The London Borough of Haringey: Health Needs, Inequalities and ICS Priorities

The Centre for Population Health January 2026

Introduction

This summary provides an integrated overview of The London Borough of Haringey's population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence-based planning across health, social care and community partners.

The pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

Borough Overview

- Haringey has 264,300 residents (2021), with population density around 9,000 people/km², making it one of London's most densely populated boroughs.
- The borough is 67% BAME or non-White British, speaking 180+ languages, requiring culturally competent, multilingual health and care services.
- Haringey is the 4th most deprived borough in London, with nearly half of wards in England's 20% most deprived.
- Life expectancy gap is 7–8 years for men and 4 years for women between richest and poorest areas.
- One-third of children live in poverty after housing costs, with 8% working-age benefit claimants, the second-highest rate in London.
- Housing pressures are severe, with 2,600 households in temporary accommodation, the 3rd highest rate in London, driving health and wellbeing inequalities.

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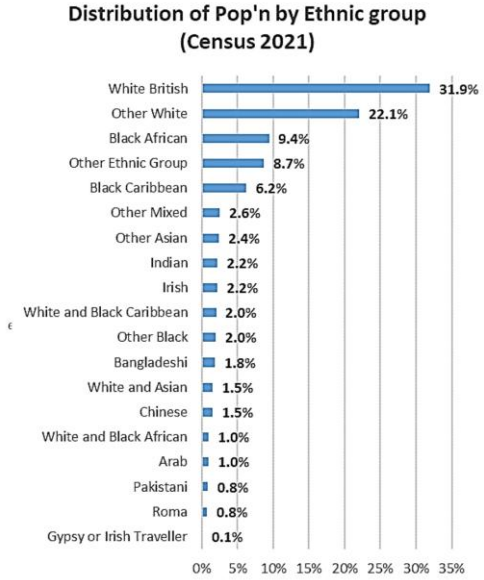
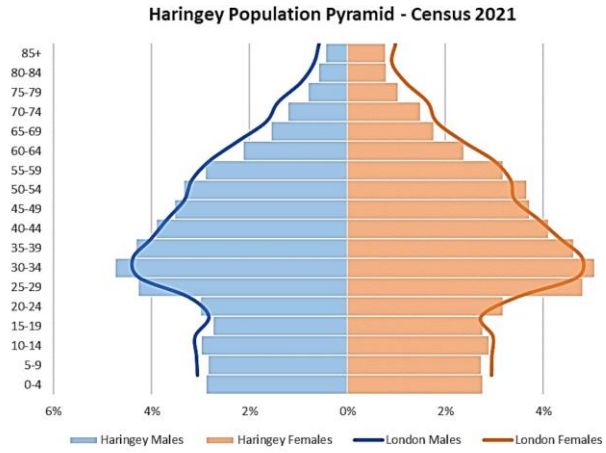
Population Characteristics

- Population stands at 264,300, projected to stabilise around 260–270k, with churn driven by migration, housing costs, and regeneration schemes.
- A younger age profile: 21% children, 71% working-age adults, and only 10.6% aged 65+, lower than England's 18.6%.
- Significant ethnic diversity: 43% BAME, 24% Other White, including major Turkish/Kurdish, Somali, Caribbean, and Eastern European communities.
- 30% do not speak English as a primary language, and 8% speak English "not well", requiring extensive interpretation and outreach.
- High migration turnover: 15% of residents lived at a different address last year, with strong international inflows from Turkey, Colombia, Nigeria.
- Birth patterns vary: 3,300 births annually, with higher fertility in deprived wards and the Haredi community, shaping maternity service demand.
- Educational attainment is polarised: 42% degree-educated, yet 6.4% have no qualifications, concentrated in eastern wards with lower health literacy.

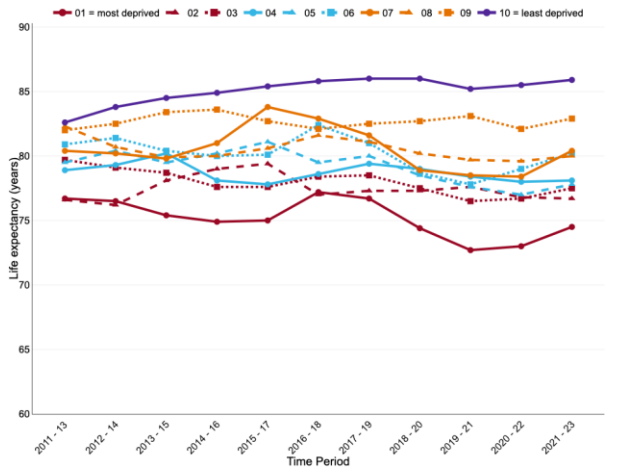




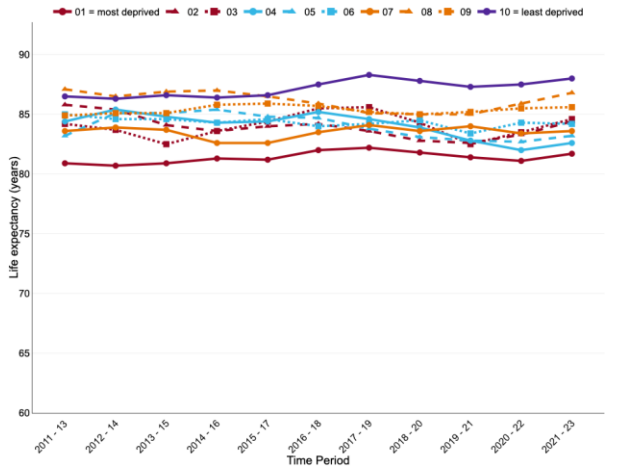
Geographic and Socio-economic Inequalities

- Men in deprived east live 7–8 years less than men in affluent west of Haringey.
- Healthy life expectancy gap reaches 15 years, reflecting cumulative deprivation and chronic disease burden.
- Under-75 cardiovascular mortality in Northumberland Park is double that of Highgate, driven by risk clustering.
- Childhood obesity in Year 6 reaches 30% in east, compared with 12% in west schools.
- Air pollution exceeds WHO limits along A10/A406, contributing to higher asthma and COPD admissions.
- Overcrowded, damp housing in east drives higher respiratory illness, especially childhood asthma emergencies.

Life expectancy at birth - Male, deprivation decile, Haringey, 2011 - 13 to 2021 - 23



Life expectancy at birth - Female, deprivation decile, Haringey, 2011 - 13 to 2021 - 23



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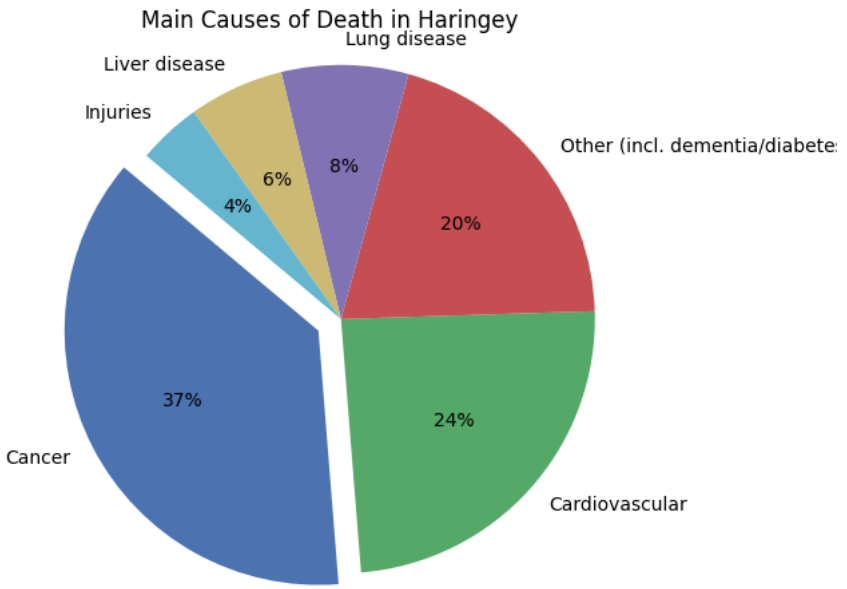
Long-Term Conditions and Premature Mortality

- Diabetes prevalence ranges from 8–9% in east practices to ~5% in west, with earlier onset.
- 1 in 5 adults with hypertension remain undiagnosed, particularly in deprived and migrant communities.
- Premature CVD mortality is 70 per 100,000, but significantly higher in deprived wards.
- Black African and Caribbean men experience 2–3 times higher diabetes rates and elevated stroke risk.
- Early-stage cancer diagnosis is 60% in deprived wards versus 75% in affluent areas, widening survival gaps.
- COPD admissions are three times higher in eastern wards, linked to smoking history and poor housing.

Causes of Death in Haringey



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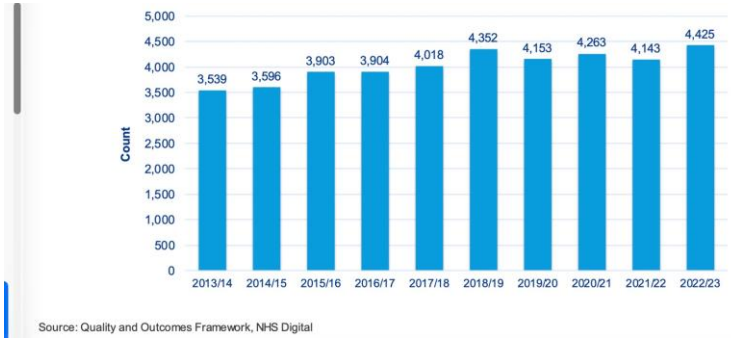
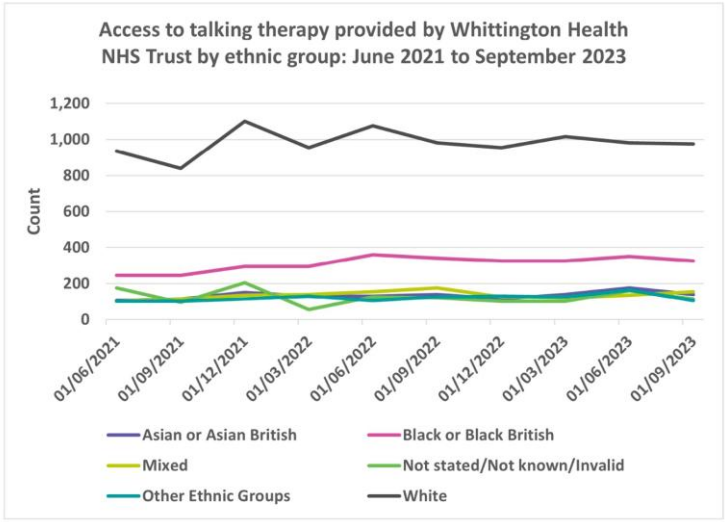
Mental Health Inequalities

- Haringey has London's highest SMI prevalence (1.37%), concentrated in deprived and minority communities.
- Black residents are four times more likely to be detained under the Mental Health Act than White residents.
- Only 40% of SMI patients receive full physical health checks, lowest in eastern practices.
- IAPT access is 18%, with under-representation of Turkish, Somali, and Black Caribbean communities.
- Young people in deprived wards show higher self-harm and CAMHS referral rates, especially post-pandemic.
- Loneliness is highest among older adults in social housing, particularly those with language barriers.

Severe Mental Illness in Haringey



Source: Quality and Outcomes Framework, NHS Digital



Children and Young People's Inequalities

Infant mortality is 4.6 per 1,000, above London's 3.3, concentrated in deprived families.

Only 60% of women in deprived wards book antenatal care by 10 weeks, versus 80% in affluent areas.

MMR2 uptake is 64.7%, among England's lowest, with pockets as low as 50% in specific communities.

Dental decay affects 30% of 5-year-olds, rising to 40% in Tottenham schools.

Youth violence disproportionately affects eastern wards, driving trauma, anxiety, and reduced outdoor activity.

Year 6 obesity reaches 30% in east, double the 12% seen in west Haringey schools.

Deprivation Overview

Haringey ranks 49th most deprived in England and 4th in London, with deprivation concentrated in eastern wards.

Over 30% of LSOAs fall within England's most deprived 10%, largely in Tottenham and surrounding areas.

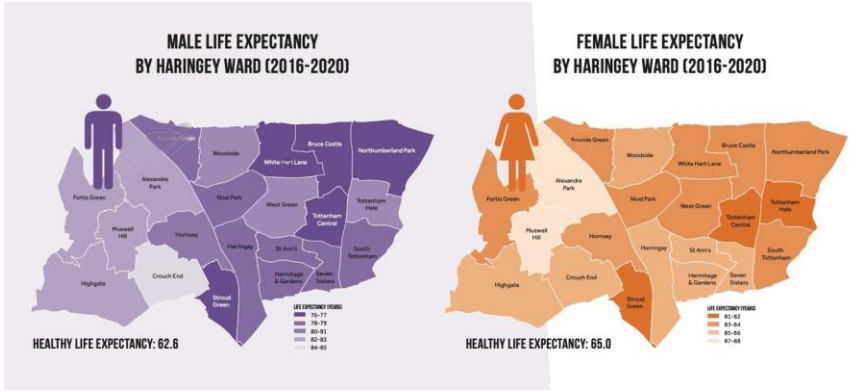
Income deprivation affects 27% of residents, with 33% of children in low-income households after housing costs.

Pensioner poverty affects 29% of older adults, particularly those living alone in eastern social housing estates.

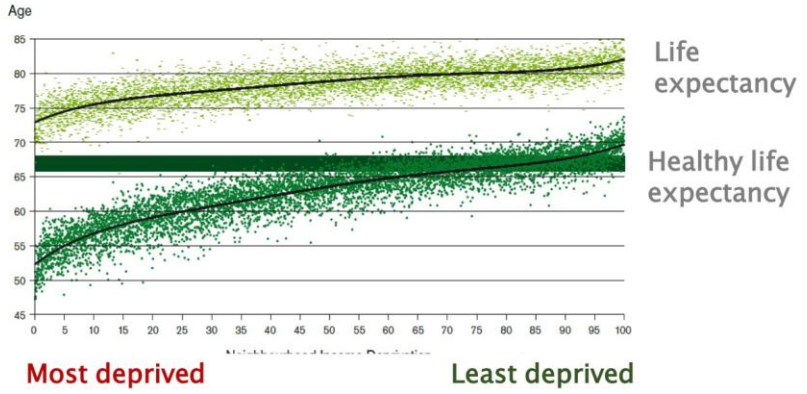
Crime rates in Northumberland Park are 50% higher than in Crouch End, impacting safety and wellbeing.

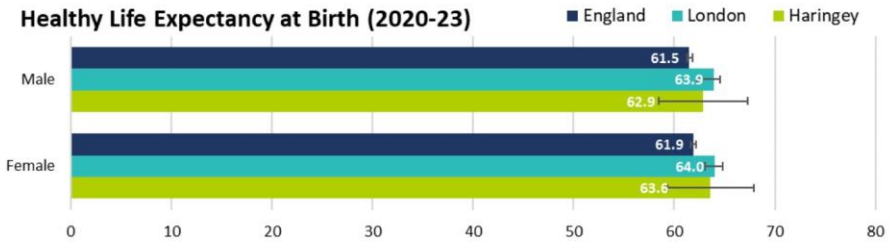
Overcrowding exceeds 25% of households in some eastern LSOAs, compared with under 5% in affluent western neighbourhoods.

Average Life Expectancy at Birth (2021)



Haringey Life Expectancy Profile





Source, PHOF, 2024

Deprivation – Housing, Employment, Education

Haringey has the 3rd highest temporary accommodation rate in London, with 2,600 households affected.

Employment deprivation persists, with 8% claimant rate, the second-highest in London.

GCSE pass rates are 10 percentage points lower for pupils eligible for free school meals.

Fuel poverty affects 12.5% of households, rising sharply after 2022 energy price increases.

Health domain scores show high morbidity and early mortality in eastern wards.

Healthy life expectancy gap reaches 15–17 years, with women spending 21 years in poor health.

Haringey JSNA 2026 – ICS Priorities

1. Improve Mental Health and Wellbeing
2. Create Healthy Environments
3. Ensure Quality Housing and Reduce Homelessness
4. Give Every Child the Best Start in Life
5. Tackle Obesity and Promote Healthy Lifestyles
6. Prevent and Manage Long-Term Conditions
7. Improve Access to Healthcare for All Communities
8. Strengthen Community Resilience and Social Connections
9. Promote Safer Communities
10. Address Poverty and the Cost of Living as Health Issues

Priority 1: Improve Mental Health and Wellbeing – Description and Importance

Haringey has London's highest SMI prevalence at 1.37%, significantly above the 0.96% London average.

Around 20% of adults report depression or anxiety symptoms, with post-pandemic increases across age groups.

Wellbeing scores are 5–10% lower than London averages, indicating widespread emotional distress.

Suicide rates remain around 8 per 100,000, with middle-aged men in deprived wards at highest risk.

Black residents face 4× higher detention rates under the Mental Health Act, reflecting structural inequities.

Deprived wards experience 30–40% higher crisis presentations, concentrated in Tottenham.

CAMHS referrals have risen 28% since 2020, with self-harm increasing among girls aged 13–17.

Only 50% of SMI patients receive all annual physical health checks, below the 60% NHS target.

Priority 1: Key Actions

Expand	Expand integrated community mental health teams in high-need PCNs to increase early intervention and reduce crisis presentations.
Commission	Commission culturally tailored talking therapies and outreach workers to improve engagement among Black, Asian and Turkish communities.
Ensure	Ensure every secondary school has a Mental Health Support Team delivering counselling and trauma-informed support.
Increase	Increase crisis alternatives by expanding evening and weekend crisis cafés to reduce A&E mental-health attendances.
Improve	Improve physical health checks for SMI patients by embedding annual screening in all GP practices and monitoring inequalities.
Scale	Scale social prescribing for isolated adults, expanding befriending, digital inclusion and community wellbeing programmes.

Priority 2: Create Healthy Environments – Description and Importance

- NO_2 levels along the A406/A10 reach 45–55 µg/m^3, exceeding WHO limits and driving respiratory illness.
- Childhood asthma admissions are 30–40% higher in eastern wards due to traffic and industrial exposure.
- Fast-food outlet density in Tottenham is 25% above the London average, reinforcing obesogenic environments.
- Some eastern LSOAs provide under 1 m^2 of green space per child, limiting safe outdoor activity.
- Residents in high-pollution areas have 20% higher COPD prevalence and 15% higher respiratory admissions.
- Only 38% of children in low-green-space wards meet recommended daily physical activity levels.
- Housing inspections show 18% of private rentals contain damp or mould, driving respiratory illness.
- High-traffic streets show 40% higher pedestrian injury rates, affecting children and older adults.

Priority 2: Key Actions

- Expand air-quality monitoring in A406/A10 hotspots and implement targeted pollution-reduction measures, including anti-idling enforcement.
- Deliver new Low Traffic Neighbourhoods and School Streets in eastern wards to reduce emissions and improve safety.
- Increase investment in parks and green spaces in deprived areas, adding play facilities and outdoor gyms.
- Strengthen planning controls limiting new fast-food outlets near schools and support healthier food retail.
- Expand housing inspections for damp and mould, prioritising private rentals in high-risk eastern wards.
- Improve climate resilience by planting street trees, creating cool spaces and supporting community-led environmental projects.

Priority 3: Ensure Quality Housing and Reduce Homelessness – Description and Importance

- Haringey has 2,600 households in temporary accommodation, the third-highest rate in London.
- Overcrowding affects 20–25% of households in eastern wards, compared with under 5% in the west.
- Poor housing conditions contribute to 15% of childhood asthma admissions.
- Rough sleepers experience mortality rates 6–10 times higher than the general population.
- Private rents exceed Local Housing Allowance by £300–£500 per month, driving arrears and insecurity.
- Families spend an average of 3.5 years in temporary accommodation.
- Rough sleeping fell 71% between 2018–2021 but has risen again post-pandemic.
- Housing-related hazards generate 1,000+ GP consultations annually.

Priority 3: Key Actions

- Accelerate delivery of new council and housing-association homes, prioritising family-sized units in overcrowded wards.
- Strengthen homelessness prevention through early identification, welfare advice and mediation with private landlords.
- Improve temporary accommodation conditions through inspections, rapid repairs and on-site health outreach.
- Expand Housing First placements for people with complex needs, providing stable accommodation and wrap-around support.
- Implement borough-wide landlord licensing to raise standards and enforce action against hazardous conditions.
- Establish a “Healthy Homes Hub” enabling GPs and health visitors to refer patients for rapid housing interventions.

Priority 4: Give Every Child the Best Start in Life – Description and Importance

Support maternal and infant health from preconception to age 2.

Improve early years development and school readiness.

Reduce inequalities in child health outcomes.

Strengthen integrated early years services and outreach.

1 in 4 children in Haringey lives in poverty.

Early development gaps persist into adulthood.

Breastfeeding rates and immunisation uptake vary widely by area.

Early intervention improves lifelong health and education outcomes.

Priority 4: Give Every Child the Best Start in Life – Description and Importance

Only 68% of Haringey children achieve a good level of development at age 5, below the 72% London average.

Infant mortality is 4.6 per 1,000 births, higher than the 3.3 London rate, with concentrations in deprived wards.

MMR2 vaccination coverage is 64.7%, among the lowest in England, with some communities falling below 50%.

Childhood obesity affects 23.4% of Year 6 pupils, rising to 30% in eastern schools.

Children from low-income families are 20 percentage points less likely to be school-ready at age 5.

Breastfeeding continuation at 6–8 weeks falls below 60% in some communities despite 75% initiation.

Youth violence admissions are 40% higher in eastern wards, affecting adolescent wellbeing and safety.

Early intervention yields strong returns: every £1 invested saves £7–£9 in later health and social care.

Priority 4: Key Actions

- Increase early antenatal engagement by establishing outreach clinics in high-need wards and supporting pregnant women with additional vulnerabilities.
- Deliver an immunisation recovery plan with door-knocking, flexible clinics and multilingual parent champions to raise MMR2 uptake above 80%.
- Expand access to high-quality early education by increasing take-up of free childcare for disadvantaged two-year-olds through targeted outreach.
- Strengthen health visiting capacity to maintain all mandated visits, prioritising families with additional needs in the first 1,001 days.
- Support healthy schools by scaling daily-mile programmes, nutrition education and family cooking classes in areas with high childhood obesity.
- Enhance youth mental-health support through school nurse drop-ins, digital counselling platforms and rapid referral pathways to CAMHS.

Priority 4: Key Actions

- Increase uptake of 2-year-old early education entitlement to 85% by 2027.
- Expand Family Hubs to cover 100% of the borough by 2026.
- Achieve 95% uptake of childhood immunisations by 2028.
- Provide perinatal mental health support to 90% of eligible mothers.
- Deliver Healthy Start vitamins to 100% of eligible families.
- Reduce childhood obesity at school entry by 10% by 2028.

Priority 5: Tackle Obesity and Promote Healthy Lifestyles – Description and Importance

Over 55% of adults in Haringey are overweight or obese, contributing to rising long-term condition prevalence.

Childhood obesity in Year 6 reaches 30% in deprived wards, compared with 12% in affluent areas.

Physical inactivity affects 27% of adults, with lower activity levels in eastern neighbourhoods.

Smoking prevalence is 14%, above the 12% London average, with higher rates among routine/manual workers.

Diabetes prevalence is 8–9% in eastern practices, significantly above the 6.5% borough average.

Obesity is linked to 30%+ of preventable deaths, including cardiovascular disease and cancer.

Fast-food outlet density is 25% higher in Tottenham, influencing unhealthy dietary patterns among children.

Physical inactivity contributes to £4.5 million in annual NHS costs locally through avoidable illness.

Priority 5: Tackle Obesity and Promote Healthy Lifestyles – Description and Importance

Promote healthy eating and physical activity across all ages.

Support weight management and behaviour change programmes.

Create environments that support healthy choices.

Address inequalities in obesity and inactivity rates.

Over 60% of adults in Haringey are overweight or obese.

Obesity increases risk of diabetes, heart disease, and cancer.

Children in deprived areas are twice as likely to be obese.

Physical inactivity costs the NHS millions annually.

Priority 5: Key Actions

Expand adult weight-management services, prioritising eastern wards with the highest obesity and diabetes prevalence.

Increase physical activity by improving walking and cycling routes, expanding community sports programmes and supporting active-travel initiatives.

Strengthen Healthy Schools accreditation, ensuring all schools deliver high-quality physical education, healthy meals and nutrition education.

Reduce smoking prevalence by expanding stop-smoking services, targeting routine/manual workers and supporting pregnant women to quit.

Improve food environments by supporting healthier takeaway options, promoting fruit-and-veg retail and restricting unhealthy advertising near schools.

Deliver a borough-wide behaviour-change campaign promoting healthy eating, physical activity and reduced sugary-drink consumption.

Priority 5: Key Actions

Double capacity of adult weight management services by 2027.

Introduce daily mile in 100% of primary schools by 2026.

Ban unhealthy food advertising near schools and playgrounds.

Subsidise healthy food options in 50 community settings.

Train 500 staff in Making Every Contact Count (MECC) by 2026.

Launch borough-wide 'Move More Haringey' campaign by Q2 2026.

PRIORITY 6: Prevent & Manage Long-Term Conditions - Description and Importance

Cardiovascular disease accounts for 24% of all deaths in Haringey, with premature mortality concentrated in deprived wards.

Adult diabetes prevalence is 6.5%, rising to 8–9% in eastern practices, with earlier onset in Black and Asian communities.

Cancer is the leading cause of death, responsible for 37% of all mortality, with late diagnosis driving poorer outcomes.

Hypertension prevalence reaches 12–13% in eastern wards, compared with 7% in affluent areas.

Premature CVD mortality is 70 per 100,000, but double this level in Northumberland Park and Tottenham Hale.

Early-stage cancer diagnosis is 60% in deprived wards, compared with 75% in affluent areas.

Undiagnosed hypertension affects 1 in 5 adults, increasing stroke and heart attack risk.

Long-term conditions account for 50% of GP appointments and 70% of inpatient bed days.

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PRIORITY 6 Key Actions

Increase NHS Health Check uptake in deprived wards through targeted outreach, mobile clinics and community-based screening events.

Expand community blood-pressure testing and follow-up pathways to identify undiagnosed hypertension and reduce stroke risk.

Improve diabetes management by delivering structured education, personalised care plans and culturally tailored support for high-risk communities.

Strengthen cancer early-diagnosis pathways by increasing screening uptake, reducing DNAs and expanding community awareness campaigns.

Integrate digital care records across providers to improve continuity of care and reduce avoidable hospital admissions.

Expand multidisciplinary care for people with multiple long-term conditions, focusing on proactive management and personalised support.

PRIORITY 7: Improve Access to Healthcare for All Communities - Description and Importance

GP registration rates are 10–15% lower in some migrant and marginalised communities, limiting access to preventive and routine care.

Cervical screening uptake falls to 55% in deprived wards, compared with 70%+ in affluent areas.

Language barriers affect 30% of residents who do not speak English as their primary language.

Digital exclusion affects 14% of households, limiting access to online appointments and remote monitoring.

Emergency cancer diagnoses reach 25% in deprived communities, compared with 15% borough-wide.

Residents in the east experience 20–30% higher A&E attendance rates, reflecting unmet primary care need.

MMR2 uptake falls below 50% in some ethnic groups, widening immunisation inequalities.

Preventable mortality is 40% higher in deprived wards than in affluent areas.

PRIORITY 7: Key Actions

Increase GP registration in migrant and marginalised communities through outreach, simplified processes and partnerships with trusted community organisations.

Improve screening uptake by delivering targeted campaigns, flexible appointments and culturally tailored engagement in low-uptake wards.

Expand interpreting services across all NHS sites, ensuring availability in the most commonly spoken community languages.

Reduce digital exclusion by providing digital-skills training, loaned devices and alternative non-digital access routes for essential services.

Deploy mobile health units to underserved areas, offering immunisations, health checks and chronic-disease reviews.

Train frontline staff in cultural competence and inclusive practice to improve patient experience and reduce inequalities in care.

PRIORITY 8: Strengthen Community Resilience and Social Connections - Description & Importance

Social isolation affects 1 in 5 older adults, with higher prevalence among those living alone in social housing.

Community participation rates are 30% lower in deprived wards, reducing access to protective social networks.

Voluntary sector organisations deliver 200+ programmes supporting wellbeing, skills and community cohesion.

Social prescribing demand has increased by 40% since 2020, reflecting rising need for non-clinical support.

Loneliness increases premature mortality risk by 26%, comparable to smoking 15 cigarettes a day.

Residents with strong social networks report 20% higher wellbeing scores and lower mental-health service use.

Communities with higher cohesion experience up to 15% reductions in youth violence.

Strengthening resilience can reduce GP attendance for social issues by up to 30%.

PRIORITY Key Actions

Expand	Expand social-prescribing capacity, connecting residents to community groups, volunteering and wellbeing activities.
Fund	Fund grassroots organisations delivering programmes that reduce isolation, build skills and strengthen neighbourhood cohesion.
Establish	Establish community connectors in high-need areas to link residents with local services, activities and support networks.
Deliver	Deliver a borough-wide loneliness-reduction strategy with targeted interventions for older adults and people living alone.
Support	Support volunteering by expanding opportunities, reducing barriers and promoting roles through local networks and employers.
Develop	Develop a digital community directory to improve awareness of local services, activities and support options.

PRIORITY 9: Promote Safer Communities (Violence and Substance Harm) - Description and Importance

Hospital admissions for violence are 47.1 per 100,000, above the London average.

Youth violence is concentrated in eastern wards, with some areas experiencing double the borough average of serious incidents.

Alcohol-related hospital admissions are 20% higher in deprived communities.

Drug-related deaths have increased by 15% over the last five years.

Exposure to violence increases risk of PTSD, anxiety and depression threefold, especially among young people.

High-violence areas show reduced outdoor activity, limiting physical activity and community use of public spaces.

Substance misuse contributes to 30%+ of safeguarding cases, affecting children's safety and long-term outcomes.

Violence and substance harm cost the NHS £3–4 million annually in emergency and inpatient care.

PRIORITY 9 Key Actions

Expand	Expand youth outreach and mentoring programmes targeting areas with the highest rates of serious youth violence.
Increase	Increase trauma-informed training for teachers, youth workers and frontline staff to support young people affected by violence.
Improve	Improve safety in public spaces through better lighting, CCTV upgrades and community-led environmental improvements.
Strengthen	Strengthen substance-misuse services, expanding treatment capacity and outreach in communities with rising alcohol-related harm.
Deliver	Deliver bystander-intervention training to residents, businesses and community groups to prevent violence and support victims.
Establish	Establish multi-agency safety hubs in priority neighbourhoods to coordinate responses to violence and vulnerability.

PRIORITY 10: Address Poverty the Cost of Living as Health Issues - Description and Importance

One-third of residents live in poverty after housing costs, among the highest rates in London.

Fuel poverty affects 12.5% of households, rising sharply after 2022 energy price increases.

Food insecurity affects 10%+ of households, with food bank usage increasing 35% in two years.

Low-income families face higher exposure to poor housing, pollution and insecure employment.

Poverty is linked to double the rate of long-term conditions such as diabetes and hypertension.

Children in poverty are twice as likely to experience developmental delays and poor educational outcomes.

Residents in the most deprived areas have 7–8 years lower life expectancy and 15 years lower healthy life expectancy.

Cost-of-living pressures increase mental-health problems, with 40% of low-income households reporting anxiety linked to finances.

PRIORITY 10 — Address Poverty and the Cost of Living as Health Issues - Key Actions

- Expand welfare-advice services to support residents with income maximisation, debt management and benefit entitlements.
- Increase emergency food and fuel support for low-income households through coordinated council and voluntary-sector provision.
- Strengthen employment support by expanding skills programmes, apprenticeships and targeted pathways for residents furthest from the labour market.
- Deliver financial-literacy training in community settings to improve budgeting skills and reduce financial stress.
- Launch a borough-wide anti-poverty strategy addressing housing, employment, food insecurity and financial resilience.
- Train frontline staff to identify financial hardship early and refer residents to appropriate support services.

Haringey Best Practice Case Studies

- Haringey Homeless Health Inclusion Team
- Community Protect: Great Mental Health Programme
- School Superzones: Healthy School Environments Initiative
- Project Future: Empowering At-Risk Youth (Violence and Mental Health)
- Reach and Connect: Tackling Social Isolation Among Older People

Description of Best Practice (HHHIT)

Multi-disciplinary outreach team providing GP care, mental health support, substance misuse treatment and housing assistance directly to homeless residents across Haringey.

Established in 2018 to address extremely poor health outcomes among rough sleepers, including high rates of tuberculosis, mental illness and premature mortality.

Delivers clinics in hostels, day centres and on the streets, ensuring people excluded from traditional services receive timely, trauma-informed care.

Integrates health and housing support, enabling immediate pathways into emergency accommodation and sustained engagement with primary care.

Builds trust through consistent staff presence, relationship-based practice and flexible engagement in non-traditional settings.

Operates collaboratively with hospitals, GPs and social care to prevent revolving-door admissions and ensure continuity after discharge.

Why It's a Best Practice (HHHIT)

Directly tackles extreme inequality by reaching people with life expectancies decades below the borough average and limited access to mainstream healthcare.

Demonstrates integrated care in action, combining health, mental health, substance misuse and housing support within one coordinated outreach model.

Significantly improves access, engaging over 300 homeless residents previously disconnected from primary care or using A&E as default healthcare.

Prevents crises and reduces system costs, with evidence showing substantial reductions in A&E attendances and non-elective admissions after engagement.

Highly person-centred and flexible, adapting to clients' circumstances and removing barriers such as appointments, documentation or fixed clinic locations.

Shows measurable health improvements, including hepatitis C cures, stabilised long-term conditions and increased vaccination uptake among vulnerable groups.

Key Lessons for Intervention Planning (HHHIT)

Cross-sector collaboration is essential; coordinated work between health, housing, social care and voluntary partners multiplies impact and prevents duplication.

Services must go to people rather than expecting marginalised groups to navigate traditional systems, reducing barriers and increasing engagement.

Trust-building requires time, consistency and trauma-informed practice; meaningful engagement only occurs once relationships feel safe and respectful.

Addressing social determinants alongside clinical needs produces better outcomes, particularly when housing and health interventions are delivered together.

Staff require specialist training, flexibility and safety protocols to operate effectively in non-clinical environments and manage complex presentations.

Continuous data collection enables adaptation, highlights gaps (e.g., women's engagement) and provides evidence to secure long-term funding.

Evaluation Results (HHHIT)

- Engaged over 250 individuals in first two years, with 85% receiving essential primary care interventions they would otherwise have missed.
- Delivered over 150 flu vaccinations and 200 COVID vaccinations to homeless residents during 2020–21, significantly improving protection in a high-risk group.
- Supported more than 100 clients into temporary or supported housing, contributing to a 71% reduction in rough sleeping between 2018 and 2021.
- A&E attendances fell by 42% and non-elective admissions by 30% among a monitored cohort, saving an estimated £200,000 in emergency care costs.
- Qualitative feedback shows improved trust, stability and wellbeing, with clients reporting life-changing support and sustained engagement with services.
- Recognised regionally for excellence, receiving ICS awards and influencing similar models across London through shared learning and replication.

Description of Best Practice (Community Protect)

- Community-led mental health programme launched in 2021 to address rising post-pandemic mental health needs through empowerment and peer support.
- Trains residents as Mental Health Champions, equipping them with mental health literacy, active listening skills and referral knowledge.
- Delivers public events, wellbeing festivals, workshops and culturally tailored outreach targeting communities with historically low mental health engagement.
- Builds a diverse volunteer network including faith leaders, barbers, youth workers and parents to normalise conversations about mental health.
- Provides peer-led support groups such as men's wellbeing circles and young mothers' networks, strengthening community resilience.
- Connects community activity with professional services through clear referral pathways and direct access to mental health trust advice lines.

Why It's a Best Practice (Community Protect)

Empowers communities to lead mental health improvement, creating sustainable capacity beyond formal services and strengthening local support networks.

Reaches underserved groups by using culturally sensitive approaches and trusted community figures to reduce stigma and increase engagement.

Focuses on early intervention, enabling champions to identify concerns before crisis point and guide residents to appropriate support.

Low-cost, scalable model that can be expanded across neighbourhoods and replicated by other boroughs seeking community-driven mental health solutions.

Builds resilience during crises, supporting residents through COVID-19 recovery and cost-of-living pressures with accessible wellbeing activities.

Demonstrates attitudinal change, with increased openness to discussing mental health and greater awareness of local support options.

Key Lessons for Intervention Planning (Community Protect)

- Leveraging existing community structures accelerates trust and engagement, enabling rapid mobilisation of volunteers and local networks.
- Volunteers require structured training, ongoing supervision and emotional support to sustain their role and prevent burnout.
- Tailored messaging is essential; culturally adapted formats significantly increase participation among groups with historically low engagement.
- Co-production with community volunteers generates innovative ideas, such as informal men's coffee groups and youth-led creative sessions.
- Visibility and celebration of achievements strengthen momentum, encouraging wider participation and normalising mental health conversations.
- Impact measurement must combine quantitative reach with qualitative stories to demonstrate value and secure continued investment.

Evaluation Results (Community Protect)

Trained over 120 Mental Health Champions, enabling more than 4,000 mental health-related conversations and interactions across the borough in 2022.

Public events engaged approximately 1,500 residents, with 90% reporting improved knowledge of mental health resources and local support options.

Community survey showed 68% of residents felt comfortable discussing mental health with a volunteer, up from 55% in 2020 baseline data.

Champions reported around 2,500 supportive conversations, including crisis interventions that directly prevented harm and improved wellbeing.

Schools, faith groups and youth organisations reported increased awareness and reduced stigma, strengthening community resilience.

Programme sustainability secured through council commitment, with champions progressing into further training, employment and leadership roles.

Best Practice 3: School Superzones – Description

Multi-agency initiative creating 400m health-protection zones around schools since 2019, targeting food environment, air quality, and youth vaping.

Implemented with public health, planning, enforcement, schools, and Trading Standards, focusing on deprived east Haringey schools.

Actions included restricting new fast-food outlets, improving existing shops' healthy options, and reducing unhealthy advertising exposure.

Air quality measures included green screens, no-idling zones, School Streets, and pollution monitoring funded by Mayor's Air Quality Fund.

Youth vaping crackdown seized 500kg illegal vapes in 18 months, with 5 shops caught selling to minors in 2023.

Student and parent engagement strengthened ownership through citizen science, letters to businesses, and active-travel campaigns.

Best Practice 3: Why It's a Best Practice

- Holistic environmental approach addressing diet, air quality, substance exposure, and safety simultaneously for stronger cumulative health impact.
- Local policy innovation, including early adoption of robust anti-vaping enforcement ahead of national policy shifts.
- Strong youth empowerment through student-led campaigns, citizen science, and advocacy, increasing sustainability of behaviour change.
- Effective cross-sector collaboration between health, education, planning, and enforcement teams, breaking traditional silos.
- Tangible environmental improvements, including reduced illegal vape supply and measurable reductions in roadside NO_2 levels.
- Transferable model now expanding to 10 more schools by 2025 and influencing other boroughs' approaches.

Best Practice 3: Key Lessons for Intervention Planning

Strong headteacher and parent buy-in significantly accelerates adoption and ensures interventions align with school priorities.

Enforcement paired with education improves compliance; punitive approaches for youth vaping proved less effective than supportive ones.

Multi-agency coordination requires dedicated resourcing and a clear coordinator role to manage competing departmental priorities.

Diplomatic engagement with local businesses reduces resistance; sharing child-health data helps secure cooperation.

Environmental change requires persistence; repeated campaigns were needed to reduce idling and shift behaviours.

Celebrating small wins, such as 8% NO_2 reduction or 20% active-travel increase, maintains momentum and community motivation.

Best Practice 3: Evaluation Results

- Active travel increased from 58% to 70% across three primaries over two years, improving fitness and reducing vehicle exposure.
- Air quality improved modestly, with NO_2 falling from 50µg/m3 to 46µg/m3 (8% reduction) after greenery and no-idling measures.
- Illegal vape sales dropped sharply; all targeted shops refused test purchases after enforcement, compared with 100% failure initially.
- Vape-related school incidents fell by 50% in one secondary, reflecting reduced access and shifting youth attitudes.
- Parent awareness reached 90%, with 84% supporting enforcement on idling and unhealthy shops near schools.
- Curriculum benefits emerged through citizen science and persuasive writing linked to Superzone activities.

Best Practice 4: Project Future - Description

- Community-based project supporting 16–25-year-olds affected by violence, gangs, and mental health issues since 2014.
- Co-production model where young men design, shape, and deliver activities, creating a trusted youth-led environment.
- Embedded psychologists provide informal therapy through conversations, group sessions, and relationship-building.
- Holistic support includes housing help, legal advice, employment pathways, and creative outlets like music production.
- Safe neutral space with strict no-retaliation ethos, enabling rival groups to engage peacefully.
- Peer-research model produced reports influencing policing and statutory services.

Best Practice 4: Why It's a Best Practice

Successfully engages high-risk youth who rarely access traditional mental health or statutory services.

Innovative co-production and informal therapeutic model recognised by Centre for Mental Health and NHS awards.

Demonstrated violence-reduction impact through empowerment, personal development, and alternative pathways.

Independent evaluation by UCL showed improved well-being, reduced offending, and increased engagement with services.

Strong qualitative evidence of life transformation, including exits from gang life and long-term employment.

Influential model shaping London's public-health approach to youth violence and inspiring replication elsewhere.

Best Practice 4: Key Lessons for Intervention Planning

- Trust-building must precede formal intervention; early months focused solely on relationship-building.
- Youth ownership increases relevance and engagement; professionals must relinquish control and adopt facilitative roles.
- Location matters; neutral, accessible neighbourhood bases outperform clinical or official settings for engagement.
- Holistic support is essential; addressing housing, hunger, or safety enables mental-health progress.
- Persistence is vital; re-engagement after disengagement prevents young people from falling through gaps.
- Clinicians require supervision and adaptation training to work effectively in informal, youth-led environments.

Best Practice 4: Evaluation Results

198 young people engaged in first 3 years, with 100 becoming long-term core participants.

Over 70% showed reduced psychological distress on clinical measures after sustained involvement.

94 participants progressed into education, employment, or training, supported by skills development and confidence-building.

Reoffending reduced by around 50% among participants, with several high-risk individuals showing no further arrests.

Improved trust in statutory services, with youth joining police scrutiny panels and advising councils.

Community perception improved as participants engaged in volunteering and visible positive contributions.

Best Practice 5: Reach and Connect – Description

- Community-based programme launched in 2019 supporting isolated older residents aged 50+, led by Age UK Haringey with council partners.
- Tackles loneliness in areas like Tottenham and Wood Green where many older adults live alone and lack community ties.
- Link Workers proactively identify isolated individuals through GP referrals, housing lists, door-knocking, and community gatekeepers.
- One-to-one personalised plans include social clubs, alarms, transport, benefits help, and confidence-building support.
- Volunteer befrienders provide weekly calls or visits, matched by interests or language, offering emotional support and companionship.
- Group activities include coffee mornings, IT classes, exercise groups, cultural events, and intergenerational storytelling sessions.

Best Practice 5: Why It's a Best Practice

Addresses hidden epidemic of loneliness linked to dementia, depression, and increased mortality, prioritising social wellbeing for older adults.

Person-centred, strengths-based approach reconnects individuals through interests such as woodworking, gardening, knitting, or cultural groups.

Mobilises volunteers effectively, expanding capacity while strengthening community cohesion and intergenerational solidarity.

Improves mental and physical wellbeing, reducing unnecessary GP or A&E visits driven by loneliness or lack of social contact.

Fully integrated with GPs, social care, and social prescribing pathways, ensuring seamless support across local systems.

Demonstrated adaptability during COVID, shifting to phone befriending and emergency support for 500+ older residents.

Best Practice 5: Key Lessons for Intervention Planning

Identifying isolated older adults requires creative referral routes, including postal workers, firefighters, pharmacists, and community gatekeepers.

Trust-building is essential; gentle persistence, GP reinforcement, and peer testimonials help overcome fear, pride, or suspicion.

Volunteer management needs strong coordination, training, emotional support, and careful matching to sustain long-term befriending relationships.

Diverse activity options are vital due to varied interests, ages, cultures, and abilities across the 50–90+ population.

Holistic support must address mobility, hearing, safety, and poverty barriers before social engagement becomes possible.

Loneliness measurement requires sensitive tools; combining UCLA scores with qualitative stories captures real human impact.

Best Practice 5: Evaluation Results

65% of participants recorded reduced loneliness on the UCLA scale after six months, moving from “often” to “sometimes” lonely.

Mental wellbeing improved by around 15% on WEMWBS, with GPs noting reduced antidepressant use and fewer distress-driven appointments.

GP consultations dropped by 25% among a small cohort; A&E visits halved from eight to four after engagement.

Over 80 volunteers trained, with 70% retention beyond one year, strengthening community capacity and intergenerational connections.

Around 600 older residents engaged in two years; 400 connected to new activities or befriending, with 90% satisfaction.

COVID response supported 500+ residents with calls, groceries, and medication, demonstrating resilience and essential community value.

Cross-Cutting Insights from Best Practices

Co-production with residents ensures services reflect lived experience, increasing trust, relevance, and long-term engagement across diverse communities.

Holistic approaches addressing housing, mental health, environment, and social needs deliver deeper, more sustainable improvements than single-issue interventions.

Trust-building is foundational; consistent, compassionate relationships enable engagement among marginalised groups often disconnected from traditional services.

Multi-agency collaboration maximises impact by combining strengths of NHS, council, schools, police, and voluntary partners to address complex needs.

Data and evaluation guide adaptation, ensuring programmes evolve based on evidence, participant feedback, and changing community contexts.

Capacity-building leaves lasting community assets, empowering residents and influencing mainstream services beyond the lifespan of individual projects.

What This Means for the Borough and ICS

Haringey is shifting from reactive illness treatment to prevention and equity, embedding health considerations across housing, transport, education, and environmental planning.

Integrated care strengthens collaboration between NHS, council, and voluntary partners, improving population health outcomes and reducing long-standing inequalities across communities.

Prevention-first strategies aim to narrow life expectancy gaps, reduce chronic disease, and create healthier environments that reduce long-term pressure on health services.

Joined-up working enables more efficient, resilient services, ensuring residents receive timely, coordinated support rather than fragmented care across multiple agencies.

Community empowerment builds trust, ensuring culturally relevant interventions that improve engagement, early help-seeking, and long-term health outcomes for diverse populations.

Haringey's approach becomes a model for national public health innovation, demonstrating how integrated systems can address social determinants and reduce inequalities.

System Recommendations

- Embed Health in All Policies by integrating health impacts into planning, housing, transport, and economic decisions to improve wellbeing and reduce inequalities borough-wide.
- Prioritise prevention by investing in early intervention, screenings, lifestyle support, and targeted programmes for deprived communities with the poorest health outcomes.
- Strengthen integrated care through multidisciplinary neighbourhood teams, shared pathways, and co-located services delivering holistic, person-centred support.
- Engage communities through co-production, citizen panels, health champions, and partnerships with grassroots organisations to design culturally relevant services.
- Use data-driven decision-making with linked datasets, dashboards, and continuous improvement cycles to track progress and refine interventions.
- Leverage anchor institution power by increasing local recruitment, apprenticeships, procurement, and fair employment to address socioeconomic drivers of poor health.

Next Steps for The London Borough and ICS

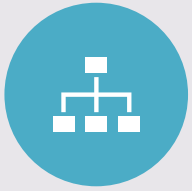
- Establish a Health in All Policies Taskforce to embed health considerations across council and ICS decisions.
- Set measurable health equity targets and allocate prevention budgets aligned with deprivation and population need.
- Develop integrated neighbourhood hubs offering joined-up health, social care, and community support in high-need areas.
- Launch a Community Partnership Forum to co-produce services with residents and voluntary sector partners.
- Implement a borough-wide population health dashboard tracking inequalities, outcomes, and system performance.
- Formalise anchor institution commitments to boost local jobs, procurement, apprenticeships, and workforce wellbeing.

Closing Reflections

Haringey's journey shows meaningful health improvement requires bold leadership, community partnership, and sustained commitment to tackling root causes.

Integrated care and prevention are essential to reducing inequalities and improving life expectancy across diverse neighbourhoods.

Community voices must remain central, shaping services that reflect cultural realities and build long-term trust.



Data-driven learning ensures accountability, transparency, and continuous improvement across the health and care system.

Anchor institution commitments strengthen local economies, supporting healthier, more resilient communities.

The strategy positions Haringey as a leading example of modern, equitable, community-centred public health transformation.