

HARINGEY COUNCIL



EQUALITY IMPACT ASSESSMENT FORM

Service: Health and Wellbeing

Directorate: Public Health/ Policy Intelligence and Partnerships

Title of Proposal: Health and Wellbeing Strategy

Lead Officer (author of the proposal): Jeanelle de Gruchy

Names of other Officers involved:

Helena Pugh

Alex Grear

Jodie Szwedzinski

Dr Nicole Klynman

Dr Fiona Wright

Susan Oti

Marion Morris

Chandreaa Bhattacharya

Step 1 - Identify the aims of the policy, service or function

1.1 Aims and objectives

This EqIA will look at the current health inequalities across Haringey in relation to the proposed outcomes and priorities identified in the draft Health and Wellbeing Strategy. It will seek to identify the gaps between the strands with regard to differing health issues and will then assess how the proposed strategic priorities will seek to address them.

1.2 Background

The [Marmot review](#); 'Fair Society, Healthy Lives', published in 2010, confirmed that health inequalities result from social inequalities and that action is required across all the wider determinants. The review identified the need for action to focus on reducing the gradient in health by focusing on those most in need.

In Haringey we have a strong commitment to promoting equality, tackling disadvantage and improving the life chances of our residents. We are aware that many factors combine to affect the health and wellbeing of individuals and communities. While health care services have an impact, other factors such as where people live, inherited characteristics, income, education, life experiences, behaviours and choices, along with relationships with friends and family, all have a considerable impact.

In Haringey, we believe that if we improve factors such as housing, nutrition, employment opportunities, community safety and citizenship for our residents and ensure optimal conditions are more equitably distributed across the borough then we can help everyone have the best possible chance of a healthy, safe and fulfilling life.

We have identified the key strategies that we feel will help us achieve this. Whilst not explicitly focusing on the improvement of health and wellbeing, they do all contribute to wider determinants essential to achieving our health and wellbeing objectives.

1.3 Purpose of the Health and Wellbeing Strategy 2011-2015

The Health and Wellbeing Strategy will use an evidence based approach to target resources to tackle health inequalities across Haringey.

We understand that there is a social gradient in health – the lower a person’s social position, the worse his or her health - we need to take action which focuses on reducing this gradient. By focusing solely on those who are most disadvantaged, we will not reduce health inequalities for all. Our actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Marmot calls this proportionate universalism’.

The strategy focuses on addressing areas of greatest need, delivering both universal and targeted actions to achieve greatest impact on the social gradient in health.

This strategy focuses predominantly on the health and social care related factors that influence people’s health and wellbeing. We understand how important the underlying determinants of health and wellbeing are in ensuring ‘*A Healthier Haringey*’; these are addressed through other key partnership strategic documents.

1.4 The Outcomes and Priorities

The strategy, developed by Haringey’s shadow Health and Wellbeing Board, is the single statutory, overarching plan setting out our approach to improving the health and wellbeing of children and adults, and reducing health inequalities between the east and west of the borough.

The vision of this strategy is:

A Healthier Haringey – We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life.

Informed by our Joint Strategic Needs Assessment (JSNA) www.haringey.gov.uk/jsna and in consultation with residents, strategic partners and other stakeholders, we have identified the delivery of three outcomes and related priorities to achieve our vision.

Outcomes	Priorities
1. Every child has the best start in life	<ul style="list-style-type: none"> 1. Reduce infant mortality 2. Reduce teenage pregnancy 3. Reduce childhood obesity 4. Ensure readiness for school at 5 years
2. A reduced gap in life expectancy	<ul style="list-style-type: none"> 5. Reduce smoking 6. Increase physical activity 7. Reduce alcohol misuse 8. Reduce the risk of cardiovascular disease (CVD) and cancer 9. Support people with long term conditions (LTCs)

3. Improved mental health and wellbeing	10. Promote the emotional wellbeing of children and young people
	11. Support independent living
	12. Address common mental health problems among adults
	13. Support people with severe and enduring mental health needs
	14. Increase the number of problematic drug users in treatment

Step 2 - Consideration of available data, research and information

In considering the impact of the proposed strategy, analysis has been broken down into the three proposed outcomes. Further data on health and wellbeing is included in the Health and Wellbeing Strategy (<http://www.haringey.gov.uk/hwbstrategy>) and the Joint Strategic Needs Assessment (www.haringey.gov.uk/jsna).

Outcome 1: Every Child has the best start in life

Priority 1: Reduce infant mortality

The infant mortality rate in Haringey for 2007-2009 is 4.8 per 1000 live births. Rates in Haringey are slightly higher than for England and London, although the difference is not statistically significant. There has been a steady decline in the infant mortality rate in Haringey from a peak of 8.1 deaths per 1000 live births in 2003-05. Our interventions need to be both universal, as well as targeted at women from Black African communities, as women from these communities are disproportionately represented in terms of infant deaths in Haringey.

Access to maternity care

Early booking to maternity care enables all women to be offered appropriate screening tests as well as receiving health promotion advice and information. Although this is a universal action, it is particularly important for socially excluded and vulnerable women. We need to do further targeted work to encourage those who fail to register early for maternity care.

Haringey Public Health's Health Equity Audit 2010 suggests that Black African women and those young women aged under 20 tend to book late for maternity care. Women under 20 are the least likely to book before 13 weeks (39%) and most likely to book after 22 weeks (23%).

In Haringey, whilst the proportion of White British women who book after 22 weeks is as low as 4.5%, for Black African women it is 12.2%.

Breast feeding

Breastfeeding rates are [higher than the national average, but are] considerably lower in the east of the borough. Targeted work is being undertaken by the Family Nurse Partnership (FNP) who are running an intensive evidence based support programme for first time mothers under 20 years of age until their child is aged 2 years old. This is a group that has been identified as having a lower uptake of breastfeeding. The FNP Annual Report 2012 showed a high ethnic diversity, 40% of clients were Black, 32.5% were White and 15.6% were of mixed heritage. The 2012 Annual Report shows high rates of both breastfeeding initiation (94.6%) and breastfeeding at 6 weeks of infancy (68.4%). The FNP team work closely with the Haringey Infant Feeding Co-ordinator undertaking joint visits and encouraging clients' attendance at breastfeeding cafes across the borough. Several clients have recently agreed to undertake training to become breastfeeding mentors for other young people. Breast feeding support will

be given across Haringey but particularly targeted to children's centres, located primarily in the east of the borough, where breast feeding rates are low.

Smoking in pregnancy

Evidence shows smoking in pregnancy increases infant mortality by about 40%. Nationally smoking in pregnancy is 1.5 times higher in women in the Routine & Manual group than the population as a whole and nearly three times higher among mothers under 20 years of age. Reducing smoking in pregnancy is a key outcome identified within the FNP and shows 2% reduction in the number of young women smoking between intake and 36 weeks. Of those who are still smoking at 36 weeks, 33.3% of them report that they are smoking fewer cigarettes. During Q2 2010/11 in Haringey, the percentage of mothers smoking at delivery was 6%. We need to target all women who smoke in pregnancy to reduce the risk of adverse events in pregnancy.

Priority 2: Reduce teenage pregnancy

Following significant decreases in 2008 and 2009, the teenage pregnancy rate increased in 2010 and at 64.7 per 1000 women aged 15-17 was the highest rate in England (England and Wales rate is 35.5 per 1000). Positively, Haringey's under-16 conception rate decreased to its lowest rate. Teenage pregnancy is significantly higher in the east of the borough, in particular in Tottenham Hale, St Ann's and Harringay wards. Local data on under 18 conceptions (from live birth notifications and abortion provider) collected by public health suggests that in 2009 and 2010, the highest number of girls becoming pregnant were White British, followed by Black Caribbean and 'Other ethnic' group. There appears to be an over-representation in Black Caribbean and 'Other ethnic' group compared to the proportion of these groups in the 0-19 year old population. According to the census, Black Caribbean make up 10.4% of the under 20 year old population whilst the proportion of abortions in this age group where ethnicity is known is 14.7%. All young women under the age of 25 will continue to have access to emergency hormonal contraception in community pharmacies. Targeted strategies will include working with schools in areas of high teenage pregnancy rates.

Priority 3: Reduce childhood obesity

Obesity is closely linked to ethnicity. Children from Black and minority ethnic (BME) groups are more likely to be obese than children that are White British. In 2011, in Haringey, out of 2477 children measured in Reception 4.7% of White British are obese compared to 15% of Black Caribbean children. In Year 6 out of 2150 children measured, 8.5% for White British and 30% of Black Caribbean are obese. Rates are also high in other Black groups in Haringey. Haringey has a high population of children of Black ethnic origin, which may disproportionately affect the number of children defined as obese. (Black ethnic origin is meant to include all Black ethnic groups).

Other ethnic groups that have high levels of obesity are the Other White population, which for Haringey includes our Turkish and Cypriot communities and other white ethnic groups.

Obesity levels increase with age. In 2011 in Haringey, 10.1% of reception year children measured are obese. This increases to 21.1% by year 6. From the National Child Measurement Programme (academic year 2010-11) in Haringey we know that a higher proportion of children are obese and overweight in reception in Haringey than England as a whole.

Obesity levels vary between sexes. The gap between boys and girls appears to widen with age. At reception there is a 2.5% gap between boys (11.7% are obese) and girls (9.2% are obese) which increases to 3.5% at year 6 (23.2% for boys and 19.7% for girls). Both universal and targeted interventions are needed to address the rising obesity levels.

Priority 4: Ensure readiness for school at 5 years

Evidence collected by Ofsted for a recent national report on the impact of the Early Years Foundation Stage (EYFS) indicates that it has had a positive impact on children's attainment at age five. Haringey results in the Foundation Stage in 2011 improved significantly in all areas assessed, including personal, social and emotional development (PSE) and communication, language and literacy (CLL). Overall results for the percentage of children attaining a good level of development increased from 42% to 54%. (Good level of development is scoring 6 or more in each area of CLL and PSE with a total of 78 point or more across all areas).

There remain, however, significant differences in attainment in the EYFS between children eligible and not eligible for free school meals (59% not on FSM achieve a good level compared to 44% of FSM). Schools and settings in the borough are divided into 3 networks, north, south and west. The percentage of children attaining a good level of development in the north is 47%, south 48% and west 64%.

There are also differences between ethnic groups. 71% of White British children are attaining a good level of development compared to 52% of Caribbean, 30% Kurdish, 35% Turkish and 48% African children.

Girls outperform boys in all areas of the Foundation Stage both nationally and in Haringey and the gender differences in Haringey are similar to national differences. This may well be linked to levels of maturation at this early age and we need to be careful not to view this as necessarily a deficiency in the boys' levels of attainment.

Outcome 2: A reduced gap in life expectancy in Haringey

Priority 5: Reduce smoking

Smoking, and tobacco consumption is the UK's greatest cause of preventable illness and early death. It is also the primary reason for the gap in life expectancy between socio-economic groups. There is a strong link between smoking rates and deprivation. If men aged 35-69 in social class V (unskilled groups) had the same smoking rates as those in social class I (professionals), and then half of the inequality in mortality would disappearⁱ.

In 2003-2005 Haringey had a predicted prevalence of current smoking of 23.5% (95% confidence interval), compared with 23.3% in London and 24.1% in England. However, smoking prevalence of between 29% and 33% were predicted in the east of the borough including Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

The "London Boost" (2006) for the Health Survey for England modelled smoking prevalence as 28.6% males and 24.2% females in Haringey compared to 25.3% for males and 18.8% for females in London.

Nationally certain groups have high rates of tobacco use and higher nicotine dependence including some specific ethnic groups e.g. Turkish, Bangladeshi, Irish menⁱⁱ.

Between the ages 16-34 there are higher numbers of smokers in Haringey (27.6%) than London (25.1%). The highest prevalence is in the 35-54 age group.

Amongst people with mental health problems, nationally the prevalence of smoking is estimated to be approximately 70% and for hard-drug users the figure is 'practically 100%'.

Nationally, almost half of all teenage mothers smoke during pregnancy and 55% of single mothers.

35.9% of routine and manual workers are smokers, compared to 21.3% of managerial and professional workers.

Universal measures to address smoking in public places such as parks will be undertaken together with more targeted work in particular areas or population groups.

Priority 6: Increase physical activity

The risk of premature death amongst physically active adults is reduced by 20%-30%, and the risk of developing major long term conditions such as coronary heart disease (CHD), stroke, diabetes and cancers are reduced by up to 50%ⁱⁱⁱ. The strong evidence for physical activity has led to physical inactivity being recognised as a major modifiable risk factor for CHD^{iv}.

In 2006 in England, 40% of men and 28% of women achieved the recommended physical activity levels. In Haringey 21.5% of adults participated in sport and active recreation at a moderate intensity equivalent to 30 minutes on 3 or more days a week. Activity levels have not changed in recent years.

Physical inactivity contributes towards obesity. In Haringey in 2006, 37.7% of men and 26.0% of women are overweight and further 12.7% men and 14.5% women are obese (2006 Health Survey for England London Boost). Children who are overweight are much more likely to be overweight as adults and experience health problems^v. The most significant predictor of childhood obesity is parental obesity^{vi}.

Younger people are generally more active than their older counterparts. Older people are disproportionately more likely to be overweight or obese. About 27.4% of all older people aged 65 and over in Haringey are classified as obese (POPPI, 2009), with a body mass index (BMI) above 30.

National trends are similar in Haringey for levels of physical activity: younger people are more active than their older counterparts; men are more active than women; white adult populations are more active than non-white adults. Activity levels are lower in those who have a limiting illness or disability.

Within Haringey, people in the lower socioeconomic groups (NS-SEC 5, 6 7 and 8) are less active than those in the higher socioeconomic groups (NS-SEC 1 and 2), at levels of 16.3% and 26.3% respectively. Targeted work will be undertaken to address people from lower socioeconomic groups who may have less access to physical activity.

Priority 7: Reduce alcohol misuse

Harm due to alcohol is considerably more apparent in more deprived groups. The most deprived fifth of the UK population suffer two or three times greater loss of life attributable to alcohol, three to five times greater mortality due to alcohol-specific causes and two to five times more admissions to hospital because of alcohol than wealthy areas^{vii}. The inequality ratio is most apparent in men^{viii}.

Haringey's alcohol related hospital admissions rates have tripled in the period 2002/03 - 2010/11 for men and women). This includes admissions that are partially attributable to alcohol, such as hypertension, and those that are 'wholly' attributable to alcohol e.g. ethanol poisoning.

Middle aged and older men make up the majority of alcohol related hospital admissions. Alcohol admissions in the under 18's account for a small percentage of overall admissions,^{ix} (55 between 2006/07-2008/9.)

Crude rates for ethnicity indicate: White British, African Caribbean and 'any other white' men are most represented in alcohol related hypertension admissions. White British, any other white and Irish men most represented in alcohol specific mental and behavioural disorders. Apart from 'any other ethnic group' Irish men had the highest wholly attributable rate of admissions^x.

Alcohol misuse comes in many forms and affects population groups in different ways. Universal measures, through primary care and community settings, ensure that adequate advice is given to all group. A targeted approach is needed to address particularly communities within the White British category, such as the Irish and Polish.

Priority 8: Reduce the risk of cardiovascular disease (CVD) and cancer

The diseases most responsible for the life expectancy gap in Haringey are cardiovascular disease (CVD) (which includes heart disease and stroke) (28%) and cancers (25%). Reducing inequalities in CVD and cancer mortality in adults (particularly men over 40) will have the greatest impact on reducing inequalities in life expectancy in Haringey. Smoking, physical inactivity, obesity, poor nutrition and alcohol are important risk factors^{xi} for cardiovascular disease and cancers, and are demonstrated through a social gradient across socio-economic groups.

Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 years and over is expected to increase in Haringey from 18.3% to 20.6% for males and increase from 20.0% to 20.9% for females by 2030. Certain ethnic groups have a higher risk of CVD. South Asian people living in the UK are one and a half times more likely to die from CHD before the age of 75 than the rest of the UK population, these groups need to be particularly targeted through community services to ensure adequate detection of early disease. After smoking, the biggest impact on inequalities in mortality is late diagnosis of cancer. Nationally incidence and mortality from cancer increases with age and men are at a higher risk and more likely to die than women. Also overall incidence of cancer in the minority ethnic groups is lower than the White British population. However certain ethnic groups are at high risk of specific cancers e.g. Black African and Black Caribbean men have higher incidence of prostate cancers.

Priority 9: Support people with long term conditions (LTC)

In Haringey, the long term conditions (LTC) that contribute to the life expectancy gap are CVD, cancer, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and diabetes. An estimated 74% of over 65s registered with a GP have a LTC equating to 18,909 people. These diseases are more common among people from lower socio-economic groups and certain Black and minority ethnic (BME) groups.

In people under 75 years of age, men are more likely to have a stroke than women. Those most likely to have a stroke are Asian, Black and mixed ethnic groups. Age is a key factor in diabetes prevalence. Type 1 diabetes tends to be diagnosed in childhood but the prevalence of Type 2 diabetes increases steadily after the age of 45 years. Compared to the general population the following groups have increased risk: Black Caribbean males (twice the risk), Black Caribbean females (three times the risk), Pakistani females (five times the risk) and Bangladeshi women (three times the risk). Haringey has much higher proportions of minority ethnic groups than England, especially in the east of the borough. Recorded prevalence of COPD is higher in east of Haringey. Smoking is closely linked to both the development and prognosis of COPD. Irish and Bangladeshi men have higher smoking levels than the general population. Programmes such as NHS Health Checks, work primarily in the east of the borough which will target many of the BME groups who are at higher risk of long term conditions.

Outcome 3: Improved mental health and wellbeing

Priority 10: Promote emotional wellbeing of children and young people,

Of the 43,000 children aged 5-16, an estimated 2,534 children have mental health problems. Overall, there is evidence to suggest that many forms of mental health problems in young people are becoming more frequent.

Studies have found nationally boys account for over 64 per cent of all children aged 5 to 16 years old with a mental health problem^{xii}. In Haringey, it is predicted in 2010 that there were 688 boys aged 5-10 years and 940 aged 11-16 years with mental health problems. There were less girls, 388 aged 5-10 years and 514 aged 11-16. Actions to improve this have not been identified in the EQIA actions because we need to take a universal approach to improve the emotional health and well being of children through offering parenting programmes to support parents; ensuring good nursery placements that support children and families and encouraging supportive environments in schools through the Healthy Schools Programme.

Boys were found to be more likely than girls to have a conduct or hyperkinetic disorder and girls were more likely to suffer from emotional disorders. 1.9 per cent of children have more than one diagnosis.

In Haringey children aged 11-16 from Black ethnic groups have a higher prevalence of mental ill-health than other groups. There were a total of 915 referrals to Child and Adolescent Mental Health Services (CAMHS), a decrease of 11 per cent on the previous year out of which 474 were females and 441 were males.

Children who suffer mental ill-health as a child may continue to have mental health problems as an adult. Some mental health problems may be triggered by circumstances in childhood and may be difficult to completely eradicate. These children may grow up with poor employment opportunities, poor housing and generally reduced levels of wellbeing. Other children may find that with treatment and improved levels of wellbeing, their mental illness resolves entirely.

All services we commission must have good outcomes in terms of mental health and wellbeing of children. Children will receive targeted interventions when we know there is an increased likelihood of the development of mental health problems.

Priority 11: Support independent living

In 2010/11 there were 5,374 adults, aged 18 years and over in Haringey, who used social care services. There were 2,390 adults receiving services aged 18-64 years and 2,984 aged 65 years and over. The population of Haringey is expected to increase in age over the next 25 years, to 24,200 people aged 65 and over which is likely to impact on social care services.

By far the largest client group is women aged over 65 years who are frail with a physical and/or sensory impairment. There are less men aged 65 years and over in the same category, reflecting Haringey's life expectancy profile with women living longer than men.

There are a disproportionate number of BME adults receiving social care services, compared to the rest of the population (1,435 Black or Black British, 888 of which were Caribbean).

In 2010/11 there were 555 adults with learning disabilities, 540 adults with a physical disability or a sensory impairment, and 1,012 adults with mental health needs receiving social care services.

Carers

15,967 people in Haringey identify themselves as unpaid carers, representing 7.4 % (1 in 13) of the usual resident population. 3,232 (20%) provide care for 50 or more hours a week; 10,637 (67%) provide care for 1-19 hours a week (2001 Census).

Men make up 41% of carers and women 59% compared with a male to female ratio of 48:52 for all people in the borough.

Women undertake a larger volume of caring:

- Of those who care 1-19 hours, 57% are women and 43% are men
- Of those who care 20-49 hours, 60% are women and 40% are men
- Of those who care 50 or more hours, 66% are women and 34% are men

From census data, the peak age for caring in Haringey is between 35-49 years. In overall terms, Haringey carers are younger and in comparison Haringey has the most young adult carers aged 18-34 years.

The White British ethnic group is over represented as carers. 47% of carers identified with the White British ethnic group, compared with 45.3% of all residents. The Indian ethnic group is also over represented as carers. 5% of carers identified with the Indian ethnic group, compared with 2.9% of all residents.

Priority 12: Address common mental health problems among adults

Local socio-economic factors are likely to have an adverse effect on the mental health of the population and a greater effect on black and minority ethnic (BME) groups in the area who live in more deprived conditions on the whole. It is estimated that 55% of Haringey's 228,000 residents come from a BME background and that one in four patients come from a BME group.

Up to 1 in 4 people will experience mental health problems at some point in their lives, with approximately one in six suffering from mental health problems at any one time.^{xiii} In Haringey,

there are an estimated 34,500 people with common mental health problems (mainly anxiety and depression) – higher than the national average.^{xiv} As of March 2011, there were 15,056 people registered with a GP, with a diagnosis of depression; of these 3,660 were in the west collaborative while 11396 were in the central, north east and south east collaboratives. This reflects the higher level of deprivation in the east and that groups at higher risk of mental health problems are more likely to live in the east – those without employment, people from BME communities, long term carers, and people living in houses of multiple occupancy, asylum seekers and refugees, victims of abuse (including domestic violence).

Women represented 69% of referrals to Improving Access to Psychological Therapies programme (IAPT), while men accounted for 31%. This may reflect the fact that women are more likely to seek help from primary care or self-refer for IAPT than men. Depression and anxiety are also more common in women than men. Roughly 60% of IAPT referrals are from those that describe themselves as 'British'. The remaining 40% of referrals come from 111 different nationalities. Over 50 languages are identified as the main spoken language of IAPT referrals. Other than English, the next commonest spoken language is Turkish (10.3% of referrals). From the Haringey Joint Strategic Needs Assessment, 11.9% of the population describes themselves as 'White British', the majority of which are Turkish/Kurdish. It is likely that the high levels of IAPT referrals from these ethnic groups represent the ethnic mix of the population. Data from the IAPT service is monitored using a national database, changes to the demographic profile of clients are reviewed on a regular basis.

Poor housing or homelessness can contribute to the development of mental health problems or can make existing mental health problems more difficult to manage. In 2010/11, 34% of homeless applicants accepted by Haringey Council were in 16-24 year olds. Further work needs to be undertaken to understand the demographics and ethnicity of these applicants so that targeted work can try to support people in housing difficulties.

Priority 13: Support people with severe and enduring mental health needs

In Haringey, high levels of psychotic disorders are concentrated in the east of the borough. Patients from Black or Black British ethnic groups account for 20% of the population but represent 46% of all admissions for schizophrenia and 39% of all admissions for bipolar disorder. It is likely that both dementia and common mental illnesses (particularly depression) are under-diagnosed both indigenous and Black and minority ethnic groups (BME).

It is estimated in 2010 there were 22,100 people aged 65 years and over of which 42% were men and 55.2% were women. The population profile of east and west Haringey is different, with west Haringey having a greater proportion of older residents. As a consequence, there are more people with dementia, predominately a disease that occurs in people over the age of 65 years. Primary care services in the west of the borough are aware of the demographics of their practices and endeavour to refer patients to memory clinics if appropriate.

Some BME groups have a higher risk of psychotic conditions such as schizophrenia with 46% of admissions being among Black residents compared to 41% in White residents. Some people from BME groups are diagnosed late with mental health problems due to a range of social and cultural factors. As a result, the mental illness may become more severe leading to increased hospital admission or even suicide. Unfortunately ethnicity is not recorded on suicide data however we are able to monitor ethnicity among mental health admissions to hospitals. Further work is being undertaken to reduce stigma in BME groups and support early diagnosis and treatment.

Priority 14: Increase the number of problematic drug users in treatment

The highest concentration of drug treatment and dual diagnosis (a term which is used to describe co-existing mental health and substance misuse problems) population is found in the east of the borough. The three super output areas with highest density of overall treatment population are in Seven Sisters, Bruce Grove and Northumberland Park wards (2009-10). Some of the highest density areas are similar to those identified by the vulnerable localities index⁽ⁱⁱⁱ⁾ which combines a variety of data sources from burglary to educational attainment, as well as indices of income deprivation.

In terms of ethnicity, dual diagnosis was most prevalent amongst White British, Caribbean, and other white and Black African. A larger proportion of clients who are referred from criminal justice system have a dual diagnosis, 25% in comparison to, for example, self referrals at 14%. People with dual diagnosis were less like to be in regular employment in comparison to the overall drug treatment population; 4% against 12% respectively. Overall, in 2009-10 67% of the drug treatment population were unemployed. Services have been particularly targeted to areas with the highest prevalence of drug use, informed by annual drug needs assessments.

Reasons for inequality

The reasons for health inequalities are varied and complex. Much research has been undertaken to determine the causes of health inequalities, most recently the **Marmot review** in 2010, '[Fair Society, Healthy Lives](#)'.

This review proposed evidence-based strategies for reducing health inequalities including addressing the social determinants of health in England, from 2010. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are the fundamentals for improving quality of life and reducing health inequalities. We understand that, to address health inequalities we need to improve opportunities for all our residents with a focus on those who are experiencing poverty and deprivation.

We in Haringey endorse the following from the [Marmot Review](#) 2010:

- to create an enabling society that maximises individual and community potential
- to ensure social justice, health and sustainability are at the heart of all policies.

In Haringey, we will ensure that all these principles are used in all strategies produced by the Council. This approach does not just encompass health but includes the wider determinants of health such as education, housing, employment etc.

'Focusing solely on those who are most disadvantaged will not reduce inequalities sufficiently. To reduce the steepness of the social gradient, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this 'proportionate universalism'.

'For specific groups who face particular disadvantage and exclusion, additional efforts and investments and diversified provisions will be needed to reach them and to try to reduce the multiple disadvantages they experience.'

Gaps in data

There are some gaps in the data for the protected characteristics as the data is not currently routinely collected. These include data on gender reassignment, and marriage and civil partnership. Some data is collected on sexual orientation, religion (or belief) and disability depending on the relevance to the specific service however we need to improve data collection for these protected characteristics both for existing services and for newly commissioned services. Further work needs to be undertaken to understand if further data needs to be collected for existing services and also to identify ways to incorporate this knowledge into service planning and commissioning.

In the protected characteristics where data is routinely collected, we need to improve the data recording so that all data is complete, accurate and timely. We already commission services based on our knowledge of the population need, as identified by the Joint Strategic Needs Assessment and need to further identify ways to incorporate our knowledge of population need into the commissioning process.

Step 3 - Assessment of Impact

How does your proposal affects existing barriers?

What specific actions are you proposing in order to reduce existing barriers and imbalances you have identified in Step 2?

The purpose of the Health and Wellbeing Strategy is to reduce health inequalities. The EqIA shows that all the proposed Health and Wellbeing Strategy objectives and priorities are likely to overall reduce the barriers for protected groups.

The table below outlines a summary of the evidence/rationale for selecting the priorities, key 'general' actions to deliver the priorities that will be incorporated into the forthcoming delivery plan and an assessment of the impact on the protected characteristics.

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
Outcome 1: Every child has the best start in life			
Priority 1: Reduce infant mortality	<ul style="list-style-type: none"> Statistics show interventions need to be targeted at women from Black African communities in particular, as women from these communities are disproportionately represented in terms of infant deaths in Haringey. Breastfeeding rates are considerably lower in the east of the borough. Black African women and those aged under 20 years old tend to book late for maternity care. 	<ul style="list-style-type: none"> Train frontline staff in the prevention of sudden unexpected death in infancy. Provide specialist breastfeeding support groups and offer antenatal booking appointments in the majority of our children's centres. Improve early access to maternity services in particular among Black African communities. 	<p>The targeted action to improve access to maternity services for Black African women will be based on the findings from the 2011 Health Equity Audit and the local research report 'Early Access to Full Assessment – Black Africans in Haringey'. Following consideration, the Health and Wellbeing Board will recommend actions to improve outcomes that will be detailed within the HWB Delivery Plan</p> <p>Breastfeeding support in children's centres is likely to improve breastfeeding rates overall. Those children's centres in the east of the borough and in the wards where breastfeeding rates are low will be the focus for activity.</p>
Priority 2: Reduce teenage pregnancy	<ul style="list-style-type: none"> The rate of teenage conceptions is significantly higher in the east of the borough compared to the west. Teenage pregnancy is significantly higher in the east, in particular in Tottenham Hale, St Ann's and Haringay wards. Local data on under 18 conceptions (from live birth notifications and abortion provider) collected by public health suggests that in 2009 and 2010, the 	<ul style="list-style-type: none"> Ensure young women under 25 have access to free emergency hormonal contraception in community pharmacies. Involve young people in devising a new communication campaign integrating teenage pregnancy, sexual health, substance misuse and domestic violence. Promote sex and relationship education (SRE) through/the Healthy Schools programme. Continue the 4YP service (a young people-friendly 	<ul style="list-style-type: none"> Pharmacies in the east of the borough will continue to be supported in offering the service. Involving young people in developing the communication campaign is likely to improve health outcomes Schools in areas where there

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
	<p>highest number of girls becoming pregnant were White British, followed by Black Caribbean and 'Other ethnic' group.</p>	<p>sexual health service) in a range of school-based and non-healthcare settings for young people under 25.</p>	<p>are high teenage pregnancy rates will continue to be targeted to improve outcomes</p> <ul style="list-style-type: none"> The 4YP service improves accessibility to sexual health services for young people under 25 and is likely to continue to improve outcomes
<p>Priority 3: Reduce childhood obesity</p>	<ul style="list-style-type: none"> 4.7% of White British children in reception year are obese compared to 15% of Black Caribbean children. By Year 6 obesity levels are 8.5% for White British children and 30% for Black Caribbean children. Haringey has a high population of children of black ethnic origin, which may disproportionately affect the rate of children defined as at risk of obesity. (Black ethnic origin is meant to include all Black ethnic groups). 	<ul style="list-style-type: none"> Continue the annual National Child Measurement Programme (NCMP). Raise awareness through the 2012 Director of Public Health Annual Report and through a resident debate. End the sale of fizzy sugary drinks and junk food from all Council premises; encourage schools to do the same. Explore all planning avenues to reduce the proliferation of fast food outlets in the borough and work with existing outlets to make their food healthier. Support schools to maintain their Healthy Schools status and achieve an enhanced Healthy Schools status with a focus on childhood obesity. Offer training to school nurses and other school staff on how to recognise child obesity and how to raise the issue with families in a sensitive way. 	<ul style="list-style-type: none"> No change as the NCMP is an annual survey and will continue to provide surveillance data to monitor childhood obesity across the borough The DPH annual report and the resident debate are likely to contribute to improve outcomes as the population will have the opportunity to shape future programmes Ending the sale of fizzy drinks and junk food in council premises is likely to contribute to improved outcomes Reducing the proliferation of fast food outlets is likely to improve outcomes Supporting schools with the evidence based Healthy

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
			<p>Schools Programme is likely to improve outcomes</p> <ul style="list-style-type: none"> The training programmes are likely to improve outcomes as health staff and other professionals can target their support to those in need
<p>Priority 4: Ensure readiness for school at 5 years</p>	<ul style="list-style-type: none"> 71% of White British children are attaining a good level of development compared to 52% of Caribbean, 30% Kurdish, 35% Turkish and 48% African children. Girls outperform boys in all areas of the Foundation Stage both nationally and in Haringey and the gender differences in Haringey are similar to national differences. 	<ul style="list-style-type: none"> Continue to provide the full offer of the Healthy Child Programme (HCP) (a prevention and early intervention programme focused on pregnancy and the first five years of life) to families defined as vulnerable; and work to extend the programme to all children under 5 and their families. Work in partnership with the Whittington Health Early Implementer Site for health visiting to increase the health visiting workforce; ensure this programme is aligned with the new Children's Centre service offer. 	<ul style="list-style-type: none"> The evidence based Healthy Child Programme is likely to improve outcomes The Department of Health Early Implementer Site programme is likely to improve outcomes Existing programmes are to be targeted at BME groups achieving low PSE scores. Decisions regarding the prioritisation of resources

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
			within programmes will take full account e.g. equalities with the intention of improved outcomes for at risk BME and boys.
Outcome Two: A reduced gap in life expectancy			
Priority 5: Reduce smoking	<ul style="list-style-type: none"> • Certain groups have high rates of tobacco use and higher nicotine dependence including some specific ethnic groups e.g. Turkish, Bangladeshi, Irish men, lower socio-economic groups and people with mental health problems • Smoking prevalence of between 29% and 33% are predicted for Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale & White Hart Lane. (23.3% in London). • More men smoke than women. 	<ul style="list-style-type: none"> • Continue to strengthen the stop smoking service to target groups at risk in accessible areas • Promote smoke free Haringey through Council workplace policies and promoting no smoking in parks (in particular in children’s areas) and bus shelters. • Encourage schools to take up the anti-smoking message in the school curriculum • Implement fines for dropping cigarettes that can be reduced if the smoker attends the stop smoking service • Stop the increase in the number of premises offering tobacco shisha smoking. • Monitor implementation of NHS North Central London’s commissioning for Quality and Innovation scheme (CQUIN) with healthcare providers to increase their smoking cessation interventions. 	<ul style="list-style-type: none"> • The stop smoking service is monitored against key performance indicators which ensure targeting of key risk groups and service provision in a range of settings. This includes people from BME groups, deprived areas (where people from BME groups are more likely to live) all ages and both genders. Accessible locations for those with disabilities are available. Workplace policies are indiscriminate and, for those in employment, provide an alternative route to supporting stop smoking. • Fines and cost of cigarettes is a disincentive to smoke, particularly for low income groups which are more likely

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
			<p>to be from BME groups, women, people with disabilities.</p> <ul style="list-style-type: none"> • Actions within the strategy and reduce smoking delivery plan will be taken forward by the Enfield and Haringey Tobacco control alliance that has a focus on reducing inequalities. • Geographical locations where people with low income and from BME groups most often reside will be targeted in most policies.
<p>Priority 6: Increase physical activity</p>	<ul style="list-style-type: none"> • Older people, women and BME groups are less likely to be physically active. • Overweight and obesity disproportionately affects individuals of Asian origin (particularly those of south Asian origin), Black African women, Black Caribbean women, Pakistani women, Black Caribbean men, and Irish men. • Overweight and obesity disproportionately affects people with physical disabilities (particularly in terms of mobility which makes exercise difficult) and people with learning difficulties. 	<ul style="list-style-type: none"> • Work with local leisure centres to ensure that they are affordable and attract clients who are inactive (particularly target groups including lower socio-economic groups, disabled and older people), encourage parents to exercise with their children (for example, through financial discounts) and expand exercise on prescriptions (including targeting those with long term conditions who are among the least active). • Continue to invest in Smarter Travel options and develop the Biking Borough programme aiming to make all roads in Haringey 'bike friendly'. • Scale up brief intervention training in physical activity and healthy eating for staff and communities. 	<ul style="list-style-type: none"> • Again BME groups, lower socio-economic groups, and arguably people with disabilities are more likely to live in these areas. • Most programmes focus on the east of the borough and work to reduce inequalities. These include the exercise referral scheme. Health

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
		<ul style="list-style-type: none"> Promote NHS Health Trainers and Health Champions programmes. 	<p>Trainers and health champions are drawn from these communities and work with these communities</p> <ul style="list-style-type: none"> Local leisure services will strengthen their focus on the inactive and those from certain target groups. The new contract should be monitored against this. Brief intervention training for core staff and the exercise referral scheme for people with long term conditions will support people with certain illnesses, disabilities, often who are from BME groups, lower socio-economic groups to become more physically active.

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
Priority 7: Reduce alcohol misuse	<ul style="list-style-type: none"> Middle aged and older men make up the majority of alcohol related hospital admissions. White British, African Caribbean and 'any other white' men are most represented in alcohol related hypertension admissions. White British, any other white and Irish men most represented in alcohol specific mental and behavioural disorders. Apart from 'any other ethnic group' Irish men had the highest wholly attributable rate of admissions¹. 	<ul style="list-style-type: none"> Continue to include alcohol screening in the NHS Health Checks programme as this programme (focused on identifying and supporting those at high risk of cardiovascular disease, including hypertension) expands. Extend the range of Identification and Brief Advice (IBA), training staff working in non-medical settings who are likely to come into contact with people with alcohol problems, such as staff working in sexual health, safeguarding and with the Irish and Polish communities. Continue commissioning a link-worker to target those who have repeat alcohol-related attendances and/or admissions. Continue a programme of outreach to traditional 'street drinkers', and the Eastern European community; develop a programme with the Irish community. 	<ul style="list-style-type: none"> Targeting of the Irish and Polish communities and in particular men within these communities is likely to reduce barriers. Groups that are more represented in alcohol related hypertension hospital admissions will be targeted through the NHS Health Checks programme, particularly in the east of the borough.
Priority 8: Reduce the risk of cardiovascular disease (CVD) and cancer	<ul style="list-style-type: none"> Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 years and over is expected to increase in Haringey from 18.3% to 20.6% for males and increase from 20.0% to 20.9% for females by 2030. Certain ethnic groups have a higher risk of CVD. South Asian people living in the UK are one and a half times more likely to die from CHD before the age of 75 than the rest of the UK population. 18% of Haringey residents receiving adult social care services are learning disabilities clients. 	<ul style="list-style-type: none"> Maximise case finding and use of case registers and care pathways within primary care and community services to ensure early detection and management of these conditions, particularly in the over 40s and in the east of the borough. Expand the NHS Health Checks programme² to full roll out, ensuring it reaches those most at risk and that they are supported to make lifestyle changes; deliver some Health Checks as community events. We will increase the number of health checks and health action plans for people with learning difficulties Build on current programmes to raise awareness of early signs and symptoms of stroke, cancer and diabetes, particularly in 'at risk' communities. 	<ul style="list-style-type: none"> More systematic case finding and case registers will reduce inequalities in health from these diseases amongst low income groups, BME groups, people with long term illnesses and disabilities. Free NHS Health checks are targeted at those over 40 years of age and on the east of the Borough. Support services to assist people with lifestyle change are also targeted on the east and are free of charge. Community

¹ Analysis of Hospital Episodes Data Haringey Public Health 2009

² Aimed at 40-74 year olds to identify those at high risk of CVD, diabetes and kidney disease and then offer advice, support and follow up to reduce their risk of illness. October 2012 (to be reviewed following finalisation of the Delivery Plan)

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
	<ul style="list-style-type: none"> • Caribbean, African, Cypriot and Asian origin, especially those of Bangladeshi and other Asian ethnic groups, were less likely to attend breast cancer screening after receiving an invitation. Caribbean, African, Cypriot and Pakistani origin are less likely to attend cervical cancer screenings. • Women in younger age groups (25-29) and those living in Seven Sisters, Tottenham Green, Tottenham Hale and St Ann's were less likely to attend cervical cancer screening. • Fewer bowel cancer screening kits being returned by men than women 	<ul style="list-style-type: none"> • Provide training and information to front line staff and community groups to raise awareness of symptoms of illness early, as well as undertake brief interventions to support lifestyle change. • Continue to improve the uptake in breast and bowel cancer screening. 	<p>based NHS Health Checks target the most deprived and ethnically diverse communities. They do not currently focus on people with mental health problems or learning disabilities. People with learning disabilities have a separate annual check relating to their health. People with mental health problems will be a target group this year for NHS Health checks.</p> <ul style="list-style-type: none"> • Health champions are being strengthened to focus on key target groups to raise awareness of symptoms and signs and support for cancer, diabetes and promote the NHS Health checks programme. Staff training would include information on groups which should be targeted. These target groups include people from deprived areas, low socio-economic groups, BME and men who have higher rates of CVD than women. • A health trainer works specifically with BME groups and in deprived areas around cancer screening uptake.

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
<p>Priority 9: Support people with long term conditions (LTC)</p>	<ul style="list-style-type: none"> • In people under 75 years of age, men are more likely to have a stroke than women. • In Haringey those most likely to have a stroke are Asian, Black and mixed ethnic groups. Studies have highlighted that the incidence of stroke among black populations is more than twice that of white populations and that black populations also tend to have a stroke a younger age than white populations. • Age is a key factor in diabetes prevalence. Type 1 diabetes tends to be diagnosed in childhood but the prevalence of Type 2 diabetes increases steadily after the age of 45 years. • Black and Asian ethnic groups have a higher risk of developing type 2 diabetes and tend to develop it at an earlier age. Compared to the general population the following groups have increased risk: Black Caribbean males (twice the risk), Black Caribbean females (three times the risk), Pakistani females (five time the risk) and Bangladeshi women (three times the risk). • Research shows that gypsy and traveller health needs are high – infant mortality around three times national average, suicide rates, three times national average and low awareness of long term conditions. 	<ul style="list-style-type: none"> • Develop integrated health and social care systems for patients with LTCs across Haringey, for example, working with Whittington Health and other providers to pilot this approach. • Continue to implement the new joint reablement pathway that offers intensive support after hospital discharge or prevents hospital admissions in patients with LTCs, particularly those who are vulnerable. • Further develop care pathways for key long term conditions. • Review and strengthen self management and patient education programmes to support patients managing their own conditions • Review and strengthen psychological support for patients with long term conditions and improve the physical health of people with mental health problems. • Support clinical education to improve quality of care. • Ensure a continued focus on fuel poverty, particularly given the number of vulnerable residents in the borough and the speed with which fuel prices are increasing. • We need to understand the specific health needs of gypsies and travellers in Haringey and will undertake a Gypsy and Traveller needs assessment 	<ul style="list-style-type: none"> • These actions will reduce inequalities in health for certain BME groups, low income groups and people with disabilities who are more likely to have long term conditions. Integrated and joined up care, improving quality of care through patient education and GP education and making care more systematic and of improved quality through implementing care pathways will all reduce inequalities for these target groups. • Addressing fuel poverty will particularly focus on the vulnerable who are again more likely to live in deprived areas, have low income, be from certain BME groups and the elderly. • The gypsy and traveller health needs assessment will attempt to get data from all of the nine protected characteristics to better understand health in this population.

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
Outcome Three: Improved mental health and wellbeing			
Priority 10: Promote the emotional wellbeing of children & young people	<ul style="list-style-type: none"> The number of children within care in Haringey is greater than the London average and looked after children five times more likely to develop mental health problems. Over 70% of children looked after have Black and minority ethnic origin – an overrepresentation compared to the population of the borough. An increased level of mental health needs among Haringey’s refugee and asylum seeking children and young people (unaccompanied minors) has been identified. Other White (22.1% compared to 16%), Black Caribbean (15.5% compared to 9.5%) and Black African (11.6% compared to 9.2%) are over represented in CAMHS referrals that are accepted by the service. Domestic violence can significantly affect children 	<ul style="list-style-type: none"> Prioritise prevention and early intervention by working with schools, young people and families to provide accessible, non-stigmatising mental health services in local community based settings. Ensure the universal services we commission are providing good outcomes in terms of wellbeing and early intervention for mental health problems, for example, the HCP, GPs, health visitors, Children Centres and schools. Promote the Healthy Schools programme, with its focus on reducing child poverty, improving emotional health and wellbeing and reducing substance misuse and smoking. Introduce children’s Improving Access to Psychological Therapies (IAPT) service (effective training and service development are key to the success of the project). Reduce the use of high cost placement in Child and Adolescent Mental Health (CAMHS) services. We are providing intensive community treatment options to reduce dependence on institutional hospital admission and this is likely to improve long term outcomes. Increase access to education, training, employment and housing particularly increasing opportunities for young people in the east of the borough (signpost to other work programmes). Support young people who are ‘Not in employment, education or training’ (NEET) or at risk of becoming NEET and ensure that programmes are in place that are relevant to their needs. Identify actions from the DGBV needs assessment to support children and families 	<p>The evidence shows that by prioritising prevention and early intervention, outcomes are most likely to improve</p> <ul style="list-style-type: none"> We have a universal approach to looked-after children plus a targeted service commissioned by the council that are likely to improve outcomes Access for 16 -18 year olds to the adult IAPT services are likely to improve outcomes. IAPT for children under 16 years of age targets improved knowledge and training for professionals working with children with mental health difficulties and this is likely to improve outcomes Reduce the impact of DGBV on children and families <p>These specific priorities identified through consultation with young people;</p> <ul style="list-style-type: none"> Reduced numbers of those not accessing education, employment and training

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
			<ul style="list-style-type: none"> Reducing offending Targeting younger age range where we know there is a risk
Priority 11: Support independent living	<ul style="list-style-type: none"> By far the largest client group of social care services is women aged 65 and over who are frail with a physical and/or sensory impairment. There are less men aged over 65 in the same category, reflecting Haringey's life expectancy profile with women living longer than men. There are a disproportionate number of BME adults receiving social care services, compared to the rest of the population (1,435 Black or Black British, 888 of which were Caribbean). In 2010/11 there were 555 adults with learning disabilities, 540 adults with a physical disability or a sensory impairment, and 1,012 adults with mental health needs receiving social care services. 15,967 people in Haringey identify themselves as unpaid carers, representing 7.4 % (1 in 13) of the usual resident population. 3,232 (20%) provide care for 50 or more hours a week; 10,637 (67%) provide care for 1-19 hours a week (2001 Census). In overall terms Haringey carers are younger and in comparison Haringey has the most young adult carers aged 18-34 years. 	<ul style="list-style-type: none"> Increase the number of health checks and health action plans for people with learning disabilities. Enable people with learning disabilities to live independently or interdependently with support and housing care. Improve care and choice in end-of-life care by: <ul style="list-style-type: none"> Continuing to implement the Gold Standard Framework within nursing and residential care homes Making sure that there is access to hospice care and care at home at end of life to ensure dignity and choice for people who are dying. Identify and support unpaid carers in their caring role and in their life apart from caring; involve carers in all developments affecting them and the people they care for. Work with the London Fire Brigade to enable them to undertake home fire safety visits for vulnerable people known to partners. 	<ul style="list-style-type: none"> Actions to provide support to those with long term conditions, learning disabilities, London Fire Brigade referral and carers are likely to reduce barriers. Develop a 'safe places' scheme where local shops and businesses display a sticker so that people with a learning disability or mental ill health who are out and about and need assistance will find refuge inside. A local stigma campaign will aim to increase awareness of mental illness and LD in east Haringey, thus particularly targeting BME groups.

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
<p>Priority 12: Address common mental health problems among adults</p>	<ul style="list-style-type: none"> The “Other White” and “Other ethnicity” groups, believed to reflect in majority the Turkish and Kurdish community. Turkish/Kurdish residents have relatively high referrals to IAPT but maybe in part due to population demographics. Nationally, 39% of homelessness acceptances had main applicants aged 16-24. In 2010/11 34% of homeless applicants accepted by Haringey Council were 16-24 years old. Worklessness is linked to poor wellbeing and leads to increased mental illness 	<ul style="list-style-type: none"> Actively encourage the development of more user-led organisations, for example, BUBIC (Building Unity Back into the Community) to build resilience into the community and improve the awareness of mental health among BME communities. Support people with both mental and physical illness: <ul style="list-style-type: none"> Improve communication between primary and secondary care and develop a shared care approach to those who become unwell Identify depression and anxiety in patients with long term conditions (LTCs) Extend IAPT provision and ensure equitable access in line with national recommendations. Ensure the regeneration of Tottenham promotes wellbeing and good mental health, for example by addressing issues of neighbourhood quality, housing design and density, housing quality and community safety (actions to deliver this will be incorporated into the Tottenham Plan). Ensure those with mental illness have access to employment opportunities 	<p>Actions to encourage more user-led organisations to improve the awareness of mental health among BME communities are likely to reduce barriers.</p> <ul style="list-style-type: none"> A link is also made to the Homelessness Strategy action to improve housing options for young people to reduce the high number of homelessness applicants aged 16-24 years. Voluntary sector organisations will target mental health awareness raising and counselling to specific BME groups which are within their remit. Actions to improve employment opportunities will lead to improved wellbeing and improve mental health
<p>Priority 13: Support people with severe and enduring mental health needs</p>	<ul style="list-style-type: none"> It is likely that there is significant under-diagnosis in some BME groups of patients due to a variety of cultural and social factors, this has led to increased hospital admissions and even suicide. There are more patients with dementia in west Haringey probably due to a greater proportion of older people. Amongst people with mental health 	<ul style="list-style-type: none"> Develop a ‘safe places’ scheme where local shops and businesses display a sticker so that people with a learning disability or mental ill health who are out and about and need assistance will find refuge inside. Continue to commission the voluntary sector to work with BME groups to raise awareness of mental health problems and offer culturally specific counselling. Run a mental health campaign to reduce stigma and promote early diagnosis in areas of the borough with 	<ul style="list-style-type: none"> The action to support mental health service users to give up smoking is likely to reduce barriers and health inequalities BME specific voluntary groups will work more closely with primary care to raise

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
	<p>problems, the prevalence of smoking is estimated to be approximately 70% and for hard-drug users the figure is 'practically 100%'</p> <ul style="list-style-type: none"> It is important to consider the mental and physical health of carers which is affected by isolation and caring for a family member with mental illness 	<p>high rates of mental illness.</p> <ul style="list-style-type: none"> Improve memory clinics, care at home and in care homes (including training for staff) for patients suffering from dementia, spanning early diagnosis to the end of life. Ensure the appropriate level of high quality mental health residential provision for those people who need it and cannot be looked after safely within the community. Support mental health service users to give up smoking and understand how better to support them in smoking cessation. Ensure carers have support through voluntary sector organisations to reduce isolation and raise awareness of the need for health checks 	<p>awareness of the increased level of mental health problems and increase referrals to provide support and counselling.</p> <ul style="list-style-type: none"> Older people will have better access to memory clinics with home and care home support. Improved physical health and management of long-term conditions in all people with mental illness. Carers of people with severe mental illness are often older. They need to look after their own wellbeing by reducing social isolation and keeping in good physical health
<p>Priority 14: Increase the number of problematic drug users in treatment</p>	<ul style="list-style-type: none"> The highest concentration of drug treatment/dual diagnosis population is found in Seven Sisters, Bruce Grove and Northumberland Park wards. Dual diagnosis was most prevalent amongst White British, Caribbean, and other white and Black African. 	<ul style="list-style-type: none"> Continue to develop networks of 'Recovery Champions' at a strategic, community and provider level to actively tackle the stigma associated with substance misuse so that people with former histories of drug/alcohol use can access employment, housing, healthcare and mainstream services. Actively encourage and support the development of more user-led services / activities, for example, BUBIC, which is a peer-led service that particularly focuses on the BME population. This will further build self reliance and foster a sense of being part of the wider community amongst this population. 	<ul style="list-style-type: none"> Drug services in Haringey have been informed by annual drugs needs assessments and therefore the geographical spread of services matches the areas with the highest prevalence. Services are designed to be welcoming to people regardless of sex, sexuality, race, religion, age, or

Priority	Evidence	General Actions to be undertaken to address impact	Impact on protected characteristics
		<ul style="list-style-type: none"> Commission services that actively help people with histories of substance misuse get back into education, training or employment. 	<p>disability. A planned re-tender of existing drug and alcohol treatment provision will see the expansion of education, training and employment opportunities for substance misusers in the east and the further development of more peer led services. This is likely to reduce barriers.</p>

If there are any barriers that cannot be removed, what groups will be most affected and what positive actions are you proposing in order to reduce the adverse impact on those groups?

There are no barriers that have been identified that cannot be removed.

Step 4 - Consult on the proposal

The purpose of the consultation was to engage with organisations and groups who work in health and wellbeing and residents to identify the outcomes and priorities for the draft strategy. The consultation period ran for four months from the 20th September 2011 to 20th January 2012.

We consulted local stakeholders, partners and the wider community including Councillors, NHS and GPs, schools, children's centres, the community and voluntary sector, and residents.

A consultation questionnaire was available in hard copy and online, including an easy words and pictures version. People were also able to contribute by submitting a free text response.

We had a total of 50 responses. Of these 44 were responses to the questionnaire and 6 written statement responses from:

- Haringey Disability First Consortium
- Haringey LINK
- Haringey Women's Forum
- Barnet, Enfield and Haringey Local Pharmaceutical Committee
- Haringey Local Medical Committee
- Community Housing Services

We also attended a number of different forums to alert people to the consultation and get feedback.

These included:

- Carers Partnership Board
- Learning Disabilities Partnership Board
- Mental Health Partnership Board
- Older People's Partnership Board
- Better Places Partnership
- Integrated Housing Board
- Children's Trust
- DAAT Board
- Early Years Health Group
- Youth Cabinet
- Area Committees
- HDFC and Haringey Women's Forum Event

A cross-party working group on health inequalities was also set up to recommend priority actions to reduce health inequalities in Haringey, with a particular focus on the Council's contribution. The work and recommendations of this group formed part of the consultation and have been fully integrated into the draft strategy.

Information about the consultation was advertised by:

- Haringey website
- Haringey People
- Area Committees

- Resident Associations

A wide range of views were collected during the consultation. The majority of people agreed with the draft proposals. There was strong overall agreement with the draft vision, with over 90% of respondents agreeing or strongly agreeing (7.1% of people who responded strongly disagreed with the vision but did not offer reasons why).

Similarly there was strong support for the draft outcomes, with the majority of respondents agreeing or strongly agreeing

The consultation report will be made available on the consultation database and on the website.

Respondents also made a number of suggestions of what else should be included in the strategy. The suggestions most relevant to equalities issues and how we plan to address them included:

The feedback was / people asked us to:	So we plan to:
Overall/Cross-cutting	
Disability as a protected characteristic is broadly absent from the strategy.	<p>Disability has been considered as a protected characteristic through the EqIA process and has been included in the strategy.</p> <p>A section will be included in the strategy about the planned integration of health, education and social care services for children with additional needs and disabilities. The aim is to have integrated and co-located, accessible and fast responding services.</p> <p>An action will be included in the delivery plan to increase the number of health checks and health action plans for people with learning difficulties.</p>
It is important to target areas of greatest need and inequality for example, in the east of the borough.	The priorities have been selected because they target areas of greatest need as identified by joint strategic needs assessments and through consultation. Actions specifically focussed on specific groups and the east of the borough will be included in the delivery plan.
The strategy should prioritise prevention and early intervention by working with schools, young people and families in local community based settings. Children's centres and schools were considered ideal providers of early intervention measures and for the promotion of wellbeing e.g. creative learning.	Children's Centres and schools are key settings to deliver various priorities in the strategy and this will be highlighted where appropriate in Outcome 1 and Outcome 3. The main principle of the HWB Strategy is prevention and intervention.
Outcome One: Every child has the best start in life	
There should be more support for parents (who have learning disabilities) e.g. childcare. This outcome should focus on 'pre birth to 3 year olds'. Health checks for 1-2 year olds were considered important. Information provision on risks of drinking alcohol during pregnancy and breastfeeding.	<p>The 83 places and subsidised child care rate for childcare is available to families categorised as in need, including those with learning difficulties. The CAF team will work closely with children with disabilities and additional needs service to identify families at an early stage so that support from the range of early help services is available to them.</p> <p>We have changed Outcome 1 to focus on 'conception to age 3'. We have described clearly who has access to the Healthy Child Programme and our intention to identify additional funding to implement the programme fully. As a result of the consultation we changed the wording to 'conception to 3'. The narrative on the Healthy Child Programme is our aspiration and is totally reliant on NHS NCL Haringey securing more funding.</p> <p>Drinking alcohol during pregnancy is part of the maternity services ante natal assessment programme for all women during pregnancy that will be included in the Delivery Plan. Drinking alcohol and other lifestyle factors are part of breastfeeding support for women that will also be included in the Delivery Plan.</p>
Domestic Violence should be included given its impact on the health and wellbeing	Partnership working to tackle domestic and gender based violence (DGBV) has been

The feedback was / people asked us to:	So we plan to:
<p>of adults and children. It was raised as a particular issue for disabled, certain BME or pregnant women. It was suggested that more information should be provided about domestic violence e.g. domestic violence awareness programme.</p>	<p>reviewed, with the creation of a commissioning group representing council, health and police which will report directly to the Community Safety Partnership Board chaired by the Cabinet Member for Communities. The commissioning group will work closely with its counterpart, an operational group representing frontline and provider services with input from an expert user group.</p> <p>The current DGBV strategy expires in 2012; in future, the strategic approach will be incorporated in the Community Safety Strategy, with a separate and more detailed delivery plan for DGBV activities which will be monitored and reviewed by the commissioning group.</p> <p>A DGBV needs assessment is in development, and current services for Haringey residents are being mapped. These will help to identify recommendations for commissioners on key areas of need and gaps in services. Services will be commissioned, monitored and reviewed using the principles outlined in the voluntary sector's commissioning and funding framework, to ensure that services are effectively tackling priority need.</p>
Outcome Two: A reduced gap in life expectancy	
<p>The strategy should consider the impact of mental ill health on life expectancy.</p>	<p>The strategy recognises the lower life expectancy of people with mental health problems and the contribution of suicides to the life expectancy gap. The Delivery Plan will include actions to improve the physical health of people with mental illness and reduce smoking. This will be across all people with mental illness from common mental illness to those with severe and enduring illness.</p>
<p>Issues were raised about the impact of alcohol misuse. Health messages could be communicated via local businesses such as pubs.</p>	<p>The Council have used a number of avenues to raise awareness of the risks of alcohol misuse – including the use of beer mats in pubs. Every year we run a week long campaign for National Alcohol Awareness week and plan to engage more local businesses this year</p>
<p>The strategy should prioritise sexual health for the over 25 year olds including testing and information.</p>	<p>Our focus is primarily on sexual health of under-25s. It is therefore one of the priority of the strategy. However, we have universal sexual health and HIV services that cover the over 25s.</p>
<p>Provide support for women to sustain change in relation to domestic violence, quitting smoking, healthy eating etc.</p>	<p>We are in the process of mapping domestic and gender based violence (DGBV) services currently available in Haringey. Along with findings of the DGBV needs assessment, this will help us to identify unmet need and gaps in services that commissioners should focus on. The needs assessment will also provide information that can be used by voluntary and community sector organisations who wish to apply for funding from a range of alternative sources, such as the Home Office's Funding Central database.</p>

The feedback was / people asked us to:	So we plan to:
	We have smoking cessation and healthy eating programmes available that will be detailed in the Delivery Plan.
A better understanding of cultural and social attitudes will be needed to effectively deliver this strategy.	The Council is organising a series of resident debates across the borough on factors driving inequalities and what we as a community can collectively do about it e.g. food and drink; alcohol; smoking; stigma
The offender population should be mentioned as a hard to reach group, who may smoke, be alcohol and substance misusers, be unemployed and be socially excluded.	The Council recognise that the offender population often have histories of substance misuse, are unemployed and socially excluded. These factors are more explicitly highlighted in our Joint Strategic Needs Assessment and will be more explicitly addressed through our annual Adult Drug Treatment plan. Through our Drugs Intervention Programme we provide services to drug related offenders and more recently this has been expanded to include those with alcohol problems. The borough is committed to tackling social exclusion through a number of education, training and employment schemes and through the work of our Recovery Champions group led by the DAAT.
The strategy should prioritise older people's health issues.	Older people are a key target group to address inequalities in life expectancy in the Delivery Plan, particularly in relation to early detection of cardiovascular disease. Actions to address dementia and older people's mental health will also be included in the Delivery Plan.
Health checks and health action plans for people with learning disabilities should be extended to other disabled people.	Currently the main target groups for health action plans are: learning disabled. Health checks are targeted at all people aged 40-74 years and we will undertake an audit including accessibility and uptake of these by disabled people.
Outcome Three: Improved mental health and wellbeing	
The strategy should prioritise improving access to psychological therapies.	An action will be included to continue working with voluntary sector organisations to increase the delivery of psychological therapies and to ensure that these meet national requirements and link with the NHS IAPT service. In line with national guidance, the criteria for IAPT will also widen.
Access to information and resources about mental health services was considered important to support self-help and promote wellbeing.	An action will be included to work with primary care and the voluntary sector to ensure early support for those with mild mental health problems. This will include further signposting of NHS and Local Authority services by voluntary sector organisations. This is as a result of the mental health needs assessment which identified late diagnosis in BME groups and lack of awareness of voluntary sector organisations by primary care.
The strategy should promote employment of people with poor mental health.	An action will be included to work with voluntary mental health sector organisations, primary care and job centres to ensure people with mental health problems have access to employment and training opportunities. This was identified as a particular issue by the cross party working group in health inequalities.
The strategy should prioritise improving work opportunities/experience for 25-30	The Haringey Guarantee continues to provide employment support to unemployed

The feedback was / people asked us to:	So we plan to:
year age group.	<p>Haringey residents. The programme for this year is focussed on supporting young people (16-24), parents and people aged 25 and over.</p> <p>The Council will be launching a new employment programme in 2012/13 that will increase our capacity to provide support to our unemployed residents, including those that are aged 25-30.</p>
Older people's mental health and dementia should be included in the strategy.	Dementia and older people's mental health will be included in the strategy. We are delivering the outsourcing of the Joint Older People's Dementia and Mental Health Commissioning Framework.
The impact of alcohol abuse, especially on those with learning disabilities was considered a key issue.	<p>In June 2011, we launched a campaign aimed at tackling hate crime directed at people with a learning disability. Working closely with people with a disability, the joint initiative was set up by Mencap, the Metropolitan Police and the Council to encourage more victims to come forward. A new easy-to-read form has been produced that victims can leave in special red boxes at key locations in the borough, such as day centres. The forms are passed on to the police who will then investigate the incident with the victim and their family or carer. This initiative makes it easier for victims and their families to report hate crimes and reflects our commitment to preserve everyone's right to live without fear of abuse.</p> <p>The campaign which aims to raise awareness of disability hate crime was featured at the HLDP Partnership Board multi-agency away-day which was attended by over 100 local people, many of them with learning disabilities in March of this year and the campaign was also featured in "Haringey People" which reached the entire Haringey population in June of this year.</p>
The strategy should consider the mental health and wellbeing of families and carers.	The delivery plan will include actions to provide support for carers to ensure their mental and physical health is not impacted as a result of caring. We fund a number of organisations already that provide services to carers - including: advocacy, counselling, information/advice drop-ins, support groups, benefits advice and yoga. www.haringey.gov.uk/index/social_care_and_health/carers.htm

Step 5 - Addressing Training

The following staff training will be included as actions in the delivery plans of the strategy:

- Training of frontline staff in the prevention of sudden unexpected death in infancy
- Offer training to school nurses and other school staff on how to recognise child obesity and how to raise the issue with families in a sensitive way
- Scale up training of brief interventions in physical activity and healthy eating for staff and communities, NHS Health Trainers and Health Champions.
- Train staff working in certain non-medical settings to increase coverage of IBA (Identification and Brief Advice) who are likely to come into contact with people with alcohol problems, such staff working in sexual health, safeguarding and with the Irish and Polish communities.
- Continue to support education and training for clinicians and other staff to improve treatment and care
- Train all frontline staff in 'Mental Health First Aid' which aims to identify mental health problems early

Step 6 - Monitoring Arrangements

The Strategy will be monitored and reviewed on a six monthly basis by the Haringey's Health and Wellbeing Board, and revised annually. It will be accompanied by a series of delivery plans which will set out a programme of activities – and progress against each one – to address the priorities and achieve the outcomes. The detailed delivery plans can be found at: The delivery plans are being written and an electronic link will be added when these are complete.

Step 7 - Summarise impacts identified

In the table below, summarise for each diversity strand the impacts you have identified in your assessment

Age	Disability	Race	Sex	Religion or Belief	Sexual Orientation	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity
<p>Haringey Public Health's Health Equity Audit 2010 suggests that women aged under 20 tend to book late for maternity care.</p> <p>Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 yrs and over is expected to increase in Haringey from 18.3% to 20.6% for males and</p>	<p>Overweight and obesity disproportionately affects people with physical disabilities (particularly in terms of mobility which makes exercise difficult) and people with learning difficulties.</p> <p>In 2010/11 there were 555 adults with learning disabilities, 540 adults with a physical disability or a sensory impairment, and 1,012 adults with mental health needs receiving social care services.</p> <p>An increased level of mental health needs</p>	<p>Haringey Public Health's Health Equity Audit 2010 suggests that Black African women tend to book late for maternity care.</p> <p>Obesity is closely linked to ethnicity. Children from Black and minority ethnic (BME) groups are more likely to be obese than children that are White British. 17.1% of Black African children in reception year are obese compared to 5.7% of White British children. By Year 6, 28.2% for Black African Children are obese compared to 10.9% for White British children.</p> <p>Local data on under 18 conceptions (from live birth notifications and abortion provider) collected by public health suggests that in 2009 and 2010, the highest number of girls becoming pregnant were White British, followed by Black Caribbean and 'Other ethnic' group.</p> <p>Caribbean, Kurdish, Turkish and African children's personal, social and emotional development (PSE) scores are much lower than White British children.</p>	<p>By the time that the children have reached Year 6 boys (25.1%) are more likely to be obese than girls (21.7%).</p> <p>By far the largest client group of social care services is women aged 65+ who are frail with a physical and/or sensory impairment. There are less men aged 65+ in the same category, reflecting Haringey's life expectancy profile with women living longer than men. Male life expectancy gap across Haringey is higher than women. Male</p>	No data is available nationally.	No data is available nationally.	No data is available nationally.	No data is available nationally.	<p>Infant mortality rates are at an all time low, however in Haringey rates are higher than those for England and Wales, in particular for African women.</p> <p>Smoking in pregnancy increases infant mortality by about 40%. During Q2 2010/11, the percentage of mothers smoking at delivery in Haringey was 6%.</p>

<p>increase from 20.0% to 20.9% for females by 2030.</p> <p>Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 yrs and over is expected to increase in Haringey.</p> <p>Nationally, 39% of homelessness acceptances had main applicants aged 16-24. In 2010/11 34% of homeless applicants accepted by Haringey Council were 16-24 years</p>	<p>among Haringey's refugee and asylum seeking children and young people (unaccompanied minors) has been identified. Also reduced levels of physical activity in disable people are identified.</p> <p>Amongst people with mental health problems, the prevalence of smoking is estimated to be approximately 70% and for hard-drug users the figure is 'practically 100%'.</p>	<p>Certain ethnic groups have a higher risk of CVD. South Asian people living in the UK are one and a half times more likely to die from CHD before the age of 75 than the rest of the UK population.</p> <p>Certain groups have high rates of tobacco use and higher nicotine dependence including Turkish and Irish men.</p> <p>Overweight and obesity disproportionately affects individuals of Asian origin (particularly those of south Asian origin), Black African women, Black Caribbean women, Pakistani women, Black Caribbean men, and Irish men.</p> <p>White British, Irish African Caribbean and 'any other white' men are most represented in alcohol related hypertension admissions.</p> <p>South Asian people living in the UK are one and a half times more likely to die from CHD before the age of 75 than the rest of the UK population.</p> <p>Caribbean, African, Cypriot and Asian origin, especially those of Bangladeshi and other Asian ethnic groups, were less likely to attend breast cancer screening after receiving an invitation.</p> <p>Caribbean, African, Cypriot and Pakistani origin are less likely to attend cervical cancer screenings.</p>	<p>mortality from CVD is higher than the national average.</p> <p>Men are more likely to commit suicide than women</p>				<p>Almost half of all teenage mothers smoke during pregnancy and 55% of single mothers. Pregnant women are a target group for the Stop Smoking service.</p>
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<p>old.</p> <p>There are more patients with dementia in west Haringey which has a greater proportion of older people.</p>		<p>Looked after children five times more likely to develop mental health problems. Over 70% of children looked after have Black and minority ethnic origin – an overrepresentation compared to the population of the borough.</p> <p>Other White (22.1% compared to 16%), Black Caribbean (15.5% compared to 9.5%) and Black African (11.6% compared to 9.2%) are over represented in CAMHS acceptances.</p> <p>There are a disproportionate number of BME adults receiving social care services, compared to the rest of the population (1,435 Black or Black British, 888 of which were Caribbean).</p> <p>Some BME groups have a higher risk of psychotic illness and hospital admissions. It is likely that there is significant under-diagnosis in this group of patients due to a variety of cultural and social factors.</p> <p>Dual diagnosis was most prevalent amongst White British, Caribbean, and other white and Black African.</p>						
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Step 8 - Summarise the actions to be implemented

Please list below any recommendations for action that you plan to take as a result of this impact assessment.

Issue	Action required	Lead person	Timescale	Resource implications
Data collection and analysis	Identify which services require data collected on the protected characteristics for which there is no current collection. Identify methodologies to collect and use data in the commissioning process to improve service design and delivery. For all new services being developed or commissioned, implement data collection for protected characteristics relevant to a particular service	Susan Otit (children) Fiona Wright (adults) Nicole Klynman (mental health)	Ongoing	Identification of current data collection can be carried out within existing resources If further data collection is required, additional resources may be needed for data collection and training. We would need to identify whether the additional cost will improve service delivery and benefit the Haringey population.
Outcome One	Review <i>Priority 3: Ensure readiness for school at 5 years</i> to include targeting of BME groups achieving low PSE scores.	Jan Doust, CYPS	May 2012	Within existing resources Within existing

	<p>Review <i>Priority 4: Reduce childhood obesity</i> to include targeting east of the borough.</p> <p>Ensure there is targeting of Black Caribbean girls, in the east of the borough under <i>Priority 2: Reduce teenage pregnancy</i></p>	<p>Susan Oti</p> <p>Susan Oti</p>	<p>March 2012</p> <p>March 2012</p>	<p>resources</p> <p>Within existing resources</p>
Outcome Two	<p>Continue to monitor the Stop Smoking Service and the Tobacco Control action plans to ensure that all 'groups in risk' are targeted e.g. Irish men, people with mental health problems are targeted under <i>Priority 5: Reduce smoking</i>.</p> <p>Ensure that older people, women, BME groups and the inactive and those with physical or learning disabilities are targeted under Priority 6: Increase physical activity. Monitor the new leisure service providers against this.</p> <p>Priority 8: Expand health trainers and health champions service as these services support reduction in inequalities.</p> <p>Priority 9: <i>Support people with long term conditions (LTC) to live a</i></p>	<p>Fiona Wright</p>	<p>May 2012</p>	<p>Within existing resources</p>

	<i>healthier life</i> . Ensure implementation of the care pathways address they key target groups e.g. specific BME and lower socio-economic groups.			
Outcome Three	Review <i>Priority 10: Promote the emotional wellbeing of children & young people</i> to include targeting at Other White, Black African and Black Caribbean children with high mental health needs.	Susan Oti	April 2013	Within existing resources
	Ensure that existing programmes are targeted at BME groups and older people with high needs under <i>Priority 13: Support people with severe and enduring mental health needs</i>	Nicole Klynman	December 2013	Within existing resources
	Ensure there is a focus on BME groups with dual diagnosis under <i>Priority 14: Increase the number of problematic drug users in treatment</i>	Marion Morris	December 2013	Within existing resources

Step 9 - Publication and sign off

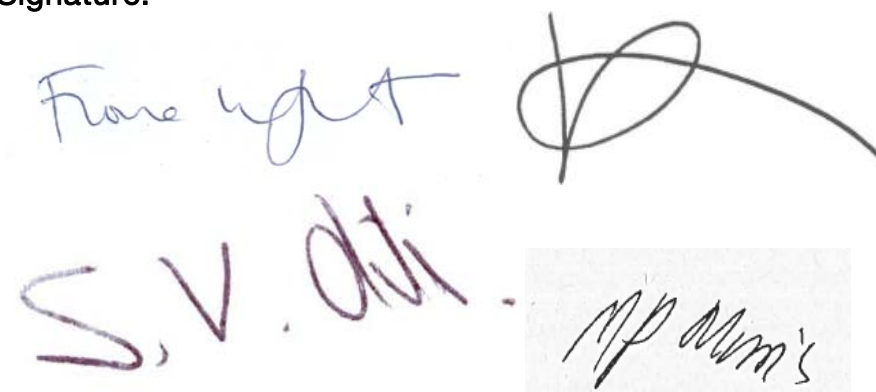
This Equalities Impact Assessment will be published on the website in May 2012. This Equalities Impact Assessment will be updated following development of the Deliver Plan.

Assessed by (Author of the proposal):

Name: Fiona Wright, Nicole Klynman, Marion Morris and Susan Oti,

Designation: Assistant Directors of Public Health

Signature:



The image shows four handwritten signatures. The first is 'Fiona Wright' in blue ink. The second is a stylized signature in black ink. The third is 'S.V. Oti' in purple ink. The fourth is 'MP Morris' in black ink on a small rectangular piece of paper.

Date: 4th October 2012

Quality checked by (Equality Team):

Name: Arleen Brown

Designation: Senior Policy Officer

Signature: *A.J. Brown*

Date: 3rd July 2012

Sign off by Directorate Management Team:

Name: Dr Jeanelle de Gruchy

Designation: Director of Public Health

Signature:



Date: 4th October 2012

ⁱ Cross Cutting Review on Health Inequalities. Department of Health, 2002.

ⁱⁱ Meltzer, H. OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1 the prevalence of psychiatric morbidity amongst adults living in private households. London : HMSO , 1995)

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^v Summerbell CD, Ashton V, Campbell KJ, Edmunds L, Kelly S and Waters E (2006) Interventions for treating obesity in children (Review) The Cochrane Collaboration, The Cochrane Library 2006, Issue 1.

^{vi} Reilly, J., Dorosty, A. and Emmett, P. (1999). Prevalence of Overweight and Obesity in British Children: Cohort Study. *British Medical Journal*, 319(7216): 1039.

^{vii} HM Government (2007) *Safe, Sensible, Social: The next steps in the national Alcohol Strategy.* London

^{viii} White I, Altman D, Nanchahal K. Alcohol consumption and mortality: modelling risks for men and women at different ages. *Br Med J* 2002; 325

^{ix} In under 18's only alcohol specific conditions are counted

^x Analysis of Hospital Episodes Data Haringey Public Health 2009

^{xi} Five Year Strategy 2009-2013. NHS Nottingham City.

^{xii} Department for Education (2011) *Support and aspiration: A new approach to special educational need and disability – a consultation.*

^{xiii} McManus, S et al (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey,* The Information Centre.

^{xiv} Of a total 16-74 year old population of 171,637. Estimating the Prevalence of Common Mental Health Problems Additional Data. <http://www.nepho.org.uk/mho/Needs>