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

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Summary

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

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

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

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

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

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

Key cross cutting issues for the plan emerged as follows:

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

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

These domains are

Smoking

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

Physical activity

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

Diet and nutrition

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

Access to health services

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

Accidents

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

Suicide

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

Infant mortality

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

Homes

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

Employment

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

Education

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

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

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

1.1 Introduction

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

1.2 National policy context

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

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

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

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

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

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

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

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

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

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

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

1.3.1 PSA targets

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

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

1.3.2 Enhanced targets for spearhead areas

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

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

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

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

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

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

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

1.3.3 Local Area Agreement (LAA) Mandatory and Stretch Targets

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

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

1.4 Background to Life Expectancy

1.4.1. What is life expectancy?

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

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

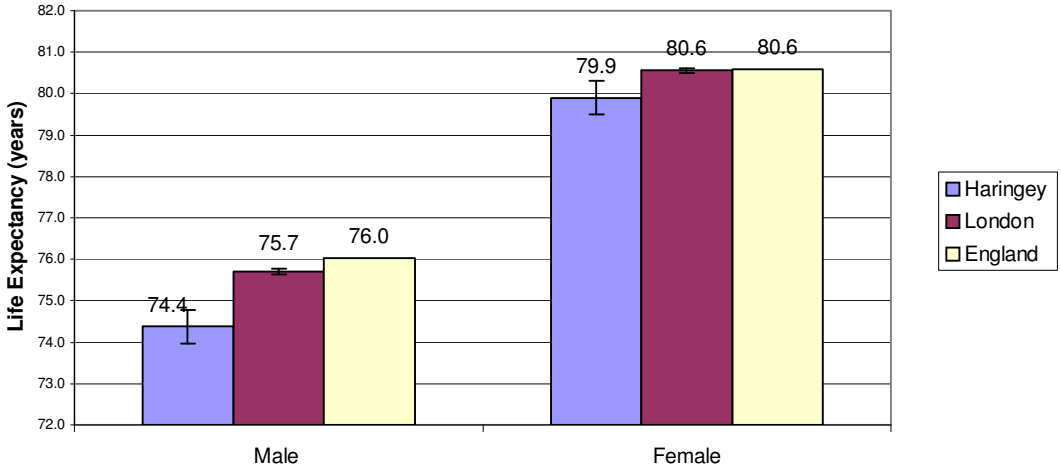
1.4.2 What is the current life expectancy in Haringey?

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

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

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

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

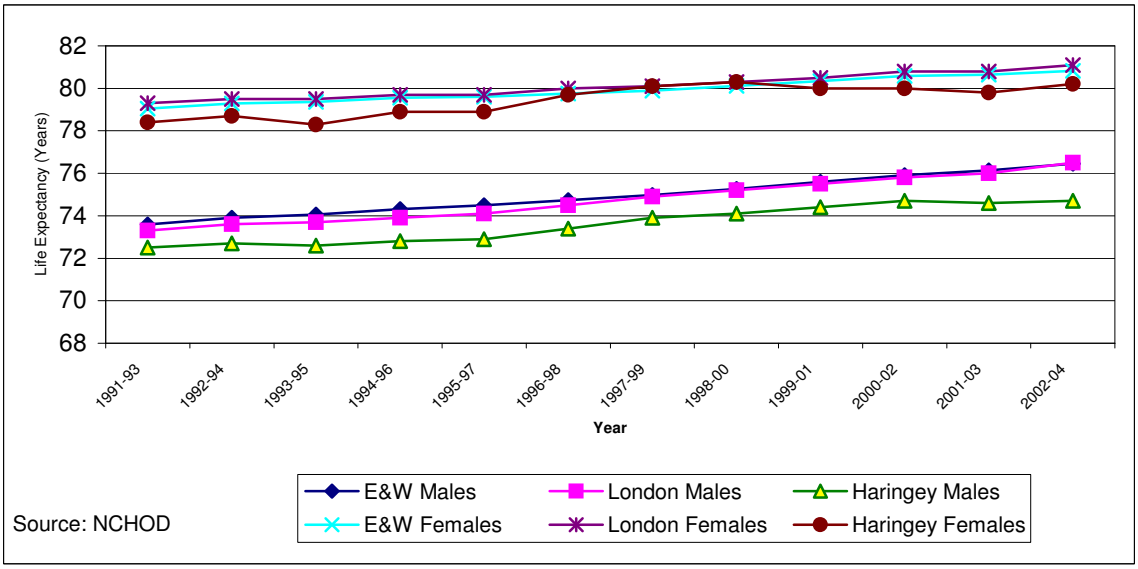


between the figures for Haringey and London are real and not due to chance year-by-year variations in death rates.

1.4.3 Is life expectancy in Haringey improving?

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

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



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

1.4.4 Does life expectancy vary within Haringey?

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

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

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

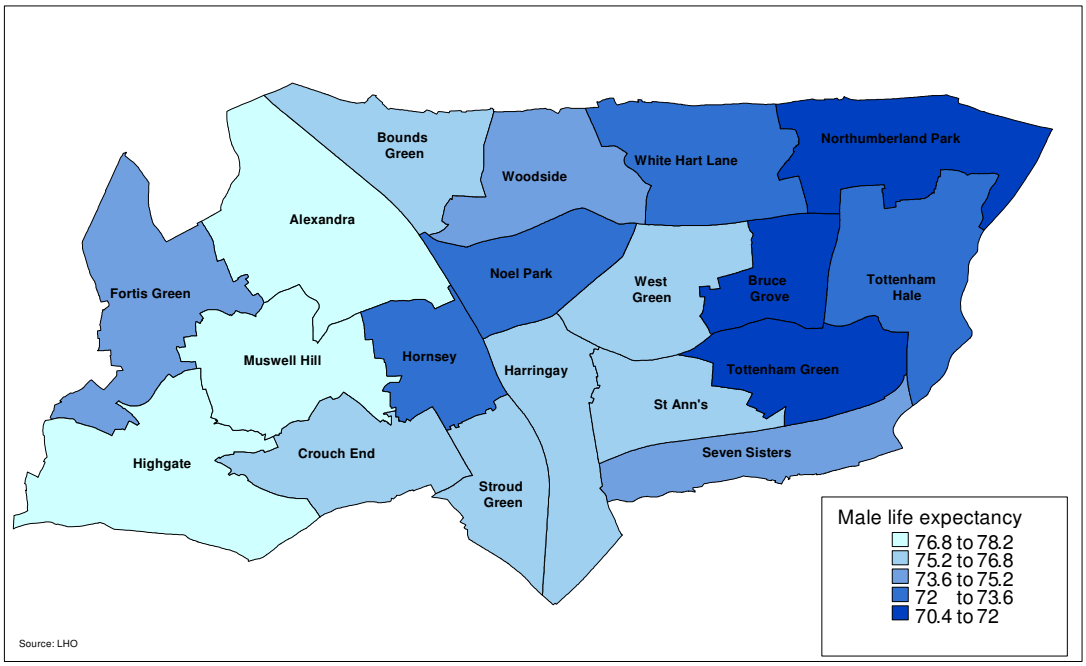
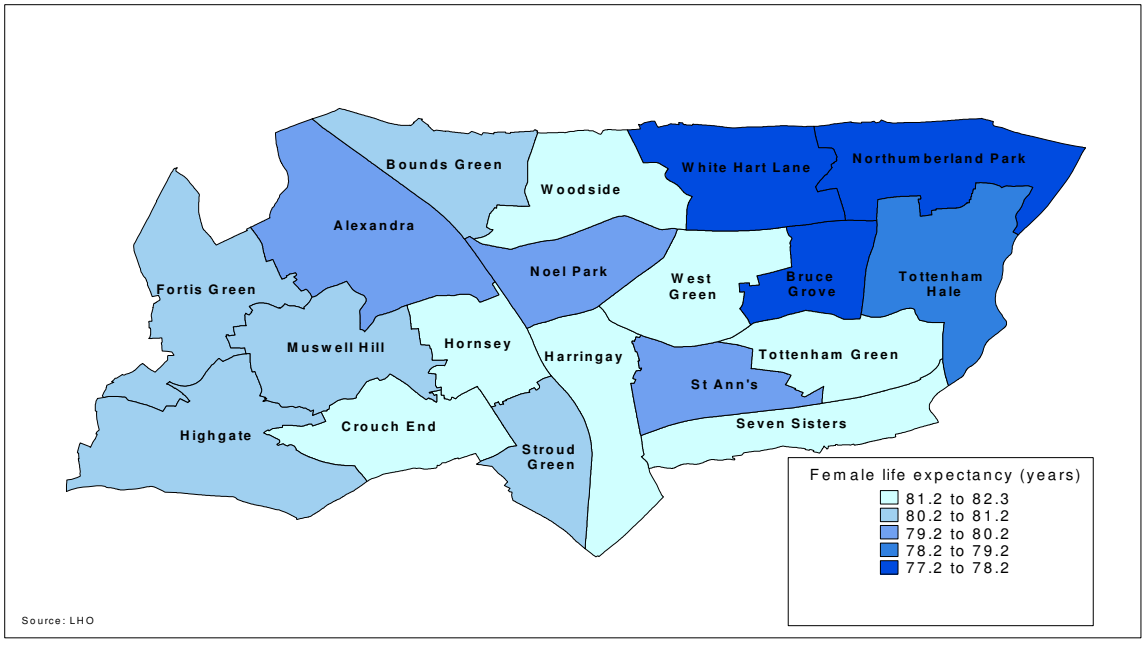


Figure 4 shows the variation in female life expectancy between wards in Haringey. There is only a weak relationship between female life expectancy and deprivation, and this is not statistically significant.

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



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

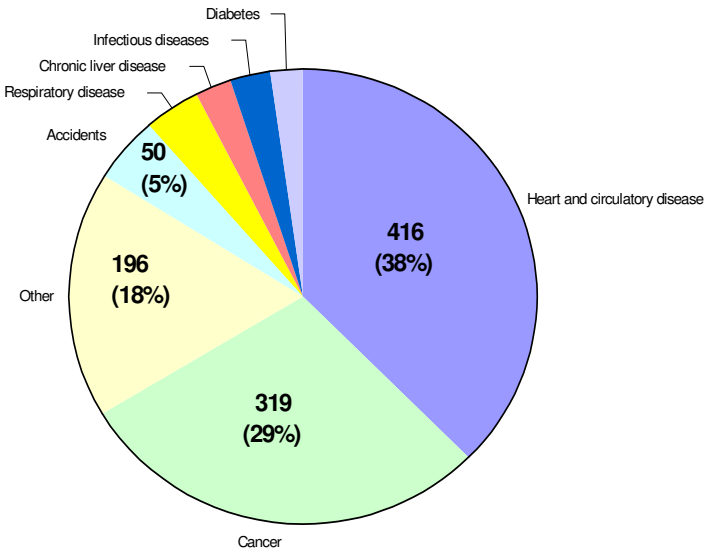
association between deprivation and health risk behaviours in men than women, or because men with poor health may be more likely to migrate to more deprived areas.

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

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

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

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



premature deaths in Haringey.

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

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

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

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

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

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

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

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

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

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

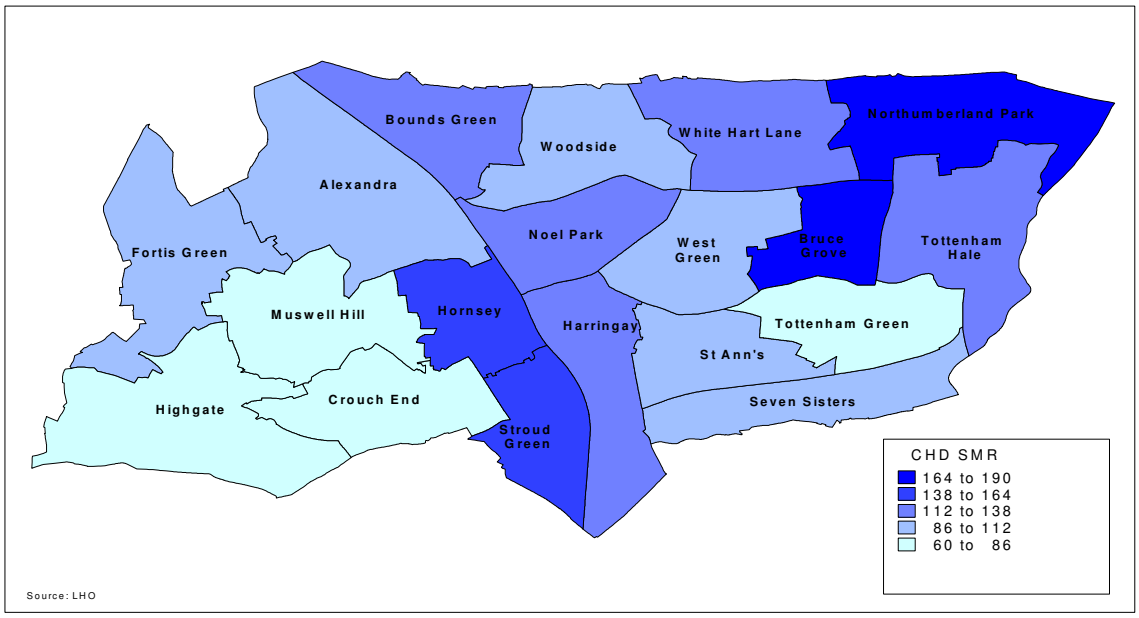
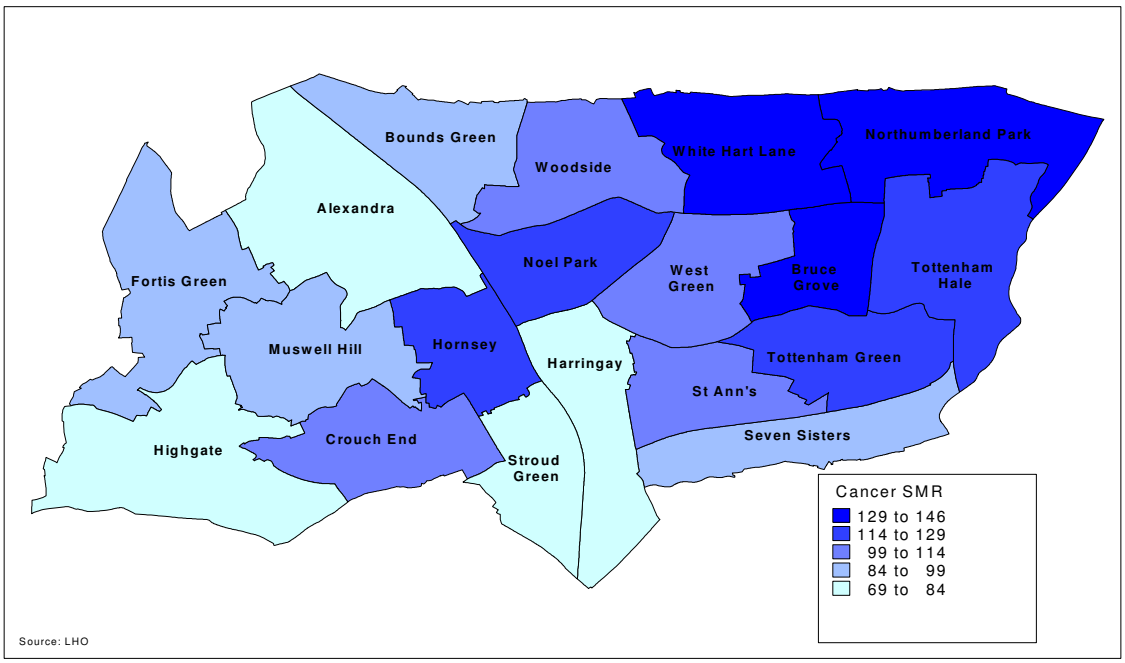


Figure 7 shows the Standardised Mortality Ratio for cancer for persons aged under 75 years by ward. Again, there is a statistically significant relationship between SMR for cancer and ward-level deprivation in Haringey.

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



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

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

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

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

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

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

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

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

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

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

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

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

Section 2. Action Plan

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

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

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

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

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

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

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

The details of these plans follow on the next pages.

SMOKING

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

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

Initiatives To Reduce The Prevalence Of Smoking

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

Stop Smoking Initiatives

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

PHYSICAL ACTIVITY

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

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

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

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

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

FOOD and NUTRITION

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

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

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

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

CARDIOVASCULAR DISEASE

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

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

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

SECONDARY PREVENTION

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

TERTIARY PREVENTION (Treatment & Rehabilitation)

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

CANCER

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

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

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

SECONDARY PREVENTION

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

TERTIARY PREVENTION (Treatment, Rehabilitation & Palliative Care)

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

ACCIDENTS

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

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

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

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

SUICIDE

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

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

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

ACCESS TO HEALTH SERVICES

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

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

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

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

INFANT MORTALITY

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

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

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

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

HOUSING

Objective: (inc. PSA & local targets)

By 2010, bring all social housing into a decent condition with most of this improvement taking place in deprived areas, and for vulnerable households in the private sector, including families with children, increase the proportion who live in homes that are in decent condition (ODPM PSA7).

LAA target: Safer and Stronger Communities Block

As part of an overall housing strategy for the district ensure that all social housing is made decent by *2010,* unless a later deadline is agreed by DCLG as part of the Decent Homes programme**.**

Increase domestic fire safety and reduce arson

Healthier Communities and Older People Block

Improve living conditions for vulnerable people ensuring that housing is made energy efficient, decent and safe

Sub-outcomes

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

Current situation

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

(NB Action plan to be confirmed following consultation with Better Places Partnership)

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

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

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

EMPLOYMENT

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

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

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

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

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

EDUCATION

Objective: (inc. PSA & local targets)

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

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

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

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

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

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

Current situation

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

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

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

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

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