Haringey's Borough Profile
Healthier people with a better quality of life

Page

Back to top

Introduction

We want a Haringey where everyone in every part of the borough has the best possible chance of an enjoyable, long and healthy life. Keeping people healthy, active and independent gives people a better quality of life, makes sound financial sense and brings wider benefits to the whole community. But while the health and longevity of Haringey's residents is improving, some are faring less well than others.

Many factors combine to affect the health and quality of life of individuals and of communities in the borough. Health care services themselves play a vital role, as do environmental factors like lifestyle, diet, smoking rates, levels of physical activity and the quality of homes.

This section provides information on the following areas, in line with the priorities of Haringey's Sustainable Community Strategy 2007-16:

- Reducing health inequalities
- Opportunities for a healthier lifestyle
- Promoting independence and providing high quality support and care for those in the greatest need
- Giving babies, children and young people the best possible start in life

Information on the quality of homes is now covered in the Borough Profile under People at the Heart of Change.

This section of the Borough Profile also seeks to update, where possible, information in our Joint Strategic Needs Assessment (JSNA) as this is a continuous process of gathering information about the current and future health, care and well-being needs of the population. This approach enables us to look to the future – over the next 5, 10, 15 and 20 years – so that we can plan now for likely changes in needs.

Haringey's Well-being Strategic Framework (WBSF) is one of the six key Haringey Strategic Partnership strategies which form the basis of our Sustainable Community Strategy 2007-16. The WBSF is currently being reviewed to reflect the new policy agendas relevant to health and well-being. It is proposed that the new Framework will focus on personalisation, safeguarding of vulnerable adults and addressing health inequalities. It will be presented to the Well-being Partnership Board for agreement in autumn 2010.

The Framework is intended to support all people in Haringey aged 18 and over. The current Framework identifies priorities for the three-year period from 2007-10 and lays the foundation for rethinking the way we promote well-being in the borough. It is based on the seven outcomes of the *Our health, our care, our say* White Paper[1] for improving well-being:

- Improved health and emotional well-being
- Improved quality of life
- Making a positive contribution
- Increased choice and control
- Freedom from discrimination or harassment
- Economic well-being
- Maintaining personal dignity and respect

[1] The White Paper set a new direction for the health and social care system, published January 2006. It confirmed the vision set out in the Department of Health's Green Paper, *Independence, Well-being and Choice*, published March 2005.

Key Statistics about Haringey

Reducing health inequalities and increasing life expectancy:

- Life expectancy is rising generally, in line with national trends, but male life expectancy remains below the national average.
- The death rate has fallen from 871 per 100,000 in 1993 to 560 per 100,000 in 2008, below the rate for England and Wales. In line with the national pattern, death rates for women (405 per 100,000) have remained consistently lower than those for men (762 per 100,000).
- Premature mortality has been steadily reducing since 1993, consistent with the trend in England and Wales. In 2008, the rate for men was 427.7 per 100,000 compared with 359.1 for England and Wales. However, the death rate amongst men aged 20-64 is 30% higher than the England and Wales average.
- The main causes of death from 2006/08 were circulatory disease, cancer, respiratory disease and disease of the digestive system. Cancer and circulatory diseases account for 60% of all deaths in the under 75 and in the all ages groups; however, cancer is more common in the under 75 age group and therefore a bigger cause of premature mortality.
- There are more emergency hospital admissions than London and England with an extra 2,000 admissions per year since 2002/03. With the exception of Hornsey, those in the west are less likely to be admitted to hospital either for elective or emergency reasons.
- There were 260 deaths related to smoking between 2006 and 2008, with 1,120 hospital admissions, at a cost of nearly £2.6million.
- The number of alcohol-related ambulance calls has remained fairly constant in recent years at 3% of the alcohol-related calls in London. The number of alcohol-related call-outs is significantly lower than for illicit drugs.
- Estimated prevalence of crack and opiate users is 2,666. Around 80% (2,141) use crack; however, Haringey also had the sixth highest proportion of crack users in treatment between 2006 and 2009.
- There were around 1,936 opiate users in 2008/09. This, alongside drug treatment data, suggests that poly use of crack and opiates is common. Problem drug use mirrors geographical deprivation with most residing in the more deprived and densely populated north east of the borough.
- Haringey has a relatively young population, reflected in the work undertaken through the recent Sexual Health Needs Assessment 2010. For London as a whole, almost 50% of the population is between the sexually active ages of 15 and 44, whereas in Haringey the figure is 54%.
- In 2007 NHS Haringey had the 10th highest prevalence of diagnosed HIV in people aged 15 and over across London. In 2008 there were 51 young people aged between 16 and 24 living with HIV, as well as twelve 11-15 year olds who will soon be sexually active. Two-thirds of the population living with HIV reside in the eastern wards.
- There are 56 general practices and 280,600 people registered with a GP (at January 2010), higher than the ONS 2010 population projection (227,700) and the GLA 2010 projection (236,379).

Back to top

Promoting opportunities for leisure, socialising and life-long learning:

- 23.2% of the adult population took part in moderate sport and physical activity three times a week for at least 30 minutes in 2008/09. The most popular activities are walking, gym, football and swimming.
- There was a significant rise to above national average in the number of pupils participating in physical activity for two hours per week. However, there continue to be difficulties engaging some of the older children.

Enabling people to live independently, exercising choice and control:

- There are currently around 5,743 adults aged 18+ in Haringey who use social care services
- By far the largest client group is women aged 65+ who are frail with a physical and/or sensory impairment (1,789 women). By comparison, there are 898 men aged 65+ in the same category, reflecting Haringey's life expectancy profile with women living longer than men.
- In 2008/09, Haringey was above both the London and England average, with 62.24% of the total number of people with learning disabilities receiving health checks.
- 1,098 adults with mental health needs are receiving social care services, 374 of whom are aged 65 or above.
- 15,967 people in Haringey identify themselves as unpaid carers while there are 1,175 people on Haringey Carers' Register, with a greater prevalence in the east of the borough, a bias most likely to correspond with the higher level of service users in the east.

Giving babies, children and young people the best possible start in life:

- In 2009, 16% of school children weighed were considered to be obese, and a further 15% overweight. There is a variation between males and females with a higher proportion of boys considered overweight or obese. Obesity in children is not evenly distributed across the borough.
- The rate of teenage pregnancies shows a continuing downward trend. By 2008, it had decreased to 52.4 per 1,000 women aged 15-17 (184 conceptions), a 16% reduction since 1998. Our target by 2010 is a reduction by 50% from 1998 levels, equivalent to a rate of 31.15 per 1,000.
- Dental provision is good compared to other areas of London. Out of 152 NHS areas nationally, Haringey is ranked 13th for the percentage of the population who visited a dentist regularly as an NHS patient in last 24 months.
- While infant mortality rates (IMRs) remain high (5.1 per 1,000 live births in 2006/08), the rate has decreased since 2003/05 (8.1 per 1,000 live births).
- In 2009/10 from Nursery to Year 11 (aged 4 to 16), there were 33,427 children and young people in Haringey schools. Of these, 1,312 children (4% of the school population) have a Statement of Educational Need.
- In 2009/10 the numbers of children subject to a child protection plan per 10,000 children and young people in Haringey was 60. This is significantly higher than the previous year of 37 and the Statistical Neighbours' average of 42.
- As of 31 March 2010, there were 591 looked after children in Haringey compared with 492 at the end of March 2009 (see Figure 33). This equates to 121 children per 10,000 children population, an increase from 100 children per 10,000 children population in 2009.

Back to top

Key messages from the 2008 Place Survey in Haringey

Self-completion postal Place Survey questionnaires were sent to 7,000 randomly selected addresses between September and December 2008. The following results are based on 1,926 completed questionnaires:

- A fifth of people (21%) say they have given unpaid help at least once a month over the past twelve months
- 65% are satisfied with libraries – up 3% since 2006/07
- 50% are satisfied with sports and leisure facilities – also up 3%
- 29% are satisfied with museums and galleries – up 6%
- 21% are satisfied with theatres and concert halls – up 4%
- 69% think local services treat all types of people fairly
- 61% say public services usually or always treated them with respect and consideration over the last year

Key messages from the 2010 Haringey Residents Survey

Adults aged 18 and over

Of 1,055 adults who took part in the 2010 Residents' Survey, the percentage rating the following services as Good to Excellent was:

- 69%: parks and open spaces (a rise of 4% on 2009), with 73% saying they or their families visit them regularly
- 63%: libraries (up 2% on 2009), with 62% using their services
- 61%: health services (up 4% on 2009)
- 45%: leisure and sports facilities (up 5% on 2009), with 47% using their services
- 28%: adult education (up 3% on 2009), with 5% of households questioned attending classes
- 38%: primary education (up 5% on 2009), with 21% of households questioned using primary schools
- 32%: secondary education (up 6% on 2009), with 21% of households questioned using secondary schools
- 30%: nursery education (up 5% on 2009), with 8% of households questioned using services
- 21%: social care services for children and families (up 5% on 2009), with 4% of households questioned using services
- 20%: social care services for adults (up 3% on 2009), with 4% of households questioned using services
- 17%: child protection services (up 8% on 2009). 17% also rated this service as Poor or Extremely Poor, an improvement of 5% on last year's figure of 22%
- 14% had given unpaid help to a group, club or organisation at least once a month or more often. However, 63% had not given any unpaid help of any sort in the past 12 months

Young people

Of 242 young people who responded to the survey, the percentage rating the following services as Good to Excellent were:

- 75%: primary schools; 73%: secondary schools; 42%: sixth form colleges
- 74%: parks and open spaces;
- 53%: leisure and sports facilities
- 73%: libraries; 43%: arts and culture
- 73%: local health services
- 26%: social services for children and families

Back to top

In addition:

- 61% said the Council is doing enough to protect young people to some extent or to a great extent
- 14% were already volunteering, and a further 72% said it was something they might consider
- 22% said that did at least 60 minutes of moderate physical activity two or three times a week, while 3% said they never did any form of moderate physical activity

Back to top

Priorities 1 and 2: Reduce health inequalities and increase life expectancy

Local Area Agreement 2008-11 (Year 2 refresh March 2010)		
NI	**Indicator**	**Monitored by HSP Thematic Board**
8*	Adult participation in sport	Well-being
39*	Rate of hospital admissions per 100,000 for alcohol related harm	Well-being
40*	Number of drug users recorded as being in effective treatment	Safer Communities
119 Local	Self-reported measure of people's overall health and well-being	Well-being
121*	Mortality rate from all circulatory diseases at ages under 75	Well-being
123*	Stopping smoking	Well-being
Local	% of HIV-infected patients with CD4 count <200 cells per mm^3 at diagnosis	Well-being
140*	Fair treatment by local services	Performance Management Group
* Designated indicator/target		

The health of people in Haringey shows a mixed picture. Life expectancy for women and estimated levels of obesity and healthy eating for adults are better than the England average. However, life expectancy for men and the rate of early deaths from heart disease and stroke are both worse than the England average.

There are health inequalities within the borough. For example, life expectancy for men living in the least deprived areas of the borough is almost six years higher than for men living in the most deprived areas.

Over the last ten years, the rate of deaths from all causes combined has improved. The rate for women is now better than for England, but for men it remains worse. The rate of early deaths from heart disease and stroke has improved but remains worse than the England average.

Further information can be found in the Haringey Health Profile 2010, which provides a snapshot of health in the local area, helping local government and primary care trusts tackle health inequalities and improve people's health.

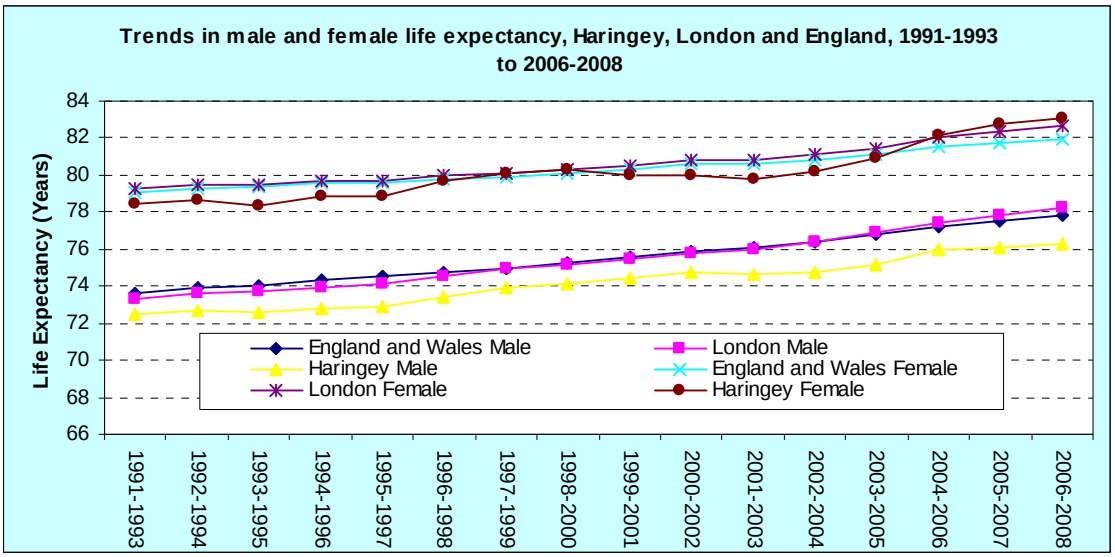
1.1 Life expectancy

Life expectancy is rising generally, in line with national trends, and we are on track to achieve improvements in 2010; but we remain below the national average for male life expectancy. Men in the west will live, on average, 6.5 years longer than those in the east. Women's life expectancy is above the national average; while the east/west is divide is less apparent, the gap between the highest and lowest life expectancy has widened. Life expectancy[2] (using 2006/08 data) is 76.3 years and 83.1 years for males and females respectively. Following a decrease in the life expectancy gap between England and

[2] 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

Haringey males from 2002/04, the gap has increased again over the last two years and is now 1.6 years lower than for England. Female life expectancy is slightly higher (1 year) than England.

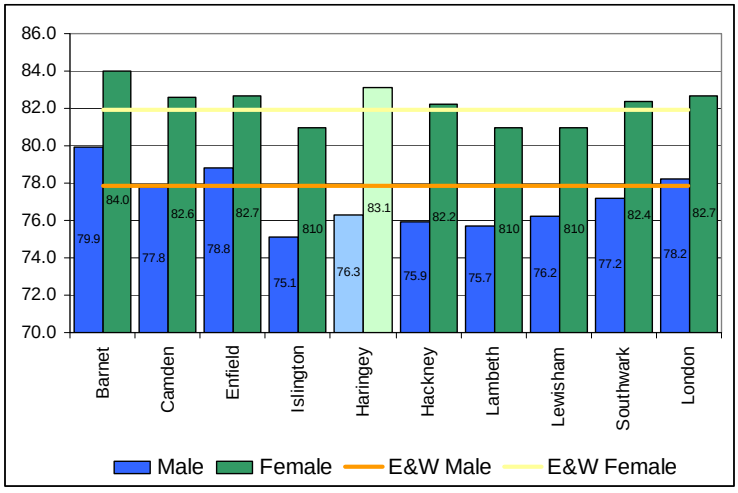
Figure 1: Trends in male and female life expectancy for Haringey, London and England between 1991/93 and 2006/08



With the exception of Islington, males in neighbouring boroughs (see left half of Figure 2 below) have a higher life expectancy, whereas female life expectancy is similar.

With the exception of Southwark, males in Haringey's statistically similar boroughs (on the right half of Figure 2 below) have similar life expectancy. Female life expectancy is slightly higher.

Figure 2: Life expectancy in Haringey: neighbouring and statistically similar boroughs



Life expectancy varies significantly between wards. At the two extremes, male life expectancy in Tottenham Green (71.3 years) is seven years lower than male life expectancy in Fortis Green (78.2 years). The gap between wards with the highest and

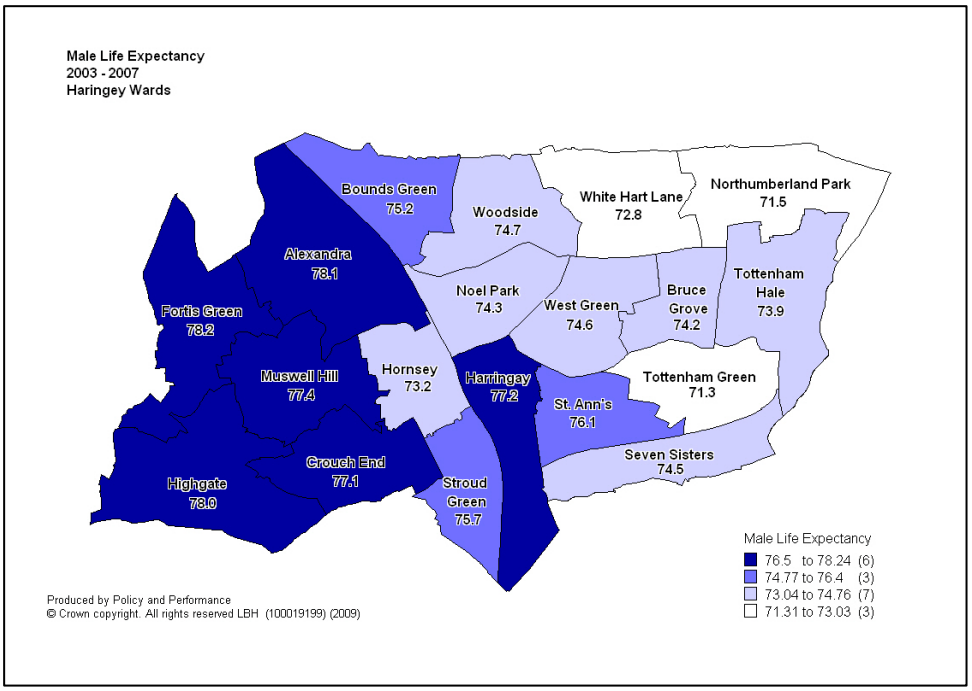
summary measure that can be used to compare death rates in different populations at different times. As deaths in earlier life contribute relatively more to lower life expectancy than deaths in older people, it also provides an indication of the number of premature deaths in an area.

Back to top

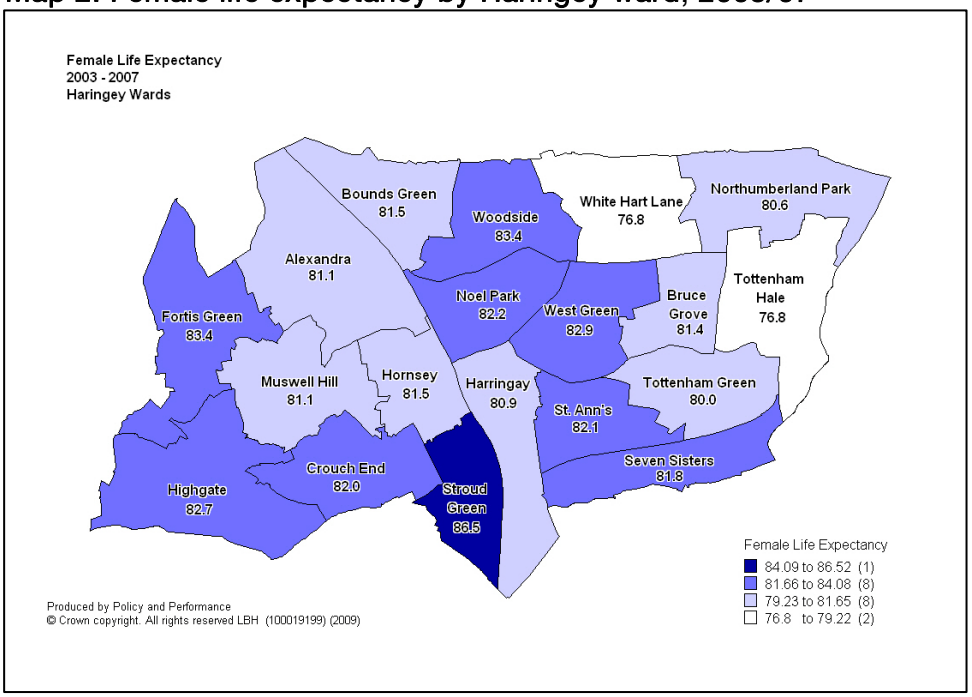
lowest life expectancy appears to be narrowing marginally, 7.7 years in 1991/2003 compared with 7.1 years in 2003/07[3]. The gap in female life expectancy between the wards with the highest (Stroud Green, 86.5 years) and lowest (White Hart Lane and Tottenham Hale, 76.8 years) is almost a decade (9.7 years) in 2003/07.

Haringey's Life Expectancy Action Plan is currently under review.

Map 1: Male life expectancy by Haringey ward, 2003/07



Map 2: Female life expectancy by Haringey ward, 2003/07

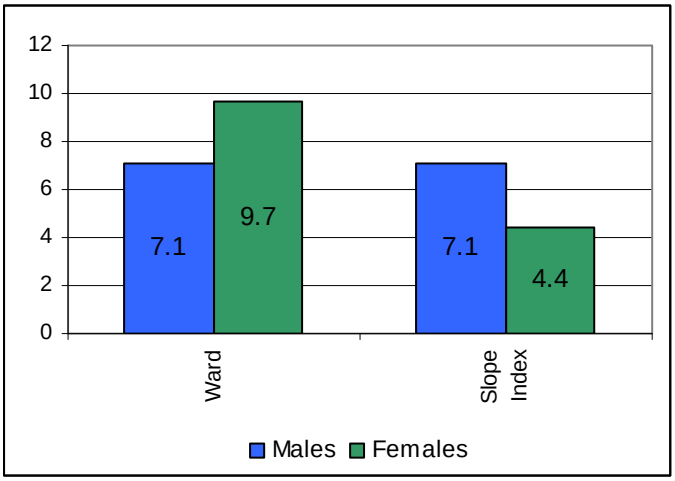


[3] Combining data from several years helps to make the data more stable by reducing the influence of year-by-year variation in numbers of deaths.

1.2 Health inequalities

In 2008, the indicator for measuring the key outcome of health inequalities was the Index of Multiple Deprivation (IMD). In 2009 a new indicator was developed and recommended using the slope index of inequality for life expectancy at birth. This measure is the gap in years of life expectancy between the best□off and worst□off within the NHS area, based on a robust statistical model of the mortality rates and deprivation scores across the whole NHS area. The measure pools five years of life expectancy data. In 2004/08 the gap for males was 6.8 years (England median = 8.6 years) and the gap for females was 4.5 years (England median = 5.8 years).

Figure 3: Variation in life expectancy at birth in Haringey using the slope index of inequality, 2003/07



It is important to note the variance in life expectancy across the borough using the above method (top and bottom 10% on deprivation) and when comparing wards. As explained earlier, the life expectancy gap for females between the highest (Stroud Green, 86.5 years) and lowest (White Hart Lane and Tottenham Hale, 76.8 years) is almost a decade (9.7 years). However, using the slope index method, the gap is only 4.4 years (2003/07). For males the gaps are the same using the two methods (7.1 years). This suggests that for females, deprivation (as measured by IMD 2007) does not correlate with life expectancy as much as the slope index model suggests.

1.3 Mortality rates

In line with national trends, there has been a consistent reduction over the last 15 years in the number of people dying relative to the borough population as a whole.

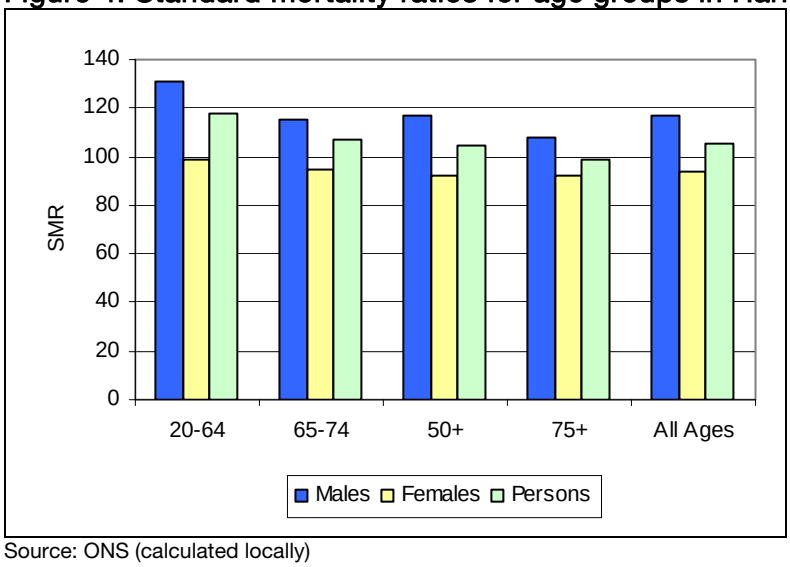
Between 1993 and 2008 the death rate fell from 871 per 100,000 to 560 per 100,000, a rate lower than England and Wales (577.2 per 100,000). In line with the national pattern, death rates for women (405 per 100,000) have remained consistently lower than those for men (762 per 100,000).

Premature mortality (all cause mortality in people under 75 years of age) has been steadily reducing between 1993 and 2008, consistent with the trend observed in England and Wales as a whole. In 2008, premature mortality in males was 427.7 per 100,000 compared with 359.1 for England and Wales. In females, premature mortality was 192.48 (per 100,000) compared with 228.8 for England and Wales.

While the all age all cause death rate is lower than that for England and Wales, this is not true of the death rate in all age groups. The following graph shows Haringey death rates in relation to the national death rates where a figure above 100 indicates a higher than

national rate and a figure below 100 a lower than national rate. The graph illustrates that the death rate amongst males aged 20-64 is 30% higher than that experienced amongst that age group across England and Wales while the death rate for those aged 75+ is on a par with England and Wales.

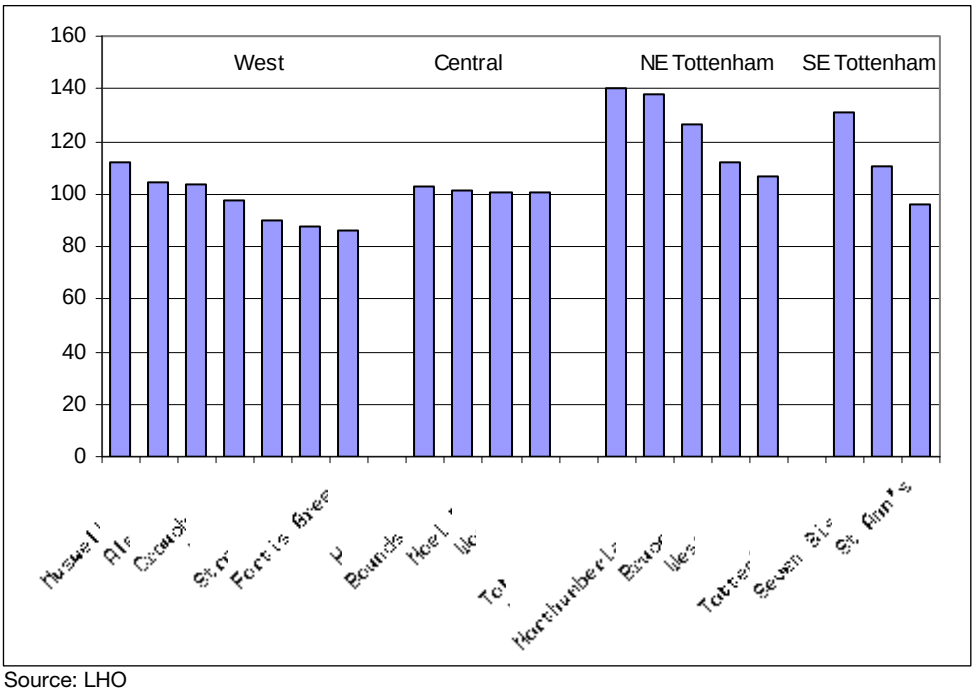
Figure 4: Standard mortality ratios for age groups in Haringey, 2006/08



Source: ONS (calculated locally)

As seen with life expectancy, the following graph illustrates how the rate of death varies, with higher rates of death in the east than in the west.

Figure 5: Standard mortality ratios for Haringey wards, 2007/08



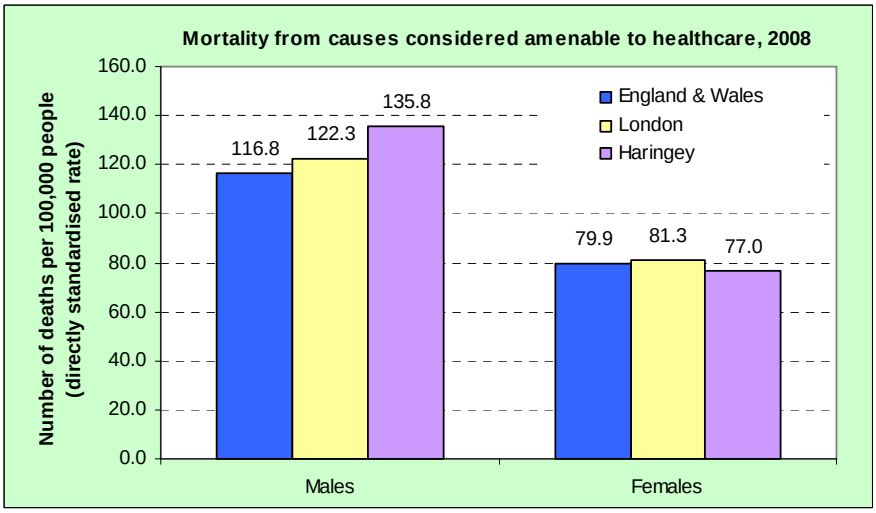
Source: LHO

Amenable mortality[4] 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

[4] 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.

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 onset[5]. This indicator provides an estimate of mortality that is considered potentially avoidable through health care. Mortality from conditions considered amenable to health care in residents aged less than 75 years is higher for males than in London and England and Wales as a whole.

Figure 6: Mortality from causes considered amenable to health care by gender for Haringey, London and England, 2008

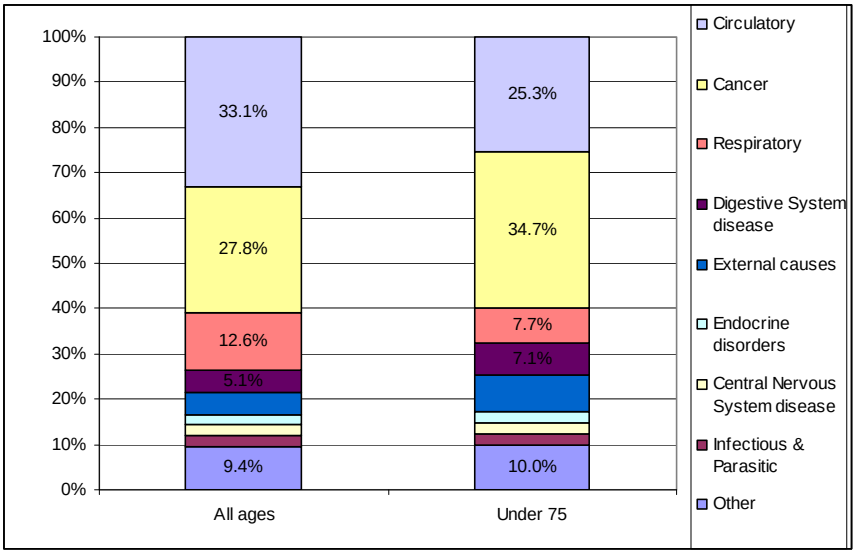


Source: NCHOD

1.4 Causes of death

During 2006 and 2008, the main causes of death were circulatory disease, cancer, respiratory disease and disease of the digestive system. Cancer and circulatory diseases account for 60% of all deaths in the under 75 and all ages groups, however, cancer is more common in the under 75 age group and therefore a bigger cause of premature mortality.

Figure 7: Major causes of death in people all ages in Haringey, 2006/08



[5] Please visit the National Centre for Health Outcomes Development website for a full list of diseases.

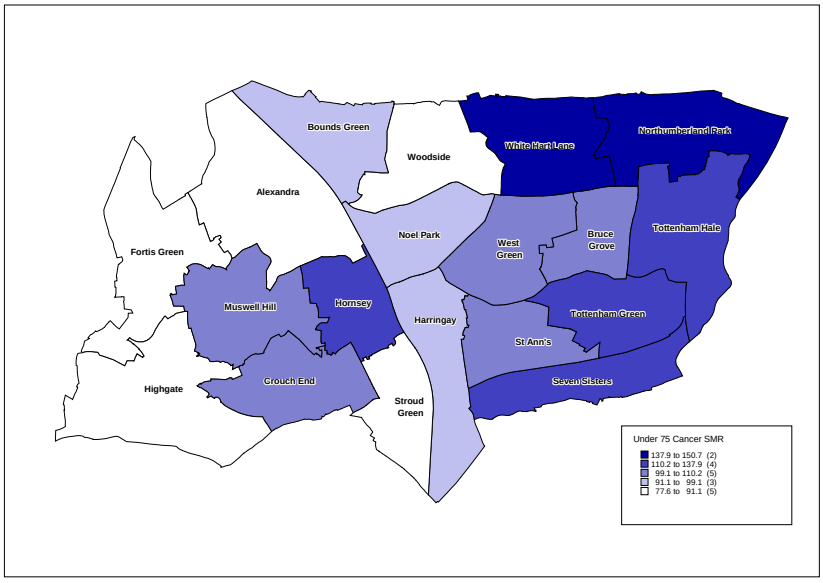
1.4.1 Cancer

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 have a unique set of factors responsible for their onset, although a number share common risk factors. These factors include smoking (responsible for the greatest number of preventable cancers), diet, infectious agents and genetic factors. Many cancers can be prevented though the avoidance of known risk factors. 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 2006/08, accounting for 35% of all deaths. Between 1993 and 2008 the rate of death per 100,000 from cancers in residents aged under 75 years fell from 156 to 112.8 deaths per 100,000 from cancers in residents aged under 75 years. In 2008 the rates for London and England and Wales were 107.6 and 112.8 respectively.

The following map 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.

Map 3: Standardised mortality ratio for cancer by ward, persons under 75 years of age in Haringey, 2003/07



In under 75 year olds, lung cancer was the most common cause of death between 1996 and 2008, followed by colorectal cancer, breast cancer and prostate cancer. This trend is similar to that observed in England as a whole. Breast cancer followed by lung cancer is the most common cause of cancer in females under 75 years. Lung cancer followed by colorectal cancer is the most common cause of cancer in males under 75 years.

1.4.2 Circulatory disease

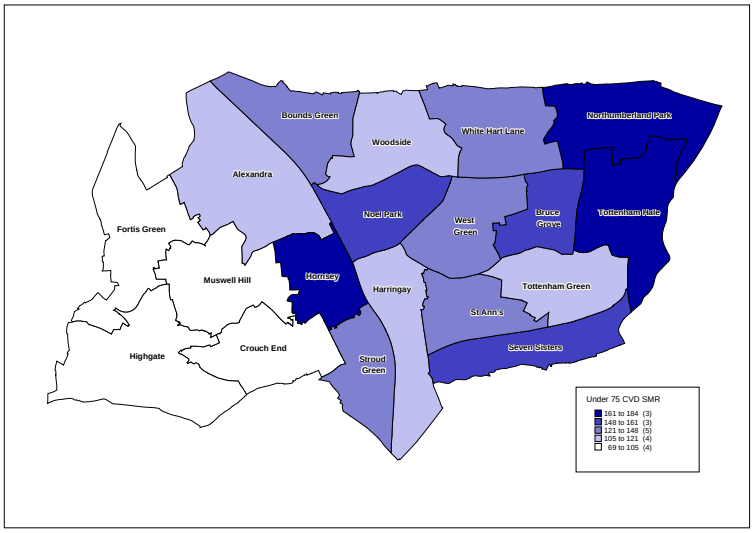
Circulatory diseases include heart diseases and stroke. Circulatory diseases are one of the major causes of death and illness leading to hospitalisation in Haringey and nationally.

Circulatory diseases were the leading cause of mortality in 2006/08, accounting for 33% of all deaths. Between 1993 and 2008 the rate of death per 100,000 from circulatory disease fell from 353 to 180.1 deaths per 100,000 from cancers in residents aged under

75 years. In 2008 the rates for London and England and Wales were 174.3 and 177.7 respectively.

The following map shows the standardised mortality ratio for circulatory diseases for persons aged less than 75 years by ward. Circulatory mortality is not evenly distributed across the borough, with the lowest rates seen in west of the borough.

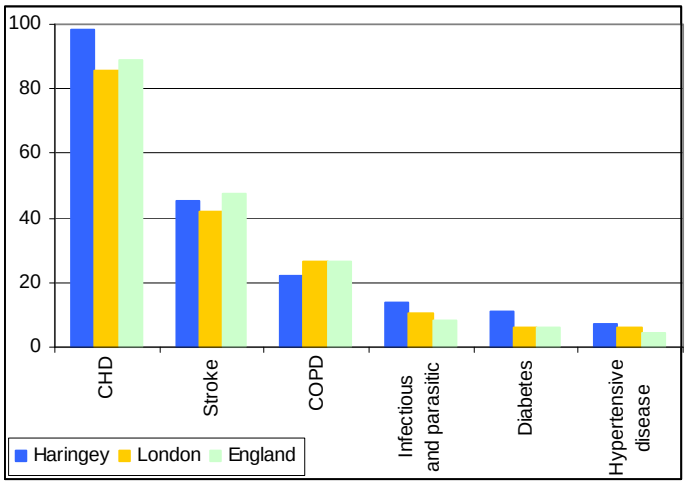
Map 4: Standardised mortality ratio for all circulatory diseases by ward, persons under 75 years of age in Haringey, 2003/07



1.4.3 Other causes of death

As indicated in the previous section, cancer and circulatory diseases account for 60% of all deaths. Coronary heart disease and stroke are two major causes of death. There are also many other diseases that account for a large proportion of deaths and illnesses as shown below. Rates of diabetes caused deaths are roughly double the rate in London and England, whereas rates of chronic obstructive pulmonary disease are lower.

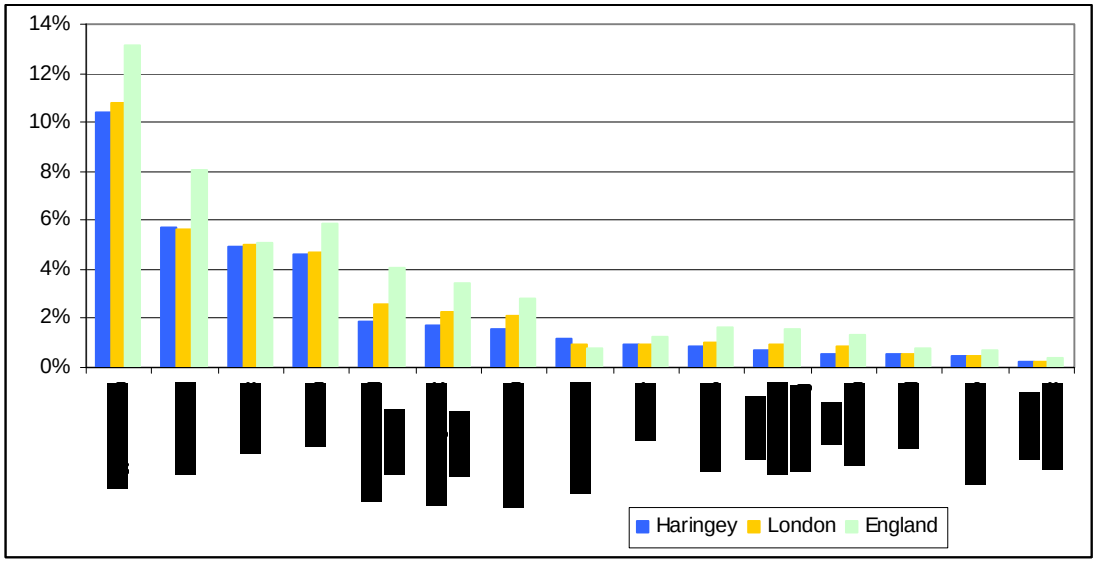
Figure 8: Directly age-standardised mortality rates, all ages in Haringey, 2006/08



Source: NCHOD

The following figures show prevalence rates of various diseases obtained from GP registers. The prevalence rate is a percentage of persons on GP registers (registered population), rather than the resident population.

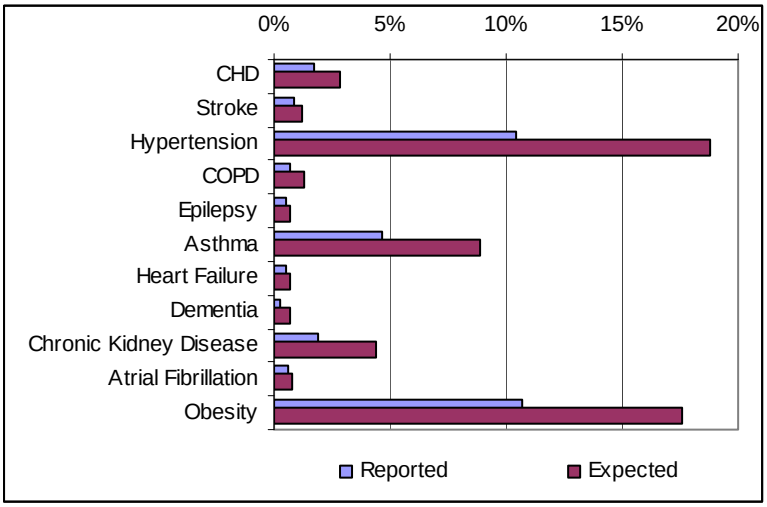
Figure 9: Prevalence rates for various diseases, all ages and population specific[6], 2008/09



Source: Quality Outcomes Framework (QOF), NHS Information Centre

It is important to note that many of these prevalence rates are likely to be undercounts of the true prevalence in the community. NHS Haringey Primary Care Commissioning has put together information on the expected versus reported (QOF) disease prevalence rates which shows there could be twice as many people with hypertension or asthma as there are on GP registers.

Figure 10: Expected and reported prevalence rates for various diseases, Haringey



Source: NHS Primary Care Commissioning

1.5 Adults and hospital admission

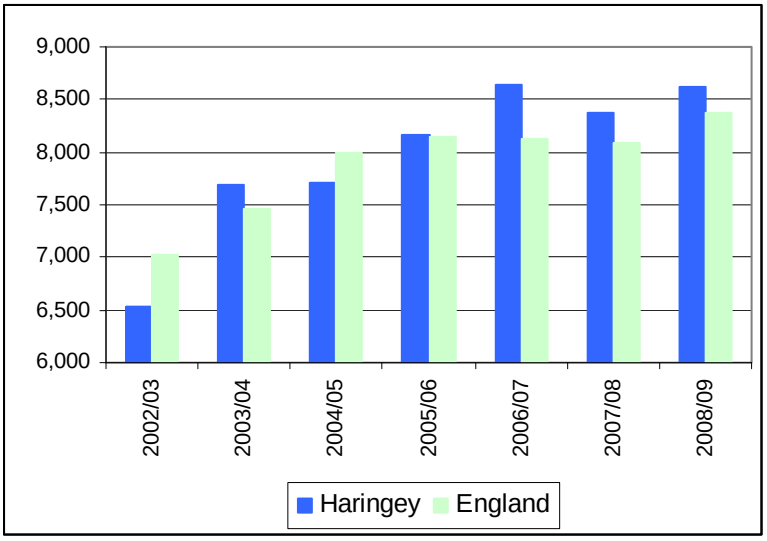
Admission to hospital is broken down into elective, emergency and maternity episodes. Between April 2008 and March 2009 there were 56,169 admissions to hospital. Half of these were elective admissions (28,278), a third were emergency admissions (19,333) with the remaining being for maternity (8,520).

The current rate of emergency admissions is marginally higher than England with an extra 2,000 admissions per year since 2002/03.

[6] Diabetes is 17+, epilepsy, chronic kidney disease and learning disabilities are 18+.

Back to top

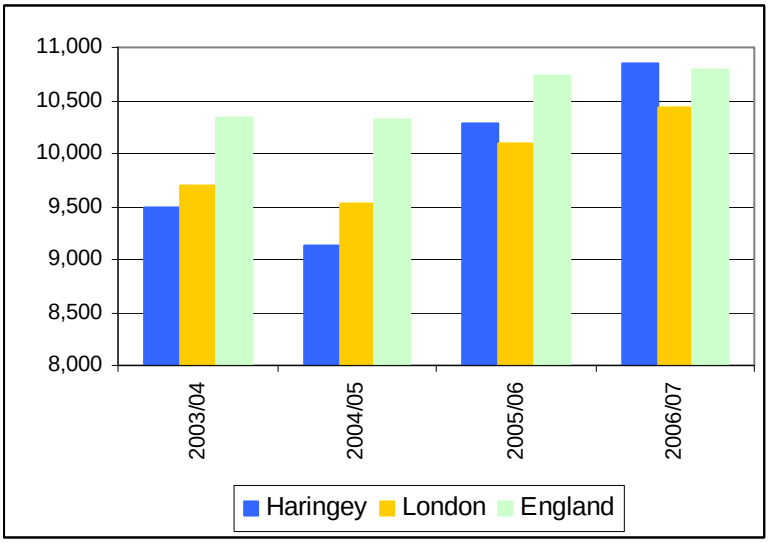
Figure 11: Age standardised hospital emergency admission rate, all ages in Haringey and England, 2008/09



Source: LHO, Basket of Indicators

The figures below show the rates in 2006/07 of emergency and elective admissions in Haringey are higher than London.

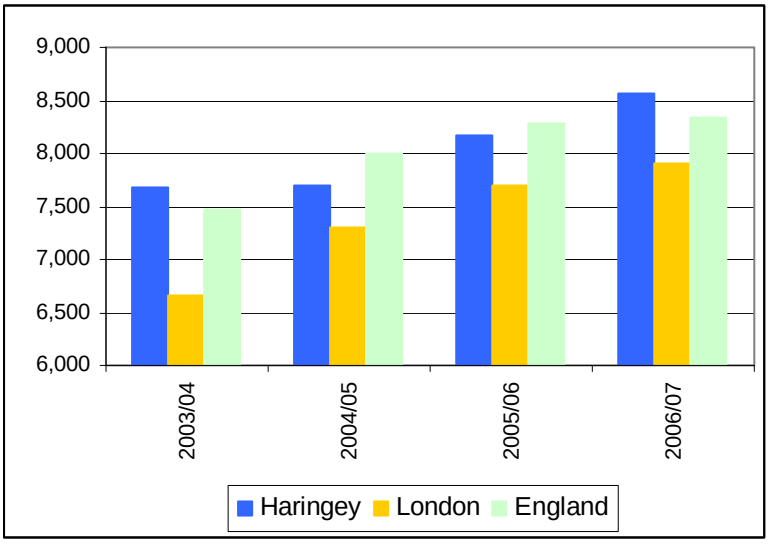
Figure 12: Age standardised hospital elective admission rate, all ages for Haringey, London and England, 2006/07



Source: LHO

Back to top

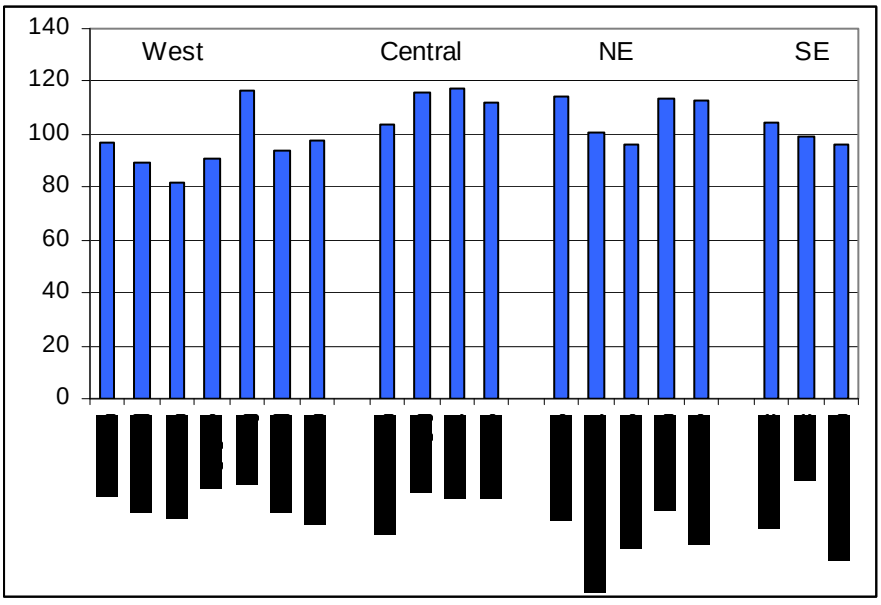
Figure 13: Age standardised hospital emergency admission rate, all ages, for Haringey, London and England, 2006/07



Source: LHO

The following two figures show the standardised admission ratios[7] for elective and emergency admissions in Haringey wards. With the exception of Hornsey, those in the west are less likely to be admitted to hospital.

Figure 14: Standardised admission ratio for elective admissions, Haringey wards and NHS Neighbourhoods, 2007/08

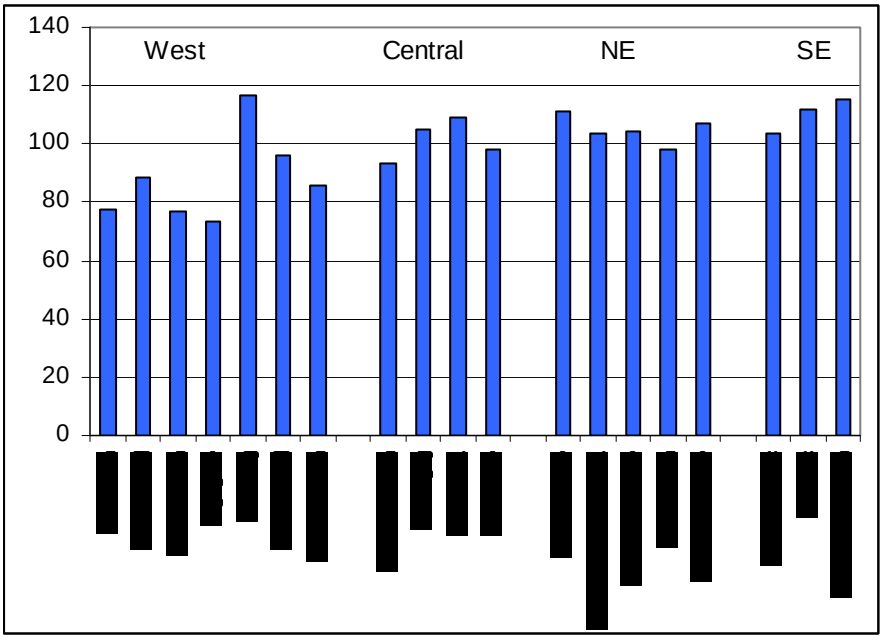


Source: LHO

[7] A SAR is essentially a comparison of the number of the observed admissions in a population with the number of expected admissions if the age-specific admission rates were the same as a standard population. It is expressed as a ratio of observed to expected admissions, multiplied by 100. SARs equal to 100 imply that the admission rate is the same as the standard admission rate. A number higher than 100 implies an excess admission rate whereas a number below 100 implies below average admissions. An SAR for an area should only be compared to the standard rate and not to other areas where SARs have been calculated.

Back to top

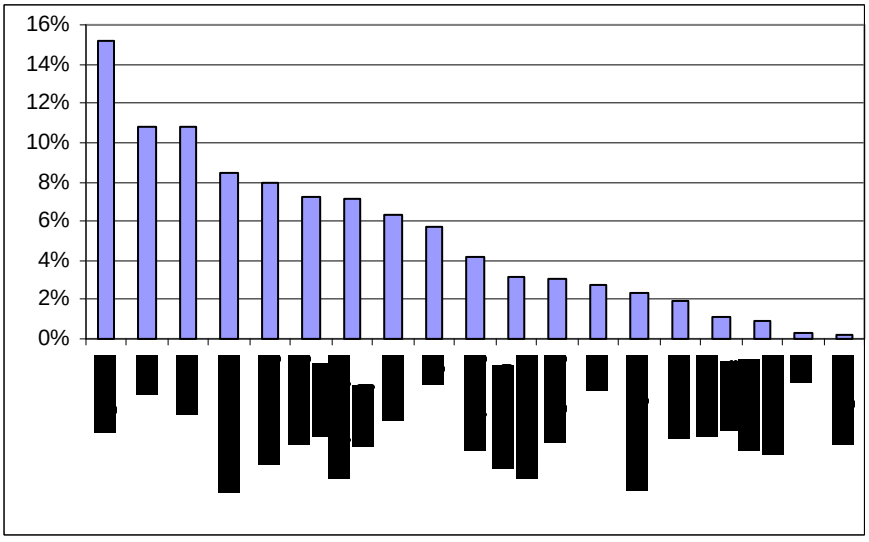
Figure 15: Standardised admission ratio for emergency admissions, Haringey wards and NHS Neighbourhoods, 2007/08



Source: LHO

In Haringey in 2008/09, digestive and cancer related diseases were the most common reason for elective and emergency admissions.

Figure 16: Emergency and elective admissions by disease type, persons aged 20+, primary reason, Haringey, 2008/09



Source: HIS

For more information on alcohol-related hospital admission rates, see section 1.6.5 Alcohol consumption.

1.6 Changing behaviour

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.

Health behaviours described in this chapter include: smoking, obesity, exercise, eating habits, alcohol, drug misuse and sexual behaviour.

1.6.1 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 areas where smoking rates tend to be higher.

Cost and deaths related to smoking

The report *Tobacco in London: the preventable burden* indicated that in Haringey in 2001 there were 260 deaths related to smoking and 1,120 hospital admissions, at a cost of nearly £2.6m[8].

From 2006/08 there were 195 deaths related to smoking. This was 203 deaths per 100,000 persons aged 35+, a similar rate to the England rate at 207 per 100,000.

Smoking prevalence

Modelled smoking prevalence data derived from the Health Survey for England (2006/08), predicts that Haringey has a current smoking prevalence of 24.1, compared with 20.8% in London and 22.2% in England. The figures for 2003/05 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.

17.7% of residents registered with a GP in Haringey were recorded as smokers as at March 2009. Smoking rates were lowest in the West Neighbourhood (15.4%) and highest in the North East Neighbourhood (19.9%).

More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant. The Association of Public Health Observatories (APHO) has released a technical briefing on this issue[9].

Smoking quit rates

In 2008/09 3,282 persons in Haringey set a smoking quit date, with a success rate of 59% (1,939 persons) at the four-week follow-up. These success rates are higher than London (47%) and England (50%) averages.

1.6.2 Exercise

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 Residents' Survey reported undertaking at least 30 minutes of moderate intensity physical activity on three or more days each week.

For information on leisure centre usage and membership, see **Priority 3: Promote opportunities for leisure, socialising and life-long learning**.

1.6.3 Adult obesity

Obesity in adults aged 18 and over has been estimated from the Health Survey for England (2006/08). 21.3% of adults are predicted to be obese, compared with 24.2% in

[8] Tobacco in London: The preventable burden. www.lho.org.uk/viewResource.aspx?id=8716
[9] Measuring smoking prevalence in local populations http://www.apho.org.uk/resource/item.aspx?RID=87192)

England. The 2003/05 estimates for obesity vary considerably across the borough, ranging from less than 10% in a MSOA in Highgate to greater than 25% in MSOAs in Tottenham Hale, West Green, White Hart Lane, Bruce Grove and Northumberland Park.

8.6% of residents registered with a GP were recorded as obese as at March 2009. Obesity rates were highest in the North East and Central Neighbourhoods (10.6% and 9.9%) respectively, followed by 8.9% in the South East Neighbourhood. The lowest obesity rate was recorded in the West Neighbourhood (5.9%).

1.6.4 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.

Fruit and vegetable consumption by adults is recorded in the Health Survey for England. The most recent prevalence data (2006/08) modelled from the Health Survey for England suggests that 39.5% of adults in Haringey consume adequate amounts of fruit and vegetables in their diet, compared with 28.7% in England and 36.4% in London. These data were released to MSOA level. MSOAs that are predicted to have adequate fruit and vegetable consumption of less than 25% include locations in Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.

1.6.5 Alcohol consumption

The effect of alcohol on health may vary, depending on the amount and nature of consumption and by age and sex. High levels of alcohol consumption are also associated with violence and injuries.

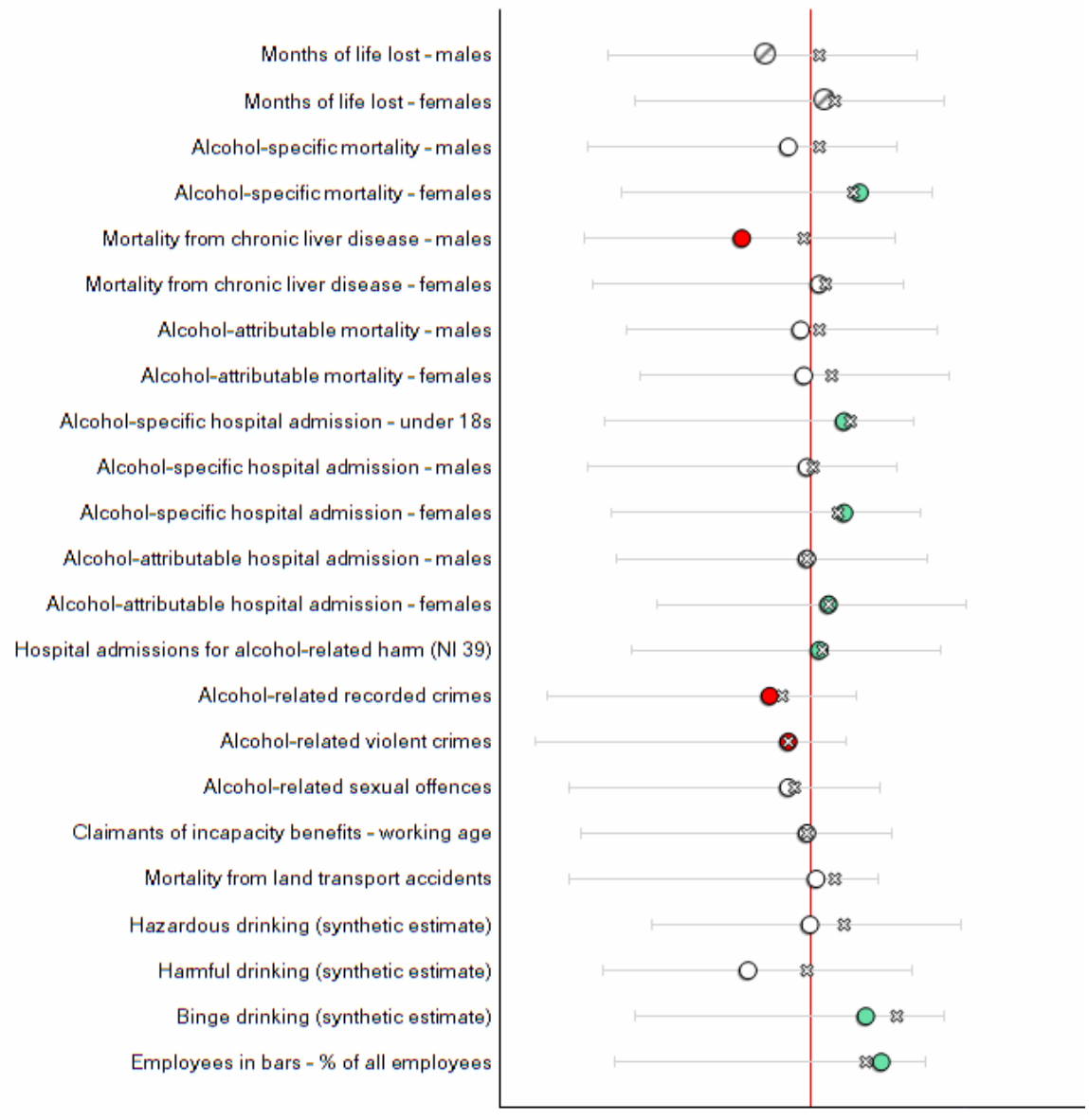
Prevalence of binge drinking in adults has been estimated from the Health Survey for England (2006-2008). 16.5% of adults in Haringey were estimated to have been binge drinking in the previous week compared to London (14.3%) and England (20.1%). The estimates for binge drinking do not show the same geographical trends as other healthy lifestyle related behaviours like obesity and smoking, with many areas in the west having the highest rates. In 2003/05 the rates varied across the borough from less than 10% in Tottenham Green, Bruce Grove and Northumberland Park to over 15% in Alexandra, Fortis Green, Muswell Hill, St Ann's, Crouch End, Stroud Green and Highgate.

In 2007/08, there were 1,404.4 hospital stays for alcohol related harm. In 2008/09 this figure increased to 1,630, similar to the England average at 1,580 stays.

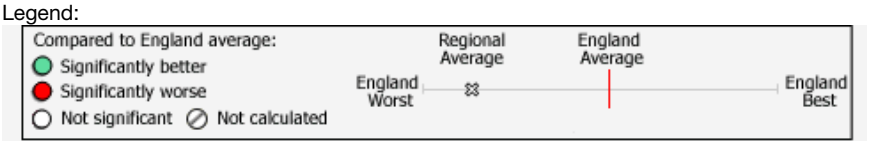
For more detailed information, please see Haringey's Alcohol Needs Assessment 2010.

Alcohol misuse use can be related to anti-social behaviour, crime and domestic violence. Further information on the borough profile can be found in **Safer for all: Address anti-social behaviour, and Create safe and secure homes and tackle domestic violence.**

Figure 17: Indicators of alcohol-related harm for Haringey



Legend:



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

1.6.6 Drug misuse

Drug misuse cuts across a broad spectrum of social issues, from health and well-being to deprivation and crime. Most problematic drugs are crack and opiates (e.g. heroin) as they are seen to have the highest impact on society. Those vulnerable to problematic use are more likely to live in deprived areas,

There are a number of crack and opiate users in Haringey; the latest estimated prevalence is 2,666[10]. A significant majority use crack (80%; 2,141) but, partly due to our

[10] Associated confidence intervals 2338 and 3068. The latest estimates are based on study by Hay G, Gannon M. et al. (2008). Estimates of the prevalence of opiate use and/or crack cocaine use (2006/07) London Region. Home Office.

specialist stimulant service Eban, commissioned in 2007, Haringey had the sixth highest proportion of crack users in treatment between 2006/07-2008/09 in London (NTA:2010)[11]. The estimate for opiate users in 2008/09 was 1,936. This, alongside drug treatment data, suggests that a poly use of crack and opiates is common, a trend by no means unique in comparison to the rest of London[1]. Problem drug use mirrors geographical deprivation with most residing in the more deprived and densely populated north east of the borough, higher levels of mental ill health and poor housing conditions, and a higher likelihood of involvement in acquisitive crime. Three key drug services are now based within this area; Drug Intervention Programme (DIP), Bringing Unity Back into the Community (BUBIC) and Eban.

There are number of drug treatment and support services available for Haringey residents. Support ranges from advice and information, needle exchanges to counselling and rehab.

For further information on separate drug treatment needs assessments for adults and young people, and the most up-to-date action plans, please go to the Drugs and Alcohol section on Haringey Council's website.

1.6.7 Sexual health

Details can be found in Haringey's Sexual Health Needs Assessment 2010.

1.7 GPs in Haringey

There are 56 general practices in Haringey. In January 2010 there were 280,600 people registered with a GP, which is higher than the ONS 2010 population projection (227,700) and the GLA 2010 projection (236,379).

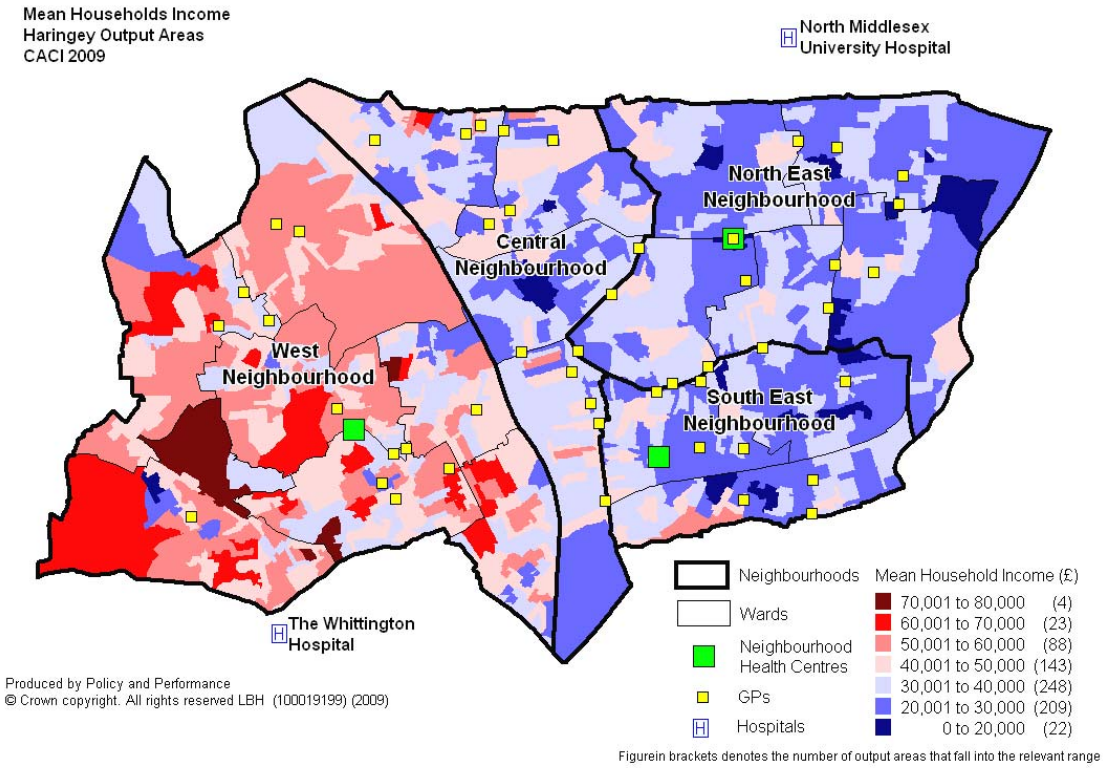
Table 1: GP practices in Haringey, by NHS Neighbourhood, 2010

Area	Number of GP practices	Total number of people registered	% of all registered	Range of practice list sizes	Average list size
West	15	86,598	31	2,295-16,269	5,773
Central	13	61,853	22	1,188-16,879	5,154
North East	15	77,627	28	1,468-10,970	5,175
South East	13	54,522	19	1,098-7,700	4,194
All practices	**56**	**280,600**	**100**	**1,098-16,879**	**5,011**

There is considerable variation in the numbers of individuals registered with individual practices. Map 5 below shows the distribution of health care across the borough.

[11] NTA (2010) Crack use in London: Analysis of the National Drug Treatment System (NDTMS) and other data sources January 2010. NTA. Although the % of crack using clients in treatment in this financial has gone down to 32% which is lower than London average of 34%, between 1st July 2008 to 30th June 2009. However the number of drug users coming to treatment in this financial year is down overall, not just crack users.

Map 5: Health services in Haringey



GP patient survey results

The Care Quality Commission uses national surveys to find out about the experience of people when receiving care and treatment from health care organisations. In 2008, responses were received from 325 people from Haringey GP practices. The results can be found in the borough profile section: **People and customer focused**.

In line with the national strategy to establish practice-based commissioning, the focus for planning health care in Haringey now rests with local clinicians and local people. The borough is divided into four more or less equal parts which include GP practices and patients within that area. These are known as neighbourhoods (sometimes referred to as collaboratives or localities). Each neighbourhood has produced its own local development plan and is GP-led, each with its own Patient Panel:

- West Neighbourhood
- Central Neighbourhood
- North East Neighbourhood
- South East Neighbourhood

It should be noted that GP practices in each of these four neighbourhoods may choose to belong to a different neighbourhood. “Going local”, using the neighbourhoods to commission and provide local services, was introduced as a new goal in the NHS Haringey Strategic Plan for 2009-14.

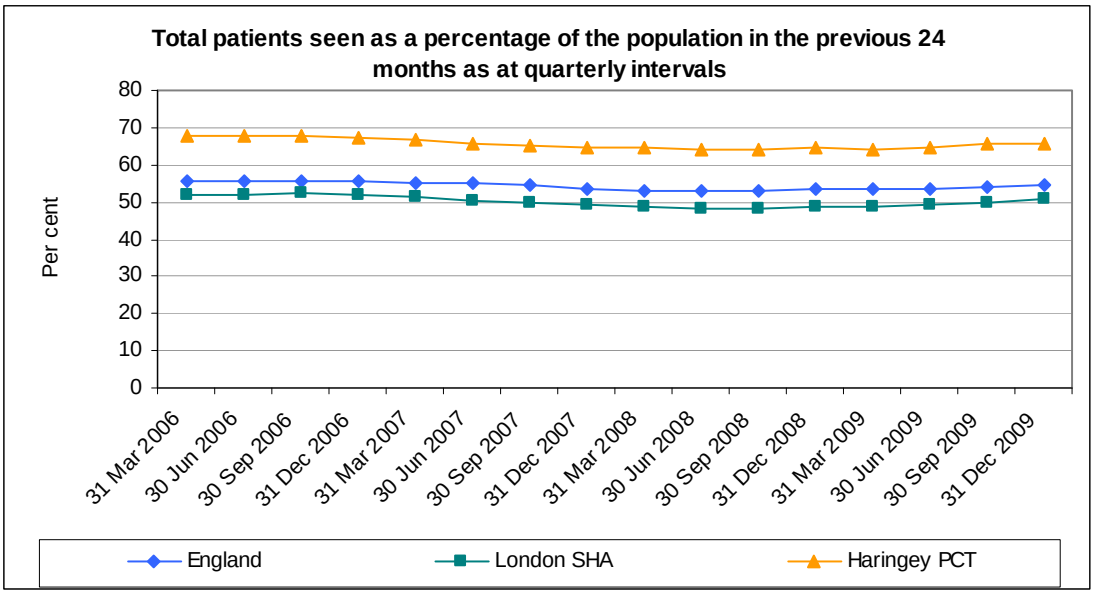
1.8 Oral health

Dental provision in Haringey is good compared to other areas of London, ranked 13th out of the 152 NHS Primary Care Trusts (PCTs) nationally for the percentage of the population who visited a dentist regularly as an NHS patient in last 24 months (NHS Dental Statistics, 2009).

Similarly, the proportion of the population who use NHS dentistry is high compared to other areas of London. Haringey ranked in joint sixth place among London PCTs for the percentage of respondents in the 2008 National Patient Survey in Haringey who said that they visit a dentist regularly (i.e. at least once every two years) as an NHS patient.

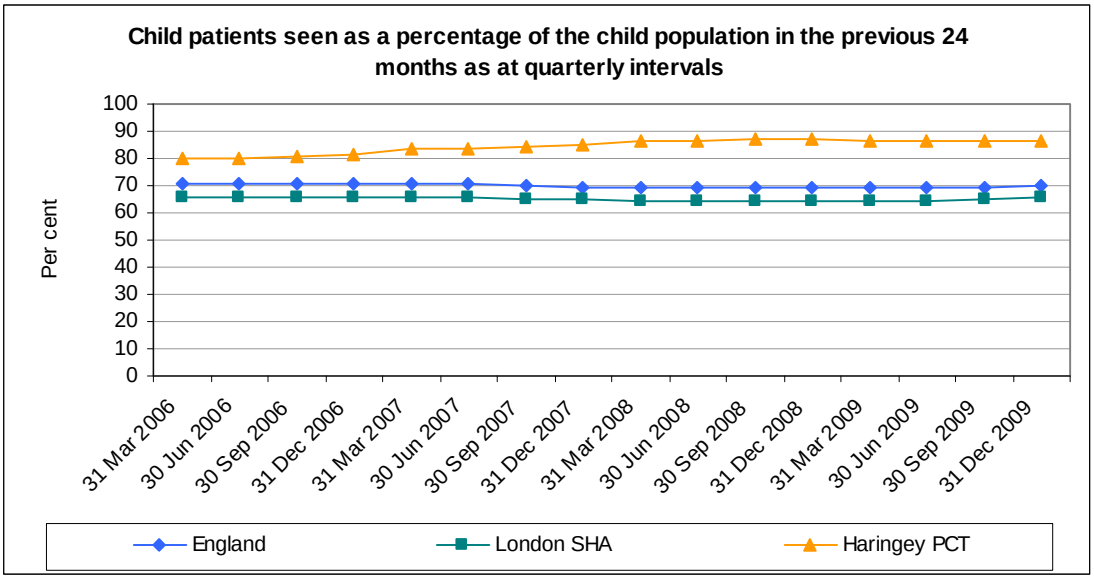
Access to primary care dentistry is measured nationally by counting the number of unique patients receiving NHS dental care over a two-year period. The number of patients seen by dentists has declined nationally and in London since the introduction of new contractual arrangements for NHS dentistry in April 2006. This is also the case in Haringey, although the percentage of the population seeing a dentist remains consistently above both national and the London levels as seen below. Access figures have shown upwards trend across London as well as nationally since December 2008. According to the NHS Information Centre (February 2009) the total patients seen as a percentage of the population in the previous 24 months ending at 31 December 2009 in Haringey was 65.9%, slightly higher than the percentage for England (54.7%) and London (50.6%).

Figure 18: Total patients seen as a percentage of the population in the previous 24 months as at quarterly intervals



In contrast to both the national and London trend, the number of child patients as a percentage of the child population seeing a dentist has increased steadily in Haringey since the introduction of the new contract. According to the NHS Information Centre (February 2009) child patients seen as a percentage of child population in the previous 24 months ending at 31 December 2009 in Haringey was 86.7%, slightly higher than the percentage for England (69.8%) and London (65.4%). Haringey is ranked 2nd nationally for the percentage of children seen by general dental practitioners.

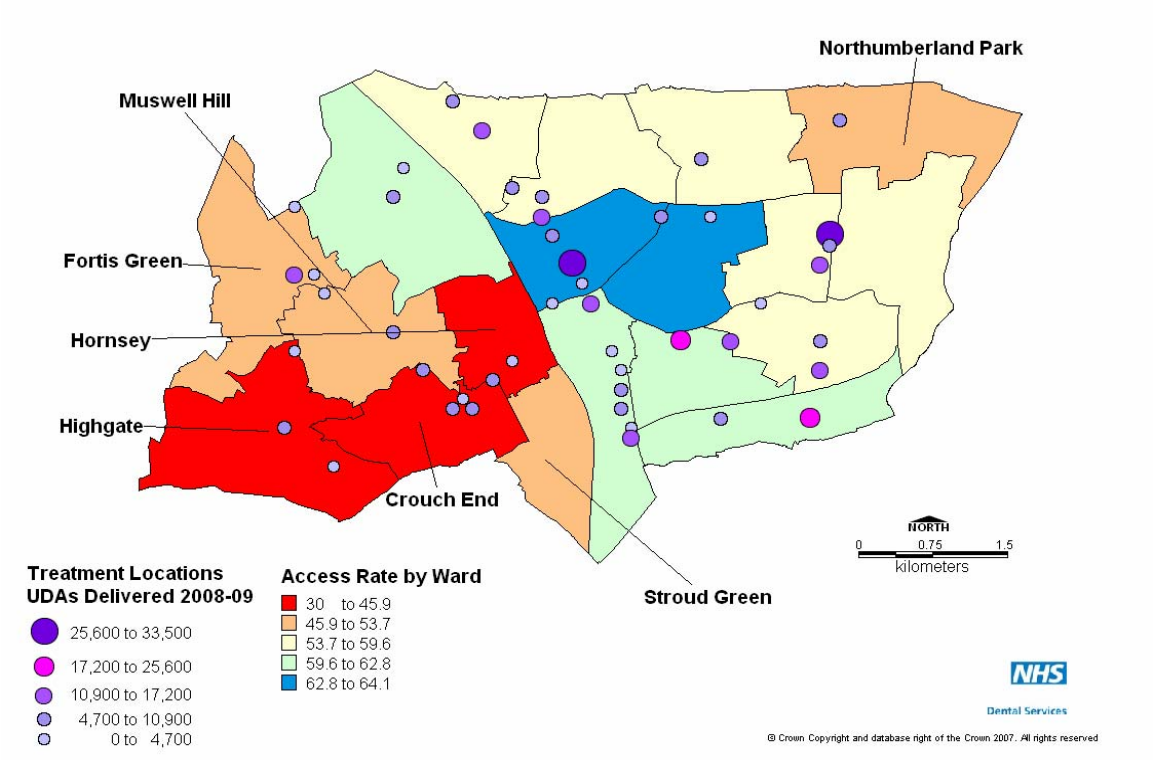
Figure 19: Child patients seen as a percentage of the child population in the previous 24 months as at quarterly intervals



Uptake and deprivation

The level of dental activity (measured in Units of Dental Activity [UDAs], i.e. dental work carried out) in an area does not correlate to the level of deprivation (as one might expect, given the link between deprivation and dental disease). The disparity is most marked in Northumberland Park – one of the most deprived areas of the borough but on the second lowest level of UDAs carried out in the period.

Map 6: Treatment locations and ward level access rate (%) 2008/09



Back to top

The most recent survey of five year-olds appears to suggest that Haringey has a better standard of oral health than London as a whole.

Table 2: National survey of the oral health of five year-old children, 2007/08

	Mean decayed teeth (dt)	% with decay	Mean decayed, missing or filled teeth (dmft)	% with decay, missing or filled teeth	Care Index (amount of decay that has been treated)	Abscess / Sepsis
Haringey	0.58	17.6	0.96	24.64	20	3.01
London	1.00	28.97	1.31	32.74	19	3.37

This would appear to suggest that Haringey has a better standard of oral health than London as a whole. However, closer analysis reveals a wide variation in figures between postcodes and, indeed, schools. For example, using 2003/04 sample figures, children in Seven Sisters had four times more decayed teeth than those in Highgate and four times more dental disease than those in Muswell Hill.

Priority 3: Promote opportunities for leisure, socialising and life-long learning

Local Area Agreement 2008-11 (Year 2 refresh March 2010)		
NI	**Indicator**	**Monitored by HSP Thematic Board**
6*	Participation in regular volunteering	Performance Management Group
Local 17	Environment for a thriving third sector	Performance Management Group
8*	Adult participation in sport	Well-being
119	Self-reported measure of people's overall health and well-being	Well-being
Local	Number of registered Haringey Guarantee participants with a completed better off calculation	Enterprise
R Local	Adults achieving a Skills for Life qualification and entered employment and those gaining a qualification in the workplace	Enterprise
R Local	Adults achieving a full level two qualification and entered employment and those gaining a qualification in the workplace	Enterprise
Local	Number of Green Flag parks (2007-10 stretch)	Better Places
Local	Number of parks achieving Green Pennant status (2007-10 stretch)	Better Places
Local	% of people who report they are satisfied or fairly satisfied with local parks and green spaces	Better Places
* Designated indicator/target		

3.1 Sport and leisure

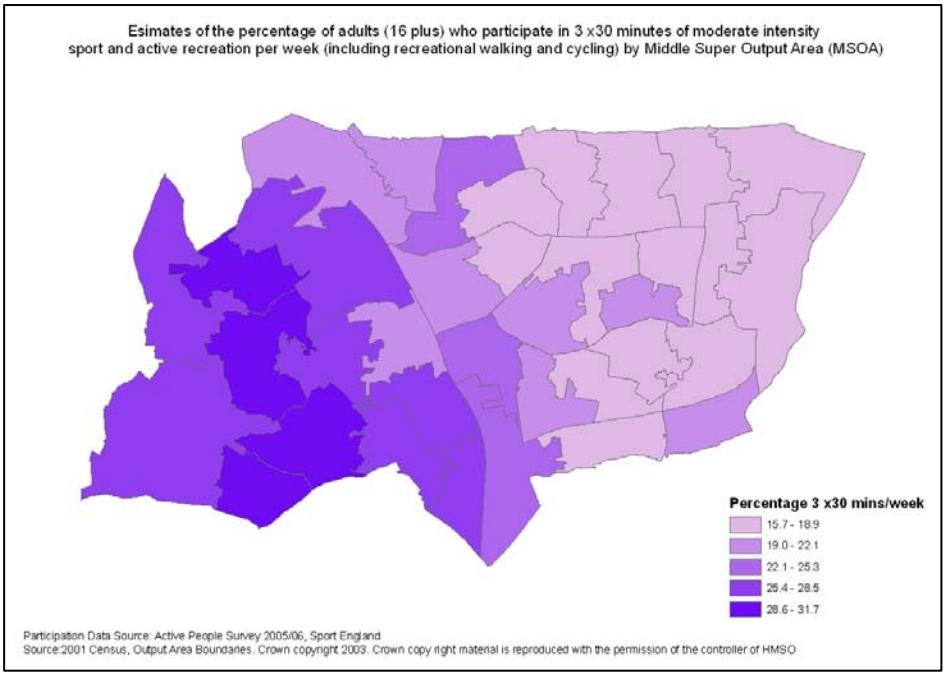
Annually since 2005/06, Sport England has commissioned an extensive survey of adult sport and physical activity participation. Overall, in 2008/09, 23.2% of the adult Haringey population was taking part in moderate sport and physical activity three times a week for at least 30 minutes. While this is a small increase on 2005/06 it is not considered statistically significant. The most popular activities are walking, gym, football and swimming.

The cross-borough picture, as Map 7 below indicates, is one of reasonable participation in the west of the borough and poor participation levels in the east. It is therefore clear that socio economic factors are a key determinant of how often individuals participate. As with much of England, 49% of the adult Haringey population do not participate at all in sport or moderate physical activity.

The borough has a challenging target to increase participation to 26.9% and Recreation Services are working on projects to achieve this and to continue improving participation by 1% per annum.

Nationally, Sport England and the Department of Health have an ambitious joint target to increase adult sport and physical activity to 50% 3 times a week by 2020. Since 2005/06 there has been a small increase in participation nationally.

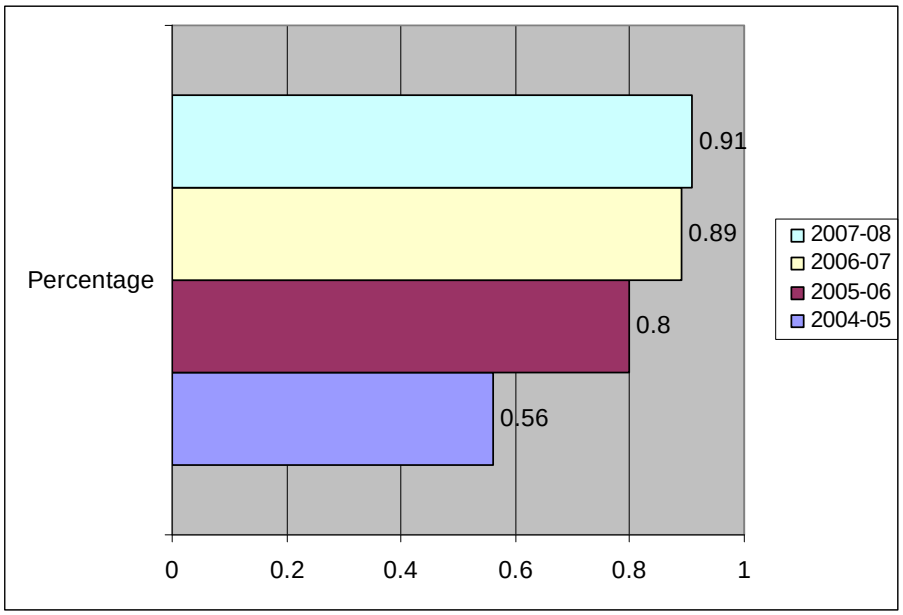
Map 7: Estimates of the percentage of adults (16+) who participate in 3x30 minutes of moderate intensity sport and active recreation per week (including recreational walking and cycling) by MSOA, Active People Survey 2005/06



In recent years, via funding from the Youth Sport Trust and better structures for the promotion of school PE/sport (specifically the introduction of School Sport Partnerships), the number of pupils participating for two hours per week in Haringey improved significantly to above national average in 2008.

The generally good picture, however, does mask some mediocre results for a small number of schools and difficulties in engaging some of the older children. From 2008/09, the target has increased to three hours a week. Currently, Haringey is scoring 42% against a national average of 51% based on the annual School Sport Survey, although an internal local survey in 2009 with 13,000 returns suggested 66%. The target for 2010 is 60% with 80% targeted for 2011.

Figure 20: Leisure Centre membership: April 2006-April 2010



Back to top

3.2 Parks and open spaces

The borough profile of achievements, activities and usage of our award winning parks and open spaces can be found in People at the heart of change: **Provide award winning parks and open spaces**.

3.3 Culture and libraries

The borough profile of achievements, activities and usage of our libraries, museums and other local cultural activity can be found in People at the heart of change: **Provide even better shopping and cultural and leisure opportunities**. Between April 2008 and April 2009, 54% of adults in Haringey used a local library at least once, 64.3% attended a museum or gallery at least once, and 56.6% engaged in the arts at least three times[12]. This places Haringey in the top 25% in the country.

3.4 Volunteering

The borough profile of participation in volunteering can be found in People and customer focused: **Draw on the strength of the voluntary and community sector**.

3.5 Life-long learning

The borough profile for adult learning can be found in Economic vitality and prosperity shared by all: **Increase skills and educational achievement**.

[12] Sport England, Active People

Priority 4: Enable people to live independently, exercising choice and control

Local Area Agreement 2008-11 (Year 2 refresh March 2010)		
NI	**Indicator**	**Monitored by HSP Thematic Board**
125*	Achieving independence for older people through rehabilitation/intermediate care	Well-being
135*	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Well-being
Local	Number of older people permanently admitted into residential and nursing care (2007-10 stretch)	Well-being
Local	Number of adults permanently admitted into residential and nursing care (2007-10 stretch)	Well-being
141*	% of vulnerable people achieving independent living	Well-being
149*	Adults in contact with secondary mental health services in settled accommodation	Well-being
Local 175	Access to services and facilities by public transport (and other specified modes): (a) primary schools (b) secondary schools (c) GP surgeries (d) food shopping	Better Places
* Designated indicator/target		

4.1 Adult social care

4.1.1 Transforming social care in Haringey

Transforming Social Care or '[personalisation]' is a national programme which aims to give people greater say over the services they receive. It requires the most radical changes since the establishment of the welfare state. It will mean that people have more choice and control over the services they receive to meet individual need and promote their independence, well-being and dignity.

This new transformation is currently in development and will begin to affect all adult service users by 2011. This will include older people and those living with a sensory impairment, physical disability, learning disability, mental ill health and substance misuse difficulties.

The transforming social care programme has been funded by a three-year grant which ends in 2011.

Creating personalised services in Haringey in 2010/11

- An [Integrated Access Team] has been set up to provide the public with advice, information and signposting to services.
- An online information directory will provide information about services.
- From October 2010, a Reablement Service will provide support for 4-6 weeks after hospital discharge, or to help avoid hospital admission. There is an assumption that this will reduce the numbers of service users requiring hospital admission and reduce some dependence on long-term provision of services.
- The process of determining level of need, support and funding will begin with a supported self-assessment questionnaire (SSAQ: help is provided to complete the

self-assessment) to determine the level of individual need, support and funding. It is hoped that, over time, more service users will depend on others than care management staff to complete the SSAQ; evidence from other authorities involved in the national pilots suggests this is the case.

- Pilot projects for people with physical disabilities, learning disabilities, older people and people with mental health needs have been testing the new self-directed support pathway and process. Self-directed support has now been implemented for people with physical disabilities and for people with learning disabilities. The process is beginning for older people but, as the numbers in this group are far larger, it will take longer to complete the pilot. The pilot in the community mental health service has only just begun.
- From October 2010, help will be offered to service users to purchase their own choice of services from a Personal Budget Support and Service Finding Team. It is hoped that more service users will take their personal budget as a direct payment. At the same time, staff are being offered training to emphasise the importance of changing their "professional culture" so that more choice and control is transferred to the service user (and carer where appropriate in agreement with the service user). The target is to achieve a minimum of 409 personal budgets by September 2010 and a maximum of 1100 by 31 March 2011.
- A wider range of service options will be made available, by changing the process of commissioning to market shaping and mapping and responding to service users' views. It has been assumed that the transformation process will continue to help reduce demand for expensive and restrictive residential care services in favour of more independent and continued life in service users' own homes.
- The Safeguarding Team will continue to deal with suspected abuse and the Out of Hours Emergency Service will continue to operate at night and at weekends.
- An advocacy service for service users will provide independent advice, information and support to use services.
- Neighbourhood networks of volunteers and self help will help people remain independent for longer without social care involvement.

The personalisation process has included an ongoing programme of consultation with service users and includes a service user and carer reference group linked to the Transforming Social Care Board. The final five months of the Transforming Social Care Programme will focus on making adjustments to the process and organisation and monitoring the outcomes for service users.

4.1.2 Social care for adults aged 18 and over

There are currently around 5,743 adults aged 18+ in Haringey who use social care services[13], using the eligibility criteria set out in Fair Access to Care Services (FACS). FACS identifies for key levels of eligibility: Critical, Substantial, Moderate and Low. At the present time, the council offers services to people who are assessed as having Critical or Substantial needs. This means that figures for people receiving social care services will usually be significantly lower than those for people who describe themselves as having a physical or learning disability, mental health need, or a support need as an older person.

Of those receiving social care services:

- In the 18-64 age group, 1,250 service users are female and 1,314 are male, a total of 2,564
- In the 65+ age group, 2,103 service users are female and 1,076 are male, a total of 3,179

[13] Figures are taken from Referral, Assessments and Packages (RAP) data at 31 March 2010

By far the largest client group is women aged 65+ who are frail with a physical and/or sensory impairment (1,789 women). By comparison, there are 898 men aged 65+ in the same category, reflecting Haringey's life expectancy profile with women living longer than men.

Figure 21: Adult social care service users by age

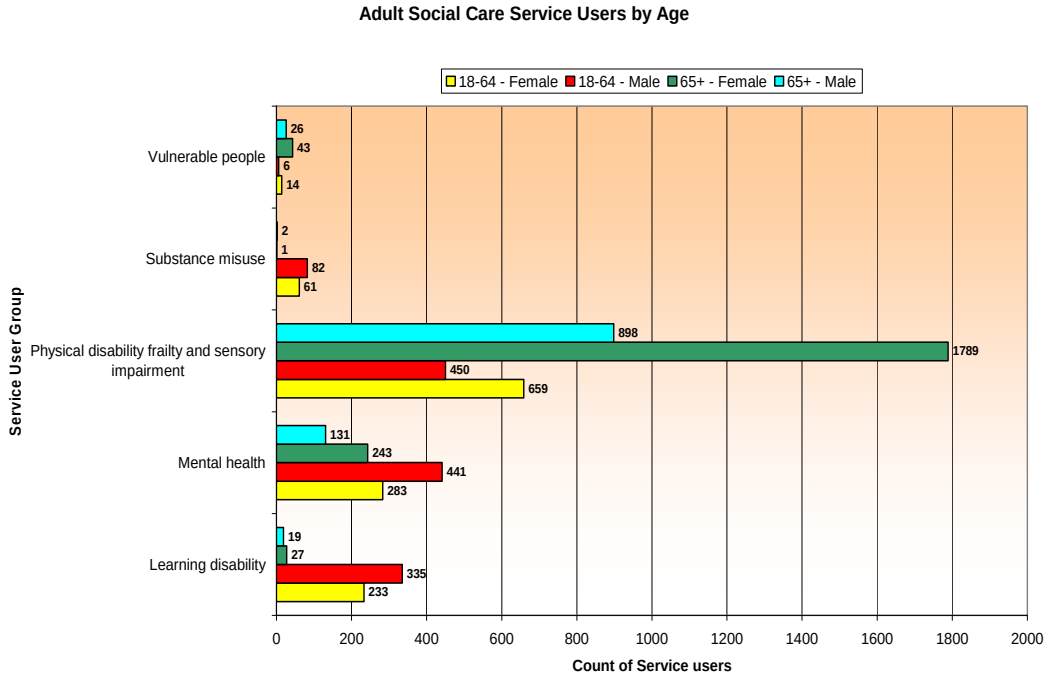
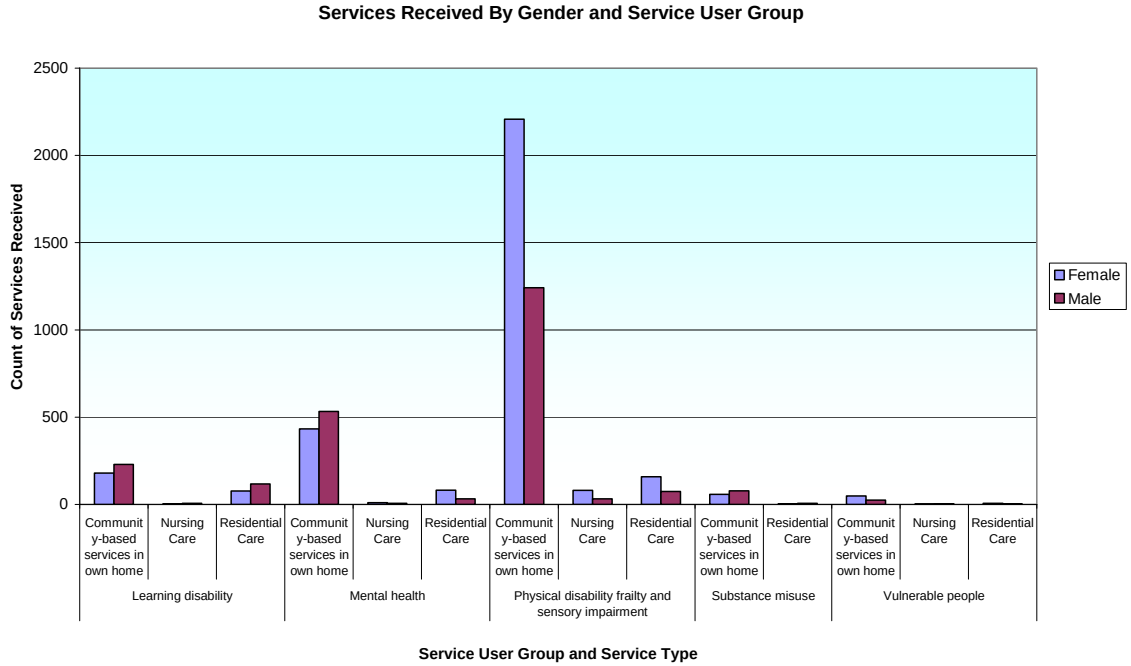


Figure 22: Services received by gender and service user group

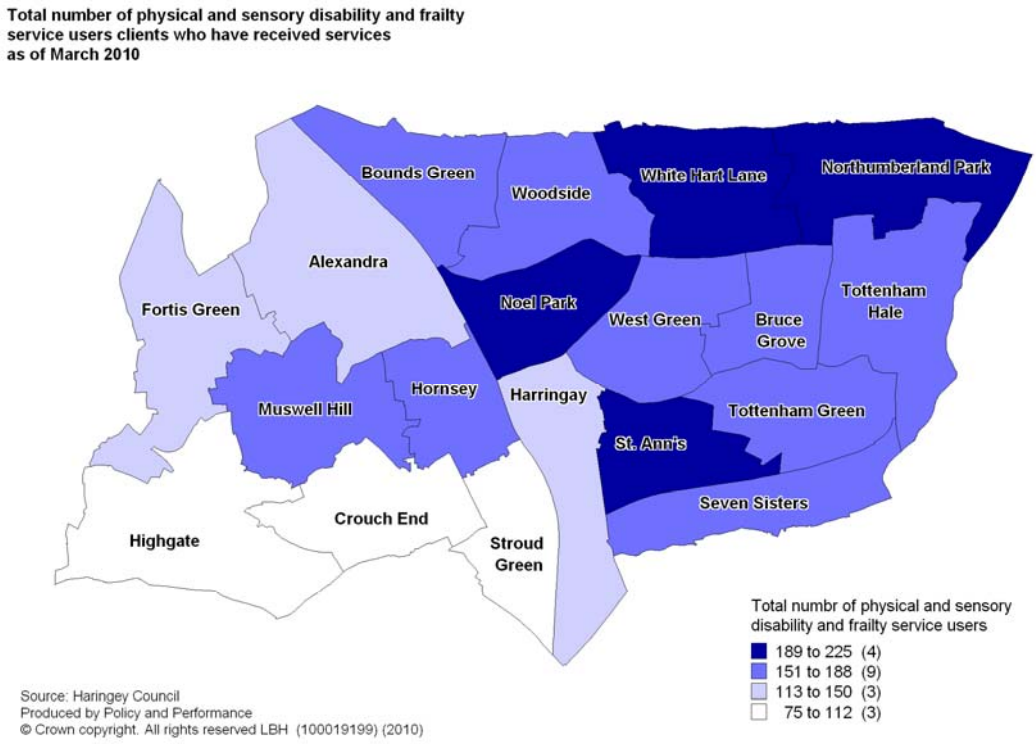


Back to top

4.1.3 Physical disabilities

- 3,796 adults with a physical disability or a sensory impairment are receiving social care services, 2,687 of whom are aged 65 or above. Of the total number, 3,449 use community-based services, 113 are in nursing care and 234 in residential care. The highest group of users are women aged 65+ (1,789 or 47% of the total in this client group), and the lowest is males aged 18-64 (450)[13].
- In Haringey, 39% of adults aged over 55 reported a limiting long-term illness (confidence interval 18-59%) compared with 8% of those aged 16-34 and 12% of those aged 35-54 years[14].

Map 8: Total number of physical and sensory disability service users receiving services at March 2010



[14] www.lho.org.uk

Table 3: Total population of people aged 18-64 predicted to have a disability (showing % of total in that age range)[15]

	2010	2015	2020	2025	2030
Moderate physical disability: 18-64 years	10,553 (6.72%)	10,972	11,455	11,808	11,937
Serious physical disability: 18-64 years	2,827 (1.8%)	2,955	3,141	3,290	3,328
Limiting long-term illness: 65+ years	10,475 (51.12%)	11,062	11,455	12,418	13,951
Moderate or severe hearing impairment: 18-64 years	4,349 (2.77%)	4,651	5,051	5,334	5,385
Moderate or severe hearing impairment: 65+ years	8,653 (41.4%)	9,264	9,427	10,465	11,415
Profound hearing impairment: 18-64 years	34 (0.02%)	37	40	43	43
Profound hearing impairment: 65+ years	224 (1.07%)	237	250	289	314
Serious visual impairment: 18-64 years	102 (0.06%)	104	107	108	110
Moderate or severe visual impairment: 65+ years	1,816 (8.69%)	1,932	1,999	2,160	2,393
Registrable eye condition: 75+ years	608 (6.4%)	659	685	736	787

Source: PANSI and POPPI[16]

4.1.4 Learning disabilities

- 614 adults with learning disabilities are receiving social care services, 46 of whom are aged 65 or above. Of the total number, 410 use community-based services, nine are in nursing care and 195 in residential care. The highest group of users are men aged 18-64 (335), and the lowest is males aged 65+ (19).[13]

Table 4: Number of adults with a learning disability who are known to social services[17]

	Number	Percentage
Age 18-64	586	93.02%
Age 65+	44	6.98%
Male	361	57.3%
Female	269	42.7%

Source: Valuing People Now: Partnership Board annual self assessment report 2009-10

[15] % rise population changes 2

% rise in total population from 2010 to 2030	2010	2015	2020	2025	2030
18-64 years	0%	2%	4%	6%	7%
65+ years	0%	5%	9%	18%	33%
75+ years	0%	8.42%	12.63%	21.05%	29.47%

[16] PANSI: Projecting Adult Needs and Service Information System and POPPI: Projecting Older People Population Information System provide a user-friendly, practical and straightforward way to analyse population data, identify key characteristics within that population, project numbers into the future, and compare future populations against performance data. It has been developed by the Institute of Public Care (IPC) for the Care Services Efficiency Delivery Programme (CSED).

[17] Valuing People Now: Partnership Board annual self assessment report 2009-10

Map 9: Total number of learning disability service users receiving services at March 2010

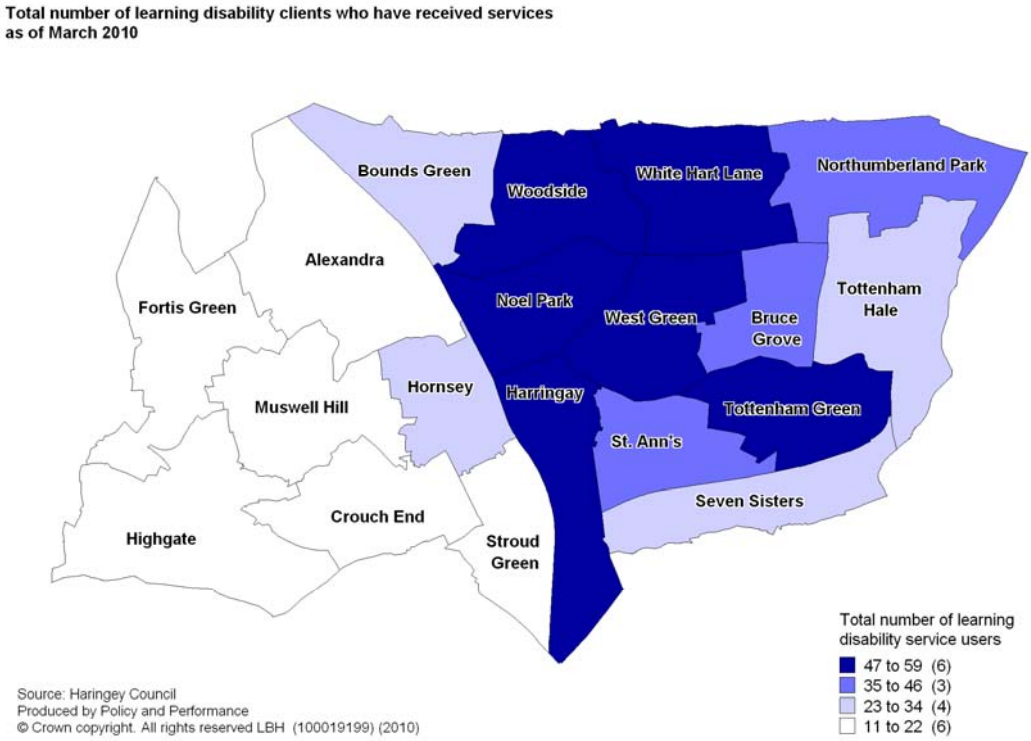


Table 5: Ethnic breakdown of adults with a learning disability (and percentages)[17]

	White	Black / Black British	Asian / Asian British	Mixed	Other
Number	385	151	44	15	35
Percentage	61.11%	23.97%	6.98 %	2.38%	5.56%

Source: Valuing People Now: Partnership Board annual self assessment report 2009-10

Table 6: Population predicted to have a learning disability (showing % of total population in that age range for 2010)

	2010	2015	2020	2025	2030
18-64 years	3,855 (2.45%)	3,937	4,020	4,091	4,150
65+ years	435 (2.08%)	456	472	512	581

Source: POPPI

Annual health checks for people with learning disabilities[18]

Annual health checks for people with learning disabilities were recommended initially by the Disability Rights Commission in 'Closing the Gap' in 2006 and in the formal investigation into the health inequalities of people with learning disabilities by Sir Jonathan Michael in 'Healthcare for All' (2008). Annual health checks and health action plans have been rated highly by people with learning disabilities and their families and carers as a way of identifying previously unmet health needs.

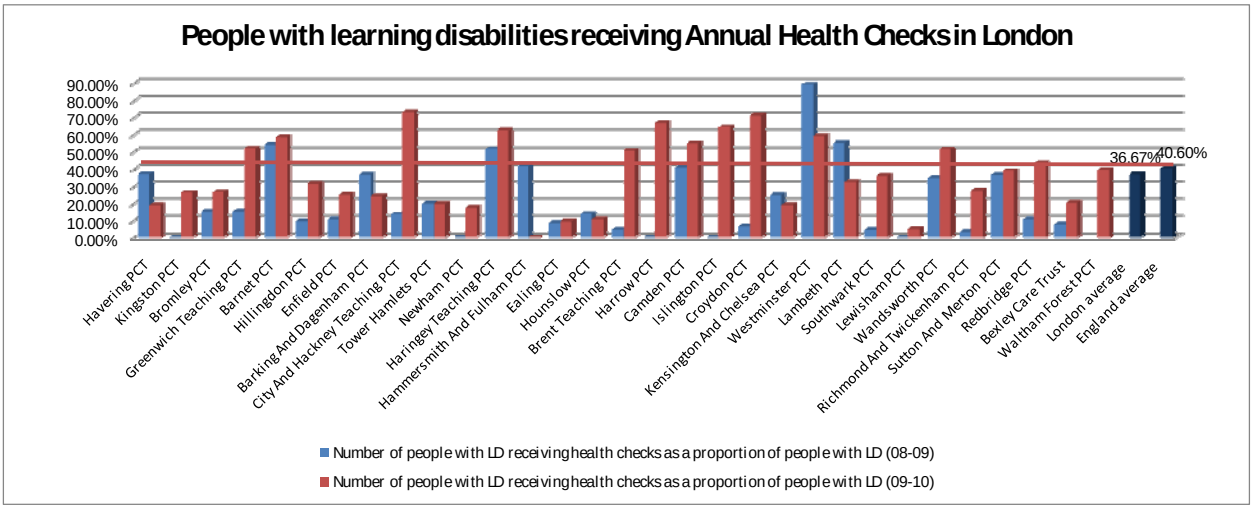
Developing local data on the physical health of people with learning disabilities remains a challenge for most PCTs, yet this knowledge base is an essential building block to

[18] Extracts from the Position Statement on the Implementation of the Direct Enhanced Service for Annual Health Checks for People with Learning Disabilities in London

providing 'reasonably adjusted' services. Annual health checks, especially if these are completed electronically, are the first step in establishing a local evidence base. Although the take-up rate across London has increased from **21.5 %** of eligible people with learning disabilities receiving an annual health check in 2008/09 to **36.7%** in 2009/10, it is lower than the national average of **41%.** Nationally, there is a **22%** difference between the highest and lowest performing sector and a **68%** difference between the PCTs with the highest and lowest uptake rate.

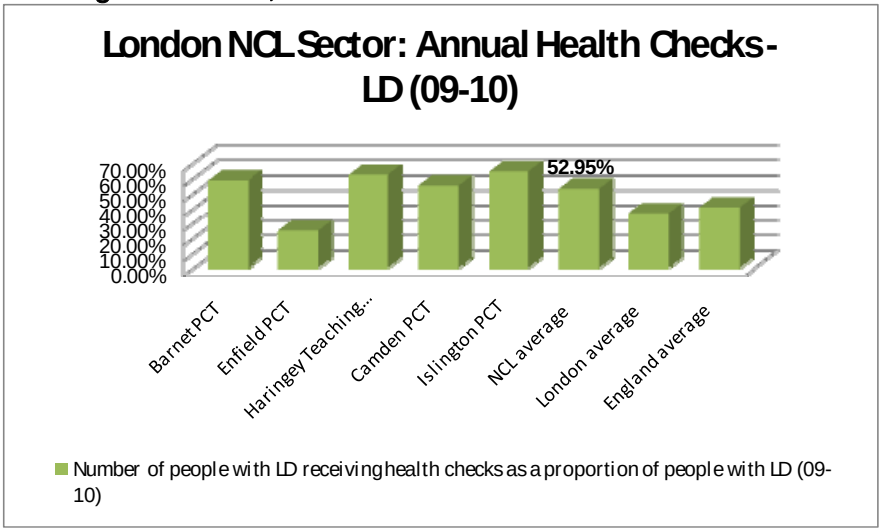
In 2008/09, Haringey was above both the London and England average, with **62.24%** of the total number of people with learning disabilities receiving health checks. The following table illustrates the uptake of annual health checks by people with learning disabilities across London in 2008/09 and 2009/10.

Figure 23: People with learning disabilities receiving Annual Health Checks for people with learning disabilities in London, 2008/09 and 2009/10



There are also differences in the uptake of annual health checks across the six London Sectors. The North Central London Sector has an average uptake of 52.95%, with only Islington (at 64.32%) slightly higher than Haringey.

Figure 24: North Central London NHS Sector: Annual Health Checks for people with learning disabilities, 2009-10



Back to top

All GP practices in Haringey have committed to providing annual health checks[17] in response to the evidence about unmet health needs in people who have learning disabilities including a Scrutiny Review in 2007. This requires practices to undertake training around learning disability and health, to provide annual health checks and to maintain a register of people who have moderate to severe learning disabilities. To date, approximately half the practices in Haringey have signed up and received training. Health action plans are now in place for 40% of people known to the learning disability service. These are in place for 90% of all people who have profound and multiple disabilities. Whilst we have a target of 100%, some people and their families do not want a formalised health action plan and prefer to make their own plans. Health outcomes for people who have both formal and informal health action plans will be audited.

Personalisation for people with learning disabilities[17]

- 40 (10.7%) of learning disabilities service users are in receipt of direct payments and personal budgets.
- We are using the outcomes of our personalisation programme to inform future commissioning of services. The current provider profile shows that 7% of our provider market is in-house; 34% from the voluntary sector; and 59% from the public sector.
- 62 assessments were provided in the last year to carers of people with learning disabilities and 97 family carers benefited from regular short breaks.
- 16.57% of carers of people with learning disabilities receiving a needs assessment or specific carers' service, or information and advice.
- 220 parents with learning disabilities are currently receiving services.
- 40 person centred plans include employment and accommodation. We help 355 people with learning disabilities to live independently.

Housing and people with learning disabilities

Table 7: Where people with learning disabilities live (age 18-64) [17]
NI 145 Adults with learning disabilities in settled accommodation

Type of accommodation	Number	Percentage
Owner occupier / shared ownership scheme	3	0.63%
Tenant – local authority / arms length management organisation / registered social landlord / housing association	30	6.33%
Tenant – private landlord	8	1.68%
Settled mainstream housing with family/friends (including flat sharing)	115	24.26%
Supported accommodation / supported lodgings / supported	256	54%
Adult Placement Scheme	14	2.95%
Sheltered housing / extra care sheltered housing / other sheltered housing	3	0.63%
Total	**429**	**90.49%**

Source: Valuing People Now: Partnership Board annual self assessment report 2009/10

Table 8: Where people with learning disabilities live (age 18-64) [17]
Adults not in settled accommodation[17]

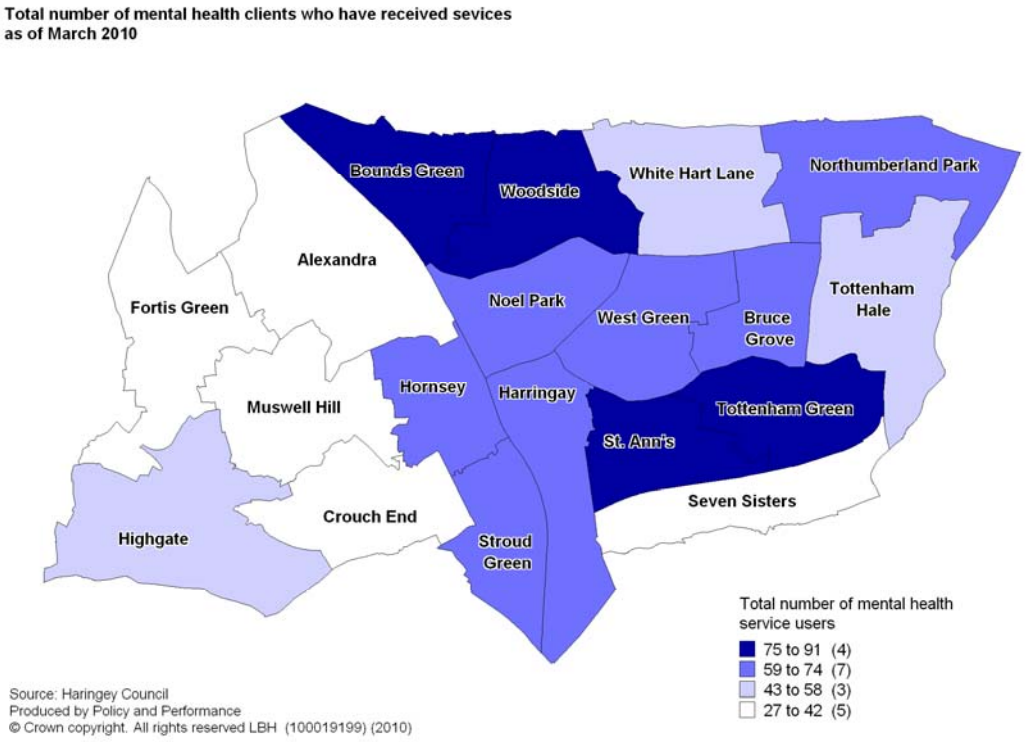
Type of accommodation	Number	Percentage
Placed in temporary accommodation by local authority (including homelessness resettlement) e.g. bed and breakfast	7	1.48%
Staying with family/friends as short-term guest	1	0.28%
Acute / long-stay health care residential facility or hospital (eg NHS or independent general hospitals/clinics, long-stay hospitals, specialist rehabilitation / recovery hospitals)	3	0.63%
Registered care home • [in local authority area] • [outside local authority area]	29 [9] [20]	6.1%
Other temporary accommodation	2	0.42%
Total	**42**	**8.85%**

Source: Valuing People Now: Partnership Board annual self assessment report 2009/10

4.1.5 Mental health

- 1,098 adults with mental health needs are receiving social care services, 374 of whom are aged 65 or above. Of the total number, 966 use community-based services, 18 are in nursing care and 114 in residential care. The highest group of users are men aged 18-64 (441), and the lowest is males aged 65+ (131).[13]

Map 10: Total number of mental health service users receiving services at March 2010



Map 11: Total number of mental health clients aged 65+ receiving services at March 2010

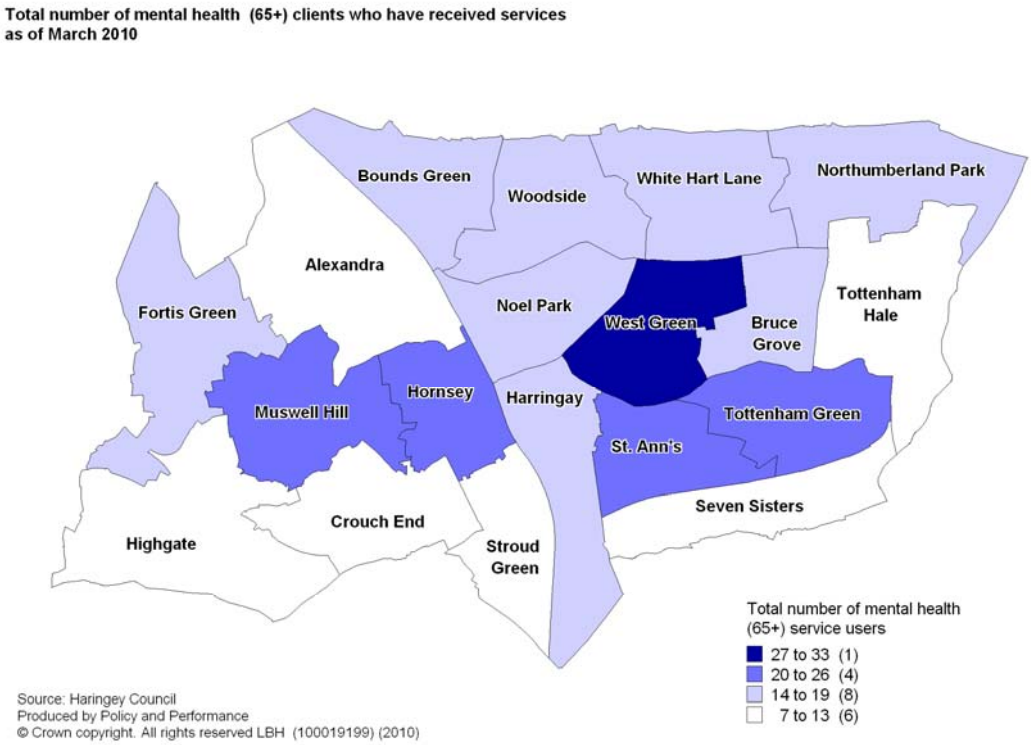


Table 9: Total population predicted to have mental ill health (showing % of total population in that age range for 2010)

	2010	2015	2020	2025	2030
Depression: 65+ years	1,822 (8.72%)	1,922	1,961	2,140	2,396
Severe depression: 65+ years	564 (2.7%)	602	620	680	757
Dementia: 65+ years	1,382 (6.61%)	1,494	1,565	1,747	1,904
Early onset dementia: 30-64 years	43	46	52	55	56
Common mental disorder: 18-64 years	25,133 (16%)	25,688	26,215	26,696	26,986
Borderline personality disorder: 18-64 years	701 (0.45%)	716	731	744	752
Anti-social personality disorder: 18-64 years	560 (0.36%)	571	583	595	601
Psychotic disorder: 18-64 years	624 (0.4%)	638	651	663	670

Source: POPPI

According to POPPI, in the 18-64 age group in 2010, it is estimated that:

- One third more women than men are predicted to have a common mental disorder
- Twice as many women as men are predicted to have a borderline personality disorder
- Six times more men than women are predicted to have an antisocial personality disorder
- One third more women than men are predicted to have a psychotic disorder

Detailed information can be found in Haringey's Mental Health Needs Assessment 2010.

Back to top

4.1.6 Substance misuse

- Alcohol plays a significant role in self-harm and suicide. It has been estimated that 15-25% of all suicides in England and Wales are associated with alcohol and that 65% of suicide attempts are related to alcohol [Department of Health. Health of the nation. HMSO. London. 1993]. Alcohol misuse may increase the risk of suicide and a study in Northern Ireland found that the risk of suicide was eight times higher in people misusing alcohol compared with those not currently misusing alcohol. There were 94 suicides in Haringey in the period 2004/08. For more detailed information, please see Haringey's Alcohol Needs Assessment 2010.
- 146 adults with mental health problems are receiving social care services, 3 of whom are aged 65 or above. Of the total number, 137 use community-based services and 9 are in residential care. The highest group of users are men aged 18-64 (82), and the lowest is women aged 65+ (1).[13]

4.1.7 Older people

Detailed information can be found in Phase 1 of our Older People's Needs Assessment, completed in August 2009, as part of our Joint Strategic Needs Assessment programme of activity. Phase 2 is due to be published in the autumn of 2010.

4.1.8 Vulnerable people

A vulnerable adult is a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. This category refers to service users outside the primary client groups set out in paragraphs 4.1.3 to 4.1.7.

Care services are provided to 89 vulnerable adults, 69 of whom are aged 65 or above. Of the 89, 74 use community-based services, 6 are in nursing care and 9 in residential care. There are almost twice as many women (57) as men (32) in this category.[13]

4.1.9 Carers

We recognise the contribution made by carers[19] and, to enable carers to care, we are committed to working with carers supporting them and the cared for person. According to the 2001 Census, shown in Table 10, 15,967 people in Haringey identify themselves as unpaid carers[20]. This means that 7.37% of the total local population are carers, compared with the London average of 8.5%.

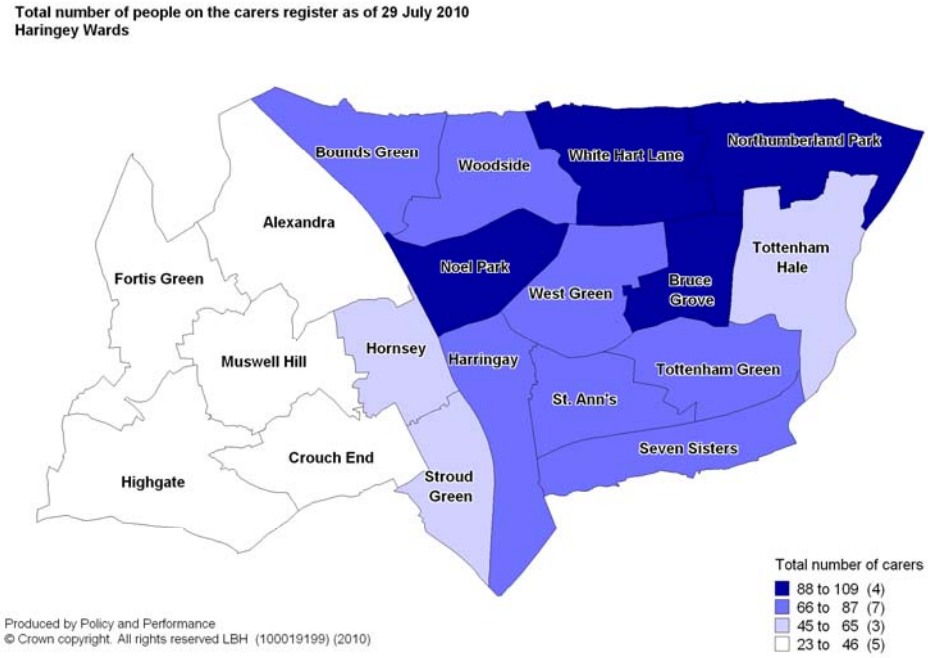
Table 10: Provision of unpaid care

Provision of unpaid care	Haringey	London	England
All people	216,507	7,172,091	49,138,831
Provides no care	200,540	6,562,201	44,261,771
Provides 1-19 hours' care a week	10,637	417,934	3,347,531
Provides 20-49 hours' care a week	2,098	72,761	530,797
Provides 50 or more hours' care a week	3,232	119,195	998,732
Total number of people identifying themselves as unpaid carers	**15,967**	**609,890**	**4,877,060**

Source: Census 2001

[19] In Haringey we define carers as 'People who look after a relative or friend who, because of disability, ill health or the effects of age, needs help or support. Carers can be partners, parents, older people, young people, family members or neighbours. They may or may not live in the same household as the person they are caring for. They are unpaid.'
[20] These figures are likely to be underestimates, as many people who provide help and support to a relative, friend or neighbour do not identify themselves as carers.

Map 12: Number of people on the Carers Register at July 2010



As at July 2010, there were 1,175 people on Haringey Carers' Register, with a greater prevalence in the east of the borough as shown in the above map. This bias is most likely to correspond with the higher level of service users in the east.

Older people as carers

According to POPPI, 2,136 (10%) of people aged 65 and above provide unpaid care to a partner, family member or other person.

At the same time, around 8,469 (40.52%) of people aged 65 plus are unable to manage at least one domestic task without help, over twice as many women as men. These tasks household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs and do practical activities.

Around 6,900 (33%) of people aged 65 and over are unable to manage at least one self-care activity on their own, almost twice as many women as men.

However, it should be noted that, in this age group overall, there are around 25% more women than men (12,000 women/9,000 men).

4.1.10 Self funders

People arrange their own social care services for different reasons; some may pay the full costs and others may be 'council supported' but still pay a charge. Those people paying the full costs of their care are known as '[self-funders]'. This means that they have:

- chosen not to approach adult social care for help, or
- been assessed but are not currently eligible for social care services, or
- approached adult social care and, although their needs show that they are eligible for services, their savings are above £23,250.

[Back to top]

We are currently unable to measure the number of people who self-fund in Haringey. This group of people may represent unmeasured need for social care services in the borough.

We are in the process of establishing an ‘e-market’ in social care; by the summer of 2010 we will have an online directory of support and services available to residents whether or not they are eligible for support from the Council. This will add to the ‘signposting’ function played by Adult Services’ Integrated Access Team where all first contacts are made. These two initiatives will together help improve the advice, information and support available to self-funders.

Priority 5: Give babies, children and young people the best possible start in life

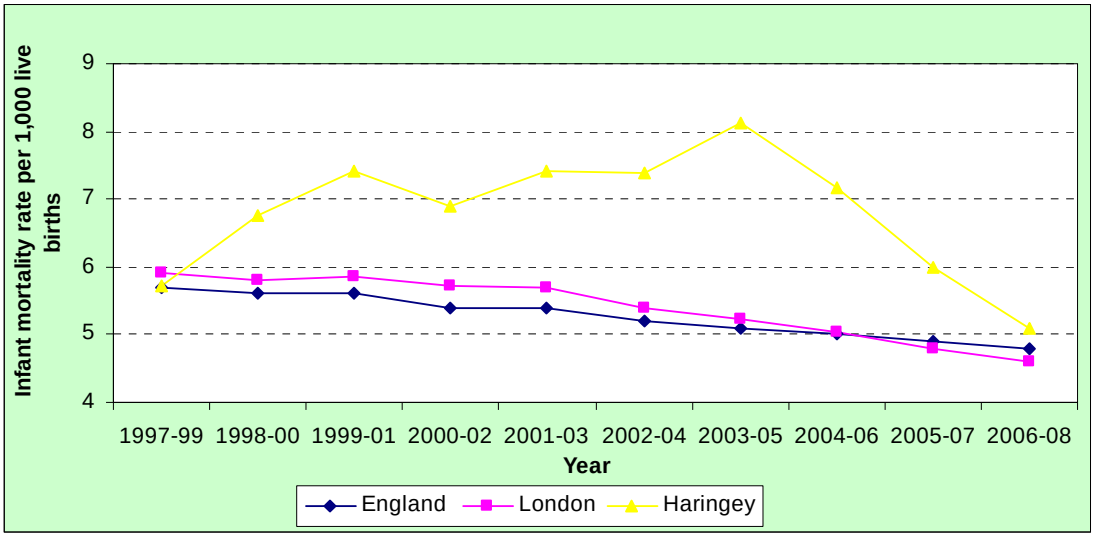
Local Area Agreement 2008-11 (Year 2 refresh March 2010)		
NI	**Indicator**	**Monitored by HSP Thematic Board**
51*	Effectiveness of Children and Adolescent Mental Health Services (CAMHS)	Children and Young People
53 Local	Prevalence of breastfeeding at 6-8 weeks from birth	Children and Young People
56*	Obesity among primary school age children in year six	Children and Young People
Local	Increase the % of children immunised by the second birthday	Children and Young People
Local	Number of schools achieving healthy schools status (2007-10 stretch)	Children and Young People
99	Children in care reaching level 4 in English at Key Stage 2 PSA 11	Children and Young People
100	Children in care reaching level 4 in Maths at Key Stage 2 PSA 11	Children and Young People
R 101	Children in care achieving 5 A*-C GSCEs (or equivalent) at Key Stage 4 (including English and Maths) PSA 11	Children and Young People
112*	Under 18 conception rate	Children and Young People
113*	Prevalence of Chlamydia in under 25 year olds	Children and Young People
126*	All pregnant women assessed	Children and Young People
Local 198	Children travelling to school – mode of transport usually used (5-16 years)	Children and Young People
* Designated indicator/target		

Detailed information on children and young people can be found in the Children and Young People's Needs Assessment (2009). Haringey's Child Poverty Needs Assessment is due for publication in April 2011 and will be available online.

5.1 Infant mortality

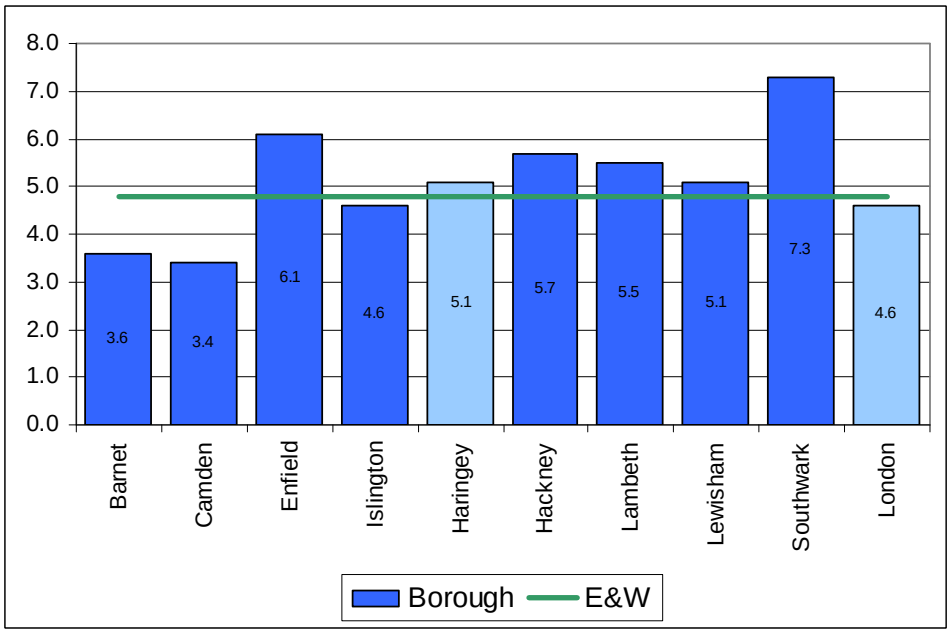
Infant mortality rate is the deaths of infants in the first year of life per 1,000 live births. Infant mortality rates (IMRs) are high in Haringey (5.1 per 1,000 live births in 2006/08), but this rate has decreased since 2003/05 (8.1 per 1,000 live births). Forty-nine per cent of infant deaths occurring between 2006 and 2008 were neonatal (deaths within 28 days of birth) and 36 (73%) of these deaths occurred in the early neonatal period (death within the first seven days of life).

Figure 25: Infant mortality rates for Haringey, London and England, 1997-99 to 2006/08



With the exception of Southwark, Haringey has similar infant mortality rates to our statistical neighbours and higher rates than our geographical neighbours (with the exception of Enfield). The decrease in the infant mortality rate since 2003/05 has brought us closer to the England and Wales and London rates.

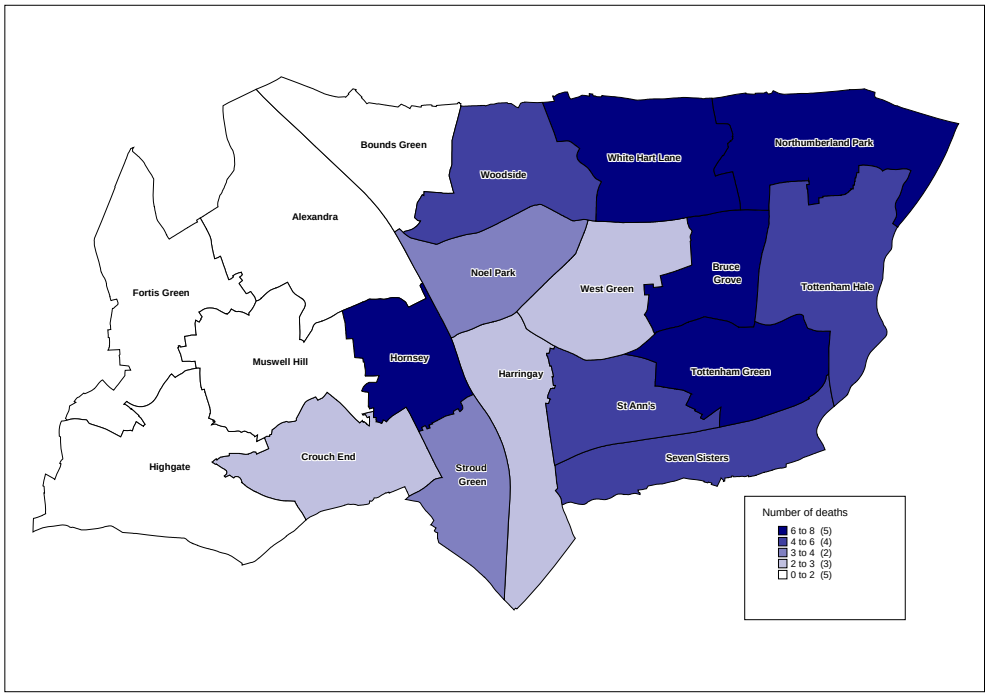
Figure 26: Infant mortality rates in North Central London and Haringey's statistical neighbours, 2006/08



The infant mortality rate tends to be higher in wards in the east of the borough but, given the numbers are small, care should be taken when interpreting the pattern across the borough.

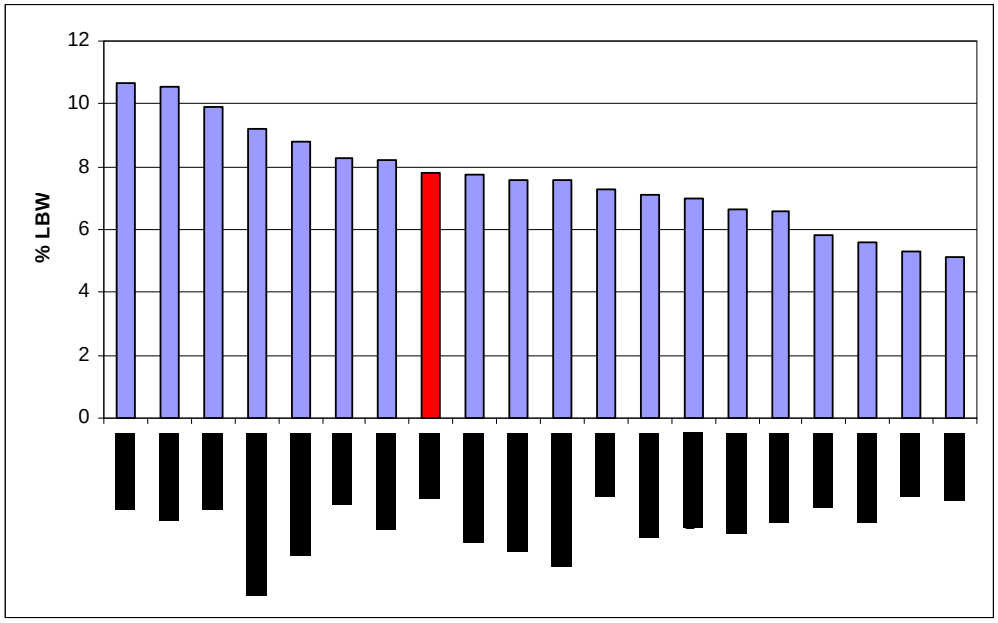
Back to top

Figure 27: Number of infant deaths under 1 year by Haringey ward, 2006/08



Given babies with low birth weight are at a higher risk of death in the first year of life, we can also look at the pattern of this indicator across the borough. As to be expected, there are higher numbers of low-weight births in the east of the borough. Overall, Haringey has an above average number of low weight births. In 2008, 7.9% of children had a low birth weight (below 2500 grams), compared to 7.5% of children born in England and Wales overall.

Figure 28: Low birth weight by Haringey ward, 2006/08



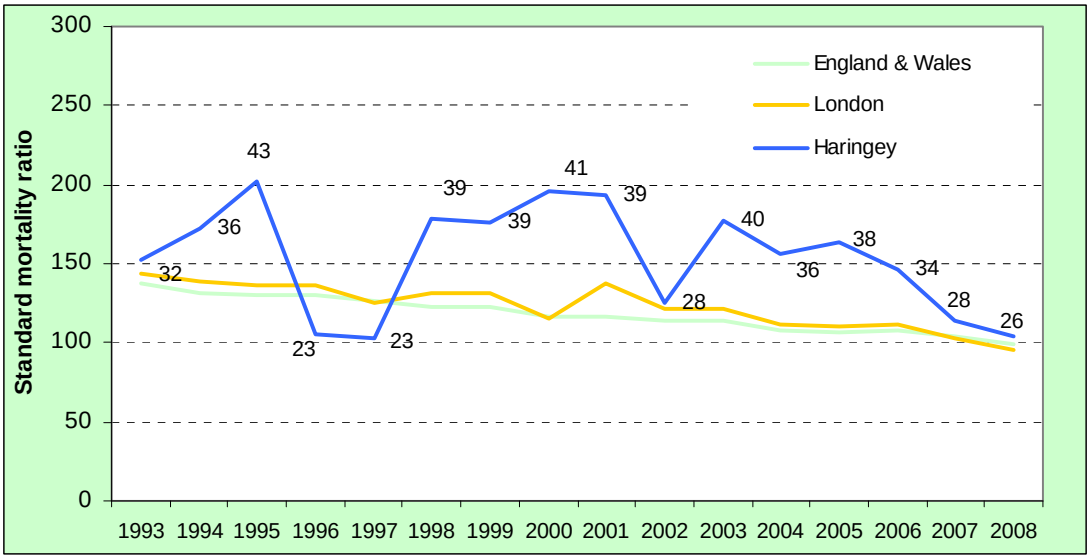
10.8% of births are sole registered births, which is the 8th highest rate in London. 50.4% of births were in super output areas with deprivation scores higher than 40, the 4th highest rate in London. 11.4% of births were to mothers born in West and East Africa and the Caribbean, the 8th highest rate in London.

Back to top

5.1.1 Other deaths

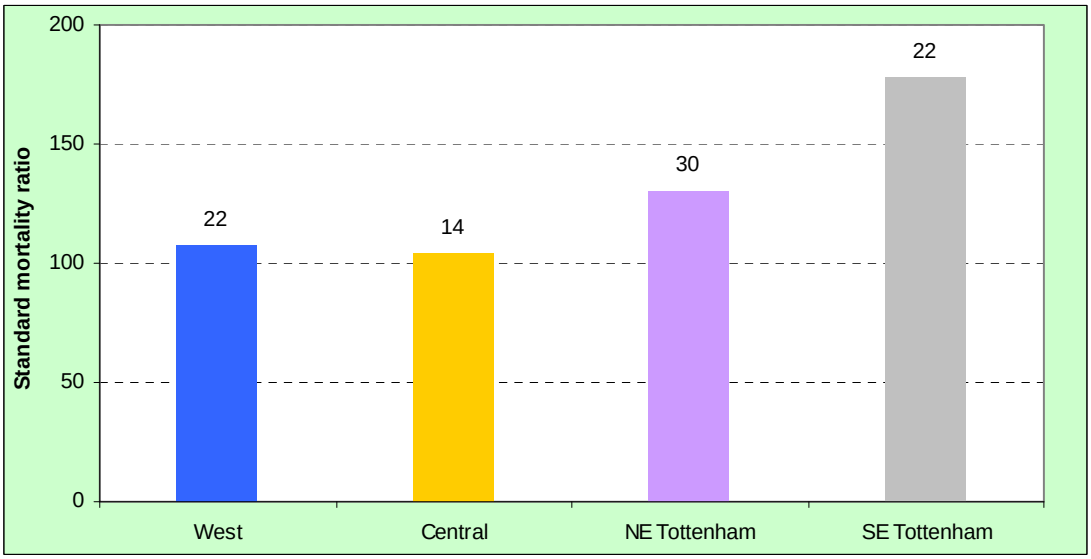
In 2008 there were 26 deaths in the 0-15 year old age group; 84% of these were in the first year of life. Of the remaining five deaths, one death each was related to the following: endocrine system, respiratory system, external causes (e.g. accidents), nervous system and infectious/parasitic disease. The standard mortality ratio in the chart below suggests that the rate for those aged under 15 has dropped putting in more in line with London and England and Wales, a trend driven by the reduction in infant mortality (see section 5.1 Infant mortality).

Figure 29: Standard mortality ratio from all causes in persons aged under 15 years for Haringey, London and England & Wales, 1993-2008



Compared to England and Wales, there is a higher overall death rate among young people (0-15 years) in the east of the borough as is seen in the chart below. This reflects the higher levels of deprivation, leading to increased risks of death in infancy and throughout childhood.

Figure 30: Standard mortality ratio from all causes in persons aged under 15 years in Haringey neighbourhoods, 2006/08



Back to top

5.2 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 pre-menopausal breast cancer. Infant mortality rates can be improved by increasing the number of women who breastfeed.

In the last 12 months, breastfeeding at 6-8 weeks has started to be measured. From January to September 2009, 2,927 women were due for a 6-8 week check. Of these 89.1% (2,609) had their breastfeeding status recorded. Of those recorded, 75% partially or totally breastfed. Of all women due for a check, 66% were partially or totally breastfeeding, 23% were not breastfeeding and 11% did not have breastfeeding status recorded.

5.3 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.

The proportion of children in Reception year who are classified as obese is worse than the England average, as is the percentage of children spending three hours or more each week on physical activity in school[21].

In 2009, 16% of Haringey school children weighed were considered to be obese, and a further 15% were overweight. This varied by age with 20.7% of year 6 children obese compared to 11.8% in reception year. The rate of childhood obesity is similar to London (Reception: 1.2% and Year 6: 21.3%) and higher than England (Reception: 9.6% and Year 6: 18.3%). There is also a variation between males and females with a higher proportion of boys considered overweight or obese.

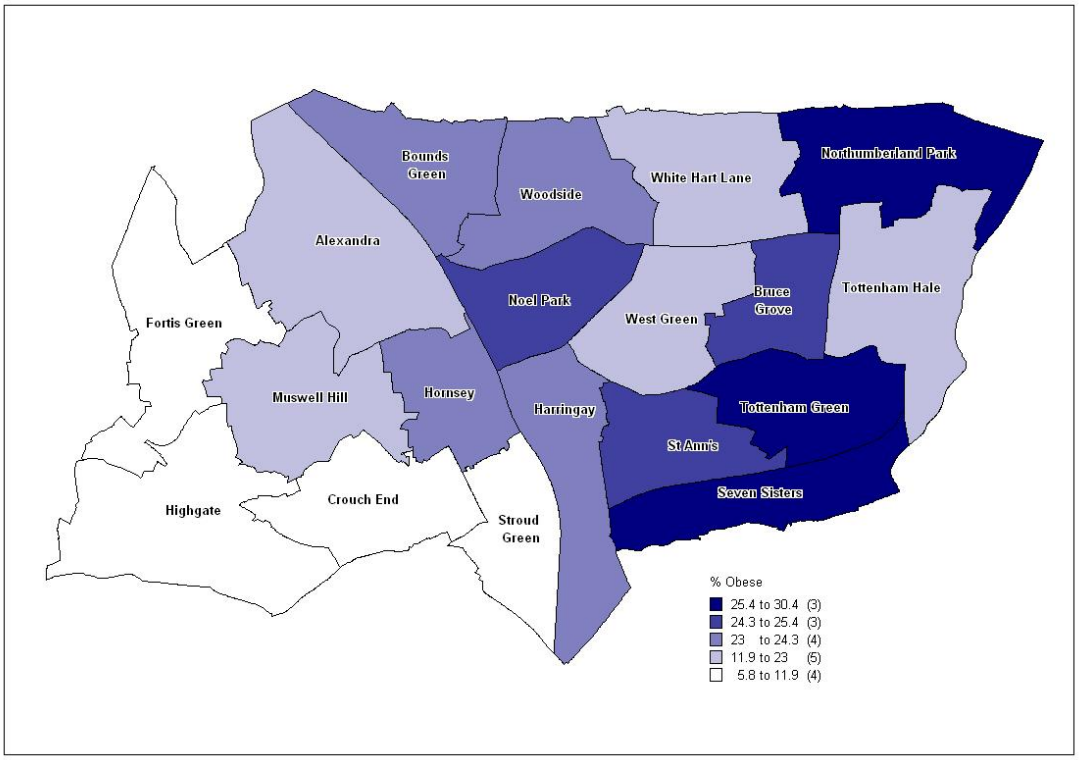
Table 11: Overweight and obesity levels in Reception and Year 6, 2006/2009

		Reception		Year 6	
		Proportion	Coverage %	Proportion	Coverage %
2006	Overweight %	12.9		15.1	
	Obese %	10.5		21.5	
2007	Overweight %	12.5		14.5	
	Obese %	12.9		23.8	
2008	Overweight %	12	90.0	15.3	89.9
	Obese %	10		23.2	
2009	Overweight %	12.2		15.8	
	Obese %	11.8	92.8	20.7	92.5

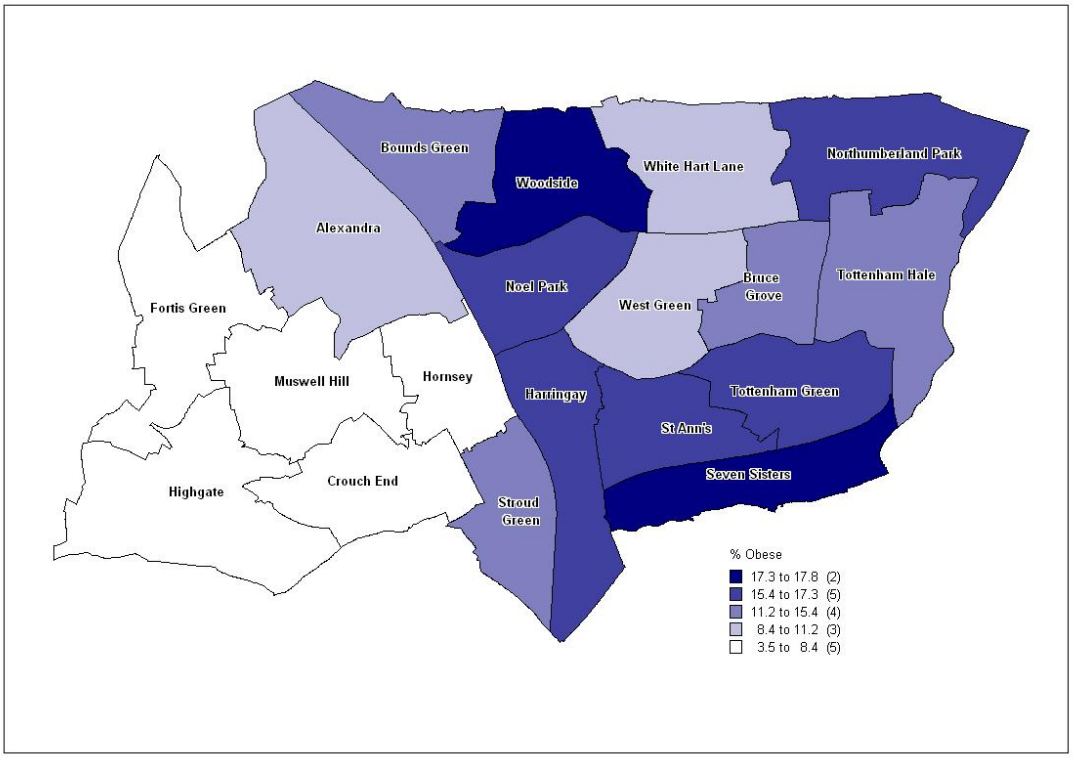
[21] Haringey Health Profile 2010

The following two maps describe the variation at both age groups within Haringey, demonstrating that obesity in children is not evenly distributed across the borough.

Map 13: Childhood obesity - Year 6



Map 14: Childhood obesity - Reception



Back to top

5.4 Teenage pregnancy

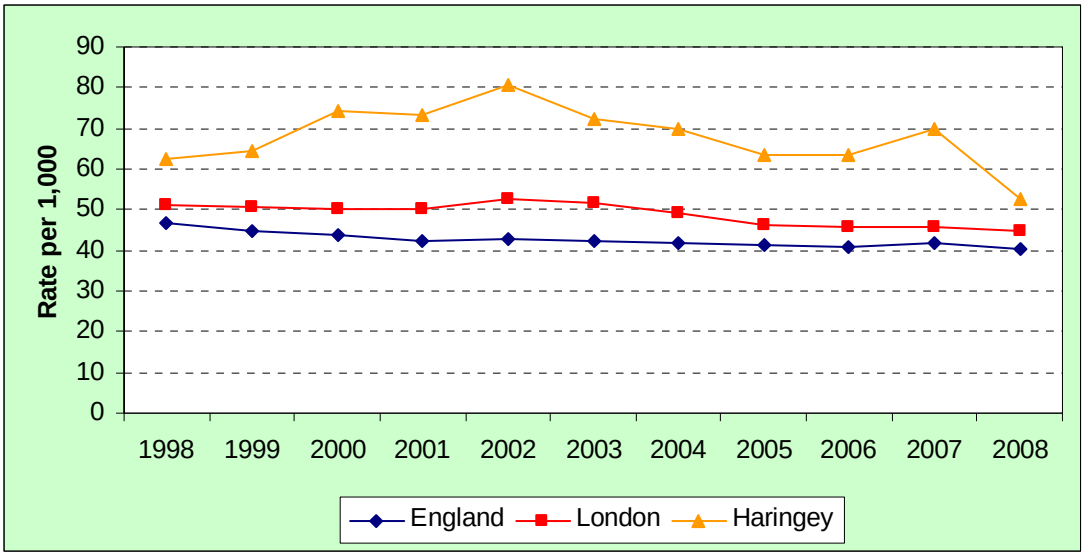
Conceptions in 2009

2009 data in the year to date shows there were 96 teenage conceptions, resulting in 29 births and 67 abortions. This suggests a continuing downward trend in the number of under 18 conceptions. Conceptions for 2009 in this age group are dominated by those from Other White (31%) and Black groups (31%).

Conceptions up to 2008

Haringey's teenage conception rate hit a peak of 80.4 per 1,000 women aged 15-17 in 2002 (323 conceptions). By 2008, it had decreased to 52.4 per 1,000 women aged 15-17 (184 conceptions), a 16% reduction since 1998. Our target by 2010 is a reduction by 50% from 1998 levels, which would be a rate of 31.15 per 1,000.

Figure 31: Rates of teenage conception per 1,000 women aged 15-17, 1998/2008



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

Table 12: London wide teenage conception rates showing percentage leading to abortion, 1998/2008

Borough	Rate[13]			% leading to abortion	
	1998	2008*	% decrease	1998	2008*
Camden	49.3	38.8	-21.3%	59	74
Hackney	77.1	61.5	-20.2%	54	60
Hammersmith and Fulham	69.0	42.2	-38.8%	59	67
Haringey	62.3	52.4	-15.9%	46	55
Islington	58.3	54.8	-6.0%	63	62
Kensington and Chelsea	41.7	24.4	-41.5%	74	67
Lambeth	85.3	71.5	-16.2%	53	58
Lewisham	80.0	68.7	-14.1%	53	57
Newham	59.9	48.3	-19.4%	42	50
Southwark	87.2	68.0	-22.0%	63	65
Tower Hamlets	57.8	33.5	-42.1%	44	53
Wandsworth	71.1	50.3	-29.3%	60	60
Westminster City	40.8	37.3	-8.5%	64	72

Source: Department for Schools, Children and Families, Teenage Pregnancy Unit and Office of National Statistics
* 2008 figures are provisional

Back to top

Table 12 above shows that conception rates are lower than for other London boroughs sharing similar demographic and deprivation profiles[22] (range: 61.5 to 71.5). Table 13 below shows that high teenage conception rates correlate closely with the wards with the highest levels of deprivation in the north and south children's networks.

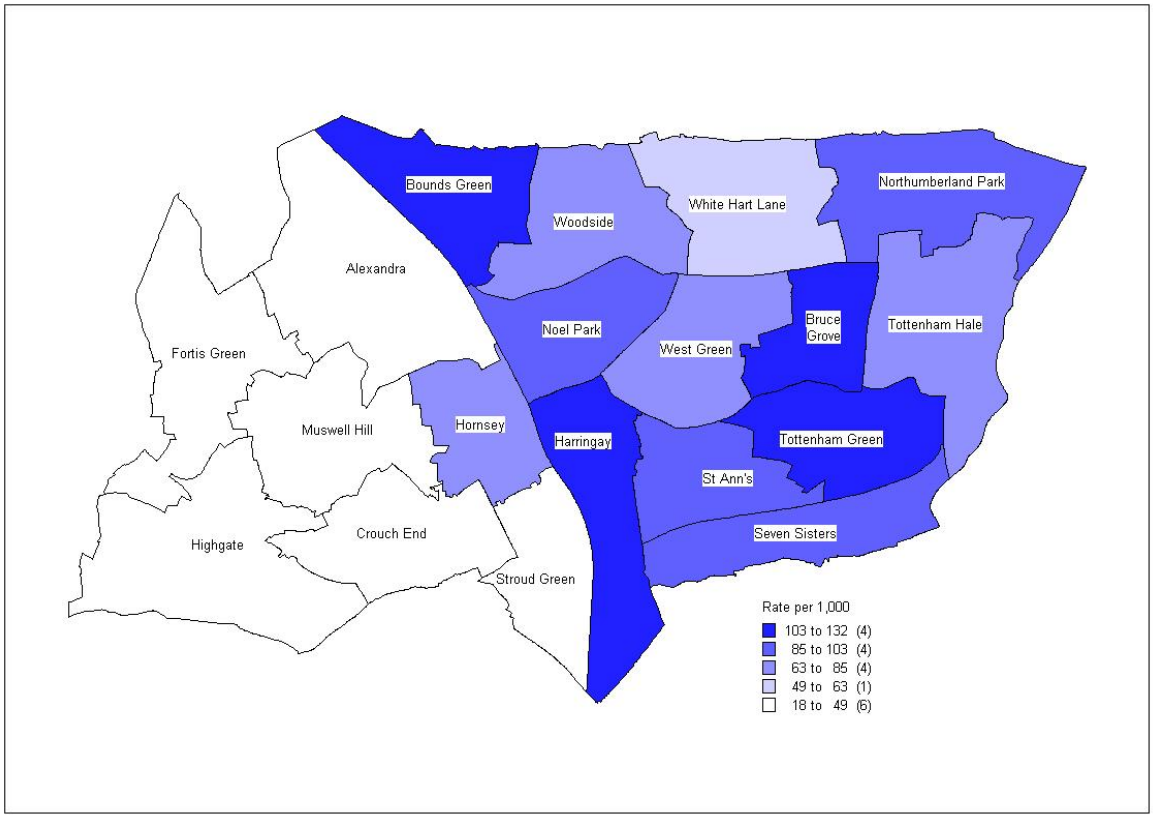
Table 13: Conceptions by ward, 2005/07

Ward	Number of conceptions		Rate per 1,000 females aged 15-17	
	2005/07[1]	2008[2]	2005/07[1]	2008[2]
Alexandra	10	0	19.0	0.0
Crouch End	15	5	48.8	49.5
Fortis Green	25	5	44.1	29.7
Highgate	10	1	45.8	13.4
Hornsey	34	4	66.8	22.5
Muswell Hill	10	2	18.5	12.0
Stroud Green	16	3	45.6	25.5
West Children's Network	120	20	39.7	20.6
Bounds Green	55	9	107.1	53.6
Noel Park	56	14	102.2	77.7
Northumberland Park	75	15	85.1	50.8
White Hart Lane	58	15	61.6	48.6
Woodside	44	13	73.8	65.0
North Children's Network	288	66	82.8	57.3
Bruce Grove	84	9	131.6	44.4
Harringay	32	9	103.4	97.9
St Ann's	50	10	87.2	55.4
Seven Sisters	75	8	88.2	29.7
Tottenham Green	68	9	121.5	51.8
Tottenham Hale	59	14	80.1	59.1
West Green	45	18	63.1	73.9
South Children's Network	413	77	94.3	55.0

Source: Dept for Schools, Children and Families, Teenage Pregnancy Unit, ONS and British Pregnancy Advisory Service
[1]Rates calculated locally from conception figures provided by ONS.
[2]Local analysis using ONS births and BPAS abortions. The ward was unknown in 17 cases, which would reduce the rate.

[22] Lewisham, Lambeth, Hackney and Southwark.

Map 15: Teenage conceptions 2005/07, rate per 1,000



Local monitoring of teenage conceptions

Data on conceptions resulting in births and abortions is now monitored locally since there is a time lag in receiving data from ONS (the latest complete year so far received is for 2008). Also, monitoring locally allows a better understanding of any trends in ethnicity, etc, and of where the young women live.

The data for 2009 suggests that the teenage pregnancy rate in Haringey is continuing to fall, and that this has been maintained into 2010. The data clearly shows that there are more conceptions in the east of the borough and that young women who become pregnant in the east are more likely to proceed with the birth.

Births to teenage mothers are highest amongst the Other White, Black Caribbean, Black African and White British groups. Terminations are highest amongst the White British and Other White (Turkish, Greek and Eastern European) and Other Black (Black British) groups.

NB: local monitoring does not exactly match the national data set due to data capture issues. It should be used as an indicative measure as a rate. The benefit in using it should be as a local commissioning tool and to develop a greater understanding of the issue.

5.5 Children and young people with additional needs

In 2009/10 from Nursery to Year 11 (aged 4 to 16), there were 33,427 children and young people in Haringey schools. Of these, 1,312 children (4% of the school population) have a Statement of Educational Need.

Back to top

There is a strong record of inclusion in local primary and secondary schools, so that currently 54% (709 children) of Haringey children with statements attend mainstream schools and 30% (386 children) with statements attend special schools in Haringey.

At the end of February 2010, 98% of statutory assessments (excluding exceptions) were completed within 26 weeks, exceeding the target of 82% and 92% of statutory assessments (including exceptions) were completed in timescale, exceeding the target of 70%. Exceptions apply in circumstances when it is not reasonable for the agencies concerned to meet those timescales, for example when a medical appointment needs to be rearranged, or there is involvement with several different medical professionals[23].

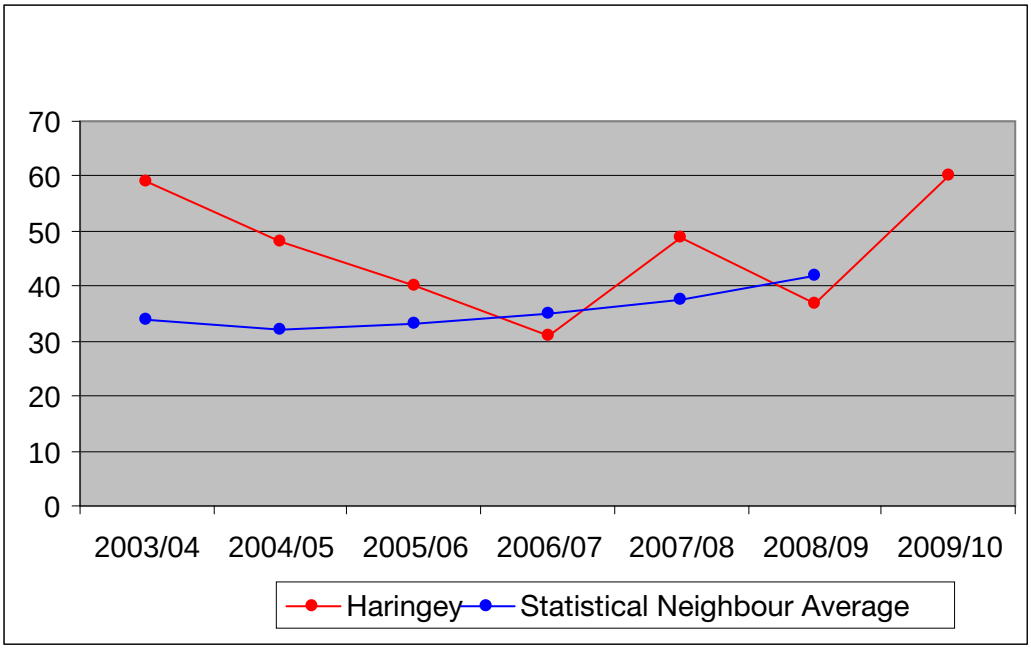
There are approximately 3,100 children and young people with disabilities in Haringey with approximately 700 having complex and long term disabilities. We are currently working with approximately 500 children and young people[23].

5.6 Children or young people who are at risk of significant harm / on the Child Protection Register (CPR)

In 2009/10 the numbers of children subject to a child protection plan per 10,000 children and young people in Haringey was 60. This is significantly higher than the previous year of 37 and the Statistical Neighbours' average of 42 (see Figure 32). The reasons given break down as follows:

- neglect 23%
- physical abuse 3%
- emotional abuse 17%
- sexual abuse 6%, and
- multiple reasons 50%.

Figure 32: Rate of children subject to a child protection plan / on child protection register (per 10,000)



At the end of March 2010, 280 children were subject to a Child Protection Plan, compared to 179 at the end of March 2009[23].

[23] From draft of Child Poverty Needs Assessment, due for publication 2011

Table 14: Children with a child protection plan by ethnicity

Ethnic group	% of children with a Child Protection Plan		
	2007/08	2008/09	2009/10
White	40	41	38
Mixed	16	19	15
Asian / Asian British	6	2	6
Black / Black British	33	35	36
Other Ethnic Groups	3	3	3
Unborn	2	n/a	1

Table 15: Children with a child protection plan by age

Age group	% of children with a Child Protection Plan		
	2007/08	2008/09	2009/10
Under 1	11.7	9	5
1-4	31	28	13
5-9	29.3	33	10
10-15	25.4	28	14
16 and over	0.9	2	2
Unborn children	1.7	0	1

Table 16: Social Care by Children's Networks[23]

Indicator	West	North	South	Total	Other	Grand
Referrals to Children and Families, April 2009-March 2010	476	1,126	1,577	3,179	119	3,298
Subject to a Child Protection Plan at 31 March 2010	54	124	110	288	1	289
Became subject to a Child Protection Plan April 2009-March 2010	49	118	142	309	7	316
Ceased to be subject to a Child Protection Plan April 2009-March 2010	27	67	92	186	15	201

Table 17: Key performance measures for protecting children[23]

	Indicator position 31/03/09	Position at 31/03/10: provisional	Statistical neighbours 31/03/09	Target 2010/11
Rate per 10,000 population of children with a Child Protection Plan	31	60.4	36.5	
% of children who became subject to a Child Protection Plan for a 2nd or subsequent time (NI65)	12.3	11.7	10	9.5
% of children ceasing to be the subject of a Child Protection Plan who had been subject of a plan for 2+ years (NI64)	7.7	16.9	5	10
% of reviews of child protection cases held in timescale (NI67)	99	95.5	100	100
% of children with a Child Protection Plan with an allocated social worker	100	96.3	100	100

Back to top

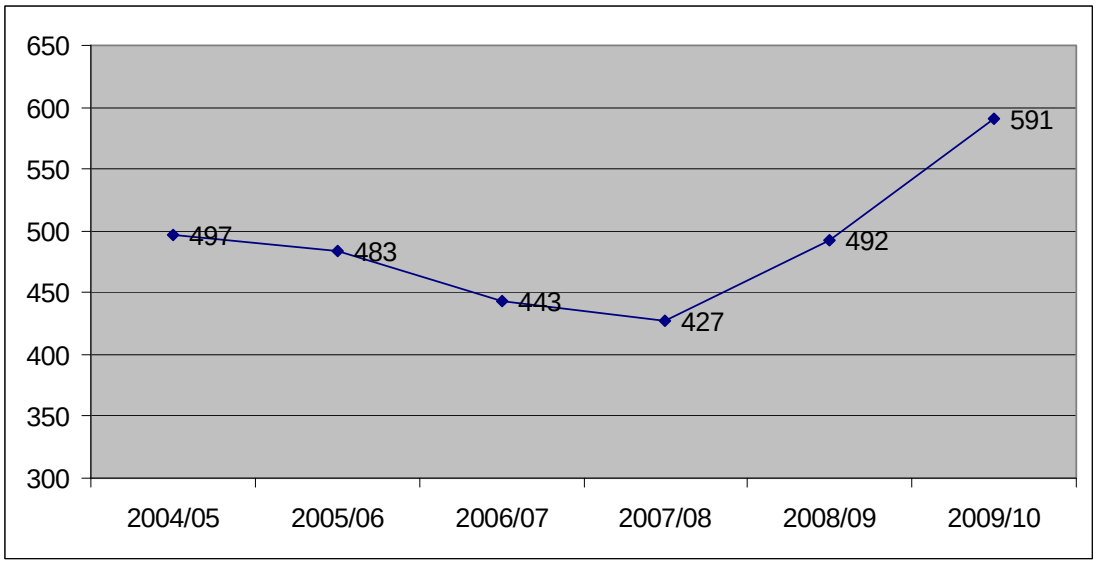
Table 18: Key performance measures for safeguarding[23]

Indicator	Position at 31/03/09	Position at 31/03/10: provisional	Statistical neighbours 31/03/09	Target 2010/11
Number of referrals of children per 10,000 population under 18	585	673	N/A	N/A
% of children whose referral occurred within 12 months of a previous referral	18.7	[awaiting verification of stat]	N/A	N/A
% of referrals that led to an initial assessment (NI68)	58	55	63.4	70
% of initial assessments completed within 7 working days of referral (NI59)	63	28	77.6	72
% of core assessments completed within 35 working days of their commencement (NI60)	63	47	82.1	81
% of children with a disability subject to a Child Protection Plan	4.5	2	N/A	N/A

5.6.1 Looked after children

Children in the care of local authorities are one of the most vulnerable groups in society. We have a special responsibility to act as a corporate parent for looked after children and it is important that these children and young people benefit from the opportunities and achievements enjoyed by other children. Approximately 90,000 children pass through the care system per year in England. As of 31 March 2010, there were 591 looked after children in Haringey compared with 492 at the end of March 2009 (see Figure 33). This equates to 121 children per 10,000 children population, an increase from 100 children per 10,000 children population in 2009. The rate of looked after children in 2009 was higher than the rate of our statistical neighbours which was 87.6 children per 10,000 children population.

Figure 33: Looked after children in Haringey, 2004/05-2009/10



Back to top

Table 19: Ethnicity of looked after children

Ethnic group	% of looked after children		
	2007/08	2008/09	2009/10
White	27	31	34
Mixed	16	17	14
Asian/Asian British	5	5	5
Black/ Black British	46	41	42
Other Ethnic Groups	6	5	5

Table 20: Age group of looked after children

Age group	% of looked after children		
	2007/08	2008/09	2009/10
0-5	18	20	25
6-10	18	16	17
11-16	50	50	42
17+	14	14	17

5.7 Schools and childcare provision

Haringey's Children Networks publish a Key Facts bulletin. This can be found on Harinet (for Haringey Council staff), or by email from: Tom.Fletcher@haringey.gov.uk

5.7.1 Location of schools

The information in this section is drawn from the 2008 Schools Census. Nursery numbers include pupils attending school nurseries and the three Children's Centres which have school status. It excludes pupil numbers from four Children's Centres, namely Triangle, Stonecroft, Woodside and Park Lane, as these do not complete the Schools Census. Children and young people living in Haringey and attending school in another local authority or privately are also excluded from this measure.

Table 21: Population by home address

Setting type	Children's Network North	Children's Network South	Children's Network West	Haringey residents	Out borough residents	Total
Nursery	749	1,187	509	2,445	290	2,735
Primary	5,103	7,179	4,592	16,874	2,388	19,262
Secondary	2,968	4,177	2,756	9,901	2,457	12,358
Special	97	99	46	242	58	300
Total	**8,917**	**12,642**	**7,903**	**29,462**	**5,193**	**34,655**

Source: School Census 2008

Table 22: Population by school attended

Setting type	Children's Network North	Children's Network South	Children's Network West	Total
Nursery	803	1,271	661	2,735
Primary	5,567	7,573	6,122	19,262
Secondary	3,081	2,739	6,538	12,358
Special	69	167	64	300
Total	**9,520**	**11,750**	**13,385**	**34,655**

Source: School Census 2008

The first table shows the total number of pupils attending Haringey schools and early years settings *broken down by home address*, whereas the second shows the figures *according to where they attend school*. There is a disparity between the two pictures in

that the south network has the largest number living within it and attending a Haringey school/setting, yet the west network has the largest number of children and young people attending school within it. This means that there are significant numbers of children and young people attending school in the West network who live either in one of the other networks or outside of the borough.

This is due largely to the fact that five large secondary schools (out of a total of eleven) are located in the west of the borough. More children and young people attend secondary school in West Network than in the other two networks combined.

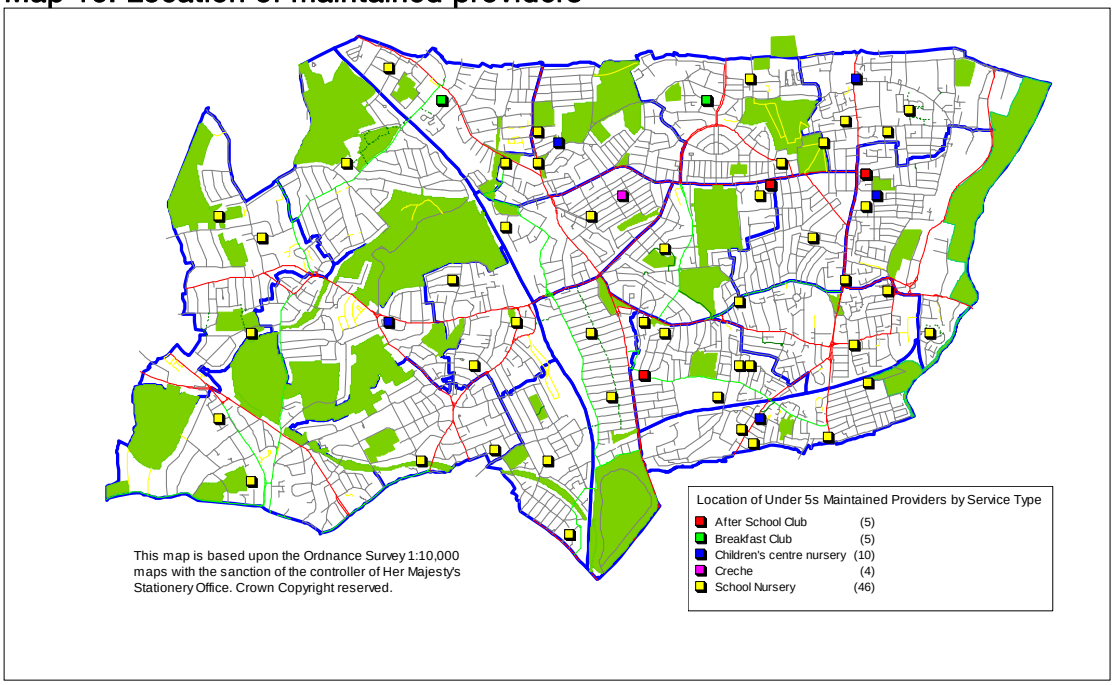
Further information about school and nursery provision, including maps, are on Haringey Council's website:

- Location of primary schools
- Location of secondary schools
- Location of special needs schools
- Information about nursery and pre-school childcare options

5.7.2 Childcare provision (under fives)

Across Haringey there are a total of 1,729 private voluntary and independent sector (PVI) places and 716 childminder places. In total there are 5,147 registered places, (including breakfast and after school clubs in children's centres) across all providers.

Map 16: Location of maintained providers



The supply of childcare varies from one part of the borough to another, both in terms of the number of places and in terms of types of care available. Tottenham Hale has the highest number of total childcare places across all sectors. Bruce Grove has the lowest number of total childcare places. Muswell Hill has the highest number of PVI group settings places with Seven Sisters having the lowest number. Alexandra has the highest number of childminder places and Fortis Green the lowest.

Back to top

Table 23: Supply of childcare places

Indicator	Highest: 2010	Lowest: 2010
Childminders	Alexandra (69)	Fortis Green (14)
Maintained Places	White Hart Lane (305)	Alexandra and Bruce Grove (26)
PVI Group Settings	Muswell Hill (204)	Seven Sisters (16)
Total PVI group settings + Childminders	Tottenham Hale (235)	Seven Sisters (50)
Total	TottenhamHale (539)	Bruce Grove (134)

A full childcare sufficiency assessment is currently being undertaken and the results will be published in April 2011. A childcare audit will be conducted in autumn 2010 providing more up to date information on the supply of childcare. Subsequently, the figures quoted above may change when the childcare sufficiency assessment report is published in the spring.

5.7.3 Children and mental health

- Based on inner London prevalence estimates there are currently 2,452 children aged 5-16 with mental health problems. (1,008 aged 5-10 and 1,444 aged 11-16) in Haringey.
- Boys are experiencing mental health problems more than girls (1,583 boys and 869 girls).
- Numbers of children in Haringey population age 0-9 are set to increase by 6% between 2008 and 2013, whereas the numbers of children aged 10-19 are set to decrease by 2%.
- By 2013, based on population estimates there will be 2,650 children aged 5-16 with mental health problems in Haringey, an increase of 8.1%.
- The number of children within care of the Local Authority in Haringey is greater than the London average. With looked after children five times more likely to develop mental health problems, there are potentially significant mental health needs in this group.
- An increased level of mental health needs among Haringey's refugee and asylum seeking children and young people (unaccompanied minors) has been identified.
- Overall, there is evidence to suggest that many forms of mental health problems in young people are becoming more frequent. Further work is needed to develop Haringey specific information sources that can be used as a basis for service planning.

A more detailed profile of mental health needs in children and young people can be found on pages 61 to 65 of the Mental Health Needs Assessment (January 2010).

Priority 6: Create more decent and energy efficient homes, focussing on the most vulnerable.

For further information, visit the Borough Profile section People at the heart of change: Meet housing demand.

Back to top