities impact assessments to accompany planning and decision making. There was a need to have an understanding of whether the different methods of data collection by the partnership would have an impact on meeting the local population needs of Haringey and Islington residents.

  Equalities considerations should also have an essential role in shaping the STP and should be part of the decision making. It was important to identify a mechanism to enable this influence. It was also important to understand where accountability was in the STP and where efforts should be focused.

  Haringey Healthwatch and Islington Healthwatch representatives continued to reiterate the importance of equalities considerations in planning and delivering services as public organisations had a public duty, under the equalities act, to give due regard to the needs of people with protected characteristics and this seemed absent from current considerations. It was imperative to ensure that there were safeguards in place, with the STP, for protected groups.

  In response to concerns about equalities considerations in decision making, there was a prevention workstream which was envisaged to have a positive impact on the mechanism to monitor the impact of the STP on protected groups.

  There was discussion about having an individual CCG representative for equalities and engagement under each level of the STP. However, it was also important not to duplicate discussion and have alignment of issues. There was a need to have common trajectory to make good use of resources as the work at the STP level was important.

  Assurance was given that the STP was well placed to consider equalities issues, in relation to planning services, and it was envisaged that responsibility for delivery would be at the workstream level. There could be particular actions where an EQIA would

involve significant engagement and user consultation and there would be a mechanism built in that proactively delivers on this.

- Co -design initiatives were already taking place and there was a need to give thought to direction levels.

- With regard to supporting the prevention agenda at the voluntary sector level, it was important for the sector to fully understand their role in prevention and ensure that this is discussed. There was confidence that the partnership was in a good place with the voluntary services that were in place and were making more of the contracts make a difference.

- It was important to note that the STP was aspirational, and at the moment focused on the top level understanding. There will be a responsibility to make sure it works and can be delivered by the Haringey and Islington partnership as the overarching aim of the STP was to deliver quality health and social care together. The STP was the instigator for this and could offer a system solution.

- Individually, partners needed to optimise co- productions and develop the democratic work around the STP. Once the Health and Social Cabinet did choose an initiative to take forward and develop, this would provide wider understanding of how the STP would work in the future.

- In relation to the Children's and Young People's workstream there was no read across to the other work streams and there was a need to ensure that children and young people's health needs from the ages of 2 to 16 were being addressed. Agreed that appropriate wording be added to the work streams terms of reference to ensure this.

8. HARINGEY AND ISLINGTON WELLBEING PROGRAMME PARTNERSHIP AGREEMENT

Noted that the Partnership Agreement had been signed by both Islington and Haringey Councils, the CCG Governing Bodies for Islington and Haringey, University College London Hospital and Whittington Health. Haringey and Islington GP Federations have also agreed to sign the Agreement and to work with the Wellbeing Partnership, noting that the Federations are signing as organisations rather than on behalf of individual member practices.

9. CARE CLOSER TO HOME INTEGRATED NETWORKS - CHINS

The Joint Committee considered a presentation on the work underway across Islington and Haringey to develop Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams (QISTs), key propositions of the North Central London sustainability and transformation plan.

The presentation further set out the case for change and provided an update of the development locally.

Comments were as follows:

- There was recognition of the importance of this work and how it supports understanding how fund flow through the partnerships; this will also help with understanding how the STP will work.

- This was a good grass roots initiative which Haringey and primary care providers were also positive about. The next theme being explored was a digital roadmap and it was hoped to have access to digital files on a shared scale to inform and utilise local working.

- With regard to a question about the decision making around commissioning of services from providers and in particular where a provider may provide one source of provision but may not be successful in gaining a contract in another related area, it was noted that this issue would be considered on a case by case basis. It may be the case that some service provision will not have a partnership solution attached but ultimately there will be consideration of cost and outcomes when commissioning the appropriate service.

10. UPDATE ON A JOINT APPROACH TO TACKLING OBESITY IN ISLINGTON AND HARINGEY

The Joint Committee noted that Haringey and Islington face similar challenges with over 1 in 3 children aged 10-11 classed as overweight or obese. Tackling obesity through the Wellbeing Partnership emerged as a priority area following the scoping of the CVD/diabetes, children's and prevention work streams of the Haringey and Islington partnership. In response, a joint approach to creating healthier environments and reducing sugar consumption was approved by the joint Health and Wellbeing Board in January 2017.

There were some bold actions for tackling Obesity highlighted in the presentation by the Islington Director for Public Health for the Joint Committee to comment on.

1. **Improve the food controlled or influenced by the Council** - Prevent any business operating on Council owned premises from selling sugar sweetened soft drinks and Introduction of a local sugar tax/levy.

2. **Support businesses and organisations to improve their food offer-** Rent relief / business rates relief for healthier retailers. Prevent ice cream vans from parking outside schools and / or playgrounds.

3. **Public events -** Provide incentives to food providers at events organised by the Council to replace unhealthy with healthier options or similar.

Comments were as follows:

- The above actions demonstrated that both Councils had an equally positive disposition to tackle obesity and there was a need to take forward bolder actions with fewer resources. In terms of the actions highlighted, there was a need to consider the resources available for enforcement and monitoring and whether both Council's had the capacity to take these actions forward. Suggested there could be separate exercise to explore the common areas of working and where actions can have an impact.

- Agreed that the report and presentation is considered by the respective partnerships and consideration given to the common actions that can have an impact, whilst also giving consideration on how they fit in with existing contracts/ services.

- The Co- Chair suggested that after consideration by the individual organisations this item is added to a future Joint HWB agenda to agree actions.

11. NEW ITEMS OF URGENT BUSINESS

None

12. EXCLUSION OF THE PRESS AND PUBLIC

Not required.

13. NEW ITEMS OF EXEMPT URGENT BUSINESS

None

14. THE NEXT MEETING OF THE HARINGEY AND ISLINGTON HEALTH AND WELLBEING BOARDS JOINT SUB-COMMITTEE WILL BE ON 9 OCTOBER 2017

Next Joint Meeting Monday 9th of October 2.00pm Islington.

Report for: Joint Health and Wellbeing Board Sub Committee

Date: 9 October 2017

Title: Update on Joint Approach to Tackling Obesity in Haringey and Islington and taking forward the Local Government Declaration on Sugar Reduction and Healthier Food

Report authorised by : Dr Jeanelle de Gruchy, Director of Public Health, Haringey
Julie Billett, Director of Public Health, Camden and Islington

Lead Officers: Susan Otiti, Assistant Director of Public Health, Haringey
Jason Strelitz, Assistant Director of Public Health, Islington

1. Purpose

1.1 The Haringey and Islington Health and Wellbeing Board Joint Sub Committee has committed to taking joint action on obesity and unhealthy food environments. The paper proposes pledges in six areas to improve healthy food choices across Haringey and Islington – and that Haringey and Islington Councils sign up to the **Local Government Declaration on Sugar Reduction and Healthier Food (LGD).**

1.2 In addition, all members of the board are encouraged to support the Declaration by signing up to a national campaign called 'Sugar Smart' that allows partners to develop pledges to take action on sugar reduction and healthier food and raise public awareness on this issue.

2. Describe the issue under consideration

The issue

2.1 Tackling obesity is a priority area for the joint Haringey and Islington Wellbeing partnership. It is an important driver of preventable poor health in both boroughs, including cardiovascular disease and diabetes, as well as an issue across the life course. Haringey and Islington face similar challenges with over 1 in 3 children aged 10-11 classed as overweight or obese, and more than half of all adults either overweight or obese[1].

2.2 Obesity, and associated diseases including type 2 diabetes, cancer and cardiovascular disease, is one of the most pressing public health issues of our

[1] PHE Fingertips data 2013-5. Haringey – 54.2%. Islington 52.8%.

day. Obesity costs the NHS alone £5.1bn every year[2], as well as leading to significant losses to the economy (through ill health, disability and early death). An estimated 7.1% of deaths in England and Wales are attributable to elevated Body Mass Index (BMI), with obese individuals losing an average of 12 years of life[3]. It can also have a significant impact on daily life and wider wellbeing for those individuals affected.

2.3 Obesity is also a pressing health inequalities issue. In both boroughs, more deprived wards have higher rates of obesity, and obesity is highly correlated with deprivation **(Appendix 1).** In Haringey, three times as many children leaving primary school in West Green ward are overweight/obese (53%) as in Alexandra ward (17%). **(Appendix 2).** Similarly, in Islington, nearly twice as many children leaving primary school in Clerkenwell ward are overweight/obese (47%) as in St. Georges ward (24%). **(Appendix 2)**

2.4 More than a fifth of children start primary school overweight, and more than a third leave for secondary school overweight[4]. Across Haringey and Islington, there are approximately 582 Year 6 children who are overweight (15%) and 918 Year 6 children who are obese (23%). Therefore, the combined prevalence of overweight and obesity in 10-11 year olds across the two boroughs is 38%[4]. The need for action on obesity is well recognised and supported by our residents.

2.5 Guidelines on sugar consumption were issued in July 2015 by the Scientific Advisory Committee on Nutrition (SACN). They recommended that sugar should account for a maximum of 5% of energy intake for adults and children. However it is estimated that sugar currently accounts for three times this proportion of children's energy intake, with sugar sweetened soft drinks being the largest single source of sugar for children[5].

2.6 An important reason for this is because of the profound changes to the food environment over the last three decades. Food is now more readily available and heavily promoted, marketed and advertised. Combined with increasing consumption of meals from the out of home sector (coffee shops, cafes, fast food outlets) people have been pushed towards overconsumption through a food environment which normalises the provision of unhealthy food and drink in everyday life and settings.

2.7 A recent evidence review by Public Health England of sugar reduction interventions also outlined the significant changes to the food environment over the last thirty to forty years[6]. The report recommended a strong focus on the food environment and in particular:

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[2] PHE (2015) Sugar reduction: the evidence for action www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

[3] IEA (2017) Obesity and the Public Purse, citing figures from the Office for National Statistics https://iea.org.uk/wp-content/uploads/2017/01/Obesity-and-the-Public-Purse-PDF.pdf

[4] National Child Measurement programme 2015/16. Haringey – 23.6% age 4/5, 38.4% age 10/11. Islington – 22.5% age 4/5, 36.5% age 10/11.

[5] Public Health England, Public Health Matters blog, Expert interview: New sugar recommendations, 17 July 2015 (accessed 30 May 2017).

[6] Public Health England (2015) Sugar reduction: the evidence for action

- Strong controls on price promotions of unhealthy food and drink
- Tougher controls on marketing and advertising of unhealthy food and drink
- A centrally led reformulation programme to reduce sugar in food and drink
- A sugary drinks tax on full sugar soft drinks, in order to help change behaviour, with all proceeds targeted to help those children at greatest risk of obesity
- Improved education and information about diet

The demand for action

2.8 The most recent survey of residents on the subject of obesity was the **Great Weight Debate** (GWD), undertaken in October 2016 as part of a London-wide programme of engagement. Although from a relatively small sample size locally (Haringey =181 and Islington =79), the insights from the GWD show that residents in both Haringey and Islington are particularly concerned about the number of fast food outlets in their area and the relative availability of unhealthy food and drink. It also found significant demand for local action to improve the food environment to promote healthier choices. This degree of consistency across both boroughs strengthens the rationale for working jointly on this agenda.

Haringey	Islington
• 69% of respondents were aware of the childhood obesity epidemic	• 32% of respondents were aware of the childhood obesity epidemic (50% of respondents didn't answer this question)
• 33% of respondents felt that tackling childhood obesity should be a top priority • 59% of respondents felt that tackling childhood obesity should be a high priority	• 33% of respondents felt that tackling childhood obesity should be a top priority • 56% of respondents felt that tackling childhood obesity should be a high priority
Haringey residents told us that the top 3 things that made it hard for children to lead healthier lives were: 1. Too many fast food outlets 2. Too many cheap unhealthy food and drink options 3. Too much advertising of unhealthy food and drink options	Islington residents told us that the top 3 things that made it hard for children to lead healthier lives were: 1. Too many cheap unhealthy food and drink options 2. Too many fast food outlets 3. The cost of healthy food and drink
Haringey residents told us that the top 3 things in the local area that encouraged children to lead healthier lives were: 1. Parks 2. Local leisure facilities 3. Local sports and youth clubs	Islington residents told us that the top 3 things in the local area that encouraged children to lead healthier lives were: 1. Parks 2. Local leisure facilities 3. Local sports and youth clubs
Haringey residents told us that in order for children to be better supported to lead healthier lives there needed to be: 1. Limit on the number of fast food outlets 2. Support or families to cook healthier food 3. Cheaper healthier food and drink options	Islington residents told us that in order for children to be better supported to lead healthier lives there needed to be: 1. Support or families to cook healthier food 2. Cheaper healthier food and drink options 3. Limit on the number of fast food outlets

The Local Government Declaration on Sugar Reduction and Healthier Food

2.9 In 2016, Sustain (a national campaigning organisation on better food and farming) launched the Local Government Declaration on Sugar Reduction and Healthier Food (LGD, or the Declaration), a voluntary initiative that aims to help local authorities tackle the proliferation and marketing of unhealthy food and drink. To sign the Declaration, a local authority must make pledges across six different areas: tackling advertising and sponsorship, improving the food controlled or influenced by the council, reducing the prominence of sugary drinks and promote free drinking water, supporting businesses and organisations to improve their food offers, public events, and raising public awareness. In addition, the local authority commits to report on progress annually.

2.10 The Declaration supports a whole-systems approach, helping to address unhealthy eating through targeted action under the six key areas of commitment. Signing the Declaration makes clear the council's commitment to tackling the causes of obesity. The aim of signing the Declaration and making these pledges is not to ban sugar or eliminate choice for our residents. Instead, it is about making a range of changes to the wider food environment which make it easier, more convenient and / or more affordable for residents to make healthier choices.

2.11 Haringey and Islington are at the forefront of the movement across London to sign up to the Declaration with only four other London Boroughs (Redbridge, Lambeth, Waltham Forest and Tower Hamlets) having signed up at the time of writing.

3. Recommendation

3.1 This paper recommends that the Haringey and Islington Health and Wellbeing Board agrees to the proposed pledges below, and signs up to the LGD.

Pledge area	Specific pledges
1. Tackle advertising and sponsorship	- Develop a policy on advertising, sponsorship and corporate partnerships
2. Improve the food controlled or influenced by the council	- Develop a Food Standards Policy - Reduce the sale of sugar sweetened soft drinks from council-owned or managed premises
3. Reduce prominence of sugary drinks and promote free drinking water	- Improve and promote access to free drinking water
4. Support businesses and organisations to improve their food offer	- Continue to promote the Healthier Catering Commitment and London Healthy Workplace charter to achieve health benefits - Support the Whittington to improve their healthy food offering across catering, retail and vending

	points.
5. Public events	- Increase the healthy food offer at Council-organised events
6. Raise public awareness	- Sign up to the Sugar Smart campaign

3.2 More detailed information regarding these proposed pledges is set out in Appendix 3.

3.3 Haringey and Islington are at different stages with their work to improve the local food environment but working on the LGD collaboratively creates opportunities to share good practice and develop consistent policies over a range of areas. It does not prevent each Council from moving forward on additional actions, outside the scope of the Declaration, to tackle obesity and improve the food environmenthrough relevant planning polices and levers.

3.4 All organisations on the joint Board can support the Declaration by signing up to Sugar Smart (pledge 6) which is an area that all partners, businesses and organisations can contribute towards. This is a national public-facing campaign on sugar reduction and obesity and signals that Haringey and Islington are leading by example. The Board are asked to consider how they can make specific pledges to raise public awareness on this issue.

4. Background

4.1 The proposal to take joint action on obesity across the London Boroughs of Islington and Haringey was originally agreed at the joint meeting of Haringey and Islington's Health and Wellbeing Boards held on 31st January 2017. Since then, officers have been working to develop practical proposals to translate this commitment into action, as set out in this report. Once these proposals have been agreed, the two Councils will work collaboratively to implement the pledges and monitor progress and improvements over time.

5. Contribution to strategic outcomes

5.1 Tackling obesity together and the recommendations outlined in this report aligns to the Haringey and Islington Wellbeing Partnerships approach of; 'Shifting care upstream by supporting people to stay and be healthy, to reduce the level of ill health within our population'.

5.2 Our joint approach to tackling obesity also supports both Haringey and Islington's Health and Wellbeing Strategies and Corporate Priorities.

5.3 In Haringey it supports the Council's Corporate Plan, Building a Stronger Haringey Together 2015-18, in particular Priority 1 and 2 and cross- cutting themes, specifically: prevention and early intervention as outlined in Objective 1 'Become an organisation focused on prevention and early help'.

5.4 In Islington, it supports the Council's Corporate Plan 2015-2019, contributing towards the commitment "Making Islington a place where residents have a good quality of life", as well as being an important part of tackling some of the deep

rooted and complex social challenges that are also the focus of the corporate plan. The underpinning principles of Islington's Corporate Plan, such as prevention and early intervention, making every contact count and building strong partnerships, are also key features of the proposed collaborative work on obesity.

6. Statutory Officers Comments (Legal and Finance)

6.1 Legal

6.2 Under Section 2B National Health Service Act 2006 (as amended by Section 12 of the Health and Social Care Act 2012) each local authority must take steps as it considers appropriate for improving the health of people in its area. The steps that may be taken include providing information and advice; providing services or facilities designed to promote healthy living; providing financial incentives to encourage individuals to adopt healthier lifestyles and making available the services of any person or any facilities. The recommended pledges falls within the statutory duty to improve public health.

6.3 The Sugar Reduction and Healthier Food initiatives fall within the Terms of Reference of the Joint Sub-Committee to encourage joint consideration and co-ordination of health and care issues that are of common interest to the population of Haringey and Islington.

6.4 The Finance Act 2017 has established a new tax called the Soft Drinks Industry Levy (the Levy) and provides that HM Revenue & Customs (HMRC) will be responsible for its collection and administration. The levy is intended to apply from April 2018 and is aimed at producers and importers of soft drinks containing added sugar. It is intended to tackle childhood obesity by encouraging the reformulation of drinks to reduce levels of added sugar, as well as portion size reduction and marketing of low sugar alternatives.

6.5 Chief Finance Officer (ref: CAPH58)

6.6 There are no financial implications arising from the recommendations in this report. Officers will need to ensure the implications of accepting any grant funding are understood before entering into any new commitments. This might include any requirements for matched funding or prescribed use of monies or clauses relating to repayment in particular circumstances.

7. Environmental Implications

7.1 This report has limited environmental implications; however it should be noted that a campaign to promote the availability of free drinking water and refill drinking points would deliver environmental benefits (reduced plastic waste, reduced waste going to landfill and reduced carbon emissions from transporting bottled water).

8. Resident and Equalities Implications

8.1 Both councils have a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

8.2 The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

8.3 This report sets out a summary of the need in Haringey and Islington to create healthier environments with the aim of tackling obesity, specifically for children, and possible interventions to meet this need.

8.4 Analysis by both councils has demonstrated that some groups are disproportionately affected by obesity and the health problems which are associated with being overweight. More people are obese in more deprived areas, and children from Black African, Caribbean and “White Other” backgrounds are more affected than those of White British backgrounds.

8.5 The proposals outlined in this paper aim not only to reduce overall levels of obesity and overweight in the borough, but also to close these health inequalities, by focusing action in schools and other educational settings and in more deprived areas, and by building the public-facing Sugar Smart campaign in collaboration with a range of partners, including small voluntary and community organisations.

8.6 In addition, consultation undertaken to date (see “The demand for action” in Section 2 above) via the Great Weight Debate demonstrates that residents in the two boroughs are keen to see action taken to improve the local food environment as a way to tackle obesity.

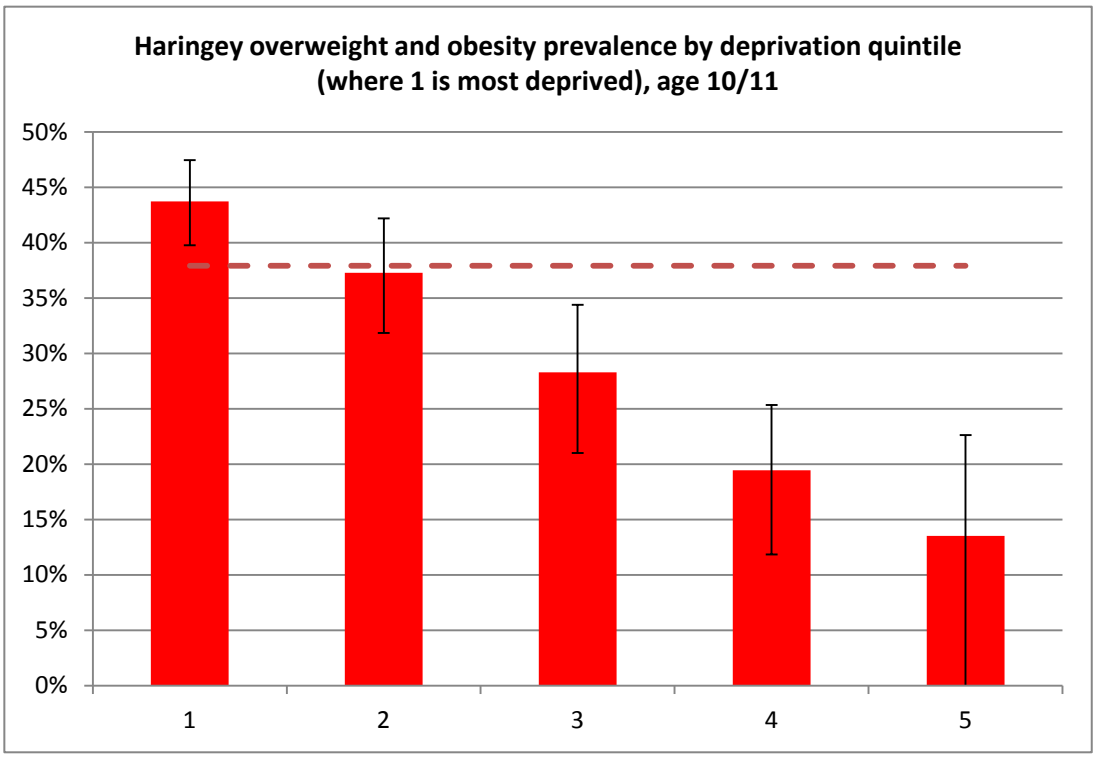
9. Use of Appendices

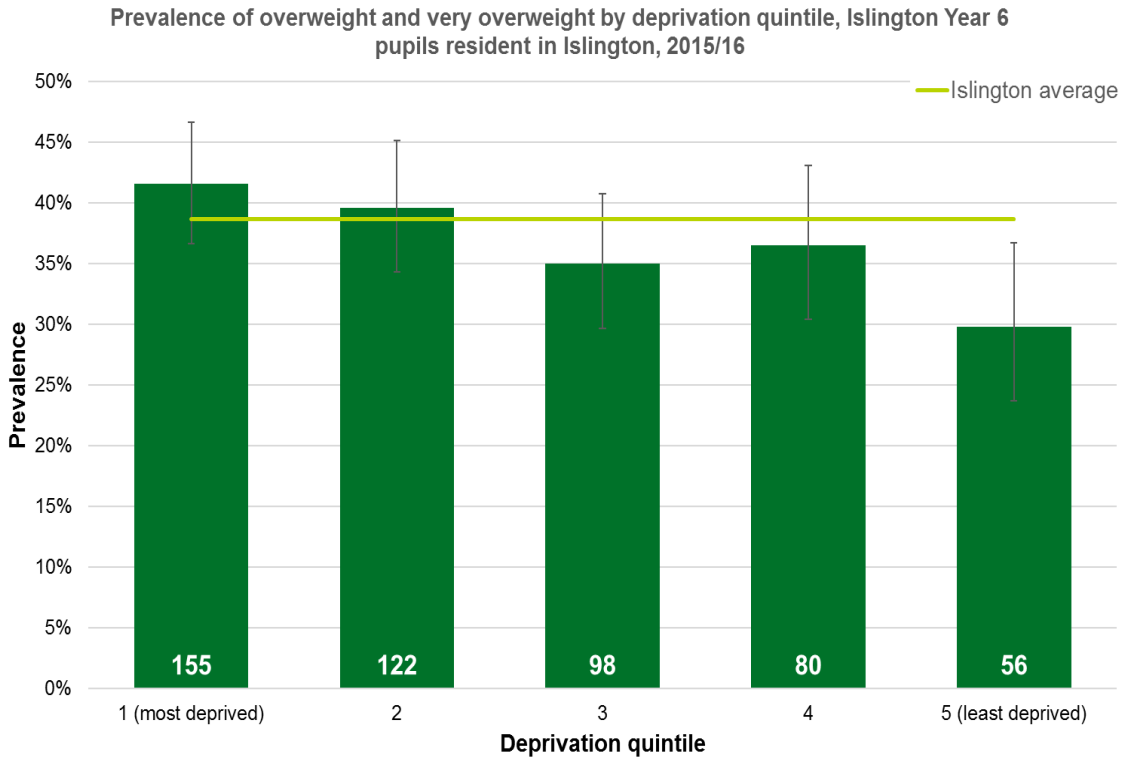
9.1 Appendix One: Haringey and Islington Childhood Obesity by deprivation quintile

Appendix two: Haringey and Islington National Child Measurement Programme 2015/16 Year 6 by ward

Appendix three: Detailed information about proposed pledges

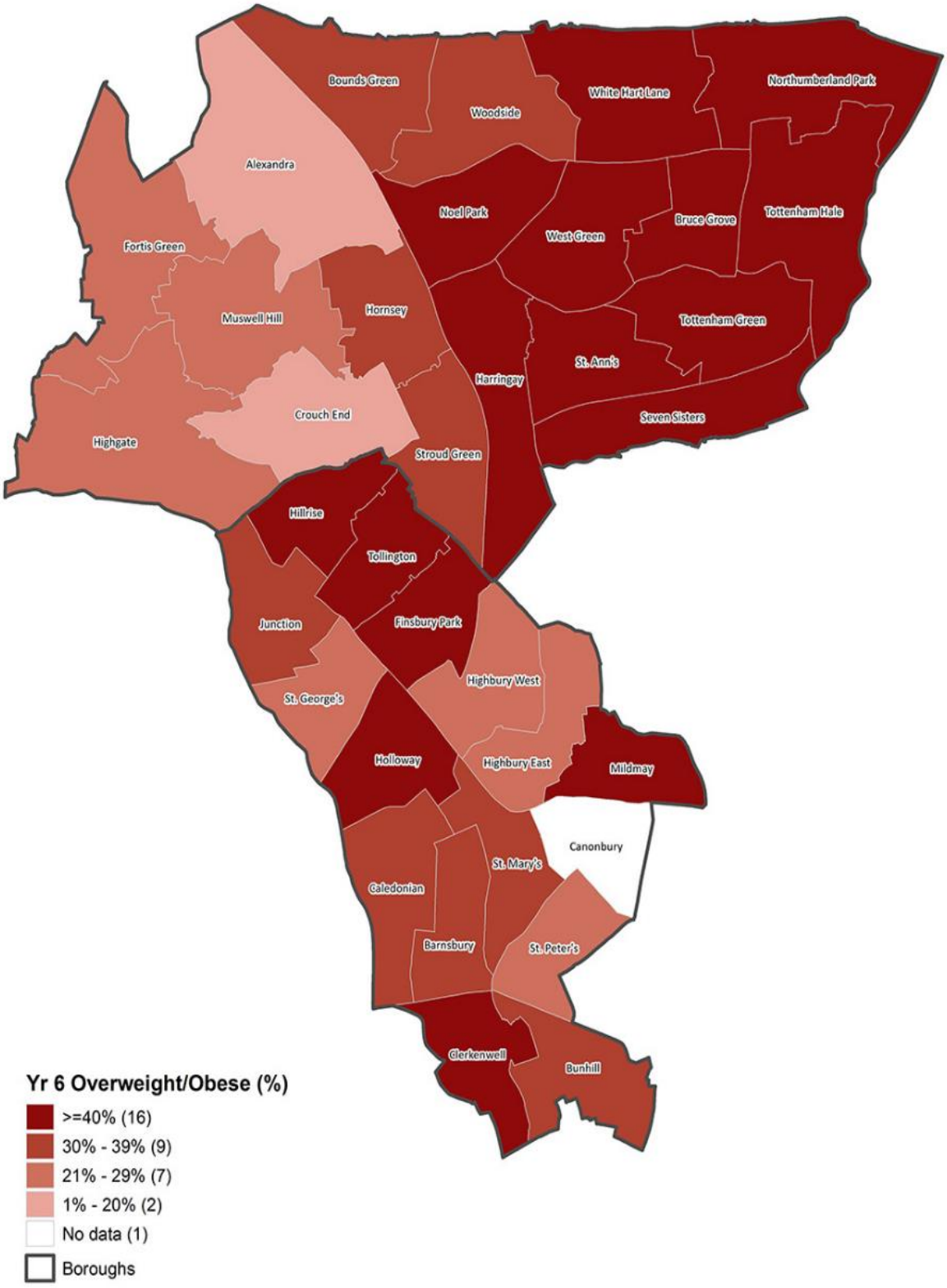
Appendix 1: Haringey and Islington Childhood Obesity by deprivation quintile





Note: Overweight and very overweight pupils with unknown deprivation quintile were excluded (N=108, 17%).
Source: NCMP 2015/16

Appendix 2: Haringey and Islington National Child Measurement Programme 2015/16 Year 6 by ward.


Bounds Green
Woodside
White Hart Lane
Northumberland Park
Alexandra
Noel Park
West Green
Bruce Grove
Tottenham Hale
Fortis Green
Muswell Hill
Hornsey
Tottenham Green
St. Ann's
Harringay
Crouch End
Seven Sisters
Highgate
Stroud Green
Hillrise
Tollington
Junction
Finsbury Park
Highbury West
St. George's
Holloway
Highbury East
Mildmay
Canonbury
St. Mary's
Caledonian
Barnsbury
St. Peter's
Clerkenwell
Bunhill
Yr 6 Overweight/Obese (%)
>=40% (16)
30% - 39% (9)
21% - 29% (7)
1% - 20% (2)
No data (1)
Boroughs

Appendix 3 - detailed information about proposed pledges

Pledge area 1 – Tackle advertising and sponsorship

<table>
<tr><th colspan="2">Pledge title: Develop a policy on advertising, sponsorship and corporate partnerships</th></tr>
<tr><td>Pledge description

Develop a coherent policy on future corporate advertising, sponsorship and commercial partnerships that welcomes opportunities for investment in the borough, whilst avoiding those that promote unhealthy foods and drinks and undermine breastfeeding.</td><td>Opportunities

Any advertising, sponsorship or commercial partnership opportunities are within the control of the council.</td></tr>
<tr><td colspan="2">What has been done elsewhere

A number of councils have implemented policies which include restrictions on such relationships with firms selling fast food, sugar sweetened beverages or other unhealthy offerings:
- Hackney Council will not accept sponsorship for children’s events by soft drinks companies
- Lambeth Council is now restricting the advertising of unhealthy food and drink in locations it can control, and has included clauses on unhealthy food and drink within its existing corporate partnerships and sponsorships policy
- Derby City Council[7] will not accept advertisements which conflict with the Council’s wider promotion of healthy and active lifestyles</td></tr>
<tr><td>What is already being done locally

Haringey:
- LB Haringey already prevents advertising on our internet and intranet sites for fast food which is considered unhealthy</td><td>

Islington:
- There is parks and green spaces adverting and sponsorship policy and a separate Corporate policy which are both in draft format</td></tr>
</table>

[7] http://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/business/DerbyCityCouncil-Final-Advertising-Policy-April-2014.pdf

Pledge area 2 – Improve the food controlled or influenced by the council

Pledge title: Develop a food standards policy

Pledge description

To develop a Food Standards Policy to promote healthier food choices. Bringing together all strands of work that influence the food offer across council-owned and managed premises that makes healthy choices easier and more affordable.

The policy is likely to affect:

- Parks cafes
- Leisure centre food outlets
- Commissioned services which include on-site food provision e.g. One You (Haringey)
- On-site food provision e.g. staff café

We will also share the policy with partner organisations including schools and colleges, and encourage others to adopt it, or similar measures.

Opportunities

Adherence to the Food Standards Policy will be a requirement for new contracts and leases for Council-owned or managed premises.

The policy will also be a lever for influencing existing tenants / providers where no contract review is imminent.

Additional related levers include:

1. Local Statement of Licensing Policy
2. Licensing Act 2003
3. Local Street Trading Guidance
4. Local Outdoor Events Policy and Events Management Plan (for those seeking to hire parks and green spaces)
5. Local Food Strategies and Policy
6. Government Buying Standards for Food and Catering Services Checklist (GBSF)

What has been done elsewhere

- Lambeth has committed to using its next leisure contract review to promote the availability of healthier options and limit unhealthy foods within Lambeth leisure centres
- Greenwich has opened a new food market where all vendors have signed up to the Healthier Catering Commitment[8]

What is already being done locally

Haringey:

- Haringey has a Sustainable Food Strategy outlining our commitment to a range of actions relating to food including increasing awareness of healthy food options and ensuring the public sector leads by example.
- Haringey is already influencing local providers, including tenants of council owned premises, through the Healthier Catering Commitment (see more detail under Pledge area 4)

Islington:

- GLL has introduced healthier vending machines, but still have sponsored machines on some sites.
- Procurement contract for GLL included healthy options where catering on site.
- All Islington schools are working towards nutritional guidelines (Opted out schools are monitored by EH on inspection and LBI work with school to improve their offer)
- All new food concessions in parks will have this written into new contracts when up for renewal- HCC and food safety.
- Commissioned youth services, Platform & LIFT have HCC.

[8] http://www.royalgreenwich.gov.uk/press/article/811/bellissimo_beresford_square

Pledge area 2 (cont.)

Pledge title: Reduce the sale of sugar sweetened soft drinks on council-owned and managed premises	
Pledge description Reduce the sale of sugar sweetened soft drinks on premises owned or managed by the Council with a view to being sugar-free in the future. As with the Food Standards Policy, this is likely to affect: - Parks cafes - Leisure centre food outlets - Commissioned services which include on-site food provision e.g. One You (Haringey) - On-site food provision e.g. staff café	**Opportunities** Additional requirements not to sell sugar sweetened soft drinks could be included in the Food Standards Policy, and therefore attached to all new leases and contracts for food provision on Council-owned or managed premises.
What is already being done locally No action has currently been taken in this area.	**What has been done elsewhere** In April 2017 NHS England announced that sugar sweetened soft drinks would be banned from hospital shops in 2018 unless retailers take significant action to reduce their sales during 2017/18. A number of NHS Trusts have voluntarily introduced such a ban, including University Hospitals of Morecambe Bay NHS FT and Walton Centre NHS FT.

Pledge area 3 – Reduce the prominence of sugary drinks and promote free drinking water

Pledge title: Improve and promote access to free drinking water	
Pledge description To use our existing relationships with food providers across the borough to promote the availability of free drinking water as an alternative to sugar sweetened soft drinks, and work towards introducing refill points for free drinking water, available in parks, children's centres, schools, colleges, businesses and other community settings.	**Opportunities** Engagement with local food providers and parks cafes will be via our existing work on the Healthier Catering Commitment and (in parks) our relationship as landlord.
What is already being done locally The snapshot food audit has identified priority areas to improve access to free drinking water. Both Councils already committed to promoting the availability of free drinking water through the Healthier Catering Commitment. The HCC already includes one voluntary criterion – that drinking / tap water is always available. It is currently voluntary as it is not applicable to many take-away venues, who would find it hard to gain HCC accreditation if it was an essential requirement. However, EHOs promoting the HCC can more actively promote this requirement to any food outlets for whom it is appropriate. In Islington, there are water fountains in all schools, leisure centres and children's centres.	**What has been done elsewhere** Other London boroughs are already promoting the availability of free drinking water through the Healthier Catering Commitment Bristol have a scheme called Refill Bristol that has 200 Refill stations to fill up your water bottle for free. Participating cafes, bars, restaurants, banks, galleries, museums and other businesses display a sticker in their window, inviting passers-by to fill up their bottle.

Pledge area 4 – Support businesses and organisations to improve their food offer

<table>
<tr><td colspan="2">Pledge title: Continue to promote the Healthier Catering Commitment and London Healthy Workplace charter to achieve health benefits</td></tr>
<tr><td>Pledge description

Continue to promote the Healthier Catering Commitment and London Healthy Workplace Charter, and consider building accreditations into contracts as they come up for re-tender.
Focus energies on providers with high footfall
Increase focus on food elements of London Healthy Workplace Charter
Harness this work through the London Healthy Workplace charter and Healthy Children’s Centre Programme e.g. support settings to develop healthy food policies and improve on healthy food promotions etc.
Explore targets for increasing reach of HCC to businesses with the greatest impact, with a focus on the East of the borough and parks in Haringey, and on workplace catering (especially for sedentary occupations), catering for people with health conditions and parks and leisure facilities in Islington</td><td>Opportunities

The Healthier Catering Commitment is a voluntary scheme, which provides recognition to businesses which demonstrate their commitment to healthier options; this can be used by the businesses to promote their services to customers and to enhance their reputation.

The London Healthy Workplace Charter is another voluntary scheme which can be used to influence the food provided by organisations to their staff e.g. on-site catering</td></tr>
<tr><td colspan="2">What has been done elsewhere

The Healthier Catering Commitment has been developed by London Environmental Health teams, and is being implemented in many boroughs across London.
Over 160 organisations across London have signed up to the London Healthy Workplace Charter</td></tr>
<tr><td>What is already being done locally

Islington:
280 businesses are signed up to HCC
HCC promote voluntary sugar tax via the Children’s Health Fund
Supplementary Planning Guidance in place (SPD) for fast food takeaways, book-makers and pay-day loan shops
Breast Feeding Friendly in place as part of UNICEF baby Friendly (Stage 3)
Promote voluntary schemes to local businesses such as Healthy Catering Commitment; Workplace charter and Healthy Start
Youth Services, Children’s Centres and other settings with food offer have healthy</td><td>

Haringey:
140 businesses are signed up to HCC
HCC promote voluntary sugar tax via the Children’s Health Fund
Attempts to introduce new Planning Guidance unsuccessful
Currently working towards UNICEF Baby Friendly (Stage 2)
Promote voluntary schemes to local businesses such as Healthy Catering Commitment; Workplace charter and Healthy Start</td></tr>
</table>

food offer	

Pledge title: Support the Whittington to improve their healthy food offer across catering, retail and vending points	
Pledge description Assisting The Whittington Hospital with their retailing re-tender, to influence the food offer and introduce the sugar levy e.g. PH officers will sit on the tender evaluation panel.	**Opportunities** NHS Hospital Trusts have a CQUIN to levy a fee for any vendor of sugar-sweetened beverages (SSB) on NHS premises by August 2018. A 20% tax on all sugary drinks and foods in NHS cafes will be introduced by 2020. Whittington Hospital food court re-tender process will be used to ensure future catering contracts embed commitment to sugar reduction and increase the number the food on
What is already being done locally The Whittington is already engaging with on-site food and drink providers to try to improve their offer, supported by existing CQUINs focused on the positioning of unhealthy foods and meal deal promotions. Their main provider is currently signed up to HCC.	**What has been done elsewhere** A number of hospitals in London, including the Royal Free NHS FT, have been undertaking this work for some years, demonstrating that retailers can remain profitable, and even increase sales, while reducing or eliminating unhealthy options.

Pledge area 5 – Public Events

Pledge title: Work to increase the healthy food offer at Council-organised events	
Pledge description Use a variety of levers to increase the healthy food offer at Council-organised events.	**Opportunities** Applies to events organised by the Councils, therefore within our control.
What is already being done locally **Islington:** Green Space specifications: - 1. Events run by Council (50% healthy offer) 2. Non-Council run events in green spaces (need food rating of 3 or higher and will have "healthy food offerings" included in next year's specification for event organisers.) **Haringey:** Requirements for the hire of parks for events already include some reference to food provision (but these relate more to health and safety than to healthy catering)	**What has been done elsewhere** Hackney employed a two-staged approach, first influencing the specification for the procurement of catering contracts and secondly influencing catering contractors after they had been appointed using their 'making healthier choices easier' food standards toolkit. Public Health England set minimum catering standards requirements for events (buffet and snacks) and developed a guide which aims to help events caterers provide buffet lunch menus that support healthier eating. Healthier and more sustainable catering toolkit - catering guidance that offers practical advice on how to make catering affordable, healthier and more sustainable.

Pledge area 6 – Raise public awareness

<table>
<tr><td colspan="2">Pledge title: Sign up to the Sugar Smart campaign</td></tr>
<tr><td>Pledge description

Sign up to the Sugar Smart and use campaign as a vehicle to engage our community and businesses to take their own action on sugar reduction.</td><td>Opportunities

As local organisations with many direct influences on local health and wellbeing, local authorities are well placed to provide local leadership on sugar reduction and the creation of a healthier food environment. This leadership is demonstrated by pledge areas 1-5; the Sugar Smart campaign invites other organisations to commit to making their own contributions.</td></tr>
<tr><td colspan="2">What has been done elsewhere

- Brighton & Hove City Council worked in partnership with Jamie Oliver Food Foundation and Sustain to reduce the availability of sugar in a wide range of settings including schools, local retailers, Brighton University and Sussex County Cricket Club
- Within London, Lewisham, Greenwich, Kensington & Chelsea and Bexley have all signed up to the Sugar Smart campaign</td></tr>
<tr><td>What is already being done locally

Haringey:
- HOA whole systems approach
- Promotion of healthier alternatives through HOA microsite, HOA monthly newsletter and various Corporate Communications channels
- Local food audit to establish baseline and areas of focus
- Healthier Catering Commitment (rolled out in 5 wards in the east of Haringey)
- One You Haringey (integrated wellness service)
- UNICEF Baby Friendly (Stage 2)
- GLA Healthy Workplace Charter</td><td>

Islington:
- GLA Healthy Workplace Charter
- Council Communications team promoting healthy options
- One You Website
- Local food audit to establish baseline and areas of focus
- UNICEF Baby Friendly (Stage 3)
- Supporting Voluntary Community Food Partnerships i.e. St. Luke’s
- Partially fund Global Generation Food Growing
- Islington Food Strategy is being refreshed</td></tr>
</table>

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Update on tackling obesity in Islington and Haringey

Julie Billett, Director of Public Health – Islington Council

12th June 2017

Haringey LONDON ISLINGTON

Proposed recommendations to the board

1. The two Councils sign up to the Local Government Declaration (LGD) on Sugar Reduction and Healthier Food at the next Joint Health and Wellbeing Board meeting in September.
2. That the Joint Health and Wellbeing Board consider and discuss the potential pledges and actions to be taken forward as part of signing up to the Declaration, in order to steer and inform this further work.
3. That all member organisations of the Health and Wellbeing Board sign up to the Sugar Smart Campaign and make an ambitious pledge relating to sugar reduction, in order to evidence visible and committed leadership on this agenda.

LGD - Recommended action to take forward

	Area	Pledge
1.	Tackle advertising and sponsorship	Develop a policy on corporate partnerships or sponsorships.
2.	Improve the food controlled or influenced by the Council	Develop, produce and implement a food standards policy to promote healthier food choices
3.	Reduce the prominence of sugary drinks and promote free drinking water	Influence local businesses and food outlets to provide free, accessible drinking water.
4.	Support businesses and organisations to improve their food offer	Promote and deliver voluntary schemes to local businesses such as the Healthier Catering Commitment to our corporate partners.
5.	Public events	Requiring caterers to implement the Healthier Catering commitment
6.	Raise public awareness	Sign up to the Sugar Smart Campaign

Haringey LONDON ISLINGTON

LGD – bold action

Bold recommendations which will position the H&I partnership at the leading edge of the fight against obesity

	Area	Pledge
1.	Improve the food controlled or influenced by the Council	• Prevent any business operating on Council owned premises from selling sugar sweetened soft drinks • Introduction of a local sugar tax/levy
2.	Support businesses and organisations to improve their food offer	• Rent relief / business rates relief for healthier retailers. • Prevent ice cream vans from parking outside schools and / or playgrounds.
3.	Public events	• Provide incentives to food providers at events organised by the Council to replace unhealthy with healthier options or similar.

Discussion

1. Which of the bold pledges should we take forward?
2. What might be some of the barriers to these, and how could they be resolved?
3. Can your organisation sign up to the Sugar Smart Campaign and make a bold pledge?
4. How do we ensure that, when working with organisations outside the HWB partnership, pledges are ambitious and meaningful?

Haringey LONDON ISLINGTON

Potential Sugar Smart pledges for board members

- Not selling sugar sweetened soft drinks
- Increasing the price of sugar sweetened soft drinks, with the proceeds donated towards children's health and wellbeing
- Removing all adverts for products high in sugar, salt and fat (including branded fridges, sun shades, shop signage etc)
- Ending meal deals / special offers which include sugar sweetened soft drinks
- Replacing vending machine contents with healthier alternatives
- Promoting healthier options and include them in price promotions
- Installing water fountains and / or making drinking water free, accessible and visible
- Removing food high in salt, sugar and fat from the area around the checkout
- Signing up to the Healthier Catering Commitment

Report for: Joint Health and Wellbeing Sub Committee

Date: 9 October 2017

Title: Update on the North Central London Sustainability and Transformation Plan

Report authorised by : Tony Hoolaghan, Chief Operating Officer, Haringey CCG and Islington CCG

Lead Officer: Tony Hoolaghan, Chief Operating Officer, Haringey CCG and Islington CCG

1. Describe the issue under consideration

This paper presents an update on the North Central London (NCL) Sustainability and Transformation Plan (STP)

2. Recommendations

2.1 The Haringey and Islington Health and Wellbeing Board Joint Sub Committee is asked to note the report.

3. Background information

3.1 North London NHS organisations are working together with the five councils of Barnet, Camden, Enfield, Haringey and Islington to form a health and social care partnership. We have developed a plan to improve the health and wellbeing of local people by making our local health and social care services more sustainable for the future. We have called this joint initiative 'North London partners in health and care'. This report provides an update on progress to date.

4. Contribution to strategic outcomes

4.1 Contributes towards achievement of financial balance and ambitions set out within both Haringey and Islington Health and Wellbeing Strategies

5. Statutory Officers comments

5.1 **Legal and Finance**
This development complies with Section 195 of the Health and Social Care Act 2012 (duty to encourage integrated working), which provides that, a Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

8.0 Environmental Implications

There are no significant environmental impacts related to the development of the STP for North central London. However, improved integration and joint working can help reduce duplication, which in turn can have a positive impact on the environment.

9.0 Resident and Equalities Implications

The Council must, in the exercise of its functions, have due regard to the need eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantage, take steps to meet needs, in particular steps to take account of disabled persons disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding. No specific resident impact assessment is required in regard to this report.

6. Use of Appendices

Appendix 1 – Slide deck with NCL STP update

NORTH LONDON PARTNERS in health and care

North Central London STP Update

Tony Hoolaghan
Chief Operating Officer
Haringey CCG and Islington CCG

NORTH LONDON PARTNERS in health and care

Milestones

- Case for change published in September 2016
- Draft STP published in November 2016 – described as ‘work in progress’ and comments sought
- Updated versions published in February 2017 and April 2017 in light of comments received and further work on detailed implementation plans
- Final version published in July 2017. Plan includes:
  - Vision to create a better health & care system
  - Priorities for 2017/18
  - Plans to improve quality of care, efficiency and productivity
  - An assessment of the financial gap in 2017/18 and beyond
- Public summary published in August 2017

Our vision is…

- *for North London to be a place where our people experience the best possible health and wellbeing. North London is a place where no-one is left behind.*

- The STP is a significant demonstration of joined up working between NHS commissioners, providers and local authorities across Barnet, Camden, Enfield, Haringey and Islington

Good progress

- Development of the plan, across a partnership of statutory organisations within limited timeframes and regular updates to ensure currency, and a more resident-friendly public summary document
- Co-ordination of commissioner leadership of workstream initiatives
- Establishment of Health and Care Cabinet ensuring social care has parity of esteem in the clinical decision-making process
- Mobilisation of Planned Care Programme Steering Group and formation of Delivery Groups i.e. MSK, Dermatology etc.
- Agreeing contracting round for 17/18 by the deadline
- Increasing levels of engagement with broader stakeholders
- Successfully transitioning from planning to implementation in most workstreams
- A sense of shared leadership across provider and commissioner

More good things

- Smooth transition to new CCG leadership structure, and establishment of Joint Commissioning Committee
- The development of the Adult Social Care programme creating a more effective working relationship with local authorities, more inclusive approach and joint working between health and social care
- Open, transparent and functional engagement with JHOSC, HOSC, HWBBs and local and regional media
- Increasing professionalisation of the STP PMO, refined reporting structures, the procurement, setup and roll-out of a document management system and reduced dependence on consultancy support
- Launch of website as a public portal for information and feedback on the programme, regular use of Twitter to share and direct audiences to website and partners for additional information: @nclstp www.northlondonpartners.org.uk

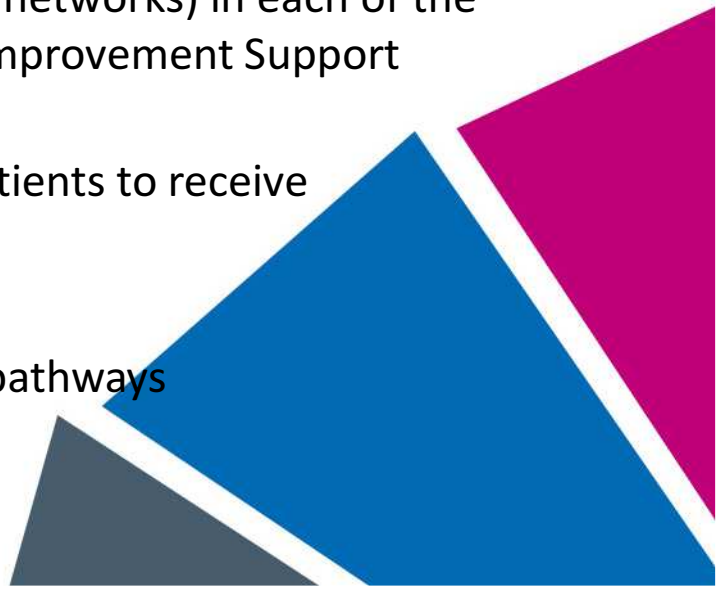
Challenges

- Money (plus Capped Expenditure Process)
- Capacity
- Extent/depth of commitment to NCL working
- Deliverability of plans
- Single version of the truth: reporting/planning
- Need to focus on prevention, primary care and community resilience
- Pressures of the day job/regulators

NORTH LONDON PARTNERS in health and care

Priorities in 2017/18 include:

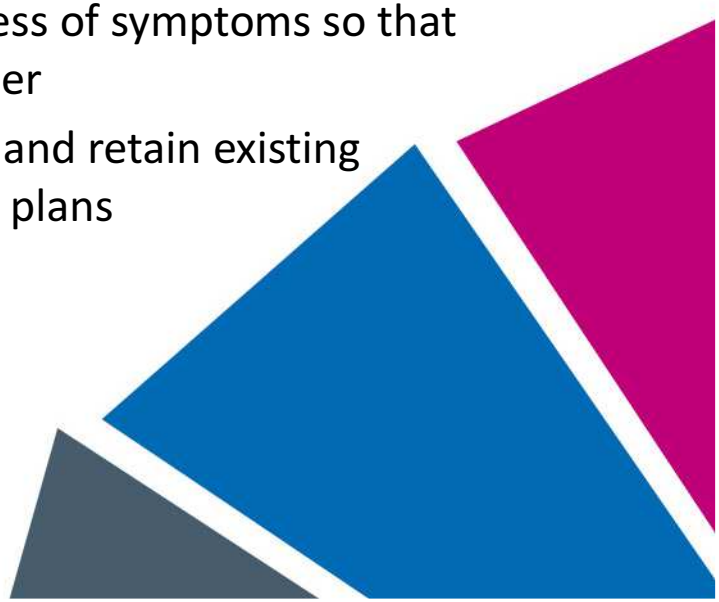
- Action to reduce obesity, smoking and alcohol misuse, increase our work in falls prevention and increase uptake of our sexual health services
- Offer improved access to Primary Care across the whole of North London: Patients will be able to access consultations with GPs or other primary care professionals in their local area between 8am and 8pm, seven days a week
- Implement the first wave of CHINs (neighbourhood networks) in each of the boroughs and invest in the corresponding Quality Improvement Support Teams.
- Join up all community-based services to support patients to receive more care at home and avoid admission to hospital
- Implement simplified discharge for patients
- Work with local clinicians and patients to redesign pathways in key areas such as dermatology, orthopaedics, neurology, urology and ophthalmology



NORTH LONDON PARTNERS in health and care

Priorities in 2017/18 include:

- Design a single point of access to assist GPs with referral advice and navigation
- Roll out primary care mental health services in Islington
- Establish a dedicated psychological therapies service within Haringey and Islington
- Improve cancer survival rates by increasing awareness of symptoms so that patients can receive a diagnosis and treatment earlier
- Work to reduce staff turnover across North London and retain existing skills to support delivery our service transformation plans
- Improve our use of technology and estates



Adult social care

Team funded by the 5 Councils to explore 4 areas for collaboration in greater depth, working with NHS colleagues within existing STP structures:

- **Streamlining health and social care processes** – focusing on the social care role in admission avoidance and hospital discharge and developing common principles and/or approach for both across North London
- **Market management** – developing the residential, nursing and home care markets to have sufficient, high quality care at an affordable price
- **Workforce** – addressing recruitment and retention issues in directly employed workforce (e.g. social workers, occupational therapists) and commissioned services (e.g. nursing, independent sector care)
- **Learning disabilities** – looking at care models and pathways for people with learning disabilities, including transitions from children's support to adult support, low to high needs and the 'transforming care' cohort

Adult social care team

Project	Lead
1. Admission avoidance and hospital discharge	Dale Phillipson dale.phillipson@camden.gov.uk
1. Market management	Sam Jacobson sam.jacobson@haringey.gov.uk
3a) Workforce – Directly employed	Dale Phillipson dale.phillipson@camden.gov.uk
3b) Workforce – Independent Care Sector	Anne Marie Gray anne-marie.gray@camden.gov.uk
1. Learning Disabilities	Anne-Marie Gray anne-marie.gray@camden.gov.uk
Business Analyst – Tony Ellis (tony.ellis@camden.gov.uk)	

NORTH LONDON PARTNERS in health and care

Workstream SROs and Clinical Leads

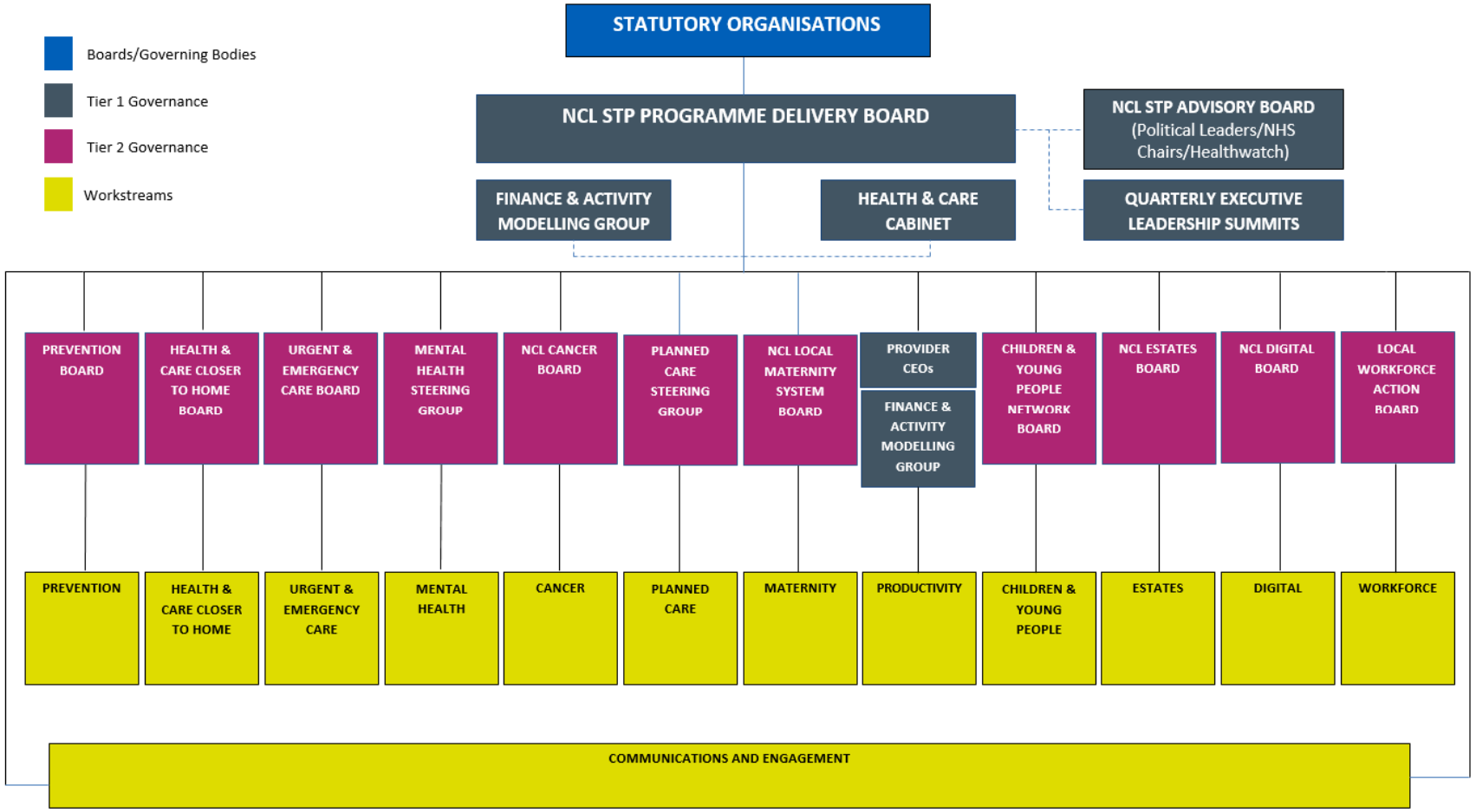
STP Workstream	SRO(s)	Clinical Lead(s)
Prevention	Dr Julie Billett, Director of Public Health, Camden and Islington	Dr Karen Sennett, GP, Islington Dr Tom Aslan, GP, Camden
Health and Care Closer to Home	Tony Hoolaghan, COO Islington and Haringey CCGs	Dr Katie Coleman, GP, Islington
Urgent and Emergency Care	Sarah Mansuralli, COO/Local Executive Director, Camden CCG	Dr Samit Shah
Mental Health	Paul Jenkins, CEO Tavistiock and Portman Foundation Trust	Dr Vincent Kirchner, Medical Director, C&I Dr Jonathan Bindman, Medical Director, BEH Dr Alex Warner, GP, Camden
Cancer	Professor Kathy Pritchard-Jones, Chief Medical Officer Dr Clare Stephens, GP Barnet CCG	Professor Geoff Bellingan, Medical Director, UCLH
Planned Care	Marcel Levi, CEO UCLH NHS Foundation Trust	Dr Richard Jennings, Medical Director, Whittington Health Dr Ahmer Farooqi, GP Barnet
Maternity	Rachel Lissauer, Director of Commissioning, Haringey CCG	Professor Donald Peebles, Clinical Director Mai Buckley, Director of Midwifery
Children and Young People	Charlotte Pomery, Haringey Council	Dr Oliver Anglin, GP, Camden
Estates	Simon Goodwin, NCL CCGs Chief Finance Officer	TBC
Digital	David Sloman, CEO Royal Free London NHS FT	Dr Katie Coleman, GP/Primary Care Lead Professor Stephen Powis, Group Medical Director, RFH Dr Cathy Kelly, Chief Clinical Information Officer, UCLH
Workforce	Maria Kane, CEO BEH Mental Health NHS Trust (Simon Pleydell covering until September)	Dr Jo Sauvage, GP, Islington
Communications and Engagement	Paul Jenkins, CEO Tavistock and Portman NHS Foundation Trust	TBC

NCL CCGs' SMT

Role	Name
Accountable officer, NCL CCGs and STP convenor	Helen Pettersen
CFO, NCL CCGs	Simon Goodwin
Director, Acute and Performance, NCL	Paul Sinden
Director of Strategy, NCL CCGs	Will Huxter
COO, Haringey & Islington CCGs	Tony Hoolaghan
COO, Barnet CCG	Kay Matthews
COO, Camden CCG	Sarah Mansuralli
COO, Enfield CCG	John Wardell (start date TBC)
POD Director, NELCSU	Eileen Fiori
Director of HR and OD	Michelle Chadwick

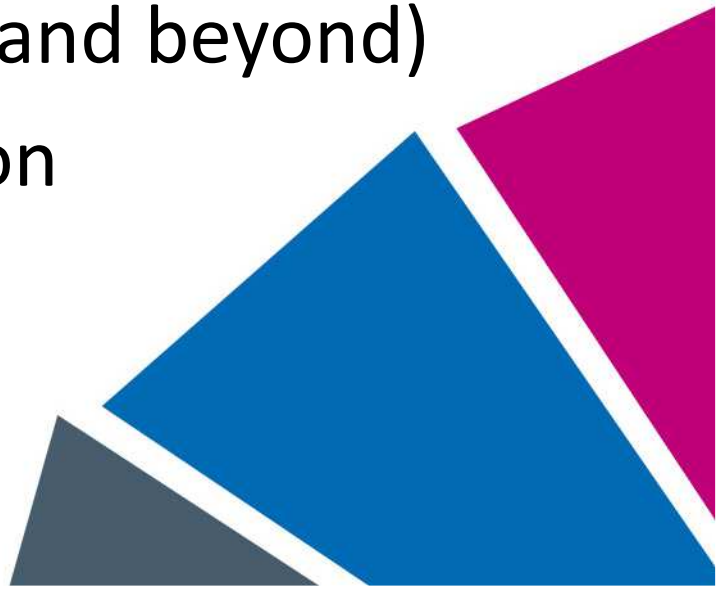
NORTH LONDON PARTNERS in health and care

STP Overarching Governance



More to do

- Public and patient engagement
- Mainstreaming the STP as core to all partners
- Communication and shared understanding
- Who's who
- Delivery not planning (18/19 and beyond)
- Transformation not transaction
- Prioritisation
- Fewer meetings



Report for: Joint Health and Wellbeing Board Sub Committee

Date: 9 October 2017

Title: Update on the Wellbeing Partnership

Report authorised by: Sean McLaughlin, Chair of the Wellbeing Partnership

Lead Officer: Rachel Lissauer, Director of the Wellbeing Partnership

1. Purpose

1.1 The Wellbeing Partnership has been established to support and drive improvement in health and wellbeing for our populations. The Partnership arose from our shared desire to focus on improving outcomes and a recognition of the inter-dependency between the organisations providing and commissioning health and care. The Wellbeing Partnership provides an infrastructure to make strategic decisions across organisations; to better support integration of care on the ground and to take a collective approach towards our all-important workforce, estates and IT infrastructure. It seeks to take opportunities to scale up good practice and reduce duplication between our organisations and boroughs. By working together, we want to develop incentives that promote improvement in outcomes and to target financial resources within our health and care economy where they will maximise health improvement and ensure future sustainability of health and care.

1.2 This paper provides an update for the Joint Health and Wellbeing Board on progress with the Wellbeing Partnership since the last meeting.

1.3 Key messages for the Board are that:

- The Wellbeing Partnership is making good progress and is recognised as an early adopter within the NCL STP. We are developing in line with national ambitions and policy in relation to accountable care partnerships / systems.
- Local leadership is key to our ability to continue to work at pace on developing our accountable care system.
- Organisations are, through the Sponsor Board, starting to share information about investment and spending decisions such as the Better Care Fund and primary care investment.
- We have started to work through the implications of using the partnership to drive service improvement where we might otherwise have relied on a competitive procurement process to achieve service change.
- The governance structure has been re-shaped in order to use the Wellbeing governance to streamline decision-making.
- Work-streams are progressing and are having a demonstrable and positive impact on care. Examples are set out in the paper.

- A substantive Director has been appointed to lead the Wellbeing Partnership and is recruiting a programme team. Sean McLaughlin has taken on the role of Chair of the Wellbeing Sponsor Board.

1.4 The next phase of work will involve:

- Participating within a network of developing Accountable Care Systems either at London or North Central London level to benefit from the learning from Vanguards and other sites.
- Recruitment to the Wellbeing Partnership team to build our delivery capacity
- Establishing how best the Wellbeing Partnership can best support Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams (QISTs).
- Development of an engagement strategy
- Increased focus on workforce and estates as enablers of system change with more dedicated project support

2. Issue under consideration

2.1 This update is an opportunity for the Joint Sub-Committee to review progress that has been made against the ambitions set out within the Partnership Agreement and to influence the pace and direction of the next phase of work.

3. Recommendation

3.1 The Joint Sub-Committee is asked to NOTE the developments set out within the paper.

4. Background

4.1 In June the committee noted that a Partnership Agreement had been approved at Board level by Islington Council and CCG; Haringey Council and CCG; Whittington Health; UCLH and the Islington and Haringey GP Federations (as organisations and not on behalf of individual member practices). It is important to note that organisations that have not signed the Partnership Agreement have continued to participate in the Wellbeing Partnership at both operational and executive level.

4.2 In June the Sponsor Board met for an informal away-day. This session was a stock-take, in light of the Partnership Agreement and the strategic direction presented by the STP. Leaders at the meeting committed to an increased delivery-focus from the Wellbeing Partnership and on the need for engagement with staff. The group reflected on the need for strong clinical and professional input into the programme of work. It agreed that primary care; community services and intermediate care (step down / step up from hospital) were core areas for joint work and that the emergent Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams

(QISTs) should be overseen and steered through the Wellbeing Partnership to ensure a genuinely system-led approach.

4.3 One of the key themes was the need to clearly articulate what benefits for our population are being achieved through our work as a system or partnership.

4.4 The Wellbeing Partnership is not a separate entity but is the enabling structure that we are putting in place to allow us to make progress more quickly and with greatest impact on outcomes and sustainability. The section below highlights examples of work that has been led from within the Wellbeing Partnership because of its importance for managing 'rising risk' and supporting improved health outcomes and sustainability of health and care services. This work is being delivered by clinicians and managers as part of their 'day job' but would previously have been carried out on a single borough footprint and not necessarily with the same level of collaboration between commissioners and providers. In all cases, joint working has facilitated spread and a consistency of approach.

5.1 Case studies of impact of working together within the Wellbeing Partnership

5.2 Intermediate Care

Intermediate care is about providing residents with effective short-term rehabilitation and re-ablement to maintain independence, prevent hospital and care home admission and support hospital discharge. Haringey and Islington have committed to work together on simplifying the discharge process, ensuring that people waiting to leave hospital have assessments in their own home environment wherever possible rather than waiting in hospital for assessments of care needs to be undertaken. We had also agreed to align our rapid response admission avoidance services and, in the long term, to jointly plan how our intermediate care beds are used.

5.3 Since the last update to the Joint Sub-Committee we have continued running this improved discharge process (or 'discharge to assess') for Haringey patients from NMH. This has released approximately 358 bed days over 35 weeks and streamlined the discharge process for 127 people. Commissioners and providers have now initiated improved hospital discharge pathways (discharge to assess) at the Whittington Hospital for both Haringey and Islington residents and at UCLH for Islington patients. The initial pilot of 10 discharge to assess patients has been completed. This is now being scaled up to become 'business as usual' with the aim of supporting three patients per week by the 25th September (a combined figure across both UCLH and Whittington Health). Islington has secured funding to support discharge to assess for patients with more complex needs. An operational model for this is being developed and recruitment processes are under way with a view to starting implementation in October.

5.4 The Boroughs have carried out an audit of our intermediate care beds, to make sure we have the right mix of intermediate care bed provision and that our beds have the right support to help residents re-gain their independence.

5.5 Cardiovascular disease and diabetes

5.6 In both Haringey and Islington there are significant issues in cardio-vascular disease (CVD) and diabetes care relating to health and wellbeing outcomes, quality of care provision, value for money of care provision and the current model of care delivery. Cardiovascular disease is a leading cause of death in both Haringey and Islington. For example, Islington is 118th worst and Haringey 147th worst out of 147 areas for premature mortality from stroke. Mortality from cardiovascular disease is closely linked to deprivation. We have large numbers of people (over 50,000) in our boroughs with undiagnosed hypertension and that primary care management of diabetes and CVD is highly variable and often below the London average. This is therefore a key area for us to focus on for long term health improvement and stabilising demand for health and social care in the long term.

5.7 In June we reported that the public health teams had successfully bid for funding from a British Heart Foundation Grant to carry out 5,000 blood pressure checks. Over 70 staff and volunteers from a range of voluntary organisations have now received training on performing blood pressure checks and the first blood pressure checks will be being carried out by early October.

5.8 For diabetes, both Haringey and Islington are developing plans to improve achievement of the 3 key treatment areas (blood pressure, blood sugar control and cholesterol) across our populations, which will reduce the risk of complications like stroke, kidney disease and blindness. Both Boroughs have received transformation funding to support the delivery of these treatment targets. This year Haringey will, for the first time, be supporting GPs to implement a locally commissioned service for improving the management of diabetes and cardiovascular disease.

9. Musculoskeletal care

9.1 Musculosketal (MSK) conditions include over 200 different conditions affecting joints, bones, muscles and soft tissues. MSK covers individual services like orthopaedics, rheumatology, chronic pain and physiotherapy. As well as back and neck pain, MSK services also deal with shoulder, elbow, wrist, knee, ankle and foot problems**.** MSK disorders account for the largest proportion of years lived with disability.

9.2 At the moment many patients – who might actually receive care more appropriately from physiotherapists – are being referred to pain management clinics; orthopaedic specialists and rheumatologists. But waiting times for

physiotherapy are very high and the referral routes at the moment are very complex, creating confusion and waste for both staff and patients. A new clinical pathway has been developed with high levels of clinical engagement. This will involve a ‘single point of accesses to an enhanced physiotherapy triage service.

9.3 The joint commissioner and provider programme team is now working up an operational plan to establish a pilot of clinical triage of MSK referrals. In order to scope and resource full scale implementation, we are also carrying out audits of current referrals to assess feasibility of the plan for enhanced triage and to establish the likely scale of shift in activity from secondary care, and capacity required in community physiotherapy / pain services.

9.4 Progress in relation to the aims set out in the Partnership Agreement

9.5 Whilst workstreams are progressing, the Partnership Agreement set out a further set of ambitions for how we wanted to work together as a system. This section sets out the work that is being taken forward in relation to the commitments made in the Partnership Agreement and identifies the areas for focus in our next phase of work.

9.6 Joint Health and Wellbeing Strategy and greater alignment between public health teams

9.7 The Partnership Agreement set out the intention for the public health teams to work collaboratively and to develop a Joint Strategic Needs Assessment (presented to today’s HWB) and single Health and Wellbeing Strategy for the two boroughs.

9.8 Public health leadership teams are working together on thematic areas in common, including diabetes and a BHF bid for stroke.

9.9 In the next phase the teams will be reviewing services and budgets between both boroughs to provide a deeper understanding of the services commissioned and supported by both Public Health teams.

9.10 Joint focus on transformation; bringing together service improvement projects and establishing single management leads for projects wherever possible

9.11 In the formation of the Partnership Agreement it was noted that organisations have separate transformation teams, with potential scope for greater alignment and joint working.

9.12 Joint service improvement work is now being undertaken across Haringey and Islington in a variety of areas. Councils have also identified opportunities for working together at a North Central London level and this joint work will support the aims of the Wellbeing Partnership.

9.13 The Partnership Agreement set out an ambition to let operational leads have authority across different organisations where appropriate. This would mean, for example, a single person having management responsibility for the range of intermediate care services and facilities available so that they can manage the workforce and the budget assigned to various forms of step-up / down care in order to make best use of resources. This is in the early stages of exploration in specific areas where service delivery is likely to benefit from bringing disparate teams together between organisations and under shared management and will be taken forward further in the next phase of work.

9.14 However, we have not yet reached the point of having a joint savings and service development plan for 2018/19 between Councils, CCGs and Trusts. Transformation programmes have not been fully shared between Trusts and commissioning organisations. All organisations are planning improvement and savings programmes for 18/19 and there is therefore an opportunity to give this further focus.

9.15 Joint Performance Measures

9.16 Within the Partnership Agreement a commitment was made to establish a set of performance indicators to help demonstrate increased collaborative working across the Partnership.

9.17 This work has been taken forward and a ‘balanced scorecard’ is being developed. Both Councils have been working on a set of ‘pledges’ or ‘I statements’ that they will use in order to guide and measure their work both at a commissioning and delivery level. This will provide a helpful shared set of indicators to direct and track the impact of our work.

9.18 Joint Budget Management

9.19 The Partnership Agreement set out an ambitious aim of developing a shadow single system control total by September 2017; monthly sharing of budget (and activity data) and to establish system-wide budgets for specific services such as diabetes and MSK to support transformation work.

9.20 We have made progress in bringing investment / dis-investment decisions to the Sponsor Board in order to understand the impact of these changes. There have been, for example, useful conversations about the impact of planned changes in MSK pathways on hospitals and the potential implications arising from investment decisions made by CCGs in CHINs and QISTs.

9.21 Consideration now needs to be given to our level of ambition in terms of financial transparency and shared decision-making. Our service development work is not, in most areas, at the stage where system-wide budgets are required. Between October and December, a piece of work will be undertaken with finance leads to consider the steps we need to take to ensure that we have shared access to service-level budgets on a case-by-case basis where needed and, more strategically, to develop a plan of how want to shape our

financial incentives and practices to support sustainability across the health and care economy.

9.22 Governance

9.23 In order to streamline governance and decision-making between Boroughs, both Haringey and Islington are bringing their integrated care boards together to become a Wellbeing Care Closer to Home group. This will review progress with CHIN / QIST development as well as workstreams and, particularly, services that are jointly commissioned through the Better Care Fund.

9.24 Chairs of the communication and engagement committees, together with management engagement leads, have advised that community engagement should take place on a range of different levels: through engagement at workstream / initiative level; through participation on relevant decision-making committees and through existing forums and engagement networks. An engagement plan is being developed and will be taken to the next Sponsor Board meeting.

10. Contribution to strategic outcomes

10.1 The Wellbeing Partnership contributes towards the strategic outcomes set by both Haringey and Islington's Health and Wellbeing Boards: Ensuring every child has the best start in life; reducing obesity; improving healthy life expectancy; improving mental health and wellbeing and reducing health inequalities. It is expected to contribute towards delivering high quality, efficient services within the resources available.

10.2 Statutory Officers comments

10.3 Legal

Legal

The Wellbeing Partnership Agreement sets out a number of commitments and targets by partners aimed at fostering a collaborative approach in strategic planning and decision making and to improve the health and care economy for residents across Haringey and Islington.

The commitments as they are developed and progressed may require formal partnership agreements between some or all the partners and will need to be managed in accordance with the partner's constitutional and decision making framework.

Overall, the push in the agreement towards more collaborative working is in accordance with health and social care legislations which actively promotes health and social care integrated working and partnership arrangements to improve the health and wellbeing of residents.

The Committee has strategic oversight of the Wellbeing Partnership arrangement.

10.4 Finance

There are no new financial implications from this update report.

We have previously noted that the creation of an Accountable Care Partnership that potentially could involve the budgets for Adults Social Care and Health in LB Haringey, Haringey CCG, LB Islington, Islington CCG and partner healthcare trusts is a major undertaking with both risks and opportunities to organisations. At this stage, we are working to establish the practical steps that would be necessary in order to establish budgets across organisations for particular populations or services and the implications. The Wellbeing Partnership needs to have access to sufficient resources to undertake this work.

10.5 Environmental Implications

10.6 Not applicable at this stage.

10.7 Resident and Equalities Implications

10.8 Not applicable for this report. Equality Analysis will be a vital part of ensuring the programme delivers improvements across our diverse population and does not impact negatively on any specific groups.

11. Use of Appendices

11.1 None.

Report for: Joint Health and Wellbeing Board Sub Committee

Date: 9 October 2017

Title: Joint strategic needs assessment executive summary

Report authorised by : Julie Billett, Joint Director of Public Health (Camden and Islington)
Jeanelle de Gruchy, Director of Public Health, Haringey

Lead Officer: Mahnaz Shaukat, Head of Health Intelligence, Islington Council

1. Describe the issue under consideration

1.1 The Joint strategic needs assessment (JSNA) is a process by which the current and future health and wellbeing needs of the local population are described. The production of a JSNA is a statutory requirement for Health and Wellbeing Boards.

1.2 The JSNA process in Haringey and Islington are currently undertaken separately and the attached combined JSNA executive summary brings together the key health and wellbeing needs in both boroughs, drawing out similarities and differences.

1.3 Over the next year both boroughs will move towards a joint JSNA process.

2. Recommendations

2.1 To note and comment on the combined Haringey and Islington JSNA executive summary and the move towards aligning the JSNA process in both boroughs over the next year.

3. Background Information

3.1 Overall the populations of Haringey and Islington have similar health and care needs and both boroughs face similar challenges to improving health and care outcomes for their residents. These shared needs, together with a focus on common health and wellbeing priorities and on reducing health inequalities and a shared provider landscape, provide significant opportunities for working across both boroughs to integrate health and care and to improve population health outcomes for residents.

3.2 Engagement with residents, service users and carers in both boroughs, as part of integrated care and service transformation developments locally, have also identified very similar issues and concerns amongst the residents of both

boroughs, including: the desire for a more coordinated and seamless experience of health, care and support services; easy access to quality services, including those services that support people to stay well; services that promote choice, control and independence; and an holistic approach to addressing health, care and wider social needs. Other engagement work has provided resident views to inform our focus, for example concerns about the level of childhood obesity in the borough and the unhealthy food environment.

3.4 A copy of the combined Haringey and Islington JSNA executive summary is attached at Appendix A. The use of evidence and analysis to understand current and future health and care needs should be used to help determine what actions the partnership needs to take to improve the health and wellbeing of the local population and reduce health inequalities.

3.5 Over the next 12 months Haringey and Islington will work together to align the current separate JSNA processes into a single continuous process of strategic needs assessment and planning.

4. Statutory Officer Comments (Legal and Finance)

4.1 Legal

Under Sections 192 and 193 of the Health and Social Care Act 2012 (the 'Act') (which amends Section 116 of the Local Government and Public Involvement in Health Act 2007) the local authority and the CCG have a duty to prepare a joint strategic needs assessment (JSNA) and joint health and wellbeing board strategies (JHWS).

Section 196 of the Act provides for the Health and Wellbeing Board to exercise the functions of the local authority and the clinically commissioning group to prepare a JSNA and JHWS. Section 198 of the Act provides that two or more Health and Wellbeing Boards may make arrangements for any of their functions to be exercised jointly.

The Statutory Guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy 2013 provides that "Two or more health and wellbeing boards could choose to work together to produce JSNAs and JHWSs, covering their combined geographical area. Some health and wellbeing boards may find it helpful to collaborate with neighbouring areas where they share common problems as this can prove to be more cost effective than working in isolation" (Paragraph 3.1).

4.2 Finance

There are no financial implications arising directly from this report.

Any future action that the council decides to take in order to further the objectives set out in this report will need to be managed from within relevant existing budgets.

Any details relating to such actions will be assessed for financial implications as and when they arise.

5. Environmental Implications

5.1 There are no significant environmental implications arising directly from this report.

6. Resident and Equalities Implications

6.1 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

6.2 A resident impact assessment has not been completed because an assessment is not necessary in this instance.

7. Use of Appendices

Appendix A – Presentation

8. Background papers

None.

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ISLINGTON & HARINGEY JSNA

SUMMARY AND KEY MESSAGES

AUGUST 2017

Population

- The combined Haringey and Islington population is just over 500,000 people (Islington: 232,400 & Haringey: 279,890
- The populations of Haringey and Islington are living longer, growing and constantly changing. Although people are living longer, residents on average spend the last 20 years of their life in poor health.
- Overall the age structure of both Haringey and Islington is, and will continue to be, dominated by a young working age population. A younger population profile presents a significant opportunity for prevention of conditions that are significant contributors to early death, disability and poor quality of health in Haringey and Islington.
- The combined populations of Haringey and Islington are estimated to increase by 10% over the next 10 years. The highest rate of growth will be amongst the older population, although in absolute numbers the older population will remain the smallest age group.
- Both boroughs have diverse populations which are projected to increase over the next 10 years. Islington will see a significant growth in the Black other group whilst Haringey will see a significant growth in populations Asian Other and Chinese population.
- Poverty is a key determinant of poor outcomes in health and wellbeing and is linked to numerous health problems. Both boroughs are the amongst the most deprived in London (Islington the 5th most deprived and Haringey the 6th most deprived).

Children and young people

- There is clear evidence of the importance of giving children the best start in life, and there are a range of early interventions (starting not only in pregnancy, but before conception) that are effective in achieving better long term outcomes and reducing inequalities.
- Teenage pregnancy rates in both boroughs have declined and rates are now similar to England and London. The proportion of babies born with low birth weight has remained steady over the past 5 years for both boroughs however rates in Haringey are significantly higher compared to England and London.
- Although the majority of children and young people in Haringey and Islington live healthy lives, there are high levels of vulnerability and disadvantage. Both Haringey and Islington have a significantly higher proportion of children under 16 living in low income households (34% and 26% respectively) compared to England and London.
- More than a third of children in Year 6 are obese or overweight. Estimates suggest that being overweight or obese contributes to 36% of all the prevalent long term conditions diagnosed.
- Mental health needs amongst children and young people are high in both boroughs, with the proportion of children estimated to have a diagnosed mental health conditions is higher than London and England.

Haringey LONDON ISLINGTON

Working in partnership

NHS Haringey Clinical Commissioning Group | NHS Islington Clinical Commissioning Group

ISLINGTON & HARINGEY JSNA

SUMMARY AND KEY MESSAGES

AUGUST 2017

Physical and mental wellbeing

- Cancer, cardiovascular disease (CVD), and respiratory disease remain the leading causes of death in both Haringey and Islington. Although death rates are declining across the population, health inequalities remain stark. This is demonstrated by the gap in life expectancy between people living in the most deprived and least deprived areas.
- Diabetes and high blood pressure are common conditions in both boroughs that significantly contribute to early death. As well as taking action to prevent these conditions in the first place, earlier diagnosis and proactive systematic management of these conditions, including self-management and support for behaviour change, can help to prevent disease progression and improve outcomes.
- Mental health conditions significantly increase the risk of early death from a number of conditions, along with wider wellbeing impacts. Both boroughs have a high prevalence of people living with serious mental health conditions. Islington has the highest diagnosed rate of serious mental health illness in London. Both boroughs are in the top 5 London boroughs for proportion of working age people claiming out of work benefits and those claiming benefits due to mental health.
- The proportion of people with more than one long term condition increases with age, as does the risk of becoming frail. Frailty is linked with poor mobility, difficulty doing everyday activity and results in large increases in the health cost for care settings such as inpatient, outpatient and nursing homes. An estimated 5% of the population aged 65 years old and over are classified as severe frail in Islington, and potentially a similar proportion in Haringey.
- People with learning disabilities are particularly vulnerable to poorer health and wellbeing outcomes compared to the general population and often have poorer physical and mental health. Ensuring good access to and uptake of preventative interventions is key to improving health and wellbeing outcomes for people with learning disabilities.
- The proportion of people with learning disabilities who have had a health check in Haringey is significantly higher than the England average whilst in Islington the rate is similar to the England average.
- Dementia is a growing challenge locally, as our populations age and people live longer. High rates of dementia diagnosis enable people with dementia and their carers to receive the right care and support at the right time. Islington has the highest estimated dementia diagnosis rate in London, at 91%, significantly higher than London and England. Haringey is closer to the London average at 69%.

Slide 2

SM3 Shaukat, Mahnaz, 07/09/17

ISLINGTON & HARINGEY JSNA

SUMMARY AND KEY MESSAGES

AUGUST 2017

Behavioural risk factors

- Healthy habits can prevent illness or at least delay it for many years. Unlike other factors such as age and genetics, poor lifestyle behaviours can be altered and in the medium term improve population health outcomes.
- Smoking, excess alcohol consumption and excess weight caused lack of physical activity and diet are habits that contribute to a range of preventable health problems amongst our residents in both boroughs.
- Though smoking prevalence has decreased over the past few years, smoking levels remain high, especially in key population groups, such as people in routine and manual occupations and people with severe mental health conditions.
- Despite improvements in treatment outcomes, the harm that alcohol causes remains high. Haringey and Islington have alcohol-related hospital admissions significantly higher than the London and England averages and both boroughs have seen rates of admission increase over the past 10 years.
- Whilst the proportion of adults in Haringey and Islington who are overweight or obese is lower than for the London and England, more than half the adult population in both boroughs (54.2% and 52.8% in Haringey and Islington respectively) is overweight or obese.

Wider determinants

- Many factors combine to affect the health of individuals and communities, including genetic factors, their circumstances, their environment, their behaviours and access to services.
- Good housing, education and employment are amongst the key wider determinants of health. A good education is strongly associated with better health outcomes including life expectancy.
- The proportion of children achieving a good level of development at the end of reception year has been increasing over the past 5 years in both boroughs although in Islington the rate is significantly lower than the England and London average.
- Decent, secure housing can have a positive impact on the physical and mental health and wellbeing. Around 3,200 households (28 per 1,000 households) in Haringey and 900 households (9 per 1,000) in Islington are living in temporary accommodation. The rate is almost double in Haringey compared to London (15 per 1,000).

ISLINGTON & HARINGEY JSNA

SUMMARY AND KEY MESSAGES

- There is a strong correlation between unemployment and poor health. About one in ten people aged 16 to 64 years are claiming an out-of-working benefit in Haringey (9%) and Islington (10%). This is higher than the London (7%) and England (8%) averages. Islington has the second highest proportion of out-of-claimants in London, and Haringey has the 6th highest proportion
- A significant proportion of people who are out of work in Haringey and Islington have a long-term illness. About 5,500 (3%) working age people in Haringey and 6,400 (4%) in Islington are on sickness / disability benefits due to mental illness, meaning one-in-three out-of-work benefit claims are due to mental illness.

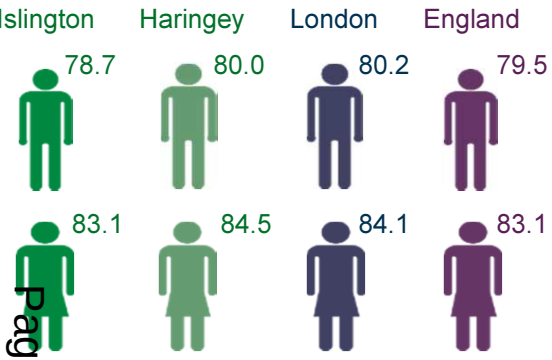
ISLINGTON & HARINGEY JSNA

DEMOGRAPHICS

DEMOGRAPHICS

Life Expectancy

Average life expectancy at birth 2013-15



Source, PHOF, 2017

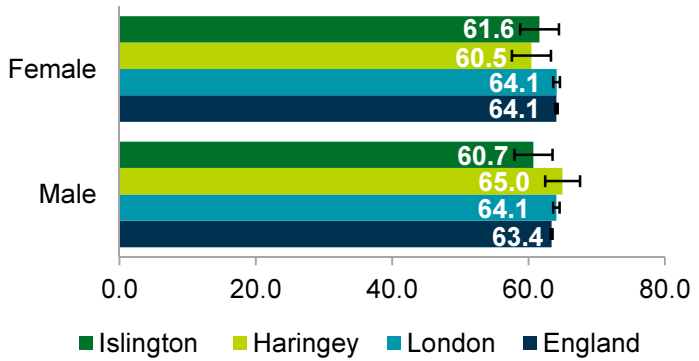
Life expectancy at birth has increased in both Islington and Haringey over the past decade.

For Haringey, life expectancy is now similar to London and England for males and for females it is similar to London and significantly higher compare to England.

Female life expectancy in Islington is significantly lower than London and similar to England. Male life expectancy in Islington remains significantly lower than both London and England.

Healthy Life Expectancy

Average healthy life expectancy at birth 2013-15



Source, PHOF, 2017

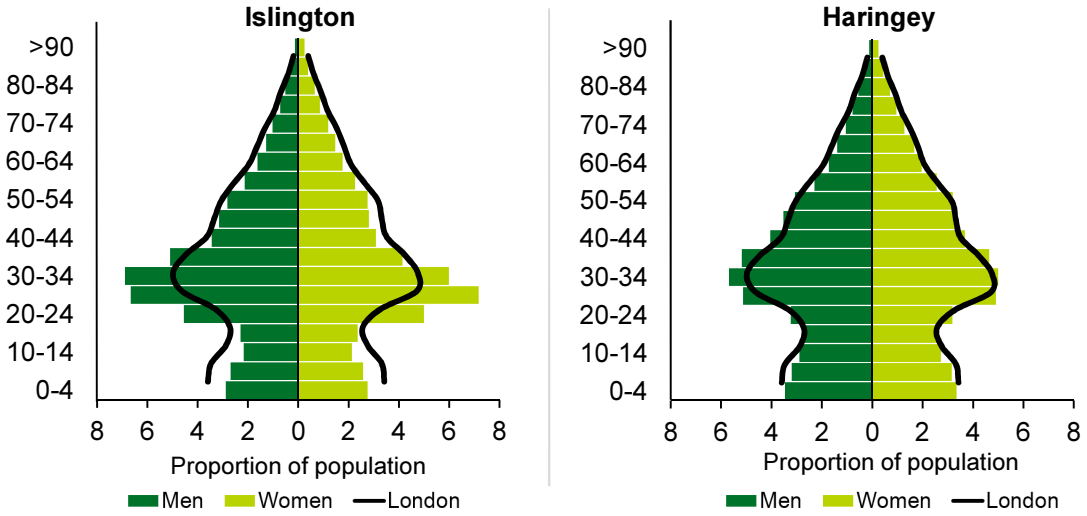
In both boroughs residents spend on average the last 20 years of life in poor health.

Male healthy life expectancy in Haringey is similar to London and England, whilst healthy life expectancy for women is significantly lower than London and England.

In Islington, healthy life expectancy for women is similar to London and England, whilst for men it is significantly lower than England but similar to London.

Population structure

Overall the populations of Islington and Haringey are young. The Haringey population is similar to London. Islington, however, has a higher proportion of younger people aged 25-39 years old compared to London and Haringey. Islington also has fewer children between the ages of 10 and 19 than the London average.



Source, GLA 2015-based population projections

DEMOGRAPHICS

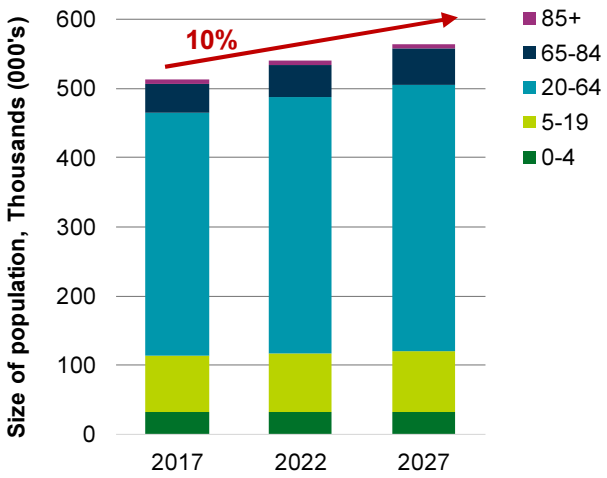
Population projections to 2027

The combined Haringey and Islington population is just over 500,000 people (Islington: 232,400 & Haringey: 279,890). This combined population size is expected to increase to 564,785 by 2027, an increase of 10% (9% increase for Islington and 11% increase in Haringey).

The highest expected growth is in the older age groups. The 85+ age group will rise from 6,535 to 7,572. The 65-84 group will rise from 41,390 to 52,626 people.

The working age population will remain the largest population overall for both boroughs.

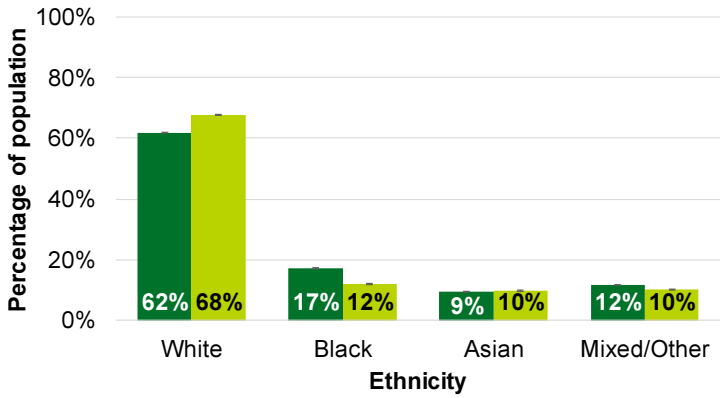
Population growth for Haringey & Islington combined, 2017, 2022 and 2027



Source, GLA 2015-based population projections

Ethnicity

Proportions of ethnic groups in Haringey and Islington, 2017

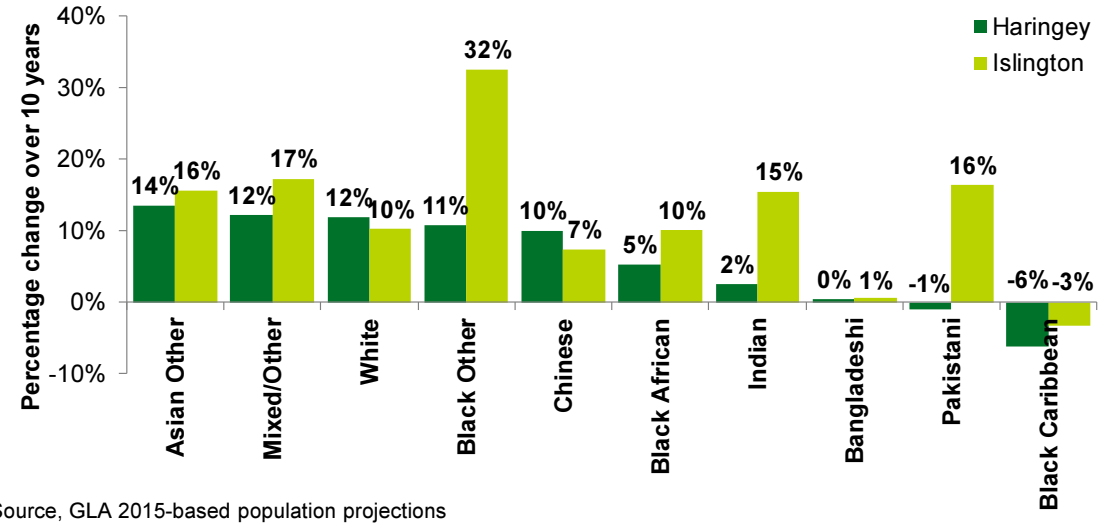


Both boroughs have ethnically diverse populations, with BME groups accounting for 38% of the whole population in Haringey and 32% in Islington.

The ethnic diversity is expected to remain stable over the next decade in both boroughs. The ethnic groups with the highest projected population growth is Black Other (32%) in Islington and Asian Other (14%) in Haringey. Both boroughs will see a reduction in the Black Caribbean population.

SM4

Percentage change in proportions of ethnic groups, 2017 to 2027



Source, GLA 2015-based population projections

Slide 7

SM4 Grid lines on the population projection graph to be consistent with the rest?
Shaukat, Mahnaz, 07/09/17

Haringey LONDON ISLINGTON

Working in partnership

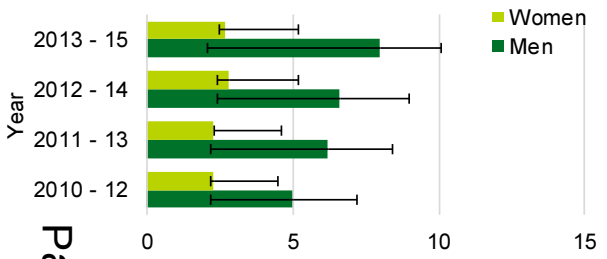
NHS Haringey Clinical Commissioning Group

NHS Islington Clinical Commissioning Group

DEMOGRAPHICS

Inequality in life expectancy

Inequality in life expectancy in Islington

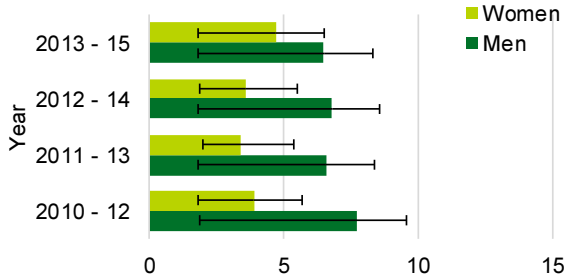


Range in years of life expectancy across the social gradient from most to least deprived residents

In Islington, men who live in the worst off areas are expected to live 8 fewer years than men living in the best off areas in the borough. Women have fewer inequality in life expectancy (2.7 years) across the social gradient (average life expectancy measured against local deprivation decile between 2013-15).

Inequality in life expectancy for men has been rising over the last 5 years, while it has remained stable for women.

Inequality in life expectancy in Haringey



Range in years of life expectancy across the social gradient from most to least deprived residents

In Haringey, men have greater inequality in life expectancy than women across the social gradient (6.5 vs 4.7 fewer years for those living in the most deprived areas than those living in the least deprived areas).

Inequality in life expectancy for men has decreased over the last 5 years (from 7.7 years in 2010-12). For women inequality in life expectancy has slightly increased in last 5 years (from 3.9 years in 2010-12).

PHOF, 2017

Deprivation

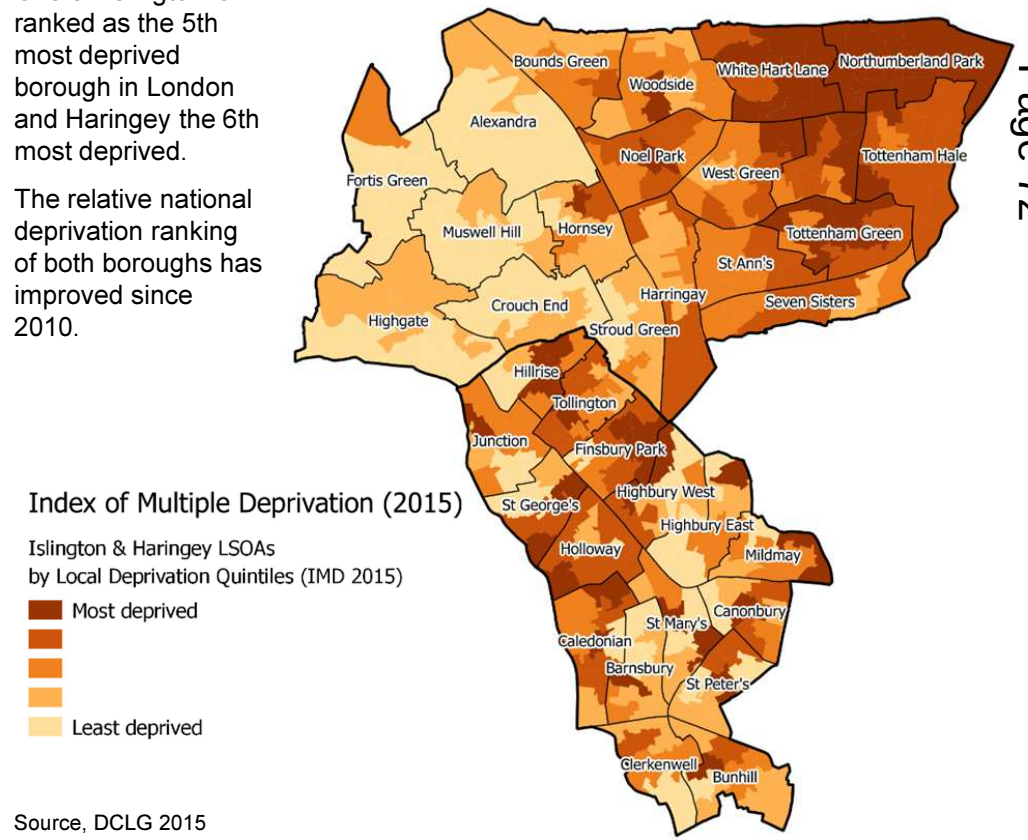
In Haringey, deprivation is more concentrated in the north east of the borough.

In Islington, areas of deprivation are more evenly spread throughout the borough, with residents from very different socio-economic circumstances living side-by-side.

Overall Islington is ranked as the 5th most deprived borough in London and Haringey the 6th most deprived.

The relative national deprivation ranking of both boroughs has improved since 2010.

Distribution of deprivation across Islington and Haringey by ward and LSOA



Source, DCLG 2015

DEMOGRAPHICS

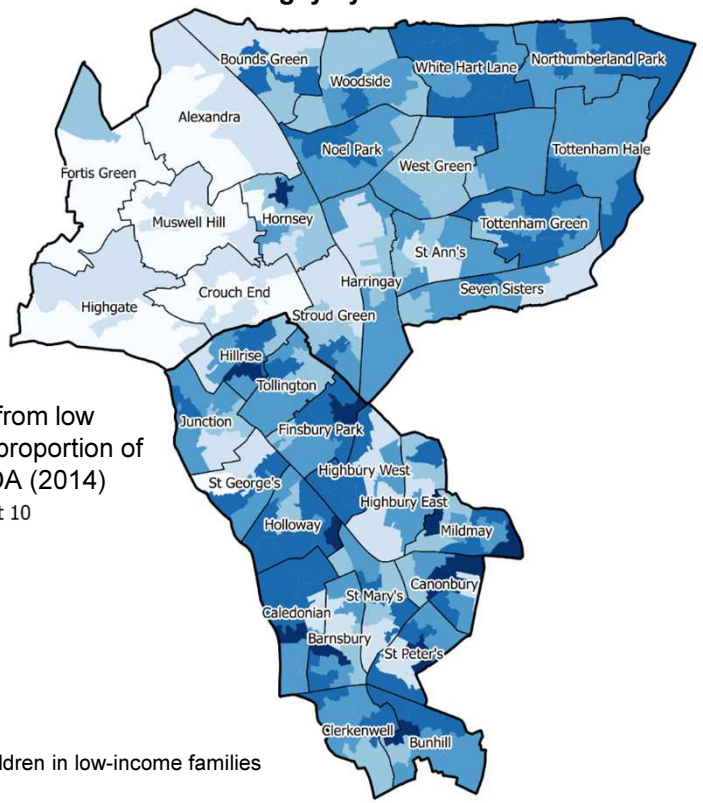
Poverty among children

The proportion of children living in low income families is significantly higher in Islington and Haringey compared to London and England.

In Haringey, children from low income households are more concentrated in the north east region of the borough. In Islington, child poverty is more evenly spread throughout the borough, with residents from very different socio-economic circumstances living side-by-side.

Overall Islington has more areas where the density of children from low income households is highest (40% - 50% of all children living within an LSOA region)

Distribution of poverty among children across Islington and Haringey by ward and LSOA



Total number of children from low income households as a proportion of total children in each LSOA (2014)

Proportions rounded to the nearest 10

- 0% - 10%
- 10% - 20%
- 20% - 30%
- 30% - 40%
- 40% - 50%
- 50% - 60%

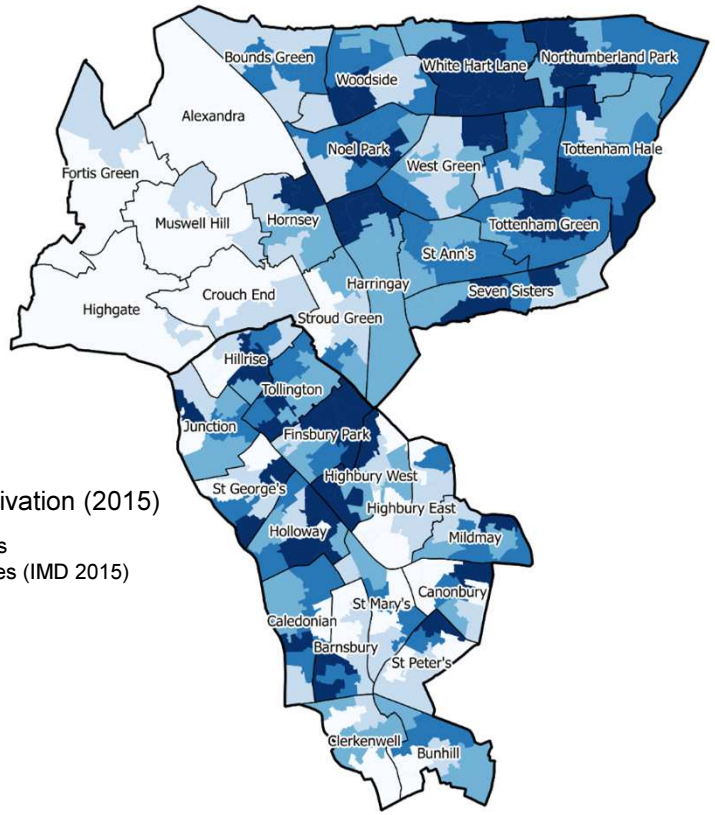
Source, Personal tax credits: Children in low-income families local measure, 2014

Poverty among older people

In Haringey, deprivation is more concentrated in the north east of the borough.

In Islington, areas of deprivation are more evenly spread throughout the borough, with residents from very different socio-economic circumstances living side-by-side.

Distribution of income deprivation among residents over 60 Islington and Haringey by ward and LSOA



Index of Multiple Deprivation (2015)

Islington & Haringey LSOAs
By local deprivation Quintiles (IMD 2015)

- Most deprived
- Least deprived

Source, DCLG 2015

Slide 9

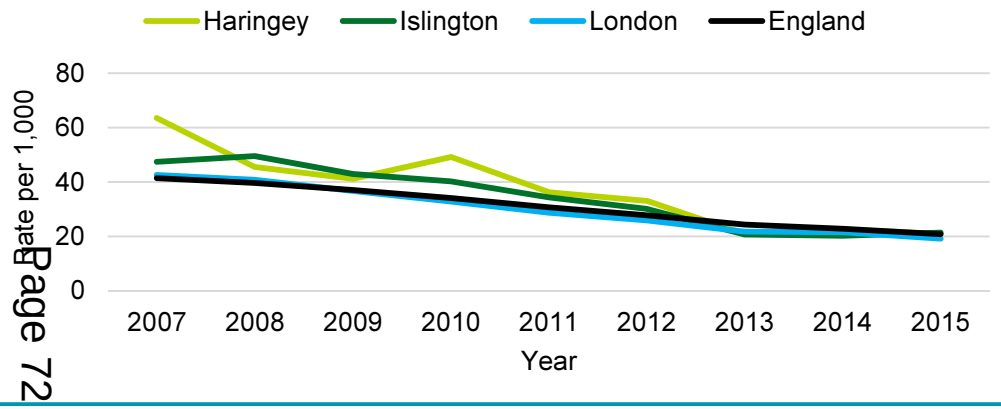
SM1 Can we include stats on inequality in life expectancy for male and females (https://fingertips.phe.org.uk/profile/wider-determinants/data#page/4/gid/1938133080/pat/6/par/E12000007/ati/102/are/E09000007/iid/92901/ along side the deprivation graph and put the child poverty map on a new slide alongside a map of income deprivation for older people
Shaukat, Mahnaz, 07/09/17

CHILDREN & YOUNG PEOPLE

CHILDREN AND YOUNG PEOPLE

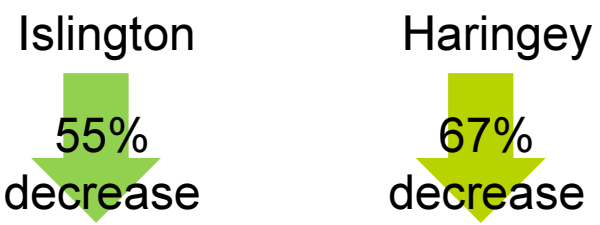
Teenage Conceptions

Conception rate per 1,000 women aged under 18, 2007-15



In 2015, there were **95** births to mothers aged under 18 years in Haringey and **61** in Islington.

Haringey and Islington's teenage conception rate has significantly declined in recent years in line with national and London trends. Between 2007 and 2015 teenage conceptions have fallen 55% for Haringey and 67% for Islington.



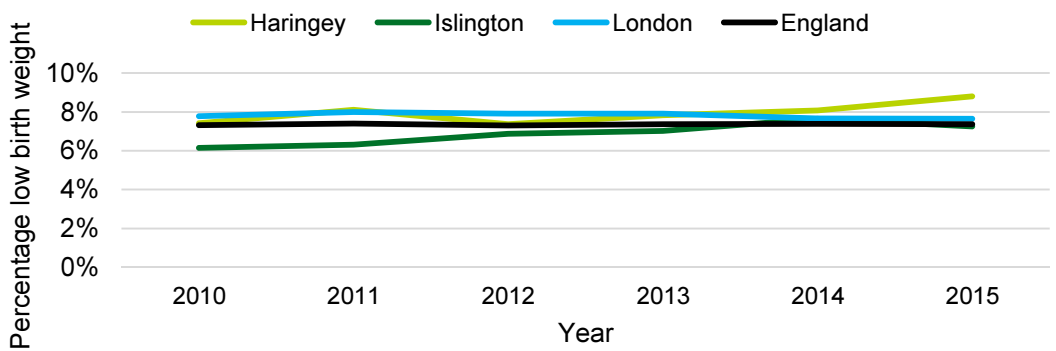
Source: PHE Child Health Fingertips, 2017

Low birth weight

The total number of live births with low birth weight in 2015:
Haringey **362**
Islington **213**

The proportion of live births with low birth weights has remained steady in both Haringey and Islington in recent years, although the latest data show an increase in proportion of babies with low birth weight, that is significantly higher compared to London and England.

Percentage of all live births with low birth weight, 2010-15



Source: PHE Child Health Fingertips, 2017

CHILDREN AND YOUNG PEOPLE

Vaccination Coverage – Dtap / IPV / Hib

Vaccination coverage of Dtap/IPV/Hib, 1 year olds, 2015/16

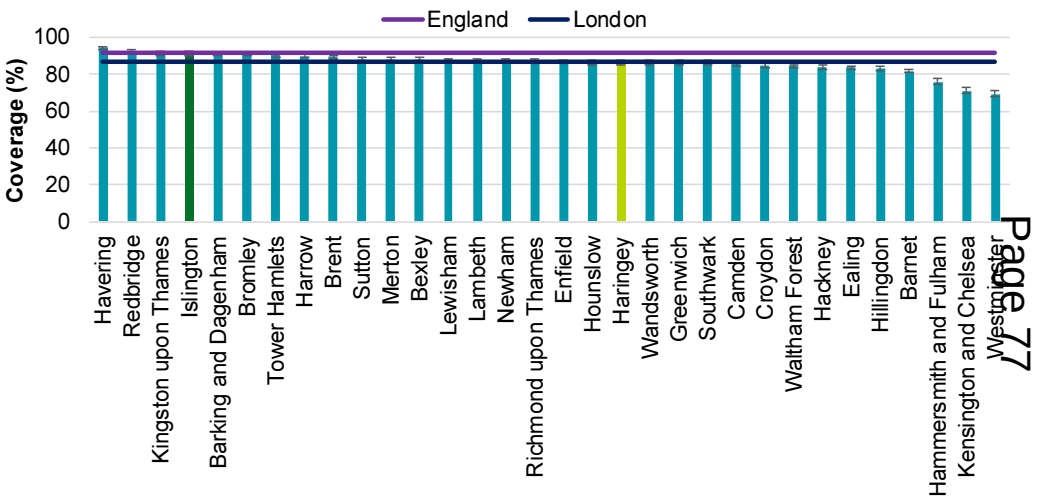
At 94.8%, Islington has the third **highest** vaccination coverage in London, which is higher than the London average of 89.2%.

Haringey has the **ninth lowest** vaccination coverage in London (88.9%).

Source: PHE Child Health Fingertips, 2017

Vaccination Coverage – MMR

Vaccination coverage of MMR for one dose, 2 years old, 2015/16



Islington has the **fourth highest** vaccination coverage per population in London (90.8%).

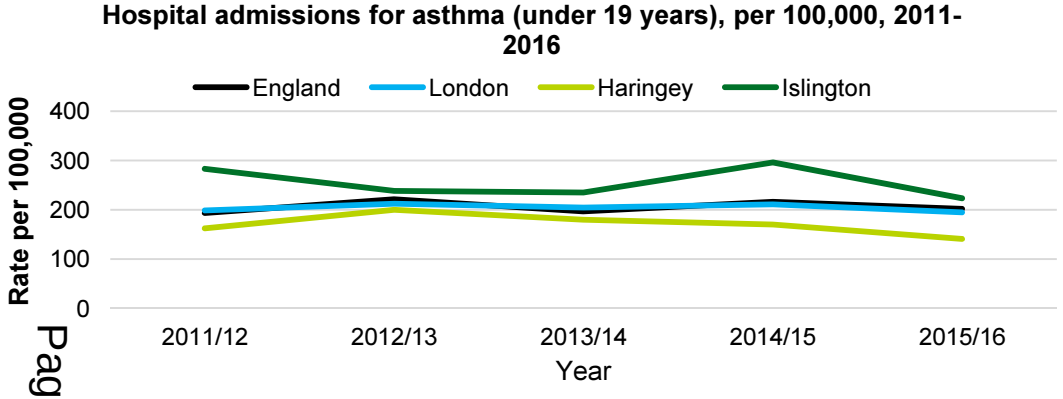
Haringey has the **fourteenth lowest** vaccination coverage in London (86.4%).

Both boroughs are **higher than** the London average of 86.3% but lower than the England average of 91.%. Islington is significantly higher than the London average.

Source: PHE Child Health Fingertips, 2017

CHILDREN AND YOUNG PEOPLE

Trends in asthma admissions

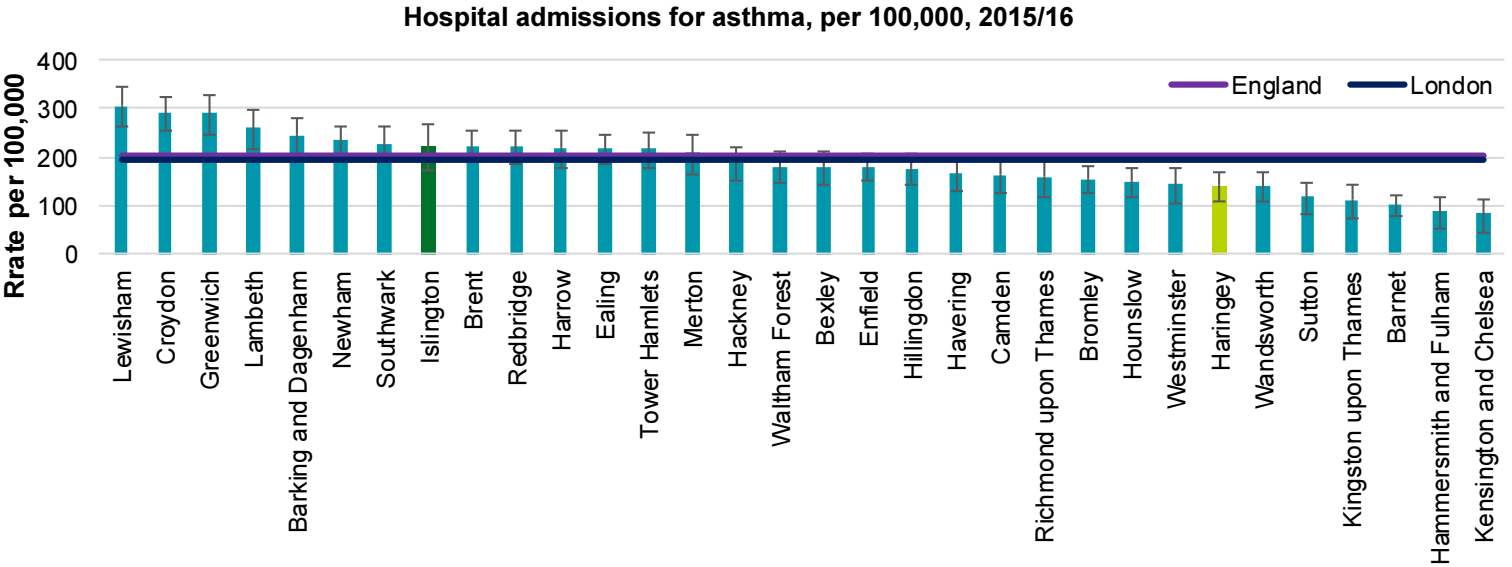


Islington's asthma admissions has significantly **decreased** since 2011, despite an increase in 2014/15. It has remained **above London** and **England** during this period.

Trends in asthma admissions for Haringey have remained **below** the **London** and **England** rates and continue to decrease.

Source: PHE Child Health Fingertips, 2017

Asthma admissions across London



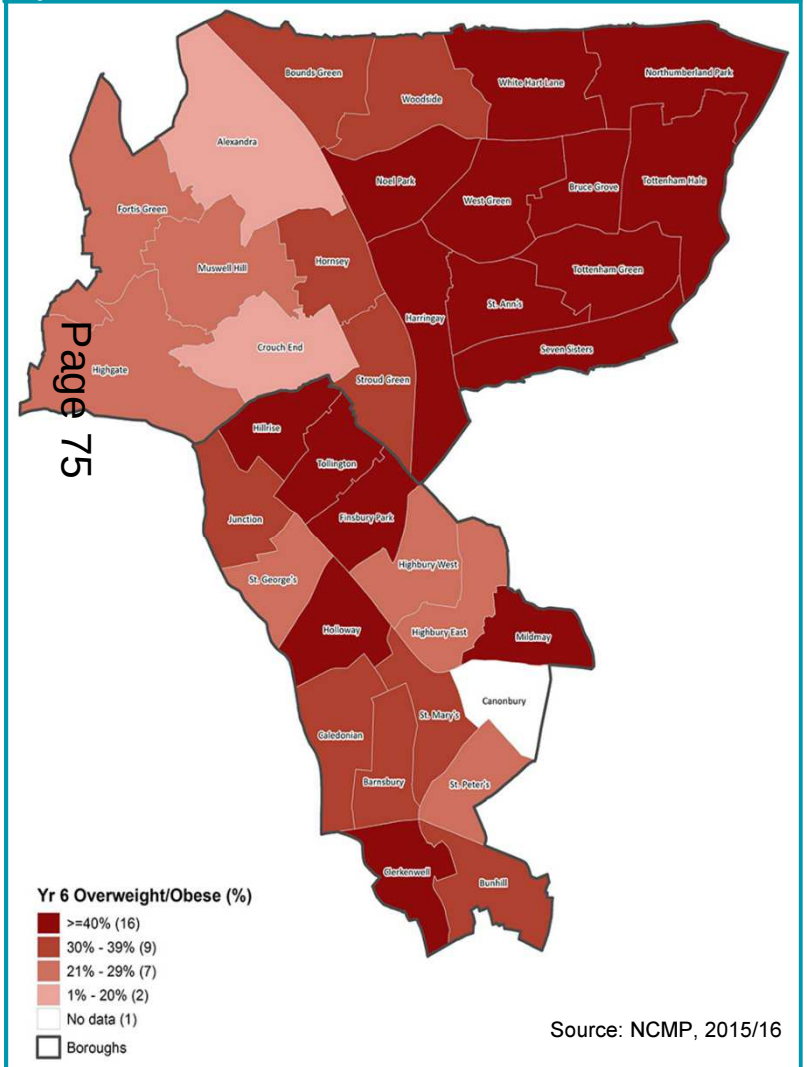
At 141 per 100,000, Haringey had the **7th lowest** admissions rate for asthma, amongst children aged under 19 years, in London (2015/16). This is significantly lower than the national average.

Islington performs far differently. With a rate of 224 asthma admissions per 100,000, Islington has the **8th highest** admissions rate in, although this rate is similar to the London and England average.

Source: PHE Child Health Fingertips, 2017

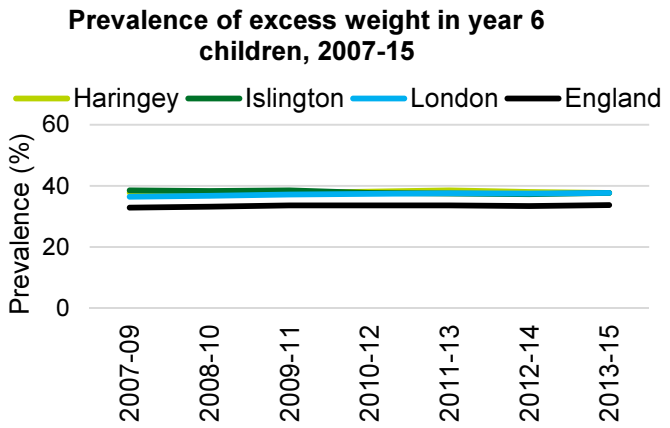
CHILDREN AND YOUNG PEOPLE

Excess weight in children aged 10-11 years old by ward



Source: NCMP, 2015/16

Trends in prevalence of excess weight amongst children

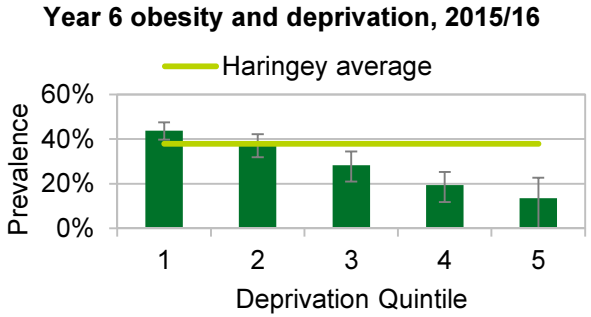


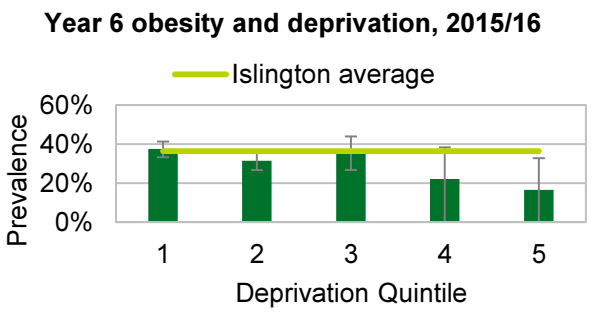
24% of children in Reception and **38%** of children in Year 6 in Haringey are overweight or obese, compared to **23%** and **37%** for Islington. As of 2015/16, both Haringey and Islington have a significantly higher prevalence of excess weight in year 6 children, compared to England.

In Haringey and Islington, there are **582** year 6 children who are overweight, and **918** year 6 children who are obese out of a total year 6 population of 3978 (2015/16)

Source: NCMP, 2015/16

Obesity and Deprivation in Year 6





Year 6 children in the most deprived wards of Haringey are **two and a half times** more likely to be overweight or obese compared to those in the most affluent parts (where 1 is most deprived). Obesity is more dispersed among deprivation quintiles in Islington.

Source: NCMP, 2015/16

CHILDREN AND YOUNG PEOPLE

Mental Health and Self harm

Estimated prevalence of mental health disorders, 5-16 years, 2015

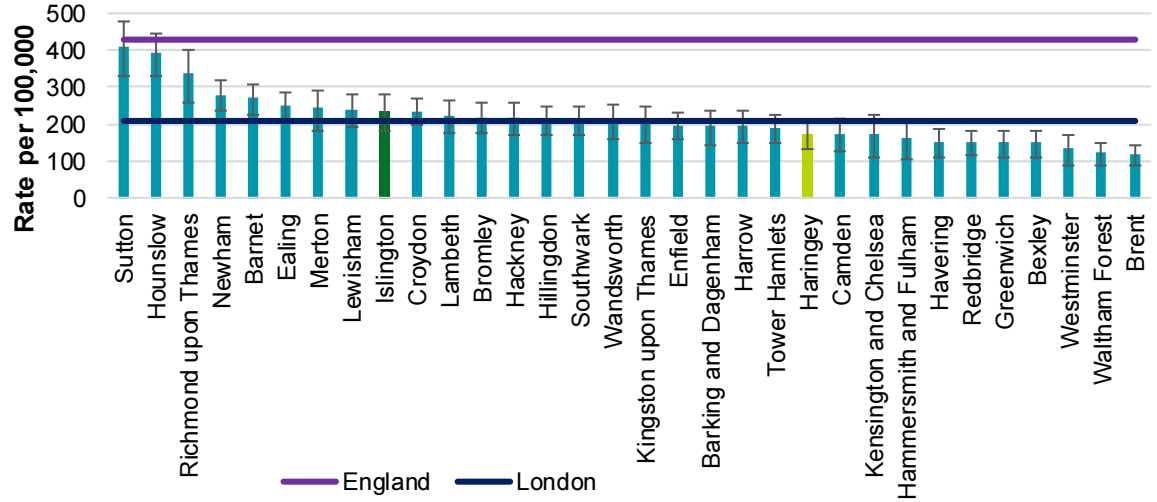
In 2015, there were **3,817** children and young people in Haringey and **2,482** children and young people in Islington with a mental health disorder. This includes anxiety disorders, emotional disorders, hyperkinetic disorders and depression.

Haringey and Islington both have a higher estimated prevalence of mental health disorders than London and England averages:

Haringey:	Islington:	London:	England:
9.9%	10.0%	9.3%	9.2%

Source: PHOF, 2017

Hospital admissions as a result of self-harm (10-24 years), rate per 100,000, 2015/16



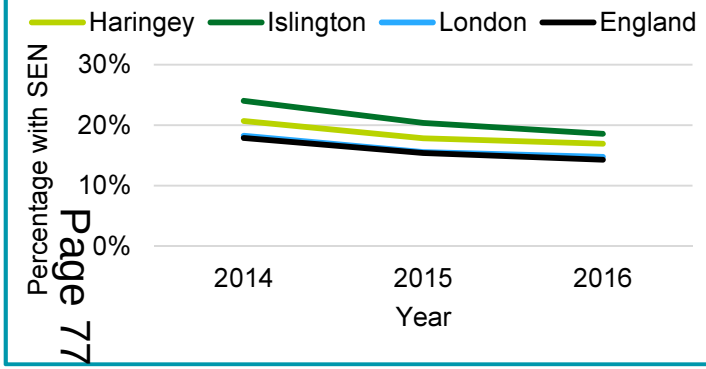
At **189.9 per 100,000 (101)**, Islington has the 9th highest rate of hospital admissions for self-harm amongst 10-24 year olds in London. At **139.1 per 100,000 (83)**, Haringey has the 22nd highest rate in London. Both Haringey and Islington are significantly lower than the national rate of 426.5 per 100,000.

Source: PHOF, 2017

CHILDREN AND YOUNG PEOPLE

Special Education Needs

Percentage of school age (4-16 years) pupils with special educational needs (SEN), 2014-16

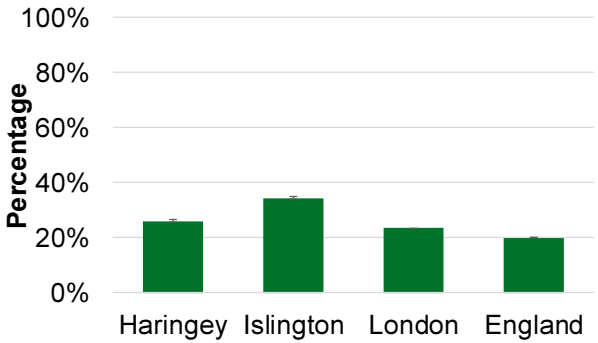


In 2016, there were **6,331** school age pupils in Haringey and **4,524** in Islington with Special Education Needs.

Source: PHE Child Health Fingertips, 2017

Children in low income families

Percentage of children aged under 16 living in low income families, 2014

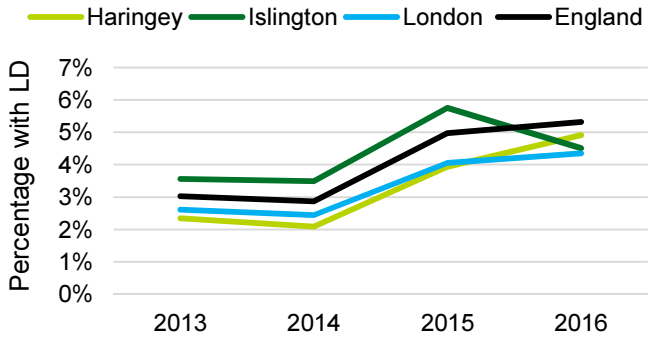


In 2014 almost **a quarter** of children aged under 16 (N=13,620) in **Haringey** and more than **one third** of under 16s (N=11,280) in **Islington** were living in low income families. The proportion has decreased over the decade in both Haringey and Islington, in line with the national trend, it is **still higher** in both boroughs **compared to London** (23%) **and England** (20%).

Source: PHE Health Profile, 2017

Learning Disability

Percentage of school age pupils with a Learning Disability, 2013-16

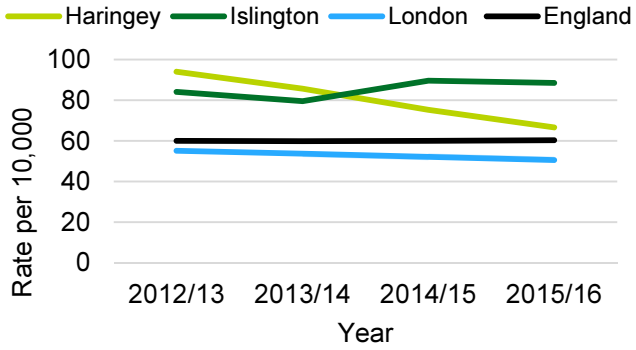


In 2016, there were **1,079** school age pupils in Islington and **1,810** in Haringey with a learning disability

Source: PHE Child Health Fingertips, 2017

Looked after Children

Rate of looked after children per 10,000, <18 years, 2012/12-2015/16



In 2015/16, there were **405** LAC <18 years old in Haringey and **110** in Islington

Source: PHE Child Health Fingertips, 2017

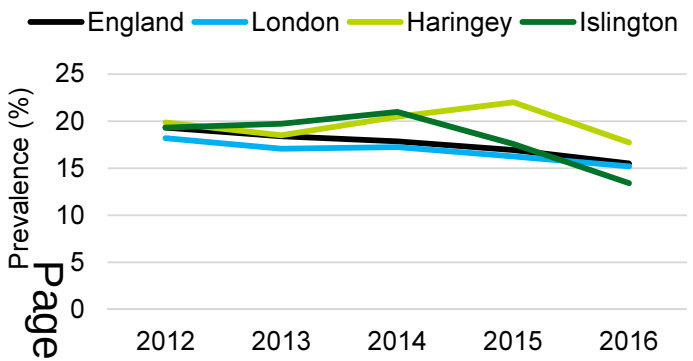
Summary | Demographics | Children and Young People | Behavioural risk factors | Physical wellbeing of adults & older people | Mental Health | Wider determinants | Further information

BEHAVIOURAL RISK FACTORS

BEHAVIOURAL RISK FACTORS

Smoking Prevalence

Smoking Prevalence in adults - current smokers, 2012-16

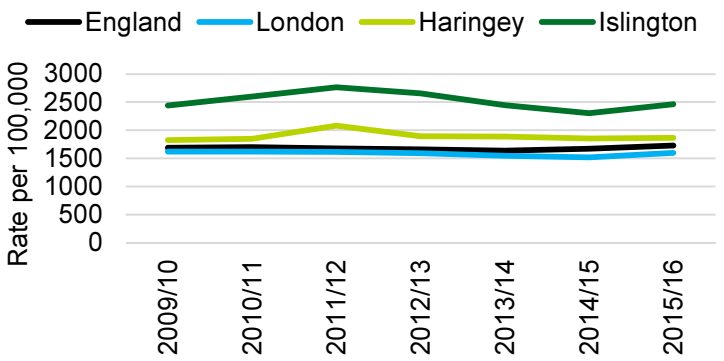


Islington's smoking prevalence has declined since 2015 and is now similar to London and England at 13.4%. Haringey's smoking prevalence remains around 2012 levels at 17.7%, and also similar to the London and England average.

Source: APS, PHOF, 2017

Smoking Attributable Hospital Admissions

Smoking attributable hospital admissions, rate per 100,000, 2009-16

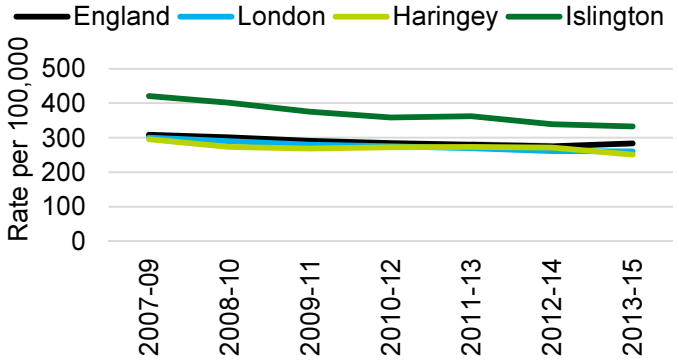


Haringey and Islington's smoking-attributable hospital admission rates have remained steady since 2009/10. Islington remains significantly higher than London and England, whilst Haringey is closer to the comparator averages.

Source: PHOF, 2017

Smoking Attributable Mortality

Smoking Attributable Mortality, rate per 100,000, 2007-15

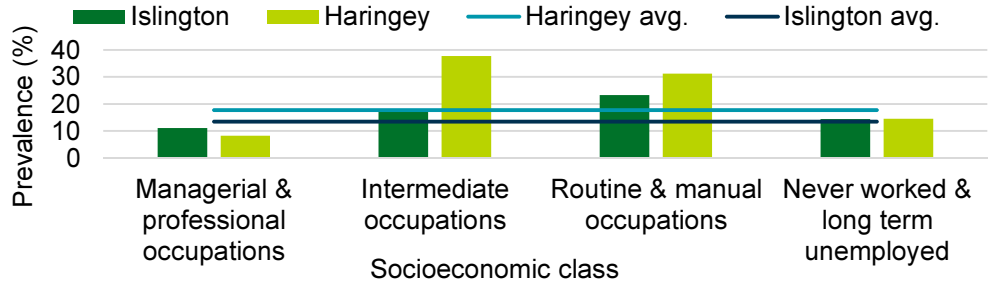


Islington's smoking-attributable mortality rate has steadily declined since 2007-09 and is now closer to Haringey's rate. Haringey has remained steady since 2007/09 and is currently lower than the London and England averages.

Source: PHOF, 2017

Smoking by Socioeconomic class

Smoking Prevalence in adults by socioeconomic class



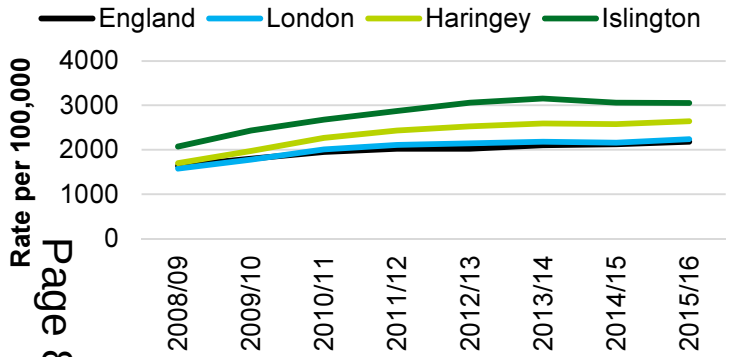
Haringey has a significantly higher smoking prevalence for those in intermediate occupations (37.8%) compared to Islington (18.1%). Haringey also has a higher prevalence for those in routine and manual occupations (31.2%) compared to Islington (23.4%).

Source: PHOF, 2017

BEHAVIOURAL RISK FACTORS

Alcohol-related hospital admissions

Admission episodes for alcohol-related conditions (Broad), per 100,000, 2008-16



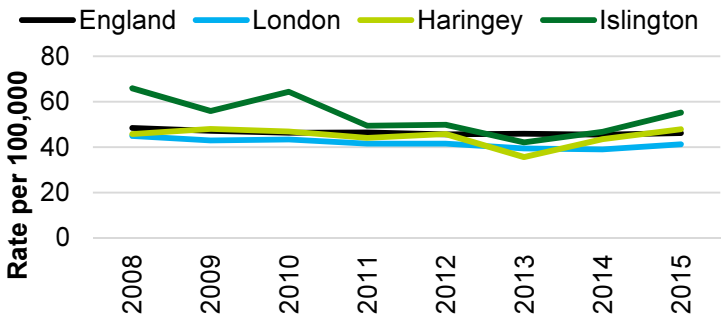
Haringey and Islington have alcohol-related hospital admissions significantly higher than the London and England averages.

Both boroughs have seen rates of admission increase since 2008/09.

Source: PHOF, 2017

Alcohol-related mortality

Alcohol-related mortality, rate per 100,000, 2008-15



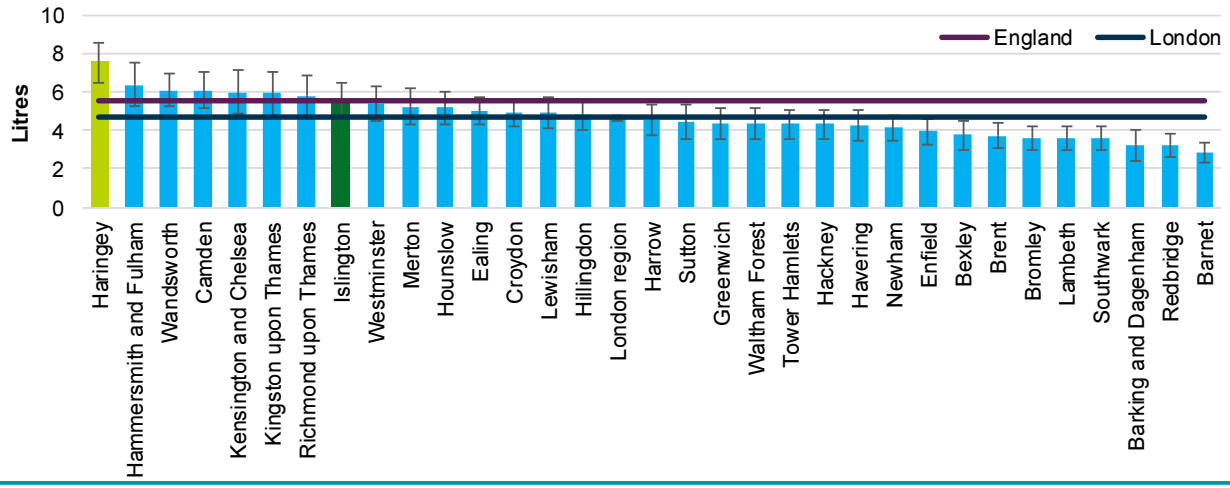
Source: PHOF, 2017

Alcohol-related mortality rates in Haringey and Islington are similar to the London rate. Compared to England, Islington has a higher rate and Haringey a similar rate.

Trends in alcohol-related mortality have not changed significantly over time in both boroughs.

Off-trade alcohol sales

Volume of pure alcohol sold through the off-trade, all alcohol sales, London boroughs, 2014



Haringey ranks **highest in London** (out of 32 boroughs) for litres sold per adult through the off-trade, significantly higher than the London average of 4.7 litres and England average of 5.5 litres. Islington ranks 8th highest with 5.3 litres, similar to London and England.

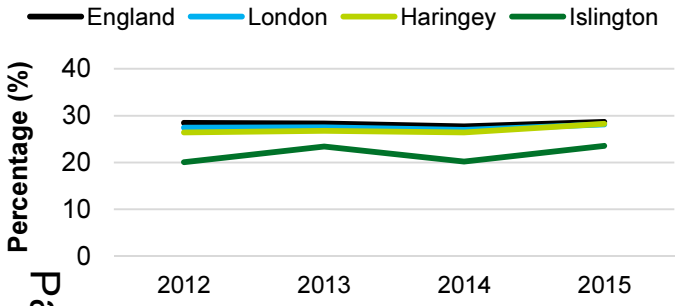
A total of 1,561,000 litres of alcohol was sold through the off-trade in Haringey in 2014, compared to 1,007,000 litres in Islington.

Source: LAPE, 2017; CGA Strategy/Nielsen, 2014

BEHAVIOURAL RISK FACTORS

Physical Inactivity

Percentage of adults achieving less than 30 minutes of physical activity per week

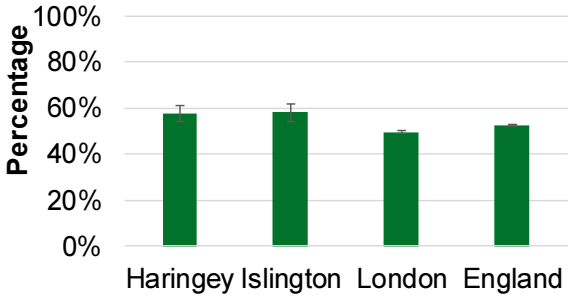


Haringey (28.2%) have a similar proportion of inactive adults as London and England, whilst Islington have remained lower than its comparators since 2012. In 2015, 23.6% of adults in Islington were inactive.

Source: PHOF, 2017

Healthy Diet

Proportion of adults (16+ years) meeting the recommended '5-a-day' on a 'usual day', 2015

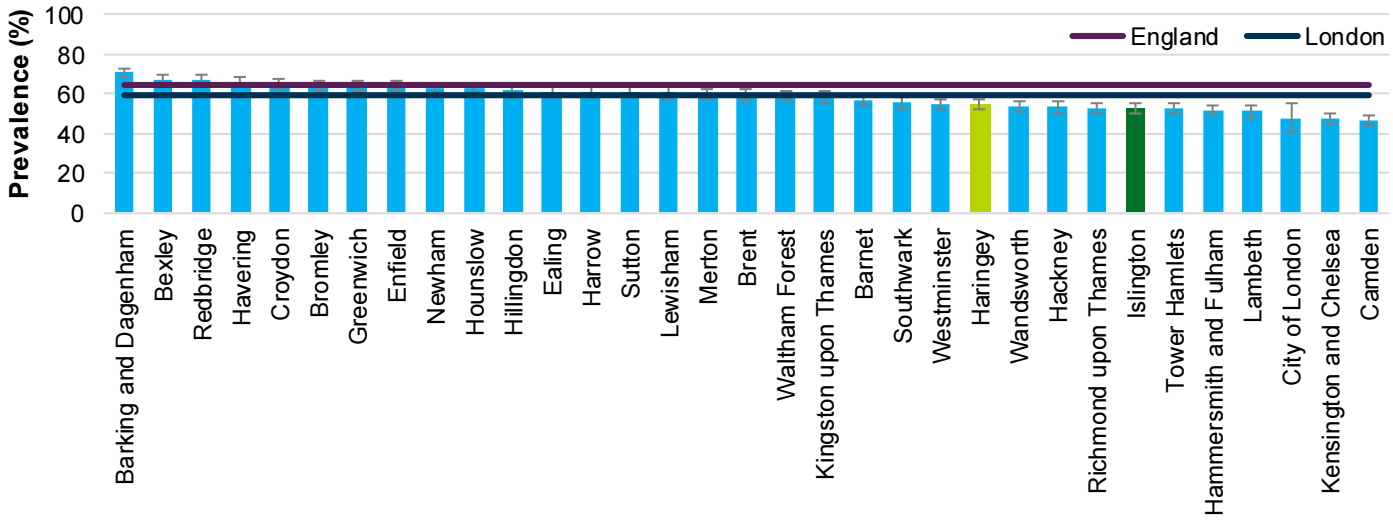


The proportion of adults meeting the recommended 5-a-day in Islington (58%) and Haringey (58%) is significantly higher than the London (49%) and England (52%) averages. Islington and Haringey are the 3rd and 4th highest achieving boroughs for this indicator in London.

Source: PHOF, 2017

Obesity in adults

Proportion of adults with an excess weight, 2013-15



Islington (57.9%) and Haringey (57.4%) have the 3rd and 4th highest proportions of adults meeting their recommended 5-a-day in 2013-15. Both boroughs have proportions higher than the London and England averages.

Haringey and Islington are both below the London and England averages for excess weight in adults, at 54.2% and 52.8% respectively. Islington is the 7th lowest proportion of adult obesity in London, whilst Haringey is the 11th lowest.

Source: PHOF, 2017

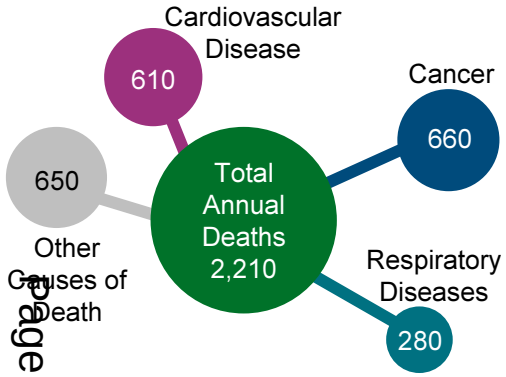
ISLINGTON & HARINGEY JSNA

PHYSICAL WELLBEING OF ADULTS & OLDER PEOPLE

ADULTS AND OLDER PEOPLE

Premature Mortality

Top 3 Killers In Haringey & Islington Combined (Rounded To Nearest 10)

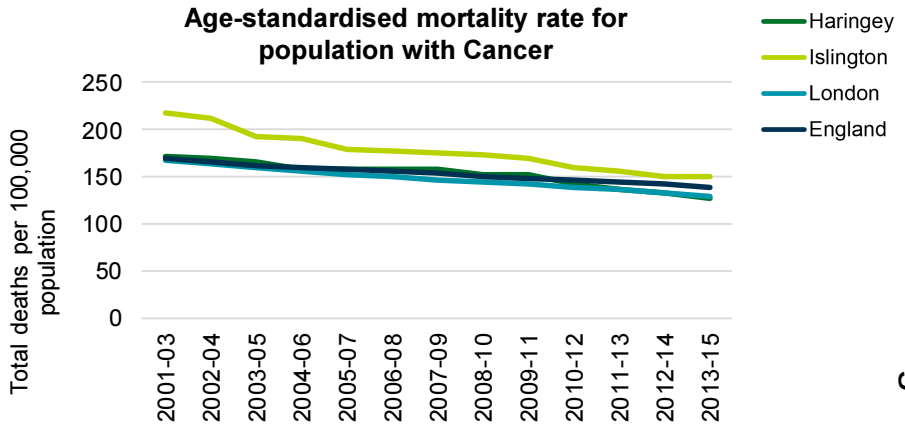


Mortality rates among the combined population of Islington & Haringey is highest among those with cardiovascular disease, cancer and diabetes.

For Islington, the mortality rates for these 3 disease are higher than the average rate for both London and England.

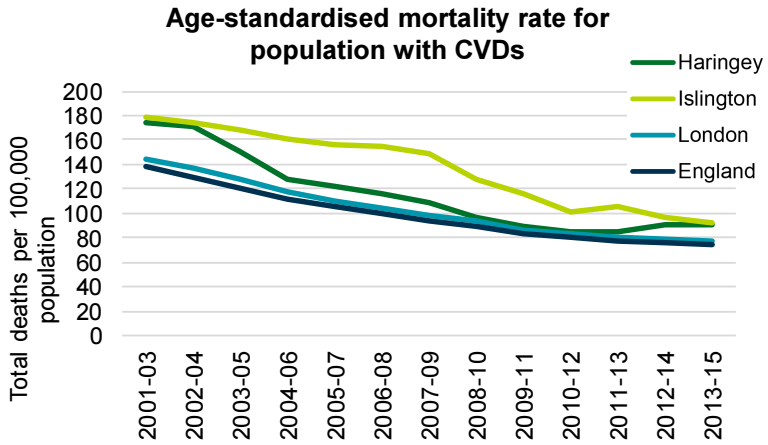
Note: Numbers do not add up due to rounding.
Source: Primary care mortality database (PCMD) 2015 - NHS Digital

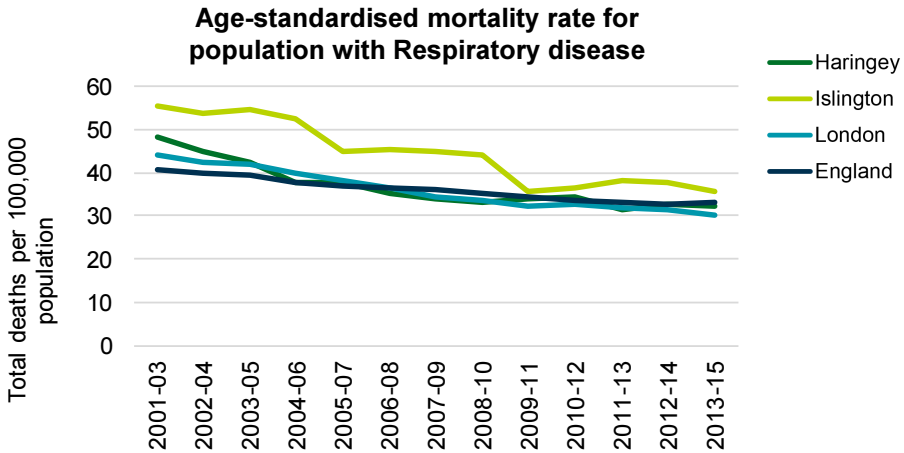
Mortality rates over time



Rates of mortality caused by the top 3 killers (Cancer, CVD and Respiratory Disease) have been declining in both Islington and Haringey over the last decade.

This is in line with both the regional and national trend.





Source, End of Life Care Profiles (PHE Finger tips), 2015

ADULTS AND OLDER PEOPLE

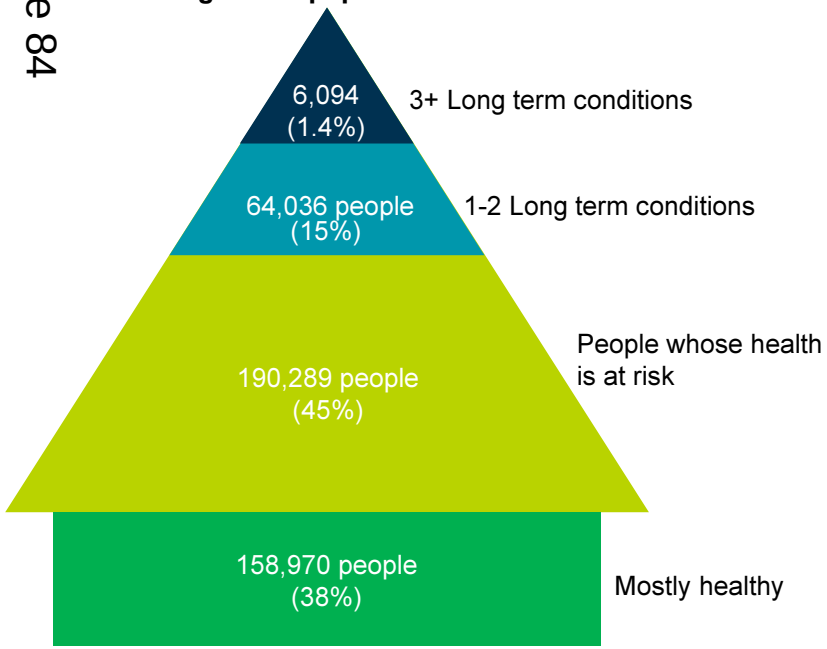
Population segmentation

Regarding the GP-registered population in both Islington and Haringey combined, 38% of the population are deemed as mostly healthy (Non-smokers, healthy BMI, no LTC and no HBP)

The highest segment (45%) of the population are classified as 'health at risk' (which may involve: being underweight/overweight, Smoker, HBP)

The majority of the population with Long term conditions are typically from the older age groups (aged 55+) whilst the 'mostly healthy' population-segment are distributed among the younger groups: 18-44.

Population segmentation: Haringey & Islington combined GP-registered population 18+



Source, Haringey's GP PH dataset (2013) & Islington's PH GP Dataset (2015)

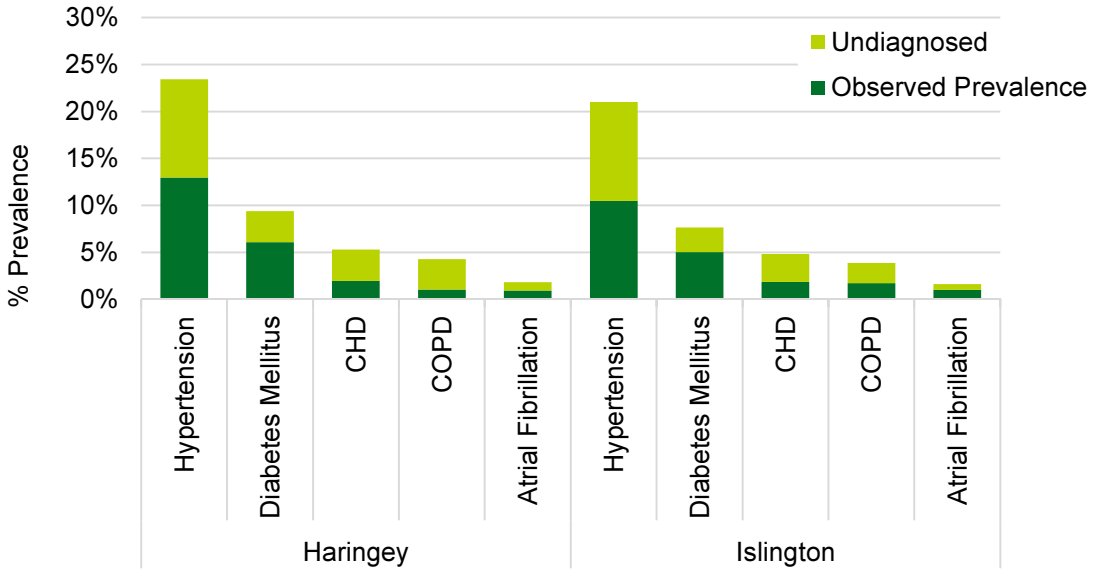
Prevalence gap of long term conditions

For both Islington and Haringey, the prevalence of Hypertension ranks highest among all long term conditions – with an estimated prevalence of 21% (42,600 people) in Islington and 23% (58,400 people) respectively.

The proportion of undiagnosed long term conditions (for both boroughs) is almost equal to that of diagnosed cases. This suggests that roughly half of the 5 conditions: Hypertension, Diabetes, CHD, COPD & Atrial Fibrillation still remain undiagnosed.

Haringey has a larger proportion of undiagnosed CHD and COPD cases when compared to Islington.

Prevalence gap for long-term conditions, Islington and Haringey registered population aged 16 and over, 2015-16



Source, Haringey's GP PH dataset (2013) & Islington's PH GP Dataset (2015)

Frailty

Frailty is a loss of resilience that means people living with frailty do not bounce back quickly after a physical or mental illness, an accident or other stressful event. People living with frailty are likely to have a number of different issues or problems, which, taken individually, might not be very serious but when added together have a large impact on health, confidence and wellbeing.

The prevalence of Frailty has been measured using a Frailty Index (eFi) - where a detailed frailty score is assigned to residents based on whether they have a combination of specific illnesses – ranging from arthritis, CVD right through to impairments in hearing and mobility.

Frailty is linked with poor mobility, difficulty doing everyday activity, or simply 'slowing up' and results in large increases in the health cost for care settings such as inpatient, outpatient and nursing homes.

Source: NHS ENGLAND

Who is at risk? – Gender

Women (65+) are more likely to have **mild frailty** (33%) than older men (30%), and **twice as likely** to have a **severe frailty** then older men (6% vs 3%).

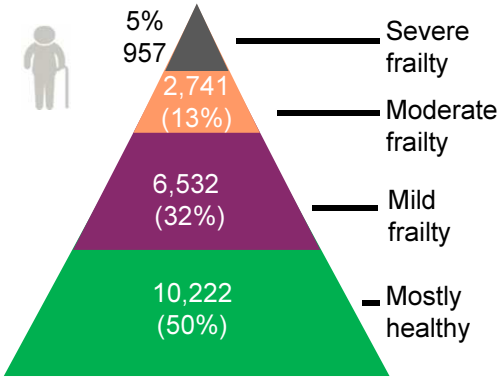
Who is at risk – Ethnicity

Black women (38%) and Black and Asian men (37%) are more likely to have a **moderate/severe frailty** compared to the Islington average (32%).

Source, Frailty Index analysis, Islington 2015. NB results are likely to apply equally to Haringey

Frailty status among Islington residents

Over 65's segmented by Frailty Status (Islington only)



Based on the local review of the frailty index approximately one third (6,532) of people aged 65 and over in Islington are classified with a mild frailty.

Source, Frailty Index analysis, Islington 2015

Falls in Islington and Haringey

Each year, an estimated 6,000 falls occur among Islington's 65+ population. 10% of all estimated falls are admitted to hospital.

In Haringey, roughly 6% of all estimated falls (among the Haringey 65+ population) are admitted to hospital.

7,740 Estimated falls in Haringey (2016) → **470** 6% of all estimated falls admitted to hospital (2014/15)

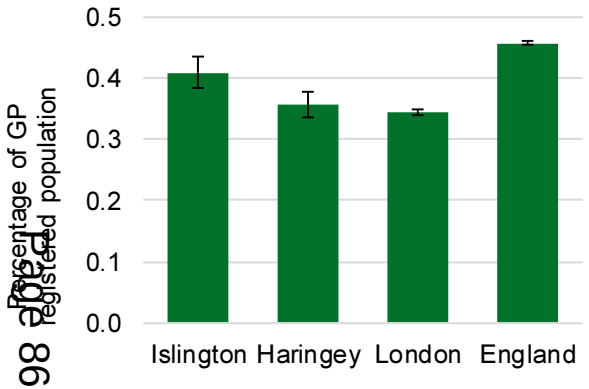
6,060 Estimated falls in Islington (2016) → **591** 10% of all estimated falls admitted to hospital (2014/15)

Source, PHOF, 2017

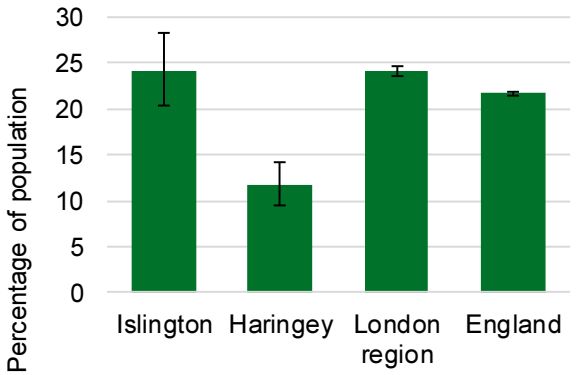
ADULTS AND OLDER PEOPLE

Learning difficulties – Prevalence, Housing, Employment & further support

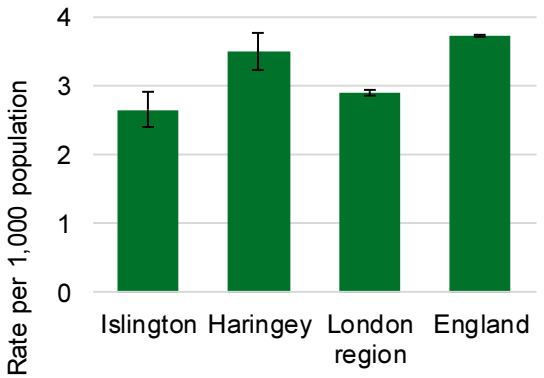
Prevalence of Learning disability among GP-registered population, All ages, 2015/16



Percentage of adults 18-64 with learning difficulties living in non-settled accommodation, 2015/16

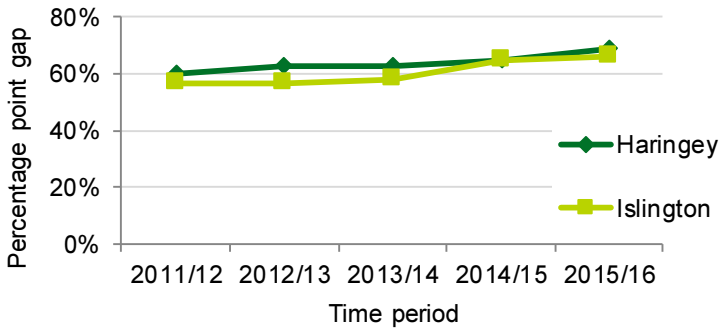


Adults (18 to 64) with learning disability getting long term support from Local Authorities



Source, QOF 2013-14

Percentage gap in employment rate between people with a learning disability and the overall population, 18-64 years, 2011/12 to 2015/16



Source, PHOF, PHE, 2017

There are 2,066 people living with a learning disability in Haringey and Islington (1,090 and 976 respectively). The prevalence of learning disabilities in Islington is significantly higher than the London average and significantly lower than the England average.

In Haringey the prevalence of learning disabilities is similar to the London average and significantly lower than the England average.

Islington has a higher proportion (24.2%) of adults with learning difficulties living in non-settled accommodation than Haringey (11.7%). This proportion in Islington is also similar to the regional and national average.

The Rate of adults receiving long term support from the Local Authority is higher than that in Islington. This rate in Haringey is higher than the regional average but similar to the national average.

The percentage gap in employment between people with learning difficulties and the overall population is 66% in Islington (2015/16) and 69% in Haringey (2015/16).

These figures are similar to the average percentage gap in employment for both London and England.

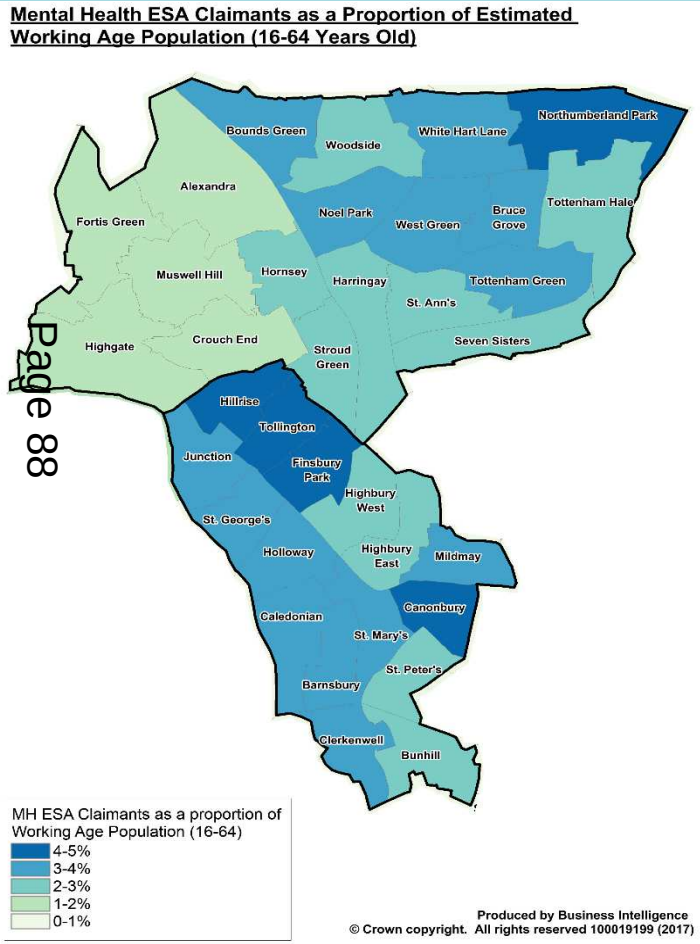
On average the percentage gap in Employment is higher in Haringey than in Islington.

This percentage gap, for both Haringey and Islington, has increased over the past 4 years, at a very similar rate to the national trend.

MENTAL HEALTH

MENTAL HEALTH

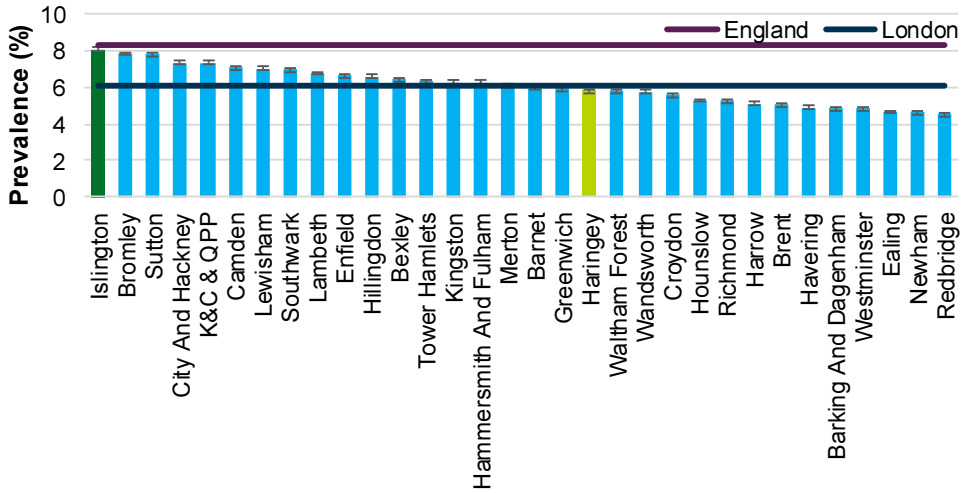
Employment Support Allowance (ESA) claimants for Mental Health reasons



There is a higher proportion of mental health ESA claimants in the east of Haringey, compared to the west. MH ESA claimants are more dispersed in Islington, with a high concentration in the northern wards that border Haringey.

Depression and severe mental illness

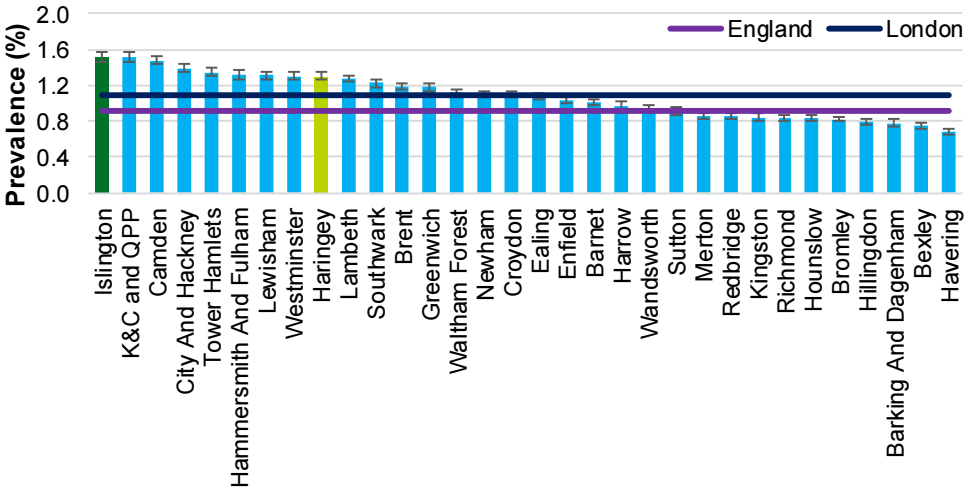
Recorded prevalence of depression, 18+ years, 2015/16



Islington has the highest recorded prevalence of depression (8.1%, N= 16,080) in London. In Haringey 5.8% of people aged 18 years or over (N=14,100) are diagnosed with depression. This is significantly lower than the England average (8.3%).

Source: QOF, 2015/16

Recorded prevalence of serious mental illness (SMI)*, 2015/16



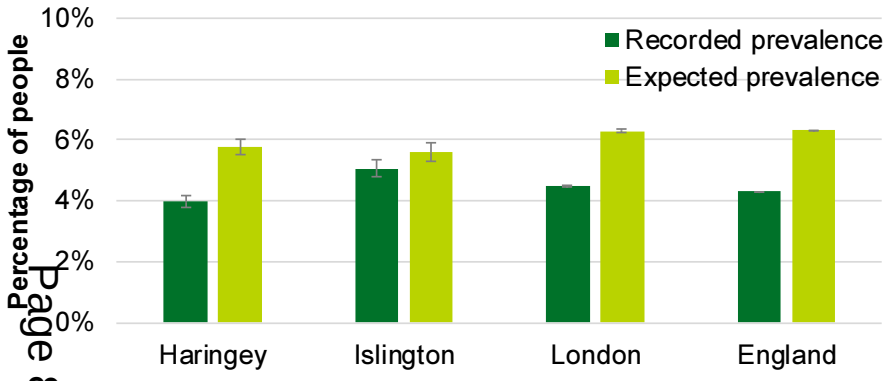
Islington has the highest prevalence of SMI in London (1.5%, N= 3,610), and Haringey has the 9th highest (1.3%, N=3,980). These are significantly higher than the London (1.1%) and England (0.9%) averages.

* includes schizophrenia, bipolar disorder or other psychoses, or patients on lithium therapy; Source: QOF, 2015/16

MENTAL HEALTH

Dementia

Recorded and estimated prevalence of dementia, 65+ years, 2017

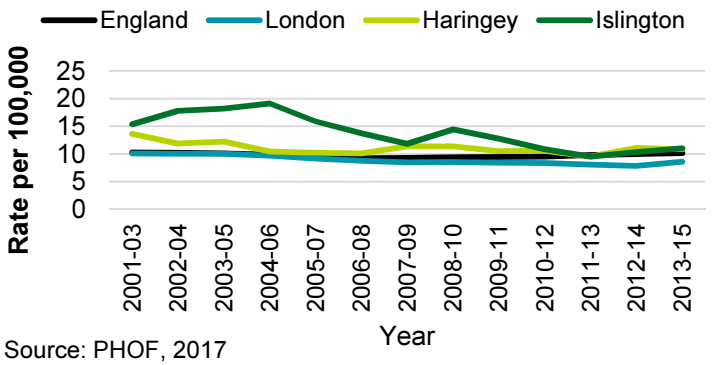


In Haringey there are an estimated 1,710 (5.8%) people aged 65 years or over are living with dementia. 69% of those are diagnosed, accounting for 4.0% of the elderly population aged 65+ (N=1,180).
In Islington 5.6% of the population aged 65 years or over are thought to have dementia (N=1,240). Most of them are diagnosed with dementia (5.1% of the population, N=1,120), leading to the highest dementia diagnosis rate (91%) in Islington among London boroughs, which is higher than both the London (71%) and England (68%).

Source: PHE Dementia profile, 2017

Suicide

Suicide: age-standardised rate, per 100,000 (3 year avg.), 2001-15

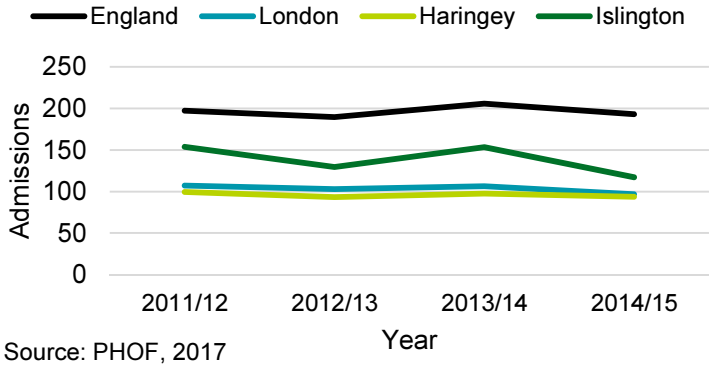


Source: PHOF, 2017

Islington's suicide rate has decreased substantially since a 2003-05 peak of 19 per 100,000 to 11 per 100,000 in 2013-15. Similarly, Haringey has decreased over the same time period and is now closer to the England average at 11.1 per 100,000.

Self-harm

Emergency Hospital Admissions for Intentional Self-Harm, per 100,000, 2011-15



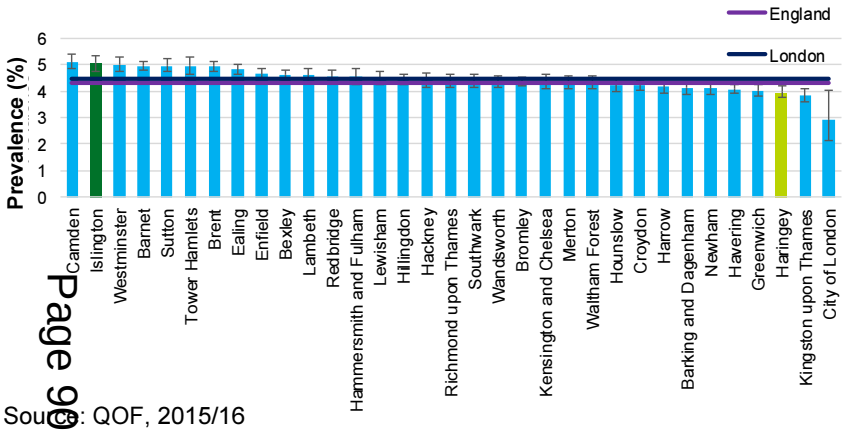
Source: PHOF, 2017

Haringey's self-harm admissions rate has remained steady since 2011/12 and remains significantly lower than the England average at 93.9 per 100,000. Islington's rate has fluctuated in recent years and remains significantly higher than both Haringey and London at 117.2 per 100,000

MENTAL HEALTH

Dementia – Prevalence & Diagnosis rate

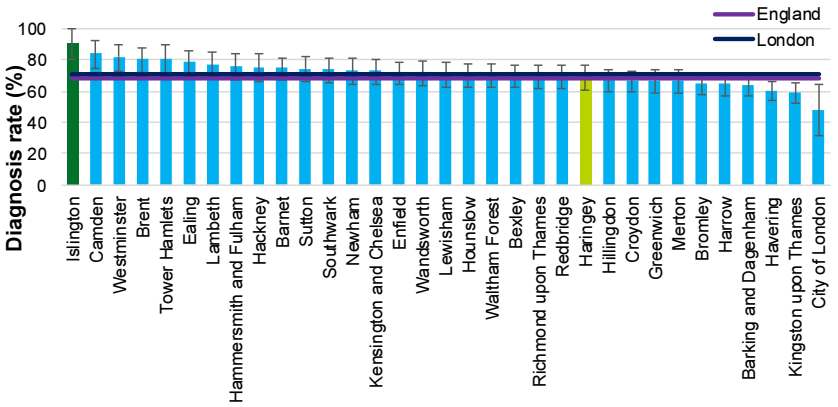
Dementia: Recorded prevalence (aged 65+), 2015/16



Islington has the 2nd highest dementia prevalence in London, at 5.1%. Haringey has the 3rd lowest prevalence in London, at 4.0%.

Source: QOF, 2015/16

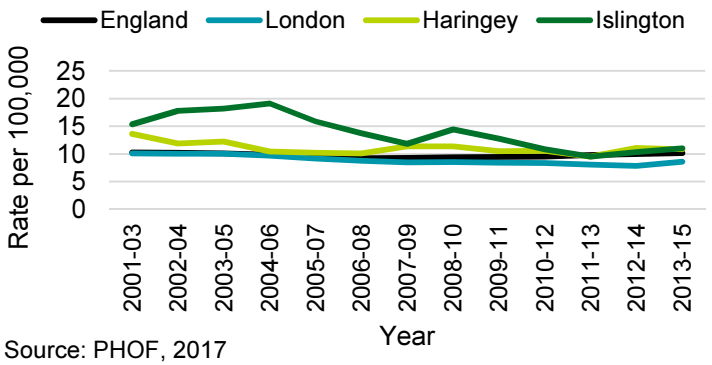
Estimated dementia diagnosis rate (aged 65+), 2017



Islington has the highest estimated dementia diagnosis rate in London, at 91%, significantly higher than London and England. Haringey is closer to the London average at 69%.

Suicide

Suicide: age-standardised rate, per 100,000 (3 year avg.), 2001-15



Source: PHOF, 2017

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Self-harm

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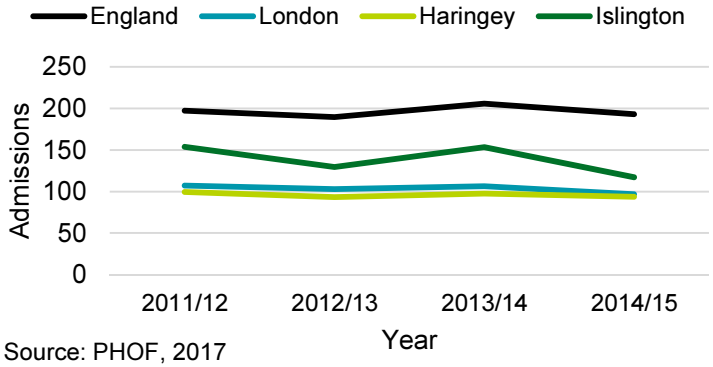


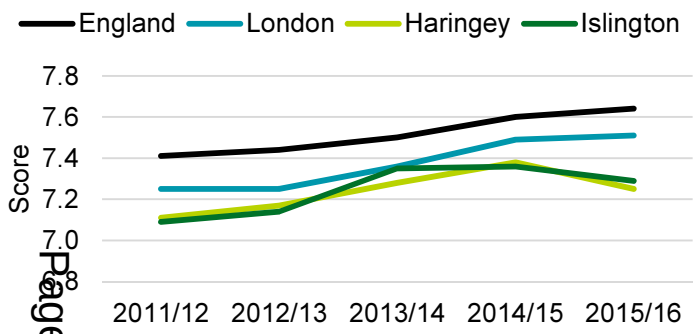
Source: PHOF, 2017

Haringey's self-harm admissions rate has remained steady since 2011/12 and remains significantly lower than the England average at 93.9 per 100,000. Islington's rate has fluctuated in recent years and remains significantly higher than both Haringey and London at 117.2 per 100,000

MENTAL HEALTH

Life satisfaction

Life Satisfaction – Mean score where 10 is highest, 2011-16

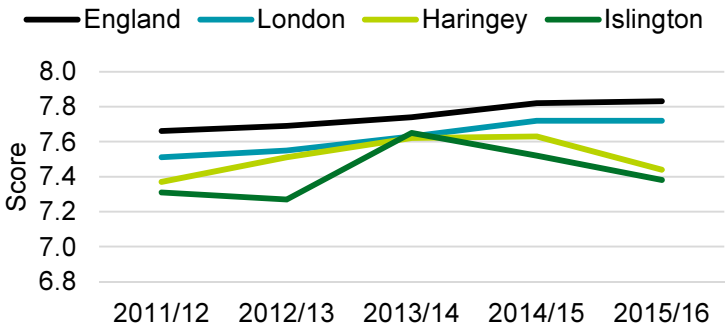


Source: ONS, 2017

Haringey and Islington have similar trends in life satisfaction (7.3), increasing slightly between 2011/12 and 2014/15 before decreasing in 2015/16. Haringey and Islington remain significantly lower than both London and England averages.

Worthwhileness

Worthwhileness – Mean score where 10 is highest, 2011-16

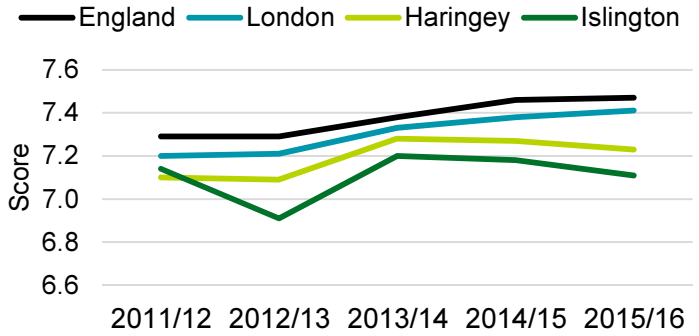


Source: ONS, 2017

Islington (7.4) and Haringey (7.4) have worthwhileness scores significantly lower than the London and England averages (both 7.8).

Happiness

Happiness – Mean score where 10 is highest, 2011-16

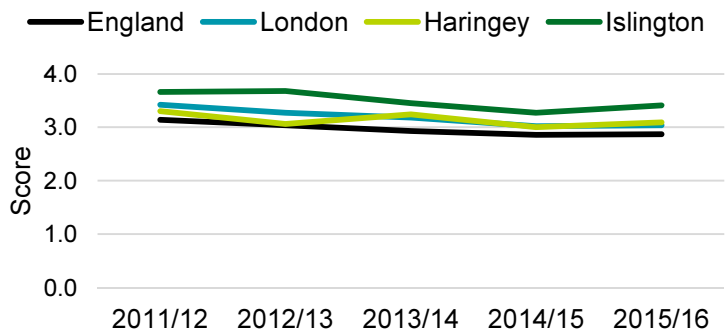


Source: ONS, 2017

Islington (7.1) has a significantly lower happiness score than Haringey (7.2). Both boroughs are currently significantly lower than the London and England averages (both 7.4).

Anxiety

Anxiety – Mean score where 10 is highest, 2011-16



Source: ONS, 2017

Haringey (3.1) has a similar anxiety score to the London and England averages (3.0). At 3.4, Islington has a significantly higher anxiety score.

ISLINGTON & HARINGEY JSNA

WIDER DETERMINANTS

Haringey LONDON ISLINGTON

Working in partnership

NHS Haringey Clinical Commissioning Group

NHS Islington Clinical Commissioning Group

WIDER DETERMINANTS

Housing

Overcrowded households, 2015/16

An estimated **18,100 households** in **Haringey** and **11,300** in **Islington** are overcrowded.

Source: 2011 Census, Department for Communities and Local Government, 2015/16

Households in temporary accommodation, 2015/16

Around **3,200 households** (28 per 1,000 households) in **Haringey** and **900 households** (9 per 1,000) in **Islington** are living in temporary accommodation. The rate is almost **double in Haringey** compared to **London** (15 per 1,000).

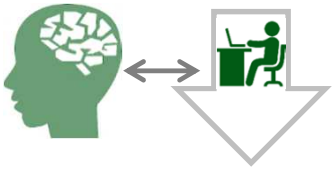
Source: PHE, 2017

Employment

Out-of-work benefit claimants, November 2016

About **one in ten people aged 16 to 64** years are claiming an **out-of-working benefit** in Haringey (9%) and Islington (10%). Islington has the **second highest** proportion of out-of-claimants in London (7%). Higher proportions of benefit claimants were found in BME groups, people with disabilities and lone parents.

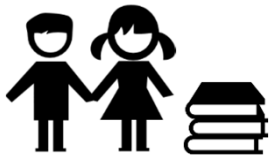
About 5,500 (3%) working age people in Haringey and 6,400 (4%) in Islington are on sickness / disability benefits due to mental illness, meaning **one-in-three out-of-work benefit** claims are due to **mental illness**.



Source: DWP, accessed the 7th of September 2017

Education

School readiness, 2015/16



72% of 5 year olds in **Haringey** and **66%** in **Islington** are reaching a 'good level of development' at the end of reception. It is significantly lower in Islington compared the London average (71%).

Young people not in education, employment or training, 2015

3.6% of **16-18 years** old in **Haringey** and **2.1%** in **Islington** are not in education, employment, or training. Compared to London (3.1%), the proportion is slightly higher in Haringey and lower in Islington. It has decreased in Islington, from 8.8% in 2012, while It has remained stable in Haringey.

Source: PHE, 2017

Violent crime

Violence offences, 2015/16

In 2015/16 almost 6,600 (**25 per 1,000 population**) violence against the person offences in Haringey and 6,030 (**27 per 1,000**) in Islington were recorded. The rates are higher compared to London (22 per 1,000) and England (17 per 1,000). **Islington** had the **second highest** violent crime rate among the London boroughs.

Sexual offences, 2015/16

In Haringey and Islington there were about 490 (**1.8 per 1,000 population**) and 430 (**2.0 per 1,000**) sexual offences recorded in 2015/16 respectively.

Domestic violence, 2015/16

In 2015/16, **22.5 domestic abuse**-related incidents and crimes **per 1,000 people aged 16 or over** were recorded in Haringey and Islington.

Source: PHE, 2017

FURTHER INFORMATION

About Islington and Haringey's JSNA

Islington Council's Evidence Hub brings together information held across different organisations into one accessible place. It provides access to evidence, intelligence and data on the current and anticipated needs of Islington's population and is designed to be used by a broad range of audiences including practitioners, researchers, commissioners, policy makers, Councillors, students and the general public: http://evidencehub.islington.gov.uk/jsna/Pages/default.aspx

Additional insight on Haringey's JSNA can found via the following webpage: http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment-jsna

This summary was produced by Mustafa Kamara (Public Health Analyst, Islington) James Barber (Senior Public Health Analyst, Haringey) Minkyoung Choi (Public Health Office, Islington) Sam Stevenson (Public Health Analyst, Haringey), reviewed and approved for publication by Mahnaz Shaukat (Head of Health Intelligence)

Contact: PublicHealth.Intelli@islington.gov.uk

Report for:	**Joint Health and Wellbeing Board Sub Committee**
Date:	**9 October 2017**
Title:	**Consultation on the Mayor's Health Inequalities Strategy**
Report Authorised by:	**Jeanelle de Gruchy, Director of Public Health (DPH) Haringey and Julie Billett, DPH, Camden and Islington**
Lead Officers:	**Jeanelle de Gruchy and Julie Billett**

1.0 Purpose

This paper notes the launch of the consultation on the Mayor of London's Health Inequalities Strategy. The Joint Health and Wellbeing Board is asked to consider the priorities set out in the strategy and discuss the opportunities to take action in support of the strategy.

2.0 Recommendation

The Board is asked to support the development of a joint Islington-Haringey response to the consultation, and to identify the key issues the Board wishes to highlight as part of that joint response. Specifically, the Board is asked to consider the consultation questions set out in section 3.2.

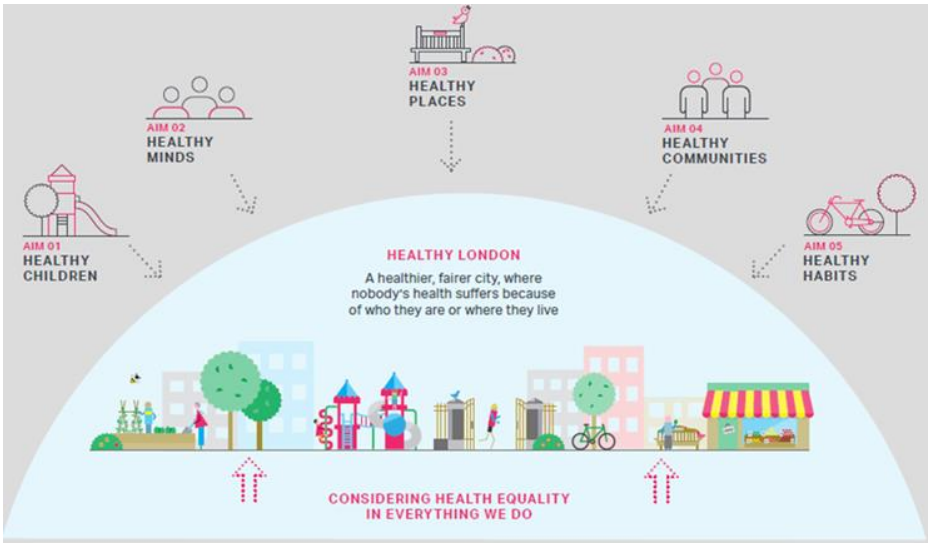
3.0 Background

The Mayor's Health Inequalities Strategy consultation launched on 23 August 2017 for a period of 3 months to November 30th. The health inequalities strategy is one of seven strategies that the Mayor of London is mandated by Parliament to develop. In developing these strategies, the Mayor must meet a set of specific statutory requirements to consider their impact on health, health inequalities, climate change and sustainable development, as well as meeting the public sector equality duty which applies to all of the GLA's functions.

The length of time that Londoners can expect to live in good health varies widely across the city. The overarching aim of the strategy is to end this unfair inequality whilst also improving the overall health of all Londoners.

3.1 Strategic Themes

To achieve its aim of ending unfair inequalities in health in London, the Health Inequalities Strategy consultation document has five key themes: Healthy Children, Healthy Minds, Healthy Places, Healthy Communities and Healthy Habits. These areas were agreed through a process of early engagement and consultation with a wide range of stakeholders. An overview of the strategy's aims and draft objectives is provided in Annex 1.



3.2 The consultation process and key questions

The deadline for the formal consultation process is 30th November. During this time, responses to the Mayoral strategy from partners and the public are being sought in a number of ways:

- Public engagement: e.g. through Talk London and a London.gov poll
- Feedback via an online consultation
- Engagement with statutory consultees
- Stakeholder engagement through attending existing meetings or bespoke workshops/events
- Working with partners to develop a set of indicators for monitoring progress.

This strategy aligns closely with the ambitions set out in other mayoral strategies, and where there are cross cutting issues, such as air quality, the GLA team is working closely with the respective policy leads across these various Mayoral strategies to ensure a coordinated approach to stakeholder consultation, as well as ensuring indicators/ metrics for monitoring progress are aligned between strategies where appropriate.

In considering the draft Health Inequalities Strategy, the consultation is asking partners and the public to consider the following questions:-

- Are the ambitions right?
- Is there more that the Mayor can do to reduce health inequalities in London?
- What can we do together that would reduce health inequalities in London?
- What support would you & your organisations need to do this?
- Are there any gaps in the strategy?
- What are the particular high priorities for your local communities?

Following analysis of the consultation responses at the end of November, the Mayor will publish a final health inequalities strategy and delivery plan, including a core set

of health inequality indicators. Through the consultation process, the mayor and GLA team are also hoping to collate any offers for action received from partners and stakeholders in support of the strategy, so that these can be reflected within the wider delivery plan.

4.0 Contribution to strategic outcomes

In Haringey and Islington, tackling inequalities in health is at the heart of our health and wellbeing strategies and partnerships. Deprivation and disadvantage is a major determinant of poorer health and shorter lives in both our boroughs, and there are significant inequalities across a wide range of health outcomes both between Haringey and Islington and the rest of London and England, but also significant within-borough inequalities as evidenced by our Joint Strategic Needs Assessment.

This consultation on the Mayor's health inequalities strategy provides the joint Health and Wellbeing Board with an opportunity to reflect on the major drivers of health inequalities at both a London level but also in our local communities, and the key priorities for action to address those inequalities and improve the length and quality of lives of all our residents.

Moreover, addressing the challenges set out in the strategy will require more than any one organisation can achieve in isolation. The strategy goes beyond the statutory duty of the Mayor and provides an opportunity for partners, organisation and individuals across London to come together to take action to reduce health inequalities.

5.0 Statutory Officer Comments (Legal and Finance)

Legal

The Mayor of London has a duty to promote a reduction in health inequalities, and to develop and lead a pan-London health inequalities strategy, working with partners such as Islington and Haringey Councils to implement the strategy (sections 309E and 41 of the GLA Act 1999).

Chief Finance Officer

There are no direct financial implications to Islington Council from implementing this strategy.

Any future action that Islington Council decides to take in order to further the strategic objectives set out in this report will need to be managed from within relevant existing budgets.

Any details relating to such actions will be assessed for financial implications as and when they arise.

6.0 Environmental Implications

There are several environmental implications of the work required to achieve the objectives in the Mayor's Health Inequalities Strategy related to both capital improvements and office work (energy/water/resource use and waste generation). However, the strategy also has several positive environmental implications, including improving air quality, encouraging walking and cycling, increasing greenspace, shade and shelter (which also contributes towards climate change adaptation), improving the energy efficiency of housing and reducing smoking rates (which in turn reduces litter).

7.0 Resident and Equalities Implications

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). This applies to the protected characteristics of age, disability, gender reassignment, marriage and civil partnership (only in regards to discrimination, harassment and victimisation), pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation.

The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

An Integrated Impact Assessment has been completed by the GLA for the Mayor's Health Inequalities Strategy. A local Resident Impact Assessment or equality impact assessment is not considered necessary at this time, as this report is concerned with developing a local response to a London-wide consultation. The proposals and priorities described in the strategy should have an overall positive impact on local residents' health and wellbeing, and on inequalities in health experienced by different population groups. Any future changes to local services and programmes that follow on from and are designed to align with and support delivery of the final Mayor's Health Inequalities Strategy, would be subject to a local resident impact assessment or equality impact assessment.

8.0 Appendices

Appendix 1 – overview of strategy aims

Appendix 2 – Health Inequalities Strategy slides

Appendix 1: Overview of strategy aims

AIM 1, healthy children: every London child has a healthy start in life

Draft objectives:

- London's babies have the best start to their life
- Early years settings and schools support children and young people's health and wellbeing.

Key Mayoral ambition:

- Launching a new health programme to support London's early years' settings, ensuring London's children have healthy places in which to learn, play and develop.

AIM 2, healthy minds: all Londoners share in a city with the best mental health in the world

Draft objectives:

- Mental health becomes everybody's business across London
- The stigma associated with mental ill-health is reduced, and awareness and understanding about mental health increases
- London's workplaces are mentally healthy
- Londoners can talk about suicide and find out where they can get help.

Key Mayoral ambition:

- To inspire more Londoners to have mental health first aid training, and more London employers to support it.

AIM 3, healthy place: all Londoners benefit from a society, environment and economy that promotes good mental and physical health

Draft objectives:

- Improve London's air quality
- Promote good planning and healthier streets
- Improve access to high quality green space and make London greener
- Address poverty and income inequality
- More Londoners are supported into healthy, well paid and secure jobs
- Housing quality and affordability improves
- Homelessness and rough sleeping is addressed.

Key Mayoral ambition:

- To work towards London having the best air quality of any major global city.

AIM 4, healthy communities: London's diverse communities are healthy and thriving

Draft objectives:

- It is easy for all Londoners to participate in community life
- All Londoners have skills, knowledge and confidence to improve health
- Health is improved through a community and place-based approach
- Social prescribing becomes a routine part of community support across London
- Individuals and communities supported to prevent HIV and reduce the stigma surrounding it
- TB cases among London’s most vulnerable people are reduced
- London’s communities feel safe and are united against hatred.

Key Mayoral ambition:

- To support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing.

AIM 5, healthy habits: the healthy choice is the easy choice for all Londoners

Draft objectives:

- Childhood obesity falls and the gap between the boroughs with the highest and lowest rates of child obesity reduces
- Smoking, alcohol and substance misuse are reduced among all Londoners, especially young people.

Key Mayoral ambition:

To work with partners towards a reduction in childhood obesity rates and a reduction in the gap between the boroughs with t