

Public Health Report 2005



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Foreword



Welcome to the 2005 Brent Primary Care Trust (PCT) Annual Public Health Report. Health and well being are important aspects of everyone's life and Brent PCT is working to improve the health of everybody living in Brent. Within the PCT it is the aim of the Public Health Directorate to improve the health of all the people in Brent, but also to improve the health of the worst off fastest in order to reduce inequalities in health.

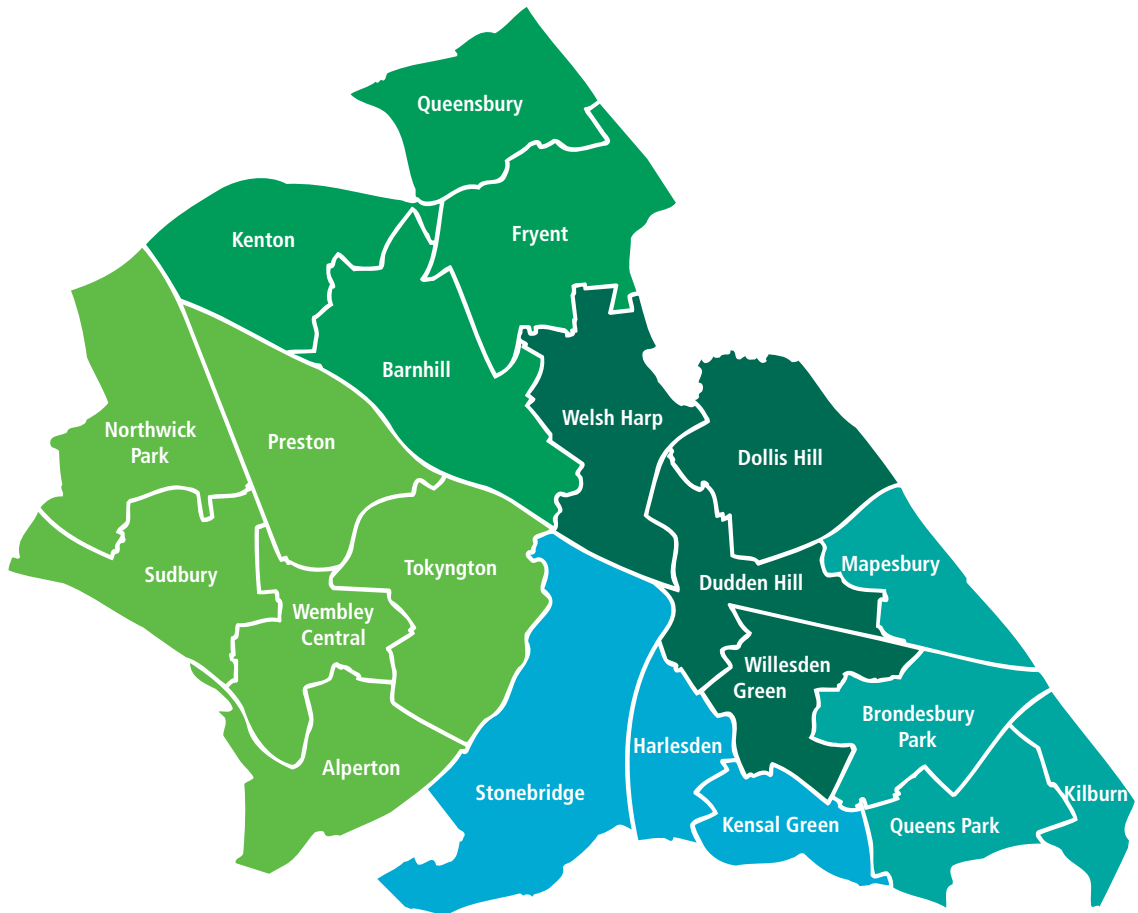
The purpose of this report is to describe the health of the people of Brent and to identify areas with the greatest need for health improvement. Brent has an ethnically and culturally diverse population and there are great variations in wealth across the borough. As a consequence there are also variations in health, with the worst health often experienced by residents living in the most deprived parts of the borough. To highlight geographical variations in health determinants and outcomes, much of the information in this report is presented at ward or locality level. There are 5 locality areas (clusters of wards) within the borough – Harlesden, Kilburn, Kingsbury, Wembley and Willesden – each with its own distinct socio-demographic characteristics and health profile. An examination of health at locality and ward level unmasks that while, on average, Brent has better health outcomes than England & Wales for diseases such as coronary heart disease and some cancers, there are areas within Brent where the health of residents is worse than the rest of the country. Knowing this information enables us to plan health services that are more responsive to local needs. This is a key aim of the PCT.

However, good health for all cannot be achieved solely through treating people once they have become ill. Therefore, the PCT also works closely with voluntary organisations and the Local Authority to ensure that appropriate services are available and accessible to individuals and communities, including services that tackle the determinants of health. I hope that this report will be of equal value to our partners and further strengthen our efforts to improve health for everybody in Brent.



Dr Judith Stanton

Director of Public Health

A map of the Five Brent Localities



Key

Locality	Colour shown on map	Composite Wards
Harlesden		Stonebridge, Harlesden, Kensal Green
Kilburn		Kilburn, Queens Park, Brondesbury Park, Mapesbury
Kingsbury		Barnhill, Fryent, Kenton, Queensbury
Wembley		Alperton, Tokyngton, Wembley Central, Preston, Sudbury, Northwick Park
Willesden		Welsh Harp, Dollis Hill, Dudden Hill, Willesden Green

1. The People of Brent Population

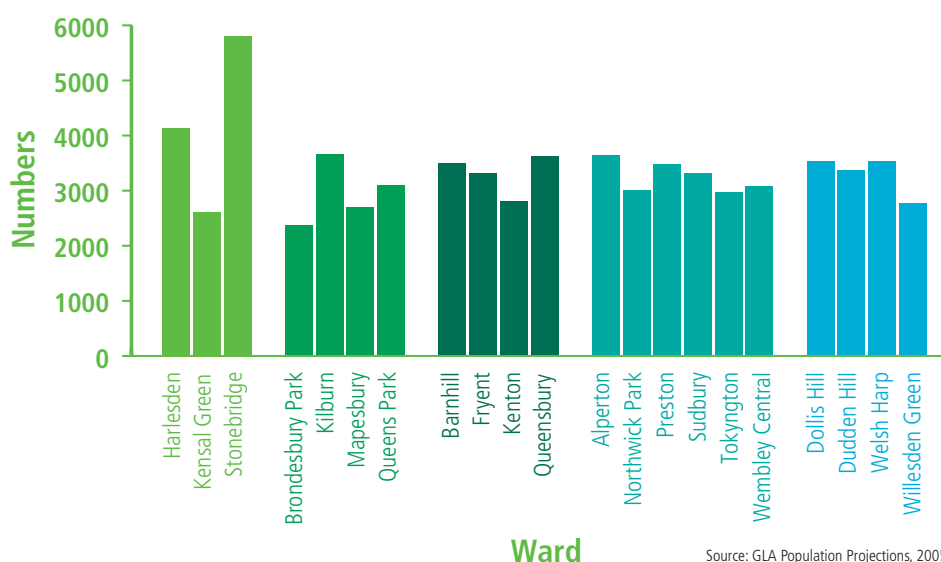


According to the 2001 Census, 263,466 people live in Brent, which makes Brent the seventh largest borough in London. Between 1991 and 2001, the population increased by 8.4%. This was the first recorded rise in population for 50 years. As in some other London boroughs, there is concern that the 2001 Census under-enumerated the population of Brent. The Greater London Authority (GLA), which produces annual population projections for all London Boroughs, estimates that Brent's population in 2005 totals 279,025.

Children and Young Adults

The age profile of Brent's population is an important consideration when planning healthcare and other services. Areas in which there are large numbers of children will require a concentration of health visitor and other services that meet the needs of children. Overall children and young people aged less than 20 make up a quarter of Brent's population. Figure 1 shows the numbers of 0-19 year olds in each of the 21 wards in Brent. The largest numbers of children and young adults are found in Harlesden and Stonebridge wards, whilst Brondesbury Park has the smallest number.

Figure 1: Persons aged 0-19 years in Brent wards, 2005

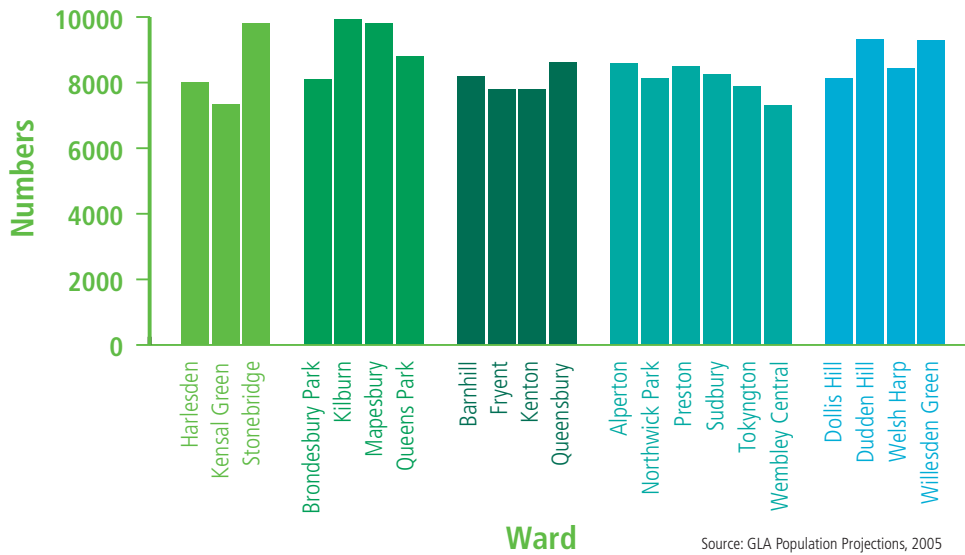


Source: GLA Population Projections, 2005

Adults of Working Age

Sixty four percent of Brent's population are aged between 20-64. Since 1991, the number of adults aged between 30 and 50 years has grown. Figure 2 shows the number of 20-64 year olds in each ward. Kilburn ward has the largest number of adults of working age (9,922 people) and Kensal Green has the smallest (7,348 people).

Figure 2: Persons aged 20-64 years in Brent wards, 2005

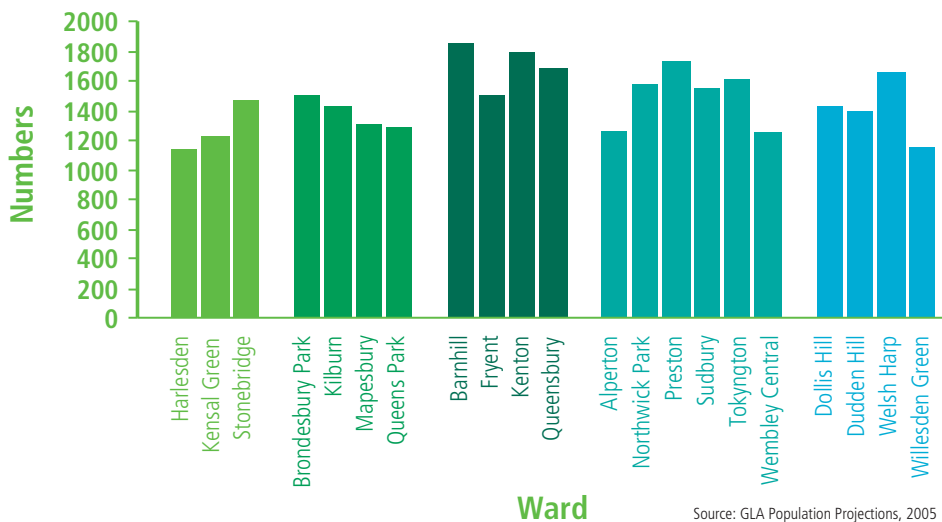


Source: GLA Population Projections, 2005

Older Adults

According to GLA population projections for 2005, 11% of Brent's population is aged 65 years or older. Figure 3 shows the number of older adults living in each ward in Brent. Harlesden ward has the smallest number of persons aged 65 years and over, whilst Barnhill ward has the largest.

Figure 3: Persons aged 65 years and over in Brent wards, 2005

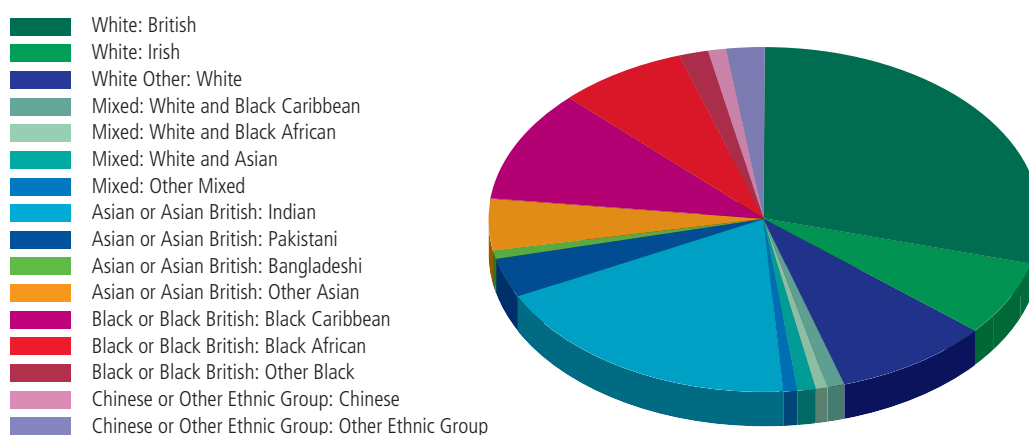


Source: GLA Population Projections, 2005

Ethnic Origin

Brent is an ethnically diverse borough, as illustrated in Figure 4. According to the 2001 Census, the majority of Brent's population is from Black and Minority Ethnic (BME) Groups. People from BME communities make up 54.7% of Brent's resident population, the second highest proportion of all London Boroughs. Asian, Black Caribbean, Black African and Irish communities are all strongly represented in the borough.

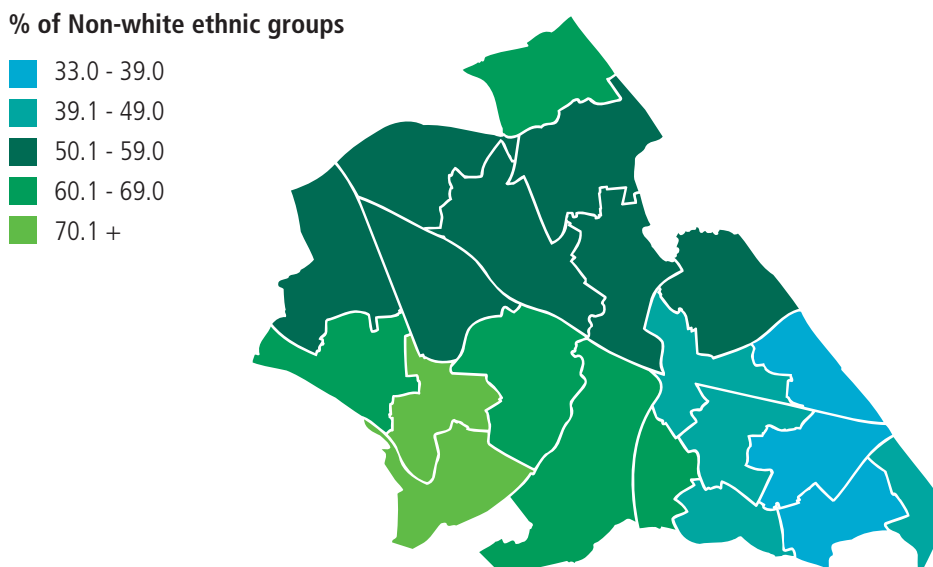
Figure 4: Brent population by ethnic origin, 2001



Source: Census 2001

Figure 5 shows the proportion of the population from non-white ethnic groups at ward level.

Figure 5: Percentage of population from non-white ethnic groups in Brent, 2001



© Crown copyright. All rights reserved. London Borough of Brent. Licence No. LA086312. Source: Census 2001

Black BME Groups

Since 1991 the largest population increase in Brent has been amongst Black BME groups, with an increase of approximately 33%. People of Caribbean ethnic origin comprise the largest sub-group within Brent's black population, making up 10.5% of Brent's total population. This is three times larger than the figure for all outer London boroughs (3.5%).

Figure 6 shows the distribution of Black ethnic groups by ward. The highest concentration of black residents is in the Harlesden locality, especially Stonebridge and Harlesden wards.

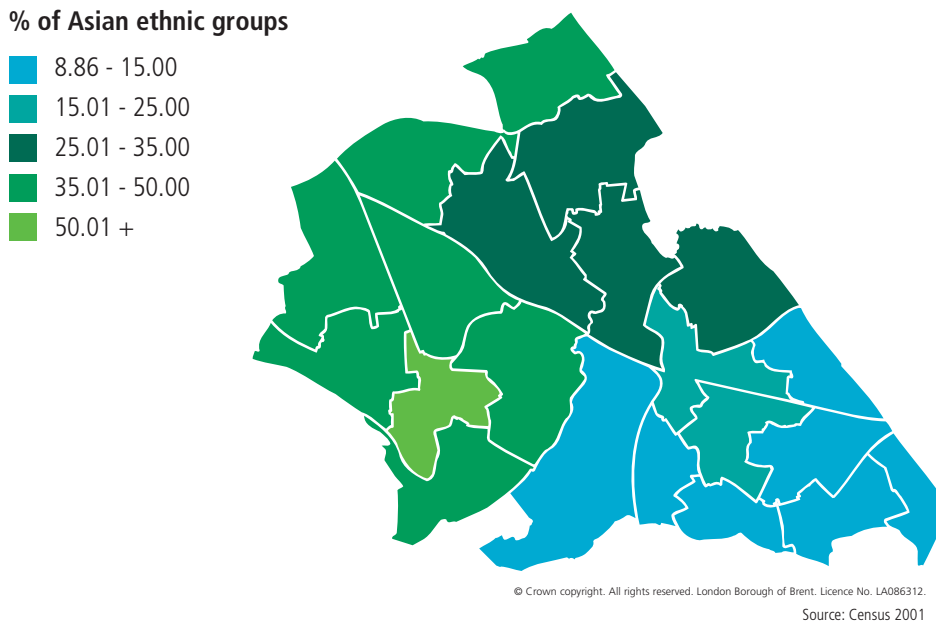
Figure 6: Percentage of population from Black ethnic groups in Brent, 2001



Asian BME Groups

Since the 1991 Census, the number of people from Asian BME groups living in Brent has increased by approximately 30%. Brent's Asian population tends to be concentrated in the west of the Borough (see Figure 7). The ward with the highest proportion of residents of Asian ethnic origin is Wembley Central (40%).

Figure 7: Percentage of population from Asian ethnic groups in Brent, 2001

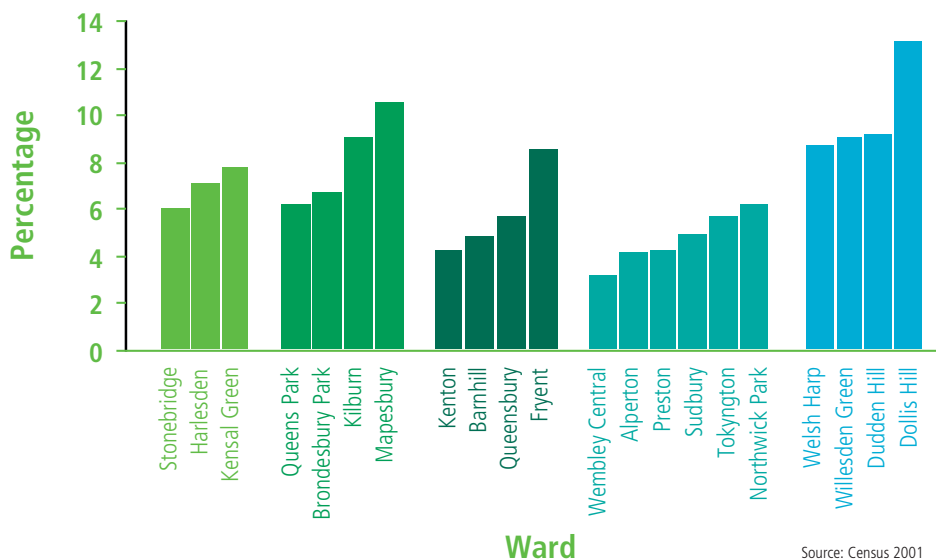


Brent's White Population

Since the last census in 1991 Brent's White population has decreased by around 24%. The White population tends to be concentrated in the east of the Borough. Brondesbury Park ward has the largest number of residents from White ethnic groups.

Seven percent of Brent's population classify themselves as White Irish, compared to 3.1% in London and 1.2% in England & Wales. Dollis Hill ward has the highest proportion of White Irish residents (13%) in Brent, as shown in Figure 8.

Figure 8: Percentage of population from White Irish ethnic groups in Brent, 2001



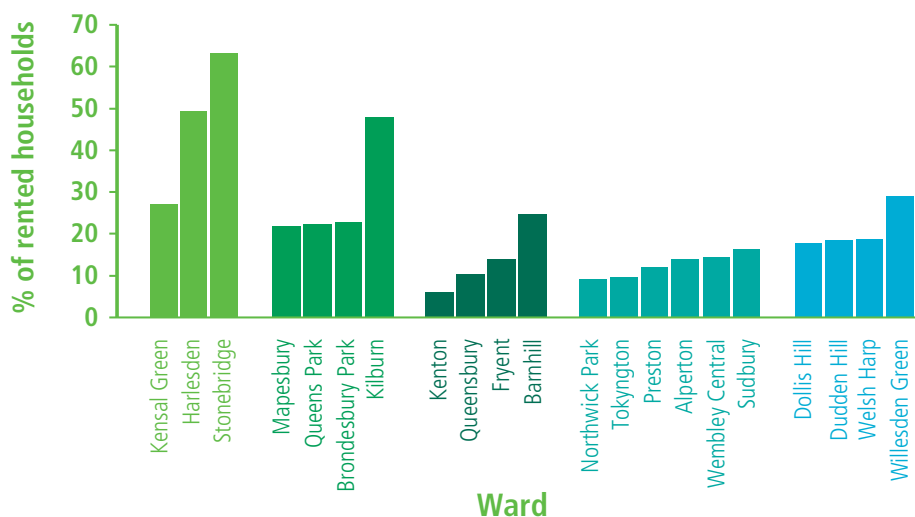
Housing

Housing is important to health. The quality of a person's home and of the homes in the surrounding area can have both direct and indirect influences on that person's health and well-being. Improving the quality of housing and the built environment can have an important positive influence on well-being. Such measures range from ensuring that dwellings are safe to live in and do not contain, for example, toxic substances such as asbestos, to making neighbourhoods secure and welcoming places to live in.

Rented accommodation in Brent

The percentage of households that are rented from the Local Authority, from Housing Associations or from registered social landlords varies enormously across Brent (see Figure 9). For example, according to the 2001 Census, at least half of all households in Harlesden and Stonebridge wards are rented. The corresponding figure for wards in the Wembley locality is less than 20%. In Brent as a whole, 24% of households live in rented accommodation, compared to 5.2% in England and Wales.

Figure 9: Percentage of households rented from the Council, Housing Associations or Registered Social Landlords



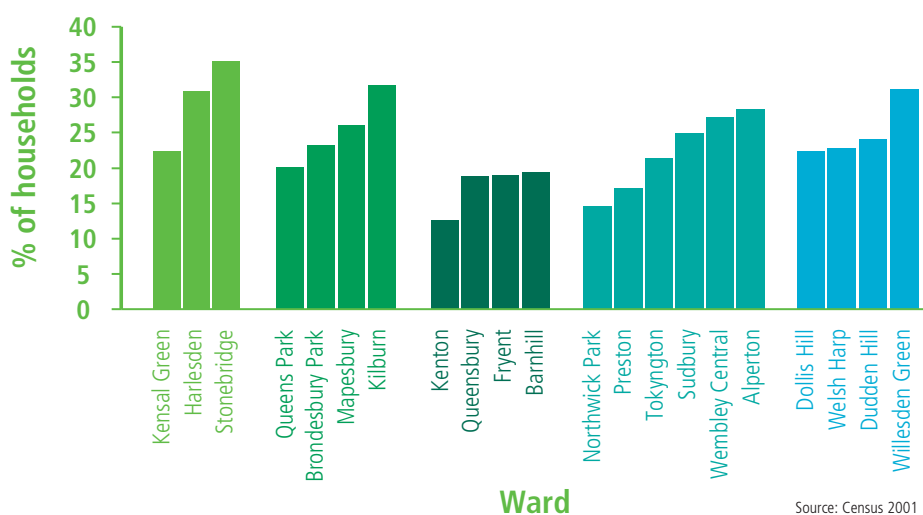
Source: Census 2001



Overcrowding

Living in overcrowded conditions can have a detrimental impact on physical and mental health. Gastrointestinal and respiratory infections are more common amongst people who live in overcrowded accommodation and mental health problems also occur more frequently. Overcrowded dwellings tend to be poorly maintained and prone to problems such as damp and poor ventilation, which can exacerbate respiratory disease. Under or over crowding can be measured by an indicator called the occupancy rating. A negative value implies that there are too few rooms and that the household is overcrowded. For example, a value of -1 on the occupancy rating implies that there is one room too few, given the number of people that occupy that household. Data from the 2001 Census show that 24% of households in Brent have an occupancy rating of -1 or less. This compares to 24.6% in London and 7% nationally. Stonebridge, Willesden Green and Harlesden wards have the highest percentages of overcrowded dwellings in Brent. Kenton and Northwick Park wards have the lowest proportions of overcrowded households (see Figure 10).

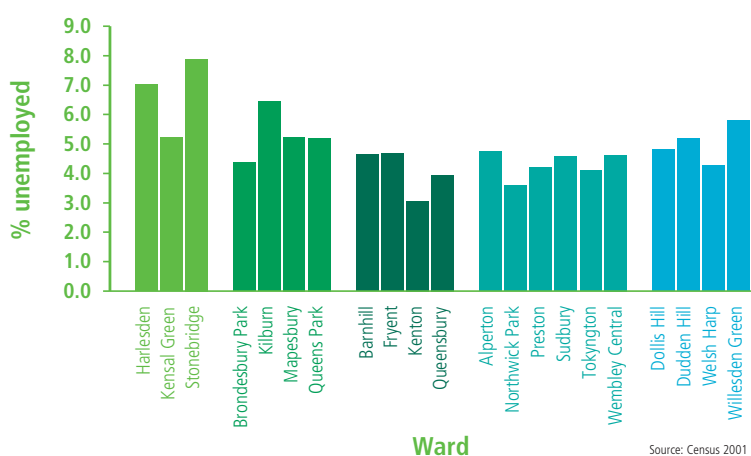
Figure 10: Percentage of households with an occupancy rating of -1 or less in Brent, 2001



Employment

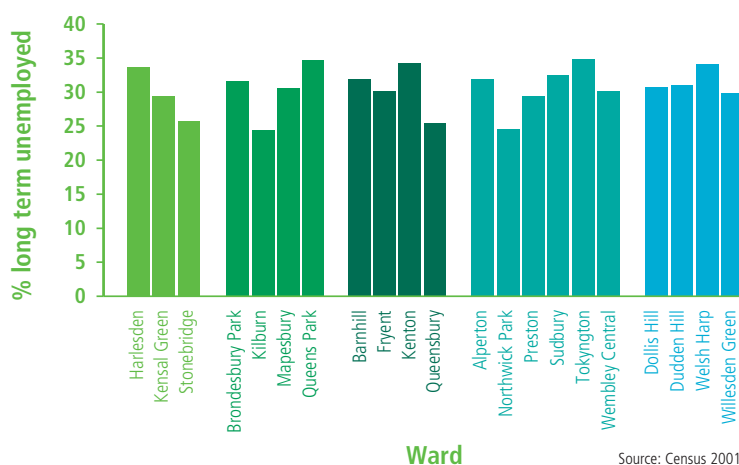
Being employed is associated with good physical and mental health. At the last Census in 2001, 5% of Brent's population classified themselves as unemployed. This compares to 4.4% and 3.3% in London and England and Wales respectively. Unemployment is closely linked to material deprivation. Unsurprisingly in Brent, those wards with the highest proportion of unemployed people aged 16-74 years old closely mirror those wards which are known to have the highest levels of deprivation.

Figure 11: Percentage of 16-74 year olds who are unemployed in Brent, 2001



Although there is quite wide variation at ward level in the percentage of the population classified as unemployed (see Figure 11), the proportion of unemployed persons who are classified as long-term unemployed (defined as people who have not worked since 1999 or earlier) is more evenly spread across the borough (Figure 12). The percentage of unemployed persons who are long-term unemployed ranges from 24.4% in Kilburn ward to 34.8% in Tokyngton ward, and there is no obvious correlation with deprivation levels. The overall proportion of unemployed persons who are classified as long term unemployed in Brent is 30.7%, which is very similar to the figure for England and Wales (30.3%).

Figure 12: Percentage of unemployed who are classified as long term unemployed in Brent, 2001

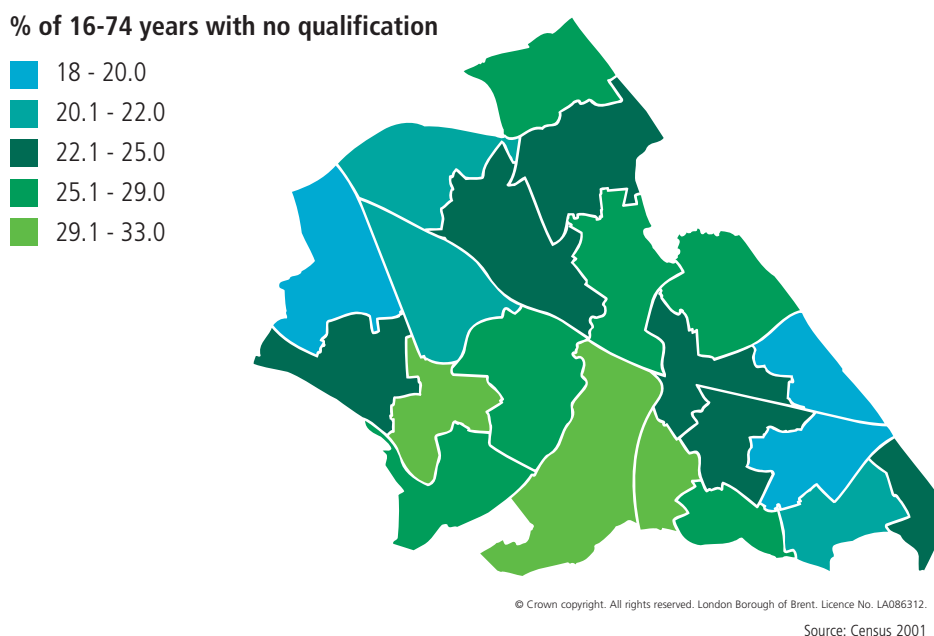


Education



There are 60 nursery/primary schools and 13 secondary schools in Brent providing education for 21,499 pupils. In 2000/2001 there were also 8,016 individuals undertaking an adult education course within the borough. Many residents in Brent have a degree or higher qualification, and in this respect, the borough is ranked 24th in the country. However Brent also has a relatively high proportion of residents with no formal qualifications (24.6%). This figure is similar to the London figure of 23.7%, but lower than for England & Wales (28.8%). The ward with the highest proportion of residents with no formal qualifications is Harlesden.

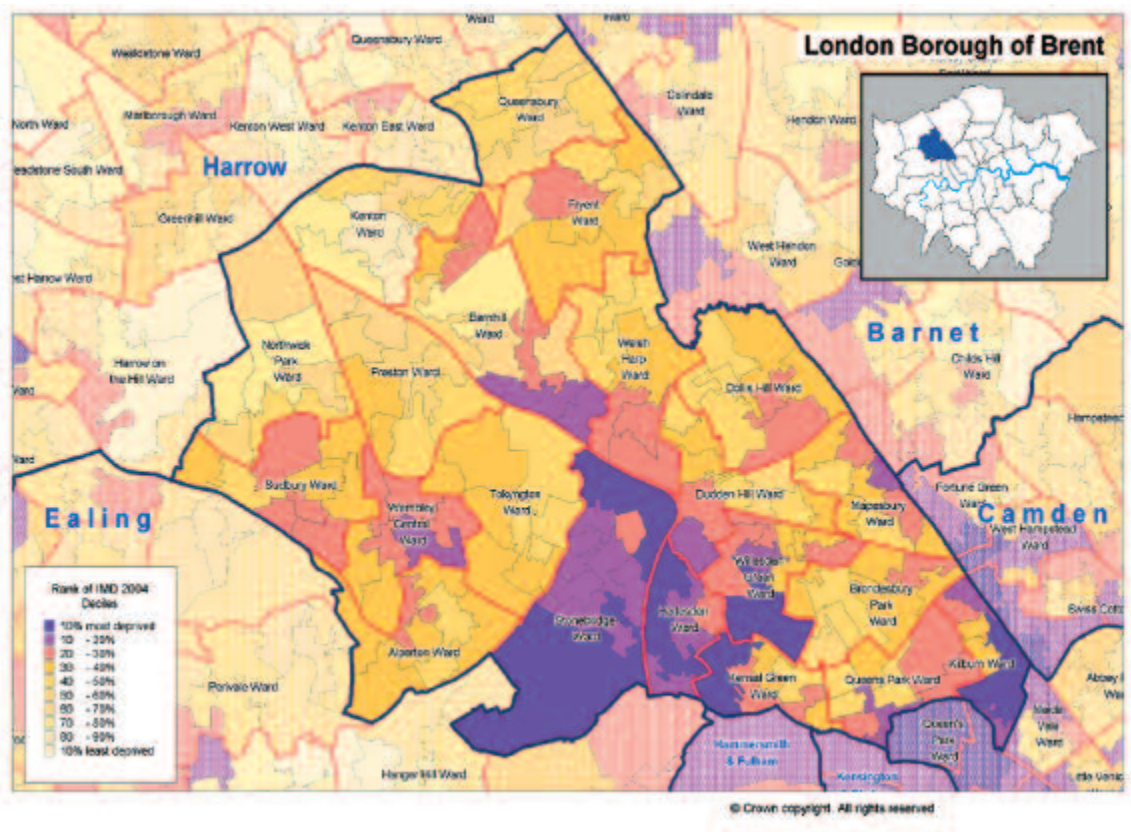
Figure 13: Proportion of residents with no formal qualifications in Brent, 2001



2. Deprivation and Health

Deprivation is closely associated with poor health outcomes. People living in areas with higher levels of deprivation tend to have poorer health than those living in more affluent areas. Levels of deprivation can be measured using the Index of Multiple Deprivation (IMD) Score 2004.¹ A higher score denotes greater deprivation. Brent has an average IMD score of 25, which ranks Brent 81st out of 354 boroughs in the country. However this value masks significant variation in ward-level IMD scores. As Figure 14 illustrates, Harlesden and Stonebridge wards have very high IMD scores, which place them in the top 20% of most deprived wards in the country.

Figure 14: Index of Deprivation Map, London Borough of Brent, 2004



¹ The IMD Score was developed by the Office of the Deputy Prime Minister and is based on income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation and crime.

Health Outcomes

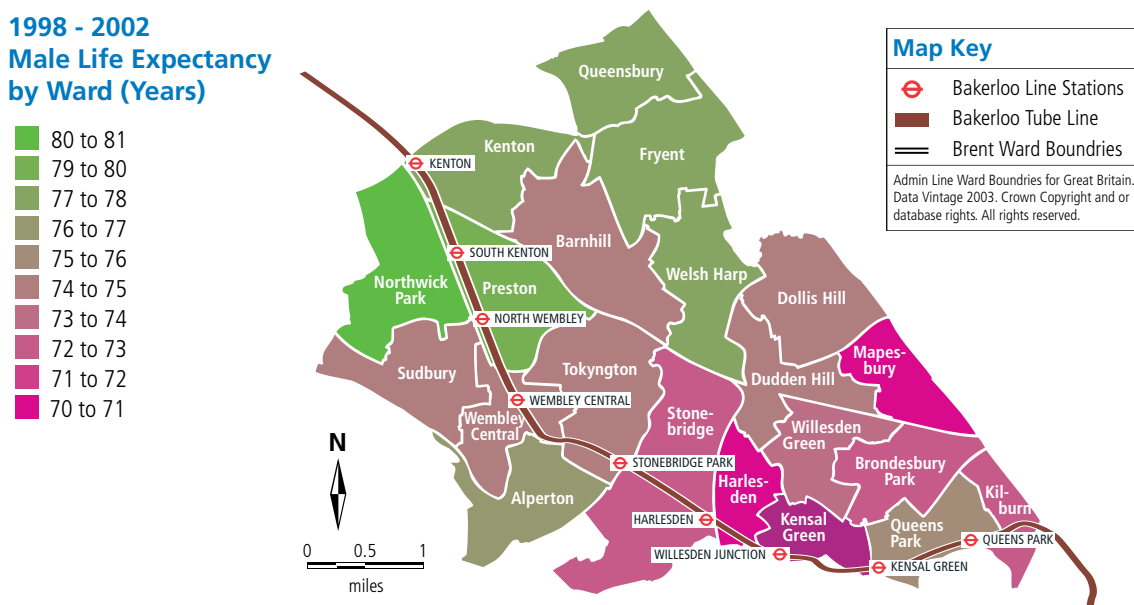
Life Expectancy in Men

Men in Brent have, on average, the same life expectancy as men in the rest of London (76.1 years and 75.7 years respectively). This however masks major discrepancies between wards. The lowest male life expectancy is in Harlesden ward, where men can expect on average to live to 73.1 years. This is significantly lower than the England figure of 76.0 years. Northwick Park ward has the highest male life expectancy in the Borough at 81.6 years, which is significantly higher than the national average.

The variation in life expectancy within Brent is illustrated in Figure 15. This map shows the change in male life expectancy as you travel through Brent on the Bakerloo Underground line. The journey between Harlesden and South Kenton tube stations is approximately 3.5 miles, yet this short journey in distance corresponds to a large gradient in life expectancy. Men living in Harlesden can expect to live on average nearly nine years less than men living in Northwick Park.

This gap in male life expectancy between the best and the worst wards has narrowed slightly over the past few years.

Figure 15: Map showing the gradient of male life expectancy (1998-2002) along the Bakerloo tube line in Brent



Admin Line Ward Boundaries for Great Britain. Data Vintage 2003. Crown Copyright and or database rights. All rights reserved

Life Expectancy in Women

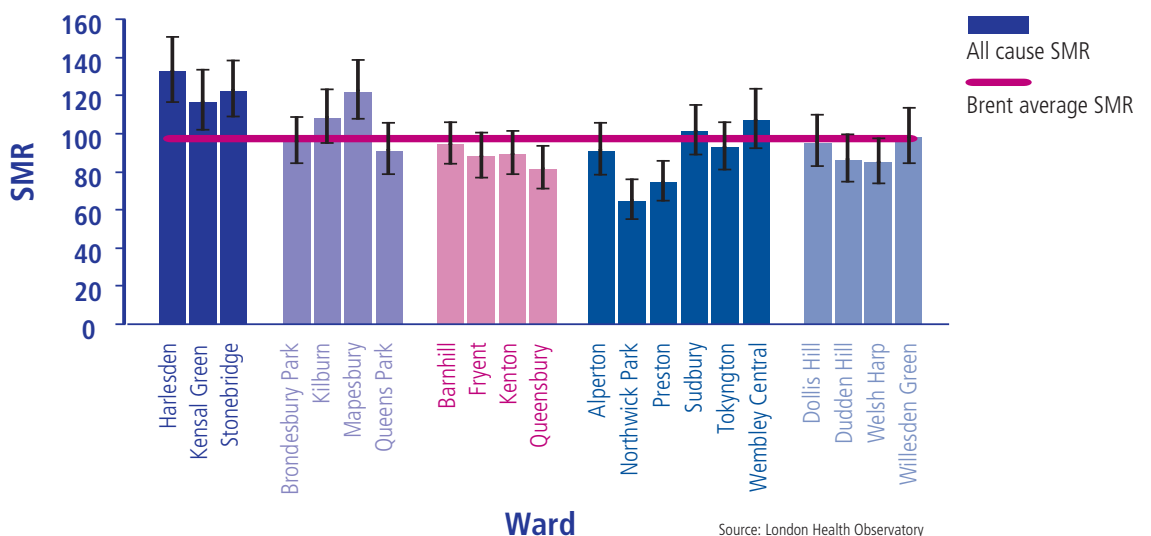
Harlesden ward also has the lowest life expectancy for women (78.6 years). The ward with the longest life expectancy for women is Dudden Hill at 84.5 years. Although the gap in life expectancy between the worst and the best off wards is smaller for women than for men, the difference is still considerable at almost 6 years. The life expectancy of women in Harlesden is significantly lower than the England average of 80.6 years. The London female average life expectancy is also 80.6 years.

Deaths from All Causes

Standardised mortality ratios (SMRs) allow us to compare death rates in a particular population, such as Brent, to that of England as a whole, after taking into account differences between the local and the national populations in terms of age and sex composition. A SMR greater than 100 means that the local population of interest experiences higher mortality than England as a whole.

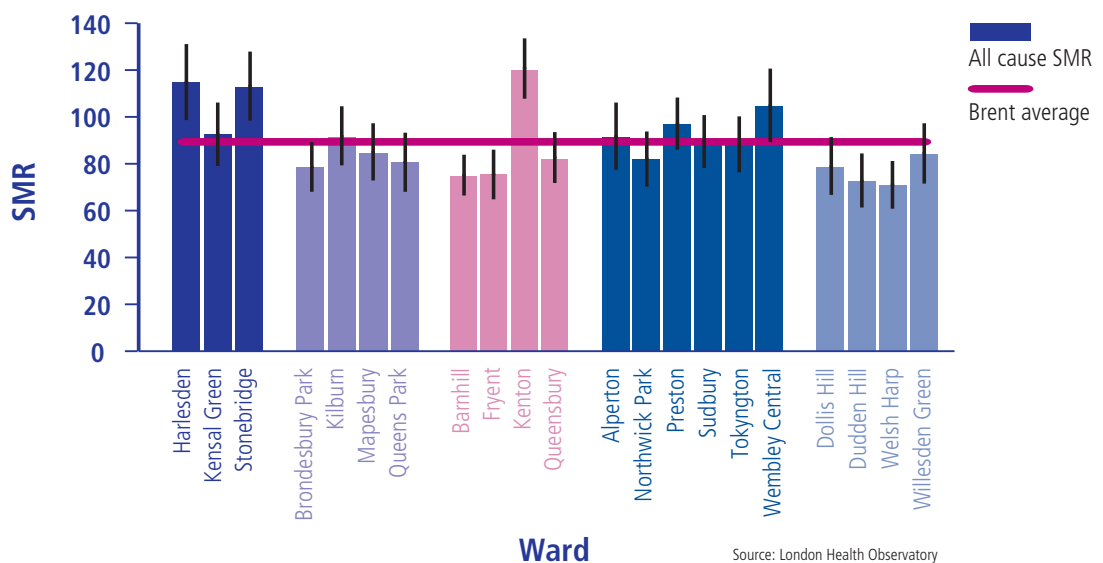
Deprivation is associated with poor health and worse health outcomes and this is borne out in Brent, where residents in the wards with highest levels of deprivation have the highest SMRs for deaths from all causes. Although the all cause SMR in Brent has fallen between 1993 and 2001, and is now statistically significantly lower than the England average, there are a few wards in Brent where the all cause SMR has remained high.

Figure 16: All cause SMRs for men of all ages, Brent 1999-2003



There are four wards in Brent where the all ages, all cause SMR in all men (1999-2003) is statistically significantly higher than the England average. These are Harlesden, Kensal Green, Stonebridge and Mapesbury wards. Queensbury, Welsh Harp, Dudden Hill, Northwick Park and Preston wards have all cause SMRs significantly below the national average.

Figure 17: All cause SMRs for women of all ages, Brent 1999-2003



Amongst women, only Kenton ward has an all ages, all cause SMR that is significantly higher than the England average. This is surprising as Kenton has a low IMD score. Interestingly, the all cause SMR for females under 75 in Kenton is statistically below the national average. This suggests that mortality in the female population aged 75 years and over in this ward is worse than the national average. Several wards have an all age, all cause female SMR significantly below the England average.

The relationship between deprivation and health is complex. Compared to populations living in more affluent areas, deprived communities tend to experience poorer physical environments, such as unsafe, overcrowded housing, and higher rates of crime, in addition to poorer access to basic amenities and services, such as affordable food, health care and education. Additionally individuals in these communities are more likely to take up health damaging behaviours, such as smoking, and are less likely to engage with preventative health initiatives such as immunisation and screening programmes.

Box 1: Tackling inequalities through partnership working in Brent

Inequalities in health status and health outcomes occur when barriers exist to people accessing health services, or when people's health is impacted negatively by environmental and socio-economic factors. Health improvement can only come about through action at a number of levels – by changing an individual's environment and providing access to good quality housing, improving access to education, employment and health services, as well as promoting healthy lifestyles and individual behaviour change. Brent tPCT is committed to working with its partners in the local authority, the voluntary sector and with local businesses to achieve these changes.

Given the need to tackle the determinants of health inequalities at a number of levels, success in reducing health inequalities requires the involvement of all sectors. Each sector brings value to this partnership approach, because of their distinct perspectives, skills, expertise, social capital, values and organisational cultures.

In 1999 Brent and Harrow Health Authority received Health Action Zone funding to establish projects in Brent aimed at:

- exploring mechanisms for breaking through current organisational boundaries
- tackling health inequalities
- delivering better services
- acting as trailblazers for new ways of local working.

Since then a range of projects have been developed to address the broader determinants of health and also to focus on some key local health priorities (TB, cancer and diabetes). The key to success of all these projects has been the involvement of local communities. Local people and organisations have been instrumental in developing programmes that they feel are relevant and responsive to the health challenges they face.

Case Study: Tackling Tuberculosis (TB) in Brent

Brent has one of the highest rates of TB in the country. Hard-to-reach groups such as the homeless, refugees and some ethnic groups have been most vulnerable to this infectious disease in the past. However, all communities are now at risk of TB infection and HAZ funding has enabled a set of inter-related projects to be developed to tackle this problem. These projects include a campaign to raise awareness of TB in at-risk communities through poster and local radio campaigns, and a project training community members to run events to educate the public about TB. A patient helpline offers support and captures information to help improve services and better understand what causes anxiety amongst patients and their carers. A patient map has been developed to help steer both patients and health professionals through referral, diagnostic and treatment services. A research project is currently underway looking at knowledge of and stigma attached to TB in hard to reach groups. This project aims to identify barriers faced by these groups by exploring individual patient experiences. This knowledge will then be used to better understand the patient experience and improve local services.

This work has only been possible because the HAZ has successfully developed partnerships across all sectors – community groups, TB health professionals, local authority departments, the national charity TB Alert and North West London NHS TB network. The projects are delivered by a variety of community organisations (Brent Refugee Forum, Brent Homeless Families Group, Brent Race, Health and Social Care Forum, Brent and Harrow Community Health Projects, Brent Indian Association and the Asian People with Disabilities Alliance) with support from the public sector agencies. A robust performance monitoring system ensures that the projects meet pre-determined targets and are delivered to high quality standards.

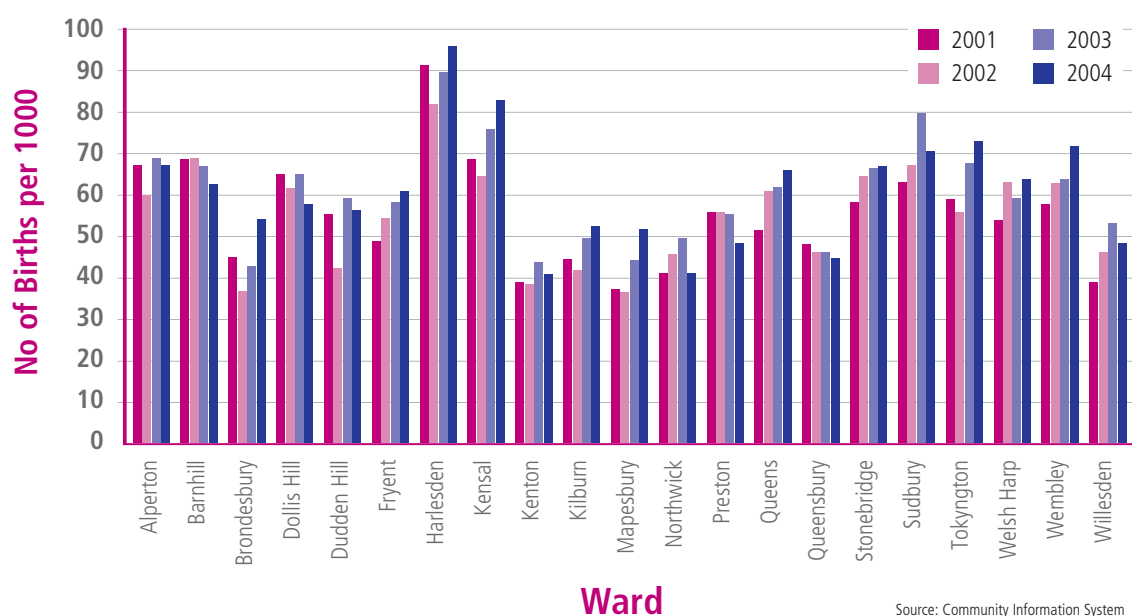
3. Children and Young People

Fertility



In 2004 there were 4,173 live births in Brent and the general fertility rate (number of live births per 1000 women aged 15-45) was 60.1 per 1000. In England and Wales in 2003 the general fertility rate was 56.8 and in London it was 61.0.

Figure 18: Standardised fertility rate per 1000 women in Brent, 2001-2004

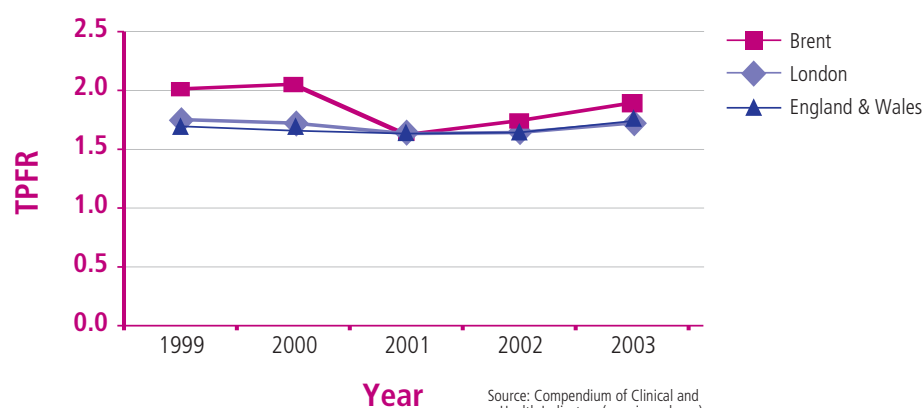


Source: Community Information System

Total Period Fertility Rate (TPFR)

The total period fertility rate can be interpreted as the average number of children per woman living in a particular area, if all women experienced the current age-specific fertility rates throughout their childbearing life span (between the ages of 15 and 44) of that area. There was a fall in the TPFR in Brent between 1999 and 2001, but the rate is now gradually increasing. This mirrors the London and national trends, although variation in the Brent rate evident in Figure 19 is greater due to smaller numbers. For most years during the period 1999 to 2003, the rate in Brent was statistically significantly higher than both the London and national rates.

Figure 19: Total Period Fertility Rate, 1999-2003

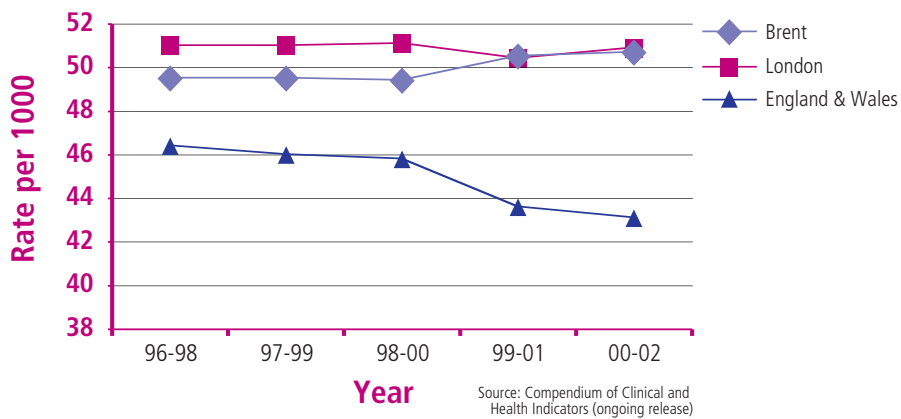


Source: Compendium of Clinical and Health Indicators (ongoing release)

Teenage Pregnancy

A teenage conception is defined as a conception to a girl aged less than 18. Teenage conception rates are expressed as the number of teenage conceptions per 1000 female population aged 15-17. Those girls who become pregnant before their 18th birthday but who deliver after it are included in this figure. Nationally under 18 conception rates have fallen since 1998 (see Figure 20). However this trend is reversed in Brent where rates have risen by 17% in this time period.² In 2003 the teenage conception rate for Brent was 56.2 per 1000 compared to 51.1 per 1000 for London and 42.3 per 1000 for England and Wales. Teenage conception rates vary by ward. Six wards in the borough have under 18 conception rates that place them in the highest 20% of wards in the country. They are Harlesden, Kilburn, Willesden Green, Stonebridge, Queens Park and Wembley Central.

Figure 20: Three year average under 18 conception rates, 1996-98 to 2000-02



² Office of National Statistics and Teenage Pregnancy Unit.



Teenage pregnancy has adverse consequences for many (although not all) girls. It is often difficult to continue in education, which makes it harder to find employment later in life and this can lead to social exclusion. Babies born to teenage mothers are at increased risk of prematurity, cot death and accidental injury in early life. They are also at higher risk of becoming teenage parents themselves.³

Box 2: Tackling teenage pregnancy in Brent

The government has set a target to halve teenage conception rates by 2010. In order to achieve this Brent tPCT and Brent Local Authority have devised a teenage pregnancy strategy. The aims of this strategy are to emphasise prevention messages through the use of media campaigns, and improve access to contraceptive services and support teenage mothers.

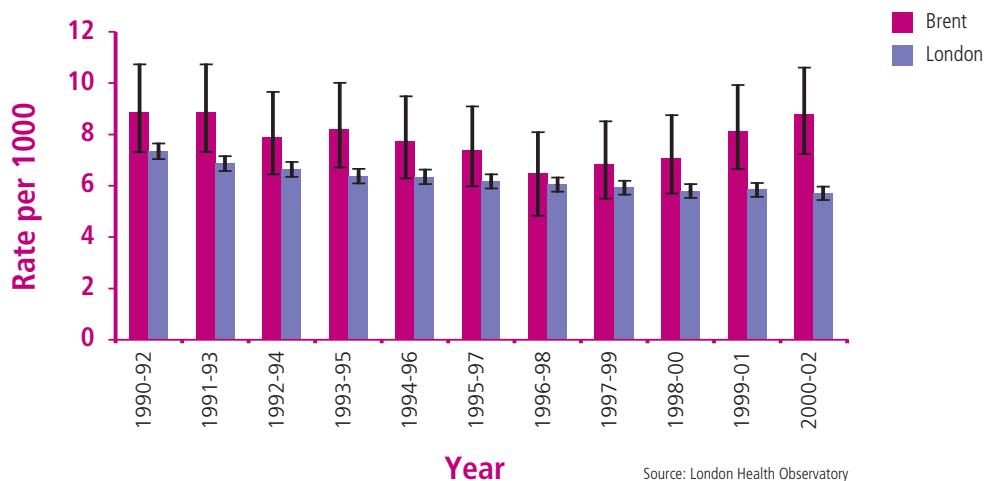
The organisation Dr Foster is currently working with young people in Brent to develop a teenage pregnancy media campaign. It has carried out focus groups with teenagers and young parents in high risk areas to explore the reasons why teenagers choose to become parents and what preventive messages they might listen to. Two celebrity endorsed magazines will be launched later this year (one for boys and one for girls) which will promote sexual health wellbeing and highlight the realities of teenage parenthood.

³ Effective Healthcare: preventing and reducing the adverse effects of unintended teenage pregnancies, February 1997.

Infant Mortality

Infant mortality is defined as the number of deaths within the first year of life expressed as a rate per 1000 live births. The three-year average infant mortality rate in Brent has been consistently higher than the London infant mortality rate. Although the difference has not always been statistically significant, in recent years the Brent infant mortality rate has been significantly higher than the London rate. Importantly, the London rate has fallen since 1996-98, but the Brent rate has increased. In 2000-2002 there were approximately 3.3 more infant deaths per 1000 live births in Brent than in London.

Figure 21: Three year infant mortality rates, 1990 to 2002



Box 3: Reducing infant mortality in Brent PCT

The government has set a national target to reduce the gap in infant mortality by at least 10% between 'routine and manual groups' and the population as a whole. Increasing the numbers of mothers who breastfeed will help achieve this goal.

Breastfeeding cafes have been set up in the 5 localities in Brent in order to promote the benefits of breastfeeding and to support women and their families through the process of breastfeeding. The cafes are run on a drop-in basis. Mothers have the chance to share their experiences and meet with other mothers, as well as health visitors and midwives from Brent tPCT, to discuss the benefits of breastfeeding as well as any difficulties they may experience.

Mothers and family members attend regularly for the social contact as well as reassurance that they are doing well. Others attend on a one-off basis seeking specific information and advice on breastfeeding. Specific health education and information is offered, as well as practical techniques on positioning for good feeding and mother-baby bonding.

The mothers attending these groups also participate in the National Breastfeeding Awareness Week by attending events or contributing to articles in the local press. New and expectant mothers also share their experience of baby friendly organisations where breastfeeding mothers are welcomed.

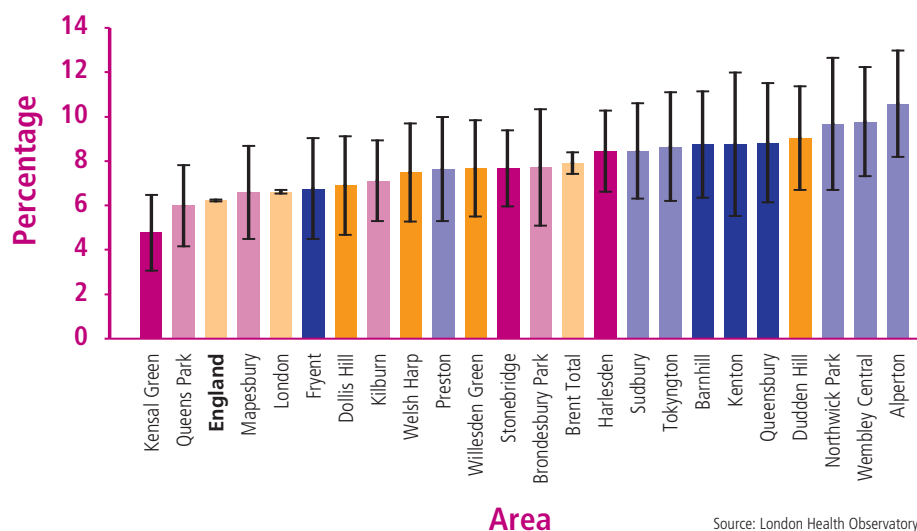
Low Birthweight Babies



Low birthweight is defined as a birthweight under 2500g. The average birthweight in England is 3400g. There are two categories of low birthweight babies – those that are born before 37 weeks gestation (i.e. prematurely) and those that are born at term but are underweight. Many maternal and foetal factors result in low birth weight, such as maternal high blood pressure and foetal genetic abnormalities. Smoking in pregnancy and poor maternal nutrition (including high alcohol consumption) are also important causes of low birthweight. Low birthweight is also associated with deprivation, and women from certain BME groups also have an increased risk of having a low birthweight baby.

Between 2001 and 2003, 7.9% of all babies in Brent were born with a birthweight below 2500g. This is statistically significantly higher than both the London (6.6%) and England (6.2%) figures for the same time period. The proportion of low birthweight babies at ward level ranged from 4.8% in Kensal Green ward to 10.6% in Alperton ward. In nine wards, the percentage of low birthweight babies was significantly higher than for England. Although low birthweight is typically associated with higher levels of deprivation, Brent wards with the highest percentages of low birthweight babies (Northwick Park, Wembley Central and Alperton) are not amongst the most deprived in the borough, suggesting that there are other contributing factors that need to be explored in greater detail.

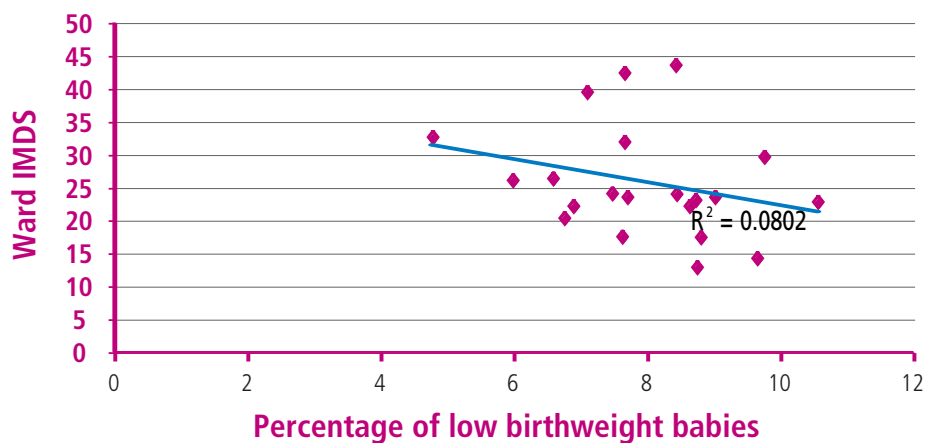
Figure 22: Percentage of low birthweight babies by ward in Brent, 2001-2003



Source: London Health Observatory

Figure 23 shows the correlation between the percentage of low birthweight babies and IMD score at ward level. Although the association is weak, surprisingly it suggests an inverse relationship between deprivation and low birthweight i.e. as ward deprivation levels rise the percentage of babies born with low birthweight decreases. This again suggests the presence of other contributing factors.

Figure 23: Scatterplot showing the association between ward Index of Multiple Deprivation Score and percentage of low birthweight babies, 2001-03



Source: London Health Observatory

Box 4: Reducing the incidence of low birth weight babies

- Do not smoke in pregnancy
- Try not to drink any alcohol during pregnancy
- Do not use illicit drugs in pregnancy
- Take folic acid supplements before and during pregnancy
- Check with your doctor that prescription drugs are safe to use in pregnancy
- Eat a healthy diet with adequate calories
- Have regular antenatal care

Childhood infections

Measles

Measles is an acute, highly infectious viral illness transmitted via droplet infection. It is characterised by a rash, which spreads over the body. Complications are common and these may include pneumonia or bronchiolitis. It is estimated that worldwide 1 million children die each year from measles, mostly in developing countries. In the UK prior to 1988, half of all children who died from measles were previously healthy.

Mumps

Mumps is an acute viral illness transmitted by direct contact with saliva or droplets from the saliva of an infected person. Symptoms begin with a headache and fever for a day or two before the disease is characterised by swelling of the parotid glands. However, at least 30% of cases in children have no symptoms. Complications of symptomatic mumps include swelling of the ovaries (oophoritis), swelling of the testes (orchitis), aseptic meningitis and deafness.

Meningitis

Meningitis is inflammation of the linings of the brain and spinal cord, while septicaemia is the blood poisoning form of the disease. These two conditions have different sets of symptoms and may occur separately or together. Additionally, they may be caused by a variety of different organisms, including bacteria, viruses and fungi.

Tuberculosis

Globally TB is a disease which is responsible for more deaths than almost any other infectious disease, and was declared a 'global emergency' by the World Health Organization in 1993. TB is curable with a combination of specific antibiotics, but treatment must be continued for at least six months. Today about 7,000 TB cases are reported each year in the UK. Most cases occur in major cities, particularly in London.

Childhood infections in Brent

Table 1: Rates of key childhood infections in Brent, 2000-2004

Year	Measles		Mumps		Meningococcal meningitis & septicaemia		Tuberculosis	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate
2000	5	8.5	4	6.8	8	13.6	25	42.3
2001	7	11.9	3	5.1	1	1.7	35	59.3
2002	6	10.0	2	3.3	2	3.3	12	20.0
2003	14	22.9	7	11.5	1	1.6	11	18.0
2004	9	14.5	1	1.6	1	1.6	16	25.7

Note: Rates have been calculated per 100,000-population aged under 18, using GLA population projections.

In Brent notifications of measles and mumps in persons aged under 18 years peaked in 2003. Nationally confirmed cases of measles also peaked in 2003. Notifications may underestimate the true level of meningitis and meningococcal disease in Brent, because, although all cases of meningococcal disease are reported directly to the local Health Protection team, some may not be formally notified (see Box 5).

Box 5: Notification of infectious diseases

Doctors in England and Wales have a statutory duty to notify a 'proper officer' of the local authority of suspected cases of certain infectious diseases. The proper officer is then required to inform the Health Protection Agency each week of all such cases.

Childhood Immunisations



Immunisation is the best protection against some very serious childhood diseases, for example, measles and meningitis C. If a child is not fully immunised, they will remain at risk of catching these diseases. As some diseases are very infectious, a high level of vaccination uptake is required to prevent outbreaks occurring. For example, 95% of children need to be vaccinated to prevent measles outbreaks occurring. A few years ago there was an outbreak of measles in Brent and several children were hospitalised. Such outbreaks demonstrate the continuing importance of high levels of immunisation uptake.

There will always be some children who are left unprotected because:

- they can not be immunised for medical reasons; for example children receiving chemotherapy should not be vaccinated with BCG.
- they are too young to be immunised.
- for a small number of children, the vaccine does not work.

Table 2 below summarises the vaccinations that children should receive to protect them against childhood infections.

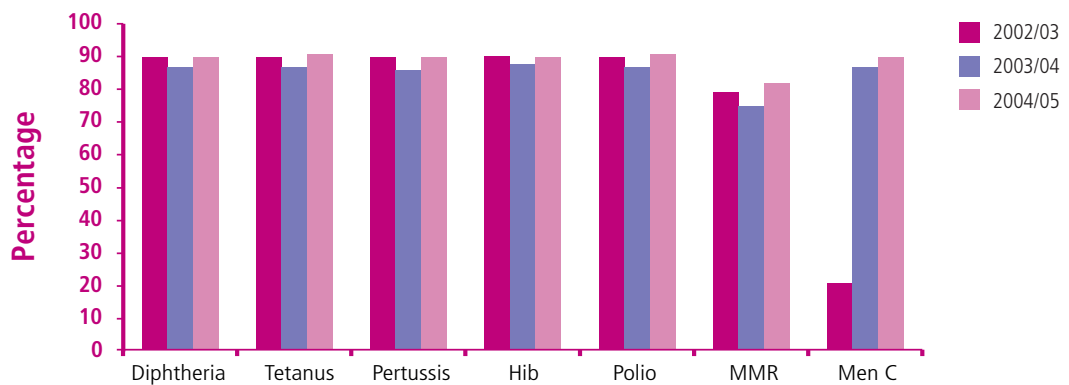
Table 2: UK Childhood Vaccination Schedule

WHEN TO IMMUNISE	WHAT IS GIVEN	HOW IT IS GIVEN
2, 3 and 4 months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (DTaP/IPV/Hib)	One injection
	Men C	One injection
Around 13 months old	Measles, mumps and rubella (MMR)	One injection
3 years and 4 months to 5 years old	Diphtheria, tetanus, pertussis (whooping cough) & polio (dTaP/IPV or DTaP/IPV)	One injection
	Measles, mumps and rubella (MMR)	One injection
13 to 18 years old	Diphtheria, tetanus, polio (Td/IPV)	One injection

In Brent, vaccination uptake is monitored carefully. Vaccination uptake in Brent varies both between geographical areas within the borough, and over time. A MMR “Capital Catch Up” campaign was launched in 2004 by PCTs across the capital, in an effort to increase uptake of the MMR vaccine. This campaign in Brent resulted in an increase of MMR uptake, and is soon to be followed by carefully tailored local initiatives to improve uptake still further.

Uptake rates of all vaccinations dipped in the year 2003/04, but rates have recovered for the year 2004/05 (see Figure 24). However, MMR vaccination uptake is still too low to prevent outbreaks occurring. Figure 25 shows how MMR vaccination rates vary by locality in Brent. Only Kingsbury locality shows a steady upward trend, and this locality now has the highest vaccination rate at 88% in 2004/05.

Figure 24: Immunisation uptake rates at 2 years of age, Brent PCT 2002/03 to 2004/05



Source: Brent Community Information System

Figure 25: MMR vaccination uptake rates at 2 years of age by Brent locality, 2002/03 to 2004/05



Source: Brent Community Information System

Children and adolescents in low-income households

Childhood is the time when people establish lifestyles and values that will have a bearing on their health for the rest of their lives. Exposure to adverse environments when young can lead to poor physical and psychological adult health. For example, research has shown that compared to children who have never experienced poverty, children who grow up poor are more likely to have lower self-esteem, lower educational attainment and believe that health is a matter of luck.⁴ Consequently they are more likely to engage in health damaging behaviours. Additionally children born into poverty frequently do not have access to good housing and good nutrition, and frequently access to health and education services is limited. These children miss out on important opportunities for health gain and accumulate health risks as they grow into adulthood. In the UK no individual lives in absolute poverty, which has been defined by the World Bank as having less than one US dollar a day. Relative poverty in the UK is defined as a total income of less than 60% of median income, after taxes and benefits, and adjusted for household size. In 1997 it was estimated that one in three babies were born into poverty, although since then this situation has improved.⁵

34.8% of children and adolescents in Brent live in low-income households receiving council tax benefit. The majority of these households are concentrated in Stonebridge, Harlesden and South Kilburn and in scattered locations in Wembley and Willesden.

Pupil Level Annual Schools Census (PLASC)

Brent Local Authority undertakes annually a one day Census of all school children in the borough. The following data are derived from the 2005 Census.

Free school meals

Children are entitled to free school meals if their parents receive income support, income-based job seekers allowance, support under part VI of the Immigration and Asylum Act 1999 or have an annual income of less than £13,910. Of the 33,135 children attending Brent schools, 9,444 (28.5%) receive free school meals. This percentage ranges from 9.5% of schoolchildren in Kenton ward to 48.7% in Stonebridge ward. Harlesden locality has the highest percentage of pupils receiving free school meals at 41.4%, followed by Willesden (32.1%), Kilburn (27.2%) and Wembley (22.8%). Kingsbury locality has the lowest percentage of children receiving free school meals at 20.8%.

⁴ Ermisch, J., Francesconi, M. & Pevalin, D.J. (2001). Outcomes for Children of Poverty. DWP Research Report 158. Leeds: Corporate Document Services.

⁵ HM Treasury. Child Poverty Review. London. The Stationery Office. July, 2004

Children in care

128 (0.4%) Brent children who attend Brent schools were in care in January 2005. Wembley and Kinsbury localities have the highest numbers of children in care, with 47 and 30 children respectively. It is important to note that these figures refer to the borough in which children in care are placed, not where they come from.

Children with Special Educational Needs

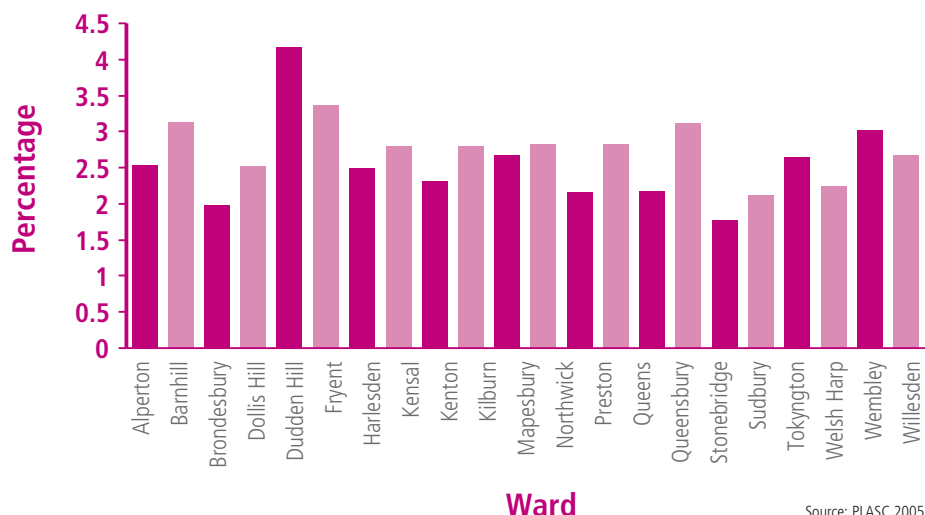
885 Brent school children (2.7%) have a statement of special educational needs. Table 3 presents a breakdown of the range of needs experienced by these children.

Table 3: Summary of needs experienced by Brent school children with a statement of special educational needs

Type of Need	Number	Percent of total school children
Autistic Spectrum Disorder	109	0.33
Behaviour, emotional and social disability	85	0.26
Hearing impairment	31	0.09
Moderate learning disability	238	0.72
Other difficulty/disability	9	0.03
Physical disability	68	0.21
Profound and multiple learning disability	35	0.11
Speech, language and communication needs	100	0.30
Severe learning difficulty	130	0.39
Specific learning difficulty	64	0.19
Visual impairment	16	0.05
Total	885	2.7

Figure 26 shows the percent of school children with a statement of special educational needs by ward.

Figure 26: Percentage of Brent school children who have special educational needs by ward



Source: PLASC 2005

Oral Health in Brent



Good oral health and an attractive smile are essential components of general health and wellbeing, social development and interaction. Poor oral health can have a serious impact on health and well being in terms of pain, reduced nutrition, impaired speech and language development and behavioural problems.

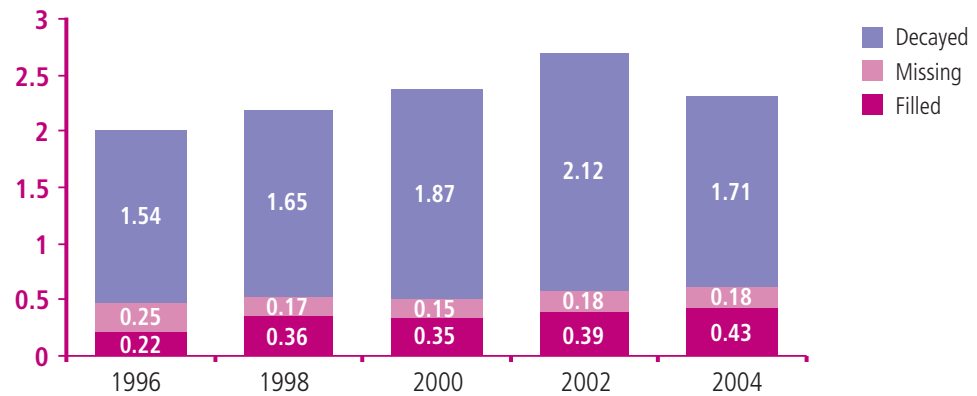
There is clear evidence that poor oral health is strongly linked to the wider determinants of health, in particular economic deprivation and social exclusion. There are areas in Brent with high levels of deprivation and significant numbers of refugee and asylum seekers, high population mobility and other groups of vulnerable people, and their poor oral health status reflects this.

Poor oral health is related to a diet high (in terms of both frequency and amount) in non-milk extrinsic sugars, lifestyle factors including poor oral hygiene practices without the use of fluoride toothpaste, use of tobacco (both smoking and chewing) and high alcohol consumption. The need to reduce oral health inequalities remains high. Reducing oral health inequalities will assist in an overall reduction in health inequalities.

Tooth extraction, usually carried out under general anaesthetic, is the most common treatment for tooth decay in young children. In Brent, as in other parts of the country with high levels of dental disease in children, many under fives have had general anaesthetics to remove decayed "milk" or deciduous teeth. Nationally there have been dramatic improvements in oral health over the last 20 years. However, in Brent there remains a significant burden of preventable disease amongst children.



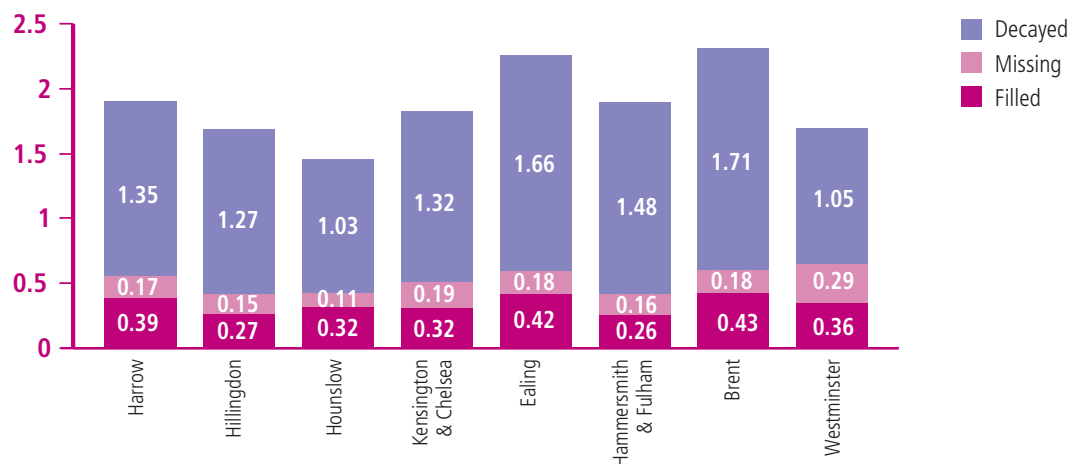
Figure 27: Mean number of decayed, missing and filled teeth in 5 year old children in Brent, 1996-2004



In Brent the average number of decayed, missing and filled teeth in five year olds in was 2.32 teeth in 2003/04, which remains well above the national targets. In Brent, the proportion of five-year-old children whose teeth are decay free is 51.4%, which is also well below the national target of 70%. Children living in poverty and areas of deprivation experience more tooth decay, as do some children from certain minority ethnic groups. The majority of dental disease in 5 year olds is untreated and active decay is present on average in 44% of 5 year olds in Brent .

Of all the boroughs in North West London, five year olds in Brent had the worst oral health status in 2003/04 (see Figure 28).

Figure 28: Decayed, missing and filled teeth in 5 year old children in North West London, 2003/4



Information on oral health is not available on a neighbourhood basis, nor is it possible to break down the available information by ethnic group. The Oral Health Strategy for Primary Care Trusts in North West London will attempt to address these two information gaps. Locally the Community Dental Service identifies high risk schools via the dental screening programme. This information is used to target oral health promotion activity to those areas of greatest need. Some of the key ways in which we are trying to improve oral health and tackle the determinants of poor oral health in Brent are outlined in Box 6.

Box 6: Strategy to improve oral health in Brent

- 1 Brent tPCT will develop a local implementation plan for improving and tackling inequalities in oral health following the publication of the delivery plan for oral health as part of Choosing Health.
- 2 Greater integration of oral health promotion (OHP) into wider health initiatives through the common risk approach. e.g. Healthy Schools Project, Breakfast Clubs, School Fruit project, nutrition strategy, accident prevention, Sure Start projects and tobacco cessation including the promotion of local smoking cessation service in dental practices.
- 3 Oral health risk factors to be included in the development of the local food strategy (e.g. the promotion of water dispensing machines in schools, support for 'chuck sweets off check out' lobby and better food labelling etc) and tobacco strategy
- 4 Continue to support other fluoridation schemes such as 'Brushing for Life' which promotes the use of fluoride toothpaste and provides information about dental disease at child developmental checks.
- 5 Continue to commission epidemiological surveys of school age children within the existing framework. The PCT is awaiting the outcome of the dental census of 5-year-old children to obtain fuller information about oral health needs. This will allow OHP to be targeted e.g. to nursery schools in areas where primary schools have poor oral health
- 6 Water fluoridation is one option for addressing inequalities in oral health and the PCT will need to review its position once the technical and feasibility study has been revisited following a pan London approach.

Child and Adolescent Mental Health

Mental illness is strongly linked to several aspects of social inequality, but also to other factors such as age and gender. Children from households with lower incomes are more likely than those from households with higher incomes to have a mental health problem of some kind. Between the 1st January 2002 and the 5th March 2005 there were 536 children and young people under the age of 21 who were resident in Brent, registered with the local Child and Adolescent Mental Health Service (CAMHS). Of these 536 children and young people, 30.4% were diagnosed as having emotional problems, 30.1% as having behavioural problems, 4.8% had learning difficulties, and 1.5% were depressed. The remaining 20.2% of patients suffered from a range of problems or were receiving support as carers. The age and sex distribution of these children are shown in Figure 29.

Figure 29: Age and sex distribution of registered CAMHS users in Brent, 2002-05

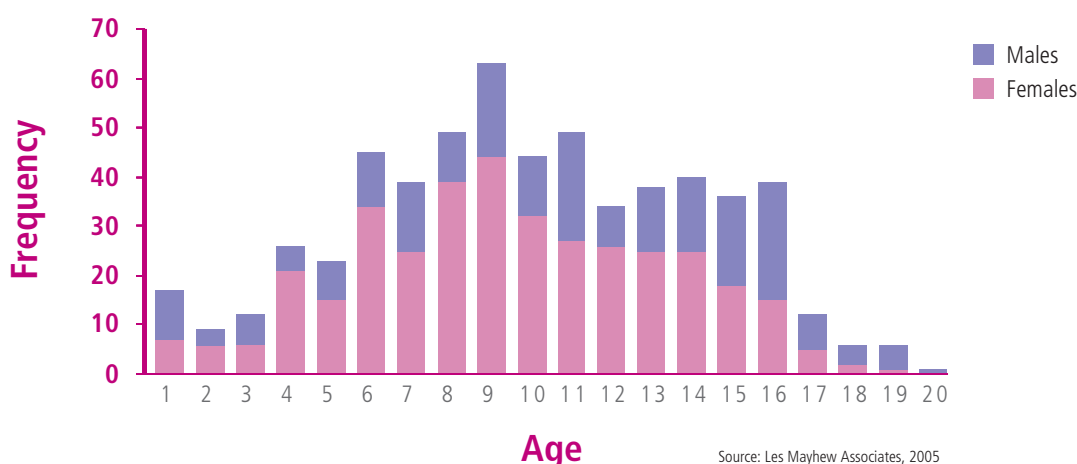


Table 4 shows the numbers of registered CAMHS users by locality and the rate per thousand persons aged under 21 in that locality.

Table 4: Number of registered CAMHS users by locality in Brent, 2002-2005

Locality	Number of registered cases of child or adolescent mental health	Rate per 1000 persons under 21
Harlesden	110	9.54
Kilburn and Kensal Rise	74	7.35
Kingsbury and Kenton	93	6.79
Wembley	147	7.31
Willesden	112	8.82
Brent total	536	7.9

According to the national survey, The Mental Health of Children and Adolescents in Great Britain,⁶ conducted in 1999, just under 12% of 5-15 year olds have a mental health disorder of any kind. The Brent rate of 7.9% for patients registered with CAMHS is less than this reported national rate. Reasons for this include:

- Many patients are seen but are not registered because they only make one visit, and so the true use of CAMHS is not fully reflected in the number of registered users;
- Some consultations regarding children's mental disorders do not go beyond a visit to a GP;
- Many of those taking part in the national survey had not in fact visited any service provider for over 1 year, suggesting that not all mental health problems were considered critical, or that they were improving, or were dormant.

However, this does not rule out the possibility that:

- There may be unmet needs for CAMH services in Brent relative to the national average;
- Some patients living in Brent receive treatment elsewhere other than at CAMHS;
- There is a much lower prevalence of mental health problems in Brent than elsewhere. This is unlikely as there are no known geographical differences in mental health prevalence between areas of the country.

Box 7: Risk factors for child and adolescent mental health in Brent

Modelling work in Brent found that the probability (odds) of a child or adolescent being registered with the CAMHS increases by:

- 9.6 times if the person has a record of truancy
- 3.6 times if the person has special educational needs
- 3.2 times if the person is known to social services
- 1.6 times if there is a record of domestic violence at the person's address
- 1.6 times if the person lives in a single adult household
- 1.4 times if the person lives in social housing
- 1.3 times if the address where the person lives is in receipt of council tax benefit
- 1.1 times if the person is white or of unknown heritage

Source: Les Mayhew Associates, 2005

⁶Office of National Statistics. The mental health of children and adolescents in Great Britain. Her Majesty's Stationery Office (HMSO): London, 2000.

Childhood Injury

An injury is defined as any physical damage to the body caused by violence or accident. It includes deliberate as well as non-intentional harm. Injuries are the leading cause of death amongst children and young people in the UK. Boys are twice as likely to be injured than girls, and children in manual socio-economic groups are estimated to be one and a half times more likely to die in accidents as children from other social groups. In Brent 32,798 children aged 0-19 years attended an A&E department between April 2004 and February 2005.

Childhood Injury Prevention in Brent

There are a number of initiatives underway in Brent focused on reducing the burden of childhood injuries in the borough. They include:-

- Child injury prevention workshops run by Brent PCT's health promotion department and the Child Accident Prevention Trust.
- Health promotion sessions run in primary schools on injury prevention, including road safety and burns and scalds.
- The Healthy Schools Programme has safety as one of its main themes, and under this programme some schools have made improvements to their playgrounds to make them safer.
- A campaign co-ordinator supports child safety week, which is held in June each year.



Chapter 4 Adults

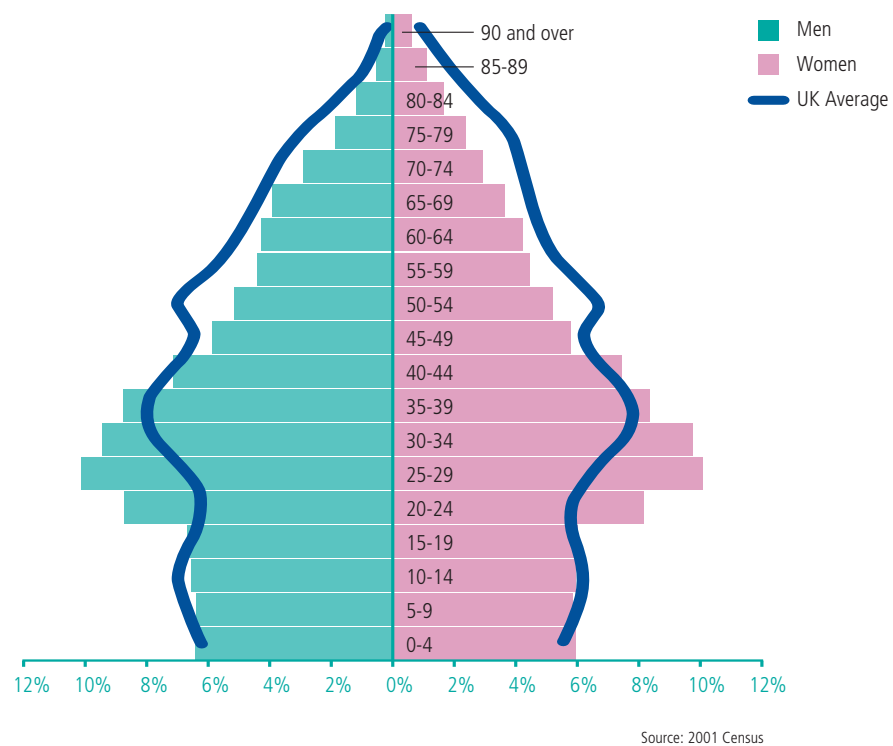


Chronic Diseases

For over a century now life expectancy for men and women has been increasing. Improvements in living conditions, nutrition and health care, particularly during the first half of the 20th century, resulted in a decrease in deaths due to infectious diseases, such as tuberculosis. This increase in life expectancy and the relative decrease in the burden of infectious diseases means that many more people are developing chronic diseases, such as coronary heart disease, diabetes and cancer, later on in life.

Figure 30 shows the age distribution of men and women in Brent compared to the UK as a whole. Brent has a younger population than the rest of the country, with a larger proportion of adults aged between 20 and 44 than the UK as a whole.

Figure 30: Population structure of Brent, by age group and sex, 2001

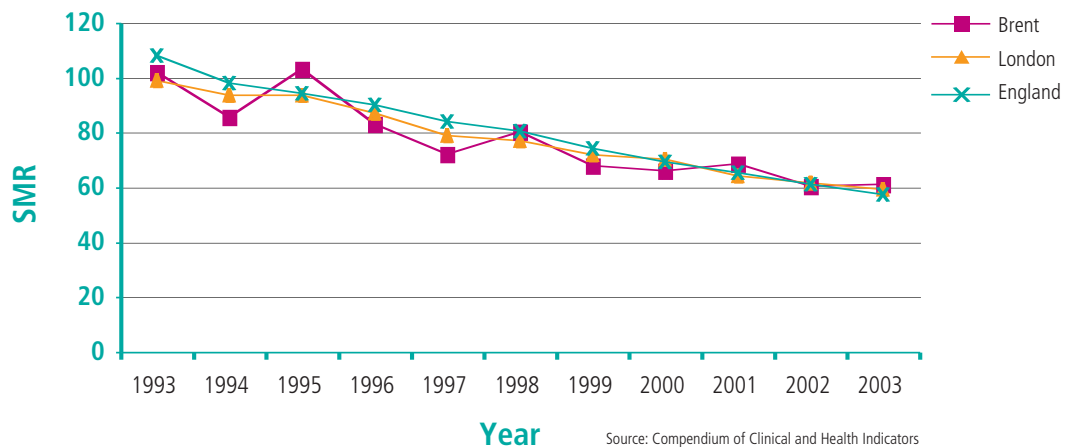


The rates of disease incidence and mortality presented in this report have been age standardised. This process of standardisation eliminates any age bias when comparing the burden of disease between Brent and other populations.

Coronary Heart Disease

Coronary heart disease (CHD) is the leading cause of premature death in the UK,⁷ with approximately 100,000 thousand people dying of the disease in England and Wales in 2003.⁸ The Government white paper "Saving Lives – Our Healthier Nation" set a target in 1999 to reduce the death rate from CHD by 40% in the under 75s.⁹ Figure 31 shows how death rates from CHD in the under 75s have fallen between 1993 and 2003 in England, London and Brent. Mortality rates have decreased at similar rates for all three areas although annual variations are greater for Brent due to the small numbers involved. The Brent rate is not significantly higher than the London or England rate.

Figure 31: Directly age standardised mortality rates for CHD for all persons under 75, 1993-2003



Since 1998 the directly age standardised death rate from CHD in Brent has fallen by 23.75%. If it continues to fall at this rate, the OHN target of a 40% reduction by 2010 will have been exceeded in Brent (see Figure 32).

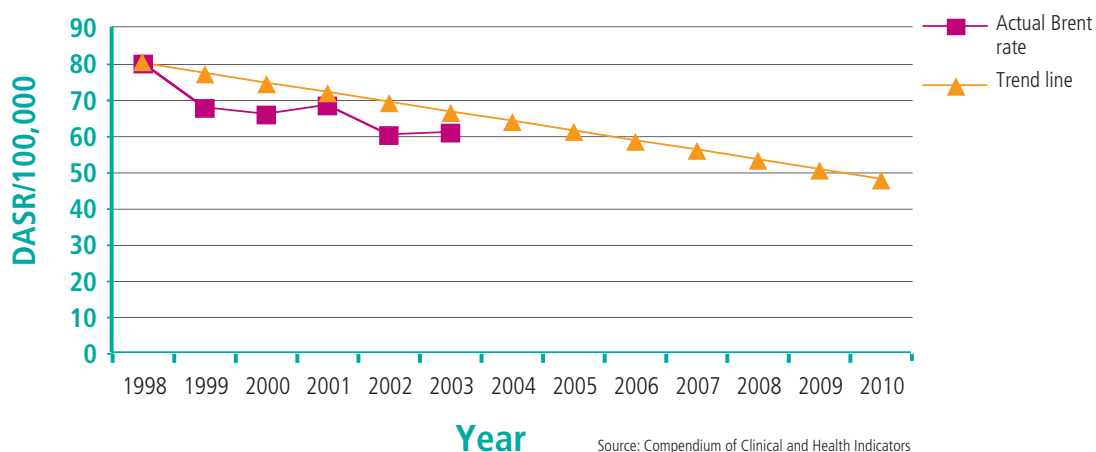
⁷ Department of Health. National Service Framework for Coronary Heart Disease. London: The Stationery Office, March 2000.

⁸ Compendium of Health and Clinical Indicators, ongoing release.

⁹ Department of Health. Saving Lives: Our Healthier Nation. London: The Stationery Office, 1999.



Figure 32: Actual directly age standardised death rate for CHD for persons <75 in Brent compared to OHN target trend line



There is marked variation in CHD death rates between the 21 wards in Brent. Figures 33 and 34 show standardised mortality ratios for CHD by ward for men and women of all ages. For men SMRs range from 50 in Northwick Park ward to 134 in Wembley Central ward, which is the only ward in Brent that has a male CHD SMR that is significantly higher than the England average. For women the range in SMRs is 58 (Northwick Park ward) to 149 (Harlesden ward). Harlesden ward is the only ward that has a SMR for CHD in females that is significantly higher than the England average.

Figure 33: SMRs from CHD for men of all ages in Brent, 1999-2003

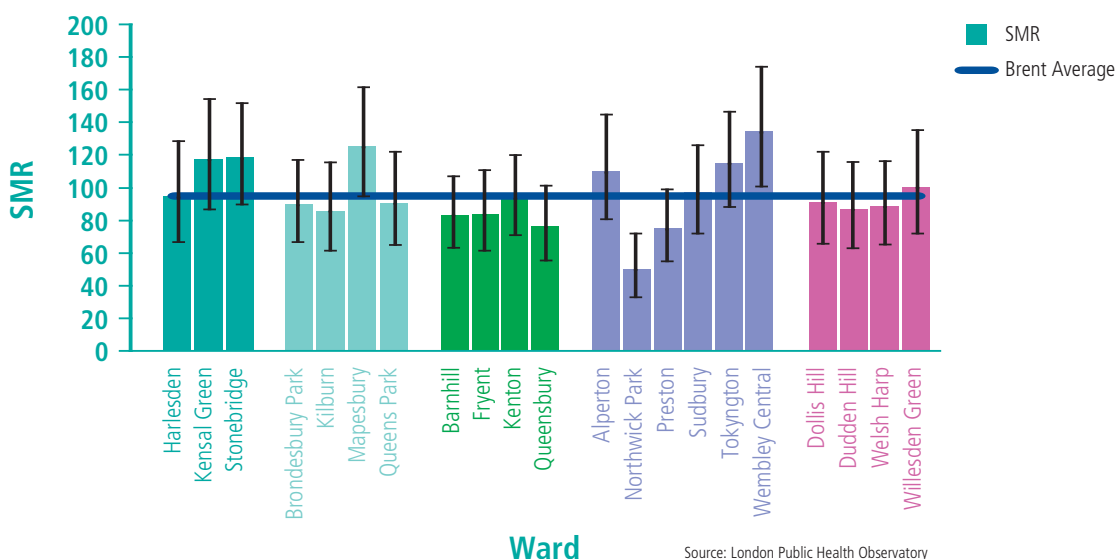
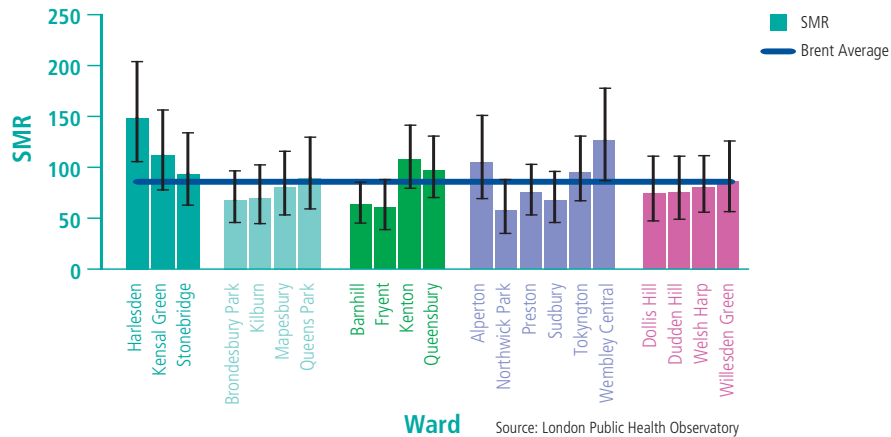
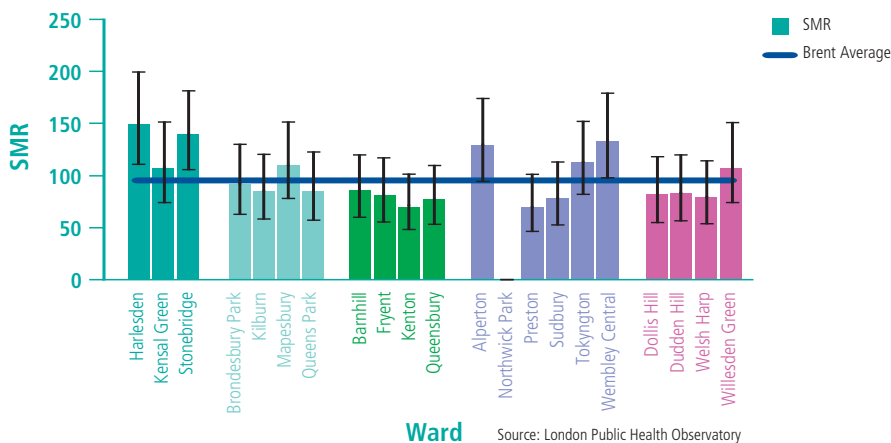


Figure 34: SMRs from CHD for women of all ages in Brent, 1999-2003



The SMR for CHD for all persons under the age of 75 in Brent (1999-2003) is 94 which is significantly lower than the England average. However, two wards in Brent, Harlesden and Stonebridge, have SMRs for CHD in persons aged under 75 years that are significantly higher than the England average, at 150 and 139 respectively (Figure 35).

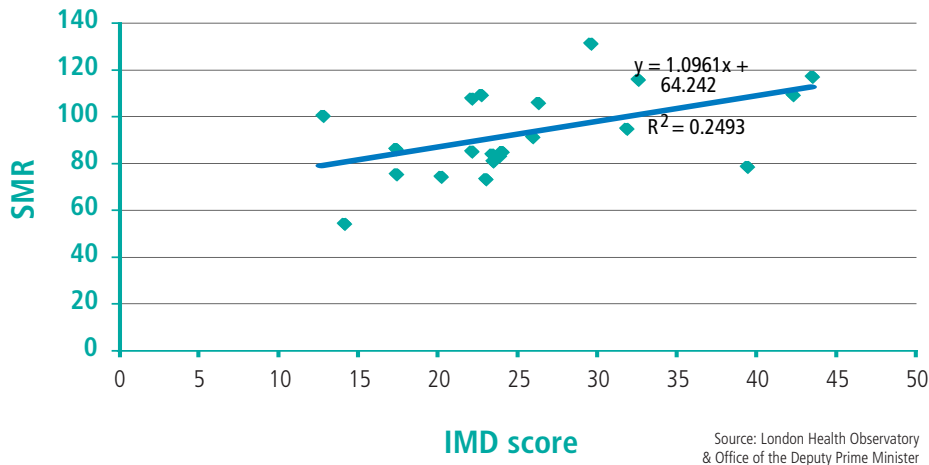
Figure 35: SMRs from CHD for all persons aged <75 years in Brent, 1999-2003



Deprivation, Ethnicity and CHD Mortality

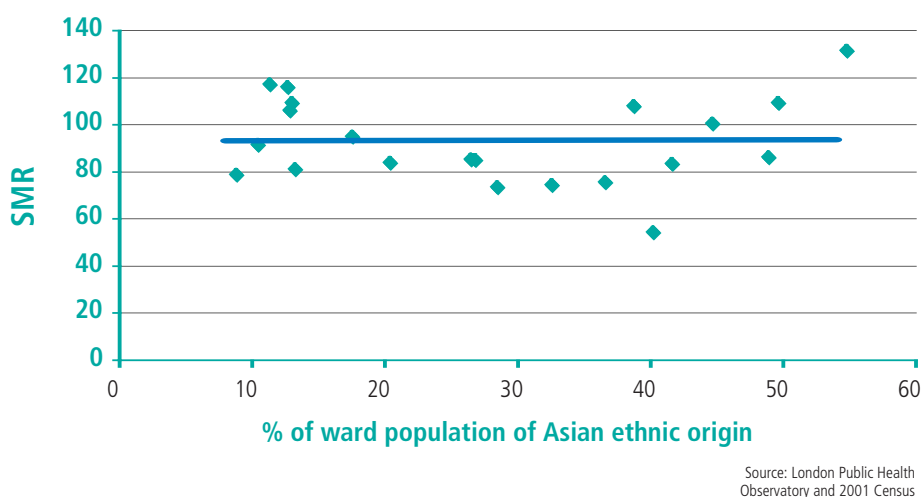
Nationally CHD mortality is strongly correlated with deprivation. Figure 36 presents a scatter plot, which shows the association between CHD mortality and IMD 2004 scores at ward level in Brent. CHD mortality is positively correlated with deprivation, although the association is not particularly strong. The association shows that 25% of the variation in CHD mortality in Brent can be explained by deprivation ($r^2=0.25$). This relatively weak association between deprivation and CHD mortality in Brent suggests that there are other factors which contribute to variations in CHD mortality at ward level.

Figure 36: Scatterplot showing the association between SMRs for CHD (for all persons of all ages) and deprivation score at ward level in Brent, 1999-2003



Death rates from CHD are known to vary by ethnic group, with particularly high rates evident amongst people of Asian ethnic origin. Figure 37 shows the correlation at ward level between standardised mortality ratios for CHD and the percentage of the ward population that is of Asian or Asian British ethnic origin. In Brent there is no obvious association between these two variables. Some of the most affluent wards in Brent have the highest percentage of residents of Asian or Asian British ethnic origin. The relative affluence of people living in these wards may be exerting a protective effect against the effects of ethnic origin, although other unknown factors are also likely to play a part. The potential protective effect of affluence may not be acting at the level of primary prevention (i.e. preventing people from developing CHD), but instead may help to extend the life expectancy of people who have the disease.

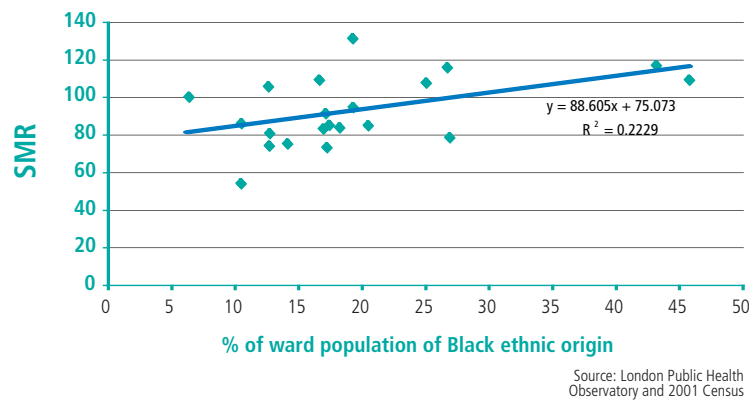
Figure 37: Scatterplot showing the association between SMRs for CHD 1999-2003 (all persons, all ages) and the percentage of the population of Asian ethnic origin by ward in Brent



Source: London Public Health Observatory and 2001 Census

Figure 38 shows the association between SMRs for CHD and percentage of the population classified as Black or Black British by ward in Brent. There is a positive association between these two variables, although some of this may be explained by deprivation. This association is a reversal of what is seen nationally, where death rates from CHD amongst Black minority ethnic groups are lower than rates for the rest of the country.¹⁰

Figure 38: Scatterplot showing the association between SMRs for CHD 1999-2003 (all persons, all ages) and the percentage Black population by ward



Prevalence of Coronary Heart Disease

Data from the 2003 Health Survey for England suggest the prevalence of CHD in England is 7.4% in men and 4.5% in women.¹¹ Prevalence of CHD tends to increase with age, with around 1 in 4 men and 1 in 5 women aged 75 years and above living with CHD. In men prevalence of CHD is also higher in certain ethnic groups, with men of Indian, Pakistani and Bangladeshi origin having particularly high prevalence rates. Prevalence is also higher in manual socio-economic groups.

Table 5 shows the prevalence of CHD by locality in Brent. These data are derived from general practice. All GP practices are required to maintain a register of patients with a diagnosis of CHD. The prevalence figures presented in Table 5 are calculated as the percentage of the total number of patients registered with GPs in each locality who are listed on practice CHD registers.

Table 5: Prevalence of diagnosed CHD in primary care, by Brent locality

Locality	Prevalence (%)
Harlesden	1.63
Kilburn	1.58
Kingsbury	2.58
Wembley	2.37
Willesden	1.79
Brent	1.99

¹⁰ British Heart Foundation Statistics Website. Accessed at url: <http://www.heartstats.org/datapage.asp?id=737> [August 2005]

¹¹ Sproston K and Primatesta P (Eds) Health Survey for England, 2003. London: The Stationery Office, 2004.

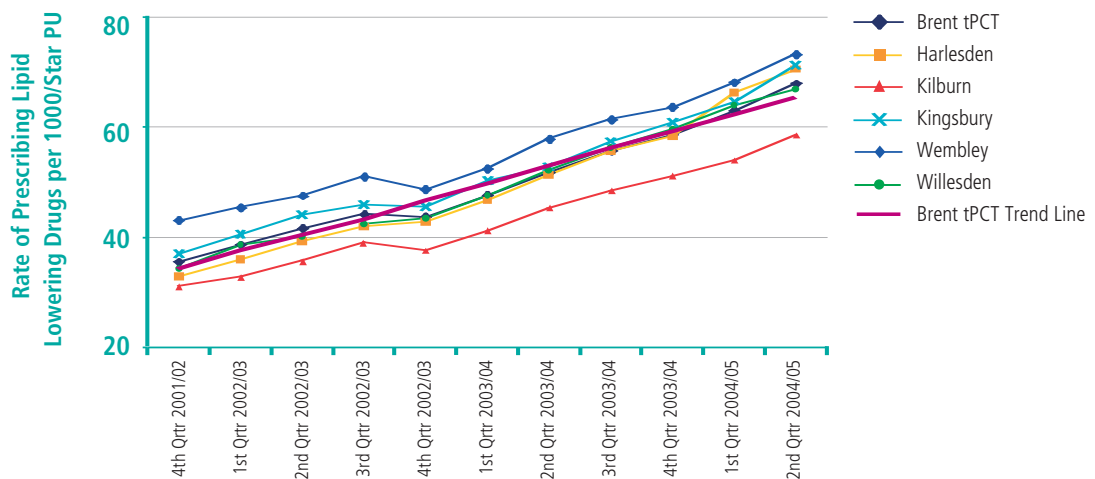
The locality prevalence figures in Table 5 are much lower than would be expected, based on data from the national Health Survey for England. Although we do not know the exact reasons for the low prevalence of diagnosed CHD in Brent, it is likely to be due to a combination of people with mild CHD not presenting to their GPs, under recording on practice registers and list inflation, which means that the size of the registered patient population (the denominator) is over-estimated.

Health Care for the Prevention and Management of CHD

Primary care services play an important role in preventing people from developing CHD and in treating mild to moderate disease. Raised cholesterol is a risk factor for CHD and there is strong evidence to show that a reduction in cholesterol reduces CHD mortality in people with both established disease or those at high risk of getting disease.¹² Figure 39 shows the prescribing rates of lipid (cholesterol) lowering drugs by Brent locality, between January 2002 and September 2005. (For an explanation of the term 'Star PU's' please refer to the glossary).

Lipid lowering drug (LLD) prescribing has been increasing in all Brent localities over this time period, but there are notable differences between localities. Considerably more LLDs were prescribed in the Wembley locality than in the other localities over this period. Kilburn consistently has the lowest prescribing rate of all localities, and the gap between localities with the highest (Wembley) and lowest (Kilburn) prescribing rates for LLDs appears to be widening.

Figure 39: Rate of prescribing lipid lowering drugs by Brent locality, (Items per 1000/Star PU) Jan 2003 to Sept 2005

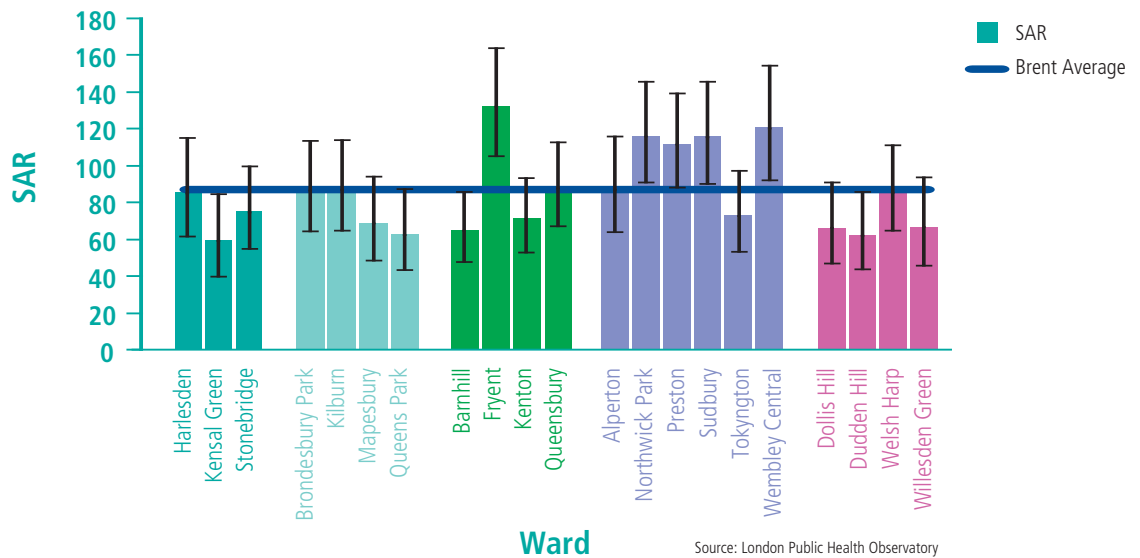


¹² Department of Health. National Service Framework for Coronary Heart Disease. London: The Stationery Office, March 2000.

Hospital admissions and CHD

People with severe CHD are generally admitted to hospital either as an emergency, because they are experiencing severe angina (chest pain) or a myocardial infarction (heart attack), or as a routine admission to undergo cardiac surgery or other therapeutic procedures to treat their disease. Figure 40 shows the age standardised admission ratios (SARs) for CHD for all Brent wards in 2002-03.

Figure 40: Standardised admission ratios for CHD for all persons in Brent, 2002-2003



The overall Brent SAR for CHD is 86 which is significantly lower than the England average. London has an SAR of 106, compared to England. Fryent is the only ward in Brent that has a significantly high SAR for CHD, although it does not experience high CHD mortality (see Figures 33-35). CHD mortality in Harlesden and Stonebridge wards is significantly higher than the England average, but the SARs for CHD in these wards are lower than the Brent average, although not statistically significantly lower than the England average. This suggests that there may be unmet need for secondary care cardiac services in Brent.

Box 8: Health Equity Audit

A health equity audit was carried out in 2005 which looked at the provision of cardiac services in relation to need. It found that CHD was the biggest killer within Brent and that deprivation was a major determinant of CHD death. It also uncovered inequity in access to cardiac services; in general as deprivation levels increased at ward level, hospital admission rates for CHD tended to decrease. In addition, fewer revascularisation procedures are performed on women with diagnosed CHD compared to men. The PCT is addressing these issues by increasing the provision of secondary care cardiac services for residents within the borough.

Stroke

Stroke is the third most common cause of death and most common cause of adult disability. Care for stroke patients consumes approximately 4% of total NHS expenditure.¹³ Each year over 130,000 people in England and Wales have a stroke. Of these stroke patients, about a third are likely to die within the first 10 days, about a third are likely to make a recovery within one month, and about a third are likely to be left disabled and in need of rehabilitation. There are two types of stroke, ischaemic stroke, which is caused by a blood clot in one of the blood vessels supplying the brain, and haemorrhagic stroke, which is caused by a leakage of blood from a burst blood vessel into the brain. The symptoms of both types of stroke depend upon which part of the brain is affected, but can include physical disability and mental impairment.

Nationally the prevalence of stroke is between 4 and 8 per 1000 population.¹⁴ Table 6 shows the prevalence of stroke within the five localities in Brent. These prevalence estimates are based on the number of people recorded on GP stroke registers in 2004/05. These locality prevalences are in line with national prevalence estimates. The highest prevalence is in the Kingsbury locality which has the highest proportion of elderly people of all the Brent localities.

Table 6: Prevalence of stroke by Brent locality, 2004/5

Locality	Stroke Prevalence (%)
Harlesden	0.62
Kilburn	0.86
Kingsbury	1.04
Wembley	0.72
Willesden	0.79
Brent total	0.82

Source: Quality Management and Analysis System, 2004/05

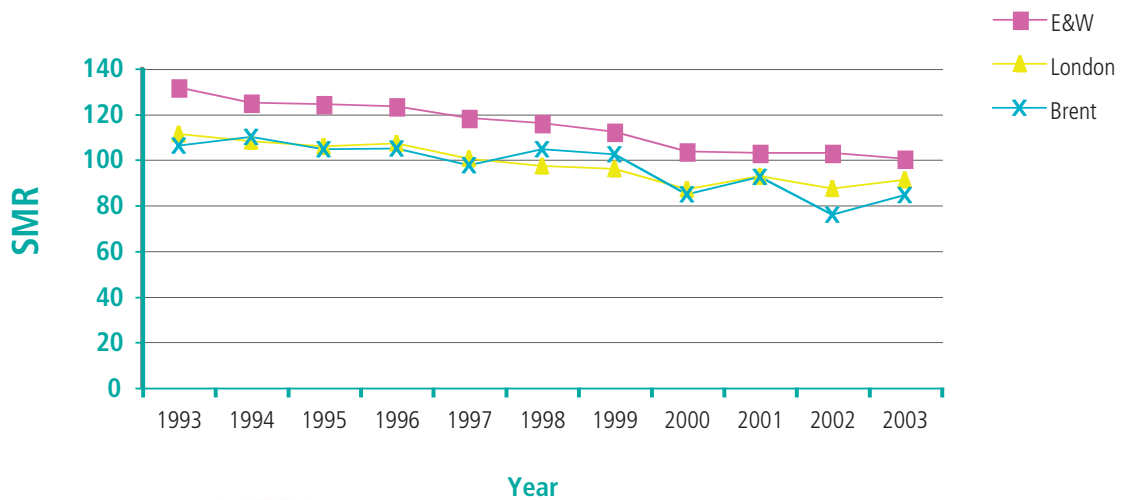
¹³ Department of Health. Our Healthier Nation: A Contract for Health. London: HMSO, 1997.

¹⁴ Wolfe CW. The burden of stroke. In: Stroke Services and Research. Ed. Wolfe C, Rudd T and Beech R. Stroke Association 1996.

Deaths from Stroke

Figure 41 shows trends in the standardised mortality ratios from stroke for Brent, London and England between 1993 and 2003. Mortality from stroke in Brent is similar to that in London as a whole, and is lower than mortality in England & Wales. Deaths from stroke have decreased in all three regions in the time period shown.

Figure 41: SMRs for stroke in Brent, London and England & Wales, 1993 to 2003



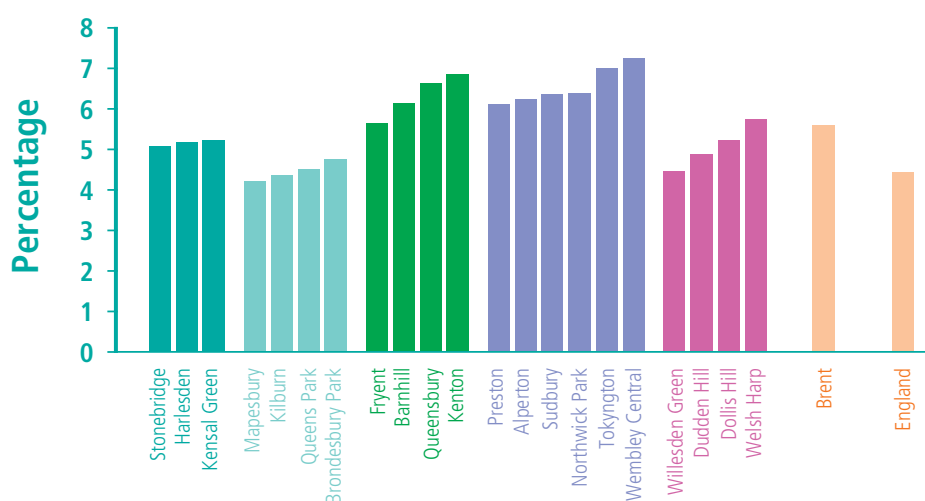
Source: Compendium of Clinical and Health Indicators



Diabetes

Establishing the true number of people with diabetes in Brent is difficult because many diabetics who do not experience symptoms remain undiagnosed. Previous modelling work undertaken in the borough predicts that the prevalence of diabetes is 5.6%, but the ward prevalence ranges from 4.2% to 7.2%¹⁵. The predicted prevalence for England is 4.4%. The predicted prevalence of diabetes in Brent is higher than the national figure because of the large numbers of BME residents in the borough, especially people from the Indian sub-continent, who are known to be at increased risk of developing diabetes.

Figure 42: Predicted prevalence of diabetes by ward in Brent, 2005



The prevalence of diagnosed diabetes in primary care, by locality, is presented in Table 7. Data on the number of diagnosed diabetics in primary care were taken from diabetes registers maintained by Brent GPs.

Table 7: Prevalence of diagnosed diabetes in primary care, by Brent Locality

Locality	Diabetic Prevalence
Harlesden	4.66%
Kilburn	3.26%
Kingsbury	4.90%
Wembley	5.28%
Willesden	3.85%
Brent total	4.35%

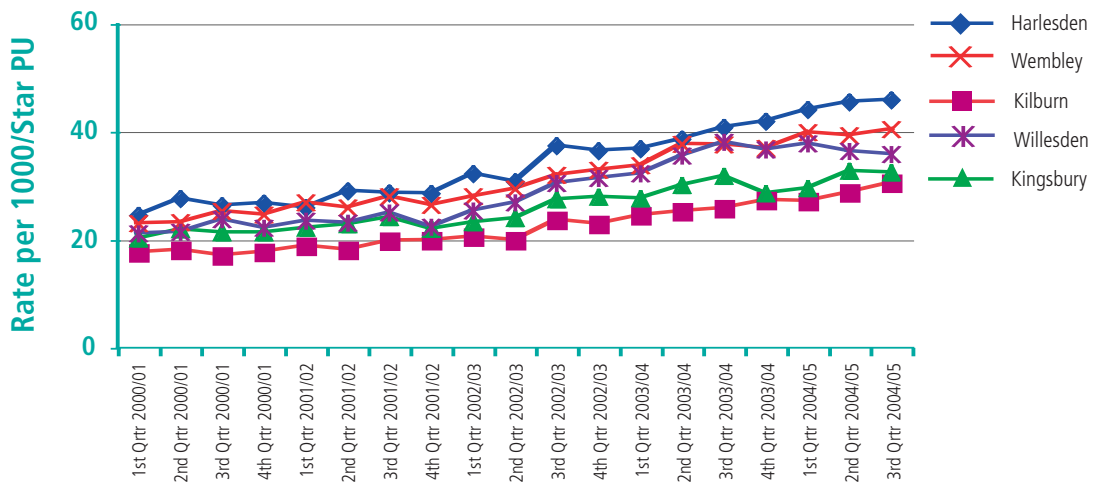
The prevalence of diagnosed and recorded diabetes in each of the five localities is lower than the predicted prevalence of 5.6%. Wembley, which has the highest predicted prevalence of diabetes, also has the highest recorded prevalence of diagnosed diabetes.

¹⁵Yorkshire & Humber Public Health Observatory, Brent, SchARR Model

Figures 43 and 44 show prescribing rates in Brent for two drugs commonly prescribed for patients with diabetes: insulin and oral hypoglycaemic drugs.

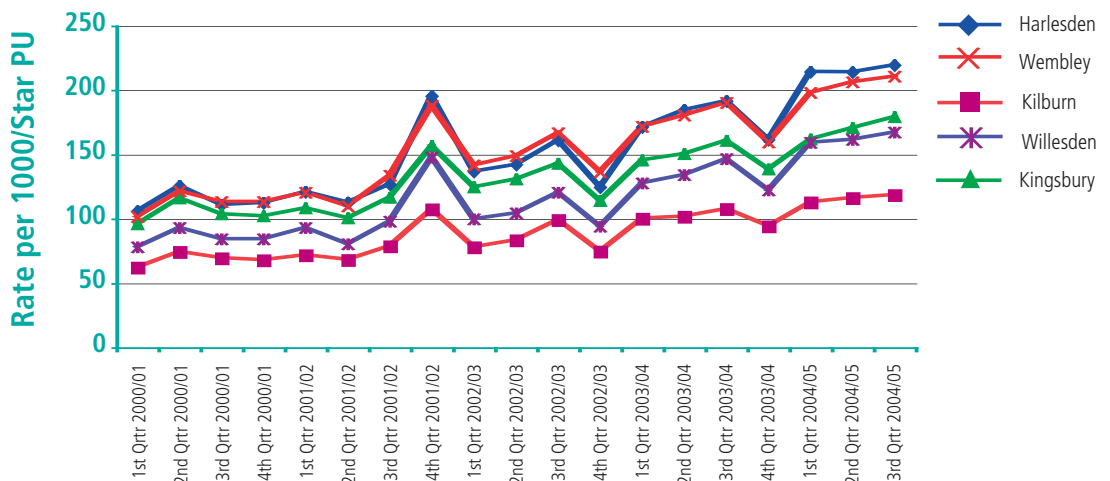
Harlesden locality has the highest rates of prescribing of all five localities, although it has a slightly lower recorded disease prevalence than Kingsbury and Wembley localities. The proportion of patients whose diabetes is controlled by diet alone may be lower in Harlesden than in the other localities.

Figure 43: Rate of insulin prescribing (Items per 1000/Star PU) by Brent locality, Apr 2000-Dec 2004



Source: Prescription Pricing Authority

Figure 44: Rate of oral anti-diabetic drug prescribing (Items per 1000/Star PU) by Brent locality, Apr 2000-Dec 2004



Source: Prescription Pricing Authority

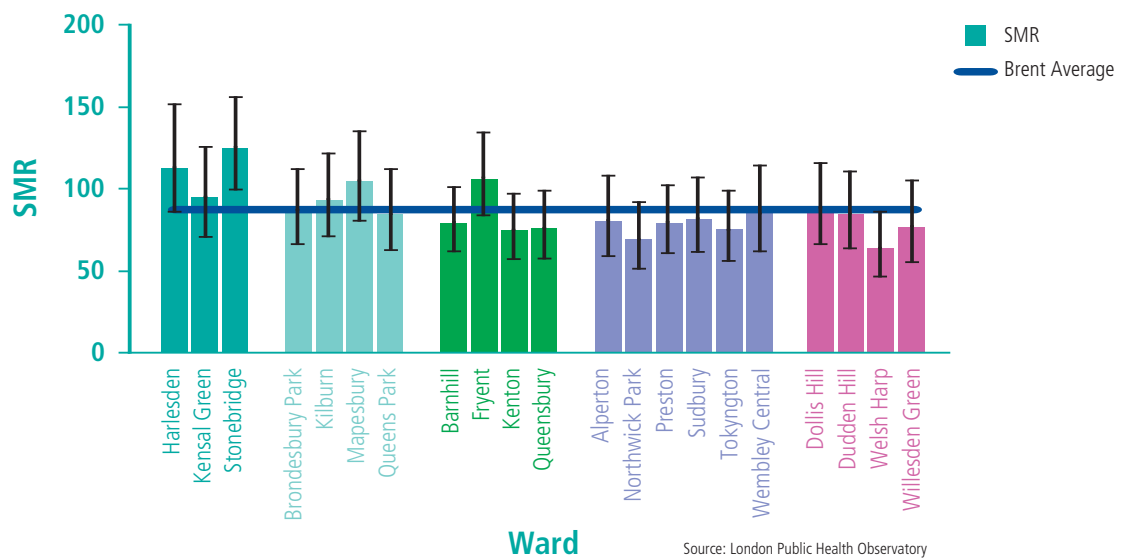
Cancer

Cancer is the leading cause of death in the UK, with 1 in 4 deaths caused by cancer.¹⁶ In 2003 approximately 127,000 people died of cancer in England & Wales, 469 of them in Brent.¹⁷

Mortality from All Cancers in Men

In Brent, overall mortality from all cancers in men of all ages is significantly lower than the England average. This mirrors the situation for London as a whole, which has a lower male SMR for all cancers than the England average. For men of all ages, there are no wards where mortality from all cancers is significantly higher than England. There are five wards – Kenton, Northwick Park, Queensbury, Tokyngton and Welsh Harp – where the all cancer mortality is significantly lower than the England average.

Figure 45: SMRs for all cancers in men of all ages, Brent 1999-2003

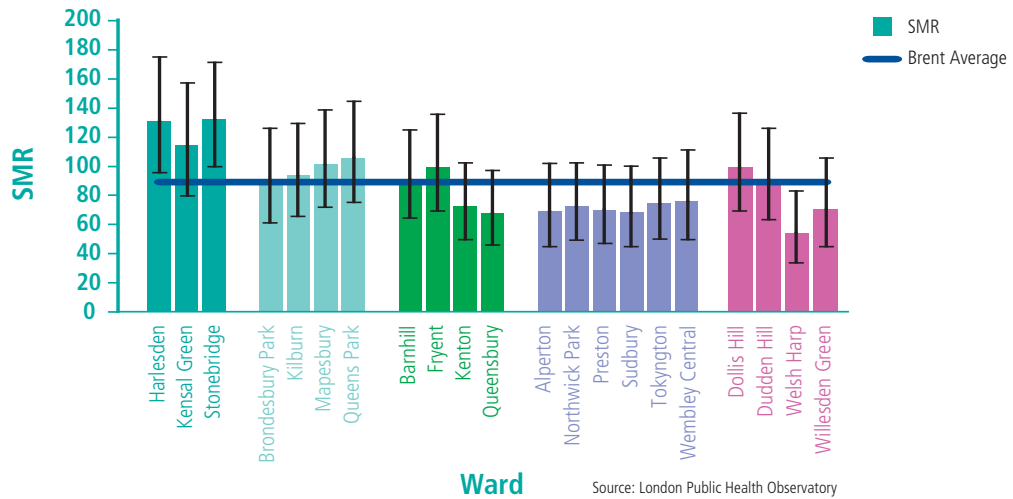


For men aged under 75, no wards in Brent have SMRs for all cancers that are significantly higher than the England average (Figure 46). The highest SMRs can be found in the three wards in the Harlesden locality. Two wards have SMRs that are significantly lower than the England average; these are Queensbury and Welsh Harp wards. Again the overall Brent SMR for all cancers in men under 75 is significantly lower than the England average (100). The corresponding SMR for London is 97.

¹⁶ Cancer Research UK Information Resource Centre (2005), CancerStats. Available from url: <http://info.cancerresearchuk.org/cancerstats> [Accessed August, 2005]

¹⁷ Compendium of Health and Clinical Indicators (ongoing release)

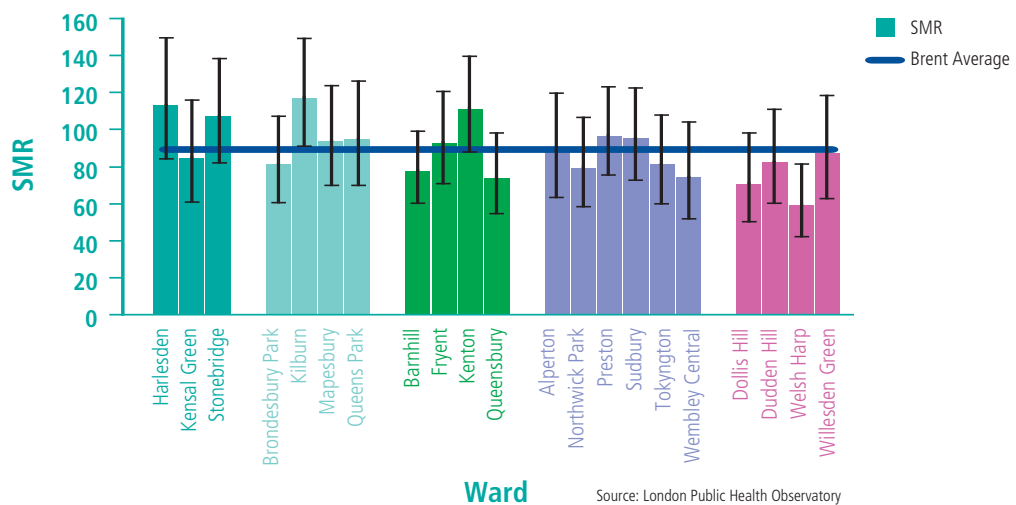
Figure 46: SMRs for all cancers for men aged <75 years in Brent, 1999-2003



Mortality from All Cancers in Women

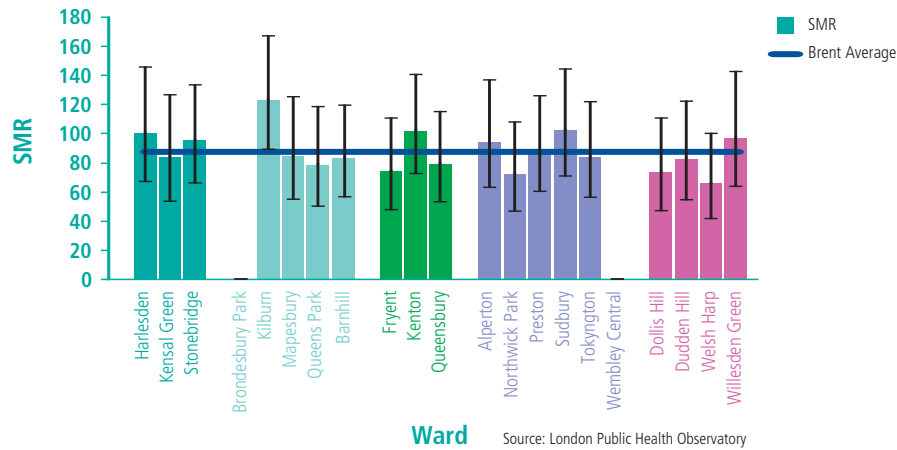
The overall Brent SMR for all cancers in women of all ages is 88, which is significantly lower than the England average; for London the comparable figure is 98. No ward in Brent has a female all ages all cancer SMR that is significantly higher than the England average, and four wards have SMRs that are significantly lower. These are Queensbury, Barnhill, Welsh Harp and Dollis Hill wards.

Figure 47: SMRs for all cancers for women of all ages, Brent 1999-2003



For women under 75 years, no wards have a SMR for all cancers that is significantly higher or lower than the England average. There is no apparent trend by locality. The overall Brent SMR for all cancers for women aged under 75 is significantly lower than the England average (86 in Brent compared to 100 for England). The corresponding London figure is 97.

Figure 48: SMRs for all cancers for women aged <75 years Brent 1999-2003



Over the last 10 years cancer mortality has decreased by 11% in the UK.¹⁸ This is largely due to falls in the number of people dying from cancer of the cervix, stomach, bowel, lung and breast. The government has set a target to reduce cancer deaths by 20% in the under 75s by 2010 (from a 1998 baseline).¹⁹ Brent has already achieved a 17% reduction in its under 75 all cancer mortality rate. From a baseline directly age standardised rate (DASR) of 131 deaths per 100,000 population in 1998, the DASR has fallen to 108 deaths per 100,000 in 2003.

Figure 49: Directly age standardised mortality rate from all cancers in under 75s in Brent, compared to OHN projections



In Brent, the top three most common cancers in men between 1993 and 2000 were prostate cancer, lung cancer and bowel cancer (Table 8). These cancers mirror the most common cancers amongst men nationally. Together new registrations of these three cancers in men accounted for nearly a quarter of all new cases of cancer in Brent men in that time period.

Amongst women in Brent, the three most common cancers are breast cancer, colorectal cancer and lung cancer. Again, these cancers mirror the most common cancers amongst women nationally. New registrations of these three cancers in women in Brent make up nearly a quarter of all new cases of cancer in that time period.

Table 8: Common cancers in men and women in Brent, 1993-2000

Top 3 cancers in Men		Top 3 cancers in women	
Cancer	Number of registrations	Cancer	Number of registrations
Prostate	739	Breast	1064
Lung	550	Colorectal	390
Colorectal	406	Lung	335

¹⁸ Cancer Research UK Information Resource Centre (2005), CancerStats. Available from url: <http://info.cancerresearchuk.org/cancerstats> [Accessed August]

¹⁹ Department of Health. Saving Lives: Our Healthier Nation. The Stationery Office: London, 1999.

Breast Cancer

Breast cancer is the leading cause of cancer death in women, and women have a one in nine lifetime risk of developing the disease.²⁰ Breast cancer is one of a few diseases where there is no association between incidence and socio-economic status.

All newly diagnosed cancers in Brent residents are registered with the Thames Cancer Registry. Registration rates are a proxy for incidence rates. Figure 50 shows the directly age standardised registration (DASR) rates for breast cancer in the five localities in Brent, for the pooled time periods 1998-2000, 1999-2001 and 2000-2002. The highest rates are seen in the Wembley locality for two of the three time periods. In the period 2000-2002, the DASR rate for Wembley was 120 per 100,000, and this was significantly higher than the Willesden locality rate of 70 per 100,000. The London DASR rate for 2000 was 110 per 100,000.²¹

Figure 50: Directly age standardised registration rates of breast cancer per 100,000 women by Brent locality, 3 year rolling averages 1998-2002



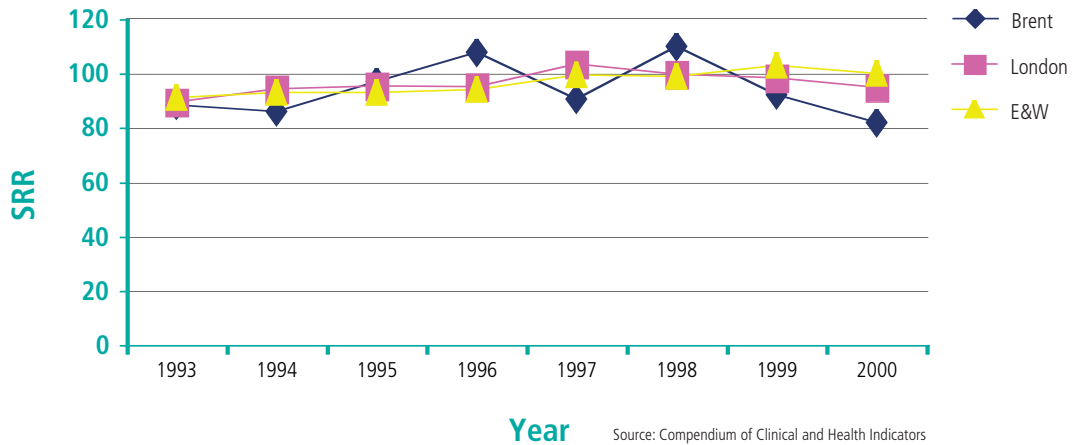
Cancer incidence rates can be compared between different regions and over time by using indirectly age standardised registration ratios (SRRs). SRRs measure how much more (or less) likely a person is to be registered with cancer in a region compared to someone of the same age and sex in the standard population (in this case, the 2003 England population). Values higher than one hundred means there are more registrations than would be expected. Values lower than 100 mean fewer registrations were observed than expected. Between 1993 to 2000 breast cancer incidence rates in Brent fluctuated around the London and national figures, but appear to have been decreasing since then (see Figure 51). For the pooled time period 1998-2000 the standardised registration ratio for breast cancer in Brent was 94, which was not significantly different from the London or England & Wales figures.²²

²⁰ Breast Cancer Care. Breast cancer facts and statistics. Available at url: <http://www.breastcancercare.org.uk/Breastcancer/Breastcancerfactsandstatistics> [Accessed August 2005]

²¹ Thames Cancer Registry

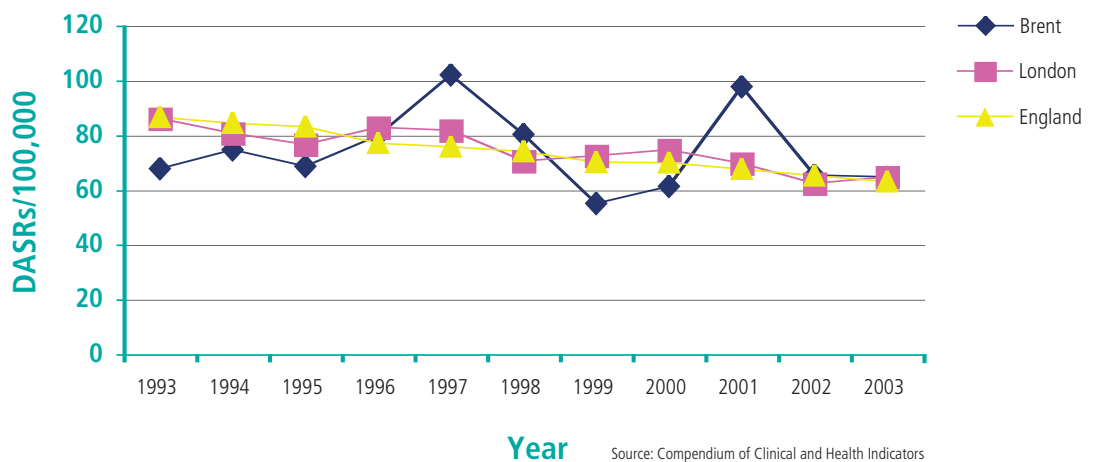
²² Compendium of Clinical and Health Indicators (ongoing release) and Clinical and Health Outcomes Knowledge Base

Figure 51: Indirectly age standardised registration ratios for breast cancer, 1993 to 2000



Trends in breast cancer mortality show that the directly age standardised mortality rate for Brent women aged 50-69 has fluctuated around the London and England & Wales rates (Figure 52). Greater variation in the Brent rate is to be expected because of the smaller numbers of deaths in Brent, compared to London or England & Wales as a whole. The London and England & Wales rates have decreased between 1993 and 2003. This trend is not mirrored in the Brent rates, partly because the rates were lower in Brent than the London and England & Wales rates at the start of the period (1993-1996).

Figure 52: Directly age standardised mortality rates for breast cancer in women aged 50-69, 1993-2003



Breast Screening in Brent

Breast screening is a method of detecting breast cancer at a very early stage. The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged between 50 and 70. Every registered woman will receive her first invitation between her 50th and 53rd birthday. She will then be invited three-yearly until her 70th birthday.

There is now good evidence that breast screening reduces mortality.^{23,24} In September 2000, research was published that demonstrated that the National Breast Screening Programme has lowered mortality rates from breast cancer in the 55-69 age group.²⁵ It is estimated that, nationally, the programme is on course to save 1,250 lives per year (a 25 per cent reduction in mortality) by the year 2010.²⁶

There are several targets against which the performance of the NHS breast screening programme is monitored. Two key measures of performance are coverage and uptake. The way in which these measures are calculated is described in Box 9.

Box 9: Coverage and Uptake of Breast Screening

Coverage

Definition: The percentage of eligible women who have had a test with a recorded result at least once in the previous 3 years. Women ineligible for screening, and therefore excluded from both the numerator and denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (e.g. those who have had a bilateral mastectomy). Coverage of the screening programme is best assessed using the 53-64 year age group as women may be first called at any time between their 50th and 53rd birthdays.

Minimum Standard: $\geq 70\%$ (increasing to 80%).

Uptake

Definition: The percentage of women who are screened within six months of their invitation, as a percentage of women invited to attend for breast screening.

Minimum Standard: $\geq 70\%$ (increasing to 80%).

²³ International Agency for Research on Cancer. Handbook of Cancer Prevention Vol 7 – Breast Cancer Screening. Lyons: IARC (2002).

²⁴ Nystrom L, Rutqvist LE, Wall S et al. Breast cancer screening with mammography: overview of Swedish Randomized Controlled Trials. Lancet. 1993 341(8851): 973-8.

²⁵ Effect of NHS Breast Cancer Screening Programme on Mortality from Breast Cancer in England and Wales, 1990-8: Comparison of Observed with Predicted Mortality. BMJ 2000:665-669

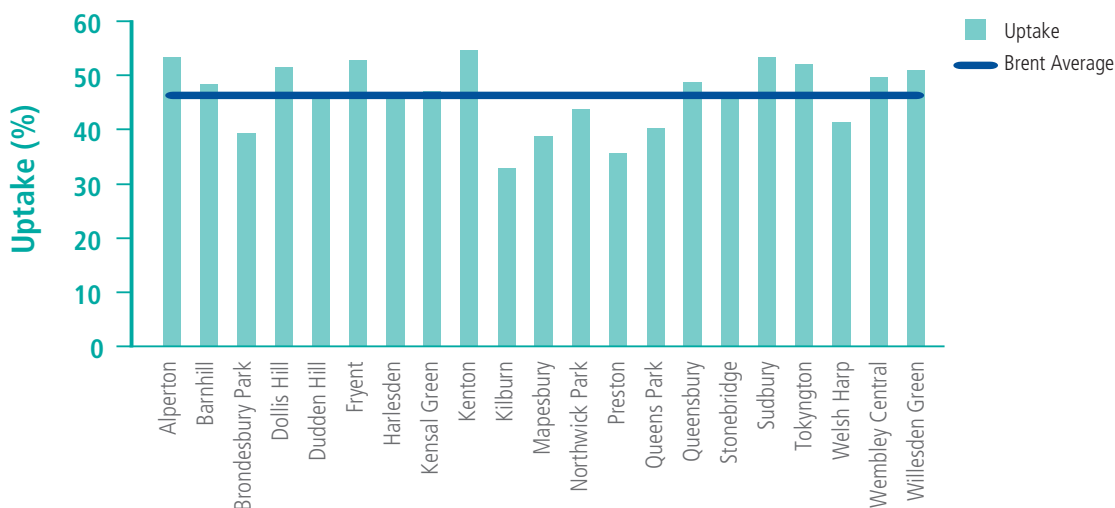
²⁶ NHS Cancer Screening Programmes. The NHS breast screening programme. Available at: <http://cancerscreening.org.uk/breastscreen> Accessed 21 June 2005.

In Brent in 2003/04, just 56% of eligible women aged 53-64 underwent breast screening within the NHS programme. This coverage figure falls short of the figure for London as a whole (64%) and is far short of the national figure of 75%. Coverage reflects both the efficiency of the breast screening programme in sending invitations to women within the 3 year review period, as well as women’s response to the invitation itself.

Uptake rates can be thought of as a more direct measure of women’s response to the invitation to attend breast screening. Achieving high levels of uptake is important, because low rates have an adverse impact on the effectiveness of the overall breast screening programme. An uptake rate of 70% corresponds to a 25% reduction in breast cancer mortality. However, if uptake falls to 63% (all other things being equal) the mortality reduction falls to 22%.

Like many other PCTs in London, Brent has historically experienced poor rates of breast screening uptake. Uptake of breast screening in Brent amongst women aged 50-70 stands at 46% as of March 2005. This compares to 75% for England in 2003/04.²⁷ The lowest uptake is in Kilburn ward (33%). The highest uptake is in Kenton ward (55%).

Figure 53: Uptake of breast screening amongst Brent women aged 50-70, 2004-2005



Ward

Source: Brent Community Information System

The reasons underlying the low uptake are numerous and range from access to services, population mobility and general lack of breast screening awareness within the eligible population. Practice-level variation in uptake rates also suggests that certain practice specific factors may have an effect on uptake of breast screening. Brent PCT is working closely with the North London Breast Screening Service and partners in primary care to develop an action plan for improving both the coverage and uptake of the breast screening programme in Brent.

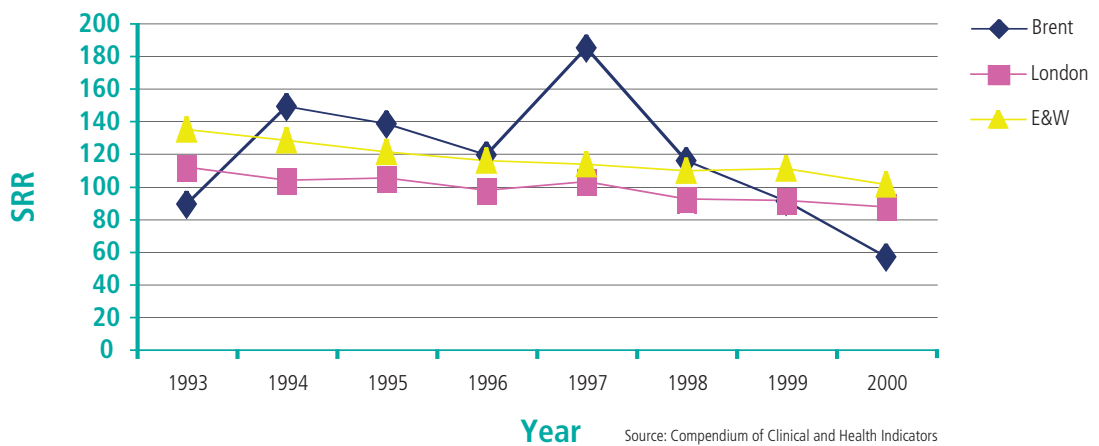
²⁷ Office for National Statistics: Breast Screening Programme, England 2003-04

Cervical Cancer

Cervical cancer is a common type of malignancy accounting for about 6% of all cancers in women. The majority of cervical cancers are diagnosed between the ages of 40-55. Within the UK there was a 40% decrease in mortality from the disease between 1979 and 1997, which can be attributed to earlier detection through screening, and improved treatment services.²⁸ Risk factors for cervical cancer include multiple sexual partners, smoking, and infection with the human papilloma virus.

Although cervical cancer does not appear in the top three cancers amongst women in Brent, it is still an important burden of morbidity in the local population. Between 1993 and 2000 these were 111 new registrations of cervical cancer amongst women in Brent. The indirectly age standardised registration ratio for cervical cancer in Brent has fluctuated around the London and England figures for the period 1993-1997, however between 1997 and 2000, the SRR for cervical cancer in Brent appears to have fallen.

Figure 54: Indirectly age standardised registration ratios for cervical cancer, 1993 to 2000

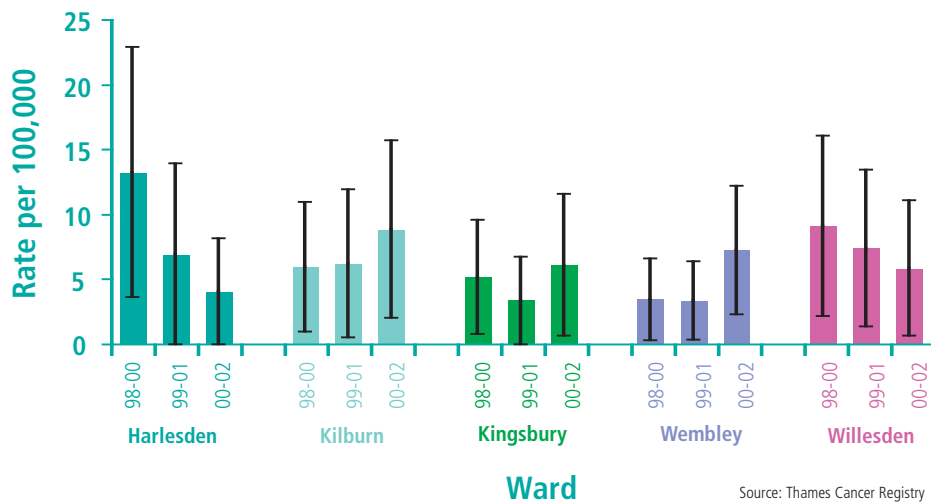


There is considerable variation in the directly age standardised registration rates for each of the five Brent localities, although over time there is no consistent pattern or trend. In all of the time periods shown, none of the differences between localities are statistically significant. The lowest registration rate was 3.4 per 100,000 in Wembley in 1999-2001 and the highest rate was 13.2 per 100,000 in Harlesden in 1998-2000. The directly age standardised registration rate for cervical cancer in London as a whole in 2000 was 7.2 per 100,000.²⁹

²⁸Cancer UK. Cervical Cancer. Available at url: <http://www.cervicalcancer.uk.com> [Accessed August 2005]

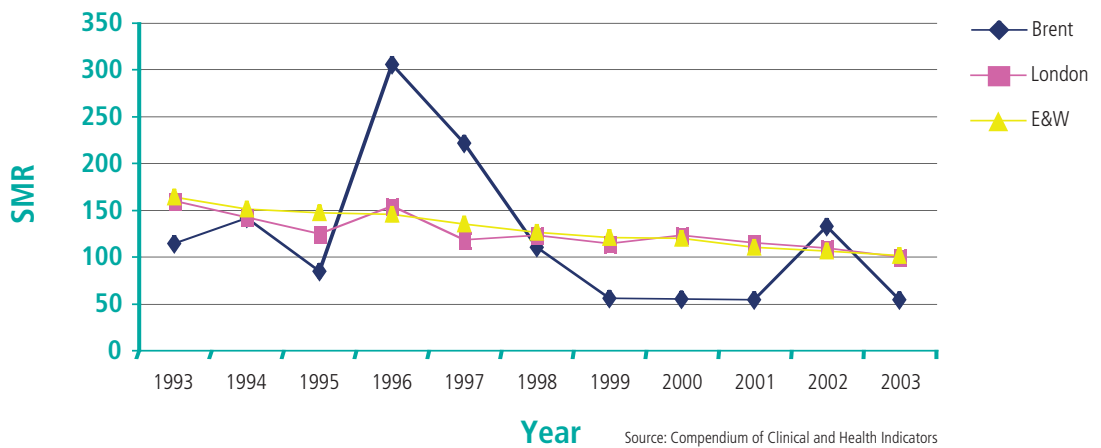
²⁹Thames Cancer Registry

Figure 55: Cervical cancer directly age standardised registration rates per 100,000 women by Brent locality, 3-year rolling averages



Between 1993 to 2003 cervical cancer deaths have been falling in England and in London. SMRs for cervical cancer in Brent have varied widely during this time period. This is due to the small numbers of deaths involved (for example, only 2 people died of the disease in Brent in 2003), and no clear trend has emerged.

Figure 56: SMRs for cervical cancer for Brent, London and England & Wales, 1993-2003



Cervical Screening in Brent

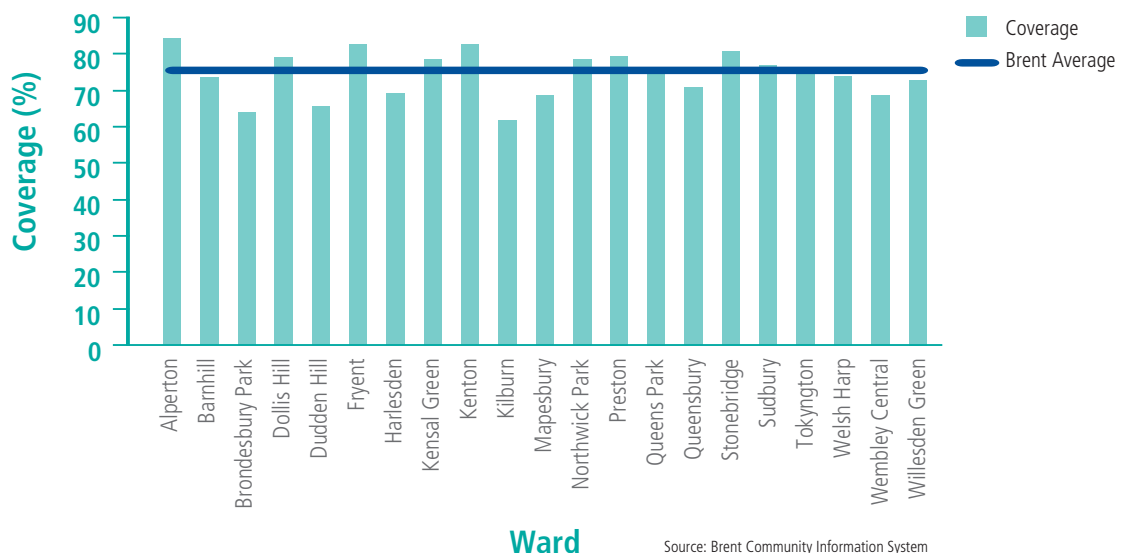
Cervical screening is a method of preventing cervical cancer through the early detection and treatment of abnormalities which, if left untreated, could lead to cancer in a woman's cervix. All women aged between 25 and 64 are entitled to free cervical screening on the NHS.

The incidence of cervical cancer in England and Wales fell by 42% between 1988 and 1997³⁰ and this fall is directly related to the NHS Cervical Screening Programme, which aims to reduce the number of women who develop invasive cervical cancer and the mortality caused by it. The current national policy on cervical screening is as follows:

- Women under 25 should not be screened
- Women should receive their first invitation for cervical screening at the age of 25
- Between the ages of 25 and 49 women should be screened every three years
- Between the ages of 50 and 64 women should be screened every five years.

Cervical screening coverage is defined as the proportion of women aged 25 to 64 who have been screened in the last 5 years. The national target is 80%. If this level of coverage can be achieved, evidence suggests that a reduction in death rates from cervical cancer of around 95% is possible in the long term. In Brent in 2004/05 overall cervical screening coverage was 75%. Ward-level coverage ranged from 62% in Kilburn ward to 84% in Alperton ward.

Figure 57: Cervical screening coverage in women aged 25 to 64, Brent wards, 2004-2005



Source: Brent Community Information System

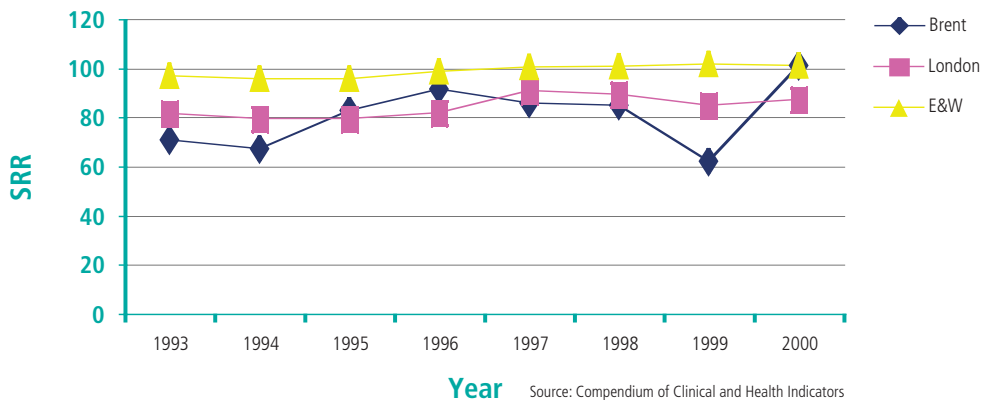
³⁰ Office for National Statistics. Health Quarterly Statistics 07, Autumn 2000.

Colorectal Cancer

There are about 35,000 new cases of colorectal cancer each year in the UK and it is the third most common form of malignancy after breast and lung cancer. It affects almost equal proportions of men and women usually between the ages of 60 and 80 years. About 50% of people diagnosed with the disease will still be alive 5 years after diagnosis.

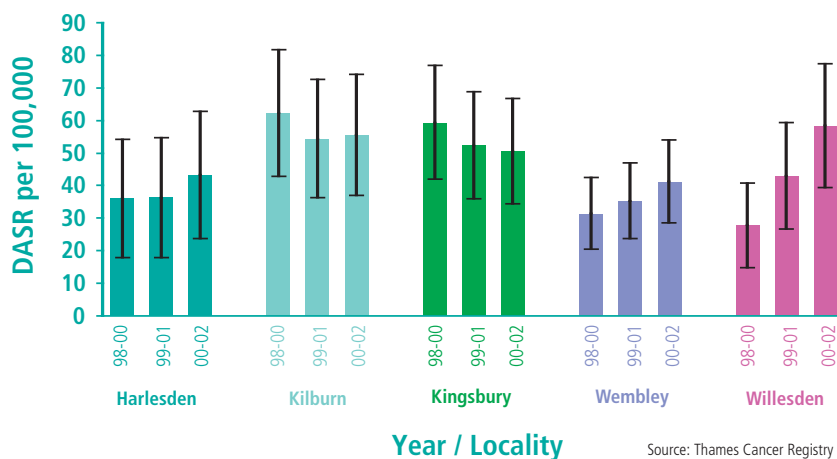
In men, the indirectly age standardised registration ratios in London and Brent are generally lower than for England and Wales as a whole (Figure 58).

Figure 58: Indirectly age standardised registration ratios for colorectal cancer in men, Brent, London and E&W, 1993 to 2000



Directly age standardised registration rates of colorectal cancer in men vary by Brent locality, but no one locality has statistically significantly high or low rates when compared to the others. Between the time period 1998 to 2002, DASR rates for colorectal cancer varied between 28 per 100,000 to 62 per 100,000. The directly age standardised registration rate for colorectal cancer for men in London in 2000 was 28 per 100,000.³¹

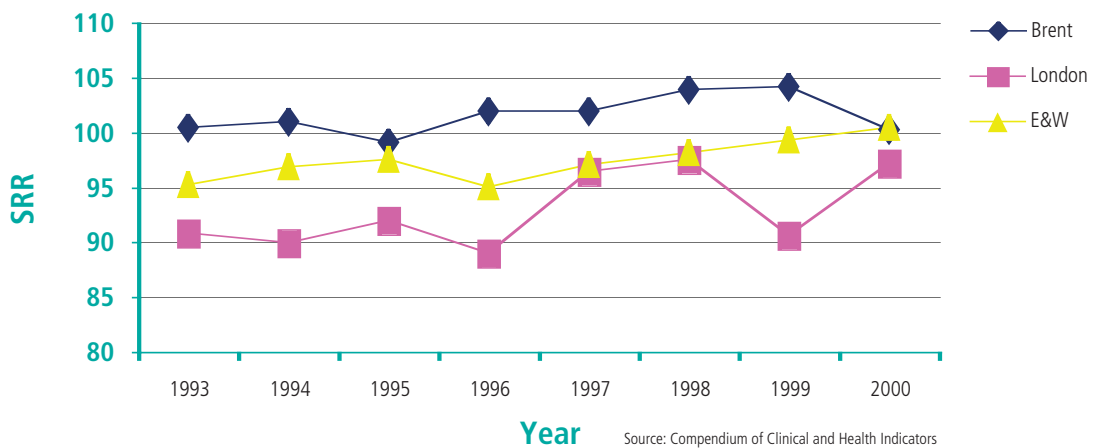
Figure 59: Directly age standardised registration ratios for colorectal cancers in males by Brent locality, 3-year rolling averages 1998-2002



³¹ Thames Cancer Registry

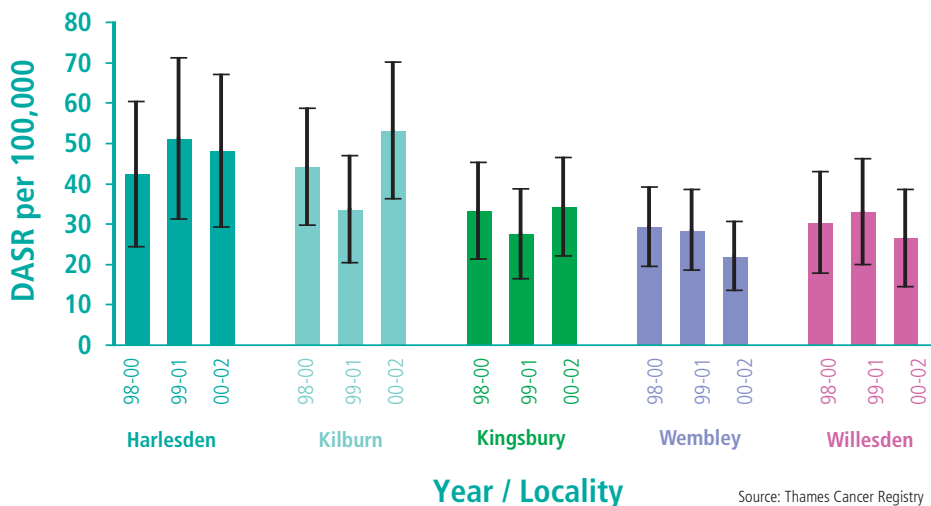
In women, the indirectly age standardised registration ratio for colorectal cancer has consistently been higher in Brent than for London or England and Wales during the period 1993-2000.

Figure 60: Indirectly age standardised registration ratios for colorectal cancer in women, Brent, London and E&W, 1993 to 2000



Directly age standardised registration rates for colorectal cancer in women vary by locality, but no one locality has significantly high or low rates when compared to the others. Harlesden and Kilburn localities appear to have the highest rates out of all of the localities, but this may be due to chance alone. Between the time period 1998 to 2002 rates varied between 22 per 100,000 women to 53 per 100,000 women. The directly age standardised registration rate for colorectal cancer for women in London in 2000 was 20 per 100,000.³²

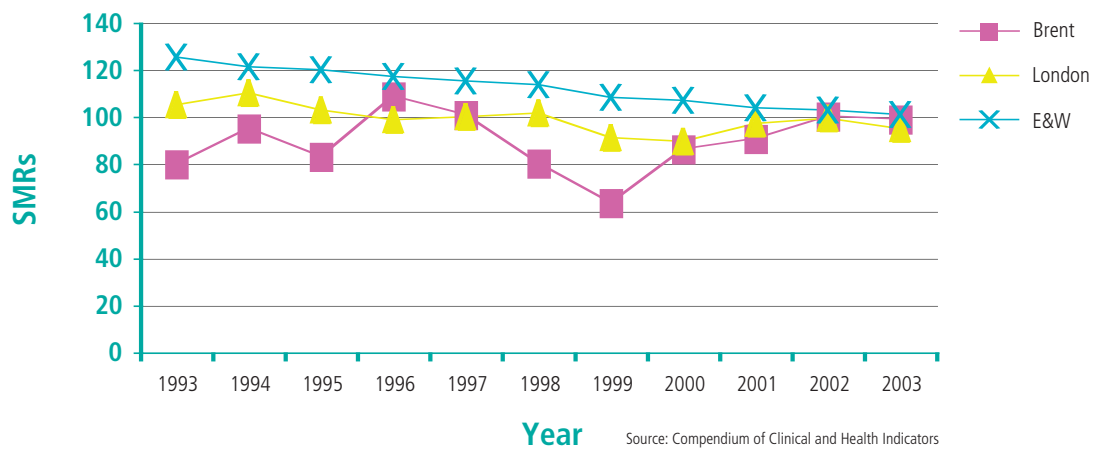
Figure 61: Directly age standardised registration rates for colorectal cancer in women in Brent, 3-year rolling averages 1998-2002



³²Thames Cancer Registry

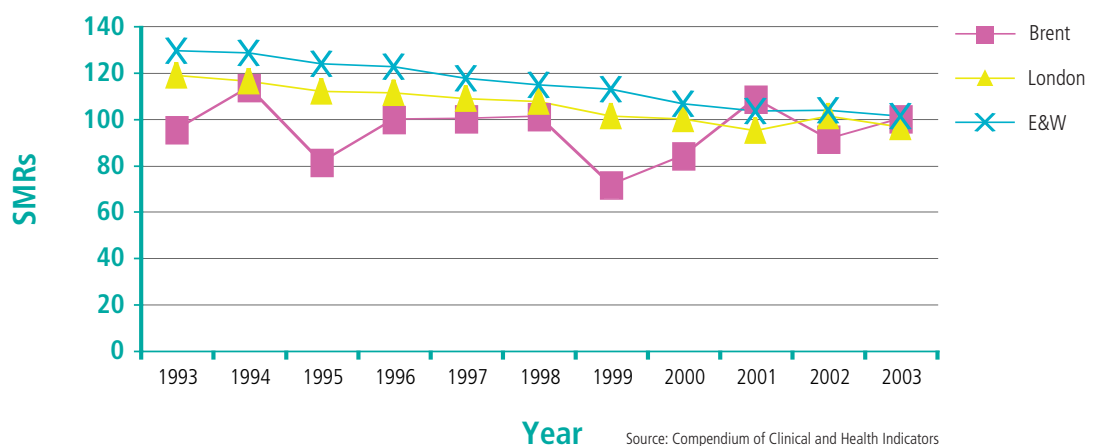
Between 1993 and 2003, male mortality from colorectal cancer in London was lower than it was for England and Wales. Deaths from colorectal cancer in men in Brent have also been lower than the national figure, although fluctuations in the SMR are greater owing to smaller numbers of deaths in Brent.

Figure 62: SMRs for colorectal cancer in men, Brent, London and England & Wales, 1993 to 2003



Between 1993 to 2003, female mortality from colorectal cancer in London was lower than it was for England and Wales. Female mortality in Brent has also been lower than the national figure, although variations in the SMR over time are greater owing to small numbers.

Figure 63: SMRs for colorectal cancer in women, Brent, London and England & Wales, 1993 to 2003



Lung Cancer

In Brent lung cancer is the second most common cancer in men and the third most common in women. The single biggest risk factor for lung cancer is smoking and it is responsible for 9 out of 10 lung cancer cases.³³ Nationally 28% of men and 24% of women smoke,³⁴ with higher proportions of smokers in the lower socio-economic groups. Smoking is also more prevalent in certain black and minority ethnic groups. For example it is estimated that 42% of Bangladeshi men smoke.³⁵

Between 1993 and 2000 the indirectly age standardised registration ratio for lung cancer in men in Brent was lower than both the London and England & Wales figures.

Figure 64: Indirectly age standardised registration ratios for lung cancer in men, Brent, London and E&W, 1993 to 2000

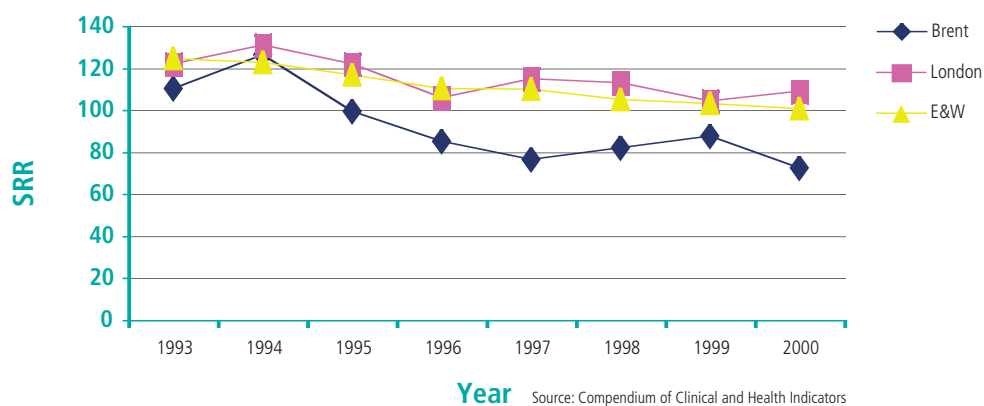
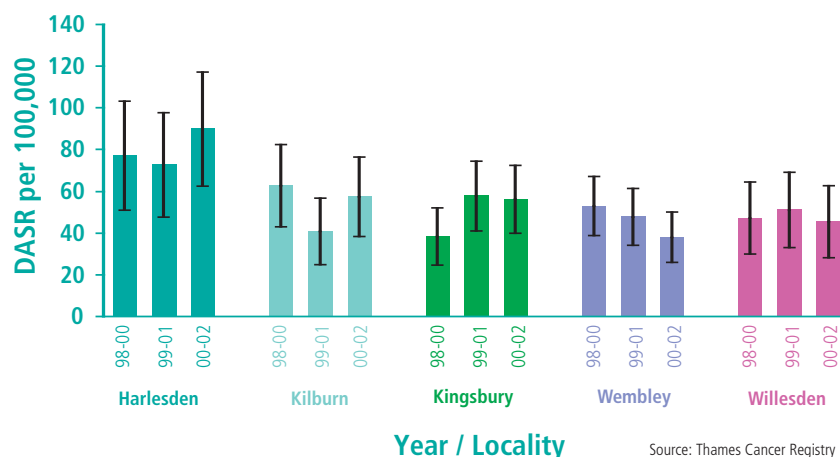


Figure 65 shows the directly age standardised lung cancer registration rates in men by Brent locality for the time period 1998 to 2002. The highest rates in Brent were in the Harlesden locality, although the differences between the localities was not statistically significant.

Figure 65: Directly age standardised registration rates for lung cancer in men in Brent, 3-year rolling averages 1998-2002



³³ Cancer Research UK. Accessed at url: <http://www.cancerresearchuk.org/aboutcancer/specificcancers/lungcancer> [August 2005]

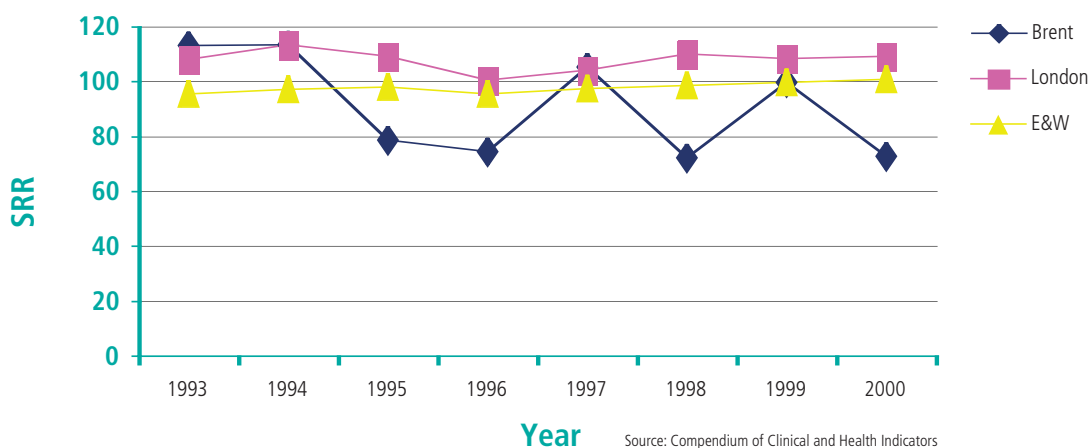
³⁴ General Household Survey, 2003. Office of National Statistics

³⁵ British Heart Foundation. Accessed at url: http://www.bhf.org.uk/smoking/sn_risk_group.s.asp [August 2005]



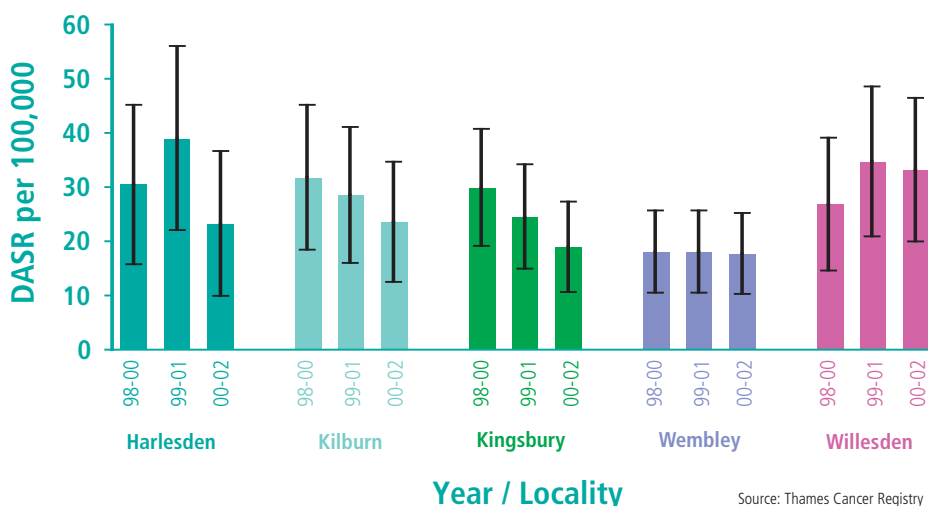
Between 1993 and 2000, the indirectly age standardised registration ratio for lung cancer in women in Brent was lower than both the London and England & Wales figures, although there is wide fluctuation in the Brent SRRs due to the small numbers involved.

Figure 66: Indirectly age standardised registration ratios for lung cancer in women, Brent, London and E&W, 1993 to 2000



The female directly age standardised lung cancer registration rates for Brent localities show that, for the time period 1998 to 2002, rates were generally lower in the Wembley locality (Figure 67). However differences between localities in that time period were not statistically significant. The low lung cancer registration rates seen in women in Wembley may be due to the high concentration of Asian BME groups in this locality. Smoking prevalence is known to be low amongst women from these ethnic groups.³⁶

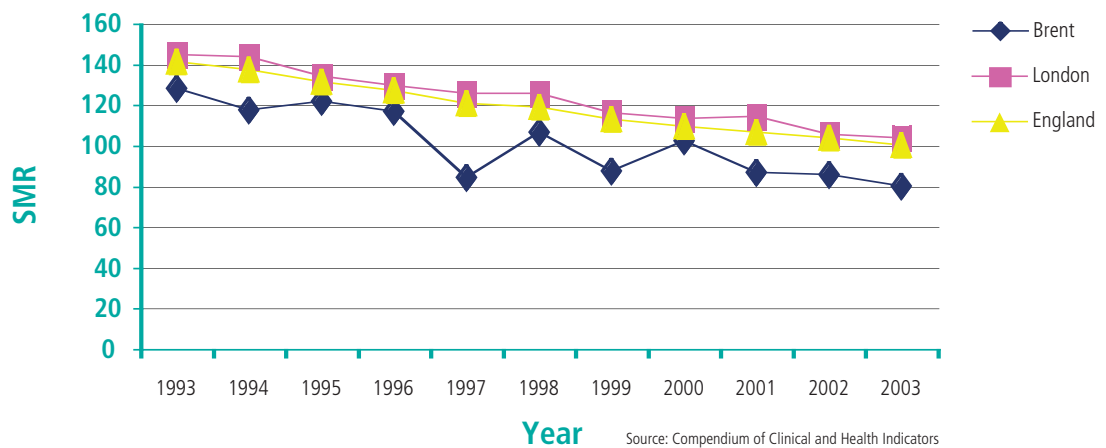
Figure 67: Directly age standardised registration rates for lung cancer in women in Brent, 3-year rolling averages 1998-2002



³⁶ British Heart Foundation. Accessed at url: http://www.bhf.org.uk/smoking/sn_risk_groups.asp [August 2005]

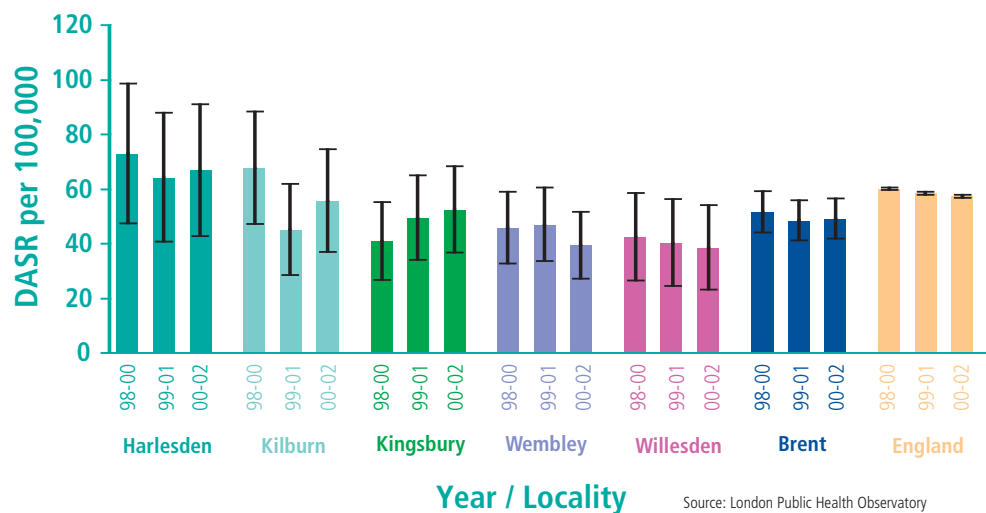
SMRs for lung cancer in men between 1993 and 2003 show that mortality from lung cancer in Brent is lower than in London or England and Wales for this time period.

Figure 68: SMRs for lung cancer in men, Brent, London and E&W, 1993 to 2003



The directly age standardised lung cancer mortality rates in men by locality for 1998-2002 are presented in Figure 69. In each time period, the overall Brent rate is significantly lower than the England rate. There is variation in DASRs by locality, with Harlesden locality having the highest lung cancer mortality rates in all three time periods. However, the difference between the five Brent localities is not statistically significant.

Figure 69: Directly age standardised mortality rates for lung cancer in men, Brent and England, 3-year rolling averages 1998-2002



Lung cancer mortality for Brent women also appears to be lower than for London and England as a whole. Lung cancer standardised mortality ratios for Brent women were generally lower than for women in London and England between 1993-2003 (Figure 70). The directly age standardised lung cancer mortality rate for women in Brent is significantly lower than the corresponding rates in London and England for the time period 1999-2002 (see Table 9).

Figure 70: SMRs for lung cancer in women, Brent, London and E&W, 1993 to 2003

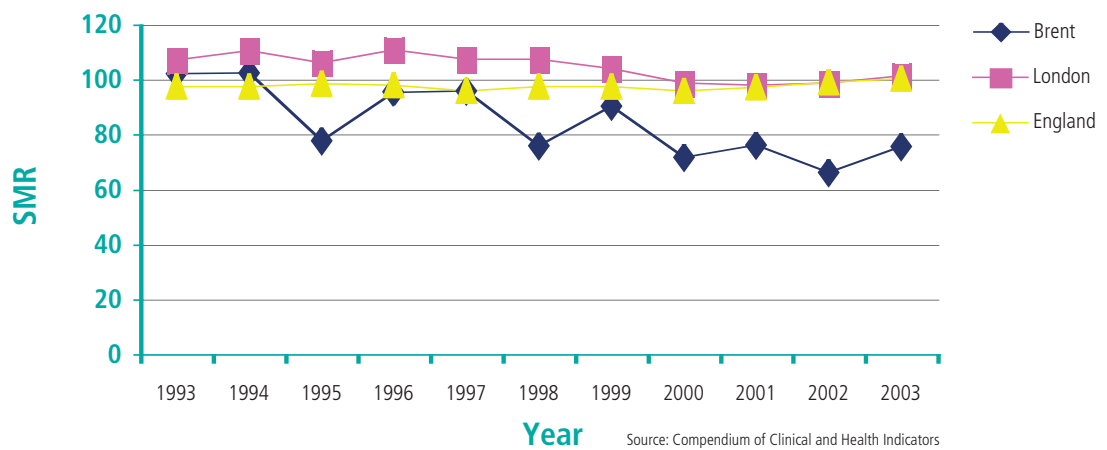


Table 9: Directly age standardised mortality rates for lung cancer in women, Brent, London and England, 3-year rolling averages 1998-2002

Area	Directly age standardised mortality rate (95% confidence intervals)		
	1998-2000	1999-2001	2000-2002
Brent	21.2 (16.8 to 25.6)	21.5 (17.1 to 26.0)	19.0 (14.8 to 23.1)
London	30.4 (29.4 to 31.4)	29.1 (28.1 to 30.1)	28.4 (27.4 to 29.4)
England	28.5 (28.1 to 28.8)	28.3 (28.0 to 28.6)	28.2 (27.9 to 28.6)

Source: London Health Observatory

Box 10: Smoking Cessation in Brent tPCT

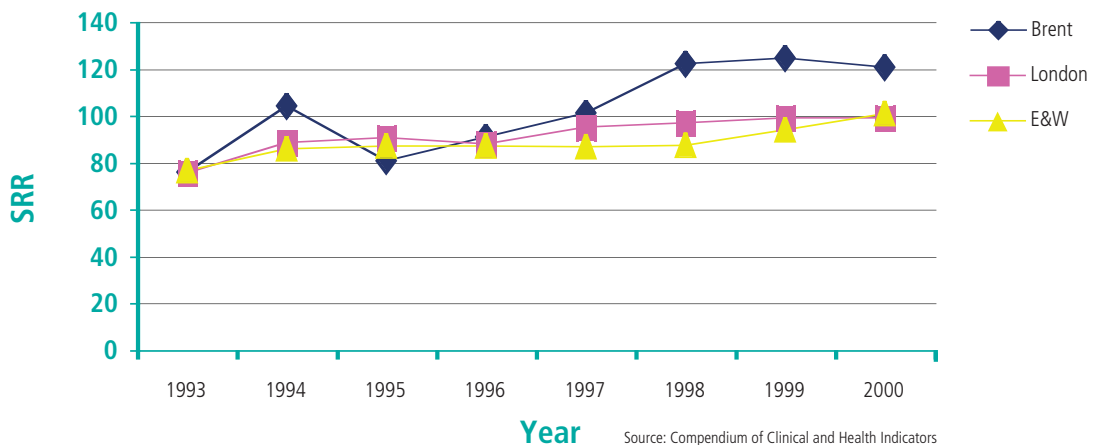
A survey of 400 Brent residents in 2002 showed that half of respondents had smoked tobacco at some time in their lives and a quarter remain smokers. Nearly half of all smokers would like to give up smoking a great deal, with just one in seven not interested in giving up. Brent PCT runs a smoking cessation service which offers support for smokers who want to give up. Support is available in the form of groups and one to ones, and via community advisors, email and telephone support. This support is offered in conjunction with nicotine replacement therapy as appropriate. Evidence shows that such interventions are effective at helping people to quit smoking. To access support call 020 8965 2244.

Prostate Cancer

A man has a 1 in 14 lifetime risk of developing prostate cancer,³⁷ although the disease is rare in men under the age of 50. Risk factors for prostate cancer include age (being over 65 years old), a family history of prostate cancer and a diet high in animal fats and proteins. Men of Asian and Oriental ethnic origin tend to have lower rates of prostate cancer.

Between 1993 and 2000 the number of new registrations of prostate cancer has been increasing. The indirectly age standardised registration ratios for prostate cancer in London and England and Wales, as well as in Brent, have increased during that time period (see Figure 71). Between 1997 and 2000 the incidence of prostate cancer in Brent was higher than the London and national figures.

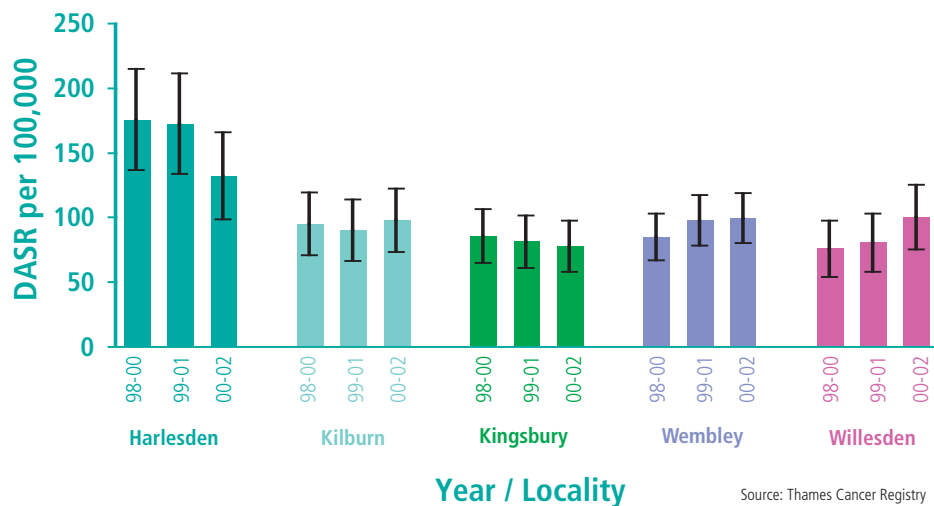
Figure 71: Indirectly age standardised registration ratios for prostate cancer, Brent, London and E&W, 1993 to 2000



The directly age standardised registration rates for prostate cancer by locality show that Harlesden has the highest incidence of prostate cancer for all three time periods between 1998 and 2002 (Figure 72). Moreover, in two of these time periods (1998-2000 and 1999-2001), the Harlesden rate was statistically significantly higher than the rates in the other localities.

³⁷ Cancer Research UK. Information about prostate cancer. Available at url: <http://www.cancerresearchuk.org/aboutcancer/specificcancers/prostatecancer> [Accessed August 2005]

Figure 72: Directly age standardised registration rates for prostate cancer in Brent, 3-year rolling averages 1998-2002



Source: Thames Cancer Registry

Table 10 below compares the directly age standardised mortality rate for prostate cancer in Brent to London and England for the time periods 1998-2000, 1999-2001 and 2000-2002. There are no statistically significant differences between the Brent rates and the London and England rates for each of these time periods.

Table 10: Directly age standardised mortality rate from prostate cancer in Brent, London and England 1998-2002

Region	Directly age standardised mortality rate (95% confidence intervals)		
	1998-2000	1999-2001	2000-2002
Brent	22.3 (17.2 to 27.3)	22.6 (17.6 to 27.7)	25.2 (19.9 to 35.4)
London	24.8 (23.8 to 25.7)	25.1 (24.1 to 26.1)	25.3 (24.3 to 26.2)
England	25.9 (25.6 to 26.3)	26.2 (25.9 to 26.5)	26.6 (26.2 to 26.9)

Source: London Health Observatory

Chronic Obstructive Pulmonary Disease

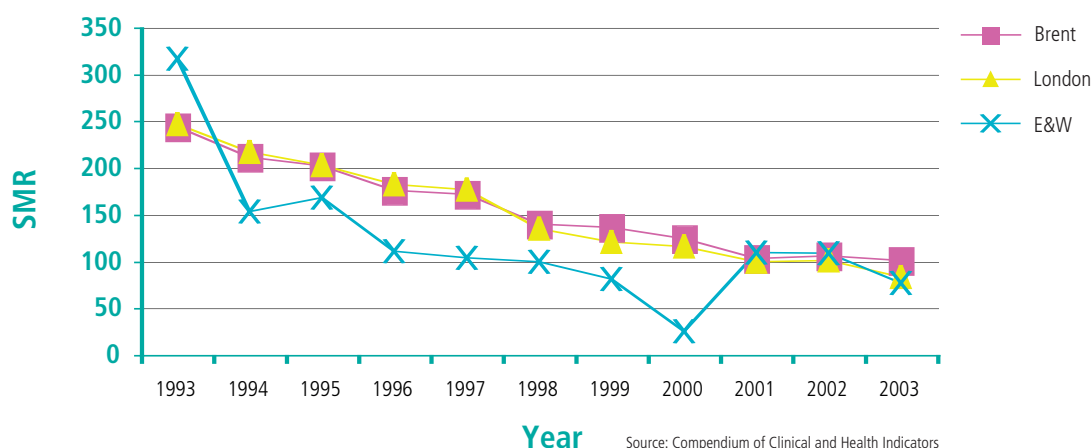
Chronic obstructive pulmonary disease (COPD) is a general term which includes the conditions chronic bronchitis and emphysema. Chronic bronchitis or emphysema can cause obstruction (or narrowing) of the airways. Chronic bronchitis and emphysema commonly occur together. The term COPD is used to describe airways which are narrowed due to chronic bronchitis, emphysema, or both.

COPD is common in the UK. It mainly affects people over the age of 40. It accounts for more time off work than any other illness. A flare-up (exacerbation) of COPD is one of the commonest reasons for admission to hospital.

Smoking is the cause in the vast majority of cases. The lining of the airways becomes inflamed and damaged by smoking. About 3 in 20 'one-pack-per-day' smokers, and 1 in 4 'two-pack-per-day' smokers develop COPD if they continue to smoke. Air pollution and polluted work conditions may play a part or make the disease worse. However, people who have never smoked rarely develop COPD.³⁸

The directly age standardised mortality rate for COPD for all persons in Brent was 2.4 per 100,000 in 2001-03.³⁹ The corresponding figures for London and England & Wales were 2.5 per 100,000 and 3.6 per 100,000 respectively. Figure 73 shows the trends in the standardised mortality ratios (standardised to the England 2003 population) for COPD for Brent, London and England and Wales between 1993 and 2003. Mortality in Brent from COPD broadly mirrors trends in the capital and nationally, with mortality declining between 1993 and 2003.

Figure 73: SMRs for COPD for persons in Brent, London and England & Wales, 1993 to 2003



³⁸ Patient UK. Available at url: <http://www.patient.co.uk/showdoc/23068705> [Accessed August 2005]

³⁹ Compendium of Clinical and Health Indicators (ongoing release).

Mental Health



Mental health problems are common. It is estimated that at any one time 1 in 6 of the population is suffering from a mental health problem.⁴⁰ Much of this mental health burden is mild to moderate disease, which in many cases is self limiting. However there is a wide range in both type and severity of mental ill health, with many people experiencing more severe and disabling forms of mental illness. National survey data puts the estimated prevalence of neurotic disorders at 17.3%, mixed anxiety and depression at 9.2%, obsessive compulsive disorder at 1.2% and schizophrenia at between 0.2 and 0.4%.⁴¹

The Centre for Public Mental Health in Durham devised a model in 2000 (called the MINI2K) which can be used to estimate the burden of mental illness in all boroughs in the country. Brent's MINI2K score is 1.08, which can be interpreted as, compared to the national average, you would expect 8% more admissions into secondary care for mental health problems in Brent. This suggests that the prevalence of more severe forms of mental illness in the borough is higher than the national prevalence. Data from the new Quality and Outcomes Framework for primary care show that the prevalence of severe and long-term mental illness recorded in general practice is 0.72%. This prevalence figure does not capture the full spectrum of people with mental illness, as it does not include those with mild to moderate disease.

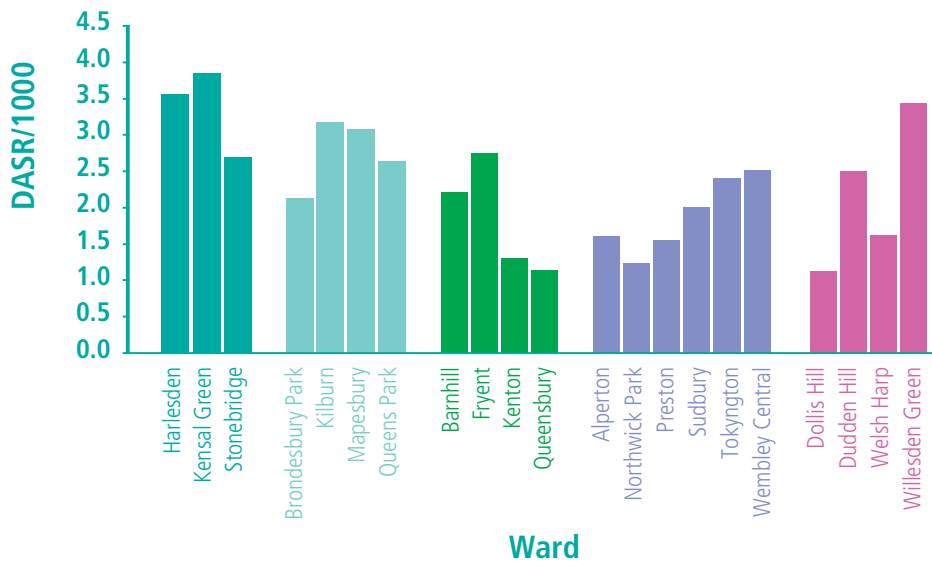
The management of mental health conditions requires input from a wide range of health professionals. The bulk of mild neurotic disorders are treated by primary health care professionals, mainly with a combination of medication and talking therapies. Other mental illnesses are managed by psychiatrists and specialist mental health nurses in both community and hospital settings.

Central and North West London Mental Health Trust (CNWLMHT) provides specialist mental health services for Brent residents. Figure 74 shows the average directly age standardised admission rates (DASRs) at ward level for Brent residents for the period 2002 to 2004 (pooled average). The DASRs range from 1.1 per 1000 in Queensbury and Dollis Hill wards to 3.9 per 1000 in Kensal Green ward. The figures suggest that Harlesden and Kilburn localities have the highest burden of serious mental illness in the borough. However, differences between wards should be interpreted with caution as the numbers are small and the variation observed may be due to chance alone.

⁴⁰ Office of National Statistics. Psychiatric morbidity among adults living in private households in Great Britain, 2000. Her Majesty's Stationery Office (HMSO): London, 2001

⁴¹ Birchwood, M et al. 1988, Schizophrenia - *an integrated approach to research and treatment*, Longman, London

Figure 74: Directly age standardised admission rates for Brent residents to Central and North West London Mental Health Trust, 2002-2004



The MINI2K model predicts that the annual number of inpatient psychiatric admissions (all causes) for adults aged between 16-59 in Brent should be 587. This compares to an actual yearly average (based on 2002-2004 data) of 551 admissions (2002/03-2004/05).

Mental Illness and Ethnicity

There is a substantial body of evidence which shows that people from certain ethnic groups, notably African Caribbean, African and Irish people, are over-represented in psychiatric hospitals.^{42,43}

For example, a study in south London found that Black populations have a rate of admission to medium-secure care 7-fold higher than their white counterparts: 28 per 100,000 population as compared to 4 per 100,000 population for white people.⁴⁴

Table 11 shows the average annual number of inpatient admissions of Brent residents to CNWLMHT by ethnic group for the pooled time period 2002 to 2004, and the crude admission rate per 100,000 for each ethnic group.

⁴² Wilson, M., Francis J., Raised Voices, Mind Publications. 1997.

⁴³ Smaje, C, 1995. Health, 'Race' and ethnicity: making sense of the evidence. London: King's Fund

⁴⁴ Guite, H et al., 1996. Diversion from courts and prisons to psychiatric inpatient care in a district. Unpublished report, Dept. of Health and Epidemiology, King's College London

Table 11 : Admissions of Brent residents to Central North West London Mental Health Trust by ethnic group

Ethnic Group	Annual number of admissions (3-year average 2002/03-2004/05)	Crude rate per 100,000
White	248	208
Black	214	409
Asian	86	118
Mixed	17	170

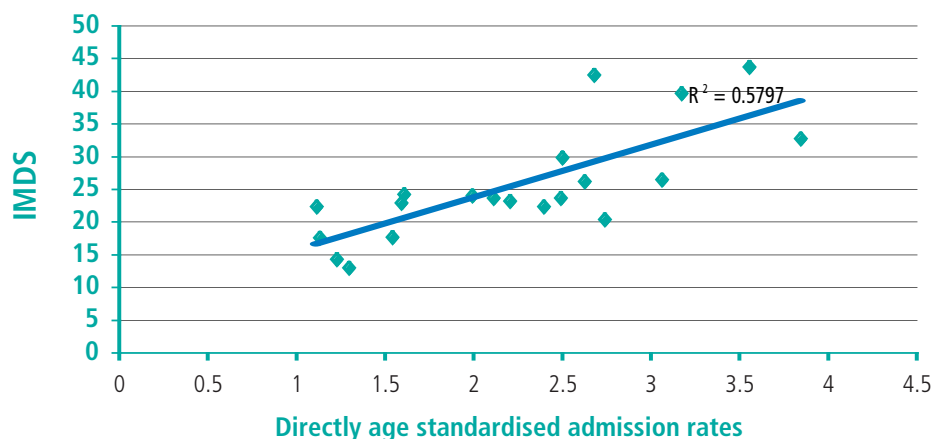
Source: CNWLMHT and 2001 Census

These figures only provide a broad indication of the rate of mental health admissions by ethnic group. Ethnicity coding for admissions is incomplete and may not be entirely accurate (6% of admissions have no ethnicity code). However, they do suggest that the ethnic composition of mental health admissions in Brent mirrors national trends, with a higher rate of admissions amongst Black minority groups.

Mental illness and deprivation

Deprivation is a known risk factor for mental illness. Figure 75 shows the correlation between directly age standardised admission rates to inpatient mental health services and IMD score at ward level in Brent. The graph shows that more than half (58%) of the variation in mental health admissions can be explained by deprivation.

Figure 75: Correlation between ward IMD score and directly age standardised rate of mental health inpatient admissions, Brent, 2002-04

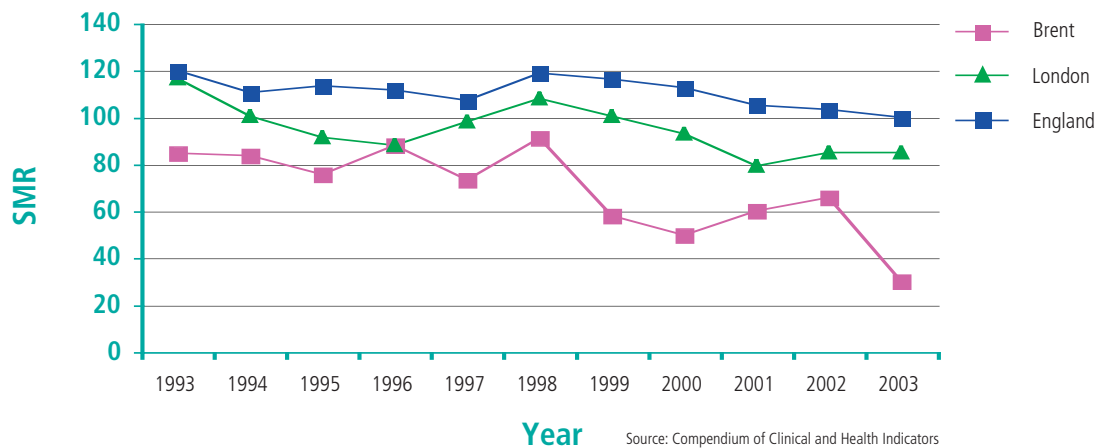


Source: CNWLMHT and Office of the Deputy Prime Minister

Suicide

Figure 76 compares the SMR for suicide for all persons in Brent between 1993 and 2003, to the figures for London and England. The actual annual number of suicides is small – suicide was recorded as the cause of death in only five deaths in the borough in 2003. Due to these small numbers of suicides at borough level, large fluctuations are seen in the SMR for Brent over time (14 deaths were recorded as suicide in 1998). The SMR for suicide in Brent has been lower than the SMR for London or for England between 1993 to 2003. The majority of suicides are in males.

Figure 76: SMRs for suicide, all persons, in Brent, London and England, 1993-2003



The Government white paper “Saving Lives: Our Healthier Nation” set a target to reduce the death rate from suicide and undetermined injury by at least 20% by the year 2010, from the baseline rate in 1998.

In Brent in 1998 the directly age standardised suicide rate for all persons was 5.74 per 100,000. By 2003 this rate had fallen to 1.74 per 100,000, which constitutes a 70% reduction. On the basis of this trend, Brent is on track to meet the target reduction set by the government. The PCT is currently developing a suicide strategy which aims to build on this reduction in the suicide rate, and reduce the number of suicides in the borough even further.

Infectious Diseases in Adults

Tuberculosis

Tuberculosis, or TB, is a disease caused by a germ (called the tubercle bacterium or *Mycobacterium tuberculosis*). TB usually affects the lungs, but can affect other parts of the body, such as the lymph nodes, the bones and (rarely) the brain. Infection with the TB germ may not necessarily develop into TB disease.

This disease used to be common in England and Wales. For example, in the mid-1930s, over 50,000 cases of TB were notified each year. These days it is much less common, although since the early 1990s the number of TB cases notified in the UK has been increasing. Nearly 7000 cases were reported in the UK in 2002, and 44% of these were in London.

Brent has one of the highest TB rates in the country. Table 12 presents data on the number of notified TB cases in persons aged 18 and over in Brent between 2000 and 2004. The rate of TB in Brent appears to be decreasing from its peak of 123.5 cases per 100,000 in 2000.

Table 12: TB cases and rate per 100,000 population in Brent, 2000-2004

Year	Number of notified case	Rate per 100,000
2000	261	123.5
2001	258	122.0
2002	213	100.3
2003	163	76.3
2004	147	68.5

Source: Health Protection Agency

HIV

The Survey of Prevalent HIV Diagnoses (SOPHID), which began in 1995, continues to provide the only national source of information on individuals with diagnosed HIV infection who are accessing HIV-related care. The survey measures prevalence of HIV, rather than new cases of infection (incidence). An increase in the prevalence of HIV may be due to more diagnoses of HIV being made, more people accessing care or people with HIV living longer.

Data for Brent PCT is available from 2001. (Prior to this date, data were reported at Health Authority level). Local trends for Brent PCT continue on from those trends previously seen at Health Authority level. In 2003, there were 627 people with diagnosed HIV resident in Brent and receiving treatment and care. There are more men with HIV receiving treatment and care than women, though the proportion of women being seen has increased in recent years. The majority of people captured by SOPHID are in the 25-39 age group; the age distribution of cases has been fairly static over time.

Table 13: Age profile of prevalent treated cases of HIV in Brent

Age group	2001		2002		2003	
	No.	%	No.	%	No.	%
0-14	24	5	20	4	26	4.2
15-24	19	4	25	5	22	3.5
25-39	272	56	298	53	339	54
40-54	139	29	187	33	194	31
55+	30	6	30	5	46	7.3
Total	484	100	560	100	627	100

Of diagnosed and treated cases of HIV in Brent, the largest proportion are of Black African ethnic origin. People of white ethnic origin form the second largest proportion of HIV cases.

Table 14: Ethnic origin of people with diagnosed HIV in Brent

Ethnicity	2001		2002		2003	
	No.	%	No.	%	No.	%
White	141	31	161	29	174	28
Black-Caribbean	30	6	38	7	47	7.5
Black-African	205	44	257	46	299	48
Black-Other	13	3	14	3	9	1.4
IPB	19	4	24	4	33	5.2
Other/mixed	38	9	37	7	26	4.1
Other			8	1	14	2.2
Asian/Oriental						
NK	14	3	21	3	25	4
Total	460	100	560	100	627	100

The main routes of exposure to HIV have altered over time. At the onset of the SOPHID survey in 1995, the largest number of infections were reported amongst men who have sex with men. Since 2000, the main reported route of exposure to HIV has been sex between men & women. In the latest survey (2003) the majority of people receiving treatment and care were asymptomatic.

Sexually Transmitted Infections

The main source of information on sexual health is the KC60 return, which measures workload in sexual health services and clinics, rather than the incidence of sexually transmitted diseases in local residents. These statistical returns give an idea of the amount of cases seen locally, but they are not necessarily all Brent residents. The Health Protection Agency also provides data on the numbers & rates of new episodes of selected sexually transmitted infections. These data generally show that London has higher rates of all sexually transmitted infections than the rest of the country.

Table 15 summarises data on the number of cases of infection seen within sexual health services in North West London in 2003, as well the numbers and rates of these infections in London and England.

Table 15: Numbers of new cases of sexually transmitted infections seen by North West London sexual health services, 2003

Infection	Northwick Park Hospital†	Patrick Clements Clinic, Central Middlesex Hospital†	London**		England**	
			Number	Rate/100,000	Number	Rate/100,000
Chlamydia	421	803	4982	272.1	85163	171.9
Gonorrhoea	106	369	1953	119.9	23432	47.3
Syphilis	3	2	230	9.8	1524	3.1
Herpes	83	163	1215	67.7	17115	34.6
Warts	228	323	3236	170.3	65196	131.6

Source: † KC60 returns; ** Health Protection Agency

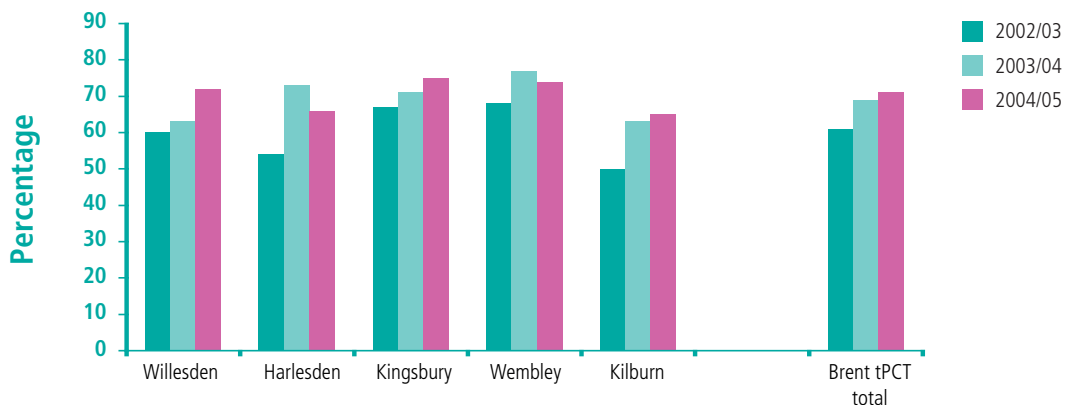
Influenza

Influenza or 'flu' is a respiratory illness associated with infection by the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. Illness associated with flu can range from minor symptoms through to pneumonia and death. There are two main types of influenza virus that cause infection: influenza A and influenza B. Influenza A usually causes a more severe illness than influenza B.

Routine vaccination is a way of protecting those people who are at high risk of infection from influenza. All people aged 65 and over, as well as people under 65 with certain chronic diseases are recommended to have an annual flu vaccination, and this is available free on the NHS. Flu vaccination is a safe and effective method of protecting against flu and its complications. Primary care practices offer the vaccine to their patients from September each year

In 2004/05 Brent PCT reached the 70% target set by the Department of Health for vaccinating residents aged 65 and over (see Figure 77). However, flu vaccination uptake varies by locality, with Kilburn having the lowest level of vaccination (65%) and Kingsbury the highest (75%).

Figure 77: Flu vaccination uptake amongst persons aged 65 years and over, by Brent locality



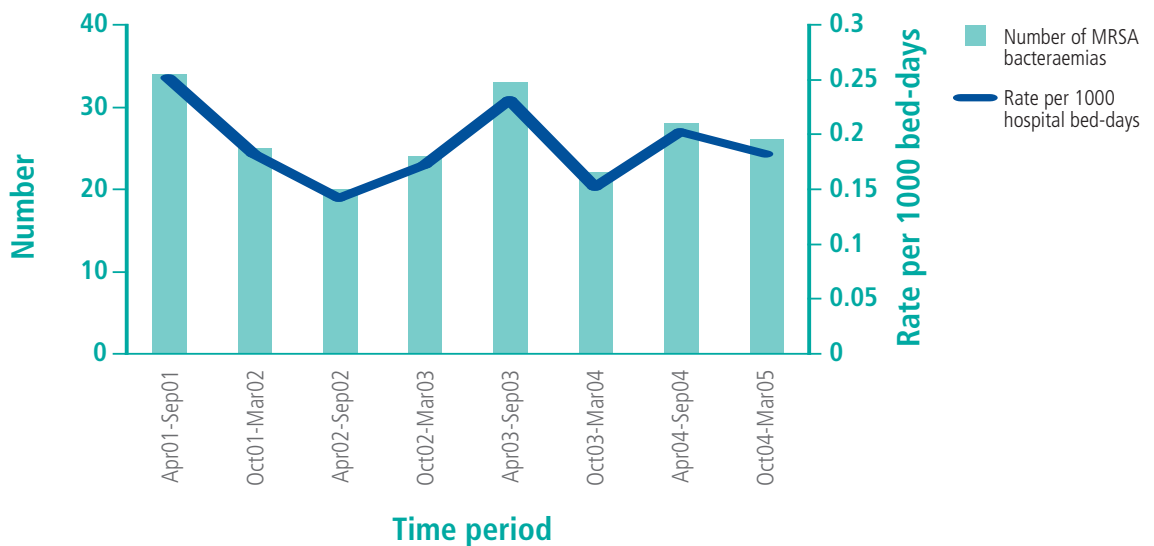
Methicillin-resistant *Staphylococcus aureus*

Staphylococcus aureus is a bacterium that lives on the skin and in the nose of about a third of normal healthy people. It can cause problems when it gets the opportunity to enter the body. This is likely to happen to people who are already unwell. *Staphylococcus aureus* can cause localised infections such as boils at the point of entry into the body. Occasionally it may then enter the blood stream (this is known as bacteraemia) and in some cases it can cause blood poisoning (septicaemia).

Infections caused by many varieties of *Staphylococcus aureus* are easily treated with antibiotics. MRSA stands for methicillin-resistant *Staphylococcus aureus*. It is a variety of *Staphylococcus aureus* that is resistant to some antibiotics, including methicillin. Around 44% of *Staphylococcus aureus* bacteraemias are methicillin resistant. MRSA is difficult to treat because only a few types of antibiotics are effective against it.

Figure 78 shows the number of patients who were diagnosed with MRSA bacteraemias in the North West London Hospitals NHS Trust (NWLHT) between April 2001 and March 2005. It also shows the MRSA bacteraemia rate per 1000 bed-days. Between October 2004 and March 2005 the NWLHT rate was 0.18 cases of MRSA bacteraemia per 1000 bed-days. This compares to 0.07 per 1000 bed days at the Liverpool Womens Hospital NHS Trust, which has the lowest rate of MRSA bacteraemias of all the teaching hospitals in the country. The highest rate of MRSA bacteraemias found in a teaching hospital in England in the time period above was 0.50 cases per 1000 bed days.

Figure 78: Number and rate per 1000 bed-days of MRSA bacteraemias in North West London Hospitals NHS Trust, April 2001 to March 2005



Box 10: Tackling MRSA in Brent

The government aims to halve the MRSA infection rate nationally by March 2008. Brent tPCT is working with NWLHT, the Health Protection Agency and Harrow PCT to develop a cohesive and co-ordinated strategy for the management and prevention of MRSA. A comprehensive surveillance programme for MRSA will soon be underway within all hospitals and other in-patient facilities within the borough. Early identification and treatment of MRSA infections will help improve the health outcomes in individual patients and also reduce the spread of infection through the hospital in-patient population. Good hygiene is very important in tackling MRSA. The PCT conducted a borough wide hand hygiene campaign earlier this year and the Infection Control Team are working closely with the shared Facilities service to review the PCT's environmental cleaning policy, to bring it in line with recent national guidance.

Glossary

Confidence Interval

The range of values within which we are 95% confident that the true population value lies.

Confidence Limits

The upper and lower values of a confidence interval.

Direct Age Standardisation

The directly age standardised rate for an indicator is the number of events that would occur in a standard population (per 100,000) if that population had the age-specific rates of a given area. The rates are standardised to the European Standard Population.

Directly Age Standardised Mortality Rates for Cancer

Directly age standardised mortality (DASM) rates have been supplied by the London Health Observatory for the five localities, Brent, London and England. Rates have been standardised to the European Standard Population. Standardisation adjusts rates to take into account any changes in the age structure of the population at risk and allows comparison over time and between different geographical locations. This data has not been supplied for some cancers due to small numbers of deaths experienced in the time periods of interest and the issue of confidentiality.

Directly Age Standardised Registration Rates for Cancer

Directly age standardised registration (DASR) rates have been calculated by the Thames Cancer Registry for the pooled time periods 1998-2000, 1999-2001 and 2000-2002 for the five localities in Brent. They have been standardised to the European Standard Population and allow comparison of the rates between localities irrespective of the different age profiles of the localities. They can be used as a proxy for cancer incidence.

General Fertility Rate

Number of live births per 1,000 females of childbearing age (between the ages of 15 and 44 years).

Incidence

Rate of occurrence of new cases of disease (within a given population over a given time period)

Index of Multiple Deprivation Score

This is calculated by scoring different dimensions of deprivation - income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services. A higher score implies greater deprivation. (For more information see the website of the Office of the Deputy Prime Minister <http://www.odpm.gov.uk>)

Indirectly Age Standardised Registration Ratios for Cancer

All cancers newly diagnosed in Brent residents are registered with the Thames Cancer Registry. Registration rates are used as a proxy for incidence rates. Indirectly age standardised registration ratios (SRRs) are supplied by the Compendium of Clinical Indicators and are given for Brent, London and England & Wales. SRRs measure how much more (or less) likely a person is to be registered with cancer in the three regions compared to someone of the same age and sex in the standard population (in this case the 2003 England population). Values higher than one hundred means there are more registrations than would be expected. Values lower than 100 mean fewer registrations are observed than would be expected. Confidence intervals are not supplied and therefore we do not know if the differences in SRRs between the three regions are statistically significant.

Infant Mortality Rate

The number of deaths of infants under age 1 per 1,000 live births in a given year.

Life Expectancy

Life expectancy is an estimate of the number of years a new-born baby would survive if they were to experience the particular area age-specific mortality rates for that time period they were born in throughout their lives.

Locality

Area consisting of several electoral wards. There are five localities in Brent.

Low Birthweight

Any baby weighing less than 2,500 grammes at birth.

Standardised Admission Ratios (SARs)

Admission rates calculated to enable fair comparison with another area allowing for the difference in age composition of the population. Expressed as a ratio to the average value - in this case England and Wales whose SAR is set to 100. Values greater than 100 indicate higher than average mortality. Values less than 100 indicate lower than average mortality.

Standardised Mortality Ratio (SMR)

The Standardised Mortality Ratio (SMR) is the ratio of the actual number of deaths in a population to the number of deaths one would expect if the population had the same death rate as the standard population (multiplied by 100). The standard population has an SMR of 100. SMRs greater than 100 indicate that the death rate in the population of interest is higher than the death rate in the standard population. Standardisation acts to even out the differences between populations with different age structures. If death rates were not standardised a higher death rate in one population compared to another may simply be because the population with the higher rate has a greater proportion of elderly people within it. Age cannot be a reason for different death rates once standardisation has taken place.

Star PUs

These are a way of comparing prescribing between general practices. Prescribing costs between practices may vary because practices have different population profiles. Star PUs are a method of standardising practice populations by age and sex for specific therapeutic groups.

Statistical Significance

The degree to which a value is greater or smaller than would be expected by chance. Throughout this report Brent has been compared to London and England (or England & Wales) with respect to many variables. If the Brent figure is described as statistically significantly different from the London or England figures, this means that we are 95% certain that the Brent value is truly higher or lower than the corresponding London/England figures it is being compared to.

Total Period Fertility Rate

The average number of live births that would occur per woman resident in the area, if women experienced the area's current age-specific fertility rates throughout their childbearing life span (namely at ages 15-44).

Ward

An administrative area that is laid down in statute. Brent has 21 wards.



Working with our partners for a healthier Brent

Contact us:

Brent tPCT

Postal address:

Trust Headquarters
116 Chaplin Road
Wembley
HA0 4UZ
Tel 020 8795 6000
www.brentpct.nhs.uk

For help on how
to stop smoking
and to get **FREE**
Nicotine Replacement
Therapy (NRT)
Tel 020 8965 2244

