Haringey Devolution Pilot

Prevention Pilot

Outline Business Case

November 2017

Haringey LONDON

NHS Haringey Clinical Commissioning Group

1. Common Introduction

Over the past eighteen months, local and sub-regional areas have been working to make rapid improvements to health and care within existing powers and exploring how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see at the most appropriate and local level. Different parts of London have diverse communities, health challenges and quality of health and care services. It is therefore entirely appropriate that different solutions are developed for different areas and that enabling tools, such as devolution, be adopted at different pace and scale based on local appetite.

In this spirit, the approach to London health and care devolution has been for five 'pilots' to develop shared local plans for health and care transformation and then identify opportunities to accelerate these plans through devolution. Each pilot business case aims to describe this local transformation vision, priorities, governance and delivery plans. The pilots have wide partnerships including local authorities, Clinical Commissioning Groups, providers of health and care services, clinical leaders, the voluntary sector and wider public sector partners. The visions and plans developed by the pilots aim to further this collaboration and accelerate health and care transformation, not just through devolution but also by accelerating progress within existing arrangements. These business cases have been developed locally and are owned by the individual pilots.

Over the past eighteen months, the work of the pilots has demonstrated that the benefits of devolution are as much from indirect as direct effects. The potential of devolution has galvanised local plans, local ownership and local partnerships and made sure that the potential of existing arrangements has been fully explored and implemented. But it is also clear that devolution itself would provide significant benefits to enable the delivery of these local ambitions.

The pilots, London and national partners have worked together explore the proposals set out in these business cases. Where there was a clear case that proposals would assist, enable or accelerate improvements to the local health and care system, steps have been taken towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners. The London Health and Care Devolution MoU contains details of the specific devolution commitments made by Government and national partners.

2. Introduction to Haringey

Haringey is a growing, increasingly diverse borough with many health and wellbeing assets and challenges. Devolution will enable partners, employers and residents in Haringey to improve the health of local residents at pace and scale.

We believe that **local government** is best positioned to take on the system-wide leadership role necessary to deliver real reform of public services and create a place where all residents can live long and fulfilling lives. This is because of:

- the direct democratic mandate and accountability that local government has with residents
- the close geographical proximity that local government holds to the communities it serves
- the wide network of stakeholders and partners that local government are engaged with and have influence over.

Devolution will enable Haringey to shape a healthier borough to improve residents' choices and prevent people with health problems dropping out of employment.

Haringey is changing rapidly. Over £1 billion will be invested in Tottenham over the next decade, building 10,000 homes and creating new opportunities for our residents in some of the most deprived areas of London. Our vision is to work with our residents and partners to harness those physical changes in pursuit of better health and wellbeing for all residents. This will enable everyone to benefit from the economic and physical development of the borough.

3. Creating a healthier Haringey

3.1 Normalising good health

Our vision is to fundamentally 'normalise good health' by supporting residents to make healthier choices and reducing unhealthy, risky behaviours. This will reduce our high level of long-term health conditions. The Council, CCG and partners recognise that nothing less than a whole system approach is required to improve the health of local residents at pace and scale. Our ambition is to embed health objectives in all public policy, shifting every partner's core business towards preventing long-term ill health.

Our physical environment is a major determinant in our behaviour and our health. The Council's 'place- shaping' role means we are best positioned, alongside the local public sector and businesses, to create a place where the healthier choice is the easy choice. Devolution will enable us to address the inter-relationship between inequality, poor health and unemployment. We will be able to join up services and prevent the development of long-term health conditions, while working with employers to prevent people with health problems from dropping out of work.

3.2 Providing strategic leadership

Haringey's Health and Wellbeing Board (HWB) provides strong strategic leadership, driving forward our strategic shift towards prevention and early help and ensuring partners

across the system are engaged in improving outcomes. Chaired by the Leader of the Council its membership is made up of:

- Council cabinet members
- Senior council officers
- CCG governing body members
- Healthwatch
- The Bridge Renewal Trust, the council's strategic partner for the voluntary and community sector.

The borough's Health and Wellbeing Strategy (2015- 2018) committed partners to tackling three priorities:

1) Reducing obesity
2) Increasing healthy life expectancy
3) Improving mental health and wellbeing

The HWB has already proven its ability to convene key stakeholders to pursue better outcomes for residents. In June 2015 local schools, the NHS, businesses and the voluntary sector came together and formed the Haringey Obesity Alliance, aiming to make Haringey a healthier place where fewer people are overweight or obese. This is the first organisation of its kind nationally. Chaired by the Cabinet Member for Finance and Health and reporting regularly to the Health and Wellbeing Board, Haringey's Obesity Alliance has grown at a rapid pace and now has 65 members pledging to deliver change.

Haringey has been developing a Haringey-Islington Wellbeing Partnership with Islington Council and CCG and Whittington Health (working in close partnership with Barnet, Enfield and Haringey Mental Health Trust and Camden and Islington NHS Foundation Trust). The first joint meeting of the two Haringey and Islington Health and Wellbeing Boards was held in early October, demonstrating the strong leadership to deliver improved health and wellbeing through innovative approaches.

The North Central London STP includes the devolution pilot proposal and recognises the importance of the Haringey-Islington Wellbeing Partnership in delivering change.

4. Haringey's challenges

Haringey's focus on prevention is driven by the specific health and wellbeing challenges faced in the borough.

4.1 Demographic challenges

Growing rapidly

Haringey currently has a population of 267,540 people and growing. By 2020 the borough's population is projected to reach 286,900; by 2025 it is projected to reach 300,600. Population growth between 2015 and 2025 is expected to be fastest among the over-65s at nearly 30%, compared to 11% amongst the general population.

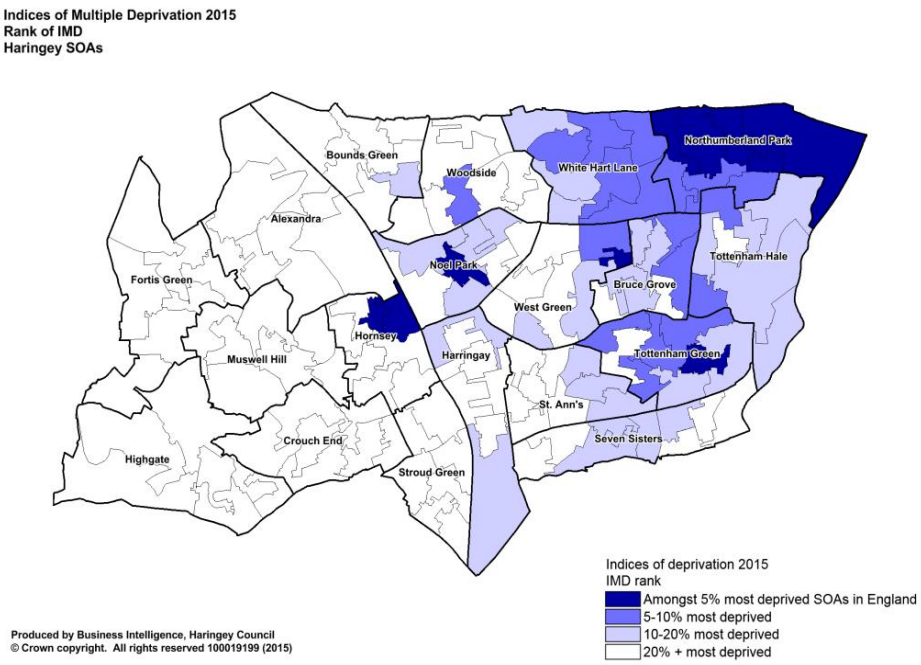
Ethnically diverse

Our population is very diverse. Almost two-thirds of our residents, and 70% of young people, are from black and ethnic minority communities. Over 100 languages are spoken in the borough.

Significant inequality

The 2015 Indices of Multiple Deprivation (IMD) rank Haringey as one of the most deprived areas in the country; it is the 30th most deprived borough in England and the 6th most deprived in London. As Figure 1 indicates there are pockets of extreme deprivation particularly in the east of the borough.

Figure 1: 2015 Indices of Deprivation



4.2 Health Profile

With a growing and diverse population, preventing poor health outcomes has never been more critical to the sustainability of health and social care services in Haringey. Our changing demographic profile means Haringey faces significant health and wellbeing challenges, particularly in the more deprived east of the borough:

- Our residents are living longer, but increasingly in poor health. Although men die on average 4 years younger than women, women are spending the last 25 years of their lives in poor health; for men the average is 16 years.
- As shown in Figure 1 inequality is stark across the borough. This is reflected by health inequalities, with the difference in life expectancy between the most (dark blue) and least (white) deprived areas currently 7 years for men and 3 for women.

A significant contributor to these challenges is the increase in residents living with long-term health conditions, such as cardiovascular disease, diabetes and severe mental illness. For example, over 30,000 people in Haringey have been diagnosed with hypertension with an additional 30,000 people not yet diagnosed. Certain behaviours are key risk factors for hypertension and among Haringey residents:

- 3 in 5 adults do not eat a healthy diet
- Nearly 2 in 3 adults are overweight or obese
- Nearly 1 in 5 people smoke
- Nearly 1 in 5 people drink too much alcohol.

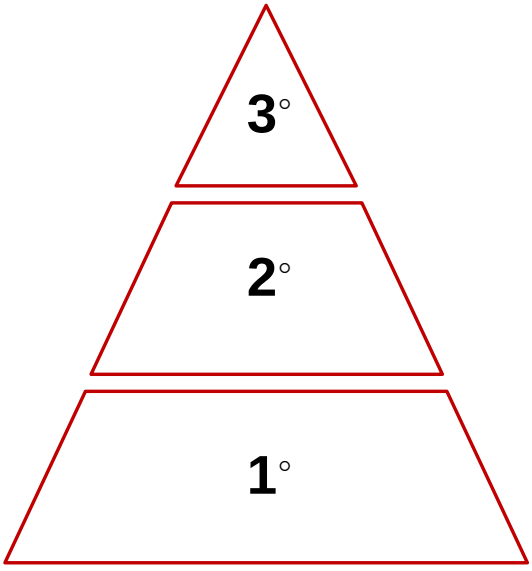
The high level of long-term conditions applies significant pressure to the local health and care economy. Treatment and care for people with long-term conditions is estimated to consume £7 in every £10 of total health and social care expenditure in Haringey. Many of these cases can be prevented, or outcomes improved by supporting residents early in changing behaviours.

The profound inequality in health outcomes – as well as the financial impact – make an urgent case for developing effective approaches to reducing harmful behaviours and preventing the rise of long-term health conditions.

5. The Haringey prevention pilot

5.1 Delivering our vision

The Haringey Prevention Pilot supports the ambition of the Council and partners to shift away from costly treatment and care interventions towards prevention and early help, in particular primary and secondary prevention.



Tertiary: Services intervening once there is a problem to stop it getting worse and to reduce the need for specialist health and/or social care

Secondary: Services and activities targeted at individuals or groups at high risk or showing early signs of a particular problem, community support . Our **Sustainable Employment** strand is secondary prevention.

Primary: Population-level policy, universal services and activities, active citizenship, Our **Healthy Environment** strand is primary prevention.

1) **Primary Prevention: interventions through population/borough-level policy in order to shape the places where people live so that the healthier choice is the easier choice for residents**

We want an environment which promotes healthy eating and exercise, and is not dominated by premises that sell tobacco, or alcohol, or contribute to debt through gambling. Primary prevention is the goal of our prevention pilot's **Healthy Environments** strand. Local government plays a critical role in this. Devolution enables us to do this more effectively.

2) **Secondary Prevention: interventions through services, creating local systems that are user-centred and support people early.**

Devolution provides an opportunity to join up local and national services - for example healthcare and employment support - to intervene early for people who are struggling at work due to mental health issues such as anxiety or depression, rather than wait until they go off long term sick and risk becoming unemployed. This secondary prevention is the goal of our **Sustainable Employment** strand. Local government, the local NHS and our partners are best placed to develop these systems for our residents and ensure they work.

5.2 Our proposals

The Haringey pilot comprises two distinct workstreams to start delivering our vision for a healthier Haringey.

1) ***Sustainable Employment:*** **a new early intervention model for mental health employment support**

This workstream aims to support people who have mental health problems and are on sickness absence earlier, in order to prevent long-term unemployment. This will be achieved through service integration, building support for the national Fit for Work scheme to integrate with existing local services.

2) ***Healthy Environments:*** **using licensing powers to create healthier environments**

This workstream will explore how devolution can provide local authorities with the powers needed to create healthier environments. We have chosen the specific focus for the workstream in two ways:

- Issues that have a major health impact in Haringey (tobacco and alcohol)
- Issues where we are not yet clear on the extent of the health impact, where the local authority has limited power and there is limited regulation (gambling).

5.3 Governance arrangements

The Health and Wellbeing Board provides overall strategic direction for Haringey's devolution pilot supported by senior officers of the council and CCG in the Joint Executive Team (JET).

1) **Sustainable Employment**

Since January 2016 Haringey Council has led a partnership 'Sustainable Employment Working Group': including senior representatives from Public Health, Economic Development, CCG and GP representatives, Barnet, Enfield and Haringey Mental Health Trust, voluntary and community sector, Job Centre Plus and DWP.

This partnership will oversee implementation of the devolution pilot project on sustainable employment, reporting to the Joint Executive Team.

2) **Healthy Environments**

Since January 2016 Haringey Council has led a partnership working group with senior representatives from Public Health and Regulatory Services who have liaised extensively with the London Healthy High Streets Group (linked to London Association of Directors of Public Health), Public Health England regional and national teams as relevant, and other experts in these areas.

6. Proposal 1: Sustainable Employment

6.1 Overview

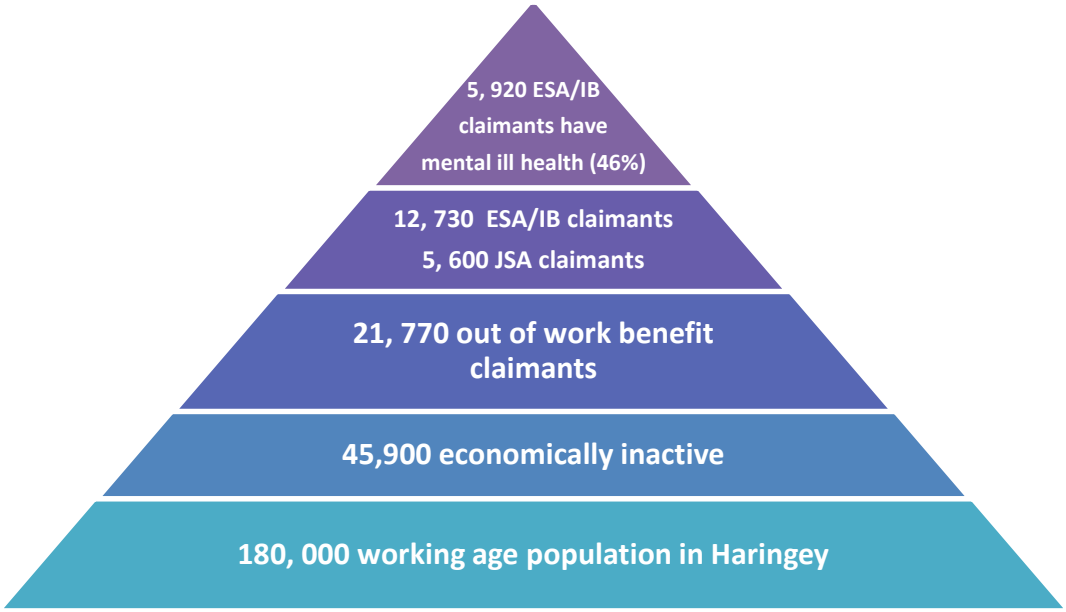
London's ambition, as set out in the London Collaboration Agreement, is to gain a million working days through an improvement in health and a reduction in sickness absence by 2020. The London Health Board, chaired by the Mayor, agreed on 28th June to develop a citywide vision and roadmap for public mental health; a key pillar of this work is health and employment. Mental wellbeing is an asset and without good mental health Londoners and communities cannot thrive and contribute to our city's continued success.

Haringey has made improving mental health and wellbeing a strategic priority, detailed in our joint CCG and LA Mental Health and Wellbeing Framework published in March 2015 and Haringey's Health and Wellbeing Strategy published in 2015. The Framework and the Strategy articulated our strategic ambitions to support people in a more integrated way to achieve their full potential, with an emphasis on enablement - supporting people with meaningful activity (employment or volunteering opportunity), maintaining adequate housing and having good social interactions. Over the last year we have therefore built a number of support mechanisms across the community, voluntary sector and our other statutory partners and concentrated on providing support to people with severe mental health back to employment. While this provides a strong foundation for our sustainable employment devolution pilot, there is a gap in how we support people with mental health problems – such as 'stress', anxiety and depression – while off work with a Fit Note.

6.2 Case for change

Promoting employment and improving support for people with mental illness are important London-wide strategic objectives (London Councils, 2014; Khan, 2016).

Haringey faces particular challenges in the fields of unemployment, mental health and wellbeing. Over 20% of Haringey's population is economically inactive (more than half claim out of work benefits; the rest are students, those who look after their families and those who are retired). Mental illness (1,782 people or 46%) and musculoskeletal conditions (14%) are the most common conditions recorded for those claiming health related work benefits (see diagram below).



Haringey findings

Our recent Haringey mental health and wellbeing survey (using the Warwick-Edinburgh mental wellbeing scale, WEMWBS) highlighted that employment was associated with better mental wellbeing, whilst those unable to work due to sickness or disability were most likely to report low mental wellbeing across the whole borough. Poor educational attainment was associated with worse mental wellbeing, as were financial difficulties.

In addition to those out of work, local analysis has identified a particular support need for people in work but at risk of losing employment as a result of mental ill-health. A local audit of one GP practice in the most deprived area of Haringey suggested that approximately 6% of the GP registered list had been issued with a Fit Note in a year[1]. This proportion is likely to be lower in more affluent parts of Haringey but our estimate is that this would equate to 10-15,000 Fit Notes a year across Haringey.

National Fit For Work service

There is a nationally commissioned service – Fit For Work – which provides telephone advice and support, and liaison with employers, to facilitate return to work for any employee signed off sick for at least four weeks. However, referral rates from Haringey have been extremely low (24 referrals in the last 18 months) and the service is contractually unable to provide link to local support and services which could facilitate job retention. Initial discussions with local GPs suggested a number of reasons for low referrals: they were unaware of the service and did not know how to refer, what the eligibility criteria were and other pragmatic barriers but some GPs also highlighted reluctance to refer to the nationally commissioned DWP service as they could not see the

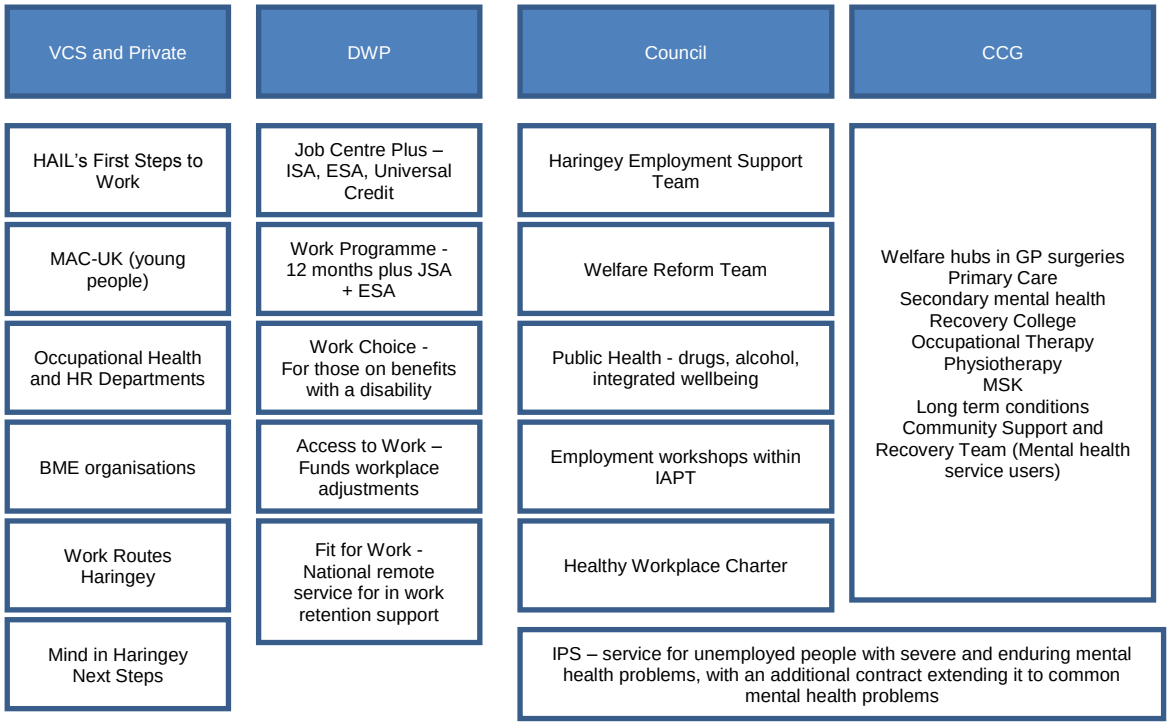
[1] Fit Notes replaced sick notes in 2010 with the aim of refocusing conversations with GPs towards what patients could do rather than what they couldn't. A fit note is generally required for any absence from work lasting longer than a week.

benefits of a telephone based, remote service. These findings are in line with previous research evidence described in detail in section 5.4 (GPs and worklessness).

Alongside this, a review of employment support available in the borough found that there were no or minimal specialist services for those currently in work; all were either generic advice services or targeted at those out of work (diagram below).[2]

Research, outlined in more detail below, shows that, for those at risk of losing employment due to a mental health condition, retaining employment can bring a range of benefits, both to the patient and to the wider health and care system. Economic evidence also suggests great savings to both the healthcare system and DWP benefit system.

Current service offer



Local high level economic analyses based on forecasts (ex-ante) estimated the savings to the wider system, by respective parts of the whole system, as shown in a table below. These analyses however did not include savings resulting in reduced GP appointments or hospital appointments as a detailed evidence base in this area was not available. Local Fit

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- Individual Placement Support (IPS) for people with severe mental illness has been commissioned jointly between the CCG, DWP and Haringey Council. IPS workers are co-located with Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) and in the first nine months, the programme has supported over 50 people; of those 16 found and maintained employment for at least six months. The model attracted additional social finance investment making it more financially sustainable.
- Co-location of Welfare Hubs at five GP practices - Citizens Advice advisors supporting people with mental ill health and substance misuse with debt and employment advice and support. This model is currently being evaluated by North Thames Collaboration for Leadership in Applied Health Research and Care (CLAHRC).
- First Steps to Work run by Haringey Association for Independent Living Ltd. (HAIL). This is a Lifelong Learning course designed to assist service-users to gain the skills and confidence to enter – or re-enter – the workforce. This course has been developed in conjunction with BEH MHT, Middlesex University, HAIL and Haringey Council's Clarendon Recovery College.
- Clarendon College is a recovery college run by the Council as part of Better Care Funding; activities are focused on supporting people to have meaningful activities and paid employment as soon as they are able to do so, including adult life-long learning.

Note audits estimate that potentially 3,500 – 4,000 people would be eligible to participate in our trial. If we achieve improved outcomes for at least a third of the cohort, savings to the whole system would be substantial.

No. people reemployed	Total QALY gain	Total savings (healthcare)	Total savings (ESA)	Total savings (combined)
1,273	87	£182,039	£6,281,000	£6,463,039
2,546	173	£364,078	£12,562,000	£12,926,078
3,819	260	£546,117	£18,843,000	£19,389,117
5,092	0.027	£728,156	£25,124,000	£25,852,156

Link to Haringey's BCF and North Central London STP

As described above diagrammatically, there is a raft of services and interventions commissioned and delivered by a range of local and national stakeholders that provide interventions to various cohorts of people with physical and mental ill health unable to be fully employed. These services form a part of the whole puzzle but, at present, there is no co-ordination function across the whole system and also, there is a lack of awareness among primary and secondary care settings as to what services are available and for which cohort of patients. Furthermore, there are a number of nationally provided services that are currently not being utilised to their full potential.

Local service mapping also highlighted a gap in local services with an exclusive focus on supporting people at an early stage, i.e. those in work but at risk of losing employment due to mental ill health.

In addition to specific employment and health services, there are also a number of other initiatives and service transformations, mainly as part of either Better Care Fund or Sustainability and Transformation Planning (STP) that focus on 'co-ordination/hub model approaches for social prescribing and primary care mental health hubs. These services are being designed at present. Our proposed pilot and proof of concept would test the feasibility of integrating a co-ordination role for worklessness and early help into wider social and health care transformation of services. More detailed plans on primary mental health hubs and community hubs are available in the North Central London STP and Haringey's Better Care Fund.

6.3 Supporting evidence

Link between health and employment

There is robust evidence showing the positive impact of employment on physical health and mental wellbeing, including reports by Waddell and Burton (2006) and Dame Carol Black (2008). Unemployed people have a higher risk of poor physical and mental health compared with those in employment. Unemployment is related to premature death, higher rates of smoking, increased alcohol consumption and lower physical activity. The health and social impacts of a long period of unemployment can last for years (IHE, 2012).

The *Five Year Forward View for Mental Health* identifies stable employment as a major factor in successful recovery, but highlights the fact that just 43% of people with mental health problems are in employment. This report sets out recommendations on how employment should be seen as a health outcome and that focus on links between good health and employment should be integrated within health and care services.

Work and health interventions

Current nationally commissioned services supporting people with health conditions back to work have had variable impact across the country. For example, the Work Programme has found it difficult to support people with long term health conditions and complex needs back into work (The Work Foundation, 2015) and generally, outcomes for those with mental health problems supported by the Work Programme are worse than those in the general population. This is certainly the case in Haringey where 27% of the unemployed population achieve employment within a year compared to only 7% of those with mental health and other complex health needs.

Better outcomes for the cohort of people with mental health and other complex health needs has been achieved through Work Choices and Access to Work, though access to these services is limited to only a specific group of jobseekers and there are a low number of referrals (DH, 2009).

Considerable evidence has been accrued about the value of Individual Placement and Support (IPS) in helping people with severe mental illness into work, and IPS is increasingly being expanded to cover those with more common mental health conditions (HWPU, 2015).

Initiatives which work closely with employers have shown some evidence of success in improving outcomes for people experiencing mental health issues. During its pilot phase in Liverpool, the Workplace Wellbeing Charter delivered noticeable improvements in workplace wellbeing for one third of participating organisations (Liverpool PCT, 2012)[3]. The social marketing campaign ‘Time to Change’ targeted, among other groups, employers, leading to a 6% reduction in the number of people reporting losing their job due to a mental health problem, and a 9% reduction in the levels of discrimination people with

[3] The evaluation of the national roll-out of the Workplace Wellbeing Charter has been commissioned by PHE but has not yet been published

mental health problems experience when searching for a job (National Social Marketing Centre 2013).

Fit for Work

A DWP report (Shiels et al., 2013) found that the replacement of the old sick note system with Fit Notes has facilitated greater communication between patients and GPs and improved outcomes. However the same study found that 6% of Fit Notes advised that the patient 'may be fit for work', with only 4% of mild-to-moderate mental health disorder Fit Notes having this advice. When the 'may be fit for work' option had been selected, 93% of Fit Notes included advice that could help the patient return to work. This evidence suggests that only a minority of Fit Note conversations involve discussion of the positive steps that might help patients return to work. Cooke et al. (2015) suggest Fit Note completion is not meeting the original expectations of positive impact due to a lack of GP training.

Many studies have identified early support as integral to reducing unemployment and improving health. Dame Carol Black's review of the health of Britain's working age population (Black, 2008) called for early support to be built into services and pathways to increase savings and reduce the likelihood of long term unemployment. There is a greater emphasis on prevention and early help in countries with the lowest unemployment rates for people with mental ill health (eg. Scandinavia).

Following the Dame Black review, a new Fit for Work Service was proposed as a proof of concept pilot, to offer support for people in the early stages of sickness absence. Eleven pilots were set up in cities and counties across the UK. The results of the Fit for Work pilots provide a strong indication of the potential of early intervention - 72% of clients who were absent from work when they contacted the pilot had returned to work by the time they had been discharged from the service or soon after, and client satisfaction levels were high. Those pilots that have an integrated wrap-around model supporting Fit For Work seemed to achieve better outcomes (e.g. North Wales, Rhyl model).

A key lesson from the Leicester & Leicestershire Fit for Work Pilot was the need to avoid over-medicalising clients' issues wherever possible. 70% of clients who returned to work reported that 'human interventions' such as confidence building or support for dialogue/mediation at the workplace was the intervention that had the most impact on facilitating their return. Pilots advised against leading clients to think that their return to work must await the completion of a period of formal 'treatment'.

When the national Fit for Work service was set up, DWP anticipated that GPs would refer 36% of their nominally eligible patients to the new service (Hillage et al 2014). This has not been the experience in Haringey, where there have been few referrals since inception of the Programme (23 in total in 2016, of which three were from GPs and 20 from employers). Other parts of the country are also seeing similar low referral rates. Without specific interventions (training, more feedback on referral outcomes) there is unlikely to be a significant number of GP referrals or referrals from employers.

GP training that communicates the health benefits of employment retention support may be the key to increasing referrals. Hillage et al (2014) found referral rates of GPs with a positive attitude to health and work were higher than those with a less positive attitude. They found that the key factors affecting GPs' propensity to refer a patient to the new service included the nature or level of service, the efficiency of the referral process, and length of waiting times, etc. There is therefore a need for any early intervention service to be understood by, and have the confidence of, GPs. The other key factors behind GP propensity to refer were patient-level factors such as the nature of their health problem, their motivation to get back to work, and whether the support they were already receiving was thought to be sufficient.

GPs and sickness certification

GPs experience difficulties in their role as advocate and gatekeeper to sickness absence and health-related employment welfare benefits (Hussey et al., 2004; Swartling et al., 2008; Winde et al., 2010; Macdonald et al., 2012). GPs may develop various strategies for implementing sickness certification; fixed strategies, such as always providing a certificate ('acquiescing'), may be associated with lower stress and time demands than deciding on a case-by-case basis (Hussey et al., 2004; Coole et al., 2015). Case-by-case negotiation may incur conflict with patients, especially where there is disagreement on the need for certification which has consistently been identified as problematic for GPs (Hussey et al., 2004; Swartling et al., 2008; Winde et al., 2010; Coole et al., 2015). GPs may deliberately provide vague information about the patient's condition to maintain confidentiality (from employer); to protect the patient from needing to justify the impact of their condition on work; and to reduce the likelihood of patient challenge (Macdonal et al., 2012; Coole et al., 2015). Furthermore, GPs may perceive a need to protect patients and the patient-doctor relationship; experience difficulties with their role as mediators between patients and state support; and feel that their responsibility to patients outweighs those to the Department for Work and Pensions (DWP).

Sickness certification for mental health

In a study of 68 UK-based general practices over a 12-month period, 29% of all GP-certified sickness absences were due to common mental disorders (CMDs), an estimate replicated in an audit undertaken in Haringey of one GP practice. Those at greatest risk of receiving fit notes for CMDs were female, younger patients, and patients from more deprived areas. The largest proportion of CMD sick notes were for 'stress', while almost half of all weeks certified for mental health problems were due to depression. A small proportion (7%) of CMD Fit Notes included advice from the GP linked to a 'may be fit' opinion, and those from the most deprived neighbourhoods were the least likely to receive any 'may be fit' advice on their fit notes (Gabbay et al., 2016). Mental health problems accounted for over a half of all days certified in same-diagnosis recurrent episodes. Male gender, residing in an area of social deprivation, a longer episode of initial certified sickness absence, not having return to work ('may be fit') advice in the first episode, having a mental disorder or musculoskeletal (particularly back) problem were all independently associated with a higher incidence of recurrence of sickness absence.

Differential risk of recurrence needs to be considered when designing return-to-work interventions and evaluations of effectiveness of interventions (particularly for sickness absentees with mental health problems) has to consider the sustainability of employment after a return to work. The complexities and insecurities for health professionals in managing mental health problems in primary care are well acknowledged (refs). GPs may experience greater difficulty in clinical decision making about fitness for work for people with mental, compared to physical ill health; for example, due to greater complexity of symptoms, co-morbidities, and more complex patient social circumstances (Macdonald et al., 2012).

While GPs may acknowledge the health and wellbeing advantages of employment, there may also be concerns about the negative consequences of work, if it is perceived to be part of the problem leading to mental ill health (Macdonald et al., 2012).

Effectiveness of early support

Early support has been highlighted as integral to a faster and more sustainable route back to employment. Early support must be interwoven within existing services and pathways to increase savings and reduce the likelihood of long term unemployment (Black, 2008). Three Scandinavian randomised controlled trials (RCT) revealed the effectiveness of interventions offering early support for people currently in work (Gronnigsaeten et al., 2012; Heany et al., 1995; Lokk, 1997). Problem solving and decision making skills were taught to staff with mental ill health or a mental disability in a RCT (Gronnigsaeten et al., 2012). Groups of 20 had six sessions of 4–5 hours training over two months, and were trained to train those in their workplace. Compared to those in the control group, the intervention group reported more supportive feedback, more ability to cope, and better team dynamics such as improved functioning and atmosphere. Among those most at risk of leaving work, those undergoing the training reported reduced depression.

Studies of the Dutch model of sickness absence found that requiring employers to put in place a rehabilitation (return to work) plan for absent employees after 8 weeks of absence led to a reduced proportion of people progressing on to benefit dependence of 15%, possibly as high as 33% (De Jong, Thio and Bartelings 2005).

Economic evidence

There is good evidence that investment in employment support for clients with long term health conditions can deliver a substantial return on investment. Social Return on Investment analysis has identified returns of between £5 and £13 for each £1 invested in employment services (Wilkins et al., 2012). Returns come from a reduction in welfare benefit payments, tax and national insurance receipts and reduced demand for health services (Beyer and Robinson, 2009).

There are also wider economic benefits. The annual economic costs of sickness absence and unemployment associated with working age ill-health are estimated to be over £100 billion (DWP, 2014). The annual cost of anxiety alone in England is estimated to be £9

billion, mostly due to lost productivity as a result of work days lost (Thomas and Morris, 2003).

Locally, our Job Centre Plus (JCP) survey of ESA claimants showed that those with mental health conditions are in very regular contact with their GP – 59% of those who responded to this question have contact with their GP roughly monthly, and 35% have contact *more* than monthly. Those with severe mental health conditions had even more frequent contact with their GP. Half were in contact with secondary health services. This concurs with anecdotal evidence from Haringey GPs.

Summary

In summary, there is a local need for support for those already in work, and current nationally commissioned services supporting people with health conditions back to work are not being fully utilised in Haringey

Black (2008) makes several recommendations that still hold true. Firstly, the awareness of the occupational health role and its importance in rehabilitation needs to be improved; secondly, GPs need to be educated on the importance of work for health and what they can do to promote employment, and lastly, there needs more coherent and coordinated communication between the different employment services to establish a clearer pathway to remaining in work. Improving existing services and developing new pathways back to work would not only reduce the costs associated with health-related unemployment and sickness absence but also improve productivity and lead to significant savings.

6.4 The proposal

Haringey would like to pilot a “proof of concept” model for increased support for people when they first seek help when mental ill health is affecting their work. This will be subject to support from national partners and agreement on a resource package. The pilot will focus on those with less severe mental health conditions who are currently employed but off sick. The population included in the trial will therefore be all working age residents in Haringey who are in work, are experiencing mental ill health which has prompted them to have a Fit Note conversation with their GP, and who GPs or employers think would benefit from support to retain the employment. Participants in the trial will be referred by their GP or their employer in line with Fit for Work’s eligibility criteria.

Haringey proposes significantly increasing referrals to the national Fit for Work service, through GP training, communications, SME engagement and the provision of feedback, whilst enhancing the Fit for Work service by enabling it to refer to local health and wellbeing services, and ensuring alignment with the HR processes of local public sector employers to ensure that staff working for the biggest employers in Haringey are benefiting from Fit for Work alongside those employed by SMEs.

We recognise that the current system is not efficient or effective and there is a lack of emphasis on early intervention and integration within mainstream services. There is also a lack of co-ordination between different stakeholders and lack of data sharing.

GPs would play a crucial role in assisting people to enrol on to a range of available services locally and nationally that would help people returning back to employment earlier and in a more flexible way, when appropriate. We will conduct a proof of concept pilot for 12 months for a whole system approach to gather the evidence for developing a full trial.

Evaluation of the proof of concept will focus on how the processes work in practice and whether meaningful data could be extracted from any subsequent trial. We will endeavour to measure some outcomes however understanding that pilot's impact on the outcomes may not be conclusive.

The objectives of the proof of concept pilot are therefore to:

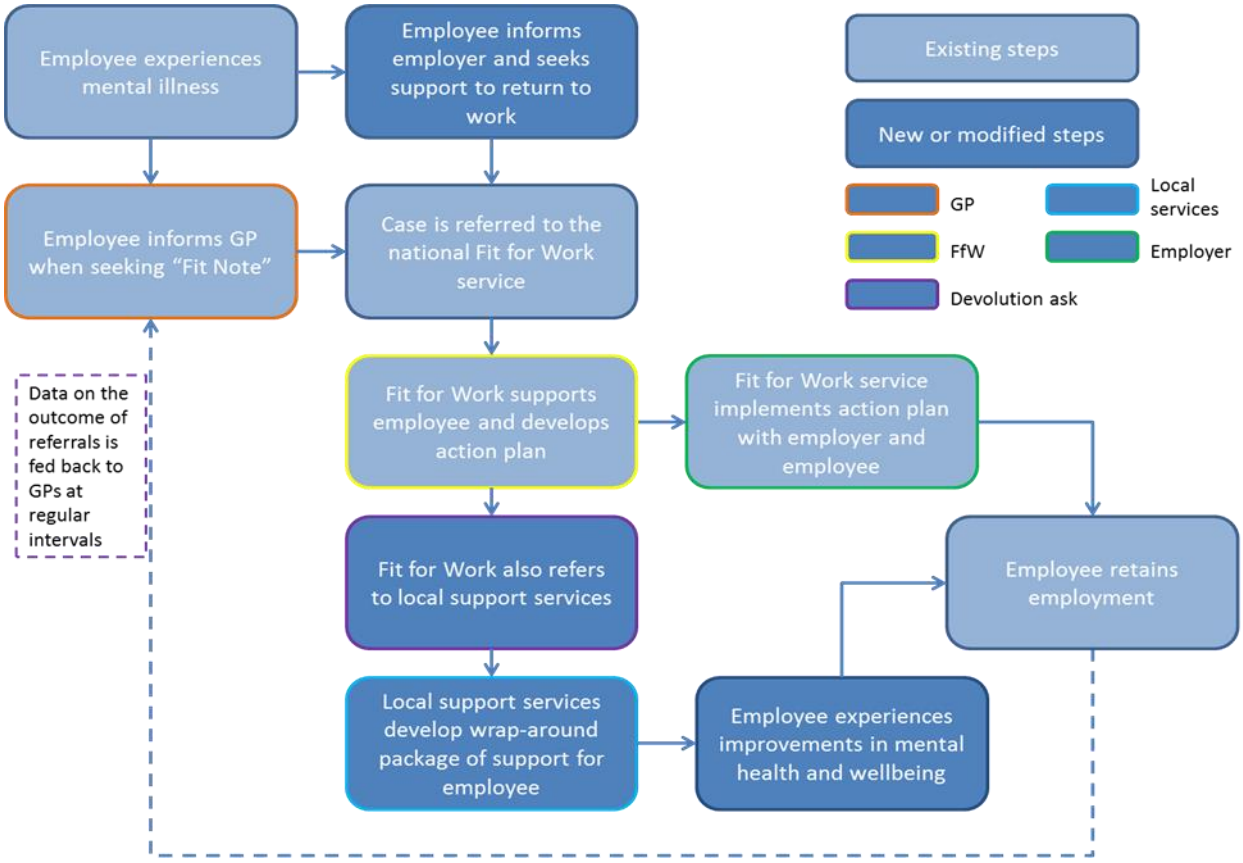
- Gather quantitative and qualitative evidence on the 'early help pilot' to inform the scale up of an integrated intervention
- Develop an integrated co-ordination role embedded within primary care as a 'place based setting' for assisting people early to maintain employment
- Develop an integrated, whole system response to maintaining employment for people experiencing mental health difficulties
- Preventing people with mental health conditions becoming long-term unemployed and claiming ESA benefits
- Reducing demand for health and care services from people with mental ill health.

Our proposal is to have a three-phase approach to this pilot:

- Phase 1 would concentrate on 'proof of concept' of the 'model' described below: duration of 12 months starting from June 2017 followed by:
- Phase 2: Scaling up 'proof of concept' across the whole borough
- Phase 3: Experimental study across North Central London and wider

The pilot trial

The population included in the trial is all working age residents in Haringey experiencing mental ill health which has prompted them to have a Fit Note conversation with their GP. Participants in the trial will be referred by their GP or employer as a result of that conversation and in line with Fit for Work's eligibility criteria. The pilot will aim to increase referrals to Fit for Work and at the same time equip Fit for Work to make referrals to local Haringey services to address support needs identified in the return-to-work plan.



The pilot will involve four different types of partners - GPs, Fit for Work, local medical and wellbeing services, and employers. The role of each type of partner is described below:

GPs

- The role of GPs is to carry out positive, asset-based Fit Note conversations with patients, and to make referrals to the Fit for Work service. It is likely that this asset-based conversation would facilitate the offer of return-to-work support.
- We will develop a GP training package that will involve general training aimed at establishing a common view on the health benefits of work, and specific training aimed at facilitating asset-based Fit Note conversations. This will involve guidance on how to use the Fit Note template to record details of positive steps that might help the patient return to work (such as phased return and workplace adjustments).
- We will develop clear communications materials that explain to GPs what the Fit for Work service is and what it does. We will develop a simple triage/referral tool that clarifies the Fit for Work eligibility criteria and the factors GPs should consider when deciding if the service is appropriate for their patient.
- We will ensure that there is ongoing feedback to GPs on the outcomes being delivered for Haringey patients by the Fit for Work service, to provide assurance and encourage continued referrals.

Fit for Work

- The role of Fit for Work (FFW) is to provide:
    - Remote assessments of referred clients, that are holistic and identify all of the client's medical and non-medical needs
    - Individually tailored return-to-work plans, setting goals for employers and employees
    - Ongoing case management to oversee the realisation of the return-to-work plan; case managers will provide ongoing support and motivation to the client
    - Communication with the employer to involve them in the creation of return to work plans. Communications might also involve mediating between employers and employees, overcoming breakdowns of communication/relationships.

- The above points summarise the existing role of the Fit for Work service, i.e. available to clients from across the country. Currently the Fit for Work service does not make referrals to local services – the client's return to work plan includes signposting links to national services (like Access to Work) or national charities/websites. The proposal for our pilot is to equip Fit for Work to make referrals to local Haringey services to address support needs identified in the return-to-work plan. This support could take the form of the FFW case manager signposting Haringey clients to Haringey services, using a directory of services provided by the pilot. This will fit with the current Fit for Work model however evidence suggests that signposting alone may not be sufficient for people with complex mental health needs.

- Our aim therefore is to enable the FFW case manager to make *coordinated* referrals, in which all referred-to services that are supporting an individual are working in a complementary way that is guided by that individual's return-to-work plan, its outcomes and timeframes. Achieving this coordination will involve establishing good lines of communication between FFW and local services, and arrangements for FFW case managers to track the progress of clients when they are being supported by local services. For FFW case managers to perform this coordinating and progress tracking role they may possibly require SLA-style agreements with local services to be established.

Local services (see Appendix I)

- The role of local services is to support clients to overcome the specific barriers that are preventing them from returning to work. The wide range of potential barriers that clients are likely to experience means that many different services, both medical and non-medical, will need to join up with the pilot.

- We will work with services to ensure they have the right processes and pathways in place (particularly in terms of triage, prioritisation and progress tracking) to deliver the fundamental outcome of the pilot - accelerated return-to-work. The ideal would

be to achieve a ‘hub’ model whereby all services work together to offer a seamless experience for the client that quickly and effectively delivers the support identified in their return-to-work plan, and enables the FFW case manager to track their progress.

- Given the importance of *quick* support, we will work with services to identify whether they can offer accelerated pathways/forms of support, or forms of support that can be delivered alongside a (possibly phased or partial) return to work.

- As well as specialist support services, we will also include within our ‘hub’ an Information and Advice service and a Social Prescribing service/Community Wellbeing Framework. The latter will signpost clients to local social/community activities to improve their wellbeing (e.g. our local Timebank) and connect them to mutual support networks (such as our Thinking Space peer-support initiative).

- We will lead on the evaluation of the model/research trial and work in collaboration with either North Thames CLAHRC (with whom we are already collaborating) or another academic institution to ensure robust clinical and economic evaluation is undertaken during the whole pilot duration (starting from proof of concept to full research trial).

Employers

- We believe that encouraging Haringey businesses to become healthy workplaces is a key part of reducing sickness absence happening in the first place. This involves businesses having HR and operational policies in place that prevent workplace stress, such as proper induction and training, flexible working policies, and grievance reporting and resolution processes. It involves improving the quality of Occupational Health services to respond when employees experience mental health problems.

- We will therefore promote the London Healthy Workplace Charter, and the Time to Change Mental Health campaign among Haringey employers. Haringey Council, Haringey CCG and Barnet Enfield and Haringey Mental Health Trust will lead by example, as the largest employers in the borough, and fully embed the Workplace Charter and Time to Change principles.

- As the largest employers, it is likely that a significant proportion of Haringey’s ESA claimant cohort will have once been employed in Haringey’s public sector. Evidence from DWP (Sissons et al. 2012) suggests that 21% of people claiming ESA immediately following employment are likely to have been employed by the public sector. Haringey Council HR data shows that 20,050 days were lost to absence in 2015/16. The top reason for sickness in the Council is ‘mental health’ (stress, anxiety, depression and fatigue) and accounts for 15% (3,242 days) of FTE absence days. It is therefore likely that there are many public sector employees in Haringey who would benefit from the early intervention offered by our pilot.

- Therefore as part of our pilot, we will ensure that the HR departments of the Council, CCG and Mental Health Trust are fully ‘joined up’ with the Fit for Work Service - in

terms of capacity to make referrals and respond positively to the return-to-work plans of employees who have been supported by FFW. We will monitor the outcomes for public sector clients and hold HR departments to account for those outcomes. We will attempt the same approach with Haringey's limited number of large employers - equipping their HR departments to work with Fit for Work.

- The vast majority of Haringey employers are SMEs so we will also take steps to communicate and engage with these businesses.

6.5 Devolution proposals

Please refer to the *Employment and health* section of the London Health and Care Devolution MoU. Through the MoU:

- London partners, DH and DWP commit to ensuring that local areas in London are able to jointly shape every element of the commissioning process: from strategy to service design, managing provider relationships and reviewing service provision. DWP commits to the transfer of the Work & Health Programme funding to London to enable London to procure and deliver an equivalent programme tailored to the needs of Londoners.

- Through the joint Work and Health Unit, DH and DWP commit to working with Haringey and London partners to test improvements to support people at risk of becoming long term unemployed; to understand what volumes of additional referrals to Fit for Work the enhanced service will achieve; and to explore signposting from Fit for Work to local services through the Return to Work plan.

- London and national partners (NHS and DWP4) commit to exploring options related to data sharing between relevant partners to facilitate a robust evaluation of the impact of enhanced local support for people experiencing mental health problems and who are at risk of falling out of work.

6.6 Proposed implementation plan

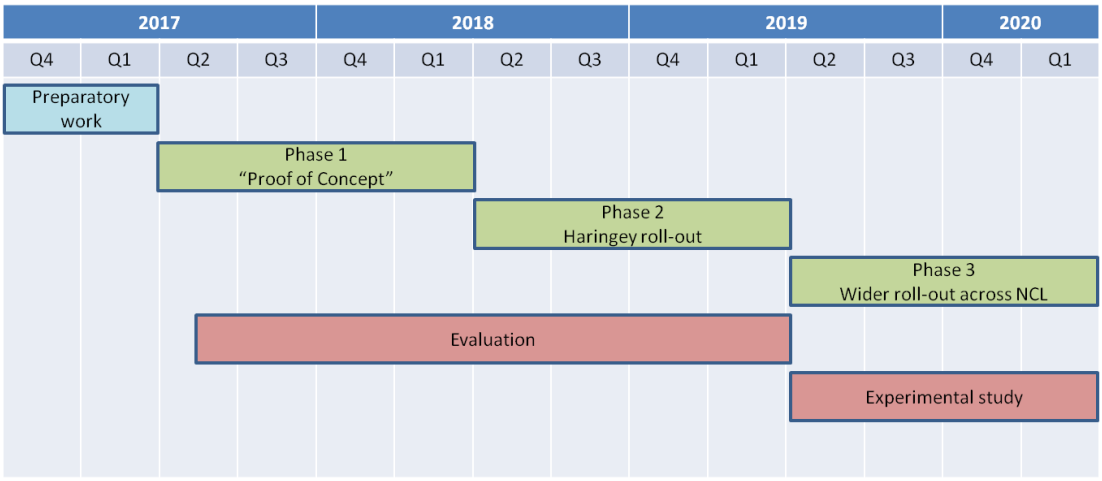
<u>Scope</u>

This work will initially focus on the London Borough of Haringey, with the potential for roll-out in the North Central London STP footprint, and potentially beyond, if the concept proves successful.

The focus will be on residents of the London Borough of Haringey who are in employment, but currently off work due to a mental health condition.

<u>Timeline</u>

[4] DWP will facilitate discussions with the Fit for Work provider when appropriate.



Preparatory work is already underway will include establishing the baseline, initial qualitative research and consideration of any necessary contract variations and agreements between partners before the project can begin.

During phase 1 we will undertake proof of concept, at a small scale, with one group of GP practices and one or two care co-ordinators. This will be to establish the referral pathways, resolve any implementation issues that arise, and test our ability to share meaningful information to enable us to undertake a rigorous evaluation.

During phase 2 we will scale up the project to cover the whole of Haringey, and undertake the proposed evaluation to inform a decision on whether to proceed further.

If the evaluation concludes that the pilot has been a success, we will look to further expand the geographical scope of the project to encompass the whole North Central London STP sub-region (Islington, Camden, Enfield and Barnet).

<u>Governance</u>

The project will be overseen by a partnership steering group, with representation from Haringey's Public Health and Economic Development teams, Haringey's CCG and GPs, Job Centre Plus, the local voluntary sector and the London Health and Care Devolution team.

<u>Evaluation work</u>

Evaluation of a localised approach to supporting residents who are absent from work with mental ill health difficulties will occur over three phases. The first two phases encompass exploratory and descriptive studies to refine the design and develop a 'proof of concept' of the localised employment retention model. The third phase will operate sequentially to the first two and involve a mixed-methods quasi-experimental research trial of effectiveness, with an embedded process evaluation. Representatives of all main stakeholders will be involved in each phase of the evaluation, including employees, employers, GPs, local service providers and Fit for Work/Access to Work.

Phase 1: Exploratory study

This phase is already underway and aims to:

a) Identify local stakeholder needs and priorities (including employees/GPs and employers).

b) Identify key local services which could provide 'wrap around' support for patients in addition to Fit for Work/Access to Work, which have previously been found to be associated with beneficial employment and health outcomes.

c) Work with local stakeholders to co-produce a design for a localised return to work service and refine and finalise a logic model linking intended activities to desired outcomes, making explicit relevant assumptions underlying these links.

d) Finalise evaluation questions and data requirements for a feasibility/descriptive study.

Activities to include:

i) Synthesis of existing local information identifying target population of interest (JSNA, mental health survey, JCP survey) (complete).

ii) Rapid review of the literature of GP issues with sickness certification and referral to Fit for Work (complete).

iii) Rapid review of the literature on interventions to support (employed) long term sickness absent individuals with mental ill health back to work (ongoing).

iv) Focus groups/interviews with relevant stakeholders (e.g., local employers/individuals on long-term sickness absence/GPs).

v) Development of logic model, engagement with stakeholders on emerging model design[5] (ongoing).

vi) Finalisation of logic model and employment intervention activities to be evaluated in phase 2.

vii) Identification of evaluation IT and data requirements and data access issues.

Phase 2 Descriptive study

This phase aims to:

a) Show whether the trial intervention is operating as planned

b) Provide feedback about its activities, identify areas for improvement and ways to improve the service

c) Determine whether the program is producing the types of outputs and outcomes expected

d) Help clarify program processes, goals and objectives

e) Apply for necessary ethical and other approvals for phase three study.

[5] Subject to employer and GPs input and agreement on logic model.

Activities to include

i) Collection of baseline survey data about those referred to vs those taking up the programme (including: age; gender; parental status; ethnicity; education; marital status; benefits receipt, employment status; employment type; income; sickness absence history; date of current sickness absence; quality of life/job satisfaction; wellbeing (WEMWBS); anxiety (GAD); depression (PHQ-9); self-reported health status (SF-12/EQ-5D); number of co-morbidities; reason for sickness absence; self-reported consultation frequency; duration of initial sickness absence certification; attitudes and barriers to, and expectations of, return to work; referral route).

ii) Collection of activity data to assess n (%) of eligible individuals at the pilot practice referred to intervention, n (%) of those referred who access the intervention, n (%) completing intervention, types of activities offered to pilot participants, activities completed.

iii) Semi-structured questionnaire to be completed before and after pilot by practitioners, vocational rehabilitation worker and employers involved in pilot to identify: perceived barriers and facilitators to intended pilot activities; confidence in fit note system; awareness of employment roles and appropriate adaptations/amendments; confidence in dealing with conflict about fit note decision; awareness of other stakeholder needs; awareness of local services; IT needs; ideas for improvement.

iv) Preliminary patient outcome data – wellbeing (WEMWBS); anxiety (GAD); depression (PHQ-9); self-reported health status (SF-12/EQ-5D); quality of life/job satisfaction; attitudes/expectations of return to work; date of return to work; recurrence of sickness absence; cumulative duration of sickness absence; uptake of health/employment-related benefits.

v) One to one interviews with service recipients for feedback, ideas for improvement etc.

vi) Comparison with aggregated return to work data/fit for work referrals/sickness certification data available from DWP.

Phase 3: Experimental study

Evaluation methodology for this phase will be developed once the first two Phases are completed. Findings of the first two Phases will inform design and evaluation of Phase 3.

Discussions with London partners regarding resourcing is ongoing. Any proposal is dependent on resources being made available.

7. Proposal 2: Creating Healthy Environments

At the beginning of this paper we emphasised that local government and local services play a crucial 'place- shaping' role in their local areas. Creating a healthier living and working environment will encourage all residents to adopt healthier behaviours, reducing the likelihood that they will develop complex, long-term health conditions.

Our vision for the prevention pilot is to work with London partners and national agencies, to find the most effective ways of using planning and licensing powers to create healthy environments and improve population level health. There are three areas of focus:

- Gambling
- Alcohol
- Tobacco

This section will address our evidence and devolution asks in turn, supporting a clear narrative for delivering greater focus on preventing ill health.

Why is Haringey focused on these issues?

Certain behaviours are leading contributors to poor physical and mental health in Haringey:

- Alcohol and Tobacco are two major contributors to early death and health inequalities in the borough
- There is growing concern about the proliferation of betting shops in the poorest parts of the borough and its impact on wider public health (beyond 'problem gambling').

We know from the academic literature and experience on the ground that there are three primary drivers that affect behaviour around alcohol, tobacco and gambling: affordability, accessibility and advertising. For example, studies show that the greater the availability of alcohol licensed premises in terms of hours and days of sale and clustering of premises then the greater potential for alcohol related harm (Campbell et al (2009), Bryden et al (2011)).

How will devolution enhance outcomes?

Our work to date has primarily focused on stretching licensing powers to influence access to substances. This is an area where local authorities have limited existing responsibilities.

Devolution will strengthen Haringey and London's ability to tackle issues surrounding alcohol, tobacco and gambling by:

- exploring the options for increased local licensing powers and;
- furthering the evidence base for the impact of gambling- related harm in the wider population.

Locally this pilot aims to prevent ill-health by pioneering new approaches to tackling problem gambling, alcohol misuse and smoking. This will support the sustainability of the health and social care system by creating an environment where it's easier to make healthy choices, thus preventing long term health conditions, or supporting people to manage them better if they do have one.

7.1 Current barriers to creating healthy environments

Limitations on local authority powers

Local authorities have responsibility for the health and wellbeing of their local population. However they are not always able to shape healthy local environments due to limitations on their powers. For example:

- Changes to the Licensing Act (2003) which came into effect in 2005 enabled a marked shift from regulatory containment to market led expansion. The Act abolished set licensing hours and the discretion of licensing authorities to assess applications based on need. This has resulted in a large increase in the availability of alcohol both in terms of hours and days of sale and the density and numbers of licensed premises.
- Similarly local authorities and the Gambling Commission are required under the terms of the Gambling Act (2005) to 'aim to permit' gambling. The net result is that local authorities are less able to influence the number of betting shops in their area.

To address this Haringey has taken steps to promote the use of voluntary alternatives to regulations in seeking to achieve public policy objectives. One example includes our Responsible Retailers Plus Scheme – which was brought in to reduce the sale of cheap, super strength alcohol following the government's re-think on minimum unit pricing of alcohol. However, this programme has had minimal impact primarily because it was not enforceable.

Lack of health considerations in licensing laws

Public Health teams – as one the newer 'Responsible Authorities' under the Licensing Act – have inputted into Licensing applications and reviews. However their efforts to address the health impacts of licensing decisions have been hindered as the current Licensing Act (2003) does not contain any health-related objectives.

Lack of local control over regulation

As a local authority we are best placed to deal with and provide more joined up services for people with gambling problems. However we are currently unable to do so as voluntary contributions from the gambling industry are not devolved to the local level. In addition

current licensing and planning regulations do not allow local authorities to influence a) the hours b) the location and c) the number of fixed odds bettering terminals (FOBT) as these are not licensed.

In Haringey and London alike the decline in smoking has not been equal across all groups. It is still the main contributor to health inequalities as it is more concentrated in disadvantaged groups. The regulatory framework for the sale of tobacco products is weak (ASH, Smoking Still Kills) and retailers do not need a license to sell a product which is uniquely dangerous. At the same time the evidence of the health benefits from the smoke-free legislation is robust and should be built upon.

7.2 Consultation with our partners

Our approach to developing and refining the Healthy Environments work stream and asks involved extensive consultation and collaboration with a range of national and regional partners: The London Healthy High Streets Group (linked to the London Association of Directors of Public Health), Home Office, DH, DCMS, PHE national and regional teams, London Illicit Tobacco Group, Safe Sociable London Partnership, London School of Hygiene and Tropical Medicine (LSHTM) and Geofutures.

As a result of this process, certain proposals deemed more effective at a cross-London level have been developed as London-wide devolution proposals (and are not part of this paper).

7.3 Tobacco

Each year, more and more Londoners are choosing to quit smoking, improving and lengthening their lives. As smoking is still the leading cause of avoidable death, we need to help more Londoners and residents in Haringey to do the same.

In Haringey 1 in 5 residents smoke (21%), rising to 1 in 3 residents from routine and manual labour occupations (39%).

As noted in 3.2 above, we have significant health inequalities challenges, with large gaps in healthy life expectancy between affluent and deprived areas in the borough. A significant contributor to this gap is residents living with long term health conditions, such as heart disease, stroke and diabetes – with smoking, alcohol, physical inactivity and poor diet being major behavioural risk factors.

Smoking impacts on sickness and productivity levels and increases demand for public sector services such as adult social care. In Haringey this costs the local authority (social care) an estimated £1.8 million and the NHS £8.4 million each year (ASH Local toolkit).

Haringey's rate of early death from stroke is the worst in London and the second worst in England; the borough has seen an increase of 120% from 2008-10 baseline, with an increasing trend. Haringey's Health and Wellbeing Board has committed to a 25% reduction in early death from stroke by 2016-2018 (from 92 to 68 deaths).

Creating an environment that prevents people from getting long term conditions in the first place – strengthening tobacco control in the borough is a key way to do this. This includes reducing the availability of cheap illicit tobacco, which makes it harder for smokers to quit and easier for young people to start.

Haringey has identified two devolution projects that can contribute to our objective of preventing long term health conditions through creating healthier environments.

7.3.1 Tackling illicit tobacco

The evidence

Retailers selling tobacco in England do not need a license to sell despite the fact that it is a uniquely dangerous product, killing half of all long term smokers.

Illicit tobacco reduces the positive public health impact of reducing tobacco use through the increased cost of tobacco taxation. The effects of this are felt most acutely at the local level, creating issues in communities and increasing demand on local council services.

A recent survey of smokers in North Central London boroughs in May 2015 found that among Haringey residents:

- Over a third (37%) were offered illicit or non-duty paid tobacco in the last year
- More than half of people who were offered illicit tobacco purchased it
- Three out of four (75%) Haringey residents surveyed had tried to make a quit attempt
- Over half of people surveyed said illicit tobacco made it harder to quit smoking.

Please refer to the *Prevention* section of the MoU for more detail and commitments on this

Impact of devolution pilot on local communities

This proposal will directly benefit both the target population and local communities as a whole. Devolution has the potential to reduce Haringey's significant health inequalities as smoking disproportionately impacts on poorer communities.

Price and tax measures are an effective and important means of reducing tobacco consumption, but this is undermined by cheap illegal tobacco. This harms local public health efforts to reduce smoking and worsens health inequalities, as smoking and the availability of illicit tobacco is more prevalent in poorer communities.

Tackling illicit and non-duty paid tobacco is highly cost effective (APPG Inquiry Report, 2010). Illicit tobacco costs the tax payer £2 billion a year (HMRC Tobacco tax gap 14/15). In Haringey recent seizures from 35 intelligence led operations by the local Trading Standards department are estimated to have lost the HM Revenue & Customs £21,600**.**

7.4 Alcohol

Alcohol is a key contributor to ill health, long term conditions and early death and the life expectancy gap in Haringey and London. The Department of Health estimates that 280,000 Londoners are dependent on alcohol, with a further 2.4 million drinking at levels which are harmful or placing them at increasing risk of harm to health. Haringey faces a similar challenge with 1 in 10 people binge drinking and over 10,000 high risk drinkers (Alcohol Treatment Performance Report, 2012).

Since 1970 the amount of alcohol consumed per person has risen by 50% in the UK. During this time alcohol has become relatively cheaper and more readily available (Information Centre). Alcohol is so aggressively and expertly marketed that drinking has become a normal feature of everyday life (Williams et al, 1980) (Home Office, 2002).

Increase in consumption has led to greater alcohol related harm. For example alcohol consumption is higher in men. In Haringey alcohol-related mortality rates for males is higher than the London average and the borough has seen a 12% increase from 2013 to 2014 (PHE Local Alcohol Profiles).

The health harms from alcohol misuse come at a huge cost to the UK economy. Alcohol-related healthcare costs associated with long term health conditions, crime and lost productivity are estimated to cost London £2 billion a year (Tackling Alcohol Misuse, GLA). In Haringey alone alcohol related Hospital Admissions increased by 49% between 2008-9 – 2014/15 (Local Alcohol Profiles), at an estimated £7.5 million cost. This is impacting negatively on already stretched local services.

7.4.1 The case for greater local control

The accessibility of alcohol

We know from the academic literature that the greater the availability of alcohol in a population the greater the potential harms due to increased consumption (Stockwell & Grunewald, 2004). A number of international studies and systematic reviews have shown that there is a relationship between availability (hours and days of sales and density of premises) on both consumption and harm including mortality rates, crime and traffic accidents (Campbell et al 2009, Bryden et al 2011).

Haringey's alcohol licensing landscape consists of an over concentration of small 'off license premises,' where alcohol-related health problems are fuelled by the availability of low cost, high volume alcohol. There are currently 884 licensed premises in Haringey, a rise of 41% or 255 new premises since 2005-6. These premises, along with larger supermarkets and on-line shopping facilities, often encourage bulk buying through considerable discounts.

The limits of current licensing laws

Historically licensing has been concerned with crime and disorder, public safety and protecting children from harm. However health impacts are linked to alcohol consumption and consumption is linked to availability. There is a need for public health bodies to be actively involved in the licensing activities of a local area. The Licensing Act 2003 does not have health as one of its four licensing objectives – making it difficult to take health considerations into account in licensing decisions.

Including health as a fifth licensing objective (HALO) would enable local authorities to take all health related harms into account when considering licensing applications. This will allow local authorities to restrict the number of new premises selling alcohol, if there is evidence of local alcohol related health problems.

7.4.2 Our devolution proposal for addressing alcohol- related health

Following a roundtable meeting with Public Health England, the Home Office and Department of Health it was confirmed that HALO (were it to be introduced) would be at the national level. The Home Office is asking for areas to continue to build the evidence base for HALO and to this end are rolling out a further round of Local Alcohol Action Areas (LAAAs).

Haringey have secured resources of the London School of Hygiene and Tropical Medicine to undertake a collaborative programme of research. This will continue to build the evidence base for health as a fifth licensing objective.

The research programme with London School of Hygiene and Tropical Medicine started in November 2016, and will conclude in March 2018.

The MoU contains a commitment from London partners to explore the interaction between planning policy and London's health and wellbeing objectives.

Impact of the devolution proposal

There is strong evidence that the concentration of outlet density impacts on alcohol related harm with a NICE review of international evidence relating to some alcohol policies including controls on the availability of alcohol concluding that *'reducing the availability of alcohol is one of the most effective policy measures to reduce the harm from alcohol consumption and misuse. Licensing is the mechanism which regulated the availability of alcohol, controlling the numbers of alcohol outlets, conditions of sale and operating hours'.*

As licensing is the mechanism which regulated the availability of alcohol, controlling the numbers of alcohol outlets, conditions of sale and operating hours, health as a fifth licensing objective can make a significant impact in reducing the availability of alcohol and levels of harm in local populations. This is because it will allow Haringey Council and other London boroughs greater scope of the use of health data licensing decisions. For example

it will allow Haringey to argue that alcohol related Accident and Emergency admissions are a public health issue, as well as a proxy indicator for crime and disorder.

Reduced alcohol consumption is likely to lead to increased productivity and reduced absenteeism. The cost of lost productivity due to alcohol misuse to substantial with up to 17 million working days lost each year because of alcohol-related sickness (NICE, June 2010). The total cost to the economy is estimated to be £7.3bn (Home Office, November 2012).

Given the levels of alcohol-related health harms and the evidence to support the link between outlet density and alcohol-related harm, health as a fifth licensing objective has the potential to support the sustainability of the NHS and reduce demand on social care by creating a supportive environment where it's easier to make healthy choices.

7.5 Gambling

Gambling, especially problem gambling, is linked to poor physical and mental health. There are also links to alcohol co-dependence (Cave & Pryer, 2012).

Until recently gambling-related harm has been understood only in terms of this harm to the individual who is gambling. While this is no doubt an important component of harm, gambling-related harm needs to be understood in the broadest sense: harm to the individual, their families, wider social network and communities, regardless of whether the gambling behaviour could be defined as problematic.

According to the Gordon Moody Association (2014) who provide help for problem gamblers, it is estimated that for every problem gambler at least 10 other family members, friends and colleagues are affected. It has also been reported that many problem gamblers have resorted to illegal activity, stealing from loved ones and their employers. Some even declare bankruptcy, adding to society's financial burden with estimated costs of up to £37,000 a year to the state.

As a result of gambling many families have broken down, affecting children both emotionally and sometimes financially. In the words of the Gambling Commission (2016):

"Gambling-related harm goes wider than the harm experienced by those identified as problem gamblers by existing screening tools - it can also affect the families of gamblers, their employers, their communities and society more widely"

Recent research by Geofutures (Wardle, 2014), with backing from the Local Government Association, has helped us better understand what is meant by vulnerability in the gambling context, including exactly which groups are most at risk from gambling related harm. Broadly these have been defined as people who are unemployed or on low-income, homeless populations, offenders, migrants, the socially isolated, people with certain mental health conditions and those with impaired judgement – e.g. learning disabilities or low educational attainment, those in treatment for substance misuse, problem gamblers and the young.

As Wardle (2014) notes a solid evidential base looking at gambling-related harm has been constricted because most research on gambling is focused on the risks of 'problem gamblers'. Haringey contends that further research is needed to understand the impact of harm beyond the individual who is gambling, building a greater evidence base for gambling as a wider public health issue.

7.5.1 The case for local control

Impact on the health and wellbeing of residents

In Haringey as elsewhere there is an over-representation of betting shops in the poorer parts of the borough (Wardle et al, 2014). Like other authorities across England we are increasingly concerned with the proliferation and clustering of betting shops in the most deprived areas. This impacts vulnerable groups, anti- social behaviour around betting shops and the longer term sustainability of our high streets.

This proliferation is in part due to the introduction of the Gambling Act (2005) which removed local controls limiting access and availability to many forms of gambling. Local authorities and the Gambling Commission are required under the terms of the Gambling Act (2005) to 'aim to permit' gambling within the context of the three gambling licensing objectives:

- to keep crime out of gambling
- to ensure it is fair and open
- to protect the young and vulnerable

It is Haringey's contention that we are not able to exercise our duty to protect vulnerable populations under the current Gambling Act as local authorities are not able to control the number of Fixed Odds Betting Terminals (FOBTs), the location and hours or operation of betting shops.

Evidence of the local impact

Haringey residents voiced their concerns about the number of betting shops as part of the extensive consultation work carried out for the regeneration of Tottenham (Tottenham Perceptions Survey, 2014) and a Health Impact Assessment carried out on one of the housing estates in Tottenham.

Research carried out in Haringey, as part of the health evidence for emerging policy concerning retail provision, suggests that where there are high concentrations of gambling facilities and there are higher levels of gambling activity in the local population.

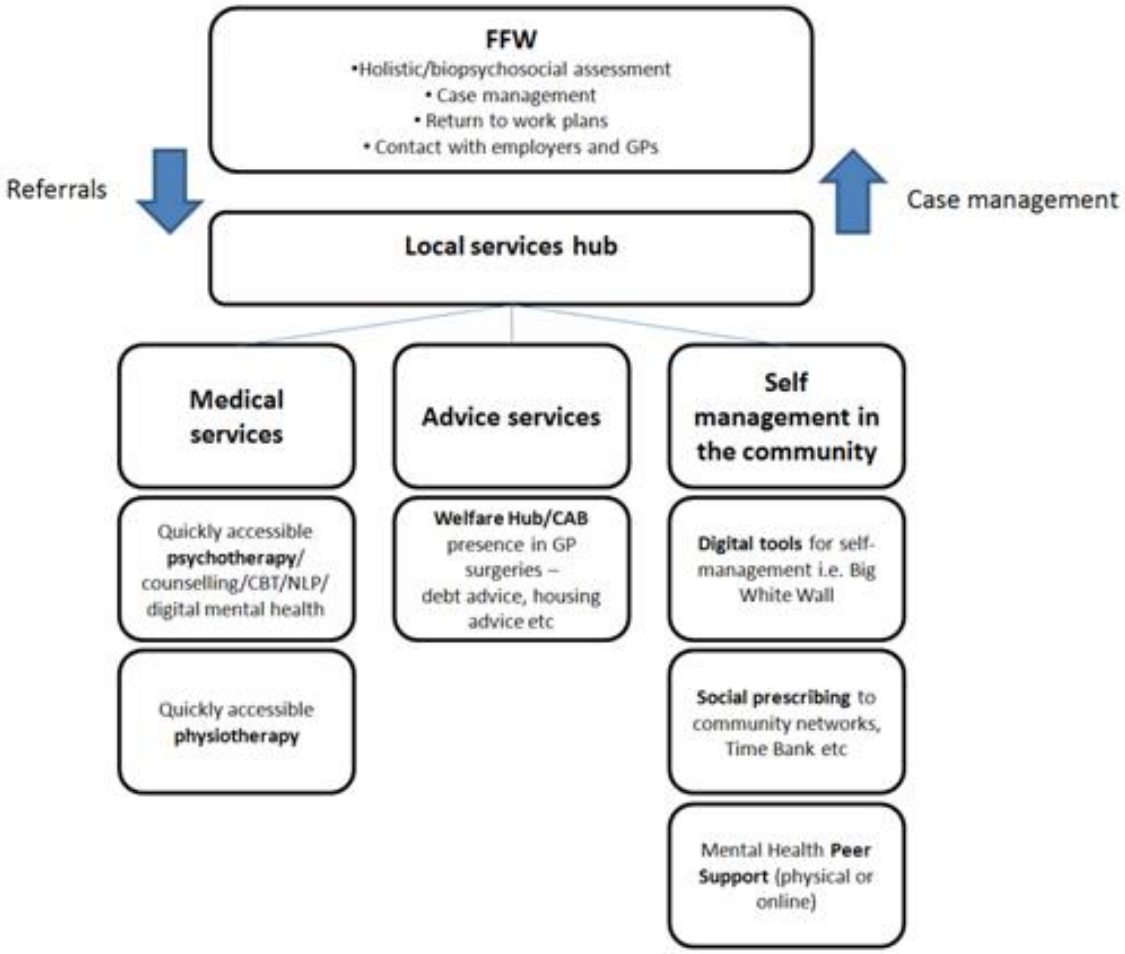
Haringey's Scrutiny Review into betting shops noted that there is some evidence that betting shops have contributed to low-level crime and antisocial behaviour. FOBTs were cited as especially susceptible to criminal damage. A joint problem solving group in

Haringey found that betting shops in Haringey had been involved in 262 crimes over 1 year. As betting shops tend to cluster it was noticed that crime rates increased in areas which already had high crime rates.

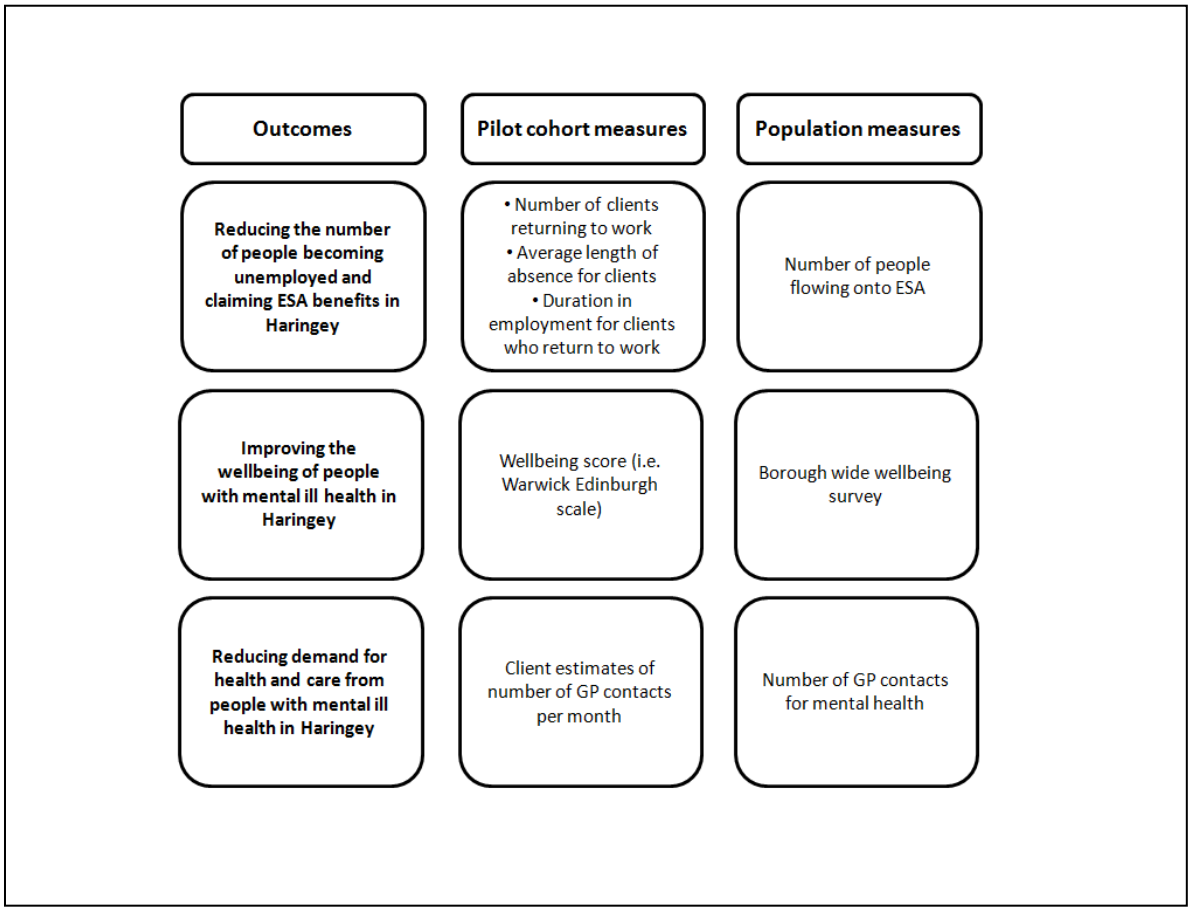
Discussions with London partners regarding resourcing is ongoing. Any proposal is dependent on resources being made available.

Please refer to the *Prevention* section of the MoU to see commitments in this area.

Appendix I: Emerging model for locally designed hub that would support Fit For Work service.



Appendix II – Proposed outcomes to be measured during pilot project



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