BRIEFING PAPER FOR CROSS PARTY WORKING GROUP

TACKLING THE LIFE EXPECTANCY GAP

PHPHFXW Page 1 12/09/2011

1.Introduction

The Cross Party Working Group (CPWG) on reducing Health Inequalities in Haringey has three working priorities. The priorities are consistent with the Marmot Review[1], London Health Inequalities Strategy, priorities identified by the National Support Team on Health Inequalities (including feedback on their visit to Haringey in 2009) and The Thematic Paper for CEMB "Towards a Health Inequalities Strategy for Haringey"[2]. Therefore the work of this group builds on work underway to reduce Health Inequalities.
This paper is for the third meeting of the CPWG that will focus on the 2nd priority:

Tackling the Life Expectancy gap:

- **Prevention: smoking, physical activity, alcohol, obesity and nutrition**
- **Early Intervention (adults over 40): cardiovascular disease, cancer, diabetes.**

The aim of this report is to:

- Give the CPWG an understanding of the key impacts on the life expectancy, what we are currently doing to address them and what more we could do, based on best practice
- Make recommendations for priority actions to take this work forward, particularly focusing on the Council's contribution.

The CPWG is asked to consider and endorse these recommendations, where appropriate.
The paper will focus more on Prevention than on Early Intervention as there is greater potential contribution for the Council in this area.

2.Life Expectancy in Haringey

Life expectancy at birth [i]in Haringey has increased over recent years as it has nationally (Figure 1). However whilst life expectancy for Haringey males is significantly worse than the England average (76.6 and 78.3 respectively in 2005-9), life expectancy in females in Haringey is significantly higher than in England (83.7 and 82.3 respectively in 2005-9)[ii]. Disability-free life expectancy is similar to the England average for both males and females. The gap between life expectancy in males in England and Haringey may be widening. There are stark differences in life expectancy in males between the East and West of Haringey (Figure 2 below): nine years difference between the highest in Fortis Green (80.9) and the lowest in Tottenham Green (71.68) (2005-8). Further analysis shows that the inequality in male life expectancy across the borough is actually better than the England average; for females it is similar to the England average. However, the gap in life expectancy across Haringey, mirrors the Index of Multiple Deprivation across the borough; this is unacceptable. Certain "vulnerable'" groups in society e.g. people with mental health problems or learning disabilities also have a lower life expectancy than the general population. For example a person with

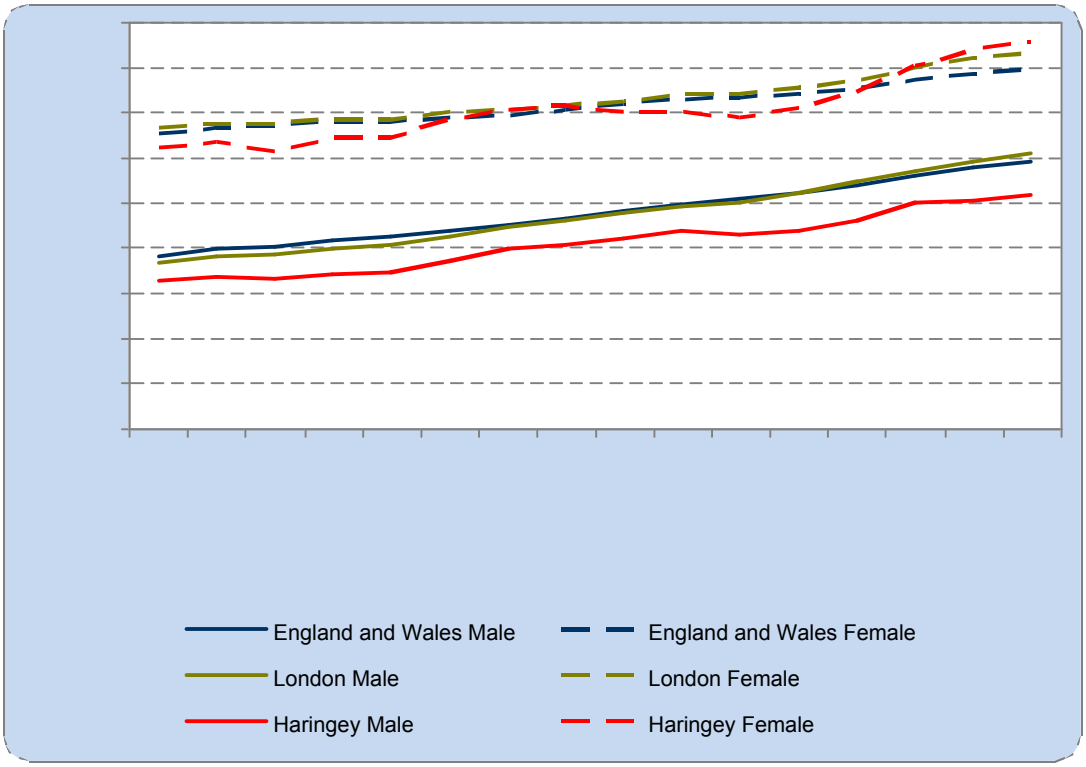
[i] Life expectancy at birth is the number of years of life from birth that can be expected on average in a give population
[ii] Marmot Indicators (London Health Observatory)

schizophrenia lives on average 10 years less than some one without a mental health problem, mainly due to physical health problems. [3]

Key messages:

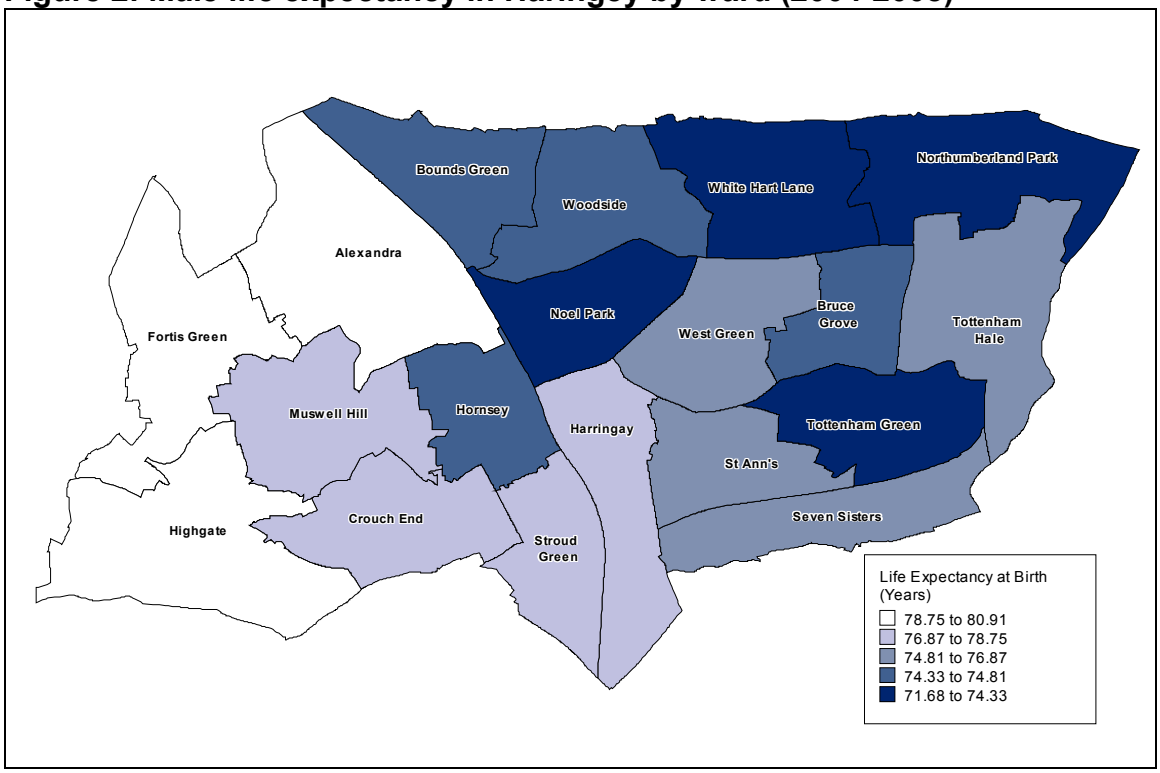
- Life expectancy is increasing in Haringey and nationally
- There are nine years gap in male life expectancy between Tottenham Green in the East and Fortis Green in the West
- Life expectancy is significantly lower in certain "vulnerable" groups

Figure 1: Trends in life expectancy (1991-2008)



Source: London Health Observatory (LHO)

Figure 2: Male life expectancy in Haringey by ward (2004-2008)



Source: LHO

3.Key drivers for addressing Gaps in Life Expectancy

3.1 What is causing the gap in life expectancy?

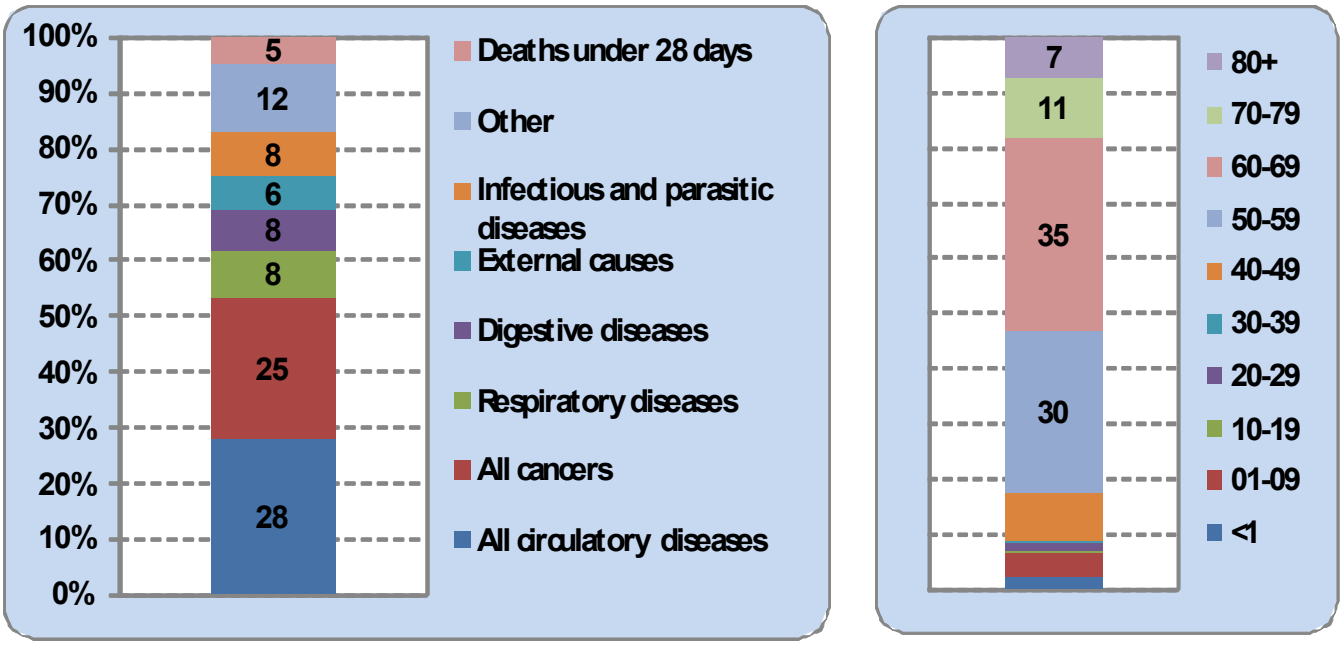
Reducing the gaps in life expectancy between boroughs of lower life expectancy (previously called Spearhead areas) and the England average has been a focus of national policy. The contributors to the gap in male life expectancy between Haringey and England is shown in Figure 3 below (also called "the scarf") The greatest contributors are circulatory disease (28%) and cancers (25%). Relating to age: 8% is due to men aged 40-49 years, 30% of the gap is due to men aged 50-59 years, 35% is due to men 60-69 years; in total 73% of the gap in male life expectancy is due to men aged 40-69 years. Figure 4 shows the large differences by ward within Haringey in cardiovascular disease (CVD) mortality. Premature mortality rates (under 75s) for CVD and for cancers in Haringey, whilst improving, are worse than in England[iii].

Reducing inequalities in cardiovascular and cancer mortality in adults (particularly men over 40) will have the greatest impact on reducing inequalities in life expectancy in Haringey. Other contributors to the life expectancy gap are respiratory disease, digestive disease, infectious diseases and external causes (including injury, poisoning and suicide) and reducing mortality in the first 28 days of life. Respiratory diseases includes Chronic Obstructive Pulmonary Disease (COPD), a long term condition closely related to smoking. Alcohol related conditions, such as chronic liver disease and

[iii] LHO Haringey Health Profile 2011 www.healthprofiles.info

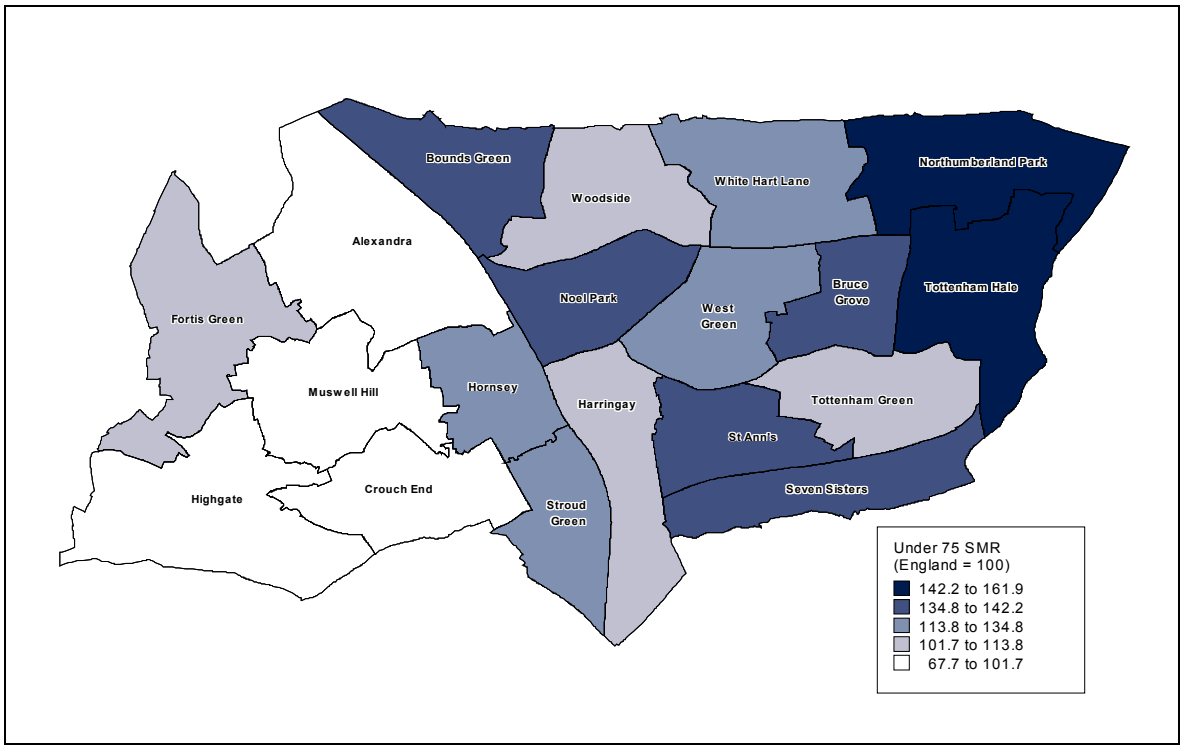
cirrhosis, are important contributors to digestive diseases. External causes, whilst not a major contributor to the gap include strong links with deprivation including injury (e.g. 28 fold difference in death on the road between children in high and low socio-economic groups) and suicides. Excess winter deaths, have an important seasonal contribution to cardiovascular, respiratory and infectious diseases. In conclusion the key contributors to the life expectancy gap are CVD (stroke and heart disease) , cancer, alcohol, lung disease, and deaths in men over 40

Figure 3: Life expectancy gap between Haringey and England. Breakdown by cause of death and by age group, males (2006-8). *"the scarf"*



Source: LHO

Figure 4: Death rates from cardiovascular disease under 75 by ward (2004-2008)



Source: LHO

Key contributors to life expectancy gap:

- stroke, heart disease, cancer, alcohol, lung disease
- deaths in men over 40

3.2 Priorities for Action

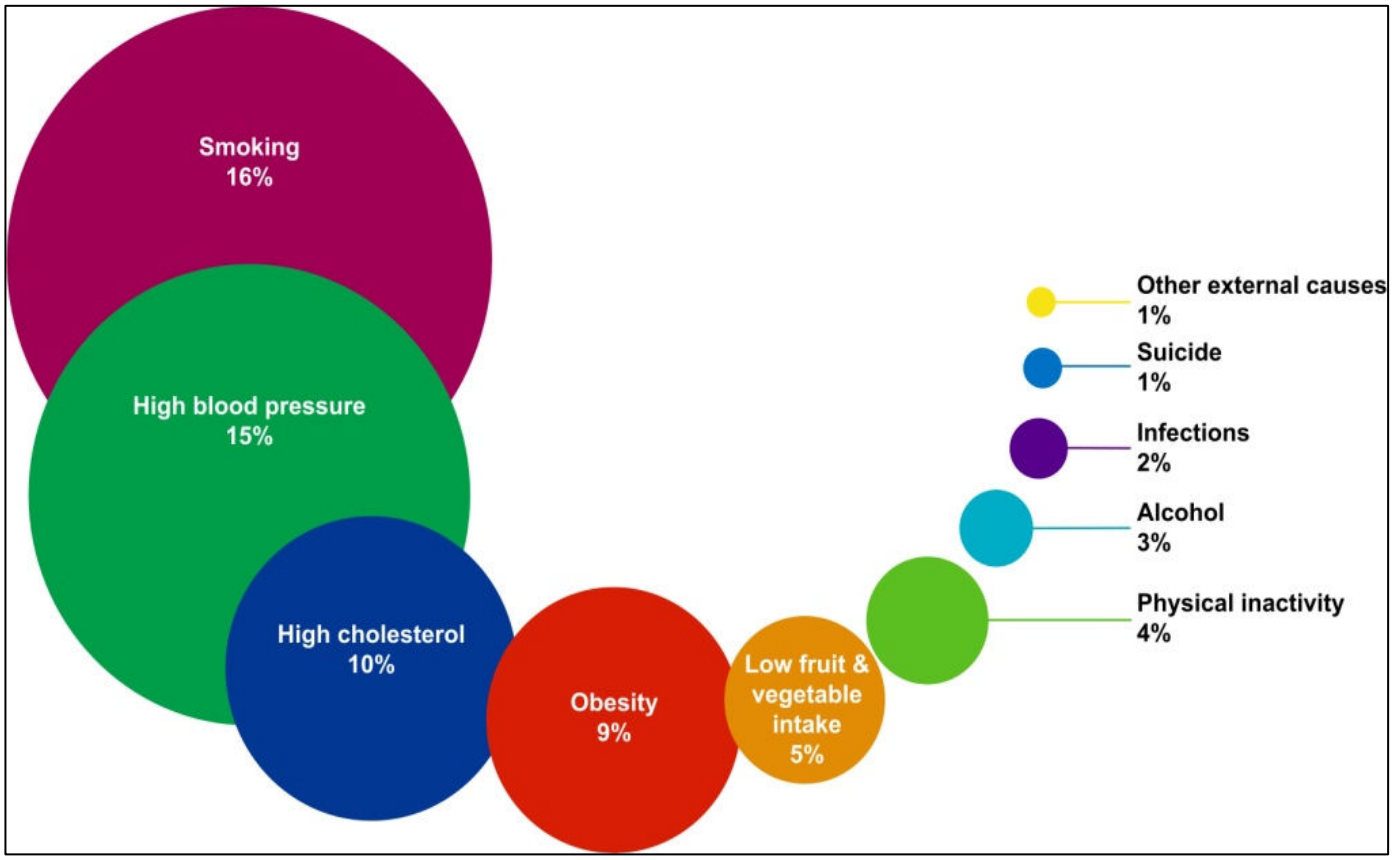
It is well established that a number of modifiable behavioural risk factors are linked to both increased likelihood of cardiovascular disease and cancers as well as other long term conditions (e.g. diabetes). Figure 5, "the caterpillar" demonstrates the proportion of deaths attributable to each factor. Addressing inequalities in these factors in the population through preventative programmes will lead to reduction the life expectancy gap. This is an important area of policy for the Council to have an impact on health inequalities.

The Health inequalities National Support Team (HINST) [4]identified evidence based actions that would have an effect within a short timescale. This includes early diagnosis and management of disease (early intervention) and effective prevention of further illness (secondary prevention) in people who have already ill e.g. had a heart attack or stroke. Though much of this is within the realm of the NHS, the Council has a key role in supporting secondary prevention and raising awareness about key diseases within communities.

Most risk factors and mortality inequalities show a gradient from worse to better health across socio-economic groups rather than just good health for the affluent and bad health for the poor in society. Marmot emphasises that policy delivery and resources should reflect this gradient rather than just focus on the worst off.
Programmes should be targeted at certain groups with poor health outcomes e.g. addressing the physical health needs of people with mental health problems.

Health Inequalities results from social inequalities. The importance of addressing wider determinants such as employment, housing and ensuring a healthy living standards is also emphasised, particularly in order to reduce inequalities in the long term[1].

Figure 5: Key modifiable behavioural factors contributing to death in Haringey. The "caterpillar"



Source: Public Health Mortality File
(Prepared by NHS Islington)

The key priorities for action to reduce inequalities in life expectancy are:

Prevention: particularly smoking. Also physical activity, alcohol, obesity, diet and nutrition. These are risk factors for cardiovascular disease and cancer. The Council has a key role.

Early Intervention: particularly cardiovascular disease and cancer but also other long-term conditions such as diabetes and lung disease and prevention of excess winter

deaths. Council's key roles are supporting secondary prevention (lifestyle change in those with illness), and awareness raising.

Approaches:

- delivery across the social gradient
- target key groups including mental health, learning disabilities
- address the wider determinants of health

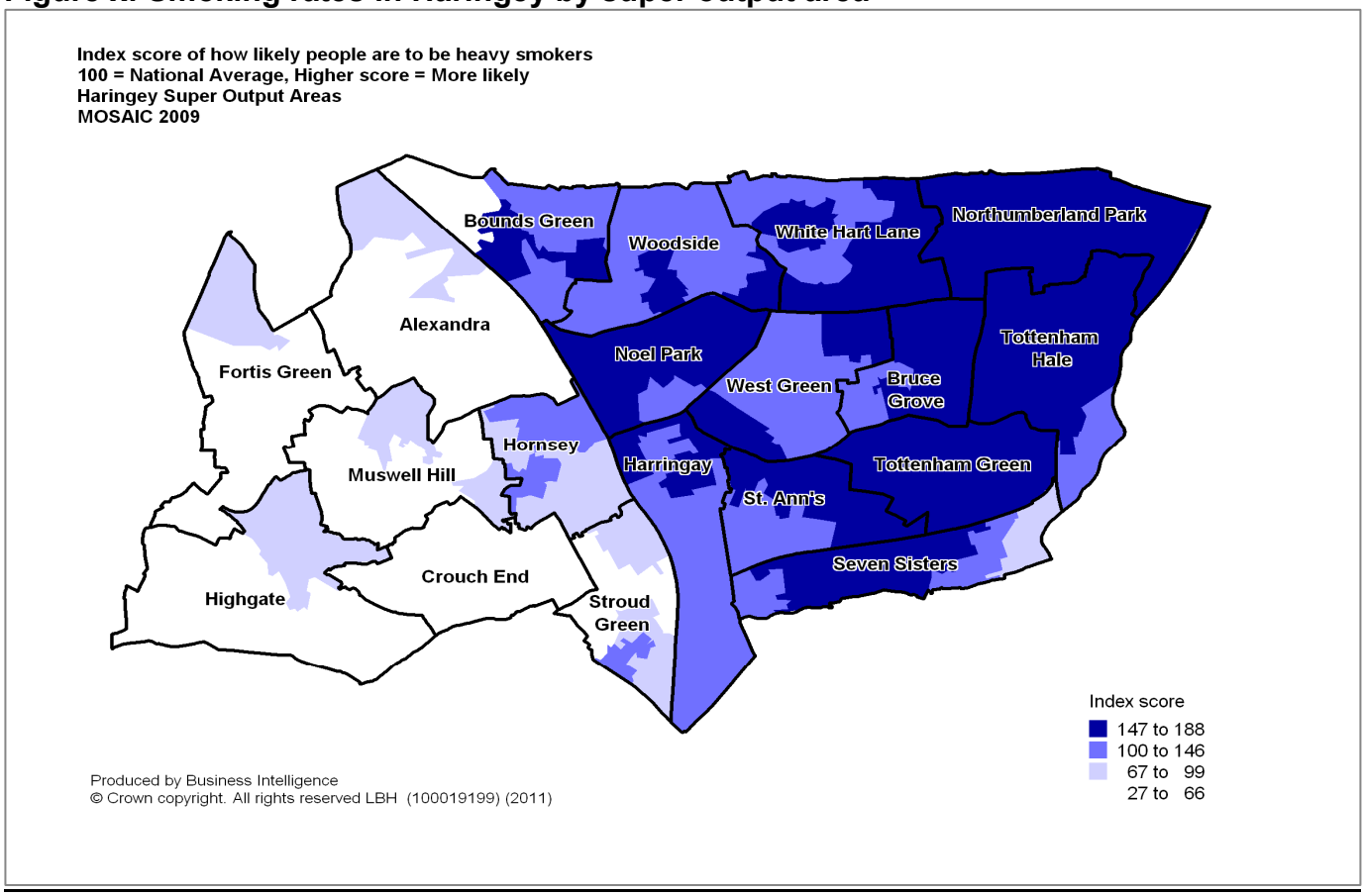
3. 2 Prevention

Smoking, physical inactivity, obesity, poor nutrition and alcohol are important risk factors[5] for Cardiovascular disease and cancers, demonstrate a social gradient across socio-economic groups and are commoner in certain Black and Minority Ethnic (BME) groups and sub-groups such as people with learning disabilities. National, regional and local policy documents emphasise the importance of reducing inequalities in these risk factors in order to reduce inequalities in life expectancy. For example: Next Steps for Delivery of the London Health Inequalities Strategy – prioritises prevention, in particular a focuses on scaling up physical activity. The HINST recommends making "Health Gain" everyone's business – this includes providing training in brief interventions (see below, physical activity section) and monitoring referrals for all front line staff from health, local authority and voluntary sector. Two policy objectives of the Marmot review [1] are to tackle ill health prevention and develop healthy sustainable places and communities. These were adopted locally in the Haringey the Thematic Paper for CEMB 2010 "Towards a Health Inequalities Strategy for Haringey"[2] and emphasise the importance of promoting health lifestyles through changes in the environment, a key area for partnership working with the council, rather than individual life style changes alone.

3.2.1Smoking

Smoking, and tobacco consumption is the UK's greatest cause of preventable illness and early death. It is also the primary reason or the gap in life expectancy between socio-economic groups. There is a strong link between smoking rates and deprivation. If men aged 35-69 in social class V had the same smoking rates as those in social class I, then half of the inequality in mortality would disappear [6]. Certain groups have high rates of tobacco use and higher nicotine dependence e.g. lone parents, specific ethnic groups e.g. Turkish, Bangladeshi, Irish men and people with mental health problems, about half of whom smoke[7]. National rates of smoking are reducing. [8]If this continues it should reduce the incidence of CVD and later on Cancer incidence. The "London Boost" (2006) for the Health Survey For England modelled smoking prevalence as 28.6% males and 24.2% females in Haringey compared to 25.3% for males and 18.8% for females in London. 26106 males and 24108 females smoke in Haringey. Figure xx shows the large difference in smoking rates across the borough

Figure x: Smoking rates in Haringey by super output area



Source: LHO

What should we be doing?

A wide strategic approach to Tobacco Control is required to impact upon smoking. Department of Health recommends that smoking cessation support should be aimed at 5% of quitters. Other smokers will quit unaided. Wider Tobacco control efforts through a

range of interventions are vital to prompt and maintain these quits, in part by changing social norms.

Best practice to support smoking cessation and Tobacco Control therefore includes:

- Establish a multi-agency strategic approach to Tobacco Control[4]
- Brief interventions: this may include opportunistic advice, discussion, negotiation and encouragement and referral, where appropriate, to intensive support e.g. through NHS Stop smoking services. [9]There is very good evidence to support appropriately trained provision by GPs, primary care or community staff. It is highly cost effective[10]
- Smoking support should be targeted at key groups to reduce smoking related inequalities within the short term[4] . These include:
  - People with CVD, lung disease, cancer and diabetes
  - Pregnant smokers
  - Smoking within lower socio-economic groups
- BME groups may be served by accessible mainstream interventions or work with local communities to develop targeted services [11]
- Media campaigns with a variety of media can be effective in encouraging and support quit attempts. [12]
- Develop social networks: advice and counselling to support smoking cessation; community based interventions to support people who wish to stop smoking and disseminate messages (evidence of success in some cases); work place programmes (particularly focusing on individual support) [13]can be effective.
- These actions should be combined with medium and longer term actions such as de-normalising tobacco use through smoke free legislation, tackling illicit tobacco control (smuggled, counterfeit under age sales) and enforcement and extension of smoke free legislation[4].
- Improve measurement of smoking prevalence to target local services[4].

What are we doing?

- We have a multi-agency Haringey Tobacco Control Alliance, supported by a strategy and action plan.
- Smoke Free Enfield and Haringey (SFEH) provides an evidence based Stop Smoking Service for Enfield and Haringey. This was recently (February) recommissioned and is being developed and performance managed in accordance with a service specification and key performance indicators that highlight: routine and manual groups, people with mental health problems, pregnant women, BME groups, media and advertising campaigns and partnership support for Tobacco Control plans.
- Tobacco control enforcement: there are regular test purchases of under age sales but they have a high failure rate, i.e. sales are still made, particularly with smaller traders. There is generally good compliance with smoke free legislation, less so within vehicles. Shisha is an emerging problem, officers are supporting proprietors in handling this. Smoking is raised as an issue by other officers during visits where possible.

What more could we do?

Continue to work with the new SFEH to improve the quality, accessibility and capacity of the service to support people from target groups to stop smoking. Focus on those with long term conditions in addition to those from lower socio-economic groups, BME, mental health problems and pregnant women. Also develop stop before the op and opt

out programmes to encourage smoking cessation in certain settings. It is important to work with partners to actively market this service within target communities.

In the light of recent organisational and resource changes, review the Tobacco Control alliance and action plan against best practice guidance to achieve "Excellence in Tobacco Control: 10 High Impact Changes" [4]

Tobacco Control measures: we should use methods other than prosecution to reduce under age sales e.g. educational initiatives with schools, work closer with new SFEH, target businesses (including those with vehicles) to encourage Smoke Free policies, particularly in areas of high prevalence.

Recommendations

1. Endorse Tobacco Control as a key strategic priority for the Council and partners as
2. Re-invigorate the Tobacco Control Alliance, working closely with the new stop smoking service and with Enfield Tobacco Control Alliance, focusing on target groups.
3. Work with partners to fully market and publicise the new stop smoking service and raise awareness about smoking within key communities in Haringey.
4. Continue to work to address illicit tobacco control practices, particularly in the East, using a range of approaches in partnership
5. Target businesses and work within the council to extend Smoke Free policies and practices.

Related Documents

Tobacco Control Strategy and Action Plan (under review)
Service Specification and Key Performance Indicators for the Stop Smoking Service

3.2.2 Physical Activity

Physical inactivity is amongst the ten leading causes of death in developed countries, causing 1.9 million deaths worldwide each year[14]. The risk of premature death amongst physically active adults is reduced by 20% -30%, and the risk of developing major long-term conditions such as CHD, stroke diabetes and cancers are reduced by up to 50%[15]. The strong evidence for physical activity has led to physical inactivity being recognised as a major modifiable risk factor for CHD[16].

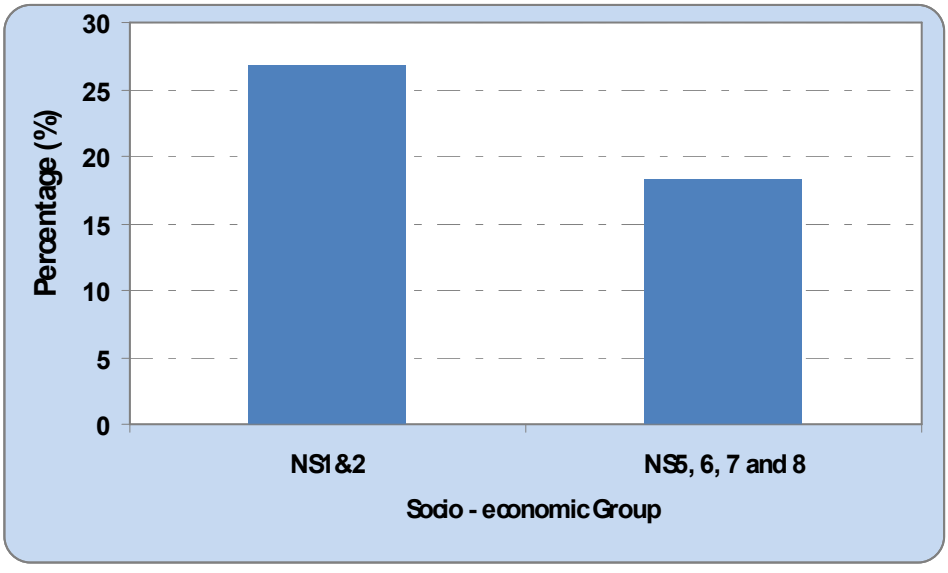
Physical inactivity is associated with increases in obesity, cardiovascular disease (CVD), cancer, hypertension, and in the development of type II diabetes. Participation in regular physical activity can help to prevent and treat over twenty long-term conditions or disorders, including stroke, obesity, some cancers, mental health and type II diabetes.

New guidance states that recommended levels of physical activity for adults are to aim to be active daily. Over a week, activity should amount to at least 150 minutes of moderate intensity physical activity in bouts of 10 minutes or more. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous activity. Adults should also undertake physical activity to improve muscle strength on at least two days a week. In 2006 one third of adults in England led sedentary lifestyles (i.e. less than 30

minutes activity per week) and only 40% of men and 28% of women achieving recommended levels. In Haringey 21.7% of adults participated in sport and active recreation at a moderate intensity equivalent to 30 minutes on 3 or more days a week. Activity levels have not changed in recent years.

There are significant inequalities in levels of physical activity in relation to age, gender, ethnicity and disability. For example, in Haringey white adult populations are more active than non-white adults, men tend to be more active than women, younger people are more active than their older counterparts and activity levels are lower in those who have a limiting illness or disability. The data also indicates that there is a very strong correlation between participation and social class. Within Haringey, people in the lower socieconomic groups (NS5, 6 7 and 8) are less active than those in the higher socioeconomic groups (NS1 and 2), at levels of 18.3% and 26.8% respectively (see figure 7) [17] .

Figure 7: Sports participation by socio-economic group



Source: Sport England (2010)

What should we be doing?

The evidence suggests a range of options including non-facility based programmes, exercise referral schemes, moderate intensity physical activity and behavioural or psychological interventions. Key messages from the limited evidence base are[18][19][20]

- Use of approaches that include a psychological, behaviour change component lead to longer term changes
- Brief interventions (by health professionals) or others are highly effective
- Exercise referral schemes are recommended
- Interventions that promote moderate intensity physical activity, especially walking and are non – facility based achieve longer term changes
- Whilst there is less evidence for walking and cycling schemes – they are recommended as a means of incorporating regular physical activity into peoples lives
- There is little evidence for pedometers
- Moderate and non-endurance exercise supports changes in older people

Other key recommendations are:
- Ensure local facilities and options are accessible to the least active target groups (BME, lower socio-economic groups, disabled, older people)
- Scale up voluntary and community sector to deliver physical activity (Mayor's Health Inequalities Strategy delivery plan)
- Develop an organisation wide policy to encourage and support employees to be more physically active, in line with NICE guidance for employers[21] e.g. facilitate activity to, from and during work.

Proposals to improve the physical environment and thus encourage physical activity recommended by NICE include[22]:
- Facilitate the use of open spaces and develop walking and cycling routes
- Planning applications should prioritise the need for people to be physically active
- Encourage active travel, walking and cycling. Effective transport interventions include: health promotion campaigns and behaviour change support to promote walking and cycling, backed by physical measures e.g. traffic calming and walking and cycle routes [23]. "Fairness" for certain vulnerable groups in a car dependent society requires a shift to more sustainable and space efficient modes of transport and giving priority to pedestrians, cyclists and public transport users[iv][24].

What are we doing?

Community Sport and Physical Activity Network (CSPAN), facilitates the effective strategic coordination of planning and provision for Haringey. It aims to ensure people of all ages and abilities have the opportunity to participate in high quality sport and physical activity and therefore reduce inequalities in access and participation.

Haringey currently has a range of sport, leisure and physical activity opportunities available within the borough:
- Five council owned facilities, provide a range of facility based physical activity options. Externalisation of management of three of these is underway; this should result in release of resources to commission other services.
- A number of sports development posts and sports and physical activity programmes are provided across the borough. Funding for a number of these programmes are time limited.

[iv] The Council established an independent Sustainable Transport Commission to to examine some of the most pressing transport issues in Haringey. The Commission's recommendations include giving priority to pedestrians, cyclists and public transport users over moving and parked vehicular traffic.

- "Active for Life" exercise (GP) Referral Scheme: focuses on people with Long Term Conditions who are amongst the least active (such as diabetes, hypertension) in the East of the borough, offering them a range of physical activity options.
- Health Trainers scheme (see below) gives one to one advice and support and brief interventions, including to increase physical activity levels.

There are a number of partnerships with the voluntary and community sector, for example, the Tottenham Hotspur Foundation who use sport, mainly football to improve health, promote social cohesion and enhance life-skills.

Make A change project, focuses on children in the East of the borough

The NHS Health Checks programme, within the East of the borough, identifies 40-74 year olds who are not physically active and offers advice and support.

There are 600 acres of parks and open spaces providing formal and informal activities – 16 have green flag awards.

A Smarter Travel programme and a Biking Borough programme is providing opportunities for a number of activities including a programme of behaviour change to encourage cycling and community participation events. Also interventions include improve the physical environment with road engineering, walk and cycle routes. The East of Haringey is currently worse affected by congestion and the negative health impacts than the West.

What more could we do?

- Public Health, Sustainable Transport, Recreation Services and the NHS are working together on Smarter Travel, Biking Borough and other initiatives. Along with CSPAN, this partnership can be strengthened moving forwards.
- Use existing (e.g. remaining ABG funds) and new resources (e.g. funds released from "externalisation) to develop physical activity opportunities proportionally across the social gradient and targeting specific groups, informed by local data and evidence of what works.
- Embed use of brief interventions and other psychological approaches in programmes.
- *Active for Life'* exercise referral scheme – originally ABG funded; funding is secured until October. Further funding opportunities should be sought to continue this programme.
- Seek external opportunities for funding or promoting physical activity, including capitalising on the 2012 Olympics
- In the past services focused on those who are moderately active. Moving forward need to focus more on the inactive, including those with disabilities.
- Increase the use of voluntary sector providers, who bring experience of local communities and may access additional funding streams.
- Use intelligence more e.g. Active People Survey, Sport England databases, information from current services to target activities and evidence base of best practice to develop services that will maximise their impact on inequalities.

Recommendations

1. Strengthen partnership working across the council, Public Health, NHS and other partners e.g. transport providers to ensure effective use of resources, joined up messages and branding.
2. Focus existing and new on addressing health inequalities, including a shift to focus on populations who are amongst the least active
3. Work with all partners to scale up the availability of brief interventions
4. Continue to fund the exercise referral scheme to manage/prevent a range of long-term conditions, as those with the poorest health are amongst the least active and have the most to gain from increasing their activity levels.
5. Ensure leisure centre specifications and ongoing partnership with the new provider is developed to improve access for hard to reach groups and include psychological approaches.
6. Continue to improve the physical environment to encourage physical activity e.g. maintaining quality Open spaces.
7. Use intelligence more intelligently.

Related documents
Sustainable Development Commission "Fairness in a Car Dependent Society" 2011

3.2.3 Obesity and Nutrition

Obesity is extremely prevalent and is a major cause of ill-health and premature death. Overweight and obesity are linked to numerous health problems including respiratory difficulties, musculo-skeletal problems and infertility, to the more serious cardiovascular problems (hypertension, stroke and coronary heart disease), diabetes, gallbladder disease, certain cancers (breast, endometrial and colon)[25]. It is estimated that, on average, obesity reduces life expectancy between 3 and 13 years[26] In the UK the prevalence of obesity has more than doubled in the last 25 years. Nearly a quarter of adults are now obese and it is estimated that by 2050, the vast majority of the UK population could be mainly obese, with some 40% obese by 2025 and nearly 60% obese by 2050[27]. In England approximately 10% of children are obese and a further 20-25% of children are overweight[28]. These increases may mean that children of today have a shorter life expectancy than their parents[29]. It has been predicted that if appropriate action is not taken, two-thirds of children will be obese or overweight by 2050 [30]

Many factors contribute to obesity including genetic, economic, social, psychological, environmental and cultural factors[31] [32]. Obesity is rising in adults and children in England. The increase is likely to be due to environmental and behavioural changes which have lead to more sedentary lifestyles and energy-dense diets[33]. Healthy eating and increased physical activity are primary solutions to preventing and overcoming overweight[34]. Obesity can also cause psychological and social problems, particularly in children. Children who are overweight are much more likely to be overweight as adults and experience health problems[35] . The most significant predictor of childhood obesity is parental obesity[36].

Overweight and obesity disproportionately affects the lower socioeconomic groups and socially disadvantaged groups (particularly women)[37],[38],[39]. They include:-

- Children from low-income families

- Children from families where at least one parent is obese
- Individuals of Asian origin (particularly those of south Asian origin)
- Ethnic groups with a higher than average prevalence of obesity (Black African women, Black Caribbean women, Pakistani women, Black Caribbean men, and Irish men)
- Adults in semi-routine and routine occupations
- People with physical disabilities (particularly in terms of mobility which makes exercise difficult)
- People with learning difficulties
- Older people

In addition, people diagnosed with a severe and enduring mental illness, particularly schizophrenia or bipolar disease, are at increased risk of greater levels of obesity and are almost twice as likely to die from CHD as the general population[40].

In Haringey there has been a slight increase in overweight and obesity between 2003 and 2006 (HSE). In 2006 37.7% of men and 26.0% of women are overweight and a further 12.7% men and 14.5% women are obese (2006 Health Survey for England London Boost). There is also a slight increase with age. Estimates suggest approximately 26,104 adults in Haringey may be obese and 60,313 overweight, and a total of 86,417 obese or overweight (see Figure 8).

Figure 8: Estimates of Overweight and Obesity levels in Haringey

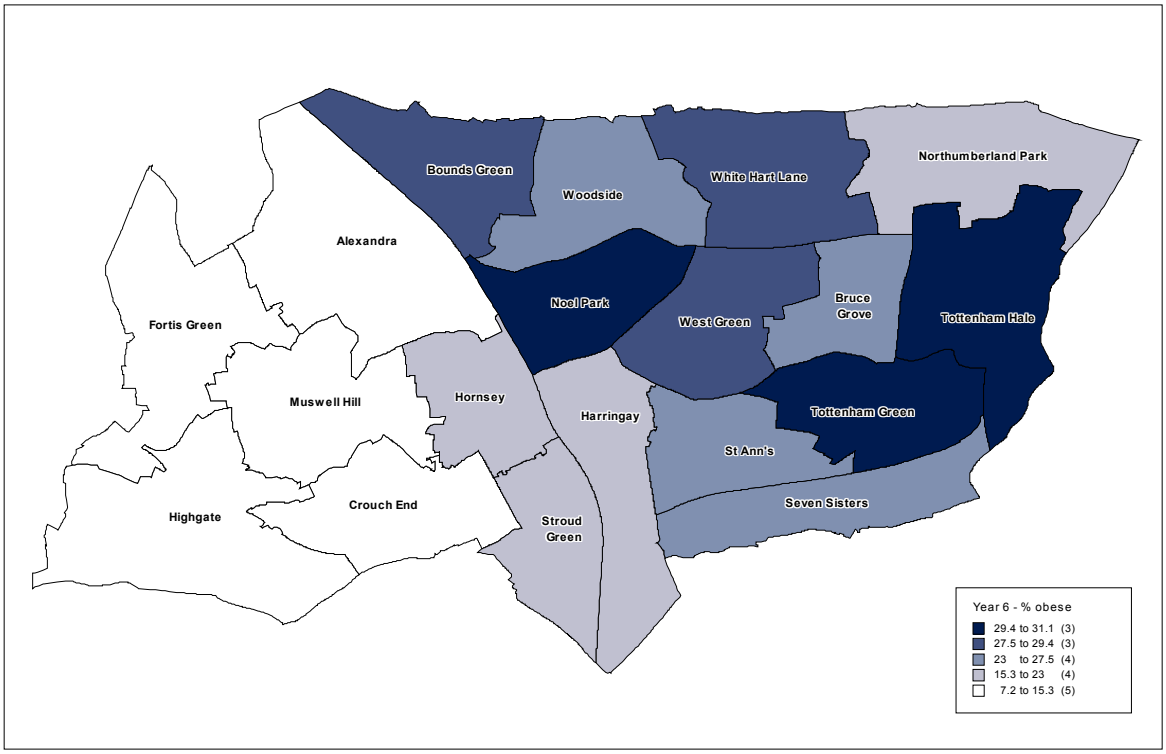
Gender	BMI < 25	BMI 25-30	BMI > 30
Male	45343	34412	11637
Female	59111	25901	14467
Total	104454	60313	26104

*Extrapolated using the 2006 HSE London Boost (Inner London rates)
Source: HSE 2006 (London Boost)/ GLA R2010 Population Projections (Using 2011)

In Haringey the prevalence of overweight and obese children is measured annually through the since 2006. Data on the heights and weights of children in Reception and Year 6 in Haringey primary schools is collected, which is then used nationally to understand child growth patterns across England as well as to inform local service planning.

Childhood obesity rates in Haringey are above the England average (National Child Measurement Programme (NCMP)). Figure 9 shows childhood obesity rates for Year 6 by Ward.

Figure x: Childhood obesity Rates by Ward –Year 6 (2010)



Source: NHS Haringey - NCMP

What should we be doing?

The evidence for effectiveness is limited, but much good practice exists. It is important to focus on prevention of obesity as well as treatment. A multi-disciplinary, long-term strategy to tackling obesity is essential.

To prevent obesity, in addition to appropriate diet and nutrition the following have some success[41]:

- Community based physical activity interventions; long term success is more likely if behavioural approaches, tailored to individuals are used.
- Moderate intensity physical activity, especially walking show longer term successes
- Interventions designed specifically for adults over 50+ are likely to have short and long term success

To treat obesity and achieve weight loss in adults was concluded as follows:-

- Physical activity alone, diet alone and physical activity and diet combined are effective interventions.
- There is evidence that a combination of behavioural therapy techniques in conjunction with other weight loss approaches is effective.

NICE[42] made recommendations to prevent, identify, assess and manage obesity in adults and children to a range of organisations including the NHS, local authorities, schools and early years providers, workplaces and the public. Key priorities for implementation by local authorities included:

"working with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion", by:

- providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas

- making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
- ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)
- considering in particular people who require tailored information and support, especially inactive, vulnerable groups.

For childhood obesity the available evidence on the cost effectiveness of different interventions suggests the most cost effect interventions are multi-faceted, supporting children and their families to eat more healthily and become more active. This kind of approach can be used for a targeted group of children, but it can also be implemented on a larger scale to help prevent and reduce obesity. A whole range of different interventions, spanning health services, schools, the transport system, the food industry and the physical environment are required[43].

What are we doing?

- The Haringey Obesity Strategy - offers practical guidance for the prevention, management and treatment of obesity with the aim of reducing health inequalities and ill-health, aimed primarily at health care professionals.
- The Adult Obesity Care Pathway - provides a formalised structure for high quality, timely, standardised and equitable care.
- Haringey Health Trainer Service provides brief intervention, one to one advice and follow up (see section 3.2.5)
- Commercial community-based weight management on referral programme (for obese adults (BMI >30) aged 40-74 who have undergone an NHS Health Check)
- Draft Hot Food Takeaway Policy – addresses concerns regarding the impact that the proliferation of hot food takeaway outlets has on children, young people and the vulnerable and sets out recommendations for the refusal of planning permission.
- Haringey Food and Nutrition Strategy
- A broad range of physical activity interventions (see above in physical activity section of the report)
- NHS Health Check programme – aims to identify adults aged 40-74 at high risk of CVD and intervening to reduce the risk, including supporting life style change (see section 3.2.5)
- Haringey Nutrition and Dietetics Service – providing one-to-one support to patients who require support and guidance regarding nutritional intake. In addition, a number of community-based interventions have been rolled out across the borough. Clinic times, locations and type of support are varied to improve access. Some languages are spoken. Training is available for community groups.
- Evidence on childhood obesity in Haringey was received by The Cross Party Working Group in the paper entitled ‘Giving Every Child the Best Start in Life’ discussed in the June meeting.

What more could we do?

- Consider a whole system approach to tackling obesity in the local population including spanning health services, schools, the transport system, the food industry and the physical environment are required
- Local awareness raising, including primary prevention.

- A wider range of community-based weight management programmes and clinic options
- Multi-component programmes using approaches based on psychological principles.
- Scale up borough wide training programmes for brief intervention to a range of staff and volunteers
- interventions for people with learning disabilities or mental health problems and their carers.
- promote physical activity across the social gradient and in target groups (see section above) to both prevent and help treat obesity
- Consider use of planning regulations to restrict plans for fast food outlets in the borough and promote healthy food options and labelling. Further joint work between Trading Standards and Public Health on nutrition and obesity

Recommendations

1. Consider adopting a whole system approach to tackling obesity in the local population
2. Focus on addressing health inequalities by focusing on populations who are at higher risk of overweight and obesity.
3. Commission interventions to address childhood obesity using an evidence-based whole family approach.
4. Work closely with key external borough partners to maximise funding and other resource opportunities.
5. Implement a local awareness raising campaign.
6. Commission a range of adult weight management services.
7. Adopt and implement a policy for the restriction of fast food outlets and promoting healthy food options.

3.2.4 Alcohol Related Harm

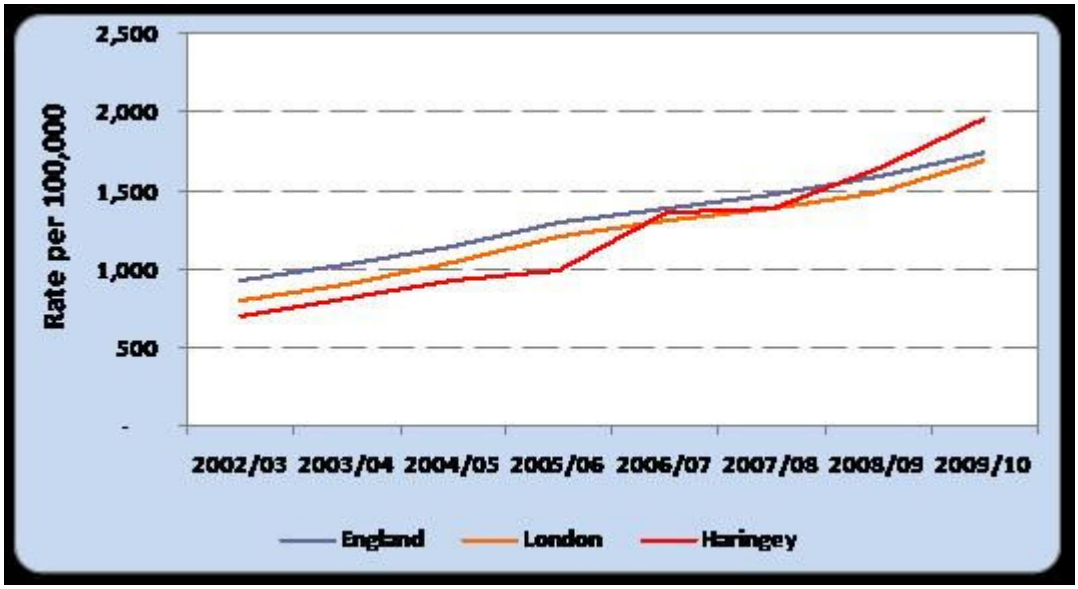
Harm due to alcohol are considerably more apparent in more deprived groups. The most deprived fifth of the UK population suffer two or three times greater loss of life attributable to alcohol, three to five times greater mortality due to alcohol-specific causes and two to five times more admissions to hospital because of alcohol than wealthy areas[44]. The inequality ratio is most apparent in men and there is a direct dose-response relationship between alcohol consumption and death[45]

Haringey's alcohol related hospital admissions rates have almost doubled in the period 2004/05 -2008/9 for men and women (see Figure 9). This includes admissions that are partially attributable to alcohol, such as hypertension, and those that are 'wholly' attributable to alcohol e.g. ethanol poisoning. Middle aged and older men make up the majority of alcohol related hospital admissions and apart from 'any other ethnic group' Irish men had the highest wholly attributable rate of admissions[v].Alcohol admissions in

[v] Analysis of Hospital Episodes Data Haringey Public Health 2009

the under 18's account for a small percentage of overall admissions,[vi] (55 between 2006/07-2008/9.)

Figure 9: Trend in alcohol related admissions (2002-2010)



Source: North West Public Health Observatory

Figure 10: Alcohol related admissions in Haringey by cause and gender (2008-09) [vii]

[vi] In under 18's only alcohol specific conditions are counted

[vii] The alcohol specific rate calculates a rate based on deaths wholly attributable to alcohol. The alcohol attributable deaths are calculated according to the application of attributable fractions to deaths from certain conditions. For more information see *Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions, NWPHO 2008*

Condition group	Male % all NI39 admissions	Female % all NI39 admissions	All admissions
Hypertensive (Chronic)	22.8	12.3	35.1
Alcohol specific (Mental)	15.5	5.0	20.5
Cardiac arrhythmias	7.2	5.6	12.8
Other diseases	4.2	6.6	10.8
Accidents & Injury (Acute)	2.5	1.1	3.6
Alcohol specific (Chronic)	2.4	2.1	4.5
Cancer	2.4	2.5	4.9
Digestive (Chronic)	2.0	0.9	2.9
Violence (Acute)	1.9	1.8	3.7
Alcohol specific (Acute)	0.5	0.6	1.1
Top ten conditions total	61.4%	38.5%	

Hypertensive disease in men over 65 accounts for 35% of alcohol related admissions.

Mental and behavioural disorders account for 20.5% alcohol related admissions*

High blood pressure is the commonest cause of alcohol related admissions (see Figure 10). Mental and behavioural disorders, the second commonest cause, include: drunkenness, acute intoxication withdrawal, harmful dependence, delirium tremens, psychotic disorder etc. Men over 50 are most represented in this category. Males outnumber females on most conditions; the one notable exception is “other diseases”. This category includes spontaneous abortion, epilepsy, ischaemic stroke and psoriasis. Crude rates for ethnicity indicate: White British, African Caribbean and ‘any other white’ men are most represented in alcohol related hypertension admissions. White British, any other white and Irish men most represented in alcohol specific mental and behavioural disorders.

Figure 11 Alcohol specific and alcohol attributable/related deaths, per 100,000 population (all ages, directly standardised)

Alcohol – Specific mortality (2006-2008)			
	England	London	Haringey
M	13.12	11.31	12.93
F	6.12	3.81	3.27
Alcohol-Attributable Mortality (2006-2008)			
	England	London	Haringey
M	37.1	35.2	42.8
F	15.3	12.8	13.1
All deaths from chronic liver disease (2006-2008)			
	England	London	Haringey
M	14.06	14.51	19.26
F	7.26	5.89	5.46

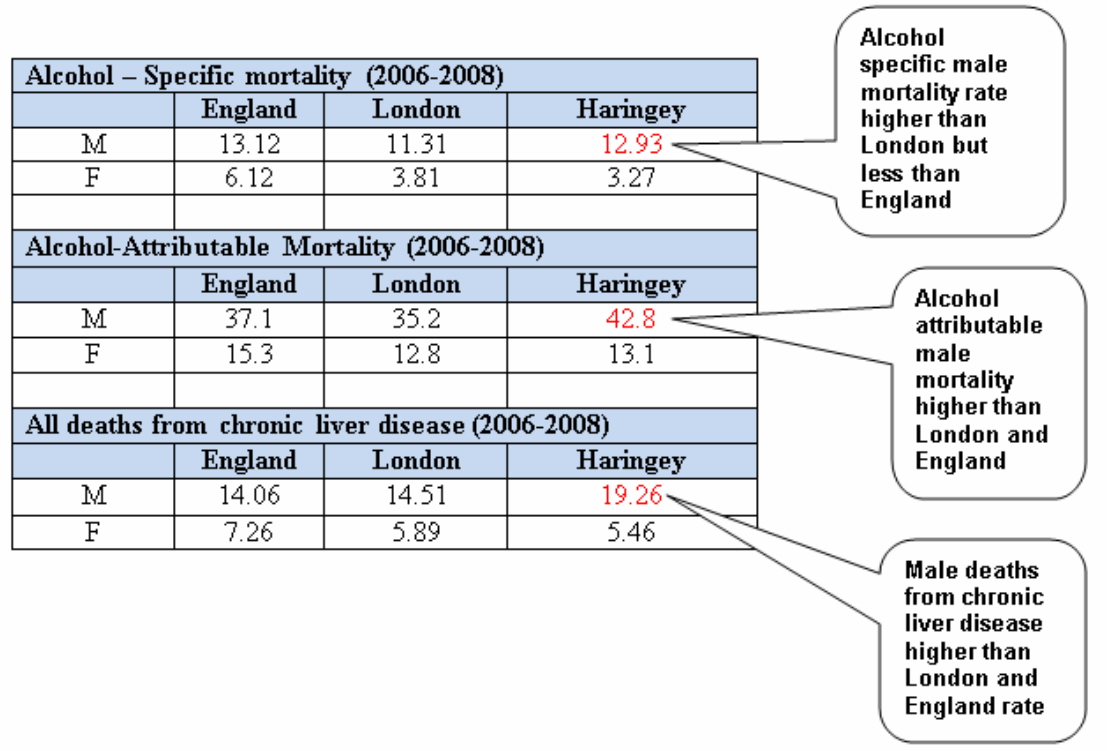
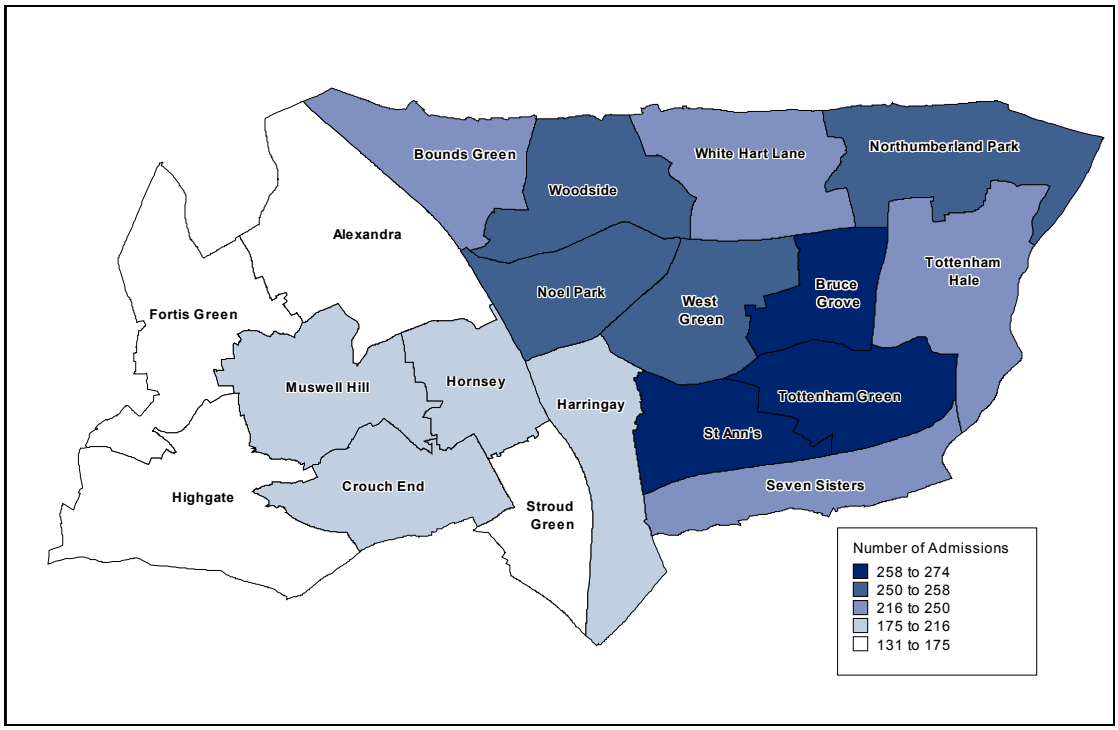


Figure 11 shows alcohol specific and attributable/related deaths by gender. If all alcohol attributable and alcohol specific deaths among men under 75 in Haringey were prevented, it is estimated that life expectancy at birth of men in the borough would increase by almost one year[viii]

Figure 12 shows an analysis on individual *patients* as opposed to *admissions* - Hospital Episode Statistics (HES) data. By analysing the individuals admitted as opposed to just the episodes (HES) we are able to more accurately understand where we need to target prevention activities. The data suggests that partially attributable admissions are more concentrated in the East in particular St Ann's. Tottenham Green and Bruce Grove. The picture is broadly similar for partially attributable admissions.

Table 4 number of *individual* male wholly attributable alcohol admission 2010/11

[viii] North West Public Health Observatory, 2011



Whilst Health Inequalities is a factor in alcohol use and young people in that, Looked After Children, School Excludees and children of substance misusing parents are more likely to develop alcohol and or substance misuse problems, it is not a leading cause of death amongst young people and is therefore not a feature of this paper.

Regulatory issues include: increasing availability of alcohol through off licences and low cost alcohol though supermarkets. Spot checks for underage sales in Haringey have a high failure rate (i.e. sales are made)

What should we be doing? What are we doing?

The work to tackle alcohol related harm in the borough is informed by the boroughs Alcohol Strategy and Action plan, overseen by the Alcohol Strategy Group and chaired by the lead member for Communities. The plan, as in previous years covers alcohol related health harms, community safety, and children and young people.

HINST is clear that key to reducing the life expectancy gap in Haringey, and in particular death from cardiovascular disease, is a reduction in the upward trend in alcohol related hospital admissions. The main evidence base for what works to prevent dependent drinking (and therefore improve life expectancy) is Identification and Brief Interventions (IBA)[46]. These interventions have traditionally been delivered in medical settings (Primary Care, A & E and certain wards). The plan is to extend IBA out into community settings.

In recognition that alcohol is often an contributing factor in the development of CVD, and as a further means of identifying those who are 'increasing and higher risk drinkers', the decision was made locally to incorporate alcohol screening into the local the NHS Health Checks programme in East Haringey (see section 3.2.5).

A programme of street outreach to traditional 'street drinkers' and work with Polish community through street outreach and liaison at North Middlesex A & E, is also an integral part of the prevention programme.

A pilot on the effectiveness of IBA in the workplace is currently being evaluated by Middlesex University (North London Hub Workplace IBA Pilot). Haringey was one of the boroughs to take part in this. Occupational health, HR and some Union representatives were trained in IBA .

Ex –service users have been trained in IBA and are now delivering this at some of the GP surgeries in the borough.

Alcohol enforcement: licensing applications are dealt with in accordance with statutory requirements. Spot checks are undertaken as with tobacco for underage sales. Counterfeit is common.

A range of universal prevention/early intervention and targeted prevention activities are in place for young people in the borough. This is supported by a dedicated Tier 3 service for those children who have started to develop substance misuse problems (Insight). The most effective means of preventing substance misuse problems in young people is by early assessment of risk of those most vulnerable. This is the approach adopted in Haringey by services working with vulnerable young people. Children of substance misusing parents are further supported by a service which works with them and their parents to reduce the harm caused by alcohol and drugs and attempt to impact on intergenerational substance misuse problems (COSMIC).

What more could we do?
Brief Interventions to be delivered in non-medical settings by groups of staff who may come into contact with those who are increasing or higher risk drinkers. This is in line with recent NICE guidance in this area[47] .
Targeted prevention – planned IBA training of staff working with Irish and Polish communities via Haringey's Irish centre and the PEEC.

Campaigning to make legislative changes in both alcohol and gambling availability.

Recommendations
1. Consideration should be given for making the pilot workplace IBA project a permanent feature of services offered by Occupational Health in the local authority (dependent in part on outcome of research).
2. To support the above: robust workplace policies on substance misuse need to be in place
3. Consideration should be given for including question on alcohol use in older people's assessment forms in adult social care (link to falls etc).
4. Consideration should be given for prioritising training of Key staff groups in IBA e.g. Safeguarding staff (First Response), Domestic Violence Staff, SOVA, Housing staff, Neighbourhood Action Officers, in order to extend range of places IBA can be delivered.
5. Further joining up work between physical activity and alcohol e.g. joint brief interventions work with alcohol IBA (see also section 3.2.5.) and propose the new leisure centre specifications include expectation that staff employed will be trained in IBA

Related documents
Alcohol Needs Assessment
Haringey's' Alcohol Strategy click on hyperlink: Dying For A Drink?

3.2.5 Generic prevention programmes

Lower socio-economic groups, certain BME groups and "vulnerable groups" such as those with mental health problems have a higher risk of most of the life style risk factors described above. A social gradient exists for each factor. There is commonality in approaches to reduce their prevalence including: brief interventions, awareness campaigns, regulatory mechanisms and changes to the physical environment.

Recommendations

1. Consider developing a generic approach to health improvement/prevention working with all partners across the range of approaches to include: alcohol, physical activity, obesity and tobacco control.
2. Work with social care and other key staff to support training in brief interventions, raising awareness of lifestyle factors and appropriate referral

Two programmes NHS Health checks and Health Trainers, are now described. They are key to addressing a number of lifestyle factors within Haringey and focus on the East of the borough.

3.2.5.1 NHS Health Checks

The NHS Health Checks programme is a key outcome in the Public Health Outcomes Framework. It aims to identify those at risk of vascular diseases: heart disease, stroke, diabetes and kidney disease, and to ensure appropriate advice, support and follow up. Those identified as high risk usually require medication and recall each year, others require lifestyle support and recall each five years. It is focused on those aged 40-74 years and is based upon good evidence of effectiveness and cost effectiveness. If delivered effectively it would have a major impact on inequalities in life expectancy.

What are we doing?

The programme commenced in Haringey in February 2010. So far more than 3500 people have been assessed by the programme. The majority of the Health Checks have been undertaken in primary care, with incentive payments, mainly in East Haringey. Others have been undertaken through a partnership with the British Heart Foundation targeting high risk groups in community centres and a one off event at World Stroke Day. Support to patients and staff within the Health Checks programme is provided as appropriate including: the Health Trainers services (see below), weight management vouchers, the exercise referral scheme and support from the stop smoking service. Training, IT and protocols support staff undertaking the checks.

What more could we do?

The programme has been well received by patients and staff. Recurrent funding is available, although further funding is required for full roll out. The programme will continue in primary care this year, mainly in the East. To maximise the impact of the programme it is essential that the public, particularly in high risk groups, take up the programme and are supported to make lifestyle changes or comply with medication as appropriate. The publicity, marketing and engagement with the communities about the primary care programme to date has been limited. It may also be helpful to pilot community based programmes in community or work place settings. Ultimately the programme needs to roll out to screen 9000 people per annum.

Recommendations

1) Engage key communities and publicise the programme to ensure uptake of the programme
2) Prioritise investment in lifestyle support services linked with this programme (see physical activity, obesity, stop smoking services above)
3) Link current health checks programmes e.g. in council staff, learning disability services with the formal NHS Health Checks approach in order to maximise outcomes from these health checks.
4) Develop community champions (volunteers) to support health trainers and promote key health messages

3.2.5.2 Health Trainers

The NHS Health Trainer initiative is a national programme, established in 2006. Health Trainers support local people who are in circumstances that put them at a greater risk of poor health. They are drawn from the communities within which they work or knowledgeable about the community. They are trained to use evidence-based techniques based on psychological evidence and theories to help people change behaviours that are known to cause ill-health. Health Trainers provide one-to-one advice, motivation and practical support to individuals in their local communities on how to make healthier lifestyle choices in the areas of smoking, alcohol use, physical activity and healthy eating. Their role involves working with clients to set goals and agree an action plan, using a client-centred approach. They also monitor and review client progress and revise plans when necessary.

What are we doing now?

The Haringey Health Trainer Service was established in 2009 and is a key initiative through which to address health inequalities. It operates in the East of the borough out of a range of community and primary care venues. Haringey health trainers are drawn from local communities and have been trained in line with national standards and have ongoing supervision and training. They give advice and support, raise awareness about health issues and refer to local services as appropriate.

What more could we do?

The service has recently changed management and is being relaunched. It is important that this service is used to capacity by target groups for one to one support. It would be useful to develop a pathway to support lifestyle change and promote health: community champions who market local health improvement programmes and raise awareness of signs and symptoms of illnesses; health trainers who give basic one to one support in

life style change; more specialist lifestyle support e.g. stop smoking services, exercise referral.

Recommendations

1. Council staff to publicise and refer target groups to the Health Trainers service
2. Consider developing a whole system approach or pathway for health improvement locally including training and education of residents from local communities. This could be taken forward with partners e.g. Tottenham Hotspur Foundation

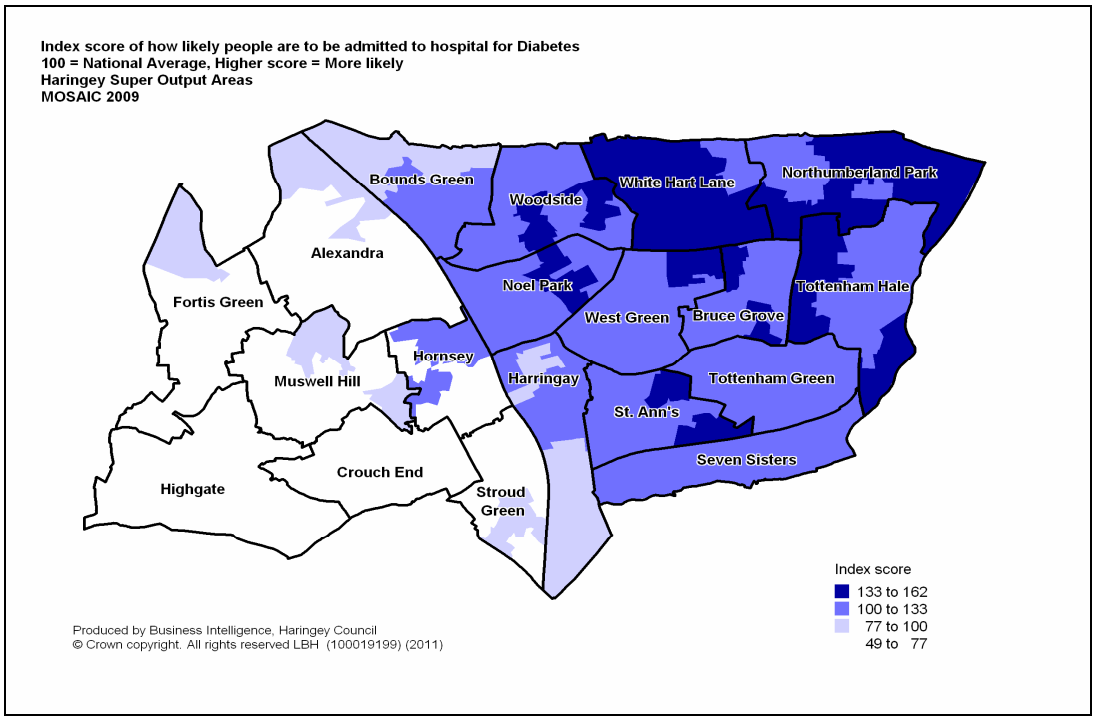
3.3 Early intervention (adults over 40)

As demonstrated above in "the scarf" in Figure 3, CVD and cancer are major contributors to the life expectancy gap. Additional long term conditions that contribute to the gap are diabetes and COPD (an important respiratory disease). Diabetes is important both as a risk factor for heart disease and stroke and prevalent in its own right particularly within BME (including South Asian and Black) groups and deprived groups. Evidence suggests that the activities that support early intervention of these long term conditions are some of the most cost effective and effective interventions to impact on the Life Expectancy Gap, particularly within the short term[4, 5] . Local information shows under-diagnosis of many of these diseases and their risk factors, high rates of admissions, and other indicators suggesting late diagnosis (e.g. indicators of poor diabetic control, poor cancer survival). Many of these indicators are worse in East Haringey than West and amongst lower socio-economic groups or BME groups. Figure 13 shows diabetes admissions are much higher in East than West Haringey. A systematic approach to diagnosis and treatment is required to tackle the socio-economic gradient and reduce inequalities in outcomes.

National guidance suggests efforts to encourage early intervention and thus reduce the Life Expectancy Gap should focus on the over 40s. This is consistent with the Haringey picture where the majority of the life expectancy gap is in the over 40s (as shown in Figure 3).

Early intervention is mainly within the remit of the NHS. However, there are key opportunities for the Council, partners and communities to engage in this and thus scale up the impact on target groups. This section gives a brief overview and makes recommendations for the Council to consider.

Figure 13: Estimated diabetes admissions in Haringey



Source: Mosaic

3.3.1 Heart disease, stroke, diabetes and lung disease

What should we be doing?

- Raise awareness/community engagement regarding signs and symptoms of disease[4]
- Early detection: use of primary care disease registers, case finding. Early management of disease and risk factors e.g. treat atrial fibrillation (irregular pulse rate), high blood pressure (good evidence of effectiveness), control of blood sugars in diabetics and steroids in COPD.
- Secondary prevention e.g. promote healthy life-styles in those who are already ill e.g. cardiac rehabilitation, smoking cessation in COPD, weight management in diabetics.
- Modelling, analysis and understanding of rates of detection and management of disease and risk factors within the population

What are we doing

- Primary prevention – see section 3.2 above
- Community awareness raising: FAST campaign for stroke. Haringey, in partnership with Diabetes UK has trained up community champions to undertake risk assessments and raise awareness of diabetes in at risk communities.
- Early detection: actions to increase atrial fibrillation and high blood pressure diagnosis. NHS Health Checks (see above). COPD early case finding via the stop smoking service and additional training (Warwick training) and ongoing educational programmes for GPs in diabetes management, including in North East Haringey.
- Secondary prevention: cardiac rehabilitation programme, exercise referral programme for people with long term conditions in East Haringey
- Diabetes epidemiological needs assessment undertaken

- Awareness raising and generic health checks for people with Learning Disability to identify risk factors and disease early and to educate

What more could we do

- Further engage with the council in awareness raising campaigns and opportunities for early detection of these diseases
- Work in partnership to promote secondary prevention advice e.g. brief intervention and appropriate referral for lifestyle advice.
- Scale up effective interventions in primary care to ensure early intervention particularly in those most at risk
- Sustain the exercise referral campaign (threatened through loss of ABG funding)
- Development of self-management programmes, particularly in target groups following a gap in the service.
- More intelligent use of information to target groups or areas with delay or underdiagnosis and inequity in service access (recommended in Haringey HINST review)
- Educate council employees of their own risks and early signs and symptoms of heart disease and stroke.

Recommendations

1. Support community engagement to raise awareness of early signs and symptoms, particularly in at risk communities
2. Training and education of council staff e.g. social care staff to raise awareness of early signs and symptoms and encourage self management and referral as appropriate, particularly in high risk target groups
3. Training and education of council staff to undertake brief interventions for life style change particularly in target groups
4. Council, NHS and partners to work in partnership to develop local intelligence to identify needs and target groups to target early interventions
5. Work with occupational health to develop educational programmes to raise awareness within council employees of early signs and symptoms of key long term conditions

Related documents

Diabetes Needs Assessment
Stroke Needs Assessment

3.3.2. Cancer

Cancer mortality contributes to 25% of gap in Life Expectancy between Haringey and England (see Figure 3 above). Of this, lung cancer mortality in Haringey is responsible

for approximately 6% of the life expectancy gap, bowel cancer 4% (mortality rate significantly higher than England) and breast cancer mortality approximately 0.5-1%. After smoking, the biggest impact on mortality is late diagnosis of cancer. Therefore lives can be saved by earlier diagnosis – particularly breast, colorectal and lung[4] . Survival rates for breast cancer are linked to deprivation[48] , with lower SEG having poorer survival (even for breast cancer). Local data shows that screening uptake varies by GP and by population group. Cancer screening programmes show some link with deprivation with lower uptake of screening programmes in more deprived groups (a strong link for bowel screening shown in local Mosaic and social marketing research) and certain ethnic minority groups have lower uptake of screening programmes[49].

What should we be doing?

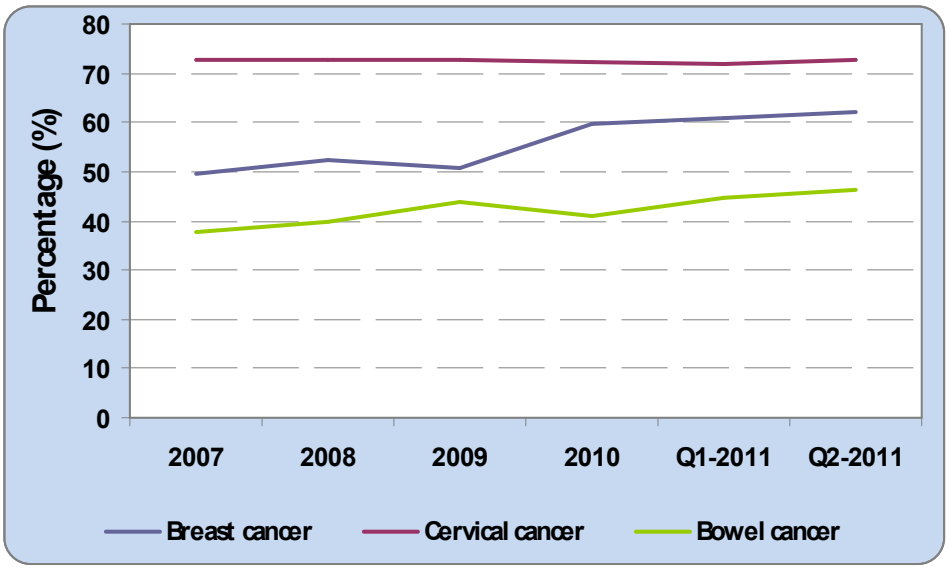
In addition to addressing lifestyle factors (section 3.2 above), key actions to address inequalities in cancer mortality include:

- Raise awareness of symptoms and signs of cancers and importance of Cancer screening programmes through community engagement programmes, media, advertising campaigns – particularly aimed at target groups
- Early detection of cancer through- engagement with primary care in early diagnosis and management of cancers
- Improving uptake of cancer screening programmes (breast, bowel and cervical), aimed at reducing incidence and mortality from cancers, particularly in target groups.
- Use of intelligence and audits to identify target groups e.g. areas/populations where late presentation of cancers impact on survival and cancer screening uptake poor.

What are we doing?

- "Haringey Life Savers" works with 4 GP practices and community groups in high prevalence areas to raise awareness and encourage early diagnosis of the four common cancers. A similar recently established programme focuses just on bowel cancer and bowel cancer screening in the East, working with the Tottenham Hotspur Foundation. A recently appointed GP lead for cancer is working with GPs to support early diagnosis based upon information from profiles of cancer by GP practice.
- Uptake in breast and bowel cancer screening has improved in recent years (see Figure 14 below). Social marketing, mosaic information is informing and a recent health equity audit on breast cancer screening are informing local action plans to increase uptake of breast, bowel and cervical cancer screening programmes. These include a health trainer working specifically on this issue in Haringey.

Figure 14: Cancer screening uptake in Haringey (2007-2011)



Source: NHS Haringey

What more could we do?
Most of the projects above are based upon external, short term funding. Whilst these are appropriately targeted and achieving good outcomes, a more systematic, scaled up and sustainable approach is required across primary care, community care and communities to maximise the impact on inequalities in cancer outcomes.

Recommendations
1. The council staff and communications support programmes to raise awareness of early signs and symptoms of common cancers and cancer screening programmes in target groups, informed by local information.

Related documents
GP Profiles for Cancers in Haringey
Haringey cancer needs assessment (draft)
Breast Cancer Screening Overview and Scrutiny Review http://www.haringey.gov.uk/index/council/decisions/overview_and_scrutiny/scrutiny_reviews/scrutiny-reviews-2009-10.htm

3.4 Seasonal excess deaths.

Seasonal excess deaths are deaths in excess of the annual average and most typically occur in winter. However, seasonal excess deaths can arise at other times, for example during periods of very hot weather.
Excess winter deaths are mainly due to respiratory, cardiovascular causes, and infectious diseases including seasonal flu. Excess winter deaths tend to be observed in older people, and those who are socially isolated or live alone. People, who live in more deprived areas, or those who are unemployed, may additionally be at risk of fuel

poverty. There are, on average, 50-55 excess deaths every winter in Haringey with excess winter mortality index[ix] well below London and England.

What should we be doing? What are we doing?
Work to tackle excess seasonal deaths in Haringey was reviewed by the National Support Team for Health Inequalities in October 2009.

A range of positive interventions and good practice were identified including:
- Development of 'Affordable Warmth Strategy'
- Comprehensive cover for the Community Matron services;
- The use of assistive technology such as Telehealth & Telemedicine;
- Social housing in the Borough has been mapped and used when accessing the focus of certain targeted activity/campaigns;
- Year on year increased coverage of seasonal flu vaccinations;
- Thermal image photography of the whole Borough.

Since then further action, in line with the identified good practice has progressed:
- Affordable Warmth Strategy launched November 2009. Delivery group has been set up which includes representatives from: Housing Associations, Utility Companies, Homes for Haringey, Age Concern and Haringey Forum for Older People
- Promoting the take up of Warm Front scheme by eligible Haringey residents: 981 households provided with £787,629 worth of heating & insulation measures in 2010/2011
- "RE:NEW" demonstration project in Bruce Grove & West Green. This is a project to improve energy efficiency in vulnerable households. 527 households have been provided with £125,000 worth of energy saving measures
- Warmth and Comfort scheme: funded by Targeted Funding Stream monies from Government via North London sub region it provided heating upgrades / new systems to vulnerable clients. 226 households provided with £408,000 worth of heating and insulation measures in 2009/2010
- Decent Homes Scheme: funded by Targeted Funding Stream monies from Government via North London sub Region. 123 vulnerable households provided with £238,000 worth of improvements to bring their accommodation up to the Decent Homes standard in 2010/2011
- Web pages are maintained to provide up to date information for residents
- Training provided to staff – e.g course being delivered on assisting residents with fuel debt

What more should we be doing?
The following actions are in development:
- Putting together a database which will contain details of all the various energy efficiency and heating improvement schemes that have been operational throughout Haringey in the past ten years. This will be on line and accessible by a number of organisations

[ix] The excess winter mortality index = (EWM / average non-winter deaths) x 100. The EWM index shows the percentage increase for deaths in winter months compared to average summer deaths. It is calculated so that comparisons can be made between gender, age groups and regions.

- Ensure that the profile of fuel poverty remains high within Haringey, particularly given the number of vulnerable residents in the borough and the speed with which fuel prices have increased and will continue to increase . For example through: staff briefings and updates, promotion and publicity activities
- Contributing to the London Assembly investigation into Fuel Poverty
- Implement a scheme similar to the Seasonal Health Interventions Network (SHINE) in Islington. Current intention is to work initially with the Whittington Hospital and roll out to other hospitals in the future
- Seek to work with GP surgeries throughout the borough to identify people and provide assistance, hence averting their admission to hospital.
- Strengthen links between Public Health, NHS, council departments and voluntary sector to promote key messages to vulnerable people

Recommendations

1. Further data analyses to be performed to identify those at highest risk of excess winter deaths locally;
2. There are a number of 'registers' of vulnerable people being drawn up by different agencies/professional services. A 'list of lists' (i.e. an overview of who is the key contact in a locality/cross District in relation to specific groups of vulnerable people) would be an important strategic resource
3. Agree and promote key messages to vulnerable groups across agencies.

4. Conclusion

This paper presents the evidence, and proposes recommendations to tackle the life expectancy gap in Haringey. The recommendations are for consideration and to inform priority actions for the developing Health and Well Being Strategy.

Key themes emerge throughout this paper. These include:

- The importance of strong leadership, governance and strategy[4]. This includes working in partnership to maximise collective use of resources
- Better use of health intelligence e.g. mosaic, service audits, needs assessments to target interventions appropriately and monitor their impact
- Allocate resources and interventions to tackle the socio-economic gradient and address inequalities in key target groups
- A whole system, partnership approach to prevention e.g. health service, transport planners, trading standards, leisure and other partners including voluntary sector work together
- An important role for the council in early intervention e.g. raising awareness and early onward referral of long term conditions
- A joined up approach to prevention, for example brief intervention training across alcohol, physical activity, obesity for a wide range of staff and volunteers

Acknowledgements

My thanks go to the many who have contributed to this document including: Keith Betts, Dr Vanessa Bogle, Tristan Brice, Anne Daley, Dr Jeanelle De Gruchy, Marc Dorfman,

Tamara Djuretic, Joan Hancox, John Hathers, Andrea Keeble, Liz Marnham, John Morris, Marion Morris, Susan Otiti, Lisa Redfern, Graeme Walsh, Fiona Yung

Dr Fiona Wright, Assistant Director of Public Health, Haringey
11th July 2011

REFERENCES

[1] Fair Society, Health Lives: The Marmot Review. 2010.
[2] Towards a Health Inequalities Strategy. Paper for CEMB. Haringey Council. 2010.
[3] Department of Health, National Service Framework for Mental Health, 1999. London: Department of Health, 1999..
[4] Redoubling Efforts to achieve the 2010 National Health Inequalities Life Expectancy Target. Resource Pack. Department of Health. March 2010.
[5] Five Year Strategy 2009-2013. NHS Nottingham City.
[6] Cross Cutting Review on Health Inequalities. Department of Health, 2002.
[7] Meltzer, H. OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1 the prevalence of psychiatric morbidity amongst adults living in private households. London : HMSO , 1995)
[8] Health Survey for England 2006-8
[9] Smoking Cessation in primary care, pharmacies, local authorities and work places, particularly for manual working groups, pregnant women and hard to reach communities. NICE, 2008).
[10] Curtis and Netten, 2006.
[11] Working with Black and Minority Ethnic Communities,: A guide for Stop Smoking Service managers, Department for Communities and Local Government)
[12] The Need for Effective Mass Media Pubic Education Campaigns As Part of Comprehensive Tobacco Control Programs, www.stopsmokingcampaigns.org.uk , 2007) NICE PH 10.
[13] Health: Everyone's Business (2010), A Report of the Overview and Scrutiny Committee, Haringey Council, March 2011.
[14] World Health Organization. (2002). *World health report*. Geneva: World Health Organization.
[15] Department of Health. (2004). *At least five a week. Evidence on the impact of physical activity and its relationship to health*. Department of Health. London.
[16] Department of Health. (2000a). *National Service Framework: Coronary Heart Disease*. Department of Health. London
[17] Sport England (2010). Active People Survey 4. http://www.sportengland.org/research/active_people_survey/active_people_survey_4.aspx)
[18] Health Development Agency (2005). *The effectiveness of pubic health interventions for increasing physical activity among adults: a review of reviews. Evidence briefing summary*. Health Development Agency.
[19] National Institute for Health and Clinical Excellence. (2006). *Four commonly used methods to increase physical activity. http//www.nice.org.uk/Guidance/PH2*

[20] Department of Health. (2007). *Department of Health statement on exercise referral (March 2007)*. http://dh.gov.uk/en/publicationsandstatistics/Bulletins/theweek/Chiefexecutivebulletin/DH_072874.

[21] National Institute for Health and Clinical Excellence. (2008). Promoting physical activity in the workplace. http://www.nice.org.uk/PH13

[22] National Institute for Health and Clinical Excellence. (2008). Physical activity and the environment. http://www.nice.org.uk/guidance/PH8

[23] DS Morrison, M Pettigrew, H Thomson "What are the most effective ways of improving population health through transport interventions? Evidence from systematic reviews, JECH, 2002. (there may be something more recent)
[24] Sustainable Development Commission "Fairness in a Car-dependent Society" 2011
[25] World Health Organisation, (2003). Obesity and overweight. Geneva: WHO.

[26] Jebb S (2004) Obesity: causes and consequences. www.medicinepublishing.co.uk/resources/sample_pages/wohm.1.1.38.pdf

[28] Canoy, D. and Buchan, I. (2007). Challenges in obesity. Short Science Review. Foresight Tackling Obesities: Future Choices. *Obesity Reviews, 8(s1)*, 1-11 (htpp://www.foresight.gov.uk)

[29] Reilly, J., Dorosty, A., and Emmett, P. (1999) Prevalence of overweight and obesity in British children: Cohort Study. *British Medical Journal, 319*, 1039.

[30] McPherson, K., Marsh, T. and Brown, M. (2007). Modelling Future Trends in Obsity and the Impact of Health. Foresight Tackling Obesities: Future Choices. http//www.foresight.gov.uk.

[31] HM Government. (2008). *Healthy weight, healthy lives: A cross-government strategy for England.* HM Government, London.

[32] Foresight. (2007). *Tackling Obesities: Future Choices* http://www.foresight.gov.uk/Obesity/Obesity_final/index.html.

[3] National Audit Office, (2001). Tackling Obesity in England. London: TSO.

[344] Department of Health, (2004). Choosing health: Making healthy choices easier. London: Department of Health.

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

[36] Reilly, J., Dorosty, A. and Emmett, P. (1999). Prevalence of Overweight and Obesity in British Children: Cohort Study. British Medical Journal, 319(7216): 1039.

[37] Avenell, A., Broom, J., Brown. T. J., Poobalan, A., et al. (2004). Systematic review of the long-term effects and economic consequences of treatments for obesity and implications for health improvement. Health Technology Assessment. 8(21): 1-473.

[38] NHS Health and Social Care Information Centre. (2005). Health Survey for England 2004: The health of ethnic minority groups – headline tables. London: NHS Health and Social Care Information Centre.

[39] Sproston, K., Primatesta, P. (eds) (2004). Health Survey for England 2003. Volume 2: Risk factors for cardiovascular disease. London: TSO.

[40] Department of Health. (2006). Choosing Health: Supporting the physical health needs of people with severe mental illness. Commissioning framework. London: Department of Health

[41] Health Development Agency. (2003). *The management of obesity and overweight An analysis of reviews of diet, physical activity and behavioural approaches Evidence briefing.* Health Development Agency.

[42] National Institute for Health and Clinical Excellence (NICE), (2006). Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children. London: NICE. www.nice.org.uk/guidance/CG43

[43] Foresight Tackling Obesities: Future Choices – Project Report. Government Office of Statistics. 2007

[44] HM Government (2007) Safe, Sensible, Social: The next steps in the national Alcohol Strategy. London

[45] White I, Altman D, Nanchahal K. Alcohol consumption and mortality: modelling risks for men and women at different ages. Br Med J 2002; 325

[46] Moyer A et al (2002) Brief Interventions for alcohol problems: a meta analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations. Addiction: March: 97 (3):279-92

[47] Public Health Guidance 24: Preventing the development of hazardous and harmful drinking NICE 2010

[48] www.statistics.gov.uk

[49] NHS Haringey Breast Screening Programme: Health Equity Audit, March 2010