Haringey Council

NHS
North Central London

Health Profile
Haringey Clinical Commissioning Group (CCG) Central Collaborative

September 2012

(For more information please see Haringey's Joint Strategic Needs Assessment 2012).

Contents

Summary

Haringey Clinical Commissioning Group (CCG) wants to commission high quality clinical services to meet the local population needs and reduce the health inequalities that exist across the borough. In January 2012, funding has become available to support transformational change through the Primary Care Strategy – 'Transforming the primary care landscape in North Central London'. This strategy supports the development of high quality primary care to enable populations to live longer, children to have the best start in life, patients to receive the best care in the right place and the NHS to deliver value for money.

As part of the commissioning cycle, Haringey CCG needs to understand its population and its needs in order to commission appropriate services. This health profile for central collaborative enables a better understanding of the characteristics of the local population (age, gender, ethnicity) as well as providing disease specific information.

Haringey is an exceptionally diverse and fast-changing borough. High levels of deprivation, low educational attainment and unhealthy lifestyles (high smoking, low physical activity, high alcohol misuse), primarily in the east of the borough, are all interrelated determinants of poor health outcomes and the considerable health inequalities in the borough.

The central collaborative covers a vibrant, ethnically diverse area of a middle-aged population which is less deprived and healthier than the collaboratives further east in the borough. Roughly 20.7% of Haringey's population (46,728 residents) live in its four wards:- Bounds Green, Harringay, Noel Park and Woodside. The number of under-5s (7.7%) whilst lower than the borough (8.1%) and the London average, is still higher than the proportion in England as a whole. There is a lower proportion of people aged over 65.

The key issues in the central collaborative that need to be addressed are:

- Late antenatal booking, particularly in Harringay ward (the worst in Haringey)
- High rates of teenage pregnancy (higher than the London and England averages)
- 20% higher than expected premature death rate
- High numbers of drug users residing in Woodside and Noel Park, with high levels of health needs
- The highest proportion of patients with coronary heart disease, and chronic obstructive pulmonary disease, compared to the other collaboratives

Central collaborative performs better than the other collaboratives in some areas:

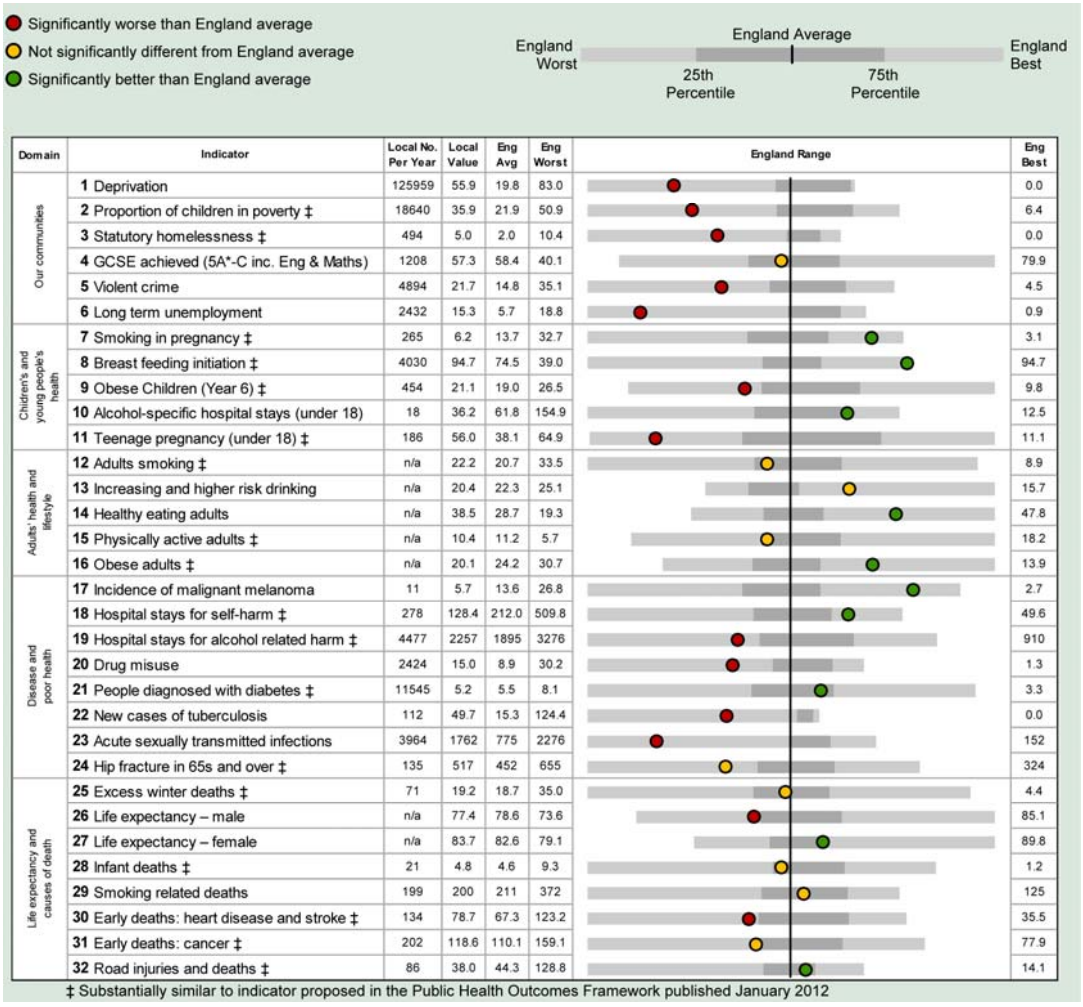
- Lowest rate of low birth rate babies in Haringey
- Highest uptake of childhood immunisation in Haringey
- Good uptake of bowel screening (higher than the Haringey average)

More detailed information on Haringey's health and well-being, services and commissioning gaps can be found in the Joint Strategic Needs Assessment (www.haringey.gov.uk/JSNA).

1. Haringey at a glance

- Haringey stretches from the prosperous neighbourhood of Highgate in the west to Tottenham in the east, one of the most deprived areas in the country.
- It has a relatively young population with almost a quarter of the population under the age of 20, and 90.5% of the population aged under 65.
- It is the 4th most deprived borough in London and the 13th most deprived in the country.
- Figure 1 shows how the health of people in Haringey compares to the rest of England. Haringey has significantly poor health behaviours and outcomes, including: childhood obesity, teenage pregnancy, alcohol related harm, drug misuse, tuberculosis, acute sexually transmitted infections, life expectancy for men and early deaths from heart disease and stroke.
- The borough has a particularly high level of severe mental illness concentrated in the east of the borough; it is ranked third in London.
- Haringey's residents experience challenging circumstances that impact negatively on their health including: deprivation, proportion of children in poverty, statutory homelessness, violent crime and long term unemployment.

Figure 1: Health summary for Haringey.
Source: Association of Public Health Observatories (APHO)



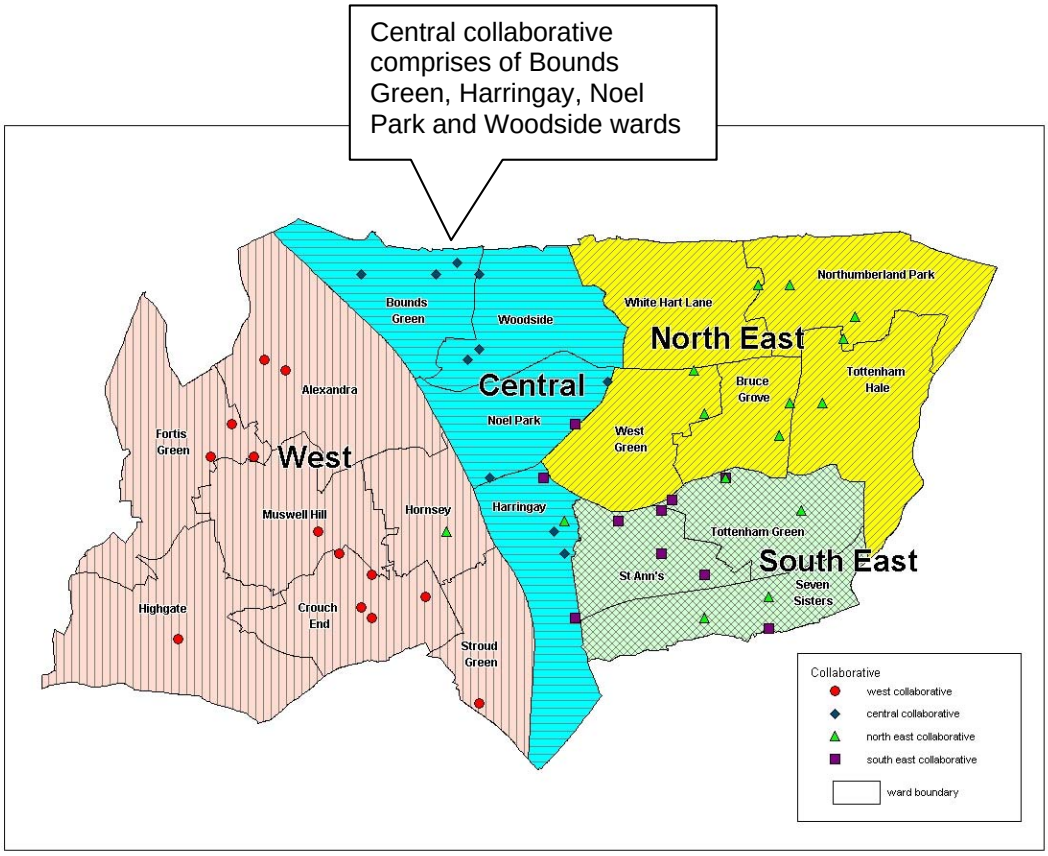
Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	125959	55.9	19.8	83.0		0.0
	2 Proportion of children in poverty ‡	18640	35.9	21.9	50.9		6.4
	3 Statutory homelessness ‡	494	5.0	2.0	10.4		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1208	57.3	58.4	40.1		79.9
	5 Violent crime	4894	21.7	14.8	35.1		4.5
	6 Long term unemployment	2432	15.3	5.7	18.8		0.9
Children's and young people's health	7 Smoking in pregnancy ‡	265	6.2	13.7	32.7		3.1
	8 Breast feeding initiation ‡	4030	94.7	74.5	39.0		94.7
	9 Obese Children (Year 6) ‡	454	21.1	19.0	26.5		9.8
	10 Alcohol-specific hospital stays (under 18)	18	36.2	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	186	56.0	38.1	64.9		11.1
Adults' health and lifestyle	12 Adults smoking ‡	n/a	22.2	20.7	33.5		8.9
	13 Increasing and higher risk drinking	n/a	20.4	22.3	25.1		15.7
	14 Healthy eating adults	n/a	38.5	28.7	19.3		47.8
	15 Physically active adults ‡	n/a	10.4	11.2	5.7		18.2
	16 Obese adults ‡	n/a	20.1	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	11	5.7	13.6	26.8		2.7
	18 Hospital stays for self-harm ‡	278	128.4	212.0	509.8		49.6
	19 Hospital stays for alcohol related harm ‡	4477	2257	1895	3276		910
	20 Drug misuse	2424	15.0	8.9	30.2		1.3
	21 People diagnosed with diabetes ‡	11545	5.2	5.5	8.1		3.3
	22 New cases of tuberculosis	112	49.7	15.3	124.4		0.0
	23 Acute sexually transmitted infections	3964	1762	775	2276		152
	24 Hip fracture in 65s and over ‡	135	517	452	655		324
Life expectancy and causes of death	25 Excess winter deaths ‡	71	19.2	18.7	35.0		4.4
	26 Life expectancy – male	n/a	77.4	78.6	73.6		85.1
	27 Life expectancy – female	n/a	83.7	82.6	79.1		89.8
	28 Infant deaths ‡	21	4.8	4.6	9.3		1.2
	29 Smoking related deaths	199	200	211	372		125
	30 Early deaths: heart disease and stroke ‡	134	78.7	67.3	123.2		35.5
	31 Early deaths: cancer ‡	202	118.6	110.1	159.1		77.9
	32 Road injuries and deaths ‡	86	38.0	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

2. The central collaborative area: demography and deprivation

- There are 12 GP surgeries with a registered population of 60,014.
- There are 46,728 residents in the area covered by central collaborative practices, 20.7% of the borough's population.
- The resident population is relatively middle-aged with a low proportion of children under-20 years compared to Haringey as a whole and there is a lower proportion of people aged over 65.
- The number of under-5s (7.7%) whilst lower than the borough (8.1%) and London average, is still higher than the proportion in England as a whole.
- 53.7% of the population within the central collaborative is from the Black and minority ethnic (BME) community, which is high compared to the population for England and Wales.
- The population is predicted to increase by 5.3% in 10 years from 2012 to 2022 compared to 7% for the whole of Haringey. The most growth (10.8%) is predicted in the 45-64 group.

Figure 2: Map of Haringey by ward showing collaborative areas with GP practices.
Source: Directorate of Public Health.



There are 12 GP surgeries in central collaborative (Fig. 2) 6 of whom are single-handed and 5 have PMS contracts.

Figure 3: List of GP Practices in the central collaborative.
Source: North Central London NHS Haringey Borough Office

Practice	Contract	Practice Type (no. Principals)	Location (ward)
Morum House Medical Centre	GMS	8	Woodside
Westbury Medical Centre	PMS	2	Noel Park
Arcadian Gardens Surgery	GMS	2	Woodside
Hornsey Park Surgery	GMS	1	Noel Park
High Road Surgery	PMS	2	Woodside
Stuart Crescent Health Centre	GMS	2	Woodside
Bounds Green Group Practice	PMS	4	Bounds Green
The Evergreen Surgery	PMS	1	Bounds Green
The Surgery (Prasad)	PMS	1	Bounds Green
Park Lane Medical Centre	GMS	1	Harringay
The Old Surgery	GMS	1	Harringay
Park Lane Medical Centre	GMS	1	Harringay

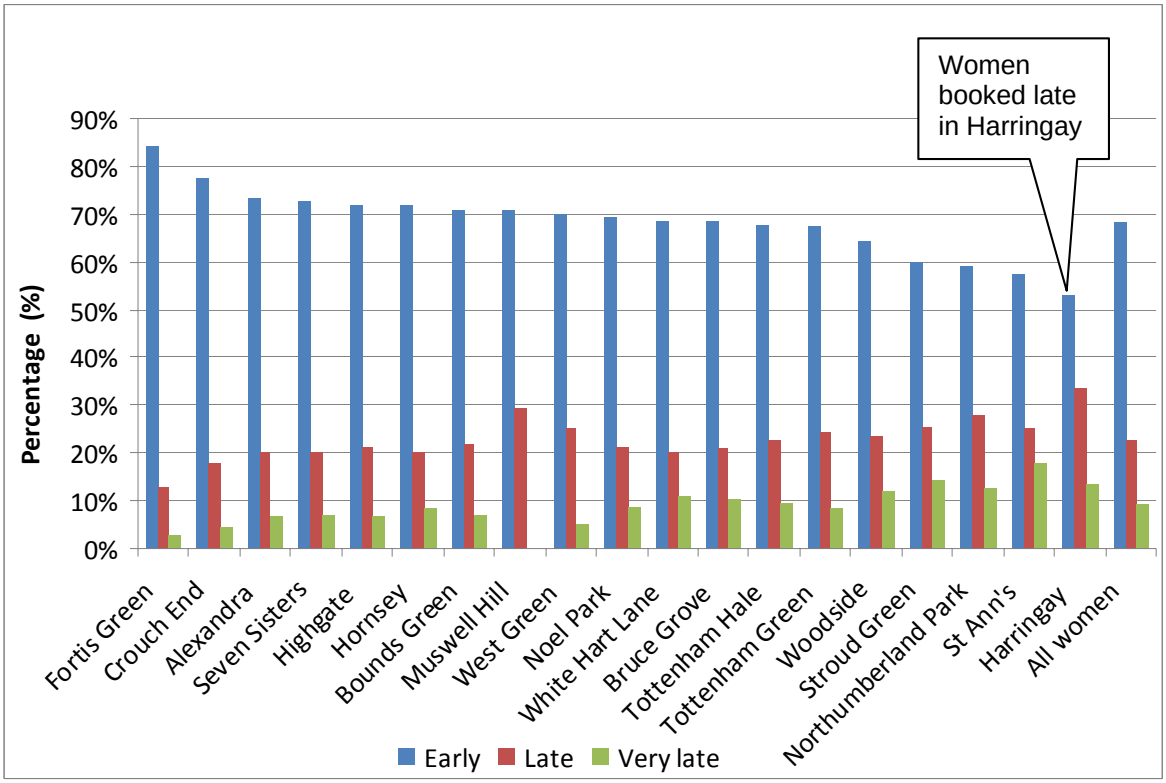
- An estimated 21,595 (36.4%) children live in poverty within Haringey, largely in the east of the borough.
- Central collaborative lies between some of the least deprived areas in the country in west Haringey and some of the most deprived areas in the country in north east Haringey.
- Noel Park has small areas classed within the 5% most deprived in the country.
- In Haringey 22% of households are overcrowded, there is high rate of worklessness.
- There are far more domestic and gender based violence offences committed in the east of Haringey, with over 36% of the total in just four wards: high, with Tottenham Hale, Tottenham Green, Northumberland Park and Noel Park.

3. Children and young people

3.1 Early access to maternity services

- The Department of Health target is for 90% of women to receive an antenatal assessment by 12 weeks 6 days of pregnancy.
- Latest figures for Haringey show that only 62.7% of women accessed maternity services by this time.
- Those aged under 20, Black African women and women living in the east of the borough are most likely to book late.
- Additional information from the North Middlesex Hospital shows that in particular, women from the Congo, Somalia, Romania and Bulgaria book late for antenatal care.

Figure 4: Access to maternity services by ward of residence 2011.
Source: Whittington and North Middlesex Hospitals.



Early: under 13 weeks ; Late: 13-22 weeks ; Very late: over 22 weeks

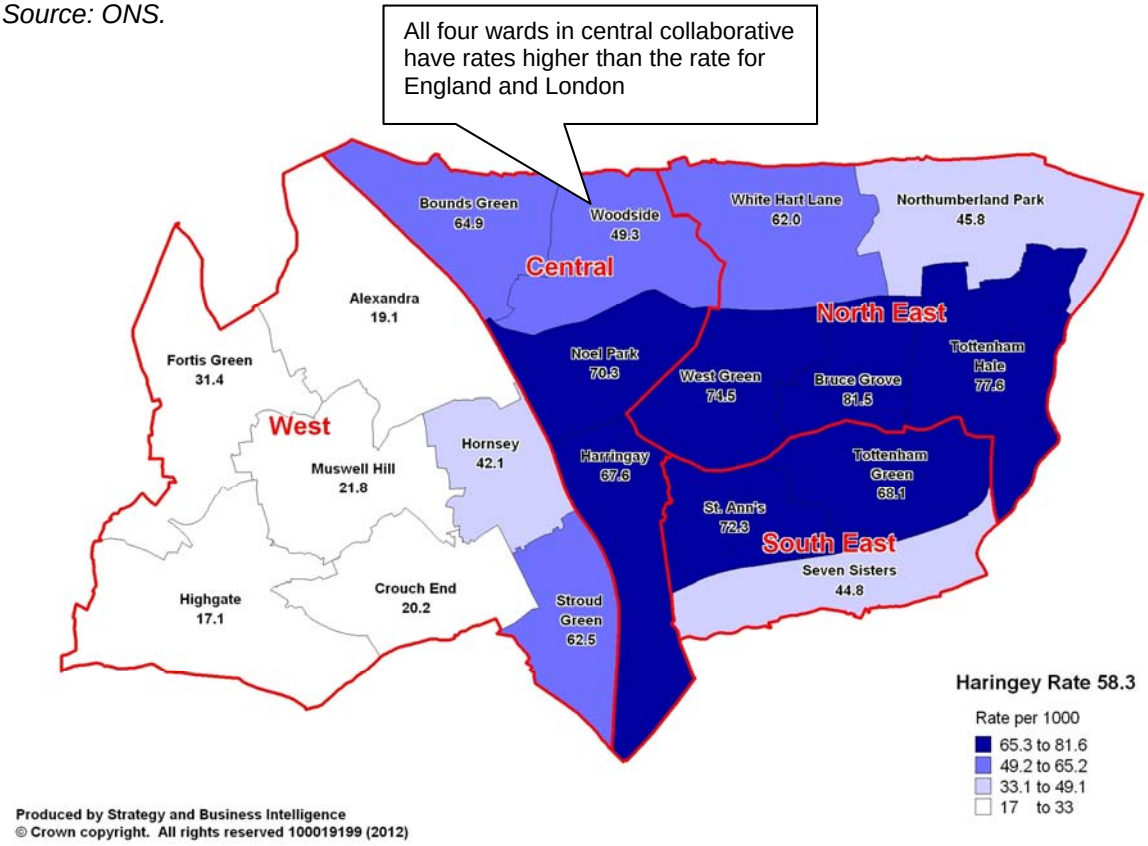
Partnership plans include:

- Hold a knowledge exchange event with faith leaders and health professionals to share ideas on promoting early access with African communities.
- Promote the importance of early access with a range of professionals, particularly those providing services for vulnerable families.
- Undertake a health promotion campaign with pharmacists to promote early booking.
- In partnership with the Family Nurse Partnership and acute trusts develop an information card for first time mothers under 20 to promote early booking for subsequent pregnancies.

3.2 Teenage pregnancy

- Following two years of going down, the teenage pregnancy rate increased in Haringey in 2010 and at 64.7 per 1000 women aged 15-17 was the highest rate in England (England and Wales rate is 35.5 per 1000); 203 teenagers became pregnant. However, given the small numbers involved, there can be large year on year fluctuations in the rate, and the overall trend (3-year 'rolling average') remains a decreasing one.
- Positively, Haringey's under-16 conception rate decreased to its lowest rate in 2010.

Figure 5: Under 18 conception rates by ward in Haringey (2007-09).
Source: ONS.



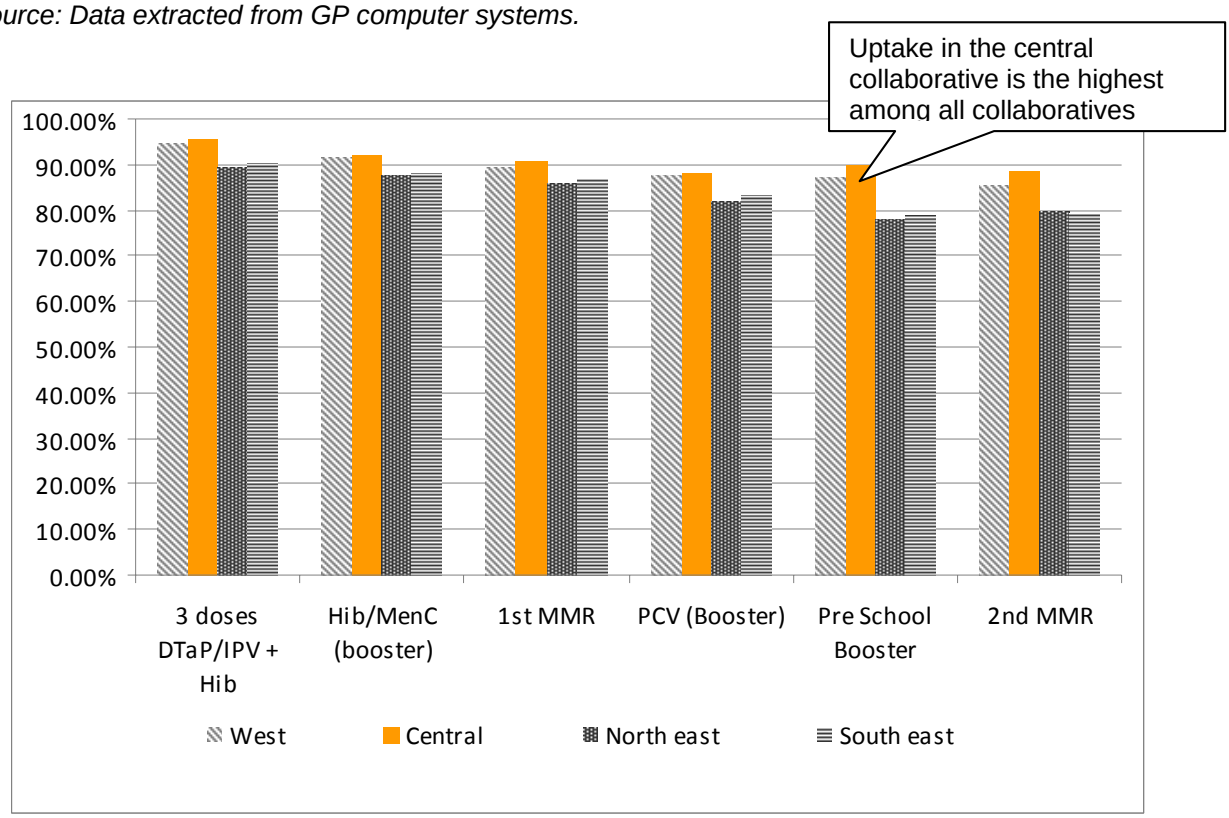
Partnership plans include:

- Continue to increase access to the C-Card scheme (accessible, free condoms for teenagers and sexual health advice).
- Ensure young women under 25 have access to free Emergency Hormonal Contraception.
- Promote sex and relationship education (SRE) through the Healthy Schools programme.
- Continue the Family Nurse Partnership programme, which provides intensive support to young first time mothers.
- Continue the 4YP service (a young people-friendly sexual health service) in a range of school-based and non-healthcare settings for young people under 25.

3.3 Childhood immunisations

- In Haringey there has been a steady increase in the coverage of childhood vaccinations since 2008 and a significant improvement in 2011/12.
- Uptake of all the childhood immunisation in the central collaborative is the highest among all the collaboratives (Fig. 6). It performs significantly better than the rest of Haringey for the pre- school booster and MMR second dose.
- It is important to note that there are significant variations within the collaboratives with some practices meeting the national target of 95% while others are underperforming.

Figure 6: Childhood immunisations coverage in 2011-12 in Haringey – comparison of 4 collaboratives.
Source: Data extracted from GP computer systems.



Partnership plans include:

- Work and liaise with the Whittington Health Child Health Records Department (CHRD) to improve the process for data flow from practice systems to the Child Health Information System, to enable us to be able to report on uptake across Haringey, by practice and at a population level.
- Support practices in conjunction with the CHRD to scrutinise individual defaulter lists and practice coverage:
  - Make sure all immunisations are coded correctly and picked up on reports.
  - Target those practices that need extra support by working alongside the primary care strategy.
- Continue to support the implementation of the local 'Best Practice Guidance' and 'Call and Recall, DNA process and make sure this is updated as appropriate.
- Promote and support the availability of appropriate training and advice for front line staff.

4. Mortality and morbidity

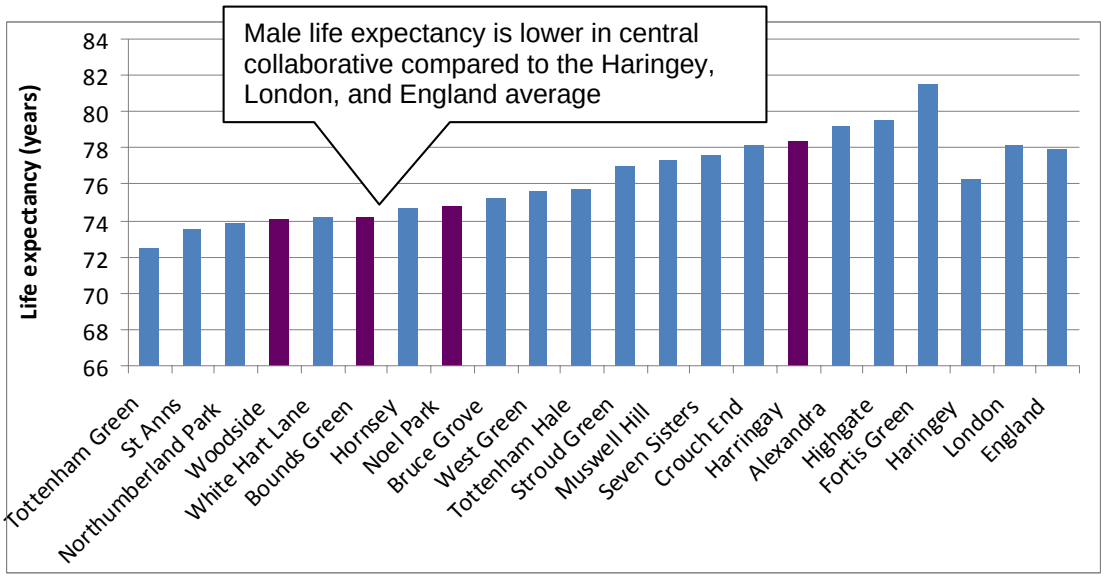
4.1 Life expectancy

- Men in Tottenham Green in east Haringey die 9 years earlier than men in Fortis Green in the west Haringey.
- Life expectancy for men in the central collaborative ranges from 74. to 78.3 (Fig. 7).
- In Haringey women's life expectancy rates are better than the England average. In the central collaborative it ranges from 81.6 (Bounds Green) to 84.6 (Noel Park).
- Haringey has a 10% higher than expected premature (under 75) death rate (SMR: 110); whereas the central collaborative has a 20% higher than expected premature death rate (SMR: 120).

Figure 7: Life expectancy in central collaborative (2005-2009).
Source: Directorate of Public Health, 2012.

	Females	Males
Central collaborative	83.1	75.3
Haringey	83.3	76.2
London	83.6	78.1
England	82.0	77.9

Figure 8: Male life expectancy by ward- 2005-09 (wards of central collaborative are shaded in purple)



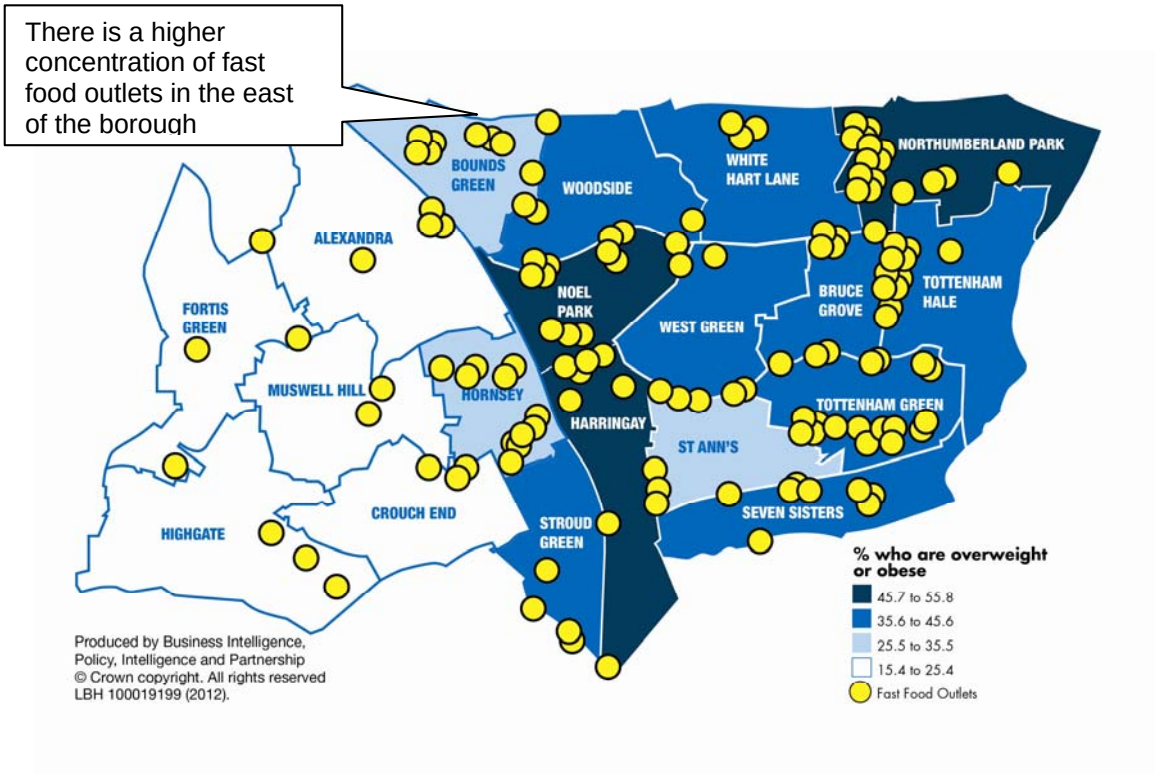
Partnership plans include:

- Allocate resources and implementing programmes that prevent ill health and detect and manage key diseases early.
- Take forward Health and Wellbeing Strategy to deliver Outcome 2, " A reduced gap in life expectancy":
  - Reduce smoking e.g. through tobacco control measures and the smoking cessation service.
  - Increase physical activity e.g. by scaling up brief interventions to encourage take up and by making Haringey more cycle friendly.
  - Reduce alcohol misuse (see 4.3).
  - Reduce early death from CVD and cancer e.g. by increasing uptake of the NHS Health Checks programme and developing community champions.
  - Support people with LTC to live a healthier life e.g. by implementing evidence based care pathways and integrated care systems.

4.2 Lifestyle risk factors: smoking, poor diet, physical activity, obesity

- Smoking levels are high with an estimated 50,000 adult smokers (28.6% of men, 24.2% of women), largely in the east of the borough.
- There is significant physical inactivity in Haringey. Only 21.5% of adults participated in sport and physical activity on three or more days a week.
- One in five children aged 4-5 and one in three children aged 10-11 are overweight or obese in Haringey (Fig.9).
- The prevalence of adult obesity is higher in Haringey at 27.6% than in England at 23%.

Figure 9: Levels of obesity in Year 6 children (10-11 year olds) in Haringey by ward; location of fast food outlets in Haringey (2011)
Source: Haringey National Child Measurement Programme data 2011.



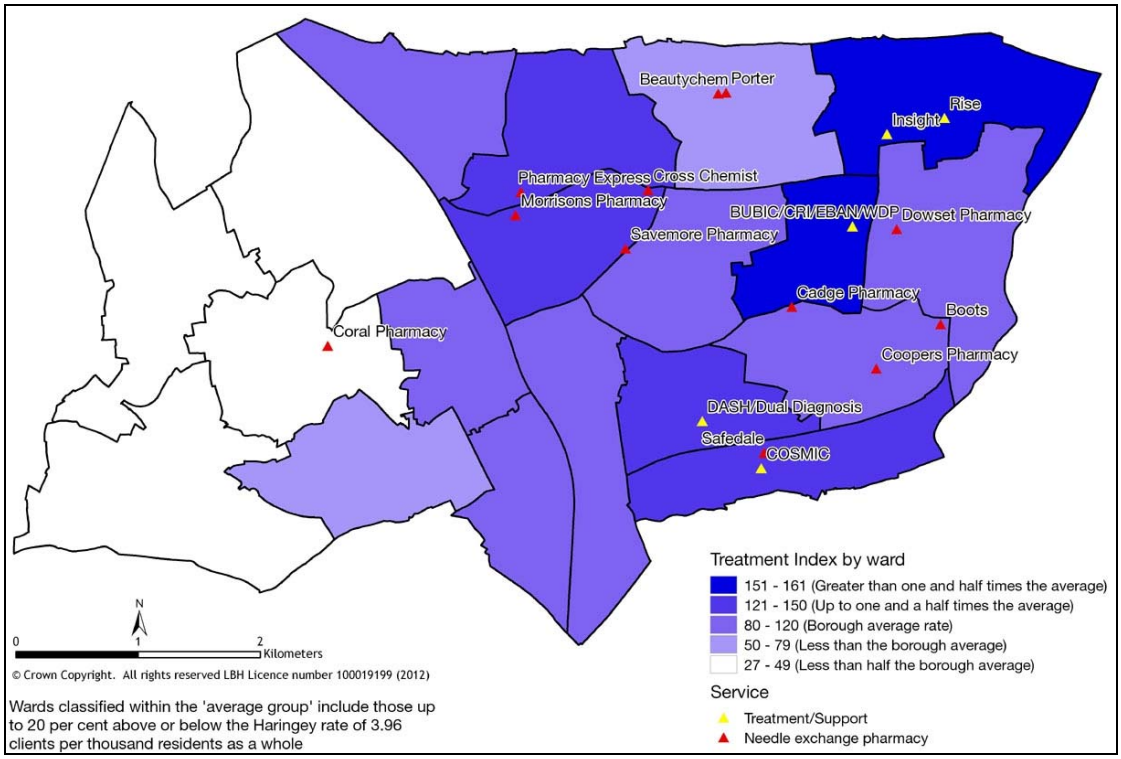
Partnership plans include:

- Continue to strengthen the stop smoking service to target groups at risk and in accessible service locations, for example, primary care, pharmacies and workplace settings.
- Mainstream physical activity into primary healthcare settings and making it a key element of regular screening, patient advice/education and referral e.g. - the DH Let's Get Moving initiative.
- Maintain and strengthening the exercise referral scheme for patients with long term conditions.
- Through the HENRY programme (Health, Exercise, Nutrition for the Really Young) offer programmes on healthy lifestyles for parents of children under the age of five.
- Tackle the growing number of fast food outlets.
- Brief intervention training for key front line staff in how to support lifestyle change.
- The Health Trainer Service supports clients with lifestyle changes.
- Implement obesity care pathway in primary care including weight management service in the community.

4.3 Lifestyle risk factors: drug and alcohol misuse

- While drug and alcohol use is widespread among all socio-economic classes, problematic misuse is more prevalent among those of lower socio-economic status, the homeless, unemployed and those suffering from mental ill health.
- Problematic drug and alcohol use is more prominent in the east of Haringey.
- The majority of service users in drug treatment live in the east of Haringey. Highest numbers in the central collaborative area reside in the Woodside and Noel Park wards.
- Alcohol-related hospital admissions are, however, more evenly spread around the borough.

Figure 10: Map showing where drug users in treatment were likely to live in 2009-10
Source: National Drug Treatment Monitoring System



Partnership plans include:

- Re-tender existing drug and alcohol services to create a recovery focused treatment system by 2014/15.
- Continue to include alcohol screening in the NHS Healthchecks programme.
- Extend the range of Identification and Brief Advice (IBA) by training staff in non-medical settings, such as sexual health and safeguarding services.
- Continue to ensure fast access to a wide range of prevention and treatment services, along with services for carers and families and children affected by parental substance misuse.
- Increase coverage and uptake of blood borne viruses screening and immunisation for injecting drug users.
- Continue a programme of outreach to traditional 'street drinkers', and the Eastern European community; develop a programme with the Irish community.

4.4 Long term conditions (LTC)

- Long term conditions (LTCs) include diabetes, respiratory disease (particularly chronic obstructive pulmonary disease (COPD)) and cardiovascular diseases (CVD); they are more common among people from lower socio-economic groups and certain Black and minority ethnic (BME) groups.
- The diseases most responsible for the male life expectancy gap are CVD (which includes heart disease and stroke) (28%) and cancers (25%).
- An estimated 74% of over 65s registered with a GP have a long term condition (LTC), equating to 18,909 people in Haringey[1].
- An estimated[1] a third of people living with a diagnosed LTC have more than one condition. The pattern of comorbidity varies depending on their first diagnosis, ranging from 59% of those first diagnosed with coronary heart disease (CHD) having another LTC down to 18% of those with dementia.
- In 2011 in comparison to other collaboratives, the central collaborative had the highest proportion of patients with CHD, and COPD on the GP registers (COPD) (Fig. 11).

Figure 11: Prevalence of long term condition on GP registers by collaborative.
Source: QOF 2011.

		West	Central	North East	South East
CHD	Number	1368	1234	1234	792
	%	1.54	2	1.54	1.45
Diabetes	Number	2457	2860	4031	2401
	%	2.77	4.64	5.04	4.41
COPD	Number	571	536	612	296
	%	0.64	0.87	0.77	0.54
Cancer	Number	1112	669	771	388
	%	1.25	1.09	0.96	0.71
Mental Health	Number	913	733	1072	732
	%	1.03	1.19	1.34	1.34

Partnership plans include:

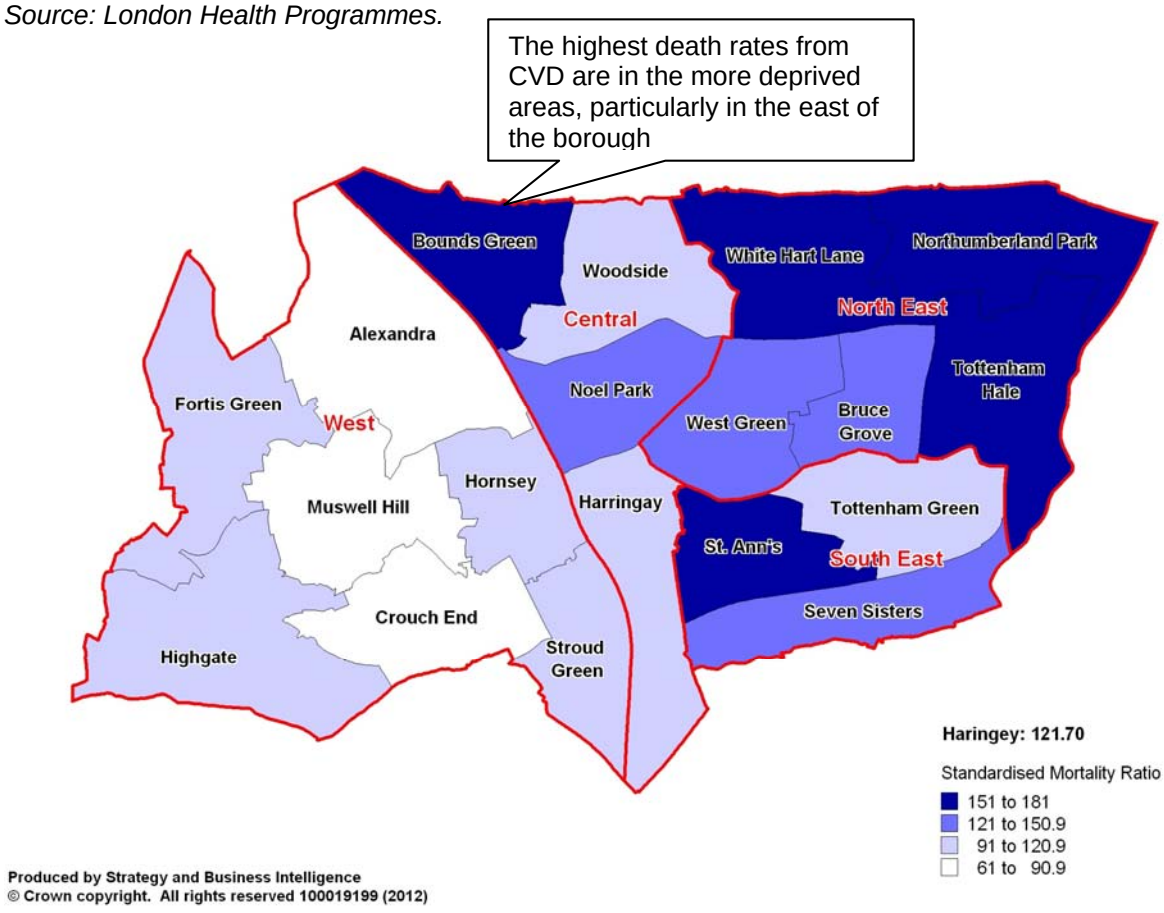
- Build on and develop the health champions programme to raise awareness of lifestyle risk factors and signs and symptoms of LTCs.
- Promote early intervention within the primary care strategy.
- Develop integrated health and social care systems for LTCs across Haringey.
- Maximise case finding and use of case registers and care pathways within primary care and community services to ensure early detection and management of these conditions.
- Continue to implement the new joint reablement pathway that offers intensive support after hospital discharge or prevents hospital admissions in patients with LTCs particularly those who are vulnerable.

[1]**Annual Public Health Report 2011: Extending life in Islington. Haringey public health will be undertaking a similar analysis of GP registers in 2012/13.**

4.5 Cardiovascular disease (CVD)

- Cardiovascular diseases (CVD) are the main cause of death in the UK causing around 156,800 deaths in England in 2008 (around a third of all deaths).
- Around 45% of all deaths from CVD are from coronary heart disease (CHD) and more than a quarter from stroke (28%).
- Haringey has a 15% higher than expected under 75 death rate for CVD (SMR: 115); the central collaborative's rate is 35% higher than expected (SMR: 135).
- Mortality rates from CVD are significantly higher than the national rate, and have decreased by 46.4% since 1995-7.
- The ratio of recorded versus expected prevalence of CHD in central is higher than the Haringey but lower than England. This suggests in the central collaborative more than half of the number of expected cases of CHD remain undiagnosed.
- The emergency admission rate for stroke in 2009/10 for people who live in the most deprived areas of Haringey was 1.5 times greater than the emergency admission rates for people who live in the least deprived areas of Haringey.

Figure 12: Premature mortality from all circulatory diseases (2005-09).
Source: London Health Programmes.



Partnership plans include:

- Develop and implementation of stroke and heart failure care pathways.
- Continue to strengthen NHS Health Checks programme and improve uptake and focus on hard to reach groups in north east, south east and central collaboratives.
- The Health Trainer Service support clients with lifestyle changes.
- Tackle the high level of lifestyle risk factors for CVD (see 4.2 and 4.3).

4.6 Cancer

- Cancer incidence has been rising steadily nationally and in Haringey and is predicted to rise further. Together with increased survival this poses an increased demand on resources.
- In 2010-11 Haringey's expenditure on cancer (£160 per weighted head of population) was significantly higher than London (£110) and England (£108). Cancer was one of the highest spend areas.
- Rates from early death from cancer are improving but remain worse than England for men.
- Cancer contributes to 25% percentage of the life expectancy gap between males in Haringey and England. Of this, lung cancer mortality in Haringey is responsible for approximately 6% of the life expectancy gap, bowel cancer 4% (mortality rate significantly higher than England) and breast cancer approximately 0.5-1%.
- The most common cancers breast, lung, large bowel (colorectal) and prostate together account for over half (54%) of all new cases.
- Smoking is the greatest modifiable risk factor for cancer, commoner in lower socio-economic groups and certain risk groups e.g. people with mental health problems.
- Haringey has a 8% higher than expected under 75 death rate for cancer (SMR: 108); the central collaborative's rate is 9% higher than expected (SMR: 109).
- Currently borough performance for bowel cancer screening (43.1%) is significantly lower than the national target (60%). Uptake in the central collaborative is better (45.4%) than the Haringey average (Fig. 13).
- Local coverage for breast cancer screening in Haringey has increased from 50% in 2008/09 to 64.4% in 2011/12 but it is still significantly lower than the national target of 70%.
- The overall coverage for cervical screening in the borough is 73.8 against the national target of 80%. Women in younger age groups (25-39) have the lowest coverage. Six practices in the central collaborative, two in the south east collaborative and one in the north east and the central collaborative respectively are meeting the national target.

Figure 13: Bowel cancer screening uptake in Haringey.
Source: London Quality Assurance Reference Centre.

Uptake for 2011-12	
North east	36.2%
Central	45.4%
West	45.4%
South east	39.1%
Haringey	43.1%

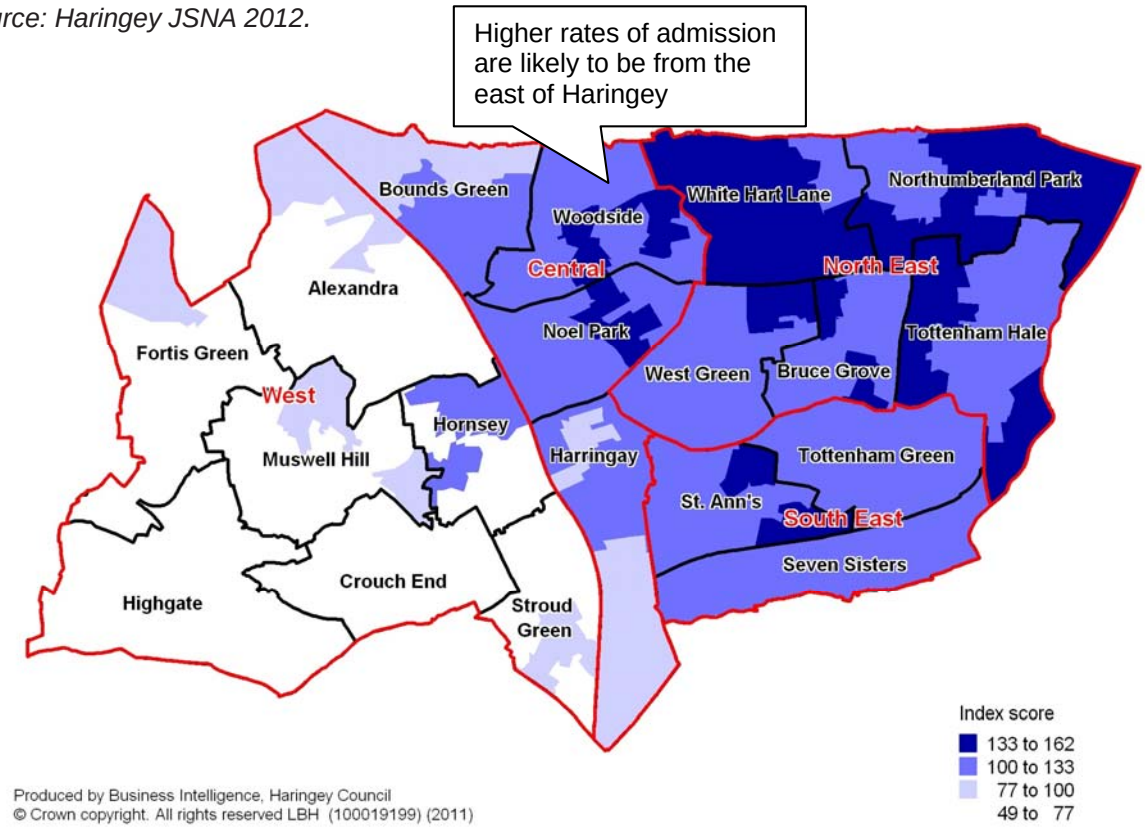
Partnership plans include:

- Raise public and professional awareness of common cancers e.g. bowel cancer through a number of programmes supported by the National Awareness and Early Diagnosis Initiative (NAEDI).
- Continue to improve uptake of breast, cervical and colorectal cancer screening, including addressing variation between practices and populations.
- Commission and contract of North London Breast Cancer Screening services to achieve better quality and uptake.
- Develop cancer commissioning pathways and associated service specifications to deliver uniformly high standards of care and improve equity of outcomes.
- Tackle the high level of lifestyle risk factors for cancer (see 4.2 and 4.3).

4.7 Diabetes

- Diabetes is an important contributor to the life expectancy gap in Haringey, both as a risk factor for CVD and as an important long term condition.
- More than 1 in 20 people in Haringey are living with undiagnosed diabetes.
- Recorded prevalence of diabetes among Haringey GP practices ranged between 2 and 9% of their adult population (QOF 2010/11).
- Data suggests that emergency hospital admissions (for ketoacidosis and coma) are rising, hospital admissions are higher in the east of Haringey and there is variability in complication rates by GP practice.

Figure 14: Likelihood of admission to hospital for diabetes in Haringey by ward.
Source: Haringey JSNA 2012.



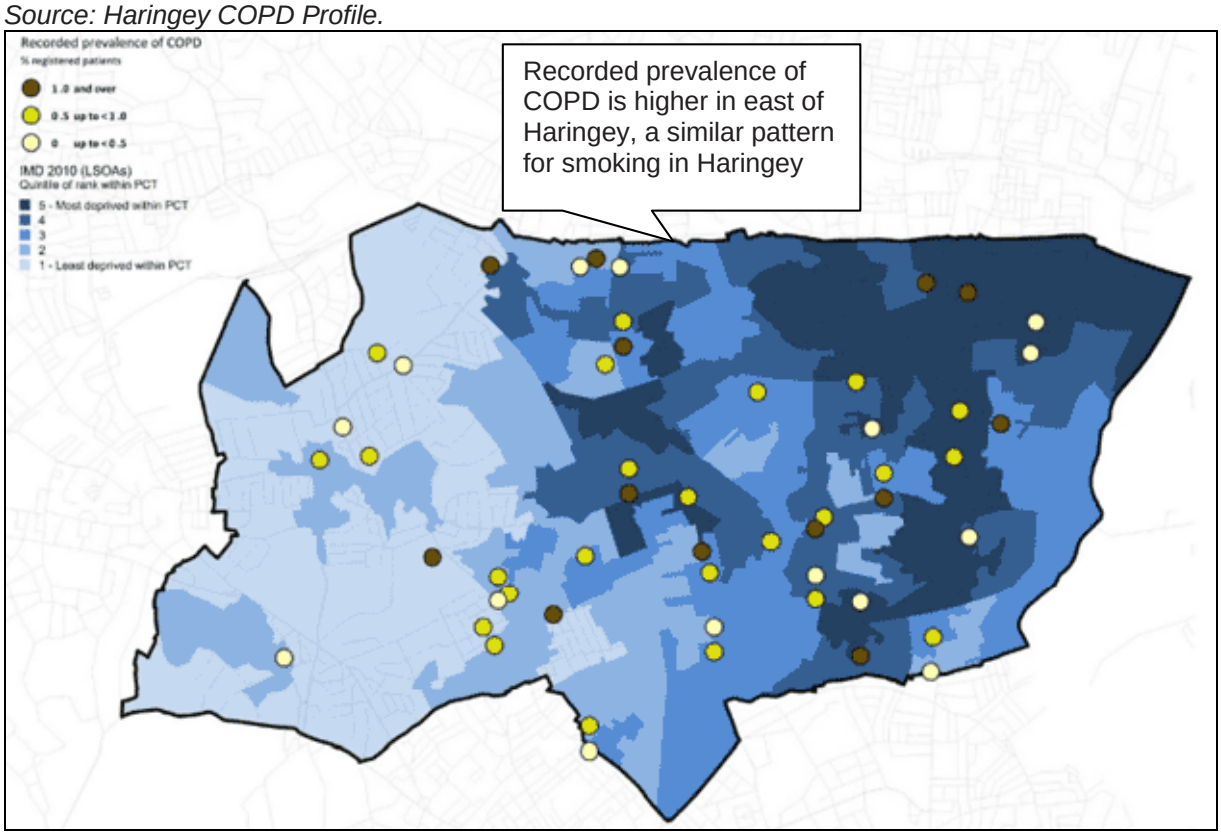
Partnership plans include:

- Evaluate north east intermediate care diabetes triage with view to roll out across Haringey.
- Build on current practice to develop GP education for diabetes.
- Build on and developing health champions programme to raise awareness of signs and symptoms of diabetes.
- Develop model of provision in line with evidence based care pathway bringing care closer to home in intermediate, primary and community services.

4.8 Chronic obstructive pulmonary disease (COPD)

- In Haringey the expected prevalence of chronic obstructive pulmonary disease (COPD) is four times that of the recorded prevalence on primary care practice registers. Finding undiagnosed cases of COPD is a challenge for primary and secondary care.
- In 2010, 4.6% of Haringey patients had asthma compared to 6% nationally.
- The hospital admission rate for COPD is higher than the national average, whereas the recorded prevalence of COPD is lower than the national average.
- Smoking is the primary cause of more than 85% of cases.

Figure 15: Recorded prevalence of COPD in Haringey (2009-10).
Source: Haringey COPD Profile.



Partnership plans include:

- Encourage more Haringey residents to quit smoking with a focus on particular minority ethnic groups, users of mental health services and pregnant women.
- Raise awareness of signs and symptoms of COPD and signpost to services.
- Develop and implement COPD care pathway to manage COPD in primary care and in the community.
- Support commissioning to identify new cases of COPD and asthma in primary care.
- Ensure that there is adequate access to spirometry e.g. stop smoking service in Haringey to support early diagnosis of COPD.
- Commission sufficient pulmonary rehabilitation services to meet patient need.

5. Mental health

- It is estimated that there are currently 2,534 children and adolescents with mental health problems living in Haringey.
- Haringey has the 3rd highest rate of psychotic disorder in London.
- Patients from black or black British ethnic groups account for 20% of the population but represent 46% of all admissions for schizophrenia and 39% of all admissions for bipolar disorder.
- The number of suicides in Haringey has increased in recent years.
- There are more people with dementia in the west of Haringey due to the greater proportion of older people.
- 3230 patients were registered with GPs as having a psychotic disorder; 842 in the west and 2388 in the east of the borough.
- In 2010-11 the highest expenditure in Haringey was on mental health (£308 per weighted head of population) in comparison to London (£258) and England (£209).

Figure 16: Number of registered patients in 2009 with a diagnosis of dementia in Haringey by collaborative.
Source: QOF 2009.

Collaborative	No of registered patients with dementia	Percentage of the register
West	231	0.28
Central	114	0.19
North east	180	0.26
South east	77	0.13
Haringey	602	0.22

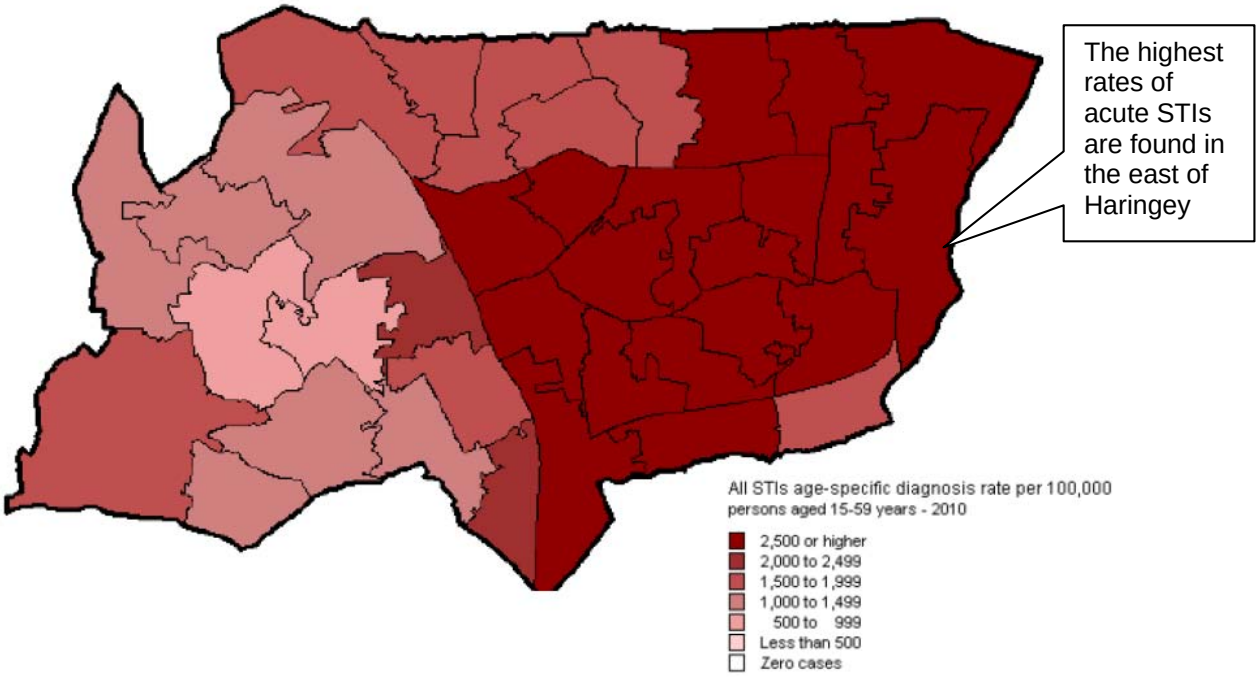
Partnership plans include:

- Address common mental health problems among adults especially in the east of Haringey.
- Work with the voluntary sector to develop effective interventions within community groups.
- Reduce the level of stigma associated with mental health conditions, particularly amongst BME groups.
- Support people with severe and enduring mental health needs and to support independent living where possible.
- Support drug users and those who abuse alcohol to manage mental illness.
- Psychological support for people with LTCs.
- Improve the physical health of people with mental health problems.

6. Sexual health

- Haringey had the 11th highest prevalence of diagnosed human immunodeficiency virus (HIV) and the 7th highest sexually transmitted infections (STI) rate in London (2010).
- Those at highest risk of poor sexual health are: young people, men who have sex with men (MSM), people from Black African communities, people from Black Caribbean communities, people living with HIV, sex workers, victims of trafficking, victims of sexual and domestic violence and abuse and other marginalised or vulnerable groups (for example, looked after children and young people).

Figure: 17: Diagnosis rate (per 100,000) of all acute STIs in Haringey.
Source: Haringey STI Profile 2010



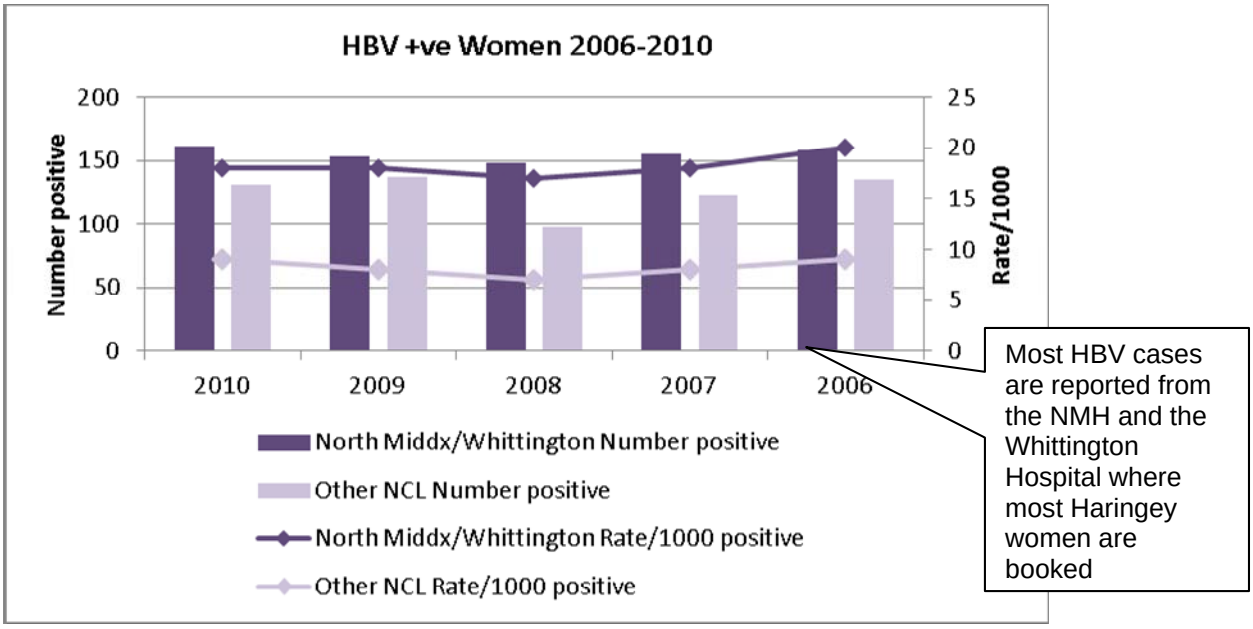
Partnership plans include:

- Continue to commission prevention and health promotion services to meet local need.
- Commission sexual health interventions with the greatest potential for cost effectiveness and impact on health outcomes e.g. incentivising long-acting reversible contraception (LARC) through all contraceptive service providers and abortion service providers, population level Chlamydia screening, HIV testing and prompt access to abortion and genitor-urinary medicine (GUM) services.
- Prioritise STI and HIV prevention programme including distribution of condoms.
- Consider increasing STI and HIV testing in community based services and for general medical admissions and new registrants in general practice.
- Reduce repeat terminations by providing targeted follow up support to access contraception, in particular LARC and condoms for high risk groups (under 25s).
- Continue to commission community based pharmacies to provide free emergency hormonal contraception (EHC) for young women under 25.
- Increase the uptake of contraception in particular LARC in primary care.
- Continue targeted community outreach for young people under 25 to include provision of LARC and other contraception and sexual health services including STI and HIV testing and advanced supply of EHC.

7. Infectious diseases

- There have been significant changes to the ethnicity and country of birth of tuberculosis (TB) cases in Haringey over the last five years.
- Incidence of TB remains at high levels, particularly within Somali population and British born population.
- There is a high prevalence of hepatitis B (HBV) in Haringey.
- It is estimated there are 1,647 people infected with hepatitis C (HCV) in Haringey and the cost of treating patients is in the region of £1.7 million.
- Total expenditure on infectious diseases in Haringey in 2010/11 was over £17m, well above the national average and within 20% of boroughs with the highest spend per 100, 000 population.

Figure 18: Laboratory reports of Hepatitis B positive women detected via antenatal screening in the acute hospitals in the North Central London Cluster.
Source: Antenatal Infection Screening Surveillance



Partnership plans include:

- Raise awareness of TB in communities, primary and secondary health care to de-stigmatise TB and increase testing.
- Engage positively with service provider partners for TB including the local authority to improve the patients whole experience during the period of care.
- Extend pilot TB awareness raising in mafrishes (Khat houses) to include rapid access referral for TB screening in wider community.
- Develop local strategy for HBV and HCV focusing on strengthening pathways to include prevention, awareness raising, early detection and timely access to treatment.
- Consider education of communities where the risk of HBV infection is greater.
- Raise awareness of HCV to increase reporting and detection of HCV amongst populations at increased risk such as South Asian communities.
- Ensure maintenance of a broad range of prevention services that are provided locally (in addition to needle and syringe exchange).
- Ensure that acute trusts provide robust information on the numbers of patients with HCV who are referred, seen and treated for HCV and their clinical outcome.