Interim progress report:
Implementation of the Haringey Life Expectancy Action Plan

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1 Background

One of the two national inequality targets is a reduction in the gap in life expectancy by at least 10% between 'routine and manual groups' and the population as a whole by 2010. The Life Expectancy Action Plan for Haringey was adopted by the Haringey Strategic Partnership in 2006 to achieve this target.

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.

2 Scope of this report

This report sets out interim findings from a review of the Life Expectancy Action Plan currently being undertaken by the Public Health Directorate in Haringey TPCT. It refreshes our understanding of trends in life expectancy and mortality from different conditions, although as an interim report the findings should be treated with caution at this stage.

3 What are the major changes since the last Life Expectancy Action Plan was released?

The HSP has taken forward its commitment to reduce inequalities in life expectancy in a number of ways since adopting the life expectancy action plan:

3.1 We have developed a Well-Being Strategic Framework, setting out the user-focused well-being outcomes that we would like to achieve for our population, and which will reduce illness and premature deaths in the population.

3.2 The Local Area agreement has also established some of the key priorities in the life expectancy action plan (including smoking, physical activity, obesity,

and ante natal care) as local priorities, guiding the development of joint commissioning decisions between the PCT, Council and other partners.

3.3 The most recent iteration of the Haringey Primary Care Strategy (developing world class primary care in Haringey) was released in May 2008, outlining how primary care in Haringey should look if we are to reduce inequalities in health and health care in the borough. Central to the strategy is *'the integration of services (health and social care in the broadest sense working together to help people be and stay healthy) around the needs of the people that use those services'.*

3.4 We have draw together the minimum data set required to meet Department of Health Guidance on Joint Strategic Needs Assessment (JSNA), and set out an ambitious plan for how we want to develop JSNA as an approach to inform the commissioning and delivery of services in the borough. The JSNA will provide an analytical platform through which partners can share local intelligence, supporting a better understanding of health and well-being needs in the borough, and the potential to commission more targeted interventions for specific groups of residents.

3.5 An external audit by Grant Thornton (2008) on work in Haringey to reduce health inequalities found that Haringey is advanced in its health inequalities agenda compared to elsewhere in the South East of England. There are good structural links in place across the partnership to promote health and well-being, and examples of strong joint working such as the appointment of the Director of Public Health. There is clear agreement that there is shared process with partners for identifying local health inequalities, and a strong relationship with the voluntary sector which has provided information to feed into the health inequalities agenda. The key areas for improvement being taken forward through an action plan are:

- Further development of the Joint Strategic Needs Assessment including putting in place an appropriate IT platform
- Use of information about people who present regularly to A&E who suffer from health inequalities, to enhance understanding of health inequality issues within the borough
- Joint training in public health needs to be enhanced at all levels
- While a number of examples of good practice in relation to well-being programmes run for staff were identified, corporate responsibility policies should be in place in all partner organisations

4 Interim findings from the LEAP review

4.1 Life expectancy in both males and females is improving. Male life expectancy (2004-06) in Haringey is 1.3 years lower than England. Female life expectancy (2004-06) is now 0.6 years higher than England.

4.2 Life expectancy is not evenly distributed in Haringey. Male life expectancy ranges from 71.0 and 71.6 years in Tottenham Green and Northumberland Park to 77.6 and 78.2 years in Highgate and Alexandra wards. Male life expectancy tends to vary with deprivation in Haringey. Variation in female life expectancy is less, ranging from 77.0 and 78.1 years in White Hart Lane and

Northumberland Park to 82.7 and 82.9 years in Woodside and Crouch End wards.

4.3 Cancer (32%) and heart and circulatory diseases (27%) together account for most deaths in Haringey residents under the age of 75 years.

4.4 Lung cancer, followed by breast, colorectal, bladder and prostate cancers were the most common causes of death from cancer in Haringey between 1996 and 2005. Further analysis of cancer waiting times and screening activity is required to better understand potential for intervention to reduce premature mortality from cancer.

4.5 Circulatory disease mortality is higher in more deprived areas of Haringey. There is likely to be under-detection (and therefore incomplete secondary prevention) of coronary heart disease in primary care in Haringey.

4.6 Higher than expected mortality from stroke is observed in Haringey. There is a relationship between stroke mortality and hospitalisation with deprivation in Haringey.

4.7 Deaths due to Chronic Obstructive Pulmonary Disease (COPD) in Haringey are lower than the national average.

4.8 Mortality rates from diabetes are higher in Haringey than nationally. We know that there is potential to improve detection and management of diabetes in primary care in Haringey.

4.9 Infant mortality rates in Haringey continue to be high.

4.10 Primary care is an important setting for enabling a reduction of premature mortality from chronic diseases, particularly in the short and medium term. Further analysis of Haringey data is required to understand potential opportunities to reduce premature mortality uniformly across Haringey.

4.11 Understanding the prevalence and distribution of behavioural risk factors for chronic diseases, particularly smoking, diet and physical inactivity, continues to be a challenge in Haringey. Prevention of these risk factors will be key to reducing premature mortality in the medium and longer term.

5 Next steps

The review of the life expectancy action plan should be considered in the context of important strategic initiatives in Haringey including the Tobacco Control Strategy, the Obesity Strategy, the Primary Care Strategy, the Wellbeing Strategic Framework, the Alcohol Strategy and others.

The next stage is to review progress in implementation of the plan, in light of a review of more recent policy, guidance and research to make recommendations on how partners can most effectively commission or provide interventions to improve life expectancy and reduce health inequalities. This work will be undertaken in the spring 2009 with the aim of reporting to the Well Being Partnership Board in quarter 2.