# Growing up in Haringey

HARINGEY
HEALTH
REPORT 2005


## Acknowledgements

Particular thanks to:

**Haringey TPCT colleagues**
Kate Allardyce, Vanessa Bogle, Sheena Carr, Michele Daniels, Patrick Dollard, Jane Elias, Julian Elston, Vicky Hobart, Juliet Jensen, Gayatri Manikkavasagan, Andrew Powles, Gerry Taylor, Aysha Tegally, Dinah Thompson, Graeme Walsh, Debbie Wilkins and Claire Wright.

**Haringey Council**
Selina Adu, Jayesh Amin, Avi Becker, Jude Clements, Peter Desmond, Rafaelle Flackett, David Holmes, Sophie Johnson, Steve Milne, Ambrose Quashie, Geoff Turner and Patricia Walker.

**Sure Start**
Michael Craft and Tom Morris.

**North Middlesex University Hospital**
Ann Hall and Prakesh Patel.



**For further information or copies contact:**
**Graeme Walsh, Health Information Analyst,**
**Haringey Teaching Primary Care Trust**
Block A1, St Ann's Hospital, St Ann's Road, London N15 3TH
Tel: 020 8442 6783
Fax: 020 8442 6939
Email: graeme.walsh@haringey.nhs.uk



Designed and produced by Column Communications Ltd
Tel: 020 8584 5255

# Contents

# Foreword

*'Children are our Future'* – is that true and do we mean it?

This is a report about the children and young people of Haringey. It attempts to describe who they are, where they live, how they live, and what impacts on their health, presenting an array of information describing progress and achievement in health and education. Almost all parents want their children to be healthy, happy and achieve, but for some this is a difficult task given the resources available to them. This report also indicates where many children are being failed, be that through their housing, household income or educational success. It highlights where children and young people have to overcome significant hurdles to achieve success, and where some live in circumstances that make them particularly vulnerable to poor health.

While this is an annual public health report, it is published with a particular context in mind and in partnership between health services and the Local Authority. There has been significant recent national guidance on children and their needs, such as 'Every Child Matters; Change for Children' and the 'National Service Framework for Children Young People and Maternity Services'. This report is structured around the key themes from Every Child Matters and is written and presented in a format that will provide the basis for the needs assessment required by 'Every Child Matters'.

The document is limited by the absence of adequate data on Haringey children on a number of issues e.g. child health surveillance and primary care data. The document may be too short for some people, and too long for others. For many young people it may seem too stilted. A second version specifically by and for young people is planned, transforming this document into a shortened version as an edition of 'Under exposure' to be distributed with 'Exposure' magazine to all young people in Haringey.

What matters about this report is that it is read and understood, with findings translated into actions that will benefit all children and in particular those most in need or most at risk. The key question is what can we all contribute to ensure that children of Haringey grow up to be happy, healthy, confident and achieving adults.

This report was brought together through much hard work and cooperation by many different people. My thanks go to Kate Allardyce, Sheena Carr, Michele Daniels, Julian Elston, Gerry Taylor, and Dinah Thompson who all contributed significantly to the drafting of the report. Haringey Council, The North Middlesex University Hospital and local Sure Start programmes contributed data and assisted with editing, for which I am very grateful. I owe particular gratitude to Vicky Hobart and Graeme Walsh for coordinating the whole project, obtaining contributions and analysing data from all these sources, and turning the report into a coherent whole. I hope that you will read, understand and be able to translate it into actions for children and young people in Haringey.

*Dr Ann Marie Connolly*
Director of Public Health

# 1. Introduction

**Key messages:**

- National policy on children's health and well-being has evolved considerably since 2000.
- Haringey Council and partners are implementing a Change for Children Programme, having appointed a Director for Children's Services in 2005.
- Three Children's Service Network areas for Haringey are proposed, covering the West, North East and South East of the borough.

Children and young people are a key component of the Government's approach to improving public health[1,2]. New challenges to current and future public health have been identified, including childhood obesity. National policy emphasises the importance of ensuring that children have the best possible start in life, and that ill-health is prevented wherever possible. While this policy is based on a principle of informed choice, it also proposes that Government should intervene in individual decision making to protect the health of children and young people, and where one person's choice inflicts harm on another.

Children and young people growing up in Haringey today face a number of threats to their health. Some of these threats are self evident, for example infectious diseases, or accidents and injuries. Others are less obvious as they do not necessarily result in immediate effects, (for example a poor diet or lack of physical activity), but are possibly as significant in the long term.

The health of children and young people in Haringey is affected by the complex interaction of physical, social, environmental and economic factors (known as the wider determinants of health) in ways that we do not always understand. Children and young people need to be protected from the worst effects of these wider determinants of health, such as poor educational opportunities, poor housing or unemployment.

A focus on prevention and early intervention, and improving the determinants of health such as child poverty and deprivation, could make a real difference to children's health into adulthood. Crucially this involves supporting families, mothers and children to ensure the best possible start in life, so breaking inter-generational cycles of ill-health. This support includes improving antenatal care and early years support in disadvantaged areas, reducing smoking, improving nutrition, supporting teenage and lone parents, and improving housing conditions.

Services for children are undergoing a period of rapid and radical change. National policy emphasises joint working and shared

responsibilities for children across local authorities and the NHS. Haringey is making good progress in its Change for Children programme. It has a strong Children and Young People's Strategic Partnership, a new Director for Children's Services and Executive Member for children and young people within Haringey Council, and a Local Safeguarding Children Board.

Services increasingly aim to provide an integrated core of universal services, which all children and families can access easily, and targeted/specialist services for children with additional needs. Achieving improved outcomes for children and families requires:

1. *better and more integrated services in early years settings, schools and health services;*

2. *specialised help to promote opportunity, prevent problems and act early and effectively if and when problems arise;*

3. *reconfiguration of services around the child and family, either through co-location of services or a lead professional. For example, through children's centres, extended schools and professionals working in multi-disciplinary teams;*

4. *shared responsibility across agencies for safeguarding children and protecting them from harm;*

5. *listening to children, young people and their families when assessing and planning service provision.*

This report is structured around the five themes of 'Every Child Matters' (see box 1). 'Being healthy' is addressed in part through two sections, chapter 3 focusing on measures of health and illness in children and young people, and chapter 4 highlighting key issues in establishing and maintaining healthy behaviours. The sections that follow draw out what we know about the relationship between each of the other themes and the health of children in the borough.

Because different data sources are constructed around different age categories it has not always been possible to present information as we would wish, but where possible we have sought to use the following age groups; under 1's, pre-school (1-4), primary school (5-11), secondary school (12-16) and sixth form/post school (17-18 and 19-24).

This report also presents information on the health of children and young people in terms of the three Children's Network areas wherever possible, namely North East, South East and West Haringey (see inside back cover for a map). These are essentially administrative areas that will bring together different agencies in assessing the need for, planning, commissioning, and delivery of services to children and young people. Over time Children's Networks are expected to develop multi-disciplinary, 'joined up' services that can be delivered close to where children and young people and their families live.

**Box 1** *Recent national policy on children and young people*

**Every Child Matters: Change for Children**[3] provides a framework for building services around the needs of young people to maximise opportunity and minimise risk. Each local partnership is to develop a single inter-agency children and young people's plan, informed by a needs analysis. Five outcomes are identified as key to well-being in childhood and later life:

1. *Being healthy*
2. *Staying safe*
3. *Enjoying and achieving*
4. *Making a positive contribution*
5. *Achieving economic well-being*

**The Children Act (2004)** provides the legislative foundation for Every Child Matters, establishing:

1. *a duty on local authorities to promote co-operation between agencies and other appropriate bodies to improve children's well-being, and a duty on key partners to take part in these arrangements;*
2. *a duty on key agencies to safeguard and promote the welfare of children, and establish a Local Safeguarding Children Board to coordinate and monitor efforts;*
3. *a requirement for local authorities to appoint a Director of Children's Services and designate a lead member, and for a single Children and Young People's Plan to be drawn up;*
4. *provision for systems of basic information about children and young people to enable better sharing of information.*

**Health for all Children**[4] provides guidance and a framework of practice for health professionals working with children in the community. It emphasises health promotion, primary prevention, and active early intervention targeted at children who are most vulnerable and most at risk. It suggests that every child should have access to a universal programme of preventive pre-school care including screening, health promotion and targeted support for families with more complex needs.

**The National Service Framework (NSF) for Children, Young People & Maternity Services**[5] provides a ten year multi-agency programme focused on the needs of children and families, patient and family views, quality and effectiveness. It sets out national standards for child health and social care, preconception and maternity.

**Healthy Schools** New standards for Healthy School status have been introduced focusing on four core areas. These are:

- Personal, social and health education
- Healthy eating
- Physical activity
- Emotional health and well-being

The national target is that 50% of schools achieve Healthy School status by December 2006 and the remainder by 2009.

# 2.Children and young people in Haringey

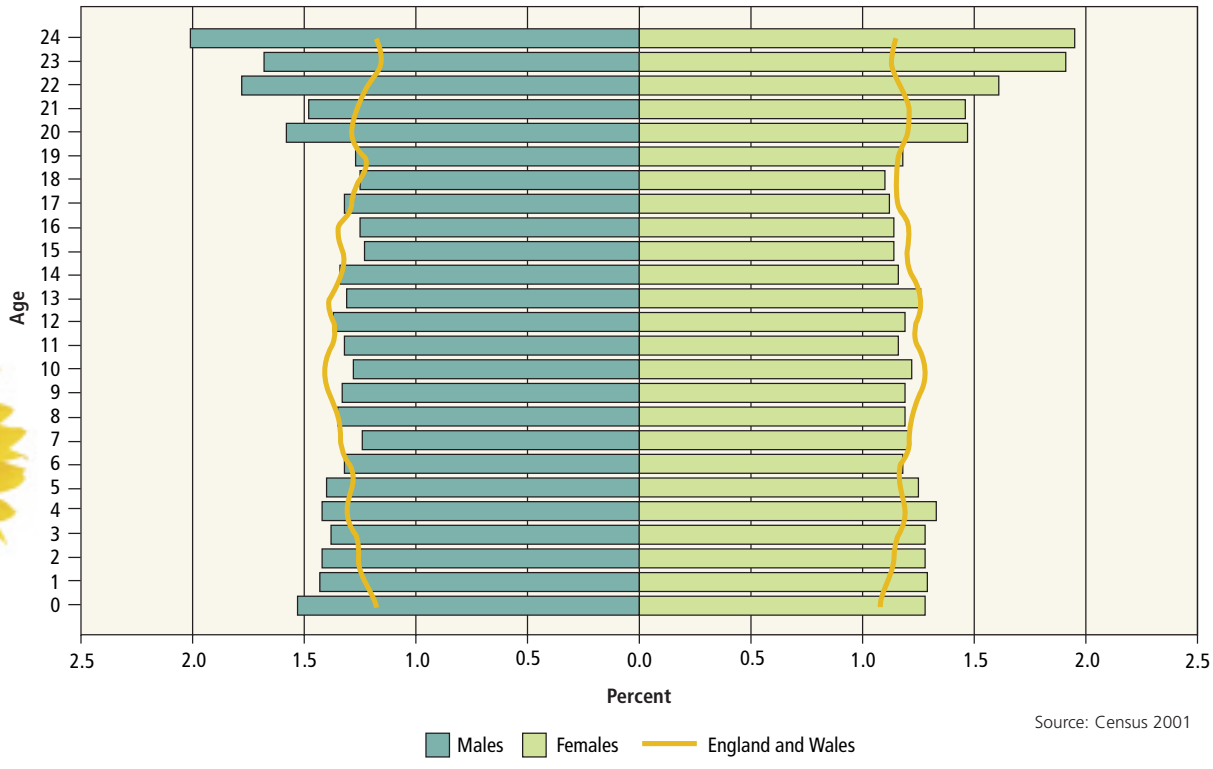
**Key messages:**

- Haringey's population is relatively young and ethnically diverse.
- The number of children and young people living in the borough is expected to grow considerably over the next 10 years, and this growth will not be evenly spread.
- Substantial numbers of children and young people in Haringey live in families or households that are vulnerable to poor health.

## 2.1 Children living in Haringey

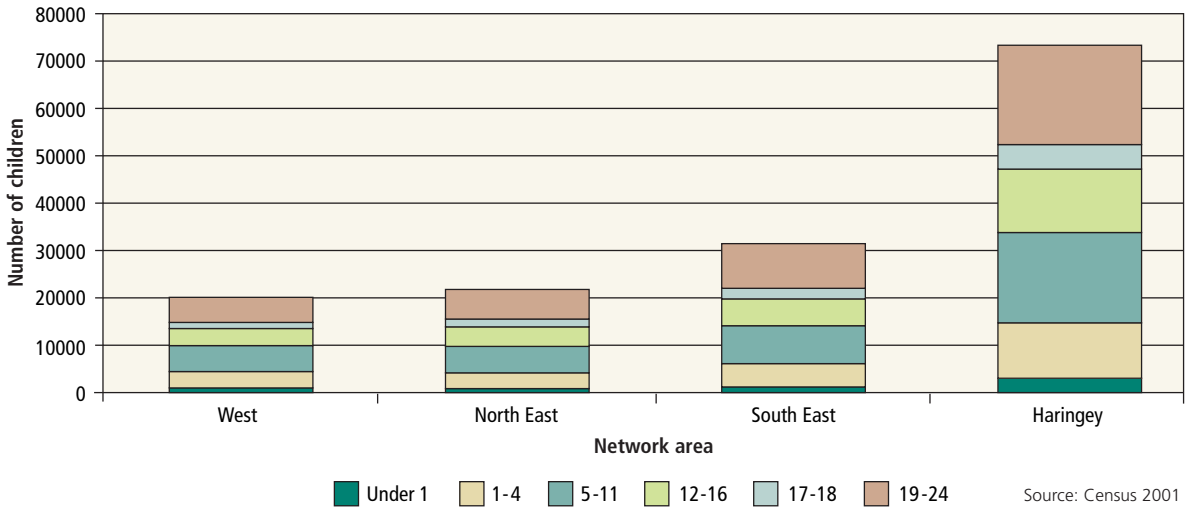
The 2001 Census identified 216,473 people living in Haringey, of which 34% were under the age of 25 (73,338). Notably 9.7% of Haringey's population was aged 19-24 years, compared to only 7.2% in England and Wales. Differences in the number of children in each year group can be seen in the population pyramid (see figure 1).

***Figure 1*** *Population pyramid for 0-24 year olds, Haringey and England and Wales, 2001*




Source: Census 2001

***Figure 2*** *Age distribution of children by Children's Network area, 2001*

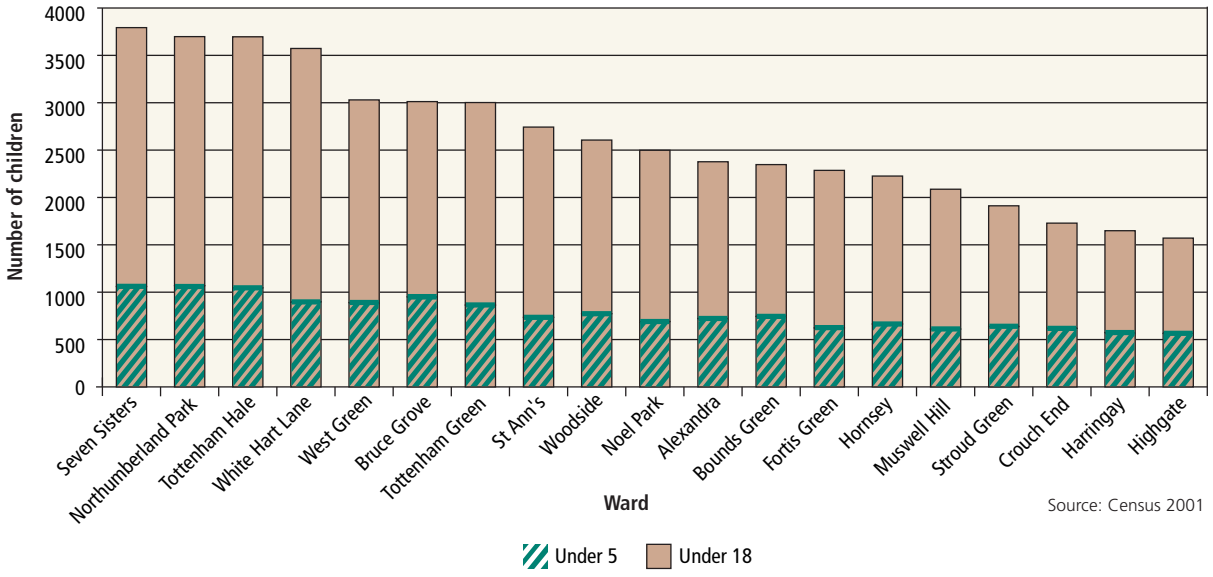



Source: Census 2001

Overall the Haringey population is younger then the national average, but the population structure of individual wards varies considerably[6]. There were more children under 18 living in the South East Network area (20,925) in the 2001 Census than West (14,188) or North East (14,722). Under 18s made up a similar proportion of the total population in the South East and North East Network areas (24.7% and 25.2% respectively). Only 19.4% of the total population in the West Network area was aged under 18. Figure 2 illustrates the varying distribution of different age groups between the Children's Network areas.

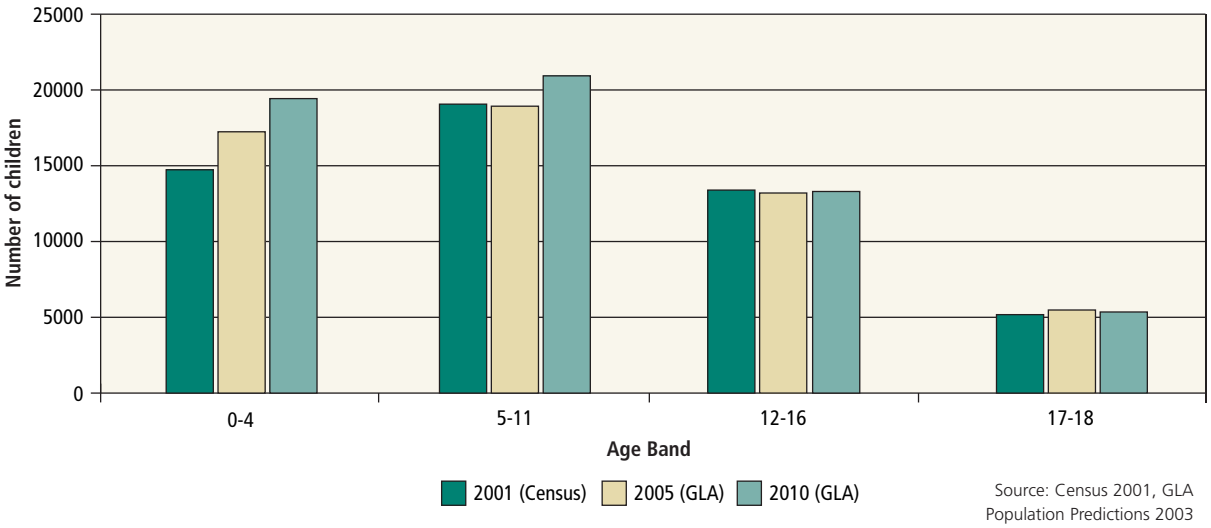
The wards with the largest number of children aged under 18 in Haringey were Seven Sisters, Northumberland Park, Tottenham Hale and White Hart Lane (see figure 3). The wards with the highest proportion of total population aged under 18 years were all in the East of the borough, notably White Hart Lane (29.8%), Northumberland Park (29.3%) and Tottenham

***Figure 3*** *Number of children aged under 5, and aged under 18 by ward, 2001*




Source: Census 2001

***Figure 4*** *Predicted increase in the number of children and young people in Haringey by age group, 2001 to 2010*




Source: Census 2001, GLA Population Predictions 2003

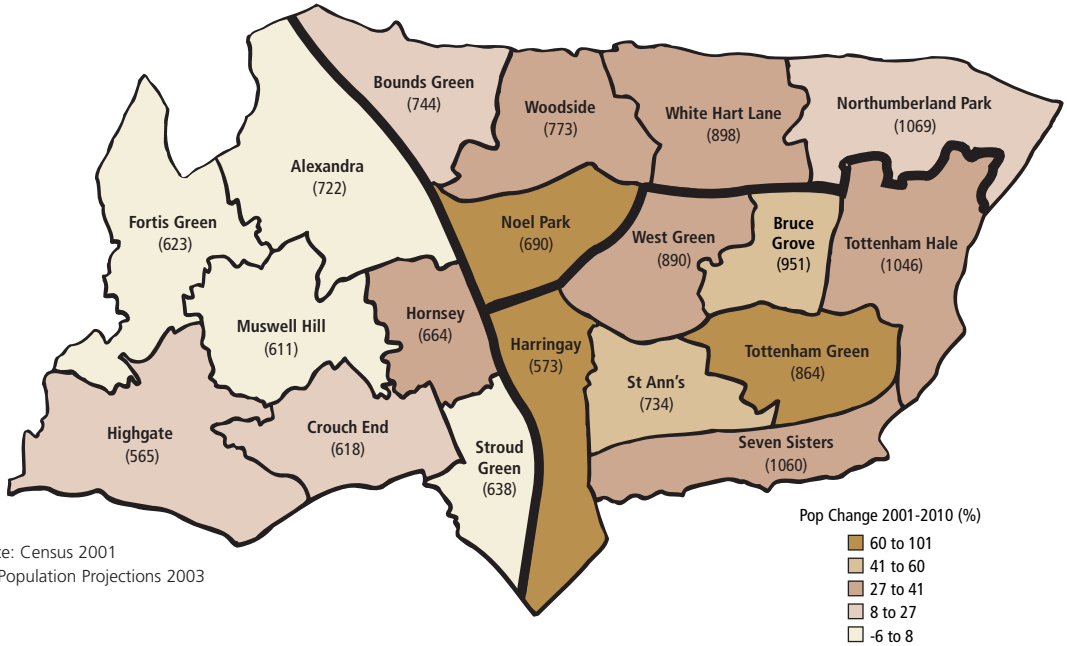
Hale (29.1%). The wards with the lowest proportions were Highgate (15.3%), Harringay (15.7%) and Crouch End (16.1%).

Under 5s comprised between 5.5% and 8.5% of the population at ward level, varying from 565 in Highgate to 1,069 in Northumberland Park. There were more under 5s living in the West (4,441) than in the North East Network area (4,174) at the last Census, with significantly more under 5s living in the South East (6,118).

## 2.2 Population Growth

The Greater London Authority has developed population predictions[7] down to ward level. They suggest a 12.7% increase in the number of 0-18 year olds in Haringey between the 2001 Census and 2010. The most marked increase is in the under 5 age group where growth is expected to reach almost 32% (see figure 4).

***Figure 5*** *Predicted percentage increase in under 5s by ward 2001 to 2010 (Census count in brackets*)*




Source: Census 2001
GLA Population Projections 2003

***Figure 6*** *Children and young people registered with Haringey GPs, August 2005 and GLA population predictions for 2005*

| | GP Registered | | | GLA 2005 |
|---|---|---|---|---|
| **Age** | **Male** | **Female** | **Total (%)** | **Total (%)** |
| Under 1 | 1635 | 1604 | 3239 (1.23%) | 3856 (1.67%) |
| 1-4 | 7046 | 6836 | 13882 (5.26%) | 13385 (5.78%) |
| 5-11 | 11379 | 11148 | 22527 (8.53%) | 18929 (8.17%) |
| 12-16 | 7836 | 7603 | 15439 (5.84%) | 13201 (5.70%) |
| 17-18 | 3342 | 3224 | 6566 (2.49%) | 5481 (2.37%) |
| 19-24 | 10662 | 11367 | 22029 (8.34%) | 22515 (9.72%) |
| Under 25 | 41900 | 41782 | 83682 (31.68%) | 77367 (33.41%) |
| Haringey total | 135632 | 128516 | 264148 | 231559 |

Source: Patient registration database, Enfield and Haringey PCTs, 2005
GLA Population Predictions, 2003

As suggested in figure 5, the South East Network area is expected to see the largest increase in the proportion of under 5s by 2010. The proportion of under 5s in Noel Park is predicted to double, while Fortis Green and Muswell Hill are predicted to decrease slightly.

Growth in the number of under 18s may not be evenly spread across the borough being higher in the South East Network area (17%) than North East (11.7%) and West (8.6%). The highest predicted growth is in Harringay ward (44.8%), while the under 18 population in Fortis Green, Muswell Hill and White Hart Lane is predicted to decrease slightly.

## 2.3 Children registered with a GP in Haringey

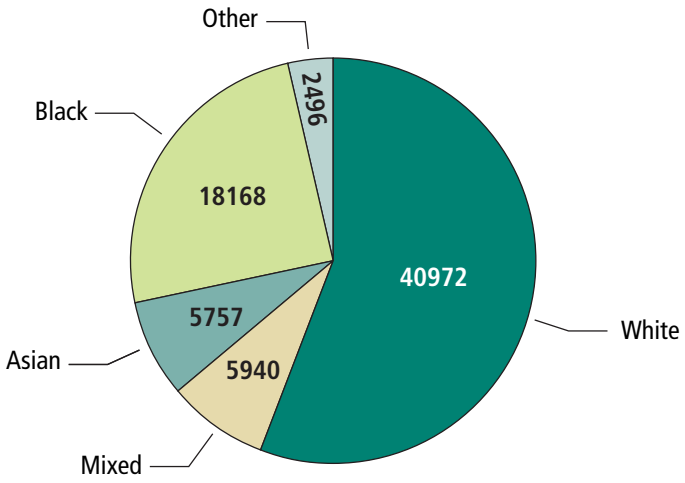
There are 60 GP practices in Haringey that serve residents of Haringey and some neighbouring boroughs. As of August 2005 there were 264,148 people living in Haringey and Enfield registered with a Haringey GP. Of these, 83,700 (32%) were aged under 25 years and 17,100 (6.5%) under 5 years. This contrasts with GLA population projections for 2005 (see figure 6) which suggest that there are fewer children living in Haringey than are registered with a GP, a finding consistent with previous Haringey Health Reports. However, children as a proportion of all people registered with a GP is smaller than children as a proportion of the projected population. This may be explained in part by a number of children who are either not registered with a GP, or registered with a GP in a neighbouring borough. Unfortunately data from the Child Health Surveillance System were not available to explore the latter further.

## 2.4 Ethnicity of children in Haringey

The 2001 Census included a larger number of ethnic classifications than those used in the 1991 Census, and so provided a more detailed picture of the ethnicity of the population. Notably, it highlighted the number of Londoners with dual ethnic heritage. Haringey is ethnically diverse, with only 45% of respondents in the 2001 Census reporting that they were white British compared to 60% in London and 87% across England.

This diversity is more marked amongst young people, with 38% of Haringey residents aged under 25 reporting white British Ethnicity (53% and 84% in London and England

***Figure 7*** *Major ethnic group of people aged under 25 years, 2001*



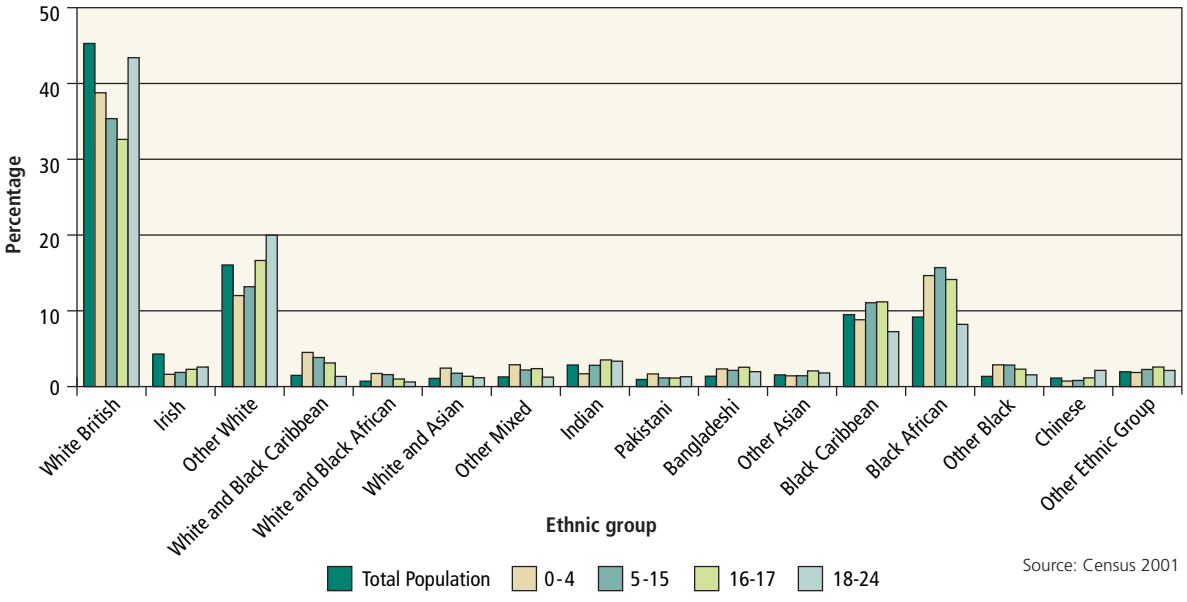

Source: Census 2001

respectively). Figures 7 and 8 suggest that children of all ethnicities are resident in Haringey, with larger populations of white British, other White, black African and black Caribbean children.

Although all wards in Haringey have an ethnically diverse population the wards in the East of the borough are more diverse. Figure 9 shows the diversity across each ward and Children's Network area for children aged 0-4 years. The proportion of children from black and minority ethnic communities varies from 78% in Northumberland Park to 30% in Muswell Hill.

According to the 2001 Census, of the approximately 50 thousand dependent[a] children in Haringey, 18% were not born in the UK. This proportion varies considerably between children of different ethnic groups, from 2% of white British and white/ black Caribbean children to 50% of other White children.

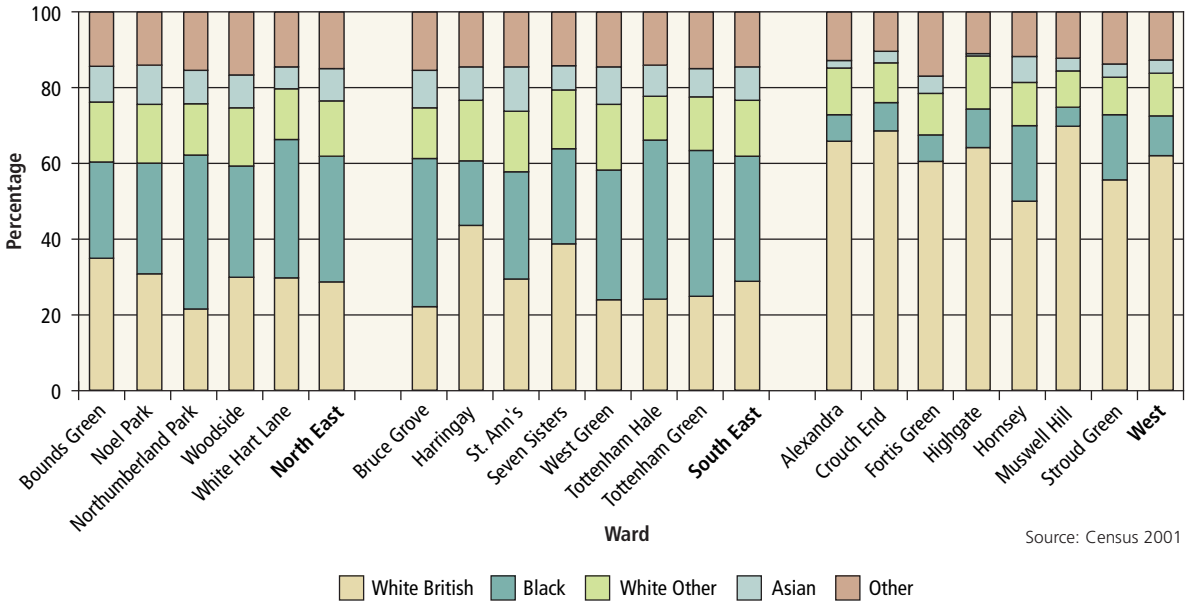
***Figure 8*** *Ethnicity of children in Haringey by age group, 2001*




Source: Census 2001

[a] Dependent children are defined as all children aged 0 to 15 years and those aged 16 to 18 years who are in full time education.

***Figure 9*** *Ethnicity of children aged under 5 by ward and network area*



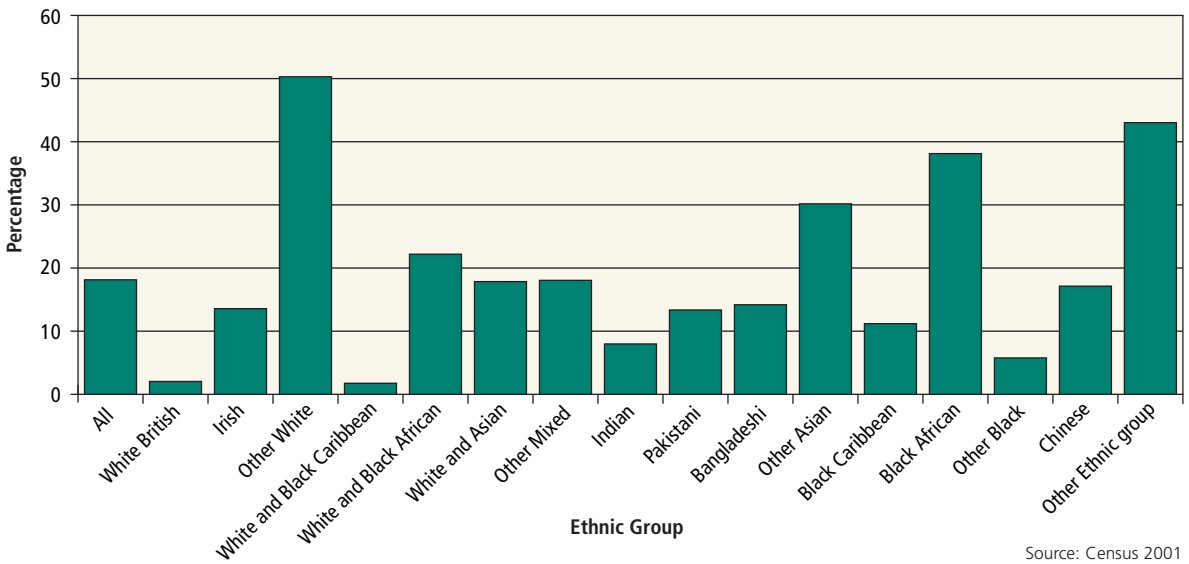

Source: Census 2001

Information from the Children's Service in Haringey suggests that over 15,000 Haringey school children are bilingual, 70% of whom are in primary schools. As of January 2004, children attending schools in Haringey spoke 166 different languages. Figure11 illustrates the range of languages spoken, reported by parents as the child's main language or mother tongue in January 2004.

## 2.5 Household structure

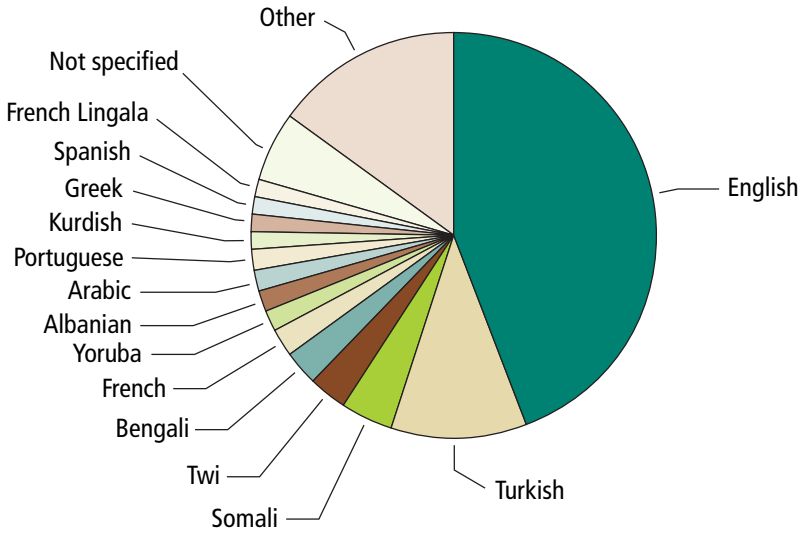
**Households with children** Of the 92,170 households that responded in the last Census, 37% (34,043) had children compared to 39% in London and England. The proportion of households with children was highest in the East of the borough, notably in Seven Sisters, White Hart Lane and Tottenham Hale (see figure 12).

***Figure 10*** *Proportion of dependent children aged under 18 not born in the UK, by ethnic group, 2001*




Source: Census 2001

***Figure 11*** *Main language spoken by children in Haringey primary and secondary schools, January 2004*




Source: Haringey Council, Jan 2004

The proportion of families with one child is fairly even across the borough but highest in Bounds Green. Seven Sisters and Northumberland Park are home to the largest proportion of households with more than one child, while families with non-dependent (ND) children are more prominent in wards in the West of Haringey.

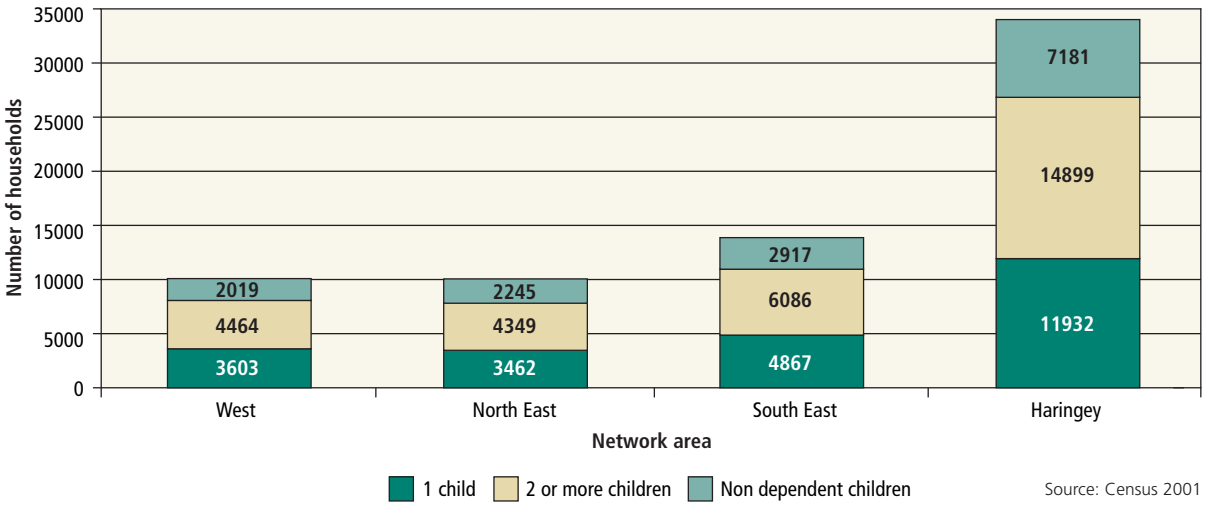
### *Children living with a lone parent*

Nearly one in ten (9.8%) households in Haringey is a household with dependent children headed by a lone parent. Lone parents head 27% of all households with dependent children in Haringey, compared to 21% in London and 17% in England. This masks considerable variation within the borough. While a third of households with children are headed by a lone parent in Northumberland Park, this falls to one in every eight households with children in Muswell Hill.

### *Looked after Children*

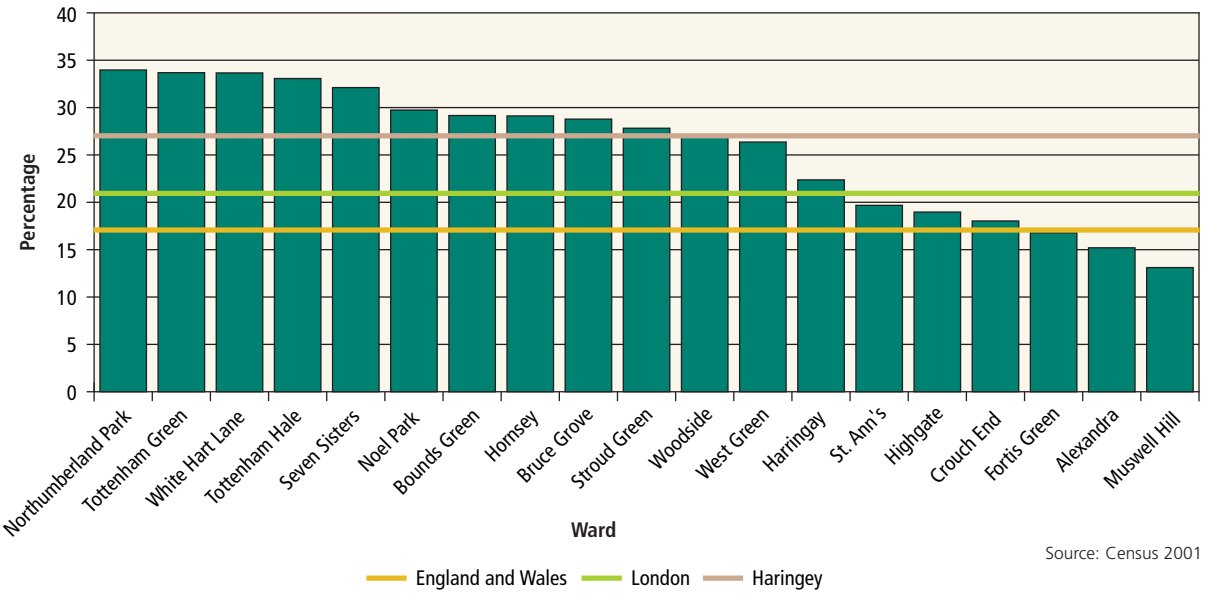
Looked after children have a higher degree of physical and mental health need than

***Figure 12*** *Number of households with children by network area, 2001*




Source: Census 2001

***Figure 13*** *Proportion of all households with dependent children headed by a lone parent, 2001*




Source: Census 2001

children as a whole. Their risk of developing mental health problems is five times greater[8]. Several surveys of looked after children in the UK found that a third of children had emotional and behavioural problems, including poor self esteem and self-image, and a quarter had a statement of special needs. Immunisation coverage was lower than that of children as a whole[9,10]. Other research indicates that placement disruption (moving looked after children between placements) is associated with a high level of mental health need[11]. Education difficulties were apparent in the group with the highest levels of mental health need.

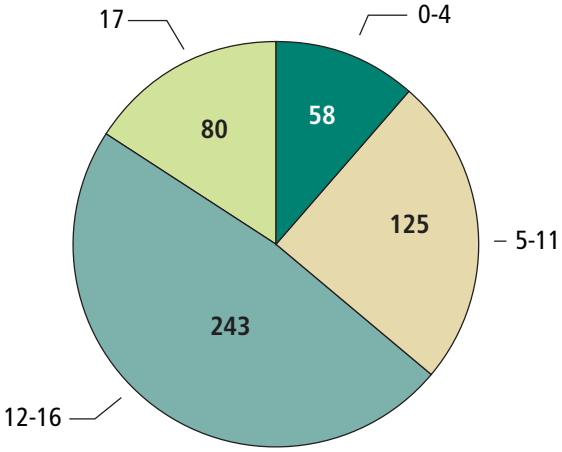
As of July 2005 there were 506 children who were being looked after by Haringey Council. 311 (61.5%) of these were placed outside the borough and 195 (38.5%) inside the borough. Of those placed outside the borough 116 (37%) were in placements that were more than 20 miles away. Almost 50% of looked after children were between the ages of 12 and 16 (see figure 14a). Figure 14b shows the ethnic origin of these children, showing an over representation of black, mixed and 'other' children. The majority of children (64%) were in foster care. A third of foster placements were within Haringey. A range of accommodation is used for children looked after who are placed in residential provision (see figure 14c).

### *Children and young people in special circumstances*

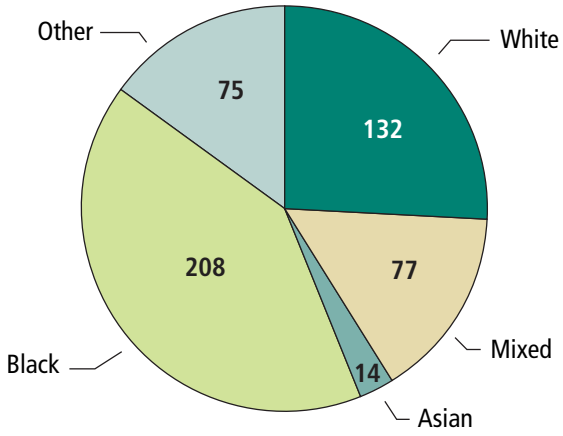
The Children's NSF raises the concern that a number of children and young people who require a high level of cooperation between staff in different agencies may not have their needs fully recognised or addressed by staff working in statutory agencies. These include children and young people living away from home, young people in prison, and children who are deliberately harmed or abused. It also includes mobile children who move frequently or rapidly. It has been repeatedly shown that these children and young people have fewer opportunities to access services, and have poorer health and social outcomes than their peers[5]. The Change for Children Programme aims to address the needs of children and young people in these circumstances.

***Figure 14*** *Looked after children in Haringey, July 2005*

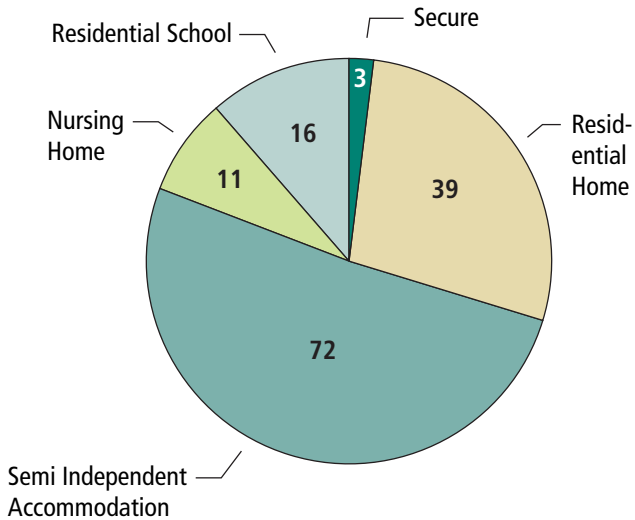
**14a Age**




**14b Ethnicity**




**14c Residential accommodation profile**



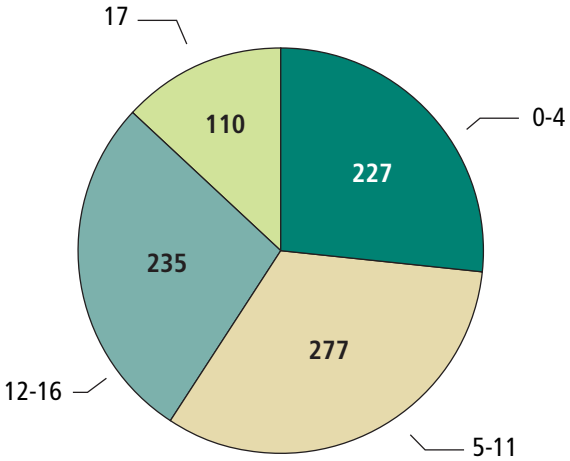

Source: Haringey Council, 2005

### *Children seeking asylum*

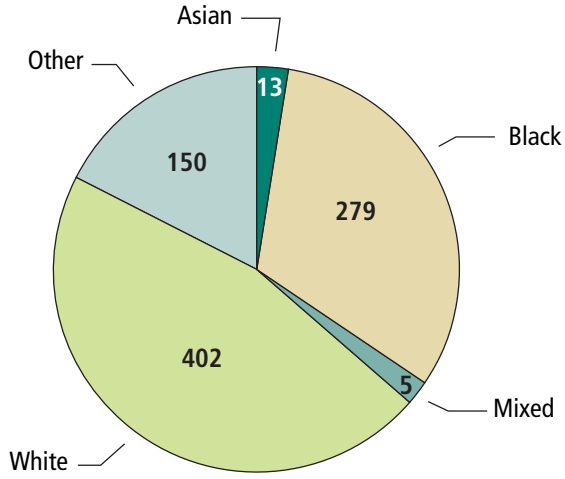
As of June 2005 there were 445 children aged under 18 seeking asylum in Haringey as part of a family. In addition there were 357 unaccompanied asylum seeking children, a third of which were care leavers aged 18 years or older. Figure 15 describes the age and ethnic profile of all children seeking asylum in Haringey as of June 2005. Figure 16 describes the age profile of all unaccompanied children seeking asylum between September 2004 and April 2005.

***Figure 15*** *Profile of all children seeking asylum in Haringey, June 2005*

**15a Age**

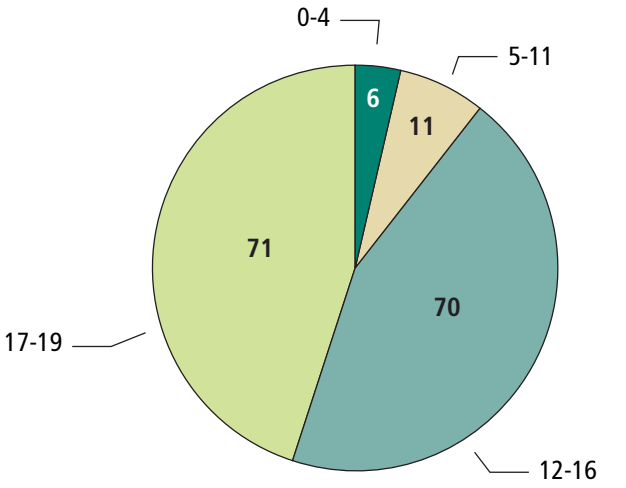



**15b Ethnicity**




Source: Haringey Council, July 2005

***Figure 16*** *Age profile of all unaccompanied children seeking asylum, Sept 2004 to June 2005*

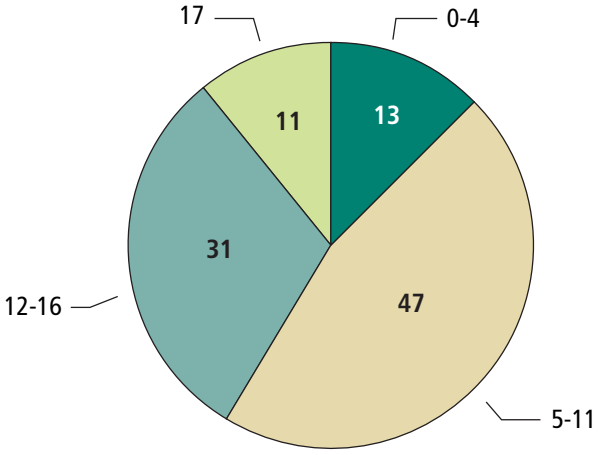



Source: Haringey Council, July 2005

*Travellers*

In July 2005 there were 52 children registered as travellers in Haringey, all of whom were of white Irish ethnic origin. Their age profile is outlined in figure 17.

***Figure 17*** *Age profile of travellers in Haringey, July 2005*




Source: Haringey Council, July 2005

*Homeless children*

As of 30th June 2005 there were 5,422 households living in temporary accommodation in Haringey, of which 4,205 (78%) included children. Only 2% (110) of the households were living in bed and breakfast accommodation, none of which included children or a pregnant woman. The remainder were predominantly housed in a mixture of accommodation owned by Haringey Council and that leased/ rented from housing associations and private sector landlords.

# 3. Measuring health and illness

**Key messages:**

- Children in Haringey experience inequalities in infant mortality and life expectancy.
- In addition to the high teenage conception rate in Haringey, an increasing proportion of women are having children after 35 years of age.
- While more young children are being immunised, the coverage is still not high enough to effectively protect all children from outbreaks of infectious disease.
- A comprehensive picture of children's need for and use of routine, unscheduled and emergency health care is not yet available.

## 3.1 General health indicators

### *3.1.1 Life Expectancy*

Life expectancy at birth measures how long a baby born in a particular year would expect to live if they experienced the current age-specific mortality rates. It therefore provides a good overall measure of the health of that population.

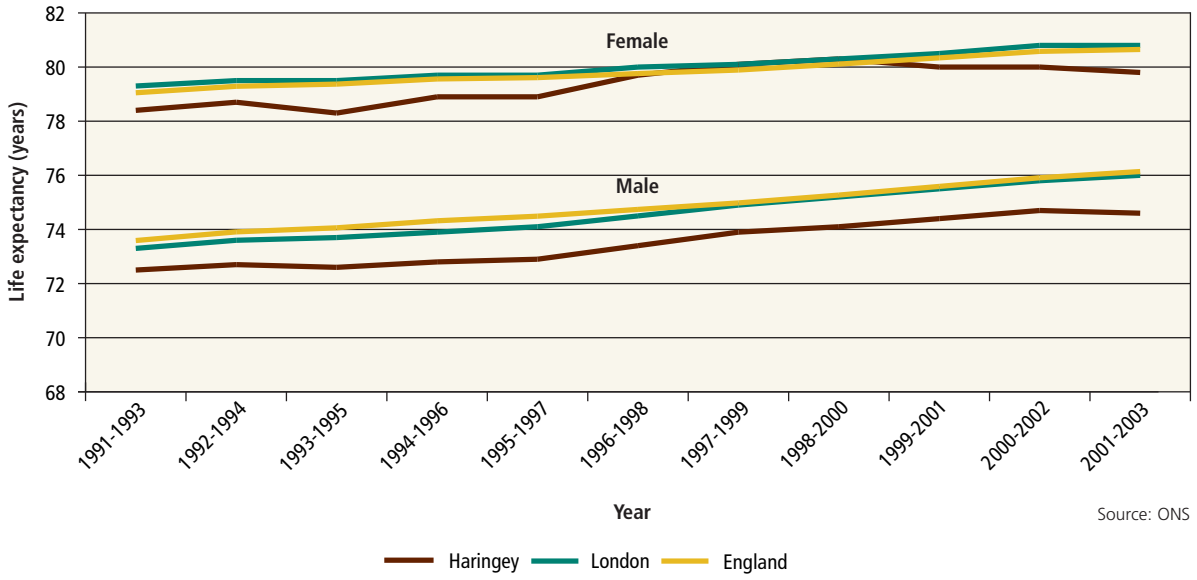
Girls born in Haringey can expect to live as long as the England and Wales average, approximately 80 years. Life expectancy for boys in Haringey is 1.5 years shorter (74.5 years) than the national expectation of 76 years. A boy born today in Haringey can expect to live 5 years less than the girl in the cot next to him (see figure 18), a bigger gender gap than seen nationally (4years).

Underlying this, life expectancy is also influenced by which part of Haringey the child grows up in. For example, a girl growing up in Muswell Hill can expect to live 3 years longer than a girl growing up in White Hart Lane. For boys, the difference is 5.5 years. This suggests that boys and girls, and children growing up in different parts of Haringey experience stark inequalities in their experience of health and longevity.

### *3.1.2 Birth*

In 2003 there were 3,819 births to women living in Haringey of which 67 were multiple births. The fertility rate of 65.6 births per 1,000 women aged 15 to 44 is higher than that for London (61.2/1000) and England and Wales (57/1000). Local analysis demonstrates that the fertility rate shows considerable variation within the borough, from 56/1000 in the West Network area, 62/1000 in the North East to 72/1000 in the South East (see figure 19).

***Figure 18*** *Life expectancy for males and females in Haringey, London and England (1991/93 to 2001/03)*

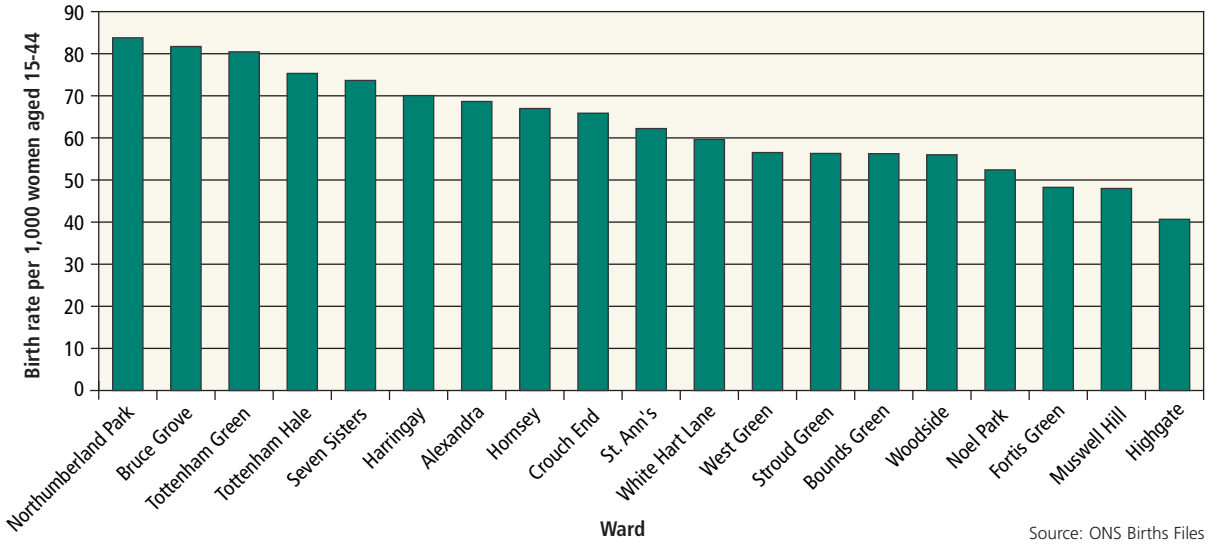



Source: ONS

Increasing use of infertility treatments, including in-vitro fertilisation (IVF) has led to a rise in the multiple pregnancy rate over the past twenty years. In 2003 one third of multiple pregnancies were to women aged 35 years or over in Haringey (see figure 20). In addition to increased assistance in pregnancies amongst this age group, this also reflects the fact that women of this age group are also more likely to have dizygotic (non-identical) twins in an unassisted pregnancy[12].

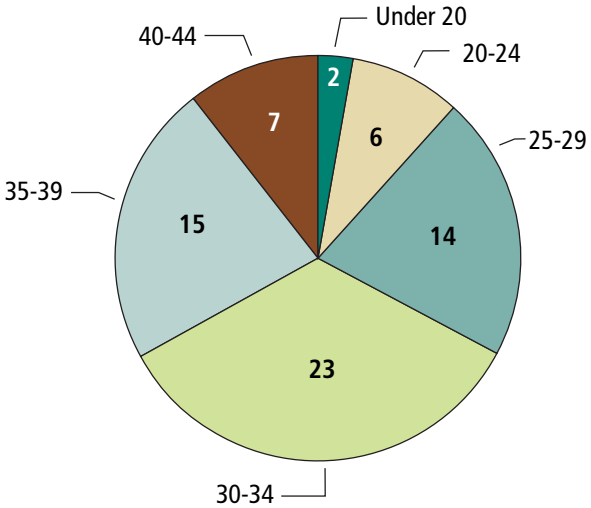
**Birth weight** The birth weight of a baby is determined by growth during pregnancy, and whether or not the baby is delivered prematurely. Children who are born weighing under 2,500 grams are defined as having a low birth weight, and less than 1,500 grams as having a very low birth weight. Low birth weight affects the baby's survival prospects during the first year, and has been linked with learning disabilities and a range of health problems in later life.

***Figure 19*** *Number of births per 1000 women aged 15-44 years by ward, 2003*



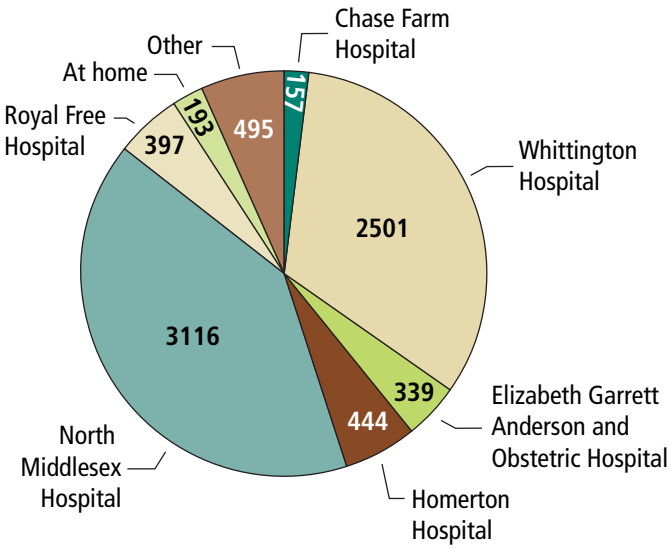

Source: ONS Births Files

***Figure 20*** *Age distribution of women with multiple pregnancies in Haringey, 2003*




Source: ONS birth files

***Figure 21*** *Where women from Haringey gave birth, 2003-2004*



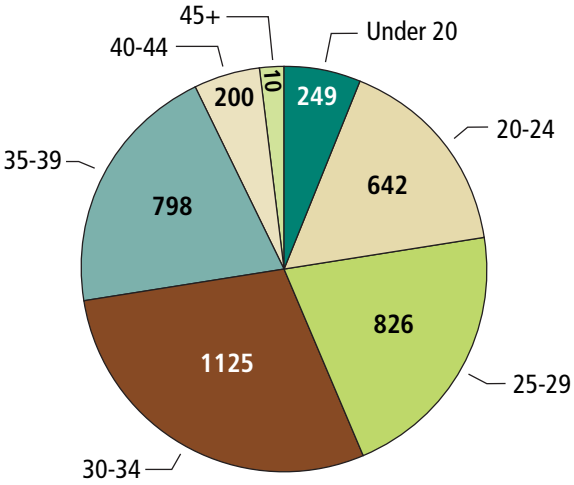

Source: ONS birth files

In 2004, 303 children (8.1%) had a low birth weight and 56 (1.5%) had a very low birth weight, similar to national figures. Again, the proportion of low birth weight babies was higher amongst children born to women living in the South East Network area (9.1%) than North East (7.9%) or West (6.7%). The proportion of very low birth weight babies was 1.5%, 1.7% and 1.2% respectively i.e. slightly higher in the North East.

**Place of birth** The majority of women in 2003 and 2004 delivered their babies in the North Middlesex University Hospital or the Whittington Hospital, with 2.5% delivering their babies at home (see figure 21). National guidance includes recommendations on how to increase the chance of a woman having a vaginal rather than caesarean delivery[13]. Data from the North Middlesex University hospital suggests that one in five women (19%) delivered by caesarean section in 2004-2005, of which 42% were elective (planned). This compares to 22% of deliveries by caesarean in England and Wales, and 24% in London.

**Maternal age** Figure 22 provides the age breakdown of women from Haringey who delivered in 2003. It suggests that while 23% of deliveries were to women aged under 25 years (compared to 26% in England and Wales), 26% were to women aged 35 years and older (compared to 18.5%). The conception rate amongst women aged under 18 is high in Haringey (see chapter 4).

***Figure 22*** *Age distribution of women who gave birth in Haringey, 2003*

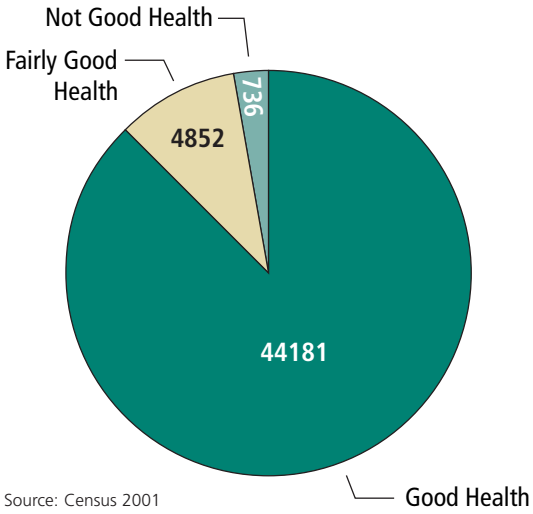



Source: ONS birth files

### *3.1.3 Self-reported health*

In the 2001 Census the overwhelming majority of dependent children aged under 18 rated their health as good or fair, with only 1.5% reporting that their health was not good. The proportion of children reporting that their health was not good was similar across all age groups, and is similar to the response rate for London and England as a whole (see figure 23).

***Figure 23*** *Reported health status of dependent children in Haringey, 2001*



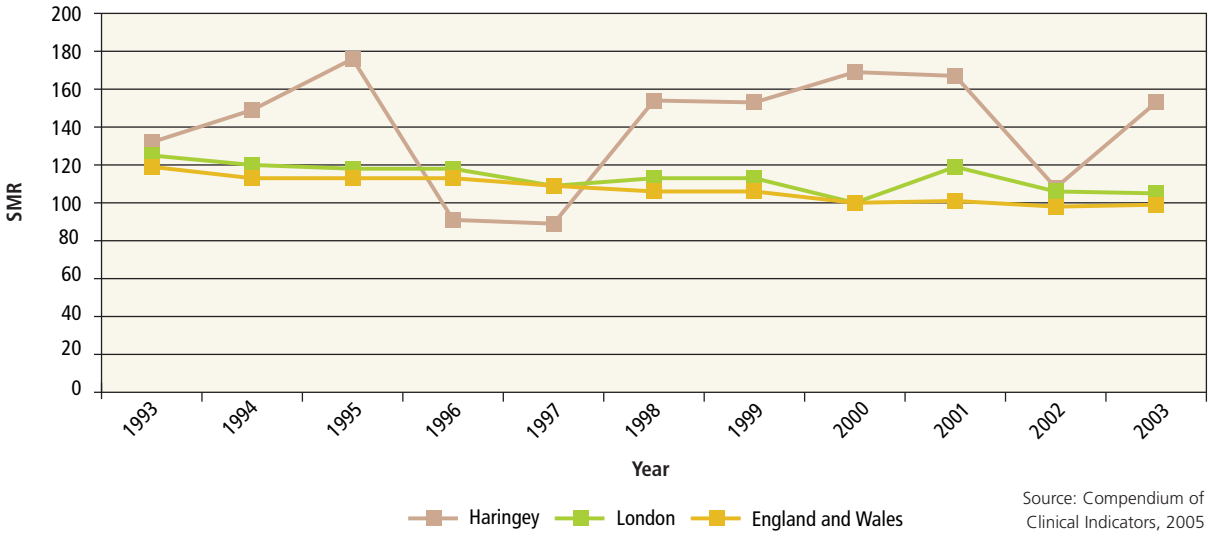

Source: Census 2001

### *3.1.4 Deaths in infancy and childhood*

One hundred children and young people aged under 24 died in Haringey in 2003-04. The 2003 Haringey Health Report showed that the death rate for children aged under 15 remained above that of London and England and Wales for much of the eight years up to 2001. Despite a dip in 2002, the rate in 2003 was one and a half times the death rate for England and Wales, with a Standardised Mortality Ratio (SMR[b]) of just over 150 (see figure 24).

Deaths amongst children in the first 28 days of life make up a significant proportion of child deaths nationally. In Haringey they accounted for 30% of all deaths in people aged under 25 years in 2003. Although the number of deaths is small, the death rate was higher amongst boys than girls. Figure 25 compares early death rates in Haringey with those of London and England in 2003.

***Figure 24*** *All Cause SMR for under 15s, 1993-2003*




Source: Compendium of Clinical Indicators, 2005

[b] The SMR[b] in this case is a standardised ratio comparing the observed annual all-cause mortality rates in Haringey / London / England and Wales amongst under 15s with the all-cause mortality rate for England and Wales in 2003. An SMR of 100 would indicate that the standardised mortality rate in an observed population was the same as that for England and Wales in 2003, a figure over 100 indicating that the observed mortality rate was higher than that for England and Wales in 2003.

***Figure 25*** *Comparison of early years death rates by sex and area, 2003*

| | Haringey | | | London | England |
|---|---|---|---|---|---|
| | **Boys** | **Girls** | **All** | | |
| Stillbirth rate (still births per 1000 total births) | 10.0 | 7.0 | 8.5 | 6.5 | 5.6 |
| Perinatal death rate (infant deaths under 7 days per 1000 births) | 14.7 | 8.1 | 11.4 | 9.3 | 8.3 |
| Neonatal death rate (infant deaths under 28 days per 1000 live births) | 6.4 | 1.1 | 3.8 | 3.6 | 3.6 |
| Infant death rate (infant deaths under 52 weeks per 1000 live births) | 7.9 | 2.7 | 5.4 | 5.6 | 5.3 |

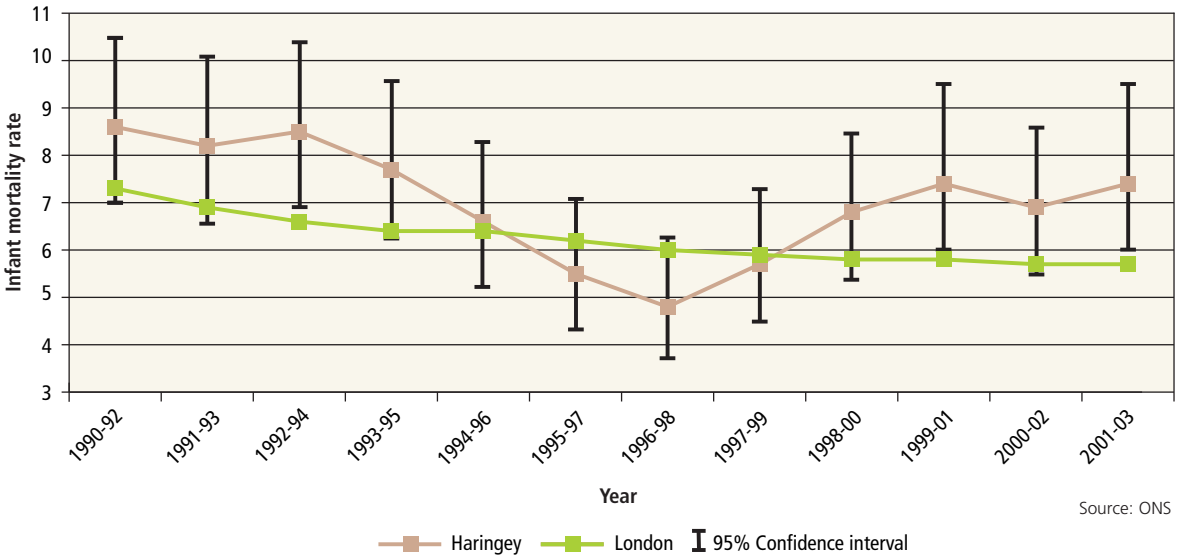
Source: ONS 2003

Previous analysis shows that the rate of infant deaths (in the first year of life) in Haringey has been higher than that of London and England for much of the past decade, making a significant contribution to the high SMR in Haringey[6]. Nearly two thirds (61%) of all deaths in people aged under 24 occurred amongst children aged under one year in 2003. When infant mortality rates are compared across the borough, deprived wards have higher infant death rates than the least deprived wards, although the small number of deaths means the difference in infant death rates is not statistically significant.

A plan to reduce inequalities in infant mortality in Haringey was developed in 2004, and is now being implemented, focusing on reducing smoking, improving antenatal and postnatal care, teenage pregnancy, education, income and employment, and social support[14].

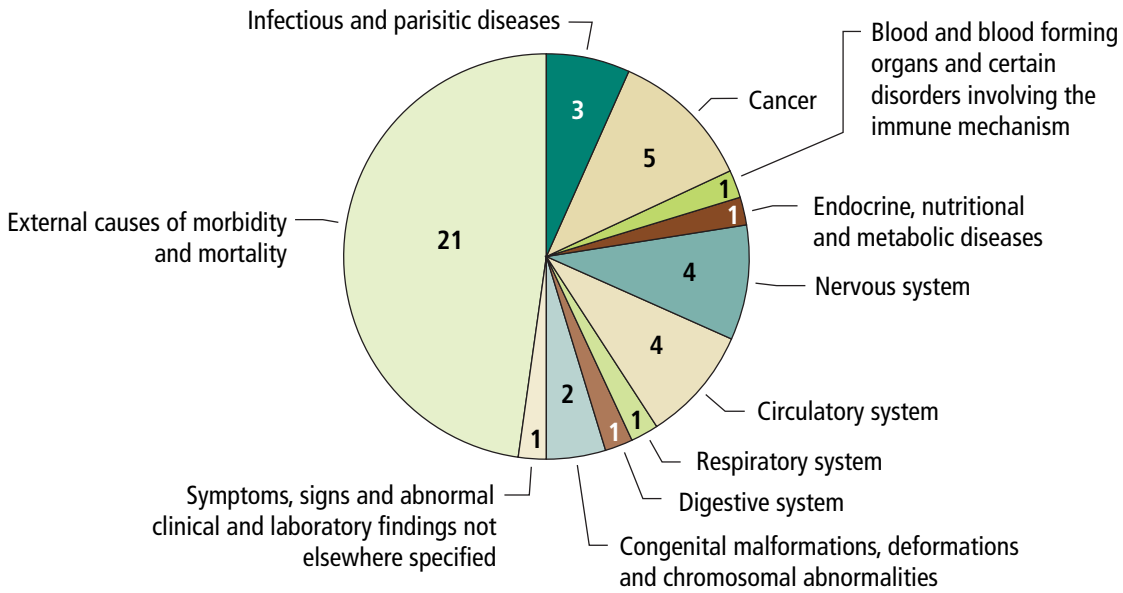
The incidence of cot deaths or SIDS (sudden infant death syndrome) has decreased nationally since the late 1980's. This has largely been attributed to campaigns to encourage parents to put their baby to sleep on their back e.g. 'Back

***Figure 26*** *Infant mortality in Haringey and London, 3 year rolling average, 1990/92-2001/03*




Source: ONS

***Figure 27*** *Cause of death in people aged under 25 in Haringey, 2002-2003*




Source: ONS death files 2002-2003

to Sleep', and to avoid smoking near the baby.

Figure 27 summarises the main causes of death amongst people aged 1-25 years in Haringey in 2002 and 2003. External causes of morbidity and mortality accounted for 21 out of the 44 deaths, of which accidents and injuries, including assaults, accounted for 15 deaths. In addition, there were 4 deaths due to intentional self-harm. These deaths may be considered to be avoidable, and identification of measures to reduce the number of deaths caused by injury, assault and self-harm will be a focus for the action plan to reduce inequalities in life expectancy currently being developed within the Haringey Strategic Partnership.

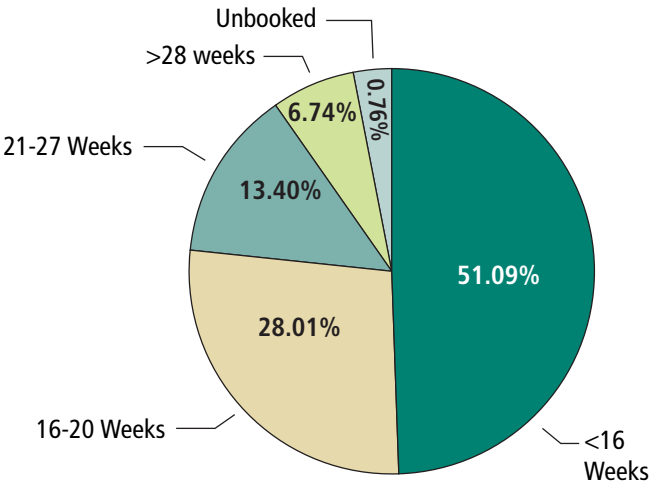
## 3.2 A healthy start

**Preconception** Having a healthy diet, taking regular exercise, stopping smoking and cutting back on alcohol all increase the chance of a women becoming pregnant, and having a healthy pregnancy and baby. Women can also review any medication they take with their GP, check that they are immune to rubella (German measles), and increase their intake of folic acid.

**Antenatal care** Maternity services invite women to get in touch with them early in the pregnancy for a first appointment or booking for antenatal care. They can help women maintain a healthy lifestyle in pregnancy, advise on and treat complications that may arise, and provide assessments or screening to detect diseases, anomalies or disorders that may affect the pregnancy or baby.

Early booking for maternity care is important as many screening tests and assessments should be undertaken before the 16th week of pregnancy. A study of women from Haringey who delivered at the Whittington Hospital Trust in 2003 found that only 51% of women had booked for antenatal care before 16 weeks (see figure 28). It also suggested a higher prevalence of social and/or psychiatric problems amongst women who booked late[15].

***Figure 28*** *Gestational age at first booking at The Whittington Hospital, 2003*




Source: Whittington Hospital, 2003

**Smoking during pregnancy** Smoking affects the health of the mother and baby. It can impact on birth-weight, still birth, cot death and respiratory problems in childhood. Pregnant women who smoke are also more likely to experience complications in pregnancy and labour. Reducing the number of women who smoke during pregnancy is a key target nationally[16]. Helping women to give up smoking before or when they are pregnant, and helping partners/ other household members to quit to protect children from exposure to environmental tobacco smoke (passive smoking), are important.

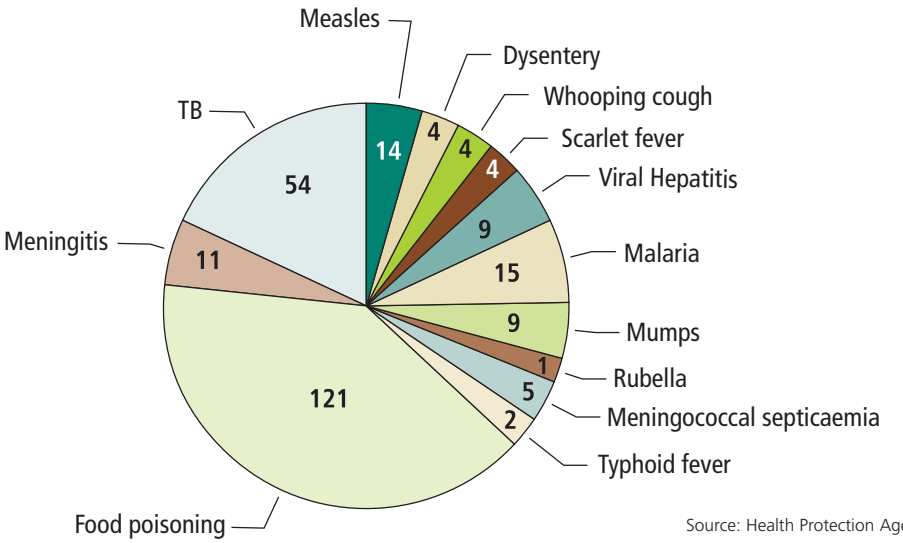
### Domestic violence in pregnancy

It is estimated that one in three women experience domestic violence at some point in their lives, and that about 30% of domestic violence starts during pregnancy[17]. A violent pregnancy places the mother and child at risk, and may occur in as many as 17% of pregnancies in England[18].

## 3.3 Protection from infectious disease

There were 257 notifications of infectious disease amongst under 18s between 2002 and 2004, or 5.2 notifications per 1,000 (see figure 29). Nearly half of these were cases of food poisoning, of which 71% were notified in children aged 4 years and under, with 14 emergency admissions to hospital for gastroenteritis amongst children under 18 in this time period. There were 54 TB notifications over the three years, or 1 per 1,000 children aged 0-18, making up 21% of all notifications in this age group. It should be noted that not all notified cases are subsequently confirmed by a laboratory. Therefore these figures may not represent the true picture of infectious disease in Haringey.

***Figure 29*** *Infectious disease notifications in children aged under 18 years, 2002-2003*




Source: Health Protection Agency

***Figure 30*** *Childhood immunisation schedule*

| When immunisation is given | What is given | How it is given |
|---|---|---|
| 2, 3 and 4 months old | Diptheria, tetanus, pertussis (whooping cough), polio and Hib<br>Meningitis C | 1 injection<br>1 injection |
| Around 13 months old | Measles, mumps and rubella (MMR) | 1 injection |
| 3 years and 4 months to 5 years old | Diptheria, tetanus, pertussis (whooping cough) and polio<br>Measles, mumps and rubella (MMR) | 1 injection<br>1 injection |
| 13 to 18 years old | Diptheria, tetanus and polio | 1 injection |

Source: www.immunisation.nhs.uk

Immunisation can protect children from some infectious diseases, which may cause serious symptoms, disability or even death. The current recommended immunisation schedule for children is set out in figure 30. BCG immunisation was removed from the routine schedule in 2005, and will now only be offered to babies and older people who are most likely to catch the disease, especially in those living in areas with a high rate of TB or whose parents or grandparents were born in a country with high prevalence. Therefore all newborn babies in Haringey will be offered BCG.

The 2003 Haringey Health Report identified poor immunisation coverage amongst children in Haringey. This has improved slightly, although coverage still falls far short of that required to protect children from outbreaks of infectious disease, particularly for measles, mumps and rubella (MMR) for which only 59% of 5 year olds in Haringey have received their 1st and 2nd dose. Reduced coverage has already led to outbreaks of measles and mumps in parts of London, including cases in Haringey.

## 3.4 Long-term ill health

For children with long-term health problems the aim of treatment and care is to manage their illness in a way that enables them to enjoy and achieve fulfilled lives. Over 2,230 (4.5%) dependent children aged under 18 were reported to have a limiting long-term illness in the last Census, 2001. Data are not currently available on the prevalence of particular conditions amongst children in Haringey, but may become available as GPs develop disease registers in their practices.

***Figure 31*** *Percentage (%) of children immunised by their 2nd birthday, 2003/04*

| Area | Diptheria | Tetanus | Pertussis | Polio | Hib | MMR | Men C |
|---|---|---|---|---|---|---|---|
| National target | 95 | 95 | 95 | 95 | 95 | 95 | 95 |
| Haringey | **87** | **87** | **87** | **87** | **87** | **72** | **85** |
| London | 88 | 88 | 88 | 88 | 88 | 70 | 86 |
| England | 94 | 94 | 93 | 94 | 94 | 80 | 94 |

Source: NHS immunisation statistics England, 2003/04, Department of Health, 2004

Children with long-term conditions and their carers may require tailored support to enable them to treat or manage their condition, thereby avoiding deterioration in their health and well-being and the need for admission to hospital. Support is also required to meet their emotional, developmental and educational needs. Primary care services play a very important role in helping children and families manage conditions such as asthma, diabetes, epilepsy, sickle cell and thalasaemia, which were the cause of a significant number of admissions/ emergency admissions to hospital amongst under 18s in Haringey. In 2003 in Haringey there were 117 emergency admissions for haemo-globinopathies and no deaths, 102 admissions and 92 emergency admissions for asthma and no deaths, 35 emergency admissions for epilepsy and 1 death, and 14 emergency admissions for diabetes and no deaths.

## 3.5 Mental health

The 2004 Haringey Health Report highlighted that a significant number of children and young people may be experiencing mental health problems in Haringey, but that their needs may not be identified. It also highlighted the lack of useful data and information on the mental health of children and young people in Haringey. Early identification and intervention for children with mental health problems is crucial in preventing a cycle of ill health and social exclusion for these children.

There is evidence to suggest that many forms of mental health problems in young people are becoming more frequent nationally[19]. For example, there has been an increase in emotional problems and conduct disorders[20] amongst adolescents

***Figure 32*** *Estimated prevalence of mental health disorders amongst children in Haringey*

| Mental health disorder | National prevalence/ Estimated numbers affected in Haringey | 5-10 year olds | 11-15 year olds | 5-15 year olds |
|---|---|---|---|---|
| | Population size (GLA 2005) | 16325 | 13469 | 29794 |
| Emotional disorders | National Prevalence %<br>Haringey (Total) | 3.3<br>539 | 5.6<br>754 | 4.3<br>1281 |
| Anxiety | National Prevalence %<br>Haringey (Total) | 3.1<br>506 | 4.6<br>620 | 3.8<br>1132 |
| Depression | National Prevalence %<br>Haringey (Total) | 0.2<br>33 | 1.8<br>242 | 0.9<br>268 |
| Conduct disorders | National Prevalence %<br>Haringey (Total) | 4.6<br>751 | 6.2<br>835 | 5.3<br>1579 |
| Hyperkinetic disorders | National Prevalence %<br>Haringey (Total) | 1.5<br>245 | 1.4<br>189 | 1.4<br>417 |
| Less common disorders | National Prevalence %<br>Haringey (Total) | 0.5<br>82 | 0.6<br>81 | 0.5<br>149 |
| Any mental health disorder | National Prevalence %<br>Haringey (Total) | 8.2<br>1339 | 11.2<br>1509 | 9.5<br>2830 |

Source: Mental health of children and adolescents in Great Britain – Office for National Statistics 1999

over the last 20-25 years. A number of possible explanations have been put forward for this increase including educational experience and future expectations, changes in the family context and parenting, and changes in the social situation. Figure 32 estimates the prevalence of a range of mental health conditions amongst children in Haringey.

The mental health of young people is closely intertwined with their physical and overall health and the environment in which they live. Certain factors may predispose the development of emotional and behavioural disorders in young people or may act to perpetuate existing problems[8]. The risk factors fall into four main groups; child, family, environment and life events. Some of these risk factors interact, therefore increasing the risk of mental health problems for some young people. There are high rates of many of these risk factors in Haringey which could in turn lead to higher rates of mental ill-health than the national estimates would suggest.

In many cases mental illness which first presents in childhood or adolescence persists into adult life, leading to a burden of suffering and the need for on-going care. Early identification of people in distress, establishment of an early and accurate diagnosis, and prompt and effective treatment is a key approach to reducing the impact of emotional disorders. There is also good evidence of the beneficial potential of early years and school settings for children's mental well-being. Work to promote mental health must encompass the range of needs as children grow up, as some disorders are more likely to emerge in the teenage years e.g. psychoses, eating disorders and self-harm[5].

## 3.6 Children and young people with disabilities

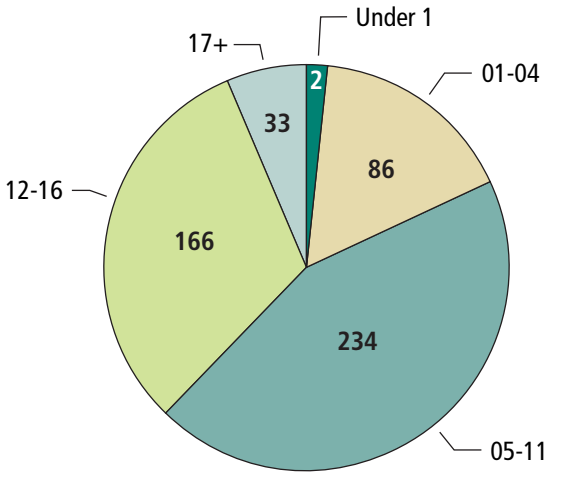
Children and young people with disabilities are a diverse group including those with physical impairments, learning difficulties, sensory impairments, and emotional/ behavioural difficulties. Some may have multiple disabilities or a long-term health condition requiring on-going management and/or nursing care. Their quality of life is determined not only by their disability, but by poverty, negative attitudes and discrimination, and a disabling environment in which they may have unequal access to education, employment, leisure etc.

The Children's National Service Framework identifies the particular needs of children and young people with disabilities. It also highlights the absence of evidence on the effectiveness of interventions in improving outcomes. It highlights the importance of promoting social inclusion, intervening early to support children and families, safeguarding particularly vulnerable children, and supporting the transition to adulthood[5]. It also raises the importance of appropriate palliative care for children with disabilities, including those with complex health needs.

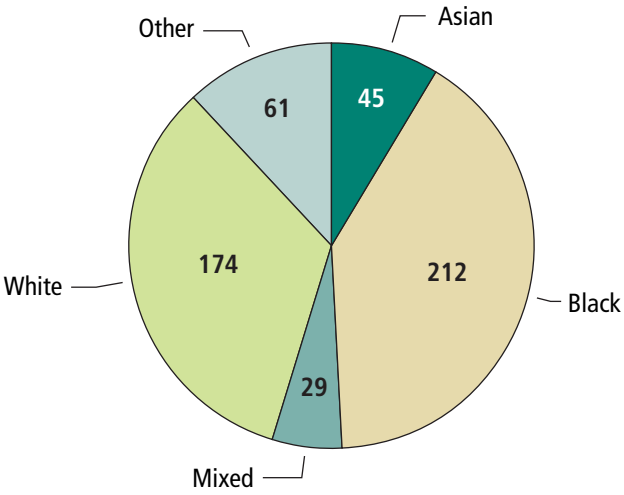
Comprehensive information on the range of children with disabilities living in Haringey is not readily available. There were 521 children with disabilities on the voluntary register with Haringey Council as of August 2005. Figures 33a and 33b set out the age and ethnicity profile of these children and young people. They suggest that a disproportionately high number of children from primary schools and black ethnic groups are registered with Haringey Council. The majority of children were registered with a learning, communication or behavioural disability (see figure 33c).

***Figure 33*** *Age, ethnicity and disability profile of children with disabilities registered with Haringey Council, August 2005*

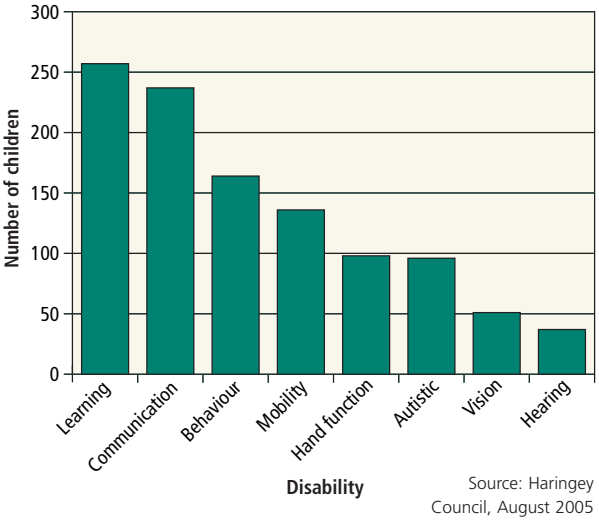
**33a Age distribution, under 25 years**




**33b Ethnicity**




**33c Type of disability**




Source: Haringey Council, August 2005

## 3.7 Need for health treatment and care services

Children and young people may need to access health services for a number of reasons, including routine care and surveillance, management of emerging and long-term conditions, and in cases where emergency treatment and care is required. Universal and targeted services are provided by the child's general practitioner, midwife, health visitor, and school health nurse. Children and young people may also require specialist services, such as those provided by therapists or through Great Ormond Street and other hospitals. In addition, they may access health services through the Walk-in Centre at the North Middlesex University Hospital, or through an Accident and Emergency Department.

Children and young people with complex healthcare needs often require cross-agency support involving a number of professionals. Good practice in joint working for such families includes the following components[5]:

- Child/ family-centred services
- Strong partnerships with families
- A single pathway for families e.g. via a key worker
- Multi-agency working, involving joint funding and delivery
- Commitment from services/professionals

### *3.7.1 Planned admission to hospital*

Between 2001 and 2004 a total of 3,008 children aged under 19 years were admitted to hospital for planned treatment and care i.e. an elective admission rather than an emergency admission. The average annual rate of planned admission to hospital in this period was 13.9 admissions per 1000 people aged under 19 years per year, ranging from 10.9/1000/year amongst 19-24 year olds to 15.1/1000/year amongst 5-11 year olds. The majority of planned admissions (72%) were

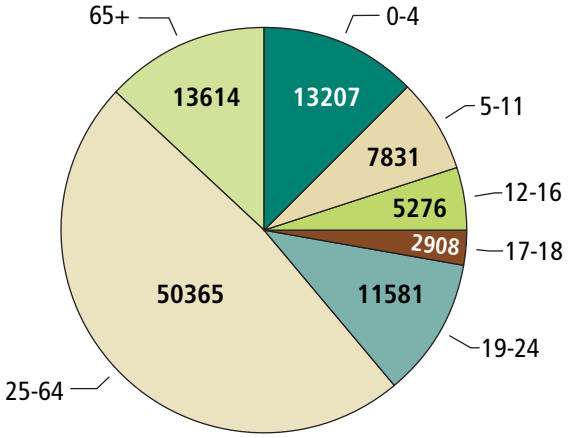
to surgical specialities, the largest proportion of these being ear nose and throat (35%), urology (9%), and trauma and orthopaedics (8%). Medical specialities accounted for a further 25% of total planned admissions.

### *3.7.2 Unplanned care*

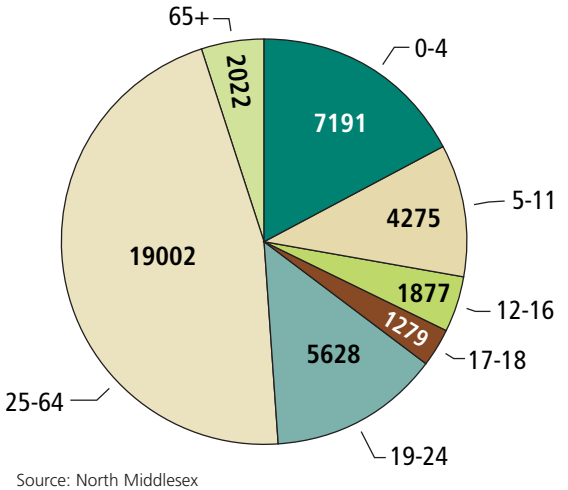
Between April 2004 and March 2005 there were approximately 104,800 attendances at the North Middlesex University Hospital accident and emergency department, of which 28% were children aged under 18 and 11% were aged 19-24 years (see figure 34a). This compares to 41,300 attendances at the North Middlesex Walk-in Centre, providing unscheduled health care services and located next to the A&E department, of which 35% were children aged under 18 and 14% were aged 19-24 years (see figure 34b). It should be noted that data are not available to confirm how many of the children and young people attending these services live outside Haringey, or the number of children and young people living in Haringey attending services provided in other settings.

***Figure 34*** *Age profile of people attending North Middlesex A&E department and Walk-in Centre, 2004/05*

**34a North Middlesex A&E Department**




**34b North Middlesex Walk-in Centre**




Source: North Middlesex University Hospital

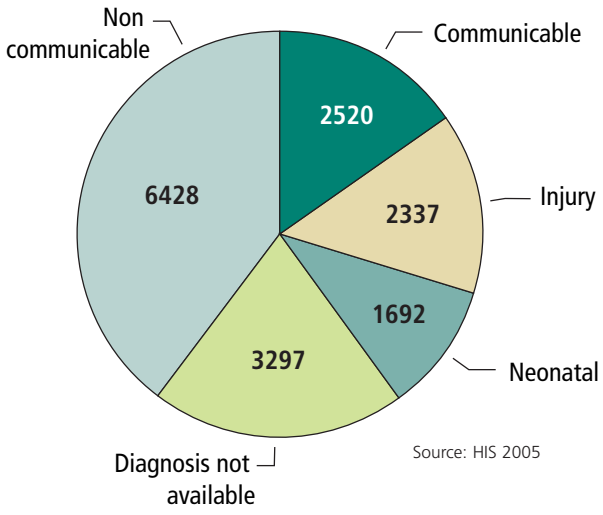
### *3.7.3 Emergency admission to hospital*

The rate of emergency admission to hospital for children and young people varied considerably between different age groups between 2001 and 2004. Overall there were 85 emergency admissions per 1000 0-18 year olds over the four years. The highest rate was observed amongst 0-4 year olds (182 emergency admissions per 1000), the rate falling dramatically amongst 5-11 and 12-16 year olds, then rising again amongst 17-24 year olds, reflecting increasing numbers of admissions for pregnancy complications and accidents/injury amongst young people.

Figure 35 identifies the cause of emergency admissions in 2001-2004 in broad categories, excluding all admissions related to pregnancy.

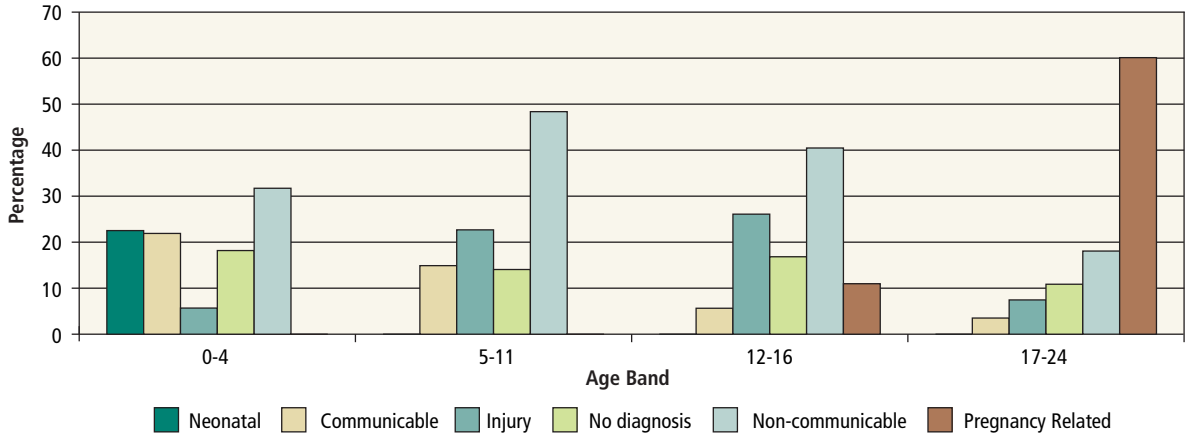
***Figure 35*** *Number of emergency admissions in Haringey aged under 25 by cause, 2001-2004*

Note: excludes all pregnancy related admissions




Source: HIS 2005

***Figure 36*** *Proportion of emergency admissions by cause and age, 2001-2004*




Source: HIS 2005

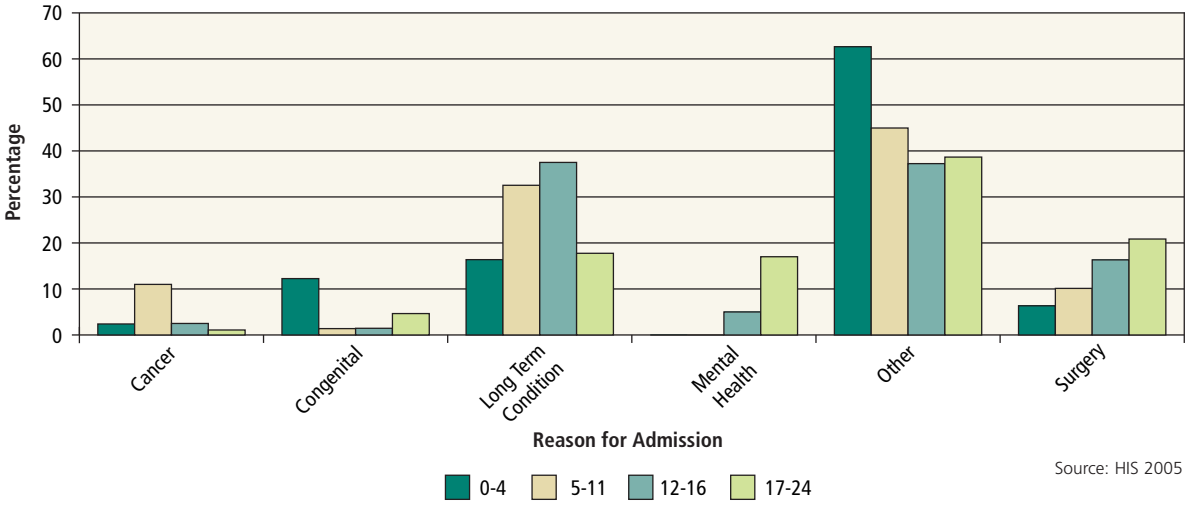
It highlights that over one fifth of these admissions were not associated with a recorded diagnosis, and that two fifths were for non-communicable diseases.

Figure 36 identifies how the cause of admission varies by age, including pregnancy related causes. A significant proportion of emergency admissions in 2001-2004 were for communicable disease, most importantly in the under 5s, mainly due to gastrointestinal and respiratory tract infections. Emergency admissions due to communicable diseases reduce in later childhood.

Injuries accounted for 14% of all emergency admissions including accidents and poisoning. Wounds, fractures, foreign bodies and burns were the most frequently recorded injuries amongst children aged under 12. This pattern changes in adolescents and young adults, with fractures and self-harm becoming the most common cause of injury. Over 10% of unplanned admissions were related to pregnancy in 12-16 year olds, increasing to over 60% in the older teenagers and young adults.

Figure 37 identifies the cause of emergency admissions for non-communicable diseases by age group. It shows that congenital disorders remain an important cause of emergency admission (including haemoglobinopathies), and illustrates the onset of mental health problems amongst children aged 12 to 16.

***Figure 37*** *Proportion of emergency admissions for non-communicable disease by age, 2001-2004*




Source: HIS 2005

# 4. Establishing and maintaining a healthy life

**Key messages:**

- The behaviours and lifestyles of children, young people and their families will impact on their health throughout their lives.
- There is limited information available to assess the extent to which children in Haringey are adopting healthy patterns of behaviour.
- Children, young people and their families should be supported and empowered to make healthier choices.

## 4.1 Physical activity

**Children should undertake at least 60 minutes of moderate intensive physical activity each day, and at least twice a week this should include activities to improve bone health, muscle strength and flexibility.**

Establishing patterns of physical activity at an early age and throughout childhood make an important contribution to healthy growth and development affecting the child's future health as an adult. Children who are physically active are more likely to be active adults. Regular physical activity, in conjunction with a balanced diet, helps to maintain a healthy body weight. It helps to prevent long-term conditions, such as cardiovascular disease and diabetes, and some cancers. Physical activity also develops social skills through peer relationships, creative and emotional intelligence, and self-esteem.

Boys tend to be more physically active than girls, but in both sexes physical activity declines rapidly with age. Nearly 3 in 10 boys and 4 in 10 girls are not sufficiently active at levels to confer health benefits[21], although nationally, between 1997 and 2002 there was a 9% and 14% increase in the number of boys and girls respectively taking part in 30 minutes or more of physical activity per day. This would suggest that nearly 6,000 boys and 8,000 girls aged 2-15 in Haringey are not meeting the recommended guidelines for physical activity.

Physical inactivity is contributing to the increase in obesity amongst children. Sport and leisure, play, and journeys to school/work all provide opportunities for children and young people to be physically active. There is evidence to suggest that amongst adolescents, walking to school is associated with a greater accumulation of moderate to vigorous physical activity per day compared to those who travel by transport[22]. Walking to school may also affect overall physical activity in children.

A number of initiatives have been developed to promote physical activity for children and

young people. For example, 32 Haringey schools have developed School Travel Plans to facilitate healthier, safer and greener ways to travel to school. Resources will be used to fund cycle storage, lockers, paths, improved lighting, and pedestrian waiting areas. Additionally, two Walking Bus coordinators have been employed to encourage children and young people to walk to school safely.

## 4.2 Food and Nutrition

**Children and young people should follow the Balance of Good Health[23] recommendations for healthy eating, including at least five portions of fruit and vegetables a day.**

A healthy and balanced diet is one that provides sufficient energy and nutrients to prevent deficiency but also to help to maintain a healthy body weight, enhance general well-being and reduce the risk of a number of diseases including heart disease, stroke, cancer, diabetes and osteoporosis. Breastfeeding is the best nutrition for infants and is associated with better health outcomes for mother and infant.

Most children in the UK eat too much fat, added sugars and salt. Fruit and vegetable intake amongst children and adolescents is low[24], resulting in a low intake of important nutrients amongst 11-18 years olds such as vitamin A, iron, calcium, potassium, zinc and riboflavin. Children on average eat only 2 of the recommended 5 portions of fruit and vegetables a day, with children from lower socio-economic groups eating 50% less fruit and vegetables than those from higher social groups[25].

The Health Survey for England 2002 reported that one in six boys and girls aged 2-15 years was obese (16.6% and 16.7% respectively). In the absence of local data, this suggests that nearly 3,280 boys and 3,215 girls are obese in Haringey. In addition, 2,691 (13.6%) boys and 2,753 (14.3%) girls are likely to be overweight. The Government has set a national target to reduce the year on year increase in obesity in children under 11 by 2010. This is to be achieved in the context of a broader strategy to tackle obesity in the population as a whole.

Various school-based initiatives have been developed to encourage healthier eating. For example, the 5 a Day programme aims to increase fruit and vegetable consumption through increased awareness of the health benefits and improved access. In Haringey all 4-6 year old children in infant and primary schools are entitled to a free piece of fruit or vegetable each school day[26]. Good quality school meals can also make an important contribution.

It is recognised that children who eat breakfast concentrate and perform better during the morning than children who do not. Breakfast clubs are currently offered by 27 Haringey schools (26 primary, 1 secondary). The clubs target pupils who tend to arrive to school early, those who do not normally get breakfast at home, and those who rely on unhealthy drinks and snacks. Work is also underway with nurseries to promote healthy eating.

## 4.3 Oral Health

**Children and young people should brush twice a day with a flouride toothpaste, avoiding food and drinks containing sugar except at meal times.**

Dental caries (tooth decay) is one of the most prevalent diseases in children and young people, despite enormous improvements in children's dental health. Poor oral health affects quality of life, causing pain and embarrassment, and limits function.

The main threats to oral health are tooth decay, dental erosion, gum disease and unintentional injury. Oral health is affected by diet, hygiene, smoking, exposure to fluoride and access to health care.

National targets for oral health in 5 year olds aim for no more than one decayed, missing or filled tooth, with 70% of 5 year olds having no decay experience. Epidemiological surveys highlight disparities between boroughs and within localities. Over one third of London's 5 year olds have active tooth decay, and inner London has some of the worst levels of decay in England and Wales.

One third of 5 year olds in Haringey had experienced dental decay as of 2003[27], fewer than the UK average of nearly 40%. Those attending schools in Haringey had on average 0.66 decayed, missing or filled teeth[28], which was a slight decrease form 2001/02, and compared favourably to the London average of 0.87. However, inequalities in oral health are evident when comparing different schools, with the average level of tooth decay being nearly four times higher in some schools than the Haringey average (e.g. 2.39 in Noel Park). Registering children at risk of tooth decay with a dentist is a key priority. The Haringey Sure Start tiny teeth programme has increased the number of 0-2s registered with a dentist from 8% to 67%.

National data from 2003 suggested that the oral hygiene of teenagers in general, and boys in particular, was getting worse. The number of 15 year olds with accidentally damaged incisors had decreased slightly to 13%, and was more common amongst boys. The survey also identified a slightly larger proportion of 15 year olds in schools in deprived areas with unmet orthodontic need (25%) compared with schools in less deprived areas (21%).

## 4.4 Smoking

**Children and young people should be supported to not start smoking, and to quit if they do. They also need to be protected from second hand smoke in public places (through smokefree policies) and their home (by supporting adults to quit).**

Smoking contributes to the development of cancer, heart disease, bronchitis, strokes and many other diseases. It also has direct impacts on children exposed to tobacco smoke, contributing to low birth weight and sudden infant death syndrome, middle ear infections, asthma and respiratory tract illness[29]. Most smokers start smoking as teenagers. It is estimated that 450 children in the UK start smoking every day, with the number increasing in recent years.

A survey commissioned by SmokeFree London[30] reported that 11% of 11-15 year old children in London smoke regularly (defined as usually smoking one or two cigarettes a week). Girls were more likely to be regular smokers than boys (12% of girls compared to 9% of boys). Smoking increases sharply with age: 2% of 12 year olds are regular smokers compared to 25% of 15 year olds. The proportion of smokers is higher amongst lower socio-economic groups, and tobacco is an important determinant of inequalities in health. It is therefore very important that children should be enabled to not start smoking.

Children are also exposed to second-hand smoke from family or friends, over which they have little control. Prolonged exposure to second-hand smoke contributes to the development of cancer and heart disease and a number of other health problems in children. It is estimated that each year approximately 17,000 children aged under 5

are hospitalised with conditions caused by smoke from people smoking in their household[31]. Smoking and exposure to second-hand tobacco smoke during pregnancy can lead to adverse health effects in both the mother and baby.

There is little evidence of effective interventions in preventing young people taking up smoking. The Haringey Stop Smoking service helps about 6 people aged under 18 each year to quit smoking, indicating that few young people are accessing the service.

Tackling adult smoking may reduce the likelihood of children taking up smoking, and protect unborn children and reduce children's exposure to second-hand tobacco smoke. The designation of smoke free public areas will also protect children's health by reducing their exposure to second-hand tobacco smoke, and provide a supportive environment for their parents and carers to give up smoking.

## 4.5 Substance misuse

**Substance misuse can be associated with a range of negative health outcomes, including accidents/injuries and transmission of infectious diseases.**

Illicit drug use has increased since the 1970s, particularly amongst young people, increasing their risk of long-term illness (including blood borne infections) and accidental injury. The Government has set targets to reduce drug use amongst children and young people[32], and local strategies for tackling drug misuse amongst young people have led to a number of initiatives to provide education on drug use and offer advice on prevention.

A 2004 survey of drug use by young people[33] suggests a rapid increase in the proportion of young people ever having taken drugs from 5% of 11 year olds to 32% of 15 year olds. Young people were far more likely to take cannabis than any other drug. Cannabis use is higher among boys (12%) than girls (10%) aged 11-15 years, and increases with age (1% of 11 year olds compared with 26% of 15 year olds having taken the drug in the last year). The use of Class A drugs (4%) has remained stable since 2001. Just over one third (36%) of pupils had ever been offered one or more drugs, down from 42% in 2003, with boys more likely to be offered drugs than girls.

## 4.6 Alcohol

**National and local policy should reduce the harm caused by alcohol, ensuring that children and young people drink sensibly.**

Alcohol is a prominent feature of many young people's lives, and children and young people experiment with and use alcohol in ways that may lead to them taking unnecessary risks, leading to possible illness, injury or even death.

A national survey of secondary school children aged 11-15 years[33] suggest that nearly a quarter of pupils had drunk alcohol in the previous week, rising from 4% of 11year olds to 45% of 15 year olds. The average weekly consumption among pupils who drink has risen to 10.7 units, with little difference between boys and girls- indicating an increase in the number of girls who drink, and the average number of units they consume.

There is little evidence for a safe limit of alcohol consumption, particularly for children and young adolescents. Many children are also victims of the consequences of drinking by others, especially family members. Alcohol-related harm may include injuries and accidents, absenteeism, underperformance,

child neglect and family breakdown, anti-social and nuisance behaviour, stranger or domestic violence, and risk taking such as unsafe sex or substance misuse.

The Health Council of the European Union has expressed concerns about young people's drinking[34], particularly binge drinking, significant unsupervised alcohol consumption outside the family at an earlier age, increasing consumption by young girls, and a trend of consuming alcohol with other drugs.

The National Alcohol Harm Reduction Strategy (2004) outlines the Government's commitment to improving alcohol education in schools to address attitudes and behaviour as well as providing information. The Strategy also promised action to reduce alcohol-related crime and disorder by reducing sales to under 18s and ensuring full use is made of existing powers to deal with under-age drinking and anti-social behaviour. A Haringey Alcohol strategy was adopted in 2005.

The Haringey Drugs and Alcohol Action Team[35] aims to raise awareness of the risks of drugs and alcohol misuse, increasing the early identification of related problems and improving treatment and support services. It is also involved in efforts to reduce crime and anti-social behaviour.

## 4.7 Sexual Health

**Young people are at particular and increasing risk of sexually transmitted infections.**

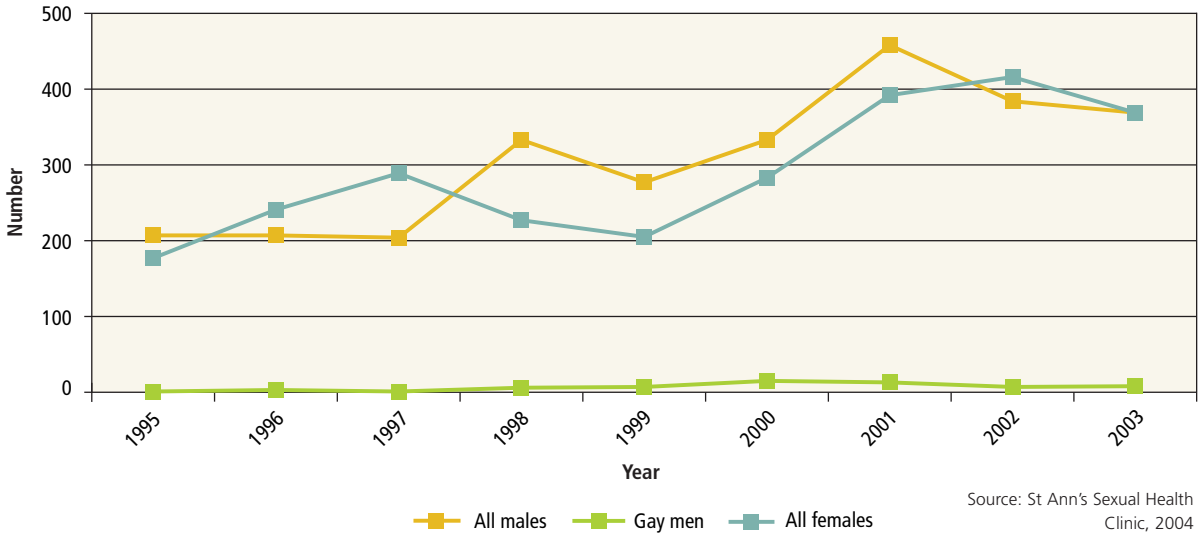
Surveys suggest that young people are becoming sexually active at an earlier age[36]. Young people who are becoming sexually active may be particularly vulnerable to sexual ill-health, including unwanted pregnancy or abortion, and exposure to sexually transmitted infections (STIs) and HIV. Protecting the sexual health of young people is a key national priority[37].

There has been an increase in the number of people attending sexual health (GUM) clinics in London in recent years, and in the diagnosis of sexually transmitted infections (STIs). This upward trend in STIs amongst young people has been observed since the mid 1990s, and is higher amongst young women than young men. This upwards trend has been observed in sexual health clinics and community health services, and disproportionately affects young Londoners[38]. The largest increase in diagnoses has been for the bacterial STIs gonorrhoea and chlamydia, which in London increased by one third and two thirds respectively amongst people aged under 25 years between 1999 and 2003. HIV infections are also increasing; with half of all HIV positive young people in England aged under 25 seeking treatment in 2003 living in London.

The burden of sexually transmitted infections falls unequally in the population, with the increase in STIs and HIV having a disproportionate impact on some minority communities. For example, while approximately one in twenty Londoners comes from a (black) African community, this community represents more than one in three Londoners living with HIV in 2003. Vaccination against Hepatitis B should be routinely offered to young gay men who may be particularly at risk.

**Chlamydia:** Between 1996 and 2002, there was a marked increase in the number of Chlamydia infections diagnosed in Haringey, up 141%. An opportunistic Chlamydia screening programme targeting young people is being developed in Haringey. The highest rates of Chlamydia were seen among females aged between 16 and 19

***Figure 38*** *Number of Chlamydia infections identified at St Ann's Sexual Health Centre, 1995-2003*




Source: St Ann's Sexual Health Clinic, 2004

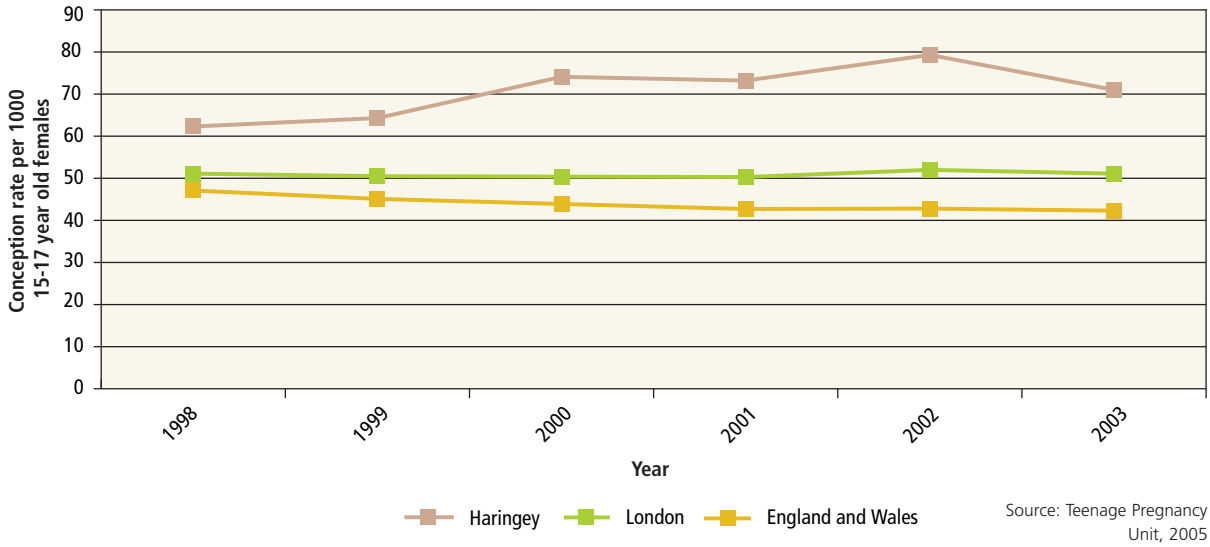
years, and young women aged under 20 years accounted for 39% of all Chlamydia diagnoses. The screening programme operates from 14 community settings and is soon to start in the North Middlesex Hospital Antenatal Clinic. From January to July 2005, 1 in 8 of the 113 screens were positive, compared to 1 in 13 of the screens amongst women aged under 18 years. No men were screened in this period, although a service is being developed at the College of North East London.

## 4.8 Teenage pregnancy

### Teenage pregnancy can have long term health implications for the mother and child

In 1999 the Government launched a 10 year, cross-government Teenage Pregnancy Strategy with the aim of halving the rate of conceptions among under 18s in England by 2010, and reducing the risk of long term social exclusion for teenage parents and their children by increasing to 60% the participation of teenage parents in education,

***Figure 39*** *Teenage conception rate in Haringey, London and England, 1998-2003*




Source: Teenage Pregnancy Unit, 2005

training and employment. Nationally there is a strong correlation between teenage pregnancy rates and deprivation.

Reducing the rate of teenage pregnancy and supporting teenage parents to continue with their education, training or employment are key priorities in Haringey. In 2003 the conception rate for under 18 year olds in Haringey (71/1000) remained higher than the rate for London (51.1/1000) and England and Wales (42.3/1000), despite having dropped by 10.5% between 2002 and 2003 (see figure 39). The conception rate in Haringey is comparable to other London boroughs with a similar demographic and deprivation profile – Lewisham, Lambeth, Hackney and Southwark. The percentage of conceptions leading to termination has increased in Haringey from being 8% below the London average to being within 0.6% of the London average.

4YP is the young people's sexual health advice and information service in Haringey, delivering specialised clinics and drop in sessions in areas with high rates of conceptions. It currently provides contraception, pregnancy testing and counselling.

Young people make an important contribution to the implementation of the Teenage Pregnancy Strategy in Haringey and are actively involved in the development of services and producing media resources such as posters, videos, and music to encourage young people to be more responsible around sexual health. Groups of local young people are recruited and trained to become peer educators to work on the 4YP bus and drop-ins. This provides paid work experience, which has contributed to improved self-confidence and expanded employment opportunities.

# 5.Staying safe

**Key messages:**

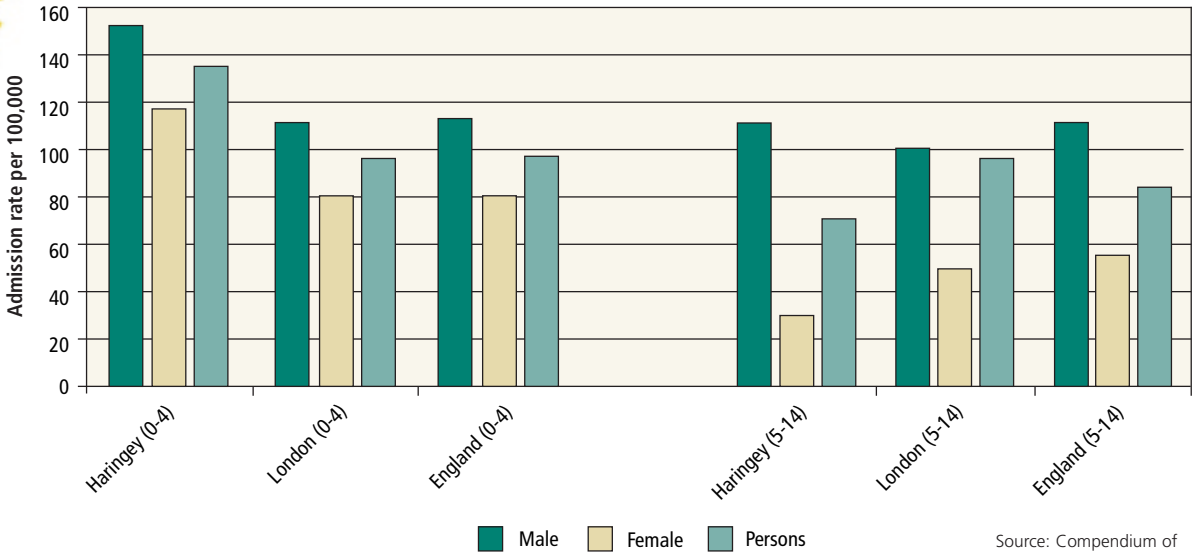
- Children need to be safeguarded against accidental injury, maltreatment, bullying and crime and anti-social behaviour, in and out of school.

## 5.1 Accidents and injury

Accidental injury has been identified as the main cause of death and a major cause of ill-health and disability in childhood[39]. Chapter 3 presented data on emergency admissions to hospital and deaths due to accidents amongst children and young people in Haringey.

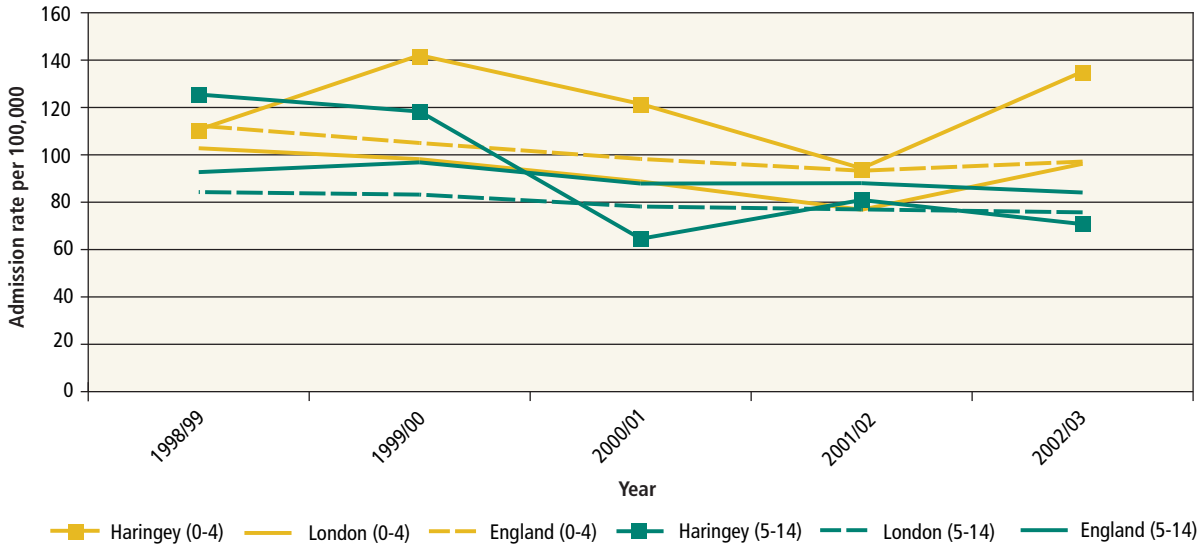
The rate of hospital admission for serious accidental injury (involving a stay of three or more days in hospital) is higher amongst boys than girls, and amongst younger children (see figures 40 and 41). It is also higher in Haringey than London or England amongst children aged under 5. Data on less serious accidental injuries was not available for this report. Analysis of admission rates at ward level suggests a four-fold difference in the admission rate between wards (see figure 42). There is evidence to suggest that deprivation increases the risk of children experiencing accidents[40], although admission rates and deprivation do not corrolate at ward level in Haringey. In fact, the admission rate is highest in one of the most affluent wards, Muswell Hill. Examination of the causes of admission

***Figure 40*** *Directly standardised rate of hospital admission for serious accidental injury in Haringey, London and England, 2002/03*




Source: Compendium of Clinical Indicators, ONS

***Figure 41*** *Comparison of directly standardised rates of hospital admission for serious accidental injury in Haringey, London and England, 1998/99-2002/03*



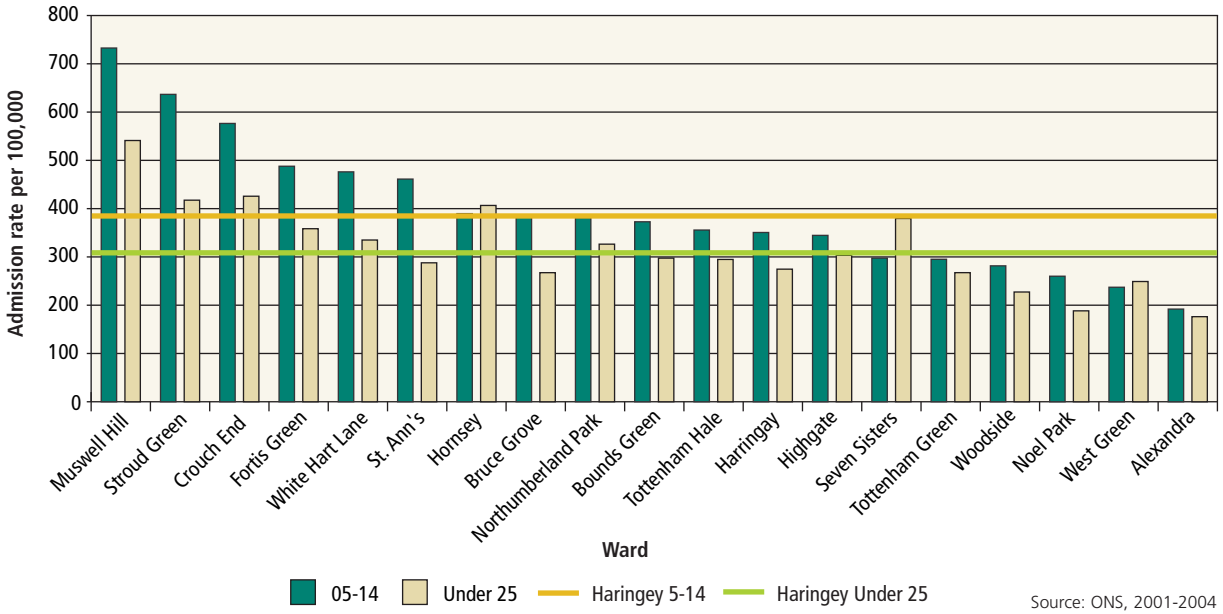

Source: Compendium of health indicators, ONS

suggests that there may be more accidents related to leisure/ recreation activities in some wards e.g. roller skating, skateboarding. However, the difference may also reflect differences in the admission policies of the hospitals to which these children were taken, for example determining how likely the children were to be kept in for observation.

## 5.2 Road Traffic Accidents (RTAs)

Road traffic accidents are the leading cause of accidental fatalities in children, accounting for nearly half. Pedestrians are at far greater risk than cyclists or passengers. The 10-14 age group has the highest proportion of all pedestrian casualties and a quarter of all pedestrian casualties for the 3-18 age group occur on journeys to and from school[41].

***Figure 42*** *Admission rates for all accidents per 100,000 children by ward, 2001-2004*




Source: ONS, 2001-2004

It has also been shown that boys have significantly higher admission and mortality rates for road traffic accidents than girls.

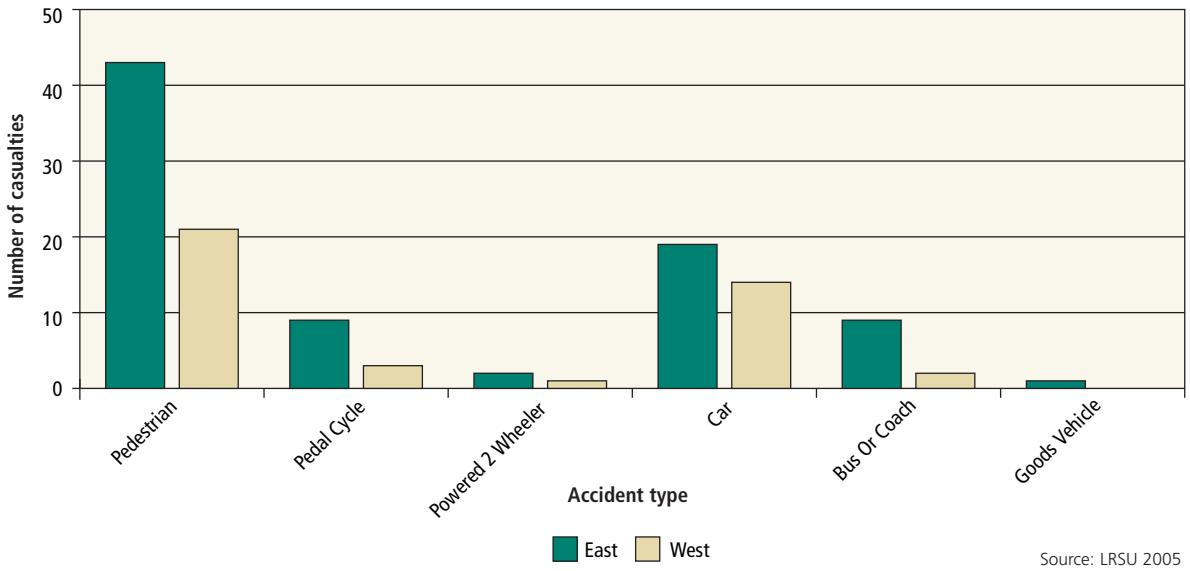
There is a strong correlation between the incidence of traffic casualties and social deprivation[42]. For example studies in various countries have shown that ethnic minority children experience a higher rate of pedestrian casualties. Across London research has shown that black African-Caribbean children have a significantly higher rate of pedestrian casualties than other groups[43].

The road casualty rate for the total population (5.3/1000) and for children (0.4/1000) in Haringey was comparable to the rates for England in 2003. There has been one child fatality from a road traffic accident in Haringey over the past three years, and several accident 'hot spots' have been identified. The highest number of child casualties occurred on Wood Green High Road (N22), followed by Broad Lane and South Tottenham High Road (N15), and West Green Road. The data also indicates that the summer months are high-risk periods, with the highest number of traffic casualties occurring in the months of July and August (see figure 44). Haringey Council is developing traffic and road safety initiatives to ensure that children have the knowledge and skills to keep safe on the roads.

## 5.3 Child Maltreatment

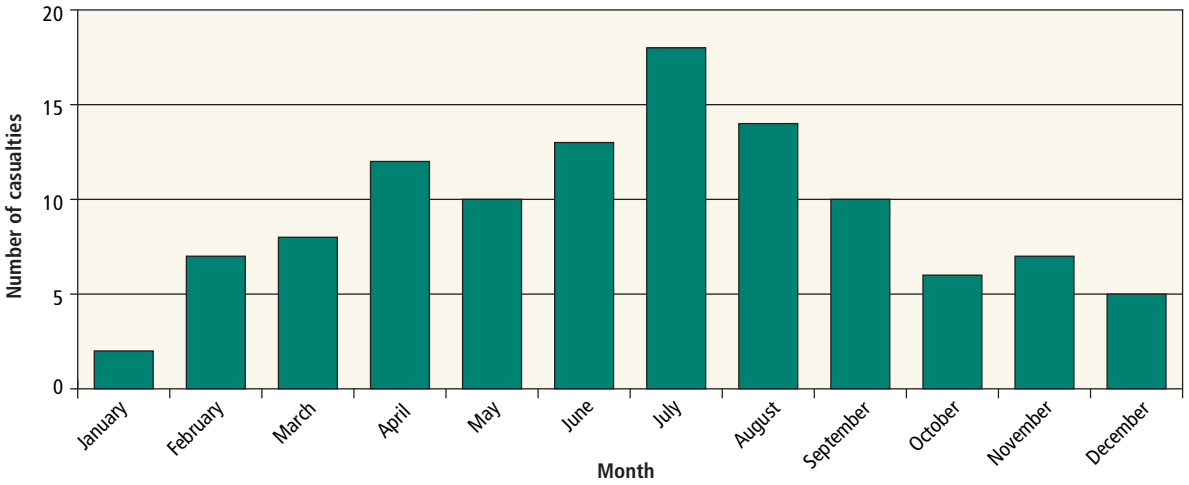
Maltreatment of children and young people may arise from physical, sexual and emotional abuse, neglect, bullying or discrimination. Maltreatment can be experienced from parents and carers, other family members, other adults in the community, professionals in positions of responsibility or from peers at school or elsewhere. The extent of child maltreatment is often unknown as many incidents remain unreported and often only the more severe or long-term cases become known to the authorities[44]. For example, studies have found that three-quarters of sexually abused children did not tell anyone about the abuse at the time and a third had not told anyone about their childhood experiences by early adulthood.

***Figure 43*** *Child road traffic accident casualties in Haringey 0-15 Years, 2004*




Source: LRSU 2005

***Figure 44*** *Number of child road traffic accident casualties per month, 2004*



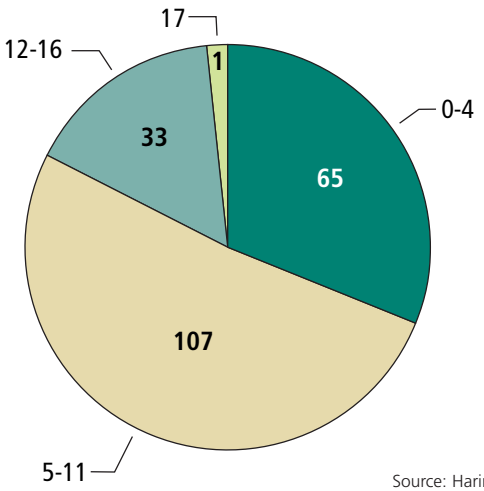

Source: LRSU 2005

The impact of child maltreatment on individuals is wide-ranging and can result in long-term physical and psychological health consequences. Physical violence may result in acute trauma requiring immediate treatment as well as more chronic conditions resulting from head or internal injuries, for example. The psychological effects of abuse and maltreatment can impact significantly on a child's development and predispose a child to future mental health difficulties such as substance misuse, depression and anxiety, risk-taking behaviour, hyperactivity, self-harm and risk of suicide, and eating and sleep disorders. The effects of abuse can result in lowered self-esteem, cognitive impairment, relationship difficulties, poor social functioning and poor school performance, which will have far-reaching consequences in adult life. There is also a strong correlation between child maltreatment and the development of violent and aggressive behaviour[45].

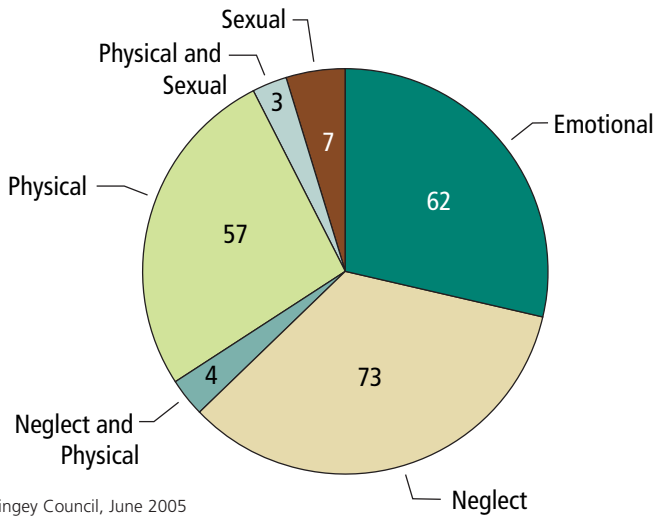
In severe cases of maltreatment, where the child is thought to be at continuing risk of significant harm, they are placed on the child protection register. Between April and August 2005 there were on average 221 children in Haringey on the child protection register.

***Figure 45*** *Children on the Child Protection Register, June 2005*

**45a Age**




**45b Type of Abuse**




Source: Haringey Council, June 2005

Data from June 2005 suggests that the majority of children on the child protection register were aged between 12 and 16 (see figure 45a). The most common reason for being placed on the register was neglect, followed by physical or emotional abuse (see figure 45b).

## 5.4 Domestic violence

Children and young people exposed to domestic violence within the home, which may not be actually directed at them, are also at great risk of emotional and psychological damage. Children are likely to feel deep hurt, fear and confusion by witnessing violence and may consequently exhibit disturbed behaviour, such as bedwetting, substance misuse or bullying and aggressive behaviour. Violence in the home can have a destructive impact on family relationships, which will have long-term consequences for a child's development.

It is estimated that children are affected in 90% of intimate partner violence incidents. Nationally, 75% of children on the child protection register live in households where they are exposed to domestic violence[45]. Recent national surveys suggest that a third of teenage girls have experienced some form of domestic violence or abuse at home, with 11% witnessing a parent being hit[46]. This has an impact on teenagers' subsequent relationships and expectations of their partners. The survey revealed that 43% think it is acceptable for their partner to be aggressive or violent towards them.

In 2004/05, police recorded 1,949 domestic violence victims of crime, and 3,515 incidents in Haringey. This is the tip of the iceberg, as many incidents go unreported. Hearthstone, a one stop shop for survivors of domestic violence, reported 1,278 clients in this period, and numbers are increasing.

## 5.5 Bullying

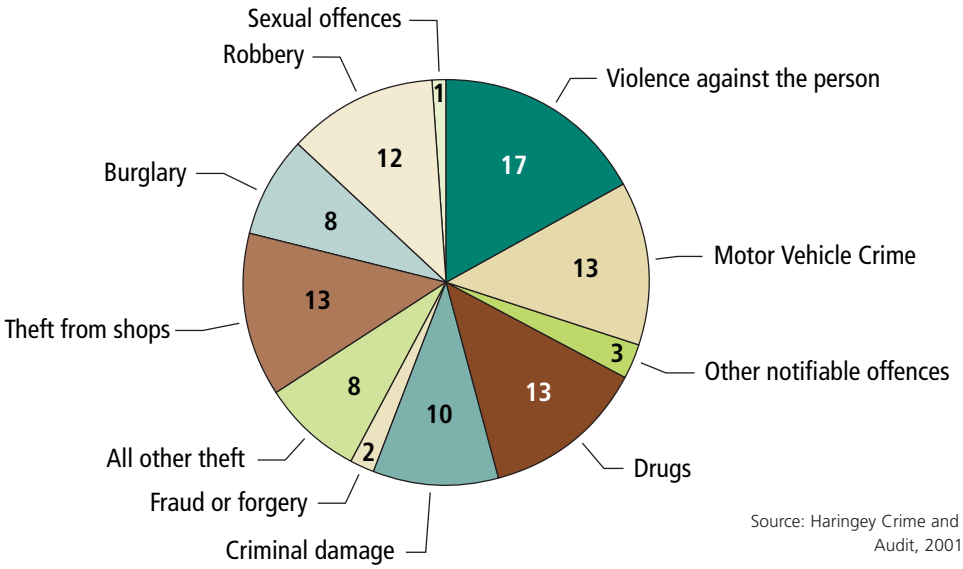
Bullying has a negative impact on a child's emotional well-being and educational performance. It can take the form of verbal abuse that is undermining and degrading, physical violence or threats of violence, theft or damage to property, abuse through mobile phone and email and ostracizing individuals from social groups. Bullying can lead to withdrawal and isolation, anxiety and depression, physical illness or psychosomatic illness and consequent intermittent and long-term absence from school. The negative effect on self-esteem and consequent feelings of worthlessness may cause individuals to have lower expectations and standards of work which may affect their ability to form positive relationships. While many young people may be able to overcome the effects of bullying, some childhood experiences may have damaging consequences that continue into adulthood[47].

It is difficult for schools to ascertain the full extent of bullying as it can be subtle and surreptitious, often remaining unreported. Proving cases of bullying can be problematic as definitions and levels of seriousness vary. In a national survey a third of 12-16 year olds reported being bullied at school in the previous year[48]. Another survey indicated that one in ten had been severely bullied and a quarter said that bullying was the main cause of stress in their lives[49]. All schools in Haringey are required to have a policy on bullying, and an anti-bullying strategy to tackle and prevent bullying. The Government also has numerous anti-bullying initiatives and the National Healthy Schools Programme considers bullying and emotional well-being as a key theme.

## 5.6 Youth crime and anti-social behaviour

Haringey has a significantly higher level of crime committed by the 10-17 age group

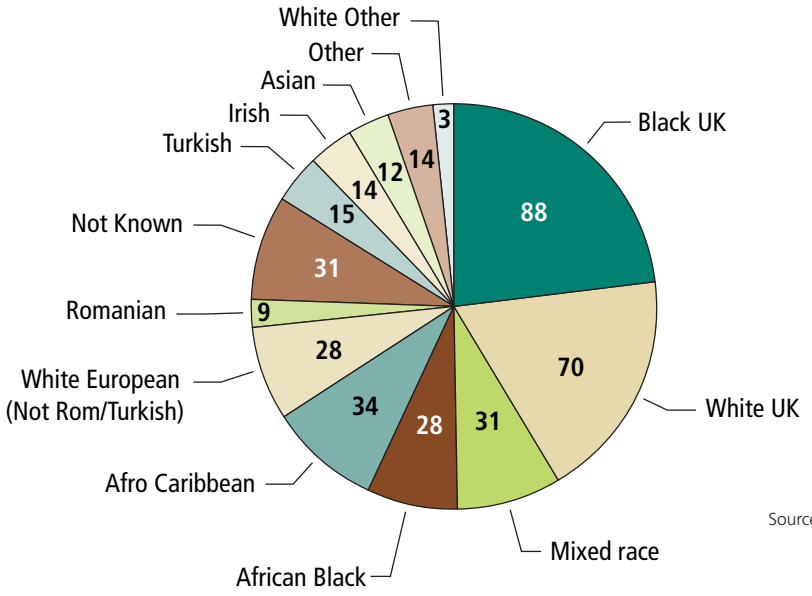
***Figure 46*** *Types of crimes committed by 10-17 year olds, April 2001 to March 2004*




Source: Haringey Crime and Drugs Audit, 2001-2004

compared with the London average. A high proportion of street and vehicle crimes are committed by young people, and young people are also involved in shoplifting, criminal damage and residential burglary. The peak time for youth offending is between 2pm and 6pm on weekdays, suggesting that the after school period is a high-risk time for youth crime[50]. The Haringey Youth Offending Service caseload (377 as of August 2005) reveals that three quarters of young people referred are male and the highest proportion of offenders live in the N17 postcode area. The largest ethnic group referred to youth offending services in 2004 were black UK (24%) followed by white UK (19%) and the majority were in the 15-17 years age group.

***Figure 47*** *Ethnicity of youth offending service active caseload (numbers), 2004*




Source: Haringey YOS, June 2005

# 6. Enjoying and achieving

**Key messages:**

- Education can provide a foundation for healthier lives.
- Children should be ready for, attend and enjoy school.
- Schools can help children achieve personal and social development.
- Breakfast clubs in schools can support health and learning.
- Inequalities start from an early age, therefore good quality childcare and early years education are important to ensure children have the best possible start in life.

## 6.1 Education and health

Education has an important influence on health, and vice versa. It contributes to the marked inequalities in socio-economic positions in our society, and has provided a route out of poverty for some living in disadvantage[51]. Educational qualifications are one determinant of an individual's labour market position, which in turn influences access to income, housing and other material resources. Low educational attainment is therefore closely related to health and health inequalities.

Education plays a vital role in preparing children for their future, ensuring they have practical, social and emotional knowledge and skills to achieve a full and healthy life. It provides young people with knowledge of the determinants of health as well as skills in developing relationships and dealing with conflict and stress. Children with poor health are less able to learn and attain through the education system, which may contribute to worsening health status.

The education system should protect and promote the health of children by providing an environment and culture which is safe, healthy and conducive to learning. With the exception of children who are excluded or who truant, schools are one of the few settings in which health promoting interventions can reach most children and young people. The Healthy Schools Programme in Haringey supports this by encouraging schools to adopt a whole school approach to health with the aim of reducing inequalities and promoting academic achievement (see section 6.5).

## 6.2 Education provision in Haringey

Education for under 5s in Haringey is provided through private or maintained nurseries, voluntary playgroups, and through Under 5s Centres or Early Excellence Centres. There are 197 places in the Under 5's Centres in Haringey, of which 40-50 are allocated for children with additional support needs.

There are 53 Primary Schools and 10 Infant and Junior Schools in Haringey with a total of 19,509 pupils. Approximately 2,000 children

(11% of primary pupils) in Haringey schools come from out of borough, and approximately 1,400 Haringey pupils go to out of borough schools.

There are 11 secondary schools with a total of 12,200 pupils. Approximately 2,000 secondary aged pupils (19%), come from out of borough; approximately 3,400 (29%) of Haringey secondary aged pupils go to out of borough schools. There are also 4 special schools with a total of 307 pupils, and 80 pupils currently attend the Pupil Support Centre.

Student's progress is assessed at several stages, generally including the level of attainment at the following stages: Key stage 1 in year 2 (7 year olds); Key stage 2 in year 6 (11 year olds); Key stage 3 in year 9 (14 year olds); and GCSEs (16 year olds).

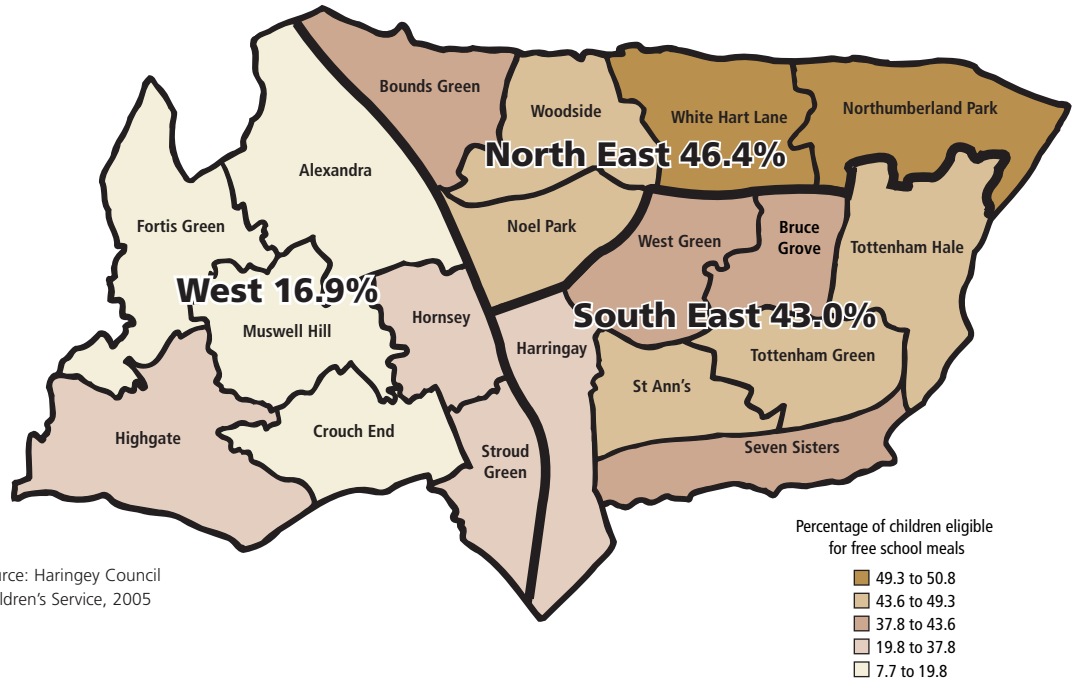
## 6.3 Deprivation profile of school children in Haringey

Free school meal eligibility is used as an indicator of deprivation. Figure 48 describes the distribution of free school meal eligibility across the borough, with an average of 39%, compared to a national average of 17%. Eligibility varies by ward, from 7.8% eligible in Alexandra ward to 50.7% in White Hart Lane. The proportions eligible at Children's Network area level are 16.9% West, 43.0% South East and 46.4% North East. Given the high proportion of children eligible for a free school meal, improvements to the nutritional quality of school meals served could reach a large number of children, and make an important contribution to their health.

## 6.4 Educational Attainment

**Early Years** The curriculum for Early Years centres around the Birth to Three Framework[52] and the Foundation Stage[53]. The Birth to Three Framework places the child at the centre and identifies four "aspects" celebrating the skill and competence of babies and young children: a strong child; a skilful communicator; a competent learner and a healthy child. The Framework recognises that children's experiences in the very early years are critical to their subsequent development and crucial in ensuring that children are ready to start school.

***Figure 48*** *Proportion of children eligible for free school meals by ward, July 2005*




Source: Haringey Council Children's Service, 2005

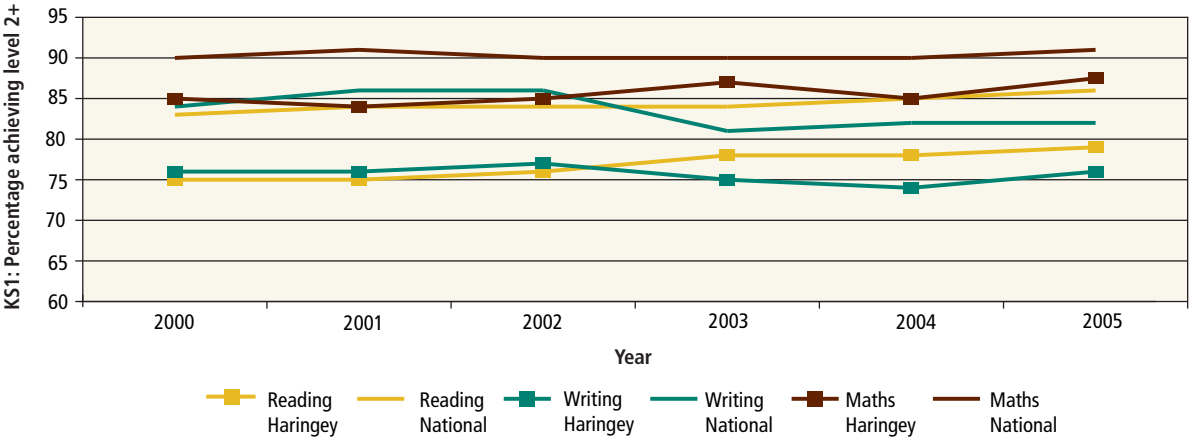
The Foundation Stage for 3-5 year olds includes six areas of learning: personal, social and emotional development; communication, language and literacy; mathematical development; knowledge and understanding of the world; physical development; and creative development. Most children should achieve the set of early learning goals by the end of the foundation stage. Children's centres will be well placed to influence early health, social and emotional development.

**Primary school** The Every Child Matters outcomes framework highlights targets relating to the percentage of 7 year olds achieving Level 2 + at Key Stage 1 (reading, writing and maths – see figure 49a), and the percentage of 11 year olds achieving Level 4+ at Key stage 2 (English, maths and science – see figure 49b). Although the proportion of children attaining these target levels in Haringey is below that achieved nationally there has been considerable improvement in recent years in most subjects. At both levels provisional Haringey figures for 2005 show an improvement on the 2004 results.

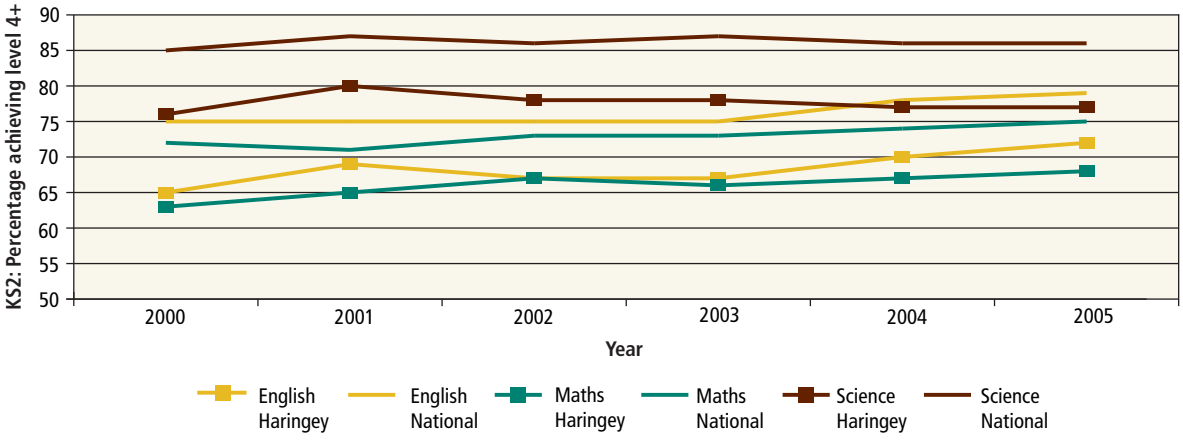
Low academic achievement can be linked to high pupil mobility in schools. For example South Harringay Infants School has developed a number of projects to engage children and parents in the school having experienced 59% pupil mobility in 2003/04 (the fourth

***Figure 49*** *Attainment at Primary School 2000-2005: Key stages 1 and 2*

**49a Key Stage 1**




**49b Key Stage 2**



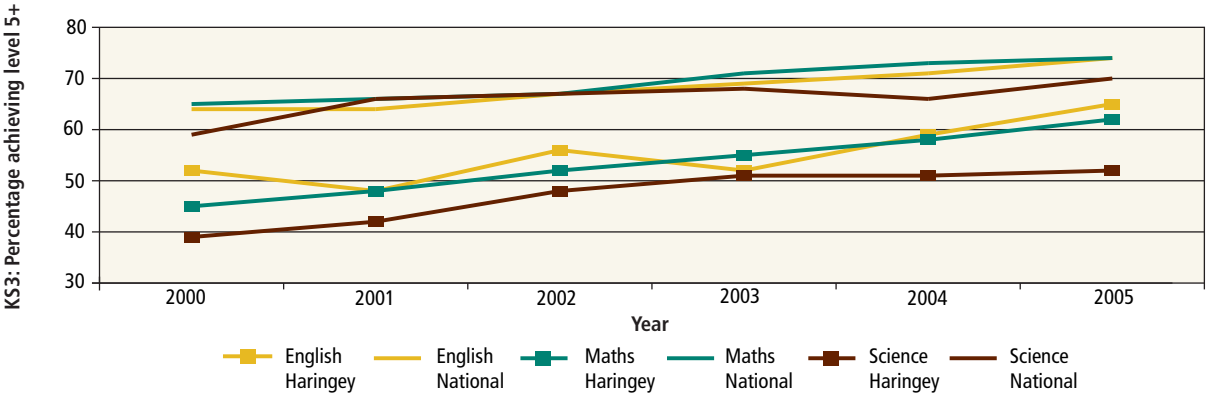

Source: Haringey Council Children's Service, 2005

highest in Haringey). The Excellence in Cities Programme[54] in Haringey has a two-pronged approach to raising achievement in the East of the borough through a 'gifted and talented' programme and learning mentors. The latter work with disaffected pupils, supporting them in overcoming barriers to learning such as poor attendance, emotional literacy, anger management, or family trauma. They also work with the Tottenham Hotspur Study Support Centre, which provides after-school study support using football as a motivating factor.

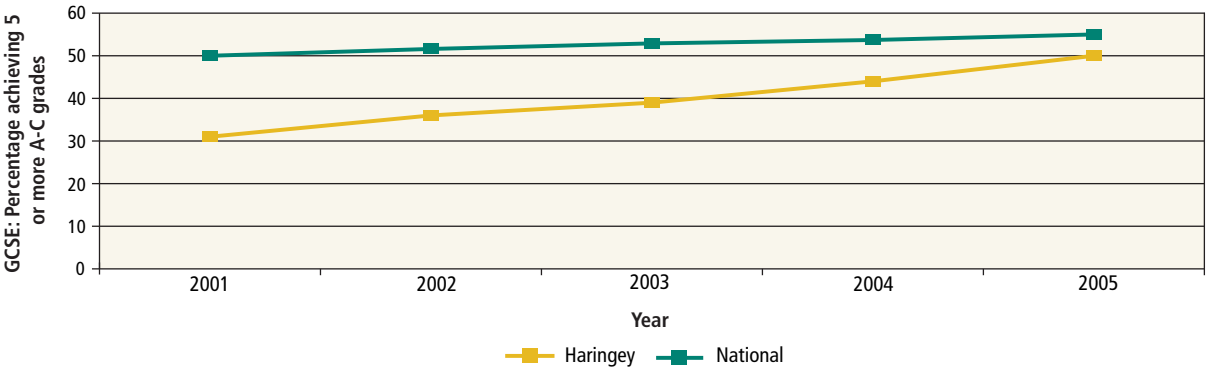
**Secondary school** The key stage 3 target focuses on the percentage of 14 year olds achieving Level 5+ in English, Maths, and Science. While there have been marked improvements in English, Maths and Science, far fewer children in Haringey attain the expected level than nationally, particularly in science (see figure 50a). Figure 50b illustrates

***Figure 50*** *Attainment in Secondary School 2000-2005: Key stage 3 and GCSE*

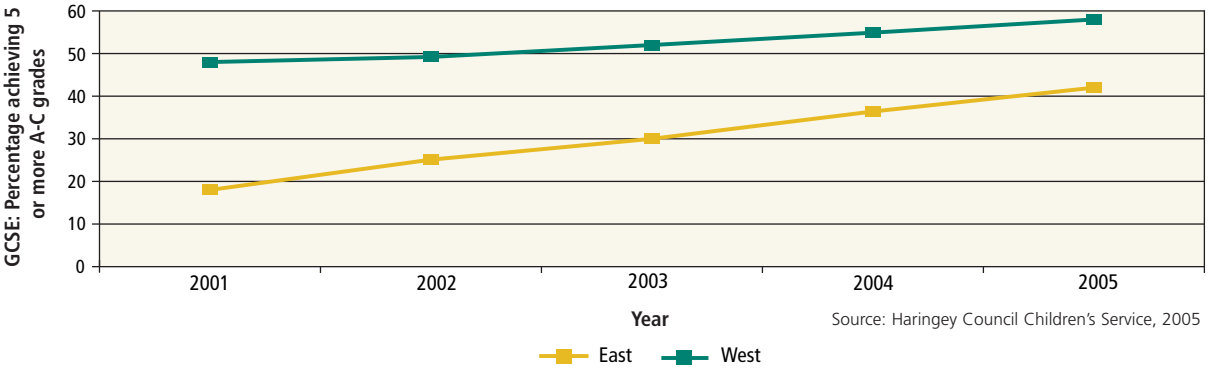
**50a Key Stage 3**




**50b GCSE – Haringey/National comparison**




**50c GCSE – East/West Haringey comparison**




Source: Haringey Council Children's Service, 2005

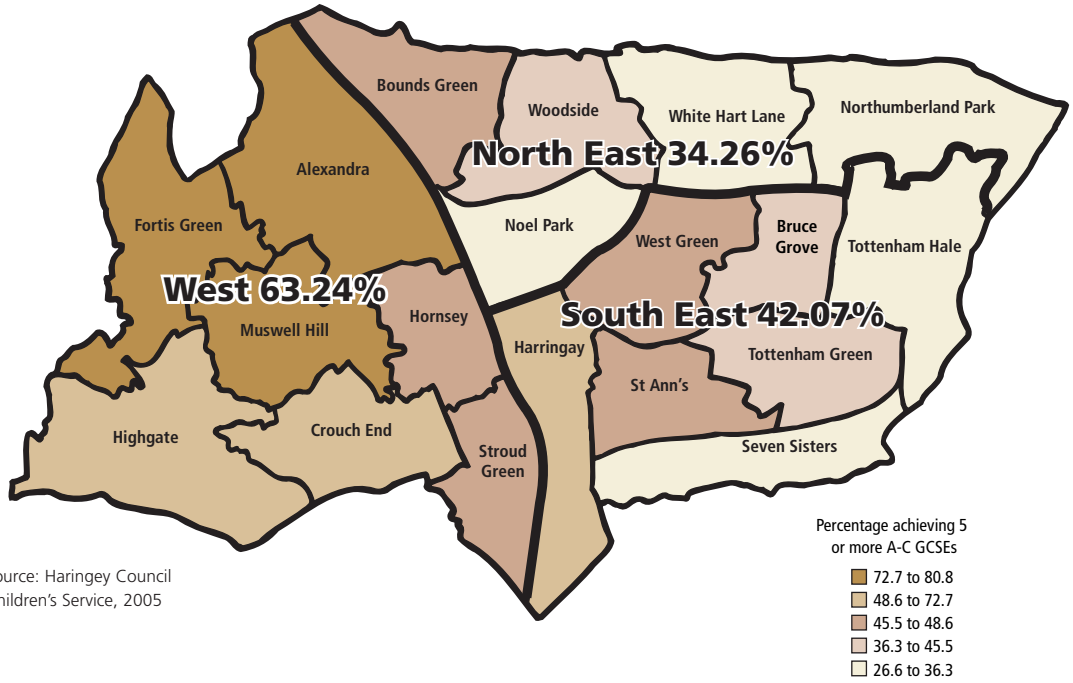
how the gap between Haringey schools and the national average is steadily decreasing, down to a provisional 5% in 2005 compared to 19% in 2001. Although there is still a difference in attainment between schools in the East and West of Haringey, results in recent years suggest that this gap is also decreasing (see figure 50c), with dramatic improvements in the GCSE results attained by students in several schools in the East of Haringey in 2005.

There are marked inequalities in educational attainment when GCSE results are presented by ward of student's residence (see figure 51) and ethnicity (see figure 52). Overall, only 34% of students attained 5 or more GCSEs at grade A* to C in the North East Network area compared to 63% in the West. Children from Chinese and Asian-Pakistani, Asian Indian and Asian Bangladeshi backgrounds achieved above the national average, while those from African – Caribbean, Kurdish and Black ethnic groups achieved well below both the Haringey and national average (see figure 52). This mostly reflects the national picture[55] with the exception of Pakistani pupils who achieve high standards in Haringey but do less well nationally.

**School attendance** The Behaviour and Attendance Strategy[56] for Secondary Schools in Haringey plays a pivotal role in ensuring that schools are equipped to deal with challenging behaviour and develop strategies to enable pupils to attend school and to have as positive an experience as possible. Electronic systems to monitor attendance, school-based Educational Welfare Officers, and improved follow-up on early absence has made a significant contribution to improving attendance. Schools are rapidly closing the gap between the Haringey and national averages. Improvements this year represent approximately 21,000 additional sessions attended compared to last year (see figure 53).

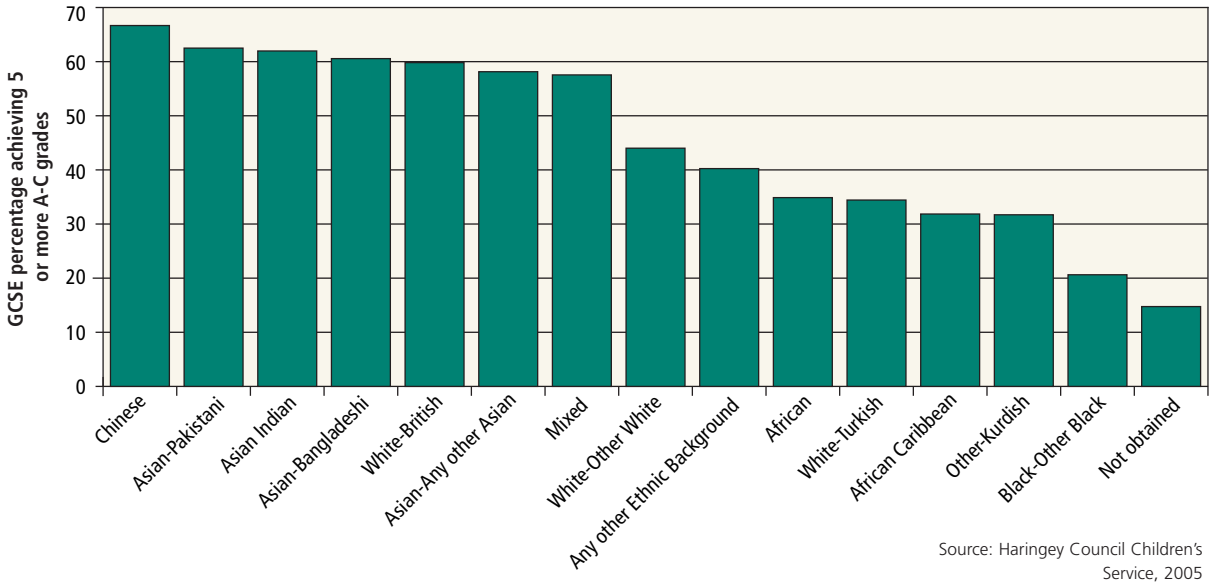
**Children excluded from school** There were 20 permanent exclusions in secondary schools in 2003/04, a reduction from the 29 in 2002/03 and a smaller proportion of all secondary students than seen nationally.

***Figure 51*** *Proportion of pupils in Haringey achieving 5 or more A*-C GCSEs by ward, 2004*




Source: Haringey Council Children's Service, 2005

***Figure 52*** *Proportion of children in Haringey attaining 5 or more A*-C GCSEs by ethnic group, 2004*




Source: Haringey Council Children's Service, 2005

Most permanent exclusions occurred in Year 10, generally due to unacceptable behaviour. Schools are tackling this by developing more appropriate curriculum routes that reduce disaffection, are more inclusive and better match the interests of pupils.

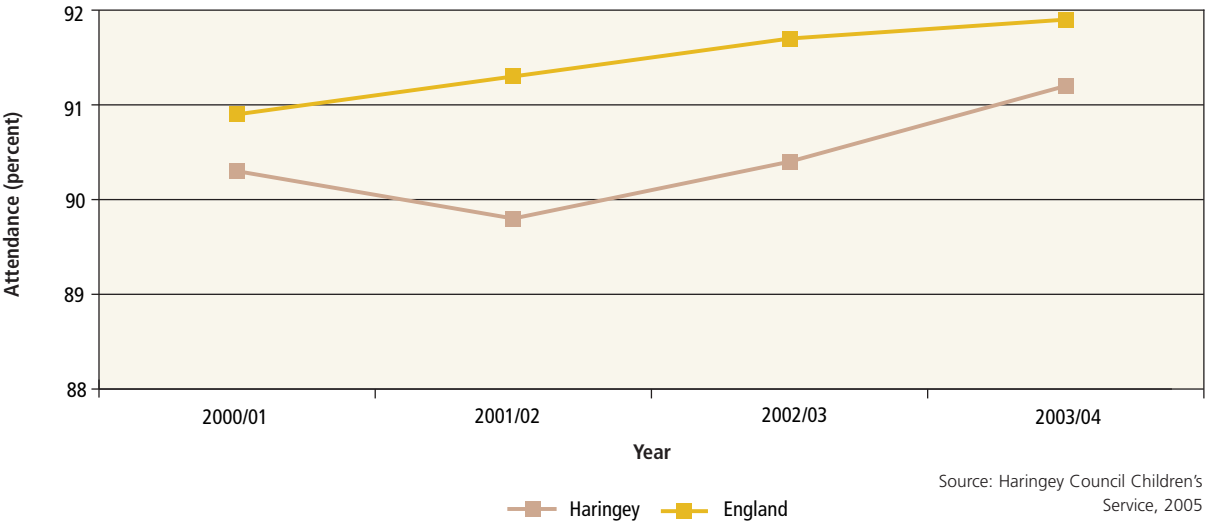
Data from the Children's Service suggest that the exclusions are drawn across the different ethnic groups with the highest numbers coming from mixed and white British ethnic groups. This contrasts with figures from 2002/03 where over 60% of the total number of permanently excluded children were either African or black British/Caribbean.

## 6.5 Enjoying childhood and youth

If a child or young person enjoys the experience of school then they are more likely to achieve. This starts within the Early Years setting by encouraging children to play and to socialise and therefore be ready to attend and enjoy school.

**Sports** The School Sport Co-ordinator Programme[57] aims to raise levels of

***Figure 53*** *Attendance at Secondary Schools, 2004*




Source: Haringey Council Children's Service, 2005

attainment and participation in PE, with every child in Haringey receiving at least two hours of quality PE both within and outside of the curriculum per week. Currently, 50% of children meet this target, which needs to rise to 80% by 2008. There are two hub schools in Haringey, St Thomas More and White Hart Lane Secondary School, who each work with "a family" of primary schools to promote school sports and provide training to staff. The Programme has introduced children to a wide variety of sports, ensuring that those who do not participate in "traditional" sports have the opportunity to try new activities in a safe and supportive environment.

**Music** The Music & Performing Arts Centre (MPAC) provides a core programme of instrumental tuition in schools across the borough, and after-school ensembles including African Drumming, Turkish folk music, choirs and orchestras. Aged from 7-18 years, these groups give concerts locally, nationally and internationally. In the academic year 2003/04, 210 pupils were taught to play violin, cello, guitar trumpet or clarinet in 3 schools in the East of the borough where take-up for the core programme of tuition had been low. The Centre is expanding its programme in Key Stage 2 (ages 7-11).

**Haringey Youth Service** The purpose of the Youth Service in Haringey is to enable young people to develop their knowledge, skills and values to widen their experiences and understanding and to realise their aspirations through fun and safe learning opportunities outside of school. The Youth Service works with 11-25 year olds, specifically targeting 13-19 year olds.

## 6.6 Early years programmes for health

**Sure Start:** There are five Sure Start programmes in Haringey working with families with pre-school children aged 0-5 years. The programmes aim to;

- Increase the availability of childcare for all children
- Improve health and emotional development for young children
- Support parents in parenting and in their aspirations towards employment.

The programmes offer a range of services that support early learning and development, including;

- Opportunities for play and learning
- Parenting support and skills development
- Targeted services e.g. for children with disabilities
- Early identification of children with special educational needs
- Speech and language support
- Book and toy mobile libraries

Local programmes have developed specific initiatives to meet the needs of families in their area, drawing on a range of expertise and testing out ways in which to provide local services in an integrated and multi-disciplinary way.

## 6.7 School based programmes for health

**Healthy schools** The whole school environment has a major influence on the development of children's knowledge and understanding of health, as well as influencing behaviour and lifestyle. Schools also need to provide a healthy physical and social environment that is conducive to learning. The Haringey Healthy Schools Programme aims to support children and young people in developing healthy behaviours, raising pupil achievement, reducing health inequalities and promoting social inclusion. Last year 38 schools (50% of schools) in Haringey achieved Healthy School status.

There have been changes to the Healthy Schools Programme nationally which will now focus on four key themes: PSHE (Personal, Social and Health Education) including Sex and Relationships Education and Drugs Education, Healthy Eating, Physical Activity and Emotional Health and Well-Being. Each theme has criteria which schools will need to meet in order to gain Healthy School status. The target is that 50% of schools achieve the new Healthy School status by December 2006, aiming for 100% by 2009.

**Breakfast clubs** Breakfast clubs can help children learn, having many benefits for children and families including improved nutrition, employment opportunities for parents, social interaction, improved behaviour and improved attendance and punctuality. Local evaluation has identified that a number of children rely on a free school meal as their main source of nutrition and often eat a minimal amount between lunches. Breakfast clubs help these children to participate fully in the school day. There are currently 27 Breakfast Clubs in Haringey schools funded by regeneration monies, located in areas of highest deprivation.

**Extended Schools** Schools are often a focal point within a community. The Government has published its vision that a core of extended services should be offered through all schools by 2010, including childcare, activities before and after school, parenting support, shared use of school facilities and improved referral to specialist support. There will be a charge for many of these services, which may not be provided by the school directly but by a range of other partners. Park View Academy is currently running as a pilot extended school, with White Hart Lane and Gladesmore Secondary Schools also developing extended schools services.

The Evaluation of the Extended Schools Pathfinder Projects[58] found that extended schools can bring about a range of positive outcomes. For children and young people, improved attainment, attendance and behaviour. For families, a positive impact on parental involvement in their children's education. For communities, a place where different sectors of the community can engage with each other through different activities.

# 7.Making a positive contribution

**Key messages:**

- Research suggests that social and community support and participation are important to a child's development and health.
- Young people may face barriers to community participation.
- There are good examples of participation in Haringey to build upon.

## 7.1 Social interaction and networks

There is a growing body of evidence that shows that communities with strong social relationships or networks have better health. Higher levels of civic engagement, social support or participation and a sense of belonging, co-operation and trust – or social capital – have been linked with better health outcomes (such as lower heart disease) and positive health behaviours (lower rates of smoking)[59]. However, lack of time, unemployment, poverty, high population mobility, disrupted family ties and changes in the economy can undermine social relationships and weaken participation[59].

Most UK research on children's friendships and peer groups has focused on the negative rather than the positive and supportive effects of group membership. Research on social capital in children and young people is scarce, but indicates that social and community support and participation are important to a child's development and health. For example, pre-school children in families with high levels of social and community support and membership of faith groups have a greater chance of thriving than in those families that do not[60]. Young people who report poor social connections are between two to three times more likely to experience depressive symptoms when compared with their peers[61]. Furthermore, the importance of childhood health for health outcomes in adult life is well recognised.

## 7.2 Social and emotional support

The parent-children relationship is a determinant of mental and physical health in adult life. Although biological make-up is important, children's mental health depends primarily on a secure and warm relationship with parents/carers[5]. Early attachment and bonding is crucial. Research suggests that sensitive and responsive interaction between a child and their parent or guardian is the most important element in learning how to relate to other people socially and developing thinking ability. Wider familial and environment ties are also important for the development of emotional security and well-being[5].

Research has shown that parenting, particularly in the early years, can influence

longer term mental well-being[62]. Group-based parenting programmes are effective in improving the emotional and behavioural adjustment of children under 3 years old[63]. In November 2004 a 16 week 'Mellow Parenting' programme was run in Haringey to provide parenting skills to vulnerable families. The project is currently being evaluated for its effectiveness.

The teenage years present a particularly challenging time, with expanding social, academic and financial demands. While parents continue to be the first choice for confiding and supportive relationships[64], this relationship can also be a source of tension. Poverty, poor housing, homelessness, community facilities and physical environments, lack of play space and poor public transport can also place strain on parents exacerbating any parenting difficulties[14]. For some children and young people, family and friends do not provide sufficient support for emotional and behavioural well-being, and professional support and advice is required through mental health services. For example, in 2003/04, 170 children were counselled by the Educational Support Team.

## 7.3 Actively participating in community life

The degree of civic engagement is central to the idea of social capital. Almost all young people participate in some form of leisure activity but involvement in more 'civic' activities is far less common. Nationally[65], civic engagement varies by social class and ethnicity, with manual workers and Indian, Pakistani and Bangladeshi households in particular reporting less civic engagement. Young people (16-29) also felt less civically engaged than all other age groups[66]. Only 6% of 16 to 29 year olds were actively involved in a local organisation, compared with between 12% and 18% of people in other age groups. Young women were more likely to have taken an action to solve a local problem than young men (18% compared with 13%). Despite the lack of routine information on participation, Haringey Youth Service is committed to developing and strengthening its links with young people[67]. In 2004/05 13.19% of young people were in contact with the youth service.

## 7.4 Citizenship education

Promoting a greater sense of security and social connectedness within the school environment may enhance emotional health[61]. In 2002, citizenship education became compulsory at Key Stages 3 and 4. In Haringey, there is a great deal of work on citizenship, for example, through children participating in school councils to influence school life, peer mentoring and leadership schemes and mediation programmes. For example, children in Gladesmore Community School organised a peace campaign around weapons and gun crime, producing a leaflet and holding a rally at Bruce Grove.

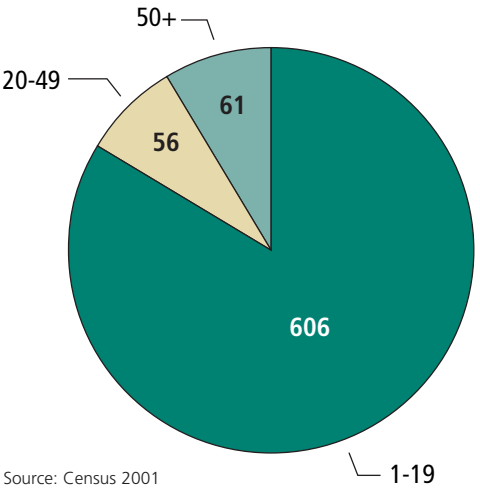
## 7.5 Young people as carers

Caring for other people who have an illness, disability or are vulnerable shows family and social responsibility. This can be a rewarding activity, but it can also be mentally and physically demanding. Carers themselves may face a number of health problems. These may include physical injuries, exhaustion, stress, emotional problems and isolation.

A significant proportion of carers are under the age of 18. Typically young carers take on the kind of responsibility that an adult would i.e. looking after an ill or disabled member of their family. This may limit their personal, social and educational opportunities. For example, the need to be close at hand may reduce access to support networks and reduce opportunities to socialise, despite

access to respite care. For young people, this may be particularly difficult. Like adults, those young carers who care the longest are more than likely to report a greater number of symptoms of poor health. Figure 54 shows that the 2001 Census identified 723 dependent children providing unpaid care in Haringey. Of these young people, 61 (8.4%) looked after someone for 50 or more hours per week.

***Figure 54*** *Number of hours of unpaid care per week provided by dependent children in Haringey, 2001*




Source: Census 2001

*Barriers to participation*

Some children and young people may have to overcome a range of barriers to participate in social networks or civic activities. This could potentially reduce social networks and in turn affect health. Barriers may come from a number of sources including discrimination and poor access. For example, 47% of young disabled people involved in the first stage of a survey for the Disability Rights Commission, said that problems with public transport made it difficult for them to participate in activities that other people their age engage in[68].

Feeling safe from physical harm or threats of physical harm or being able to express a point of view without being belittled or ridiculed, as well as feeling able to take part in school and class activities without being left out or isolated, are important for emotional security. Students who report being victimised are three times more likely to be at risk of having depressive symptoms when compared with those not reporting such experiences[61].

Children and young people may experience significant discrimination from both individuals and institutions, affecting their health and the quality and delivery of child health services[69]. For example, racial and ethnic discrimination are closely associated with multiple indicators of poorer physical and, especially, mental health status in adults and children[70,71]. In the UK, individuals from minority ethnic communities perceiving unfair treatment and reporting racial insults are at least twice the risk of suffering mental disorders than individuals who do not[71]. Frequent and prolonged bullying at school as a result of actual or perceived sexual orientation can have a lasting affect.

Young people who are experiencing difficulties with relationships (family, friends and personal) and discrimination, abuse or racism or bullying can seek support form Haringey Young People's Counselling Service. This service provides space for young people to talk freely about their feelings and to help young people understand and take control of a situation.

## 7.6 Enterprising activity

There are very good examples of civic activity amongst young people in Haringey including Health for Young People which provides training to young people to become Community Health Mentors who deliver health advice and information to their peers. Young people are seen as productive members of the community and act as positive role models. Seventy young people

aged between 15 and 25 have taken part in the accredited and certificated training over the past three years which has helped to increase their knowledge, skills and employability. Eight community health mentors have been trained as after-school club leaders providing play opportunities for children identified as having low self-esteem, behavioural and emotional problems and over 30 young people have engaged in voluntary work, some of whom have become Millennium Volunteers.

Encouraging and supporting young people to develop strong relations with their peers and engage positively with their local community will not only result in strong and well-developed support networks but also help develop self-confidence, self-esteem and belief. For some, this will provide the confidence and ambition to start an enterprising activity such as a business. The National Young Entrepreneur of the Year in 2004 was a pupil from Gladesmore School. The challenge will be to spread this enterprising attitude more widely in a borough that has one of the highest levels of unemployment in the country.

# 8. Achieving economic well-being

**Key messages:**

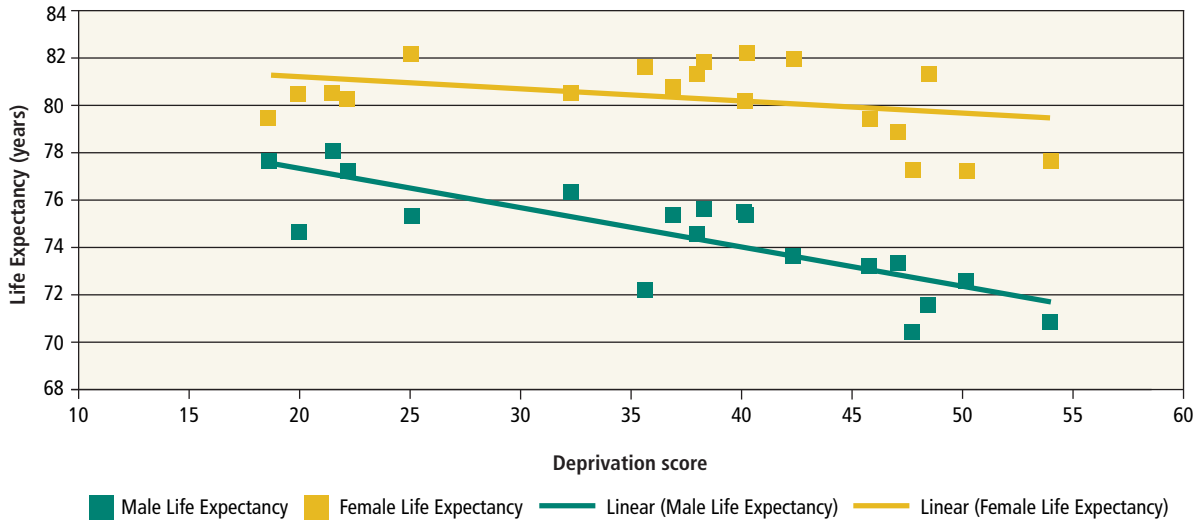
- The economic well-being of families is key to their health and well-being.
- A significant number of children and young people in Haringey live in relative poverty and deprivation.
- There are stark inequalities in the attainment of qualifications and employment status across Haringey.

## 8.1 Health and deprivation scores in Haringey

Health and life expectancy are closely linked to social circumstances and child poverty[1]. There is a correlation between life expectancy and deprivation at ward-level for men and women in Haringey, life expectancy declining as deprivation increases as measured using the index of multiple deprivation (2004).

Many children in Haringey live in families surviving in relative income-poverty. The 2001 Census collected data at small area level, and

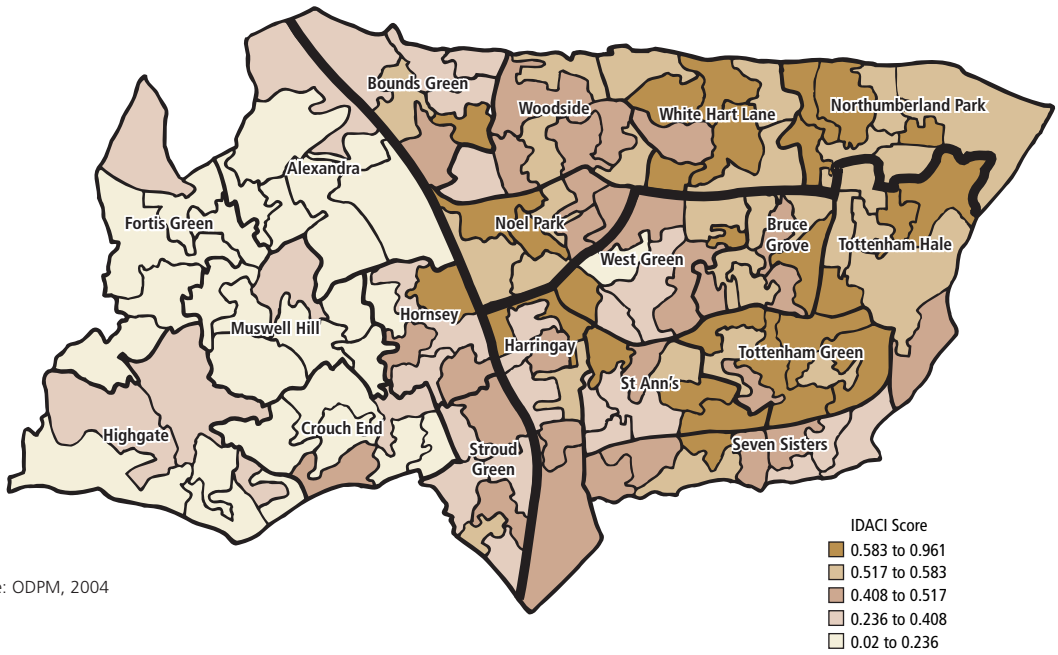
***Figure 55*** *Relationship between male and female life expectancy and ward-level index of multiple deprivation scores in Haringey*




Source: Life Expectancy: LHO, 2004
Deprivation Score, ODPM, 2004

[c] Income deprivation affecting children is defined as the proportion of children aged under 16 years living in families in receipt of income support, job seekers allowance or working families/ disabled persons tax credit whose comparative income is below 60% of the median before housing costs.
[d] Each ward is divided into a number of super output areas for which information is available at this small area level.

***Figure 56*** *Income deprivation amongst Haringey children*




Source: ODPM, 2004

measured the proportion of dependent children living in an income-deprived household[c]. This Income Deprivation Affecting Children Index reveals that of the 144 super-output areas[d] in Haringey, 70% ranked in the top twenty percent most income-deprived for children in England. In contrast only 5% ranked in the bottom twenty percent of areas for income deprivation for children in England i.e. the most affluent. The shading in Figure 56 ranks each area into five equal bands, from most to least income deprived. It shows the unequal distribution of children living in income poverty across Haringey, with up to 90% of children living in income poverty in some parts of the borough compared to less than 2% of children in other areas.

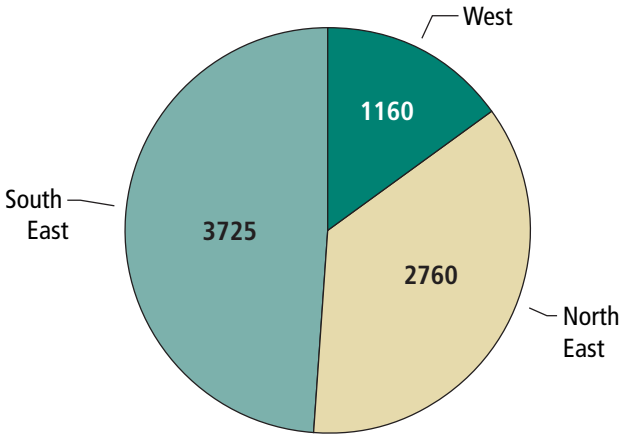
Poverty is just one aspect of deprivation that often combines with a number of other factors in a community to create social exclusion and poor health[72], including unemployment, discrimination, poor skills, poor housing, and crime. The negative health impact of deprivation arises not only from material deprivation but also from the social and psychological problems resulting from living in relative poverty[73]. Children are particularly vulnerable to these factors, and their life chances are fundamentally affected by the circumstances of their parents, such that social exclusion may pass from generation to generation.

As noted in Chapter 2, there are a significant numbers of families at increased risk of deprivation living in Haringey, including lone parent families, homeless families in temporary accommodation, travellers, and refugees and asylum seekers. Enabling these families to access education, training, income generation and employment opportunities will have a significant impact on their health and well-being.

## 8.2 Low income households

The amount of money coming into a household is a key determinant of people's lifestyles, and a key health resource. Access to health through decent housing, good nutrition and leisure facilities, for example, depends on income. Numerous studies have shown that poverty excludes households with

***Figure 57*** *Number of lone parent households receiving income support, 2004*




Source: Haringey Council, 2004

children from 'healthy lifestyles' and results in stresses, which may be associated with health damaging behaviour such as smoking. The Acheson report on inequalities in health[51] recommended increasing benefits to women (of child bearing age) experiencing poverty, and measures to increase the uptake of benefits in entitled groups. Lone parent households are particularly vulnerable to low income. The number of these households receiving income support varies widely from 720 lone parent families receiving income support in White Hart Lane ward down to 70 lone parent families in Muswell Hill ward in August 2005.

## 8.3 Unemployment

Employment plays a fundamental role in our society, contributing to income, social support, structure and purpose in life. Because of this unemployment is potentially a major risk to health. Unemployment is generally much higher for young adults, people from minority ethnic groups, and those with few qualifications. Parents, and particularly lone parents, may find it hard to obtain work because of the high costs of childcare, limited flexibility to care for children, or unsociable hours.

Unemployment is a considerable challenge in Haringey. The employment rate amongst the total Haringey working age population was 57% in 2003/4, 18% below the England average of 75%. The employment rate for ethnic minorities and lone parents also fell 18% short of the England averages at 40% and 32% respectively.

In July 2005, 7.5% of Haringey residents were claiming Job Seekers Allowance as compared to 4.5% in greater London[80]. Areas of particularly high unemployment include Northumberland Park, White Hart Lane and Bruce Grove (see figure 58).
In the last Census, 16% of households with dependent children were headed by someone who was long-term unemployed or had never worked, this proportion being notably higher amongst families of black-African (26%) and other White (31%) ethnicity.

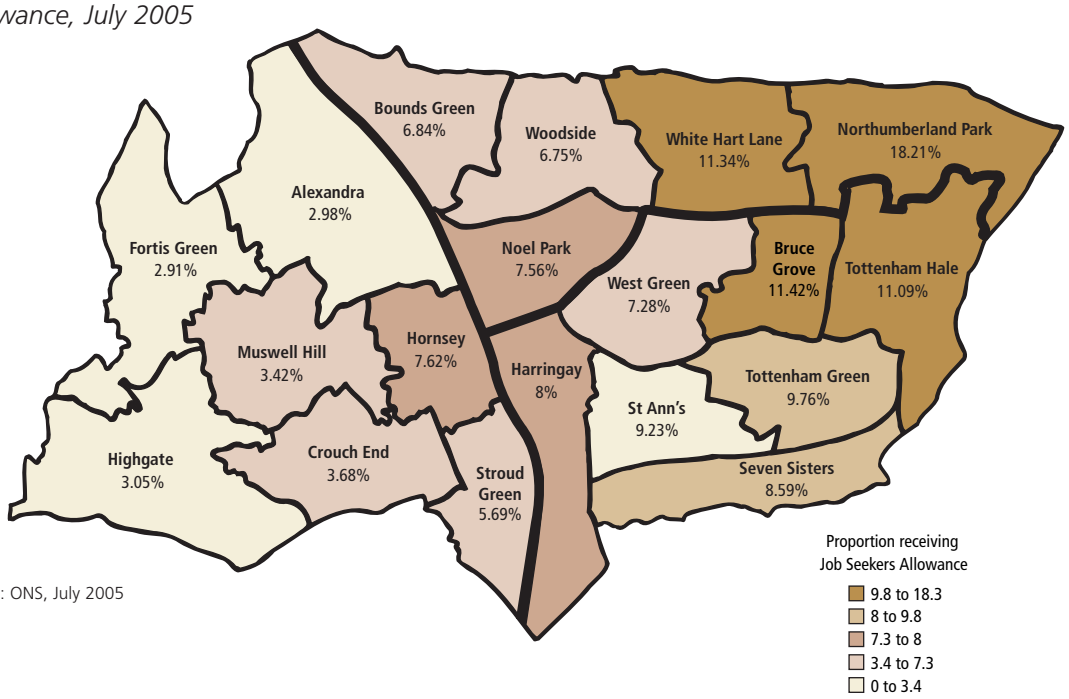
## 8.4 Living in a decent home

People on low income are less likely to own their home and more likely to live in damp, overcrowded homes that are poorly constructed and in need of repair. Women and children may spend more time at home, and so are more affected by poor housing conditions. Unhealthy conditions within the home may be compounded by poor external environments and geographical locations which have poor community resources, such as childcare, education and leisure facilities.

Nearly 60% of local authority housing in Haringey did not meet decent home standards in 2003. Haringey Council faces a challenging target to ensure that all its accommodation meets the decent homes standards by 2010.

Haringey has a significant homelessness problem. Over 5,000 households are living in temporary accommodation – the majority of these being households with children. In

***Figure 58*** *Proportion of economically active work force in Haringey claiming Job Seekers Allowance, July 2005*

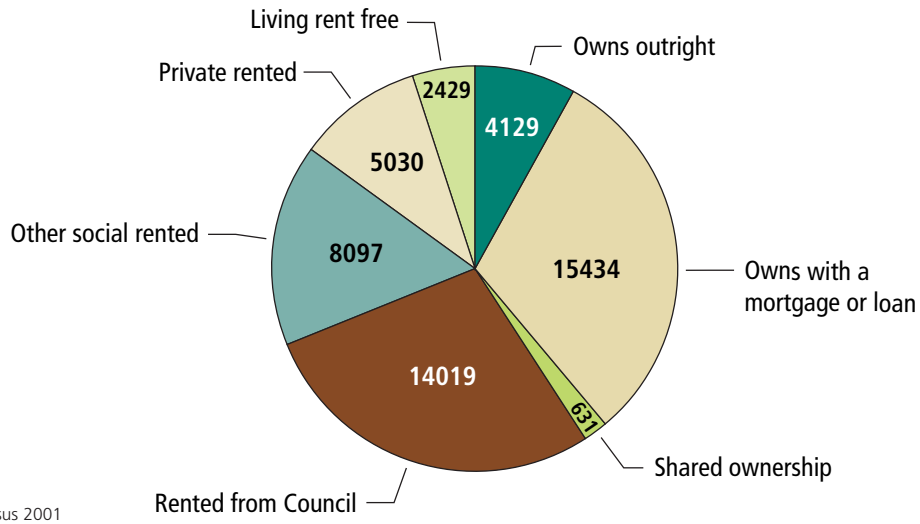



Source: ONS, July 2005

2003/04, 2,492 households approached Haringey Council as homeless, of which 1,309 (53%) were accepted[74]. The majority (815) of these were households with children. Figure 59 identifies the tenure of all households with dependent children in the 2001 Census.

Some Haringey residents are highly mobile. One analysis showed that families move an average of 3 or 4 times before settling, often with as many changes of school. A 2002 study on Social Exclusion and Children showed that environment and neighbourhood are strong influences on how or whether young people were able to access the relationships that develop their sense of belonging[75]. In April 2003, a Health Impact Assessment of Haringey Council's homeless-ness review identified that women and children appear at most risk of developing health problems as a result of being homeless.

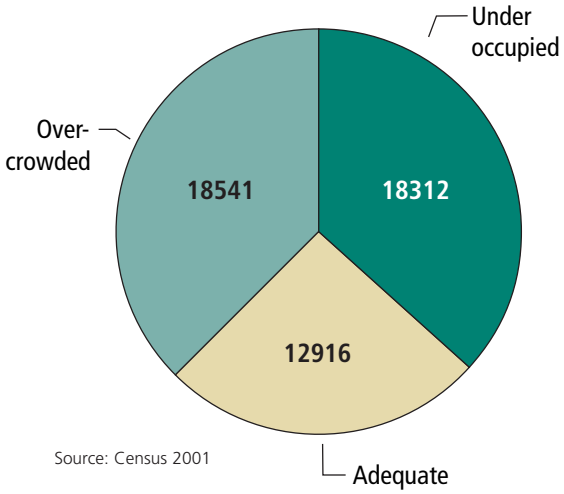
***Figure 59*** *Tenure of households with dependent children, 2001*




Source: Census 2001

The 2001 Census also suggested that a third of households with dependent children were overcrowded. Again this varied by ethnic group, with a larger proportion of black African and Bangladeshi families living in overcrowded housing than other ethnic groups.

***Figure 60*** *Number of households with dependent children in accommodation that is overcrowded, adequate or under occupied, 2001*




Source: Census 2001

## 8.5 Engaging in further education

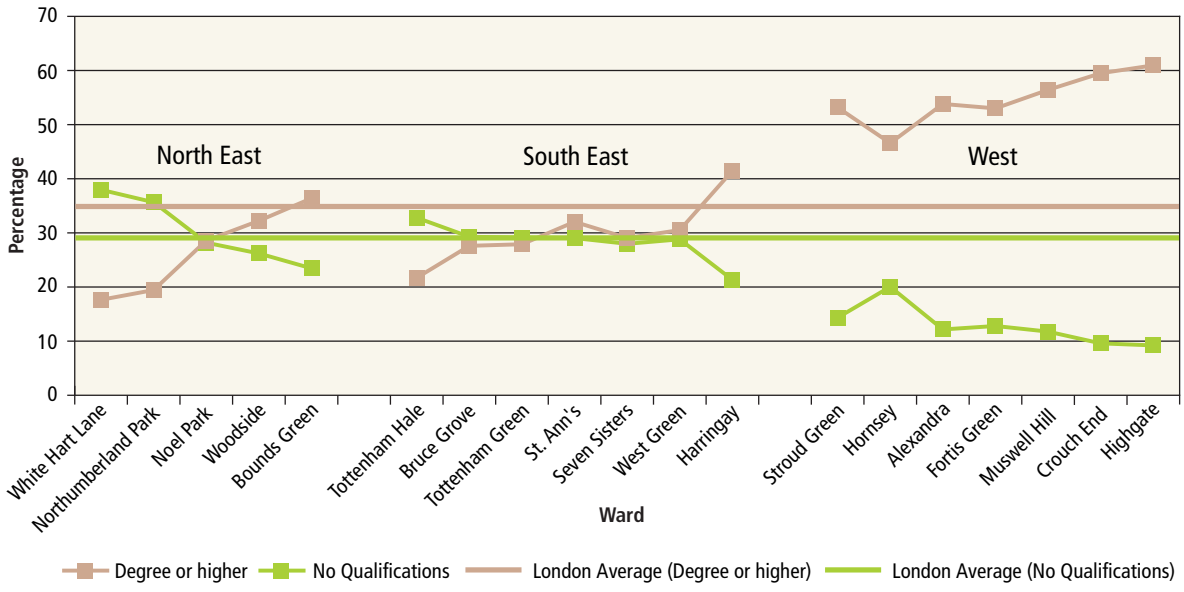
Education is a traditional route out of poverty for those living in disadvantage and can prepare children with the knowledge and skills to lead a healthy life. As illustrated in figure 61, there are fewer adults with no qualifications and higher proportion with degree level qualifications in the West Network area. Nearly 40% of the population of White Hart Lane have no qualifications.

## 8.6 Parental age

Women who have their children in their teenage years experience higher levels of socio-economic deprivation, and lower levels of educational attainment for both themselves and their children. Their children are also more likely to experience illness or injury[76].

The Haringey teenage pregnancy strategy aims to help teenage parents back into education, training and employment, and to reduce long-term social exclusion. The needs of teenage parents vary depending on their own childhood experiences, cultural background, support mechanisms, education, confidence, self esteem etc. A holistic approach is necessary to ensure that individuals are given an appropriate level of support i.e. parenting, childcare, confidence building, peer support, counselling, easier access to sexual health services and education, training and employment.

***Figure 61*** *Qualifications profile of Haringey residents aged 16-74, Census 2001*




Source: Census 2001

# 9. Conclusions and recommendations

This report suggests that the need for children's services varies between the West, North East and South East Network areas, both in terms of the number/age profile of children and their health and well-being. The detailed understanding of this need is essential to better plan and commission health and other services in partnership for each population of children. Some key issues to consider are;

- **Population distribution**
  There are more children and children aged under 5 in the South East Network area, which is also home to more vulnerable families (e.g. lone parents).

- **Population growth**
  The population of Haringey, and notably the number of children in Haringey, is expected to grow considerably by 2010, with growth most notable in the South East and North East Network areas.

- **Deprivation and inequalities**
  The close association between life expectancy and deprivation in Haringey reinforces the message from previous Health in Haringey reports that inequalities in social and economic factors are major drivers of health inequalities in our borough.

- **Family mobility**
  Family mobility poses major challenges to health and education services in assessing and meeting the needs of families. This may be a more prominent feature of particular network areas.

- **Vulnerable young people**
  There are significant numbers of children and young people living in Haringey who are especially vulnerable to poor health, through disability, mental health problems, living in temporary accommodation, living in poverty, being asylum seekers (especially without their families) or through being a traveller.

- **Emotional well-being**
  Emotional well-being is critical to all areas of development and social, educational and work achievement. Emotional disorders amongst young people are increasing.

- **Education**
  Significant and impressive year on year improvements in educational achievement are being made by Haringey children. However there remains a gap with the national average, and between different parts of the borough.

- **Immunisation**
  Immunisation coverage is insufficient to protect children in Haringey from infectious diseases.

- **Long term conditions**
  A substantial number of children live with long term conditions that adversely affect their health and well-being.

- **Accidents and injuries**
  Accidents and injuries are an important source of emergency admissions to

hospitals and death amongst children and young people.

- **Smoking – Adults and Young People**

Significant numbers of children smoke and even more are potentially exposed to second hand smoke. Measures to help adults quit smoking, and reduce children's exposure to tobacco smoke in public places would protect children's health.

- **Sexually Transmitted Infections (STIs)**

Young people are increasingly vulnerable to sexually transmitted infections, for example rates of Chlamydia infection are increasing.

- **Mortality**

More children and young people die in Haringey than would be expected given the size of the population. This is a trend that needs to be stopped.

## Recommendations

This report provides a first step in undertaking a needs assessment to inform the development of children's service networks in Haringey. It is hoped that the findings will inform the work of a range of partner organisations (separately and together) to plan, commission and deliver services together.

Key recommendations to all involved in services for Haringey, but especially to the Children and Young Peoples Partnership are:

- **Improve data quality, analysis and use**

This report highlights the lack of information on the extent to which children and young people are making healthy choices, and adopting and maintaining healthy behaviours. We know very little about emotional well-being, and do not understand enough about the cultural, social and economic barriers that may stand in the way of healthy choices.

- **Increase physical activity and eating of healthy foods**

Physical activity and good food do not have to be boring or feel like a dull duty. All services in Haringey should work together to help young people access the physical activity they enjoy and maintain that activity into adulthood. Nurseries and schools in particular can help with healthy eating by making meals attractive as well as nutritious. Reducing the number of fast food outlets in Haringey might be a single significant step toward healthy eating, particularly those close to our schools.

- **Enhance emotional well-being**

Focus on emotional well-being, self esteem and confidence from an early age and right through as these are key to achievement, breaking through cycles of poverty and deprivation and to overcoming their impact.

- **Minimise impact of inequalities**

Children are not born equal in their access to a decent home, a reasonable income, good schools, safe environments or even to the quality of the parenting they experience. All services should focus on readdressing these inequalities to reduce the likelihood of young people having their potential limited by the circumstances into which they are born.

- **Reduce mortality**

Reduce premature deaths through addressing the causes of infant mortality, reducing accidents and injuries amongst all young people, and through reducing the impacts of long-term illness on health.

# 10. Services and further information

## HARINGEY COUNCIL

**Directory of services for children, young people and their families in Haringey**
Tel: 020 8489 0000
Website: www.haringey.gov.uk/children.htm

**Haringey Childcare Information Service**
Tel: 0220 8801 1234
Website: www.childcarelink.gov.uk

**School Admissions Team**
48 Station Road, Wood Green, London N22 7TY
Tel: 020 8489 3876/3338

**Youth Service**
Podium Floor, River House Park,
225 High Street, Wood Green N22 8HQ
Tel: 020 8489 3312/3388
Email: youthoffice@haringey.gov.uk

**Young Carers Service**
Red Gables Family Centre,
113 Crouch Hill, N8 9QN
Tel: 020 8489 8001

**Haringey Young People's Counselling Service**
Wood Green Area Youth Project, New River Sports Complex, White Hart Lane,
Wood Green N22 5QW
Tel: 020 8489 8944
Email: sharon.akinkunmi@haringey.gov.uk
Website: www.haringey.gov.uk/children/youthservices/youthprojects

**Disabled Children's Team (Social services)**
Tel: 020 8489 3668

**Special Educational Needs Service**
Tel: 020 8489 3877

## CHILD PROTECTION

**Social Services**
Tel: 0845 070 1998

Tottenham District Office, 768-772 High Road,
Tottenham N17 OBU
Tel: 020 8489 5402

Hornsey District Office, The Broadway
Annexe, Hornsey Town Hall, Crouch End N8 9JJ
Tel: 020 8489 1856

## SURE START

**High Cross**
Lansdowne Health Centre,
1a Lansdowne Road, Tottenham N17 OLL
Tel 020 8885 6196

**Noel Park**
Shropshire Hall, Gladstone Avenue,
Wood Green London N22 6LN
Tel: 020 8826 9295

**Park Lane**
Neighbourhood Resource Centre,
177 Park Lane, Tottenham London N17 0HJ
Tel: 020 8489 2463

**Roundway**
Lansdowne Health Centre,
1a Lansdowne Road, Tottenham N17 OLL
Tel 020 8885 6196

**West Green & Chestnuts**
Flat 3 Oak House,
St Ann's Hospital, St Ann's Road,
Tottenham N15 3TH
Tel: 020 8442 6186/4186

## OTHER LOCAL SERVICES

**Connexions Tottenham**
*Provides advice, guidance and access to personal development opportunities for all young people aged 13 to 19.*
560-568 High Road, Tottenham,
London N17 9TA
Tel: 020 8808 0333
Website: www.connexions-direct.com

**Open Door**
*A free counselling service for young people aged 12-25.*
12 Middle Lane, Crouch End, London N8 8PL
Tel: 020 8348 5947
Website: www.opendooronline.org

**Antenna Outreach Service**
*A mental health support service for young black African and African-Caribbean people.*
Excel House, 312 Tottenham High Road,
London N15 4BN
Tel: 020 8365 9537
Email: antenna@outreachservice.fsnet.co.uk

**Step Ahead**
*Substance misuse support agency.*
Tel: 0800 028 6049
Email: simon.boyton@beh-mht.nhs.uk

**COSMIC**
*Support for families who are affected by alcohol or drugs.*
590 Seven Sisters Road, Haringey,
London N15 6HR
Tel: 0800 389 5257

**4YP**
*Directory of drop-in sessions and local support for sexual health matters.*
Tel: 020 8442 6892
Website: www.4yp.co.uk

## NATIONAL ORGANISATIONS

**Childline**
Tel: 0800 11 11
Website: www.childline.org.uk

**NSPCC Child Protection help-line**
Tel: 0808 800 5000
Website: www.nspcc.org.uk
www.worriedneed2talk.org.uk

**Young Minds**
Tel: 020 7336 8445
Website: www.youngminds.org.uk

**FPA – Family Planning Association**
*Contraception and sexual health guide.*
Tel: 0845 310 1334
Website: www.fpa.org.uk

**Talk to FRANK (national drugs help-line)**
Tel: 0800 776600
Website: www.talktofrank.com
Email: frank@talktofrank.com

**Wired For Health**
Healthy Schools Programme.
Website: www.wiredforhealth.gov.uk

**Bullying Online**
Website: www.bullying.co.uk

**Kidscape**
Works to prevent bullying and child abuse.
Tel: 020 7730 3300
08451 205 204 (parent help-line)
Website: webinfo@kidscape.org.uk

# 11. References


[1] Department of Health, 2004, Choosing Health- Making healthy choices easier

[2] Department of Health, 2003, Tacking Health Inequalities: A programme for action

[3] HM Government, 2004, Every Child Matters: Change for children,

[4] Hall, D.M.B. & Elliman D., (Ed.) 2003, Health for all Children: Fourth edition. OUP.

[5] Department for Education and Skills, 2004 National Service Framework for Children, Young People and Maternity Services.

[6] Haringey Teaching Primary Care Trust, 2003, The Haringey Health Report 2003

[7] Greater London Authority, 2003, Population projections for London

[8] Meltzer, H. and Gatwood, R., 2000, Mental health of children and adolescents in Great Britain, Office for National Statistics

[9] Rodrigues, V.C., 2004, Health of children looked after by the local authorities. Public Health, July 2004; 188:370-376

[10] Flemming, P., et al, 2005, An exploration of the health and social wellbeing needs of looked after young people – a multi-method approach. Journal of Interprofessional Care. Jan 2005;19(1):35-49.

[11] Stanley, N., et al, 2005, The mental health of looked after children: matching response to need. Health & Social Care in the Community. 2005 May; 13(3):239-48.

[12] Umstad, M. & Gronow, M., 2003, Multiple pregnancy: a modern epidemic? Medical Journal of Australia 278(12), 613-615

[13] National Institute of Clinical excellence, 2004, NICE clinical guidelines 1; Caesarean section

[14] Haringey Teaching Primary Care Trust, 2004, Infant mortality action plan 2003-2005

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

[16] Haringey Teaching Primary Care Trust, 2005, Local delivery plan 2005-8

[17] Drife, J., et al, 1998, Why mothers die- Report of the confidential enquiries into maternal deaths in the UK 1994-1996, London, The Stationery Office

[18] Johnson J. K. et al, 2003, The prevalence of domestic violence in pregnant women, British Journal of Obstetrics and Gynaecology, 110:272-5

[19] Hagel A., 2004, Time Trends in Adolescent Well-being. The Nuffield Foundation

[20] Collishaw S. et al, 2004, Time Trends in Adolescent Mental Health. Journal of Child Psychology and Psychiatry 45:8 (2004),pp 1350-1362.

[21] Department of Health, 2005, Choosing physical activity

[22] Alexander B. et al, 2005, The broader impact of walking to school, BMJ, 17th August 2005 (accessed on line)

[23] www.eatwell.gov.uk

[24] Gregory P. et al, 2002, The National Diet and Nutrition Survey: Adults Aged 19-64 years, and young people aged 4-18 years. London: the Stationery Office.

[25] Department of Health, 2005, Choosing a Better Diet: A Food and Health Action Plan. London

[26] Department of Health, 2002, School Fruit and Vegetable Scheme: Information for schools.

[27] Pitts et al. 2003, BASCD Coordinated Surveys. 2003

[28] Haringey Community Dental Service, 2004, Survey of Oral Health of five year olds in Haringey

[29] Chief medical officer, 2002, CMO Annual Report: second hand smoke kills

[30] White, P. and Watt, J., 2002, Tobacco in London: Facts and issues, SmokeFree London

[31] Department of Health, 1998, Smoking Kills – a white paper on tobacco

[32] Home Office, 1998, Tackling Drugs to Build a Better Britain – The Government's Ten year Strategy for Tackling Drugs Misuse

[33] Fuller, E. (Ed), 2005, Smoking, drinking an drug use among young people in England in 2004, Health and social care information centre, UK

[34] Working group on alcohol and health, 2005, Discussion paper on the European Union strategy on alcohol, E.U.

[35] Further information available at www.haringey.gov.uk

[36] Erens, B. et al, 2003, National survey of sexual attitudes and lifestyles II: reference tables and summary support. NatCen.


[37] Department of Health, 2001, National strategy for sexual health and HIV.

[38] Health protection agency, 2004, Sexually transmitted infections in young Londoners 2004: Response to the London Assembly Scrutiny into young people's sexual health, London Regional Epidemiology Unit

[39] Towner and Dowswell, 2001, What works to prevent unintentional injury amongst children? Department of Child Health, University of Newcastle

[40] Department of Health, 2005, Tackling health inequalities: Status report on the programme for action, DOH

[41] The health of Londoners programme, 2001, Too high a price: Injuries and accidents in London

[42] Grayling C., et al, 2002, Streets ahead: Safe and liveable streets for children. London: Institute for Public Policy Research

[43] London Health Commission, 2004, Health in London Report

[44] NSPCC, 2003, Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect.

[45] McVeigh, C. et al, 2005, Violent Britain: People, prevention and public health. Liverpool John Moores University.

[46] NSPCC, 2005, Sugar: Teen abuse survey of Great Britain

[47] Ofsted, 2003, Bullying: Effective action in secondary schools,

[48] Flood-Page, A., 2000, Youth crime: Findings from 1998/1999 Youth Lifestyles Survey

[49] Katz, A., 2001, Bullying in Britain: Testimonies from teenagers,

[50] Haringey Council, 2004, Crime and drugs audit 2001-2004,

[51] Acheson, D., 1998, Independent Inquiry into Inequalities in Health Report.

[52] Department for Education and Skills, 2002, Birth to three matters: A Framework to support children in their earliest years.

[53] Qualifications and Curriculum Authority, 2003, Foundation Stage Profile.

[54] Department for Education and Skills. 2004, Excellence in Cities

[55] Home Office, 2005, Race Equality in Public Services.

[56] Department for Education and Skills. 2003, Key Stage 3 National Strategy. Advice on whole school behaviour and attendance policy.

[57] Department for Education and Skills, 2003, Learning through PE and Sport. A guide to the Physical Education, School Sport and Club Links Strategy

[58] Cummings, C. et al, 2004, Evaluation of the Extended Schools Pathfinder Projects. DfES Research Brief and Report 530.

[59] Cooper, H., et al The influence of social support and social capital on health. A review and analysis of British data. Social Capital for Health. Health Education Authority, 1999

[60] Morrow V., 2003, Children's experience of 'community': implications of social capital discourses.

[61] Glover, S., et al, Social environments and the emotional wellbeing of young people, Family Matters, Australia: 49, 11-17, 1998

[62] Royal College of Paediatrics and Child Health, 2002, Helpful parenting: the report of a Joint Working Party

[63] Barlow, J., et al Preventing emotional and behavioural problems: the effectiveness of parenting programmes with children less than 3 years of age. Child Care Health Development. 2005 Jan; 31(1):33-42.

[64] Park, A., et al, 2004, Young People in Britain: The attitudes and experiences of 12 to 19 year olds. Research Report No 564, National Centre or Social Research

[65] Coulthard, M., et al, 2002, People's perceptions of their neighbourhood and community involvement. Results from the social capital module of the General Household Survey 2000. London Stationery Office

[66] General Household Survey 2000

[67] Haringey Youth Service, 2004, Business Plan 2004 to 2007

[68] Edwards, D.M., et al, 2002, Access to dental services for disabled people. A questionnaire survey of dental practices in Merseyside. British Dental Journal. Sep 14; 193(5):253-5.

[69] Webb E., 2004, Discrimination against children. Arch Dis Child. Sep; 89(9):804-08.

[70] Bhui, K. et al., 2005, Racial/ethnic discrimination and common mental disorders among workers: findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom. American Journal of Public Health. Mar; 95(3):496-501.

[71] Williams D. et al, 2003, Racial/ethnic discrimination and health: findings from community studies. American Journal of Public Health. Mar; 93(2):200-08.

[72] Social Exclusion Unit, 2004, Breaking the Cycle: taking stock of progress and priorities for the future, Office of the Deputy Prime Minister

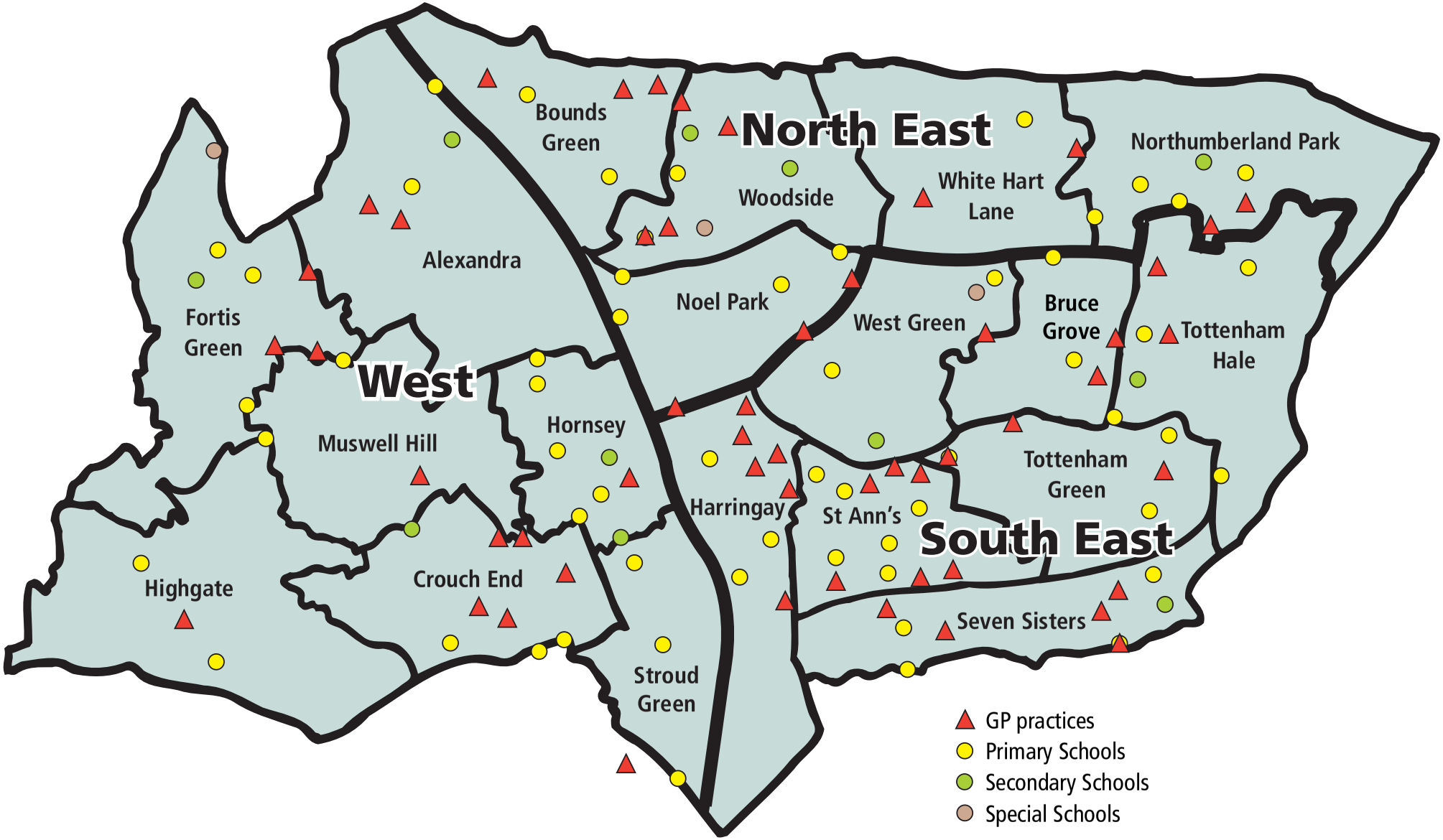
[73] Marmot, M. and Wilkinson R., 1999, Social Determinants of Health, Oxford UP,

[74] Haringey Council, 2003, Haringey Homelessness Strategy 2003 – 2008

[75] Health Development Agency, 2002, Social capital for health – Insights from qualitative research

[76] Social Exclusion Unit, 1999, Teenage pregnancy strategy

## Location of GP practices and schools in Haringey Children's Network Areas



HARINGEY COUNCIL

Haringey NHS
Teaching Primary Care Trust