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NOTICE OF MEETING

HARINGEY CHILDREN & YOUNG PEOPLE'S STRATEGIC PARTNERSHIP BOARD

TUESDAY 27 MARCH 2007 AT 18.30hrs
CIVIC CENTRE, HIGH ROAD WOOD GREEN, LONDON N22.

MEMBERSHIP: Please see attached table for list of members

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS:

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at Item 12 below).

3. DECLARATIONS OF INTEREST:

Members must declare any personal and/or pecuniary interests with respect to agenda items and must not take part in any decision required with respect to these items.

4. MINUTES: (PAGES 1 - 8)

To approve the minutes of the Haringey Children & Young People's Strategic Partnership Board meeting held on 22 January 2007 (attached).

5. BUSINESS ITEMS:

Three minute oral update items from all partners as necessary. Longer items to be accompanied by a short paper sent in advance.

6. MONITORING ITEMS: (PAGES 9 - 12)

Changing Lives 2006/07.

7. STRATEGIC FOCUS ITEM (I): (TO FOLLOW)

Teenage Conceptions: a presentation and discussion on the joint strategy to reduce teenage conceptions (as part of the overarching work around child poverty) and a focus on how this might be improved.

8. STRATEGIC FOCUS ITEM (II): (PAGES 13 - 62)

Reducing inequalities in life expectancy.

9. STRATEGIC FOCUS ITEM (III) (PAGES 63 - 82)

Reducing inequalities in infant mortality.

10. GROUP TASK: (PAGES 83 - 90)

Changing Lives 2007/08: this will be a verbal report of the Director of Children & Young People's Service

11. ANY OTHER BUSINESS

12. ITEMS OF URGENT BUSINESS:

To consider any new items admitted under Item 2 above.

13. DATES OF FUTURE MEETINGS:

- 14 May 2007 at 6.30pm
- 9 July 2007 - to be confirmed
- 25 October 2007 - to be confirmed
- 13 November 2007 - to be confirmed
- 10 December 2007 - to be confirmed

14. FUTURE AGENDA ITEMS:

Partners should submit proposed agenda items for the next meeting (14 May 2007) to Nicolas Mattis (nicolas.mattis@haringey.gov.uk) no later than 9 April 2006. **Current suggested Agenda Items for 14 May 2007 meeting:**

Business items: tba
Monitoring: tba
Strategic focus: mental health, joint commissioning, Changing Lives 2007/08.
Group Task: NEETS - a scrutiny of the action plan.

YUNIEA SEMAMBO
Head of Local Democracy & Member Services
River Park House
225 High Road
Wood Green
LONDON N22 4QH

NICOLAS MATTIS
Principal Committee Co-ordinator
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nicolas.mattis@haringey.gov.uk
www.haringey.com

19 March 2007

CYPSPB MEMBERSHIP 2006/7

NOTE: Please inform the Committee Clerk if the name and/or contact details of a representative changes for any

SECTOR GROUP	AGENCY	NO. OF REPS	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	6	**Councillor Liz Santry**, Exec Member, Children & Young People (Chair) **Councillor George Meehan**, Leader of the Council **Councillor Nilgun Canver**, Exec Member, Crime and Community Safety **Dr Ita O'Donovan**, Chief Executive **Councillor Emma Jones**, **Sharon Shoesmith**, Director of Children and Young People's Service
PCT	Haringey Teaching Primary Care Trust	4	**Sue Baker**, Non-Executive Director **Pam Constantinides**, Non-Executive Director **Dr Vivienne Manheim**, General Practioner **Helen Brown**, Director, Strategy, Performance & Children's Services
	North Middlesex Hospital trust	1	**Claire Panniker**, Chair of Trust
	Mental Health Trust	1	**Jane Lithgow**, Director of CAMHS
	Whittington Hospital Trust	1	**David Sloman**, Chief Executive
	Great Ormond Street Hospital	1	**Maria Collins**, Director of Partnership Development
Voluntary Sector	Haringey Association of Voluntary and Community Organisations (HAVCO)	2	**Jim Shepley**, Chair of HAVCO **Stanley Hui**, Director of HAVCO
	Haringey Community Engagement Network (HarCEN)	1	**tbc**
Education	Connexions (North London)	1	**Lenny Kinnear**, Chief Executive
	Learning and Skills Council (London North)	1	**Mary Vine Morris**, Chief Executive
	Middlesex University	1	**Dr David Shemmings**, Principal Lecturer & Chair of Social Work
	College of North East London	1	**Paul Head**, Principal
Schools	Early Years and Play	1	**Bev Johnson**, Development Manager,
	Primary Schools	1	**Andrew Wickham**, Head Teacher, Weston Park Primary School
	Secondary Schools	1	**Andy Kilpatrick**, Head Teacher, Northumberland Park Community School
	Special Schools	1	**Margaret Sumner**, Head Teacher, William C Harvey School
Other Community Agencies and Groups	Haringey Probation Service	1	**Sean Walker**, Head of Service Delivery
	Metropolitan Police	1	**Commander Simon O'Brien**, Borough Commander
	Youth Offending Service	1	**Jean Croot**, Head of Community Safety, Haringey Council
	Haringey Youth Council	2	**Youth Councillor Shayan Mofitzedeh** **Youth Councillor Adam Jogee**
	Total	**30**	

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Agenda Item 4

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HARINGEY CHILDREN & YOUNG PEOPLE'S STRATEGIC PARTNERSHIP BOARD

MONDAY 22 JANUARY 2007 AT 18.30hrs
CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON, N22.

DRAFT MINUTES

PLEASE SEE APPENDIX ONE (BELOW) OF THE MINUTES FOR A LIST OF THOSE MEMBERS, OBSERVERS, AND OFFICERS PRESENT AT THE MEETING.

1. APOLOGIES (Agenda Item 1):

Apologies were received on behalf of the following members:

Andrew Kilpatrick
Councillor Nilgun Canver
Sue Baker
Dr Ita O'Donovan

2. URGENT BUSINESS (Agenda Item 2):

None

3. DECLARATION OF INTERESTS (Agenda Item 3):

None

4. MINUTES (Agenda Item 4):

RESOLVED:

That the minutes of the last meeting of the HSP on 20 November 2006 be agreed and signed by the Chair.

5. THE COMMUNITY STRATEGY UPDATE (Agenda Item 5):

The Board heard that following the open consultation on the Draft Sustainable Community Strategy, the document is being redrafted. The redrafted document would:

- Give greater prominence to issues around children and young people
- Have a greater focus on inequality and health inequalities.
- Be a document of two parts – the top strategy, supported by a more "technical" document that contains the action plans and targets.
- The redrafted document is to be discussed with the council's Executive and the HSP Steering Group. The HSP Steering Group was set up to oversee and authorise the drafts.
- Comments from the CYPSPB can still be considered if they are received by 26 January 2007.
- The final strategy is scheduled to be published in April.

Further information is available from the Project Manager, Janice Robinson (janice.robinson@haringey.gov.uk).

6. PROGRESS WITH PLAY STRATEGY AND BIG LOTTERY FUND (Agenda Item 6):

This item was a revisit to the Board as improvements had been made since the Board last considered it, and it would go before the Board at its absolute final stage. A bid to the BLF would be made in March 2007 after the Strategy had gone through the Council's Executive. Concerns over the term "play" as opposed to "leisure" were raised and taken on board by the project team managing the Strategy.

7. SAFER SCHOOLS PROGRESS REPORT (Agenda Item 10):

The Board had received three reports focussed on safer schools issues and various projects. The Board was informed that funding had been gained up to March 2008, but that more was needed once this date had past. The importance of securing this funding for the benefit of continuity of the good work done so far was highlighted by the Board. The Board also heard that SCF would be ending in 2008, in large part going directly to schools and that this transition would need to be considered by the Board in due course.

RESOLVED

That the reports be noted in order for thinking on future funding to continued.

8. JAR ACTION PLAN (Agenda Item 7):

The Board was informed that the draft post-JAR Action Plan had been developed but that there was still work in progress. The Board noted that good progress had been made especially in the evaluation of social workers. The Action Plan would not be brought back to the Board once it had been finalised, but it would be subjected to internal exception reporting.

9. THREE MONTHLY EXCEPTION REPORT ON YOUTH SERVICES ACTION PLAN (Agenda Item 8):

The Board heard that this report was unavailable at present and would be brought to the Board at its meeting on 22 March 2007. The Board noted that the Council's Youth Member Working Group also received this report for monitoring.

10. REPORT ON FINAL EXAMINATION RESULTS (Agenda Item 11):

A report was tabled outlining CoNEL's successes in retention and achievements for 2005/6. The overall position was reported as follows:

Achievement:	92% (against a benchmark of 84%)
Retention:	94% (against a benchmark of 86%)
Success:	86% (against a benchmark of 72%)

The Board heard that in future, these results should be brought together in order to manifest joint service provisions throughout education/schooling careers (for example from schools into colleges).

The Board also heard that examination results for the borough's schools had continued to improve, and that "value-added" scores were significant. Full details about school examination results would be available on the Council's web-site in due course.

11. CHANGING LIVES 2007/8 (Agenda Item 9):

The Board were invited to reconsider the twenty priorities of the *Changing Lives* plans as it approached it's second year and thus taking into account the following:

- The Local Area Agreement targets and stretch targets especially in terms of partners' inputs.
- The costs associated to each of the priorities.
- Childrens Trust arrangements

The Board split into small work-groups to consider these issues before feeding back their thoughts as follows:

- It was felt that the current plan used included some "woolly" outcomes.
- The plan should include language that emphasised positive improvement/direction of travel.
- Consideration over developing the role of external partners' roles to ensure positive contribution in the outcomes.
- A spread of best practice by focussing not just on Council related activities, but also on partner activities.
- Work on focussing on preventative work rather than reactive especially in terms of mental health.
- Information on costs needed.
- Ensure that the headline priorities remain up-to-date and relevant according to the information that becomes available.
- Time based specific outcomes needed.
- Consideration of a risk assessment for short-term funded priorities.
- Consideration of hierarchy around priorities to ensure a domino effect starting with the hard hitting priorities that will stimulate others.
- In terms of some specific priorities within the current plan, the following was suggested:
    - Add "learning" to priority three – *improve outcomes for children and young people with "learning" disabilities.*

- Add “alcohol dangers” to priority eight
- Priority 11 to be reviewed in line with new targets
- Priority 19 to be reversed in its approach in order to express a positive impact, ie to *increase* the number of young people between the ages 16-19 who are in education, employment or training, especially those looked after by the local authority.

The Board heard that these comments would be taken on board during the redrafting of the plan.

12. CONNEXIONS FUTURE AND ACTION PLAN (Agenda Item 12):

The Board was given a summary of the situation by with responsibility for the services currently delivered by Connexions, and the funding that goes with it, will progressively transfer to local authorities between now and 2008. This would also be a target for the LAA. In terms of the transition, there were four option models available to manage this. The Board heard that option 4 (a hybrid of in-sourcing and out-sourcing), and that it had been agreed with neighbouring boroughs to maintain the status quo until April 2008. The Report before the Board highlighted weaknesses of the current Connexions service, but the Board heard that work had been done to rectify these with plans in place to address the weaknesses in all areas identified which was not reflected in the Report. It was agreed to update and undertake to reflect these efforts and improvements before the Report went to the Council’s Executive. The Board heard that improvements to performance were vital and that the ad-hoc group on NEETS which was being set up by the Haringey Strategic Partnership would report on this.

RESOLVED

That the Report be agreed subject to said updates.

13. ANNUAL REPORT FROM LSCB (Agenda Item 13):

The Board heard that the Learning Safeguarding Children Board had been functioning generally well and that its core membership had been achieved which included an element of direct young people involvement. A DVD had been produced raising awareness of safeguarding which had aided a popular training programme. The Board also heard that there had been no serious case reviews held in Haringey to date in 2006/7. The Board finally heard that as the LSCB is funded through a pooled budget, future funding contributions would be sought from partners.

14. NRF PROGRESS (Agenda Item 14):

The Board was given an update on what projects would need to be carried on in 2007/8 but with £100k less in the NRF budget that the current year. After discussion about various projects included in the funding, including funding for the Muslim Cohesion Group and supplementary schooling, the Board agreed to receive the 2008/9 plan at its meeting in September 2007 in order to incorporate/rectify some of the concerns identified – one of which was to link allocations of NRF to the LAA.

15. LOCAL AREA AGREEMENT (Agenda Item 15):

The Board heard that the final LAA submission to GOL was nearing completion – awaiting final agreement on a small handful of *stretch* targets which would need to be measurable before signing off the agreement.

RESOLVED

The Board agreed to the following recommendations:

- To note the report and the current children and young people's LAA
- To note the need to monitor future progress of the LAA and carry this out via the quarterly *Changing Lives* performance monitoring reports

16. CHILDREN'S NETWORK DEVELOPMENT UPDATE, SOUTH NETWORK, IMPROVEMENTS FOR THE INDIVIDUAL IN NEED (Agenda Item 16):

The Board was given an updated summary of the work being carried out on expanding the Children's Network pilot into the borough which will streamline and fast-track child protection systems – ultimately building a "team around the child". The Board also heard that guidance had been produced in order highlight the new processes. Evaluation systems would also be in-place going forward, in order to ensure deliverability and improvements.

RESOLVED

The Board agreed to the following recommendations:

- To continue to endorse the work in progress
- That individual agencies within the CYPSP continue to review their own practice in relation to delivering the "team around the child" approach and reflect the move to more integrated service delivery within their own planning processes.
- To continue to monitor the implementation of the Children's Networks approach and request a further update in April 2007.

17. ANY OTHER BUSINESS (Agenda Item 17):

- An invite was extended to partners to the HAVCO CYP VCS Theme Group Event to be held on 6 February 2007 between 12:30 and 4:30pm at the Selby Centre.

18. ITEMS OF URGENT BUSINESS (Agenda Item 18):

None.

19. DATES OF NEXT MEETINGS (Agenda Item 18):

The following dates for future meetings of the CYPSPB were confirmed as follows:

- 12 March 2007, 6:30pm
- 14 May 2007, 6:30pm

20. FUTURE AGENDA ITEMS (Agenda Item 16):

Partners wishing to put forward items for a future agenda are asked to contact Nicolas Mattis, Principal Committee Co-ordinator at: nicolas.mattis@haringey.gov.uk

The meeting ended at 21:00 hours.

_____

Councillor LIZ SANTRY
Chair, Children and Young People's Strategic Partnership Board 2006/7

Date:_____

APPENDIX ONE

MEMBERS PRESENT AT THE MEETING

22 January 2007

SECTOR GROUP	AGENCY	NAME OF REPRESENTATIVE
Local Authority	Haringey Council	**Councillor Liz Santry**, Exec Member, Children & Young People (Chair) **Councillor George Meehan**, Leader of the Council **Sharon Shoesmith**, Director of Children and Young People's Service **Councillor Emma Jones**
PCT	Haringey Teaching Primary Care Trust	**Pam Constantinides**, Non-Executive Director **Helen Brown**, Director, Strategy, Performance & Children's Services
	North Middlesex Hospital trust	
	Mental Health Trust	**Jane Lithgow**, Director of CAMHS
	Whittington Hospital Trust	**David Sloman**, Chief Executive
	Great Ormond Street Hospital	**Maria Collins**, Director of Partnership Development
Voluntary Sector	Haringey Association of Voluntary and Community Organisations (HAVCO)	**Jim Shepley**, Chair of HAVCO **Stanley Hui**, Chief Executive of HAVCO
	Haringey Community Engagement Network (HarCEN)	
Education	Connexions (North London)	
	Learning and Skills Council (London North)	**Yolande Burgess**
	Middlesex University	
	College of North East London	**Paul Head**, Principal
Schools	Early Years and Play	
	Primary Schools	
	Secondary Schools	
	Special Schools	**Margaret Sumner**
Other Community Agencies and Groups	Haringey Probation Service	
	Metropolitan Police	**Commander Simon O'Brien**, Borough Commander
	Youth Offending Service	**Jean Croot**
	Haringey Youth Council	

OBSERVERS/OFFICERS PRESENT AT THE MEETING

11 September 2006

AGENCY	NAME
CYP Partnerships for Health	**Devala Dookun**
Safer Schools Project	**Vic Lofthouse**
Haringey Children and Young People's Service	**Patricia Walker**
Haringey Member Services	**Nicolas Mattis**

Agenda Item 6

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AGENDA ITEM

MEETING

Children and Young People's Strategic Partnership Board
27 March 2007

TITLE

Monitoring of *Changing Lives*

SUMMARY

Attached are the key performance indicators for

RECOMMENDATIONS

That the CYPSP note and comment on the monitoring for *Changing Lives*

LEAD OFFICER(S)

Sharon Shoesmith,
Director
The Children & Young People's Service

Summary of Key Performance Indicators for CYPSP Monitoring (Feb 06)

	Ref	Description	YTD Outturn (end Feb)	06/07 Target	RAG
1.	Be Healthy 1047SC/ LAA*	Number of Conceptions amongst 15-17 year olds per 1000 population	2004 data	2002-2004 Baseline 72.8	A
2.	Be Healthy (CL)P4.1b&c/ LAA*	Infant Mortality - smoking during pregnancy - breast feeding	12.1% 87.99%	5% 79%	R G
3.	Be Healthy (CL)5.3	% schools receiving Healthy Schools status	10	39 (50%) (July 07)	A
4.	Stay Safe 2020sc	% of initial assessments completed in timescale	75%	63%	G ↑
5.	Stay Safe 2022sc	% of core assessments completed in timescale	63%	72%	R ↑
6.	Stay Safe 2023sc	Number of Children on the CPR (Figure in brackets relates to rate per 10,000 population)	132 (26.6)	195 (39)	G ↑
7.	Stay Safe 2034sc	% of Children on the CPR reviewed in timescale	100%	100%	G →
8.	Stay Safe 2042sc	Number of Children Looked After (LAC) (Figure in brackets relates to rate per 10,000 population)	443 (89.3)	465 (93)	G ↑
9.	Stay Safe 2043sc	% of LAC with 3+ placements in the year	11%	13%	G ↑
10.	Stay Safe 2059sc	Number of Adoptions	17	22	A →
11.	Stay Safe/ LAA*	Percentage of School Travel Plans completed	65 STP Complete	86 STP	A
12.	Enjoy & Achieve 3072sc	% of LAC aged 16+ who left care in the year with 1+ GSCE at grades A*-G	51%	55%	A ↑
13.	Enjoy and Achieve/ LAA	% Children looked after for 12 months or more achieving 5+GCSE's A*-G	21%	12.2% 05/06	G ↑
14.	Enjoy and Achieve / LAA	% Children looked after for 12 months or more achieving 5+GCSE's A*-C	50%	40.3% 05/06	G ↑
15.	Enjoy & Achieve 3070AC/43a	BV 43a – Percentage of SEN Statements completed in 18 weeks (excluding exceptions)	100%	99%	G →
16.	Enjoy & Achieve 3070AC/43b	BV 43b – Percentage of SEN Statements completed in 18 weeks	80%	85%	R
17.	AEW (CL)P19.2	Not in Education, Employment or Training (NEETs)	13% (Jan)	12.9%	R

*The Local Area Agreement (LAA) is part of a Government 10 year strategy to build a new relationship between central and local government. This includes mandatory outcomes, optional outcomes and stretch targets.

→ = in line with 05/06 outturn; ↑= improvement on 05/06 outturn; ↓ = decline from 05/06 outturn
R = target not likely to be achieved; A = to keep under close review; G = target achieved/exceeded

	PAF/BV/ Local Ref	Description Years are expressed as academic years	Haringey 2005	Haringey 2006 provisional	Haringey Target 2006	Haringey Target 2007	Haringey Provisional Target 2008	RAG
ENJOY AND ACHIEVE	FSP	% of children scoring 6 or more in all PSED scales	68	63	Not set	68	70	A
	FSP	% of children scoring 6 or more in all CLL scales	44	41	Not set	44	48	A
	3002OF	KS1 Reading Level 2+	79%	78%	79%	80%	82%	A
	3003OF	KS1 Writing Level 2+	76%	74%	76%	77%	78%	A
	3004OF	KS1 Maths Level 2+	88%	87%	88%	88%	89%	A
	3005OF/BV 41/ LAA	KS2 English Level 4+	73%	75%	75%	76%	78%	G
	3006OF/BV 40/ LAA	KS2 Maths Level 4+	68%	70%	75%	75%	76%	R
	3007OF/ LAA	KS2 Science Level 4+	78%	79%	80%	82%	83%	A
	BV194a	KS2 English Level 5+	25%	30%	29%	31%	32%	G
	BV194b	KS2 Maths Level 5+	25%	28%	29%	31%	32%	A
	3008OF	Value Added Measure KS1 to KS2	100.4	100.0				G
	3009OF/BV 181A	KS3 English Level 5+	64%	61%	65%	67%	68%	R
	3010OF/BV 181B	KS3 Maths Level 5+	61%	64%	65%	68%	70%	A
	3011OF/BV 181C	KS3 Science Level 5+	52%	56%	60%	63%	65%	R
	3012OF	Value Added Measure KS2 to KS3	99.4	99.5				A
	3013OF/BV 38	% achieving 5+ A* - C	49%	52%	53%	57%	59%	G
		% achieving 5+ A* - C (inc Eng and maths)	32%	34%	Not set	41%	44%	A
	3014OF	% achieving 1+ A* - G	95%	95.0%	96.0%	96.0%	96.5%	A
	3017OF	Value Added Measure KS2 to GCSE/Equivalent	1003.10	1011.2				G
	3018OF	Value Added Measure KS3 to GCSE/Equivalent	1015.40	1001.4				G
	Local indicators LPSA 2	% half days missed - absence in secondary schools	8.63%	8.24%	8.60%	8.40%	7.7%	G
	Local indicators LPSA 2	% half days missed - absence in primary schools	6.41%	6.63%	5.80%	5.60%	5.4%	R
	5003OF	Schools with 6th forms: Avg point score of students entered for GCE/VCE A/AS	188.8	566.2 (new points system)	580	590	600	A
	AEW (CL)P20.1	% 19 year olds qualified to Level 2	57	62	60	65	68	A
		% 19 year olds qualified to Level 3	40	43	42	45	47	A

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AGENDA ITEM

MEETING

Children and Young People's Strategic Partnership Board
27 March 2007

TITLE

Haringey Life Expectancy Action Plan

SUMMARY

Presentation of the Haringey Life Expectancy Action Plan for discussion

RECOMMENDATIONS

1. That the CYPSP note the Life Expectancy Action Plan has been proposed for adoption by the HSP, pending revisions following discussions in partnership boards

2. That member organisations note their roles in delivering the plan, and actively engage in taking the work programme forward.

LEAD OFFICER(S)

Dr Ann-Marie Connolly, Director of Public Health ,Haringey TPCT
E-mail: ann-marie.connolly@haringey.nhs.uk Tel: 020 8442 6070

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Helena Pugh, Interim Head of Policy and Strategy, Strategic Services, Adult, Culture and Community Services, Haringey Council
Email: Helena.pugh@haringey.gov.uk Tel: 020 8489 2943

Haringey Life Expectancy Action Plan

1. Background

Death rates have decreased significantly in Haringey over recent years, including deaths from the major causes such as cardiovascular disease and cancers. Yet despite this, too many people die young in Haringey, and the death rate amongst people aged 20-64 is 15% higher in Haringey than for England and Wales. These premature deaths result in a significant number of potential years of life lost, contributing to lower life expectancy for Haringey residents.

Life expectancy is significantly shorter for men and women in Haringey than for the population of England and Wales as a whole- a gap of 1.7 years for men and 0.6 years for women, and these gaps show no sign of narrowing. The gap in life expectancy between people living in deprived and affluent wards is even greater- 8 years for men, and 5 years for women. The evidence strongly suggests that health inequalities between different population groups and areas in Haringey are persistent.

2. Why is reducing the gap in life expectancy a priority for the HSP?

Our Health, Our Care, Our Say (DOH 2006) requires local areas to promote outcomes that address health inequalities, inclusion and well-being across the range of public services that affect people's lives (i.e. beyond health and social care to housing, education, careers, transport and leisure). The shift is from the narrow focus of treating illness to the promotion of the broader concept of well-being.

More recently the *Local Government and Public Involvement in Health Bill* requires a sustainable framework for local action on health and well-being, so that partnership working is strengthened and there is greater clarity over who is responsible for agreeing and delivering local health and well-being targets. The Bill also proposes that a new statutory partnership for health and well-being under the Local Strategic Partnership (LSP) be set up and a new duty for PCTs and local authorities to cooperate so that a truly integrated approach to delivery of local government and NHS priorities is achieved[1].

Haringey is a spearhead PCT and local authority because the key health indicators[2] for our population are in the worst 20% for the country. Achieving more rapid improvements in life expectancy in areas like Haringey is key to delivering the national health inequalities target *to reduce the gap in life expectancy between spearhead areas and the population as a whole by 10% by 2010*.

The draft Community Strategy includes healthier people with a better quality of life is a key part of its vision for the borough. Haringey has now agreed a local target to reduce the gap in Life Expectancy through the Local Area Agreement, which includes a mandatory target to reduce the gap in the death rate (all age and all cause) between Haringey and England & Wales. How Haringey is achieving

[1] Haringey set up the Well-being Partnership Board in June 2005 to do this.
[2] Spearhead areas are defined in terms of male and female life expectancy, cardiovascular and cancer mortality, and deprivation.

against this target will be monitored on a quarterly basis. The LAA stretch targets to increase the number of people quitting smoking in Tottenham, to increase the number of people that are physically active, bring forward the attainment of health school's status by Haringey schools, increase breastfeeding initiation, and reduce the number of women who smoke in pregnancy will make a major contribution this mandatory outcome.

Progress is also being monitored through the following PSA targets:

- Reduce mortality rates from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between Haringey and the population as a whole.

- Reduce mortality rates from cancer by at least 20% in people under 75, with a reduction in the inequalities gap between Haringey and the population as a whole of at least 6%

- Reduce adult smoking rates to 21% or less with a reduction in prevalence among routine and manual groups to 26% or less

- Reduce mortality from suicide and undetermined injury by at least 20%

- Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

- To deliver a 2% increase annually in the proportion of women initiating breastfeeding, focusing particularly on women from disadvantaged groups.

- To deliver a 1% reduction, annually, in the proportion of women smoking through pregnancy, especially focusing on smokers from disadvantaged groups.

- Reduce the 1998 teenage conception rate by 50% (55% in Haringey).

3. Development of an action plan to reduce inequalities in life expectancy

An action plan to reduce the gap in Life Expectancy has been developed over the past year, focusing on the preventable determinants of poor health and death. It is based on a detailed analysis of causes of premature death, and the pattern of risks factors for poor health in Haringey. The process involved work with officers working in housing, education and employment to identify best practice and opportunities, and a stakeholder event held on 6th February 2006.

The plan has draft plan been subject to wide consultation, including Haringey Council's Senior Management Groups, the TPCT Board and the HAVCO well-being

theme board. The plan is also being discussed in each of the five thematic partnership boards[3].

The plan identifies priority actions to reduce the gaps in life expectancy for people in Haringey, focusing on:

- Reducing the number or people who smoke
- Increasing physical activity
- Improving diet and nutrition
- Prevention of cardiovascular disease and cancer
- Suicide and accident prevention
- Access to health services
- Reducing infant mortality
- Improving housing
- Income and employment
- Education and skills

One major opportunity to improve life expectancy in Haringey is the introduction of the ban on smoking in public places that comes into force on 1st July 2007. This will lead to major reductions in poor health due to exposure to environmental tobacco smoke, and has been shown to help people successfully quit smoking when introduced elsewhere. Implementation of strategies to maximise income amongst deprived communities, prevent obesity, and develop world-class primary care services also provide major opportunities to address health inequalities in Haringey.

4. What is the role of partner organisations in implementing this plan?

Achieving the 'fully engaged' identified by Derek Wanless[4] as crucial to our future health service and economy rests on health services become more productive in terms of health outcomes, and people being more engaged in living healthy lives. While individuals are ultimately responsible for their own and their children's health, it is the collective action of individuals that will determine whether or not this fully engaged scenario unfolds.

There are widespread barriers to people making healthy choices that can be addressed. Health and care services, local government, media, business, families and the voluntary and community sector all have a role in taking forward wide-ranging action to reduce these barriers.

The Haringey Strategic Partnership and its member organisations are key to determining how engagement in the health of our population moves forwards. Specifically, Haringey Council has a duty to promote well-being, and a responsibility to scrutinise both health and health services within the borough. The Council and Primary Care Trust are major employers and commissioners of services and as such influence key determinants of good health including access to services, housing quality, education and skills, and income and employment. And voluntary

[3] The action plan has been discuss in each board except the Children and Young People's Partnership (scheduled for Tuesday 27th March) or the Better Places Partnership (tbc).
[4] Derek Wanless, 2004, Securing good health for the whole population

and community organisations play a crucial role in addressing the needs of the diversity of communities living in Haringey.

5. How will implementation be monitored?

At a high-level, implementation of this plan will be monitored through the mandatory and optional indicators included in the Local Area Agreement and Community Strategy (once agreed). But because improving health and reducing health inequalities is a cross-cutting issue with implications for all five thematic partnerships, monitoring implementation of the plan across the HSP will be key to success.

The Well-Being Partnership Board is well placed to oversee implementation plans and report progress to the HSP, and this function of the Well-Being Partnership Board becomes a statutory duty under the *Local Government and Public involvement in Health* Bill. Relevant indictors are being included in the well-being scorecard, but the monitoring framework for the plan will include actions being taken forward by the other thematic partnership boards.

5. Recommendations:

1. That the CYPSP note the Life Expectancy Action Plan has been proposed for adoption by the HSP, pending revisions following discussions in partnership boards.

2. That member organisations note their roles in delivering the plan, and actively engage in taking the work programme forward.

15th March 2007

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Reducing Inequalities in Life Expectancy in Haringey
Actions for Haringey Strategic Partnership.

March 2007

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Reducing Inequalities in Life Expectancy in Haringey
Actions for Haringey Strategic Partnership.

Summary

The purpose of the Haringey Life Expectancy Action Plan is to enable the Haringey Strategic Partnership to deliver priority actions to improve life expectancy and reduce health inequalities to meet the 2010 PSA health inequalities targets.

Improving health and reducing health inequalities is a key priority for Haringey. As a spearhead area Haringey is aiming to ***reduce the gaps in life expectancy and infant mortality by at least 10% between Haringey and the population as a whole by 2010.*** Partners are being monitored on delivery of the targets, achievement of which will contribute significantly to reducing the gap;

People in Haringey are living longer healthier lives than they did 20 years ago. However, on average people in Haringey still die younger than in England as a whole, and there are substantial differences in health between neighbourhoods within the borough. For example, men born in one the most deprived wards can expect to die eight years before men born in one of the most affluent.

The causes of inequalities in health are multiple and complex, with genetic and biological differences accounting for a small proportion. The other influences on health are largely avoidable and are the result of differences in life circumstances, access to safe and healthy living arrangements, the choices available about how to live, and access to services.

The development of the action plan is based on
- a detailed analysis of routine data on disease-specific causes of early deaths and socio economic data in Haringey
- detailed analysis of current evidence on local need and effectiveness of interventions
- a large stakeholder event held in February 2006[1] to discuss potential priorities to address low life expectancy and health inequalities in the borough.
- discussions with policy leads from across the partnership on key interventions

with the final draft being informed by
- consultation with a wide range of stakeholder and partnership groups
- other emerging strategies
- LAA negotiations and agreement

Key cross cutting issues for the plan emerged as follows:

- Interventions should be targeted on the most needy areas and people, addressing specific needs of black and minority ethnic communities, people with mental health problems or disabilities, and individuals that do not speak English or who are relatively new to Haringey.
- Improving integration between, and co-location of, health and social care and other services to disadvantaged communities.
- Making the most of the important role of voluntary and community organisations in reaching marginalised and socially excluded communities
- The importance of focusing on children and people in their middle years in reaching the life expectancy target.

A number of domains of action emerge from this detailed plan because they are supported by strong evidence of effectiveness and local need. These should be taken forward as a matter of priority by the HSP. (Full plan in Section 2), The plan will focus on areas and groups most in need especially those at risk of reduced life expectancy.

These domains are

Smoking

1. Offer stop-smoking advice as part of clinical assessment in surgical care pathways.
2. Prepare local businesses for implementation of smoke-free legislation.
3. Expand coverage of the Haringey smoke-free award amongst venues serving deprived communities in Haringey, and amongst partner-accredited schemes such as child minder certification.

Physical activity

4. Train primary health workers to identify inactive adults opportunistically, and provide advice on physical activity.
5. Expand opportunities for people to be physically active through walking and cycling, and access to sport, leisure and open spaces.
6. Expand targeted approaches to promoting physical activity (e.g. exercise referral schemes or volunteer walks) based on the outcomes of local and other evaluation.

Diet and nutrition

7. Ensure all school achieve healthy school status accreditation, and that the food they provide meets national nutritional standards for school food.
8. Review the Haringey Food and Nutrition strategy focusing on groups with high levels of need e.g. people living on low incomes, and those living with cardiovascular disease, diabetes and cancer.
9. Complete and implement a strategy to prevent obesity amongst adults and children, including care pathways.

Access to health services

10. Develop needs-based approaches to commission primary care services, building on an equity audit of resource allocation to GP practices.
11. Ensure that prescription of statins to individuals with cardiovascular disease, or who have a greater than 20% risk of developing it over the next 10 years, is equitable.
12. Increase the proportion of GP practices with PCT-validated registers of patients with Coronary Heart Disease.
13. Ensure equitable implementation of NICE guidelines on hypertension and management of heart failure.
14. Increase uptake rates for cervical and breast screening, including non English-speaking communities.

Accidents

15. Develop safer routes to school, and traffic safety measures.
16. Ensure that housing interventions include accident prevention measures such as fire safety, and removing the causes of trips and falls.

Suicide

17. Develop a suicide prevention strategy incorporating mental health promotion, risk reduction amongst key population groups, and reducing the availability of suicide methods.

Infant mortality

18. Develop a strategy to reduce the number of women booking late in their pregnancy for ante-natal care.
19. Establish systems to monitor the smoking status of, and interventions received by, families with children.
20. Develop smoking cessation services as a core element of care pathways developed within children's centres.
21. Develop a breastfeeding maintenance monitoring system using the child health surveillance system (6-8 week check), and use this to target interventions for women/families less likely to maintain breastfeeding.

Homes

22. Develop housing condition assessment criteria and referral pathways to housing/environmental health services for use by a range of service providers visiting vulnerable people in their own homes.
23. Develop strategies to reduce fuel poverty and improve thermal comfort, particularly for households vulnerable to poor health.
24. Improve housing conditions in the private rented sector through the private sector housing service.

Employment

25. Develop employment opportunities for disadvantaged groups, including people with mental health problems, with physical or learning disabilities, lone parents, and refugees.
26. Ensure Haringey residents have access to help ensure income maximisation for eligible households.
27. Identify systems to assist workplaces to be health promoting environments

Education

28. Support schools in developing provision that raises the achievement of pupils from Black and Minority Ethnic communities that are currently not achieving as well as the general population.
29. Ensure that all schools attain accreditation as meeting the national Healthy Schools standards.

This plan will be overseen by the Well-Being Theme Board, who will to agree a commissioning and monitoring framework for implementation and it will championed by the Director of Public Health Dr Ann-Marie Connolly.

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Section 1: The case for action by the Haringey Strategic Partnership

1.1 Introduction

The purpose of the Haringey Life Expectancy Action Plan is to enable the Haringey Strategic Partnership to deliver priority actions to improve life expectancy and reduce health inequalities to meet the 2010 Public Service Agreement Targets.

1.2 National policy context

Local authorities and primary care trusts have a responsibility for promoting the health and well being of their residents. Overall, people in Haringey are living longer healthier lives than they did 20 years ago. However, on average people in Haringey still die younger than in England as a whole, and there are substantial differences in health between neighbourhoods within the borough.

The causes of inequalities in health are multiple and complex. A small proportion of differences in health result from genetic and biological differences. The other influences on health are avoidable, and are the result of differences in:

- life circumstances (the opportunities we have in life, including our general socio-economic, cultural and environmental conditions);
- lifestyle (the choices we are able to make about how we live and their impact on health);
- access to services (our ability to have the same access to services whatever our background, age, or wherever we live).

Reducing disadvantage and health inequalities is a complex agenda that requires close partnership working across sectors and policy areas. This has been recognised by the Government in a number of policy initiatives over the past few years.

The 2003 report '*Tackling Health Inequalities: A Programme for Action*'[2] identified a key role for both national government and Local Strategic Partnerships in addressing the wider determinants of health inequalities.

The White Paper: '*Choosing Health*; making healthier choices easier' [3] emphasised the role of partnerships across communities, including local government, the NHS, business, the voluntary sector and faith communities in securing better access to healthier choices, especially for those in the most disadvantaged groups. *Our Health, Our Care, Our Say (DOH 2006)* requires local areas to promote outcomes that address health inequalities, inclusion and well-being across the range of public services that affect people's lives (i.e. beyond health and social care to housing, education, careers, transport and leisure). The shift is from the narrow focus of treating illness to the promotion of the broader concept of well-being.

More recently the *Local Government and Public Involvement in Health Bill* requires a sustainable framework for local action on health and well-being, so that partnership working is strengthened and there is greater clarity over who is responsible for agreeing and delivering local health and well-being targets. The Bill also proposes that a new statutory partnership for health and well-being under the Local Strategic Partnership (LSP)

be set up and a new duty for PCTs and local authorities to cooperate so that a truly integrated approach to delivery of local government and NHS priorities is achieved[1].

Haringey is a spearhead PCT and local authority because the key health indicators[2] for the population are in the worst 20% for the country. Achieving more rapid improvements in life expectancy in areas like Haringey is key to delivering the national health inequalities target *to reduce the gap in life expectancy between spearhead areas and the population as a whole by 10% by 2010*.

The draft Community Strategy includes healthier people with a better quality of life as a key part of its vision for the borough. Haringey has now agreed a local target to reduce the gap in Life Expectancy through the Local Area Agreement, which includes a mandatory target to reduce the gap in the death rate (all age and all cause) between Haringey and England & Wales. How Haringey is achieving against this target will be monitored on a quarterly basis. The LAA stretch targets to increase the number of people quitting smoking in Tottenham, and to increase the number of people that are physically active will make a major contribution this mandatory outcome.

1.3. What are the key targets that Haringey Strategic Partnership must meet?

1.3.1 PSA targets

The Public Service Agreement targets of 2004 gave an increased profile to tackling inequalities in health. The targets aim to see faster improvements in health outcomes amongst the 'fifth of areas with the worst health and deprivation indicators' in the country.

As Haringey falls in the bottom fifth of local authorities nationally for male and female life expectancy, heart and circulatory disease mortality and the Index of Multiple Deprivation (IMD) 2004 it has been designated one of the 88 'Spearhead LAs/PCTs' [4].

1.3.2 Enhanced targets for spearhead areas

As a member of the 'Spearhead' group, Haringey is aiming to meet the following Public Service Agreement Floor Targets by 2010:

- Reduce the gap in life expectancy by at least 10% between Haringey and the population as a whole
- Reduce mortality rates from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between Haringey and the population as a whole.
- Reduce mortality rates from cancer by at least 20% in people under 75, with a reduction in the inequalities gap between Haringey and the population as a whole of at least 6%
- Reduce mortality from suicide and undetermined injury by at least 20%
- Reduce the gap in infant mortality by at least 10% between "routine and manual groups" and the population as a whole

[1] Haringey set up the Well-being Partnership Board in June 2005 to do this.
[2] Spearhead areas are defined in terms of male and female life expectancy, cardiovascular and cancer mortality, and deprivation.

- Reduce adult smoking rates to 21% or less with a reduction in prevalence among routine and manual groups to 26% or less

- Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

- Reduce the under –18 conception rate by 50% as part of a broader strategy to improve sexual health.

The full programme of Public Service Agreement Floor Targets includes a number of other targets which impact on health inequalities, including improvements in employment rates, housing, community safety, and education.

1.3.3 Local Area Agreement (LAA) Mandatory and Stretch Targets

In addition, Haringey is negotiating local targets to address a number of local priorities through the Local Area Agreement (LAA) including;

- Mandatory target of arrowing the gap in premature mortality between Haringey and England, and between the most and least deprived wards in Haringey as well as stretch targets of
- Improving the uptake of smoking cessation services amongst people living in deprived areas
- Increasing physical activity for adults including older people
- Improving homes for the most vulnerable
- Increasing the number of primary and secondary schools in the borough that meet the standards for Healthy School accreditation

1.4 Background to Life Expectancy

1.4.1. What is life expectancy?

Life expectancy is the number of years a baby born and living its whole life in an area would be expected to live if it were to experience the current (age-specific) death rates of that area. Life expectancy is best interpreted as a snapshot of the overall level of mortality in an area. It is not a forecast of how long babies will actually live, as current death rates are likely to change.[5] Nevertheless, it is a useful, easily understandable summary measure that can be used to compare death rates in different populations at different times. As deaths in earlier life contribute relatively more to lower life expectancy than deaths in older people, it also provides an indication of the number of premature deaths in an area.

Since age-specific deaths rates in men and women differ, life expectancy is usually calculated separately for each sex.

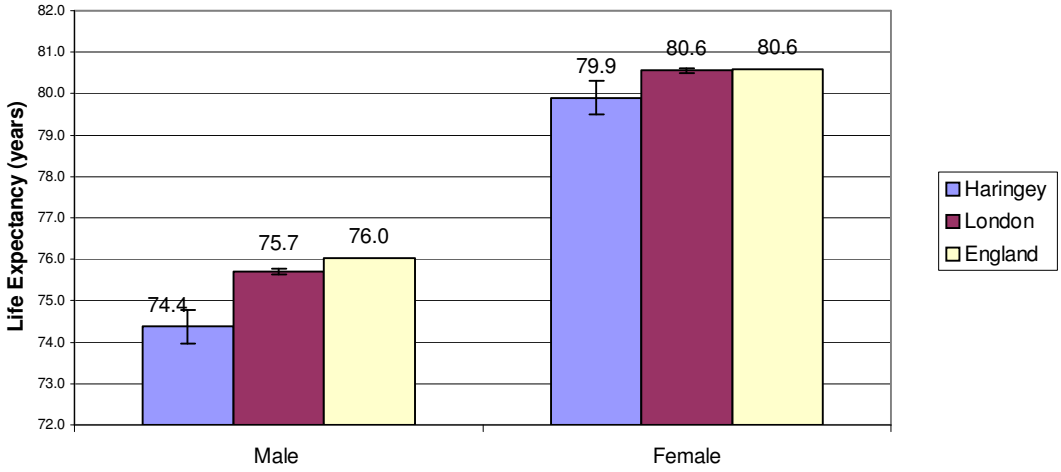
1.4.2 What is the current life expectancy in Haringey?

The life expectancy for men and women in Haringey compared to London and England using mortality data from 1999-2003 [3] is shown in figure 1. The lower life expectancy for men and women in Haringey compared to England and Wales is statistically significant[4].

[3] Combining data from several years helps to make the data more stable by reducing the influence of year-by-year variation in numbers of deaths.

[4] The error bars on the graph represent the 95% confidence intervals of the data. As the confidence intervals for the life expectancy in Haringey and London do not overlap, there is a 95% probability that the differences

Fig. 1 Life expectancy in Haringey compared to London and England, (pooled data from 1999-2003)

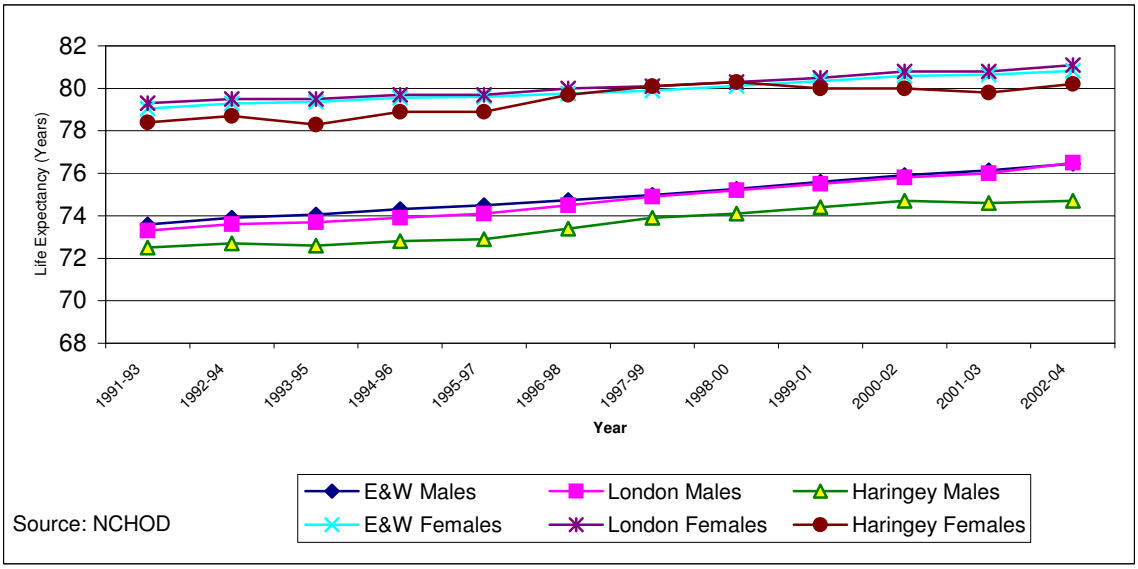


between the figures for Haringey and London are real and not due to chance year-by-year variations in death rates.

1.4.3 Is life expectancy in Haringey improving?

Along with national trends, life expectancy in Haringey for men and women has improved steadily over the past decade (see fig 2).

Fig 2. Trends in Life Expectancy for Haringey and England and Wales (E&W) 1991-2004



Due to year on year fluctuations in mortality rates at the small area level, it is not possible to use current trends to predict whether the life expectancy gap between Haringey and England as a whole is likely to widen or narrow by 2010. However, at both the London level[6] and the national level[7] the gap in life expectancy at birth between England and the Spearhead Group continues to widen. Therefore it is likely that the gap between Haringey and England will widen unless specific action is taken to improve the health of the most disadvantaged groups.

1.4.4 Does life expectancy vary within Haringey?

Within Haringey, life expectancy varies significantly between different wards. The variation in life expectancy between wards in Haringey is even greater than the variation in life expectancy between local authorities in London[8].

Figure 3 shows the variation in male life expectancy between wards in Haringey. Generally, the more deprived wards (as measured by the Index of Multiple Deprivation 2004) have a lower male life expectancy than the more affluent wards. At the two extremes, male life expectancy in Bruce Grove (70.5 years) is nearly 8 years lower than male life expectancy in Muswell Hill (78.2 years). The relationship between male life expectancy and ward-level deprivation is strong and statistically significant.

Figure 3. Male life expectancy 1999-2003 by ward in Haringey

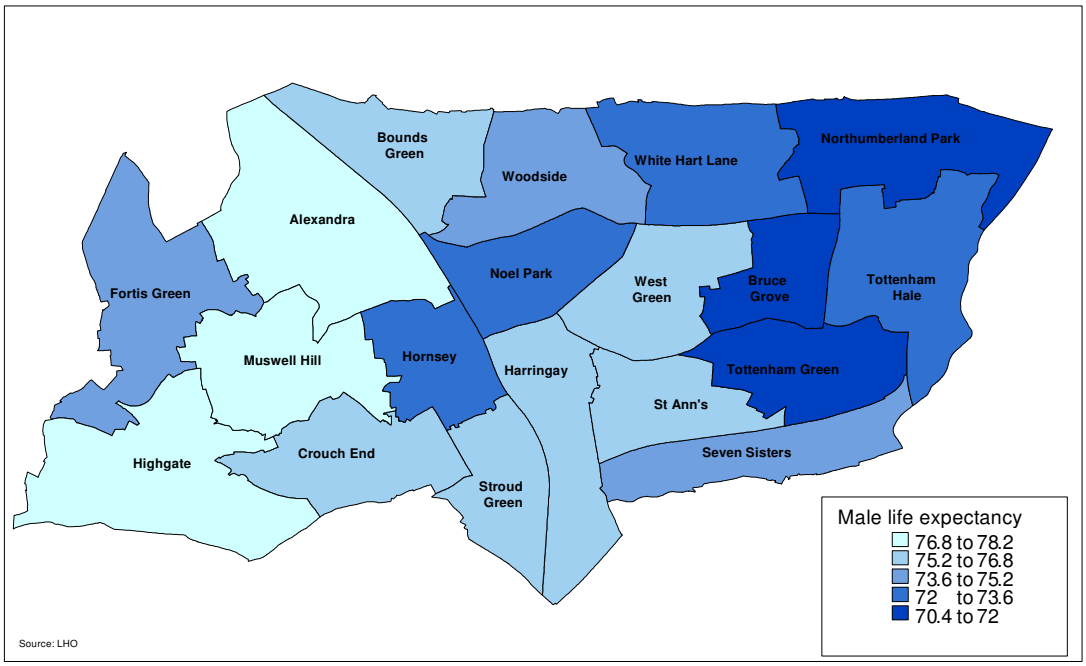
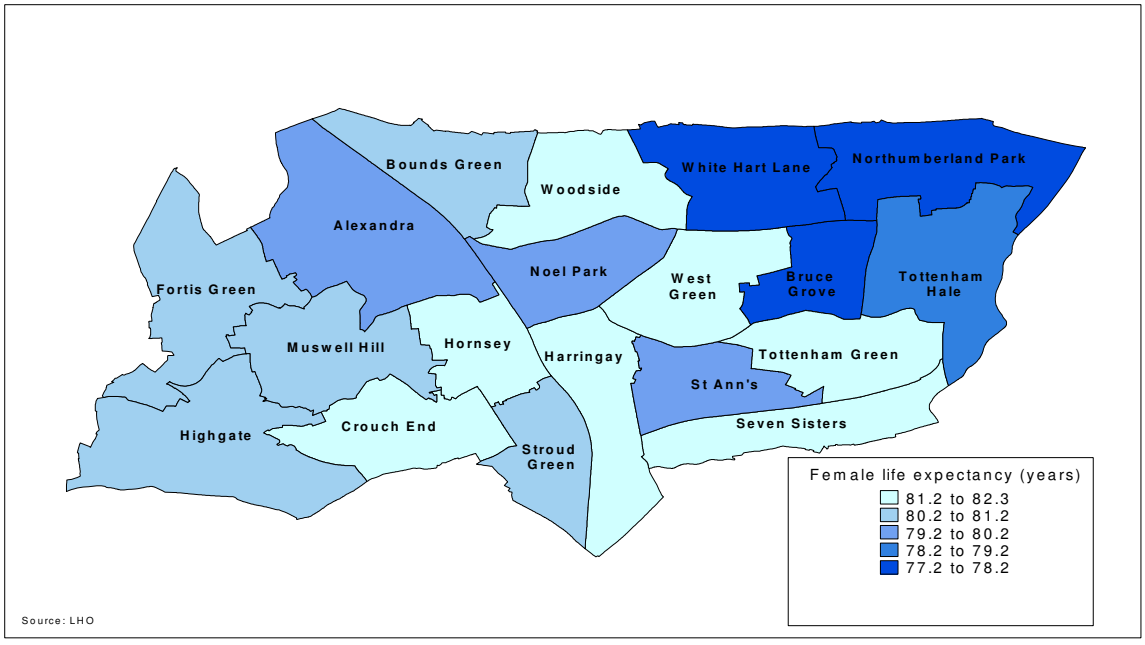


Figure 4 shows the variation in female life expectancy between wards in Haringey. There is only a weak relationship between female life expectancy and deprivation, and this is not statistically significant.

Fig 4. Female life expectancy 1999-2003 by ward in Haringey



A stronger relationship between life expectancy and deprivation for men than for women is also found across London[9] and at the national level[10]. The reasons for this are not fully understood. Previous studies have speculated that this might be due to a stronger

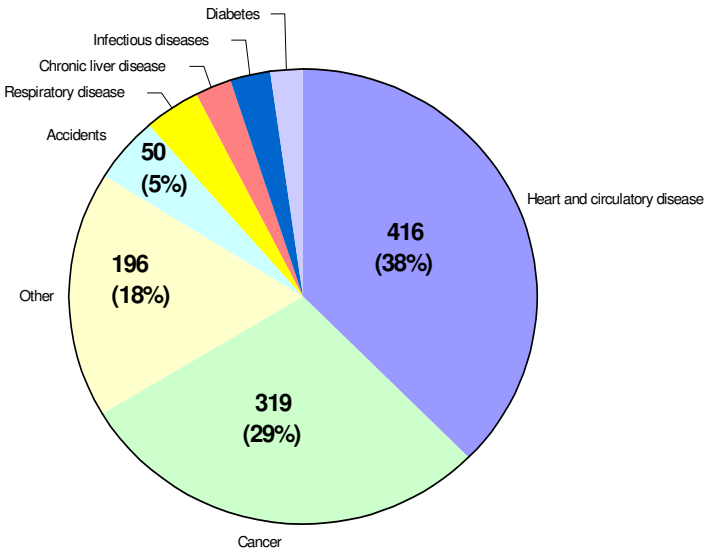
association between deprivation and health risk behaviours in men than women, or because men with poor health may be more likely to migrate to more deprived areas.

1.4.5 What causes of early death impact most on life expectancy in Haringey?

Figure 5 shows the main causes of premature death (deaths under the age of 75 years) in Haringey over the 3-year period from 2001-2003.

As shown, heart and circulatory diseases and cancer together account for 67% of all

Fig 5. Main causes of death for persons <75 years in Haringey 2001-2003 (numbers and percent)



premature deaths in Haringey.

Deaths occurring earlier in life contribute relatively more to lower life expectancy than deaths in later life. One way of looking at the causes of death that contribute most to life expectancy is by calculating, for each cause of death, the number of years that people would have lived had they lived until they were 75. This is known as the Years of Potential Life Lost (YPLL).

Table 1 shows that heart and circulatory diseases and cancer account for around half of all the years of potential life lost. However, accidents and suicide, and injuries of undetermined intent also account for a significant proportion of YPLL (20% in males and 9% in females). This is because these causes of death disproportionately affect younger people, and so contribute more to years of potential life lost and life expectancy than to overall mortality rates.

Table 1. Main causes of Years of Potential Life Lost (YPLL) Haringey 2001-3

Cause	Males – number of YPLL (%)	Females - number of YPLL (%)
All heart and circulatory diseases	4,853 (25)	2,579 (22)

All cancers	4,279 (22)	3,911 (33)
Accidents	2,317 (12)	390 (3)
Suicide and injuries of undetermined intent	1,617 (8)	692 (6)
Infectious and parasitic disease	805 (4)	433 (4)
Respiratory disease	596 (3)	635 (6)

1.4.6 How are the main causes of premature death distributed in Haringey?

To compare the distribution of deaths between different populations it is important to take into account not just the number of deaths, but also the size of the populations and their age profiles. The commonest way to do this is by calculating the Standardised Mortality Ratio (SMR)[5].

Figure 6 shows the Standardised Mortality Ratio for Coronary Heart Disease (the most common cause of death due to heart and circulatory disease) for persons under the age of 75 by ward. Northumberland Park and Bruce Grove (the most deprived wards in Haringey as measured by IMD 2004) have mortality rates due to Coronary Heart Disease (CHD) more than 70% higher than the average CHD mortality rates in England and Wales. There is a statistically significant relationship between SMR for coronary heart disease and ward-level deprivation in Haringey.

Figure 6. Standardised Mortality Ratio for Coronary Heart Disease by ward in Haringey, 2000-2004

[5] The SMR is the ratio of the number of deaths occurring in a population to the number that would have occurred if that population had the same age-specific death rates as the population of England and Wales. The ratio is multiplied by 100. An SMR of 100 means that a population has the same age-specific death rates as the England and Wales population. An SMR of 120 means that a population has 20% more age-specific deaths than the E&W population. An SMR of 80 means that a population has a 20% lower age-specific death rate than the E&W population.

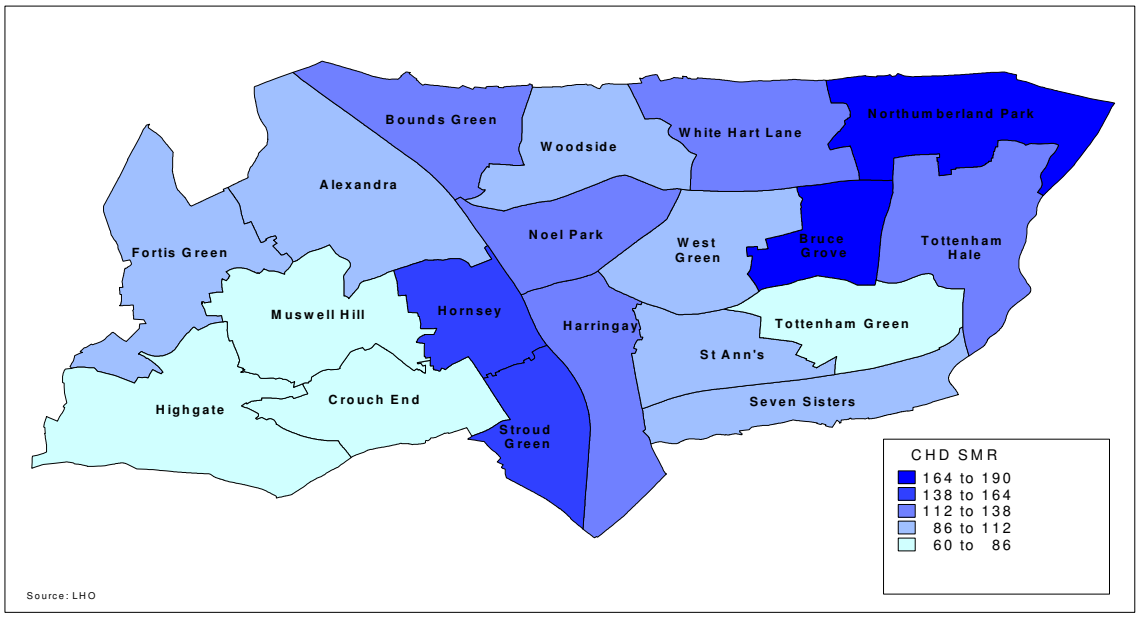
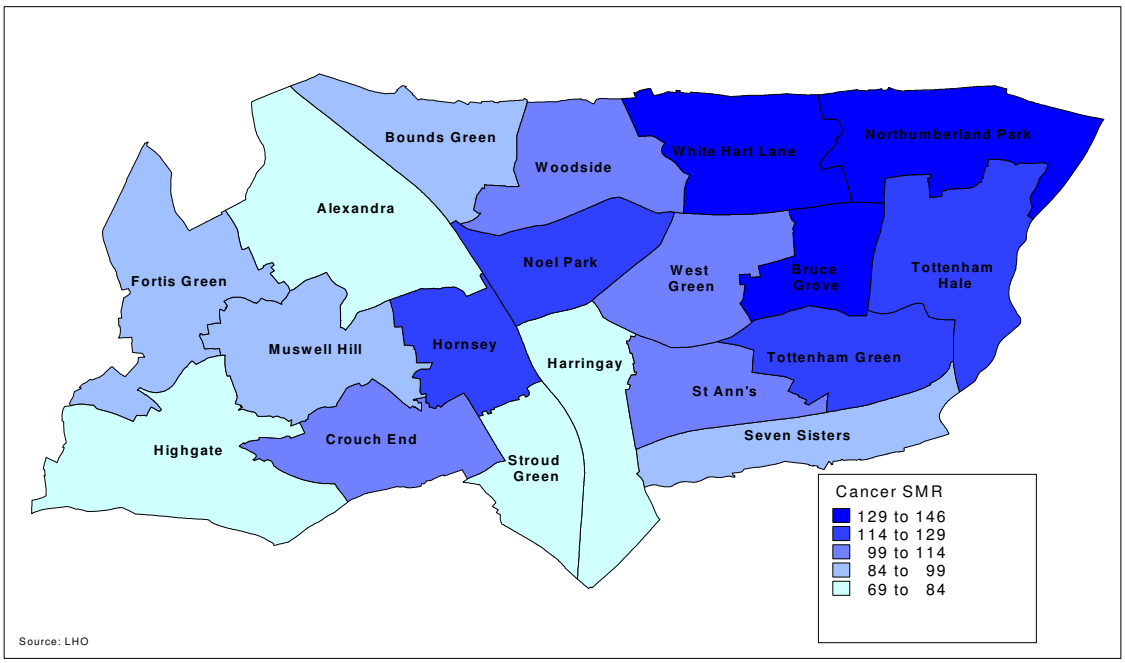


Figure 7 shows the Standardised Mortality Ratio for cancer for persons aged under 75 years by ward. Again, there is a statistically significant relationship between SMR for cancer and ward-level deprivation in Haringey.

Figure 7 Standardised Mortality Ratio for Cancer by ward in Haringey, 2000-2004



1.5. What factors influence the life expectancy picture in Haringey?

As mentioned earlier, the causes of inequalities in health are complex and relate to a combination of people's social and economic circumstances, their access to services and their personal behaviour, which is itself influenced by the social and cultural environment. However, there are a number of clear risk factors for the main causes of premature death and inequalities in health in Haringey that are amenable to change:

- **Smoking**
  - Smoking is the individual health behaviour with the single largest impact on health inequalities.
  - Smoking is a major risk factor for heart and circulatory diseases, lung cancer, chronic lung disease and many other conditions.
  - The prevalence of smoking is considerably higher amongst people of lower socio-economic class, lone parents, the unemployed and people with mental illness than amongst the rest of the population[11].
  - It has been estimated that around two thirds of the observed difference in risk of death across social groups in middle age is caused by smoking tobacco[12].
  - Reducing smoking will result in substantial reductions in mortality form coronary heart disease within 12-24 months[13]

- **Food and nutrition**
  - High blood pressure (which is directly related to obesity and high salt intake) and high serum cholesterol (which is directly linked to high intakes of saturated fat) are the two main risk factors for diseases of the heart and circulatory system[14].
  - Low fruit and vegetable intake is closely linked with a high prevalence of some cancers and heart and circulatory disease.
  - Poorer households in poorer communities are less likely to have access to healthy, affordable food.
  - Poorer households eat less fruit and vegetables, salad, wholemeal bread, wholegrain and high-fibre cereals and oily fish, and more white bread, full-fat milk, table sugar and processed meat products.

- **Physical activity**
  - People who have a physically active lifestyle are at approximately half the risk of developing heart disease compared to those who have a sedentary lifestyle[15].
  - Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon cancer, and with improved mental health.
  - In older adults physical activity is associated with increased functional capacities.
  - Physical inactivity is associated with low social class, income and educational attainment, indicating that developing opportunities for physical activity is particularly important in these groups
- **Housing**
  - Housing affects people's physical and mental health in a range of ways, from the quality of the indoor environment to neighbourhood quality and safety and housing allocation and homelessness[16].
  - In Haringey a significant proportion of local authority homes and private rented homes are considered to be non-decent.

  - The most vulnerable people live in non-decent homes: people who live alone, ethnic minorities and households with no one in full-time employment are most likely to live in such accommodation.

- **Employment**
  - Employment status is a key determinant of income and social status, and thus closely linked with health and health inequalities.
  - A middle-aged man who loses his job is twice as likely to die in the next 5 years as a man who remains in employment.
  - Worklessness and workless households are highly concentrated in particular neighbourhoods. This has important implications for community regeneration and the economic vitality of neighbourhoods.

- **Education**
  - Education influences health in a variety of ways.
  - Educational qualifications are an important determinant of employment prospects, which in turn influence access to income and material resources.
  - Education also provides children and young people with the knowledge and skills to lead a healthier life
  - The educational attainment of 14-year olds and 16-year olds in Haringey schools are well below the national average. However, attainment in Haringey schools is improving faster than the national average, and the gap between schools in the east and the west of the borough is closing

- **Accidents**
  - Accidents were the leading cause of death in under 20 year olds in Haringey in 2001-2
  - Accidental death is much more common amongst males than females.
  - Road traffic accidents account for more than half of accidental deaths in Haringey.
  - Local data show that more than a quarter of child pedestrian casualties happen in the 10% most deprived wards.

- **Suicide**
  - Suicide is a significant contributor to early death in Haringey.
  - In Haringey, approximately 35 people commit suicide in 2001, which is more than 50% higher than the national average. This is in part due to the high levels of factors increasing the risk of suicide, such as mental illness, unemployment, substance misuse and social exclusion.
  - Three quarters of suicides in Haringey are amongst people who have not had contact with mental health services

- **Health services**
  - There are a number of health service interventions that can significantly reduce mortality amongst patients with heart disease and cancer and those at high risk for these diseases. Most important are those that reduce risk factors for the development of heart disease (smoking cessation services, treatment of hypertension and the use of statins to reduce the risk of cardio-vascular events in those at risk of heart disease or with established heart disease) and the early detection and treatment of cancers.
  - The 2010 time-scale for the life expectancy, cancer and heart disease targets means that we need to focus attention on reducing premature death amongst those that already have, or are at high risk of developing these diseases[17].

- There are a number of barriers to accessing good quality health services, and there is evidence that those who are most vulnerable often have poorest access to services.

Section 2. Action Plan

What are the actions that the Haringey Strategic Partnership should take to improve life expectancy and reduce inequalities?

The development of the action plan is based on the detailed analysis of routine data shown in section 1 and on detailed analysis of current evidence on effectiveness of interventions. A large stakeholder event was held in February 2006[18] to discuss potential priorities to address low life expectancy and health inequalities in the borough with a wide range of partners using the data analysis and evidence of effectiveness as a basis for the discussions. This was followed by discussions with policy leads from across the partnership on key interventions, strategies and action plans underway.

Following drafting of the plan there consultation with a wide range of stakeholder and partnership groups e.g. HTPCT, Partnership Board reporting to the HSP. It is linked with other emerging strategies, action plans and work programmes of different partners e.g. on housing, young people etc.

As the life expectancy target is the key mandatory target of the LAA under the Healthier Communities and Older People Block, this plan will underpin the achievement of that target.

The basis of the plan is to build on existing work and strategies and programmes, focussing activities on those most in need and on those groups most at risk of shortened life expectancy, either due to socio-economic status or by virtue of belonging to groups where there is a higher risk . Examples of these are using NRF funding to support action on physical activity and diet in the wards with the worst health indicators as well as the partnership project P4, working to integrate action in the Northumberland Park so as to maximise resource use and impact.

The action plans have been develop in the following domains as these have been identified as having the greatest impact on life expectancy. These are

- Smoking
- Physical activity
- Food and Nutrition
- Cardiovascular Disease
- Cancer
- Accidents
- Suicide
- Access to health services
- Infant Mortality
- Housing
- Employment
- Education

The details of these plans follow on the next pages.

SMOKING

Objective: (inc. PSA & local targets)
DH PSA3 / **DfES PSA3:** Reduce adult smoking rates to 21% or less with a reduction in prevalence among routine and manual groups to 26% or less
LAA target: tbc Likely to be Increase Number of 4-week smoking quitters living in N17 (Tottenham) by 150 quitters

Current situation
Recent surveys/modelling from the HDA suggest Haringey is likely to have a smoking prevalence of 27-32%[19]. There are no local data on trends in smoking prevalence. However, national data show a reduction in overall prevalence of smoking over the past 30 years, with little change in smoking rates among those living on low incomes and those who are least advantaged[20].

Initiatives To Reduce The Prevalence Of Smoking

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Expansion of coverage of Haringey Smoke Free Award with focus on: • targeting venues and homes in east of borough • partnership-organisation accredited schemes e.g. child minder certification	Venues in the east of the borough & accredited scheme users	Strong (4% reduction in workforce quitting[21])	Smoking cessation service (SCS)	June 2008
Preparation of local businesses for implementation of smoke free elements of Health Improvement and Protection Bill.	Local businesses likely to have high smoking prevalence	Strong (4% reduction in workforce quitting)	Environmental Health (LBH) Public Health (TPCT)	July 2007
Make no-smoking policies a requirement when local NHS organisations and Haringey Council are contracting/commissioning	Commissioned service users	Good practice	Service Commissioners	Dec 2007
Ensure that all strategic partners (e.g. police force, fire brigade and voluntary sector organisations) have policies in place to promote smoke-free messages	Strategic partners	Strong (4% reduction in workforce quitting)	SCS with partners	Dec2007
Increased enforcement of regulations on tobacco smuggling	Targeting should be based on assessment	Limited evidence on effectiveness of local measures	Environmental Health (LBH)	July 2008

Stop Smoking Initiatives

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Continue development of NHS smoking cessation services: ▪ Establish choose and book system through GP practices from 2006. ▪ Move level 3 clinic from NMH to Tynemouth Road ▪ Establish level 3 clinic in Wood Green Library ▪ Deliver services to hit LAA target	Smokers, particularly in deprived areas	Strong. (Cost per QALY £135 - £6472)[22]	SCS	Complete Complete Start April 2007 until March 2010
Offer of stop smoking advice as part of clinical assessment in surgical care pathways	Smokers awaiting elective surgery (about 5,739/yr)	Strong[23]	Commissioners with Hospitals	April 2007
Workplace Initiatives • Maintain level 2 quit Smoking Programme for Haringey Council Staff • Programme for Haringey police force • Develop programme with medium sized local employers	LBH staff Haringey Police Haringey Employees	Strong	SCS	Ongoing Underway April 2007 start

PHYSICAL ACTIVITY

Objective: (inc. PSA & local targets)
DCMS PSA3 By 2008 increase the number who participate in active sports at least 12 times a year by 3% and increase the number who engage in at least 30 minutes of moderate intensity level sport at least 3 times a week by 3%. A year-on-year incremental increase by 1% per annum in physical activity levels of the whole population (Choosing Health delivery recommendation). Physical activity also contributes to the PSA targets on CHD, cancer and obesity (halting the year-on-year increase in obesity amongst children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole)
LAA target: Increase the proportion of adults taking part in sport and recreational activity by 4%

Current situation
On the basis of national data, it is estimated that in Haringey approx 78% of adults [24] and 6,000 boys and 8,000 girls aged 2-15 are insufficiently active [25]. It is further estimated that of approximately 252 CHD deaths per year in Haringey, approx 94 are attributable to physical inactivity [26].

Sports and Physical Activity Strategy All actions to be conducted within context of Haringey Sports and Physical activity strategy and focussed particularly on the most needy areas of borough.

Action	Target group	Evidence of effectiveness	Delivery lead	Time
School Sport Co-ordinators to ensure that 5-16 year olds in Haringey engage in a minimum of two hours of high quality PE and school sport every week and high quality play opportunities.	School children	National policy	Healthy Schools Programme	Ongoing
Training of Frontline workers • Train frontline staff to provide advice on physical activity including, practice nurses, Haringey Council Leisure centre staff, dieticians, physiotherapists, health care assistants.	Service Users Especially vulnerable groups	Good	HTPCT and Leisure staff	June 2007 onwards
• Primary care health workers to be trained in opportunistic identification of inactive adults and providing advice	Inactive adults	Strong	HTPCT Public Health	June 2007 onwards

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Expand joint work between HTPCT and LBH to increase opportunities for physical activity for older people and other vulnerable groups e.g. chair-based exercise sessions at Leisure Centres.	Older people,	Good practice	Age Concern HAVCO	Summer 2007 onwards
Promote access to open spaces by addressing safety concerns (e.g. through the provision of wardens, parks officers, improved lighting, community facilities) in accordance with Open Spaces strategy	Adults and Children	Good practice	LBH Environmental Services	Strategy timeline
Ensure environment and opportunities to promote physically active modes of transport e.g. walking and cycling.	Adults and Children	Good practice	LBH Environmental services	Open spaces strategy
Evaluate initiatives underway to ensure appropriate for delivery as follows:				
Exercise referral scheme being developed and evaluated as part of a randomised controlled trial in 3 deprived neighbourhoods in Northumberland Park, Bruce Grove and Noel Park wards.	Inactive Adults in 3 deprived neighbourhoods	To be established as part of RCT as recommended by NICE	NRF funding	Programme underway Evaluate March 2008
Evaluate Haringey Get Up and Walk programme providing training for volunteer walk leaders to lead walks in their local communities	Inactive Adults	Insufficient-only be conducted as research study [27]	HTPCT Public Health	Programe underway Evaluate Dec 2007
Evaluate Fit for Life Programme: 8-10 week courses of physical activity and healthy lifestyle advice for people at risk of CHD.	People at risk of CHD	To be evaluated	HTPCT Public Health	Programe underway Evaluate June 2007
Evaluate Health for Haringey, a 5-year programme providing exercise and social support opportunities to 3,000 people in deprived areas and amongst most vulnerable groups	Physically inactive individuals in deprived areas	To be evaluated	Health for Haringey Programm (Big Lottery Fund)	Programe underway Evaluate by Nov 2008
Evaluate HPCT and LBH Health at Work programmes: promoting physical activity for employees of the PCT and LBH	Employees of the HPCT and LBH	To be evaluated	HTPCT-Public Health	
Libraries walking prgramme from five libraries activities programme	Residents	To be evaluated	Libraries	Tba

FOOD and NUTRITION

Objective: (inc. PSA & local targets)
Halt the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.
Also contributes to CHD and cancer PSA targets
LAA target: no

Current situation
Local obesity data demonstrates that obesity level in reception classes are 19% similar national average but year 6 classes have 22% obesity compared with national average of 17% and the greater proportion of obese children are attending schools in the east of the borough. Nationally 22% of men and 23% of women in England are now obese, and has been trebling since the 1980s, and 70% of men and 63% of women are either overweight or obese. The greatest problems are in the lowest socioeconomic groups and amongst children and young people.

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Strengthen implementation of infant feeding guidelines, including promotion of breastfeeding.	Parents of babies	Strong[28]	Children's service	Immediate and ongoing
Healthy Schools Programme to ensure all schools meet national standards for school food.	School children	National policy	Healthy Schools Programme	Ongoing
Develop children's access to healthy food through the extended schools programme e.g. breakfast clubs, with particular focus on areas of high deprivation.	School children in deprived areas	Good practice	Children's service	Ongoing
Update the Haringey Food and Nutrition Strategy focusing on those most in need particularly people living on low incomes and the those living with CHD, strokes, diabetes and cancer	Low income & people with CHD, stroke, diabetes and cancer	Good practice	HTPCT Public Health	December 2007
Finalise and implement obesity strategy and care pathway	People at risk of / with obesity	National policy	HTPCT LBH	April 2007

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Set standards and use contracting to improve the nutritional quality of meals provided by catering contractors e.g. in residential settings, day centres, meals on wheels, staff canteens and vending machines	Residents of residential settings	Good practice	HTPCT and LBH commissioners	Tba
Work with local businesses/suppliers to promote access to affordable healthy food (e.g. through positive award schemes)	Local population	Good practice	LBH Environmental Health	Dec 2008
Work with local residents to share good practice in local food schemes e.g. allotments, food co-ops, community cafes, window boxes,	Local community groups	Good practice	HAVCO	June 2008
Limit the number and density of fast food outlets	Consumers of fast food	Good practice	Environmental services	June 2008 onwards
Target vulnerable and disadvantaged communities through community initiatives e.g. • community nutrition assistants • distribution of healthy eating messages through libraries • Health for Haringey project	Disadvantaged communities	Good practice	HTPCT teaching programme, HAVCO,	Ongoing
Education/training programmes for service providers including school nurses to provide support and advice to prevent obesity and promote healthier eating	Service providers	Good practice	HTPCT Public Health	Dec 2007 and Ongoing

CARDIOVASCULAR DISEASE

Objective: (inc. PSA & local targets) DH PSA1
Reduce mortality rates from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between Haringey and the population as a whole.

Current situation
Haringey's cardiovascular disease mortality rate has fallen significantly from 152.6 per 100,000 population under 75 (152.6/100,000) in 1996/98 to 128.6/100,000 in 2002/04. However, the gap between the Haringey and England average widened by 14.7/100,000 over the same period to reach 31.9/100,000 in 2002/04 [29]. In addition there are significant inequalities across the borough with mortality rates from CHD in those under 75 in Bruce Grove in 2000-4 89% higher than the national average[30]. Based on current trends, the LHO predicts that CHD mortality will fall by about 48% (from the 1995-7 baseline until 2010) but the gap in CHD morality rates between Haringey and England will continue to increase.[31]

PRIMARY PREVENTION
See Sections on Smoking, Physical Activity, Food, Employment And Education

SECONDARY PREVENTION

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Increase percentage of GP practices with the following PCT-validated CHD registers: • asymptomatic patients with CHD risk >30% over 10 years (PSA01b target) • patients with CHD • patients on CHD registers whose last measured cholesterol (measured within last 15 months) is 5mmol/l or less (PSA01d)	Patients with CHD or at high CHD risk	Strong [32]	General practice / HTPCT Primary Care Performance	Ongoing Year on year improve
Prescription of statins to adults with clinical evidence of CVD and adults without CVD who have a >20% risk of developing CVD within 10 years	Patients at high risk of CVD & patients with CVD	Strong[33]	General Practice and HTPCT Pharmacy lead	Ongoing Year on year improve
Improving equity of access to health services (see section on ACCESS TO HEALTH SERVICES)				

TERTIARY PREVENTION (Treatment & Rehabilitation)

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Update PCT hypertension guidelines (in line with NICE guidelines) and monitor implementation	Patients with hypertension	Strong[34]	HTPCT Public Health/ primary care	Dec 2007
Ensure management of heart failure in line with NICE guidelines	Patients with heart failure	Strong[35]	HTPCT Public Health/primary care	Ongoing
Phase IV Community-based Cardiac rehabilitation group exercise programme	Adults with established CHD	Strong[36]	Participant contributions & HTPCT Public Health	Ongoing
Increase % of patients with heart attack who have PCI	Patients with heart attack	Strong[37]	Cardiac centre	Ongoing

CANCER

Objective: (inc. PSA & local targets)
DH PSA1 Reduce mortality rates from cancer by at least 20% in people under 75, with a reduction in the inequalities gap between Haringey and the population as a whole of at least 6%

Current situation
Haringey's cancer mortality rate has fallen from 133.6 per 100,000 population under 75 (133.6/100,000) in 1996/98 to 124.0/100,000 in 2002/04. However, the England average has fallen faster over the same period. Haringey's cancer mortality rate is now marginally 4% above the England average, and the gap between the two beginning to widen[38] Based on current trends, the LHO predicts cancer mortality will fall by about 5% by 2010 (from the 1995-7 baseline) but the gap in mortality rates between Haringey and England will continue to increase.[39]. There are significant inequalities across the borough with mortality rates from cancer in those under 75 in Northumberland Park in 2000-4 45% higher than the national average[40].

PRIMARY PREVENTION
See Sections on Smoking, Physical Activity, Food, Employment And Education

SECONDARY PREVENTION

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Tackle low screening uptake rates for cervical and breast cancer including identification of communities that do not attend for screening, promotion of screening amongst low uptake groups, development of screening resources for non-English-speaking communities.	Women with low uptake of screening	Strong for certain interventions[41]	Screening co-ordinator	Ongoing

TERTIARY PREVENTION (Treatment, Rehabilitation & Palliative Care)

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Implement National Cancer Plan in accordance with it national quality standards	Cancer patients	National policy Good	North central London cancer network	Ongoing
Implement and maintain cancer waiting times targets (time to see a specialist after GP referral, time to diagnosis, time to treatment)	Cancer patients	National Policy	HTPCT With providers	Ongoing
Extend the “Fit for Life” programme to cancer patients	Cancer patients	Good practice	HTPCT Public Health	Tba

ACCIDENTS

Objective: (inc. PSA & local targets)
PSA 5 Reduce the number of people killed or seriously injured in Great Britain in road accidents by 40% and the number of children killed or seriously injured by 50%, by 2010 compared with the average for 1994-98, tackling the significantly higher incidence in disadvantaged communities
LAA Stretch target: Improve living conditions for vulnerable people ensuring that housing is made energy efficient, decent and safe
Sub-outcomes

i) Maintaining vulnerable people in Haringey in their own homes by increasing thermal comfort, reducing the risk of fuel poverty and minimising carbon emissions.
ii) Reduced health impact from slips, trips and falls.
iii) Reducing the risk to vulnerable people from fire and fire related injuries.

Current situation
Accidents are the leading cause of death in males under 20 in Haringey. As deaths from accidents occur at a relatively young age, they are the third most important cause of years of potential life lost (YPLL), after CVD and cancer. Land transport accidents account for nearly half of all deaths due to accidents. However, deaths and serious injuries caused by road traffic accidents have fallen from 131 in 2004 to 82 in 2005 and the gap between the borough and national average has been eliminated

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Maximise 20mph schemes and Safe Routes to School schemes	School children	Good practice	LBH Environmental Services	Ongoing
Ensure that accident prevention strategies are incorporate into home improvement schemes, particularly fire safety and prevention of trips and falls. **LAA Stretch target working with older people**	Households living in poor housing conditions.	Good practice	LBH Environmental Health Age Concern Fire services	April 2007
Development of local alcohol harm reduction strategy, inc. voluntary social responsibility scheme for alcohol retailers (code of practice and reporting of breaches), local authority enforcement, esp. sales to under 18s and alcohol screening and brief interventions in primary care and A&E Enhance integration of work with DAAT including on youth drinking	Will reflect strategy	Good practice, available, and evidence on a range of one-to-one interventions is expected.	DAAT	Based on strategy
Maintain Children's Traffic Club for children aged 3+ to promote road safety.	Primary school children and parents	Good practice	Funded by Transport for London	Continue
Pilot alternative measures of traffic safety management- including Vehicle Activated Signs; priority give-ways; oversized mini-roundabouts; Homes Zones	To reflect intervention	Good practice	LBH Environmental Services	Tba

SUICIDE

Objective: (inc. PSA & local targets)
Reduce mortality from suicide and undetermined injury by at least 20% by 2010.
PSA05

Current situation
The suicide mortality rate in Haringey has fallen from 10.7 per 100,000 population (10.7/100,000) in 1996/98 to 9.1/100,000 in 2002/04. If this trend continues, Haringey will meet the target 20% reduction by 2010.The gap between the Haringey and England average narrowed by 0.9/100,000 between 1996/98 and 2002/04 and is currently 0.4/100,000. Haringey had the third highest suicide mortality rate of its comparable boroughs in 2002/04, behind Lambeth (9.7/100,000) and Southwark (11.0/100,000). 75% if suicides in Haringey are amongst people who have not had contact with mental health services.

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Work to complete BEHMHT suicide Prevention Strategy	High Risk groups	Moderate	HTPCT BEHMHT	Sept 2007
Identify Haringey specific and wider community issues for local plan to reduce suicide	Haringey residents	Moderate	HTPCT	Oct 2007
Ensure inclusion of national identified priorities for prevention with BME communities	Haringey BME residents at risk	Good	HTPCT	Oct 2007
Identify resource requirements and move to identify appropriate resources	As in plan		HTPCT	Nov 2007
Link to work on self harm strategy	People who self-harm and risk of suicide	Moderate	BEHMHT/ HTPCT	Oct 2007
Ensure links on suicide prevention with work in primary care Local Enhanced scheme and on access to psychological Therapies	People with ongoing mental health problems being cared for by primary care	Moderate	HTPCT	Ongoing

ACCESS TO HEALTH SERVICES

Objective
Reduce number of Haringey residents not registered with a GP, and improve equity of access to health services.

Current situation
There is little data on equity of access to services in Haringey. However, there is indirect evidence of inequity of access. In 2005, 955 Haringey residents had to be allocated a GP by the PCT, as they had approached 3 or more practices and been unable to register. The majority of these lived in the East of the borough. Despite CHD mortality being twice as high in some deprived wards in the east compared to more affluent boroughs in the west, standardised rates for CHD patients being treated in general practice and standardised hospital admission rates for CHD are not higher in the East of the borough, implying poor access to treatment.

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Develop Strategy for the long term development of primary care services in Haringey which will be of world class standard	Haringey population	Good practice and some good evidence	HTPCT	Strategy for consultation by May 2007
Institute monitoring framework for quality of care and outcomes for primary and secondary care services	Haringey patients	Good	HTPCT	Framework development underway
Work to develop one-stop-shops for health and social care services in accessible locations especially in east of the borough as part of primary care strategy .	Service users	National policy	HTPCT, LBH, HSP	In accordance with PC strategy timetable
Use Equity audit of resource allocation to inform equitable commissioning of primary care services, and practice-based commissioning of services	Primary care population especially most needy	Good practice	HTPCT-Commissioning Directorate	Underway
Improve funding and support for independent health advocates.	Vulnerable groups	Good practice	HTPCT teaching programme	tba
Improve and monitor front-line health workers (e.g. receptionists) skills in communication and client care.	Service users	Good practice	HTPCT-Commissioning Directorate	Ongoing as part of QOF
Re-commission interpreting services to support improves access for patients with little or no English	Patients with little or no English	Good practice	HTPCT	Underway

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Implement mental health enhanced service in primary care to improve/develop services that address the physical and mental health needs of people with mental health problems	Primary care service users with mental health problems	Good practice	HTPCT	Underway
Enhance involvement of voluntary sector and community groups in decision-making around service planning and development	Voluntary & community groups	Good practice	HSP and its partnership groups,	Part of outcome of HSP review
Improve transport services to hospitals/ health services for disabled and older people	Disabled /older people	Good practice	HTPCT with HAVCO	tba
Explore the role of libraries in providing information to inform health choices, and facilitating access to services.	Library service users	Good practice	LBH	Underway

INFANT MORTALITY

Objective (inc.PSA and local targets)
Starting with children under one year, by 2010 reduce by at least 10% the gap in mortality between 'routine and manual' groups and the population as a whole.
PSA6a- Reducing the number of women who smoke during pregnancy
PSA6b- Increasing the number of women who initiate breastfeeding

LAA Target: Optional Target Reduce the rate of infant mortality in Haringey by reducing the proportion of expectant and new mothers who report smoking and increasing the proportion who initiate breastfeeding (*Changing Lives priority 4)*

Current situation
The infant mortality rate in Haringey (7.4/1000 live births in 2002-2004) remains higher than London and England, and varies between Children's Network Area from 6.1/1000 in the West to 7.5 and 8.3 in the North and South patches respectively. Approximately 1 in 10 pregnant women in Haringey are current smokers at the time of delivery, twice the LDP target of 1 in 20. Approximately 84% of women in Haringey initiate breastfeeding, but data is not currently collected on breastfeeding maintenance. The Haringey Infant Mortality Action Plan 2004-5 is currently being reviewed, and this action plan will be updated in light of the outcomes.

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Revise and Implement interagency Infant Mortality Action Plan covering breast feeding, smoking, infant feeding, teen preg and early ante-natal booking	High Risk mothers and babies	Strategy based on good evidence	HTPCT Public health (PH)	Underway
Strategy to reduce the number of women booking late in their pregnancy for ante-natal care, in line with recent NICE guidance.	Pregnant women	Strong	HTPCT PH	Dec 07
Local hospitals to apply for Baby Friendly status Pilot Baby Friendly accreditation for one children's centre	Mothers and their newborn babies , especially higher risk	Good	Hospitals HTPCT Public health	April 08
Ensure new infant feeding coordinator role is able to promote breastfeeding and best practice in weaning, including implementation of infant feeding guidelines and	Young children and parents/ carers	Strong	HTPCT AD Children Services	Underway
Develop a breastfeeding maintenance monitoring system to target interventions for women/families less likely to maintain breastfeeding at every contact.	Groups with low breastfeeding maintenance rates	Good practice	HTPCT PH	Dec07
Systems to record and monitor the smoking status of, and interventions received by, families with children should be set up in line with NICE guidance. These systems should ensure service providers ask about smoking at all contact episodes (e.g. ante-natal visits)and refer to smoking cessation services .	Parents who smoke	Strong	Children's network. Hospitals, HVs (part of IMAP)	Sept 07
Smoking cessation services should be a core element of care pathways developed within children's centres.	Children's centre service users	Strong	SCS	April 08

HOUSING

Objective: (inc. PSA & local targets)
By 2010, bring all social housing into a decent condition with most of this improvement taking place in deprived areas, and for vulnerable households in the private sector, including families with children, increase the proportion who live in homes that are in decent condition (ODPM PSA7).
LAA target: Safer and Stronger Communities Block
As part of an overall housing strategy for the district ensure that all social housing is made decent by *2010,* unless a later deadline is agreed by DCLG as part of the Decent Homes programme**.**
Increase domestic fire safety and reduce arson

Healthier Communities and Older People Block
Improve living conditions for vulnerable people ensuring that housing is made energy efficient, decent and safe
Sub-outcomes

i. Maintaining vulnerable people in Haringey in their own homes by increasing thermal comfort, reducing the risk of fuel poverty and minimising carbon emissions.
ii. Reduced health impact from slips, trips and falls.
iii. Reducing the risk to vulnerable people from fire and fire related injuries

Current situation
Within the social housing sector, providers have been active and are now on target to meet decent homes in 100% of stock by 2010. The level of non-decent local authority owned housing stock has reduced from 58% in 2003/04 to 45% in March 2006. The majority of Registered Social Landlord (RSL) properties in Haringey meet the decent homes standard with approximately 80% of 10,500 properties meeting the standard as at April 2006
(NB Action plan to be confirmed following consultation with Better Places Partnership)

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Improve energy efficiency in private sector housing, especially homes which fail to meet standards due to a lack of thermal comfort. **Link with LAA stretch target**	Tenants in renewal areas	British Research Establishment modelling to identify key issues and areas for focus	LBH Environmental Health	tbc

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Develop standard housing condition assessment criteria, guidance, and referral mechanisms to support services (e.g. private sector housing service) for a range of service providers visiting people in their own homes	Households living in poor accommodation that are vulnerable to poor health	Good practice	LBH Environmental Health	
Implement system to ascertain and monitor levels of non-decency in the RSL sector.	Residents of non-decent housing	Good practice	LBH Housing Strategy	
Implementation of Housing Association Forum joint service standards for all social landlords in Haringey.	Residents of social housing	Good practice	Housing Association Forum	
Work with larger partner RSL associations and those which have more than 50% of properties failing to meet the Decent Homes standard, on their asset management plans to agree disposal programmes and with modified nominations agreements to enable decants for major works.	Tenants of larger RSLs failing to meet Decent Homes Standards	Good practice	LBH Housing Strategy	
Implementation of Accredited Lettings Scheme to provide high quality private sector housing options	Tenants of private sector housing	Good practice	LBH Housing Strategy	
Improve housing conditions in private rented sector accommodation above shops	Tenants of private sector housing above shops	Good practice	LBH Neighbourhood Management	

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Improve dilapidated private sector terrace properties in South Tottenham	Residents of private sector terrace properties in South Tottenham	Good practice	Bridge NDC	
Develop initiatives to tackle fuel poverty **Link with LAA Stretch target working with older people**	Residents living in fuel poverty	Strong evidence of links between fuel poverty and health outcomes	LBH Environmental Health	
Continue to provide high quality floating support to those with housing support needs across all tenures through the supporting people programme	Residents with housing support needs	Good practice	LBH Supporting People Programme	

EMPLOYMENT

Objective: (inc. PSA & local targets)
DWP PSA 4 In the 3 years to Spring 2008 demonstrate progress on increasing the employment rate; increase the employment rate of disadvantaged groups; significantly reduce the difference between the employment rate of disadvantaged groups and the overall rate.
DWP PSA 8 In the three years to March 2008 increase the employment rate of disabled people, taking account of the economic cycle; and significantly reduce the difference between their employment rate and the overall rate, taking account of the economic cycle.
DfES PSA 13 Increase the number of adults with the skills required for employability and progression to higher levels of training
LAA target: Increase Employment

- Within each NRF district, for those living in the wards identified by DWP as having the worst initial labour market position (as at February 2004), significantly improve their overall employment rate and reduce the difference between their employment rate and the overall employment rate for England.
- Reduce worklessness – Increase number of people from priority neighbourhoods helped into sustained work. Increase number of residents on Incapacity benefit for 6 months or more helped into work of 16 hours per week or more for at least 13 weeks

Current situation
Employment: The employment rate amongst the total Haringey working age population was 60.3% in 2004/05. This was 14.5 percentage points below the England average of 74.8%. The gap between the Haringey and England average widened by 3.4 percentage points between 1997/98 and 2004/05, and is currently 14.5 percentage points.
Education: More than 85% of three-year-olds are accessing early years education. The attainment of 14 year-olds (Key Stage 3) has improved faster than the national trend since 2000, but the overall levels are still well below national figures. Although there is still a difference in attainment between schools in the East and West of Haringey, results in recent years suggest that this gap is also decreasing.

Action	**Target group**	**Evidence of effectiveness**	**Delivery lead**	
Income Maximisation Strategy- complete, consult on and implement income maiximisation strategy linking with	Low income households and those already on benefits	Strong	Adult, culture and community Services	In development
Pathways to employment Pre-employment training and skills development	Long term unemployed	Good practice	Economic Regeneration LBH	Underway
Linking people to jobs e.g. Learn for work, Employment pathways to Health	Long term unemployed	Good Practice	Economic Regeneration LBH	Underway

Outreach approaches to for excluded communities e.g. BME, Lone Parents, Refugees	Some BME communities, lone parents , refugees	Good practice	Economic Regeneration LBH	Underway
Targeted approaches for people with physical learning disabilities and mental health problems	People with Phys dis, learning dis, and mental health problems	Good	Economic Regeneration LBH	Underway
Work with City Growth programme and HVACO to develop programme of workforce health promotion that is feasible in context of local work settings	Employed staff in Haringey (medium sized enterprises)	National Policy	HTPCT	December 2007

EDUCATION

Objective: (inc. PSA & local targets)

DfES PSA6 Raise standards in English and maths so that: y 2006, 85% of 11 year olds achieve level 4 or above, with this level of performance sustained to 2008; and by 2008, the proportion of schools in which fewer than 65% of pupils achieve level 4 or above is reduced by 40%.

DfES PSA 7 Raise standards in English, maths, ICT and science in secondary education so that: by 2007, 85% of 14 year olds achieve level 5 or above in English, maths and ICT (80% in science) nationally, with this level of performance sustained to 2008; and by 2008, in all schools at least 50% of pupils achieve level 5 or above in each of English, maths and science.

DfES PSA10 By 2008, 60% of those aged 16 to achieve the equivalent of 5 GCSEs at grades A* to C; and in all schools at least 20% of pupils to achieve this standard by 2004, rising to 25% by 2006 and 30% by 2008.

DfES PSA 13 Increase the number of adults with the skills required for employability and progression to higher levels of training

LAA target: **Mandatory** By 2008 all schools located in Local Authority Districts in receipt of NRF to ensure that at least 50% of pupils achieve level five or above in each of English, maths and science.

- **Stretch** target on increasing the percentage of 19 year olds with level 2 qualifications (*Changing Lives priority 20)*
- **Stretch** target on increasing he percentage of 16-18 year olds not in education, employment or training (NEET). (*Changing Lives priority 19)*

Current situation

Education: More than 85% of three-year-olds are accessing early years education. The attainment of 14 year-olds (Key Stage 3) has improved faster than the national trend since 2000, but the overall levels are still well below national figures. Although there is still a difference in attainment between schools in the East and West of Haringey, results in recent years suggest that this gap is also decreasing.

(NB Action plan to be confirmed following consultation with Children and Young people Partnership Board)

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Roll out of national EAL programme to improve English language competency for bilingual learners	Bilingual learners	Good practice	Children's Service	
Support the introduction of Personal Advisors in 5 secondary schools to help pupils at risk of exclusion	Pupils at risk of exclusion	Good Practice	Children's Service	

Action	Target group	Evidence of effectiveness	Delivery lead	Time
Development of programmes for secondary pupils from overseas who enter the education system at 14 plus. Programmes to ensure continuity into post 16 provision	Secondary pupils from overseas	Good practice	Children's service	
Provide a wide range of Family Learning opportunities to parents and their children at pre-Foundation and Foundation Stage to boost early years attainment levels, particularly for those who are vulnerable.	Vulnerable pre-school children and parents	Good practice	CYPSP	
Support schools in developing provision that raises the achievement of Black and Minority Ethnic including promoting partnership between mainstream, supplementary and community language schools	BME children and young people	Good practice	CYPSP	
Target schools where attendance is not improving consistently.	Children with poor school attendance	Good practice	CYPSP	

References

[1] A Healthier Haringey: Improving wellbeing and tackling inequalities, report of an event on 8th February 2006'
[2] Department of Health. Tackling Health Inequalities; a programme for action. 2003.
http://www.dh.gov.uk/assetRoot/04/01/93/62/04019362.pdf
[3] Department of Health. Choosing Health: making healthier choices easier. 2004.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094559&chk=H29Li6
[4] The Healthcare Standards Unit. Tackling health in equalities. The Spearhead group of local authorities. 2005.
www.hcsu.org.uk/index.php?option=com_docman&task=doc_download&gid=271
[5] Fitzpatrick J, Jacobson B. Mapping health inequalities across London. LHO, September 2001.Calculating life expectancy and infant mortality rates. Mapping health inequalities across London: technical supplement.
[6] London Health Observatory. The London Health Forecast: Can London's health divide be reduced? 2004.
http://www.lho.org.uk/viewResource.aspx?id=8990
[7] Department of Health. Tackling health inequalities: status report on the programme for action. August 2005
http://www.dh.gov.uk/assetRoot/04/11/76/98/04117698.pdf
[8] Health inequalities in London. Life expectancy and infant mortality 1998-2002, London Health Observatory, April 2004
[9] London Health Observatory. Health inequalities in London: Life expectancy and mortality. 2004
[10] London Health Observatory. Mapping health inequalities across London. 2001.
http://www.lho.org.uk/Download/n3eq2c55x2pvaynmzdhwr0j5/live/7652/map_hilond_3.pdf
[11] Social patterning of individual health behaviours: the case of cigarette smoking. Jarvis MJ and Wardle J. In Marmot M and Wilkinson RG. Social Determinants of Health. Oxford. Oxford University Press. 2006
[12] Social patterning of individual health behaviours: the case of cigarette smoking. Jarvis MJ and Wardle J. In Marmot M and Wilkinson RG. Social Determinants of Health. Oxford. Oxford University Press. 2006.
Kelly M and Capewell S 2004.Relative contribuytions of changes in risk factors and treatment to the reduction in coronary heart disease mortality. Health Development Agency Briefing Paper[13]
[14] World Health Organisation 2004. Food and health in Europe: a new basis for action.
http://www.euro.who.int/document/e78578.pdf
[15] Health development Agency 2004.The effectiveness of public health interventions for increasing physical activity among adults evidence briefing http://www.publichealth.nice.org.uk/download.aspx?o=502697
[16] National Institute for Health and Clinical Excellence. 2005. Housing and public health: a review of reviews of interventions for improving health - Evidence briefing
http://www.publichealth.nice.org.uk/page.aspx?o=526671
[17] Department of Health 2005. Tackling health inequalities: what works?.
http://www.dh.gov.uk/assetRoot/04/10/34/06/04103406.pdf
[18] A Healthier Haringey: Improving wellbeing and tackling inequalities, report of an event on 8th February 2006'

[20] HDA. Smoking and health inequalities.2002
[21] Scollo M et al, Review of the Quality of Studies on the Economic Effects of Smoke-free Policies on the Hospitality Industry. Tobacco Control 2003:12;13-20.
[22] NICE Smoking cessation guidance. March 2006. http://www.nice.org.uk/page.aspx?o=299611
[23] London Health Observatory. Stop before the Op. May 2006.
http://www.lho.org.uk/Download/fqb2zui11mlohb2u2hg5z42h/live/10495/Stop%20before%20the%20Op%20Final.pdf
[24] Sport Engand : Active People Survey 2006
[25] Department of Health (1999) Health Survey for England 2003
[26] Britton, A, McPherson, K. (2000) Monitoring the progress of the 2010 target for coronary heart disease mortality: Estimated consequences on CHD incidence and mortality from changing prevalence of risk factors. National Heart Forum: London
[27] NICE Physical activity guidance. March 2006. http://www.nice.org.uk/page.aspx?o=299531
[28] Breastfeeding reference
[29] LHO Mortality from all circulatory diseases 2002-4
[30] LHO Standardised mortality ratio CHD 2000-4
[31] LHO The London Forecast. Can London's health divide be reduced? 2004
[32] DH Quality and Outcomes Framework (QOF) guidance and evidence base 2004.
http://www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf
[33] NICE. Statins for the prevention of cardiovascular events. Jan 2006.
http://www.nice.org.uk/page.aspx?o=TA094guidance
[34] DH Quality and Outcomes Framework (QOF) guidance and evidence base 2004.
http://www.dh.gov.uk/assetRoot/04/08/86/93/04088693.pdf
[35] NICE Management of chronic heart failure in adults in primary and secondary care 2003
http://www.nice.org.uk/page.aspx?o=CG005

[36] NICE guideline on prophylaxis for patients who have experienced a myocardial infarction 2001 http://www.nice.org.uk/page.aspx?o=16529
[37] NICE The clinical effectiveness and cost effectiveness of early thrombolysis for treatment of myocardial infarction 2002 http://www.nice.org.uk/page.aspx?o=ta052&c=cardiovascular
[38] LHO Standardised mortality ratio cancer 2000-2004
[39] LHO The London Forecast. Can London's health divide be reduced? 2004
[40] LHO Standardised mortality ratio cancer 2000-2004
[41] HTA The determinants of screening uptake and interventions for increasing uptake: a systematic review. 2000. http://www.hta.nhsweb.nhs.uk/fullmono/mon414.pdf

haringey strategic partnership

for children & young people

AGENDA ITEM

MEETING

Children and Young People's Strategic Partnership Board
27th March 2007

TITLE

Haringey Infant Mortality Action Plan: 2007-2010

SUMMARY

While the infant mortality rate for England is at an all time low, the rate in Haringey continues to be significantly higher than that for England and Wales, London and our neighbouring boroughs.

This revised Action Plan to reduce infant mortality in Haringey builds on work first carried out in 2004. A review of the Infant Mortality Action Plan 2004-05 was subsequently undertaken at the end of last year to assess progress against the identified actions. This updated action plan incorporates the findings of the review and takes into account consultation with key stakeholders.

The 2007-10 plan identifies priority actions to reduce infant mortality in Haringey focussing on:

- Strengthening local delivery
- Teenage Pregnancy
- Smoking Cessation
- Antenatal to Postnatal Care including Breastfeeding
- Social Support
- Income, Education and Employment

RECOMMENDATIONS

a) The Children and Young People's Strategic Partnership Board adopt the Infant Mortality Action Plan, subject to any revisions.

b) The Children and Young People's Strategic Partnership Board agree to incorporate monitoring of the Infant Mortality Action Plan through the existing monitoring arrangements for the Children and Young People's Plan.

c) Identified stakeholders note their roles in delivering the plan and agree to take forward attributed actions.

LEAD OFFICER(S)

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Infant Mortality Action Plan March 2007 - 2010

1. Why focus on Infant Mortality[1]

While the infant mortality rate for England is at an all time low, rates in Haringey are increasing and continue to be significantly higher than those for England and Wales, London and our neighbouring boroughs.

The following table compares the infant mortality rate in Haringey with England and Wales and London:

Infant mortality rates (2003-2005)

	England and Wales	London	Haringey (Rate and number)
Under 1 year	5.1	5.2	8.1 (97)
Neonatal (infant deaths under 28 days per 1,000 live births)	3.5	3.5	5.1 (61)
Perinatal (Stillbirths & Infant deaths under 7 days per 1,000 total births)	2.7	2.6	4.0 (48)

It is important to note that as the number of deaths in infancy each year is small there is likely to be some year on year fluctuations that could affect the rate. Nevertheless the Haringey rate continues to be significantly above the London average and is therefore a cause for concern.

Analysis over a 3 year period shows that the Infant Mortality rate is higher in wards in the east of Haringey, although it is difficult to interpret the significance of this because of the small number of deaths involved.

Success in reducing our Infant Mortality rate depends on sustained and concerted effort from a wide range of partners in order to make a real difference to babies born in Haringey.

2. Policy framework to reduce Infant Mortality

The Government has made tackling health inequalities a priority by setting a national health inequalities PSA target, which is underpinned with objectives on reducing infant mortality and increasing life expectancy in disadvantaged populations. The infant mortality element of the target is:

[1] Infant mortality rates describe the deaths of infants in the first year of life. The rate is the number of live newborns dying under one year per thousand live births

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group[2] and the population as a whole.

To achieve this target, the government has set three complementary targets. These targets measure progress on the three most important risk factors for infant mortality which include: breastfeeding, smoking and teenage pregnancy. The targets are:

1. To deliver a 2% increase annually in the proportion of women initiating breastfeeding, focusing particularly on women from disadvantaged groups.
2. To deliver a 1% reduction, annually, in the proportion of women smoking through pregnancy, especially focusing on smokers from disadvantaged groups.
3. Reduce the 1998 teenage conception rate by 50% (55% in Haringey).

The Local Delivery Plan (LDP) 2005-08 outlines both the Haringey TPCT plans for addressing these national public sector agreement (PSA) targets and more broadly its strategies for overarching issues such as tackling health inequalities.

The Department of Health's recent review on the Infant Mortality PSA target[3] identified the following key principles or "high impact changes" that could achieve change at a local level and help deliver the target:

- Know the target, know your gap
- Make the target part of everyday business – integrate it into commissioning plans and provider contracts
- Take responsibility, engage communities and families in this work
- Match resources to need
- Focus on what can be done

These principles have been incorporated into this local action plan in the "Strengthening Local Delivery" section and will guide the implementation of the plan overall. Further guidance on reducing infant mortality is expected from the Department of Health in Spring 2007.

Actions to reduce infant mortality within this plan will also be guided by the implementation of the National Service Framework for Children, Young People and Maternity Services, together with relevant NICE Guidance.

[2] The routine and manual group includes those in lower supervisory and technical, semi-routine and routine occupations. Typical examples might be porters, cleaners, bar staff, waiters/waitresses, sales assistants, catering assistants, train drivers, people working call centres, electricians and sewing machinists.

[3] Department of Health February 2007 Review of the Health Inequalities Infant Mortality PSA Target;

3. Development and implementation of an action plan to reduce infant mortality

This revised Action Plan to reduce infant mortality in Haringey builds on work first carried out in 2004. A review of the Infant Mortality Action Plan 2004-05 was subsequently undertaken at the end of last year to assess progress against the identified actions. This updated action plan incorporates the findings of the review and takes into account consultation with key stakeholders including the acute trusts, the TPCT and Local Authority representatives.

The 2007-10 plan identifies priority actions to reduce infant mortality in Haringey focussing on:

- Strengthening local delivery
- Teenage Pregnancy
- Smoking Cessation
- Antenatal to Postnatal Care including Breastfeeding
- Social Support
- Income, Education and Employment

5. Monitoring of the action plan

Implementation of this plan will be monitored through the Local Delivery Plan, the Children and Young People's Plan and the Community Strategy.[4]

6. Recommendations

a) The Children and Young People's Strategic Partnership Board adopt the Infant Mortality Action Plan, subject to any revisions.

b) The Children and Young People's Strategic Partnership Board agree to incorporate monitoring of the Infant Mortality Action Plan through the existing monitoring arrangements for the Children and Young People's Plan.

c) Identified stakeholders note their roles in delivering the plan and agree to take forward attributed actions.

March 14th 2007

[4] We are currently developing a local target for Infant Mortality to be included in the Haringey Community Strategy

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Infant Mortality Action Plan 2007 - 2010

1. Strengthening local delivery

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
1.1 Raise awareness of the Infant Mortality target and action plan with key stakeholders	Establish mechanisms to clarify and communicate the target using existing networks to spread the message and promote the key actions that are most likely to contribute to the target and improve outcomes for mothers and babies; ensure high level support and sign up to the Action Plan	Public Health TPCT	2007-2008	From existing resources	Action Plan signed off by the Children and Young People's Strategic Partnership Board. Communication mechanisms established.
1.2 Improve data quality and strengthen evidence base	Develop the evidence base to ensure that interventions are targeted to make the biggest impact in reducing inequalities in Infant Mortality amongst vulnerable groups.	Public Health TPCT	2007-2008	From existing resources	Development of an evidence base and local profiling to address targets
1.3 Act on existing and planned guidance to review and revise Action Plan	Review and revise the Action Plan to take into account new guidance and recommendations e.g. Best Practice Guidance to reduce inequalities in Infant Mortality from Department of Health (expected Spring 2007); Reaching Out – action plan on social exclusion etc	Public Health TPCT	2007	From existing resources	New evidence of effectiveness incorporated into Action Plan and communicated to key stakeholders
1.4 Ensure ownership of target through effective performance management	Develop a local target around Infant Mortality in partnership with the Local Authority and establish performance management protocols to monitor progress	LA Policy and Performance Team	Short term	From existing resources	Local target set and performance management protocols in place
1.5 Establish an understanding of causes of death in those aged under one	Review local causes of death in the under 1s to identify major causes and trends	Public Health TPCT North Middlesex Hospital Whittington Hospital	2007-2008	From existing resources	Clearer understanding of causes of death
1.6 Maximise opportunities to work with women preconceptually to improve overall health	Use available opportunities to promote the importance of weight management; smoking cessation; nutrition etc to women of reproductive age considering a pregnancy i.e. through Children's Centres; community events; primary care settings; family planning services etc	Children's Networks Family Planning Services	Ongoing	From existing resources	Health needs of women of reproductive age put on public health agenda
1.7 Improved monitoring	Ensure the Infant Mortality Action Plan is reviewed as part of	Children's Service	2008	From	Monitoring arrangements in place

arrangements to assess progress in reducing infant mortality	the monitoring of the Children and Young People's Plan			existing resources	and implementation leads agreed.

2. Teenage pregnancy

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
2.1 Continued links with the Smoking Cessation Service (SCS)	Increase number of people trained to level 1 or higher in smoking cessation in the services dealing with teenage parents; • 4YP Team • Teenage Parents Support Team (TPST) • Designated Children's Centre staff	Smoking Cessation Service (SCS)	2007/2008	Training provided by the SCS free	All of TPST and 50% of 4YP staff trained by end 2007 Identification of key staff to be trained to Level 2 and training programmes put into place
2.2 Implementation of Teenage Pregnancy Strategy	Communicate importance of how achieving teenage pregnancy targets impacts on achievement of Infant Mortality targets Ensure cross reporting mechanisms are established.	Public Health, TPCT Teenage Pregnancy Co-ordinator	Ongoing	From existing resources	Conception data – progress towards meeting Teenage Pregnancy PSA target; Children and Young People's Plan to draw together Action Plans
2.3 Improve links between agencies working with teenage parents	Improve data collection and sharing to ensure that services are aware of where teenage parents are to ensure timely and effective support.	TPCT: Public Health; Child Health Children's Networks North Middlesex Hospital; Whittington Hospital; Teenage Pregnancy Co-ordinator	Short term	From existing resources	Data sharing protocols between key agencies established.
	Improve links between housing and the health service to help improve early access to service and appropriate housing provision.	LA Housing TPCT Teenage Pregnancy Co-ordinator	Short term	From existing resources	Information sharing protocols established and acted upon
	Establish clear lines of accountability with services working with teenage pregnancy and teenage parents to ensure all key stakeholders are aware of roles and responsibilities	Teenage Pregnancy Co-ordinator TPCT Maternity Services Reintegration Team	Short term		All agencies aware of specific roles and responsibilities around teenage pregnancy and teenage parents

2.4 Earlier identification and referral of pregnant teenagers to relevant support services	Ensure effective systems are in place to refer pregnant teenagers to appropriate support services and ensure new referrals are made known to Teenage Pregnancy Co-ordinator; and relevant Children's Centres	HV/Midwife group NMH Whittington Hospital TPCT Child Health Surveillance Team Teenage Pregnancy Co-ordinator	Short term		Clear referral pathways established; Children's Centres aware of teenage parents requiring support in their reach area
2.5 Antenatal Care services tailored to accommodate needs of teenagers	Evaluate the impact of the specialist teenage pregnancy midwives at the Whittington in terms of improved outcomes for teenage mothers and their babies	Whittington Hospital	2008-2009	From existing resources	Evaluation of the impact of specialist Teenage Pregnancy midwives and dissemination of findings
2.6 Ensure services meet the needs of teenage parents and are young people friendly	Training for Children's Centres and other professionals working with teenage parents to ensure services are welcoming, non-judgemental and accessible to teenage parents	Teenage Parents Support Team; Children's Network Area Leads	Short term	From existing resources	Number of Children's Centre staff receiving training; Children's Centres meeting their reach targets around teenage parents
	Pilot drop ins for teenage parents at five identified Children's Centres to encourage networking; reduce social isolation and promote information sharing	Teenage Parents Support Team Children's Centres	2007-2008	From existing resources	Drop ins established; numbers of teenage parents accessing drop ins and perceived satisfaction with services
2.7 Ensure strong support for breastfeeding	Identify young mothers willing to be trained as peer breastfeeding supporters and pilot a specific teenage breastfeeding support group	Infant Feeding Co-ordinator; Teenage Parents Support Team	Short term		Number of young people trained; young mothers breastfeeding groups established

3. Smoking cessation

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
3.1 Smoking cessation to be an integral part of service delivery for whole family during and after pregnancy	Ensure SCS level 1 (or higher) is part of • mandatory training programme for appropriate staff in TPCT (i.e. dealing with (teenage) mothers/parents) • Health Visitor training • Midwives • Student health professionals training/education (also approach Royal Colleague to include in curriculum • Educational services which deal with teenage parents • Children's Centre staff training Level 2 training made available for midwives and health visitors working with Teenage parents	Smoking Cessation Service Service managers for Midwifery and Health Visiting	Ongoing	Training provided free by SCS within existing resources	Training strategy in place, which targets staff and students. Level 1 training part of the curriculum Training of all new Health Visitors and identified Children's Centre staff to Level 1 by end of 2007
	Continued close liaison between midwifery and SCS to maintain good relationships and referral rates	Smoking Cessation Service NMH Whittington	Ongoing	From existing resources	Referral forms in booking in notes Increase in referral rates identified
	All pregnant women to be asked their smoking status at booking , throughout pregnancy and in post natal period. Status recorded and referrals made to SCS	North Middlesex Hospital; Whittington Hospital; Health Visiting Service Smoking Cessation Service Children's Networks	September 07	From existing resources	Numbers of pregnant women referred to Smoking Cessation Service from Hospital Trusts and Health Visiting Service
	Teenage Parents Support Team to monitor levels of smoking in teenage parents and the number of referrals made to the smoking cessation service	Teenage Parent Support Team; Smoking Cessation Service	Ongoing	From existing resources	System in place to collect data on smoking in TP.
	Improve GP referral rates for pregnant women to the smoking cessation services, through Primary Care facilitators. Maintain good links with Level 2 GPs and encourage other GPs to access training	Smoking Cessation Service; Primary care Facilitators	Ongoing	From existing resources	Every new Practice Nurse to receive level 1 Training delivered to all GP collaboratives

					Smoking booklet sent to all GPs
	Develop referral pathways for pregnant women to Smoking Cessation Service through other sources e.g. Pharmacists, Dentists etc. Children's Centres	Smoking Cessation Service	2007-2008	From existing resources	Referral pathways in place for other professionals
3.2 Utilise opportunities to promote Health Promotion messages	Utilise forthcoming legislation around smoking in public places, maximise opportunities to encourage smokers to quit	Public Health, TPCT Children's Networks Smoking Cessation Service	2007	From existing resources	Numbers of quitters amongst relevant groups
3.3 Make the smoking cessation service more accessible and community based	Build on existing work undertaken with pharmacists etc to monitor usage to assess appropriateness of times of service etc. Expansion of workplace initiatives; promote languages spoken by Level 2 counsellors	Smoking Cessation Service	Long term	From existing resources	Patient satisfaction with smoking cessation services
	Health Equity Audit on access to Smoking Cessation Service to highlight usage and outcomes for pregnant women	Public Health TPCT	Short term	From existing resources	Findings of health equity audit disseminated and acted upon

4. Antenatal to Postnatal care

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
4.1 Improve access to effective and appropriate antenatal and postnatal care	Implementation of Child Health Promotion Programme and modernised Health Visiting service as part of the National Service Framework for Children, Young People and Maternity Services.	TPCT	Long- term	Within existing resources	Programme successfully implemented
	Include telephone numbers of mothers on first page of electronic new birth form to ensure Health Visitors can make appointments at an earlier stage with new parents	IT Services Acute Trusts Child Health Surveillance Team	Short term	To be confirmed	Telephone numbers included on first page of electronic new birth form.
	Develop more targeted community-based antenatal and post natal services through the Children's Centres core offer to improve access to deprived and vulnerable communities	Children's Networks TPCT North Middlesex Hospital Whittington Hospital	2007-2010	To be confirmed	% of Children's Centres antenatal and post natal care; Health Visitor appointments
4.2 Implement NICE guidance on antenatal and postnatal mental health once published	Recognise mental health problems during pregnancy and in the first year after giving birth and ensure systems in place to provide: • care and treatment (including drugs and psychological treatments) of women who develop a mental health problem during pregnancy or in the first year after giving birth, and women who have a higher chance of developing a problem at this time • care and treatment (including drugs and psychological treatments) of women who already had a mental health problem before becoming pregnant • how families and carers may be able to support women with mental health problems and get support	North Middlesex Hospital Whittington Hospital Perinatal mental health team	Ongoing		

	for themselves				
4.3 Target women in routine and manual groups and other vulnerable groups to ensure earlier booking	Conduct an Health Equity Audit of women booked by 12 weeks and after 22 weeks to identify inequalities in early booking and act upon recommendations	Public Health TPCT	2007-2008	From existing resources	Recommendations made and incorporated into action plan
4.4 Promotion of ante natal screening to identify potential problems at an earlier stage	Utilise annual screening audits to identify if inequalities exist in those accessing screening (Department of Health has evidence that there are ethnic differences and recommends work to identify if there are social inequalities)	North Middlesex Hospital Whittington Hospital	2007-2008		Information obtained from screening audits used to improve screening uptake
4.5 Revision of antenatal risk assessment form	In partnership with the acute trusts, review referrals for risk factors relating to domestic violence; safeguarding children; substance misuse; mental health etc with a view to improving liaison with other agencies through CAF (Common Assessment Framework)	North Middlesex Hospital Whittington Hospital TPCT	2007-2008	From existing resources	Monitor referrals and follow up individual Trusts
4.6 Promotion and effective targeting of neonatal screening to improve outcomes	Clearly communicating to parents the purpose and benefits of neonatal screening e.g. physical examination at birth and at 6 weeks and newborn bloodspot screening these tests to improve outcomes for babies Develop system whereby results of tests sent to Great Ormond Street can be sent back to the relevant acute trusts as well as to the GP.	North Middlesex Hospital Whittington Hospital TPCT Health Visiting Service GPs	Ongoing	From existing resources	Monitoring uptake of screening tests among targeted groups Test results received by Acute trusts and information acted upon
4.7 Development of a local referral form for access to antenatal and postnatal services	Raise awareness of and accessibility to antenatal and postnatal services through: • Advertising more widely routes to care in the community	TPCT Whittington Hospital North Middlesex	Ongoing	From existing resources	Yearly review of any changes Service user feedback

	(i.e. with midwives or GPs) and the types of service available (screening, smoking cessation etc) • Increasing venues at which booking can be undertaken in community (i.e. children's centres)	Children's Networks			
4.8 Implementation of NICE Guidance on Antenatal and Postnatal Care and NICE guidance on Effective Actions on initiation and duration of breastfeeding	Ensure practice is guided by evidence of best practice	North Middlesex Hospital Whittington Hospital TPCT Children's Networks	Ongoing	From existing resources	Guidelines implemented and progress against guidance continually reviewed
4.9 Increase exclusive breast-feeding rates (e.g. first 6 months)	Develop a multi-agency breastfeeding policy framework, with senior management level support from local authority, TPCT and Acute Hospital Trusts to ensure: • Consistent information given by healthcare and other providers • Support is co-ordinated between midwives, health visitors; children's centre staff and community/voluntary groups • Local organisations provide space and resources to support breast feeding as service providers and employers of mothers • All pregnant women are given information about the benefits of breastfeeding and how to initiate breastfeeding • Women are given information about where to access breastfeeding support in their local area	TPCT Infant feeding Co-ordinator Health Visiting Service North Middlesex Hospital Whittington Hospital	Ongoing	From existing resources	Increase in breastfeeding initiation and maintenance rates.
	Build on existing system for collating and analysing breastfeeding data using hospital computerised records and data collated from parent-held child health record i.e. at new birth visit; 6-8 week check and every other contact.	TPCT Child Health Surveillance Team North Middlesex Hospital Whittington Hospital	December 07	Within existing resources	Improved intelligence on breastfeeding initiation and maintenance System introduced to analyse data and provide baseline for national target
	Ensure health visitors, midwives and other interested parties	TPCT	Ongoing		All health visitors receive regular

	receive training based on the UNICEF UK Baby Ten Steps to improve breastfeeding maintenance	Maternity Services Children's Networks			training and is included as part of a package of training for new Health Visitors
	Acute trusts to work towards registering for the Baby Friendly certificate of commitment TPCT to identify community site to pilot implementing the Baby Friendly 10 Steps	North Middlesex Hospital Whittington Hospital TPCT Infant Feeding Co-ordinator Children's Networks	2007-2008	Cost associated with applying and achieving Baby Friendly Accreditation Funding to be identified	Hospitals register intent. Process of accreditation undertaken in Children's Centre and learning disseminated
	Encourage local organisations (LA, PCT, Children's Centres and private) sector to adopt a joint breastfeeding policy by: • Providing appropriate facilities and health promotion messages on breast feeding at sites where mothers with small children frequent • Breastfeeding policy to be communicated to all staff working with parents with children aged 0-5 • Breastfeeding policy to be displayed in settings accessed by parents of 0-5 year olds • Ensuring TPCT and LA maternity policies make support for breastfeeding more explicit	LA and TPCT Human Resources Departments	Ongoing		HR policies reviewed. Women feel comfortable about breastfeeding in public
4.10 Ensure health promotion messages are being targeted to the most vulnerable groups to achieve greatest impact in reducing infant mortality	Midwives and health visitors to reinforce and target 'Back to Sleep' campaign to reduce Sudden Unexpected Deaths in Infancy. Information to be made available in Children's Centres and other places where people with young families attend. In particular, advice needs to be targeted to those in the Routine and Manual groups and other vulnerable groups to achieve greatest reduction in infant deaths.	TPCT Health Visiting Service/CONI (Care of Next Infant Co-ordinator) North Middlesex Hospital Whittington Hospital Children's Networks GPs	Ongoing	From existing resources	Sleeping position is recorded as part of new birth visit
	Interventions to increase immunisation rates are targeted to	TPCT Public Health	Ongoing	From	Increase in immunisations ??

	those in greatest need. Information is readily available to explain the importance of immunisations through a variety of outlets including Children's Centres; community organisations etc	Health Visiting Service Children's Networks GPs		existing resources	

5. Social Support

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
5.1 Extra support and follow up for vulnerable families and babies and improving links/referral between agencies	Roll out of Common Assessment Framework. Ensure training for staff in use of CAF	TPCT LA Acute trusts	Ongoing		All key professionals trained in use of CAF.
5.2 Provide an assortment of evidence based parenting programmes for families who are experiencing difficulties in parenting (including for young fathers)	Develop a borough wide parenting strategy to consider parenting in schools, Children's Centres, nurseries and antenatal clinics etc to be delivered by skilled multi agency teams	TPCT Children's Networks	2007-2008	To be confirmed	Borough wide strategy developed highlighting models of good practice
	Embed 'Mellow Parents' parenting programme as part of borough wide parenting strategy	TPCT Children's Networks	Ongoing	To be confirmed	Funding identified to continue roll out of Programme
	Explore how parenting skills (antenatal care, breastfeeding and smoking cessation) can be included in the National Curriculum (i.e. in drama etc) . Implement and evaluate the Teens to Toddlers Programme currently being piloted	TPCT/LA Healthy Schools Programme Teenage Pregnancy Co-ordinator	2007-2008	To be confirmed	Evaluation of Teens to Toddlers disseminated and recommendations acted upon
5.3 Establish a Young Father's Group	Investigate potential for Young Fathers Group as part of Teenage Pregnancy Strategy	4YP	2007-2008	To be confirmed	Young Father's Group established; regular attendance and ownership of group (s) by young fathers
5.4 Housing agencies to prioritise vulnerable families and expand provision of supported housing for teenage parents	Increase the allocation of mother and baby supported housing units in new supported housing scheme	Supporting People	Long term	Supporting People	More supported housing available for teenage parents

6. Income, Education, Employment

Policy recommendation	Action	Area lead/key stakeholder	Time-scale	Resources	Progress measure
6.1 Improving employment and education opportunities for parents, particularly lone and teenage parents	Work in partnership with the Teaching Programme Centre at the TPCT to explore how *New Deal for Lone Parents* scheme can support parents Consider targeting Community Nutrition Assistant training scheme at Teenage and Lone parents	Teaching Programme Centre, TPCT	Ongoing		Numbers of teenage parents and lone parents back in to education/employment
	Work in partnership with Teenage Parents Support Team and Teenage Pregnancy Co-ordinator to develop programmes to encourage teenage parents to access education and employment opportunities	Teenage Parents Support Team Teenage Pregnancy Co-ordinator	Ongoing	NRF	Percentage of teenage parents going back into education or employment
6.2 Improve benefit uptake by teenage and lone parents	• Target advice in community facilities such as GP surgeries, Children's Centres, antenatal clinics and community outlets • Promote the Local Authority website www.haringey.gov.uk/index/advice_tax_and_benefits/benefits_and_advice highlighting the 'Benefits for Families' section and related links to Government websites	Job Centre Plus Local Authority	Ongoing	Within existing resources	Teenage and lone parents able to access benefits advice in a variety of settings
	Develop the Income Maximisation Strategy to improve outcomes for vulnerable families	Adult, Culture and Community Services Local Authority	Long term		

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haringey strategic partnership
for children & young people

AGENDA ITEM

MEETING

Children and Young People's Strategic Partnership Board 2007

TITLE

Changing Lives Review 2007-8

SUMMARY

Legislation requires that Children & Young People's Plans are reviewed annually. This report sets out proposals for the review of Changing Lives.

These annual reviews now from part of the Annual Performance Assessment (APA) process for Children & Young People's Services.

RECOMMENDATIONS

The CYPSP notes and comments on the reports
Partners consider how they would wish to contribute to the review.

LEAD OFFICER(S)

Sharon Shoesmith,
Director
The Children & Young People's Service

Introduction

1. We are now one year in to *Changing Lives: The Children and Young People Plan* and we are preparing to review our progress against the 20 priorities outlined in the Plan.

2. Although regulations do not specify when the review has to take place it is advantageous to publish the review during late May using the findings from the Joint

Area Review (JAR), the updated Needs Analysis, the *Changing Lives* end of year monitoring report and others sources. The Review will become the self assessment document for the Annual Performance Assessment (APA) and needs to be with OfSted by June 14th 2007.

3. There is no prescribed format for the review but it must include a detailed assessment of impact, progress and improvement over the course of the last year, against the outcome areas and the priorities contained with *Changing Lives*. It should be concise and clear, focussing on analysis and evaluation rather than description; outcomes and impact rather than processes; and highlighting where progress has been slower as well as successes.

Progress on Priorities

4. We believe the 20 priorities are still very much relevant and the right ones for improving the life chances of our children and young people and this is confirmed in the end of year evaluation document for *Changing Lives*. The review will examine the work that has been carried out and assess its impact on delivering our priorities as well as setting out how we progress further over the coming year.

5. It has become clear to us over the last year that if we are to deliver on these priorities then further work needs to take place on a number of cross-cutting key areas. We propose that these areas are:

- Reducing teenage conceptions and supporting teenage parents to provide better life chances for their children.
- Improving life chances for children and/or young people:
  - in the care of the local authority
  - with disabilities and additional needs
  - with mental health needs
  - under 5
- Reducing the number of young people aged 16-19 who are not in education, employment and training (NEETs) and raising the number of 19 year olds with at least a Level 2 qualification.
- Raise standards at Key Stage 2.
- Improve the safety of children and young people both in and out of school.
- Improve the choice and opportunities available to children and young people.

6 It is further proposed that for each of these areas we conduct a 'Turn the Curve' exercise – an approach developed by Professor Mark Friedman - to examine these areas in detail and draw up detailed action plans drawing upon all relevant agencies and the voluntary sector.

Child Poverty

7 Increasingly *Changing Lives* and the priorities it contains can be seen as contributing towards the government's pledge to end child poverty by 2020 and halving it by 2010. Below are some stark statistics relating to child poverty in London:

- Two out of five children (39 per cent) in London live under the poverty line after housing costs are accounted for – over 600,000 children.
- Rates of child poverty are very high in Inner London, where over half of all children live in poverty (52 per cent).

- London has the highest rate of child poverty (after housing costs) compared to other regions. This remains the case whether you adopt the 'official' poverty line of 60 per cent median income or use the 50 or 70 per cent measures.
- London children with a very high risk of living in poverty include: those from Pakistani and Bangladeshi groups (69 per cent), Black ethnic groups (51 per cent) and those living in lone parent families (60 per cent).
- Children whose parents are workless are the most likely to be in poverty. 79 per cent of children in workless lone parent families live in poverty and 88 per cent of those living in workless couple families.
- Over the last ten years, the child poverty rate has fallen nationally, but these improvements have not been evident in London, where rates have remained stubbornly high.

8 There are currently few data sets at a London borough level that provide comparative information on child poverty. However, means-tested benefits provide a good insight in to this and the relative position of London boroughs. On this basis, Haringey came out in sixth position with 37.7% of children and young people living in families on key benefits against a London average of 27% based upon 2005 data.

9 Working intensely on the six cross cutting areas chosen will not only help us deliver on our 20 priorities but we hope will reduce and indeed eradicate child poverty within Haringey.

10 Appendix 1 outlines a suggested format for the review of *Changing Lives*.

11 Appendix 2 lists some key points from the supplementary guidance that has been issued on the plan.

12 Appendix 3 gives the 20 priorities from *Changing Lives*..

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APPENDIX 1

Suggested Format for the Review of Changing Lives

1. Methodology
   - The methodology that has been used during the review and the consultation carried out.

2. Outcome Area – Vulnerable Children and the 5 ECM Outcomes.
   - Overview of progress around outcome area

3. Review of progress around each priority
   - Key Achievements against the priority
   - Key improvements and outcomes/impact
   - Identified weaknesses/gaps and what are we doing to deal with these
   - Links with JAR/APA/priorities meeting outcomes/consultations if applicable.
   - Performance Measures linked to specific priority and overview of outturns here – are these adequate, what are we changing/adding (these could go alternatively go under outcome area comments)
   - Next Steps: Key actions and plans for 2007/08 (these to include targets, milestones, resources and possible changes in priority) (these could go under outcome area comments also).

4. Overall analysis
   - To include description of how we monitor and evaluate the CYPP and who contributes to this (e.g. CYPSP overview, link with LSCB, role of Leadership Team etc.)
   - Change management
   - Service Development
   - Workforce Management
   - Resource Management

4. Cross-Cutting Areas
   - Identify what these are and how they have been arrived out.
   - Methodology used around the Turning the Curve Exercise.
   - Examples, or indeed all of, the action plans around the areas (depending upon time).

5. Appendices being the Changing Lives monitoring document which shows progress etc against each target and possibly the Needs Analysis.

APPENDIX 2

Annual Review of the Children and Young People's Plan – Supplementary Guidance

Key Points

- Regulations do not specify when they LA should publish the review but may find it advantageous to publish the review between April and June – using the findings from the previous year's APA or JAR and the Priorities Meeting discussion.
- Reviewing the CYPP required the active involvement of a wide range of partners (a list of these people/organisation is available if needed).
- LAs must publish the results of the review but can determine the manner and type of publication – a standalone document/amended plan etc – in electronic or hard copy.
- No prescribed format for the CYPP review, but should include a detailed assessment of impact, progress and improvement.
- Should be concise and clear, focussing on analysis and evaluation rather than description; outcomes and impact rather than processes; and highlighting where progress has slower as well as successes.
- A need for an equality assessment of the work carried out to ensure the priorities and the work carried out addresses relevant equalities issues.
- LAs do not need to produce a separate self assessment for the APA rather the published review becomes this document.
- However LAs can provide supplementary material for the APA should a review of a particular area substantially alter the assessment of progress contained in the CYPP review.
- Deadline for this is June 14th.
- Need to ensure consistency in the CYPP review with the LAA and other statutory documents, such as the Community Strategy.
- Emphasis is placed on involving children and young people themselves in the CYPP review and the review should show how this has been done and more widely how partners have been consulted.
- The guidance contains a list of 12 key questions that the review might want to take account of.
- The guidance also sets out research findings to further develop the CYPP, such as setting out the next stages in planning and/or implementation, e.g. where next sections.
- The guidance also has a lengthy section on new duties and requirements for the future development of the CYPP which LAs may want to take account of in their reviews.
- The two specific changes are that the vision statement must not include more specific statements of intent and LAs are now required to consult with schools, school forums and school admissions forums in the preparation of the plan.

APPENDIX 3

Changing Lives: Summary of priorities

Priority one – We will improve outcomes for vulnerable children and young people through implementing strategies that will ensure earlier intervention.

Priority two – We will continue to improve life chances for looked after children and care leavers.

Priority three – We will improve outcomes for children and young people with disabilities.

Priority four – We will reduce the number of still births and babies who die before their first birthday.

Priority five – We will promote healthier lifestyles to children, young people and parents.

Priority six – We will prevent young people from developing mental health problems by strengthening their emotional well-being and self-esteem and improve services to those who have mental health needs.

Priority seven – We will work with young people to reduce teenage conception rates in Haringey as part of a broader aim to improve sexual health.

Priority eight – We will reduce the incidence of specific dangers affecting some or all children and young people in the community in partnership with parents and the wider community and through the implementation of the Pan-London child protection procedures.

Priority nine – We will renew our efforts to reduce bullying, discriminatory incidents and the gang culture in line with what young people have told us is most important to them.

Priority ten – We will create more safe places for children to play and for young people to go to through working with partners from Haringey Council, the police and the voluntary sector.

Priority eleven – We will reduce the numbers of children and young people who are involved in crime or become victims of crime.

Priority twelve – We will further improve the quality of early years education.

Priority thirteen – We will enable children and young people to enjoy wider opportunities through a broad curriculum and out-of-school learning activities.

Priority fourteen – We will improve attendance and raise standards of achievement for all children and young people reflected across all sections of our community.

Priority fifteen – We will empower children and young people to have a more effective voice in decision making.

Priority sixteen – We will ensure that children and young people living in Haringey are given wider opportunities to broaden their experiences to be creative, and equip them to live in a global society.

Priority seventeen – We will work together to give a more positive profile to children and young people drawing attention to their positive contributions, reinforcing rights and responsibilities for children and future adults, and celebrating their achievements.

Priority eighteen – We will improve access to services for young people and parents that support them to be more economically active.

Priority nineteen – We will reduce the number of young people between the ages of 16 and 19 who are not in education, employment or training, especially those looked after by the local authority.

Priority twenty – We will improve the percentage of young people at age 19 qualified to Level 2 and Level 3.

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