haringey strategic partnership

for health and social care

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NOTICE OF MEETING

PLEASE NOTE START TIME

SPECIAL HARINGEY WELL-BEING PARTNERSHIP BOARD

THURSDAY 15 FEBRUARY 2007 at 19:00hrs

RIVER PARK HOUSE, 225 HIGH ROAD WOOD GREEN, LONDON N22

AGENDA

MEMBERS: Tracey Baldwin (Haringey Teaching Primary Care Trust), Councillor Gideon Bull (Haringey Council), Stephen Clarke (Haringey Council), Deborah Cohen (BEH Mental Health Trust NHS), Dr Ann Marie Connolly (Haringey Teaching Primary Care Trust), Jim Crook (Haingey Council), Councillor Isidoros Diakides (Haringey Council), Councillor Dilek Dogus (Haringey Council), Robert Edmonds (Haringey Association of Voluntary and Community Organisations (HAVCO)), Councillor Bob Harris (Haringey Council) **(Chair),** Deborah Harris (Haringey Community Empowerment Network (HarCEN)), Cathy Herman (Haringey Teaching Primary Care Trust), Cecilia Hitchen (Haringey Council), Stanley Hui (Haringey Association of Voluntary and Community Organisations (HAVCO)), Carl Lammy (Barnet, Enfield and Haringey Mental Health Trust), Clive Lawton (North Middlesex Hospital NHS Trust), Councillor George Meehan (Haringey Council), Narendra Mikanji (Whittington Hospital Trust), Lesley Mishrahi (Haringey Teaching Primary Care Trust), John Morris (Haringey Council), Simon O'Brien (Haringey Metropolitan Police Service), Gillian Prager (Haringey Teaching Primary Care Trust), Faiza Rizvi (Haringey Community Empowerment Network), Richard Sumray (Haringey Teaching Primary Care Trust) **(Vice-Chair)** and Sean Walker (Haringey Probation Service)

1. APOLOGIES FOR ABSENCE

2. 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.

3. JOINT REPORT ON FINANCIAL PLANNING FOR 2007/08 (PAGES 1 - 10)

4. PROGRESS UPDATE FROM ST ANN'S STEERING GROUP (PAGES 11 - 12)

5. LIFE EXPECTANCY ACTION PLAN (PAGES 13 - 52)

6. DATE OF NEXT MEETING:

- 15 March 2007, 7pm

7. FUTURE AGENDA ITEMS:

Partners should submit proposed agenda items for the next scheduled meeting of the Board (15 March 2007) to Nicolas Mattis no later than 16 February 2007.

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6 February 2007
12 February 2007

Agenda Item 3

Haringey NHS
Teaching Primary Care NHS Trust

HARINGEY COUNCIL

Well-being Partnership Board – 15 February 2007
Joint report on financial planning for 2007/08

1. Background

1.1. Haringey TPCT

1.1.1. The TPCT is midway through its financial planning process for next year.

1.1.2. At the end of October it published draft Commissioning Intentions setting out priority areas for investment, disinvestment and service change.

1.1.3. On January 15th 2007 the TPCT submitted its first draft "Operating Plan" to the London Strategic Health Authority. This paper summarises key achievements and outstanding risks relating to 2006/2007 although the major focus is on planning for 2007/2008 – strategic priorities, financial plans, performance improvement, governance and risk. The paper is available on the TPCT's website www.haringey.nhs.uk

1.1.4. The TPCT are due to submit a second draft of the Operating Plan on the 16th February, with a final iteration and submission, including a final 2007/2008 budget to be submitted by mid March. A number of factors will influence the final budget submission – with one key area being the sign off of service level agreements with all main hospital providers by the end of February 2007 (i.e. the current plan includes an estimate of the level the TPCT expect to set contracts at but this may substantially change through the negotiation process).

1.1.5. The position set out within this paper is therefore subject to potentially reasonably significant change over the next two months, although it should give a good indication of the TPCT's proposed approach and strategic investment and disinvestment priorities.

1.1.6. The TPCT has a clear duty to manage its financial resources effectively and to achieve financial balance. Investment in strategic priorities will only be possible if the savings proposals set out are achieved – the TPCT will be seeking to balance the two aspects of the plan and will keep this under continual review through 2007/2008 to ensure it meets its financial duties, whilst progressing strategic priorities.

1.2. Haringey Council adult social care

1.2.1. The Executive on 4 July 2006 considered a comprehensive report on financial strategy for the period 2007/08 to 2010/11 and agreed a business planning and budget-setting process. At that time the Social Services budget showed a significant gap for the years 2007/08 and 2010/11, with an overall gap of £13.6m over the full four-year planning period. This assumes the achievement of pre-agreed savings proposals of £8.2m. The assumed Council Tax in the projection is an increase of

2.5% in each of the four years and a known grant settlement figure of 2.7% in 2007/08. A further report was considered by the Executive on 31 October 2006 to release the pre-business plan reviews for scrutiny and a number of national and local updates were considered.

1.2.2. As part of the pre-business planning review process, targets were set for individual business units to identify potential savings opportunities. The targets took account of the level of savings already identified in current financial plans and previous years. These savings targets were aligned to the government's Gershon efficiency targets of 2.5% per annum.

2. Financial positions

2.1. Haringey TPCT

2.1.1. The table above summarises net changes in the TPCT's resource allocation for next year.

Available resources (2007/2008 vs 2006/2007)	**£m**
Growth at 8.5%	28.9
Required efficiency savings (all NHS providers – national requirement)	2.9
Sub total	**31.8**
Non discretionary calls against available resources	
London top slice at 3.6%	-12.5
Inflation and generic cost pressures	-10.9
Reserves / contingency at 1.5%	-5.5
Sub total	**28.9**
Difference = growth available for (discretionary) investment	**2.9**

2.1.2. The table shows that the TPCT's overall 'new' resource for 2007/2008 totals £31.8m. Set against this are £28.9m of mandatory investment requirements including the anticipated further London top slice (increased from c. £9.5m in 2006/2007 to £12.5m in 2007/2008) which will support the overall London Health economy to achieve financial balance, inflation and generic cost pressures (for example the cost of new NICE guidance on high cost drugs) and a required contingency / reserve of 1.5% of the TPCT's total budget (to enable the TPCT to manage unexpected increases in costs / demand over the year).

2.1.3. After all the above is taken in to account the TPCT has £2.9m available to invest in service development against the priorities outlined below. It is clear that the total cost of proposed investment significantly exceeds the £2.9m figure available – the TPCT is therefore seeking to identify areas for cost improvement and savings to be made out of existing spend to support investment in the strategic priorities identified. New investment will only be achievable to the extent that off setting savings from existing areas of spend are identified.

2.1.4. The TPCT expects to go into 2007/2008 with a relatively modest list of confirmed new investments but will have a rolling programme of investment with part year effect as savings from other areas are achieved / as the budget position allows.

2.2. Haringey Council adult social care

2.2.1. The strategic objective of Social Services is to enable adults and older people living and working in Haringey to maintain a good quality of life. By working in partnership with service users, carers, Health and the private and voluntary sectors, Social Services aims to ensure that its services maximise independence, provide real choices and are appropriate to the needs of the local population. The overall strategic objective informs the Directorate's preventative approach reflecting the proposed outcomes of "Our Health, Our Care, Our Say," Sure Start in Later Life, and the Choosing Health" agenda.

2.2.2. The national context for Social Services is a trend of growth in both the demand and complexity of services. In recent years, Haringey has experienced demand pressures across all client groups. In Older People's Services there has been an increase in the numbers of clients with dementia. In Adults Services there has been a 14% increase in the numbers of clients supported over the last 5 years. In addition, there have been increasing pressures from Health around reducing waiting lists. These pressures have been escalating in recent years.

2.2.3. While Social Services has been successful in managing these pressures and has largely managed to balance its budget in recent years, the current financial position for 2006/07 is a projected overspend, excluding expenditure on asylum seekers, of £2.4m. However the Council has decided to make a virement from Corporate Resources to negate this overspend, on the understanding that it was due to unavoidable growth in the need for services.

2.2.4. Older People's Services continues to experience pressures in commissioning, particularly around hospital discharges. The demand for dementia and nursing care beds is also increasing.

2.2.5. The main element of the overspend is in the Adults commissioning budget and is comprised:

- Mental Health - £0.7m
- Physical Disabilities - £0.5m
- Learning Disabilities - £0.4m

2.2.6. In Mental Health, the overspend is largely in residential placements where there are some 31 clients being supported in excess of the budget. Main reasons for the pressures being experienced include:

- There is projected growth in both client numbers and levels of need and the NHS has re-designated Haringey as a higher need area for Mental Health. There will be more pressure in the system to provide more community care services.

- The remodelling of Supporting People provision following contract review is taking place later than anticipated

2.2.7. With respect to Physical Disabilities, the extent of the growth in demand in terms of both client numbers and levels of need were not appreciated or funded in the budget setting process.

2.2.8. Learning Disabilities is at the end of a three year commissioning strategy which included the refurbishment of both of its residential homes and plans for a named number of clients. This has now been implemented, although there was some slippage in the reopening of Whitehall Street, from May to August 06. The overspend reported in Learning Disabilities is £0.4m which is partly due to this slippage and partly due to some unanticipated growth in service. The pressure is in domiciliary care where there are 38 clients supported in excess of the budget. This too is in keeping with the national trend. Haringey is actually experiencing less growth than other London Boroughs, which is due in part to strong demand management.

2.2.9. Social Services has put into place a number of actions to mitigate against any further growth in expenditure. These include:

- Maintenance of the freeze put in place in December 05 on anything other than essential expenditure
- There have been VFM reviews carried out on the Adaptations Service and in Home Care that has improved the cost of the services provided.
- There has been a reduction in the use of agency staff.
- The Directorate is also considering how to reduce management costs in its reshaping of services.

3. Investment proposals

3.1. Haringey TPCT

3.1.1. The TPCT's strategic priorities going into 2007/2008 are as follows:

- Tackling health inequalities.
- Delivering clinically effective, patient focused care closer to home ("Right person, Right time, Right place").
- Transforming primary care.
- Improving the mental health and well being of the Haringey population.
- Performance – ensuring the TPCT meets all core performance targets as required by the Department of Health and assessed by the Healthcare Commission.
- Strengthening commissioning and maintaining financial stability.

3.1.2. In terms of health inequalities the TPCT has identified the following areas as local priorities for investment:

- CHD and Stroke including primary and secondary prevention
- Cancer including prevention and early identification
- Mental health e.g. prevention versus investment in forensics

- Diabetes including primary and secondary prevention
- Renal Disease prevention including management of diabetes and hypertension
- HIV
- Sickle cell

3.1.3. These sit alongside the National 'top' priorities set out by the DH, as follows:

- Delivering the 18 week wait (referral to treatment) milestones
- Reducing rates of healthcare associated infections (i.e. LDP targets for MRSA and new local targets for C. diff.)
- Reducing health inequalities and promoting health
- Achieve financial health - achieve a surplus by 2007/08
- Existing targets must be sustained, such as maintaining the 98% A&E 4 hour maximum wait and maintaining the cancer wait targets.

3.1.4. On this basis the TPCT is seeking to invest additional resources in the following areas:

- Acute hospital capacity to ensure that the 18 week referral to treatment pathway milestones for 2007/2008 are met and that new treatments (where clinical effectiveness is proven) and growth areas are adequately resourced.
- 'Core' Primary Care services – including for example additional capacity, improving access, primary care mental health services.
- Investment in new and enhanced community and primary care services that are targeted at reducing reliance on acute hospital care – for example full roll out of the new primary care based anti-coagulant monitoring service, investment in clinical support to nursing and residential homes to reduce admission rates to hospital from these settings. (See below re. 'demand management' savings).
- Screening and public health priorities – including bowel cancer screening, retinal screening, Chlamydia screening, Hepatitis B service improvements, HIV rapid access tests, obesity strategy priorities.
- Child and Adolescent Mental Health Services – preventative and early intervention services.

3.1.5. The TPCT is developing additional plans for investment in areas not listed above in line with the strategic and health improvement priorities outlined.

3.1.6. Investment in any of the above will only be achieved to the extent that savings and efficiencies are delivered as set out below.

3.1.7. The TPCT estimates that investment of approximately £10m per annum is required to meet the priorities set out above. It is therefore targeting cost efficiencies and savings of c. £7m to enable this strategic investment to be undertaken.

3.2. Haringey Council adult social care

3.2.1. The significant capital investment bid is in respect of Adaptations. There was a change in the housing subsidy regime last year that reduced the funding to the council for adaptations. The bid included is in respect of the annual requirement to maintain the current level of programme.

3.2.2. The e-Care Phase 2 project was agreed last year.

4. Savings Proposals

4.1. Haringey TPCT

4.1.1. The TPCT is looking for 'savings' in two key areas, reflective of its main areas of spend.

Acute hospital services

4.1.2. The NHS financial regime requires PCTs, as commissioners of health services, to pay acute hospitals on a cost per case basis for all use of hospital services. These services are generally accessed in either an emergency (for example via A&E services) or following a GP or consultant to consultant referral for assessment and treatment.

4.1.3. In Haringey use of emergency hospital and inpatient services is generally in line / below national averages utilisation (i.e. the TPCT uses relatively low levels of hospital resource in these areas.) However in relation to outpatient care the TPCT is well above national average utilisation (i.e. relatively high levels of hospital resources are used in these areas). This is particularly the case for West Haringey.

4.1.4. The TPCT, in common with most other PCTs across the country, has put in place a 'demand management' programme that is designed to ensure that people are only referred to hospital for specialist care where their clinical condition requires it. In many cases where patients are currently referred to hospital the care required should be able to be provided within existing community and primary care services, recognising that in some areas there may be a need for additional training and development to support this. In some cases additional 'enhanced' services in primary care are required – including clinicians with a special interest or extended skill – to enable this to happen.

4.1.5. NHS efficiency benchmarks indicate that if the TPCT were to achieve 'best practice' in this area savings could be expected of approximately £4m per annum. The TPCT has set a target of £3m savings for 2007/2008 against hospital care, primarily focused on outpatient care and will be tracking this carefully through the year.

4.1.6. As highlighted above the TPCT are targeting additional investment in a number of areas to help us to achieve this. (This investment is sometimes referred to as "demand management pump priming").

4.1.7. Additionally the TPCT will be seeking to put in place much clearer criteria to restrict access to clinical interventions where the evidence of clinical effectiveness is poor, and particularly where there is positive evidence that interventions are clinically ineffective in most circumstances (e.g. grommets, tonsillectomies).

Primary care services

4.1.8. The TPCT budget for primary care is approximately £80m per annum, of which £30m per annum is spent on prescribing costs and the remaining costs represent payments to independent contractors (GPs, pharmacists, dentists and optometrists) for the services they provide.

4.1.9. The TPCT will be publishing a 'Primary Care Strategy' for consultation in early April which will set out a radical blueprint as to how it intends to transform primary care services in Haringey over the next 5 – 10 years. What is clear is that currently there is a great deal of variability in service provision – with some excellent services providing accessible, high quality primary care services as well as some much weaker areas of service provision. There are substantial variations in levels of funding between practices and there is no apparent correlation between resource allocation and quality of service provided.

4.1.10. On this basis the TPCT is looking to target areas of inefficiency through a series of contractual and technical areas – e.g. making sure that GP lists are 'clean' and through robust and transparent performance review and payment processes.

4.1.11. The TPCT is achieving well on prescribing efficiency (and expects to be the highest performing PCT in London in 20006/2007 against key prescribing performance indicators). The TPCT will continue to focus on prescribing costs in 2007/2008 to minimise inflationary pressures in this area and release resources for investment in strategic priorities as above.

4.1.12. The extent to which the TPCT is successful in delivering efficiency savings in these two key areas will determine the extent to which it is able to invest in the strategic priorities set out above.

4.2. Haringey Council adult social care

Older People's Services efficiency proposals

4.2.1. The implementation of the Community Care Strategy has realised a significant shift over the last two years in reducing the number of people placed in care homes. It is anticipated that this overall reduction in placements will continue, though the trend is clearly towards a higher level of need for placements for people with complex needs, specifically dementia. The service anticipates a reduction in the number of residential placements over the next four years.

4.2.2. It is anticipated that there will be growth in community based services in that time period and provisions have been assumed within the proposal for residential care to fund this growth. In addition, it is planned to improve efficiency within the home care service through implementing the recommendations of the VFM review.

4.2.3. The service plans to implement a new telephone monitoring system for home care. The benefits of the system are that it will verify the level of service given and ensure the accuracy of the charges made by external

providers. This will give increased efficiency in the processes for invoice payment.

Adult Services efficiency proposals

4.2.4. The commissioning strategy for mental health services is planned to make savings of £450k. The strategy will focus on two major pieces of service reconfiguration. These are the remodelling of existing day services provision in both the statutory and voluntary sector commissioned by health and social care and the reconfiguration of the mental health accommodation commissioned by Supporting People. These reflect the intentions of the Joint Mental Health Strategy agreed in 2005. The day services element addresses the need to modernise current provision in line with the views of service users and in accordance with government policy as described in the Mental Health and Social Exclusion report. Haringey remains a high user of residential care when compared with its audit comparator group of local authorities and it is a long stated service ambition to change this model of service use.

4.2.5. The proposals for mental health involve reviewing/providing support packages that are appropriate need for 90 people, combined with transfer from residential care to supported housing.

4.2.6. Any proposal to merge the Winkfield and the Haven day centres will require careful project planning in order to maximise the capacity at the Winkfield centre. There a currently 60 people 'on the books' at Winkfield, with an average daily attendance of 25. The equivalent figures for the Haven are 55 and 22. Any reduction in costs would be achieved through savings on staffing, transport and building costs.

4.2.7. Transfer of respite provision for people with Learning Disabilities at Talbot Road to Whitehall Street, allowing closure of Talbot Road. Currently 25 people regularly use Talbot Road for respite during the year and it is anticipated that this can be provided within the newly refurbished Whitehall Street facility. The savings from this proposal will be £250k.

4.2.8. The strategic objective for people with learning disabilities is to replace traditional, buildings-based day care with ‘day opportunities’ which more closely reflect people’s aspirations – supporting them into employment where possible, and also supporting mainstream leisure activities. This promotes independence and choice, and contributing to people’s life chances in a more appropriate way. To deliver this agenda it is proposed to close Keston Road, with re-provision of service in a range of other community-based facilities. Approximately 110 people are on Keston's books with an average daily attendance of 95. There is no plan to reduce the number of people who receive a service – it will just be provided in different and enhanced ways. The savings from this proposal will be £130k.

The Voluntary Sector Review

4.2.9. This is a cross-Council initiative rather than a proposal that affects just Social Services. This will require a root-and-branch review of what the Directorate is commissioning from voluntary organisations. The identified

savings are a target figure. The precise level of savings will only be verified once the review has been completed.

Administration and Support Services

4.2.10. The Council has implemented a number of new technology initiatives in recent years and the changes to business processes will generate efficiencies. The restructuring of Social Services, following the Council reshaping is also expected to reduce support services costs.

The Charging Policy

4.2.11. This proposal has already been pre-agreed by the Council to be implemented in 2008/09. It is proposed that this is brought forward one year. The specific changes to the policy would include:

- Increasing internal residential charges from £388.50 per week to £520 per week to reflect the actual costs of services provided.
- Increasing charging for domiciliary care from £10 to £12.50.
- Adjusting the fairer charging disregard from 70% to 60%.

It is not anticipated that these changes will affect many service users as analysis shows that very few are full cost-payers. These changes to charging policy would bring Haringey into line in terms of community care charging with the rest of London, as Haringey Council is currently under-charging for some services.

5. Next steps

5.1. Haringey TPCT

- Negotiation with local service providers of service level agreements for next year. Target completion date – end February 2007.
- Further work to refine investment priorities and potential areas of saving – to mid March 07 (for final financial submission) and ongoing (such that new investments will be phased to reflect success of savings initiatives).
- Stakeholder meeting – early March – for fuller discussion of proposed approach to resource management in 2007/2008 with a range of stakeholders.
- Final formal budget submission – mid March. Formal Board approval 28th March 2007.

5.2. Haringey Council adult social care

5.2.1. The reviews have been prepared in conjunction with Executive Members and have been released for scrutiny. They have been sent to key partner organisations, the voluntary sector and trade unions. In addition, there has been specific consultation with users and/or carers in relation to those proposals that would have the most direct impact on these groups.

6. Conclusion

6.1.1. Both Haringey TPCT and Haringey Council are determined to minimise the impact on residents of the challenging joint financial position in the borough. This is being done through ongoing discussion at a political and senior managerial level, by aligning resources to joint priorities and jointly seeking to make efficiency savings where they can be made.

Well-Being Partnership Theme Board **Item No:**

Date: 15th February 2007

Report Title: Progress Update from St. Ann's Hospital Steering Group

1.1 The vast 29 acre St. Ann's site is owned by Barnet, Enfield & Haringey Mental Health Trust (BEHMHT), who are also the largest single occupier.

1.2 Other parts of the NHS that lease premises on the site are Haringey Teaching Primary Care Trust (HTPCT), Moorfields Eye Hospital NHS Foundation Trust, North Middlesex University NHS Trust and the London Ambulance Service. The site includes the headquarters of HTPCT.

1.3 With the exception of the newest facilities, most of the existing buildings are no longer fit for the provision of modern, effective health care. They do not meet modern accommodation standards and have sprawling layouts, poor sightlines and failing infrastructure.

1.4 Changes planned at St. Ann's are being driven by the reform and modernisation of the NHS set out in the 2000 NHS Plan and the National Service Frameworks for Mental Health, Older People and Children, respectively, as well as new legislation in this field.

1.5 The current layout and condition of St Ann's and certain models of care are no longer tenable, do not allow compliance with best clinical practice, and do not provide value for money. It is on this basis that BEHMHT presented a Strategic Outline Business Case to the Strategic Health Authority. Responding to the new service model, it makes the case for investment in new hospital and community-based facilities (e.g. to provide single room accommodation for patients, access to outdoor space and provide community teams based in the communities they serve). The Case will be moved forward to the next stage in March.

1.6 A Strategic Outline Business Case is a high level document which makes the case for change. It doesn't finalise options or commit anyone to anything. The Strategic Outline Business Case in question purely concerns the mental health services at St. Ann's. BEHMHT is using the Strategic Outline Business Case to demonstrate to the Strategic Health Authority that the current mode of operation not sustainable. It does not comment on or make proposals about the other services offered at the St. Ann's site.

1.7 Most of the work on the Strategic Business Case was done in early 2006. The delay in approval has been because of the reorganisation of the London health service, which is beyond the control local health services.

1.8 Running in parallel with the Strategic Outline Business Case is a master planning exercise regarding the whole site. This will bring together the formal decisions of all the site occupiers. This exercise has not yet started. Master planning involves full consultation with members of a community (including local authorities).

1.9 In the longer term, the other site occupiers will have to reach formal decisions about their own services and estate, but given current legislation and Governmental policy, it is likely HTPCT will want to shift some of its services to a community based setting through its planned network of neighbourhood health centres. This would be procured through the Local Improvement Finance Trust programme. Moorfields' remote operating theatre is likely to remain, whilst the North Middlesex remote services will be re-provided as part of its major Private Finance Initiative development on the main hospital site in Enfield. There is scope at St. Ann's to expand the existing London Ambulance Service station. Again, this has to do with master planning and is outside the scope of the Strategic Outline Business Case.

1.10 Only if and when all of these service and estate changes come to pass will there be land freed up for other uses, which could include social care, education, residential, employment, retail, etc. However, these would need to be shown as part of the overall master plan, subject to public consultation and town planning approval. In addition, they would need to be compatible with the majority usage and status of the site, which would continue to be *Health*.

1.11 The New Deal for Communities (NDC) boundaries include St. Ann's so that any future regeneration benefit from rationalisation of the site can be 'captured', at least in part, for the 'Bridge Neighbourhood'.

1.12 In the meantime the Mental Heath Trust has received a modest Growth Area Fund Grant to begin site surveys and a feasibility study to examine whether a case could be made to the Department for Transport / Transport for London for an additional station stop on the Gospel Oak to Barking railway, which runs along the southern boundary of the site. This could provide much needed public transport access for staff, patients, visitors and other future users - other than the poorly served bus stops on St. Ann's Road.

Reducing inequalities in Life Expectancy in Haringey
Actions for the Haringey Strategic Partnership.

November 2006

Summary

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. 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- a shocking statistic.

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 following targets, achievement of which will contribute significantly to reducing the gap;

- 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.

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.

Reducing the gap in life expectancy is the overarching target of the Well-Being Theme Board, supported by the Local Area Agreement target to reduce the gap in premature mortality rates between Haringey and England, and between deprived and more affluent parts of the borough. It is also reflected in the Haringey Sustainable Community Strategy.

The causes of inequalities in health are multiple and complex, 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, the choices we are able to make about how we live, and access to services.

This action plan is based on a detailed analysis of routine data on disease-specific mortality and socio economic data in Haringey. Key partners from the Haringey Well Being Theme Board planned and hosted an event for stakeholders in February 2006[1] to discuss potential priorities to address low life expectancy and health inequalities in the borough. These discussions were informed by detailed analysis of current evidence on local need and effectiveness of interventions provided by policy leads from across the partnership.

The consultation drew out a number of underlying themes that were considered in the development of this plan:

1. The advantages of improved integration between, and co-location of, health and social care and other services to disadvantaged communities. In particular, the need to join up outreach services better to meet the full range of needs that affect well-being.

2. That interventions should be targeted on the basis of need, addressing issues that are particular to specific 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. Services should work together to establish the best ways to target services to those in need, whether it be geographically by neighbourhood, or by care group, or through improved assessment processes.

3. The important role of voluntary and community organisations in reaching marginalised and socially excluded communities, and how this can be integrated more effectively into care pathways.

4. The importance of focusing on children and people in their middle years in reaching the life expectancy target. The HSP should aim to ensure that children have the best possible start in life to maximise their life chances, and improve access to health services for middle-aged individuals to ensure that effective interventions to prevent avoidable illness are utilised (eg secondary/tertiary prevention).

The action plan was drawn together based on the analysis leading up to and outcomes from the Healthier Haringey event, and a feasibility review and prioritisation of relevant actions. The full action plan is presented in Section 1, identifying risk factors for the main causes of premature death and inequalities in

health in Haringey that are amenable to change, and actions that should be taken forward by partners to address them. There are varying levels of evidence available to support the effectiveness of these interventions ranging from a sense of good practice, through national policy to strong evidence that the intervention would be effective in improving health and reducing health inequalities.

Section 2 provides a summary of the data and evidence on why reducing health inequalities in Haringey is a priority for all partners in the HSP. Additional information and copies of background papers from the Healthier Haringey event are available from karen.dunn@haringey.nhs.uk on request.

A number of actions emerge from this detailed plan because they are supported by strong evidence of effectiveness and local need, and are not currently being comprehensively addressed. These should be taken forward as a matter of priority by the HSP:

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 (eg 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 eg people living on low incomes, and those living with cardiovascular disease, diabetes and cancer.
9. Develop 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 equitable access to the employment opportunities offered by local developments (eg Tottenham Hale) and our location in the London-Stanstead-Cambridge-Peterborough corridor Growth Area.
27. Evaluate the effectiveness of providing employment and income advice in GP practices to support individuals on incapacity benefit who want to return to work.

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 document will be presented to the five theme boards of the HSP for discussion and to agree a commissioning and monitoring framework for implementation. This will be overseen by the Well-Being Theme Board, and championed by the Director of Public Health Dr Ann-Marie Connolly.

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Contents

Section 1: What are the actions that the Haringey Strategic Partnership should take to improve life expectancy and reduce inequalities?

1.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

Current situation
Recent surveys/modelling from the HDA suggest Haringey is likely to have a smoking prevalence of 27-32%[2]. 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[3].

Initiatives To Reduce The Prevalence Of Smoking

Action	Target group	Evidence of effectiveness	Estimated cost	Delivery lead
Expansion of coverage of Haringey Smoke Free Award with focus on: • targeting venues 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[4])	£7K 2006/07	E&H SSS
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)	N/A	Environmental Health (LBH) Public Health (TPCT)
Make no-smoking policies a requirement when local NHS organisations and Haringey Council are contracting/commissioning	Commissioned service users	Good practice	N/A	Service Commissioners
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)	N/A	Haringey Strategic Partnership
Increased enforcement of regulations on tobacco smuggling	Targeting should be based on assessment	Limited evidence on effectiveness of local measures	N/A	Environmental Health (LBH)

Stop Smoking Initiatives

Action	Target group	Evidence of effectiveness	Estimated cost	Delivery lead
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 ▪ Expand services in deprived parts of the borough	Smokers, particularly in deprived areas	Strong. Cost per QALY £135 - £6472[5]	N/A	E&H SSS
Offer of stop smoking advice as part of clinical assessment in surgical care pathways	Smokers awaiting elective surgery (about 5,739/yr)	Strong Estimated 433-904 elective patients would give up smoking, with a reduction in post-op complications of 77-160[6]	Estimated annual cost saving due to reduction in complications and bed days of about £850,000	HTPCT to address through surgical care pathways
Maintain level 2 quit Smoking Programme for Haringey Council Staff	LBH staff	Strong	N/A	E&HSSS

2.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: tbc

Current situation
On the basis of national data, it is estimated that in Haringey approx 123,000 adults [7] and 6,000 boys and 8,000 girls aged 2-15 are insufficiently active [8]. It is further estimated that of approximately 252 CHD deaths per year in Haringey, approx 94 are attributable to physical inactivity [9].

Action	Target group	Evidence of effectiveness	Estimated cost	Delivery lead
Primary care health workers to be trained in opportunistic identification of inactive adults (using validated tool e.g. a GPPAQ), and advice to aim for 30 minutes of moderate activity on 5 days of the week (or more)	Inactive adults	Strong for giving advice (£750 to £3150 per QALY)	N/A	HTPCT Public Health
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 that as many children as possible benefit from high quality play opportunities.	School children	National policy	N/A	Healthy Schools Programme
Train frontline staff to provide advice on physical activity including, practice nurses, Haringey Council Leisure centre staff, dieticians, physiotherapists, health care assistants.	Service users	Good evidence of effectiveness of primary care practitioners providing physical activity advice.	Approx £2,000 per course (20-27 participants)	Spearhead PCT Obesity Training Fund

Action	Target group	Evidence of effectiveness	Estimated cost	Delivery lead
Promote access to open spaces by addressing safety concerns (e.g. through the provision of wardens, parks officers, improved lighting, community facilities).	Adults and Children	Good practice	N/A	LBH Environmental Services
Develop opportunities to promote physically active modes of transport e.g. walking and cycling.	Adults and Children	Good practice	N/A	LBH Environmental services
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	N/A	NRF funding
Evaluate Haringey Get Up and Walk programme providing training for volunteer walk leaders to lead walks in their local communities	Inactive Adults	Insufficient-should only be conducted as part of a research study [10]	N/A	HTPCT Public Health
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	Approx £11,000 total (8 courses per year)	HTPCT Public Health
Evaluate Health for Haringey, a 5-year programme providing exercise and social support opportunities to 3,000 people in deprived areas	Physically inactive individuals in deprived areas	To be evaluated	£1 million over 5 years	Health for Haringey Programme (Big Lottery Fund)
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	Approx £800 to-date	HTPCT-Public Health
Expand joint work between HTPCT and LBH to increase opportunities for physical activity for older people e.g. chair-based exercise sessions at Leisure Centres.	Older people	Good practice	N/A	Age Concern

3.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: tbc

Current situation
There are no local data on obesity and food consumption. 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. Around 16% of 2 to 15 year olds are now obese.

Action	Target group	Evidence of effectiveness	Delivery lead
Strengthen implementation of infant feeding guidelines, including promotion of breastfeeding.	Parents of babies	Strong[11]	Children's service
Healthy Schools Programme to ensure all schools meet national standards for school food.	School children	National policy	Healthy Schools Programme
Develop children's access to healthy food through the extended schools programme e.g. breakfast clubs, particularly in areas of high deprivation.	School children in deprived areas	Good practice	Children's service
Establish baseline data on the prevalence of childhood obesity amongst reception and year 6 children Haringey, and systems for monitoring and acting on future trends.	School age children	National Policy	Children's Service and HTPCT Public Health
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
Develop an obesity strategy and care pathway	People at risk of / with obesity	National policy	HTPCT LBH

Action	Target group	Evidence of effectiveness	Delivery lead
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
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
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/ HARCEN
Limit the number and density of fast food outlets	Consumers of fast food	Good practice	Environmental services
Target vulnerable and disadvantaged communities through community initiatives such as community nutrition assistants, and distribution of healthy eating messages through libraries etc	Disadvantaged communities	Good practice	HTPCT teaching programme, HAVCO, & HARCEN
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

4.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 [12]. 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[13]. 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.[14]

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

SECONDARY PREVENTION

Action	Target group	Evidence of effectiveness	Delivery lead
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 [15]	General practice / HTPCT Primary Care Performance
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[16]	General Practice and HTPCT Pharmacy lead
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
Implementation of PCT hypertension guidelines (in line with NICE guidelines)	Patients with hypertension	Strong[17]	HTPCT Public Health
Improve management of heart failure in line with NICE guidelines	Patients with heart failure	Strong[18]	HTPCT Public Health
Phase IV Community-based Cardiac rehabilitation group exercise programme	Adults with established CHD	Strong[19]	Participant contributions & HTPCT Public Health
Improve % of patients with heart attack who receive thromobolysis within 60 minutes	Patients with heart attack	Strong[20]	Whittington and NMUH.

5.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[21] 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 CHD morality rates between Haringey and England will continue to increase.[22]. 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[23].

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

SECONDARY PREVENTION

Action	Target group	Evidence of effectiveness	Delivery lead
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[24]	Screening co-ordinator

TERTIARY PREVENTION (Treatment, Rehabilitation & Palliative Care)

Action	Target group	Evidence of effectiveness	Delivery lead
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
Implementation of Integrated Cancer Care Programme	Cancer patients	Good practice	HTPCT Adult services
Extend the “Fit for Life” programme to cancer patients	Cancer patients	Good practice	HTPCT Public Health

6.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

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
Maximise 20mph schemes and Safe Routes to School schemes	School children	Good practice	LBH Environmental Services
Ensure that accident prevention strategies are incorporate into home improvement schemes, particularly fire safety and prevention of trips and falls.	Households living in poor housing conditions.	Good practice	LBH Environmental Health
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	Will reflect strategy	Good practice, available, and evidence on a range of one-to-one interventions is expected.	DAAT
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
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

7.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
Continue to develop a Haringey suicide prevention strategy to include;

- Promotion of mental well-being amongst the wider population: building on findings from the Health in Mind project promoting access to support at early stages of mental distress through libraries and community settings.
- Reduction in the risk of suicide amongst key high-risk groups: including specific BME communities building on the 2006 report by Professor McKenzie.
- Reduction in the availability and lethality of suicide methods.

8.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
Work to develop one-stop-shops for health and social care services in accessible locations.	Service users	National policy	HTPCT, LBH, HSP
Equity audit of resource allocation to inform equitable commissioning of primary care services, and practice-based commissioning of services	Primary care population	Good practice	HTPCT-Commissioning Directorate
Improve funding and support for independent health advocates.	Vulnerable groups	Good practice	HTPCT teaching programme
Improve front-line health workers (e.g. receptionists) skills in communication and client care.	Service users	Good practice	HTPCT-Commissioning Directorate
Local enhanced service for the provision of services to patients who speak little or no English	Patients with little or no English	Good practice	HTPCT
Implement mental health enhanced service in primary care to improve/develop services that address the phyisical and mental health needs of people with mental health problems	Primary care service users with mental health problems	Good practice	HTPCT
Enhance involvement of voluntary sector and community groups in decision-making around service planning and development	Voluntary & community groups	Good practice	HTPCT, LBH, HAVCO & HARCEN
Improve transport services to hospitals/ health services for disabled and older people	Disabled /older people	Good practice	HTPCT
Explore the role of libraries in providing information to inform health choices, and facilitating access to services.	Library service users	Good practice	LBH

9.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

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
Develop a 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	Children's Service
Ensure new infant feeding coordinator role is able to promote breastfeeding and best practice in weaning, including implementation of infant feeding guidelines and development of programmes to promote breastfeeding that meet the Baby Friendly Initiative standards as a minimum.	Young children and parents/ carers	Strong	Children's service
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 support service providers in providing smoking cessation support, for example at ante-natal appointments, delivery, during home visits, and other contacts.	Parents who smoke	Strong	Children's service
Smoking cessation services should be a core element of care pathways developed within children's centres.	Children's centre service users	Strong	Children's service
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.	Groups with low breastfeeding maintenance rates	Good practice	Children's Service

10.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: tbc

Current situation
Within the social housing sector, providers are 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

Action	Target group	Evidence of effectiveness	Delivery lead
Improve energy efficiency in private sector housing, especially homes which fail to meet standards due to a lack of thermal comfort.	Tenants in renewal areas	British Research Establishment modelling to identify key issues and areas for focus	LBH Environmental Health
Develop standard housing condition assessment criteria, guidance, and referral mechanisms to support services (eg 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

Action	Target group	Evidence of effectiveness	Delivery lead
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
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	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

11.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: tbc

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
Provide pre-employment training	Workless residents	Good practice	Urban futures
Contracts commissioned with Enfield College, Delta Club, John Grooms and Newton Housing delivering employment & skills support to Lone Parents, BME communities, Refugees, Disabled people	Lone Parents, BME communities, Refugees, Disabled people	Good practice	Enfield College Delta Club, John Grooms and Newton Housing
Provide pathways to work, flexible outreach services, generic and intensive support, job brokerage and work placements through the women stepping up programme	Women particularly from BME communities	Good practice	Haringey Women's Forum
Implement commissioned projects: ▪ Getting Haringey Working (At Work) ▪ Employment Pathways to Health (Haringey Teaching PCT), ▪ Learn for Work (I Can Do It Ltd.)		Good practice	Haringey learning and skills partnership

Action	Target group	Evidence of effectiveness	Delivery lead
KIS Business Challenge Assisting individuals in making the transition to self-employment by providing business start-up assistance to SMEs and young adults	SMEs and young adults	Good practice	
Continue to reduce the proportion of young people not in education, employment or training (NEET)	Young People	National policy	Connexions
Maximise Growth Area opportunities for new jobs and homes eg in Tottenham Hale, Hale Wharf and the London Stansted Cambridge Peterborough Corridor.	Residents in Tottenham Hale & Hale Wharf	Good practice	HSP
Continue to create new training opportunities to address the skills gap and get people into work.	Unemployed	Good practice	European Structural funds, LDA and Lottery funding
Health and Welfare to work Mental Health and employment project	People with mental health problems	Good practice	Richmond Fellowship
Workstep JCP contract to support disabled people gain and retain employment	Disabled people	Good practice	Haringey Council
Pilot effectiveness of offering employment advice in GP practices to target people on Incapacity Benefit who want to return to work.	People on incapacity benefit	Good practice	Haringey TPCT & Tomorrow's People (charity)

12.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: tbc

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.

Action	Target group	Evidence of effectiveness	Delivery lead
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
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

Action	Target group	Evidence of effectiveness	Delivery lead
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

Section 2: The case for action by the Haringey Strategic Partnership

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.

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*'[25] 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' [26] 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'* reiterated the importance of reducing health inequalities by improving access to health services, and through better prevention and earlier intervention.

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

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' [27].

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

- 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.

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

- Narrowing the gap in premature mortality between Haringey and England, and between the most and least deprived wards in Haringey.
- Improving the uptake of smoking cessation services amongst people living in deprived areas
- Increasing physical activity amongst all ages, including older people

- Improving accces to health services and homes for the most vulnerable
- Increasing the number of primary and secondary schools in the borough that meet the standards for Healthy School accreditation

What is life expectancy?

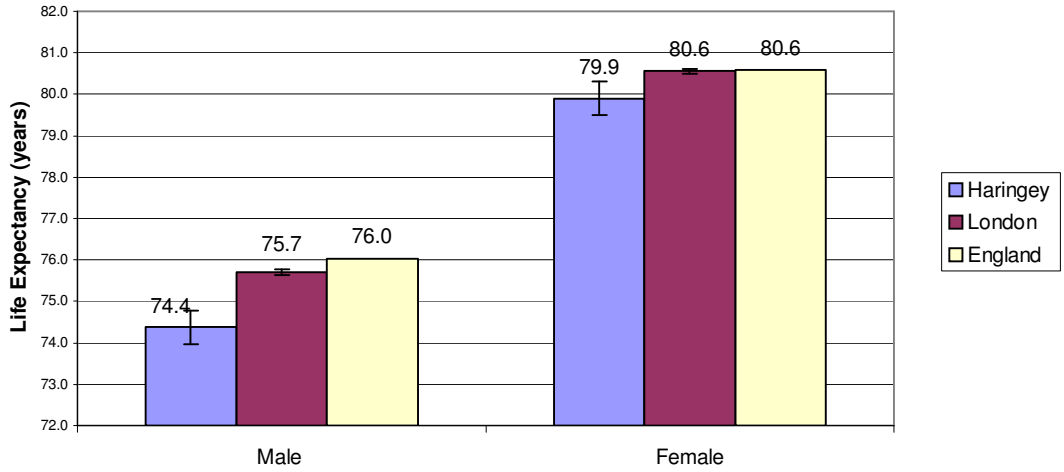
Life expectancy is the number of years a baby born and living its whole life in an area would be expected to live if it were to experience the current (age-specific) death rates of that area. Life expectancy is best interpreted as a snapshot of the overall level of mortality in an area. It is not a forecast of how long babies will actually live, as current death rates are likely to change.[28] 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.

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 [1] is shown in figure 1. The lower life expectancy for men and women in Haringey compared to England and Wales is statistically significant[2].

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



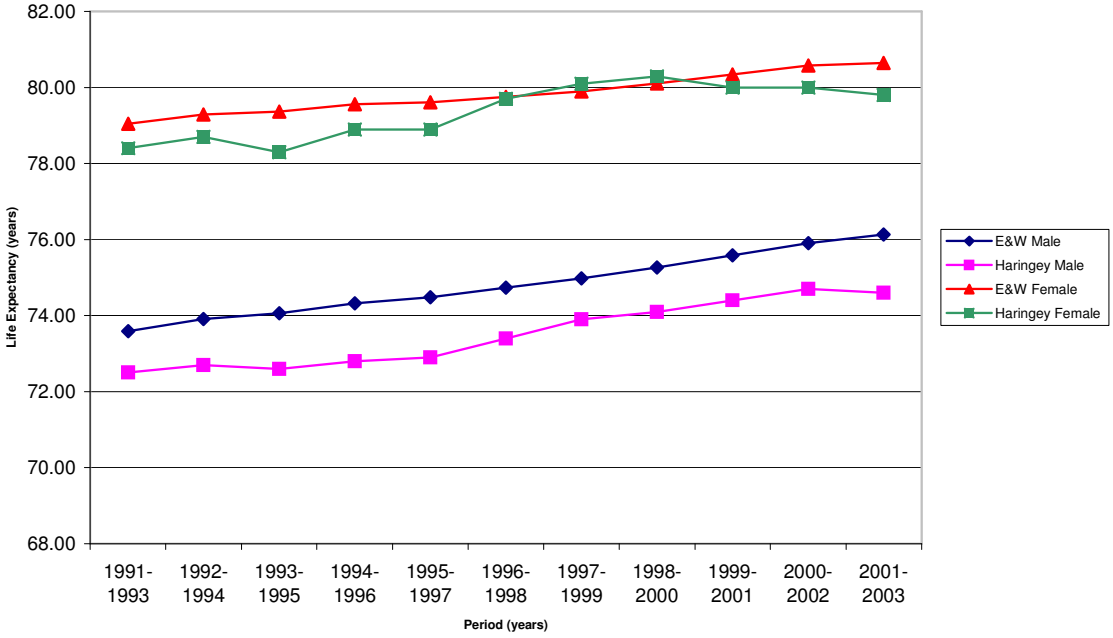
[1] Combining data from several years helps to make the data more stable by reducing the influence of year-by-year variation in numbers of deaths.

[2] 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

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) 1991-2003



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[29] and the national level[30] 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.

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[31].

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

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

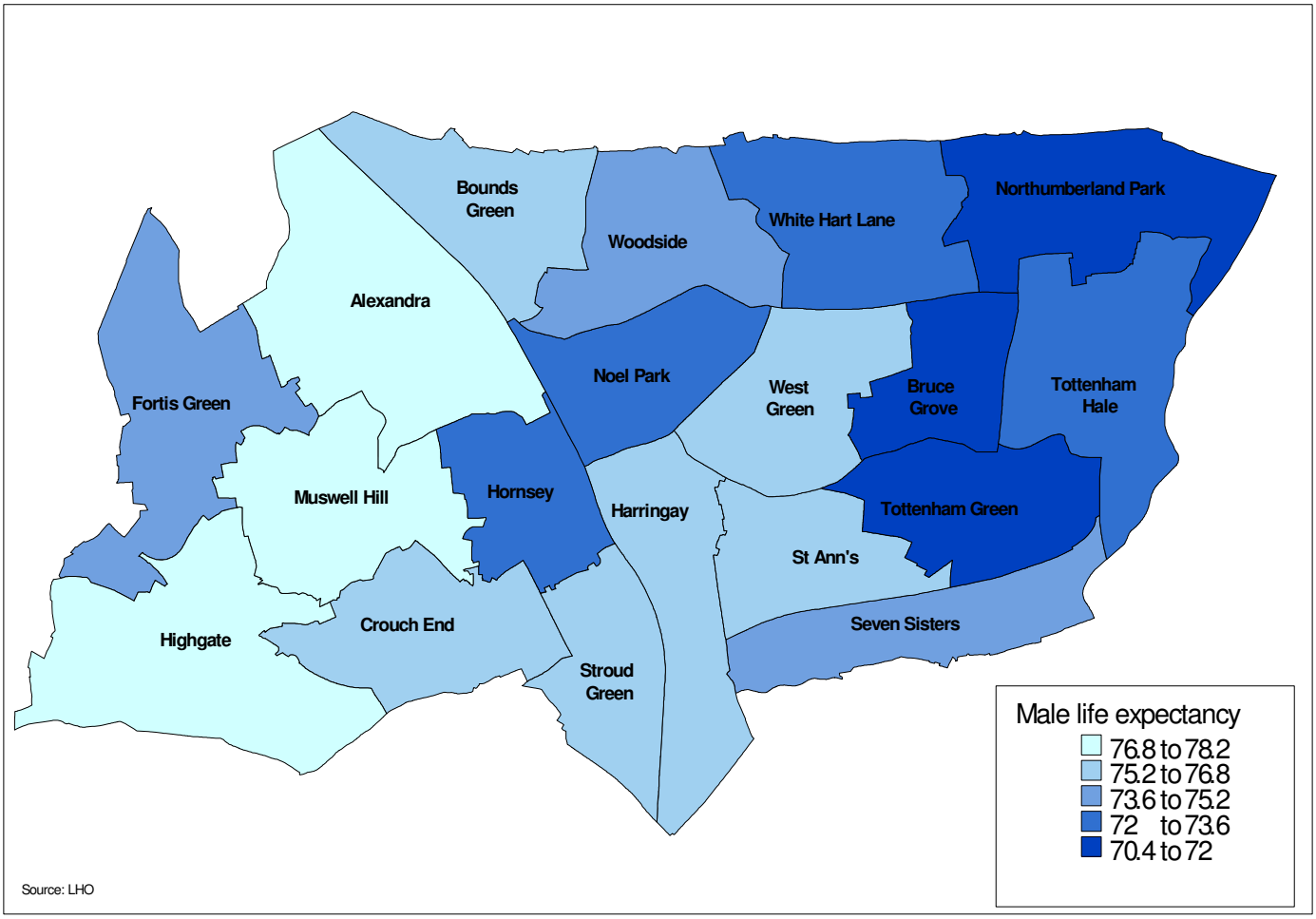
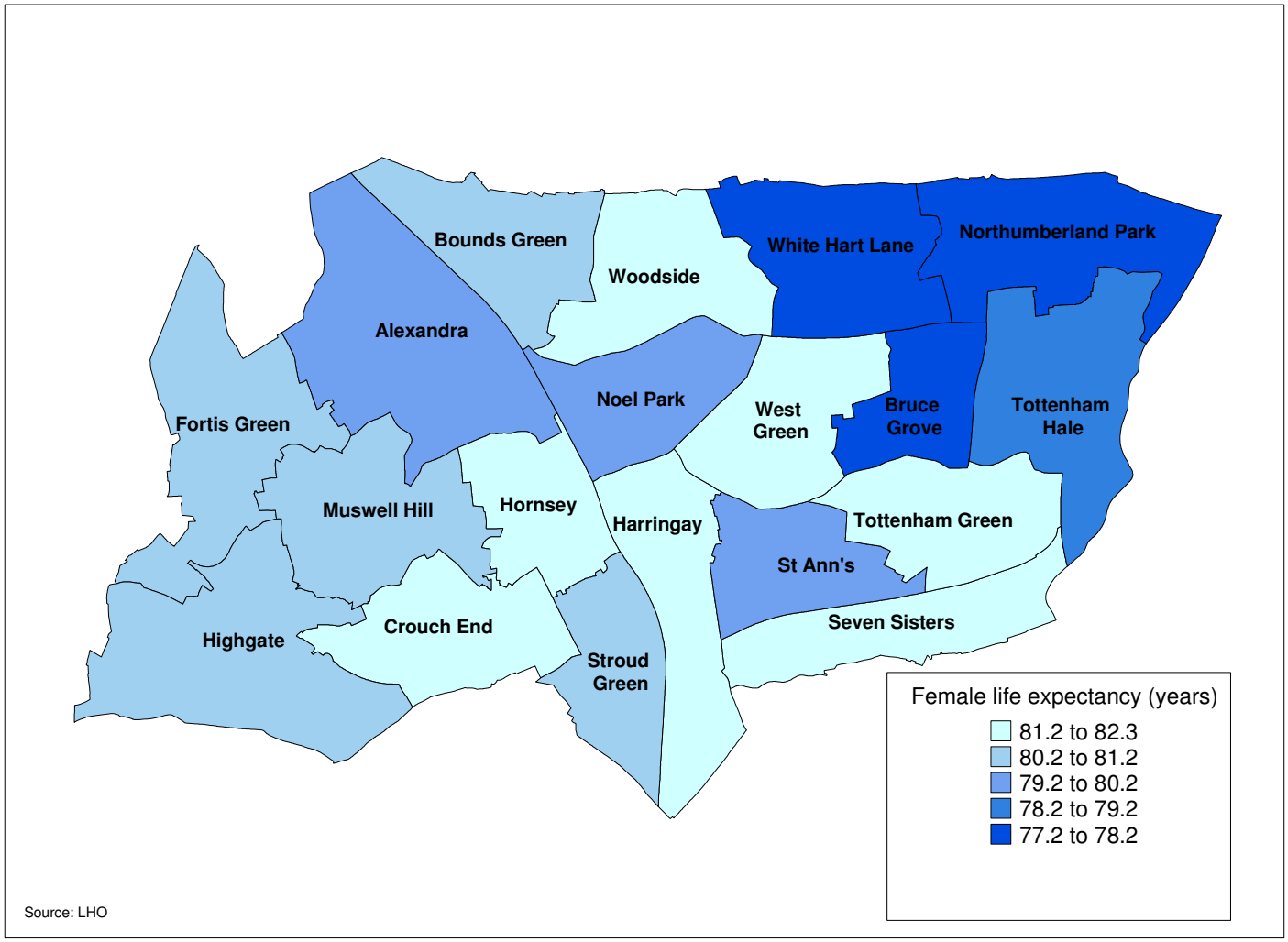


Figure 4 shows the variation in female life expectancy between wards in Haringey. There is only a weak relationship between female life expectancy and deprivation, and this is not statistically significant.

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

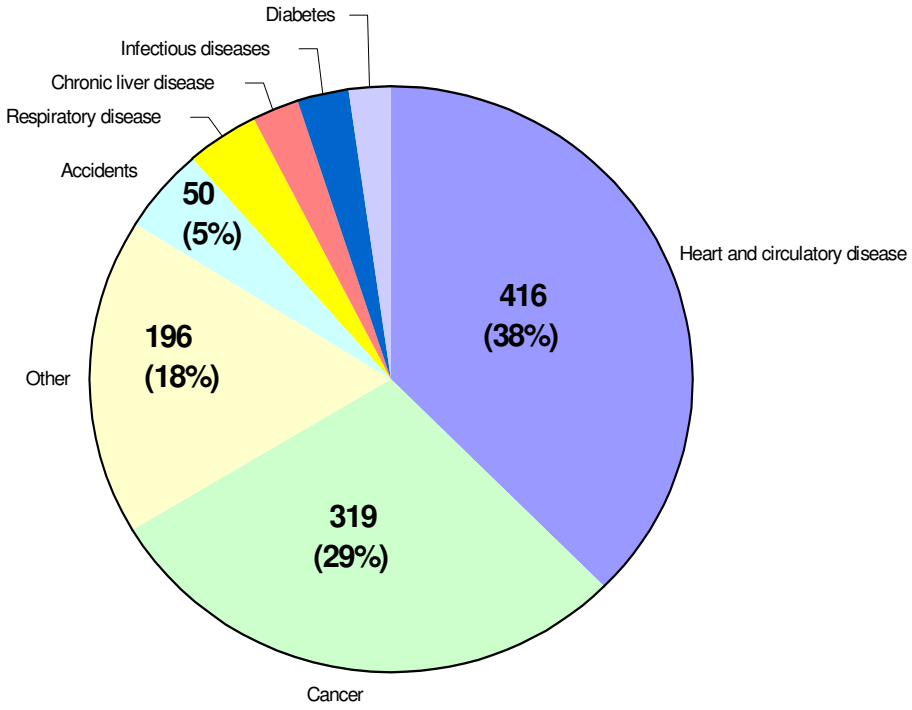


A stronger relationship between life expectancy and deprivation for men than for women is also found across London[32] and at the national level[33]. The reasons for this are not fully understood. Previous studies have speculated that this might be due to a stronger association between deprivation and health risk behaviours in men than women, or because men with poor health may be more likely to migrate to more deprived areas.

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.

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



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

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)[3].

[3] 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 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

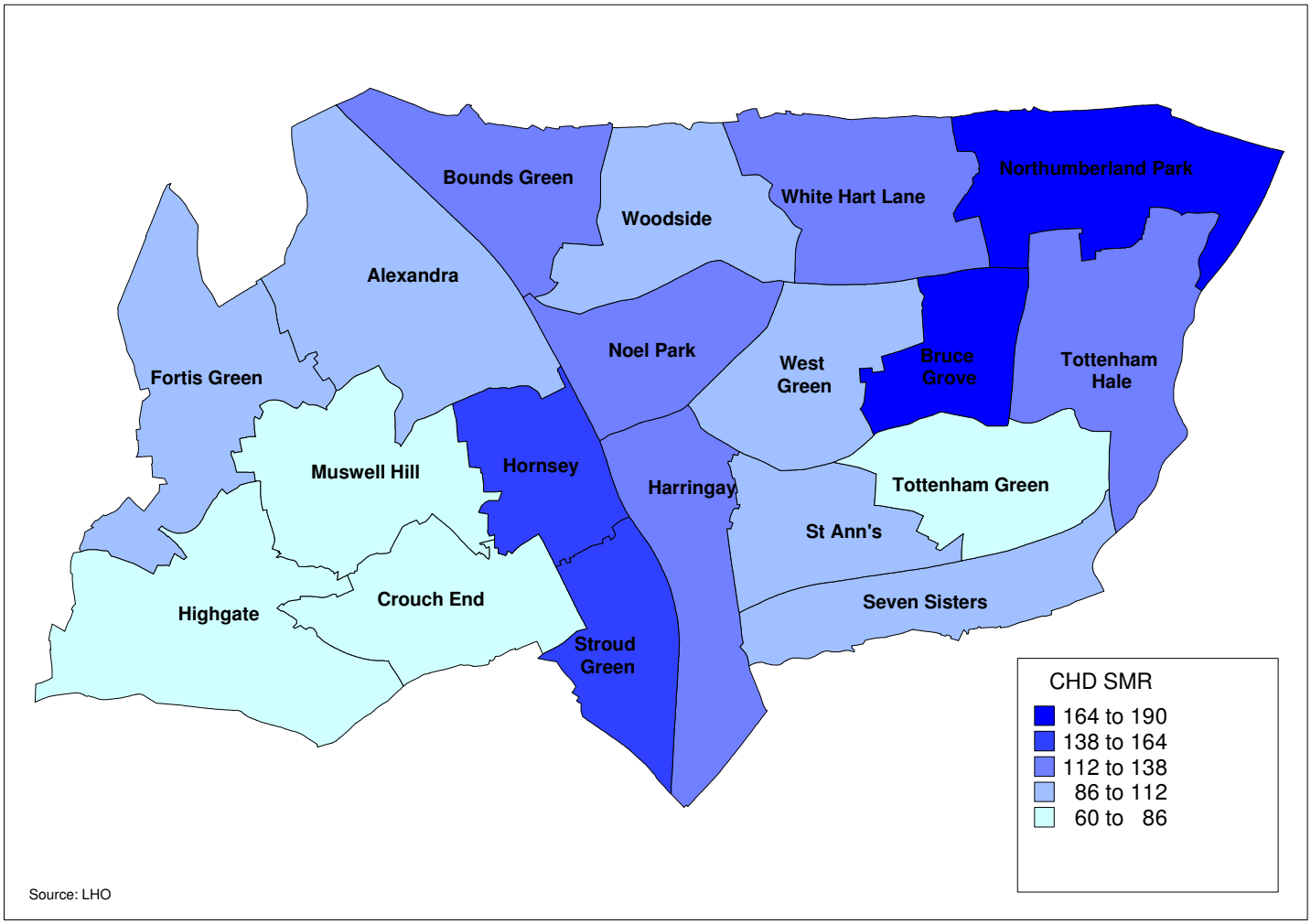
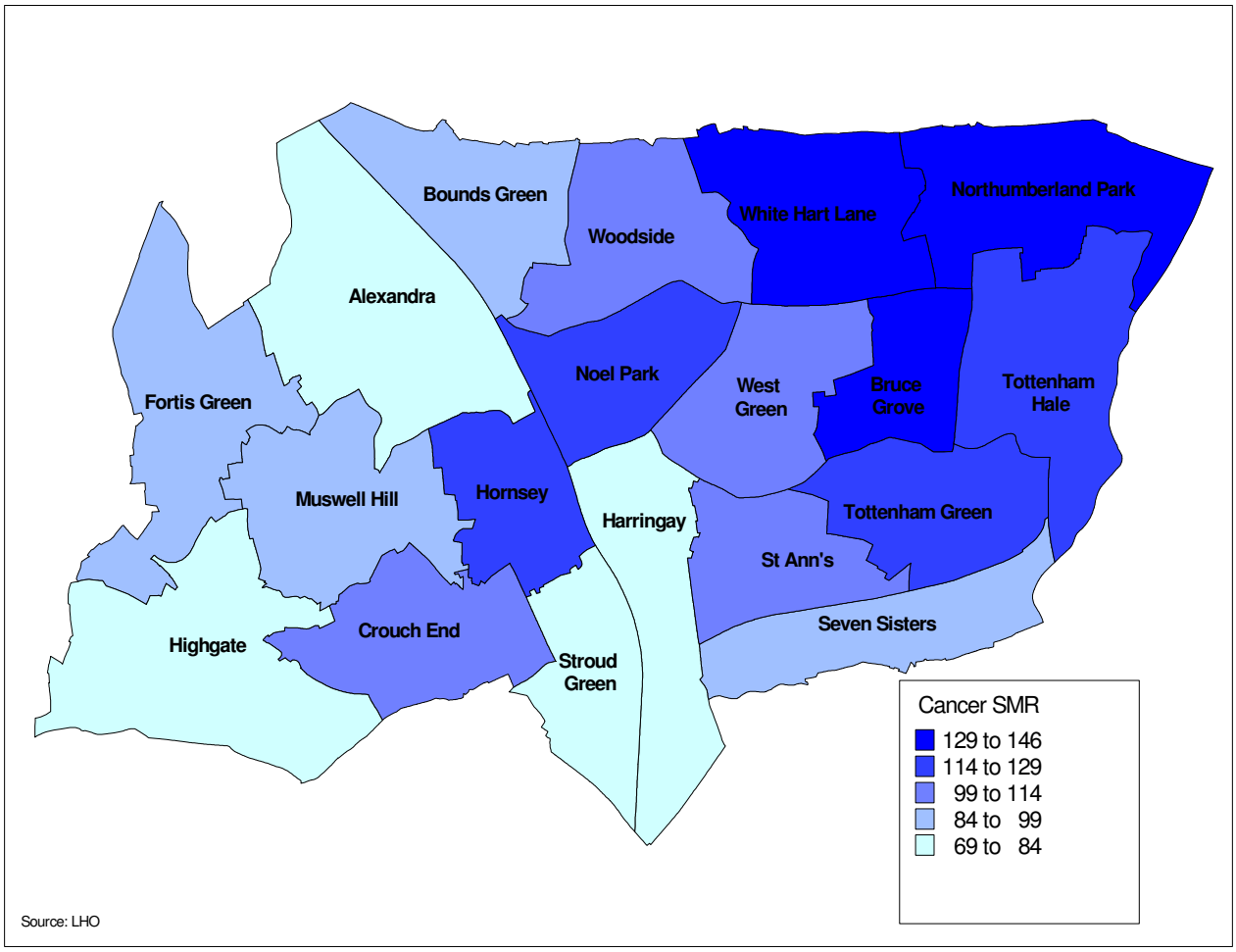


Figure 7 shows the Standardised Mortality Ratio for cancer for persons aged under 75 years by ward. Again, there is a statistically significant relationship between SMR for cancer and ward-level deprivation in Haringey.

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



What are the main determinants of inequalities in life expectancy 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[34].
  - 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[35].
  - Reducing smoking will result in substantial reductions in mortality form coronary heart disease within 12-24 months[36]

- **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[37].
  - 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[38].
  - 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[39].
- 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[40].
  - 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.

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