

4.0 Disease risk factors and lifestyle

Organisational, economic, and environmental factors have major influences on the health of individuals. However, health-related behaviours also contribute significantly to cardiovascular and respiratory diseases, cancer, and other conditions that account for much of the burden of morbidity and mortality in later life.

Measuring and reporting health behaviours at a local level provides important information for monitoring within area inequalities, for planning and targeting public health interventions, monitoring trends over time, and for evaluation. The Association of Public Health Observatories recently published useful guidance on using data on lifestyle risk factors for local use¹. Health behaviours described in this chapter include: tobacco smoking, healthy eating, obesity, alcohol, drug misuse and sexual behaviour.

4.1 Smoking

Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities. Reducing prevalence is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher. We currently do not have data on tobacco prevalence across the borough, particularly at ward level and amongst different population groups.

Every year in Tottenham there are 130 deaths related to smoking and 600 hospital admissions, at a cost of nearly £1.4m (as at 2004)².

In 2007, Haringey PCT commissioned a piece of work on tobacco control activities in Haringey. Data on deprivation, ethnicity, housing condition, health status, income and employment were aggregated to identify postcodes and wards that are likely to have the highest smoking prevalence. The worst third of wards were identified as Northumberland Park, White Hart Lane, Noel Park, Tottenham Green, Tottenham Hale, Bruce Grove and St Ann's. These areas were matched against numbers of residents who accessed quit smoking services and were successful quitters at 4 weeks post attempt. The results suggest that, mostly, the best quitting performance is being achieved in areas where the problems are generally not the worst.

Modelled smoking prevalence data derived from the Health Survey for England (2003-2005)³, predicts that Haringey has a prevalence of current smoking of 23.5% (95% Confidence Interval 22.6-28.3%), compared with 23.3% in London and 24.1% in England. These data were released to Middle Super Output Area (MSOA) level. Highest smoking prevalence of between 29 and 33% was predicted for MSOAs in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

Prevalence of current smoking is reported for major ethnic groups. Respondents from the Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups

¹

www.apho.org.uk/resource/item.aspx?RID=39441

²

Tobacco in London: The preventable burden. www.lho.org.uk/viewResource.aspx?id=8716

³

Available at: www.neighbourhood.statistics.gov.uk

were less likely to be current smokers than England as a whole, whereas Irish respondents were more likely to be current smokers.

It should be noted that these estimates do not reflect the ethnic diversity within Haringey and the complex relationship between ethnicity and smoking prevalence. More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant.

4.2 Eating habits

Nutrition is important at all stages of life. Dietary factors are linked to health and disease, as protective influences or as risk factors, including: coronary heart disease, some cancers, type-2 diabetes, overweight and obesity, osteoporosis, dental caries, gall bladder disease, and diverticular disease. Accurate data on eating habits are not readily available at small geographical areas.

Fruit and vegetable consumption by adults is recorded in the Health Survey for England. The most recent prevalence data modelled from the Health Survey for England⁴ suggests that 27.8% of adults in Haringey (95% confidence interval 25.2-30.8%) consume adequate amounts of fruit and vegetables in their diet, compared with 26.3% (25.6-27.0%) in England and 29.7% (27.5-31.9%) in London. These data were released to Middle Super Output Area (MSOA) level. MSOAs that are predicted to have adequate fruit and vegetable consumption of less than 25% include MSOAs in Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

4.3 Breastfeeding

Breastfeeding has health advantages for both infants and mothers. For infants, these include protection against childhood infections; reduced risk of childhood obesity; and improved visual and psychomotor development. For mothers, benefits include quicker recovery from childbirth, and reduced risk of ovarian cancer and premenopausal breast cancer. Infant mortality rates can be improved by increasing the number of women who initiate breastfeeding. We currently record breastfeeding initiation. Breastfeeding was initiated for 87% of births to Haringey residents in 2007. We have agreed under the new Local Area Agreement to measure breastfeeding at 6-8 weeks post birth and will be reporting on this indicator in the future.

4.4 Childhood obesity

Obesity is a major risk factor for the future health of children; it can lead in turn to complications such as heart disease, diabetes, joint problems and emotional problems.

In 2007, 18% of Haringey School children weighed were considered to be obese, and a further 14% were overweight. This varied by age, 24% of year 6 children were obese compared to 13% in reception year. These figures are currently above the national predicted levels for 2010. There is also a variation between males and females with a higher proportion of boys considered overweight or obese. Figures 4.4.1 and 4.4.2 depict the variation at both age groups within Haringey, demonstrating that obesity in children is not evenly distributed across the borough.

⁴ Available at: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles

Figure 4.4.1: Percentage of obese year 6 children by ward (June 2007)

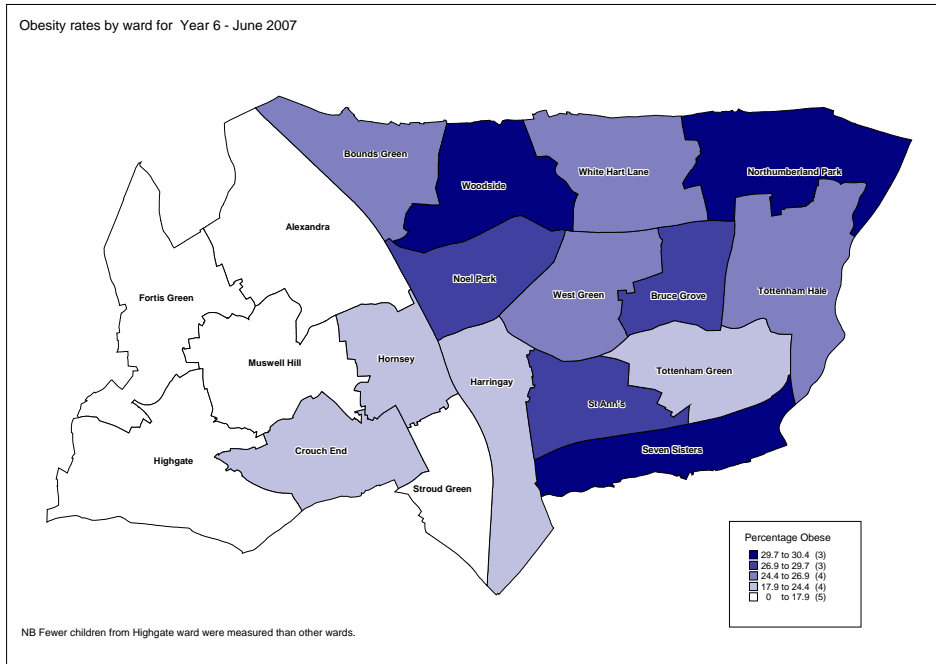
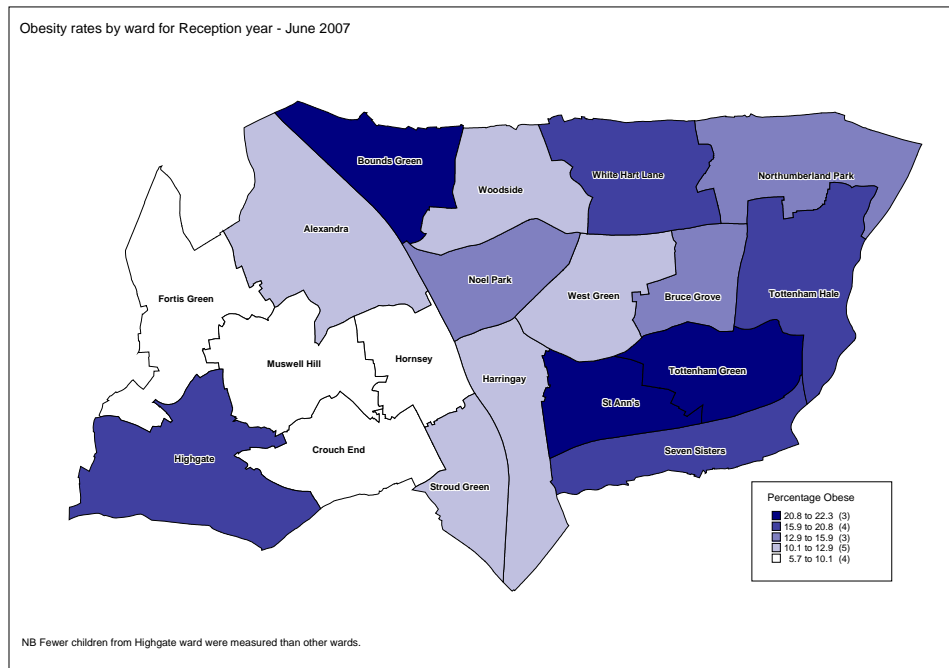


Figure 4.4.2: Percentage of obese reception class children by ward (June 2007)



A more detailed assessment was undertaken by Haringey PCT in conjunction with University College London Institute of Child Health specifically to understand some of the barriers to healthier eating and active lifestyles for children and their families in Haringey. The project involved two phases. The first involved identifying, collating and mapping routinely collected data and local information on the prevalence of obesity and behavioural, social and environmental determinants of obesity. Data included height and weight, locations of fast food outlets across Haringey and location of parks

and open spaces. Interestingly those wards with higher prevalence of obesity broadly correspond to those that have higher density of fast food outlets and lower density of open spaces.

The second phase of the project involved reviewing children's perspectives of their local environment relating to eating and physical activity. Focus group research was conducted with 36 10-11 year old children to identify barriers and facilitators to physical activity and healthy food choices. A key finding was the importance of access to food. Proximity was cited as a common reason for accessing a particular food outlet. Safety and proximity were cited as common reasons for accessing facilities for physical activity.

4.5 Obesity in Adults

Obesity in Adults has been estimated from the Health Survey for England (2003-2005). 17.9% (95% confidence interval 16.2 to 19.7%) of adults are predicted to be obese, compared with 18.4% (16.8-20.1%) in London and 23.6% (23.0-24.2%) in England. The estimates for obesity vary considerably across the borough, ranging from less than 10% in a middle super output areas in Highgate to greater than 25% in middle SOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

8% of residents registered with a GP in Haringey were recorded as obese in March 2008. Obesity rates were highest in the north and central general practice collaboratives (8.9% and 9.7%) respectively, followed by 8.4% in the east collaborative. The lowest obesity rate was recorded in the west collaborative (5.5%).

4.6 Alcohol consumption

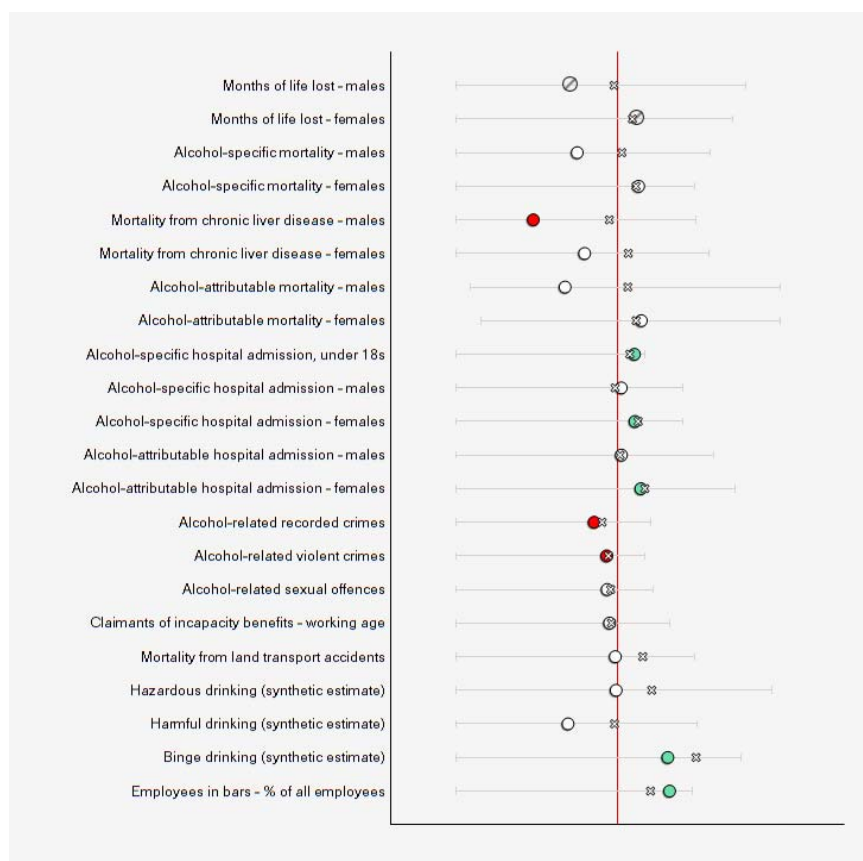
Alcohol can have both a positive and negative effect on health, which varies depending the amount and nature of consumption and by age and sex. High levels of alcohol consumption are associated with violence and injuries as well as ill-health. For a more detailed discussion of alcohol and health related issues in London, please refer to the London Health Observatory publication, *Choosing health: A briefing on reducing alcohol-related harm and encouraging sensible drinking in London*⁵.

4.6.1 Alcohol-related harm

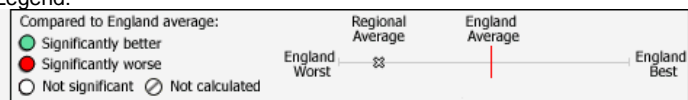
Detailed information on alcohol related hospital admissions, mortality and crime is available from the Local Alcohol Profiles for England⁶. The main features of the local profile are summarised in the figure below:

⁵ Available at: www.lho.org.uk/Download/Public/10367/1/LHO%20Alcohol%20Brief%20PDF%20for%20Web.pdf
⁶ North West Public Health Observatory, available at: www.nwph.net/alcohol/lape/

Figure 4.6.1: Indicators of alcohol-related harm for Haringey



Legend:



Source: North West Public Health Observatory, available at: www.nwph.net/alcohol/lape/

Alcohol-related crime in Haringey is significantly worse than the English average⁷. Mortality rates from chronic liver disease are significantly higher for Haringey than both the regional and English average.

A slight increase in alcohol related hospital admissions was observed in Haringey between 2003 and 2005⁸.

4.6.2 Police Statistics on alcohol use

In the 2006/07 performance year, there were 3,834 domestic violence offences in Haringey. Sixty of these domestic violence offences were flagged as alcohol related. All wards except Alexandra had at least one alcohol related incident with the highest number being in White Hart Lane, Tottenham Green and Noel Park.

⁷ Note that this is based on a synthetic estimate, that is, this is based on modelled data rather than real figures.

⁸ Please note that guidance for calculating performance against the new National Indicator for alcohol related hospital admissions is currently being drafted by the Department of Health. Ward level analysis for alcohol related admissions will be available at that time.

4.6.3 Prevalence of binge drinking

Prevalence of binge drinking⁹ in adults has been estimated from the Health Survey for England (2003-2005). 14.6% (95% confidence interval 12.7 – 16.7) of adults were estimated to have had engaged in binge drinking in the previous week. The estimates for binge drinking vary considerably across the borough, ranging from less than 10% in a middle super output areas in Highgate to greater than 25% in middle SOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

4.7 Physical activity

Physical inactivity is an important risk factor for many diseases including ischaemic heart disease, type 2 diabetes and stroke.

56.3% of respondents in the 2006 Haringey Resident's Survey reported undertaking at least 30 minutes of moderate intensity physical activity on three or more days each week.

Table 4.7.1: Proportion of respondents to the 2006 Haringey Resident's Survey who reported greater than 30 minutes of moderate intensity physical activity during the previous week.

During the last seven days, on how many days did you do a total of at least 30 minutes of moderate intensity physical activity?

1 day	10%
2 day	11.20%
3 day	12.50%
4 day	9.30%
5 day	9.90%
6 day	2.60%
7 day	22%
None	21.50%
Don't know	1.10%

The Active Participation Survey is to be conducted annually from October 2008. Proxy measures show encouraging signs with leisure centre usage on target for 1.18m user visits for 2007/8, up 4% on 2006/7; and ActiveCard Memberships (which allows users access to Haringey leisure facilities depending on the type of membership) are up 11.5% against target at 8,433.

4.8 Sexual Health

Nationally there is widespread concern at the increase of sexually transmitted infections (STIs) reported at Genito-Urinary Medicine Services (GUM). These sexual health concerns are mirrored in Haringey where there are increasing levels of STIs, high teenage conception rates, high termination of pregnancy rate and an increase in the number of HIV infections. Notably, young people who become sexually active are vulnerable to sexual ill-health, including unwanted pregnancy or abortion, and

⁹ The quantities of all the different types of alcoholic drink (beer, wine, spirits, sherry and alcopops) consumed on a respondent's heaviest drinking day were collected from the Health Survey for England. These measures were combined to give the number of units of alcohol consumed on the heaviest drinking day. Adult respondents to the Health Survey for England were defined to be binge drinkers if they reported that in the last week they had drunk 8 or more units of alcohol if they were a man, or 6 or more units of alcohol if they were a woman, on any one day or more. They were not considered a binge drinker if they had not drunk this amount of alcohol on any day in the past week.

exposure to sexually transmitted infections (STIs) and HIV. Improving the sexual health of young people is a key national and local priority.

In 2005 a detailed service mapping exercise and needs assessment was undertaken by the Haringey sexual health service¹⁰. A refresh of this needs assessment is due.

In 2004 there were 1070 attendances at the young people’s sexual health drop-in clinic at St Ann’s Hospital in Haringey (67% of these were female). Sexual health services nationally have consistently been stretched. In quarter 3 2008, Haringey achieved a rate of 98% of patients were seen at a GUM service within 48 hours of seeking an appointment.

Between April and December 2007, 625 screening tests for Chlamydia were performed, of which 115 (18.4%) were positive. Chlamydia screening was a target under the previous local area agreement. Haringey consistently recorded screening rates far below target. Chlamydia prevalence in people under the age of 20 is a target under the new local area agreement.

The Health Protection Agency (HPA) conducts an annual survey of HIV infected individuals, the Survey of prevalent HIV infections diagnosed (SOPHID¹¹). SOPHID is a cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales, and Northern Ireland (E, W & NI) within a calendar year. In 2006, 1054 Haringey residents with HIV were seen for treatment and care. 47% of these individuals were identified as black-African ethnic origin, 34% were of white ethnic origin. Most (55%) of transmission occurred through heterosexual sex. It is estimated that 31% of HIV infections in the UK are undiagnosed¹²; 31% of these are expected to be amongst African born individuals. A better understanding of barriers to accessing sexual health services, particularly amongst people born outside the UK is required in Haringey to ensure that detection rates improved.

4.8.1 Teenage Conceptions

16 of Haringey’s 19 wards have teenage conception rates over 54.3 per 1000 (conceptions in females less than 18 years of age). Haringey’s teenage conception rate, however, is beginning to fall, down from 79.3 girls in every 1000 in 2002 to 63.7 in 2005. High rates correlate closely within the wards with the highest levels of poverty and deprivation. Between 2001 and 2003 the rate of teenage conception varied from 11.8 per 1,000 in Muswell Hill to 120.9 per 1,000 in Bruce Grove.

Figure 4.8.1: Teenage conceptions by Inner London borough, 1998 & 2005

Borough	Rate ¹³		% leading to abortion	
	1998	2005	1998	2005
Camden	49.3	39.6	58.5	71.0
Hackney & City of London	77.1	55.7	54.2	58.0
Hammersmith and	69.0	36.8	59.0	52.7

¹⁰ Available at: www.haringey.gov.uk/haringey_sexual_health_strategy_-_part_3.pdf

¹¹ www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733790666

¹² www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203084355941

¹³ Rates are per 1,000 of the female population aged 15-17. Counts for the City of London have been combined with Hackney.

Fulham				
Haringey	62.3	63.7	46.3	55.3
Islington	58.3	55.8	62.6	57.1
Kensington and Chelsea	41.7	28.4	74.0	64.7
Lambeth	85.3	79.7	53.4	60.8
Lewisham	80.0	70.1	52.7	57.3
Newham	59.9	46.0	42.2	56.8
Southwark	87.2	68.1	62.6	62.9
Tower Hamlets	57.8	43.2	43.7	62.7
Wandsworth	71.1	49.2	60.4	54.8
Westminster	40.8	21.7	64.4	69.4

Source: Department for Children, Schools and Families, Teenage Pregnancy Unit

4.9 Drug Users in Effective Treatment

Misuse of illicit drugs can affect health directly through personal harm or by its effect on criminal and anti-social behaviour. For sustained reductions in drug offences to occur, drug users must tackle their drug dependency. For this reason the numbers of drug users in effective treatment¹⁴ is a useful indicator towards tackling overall problems with drugs and crime. There was an overall increase in the number of users in effective treatment between 2005-06 and 2007-08.

Table 4.9.1 : Drug Users in effective treatment 2005/06-2007/08

Year	Number of users in treatment	Percentage increase/decrease
2005-06	1240	
2006-07	1348	8.7% increase
2007-08	1308*	2.9%* ¹⁵ decrease

From 2008-09 we will measure only those users who have Crack and/or Opiates habit in effective treatment. Misusers of other drugs will be excluded.

4.10 Key issues and gaps in understanding

- Modification of lifestyle risk factors, particularly in high-risk populations, will be critical to reducing health inequalities into the future. Data on health behaviours are difficult to obtain at sufficiently fine geographical detail to allow detailed planning of health interventions. This issue is not unique to Haringey; borough and ward level data is only available for a small number of indicators.
- In particular, data on smoking behaviour and eating habits at ward level is required so that these behaviours can be understood and interventions can be targeted at high-risk communities.
- Sexual health is a priority for Haringey. Haringey has high teenage conception rates, increasing levels of STIs, high termination of pregnancy rate and an increase in the number of HIV infections. A needs assessment of sexual health in Haringey is required.
- Further research on childhood obesity discussed in this chapter demonstrates the potential of detailed research involving communities to more fully understand determinants of behaviour at local level.
- MOSAIC™ and other social segmentation tools provide potential to subdivide populations to understand need and determinants of health more

¹⁴ Effective treatment is defined as those clients who: have been in treatment for 12 weeks, or if less than 12 weeks have either completed treatment successfully, or have an onward referral to more treatment.

¹⁵ Projected

fully. These tools may also allow for a better understanding of how to reach these communities more effectively.

- General practices/ primary care settings also provide an excellent opportunity to obtain data on risk factors.



5.0 Illness and premature death

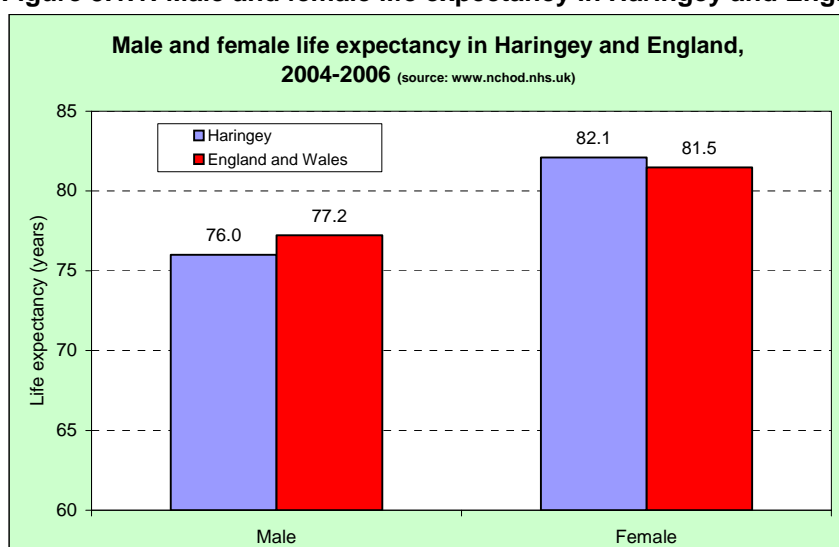
5.1 Premature mortality and life expectancy in Haringey

The following information on premature mortality and life expectancy has largely been extracted from the 2008 review of the life expectancy action plan, which is currently in draft form. This review will be released in late 2008 and will provide further detailed information on these issues in Haringey¹⁶.

5.1.1 What is the life expectancy of the people of Haringey?

Life expectancy¹⁷ in Haringey (using 2004-2006 data) is 76.0 years and 82.1 years for males and females respectively. Haringey has a slightly lower male life expectancy than England as a whole; male life expectancy is 1.3 years lower than England for males. Female life expectancy in Haringey is slightly higher (0.6 years) than England.

Figure 5.1.1: Male and female life expectancy in Haringey and England, 2004-2006



Healthy life expectancy¹⁸ is the expected years of good or fairly good health. It is used to provide additional information on expected years of good health. Healthy life expectancy in Haringey (1999-2003) is 74.3 years and 79.9 years for males and females respectively, compared with 72.3 and 69.0 years for males and females in England as a whole.

5.1.2 Is life expectancy in Haringey improving? Is the gap narrowing?

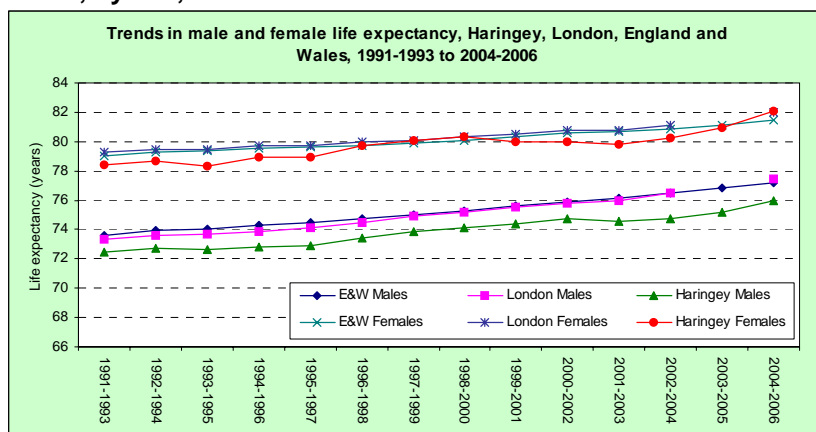
Consistent with national trends, life expectancy in Haringey for men and women has improved steadily over the past decade. The gap between Haringey and England is narrowing slightly for males. Female life expectancy is now above England.

¹⁶ The current life expectancy action plan (2006-2010) can be viewed at: www.haringey.nhs.uk/foi/foi_docs/4817_leap_15th%20nov%2006.doc.

¹⁷ Life expectancy at birth in an area can be defined as the average number of years a baby born and living its whole life in an area would be expected to live if it were to experience the current (age-specific) death rates of that area. Life expectancy is best interpreted as a snapshot of the overall level of mortality in an area. It is not a forecast of how long babies will actually live, as current death rates are likely to change. Nevertheless, it is a useful, easily understandable summary measure that can be used to compare death rates in different populations at different times. As deaths in earlier life contribute relatively more to lower life expectancy than deaths in older people, it also provides an indication of the number of premature deaths in an area.

¹⁸ www.statistics.gov.uk/downloads/theme_health/Males_Females_Persons%20_HLE.xls

Figure 5.1.2: Trends in male and female life expectancy, Haringey, London and England and Wales, by sex, 1991-1993 to 2004-2006.



Source: NCHOD

The latest report against the health inequalities target¹⁹ published by the Department of Health states that Haringey is on target to achieve its contribution towards the National Life Expectancy Target for Males and Females, based on 2004-06 rolling averages. This is an encouraging sign and indicates that we are continuing to make solid progress towards improving life expectancy in Haringey. These data were not available for review on publication of this report.

5.1.3 All-age all-cause Mortality in Haringey.

In order to monitor progress against the National life expectancy target, the Department of Health recommends the use of all-age all-cause directly standardised mortality (AAACM²⁰) as a proxy for life expectancy²¹. AAACM is now an indicator in the National Indicator set.

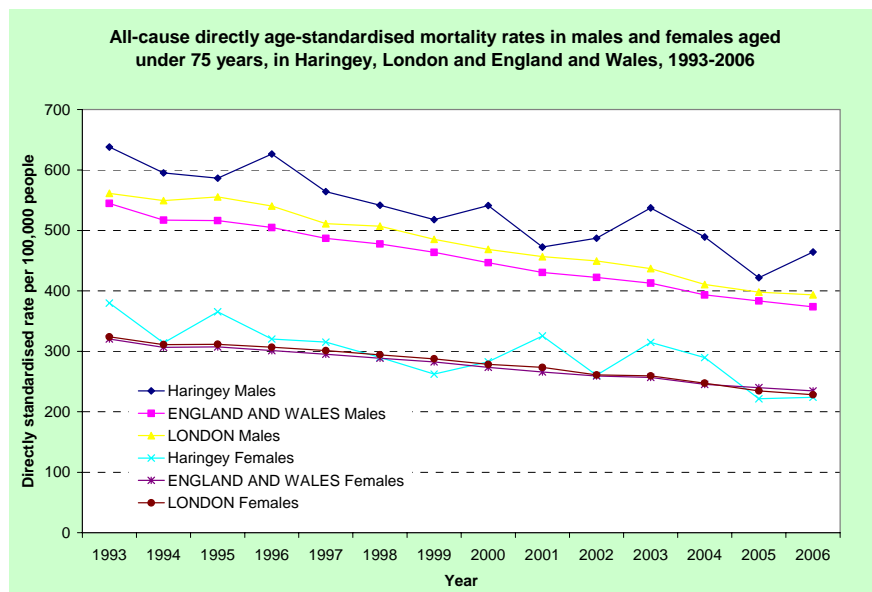
Premature mortality (all cause mortality in people aged under 75 years) has been steadily reducing in Haringey between 1993 and 2006, consistent with the trend observed in London and in England as a whole. In 2006 premature mortality in Haringey males was 464.4 (Directly age-standardised rate per 100,000) compared with 375.4 and 393.4 for England and Wales and London respectively. In females premature mortality in Haringey was 224.1 (per 100,000) compared with 241.2 and 234.7 for England and Wales and London respectively.

¹⁹ Tackling Health Inequalities: 2007 Status Report on the Programme for Action. Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083471

²⁰ The AAACM is the proportion of an abstract reference population that is expected to die if it had the age specific mortality rates of the local population of interest.

²¹ For further information refer to: Yorkshire and Humber Public Health Observatory, Life expectancy and all-age all-cause mortality rates: issues for identifying local health inequalities

Figure 5.1.2: Trend in premature mortality, Haringey, London and England and Wales, by sex, 1993 to 2006.

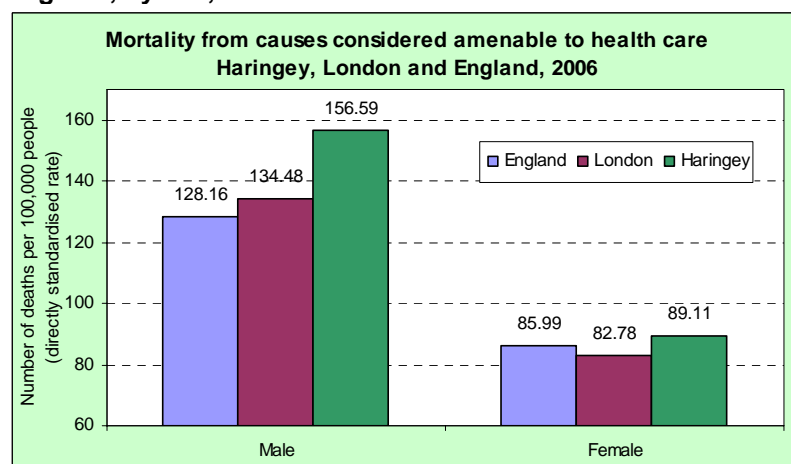


Source: NCHOD

5.1.4 Mortality from conditions considered amenable to healthcare.

Amenable mortality²² is defined as mortality that can *theoretically* be averted by good health care, for example mortality caused by conditions such as breast cancer, cancer of the colon and rectum, leukaemia, gastric and duodenal ulcer, and hypertensive diseases. Deaths from these causes may be avoidable through treatment of the condition after onset²³. This indicator provides an estimate of mortality that is considered potentially avoidable by health care. Mortality from conditions considered amenable to healthcare in residents aged less than 75 years is higher in Haringey (males and females) than in England and London as a whole, particularly in males.

Figure 5.1.3: Mortality from causes considered amenable to health care in Haringey, London and England, by sex, 2006



Source: NCHOD

²² For further information please refer to: Nolte E. and McKee M. (2003), Measuring the health of nations: an analysis of mortality amenable to health care, British Medical Journal 327:1129-1134, and Nolte E. and McKee M. (2004) (851kb). Does Health Care Save Lives? Avoidable Mortality revisited. The Nuffield Trust, London.

²³ Please see www.nchod.nhs.uk/ for a full list of diseases.

5.1.5 Does life expectancy vary within Haringey?

As important as our overall performance, is ensuring that we minimise existing inequalities in life expectancy. Within Haringey, life expectancy varies significantly between wards. Generally, the more deprived wards (as measured by the Index of Multiple Deprivation) have a lower male life expectancy than the more affluent wards. At the two extremes, male life expectancy in Tottenham Green (71.0 years) is nearly 8 years lower than male life expectancy in Alexandra (78.2 years). The gap in male life expectancy between wards with the highest and lowest life expectancy appears to be narrowing marginally. 7.7 years in 1991-2003 compared with 7.2 years in 2001-2005²⁴. The gap in female life expectancy between the boroughs with the highest and lowest life expectancy is 5.9 years in 2001-2005.

Table 5.1.1: Male and female life expectancy by ward in Haringey, 2001-2005

Region	Male life expectancy	Lower 95% confidence limit	Upper 95% confidence limit	Female life expectancy	Lower 95% confidence limit	Upper 95% confidence limit
Tottenham Green	71.0	69.2	72.8	81.1	78.7	83.6
Northumberland Park	71.6	69.7	73.4	78.1	76.3	79.9
Bruce Grove	72.6	70.8	74.3	79.3	77.4	81.1
White Hart Lane	72.9	71.0	74.7	77.0	75.2	78.7
Tottenham Hale	73.1	71.4	74.9	78.5	76.7	80.3
Hornsey	73.2	71.3	75.0	81.1	79.3	82.9
Seven Sisters	75.0	73.2	76.7	81.6	79.3	83.9
Fortis Green	75.1	73.4	76.8	81.2	79.7	82.7
West Green	75.1	73.4	76.8	82.2	80.1	84.2
Noel Park	75.4	72.8	78.1	79.6	77.6	81.6
Bounds Green	75.5	73.7	77.3	81.1	79.4	82.9
St Ann's	75.6	73.8	77.3	80.9	79.0	82.9
Woodside	76.0	74.1	77.9	82.7	81.0	84.4
Stroud Green	76.3	73.9	78.7	82.5	80.1	84.8
Haringay	76.5	74.5	78.5	82.4	79.8	84.9
Crouch End	77.1	74.8	79.4	82.9	81.0	84.8
Muswell Hill	77.5	75.8	79.3	81.3	79.6	83.0
Highgate	77.6	75.8	79.5	80.4	78.7	82.1
Alexandra	78.2	76.5	80.0	80.7	78.9	82.4
Haringey	74.9	74.5	75.3	80.4	80.0	80.9

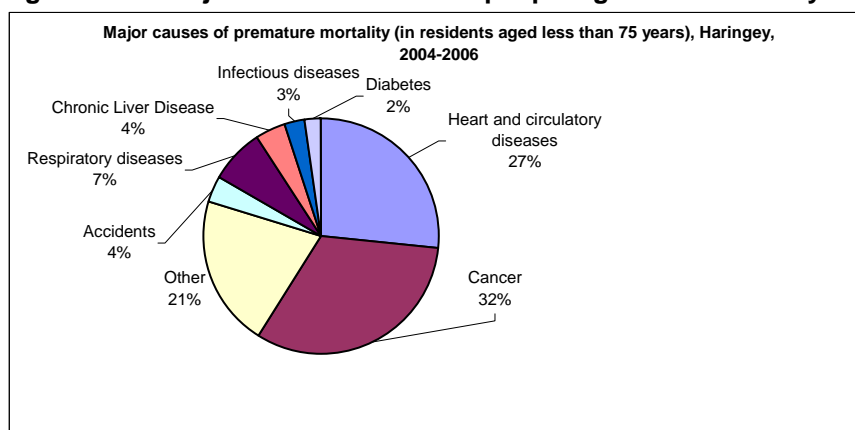
Source London Health Observatory, 2001-2005 data, www.lho.org.uk

5.1.6 Which illnesses impact most on life expectancy and hospitalisation in Haringey?

Figure 5.1.4 shows the main causes of premature death (deaths under the age of 75 years) in Haringey over the period from 2004-2006. Heart and circulatory diseases and cancer together account for 69% of all premature deaths in Haringey and thus represent the greatest opportunity for interventions to reduce premature mortality.

²⁴ Combining data from several years helps to make the data more stable by reducing the influence of year-by-year variation in numbers of deaths.

Figure 5.1.4: Major causes of death in people aged less than 75 years, Haringey 2004-2006



Circulatory disease was the most common cause of hospital admission in Haringey over the period 2003/04 to 2005/06²⁵; genitor-urinary conditions were the second most common cause of hospitalisation during this period. Please refer to the Haringey Health Report 2006²⁶ for a more detailed discussion of illness leading to hospital care in Haringey (Chapter 5).

5.1.7 Infant mortality

Infant mortality rate is the deaths of infants in the first year of life per one thousand live births. Infant mortality rates (IMRs) are high in Haringey (7.2 per 1000 live births in 2004-2006)²⁷. Between 2004 and 2006 infant mortality rates in Haringey were the highest in London. 51 (60%) of the infant deaths occurring between 2003 and 2005 were neonatal deaths (deaths within 28 days of birth) and 41 (80%) of these deaths occurred in the early neonatal period (death within the first seven days of life). IMRs are higher in the Northeast and Southeast GP collaborative areas, and in the North and South children's network areas²⁸.

Low birth weight (LBW) babies (less than 2500g) are at a higher risk of death in the first year of life than heavier babies with a rate of 10.8 deaths per 1,000 births. 8.2% of babies born in Haringey between 2004-2006 were low birth weight, compared with 6.7 in London and 6.4 in England. Other risk factors for higher infant mortality in London include:

- mothers who live in the most deprived parts of London
- mothers who register their babies alone (sole-registered births)
- mothers born in East or West Africa and the Caribbean
- babies born to couples in the routine and manual groups.

10.8% of births in Haringey are sole registered births, which is the 8th highest rate in London. 50.4% of births in Haringey were in super output areas with deprivation scores higher than 40, which is the 4th highest rate in London. 11.4% of births in

²⁵ Haringey Health Report 2006. Available at: www.haringey.nhs.uk/about_us/public_health/index.shtml

²⁶ Haringey Health Report 2006. Available at: www.haringey.nhs.uk/about_us/public_health/index.shtml

²⁷ Further detail can be obtained from the 2006 review of the Haringey Infant Mortality Action plan, Available at: www.haringey.nhs.uk/foi/foi_docs/6355_infant_mortality%20action%20plan%20march%2007.doc and from the publication Born equal? A briefing on inequalities in infant mortality in London, Available at: www.lho.org.uk/viewResource.aspx?id=12371

²⁸ Further detail can be obtained from the 2006 review of the Haringey Infant Mortality Action plan, Available at: www.haringey.nhs.uk/foi/foi_docs/6355_infant_mortality%20action%20plan%20march%2007.doc

Haringey were to mothers born in West and East Africa and the Caribbean, which is the 8th highest rate in London.

Key short-term interventions found to improve infant mortality include:

- Improving the quality and accessibility of antenatal care and early years support in disadvantaged areas,
- Reducing smoking and improving nutrition in pregnancy and early years,
- Preventing teenage pregnancy and supporting teenage parents,
- Improving housing conditions for children in disadvantaged areas.

These risk factors are discussed in more detail in relevant sections of this document.

A study of women from Haringey who delivered at the Whittington Hospital Trust in 2003 found that just over half (51%) booked for antenatal care before their 16th week and 0.8% were unbooked deliveries²⁹. Average gestational age at booking for teenagers was 20 weeks, compared to 16 weeks for the over 35 year age group, and 17 weeks for the 20-35 year age group. Average number of antenatal visits was 8.29 visits per delivery.

5.2 Diabetes

Diabetes mellitus is a group of closely related chronic conditions characterised by high blood sugar (glucose) levels. It is caused by a deficient production of insulin, resistance to its action or both. Insulin is a hormone produced in the pancreas that helps glucose to enter body cells for energy metabolism.

In Haringey in the 2005/06 financial year, 3.5% (or 8468 people) of people registered with a general practitioner were reported to have diabetes, compared with 3.6% in both England and London. It should be noted that registrations for diabetes with general practitioners may be an underestimate of disease prevalence where there is under-detection of diabetes in Primary Care.

The Yorkshire and Humber Public Health Observatory were commissioned to produce a model that estimates expected diabetes prevalence by primary care trust and ward³⁰. The model applies age/sex/ethnic group-specific estimates of diabetes prevalence rates, derived from epidemiological population studies, to population estimates. Estimates are also adjusted for geographic variations in socio-economic deprivation. The model suggests that the prevalence of diabetes in Haringey is actually closer to 4.4% (or 9852 residents); 3.6% in males and 5.2% in females. This prevalence is likely to be considerably higher in people identifying as of Black (6.8%) or Asian (8.7%) ethnic origin. The model also predicts prevalence to vary considerably between wards. For example, the highest prevalence would be expected in Bruce Grove (5.3%) and the lowest in Crouch End (3.4%). Further analysis would be required to determine whether this expected prevalence is reflected in general practice

²⁹ McCoy, D., 2004, An assessment of ante-natal care and delivery at the Whittington Hospital 2003, Haringey TPCT Health Improvement Directorate.

³⁰ This is a spreadsheet model that generates expected total numbers of persons with Type 1 and Type 2 diabetes mellitus (diagnosed plus undiagnosed combined) for 2005. Estimates are presented for England, Government Office Regions, Local Authority Districts, Strategic Health Authorities, Primary Care Trusts and wards. The model applies age/sex/ethnic group-specific estimates of diabetes prevalence rates, derived from epidemiological population studies, to population estimates. Estimates are also adjusted for geographic variations in socio-economic deprivation, as a proxy for obesity. Forecasts of diabetes prevalence up to 2025 are presented for sub-national areas based on projected population change and current trends in obesity. This model is available at: www.yhpho.org.uk/PBS_diabetes.aspx#WhatisthePBSDiabetesPopulationPrevalenceModel

registrations regionally. The model also predicts that diabetes prevalence will increase to 5.0% by 2010³¹.

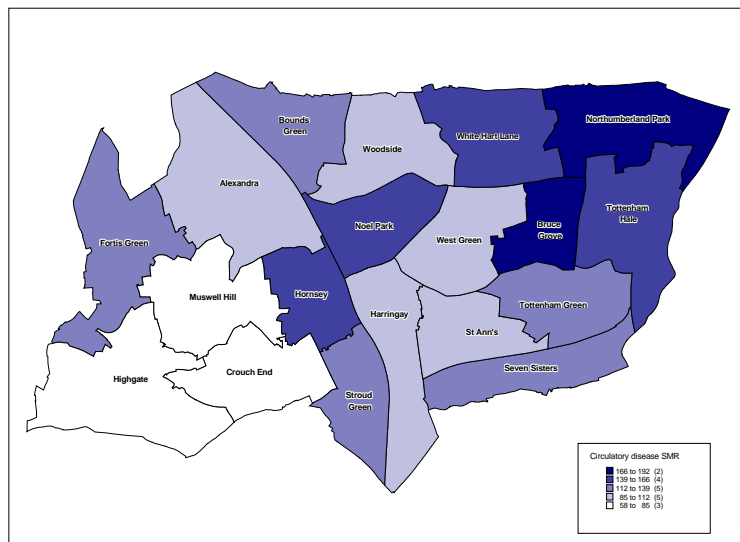
We know that in Haringey admission rates for diabetes are higher than neighbouring boroughs and mortality rates are higher than England and London³². This suggests that there may be poor detection or control of diabetes in primary care in Haringey. Further analysis would be required to assess this.

A detailed analysis of primary care management of diabetes was undertaken in the preparation of the 2006 Annual Public Health Report³³. This analysis suggested that there is potential to improve the detection and management of diabetes in primary care in Haringey. One key finding of this review was that management of diabetes (and other diseases) varied considerably between general practices across the borough. This analysis also highlights the potential for use of general practice monitoring data to better understand the needs of the community in relation to diseases that are managed in primary care. This analysis would enable us to determine whether there are areas of significant unmet need or where systems may be enhanced or targeted to improve outcomes for people with these diseases.

5.3 Circulatory diseases

Circulatory diseases include heart diseases and stroke. Circulatory diseases are one of the major causes of death and illness leading to hospitalisation in Haringey and nationally. Deaths from circulatory diseases are not evenly distributed across Haringey. Deaths are highest in Northumberland Park and Bounds Green and lowest in Highgate, Crouch End and Muswell Hill, suggesting that there are differences in prevalence of disease and disease risk factors as well as management of circulatory diseases in different areas of the borough.

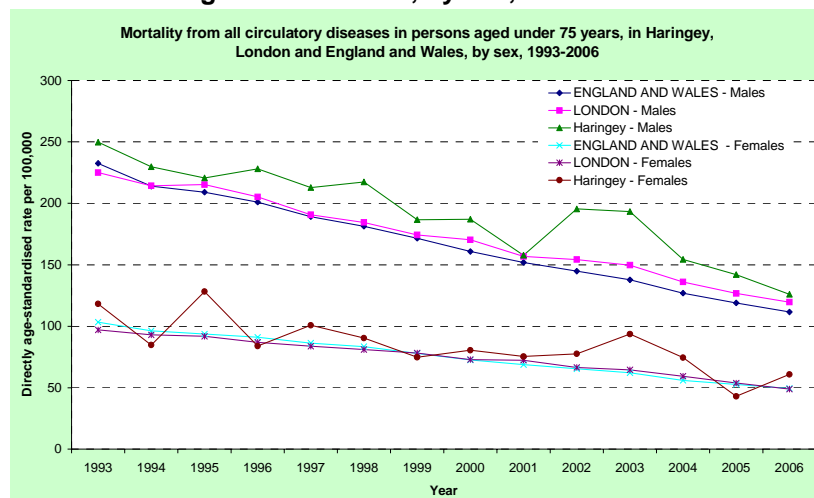
Figure 5.3.1: Standardised Mortality Ratio for all circulatory diseases by ward, persons under 75 years of age, Haringey, 2001-2005



31 If there is no change in the prevalence of obesity.
 32 2006 Annual Public Health Report (Available at: www.haringey.nhs.uk/about_us/public_health/index.shtm) page 59.
 33 Available at: www.haringey.nhs.uk/about_us/public_health/index.shtm pages 54-59

Mortality due to circulatory diseases in Haringey is reducing with time, but remains slightly higher than England and Wales and London, particularly in males.

Figure 5.3.2: Mortality from all circulatory diseases in persons aged under 75 years, Haringey, London and England and Wales, by sex, 1993-2006



5.3.1 Coronary Heart Disease

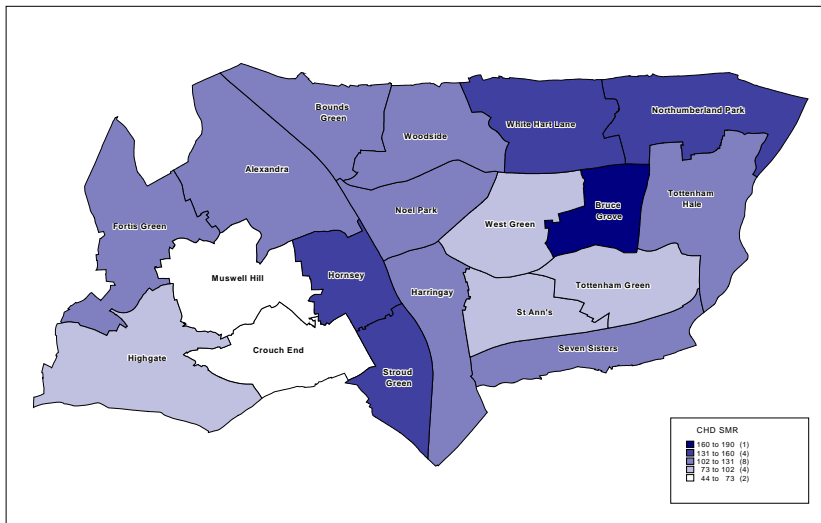
The main underlying problem in coronary heart disease (CHD), or ischaemic heart disease (IHD), is atherosclerosis, a build-up of plaque (fat, cholesterol and other substances) on the inner lining of arteries that supply the muscle of the heart. In Haringey in the 2005/06 financial year, 1.9% of people registered with a general practitioner were reported to have coronary heart disease (CHD), compared with 3.6% in England and 2.3% London. In contrast to this, modelling evidence suggests that the prevalence of CHD in Haringey may be as high as 2.8%³⁴. Thus there may be as many as 3400 cases of coronary heart disease in Haringey not currently detected in primary care. Further analysis of registration, hospitalisation and mortality data would be required to better understand whether these data are truly suggesting unmet need in areas of Haringey and how this unmet need is distributed in the population.

Mortality rates for CHD in Haringey in 2006 were similar to that observed in England and London (44.4 deaths observed in Haringey per 100,000 people in 2006 compared with 43.5 in London and 44.9 in England). Figure 5.3.3 shows the Standardised Mortality Ratio³⁵ for Coronary Heart Disease (the most common cause of death due to heart and circulatory disease) for persons under the age of 75 by ward. Northumberland Park and Bruce Grove (the most deprived wards in Haringey as measured by IMD 2004) have mortality rates due to Coronary Heart Disease (CHD) more than 70% higher than the average CHD mortality rates in England and Wales.

³⁴ The coronary heart disease model applies national age-sex specific self-reported doctor-diagnosed coronary heart disease rates to PCT populations and adjusts for deprivation using the 2001 Census. Available at: www.apho.org.uk/resource/item.aspx?RID=48310

³⁵ To compare the distribution of deaths between different populations it is important to take into account not just the number of deaths, but also the size of the populations and their age profiles. The commonest way to do this is by calculating the Standardised Mortality Ratio (SMR). The SMR is the ratio of the number of deaths occurring in a population to the number that would have occurred if that population had the same age-specific death rates as the population of England and Wales. The ratio is multiplied by 100. An SMR of 100 means that a population has the same age-specific death rates as the England and Wales population. An SMR of 120 means that a population has 20% more age-specific deaths than the E&W population. An SMR of 80 means that a population has a 20% lower age-specific death rate than the E&W population.

Figure 5.3.3. Standardised Mortality Ratio for coronary heart disease by ward, persons under 75 years of age, Haringey, 2001-2005



5.3.2 Hypertension

Hypertension, or high blood pressure, is an important risk factor for morbidity and mortality from circulatory diseases. The modelled prevalence of hypertension in Haringey is 20.1%, which is slightly lower than that predicted for England (23.8%)³⁶. This proportion corresponds to 56,186 of all registered general practice patients.

5.3.3 Stroke

Stroke is one of the major causes of death from circulatory disease. Deaths from stroke in Haringey are higher than for England as a whole. In 2004-06 the SMR in residents aged less than 75 years³⁷ was 153, so 50% higher than expected. Higher than expected mortality rates from stroke (in residents aged less than 75 years) were observed in almost all areas in the borough, particularly in St Ann's and Northumberland Park wards. Hospital admissions for stroke in Haringey occurred in 2004/05 to 2006/07 at a rate of 47.7 per 100,000. Higher rates of stroke admissions were observed in the wards of Tottenham Hale, Seven Sisters, Woodside and White Hart Lane. Lower rates were observed in Muswell Hill and Stroud Green.

³⁶ The hypertension model is based on re-analysis of the Health Survey for England responses for 2003 and 2004 to derive age, sex and ethnic-group specific estimates of hypertension (using the variable hy140om) and includes all persons with a mean systolic blood pressure >140 mmHg and diastolic blood pressure >90 mmHg (based on 2nd and 3rd of three readings) following the 2004 Joint British Hypertension Society guidelines OR currently taking antihypertensive medication. It updates a previous model available from the Faculty of Public Health (www.fphm.org.uk) with more recent data and an adjustment for ethnicity using published relative risks (Joint Surveys Unit). The model is available at: www.apho.org.uk/resource/item.aspx?RID=39384.

³⁷ To compare the distribution of deaths between different populations it is important to take into account not just the number of deaths, but also the size of the populations and their age profiles. The commonest way to do this is by calculating the Standardised Mortality Ratio (SMR). The SMR is the ratio of the number of deaths occurring in a population to the number that would have occurred if that population had the same age-specific death rates as the population of England and Wales. The ratio is multiplied by 100. An SMR of 100 means that a population has the same age-specific death rates as the England and Wales population. An SMR of 120 means that a population has 20% more age-specific deaths than the E&W population. An SMR of 80 means that a population has a 20% lower age-specific death rate than the E&W population.

5.3.4 Projections of future circulatory disease burden in people aged over 65 years

The Care Services Improvement Partnership has produced a tool to predict needs of older people. Projections are available for age, ethnicity, religion, living and supporting arrangements and health and disability indicators. The tool is called POPPI, which stands for Projecting Older People Population Information. POPPI produces forecasts to the year 2025, split by gender and age-band³⁸. Two circulatory disease indicators are available including numbers of people aged 65 years and over predicted to have a longstanding health condition caused by a heart attack and stroke. The model predicts that 1610 and 586 Haringey residents over 65 will have a long term health condition caused by a heart attack and stroke, respectively, by 2025 (see Tables below).

Table 5.3.1: People aged 65 and over predicted to have a longstanding health condition caused by a heart attack³⁹, by gender and by age (65-74, 75 and over), projected to 2025

	2008	2010	2015	2020	2025
Males aged 65-74 predicted to have a longstanding health condition caused by a heart attack	462	454	454	462	487
Males aged 75 and over predicted to have a longstanding health condition caused by a heart attack	291	299	324	324	357
Females aged 65-74 predicted to have a longstanding health condition caused by a heart attack	316	311	326	337	357
Females aged 75 and over predicted to have a longstanding health condition caused by a heart attack	355	355	369	375	409
Total population aged 65 and over predicted to have a longstanding health condition caused by a heart attack	1,424	1,419	1,472	1,498	1,610

Source: POPPI

Table 5.3.2: People aged 65 and over predicted to have a longstanding health condition caused by a stroke⁴⁰, by gender and by age (65-74, 75 and over), projected to 2025

	2008	2010	2015	2020	2025
Males aged 65-74 predicted to have a longstanding health condition caused by a stroke	94	92	92	94	99
Males aged 75 and over predicted to have a longstanding health condition caused by a stroke	189	194	211	211	232
Females aged 65-74 predicted to have a longstanding health condition caused by a stroke	74	73	77	79	84
Females aged 75 and over predicted to have a longstanding health condition caused by a stroke	148	148	154	157	171
Total population aged 65 and over predicted to have a longstanding health condition caused by a stroke	505	508	533	540	586

Source: POPPI

³⁸ This tool is available at: www.csed.csip.org.uk/workstreams/demand-forecasting--capacity-planning/poppi.html

³⁹ 8.4% of 65-74 year old males, 8.3% of males aged 75 and over, 5.1% of 65-74 year old females, and 6.7% of females aged 75 and over report heart attacks. These prevalence rates are based on the 2004/05 General Household Survey, National Statistics, General health and use of health services, Table 7.15 Chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age. Information on chronic sickness was obtained by asking about any longstanding illness that has had an effect or will have an effect over a period of time. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have a heart attack to 2025.

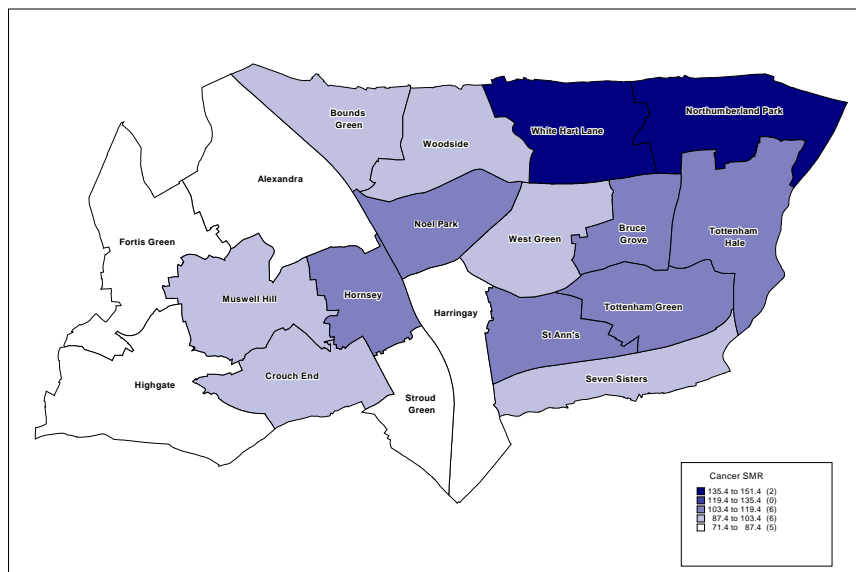
⁴⁰ 1.7% of 65-74 year old males, 5.4% of males aged 75 and over, 1.2% of 65-74 year old females, and 2.8% of females aged 75 and over report strokes. These prevalence rates are based on the 2004/05 General Household Survey, National Statistics, General health and use of health services, Table 7.15 Chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age. Information on chronic sickness was obtained by asking about any longstanding illness that has had an effect or will have an effect over a period of time. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have a stroke to 2025.

5.4 Cancer

Cancers are a major cause of mortality in the UK and contribute much to morbidity and disability. Causal factors for many cancers remain unknown; most cancers have a unique set of factors responsible for their onset, although a number share risk factors. These common risk factors include smoking (responsible for the greatest number of preventable cancers), diet, infectious agents, and genetic factors. Many cancers can be prevented through the avoidance of known risk factors. Some key cancer risk factors are described in more detail in Chapter 3. Risk of death for some cancers can be reduced by screening, early detection and treatment, and appropriate management and follow-up.

Cancer was the leading cause of premature mortality (deaths in residents under 75 years) in Haringey in 2004-06, accounting for 32% of all deaths. In 2006, there were 118.6 deaths per 100,000 from cancers in residents aged under 75 years in Haringey, compared with 112.9 in London and 115.5 in England and Wales. Figure 5.4.1 shows the Standardised Mortality Ratio for cancer for persons aged less than 75 years by ward. Cancer mortality is not evenly distributed across the borough. Cancer mortality was highest in Northumberland Park and White Hart Lane wards between 2001 and 2005.

Figure 5.4.1: Standardised Mortality Ratio for Cancer by ward, persons under 75 years of age, Haringey, 2001-2005



Lung cancer was the most common cause of death from cancer in Haringey between 1996 and 2005, followed by breast cancer, colorectal cancer, prostate cancer and bladder cancer⁴¹, this trend is similar to that observed in England as a whole. Breast cancer, followed by lung, prostate and colorectal cancer was the most common type of cancer notified in Haringey between 1996 and 2005. Breast cancer followed by lung cancer is the most common cause of cancer in females. Prostate cancer followed by lung cancer is the most common cause of cancer in males.

⁴¹ Thames Cancer Registry and King's College London, Cancer in Haringey PCT, 1996-2005

5.5 Infectious Diseases

Notifications of Infectious diseases are monitored through the Health Protection Agency and regional Health Protection Units. Notifications from Haringey are monitored and managed by the North East and North Central London Health Protection Unit⁴². National and regional figures are periodically published by the Health Protection Agency⁴³. The number of cases of communicable diseases that are notified is almost always less than the number of cases that actually occur. For a condition to be notified, a patient must seek medical help, be diagnosed with the condition, in some cases must have the appropriate laboratory tests done, and then the diagnosis must be reported to the local public health unit or the Department of Health. Nonetheless, notifications provide valuable information on patterns of communicable diseases.

Despite substantial progress in reducing the incidence of vaccine-preventable diseases, increases in immunisation levels are needed to further reduce and finally eliminate these causes of illness and death. Safe and effective vaccines are now freely available. However, the growing number of vaccines, and the complexity of immunisation schedules, makes delivering appropriate immunisations on time increasingly difficult for service providers.

Vaccination for influenza (or flu) in people aged over 65 years by general practice was reported in the 2006 Annual Public Health Report⁴⁴. 64% of practices recorded a vaccination uptake of 70% of registered patients or higher. There was considerable variation in uptake across Haringey.

Problems with the Child Health Surveillance System (CHIA) have meant that many London boroughs have been unable to supply childhood immunisation data for recent years. We are currently exploring better mechanisms for obtaining immunisation coverage data. We have a target to increase this coverage to 90% by 2010/2011.

Tuberculosis is caused by infection with the bacterium *Mycobacterium tuberculosis*. Haringey has higher rates of tuberculosis than most other regions in England. In 2006 there were 68.8 notifications per 100,000 population in Haringey, compared with 44.7 in London. Over 70% of all notifications of tuberculosis are in people who were not born in the United Kingdom.

5.6 Respiratory Diseases

Respiratory diseases include conditions that relate to breathing and include chronic obstructive pulmonary disease (COPD), asthma and pneumonia.

5.6.1 Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a long-term lung disease characterised by progressive development of airflow limitation that is not fully reversible. It is marked by shortness of breath that initially occurs with exertion and becomes progressively worse over time. In most instances emphysema is the underlying condition, although people with COPD often also have chronic bronchitis. Tobacco smoking is overwhelmingly the strongest risk factor for COPD. Other risk

⁴² www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1160135983515

⁴³ www.hpa.org.uk

⁴⁴ Available at: www.haringey.nhs.uk/publications/public_health/index.shtml pages 53-54

factors include exposure to environmental tobacco smoke, indoor and outdoor air pollution, occupational dusts and chemicals, and viral respiratory infections.

In Haringey general practitioner registrations for COPD (between April 2004 and March 2005), as a percentage of total registered population, were lower than England and London (0.7%, 1.4% and 0.9% respectively).

Deaths from COPD in Haringey are lower than for England as a whole. In 2004-06 the SMR in residents aged less than 75 years⁴⁵ was 80. Higher mortality rates from COPD (in residents aged less than 75 years) were observed in the south east GP collaborative.

5.7 Oral Health

Oral health is an integral component of lifelong health. Oral health includes a person's comfort in eating and social interactions, their self-esteem and their satisfaction with their appearance. The NHS Information Centre for health and social care publishes regular information on National Health Service (NHS) primary care dental services⁴⁶. 85% of children aged under 18 years in Haringey had been seen by an NHS dentist in the previous 24 months (at 31 December 2007), which is slightly higher than the percentage for England (70%) and London (65%)⁴⁷. 59% of adults (aged over 18 years) in Haringey had been seen by an NHS dentist in the previous 24 months (for the same period), which is slightly higher than the percentage for England (49%) and London (45%).

Most treatments carried out by NHS dentists in Haringey (between October and December 2007) were Band 1 or Band 2⁴⁸ (less complex treatments). 22% of treatments in Haringey were Band 3 or urgent, compared with 18% in England and 14% in London as a whole, indicating higher treatment needs in those attending NHS dentists in Haringey. In Haringey, there is also strong evidence of a complex association of uptake of dental care with deprivation.

Figure 5.7.1: Proportion of courses of treatment provided by NHS dentists in Haringey, London and England, October to December 2007

⁴⁵ To compare the distribution of deaths between different populations it is important to take into account not just the number of deaths, but also the size of the populations and their age profiles. The commonest way to do this is by calculating the Standardised Mortality Ratio (SMR). The SMR is the ratio of the number of deaths occurring in a population to the number that would have occurred if that population had the same age-specific death rates as the population of England and Wales. The ratio is multiplied by 100. An SMR of 100 means that a population has the same age-specific death rates as the England and Wales population. An SMR of 120 means that a population has 20% more age-specific deaths than the E&W population. An SMR of 80 means that a population has a 20% lower age-specific death rate than the E&W population.

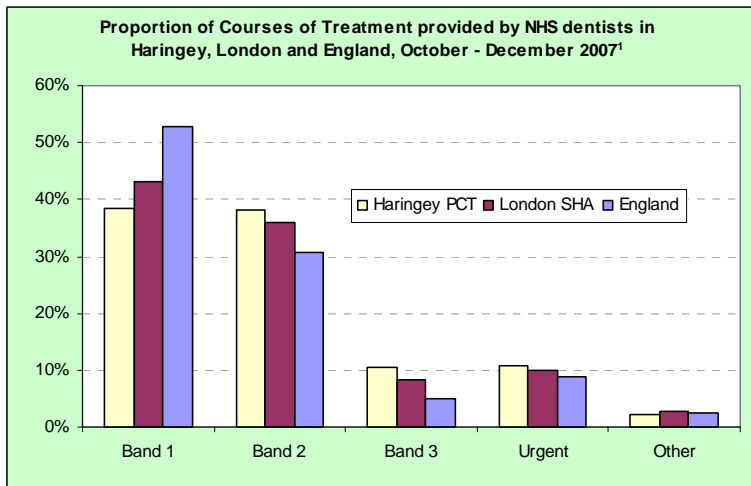
⁴⁶ Available at: www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-for-england:-quarter-3:-31-december-2007

⁴⁷ Child population for the 18 months ending Sept 2007, calculated with the Office for National Statistics (ONS) mid-2006 population estimates using the ONS 2007 methodology

⁴⁸ Courses of Treatment fall into three main bands (based on the complexity of the most complex aspect of the treatment). Band 1 covers a check up and simple treatment (such as examination, diagnosis (e.g. x-rays), advice on preventative measures, and a scale and polish), Band 2 includes further mid range treatments (such as fillings, extractions, and root canal work) in addition to Band 1 work, and Band 3 includes further complex treatments (such as crowns, dentures, and bridges) in addition to Band 1 and Band 2 work. PCTs and others need to know how many Courses of Treatment fall into each band in order to understand and plan appropriate service provision. Urgent - a specified set of possible treatments provided to a patient in circumstances where:

a) Prompt care and treatment is provided because, in the opinion of the dental practitioner, that person's oral health is likely to deteriorate significantly, or the person is in severe pain by reason of their oral condition; and

b) Care and treatment is provided only to the extent that is necessary to prevent that significant deterioration or address that severe pain.



More detailed local information on periodontal disease, trauma and other conditions will subsequently become available from the new FP17 forms introduced in April 2008. These can then be compared with the results of the national Adult Oral Health Survey next year.

One third of 5 year olds in Haringey had experienced dental decay as of 2003, fewer than the UK average of nearly 40%. However, inequalities in oral health are evident when comparing different schools, with the average level of tooth decay nearly four times higher in some schools than the Haringey average.

5.8 Mental Health

Mental health is as important as physical health to the overall well-being of individuals and communities. Mental ill health is one of the leading causes of non-fatal burden of disease and injury in the UK. Mental health problems are also associated with higher rates of health risk factors, poorer physical health, and higher rates of deaths from many causes including suicide. There are a number of wide determinants of good mental health, which contribute to the overall level of need: these include, housing, employment and educational attainment.

Mental health needs are difficult to measure. We frequently report on service use or illness (including hospital admissions) at the more severe end of the mental health spectrum as a proxy for mental health. Figure 5.8.1 illustrates the number of mental health clients who received services in Haringey by ward. The highest service use was observed in Bruce Grove. Figure 5.8.1 illustrates rates of hospital admissions by ward in Haringey and also shows that there is an uneven distribution of admissions across the borough.

Figure 5.8.1: Total number of mental health clients who received services, by ward, as of January 29 2008

Total number of Mental Health clients who have received Services as of January 29th 2008
Haringey Council

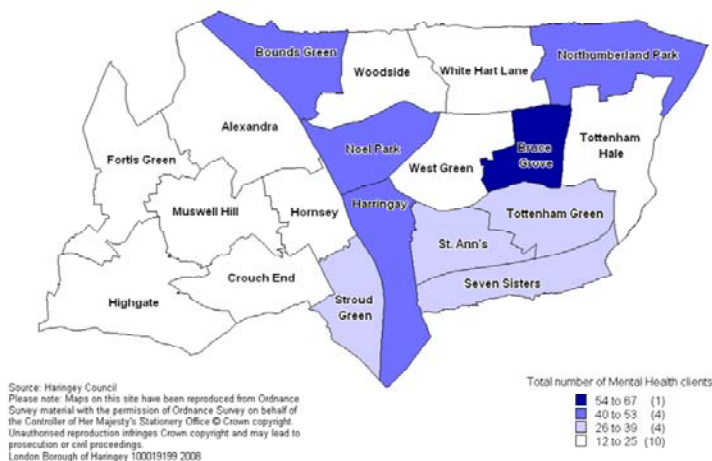
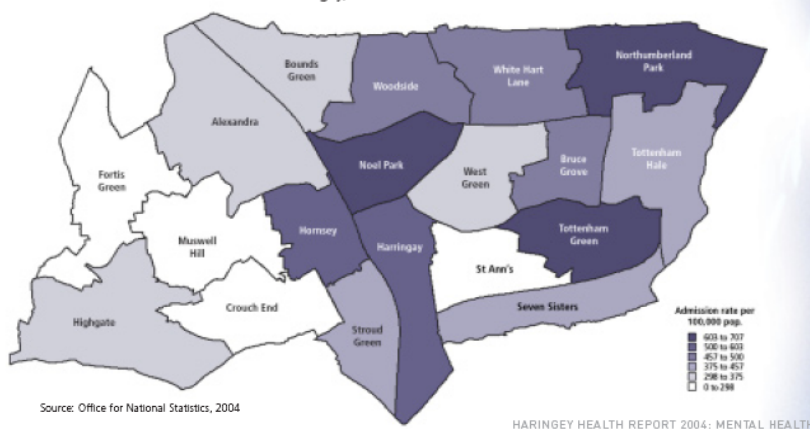


Figure 5.8.2: Admission rates (per 100,000) for mental illness in Haringey, by ward, 2002-2004

Mental health admission rates in Haringey, 2002-2004



Source: Haringey Health Report, Mental Health (2004)

Another possible indicator of severe mental ill health is the suicide rate. Analysis of suicides in Haringey between 2001 and 2004 show that an average of 35 Haringey residents commit suicide each year, which is approximately 50% higher than the national average. Around three-quarters of people who committed suicide in Haringey had no contact with mental health services in the previous 12 months.

We currently have a poor understanding of the needs of Haringey residents for mental illness preventive and treatment services and the distribution of these needs across the borough. The 2004 Annual Public Health Report⁴⁹ reports on mental health issues in greater detail.

⁴⁹ Available at: www.haringey.nhs.uk/publications/pdf/haringey_report_2004.pdf

Estimating the prevalence of mental ill health at borough level is difficult as there is little information available at this level of geography. Attempts have been made to model mental health need. The Care Services Improvement Partnership (CSIP) developed a tool to estimate prevalence of Common Mental Illness (CMI) and estimate the numbers of people with mental illness who will present for primary care. The tool is based on data from *Office of National Statistics Psychiatric Morbidity Survey*⁵⁰ and population estimates from 2006. Below we describe how we have used this tool to estimate prevalence of psychiatric morbidity in Haringey.

Text Box: Estimating prevalence of common mental illness in Haringey

Using the CSIP tool, we estimate that a total of 28,757 people aged 16-74 years are currently experiencing Common Mental Illness (CMI) in Haringey. The majority of these would experience mixed anxiety and depressive disorder and generalised anxiety disorder (Table 1).

Table: Estimated weekly prevalence of common mental problems in Haringey in people aged 16-74, by type of mental illness

	Estimated number
Mixed Anxiety and depressive disorder	15,547
Generalised Anxiety Disorder	7,565
Depressive episode	4,475
All phobias	3,173
Obsessive compulsive disorder	2,022
Panic disorder	1,202
Total	28,757

We expect that the prevalence of CMI in Haringey may be even higher than these predictions due to the demographic mix of residents in Haringey, discussed further below:

Haringey is the 18th most deprived borough in England and the 5th most deprived borough in London. Deprivation is not evenly distributed across the borough. Psychiatric morbidity (including anxiety, depression, schizophrenia and psychotic disorders) is known to be associated with social deprivation^{51,52}. Social deprivation is also known to result in longer duration of illness episode, higher risk of relapse, poorer treatment response and clinical outcome. Closely related to social deprivation is employment. At 2006/07, 8,000 people were estimated to be unemployed in Haringey, 7.1% of the working age population (see Section 3.5). This was higher than the figure for England (5.5%). Unemployment affects mental health especially anxiety and depression, and increases the risk of suicide and self-harm⁵³. Unemployment is not evenly distributed across the borough, with Northumberland Park experiencing 17.2%

⁵⁰ Singleton N, Bumpstead R, O'Brien M, Lee A, Melter H (2001) Psychiatric morbidity among living in private households, 2000. HMSO: London.

⁵¹ Thornicroft G. Social deprivation and rates of treated mental disorder, developing statistical models to predict psychiatric service utilisation. *British Journal of Psychiatry* 1991;158:475-84

⁵² Child Poverty Group. Not to be ignored: Young people, poverty and health. 1997. London Child Poverty Group (Report)

⁵³ Office of National Statistics. Population at mid- 2000: Health authorities in England and Wales. 10-4-2001

unemployment. Duration of unemployment is also an important predictor of psychiatric morbidity. 8.8% of unemployed people in Haringey have been unemployed for 2 years or more.

Housing and homelessness is an important determinant of mental health. Higher prevalence of mental illness has been found in homeless people or in people in insecure accommodation⁵⁴. Haringey has one of the highest rates of people living in temporary accommodation in the country.

There is evidence that refugees are especially vulnerable to psychiatric disorders including depression, suicidality and post-traumatic stress disorder^{55,56}. It is estimated that between 25,000 and 30,000 refugees and asylum seekers live in Haringey. This group also has more complex needs and often have more difficulty accessing health services than the general population.

Patterns of prevalence of mental illness vary across different ethnic communities and evidence is hampered by smaller sample sizes in minority communities. There is evidence that people of Black Caribbean ethnic origin are at higher risk of being admitted to psychiatric hospital than people of white ethnic origin. The Greater London Authority predict that 8.3% of Haringey residents were of Black Caribbean origin in 2005. This proportion is higher than that predicted for London and nationally.

Nonetheless, there is a great disparity between observed service use for mental ill health and predicted mental illness in the borough. Further work needs to be done to understand the extent of unmet need in the community and to obtain population information on mental health and illness to develop preventive services in Haringey. In Haringey stigma and reluctance to access services has been identified as a local issue, which may explain why the predicted prevalence does not match service use.

5.8.1 Mental health of children and young people

Similarly mental health in children is difficult to measure. The estimated prevalence of a range of mental health disorders amongst children and young people in Haringey is provided in the table below⁵⁷: It is estimated that 1579 5-15 year olds have conduct disorders, 1281 have emotional disorders and 1132 are suffering from anxiety. Further information can be obtained from the 2005 Haringey Annual Public Health Report *Growing Up in Haringey*⁵⁸.

Table 5.8.1: Estimated prevalence of mental health disorders amongst children and young people in Haringey

<i>Mental health disorder</i>	<i>National prevalence / Estimated numbers affected in Haringey</i>	<i>5-10 olds</i>	<i>year 11-15 olds</i>	<i>year 5-15 olds</i>	<i>year</i>
	Population size (GLA 2005)	16325	13469	29794	
Emotional disorders	National Prevalence %	3.3	5.6	4.3	
	Haringey (Total)	539	754	1281	
Anxiety	National Prevalence %	3.1	4.6	3.8	
	Haringey (Total)	506	620	1132	
Depression	National Prevalence %	0.2	1.8	0.9	

⁵⁴ Bhugra D. Unemployment, poverty and homelessness. In D Bhugra & J Leff ed. Principles of social psychiatry, Oxford: Blackwell, 1993

⁵⁵ Henderson C, Thornicroft G. Inequalities in mental health. Journal of Psychiatry 1998; 173: 105- 9

⁵⁶ Jahoda M. The impact of unemployment in the 1930s and the 70s. Bulletin of the Psychological Society 1979;32:309-14

⁵⁷ Available at: www.haringey.nhs.uk/foi/foi_docs/2819_haringey_children_rep_2005.pdf

⁵⁸ Available at: www.haringey.nhs.uk/foi/foi_docs/2819_haringey_children_rep_2005.pdf

Conduct disorders	Haringey (Total)	33	242	268
	National Prevalence %	4.6	6.2	5.3
Hyperkinetic disorders	Haringey (Total)	751	835	1579
	National Prevalence %	1.5	1.4	1.4
Less common disorders	Haringey (Total)	245	189	417
	National Prevalence %	0.5	0.6	0.5
Any mental health disorder	Haringey (Total)	82	81	149
	National Prevalence %	8.2	11.2	9.5
Haringey (Total)		1339	1509	2830

Source: Mental Health of Children and Adolescents in Great Britain – Office for National Statistics 1999

5.9 Musculoskeletal conditions

Musculoskeletal conditions (for example back pain and arthritis) cause significant morbidity in all communities. We know that 16.1% of people who require incapacity benefit and severe disablement allowance (IB/SDA) in Haringey do so because of a musculoskeletal condition. Hospital admissions for musculoskeletal conditions do not reflect the prevalence, as only some conditions and cases can benefit from surgery or other treatments provided in a hospital.

The health impact of arthritis and musculoskeletal conditions can be reduced through early prevention and appropriate management. Joint replacement is a cost-effective intervention for osteoarthritis, capable of restoring function. The age standardised rates of hip and knee replacement in Haringey was 73.9 replacements per 100,000 (all ages) in 2004/05 to 2006/07. Higher rates of hip or knee replacement were observed in central areas of the borough and lower rates were observed in south east Tottenham.

Fractured neck of femur is a common outcome of falls in elderly people or those suffering from osteoporosis. The age standardised rate of hospital admission for fractured neck of femur Haringey was 73.9 per 100,000 (all ages) in 2004/05 to 2006/07. Higher rates of fractured neck of femur were observed in central areas of the borough and lower rates were observed in the east of the borough.

5.10 Self reported health and wellbeing

Longitudinal studies worldwide have consistently shown that global self-rated health is a strong and independent predictor of subsequent illness and premature death. An item on self reported health and well being will be included in the 2008 Haringey Resident's survey and has been identified as a local target in the latest Local Area Agreement⁵⁹.

5.11 Key issues and gaps in understanding

- We have many existing mechanisms for monitoring the health of the population and regularly report on this.
- Haringey's life expectancy is improving but is male life expectancy is still lower than nationally. We understand that inequalities still exist in life expectancy between parts of the borough.
- There are many diseases managed in primary care, where there may be significant unmet need in the community (including diabetes and circulatory disease). Further detailed analysis of the distribution of hospitalisations, mortality and general practice registrations is required to better characterise this

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www.haringey.gov.uk/index/council/strategiesandpolicies/local_area_agreement.htm

potential unmet need and determine the best way to intervene to ensure these residents have adequate disease management into the future.

- Further analysis will be conducted in a planned review of the Life Expectancy Action Plan to better characterise which diseases are contributing most to this disparity and what the opportunities for intervention are, particularly in primary care.
- Cardiovascular diseases and cancer continue to be the disease areas contributing most to premature mortality in Haringey. Mortality from these diseases is not evenly distributed across the borough.
- Reductions in health inequalities will have an impact on many other measures of well being in the borough. Similarly we understand that many factors such as income, education and housing have a significant impact on the health of Haringey's residents. Health indicators cannot be viewed in isolation from those factors that impact on health. Further work may be done in Haringey to understand these interactions more fully.
- We have undertaken work to better understand the mental health needs of residents of Haringey. Significant challenges remain in understanding mental health needs of adults and children. Much of the data we have is proxy and we are concerned that there is a large amount of unmet need in the community. Mental health is an identified as a priority for the partnership.
- Further work needs to be done to determine the impact of population change on ill health experience and health service needs.