Haringey Council

NHS

North Central London

Haringey's Health and Wellbeing Strategy

2012-2015

www.haringey.gov.uk/hwbstrategy

Document control

Document details	
Document name	*Haringey's Health and Wellbeing Strategy 2012-2015*
Document version number	*1.0*
Document status	*Live*
Author	*Susan Otiti, Fiona Wright, Marion Morris,* *Nicole Klynman, Chandraa Bhattacharya* *Public Health Directorate, Haringey Council/ NHS North Central London* *Jodie Szwedzinski, Helena Pugh, Alex Grear,* *Liz Marnham* *Policy and Equalities Team, Chief Executive's Service, Haringey Council*
Lead Officer	*Jeanelle de Gruchy, Director of Public Health , Haringey Council/NHS North Central London 020 8489 5119*
Approved by	*Shadow Health and Wellbeing Board (sHWB)*
Scheduled review date	*April 2013*

Version history

Version	Change/Reasons for Change	Date
V0.1	*Summary Strategy*	*20th September 2011*
V0.2	*Initial draft of full strategy*	*30th November 2011*
V1.0	*Final*	*5th May 2012*

Approval history

Version	Approving body	Date
V0.1	*Health and Wellbeing Board Executive*	*12th September 2011*
V0.2	*Health and Wellbeing Board Executive*	*22nd November 2011*
V1.0	*Shadow Health and Wellbeing Board*	*21st May 2012*

Contents

Executive summary

This strategy has been developed by Haringey's shadow Health and Wellbeing Board (sHWB). It is our overarching plan to improve the health and wellbeing of children and adults in our borough and to reduce health inequalities between the east and west of the borough.

The **vision** of this strategy is:

A Healthier Haringey –
We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life.

The focus for this strategy is predominantly on the health and social care related factors that influence health and wellbeing. The important underlying determinants of health and wellbeing are addressed through other key strategies.

Informed by our Joint Strategic Needs Assessment (JSNA) www.haringey.gov.uk/jsna and in consultation with residents, strategic partners and other stakeholders, we have identified the delivery of three outcomes, with related priorities, to achieve our vision. A summary of key actions, measures and programmes of delivery are at the back of the strategy for easy reference.

Outcomes	Priorities
1. Every child has the best start in life	1. Reduce infant mortality 2. Reduce teenage pregnancy 3. Reduce childhood obesity 4. Ensure readiness for school at 5 years
2. A reduced gap in life expectancy	5. Reduce smoking 6. Increase physical activity 7. Reduce alcohol misuse 8. Reduce the risk of cardiovascular disease (CVD) and cancer 9. Support people with long term conditions (LTC)
3. Improved mental health and wellbeing	10. Promote the emotional wellbeing of children and young people 11. Support independent living 12. Address common mental health problems among adults 13. Support people with severe and enduring mental health needs 14. Increase the number of problematic drug users in treatment

This strategy emphasises the importance of partnership working and joint commissioning of services to achieve a more focused use of resources and better value for money. It is based on the principles of prevention and early intervention, 'think family' and ensuring choice, control and empowerment of our residents.

The strategy will be monitored and reviewed on a six monthly basis by the sHWB and revised annually.

Foreword

We believe that everyone has the right to enjoy good health and wellbeing. However, many of our residents do not experience this and there are large inequalities across the borough. Residents in the poorest parts of Haringey are not only more likely to die early but they will also spend a greater proportion of their shorter lives unwell. We understand that to reduce these health inequalities we need to focus not only on health, but also reducing inequalities in socio-economic circumstances and opportunity, particularly education and employment.

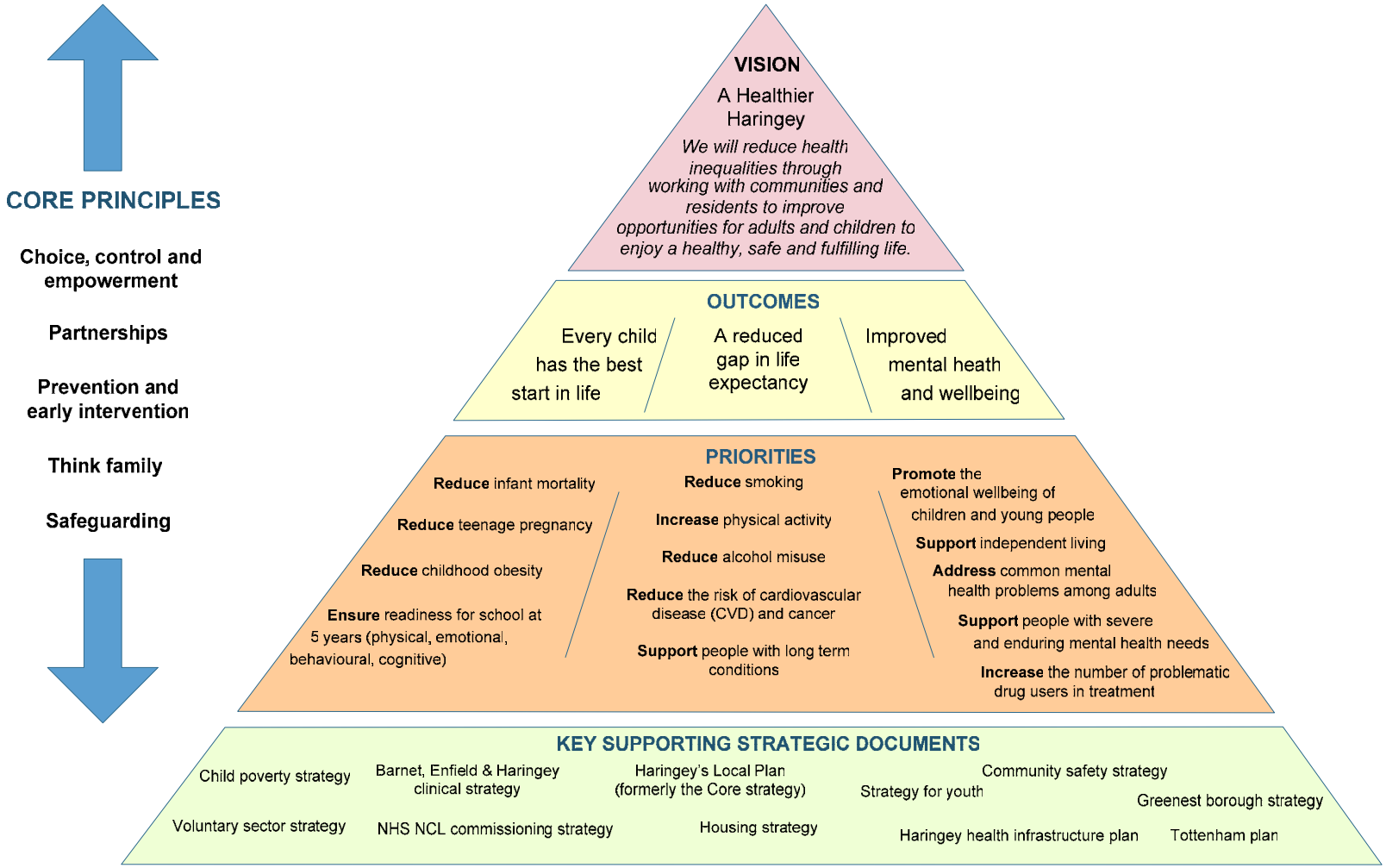
We know we face real challenges in overcoming these deep-seated issues, but we must all be ambitious in our thinking and in our desire for change. Through the Health and Wellbeing Board we aim to enhance joint working and fresh approaches. We know it will be increasingly difficult but the benefits are substantial.

We continue to make significant investment in improving health and wellbeing locally and, as a result, we have a lot to be proud of. There has been a steady decline in deaths of babies under one year old; women's life expectancy is above the England average; and educational attainment has continued to rise throughout the borough. This strategy sets out how we want to build on these successes over the next three years, working in partnership across Haringey and moving further towards the goal of good health and wellbeing, something that every resident can aspire to and enjoy.

Good health and wellbeing is in everyone's interest, is everyone's responsibility, and requires everyone to play their part.

Councillor Dilek Dogus
Cabinet Member for Health and Adult Services

Dr Helen Pelendrides
Chair, Haringey Clinical Commissioning Group



Haringey's Health and Wellbeing strategy

1. Achieving our vision

The vision of this strategy is:

A Healthier Haringey

We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life.

Informed by our Joint Strategic Needs Assessment (JSNA) (www.haringey.gov.uk/jsna), we have prioritised the delivery of three outcomes to achieve our vision:

1. **every child has the best start in life**
2. **a reduced gap in life expectancy**
3. **improved mental health and wellbeing**

The 'pyramid' diagram captures our approach, including our 14 priorities to deliver these outcomes. Partnership working and joint commissioning of services is key to delivery, as are the principles of prevention and early intervention, 'think family' and ensuring choice, control and empowerment of our residents. Tables that set out the outcome, priorities, key actions, measures and programmes of delivery are in appendix 4. We will work to detailed delivery plans in each of these programmes.

2. Scope and purpose of this strategy

This strategy sets out to improve the health and wellbeing of children and adults in our borough and reduce health inequalities between the east and west of the borough. The strategy:

- incorporates the health and wellbeing priorities of the Children and Young People's Plan 2011 review
- replaces the Wellbeing Strategic Framework which aimed to improve wellbeing and tackle health inequalities among adults in Haringey (expired in 2010)
- incorporates Experience Still Counts, our strategy for improving the quality of life for older people (2009-2012).

This strategy focuses predominantly on the health and social care related factors that influence people's health and wellbeing. We understand how important the underlying determinants of health and wellbeing are in ensuring '*A Healthier Haringey*'; these are addressed through other key partnership strategic documents. Links to other strategies are noted in chapter 6.

3. How we developed this strategy

This strategy builds on work that has been undertaken in Haringey over the last five years (see Appendix 1). We consulted organisations and groups who work in the area of health and wellbeing, as well as residents, to identify the outcomes and priorities for the strategy. The consultation period was for four months from 20 September 2011 to 20 January 2012 (see Appendix 2).

An equalities impact assessment (EqIA) was completed, as well as a full review of compliance with the Haringey Compact: Working Better Together (see Appendix 3). The full EqIA and the Haringey Compact review can be found at: www.haringey.gov.uk/hwbstrategy.

4. Context

Our strategy is grounded in a firm understanding of Haringey's population and its needs, and national and local trends and drivers (detailed in the JSNA).

4.1 Our population

Haringey is an exceptionally diverse and fast-changing borough. We have a population of about 225,000 residents (ONS). This may be an underestimate however, for example, 237,268 people are both registered with a Haringey GP and live in the borough (out of about 276,000 registered with a Haringey GP). The resident population is constantly changing with about 19,280 people moving in and 23,300 leaving the borough in 2009/10.

Haringey has a relatively young population with almost a quarter of the population under the age of 20, and 90.5% of the population aged under 65 (88.5% London and 83.4% England and Wales). Following the national trend, our population is ageing – 9.5% are of pensionable age (65 plus), with a projected increase to 11.7% by 2021.

Haringey is the 5th most ethnically diverse borough in the country. Nearly half of the residents come from Black and minority ethnic (BME) communities, and nearly 81% of our school children; 190 different languages are spoken in our schools. The proportion of children from BME communities varies from 30% in Muswell Hill to 78% in Northumberland Park.

Haringey is the 4th most deprived borough in London and the 13th most deprived in the country. An estimated 21,595 (36.4%) children live in poverty, largely in the east of the borough. The borough stretches from the prosperous neighbourhood of Highgate in the west to Tottenham in the east, one of the most deprived areas in the country.

We have significant levels of homelessness; more than 3,000 households are officially in temporary accommodation, the highest in London. Just over 30% of households live in social housing with high concentrations in the east of the borough. The east of the borough is more densely populated than the west.

Changes to the welfare system are likely to have significant impacts on the levels of child poverty, homelessness and overcrowding. The anticipated increase in inward-migration caused by poorer households being priced out of inner London boroughs will exacerbate the situation.

We continue to feel the effects of the current economic recession. The Job Seeker Allowance (JSA) claimant count was 10,393 at March 2012, or 6.5% of the total working age population (16-64); Haringey rates are significantly above the England and London rates.

4.2 Key improvements

While we are aware that we face significant challenges in addressing health inequalities and improving wellbeing locally, we are also proud of the significant improvements that have recently been made.

Children and young people's health is improving

- There has been a steady decline in the infant mortality rate.
- There has been steady increase in the coverage of childhood vaccinations since 2008 and a significant improvement in 2011/12.

Adult health is improving

- Women's life expectancy rates are better than the England average.
- Haringey ranks 9th nationally for completing annual health checks for people with learning disabilities.
- Haringey has a very effective drug treatment system; we are ranked higher than the national average for people successfully completing drug treatment.
- 5,000 NHS Health Checks for 40-74 year olds were completed in 2011/12.

Educational attainment is increasing

- Results for 2010/11 Foundation Stage increased from 42% to 54% of those achieving 78 points.
- GCSE results indicate 57.3% of pupils achieved 5 A* to C in 2011.

Overall violent crime is reducing

- 4.5% less crime than 2010. Neighbourhood policing is strengthening with 50 additional officers deployed.

Fewer families are in temporary accommodation

- Number of households living in temporary accommodation reduced by 305 and the Council prevented 581 households from becoming homeless in 2011.

Our employment programmes are successfully getting people qualified and into work

- During the last phase of the Haringey Guarantee (April 2009 to December 2011) 2,435 residents without work were supported into work.

4.3 National context

The coalition government has introduced new policy and legislation that will have a fundamental impact on the way in which public health, health services and social care are to be delivered. The Health and Social Care Act is possibly the most radical restructuring of the NHS since its inception. The major changes include:

- shifting many of the responsibilities historically located in the Department of Health to a new, politically independent NHS Commissioning Board
- giving groups of GP practices and other professionals – Clinical Commissioning Groups (CCGs) – responsibility for the majority of NHS commissioning
- transferring responsibility for public health from the NHS to the local authority
- giving local authorities, through Health and Wellbeing Boards (HWBs), a new role in encouraging joined-up commissioning across the NHS, social care, public health and other local partners
- moving all NHS trusts to foundation trust status
- the creation of a health specific economic regulator (Monitor) with a mandate to guard against 'anti-competitive' practices.

The **Marmot review** in 2010, '**Fair Society, Healthy Lives**' proposed evidence-based strategies for reducing health inequalities including addressing the social determinants of health in England, from 2010. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are the fundamentals for improving quality of life and reducing health inequalities. We understand that, to address health inequalities we need to improve opportunities for all our residents with a focus on those who are experiencing poverty and deprivation.

We endorse the following from the Marmot Review 2010:

- to create an enabling society that maximises individual and community potential
- to ensure social justice, health and sustainability are at the heart of all policies

'Focusing solely on those who are most disadvantaged will not reduce inequalities sufficiently. To reduce the steepness of the social gradient, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. ***We call this 'proportionate universalism'.***

'For specific groups who face particular disadvantage and exclusion, additional efforts and investments and diversified provisions will be needed to reach them and to try to reduce the multiple disadvantages they experience.'

4.4 Local context

4.4.1 Changes in the NHS

From 1 April 2011, the five primary care trusts (PCTs) for the NHS North Central London (NCL) Cluster – Barnet, Camden, Enfield, Haringey and Islington – created a single management team across the Cluster with a local borough team in each of the five boroughs to support the transition to clinically-led commissioning (by the new Clinical Commissioning Groups).

Haringey's Clinical Commissioning Group (CCG) has 'pathfinder' status, and is operating in shadow form alongside the Cluster while it develops towards full authorisation. It is coterminous with the borough boundaries and includes 52 GP practices and a population of about 276,000. Board membership includes wide representation from the GP community, a non-executive director of NHS Haringey, members of the local NHS borough transition team, the Cabinet Member for Health and Adult Services, senior officers from Haringey Council, patient representatives and the Director of Public Health.

NHS NCL Cluster and Haringey CCG's strategic plan and commissioning intentions are closely aligned with this strategy. More detail is given in Chapter 8.

4.4.2 Public health

The public health team in Haringey moved to the local authority in March 2011. In the transition period to April 2013, it is both a directorate of the Council, as well as part of the NCL NHS Cluster. The Director of Public Health, a joint appointment of the local authority and NHS, is a director of both Haringey Council and of the NCL NHS Cluster.

4.4.3 Shadow Health and Wellbeing Board (sHWB)

Haringey is part of the government's early implementers programme for health and wellbeing. We have established a shadow Health and Wellbeing Board (sHWB) which will operate until the new statutory board is in place in April 2013.

The sHWB has been established as a small, focused decision-making partnership board. Membership includes representation from elected Councillors, Haringey Council (including adults' and children's services, and public health), NHS Haringey and the CCG; wider stakeholders are being engaged as appropriate.

4.4.4 Joint strategic needs assessment (JSNA)

Our strategy is grounded in a firm understanding of our JSNA, which details Haringey's population and its needs, national and local trends and drivers, service users' and carers' views, expert opinion and the evidence base for interventions. It then explores any unmet needs and service gaps and makes recommendations for consideration by commissioning. Our JSNA is web-based allowing it to be updated when new data becomes available, and to use hyperlinks to other documents and datasets, ensuring that a wealth of information is available on any one topic, all in one place.

4.4.5 Financial landscape

Both the local NHS and the Council are facing a highly challenging financial position in the short and medium term. We are facing significant budgetary pressures while operating in an environment of rising customer expectations and demand for higher quality services. In addition, demand for health and social care services is expected to continue to rise due to demographic change and the increase in illness related to lifestyle risk factors. These factors are placing additional pressures on our finite available resources.

NHS Haringey budget

The overall budget available for 2011/12 is £472 million. The local NHS is forecasting it will overspend its budget in 2011/12 by around £19 million (although this is consistent with the financial plan as agreed with the Department of Health). Therefore the annual forecasted expenditure for 2011/12 is £491 million. Our forecasted public health expenditure for 2011/12 will be in excess of £9 million, of which £4.7 million is used for drug and alcohol services. A breakdown of forecasted 2011/12 expenditure is shown in the table below.

	Forecast 2011/12 expenditure (£million)
Primary Care	89
Acute Services	306
Non Acute (including Mental Health and Community)	75
Corporate (Both NCL Cluster and Borough Teams)	19
Capital Charges	2
Total	**491**

The financial outlook for 2012/13 is challenging. The planned financial position is to achieve a surplus of £0.5 million at the end of the 2012/13 financial year. In order to achieve this, we will need to make efficiencies of over £27 million.

Public health allocation
The public health allocation is currently being determined prior to the full transfer of this responsibility from the NHS to the Council. The new allocation will be an estimated £14 million, which includes new public health responsibilities, particularly for sexual health (£5.4 million).

Council budget
The Spending Review 2011-15 set out plans to reduce average local government funding by approximately 29% over that period; for Haringey this amounts to a reduction of circa £84 million. The Council has successfully reduced its budget by £41 million as part of the 2011/12 process with the remainder expected to be achieved over the remaining years. The Council's 2012/13 total net budget is £278m, which includes:

- adult social care: £73 million (of which voluntary sector: £12 million)
- children's social care: £49 million
- children's prevention and early intervention: £11 million.

Our local evidence and the direction of national policy highlights that partnership working between primary care, local authorities and the third sector to deliver effective prevention and early intervention services can bring important benefits, including reducing costs. This strategy therefore focuses on:

- implementing an evidence-based programme of actions to prevent ill health and to reduce health inequalities
- increasing access to primary care and primary care programmes such as vaccination or screening at an early stage for the groups with highest health needs
- building the capacity of individuals and communities to grasp opportunities to take control of their own health
- increasing the capacity and capability of the NHS and local authority workforce to support individuals to improve their health.

However, it needs to be noted that not all desired investments will be able to be funded. Rather, the NHS and the Council will firstly need to identify the level of discretionary funding available for investment and then prioritise based upon those interventions which will have the greatest and most equitable benefit for all our residents.

5. Health and wellbeing outcomes and priorities[1]

Outcome One: Every child has the best start in life

Introduction

Poverty in childhood permeates every part of children's lives, from economic and material disadvantages, to impacting negatively on their health and their education, through to the personal and more hidden aspects of poverty associated with shame, sadness and the fear of difference and stigma. Giving every child the best start in life was highlighted in The Marmot Review of Health Inequalities *Fair Society, Healthy Lives* as the highest priority recommendation for reducing health inequalities; it called for 'a second revolution in early years'.

Pregnancy and the first years of life are critical and this is a time when parents are particularly receptive to learning and making changes. Prevention and early intervention in the first years of a child's life has a significant positive impact for a child's later outcomes.[2] It can help prevent emotional and behavioural difficulties, under-attainment at school, truancy and exclusion, criminal behaviour, drug and alcohol misuse, teenage pregnancy and the need for statutory social care. It can break the links between early disadvantage and poor outcomes later in life.

What we want to see

We want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient, with a network of support to enable them to live independent and healthy lives. Using the growing national and international evidence of effective programmes of prevention and early intervention, we will review and build on our services from conception to age 3 to improve outcomes by age 5. We want targeted programmes of support to have lasting impact, especially towards the most vulnerable, in order to prepare for the responsibilities of adulthood and build up resilience for the future.

Our four priorities to ensure every child has the best start in life:

1. Reduce infant mortality
2. Reduce teenage pregnancy
3. Reduce childhood obesity
4. Ensure readiness for school at 5 years (physical, emotional, behavioural and cognitive)

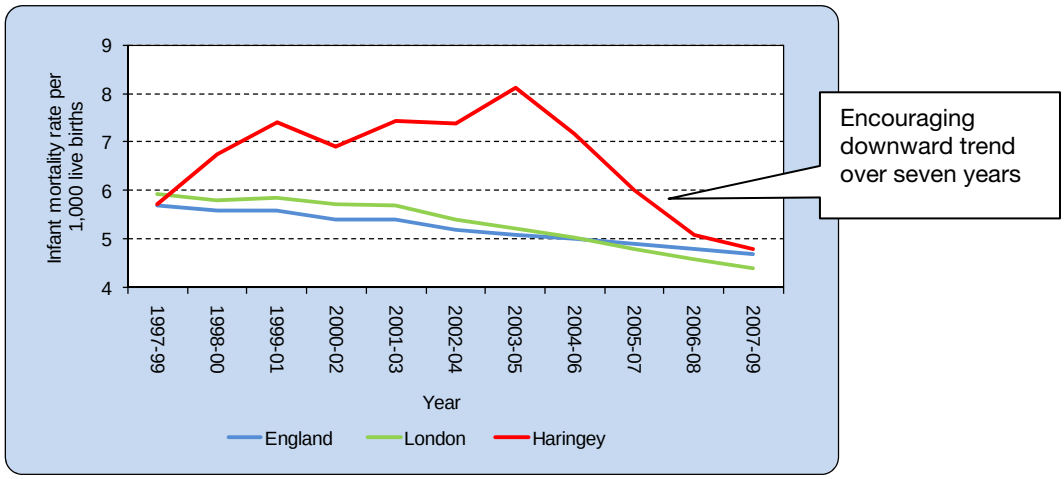
[1] All facts and figures in this chapter are from the JSNA, where their sources are referenced.
[2] This is supported by The Marmot Review of Health Inequalities *Fair Society, Healthy Lives*; Clare Tickell's first report on the Early Years Foundation Stage; the recent Cabinet Office report on social mobility, Frank Field's report on poverty and Graham Allen's independent report on early intervention.

Priority 1: Reduce infant mortality[3]

What we know about Haringey

- While our infant mortality rate is at an all time low, with a steady decline since 2003-05, rates are higher than those for England and London (Fig. 1).
- Approximately five in every 1,000 babies die before their first birthday.
- Breastfeeding rates are considerably lower in the east with 58.2% of women breastfeeding in Tottenham Green compared to 85.7% in Crouch End.
- Black African women and women under the age of 20 tend to book late for maternity care: 51% of Black African women book after 13 weeks compared with 30% of White British women. Only 39% of women under 20 are likely to book before 13 weeks.
- 6% of women smoke during pregnancy.
- While vaccination rates have increased, rates in both Haringey and London are below levels required to positively impact on the population (95%). In 2010/11, 91.1% of children at age 1 and 85.3% at age 2 were immunised.

Figure 1: Trends in infant mortality in Haringey, London and England.
Source: NHS Information Centre.



What we plan to do

- Provide specialist breastfeeding support groups and offer antenatal booking appointments in the majority of our children's centres.
- Train frontline staff in the prevention of sudden unexpected death in infancy.
- Improve early access to maternity services in particular among Black African communities.
- Continue to ensure on-site smoking cessation support in maternity services at the North Middlesex Hospital and Whittington hospitals.
- Continue to improve our information technology (IT) and data reporting processes for immunisation so that we can accurately report and analyse the coverage and improve the service we provide.

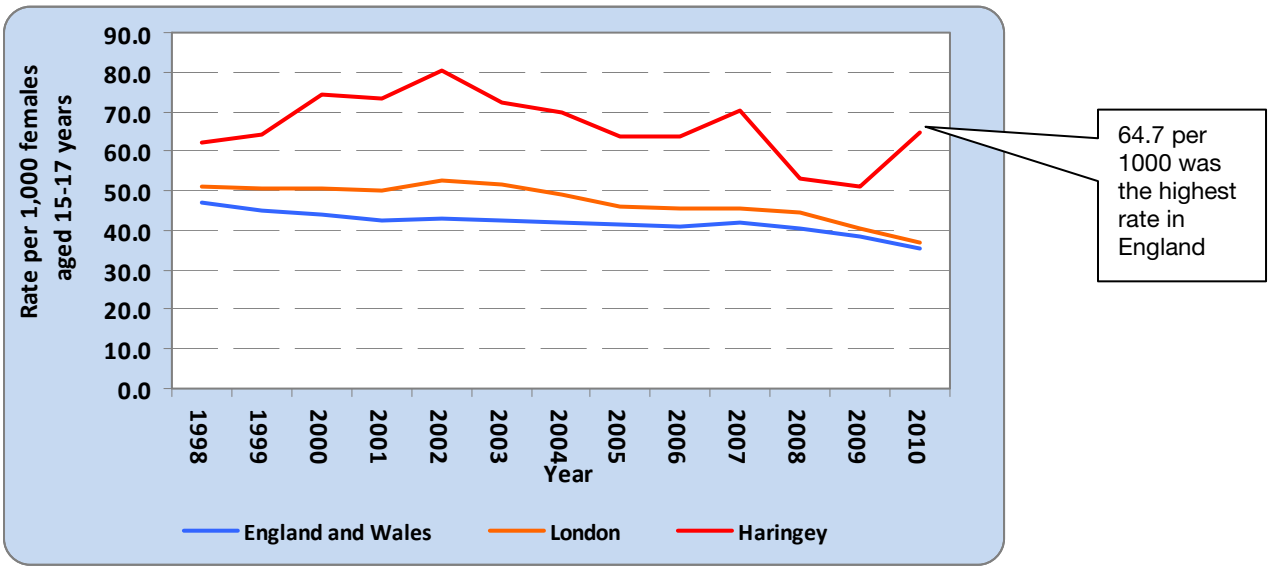
[3] 'Infant mortality' is the term used for deaths of children who are born alive but who die before their first birthday.

Priority 2: Reduce teenage pregnancy

What we know about Haringey

- Following three years of going down, the teenage pregnancy rate increased in 2010 (Fig. 2) and at 64.7 per 1000 women aged 15-17 was the highest rate in England (England and Wales rate is 35.5 per 1000); 203 teenagers became pregnant. Given the small numbers involved, there can be large year on year fluctuations in the rate, and the overall trend (3-year 'rolling average') remains a decreasing one. Positively, Haringey's under-16 conception rate decreased to its lowest rate.
- Teenage pregnancy is significantly higher in the east, in particular in Tottenham Hale, St Ann's and Harringay wards.
- The highest number of girls becoming pregnant were White British, followed by Black Caribbean and 'Other ethnic' group; there appears to be an over-representation in Black Caribbean and 'Other ethnic' group compared to the proportion of these groups in the 0-19 year old population.

Figure 2: Trends in teenage conceptions in Haringey, London and England & Wales.
Source: Teenage Pregnancy Unit.



What we plan to do

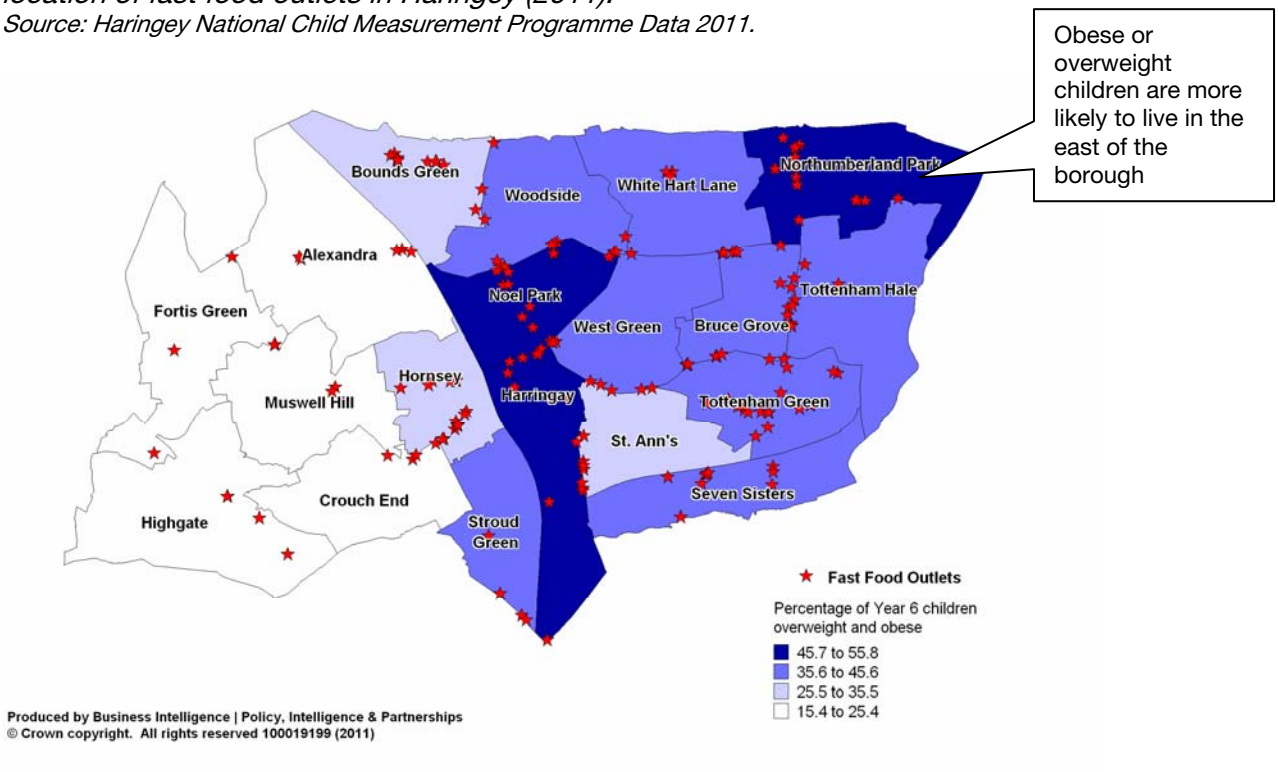
- Continue to fund support for tracking and supporting vulnerable under 19s.
- Continue to increase access to the C-Card scheme (accessible, free condoms).
- Ensure young women under 25 have access to free Emergency Hormonal Contraception.
- Involve young people in devising a communication campaign integrating teenage pregnancy, sexual health, substance misuse and domestic violence.
- Promote sex and relationship education (SRE) through the Healthy Schools programme.
- Continue the Family Nurse Partnership, which provides intensive support to young first time mothers.
- Continue the 4YP service (a young people-friendly sexual health service) in a range of school-based and non-healthcare settings for young people under 25.

Priority 3: Reduce childhood obesity

What we know about Haringey

- Childhood obesity rates are higher than the London and England average.
- One in four children aged 4-5 and one in three children aged 10-11 are overweight or obese; they are more likely to live in the east of the borough (Fig. 3).
- Children in Year 6 from BME groups (Black Caribbean 30% and Black African 25.5%) are more likely to be obese than White British children (8.4%).

Figure 3: Levels of obesity in Year 6 children (10-11 year olds) in Haringey by ward; location of fast food outlets in Haringey (2011).
Source: Haringey National Child Measurement Programme Data 2011.



What we plan to do

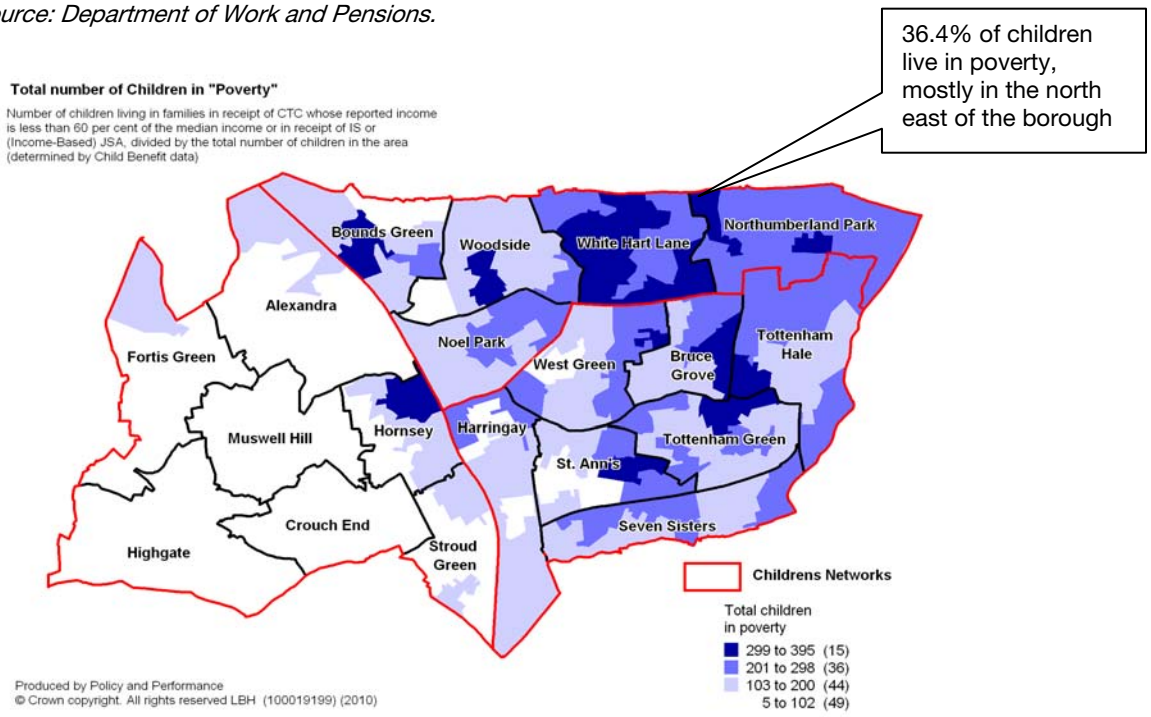
- Continue the annual National Child Measurement Programme (NCMP).
- Raise awareness through the 2012 Director of Public Health Annual Report and through a resident debate.
- End the sale of fizzy sugary drinks and junk food from all Council premises; encourage schools to do the same.
- Explore all planning avenues to reduce the proliferation of fast food outlets in the borough and work with existing outlets to make their food healthier.
- Support schools to maintain their Healthy Schools status and achieve an enhanced Healthy Schools status with a focus on childhood obesity.
- Offer training to school nurses and other school staff on how to recognise child obesity and how to raise the issue with families in a sensitive way.
- Work with local leisure centres to ensure that they are affordable and encourage families to be active.

Priority 4: Ensure readiness for school at 5 years (physical, emotional, behavioural and cognitive)

What we know about Haringey

- There are an estimated 21,595 children (36.4%) living in poverty, largely in the east of the borough (Fig. 4); the 9th highest proportion of children living in poverty in the UK (8th in London).
- Over the last two years, numbers of children looked after have increased to over 600; numbers subject to a child protection plan have increased to over 300. This reflects a national trend.
- Results in the Early Years Foundation Stage (EYFS) in 2011 improved significantly from 2010 in personal, social and emotional development (from 64% to 75%) and in communication, language and literacy (from 46% to 58%). However, 46% of children do not have a good level of development (compared to 41% in England). There are differences in attainment at EYFS between children eligible and not eligible for free school meals, in geographical distribution across the borough and between different ethnic groups.

Figure 4: Number of children in poverty living in Haringey.
Source: Department of Work and Pensions.



What we plan to do

- Increase our focus on interventions targeting conception to age 3.
- Continue to provide the full offer of the Healthy Child Programme (HCP) (a prevention and early intervention programme focused on pregnancy and the first five years of life) to families defined as vulnerable; and work to extend the programme to all children under 5 and their families.
- Work in partnership with the Whittington Health Early Implementer Site for health visiting to increase the health visiting workforce; ensure this programme is aligned with the new Children's Centre service offer.
- Meet our statutory duty to provide child care places for vulnerable 2 year olds.

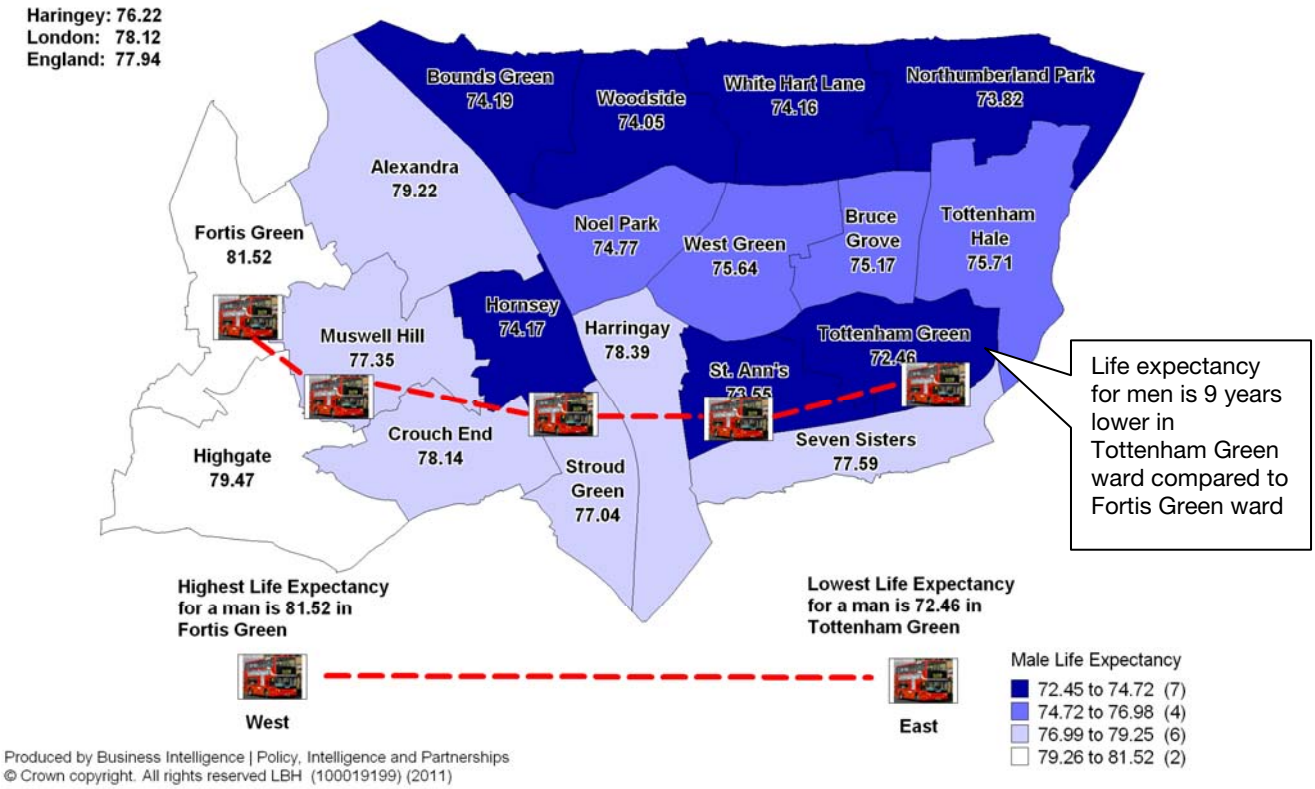
Outcome Two: A reduced gap in life expectancy

Introduction

Although life expectancy is increasing nationally and locally, for Haringey men it is significantly worse than in England and London and this gap may be widening. In addition, **there is a stark nine year gap in life expectancy across Haringey.** Figure 5 illustrates the drop in life expectancy as the number 41 bus crosses the borough from the west to the east.

High levels of deprivation, low educational attainment, unhealthy lifestyle factors (high smoking, poor diet, low physical activity) and access to quality primary care are all interrelated determinants of early death and lower life expectancy. In particular, smoking contributes to half of the life expectancy gap. Life expectancy is also significantly lower in certain groups such as those with severe mental illness, learning disabilities or problematic drug users; there are higher than average proportions of people in these groups in Haringey.

Figure 5: Life expectancy for men in Haringey by ward (2005-2009); and the route of the 41 bus through Haringey.
Source: London Health Observatory.



What we want to see

We will work in partnership to prevent people becoming ill in the first place by supporting our residents to address the key lifestyle risk factors of smoking, physical inactivity and alcohol misuse, which are more common in the deprived areas of the borough. We will also encourage early diagnosis and management of the major killer

diseases such as cardiovascular disease (CVD) and cancer as reducing deaths from these diseases, particularly in men, will have the greatest impact on reducing the gap in male life expectancy.[4]

To achieve a reduction in the life expectancy gap, our actions will range from universal to targeted to meet the different levels of need, as appropriate – what Marmot terms 'proportionate universalism' (see 4.3).

Our five priorities to reduce the gap in life expectancy:

5. Reduce smoking
6. Increase physical activity
7. Reduce alcohol misuse
8. Reduce the risk of cardiovascular disease (CVD) and cancer
9. Support people with long term conditions (LTCs)

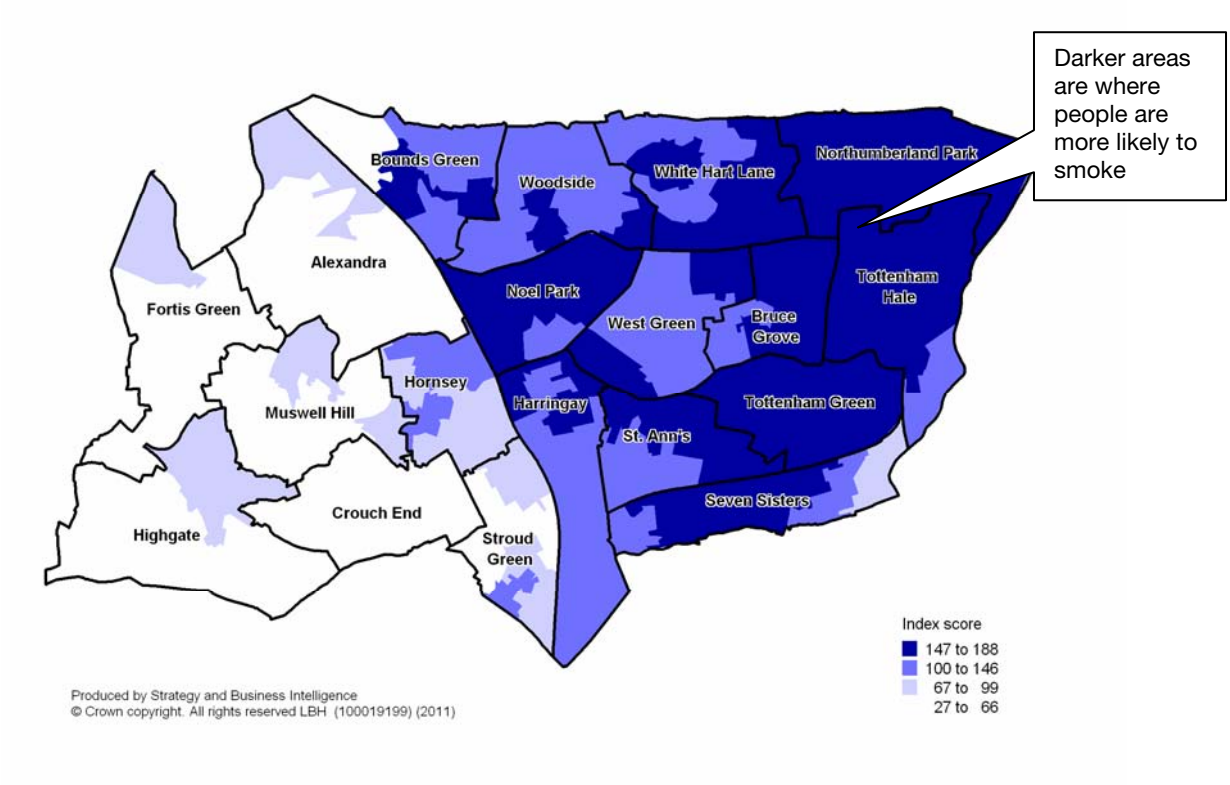
[4] Redoubling Efforts to achieve the 2010 National Health Inequalities Life Expectancy Target. Resource Pack. Department of Health. March 2010.

Priority 5: Reduce smoking

What we know about Haringey

- Smoking contributes to 50% of the life expectancy gap (it is the major risk factor for cardiovascular disease, lung disease and cancers).
- Smoking levels are high with an estimated 50,000 adults smokers (28.6% of men, 24.2% of women), largely in the east (Fig. 6).
- Some groups have particularly high nicotine dependence such as Turkish, Bangladeshi and Irish men, lone parents, and people with mental health problems (about half of whom smoke.)
- There were 630 deaths related to smoking between 2007 and 2009, with 1,527 hospital admissions, at a cost of nearly £4.3 million in 2009/10.

Figure 6: Map showing areas in Haringey where people are likely to smoke.
Source: Mosaic 2010.



What we plan to do

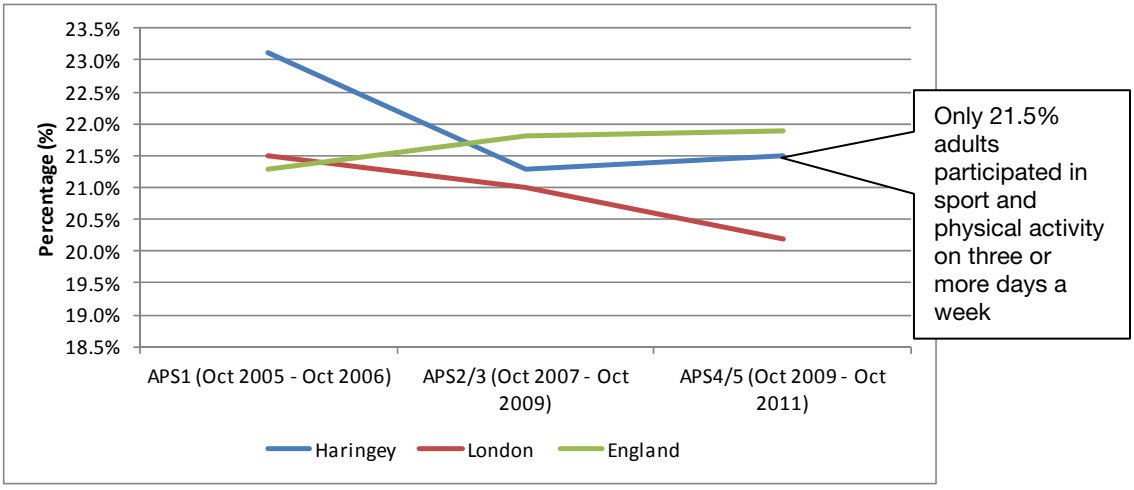
- Continue to strengthen the stop smoking service to target groups at risk and in accessible service locations, for example, primary care, pharmacies and workplace settings.
- Promote smoke free Haringey through Council workplace policies and promoting no smoking in parks (in particular in children's areas) and bus shelters.
- Implement fines for dropping cigarette butts which can be reduced if the smoker attends the stop smoking programme.
- Stop the increase in the number of premises offering tobacco shisha smoking.
- Encourage schools to integrate anti-smoking messages into the curriculum.
- Monitor implementation of NHS North Central London's commissioning for quality and innovation scheme (the 'CQUIN') with healthcare providers to increase their smoking cessation interventions.

Priority 6: Increase physical activity

What we know about Haringey

- About 112,865 adults are estimated to be overweight or obese (52.7% of men and 47.2% of women).
- Only 21.5% of adults participated in sport and physical activity on three or more days a week (Fig.7).
- There are large differences in levels of physical activity in relation to age, gender, ethnicity, socio-economic status and disability.

Figure 7: Active People Survey Results for Haringey, London and England (2007/08–2010/11).
Source: Sport England.



What we plan to do

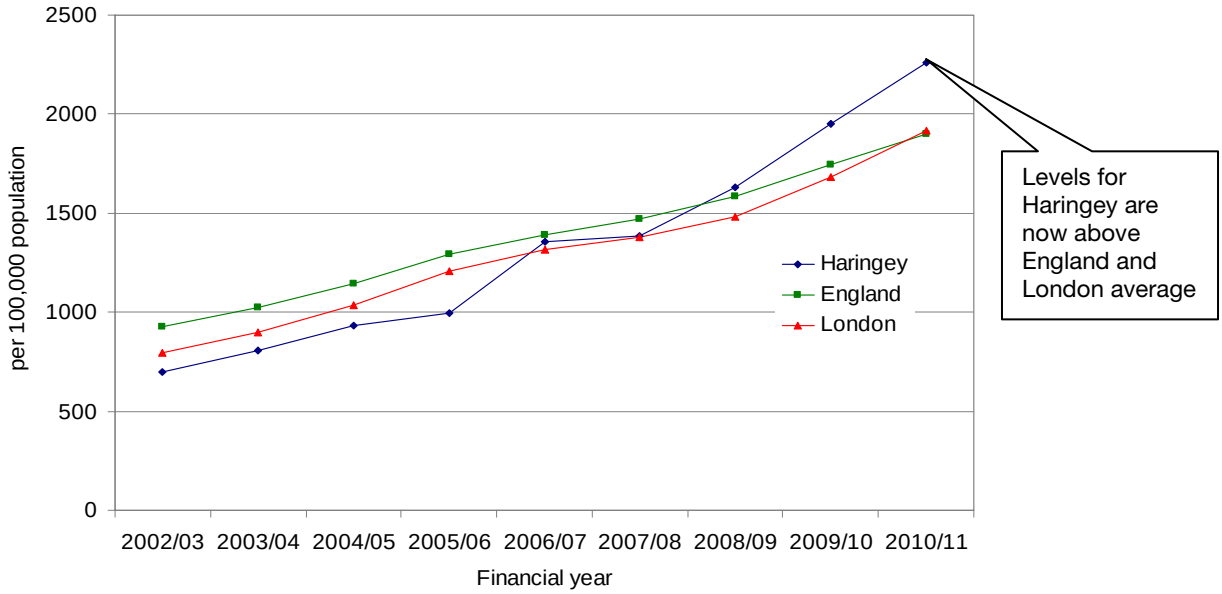
- Work with local leisure centres to ensure that they are affordable and attract clients who are inactive (particularly target groups including lower socio-economic groups, disabled and older people), encourage parents to exercise with their children (for example, through financial discounts) and expand exercise on prescriptions (including targeting those with long term conditions who are among the least active).
- Continue to invest in Smarter Travel options and develop the Biking Borough programme aiming to make all roads in Haringey 'bike friendly'.
- Ensure the regeneration of Tottenham improves the physical environment to encourage physical activity and reduce obesity, in particular developing cycling and walking routes.
- Scale up brief intervention training in physical activity and healthy eating for staff and communities.
- Promote NHS Health Trainers and Health Champions programmes.
- Continue to encourage parents to walk their children to school.

Priority 7: Reduce alcohol misuse

What we know about Haringey

- Male deaths from alcohol-attributable causes and from chronic liver disease is higher than the London and England average.
- In line with national trends, alcohol-related hospital admissions rates have almost doubled in the period 2002/03-2009/10 with middle aged and older men accounting for the majority of these admissions.
- Irish men and 'any other ethnic group' (which includes Polish) have the highest rates of admissions that are only due to alcohol ('wholly attributable').
- The most common cause of admissions with alcohol as a contributing factor is high blood pressure which is highest in White British, African Caribbean and 'any Other White' men.

Figure 8: Trend in alcohol related admissions for Haringey, London and England.
Source: North West Public Health Observatory.



What we plan to do

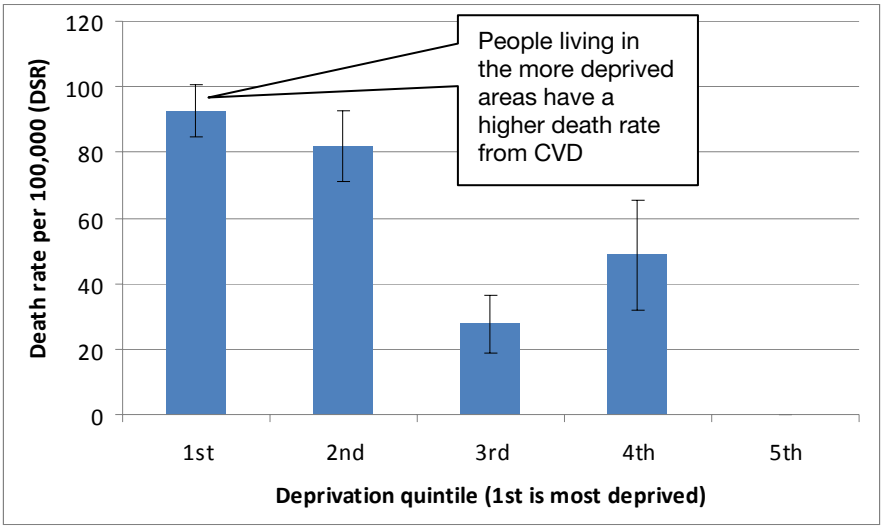
- Continue to include alcohol screening in the NHS Healthchecks programme as this programme (focused on identifying and supporting those at high risk of cardiovascular disease, including hypertension) expands.
- Extend the range of Identification and Brief Advice (IBA), training staff working in non-medical settings who are likely to come into contact with people with alcohol problems, such as staff working in sexual health, safeguarding and with the Irish and Polish communities.
- Monitor implementation of NHS North Central London's quality incentive scheme (the 'CQUIN') with healthcare providers, to improve alcohol screening and brief interventions at Accident and Emergency departments and Urgent Care Centres.
- Continue commissioning a link worker to target those who have repeat alcohol-related attendances and/or admissions.
- Continue a programme of outreach to traditional 'street drinkers', and the Eastern European community; develop a programme with the Irish community.

Priority 8: Reduce the risk of cardiovascular disease (CVD) and cancer

What we know about Haringey

- The diseases most responsible for the life expectancy gap are cardiovascular disease (CVD) (which includes heart disease and stroke) (28%) and cancers (25%).
- Rates of early death from CVD and cancer are improving, but remain worse than England.
- Rates of early death from cancer are improving, but remain worse than England for men.
- The highest death rates from CVD are in the more deprived areas, particularly in the east of the borough (Fig 9).
- Smoking is the major reversible risk factor for CVD and cancer.

Figure 9: Haringey: death rates from cardiovascular disease (CVD) by level of deprivation (2008-10)[5].
Source: Public Health Mortality Files and Department for Communities and Local Government 2011.



What we plan to do

- Maximise case finding and use of case registers and care pathways within primary care and community services to ensure early detection and management of these conditions, particularly in the over 40s and in the east of the borough.
- Expand the NHS Health Checks programme[6] to full roll out, ensuring it reaches those most at risk and that they are supported to make lifestyle changes; deliver some Health Checks as community events.
- Build on current programmes to raise awareness of early signs and symptoms of stroke, cancer and diabetes, particularly in 'at risk' communities.
- Provide training and information to front line staff and community groups to raise awareness of symptoms of illness early, as well as undertake brief interventions to support lifestyle change.
- Continue to improve the uptake in breast and bowel cancer screening.

[5] Based on quintiles of Lower Super Output Areas (LSOAs) by national IMD score 2010. There are no (LSOAs) in Haringey in the 5th deprivation quintile (i.e. least deprived).
[6] Aimed at 40-74 year olds to identify those at high risk of CVD, diabetes and kidney disease and then offer advice, support and follow up to reduce their risk of illness.

Priority 9: Support people with long term conditions (LTCs)

What we know about Haringey

- An estimated 74% of over 65s registered with a GP have a long-term condition (LTC), equating to 18,909 people (Fig. 10).
- LTCs include diabetes, respiratory disease (particularly chronic obstructive pulmonary disease) and CVD; they are more common among people from lower socio-economic groups and certain Black and minority ethnic (BME) groups.
- They are major causes of early death, contributing substantially to the life expectancy gap.

Figure 10: Estimate of number of people over 65 in Haringey with long term conditions
Source: based on data from Islington GP practices, Islington's Annual Public Health Report 2011

Long term condition	Number of people over 65 in Haringey estimated to have a LTC
Kidney disease	3,802
Atrial fibrillation	1,786
Heart failure	1,371
Dementia	939
Chronic obstructive pulmonary disease (COPD)	2,459
High blood pressure	13,679
Diabetes	5,046
Coronary heart disease	3,600
Cancer	2,493
Stroke/Transient ischaemic attack	2,069
Chronic depression	1,082
Psychotic disorders	626
Chronic liver disease	409

What we plan to do

- Further develop and implement care pathways for diabetes, COPD, stroke and heart failure.
- Develop integrated health and social care systems for patients with LTCs across Haringey, for example, working with Whittington Health and other providers to pilot this approach.
- Continue to implement the new joint reablement pathway that offers intensive support after hospital discharge or prevents hospital admissions in patients with LTCs, particularly those who are vulnerable.
- Continue to support education and training for clinicians and other staff to improve treatment and care.
- Review and strengthen self-management and patient education programmes to support patients in managing their own conditions.
- Review and strengthen psychological support of people with physical LTCs and the management of the physical health of those with enduring mental health problems.
- Ensure a continued focus on fuel poverty, particularly given the number of vulnerable residents in the borough and the speed with which fuel prices are increasing.

Outcome Three: Improved mental health and wellbeing

Introduction

The factors that drive both material and emotional wellbeing are not evenly distributed. Some people have better quality housing, better jobs or fewer money concerns. Some people have stronger support networks and feel more included, connected and respected than others. Some are unfairly pushed to the edge of society – 'socially excluded' – because of poverty, or a lack of basic skills, or as a result of stigma or discrimination (for example, because of social class, gender or ethnicity, or having a mental health problem or using drugs). Wellbeing is therefore highly dependent on the distribution of the social, economic and environmental resources in a population.

High levels of inequality are damaging to communities and society as a whole, eroding mental wellbeing and increasing stress – and potentially put a strain on social relations by reducing trust and interaction. Children's wellbeing is especially important at a time when young people are growing up in a society where job opportunities are decreasing, access to further education is getting increasingly competitive, and there are a wide range of concerns around crime and safety. The Tottenham riots can be seen as a highly visible result of these underlying issues. The evidence is that 'communities are more cohesive and people trust each other more in more equal societies'.[7] Everyone would benefit, although the poorest would gain the most.

Increasing attention is being paid to a 'neighbourhood effect', where factors closely associated with a negative impact on mental health are: high density buildings, overcrowding and noise with little opportunity to 'escape'; high rise and 'ugly' environments; vandalism and poor property maintenance; poor quality housing; fear of crime.[8] The regeneration of Tottenham needs to ensure that it addresses these factors in its design and implementation.

If we are to build a healthier, more productive and fairer society in which we recognise difference, we have to build resilience, promote mental health and wellbeing, and challenge stigma and discrimination. We need to prevent mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families.

What we want to see

We want all residents in Haringey to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

Our five priorities to improve mental health and wellbeing:

10. Promote the emotional wellbeing of children and young people
11. Support independent living
12. Address common mental health problems among adults
13. Support people with severe and enduring mental health needs
14. Increase the number of problematic drug users in treatment

[7] Equality Trust. The evidence in detail – mental health. http://www.equalitytrust.org.uk/why/evidence.

[8] Delivering healthier communities in London. NHS London Healthy Urban Development Unit

Priority 10: Promote the emotional wellbeing of children and young people

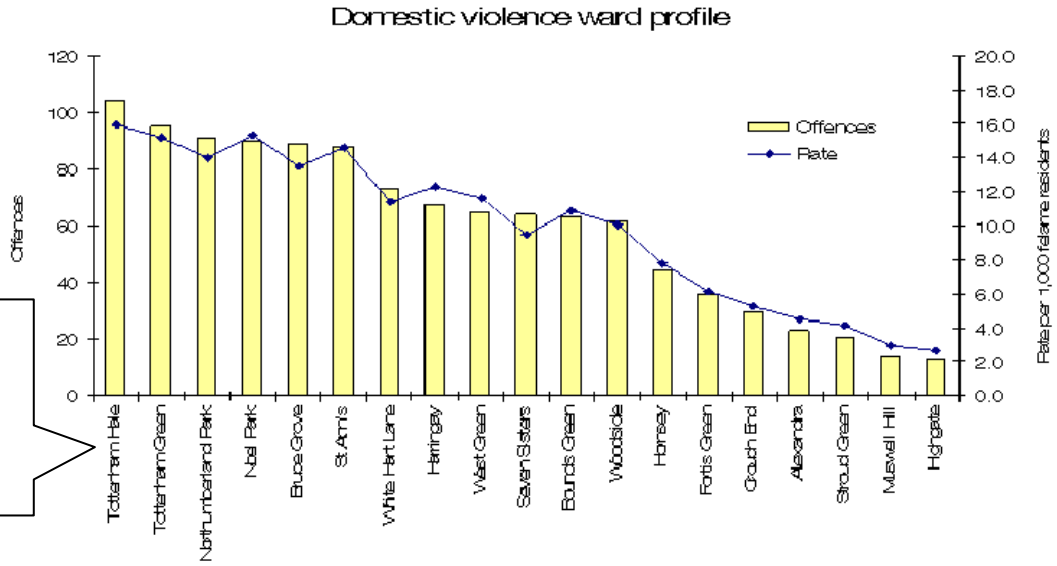
What we know about Haringey

- Of the 43,000 children aged 5-16, an estimated 2,534 children have mental health problems; this is predicted to rise to 2,633 by 2013.
- An estimated 379 of 15-25 year olds are problem drug users, 215 are in treatment.

Haringey has high levels of risk factors for poor mental health and wellbeing:

- There are an estimated 21,595 children (36.4%) living in poverty, largely in the east of the borough. The 9th highest proportion of children living in poverty in the UK (8th in London).
- Anecdotal evidence suggested the Tottenham riots increased anxiety and concerns regarding personal safety among children and young people living in Tottenham.
- Domestic violence (DV) is the presenting issue for around 20% of children with child protection plans – the highest primary concern by a good margin. DV accounts for 30% of child referrals to social care, the highest number in the 0-4 year old age group. Around 35% are repeat referrals. (Fig. 11).
- The Haringey Youth Offending service has a caseload of 396: 7% serving a custodial sentence, 4% on bail or remand; and 8% children in care (Dec. 2011).
- 4.2% of young people aged 16-19 were Not in Education, Employment or Training (NEET) as at November 2011; 59.2% were young women.

Figure 11: Reports of domestic violence in Haringey by ward (1 October 2010-30 September 2011).
Source: 2010 Ward Population Estimates for England and Wales, mid-2010 - experimental statistics.



Over a third of all reported domestic violence offences are in just four wards in the east

What we plan to do

- Prioritise prevention and early intervention by working with schools, young people and families to provide accessible, non-stigmatising mental health services in local community based settings.
- Ensure the universal services we commission are providing good outcomes in terms of wellbeing and early intervention for mental health problems, for example, the HCP, GPs, health visitors, Children Centres and schools.
- Promote the Healthy Schools programme, with its focus on reducing child poverty, improving emotional health and wellbeing and reducing substance misuse and smoking.
- Introduce children's Improving Access to Psychological Therapies (IAPT) service.

- Reduce the use of high cost Child and Adolescent Mental Health (CAMHS) services.
- Review the Multi-Agency Risk Assessment Conference (MARAC) using a ‘Think Family’ framework.
- Increase access to education, training, employment and housing particularly increasing opportunities for young people in the east of the borough (signpost to other work programmes).
- Support young people who are ‘Not in employment, education or training’ (NEET) or at risk of becoming NEET and ensure that programmes are in place that are relevant to their needs.

Priority 11: Support independent living

What we know about Haringey

- There are 4,363 clients receiving adult social care services: of these, 687 live in residential/nursing care; 12% are learning disabilities clients, 6% are mental health clients, 21% are physical disabilities clients, 61% are older clients (February 2012).
- 1,859 (41.3%) of clients use self directed support: of these 1,627 are on a personal budget and 232 are on direct payments (February 2012).
- 15,967 people in Haringey identify themselves as unpaid carers, representing 7.4 % (1 in 13) of the usual resident population: 3,232 (20%) provide care for 50 or more hours a week and 10,637 (67%) provide care for 1-19 hours a week (2001 Census).
- 99.5% of vulnerable people are supported through a range of different services to maintain independent living (December 2011).
- 85% of older people were helped to live independently at home after discharge from hospital – recorded at 91 days after discharge (December 2011).

Independence and choice with a personal budget

Mrs A, in her late 50s, had a major heart attack which left her with shortness of breath. She has a range of health conditions, including high blood pressure, diabetes and arthritis in her spine. Through the personalisation assessment she was awarded a budget of £146 per week. She has used her budget for daily assistance with personal care. This has relieved the pressure on her husband, her informal carer, and supported her in her weight loss which has greatly improved her health and given her more confidence. She has returned to work and is now using the budget and her personal assistant to help her.

What we plan to do

- Continue to offer more choice, control and greater independence through personal budgets to support those living with long term conditions (LTCs).
- Continue to increase co-ordination of personal care by commissioning and delivering health, social care and housing services in a more joined up way.
- Increase the number of health checks and health action plans for people with learning disabilities.
- Enable people with learning disabilities to live independently or interdependently with support and housing care.
- Improve care and choice in end of life care by:
  - Continuing to implement the Gold Standard Framework within nursing and residential care homes
  - Making sure that there is access to hospice care and care at home at end of life to ensure dignity and choice for people who are dying.
- Identify and support unpaid carers in their caring role and in their life apart from caring; involve carers in all developments affecting them and the people they care for.
- Ensure that comprehensive pensions advice is widely available.
- Provide comprehensive advice on the full range of benefits and entitlements and increase take-up of these.
- Work with the London Fire Brigade to enable them to undertake home fire safety visits for vulnerable people known to partners.

Priority 12: Address common mental health problems among adults

What we know about Haringey

- There are an estimated 34,500 people with common mental health problems (mainly anxiety and depression).
- In 2009, there were 14,000 people registered with a GP with a diagnosis of depression; 3,200 in the west and 10,800 (three times more) in the east (Fig. 12).

Haringey has high levels of risk factors for poor mental health and wellbeing:

- A high rate of worklessness; Northumberland Park has the highest proportion of working age people claiming JSA in London (GLA, July 2011).
- Overcrowded housing: 22% of households (20,455), largely in the east of the borough (Census, 2001).
- Domestic violence rates are seven times higher in the deprived parts of east Haringey than the level in the west of the borough. It constitutes 30% of all violent crime which is high when compared to other London boroughs.

Figure 12: Estimated number of people in Haringey (aged 16-74) with common mental health issues, by type of mental illness.
Source: ONS Psychiatric Morbidity Survey.

Condition	Estimated number
Mixed anxiety and depressive disorder	15,966
Generalised anxiety disorder	10,074
Depressive episode	6,669
All phobias	4,161
Obsessive compulsive disorder	2,942
Panic disorder	1,594
Total	**41,406**

What we plan to do

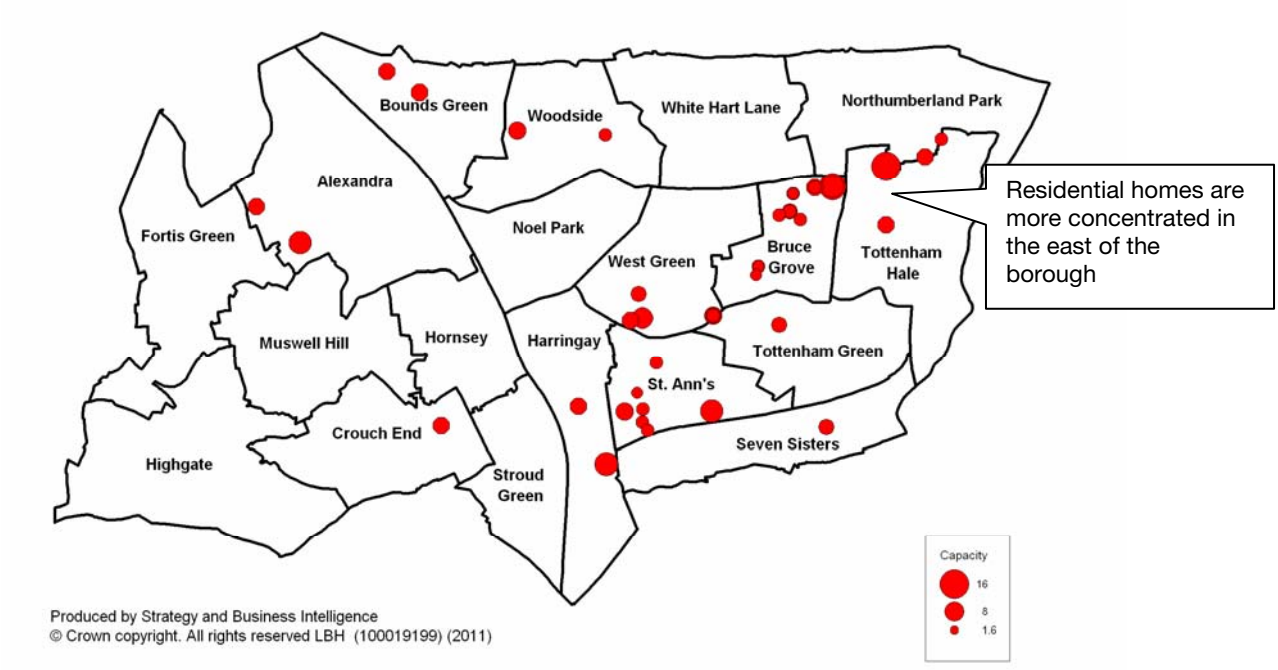
- Train all frontline staff in 'Mental Health First Aid' which aims to identify mental health problems early.
- Actively encourage the development of more user-led organisations, for example, BUBIC (Building Unity Back into the Community) to build resilience into the community and improve the awareness of mental health among BME communities.
- Ensure the regeneration of Tottenham promotes wellbeing and good mental health, for example by addressing issues of neighbourhood quality, housing design and density, housing quality and community safety (actions to deliver this will be incorporated into the Tottenham Plan).
- Reduce stigma by implementing an 'early' awareness programme in schools to promote good mental health and recognise when someone is not coping.
- Support people with both mental and physical illness:
    - Improve communication between primary and secondary care and develop a shared care approach to those who become unwell
    - Identify depression and anxiety in patients with long term conditions (LTCs)
    - Extend IAPT provision and ensure equitable access in line with national recommendations.

Priority 13: Support people with severe and enduring mental health needs

What we know about Haringey

- There is a particularly high level of severe mental illness, with high levels of psychotic disorders (including schizophrenia and bipolar disorder), concentrated in the east of the borough; Haringey is ranked third in London.
- There are 40 independent residential care homes for people with mental health issues (including forensic), with a total capacity of 245 beds. Haringey Council funds people in 104 of these placements; the majority of care homes that work with mental health are in the east of the borough (Fig 13).
- 3,230 patients were registered with GPs as having a psychotic disorder – 842 patients in the west, and 2,388 in the east (2009/10 NHS Quality and Outcomes Framework [QOF]).
- The use of inpatient services for severe mental illness is 60% higher than the England average and similar to London (London Adult Mental Health Scorecard 2011).
- Patients from Black or Black British ethnic groups account for 20% of the population, but represent 46% of all admissions for schizophrenia and 39% of all admissions for bipolar disorder.
- There are lower rates of dementia than London reflecting the relatively young population; conversely there are more people with dementia in the west of the borough due to the greater proportion of older people.
- In 2008/10, the suicide rate of 9.8% was not significantly different from the national average of 7.9%.
- 48% of Incapacity Benefits in 2010 were mental health related; claimants are more likely to live in the east of the borough.

Figure 13: Haringey: location and capacity of residential care homes for people with mental health issues (2011).
Source: Haringey Council.



What we plan to do

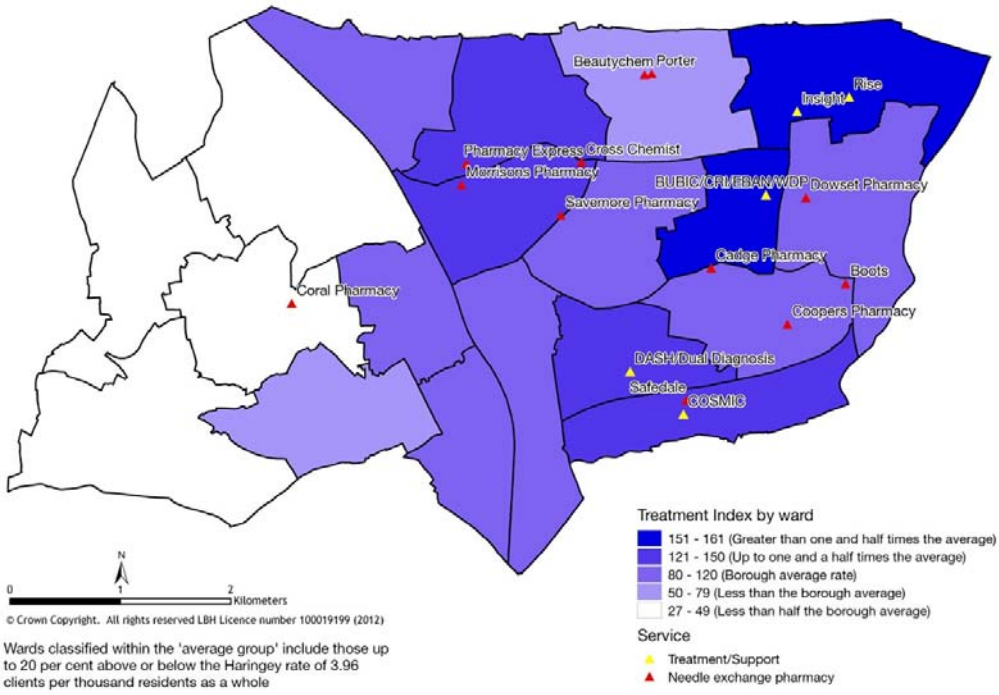
- Ensure effective communication between primary care and the mental health trust so that the medical management of long term conditions (LTCs) is well managed.
- Better support individuals and carers in times of crisis.
- Support mental health service users to give up smoking and understand how better to support them in smoking cessation.
- Improve memory clinics, care at home and in care homes (including training for staff) for patients suffering from dementia, spanning early diagnosis to the end of life.
- Develop a 'safe places' scheme where local shops and businesses display a sticker so that people with a learning disability or mental ill health who are out and about and need assistance will find refuge inside.
- Run a mental health campaign to reduce stigma and promote early diagnosis in areas of the borough with high rates of mental illness.
- Provide support to people with long-term mental illness to find suitable work opportunities.
- Ensure the appropriate level of high quality mental health residential provision for those people who need it and cannot be looked after safely within the community.
- Support mental health service users to find secure housing (monitor the number of people in settled accommodation).

Priority 14: Increase the number of problematic drug users in treatment

What we know about Haringey

- Haringey has a young population with high rates of drug and alcohol misuse – the 10th highest rate (15/1,000 population) in London and higher than the London overall rate.
- There are an estimated 2,424 problematic drug users aged 15-64 (primary crack cocaine or heroin users) along with users of other substances such as cannabis, khat, and benzodiazepines. Data from our drug treatment services indicate that:
  - the most represented age group is people in their twenties (37%)
  - many are poly-substance misusers
  - a third have a co-existing mental health problem, particularly prevalent amongst some BME groups, younger users and those in or referred from the criminal justice system
  - over 25% of women had a mental health issue, lower than men (30%)
  - nearly half have children
  - 67% are unemployed
  - 16% of 'No Fixed Abode'
  - 15% in treatment reported regular work or study.
- Problematic drug use mirrors other patterns of deprivation with the highest concentration of people accessing drug treatment/dual diagnosis in the east.
- At least 60 different nationalities use our drug treatment services; women making up a quarter of the treatment population (Fig. 14).

Figure 14: Map of Haringey showing drug treatment population[9] in 2009-10.
Source: NDTMS (National Drug Treatment Monitoring System) and local agencies: DASH (Drug Advisory Service Haringey), Eban and Dual Diagnosis.



[9] All clients in treatment at DASH, Eban and Dual Diagnosis in 2009/10 (n=891)

What we plan to do[10]

- Redesign existing drug and alcohol treatment provision to better meet the needs of local population.
- Continue to develop networks of 'Recovery Champions' at a strategic, community and provider level to actively tackle the stigma associated with substance misuse so that people with former histories of drug/alcohol use can access employment, housing, healthcare and mainstream services.
- Actively encourage and support the development of more user-led organisations/ activities, for example, BUBIC, to further build self reliance and foster a sense of being part of the wider community amongst this population.
- Expand education and employment opportunities for substance misusers and others through the contracting with small businesses who are supportive of this group and through the launch of the new employment programme planned in the east focussing on young people and other groups).

[10] A fuller description of our commissioning intentions and activities in this area can be found in our Adult Drug Treatment Plan.

6. Delivering the outcomes

This strategy is accompanied by a delivery plan for each of the three outcomes described in chapter 5 and summarised in appendix 4. They are complemented by the following strategies and action plans.

Relevant plans & strategies
• Alcohol Action Plan • Adult Drug Treatment Plan • Young People Substance Misuse Plan • Working together to improve the emotional wellbeing and mental health of children and young people in Haringey (2011-2014) • Moving Forward, Haringey Adult Services and NHS Haringey's Joint Mental Health and Wellbeing Strategy for Adults 2010-2013 • Older People's Mental Health and Dementia Commissioning Framework for 2010-2015 • Carers Strategy (2009-2014)

While this strategy focuses predominantly on the health and social care related factors that influence health and wellbeing, we recognise the importance of the wider determinants of health. Actions to address these will be delivered through the following partnership and strategic partners' organisational documents.

Haringey's strategies	Strategic partners' documents
• Child Poverty Strategy (forthcoming) • Greenest Borough Strategy • Haringey Compact • Homelessness Strategy • Regeneration Strategy • Tottenham Plan (forthcoming) • Multi-Agency Safeguarding Hub arrangements • Safeguarding Adults Prevention Strategy • Voluntary Sector Strategy • Youth Strategy (forthcoming)	• Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) Clinical Strategy • Council Plan (forthcoming) • Council's Core Strategy • College of Haringey, Enfield and North East London key documents • Health Infrastructure Plan • London Fire Brigade Safety Plan • Job Centre Plus Plan • Transforming the primary care landscape in North Central London • NHS NCL Commissioning Strategy

7. Our approach to improving health and wellbeing

This chapter sets out the principles underlying our strategy, and the range of enabling programmes that underpin it.

7.1 Prevention and early intervention

Prevention describes those interventions that occur before the initial onset of illness or a specific condition. They can be divided into:

- *Universal interventions which aim to prevent ill-health* before its onset; at any stage of the life course, they can improve quality of life and prevent problems escalating thus avoiding or delaying the need for intensive and more costly interventions or services later on. Examples include the childhood immunisation programme; Haringey Neighbourhood Wellbeing Networks (set up to promote increased participation of older people in their neighbourhood communities, facilitate more involvement of community members in the care of older people and support the personalisation of social care).
- *Interventions aimed at detecting and treating pre-symptomatic disease* that, if left undetected, could become harmful. Examples include NHS health checks; cancer screening programmes.
- *Interventions aimed at improving the quality of life for people with various conditions* by limiting complications and disabilities, reducing the severity and progression of disease, and aiding rehabilitation or recovery. Examples include:
    - supporting people to manage their long term conditions (LTCs)
    - the reablement service focused on very high intensity users of health and social care. The majority of these are older people with LTCs who are frail and vulnerable, who have experienced a recent trauma and/or dip in their general health and/or complication in their LTC
    - keeping children and vulnerable adults safe. This is coordinated through the Local Safeguarding Children's Board (LSCB) and the Safeguarding Adults Board (SAB) which work closely with the sHWB.

7.2 'Think family'

While the primary responsibility for a family's welfare will always rest with parents, the task of public services is to provide the best possible support to enable parents to fulfil that responsibility. Excellent children's and adults' services are not enough in isolation. To transform life chances and break the cycle of disadvantage, services must go further. They must 'think family'.[11]

A system that 'thinks family' has no 'wrong door': contact with any one service gives access to a wider system of support. Individual needs are looked at in the context of the whole family, so service users are seen not just as individuals but as parents or other family members. Services build on the strengths of families, increasing their resilience and aspirations. Support is proportionate to need, so that families with the most complex needs receive the most intensive help.

For all three outcomes in the strategy to be successful they would benefit from a 'think family' approach. For example, in order to tackle childhood obesity, families need to have access to affordable healthy food and leisure services; to improve children's

[11] Cabinet Office (2008). Think Family: Improving the life chances of families at risk.

emotional wellbeing and resilience, a happy and secure family environment is important.

7.2.1 Troubled Families Programme

Haringey is taking part in a national initiative to provide more coordinated and intensive support to the most troubled families. The programme aims to identify and support approximately 850 families locally that have entrenched problems of worklessness, anti-social behaviour, crime or truancy. Many such families have overlaying problems of family breakdown or physical and mental health issues which may make it difficult for them to solve these issues themselves. It is estimated that, nationally, the cost of supporting such families costs around £9 billion a year.

The initiative aims to identify those households which may require support using the following criteria:

- household members involved in crime or anti-social behaviour, including those aged under 18 years
- households where children are not in school
- households where an adult receives out of work benefits
- local discretion (for example, cost, ill-health or other local factor).

7.3 Choice, control and empowerment

7.3.1 Personalising care

We need to develop our public services so that service users, carers and families have more influence and choice, with services more responsive to both their needs and wishes. Haringey currently offers a personal budget to about 51% of vulnerable adults in need of social and health care. The aim of personalised care and personal budgets[12] is to give vulnerable adults more choice, control and independence. People who have a complex health need will also soon be able to receive a personal health budget.

7.3.2 Care closer to home

In essence this means providing care, even for those with complex health needs, in a person's own home or in a primary care setting rather than receiving care in a hospital. The aim is to ensure greater consistency of good quality, cost effective local services where the 'pathway' a patient follows is a helpful journey for them. Integration is a key element to the success of the model. Working across professional boundaries reduces duplication across the patient pathway.

7.3.3 Health trainers, volunteers and health champions

Health trainers provide free confidential one-to-one support and guidance to people over the age of 18 years who want to make a lifestyle change. They are local people who have been extensively trained to help those wanting to improve their general health through making healthier choices.

Health trainers also work with volunteers from local communities who raise awareness of key diseases, lifestyle risk factors and preventative public health programmes specifically in areas of deprivation. Current local models include: diabetes champions

[12] Think Local, Act Personal: Next Steps for Transforming Adult Social Care (04.11.2010) is the sector –wide statement of intent which makes the link between the government's new vision for social care and Putting People First, has now been finalised as the way forward for personalisation and community-based support.

(in partnership with Diabetes UK), Haringey lifesavers (raising awareness about common cancers) and drug and alcohol volunteers.

7.3.4 Resident debates

We plan to organise a series of resident debates across the borough on health inequalities and the role of communities in addressing them; the first debate will focus on childhood obesity.

7.4 Partnership working

We recognise that partnership working is essential to make sure that we achieve the best possible outcomes for everyone who lives or works in Haringey. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in the delivery of the health and wellbeing agenda. This is even more imperative given the challenges brought about by the current economic climate and the introduction of government policies that will change how local services are delivered.

This strategy will strengthen joint commissioning for local NHS services, public health and social care services. Through working together we will:

- Encourage commissioners to work in an integrated way, for example:
  - jointly commission services for children with additional needs and disabilities across health, education and social care to ensure that we create integrated and co-located, accessible and fast responding services[13]
  - jointly commission services for vulnerable adults across health and social care
- Ensure patients and the public have a voice through HealthWatch
- Facilitate engagement throughout the partnership structure by ensuring community involvement in consultations, conferences, good practice events, and any sub groups.

This strategy complements the recently approved Voluntary Sector Strategy 2011-2016; we will adopt a commissioning approach to the funding of voluntary sector organisations.

7.5 Communicable disease priorities

7.5.1 Tuberculosis

Effectively diagnosing, treating and stopping the spread of tuberculosis (TB) has been a priority in Haringey for the last five years and has led to a decrease in TB rates from 67.8 per 100,000 population in 2006 to 45.2 per 100,000 population in 2010 (34.8 per 100,000 in North Central London, 42.6 per 100,000 population for London).

There have been significant changes to the ethnicity and country of birth of TB cases in Haringey over the last five years. TB has decreased in Black African communities with the exception of the Somali community where it has increased. Residents born in Turkey, India and Pakistan and those born in the UK have shown marked increases. The most significant increase was in UK-born residents. Half of the TB notifications in UK-born were from non-White ethnic background and the majority of notifications were in those over 50 years of age.

[13] This builds on the strong multi-agency partnerships already in place through *Early Support,* developed in line with *Aiming High for Disabled Children (2008)*

Haringey will support the implementation of the pan-London approach that focuses on more effective public and patient engagement. Locally, there is a focus on TB awareness raising amongst the Somali population, especially among those who are Khat users.

7.5.2 Sexually transmitted infections and human immunodeficiency virus

There has been a marked increase in sexually transmitted infections (STIs) in England over the last ten years. The most common conditions now are chlamydia, non-specific urethritis and wart virus infections, but almost all STIs are becoming more common. Rates of STIs vary across England with highest rates in London. Haringey faces high levels of need for sexual health services with evidence of poor sexual health including, in 2010, having the 11th highest prevalence of diagnosed human immunodeficiency virus (HIV) and the 7th highest STI rate in London.

Sexual ill health is not equally distributed among the population. Those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include; young people, men who have sex with men (MSM), people from Black African communities, people from Black Caribbean communities, people living with HIV, sex workers, victims of trafficking, victims of sexual and domestic violence and abuse and other marginalised or vulnerable groups (for example, looked after children and young people).

Many people lack the information they want and need to make informed choices that will affect their sexual health.[14] Haringey will continue to foster a culture of positive sexual health by making sure that everyone gets the information they need – without stigma, fear or embarrassment – so that they can take informed decisions to prevent STIs, including HIV. Our approach needs to continue to recognise that sexual health is important throughout life and that people's needs for information and demands for services vary according to their age, way of life and sexual orientation. We will continue to promote HIV testing in order to reduce late diagnosis. We will continue to review our local services to ensure they are accessible to those population groups at high risk of poor sexual health.

8. Key developments shaping our local context

8.1 Tottenham riots and regeneration

The riots in August 2011 had a major impact on local communities and businesses, particularly in Tottenham. Almost fifty families had their homes and possessions destroyed or were made homeless, while local businesses, often existing at the margins, suffered from both direct damage and reduced levels of trade. Community members came together at a range of meetings and forums to discuss how the riots had affected them and their area, and an independent Community Panel made recommendations on actions that will make Tottenham a better place to live, work and visit. Building on these recommendations and on wider engagement with the local community, businesses, and other stakeholders, the Council is developing a long-term regeneration strategy for Tottenham.

Health outcomes in Tottenham are worse than in other areas of the borough; regeneration in the area will support improvements in health and wellbeing by tackling

[14] Department of Health (2001) Better Prevention Better Services Better Sexual Health, The National Strategy for Sexual Health and HIV. Department of Health. London

wider determinants to create jobs for local people and to secure high quality housing, public space and transport in the area. Regeneration will also play a role in tackling unhealthy lifestyles, for example, by improving residents' access to green space and sustainable transport, and limiting the spread of fast food outlets; this will help in addressing mental health issues.

8.2 NHS commissioning strategic plans

The NHS North Central London Commissioning Strategy and the Quality, Innovation, Productivity and Prevention (QIPP) plan for 2012/13-2014/15 has been refreshed and developed further as part of NHS London's overall planning requirements. The plan focuses on five major workstreams; these are incorporated into this strategy as appropriate:

1. Prevention
2. Primary care
3. Integrated care
4. Clinical and cost-effectiveness
5. Other clinical priorities (for example, stroke, learning disabilities, cancer, maternity).

8.2.1 Primary Care Strategy

Transforming the primary care landscape of North Central London is the new primary care strategy which sets out to modernise general practice, improve clinical quality and patient experience as well as enhance GP premises and IT systems. In North Central London, there are 1.3 million people in 269 general practices. Many of these patients receive good quality primary care, but there is disparity in the clinical services and the quality of premises between some practices and boroughs.

At the heart of the strategy is an 'integrated care network' where roughly six to eight practices will work together to provide a range of clinical services. These will be structured within the CCG's four collaboratives. Some core services such as immunisation and contraceptive advice will be provided by all practices. Other services, such as parenting classes and diabetes, might be better provided on a larger scale which will enable a sharing of skills and expertise.

8.3 Safeguarding

8.3.1 Adults

The coalition government policy on adult safeguarding was issued on 16 May 2011. Haringey's multi-agency SAB is committed to benchmarking our safeguarding arrangements associated with the six key principles:

- Empowerment: presumption of person led decisions and informed consent
- Protection: support and representation for those in greatest need
- Prevention: it is better to take action before harm occurs
- Proportionality: proportional and least intrusive response appropriate to the risk presented
- Partnership: local solutions through services working with their communities who can assist in preventing, detecting and reporting abuse and neglect
- Accountability: accountability and transparency in delivering safeguarding.

We will also know the outcome of the Adult Social Care Law Review and the national review of the current policy framework for safeguarding adults will be announced in the spring of 2012. The original guidance, No Secrets, was published by the

Department of Health in March 2000. The government has indicated that SABs will be put on a statutory footing and the law on safeguarding adults will be strengthened to ensure that 'the right powers, duties and safeguards are in place'. Haringey's SAB will be responding positively to these developments.

8.3.2 Children

Our multi-agency safeguarding hub (MASH) brings together a variety of agencies into an integrated multi-agency team where they can share intelligence on vulnerable children, families and adults. It is in line with best practice around the safeguarding of children and adults, including the Munro Review of Child Protection which highlighted the benefits of co-location. The key objectives of the MASH are to:

- Identify risks to children and adults at the earliest possible point
- Ensure better information sharing and therefore more effective interventions
- Deliver cashable efficiencies in the longer term
- Identify and reduce harm, crime and anti-social behaviour.

8.4 Barnet, Enfield and Haringey Clinical Strategy

The Barnet, Enfield and Haringey Clinical Strategy is currently being implemented. Broadly, this recommended the separation of sites for planned and emergency care, concentrating planned care on the Chase Farm site and increased provision outside of the (acute) hospital setting, in line with the modernisation of healthcare delivery.

8.5 Haringey Health Infrastructure Plan

The Haringey Health Infrastructure Plan (HIP) provides a vision for health infrastructure over the next 15 years: 'Improving the health of Haringey residents and reducing health inequalities through facilities fit to deliver accessible, equitable, integrated, cost-effective services'.

In developing this plan, key public sector health providers came together and agreed a physical plan of where health services will be delivered from and how this will relate to service quality and health outcomes over the next 15 years. The plan includes analyses of existing health facilities and a summary of planned infrastructure facilities including when and where they will be located, size, cost and funding sources.

The HIP feeds into Haringey's Community Infrastructure Plan (CIP) which in turn is part of Haringey's Core Strategy. Progress on delivery of the health infrastructure will be communicated through the annual monitoring report of Haringey's Core Strategy; and reported to the HWB.

8.6 Voluntary Sector Commissioning and Funding Framework[15]

This framework recognises the voluntary sector's ability to deliver effective and innovative support that reaches into the heart of local communities. The diversity and wide range of local voluntary sector organisations means that it has a highly significant

[15] In Haringey, the term 'voluntary sector' includes not for profit independent, voluntary and community groups or organisations formed by local people, or those with a local interest, to improve the quality of lives for themselves and/or others in Haringey. These include a range of registered charities; voluntary organisations; community groups; faith groups involved in social action; community interest companies, mutuals and co-operatives, social enterprises, and citizen-led organisations.

role in helping to improve the health and wellbeing of people who live and work in the borough, particularly vulnerable adults and children.

The framework sets out clear roles and responsibilities in a two-way relationship with the voluntary sector which will:

- significantly improve the clarity and accountability of funding to the local voluntary sector
- bring consistency to how we work with partner organisations
- provide a transparent, accessible and equitable process
- enable Haringey Council to more effectively manage and monitor the performance of contracts
- improve services for residents and ensure services commissioned are those most needed
- use a commissioning approach to ensure value for money is achieved.

9. Monitoring and implementation of the strategy

This strategy will be monitored and reviewed on a six monthly basis by the Haringey's Health and Wellbeing Board, and revised annually. It will be accompanied by a series of delivery plans which will set out a programme of activities – and progress against each one – to address the priorities and achieve the outcomes. These are summarised in appendix 4.

Abbreviations

BEHMHT	Barnet, Enfield and Haringey Mental Health Trust
BME	Black and minority ethnic
BUBIC	Bringing Unity Back into the Community
CAMHS	Child and adolescent mental health service
CCG	Clinical commissioning group
CIP	Community infrastructure plan
COPD	Chronic obstructive pulmonary disease
CQUIN	NHS scheme for commissioning for quality and innovation
CVD	Cardiovascular disease
DAAT	Drug and alcohol action team
DV	Domestic violence
EqIA	Equalities impact assessment
EYFS	Early years foundation stage
GLA	Greater London Authority
HDFC	Haringey Disability First Consortium
HIP	Health infrastructure plan
HIV	Human immunodeficiency virus
sHWB	Shadow Health and wellbeing board
IT	Information technology
HCP	Healthy child programme
IAPT	Improving access to psychological therapies
IBA	Identification and brief advice
JSA	Job seeker's allowance
JSNA	Joint strategic needs assessment
LINk	Health and social care local improvement network
LSCB	Local safeguarding children's board
LSOA	Lower super output area
LTC	Long term condition
MARAC	Multi-agency risk assessment conference
MASH	Multi-agency safeguarding hub
MSM	Men who have sex with men
NCL	North Central London
NCMP	National child measurement programme
NEET	Young people aged 16-19 not in education, employment or training
ONS	Office for National Statistics
PCT	Primary care trust
QIPP	NHS quality, innovation, productivity and prevention plan
QOF	NHS quality and outcomes framework
SAB	Safeguarding adults' board
sHWB	Shadow Health and wellbeing board
SOA	Super output area
SRE	Sex and relationship education
STI	Sexually transmitted infection
TB	Tuberculosis

Appendix 1: The development of our approach to health and wellbeing

This strategy builds on work and consultations that have been undertaken in Haringey over the last five years.

Children and young people

Since the Children's Act 2004, local authorities have been required to develop in partnership a children and young people's plan based on the five Every Child Matters outcomes, including *Be healthy*. The Children and Young People's Strategic Plan 2009-2020 prioritised: 'Improving health and wellbeing throughout life' and 'Improving the sexual health of young people'. The review of this plan and its delivery has informed the HWB strategy's outcome *Giving every child the best start in life* (with a particular focus on conception to 3 years of age).

Adults

In February 2006 we held *A Healthier Haringey* event which helped us identify relevant priorities. Many of these were included in our Life Expectancy Plan to help us address health inequalities and improve life expectancy. In December 2006, work began to develop our Wellbeing Strategic Framework, bringing together our diverse programmes to improve health and wellbeing for adults. This work was recognised when Haringey was a finalist for the Health Service Journal 2007 Award for Cost-Effective Partnerships Working and commended for partnering with health services in the 2008 Municipal Journal Achievement Awards.

Experience Still Counts 2009-2012, Haringey's strategy for improving the quality of life for older people, was originally developed in 2005 and updated in 2009 to tackle discrimination and to promote positive attitudes towards ageing in Haringey. Its vision was that 'older people are enabled to be as informed, active, healthy and independent as possible and empowered citizens at the heart of the community'. The strategy covered all aspects of older people's lives. It was recognised by the London Older People's Advisory Group as putting Haringey 'in the "top division" because of the way it networks across partner organisations in close liaison with older people. It also gives respect and value to older people's contributions to the strategy'.

Combining approaches to children and adults' health and wellbeing

An Overview and Scrutiny Committee event was held in late 2008 to highlight Health: everyone's business. A second event was held in 2010 focusing on specific areas where there are health inequalities in the borough and bringing the Haringey Strategic Partnership together to discuss next steps for reducing them. A visit from the Department of Health National Support Teams on Health Inequalities and Infant Mortality in late 2009 built on this work. Through several stakeholder events, a number of high level recommendations were made and an action plan implemented.

Following the successful transfer of public health to Haringey Council in March 2011, we set up a cross party working group on health inequalities to identify priority areas to be addressed to improve health and wellbeing. The work and recommendations of this group formed part of the consultation and have been fully integrated into this strategy.

An Overview and Scrutiny review, *Men's health: getting to the heart of the matter*, is specifically focused on early death of men in the east of the borough. Once agreed, the recommendations from this work will be incorporated into the HWB strategy.

Appendix 2: Consultation about this strategy

We consulted organisations and groups who work in the area of health and wellbeing as well as residents to identify the outcomes and priorities for the strategy. The consultation period was for four months from 20 September 2011 to 20 January 2012.

Specifically we consulted with:

- statutory partners such as NHS and GPs, schools, children's centres and community and voluntary sector organisations
- health and social care client group partnership boards
- Council staff
- residents
- anyone interested in improving health and wellbeing in Haringey.

The consultation questionnaire was available in hard copy, online and in an easy words and pictures format. People were also able to contribute by submitting a free text response.

We received a total of 50 responses. Of these, 44 were responses to the questionnaire and six written statement responses from:

- Haringey Disability First Consortium (HDFC)
- Haringey Health and Social Care Local Improvement Network (LINk)
- Haringey Women's Forum
- Barnet, Enfield and Haringey Local Pharmaceutical Committee
- Haringey Local Medical Committee
- Community Housing Services.

We also attended a number of different forums to alert people to the consultation and to hear their views including:

- Carers Partnership Board
- Learning Disabilities Partnership Board
- Mental Health Partnership Board
- Older People's Partnership Board
- Better Places Partnership
- Integrated Housing Board
- Children's Trust
- Drug and Alcohol Action Team (DAAT) Board
- Early Years Health Group
- Youth Cabinet
- Area Committees
- HDFC and Haringey Women's Forum Event.

Responses to the consultation

A wide range of views were expressed during the consultation; the majority of people agreed with the draft content of the strategy. There was strong overall agreement with the vision, with over 90% of respondents agreeing or strongly agreeing. Similarly there was strong support for the outcomes and priorities, with the majority of respondents agreeing or strongly agreeing.

Respondents also made a number of suggestions about what else should be included and these comments have been used to develop this final version of the strategy. These include:

- The strategy needs a clear and detailed delivery plan

- Working in partnership is key to delivering the strategy
- Disability as a protected characteristic was broadly absent from the strategy
- Obesity and healthy eating was a key issue, in particular the regulation of fast food shops; the main concern was the proliferation of fast food outlets and access to them by young people
- It is important to target areas of greatest need and inequality, for example, in the east of the borough
- The impacts of funding cuts should be mentioned.

We received many different comments about how individuals and organisations felt they could contribute to improving health and wellbeing. It is clear from these comments that 'working in partnership' is vital and that as there is a great deal of work currently being undertaken across the Council and with partner organisations we must work strategically to avoid duplication.

For more detail on the consultation, the full consultation report can be found on the website at: www.haringey.gov.uk/hwbstrategy

This strategy will be monitored and reviewed on a six monthly basis by the Haringey's Health and Wellbeing Board, and revised annually. It will be accompanied by a series of delivery plans which will set out a programme of activities – and progress against each one – to address the priorities and achieve the outcomes. These are summarised in appendix 4.

Appendix 3: Equalities impact assessment and compact proofing

An equalities impact assessment (EqIA) was completed as well as a full review of compliance with the Haringey Compact: Working Better Together.

The EqIA found that overall the strategy will reduce existing barriers to equality, as its purpose is to reduce health inequalities. Recommendations to address both the gaps in the data and the needs of, or health inequalities experienced by, specific equalities groups as identified by the data have informed the development of the strategy and delivery plan.

Through the Compact we confirmed that we had correct processes in place throughout the consultation to engage key partners in the development of the strategy, in particular BME and voluntary and community groups.

The full EqIA and the Haringey Compact review can be found on the website at: www.haringey.gov.uk/hwbstrategy

Appendix 4: Summary of outcomes, priorities, actions and measures

Outcome 1: Every child has the best start in life		
Priorities	**Actions**	**Key measures**
1. Reduce infant mortality	• Provide specialist breastfeeding support groups and offer antenatal booking appointments in the majority of our children's centres. • Train frontline staff in the prevention of sudden unexpected death in infancy. • Improve early access to maternity services in particular among Black African communities. • Continue to ensure on-site smoking cessation support in maternity services at the North Middlesex Hospital and Whittington hospitals. • Continue to improve our information technology (IT) and data reporting processes for immunisation so that we can accurately report and analyse the coverage and improve the service we provide.	• Infant mortality rate • Early access for women to maternity services • Breastfeeding at 6-8 weeks • % of women smoking at the time of delivery • Childhood vaccination coverage
2. Reduce teenage pregnancy	• Continue to fund support for tracking and supporting vulnerable under 19s. • Continue to increase access to the C-Card scheme (accessible, free condoms). • Ensure young women under 25 have access to free Emergency Hormonal Contraception. • Involve young people in devising a communication campaign integrating teenage pregnancy, sexual health, substance misuse and domestic violence. • Promote sex and relationship education (SRE) through the Healthy Schools programme. • Continue the Family Nurse Partnership, which provides intensive support to young first time mothers. • Continue the 4YP service (a young people-friendly sexual health service) in a range of school-based and non-healthcare settings for young people under 25.	• Under 18 conception rate
3. Reduce childhood obesity	• Continue the annual National Child Measurement Programme • Raise awareness through the 2012 annual public health report and through a resident debate • End the sale of fizzy sugary drinks and junk food from all Council premises; encourage schools to do same • Explore all planning avenues to reduce the proliferation of fast food outlets in the borough and work with existing outlets to make their food healthier. • Support schools to maintain their Healthy Schools status and achieve an enhanced Healthy Schools status with a focus on childhood obesity. • Offer training to school nurses and other school staff on how to recognise child obesity and how to raise the issue with families in a sensitive way. • Work with local leisure centres to ensure that they are affordable and encourage families to be active.	• Prevalence of overweight and obesity in 4-5 year olds • Prevalence of overweight and obesity in 10-11 year olds
4. Ensure readiness for school at 5 years (physical, emotional, behavioural and cognitive)	• Increase our focus on interventions targeting conception to age 3. • Continue to provide the full offer of the Healthy Child Programme (HCP) (a prevention and early intervention programme focused on pregnancy and the first five years of life) to families defined as vulnerable; and work to extend the programme to all children under 5 and their families. • Work in partnership with the Whittington Health Early Implementer Site for health visiting to increase the health visiting workforce; ensure this programme is aligned with the new Children's Centre service offer. • Meet our statutory duty to provide child care places for vulnerable 2 year olds.	• Child development at 2-2.5 years (available from 2014/15) • School readiness • Attainment at EYFS

Outcome 2: A reduced gap in life expectancy		
Priorities	**Actions**	**Key measures**
5. Reduce smoking	• Continue to strengthen the stop smoking service to target groups at risk and in accessible service locations, for example, primary care, pharmacies and workplace settings. • Promote smoke free Haringey through Council workplace policies and promoting no smoking in parks (in particular in children's areas) and bus shelters. • Implement fines for dropping cigarette butts which can be reduced if the smoker attends the stop smoking programme. • Stop the increase in the number of premises offering tobacco shisha smoking. • Encourage schools to integrate anti-smoking messages into the curriculum. • Monitor implementation of NHS North Central London's commissioning for quality and innovation scheme (the 'CQUIN') with healthcare providers to increase their smoking cessation interventions.	• Smoking prevalence in over 18s • Number of 4 week smoking quitters (through Stop smoking services).
6. Increase physical activity	• Work with local leisure centres to ensure that they are affordable and attract clients who are inactive (particularly target groups including lower socio-economic groups, disabled and older people), encourage parents to exercise with their children (for example, through financial discounts) and expand exercise on prescriptions (including targeting those with long term conditions who are among the least active). • Continue to invest in Smarter Travel options and develop the Biking Borough programme aiming to make all roads in Haringey 'bike friendly'. • Ensure the regeneration of Tottenham improves the physical environment to encourage physical activity and reduce obesity, in particular developing cycling and walking routes. • Scale up brief intervention training in physical activity and healthy eating for staff and communities. • Promote NHS Health Trainers and Health Champions programmes. • Continue to encourage parents to walk their children to school.	• Sports and leisure usage – access to all • Adult participation in sport and active recreation • Percentage of population exercising three or more times a week • Proportion of physically active and inactive adults
7. Reduce alcohol misuse	• Continue to include alcohol screening in the NHS Healthchecks programme as this programme (focused on identifying and supporting those at high risk of cardiovascular disease, including hypertension) expands. • Extend the range of Identification and Brief Advice (IBA), training staff working in non-medical settings who are likely to come into contact with people with alcohol problems, such as staff working in sexual health, safeguarding and with the Irish and Polish communities. • Monitor implementation of NHS North Central London's quality incentive scheme (the 'CQUIN') with healthcare providers, to improve alcohol screening and brief interventions at Accident and Emergency departments and Urgent Care Centres. • Continue commissioning a link worker to target those who have repeat alcohol-related attendances and/or admissions. • Continue a programme of outreach to traditional 'street drinkers', and the Eastern European community; develop a programme with the Irish community.	• Alcohol-related hospital admissions
8. Reduce risk of CVD and cancer	• Maximise case finding and use of case registers and care pathways within primary care and community services to ensure early detection and management of these conditions, particularly in the over 40s and in the east of the borough. • Expand the NHS Health Checks programme to full roll out, ensuring it reaches those most at risk and that they are supported to make lifestyle changes; deliver some Health Checks as community events.	• NHS Health Checks undertaken • Early CVD disease deaths (under 75 years) • Recorded diabetes • Cancer screening coverage

Outcome 2: A reduced gap in life expectancy		
Priorities	**Actions**	**Key measures**
	• Build on current programmes to raise awareness of early signs and symptoms of stroke, cancer and diabetes, particularly in 'at risk' communities. • Provide training and information to front line staff and community groups to raise awareness of symptoms of illness early, as well as undertake brief interventions to support lifestyle change. • Continue to improve the uptake in breast and bowel cancer screening.	
9. Support people with LTCs	• Further develop and implement care pathways for diabetes, COPD, stroke and heart failure. • Develop integrated health and social care systems for patients with LTCs across Haringey, for example, working with Whittington Health and other providers to pilot this approach. • Continue to implement the new joint reablement pathway that offers intensive support after hospital discharge or prevents hospital admissions in patients with LTCs, particularly those who are vulnerable. • Continue to support education and training for clinicians and other staff to improve treatment and care. • Review and strengthen self-management and patient education programmes to support patients in managing their own conditions. • Review and strengthen psychological support of people with physical LTCs and the management of the physical health of those with enduring mental health problems. • Ensure a continued focus on fuel poverty, particularly given the number of vulnerable residents in the borough and the speed with which fuel prices are increasing.	• Numbers of people with long term conditions diagnosed with mental health conditions • Fuel poverty

Outcome 3: Improved mental health and wellbeing		
Priorities	**Actions**	**Measures**
10. Promote the emotional wellbeing of children and young people	• Prioritise prevention and early intervention by working with schools, young people and families to provide accessible, non-stigmatising mental health services in local community based settings. • Ensure the universal services we commission are providing good outcomes in terms of wellbeing and early intervention for mental health problems, for example, the HCP, GPs, health visitors, Children Centres and schools. • Promote the Healthy Schools programme, with its focus on reducing child poverty, improving emotional health and wellbeing and reducing substance misuse and smoking. • Introduce children's Improving Access to Psychological Therapies (IAPT) service. • Reduce the use of high cost Child and Adolescent Mental Health (CAMHS) services. • Review the Multi-Agency Risk Assessment Conference (MARAC) using a 'Think Family' framework. • Increase access to education, training, employment and housing particularly increasing opportunities for young people in the east of the borough (signpost to other work programmes). • Support young people who are 'Not in employment, education or training' (NEET) or at risk of becoming NEET and ensure that programmes are in place that are relevant to their needs.	• Percentage of children who live in families who are receipt of out of work benefits • Number of victims of domestic violence advised and supported • Percentage of 16 to 18 year olds who are not in education, employment or training (NEET) • Number of children using IAPT and Tier 4 services
11. Support independent living	• Continue to offer more choice, control and greater independence through personal budgets to support those living with long term conditions (LTCs). • Continue to increase co-ordination of personal care by commissioning and delivering health, social care and housing services in a more joined up way. • Increase the number of health checks and health action plans for people with learning disabilities. • Enable people with learning disabilities to live independently or interdependently with support and housing care. • Improve care and choice in end of life care by: • Continuing to implement the Gold Standard Framework within nursing and residential care homes • Making sure that there is access to hospice care and care at home at end of life to ensure dignity and choice for people who are dying. • Identify and support unpaid carers in their caring role and in their life apart from caring; involve carers in all developments affecting them and the people they care for. • Ensure that comprehensive pensions advice is widely available. • Provide comprehensive advice on the full range of benefits and entitlements and increase take-up of these. • Work with the London Fire Brigade to enable them to undertake home fire safety visits for vulnerable people	• Proportion of people who use services who have control over their daily life • Proportion of carers who report that they have been included or consulted in discussions about the person they care for • Overall satisfaction of carers with social services
12. Address common mental health problems among adults	• Train all frontline staff in 'Mental Health First Aid' which aims to identify mental health problems early. • Actively encourage the development of more user-led organisations, for example, BUBIC (Building Unity Back into the Community) to build resilience into the community and improve the awareness of mental health among BME communities. • Ensure the regeneration of Tottenham promotes wellbeing and good mental health, for example by addressing issues of neighbourhood quality, housing design and density, housing quality and community	• Number of people using IAPT • Numbers of people with long term conditions diagnosed with mental health conditions

Outcome 3: Improved mental health and wellbeing		
Priorities	**Actions**	**Measures**
	safety (actions to deliver this will be incorporated into the Tottenham Plan). • Reduce stigma by implementing an 'early' awareness programme in schools to promote good mental health and recognise when someone is not coping. • Support people with both mental and physical illness: • Improve communication between primary and secondary care and develop a shared care approach to those who become unwell • Identify depression and anxiety in patients with long term conditions (LTCs) • Extend IAPT provision and ensure equitable access in line with national recommendations.	
13. Support people with severe and enduring mental health needs	• Ensure effective communication between primary care and the mental health trust so that the medical management of long term conditions (LTCs) is well managed. • Better support individuals and carers in times of crisis. • Support mental health service users to give up smoking and understand how better to support them in smoking cessation. • Improve memory clinics, care at home and in care homes (including training for staff) for patients suffering from dementia, spanning early diagnosis to the end of life. • Develop a 'safe places' scheme where local shops and businesses display a sticker so that people with a learning disability or mental ill health who are out and about and need assistance will find refuge inside. • Run a mental health campaign to reduce stigma and promote early diagnosis in areas of the borough with high rates of mental illness. • Provide support to people with long-term mental illness to find suitable work opportunities. • Ensure the appropriate level of high quality mental health residential provision for those people who need it and cannot be looked after safely within the community. • Support mental health service users to find secure housing (monitor the number of people in settled accommodation).	• Numbers of smokers and quitters among people known to have mental health conditions • Number of suicides in people known to mental health services • Hospital admissions for dementia care
14. Increase the number of problematic drug users in treatment	• Redesign existing drug and alcohol treatment provision to better meet the needs of local population. • Continue to develop networks of 'Recovery Champions' at a strategic, community and provider level to actively tackle the stigma associated with substance misuse so that people with former histories of drug/alcohol use can access employment, housing, healthcare and mainstream services. • Actively encourage and support the development of more user-led organisations/ activities, for example, BUBIC, to further build self reliance and foster a sense of being part of the wider community amongst this population. • Expand education and employment opportunities for substance misusers and others through the contracting with small businesses who are supportive of this group and through the launch of the new employment programme planned in the east focussing on young people and other groups).	• Number leaving drug treatment free of drug/s dependence

Cross-cutting actions: Health and wellbeing		
	Actions	**Measures**
	• Establish HealthWatch to give residents and communities a stronger voice to influence and challenge how health and social care services are provided locally by April 2013 • Facilitate engagement throughout the partnership structure by ensuring community involvement in consultations, conferences, good practice events, and any sub groups • Organise a series of resident debates across the borough on factors driving inequalities and what we as a community can collectively do about it e.g. child obesity; alcohol; smoking; stigma	
	• Implement recommendations from the Adult Social Care Law Review and the national review of the current policy framework for safeguarding adults	
	• Develop mechanisms to ensure that the JSNA is maintained and updated on a regular basis	