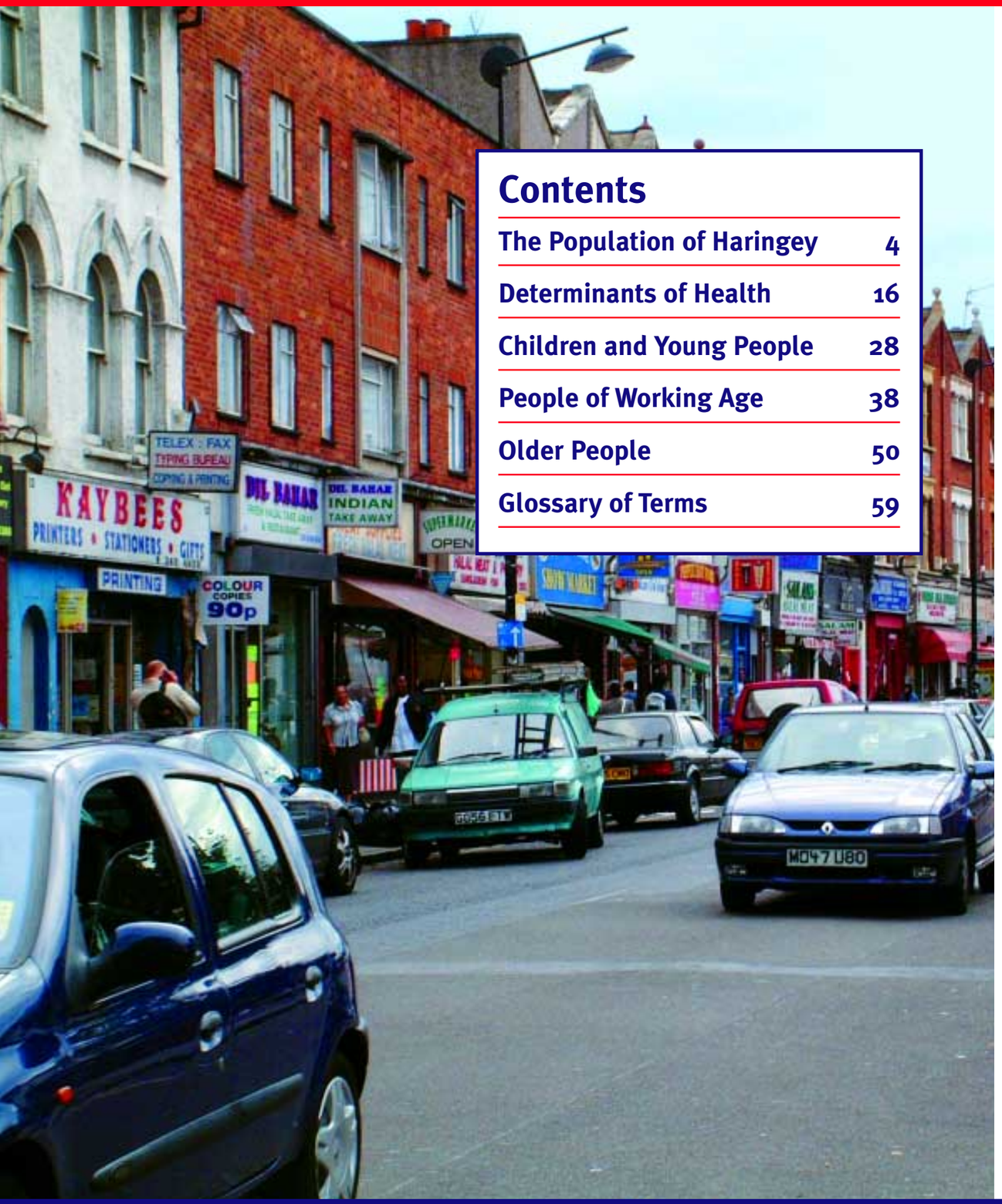
Haringey Health Report 2003



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Foreword

Welcome to Haringey Health Report 2003. This is the first report in recent years which focuses solely on the health of people in Haringey. With the advent of Haringey Teaching Primary Care Trust (TPCT) Haringey has its own Director of Public Health and in keeping with responsibilities of such Directors I have produced the first public health report to the TPCT.

In 2001 a national Census was conducted across the country. Analyses of data from that Census has now been released. This Census provides us with opportunities to understand more about who lives in Haringey, where they live and how this impacts on their health. It allows us to calculate afresh rates of sickness and death in Haringey. It also updates us on some of the factors which influence people's health such as housing, employment, income and education.

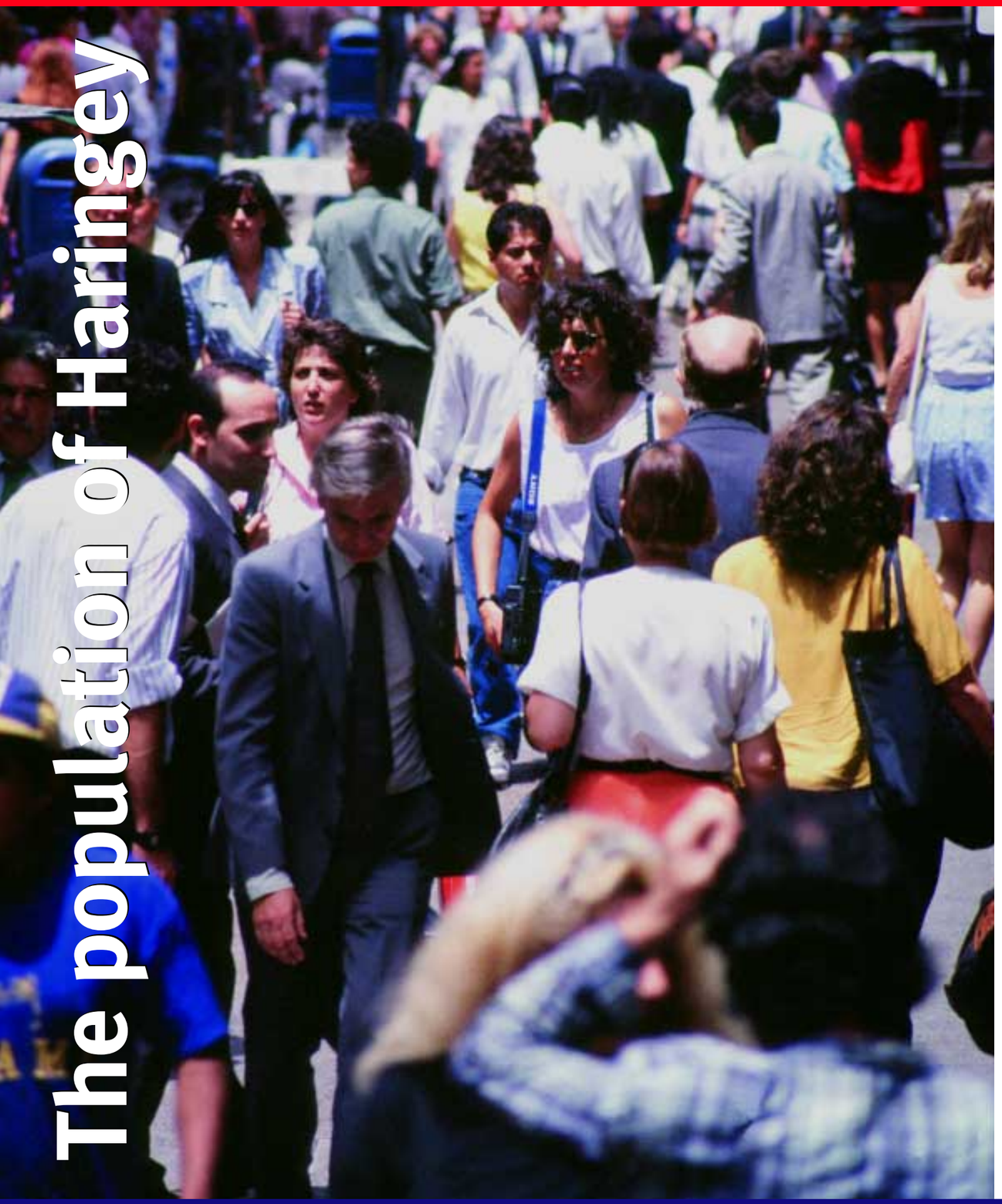
Throughout the report data is presented to help explain how Haringey compares with London and with England and Wales as a whole. It also attempts to show the many differences between wards in Haringey whether it be about who lives where, who becomes ill or who is most likely to die early. It raises some questions and poses some challenges. For instance why are people of Northumberland Park so likely to have poor health and living experience? Are there reasons why older people in Muswell Hill are more likely to have accidents?

This is not a comprehensive report on all aspects of health in Haringey. Rather it is a starting point for further explorations and understanding. It is here to inform, to stimulate discussion and to encourage actions by all sectors of the community to improve health.

There were a number of key people involved in the preparation of this report. I would particularly like to thank Cam Lugton for making it all happen; Chikwe Ihekweazu for meticulous and extensive analysis of data working to very short timescales; Gerry Taylor, Michele Daniels and Julian Elston for significant contributions to the content of the report. Chris Oram of the Health Infomatics Service gave us much assistance with data collection. In addition we received substantial assistance from Haringey Council, in particular Tim Lyne who helped with analysis of data and production of maps. Very importantly I would like to thank those people who were generous enough to share their stories of health and illness in Haringey. Jude Clements, Khalid Ali, Lynn Altass, Jan Edwards and Telsa Walker helped bring these experiences to our attention.

I hope you find the report of interest.

Ann Marie Connolly
Director of Health Improvement
Haringey Teaching Primary Care Trust



The population of Haringey

Haringey has a relatively young, economically disparate, ethnically and culturally diverse population. It is made up of 19 wards. New ward boundaries were delineated in 2002.

This report will include data based on new ward boundaries for the first time. A wealth of information was released in the 2001 Census.[1] Borough and ward level information were released at different times during 2003. In this report, we have included summary data from the Census with relevance to Haringey.

The projected population for Haringey is 221,947. This is based on the Census figures of 2001, which placed the population of Haringey at 216,507. Approximately 48% of the population are male and 52% are female. This is in line with sex distribution at national level. About 25% of the population are aged 0-19 years; this too is in line with national and London-wide distributions.

As may be seen from the two pyramids overleaf (Figures 2 & 3), this is where the population similarities with England and Wales, as well as with London, end. The age group 20 – 39 accounts for about 40% of the population of Haringey while it accounts for 36% in London and only 28% at the national level. Only about 35% of Haringey's population is aged 40 and above. People aged over 40 account for approximately 40% of London's population and approximately 47% of the population of England and Wales. The proportion of the population aged over 65 accounts for 1.7 times more of the population in England and Wales (16.0%) compared with Haringey (9.8%).

The population pyramids show 5-year proportions of the population by sex as compared to each other, across the entire age spectrum.

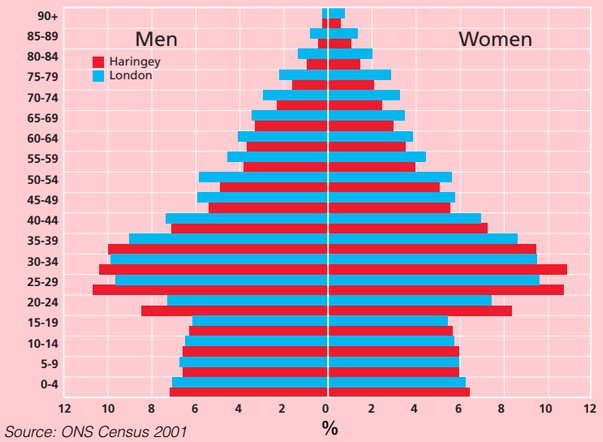
1 The new ward boundaries in Haringey (from May 2002)

The population of Haringey

2 Population Pyramid of Haringey Vs. England

Source: ONS Census 2001

3 The Population Pyramid of Haringey Vs. London



Source: ONS Census 2001

In summary, the proportion of our 'young adult' population i.e. people aged between 20 and 39 is significantly more than the national average while we have a significantly lower proportion of people aged over 40. This is easily recognised in the population pyramids (Figures 2&3).

There are also wide variations in the population structures of the individual wards in Haringey. The two population pyramids for the wards Crouch End and White Hart Lane (Figure 4) depicts this.

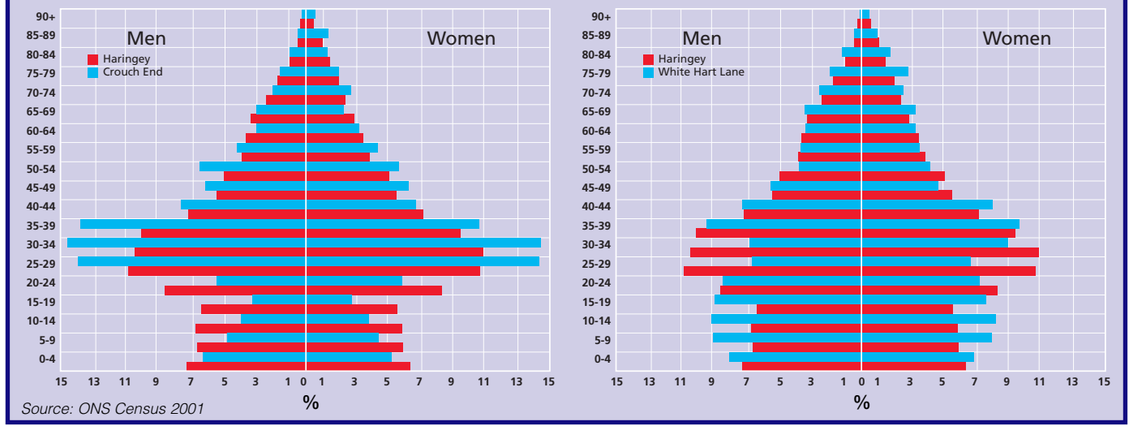
Although the 2001 Census suggests that the population of Haringey grew only by about 4% between 1991 and 2001, the substantial population mobility in Haringey has lead to a varying rate of growth among the various ethnic groups resident in the borough. The population of people registered with GPs as resident in Haringey is also substantially larger than the Census resident population. These two phenomena are explored in more detail below.

The GP registered population

There is a persisting variance between the 'resident population' (the projected population of Haringey based on the Census of 2001) and the 'registered population' (the population of people registered with GP practices as resident in Haringey). The 'registered population' is based on the address given to GPs. The GPs' practices themselves might extend beyond the boundaries of Haringey.

While the 'resident population' for 2003 is 221,947, the 'registered population' based on GP registers as at April 2003 was 275,251, a difference of 53,304 (19.37%). People aged 25-49 accounted for the largest differences of 50.6% (26,953 people). In this population difference of 53,304, there are 1.8 times more males than females (34,400 to 18,904). The largest differences of 2-4 times are in those aged 35-65.

4 The Population Pyramids of Haringey Vs. Crouch End and White Hart Lane



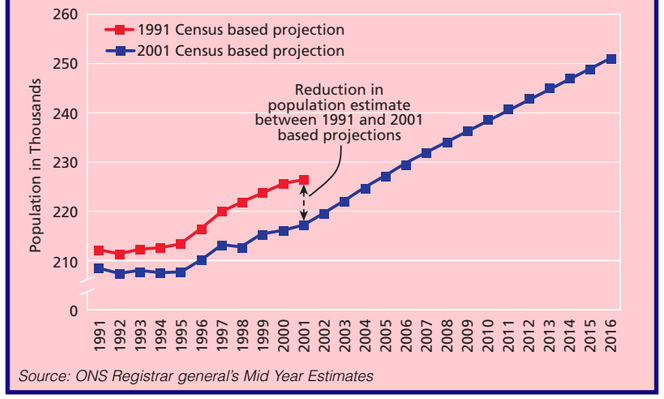
Source: ONS Census 2001

A possible explanation for this situation is that Haringey is known to have highly mobile populations. The possible effect of this is that people are not removed from GP registers when they move, leading to list inflation. Another possible factor is the high number of refugees and asylum seekers in the borough who may not have filled in Census forms due to language difficulties or anxiety about official forms. Therefore these groups may be under-represented in the Census. It is likely that both these explanations contribute to this occurrence.

Population Change

Haringey's population based on the 2001 Census was considerably lower than the expected population based on projections from the 1991 Census, as depicted in Figure 5. This apparent demographical change will invariably lead to mortality rates for several disease conditions being higher than previously estimated due to a reduction in the denominator data; the population.

5 Difference between population estimates based on the 1991 and 2001 Census



Source: ONS Registrar general's Mid Year Estimates

The population of Haringey

Ethnicity

The 2001 Census provided a comprehensive source of information about the ethnic origin of Haringey residents. This will provide benchmarks for targeting services and prevention programmes at the Borough's ethnic groups. The table below shows a detailed breakdown of the new data.

The 2001 Census was the first to provide separate data on the proportion of residents of other white ethnic origin. Haringey was found to have the third largest proportion of other white residents in London (16.1%).

Of the 34,752 people who classified themselves as white-other, 30% said they were born in Eastern Europe (including Turkey) and 14% in the Middle East including Cyprus. Anecdotal evidence shows that this seems to be an underestimation of the Turkish, Kurdish and Turkish Cypriot and Greek Cypriot communities in Haringey.

Haringey has the second highest proportion of residents in London who classified themselves as being of mixed ethnic origin (4.6%). It also has the fifth highest proportion of residents of black African ethnic origin, as well as the fifth highest proportion of residents of black Caribbean ethnic origin (9.5%) in London in 2001. The proportions of Haringey residents in all the Asian or Asian British categories (Indian, Pakistani, Bangladeshi and other Asian) were below the London average in 2001. Less than half of Haringey's residents (45.3%) are of white British ethnic origin, the sixth lowest in London.

Table 1. Ethnic Origin of Haringey Residents 2001

	Haringey		London	England
Ethnic Group	Number	%	%	%
White – British	98,028	45.3	59.8	87.0
White – Irish	9,302	4.3	3.1	1.3
Other White	34,752	16.0	8.3	2.7
Sub Total White	**142,082**	**65.7**	**71.1**	**90.9**
White & Black Caribbean	3,205	1.5	1.0	0.5
White & Black African	1,551	0.7	0.5	0.2
White & Asian	2,329	1.1	0.8	0.4
Other Mixed	2,761	1.3	0.8	0.3
Sub Total Mixed	**9,846**	**4.6**	**3.2**	**1.3**
Indian	6,171	2.8	6.1	2.1
Pakistani	2,046	0.9	2.0	1.4
Bangladeshi	2,961	1.4	2.1	0.6
Asian or Asian British – Other	3,348	1.5	1.9	0.5
Sub Total Asian & Asian British	**14,526**	**6.7**	**12.1**	**4.6**
Caribbean	20,570	9.5	4.8	1.1
African	19,879	9.2	5.3	1.0
Black or Black British – Other	2,928	1.3	0.8	0.2
Sub Total Black or Black British	**43,377**	**20.0**	**10.9**	**2.3**
Chinese	2,444	1.1	1.1	0.4
Other Ethnic Group	4,232	1.9	1.6	0.4
Sub Total Chinese or Others	**6,676**	**3.1**	**2.7**	**0.9**
Total	**216,507**	**100%**	**100%**	**100%**

Source: ONS Census 2001

Census-identified changes in Ethnicity 1991 –2001

The biggest change in an ethnic group identified by the Census was for residents of black African ethnic origin, which almost doubled from 5.5% (11,000) in 1991 to 9.2% (over 21,000) in 2001. The number of residents of black Caribbean ethnic origin rose by a quarter from almost 19,000 to nearly 24,000. Large proportional increases also occurred for Pakistani, other Asian and other non-white ethnic origins, but the numbers involved are much smaller. Changes in 'other' categories may have be affected by definitional changes between Censuses i.e. people who previously classified themselves as 'other' might now have classified themselves into one of the new groups which did not exist in the 1991 Census. Residents of Indian ethnic origin fell by over 1,000 (15%) to just over 6,000. The fall in residents of black other ethnic origin may be due to definitional changes. The white population overall fell by only 1,500 (1%) to 142,000 but as a proportion of the borough's population as a whole fell from 71% to less than 66%.

Table 2. Changes in Ethnicity 1991 –2001

Ethnic Origin	1991		2001		1991-2001
1991 Census Definition	Number	%	Number	%	% Change
Black Caribbean	18862	9.3	23775	11.0	+26%
Black African	11085	5.5	21430	9.9	+93%
Black Other	4613	2.3	2928	1.4	-37%
Indian	7265	3.6	6171	2.9	-15%
Pakistani	1476	0.7	2046	1.0	+39%
Bangladeshi	3060	1.5	2961	1.4	–3%
Chinese	2270	1.1	2444	1.1	+ 8%
Other Asian	4571	2.3	5677	2.6	+24%
Other Non White Ethnic Origin	5465	2.7	6993	0.2	+28%
White	143537	71.0	142082	65.6	– 1%
Total (1991 Census residents not revised)	202204	100%	216507	100%	+7%

Note: Comparisons between 1991 and 2001 are problematic because of changes in definitions, particularly for white sub categories and mixed black/white ethnic origins. Percentages may not add due to rounding

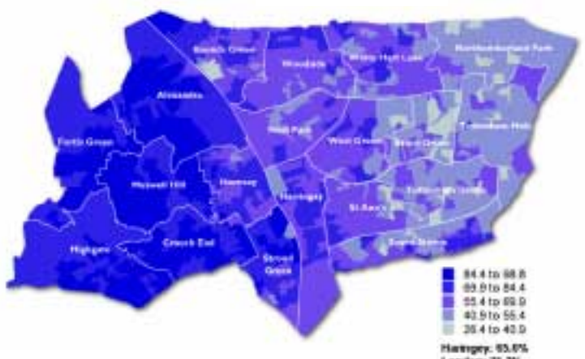
Ethnicity: Intra-borough distribution

As can be seen in the maps below (Figures 6-9), the distributions of the major ethnic groups within the borough follow an interesting pattern. The geographical areas used in these maps are 'Census output areas'. Output areas are the smallest geographical unit in the Census and represent about 125 households. These normally comprise of whole unit postcodes.

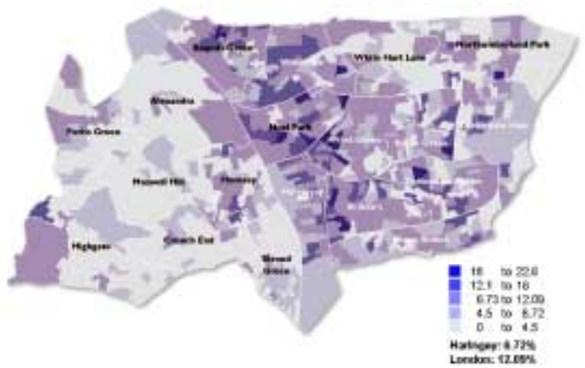
While there is a larger concentration of those who classified themselves as white in the more affluent west of Haringey, both the black African and black Caribbean communities are concentrated in the less affluent east of Haringey. Residents of Asian ethnic origin seem to be concentrated in the middle of the borough.

6, 7, 8 & 9 Percentage of population belonging to Ethnic groups in Census Output areas

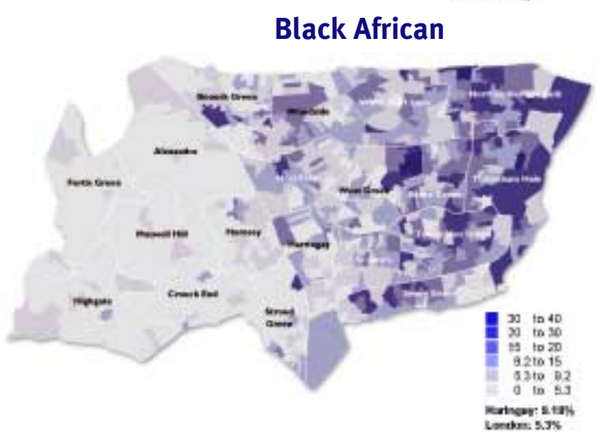
White



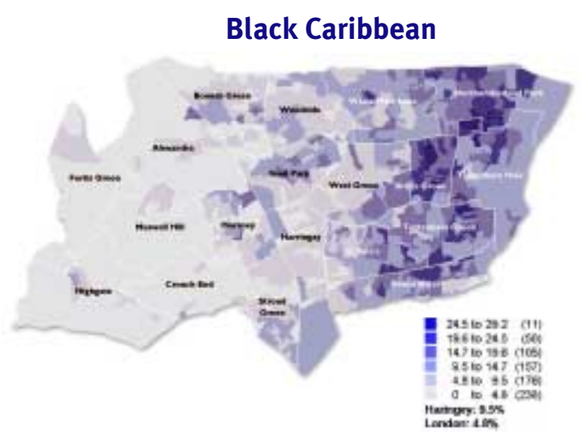
Asian



Black African



Black Caribbean



Source: ONS Census 2001

Asylum Seekers and Refugees in Haringey

Haringey is the destination for many asylum seekers and currently accommodates the largest number in London (there are around 7,000 known asylum seekers in the borough placed by Haringey Council and the National Asylum Support Service (NASS)). However, in addition to this number there are placements in Haringey made by other local authorities. There are those refused asylum who have not left and those here illegally. There are a large number of people granted refugee status or extended leave to remain. The precise number is unknown. In 2001 the Greater London Authority (GLA) estimated there to be between 352,000 and 422,000 refugee and asylum seekers living in London. The Census 2001 suggests that around 35,000 people living in Haringey were born in countries which have historically produced refugee and asylum seekers.[5]

Research indicates that asylum seekers and refugees have diverse and complex health needs. Many experience mental health problems and may have chronic infectious diseases. They are generally a young population with high levels of need for sexual, maternity and child health services.[4]

Research also shows that they have poor access to health care and other services, language being a major barrier.

In primary care, the majority of refugee and asylum seekers seen are Kurdish, Kosovan or Somalian. Most of these patients are under the age of 40 years. Some practices are seeing refugees and asylum seekers from as many as 50 different countries.

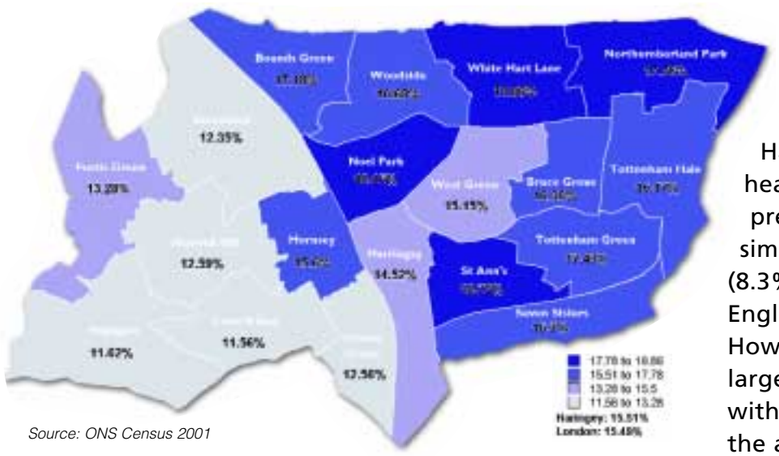
Summary of Health Status

Census Indicators on Health

The Census 2001 contained three broad questions about health. These indicate that Haringey as a whole has a self-reported health status slightly better than that of London and England and Wales.

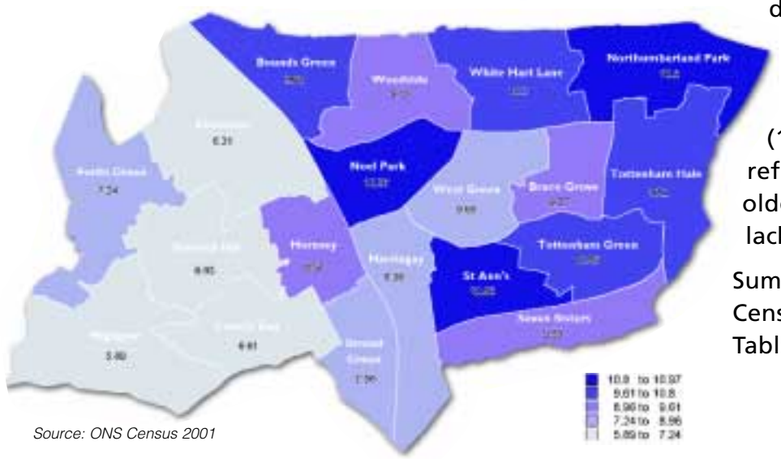
The proportion of people reporting any long-term illness, health problem or disability, which limits daily activities or work, including problems due to old age in Haringey was the same as London (15.5%), nearly 3% lower than from England and Wales (18.2%). This difference might be explained by the relatively young population in Haringey as the proportion of people with a limiting long-term illness in the working population (16-64 for men and 16-59 for women) is much less (8.7%), as might be expected, although similar to England and Wales (8.3%) but slightly higher than London (7.7%).

10 People with Limiting Long-term Illness in Haringey Wards (all ages)



Source: ONS Census 2001

11 Percentage of People whose health was: 'not good'



Source: ONS Census 2001

However, Figure 10 shows there are large intra-borough differences, with wards in the north east of the borough generally having worse rates than those on the west.

The proportion of people in Haringey who reported their health as 'not good' over the previous 12 months was 8.5%, similar to the London average (8.3%) and slightly below that of England and Wales (9.2%). However, Figure 11 shows there are large intra-borough differences, with some wards showing double the average.

Finally the levels of 'unpaid care' in Haringey – people looking after or giving help or support to family members, friends, neighbours or others, because of long-term physical or mental ill-health or disability, or problems related to old age – are slightly lower at 7.4% than in London (8.5%) and England and Wales (10.0%). Again, this probably reflects the lower proportion of older people locally rather than a lack of need for carers.

Summary data from the 2001 Census for Haringey is presented in Table 3.

Table 3. Census summary for Haringey

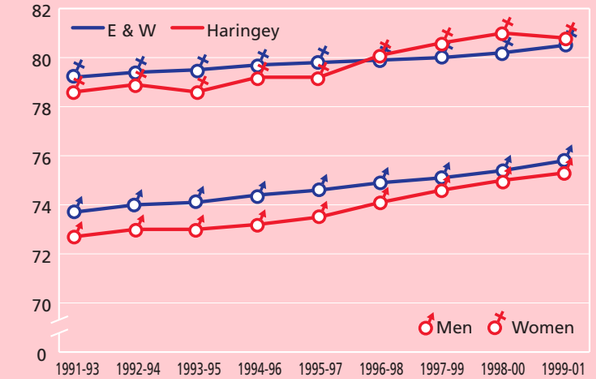
	Haringey	London	England & Wales
Population Density (Persons per Hectare)	73.2	45.0	3.4
People Aged 75 and Over (%)	4.3	5.9	7.5
Population Change 1991-2001 (%)	4.6	5.0	2.5
People, Places and Families			
Households Without Car or Van (%)	46.5	37.5	26.8
One Person Households (%)	35.9	34.7	30.0
Lone Parent Households (%)	13.6	11.1	9.6
Ethnicity and Religion			
Non-White Ethnic Group (%)	34.4	28.8	8.7
People Born Outside UK (%)	37.1	27.1	8.9
Christians	50.1	58.2	71.7
Health			
People with a Limiting Long-Term Illness (%)	15.5	15.5	18.2
People with General Health 'Not Good' (%)	9.0	8.3	9.2
People who provide Unpaid Care (%)	7.4	8.5	10.0

Source: ONS Census 2001

Life Expectancy

Life expectancy in Haringey has continued to rise along with national trends. Life expectancy for females has remained higher than the national average since 1996, whilst life expectancy for males has remained below the national trend. Among the boroughs in London, Haringey ranks 22nd in terms of male life expectancy and 21st in terms of female.[2]

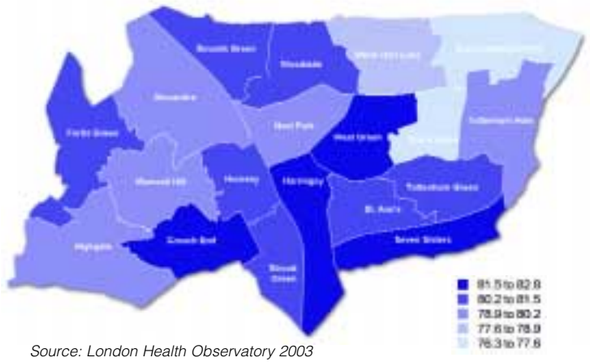
12 Life Expectancy in Haringey compared to England and Wales



Source: London Health Observatory 2003

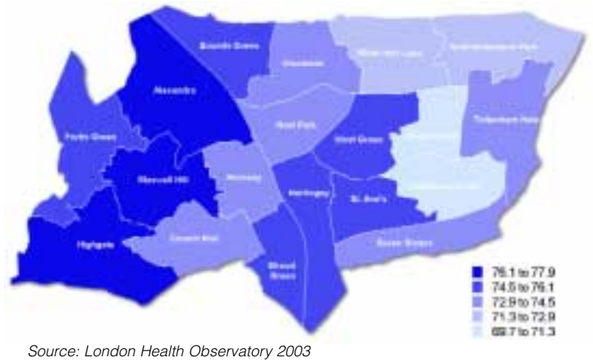
The population of Haringey

13 Ward Level Life expectancy for Women



Source: London Health Observatory 2003

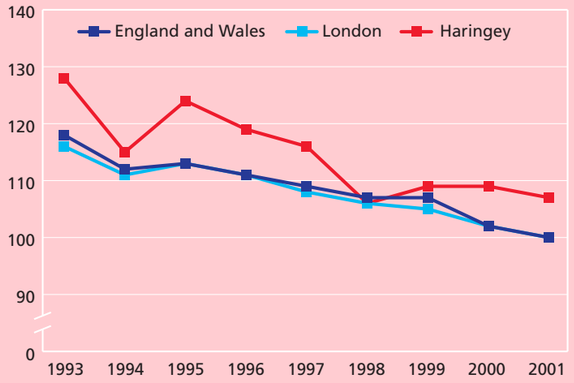
14 Ward Level Life expectancy for Men



Source: London Health Observatory 2003

These two maps show ward-level life expectancy across the borough. This is produced with mortality data spanning 5 years. For males, there is an obvious east-west gradient, darker shades reflecting longer life. However this is not as obvious for females.

15 SMR in Haringey compared to England and Wales and London



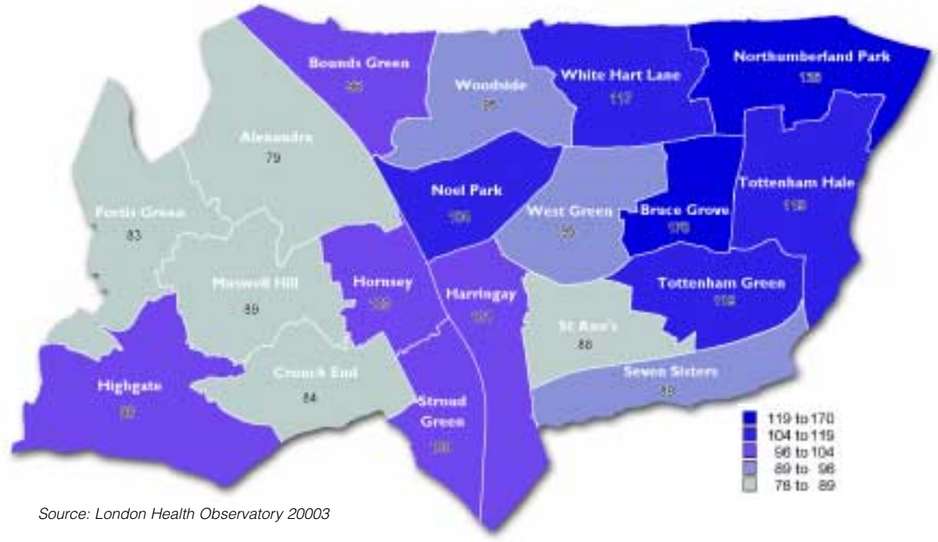
Source: Compendium of Clinical Indicators 2002

Standardised Mortality Ratio (SMR)

SMRs are a way of comparing death rates in an area to that of a standard population, usually England and Wales. Standardised means that the calculations have taken into account the differences in the age and sex composition of each population (for a more detailed explanation see the Glossary). Figure 15 shows the SMR for Haringey is slightly but significantly higher than that of England and Wales.[3]

Using Haringey as a standard population allows comparison between wards, and for differences in age and sex. Figure 16 shows the SMRs for all causes at all ages by ward, using pooled mortality data for 2001-2002. Haringey has an SMR of 100 for this map. All cause mortality is higher in the east than the west, with particularly high SMRs in Bruce Grove and Northumberland Park.

16 SMR in Haringey wards



Source: London Health Observatory 20003

Conclusion

In summary, while the overall population of Haringey is growing at similar rates to the national average, there are widely varied rates of growth among the different ethnic populations resident in the borough. Most significant of these is the black African population whose population has doubled since the last Census.

The age structure of the population is also significantly different from the national picture with Haringey having a much larger proportion of young adults, and relatively fewer older people.

Summary health indicators show that while Haringey's population is on the average as healthy as people living in the rest of the country, large differences exist within the east and west of the Borough.

References

1 Office of National Statistics (ONS), http://www.statistics.gov.uk/census2001/default.asp

2 London Health Observatory, http://www.lho.org.uk/

3 Clinical and Health Outcomes Knowledge base, http://nww.nchod.nhs.uk/

4 Klynman N & Connolly, Pilot Study : Primary Care Services for Refugees and Asylum Seekers in Haringey, 2000

5 Haringey Council – Office of the Chief Executive. Estimates based on various studies and current numbers of asylum seekers supported by LBH

Determinants of Health

What determines how healthy we are often lies beyond the direct influence of health and social care services.

There are many factors relating to our social and economic environment which impact significantly on our health and well-being. These are often referred to as the 'determinants of health'. There is now a large body of research that demonstrates education, unemployment, poverty and low income, housing and the environment significantly affect physical and mental health, for better or worse. However, these determinants are not evenly distributed across society. Furthermore, determinants often interact with one another, reinforcing their impact. The diagram shows how deprivation in communities can be self-reinforcing. As a consequence, some communities are affected more than others and show marked difference in health status.[1] This can lead to a 'cycle of inequalities' where inequalities in determinants begin at birth, continue throughout life and are passed on to the next generation.[2] This chapter explores the distribution of the determinants of health in Haringey, revealing stark contrasts across the borough.

1 A generalised cycle of community deprivation

Education

Education is a fundamental determinant of health and plays a significant role in health inequalities.[1,2] Research, for example, has demonstrated an association between educational attainment at 15-16 and coronary heart disease.[2] Education may impact on health in a number of ways.[1] Primarily, education attainment influences socio-economic position, which in turn influences income, housing and other material resources available to

Determinants of Health

individuals. However, education also helps ensure that individuals have the knowledge and skills to lead a full and healthy life, enhancing awareness of their rights and access to services. Finally, educational institutions can provide a safe and healthy environment in which people can develop.

Levels of education in Haringey

Census data shows that Haringey has a similar percentage of people (16-74 years) without any qualifications (23.4%) as the London average (23.7%), although this is less than the average for England and Wales (29.1%).

However, people without qualifications are not evenly distributed across the borough. Wards in the east and several central wards have lower levels of educational attainment than the London average. Levels of qualifications are particularly poor in White Hart Lane, Northumberland Park and Tottenham Hale.

In contrast, there is a relatively high number of people qualified to degree level or higher in Haringey (37.9%), greater than the London average (31.0%), and almost twice the level of England and Wales (19.8%). However, the wards with highest levels of people qualified to degree level are in the west.

Levels of educational achievement may not reflect directly the quality of education in local schools as people who have been educated elsewhere move into the area. Academic achievement in Haringey schools is below the national average in both primary and secondary education. However, levels in 2002 had improved since the previous year. GCSE results in 2002 show only 35% of pupils gained 5 or more A* to C grades, over 15% below the national average (51%).[3] Performance across the borough is not evenly distributed. Primary schools in the west of Haringey achieve higher Key Stage scores than those in the east.

One factor that significantly influences school performance locally is pupil mobility – movement between or changes of school.[3] The longer children stay in their schools, the better their levels of academic achievement. Mobility across the borough however varies from 2% to 68%. Schools with the highest turnover are in central and eastern wards. One cause is the movement of asylum seekers housed in the borough as they move from temporary to permanent accommodation. Attendance at schools by children from these families tends to be transitory.[3] Further information around educational attainment and deprivation is discussed later in this chapter.

National figures show that achievement is also influenced by gender and ethnicity. In England and Wales, average attainment level for boys is around 10% lower than for girls.[4] Pakistani and Bangladeshi children (22%) and black[∞] boys' (31%) pass rate of 5 or more A* to C grades is less than white boys. Although black girls (46%) perform considerably better than their male counterparts, achievement is only marginally better than white boys and not as high as white girls.[5]

(Un)employment

Employment status is also a key determinant of health and health inequalities.[2] Employment can provide a source of social status and purpose, giving structure and meaning to life.[1] This can contribute positively to health status, directly through increasing self-esteem or indirectly through improving material wealth and social support. On the other hand, poor working practices or conditions or lack of control over work can also expose individuals to health risks.[6] Similarly, unemployment can impact on physical and mental health, increasing the risk of illness and premature death.[7] For example, a middle-aged man who loses his job is twice as likely to die in the next five years as a man who remains employed.[7]

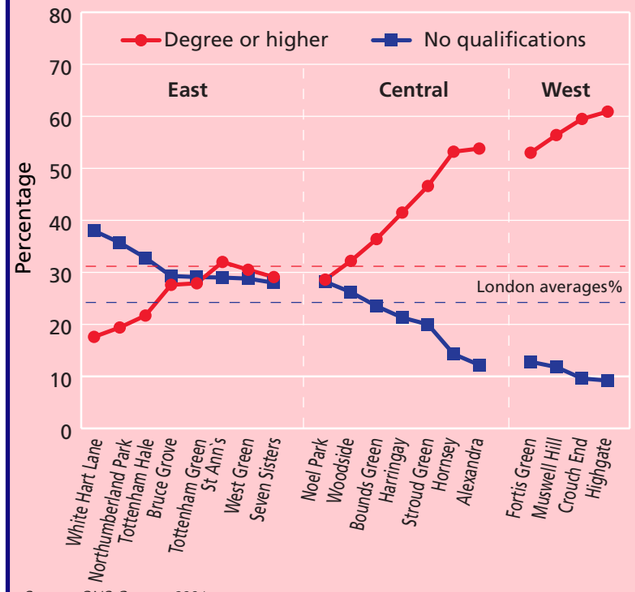
However, in society certain individuals or populations are more likely to be employed than others, experiencing different levels of environmental risks and control.

(Un)employment in Haringey

ONS 2001 Census data show the level of employment in Haringey at 56.2%, 4% points lower than the London average (60.2%). The unemployment rate is 8.9%, slightly higher than the London average at 6.5%. Wards with the highest rates of unemployment are in the east.

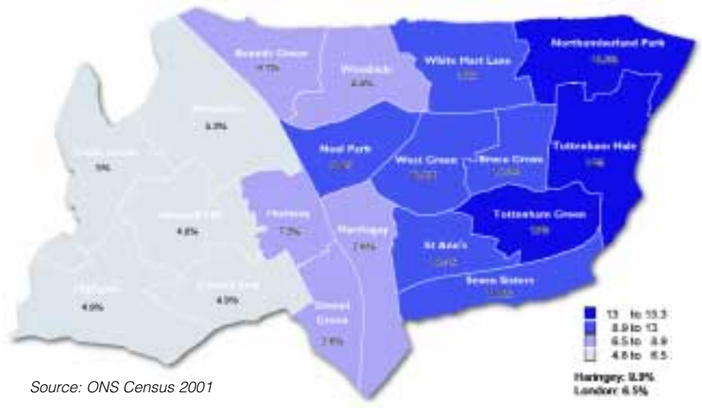
In terms of the numbers of people unemployed, three wards account for a quarter (23.6%) of the total. (Tottenham Central[Ω] (6.8%), Bruce Grove[Ω] (7.7%) and Coleraine[Ω] (9.2%)).

2 Qualifications profile of Haringey by East, Central and West districts



Source: ONS Census 2001

4 Unemployment rates across Haringey



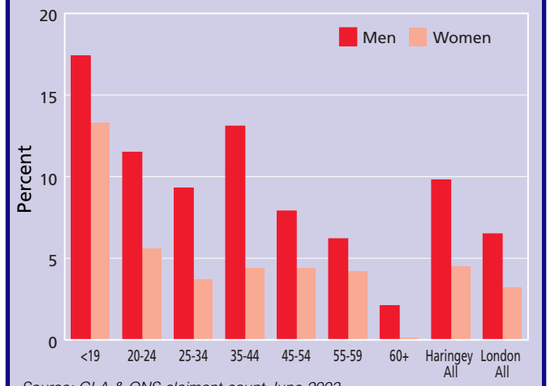
Source: ONS Census 2001

∞ *ONS black category includes Caribbean, African and other black*

Ω *Data collected on pre-2002 ward boundaries*

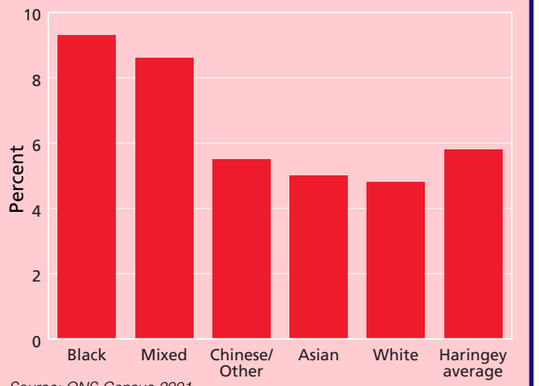
Determinants of Health

5 Unemployment rates in Haringey by age group for men and women



Source: GLA & ONS claimant count June 2003

6 Unemployment rates in Haringey by ethnic group



Source: ONS Census 2001

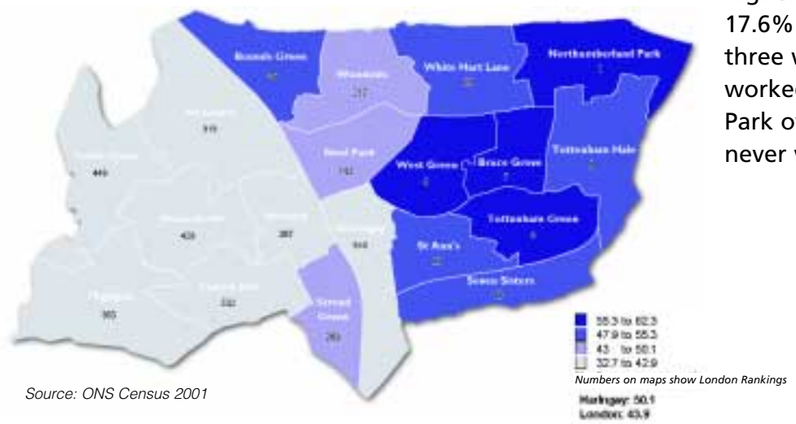
Men are more likely to be unemployed than women, for all age groups. Locally levels of unemployment fall with age, the exception being men aged 35-44. In women, rates plateau off at 25.

Unemployment in Haringey's black population (9.3%) is nearly twice the rate of the white population (4.8%). It is also high in the mixed race category (8.6%). These two populations account for a third of Haringey's unemployed (34.3%).

Long-term unemployment rates in Haringey are particularly high. This includes those who have never worked as well as those who are long-term employed. The map shows that five out of the top ten wards in London for long-term unemployment are located in the east of Haringey, with Northumberland Park having the highest rate in London.

Much of this excess rate is due to individuals who have never worked, the rate of which is almost 40% higher than the London average at 17.6%. In Bruce Grove, nearly one in three women (31.3%) have never worked, while in Northumberland Park over one in four men have never worked (25.7%).

7 Long-term unemployment in Haringey



Source: ONS Census 2001

Poverty and Income

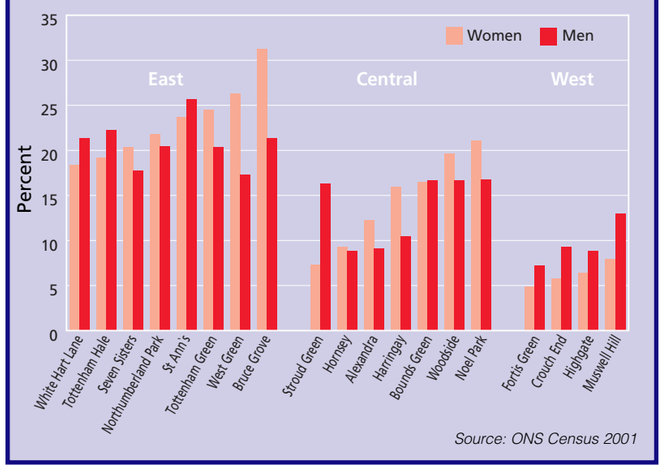
There is a large body of research that demonstrates that people living in poverty or on a low income are more likely to be ill or die prematurely.[1] Low income is usually defined as half average household income (<£15,000). In 2002, average household income in Haringey was £30,100, just below the London average (£31,100).

Average annual household income is lowest in the east of the borough, mostly notably in parts of Northumberland Park, Seven Sisters and St Ann's where it is below the poverty line. Just under a third of Haringey households (29.2%) have no earned income (although they may be receiving state benefits or a pension).[8] All black and minority ethnic groups show average income levels considerably below the borough average.

A child's health is significantly influenced by their parents' socio-economic status and children are disproportionately represented in low income households.[2,9] In Haringey, 29.1% of households have dependent children, a third of these are lone parents (9.8%) with an average income of £6,762 (including benefits, £10,434).

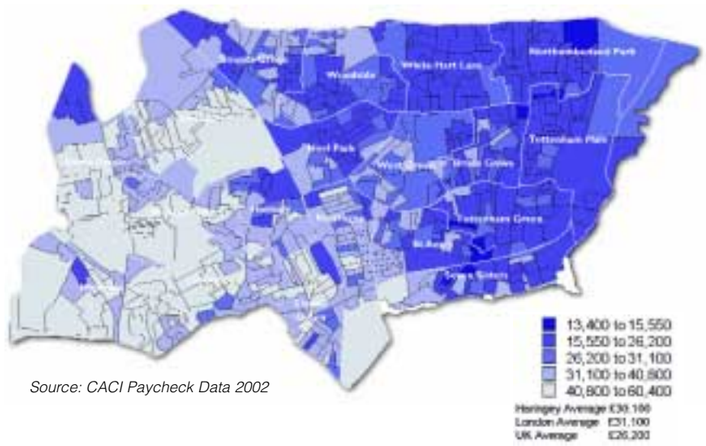
One measure of poverty in families with children is the level of pupils eligible for free school meals (FSM). Local figures show that 38% of primary and 39% of secondary school pupils were eligible in 2003, more than double national averages (2002) for primary (17%) and secondary (15%) schools.[3]

8 Percentage of unemployed who have never worked in East, Central and West districts



Source: ONS Census 2001

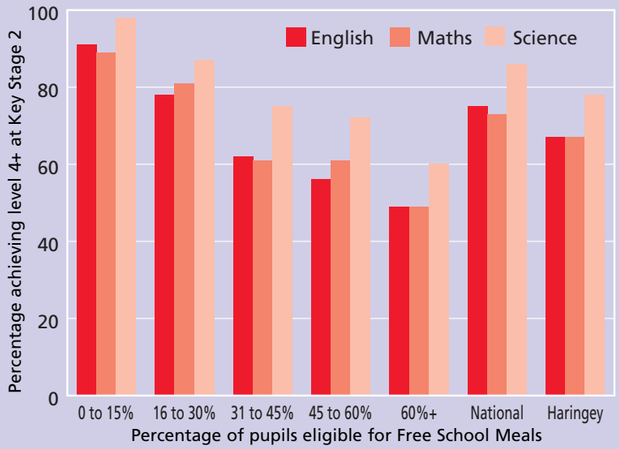
9 Average household income in Haringey



Source: CACI Paycheck Data 2002

Determinants of Health

10 Educational achievement in Haringey primary schools by percentage of pupils eligible for Free School Meals



Source: Haringey LEA 2002

National data suggests that poverty can impact on children's educational performance. Schools with 35% or more pupils on FSM attain significantly less than average.[10] Local data supports this, showing decreasing educational performance with increasing levels of FSM.

Housing

Access to safe, stable, good quality housing is an important pre-requisite for health. People who are homeless or in poor housing have an increased risk of respiratory conditions, gastro-intestinal problems, mental health conditions and infections. The majority of these conditions can either be caused or exacerbated by overcrowded, cold, damp and insanitary living conditions.[11,12]

Housing in Haringey

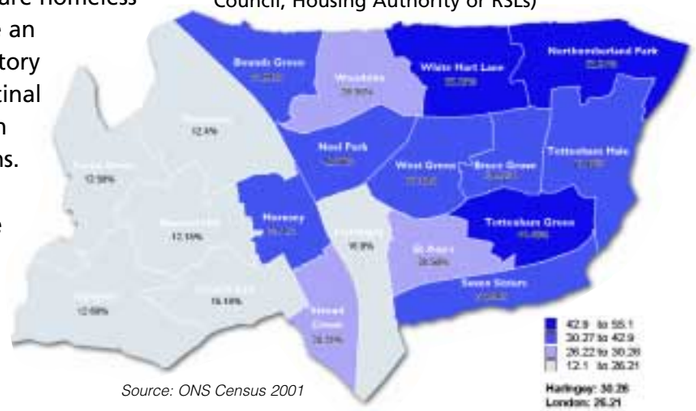
Just over 50% of Haringey households are owner occupiers, which is below the national average. 20.2% rent from the Council, 19.2% from private landlords and 9.0% from Registered Social Landlords (RSLs) such as a housing association.[8]

The wards with the highest level of social housing are in the northeast of the borough, while those households that rent privately or are owner occupiers levels are highest in the west. However, the private sector properties that are in the worst condition tend to be in the east of the borough.

Nearly a third of households (31.0%) consider their home as unsuitable.[8] Reasons include disrepair or unfitness (18.5%), over-crowding (6.8%), family tensions (4.3%), lack of adaptation to meet health or mobility needs (3.6%), expense (2.2%), harassment (2.1%), ability to maintain property (2%) and sharing or lack of a bathroom toilet or kitchen (1.5%). Over half (55.4%) of unsuitable households are occupied by council tenants, while 19.2% are owner-occupiers.

11 Social Housing in Haringey

(Percentage of all households renting from Council, Housing Authority or RSLs)



Source: ONS Census 2001

Most of the unsuitable housing is located in the northeast and northcentral wards, with 40% of households reporting problems. Lone parent (63.3%) and black and ethnic minority households (52.4%) report the highest levels of unsuitability, with the latter representing a nearly third (28%) of all unsuitable households. Special needs households are also over represented for the size of population.

Resolving an unsuitable housing problem may require housing repairs or improvements or moving. However, the ability of households to resolve their housing problems are often limited by low income.

Haringey Council estimates that 84.1% of those in unsuitable accommodation cannot afford to move to private housing. Furthermore, with stocks of social housing decreasing and demand high, options are further limited with potential implications for health.

Levels of homelessness in Haringey

Homeless people face additional health problems which put them in greater need of health services.[11] In terms of households in temporary accommodation, Haringey has the highest levels in the UK,[13] with over 4,300 households accommodated by the Council. However, only 46.0% of applications were accepted in 2001/02.[14] Over 90% of households living in temporary accommodation have children.[14]

12 Average gross income by household tenure

Source: Housing Needs Survey 2002, Haringey Council

Temporary accommodation is mainly located in the east of the borough. A high number of asylum seekers and households placed by other boroughs are also located in the east. Lack of a permanent base can be disruptive for families and impact on access to health and social services as well as education or employment. A local survey of homeless people found 84% had health problems and 35% had been admitted to hospital in the last year.[14]

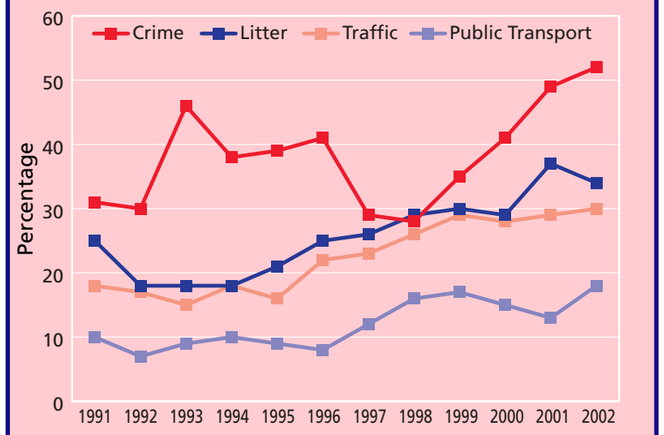
Environment

The environment in which we live and work can also influence our health status. There is substantial evidence that shows the physical and social environment can impact on our physical and mental health.[1]

In Haringey environmental issues such as crime, litter and traffic are now residents' top concerns, higher than for London residents.[15]

Determinants of Health

13 Issues of concern for all Haringey residents



Source: Residents Survey, Haringey Council 2002

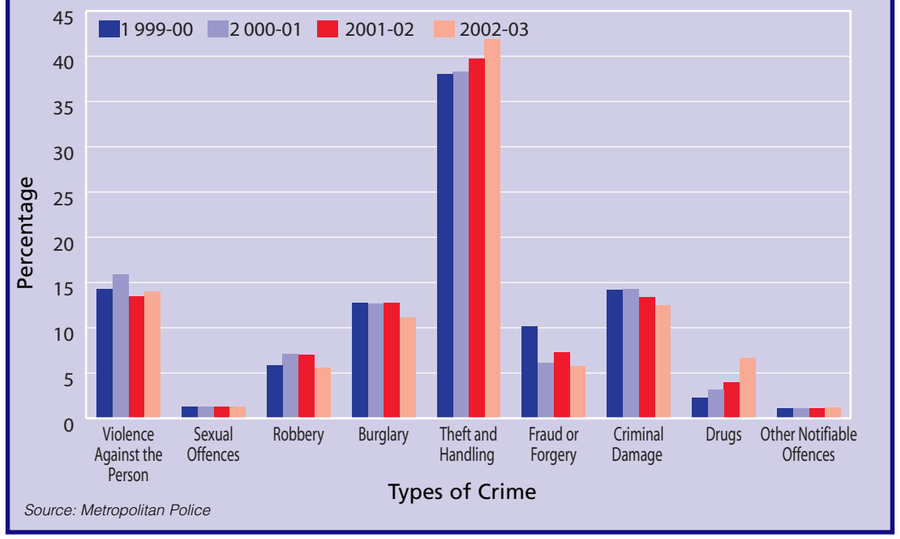
Crime

In contrast to many people's perceptions, crime rates fell during the 1990s. In London, the crime rate (152/1000) has persisted at about 40% higher than for England and Wales (107/1000).[16] The crime rates in Haringey are similar to inner London, ranking tenth out of all London boroughs.

Nationally, people on low incomes are more likely to live in areas with higher crime rates and experience crime directly.[16] Lone parents are more than twice as likely to be burgled than other families with dependent children. Ethnic minorities are also at high risk, particularly of violent crime and racial harassment.[1,16] In Haringey crime is a top concern of the black community, with just over half of residents witnessing crime and a quarter being the victims of crime in the past two years.[17] Young people are also significantly more likely to have experienced any crime than older groups.

Theft is the most common crime in Haringey, representing around 40% of all notifiable offences. As a proportion of all crime, this has increased every year in the past four

14 Crime profile in Haringey between 1999-03



Source: Metropolitan Police

and is at least twice the rate of the second most common crime, violence against the person. Drug offences are also increasing, although in absolute numbers they are relatively small.

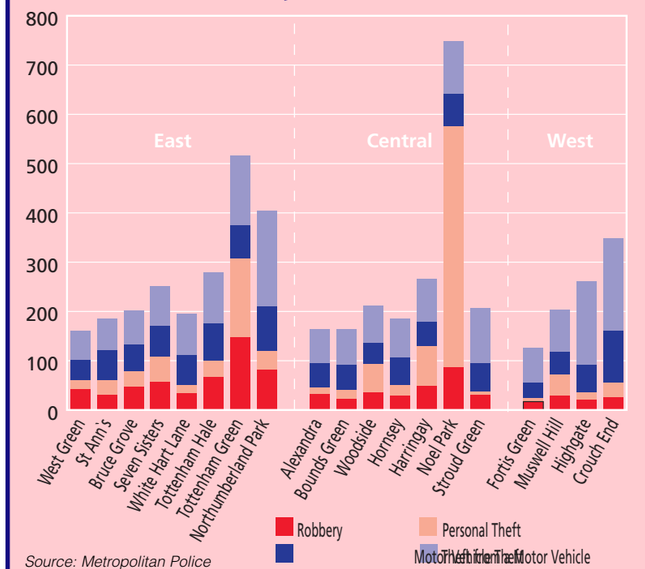
There are three theft 'hot spots' in Haringey, around Noel Park, Tottenham Green and Northumberland Park. Theft from persons is particularly high in Noel Park (489) and Tottenham Green (159), accounting for 56.0% of all incidences locally. Motor vehicle thefts are also high in these two areas as well as in Highgate and Crouch End.

Transport

Haringey is generally well served by roads and public transport. Transport links in the east are good, offering easy access to central London. However, there are large areas of poor accessibility in the west and northeast.[13] This has major implications for low income communities, making access to services, activities and employment more difficult and expensive, reinforcing social exclusion. For example, nearly a third of people without a car nationally have difficulty travelling to their local hospital, nearly twice the rate of those with their own transport.[18]

In Haringey, there is greater use of public transport (53.9%) and lesser use of the car to get to work than for London. Use of the underground accounts for much of the extra use of public transport. Many people who use public transport do so as they do not own a car. Wards with

15 Profile of robbery and theft in Haringey wards between April-December 2002



Source: Metropolitan Police

low levels of car ownership tend to be in the east. Although car ownership might be expected to be lower in areas well served by public transport, in Haringey it is also low in areas poorly served by public transport. In Northumberland Park, for example, 50.7% of public transport users do not have use of a car, while in Woodside and White Hart Lane it is 47.9% and 43.2% respectively.

Accidents

While large and busy road systems can help improve mobility they can also isolate communities and individuals from friends and family. Furthermore, road traffic can also disproportionately impact on socially excluded areas and individuals through air pollution, noise and pedestrian accidents.[19] Children are

particularly vulnerable. More than a quarter of child pedestrian casualties happen in the 10% most deprived wards.[19] Children from low income households are more likely to live near main roads, more likely to play by or in roads and walk rather than travel by car.[2]

In Haringey, the number of pedestrians killed and seriously injured per 100,000 in 2001/02 was 40.9, 57% higher than the London average (26/100,000). Rates for slightly injured (120.4/100,000) were a third higher (32.3%) than for London (91/100,000).[18]

Casualties are the highest for car users. However, pedestrians involved in accidents also contribute significantly to the overall figures. Around 80% of pedestrian casualties in Haringey involve being hit by a car, and around half occur whilst crossing the road without using facilities. Children under 16 and young people aged 16-24 contribute significantly to the proportion of pedestrian casualties locally.

Conclusion

This chapter examines the determinants of health across Haringey. It shows a stark east-west divide with respect to (un)employment, poverty, housing and most environmental factors. Wards in the northeast have particularly poor determinants, especially in education and long-term unemployment. This is accompanied by low income, high levels of unsuitable housing and poor transport links. However, the divide is not just geographical. Certain ethnic groups, such as the black community have particularly poor determinants (as do refugees and asylum seekers, lone parents, people with special needs), with lower levels of qualifications, higher rates of unemployment, unsuitable housing and more likely to be victims of crime.

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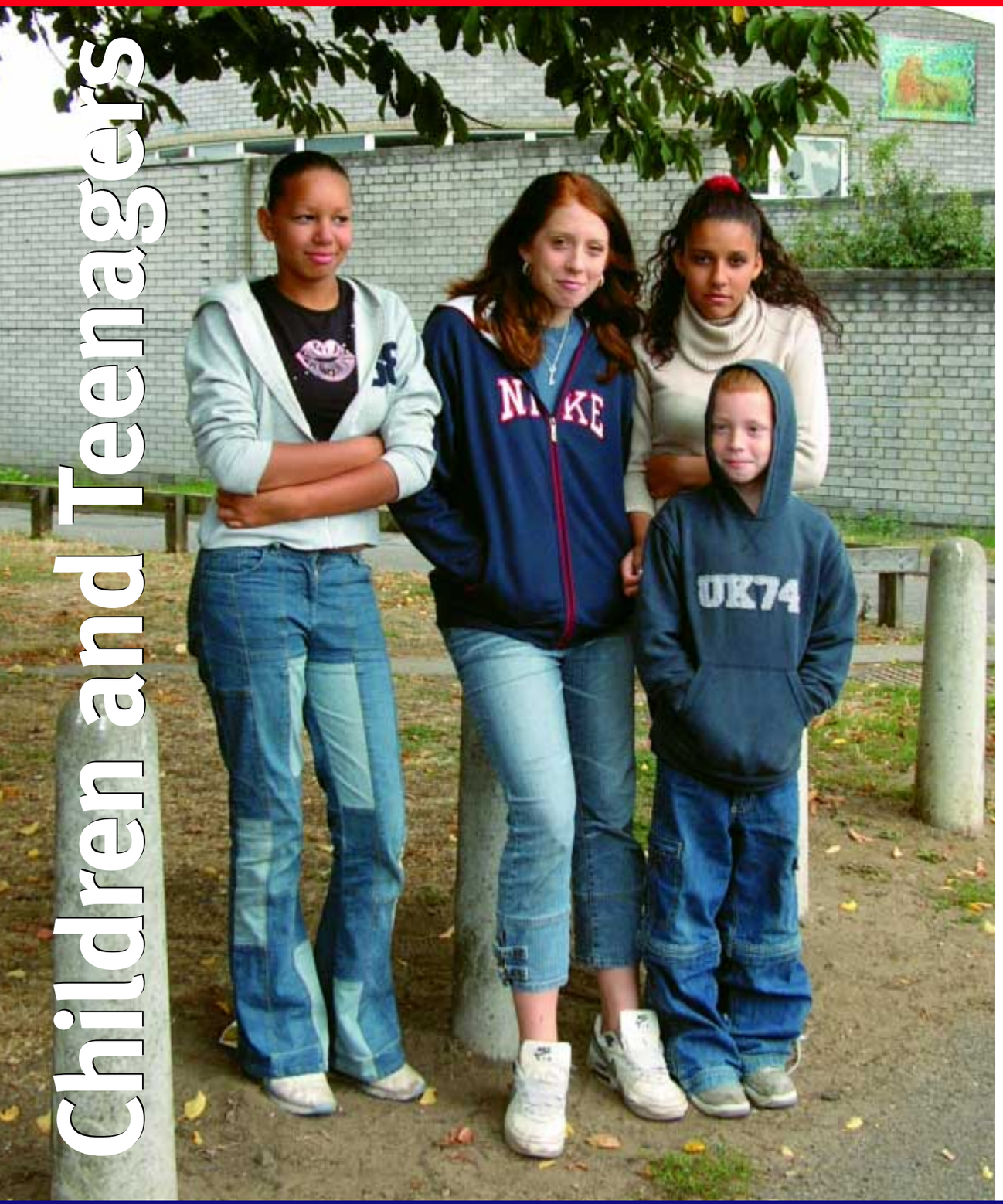


Children and teenagers

Childhood is a critical stage where socio-economic circumstances and health risks may have lasting effects[1].

Early life has a crucial influence on subsequent mental and physical health and quality of life. This suggests that policies to reduce early adverse influences may result in multiple benefits. A range of projects are underway to attempt to tackle these influences. These include breakfast clubs in schools; Sure Start which aims to improve the life chances of children aged less than four, the provision of fruit in schools and the Healthy Schools Programme. This aims to improve pupils' health, learning opportunities, experience and achievement.

Breakfast Club

Devonshire Hill Primary school breakfast club is financed by the Neighbourhood Renewal Fund, because of high levels of unemployment in the area.

The school has a large ethnic minority population with 30 languages spoken; two thirds of pupils have English as an additional language.

A group of seven children were asked for their views on the breakfast club. Meis, Ayten, Ayse, Lise, Kayley, Tunde and Mohammed are aged between 8 and 11 years. All the children enjoyed attending the breakfast club, as it was a great place to meet up with friends before lessons 'to have time to talk instead of talking in class'. Lisa said 'It was good to have a breakfast club because you could have fun, play games and eat breakfast!' They also liked it because it helped them arrive at school on time. Kayley said, 'I don't have to rush around in the morning – I know now I won't be late for school'. She also valued the opportunity to do her homework and enjoyed spending time with staff working at the club, because they helped with her learning. Ayten said that the staff had helped her improve her spelling.

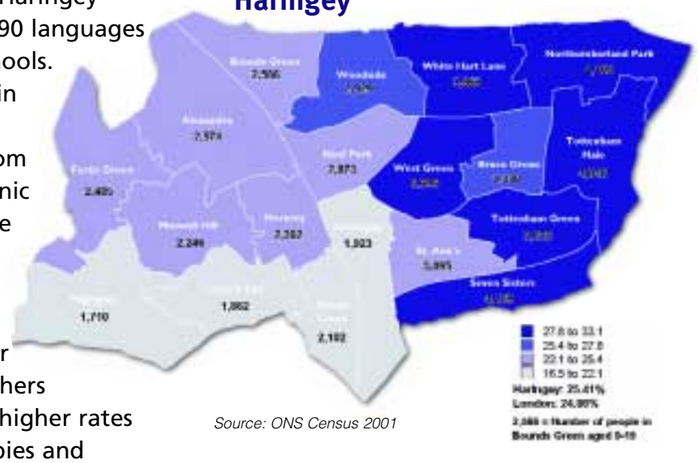
The children liked the food too! They all enjoyed Coco Pops and the toast. When asked what he would eat if he could have anything at all for breakfast, Tunde replied 'Eggs, bacon, toast and beans and sausages!' Perhaps a more diet conscious Kayley said she enjoyed fruit, but was also addicted to Coco Pops. Several of them said that having breakfast at school meant that they did not feel hungry later in the morning. A word with one of the staff confirmed that many of the children attending would not have breakfast if the club did not exist.

Haringey's young people

There are 55,000 people aged 0-19 living in Haringey. There are relatively high numbers of young people in the east, the highest numbers in White Hart Lane and Northumberland Park.

There are high proportions of young people from black and minority ethnic communities in Haringey (Figure 2) and nearly 190 languages spoken in Haringey schools. Figure 3 shows the main languages spoken. In many cases children from black and minority ethnic communities have more adverse health outcomes than children from the general population. For example, births to mothers born in Pakistan show higher rates of low birthweight babies and perinatal mortality than the general population. Children from African, Caribbean and Mediterranean families can be affected with genetic blood disorders known as haemoglobinopaties. However, many of these differences in outcome may relate to poverty and studies that have attempted to take socio-economic status into account have shown a reduction in the health differences between ethnic communities[2].

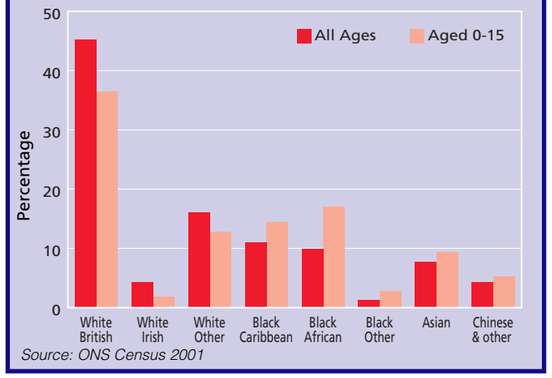
1 Distribution of Young People in Haringey



Source: ONS Census 2001

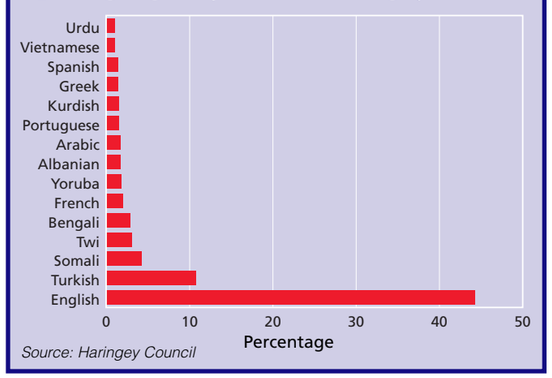
Haringey has high numbers of refugees and asylum seekers. As at February 2003, Haringey Council were supporting 235 asylum-seeking children, who arrived with no adult carer. Unaccompanied children are especially isolated and vulnerable and will be with unfamiliar carers. They may have experienced violence or torture themselves or have witnessed atrocities. They may have developmental difficulties, show anxiety, nightmares, withdrawal or hyperactivity[3].

2 Ethnicity – Haringey Residents aged 0-15



Source: ONS Census 2001

3 Languages spoken in Haringey schools



Source: Haringey Council

Births

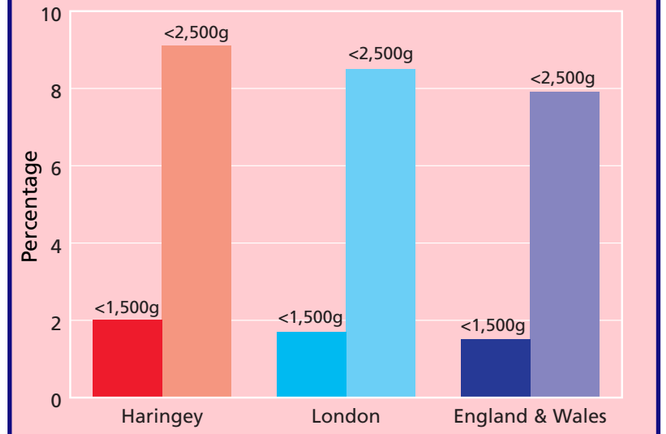
In 2001 there were 3,830 live births and 31 stillbirths in Haringey. The number of births has been increasing in recent years and was 3,599 in 1998. Haringey has relatively high proportions of low birthweight babies. Low birthweight is strongly associated with adverse health outcomes and deaths in infancy[2].

Inequalities amongst children and young people in Haringey

Socio-economic circumstances within the family relate strongly to a child's educational opportunities and subsequent occupation and income[4]. Differences in health are seen even in the first year of life. Babies born to poorer families are more likely to be born prematurely and be of low birthweight. This has implications for later life including the development of coronary heart disease, hypertension and diabetes[5]. More children in the east of Haringey live in relatively poorer socio-economic circumstances (Figure 5). These issues are more fully addressed in Chapter 2.

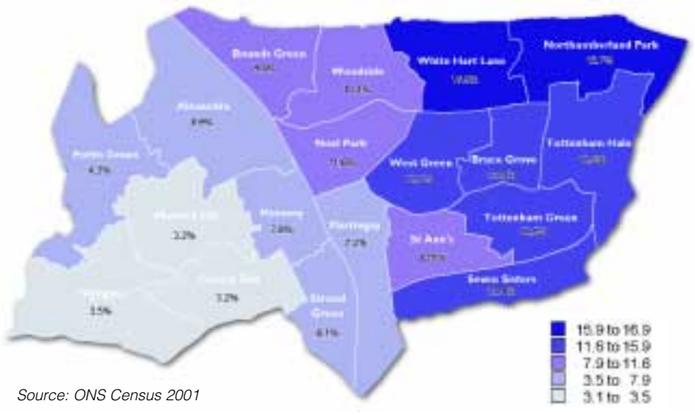
Children looked after by social services are at particular risk of both early and later life disadvantage. They have a greater risk of obtaining no educational qualifications and becoming homeless. They are more likely to have alcohol problems, smoke or become teenage parents and are vulnerable to substance misuse or mental health problems in adult life[1]. The number of children on the child protection register in Haringey has increased in recent years.

4 Low Birthweight Babies



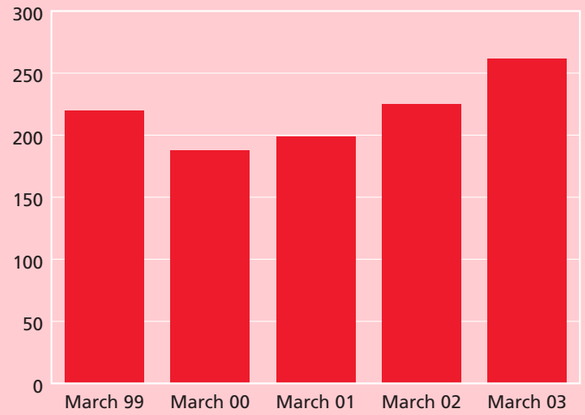
Source: Compendium of Clinical Indicators 2002

5 Employment Deprived Households with Dependent Children



Source: ONS Census 2001

6 Haringey Children on the Child Protection Register



Source: Haringey Council

Natasha, 17

Natasha was born in Haringey 17 years ago. She has been pregnant twice in her life.

The first pregnancy ended in termination and Natasha became pregnant again one year later. She did not consult a GP when she was pregnant, preferring to do a test at home. When she was in hospital she was given leaflets on contraception. She had lots of questions at the time, but did not know whom to ask for advice. She had her baby in January 2001 and was given the support of a Social Worker. She felt that all the way through her pregnancy and the birth she was treated differently because she was a young mother and she did not know how to breast feed or bath her baby.

Natasha is now involved in a Young Mothers' group, based in Northumberland Park, Tottenham. This group meets twice a week, and provides first hand support to teenage mothers on a variety of every day issues. Various organisations attend workshops providing advice and guidance, such as Connexions and The Sexual Health Education Project, which is part of the local Teenage Pregnancy Strategy. The Education Project recently have had close connections with several other 4YP Young Mums' Groups, and regularly attended a special lunch club in Edmonton.

These groups are just a small part of the support that young parents like Natasha may access.

Health behaviour

Health behaviours such as a child's diet, exercise and whether they smoke may have significant impacts on their current and future health. For example, recent reports have suggested an increasing number of young people with diabetes related to obesity[6]. There is no information on the levels of obesity or uptake of a healthy diet in Haringey, but a range of projects are underway to improve diet, such as the provision of fruit in schools.

Smoking causes a range of health problems such as heart disease, stroke and cancer in later life, but can also cause cot deaths. It is the principle cause of inequalities in death rates between rich and poor.

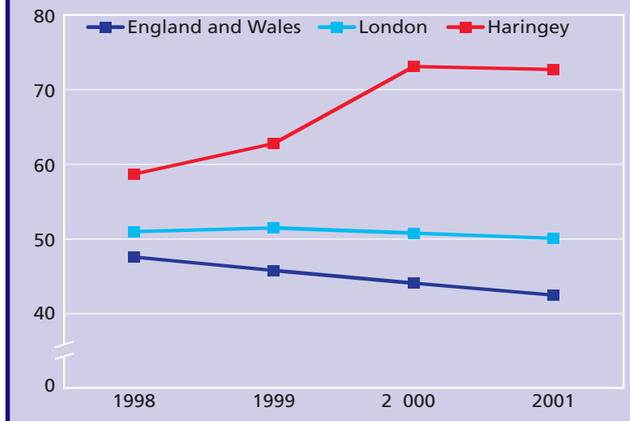
Children are particularly vulnerable to second-hand cigarette smoke as they are more susceptible to respiratory and ear infections triggered by smoking and small children have less choice than adults to leave a smoke-filled room[7]. A London-wide survey suggested that[8]:

- 11% of children aged 11-15 smoked
- Girls were more likely to smoke than boys (12% of girls compared to 9% of boys).
- 44% lived with at least one parent who smoked
- 52% were exposed to passive smoking by someone in the home.

Teenage pregnancies

For many young women, pregnancy and motherhood are positive and welcomed experiences without long term negative outcomes. However, teenaged mothers and their children are at higher risk of experiencing adverse health, educational, social and economic outcomes[1]. Haringey has a high teenage pregnancy rate compared with London and England and Wales. Reducing teenage pregnancies is one of the Government's key health targets. A great deal of work is being undertaken by the TPCT to tackle this and 2001 saw a slight decrease in this rate.

7 Conception rates per 1000 for under 18s 1998-2001



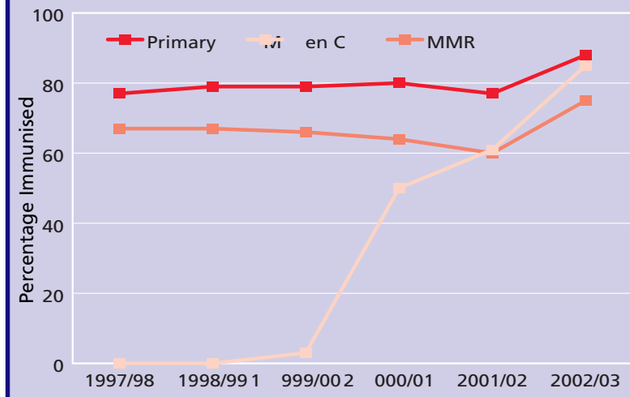
Source: Compendium of Clinical Indicators 2002

Health & Illness

Immunisations

Immunisation plays a major role in protecting children from serious illness by protecting individual children and the population as a whole. Figure 8 shows that there was a decrease in uptake for diptheria, tetanus, whooping couch, polio and haemophilus influenzae B during 2001/02. Uptake of measles, mumps and rubella (MMR) vaccine had begun to decrease a year earlier. This decrease was also found across

8 Immunisation Status Age Two

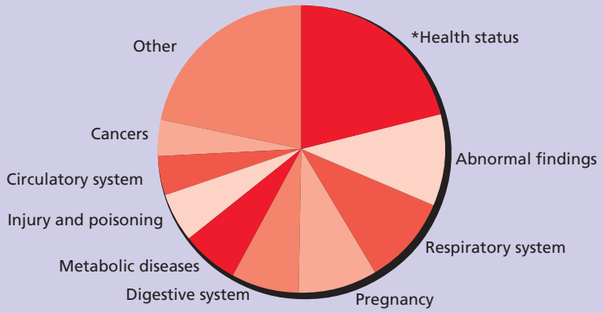


Primary = Diphtheria, tetanus, whooping cough, polio, haemophilus influenza B.
Men C = meningitis C
MMR = measles, mumps & rubella

Source: Child Health System

Children and Teenagers

9 Cause of Admissions for Children and Young People aged 0-19, 2001-02



*Health status incorporates hazards related to communicable disease, factors related to reproduction, social & psychosocial factors and personal or family history.

Source: HIS 2003

London and England. It followed falling public confidence and media speculation about the safety of the MMR jab, where there has been shown to be no link with autism or Crohn's disease[9]. Figures for 2002/03 showed that the immunisation rate had begun to increase. This was sustained in the first quarter of 2003/04, but uptake still does not reach target levels of 95% coverage. Uptake of immunisation for meningitis C has increased each year since it became part of the immunisation programme.

Admissions to hospital

Some children will become ill enough to require admission to hospital. Figure 9 shows the main causes of admission for Haringey young people. The highest number of admissions was for factors influencing health status*.

Ward level data shows that, compared to the Haringey average; there were relatively high admission rates in Hornsey and White Hart Lane wards and low rates in Fortis Green.

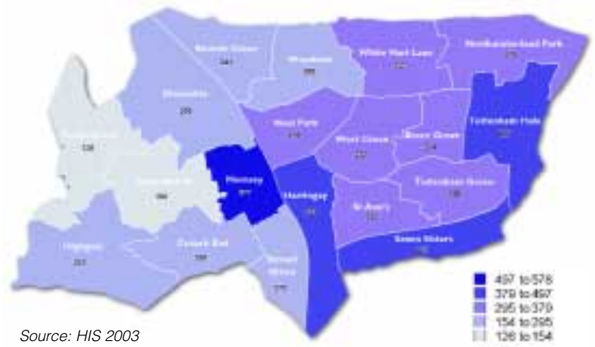
A slightly different pattern is seen when looking at asthma, one of the most common chronic disorders of childhood. Hornsey still has the highest rate of admission, followed by Tottenham Hale and Seven Sisters.

Injuries and accidents are major causes of ill health for children and young people. The number of children admitted to hospital because of accidents has varied over the last few years. The rate was often higher than the London and national average. There appears to have been some decrease in admissions compared with the high

10 Standardised Admission Rates for All Causes ages 0-19 per 100,000

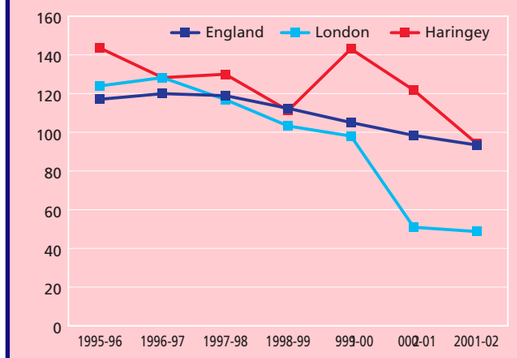
Source: HIS 2003

11 Standardised Admission Rates for Asthma ages 0-19 per 100,000



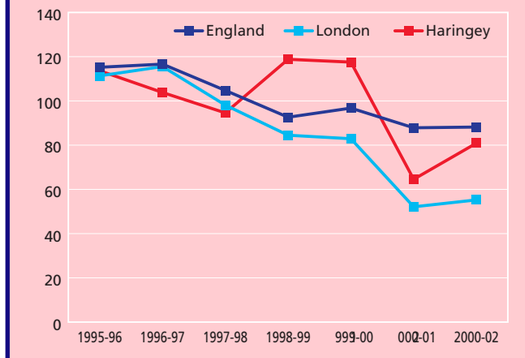
Source: HIS 2003

12 Serious Accidental Injury in Children 0-5
Standardised Admission rates per 100,000



Source: Compendium of Clinical Indicators 2002

13 Serious Accidental Injury in Children 5-14
Standardised Admission rates per 100,000



Source: Compendium of Clinical Indicators 2002

rates during 1999/2000. This will, however, require further monitoring to see if the decrease persists.

Mental Health

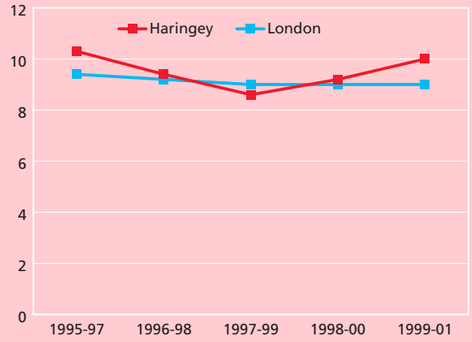
An Office for National Statistics[10] survey found that 10% of children between the ages of 5 and 15 had diagnosable mental health problems. In Haringey this would account for nearly 4,500 children. There has been an increasing national and local demand for Child and Adolescent Mental Health Services (CAMHS) in recent years. Haringey has high levels of risk for mental health problems including deprivation and unemployment. There is evidence that childhood difficulties may lead to mental and social problems in later life[11]. Emotional and behavioural disorders may affect a child's development, future capacity to make long-term relationships, and the adequacy of parenting of their own children. Mental health problems may interfere with education and capacity to enter employment, increasing the risk of psychological problems[12]. There is increasing evidence on what works in primary prevention, the most robust evidence is for behavioural and parent education programmes[13]. These can be incorporated into programmes such as Sure Start.

Deaths

Perinatal (stillbirth and death in the first week of life) and infant mortality (deaths in the first year of life) have been used internationally as proxies for a country's general health status. Infant mortality rates in England and Wales show consistent differences associated with socio-economic status, with an increased risk of infant death for children of unskilled worker families compared with children of professional families[2]. Infant mortality is therefore one of the Government's key inequalities targets. Perinatal and infant mortality rates have tended to increase in Haringey in recent years, whereas the rate in London has decreased. The TPCT is therefore drawing up an action plan to tackle this.

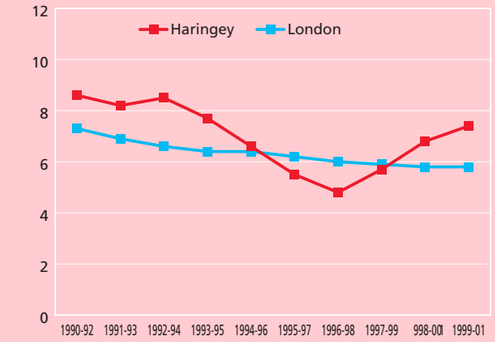
Children and Teenagers

14 Perinatal Mortality Rate per 1000 total births 1995-2001



Source ONS 2002

15 Infant Mortality Rate per 1000 live births

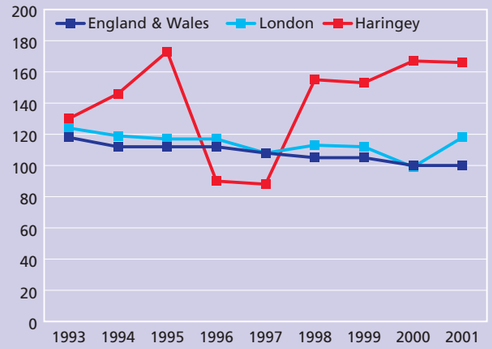


Source ONS 2002

Deaths beyond the first year of life are very unusual in this country and are usually associated with unnatural causes and accidents. However, the same socio-economic gradients described for death in infancy are also found in this age group[2]. In Haringey death rates for children have been relatively high in recent years. The number of deaths is, however, quite small, 39 in 2001. The majority of these deaths were infant deaths (29), but six boys and four girls died between the ages of 1 and 14.

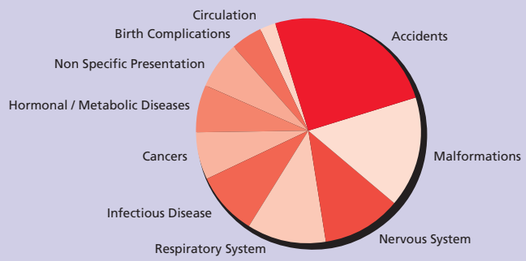
Figure 17 shows the main causes of death for young people in Haringey. This does not include all infant deaths (below 1 year) as the cause of death was not always coded for these children. One quarter of deaths in young people aged less than 20 were caused by accidents. This reflects the national picture where accidents are the highest cause of death in this age group.

16 All Cause SMR 1993-2001 under 15s



Source: Compendium of Clinical Indicators 2002

17 Causes of Death in the Under 20s in Haringey 2001-2002



Source: HIS 2003

Conclusions

A child's early life has a crucial influence on subsequent health and quality of life. These can be influenced by a range of health determinants including socio-economic status. There are a number of vulnerable children in Haringey. Although a range of actions are in place to improve the health of Haringey's children; there are still high numbers of low birthweight babies and infant deaths. Uptake of immunisation does not reach target levels and there are high admission rates in some parts of the borough. Work has been underway to reduce teenage pregnancies which fell slightly in 2001. Although the overall number of deaths between 1 and 19 is not great, the death rate is relatively high, a large proportion of these deaths due to accidents.

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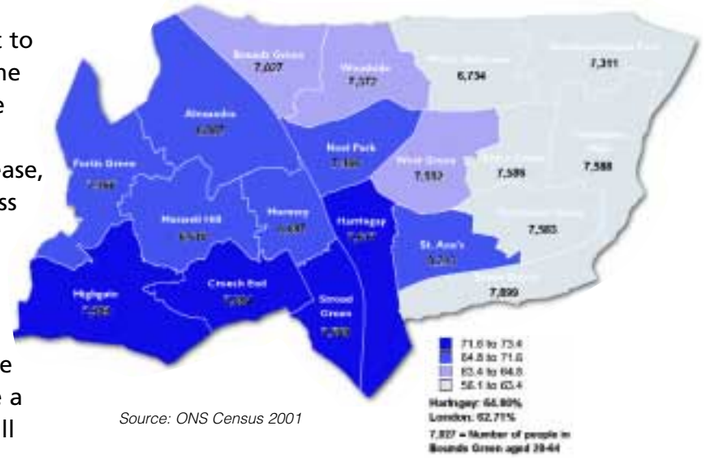
People of Working Age

There is a broad range of age, race, wealth and experience in Haringey's adult population.

Average life expectancy is 75 for men and 81 for women. Every person in Haringey can reasonably expect to live beyond midlife, but for some this does not happen. These are usually described as 'avoidable deaths' due to preventable disease, avoidable accidents and needless harm or injury. Through improved understanding, tackling inequality, increased prevention, equitable access, early identification and effective treatment it is possible to make a significant impact on reducing ill health and early deaths.

1 Distribution of People aged 20-64 in Haringey



Source: ONS Census 2001

The adult population

As described in Chapter 1 Haringey's adult population differs from that of England and Wales. Almost 40% of the population are younger adults (20 – 39), nationally there are less than 30%. In the south west of the borough more than 70% fall within the age range 20 – 64 years. Black and ethnic minority communities make up about 45% of the adult population, proportions are higher in the east.

Determinants of health

As shown in Chapter 2 economic and social factors impact on health during adult years. Unemployment, which mostly occurs in adult populations is 8.9% in Haringey more than 2% higher than London, and all eastern wards are above the borough average. Low income impacts most in the east, particularly Northumberland Park, Noel Park, White Hart Lane and Tottenham Green. Many households (31%) consider their homes unsuitable, and crime and environment have an impact. People in the east generally experience the more severe conditions. Considering these factors there may be a relatively unhealthy adult population in the east of the borough.

People of Working Age

Adult health

Health in Haringey is improving; life expectancy is increasing, and Figure 2 shows the SMR for ages 15-64 is decreasing over time. However, the figure also shows that adult health is generally not as good as England and Wales.

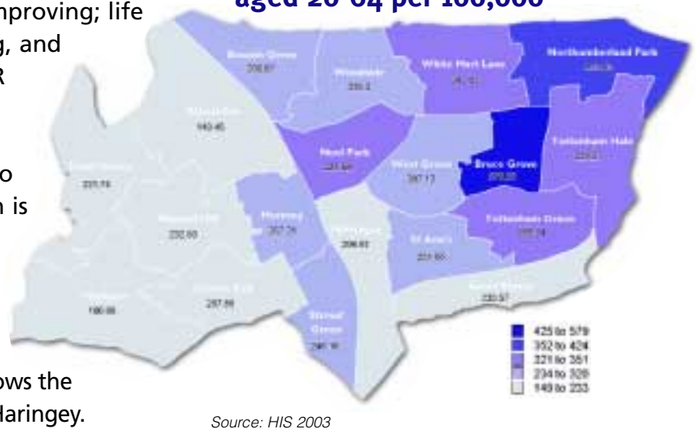
Over the two years 2001 and 2002 there were 618 adult deaths. Figure 3 shows the main causes of death in Haringey. Cancer and circulatory disease account for almost 60% of adult deaths. When adding in accidents, the digestive system and respiratory disease, five categories account for almost 90% of adult deaths.

The map in Figure 4 shows adult deaths across the borough. Death rates are higher in the east, and are particularly high in Bruce Grove and Northumberland Park.

Admission rates to hospital are a reasonable measure of ill health, though these usually only represent more serious illness. In the years 2001 and 2002 there were 33,191 adult admissions. Reasons for admission (Figure 5) are varied, 26% relate to cancer and circulatory disease, and 19% are genitourinary related.

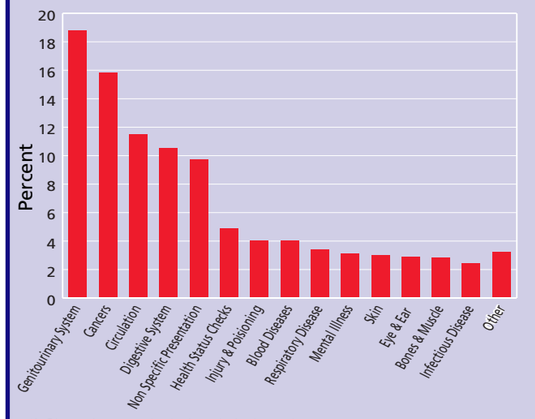
Considering deprivation in the east of the borough it may be expected that there is greater need for health services. Admission rates seem to reflect this.

4 All Mortality in adults in Haringey aged 20-64 per 100,000



Source: HIS 2003

5 Adult Admissions to Hospital 2001-02



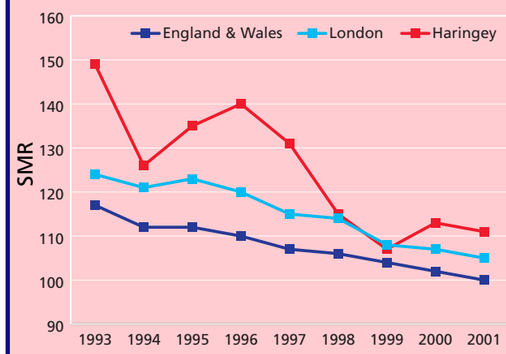
1) Chart does not include admissions due to pregnancy.
2) Health status checks incorporate hazards related to communicable disease, factors related to reproduction, social & psychosocial factors and personal or family history.

Source: HIS 2003

6 Standardised Admissions for adults aged 20-64 per 100,000

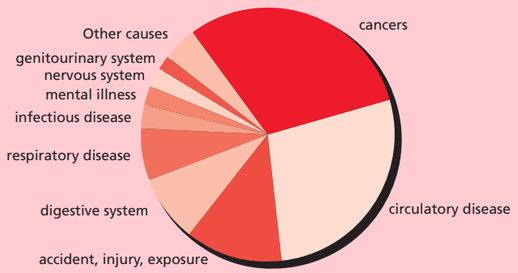
Source: HIS 2003

2 All Cause SMR in those aged 15-64, 1993-2001



Source: Compendium of Clinical Indicators 2002

3 Causes of Death in the 20-64s in Haringey 2001-02



Source: HIS 2003

Main causes of death and ill health

To fully understand the health picture it is important to look at specific diseases, illnesses and populations.

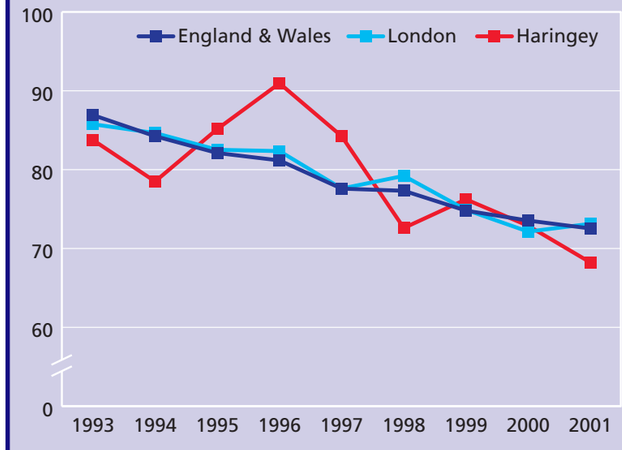
Cancer

A recent national survey found that the public believe that reduction in cancer deaths should be a top priority for the NHS[1]. Approximately one in three people will have cancer at some time in their lives[2]. It is the single largest cause of death among the Haringey adult population. There are a range of cancers with different causes, prevention measures, detection methods and treatments. There is good evidence that some cancers can be prevented, and many people who get cancer can be successfully treated.

Cancer death rates have been falling for some time. Haringey rates in this age group, are similar to, and have recently fallen below, those of London and England and Wales. Figure 8 shows specific cancers that contribute high numbers of deaths. Haringey rates are low, particularly when compared to England and Wales.

7 Cancer in those under 65

Standardised mortality rates per 100,000



Source: Compendium of Clinical Indicators 2002

People of Working Age

8 Cancer specific Death Rates - all ages
Standardised per 100,000 in 99 and 01

Source: Compendium of Clinical Indicators 2002

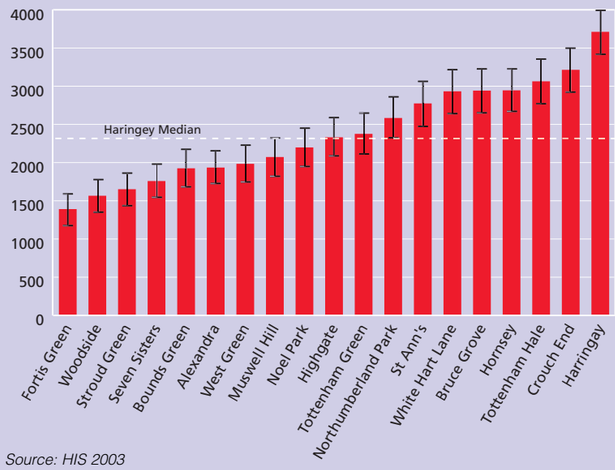
Screening

Survival rates for some cancers can be improved through early diagnosis and screening can aid early detection. The main programmes are for breast and cervical cancers. Cervical screening is undertaken through primary care where it is recommended that registered women aged 20-64 attend for testing. While the national screening target is 80%, our local rate in Haringey is 73.6%. However, it is often more difficult to reach targets in areas which have highly mobile populations and where not every practice has access to a female practitioner trained to carry out the tests.

The breast screening target is 80% of women aged 50-64 (those aged 65-69 will be screened in the future). Recent data (2001) shows only 56% of women being screened. The reasons described above contribute but uptake can be low among those who do not have English as a first language or may for religious or cultural reasons choose not to attend.

Cancer risk factors such as smoking and poor diet are more prevalent in deprived areas so higher death and admission rates may be expected. Interventions to improve health in these areas are targeted through priority neighbourhoods, with such projects as 'Health for Haringey – Healthy Living Centre.' There are wide ranging admission rates, wards are significantly above and below average, but there is no discernable geographic pattern.

9 Cancer Admissions for those aged 20-64
Standardised Admission Rates per 100,000.



Source: HIS 2003

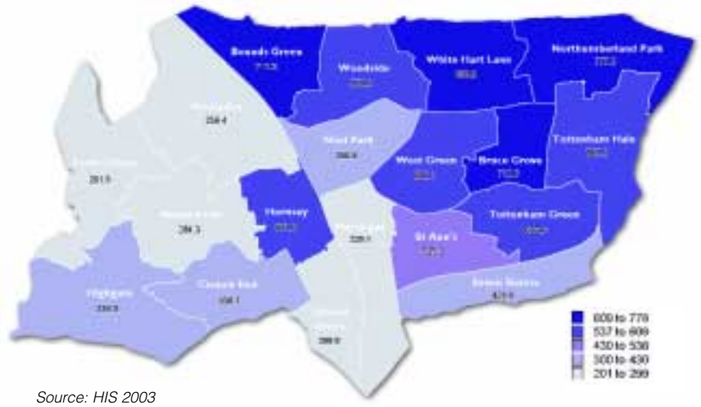
Heart Disease and Hypertension

CHD is the most common cause of premature death in the UK[3] and accounts for 28% of adult deaths in Haringey. It results from the reduction or complete obstruction of blood flow supplying oxygen to the heart. It causes chest pain, heart attack, irregular heart beat and heart failure.

Mortality from heart disease in Haringey has been falling over the last 10 years. Local rates fluctuate but are generally around the national rate. Heart disease is more common in deprived communities. Risk varies between communities groups, for instance people from South Asia have a higher risk than the general population. Ward level admissions rates are higher in the east, particularly Northumberland Park, White Hart Lane and Bruce Grove.

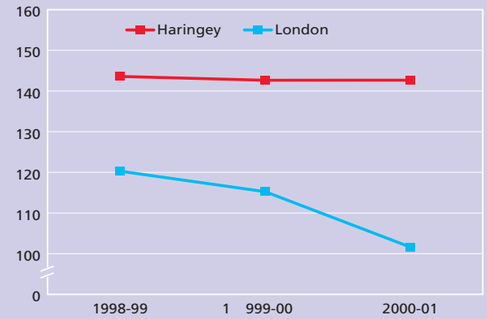
Haringey's high admission rates for heart failure remain constant, while

10 CHD Standardised Admissions for adults aged 20-64 per 100,000



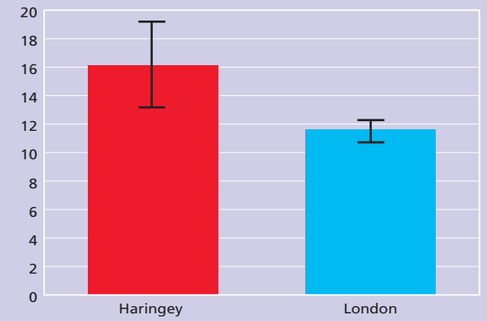
Source: HIS 2003

11 Heart Failure all ages
Standardised Admission Rates per 100,000



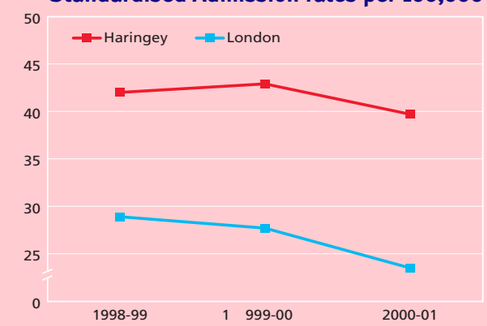
Source: London Health Observatory 2003

12 Heart Failure all ages 1999-2001
Standardised Mortality Rate per 100,000



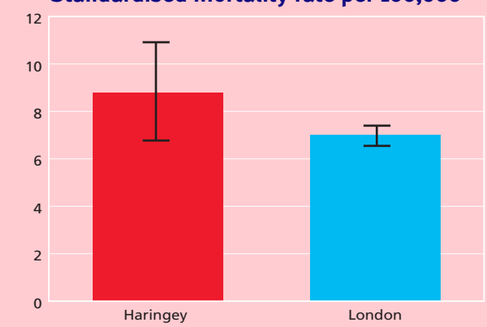
Source: London Health Observatory 2003

13 Hypertension all ages
Standardised Admission rates per 100,000



Source: London Health Observatory 2003

14 Hypertension all ages 1999-2001
Standardised Mortality rate per 100,000



Source: London Health Observatory 2003

London wide they are lower and have reduced. The death rate is significantly higher than London. Hypertension is similar, admission rates are considerably higher than London, death rates are higher too. This may link to high numbers with high blood pressure in the borough but this does not fully explain why admissions are almost double London's.

High admission and death rates for these two diseases relate to a high risk population. A key feature of improving health is to have systems in place to identify those at risk. GPs continue to develop systems to ensure when patients are identified as having heart disease they receive appropriate advice and treatment.

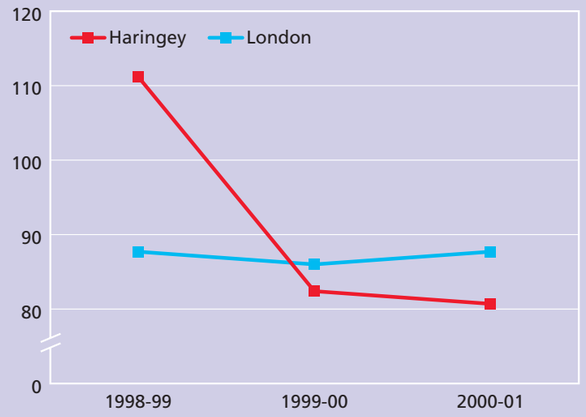
Diabetes

Approximately 2-3% of the UK population have diabetes, but as many people remain undiagnosed actual prevalence is likely to be higher[4]. It is a chronic and progressive disease that may result in ill health, disability and premature death. It is characterised by a raised glucose level resulting from either lack of or insensitivity to the hormone insulin. The two main types are: Type 1 (insulin dependent) and type 2 (non-insulin dependent). Both may lead to serious complications, including CHD, stroke, renal failure, amputation and blindness. Diabetes is up to six times more common in South Asians and up to three times more common amongst African-Caribbean groups.

Those who are: overweight/obese, physically inactive, have a family history of diabetes; or are less affluent are more at risk of developing diabetes. Locally both primary and secondary care have seen recent increases in the use of diabetic and related services. Providing education and support to enable people with diabetes to self-manage, often through changing behaviours, diet and medication, is central to providing high quality care. 'Fit for Life' projects aimed at people with diabetes encourages increased levels of physical activity.

Haringey admission rates, although once high, have reduced, suggesting improved management in primary care. A recent report on diabetic care[5] in Haringey shows 98% of GP practices have a diabetes register and 66% have dedicated diabetes clinics. Most practices refer patients to services linked to diabetes such as foot health and retinal screening services. Deaths attributed to diabetes in Haringey are low, although deaths linked to diabetes are often attributed to complications such as CHD or renal failure.

15 Diabetes Admissions all ages
Standardised rates per 100,000



Source: London Health Observatory 2003

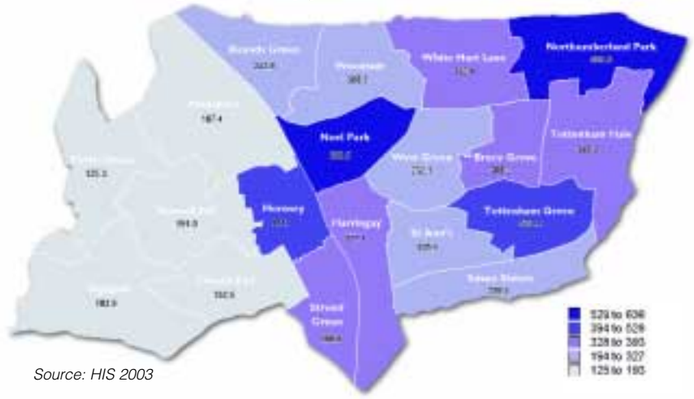
Mental Health

At any one time around one adult in six suffers from a form of mental illness, ranging from common conditions, such as depression, to schizophrenia[6]. Mental illness is complex, not as easily measured as some other illnesses, and can too easily be overlooked as a serious health issue. Many mental health service users experience long-term unemployment and poverty.

Haringey has a large population at risk of mental health problems: it is more common among some ethnic groups, though this is mostly linked to higher numbers living under severe conditions[7]. Refugees and asylum seekers may have mental health needs related to recent experiences. It is also linked with unemployment, poverty and deprivation, and many people live in inadequate or overcrowded accommodation.

Available data shows that mental health admissions are higher in Haringey than in most London boroughs. Haringey has high admission rates for both schizophrenia and neurosis, in the case of schizophrenia more than three times the national rate.

16 Mental Health Standardised Admissions for Adults aged 20-64 per 100,000

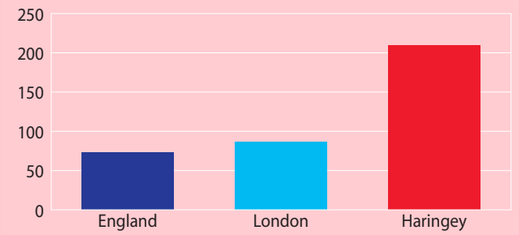


Source: HIS 2003

Pressure on local acute services is being relieved through expanding and improving community services. Community Mental Health Teams, Assertive Outreach Teams and the Crisis Resolution Service are being developed to meet need appropriately in the community.

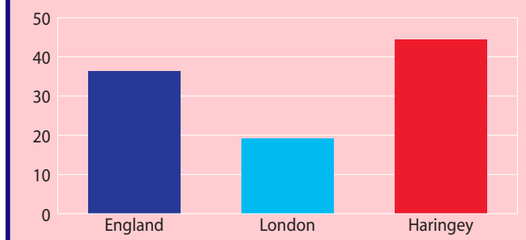
There is a clear east/west split in mental health admissions, rates are higher in the east particularly Noel Park and Northumberland Park. This is not unexpected as most risk factors for mental health also occur in the east.

17 Schizophrenia ages 15-74 2000-01
Standardised Admission Rates per 100,000



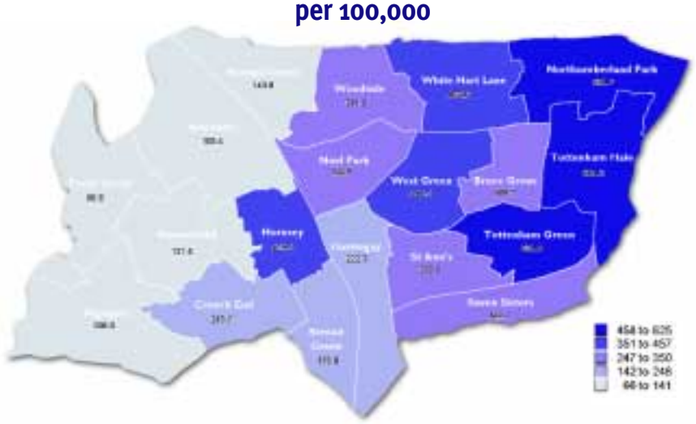
Source: Compendium of Clinical Indicators 2002

18 Neurosis ages 15-74 2000-01
Standardised Admission Rates per 100,000



Source: Compendium of Clinical Indicators 2002

19 Infectious Disease Standardised Admissions for Adults aged 20-64 per 100,000



Source: HIS 2003

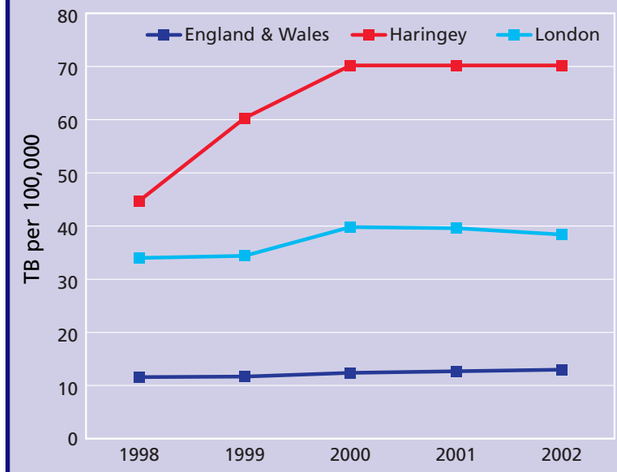
Infectious Diseases

Diseases such as tuberculosis (TB), meningitis, gastrointestinal and sexually transmitted diseases continue to rise, especially in deprived areas. Transmission is more likely in high risk populations where there is high density, poor housing, overcrowded living conditions, poor sanitation and poverty. Figure 19 shows that ward level infectious disease admissions are much higher in the east of Haringey.

One important infectious disease is TB. Haringey has a large high risk population, there is increasing drug resistance and some patients do not complete their treatment. Figure 20 shows that notifications have not increased in recent years but rates in Haringey remain high.

Most TB cases in Haringey are found in the east of the borough. 40% of people with TB are black African, although these account for only 9% of the total population. More than one third of these are Somali. This specific health issue is being addressed through raising awareness and improving access to TB services. The Turkish/Kurdish and Zimbabwean community also have relatively high numbers with TB. Additional TB nurses are working in partnership with statutory services and local communities to raise awareness and reduce incidence.

20 TB Notification rates

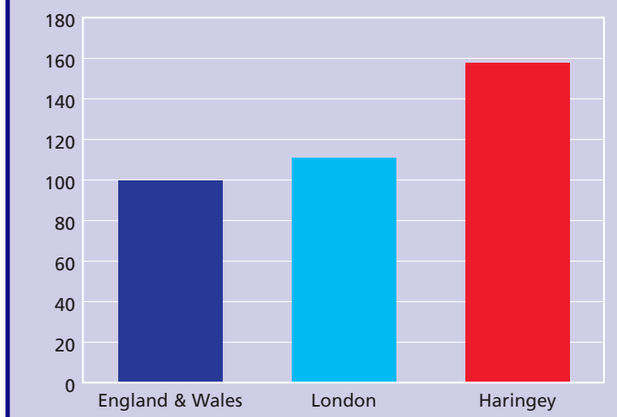


Source: Health Protection Agency 2003

Kidney Disease

Chronic renal failure is the persistent loss of kidney function, end stage is an irreversible reduction in functioning where renal replacement therapy (RRT) is needed. RRT can be haemodialysis, peritoneal dialysis or kidney transplant. The need for RRT is increasing year on year due to people living longer and particular needs of different populations. Overall rates of RRT for minority ethnic communities are three times higher than the population as a whole. This rises to four to five times the average for Asians and African Caribbeans. Figure 21 shows a high SMR for Haringey, which is linked to problems leading to renal failure such as high blood pressure and diabetes, both of which are significant health problems in Haringey.

21 SMR for Chronic Renal failure



Source: Compendium of Clinical Indicators 2002

Ismet, 44

Ismet was born in Turkey, 44 years ago. He came to this country in 1996, as his political views were not acceptable in his own country and he was often detained.

He is now the editor of a local Kurdish newspaper. In March 2002, Ismet experienced a great deal of stress due to his application to become a UK resident. He started to experience night sweats, coughing, and loss of appetite. He assumed he had TB as his mother had experienced similar symptoms when she was diagnosed with TB. His GP referred him to the contact clinic at St Ann's, where a blood sample and chest x-ray were taken. It was confirmed that he had TB. Ismet had been very worried that it was lung cancer, as he was a heavy smoker. 'It was like a weight being lifted off my shoulders. I have a new outlook on life and was happy it was TB, because that can be cured'.

After the diagnosis Ismet started to change the way he lived by giving up smoking, exercising regularly, eating healthier foods and changing his social behaviour. He said 'My wife played a key role in changing my lifestyle and social habits'. During the six months of treatment Ismet did not have too many side effects and has now completed the treatment regime. He is concerned about the rate of TB in the community, which he attributes to lack of education about TB, lack of knowledge about the NHS and communication difficulties. 'I was fortunate my GP was Turkish, I could speak to him without a problem.'

Haemoglobinopathies

Haemoglobinopathies are inherited, genetic disorders of the blood including sickle cell disease and thalassaemia. Sickle Cell disorders are found predominantly in people who originate from Africa or the Caribbean. Thalassaemia is found predominantly in people originating from the Eastern Mediterranean, Middle East and Asia. Antenatal screening for both sickle cell and thalassaemia has been carried out for several years and is linked to a decreasing trend in numbers of babies born with these disorders.

It is estimated that in Haringey there are approximately 600 people with sickle cell disease and thalassaemia. People with sickle cell disorder experience pain crises, are at risk of severe infections, anaemia, jaundice and 'chest syndrome' which leads to relatively high hospital admissions. Work over the last five years has focussed on providing appropriate supportive home health care services to help people manage their condition. This has led to a decrease in hospital use.

Elizabeth, 39

Elizabeth was born in Haringey 39 years ago. She was diagnosed with sickle cell when she was ill with joint pains at the age of two.

Elizabeth missed a lot of schooling due to her admissions for sickle cell crisis to hospital. She has had a variety of jobs, which were all disrupted by her illness to varying degrees. In 1996 she went to Jamaica for her sister's funeral and was bitten by mosquitoes. The bites became infected and ulcerated and continue to cause problems. Whilst in hospital she was offered redundancy from her work and as she was weak from illness accepted. She is now registered disabled. Since 2001 Elizabeth has been in and out of hospital. She uses the Home Care Pain Management Service to enable her to stay out of hospital as much as possible. She lives in her own house with her two children. The house has a stair lift and a toilet on the ground floor. Her family look after her youngest child when she is in hospital.

Elizabeth is working with the New Deal for Disabled People Scheme to find a part time job and she is also wants to learn to drive. She is an active member of the local Sickle Cell Support Group. Elizabeth is a regular churchgoer and is visited by church members when she is in hospital. Elizabeth is philosophical in not letting sickle cell stop her from what she wants to do -'You've only got one life'.

Conclusions

Unemployment, low levels of income, inadequate housing and social isolation impact on health. The biggest causes of early death are cancer and heart disease. Work is happening locally to improve standards of care for CHD, diabetes and cancer. Screening to detect conditions such as breast cancer remain a vital element of services. Prevention is also key, with projects targeting people at risk from these diseases to increase exercise, improve diet and give up smoking. Some conditions are linked to particular communities in Haringey and when this is the case appropriate interventions need to be tailored to meet need and increase awareness. It is hoped work at a neighbourhood level on regeneration and creating employment opportunities for local people will have a lasting impact.

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2 Quinn, M et al. Cancer Trends in England and Wales 1950-1999. Office for National Statistics, 2001.

3 British Heart Foundation. www.bhf.org.uk

4 Based on figures from Diabetes UK and Department of Health. Health Survey for England 1999.

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7 INPHO briefing paper – Ethnicity and health inequalities. Eastern Region Public Health Observatory. Sept 2002.

Older People

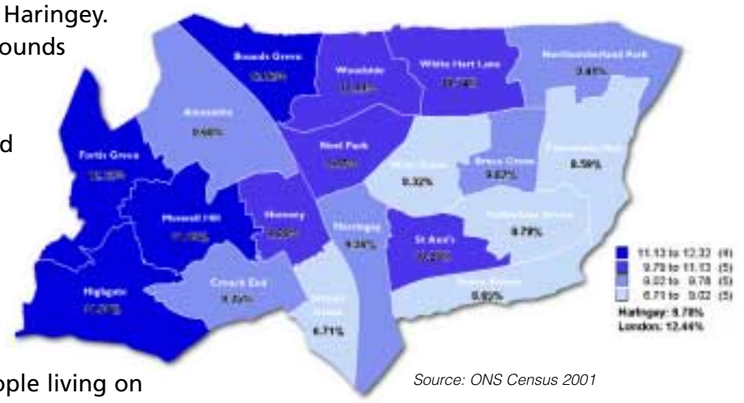
People aged 65 years and older make up approximately 10% of the Haringey's population. This is a relatively small proportion compared with the national or London average.

Figure 1 shows where people over age 65 live in Haringey. Fortis Green and Bounds Green wards have the highest proportions of older people and Stroud Green the lowest.

Older people are more likely to require social and physical support especially in later years. Figure 2 shows the proportion of older people living on their own in Haringey. A greater proportion of older men in particular are living on their own when compared with either the London average or the country as a whole.

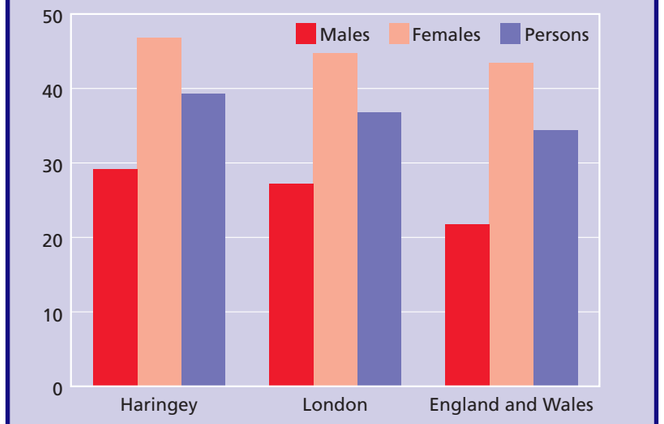
Figure 3 shows the ethnic make up of the population of older people in Haringey. People from minority ethnic communities are more likely to experience poorer health in old age which is likely to result from social and economic disadvantage and also from factors particular to those communities, such as genetic predisposition and discrimination.[1] 11% of the older population are from the African Caribbean communities. While the majority of the older population (80%) are white, it is of note that 7% of these are Irish and a further 13% are from other white communities which are also more at risk of experiencing poorer health in old age. This 13% consists mainly of groups from Turkish, Kurdish and Turkish Cypriot and Greek Cypriot communities.

1 Older people Living in Haringey



Source: ONS Census 2001

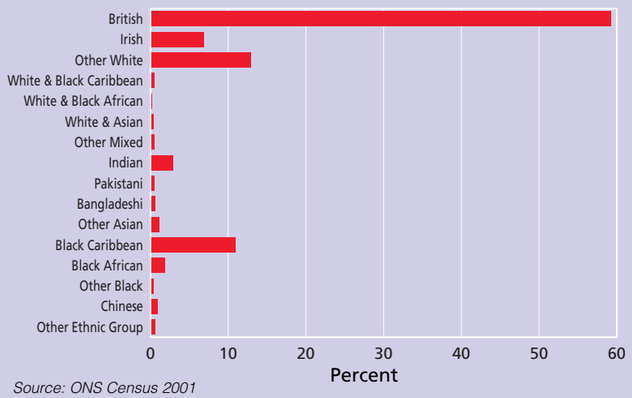
2 Percentage of over 65 year olds Living Alone



Source: ONS Census 2001

Older People

3 Percentage Ethnicity in the over 65s



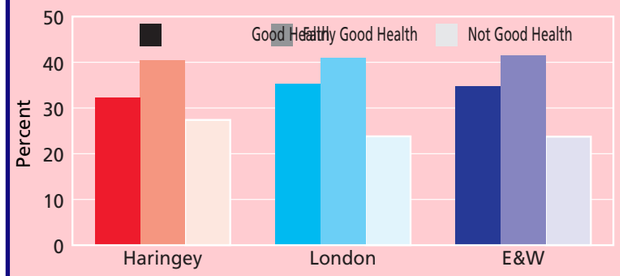
Source: ONS Census 2001

Older People's Perceptions of their Health

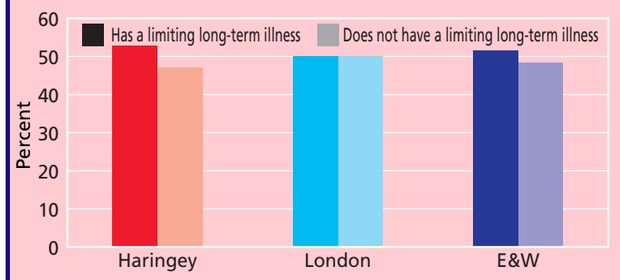
Older age does not necessarily result in poorer health. However, for some it does equate with declining well-being. Information from the 2001 Census shows that only 32% of those aged over 65 believe themselves to be in good health, while 27% are not in good health. Increased life expectancy has been accompanied by higher rates of self-reported chronic illness. However, reporting rates of these illnesses may be influenced by additional factors such as material circumstances, gender, ethnicity and area of residence[2]. Figure 4 shows that Haringey older people's perceptions of their health is slightly worse in comparison with London or the country as a whole.

This is also the picture when the figures of those with limiting long-term illness are examined. Haringey is just slightly above the London and the national average as seen in Figure 5.

4 General Health Status of Older People



5 Older People with Limiting longterm Illness



Source: ONS Census 2001

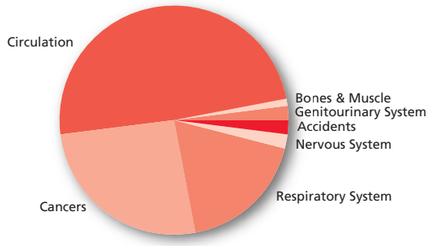
Deaths of Older People in Haringey

The main causes of death amongst older people in Haringey are circulatory disorders (including coronary heart disease and stroke), cancer and respiratory illness.

When comparing deaths rates our pattern for deaths matched that in London and the rest of the country as shown in Figure 7. This shows that the SMR for those aged between 65 and 75 has been declining over the past ten years.

When looking at deaths across the borough it can be seen that the death rates vary a little between wards when compared with the Haringey average. However death rates in the Northumberland Park and Bruce Grove area are significantly above the Haringey average.

6 Main Causes of Death in the over 65s, 2001-02

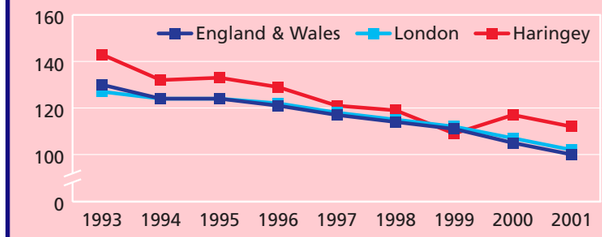


Source: HIS 2003

Using Health Services

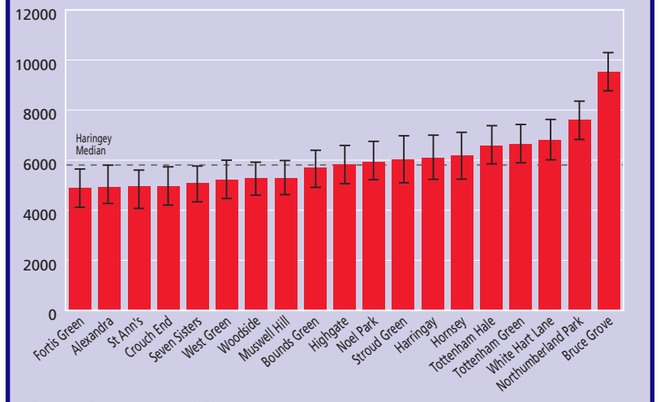
Some other indicators of health and illness in older people are shown through hospital admission data. The main causes for admission are shown in Figure 9. Circulatory disorders, cancers and respiratory diseases feature as key problems leading to admission.

7 SMR for those aged 65-74



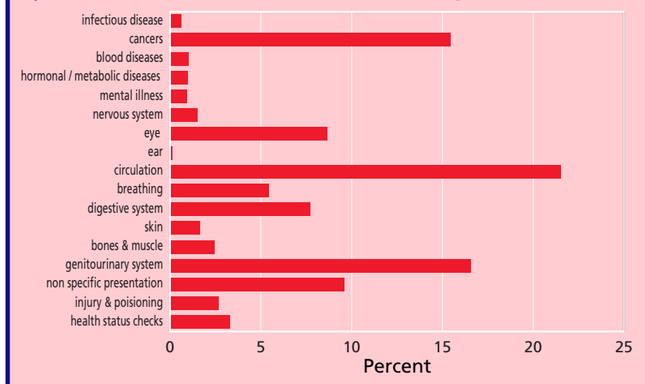
Source: Compendium of Clinical Indicators 2002

8 Over 65 Mortality, All Causes
Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

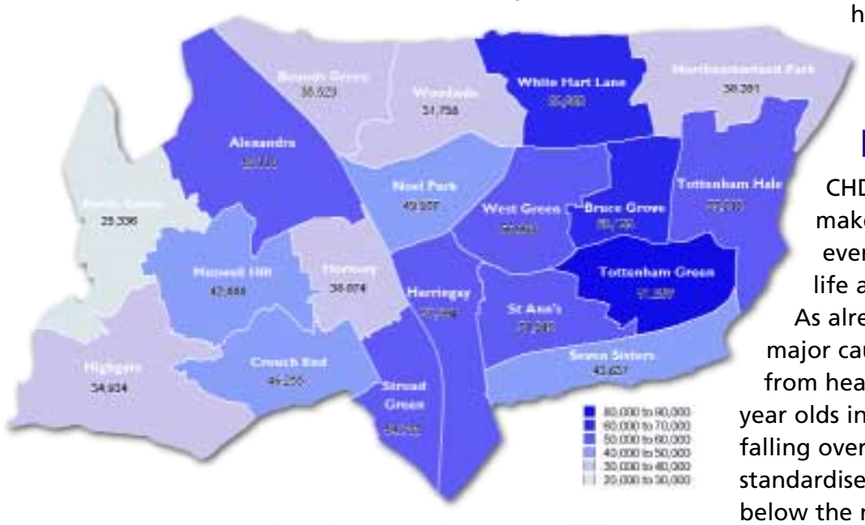
9 Cause of Admission in the over 65s, 2001-02



Source: HIS 2003

Health status checks incorporate hazards related to communicable disease, factors related to reproduction, social & psychosocial factors and personal or family history.

10 Over 65 Admission, All Causes
Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

Figure 10 shows the overall rate of admission for people over 65 in Haringey. While a greater proportion of older people live in the west of the borough, older people living in the east of the borough are more likely to be admitted to hospital. This is consistent with the expectation of high admissions from those in socio-economically deprived areas.

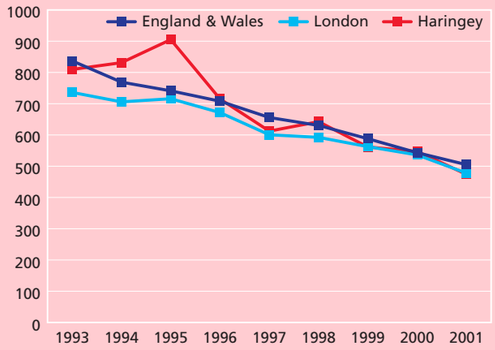
Heart Disease

CHD is a condition which makes a significant impact on every aspect of an individual's life and personal relationships. As already noted, it is also a major cause of death. Mortality from heart disease amongst 65-74 year olds in Haringey has been falling over the last 10 years. Age standardised rates are now slightly below the national average.

Death rates are highest in some of the more deprived wards of Haringey namely Bruce Grove and Northumberland Park. However, some of the more deprived areas have relatively low death rates such as St Ann's and Seven Sisters. One of the main risk factors associated with heart disease is smoking. The smoking cessation service offers support to those wanting to quit, preventing heart disease or decreasing the risk of further attacks.

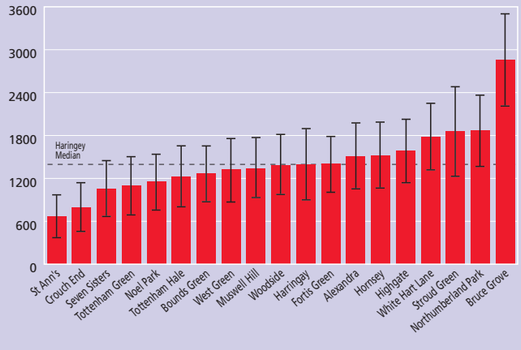
The pattern for admissions for heart disease is somewhat different in that Northumberland Park had a relatively low rate of admissions and White Hart Lane had relatively high admission and mortality rates.

11 CHD Mortality in those aged 65-74
Standardised Rates per 100,000



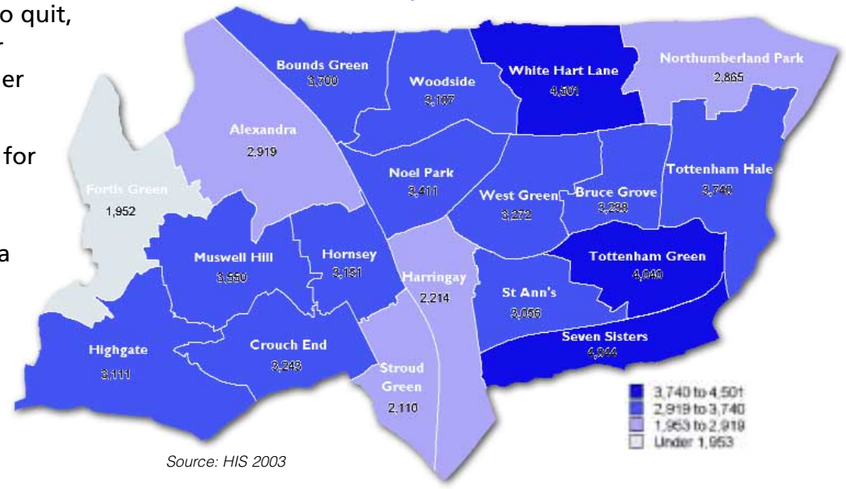
Source: Compendium of Clinical Indicators 2002

12 CHD Mortality in those aged 65 and over
Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

13 CHD Admissions for those aged 65 and over
Standardised Rates per 100,000



Source: HIS 2003

Mick and Josie

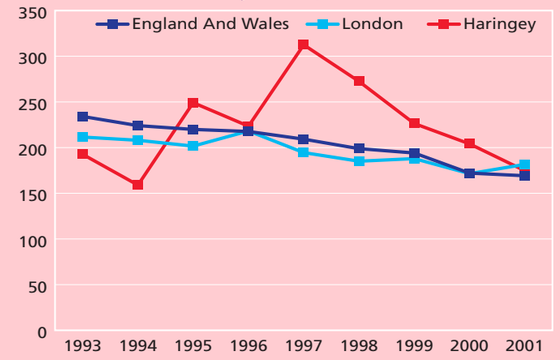
Mick and Josie attended the local Quit Smoking Clinic after Mick suffered two heart attacks.

He had been ill for some time, experiencing pain in his chest and difficulty with breathing. After undergoing tests it was confirmed that he had heart disease. The only option was heart surgery to relieve his symptoms. They started smoking as teenagers and were on 20 – 30 cigarettes each by the time they sought help. Mick had tried to stop smoking on his own but had never been successful. Josie had never tried to quit before and felt very nervous about attending the clinic but she wanted to support Mick. They went through the seven-week treatment programme together, supported by the specialist advisors. They both used patches to help with the cravings and withdrawal symptoms. They attribute their success to determination, attending the clinic and going through it with other people. Using patches 'was great' said Mick. Having their carbon monoxide readings taken each week to monitor progress and the support from the group and the specialist advisors, 'was brilliant'. Mick said, 'the companionship of the group helped, being there each week and thinking to myself, if they can do it so can I'. If you would like help and support to quit smoking please call the free phone number **0800 085 6258**

Older People

14 Stroke Mortality in those aged 65 and over

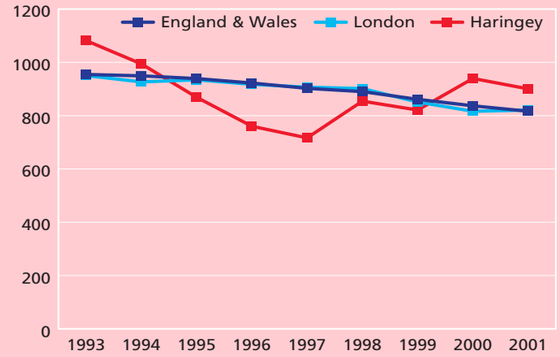
Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

15 Cancer Mortality in those aged 65-74

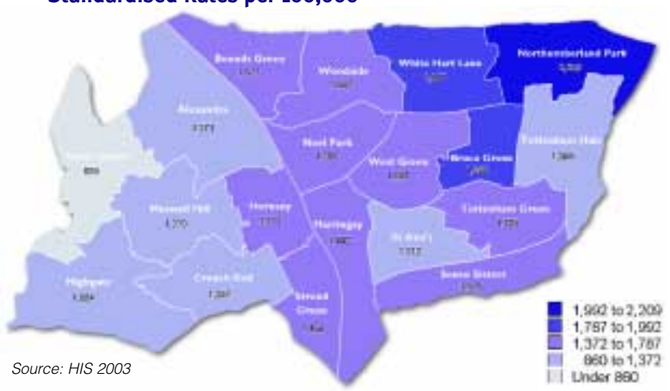
Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

16 Cancer Mortality in those aged 65 and over

Standardised Rates per 100,000



Source: HIS 2003

Stroke

A stroke occurs when the blood supply to part of the brain is disrupted. As a result there is loss of function in the area of the body supplied by that part of the brain. Stroke is the third most common cause of death in England and Wales, and is particularly prevalent in the African-Caribbean population. It is the main cause of acquired disability in adults. The death rate from stroke has varied considerably in Haringey in recent years, whereas there has been a steady decline in the rates for London and England and Wales. Haringey rates have been decreasing since 1997 and in 2001 were similar to the national average.

Cancer

There are wide inequalities in cancer incidence. People from deprived backgrounds are more likely to get some types of cancer and to die from them once they have been diagnosed. For example, in the early 1990s the death rate from lung cancer amongst professional men was 17 per 100,000 compared to 82 per 100,000 amongst unskilled men. There are also variations in cancer incidence related to ethnicity. Mortality from lung cancer is lower in people born in the Caribbean, Asia and Africa and higher in people born in Scotland and Ireland. Deaths from cervical cancer are more common in women born in the Caribbean. Different levels of exposure to risk factors such as smoking and diet are important in helping to explain these variations[3].

Mortality rates for cancer in Haringey had been falling steadily during the 1990s and were lower that the London and national average. Rates began to increase in 1998 and are now slightly higher than both the London and national rates.

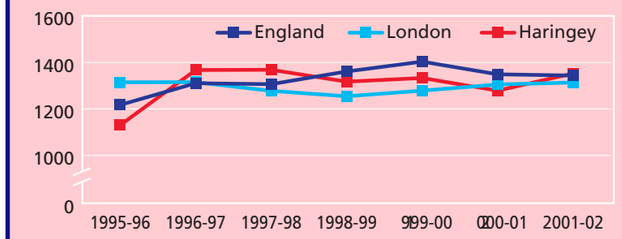
Death rates were particularly high in the east of the borough in the wards Northumberland Park, Bruce Grove and White Hart Lane.

Accidents

Accidents are a considerable health risk for older people mainly due to declining mobility, poorer vision and general frailty making it more difficult to protect themselves against injuries and falls. Accidental injury, particularly from a fall is the event most likely to reduce an older person's autonomy[4].

17 Admission due to Accidents for those aged 65 and over 1995-2002

Standardised Rates per 100,000



Source: Compendium of Clinical Indicators 2002

There are considerable variations in admission rates for older people who have had accidents, as shown in Figure 18. The higher rates are from people living in the west of the borough.

Jean, 73

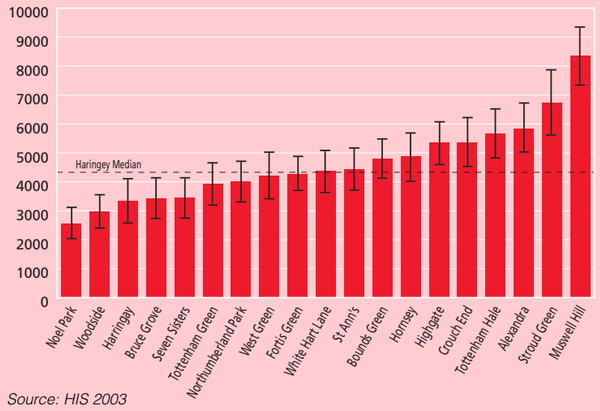
Jean was born 73 years ago in Wales.
She and her husband moved to London to work.

When he became disabled they moved to a specially adapted flat in Tottenham were Jean continues to live. Jean enjoys her retirement; she frequently goes on weekend trips and holidays. She is an active member of the voluntary organisation HAVCO, Age Concern and Haringey Pensioners' Action group. Two years ago Jean went to France, where she fell and broke her arm. She was very impressed with the quick response of the French emergency services, but had to wait quite some time before she was treated on her return home. After several trips to the hospital she had a plate put in her arm, which then began to gradually improve.

Very soon afterwards she fell again and broke her other arm. Part of the reason for the frequent fractures is that Jean has osteoporosis. As she was keen to continue to keep active Jean was delighted to be invited to join the community falls prevention exercise group. This group has been invaluable as it provides exercise and improves balance. Jean says she has made friends on the group who would like to continue to meet. She hopes that the classes have helped her balance and so enable her to avoid another fall. She wants to continue to take part in the University of the 3rd Age and plans lots more activities with excitement and confidence.

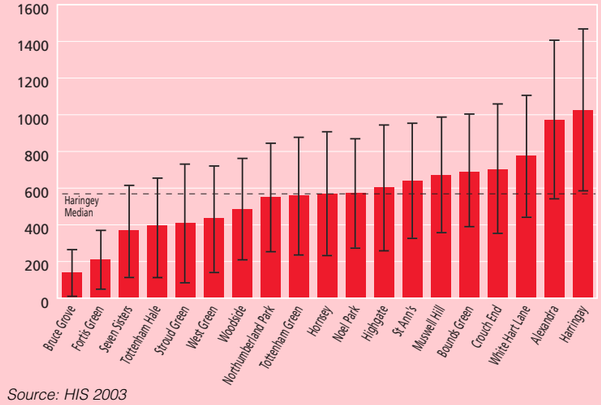
Glossary of Terms

18 Admissions due to Accidents, 65 and over
Standardised Rates per 100,000



Source: HIS 2003

19 Admissions due to Knee and Hip, 65 and over
Standardised Rates per 100,000



Source: HIS 2003

Joints and older people

Admissions for hip and knee operations in Haringey are at a rate of just under 600 per 100,000 population. This again varies across wards with significantly lower rates in Bruce Grove and Fortis Green. There are higher than average rates in other parts of the borough, but these differences in rates are not statistically significant.

Conclusions

Older people form a significant section of the Haringey population even though there are fewer older people in Haringey compared with many other boroughs. Some key indicators of health show that Haringey older people have death and sickness rates comparable to the rest of London. However, older people's experience of heart disease, cancer and falls varies in different parts of the borough. The National Service Framework for Older People highlights the range of needs of older people at different stages of ageing. It also importantly sets standards for prevention, support and care for older people which are being implemented locally in Haringey.

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5 Older People. National Service Framework. Department of Health:2001.

APHR Annual Public Health Report

ASR Age Standardised Rates – The numbers of events (disease/death) occurring among individuals in each specific age category divided by the total number of persons in each age stratum.

BME Black and Minority Ethnic

CHD Coronary Heart Disease

Compendium of Clinical Indicators Previously known as Public Health Common Dataset (PHCDS). The Compendium brings together, in a restructured format, indicators from a number of the data sets developed by the Department of Health. It is managed by Centre for Public Health Monitoring and the London School of Hygiene and Tropical Medicine.

Demography Age, sex and locations of populations

Determinants of health Causes and factors that influence the risk of disease

DSR Directly Standardised Mortality Rate – This is based on the average local age and sex specific rates, weighted according to a standard population (the European Standard population is used here). The results are expressed in terms of number of deaths per 100,000 population.

Ethnic Group An ethnic group is a group of people who share characteristics such as language, culture, religion and nationality. This provides the group with a distinct identity as seen both by themselves and by others. Its use in this document is based on the ONS Census 2001 categories.

GP General Practitioner

Haemodialysis The removal of the body's waste products from the blood with a haemodialysis machine or filter.

HIS Health Informatics Service

Incidence rate The number of new cases of a disease in a given population over a given time. It is usually expressed as the number per 100,000 population for a given year.

Infant mortality The number of infant deaths (deaths in the first year on life) to those born in a particular year per 1000 live births in that year.

Life-expectancy Life-expectancy is a measure of mortality experience within populations. Life-expectancy at birth is the number of years a newborn can be expected to live given prevailing mortality conditions within that geographical location and time period.

ONS Office For National Statistics

PCT Primary Care Trust

Prevalence Proportion of people with a disease at a point in time.

Peritoneal dialysis A type of dialysis, in which special solution is run through a tube into the peritoneum. The body's waste products are removed through the tube.

Screening Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of disease or complications.

SMR Standardised Mortality Ratio – A SMR is calculated as the number of deaths observed within a population group divided by the expected number of deaths within that group if national age and sex specific mortality rates were to apply. This ratio is then multiplied by 100. Thus, an SMR of 100 suggests that local mortality rates are the same as national mortality rates when age and sex differences in the two populations are taken into account.

Statistically significant Describes a mathematical measure of difference between groups. The difference is said to be statistically significant if it is greater than what might be expected to happen by chance alone.

TPCT Teaching Primary Care Trust

Haringey NHS
Teaching Primary Care Trust

Haringey Health Report 2003

For further information contact:

Ama Iyoyo
Health Improvement Directorate
Haringey Teaching Primary Care Trust
Trust Headquarters Block B1
St Ann's Hospital
St Ann's Road
N15 3TH

Tel: 020 8442 6786

Email: ama.Iyoyo@haringey.nhs.uk

www.beh.nhs.uk/haringeypct

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